International Journal of Drug Policy 41 (2017) 65–73

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Six-month outcomes among socially marginalized alcohol and drug users attending a drop-in center allowing alcohol consumption

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ARTICLE INFO

Article history:
Received 11 June 2016
Received in revised form 24 November 2016
Accepted 19 December 2016

Keywords:
Socially marginalized individuals
Alcohol
Drugs
Harm reduction
Drop-in center
Health-related QoL

ABSTRACT

Background: Despite their experience of substance-related harm, few socially marginalized alcohol and other drug (AOD) users access substance use treatment. Thus, identifying alternative approaches for this population is important. This program evaluation documented substance use and health-related quality of life (QoL) following exposure to such an alternative approach: a harm-reduction drop-in center allowing alcohol consumption onsite.
Methods: Participants ($N = 85$) were socially marginalized AOD users (e.g., alcohol, heroin) attending a harm-reduction drop-in center in the French-speaking part of Switzerland. Time and drop-in center attendance were predictors of substance-use outcomes and mental and physical health-related QoL, which were measured at baseline, 1- and 6-month follow-ups.
Results: Findings indicated that, for each month of the evaluation, participants' alcohol use and related problems decreased by 5% and 7%, respectively. Drop-in center attendance predicted additional decreases in drug-related problem severity and improvements in mental health-related QoL.
Conclusion: Participants' alcohol use and related problems decreased over time. Additionally, participants evinced improved mental health-related QoL and decreased drug-related problem severity with greater drop-in center attendance. Harm-reduction drop-in centers allowing alcohol consumption onsite are promising interventions for socially marginalized AOD users.

Introduction

Socially marginalized individuals are characterized by the European Network of Social Inclusion and Health as "individuals, groups or populations outside of mainstream society, living at the margins of those in center of power, of cultural dominance and economical social welfare" (Schiffer & Schatz, 2008, p. 6). Social marginalization has been used in Europe as an umbrella term to refer to individuals who regularly use publicly funded clinical and social services (i.e., shelters, drop-in centers, case management, and medical and psychiatric centers), marginally housed or homeless individuals, social assistance recipients, and drug users (Pedersen, Gronbaek, & Curtis, 2012).

Worldwide, socially marginalized individuals are more severely affected by alcohol and drug-use disorders than the general population (Fazel, Khosla, Doll, & Geddes, 2008; Fazel, Geddes, & Kushel, 2014; Naper, 2009; Philippot, Lecocq, Sempoux, Nachtergael, & Galand, 2007). A Swiss study of substance use among socially marginalized individuals showed that more than half of the people surveyed engaged in "harmful drinking" (i.e., drinking 60 grams or more of pure alcohol per day; Labhart, Notari, & Gmel, 2010). Additionally, 40% reported polysubstance use (e.g., heroin, cocaine), which is associated with increased substance-related harm (e.g., falls, injuries, overdose), reduced health-related quality of life (QoL), and higher mortality rates than those seen in the general population (Costenbader, Zule, & Coomes, 2007; Labhart et al., 2010; Naper, 2009). Despite their clearly demonstrated needs, most socially marginalized individuals do not present for widely available abstinence-based treatments. In fact, the Treatment systems Research on European Addiction Treatment project (TREAT) documented that only 7% of those with substance use disorders in Zurich, Switzerland reported

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http://dx.doi.org/10.1016/j.drugpo.2016.12.015
0955-3959/

having attended abstinence-based treatment over the past 6 months (Reissner et al., 2012).

To more adequately address this situation, the Swiss government has called for innovative approaches that could better engage and address the needs of socially marginalized AOD users (Info drog, 2010). Harm-reduction interventions are well-positioned to respond to this call. Harm reduction comprises a set of pragmatic, compassionate and user-driven approaches that aim to improve health-related QoL and reduce substance-related harm without requiring abstinence or use reduction (Collins et al., 2011).

Alcohol-related harm-reduction interventions have been surrounded by some controversy because of concerns that nonabstinence-based interventions could "enable" or augment harmful alcohol use (Collins et al., 2011). Contrary to this enabling hypothesis, however, pilot studies of harm-reduction interventions conducted in North America have shown promising findings for socially marginalized AOD users. For example, recent pilot studies conducted in Canada evaluated shelter-based, managed alcohol programs in which homeless individuals with alcohol dependence received alcohol on a controlled hourly schedule. Findings indicated managed alcohol programs were associated with a range of positive outcomes, including increases in QoL as well as decreases in alcohol use and related harm, inpatient detoxification admissions and publicly funded service utilization (i.e., emergency medical and police contacts leading to custody) (Pauly et al., 2016; Podymow et al., 2006; Vallance et al., 2016). Other recent research has shown that Housing First, which entails the provision of immediate, permanent, low-barrier, nonabstinence-based supportive housing, is associated with decreased alcohol use and problems as well as decreases in publicly funded service utilization and associated costs (Collins et al., 2012; Larimer et al., 2009; Stergiopoulos et al., 2015). Finally, a recent pilot study of harm-reduction counseling (i.e., interactive alcohol feedback; client-driven, harm-reduction goal elicitation; and discussion of safer drinking strategies) coupled with anticraving medication showed harm-reduction alcohol treatment is feasible and acceptable to the participants and is associated with significant decreases in alcohol craving, use and problems among homeless individuals with alcohol use disorders in the US (Collins et al., 2015).

Given most European countries' comprehensive social safety net, unsheltered homelessness is not the large-scale problem it is in North America (Homeless Worldcup, 2015). In Switzerland, however, there are concerns about lack of daytime shelter and public intoxication among socially marginalized AOD users, who often gather and drink in public spaces (Labhart et al., 2010). There have thus been calls to address this situation by developing low-threshold drop-in centers that provide a safe space for these individuals to engage with social services, help reduce substance-related harm, and limit public disorder (Info drog, 2010).

In response, a new harm-reduction drop-in center allowing alcohol consumption onsite and serving socially marginalized AOD users was recently opened in a city within the French-speaking part of Switzerland. The present program evaluation documented AOD outcomes (i.e., quantity, frequency and related problems) and health-related QoL among socially marginalized AOD users following exposure to this new harm-reduction drop-in center. Contrary to the enabling hypothesis and in line with recent, promising findings for harm-reduction approaches, we predicted drop-in center clients would evince decreases in AOD use and related problems as well as improvements in health-related QoL. We also hypothesized that greater attendance at the drop-in center would be associated with additional improvements in AOD and health-related QoL.

Methods

Setting

The setting for this program evaluation was a harm-reduction drop-in center that serves socially marginalized AOD users and allows alcohol consumption onsite. The drop-in center is located in the French-speaking part of Switzerland and opened in February 2014. It is open every day from 12pm to 7pm and can serve 25 individuals at a time. When first attending the drop-in center, clients meet drop-in center staff who explain the center's ground rules and assess their eligibility for services there (i.e., presence of a substance use disorder or history of a substance use disorder). Eligible clients then provide written informed consent stating they are aware of the center rules and agree to sanctions in case they fail to follow them (i.e., temporary or permanent bars from the center).

Clients may bring and consume their own alcoholic beverages onsite but are required to leave their alcoholic beverages at the reception. They may consume one alcoholic beverage at a time and must request each additional beverage from drop-in center staff. This procedure facilitates staff's and clients' monitoring of alcohol use and provides an opportunity for staff to engage clients in harm-reduction counseling. There is no restriction regarding the quantity and types of alcohol consumed (e.g., beer, wine, liquors), but staff may not overserve clients in case they may put themselves or other attendees/staff in danger because of their drinking. Verbal and physical violence towards staff and clients is not tolerated. If clients engage in verbal or physical violence, they will be required to leave the drop-in center immediately and may face a bar. Nonbeverage alcohol use is not common in Switzerland; thus, there are currently no specific regulations regarding its use.

Nonalcoholic beverages and snacks (i.e., sandwiches and pastries) are provided free of charge, and a lunchtime meal is available at a reduced price. Additionally, there is a pre-existing, harm-reduction drop-in center nearby that serves primarily intravenous drug users. That center does not allow alcohol consumption onsite, but it does provide complementary harm-reduction services (e.g., safer drug use kits, shower and laundry facilities, secondhand clothes distribution) and nursing care to both centers' clients.

Given the center's low-barrier, harm-reduction approach, clients are not required to attend treatment; however, onsite staff (i.e., 1–2 social workers, 1–2 nurses and a psychologist) are available to provide interested clients with harm-reduction substance-use counseling and vocational opportunities. The harm-reduction substance-use counseling was adapted from a brief intervention developed by the second author and focuses on eliciting and supporting participants' own goals and engaging participants around safer-drinking strategies (e.g., tips for tapering and maintenance drinking to avoid alcohol withdrawal, buffering the effects of alcohol on the body by taking B-complex vitamins and eating before and during use; Collins et al., 2015). Harm-reduction goals are entirely participant-driven and do not require a focus on substance-use abstinence or reduction (Collins et al., 2015).

Participants

Participants ($N = 85$) were socially marginalized AOD users who attended a harm-reduction drop-in center in the French-speaking part of Switzerland. Inclusion criteria were being at least 18 years of age, having adequate French language skills to complete study questionnaires, being able to provide informed consent, having visited the drop-in center at least once, and having provided written or oral informed consent to participate in the evaluation. The initial sample included 101 participants. One participant was excluded