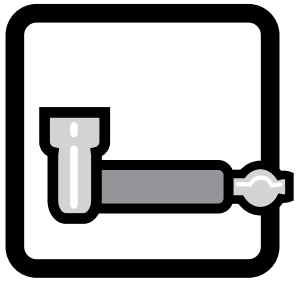
Low-threshold Care for Marginalised Hard Drug Users

Marginalisation and Socialisation in the Rotterdam Hard Drug Scene

Agnes van der Poel

Low-threshold Care for Marginalised Hard Drug Users

Marginalisation and Socialisation in the Rotterdam Hard Drug Scene



Agnes van der Poel

IVO

Low-threshold Care for Marginalised Hard Drug Users.
Marginalisation and Socialisation in the Rotterdam Hard Drug Scene.
A. van der Poel

Cover photo:
Design & print: Basement Grafische Producties, Den Haag
ISBN/EAN: 978-90-74234-85-6

Low-threshold Care for Marginalised Hard Drug Users

Marginalisation and Socialisation
in the Rotterdam Hard Drug Scene

Laagdrempelige zorg voor gemarginaliseerde harddruggebruikers

Marginalisering en socialisering in de Rotterdamse harddrugscene

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam
op gezag van de rector magnificus

Prof.dr. H.G. Schmidt

en volgens besluit van het College voor Promoties.

De openbare verdediging zal plaatsvinden op
woensdag 16 december 2009 om 11.30 uur
door
Jannigje van der Poel
geboren te Rhenen

ERASMUS UNIVERSITEIT ROTTERDAM

Promotiecommissie

Promotor
Prof.dr. H. van de Mheen

Overige leden
Prof.dr. M.C.H. Donker
Prof.dr. J. Wolf
Prof.dr. J.P. Mackenbach

Contents

chapter 1

General introduction

Chapter 1

General introduction

Aim

Since the early 1990s several developments have taken place in the hard drug scene in the Netherlands. Key elements in these developments were harm reduction measures, introduction of crack, open drug scenes, police interventions, drug-related nuisance, low-threshold care facilities and the well-being of drug users. Drug policy and drug scenes have also changed in the past 15 years.

The aim of this thesis is to provide insight into the role of low-threshold care facilities in the process of marginalisation and socialisation of drug users. Marginalisation entails that chronic hard drug users drift away from the core institutions of society, e.g. family and friends, the labour market and health care; socialisation is the opposite of marginalisation (Coumans, 2005). The roles that low-threshold care facilities can play are derived from this process. First, low-threshold care facilities can contribute to the discontinuation of marginalisation. Second, low-threshold care facilities can function as re-integration instruments. Both marginalisation and socialisation have their effects on individual drug users and on society in a broader perspective (in terms of public health and public safety). By understanding the role of low-threshold care facilities within a changing environment, these facilities can be utilised more effectively.

First, this chapter outlines the concepts of 'hard drug scenes and nuisance' and 'harm reduction and low-threshold care'. Then, Coumans' theory of marginalisation and socialisation is presented and the six chapters of this thesis are introduced. Finally, the methodology and data used are presented.

Hard drug scenes and nuisance

A hard drug scene is a concentration of drug users and drug dealers who come together at a certain location for a certain period of time (cf. Van der Torre & Van Galen, 2003). The most commonly involved drugs are opiates and crack [note 1]. Examples of locations are a certain house, street or neighbourhood, or a park, railway station or shopping centre. Drug scenes sometimes evolve around treatment or care facilities from the addiction treatment system or the social relief sector. Characteristic of a drug scene is that people

come together to buy, sell and (in many cases) to use drugs. Some users stay there for a short period (e.g. they only come to buy drugs), whereas others are there for longer periods of time (e.g. homeless users who buy and use crack, preferably all the time). The same applies to drug dealers and others who hang around, such as men who 'taxi' drug prostitutes to and from their working places. The police are often fully aware of the locations of drug scenes, as are those who live close to a drug scene (e.g. neighbours who may experience nuisance) and the general public (e.g. from police actions and newspaper articles). Social workers often have access to drug scenes and may provide drug users with, for example, blankets, soup, injection materials and information/education.

Drug scenes are often a cause of nuisance. A commonly used categorisation of drug-related nuisance distinguishes three elements: (1) criminal nuisance, (2) nuisance of public order, and (3) audiovisual nuisance (Bossaerts, 2002; Decorte et al., 2004; Snippe & Bieleman, 1999). Criminal nuisance is the most objective category because it concerns criminal activities (e.g. theft and burglary) to obtain money to buy drugs. Nuisance related to public order is less objective; this category includes annexation of public space, (street) fights, and noise and litter on the streets, which are not necessarily directly related to drug use. Audiovisual nuisance is the most subjective category. Feelings of unsafety and/or nuisance can arise or increase due to the occurrence of deviant behaviour and/or by the visible presence of marginalised groups in the neighbourhoods.

Harm reduction and low-threshold care

The Dutch drug policy is coordinated by the Ministry of Health, Welfare and Sport because drug use problems are mainly regarded as health problems. 'Harm reduction' is an important principle of the Dutch drug policy, meaning that it aims at the reduction of risks and harm caused by drug use, for individual users as well as for their direct environment and for society as a whole (Ministry of Health, Welfare and Sport, 1995; Trimbos Institute 2006). The International Harm Reduction Association (IHRA) defines harm reduction as the principle referring to policies, programs and projects which aim to reduce the health, social and economic harms associated with the use of psychoactive substances (www.ihra.net). Three goals are central in the Dutch drug policy: (1) the demand for drugs is discouraged by the existence of good quality prevention and treatment/assistance, (2) the supply of drugs is opposed by contesting organised crime, and (3) action is undertaken when and where drug use causes public or any other kind of nuisance (Verdurmen, Ketelaars & Van Laar, 2004). Evaluation of the Dutch drug policy showed that the goals of the harm reduction policy are not unambiguous: it is from the perspective of public safety (nuisance reduction), from the perspective of social deprivation (increase of physical and social functioning of the drug user without treatment of the addiction itself), and from the context that strives for protection of public health. The most important pilars of the harm reduction policy are low-threshold care facilities, methadone maintenance programs (including syringe exchange programs), and prevention of infectious diseases (Croes & Van Gageldonk, 2009).

Low-threshold care facilities are drug consumption rooms, day and night shelters, and supported housing; these facilities are run by the addiction care system and/or the social relief sector (in Dutch: maatschappelijke opvang) (cf Croes & Van Gageldonk, 2009). Some facilities are exclusively for drug users, others for otherwise marginalised people (e.g. psychiatric patients, homeless people). These care facilities have no

explicit aims to change the drug use patterns of their visitors or clients (in contrast to treatment facilities), but serve harm reduction purposes. Within the care facilities drug users have access to services that meet their everyday needs, e.g. a meal, shower, bed, and clean needles. In many cases, care facilities are set up to serve homeless drug users. Thus, the target groups of low-threshold care facilities can be defined as: (1) chronic drug users who are homeless – because many chronic drug users are (periodically) homeless. They can have access to drug consumption rooms, some shelters and some types of supported housing; and (2) homeless people among whom chronic drug users – because many chronic homeless people are drug or alcohol users. They can have access to some shelters and some types of supported housing.

The Dutch Federation of Shelters describes the main activity for day and night shelters as the provision of low-threshold shelter/refuge during the day (no possibilities for sleeping) for the first, and during the night, mostly in dormitories, for the latter (Planije & Wolf, 2004). Both have limited opening hours. In some cases the closing hours of day shelters are congruent with the opening hours of night shelters, and vice versa. Services that the shelters minimally provide are accommodation, information and advice, support, recreation, and washing. The target group of the shelters are homeless people and people with multiple problems who do not want or wish to make use of other available 24-hour agencies (such as supported housing). Aim of the provision of the basic services is that these people do not further marginalise. Planije & Wolf (2004) report in the 'Monitor Social Relief' on the developments in, for example, the capacity of the sector on a national level. In 2003, 58 day shelters and 52 night shelters (with a capacity of 2,418 and 1,170 places, respectively) were united in the Federation of Shelters. Information on unique persons making use of the shelters was not available for all facilities, but was available for the 19 day and 18 night shelters of the Salvation Army, a large contributor to the Federation. These latter day and night shelters had a capacity of 691 chairs and 464 beds, respectively, and 2,276 and 2,913 unique persons, respectively, making use of them. The 2003 capacity of the Salvation Army night shelters had doubled since 1999.
Croes & Van Gageldonk (2009) noted that there is no national overview of the size of the supply in drug consumption rooms/day and night shelters that are specifically used by drug users in the Netherlands. But they did report that social workers are under the impression that the size and content of the supply largely meet the needs of drug users, also geographically.

Supported housing can be provided in residential facilities (such as a 'social boarding house' or 'hostel') or for a limited number of hours per week to persons who live independently (ambulant). In 2002, 105 residential facilities, with a capacity of 3,327 places, were united in the national Federation of Shelters, as were 140 facilities that provide ambulant housing support, with a capacity of 2,859 places (Federation of Shelters, 2002). Since the late 1990s about 30 hostels for drug addicts were realised (Croes & Van Gageldonk, 2009). Hostels differentiate themselves from other residential facilities in that residents are allowed to use drugs privately in their own room.
Support can be provided in several life areas. Van den Berg (1997) differentiates four domains on which housing support can take place: material matters, day activities, practical housing skills and social network. The 'eight-phase model' is used in many supported housing facilities and within this model support can take place in eight life areas: housing, finances, social functioning, mental functioning, giving 'meaning' to life, physical functioning, practical functioning and day activities (Van Leeuwen & Heineke, 2004).

A drug consumption room is defined as a facility, run by a formal organisation, where chronic users, who normally use their drugs in public, have the opportunity for the hygienic and safe use of hard drugs in a non-judgemental environment (Barendregt, Van der Poel & Van de Mheen, 2002; Hedrich, 2004; Linssen, De Graaf & Wolf, 2002; Trimbos Institute, 2006). Drug consumption rooms have two main goals: reduction of drug nuisance and harm reduction for the users. All Dutch drug consumption rooms have a maximum number of clients and apply admission criteria, e.g. causing nuisance in a specific area, being homeless, being older than a specific age, and having a poor health and social situation (Linssen et al., 2002). Admission passes are granted to chronic drug users with multiple problems. Those users who are registered can use their drugs in the smoking or injection room. At a national level drug consumption rooms have limiting conditions: they must be small-scaled, drug dealers are not allowed in, and there are limits set to the length of stay (Croes & Van Gageldonk, 2009).
Between 2001 and 2003 the number of drug consumption rooms in the Netherlands increased by 12 to 32 (Bransen, Van 't Land & Wolf, 2004). Most of them (25) were run by the addiction care system. The function of a 'safety net' is most important: a place where users can use their drugs quietly. Additional services provided vary from refreshments, a sandwich and safe use of materials, to health education, primary health care and a postal address. In 2006 about 40 drug consumption rooms were operational in approximately 15 cities throughout the Netherlands (Croes & Van Gageldonk, 2009).

The quality of low-threshold care for chronic hard drug users can be considered poor (Van 't Land, Vruggink & Wolf, 2003). In the care for this group 67 tasks were identified and categorised in five domains: (1) basic care, (2) material help, (3) substance use, (4) medical and psychiatric care, and (5) coordination of care. Workers in the social relief sector, addiction care system, Public Health Services, psychiatric services (and the police) generally do not give care to chronic users on all of these domains. These workers mainly provide basic care ("bed, bath & bread") and assistance related to drug use. They seldom perform tasks such as actively approaching drug users, assisting with housing and day activities, nursing care, and follow-up care. However, these tasks are essential in the aim to improve physical and mental health, stabilise the situation of drug users, and work with them to improve their living conditions. Van 't Land et al. (2003) concluded that what many workers miss is what the drug users need most, i.e. intensive case management.

Theoretical framework and hypotheses

The role of low-threshold care facilities will be analysed within Coumans' theory of marginalisation among chronic heroin users (Coumans, 2005; Coumans, Barendregt, Van der Poel & Van de Mheen, 2001; Coumans & Spreen, 2003). Marginalisation refers to the process through which chronic heroin users drift away from the core institutions of society. Figure 1 shows the three dimensions in this process: social relations, sources of income and health. The social dimension refers to the changing relationships with family and friends, such that these relationships become more one-sided in the drug scene. The dimension sources of income (or the economic dimension) refers to the decreased accessibility to the regular labour market; many are dependent on social benefits and complementary income is often obtained illegally by, for example, property crime and drug dealing. The health dimension involves deteriorating personal health, indifference to health issues, and a distancing from the regular health system. Furthermore, the use

of crack and homelessness were identified as catalysts in this marginalisation process; however, that does not alter the fact that marginalised drug users are also more likely to be crack users and/or to be homeless. Socialisation refers to the process opposite to the process of marginalisation. External actors (bystanders, social work/addiction care, and police) have an effect on the process of marginalisation, either in strengthening the marginal position of drug users or in turning marginalisation into socialisation.

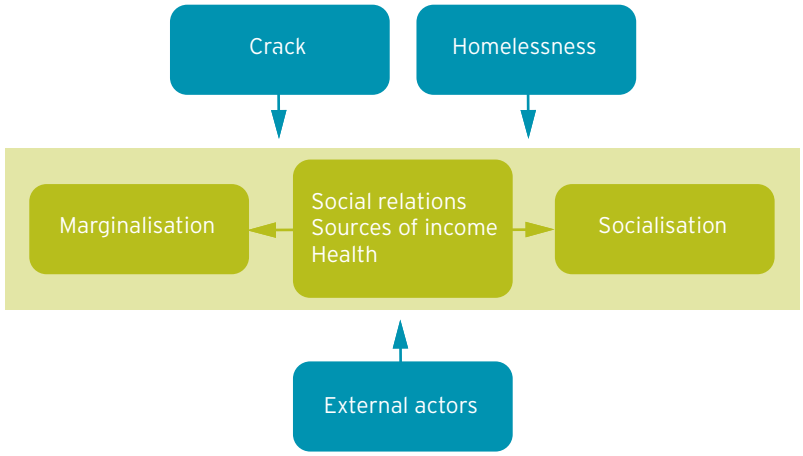


Figure 1. The process of marginalisation and socialisation (Coumans, 2005).

Regarding the influence of external actors, particularly the repressive policy as carried out by the police has received much attention. To further explore the influence of external actors, in this thesis we focus on the role of low-threshold care facilities in the process of marginalisation and socialisation.

In the 1980s and 1990s several Dutch cities had large-scale open drug scenes that caused nuisance for the environment (e.g. neighbours) and the general public (e.g. bystanders, shop owners). Harm reduction measures, such as methadone maintenance and syringe exchange programs, were important policy instruments carried out by the addiction care system with respect to improving the health situation of drug users and protecting public health (especially infectious diseases). For drug-related nuisance a policy of repressive measures was instituted and the police performed various repressive actions to reduce it, such as closing down open drug scenes and dealing houses [note 2]. Although there is no hard evidence, these repressive actions seem to have caused the drug scene to spread throughout the city into more 'hidden' smaller-scale scenes (Barendregt & Van de Mheen, in press; Hoogenboezem, Ensdorff & Croes, 2008; Van Ooyen-Houben et al., 2009; Wildschut, Lempens & Van de Most, 2003). From the mid-1990s onwards the drug policy changed: nuisance was no longer the domain of the police alone, care agencies and social work also started to play a role (whereas the harm reduction measures maintained their important role). An important example of this policy shift is the way in which the police and care agencies work together with homeless drug users. The catalysts 'crack use' and 'homelessness' come together

in the nuisance that is associated with homeless drug users (since they have no place to go, have lost control of their crack use, etc.). External actors have different means to reduce this nuisance: the police by repressive measures ('move on' policy, fining offences, etc.), and care agencies and social work reduce nuisance by, e.g., realising drug consumption rooms (for safe and quiet drug use inside) and supported housing projects. In general (not specifically for homeless drug users) the police and care agencies work together whenever possible since they pursue, at least in part, the same goal. This means that the well-being of drug users is becoming increasingly important in reducing nuisance. The state of their well-being is reflected in their social relations, sources of income, and health – the dimensions of the process of marginalisation and socialisation. Both marginalisation and socialisation have effects on individual drug users and on society in general (in terms of public health and public safety). For drug users the hypothesised role of low-threshold care facilities can be the following:

(1) low-threshold care facilities can contribute to the discontinuation of the process of marginalisation, meaning that drug users do not marginalise any further – through the dimensions social relations, sources of income and health;

(2) low-threshold care facilities can contribute to the start of the process of socialisation, meaning that drug users start to re-integrate into society – through the dimensions social relations, sources of income and health.

This thesis

The hypotheses stated above are presented in Figure 2.

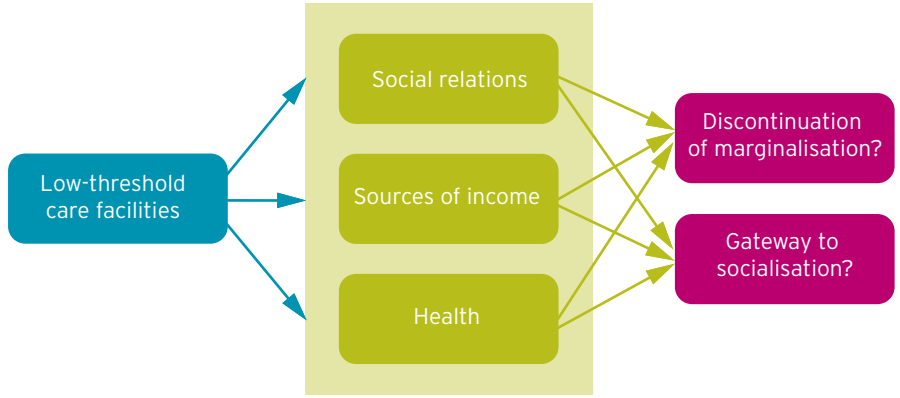


Figure 2. The possible effects of low-threshold care facilities on marginalisation and socialisation.

For this thesis we studied a selection of possible relationships. In the following chapters the effects of drug consumption rooms and the effects of health care integrated in low-threshold care facilities are addressed. Social relations, sources of income and health are discussed in several studies presented in this thesis. In the final chapter, general conclusions are drawn from these studies and related hypotheses are elaborated on.

In the various chapters, the following questions are addressed.

Is the process of marginalisation, as originally presented for adult drug users, also valid for adolescent crack users? (Chapter 2)
Coumans presented her theory for adult drug users. However, in the last decade the drug scene has changed in two major ways: (1) the mean age of chronic drug users is increasing, indicating that the drug scene as a whole is becoming older (and may perhaps be extinguished over time); however, young users are becoming new members of the drug scene; (2) these young users start their drug use career with crack, in contrast to most older users who started theirs with heroin. Main question is whether the process of marginalisation and socialisation is also valid for young users, and what dimension(s) are foremost in the process of marginalisation and/or socialisation.

What are the effects of policy measures (repression and care/treatment) on the living conditions of drug users in 2007, compared to 2003? (Chapter 3)
Drug use, homelessness and nuisance are intertwined. Until the mid-1990s Rotterdam executed its policy for reducing drug-related nuisance with (mostly) repressive measures; from 1996 onward repressive measures were used in conjunction with care provision for homeless drug users. From 2003 onwards, nuisance-causing drug users were forced to cooperate in an individual plan with a mixture of repressive and caring measures. Over the years low-threshold care facilities for homeless drug users were realised. Main question is whether the living conditions of drug users have changed over time, and to what extent changes can be attributed to the shift in policy measures.

What are the characteristics of drug users who make use of treatment and/or care agencies, and what is the role of low-threshold care agencies in the addiction care system? (Chapter 4)
Earlier studies compared treatment and non-treatment groups regarding their participation in the addiction care system. However, since care agencies have been included in the addiction care system, the concept of treatment has become more complex. In this study, drug users in the treatment group are divided into three groups: (1) only treatment agencies, (2) only care agencies, and (3) both treatment and care agencies. The fourth group consists of those who have contact with neither treatment nor care agencies. Characteristics of drug users in the four groups are compared, and the role of care agencies in the help-seeking process is examined.

What is the mobility of drug users, and can facilities be deconcentrated in order to reduce nuisance? (Chapter 5)
Drug users are most visible in neighbourhoods where many low-threshold care facilities are located, and those are the few neighbourhoods in which local residents experience the majority of all reported nuisance. Deconcentration of facilities, and thereby of drug users, is an ongoing theme of debate. Therefore, it is important to determine the level of attachment of drug users to these facilities, because the transfer of facilities can only be successful when drug users are prepared to go elsewhere to visit them. Deconcentration and mobility are linked; however, knowledge is lacking about actual mobility, and motives for mobility, of drug users.

For drug users, what are the effects of drug consumption rooms? (Chapter 6)
In the 1990s drug consumption rooms, where (homeless) drug users are given the opportunity to safely use drugs, were established in Rotterdam, some of them as part of official policy measures, the so-called 'Safe & Clean in Rotterdam' policy. Broader goals of these new low-threshold care facilities are the reduction of personal harm from drug use and the reduction of nuisance. Main question is how drug users who have an admission pass experience the drug consumption room they frequent and whether, from their viewpoint, the goals are reached.

What are the health characteristics of the Street General Practice's patients, how can changes be explained, and what factors contributes to the success of the practice? (Chapter 7)
The health situation is one of the marginalisation dimensions in Coumans' theory. Substance abuse, homelessness, physical problems and mental/psychiatric problems are intertwined. In Rotterdam, health care is available in low-threshold care facilities for all homeless people, including drug users. Primary health care is provided by 'Street General Practitioners', whose practice is called the 'Street General Practice'. Insight into (changes within) health characteristics of patients and into success factors of the practice is needed to further improve health care for the homeless.

In the final chapter (General conclusion and discussion) main conclusions are summarised and discussed within the context of Coumans' theory of marginalisation and socialisation. Furthermore, the methodology is addressed and implications for further research, policy and practice are elaborated on.

Data

Rotterdam, the Netherlands
The city of Rotterdam is used as the location of our one-case study. With about 600,000 inhabitants Rotterdam is the second-largest city in the Netherlands (Amsterdam has about 750,000 inhabitants). In total, the Netherlands has about 16.5 million inhabitants.

Rotterdam has several distinctive characteristics: the data presented here are derived from the websites of the Rotterdam Centre for Research and Statistics (www.cos.rotterdam.nl) and Statistics Netherlands (www.cbs.nl):

(1) Rotterdam is located in the west part of the country (near the North Sea) and has one of the world's largest and most important harbours. The river Maas divides the city into the southern part and the centre/west/northern part.
(2) Many have a non-Dutch cultural background; about 53% of the Rotterdam inhabitants have a Dutch cultural background, about 10% have a West (European) cultural background and about 37% have a non-Western cultural background. For the Netherlands as a whole these percentages are about 80% Dutch, about 9% Western and about 11% non-Western. Over 160 different nationalities are represented in the Rotterdam population, and large parts have their roots in Surinam, Turkey, Morocco, the Antillian Islands and Cabo Verde.

(3) Rotterdam is a relatively poor city: 16% of the Rotterdam households has an income below the Dutch poverty limit (national level: 9%). Furthermore, 58% of the households gain income through work, 16% through social or disabled benefits and 24% through state pensions (national levels: 65%, 9%, 24%, respectively).

Number of drug users

For 2008, it was estimated that there are about 2,000 problematic hard drug users in Rotterdam (Schoenmakers, Baars & Van de Mheen, 2009). In 2003, Rotterdam was estimated to have about 3,000 problematic hard drug users (Biesma, Snippe & Bieleman, 2004). Both studies used the same definition: problematic hard drug users are persons who for at least a minimum of one year use hard drugs (opiates, crack and similar drugs) daily or almost daily (three or more days a week in the previous month), and in addition who demonstrate one or more of the following characteristics:

- commit criminal activities to obtain money and thereby have been confronted with the police and/or judiciary;
- have psychiatric problems;
- have lifestyles that cause public nuisance;
- do not have their own housing, or in spite of having one's own housing stay mainly on the streets.

This definition excluded weekend users and problematic users of club drugs (ecstasy, amphetamines etc.) and users of cannabis/marihuana. For 2003 it was estimated that Rotterdam had 8.3 problematic hard drug users per 1,000 inhabitants aged 15-64 years.

In the 1990s the number of 'dependent heroin and cocaine users' in Rotterdam was estimated at about 4,000 persons (Rotterdam Public Health Service, 1999). Since then the number of problematic hard drug users seems to have halved.

On a national level, all estimations of the number of problematic hard drug users are estimations of the number of dependent opiate users who may or may not also use crack. Users who solely use crack were not taken into account. The most recent estimation was made with data from 2001; the estimation came to about 33,500 users (Smit, Van Laar & Wiessing, 2006), this means that 3.1 persons of every 1,000 inhabitants is a problematic (opiate) user (Trimbos Institute, 2008). Although the definitions are not entirely comparable, it can be argued that Rotterdam has relatively many (problematic) hard drug users per 1,000 inhabitants.

Monitoring the Rotterdam drug scene

From 1994 on, the Rotterdam drug scene was monitored with the 'Drug Monitoring System' (DMS; 1994-2003) and 'Trendspotting' (from 2006 onward), ordered by the Rotterdam Public Health Service. Both DMS and Trendspotting were (and are) carried out by IVO Addiction Research Institute. The studies on which the articles in this thesis are based were conducted within this framework [note 3].

The Rotterdam Drug Monitoring System (DMS) was a local information and observation system continuously collecting both quantitative and qualitative data about drugs, drug users and related issues, designed in the 1990s by Hendriks, Blanken, Adriaans & Vollemans (1994) [note 4]. The research population was the group of (nearly) daily users of crack, heroin and/or methadone. The focus of the DMS was on the drug user in his/her natural environment, or 'the daily life'. Because of this, the meaning of the described phenomenon could be interpreted in its natural context (cf. drug – set – setting; Zinberg, 1984).
The continuity of the research made it possible to report on trends and developments within and around the drug scene to, e.g., policy makers and care providers. Important themes of the DMS were: characteristics of the drug users' group, buying and using substances (type of substances, location of buying and use, route of administration, etc.), work and income, accommodation and housing, and physical and metal health situation (cf. the components of the Addiction Severity Index; Hendriks, Van der Meer & Blanken, 1991).

The research population is categorised as a so-called 'hidden population'. Characteristics of this group include: (1) there is no random sample framework, such as a registration system, for this group, (2) from the societal viewpoint belonging to such a group is seen as undesirable and/or controversial, and (3) the group is relatively small so that a random sample among the general population will produce insufficient power for analysis (Heckathorn, 1997). Therefore, the DMS combined qualitative and quantitative methods in their research. The three methods used were daily community fieldwork, a periodical survey, and interviews with key informants (professionals and drug users), see Figure 3.
In the DMS community fieldworkers were important. As part of the studied group of (nearly) daily drug users, they had knowledge from and experience with the drug scene that went beyond the scope of professional researchers (Blanken, Barendregt & Zuidmulder, 2000). The community fieldworkers played a significant role in carrying out the fieldwork (writing field notes about their day-to-day life and extraordinary experiences) and assisting with the survey (in making the ethnographic map needed for targeted sampling, as guides in respondent recruitment or as interviewers in face-to-face data collection).

Qualitative research methods (especially when used to study a hidden population) always raise questions with respect to internal and external validity of results. Therefore, the DMS applied the criteria of Lincoln & Guba (1985) to their research. These criteria are: credibility, transferability, dependability and confirmability; all referring to the overall criterion of 'trustworthiness' of data and results. It was shown that it was possible to include strategies to meet these criteria of trustworthiness, and these were triangulation, prolonged engagement, persistent observation, member checks, peer debriefing, negative case analyses, thick description and a reflexive journal (Van de Mheen, Coumans, Barendregt & Van der Poel, 2006). Especially the technique of triangulation was important. The DMS used methodological triangulation in a complementary model, meaning that information gathered with one method is used to supplement the results from other methods (see Figure 3).

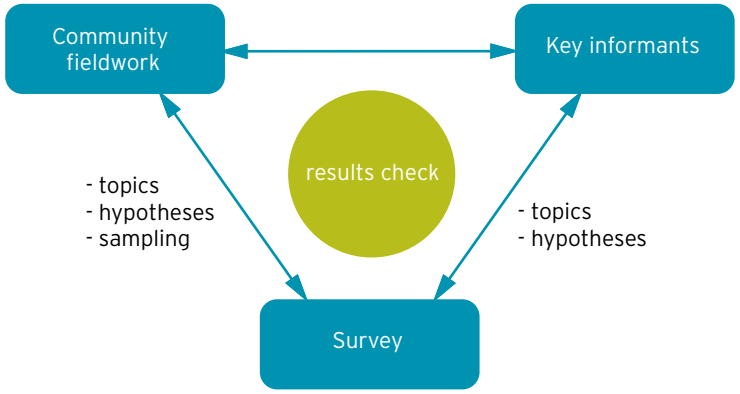


Figure 3. Complementary methods used in the Drug Monitoring System (Van de Mheen et al., 2006).

The DMS was active from begin 1994 to end 2003. Then, for two years the Rotterdam Public Health Service stopped data collection and analysis in and around the drug scene. In that time the main policy aims shifted from the topic of drug users and the drug scene to the topic of homeless people and the homeless scene. Because both are intertwined, IVO was asked to further monitor the drug and homeless scenes. The framework in which these annual studies took (and take) place is called 'Trendspotting'. Instead of a continuous information system, a special topic (and corresponding methodology) is chosen. In 2006 the Rotterdam policy of the past 15 years was described (Barendregt & Van de Mheen, in press). In 2007 a structured face-to-face interview survey was held among 118 marginalised drug/alcohol users and homeless people and interviews were held with police officers (Barendregt & Van der Poel, 2008); the goal was to describe the current living situation of the target groups. In 2009 interviews were held with 25 residential homeless people to find out what they perceive as a 'meaningful life' for themselves, i.e. social relations and day activities; results will be discussed with policymakers and implementors (police, social work).

Data sources used in this thesis

For the studies described in this thesis, data from both DMS and Trendspotting were used. For the study described in Chapter 7, also registration data from the primary health care system for the homeless were analysed, and combined with survey data among health care professionals.

Issues related to the generalisability of the results will be discussed in the General conclusion and discussion (Chapter 8).

Notes

[1] To enhance readability, in the remainder of this thesis we use 'drugs', 'drug use' and 'drug users' to indicate 'hard drugs', 'hard drug use' and 'hard drug users'.

[2] The city of Utrecht, for example, had the Passage (Tunnel); a passage under a shopping mall that gave access to the shops for deliveries and supplies, etc. Many drug users resided in the Passage, some for short periods per day or week, others were there 24/7. The Passage was closed in 2001, resulting in the spread of drug users and dealers throughout adjacent neighbourhoods (Wildschut, Lempens & Van de Most, 2003). In 2002 three drug consumption rooms were opened and 250 drug users received an admission pass.
The city of Rotterdam had Platform Zero (Perron Nul), a large open drug scene near the central railway station (Blanken, Vollemans, Verveen, Hendriks & Adriaans, 1995). Crack was introduced in the early 1990s and contributed to the 'hurriedness' of the Rotterdam drug scene (Blanken, Barendregt & Zuidmulder, 1999; Barendregt, Van de Mheen & Blanken, 1999; Grund, Adriaans & Kaplan, 1991). Because of its considerable size Platform Zero became unmanageable, and some lethal incidents occurred. In 1994 and 1995 the Rotterdam police undertook repressive action. First, Platform Zero was closed down and drug users and dealers were then mainly visible in the West and South part of the city. Second, under 'Operation Victor' the police arrested local and international drug dealers that operated in nuisance-causing dealing houses. With the closure of many of these dealing houses, small-scale drug dealing, specifically for the local users, began to increase (Barendregt, Lempens & Van de Mheen, 2000).

[3 In 2004 and 2005 IVO executed a 'mini DMS', meaning that a limited amount of time was spent on fieldwork carried out by the former coordinator of the community fieldwork. Aim was to monitor the drug and homeless scene from a distance. During these years IVO conducted research within the drug and homeless scenes, e.g. the functioning of the Street General Practice (see Chapter 7).

[4] Drug Monitoring Systems were also carried out in the city of Utrecht (1998-2003) and the city of Heerlen/region Parkstad Limburg (1998-2006).

References

Barendregt, C., Lempens, A., & Van de Mheen, D. (2000). Drugs kopen op straat. Achtergronden en motieven van Rotterdamse druggebruikers die bij straatdealers kopen [Buying drugs on the street. Background and motives of Rotterdam drug users who buy from street dealers]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., & Van de Mheen, D. (in press). "Then there was silence on the streets". Developments in the street scene of Rotterdam in the last decade. Drugs: education, prevention and policy.

Barendregt, C., Van de Mheen, D., & Blanken, P. (1999). Het roken van cocaïne-base in Rotterdam; de invloed van gebruikslocatie en zelfcontrolemechanismen [Smoking crack in Rotterdam; the influence of using location and self-control mechanisms]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., & Van der Poel, A. (2008). Dak- en thuislozen en verslaafden in Rotterdam: leefsituatie en overlast. Resultaten van Trendspotting 2007 [Homeless people and drug users in Rotterdam: living conditions and nuisance. Results of Trendspotting 2007]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., Van der Poel, A., & Van de Mheen, D. (2002). Gebruiksruimten in het perspectief van gezondheidsbevordering en overlastvermindering [Drug consumption rooms in the perspective of health promotion and nuisance reduction]. Rotterdam: IVO Addiction Research Institute.

Biesma, S., Snippe, J., & Bieleman, B. (2004). Harddrugsgebruikers geregistreerd. Aard, omvang en mobiliteit van problematische harddrugsgebruikers in Rotterdam [Hard drug users registered. Nature, extent and mobility of problematic hard drug users in Rotterdam]. Groningen/Rotterdam: Intraval, bureau for research and consultancy.

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community field work: bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291–296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

Blanken, P., Barendregt, C., & Zuidmulder, L. (1999) The evolution of crack and basing cocaine in the Rotterdam heroin scene. Journal of Drug Issues, 29(3), 609-626.

Blanken, P., Vollemans, L., Verveen, J., Hendriks, V., & Adriaans, N.F.P. (1995). Perron Nul en de bezoekers die er kwamen. Het Rotterdams Drug Monitoring Systeem – 1994 [Platform Zero and the visitors that came there. The Rotterdam Drug Monitoring System – 1994]. Rotterdam: IVO Addiction Research Institute.

Bossaerts, B. (Ed.) (2002). Naar minder hinder: draaiboek aanpak drugsoverlast [Towards less nuisance, scenario approach drug nuisance]. Brussels: VAD, Vereniging voor Alcohol- en andere Drugproblemen vzw.

Bransen, E., Van 't Land, H., & Wolf, J. (2004). Gebruiksruimten, trends 2001-2003 [Drug consumption rooms, trends 2001-2003]. Utrecht: Resultaten Scoren / Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Coumans, A.M. (2005). Survival on the fringes of society. Marginalisation and hardening among chronic heroin users. Maastricht: University of Maastricht (dissertation).

Coumans, M., Barendregt, C., Van der Poel, A., & Van de Mheen, H. (2001). Marginalisering en verharding in het perspectief van de Rotterdamse drug scene [Marginalisation and hardening in the perspective of the Rotterdam drug scene]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalisation. Substance Use & Misuse, 38(3-6), 311-338.

Croes, E., & Van Gageldonk, A. (2009). Preventie en harm reduction [Prevention and harm reduction]. In M. van Laar, M. van Ooyen-Houben (Eds.). Evaluatie van het Nederlandse drugsbeleid [Evaluation of the Dutch drug policy]. Utrecht / The Hague: Trimbos Institute, Netherlands Institute for Mental Health and Addiction / WODC, Research and Documentation Centre for the Ministry of Justice.

Decorte, T., De Ruyver, B., Ponsaers, P., Bodein, M., Lacroix, A.C., Lauwers, S., & Tuteleers, P. (2004). Drugs and nuisance. Study of the phenomenon, the control and the effects of drug-related nuisance from different perspectives. Gent: Academia Press.

Federation of Shelters (2002). De maatschappelijke opvang in figuren en cijfers [Social relief sector in facts and figures]. Utrecht: Federation of Shelters.

Grund, J.P., Adriaans, N.F., & Kaplan, C.D. (1991). Changing cocaine smoking rituals in the Dutch heroin addict population. British Journal of Addictions, 86(4), 439-448.

Heckathorn, D.D. (1997). Respondent-driven sampling: a new approach of the study of hidden populations. Social Problems, 44(2), 174-199.

Hedrich, D. (2004). European reaport on drug consumption rooms. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Hendriks, V.M., Blanken, P., Adriaans, N.F.P., & Vollemans, L.C. (1994). Continue gegevensverzameling over druggebruik: de opzet van een locaal Drug Monitoring Systeem (DMS) [Continuous data collection about drug use: the design of a local Drug Monitoring System (DMS)]. Rotterdam: IVO Addiction Research Institute.

Hendriks, V.M., Van der Meer, C.W., & Blanken, P. (1991). De Addiction Severity Index: ASI ®. Handleiding bij training en afname [The Addiction Severity Index: ASI ®. Manual for training and administering]. Rotterdam: IVO Addiction Research Institute.

Hoogenboezem, G., Ensdorff, J., & Croes, E. (2008). Basecoke en infectieziekten. Risicogedrag en gezondheid onder gemarginaliseerde basecokegebruikers in Nederland [Crack and infectious diseases. Risky behavior and health among marginalised crack users in the Netherlands]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Lincoln, Y.S., & Guba, G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage Publications.

Linssen, L., De Graaf, I., & Wolf, J. (2002). Gebruiksruimten in beeld. Handreiking bij de organisatie en inrichting [Drug consumption rooms in sight. Manual to the organisation and set up]. Utrecht: Resultaten Scoren / Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Ministry of Health, Welfare and Sport (1995). Het Nederlandse drugbeleid: continuïteit en verandering [The Dutch drug policy: continuity and change]. The Hague: Ministry of Health, Welfare and Sport.

Municipality of Rotterdam (1999). Factsheet: de hoofdlijnen van het gemeentelijk verslavingszorgbeleid in Rotterdam [Factsheet: the outline of the municipal addiction care policy in Rotterdam]. Rotterdam: Rotterdam Public Health Service.

Planije, M., & Wolf, J. (Eds.) (2004). Monitor Maatschappelijke Opvang. Jaarbericht 2004 [Monitor Social relief and care. Year report 2004]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.
Schoenmakers, T.M., Baars, J., Van de Mheen, D. (2009). Schatting van het aantal problematisch hard-druggebruikers in Rotterdam voor 2008 [Estimation of the number of problematic hard drug users in Rotterdam in 2008]. Rotterdam: IVO Addiction Research Institute.

Smit, F., Van Laar, M., & Wiessing, L. (2006). Estimating problem drug use prevalence at national level: comparison of three methods. Drugs: education, prevention and policy, 13(2), 109-120.

Snippe, J., & Bieleman, B. (1999). Buurten over last. Monitoren van drugsoverlast in de SVO-gemeenten 1993-1998 [Neighbourhoods about nuisance. The monitoring of drug nuisance in the SVO municipalities 1993-1998]. Groningen/Rotterdam: Intraval, bureau for research and consultancy.

Trimbos Institute (2008). The Netherlands drug situation 2007. Report to the EMCDDA by the Reitox National Focal Point. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Trimbos Institute (2006). Prevention and reduction of health-related harm associated with drug dependence. An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003. Synthesis report. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Van de Mheen, H., Coumans, M., Barendregt, C., & Van der Poel, A. (2006). A Drug Monitoring System: keeping a finger on the pulse by triangulation of qualitative and quantitave methods. Addiction Research and Theory, 14, 461-473.

Van den Berg, R. (1997). In huiselijke sfeer, methodiek van de woonbegeleiding [In domestic atmosphere, methodology of supported housing]. Utrecht: NIZW.

Van der Torre, E.J., & Van Galen, A.C.E. (2003). Strategische drugsanalyse. Empirische scan in drie deelgemeenten, operationalisatie [Strategic drug analysis. Empirical scan in three boroughs, operationalisation]. The Hague: Institute for Safety, Security and Crisis Management.

Van Leeuwen, P., & Heineke, D. (2004). Het 8-fasen model. Planmatig werken in de maatschappelijke opvang [The eight fase model. Working systematically in the social relief sector]. Utrecht: NIZW.

Van Ooyen-Houben, M., Bieleman, B., Biesma, S., Snippe, J., Van der Wagen, W., & Beelen, A. (2009). Drugsgerelateerde overlast [Drug-related nuisance]. In M. van Laar, M. van Ooyen-Houben (Eds.). Evaluatie van het Nederlandse drugsbeleid [Evaluation of the Dutch drug policy]. Utrecht / The Hague: Trimbos Institute, Netherlands Institute of Mental Health and Addiction / WODC, Research and Documentation Centre of the Ministry of Justice.

Van 't Land, H., Vruggink, J., & Wolf, J. (2003). Van later zorg? Over de kwaliteit van de laagdrempelige zorg voor langdurig verslaafden [Of later care? On the quality of the low-threshold care for chronic addicts]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Verdurmen, J.E.E., Ketelaars, A.P.M., & Van Laar, M.W. (2004). Factsheet Drugsbeleid [Factsheet Drug policy]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Wildschut, J., Lempens, A., & Van de Most, D. (2003). 'Na de tunnelsluiting': een onderzoek naar de eerste effecten van de verandering in de Utrechtse harddrugscene. Rotterdam: IVO Addiction Research Institute.

www.IHRA.net (International Harm Reduction Association): accessed August 2008.

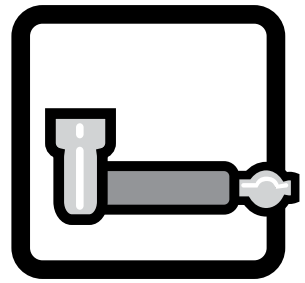
www.COS.ROTTERDAM.nl (Centre for Research and Statistics of the municipality of Rotterdam): accessed August 2009.

www.CBS.nl (Statistics Netherlands): accessed August 2009.

Zinberg, N. (1984). Drug, set and setting. The basis for controlled intoxicant use. New Haven/London: Yale University Press.

chapter 2

Young people using crack and the process of marginalisation



Chapter 2

Young people using crack and the process of marginalisation

Published as
Van der Poel, A., & Van de Mheen, D. (2006). Young people using crack and the process of marginalisation. Drugs: education, prevention and policy, 13(1), 45-59.

Abstract
Thirty current and former crack users aged 16-24 years participated in a qualitative study about their crack use and related behaviours. The study investigates the process of marginalisation (social relations, sources of income and health situation) before and after the start of crack use. Results show that because many crack users were raised in a problematic home situation and have little education, they were already in a marginal position before they started using crack. However, the use of crack accelerated the process of marginalisation, because they experienced a shrinking social network that developed around other users, and because they performed illegal activities to buy crack. As result, many users spent time in prison. Regarding health, they experienced respiratory problems, deteriorating physical fitness, paranoia and heart palpitations. Furthermore, homelessness and crack use are intertwined.

Introduction
Little is known about the use of crack amongst young people and the role crack plays in their lives. Some studies have explored the relationship between crack use and (preceding) problems in other areas. In Western Europe crack is mainly used by marginalised juveniles, i.e. juveniles from socially deprived neighbourhoods/young migrants, and young male and female prostitutes (Nabben & Korf, 1999; Stoever, 2002). Studies have shown that multiple social deprivation is the underlying cause of problematic crack use (Evans, Forsyth & Gauthier, 2002; Hardwick & Kershaw, 2003; Johnson, Dunlap & Maher, 1998).

Hardwick & Kershaw (2003) studied the needs of crack users aged 18-35 years, and found that their needs are poorly met because "crack-cocaine use cannot be separated from problems of poverty, long-term unemployment and lack of opportunities/new experiences for users and their communities" (p.133). Evans et al. (2002) reported that crack addicts were likely to have experienced a childhood plagued with emotional and/or physical abuse, a finding consistent with earlier American studies (e.g. Chitwood, Rivers, Inciardi & The South Florida AIDS Research Consortium, 1996; Cohen & Stahler, 1998; Ratner, 1993). Two main routes from an abused childhood to crack use are through self, medication (e.g. Kandel & Davies, 1996) and through standards of family conduct (e.g. Johnson et al., 1998). Both these routes into crack use are found in Dutch youth (Van der Poel, Hennink, Barendregt & Van de Mheen, unpublished manuscript).

All respondents and interviewees in the above studies fit into the categories of 'immersed' and 'grappling' crack users within the typology of crack users proposed by German & Sterk (2002), which is based on varying levels of control of crack use. 'Immersed' crack users are those who most fit the public stereotype of crack users; their lives tend to be dominated by crack use that they cannot control and they are unable to solve their many problems alone. 'Grappling' users are those who have few protective mechanisms; they have moved from a marginal position outside the crack scene to a marginal position within the scene. They describe their crack use as an escape from continuous daily problems. As well as these two categories, German & Sterk (2002) also described 'stable' and 'tempted' users. 'Stable' users smoke occasionally and have a highly structured daily life with a job and social relationships with non-users (protective factors). 'Tempted' users use crack more frequently and face the risk of chaotic use, especially after negative experiences such as losing a job or accommodation, or becoming increasingly alienated from non-using friends.

The present study focuses on the role crack plays in the lives of young drug users and is based on a description of relatively young crack users (16-24 years old) in the city of Rotterdam, in the Netherlands. The framework for our description is the theory of marginalisation among chronic drug users (Coumans, 2005; Coumans, Barendregt, Van der Poel & Van de Mheen, 2001; Coumans, Neve & Van de Mheen, 2000). Marginalisation refers to the process through which chronic drug users drift away from the core institutions of society, and explains how chronic drug users fit into one of German & Sterk's categories. Figure 1 shows the three dimensions in the process of marginalisation: social relations; economic situation; and health situation. Furthermore, the use of crack and homelessness are catalysts in this process (Coumans & Spreen, 2003). Socialisation refers to the process opposite of the process of marginalisation. External actors (bystanders, social workers/addiction care, and police) have an influence on the process of marginalisation, either in strengthening the marginal position of drug users or in turning marginalisation into socialisation.

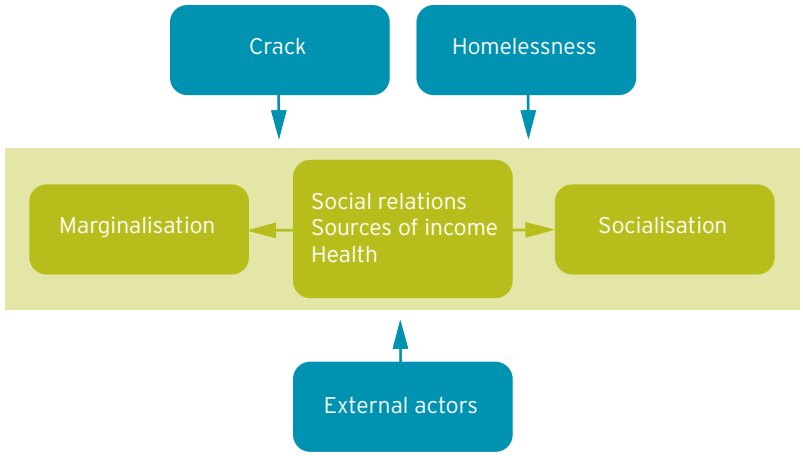


Figure 1. The process of marginalisation and socialisation (Coumans, 2005; Coumans et al., 2001, 2000).

Marginalisation means that chronic drug users become increasingly distanced from core institutions such as the labour market and health care. The social dimension refers to the changing relationships with family and friends, such that they become more one-sided in the drug scene. The economic dimension refers to the decreased accessibility to the regular labour market; income is often obtained illegally by, for example, theft/stealing and drug dealing. The health situation involves deteriorating personal health, indifference to health issues, and a distancing from the regular health system.

There are two reasons for studying crack-using youth in this framework; both are related to two major changes in the drug scene in the last decade. The first is that the mean age of chronic drug users in the Netherlands is increasing – to about 40 years old (Ouwehand, Van Alem, Mol & Boonzajer Flaes, 2004). However, young drug users do regularly join the drug scene (Van der Poel, Barendregt, Schouten & Van de Mheen, 2003). These newcomers on the scene are largely invisible because they do not, yet, have the physical appearance of a 'junkie' and they have little contact with the addiction care system (see also SIVZ, 2004). The second reason is that there has been a shift from starting a drug career with heroin to starting it with crack. In the 1970s and 1980s, the vast majority of now chronic older drug users started with heroin and later used crack (Blanken, Barendregt & Zuidmulder, 1999). Nowadays, young people start with crack and sometimes heroin is used later (Lempens, Barendregt, Zuidmulder & Blanken, 1999; NDM, 1999; Van der Poel et al., 2003; Vermeulen, Wildschut & Knibbe, 2001). Both issues raise the question whether the process of marginalisation is also valid for younger users. Therefore, the research question of the present study is: How did the process of marginalisation (social relations, sources of income and health situation) develop before and after young people started using crack?

Methods

To address this question, data were collected by means of face-to-face interviews with thirty adolescents and young adults from June to December 2003. We interviewed fifteen **current** and fifteen **former** crack users who were recruited (1) via local organisations and (2) via fieldwork.

(1) We approached over forty organisations and institutions in youth work, community centres, youth welfare work, youth assistance, Child Welfare Council, police, youth rehabilitation, Public Health Services for prostitution matters, refugee aid, addiction care (rehabilitation clinic, field work, methadone programs, care brokers), day and night shelters, and drug dealing addresses. According to staff members from these organisations, crack is not used in their target group (e.g. if crack use is a contraindication for treatment). Many staff members checked their registrations and discussed the issues of young crack users with co-workers. Through some of them we got into contact with current and former crack-using young people. In many of these organisations, we also placed advertisements on the bulletin board to which young people using crack could respond. In total 28 respondents were recruited through organisations.

(2) We approached young people in parks, shopping malls and community centres and asked if they sometimes use drugs, what kind of drugs they used and if they sometimes used crack. Most young people said they never used crack. Some said their friends sometimes used crack, and we then asked them to bring their friends to meet us. Although the fieldwork took many hours and led to interesting conversations, eventually only two respondents decided to participate in this study through this method of contact.

The interviews were conducted with a checklist and lasted about one hour. Each respondent was 'rewarded' with €10. After each completed interview, the respondent was asked to contact the interviewer with another crack user. Unfortunately, this 'snowball' recruitment method was not effective. We also placed several advertisements on various Dutch youth websites which generated lots of communication but yielded no participants.

All interviews were transcribed and analysed with the Constant Comparative Method (Boeije, 2002), which means that categories are continuously compared. In the comparison we focused on the three dimensions in the process of marginalisation: social relations (one-sided in drug scene or not), economic situation (income mainly through legal or illegal activities) and health situation (deteriorated health as result of crack use or not). Also, we compared current with former crack users in relation to these three dimensions, and when this distinction is relevant, it is mentioned in the text.

Results: process of marginalisation

The thirty respondents are introduced in the Appendix (their names have been changed to protect their identities). From these descriptions, two distinctions between current and former crack users should be mentioned here. First, former crack users are younger than current crack users, and, second, many current crack users also use heroin, while former crack users never started using heroin.

Social relations

As they grew up, the respondents all had friends, hung about with other young people, and had active social lives. They started their drug use career with cannabis and some started using ecstasy and/or sniffing cocaine later on [note 1]. Cannabis, ecstasy and cocaine use had a social dimension. They used it when they were together and enjoyed the effects. Using crack for the first time also took place in the company of friends. Many thought this was the best time of their life so far (i.e. experimenting with drugs, doing things with friends, etc).

"The most fun time was from the 9th grade until I was 16 years old. And the first year with the drugs was fun too, I'll tell you honestly. That was exciting for a while. Later I had regrets, but in the beginning it was fun. […] Just doing nice and funny things, and going out and stuff" (John, aged 24).

When the young people began using crack, contact with friends became more functional. Because the positive effects of the drug disappear quickly, to get the same high more crack must be used quickly.

"Most of the time you use crack by yourself. Usually, yes. Because you get really stingy. Not with sniffing coke, that you share, pills too. But crack, no, everything to yourself. Don't give anything away" (Mart, aged 23).

"Yes, everybody went his own way, because everybody wanted his own crack. The whole group was separated. Yes, in the beginning we did it together, but at a certain time you get greedy. You're acting very selfish" (Pepijn, aged 16).

In general, crack use was not widespread within their peer group, but those who experimented felt they had become addicted. Some users initially concealed their (continued) use from their friends, but soon became isolated. Their friends get tired of saying that they should stop and eventually these friends withdraw.

"I don't see my friends as much as I used to. Because of my drug use. They weren't involved in drugs. They didn't care about drugs. And they said, 'you're on the wrong path, you're doing the wrong things', always warning me. But at a certain point I didn't feel like hearing that all the time, so yes, it gets less. By hindsight they were right, of course. I could've saved myself a lot of trouble" (Peter, aged 24).

"Not all my friends used and for them, I tried to hide it. And because of that, well, your character changes. At a certain point, you want to split up in two: one is the drug user and the other is the non-user. […] You have appointments and dates, and you don't go anymore. And you don't pick up the phone because you're using. That's how things turn out and you don't have any friends left, except for the crack, because crack has become your friend" (Jorge, aged 24).

"I miss those things, a house, a car. Sometimes I'm ashamed of myself when I see friends from before and they are 22 and they have a drivers licence. Some already have a car. Some have a house of their own. And I'm here [in rehab] now…" (Harry, aged 24).

Some have friends and acquaintances only within the drug scene. Very few have a social network outside of the scene. Some claim to have friends within the drug scene; others claim that this is impossible ("You've only got friends if you have money", says 24-year-old John). Crack users who also use heroin state they mainly interact with other drug users. Former crack users find it difficult to renew their social network. However, they start new friendships mostly with peers, e.g. within the youth rehabilitation clinic.

"I was hardly ever at home. I was everywhere, at friends', outside. I didn't go to school anymore. Those friends hung about the whole day. They were a lot older than me, maybe 18 and older [she was 12/13]. […] No, I don't see them anymore. Sometimes I hear about them, but I don't really care. Otherwise I would look them up. […] Right now, I'm not friends with anybody actually" (Natasja, aged 22).

"No, none [friends from before], they're all gone. All moved or dead or in jail" (Michael, aged 24).

"… but they're not really my friends. I mean, they are my friends, but I don't want that anymore. I still want to know them… but I'm not hanging out with them or something. I'm not going back because they still use some drugs. […] Here in the project I have become friends with almost everybody here" (Vincent, aged 17).

When the young people started using crack they started to lie to and steal from their parents, which resulted in parents' distrust of their child. The warning attitude of parents often increased the amount and frequency of use. ("It's like forbidden fruit", according to 24-year-old Galit.) Some respondents were kicked out after the situation at home became untenable.

From the stories the youngsters tell, it appears that during childhood the contact between them and their parents was not optimal. Their relationships were disturbed by parents' excessive use of alcohol and/or illegal drugs, sexual abuse or just showing no interest at all (affective neglect). As a result, there were many fights, arguments and episodes of running away from home. Even when prompted, some could not remember any fun times in their childhood.

"Well, nobody ever asked me that and I've never thought about it. Honestly, I must say that I don't really have a nice memory. And maybe that's weird for me to say. No, I don't have anything nice that comes to mind" (Wouter, aged 19).

Many respondents were in contact with social-work agencies in their early childhood (e.g. Child Protection, custody authorities, juvenile social work, regional institute for mental welfare). Some of them developed an aversion to any kind of social work. They felt not taken seriously by social workers.

"Those people learned everything from books. They have no experience whatsoever. They can't help you because they don't know what it's like" (Monica, aged 17).

"They all knew what was best for me and I was placed everywhere where I didn't want to be, and eventually I ran away 10,000 times. All they do is write reports…" (Clarissa, aged 22).

Regarding contact with family, almost all the current and former crack users stated that they have renewed contact with one or both parents (including step and foster parents) and siblings at the time of the interviews. Some live with one or both parents and see them daily, others occasionally visit or telephone them. Some evaluate the contact as good, others see that the trust is not yet re-established. Former crack users find it particularly important to re-establish good contact with their home base. The realisation that they have caused all kinds of (emotional) distress works as a stimulant to better their lives. Some current crack users also rely on their parents: a homeless youngster can eat a meal at his mothers home, a mother raises her grandchild (because her addicted daughter cannot do that on her own), parents look after the finances of their son, and a mother saves drugs for her son so he cannot use it all in one time.

"Pinching money from my mom, and when she said, 'There's money missing' ... I would say, 'I didn't take it', and she'd say, Well, I'm not stupid am I?' That's what I find awful, it really sucks looking back" (Vincent, aged 17).

"When my mother found out that I was using, [...] we made a deal. I had to go to school every day and she then would give me money to buy my drugs. And when I got my diploma, we immediately went here, to the rehab. I was very lucky with my mom helping me" (Maria, aged 17).

"For a long time my mother came along with me to the prostitution zone. She used to wait there for me, and I would give her the money, so that I could do something with it. Because she knew that I wasn't going to quit. So she preferred that I did it under supervision and at her house, instead of her not knowing anything" (Robine, aged 24).

Sources of income

Those interviewed were young when they started using crack. Most were 14-17 years old. Although they attended secondary school, most have no diploma; some because of their drug use. Two youngsters are still in school and a few others can return to school in the next academic year.

"I used crack for about a year and a half. [...] Yes, I went to school, but don't ask me how! I went sort of to school until I came here [youth rehab]. [...] No, no diploma, but I'm going to do a learn-and-work route next year, I want to be a welder" (Pepijn, aged 16).

Most of those interviewed had no work experience, although some have worked briefly in a supermarket or had a newspaper round. Some dropped out of school aged 15-16 years to work in a practical profession such as cook, driver, mover, etc. Almost all lost their job(s) because of their drug use. They used crack (and some also heroin) in the toilet during lunch breaks, often called in sick or did not show up at work. Generally, these youngsters do not have a good (start) position in the labour market.

"I lost my job because I didn't feel like doing anything. I couldn't get out of bed because I used all evening and night. To bed at 4 a.m. and I had to get out at 7 a.m. Well, that didn't go too well, so they didn't prolong the contract" (Stef, aged 21).

"I did the 12th grade for the third time, and I had to leave school. I started working at a removal company, I was 15 or 16 at that time. [...] I worked fulltime. Smoking crack then was once a week, on a Thursday evening. [...] But I called in sick more often to be able to smoke. At a certain time, they were fed up. Understandably. I had to leave and then it really got started with doing drugs; I was 19" (Tjeerd, aged 22).

A number of the respondents were involved in criminal activities, (e.g. theft and drug dealing), before they started using crack. However, after starting crack use the majority started stealing to support their habit. Goods, including money, were (and are) stolen from parents, acquaintances, strangers (burglary) and shops/stores. According to those interviewed, it is easy to sell stolen things (e.g. bottles of liquor to bars, and shampoo and skin products to hairdressers). Sometimes people placed 'orders', e.g. for diapers and clothing. Other illegal income sources were (and are) swindling, robbery, drug trafficking, prostitution, begging, drug dealing and moonlighting. Eleven respondents spent one or more periods of time in prison, as a result of their illegal activities.

"We recently got a small room through a friend I know from prison who I happened to run into. So we're not homeless anymore, but we didn't pay anything yet and we still have to beg for money to buy dope and food. That's how bad it is. How low can you go..." (Joost, aged 21).

"I'd rather steal than go working as a whore, that's how I see it. If I can take something, I will. From shops, from houses. If I'm at somebody's place, and I don't really like this person, and I see a cell phone lying there, I'll just take it. And from shops, clothes, liquor, everything" (Destiny, aged 23).

"No, it's not a fun life, you're addicted, living on the street, and you must get something to eat. [...] And then it all goes without thinking: with crowbars and screwdrivers you go inside. [...] I was caught for 24 cases, also for dealing drugs and for theft and stealing cars. Then I went to prison for six months, juvenile prison" (Paul, aged 18).

Crack use, sources of income and homelessness are intertwined. Many young people had been homeless for one or more periods of time, and some were still homeless or 'marginally accommodated' (they risk being homeless because, for example, they have no legal rental contract or they live with friends/acquaintances).

"Sometimes, when I'm staying with my mom and I haven't used for a couple of days I find it difficult to go back. But when I'm back in Rotterdam and I'm walking the streets again and I'm working on the prostitution zone again, then it doesn't matter anymore. As long as I'm outside on the streets, I'll be using drugs. I've nowhere to go. [...] No, I can't stay at my mom's, too many problems" (Natasja, aged 22).

"I stayed for a couple of months in the surrogate family home, but I didn't stay. I ended up on the streets. And then I ran into all kinds of drug dealers who let me spend the night in their apartments. The nightlife is drugs. If I had some money I spent it straight away on dope. You could use at their place. Let's just say that I really came to like it, I was in such deep trouble... but if you use you feel fine" (Wouter, aged 19).

Health situation
As a result of being born addicted, two respondents suffered from deafness and poor sight. According to the others their physical condition was good before they started using crack. Most of the sample had not used crack long enough to have developed long-term health complaints. However, some experienced respiratory problems caused by the frequent use of crack. Another problem for some respondents was deteriorating physical fitness (endurance). Some youngsters have no health insurance.

"But I have to say that I've been on crack for so long that my body doesn't ache for it any longer. My lungs were so painful. Once I smoked for 15 hours in a row. Seriously, I had so much money that I could smoke for 15 hours, until I just fell down. My lungs were hurting, my ribs, everything hurt… But you keep on going. Crack has a short effect and you keep on going. You keep on going, trying to get that same taste or boost you got the first time" (Wouter, aged 19).

"I'm a lung patient. I've been in and out of the hospital for over twenty times in the past three years. I'm out again just three weeks. Always for my lungs. And now, this last time, I didn't finish, look at my scars…" (Robine, aged 24).

Almost half of those interviewed have experienced malnutrition, damaged feet, lack of sleep and exhaustion due to homelessness. Those working as a street prostitutes also mentioned these complaints. Being outdoors for many hours lowers physical resistance. Inflammation of the lungs and bowels occurs frequently.

Current crack users tended to be thin. Crack depresses the appetite and upsets the digestion. If they have money some buy groceries, indicating they have some control over their crack use. Physical appearance is important for many youngsters: they brush their teeth, shave and wear clean clothes, because they do not want be associated with 'junkies'. For those living with their parents this is relatively easy, others have to make an effort. Many former users later gain weight, which makes them feel stronger.

"I worked in a kitchen, I ate well, a bit of cream on my face works miracles. But at a point in time I couldn't hide the crack use any longer. I was getting skinny, my cheeks were sunken. And that's when I told my dad" (Jorge, aged 24).

"I kicked the habit in prison […]. I gained 20 kilos. When I was outside you could count my ribs. Normally, you don't feel your stomach, well I felt it all curled up. I didn't eat any food, the whole day you go on on the drugs. And my feet were all to pieces, there were cracks in my feet" (Paul, aged 18).

Regarding mental health, a few of those interviewed took medication for ADHD or schizophrenia. A small number have been admitted to a psychiatric hospital and/or tried to commit suicide. These youngsters could not tell whether their mental health problems and their use of crack were intertwined. Many youngsters suffer from paranoia and palpitations of the heart due to their use of crack. They are suspicious and hear sounds and voices.

"For example last week I smoked up three months of social security in one night. […] Oh yes, you get more and more insane. You hear things, you take things into your head. That people come to my door or whatever and I'm looking outside through the letterbox. Yeah, that's strange behaviour, isn't it?" (Tjeerd, aged 22).

"If I smoke crack I get paranoia right away, suspicious, I hear sounds. I thought: my neighbours are coming with lasers and I took my chopping-knife. I sat on the roof from 2 a.m. until the next morning. […] No, I lost those voices when I stopped using crack. It's all got to do with crack: if you smoke every day, you hear that voice, that sound" (Harry, aged 24).

Conclusion and discussion

Process of marginalisation
Coumans and colleagues (2005, 2001, 2000) have described the process of marginalisation for chronic, older, drug users; this process has not earlier been described for young crack users (16-24 years old). We conclude that the use of crack for young users initiates a process of, further, marginalisation. Many young people experience a shrinking social network, which develops especially around other hard drug users. Because few have a school diploma, they have a relatively bad (start) position in the labour market. Almost all those interviewed engaged in illegal activities to buy crack; many have spent time in prison. Some experienced respiratory problems from frequently smoking crack and many suffer from paranoia and other mental-health problems. Most of the respondents had not used drugs long enough to have developed (long-term) health complaints. The vast majority are not (yet) recognizable as an addicted drug user. Crack use, homelessness and marginalisation strengthen each other.

Once the young people started using crack they all fit into German & Sterks (2002) categories of immersed crack users whose lives are dominated by drug use, and grappling crack users who use drugs as a means of escape from continuous daily problems.

Some succeeded in stopping using crack (and other drugs), thus turning the process of marginalisation into socialisation (see Figure 1). Former crack-using youngsters are younger than those who currently use crack. From our study it remains unclear why the younger respondents are more successful in getting clean. We found no profound differences between former and current crack users in background characteristics such as use of alcohol/drugs by parents and school/work career. Furthermore, many current crack users also use heroin, while many former crack users never started heroin use. Heroin is a highly addictive drug and is often used to soften the effects of crack. Using heroin involves severe physical (and mental) withdrawal symptoms when it is not used. It appears that heroin functions as a catalyst in the process of marginalisation for crack-using youngsters, as did crack for heroin users in the late 1980s (Blanken, Vollemans, Verveen, Hendriks & Adriaans, 1995; Blanken et al., 1999; Grund, 1993).

Prevention and treatment
Many young crack users were involved with children's assistance agencies early in life, because of problems in their family. Their childhood was marked by parental alcohol or drug use, affective neglect, running

away from home, truancy, dropping out of school, etc. Our data indicate that they were already in a marginal position before they started using crack. They have moved from a marginal position in society to a marginal position within the drug scene (cf. the grappling crack users of German & Sterk, 2002; see also Johnson et al., 1998). From this it is clear – at least for these youngsters – that the assistance early in life did not have the desired effect. How to address or prevent family problems or drug use by vulnerable young people was not the topic of this study. Here, we can only confirm the conclusion of the brief report of the EMCDDA (2003) that it is necessary to study and monitor drug use and vulnerability factors among those at high risk of developing chronic drug use.

As result of the failing assistance early in life, many youngsters have little confidence in social workers working in addiction care and, for example, low-threshold shelters. Currently, the local (and national) government and addiction care system invest in assertive outreach programs such as Assertive Community Treatment (ACT) and case management (Roeg, Van de Goor & Garretsen, 2005, 2004). Characteristic of these methods is that professionals from different fields work together as a team, which includes drug professionals and the police. With these methods, young people using crack will be in sight of these professionals earlier in the process of marginalisation, which makes the chance of socialisation more likely. Referrals to general addiction care programs can be made, however, from this study we learned that former crack-using youngsters appreciated the youth rehabilitation clinic, especially because it enabled them to regain social contact with non-using peers. It seems that the social dimension in the process of marginalisation is the most important to address within a treatment setting, whereas health and income are of lesser significance. Stealing as a source of income becomes unnecessary when the youngster is clean, and the health situation automatically improves when crack is no longer used. The social network, however, needs attention and (inter)action.

In the Netherlands drug assistance and interventions for drug-using youngsters are in a state of development. A number of addiction care centres offer ambulant counselling for youngsters. At this moment there are two youth rehabilitation clinics with a total of 24 beds; both clinics have waiting lists. Treatment is focused on relapse prevention and on new perspectives on self, esteem, social relations and school or work. This seems to connect with the young people's wishes for their present and future. Getting clean is not the major issue, but rather staying clean and building a new life. It would be valuable to evaluate future programs and projects in order to improve drug-assistance programs for young people using crack.

Note

[1] For clarity we emphasize that the use of cannabis does not automatically lead to the use of crack and/or other drugs, so we do not support the gateway theory. If that theory were true, there would be many more crack users because the use of cannabis is far more widespread than that of crack. The routes into crack use of those interviewed is described in an unpublished manuscript by Van der Poel et al.

References

Blanken, P., Vollemans, J., Verveen, J., Hendriks, V., & Adriaans, N.F.P. (1995). Perron Nul en de bezoekers die er kwamen. Het Rotterdams Drug Monitoring Systeem – 1994 [Platform Zero and the visitors that came there. The Rotterdam Drug Monitoring System – 1994]. Rotterdam: IVO Addiction Research Institute.

Blanken, P., Barendregt, C., & Zuidmulder, L. (1999). The evolution of crack and basing cocaine in the Rotterdam heroin scene. Journal of Drug Issues, 29(3), 609-626.

Boeije, H. (2002). A purposeful approach to the Constant Comparative Method in the analysis of qualitative interviews. Quality and Quantity, 36, 391-409.

Chitwood, D.D., Rivers, J.E., Inciardi, J.A., & The South Florida AIDS Research Consortium (Eds.) (1996). The American pipe dream: crack cocaine and the inner city. Orlando, Florida: Harcourt Brace College Publishers.

Cohen, E., & Stahler, G.J. (1998). Life histories of crack-using African-American homeless men: salient themes. Contemporary Drug Problems, 25(2), 373-397.

Coumans, A.M. (2005). Survival on the fringes of society. Marginalisation and hardening among chronic heroin users. Maastricht: University of Maastricht (dissertation).

Coumans, M., Barendregt, C., Van der Poel, A., & Van de Mheen, H. (2001). Marginalisering en verharding in het perspectief van de Rotterdamse drug scene [Marginalisation and hardening in the perspective of the Rotterdam drug scene]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., Neve, R.J.M., & Van de Mheen, H. (2000). Het proces van marginalisering en verharding in de drugsscene van Parkstad Limburg. Resultaten van het Drug Monitoring Systeem 1998-2000 [The process of marginalisation and hardening in the drug scene of Parkstad Limburg. Results of the Drug Monitoring System 1998-2000]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalisation. Substance Use & Misuse, 38(3-6), 311-338.

EMCDDA (2003). Drug use among vulnerable young people – prevention strategies to target young people most at risk (Drugs in focus nr 10). Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Evans, R.D., Forsyth, C.J., & Gauthier, D.K. (2002). Gendered pathways into and experiences within crack cultures outside the inner city. Deviant Behavior, 23(6), 483-510.

German, D., & Sterk, C.E. (2002). Looking beyond stereotypes: exploring variations among crack smokers. Journal of Psychoactive Drugs, 34(4), 383-392.

Grund, J-P.C. (1993). Drug use as a social ritual. Functionality, symbolism and determinants of self, regulation. Rotterdam: IVO Addiction Research Institute / Erasmus University (dissertation).

Hardwick, L., & Kershaw, S. (2003). The needs of crack users: lessons to be learnt from a study into the needs of crack users. Drugs: education prevention and policy, 10(2), 121-134.

Johnson, B.D., Dunlap, E., & Maher, L. (1998). Nurturing for careers in drugs use and crime: conduct norms for children and juveniles in crack-using households. Substance Use & Misuse, 33(7), 1511-1546.

Kandel, D.B., & Davies, M. (1996). High school students who use crack and other drugs. Archives of General Psychiatry, 53(1), 71-80.

Lempens, A., Barendregt, C., Zuidmulder, L., & Blanken, P. (1999). Kenmerken van Rotterdamse druggebruikers: enkele resultaten van de survey 'drugs, huisvesting, schulden en gezondheid [Characteristics of Rotterdam drug users: some results from the survey 'drugs, accommodation, debts and health]. Rotterdam: IVO Addiction Research Institute.

Nabben, T., & Korf, D.J. (1999). Cocaine and crack in Amsterdam: diverging subcultures. Journal of Drug Issues, 29(3), 627-651.

NDM (1999). Nationale Drug Monitor. Jaarrapport 1999 [National Drug Monitor. Year report 1999]. Utrecht: Bureau NDM / Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Ouwehand, A.W., Van Alem, V.C.M., Mol, A., & Boonzajer Flaes, S. (2004). Key figures addiction care 2003. National Alcohol and Drugs Information System (LADIS). Houten: Stichting Informatievoorziening Zorg.

Ratner, M.S. (Ed.) (1993). Crack pipe as pimp: an ethnographic investigation of sex-for-crack exchanges. New York: Lexington Books.

Roeg, D.K.P., Van de Goor, L.A.M., & Garretsen, H.F.L. (2005). Towards quality indicators for assertive outreach programmes for severely impaired substance abusers: concept mapping with Dutch experts. International Journal for Quality in Health Care, 17(2), 1-7.

Roeg, D.K.P., Van de Goor, L.A.M., & Garretsen, H.F.L. (2004). When a push is not a shove: assertive care, Dutch style. Drugs and Alcohol Today, 4, 26-32.

SIVZ (2004). Ontwikkeling van de cocaïne hulpvraag in de ambulante verslavingszorg, periode 1994-2000 [Development of cocaine related treatment demand in outpatient addiction care, period 1994-2002]. Houten: Stichting Informatievoorziening Zorg.

Stoever, H. (2002). Crack cocaine in Germany – current state of affairs. Journal of Drug Issues, 32(2), 413-421.

Van der Poel, A., Barendregt, C., Schouten, M., & Van de Mheen, D. (2003). De leefsituatie van gebruikers in de Rotterdamse harddrugsscene. Resultaten van de survey 2003 [Living conditions of users in the Rotterdam hard drug scene. Results from the survey 2003]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Hennink, M., Barendregt, C., & Van de Mheen, D. (manuscript). Drug routes into crack use, or: how youngsters start using crack.

Vermeulen, K., Wildschut, J., & Knibbe, R. (2001). "Zo'n beetje alles staat in het teken van de wit". Een verkennend onderzoek naar (base)cocaïne in de Utrechtse gemarginaliseerde gebruikersscene ["Almost everything is about white". An explorative study on crack-cocaine in the marginalised drug scene in Utrecht]. Rotterdam: IVO Addiction Research Institute.

Appendix

Current crack users

Clarissa (f, 22, Dutch). Ran away from home at a young age, and has stayed in many shelters since. No secondary school diploma. After a period of homelessness she now lives with her drug-using uncle, and earns a living by stealing.

Destiny (f, 23, Surinamese-Dutch). Her parents used cannabis excessively, father used cocaine too. She sometimes sees her daughter who lives with her mother. No diplomas. She rents a scarcely furnished apartment, drinks excessively, and steals for a living.

Monica (f, 17, Dutch). Growing up, Monica was a runaway-girl, and placed under custody at a young age. She has a diploma. Monica and her boyfriend Joost beg for money on the streets to support their heroin and crack habit.

Natasja (f, 22, Dutch). Learned recently that her mother also was a homeless prostitute once. She grew up in foster families and youth welfare institutions. No diplomas, spent time in jail.

Robine (f, 24, Dutch). Grew up in a dysfunctional family (alcoholic mother, sexual abuse), and has seen many assistance agencies in her life. Diploma and some work experience. She uses heroin/methadone, and earns money in street prostitution. Poor physical health. Always together with Galit.

Anthony (m, 24, Dutch). Frequent cannabis and alcohol-using parents. His brother introduced him to drugs. No diplomas. He has social benefits and is a shoplifter. Anthony is schizophrenic, spent time in prison, is now homeless, and uses heroin and methadone.

Emre (m, 24, Dutch-Moroccan) grew up in a 'normal' family and has some diplomas. Homeless since his parents discovered his crack use. Besides social benefits, he brings foreign drug buyers to dealers for money.

Galit (m, 24, Iran). Came to the Netherlands in the 1980s. Years later his marriage (with children) broke up and he had nowhere to go. In the homeless/drug scene he was introduced to crack. He got clean, but became addicted again out of boredom. Spent time in prison. Always together with Robine.

Gurkan (m, 19, Dutch-Moroccan). Lives with his parents. He was expelled from school, had a small-time job and smoked crack-joints almost every day. He is now back in school. Friend of Ozal. Gurkan and Ozal occasionally drink huge quantities of alcohol.

John (m, 24, Dutch). He grew up with his ex-alcoholic mother with whom he still lives. He had little contact with his father who recently died of a drug overdose. He has no diplomas, and got fired because of (heroin) withdrawal symptoms; now he has social benefits.
Joost (m, 21, Dutch-Turkish). Ran away from home, had contact with many assistance agencies, spent years in compulsory boarding institutions – and in prison. No diplomas, some work experience. After being homeless, Joost recently rents a room with his girlfriend Monica. Together they beg for money on the streets to support their heroin and crack habit.
Ozal (m, 20, Dutch-Turkish). Friend of Gurkan. Has a diploma and is still in school. Spent a short time in police custody. He rents a room with no kitchen. Ozal and Gurkan occasionally drink huge quantities of alcohol.
Peter (m, 24, Dutch). Has no diploma. He once had a psychosis, became homeless for a period of time and got clean in a psychiatric hospital. After involuntary release he started using crack (and heroin and methadone) again. He now lives with his (non-using) partner in her apartment. Spent time in prison.
Robert (m, 21, Dutch-Surinamese). Went to live with his mother in Rotterdam in the late 1990s. No diplomas. He made friends who used crack-joints. He now stays with friends and earns income through working for a drug users' employment agency.
Tjeerd (m, 22, Dutch). He grew up in compulsory boarding institutions and with his alcoholic father. No diplomas, a few years' work experience. He is mentally ill. He lives alone in a rented apartment and uses methadone and heroin.

Former crack users

Fatima (f, 18, Dutch-Moroccan). She was adopted, after being sexually abused. Outgoing girl, would try anything. She has a diploma. Ended up lying to parents, stealing, prostitution. Her boyfriend is in prison. Her parents made her chose: homeless or the youth rehab clinic. She picked the clinic.
Maria (f, 17, Dutch). Has her diploma from secondary school and lives with her mother. Now, she is in the adult rehab clinic.
Abdul (m, 24, Iran). Arrived in the Netherlands in 2000. When his mother died in Iran, he starts using drugs he bought from his roommate in the asylum. He became a homeless beggar. A field worker brought him to the detox/rehab.
Alex (m, 22, Dutch). He was born addicted to hard drugs. His childhood was characterized by sexual abuse, using and dealing alcohol and drugs, and social work. He gets clean when he met his (former) girlfriend. He now rents a room from a social-work housing project.
Eric (m, 20, Dutch). Grew up in a Christian family with many rules. Diploma. Colleagues introduce him to all kinds of drugs. Paranoia, stealing, homeless, prison. Now, he goes to a youth day project and sleeps in a youth night shelter.
Harry (m, 24, Dutch-Indonesian). He was 16 when he started smoking crack-joints. He went to prison for robbery. After that, he lived with his aunt in Rotterdam. Using crack made him paranoia, which resulted in doing prison time again. After being homeless, he is now in detox/rehab.
Jorge (m, 24, Dutch). He was born addicted to drugs, and was adopted. He gets diplomas, and for a while he was able to hide his crack use at his job. He goes in and out of rehab for a couple of times. Lost his job, was kicked out, and after months on the streets, he is now back in rehab.

Mart (m, 23, Dutch). Smoked marihuana and drank alcohol at home. As an adolescent he experienced two deaths of friends. Show-off. Problems. More drugs. After prison, he is now for the second time in the youth rehab clinic.
Michael (m, 24, Dutch). Grew up in boarding schools. At 14, he started working in the greenhouses. At another job (still using drugs) he met a girl but it never worked out. He lives in the youth pension where his sister also got clean.
Mo (m, 24, Moroccan-Dutch). He came to live with his family in the Netherlands at 18. Shortly after, he started using crack and heroin, and heard voices in his head. After being clean for couple of years, he started again after his mother died. He is now in prison.
Paul (m, 18, Dutch). Never finished school. At 15, he was kicked out by his father, lived for months in a crisis shelter where he was kicked out also and ended up on the street. Gained 20 kg in prison. Now lives in a youth pension.
Pepijn (m, 16, Dutch). Thrill seeker. Trades one drug for another, but it is not easy to stop using crack. No diploma. Many rows at home; his father is a former alcoholic. He is in the youth rehab clinic.
Stef (m, 21, Dutch). Lives with his mother again after his girlfriend left him. He has several diplomas but lost his job because of his crack use. Was a drug trafficker. He is on the waiting list for the youth rehab clinic.
Vincent (m, 17, Dutch). His divorced mom could not handle him and his siblings very well. His brother introduced him to crack, which led to stealing and skipping school. No diploma. He is in the youth rehab clinic.
Wouter (m, 19, Dutch). From an alcoholic family. He went into the whole system of youth welfare work. No diplomas; learning is difficult because he is a bit mentally retarded. Wrong friends, many thefts, homeless. He is tired of the hard life on the streets.

chapter 3

homelessness

Homelessness and other living condition characteristics of drug users 2003 – 2007, in Rotterdam, the Netherlands

Chapter 3

Homelessness and other living condition characteristics of drug users 2003 – 2007, in Rotterdam, the Netherlands

Published as
Van der Poel, A., Barendregt, C. & Van de Mheen, D. (2008). Homelessness and other living condition characteristics of drug users 2003 - 2007, in Rotterdam, the Netherlands. European Journal of Homelessness, 2, 235-257.

Abstract

Drug use, homelessness and nuisance are intertwined. Especially homeless drug users cause nuisance in buying and using drugs on the streets. Until the mid-1990s the city of Rotterdam, in the Netherlands, aimed its policy at reducing drug-related nuisance with mostly repressive measures; the police shut down open drug scenes and dealing houses. However, the once concentrated nuisance was then spread over the city. In 1996 repressive measures were used in conjunction with care provision for homeless drug users. Drug consumption rooms were opened and supported housing programs were started. In 2000 and 2006 the supported housing program was extended. From 2003, nuisance-causing drug users were forced to cooperate in an individual plan with a mixture of repressive and caring measures.

In this article we compare the living conditions of drug users in 2003 and 2007, with survey data (respectively n=201 and n=102). These quantitative results show that homelessness has decreased, users spend less time in public space, income is gathered by more legal means, more users have health insurance (and more of them use mental health medication), heroin and crack cocaine use has decreased, methadone use has increased, and fewer users buy drugs on the streets. Furthermore, in 2007 the group was divided into three subgroups: actual homeless; residential homeless; and those with independent housing. The actual homeless seem to have the worst living conditions, related to their homelessness (being outdoors almost eight hours per day and being fined). The other major difference is the intensity of drug use. Not only do actual homeless users (compared to residential homeless and independently housed users) use heroin and crack on more days per month – and in public, they also use larger quantities per day. The 2006 Rotterdam Strategy Plan for Social Relief aims at having an individual care plan for 2,900 homeless people before 2010, of which 60% should be housed and receiving the necessary care and treatment. The developments in the past decade suggest that this ambitious goal can be reached.

Introduction

In the Netherlands as in other countries, drug use and homelessness are intertwined (Bieleman, Boendermaker, Kruize & Van Zwieten, 2007; Biesma, Snippe & Bieleman, 2004; Coumans & Spreen, 2003; EMCDDA, 2007; Lempens, Van de Mheen & Barendregt, 2003; NDM, 2008; Planije & Wolf, 2004; Van Doorn, 2002; Van 't Land, Vruggink & Wolf, 2003; Wolf, Nicholas & Reinking, 2002). Drug use (heroin, methadone and crack) is frequently prevalent among the homeless. In the Netherlands it is estimated that about a third of the homeless use drugs (De Bruin et al., 2003; Jansen, Kolk, Maaskant & Stoele, 2002). Sometimes drug use causes homelessness since many users spend money on drugs rather than on rent and bills (Debt Commission, 1994; Van der Poel, Masic, Barendregt & Van de Mheen, 2003). Buying and selling drugs may cause audio/visual nuisance and annexation of public space, with users walking noisily in and out of dealing houses day and night; street dealers waiting for customers or approaching non-users; and groups of users waiting for an appointment with their dealer on the corner of the street, resulting in feelings of a lack of safety by the public (Barendregt, Blanken & Zuidmulder, 1998; Barendregt, Van der Poel & Van de Mheen, 2006; Decorte et al., 2004; Snippe, De Bie & Bieleman, 1996). In effect, homeless drug users are likely to cause nuisance in their less purposeful movements during the day, buying and using drugs on the streets and perceiving the public space as their 'home' (Van de Mheen, Van der Poel, Lempens & Maalsté, 2007).

In this article we focus on drug use and homelessness in Rotterdam. After a description of the drug-related nuisance and homelessness reduction policy through the years, we will answer and discuss the research question, as stated below.

Rotterdam policy

With 600,000 inhabitants, Rotterdam is the second largest city in the Netherlands. It is estimated that Rotterdam counted about 5,000 addicted drug users in 2003 (Biesma et al., 2004). Reduction of drug-related nuisance, including that nuisance caused by homeless drug users, has been a central policy aim for some decades. Public safety for residents and the general public were of the highest priority. Rotterdam was the first Dutch city with a department and programs specifically aimed at 'public safety'. Not until recent years did policy aims shift to the housing of homeless people in general and the prevention of homelessness. The number of people registered as homeless decreased from 4,881 in 2001 to 3,712 in 2006 (Jansen et al., 2002; Maaskant & Van der Giesen, 2007).

Until 1996 the city of Rotterdam dealt with drug-related nuisance in a repressive manner. Many Dutch and foreign drug users were attracted to Rotterdam for its central location (Van der Torre, 1996). Overt drug dealing and drug using was concentrated in a district close to the harbour and highway (district West), and around the railway station in an open drug scene called Platform Zero which attracted 300-400 visitors per day (Blanken, Vollemans, Verveen, Hendriks & Adriaans, 1995). The dealing and use of ready-to-smoke cocaine (crack) – since the early 1990s – had contributed negatively to the already busy open drug scenes (Blanken, Barendregt & Zuidmulder, 1999; Barendregt, Van de Mheen & Blanken, 1999; Grund, Adriaans & Kaplan, 1991). In 1994 and 1995 the police undertook repressive action. Platform Zero was closed down, spreading many drug users throughout the city, while others left Rotterdam. Furthermore, in 'Operation Victor' the police arrested local and international drug dealers operating in dealing houses. When dealing houses were closed down, small-scale street drug dealing, especially for the local users, began to rise (Barendregt, Lempens & Van de Mheen, 2000). Due to the rising use of the cell phone in society (from 1994), and the 'Victoria Act' (the 1997 municipal law making it easier to close down dealing houses), deals arranged by cell phone became the most popular way of buying and selling drugs (Barendregt et al., 2006).

Since the mid 1990s homeless drug users were addressed by local policy because they seemed to grow in number; from 21% in 1998 (Lempens et al., 2003), to 28% in 2000 (Van der Poel, Barendregt & Van de Mheen, 2001) and 40% in 2003 (Van der Poel, Barendregt, Schouten & Van de Mheen, 2003). Homeless drug users caused much drug-related nuisance and the policy focus took a pragmatic turn, not only meaning that repressive measures were undertaken (buying drugs remains illegal), but also care was provided for drug users in low-threshold facilities in order to reduce drug-related nuisance (Barendregt & Van de Mheen, in press). In 1996 the Rotterdam project 'Safe & Clean' began (Quadt, 1996). The two care 'pillars' of the project were the implementation of drug consumption rooms and supported housing, both for homeless drug users. Evaluation showed that the project was largely successful with four drug consumption rooms offering a safe using place for about 100 homeless drug users as well as housing for about 200 drug users (Spijkerman et al., 2002). The drug consumption rooms also function as a gateway to further assistance in offering all kinds of low-threshold services such as: meals; laundry; showers; medical care; information about assistance, counselling and therapy; and information on safe use (Van der Poel, Barendregt & Van de Mheen, 2003; Wolf, Nicholas & Reinking, 2003). In 1999 the supported housing project was extended under the name 'With(out) a roof'. Evaluation (Keegel, 2002) shows that in the first two years the drop-out rate was about 15%, mostly comprising drug users who received assistance for a short period of time and who could not settle down. Later the total dropout increased to 27% (of the total of 201 drug users in the project since 1999), mainly 'because it did not work' for reasons of nuisance for the neighbours, excessive drug use and/or letting other drug users reside in the room or house. Keegel (2002) suggests that dropout increased because the group who could most easily grow accustomed to having a house was the first to be housed. Furthermore, the cooperation between the city administration and the public housing corporations was flawed; the first years resulting in too few good quality rooms and houses being available for the drug user target group. After new agreements were made, the cooperation and the quality of rooms and houses improved (Keegel, 2002; Spijkerman et al., 2002). In mid-2006 about 350 drug users participated in the supported housing project (Barendregt & Van de Mheen, 2007).

In 2003 the city further differentiated the approach of the homeless and drug users with the 'personal approach', alongside the 'area approach'. The area approach focuses on areas where nuisance is high, with drug consumption rooms, CCTV and area bans for some users. The personal approach (**PGA**) focuses on the drug users who cause the most nuisance – "in conducting criminal behaviour, frequently violating local by-laws, being homeless and/or having a psychiatric condition" (Municipality of Rotterdam, 2005a). The goal is to get them off the streets by means of a compelling individual plan in which many parties work intensively together at improving the personal situation of the drug user. Each of the five plans consists of punitive measures on the one hand, with care and treatment on the other. Supported housing (varying from housing with 24/7 assistance, to independent housing with counselling once a week) is an important component of the care. In 2005, as a result of the success of PGA, in terms of the increased number of drug users in care and the reduced drug-related nuisance, the city administration decided to expand the approach to non-using nuisance causers and criminal offenders. In three years 955 people were placed in an individual plan (Blaauw, Lange, De Jong & Van Marle, without year).

The latest policy development is the Strategy Plan for Social Relief (Plan van Aanpak Maatschappelijke Opvang) of 2006, outlined by the national Government and the four largest Dutch cities: Amsterdam; Rotterdam; The Hague; and Utrecht. The personal approach is central to this policy. The goal is that before 2010, about 10,000 homeless people will have an individual care plan; 60% of them should be housed and receiving adequate care and treatment. For Rotterdam the goal is set at 2,900 individual care plans (Ministry of Health, Welfare and Sport, 2006). This means that 1,740 actual homeless people must be housed somewhere, varying from independent housing with or without counselling, to housing with 24/7 assistance, dependent on their skills. To make this possible, Rotterdam started Central Welcome (Centraal Onthaal), one office window where homeless people are registered and referred to care, assistance and treatment (Municipality of Rotterdam, 2005b). The Strategy Plan for Social Relief aims at enlarging 'social and life skills' and housing the homeless accordingly (outcome).

Research question

Many policy measures were and are implemented in reducing drug-related nuisance and improving the living conditions of homeless drug users, as described above. Policy and evaluations of policy usually take the perspective of non-using citizens in their attempts to reduce drug-related nuisance and homelessness, not the perspective of homeless drug users. What about the drug users themselves? What are policy effects on their living conditions? The research question we will answer in this article is: Have the living conditions of drug users changed between 2003 and 2007? Living conditions are: housing; hours per day in public; sources of income; debts; physical and mental health; social relations; substance use; buying drugs; and contact with the police. In the discussion we will try to explain those changes in living conditions caused by the policy measures of the last decade.

Methods

Since 1995 the Rotterdam drug and homeless scene has been studied by IVO through surveys among drug users. In order to answer the research question we analysed and compared the two latest survey data sets:

2003 (n=201); and 2007 (n=102). In both years, we interviewed marginalised drug users who were located and recruited through targeted sampling (Watters & Biernacki, 1989; see also note 1). In 2003 the ethnographic map was composed of street locations and low-threshold facilities. In parts of Rotterdam where the situation was relatively unknown to the researchers, we made use of 'guides', who were members of the researched group and worked for the research team as community field workers (Blanken, Barendregt & Zuidmulder, 2000). In 2007 we made a new ethnographic map and recruited respondents only in and around low-threshold care facilities. In both years the same team conducted the research. They made the ethnographic map, interviewed the respondents with a structured questionnaire and analysed and discussed the data (Barendregt & Van der Poel, 2008; Van der Poel et al., 2003b).

Variables that are measured similarly in 2003 and 2007 are: hours per day outdoors/in public space; sources of income; debts; social relations; physical health; substance use; buying drugs; and contacts with the police. Some variables are measured in more detail in 2007: alcohol use; mental health; social relations and housing. Regarding housing, in 2003 we only made a difference in actual homeless people (for instance living on the street, sleeping in night shelters and in squads) and people who are (in)dependently housed (with or without housing counselling). In 2007 we divided the latter group into residential homeless people (those who live on their own, often in a room of a house with others, and who receive support and counselling; see note 2) and independently housed people who live on their own without any housing counselling, according to the 'housing ladder' that the city uses to categorise the homeless (Weltevreden, 2006).

Housing is the leading variable in the analysis. For both years, the living conditions of drug users are analysed with SPSS according to the two and three housing situations (respectively 2003 and 2007, see above) and tested with Pearson's Chi^2 (proportions) and Anova (means). The same tests are used to analyse changes between 2003 and 2007 in the overall living conditions of drug users. Differences are significant at 95% reliability ($p \leq 0.05$).

Results

Living conditions 2003-2007

Table 1 shows that the living conditions for drug users have improved in general between 2003 and 2007. Most important is that fewer drug users were actually homeless; a decrease from 40% in 2003 to 27% in 2007 ($p < 0.05$). Related to this is the time spent in public. In 2003 drug users spent about ten hours per day in public, in 2007 this had decreased to just over five hours. Another improvement is in the sources of income in 2007. The number of drug users who earned income legally in social activation projects designed especially for them has nearly doubled to 55%, while the number who earned income illegally in the drug economy and through crimes against property has halved to 23% and 17% respectively. Regarding health, 91% had health insurance in 2007 and about one third (37%) used prescription medication for mental health problems (in 2003 this was 77% and 21% respectively). Substance use in general decreased. Although the number of heroin users had not changed, users used it on fewer days per month (from twenty-four to twenty days) while also using less per day when they did (from 0.68 to 0.47 grams). Crack use decreased; there were fewer users (from 96% to 87%), fewer using days (from twenty-four to twenty days) and fewer grams on a using day (from 0.97 to 0.70 grams). Related to the decrease in

Table 1. Characteristics and substance use for drug users in specific housing situations in 2003 and 2007 [1].

Characteristics	2003 - 2007	2003 (n=201)				2007 (n=102)				
	Comparison totals p	Total (100%)	Housing: (in)dependent, with family (60%)	Actual homeless (40%)	p	Total (100%)	Independent housing (30%)	Residential homeless (43%)	Actual homeless (27%)	p
Male	ns	78%	79%	76%	ns	73%	81%	66%	74%	ns
Age (mean)	***	39 years	39 years	39 years	ns	45 years	46 years	44 years	43 years	ns
Dutch nationality	ns	86%	90%	79%	*	93%	90%	96%	93%	ns
In public										
Hours per day spent in public (mean)	***	9,8 hours	7,3 hours	13,4 hours	***	5,3 hours	4,6 hours	4,1 hours	7,9 hours	**
Income and debts (in past 6 months)										
Income: benefit/ welfare	ns	75%	84%	61%	***	78%	77%	86%	67%	ns
Income: projects esp. for homeless / users	***	29%	26%	34%	ns	55%	42%	75%	37%	**
Income: drug economy	***	44%	44%	44%	ns	23%	16%	30%	19%	ns
Income: crime against property	**	32%	31%	34%	ns	17%	19%	9%	26%	ns
Income: violent offences	ns	5%	4%	5%	ns	1%	3%	0%	0%	ns
Income: prostitution	ns	14%	10%	21%	*	10%	3%	14%	11%	ns
Income: begging	ns	13%	7%	23%	**	10%	3%	9%	19%	ns
Debts	ns	89%	88%	90%	ns	92%	84%	93%	100%	ns
Debt: public transport fare-dodging	ns	61%	58%	64%	ns	60%	32%	68%	78%	***
Debt: police fines	ns	56%	53%	61%	ns	57%	42%	57%	74%	*
Debt amount (mean)	ns	€ 7,169	€ 5,552	€ 9,714	ns	€ 7,434	€ 13,482	€ 4,578	€ 6,438	*
Physical and mental health										
Health insurance	**	77%	90%	57%	***	91%	94%	91%	89%	ns
(Very) good health [2]	ns	58%	60%	54%	ns	56%	61%	48%	63%	ns
Depression [3]	-	-	-	-	-	39%	42%	34%	44%	ns
Psychotic complaints [3]	-	-	-	-	-	26%	10%	41%	19%	**
Medication for mental health problems	**	21%	26%	15%	ns	37%	29%	50%	26%	ns
Social relations										
Contact with family (in past month)	ns	73%	79%	65%	*	65%	71%	64%	59%	ns
Very lonely [4]	-	-	-	-	-	26%	19%	30%	26%	ns

Continued on next page

Characteristics	2003 - 2007	2003 (n=201)				2007 (n=102)				
	Comparison totals p	Total (100%)	Housing: (in)dependent, with family (60%)	Actual homeless (40%)	p	Total (100%)	Independent housing (30%)	Residential homeless (43%)	Actual homeless (27%)	p
Alcohol and drug use										
Alcohol (in past month) [5]	**	24%	27%	19%	ns	38%	36%	41%	37%	ns
Days use (mean) *	*	21 days	21 days	20 days	ns	16 days	18 days	13 days	19 days	ns
Amount used on last using day (mean) *	ns	13 drinks	11 drinks	16 drinks	ns	12 drinks	12 drinks	11 drinks	13 drinks	ns
Alcohol use in public *	–	–	–	–	–	81%	69%	81%	92%	ns
Days use in public (mean) *	–	–	–	–	–	13 days	10 days	10 days	21 days	*
Heroin (in past month)	ns	80%	76%	85%	ns	78%	77%	82%	92%	ns
Days use (mean) *	*	24 days	22 days	25 days	ns	20 days	19 days	17 days	29 days	***
Amount used on last using day (mean) *	**	0.68 gram	0.60 gram	0.78 gram	ns	0.47 gram	0.31 gram	0.35 gram	0.88 gram	***
Methadone (in past month)	***	58%	65%	48%	*	81%	87%	89%	63%	*
In methadone program *	ns	88%	91%	82%	ns	93%	93%	92%	94%	ns
Days use (mean) *	ns	25 days	26 days	25 days	ns	27 days	25 days	29 days	27 days	ns
Amount used on last using day (mean) *	**	27 cc	26 cc	28 cc	ns	35 cc	35 cc	37 cc	31 cc	ns
Crack (in past month)	**	96%	95%	96%	ns	87%	77%	91%	93%	ns
Days use (mean) *	***	24 days	23 days	24 days	ns	18 days	17 days	15 days	23 days	**
Amount used on last using day (mean) *	*	0.97 gram	0.78 gram	1.24 gram	**	0.70 gram	0.41 gram	0.62 gram	1.12 gram	*
Drug use in public *	***	62%	49%	83%	***	37%	17%	35%	63%	**
Days use in public (mean) *	ns	18 days	16 days	20 days	*	16 days	16 days	9 days	23 days	**
Buying drugs (in past month)										
By telephone	ns	66%	69%	61%	ns	71%	61%	71%	82%	ns
On the street	***	64%	54%	80%	***	32%	19%	41%	33%	ns
At dealing house	***	29%	32%	24%	ns	8%	13%	2%	11%	ns
Contact with police (in past 6 months)										
ID, area denial, APV fine, frisking [6]	ns	72%	65%	83%	**	70%	55%	68%	89%	*

[1] Means are tested with Anova, proportions with Chi²: * p ≤ 0.05, ** p ≤ 0.01, *** p ≤ 0.001. The symbol – means that this particular variable was not measured in 2003.
[2] Measured in three categories: (very) good, moderate, bad/changing.
[3] Measured with the PrsnQst (Shaw et al., 2003), as translated and validated for people who visit day and night shelters (Van Rooij et al., 2007).

[4] Measured in three categories: very, moderate, not (standard question (Monitor Volksgezondheid, 2004; De Jong-Gierveld & Kamphuis, 1985)).
[5] In 2003: 5 or more drinks on a drinking day. In 2007: 4 or more drinks for women and 6 or more drinks for men (definition of excessive drinking, see www.alcoholinfo.nl).
* The n is the number of respondents that used the substance in the past month.
[6] Check of ID on the street, area denial (usually for three months) is given to nuisance-causing drug users, APV fines are local by-law fines, frisking for drugs and weapons is sometimes done preventively in an area.

homelessness is the decrease in the number of users who used drugs in public (almost halved to 37%). However, the number of those who did use in public remained unchanged and they did so on sixteen to eighteen days per month on average. The majority ordered drugs by telephone (no change). Buying on the street and at dealing houses has (more than) halved, to 32% and 8% respectively.

No changes were found in the number of drug users who earned income through prostitution and begging (both 10%). Similarly unchanged were the debt situation (about 90% had a mean debt of about € 7,000); the number of users who indicated having (very) good health (less than 60%); the number of users who had contact with their families (about two thirds); and the number of users who were in contact with the police (about 70%).

Lastly, there are positive and negative changes in alcohol and methadone use. An increased number of drug users (also) used large amounts of alcohol (from 24% to 38%), however, the number of drinking days have decreased (from twenty-one to sixteen days per month). In both years, the mean number of drinks per day was twelve to thirteen. In addition, more drug users used methadone (from 58% to 81%) on average on twenty-five to twenty-seven days. The daily amount used increased from 27 cc to 35 cc. The increase in methadone use will be discussed later.

2007: living conditions for the three housing situations

The last column of Table 1 also shows the 2007 living conditions of drug users in the three housing situations: those who lived independently (30%); those who were residential homeless (43% living in a supported housing project); and those who were actual homeless (27% living on the street, sleeping in shelters or at friends). The groups do not differ significantly in many of the ways they earned income and in the number of users who had debts. Furthermore there was no difference in the number of drug users who had health insurance; those with self-perceived (very) good health; or those who suffered from depression and took medication for mental health problems. The number of users who had contact with their family, and who were very lonely; the number of heroin and crack users; the number of alcohol users; the mean number of alcohol-using days per month; the number of drinks consumed on a using day; and the ways in which they bought drugs were also about the same.

However, there are some differences. The **independently housed** drug users seem to be best off, in general. It is remarkable that their mean debt amount was the highest, over € 13,000 (at least twice as high as the other groups). The **residential homeless** are the middle group, sometimes resembling the independently housed group (in most of the drug use variables), sometimes resembling the actual homeless group

(because of debts from fare-dodging). For the residential homeless it is remarkable that 75% participated in special income projects (compared with 40% of the other groups). Regarding mental health, 41% suffered from psychotic complaints (two to four times as many as the other groups). The **actual homeless** seem to have the poorest living conditions, related to their homelessness. They spent about eight hours per day in public (twice as many hours as the other groups), over 70% had unpaid police and fare-dodging fines resulting in debt (over 30% among the other groups), and 89% were in contact with the police (over 55% of the other groups). They had the highest number of heroin and crack using days (29 and 23 days respectively) and used the highest amounts on a using day (respectively 0.88 and 1.12 grams). Furthermore, 63% used drugs in public (about two to three times as many as the other groups) on a mean of 23 days per month. They used alcohol in public on a mean of 21 days per month.

Discussion

Methodology

In 2003 and 2007 marginalised drug users (heroin, methadone and crack) from the Rotterdam drug scene were interviewed using a structured questionnaire. In both years drug users were recruited with targeted sampling. In 2003 drug users could not only be found in low-threshold care facilities but also on the streets. In 2007 the streets were no longer a target area because policy measures pulled drug users inside low-threshold care facilities and supported housing projects. It is much quieter on the streets (Barendregt & Van de Mheen, in press). This means that in 2007 we only sampled drug users in facilities and projects, thus the sampling method reflects the changed situation in the city. We interviewed 201 drug users in 2003 and – due to limited resources – a smaller sample of 102 drug users in 2007. The quantitative results are based on self-reported data (perspective of users).

Changes in living conditions 2003-2007

Between 2003 and 2007 the living conditions for drug users changed for the good. As reported earlier, actual homelessness decreased from 40% to 27%. In 2007 43% are residential homeless and 30% are housed independently. In 2003 we did not make this distinction. Of these three groups, the actual homeless are in the worst living conditions, a situation related to their homelessness. They spend much time in public, often drinking and using drugs, where they get fines from the police for violating local by-laws (such as drinking alcohol and using drugs in public, gatherings of people in certain places, sleeping in public or begging), and from the public transport system for fare-dodging. Being fined is related to spending time in public space, which in turn is related to being homeless. To put it strongly, this means that the homeless cannot spend time in public without getting fined, which means that the homeless drug user is not 'allowed' to spend time 'at home'. Homeless drug users complain about this and so do some police officers who argue that merely fining 'offenders' renders no positive results – not for the police because fining takes up a lot of time, and not for the homeless because the officers know that the majority will not pay the fine.

Regarding drug use, the actual homeless use heroin and crack on many days per month and in large quantities on a using day. Living the homeless life and the excessive use of alcohol and drugs seem to be two sides of the same coin (see also Coumans, 2005).

In contrast with the actual homeless, the residential homeless and the independently housed have their own place (usually a room) where they can rest and not be hurried. This seems to have an influence on the lesser intensity of their drug use; compared to the actual homeless, both other groups use heroin and crack on fewer days per month and in lesser quantities on a using day. Other authors have argued that the rest and safety provided by having one's own room causes a decrease in crack use over time (Vermeulen, Toet & Van Ameijden, 2005). It is notable that methadone use is more prevalent among these two groups; almost 90% use methadone compared with 63% of the actual homeless. It is plausible that more drug users are prescribed methadone after being housed and getting (drug) counselling, and that methadone use has thus replaced some of the heroin use (see note 3). Further, psychotic complaints are more prevalent among the residential homeless than among the other groups. Besides that medical care is more accessible to them (psychiatrist's diagnosis), the decrease in drug use might make mental health issues more apparent. Lastly, the residential homeless make ample use of the social activation projects that the city specifically designed for them, e.g. sweeping the streets in teams, selling 'Street Magazine' and washing trams and police cars. Participation in these projects gives their days a structure and regularity rather than being taken up by buying and using drugs and, in addition, participants take pride in contributing to the city (to society) in a positive way (Davelaar, Nederland, Wentink & Ter Woerds, 2005; Davelaar, Van Dongen, Rijkschroeff & Flikweert, 2007). It seems that because the residential homeless receive all kinds of assistance and housing counselling, they feel more in control of their situation. However, their (mental) health situation must remain a focus of attention.

Nuisance 2003-2007

Substance use in public can be defined as an indicator of the nuisance drug users may cause. Between 2003 and 2007 the percentage of users who used drugs in public (in the previous month) has decreased from 62% to 37%. Those who do use drugs in public still do so on sisxteen days (no change). However, many of the drug users interviewed who use drugs in public, told the researchers that nowadays it is more difficult than ever because of police activity and CCTV on the streets. They say they want to use crack immediately after they bought it. Usually they meet their 'telephonic' dealer on the street and therefore they have developed strategies to avoid police fines for public drug use, such as using while walking (instead of being stationary) and looking for quieter places further away from the buying spots.

Alcohol use in public was only measured in 2007. 81% of alcohol drinkers used alcohol in public on a mean of thirteen days per month. Drinking in the social relief centres (shelters) is not allowed and there are no 'alcohol consumption rooms' in Rotterdam comparable to the drug consumption rooms. A homeless user is therefore 'obliged' to drink in public. Public alcohol use is distinctive in that it often takes place among groups, where 'sharing' alcohol is common. Some of the alcohol users interviewed told the researchers that they try to avoid police contact by hiding their beer cans in plastic bags or coat pockets, and drinking while walking around.

Drug use in public has decreased, and although users do get fined for using in public, we have no information from them about how often that occurs. Figures from the Department of Public Prosecution show that the number of unpaid fines (note 4) for violating local by-laws have decreased with 65% for public drug use (from 1,264 in 2005 to about 450 in 2007; see note 5) and with 26% for public alcohol use (from 3,434 in 2005 to about 2,500 in 2007) (see Barendregt & Van der Poel, 2008).

We could conclude from the above that drug-related nuisance has decreased. However, drug-related nuisance is defined by those, usually residents, who are experiencing the nuisance. Often they define all kinds of nuisance as being drug-related. In Rotterdam it appeared that almost half of the complaints made to Report Centres Drug Nuisance about drug-dealing nuisance could not be related to dealing or using drugs (Gruter & Van de Mheen, 2002).

Results of policy?

Since our study is not an effect evaluation of the Rotterdam policy, we cannot 'prove' that the better living conditions of drug users is as a direct result of the policy measures. However, when the results are put next to the policy measures, the timeline shows convincingly that the policy had (and has) positive effects (Table 2). The combination of repressive (punitive and judicial) measures and care (housing and other assistance) measures seem to have positive effects on the living conditions of the target groups. Repression and care organisations had to overcome difficulties in working together since their aims and methods are different; however, the possible positive results made these organisations determined to combine their efforts. The police, for example, had no suitable choice of what to do with homeless drug users whom they took to the precincts when it was obvious that they were in need of help or treatment. Care and treatment agencies, for example, were not informed about drug users who went to prison for unpaid fines, and they had to start long lasting procedures after their release to start social benefits, medical insurance, housing an so on. It is now clear that the combination of repression and care can only have positive effects when the many involved organisations (including police, social affairs, housing corporations, treatment and care organisations, social relief sector) work together as a team to achieve a collective goal (see also FEANTSA, 2005; Johnsen & Fitzpatrick, 2008). Tosi (2007) warns that this collective goal should not be reduced to a principle of order, in which the elimination of homelessness is equivalent to making homeless people invisible. Instead, the collective goal should meet the needs of the homeless. In the past years the Rotterdam organisations have shown that they are more and more capable of doing so.

Table 2. Timeline of the Rotterdam drug and homelessness situation and policy measures.

Time: situation	Policy measures
Until 1996: open drug scenes, nuisance from (international) drug dealing and drug using.	Repressive measures: Platform Zero and dealing houses closed down. Drug users and nuisance are spread throughout the city.
1996-2002: nuisance from local homeless drug users in the neighbourhoods (in 2000 28% of drug users are actual homeless, and 42% use drugs in public).	Start of the combination of repressive and care measures ('Safe & Clean'/1996); drug consumption rooms and housing projects. The cooperation between involved parties slowly improved and amplified.
2002-now: in 2003 actual homelessness among drug users has increased to 40% and drug use in public to 62%. From 2003 on, after start-up problems, more and more homeless drug users participate in supported housing projects, get housing counselling, debt assistance, drug treatment etc.	Repression and care go hand in hand, just as area and personal approach ('With(out) a roof'/2000, 'PGA'/2003). The personal situation of (now) residential homeless drug users is improving.
2006-now: homelessness is regarded a major issue in the four major cities (including Rotterdam). At the end of 2007 'With(out) a roof' can house over 450 drug users [note 6]. In 2007 actual homelessness has decreased to 27% and drug use in public to 37%.	Continuation of repression/care and personal/area approach ('Strategy Plan for Social Relief'/2006); more supported housing projects are started, coincident with adequate help and assistance.

Future

By the year 2010 the city of Rotterdam intends to house 1,740 actual homeless people (among whom many are drug users). Depending on the skills of the homeless, there is a range of types of residency varying from independent housing with no assistance, through independent housing with ambulant housing counselling, to group housing with 24/7 assistance. In order to be able to compose individual care plans for the 1,740 homeless, the city started 'Central Welcome', the only office window for the homeless, where they are registered and referred to further assistance. In the past decade, together with the organisations involved, including the addiction care system and social relief sector, the city administration has developed and implemented policy measures that have changed the homeless and drug scenes in Rotterdam. The situation has changed positively at group level, as well as at the individual level for those who are no longer actually homeless. These developments of the past decade suggest that the ambitious goal of the Rotterdam Strategy Plan for Social Relief can be reached. In addition, the program has the three dynamics that Anderson (2007) found to be of importance for the Scottish homelessness strategy: homelessness policy is a priority; the homelessness program is multi-agency and housing-led; and it is a long-term program.

However, we must keep in mind that homelessness and drug use will never disappear from our society, and that – in spite of all policy measures – there will always be homeless people and drug users on the streets. Therefore, in cities like Rotterdam, an effective care system for people living in the margins of society (including all kinds of shelter and housing projects) must be part of a continuous program.

Notes

[1] Targeted sampling is a sampling technique for locating and recruiting members of hidden populations especially in drug research (Peterson et al., 2008). Ethnographic methods are used to describe the population (approximate size, location, characteristics) within defined geographical areas. Then respondents/participants are actively approached; usually chain referral sampling is used to find other respondents. (As opposed to convenience sampling where only easily available respondents are recruited.) In Rotterdam we made ethnographic maps of areas of interest (south, west and center/north), based on which it was determined how many users and thus respondents with certain characteristics should be recruited there (stratified sampling). In 2003 we sometimes used 'guides' to find respondents (instead of chain referral), in 2007 the chain referral sampling technique was not effective (and we hypothesised that the informal support systems of drug users – the basis of chain referral – have been weakened by formal support systems, e.g. addiction care and the relief sector).

[2] The residential homeless in this study are comparable to the 7th conceptual category 'houseless' of the European Typology of Homelessness and housing exclusion (ETHOS, 2007): "people receiving longer-term support (due to homelessness)".

[3] Methadone use among the actual homeless has increased as well (from 48% in 2003 to 63% in 2007), but their heroin use has not decreased.

[4] Fines are sent in to the Rotterdam Department of Public Prosecution when they are not paid. Marginalised drug users often do not pay their fines, see also table 1: 57% of drug users have debts because of unpaid fines.

[5] During the study the figures were known for January to August (8 months), we extrapolated these figures to the full year of 2007, hence use of the word 'about'.

[6] Source: "Catalogue of supported housing projects" from the Rotterdam Public Health Service (received March 2008).

References

Anderson, I. (2007). Sustainable solutions to homelessness: the Scottish case. European Journal of Homelessness, 1, 163-183.

Barendregt, C., Blanken, P., & Zuidmulder, L.J. (1998). Drugshandel en overlast in Rotterdam [Drug dealing and nuisance in Rotterdam]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., Lempens, A., & Van de Mheen, D. (2000). Drugs kopen op straat. Achtergronden en motieven van Rotterdamse druggebruikers die bij straatdealers kopen [Buying drugs on the street. Background and motives of Rotterdam drug users who buy from street dealers]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., & Van de Mheen, D. (in press). "Then there was silence on the streets". Developments in the street scene of Rotterdam in the last decade. Drugs: education, prevention and policy.

Barendregt, C., & Van de Mheen, D. (2007). Ambulante woonbegeleiding voor verslaafden. Evaluatie van het project (z)Onderdak [Ambulant supported housing for drug users. Evaluation of the project With(out) a roof]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., Van de Mheen, D., & Blanken, P. (1999). Het roken van cocaïne-base in Rotterdam; de invloed van gebruikslocatie en zelfcontrolemechanismen [Smoking crack in Rotterdam; the influence of using location and self-control mechanisms]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., & Van der Poel, A. (2008). Dak- en thuislozen en verslaafden in Rotterdam: leefsituatie en overlast. Resultaten van Trendspotting 2007 [Homeless people and drug users in Rotterdam: living conditions and nuisance. Results of Trendspotting 2007]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., Van der Poel, A., & Van de Mheen, D. (2006). The rise of the mobile phone in the hard drug scene in Rotterdam. Journal of Psychoactive Drugs, 38(1), 77-87.

Bieleman, B., Boendermaker, M., Kruize, A., & Van Zwieten, M. (2007). Monitor verslaafden en daklozen in Enschede 2007. Metingen 2001, 2002, 2003, 2004, 2005 en 2006 [Monitoring the addicted and the homeless in Enschede 2007. Measurements 2001, 2002, 2003, 2004, 2005 en 2006]. Groningen/Rotterdam: Intraval, bureau for research and consultancy.

Biesma, S., Snippe, J., & Bieleman, B. (2004). Harddrugsgebruikers geregistreerd. Aard, omvang en mobiliteit van problematische harddrugsgebruikers in Rotterdam [Hard drug users registered. Nature, extent and mobility of problematic hard drug users in Rotterdam]. Groningen/Rotterdam: Intraval, bureau for research and consultancy.

Blaauw, E., Lange, N.E., De Jong, K., & Van Marle, H.J.C. (without year). Evaluatie Persoonsgerichte Aanpak 700 overlastgevende verslaafden [Evaluation Person Approach 700 nuisance-causing drug users]. Rotterdam: ErasmusMC.

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community field work: Bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291-296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

Blanken, P., Barendregt, C., & Zuidmulder, L. (1999) The evolution of crack and basing cocaine in the Rotterdam heroin scene. Journal of Drug Issues, 29(3), 609-626.

Blanken, P., Vollemans, L., Verveen, J., Hendriks, V., & Adriaans, N.F.P. (1995). Perron Nul en de bezoekers die er kwamen. Het Rotterdams Drug Monitoring Systeem – 1994 [Platform Zero and the visitors that came there. The Rotterdam Drug Monitoring System – 1994]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M. (2005). Survival on the fringes of society. Marginalisation of and hardening among chronic heroin users. Maastricht: University of Maastricht (dissertation).

Coumans, A.M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalisation. Substance Use & Misuse, 38(3-6), 311-338.

Davelaar, M., Nederland, T., Wentink, M., & Ter Woerds, S. (2005). Aan de slag in de rafelrand. Werk en activering voor daklozen en verslaafden [Get to work in the margin. Social economy activity and activation for the homeless and addicted]. Utrecht: Verwey-Jonker Institute.

Davelaar, M., Van Dongen, M., Rijkschroeff, R., & Flikweert, M. (2007). Van de straat aan het werk. Dagbesteding en activering voor dak- en thuislozen in Rotterdam [Of the street on the job. Spending time and social activation for the homeless in Rotterdam]. Utrecht: Verwey-Jonker Institute.

De Bruin, D., Mijerman, C., Verbraeck, H., Braam, R., Leenders, F.H.R., & Van de Wijngaart, G. (2003). Zwerven in de 21e eeuw. Een exploratief onderzoek naar de geestelijke gezondheidsproblematiek en overlast van dak- en thuislozen in Nederland [Wandering in the 21st century. An explorative study of the mental health problems and nuisance of the homeless in the Netherlands]. Utrecht: CVO.

De Jong-Gierveld, J., & Kamphuis, F. (1985). The development of a Rasch-type loneliness scale. Applied Psychological Measurement, 9, 289-299.

Debt Commission (1994). Schulden: naar. Nieuwe impulsen in de schuldenproblematiek [Debts: debtor. New impulses in the issue of debts]. The Hague: Ministery of Social Affairs and Employment.

Decorte, T., De Ruyver, B., Ponsaers, P., Bodein, M., Lacroix, A.C., Lauwers, S., & Tuteleers, P. (2004). Drugs and nuisance. Study of the phenomenon, the control and the effects of drug-related nuisance from different perspectives. Gent: Academia Press.

EMCDDA (2007). Responding to drug problems in Europe – an overview. In EMCDDA, The state of the drugs problem in Europe. Annual report 2007 (pp. 28-36). Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

ETHOS (2007). European typology of homelessness and housing exclusion. Brussels: FEANTSA, European Federation of National Organisations Working with the Homeless.

FEANTSA (2005). Editorial. Local authorities and the fight against homelessness. Homeless in Europe, the Newsletter of FEANTSA (European Federation of National Organisations Working with the Homeless) Summer, 2.

Grund, J.P., Adriaans, N.F., & Kaplan, C.D. (1991). Changing cocaine smoking rituals in the Dutch heroin addict population. British Journal of Addictions, 86(4), 439-448.

Gruter, P., & Van de Mheen, D. (2002). Interventies op de aanbodzijde van de harddrugsmarkt in Rotterdam. Mogelijkheden voor een gereguleerde harddrugshandel [Interventions on the supply-side of the hard drug market in Rotterdam. Possibilities for a regulated hard drug trade]. Rotterdam: IVO Addiction Research Institute.

Jansen, H., Kolk, R., Maaskant, J., & Stoele, M. (2002). Dak en thuislozenmonitor 2001-2002 [Monitoring the homeless 2001-2002]. Rotterdam: IVO Addiction Research Institute / Department of Social Affairs and Employment.

Johnsen, S., & Fitzpatrick, S. (2008). The use of enforcement to combat begging and street drinking in England: a high risk strategy? European Journal of Homelessness, 2, 191-204.

Keegel, J. (2002). Evaluatie (z)Onderdak / wonen voor verslaafden [Evaluation With(out) a roof / housing for drug users]. Rotterdam: Rotterdam Public Health Service.

Lempens, A., Van de Mheen, D., & Barendregt, C. (2003). Homeless drug users in Rotterdam, the Netherlands: profile, way of life and the need for assistance. Substance Use & Misuse, 38(3-6), 341-377.

Maaskant. J., & Van der Giesen, E. (2007). Daklozenmonitor 2006-2007 [Monitoring the homeless 2006-2007]. Rotterdam: Department of Social Affairs and Employment.

Ministry of Health, Welfare and Sport (2006). Plan van Aanpak Maatschappelijke Opvang. Het Rijk en de vier grote steden [Strategy Plan for Social Relief. National Government and the four largest cities]. The Hague: Ministery of Health, Welfare and Sport.

Monitor Volksgezondheid (2004). Standaardvraagstelling indicator eenzaamheid voor de Lokale en Nationale Monitor Volksgezondheid [Standard question indicator loneliness for the Local and National Monitor Public Health]. Utrecht / Bilthoven: GGD Nederland / RIVM, National Institute for Public Health and the Environment.

Municipality of Rotterdam (2005a). Vijfjarenactieprogramma veilig Rotterdam 2006-2010 [Five year action program Rotterdam safe 2006-2010]. Rotterdam: Department of Public Safety.

Municipality of Rotterdam (2005b). Beleidsnotitie Centraal Onthaal. Ketenregie in de Maatschappelijke Opvang [Policy statement Central Welcome. Chain management in the Social Relief sector]. Rotterdam: Department of Social Affairs and Employment.

NDM (2008). Nationale Drug Monitor. Jaarbericht 2007 [National Drug Monitor. Year report 2007]. Utrecht: Bureau NDM / Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Peterson, J.A., Schacht Reisinger, H., Schwartz, R.P., Mitchell, S.G., Kelly, S.M., Brown, B.S., & Agar, M.H. (2008). Targeted sampling in drug abuse research: a review and case study. Field Methods, 20(2), 155-170.

Planije, M., & Wolf, J. (Eds.) (2004). Monitor Maatschappelijke Opvang. Jaarbericht 2004 [Monitor Social relief and care. Year report 2004]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Quadt, T. (Ed.) (1996). Verantwoord Schoon in Rotterdam [Safe & Clean in Rotterdam]. Rotterdam: Rotterdam Public Health Service.

Shaw, J., Tomenson, B., & Creed, F. (2003). A screening questionnaire for the detection of serious mental illness in the criminal justice system. Journal of Forensic Psychiatry & Psychology, 14(1), 138-150.

Snippe, J., De Bie, E., & Bieleman, B. (1996). Achtergrondstudie drugsoverlast [Background study drug-related nuisance]. Groningen/Rotterdam: Intraval, bureau for research and consultancy .

Spijkerman, R., Biesma, S., Meijer, G., Van der Poel, A., Van den Eijnden, R.J.J.M., & Bieleman, B. (2002). Vier jaar Verantwoord Schoon. Evaluatie van Verantwoord Schoon; een programma voor aanpak voor drugsoverlast in Rotterdamse deelgemeenten [Four years 'Safe & Clean'. Evaluation of Safe & Clean; a program for tackling drug nuisance in Rotterdam boroughs]. Rotterdam/Groningen: IVO Addiction Research Institute / Intraval, bureau for research and consultancy.

Tosi, A. (2007). Homelessness and the control of public space – criminalising the poor? European Journal of Homelessness, 1, 225-236.

Van de Mheen, D., Van der Poel, A., Lempens, M.A., & Maalsté, N. (2007). Mobility of hard drug users: patterns and characteristics relevant for deconcentration of facilities. Journal of Psychoactive Drugs, 39(2), 191-200.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2001). Druggebruikers en hun gebruik van de Rotterdamse verslavingszorg [Drug users and their use of the Rotterdam addiction care system]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Masic, S., Barendregt, C., & Van de Mheen, D. (2003a). De schuldenlast van druggebruikers in Rotterdam [The debt situation of drug users in Rotterdam]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Barendregt, C., Schouten, M., & Van de Mheen, D. (2003b). De leefsituatie van gebruikers in de Rotterdamse harddrugsscene. Resultaten van de survey 2003 [Living conditions of users in the Rotterdam drug scene. Results of the survey 2003]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Barendregt, C. & Van de Mheen, D. (2003c). Drug consumption rooms in Rotterdam: an explorative description. European Addiction Research, 9, 94-100.

Van der Torre, E.J. (1996). Drugstoeristen en kooplieden. Een onderzoek naar Franse drugtoeristen, Marokkaanse drugsrunners en het beheer van dealpanden in Rotterdam [Drug tourists and dealers. A study of French drug tourists, Moroccan drug runners and the management of dealing-houses in Rotterdam]. Arnhem: Gouda Quint.

Van Doorn, L. (2002). Een tijd op straat. Een volgstudie naar (ex)daklozen in Utrecht 1993-2000 [A time on the streets. A follow-up study on (former) homeless people in Utrecht 1993-2000]. Utrecht: Netherlands Institute for Care and Welfare (dissertation).

Van Rooij, T., Mulder, N., Wits, E., Van der Poel, A., & Van de Mheen, D. (2007). Screeningsinstrument Verslaving en Psychiatrie voor de maatschappelijke opvang [Screener Addiction and Psychiatry for the social relief sector]. Rotterdam: IVO Addiction Research Institute / O3 Onderzoekcentrum GGZ Rijnmond.

Van 't Land, H., Vruggink, J., & Wolf, J. (2003). Van later zorg? Over de kwaliteit van de laagdrempelige zorg voor langdurig verslaafden [Of later care? On the quality of the low-threshold care for chronic addicts]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Vermeulen, K., Toet, J., & Van Ameijden, E. (2005). Eindrapportage Hostelonderzoek Utrecht. Beter af met bad, bed, brood en begeleiding? [Final report study of Hostels Utrecht. Better off with bath, bed, bread and counselling?] Utrecht: Utrecht Public Health Service.

Watters, J., & Biernacki, P. (1989). Targeted sampling: options for the study of hidden populations. Social Problems, 36(4), 416-430.
Weltevreden, J. (2006). Woonladder maatschappelijke opvang [Housing ladder for the social relief sector]. Rotterdam: Department of Social Affairs and Employment.

Wolf, J., Linssen, L., & De Graaf, I. (2003). Drug consumption facilities in the Netherlands. Journal of Drug Issues, 33(3), 649-662.

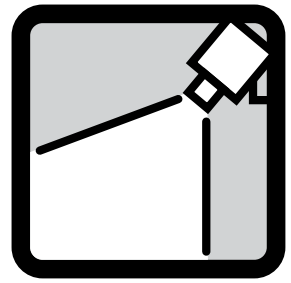
Wolf, J., Nicholas, S., & Reinking, D. (2002) Dakloos in Den Haag [Homeless in The Hague]. Epidemiologisch bulletin, 37(3), 16-23.

www.ALCOHOLINFO.nl (first published: 2006). This Dutch site refers to Gaziano, M.J. & Hennekens, C. (1995). Royal College's advice on alcohl consumption. British Medical Journal, 311, 3-4.

chapter 4

participation

Drug users' participation in addiction care: different groups do different things



Chapter 4

Drug users' participation in addiction care: different groups do different things

Published as
Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2006). Drug users' participation in addiction care: different groups do different things. Journal of Psychoactive Drugs, 38(2), 123-132.

Abstract
This study allocated 201 (nearly) daily users of heroin and/or crack into four groups, depending on their addiction care participation. Earlier studies have compared treatment groups and nontreatment groups. In this study the treatment group is divided into three categories: (1) drug users in contact with only treatment agencies – i.e. methadone maintenance, clinical and ambulant drug treatment; (2) drugs users in contact with only care agencies – i.e. day and night shelters and drug consumption rooms, which have no explicit aims to change patterns of drug use; and (3) drug users in contact with both treatment and care agencies. This allocation intro three different groups fits the notion of harm reduction, one of the policy aims in the Netherlands. The fourth group consists of drug users in contact with neither treatment nor care agencies. The results show that it is useful to distinguish these four categories, instead of two. The four groups are different from each other with respect to some of their characteristics (e.g. debt situation, prostitution, homelessness) and their drug use (e.g. drug use in public, use of crack, and use of other drugs). A much clearer distinction can be made between the 'care' group and the 'treatment and care' group. Treatment and care agencies can thus better match their services to their clients or patients.

Introduction
To make a better match between treatment and care and dependent drug users' needs, it is important to understand the characteristics and motives of drug users who do and those who do not participate in

addiction care. The present study addresses several notions of help-seeking. Hartnoll (1992) discerns three clusters of hypotheses in his review of help-seeking.

1) The availability and characteristics of services and policies are in part responsible for determining patterns of help-seeking
Earlier studies (e.g. Chitwood & Morningstar, 1985; Eland-Goossensen, 1997; Ferri, Gossop & Laranjeira, 2001; Fiorentine & Anglin, 1994; Hausser, Kuebler & Dubois-Arber, 1999; Kuebler, Hausser & Gervasoni, 2000; Robson & Bruce, 1997; Rounsaville & Kleber, 1985) have compared treatment and nontreatment groups. Drug users in treatment groups sought help at treatment agencies which aim at modifying the use of heroin and/or crack (e.g. methadone maintenance or detox/rehab). Drug users in nontreatment groups state that their reasons for not seeking drug treatment are: handling problems on their own, treatment would not help, and fear of the stigma of treatment (Cunningham, Sobell, Sobell, Agrawal & Toneatto, 1993; Kuebler et al., 2000). Other self-changers strongly reject professional aid or deem it as irrelevant to their own treatment needs (Coumans, Neve & Van de Mheen, 2000; De Graaf, Wildschut & Van de Mheen, 2000; Eland-Goossensen, 1997; Klingemann, 1991). Nonparticipants are relatively satisfied with their living situation and spare time activities (Eland-Goossensen, 1997). They experience good health, control over their drug use, and feel no need for treatment (Hausser et al., 1999; Kuebler et al., 2000).

However, in the course of the years care agencies have been included in the addiction care system. Care agencies such as day shelters and drug consumption rooms have no explicit aims to change drug use patterns as treatment agencies do. The notion of care agencies is compatible with the harm reduction notion. In some recent studies (e.g. Kuebler et al., 2000), treatment is defined to include care agencies such as needle exchanges and outreach work, which makes 'treatment' a troubled concept in research and assistance practice.

In the present study, care agencies are treated as a separate category of addiction care. This means that the treatment group is divided into three categories: (1) drug users in contact with only treatment agencies – i.e. methadone maintenance, clinical and ambulant drug treatment; (2) drug users in contact with only care agencies – i.e. day and night shelters and drug consumption rooms; and (3) drug users in contact with both treatment and care agencies. A fourth group consists of drug users in contact with neither treatment nor care agencies.

2) Seeking help is a function of the severity of people's problematic drug use
Compared to treatment groups, nontreatment groups appear to have a less problematic pattern of drug use (Hausser et al., 1999; Robson & Bruce, 1997; Rounsaville & Kleber, 1985). These differences in drug use patterns are at least partly the result of the inclusion criteria for subjects to enter the study, e.g. 'having used heroin and/or cocaine at least 25 times during life or at least once in the six months prior to the interview' (Hausser et al., 1999) and 'using amphetamine, cocaine or heroin at least monthly for three of the last four months' (Robson & Bruce, 1997). This causes differences in severity of drug use within the drug-using group.

In the present study we investigate the group of drug users who use heroin and/or crack on at least 20 days per month and who are more or less marginalized. Therefore, the differences in severity of problematic drug use should be small and therewith excluded as an influential factor in help-seeking behaviour.

3) Help-seeking is influenced by individual characteristics, environmental circumstances and socio-cultural contexts

These last two components have received little attention from researchers. Only the characteristics of drug users are considered in the present study. The individual characteristics under study are personal characteristics, drug use characteristics and characteristics of users' participation in the addiction care system. For each of the four groups, these characteristics combined indicate in which stage of the help-seeking process they are. The model used is the Stages of Change Model with the following stages: precontemplation, contemplation, preparation, action and maintenance (Prochaska, DiClemente & Norcross, 1992). In precontemplation and contemplation problems are recognized. Preparation and action are the stages in which (small) changes are prepared and made, followed by attempts to maintain these changes. The stages that lead towards action are also referred to as problem recognition, desire for help and treatment readiness; preceding stages have strong direct and indirect positive effects on the next stage (De Weert-Van Oene, Schippers, De Jong & Schrijvers, 2002; Nwakeze, Magura & Rosenblum, 2002).

Earlier research (Kuebler et al., 2000) suggests that new users (up to five years of use) report no need for treatment (including from care agencies), because they may be in an earlier stage of their drug career and, therefore, experience no problems with drug use and/or other areas. They might turn to some kind of treatment later on when problems are expierenced. Others (Robson & Bruce, 1997) suggest that a 'zero-contact' group is largely composed of 'precontemplators'; however, this group is not necessarily at an earlier stage in their drug use career then the 'contact' group. Precontemplation, according to Robson & Bruce (1997), is connected with a less problematic drug use pattern.

The present study combines these insights and investigates the differences and similarities between drug users in four addiction care conditions (only treatment agency, only care agency, both treatment and care, and neither treatment nor care). Results will be discussed within the framework of the Stages of Change Model (Prochaska et al., 1992).

Methods

Data were collected in Rotterdam, which is the second largest city in the Netherlands with about 600,000 inhabitants, within the Rotterdam Drug Monitoring System (DMS): an information and observation system which continuously collects information on drugs, drug use and drug-related phenomena and problems in Rotterdam. The DMS studies a specific group of drug users, namely those who use heroin, crack and other drugs on at least 20 days per month for at least several months. The DMS started its research in 1994 and takes the perspective of drug users as its starting point.

This study uses quantitative data from the periodic survey among drug users which was carried out in September and October 2000. The structured questionnaire included: (1) monitor questions, e.g. about buying and using drugs, their accommodations and health; and (2) questions about the Rotterdam addiction care facilities. Because we were not only interested in drug users who follow some kind of treatment but also in those who do not, we did not take a sample from addiction care registrations. Instead, we sampled respondents throughout the city of Rotterdam by means of targeted and snowball sampling (Barendregt, Van de Mheen, Van der Poel & Spreen, 2001). A total of 203 respondents were interviewed face-to-face by five community fieldworkers. These community fieldworkers were part of the researched group of (nearly) daily drug users and have knowledge from and experience with the drug scene (Blanken, Barendregt & Zuidmulder, 2000). Before the data collection, they received an extensive training in interviewing and in a-select respondent recruitment. Furthermore, in their work they were closely assisted by the coordinator of the field work and the researchers. Data from 201 respondents are analysed; two respondents were excluded because of missing data.

Table 1 shows the allocation of the respondents investigated into four groups: (1) those with contact only with treatment agencies: the **treatment** group (19%); (2) those with contact only with care agencies: the **care** group (18%); and (3) those with contact with both agencies: the **treatment and care** group (49%). These three groups comprise 173 respondents who reported contact with treatment and/or care agencies. The remaining 28 respondents report no contact with either kind of agencies, and is referred to as the **neither treatment nor care** group (14%).

The four groups were compared with regard to personal characteristics, drug use and (addiction) care variables (all self-reported). Personal characteristics include age, gender, cultural background (Dutch/other), housing situation (residence/homeless), living situation (alone/other), health situation (good/moderate/bad), illegal activities in past month (yes/no), prostitution in past month (yes/no), and having debts (yes/no). Drug use variables include the age at which regular heroin and/or crack use was started (under/above median), frequency of heroin and crack use in the past month (daily/other), the use of other drugs in the past month (amphetamines, cannabis, pills and/or alcohol: no/1/2-3 other drugs), and drug use in public in the past month (yes/no). Respondents reacted to the statement: 'I accept the fact that I am addicted' (yes/no). Variables about addiction-related care include: ever been in contact with youth welfare work (yes/no), ever having been in a psychiatric hospital (yes/no), the year of first contact with Rotterdam addiction care (under/above median), expectations of the Rotterdam addiction care (clean/control over drug use/control over other life areas/no help needed), and the number of treatment and care facilities respondents make use of (1-6: methadone maintenance, other ambulant treatment, clinical treatment, drug consumption room, day shelter and/or night shelter).

Analysis

The SPSS package (9.0/1998) was used to analyse the survey data, which are presented as frequencies (counts, averages, medians and means). Differences are tested with chi-square test (categorised variables), with 95% confidence intervals. Multivariate discriminant analysis was performed to explore what characteristics and variables are discriminative for the four groups.

Table 1. Allocation of respondents (n=201).

Group				n	%
(1) Treatment	(Drug users in contact only with treatment agencies)			39	19
	- Methadone maintenance (current*)	33	(85%)		
	- Other ambulant treatment (in past year)	10	(26%)		
	- Clinic/detoxification (in past year)	5	(13%)		
	84% one treatment agency, 8% two and 8% all three				
(2) Care	(Drug users in contact only with care agencies)			36	18
	- Day shelter (in past month)	36	(100%)		
	- Drug consumption room (in past week)	18	(50%)		
	- Night shelter program (in past month)	7	(19%)		
	44% one care agency, 42% two and 14% all three				
(3) Treatment and care	(Drug users in contact with both kinds of agencies)			98	49
	- Day shelter (in past month)	96	(98%)		
	- Methadone maintenance (current)	93	(95%)		
	- Drug consumption room (in past week)	42	(43%)		
	- Night shelter program (in past month)	24	(25%)		
	- Ambulant treatment (in past year)	15	(15%)		
	- Clinic/detoxification (in past year)	13	(13%)		
	35% two agencies, 44% three and 21% four or five				
(4) Neither treatment nor care	(Drug users not in contact with treatment or care agencies)			28	14
Total				201	100

* The periods refer to the amount of time before the interview.

Results

Table 2 presents data on the respondents, their drug use and their addiction-related care. The four groups are comparable in terms of gender ratio, age, living situation, health and illegal activities. Although not significant, the proportion of younger respondents was largest in the treatment group and care group (mean ages in the four groups are also not significantly different) and the proportion of respondents reporting good health was largest in the neither treatment nor care group.

In both the treatment group and the neither treatment nor care group about 75% of the respondents had a Dutch cultural background, which is about 20% more than in the other two groups ($p<0.10$). About one third of the care group and the treatment and care group consisted of homeless respondents, which is about twice as much as in the other two groups ($p<0.10$).

The proportion of respondents without debts was highest in the neither treatment nor care group. Income generated through prostitution was most prevalent in the care group. This is due to the fact that all but one of the females in the care group earned income through prostitution and visited a low threshold shelter for female drug prostitutes (located at the prostitution zone).

Table 2 also shows that there were no differences between the four groups in the median age of starting heroin and/or crack use (mean age is also not significantly different) and in the frequency of heroin use. The largest proportion of daily crack users was found in the care group (91%), followed by the neither treatment nor care group, the treatment group and the treatment and care group ($p<0.10$). The use of other drugs (amphetamines, cannabis, pills and alcohol) was more prevalent in the care group and treatment and care group. Almost half of the neither treatment nor care group and of the treatment group did not use any of these other drugs. Drug use in public occurred significantly less frequently in the treatment group and the neither treatment nor care group (15 to 18% of the respondents) than in the treatment and care group and care group (53 to 64%). This is probably due to homelessness: additional analyses show that 70% of the homeless respondents used drugs in public; none or a few of them were in the treatment group and in the neither treatment nor care group. Of respondents with a fixed abode, 32% used drugs in public, and most of them were in the care group and in the treatment and care group.

About the same proportion of respondents 'accept their addiction' in the three groups (no data available for the neither treatment nor care group since they were not asked this question).

For the addiction-related care variables, there are no significant differences between the four groups for ever having been in contact with youth welfare work, and ever having been in a psychiatric hospital. The proportion of respondents in the treatment group who came in contact with the Rotterdam addiction care (which can vary from outreach worker to clinic) before 1988 is larger (64%) than in the other groups (48-50%).

Of the treatment group, 84% made use of only one treatment facility (probably methadone maintenance; see table 1), whereas 86% in the care group made use of one or two facilities (day shelter and drug consumption room and/or night shelter). About one fifth of the respondents in the treatment and care group made use of (almost) all kinds of facilities. This may be because about 30% of these two groups are homeless respondents, some of whom make use of the 24-hour addiction care facilities. Of the homeless respondents, 72% made use of three or more facilities as opposed to 29% of those with fixed residence.

Comparison of the treatment group, the care group and the treatment and care group shows no significant differences in their expectations with regard to addiction care (no data are available for the neither treatment nor care group). However, some interesting figures emerged. In the treatment group 49% expected addiction care to help them to resolve drug issues (31% wanted help to become clean and 18% to control their drug use). In the other groups 30% and 37% expected help with drug issues. Also, more respondents in the care group and the treatment and care group (52% and 54%) expected help to resolve issues in other life areas, compared with 31% of the treatment group. The treatment and care group had a smaller percentage of respondents (9%) that did not need help from the addiction care than the other groups (18-20%).

Table 2. Respondent characteristics, drug use and (addiction) care variables (n= 201, %).

	Total	Treatment n = 39	Care n = 36	T and C n = 98	Neither T nor C n = 28		
Respondent characteristics							
Males	69	72	56	71	75		
Age up to 37 years (=median)	52	61	58	48	46		
Dutch cultural background	62	77	56	56	71	*	
Homeless	28	13	33	34	21	*	
Living alone	60	64	58	57	64		
(Very) good health	50	54	44	44	68		
No debts	7	10	3	3	21	**	
Illegal activities	64	55	72	65	63		1
Prostitution	20	3	42	20	14	**	2
Drug use variables							
Start age up to 19 years	54	59	50	53	54		3
Daily heroin use (≥20 days/m)	88	89	94	86	86		4
Daily cocaine use (≥20 days/m)	80	83	91	73	88	*	5
Use of no other drugs	24	41	14	14	46	**	6
Drug use in public	43	15	64	53	18	**	
'Accept addiction'	68	62	64	72	no data		7
(Addiction) care variables							
Never youth welfare work	71	77	69	66	79		
Never in psychiatric hospital	82	77	86	83	79		
First contact up to 1987	52	64	48	49	50		8
Number of facilities: 1/2 facilities	58	92	86	35	no data	**	9
"Addiction care has helped me when..."							
- they leave me alone	14	20	18	9			
- I will become and stay clean	27	31	21	27	no data		10
- I have control over my drug use	12	18	9	10			
- I have control over my situation in other life areas	48	31	52	54			

* p<0.10
** p< 0.05

1 Illegal activities = working in drug economy (e.g. dealer, courier, weigher) and/or committing offences against property and/or violent offences in past month (n=199).
2 Generation of income through prostitution in the past month.
3 Youngest age of initiation of use of heroin and/or crack (median=19 years).
4 n=186 heroin users.
5 n=185 crack users.
6 Other drugs are amphetamines, cannabis, pills and/or alcohol (three categories in analysis: no other, one other, two or three other drugs).
7 "I accept the fact that I'm addicted" (n=162; four respondents with neutral answer are excluded).
8 First contact with Rotterdam addiction care, median is 1987 (n=182).
9 Number of treatment and/or care facilities respondents made use of: methadone, clinic, ambulant, drug consumption room, day shelter, night shelter (four categories in the analysis: 1, 2, 3, 4/5 facilities).
10 The percentages of the four options add up to 100% per group.

To determine the importance of the tested variables, multivariate discriminant analysis was performed. The variable 'year of first contact with Rotterdam addiction care' was, however, excluded because of a relatively large number of missing values. Three other variables were excluded because of missing values in the neither treatment nor care group (the statements regarding accepting their addiction and addiction care expectations, and the number of facilities utilized). The final analysis included 168 respondents: 31 from the treatment group, 36 from the care group, 98 from the treatment and care group and 19 from the neither treatment nor care group. Three canonical discriminant functions were yielded by the analysis of which the first two explain 91% of the variance (function 1: 78.5% and function 2: 12.5%). These two functions are shown in the structure matrix in table 3.

Table 3. Discriminant analysis: pooled within-groups correlations between discriminating variables and standardized canonical discriminant functions.

Discriminating variables		Discr. function 1 (drug use/homelessness)		Discr. function 2 (income/health)	
Drug use in public	(0=no; 1=yes)	0.518	*	0.230	
Use of other drugs	(0; 1; 2-3 other drugs)	0.424	*	-0.194	
Housing	(0=house; 1=homeless)	0.238	*	0.204	
Cultural background	(0=Dutch; 1=other)	0.219	*	-0.043	
Prostitution	(0=no; 1-yes)	0.275		0.496	*
Health	(0=good; 1=moderate; 2=bad)	0.143		-0.348	*
Living situation	(0=alone; 1=with others)	0.025		-0.195	*
Youth welfare work	(0=no; 1-yes)	0.127		-0.190	*
Illegal activities	(0=no; 1-yes)	0.114		0.136	*
Start age of drug use	(0=20+ yrs; 1=1-19 yrs)	-0.100		0.131	*
Freq. of cocaine use	(0=1-19 days; 1=20+ days)	-0.120		0.214	
Gender	(0=male; 1=female)	0.079		-0.010	
Freq. of heroin use	(0=1-19; 1=20+ days)	0.012		0.219	
Age	(0=up to 37; 1=38+ yrs)	0.085		0.012	
Debts	(0=no; 1=yes)	0.213		-0.229	
(Psychiatric) hospital	(0=no; 1-yes)	-0.020		0.124	

* Largest absolute correlation between each variable and any discriminant function.

Drug use in public, the use of other drugs beside heroin and/or crack, housing situation (homeless or not) and cultural background are components of the first function which allows classification of respondents into one of the four groups considered. This function addresses issues of drug use and homelessness. Other Dutch drug research also connects homelessness with drug use (Coumans & Spreen, 2003; Lempens, Van de Mheen & Barendregt, 2003; Van der Poel, Barendregt & Van de Mheen, 2003). The second discriminant function contains prostitution, health situation, contact with youth welfare work, illegal activities, and age of initiation of heroin and/or crack use; this function addresses issues of income-generating activities and health. It shows a positive relation between working as a prostitute and a self-reported good health. Earlier research also connects working as a prostitute with a self-reported good health (Vitale & Wits, 2003). It is plausable that the health perception of prostitutes is crack-induced: even though objectively their health situation is relatively bad, using crack makes them feel good.

Figure 1 shows the position of the four groups with respect to the two functions. Each of the four groups has its group centroid in a different quadrant. However, with regard to the first function (drug use/homelessness), the treatment and the neither treatment nor care groups are close to one another, as are the care and the treatment and care groups. These latter two groups score relatively high on the first function, indicating that in these groups drug use and homelessness are more problematic. With regard to the second function (income/health), the care group and treatment and care group are also closest to each other. Here the treatment group and the neither treatment nor care group are furthest apart; perceived good health and illegal activities (especially prostitution) are more prevalent in the neither treatment nor care group than in the treatment group.

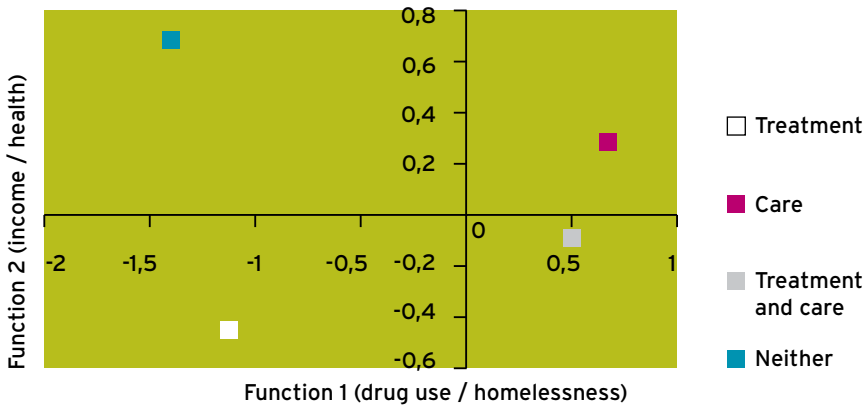


Figure 1. Unstandardised canonical discriminant functions at group centroids.

Discussion

In many studies treatment readiness, action and motivation are aimed at drug use modification, especially 'kicking the habit' (Prochaska et al., 1992). In Rotterdam, and in the Netherlands as a whole, there are two policy aims: abstinence and harm reduction (Ministry of Health, Welfare and Sport, 2002, 1995). The latter is seen in 'social addiction care' for more or less marginalized drug addicts (Development Centre Social Addiction Policy, 2000). In services and programs such as drug consumption rooms and day shelters, abstinence is not an aim and it is accepted that drug users use drugs. It is clear that concepts from the Stages of Change Model, such as contemplation, preparation and action, can also be applied in the harm reduction approach. In this approach goals include stabilization of drug use, improving health, and finding employment or housing. In the present study, this is confirmed in the expectations that drug users have about addiction care. Many expect help with gaining control over life areas other than drug use. In the following sections the four groups in this study are briefly described, placed into the Stages of Change (Proschaska et al., 1992), and then discussed.

Neither treatment nor care group and precontemplation

Drug users in this group have no contact with either treatment or care agencies. Compared to the other groups, the neither treatment nor care group is doing relatively well: 21% had no debts, 86% did not earn income through prostitution, 46% used no other drugs, and 82% did not use drugs in public. Notably (but not significantly different from the other groups) 68% reported a (very) good health and 79% had a fixed residence. This is also shown in the discriminant analyses: the neither treatment nor care group had the lowest score on the function drug use/homelessness, and the highest on income-generation/health. The group can be clearly distinguished from the other three groups. Many respondents in this group stated that they did not feel the need to contact either treatment or care agencies – because they were satisfied with their situation, did not see their drug use as a problem, or planned to solve problems by themselves – and only 44% would make use of facilities and services in the future in case they were needed. In general, these results are in accordance to the conclusions drawn by Robson & Bruce (1997) and Hausser et al. (1999): those with no contact with agencies have a less problematic pattern of drug use and do not need or search for help or treatment.

The majority of the neither treatment nor care group was in the precontemplation stage of change: there was no intention to change behaviour in the foreseeable future and there was unawareness or under-awareness of problems that may exist. Some respondents in the neither treatment nor care group did have debts, were (street) prostitutes, used drugs in public, and/or reported bad health or homelessness. This behavior can be risky for the drug users themselves, and can also be risky from a public health and public order perspective. A minority were in the contemplation stage: there was awareness that a problem exists. Reasons given for not contacting addiction care are 'strict rules' (such as the suspension regime) and 'lack of trust' in the care system. A central element in contemplation is serious consideration of problem resolution. Individuals are weighing the pros and cons of the problem and the solution to the problem, and may be in this stage for a long time. In policy documents, drug users who do not have contact with treatment and/or care agencies are usually labelled 'alarming assistance/care avoiders'. The present results show that 'carefully seeking assistance/care demanders' maybe is a better label (see also Van de Mheen, 2002).

Addiction care (e.g. outreach work) should be able to get in touch and build some trust with this group. Especially outreach workers and case managers should be able to motivate drug users to visit a physician or find a fixed abode.

Treatment group and contemplation/preparation

Treatment agencies have the goal of modifying the use of heroin and/or crack. In our study, the treatment group had contact only with treatment agencies (i.e. methadone maintenance, other ambulant treatment and/or clinic). Compared to the other groups, the treatment group was also doing relatively well: 87% had a fixed abode, 97% did not earn income through prostitution, 41% used no other drugs, and 85% did not use drugs in public. Many were young (58%) and many reported having good health (68%). This is also found in the discriminant analyses where the treatment group is different from the other three groups: i.e. with negative scores on both drug use and housing, and income and health (negative scores mean a relatively good situation).

Almost half of the treatment group expected addiction care to help them become drug free (31%) or have control over their drug use (18%). The majority were in a methadone maintenance program. Nevertheless, 89% used heroin and 83% used crack on a daily basis. Furthermore, 31% wanted help from addiction care resolving issues in other life areas. This shows that entering treatment for purposes other than abstinence is common (see also Tucker, 2001). Being in a methadone maintenance program is also suitable for goals in life areas other than drug use: every methadone client has a mentor who can offer help with these issues. These respondents may be in the contemplation stage of change (see above), or even in the preparation stage. In the preparation stage there is the intention to take action soon and there already may have been unsuccessful actions in the past period. People may also be making small steps toward the behaviour change without yet going all the way toward the goal; again, mentors in methadone programs can play an important role in this stage.

Care group and precontemplation

Care agencies have no explicit aims to modify drug use, but fit into the harm reduction approach where drug users can rest, wash themselves, and use drugs safely. The care group had contact only with care agencies (day shelters, drug consumption rooms and night shelters). The care group was not doing very well: 33% were homeless, 97% had debts, 42% earned income through prostitution, 91% used heroin on a daily basis, 86% used other drugs, and 64% used drugs in public. Furthermore, many use crack daily (91%) and many had a non-Dutch cultural background (44%). Finally, the care group had a large proportion of females (44%), reflected in the number of street prostitutes. The care group has the highest positive score on the first function in the discriminant analyses (drug use and homelessness) and a positive score on the second (which means a relatively poor income/health situation). Clearly, issues of homelessness and prostitution are intertwined in this group.

In the care group, 52% stated that addiction care had helped them when issues in areas other than drug use were resolved, and 30% wanted drug issues to be resolved. Obviously, the majority of the care group is in the precontemplation stage in which people do not (want to) recognize problems. Within the shelters

and drug consumption rooms they can use the services and may find some rest. In an earlier study (Van der Poel et al., 2003) we found that Rotterdam drug consumption rooms serve mainly as places to use drugs and secondly to get (short-term) help and assistance. It may be that many drug users in de care group have reconciled themselves to their situation; however, workers in the care agencies should be able to reach out and build trust.

Treatment and care group and (pre)contemplation

Respondents in the treatment and care group contacted both treatment and care agencies. This group falls in between the other groups; it has 'good' aspects (e.g. 80% did not earn income through prostitution and 27% did not use cocaine daily) but 34% were homeless, 86% used also other drugs, and 53% used drugs in public. The treatment and care group has a high positive score on drug use and homelessness (the first function in the discriminant analyses) and a small negative score on income and health (the second function).

Only 9% of the treatment and care group said they did not need help from addiction care. Furthermore, 65% visited three or more kinds of facilities: e.g. many get their methadone, go to a day shelter for refreshments, go to a drug consumption room to use drugs, and some spend the night in night shelters. It is suggested that they actually need different kinds of addiction care as a matter of survival assistance. Since many respondents in this group are just 'surviving' they do not have much (if any) time and energy for contemplation, let alone to make preparations to change something in their situation. On the other hand, 53% wanted addiction care to help them get control in life areas other than drug use. Staff of methadone maintenance programs, shelters and drug consumption rooms may function as a portal to additional addiction care to obtain certain goals; however, they only act at the initiative of drug users themselves (Van der Poel, Barendregt & Van de Mheen, 2001). Because of the great case loads of staff members and therefore the lack of time, drug users who do want to make a change sometimes feel not taken seriously. In order to help drug users improve their situation, additional qualified addiction care staff members are needed. With a smaller case load there can be meaningful contact, which is appreciated by Rotterdam drug users (Henskens, 2004; Van der Poel et al., 2003, 2001).

Role of care agencies

Help-seeking is often motivated to address problems related to substance use, more so than by a desire to reduce drug use (Tucker, 2001). The qualitative research of Eland-Goossensen (1997) shows that most often an accumulation of problems other than drug use were stimuli to seek help – this process is also described by Hartnoll (1992) – and that the experience of drug problems and good social relations with close relatives are factors that facilitate help-seeking behaviour. In earlier studies (Oppenheimer, Sheehan & Taylor, 1988; Power, Hartnoll & Chalmers, 1992), it is concluded that help is sought when life becomes unmanageable, when it is out of control. Low-threshold care agencies can play an important role by taking drug users under their wings and referring them to the appropriate treatment programs and projects.

In general, it is believed that early rather than late drug treatment is preferred (e.g. Oppenheimer et al., 1988). We also think that early rather than late harm reduction measures are preferred, because home-

lessness is an important feature in care agencies. In Rotterdam, it has been shown that the longer drug users are homeless, the longer they will remain homeless (Lempens et al., 2003). Early interventions by accessible care agencies are of utmost importance in the prevention of prolonged homelessness. The same probably applies to street prostitution. Furthermore, we concur with Tucker (2001) who concluded that there must be a greater emphasis on understanding the environmental contexts of drug use, because it is intertwined with daily functioning. This means that interventions should attend to the functional dimensions of the drug use if they are to serve the variable needs of individual clients. The present study has shown that these interventions should be found especially in care agencies (day shelters, night shelters and drug consumption rooms).

It is, therefore, useful to distinguish the four groups, as done in this study – which is also shown by the discriminant analysis. Otherwise, care group respondents would be classified as neither treatment nor care group respondents, and treatment and care group respondents would be classified as treatment group respondents. As the results show, the neither treatment nor care group and the treatment group are more similar, as are the care group and the treatment and care group. By describing the care group separately, a much clearer distinction is made than is done in other studies so far. Treatment and care agencies can thus better match their offer to their clients or patients.

Final remarks

Unfortunately, data on two variables were missing for respondents who do not have contact with either treatment or care agencies (acceptance of addiction and expectancies of addiction care). Also, problem recognition, desire for help and treatment readiness were not measured in our survey. In future studies, motivation must be assessed to better describe the help-seeking process with respect to (especially) care agencies, preferably in a longitudinal design. Because we analysed cross-sectional data, it is not possible to examine e.g. the idea that care agencies function as a portal to treatment agencies. Finally, we did not pay attention to environmental circumstances and socio-cultural contexts of help-seeking. The findings of this study, however, do contribute to a better distinction between the different types of drug users who seek help in some way.

References

Barendregt, C., Van de Mheen, D., Van der Poel, A., & Spreen, M. (2001). DMS survey 2000: one sample, two methods. Rotterdam: IVO Addiction Research Institute (paper presented at the Netherlands Forum for Alcohol and Drug Research (FADO), Utrecht).

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community fieldwork: bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291-296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

Chitwood, D.D., & Morningstar, P.C. (1985). Factors which differentiate cocaine users in treatment from nontreatment users. International Journal of the Addictions, 20, 449-459.

Coumans, A.M., Neve, R.J.M., & Van de Mheen, H. (2000). Het proces van marginalisering en verharding in de drugsscene van Parkstad Limburg. Resultaten van het Drug Monitoring Systeem 1998-2000 [The process of marginalisation and hardening in the drug scene of Parkstad Limburg. Results of the Drug Monitoring System 1998-2000]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., & Spreen, M. (2003). Drug use and the role of homelessness in the process of marginalization. Substance Use & Misuse, 38(3-6), 311-338.

Cunningham, J.A., Sobell, L.C., Sobell, M.B., Agrawal, S., & Toneatto, T. (1993). Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment. Addictive Behaviors, 18, 347-353.

De Graaf, I., Wildschut, J., & Van de Mheen, D. (2000). Utrechtse druggebruikers: een jachtig bestaan. Verslag van twee jaar Drug Monitoring Systeem onder Utrechtse (bijna) dagelijkse gebruikers van heroïne, cocaïne en andere drugs [Utrecht drug users: a hurried existence. Report of two years Drug Monitoring System among (nearly) daily users of heroin, crack and other drugs in Utrecht]. Rotterdam: IVO Addiction Research Institute.

De Weert-Van Oene, G.H., Schippers, G.M., De Jong, C.A.J., & Schrijvers, A.J.P. (2002). Motivation for treatment in substance-dependent patients. European Addiction Research, 8(2), 2-9.

Development Centre Social Addiction Policy (2000). Ontwikkelprogramma Sociale Verslavingszorg [Development Program Social Drug Assistance]. Utrecht: GGZ Nederland.

Eland-Goossensen, M.A. (1997). Opiate addicts in and outside of treatment; different populations? Rotterdam: IVO Addiction Research Institute / Erasmus University Rotterdam (dissertation).

Ferri, C.P., Gossop, M., & Laranjeira, R.R. (2001). High dose cocaine use in Sao Paulo: a comparison of treatment and community samples. Substance Use & Misuse, 36(3), 237-255.

Fiorentine, R., & Anglin, M.D. (1994). Perceiving need for drug treatment: a look at eight hypotheses. International Journal of the Addictions, 29(14), 1835-1854.

Hartnoll, R. (1992). Research and the help-seeking process. British Journal of the Addictions, 87, 429-437.

Hausser, D., Kuebler, D., & Dubois-Arber, F. (1999). Characteristics of heroin and cocaine users unknown to treatment agencies. Results from the Swiss Hidden Population Study. Sozial Praeventivmedicine, 44, 222-232.

Henskens, R. (2004). Grab and hold. Randomized contolled trial of the effectiveness of an outreach treatment program for chronic high-risk crack abusers. Rotterdam: Rotterdam Public Health Service (dissertation).

Klingemann, H.K. (1991). The motivation for change from problem alcohol and heroin use. British Journal of the Addictions, 86, 727-744.

Kuebler, D., Hausser, D., & Gervasoni, J. (2000). The characteristics of 'new users' of cocaine and heroin unknown to treatment agencies: results from the Swiss Hidden Population Study. Addiction, 95, 1561-1571.

Lempens, A., Van de Mheen, D., & Barendregt, C. (2003). Homeless drug users in Rotterdam, the Netherlands: profile, way of life and the need for assistance. Substance Use & Misuse, 38(3-6), 341-377.

Ministry of Health, Welfare and Sport (2002). Voortgangsrapportage drugbeleid 2001–2002 [Progress report drug policy in the Netherlands 2001–2002]. The Hague: Ministry of Health, Welfare and Sport.

Ministry of Health, Welfare and Sport (1995). Het Nederlandse drugbeleid: continuïteit en verandering [The Dutch drug policy: continuity and change]. The Hague: Ministry of Health, Welfare and Sport.

Nwakeze, P.C., Magura, S., & Rosenblum, A. (2002). Drug problem recognition, desire for help, and treatment readiness in a soup kitchen population. Substance Use & Misuse, 37(2), 291-312.

Oppenheimer, E., Sheehan, M., & Taylor, C. (1998). Letting the client speak: drug misusers and the process of help-seeking. British Journal of the Addictions, 83, 635-647.

Power, R., Hartnoll, R., & Chalmers, C. (1992). Help-seeking among illicit drug users: some differences between a treatment and nontreatment sample. International Journal of the Addictions, 27(8), 887-904.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Robson, P., & Bruce, M. (1997). A comparison of 'visible' and 'invisible' users of amphetamine, cocaine and heroin: two distinct populations? Addiction, 92(12), 1929-1736.

Rounsaville, B.J., & Kleber, H.D. (1985). Untreated opiate addicts; how do they differ from those seeking treatment? Archives of General Psychiatry, 42, 1072-1077.

Tucker, J.A. (2001). Resolving problems associated with alcohol and drug misuse: understanding relations between addictive behavior change and the use of services. Substance Use & Misuse, 36, 1501-1518.

Van de Mheen, H. (2002). Vraaggestuurde zorg: ook mogelijk in de verslavingszorg? [Demand-driven care: also possible in addiction care?]. In H. Bosselaar, J. van der Wolk, K. Zwart & H. Spies (Eds.), Vraagsturing, de cliënt aan het roer in de sociale zekerheid en zorg [Demand-driven care, the client at the helm in social security and care]. Tijdschrift voor Arbeid en Participatie, 23(3/4), 117-125.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2003). Drug consumption rooms in Rotterdam: an explorative description. European Addiction Research, 9, 94-100.

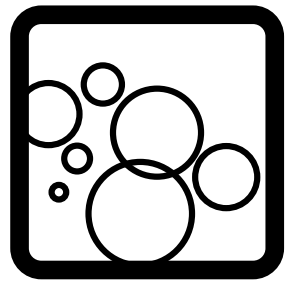
Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2001). Druggebruikers en hun gebruik van de Rotterdamse verslavingszorg [Drug users and their use of the Rotterdam addiction care system]. Rotterdam: IVO Addiction Research Institute.

Vitale, S., & Wits, E. (2003). Gezondheidsklachten en zorgbehoefte van drugsgebruikende prostituees in Rotterdam [Health complaints and need for assistance of drug using prostitutes in Rotterdam]. Rotterdam: IVO Addiction Research Institute.

chapter 5

mobility

Mobility of hard drug users: patterns and characteristics relevant for deconcentration of facilities



Chapter 5

Mobility of hard drug users: patterns and characteristics relevant for deconcentration of facilities

Published as
Van de Mheen, D., Van der Poel, A., Lempens, A., & Maalsté, N. (2007). Mobility of hard drug users: patterns and characteristics relevant for deconcentration of facilities. Journal of Psychoactive Drugs, 39(2), 191-199.

Abstract
Mobility is related to problematic hard drug use. It remains unclear, however, to what extent the availability of care facilities attracts drug users. The aim of the study is to gain insight into the mobility of problematic hard drug users, with particular focus on the possibilities for deconcentration of facilities. Quantitative and qualitative methods were used: a survey and in-depth interviews with problematic hard drug users. The results show that the extent of mobility is not related to specific characteristics of the target group. The most relevant concepts related to possible deconcentration/displacement of problematic drug users are the nature of mobility and visibility of the users. A high level of mobility does not necessarily lead to more visibility and nuisance. Having a structured daily pattern (housing and/or working) largely determines the visibility. More purposeful movement of drug users is associated with a lower level of visibility and nuisance. Mobility of users is strongly determined by the need to buy drugs. Low-threshold facilities are not a trigger for mobility as such, and need to be located near places where drug users stay and/or close to well-known dealing areas.

Introduction
For most public authorities, the control of drug-related nuisance and the prevention of concentrations of drug problems are major issues. In Rotterdam (the Netherlands), improvement in the safety of individual

neighbourhoods, and in the city as a whole, has high priority (Municipality of Rotterdam, 2001). To achieve this goal a systematic, integral approach to safety issues is essential. Within this approach, a major aim is to acquire a critical overview of the drug market and the drug scene. To date, however, knowledge is still lacking on some important aspects related to problematic hard drug use, particularly concerning the possibility to deconcentrate groups of hard drug users. The feasibility and efficacy of such a goal is dependent on (amongst other factors) the mobility of this particular group.

Nuisance
Since reduction of public nuisance is one of the major goals it is necessary to define 'nuisance'. A commonly used categorisation of drug-related nuisance distinguishes three elements: (1) criminal nuisance, (2) nuisance of public order, and (3) audiovisual nuisance (Bossaerts, 2002; Decorte et al., 2004; Snippe & Bieleman, 1999). Criminal nuisance is the most objective category, because this kind of nuisance concerns criminal activities (e.g. theft and burglary) to obtain drugs. Nuisance related to public order is, however, less objective. This category includes annexation of public space, (street)fights, noise and litter on the streets which are not necessarily directly related to drug use. Audiovisual nuisance is the most subjective category. Feelings of unsafety and/or nuisance can arise or increase due to the occurrence of deviant behaviour and/or by the visible presence of marginalised groups in the local environment.

Deconcentration
One of the aspects that negatively influence the perception of local residents is the presence and obvious manifestation of drug-related problems in their neighbourhood. Although drug-related nuisance occurs, to some extent or another, throughout the city, almost 70% of such nuisance is reported to occur in 10 of the 89 Rotterdam neighbourhoods, whereas about half of all nuisance occurs in five particular neighbourhoods (Municipality of Rotterdam, 2003). Therefore, deconcentration of drug users by promoting their displacement throughout the city, is a recurring theme of debate.

The current spread of drug users in Rotterdam is, in part, dependent on the location of various facilities for this target group; in other words, they are currently most visible in those places where many facilities are available. However, it remains unclear to what extent the availability of facilities attracts addicts; for example, are they specifically drawn towards these facilities? An earlier evaluative study of the Rotterdam policy (Spijkerman et al., 2002) revealed that the plan to spread the facilities for homeless drug users throughout the entire city has not yet been realised. Indeed, neighbourhoods with the most drug-related nuisance were those with the most facilities for substance users. Facilities are addiction care (including methadone service) and low-threshold facilities (e.g. drug consumption rooms and shelters).

Mobility
When considering the deconcentration of facilities, it is important to establish to what extent problematic hard drug users are particularly attached to their specific (aid/care) facilities. If it appears that the target group is (for whatever reasons) strongly attached to a particular place, then the spread of facilities will serve little purpose. Only when the transfer to a similar (aid/housing) facility elsewhere in the city is both easy and attractive will deconcentration become a viable option. From this viewpoint, deconcentration and mobility are unavoidably connected.

Studies on the mobility of drug users have generally been conducted from the perspective of the related nuisance, the drug trade and criminality; the goal was mainly to assess the influence of government policy on these particular factors. International studies on the actual mobility of drug users (e.g. where they come from, to what extent they are mobile, and the motivations for their movements) are scarce, but a few Dutch studies have been published. For example, Lempens, Van der Most & Knibbe (2005) and Lempens, Wildschut, Knibbe & Van de Mheen (2001) investigated the drug scene in the city of Utrecht and distinguished three main groups of hard drug users on the basis of the frequency and duration of their presence in the open drug scene there. The 'centre-avoiders' come to the scene only to buy drugs and then return to their home or work; they may travel a considerable distance (sometimes more than once a day) and are, thus, very mobile. In contrast, for the 'centre-inhabitants' the drug scene is their only home and consequently they are extremely immobile. Between these two poles is another group called the 'centre-visitors'. Push-and-pull factors determine the appeal of the drug scene, and thereby the mobility of drug users. The 'push' side includes factors such as homelessness, absence of social contact outside the scene, lack of regular daily activities, and the chance to obtain/earn some money; these types of activities drive/push drug users towards the central drug scene. Some of the 'pull' factors (which attract users) include the continuous supply of (small quantities of) drugs, the opportunity to make some money, and the social contacts. Another study conducted in Utrecht (Lempens, Wildschut, Van der Most & Knibbe, 2003) showed that the physical closure of a central market/meeting place for the drug scene resulted in a dispersion of users to other locations (geographical displacement), as well as a new time for gathering, namely at night (temporal displacement). Coumans & Knibbe (2002) showed that users in the hard drug scene of Parkstad Limburg (a region in the south of the Netherlands) were almost constantly on the move, whether alone or in small groups; this movement was mainly towards the city centre. This constant movement is primarily attributable to and/or determined by the presence of the police. Generally speaking, dealers and users did not move **en masse** to the neighbourhoods outside the city centre, but tend to disperse over locations at the edge of the city centre.

The international literature includes a few review studies that describe the extremely dynamic nature of the drug trade, especially under the influence of a repressive police policy (see e.g. Caulkins, 1992; Eck, 1993; Rengert, 1990; Sherman, 1990). The study on criminality by Cromwell, Olson, Avery & Marks (1991) hypothesised that the need for criminal offences is flexible, so that preventative strategies do not necessarily lead to displacement. Studies by Lowman (1992) and Mathews (1993) explored whether relocation of prostitution was a result of repressive measures, and concluded that this was largely dependent on the involvement that the prostitutes have with their work, i.e. the greater the involvement, the greater the displacement.
The terms 'displacement effect' or 'waterbed effect' are well known in relation to repression as a means to deal with nuisance; i.e. exerting pressure on one place leads to the reappearance of the same problem in another place. In a criminological review, Hesseling (1994) concluded that (following crime prevention initiatives) displacement does not always occur and is seldom, or never, sufficient. Displacement is therefore a feasible but not necessary result of restrictive police strategies. A few studies have specifically investigated the relationship between displacement and the drug scene (Grapendaal, Leuw & Nelen, 1991; Van Burik & Starmans, 1990; Van Gemert, 1988). However, conclusions regarding the effect of displacement of the drug

scene on the extent of nuisance are not simple. According to Bless, Korf & Freeman (1995) who compared different policy strategies in European countries, some considered 'thinning out' (spreading drug users throughout the city) as decreasing the nuisance because (the obviously visible) concentrated drug scene falls apart. In contrast is an equally plausible argument that thinning out in fact leads to more nuisance because the presence of drug users becomes apparent over a larger area, such that both the drug users and their (undesired) activities are observed by more people.

Study Aims

The aim of the current study is to gain insight into the mobility of problematic hard drug users, with particular focus on the effects of deconcentration of various facilities. The two research questions are:

1. What is the mobility pattern of problematic hard drug users, and what motives underlie this pattern?
2. Based on the nature and extent of the mobility, to what extent can we expect that deconcentrated facilities will in fact be utilised by the target group?

For the purpose of this study, we define problematic hard drug users as follows (Biesma, Snippe & Bieleman, 2004; Lempens, Boers & Maalsté, 2004) as those persons who for at least a minimum of one year use hard drugs (opiates, crack-cocaine, amphetamines, and similar drugs) daily or almost daily (three or more days a week in the previous month) and also demonstrate one or more of the following characteristics:

- commit criminal activities to obtain money and thereby has been confronted with the police and/or judiciary;
- have mental/psychiatric problems;
- have lifestyles that cause public nuisance;
- do not have own housing, or in spite of having own housing stay mainly on the streets.

Methods

This study used a combination of quantitative and qualitative research methods: namely, a survey and in-depth interviews with problematic hard drug users.

Survey

The survey consisted of a structured face-to-face interview (each lasting about 45 minutes) with 182 problematic hard drug users. Data were collected in April and May 2003 by means of targeted sampling. This implies that respondents were recruited at all possible locations that the target group is known to frequent (e.g. in and around aid/care facilities, near the street drug trade, places visited during their search for money, at outside sleeping places, etc.). In this way the broadest group of users was reached. At places where drug users are easily recognisable, the researchers recruited respondents themselves. At locations that both users and non-users frequent, the research teams worked together with 'guides'; the latter were themselves drug users who know that particular neighbourhood very well. Recruitment of the respondents was a-selective: for example, every second or third user who entered a particular place or who crossed an imaginary line on the street was approached. After the verbal interview had taken place each respondent received a reward of 10 Euros.

The group of 182 respondents had an average age of around 30 years and about 75% were male. About 50% were autochthonous Dutch, and the remainder were comprised of allochthonous subgroups of (successively) Surinamese, Moroccans and Antillians/Arubanese. The most used substance was a combination of opiates (heroin and/or methadone) with crack-cocaine on almost all days of the month. About half of the respondents participated in a methadone program. Besides drugs, about 20% also regularly used alcohol. The mean duration of addiction was long (range 16 to18 years) and 50% of the population was homeless. For men, the most important sources of income were social benefits, offences against property (stealing) and illegal work, whereas for women prostitution was the main source followed by social benefits and offences against property. In addition, alternative sources of income such as day labouring and work in/around the drug trade played an important role. The large majority were regularly confronted with fines related to, for example, being in breach of the municipal laws. Many regularly bought and used drugs on the street, and about 30% had mental problems.

In relation to the daily activities of users, five core categories can be distinguished: housing, buying drugs, using drugs, obtaining money, and use of aid/care agencies (Lempens et al., 2003). In order to establish mobility, we explored in which of the 89 Rotterdam neighbourhoods each of the five core activities was carried out; the reference period for the users was the previous month. Thus, the number of neighbourhoods frequented by each respondent was used to determine the extent of their personal mobility.

In-depth interviews

In order to collect background information on mobility, additional in-depth interviews (using a semi-structured questionnaire) were held with 34 problematic hard drug users. In October and November 2004 respondents were recruited at the same places and in the same way as respondents for the survey. The researchers approached 38 persons and this resulted in 34 valid interviews. The length of the interviews was about one hour; location was in almost all cases a quite place near the sites were respondents were recruited.

Data analyses

The survey data were analysed using the statistical package SPSS (Field, 2005). Exact scores and averages were calculated. Where appropriate, relationships were determined using t-tests and chi-square tests (95% CI; $p \leq 0.05$). The in-depth interviews were tape recorded and typed out verbatim. Interviews were coded and analysed with the software program Kwalitan (Wester & Peters, 2004).

Results

Mobility in the neighbourhoods

On average the problematic hard drug users visited about five different neighbourhoods in order to conduct their daily activities, i.e. buying drugs, using drugs, obtaining income, making use of aid/care facilities, sleeping and/or residing. Indeed, there was concentration of daily activities in four Rotterdam neighbourhoods (which may cause nuisance): in these neighbourhoods at least ten drug users conducted four or five of their daily activities. Some years ago the municipality designated the same four neighbourhoods as

'problem areas': each year they show low scores on the Rotterdam Safety Index. Partly, these low scores are caused by drug-related nuisance (Municipality of Rotterdam, 2005).

With respect to the level of mobility, almost 40% of the users had a relatively low level of mobility in that they frequented only one to three different neighbourhoods, compared with 20% who frequented seven or more neighbourhoods (table 1). Only 6% reported to move among ten or more neighbourhoods; these are users who tend to see the entire city as their home.

Table 1. Number of different neighbourhoods in which daily activities take place (n=182).

No. of neighbourhoods	No. of users
1, 2 or 3 neighbourhoods	71 users (39%)
4, 5 or 6 neighbourhoods	75 users (41%)
7 or more neighbourhoods	36 users (20%)

Using drugs and using aid/care facilities were the two core activities that cause problematic drug users to be most mobile throughout the city (table 2). On average drugs were used in at least two neighbourhoods, generally twice a day. Similarly, almost two thirds of the group used aid/care facilities in two or more neighbourhoods. More than 50% bought their drugs in two or more neighbourhoods, whereas obtaining money tended to take place (in about 65% of cases) in one neighbourhood only. The differences between the respondents were relatively small: the highest average number of neighbourhoods per activity was 2.1 and the lowest was 1.4 (table 2).

Table 2. Average number of neighbourhoods in which core activities take place (n=182).

Core activities	Average no. neighbourhoods
Use of drugs	2.1
Use of aid/care facilities	2.0
Buying drugs	1.8
Living/sleeping	1.5
Obtaining money	1.4

The relationship between activities is closest for living and using drugs: drug use often takes place in the same neighbourhood where the problematic drug users live or stay (almost 25% uses nowhere else). For 36% of the users (mainly users with regular housing) the most important place to use was at home. For 25% the most important place to use was in a drug consumption room, and for 23% this was in public/on the street. Although the homeless have no fixed abode, almost all of them used drugs 'at home' in their own neighbourhood. When asked in which neighbourhood they lived or mainly stayed, generally the drug-using homeless named the same neighbourhood where they mainly used their drugs.

Moreover, it appears that (use of) aid/care facilities least often occurs in the same neighbourhood where problematic drug users live or stay: almost two thirds of them leave the neighbourhood where they live/stay in order to make use of care facilities. On the way from home to the facilities they traverse the largest number of neighbourhoods. This implies that care facilities have a great pulling power. Nevertheless, the pull of these facilities is not great enough to cause users to adjust their daily living pattern around such facilities: for example, the homeless did not stay near the facilities they visited longer/more often than users who had a fixed abode.

Relationship between mobility and user characteristics

Is there an association between the extent of mobility and characteristics of problematic hard drug users? There appears to be minimal differences in mobility between the various categories of users. None of the characteristics – age, gender, number of days of use of heroin, crack-cocaine or methadone, duration of addiction, criminal activities, and behaviour causing nuisance – are related to the extent of mobility. The only two groups that deviated from the general mobility pattern were homeless drug users and those with mental problems. Homeless drug users frequented more different neighbourhoods than those with a fixed abode. Further analysis reveals that this greater mobility is explained by the homeless sleeping in night shelter facilities in a different neighbourhood then where they conducted other daily activities. Finally, users with mental problems were less mobile: on average they frequented fewer neighbourhoods to conduct their daily activities.

Relationship between visibility and user characteristics

Because the extent of mobility proved not to be a valid basis on which to distinguish between users, we therefore looked at another factor possibly associated with mobility, namely visibility. By this we mean the extent to which someone either visibly carries out drug-related activities and/or is recognisable as a drug user. Visibility is operationalised in the number of hours per day that a user spends outside: this varies strongly between users. About 30% of the survey respondents spent 13-24 hours a day on the streets (table 3).

Table 3. Number of hours per day that problematic users spend outside (n=182).

Hours/day spend outside	No. of users
1 – 3 hours	27 users (15%)
3.5 – 9 hours	64 users (35%)
9.5 – 12 hours	39 users (21%)
13 – 24 hours	52 users (29%)

The number of hours a drug user stays on the streets is related to some characteristics of users. For example, the homeless spend more time outside than those who have housing, and those with mental problems spend fewer hours on the streets. In addition, the longer a user stays outside the greater the chance that he/she causes nuisance or commits an offence. Moreover, the survey data show that the number of days of use of heroin/crack-cocaine is higher among those who spend more time outside, whereas those who use methadone spend less time on the streets. Age, gender and duration of addiction are not related to the number of hours spent outside.

Relationship between mobility and visibility

One of the premises of the present study is that users who are extremely mobile are more visible and thereby contribute to more drug-related nuisance, and cause more residents to feel unsafe. Therefore, the question that arises is: what is the relationship between mobility and visibility?
In order to assess to what extent the above hypothesis is valid, we evaluated the 34 in-depth interviews with respect to the extent of their mobility (high/low) and their visibility (more/less). The results show that there is no specific relationship between the extent of mobility and visibility. There is a group of users with a high level of mobility that is not visible, and a group with low mobility that is visible. Further analysis reveals that users do differ in the nature of their mobility, i.e. in the purposefulness (goal orientation) of their mobility. This means that the nature of mobility is not so much related to the distances covered, but rather to the reasons why a user moves around. Some users move around mainly when they have a definite goal in mind (e.g. to get methadone or buy drugs), whereas the reasons of others are less clear. The analyses show that the homeless, men, and those causing nuisance generally move in a less goal-oriented way. The lack of purposefulness of movements is associated with their visibility: i.e. users who move around aimlessly are generally more visible (and cause more drug-related nuisance).

Pattern of mobility

To gain insight into the pattern of mobility, drug users were asked to what extent the outline they sketched of their previous day (24 hours) was exemplary. In other words, to what extent do they have a structured daily routine, or is each day filled in totally differently? The interviews show that most users have a fairly stable routine.

"What did I do yesterday? … (thinks deeply and sighs:) I don't know any more. You know, my actions are always the same: I grab a client, I have a smoke, and then I start all over again" (woman, aged 34).

"A year ago it was exactly the same. OK, I lived with someone else, but in the same situation. Ten years ago it was the same and even 15 years ago. I've never lived completely on the streets; I always manage to stay somewhere" (man, aged 47).

Although most respondents reported that 'every day is the same', differences exist between groups of users who have or do not have a regular structure in their day. Users with a structured day pattern have an agenda with appointments that determine the course of their day. For example, they go working in the morning and afterwards eat a meal in a day shelter. These drug users also go to aid/care facilities where they can access the Internet, or play billiards and games. This offers an alternative to street life and gives them the opportunity to think about something other than drugs. They state that this structure is important in order to decrease their use of drugs and/or their illegal activities. Users with a more structured daily pattern have a more goal-oriented mobility: reasons for their movement are clearer and often planned in advance.

"At 6:30 I got up in night shelter Havenzicht and took a shower. You have to get out by 8 a.m., but because I was going to work I got the tram at 7:30 a.m. Yesterday I had to get my methadone first and then I can get to Topscore (an employment agency for drug users) a bit later. Between 8:45 and 9:15 a.m. I go and get my methadone (three times a week). Then, I went to my work place where they were already started. I'm a work supervisor so I cycle through eight neighbourhoods to check on the sweep teams. At 3:10 p.m. I went to the Topscore office where everyone has to sign in – only then you get paid. Then I went to a dealer (in a house) where I got some crack-cocaine: half a gram for 20 Euros. I used inside (...) and stayed until about 6:30 p.m." (man, aged 52).

Respondents who live in supervised housing also reported having more structure in their life. Household tasks such as clearing up, cleaning, cooking etc. are a means of avoiding thinking about drugs.

For many respondents without a structured daily pattern, buying and using drugs (and obtaining money to pay for drugs) determined the course of their day. The extent to which drugs determine their daily pattern depends on whether or not alternative activities are available: e.g. going home, or doing some type of work. When a user has to spend the entire day on the streets, there is little else to do except search for and use drugs. Once they have used, the urge for more comes rapidly. Although the authorities have little influence on the activities of these users, the 'keep moving' policy ensures some degree of (enforced) mobility and displacement of these activities or of just 'hanging out'.

Important triggers and prioritisation

Thus it appears that the most relevant concepts related to possible deconcentration/displacement of problematic drug users throughout the city are the nature of mobility and visibility of the users. Therefore, the next question to be addressed is: to what extent are respondents prepared to travel for their various daily activities? The 34 respondents who provided in-depth interviews indicated their priorities within the following activities: finding a place to sleep (at their preferred place), personal care (free/cheap food, toilets, and washing/showering), to use different types of drug aid agencies (e.g. methadone program, medical care, night shelter, drug consumption room and low-threshold centres), buying drugs from own dealer, finding good quality drugs, the cheapest drugs, and using drugs (at their preferred place). It should be emphasised that this list is based on a hypothetical situation that the service/activity that the users normally use/undertake is not available and that they would have to go 'a long way' to get them. This resulted in a list of the top four most important (table 4) and the top four least important activities/ destinations (table 5).

Table 4. Top four activities which respondents would go 'a long way for' or 'as far as needed'.

	Activity
1.	Medical care
2.	To obtain good quality crack-cocaine and/or heroin
3.	To get methadone
4.	To get crack-cocaine or heroin from one's own regular dealer

Table 5. Top four activities which respondents would 'not go anywhere for' or 'not go a long way for'.

	Activity
1.	To use heroin and/or crack-cocaine undisturbed/quietly (in a drug consumption room or outside)
2.	To visit friends
3.	To get cheap crack-cocaine and/or heroin
4.	To get (cheap/free) food or personal hygiene facilities (e.g. to wash, shower, use toilet)

It is noteworthy that 'medical care' tops the list in table 4, while in the interviews it was stressed that acute medical care problems are not the issue here.

"My health's very important. I had a lung photo made because I'd been with someone who may have had something. I'm very careful about that" (man, aged 21).

Based on further questioning it appeared that medical care is not a daily activity. In other words: in practice respondents seldom make use of medical care, but when considered necessary they are prepared to go as far as is needed. Good quality crack-cocaine and/or heroin are a close second. In this context, most respondents refer to the importance of a good price-quality ratio and a high level of reliability.

"For homeless users quality is really important. They've only got two Euros to spend. So for the couple of Euros they've got, they don't want to buy any rubbish" (woman, aged 40).

The majority of methadone users seem to be very dedicated to their therapy, because getting methadone is high on their list of priorities. Getting heroin or crack-cocaine from their own dealer is also important, but less so than good quality. Most users have one or more reserve telephone numbers or addresses, or consider themselves experts enough to buy good quality drugs from an unknown dealer.
Heroin and crack-cocaine are mainly used when and where it happens to be convenient: the majority are not interested in making a detour to use drugs.

"I use at home, but also everyday outside. (...) When I've bought something I take one or two puffs straight away (near metro station Delfshaven) and then I go home. (...) I do it inside, near where the ticket offices are. Maybe they see it, but it's only a moment, then I'm gone. I think they probably know about it" (man, aged 52).

Similarly, visiting friends, family or acquaintances is not an important mobility factor, often because either these relationships are scarce or do not run smoothly. The large majority of the interviewees said that they have no friends ("in the drug scene you don't have friends"). Nevertheless, many drug users attach importance to their personal contact with social workers, or with each other within the shelters. Most users see cheap drugs as a synonym for bad drugs and show little interest in them. Similarly, they are not bothered about free or cheap food, and the same applies to the possibility of using washing facilities/showers and toilets. The only subgroup that is particularly interested in personal care is prostitutes, because their appearance is important in order to earn their money.

Conclusions

Representativeness and generalisability

Before drawing conclusions, we first discuss to what extent the results can be generalised to the entire population of problematic hard drug users in Rotterdam. First of all, problematic hard drug users are categorised as a so-called 'hidden population'. Characteristics of this group include: (1) there is no random sample framework for this group, (2) from the societal viewpoint belonging to such a group is seen as undesirable and/or controversial, and (3) the group is relatively small so that a random sample among the general population will produce insufficient power for analysis (Heckathorn, 1997). In particular, due to the lack of a random sample framework (such as a registration system) a random sample among this 'hidden group' can never be totally representative. These limitations need to be taken into consideration when the results are generalised to the entire population of problematic hard drug users.

In the present study we applied targeted sampling, a recruitment strategy often used for this type of hidden population. In this way the reach is not limited to respondents known to institutions such as the police and care agencies. In practice, however, it appears that some selection bias occurs: i.e. with targeted sampling the most visible and most problematic users are over-represented (Carlson, Wang, Harvey, Falck & Guo, 1994; Watters & Biernacki, 1989). Nevertheless, when recruitment takes place at different places and at different times (as was the case in the present study), there is less selection bias. In addition, we used guides (themselves members of the target group) to recruit at locations where users are not immediately recognisable (or hardly recognisable), for example in more residential areas.

After data collection, the application of data triangulation and various retrospective checks of the random sample are effective methods to gain insight into possible selection bias (Barendregt, Van der Poel & Van de Mheen, 2005). The qualitative and quantitative data were combined, and this data triangulation increases the reliability of the data. The data emerging from the in-depth interviews and from the survey complement each other, and confirm the results obtained from both methods independently. With reference to retrospective checks, a comparison of some characteristics of the respondents participating in the survey with data from the most recent (Rotterdam) methadone register confirms that the two populations are highly comparable (Barendregt et al., 2005). Thus, the representativeness of the random sample seems to be the maximum that can be achieved in a hidden population such as this. Therefore, we consider that the results of this study realistically reflect the situation of the group of problematic hard drug users in Rotterdam.

Extent of mobility and underlying motives

The results show that the extent of mobility is not related to specific characteristics of the target group. Moreover, a high level of mobility does not necessarily lead to more visibility and nuisance. Problematic hard drug users appear to differ in the nature of the mobility: specifically, on the goal-oriented nature of their movements. More purposeful movement of drug users is associated with a lower level of visibility and nuisance. Having – or lacking – a structured daily pattern largely determines the purposefulness of the presence, and thus the visibility, on the streets. The only significant alternatives for a daily pattern dominated by buying and using drugs are the factors housing and work. Users with own housing and/or work

have a more regulated daily structure; because their mobility and presence on the streets is more goal-oriented they have little (or even no) impact on their immediate surroundings.

A repressive policy appeared to have no effect on the nature of the mobility of users. However, repression does have an impact on the locations where users congregate, and can result in users becoming mobile and staying more mobile ('keep moving' policy). However, this does not necessarily lead to an immediate increase in the extent of mobility (e.g. to other neighbourhoods) because the distances involved are often minimal; i.e. this generally involves simply 'going round the block'. When users lack a good alternative to being on the street (e.g. having their own home, a dealing address, a work place, or a regular way of obtaining money), then repression will tend to reduce their visibility and thus the pressure at one particular location but increase visibility and pressure elsewhere. Thus, the nature of mobility does not change under a repressive policy: this finding confirms the results of previous studies that explored this topic (Bless et al. 1995; Coumans & Knibbe 2002; Hesseling 1994; Van Burik & Starmans 1990; Van Gemert 1988).

An important item related to the extent and nature of mobility is: what are the main triggers that cause problematic hard drug users to move around? The results show that the mobility of users is strongly determined by the need to buy drugs; in this respect reliability and quality take precedence. Surprisingly, the importance of (low-threshold) medical care was also rated high, even though this was not a daily activity. Drug consumption rooms and facilities offering only a 'bath, bread and bed' were not considered particularly important.

Deconcentration of facilities and mobility

The triggers for mobility emerging from this study show that users are more inclined to make use of facilities when additional 'services' are present in that particular neighbourhood that do serve as strong triggers. This primarily concerns the presence of a drug infrastructure: i.e. a steady supply of drugs with a good price-quality ratio. When the drug trade is coupled with the presence of supplementary services, such as the possibility to use drugs indoors or other facilities (e.g. sleeping, recreation, food and a bed) then this becomes not only an attractive factor but also a 'binding' factor for users.

The current policy in the Netherlands is to avoid having users be caught up in a 24-hour cycle of aid/care agencies. This implies that the opening hours of the various facilities are not synchronised such that users can wander in somewhere every moment of the day. As a result, mainly the homeless users have to turn to public places at certain times and/or are obliged to wait outside until the facility opens again; this is often accompanied by related nuisance. Low-threshold facilities (e.g. drug consumption rooms and shelters) do not exert an important pull on problematic hard drug users. It is the location of the low-threshold facility that mainly determines to what extent it is used. Problematic hard drug users are less inclined to use these facilities if they have to travel to get to them. This implies that these facilities need to be located near the places where drug users stay and/or close to the well-known dealing areas. An exception to this is the supply of medical care and of methadone for which most of the target group were prepared to travel a far distance; however, these are not services that bind the users to that specific place. Locations that offer a daily supply of drugs and the means to buy them are the most important in this respect.

References

Barendregt, C., Van der Poel, A., & Van de Mheen, D. (2005). Tracing selection effects in three non-probability samples. European Addiction Research, 11(3), 124-131.

Biesma, S., Snippe, J., & Bieleman, B. (2004). Harddrugsgebruikers geregistreerd. Aard, omvang en mobiliteit van problematische harddrugsgebruikers in Rotterdam [Hard drug users registered. Nature, extent and mobility of problematic hard drug use in Rotterdam]. Groningen / Rotterdam: Intraval, bureau for research and consultancy.

Bless, R., Korf, D.J., & Freeman, M. (1995). **Urban drug policies in Europe**. Amsterdam: O+S, Department for Research and Statistics.

Bossaerts, B. (Ed.) (2002). Naar minder hinder: draaiboek aanpak drugsoverlast [Towards less nuisance, scenario approach drug nuisance]. Brussels: VAD, Vereniging voor Alcohol- en andere Drugproblemen vzw.

Carlson, G.C., Wang, J., Harvey A.S., Falck R.S., & Guo, J. (1994). An ethnographic approach to targeted sampling: problems an solutions in Aids prevention research among injecting drug and crack-cocaine users. Human organisation, 53(3), 279-286.

Caulkins, J.P. (1992). Thinking about displacement in drug markets: why observing change of venue isn't enough. Journal of Drug Issues, 22(1), 17-30.

Coumans, A.M., & Knibbe, R.A. (2002). Drugsgebruikers in Parkstad Limburg: trends en profielen. Resultaten van het Drug Monitoring Systeem 2001-2002 [Drug users in Parkstad Limburg: trends and profiles. Results of the Drug Monitoring System 2001-2002]. Rotterdam / Maastricht: IVO Addiction Research Institute.

Cromwell, P.F., Olson, J.N., Avery, D.W., & Marks, A. (1991). How drugs affect decisions by burglars. International Journal of Offender Therapy and Comparative Criminology, 35(4), 310-321.

Decorte, T., De Ruyver, B., Ponsaers, P., Bodein, M., Lacroix, A.C., Lauwers, S., & Tuteleers, P. (2004). Drugs and nuisance. Study of the phenomenon, the control and the effects of drug-related nuisance from different perspectives. Gent: Academia Press.

Eck, J.P. (1993). The threat of crime displacement. Criminal Justice Abstracts, 25(3), 527-546.

Field, A. (2005). Discovering statistics using SPSS. Second edition. London: Thousand Oaks, New Delhi: Sage Publications.

Grapendaal, M., Leuw, E., & Nelen, J.M. (1991). De economie van het drugsbestaan. Criminaliteit als expressie van levensstijl en loopbaan [The economics of the drug existence. Criminality as expression of lifestyle and career]. Arnhem: Gouda Quint.

Heckathorn, D.D. (1997). Respondent-driven sampling: a new approach of the study of hidden populations. Social Problems, 44(2), 174-199.

Hesseling, R.B.P. (1994). Stoppen of verplaatsen? Een literatuuronderzoek over gelegenheidsbeperkende preventie en verplaatsing van criminaliteit [To stop or displace? A literature study on opportunity restriction prevention and displacement of criminality]. Arnhem: Gouda Quint.

Lempens, A., Boers, R., & Maalsté, N. (2004). Harddrugsgebruikers in beweging. Aard, omvang en mobiliteit van harddrugsgebruikers in Rotterdam [Hard drug users on the move. Nature, extent and mobility of problematic hard drug users in Rotterdam]. Rotterdam: IVO Addiction Research Institute.

Lempens, A., Van der Most, D., & Knibbe, R.A. (2005). "Wij zijn ook een beetje mensen". Een onderzoek naar de deelgroep harddrugsgebruikers in Utrecht die buiten de nieuwe voorzieningen blijft ["We are also humans". A study into the sub group of hard drug users in Utrecht that cannot go into the new facilities]. Rotterdam/Utrecht: IVO Addiction Research Institute.

Lempens, A., Wildschut, J., Knibbe, R.A., & Van de Mheen, D. (2001). Straatgroep Utrechtse drugsgebruikers rondom Hoog Catharijne [Street group of Utrecht drug users near Hoog Catharijne]. Rotterdam: IVO Addiction Research Institute.

Lempens, A., Wildschut. J., Van der Most, D., & Knibbe, R.A. (2003). "Na de tunnelsluiting". Een onderzoek naar de eerste effecten van de verandering in de Utrechtse harddrugsscene ["After the closure of the Tunnel". A study into the first effects of the changes in the Utrecht hard drug scene]. Rotterdam/Utrecht: IVO Addiction Research Institute.

Lowman, J. (1992). Street prostitution control: some Canadian reflections on the Finsbury Park Experience. British Journal of Criminology, 32(1), 1-17.

Mathews, R. (1993). Kerb-crawling, prostitution and multi-agency policing. London: Home Office Department.

Municipality of Rotterdam (2005). Veiligheidsindex 2005. Meting van de veiligheid in Rotterdam. Rapportage bewonersenquête januari-februari 2005 en feitelijke criminaliteitsgegevens en contextgegevens over 2004 [Safety index 2005. Measurement of the safety in Rotterdam. Report survey inhabitants January-February 2005 and actual criminality and context data on 2004]. Rotterdam: Department of Public Safety.

Municipality of Rotterdam (2003). Resultaten van een tussentijdse meting van de veiligheidsindex [Results of an interval measurement of the safety index]. Rotterdam: Department of Public Safety.

Municipality of Rotterdam (2001). Versterking veiligheid Rotterdam. Vijfjarenprogramma in samenwerking tussen stadsbestuur, deelgemeenten, stedelijke diensten, politie, justitie, bewoners, maatschappelijke organisaties en bedrijven [Reinforcement safety Rotterdam. Five-year program in collaboration with city council, boroughs, municipal services, police, justice, inhabitants, social organizations and companies]. Rotterdam: Department of Public Safety.

Rengert, G.F. (1990). Drug purchasing as a routine activity of drug dependent property criminals and the spatial concentration of crime. Contribution to the ASC Conference.

Sherman, L.W. (1990). Police crackdowns: initial and residual deterrence. In M. Tonry & N. Morris (Eds.), Crime and justice; a review of research 12 (pp. 1-48). Chicago: The University of Chicago Press.

Snippe, J., & Bieleman, B. (1999). Buurten over last. Monitoren van drugsoverlast in de SVO-gemeenten 1993-1998 [Neighbourhoods about nuisance. The monitoring of drug nuisance in the SVO municipalities 1993-1998]. Groningen / Rotterdam: Intraval, bureau for research and consultancy.

Spijkerman, R., Biesma, S., Meijer, G., Van der Poel, A., Van den Eijnden, R.J.J.M., & Bieleman, B. (2002). Vier jaar Verantwoord Schoon. Evaluatie van Verantwoord Schoon; een programma voor aanpak van drugsoverlast in Rotterdamse deelgemeenten [Four years 'Safe & Clean'. Evaluation of Safe & Clean; a program for tackling drug nuisance in Rotterdam boroughs]. Rotterdam / Groningen: IVO Addiction Research Institute / Intraval, bureau for research and consultancy.

Van Burik, A.E., & Starmans, I.H.J. (1990). Evaluatie beleidsexperimenten veel voorkomende criminaliteit Hoog Catharijne Utrecht [Evaluation of policy experiments frequently occurring criminality Hoog Catharijne Utrecht]. Utrecht: University of Utrecht.

Van Gemert, F. (1988). Mazen en netwerken; de invloed van beleid op de drugshandel in twee straten in de Amsterdamse binnenstad [Meshes and networks; de influence of policy on the drug trade in two streets in the Amsterdam city centre]. Amsterdam: University of Amsterdam.

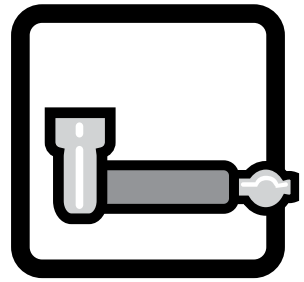
Watters, J.K., & Biernacki, P. (1989). Targeted sampling: options for the study of hidden populations. Social Problems, 36(4), 416-430.

Wester, F., & Peters, V. (2004). Kwalitatieve analyse. Uitgangspunten en procedures [Qualitative analysis: basic assumptions and procedures]. Bussum: Coutinho.

chapter 6

consumption

Drug consumption rooms in Rotterdam: an explorative description



Chapter 6

Drug consumption rooms in Rotterdam: an explorative description

Published as
Van der Poel, A., Barendregt, C, & Van de Mheen, D. (2003). Drug consumption rooms in Rotterdam: an explorative description. European Addiction Research, 9, 94-100.

Abstract
The Rotterdam Drug Monitoring System (DMS) used survey data, fieldnotes and interviews with staff to investigate the functioning of four (out of six) consumption rooms in Rotterdam. The results show that for most drug users, access to the drug consumption room results in less frequent drug use in public places and more time and rest. Pass holders value being able to use drugs safely inside, and make use of the additional services provided, such as refreshments, washing/showering facilities and talking with others about their personal problems. Two 'weak points' reported by the drug users are discussed in relation to their personal health and public nuisance reduction.

Introduction
In the Netherlands, a drug consumption room is defined as a facility under the administration of an official organisation, where drug users are given the opportunity to take drugs (De Jong & Weber, 1999; Geurs, 1996; Municipality of Rotterdam, 1998). The core activity within a drug consumption room is the consumption of drugs and the facility is furnished to allow efficient and safe consumption. The executive organisation of the facilities also aims to realise a broader objective, particularly in the field of harm reduction (such as preventing overdoses and HIV) and tackling the public nuisance caused by drug use on the street (De Jong & Weber, 1999; Geurs, 1996).

In the year 2000, the city of Rotterdam had six drug consumption rooms. About 500 drug users have an admission pass for one of these facilities, which is obligatory in order to use drugs on the premises. Rotterdam has about 4,000 dependent heroin and cocaine users (Municipality of Rotterdam, 1998), meaning that about 15% has an admission pass. Since 1996, the city of Rotterdam formally supports the development of drug consumption facilities within a policy that aims at reducing drug-related nuisance, 'Safe & Clean in Rotterdam' (Municipality of Rotterdam, 1997). The aims of 'Safe & Clean in Rotterdam' are to be attained with three initiatives: housing projects, drug consumption rooms and interventions in the supply side of the drug market. Drug consumption rooms have to meet as many of the 17 conditions compiled by the Rotterdam Public Health Service as possible (Municipality of Rotterdam, 1998). Conditions that reduce public nuisance include: a clearly described target group, a consistent front door policy, and collaboration with the police. Conditions that improve the health situation of drug users include: availability of drug use materials, information/education, and integration into the complete drug assistance and care available.

This explorative description aims to elucidate the meaning and importance of the Rotterdam drug consumption rooms for those who have an admission pass, and addresses the following research questions:

1. What are the strong/weak points (advantages/disadvantages) experienced by pass holders in relation to the drug consumption room?
2. Which of the available services/assistance do pass holders make most use of? (For instance, the opportunity to use of drugs inside the facility, and the gateway to additional care and assistance.)

Description of the drug consumption rooms
Four of the six Rotterdam drug consumption rooms are included: the 'Pauluskerk' (PK), 'Keetje Tippel' (KT), the 'Buurthuis' (BH) and the 'Moerkerkestraat' (MS). These four facilities are longer established and have standardised procedures, in contrast to the two other consumption rooms that started in 2000 and which are excluded. In all consumption rooms, the employees register all admissions, ensure that house rules are adhered to, and supply drug use materials such as clean needles, tin foil, and alcohol pads. All facilities have separate rooms for smoking and for injecting drugs. More pass holders make use of the smoking rooms than the injecting rooms. Some basic characteristics are listed in table 1.

All four consumption rooms aim at a reduction of public nuisance and personal harm. The PK is a foundation involved in church social welfare work. Besides a drug consumption room and a living room, the PK also offers a night shelter and consultation hours with professional social workers, which means that (part of) the assistance actually takes place on the premises of PK. KT (for female street prostitutes), BH and MS (both intended for homeless addicts) function as a gateway to addiction care, and their assistants give access to, for example, housing projects, the Cocaine Project or rehabilitation clinics.
Furthermore, in order to obtain or update a pass, all women of KT are obliged to see a physician (STD control) about once every three months.

Table 1. Characteristics of the four Rotterdam drug consumption rooms investigated.

Characteristics	Pauluskerk PK	Keetje Tippel KT	Buurthuis BH	Moerkerkestraat MS
Location	City centre	Streetwalkers' district (harbour)	Residential area	Residential area
Year of start	1990	1997	1997	1998
Organisation	KSA Foundation	Addiction care *	Addiction care *	Addiction care *
Main goal	Harm reduction	Nuisance reduction	Nuisance reduction	Nuisance reduction
Target group	No specific criteria	Street prostitutes (f)	Homeless	Homeless
Number of passes	250	150	25-30	25-30
Smoking room: places	20 places	14 places	10-14 places	10-14 places
Time limit per visit	15-30 min	30 min	no time limit	no time limit
Injection room: places	20 places	5 places	5-6 places	5-6 places
Time limit per visit	no time limit	60 min	no time limit	no time limit
Opening hours (daily)	09:30-16:00 and 19:00-22:00 hrs	18:00-07:00 hrs	10:00-22:00 hrs	11:00-21:00 hrs

* 'Bouman Addiction Care Centre' organises alcohol and drugs prevention and addiction care for the Rotterdam area.

Methods

Data were collected within the Rotterdam Drug Monitoring System (DMS), an information and observation system which continuously collects information on drugs, drug use and drug-related phenomenon and problems in Rotterdam amongst daily or nearly-daily users of heroin, cocaine and other drugs. DMS takes the perspective of drug users as a starting point. For this explorative description, DMS used data from (1) a survey among drug users, (2) community fieldwork and (3) interviews with key informants.

(1) In September and October 2000, DMS carried out their bi-annual survey, which included monitor questions and questions on addiction care facilities. Respondents were not primarily found in places with active addiction care, but by means of targeted sampling and snowball sampling (Barendregt, Van de Mheen, Van der Poel & Spreen, 2001). Community fieldworkers [see (2)] conducted face-to-face interviews with 213 respondents, of whom 67 had an admission pass for one of the four consumption rooms: 37 for PK, 20 for KT, 5 for BH and 5 for MS. These latter 10 respondents are grouped together since BH and MS are organised in a similar way. The four consumption rooms have a total of about 450 pass holders, which means that about 15% of them have been interviewed.

(2) Community fieldworkers play an important role in the DMS, since they are drug users who report on events and phenomenon in the Rotterdam drug scene. These fieldworkers are part of the researched group of daily drug users, and they have knowledge of and experience with the drug scene (Blanken, Barendregt & Zuidmulder, 2000). They write down their observations and reflections in fieldnotes. In 1999 and 2000, the four drug consumption rooms were mentioned in 53 passages in 47 fieldnotes.

(3) All project leaders of the four drug consumption rooms were interviewed about the functioning of 'their' facility, as was one of the employees of each drug consumption room. In total seven key informants were interviewed (one person is project leader of two drug consumption rooms).

The SPSS package (9.0/1998) was used to analyse the survey data, which are presented as frequencies (counts, averages, medians and means). Due to the small number of respondents (n=67), differences between the four drug consumption rooms were not tested. The 47 fieldnotes and 7 interviews were analysed by close reading and free-coding.

Results

Description of pass holders and visits

Table 2 presents characteristics of the 67 pass holders. For each of the consumption rooms, the sample of respondents included in the survey is representative for the total group of pass holders for gender, age, cultural background and housing status (confirmed in interviews with the key informants).

On average, respondents had visited a drug consumption room on 6 days (median 7 days for each of the four facilities) in the week prior to the interview, and twice in the preceding 24 h (median 2-2.5 visits for each facility). The fieldnotes also clearly show that drug consumption rooms are places that pass holders visit frequently.

A minority of respondents (23%) (also) injects in the drug consumption room. Many more respondents (also) smoke drugs: 81% by means of 'chasing the dragon' and 67% with a base pipe. Basing cocaine is the preferred way of using drugs in BH, MS and KT (90-100%). Officially, basing is prohibited in PK; however, 46% of the respondents state that they use a base pipe there.

Table 2. Characteristics of the 67 pass holders (survey data).

Characteristics	PK n=37	KT n=20	BH / MS n=10	Total n=67
Females	1 (3)	20 (100)	1 (10)	22 (33)
Mean age (years)	36 years	36 years	36 years	36 years
Dutch cultural background	10 (27)	13 (65)	5 (50)	30 (45)
Permanent address[1]	22 (59)	5 (25)	0	37 (55)

Figures in parentheses are percentages.

[1] Permanent address (living in a house or a room), as opposed to no fixed abode, i.e. homeless, night shelters, living in squats, wandering around.

Strong and weak points experienced

Survey results show that one strong point, or advantage, of going to the drug consumption room is the mere fact that drugs can be used quietly inside the facility. Some respondents emphasise that they "can smoke there without getting caught". Others mention the shelter function, stating that "it's very nice to be able to sit inside if you don't have a house and it's cold". The opening hours are important in this respect; especially in the case of PK, which is "open many hours, also in the evening". A homeless respondent from BH says: "I can go there all day, I'm not hunted". In all consumption rooms 'injecting and smoking are kept separate" and "it's well regulated how long you are inside".

Other strong points are beyond the respondents immediate interest of using drugs. Some stress the value of the workers because they have a "helpful, listening ear" and "they have consideration for people who have no money". The fact that in some consumption rooms "the coffee is free" and that pass holders "can take a shower or wash clothes" is considered as added value. Finally, one PK visitor points out the social value of the facility by stating that he "sometimes meets old acquaintances and can use [drugs] with them".

Almost all weak points concern the immediate interest of drug users with drugs and drug use. Many of these disadvantages relate to the large scale of both PK and KT, and these disadvantages often interact with each other. Visitors say they "have to wait for a long time before [they] can go inside", and once they are inside they "can stay for only half an hour". Crowds lead to waiting times and this sometimes causes pass holders to "go outside to smoke". At KT, women state that it is "too crowded, [they] can't use the drugs properly with all these annoying girls around". A PK pass holder says: "They make such a **** noise. They spoil the flash of the coke". A crowded environment with people who are often short of dope leads to "begging for dope, fights, noise". Pass holders say they "have to watch [their] stuff all the time". Some relate the stressed situations to the employees who "are not all qualified for this kind of work". This is taken for granted because some pass holders want the opening hours extended: "it opens late on the weekend". In the BH and the MS, weak points concerning drugs and drug use are less clearly related to their smaller scale, and do not interact with each other. It is, however, sometimes "noisy and the staff does nothing when there is an argument", and "if something happens, a fight or something, nobody steps in". An extension of opening hours is also desired: "it should be open during the night".
Only one respondent (of KT) mentioned a weak point concerning the care/assistance offered: "The assistance is not good". In general, respondents reported less weak points than strong points. Some respondents of each of the four consumption rooms had no weak points to report at all.

The opportunity to use drugs inside
Survey results show that BH and MS are important places to use drugs for all of their respondents, and PK is important for 84% of PK respondents. Only 35% of the KT respondents see KT as an important place to use drugs, probably because these women are primarily working and can use drugs during the opening hours.

Drug use outdoors or in public places
Drug-related (visual) nuisance is reduced when drugs are consumed in the consumption room and not in public places. When asked whether respondents used drugs outdoors during the previous month, 69% answer this question with 'yes'; these 46 respondents had, on average, used drugs outdoors on 18 days in the previous month. Nevertheless, 83% of all respondents state that they use drugs less often outdoors since having an admission pass (table 4).

In the fieldnotes, several reasons for using drugs outdoors (or rather, for not using drugs in the consumption room) become clear. Besides strong craving, the time between buying and consuming drugs can be too long:

"Thursday afternoon, I have to buy something, but where? I have money and because of that I crave for white. […] He takes the scales out of the cupboard and weighs a 'line' [0.1 gram]. I want to use in the Buurthuis, and therefore I leave immediately. I know myself: if I smoke a base upstairs, I'll smoke everything I have. I feel more at ease in the Buurthuis than at this dealing address. I'm walking fast in the direction of the Buurthuis, but I feel such a craving that I stop in a doorway to smoke a base. That wasn't a good idea because the pipe was broken and instead of coke I mostly smoked ashes. Coughing, I move on to the Buurthuis" (fieldnote mbru1103).

Another reason is that friends of pass holders may not have an admission pass. Finally, the house rules (time limit per visit) and opening hours of the facilities are given as additional reasons for using drugs outdoors or in public places.

Data from the key informants contain little information about pass holders using drugs outdoors and the possible reasons for doing so. Generally, a pass holder (especially from PK) is suspended if caught using outdoors or in the neighbourhood of the drug consumption room. Although some facilities are organised to reduce public nuisance, according to some staff this is barely feasible:

"It would be strange to think that a small-scale drug consumption room would solve the drug nuisance problem; people tend to forget that drugs still have to be bought somewhere" (interview at BH/MS).

Gateway to assistance
Which services and assistance do pass holders make most use of? In the survey, respondents were asked whether or not they made use of the services provided by the facility (table 3). Only 8 respondents (all KT) in fact make no use of any services provided, which means that 88% of all respondents go to the drug consumption room to use drugs and to make use of the other services. Most popular services are 'coffee and a chat' (73%), 'eat a meal' (57%), and 'wash clothes, take a shower' (46%). A similar picture is provided by the fieldnotes and interviews:

"Plenty of use is made of the things that the Buurthuis offers. Most of them come in on a daily basis to use drugs, drink coffee, and have soup and a sandwich" (interview at BH).

"Often they say 'Mom' to me or something, so sweet. And I get letters, or little presents. At home I make cigarettes that I give them when we talk. Social contact is so important" (interview at KT).

"I get up and tell her that I'm leaving to wash my clothes in the Buurthuis. She says she'll stay there for a while [in the squat] and will come there later. […] I stay in the Buurthuis till she comes but I'm getting bored. There's nothing to do on a Saturday!" (fieldnote delf0401).

Table 3. The use of services provided by drug consumption rooms (survey data).

Service	PK n=37	KT n=20	BH/MS n=10	Total n=67
Coffee and a chat	31 (84)	8 (40)	10 (100)	49 (73)
Eat a meal	27 (73)	3 (15)	8 (80)	38 (57)
Wash clothes, take a shower	16 (43)	6 (30)	9 (90)	31 (46)
Talk about personal problems	22 (60)	4 (20)	4 (40)	30 (45)
Information on assistance (e.g. housing, debts, justice)	22 (60)	2 (10)	2 (20)	26 (39)
Medical care, treatment	16 (43)	6 (30)	3 (30)	25 (37)
Syringe exchange	7 (19)	5 (25)	4 (40)	16 (24)
Information on therapy (e.g. cure, methadone)	10 (27)	1 (5)	2 (20)	13 (19)
Information on safe use of drugs	8 (22)	2 (10)	0	10 (15)
Only to use drugs	0	8 (40)	0	8 (12)

Figures in parentheses are percentages.

For some respondents the drug consumption room serves as a place to obtain information about assistance (39%), therapy (19%), and/or safe use (15%) (table 3). Over a third of all pass holders receive some medical care/treatment within the facility. Although KT pass holders see a physician every three months, many of them (70%) apparently do not see this as medical care or treatment.

"Recently, I almost quit working on the streetwalkers' district but from the moment we became homeless, I've been back there more often. At Keetje Tippel I went to the doctor's to have my lungs listened to and to get a blood test for my anaemia. I need iron tablets. When I was there at night, I also used drugs inside the drug consumption room" (fieldnote zorg0628).

"We don't organise theme nights or anything like that. If users want to know something I'll do my utmost best to provide them with information. Actually, we get few questions, there is not much need for prevention and so on" (interview at BH).

Effects

Visiting a drug consumption room has the following (self-reported) effects (table 4): 'more time and rest' (67%), 'more attention to hygiene' (49%), and 'more attention to physical condition' (30%). The fieldnotes describe many people who sleep in the night shelter of PK or sleep on couches in the living room of one of the other facilities. A positive effect may be that pass holders get more rest and improve their physical condition because they have some place where they can sleep for a while.

According to 59% of the respondents, visiting the drug consumption room had no effect on their drug use (table 4); 11 respondents even state that they smoke or inject more frequently since going to a consumption room. From this perspective, consumption rooms can have a negative effect on drug use. The fieldnotes record that pass holders continuously use drugs (especially cocaine), make money, buy drugs, use drugs, make money and so on. The facility could then be seen as a place that may even enhance drug use:

"I'm tired, I haven't slept for a couple of days. I plan to smoke what I have here and then go to sleep. […] I'm not tired, I'm exhausted! Eventually I prepare my last base and I smoke it in one time. It's magic, I'm full of energy, I think. Go to sleep, me? Not necessarily now. […] At this moment anything can happen and actually it's really dangerous to go on, to continue. It's aggression towards yourself and towards your health" (fieldnote coke0126).

Table 4. Effects of going to a drug consumption room (survey data).

Since having an admission pass …	PK n=33	KT n=20	BH/MS n=10	Total n=63
I use drugs less often in public	26 (79)	16 (80)	10 (100)	52 (83)
I have more time and rest	26 (79)	6 (30)	10 (100)	42 (67)
My drug use has not changed (in general)	16 (49)	15 (75)	6 (60)	37 (59)
I pay more attention to hygiene	19 (58)	5 (25)	7 (70)	31 (49)
I pay more attention to my physical condition	13 (39)	2 (10)	4 (40)	19 (30)
I smoke drugs more frequently (again)	1 (3)	7 (35)	1 (10)	9 (14)
I use less drugs (in general)	6 (18)	2 (10)	0	8 (13)
I smoke drugs less frequently	4 (12)	2 (10)	0	6 (10)
I inject drugs less frequently	2 (6)	0	0	2 (3)
I inject drugs more frequently (again)	1 (3)	1 (5)	0	2 (3)

Figures in parentheses are percentages.

Discussion

This explorative description is the first to investigate the meaning and importance of Rotterdam drug consumption rooms for the drug users themselves. Three research methods are combined and applied to the four Rotterdam consumption rooms that have existed for more than two years. The data obtained from the survey and the fieldnotes both support and complement each other. For example, the survey gives more detailed, but no different information, than the fieldnotes about visits to the consumption room. By means of this validation approach (Kelle, 2001), exploration of the meaning and importance that pass holders attribute to drug consumption rooms can be assumed to be valid. By ways of supplement, interviews with key informants were included.

The question as to whether these results are representative for other (Dutch) cities is difficult to answer, because Rotterdam is in a unique position. For example, Rotterdam has the largest number of consumption rooms in the Netherlands, and independent Rotterdam organisations, such as the Junkie Union (interest group of drug users), serve to keep local policymakers alert to drug users and their needs. Furthermore, the Dutch set-up for drug consumption rooms is different from that in other countries; for example, Germany has more drug injectors and does not issue admission passes (Zurhold, Kreutzfeld, Degkwitz, Verthein &

Krausz, 2001). However, the results do provide an insight into possible reactions and evaluations of drug users towards 'their' drug consumption room; policy makers, (drug) assistants and others can learn from the Rotterdam situation.

Definition

According to pass holders, a drug consumption room is primarily a place where they can use drugs safely and quietly, the fact that they can get (short-term) assistance is of secondary importance. Employees define a drug consumption room in a similar way. one of them describes it as follows:

"It's a simple story. I think it is a low-threshold facility where a number of people that live poorly have the opportunity to get some rest and use their drugs. A kind of day shelter facility. Bread, coffee, a bite and a drink, laughter and tears. This definition goes a long way, I think it covers about 99% of the people here".

These definitions match the official definition of a drug consumption room – a facility where drug users are given the opportunity to take drugs efficiently and safely; besides this, broader objectives are intended to be realised: reduction of public nuisance and personal harm (De Jong & Weber, 1999; Geurs, 1996). We can cautiously draw the conclusion that these goals have partially been reached. Public nuisance is being reduced because any time a pass holder uses drugs inside he or she is not causing (visual) nuisance outside. The personal (health) situation of pass holders improves because they make ample use of the additional services offered. Thus the advantages reported by the pass holders do indeed match the goals of a drug consumption room. The reported weak points and disadvantages are discussed below.

Weak points

The opening hours (or rather, the closing hours) of the facilities can cause pass holders to use drugs outdoors or in public places. Thus, theoretically, 24/7 opening hours could reduce drug-related nuisance even further. However, it has been argued that drug dealing causes more nuisance than the use of it, in which case extended opening hours would not necessarily reduce drug-related public nuisance. Moreover, for pass holders round-the-clock access to a facility may even stimulate drug use. Thus the notion that a drug consumption room necessarily motivates its users to improve their personal situation and that longer opening hours will enhance this motivation is not substantiated by our results.

Pass holders from the large-scale PK and KT facilities report that this leads to crowds, waiting, annoyance and chaos. When they eventually get into the smoking or injecting room, they can stay only for 15 to 60 minutes, then they have to leave, and can return after a break of at least 30 minutes. If the time was unlimited they would probably stay longer, but then the queues would become longer. Or, those waiting would use drugs outdoors rather than wait their turn. Pass holders from the small-scale BH and MS facilities have few criticisms. These two consumption rooms have no limit to the time pass holders can spend in the smoking or injecting room. However, this does not lead to uncontrolled drug use because a check is made on the length of time each person stays in one of the rooms and on the intoxication level of each pass holder. Furthermore, pass holders have to leave the premises to buy their drugs, which entails a break in drug use. The results indicate that pass holders prefer a small-scale facility to a larger one.

Integration?

The question arises to what degree the drug consumption rooms are integrated in the lives of pass holders who, by meeting the criteria for an admission pass, are already marginalised. They tend to visit the facility twice a day to use their drugs, have refreshments, chat, sleep, watch TV, wash clothes, etc. This could indicate that drug consumption rooms are integrated in the lives of the pass holders. This is corroborated by the staff:

"Most of the clients we have here, really stay here. It rarely happens that a client is gone, and when that is the case, usually it's prison or abroad or a rehab, things like that".

This notion of integration may, however, have two implications which require future study:

(1) Does an admission pass perpetuate the current situation of drug users, implying that they continue to be homeless, work as prostitutes or continue to be marginalised in one way or another?
(2) Could an admission pass serve to re-establish the trust that drug users may have lost in the addiction care or in society as a whole?

Acknowledgements

We thank Heike Zurhold, Peter Degkwitz and Uwe Verthein from the Institute for Interdisciplinary Addiction Research (ISD, Hamburg) for inviting IVO to participate in a European study on drug consumption rooms (Zurhold, Kreutzfeld, Degkwitz, Verthein & Krausz, 2001). It has been a pleasant and fruitful co-operation.

References

Barendregt, C., Van de Mheen, D., Van der Poel, A., & Spreen, M. (2001). DMS survey 2000: one sample, two methods. Rotterdam: IVO Addiction Research Institute (paper presented at the Netherlands Forum for Alcohol and Drug Research (FADO), Utrecht).

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community fieldwork: bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291-296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

De Jong, W., & Weber, U. (1999). The professional acceptance of drug use: a closer look at drug consumption rooms in the Netherlands, Germany and Switzerland. International Journal of Drug Policy, 10, 99-108.

Geurs, R. (1996). Ruimte om te gebruiken [Room for use]. In T. Quadt (Ed.), Verantwoord Schoon in Rotterdam [Safe & Clean in Rotterdam] (pp. 16-20). Rotterdam: Rotterdam Public Health Service.

Kelle, U. (2001). Sociological explanations between micro and macro and the integration of qualitative and quantitative methods. Forum Qualitative Sozialforschung/Forum Social Research, On-line journal. Available at: http://qualitative-research.net/fqs/fqs-eng.htm.

Municipality of Rotterdam (1998). The outlines of the Rotterdam addiction policy. Rotterdam: Rotterdam Public Health Service.

Municipality of Rotterdam (1997). Factsheet Verantwoord Schoon in Rotterdam [Factsheet Safe & Clean in Rotterdam]. Rotterdam: Rotterdam Public Health Service.

Zurhold, H., Kreutzfeldt, N., Degkwitz, P., & Verthein, U. (2001). Drogenkonsumräume. Gesundheidsförderung und Minderung öffentlicher Belastungen in europäischen Grossstädten [Drug consumption rooms. Increasing health and reducing public nuisance in European cities]. Hamburg: Institut für interdisziplinäre Sucht- und Drogenforschung.

chapter 7

health care

Specialised health care for the homeless: the Street General Practice in Rotterdam, the Netherlands

Chapter 7

Specialised health care for the homeless: the Street General Practice in Rotterdam, the Netherlands

Submitted as
Van der Poel, A., & Van de Mheen, D. Specialised health care for the homeless: the Street General Practice in Rotterdam, the Netherlands.

Abstract

Homeless people generally suffer from multiple complex problems related to their substance abuse, physical and mental problems, making specialised health care necessary. In Rotterdam primary health care is offered in the Street General Practice. This practice is integrated in low-threshold care facilities, such as day and night shelters, drug consumption rooms and social pensions. To further improve the functioning of this practice, health characteristics of patients, changes in the patient group and type of complaints, and success factors were analysed using registration data and a questionnaire among GPs and nurses. The patient group is mostly male, older than 40 years, insured, and had 3 to 4 contacts each year (mean). Of those with registered problems (54%), most had substance abuse problems (67%), psychiatric problems (11%) or both (23%). The patients expressed about 1.4 complaints (mean per three-month period). The proportion of patients expressing complaints about joints, lungs, skin and stomach remained the same, about psychological issues and feet complaints decreased, and 'other' complaints increased over the years. GPs and nurses see that the aging patient group (especially with long-term substance abuse) got more chronic complaints. GPs and nurses experience that residential homeless people (those who live in supported housing projects, as initiated by the municipality of Rotterdam) take better care of themselves. However, psychiatric problems can surface. According to GPs and nurses the Street General Practice is a succes because of the accessibility (integrated within the social relief sector in low-threshold care facilities), the continuity (in that medical files are available online at every facility) and the cooperation both at management level – between municipality, insurance companies and social relief sector – and at operational level – between GPs and nurses.
Integrated care, addressing medical and social issues, remains necessary as long as mainstream health care is not accessible for many of the homeless and does not adequately respond to the needs of homeless people.

Introduction

Homeless people generally suffer from multiple complex problems related to their physical and mental health (Blow, De Wacker, Louckx, Van Heusden & Van Menxel, 2006; Boardman, 2006; Brandt, 2007; Bronsveld, 2004; Hwang, Tolomiczenko, Kopuyoumdjian & Garner, 2005; Kunstmann, Becker, Schulte & Völlm, 1997; McCabe, Macnee & Andersen, 2001; Moore, Gerdtz & Manias, 2007; O'Toole et al., 2007; Schanzer, Dominguez, Shrout & Caton, 2007; Tucker et al., 2005; Victor, 1997; Wright & Tompkins, 2006). Also in the Netherlands, homelessness, substance abuse, physical problems and mental/psychiatric problems are intertwined (Bronsveld, 2004; Lempens, Van de Mheen & Barendregt, 2003). Dutch studies show that mental disorders and addiction frequently occur among the homeless (Reinking, Wolf & Kroon, 2001; Van Rooij, Mulder, Wits, Van der Poel & Van de Mheen, 2007; Wolf et al., 2002), and that complaints that burden homeless persons are particularly associated with skin complaints, small wounds, tooth problems, bad feeding condition, respiratory problems, problems in the locomotor system, stomach diseases and (post) traumatic disorders (Jansen & Karaköse, 2003; Jansen, Kolk, Maaskant & Stoele, 2002; Roorda-Honée & Heydendaal, 1997; Van Laere, 2000, 1997; Van Laere & Buster, 2001; Wolf et al., 2002). Furthermore, medical consumption and the help-seeking behaviour of homeless people differ from that of the typical citizen; for example, homeless persons see a physician about twice a year (Bronsveld, 2004) and generally *"only when it can no longer be postponed"* (Barends, 1995). In contrast, the typical citizen sees a physician about five times a year (www.linh.nl). When homeless people see a general practitioner (GP) the treatment load is generally high because GPs may have to apply several medical interventions (Bronsveld, 2004). Moreover, compliance with treatment is not self-evident (Health Council of the Netherlands, 1995); many homeless have more urgent priorities than complying with treatment, e.g. surviving in the scene, and buying/using alcohol or drugs. Self-medication with alcohol and all kinds of drugs (including medicinal drugs) is frequent (e.g. Van der Poel, Barendregt, Schouten & Van de Mheen, 2003).

In 1995, the Health Council of the Netherlands recommended the establishment of specialised social medical care for the homeless. This care should consist of low-threshold nursing consultation hours, GP consultation hours, and nursing beds. Some Dutch cities have realised these medical facilities in order to improve the accessibility of health care for the homeless (Elissen, Van Raak & Vrijhoef, 2008; Van Laere, 2002, 2000; Van Laere & Buster, 2001). In Rotterdam (with 600,000 inhabitants the second largest city of the Netherlands) nursing hours, GP hours and nursing beds are incorporated in the social relief system. This means that the social medical care is integrated in a larger organisation that also offers care with respect to other life areas (e.g. sleeping, housing, work/activities, income and debts, social work, safe drug use). Medical care is thus integrated in low-threshold care facilities, such as day and/or night shelters, drug consumption rooms and social hostels (a type of residential supported housing). By organising medical

care in this manner, it is suggested that the reach of the medical care would be enlarged and herewith the health situation of the homeless would be improved.

The present study evaluates the GP consultation hours as offered in the so-called 'Street General Practice'.

Street General Practice

For several decades, primary health care for the homeless in Rotterdam was offered by a few physicians (on their own initiative) and encouraged by various Rotterdam social relief centres (Quispel & Slockers, 1985). In 2003, the Street General Practice for the homeless became official when 7 physicians collaborated in the cooperative practice. Each week the GPs run at least 16 practice hours at 10 different low-threshold care facilities. For each patient an electronic medical file is made and all GPs have on-line access to these files at all locations.

Nurses are important for the Street General Practice (Van der Poel & Krol, 2008, 2007; Van der Poel, Krol & De Jong, 2005a; Van der Poel, Krol, De Jong & Jansen, 2005b). They have nursing hours at the 10 locations and refer patients, if necessary, to the Street General Practice. During consulting hours, GPs and nurses work together (nurses are always present) and after the consulting hours nurses have follow-up responsibilities, e.g. changing bandages, cleansing wounds, and supervising the intake of medication.

The Rotterdam Public Health Service is responsible for organising accessible health care for the homeless, including the Street General Practice. It does so by collaborating with other local organisations, including Municipal Social Affairs and Employment, the local association of health care insurance companies, Basisberaad Rijnmond (a client participation platform for consumers of mental health care), and the four social relief organisations that integrated social medical care in their low-threshold care facilities.

The Street General Practice aims to reach 'actual homeless people' who (occasionally) sleep in night shelters, and 'residential homeless people' who visit day shelters (and who may or may not have a permanent abode with housing counselling). Additionally, homeless persons who are admitted to official shelter-based nursing beds are also patients of the Street General Practice (Krol, 2003).

Study aims

To further improve the functioning of the Street General Practice, as a part of the specialised health care for the homeless, the following research questions were posed:

1. What are the health characteristics of the patients visiting the Street General Practice?
2. What changes in the patient group and type of complaints are observed by the GPs and nurses, and are there explanations for them?
3. What, according to GPs and nurses, are success factors of the Street General Practice and which improvements could be made?

Methods

To answer the first question we analysed the Street General Practice registration data; for the second and third question the GPs and nurses were requested to fill out a questionnaire.

Registration data

The Street General Practice uses an electronic GP registration system, accessible to physicians and nurses at all participating low-threshold care facilities. In 2004, 2005 and 2006 a total of 1,181 patients (aged ≥16 years) were registered. The registration system has two separate data sets: (a) patient data and (b) visit data.

(a) Patient data include: patient number, name, sex, year of birth, and information on health insurance. Insurance data are included in the registration system for each year in which a patient was seen by a GP; however, because these data can change over time (e.g. a patient may have insurance in 2005 but not in 2006), they are not available at the aggregate level.

(b) Visit data include: dates, complaints expressed by patients (as typed into the system by GPs), evaluation and action by GPs, ICPC codes, prescribed medication, and correspondence with, for example, hospitals. In a 'normal' Dutch General Practice, complaints and evaluations are generally registered with the International Classification of Primary Care (ICPC) codes (Gebel & Lamberts, 2000). In the Street General Practice, although GPs do not always use the ICPC codes, they do always register complaints and evaluations in their own words. Therefore, we analysed complaints expressed by patients (and typed into the medical file) for a three-month period (September through November) for 2004, 2005 and 2006. Substance abuse and the psychiatric condition of patients are also registered with ICPC codes (P15 for alcohol abuse, P19 for drug abuse, and P71 to P99 for e.g. psychoses, schizophrenia and personality disorders). Since these conditions are more 'chronic' types, GPs tend to register them more accurately. Therefore, for all patients we searched for these ICPC codes back to the year 2000; many patients were registered as substance abusers or as having psychiatric problems more than once throughout the years.

The patient and visit data sets of 1,181 patients were used to explore the first research question (with the exception of health complaints and medication). These data were put into SPSS version 15 and subsequently analysed (frequencies, cross-tabulations and means, tested with Chi-square tests and ANOVA). For health complaints and medication, data were analysed from patients who visited the Street General Practice in September, October and/or November of 2004 (n=247 patients), 2005 (n=273 patients) and 2006 (n=245 patients). For each patient we categorised the complaints (as entered in the medical file) that the patient expressed during their Street General Practice visit(s) and the type of medication prescribed. Changes in health complaints and medication over the 3 years were not tested for significance because the data are the typed-in registration of complaints and should therefore be regarded as indicative.

Questionnaire

In 2007 a written questionnaire was sent to the 7 GPs and 11 nurses of the Street General Practice. They were asked if, and how, the patient group and type of complaints have changed over recent years. After follow-up, 6 GPs and 9 nurses returned the questionnaire. Answers from the GPs and nurses (separate and combined data) were analysed by means of close reading and categorisation.

Results

The majority of the 1,181 patients was male (87.4%). The mean age was 43 years (SD 11.61 years), the median age 42 years. The oldest patient was 81, the youngest 19 years old. Male patients were on average 4 years older than female patients (p<0.001).

Contacts, insurance

During the years 2004, 2005 and 2006 the 1,181 patients had a total of 5,876 contacts with the Street General Practice. The average patient had 4.98 contacts (Table 1); there were no significant differences between male and female patients. Older patients visited on average more frequently than younger patients: ranging from 3 visits for patients aged 18-30 years, to 4 visits for those aged 31-40 years, to 5 visits for those aged 41-50 years, and to 7 visits for those aged 51 years and older (p<0.0001; results not shown).

In each of the years (2004, 2005 and 2006) about 75% of patients had health insurance (Table 2); there were no significant differences between male and female patients. Regarding age, for 2004 and 2005 the youngest age group (18-30 years) had the smallest proportion of insured patients (<60%; both years p<0.05). In 2006 there were no significant differences between the age groups (results not shown). Table 2 also shows that the group with health insurance visited the Street General Practice 3.5 to 4 times each year. The group with no insurance consisted of about 15% of patients who could have health insurance but had not (yet) arranged it; they made 2 to 4 visits each year. The remainder of the uninsured group (about 10%) were illegal migrants who therefore could not arrange health insurance; they made about 3 to 4 visits each year.

Table 1. Number of contacts with the Street General Practice by the study population (n=1,181).

		Patients (n)	Mean number of contacts per patient (SD)	Range contacts
Total		1,181	4.98 (7.30)	1-76
Per year *	- in 2004	425	3.25 (3.48)	1-29
	- in 2005	647	3.42 (4.16)	1-38
	- in 2006	569	4.01 (5.27)	1-33
Through the years **	- only in 2004	215	2.55 (3.04)	1-29
	- only in 2005	306	2.13 (2.26)	1-23
	- only in 2006	298	2.98 (4.04)	1-33
	- in 2 years	264	7.50 (6.56)	2-41
	- in 3 years	98	18.45 (13.91)	3-76

* The mean number of contacts in the "only years" does not significantly differ from each other.

** Each of the "only years" significantly differs from the "in 2 years" and "in 3 years" (both p<0.0001). The mean number of contacts "in 2 years" significantly differs from that "in 3 years" (p<0.0001).

Table 2. Health insurance and mean number of contacts per year.

	Health insurance - mean number of contacts			
Year	% with insurance - contacts (SD)	% no insurance (but could have) - contacts (SD)	% no insurance (illegal migrants) - contacts (SD)	
2004 (n=421)	76.5% - 3.47 (3.65)	14.5% - 2.21 (1.99)	9.0% - 3.26 (3.80)	*
2005 (n=646)	71.5% - 3.57 (4.36)	17.7% - 2.52 (3.45)	10.8% - 3.99 (3.72)	*
2006 (n=558)	74.2% - 4.04 (5.24)	14.7% - 3.91 (5.57)	11.1% - 4.08 (5.40)	ns

* p<0.05.

Substance abuse and psychiatric problems

GPs registered substance abuse and/or psychiatric problems for 54.2% of the patients seen in 2004, 2005 and/or 2006 (Table 3). Of these, 67.2% had a substance abuse problem, 10.5% suffered from psychiatric problems, and 22.3% had a registered substance abuse and psychiatric problem (dual diagnosis). Fewer females had registered problems; when ICPC codes were registered it appeared that more females than males had substance abuse problems and less had psychiatric and dual problems. Also, fewer patients in the youngest and in the oldest age group had registered problems. Furthermore, the younger the age of the patients, the higher the proportion with substance abuse problems. Similarly, the older the age of the patients, the higher the proportion with psychiatric problems and dual problems.

Patients with a registered problem visited the Street General Practice more often (on average 6.50 times) than those without a registered problem (on average 3.17 times, p<0.0001; results not shown).

Table 3. Substance abuse and psychiatric problems among the study population.

		ICPC (n=1,181)	n=640	Substance abuse (n=430)	Psychiatric problems (n=67)	Both (n=143)
Total		54.2%	100%	67.2%	10.5%	22.3%
Sex	- male	* 56.4%	582	* 65.3%	11.0%	23.7%
	- female	38.9%	58	86.2%	5.2%	8.6%
Age (yrs)	- 18-30	** 42.5%	71	* 84.5%	0%	15.5%
	- 31-40	54.3%	188	73.4%	7.4%	19.1%
	- 41-50	63.7%	253	67.6%	10.3%	22.1%
	- 51-60	52.8%	94	48.9%	18.1%	33.0%
	- 61+	36.6%	34	44.1%	29.4%	26.5%

* p<0.0001.

** p<0.01.

Complaints and medication

A total of 636 patients were seen by a GP in the period September through November of 2004, 2005 and 2006. Of these patients, 83.2% came in one period, and 16.8% came in two or all three periods; together they made a total of 1,942 visits. Table 4 shows that there was a mean of about 1.4 to 1.5 complaints per patient. Over the years, complaints about joints, lungs, skin and stomach were expressed by at least 9-10% of the patients. Compared with 2004, the number of patients expressing psychological complaints in 2006 had halved (to 9%), and the number of patients with feet problems decreased from 16% in 2004 to 10% in 2006. In contrast, there was an increase in patients expressing 'other' specified complaints from 14% in 2004 to 38% in 2006. Although these percentages are an indication of the kinds of problems that the homeless are confronted with, it says little about the severity or complexity of these problems.

For the months September through November: medication was prescribed for 44% of patients (244 prescriptions) in 2004, for 26% (137 prescriptions) in 2005, and for 28% (119 prescriptions) in 2006. In all periods, about 60% received one prescription. The prescribed medication was predominantly antibiotics and painkillers, followed by medications for lung, stomach and skin disorders. Anti-psychotic medication was prescribed less frequently. Compared with 2004, in 2005 and 2006 GPs more often prescribed medication for diabetes mellitus. In 2006 hypertensive medication was also prescribed more often. Throughout the years, many homeless people were vaccinated for hepatitis B and had an anti-influenza injection (neither analysed as 'medication').

Explanations for changes

Most GPs and nurses noted changes in the patient group and type of complaints over the years. According to them, the most obvious changes among the patients are: the group is aging, there are more psychiatric problems, there are more illegal and uninsured patients, and patients have a better physical condition and take better care of themselves and their appearance (than years ago). The main changes seen in the type of complaints are: more chronic diseases, less wound problems, and less body lice. The changes tend to be intertwined, as are the explanations given for them. For example, because the homeless (as a group) are aging, their complaints include chronic diseases associated with older age, e.g. diabetes, vascular problems and COPD. Because of long-term substance use, there is an increase in chronic stomach complaints (due to alcohol abuse), chronic lung complaints (due to smoking heroin and crack) and other chronic complaints related to the locomotor system (due to use of crack). Furthermore, the Rotterdam municipality has established many supported housing projects for drug users and homeless people in recent years (Ministry of Health, Welfare and Sport, 2006; Quadt, 1996). People living in these supported housing projects are called "residential (drug using) homeless". GPs and nurses observe that they take better care of themselves since living in such facilities, because they see, for example, fewer serious feet problems, less infections, less scabies, and less body lice. According to some GPs and nurses, due to the more stable housing situation of these residential homeless, psychiatric problems are now able to surface and be treated.

Table 4. Complaints expressed by the patients (n=636) *.

September through November Patients Mean number of contacts per patient	2004 n=247 2.41	2005 n=273 2.49	2006 n=245 2.73
Complaints **			
Joints: back (including lumbago), knees, shoulders, ankles, hips	18%	14%	16%
Psychological/psychiatric complaints: feeling depressed, restless in the head, thinking about unpleasant things	18%	18%	9%
Lungs: coughing, pain, dyspnea, etc.	16%	19%	15%
Feet: tramp's feet, fungal infection, damaged heel, etc.	16%	11%	10%
Skin: itch (scratch), eczema, spots/pimples, fungus, etc.	14%	11%	18%
Stomach: painful stomach/intestines, obstipation, etc.	10%	9%	11%
Feelings of influenza, headache, dizziness	6%	4%	5%
Legs: thrombosis, oedema, erysipelas	4%	7%	4%
Ears: need syringing, bad hearing	4%	5%	4%
Wounds (elsewhere on body)	4%	4%	5%
Teeth: need a dentist, toothache	4%	5%	3%
Chest pain, pressure on chest (heart)	3%	4%	5%
Eyes: dirt, pain	2%	3%	3%
Throat and/or nose	2%	5%	6%
Kicking alcohol or drug habit	2%	1%	1%
HIV: ask for test, questions about medication, compliance	2%	<0.5%	1%
Other complaints e.g.: haemorrhoids, broken nose, muscular pain, incontinence, STDs, overdose, collapse, epilepsy, kidney stones, sore mouth, cold, pain in side, birth control, pregnancy, tuning medication, fatigue, difficulties urinating	14%	20%	38%
Total number of complaints Mean number of complaints per patient	343 1.39	382 1.40	373 1.52

* Complaints entered by the GPs (in their own words) in the electronic GP registration system were categorised for each period; results were not tested for significance.

** A patient can express the same complaint at more than one visit; this was counted as one complaint (e.g. a patient visited the Street General Practice four times concerning his lungs = 1 complaint: lungs). Also, a patient can express more than one complaint during one consultation (e.g. a patient reports feet pain and has a question about birth control = 1 complaint feet, and 1 complaint 'other').

Success of Street General Practice

According to GPs and nurses, the success of the Street General Practice can be explained by three factors. First, the Street General Practice operates within low-threshold care facilities thus making health care accessible for homeless people. Secondly, there is continuity; medical files are available online for GPs and nurses at all participating facilities so that the patient's latest medical history is known. The third factor

is cooperation: this takes place at the management level between the municipality, the local health care insurance companies and the four social relief organisations that realise the Street General Practice, and at the operational level between the GPs and nurses.

Rotterdam GPs and nurses also mentioned several areas for improvement: e.g. more hours of nursing care, improved screening and registration, extended and more accurate collaboration with other organisations (psychiatry, addiction care, hospitals), and greater accessibility of medication for the uninsured.

Discussion

Aim of this study was identify leads to further improve the functioning of the Street General Practice, as a part of the low-threshold health care for the homeless. We will elaborate upon these leads as we discuss health characteristics, explanations for changes in the patient group and types of complaints, and factors that contribute to the succes of the Street General Practice.

Health characteristics

The majority of the 1,181 homeless people who visited the Rotterdam Street General Practice (in the local shelters) are male and over 40 years of age. About 25% had no health insurance, because they had not arranged it (15%) or because they are illegal migrants (10%). These data are in line with other Dutch studies among the homeless (Jansen et al., 2002; Rensen, 2008, 2007; Van der Poel et al., 2005a/b). Although not having health insurance is not a barrier to receiving medical care in the Street General Practice, it does cause problems with medication prescriptions. Patients with no health insurance who reside legally in the Netherlands must pay for medication at the pharmacy. For many (addicted) homeless people that is too much to ask because their main priorities may not be their health. The costs of medication prescribed to patients who are illegal migrants are reimbursed to the Street General Practice via the national 'Connection fund' (founded by law; Ministry of Health, Welfare and Sport, 2005). This system is flawed, e.g. some pharmacies refuse 'Connection fund' prescriptions. This means that for both groups of uninsured Street General Practice patients medication is 'saved up' and hence that they often do not receive the exact medication needed (e.g., a specific antibiotic). GPs and nurses emphasise that this is a major obstacle to adequate treatment.

Homeless lifestyle

Many health complaints expressed by the homeless at the GP consulting hours are related to drug and alcohol abuse (e.g. stomach and lung complaints) and the homeless 'lifestyle' (e.g. tramps' feet, joint complaints) (see also Elissen, Van Raak, Derckx & Vrijhoef, 2009). Regarding physical complaints, there seems to be a shift from acute health problems with a chronic element (e.g. scabies) to chronic health problems with acute elements (e.g. diabetes, COPD). GPs and nurses indicated that this is due to aging and long-term substance abuse combined with more stable (self)-care and a better physical condition. Compliance, especially with medication intake, will become more important and nurses play a vital role in this. In addition, patients have recently been raising matters unrelated to substance abuse and lifestyle (concerning birth control, fatigue, etc.). Important in this trend are the new housing projects – the latest

with the support of the national government (Ministry of Health, Welfare and Sport, 2006) – resulting in a shift from 'actual homeless' to 'residential homeless', i.e. with a roof, a shower and housing counselling.

Substance use and psychiatric condition

Over the years, fewer patients expressed psychological complaints, which seems to contradict the increase in psychiatric problems as reported by the GPs and nurses. However, the two are not necessarily causally related; for example, a patient may have a psychiatric condition but will visit a GP because of a physical complaint.

It is important to register psychiatric conditions and substance abuse because these are often components of the homeless lifestyle. GPs registered these problems in 54% of the patients: of these, 67% with substance abuse, 10% with a psychiatric problem, and 23% with both problems. Although this could imply that 46% has no such problem(s), GPs admitted that they do under-register thus causing flaws in the registration system. Comparison of the Street General Practice patients with a similar group of homeless people in Rotterdam (Van Rooij et al., 2007) and 'actual' homeless people in The Hague (Wolf et al., 2002) and Utrecht (Reinking et al., 2001) revealed no meaningful differences in substance abuse. For psychiatric problems, the Street General Practice group had the lowest percentages: 18% with depression and/or psychotic disorders compared to 28-32% with depression, and 5-15% with psychotic disorders in the other studies. Therefore, we conclude that under-registration does occur. To improve registration, at each initial contact GPs and nurses could ask about and register psychiatric problems (including substance abuse and dual diagnosis); the screener 'Addiction and Psychiatry for the Homeless' could be helpful for this (Van Rooij et al., 2007). Better screening is necessary making appropriate help and ongoing monitoring available (Bonner, 2006) and quality assessment possible (Thiesen, 2006).

Success factors

In an earlier study, patients evaluated the Street General Practice positively: *"When you have a health issue, you go and see a nurse or a doctor"* (Van der Poel et al., 2005b). GPs and nurses see (1) the accessiblity of primary health care as realised in low-threshold care facilities, (2) the continuity of care with the online available up-to-date medical files, and (3) the effective cooperation at management and operational level as important success factors. In addition, nurses are important for the functioning of the Street General Practice, because they offer health care in nursing hours at the ten low-threshold care facilties and effectively refer patients to the GP (Van der Poel et al., 2005a/b). These success factors illustrate what O'Carroll (2007) reported to be important in the development of primary care for the homeless in Dublin: *"It has become apparent that what appeared to be a lack of services was in many instances a lack of service coordination"*.

Health and marginalisation

According to the European Federation of National Organisations working with the Homeless *"The right to health is a human right"* (FEANTSA, 2006); therefore, access to health must be ensured for all people, including those who are homeless. As long as mainstream health care is not accessible for many of the homeless and does not adequately respond to the needs of homeless people, this kind of specialised health care remains necessary (FEANTSA, 2006; Wright & Tompkins, 2006).

Not having access to regular health care is part of the "health dimension" in the process of marginalisation of chronic drug users. With regard to health, marginalisation further refers to e.g. indifference of health issues and a deteriorating personal health. Homelessness and the use of crack are catalysts in the marginalisation process. This is in accordance with the observation of Van Laere & Withers (2008) that health issues of the homeless are intertwined with issues related to homelessness, and that therefore, the GPs and nurses working in social medical care for the homeless are confronted not only with medical care needs (e.g. for addiction, mental and physical health problems) but also with social care needs (e.g. housing, income and daily activities) – see also Elissen et al. (2008, 2009). They advocate that integrated care for the homeless is necessary to address all these issues, in the words of Andersen et al. (2006): *"… access to good health care provision requires joint working across health, housing and social care agencies".*

We suggest that the Rotterdam Street General Practice may play an important role in discontinuing the process of marginalisation and possibly even start a process of socialisation for homeless people, who may or may not also suffer from addiction and/or psychiatric problems. First, because the practice ensures access to health care, as it is integrated in low-threshold care facilities for the homeless, such as day and night shelters, drug consumption rooms and social hostels (a type of residential supported housing). Second, because the Street General Practice is integrated in larger organisations that also offer help and care in other life areas (e.g. housing, debts, social work), which makes it easier to make referrals and to cooperate in order to address not only medical but also social needs of homeless people.

References

Anderson, I., Baptista, I., Wolf, J., Edgar, B., Benjaminsen, L., Sapounakis, A., & Schoibl, H. (2006). The changing role of service provision: barriers to access to health services for homeless people. Brussels: European Observatory on Homelessness of FEANTSA.

Barends, W. (1995). AHV Valckenier, een papieren huisarts. Onderzoek naar gezondheid en gezondheidsconsumptie van dak- en thuislozen in Amsterdam [AHV Valckenier, a GP on paper. Research into health and health care use of homeless in Amsterdam]. Utrecht: Netherlands School of Public Health.

Blow, H., De Wacker, A., Louckx, F., Van Heusden, L., & Van Menxel, G. (2006). Health profiles of people who are homeless in Belgium. Homeless in Europe, the Newsletter of FEANTSA (European Federation of National Organisations Working with the Homeless), winter, 3-5.

Boardman, J.B. (2006). Health access and integration for adults with serious and persistent mental illness. Families, Systems & Health, 24(1), 3-18.

Bonner, A. (2006). Come in from the cold: a review of the screening and assessment strategies for working with the socially excluded. Clinical Effectiveness in Nursing, 9(3 Suppl), e243-e252.

Brandt, P. (2007). Employment, homelessness and health. Homeless in Europe, the Newsletter of FEANTSA (European Federation of National Organisations Working with the Homeless), winter, 16-17.

Bronsveld, C. (2004). "Het kan altijd beter…" De sociaal-medische zorg voor dak- en thuislozen in Rotterdam ["It can always be better…" The social medical care for the homeless in Rotterdam]. Rotterdam: Department of Social Affairs and Employment.

Elissen, A., Van Raak, A., Derckx, E., & Vrijhoef, B. (2009). Dokter voor vagebonden. Laagdrempelige straatdokterspraktijk haalt daklozen wél binnen [Physician for vagrants. Low-threshold Street General Practice does bring in the homeless]. Medisch Contact, 64(19), 842-845.

Elissen, A.M.J., Van Raak, A.J.A., & Vrijhoef, H.J.M. (2008). De Nurse Practicioner als 'Street Nurse': een onderzoek naar de haalbaarheid en kosten van het Eindhovense straatdokterproject. Onderzoeksrapport [The nurse practicioner as 'Street Nurse': a study into the feasability and costs of the Eindhoven Street General Practice project. Research report]. Maastricht: UMC+.

FEANTSA (2006). The right to health is a human right: ensuring access to health for people who are homeless. Annual European Report 2006. Brussels: European Federation of National Organisations Working with the Homeless (FEANTSA).

Gebel, R.S., & Lamberts, H. (Eds.) (2000). NHG ICPC-1 met Nederlandse subtitels [Dutch College of General Practitioners ICPC-1 with Dutch subtitles]. Utrecht: Dutch College of General Practitioners.

Health Council of the Netherlands (1995). Daklozen en thuislozen [Homeless and houseless]. The Hague: Health Council of the Netherlands.

Hwang, S.W., Tolomiczenko, G., Kopuyoumdjian, F.G., & Garner, R.E. (2005). Interventions to improve the health of the homeless. A systematic review. American Journal of Preventitive Medicine, 29(4), 311-319.

Jansen, H., & Karaköse, T. (2003). Gezondheidsproblemen van gemarginaliseerde druggebruikers [Health problems of marginalised drug users]. Rotterdam: IVO Addiction Research Institute.

Jansen, H., Kolk, R., Maaskant, J., & Stoele, M. (2002). Dak- en thuislozenmonitor 2001-2002 [Monitoring the homeless 2001-2002]. Rotterdam: IVO Addiction Research Institute / Department of Social Affairs and Employment.

Krol, L. (2003). Sociaal-medische zorg dak- en thuislozen in Rotterdam en omstreken, situatie 2003 [Social-medical care for the homeless in Rotterdam and surroundings, situation 2003]. Rotterdam: Rotterdam Public Health Service.

Kunstmann, W., Becker, H., Schulte, R., & Völlm, B. (1997). Health and sickness behavior among homeless men. European Psychiatry, 12(2), 167s.

Lempens, A., Van de Mheen, D., & Barendregt, C. (2003). Homeless drug users in Rotterdam, the Netherlands: profile, way of life and the need for assistance. Substance Use and Misuse, 38(3-6), 341-377.

McCabe, S., Macnee, C.L., & Anderson, M.K. (2001). Homeless patients' experience of satisfaction with care. Archives of Psychiatric Nursing,15(2), 78-85.

Ministry of Health, Welfare and Sport (2006). Plan van Aanpak Maatschappelijke Opvang. Het Rijk en de vier grote steden [Strategy Plan for Social Relief. National Government and the four largest cities]. T he Hague: Ministry of Health, Welfare and Sport.

Ministry of Health, Welfare and Sport (2005). Medische zorg voor illegalen redelijk toegankelijk [Medical care for illegal immigrants fairly accessible]. The Hague: Ministry of Health, Welfare and Sport.

Moore, G., Gerdtz, M., & Manias, E. (2007). Homelessness, health status and emergency department use: an integrated review of the literature. Australian Emergency Nursing Journal, 10(4), 178-185.

O'Carroll, A. (2007). Reaching out and encouraging. In: The development of primary health care for homeless people in Dublin. Newsletter European Network of Homeless Health Workers, 2, 4-7.

O'Toole, T.P., Pollini, R., Gray, P., Jones, T., Bigelow, G., & Ford, D.E. (2007). Factors identifying high-frequency and low-frequency health service utilization among substance-using adults. Journal of Substance Abuse Treatment, 33(1), 51-59.

Quadt, T. (Ed.) (1996). Verantwoord Schoon in Rotterdam [Safe & Clean in Rotterdam]. Rotterdam: Rotterdam Public Health Service.

Quispel, F., & Slockers, M.T. (1985). Medische zorg voor daklozen. Een zorg voor artsen [Medical care for the homeless. A concern for doctors]. Medisch Contact, 40(51/52), 1593.

Reinking, D., Wolf, J.R.L.M., & Kroon, H. (2001). Hoge prevalentie van psychische stoornissen en verslavingsproblemen bij daklozen in de stad Utrecht [High prevalence of mental disorders and substance abuse problems among homeless in the city of Utrecht]. Nederlands Tijdschrift voor Geneeskunde, 145, 1161-1166.

Rensen, P. (2008). Health care insurance the Dutch way: market principles, pragmatic provisions. Newsletter European Network of Homeless Health Workers, 5, 4-6.

Rensen, P. (2007). Dakloos en onverzekerd in de grote stad. Een onderzoek naar de gevolgen van de invoering van de nieuwe Zorgverzekeringswet voor daklozen in de vier grote steden [Homeless and uninsured. An investigation into the consequences of the introduction of the new Law on Health Care Insurance for the homeless in the four largest cities]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Roorda-Honée, J.G.M.Th., & Heydendael, P.H.J.M. (1997). De gezondheidstoestand van dak- en thuislozen [The health situation of the homeless]. In J.P. Mackenbach & H. Verkleij (Eds.), Volksgezondheid Toekomst Verkenning 1997. Deel II, Gezondheidsverschillen [Public Health Future Examination 1997. Part III, Health inequalities] (pp. 241-246). Maarssen: Elsevier / De Tijdstroom.

Schanzer, B., Dominguez, B., Shrout, P.E., & Caton, C.L.M. (2007). Homelessness, health status, and health care use. American Journal of Public Health, 97(3), 464-469.

Thiesen, H. (2008). Documentation and quality assessment in health-related work in Copenhagen, DK – a potential model? Newsletter European Network of Homeless Health Workers, 5, 10-12.

Tucker, J.S., D'Amico, E.J., Wenzel, S.L., Golinelli, D., Elliott, M.N., & Williamson, S. (2005). A prospective study of risk and protective factors for substance use among impoverished women living in temporary shelter settings in Los Angeles County. Drug and Alcohol Dependendence, 80(1), 35-43.

Van der Poel, A., Barendregt, C., Schouten, M., & Van de Mheen, D. (2003). De leefsituatie van gebruikers in de Rotterdamse harddrugsscene. Resultaten van de survey 2003 [Living situation of drug users in the Rotterdam drug scene. Results of the survey 2003]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., & Krol, L. (2008). Specialised health care for people who are homeless: an evaluation of the Rotterdam Street GP system. Newsletter European Network for Homeless Health Workers, 5, 8-10.

Van der Poel, A., & Krol, L. (2007). Huisartsenpraktijk 'de Straatdokter'. Sociaal medische zorg in Rotterdam: bereikbaarheid, continuïteit en samenwerking [The Street General Practice. Social medical care in Rotterdam: accessibility, continuity and collaboration]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Krol, L., & De Jong, W. (2005a). De Rotterdamse Straatdokter. Huisartsenpraktijk voor dak- en thuislozen waarborgt toegankelijkheid van zorg [The Street General Practice in Rotterdam. General Practice for the homeless guarantees access to care]. Medisch Contact, 60(23), 973-976.

Van der Poel, A., Krol, L., De Jong, W., & Jansen, H. (2005b). Huisartsenpraktijk 'de Straatdokter'. Sociaal medische zorg aan dak- en thuislozen in Rotterdam. Verslag van een onderzoek naar het functioneren van de Straatdokter ['Street General Practice', social medical care for the homeless in Rotterdam. Results of a study on the functioning of the Street General Practice]. Rotterdam: IVO Addiction Research Institute.

Van Laere, I.R.A.L. (2002). De zwervende alcoholist: voor wie een zorg? [The vagrant alcoholic: who cares?] Nederlands Tijdschrift voor Geneeskunde, 146(42), 1965-1968.

Van Laere, I.R.A.L. (2000). Zorg voor zieke zwervers. Specifieke medische zorg voor daklozen noodzakelijk [Care for sick vagrants. Specialised medical care for the homeless is necessary]. Medisch Contact, 55(44), 1567-1569.

Van Laere, I.R.A.L. (1997). 'Loopvoeten' bij zwervers ['Tramp's feet' in vagrants]. Nederlands Tijdschrift voor Geneeskunde, 141(51), 2481-2483.

Van Laere, I.R.A.L., & Buster, M.C.A. (2001). Gezondheidsproblemen van daklozen op zogenaamde dr. Valckenier-spreekuren in Amsterdam [Health problems of the homeless at the so-called dr. Valckenier surgery hours in Amsterdam]. Nederlands Tijdschrift voor Geneeskunde, 145(24), 1156-1160.

Van Laere, I., & Withers, J. (2008). Integrated care for homeless people – sharing knowledge and experience in practice, education and research: results of the networking efforts to find Homeless Health Workers. European Journal of Public Health, 18(1), 5-6.

Van Rooij, T., Mulder, N., Wits, E., Van der Poel, A., & Van de Mheen, D. (2007). Screeningsinstrument Verslaving en Psychiatrie voor de maatschappelijke opvang [Screener Addiction and Psychiatry for the social relief sector]. Rotterdam: IVO Addiction Research Institute / O3, Onderzoekcentrum GGZ Rijnmond.

Victor, C.R. (1997). The health of homeless people in Britain. A review. European Journal of Public Health, 7, 398-404.

Wolf, J., Zwikker, M., Nicholas, S., Van Bakel, S., Reinking, D., & Van Leiden, I. (2002). Op achterstand. Een onderzoek naar mensen in de marge van Den Haag [Lagging behind. A study on marginalised persons living in The Hague]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

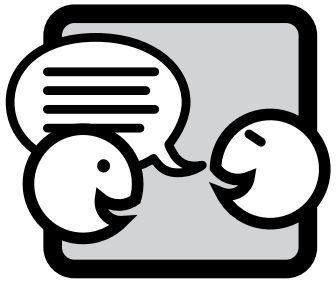
Wright, N.M.J., & Tompkins, C.N.E. (2006). How can health services effectively meet the health needs of homeless people? British Journal of General Practice, 56(525), 286-293.

www.LINH.nl (Netherlands Information Network of General Practice): accessed August 2007.

chapter 8

discussion

General discussion and conclusion



Chapter 8

General discussion and conclusion

This thesis aims to provide insight into the role of low-threshold care facilities within the changing Rotterdam drug scene during the past 15 years. The first hypothesis is that these facilities may contribute to the discontinuation of the marginalisation process, meaning that drug users who make use of the services provided do not marginalise any further. The second hypothesis is that these facilities may contribute to the start of the process of socialisation, meaning that drug users who make use of the services provided re-integrate into society.

In this final chapter first the results of the studies are summarised and some methodological issues are discussed. Second, developments in drug policy from the mid-1990s onward are presented. Third, the hypotheses are elaborated upon within the theoretical framework of marginalisation and socialisation. In the last section recommendations are made for policy, practice and further research.

Summary of study results

Adolescent crack users and the process of marginalisation (Chapter 2)

Chronic drug users are aging as a group, and most younger drug users nowadays start their drug use career with crack. The theory of marginalisation was originally presented for adult chronic heroin users. The research question in this study was whether the process of marginalisation and socialisation is also valid for young users, and what dimension(s) are foremost. A total of 15 current and 15 former crack users (aged 16-24 years) were interviewed. The age at which crack use commenced ranged from 14 to 17 years. It appeared that young crack users moved from a marginal position in society to a marginal position within the drug scene. Conclusion is that the use of crack initiates a process of (further) marginalisation. With the use of crack, social relations became instrumental. Many had no good (start) position in the labour market, and through stealing and drug dealing they acquired a record of criminal offences and spent time in prison. Regarding health, some experienced respiratory problems from frequently smoking crack and many suffered from paranoia. Most adolescents had not used drugs long enough to have developed long-

term health complaints. Some were homeless and/or had been in prison for periods of time. Similar to adults, crack use and homelessness strengthen the marginalisation process for young users. Some young crack users were able to stop their drug use, and start a process of socialisation. Two factors seemed important in this: (1) former crack users were younger than current users, and (2) many former crack users did not use heroin, whereas some current crack users also started heroin use. The latter suggests that heroin can be a catalyst in the marginalisation process for adolescent drug users, whereas crack was a catalyst for the aging heroin users. Both groups of current and former crack users were similar in background characteristics (other than age) and both groups had little confidence and trust in social workers in addiction care (e.g. low-threshold care facilities, such as shelters). Those former crack users who were in youth rehab appreciated this clinical facility, especially because it enabled them to renew social contact with non-using peers. It can be concluded that within a treatment setting (and perhaps also in other settings) the social dimension is the most important one to address. The income and health dimensions are of less importance, because the need for illegal sources of income disappears and the health situation improves when crack is no longer used. In contrast, the adolescents' social network needs attention and (inter)action.

Effects of policy measures on drug users' living conditions 2007- 2003 (Chapter 3)

Drug use and homelessness are intertwined: about one third of homeless people are chronic drug users. It is shown that homeless drug users are likely to cause nuisance in their less purposeful movements. In order to reduce public nuisance, nowadays repressive measures are combined with tailor-made care and treatment measures, including drug consumption rooms and housing projects. Different organisations, including the addiction care system, the social relief sector, the police and the city administration, work together to achieve collective goals. With survey data from 2003 (201 users) and from 2007 (102 users), it is shown that the living conditions of drug users in general have improved. Most important is the decrease in actual homelessness (from 40% to 27%); furthermore, there was a decrease in the number of hours per day spent in public, in illegal sources of income, in heroin and crack use, in the number of users who use drugs in public and buy drugs on the streets. There was an increase in the number of users who had health insurance. The 2007 group of drug users was divided in three subgroups: actual homeless (27%), residential homeless (43%), and those with independent housing (30%). The latter group is generally best off, whereas the first has the poorest living conditions, related to their homelessness. One important difference is the intensity of drug use: not only did actual homeless users (compared to the other two groups) use heroin and crack on more days per month (also in public), they also used larger quantities per day. It is concluded that the homeless life and excessive alcohol and drug use are intertwined. Independent housed users and residential homeless users have their own place, which is associated with less heroin and crack use (and more methadone use, possibly to replace some of the heroin use), and (especially for the residential homeless) with an increase in psychiatric complaints. Many residential homeless make use of social activation projects, thereby gaining some structure in their daily life.

Drug users' characteristics and low-threshold care agencies (Chapter 4)

In earlier studies on the help-seeking process, drug users were categorised in either the treatment group (aimed at abstinence) or the non-treatment group (no drug treatment). However, since the emergence of low-threshold care facilities these concepts have become more complex. In the present study, care facili-

ties (drug consumption rooms, shelters) are categorised separately, additional to treatment facilities. Earlier drug users making use of only care facilities would be included in the non-treatment group.
A total of 201 drug users were divided into four groups that make use of: (1) only treatment agencies – 19%, mostly in a methadone program; (2) only care agencies – 18%, mostly day shelter and drug consumption room; (3) treatment and care agencies – 49%, mostly day shelter and methadone program; and (4) neither treatment nor care agencies – 14%. Results showed that it is useful to distinguish between these four groups, because the 'neither treatment nor care' and the 'treatment' groups are similar, as are the 'care' and 'treatment and care' groups. Two functions were extracted from the drug users' characteristics: (1) drug use and homelessness, and (2) illegal sources of income and perceived good health. The four groups were described within the framework of the Stages of Changes from Prochaska, DiClemente & Norcross (1992). Two groups scored relatively well: the neither treatment nor care group, and the treatment group. The first group seemed satisfied with their situation and planned to solve any problems on their own (precontemplation stage of change). The latter group appeared to enter treatment for reasons of resolving drug issues (including becoming abstinent) as well as to resolve issues in other areas (contemplation/preparation stage of change). Further, there is the treatment and care group, which scored 'in between'; these drug users go to many different facilities and want help in areas other than drug use, which suggests that they need different kinds of addiction care as a way of survival in the scene (precontemplation/contemplation stage of change). The last group is the care group which scores worst: they are in care, but most of them do not wish drug issues to be resolved (precontemplation stage of change). The conclusion is that help-seeking is primarily motivated by the need to address substance-related problems, not the substance use itself. Furthermore, help is sought when life becomes unmanageable, and low-threshold care agencies can play an essential role in the survival of everyday life of drug users and in referring them to other appropriate programs and projects.

Mobility of drug users in relation to deconcentration of facilities (Chapter 5)
Deconcentration of care facilities, and thereby of drug users, is a recurring theme in the debate over the spread of drug-related nuisance. Deconcentration of facilities and mobility of drug users are linked because the transfer of facilities can only be successful if drug users are willing to 'travel' for them. This study investigated mobility and the motives underlying mobility of drug users with survey data from 182 users and interview data from 34 users.
Survey data showed that 4 out of 10 users are low-mobile, in that they travel through one or two neighbourhoods to perform their daily activities, another 4 out of 10 are medium-mobile (3-6 neighbourhoods), and 2 out of 10 are high-mobile (7+ neighbourhoods). Activities that instigate mobility are especially using drugs and visiting low-threshold care facilities. Activities that are most linked together are housing (sleeping) and using drugs, whereas activities that are least linked together are housing and making use of facilities. This means that although care facilities have great pulling power, it is not enough to get users to adjust their daily living pattern around such facilities.
Homeless drug users have the highest mobility (visit most neighbourhoods) and visibility (are in public space many hours per day). Interview data showed that mobility and visibility are unrelated. However, users differ in the purposefulness of their mobility, meaning that those who move around in a less goal-oriented way (especially homeless users) are generally more visible. Their course of the day is largely

determined by buying and using drugs. Users who have a structured routine (with e.g. work) move around in a more goal-oriented way. Users were prepared 'to travel' for medical care, good quality drugs, methadone, and drugs from their preferred dealer. They were not prepared 'to travel' for quiet use of drugs (e.g. in a drug consumption room), to visit friends, or for cheap drugs, food or personal hygiene. This leads to the conclusion that the nature of mobility (reasons for moving around) does not change under a repressive policy, but that drug-related nuisance can be reduced when users have a structured pattern with stable housing and work. However, triggers for moving around are buying drugs (and medical care). Low-threshold care facilities that offer 'bath, bed & bread' and/or safe drug use are not triggers, meaning that these facilities are best located in neighbourhoods where the users and/or dealers are.
A drug infrastructure remains important in the mobility of drug users.

Effects of drug consumption rooms, for drug users (Chapter 6)
One of the low-threshold care facilities under study are drug consumption rooms. These facilities serve purposes of harm reduction (drug users can use drugs safely) and public nuisance reduction (drug use takes place inside). Survey data from 67 admission pass holders were used to find out whether these goals are reached from the standpoint of pass holders, as were 47 field notes written by community fieldworkers and interviews with 7 key informants working in a drug consumption room.
Results showed that the goals that consumption rooms aim at are, partially, reached. Pass holders frequent a drug consumption room on average six days per week, and twice in the past 24 hours. They mentioned drug-related issues as the most important strong points or advantages of the consumption rooms (e.g. use drugs quietly and safely inside, shelter function). Eight out of 10 pass holders stated that they used drugs less often in public since going to the drug consumption room. Furthermore, the workers and the possibility of assistance are valued. Nine out of 10 pass holders stated that they made use of the provided services and assistance in the consumption room (e.g. meals, washing clothes, shower), and 4 out of 10 received some medical treatment and/or obtained information about assistance, therapy and/or safe use. Self-reported health effects are 'more time and rest', 'more attention to hygiene', and 'more attention to physical condition'.
The two weak points or disadvantages pass holders mentioned are drug-related: the large scale of some consumption rooms resulting in crowds, chaos and drug use in public, and the fact that the consumption rooms are not open 24/7. An argument for longer opening hours is the further reduction of nuisance; however, buying drugs may also cause nuisance, and this nuisance cannot be solved within the scope of the consumption room (unless drug dealers were allowed in the facility). An argument against longer opening hours is that it might promote drug use and stimulate marginalisation because the drug consumption room then perpetuates the current situation of drug users, implying continuation of e.g. homelessness and prostitution.

Street General Practice: health of patients and success factors of the practice (Chapter 7)
Homeless people, and especially homeless drug users, suffer from multiple physical and mental problems intertwined with being homeless and substance use. Because of their poor health, and because of their complex help-seeking behaviour and medical consumption, specialised health care is provided for within the 'Street General Practice'. GP consultation hours are integrated in 10 different Rotterdam low-threshold

care facilities (day and night shelters, drug consumption rooms, social pensions). By analysing (1) registration data (a) of three subsequent years (n=1,181) and (b) of a three-month period of these subsequent years (n=636), and (2) survey data from 6 GPs and 9 nurses, this study provides insight into the health characteristics of patients, changes in the patient group and type of complaints, and success factors of the practice. The patient group is mostly male, older than 40 years, health insured, and had 3 to 4 contacts each year (mean). Of those with registered problems (54%), most had substance abuse problems (67%), psychiatric problems (11%) or both (23%). The total group of patients expressed about 1.4 complaints (mean per three-month period). Over the years, the proportion of patients expressing complaints about joints, lungs, skin and stomach remained the same, complaints about psychological issues and feet decreased, and 'other' complaints increased. When medication was prescribed, patients generally received one prescription. GPs and nurses observed that the aging patient group (especially those with long-term substance abuse) had more chronic complaints, e.g. COPD, stomach complaints and diabetes. Many former actual homeless people are now living in supported housing projects initiated by the Rotterdam municipality. According to GPs and nurses, these so-called 'residential homeless people' take better care of themselves, which is shown in a decrease in e.g. wound problems and clothes lice, and a better general physical condition. However, psychiatric problems can surface.
GPs and nurses also identified three factors that explain the success of the Street General Practice. First, the practice is accessible because it is integrated in the social relief sector in low-threshold care facilities. Second, medical files are available online at every facility, ensuring continuity. Third, there is cooperation at the management level between the municipality, health insurance companies and the social relief sector, and at the operational level between GPs and nurses. In addition, nurses effectively refer patients to the GP hours from their nursing hours.
It is concluded that better screening and registration of psychiatric problems and substance abuse is necessary in order to provide the required health care. Another problem lies with the unavailability of medication for the uninsured, especially illegal migrants. Finally, integrated care, addressing medical and social issues, remains necessary as long as mainstream health care is not accessible for many of the homeless and does not adequately respond to the needs of homeless people.

Methodological notes

All studies were conducted within the framework of the Rotterdam Drug Monitoring System and Trendspotting. Both data collection and analysis systems were and are ordered by the Rotterdam Public Health Service.

First, it is important to recognise that not all possible relationships in the research model (see Figure 2 in Chapter 1) were tested. Not all low-threshold care facilities were investigated to the same extent, e.g. drug consumption rooms were the subject of one of the studies, but day and night shelters and supported housing were not. Also, not all of the three dimensions were equally studied. For example, 'health' was studied by means of an evaluation of the social medical care that is integrated within low-threshold care facilities, but 'social relations' and 'sources of income' were not specific study topics. Second, it is necessary to emphasise that the results presented are based on cross-sectional data, which were employed to

examine the longitudinal process of marginalisation and socialisation. In spite of these significant limitations, the hypotheses will be addressed in the following sections.

Internal validity

The data used for this thesis were collected and analysed within the framework of the Rotterdam Drug Monitoring System (DMS 1994-2003 and a 'mini DMS' in 2004 and 2005) and Trendspotting (from 2006 onward). The DMS was a local information and observation system continuously collecting both quantitative and qualitative data about drugs, drug users and related issues. The research population was the group of (nearly) daily users of crack, heroin and/or methadone. The focus of the DMS was on the drug user in his or her natural environment, which made it possible to interpret events within Zinberg's triangle of "drug, set and setting", meaning characteristics of the substance, the drug-using person and the user's environment, respectively (Zinberg, 1984).

The DMS used three research methods (see Figure 3 in Chapter 1): daily community fieldwork, a periodical survey, and interviews with key informants (professionals and drug users). Community fieldwork means that members of the studied group (drug users) shared their knowledge and experiences, observations and reflections with the professional researchers (Blanken, Barendregt & Zuidmulder, 2000). Community fieldworkers are trained in the methodology of fieldwork and in the writing of field notes. They report 'from the inside' and are therefore valued as the 'eyes and ears' of the research team. Further, the surveys were not conducted among 'easy to find' drug users (e.g. in treatment), but also among the 'hidden population' of street drug users. The surveys were carried out using targeted sampling, the sampling technique for locating and recruiting members of hidden populations such as drug users (see also Peterson et al., 2008). Last, the interviewed key informants were professionals with relevant functions in relevant organisations. Interviewed drug-using key informants were 'found' through e.g. professional key informants or through the ethnographic field work which is part of the targeted sampling technique.

Methodological triangulation was applied in a complementary model; information from the different methods complemented each other (Hendriks, Blanken, Adriaans & Vollemans, 1994; Van de Mheen, Coumans, Barendregt & Van der Poel, 2006). All topics of the studies presented surfaced from results from one or more methods, and most studies were conducted using more than one method. For example, the topic 'drug consumption rooms' (Chapter 6) emerged through key informants and community fieldwork, and became a topic in the subsequent survey, which was combined with interviews with key informants and the analysis of fieldnotes; the topic 'youngsters using crack' (Chapter 2) surfaced through community fieldwork and survey results, and the study was carried out with interviews among young people; and the topic 'mobility' (Chapter 5) emerged through community fieldwork and key informants, and became a topic in the survey of 2003, combined with interviews with drug users.

The DMS and Trendspotting are similar in some ways and different in others. An important difference is that the target group shifted from marginalised drug users (DMS) to marginalised homeless people and drug users (Trendspotting). Methodologically, the daily community fieldwork was no longer used in Trendspotting, mostly because of the high costs involved; in this way a valuable research method was lost.

Furthermore, from 2006 onwards, each year one topic and matching research methods were selected in advance. In 2006 the topic was 'policy since 1990', which was studied with literature and policy notes. In 2007 the topic was 'living conditions of marginalised homeless people and drug users', which was examined by conducting a survey among the target groups. The topic 'comparison of living conditions of drug users' (Chapter 3) emerged through key informants and the results of the policy description since 1990; and results of the Trendspotting 2007 survey were compared to results of the DMS 2003 survey.

To answer the specific research questions (see Chapters 2-7), methods were carefully selected and applied. It is argued that the research methods and the combination of these methods result in valid study results (see Van de Mheen et al., 2006). It is concluded, therefore, that the results presented in this thesis (and results from DMS and Trendspotting in general) realistically reflect the Rotterdam situation.

External validity

Are the results valid for other Dutch cities? First, drug use and homelessness are not exclusive to Rotterdam, they are prevalent in all major and also smaller cities. Many cities experience nuisance related to drug use and homelessness, which is a topic of high (political) interest. The addiction care system and the social relief sector are well developed in many cities. Research on the size, characteristics and behaviour of drug users and homeless people is also not exclusive to Rotterdam; research has been performed in other cities and regions. For example, a DMS was operational in the cities of Utrecht (e.g. De Graaf, Wildschut & Van de Mheen, 2000; Lempens, Wildschut, Van der Most & Knibbe, 2003; Vermeulen, Wildschut & Knibbe, 2001) and Heerlen and surroundings (Coumans & Knibbe, 2001, 2002; Coumans, Neve & Van de Mheen, 2000; Van der Dam, Coumans & Knibbe, 2006a/b). In recent years studies were conducted in e.g. the cities of Amsterdam, The Hague, Eindhoven, Enschede, Zwolle and Breda, and in the provinces of Zeeland and Flevoland (Witteveen, 2008; Wolf et al., 2002; Rezai, Van 't Klooster, Van Dongen & Van der Poel, 2005; Bieleman, Boendermaker, Kruize & Van Zwieten, 2007; Vocks, Meertens & Wolf, 2007; Steuns, Janssen, Van Lokven & Van der Poel, 2008; Jansen, Mensink & Wolf, 2007; Barendregt & Wits, 2009). In general, these studies found similar results with respect to developments in the drug and homeless scene, and recommended similar solutions in the direction of an individual approach to solve issues of nuisance and improvement of the situation of drug users and homeless people.

Day and night shelters, drug consumption rooms and supportive housing can be found in many Dutch cities (see Chapter 1). These low-threshold care facilities are not only important for Rotterdam, but also for other cities. For example, about 40 drug consumption rooms were realised in no less than 15 Dutch cities from the 1990s on (Bransen, Van 't Land & Wolf, 2004; Trimbos Institute, 2006). Further, in 2006 the Strategy Plan for Social Relief was initiated by the Dutch government and the four major cities (Ministry of Health, Welfare and Sport, 2006). In 2008, each of the remaining 39 Dutch cities composed a Municipal Compass (Stedelijk Kompas), which is a local Strategy Plan derived from the 2006 original. This means that these Dutch cities have developed policy plans for marginalised groups, and the basis of this policy is the cooperation of all organisations involved (local administration, social relief sector, addiction care system, housing corporations, etc.). This demonstrates that, throughout the Netherlands, there is a need for unambiguous solutions for reducing public nuisance and improving the personal situation of drug

users and otherwise marginalised people. Effective low-threshold care facilities play an important role in these solutions. Because there is no reason to presume that developments in Rotterdam are remarkably different from other cities, the results presented in this thesis can be helpful in understanding the behaviour of marginalised drug users and realising low-threshold care facilities such that these may effectively improve the drug users' situation and reduce public nuisance for both Rotterdam as well as other cities in the Netherlands.

Developments since the mid-1990s

Low-threshold care facilities (drug consumption rooms, day shelters, night shelters, and supported housing) are care facilities that have no explicit aims to change drug-use patterns. Target groups of low-threshold care facilities can be defined as (1) chronic drug users who are homeless, and (2) homeless people among whom chronic drug users. Drug use and homelessness are intertwined.

In the past 10 years homelessness among drug users increased from 21% in 1998, to 28% in 2000, to 40% in 2003, and then decreased to 27% in 2007 (see Chapter 3). The increase in actual homelessness until 2003 is associated with the closure of dealing houses, as implemented by the municipality from 1994 onwards (with e.g. Operation Victor and the Victoria Act). It is acknowledged that the longer drug users are homeless, the longer they will remain homeless. Moreover, homeless drug users are associated with public nuisance.

The decrease in actual homelessness between 2003 and 2007 is related to the new drug policy (since the mid-1990s) aimed at homeless drug users (starting in 1996 with Safe & Clean; Quadt, 1996). The aim was to reduce public nuisance and to improve the personal situation of drug users. Within the framework of this policy new low-threshold care facilities for homeless drug users were realised: drug consumption rooms and supported housing projects. Day and night shelters functioned (among other things) as places where candidates for drug consumption rooms and supported housing projects could be found. These are the low-threshold care facilities under study in this thesis.

Drug consumption rooms were successful from the start (Spijkerman et al., 2002); actual homeless drug users have access to a clean environment to safely use their drugs. Supported housing projects for drug users became successful from the early 2000s (Keegel, 2002); these housing projects produced a new category of drug users: residential homeless drug users.

Furthermore, low-threshold care facilities had to work with other agencies with the purpose of reaching the goals set by the municipality. From 2003 onwards Rotterdam focused on nuisance-causing drug users: "in conducting criminal behaviour, frequently violating by-laws, being homeless and/or having a psychiatric condition" (Municipality of Rotterdam, 2005). The goal was to get these drug users off the streets (in supported housing projects, shelters or prison) and improve their personal situation; in order to reach that goal individual plans are composed with punitive measures on the one hand, and care and treatment on the other. Local parties, such as the social relief sector, the addiction treatment system, the police, housing

corporations and different departments of the municipality, were encouraged to intensively work together to compose, execute and monitor these plans, since only then could the goals be reached. With this cooperation, more and more 'external actors' are involved in the possible socialisation of drug users.

Because the personal approach that combines repression and treatment and care was successful, in 2005 Rotterdam broadened the scope from drug users to non-using nuisance causers and criminal offenders. In 2006 the focus was directed at homeless people in general with the Strategy Plan for Social Relief (Ministry of Health, Welfare and Sport, 2006), and again the personal approach is evaluated as successful (Federation of Shelters, 2009; Ministry of Health, Welfare and Sport, 2009, 2008; Trimbos Institute, 2009). One of the success factors is the increase in the capacity of night shelters and supported housing projects (e.g. Maaskant & Van der Giessen, 2007). (Homeless) drug users benefit from this.

Because of the intensified cooperation of all kinds of organisations and the realisation of housing projects, actual homelessness among drug users has decreased and residential homelessness has increased (see Chapter 3). The same applies to homeless people in general: actual homelessness has decreased and residential homelessness has increased (see Maaskant & Van der Giesen, 2007). Residential homeless people remain categorised as homeless, because they are *"vulnerable and at relatively high risk of becoming homeless"*, because of their lifestyle (e.g. drug and alcohol use, making use of day shelters; p. 20).

Low-threshold care and the process of marginalisation and socialisation

Marginalisation refers to the process through which chronic drug users drift away from core institutions of society, socialisation refers to the opposite process (Coumans, 2005). The dimensions in which this process occurs are: social relations, sources of income and health. The use of crack and homelessness are catalysts in the process of marginalisation. External actors (in this thesis: low-threshold care facilities) either strengthen the marginal position of chronic drug users or play a role in turning marginalisation into socialisation.

Two hypotheses about the role of low-threshold care facilities in the process of marginalisation and socialisation were posed (Figure 1):

(1) low-threshold care facilities can contribute to the discontinuation of the process of marginalisation, meaning that drug users do not marginalise any further – through the dimensions social relations, sources of income and health;

(2) low-threshold care facilities can contribute to the start of the process of socialisation, meaning that drug users start to re-integrate into society – through the dimensions social relations, sources of income and health.

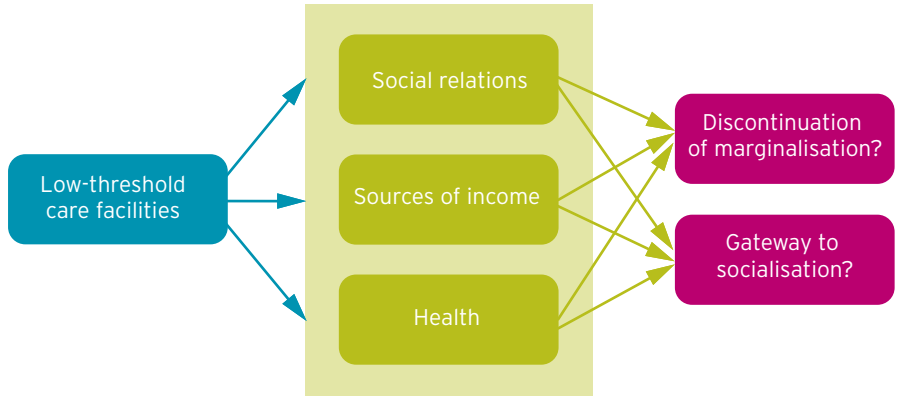


Figure 1. The possible effects of low-threshold care facilities on marginalisation and socialisation.

First, the relationships are presented between social relations, sources of income and health on the one hand, and marginalisation and socialisation on the other, as found in the conducted studies. The catalysts crack and homelessness are then discussed, as are other external actors. Finally, we will discuss the possible effects of low-threshold care facilities.

Social relations

Drug users get marginalised when their social network is more and more situated only in the drug scene. The social dimension is described as *"a process of alienation in which the burden of the addiction is externalised from one sector to another; i.e. from primary contacts to society as a whole. Close friends are rare in this setting [AP: in the drug scene] and drug users become dependent on low-threshold services"* (Coumans, 2005, p. 152). Furthermore *"A cyclic connection was observed between control of drug use, especially of cocaine, and quality of social relationships"* (p. 152). Thus, marginalisation sets in as the social network of drug users deteriorates and they become dependent on low-threshold services, at least for their social relations. In addition, marginalised drug users generally have lost control over their drug use, implying that the quality of their social relationships has decreased accordingly.

Socialisation sets in when drug users remain in contact (also) with people outside of the drug scene. These people can be, e.g., parents and other family members, friends, neighbours (when a drug user has a residence), colleagues (when a drug user has a job), and others – e.g. regular buyers of the Street Magazine from homeless drug users, or residents from streets that are swept by drug users in a social activation project. Socialisation has to do with rebuilding trust and kindness towards each other, e.g. contact with family is often lost because the drug user could not be trusted and because the drug user felt ashamed of his actions. This relationship can only be 'repaired' when there is a renewed basis of trust between the drug user and the family.

Both processes were recognised in this thesis. Within low-threshold care facilities drug users are among peers and the topic of discussion is often drug-related, whether it is the lack of drugs or the price/quality

ratio of the drugs used. Drug consumption rooms are low-threshold care facilities where the use of drugs is allowed. Many drug users visit drug consumption rooms for coffee and a chat, to eat a meal, to talk about personal problems and to obtain information on assistance (e.g. housing), which implies that they have contact there with other drug users and with the social workers (Chapter 6). However, drug users would not 'travel' to visit friends (Chapter 5), which does not necessarily mean that friendships are not valued, but that friends should be just a stone's throw away. The question remains what drug users understand by the concept of 'friends', after all, they often state that *"true friendship is rare in the drug scene"* and *"if you have drugs, you have many friends"*. Positive is that two-thirds of drug users had some kind of contact with one or more of their family members in the past month (Chapter 7).

This thesis shows that the dimension of social relations is especially important in the socialisation process of young crack users (Chapter 2). Those young users who succeeded in remaining clean were able to renew social contacts outside of the drug scene (parents, friends). This corroborates the statement that uncontrolled drug use and high quality social relationships do not go well together.

Sources of income

Drug users get marginalised when there is *"a decline of possibilities to take part in legitimate economic activities"* (Coumans, 2005, p. 152). Drug users undertake illegal activities to obtain their income, such as theft, drug dealing and street prostitution. This is corroborated by the results presented in this thesis. Young people who use crack start stealing money from their parents to support their drug habit (Chapter 2) and in older users there is a strong association between problematic drug use and illegal activities (Chapters 3 and 4).

Socialisation sets in when marginalised drug users are able to obtain income through legal activities. Social activation projects have been realised that give drug users the opportunity to earn money legally and give them a more structured daily pattern. Many drug users participate in these projects (Chapter 3). Indeed, drug users who have some kind of a job move around in a more goal-oriented way, and this is associated with lower levels of visibility and nuisance on the streets (Chapter 5). For younger users, it appeared that when they stopped using crack there was no necessity to further engage in illegal activities (Chapter 2).

Health

Drug users become marginalised when their *"physical, lifestyle-related and psychological problems articulate the deviancy of the drug user, thus implying decreasing possibilities to fully participate in society"* (Coumans, 2005, p. 152). Marginalising drug users show indifference towards health issues and have a deteriorating personal health situation. This thesis contains several indications that confirm these findings. Young crack users describe their physical condition as good before they started using; because of frequent use of crack some experienced respiratory problems and a deteriorating physical fitness (Chapter 2). Many adult drug users do not perceive their health as good (Chapters 3 and 4). GPs and nurses of the Street General Practice see that long-term drug (and alcohol) abuse is associated with many of the health complaints that homeless people suffer from (Chapter 7). Between 2003 and 2007 there was no increase in the numbers of drug users that perceive their health as (very) good (Chapter 3).

Socialisation can set in when there is a change for the better regarding health. For example, drug users who visit drug consumption rooms report making ample use of health-related services, such as eating, washing, medical care and syringe exchange. They also state positive health effects of going to a drug consumption room, in that they take more rest and pay more attention to hygiene (Chapter 6). In 2007, 9 out of 10 drug users had health insurance (Chapter 3). Drug users state that they would 'travel' to make use of medical care when they consider it necessary (Chapter 5). However, as long as mainstream health care is largely inaccessible, medical care integrated within low-threshold care facilities is the next best thing.

Crack use

Both crack and homelessness were identified to be specific factors that accelerate marginalisation. Crack was introduced in the Rotterdam heroin scene in the early 1990s (Blanken, Barendregt & Zuidmulder, 1999; Grund, Adriaans & Kaplan, 1991), years before the drug was launched in other parts of the Netherlands. From the mid-1990s almost all Rotterdam drug users were users of both heroin and crack (e.g. Blanken, Barendregt & Zuidmulder, 1999; Van der Poel, Barendregt, Schouten & Van de Mheen, 2003). It is therefore difficult to study the catalyst effect of the use of crack in the process of marginalisation. Nonetheless this thesis shows that, for young people, their use of crack initiated a process of (further) marginalisation, and those young users who managed to discontinue the use of crack were able to start the socialisation process (Chapter 2).

Homelessness

Besides crack, homelessness was identified as a second catalyst in the process of marginalisation. Drug use, homelessness, and physical and mental problems are closely intertwined (Chapters 3, 4 and 7). Homelessness appears to be more problematic among drug users who visit care facilities (Chapter 4). Homeless drug users frequent many neighbourhoods to carry out their daily activities, and are highly visible in that they spend many hours per day in public. Especially homeless drug users move around the city in a less goal-oriented way (Chapter 5). Actual homelessness among drug users has decreased from 40% in 2003 to 27% in 2007. Being in public, using alcohol and drugs in public, fare-dodging and getting fined by the police are associated with actual homelessness. Further, actual homeless drug users have a higher frequency of drug use than residential homeless drug users and those living independently (Chapter 3). Therefore, actual homelessness is interpreted as a catalyst in the marginalisation process.

The living situation for drug users at the group level changed positively, as it did for individual drug users who are no longer actually homeless (but who are residential homeless or independent housed; Chapter 3). Also, Street GPs and nurses observed more stable self-care and a better physical condition among the homeless, which they related to the increase in the number of residential homeless people (Chapter 7). It seems plausible that housing homeless drug users is associated with a process of socialisation.

Other external actors

The location of low-threshold care facilities defines the extent to which it is used (see Chapter 5). Rotterdam (as many other Dutch cities) has a history of difficulties in realising facilities in neighbourhoods, because local citizens resisted the locating of facilities and drug users in their neighbourhoods. The evalu-

ation of Safe & Clean (Spijkerman et al., 2002) showed that the spread of facilities through the entire city was not reached; neighbourhoods that experienced the most drug-related nuisance got the most facilities for drug users. Nowadays, the administration still determines in which part of the city low-threshold care facilities must be realised and finances the facility. The local administration (in Dutch: deelgemeente) then searches for a location, together with the care agency that will run the facility and the local citizens. More neighbourhoods now accept a low-threshold care facility, because communication about the procedures has improved. It is absolutely clear that the municipality must be cautious and transparent, about the fact that the facility will be located in that neighbourhood and that everything possible will be done to avoid public nuisance. Also, effective complaint procedures and keeping a finger on the pulse after the facility is operational, tend to increase the acceptability of the facility by the neighbourhood (Van Bergen & Van Deth, 2008; www.dakloos-inrotterdam.nl). This means that local citizens and neighbours have become important 'external actors'.

Conclusion

Especially Chapters 4 and 6 are informative about the role of day and night shelters and drug consumption rooms. Two-thirds of drug users are in contact with one or both kinds of facilities, many of whom have no intention of quitting their drug use. However, these facilities play a role in the daily functioning of drug users, as a matter of survival assistance: sleeping, eating, using drugs, washing, talking with others and so on. Chapter 5 shows that it is the location of the shelters and drug consumption rooms that determines to what extent they are used. Drug users are more inclined to make use of these low-threshold care facilities when these are located near places where drug users stay and where they can buy drugs. In Chapter 7 it is concluded that accessibility is an important success factor for the Street General Practice to have an effect on the health situation of (drug using) homeless people – the Street General Practice is integrated in low-threshold care facilities. In Chapter 3 it is shown that many homeless drug users earn legal income by participating in social activation projects, especially designed for drug users and homeless people.

Supported housing is the third kind of low-threshold care facility. These facilities were not explicitly studied in this thesis. Barendregt & Van de Mheen (2007) recently conducted an evaluation of "With(out) a roof", the Rotterdam supported housing program for homeless drug users. Briefly, the results showed that clients express no need for help or care for drug and alcohol use. They do need – and receive – financial and administrative support. Besides that, drug users state that they need help in the social arena (many are lonely), and want help regarding how to spend the day (social activation and work).

It is concluded, first, that interventions to improve the economic and health situation (and not the social situation) of drug users could be found in shelters and drug consumption rooms. Second, these facilities can play a role in the socialisation process by taking drug users under their wings and referring them to the appropriate treatment, housing, activation and other programs and projects.

Therewith, the two hypotheses posed earlier can be accepted: low-threshold care facilities can contribute to both the discontinuation of the process of marginalisation as well as to the start of the process of socialisation, through the dimensions sources of income and health (and maybe through the dimension of social relations).

Socialisation: springboard function

Low-threshold care facilities can have three functions: broom wagon, safety net and springboard (as was noted for drug consumption rooms: Linssen, De Graaf & Wolf, 2002). In the early and mid-1990s, when drug policy emphasised reduction of public nuisance, low-threshold care facilities functioned as a broom wagon. Nuisance-causing drug users were kept off the streets in facilities that could be seen as end stations. Nonetheless, minimal care was provided within the facilities. This could be called the safety net function. Day and night shelters and drug consumption rooms can function as safety nets, and this can be interpreted as contributing to the discontinuation of marginalisation of drug users.
Later, it was no longer politically acceptable that marginalised people, including drug users and homeless people, were simply taken off the streets; it was seen as inhuman to accept e.g. sleeping rough or street prostitution (see Barendregt & Van de Mheen, in press; Bruins & Van Erkel, 2005). Low-threshold care facilities then got the additional function of springboard, meaning that they could play a positive role in providing opportunities that make a new start possible or, in other words, play a positive role in socialisation. This role consists of assisting in the improvement of living conditions of drug users, referring drug users to appropriate care and treatment facilities, and calling in other parties (e.g. debt counsellors, organisers of social activation projects). The latter function of springboard is becoming increasingly important. In 1996 the Rotterdam administration ordered the project 'Safe & Clean'; homeless drug users were kept off the streets with the realisation of drug consumption rooms and supported housing. From 2003 onward, individual care plans for nuisance-causing drug users were introduced with the 'Personal approach', and from 2006 onward individual care plans for homeless people were made within the 'Strategy Plan for Social Relief'. The common goal is to encourage people to function at the highest level of self-management possible. Over the years, all types of organisations were encouraged to work together in solving issues related to chronic drug use and homelessness, which would make the springboard function of low-threshold care facilities all the more viable. Referrals and agreements to work together can best be made based on systematic identification of problem areas and diagnosis of physical and mental diseases, e.g. high debts or symptoms of depression. When problems are identified action can be undertaken by offering care or referring drug users to the appropriate programs. There is growing interest in improving possibilities for identification and diagnosis of problems (e.g. depression and alcohol abuse; Heijerman-Holtgrefe & Wits, 2009; Van Rooij, Mulder, Wits, Van der Poel & Van de Mheen, 2007; Van Rooij, Wits, Van de Mheen & Mulder, 2008). Also, the integration of services and care (e.g. social activation projects and health care) in low-threshold care facilities can create effective opportunities for socialisation.

The functions of broom wagon and safety net go well together (those who are of the street are offered minimal care), as do the functions of safety net and springboard (those who are in low-threshold care can stabilise and can be motivated to further socialise). Shelters and drug consumption rooms can function as broom wagon, safety net and springboard; supported housing can function as safety net and springboard.

Unintentional effects of low-threshold care facilities

Low-threshold care facilities could have unintentional effects, namely that they promote marginalisation or put a stop to socialisation. Especially with respect to drug consumption rooms, there were serious matters to be discussed. For example, when drug consumption rooms were introduced, workers were concerned that these low-threshold care facilities would endorse and promote drug use; they felt it would be like 'giving up' on clients if they gave them the opportunity to use drugs within a facility run by addiction care (Bransen et al., 2004). In Rotterdam, some staff of a social relief organisation were opposed to the integration of a drug consumption room in their building; it took a radical change in attitude before workers could appreciate the benefits of the drug consumption room (Barendregt, Van der Poel & Van de Mheen, 2002). In time, concerns were overcome (which was not always easy) and nowadays drug consumption rooms are regular facilities within the Dutch addiction care system. Another example is the accessibility or the opening hours of drug consumption rooms. Drug users tend to want opening hours extended so they can use drugs anytime they like, and they want opening hours to be congruent with the opening and closing hours of e.g. night shelters that they frequent; workers tend to oppose this, because of the notion of 'hospitalisation' (see e.g. Chapters 5 and 6; Bransen et al., 2004). Nowadays there seems to be consensus about the idea that the opening and closing hours of low-threshold care facilities should be congruent (recommended by e.g. Van Straaten, Wits & Van de Mheen, 2009 and Van 't Land, Vruggink & Wolf (2003) in order to improve the low-threshold care for chronic drug users). The facilities are there for drug users to make use of and 'hospitalisation' can be prevented by e.g. offering social activation. In addition, when drug users are inside, they cannot be fined by the police for violations of by-laws. Drug consumption rooms seem to contribute positively to the reduction of drug-related nuisance (Van Ooyen-Houben et al., 2009).

Recommendations

In recent years much has been done for drug users in the related aims to discontinue marginalisation and enhance socialisation. However, the following questions remain: what is needed within low-threshold care facilities to advance socialisation, and how can low-threshold care facilities be employed more effectively?

Socialisation

What further significance can low-threshold care facilities have for the three socialisation dimensions?

In the process of socialisation, the social dimension is the most difficult in which to intervene because social relationships are essentially a private matter. Nevertheless, there is much to gain in this dimension. A new social network (also with non-using people) is not easy to build and maintain. Contacts with family are often delicate because of issues of distrust and insecurities. Professionals have to look for 'out-of-the-box' solutions if they want to contribute to opportunities in the social dimension. The Rotterdam Public Health Service sees that stabilisation and socialisation should also be reflected in the dimension of social relations or, in a broader perspective, by giving 'meaning to life'. For example, in 2009 a pilot project was started (and evaluated) called 'Own strength conferences' (in Dutch: 'Eigen kracht-conferenties') for residential homeless people – whose possible drug problems must be under control. These conferences are successful with multi-problem families and youth (Burford & Hudson, 2000). The idea is that a person's social network is used to increase that person's ability to provide for him or herself (depending on the goals of the person). The conference is prepared by a volunteer that is trained in the Own strength method. 'Out-of-the-box' means that plans are made without interference of social workers or other professionals, it is up to the person and his/her social network to make plans. However, professionals are important in supporting the homeless before and after the conference. Working with this method enhances the social cohesiveness of the family and the social network and, in this case, the residential homeless person.

Regarding the economic dimension of the process of socialisation, increasing numbers of social activation projects are organised by and within low-threshold care facilities and many drug users participate in these projects. The problem remains that only very few (former) drug users make the transition from working in a social activation project to a regular paid job. First, few drug users have a good quality (start or re-entry) position on the labour market and/or have recent work experience. Second, keeping a job requires specific skills, such as being on time and being accurate; skills that may be difficult for drug users. It remains to be seen to what extent drug users are able to get and keep a regular job. That does not mean that investments in social activation projects should be decreased or stopped. Working in such projects gives structure and meaning to the day, and are important in giving drug users, and homeless people, a sense of belonging.

As stated earlier, the health dimension of the process of socialisation has two sides. On the one hand, low-threshold care facilities have improved access to health care and played a significant positive role in the health situation of drug users and homeless people. This is largely because nurses and physicians of the Street General Practice offer their medical assistance within the low-threshold care facilities. On the other hand, stabilisation (housing, drug use) brings psychological and psychiatric problems to the surface. Getting drug users diagnosed is important, because then there is a starting point for treatment (e.g. medication, psychological help). There are several successful initiatives, e.g. the screener for addiction and depression, which is implemented in the intake in Central Welcome (Van Rooij et al., 2007; Heijerman-Holtgrefe & Wits, 2009) and the diagnoses made by the psychiatrists of the ACT team. These health initiatives should be further developed and made part of regular care for homeless people and drug users.

Other recommendations

In general, the low-threshold care facilities aim at 'people with multiple problems', whose problems cannot be solved by one (type of) organisation. Instead, all kinds of organisations have to work together to better the lives of persons with multi-problems; it is about delivering tailor-made solutions. In order to be able to deliver tailor-made solutions, there has to be a party that pursues the 'régie' (e.g. a trajectory director) (cf. Kruiter, De Jong, Van Niel & Hijzen, 2007). Kruiter and colleagues described principles of adequate assistance and care for these people, the first being *"work on an individual basis, the person with all of his problems is central"*. In this thesis the people with multiple problems are chronic drug users that experience all kinds of problems (physical, mental, social, economic, etc.). Do low-threshold care facilities deliver tailor-made solutions in order to solve some of the problems? The answer is affirmative, albeit only in cooperation with other agencies. A result of the cooperation between care and repression agencies (the personal approach) is that almost all drug users (and homeless people) have a trajectory manager that has the 'régie' over the performance of the individual treatment and care plan. The personal approach is

aimed at having a place to stay (ranging from a night shelter to independent or supported housing), having a legal source of income (usually social benefits and working in a social activation project), and being in touch with appropriate care and treatment agencies. Regarding the latter there is a tendency to integrate services (e.g. health care, activation projects, debt counselling) and facilities (e.g. drug consumption rooms) in other facilities (e.g. day and night shelters, social hostels). It is recommended that the interest of the individual drug user (and of society in general) should continue to prevail. Cooperation is successful, but efforts should be made by organisations to maintain it (e.g. organisational and financially). There should be time and space for research and reflection on the procedures, processes and constraints that could further develop cooperation. Moreover, cooperation should not only focus on existing problems, but also on the prevention of addiction problems and homelessness.

In 2000 about 65% of drug users were in contact with day and night shelters and drug consumption rooms, and 14% of drug users were in contact with neither treatment nor care agencies (see Chapter 4). Nowadays, due to implementation of the personal approach, together with the expansion of outreach activities and an increase in the capacity of low-threshold care facilities, there is presumably a smaller number of drug users that are not in contact with agencies. The idea is that those who do not receive any treatment or care should at least be known by fieldworkers. Fieldwork is and will always remain important. It is recommended that continuous investment be made in this specialised segment of professionals. They need to be appreciated for their difficult task and for the results they eventually achieve.

Shelters and drug consumption rooms are employed as sites from where drug users can be further referred in the treatment and care system. There are different types of supported housing, ranging from a number of hours of housing counselling per week to residential settings. The ultimate goal is that drug users function at the highest level of self-management that is possible. For one person that may mean living in shelters, for another living in a social hostel, and for a third this may mean living independently. It is recommended that research be conducted into these levels of self-management. How can the highest level be reached? What (other or additional) differentiations can be made, both in characteristics of drug users as well as in treatment and care settings? Answers can be helpful to avoid disappointments and set backs, for professionals as well as for drug users.

In general, it is important that professionals (policymakers as well as implementors; low-threshold as well as other care and treatment agencies) stay in contact with the drug users and homeless people that are the target of their programs and projects. They should take the members of the target groups seriously, talk to them, and listen to them. Low-threshold care can only be successful (in turning marginalisation into socialisation) when there is meaningful and honest interaction between professionals and clients. Only then can the demand for help (by drug users) and the offer of care and treatment (by agencies/facilities) be matched. Rotterdam has several client organisations, e.g. of the addiction care and treatment organisation and of organisations in the social relief sector, as well as interest groups (e.g. 'junky unions') and target group ambassadors (in Dutch: doelgroepambassadeur; initiated by the city administration). They should be involved in the discussion of new ideas and plans, as well as in the evaluation of implemented projects and programs. Their experiences are valuable in explaining how a facility functions and what they

perceive as bottlenecks. It is recommended that their advice – whether it is invited or uninvited – should be taken into account.

Although the group of chronic drug users is aging, there are and will be new users in the drug scene. Young users tend to start their hard drug career with crack, which initiates a process of (further) marginalisation (see Chapter 2). It is recommended that professionals should intervene as early as possible in the lives of these (often multi-problem) youngsters.

Final remark

Although the majority of chronic drug users will ultimately remain drug users, the quality of life of drug users has improved in recent years. It is important to gain insight into how to consolidate the results of socialisation. What is needed on the longer term to prevent relapse – to life on the streets, to unsafe drug use, to nuisance-causing behaviour? Future research should focus on these and related questions.

References

Barendregt, C., & Van de Mheen, D. (in press). "Then there was silence on the streets". Developments in the street scene of Rotterdam in the last decade. Drugs: education, prevention and policy.

Barendregt, C., & Van de Mheen, D. (2007). Ambulante woonbegeleiding voor verslaafden. Evaluatie van het project (z)Onderdak [Ambulant supported housing for drug users. Evaluation of the project With(out) a roof]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., Van der Poel, A., & Van de Mheen, D. (2002). Gebruiksruimten in Rotterdam, in het perspectief van gezondheidsbevordering en overlastvermindering [Drug consumption rooms in Rotterdam, in the perspective of health promotion and nuisance reduction]. Rotterdam: IVO Addiction Research Institute.

Barendregt, C., & Wits, E. (2009). Chronisch problematische verslaafden in Flevoland. Problematiek en behoefte aan woonzorg, laagdrempelige voorzieningen en dagbesteding [Chronic problematic hard drug users in Flevoland. Problems and need for supported housing, low-threshold facilities and social activities]. Rotterdam: IVO Addiction Research Institute.

Bieleman, B., Boendermaker, M., Kruize, A., & Van Zwieten, M. (2007). Monitor verslaafden en daklozen in Enschede 2007. Metingen 2001, 2002, 2003, 2004, 2005 en 2006 [Monitoring the addicted and the homeless in Enschede 2007. Measurements 2001, 2002, 2003, 2004, 2005 en 2006]. Groningen / Rotterdam: Intraval, bureau for research and consultancy.

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community field work: bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291–296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

Blanken, P., Barendregt, C., & Zuidmulder, L. (1999) The evolution of crack and basing cocaine in the Rotterdam heroin scene. Journal of Drug Issues, 29(3), 609-626.

Bransen, E., Van 't Land, H., & Wolf, J. (2004). Gebruiksruimten, trends 2001-2003 [Drug consumption rooms, trends 2001-2003]. Utrecht: Resultaten Scoren / Trimbos Institute, Netherlands Institute for Mental Health and Addiction.

Bruins, M., & Van Erkel, J. (2005). Het opheffen van tippelzones in grote steden en het recht op gezondheid van vrouwen [The closing of street prostitution zones in major cities and women's right to health]. Amersfoort: Johannes Wier Stichting.

Burford, G., & Hudson, J. (Eds.) (2000). Family group conferencing. New directions in community-centered child & family practice. Piscataway, NJ: Transaction Publishers.

Coumans, A.M. (2005). Survival on the fringes of society. Marginalisation and hardening among chronic heroin users. Maastricht: University of Maastricht (dissertation).

Coumans, A.M., & Knibbe, R.A. (2001). Druggebruikers in Parkstad Limburg: noden en behoeften. Resultaten van het Drug Monitoring Systeem 2000 – 2001 [Drug users in Parkstad Limburg: needs and wants. Results of the Drug Monitoring System 2000 – 2001]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., & Knibbe, R.A. (2002). Druggebruikers in Parkstad Limburg: trends en profielen. Resultaten van het Drug Monitoring Systeem 2001 – 2002 [Drug users in Parkstad Limburg: trends and profiles. Results of the Drug Monitoring System 2001 – 2002]. Rotterdam: IVO Addiction Research Institute.

Coumans, A.M., Neve, R.J.M., & Van de Mheen, D. (2000). Het proces van marginalisering en verharding in de drugscene van Parkstad Limburg. Resultaten van het Drug Monitoring Systeem 1998 – 2000 [The process of marginalisation and hardening in the drug scene of Parkstad Limburg. Results of the Drug Monitoring System 1998 – 2000]. Rotterdam: IVO Addiction Research Institute.

De Graaf, I., Wildschut, J., & Van de Mheen, D. (2000). Utrechtse gebruikers: een jachtig bestaan. Verslag van twee jaar Drug Monitoring Systeem onder Utrechtse (bijna) dagelijkse gebruikers van heroïne, cocaïne and andere drugs [Drug users in Utrecht: a hurried existence. Report of two years Drug Monitoring System among Utrecht (nearly) daily users of heroin, cocaine and other drugs]. Rotterdam: IVO Addiction Research Institute.

Federation of Shelters (2009). Daklozen aller steden verzamelt u, maar niet op straat! Een evaluatieonderzoek in essays naar de uitvoering van het Plan van Aanpak Maatschappelijke Opvang in Amsterdam, Rotterdam, Den Haag en Utrecht [Homeless in every city unite, but not on the streets! An evaluation study in essays into the implementation of the Strategy Plan for Social Relief in Amsterdam, Rotterdam, The Hague and Utrecht]. Amersfoort: Federation of Shelters.

Grund, J.P., Adriaans, N.F., & Kaplan, C.D. (1991). Changing cocaine smoking rituals in the Dutch heroin addict population. British Journal of Addictions, 86(4), 439-448.

Heijerman-Holtgrefe, A., & Wits, E. (2009). Resultaten van het screeningsinstrument Verslaving en Psychiatrie. Evaluatie van de zorgtoeleiding van dak- en thuislozen in de Rotterdamse maatschappelijke opvang [Results of the screening questionnaire Addiction and Psychiatry. Evaluation of referral to care of residential and actual homeless people in the Rotterdam social relief sector]. Rotterdam: IVO Addiction Research Institute / O3, Onderzoekcentrum GGZ Rijnmond.

Hendriks, V.M., Blanken, P., Adriaans, N.F.P., & Vollemans, L.C. (1994). Continue gegevensverzameling over druggebruik: de opzet van een locaal Drug Monitoring Systeem (DMS) [Continuous data collection about drug use: the design of a local Drug Monitoring System (DMS)]. Rotterdam: IVO Addiction Research Institute.

Jansen, C., Mensink, C., & Wolf, J. (2007). Dakloos in Zeeland. Onderzoek naar profiel en perspectief van daklozen en zwerfjongeren [Homeless in Zeeland. Research into profile and perspective of homeless adults and youth]. Nijmegen: Onderzoekscentrum maatschappelijke zorg, Umc St Radboud Nijmegen.

Kruiter, A.J., De Jong, J., Van Niel, J., & Hijzen, C. (2007). De Rotonde van Hamed. Maatwerk voor mensen met meerdere problemen [The Roundabout of Hamed. Tailor-made solutions for people with multiple problems]. The Hague: Nicis Institute.

Lempens, A., Van de Mheen, D., & Barendregt, C. (2003). Homeless drug users in Rotterdam, the Netherlands: profile, way of life and the need for assistance. Substance Use & Misuse, 38(3-6), 341-377.

Lempens, A., Wildschut, J., Van der Most, D., & Knibbe, R.A. (2003). "Na de tunnelsluiting". Een onderzoek naar de eerste effecten van de verandering in de Utrechtse harddrugsscene ["After the closure of the Tunnel". A study into the first effects of the changes in the Utrecht hard drug scene]. Rotterdam/Utrecht: IVO Addiction Research Institute.

Linssen, L., De Graaf, I., & Wolf, J. (2002). Gebruiksruimten in beeld. Handreiking bij de organisatie en inrichting [Drug consumption rooms in sight. Guidelines for the organisation and design]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Maaskant. J., & Van der Giesen, E. (2007). Daklozenmonitor 2006-2007 [Monitoring the homeless 2006-2007]. Rotterdam: Department of Social Affairs and Employment.

Ministry of Health, Welfare and Sport (2009). Voortgangsrapportage maatschappelijke opvang 2008 [Progress report social relief sector 2008]. The Hague: Ministery of Health, Welfare and Sport.

Ministry of Health, Welfare and Sport (2008). Voortgangsrapportage maatschappelijke opvang (Tweede Kamer vergaderjaar 2007-2008, 29 325, nr. 25) [Progress report social relief sector (House of Representatives year 2007-2008, 29 325, no. 25)]. The Hague: Ministery of Health, Welfare and Sport.

Ministry of Health, Welfare and Sport (2006). Plan van Aanpak Maatschappelijke Opvang. Het Rijk en de vier grote steden [Strategy Plan for Social Relief. National Government and the four largest cities]. The Hague: Ministery of Health, Welfare and Sport.

Peterson, J.A., Schacht Reisinger, H., Schwartz, R.P., Mitchell, S.G., Kelly, S.M., Brown, B.S., & Agar, M.H. (2008). Targeted sampling in drug abuse research: a review and case study. Field Methods, 20(2), 155-170.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Quadt, T. (Ed.) (1996). Verantwoord Schoon in Rotterdam [Safe & Clean in Rotterdam]. Rotterdam: Rotterdam Public Health Service.

Rezai, S., Van 't Klooster, B., Van Dongen, A., & Van der Poel, A. (2006). REGIO Monitor Eindhoven 2006: aard en omvang van (ernstige) verslavingsproblematiek en knelpunten in de zorgverlening [Region Monitor Eindhoven 2006: nature and size of (severe) addiction problems and bottlenecks in the care system]. St Oedenrode: Novadic-Kentron / Rotterdam: IVO Addiction Research Institute.

Steuns, A., Janssen, M., Van Lokven, M., & Van der Poel, A. (2008). Regiomonitor Breda 2007. Resultaten van onderzoek naar verslavingsproblematiek en verbeterpunten voor het zorgaanbod. [Region Monitor Breda 2007. Results of research into addiction problems and recommendations for the supply of care]. Vught: Novadic-Kentron, Rotterdam: IVO Addiction Research Institute.

Trimbos Institute (2009). Monitor Plan van Aanpak Maatschappelijke Opvang. Rapportage 2008: Amsterdam, Den Haag, Utrecht en Rotterdam [Monitor Strategy Plan for Social Relief. Report 2008: Amsterdam, The Hague, Utrecht and Rotterdam]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Trimbos Institute (2006). Prevention and reduction of health-related harm associated with drug dependence. An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003. Synthesis report. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Van Bergen, A., & Van Deth, A. (2008). Het wordt rustiger op straat. Aanpak daklоosheid werpt eerste vruchten af [It is becoming more quiet on the streets. Tackling homelessness shows first good results]. Tijdschrift voor Sociale Vraagstukken, 7-8, 8-11.

Van de Mheen, H., Coumans, M., Barendregt, C., & Van der Poel, A. (2006). A Drug Monitoring System: keeping a finger on the pulse by triangulation of qualitative and quantitave methods. Addiction Research and Theory, 14, 461-473.

Van der Dam, S., Coumans, A.M., & Knibbe, R.A. (2006a). Frequent harddruggebruik onder jong volwassenen in Parkstad Limburg [Frequent use of hard drugs among young adults in Parkstad Limburg]. Rotterdam: IVO Addiction Research Institute.

Van der Dam, S., Coumans, A.M., & Knibbe, R.A. (2006b). Eindrapportage Drug Monitoring System Parkstad Limburg [Final report Drug Monitoring System Parkstad Limburg]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Barendregt, C., Schouten, M., & Van de Mheen, D. (2003). De leefsituatie van gebruikers in de Rotterdamse harddrugsscene. Resultaten van de survey 2003 [Living conditions of users in the Rotterdam drug scene. Results of the survey 2003]. Rotterdam: IVO Addiction Research Institute.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2008). Homelessness and other living condition characteristics of drug users 2003 - 2007, in Rotterdam, the Netherlands. European Journal of Homelessness, 2, 235-257.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2001). Druggebruikers en hun gebruik van de Rotterdamse verslavingszorg [Drug users and their use of the Rotterdam addiction care system]. Rotterdam: IVO Addiction Research Institute.

Van Ooyen-Houben, M., Bieleman, B., Biesma, S., Snippe, J., Van der Wagen, W., & Beelen, A. (2009). Drugsgerelateerde overlast [Drug-related nuisance]. In M. van Laar, M. van Ooyen-Houben (Eds.). Evaluatie van het Nederlandse drugsbeleid [Evaluation of the Dutch drug policy]. Utrecht / The Hague: Trimbos Institute, Netherlands Institute of Mental Health and Addiction / WODC, Research and Documentation Centre of the Ministry of Justice.

Van Rooij, T., Mulder, N., Wits, E., Van der Poel, A., & Van de Mheen, D. (2007). Screeningsinstrument Verslaving en Psychiatrie voor de maatschappelijke opvang [Screener Addiction and Psychiatry for the social relief sector]. Rotterdam: IVO Addiction Research Institute / O3, Onderzoekcentrum GGZ Rijnmond.

Van Rooij, T., Wits, E., Van de Mheen, D., & Mulder, N. (2008). Toeleiding van dak- en thuislozen naar de ggz. Verloop van zorggebruik en psychosociale problematiek onder dak- en thuislozen in de Rotterdamse maatschappelijke opvang in 2006 [Referral of residential and actual homeless people to mental health care. Verloop of use of care and of psycho-social problems among the homeless in the Rotterdam social relief sector in 2006]. Rotterdam: IVO Addiction Research Institute / O3, Onderzoekcentrum GGZ Rijnmond.

Van Straaten, B., Wits, E.W., & Van de Mheen, D. (2009). Alcohol- en drugsproblematiek in Arnhem. Analyse ten behoeve van het gemeentelijk verslavingsbeleid 2010-2014 [The alcohol and drug situation in Arnhem. Analysis for the municipal addiction policy 2010-2014]. Rotterdam: IVO Addiction Reseach Institute.

Van 't Land, H., Vruggink, J., & Wolf, J. (2003). Van later zorg? Over de kwaliteit van de laagdrempelige zorg voor langdurig verslaafden [Of later care? On the quality of the low-threshold care for chronic addicts]. Utrecht: Trimbos Institute, Netherlands Institute of Mental Health and Addiction.

Vermeulen, K., Wildschut, J., & Knibbe, R. (2001). "Zo'n beetje alles staat in het teken van de wit". Een verkennend onderzoek naar (base)cocaïne in de Utrechtse gemarginaliseerde gebruikersscene ["Almost everything is about white". An explorative study on crack-cocaine in the marginalised drug scene in Utrecht]. Rotterdam: IVO Addiction Research Institute.

Vocks, J., Meertens, V. & Wolf, J. (2007). Dakloos in Zwolle. Onderzoek naar omvang en profiel van de daklozenpopulatie [Homeless in Zwolle. Research into the size and profile of the homeless population]. Nijmegen: Onderzoekscentrum maatschappelijke zorg, UMC St Radboud Nijmegen.

Witteveen, E. (2008). Knowledge gained through experience in young problem drug users. Reflections on interventions and change. Amsterdam: Public Health Service Amsterdam / University of Amsterdam (dissertation).

Wolf, J., Zwikker, M., Nicholas, S., Van Bakel, S., Reinking, D., & Van Leiden, I. (2002). Op achterstand. Een onderzoek naar mensen in de marge van Den Haag [Lagging behind. A study on marginalised persons living in The Hague]. Utrecht: Trimbos Institute, Netherlands Institute for Mental Health and Addiction.

www.DAKLOOSINROTTERDAM.nl (homeless in Rotterdam): Accessed August 2009.

Zinberg, N. (1984). Drug, set and setting. The basis for controlled intoxicant use. New Haven/London: Yale University Press.

Summary

Introduction

Since the early 1990s several important developments have taken place in the hard drug scene in the Netherlands. Key elements in these developments were harm reduction measures, introduction of crack, open drug scenes, police interventions, drug-related nuisance, low-threshold care facilities and well-being of drug users. Drug policy and drug scenes have changed over the past 15 years.

The aim of this thesis is to provide insight into the role of low-threshold care facilities in the process of marginalisation and socialisation of drug users. Low-threshold care facilities do not aim to change drug use patterns; they are day and night shelters, drug consumption rooms and supported housing. Marginalisation entails that chronic hard drug users drift away from the core institutions of society, e.g. family and friends (social relations), the labour market (sources of income) and health care (health); socialisation is the opposite of marginalisation. The hypothesised roles that low-threshold care facilities can play are derived from this process. First, low-threshold care facilities can contribute to the discontinuation of marginalisation. Second, low-threshold care facilities can function as re-integration instruments. Both marginalisation and socialisation have their effects on individual drug users and on society in a broader perspective (in terms of public health and public safety). By understanding the role of low-threshold care facilities within a changing environment, these facilities can be utilised more effectively.

Each of the six chapters report on a study conducted within the framework of two research projects: the Rotterdam Drug Monitoring System (DMS 1994-2003 and a 'mini DMS' in 2004 and 2005) and Trendspotting (from 2006 onward). The DMS was a local information and observation system continuously collecting both quantitative and qualitative data about drugs, drug users and related issues. The research population was the group of (nearly) daily users of crack, heroin and/or methadone. The focus of the DMS was on the drug user in his or her natural environment, or 'the daily life', which was important since the research population is categorised as a 'hidden population'. Three research methods were used to collect data: daily community fieldwork, a periodical survey, and interviews with key informants (professionals and drug users); the data were analysed using methodological triangulation in a complementary model. The continuity of the research made it possible to report on trends and developments within and around the drug scene to e.g. policy makers and care providers. The DMS was active from 1994 to 2003 inclusive. In 2004 and 2005 IVO was asked to monitor the drug and homeless scenes. From 2006 onward, annual studies were conducted under the name Trendspotting. Instead of a continuous information system, a special topic (and corresponding methodology) is chosen. Trendspotting focuses on the drug and homeless scene, since the two became more and more intertwined.

Results

Chapter 2 describes the process of marginalisation for young crack users (aged 16-24 years). The age at which crack use commenced ranged from 14 to 17 years. It appeared that young crack users moved from a marginal position in society to a marginal position within the drug scene. The conclusion is that the use of crack initiates a process of (further) marginalisation. Similar to adults, crack use and homelessness

strengthen the marginalisation process for young users. Some young crack users were able to stop their drug use, and start a process of socialisation. Two factors seemed important in this: (1) former crack users were younger than current users, and (2) many former crack users did not use heroin, whereas some current crack users also started heroin use. Former crack users appreciate youth rehab, because it enables them to renew social contact with non-using peers. The need for illegal sources of income disappears and the health situation improves when crack is no longer used. In contrast, the adolescents' social network needs attention and (inter)action.

Chapter 3 shows that the living conditions of drug users in general have improved between 2003 and 2007. Most important is the decrease in actual homelessness. Furthermore, there was a decrease in the number of hours per day spent in public, in illegal sources of income, in heroin and crack use, in the number of users using drugs in public and buying drugs on the streets. There was an increase in the number of users with health insurance, as well as an increase in alcohol and methadone use. In 2007 the group of actual homeless drug users had the poorest living conditions (related to their homelessness), and also showed a more intensive drug use pattern. The homeless life and excessive alcohol and drug use are intertwined. Independent housed users and residential homeless users have their own place, which is associated with reduced heroin and crack use, and (especially for the residential homeless) with an increase in psychiatric complaints. Many residential homeless make use of social activation projects, thereby gaining structure in their daily life.

In **Chapter 4** it was concluded that it is useful to distinguish four groups of drug users with respect to their help-seeking behaviour. The 'neither treatment nor care' and the 'treatment' groups are similar, as are the 'care' and 'treatment and care' groups. Earlier, the 'only care' group would have been included in the 'neither' group. However, the 'neither' group seemed satisfied with their situation. The 'treatment' group wants to resolve drug issues and issues in other areas. The 'treatment and care' group seems to need different kinds of addiction care as a way of survival in the scene. The 'care' group scores worst: they are in care, but not for resolving drug issues. Help seeking is primarily motivated by the need to address substance-related problems, not the substance use itself. Low-threshold care agencies can play a role in the survival of everyday life of drug users and in referring them to other appropriate programs and projects.

Chapter 5 describes the mobility of drug users. Activities that instigate mobility are using drugs and visiting low-threshold care facilities. Mobility (number of neighbourhoods frequented) and visibility (number of hours in public) are unrelated. However, users who move around less goal oriented – especially homeless users – are generally more visible. Users who have a structured routine (with e.g. work) move around more goal oriented. Drug-related nuisance can be reduced when users have a structured pattern with stable housing and work. However, triggers for moving around are buying drugs, and medical care. Low-threshold care facilities that offer 'bath, bed & bread' and/or safe drug use are not triggers, meaning that these facilities are best located in neighbourhoods where the users and/or dealers are.

The subject of **Chapter 6** was drug consumption rooms, i.e. facilities that serve the purpose of harm reduction (drug users can use drugs safely) and reduction in public nuisance (drug use takes place inside). The goals of

the consumption rooms have (partially) been reached. Drug users with an admission pass value the possibility of quiet and safe drug use inside, moreover, they used drugs less often in public since going to the drug consumption room. Also, the workers and the possibility of assistance are valued, and self-reported health effects are 'more time and rest', 'more attention to hygiene', and 'more attention to physical condition'. Pass holders mentioned two drug-related weak points of the facilities: first is the large scale of some drug consumption rooms resulting in crowds and chaos (they prefer small scale facilities), second is the limited opening hours (they prefer facilities to be open 24/7).

Chapter 7 evaluated the Street General Practice, health care for the homeless integrated in low-threshold care facilities. The patient group is mostly male, older than 40 years, health insured, and had 3 to 4 contacts each year (mean). Substance abuse and/or psychiatric problems were registered for over half of the patients. GPs and nurses observed that the residential homeless take better care of themselves, but also that psychiatric problems can surface. GPs and nurses identified three factors that explain the success of the Street General Practice: (1) accessibility, because it is integrated in low-threshold care facilities, (2) continuity, because medical files are available online at every facility, and (3) cooperation at both the management and the operational level. Better screening and registration is necessary to provide the required health care. Integrated care, which addresses medical and social issues, remains necessary as long as mainstream health care is not accessible for many of the homeless and does not adequately respond to the needs of homeless people.

Low-threshold care and the process of marginalisation and socialisation

Two hypotheses were posed:

(1) low-threshold care facilities can contribute to the discontinuation of the process of marginalisation, meaning that drug users do not marginalise any further – through the dimensions social relations, sources of income and health;

(2) low-threshold care facilities can contribute to the start of the process of socialisation, meaning that drug users start to re-integrate into society – through the dimensions social relations, sources of income and health.

It is concluded, first, that interventions to improve the economic and health situation (and not the social situation) of drug users could be found in shelters and drug consumption rooms, and second, that these facilities can play a role in the socialisation process by taking drug users under their wings and referring them to the appropriate treatment, housing, activation and other programs and projects. Therefore, there is evidence for the acceptance of both hypotheses.

Especially Chapters 4 and 6 are informative about the role of day and night shelters and drug consumption rooms. Two-thirds of drug users are in contact with one or both kinds of facilities, many of whom have no intention of quitting their drug use. However, these facilities play a role in the daily functioning of drug users, as a matter of survival assistance: sleeping, eating, using drugs, washing, talking with others and so on. Chapter 5 shows that it is the location of the shelters and drug consumption rooms that determines to what extent it is used. Drug users are more inclined to make use of these low-threshold care facilities when

these are located near places where drug users stay and drugs can be bought. In Chapter 7 it is concluded that accessibility is an important success factor for the Street General Practice to have an effect on the health situation of (drug using) homeless people; the Street General Practice is integrated in low-threshold care facilities. In Chapter 3 it is shown that many homeless drug users earn legal income by participating in social activation projects, especially designed for drug users and homeless people. (Supported housing was not explicitly studied in this thesis.)

Low-threshold care facilities are aimed at chronic drug users who are homeless and at homeless people among whom chronic drug users. Earlier research identified homelessness as a catalyst in the process of marginalisation; this thesis shows that it is plausible that housing the homeless can function as a catalyst in the process of socialisation.

Recommendations

What further significance can low-threshold care facilities have for the three socialisation dimensions? The social dimension is the most difficult in which to intervene, because social relationships are essentially a private matter. Professionals have to look for 'out-of-the-box' solutions if they want to contribute to opportunities in the social dimension, e.g. the Rotterdam Public Health Service started the pilot project 'Own strength conferences' (in Dutch: 'Eigen kracht-conferenties') for residential homeless people. Regarding the economic dimension of the process of socialisation, an increasing number of social activation projects are organised by and within low-threshold care facilities in which many drug users participate. Investments in social activation projects should be continued, because working in such projects gives structure and meaning to the day, and gives drug users a sense of belonging.
With respect to health, access to health care is guaranteed by organising the Street General Practice in low-threshold care facilities. Psychological and psychiatric problems can surface when people are residentially housed. Diagnoses are important, because these provide a starting point for (medical, psychological) treatment.

Further, it is recommended that:

- the cooperation between all kinds of organisations should be examined to further develop and secure successful collaboration;
- the expertise of fieldworkers should be appreciated and invested in;
- research should be done into matching professional goals (drug users functioning at the highest level of self-management) with the capabilities of drug users;
- professionals maintain contact with the drug users and homeless people (the target group of their programs and projects) in the discussion of new ideas and plans, as well as in the evaluation of implemented projects and programs; and
- all necessary steps should be taken to prevent young people (who tend to start their drug use career with crack) entering the scene of chronic drug use.

Final remark

Although the majority of chronic drug users will remain drug users, the quality of life of drug users has improved in recent years. It is important to gain insight into how to consolidate the results of socialisation. What is needed on the longer term to prevent a drug user from relapsing into life on the streets, to unsafe drug use, and/or to nuisance-causing behaviour? Future research should focus on these important questions.

Samenvatting

Dit proefschrift tracht inzicht te verschaffen in de rol van laagdrempelige zorgvoorzieningen in de veranderende Rotterdamse drugscene in de afgelopen 15 jaar. De eerste hypothese luidt dat deze voorzieningen kunnen bijdragen aan de discontinuering van het proces van marginalisering, dat wil zeggen dat druggebruikers die gebruik maken van deze voorzieningen niet verder marginaliseren. De tweede hypothese luidt dat deze voorzieningen kunnen bijdragen aan de start van het proces van socialisering, dat wil zeggen dat druggebruikers die gebruik maken van deze voorzieningen re-integreren in de maatschappij.

In dit hoofdstuk worden eerst de studieresultaten samengevat en enkele methodologische kanttekeningen geplaatst. Daarna worden ontwikkelingen in het drugbeleid sinds midden jaren '90 gepresenteerd. Vervolgens worden de hypothesen in het theoretische kader van marginalisering en socialisering beantwoord. In het laatste deel worden aanbevelingen gedaan voor beleid, praktijk en verder onderzoek.

Samenvatting van studieresultaten

Jongeren die basecoke gebruiken en het proces van marginalisering (Hoofdstuk 2)
Chronische druggebruikers worden als groep steeds ouder, en de meeste jonge druggebruikers starten tegenwoordig hun gebruikscarrière met basecoke (oftewel: gekookte cocaïne of crack). De theorie van marginalisering is opgesteld voor chronische (oudere) heroïnegebruikers. De onderzoeksvraag luidde of het proces van marginalisering en socialisering ook zou gelden voor jonge gebruikers en welke dimensies leidend zijn in dat proces. Vijftien huidige en vijftien voormalige basecokegebruikers (van 16 t/m 24 jaar oud) werden geïnterviewd. De leeftijd waarop zij startten met basecokegebruik varieerde van 14 t/m 17 jaar. Jonge basecokegebruikers bleken van een marginale positie in de maatschappij te gaan naar een marginale positie in de drugscene. Geconcludeerd werd dat basecokegebruik een proces van (verdere) marginalisering op gang brengt. Met het gebruik van basecoke werden sociale relaties functioneel van aard. Veel jongeren hadden geen goede (start)kwalificatie voor de arbeidsmarkt, en door diefstal en drugs dealen kregen zij een strafblad en belandden zij in detentie. Met betrekking tot gezondheid ontwikkelden sommigen ademhalingsproblemen door hun frequente basecokegebruik en velen hadden paranoïde ervaringen. Het basecokegebruik van veel jongeren duurde (nog) niet lang genoeg om lange termijn-gezondheidsproblemen te hebben ontwikkeld. Sommigen waren dakloos en/of hadden in de gevangenis gezeten. Basecokegebruik en dakloosheid versterkten het marginaliseringsproces bij jongeren, net als dat eerder bij volwassenen was geconstateerd. Sommige jonge basecokegebruikers was het gelukt te stoppen met het gebruik van drugs en een proces van socialisering te starten. Twee factoren leken hierbij belangrijk: (1) leeftijd: voormalige basecokegebruikers waren jonger dan huidige basecokegebruikers, en (2) heroïnegebruik: veel voormalige basecokegebruikers gebruikten geen heroïne, terwijl sommige huidige basecokegebruikers ook heroïne waren gaan gebruiken. Dit laatste suggereerde dat heroïne een katalysator kan zijn in het proces van marginalisering voor jonge druggebruikers, terwijl basecoke een katalysator in dat proces was voor oudere heroïnegebruikers. Zowel de huidige als de voormalige basecokegebruikers verschilden niet in achtergrondkenmerken (behalve leeftijd) en beide groepen hadden weinig vertrouwen in hulpverleners in de verslavingszorg (bijvoorbeeld laagdrempelige zorgvoorzieningen

zoals de opvang). De voormalige basecokegebruikers die in de jeugdkliniek waren waardeerden deze voorziening, vooral omdat die hen in staat stelde om sociale contacten met niet-gebruikende leeftijdgenoten te herstellen. Geconcludeerd kon worden dat in een behandelsetting (en wellicht ook in andere settings) de sociale dimensie de belangrijkste is om aan te werken. De dimensies inkomen en gezondheid zijn van ondergeschikt belang, omdat de noodzaak om op illegale wijze inkomen te vergaren verdween en de gezondheidssituatie verbeterde wanneer de jongeren geen basecoke meer gebruikten. Dit in tegenstelling tot het sociale netwerk, dat aandacht en (inter)actie nodig had.

Effecten van beleidsmaatregelen op de leefsituatie van druggebruikers 2007-2003 (Hoofdstuk 3)
Druggebruik en dakloosheid zijn met elkaar verweven: ongeveer eenderde deel van de daklozen is chronisch druggebruiker. Aangetoond is dat dakloze druggebruikers meer overlast kunnen veroorzaken omdat zij zich minder doelgericht bewegen in de openbare ruimte. Om overlast te verminderen worden tegenwoordig repressieve maatregelen gecombineerd met zorg en behandeling op maat, waaronder gebruiksruimten en huisvestingsprojecten. Verschillende organisaties, waaronder de verslavingszorg, de maatschappelijke opvang, politie en gemeentelijke instellingen, werken samen om collectieve doelstellingen te behalen. Met gegevens van de survey van 2003 (201 gebruikers) en van 2007 (102 gebruikers) werd aangetoond dat de leefsituatie van druggebruikers in het algemeen was verbeterd. Meest belangrijk was de afname van het aantal feitelijk daklozen (van 40% naar 27%); verder was er een afname in het aantal uur dat gebruikers per dag in het openbaar verbleven, in illegale bronnen van inkomsten, in gebruik van heroïne en basecoke, in het aantal gebruikers dat in het openbaar drugs gebruikte en drugs kocht op straat. Ook was er een toename van het aantal gebruikers met een ziektekostenverzekering.
De groep gebruikers die in 2007 onderzocht is, kon verdeeld worden in drie subgroepen: feitelijk daklozen (27%), residentiële daklozen (43%) en gebruikers die zelfstandig wonen (30%). Deze laatste groep stond er in het algemeen het best voor, terwijl feitelijk daklozen er het slechtst voor stonden, gerelateerd aan hun dakloosheid. Een belangrijk verschil was de intensiteit van het druggebruik: niet alleen gebruikten feitelijk daklozen (afgezet tegen de andere twee groepen) heroïne en basecoke op meer dagen per maand, ook in het openbaar, zij gebruikten ook grotere hoeveelheden per dag. Geconcludeerd werd dat dakloosheid en excessief alcohol- en druggebruik met elkaar verweven zijn. Zelfstandig wonende en residentieel dakloze gebruikers hebben hun eigen plek, en dat was gerelateerd aan minder gebruik van heroïne en basecoke (wel met meer methadongebruik, mogelijk ter vervanging van heroïne), en (met name voor residentieel daklozen) met een toename van psychiatrische klachten. Veel residentieel daklozen maakten gebruik van sociale activeringsprojecten.

Kenmerken van druggebruikers en laagdrempelige zorgvoorzieningen (Hoofdstuk 4)
In eerdere studies over hulpzoekgedrag werden druggebruikers gecategoriseerd als 'in behandeling' (gericht op abstinentie) of als 'niet in behandeling' (niet voor druggebruik). Echter, met de komst van laagdrempelige zorgvoorzieningen zijn deze begrippen complexer geworden. In de huidige studie zijn laagdrempelige voorzieningen (gebruiksruimten, dag- en nachtopvang) als aparte categorie opgenomen, als aanvulling op behandelvoorzieningen. Eerder zouden druggebruikers die gebruik maakten van alleen laagdrempelige voorzieningen namelijk geïncludeerd worden in de 'geen behandeling' groep. In totaal werden 201 druggebruikers ingedeeld in vier groepen die gebruik maken van: (1) alleen behandelvoor-

zieningen – 19%, vooral methadonprogramma; (2) alleen laagdrempelige voorzieningen – 18%, vooral dagopvang en gebruiksruimten; (3) behandel- én laagdrempelige voorzieningen – 49%, vooral dagopvang en methadonprogramma; en (4) geen voorzieningen – 14%. Deze groepen worden geduid als respectievelijk de 'behandel', 'care', 'behandel en care' en 'geen' groep. Het bleek nuttig om deze vier groepen te onderscheiden, omdat de 'geen' en de 'behandel' groep vergelijkbaar waren, net als de 'care' en de 'behandel en care' groepen. Twee functies werden gevonden vanuit de kenmerken van de druggebruikers: (1) druggebruik en dakloosheid, en (2) illegale inkomstenbronnen en zelfgerapporteerde goede gezondheid. De vier groepen werden beschreven met behulp van de Stadia van Gedragsverandering ('Stages of Change') van Prochaska, DiClemente & Norcross (1992). Twee groepen scoorden relatief goed: de 'geen' groep en de 'behandel' groep. De eerste groep leek tevreden met hun situatie en zou problemen zelf willen oplossen (precontemplatie stadium). De tweede groep leek in behandeling om drugsproblemen op te lossen (ook om abstinent te worden) en om problemen op andere gebieden op te lossen (contemplatie/voorbereiding stadia). De 'behandel en care' groep scoorde 'tussenin'; deze gebruikers bezochten veel verschillende voorzieningen en zouden hulp willen op andere gebieden dan druggebruik. Dit suggereerde dat zij verschillende soorten hulpverlening nodig hebben om te overleven in de scene (precontemplatie stadium). De conclusie luidde dat gebruikers in eerste instantie hulp zoeken om problemen gerelateerd aan hun middelengebruik op te lossen, niet om te werken aan het middelengebruik zelf. Bovendien zoeken zij pas hulp als het leven uit de hand dreigt te lopen. Voor druggebruikers kunnen laagdrempelige zorgvoorzieningen een essentiële rol spelen in hun dagelijks overleven in de scene en in de doorverwijzing naar andere passende programma's en projecten.

Mobiliteit van druggebruikers in relatie tot de deconcentratie van voorzieningen (Hoofdstuk 5)
Deconcentratie van zorgvoorzieningen, en daarmee van druggebruikers, is een terugkerend thema van het debat over de verspreiding van druggerelateerde overlast. Deconcentratie van voorzieningen en mobiliteit van druggebruikers hangen samen omdat de verplaatsing van voorzieningen alleen maar succesvol kan zijn als gebruikers zouden willen 'reizen' om deze voorzieningen te bezoeken. Mobiliteit en de onderliggende motieven voor mobiliteit werden onderzocht met surveygegevens van 182 gebruikers en interviewgegevens van 34 gebruikers.
Surveygegevens lieten zien dat vier van de tien gebruikers 'laag mobiel' waren, dat wil zeggen dat zij door een of twee buurten reizen om hun dagelijkse activiteiten uit te voeren. Vier andere waren 'gemiddeld mobiel' (3 t/m 6 buurten) en de overige twee van de tien waren 'hoog mobiel' (7 of meer buurten). Activiteiten die mobiliteit veroorzaken waren met name drugs gebruiken en bezoeken van laagdrempelige zorgvoorzieningen. Activiteiten die het meest aan elkaar gekoppeld waren, zijn huisvesting (slapen) en drugs gebruiken. Activiteiten die het minst aan elkaar gekoppeld waren, zijn huisvesting en gebruik maken van voorzieningen. Dit betekende dat hoewel zorgvoorzieningen een sterke aantrekkingskracht hebben, dit onvoldoende was dat druggebruikers hun dagelijks leefpatroon aanpasten rondom dergelijke voorzieningen. Dakloze druggebruikers hadden de hoogste mobiliteit (zij bezochten de meeste buurten) en zichtbaarheid (zij spendeerden vele uren per dag in de openbare ruimte). Interviewgegevens lieten zien dat mobiliteit en zichtbaarheid niet met elkaar samenhangen. Echter, gebruikers verschilden in de doelgerichtheid van hun mobiliteit, dat wil zeggen dat gebruikers die zich minder doelgericht verplaatsten (dat waren met name dakloze gebruikers) in het algemeen meer zichtbaar waren. Het verloop van hun dagen werd voor-

namelijk ingegeven door het kopen en gebruiken van drugs. Gebruikers met een gestructureerde routine (doordat zij bijvoorbeeld werk hebben) verplaatsten zich meer doelgericht. Gebruikers waren bereid 'te reizen' voor medische zorg, drugs van goede kwaliteit, methadon, en drugs van hun favoriete dealer. Zij waren niet bereid 'te reizen' voor rustig gebruik van drugs (bijvoorbeeld in een gebruiksruimte), bezoek aan vrienden, goedkope drugs, eten of persoonlijke hygiëne. Dit leidde tot de conclusie dat de aard van mobiliteit (redenen voor verplaatsing) niet verandert door het voeren van een repressief beleid, maar dat druggerelateerde overlast verminderd kan worden als gebruikers een gestructureerd leefpatroon hebben met stabiele huisvesting en werk. Echter, reden voor verplaatsing was drugs kopen (en medische zorg). Laagdrempelige zorgvoorzieningen die 'bed, bad & brood' en/of veilig gebruik van drugs bieden waren geen redenen voor verplaatsing. Dit betekent dat deze voorzieningen het best gerealiseerd kunnen worden in buurten waar gebruikers en dealers toch al zijn. Een drug-infrastructuur blijft belangrijk in de mobiliteit van druggebruikers.

Effecten van gebruiksruimten, voor druggebruikers (Hoofdstuk 6)
Een van de onderzochte laagdrempelige zorgvoorzieningen zijn gebruiksruimten. Deze voorzieningen doelen op 'harm reduction' (gebruikers kunnen veilig drugs gebruiken) en vermindering van overlast (gebruik van drugs vindt binnen plaats). Surveygegevens van 67 gebruikers met een toegangspas voor een gebruiksruimte werden geanalyseerd om te zien of deze doelen zijn bereikt vanuit het perspectief van de pashouders. Ook werden 47 veldnotities, geschreven door veldwerkers, en interviewgegevens van 7 sleutelinformanten werkzaam in gebruiksruimten geanalyseerd.
Resultaten lieten zien dat de doelen van de gebruiksruimten gedeeltelijk werden behaald. Pashouders bezochten een gebruiksruimte op gemiddeld zes dagen van de week, en twee keer in de afgelopen 24 uur. Zij noemden druggerelateerde zaken als de belangrijkste sterke punten of voordelen van de gebruiksruimten (bijvoorbeeld binnen rustig en veilig drugs kunnen gebruiken, opvangfunctie). Acht van de tien pashouders gaven aan dat zij minder vaak drugs gebruikten in het openbaar sinds zij naar de gebruiksruimte gingen. Verder waardeerden zij de hulpverleners en de mogelijkheid van hulp- en dienstverlening. Negen van de tien pashouders meldden dat zij gebruik maakten van de geboden diensten in de gebruiksruimte (bijvoorbeeld maaltijden, kleding wassen, douchen), en vier van de tien ontvingen enige medische zorg en/of verkregen informatie over hulpverlening, therapie en/of veilig gebruik. Zelfgerapporteerde gezondheidseffecten waren 'meer tijd en rust', 'meer aandacht voor hygiëne' en 'meer aandacht voor lichamelijke conditie'.
De twee zwakke punten of nadelen die pashouders noemden, zijn druggerelateerd: de grote omvang van sommige gebruiksruimten die zich uit in menigten, chaos en druggebruik in het openbaar, en het feit dat de gebruiksruimten niet alle uren van de dag geopend zijn. De vermindering van overlast was een argument voor langere openingstijden; echter, het kopen van drugs kan ook overlast veroorzaken, en deze overlast kan niet opgelost worden binnen de kaders van een gebruiksruimte (tenzij drugdealers zouden worden toegelaten in de voorziening). Een argument tegen langere openingstijden was dat druggebruik en marginalisering hiermee gestimuleerd zouden worden, omdat de gebruiksruimte dan de huidige situatie van druggebruikers (zoals dakloosheid en prostitutie) continueert.

Huisartsenpraktijk de Straatdokter: gezondheid van patiënten en succesfactoren van de praktijk (Hoofdstuk 7)

Dakloze mensen, en vooral dakloze druggebruikers, hebben verschillende lichamelijke en psychische problemen die verweven zijn met hun dakloosheid en middelengebruik. Vanwege hun slechte gezondheid, en vanwege hun complexe hulpzoekgedrag en medische consumptie, wordt medische zorg geboden in 'huisartsenpraktijk de Straatdokter'. Artsenspreekuren zijn geïntegreerd in tien verschillende Rotterdamse laagdrempelige zorgvoorzieningen (voorzieningen voor dag- en nachtopvang, gebruiksruimten, sociale pensions). Door de analyse van (1) registratiedata van (a) drie opeenvolgende jaren (n=1.181) en (b) een periode van drie maanden van elk van deze drie jaren (n=636), en (2) surveygegevens van zes artsen en negen verpleegkundigen, werd inzicht verkregen in gezondheidskenmerken van patiënten, in veranderingen in de patiëntengroep en in het type klachten, en in de factoren die het succes van de praktijk verklaren.
De patiëntengroep bestond voornamelijk uit mannen, ouder dan 40 jaar, die verzekerd zijn voor ziektekosten. Gemiddeld hadden patiënten ieder jaar drie tot vier contacten. Van degenen met geregistreerde problemen (54%), hadden de meesten problemen met middelengebruik (67%), psychiatrische problemen (11%) of beide problemen (dubbele diagnose, 23%). De totale groep patiënten uitte ongeveer 1,4 klacht (gemiddeld per periode van drie maanden). Door de jaren heen bleef het percentage dat klachten uitte over gewrichten, longen, huid en maag ongeveer gelijk. Het percentage dat psychische klachten en voetproblemen uitte nam af, en het percentage dat 'overige' klachten uitte nam toe. Als patiënten medicatie kregen voorgeschreven, dan kregen zij meestal één recept. Artsen en verpleegkundigen zagen dat de ouder wordende patiëntengroep (met name degenen met langdurig middelengebruik) meer chronische klachten hadden, bijvoorbeeld COPD, maagklachten en diabetes. Veel voormalige feitelijk daklozen zijn tegenwoordig gehuisvest in begeleid wonen-projecten die de gemeente Rotterdam heeft gerealiseerd. Volgens artsen en verpleegkundigen zorgen deze zogenaamde residentieel daklozen beter voor zichzelf, en dat uit zicht in een afname van bijvoorbeeld wondproblemen en kledingluis, en in een betere algemene lichamelijke conditie. Echter, psychiatrische problemen kunnen zichtbaar worden bij deze groep.
Artsen en verpleegkundigen identificeerden ook drie factoren die het succes van de Straatdokter verklaren. Ten eerste is de praktijk toegankelijk, omdat die geïntegreerd is in laagdrempelige zorgvoorzieningen van de maatschappelijke opvang. Ten tweede zijn de medische dossiers in iedere voorziening online toegankelijk, en dat waarborgt de continuïteit van zorg. Ten derde is er samenwerking op organisatieniveau (gemeente, zorgverzekeraars, maatschappelijke opvang) en op operationeel niveau tussen artsen en verpleegkundigen. Daarbij komt dat de verpleegkundigen patiënten effectief doorverwijzen naar de artsenspreekuren vanuit hun verpleegkundigenspreekuren.
Geconcludeerd werd dat betere screening en registratie van psychiatrische problemen en middelengebruik nodig is om de noodzakelijke gezondheidszorg te kunnen leveren. Een ander probleem was de onverkrijgbaarheid van medicatie voor onverzekerden, met name voor patiënten die illegaal in Nederland verblijven. Tot slot blijft geïntegreerde zorg, die zowel medische als sociale problemen aanpakt, nodig zolang de reguliere gezondheidszorg niet toegankelijk is voor een groot deel van de daklozen en niet adequaat reageert op de behoeften van dakloze mensen.

Methodologie

Alle studies zijn uitgevoerd binnen het Rotterdams Drug Monitoring System en binnen Trendspotting. Zowel de dataverzameling als de analyse zijn in opdracht van de GGD Rotterdam-Rijnmond uitgevoerd.

Ten eerste is het belangrijk te onderkennen dat niet alle mogelijke relaties in het model (zie Figuur 2 in Hoofdstuk 1) zijn getoetst. Niet alle laagdrempelige zorgvoorzieningen zijn in dezelfde mate onderzocht, gebruiksruimten bijvoorbeeld waren specifiek onderwerp van onderzoek, maar voorzieningen voor dag- en nachtopvang en begeleid wonen waren dat niet. Daarnaast zijn niet alle drie dimensies in dezelfde mate onderzocht. Gezondheid, bijvoorbeeld, werd bestudeerd door de sociaal medische zorg die geïntegreerd is in laagdrempelige zorgvoorzieningen te evalueren, maar sociale relaties en bronnen van inkomsten waren geen specifiek onderwerp van onderzoek. Ten tweede is het nodig te benadrukken dat het longitudinale proces van marginalisering en socialisering bestudeerd is met cross-sectionele data. Ondanks deze significante beperkingen wordt in de komende paragrafen ingegaan op de hypothesen.

Interne validiteit

De gegevens die voor dit proefschrift gebruikt zijn, zijn verzameld en geanalyseerd binnen het raamwerk van het Rotterdamse Drug Monitoring Systeem (DMS 1994-2003 en een 'mini DMS' in 2004 en 2005) en Trendspotting (vanaf 2006). Het DMS was een lokaal informatie- en observatiesysteem waarin continue zowel kwantitatieve als kwalitatieve gegevens werden verzameld over drugs, druggebruikers en gerelateerde onderwerpen. De onderzoekspopulatie bestond uit de groep (bijna) dagelijks gebruikers van basecoke, heroïne en/of methadon. De focus van het DMS lag op de gebruiker in zijn of haar natuurlijke omgeving, en dat maakte het mogelijk om gebeurtenissen en fenomenen te duiden met behulp van de driehoek van Zinberg: drug, set en setting, respectievelijk kenmerken van de stof, van de gebruiker en van de omgeving (Zinberg, 1984).

Het DMS gebruikte drie onderzoeksmethoden (zie Figuur 3 in Hoofdstuk 1): dagelijks veldwerk, een periodieke survey en interviews met sleutelinformanten (professionals en druggebruikers). Veldwerk betekent dat leden van de doelgroep (druggebruikers) hun kennis en ervaringen, hun observaties en reflecties deelden met de onderzoekers (Blanken, Barendregt & Zuidmulder, 2000). Veldwerkers werden getraind in het doen van veldwerk en in het schrijven van veldnotities. Zij rapporteerd 'van binnenuit' en werden daarom gewaardeerd als de 'ogen en oren' van het onderzoeksteam. De surveys werden niet gehouden onder 'gemakkelijk te vinden' gebruikers (bijvoorbeeld degenen in behandeling), maar ook onder de 'verborgen' populatie van de straatgroep druggebruikers. De surveys werden uitgevoerd met 'targeted sampling', een wervingsmethode met behulp waarvan leden van verborgen populaties, zoals druggebruikers, gelokaliseerd en voor onderzoek geworven kunnen worden (zie ook Peterson et al., 2008).
Als laatste waren de geïnterviewde sleutelinformanten professionals met relevante functies in relevante organisaties. Geïnterviewde druggebruikende sleutelinformanten werden 'gevonden' via bijvoorbeeld professionals of via het etnografische veldwerk dat onderdeel is van de targeted sampling methode.

Methodologische triangulatie werd toegepast in een complementair model; informatie uit verschillende methoden vulden elkaar aan (Hendriks, Blanken, Adriaans & Vollemans, 1994; Van de Mheen, Coumans,

Barendregt & Van der Poel, 2006). Alle onderwerpen van de gepresenteerde studies kwamen naar boven door een of meer methoden, en de meeste studies zijn uitgevoerd met behulp van meer dan een methode. Zo kwam, bijvoorbeeld, het onderwerp 'gebruiksruimten' (Hoofdstuk 6) naar boven door sleutelinformanten en veldwerk, en werd het een onderwerp in de volgende survey, die werd gecombineerd met interviews met sleutelinformanten en de analyse van veldnotities. Het onderwerp 'jongeren die basecoke gebruiken' (Hoofdstuk 2) kwam naar boven door veldwerk en surveyresultaten, en het onderzoek is uitgevoerd door jongeren te interviewen. Het onderwerp 'mobiliteit' (Hoofdstuk 5) kwam naar boven door veldwerk en sleutelinformanten, en werd een onderwerp in de survey van 2003, gecombineerd met interviews met druggebruikers.

Het DMS en Trendspotting zijn gelijk in bepaalde opzichten en verschillend in andere. Een belangrijk verschil is dat de doelgroep is verschoven van gemarginaliseerde druggebruikers (DMS) naar gemarginaliseerde daklozen en verslaafden (Trendspotting). Een ander verschil is dat het veldwerk niet langer onderdeel uitmaakte van de gebruikte methoden van Trendspotting, met name door de hoge kosten; hiermee ging wel een belangrijke onderzoeksmethode verloren. Verder werd vanaf 2006 ieder jaar een onderwerp en passende onderzoeksmethoden gekozen. In 2006 was het onderwerp 'beleid sinds 1990' (onderzocht met literatuur en beleidsstukken), in 2007 was het onderwerp 'leefsituatie' (onderzocht met een survey onder de doelgroepen). Het onderwerp 'vergelijking van de leefsituatie van druggebruikers' (Hoofdstuk 3) kwam naar boven door sleutelinformanten en de resultaten van de beleidsbeschrijving; en resultaten van de Trendspotting 2007 survey zijn vergeleken met de resultaten van de DMS 2003 survey.

Om de specifieke onderzoeksvragen te beantwoorden (zie Hoofdstukken 2-7), zijn methoden zorgvuldig gekozen en toegepast. Het is aannemelijk dat de onderzoeksmethoden en de combinatie van deze methoden resulteren in valide onderzoeksresultaten (zie Van de Mheen et al., 2006). Geconcludeerd wordt derhalve dat de in dit proefschrift gepresenteerde resultaten (en resultaten van DMS en Trendspotting in het algemeen) een realistische weergave zijn van de Rotterdamse situatie.

Externe validiteit

Zijn de resultaten ook geldig voor andere Nederlandse steden? Ten eerste zijn druggebruik en dakloosheid niet voorbehouden aan Rotterdam, maar hebben veel grotere en ook kleinere steden ermee te maken. In veel steden wordt overlast gerelateerd aan druggebruik en dakloosheid ervaren; het is onderwerp dat hoog op de (politieke) agenda staat. De verslavingszorg en de maatschappelijke opvang zijn goed ontwikkeld in vele steden. Onderzoek naar de omvang, de kenmerken en het gedrag van druggebruikers en daklozen is eveneens niet voorbehouden aan Rotterdam, maar wordt ook gedaan in andere steden en regio's. Zowel Utrecht als Heerlen en omgeving, bijvoorbeeld, kende een DMS (zie voor Utrecht onder andere: De Graaf, Wildschut & Van de Mheen, 2000; Lempens, Wildschut, Van der Most & Knibbe, 2003; Vermeulen, Wildschut & Knibbe, 2001; en voor Heerlen: Coumans & Knibbe, 2001, 2002; Coumans, Neve & Van de Mheen, 2000; Van der Dam, Coumans & Knibbe, 2006a/b). In de afgelopen jaren is onderzoek gedaan in bijvoorbeeld Amsterdam, Den Haag, Eindhoven, Enschede, Zwolle en Breda, en bijvoorbeeld in de provincies Zeeland en Flevoland (Witteveen, 2008; Wolf et al., 2002; Rezai, Van 't Klooster, Van Dongen & Van der Poel, 2005; Bieleman, Boendermaker, Kruize & Van Zwieten, 2007; Vocks, Meertens & Wolf,

2007; Steuns, Janssen, Van Lokven & Van der Poel, 2008; Jansen, Mensink & Wolf, 2007; Barendregt & Wits, 2009). In het algemeen zijn overeenkomstige resultaten gevonden met betrekking tot ontwikkelingen in de drug- en daklozenscene. Ook zijn in het algemeen overeenkomstige oplossingen aanbevolen, en wel in de richting van een individuele aanpak om overlastproblematiek aan te pakken en om de situatie van druggebruikers en daklozen te verbeteren.

Dag- en nachtopvang, gebruiksruimten en projecten voor begeleid wonen zijn er in veel Nederlandse steden (zie Hoofdstuk 1). Deze laagdrempelige zorgvoorzieningen zijn niet alleen belangrijk in Rotterdam, maar ook in andere steden. Zo zijn er bijvoorbeeld vanaf de jaren '90 ongeveer veertig gebruiksruimten gerealiseerd in niet minder dan vijftien Nederlandse steden (Bransen, Van 't Land & Wolf, 2004; Trimbos-instituut, 2006). Verder werd in 2006 het Plan van Aanpak Maatschappelijke Opvang geïnitieerd door de landelijke overheid en de vier grote steden (Ministerie van Volksgezondheid, Welzijn en Sport, 2006). In 2008 maakten elk van de overige 39 Nederlandse steden een Stedelijk Kompas, een lokaal plan van aanpak gebaseerd op het originele Plan van 2006. Dat betekent dat deze steden beleidsplannen hebben opgesteld voor gemarginaliseerde groepen, en de basis voor dit beleid de samenwerking is van alle lokale relevante organisaties (lokaal bestuur, maatschappelijke opvang, verslavingszorg, woningcorporaties et cetera). Dit toont aan dat er in heel Nederland behoefte is aan eenduidige oplossingen om overlast te verminderen en de persoonlijke situatie van druggebruikers en anderszins gemarginaliseerde groepen te verbeteren. Effectieve laagdrempelige zorgvoorzieningen spelen een belangrijke rol in deze oplossingen. Omdat er geen reden is om aan te nemen dat ontwikkelingen in Rotterdam op bepalende kenmerken verschillend zijn van ontwikkelingen in andere steden, kunnen de resultaten die gepresenteerd zijn in dit proefschrift behulpzaam zijn bij het verkrijgen van inzicht in het gedrag van gemarginaliseerde druggebruikers en bij de realisatie van laagdrempelige zorgvoorzieningen. Met deze inzichten kan de leefsituatie van druggebruikers effectief worden verbeterd en de overlast effectief worden gereduceerd, zowel in Rotterdam als in andere Nederlandse steden.

Ontwikkelingen sinds midden jaren '90

Laagdrempelige zorgvoorzieningen (gebruiksruimten, voorzieningen voor dagopvang, voorzieningen voor nachtopvang en projecten voor begeleid wonen) zijn voorzieningen die niet tot expliciet doel hebben gebruikspatronen te veranderen. Doelgroepen van laagdrempelige zorgvoorzieningen zijn (1) chronische druggebruikers die dakloos zijn, en (2) dakloze mensen onder wie chronische druggebruikers. Druggebruik en dakloosheid zijn met elkaar verweven.

In de laatste tien jaar is de feitelijke dakloosheid onder druggebruikers toegenomen van 21% in 1998, naar 28% in 2000, naar 40% in 2003, en vervolgens afgenomen naar 27% in 2007 (zie Hoofdstuk 3). De toename in feitelijke dakloosheid tot 2003 hangt samen met gemeentelijke maatregelen voor de sluiting van dealpanden vanaf 1994 (bijvoorbeeld Operatie Victor en de wet Victoria). Het is bekend dat hoe langer druggebruikers dakloos zijn, des te langer zij dakloos zullen blijven. Bovendien worden dakloze druggebruikers geassocieerd met overlast.

De afname van feitelijke dakloosheid tussen 2003 en 2007 is gerelateerd aan het nieuwe drugbeleid (sinds midden jaren '90) voor dakloze druggebruikers (in 1996 begonnen met Verantwoord Schoon; Quadt, 1996). Het doel was de overlast te verminderen en de persoonlijke situatie van druggebruikers te verbeteren. Met dit beleid werden nieuwe laagdrempelige zorgvoorzieningen voor dakloze druggebruikers gerealiseerd: gebruiksruimten en begeleid wonen-projecten. Voorzieningen voor dag- en nachtopvang functioneerden (onder andere) als vindplaats voor mogelijke gebruikers/bezoekers van gebruiksruimten en projecten voor begeleid wonen. Dit zijn de laagdrempelige zorgvoorzieningen die onderwerp zijn van dit proefschrift.

Gebruiksruimten waren succesvol vanaf het begin (Spijkerman et al., 2002); feitelijk dakloze druggebruikers hebben toegang tot een schone omgeving waar zij veilig hun drugs kunnen gebruiken. Projecten voor begeleid wonen voor druggebruikers werden succesvol vanaf de vroege jaren 2000 (Keegel, 2002); door deze woon-projecten kwam er een nieuwe categorie druggebruikers: residentieel dakloze druggebruikers.

Om de doelen die de gemeente had gesteld te behalen, moesten laagdrempelige zorgvoorzieningen samen-werken met andere organisaties. Vanaf 2003 lag de focus van het Rotterdamse beleid op overlastgevende druggebruikers: zij veroorzaakten overlast "door crimineel gedrag, frequente overtredingen van de APV, dakloosheid en/of een psychiatrische aandoening" (Gemeente Rotterdam, 2005). Het doel was deze gebruikers van de straat te halen (en in begeleid wonen-projecten, opvangvoorzieningen of de gevangenis te plaatsen) en hun persoonlijke situatie te verbeteren. Om dit doel te bereiken werden individuele traject-plannen opgesteld met enerzijds repressieve maatregelen en anderzijds zorg en behandeling. Lokale partijen, zoals de maatschappelijke opvang, de verslavingszorg, de politie, woningcorporaties en verschillende gemeentelijke diensten, werden aangemoedigd om intensief met elkaar samen te werken om trajectplannen op te stellen, uit te voeren en te monitoren. Alleen dan konden de doelen behaald worden. Door deze samen-werking raakten steeds meer externe actoren betrokken bij de mogelijke socialisering van druggebruikers.

Doordat de persoonsgebonden aanpak (met de combinatie van repressie en zorg/behandeling) succesvol was, werd deze vanaf 2005 ook toegepast op niet-gebruikende overlastgevers en veelplegers. In 2006 kwam er een focus op dakloze mensen in het algemeen met het Plan van Aanpak Maatschappelijke Opvang (Ministerie van Volksgezondheid, Welzijn en Sport, 2006), en wederom werd de persoonsgebonden aanpak als succesvol geëvalueerd (Federatie Opvang, 2009; Ministerie van Volksgezondheid, Welzijn en Sport, 2009, 2008; Trimbos-instituut, 2009). Een van de succesfactoren is de toename van de capaciteit van de nachtopvang en begeleid wonen-projecten (bijvoorbeeld Maaskant & Van der Giessen, 2007). (Dakloze) druggebruikers hebben hier baat bij.

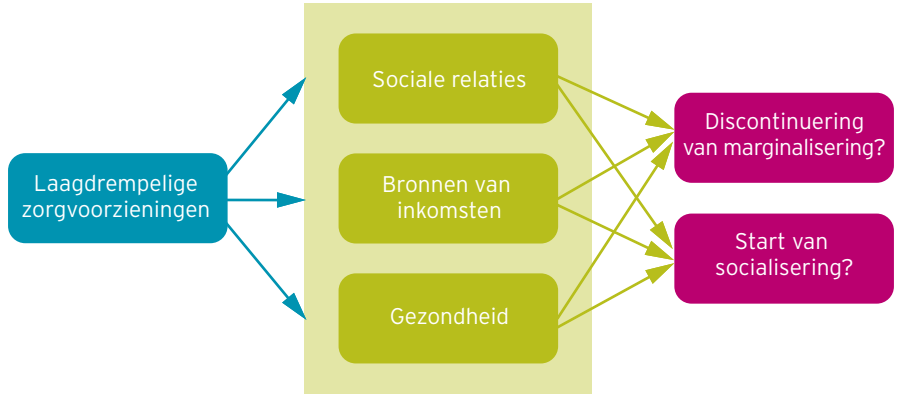
Door de intensieve samenwerking tussen allerlei organisaties en de realisatie van woonprojecten is de feitelijke dakloosheid onder druggebruikers afgenomen en de residentiële dakloosheid toegenomen (zie Hoofdstuk 3). Hetzelfde geldt voor dakloosheid in het algemeen: feitelijke dakloosheid is afgenomen en residentiële dakloosheid is toegenomen (zie Maaskant & Van der Giesen, 2007). Residentieel dakloze mensen blijven gecategoriseerd als daklozen, omdat het *"naar alle waarschijnlijkheid om mogelijk kwets-bare personen gaat met verhoogd risico om dakloos te worden"*, vanwege hun levensstijl (zoals gebruik van alcohol en drugs en bezoek aan dagopvang; p. 20).

Laagdrempelige zorgvoorzieningen en het proces van marginalisering en socialisering

Marginalisering heeft betrekking op het proces waarmee chronische druggebruikers wegraken van maat-schappelijke kerninstituties, socialisering heeft betrekking op het tegengestelde proces (Coumans, 2005). De dimensies waarin dit proces zich afspeelt zijn: sociale relaties, bronnen van inkomsten en gezondheid. Gebruik van basecoke en dakloosheid zijn katalysatoren in het proces van marginalisering. Externe actoren (in dit proefschrift: laagdrempelige zorgvoorzieningen) versterken de marginale positie van chronische druggebruikers of spelen een rol in de omwenteling van marginalisering naar socialisering.

Twee hypothesen werden gesteld over de rol van laagdrempelige zorgvoorzieningen in het proces van marginalisering en socialisering (Figuur 1):

- laagdrempelige zorgvoorzieningen kunnen bijdragen aan de discontinuering van het proces van marginalisering. Dit betekent dat druggebruikers niet verder marginaliseren – door de dimensies sociale relaties, inkomstenbronnen (economische dimensie) en gezondheid;
- laagdrempelige zorgvoorzieningen kunnen bijdragen aan het begin van het proces van socialisering. Dit betekent dat druggebruikers gaan re-integreren in de maatschappij – door de dimensies sociale relaties, inkomstenbronnen en gezondheid.



Figuur 1. De mogelijke effecten van laagdrempelige zorgvoorzieningen op marginalisering en socialisering.

Eerst worden de verbanden tussen enerzijds sociale relaties, bronnen van inkomsten en gezondheid en anderzijds marginalisering en socialisering gepresenteerd, zoals die gevonden zijn in de uitgevoerde studies. De katalysatoren basecoke en dakloosheid worden daarna bediscussieerd, net als andere externe actoren. Als laatste komen de mogelijke effecten van laagdrempelige zorgvoorzieningen (de hypothesen) aan bod.

Sociale relaties

Druggebruikers raken gemarginaliseerd als hun sociale netwerk meer en meer eenzijdig in de drugscene komt te liggen. De sociale dimensie is beschreven als *"een proces van vervreemding waarin de last van de*

verslaving geëxternaliseerd is van de ene sector naar de andere; dat wil zeggen van persoonlijke contacten naar de maatschappij in het algemeen. Hechte vriendschappen zijn zeldzaam in deze setting [AP: in de drugscene] en druggebruikers raken afhankelijk van laagdrempelige voorzieningen" (Coumans, 2005, p. 152). Bovendien werd *"een cyclisch verband geobserveerd tussen controle over druggebruik, met name over basecoke, en de kwaliteit van de sociale relaties"* (p. 152). Er is dus van marginalisering als het sociale netwerk van druggebruikers verslechtert en zij afhankelijk worden van laagdrempelige voorzieningen, in ieder geval voor hun sociale contacten. Daarbij komt dat gemarginaliseerde druggebruikers gewoonlijk de controle over hun druggebruik hebben verloren, en dat impliceert dat de kwaliteit van hun sociale contacten daarmee ook verslechterd is.

Er is sprake van socialisering wanneer druggebruikers (ook) in contact blijven met mensen buiten de drugscene, zoals ouders en andere familieleden, vrienden, buren (als een gebruiker huisvesting heeft), collega's (als een gebruiker werk heeft), en anderen – bijvoorbeeld regelmatige kopers van het Straatnieuws van dakloze druggebruikers, of buurtbewoners wiens straten worden geveegd door gebruikers die deelnemen aan een sociaal activeringsproject. Socialisering gaat om het weer opbouwen van onderling vertrouwen en sympathie naar elkaar toe; contacten met familie zijn vaak verloren gegaan doordat de druggebruiker niet te vertrouwen was en omdat de gebruiker zich schaamde voor zijn gedrag. Deze relatie kan alleen worden hersteld als er een basis van hernieuwd vertrouwen is tussen de gebruiker en zijn familie.

Beide processen zijn terug te vinden in dit proefschrift. In de laagdrempelige zorgvoorzieningen zijn druggebruikers onder elkaar en het onderwerp van gesprek is vaak druggerelateerd, of het nu het gebrek aan drugs is of de prijs/kwaliteit-verhouding van de gebruikte drugs. In gebruiksruimten is het gebruik van drugs toegestaan. Veel druggebruikers bezoeken gebruiksruimten voor koffie en een praatje, om een maaltijd te nuttigen, om over persoonlijke problemen te praten en om informatie over hulpverlening (bijvoorbeeld huisvesting) te krijgen. Dat impliceert dat zij contacten hebben met andere druggebruikers en met de hulpverleners ter plekke (Hoofdstuk 6). Echter, druggebruikers zouden niet 'reizen' om vrienden te bezoeken (Hoofdstuk 5), wat niet meteen wil zeggen dat vriendschappen niet gewaardeerd worden, maar wel dat vrienden in de buurt zouden moeten zijn. Het blijft de vraag wat druggebruikers verstaan onder het begrip 'vriendschap', immers, zij zeggen vaak dat *"echte vriendschap zeldzaam is in de drugscene"* en dat *"als je drugs hebt, heb je vrienden"*. Het is positief dat tweederde deel van de druggebruikers op enige wijze contact had met een of meer familieleden in de afgelopen maand (Hoofdstuk 7).

In dit proefschrift is aangetoond dat de sociale dimensie vooral belangrijk is in het socialiseringsproces van jonge basecokegebruikers (Hoofdstuk 2). Jonge gebruikers die erin geslaagd zijn om clean te worden en te blijven bleken in staat om sociale contacten te vernieuwen of (weer) aan te gaan buiten de drugscene (ouders, vrienden). Dit bevestigt de bevinding dat ongecontroleerd druggebruik en sociale relaties van hoge kwaliteit niet goed samen gaan.

Bronnen van inkomsten

Druggebruikers raken gemarginaliseerd als er sprake is van een *"afname van mogelijkheden om deel te nemen aan legitieme economische activiteiten"* (Coumans, 2005, p. 152). Druggebruikers verkrijgen op

illegale wijze inkomen, zoals door diefstal, drugs dealen en tippelprostitutie. Dit wordt door de in dit proefschrift gepresenteerde resultaten bevestigd. Jongeren die basecoke roken beginnen met geld te stelen van hun ouders om hun verslaving te bekostigen (Hoofdstuk 2) en bij oudere gebruikers is er een sterke relatie tussen problematisch druggebruik en illegale activiteiten (Hoofdstukken 3 en 4).

Er is sprake van socialisering als gemarginaliseerde druggebruikers in staat zijn om inkomen op legale wijze te verkrijgen. De gerealiseerde sociale activeringsprojecten geven druggebruikers de kans om op een legale wijze wat geld te verdienen, bovendien geeft werken hen wat meer structuur in hun dagelijkse gang van zaken. Veel druggebruikers nemen deel aan dergelijke projecten (Hoofdstuk 3). Gebruikers die legaal werk hebben, wat voor werk dan ook, bewegen zich doelbewuster rond, en dit hangt samen met lagere niveaus van zichtbaarheid in het openbaar en overlast op straat (Hoofdstuk 5). Voor jonge gebruikers bleek dat wanneer zij stoppen met basecokegebruik, er geen noodzaak meer was om zich bezig te houden met illegale activiteiten (Hoofdstuk 2).

Gezondheid

Druggebruikers raken gemarginaliseerd als hun *"lichamelijke, leefstijlgerelateerde en psychologische problemen de deviantie van de druggebruiker duiden, daarmee implicerend dat hij minder mogelijkheden heeft om volledig aan de maatschappij deel te nemen"* (Coumans, 2005, p. 152). Marginaliserende druggebruikers staan onverschillig tegenover gezondheidsgerelateerde zaken en hebben een verslechterende persoonlijke gezondheidstoestand. In dit proefschrift zijn verschillende indicaties gevonden die deze bevindingen bevestigen. Jonge basecokegebruikers omschrijven hun lichamelijke conditie als 'goed' voordat zij basecoke gingen gebruiken; door het frequente gebruik van basecoke ervaarden sommigen ademhalingsproblemen en een verslechterende fysieke conditie (Hoofdstuk 2). Veel volwassen druggebruikers ervaren hun gezondheid niet als 'goed' (Hoofdstukken 3 en 4). Artsen en verpleegkundigen van de Straatdokter zien dat langdurig gebruik van drugs (en alcohol) samenhangt met een groot deel van de gezondheidsklachten van daklozen (Hoofdstuk 7). Tussen 2003 en 2007 was er geen toename van het aantal druggebruikers dat hun gezondheid als '(zeer) goed' ervaart (Hoofdstuk 3).

Wanneer de gezondheid ten goede verandert, kan er sprake zijn van socialisering. Zo geven druggebruikers die gebruiksruimten bezoeken aan dat zij volop gebruik maken van gezondheidsgerelateerde diensten, zoals het nuttigen van maaltijden, zichzelf wassen, medische zorg en spuitomruil. Zij geven ook aan dat zij positieve effecten van het bezoeken van een gebruiksruimte op hun gezondheid ervaren; zo nemen zij meer rust en besteden meer aandacht aan hygiëne (Hoofdstuk 6). In 2007 waren negen van de tien druggebruikers voor ziektekosten verzekerd (Hoofdstuk 3). Druggebruikers geven aan dat zij zouden 'reizen' om gebruik te maken van medische zorgverlening als zij dat nodig zouden hebben (Hoofdstuk 5). Echter, zolang de reguliere gezondheidszorg grotendeels ontoegankelijk is, is de in de laagdrempelige zorgvoorzieningen geïntegreerde medische zorg het hoogst haalbare.

Gebruik van basecoke

Zowel basecoke als dakloosheid zijn geïdentificeerd als specifieke factoren die marginalisering versnellen. Basecoke is in de vroege jaren '90 in de Rotterdamse heroïnescene geïntroduceerd (Blanken, Barendregt

& Zuidmulder, 1999; Grund, Adriaans & Kaplan, 1991), jaren voordat de drug in andere delen van Nederland zijn opmars maakte. Vanaf midden jaren '90 gebruikten Rotterdamse gebruikers zowel heroïne als basecoke (zie bijvoorbeeld Blanken, Barendregt & Zuidmulder, 1999; Van der Poel, Barendregt, Schouten & Van de Mheen, 2003). Het is daarom moeilijk om het katalyserende effect van basecoke in het proces van marginalisering in Rotterdam te bestuderen. Niettemin wordt in dit proefschrift aangetoond dat het gebruik van basecoke voor jonge mensen een proces van (verdere) marginalisering in gang zette, en dat die jonge gebruikers die het lukte te stoppen met basecokegebruik in staat bleken om een proces van socialisering te starten (Hoofdstuk 2).

Dakloosheid

Naast basecoke is dakloosheid de tweede katalysator in het proces van marginalisering. Druggebruik, dakloosheid en lichamelijke en geestelijke problemen hangen sterk met elkaar samen (Hoofdstukken 3, 4 en 7). Dakloosheid lijkt meer problematisch te zijn voor druggebruikers die zorgvoorzieningen bezoeken (Hoofdstuk 4). Dakloze druggebruikers bezoeken veel buurten in de uitvoering van hun dagelijkse activiteiten en zijn zeer zichtbaar, in die zin dat zij per dag veel uren in het openbaar doorbrengen. Met name dakloze druggebruikers bewegen zich minder doelgericht door de stad (Hoofdstuk 5). Feitelijke dakloosheid onder druggebruikers is afgenomen van 40% in 2003 naar 27% in 2007. Zich in het openbaar bewegen, alcohol en drugs gebruiken in het openbaar, zwart rijden en boetes krijgen van de politie zijn geassocieerd met feitelijke dakloosheid. Daarnaast hebben feitelijk dakloze druggebruikers een hogere gebruiksfrequentie dan residentieel dakloze druggebruikers en druggebruikers die zelfstandig wonen (Hoofdstuk 3). Om deze redenen is feitelijke dakloosheid bestempeld als een katalysator in het proces van marginalisering.

De leefsituatie van druggebruikers op groepsniveau is ten goede veranderd, net als voor individuele druggebruikers die niet langer feitelijk dakloos zijn (maar residentieel dakloos of zelfstandig wonend; Hoofdstuk 3). Daarnaast zien artsen en verpleegkundigen van de Straatdokter dat daklozen beter voor zichzelf zorgen en een betere lichamelijke conditie, en zij relateren dit aan de toename van het aantal residentieel dakloze mensen (Hoofdstuk 7). Het lijkt aannemelijk dat het huisvesten van dakloze druggebruikers samenhangt met een proces van socialisering.

Andere externe actoren

De locatie van laagdrempelige zorgvoorzieningen bepaalt de mate waarin er gebruik van wordt gemaakt (zie Hoofdstuk 5). Rotterdam (en veel andere Nederlandse steden) heeft een geschiedenis als het gaat om de realisatie van voorzieningen, omdat lokale inwoners in opstand kwamen tegen de plaatsing van voorzieningen in hun buurt. De evaluatie van Verantwoord Schoon (Spijkerman et al., 2002) laat zien dat voorzieningen niet door de gehele stad verspreid werden, maar dat buurten die de meeste overlast ondervonden ook de meeste voorzieningen voor druggebruikers kregen. Tegenwoordig is het nog steeds de gemeente die bepaalt in welke delen van de stad laagdrempelige zorgvoorzieningen gerealiseerd moeten worden en ligt de financiering van de voorziening bij de gemeente. De deelgemeente zoekt vervolgens naar een locatie, samen met de organisatie die de voorziening gaat beheren en de lokale bevolking. Meer buurten accepteren een laagdrempelige zorgvoorziening, omdat de communicatie over de procedures verbeterd is. Het is volstrekt duidelijk dat de gemeente zorgvuldig en transparant moet zijn over het feit

dat de voorziening geplaatst zal worden in die bepaalde buurt en dat al het mogelijke gedaan zal worden om overlast te vermijden. Ook blijkt het zo te zijn dat buurten een voorziening beter accepteren als er effectieve klachtenprocedures zijn en er een vinger aan de pols gehouden wordt nadat de voorziening geopend is (Van Bergen & Van Deth, 2008; www.dakloosinrotterdam.nl). Dit betekent dat lokale burgers en buurtbewoners van voorzieningen belangrijke 'externe actoren' zijn geworden.

Conclusie

Met name Hoofdstukken 4 en 6 zijn informatief over de rol van voorzieningen voor dag- en nachtopvang en gebruiksruimten. Tweederde deel van de druggebruikers heeft contact met een of beide typen voorzieningen; veel van hen hebben niet de intentie om hun druggebruik te staken. Echter, deze voorzieningen spelen een rol in het dagelijks functioneren van druggebruikers, in de ondersteuning bij het overleven in de scene: slapen, eten, drugs gebruiken, wassen, praten met anderen enzovoorts. Hoofdstuk 5 laat zien dat het de locatie van de opvang en de gebruiksruimten is die de mate bepaalt waarin er gebruik van wordt gemaakt. Druggebruikers zijn meer geneigd om gebruik te maken van deze voorzieningen als deze zich op kleine afstand bevinden van de plaatsen waar zij toch al komen of plaatsen waar zij drugs kunnen kopen. In Hoofdstuk 7 werd geconcludeerd dat de toegankelijkheid van de Straatdokter (die is geïntegreerd in laagdrempelige zorgvoorzieningen) een belangrijke succesfactor is; op deze manier kan de Straatdokter een positief effect hebben op de gezondheidssituatie van (druggebruikende) dakloze mensen. In Hoofdstuk 3 wordt aangetoond dat veel dakloze druggebruikers een legaal inkomen verdienen door deel te nemen aan sociale activeringsprojecten, die speciaal voor gebruikers en daklozen in het leven zijn geroepen.

Voorzieningen voor begeleid wonen is het derde type laagdrempelige zorgvoorziening. Deze voorzieningen zijn niet expliciet bestudeerd in dit proefschrift. Barendregt & Van de Mheen (2007) hebben recent '(z)Onderdak' geëvalueerd, het Rotterdamse begeleid wonen programma voor dakloze druggebruikers. Samengevat laten de resultaten zien dat cliënten aangeven geen behoefte te hebben aan hulp of zorg voor hun middelengebruik. Zij hebben wel behoefte aan financiële en administratieve hulp, en zij krijgen deze hulp ook. Daarnaast geven druggebruikers aan dat zij hulp nodig hebben op het sociale vlak (er is veel eenzaamheid) en dat zij hulp zouden willen op het gebied van dagbesteding (sociale activering en werk).

Geconcludeerd wordt, ten eerste, dat interventies die de economische en gezondheidssituatie van druggebruikers verbeteren (en niet die hun sociale situatie verbeteren) gevonden kunnen worden in de opvang en gebruiksruimten. Ten tweede kunnen deze voorzieningen een rol spelen in het socialiseringsproces door druggebruikers onder hun vleugels te nemen en hen door te verwijzen naar passende behandelingen, huisvesting, activering en andere programma's en projecten.

Daarmee kunnen de twee eerder gestelde hypothesen worden geaccepteerd: laagdrempelige zorgvoorzieningen kunnen bijdragen aan zowel de discontinuering van het proces van marginalisering als de start van het proces van socialisering, door de dimensies inkomstenbronnen en gezondheid (en wellicht door de dimensie sociale relaties).

Aanbevelingen

Wat kunnen laagdrempelige zorgvoorzieningen verder betekenen met betrekking tot de drie socialiseringsdimensies? De sociale dimensie is het meest moeilijk te beïnvloeden, omdat sociale relaties in principe een persoonlijke zaak zijn. Professionals moeten 'out of the box' oplossingen zoeken als zij willen bijdragen aan het vergroten van kansen in de sociale dimensie, zoals bijvoorbeeld de GGD Rotterdam-Rijnmond doet met de start van het pilotproject 'Eigen kracht-conferenties' voor residentieel dakloze mensen. Met betrekking tot de economische dimensie van het proces van socialisering (bronnen van inkomsten) worden er meer en meer sociale activeringsprojecten georganiseerd door en in laagdrempelige zorgvoorzieningen, en veel druggebruikers nemen deel aan deze projecten. Investeringen in sociale activering zouden gecontinueerd moeten worden, omdat het werken in dergelijke projecten de dag structureert en zin geeft; bovendien geeft het gebruikers het gevoel dat ze erbij horen. Met betrekking tot gezondheid, wordt toegang tot gezondheidszorg gegarandeerd doordat huisartsenpraktijk de Straatdokter geïntegreerd is in laagdrempelige zorgvoorzieningen. Psychologische en psychiatrische problemen kunnen zichtbaar worden wanneer dakloze mensen gehuisvest worden. Diagnoses zijn belangrijk, omdat die een startpunt geven voor (medische, psychologische) behandeling.

Verder wordt aanbevolen:

- om de samenwerking tussen allerlei organisaties te onderzoeken om zodoende succesvolle samenwerking verder te kunnen ontwikkelen en borgen;
- om de expertise van veldwerkers te waarderen en erin te investeren;
- om onderzoek te doen naar de match tussen professionele doelen (druggebruikers die op het hoogst haalbare niveau van zelfredzaamheid functioneren) met de capaciteiten van druggebruikers;
- dat professionals in contact blijven met druggebruikers en dakloze mensen (de doelgroepen van hun programma's en projecten) als het gaat over nieuwe ideeën en plannen, maar eveneens als het gaat om de evaluatie van geïmplementeerde projecten en programma's; en
- om alle noodzakelijke stappen te zetten om te voorkomen dat jongeren (die hun gebruikscarrière gewoonlijk starten met basecoke) terechtkomen in de scene van chronische gebruikers.

Laatste opmerking

Hoewel de meerderheid van de chronische druggebruikers gekenmerkt zal blijven door hun druggebruik, blijkt wel dat hun kwaliteit van leven er in de laatste jaren erop vooruit is gegaan. Het is belangrijk inzicht te verkrijgen hoe deze resultaten te bestendigen. Wat is er nodig op langere termijn om te voorkomen dat een gebruiker terugvalt naar het leven op straat, naar onveilig druggebruik, en/of naar overlastgevend gedrag? Toekomstig onderzoek zou zich moeten richten op deze belangrijke vragen.

Referenties

Barendregt, C., & Van de Mheen, D. (2007). Ambulante woonbegeleiding voor verslaafden. Evaluatie van het project (z)Onderdak. Rotterdam: IVO.

Barendregt, C., & Wits, E. (2009). Chronisch problematische verslaafden in Flevoland. Problematiek en behoefte aan woonzorg, laagdrempelige voorzieningen en dagbesteding. Rotterdam: IVO.

Bieleman, B., Boendermaker, M., Kruize, A., & Van Zwieten, M. (2007). Monitor verslaafden en daklozen in Enschede 2007. Metingen 2001, 2002, 2003, 2004, 2005 en 2006. Groningen / Rotterdam: Intraval.

Blanken, P., Barendregt, C., & Zuidmulder, L.J. (2000). Community field work: bringing drug users into research action. In J. Fountain (Ed.), Understanding and responding to drug use: the role of qualitative research (pp. 291–296). Lisbon: European Monitoring Centre for Drugs and Drug Addiction (Scientific Monograph Series vol. 4).

Blanken, P., Barendregt, C., & Zuidmulder, L. (1999) The evolution of crack and basing cocaine in the Rotterdam heroin scene. Journal of Drug Issues, 29(3), 609-626.

Bransen, E., Van 't Land, H., & Wolf, J. (2004). Gebruiksruimten, trends 2001-2003. Utrecht: Resultaten Scoren / Trimbos Institute.

Coumans, A.M. (2005). Survival on the fringes of society. Marginalisation and hardening among chronic heroin users. Maastricht: University of Maastricht (dissertatie).

Coumans, A.M., & Knibbe, R.A. (2001). Druggebruikers in Parkstad Limburg: noden en behoeften. Resultaten van het Drug Monitoring Systeem 2000 – 2001. Rotterdam: IVO.

Coumans, A.M., & Knibbe, R.A. (2002). Druggebruikers in Parkstad Limburg: trends en profielen. Resultaten van het Drug Monitoring Systeem 2001 – 2002. Rotterdam: IVO.

Coumans, A.M., Neve, R.J.M., & Van de Mheen, D. (2000). Het proces van marginalisering en verharding in de drugscene van Parkstad Limburg. Resultaten van het Drug Monitoring Systeem 1998 – 2000. Rotterdam: IVO.

De Graaf, I., Wildschut, J., & Van de Mheen, D. (2000). Utrechtse gebruikers: een jachtig bestaan. Verslag van twee jaar Drug Monitoring Systeem onder Utrechtse (bijna) dagelijkse gebruikers van heroïne, cocaïne and andere drugs. Rotterdam: IVO.

Federatie Opvang (2009). Daklozen aller steden verzamelt u, maar niet op straat! Een evaluatieonderzoek in essays naar de uitvoering van het Plan van Aanpak Maatschappelijke Opvang in Amsterdam, Rotterdam, Den Haag en Utrecht. Amersfoort: Federatie Opvang.

Grund, J.P., Adriaans, N.F., & Kaplan, C.D. (1991). Changing cocaine smoking rituals in the Dutch heroin addict population. British Journal of Addictions, 86(4), 439-448.

Hendriks, V.M., Blanken, P., Adriaans, N.F.P., & Vollemans, L.C. (1994). Continue gegevensverzameling over druggebruik: de opzet van een locaal Drug Monitoring Systeem (DMS). Rotterdam: IVO.

Jansen, C., Mensink, C., & Wolf, J. (2007). Dakloos in Zeeland. Onderzoek naar profiel en perspectief van daklozen en zwerfjongeren. Nijmegen: Onderzoekscentrum maatschappelijke zorg, Umc St Radboud Nijmegen.
Lempens, A., Van de Mheen, D., & Barendregt, C. (2003). Homeless drug users in Rotterdam, the Netherlands: profile, way of life and the need for assistance. Substance Use & Misuse, 38(3-6), 341-377.

Lempens, A., Wildschut, J., Van der Most, D., & Knibbe, R.A. (2003). "Na de tunnelsluiting". Een onderzoek naar de eerste effecten van de verandering in de Utrechtse harddrugsscene. Rotterdam/Utrecht: IVO.

Maaskant. J., & Van der Giesen, E. (2007). Daklozenmonitor 2006-2007. Rotterdam: SoZaWe.

Ministerie van Volksgezondheid, Welzijn en Sport (2009). Voortgangsrapportage maatschappelijke opvang 2008. Den Haag: Ministerie van VWS.

Ministerie van Volksgezondheid, Welzijn en Sport (2008). Voortgangsrapportage maatschappelijke opvang (Tweede Kamer vergaderjaar 2007-2008, 29 325, nr. 25). Den Haag: Ministerie van VWS.

Ministerie van Volksgezondheid, Welzijn en Sport (2006). Plan van Aanpak Maatschappelijke Opvang. Het Rijk en de vier grote steden. Den Haag: Ministerie van VWS.

Peterson, J.A., Schacht Reisinger, H., Schwartz, R.P., Mitchell, S.G., Kelly, S.M., Brown, B.S., & Agar, M.H. (2008). Targeted sampling in drug abuse research: a review and case study. Field Methods, 20(2), 155-170.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviors. American Psychologist, 47(9), 1102-1114.

Quadt, T. (Ed.) (1996). Verantwoord Schoon in Rotterdam. Rotterdam: GGD Rotterdam-Rijnmond.

Rezai, S., Van 't Klooster, B., Van Dongen, A., & Van der Poel, A. (2006). REGIO Monitor Eindhoven 2006: aard en omvang van (ernstige) verslavingsproblematiek en knelpunten in de zorgverlening. St Oedenrode: Novadic-Kentron / Rotterdam: IVO.

Steuns, A., Janssen, M., Van Lokven, M., & Van der Poel, A. (2008). Regiomonitor Breda 2007. Resultaten van onderzoek naar verslavingsproblematiek en verbeterpunten voor het zorgaanbod.. Vught: Novadic-Kentron, Rotterdam: IVO.

Trimbo-iInstituut (2009). Monitor Plan van Aanpak Maatschappelijke Opvang. Rapportage 2008: Amsterdam, Den Haag, Utrecht en Rotterdam. Utrecht: Trimbos-instituut.

Trimbos-instituut (2006). Prevention and reduction of health-related harm associated with drug dependence. An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003. Synthesis report. Utrecht: Trimbos-instituut.

Van Bergen, A., & Van Deth, A. (2008). Het wordt rustiger op straat. Aanpak dakloosheid werpt eerste vruchten af. Tijdschrift voor Sociale Vraagstukken, 7-8, 8-11.

Van de Mheen, H., Coumans, M., Barendregt, C., & Van der Poel, A. (2006). A Drug Monitoring System: keeping a finger on the pulse by triangulation of qualitative and quantitave methods. Addiction Research and Theory, 14, 461-473.

Van der Dam, S., Coumans, A.M., & Knibbe, R.A. (2006a). Frequent harddruggebruik onder jong volwassenen in Parkstad Limburg. Rotterdam: IVO.

Van der Dam, S., Coumans, A.M., & Knibbe, R.A. (2006b). Eindrapportage Drug Monitoring System Parkstad Limburg. Rotterdam: IVO.

Van der Poel, A., Barendregt, C., Schouten, M., & Van de Mheen, D. (2003). De leefsituatie van gebruikers in de Rotterdamse harddrugsscene. Resultaten van de survey 2003. Rotterdam: IVO.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2008). Homelessness and other living condition characteristics of drug users 2003 - 2007, in Rotterdam, the Netherlands. European Journal of Homelessness, 2, 235-257.

Van der Poel, A., Barendregt, C., & Van de Mheen, D. (2001). Druggebruikers en hun gebruik van de Rotterdamse verslavingszorg. Rotterdam: IVO.

Vermeulen, K., Wildschut, J., & Knibbe, R. (2001). "Zo'n beetje alles staat in het teken van de wit". Een verkennend onderzoek naar (base)cocaïne in de Utrechtse gemarginaliseerde gebruikersscene. Rotterdam: IVO.

Vocks, J., Meertens, V. & Wolf, J. (2007). Dakloos in Zwolle. Onderzoek naar omvang en profiel van de daklozenpopulatie. Nijmegen: Onderzoekscentrum maatschappelijke zorg, UMC St Radboud Nijmegen.

Witteveen, E. (2008). Knowledge gained through experience in young problem drug users. Reflections on interventions and change. Amsterdam: GGD Amsterdam / Universitiet van Amsterdam (dissertatie).

Wolf, J., Zwikker, M., Nicholas, S., Van Bakel, S., Reinking, D., & Van Leiden, I. (2002). Op achterstand. Een onderzoek naar mensen in de marge van Den Haag. Utrecht: Trimbos-instituut.

www.DAKLOOSINROTTERDAM.nl (homeless in Rotterdam): augustus 2009.

Zinberg, N. (1984). Drug, set and setting. The basis for controlled intoxicant use. New Haven/London: Yale University Press.

Dankwoord

It takes a village to raise a child, zo luidt een gezegde waar ik het van harte mee eens ben. Hetzelfde geldt voor het schrijven van een proefschrift; dat doe je ook niet in je eentje. Veel mensen verdienen mijn waardering en dank.

Allereerst Dike van de Mheen, promotor en mijn IVO-baas, zonder jouw aansporingen was het nooit zover gekomen. Dank voor je vertrouwen en je enthousiaste en kritische houding. Door de jaren heen heb ik veel van je geleerd! En Cas Barendregt, jaren geleden heb jij me wijs gemaakt in de Rotterdamse drugscene. Dank voor je openheid en teamgeest. In onze samenwerking vulden we elkaar goed aan en wat hebben we een pret gehad. Op de DMS-jaren (en ook op de jaren die volgden) zal ik altijd met veel plezier terugkijken. Niet in de laatste plaats ook door de veldwerkers die bij ons over de vloer kwamen; het ga jullie goed.

Uiteraard ook een woord van dank aan allen die onderwerp zijn geworden van dit proefschrift. Druggebruikers, ex-gebruikers, daklozen, ex-daklozen, in alle soorten en maten hebben we jullie leren kennen in ons onderzoek. Dank voor jullie medewerking! Dat geldt ook voor de professionals die werken met en voor de doelgroep: hulpverleners in de maatschappelijke opvang en verslavingszorg, managers van instellingen, politiemensen, beleidsmakers enzovoorts. En een woord van dank aan de mensen van de GGD Rotterdam-Rijnmond, die het ons door de jaren heen mogelijk hebben gemaakt mooi onderzoek in de stad te doen.

Terug naar de mensen van het IVO. Het onderzoek dat ten grondslag ligt aan dit proefschrift is het resultaat van samenwerking met collega-onderzoekers, zowel in de dataverzameling als in de analyse ervan. Dank aan Ankie Lempens, Gerdien de Kam, Madelon Stoele, Marion Hennink, Marjolijn Schouten, Moniek Coumans en Nicole Maalsté. In het bijzonder dank ik Elske Wits, Miranda Audenaerdt, Regina van den Eijnden, Brigitte Boon, Marloes Kleinjan en Tim Schoenmakers. Jullie deuren stonden altijd open. Gerda Rodenburg, Gert-Jan Meerkerk, Harrie Jansen, collega's vanaf het prille begin, Cindy van der Ent voor alle secretariële ondersteuning, en alle andere IVO-collega's door de jaren heen: dank voor de interesse en het meeleven.

De allerlaatste loodjes van dit proefschrift zijn gedragen vlak voor en na mijn overstap van het IVO naar het Trimbos-instituut. Ook een woord van dank aan Judith Blekman en m'n collega's van Publieke Geestelijke Gezondheid, Psychische Gezondheid Jeugd en I.Com.

Mijn vriendinnen Mascha en Gerdine, wat ben ik blij dat jullie mijn paranimfen willen zijn. Dank voor de vele kaartjes en gesprekken, in voor- en tegenspoed!

Eveline en Kim, samen afgestudeerd als sociologisch onderzoeker, nog steeds vriendinnen door dik en dun. Debby, dank voor de vrijdagochtenden met koffie en natuurlijk lunch. Tegelijk zwanger, prachtige dochters, tegelijk proefschrift schrijven, ik kijk uit naar jouw verdediging! En Mark en Marijke, dank voor jullie vriendschap.

Natuurlijk mijn trotse familie: mijn vader en moeder Bert en Joke (ook voor de zorg voor Dorine in de uren dat ik op zolder zat te schrijven), en mijn broer Bertho en mijn schoonzus Hanny, en mijn nicht Maartje en mijn neef Sebas. Speciaal dank aan mijn broer(tje) René, wat een gedoe! Dank jullie voor alles, en dat is veel!

Schoonfamilie ook trots en ook bedankt: Annet en Gerard †, Marieke, Petra, Peter en Jeroen – en natuurlijk jullie partners en kinderen.

Egbert, al dan niet in pak tijdens de verdediging, en Dorine, mijn liefies, het meest van allemaal, dank voor de fijne dag, elke dag!

Curriculum Vitae

Agnes van der Poel was born in Rhenen on September 1, 1970. She first studied Communications at the HEAO in Utrecht (graduation in 1993) and Sociology specialising in research at the Utrecht University (graduation in 1996). Since 1998 she worked at the IVO Addiction Research Institute in Rotterdam. The first years she participated in different studies on e.g. medication at the workplace and substance use in youth assistance. From 2000 to 2004 she worked as a researcher on the Rotterdam Drug Monitoring System, a local information and observation system continuously collecting both quantitative and qualitative data about drugs, drug users and related issues. The research population was the group of (nearly) daily users of crack, heroin and/or methadone. In these years the idea of a PhD project was born. From 2004 onward she became project leader of e.g. a study into substance use in different nightlife scenes and local studies into the needs of marginalised drug users and homeless people. As research manager, from 2006 onward, she was responsible for project leading and acquisition of projects within the themes 'Drugs' and 'Social relief and care' and was part of the management team of the institute. In 2009 she started working as a senior staff member of the program Public Mental Health at the Trimbos Institute, Netherlands Institute for Mental Health and Addiction, in Utrecht.

IVO
Heemraadssingel 194
3021 DM Rotterdam
T 010 425 33 66
F 010 276 39 88
Secretariaat@ivo.nl
www.ivo.nl