

IDPC Briefing Paper

The Dutch treatment and social support system for drug users

Recent developments and the example of Amsterdam

Eberhard Schatz, Coordinator Correlation Network
Katrin Schiffer, Policy Coordinator Correlation Network
John Peter Kools, consultant on drug use and harm reduction

January 2011

This paper was made possible thanks to the Correlation Network.

The International Drug Policy Consortium (IDPC) is a global network of NGOs and professional networks that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces occasional briefing papers, disseminates the reports of its member organisations about particular drug-related matters, and offers expert consultancy services to policy makers and officials around the world.

Summary

This paper briefly describes the history and the basic elements of the Dutch drug dependence treatment policy, including recent trends in drug use and the current drug treatment system implemented in the four largest cities in the Netherlands. Building on more than 30 years' experience, the Dutch approach focuses on an integrated treatment system, which provides comprehensive support and services to the most vulnerable groups, including homeless people, problematic drug users and chronic psychiatric patients. At the same time, a strong emphasis is given to public order and crime reduction.

This paper describes the law enforcement and community involvement elements of the strategy,

and provides available data on the results achieved so far. Although the current policy has shown positive results for individuals and society as a whole, the system is at risk of losing its balanced approach. The approach of public health-based regulation may have reached its limits and is losing focus in over-medicalization and over-regulation. The policy may have been under pressure from surrounding countries in the 1980s and 1990s, but nowadays, the biggest threat for turning back the clock is coming from inside the country. There is a growing concern among service providers and drug using communities that the new government will be redrafting the policy agenda away from the primary interest of drug policy: increasing the quality of life of people who use drugs.

1. Principles of an effective drug dependence treatment system

The International Drug Policy Consortium (IDPC) describes three key stages of an effective drug dependence treatment system that need to fit together in an integrated way¹.

- **Identification and assessment.** An appropriate treatment system needs to include an efficient process for identifying the individuals who need treatment, assessing their problem, and referring them promptly to the appropriate services. This process normally consists of a mixture of street and other outreach services, and referral mechanisms in settings such as police stations, hospitals, and social services. In many countries, this crucial process is undermined by difficulties in making contact with users who live on the margins of society, or in providing a sufficient range of treatment services in order to meet diverse needs. In the Dutch system, this element seems to work very well, with a comprehensive and well established outreach system (supplemented by clear criminal justice referral pathways), that is able to place individuals quickly into a wide range of treatment facilities.
- **Provision of treatment.** As the nature of the problems faced by each individual is different and changes over time, it is important that a 'menu' of treatment services – encompassing low and high intensity options, and abstinence or substitution based models, in a range of settings – are available in any given locality. Some treatment systems are dominated by a single method or model of treatment. This leads to the referral of most or all drug dependent individuals into a 'one-size-fits-all' facility, therefore limiting the success rates. In the Dutch example, a wide range of treatment facilities are available and funded by the state, so there are fewer barriers to providing individuals with the treatment that meets their needs.

- **Reintegration.** The ultimate objective of the drug dependence treatment process is to reintegrate individuals into their own communities – making a positive contribution to society. An important element in any treatment system are facilities that help marginalized people to get access to stable accommodation, prepare for work or education, and to rebuild relationships with their families. Once again, this report will show that the Dutch system has a strong focus on the reintegration of drug dependent individuals, with particularly strong processes for helping them find and maintain decent housing. Attention to these issues helps improve the rates of sustained recovery from dependence.

While the Dutch treatment system still faces many challenges, both financial and practical, it is an example of a well designed and financed system that produces significant benefits to Dutch society in terms of reduced crime, health and social problems. At the same time, it demonstrates the challenges and key issues that need to be addressed for a balanced and pragmatic approach.

The Netherlands, and in particular Amsterdam, is internationally well known for its progressive, advanced and pragmatic drug policies, dividing the market in soft and hard drugs, and using needle exchange, methadone treatment and other harm reduction responses as part of an effective public health approach to illicit drugs. Although this approach has led to vigorous debates with neighboring (and other) countries in the past, these applied policies have now become common practice in most European countries and are fully supported by European Commission recommendations. However, public health arguments are currently being increasingly linked to public order interests. Service providers are closely cooperating with the police and the justice system. Local support programs are focusing on the development of individual self sufficiency (through intensive support, but also with the use of coercive measures), both to

improve the participation of individuals and to reduce crime. There is a growing concern among service providers and drug using communities that the primary interest of the drug policy (increasing drug users' quality of life) is coming out of focus, reprioritized and will be sacrificed to the new political priorities of security and safety. To avoid an unbalanced approach, highlighting the significant gains and benefits of the past years policy and a revival of activism is likely to be required. Involvement of service providers in decision making processes at policy and service provision levels need to be improved.

2. Background

History

Just like in many other countries in the West, drug use in the Netherlands emerged in the 1960s, with cannabis, LSD and other psychotropic substances. Heroin was introduced in the early 1970s and heroin use took off in 1975 among a wide range of people: not only among the experimenters from the 1960s, but also among the less fortunate such as unemployed youngsters, people who had suffered traumatic experiences or people with mental health issues. Heroin also became popular among a significant group of immigrants from Suriname (the Dutch colony in Latin America which became independent in 1975).

It is mainly because of the decriminalization of cannabis retail and possession in 1976 that the Netherlands, and especially Amsterdam, gained the reputation of a 'Drugs Mecca'; a place for cheap available drugs and more liberal drug policies. This reputation attracted many young people from other European countries including Germany, Belgium, France and Italy. At the same time, many young people fled the more repressive drug climates of their country of origin.

In 2006, the national government and the local authorities of the country's four largest cities (the so-called G4: (Amsterdam, Rotterdam,

The Hague and Utrecht) combined forces and agreed on a common Social Support approach, targeting the most vulnerable groups in the cities and improving their living conditions (including access to housing, social benefits, and employment). These factors have strongly contributed to improved public order, and a reduction in drug-related petty crime.

Drug situation

At the peak of the heroin epidemic, around 1985, there were an estimated 25,000 problematic drug users in the Netherlands, around 9,000 of whom lived in Amsterdam, including 3,000 people originating from neighboring countries. A substantial percentage (30% to 40%) of the Amsterdam drug using population preferred injection². Important differences in injecting behavior were recorded according to (ethnic) background: 40% of Dutch drug users injected, whereas only 5% of drug users of ethnic origin (mainly coming from Suriname or the Dutch Antilles) reported injecting behavior. The prevalence of injection among drug users from other European countries such as Germany or Italy reached up to 70%.

The main health concerns among drug injectors in the mid 1980s were overdoses (73 cases of overdose were reported in 1984 alone), hepatitis B (very common among injectors in the 1980s, reaching up to two thirds of injecting users) and HIV (already prominent, reaching up to 1/4 of injectors according to the first tests conducted in 1985). Although HIV prevalence among injectors in the early 1990s stabilized after the alarming onset of the HIV epidemic in the mid 1980s, it was considered a serious public health problem, showing regional differences, from 26% in Amsterdam, 14% in Heerlen/Maastricht (the area bordering Germany and Belgium) to 1% in other areas (Groningen, Arnhem)³.

In the early 1980s, the case of 'poisoned heroin' in Amsterdam, which caused serious brain damage in at least 47 heroin chasers (including 11 fatalities), also constituted a significant health incident.

In parts of Amsterdam and several other main cities, open drug scenes were established with large groups of (often marginalized) drug users, which led to a heated debate in neighborhoods, among the police, service providers, interest groups and the general public.

Drug policy

Drug policy in the Netherlands consists of an integrated approach between drug supply, prevention, treatment and harm reduction. The Dutch drug policy, as established in 1976, aims to balance the maintenance of public health, public order and compliance with international law. The strong emphasis on values such as public health and individual responsibility are essential characteristics of these health policies, based on evidence and pragmatism rather than ideology. Dutch drug policies are based on the principle of differentiation of policies ('a different horse for a different race'), some targeting recreational drug use (with the regulation of cannabis selling), and others targeting problematic drug use. This differentiation between policies targeting problematic and those focusing on non-problematic/recreational drug use derives from the distinction between substances constituting a risk to public health ('hard drugs') and cannabis, a substance that poses a less serious threat. In the late 1970s, the Dutch government and service providers initiated a debate on possible innovations in the field of drug treatment. The outcome of this debate was the introduction of methadone and other services for drug users that are now known collectively as 'harm reduction' interventions.

Large scale low threshold drug treatment and other harm reduction services (e.g. methadone programs and needle exchange programs) were initiated at an early stage of the emerging opiate use. These developments were further intensified by the emergence of the HIV epidemic in the mid 1980s. The 1995 Drug Policy Paper issued by the Dutch government underpinned the results of earlier principles, policies and experiences. It described procedures of collaborations between government departments and municipalities,

and suggested initiating a range of innovative approaches, including heroin-assisted treatment, drug consumption rooms and programs that provided integrated social and health services. The Policy Paper consolidated the government's harm reduction policies and enabled for a wider implementation of social and health policies towards 'full-scale harm reduction'.

In recent years, policies on hard drugs have no longer been considered as a major issue in the media and among the public in the Netherlands, mainly because some of drug users' main needs (including adequate drug treatment, access to specialized health care, housing, safer consumption options) are being met, and drug users disappeared almost entirely from open scenes and are hardly visible in the public scene. Discussions have focused instead on the coffee shop policies, drug supply policies, high alcohol consumption rates among youngsters, and the nuisance that coffee shops cause in border regions. It is expected that the current conservative – liberal government, supported by a populist 'law and order' party, are likely to shift the focus of drug policy to more control and punitive measures. However, the well established and integrated harm reduction system will hopefully not be affected, and current programs will be maintained.

A political review of the Dutch drug policy was planned in 2009/2010, but due to the fall of the government and the establishment of a new one, discussions on the evaluation have been pushed to an unknown later stage.

Current situation

The current drug situation in the Netherlands can be summarized by the following, broadly positive, trends:

- No new influx of problematic opiate users. Opiate use has lost its appeal to the mainstream youth and is currently considered as a 'dead-end street drug'. The number of problematic opiate users has dropped significantly and the average age

of users has risen considerably, from people in their early twenties to middle aged and elderly men and women. A large number of users from neighboring countries returned to their home countries, when local drug policies started to provide similar treatment and harm reduction services to those developed in the Netherlands.⁴

- A dramatic decrease in injecting prevalence. An Amsterdam open cohort study, including more than 1,000 Amsterdam drug users, confirms the huge changes that occurred regarding injecting behavior over the years. The latest available national data from 2005 indicate that only 10% of the estimated 33,500 problematic users in the Netherlands were using their drugs intravenously with even lower rates of injecting behavior in Amsterdam (4% currently injecting). Only relatively small groups (long-term injectors, migrants and tourists from Eastern Europe, for example) continue to inject.⁵
- Stable rates of HIV, HBV, and HCV. Although the prevalence of infectious diseases is still high among current and former drug injectors, their prevalence has stabilized and even declined since the mid 1990s. More notably there has been a marked decrease in incidence rates and new cases. For example, in 2008, Amsterdam counted only two new HIV cases related to injecting drug use, three new cases of HBV and one new case of HCV.⁶
- Public nuisance has reduced significantly in most areas of Dutch cities. In the 1980s and 1990s, open drug scenes – groups of (often marginalized) drug users – covered significant areas in many Dutch cities. Today, these notorious no-go areas have turned into cozy touristic streets, markets and town squares, and the drug using population is no longer so obviously present in public spaces. The majority of users who used to be dependent on street dealing and illicit drugs, now live in social housing, receive drug dependence treatment and other medical care in one of the integrated service centers, and/or consume their illicit drugs in one of the available consumption rooms.
- Slightly higher prevalence of use for other stimulants. At the same time, the use of other stimulants (cannabis, GHB, alcohol) has reached a slightly higher prevalence among adolescent drug users and the number of problematic cannabis users has increased in the last couple of years. In 1994, 16 out of 100.000 inhabitants asked for support for their cannabis use, in 2008, the numbers reached 62 out of 100.000. Crack cocaine use has also developed over the last 15 years, leading to an initial increase of overall problematic drug use and then stabilizing at around 33,500.⁷

Box 1. Example: One stop shop

The first integrated service center (Geïntegreerde Voorzieningen, GV) was opened 2004 in a problematic neighborhood in Amsterdam, with a higher than average unemployment rate, lower than average income, more immigrants and an open drug scene. Following the successful evaluation of the project in 2007, GV's are being introduced in 4 other parts of the city before the end of 2010.

The multi disciplinary team of these centers consists of a medical doctor, a nurse, a social worker, a consultant for income and budget and a consultant for daily activities (dagbesteding). Methadone and medicinal heroin treatment are provided in the centers, as well as social benefit, housing services and mediation to night shelters

However, the main cause of concern among health experts in the Netherlands is alcohol, especially among youngsters who have taken up a more intensive drinking pattern than in earlier years (e.g. binge drinking).

3. The Dutch treatment system: an integrated approach

In recent years, the focus of drug policy in the Netherlands has shifted towards an integrated approach, gathering the main players working with problematic drug use and focusing on public order as well as public health and the effectiveness of care and treatment programs. An important political aim is to significantly reduce drug-related disturbance of public order and, at the same time, improve services and treatment options for drug users with problematic behavior. For those users with a long criminal record, who do not fit into existing services, or who avoid treatment or any other support, specific approaches were introduced, including coercive and coercive treatment.

This integrated approach is part of a broader set of measurements under the Social Support Strategy (SSS), which was implemented in 2006/2007 in the G4.8 The SSS aims to guide vulnerable groups, such as drug users and homeless people, often suffering from psychiatric disorders, into systems of care and treatment, including housing, employment, reintegration, social benefits and medical care. The number of target groups in the four cities was estimated to more than 20,000 people (10,150 homeless people and more than 11,000 people at risk of becoming homeless). Most of them have complex mental and social problems, and therefore need specific and combined support.

Each of the four cities translates this overall approach into a local strategy, based on a result-oriented personal approach and an integrated social support system, which depends on the collaboration of various partners. The personal

approach includes the development of an individual social support plan, to which both the target group and the agencies involved commit. The implementation of the plan takes 7 years (2006-2013), and it is expected that the target group will become self-reliant and independent (again). Furthermore, it is expected that public disturbance and crime among the target group will be significantly reduced, compared with 2006.

Elements of the integrated approach in the G4

To ensure effectiveness and impact, a coherent and integrated approach was adopted in 2007 to target specifically problematic drug users, who are often associated with criminal offences and public disturbance (Programma bestrijding Drugsoverlast). The main pillars of this balanced approach are prevention, treatment, care and the maintenance of public order through law enforcement and coercive care.⁹

Structure

A wide range of institutions are involved in the integrated social support approach, including housing corporations, health insurance companies, healthcare providers, the police and the justice department. All stakeholders have signed a covenant, agreeing on common goals, including the provision of financial and human resources. Well equipped support units have been established in different neighborhoods to provide medical treatment, social support, employment, and day activity programs. Meanwhile, the local government has a clear function of management and coordination and controls the financial (medical care) resources.

To realize such a challenging concept, a complex organizational structure was established. An administrative management team (mayor, high-level administrative local officers) meets twice a year to reach agreements at the general level. An interdisciplinary working group, the operational team, is responsible for the implementation of the program. This group consists of representatives of the local government, representatives of the justice system and the police, and the managers of housing, healthcare and social benefit

services. A program manager coordinates the implementation of the project and reports regularly to the working group.

A 'veldtafel', consisting of local service providers, has regular meetings to monitor the progress of individual clients and to refer them to the appropriate services. A 'chain unit', consisting of the police and representatives from the justice department, monitors the clients within the judicial system.

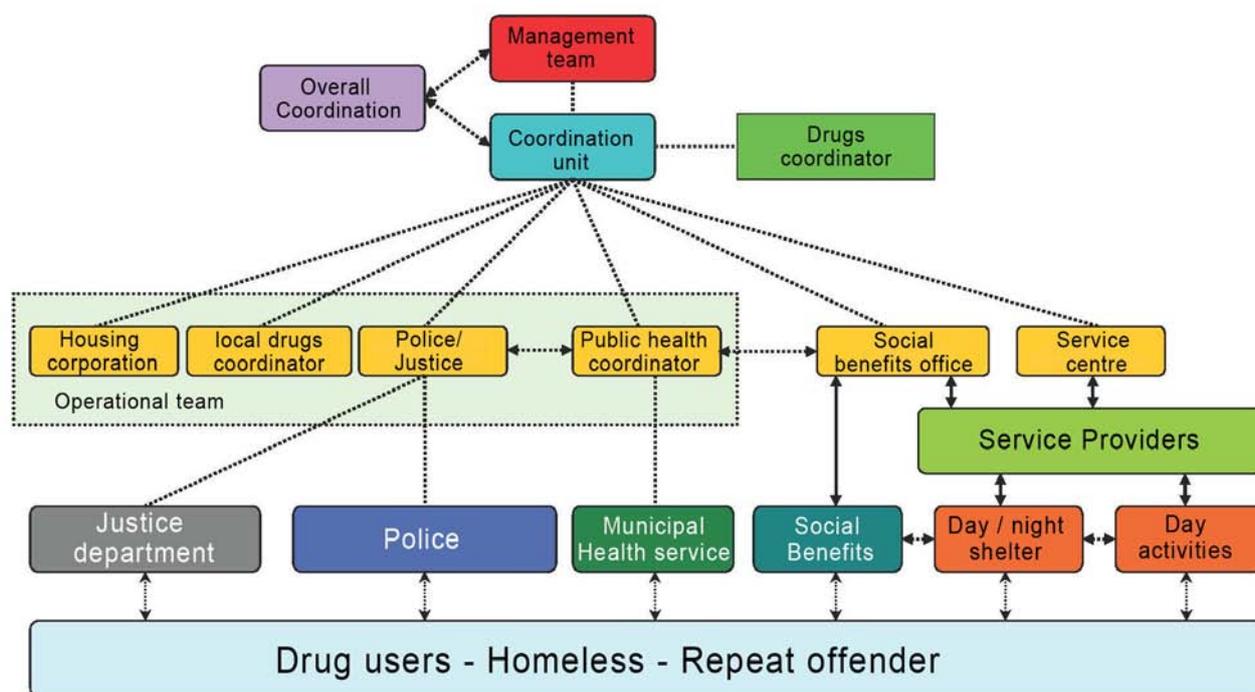
Main players involved

- *The national government.* In 2007, the Social Support Act (WMO - Wet Maatschappelijke Ondersteuning) was passed by the national government. It is now effective in all municipalities in the Netherlands and combines several laws in the social support sphere. The aim was to improve the reintegration and participation of all citizens through the provision of basic healthcare and social services – this includes drug

users. In collaboration with the G4, a strategic plan for social relief 2006-2013 was developed (SSS-G4).

- *The municipality.* The local government is responsible for developing and implementing drug policies within the municipality, providing resources for service providers and organizing the collaboration between stakeholders, including the mayor, the administration for social and health policy, the head of the police and the criminal justice administration.
- *The Municipal Health Service.* The Municipal Health Service (Geestelijke Gezondheidsdienst GGD) is the main provider of treatment programs such as clinics for opiate substitution treatment, the heroin program, the treatment of blood borne infectious diseases such as HIV/AIDS, tuberculosis and hepatitis, and psychiatric treatment, if applicable. A

Picture 1. Overview of stakeholders within the Dutch integrated approach



From 'Bestrijding Drugsoverlast Amsterdam Zuidoost 2006 - 2010'

special GGD unit is responsible for the 'support approach', that is, for coordinating the individual support for clients offered by different agencies such as social benefits, medical care, housing, 24 hours emergency service, etc. (Vangnet & Advies). A unit for foreign drug users in Amsterdam completes the range of GGD services.

- *The justice department.* The police, the public prosecutor and probation officers are closely involved in the development and implementation of the 'integral approach' towards dependent drug users. Regular exchange of data and information, direct client monitoring systems within the justice system, coercive treatment programs and detention are part of their role within the system.
- *Service Providers (NGOs).* A number of service providers focus on particular target groups or situations: outreach work, low threshold services (including consumption rooms, night shelter, daytime activities) and drug free treatment – out-patient and clinical treatment facilities, reintegration into the work force (labor projects, support in finding work, etc.), training and education.¹⁰
- *Other Institutions.* In addition to the direct partners mentioned above, other institutions in the greater municipal area are involved in the implementation of the program, including housing corporations, the social benefits agency, the employment agency, health insurance companies and others.

Box 2. Harm reduction programs

Consumption rooms

6 consumption rooms are run by low threshold service providers in Amsterdam. The consumption rooms are frequented by chronic drug users from the neighborhood.

Criteria

- older than 21 years
- long term problematic drug use
- TB control
- homelessness
- approval by social worker, municipal health service or police
- checked on criminal record by police (neighborhood officer)
- monthly visitor list (name, birth date and nationality) is sent to police

Opioid substitution treatment

Methadone is provided by General Practitioners and through the municipal health service. There is no countrywide regulation or criteria for methadone treatment. Amsterdam has approx. 2,500 methadone patients. Methadone patients are checked medically every 3 months and they are screened for TB every 6 months. Buprenorphine still plays a minor role in the Dutch OST.

Heroin on prescription

In 2007 heroin was registered officially as medicine in the Netherlands. In Amsterdam, 2 clinics provide heroin on prescription for +/- 140 clients.

Criteria

- 5 years addiction to heroin
- regular methadone treatment in the last 6 months
- chronic addiction without successful treatment with methadone before
- almost daily use of heroin
- bad mental or physical health and/or bad social functioning
- injecting or smoking drug user
- at least 25 years old
- other

Contract with every client for 1 year > evaluation of the social or health situation. If there is no improvement, treatment can be stopped.

Interventions

New clients are referred to treatment programs by outreach workers or specific outreach work agencies, the municipal health services and the police. A central intake unit registers new clients, analyzes their need for support and couples the client with a mentor, related to the particular problems of the person. The mentor, usually a nurse or a social worker, supports and accompanies the client during the period of care and treatment, giving advice, mediating to services, providing administrative support, etc. A client can request another mentor in case he/she experiences relationship issues with the current mentor. The relationship between the mentor and the client is based on regular consultations and consensus. Young people also have access to the services available, usually with special attention by their mentors. Special programs for young people living in the streets have also been developed.

The new clients can use every service available, but they have to agree to the conditions and they may be pushed to make use of certain facilities or services. Clients are stimulated to gradually use more of the services provided, especially drug treatment, housing and employment. Housing is regarded as a key element of a successful reintegration process. This 'stable support' of services provided aims to enable the client to stabilize her or his social situation for at least 3 months in the first instance.¹¹

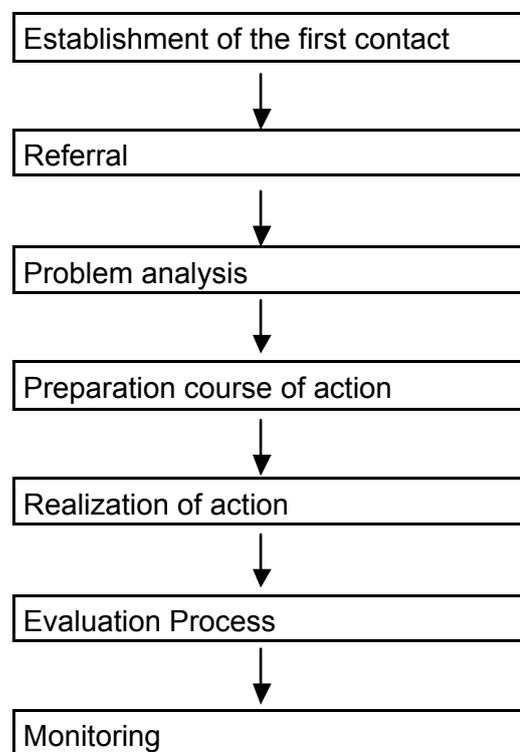
The five components of the chain approach/ care system are:

1. Housing
2. Income generation
3. Access to care and use of medical care (including methadone or heroin treatment, see boxes 1 and 2)
4. Day activities (e.g. a work team in the public space, a craft team working in gift shops, a farm labor team working on farms)
5. Access to safe drug consumption facilities.

In case the clients refuse particular services (e.g. housing, day activities) and keep disturbing public order, punitive measures can be taken such as withholding social benefits, coercive treatment, and restraining orders which can involve revoking suspension of detention (for example, social benefits can be conditional on sleeping in a night shelter or taking part in day-time activities).

Once registered, the new client has immediate access to night shelters, medical treatment and safe drug use facilities. For other services there may be a waiting list. Regular case management meetings and a monitoring and evaluation system ensures the effectiveness of interventions on the general and individual level.

Picture 2. Steps of the client support system



From: Van de Straat, Gemeente Amsterdam 2007

Picture 3. Facilities and services of the integrated approach

Housing	Day Activities	Income	Care	Drug Use
Living independently	Independent job	Income from work	Independently chosen medical care	No use
Living Protected	social working program	Social benefit on own address	Regularly medical control regular care	Regulated use (at home)
Social pension	Voluntary work	Social benefit on post address	Regularly medical control regular care	Regulated use (in the pension)
Night shelter	Day activity	Consolidation of debts	Regularly medical control mobile care	Protected use (user room)
Basic shelter	Drop In Centre		Regularly medical control mobile care	Protected use (user room)

From 'Aanpak drugsproblematiek Amsterdam Zuidoost', 2003

Monitoring and evaluation

An important element of the integrated approach is data collection and monitoring of the progress of individual clients, as well as general developments.

Every intake is registered and followed through the different programs. Clients can only register in their own region/neighborhood. An electronic client follow up system (Client Volg Systeem - CVS) monitors the progress and activities undertaken by the client within the various services.

Every three months, information is shared between the justice department, the police, the municipal health service, shelter/day activity centers, housing corporations, the local government, and social services providing benefits. The information includes the number of clients, the number of new entries and clients who have left the program, along with data on other indicators. However, information about individual clients is not passed on by service providers to law enforcement agencies due to privacy regulations.

Law enforcement and coercion

Coercive treatment is a relative new element in the Dutch drug policy. In 2004, the Dutch law introduced a particular measure to bring repeat offenders into prison fast and more effectively

with the Device for Repeat Offenders measure (ISD - Inrichting voor Stelselmatige Daders).¹² The measure is targeted at people involved in relatively small offences such as petty crime, drug use in open spaces, violation of articles of the general municipal ordinance on restricted territories etc. The vast majority of the ISD clients are often long-term drug users and/or individuals with mental health problems. Drug use as such is not regarded as a crime.

These criminal offenses do not entail serious sentences, and punishment has therefore little impact on the behavior of the particular person. Through the ISD measure, the judge can impose a 2-year intake in a special prison unit with specific treatment programs. One pre-condition is that offenders have been in contact with the police at least 10 times or have been sentenced at least 3 times in the last 5 years.

Problematic drug users with a long judicial history can be sentenced to coercive drug withdrawal. On an individual basis and after a detention period of 6 months, the client can also enter an external treatment program. If the person concerned fails to complete this treatment, he/she will be detained again.

In the G4 cities, the focus is given to tight collaboration between the police, the public prosecutor and the probation officer. A special



Integrated Service provision Amsterdam South East (see Box 1 for more details)

database is established to monitor the target group. There is no data exchange with service providers, but they are obliged to implement punitive measures: released prisoners therefore have a strong pressure to participate in programs, as they might be detained again if they refuse to cooperate.

Community and client involvement

Community members (local residents, shop owners, volunteer organizations, civil society associations) are involved in the implementation of the various measures and participate in neighborhood committees.

Client participation is encouraged and client councils are formed to facilitate the implementation of the program at the level of service provision. Regular contact with staff and management is ensured. The Amsterdam Drug User Organization (Medisch-sociale Dienst Heroïne Gebruikers - MDHG), which represents the interests of drug users, takes part in consultation meetings and can assist individual drug users in case of complaints.

4. Results and effectiveness of the SSS approach

The first pilot phase of the project for the period 2003 to 2006 was carried out in the South-Eastern part of Amsterdam. It demonstrated the effectiveness of the integrated approach, especially with regard to the reduction of criminality and disturbance of public order.

175 clients were screened (based on police databases) from 2005 to 2007, when they were first admitted into one of the housing projects. In the two years before admission into the housing project, 2,692 police contacts (this includes all kinds of contacts, not necessarily resulting in arrests) were reported. In the period after admission in the housing project, 757 police contacts were reported – a 66% reduction.¹³

The Monitor Report of the SSS 2009¹⁴ provides specific information with regard to the progress, the outcomes and the results of the program in the 4 cities in general:

Main goals	Indicators	Preliminary outcomes/results
Eviction: Significant reduction homelessness due to eviction.	1. Number of evictions within housing agencies reduced to 30% in 2008, compared to 2005 2. Number of evicted persons, contacting the social support program, reduced to 30% in 2008, compared to 2005	<ul style="list-style-type: none"> - Reduction of eviction in Rotterdam and Utrecht to 30% - 18% reduction in Amsterdam - 11% reduction in Den Hague
Prison: Significant reduction in homelessness directly after release from prison	Reduction in the number of ex-prisoners contacting the social support program within one month after their release and being homeless within that period.	<ul style="list-style-type: none"> - All cities meet the requirements (partly due to the fact that the cities are responsible for the after-care of ex-prisoners)
Care and service provision: Significant reduction in homelessness because of drop-out from social care services.	Reduction in the number of target group members, contacting the social support program one month after dropping out.	<ul style="list-style-type: none"> - All cities meet the requirements
Support Plan / Stable support**: Before 2010, all 10,150 homeless people in the G4 are provided with an individual social support plan and – as far as possible – provided with income, housing, effective support, care, a useful occupation and employment.	1. Increase in the number of homeless people with an intake and an individual social support plan (Indicator for Amsterdam: 3,600 people) 2. Increase in the number of homeless people provided with a stable support of support (Indicator for Amsterdam: 2.800 persons), including : <ul style="list-style-type: none"> - stable housing - stable legal income - insurance - stable contact with social service providers - useful occupation or employment 	<ul style="list-style-type: none"> - 9,786 homeless people have an individual support plan - 5,929 homeless people have a stable mix of support In Amsterdam: <ul style="list-style-type: none"> - 3,814 homeless people have an individual support plan - 2,679 homeless people have a stable mix of support
Reduction in disturbance of public order Reduction of nuisance among a large part of the target group.	Reduction in the number of offenses and reports of nuisance among the target group of homeless persons.	For Amsterdam: people who were in contact with the police 5 times or more:** Those with intake and social support plan (based on a total of 3,503 individuals interviewed in October 2009): In 2009, 361 persons (10%) had been involved with the police or the justice system 5 times or more. In 2008, this percentage dropped to 17%, a reduction of 41% between 2008 and 2009. Those benefiting from a stable mix of support (based on a total of 2,387 individuals interviewed in October 2009): 151 persons (6%) had been involved with the police or the justice system 5 times or more in 2009, a reduction of 54% compared with 2008.

* 'stable support' means that persons have for at least 3 month stable housing, relevant care and support and legal income.

** A sample is taken from those, who already have a stable mix of support and those, who don't. However, uniform operationalization of this indicator seemed to be impossible. Outcomes are available per city, but can be compared. Outcomes were not corrected in regard to intensified police efforts.

We can conclude that the SSS approach is effective in terms of:

- Reducing disturbance of public order and criminality
- Identifying and assessing the needs of group of homeless persons/problematic drug users
- Providing adequate and integrated services (stable support) to vulnerable groups (including housing, social care, etc.)

Although the SSS approach is being carefully monitored, little is known about coverage of the system. The estimation of 10,150 homeless people dates from 2006. However it is generally known that this group changes constantly and is very dynamic. This means that the problem of homelessness is ongoing. An additional annual survey assessing the actual number of homeless individuals in Amsterdam in the wintertime showed that the total number of those sleeping rough had significantly decreased compared to 2006.¹⁵ Nevertheless there is still a large group of homeless people sleeping rough every night (approximately 200 people per night). 40% of this group could benefit from support, care and treatment. The remaining 60% (undocumented foreigners or EU citizens without insurance) are individuals without 'rights', who are not eligible for the SSS (a total of 330 non-eligible people were estimated in Amsterdam in 2009). The group of undocumented foreigners is generally excluded from the provision of services. AMOC – one of the Drop-Ins of the Foundation De Regenboog Groep – is providing basic and low threshold services to this group, including day shelter, night shelter, drug consumption room, and social support. Additional services, such as reintegration projects, work projects, medical care, treatment, social benefits and housing programs are not available for this group.

There is also little information about the cost-effectiveness of the approach. The SSS G4 approach requires large investments from

the national and the local governments. Investments are used to develop new services, tools and instruments, to improve collaboration between agencies and to increase the capacity of existing services, based on available best practice. The total cost of the SSS increased from EUR 61 million in 2006 to EUR 175 million in 2009. Two thirds of the total budget is covered by the national government, the rest is covered by the cities.

There is no information on the coercive elements within the SSS approach. Monitoring and evaluation mechanisms should provide data on the sanctions being used, in case of refusal or negative behavior, and analyze their impact on levels of engagement and success rates.

Despite these weaknesses in terms of monitoring, there is sufficient evidence (Trimbos Monitor Report SSS 2009) that the 'housing first' strategy shows positive effects on the stabilisation of vulnerable groups and also contributes to a significant reduction of disorder of public order and criminal behavior.

5. Conclusions

Pragmatic drug policies and tailored services including full scale harm reduction has been highly successful to tackle drug related harms for thousands of individuals, their families, and the wider communities in the Netherlands. Low rates of drug related deaths and relatively low infection rates of blood borne infectious diseases among drug users strongly confirm this conclusion.

The newly developed Social Support Strategy continues this pragmatic harm reduction approach, combining it with law enforcement and coercive elements. This new approach involves major investments in housing, social care and other social support measures and it has pushed all relevant stakeholders to work together effectively on a structural basis. There

is evidence that this integrated approach and the 'housing first' principle have strong benefits both for the well-being of affected individuals and the general public, which experiences less problems relating to public disorder and crime.

However, even if the extensive financial resources are available to reach the envisaged targets (e.g. no homeless people in Amsterdam in 2012), there are still challenges to be met when it comes to the group of non-eligible individuals, long waiting lists, and the coercive character of the system, which might collide with the principle of self-determination.

In addition to these specific conclusions on the Social Support System in the Netherlands, a number of general remarks can be made, taking into account recent overall developments.

In the Netherlands NGOs and government health and social care organisations have a tradition of close cooperation with law enforcement agencies and the police. This tradition stems from the pragmatic approach of the Dutch legal system not to criminalise drug use and the early understanding by the police that repression in itself is ineffective to tackle drug related public disorder and crime. Consequently, they supported the development of harm reduction services. This pragmatic approach led to a well-balanced cooperation, serving both public health and public order interests.

There is currently a shift in this pragmatic, non-ideological approach. Public order units patrol public spaces, disrupt open drug scenes (if any) and close down premises where drug dealing takes place. In addition, a new development has taken place in the Netherlands: the mayors have recently allowed for the installation of security cameras and video surveillance in specific areas and the introduction of preventative

surveillance by the police, allowing the police to search members of the public as a preventative measure in order to temporarily ban them from a certain area in case of disorderly conduct.

New paradigms require new approaches. While public health was an important policy paradigm in the past, security issues and the need to (re)integrate and promote the participation of drug users in society are now at the forefront of current social policies (participation is currently one of the key policy principles in the Netherlands).

Another phenomenon, which is closely linked to the former, is the transformation of harm reduction approaches into a more medicalized approach. This development does not only apply to the Netherlands, it can also be observed in other countries where harm reduction is well developed, such as the UK, Switzerland and Germany. Although this approach does have advantages (especially when it comes to the variety of treatment opportunities available), the management of drug users through social workers and medical staff (and, in the background, the police) can transform the individual into an object of interventions and policies, rather than a subject able to take his own decisions.

A crucial element of well balanced drug policy, treatment and harm reduction interventions therefore is the participation of the people affected by the policy.¹⁶ This participation is essential for the development and good running of effective services and drug policies, but has not yet been sufficiently stimulated in the Netherlands and abroad. Next to international law, public health and public order, the interest of individuals using drugs (being user, ex-user, consumer, client, patient, etc.) should constitute one of the touchstones of drug policy.

Endnotes

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This paper was made possible thanks to the valuable contribution of the Correlation Network



This publication has been produced with the financial support of the Drug Prevention and Information Programme of the European Commission. The contents of this publication are the sole responsibility of the author/contractor/ implementing partner and can in no way be taken to reflect the views of the European Commission.

International Drug Policy Consortium
c/o Release, 124–128 City Road, London
EC1V 2NJ, United Kingdom

telephone: +44 (0)20 7324 2975

email: contact@idpc.net

website: www.idpc.net

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