Longitudinal Observation of a Sample of German Drug Consumption Facility Clients

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Introduction: We aimed at investigating whether attendance of a drug consumption facility (DCF) was associated with both a reduction of drug-associated at-risk behavior and referral to the health care treatment system. Methods: A sample of 129 consecutive clients out of those 256 who self-referred to the DCF during the 13-month observation period (i.e., from November 2002 to December 2003) was interviewed both at baseline and at 1-, 2-, 3-, and 6-month follow-ups. Subjects were repeatedly assessed using a structured approach based on both the European Addiction Severity Index (EuropASI) and the Deutsche Gesellschaft fuer Suchtforschung und Therapie (DG-Sucht). Results: Typical DCF clients were males, in their early 30s, single, with no vocational training, and with a long history of injectable opiate addiction in the context of polydrug misuse. A recent discharge from prison was recorded in 37% of cases. Median length of DCF attendance was of 5 weeks; 22% of clients attended for less than 1 week. Although with respect to the period previous to recruitment at-risk behavior rates remained unchanged, by the 3-month follow-up 13 (10%) clients out of those 129 who had initially enrolled had taken advantage of the DCF counseling opportunities. Some 37% of clients were referred on to start a methadone treatment following their DCF experience. Discussion: DCF attendance was not associated with reduction in at-risk behavior over time, but a need was here identified for additional intervention to be available in the DCF to address clients’ psychosocial issues. Limitations of the present study include both issues related to the representativeness of the sample of clients here recruited and the lack of a control/comparison group.

Keywords  drug consumption facility; opiate addiction; intravenous drug abuse; harm reduction

The research was supported by internal funds only.
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Introduction

Medically supervised drug consumption facilities (DCFs) for opiate and cocaine addicts have been established in a number of countries, namely Switzerland (Ronco, Spuhler, Coda, and Schopfer, 1996; Zobel and Dubois-Arber, 2004), the Netherlands (van der Poel, Barendregt, and van de Mheen, 2003), Spain (de la Fuente et al., 2006), Australia (Fry, Fox, and Rumbold, 1999), and Canada (Wood et al., 2001). Initiatives to establish such facilities in Germany started in the early 1990s, but their legal framework was only eventually provided by a modification of the local Narcotics Act. The legislation amendments were prompted by the worrying persistence of open drug “scenes” in larger German cities. These scenes were considered as a security threat to the public due to the spread of hepatitis B and C as well as of HIV infections, obviously linked to both needle sharing and prostitution. The establishment of DCFs was suggested as a way to contain and reduce the impact of these problems (Kleiber and Pant, 1999; Landesregierung Nordrhein-Westfalen, 2000). Addicts could use drugs both safely and under hygienic conditions, out of the public eye and without fear of police prosecution. DCFs aimed at improving addicts’ physical health, reducing mortality through provision of safe drug self-administration settings, reducing social problems associated with persistence of open drug scenes, and referring on clients to the health insurance treatment system facilities.

In contrast to DCFs’ increasingly widespread establishment, still there is a lack of empirical studies regarding their effectiveness in terms of clients’ outcome, individual utilization patterns, and achievement of institutional objectives (Hedrich, 2004). A few cross-sectional international studies have reported high client attendance rates (Benninghoff and Dubois-Arber, 2002; Happel, 2000; van der Poel et al., 2003), but longitudinal reports have found both high attrition rates over time and short-term attendance periods (Hedrich, 2004; MSIC Evaluation Committee, 2003; Solai, Benninghoff, Meystre-Agustoni, Jeannin, and Dubois-Arber, 2004). Some evidence highlighted high rates of clients reporting decreased at-risk behavior in association with their utilization of DCFs (MSIC Evaluation Committee, 2003; Poschadel, Höger, Schnitzler, and Schreckenberg 2003; van der Poel et al., 2003; Wright and Tompkins, 2006a), but more pre–post comparisons are needed both to confirm initial encouraging reports and to evaluate rates of clients’ referrals to health insurance treatment system facilities as an outcome of their DCF attendance.

A longitudinal prospective design was used here in order to assess utilization patterns of a medically supervised DCF located in a large German city and whether attendance of such a facility was associated with both decreased at-risk behavior and increased referral rates to health insurance treatment system facilities.

Methods

Setting

The Essen (a town of about 600,000 inhabitants in the center of the Ruhr zone of western Germany) DCF is located within a building in which a number of other services are offered to its clients, including basic medical treatment and emergency help, a low-threshold maintenance clinic, a canteen, a rest/sleeping area, and a drug counseling service. Within the DCF, open for 12 and 7 hr respectively on weekdays and weekends, eight locations for drug injection and four for smokable/inhaling self-administration are offered. The center location is within walking distance of the Essen main railway station, commonly perceived as the traditional open drug scene with some 200–300 addicts being there identified at any
time. The estimated number of Essen drug addicts (either in treatment or not) is between 3,000 and 3,500.

In Germany, any medical and/or psychiatric treatment offered to drug addicts is provided by a number of academic and/or hospital institutions, where the costs are covered by health insurance and pension funds. In contrast, the social support activities available (which include both shelter homes and the DCFs) are paid for by the social welfare departments of the single municipalities. In Germany, there is no self-referral to the health insurance medical/psychiatric system (apart from emergency situations). To be allowed to attend a specialized maintenance treatment clinic, any putative client would need a referral made by his/her general practitioner. Since the DCF is not part of the health insurance treatment system, clients are typically self-referred.

Subjects

All new consecutive clients who had started attending the DCF during the 13-month study period (i.e., from November 1, 2002, to December 31, 2003) were eligible to be included in the study. Clients who had previously used the facility were recruited only if they had presented themselves to the facility after at least 6 weeks of nonattendance. Participation in the study was voluntary; subjects were first informally asked if they were happy to be repeatedly assessed over time in terms of a number of medical and psychosocial areas; eventually, those who were interested in being recruited to the study gave their written consent for their data being analyzed anonymously and findings published in scientific journals.

Instruments and Data Collection

Subjects were repeatedly interviewed using a structured approach based on both the European Addiction Severity Index (EuropASI; Gsellhofer, Küfner, Vogt, and Weiler, 1999) and the DG-Sucht (Deutsche Gesellschaft fuer Suchtforschung und Therapie, 2001) standardized documentation for substance-related disorders. Most typically, baseline interviews were carried out by the DCF social workers on the enrollment day. In a minority of cases, the assessment had been delayed by a few days (but always by less than a week). Follow-up structured assessments were carried out at 1, 2, 3, and 6 months. Most data collected at baseline referred to the month before enrollment and included, apart from sociodemographic details, lifetime history of drug misuse and history of previous treatments. For a few more indicators, including levels of psychotropic drug self-administration, possible treatment for a drug-injection-related abscess, and level of health system drug treatment recent attendance, data collected referred to the 3 months previous to enrollment. Issues discussed with clients at both baseline as well as at follow-up included frequency of at-risk behavior (i.e., use of nonsterile equipment, sharing of paraphernalia/needles, drug consumption in public spaces; see Table 1); health (i.e., abscesses, number of emergency admissions, acquired infection with hepatitis B, hepatitis C, or HIV, feeling sick/ill); accommodation (days without a stable accommodation); and level of use of ancillary services (i.e., emergency shelters, drug counseling, probation counseling, etc.). When discussed at follow-up, the above issues covered the previous month. During a pilot study period, both the interview format and related instruments were checked for intelligibility, appropriateness, and clarity.

Every single DCF client’s attendance was recorded. A client was considered as having dropped out of DCF after having not attended the facility for at least 1 month. Possible
Table 1

Drug-related at-risk behavior issues raised with the Essen DCF clients at both baseline and follow-ups (1, 2, 3, 6 months)

| Q: How often during the last month did you utilize an equipment you already had used previously and/or nonsterile water? | A: At least once weekly; Less then once weekly; Never. |
| Q: How often during the last month did you share injection equipment, filters, and/or other paraphernalia with others? | A: More frequently than once per week; Once per week or less often; Not at all. |
| Q: During the last month, how often did you consume heroin and/or cocaine outside of flats/rooms, for example, on the streets, in parks, public toilets, etc.? | A: More frequently than once per week; Once per week or less often; Never. |
| Q: During the last month, did you visit a physician because of an abscess? | A: Yes; No. |
| Q: How often during the last month were you admitted to a clinic because of an emergency? [Fill in the stated number] |

Note: Q = question; A = possible answers to the question.

Outcomes at 6-month follow-up included being still a DCF regular client, moved on to a health insurance treatment system facility, in prison, dead, unknown.

Data Analysis

Statistical inferences about intra-individual changes between ordered categories were analyzed using the sign test; intra-individual changes on ordinal scales were analyzed using the Wilcoxon test.

Results

Subjects

During the study period, 129 clients who fulfilled the above inclusion criteria were recruited out of those 256 consecutive clients first admitted to the DCF. Although most (82; 65%) of those 127 clients who were not included in the study were in principle in agreement to take part to it, they told the staff that at present, before any interview being carried out, their concern was the immediate need of self-administering themselves with their own drug(s). Afterwards, it was technically inappropriate to carry out the interviews due to their acute intoxication state. Although in the remaining 45 out of 127 (35%) cases the clients did not give any reason for their refusal to participate, the DCF staff remained of the opinion that most frequent reasons included either the clients’ present status of already being in a substitution treatment elsewhere or not being resident in the Essen area. In both cases, in fact, the DCF attendance is not allowed by German regulations. Most (75%) of the 129 study clients were males, with an average age of 31 ± 6 [standard deviation (SD)] years. Similarly, average age of those 127 clients who were not recruited was 32.2 years and 84% were males. Ninety-one percent of study clients were either divorced or had never married; 93% were of German origin; 60% did report to have not undergone any vocational training; and 43% were on probation while at baseline. Study clients’ mean duration of opiate addiction was 11 ± 6 years. A recent (within the last 2 months) discharge from prison was recorded in 37% of cases and attendance of a health insurance treatment
system facility had occurred shortly before recruitment (e.g., within the previous 3 months) in 38% of cases. Some 80% of clients had used three or more substances at least once during the month previous to baseline assessment. Apart from opiates, cocaine (used by 71% of the whole sample, and by 44% on a daily/alternate day basis), cannabis (59% and 38% respectively), and alcohol (65% and 45% respectively) were mostly reported. Eighty-six percent of study clients were drug injectors and most reported at least a previous episode of medical/psychosocial treatment for drug dependence in the past [e.g., inpatient detoxification treatment (78% of the sample), long-term residential treatment (55%), and methadone maintenance (62%)]. During the 3 months previous to DCF registration, 83% of clients had been in contact at least once with low-threshold ancillary services such as emergency shelter, canteen/cafeteria facility (which was located in the same building of the DCF), and mobile medical unit. However, a regular use of available services and facilities (i.e., repeated visits to drug counselors, probation officers, church welfare advisors) was reported by 46% of the sample, while 40% had used none of these services.

**Length of DCF Attendance**

Median length of DCF attendance was of 5 weeks. A regular and consistent DCF attendance over time was observed only for nine (7% of the sample) clients, who were still users of the facility by the end of the 6-month observation period (see Figure 1). Twenty-nine (22%) clients attended the DCF for more than 3 months and a further group of 26 clients (20%) left the DCF by week 4. Conversely, 29 clients (22%) attended the facility for less than a week; of these, 20 clients attended only once.

During the 6-month observation period, number of visiting days per client ranged from 1 to 122, with a median of 9 days (mean value: 19 ± 24 days). For those clients who

![Figure 1](image)
Longitudinal Observation of German Drug Consumption Facility Clients

Table 2
Clients’ outcome, either at the end of their Essen DCF attendance or at the end of the 6-month observation period

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Still attending the DCF</td>
<td>7%</td>
</tr>
<tr>
<td>Referred and engaged with the health system addiction treatment</td>
<td>37%</td>
</tr>
<tr>
<td>Detoxification</td>
<td>8</td>
</tr>
<tr>
<td>Residential rehabilitation treatment</td>
<td>4</td>
</tr>
<tr>
<td>Naltrexone treatment</td>
<td>3</td>
</tr>
<tr>
<td>Others</td>
<td>26%</td>
</tr>
<tr>
<td>Incarceration</td>
<td>22</td>
</tr>
<tr>
<td>Moved to another area</td>
<td>6</td>
</tr>
<tr>
<td>Drug-free status</td>
<td>2</td>
</tr>
<tr>
<td>Violation of DCF regulations</td>
<td>8%</td>
</tr>
<tr>
<td>Died</td>
<td>2%</td>
</tr>
<tr>
<td>Unclear</td>
<td>20%</td>
</tr>
</tbody>
</table>

attended for longer than a week, the intensity of DCF use (i.e., number of visiting days out of number of days between first and last visit) ranged between 7% and 92%, with 23 (18% of the whole sample) clients having attended the facility for more than 50% of days and 16 (12% of the total group) clients having attended on average only once a week.

At baseline, 124 clients (96% of those 129 with valid data) reported heroin use (intravenously in 80% of cases) at least once during the previous month. At baseline, cocaine use (intravenously in 65% of cases) was reported by 71% of clients. By the 1-month follow-up, all 71 clients interviewed reported heroin use at the facility (90% of them through injection); 46 clients (65%, of which 96% of them through injection) had used cocaine as well while in the facility. By the 2-month follow-up, all 38 interviewed clients had consumed heroin at the DCF (which was carried out intravenously in 89% of cases) and 53% had consumed cocaine intravenously as well. By the 3-month follow-up, 19 (76%) of 25 interviewees had consumed heroin intravenously while in the DCF, 4 (16%) had smoked it, and 2 (8%) had not consumed heroin but had cocaine instead. Within the DCF facility, each study client self-administered with psychoactive drugs on an average of 1.6 ± 1 occasions (range: 1–7). For the study sample, the total number of recorded drug self-administrations within the DCF over time was 3,904.

Most frequent reasons for stopping DCF attendance (Table 2) included transfer to the health insurance treatment system facilities (37%), mainly to start a methadone maintenance, and imprisonment (17%). Twenty-seven clients (21%) stopped attending without giving any reason and two clients died (one from suicide, one from unknown reasons).

Changes in Drug-Related At-Risk Behavior Over Time; Further Referral to the Health Insurance Treatment System

At the 1-month follow-up interview, 71 (96%) out of those 74 clients who were still attending the DCF were regularly interviewed. For this group, the mean number of visiting
days during the first month of attendance was 10 ± 7 days, and the mean number of drug self-administration occasions was 16 ± 14. Compared to the month previous to registration, the rate of clients reporting at their interviews drug-related at-risk behavior and health problems remained almost unchanged. In particular, rates of clients who had self-administered with drugs outdoors and/or who had used nonsterile equipment remained unchanged at around 50%, while rates of equipment sharing remained stable at about 20%. In addition, rates of clients reporting accommodation problems remained unchanged (i.e., 44% at baseline vs. 42% during the first month; not significant).

By the 3-month follow-up, clients used a median of three ancillary psychosocial services offered (which typically included canteen/cafeteria facility, drug counseling, mobile medical unit, and church welfare advice center).

At the 2-month follow-up interview, 38 (88%) out of those 43 clients who were still attending the DCF were regularly interviewed. At 3-month and 6-month follow-ups, respectively 26 (90%) out of 29 and 9 out of 9 clients were regularly interviewed. Results presented here refer to the 3-month follow-up data only. In fact, the 2-month and 3-month data were comparable and the 6-month data referred to an inadequate sample size.

On average, those clients who were still attending by the 3-month follow-up had visited the facility for 35 ± 18 days and reported to have self-administered with drugs on 49 ± 42 occasions. At the 3-month follow-up, rates of both outdoor consumption and nonsterile equipment use were comparable to baseline. More clients reported sharing equipment by month 3 (n = 9) than at baseline (n = 3), although none of the above changes turned out to be statistically significant. Out of those 129 clients who were eventually recruited for the trial, 11 (8.5%) and 7 (5.4%) respectively reported having been treated for an abscess during the 3 months and 1 month previous to baseline assessment. Furthermore, taking into account only those with available data at the respective follow-ups, data remained substantially unchanged (see Table 3).

Finally, it is worth noting that by the 3-month follow-up 13 clients out of those 129 who had initially enrolled had taken advantage of the DCF counseling opportunities.

### Discussion

To the best of our knowledge, the present report constitutes one of the very few European longitudinal studies assessing efficacy of low-threshold drug facilities in modifying...
drug-related at-risk behavior, use of ancillary psychosocial services, and further referral to health insurance treatment system facilities. Typical users of the investigated DCF were males, with a low level of education and an average of 11-year-long history of opiate addiction in the context of polydrug misuse. Although only 38% of them had recently been in contact with health insurance treatment system facilities, 83% had already taken advantage of low-threshold ancillary services. Finally, 37% had been discharged from prison within the previous 2 months and 43% were on probation at baseline. Median length of DCF attendance was of 5 weeks, with an average number of nine attendance occasions per participant; some 22% of clients attended for less than a week, another 22% attended for more than 3 months, and only a very limited number of clients were still attending the DCF at the 6-month follow-up.

Participants self-administered with drugs within the DCF on an average of about two occasions each and rates of at-risk behavior remained substantially unchanged over time. Finally, 37% of clients were referred to health insurance treatment system facilities, mostly to start a methadone maintenance treatment, following registration to the DCF and 17% were imprisoned during the observation period.

One could speculatively interpret the short-term use of the DCF as a positive factor, since more than a third of clients were referred to the health insurance treatment system. According to the local health policy, German DCFs, far from serving as “shooting galleries,” should function mainly as sheltered spaces for drug use. DCFs should be seen as part of primary health care centers which include medical services, counseling, and low-threshold maintenance treatment on site. From this point of view, the DCF should not be intended for long-term attendance and its proximity with other services is meant to facilitate the shift from DCFs to proper treatment.

Conversely, DCF attendance was not associated here with reduction in drug-related at-risk behavior over time as elicited during the clients’ interviews. Since clients typically used the facility to self-administer with drugs only on a relatively few occasions, one could assume that most self-administration episodes occurred outside the DCF. Furthermore, unchanged occurring rates of abscesses seem to suggest that DCF attendance was associated with only a limited effect, if any, in terms of drug use.

Present findings are somewhat in line with those from previous studies. In the medically supervised injection center in Sydney, Australia, the individual number of visits ranged between 1 and 646 during an 18-month observation period, with a mean of 15 visits (MSIC Evaluation Committee, 2003). One third of recruited clients had visited the Sydney facility only once, and only one fourth of the sample was made up by frequent attenders. Similarly, 23% of clients of the Geneva drug injection room visited the facility only once, and only 18% were classified as intense users (Solai et al., 2004). During the first 26 months of its operation, clients of the Madrid consumption room self-administered with drugs on some 15 occasions each (Hedrich, 2004), which is in line with present observations. Furthermore, van der Poel et al. (2003) confirmed high rates of use of counseling opportunities found here (MSIC Evaluation Committee, 2003), while Benninghoff et al. (2003) described frequent referrals to a range of social services in a group of drug users attending a low-threshold facility in Lausanne, Switzerland. On the other hand, impact of DCF attendance on drug-related at-risk behavior has been scarcely investigated. Although occurring rates of drug-injecting episodes in public places decreased during the Sydney DCF trial period and 41% of sampled clients reported using safer injecting techniques, more than half of the subjects still reported injecting in public places despite their use of the facility itself (MSIC Evaluation Committee, 2003). Furthermore, rates of referral to health insurance treatment system facilities observed in the Sydney study appeared to be lower (e.g., 11%)
with respect to rates found here. Similarly, only 9% and 8% respectively of the Madrid and Geneva DCF clients were referred to more specialized addiction treatment facilities (Hedrich, 2004; Zobel and Dubois-Arber, 2004).

Limitations of the present study include issues related to the representativeness of the sample of clients here recruited. Only about 50% of DCF clients showed a sufficient level of engagement with the hosting institution at baseline to allow recruitment, and only those still in the DCF were interviewed at follow-ups. On the other hand, similarly to study clients, those not included were mostly males in their early 30s. Furthermore, if it is taken into account that research in this population in Germany is somewhat limited by the total anonymity granted to DCF clients, it is remarkable that such a study was at all possible. Secondly, the lack of a control or comparison group may limit the generalizability of our findings. More in particular, it cannot be understood from here how many clients would have been referred to health insurance treatment system facilities over a naturalistic course.

Furthermore, although it has been claimed that safer environments for heroin use, such as injecting rooms, may reduce the chances of overdose (Dietze, Jolley, Fry, and Bammer, 2005), it was not possible to ascertain from here how many clients would have died without being offered attendance of the consumption room. On the other hand, traditional randomized assignment would have been contrary to the philosophy of low-threshold intervention and, according to Bammer (2000), any research evaluation of supervised consumption facilities presents with its own design limitations. However, if statements of the local police management are to be taken into account, levels of social problems linked with the persistence of open drug scenes were indeed sensibly reduced with the establishment of the Essen consumption room. According to the police anecdotal observations, the DCF implementation itself appeared to be associated with a number of factors, including decreased rates of local drug-related deaths, reduction in terms of drug self-administration episodes in the public space, overall reduction in criminal activities in the town center (but not for the whole area of Essen; Protocol of the Essen DCF Task Force, May 25, 2005; Report of the Head of Essen Police, February 19, 2004), and lack of complaints from the DCF neighborhood (Protocol of the Essen DCF Task Force, September 6, 2006). Similarly, van der Poel et al. (2003) showed that for most drug users access to the Rotterdam drug consumption room resulted in less frequent drug use in public places. In line with these observations, Rhodes et al. (2006) have suggested that purpose-built drug consumption rooms may represent the only acceptable option of “safer environment intervention” to tackle the problem of reducing risks related to public injecting.

In contrast with the purpose of establishing the DCF as a way to attracting clients into treatment, it appeared from here that a good proportion of the sample had already been recently exposed to proper treatment. This is in line with what was already suggested by Perez Gonzalez, Domingo-Salvany, and Hartnoll (1999) that Spanish low-threshold/emergency rooms for highly vulnerable addicts in Spain were not the first contact point with health services. Furthermore, no evidence was found here that recruited clients showed any improvement in terms of physical health parameters (i.e., abscesses, number of emergency admissions, etc.). In taking into account the present results, one could conclude that it might be useful to re-discuss the goals and the organization of the DCF itself. Some 13 out of those 129 initially enrolled showed here some interest toward the counseling opportunities the DCF offered and one could argue that for such a highly problematic population a 10% rate of involvement in structured psychological intervention is an element not to be overlooked. From this point of view, future studies should also include open-ended interviews in the context of a mixed qualitative/quantitative approach. Conversely, if both at-risk behavior and social issues associated with persistence of open drug scenes are to be tackled, then one
could wonder if longer opening hours and higher numbers of DCFs should be organized in large city settings. Evaluation of drug consumption rooms deserves further research activity (Wright and Tompkins, 2006b) to better understand their role in dealing with drug-related at-risk issues, at both individual and society levels.

Declaration of interest: The authors report no conflict of interest. The authors alone are responsible for the content and writing of this paper.

RÉSUMÉ

Observation longitudinale d’un échantillon de clients allemands dans les salles de consommation (SdC)

Introduction: Nous avons visé d’étudier si la présence de SdC a été associée, à la fois, à la réduction du comportement dangereux lié aux médicaments ainsi qu’à l’orientation au système de traitement des services médicaux. Méthodologie: Sur les 256 clients qui se sont auto-présentés au SdC durant une période d’observation qui porte sur 13 mois (exp. de novembre 2002 jusqu’à décembre 2003), un échantillon de 129 consécutifs clients a été interrogés au début de la période d’observation ainsi que durant les 1, 2, 3, 6 mois suivants. Les sujets ont été évalués à plusieurs reprises en utilisant une approche structurée basée sur l’European Addiction Severity Index (EuropASI) et la Deutsche Gesellschaft fuer Suchtforschung und Therapie (DG-Sucht). Résultats: Typiquement les clients du SdC sont des hommes dans les début de leur trentaine, célibataires, sans formation professionnelle et ayant une longue histoire de dépendance aux opiacés injectables dans le contexte de la polyconsommation abus. Parmi ces cas, 37% ont été récemment libérées de prison. La durée moyenne de présence au SdC est de 5 semaines; 22% des clients se sont présentés pour moins d’une semaine. Bien que les taux de comportement dangereux ont restés identiques durant la période qui précède leur recrutement, 13 (10%) parmi les 129 clients qui se sont initialement inscrits ont profité des opportunités de conseils offerts par les SdC et cela au bout du troisième mois de suivi. Suite à leur expérience dans les SdC, environ 37% des clients on été orientés pour initier un traitement au méthadone. Discussion: La présence aux SdC n’a pas été associée à la réduction du comportement dangereux avec le temps. Toutefois une nécessité de disposer d’une intervention supplémentaire au sein des SdC a été identifiée pour adresser les problèmes psychosociaux des clients. Les limites de cette présente étude comportent les questions relatives, à la fois, à la représentativité de l’échantillon des clients recrutés dans le cadre de cette étude ainsi qu’au manque d’un groupe témoin.

RESUMEN

Estudio longitudinal observacional en una muestra de usuarios alemanes de salas de consumo de drogas.

Introducción: Se intento analizar la posible asociación entre el uso de las salas de consumo de drogas (SCD) y una posible reducción de conductas de riesgo y solicitudes de tratamiento medico por parte de los usuarios de las mismas. Métodos: Durante un periodo de 13 meses (de Noviembre de 2002 hasta Diciembre de 2003) fueron entrevistados una muestra de 129 usuarios consecutivos de un total de 256 usuarios de la SCD, mediante una entrevista inicial y 4 entrevistas de seguimiento (1, 2 3 y 6 meses después). Los
participantes fueron evaluados de forma repetida mediante el ‘European Addiction Severity Index (EuropASI)’ y el ‘Deutsche Gesellschaft fuer Suchtforschung und Therapie (DG-Sucht)’. Resultados: El perfil típico de los usuarios era el de un varón de unos treinta años sin preparación laboral y con una larga historia de adicción de opiáceos por vía endovenosa en el contexto de poliabuso de drogas. El 37% había salido recientemente de prisión. La mediana de asistencia a la SCD era de 5 semanas, con una asistencia inferior a una semana en el 22% de los usuarios. Si bien no existió un descenso de las conductas de riesgo durante el estudio, a los 3 meses de seguimiento, 13 de los 129 usuarios inscritos (10%) se habían beneficiado de tratamiento de apoyo psicológico. Además, tras su experiencia en el SCD, el 37% de los usuarios fueron derivados para inicio de tratamiento sustitutivo con metadona. Discusión: El uso de la SCD no se asoció con un descenso de las conductas de riesgo, durante el seguimiento. Sin embargo, se identificaron las necesidades de tratamiento de apoyo psicológico. Algunas de las limitaciones de este estudio pueden ser la representatividad de la muestra reclutada y la falta de un grupo de control para poder realizar las comparaciones pertinentes.

THE AUTHORS

Norbert Scherbaum is a specialist in psychiatry as well as in child and adolescent psychiatry. He is Professor for Clinical Research in Addictive Disorders and Head of a Department of Addiction Medicine. His main topics of research are maintenance treatment of opiate addicts, opiate detoxification treatment, and assessment of the health care system for drug addicts.

Michael Specka is a degreed psychologist and doctor of medical science. His main contributions were in the areas of opiate addiction and opioid agonist maintenance treatment.
Fabrizio Schifano, M.D., is one of the very few European physicians with training and specialist qualifications in both psychiatry and clinical pharmacology. Schifano’s contribution has been in the areas of addiction psychiatry, including stimulant synthetic drugs, drug mortality studies, Internet, and drugs.

Johannes Bombeck is a social education worker who has been practicing in drug counseling services for more than 18 years, e.g., in prisons and in a low-threshold drop-in center. As the coordinator of the consumption room in the city of Essen he is concerned with the open drug scene and the users’ living conditions.

Bärbel Marrziniak is the assistant managing director and the quality controller of a large drug help provider. She completed her studies in social casework. As a certified TQM assessor according to the EFQM model and DIN ISO Co-ordinator of the quality management, she stands for a modern and innovative drug help system.

Glossary

Deutsche Gesellschaft für Suchtforschung und Therapie (German Association for Substance Abuse Research and Therapy; DG-Sucht): This constitutes a standard for documenting therapeutic work in the field of substance-related disorders, which has been designed to facilitate evaluation studies and meta-analyses while improving data comparability.

European Addiction Severity Index (EuropASI): It is an objective face-to-face structured interview, typically used as a multidimensional clinical and research instrument. The EuropASI is used for client clinical assessment and research purposes to (a) assess the
problem severity of the interviewee and (b) for periodic repeated administrations to monitor and quantify change in problems commonly associated to substance abuse.

References


