Homelessness and other Living Condition Characteristics of Drug Users 2003 – 2007, in Rotterdam, the Netherlands

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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

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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.

› **Key Words**_ *Addiction, homelessness, nuisance, personal approach, targeted sampling*

Introduction

In the Netherlands as in other countries, drug use and homelessness are intertwined (EMCDDA, 2007; NDM, 2008; Bieleman *et al.*, 2007; Biesma *et al.*, 2004; Planije & Wolf, 2004; Coumans & Spreen, 2003; Van't Land *et al.*, 2003; Lempens *et al.*, 2003; Van Doorn, 2002; Wolf *et al.*, 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 *et al.*, 2002). Sometimes drug use causes homelessness since many users spend money on drugs rather than on rent and bills (Van der Poel *et al.*, 2003a; Debt Commission, 1994). 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 *et al.*, 2006; Decorte *et al.*, 2004; Barendregt *et al.*, 1998; Snippe *et al.*, 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 *et al.*, 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 *et al.*, 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 *et al.*, 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 *et al.*, 1999; Barendregt *et al.*, 1999; Grund *et al.*, 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 *et al.*, 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 *et al.*, 2001) and 40% in 2003 (Van der Poel *et al.*, 2003b). 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, 2007a). 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 *et al.*, 2003c; Wolf *et al.*, 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, 2007b).

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" (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 PG, 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 *et al.*, without year).

The latest policy development is the Strategy Plan for Social Relief (*Plan van Aanpak MO*) 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 (VWS, 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 (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.

Method

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[1] (Watters & Biernacki, 1989). 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 *et al.*, 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 (Van der Poel *et al.*, 2003b; Barendregt & Van der Poel, 2008).

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1 Targeted sampling is a sampling technique for locating and recruiting members of hidden populations esp. 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).

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[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).

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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)».

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 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 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 unchanged.

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 (twenty nine and twenty three 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 twenty-three days per month. They used alcohol in public on a mean of twenty-one 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, 2007a). 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 *et al.*, 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[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 *et al.*, 2005, 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.

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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.

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[4] for violating local by-laws have decreased with 65% for public drug use (from 1,264 in 2005 to about 450 in 2007[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).

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4 Fines are sent in to the 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'.

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 and the article of Johnsen & Fitzpatrick in this journal). 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.

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.

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	*

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
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
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	41 days	37 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	***

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
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 Chi^2: * $p \leq 0.05$, ** $p \leq 0.01$, *** $p \leq 0.001$. 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: five or more drinks on a drinking day. In 2007: four or more drinks for women and six or more drinks for men (definition of excessive drinking).

* 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.

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[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.

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

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