Treatment of drug-addicted detainees

Gezondheidsraad **President**
Health Council of the Netherlands

To the Minister of Health, Welfare and Sport

Subject	: Presentation of advisory report on Treatment of drug-addicted detainees
Your reference	: GVM/Vz/98734
Our reference	: 0853/HvdK/iv/601-G
Appendix	: 1
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Dear Minister,

At your request (contained in letter no. GVM/Vz/98734), I hereby present an advisory report on the treatment of drug-addicted detainees. It has been prepared by the Health Council's Committee on the Medical Supervision of Addicted Detainees and reviewed by the Standing Committee on Medicine and the Standing Committee on Medical Ethics and Health Law. In accordance with the request for advice, I have also presented this advisory report today to the Minister of Justice.

At various points in the advisory report reference is made to another Health Council report, namely the advisory report on Pharmacotherapeutic Interventions in Drug Addiction. This report will be presented to you after the summer.

Yours sincerely,
(Signed)
Professor JA Knottnerus

P.O. Box 16052
NL-2500 BB The Hague
Telephone +31 (70) 34069 31
Telefax +31 (70) 340 75 23
E-mail: hanneke.vd.klippe@gr.nl

Visiting Address
Parnassusplein 5
NL-2511 VX The Hague
The Netherlands
www.healthcouncil.nl

Treatment of drug-addicted detainees

to:

the Minister of Health, Welfare and Sport

the Minister of Justice

No. 2002/08E, The Hague, June 12, 2002

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Executive summary

Request for advice

The Minister of Health, Welfare and Sport and the Minister of Justice requested advice from the Health Council, on the basis of the current scientific situation, concerning options for the treatment of detainees who are addicted to drugs. In order to answer this question, a Health Council Committee has studied the nature and scope of the problem of drug addiction in prisons. It has also examined the legal framework within which treatment takes place, the organisation involved, the policies and practical implementation of care for addicts in prisons and the scientific situation with regard to the treatment of drug addiction in penal institutions. On this basis, the Committee addresses the options and limitations with regard to the treatment of drug addiction in penal institutions, and formulates its conclusions and recommendations.

Nature and scope of the problem

Any attempt to determine the number of detainees who are also drug users is hampered by the fact that there is no official, national source of information in this area. Studies in individual institutions have shown that about 30% of detainees meet drug-dependence criteria. If a broader definition of the problem (substance abuse in general) is used, then this percentage rises to 44%. It is generally assumed that about one third to half of all detainees have some form of addiction problem. On an annual basis, this amounts to 15,000 to 23,000 individuals (excluding Youth Custody Centres and placement under a

hospital order), which involves allowing for counting the same individual several times, since given individuals may be detained several times in one year. In two thirds of those inmates of standard penal institutions who have addiction problems (about 10,000 to 15,000 individuals per annum) these problems can be defined as 'serious'. Such individuals have often been addicted for many years.

The periods of detention served by drug addicts are usually slightly shorter than the periods of detention served by the total prison population. Fifty percent of them serve as little as two months, while 75% re-enter society within four months. There are relatively few women among the group of detainees who are addicted to drugs. More than half of this group of drug-addicted detainees were born in the Netherlands.

About half of all detainees who meet the DSM-III-R psychiatric classification system criteria for dependence or abuse of substances also meet the DSM criteria for at least one other disorder. This amounts to well over 11,000 individuals per annum. Few details are available concerning the somatic problems of those detainees whose drug use is problematical. According to the Inspectorate for Health Care, there are relatively few seropositive drug users in penal institutions. Throughout the penitentiary system, there are about 20 to 25 cases of tuberculosis per annum. Attending physicians should be on the lookout for pneumonia, tuberculosis, HIV and hepatitis C, the same diseases that they would expect to find among addicts on the streets. Many of the older addicts, who have been heavy smokers (of tobacco and other substances) since their youth, suffer from Chronic Obstructive Pulmonary Disease (COPD).

Most addicted detainees are polydrug users. Most of them are heroin or cocaine users. They are generally poorly educated, have seldom had employment and many are of foreign origin. Those indicating that cocaine is their drug of choice are generally younger than those who mainly use heroin. The vast majority of these individuals prefer to inhale their drug of choice (by snorting or smoking it). Those who prefer injection are in the minority. Drug use is probably quite common in Dutch penal institutions, but injected drugs are seldom, if ever, used.

Besides the large group of polydrug users, there is a small group of detainees who only use cocaine. Nothing is known about the size of this group, whether it is growing and what the characteristics of these users might be. According to the annual report of the National Drug Monitor, 10 to 15% of those hard drug users whose habit is problematical use cocaine alone, in other words they do not use heroin. Some members of the group of detainees that only used cocaine seem to use this drug to facilitate their criminal behaviour, and the comorbidity in these cases appears to be limited to the antisocial personality disorder. If this impression is correct (something that must first be corroborated by means of scientific studies), then there is little point in developing treatment options in detention for this particular group of drug addicts. The number of opiate addicts in the general population remains relatively stable, and the average age of this

group is increasing. After an increase in the period from 1988 to 1996, cocaine use by young people aged 12 and above stabilised in 1999 (annual report, National Drug Monitor).

It is estimated that at least half of all addicted detainees have had previous contacts with professional practitioners, in connection with their addiction problem. Most of them can therefore be said to have a history of interaction with professional practitioners. In all probability, however, very few of those detainees who only use cocaine would have been treated by the addiction treatment and care system prior to their detention.

Legal framework

Detainees have just as much right to health care as any other citizen (principle of equivalence). On the basis of the Custodial Institutions Act, detainees have the right to adequate medical care from the physician associated with the institution in question. They also have a right to any necessary psychological and psychiatric care. These rights also include the right to treatment for drug addiction, although this right can be restricted if such treatment were to disturb the orderly running of the institution in question. The Medical Treatment Agreements Act (WGBO) is similarly applicable to the relationship between the institution's physician and the detainee. Inasmuch as the Custodial Institutions Act imposes no exceptions, drug-addicted detainees have the same rights (and responsibilities) with regard to the institution's physician as do addicts in society with regard to their attending physician.

Within the regime of the WGBO and the Custodial Institutions Act, the use of *compulsion* in the treatment of addiction in detention is only permitted under very limited circumstances. The only real compulsion that can be exerted in this situation is incarceration in a drug-free (or virtually drug-free) environment. If the institution's physician replaces an existing methadone maintenance treatment with a treatment based on abstinence (detoxification) without the detained patient's informed consent permission, then the Committee feels that in essence, and by dint of its repercussions, this amounts to compulsory treatment, even if no higher court has made an official decision to this effect. Under the Penal Care Facility for Addicts (SOV), *pressure* will be exerted on detainees to cooperate with the treatment. Whether or not this pressure will produce the desired result remains open to question.

Organisation, policy, daily practice

The current penal addiction policy aims to discourage drug use during detention, and to promote a drugs-free environment. According to guidelines issued by the Ministry of

Justice, methadone can be administered to short-term detainees, provided that they had been prescribed the drug prior to their detention. In practice, however, some institutions' physicians contravene these guidelines by cutting down the amounts of methadone provided, or by suspending such provision altogether. Each year, approximately 1,200 addicted detainees are admitted to a so-called Addiction Support Section (VBA), which has been specially set up for addicts. These sections are only for those detainees who are genuinely motivated to give up their drug habit. Under the current penal addiction policy, the use of methadone is a contraindication for placement in a VBA. The VBAs are currently under-utilised by approximately 25%.

Scientific situation

Relatively little research has been carried out into the effects of treatment programmes for drug addiction in the penitentiary system. Most of this research was done in the United States. There is only a modest amount of evidence to support the effectiveness of therapeutic communities in the treatment of drug addiction in the penitentiary system. Even this evidence relates to limited effects. Furthermore, this successful therapeutic-community model is substantially different from the therapeutic communities that exist within the Dutch mental health care system. Even in the case of successful treatment programmes such as these, the effects appear to disappear over the longer term, if they are not succeeded by adequate follow-up care. Methadone maintenance programmes in penal institutions, which are intended to prevent addicts from reverting to the use of illegal drugs, seem to offer some promise. With regard to *compulsory* treatment in penitentiaries, there is so much criticism of what little research has been carried out, both at home and abroad, that there is no evidence to support the usefulness of this approach. Modest effects can be achieved using *pressure* projects, provided that the projects in question are maintained for extended periods of time.

Opportunities and limitations

The Committee feels that the greatest possible use can and must be made of detention periods to motivate drug addicts to start (or continue) to work on their addiction problem. The main aspects of detention are to give people opportunities (and new opportunities), the provision of continuity of care and the initiation of treatment, which can be continued following the individual's release. It should be recognised, however, that there are limited opportunities for treating drug addicts in penitentiary situations. The limitations are inherent to the nature of detention, the duration of detention, the nature of the treatment and the nature of addiction.

The Committee takes the view that any opportunities should be fully exploited. Under current penitentiary policy, these opportunities are primarily linked to abstinence. The Committee feels, however, that these opportunities could be considerably expanded. Horizons could be widened beyond mere abstinence, to include harm reduction in particular. The Committee feels that consideration should be given to the introduction of certain elements of pressure into follow-up care procedures, in order to nurture and support the motivation for treatment that developed during detention. The Committee considers it vitally important that post-detention follow-up care should commence immediately after drug addicts are released from detention.

Conclusions and recommendations

The Committee has organised its conclusions and recommendations around the topics of methadone treatment, Addiction Support Sections (VBAs), follow-up care, psychiatric comorbidity, continuity of care and the Penal Care Facility for Addicts (SOV).

Methadone treatment

The Committee concludes that Dutch penal institutions vary markedly in terms of the methadone treatment that they provide. The Committee feels that this situation is far from ideal. The members of the Committee have explored the problem of how to promote consensus on this issue. They consider that the professionals involved should themselves develop a consensus in order to draw up a guideline for methadone medication for these professionals to follow. Given the large numbers of professional associations and institutions that will be involved in drawing up a common guideline, the Committee considers it vitally important that the activities to be undertaken are coordinated. This, the Committee feels, should be undertaken by the Steering Committee for the Development of Multidisciplinary Guidelines in the mental health care service.

With regard to decision-making about the continuation (or discontinuation) of methadone maintenance treatment in detention, the Committee made the following comments. The Ministry of Justice guidelines recommend that maintenance treatment be continued if detainees had been using methadone prior to their detention and if they plan to resume such treatment after a short period of detention. ‘Short’ in this context is defined as ‘less than four weeks, for example’. Scientific studies have shown, however, that abstinence programmes must be followed for a given period of time if they are to have any effect. The Committee therefore recommends that this four-week period be considerably extended. In this context, the Committee draws a distinction between those detained on remand and individuals who have been sentenced. Methadone maintenance therapy should always be continued for those on remand, provided that addicts indicate

to the physician that this is what they want. This is because the duration of detention for those on remand is, by definition, uncertain. The Committee feels that an abstinence programme (involving reductions in the dose of methadone) should only be considered if the period of detention is to exceed six months, for example. The latter would apply to very few addicts in normal detention. The institution's physician requires the addict's informed consent in order to initiate an abstinence programme.

Addiction Support Sections (VBAs)

The Committee concludes that past studies of the Addiction Support Sections' (VBAs) effectiveness were lacking in clarity. The presence of VBAs has beneficial spin-off effects, such as the introduction of a degree of structure within the institution, and although they are somewhat under-utilised, their continued existence is not in question. In view of these two points, the Committee has opted to put forward suggestions aimed at improving the results obtained by the VBAs. The Committee has listed the conditions under which, in their view, VBAs could be genuinely successful. These are a lowering of thresholds, revised programmes, improved implementation of the admission and orientation programmes, longer stays in the VBA and an expansion of the opportunities for mandatory follow-up care.

One particular goal recommended by the Committee is that future policy should not be so strongly focused on abstinence but that it should also include harm reduction. This might, for example, involve stabilisation using a maintenance dose of methadone. A switch of this kind might make it easier to orient and admit people to the VBA, since it would make the idea of a transfer to the VBA more attractive to addicts. Furthermore, it would enable the range of treatment available at the penitentiary-based VBAs to be better attuned to socialisation-related changes elsewhere in the addiction treatment and care system. The range of programmes available at the VBAs should be modified in accordance with the new goals. In this context, the Committee advocates a practical, down-to-earth approach (for example, retaining accommodation, taking care of debts, social skills training, short behaviour-oriented programmes, resocialisation).

Follow-up care

The Committee has reached the following conclusions with regard to follow-up care. There are indications that the success of interventions in addicted detainees is largely dependent on follow-up care after the period of detention. This post-detention care should be attuned to the detention period and should be just one part of the entire approach. This involves a long-term, intensive and practically oriented sequence of follow-up care, requiring considerable compulsion and monitoring. In the Netherlands,

however, there are limited legal means for compelling addicts to attend specific addiction programmes after they have completed their period of detention. The only option that is presently available involves a combination of unconditional and conditional custodial sentences. Conditional release was dispensed with in the 1980s. In addition, the official duties of the probation service do not extend to the provision of follow-up care after the execution of a sentence or other punishment measure.

The Committee feels that the shortcomings in terms of providing, or imposing, follow-up care within the current Dutch system constitute a major problem. The Committee therefore recommends that all obstacles to the implementation of effective forms of follow-up care be removed, and that conditions be created under which such follow-up care can be realised. In this context, the Committee feels that action should be taken to expand the legal means of compelling individuals to undergo follow-up care (for example, introduction of the option of combining a sentence with mandatory probation contact, and the reintroduction of conditional release). Secondly, the Committee takes the view that one or more organisations should be assigned a statutory monitoring role in the area of follow-up care. Thirdly, there should be better cooperation between organisations that are involved in the preparation and implementation of follow-up care for addicted detainees. Fourthly, all addicted detainees (and ex-detainees) should be assigned a fixed supervisor who will check that they honour the relevant agreements and conditions.

Psychiatric comorbidity

The Committee has reached the following conclusions with regard to psychiatric comorbidity among addicted detainees. In penitentiary situations, more so than elsewhere, the possibility that individuals are suffering from psychiatric disorders should be borne in mind. This is due to the relatively high percentage of detainees who are addicts and to the relatively high percentage of addicted detainees suffering from psychiatric disorders. Another thing that should be more readily available here than elsewhere is psychiatric care. These additional facilities derive from the principle of equivalence. The Committee recommends that professionals, in this case the National Association of Penitentiary Physicians, in consultation with the Forensic Psychiatric Service, should develop numerical standards for the provision of such facilities.

In addition, the Committee takes the view that special consideration should be given to dual-diagnosis patients. These are patients who, in addition to being diagnosed as ‘drug dependent’, have been diagnosed as having a concomitant psychiatric condition. Such patients should be eligible for placement in an Addiction Support Section (VBA), with a view to harm reduction. The pros and cons of placement in a Special Care Section (BZA), an Individual Supervision Section (IBA) or a VBA should be evaluated on a per-

son by person basis. An individual's particular problems largely determine the section in which he can receive the most appropriate care. Consideration should be given to the possibility of transferring people from BZA/IBA to VBA.

Continuity of care

The Committee's conclusions regarding the continuity of care are as follows. Continuity of care is an extremely important principle for the medical supervision of addicted detainees. One of the conditions required to achieve this is an adequate transfer of information from one care provider to another. In the case of addicted detainees, however, there is often no such transfer of information. The Committee feels that this is partly caused by the patient/detainee and partly by the care provider. The Committee has gained the impression that it is the institutional physicians in remand prisons, in particular, who feel that collecting and passing on information about their addicted patients does not have a high priority. The Committee therefore recommends that institutional physicians should assign greater priority to this transfer of information, although it is well aware that the transfer of collected information may sometimes be difficult. Perhaps the National Central Medicine Registration (LCMR) can help to promote this exchange of data between medical practitioners.

Penal Care Facility for Addicts (SOV)

With regard to the Penal Care Facility for Addicts (SOV), the Committee concludes that the fundamental question as to whether this is required is no longer relevant, since the SOV Act took effect on 1 April 2001. The Committee would nevertheless like to make a few remarks about the SOV. In the first place, the Committee feels that there is insufficient evidence to support the effectiveness of the SOV approach. In the second place, the Committee would like to point out the possible drawbacks of the SOV. It feels that insufficient consideration has been given to the matter of whether the SOV might be harmful to addicts. In this connection, the Committee would like to draw attention to issues such as the risk that addicts' motivation to do something about their addiction problems will be weakened rather than boosted by their compulsory placement in the SOV. This would produce exactly the opposite effect to the one intended. Furthermore, the Committee would like to point out that insufficient attention has been paid to the special dynamics of the relationship between those involved in the SOV. This refers not only to the relationship between the addicts and those treating them, but also to interactions between the addicts themselves. Since the addicts are unable to leave, tensions may arise that can find their release in acts of violence. These reactions may transmit themselves to other detainees. The Committee would also like to point out that lengthy exposure to the aus-

tere regime may damage the health of those involved, since they opt to remain here rather than participate in the programme offered by the SOV.

The Committee feels that the SOV measure should be evaluated, as a matter of the utmost importance. Rather than focusing solely on reductions in criminal behaviour, any evaluation of this kind must also address the issue of long-term reduction of the addiction problem. In addition, the evaluation study should also clarify the issue of previously identified adverse effects. The Committee considers an effective registration and analysis of possible disasters to be of the utmost importance. It also feels that the effects of methadone treatment for addicts for whom SOV makes up part of their sentence should be investigated within the context of the SOV evaluation.

Finally, the Committee would like to emphasise the subsidiarity of the SOV. The SOV is by far the most draconian measure within the range of pressure and compulsion that the state can apply to delinquent addicts. This should only be used as a last resort, provided it can be demonstrated that more moderate means (pressure applied by means of special conditions) have been tried and have failed in these individuals. The Committee strongly supports the view that this range of more moderate means should be maintained or framed by the state. It believes that these means could be made more effective. This advisory report identifies the conditions under which this might be possible, and the way in which this could be tackled. The Committee considers the introduction of pressure in the area of follow-up care to be of crucial importance in this regard.

Chapter 1

Introduction

1.1 Request for advice

In a letter to the President of the Health Council (reference GVM/Vz/98734) dated 23 February 1998, the Minister of Health, Welfare and Sport (speaking also on behalf of the Minister of Justice) indicated that she required an overview of the current level of knowledge with regard to the medical supervision of drug addicts under different penitentiary regimes (see Annex A for the full text of the request for advice). The starting point for this overview was to be the influence that the various detention settings can have on the different categories of drug addicts. Consideration was to be given both to the policy pursued by the institution and the interdependence of different medical and penitentiary regimes, as well as to the duration of detention. On this premise, the Health Council was to indicate what options are available, according to current thinking, for the treatment of addicted detainees.

The Minister then explained what she meant by different categories of drug addicts. In doing so, she referred to differences in the nature, severity and duration of addiction, pointing out that the possibility of psychiatric comorbidity also needs to be taken into account. She noted that these different categories may possibly require a different approach under different penitentiary regimes.

When she referred to ‘options for treatment’, the Minister not only had pharmacotherapeutic treatments in mind, but also non-medicinal measures. It is, she said, appropriate that the Health Council should also examine the impact of different forms of pressure and compulsion that can be applied when offering a treatment, with the primary

aim here being to use the detention period to bring about a change in the addict's behaviour. The Minister realised that medical and penitentiary regimes are closely intertwined.

Finally, the Minister requested the Health Council to consider the possible benefit of continuity of care before, during and after the detention period. She assumed that the Health Council would take into account the fact that recent years have also seen the development of a body of knowledge in connection with 'care' and 'implementation of care'.

1.2 Background to the request for advice

In her letter, the Minister looked briefly at the background to the request for advice. She pointed out that her predecessors and those of the Minister of Justice have been giving attention to problems experienced with the care, treatment and medical supervision of addicts since the early 1980s. This gave rise to a number of policy documents and debates in the Second Chamber. The intention of the resultant policy decisions was, on the one hand, to enhance the physical, psychological and social situation of addicts, and on the other hand – especially more recently – also to limit the nuisance that addicts can cause. According to the Minister, manifest progress has been made in both of these areas. Both she and the Minister of Justice acknowledged, however, that certain aspects of the situation can be further improved.

The Minister then referred to the increased number of addicts in penal institutions, which is a direct consequence of the efforts that have been made to curb troubles to society. It is estimated that around half of all detainees in these establishments have addiction problems of some kind. Citing the report of the Van Dinter Committee (1995), the Minister emphasised that the number of drug addicts cannot be precisely determined "since there is no unambiguous definition of addiction, and the figures are based on the assertions of the detainees themselves". Approximate estimates of the number of addicts detained every year – whether for relatively short or long periods – put the figure at around 18,000, though account needs to be taken of the fact that the same individual may be counted several times over, since drug users frequently relapse. Treatment of these detainees poses considerable problems for the judicial system.

The Minister then emphasised the diversity of opinions regarding the medical supervision of addicts on hard drugs during detention. These divergent opinions are reflected in the different penal institutions. As a result, she said, it is – for example – not currently possible to give an unequivocal answer to the question of whether it is advisable to give (or continue giving) methadone to addicted detainees. Nor, according to the Minister, is there any clear-cut answer to the question as to whether the commencement of detention can be the reason for changing an addict's medical supervision.

1.3 Analysis of aspects of the request for advice

The principal question posed by the request for advice is as follows:

- What, according to current thinking, are the treatment options for drug-addicted detainees?

This key question can be broken down into a number of subsidiary questions that are summarised below. We also indicate the chapter of this advisory report in which each question is answered.

- What categories do drug-addicted detainees fall into (Chapter 2)?
- What is known about psychiatric comorbidity within these categories (Chapter 2)?
- What is the legal framework underlying the treatment of drug-addicted detainees (Chapter 3)?
- In which detention settings or regimes are drug-addicted detainees held (Chapter 4)?
- What treatment options (medical and non-medical) are available for different categories of detainees who are addicted to drugs (Chapter 4, Chapter 5)?
- What is the current level of knowledge with regard to these options (Chapter 5)?
- What limitations does detention impose with regard to the performance of treatments in general and the performance of the treatment options that are available for the different categories of drug addicts, in particular (Chapter 3, Chapter 6)?
- Besides imposing limitations, does detention also present opportunities as far as treatment options are concerned (Chapter 6)?
- What forms of pressure and compulsion can be identified in connection with the treatment of drug addicts in a detention setting (Chapter 3, Chapter 4)?
- What is known from the scientific literature about the effectiveness of pressure and compulsion in connection with addicted detainees (Chapter 5)?
- What relevance does continuity of care before, during and after the detention period have in relation to the treatment options for addicted detainees (Chapter 5, 6 and 7)?
- How can continuity of care be realised (Chapter 6 and 7)?

1.4 Scope

This advisory report is not aimed at addiction problems in general, but exclusively at drug addiction, since the request for advice confines itself to this particular issue. Alcohol, gambling and other addictions receive only cursory attention.

The Committee draws readers' attention at this juncture to the activities of another Health Council committee, namely the Committee on Pharmacotherapeutic Interventions in Drug Addiction. That Committee is reporting on the current level of knowledge

regarding pharmacotherapeutic interventions for drug addicts in general. In this advisory report, the emphasis is placed on the level of knowledge regarding the medical supervision of addicted *detainees*. Therefore, the subject-matter of this advisory report (drug-addicted detainees) is on the one hand more limited than that of the other Committee (drug addicts in general). On the other hand, however, the subject-matter is also broader, since this advisory report does not confine itself to pharmacotherapeutic interventions. Where necessary, reference will be made to the report of the Committee on Pharmacotherapeutic Interventions.

The above-mentioned limitation to the detention setting implies that events prior to detention will only be considered indirectly here – for example, where this is necessary in relation to continuity of care. Criminal law affords possibilities for making justiciable addicts undergo treatment as an alternative to detention, under threat of a penal sanction (i.e. imposed conditions with regard to behaviour). These possibilities are likewise indirectly considered in this advisory report. Events following the detention period are discussed where they may have a bearing on follow-up care and continuity of care. This can, of course, include admission to a residential treatment centre.

In effect, the Minister is asking the Health Council to give consideration to the different forms of compulsion and pressure under which treatment can be offered. The Committee has applied this question to the detention situation in the context of deprivation of liberty (see section 1.5 for a definition of this term), because this situation forms the crux of the request for advice. It formulates the question that needs to be addressed in relation to compulsion and pressure as follows: To what extent can the detention situation be used in order to bring about positive changes in a person's addiction, whether or not through the use of compulsion or pressure?

1.5 Definitions

The definitions of several important terms that the Committee will employ in this advisory report are examined below. The terms in question are addiction, deprivation of liberty, supervision, treatment, care, medical, and compulsion and pressure.

Addiction

'Addiction' is a widely used term and also appears in the name of the Committee. From a scientific viewpoint, however, it is somewhat imprecise. The essence of the term is dependence (as manifested in loss of control, unsuccessful attempts to stop, etc.), but in everyday usage the term 'addiction' sometimes also refers to abuse, or else harmful use (that is to say, harmful to the health of the user), without there being any question of

dependence. Wherever the term ‘addiction’ is used in this advisory report, the intended meaning is ‘dependence’.

Not only are the definitions of the term ‘dependence’ in two widely used psychiatric classification systems (DSM-IV and ICD-10) extremely similar from a conceptual point of view, but in empirical studies too, dependence according to the DSM-IV definition and dependence according to the ICD-10 definition appear to be almost completely synonymous.

Furthermore, the DSM-IV has a section entitled ‘abuse’, while the ICD-10 has one entitled ‘harmful use’. Both relate to disorders in which the patient in question does not conform to the diagnosis of ‘dependence’. The ‘abuse’ diagnosis relates to a pattern of use in which the concerned individual can potentially expect to experience problems in his psychological and/or social functioning, whereas the diagnosis ‘harmful use’ involves a pattern that has given rise to physical and psychological harm. Research has shown that the ‘abuse’ diagnosis has a lower threshold than the diagnosis ‘harmful use’ (in virtually all of the studies, more people satisfy the diagnosis of ‘abuse’ than ‘harmful use’). Moreover, the overlap between the rather more severe patients with an ‘abuse’ diagnosis and the patients with a ‘harmful use’ diagnosis is also minimal. In short, we appear to be dealing with two somewhat different concepts of an inappropriate pattern of use that does not satisfy the criteria for the ‘dependence’ diagnosis. The World Health Organisation has opted for the diagnosis ‘harmful use’, since this diagnosis appears to be somewhat less culturally sensitive.

In general, the Committee’s deliberations relate to dependence.

Deprivation of liberty

In this advisory report ‘deprivation of liberty’ is understood to mean detention on remand, imprisonment and the Penal Care Facility for Addicts (SOV).

Supervision, treatment, care

It is a long-established principle within the Dutch prison system that offenders are not ‘treated', but ‘supervised’. The purpose of a penal institution is not to administer treatment: deprivation of liberty in connection with imprisonment must not be used in order to make someone undergo psychiatric treatment. In any case, a distinction needs to be drawn between sentencing someone to imprisonment in order to make him undergo treatment and offering treatment once the sentence has been imposed.

The Explanatory Memorandum accompanying the Penitentiary Order (PM), which is an Order in Council accompanying the Custodial Institutions Act (PBW), effectively states that, in principle, treatment for a psychiatric disorder does not take place within

the prison system. In practice, however, an increasing number of exceptions are being made to this principle (Veg99). Not infrequently, it is asserted that these cases do not constitute treatment; instead, there is a tendency to apply the label of 'supervision'. This is the background to the growing practice within the prison system of consistently using the term 'supervision' for measures which, in a different context, would be termed 'treatment'.

The Committee agrees with Vegter (Veg99) that it is artificial to draw a distinction between treatment and supervision, since in practice the measures involved are usually the same. If the Committee were to adopt this distinction, it would create the erroneous impression that the distinction has a scientific background, which is not the case.

In the context of this advisory report, the Committee prefers to interpret 'supervision, treatment and care' as a single, unitary concept and hence to define it broadly, thereby avoiding subtle, possibly ideologically charged, distinctions and questions of definition. The Committee also has the following reasons for adopting this approach:

1 This advisory report is concerned with people whose freedom has been taken away from them, and thus situations involving an imbalance of power. Considering these situations, the Committee finds it important to choose the definitions in such a way that the applicability of the Medical Treatment Agreements Act (WGBO) is emphasised in situations of this kind. The WGBO is a statutory framework that is, in theory, eminently suitable for regulating these situations.
2 The Medical Treatment Agreements Act also adopts a broad definition of "actions performed in the field of medicine" as defined in Article 446 of Book 7 of the Netherlands Civil Code (BW), also including nursing and care in this category insofar as these are performed in connection with the medical actions.

In those normative sections of its advisory report where the Committee uses the terms supervision, treatment or care, it is therefore referring to this broad nexus of terms, for which it generally uses the term 'treatment'. This not only includes measures that seek to achieve a cure, but also measures that aim to stabilise the patient's mental condition or to prevent the development of new pathology, including the necessary nursing, supervision and care. With this in mind, the Committee has entitled its advisory report 'Treatment of drug-addicted detainees'.

Medical

The term 'medical' is less widely used by practitioners than in other circles. Not surprisingly, therefore, it does not appear in the DSM-IV glossary or among the ICD-10 definitions. The Committee wishes to emphasise that the term 'medical', as used in this report,

has a broad sense and it therefore embraces not only somatic, but also psychological and social aspects.

Compulsion, pressure

As far as compulsion and pressure are concerned, we endorse the definitions used by the National Advisory Council for Public Health (NRV) in *Wéldoen of niet doen (*Do good or do nothing*)* (NRV92), its discussion document on the use of pressure in mental health care, and those adopted by the Health Council in the advisory report *Dwang en drang in de tuberculosebestrijding* (Compulsion and pressure in tuberculosis control) (GR96a). The Committee has a slight preference for a two-stage process, pressure/compulsion, over the three-stage model, persuasion/pressure/compulsion, since persuasion and pressure are difficult to distinguish from one another – both theoretically and in practice.

Compulsion is understood to mean an intervention that takes place despite, or else against, the wishes of the patient, while pressure is construed as an intervention in which a final appeal is made to the patient in order to motivate him in a particular direction. This will often be achieved by forcing someone to choose between two possibilities, whereby one option has been made marginally more attractive than the other. The essence of the distinction between compulsion and pressure is that compulsion leaves the patient with no choice whatsoever, whereas pressure does allow the patient some (albeit minimal) freedom of choice. In the case of compulsion, the concerned individual may be induced to do something by means of physical force, which is inconceivable when merely applying pressure. Whereas compulsion renders the undesirable behaviour impossible, pressure merely involves making that behaviour unattractive.

Although the distinction is clear in theory, the boundary between compulsion and pressure is sometimes difficult to define in practice. It may be that the pressure is so intense that the concerned person has no real possibility of backing out – in which case what is being applied is, in fact, no longer pressure, but compulsion.

1.6 Working methods

The Committee has chosen not to hold hearings, since it was already sufficiently familiar with the positions of the various parties involved. Its Chairman and Secretary did, however, have a discussion with Prof. A.M.H. van Leeuwen, the District Psychiatrist in Maastricht, about his policy on (the reduction of) methadone.

For the purposes of Chapter 2 (Nature and extent of the problem), use was made of data from the Ministry of Justice's TULP system (among other sources). This data was provided by Mr P. Linckens of the Department of Information Analysis and Documentation in that Ministry's Correctional Institutions Agency.

When examining the international literature in connection with Chapter 5 (Current level of knowledge), the main emphasis was placed on recent review articles and meta-analyses. Where these were not available, primary sources were studied. The review of the literature was concluded in September 2001. For an account of the current level of knowledge concerning pharmacotherapeutic interventions in drug addiction, the Committee refers the reader to the advisory report of the Health Council Committee of the same name (GR02). Chapter 5 outlines the principal findings of this Committee with regard to the treatment of addiction to opiates (especially in relation to methadone therapy).

1.7 Organisation of the advisory report

The organisation of this advisory report is as follows. Chapter 2 starts by weighing the facts with regard to addicted detainees (insofar as they are known), addressing such questions as: How many people are involved? What is the nature, severity and duration of their addiction? What is known about comorbidity (accompanying psychological and physical disorders)? What do we know about the use of drugs during detention? And how long do addicted detainees generally remain in penal institutions?

Chapter 3 then outlines the legal framework within which the medical supervision of addicted detainees takes place: What legislation and regulations are in place? What obligations is the government under as far as the care of detainees is concerned? What possibilities does criminal law afford for pressuring suspected and proven offenders who are addicted to drugs into undergoing treatment? And what legal instruments can be applied in order to achieve continuity of involvement?

Chapter 4 describes penal addiction policy, and organisational and practical aspects of the care of addicted detainees. Attention here is focused, among other things, on the different regimes, with their respective treatment options, the policy on methadone, the developments surrounding the Addiction Support Sections (VBAs), and the introduction of compulsion into the care of addicts (Penal Care Facility for Addicts (SOV)). This chapter closes with a description of the organisation and structure of the probation service.

Chapter 5 presents an explanation of the current level of knowledge regarding the treatment of addicted detainees. The spotlight then falls successively on the effectiveness of the treatment of cocaine addiction, addiction to opiates and drug addiction in detention, the effectiveness of judicial compulsion and pressure in the treatment of addicts, and the effectiveness of follow-up care programmes.

In Chapter 6 the Committee discusses what is, and what is not, possible in connection with the treatment of drug-addicted detainees. Chapter 7 contains the Committee's

conclusions and recommendations. This chapter, together with Chapter 6, forms the normative section of the advisory report.

Chapter 2

Nature and extent of the problem

This chapter describes the nature and extent of the problem, insofar as this is possible given the available data. How many detainees have addictions, what is the nature, severity and duration of their addiction, what role is played by comorbidity (the presence of other psychological and physical disorders), what are the distinguishing demographic characteristics of addicted detainees, and what is their history of interaction with the professional practitioners? What do we know about the use of drugs during detention? And what is known about the periods of detention served by addicted detainees?

2.1 The number of addicted detainees

On 1 January 1999 there were around 11,100 detainees in penal institutions in the Netherlands (excluding youth custody centres and placement under a hospital order). During 1999 as a whole, a total of nearly 47,000 people were detained in these establishments (DJI01). It is possible that half of them had addiction problems of some kind or another. It is impossible to give an exact figure for the number of drug addicts in penal institutions, but estimates can be made, based on data recorded at the national level and research into the prevalence of addiction problems in individual establishments.

In 1971 prevalence in remand prisons was still 10% (Wis71). More recent estimates put the figure considerably higher, ranging from 35% (Erk87) to 50% (BGI92, NeV96). In the request for advice, the Minister referred to the report of the Van Dinter Committee, which likewise estimated the percentage of alcohol and/or drug addicts within penal institutions at 50% (Din95). This Committee emphasised the impossibility of putting an

exact figure on the number of drug addicts, since there is no unambiguous definition of addiction and the figures are based on the assertions of the detainees themselves. The Van Dinter Committee established that the percentage of detainees addicted to hard drugs has shown an upward trend in the past few years. According to this Committee, there has been no parallel increase in the total number of addicts in the community in recent years that might explain this development. In her request for advice, the Minister therefore established a link between the increase in this percentage and the government's efforts to curb the nuisance that addicts can cause.

National data

The only registration system that can provide national figures is the TULP system operated by the Department of Information Analysis and Documentation (formerly known as the Management Information department) of the Ministry of Justice's Correctional Institutions Agency (DJI). TULP is a Dutch acronym meaning "enforcement of custodial measures in penal institutions". The purpose of this registration, which is kept up to date by the records office of the institution in question, is to promote the due process of law or else the proper enforcement of a sentence. Detainees are registered on arrival, based on the documents that accompany them (i.e. not on the basis of a conversation with the detainees themselves). The section on 'addiction' forms part of a series of data that includes such items as diet, religion/creed and language. Although the TULP user's manual does not contain a definition of what is to be understood by 'addiction', according to the additional options listed in the registration form, addiction to drugs is, in any case, included in addition to addiction to alcohol and gambling. Nor does the manual give a closer definition of the term 'drugs'.

The 'addiction' section of the form is not filed in for many detainees. Penal institutions apparently lack sufficient data to classify newly arrived detainees as being either addicts or non-addicts, which could also be linked to the fact that justiciable addicts have insufficient reason to declare their addiction in their contacts with the police. Thus, even though the data that the TULP system can provide on the incidence of addiction among detainees is deficient, we shall nevertheless reproduce it below, since it is the only national data that is available to us.

A total of 23,784 detainees re-entered society in 2000*. For 13,321 of them, the section on addiction was not filled in. Therefore, it was not known in around half of the cases whether the detainee in question was addicted. Addiction to drugs was recorded in

* Detainees who have been released from a detention centre for aliens have not been taken into account. The same applies to convicted detainees who have avoided detention and people who have been released following suspension of their pre-trial detention.

3,801 cases and multiple addictions were recorded in 218 cases. There were 5,705 cases in which it was stated that the detainee was not addicted. Based on the data from the TULP system, we arrive at a figure of approximately 16% drug addicts. This is to be regarded as a minimum percentage because of the incompleteness of the data.

Data based on research in penal institutions

In addition to data recorded at the national level, estimates of the percentage of addicted detainees can also be based on research into the prevalence of addiction problems in individual penal institutions. The percentages discovered in such studies vary. There is no single facility that can be regarded as representative of the entire Dutch prison system. The variation in the results arises from the diverse nature of the prison population, and from differences in experimental methods and the definition of addiction. We distinguish below between studies that attempt, as far as possible, to arrive at a representative group of detainees and those that specifically select a particular subgroup of detainees.

Examples of studies that sought to examine a representative group of detainees are those performed by Schoemaker and Van Zessen (Sch97) and Koeter and Luhrman (Koe98). Schoemaker and Van Zessen conducted an investigation at Scheveningen Penitentiary Complex in 1997 in order to determine the prevalence of mental disorders among detainees. Their study group mainly consisted of detainees in remand prisons, including both detainees held under the standard regime and those in Special Care Sections (see sections 4.1.3 and 4.1.4 of this report for an explanation of these terms). They used structured diagnostic interviews, as featured in the Composite International Diagnostic Interview (CIDI) system, with a sample survey of detainees and a survey of prison psychologists. To allow for comparisons between the two sets of opinions, the same classification system (namely DSM-III-R*) was used in each part of the study. This system draws a distinction between abuse of substances and dependence (see section 1.5). Abuse of substances also covers abuse of alcohol or soft drugs. Based on the CIDI interviews in the standard and Special Care sections, the monthly prevalence for dependence/abuse of substances (alcohol *and* drugs) was 18.5%, the annual prevalence was 44%, and the lifetime prevalence 60%. For drug abuse, the monthly prevalence was nearly 1%, the annual prevalence nearly 7% and the lifetime prevalence more than 18%; the corresponding figures for drug-dependence were more than 13%, nearly 29% and more than 36%, respectively. According to the psychologists, 36% of the detainees in the institution as a whole (excluding the hospital) could be said to have alcohol or drug

* DSM-III-R includes cocaine addiction. Cocaine was included in research employing this classification system, even though there is no explicit breakdown into opiate and cocaine addiction.

problems. Schoemaker and Van Zessen believed that the psychologists underestimated the incidence of mental disorders, especially in the standard wings, because they lacked information on the detainees there. The same could also apply in the case of addiction problems.

Koeter and Luhrman conducted research in the period from 1995 to 1997 among detainees in two standard wings and two drug-free wings of the Overamstel Penal Institution in Amsterdam (popularly known as *Bijlmerbajes*). Among the investigative tools employed were two structured interviews (EuropASI (the European version of the Addiction Severity Index) and the CIDI) and the Personality Disorder Questionnaire, Revised edition (PDQ-R). Cocaine was included in this study.

In this study, respondents were classed as 'addicted' if, in the course of the previous two years, they had regularly used drugs for a period of at least two months and if they had a severity score of more than 4 in the 'Drugs' section of the EuropASI (a severity score of 4-5 in this section indicates that the problem is fairly serious and that some form of treatment is probably necessary). The estimated prevalence of regular substance use was 51%. Of these 51% regular users, 87% satisfied the criteria for addiction (i.e. 44% of all detainees). This ties in nicely with the findings of Schoemaker and Van Zessen, who identified an annual prevalence of 44% for substance dependence/abuse. Based on this study, the prevalence of severe drug addiction problems (defined as a severity score of >6 in the Drugs section of the EuropASI; a severity score of 6-7 indicates a fairly serious problem, for which treatment is required) among detainees in standard wings was estimated at 29%. This estimate is in line with the annual prevalence of 29% detainees who satisfied the DSM-III-R criteria for drug-dependence as reported by Schoemaker and Van Zessen.

In addition to representative groups of detainees, research has also been conducted with specific groups of detainees. This category includes the studies by Bulten (Bul98), Van den Hurk (Hur98), and Bieleman and Van der Laan (Bie99). Bulten studied 200 young male short-term offenders at Nieuw Vosseveld juvenile prison, Vught, in the early 1990s. The concerned individuals were between 18 and 24 years of age. One of the investigative tools used was the Diagnostic Interview Schedule (DIS). Among the parameters measured were addiction problems according to DSM-III (dependence and abuse). Almost 58% had experienced a drug addiction disorder at some time in their lives, while more than 48% had the disorder the previous year and more than 19% had it the previous month. Two-thirds of the experimental population had experienced addiction problems (alcohol, drugs and gambling) during the year preceding the study, whereas nearly 80% had experienced such problems at some time in their lives.

Van den Hurk conducted research in 1990 and 1991 among addicted detainees in VBA units (see section 4.1.4) at two penal institutions, namely Noordsingel remand

prison in Rotterdam and the Drug-Free Shelter (DOC) in Doetinchem (part of Kruisberg prison). Among the investigative tools used were the DIS and the Addiction Severity Index (ASI). As might be expected in this particular population, the prevalence of addiction problems (defined according to DSM-III criteria) was high. On a lifetime basis, 94% were found to have experienced addiction problems. Broken down by type of addiction, 85% of the respondents had, on a lifetime basis, experienced a drug addiction, 63% an alcohol addiction and 17% a gambling addiction. 'Recent' (i.e. during the previous six months) prevalence of addiction problems was also high (82%), while 71% had 'recently' been addicted to drugs.

As part of an inventory study of the functioning of probation for addicts, Bieleman and Van der Laan interviewed 91 detainees who were known to have had substance-use problems. These individuals were being held in the facilities at Kruisberg, Overamstel, IJssel and Nieuw Vosseveld. Three quarters of the detainees interviewed had a drug-related problem, more than one tenth (14%) being addicted to alcohol or to a combination of alcohol, drugs or gambling (10%), while only a handful (2%) were addicted to gambling only. The percentage of drug addicts varied somewhat from one institution to another. Of the 91 interviewees, 96% had used alcohol or drugs excessively in the three months prior to detention.

The conclusion is that the prevalence of addiction problems identified among detainees ranges from around 16% (TULP system) to 80% (Van den Hurk), depending on the population studied, the experimental methods used and the definitions applied. The figures produced by Schoemaker & Van Zessen and van Koeter & Luhrman are particularly representative and, moreover, they are very similar. These authors report that around 44% of the detainees have addiction problems in the sense of substance abuse/dependence (alcohol *and* drugs). If we look at drug-dependence, i.e. serious drug addiction problems, then this figure approaches 30%.

The figures from the TULP system (16% drug addicts) must therefore be regarded as an absolute minimum. A more serious estimate might easily be nearly 30% (for drug-dependence) and, if a broader definition of the problem is adopted (abuse of substances in general), 44%. Percentages that relate to specific detainee populations come out well in excess of 50%.

2.2 Distinguishing characteristics of addiction and addicts

In order to identify the nature, severity and duration of addiction, and a few distinguishing characteristics of addicted detainees, we shall once again turn to research conducted among representative groups of detainees (Koeter and Luhrman (Koe98)) and in specific populations (Van den Hurk (Hur98), Bieleman and Van der Laan (Bie99)). Consid-

eration is given first of all to research in specific populations of detainees, and then to research among representative groups of detainees.

For the majority of the population of addicted detainees studied by Van den Hurk, the drugs of choice were heroin and/or cocaine. A minority identified cannabis, alcohol or methadone as the principal problem. For most of them, heroin and/or cocaine was also found to be the second choice. The majority could be regarded as polydrug users. Cannabis tended to be the first substance to be tried, followed by alcohol and heroin. The average respondent started using cocaine and methadone somewhat later. Simultaneous use of several substances began, on average, at the age of 19. 'Chasing the dragon'* was the most popular mode of use. Injecting – with the attendant risk of infection – was the preferred mode of use for one in six.

Around a third of the total experimental population had not been drug-free at any time during the previous three years and 14% had been 'clean' for no longer than one month. Only 10% had been clean for longer than a year (Hur98, p. 74).

Around two-thirds of the respondents in Van den Hurk's study had occasionally made use of some form of drug support programme (methadone programme, drug-free therapeutic community, detoxification, drug-free day treatment, etc.). The experimental population tended to be relatively old (average age 30 years), with a disproportionate number of people of non-Dutch origin (46%), extremely poorly educated, single and with many problems within the parental family.

Of the detainees interviewed by Bieleman and Van der Laan, three quarters (74%) were addicted to drugs, while 96% had used alcohol or drugs to excess in the three months prior to detention. A third of them named cocaine (32%), and a third heroin (31%), as their drug of choice in the three months prior to detention. Other substances mentioned were alcohol, cannabis and amphetamine. Of this group, 85% used more than one substance (with cocaine and heroin being the combination involved in 51% of the cases). Another common combination was cocaine/heroin and cannabis. As far as age is concerned, it is striking that the under-25 category mainly named cannabis (36%) and amphetamine (21%) as the drugs of choice, while the 25-34 year olds mainly cited cocaine (53%) and the over-35 category, mainly heroin (51%). The majority had been in contact with a drug support service apart from the prison addiction probation unit (in most cases it was the community addiction probation services).

The vast majority of the addicts in the various penitentiary settings studied by Koeter and Luhrman named heroin and/or cocaine as the most problematic substances. Poly-

* 'Chasing the dragon' means heating a small quantity of heroin or cocaine-base on aluminium foil and inhaling the vapour through a tube which is held in the mouth

drug use was widespread. Cannabis was very much further towards the bottom of the list. The percentage of polydrug use is higher in all settings than exclusive use of either heroin or cocaine. Nearly 28% of the addicts in normal detention had injected at some time, whereas this figure stood at around 40% in the sections designated for compulsory placement of 'street junkies'. More than 10% of the addicts in normal detention had injected in the previous six months and around 8% within the previous month. On average, injecting started between the ages of 21 and 24. Unsafe injecting – i.e. injecting with needles that have already been used by someone else – seldom occurs.

Around half of the addicts in normal detention have previously been treated for their addiction problems (detoxification, inpatient, outpatient), while just under half have never previously received treatment. The number of addicts who have never been treated before is considerably lower in the drug-free wings. More than 40% of the addicts have never succeeded in voluntarily abstaining for a period of at least one month since the onset of their addiction. For the addicts in normal detention who had managed to do so, this had occurred around an average of 2½ years previously. Approximately 20% of the addicts in normal detention have, on one or more occasions in their lives, taken an overdose. Apart from those who had voluntarily opted for a drug-free wing, addicts spent an average of NLG 2,500 – 3,000 on drugs in the 30 days preceding their detention.

Koeter and Luhrman's findings with regard to the severity of the addiction problems identified were as follows. Sixty six percent of the addicts whom they studied in the normal detention wings were found to have serious addiction problems (a severity score of >6 in the Drugs section of the EuropASI). Indeed, addicts in normal detention displayed a lower prevalence of heroin and cocaine use than addicts in drug-free wings and in the 'Street Junkies' Project ('compulsory placement', see also section 4.2.5 with regard to Demersluis Prison). They also had less contact with the addiction treatment and care system, injected less, had less need for help with addiction problems and had a considerably lower lifetime and monthly prevalence of methadone use. However, these differences disappeared when the subgroup of addicts in normal detention with serious addiction problems was compared with the addicts in the drug-free wings and in the 'Street Junkies' Project. As far as user characteristics are concerned, this subgroup was virtually identical to the addicts in the drug-free wings. Of this group, 26% claimed never to have received treatment, while 40% had injected at some time in their lives (16% of them in the previous six months and 13% within the previous month). Nobody named cannabis as their most problematic substance. Seventy-five percent admitted to being troubled by their addiction problems and 62% said they needed help with these problems.

With regard to duration of use, Koeter and Luhrman (Koe98, pp. 31 ff.) found that 72% of the addicts in normal detention (ASI severity score >4) had used heroin regu-

larly (more than three times a week) at some point in their lives and almost 80% had used cocaine regularly. Eighty-seven percent indicated that they had regularly used more than one substance per day. Those who reported regular heroin use had been taking this substance for an average of 8 years, while the regular cocaine users had done so for an average of around 7 years and those who said they had regularly used more than one substance per day had done so for an average of almost 9 years. Koeter and Luhrman also looked at the monthly prevalence (i.e. use during the 30 days prior to the interview) in the same population. Nearly 65% reported having used heroin in that period, while more than 71% had used cocaine, and 84% more than one substance per day. The number of days for which these substances were used in this period was approximately 19. All of these figures were found to be higher in the subgroup of addicts with serious addiction problems in normal detention. The majority of addicted detainees have, therefore, been addicted for many years.

Reviewing the demographic characteristics of the justiciable drug addicts in their study, Koeter and Luhrman characterise their experimental population as being in their early thirties, poorly educated, largely unemployed and relatively often of foreign origin.

This study showed that, besides the large group of polydrug users, there is a small group of detainees who only use cocaine. Nothing is known, however, about the size of this group, whether it is growing or the distinguishing characteristics of these users. According to the 2001 annual report of the National Drug Monitor, 10 to 15% of problematic hard-drug users use cocaine alone (without also using heroin). Some members of the group of detainees that only uses cocaine seem to use this drug to facilitate their criminal behaviour, and in these cases comorbidity appears to be limited to the antisocial personality disorder. This must first be corroborated by means of scientific studies. The number of opiate addicts in the general population remains relatively stable, and the average age of this group is increasing. After an increase in the period from 1988 to 1996, cocaine use by young people aged 12 and over stabilised in 1999 (annual report, National Drug Monitor). In all probability, very few of those detainees who only use cocaine would have been treated by the addiction treatment and care system prior to their detention.

Summing up, it may be said that the majority of addicted detainees are polydrug users and that the most widely used substances are heroin and cocaine. In general, they are relatively (i.e. compared with the total detainee population) old (early thirties), poorly educated, have little work experience and are frequently of foreign origin. Those indicating that cocaine was their drug of choice are, in general, younger than those who mainly use heroin. An estimated 17% of the addicted detainees inject the substance. The over-

whelming majority prefer to inhale their drug of choice (by snorting or smoking it). Far more is thus inhaled than is taken intravenously. Two-thirds of the addicts in normal detention probably have to contend with serious addiction problems. Addicted detainees have frequently already been addicted for many years – especially if they suffer from serious addiction problems.

2.3 Comorbidity (accompanying psychological and physical disorders)

Psychiatric comorbidity

The prevalence of mental disorders among detainees is significantly higher than in the general population. Bulten *et al*. have recently summarised the international literature on psychopathology in detainees (Bul99). Comorbidity also appears to play an important role in the case of many addicts serving custodial sentences. In reporting what is known about this phenomenon with regard to the Dutch situation, we once again draw a distinction between research among representative groups of detainees (Sch97, Koe98) and research among specific groups of detainees (Bul98, Hur98). We shall look first of all at research among representative groups and then at research in specific populations.

Schoemaker and Van Zessen (Sch97) found that 60% of the detainees in the remand prisons had at least one diagnosis according to DSM-III-R in a period of one year: 20% had a mental disorder, 20% were addicted, and 20% had both diagnoses. Thus, 50% of the addicts had an accompanying psychiatric disorder. According to the psychologists interviewed by the authors, 16% of the detainees in the standard wings with addiction problems also had another mental disorder. According to these psychologists, 48% of the detainees in the standard wings whom they considered to be mentally disturbed were also addicted.

In the Addiction Support Section (VBA), only one in ten detainees had another mental disorder, according to the psychologists. In the authors' opinion, this is a surprisingly low percentage, since one might assume that the population of a VBA, which largely consists of problematic drug users, would include a relatively large number of people with a mental disorder. One explanation – not adduced by the authors – could be that an acute psychiatric disorder is a contra-indication for placement in a VBA (see also section 4.1.4 under the heading "Special care for addicts: the VBA"). A further explanation might be that the psychologists have confined themselves exclusively to the presenting problem(s).

Based on their research findings, Schoemaker and Van Zessen are of the opinion that the psychologists generally underestimate the psychological problems of the detainees. According to the authors, this is due not only to the concealed nature of many disor-

ders, but also to the high turnover of detainees and the limited extent of the Psychomedical Teams (PMTs). They consider it not inconceivable that monitoring can be improved by expanding these teams (both in terms of their responsibilities and their scale). The number of meetings between detainees and members of the team can consequently be increased and there will be more scope for holding an intake interview with a larger proportion of the detainees on arrival.

According to Schoemaker and Van Zessen, the penal institution workers (Dutch acronym, PIWs) have an important function in identifying disorders that are evinced in manifest behaviour. However, they consider the PIW teams to be less suitable as monitors of signals that might point to psychological problems as such.

According to Koeter and Luhrman (Koe98), almost 60% of the detainees in normal detention who satisfy the criteria for ‘addiction' (ASI>4) have to contend with psychological problems not directly connected with their addiction. Forty percent of the addicts display dual-diagnosis problems, i.e. a combination of serious addiction problems and serious psychological problems (notably depression, psychosis, antisocial behaviour and self-mutilation). The problems are even more complex in 20-30% of the detainees (dual-diagnosis problems *and* serious problems in at least one of the following areas: physical health, employment/education/income, alcohol, family and social relationships). The average age of detainees with serious addiction problems was 33.6 years (compared with 28.7 years for detainees without these problems), while that of detainees with dual-diagnosis problems was 31.9 years and for detainees with complex problems, 32.6 years.

Koeter and Luhrman concluded that addicted detainees are characterised by numerous psychological complaints. The vast majority of them also have a personality disorder. A large proportion of the addicts are seriously troubled by their addiction and other psychological problems, and have need for help with these problems. These authors find it important that attention should be paid when training penal institution workers to the recognition of addiction problems and psychological problems, and that strategies should be offered for dealing with these problems, since for the most part the penal institution workers fail to recognise them. Moreover, Koeter and Luhrman point out that the treatment options for addicted detainees must not be overestimated, given their limited intellectual capacities and the high prevalence of personality disorders.

Bulten conducted research among a specific group of detainees, namely detainees in a juvenile prison aged from 18 to 24 years (Bul98). He, too, found a strong association between addiction problems and other forms of psychopathology (Bul98). He concluded that there is a high comorbidity between addiction problems and antisocial personality.

Bulten found that Axis I disorders (notably mood disorders, anxiety disorders, schizophrenia and other psychotic disorders) frequently precede the addiction. This, he

says, supports the hypothesis that, in this group of individuals, addiction shares certain characteristics with 'self-medication'. He also points out that polydrug use is most prevalent in detainees with a lifetime Axis I disorder and a lifetime anti-social personality disorder. According to Bulten, this combination of Axis I disorders, personality pathology and polydrug use underlines the inherent complexity of the problems confronting this specific subgroup of detainees.

This applies to 16% of Bulten's experimental population, a finding that ties in reasonably well with the size of the problematic groups reported by Schoemaker and Van Zessen (mentally disturbed *and* addicted: 20%) and Koeter and Luhrman (complex problems: 30% of 50% = 15%). Bulten maintained that his percentage is, in all probability, still an underestimate, since the Axis I and Axis II personality disorders have not been exhaustively investigated. He perceived a need for close co-ordination between the addiction treatment and care system and the prison mental health service.

Van den Hurk also studied a specific population, including detainees who had been placed in a VBA and in a drug-free shelter (Hur98). Using the Diagnostic Interview Schedule (DIS), he established that 56% of the respondents had, at some point in their lives, suffered from a clinical psychiatric illness, that is to say an affective, anxiety and/or schizophrenic disorder. One in three detainees were diagnosed with an anxiety disorder, one in five with an affective disorder, and one in ten with a schizophrenic disorder. Nearly half of the respondents had also recently suffered from a disorder of this kind. This percentage was only 12% lower than the lifetime percentage. According to Van den Hurk, these figures tie in with those from other studies performed with the aid of the DIS, in which similarly high prevalence figures were discovered.

Based on the research findings reported here, we can assume that at least half of the detainees with addiction problems have mixed pathology, i.e. they satisfy the DSM criteria for dependence or abuse and, at the same time, the criteria for at least one other DSM disorder. If we assume that at least 40% of the detainees have to contend with addiction problems (dependence or abuse), then this would mean that around 20% are experiencing psychological comorbidity in addition to these problems.

Physical comorbidity

Whereas research has been performed in the Netherlands into psychiatric comorbidity in (addicted) detainees, little is known about somatic comorbidity in this group. Koeter and Luhrman (Koe98) did, however, use the EuropASI (only a rough indicator of the respondent's actual state of health) to find that almost 30% of the addicts in normal detention had chronic physical complaints, whereas 10% of cases reportedly involved serious physical problems. Addicted detainees frequently appear unhealthy on arrival in an

institution and have many somatic complaints, but once there they usually show a rapid improvement as a result of the enforced rest and routine, and the relatively good diet. It is also worth bearing in mind here that these are, for the most part, young people.

HIV

No hard data are available on numbers of detained seropositive drug users or drug users suffering from AIDS. The Medical Inspectorate's report entitled *Zorg achter tralies* (Care behind bars)(IGZ99) states, in general, that the number of seropositive individuals in penal institutions is low, and that the incidence of AIDS is virtually zero. In each of the facilities investigated, there were less than ten detainees known to be seropositive, whereas not more than one AIDS patient was known to the 30 participating prison medical services at the time of the interviews. (In fact, this particular figure is in all probability a case of under-reporting.) One complication confronting efforts to detect seropositivity in the penitentiary setting is that even though they are aware of their seropositivity, people are not always inclined to report it owing to the attendant stigma. A distorted picture could therefore arise if estimates were to be based exclusively on the assertions of the concerned individuals.

Research (including blood tests) conducted by Van Haastrecht *et al*. among 188 injecting Amsterdam drug users who were detained in the period 1994-1996 (Haa97) showed that 34% of them had HIV antibodies. This is not markedly different from the percentage of HIV-positive individuals among all intravenous users in Amsterdam in 1985 (when the HIV antibody test became available), which stood at around 30%. Research conducted among injecting drug users in Amsterdam in 1998 produced a figure of 26% (Beu99). (This can be interpreted as an indication that there will not be any substantial difference between the percentage of HIV-positive individuals among injecting drug users inside and outside the penitentiary setting).

HIV prevalence among injecting drug users was considerably lower elsewhere in the Netherlands, ranging in most cities/regions from 0% to 5% (Utrecht/1996: 5% (Wie96); Groningen/1997/1998: 0.5%(Ber99); North Brabant/1999: 4.6% (Ber00); The Hague/2000: 1.9% (Beu01); Twente/2000: 2.5% (Hak01)). However, cities and regions with large, open drug scenes (such as Heerlen/Maastricht and Rotterdam), saw higher levels of 9–14% among intravenous users in the second half of the 1990s (Heerlen/Maastricht/1996: 12% (Car97), Heerlen/Maastricht 1998/1999: 14%; Rotterdam/1997: 9% (Ber98)). The HIV prevalence among injecting drug users in South Limburg in 2000 was estimated with the use of a capture-recapture analysis at 13% (Hoe01).

If we assume that the percentage of HIV-positive individuals among injecting drug users* is approximately the same in penal institutions as it is on the outside, then the proportion of HIV-positive individuals among injecting drug users will also vary between 0% and 5% in the penitentiary setting. The percentages are even smaller if we look not merely at injecting drug users in the penitentiary setting, but at all drug users in this environment. It should be noted that the percentages in the penitentiary setting in Amsterdam, Rotterdam and South Limburg will certainly be higher.

Hepatitis

Intravenous drug users are among the risk groups for hepatitis B and C (GR96b, GR97). Although the incidence of acute hepatitis B in this risk group fell from 49 per 10,000 in 1984 to 9 per 10,000 in 1988, the Health Council stood by the recommendation in a report published in 1996 that this group should be vaccinated (GR96b). According to the Health Council, the decrease coincides with a decline in high-risk behaviour, made possible in part by the needle-exchange programmes. A further factor that may have played a role in this reduction, according to the Health Council, is the high level of infection that has already been recorded in this group, which has meant that the number of 'susceptible' individuals has decreased and that new cases will consequently occur less frequently. Based on interviews with detainees, Koeter and Luhrman (Koe98) reported that almost 13% of the addicts in normal detention had suffered from hepatitis at some time in their lives.

Although hepatitis-C infection is far more infectious than HIV, most people do not become acutely ill. According to the Amsterdam Municipal Health Service, the majority of people who have, at some time, injected with a used needle are infected with hepatitis C. In Amsterdam, more than 80% of injectors fall into this category (GGD99b). Depending on the duration of intravenous use, the prevalence of antibodies to HCV rises to 95% in those who have been injecting for longer than two years. The prevalence had also risen sharply (to 10%) among those who reported never having injected. The great danger is that hepatitis C, unlike hepatitis B, does not resolve in more than 80% of cases and gives rise to a chronic infection, in the course of which the virus damages the liver. Around 30% of cases culminate in (potentially fatal) cirrhosis of the liver after 20 to 30 years. The risk of illness or death increases in connection with simultaneous excessive alcohol use. The Health Council published an advisory report on the detection and treatment of hepatitis C in 1997 (GR97).

* By 'injecting drug users' we mean drug users who have, at some time, injected.

Tuberculosis

Some data are available on the incidence of tuberculosis among detainees. These figures are published in the Annual Report on Tuberculosis Screening in Penal Institutions (GGD99a). In 1998 chest X-rays were made of newly arrived detainees in 39 penal institutions. Based on guidelines from the Ministry of Justice's Medical Inspector for Prisons, the medical service of the concerned institution decides which detainees are eligible for this study. In 1998 a total of 15 cases of TB were detected in this way (including nine cases of infectious pulmonary tuberculosis). A total of 93 cases of tuberculosis (51 of them infectious) were discovered in this manner in the years 1994 to 1998. Based on this data, the incidence of TB among detainees is estimated to be around 25 cases per annum.

Other somatic problems

It can furthermore be assumed that addicted detainees suffer from the same somatic problems as addicts on the streets. Data from the Amsterdam Municipal Health Service concerning somatic problems in opiate addicts (GGD99b) therefore also give an impression of the principal somatic problems experienced by addicted detainees. This Municipal Health Service has a relatively large number of opiate addicts in treatment who are over 40 years of age, whereas addicts tend to have most contact with the police and the courts between the ages of 30 and 40 years. Consequently, the Amsterdam Municipal Health Service will probably be confronted more often than the institutional physician with worsening of health problems associated with advancing age, as can be the case with hepatitis and chest complaints. This needs to be borne in mind when considering the findings of the Municipal Health Service in Amsterdam for the years 1996-1998, as outlined here.

Street drug users, by virtue of their lifestyle (self-neglect and homelessness), run the risk of respiratory tract infections such as pneumonia and TB. In the case of injecting drug users, there is a risk of specific infections such as HIV and hepatitis C. The hazard arising from infections caused by injecting drugs has declined in recent years as a result of the shift to inhaled use – which, it should be noted, has its own particular hazards (see below). Individuals with poor general hygiene and an unhygienic injection technique can develop trivial infections, abscesses and wounds, with a risk of infectious foci in the heart (endocarditis), lungs and other organs. Drug-associated prostitution increases the risk of sexually transmitted diseases.

The transition from injecting to smoking brings new hazards and risks. The inhalation of large quantities of heroin and cocaine fumes is bad for the respiratory tract, which in many cases has already been damaged by the large quantities of tobacco

smoked since early adolescence. Serious respiratory health problems are a particularly important issue in users with a predisposition to asthma. These problems are attributable to decades of heavy smoking, combined with the practice of inhaling – as deeply and intensively as possible – large quantities of fumes and smoke from heroin and cocaine base ('crack'). The Municipal Health Service expects the incidence of chronic obstructive pulmonary disease (COPD) to increase in the near future.

To summarise, it can be concluded that little data is available on the somatic problems of addicted detainees. The number of seropositive drug users in penal institutions is low and AIDS seldom occurs. Between 20 and 25 cases of tuberculosis can be expected to occur annually in the penitentiary setting. No figures are available on the incidence of hepatitis among detainees, but around 13% of the addicted detainees in normal detention reported having had hepatitis at some time. In general, addicted detainees suffer from the same sort of somatic problems as non-detained addicts. Street drug users can be expected to suffer from respiratory tract infections such as pneumonia and TB, while injecting drug users are additionally susceptible to specific infections such as HIV and hepatitis C. Where hygiene and injection technique are poor, trivial infections, abscesses and wounds can occur. The shift from intravenous drug use to inhaled use does, of course, have repercussions with regard to the nature of the somatic problems that can be expected. Where substances are inhaled, doctors need to watch out for COPD, especially in older users who have already been continually inhaling large quantities of nicotine ever since the age of ten or eleven.

2.4 Drug use during detention

Whereas sections 2.1 and 2.2 focused on addiction or drug use among detainees in general, this section concerns drug use in the detention setting. What is known about this problem? Is there reason to suppose that detention can increase the risk of developing an addiction?

Every possible effort is made to combat the use of drugs during detention. The official Drug Determent Policy (Dutch acronym: DOB) adopted in penal institutions sets out to prevent the arrival, presence and use of drugs in these establishments. There are numerous measures that institutions can undertake in order to flesh out this policy, such as clothing and body searches, urine tests and disciplinary punishments (see section 4.2.2). Nevertheless, drugs *are* used in penal institutions; not only cannabis products, but also heroin and cocaine. How these substances are smuggled in is frequently a mystery, but the most likely route is via visitors (Kel98).

There are, of course, no official figures available on the use of drugs in penal institutions – although research has been performed that gives an impression of the frequency with which psychoactive substances are used in individual institutions. Bieleman and Van der Laan (Bie99) interviewed 91 detainees from four different penal institutions. While 32% of them claimed not to have used any drugs during detention, the remaining detainees (68%) mentioned a range of substances. The substance cited most frequently was cannabis (45%), followed by methadone (22%), cocaine (11%), heroin (9%) and various medicines (9%).

The nature of the drug use varied markedly from one institution to another. A total of 463 injecting drug users were interviewed in a study into HIV risk behaviour in Dutch prisons (Haa97), 188 of whom (41%) indicated they had served time in a Dutch prison in the previous three years. A further 104 interviewees (55%) reported some use of cannabis. The use of heroin and cocaine, too, was found to be fairly widespread: 69 (37%) and 38 (20%) drug users, respectively, reported having used these substances on at least one occasion during their most recent period of detention. Only five drug users (3%) reported having injected during detention. No shared use of needles was reported. These experimental findings were not deemed to justify making clean needles or bleach available in Dutch prisons.

Although the fact that the above figures are based on assertions made by the addicts themselves means that we cannot be absolutely sure, the results force us to conclude that drug use in detention is probably relatively widespread, notwithstanding the DOB. One cannot, therefore, rule out the possibility that non-addicts or former addicts may come into contact with drugs during detention, and that they may consequently become (re)addicted. It is not possible, however, to make judgments about the extent to which this actually occurs. One can only speculate on the importance of detention as a time of risk for the development of addiction.

2.5 Duration of detention for addicted detainees

The only source that can provide information about the periods of detention served by addicted detainees is the aforementioned TULP system, operated by the Ministry of Justice's Correctional Institutions Agency (DJI). It was indicated earlier that this system is inadequate as a source of data about addicted detainees, since the addiction section of the form was not completed for approximately half of the detainees. However, we have no other sources to go on.

According to the TULP system, 23,784 convicted detainees definitively re-entered society in 2000 (not including suspensions of pre-trial detention, early releases from custody, unauthorised absence, and the detention of aliens). They remained in the final

institution for an average of 67 days before being released. If we also count the time that they may previously have spent in another institution (or institutions) – i.e. before being transferred to the institution from which they were eventually released – then the average length of stay is 131 days (approximately 4½ months). The median length of stay is 48 days (more than 1½ months). Thus 50% of the detainees spent 1½ months or less in detention. The detention was ended within five months in around 75% of cases*.

In the case of registered drug users (3,801 people), the continuous period spent in detention averaged 99 days, with a median term of 41 days (just under 1½ months). Seventy-five percent of the drug users re-entered society within four months. Thus, registered drug users spend somewhat less time in detention than detainees in general.

These figures are probably somewhat distorted by those individuals who receive extremely short sentences. If these very short-term detainees (including custodial sentences and alternative imprisonment) are excluded from the definitive releasee population, then the total number of releasees in 2000 was 18,347, of whom 2,671 were drug users and 4,664 were non-addicts. The average period of detention served by the total releasee population was 146 days (approximately five months), whereas 50% served a total of 60 days or less (barely two months). On average, the drug users served 108 days (approximately 3½ months), whereas 50% of them served 51 days or less (between 1½ and two months). The non-addicts served an average of 169 days, whereas 50% of them served 60 days or less (two months). The drug users therefore served somewhat shorter sentences than the non-addicts.

For data on the sex, age and country of birth of addicted detainees, we refer to the second set of data, i.e. not including the extremely short-term detainees (the total releasee population numbered 18,347, of whom 2,671 were drug users). Only a few of the registered drug users were women (409 out of 2,671), 50% of whom served 37 days or less, i.e. shorter sentences than the men (for whom the median was 56 days).

The majority of drug users were in the age range 25-44 years. There were a disproportionately large number of older people (35-44 years) among them compared with the general detainee population. In general, younger drug users spent longer periods in detention than older drug users: of the 25-29 year-olds, 50% served 60 days (two months) or less, whereas 50% of the 35-39 year-olds served 48 days (1½ months) or less.

More than half of the drug users (1,615) had been born in the Netherlands, and 50% of these individuals served 56 days or less. Of those with a different country of birth (total: 1,056), the Surinamese formed the largest group (353 people), followed by the Moroccans (198) and the Antillians/Arubans (108). Fifty percent of the Surinamese

* A comparison of the figures furnished by the TULP system for 2000 with TULP figures for 1998 reveals a slight reduction in the duration of detention.

served 30 days or less and 50% of the Moroccans served 52 days or less, whereas the median term for the Antillians/Arubans was 42 days (1½ months). Also striking are the relatively long periods of detention served by the Turks (total: 47), 50% of whom spent 105 days or less in detention.

The TULP system is not designed to provide data specifically on addicted detainees. The data that this system furnishes with regard to drug users contains omissions, since in many cases the addiction section is not completed. We must therefore confine ourselves to a few overall conclusions.

The period of detention served by drug users is somewhat shorter than the period of detention served by the total detainee population. For 50% of the detained drug users, detention is concluded within just two months, whereas 75% of them were back in the community within four months. It should be noted here that these figures are somewhat distorted by the extremely short-term detainees. If this category is excluded, the period of detention served by drug users comes out somewhat higher, but it is still lower than that served by the non-addicts. There are considerably more men than women among detained drug users and the period of detention served by the female drug users is somewhat shorter than that served by the males. The majority of detained drug users fall into the 25-39 age bracket. Drug users in the 35-44 age range are somewhat over-represented in comparison with the total detainee population. More than half of the drug users in detention were born in the Netherlands. Of those with a different country of birth, the Surinamese form the largest group, followed by the Moroccans and the Antillians/ Arubans.

2.6 Summary

No national databases are available with which it is possible to precisely determine how many drug users there are among the detainee population. Research in individual institutions shows that approximately 30% of the detainees satisfy the criteria for drug-dependence. If a broader definition of the problems is applied (abuse of substances in general), then the percentage is 44%. In general, it is assumed that between a third and half of detainees have some form of addiction problem.

On 1.1.1999 around 11,000 detainees were being held (point prevalence) in Dutch penal institutions (excluding youth custody centres and placement under a hospital order). In the course of 1999, nearly 47,000 people were detained (annual prevalence). If we assume that approximately a third to half of them have addiction problems, then the figure ranges from 15,000 to 23,000 people per year. This estimate is approximately in line with the figure of 18,000 advanced by the Minister in her request for advice. As she indicated, however, allowance needs to be made for the possibility that the same individual may be counted several times.

Two-thirds of the individuals in normal detention with addiction problems (around 10,000-15,000 people per year) have to contend with severe addiction problems. Addicted detainees have frequently already been addicted for many years – especially if they suffer from severe addiction problems.

Compared with the total detainee population, the period of detention served by the drug users is relatively short. For 50% of them, their detention is over within just two months, whereas 75% are back in the community within four months. Few drug-using detainees are of the female sex. The majority of them fall into the 25-39 age bracket. More than half of drug-using detainees were born in the Netherlands – though they do include many second-generation and third-generation immigrants.

Around half of the detainees with problematic drug use (i.e. around 11,000 people per annum) have mixed pathology. That is to say, they satisfy the DSM criteria for dependence or abuse of substances and, at the same time, the criteria for at least one other DSM disorder. Little hard data is available on the somatic problems of detainees with problematic drug use. According to the Health Care Inspectorate, the number of seropositive drug users in penal institutions is low and AIDS is rare. The total incidence of tuberculosis in the penitentiary setting is calculated to be around 20-25 cases per year. In general, doctors examining addicted detainees need to look out for the same sort of somatic problems as are encountered in non-detained addicts (pneumonia, tuberculosis, HIV, hepatitis C). In the case of inhaled drug use, doctors must be alert to the possibility of chronic obstructive pulmonary disease (COPD), particularly in older people who have had a permanently high nicotine intake since childhood.

The majority of addicted detainees are polydrug users. Besides the large group of polydrug users, there is a small group of those who exclusively use cocaine. We do not know about the size of this group, whether it is growing or the distinguishing characteristics of these users. Heroin and cocaine are the most widely used substances among polydrug users. In general, drug-addicted detainees are poorly educated and have little work experience. Many are of foreign origin. Those who name cocaine as their drug of choice are usually younger than those who mainly use heroin. The overwhelming majority prefer to inhale their drug of choice (by snorting or smoking it), with only a minority injecting. Thus, far more is inhaled than taken intravenously. Though drug use is probably fairly widespread in Dutch penal institutions, substances are seldom, if ever, injected.

It is necessary to be circumspect when interpreting what little data is available regarding the addicted detainees' life-history of health care use. A cautious estimate is that at least half of the addicted detainees have previously had contact with the care services in connection with addiction problems. In all probability, only very few of the small group of detainees who exclusively use cocaine were under treatment for cocaine addiction prior to their detention.

Chapter 3

Legal framework

In this chapter, we outline the legal framework underlying the medical supervision and treatment that is given to (addicted) detainees. First we discuss legislation and regulations (3.1). Then we look at the rights enjoyed by detainees in their capacity as patients (3.2). Consideration is then given to the ways in which the detainee's right to care needs to be fleshed out (3.3) and the possibilities that criminal law affords for pressuring or compelling suspected or convicted offenders with addictions to undergo treatment (3.4). Finally, we outline the penal options for achieving some degree of continuity of involvement with addicted detainees (3.5).

3.1 Medical care: the regulatory framework

The following is a discussion of relevant legislation and regulations. Attention is focused first of all on international regulations and treaties (3.1.1), then on the constitutional basis of the right to health care (3.1.2) and finally on the Custodial Institutions Act (PBW) (3.1.3) and the Penitentiary Order (PM) (3.1.4).

3.1.1 International regulations and treaties

The principal international treaties of relevance to the medical supervision and treatment of detainees are the European Convention on Human Rights (ECHR) and the International Covenant on Civil and Political Rights (ICCPR).

As far as the medical care of detainees is concerned, Article 3 of the ECHR (concerning the prohibition of torture and inhuman or degrading treatment or punishment) only sets a lower limit. This Article can only be deemed to have been contravened where medical care is of such a low standard that the concerned individual can, in fact, be said to have been treated in an inhuman or degrading manner – a situation that will not arise very often. Even the use of compulsion when administering medical care is unlikely to infringe the ECHR. In the Herczegfalvy case, the European Court of Human Rights ruled that the use of compulsion in the medical treatment of a detainee who is mentally ill and mentally incompetent does not constitute a contravention of Articles 3 and 8 (concerning the right to privacy), providing that there is a medical need for compulsory treatment of this kind (ECtHR 24.9.1992, NJ 1993, 523).

As far as the ICCPR is concerned, mention should chiefly be made here of Articles 7 and 10. Article 7 prohibits subjecting a person to medical experimentation without his free consent. Kelk points out that voluntariness is a paradoxical concept to apply to the situation of compulsion in which the detainee finds himself (Kel98). Kelk is therefore of the opinion that experimentation of any kind whatsoever must be banished from the prison setting. A comparison can be drawn in this connection with Section 5 of the Medical Research Involving Human Subjects Act (WMO), which contains a similar prohibition, although scientific research that might benefit the concerned individual is excluded. Article 10 of the ICCPR provides that detainees must be treated with humanity and respect for the inherent dignity of the human person. Furthermore, Article 10, para. 3 states that the penitentiary system should include treatment of prisoners, the essential aim of which will be their reformation and social rehabilitation.

The European Prison Rules (Recommendation No. R (87)3, adopted by the Committee of Ministers of the Council of Europe on 12 February 1987) contain a section on medical services for prisoners. These rules are a revised European version of the United Nations' Standard Minimum Rules for the Treatment of Prisoners. Being of an advisory nature only, they are not binding in the formal, legal sense. The Explanatory Memorandum to the European Prison Rules indicates minimum requirements with regard to medical care: "The medical services in prison establishments should be organised to standards comparable in quality to those in the community at large." Thus, the medical care given to detainees is to be measured against the requirement of equivalency. This requirement, at least, must be satisfied if a detainee is to be said to have received the standard of medical care to which he is entitled as a Dutch citizen (Kel98). The following rules, in particular, are of relevance to the subject matter of this advisory report:

- Rule 26, para. 1: "(…) The medical services (…) shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality."

- Rule 27: “Prisoners may not be submitted to any experiments which may result in physical or moral injury.”
- Rule 29: “The medical officer shall see and examine every prisoner as soon as possible after admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all measures necessary for medical treatment; (…) the noting of physical or mental defects which might impede resettlement after release (…).”
- Rule 30, para. 1: “The medical officer shall have the care of the physical and mental health of the prisoners and shall see (…)all sick prisoners, all who report illness or injury and any prisoner to whom attention is specially directed.”
- Rule 30, para. 2: “The medical officer shall report to the director whenever it is considered that a prisoner’s physical or mental health has been or will be adversely affected by continued imprisonment or by an condition of imprisonment.”
- Rule 32: “The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may impede a prisoner’s resettlement after release. All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner to that end.”

More recent than the European Prison Rules is Recommendation No. R (98)7 of the Committee of Ministers to member states concerning the ethical and organisational aspects of health care in prison (adopted by the Committee of Ministers on 8 April 1998). The Annex to this Recommendation contains a separate section devoted to the organisation of care in the case of addiction (IIIB). This section reads as follows:

- “43 The care of prisoners with alcohol and drug-related problems needs to be developed further (…). Therefore, it is necessary to offer sufficient training to medical and prison personnel, and to improve co-operation with external counselling services, in order to ensure continuing follow-up therapy on discharge to the community.
- 44 The prison doctor should encourage prisoners to take advantage of the system of social or psychotherapeutic assistance in order to prevent the risks of abuse of drugs, medication and alcohol.
- 45 The treatment of the withdrawal symptoms of abuse of drugs, alcohol or medication in prison should be conducted along the same lines as in the community.
- 46 If prisoners undergo a withdrawal cure, the doctor should encourage them, both while still in prison and after their release, to take all the necessary steps to avoid a relapse into addiction.
- 47 Detained persons should be able to consult a specialised internal or external counsellor who would give them the necessary support both while they are serving

their sentence and during their care after release. Such counsellors should also be able to contribute to the in-service training of custodial staff.

- 48 Where appropriate, prisoners should be allowed to carry their prescribed medication. However, medication that is dangerous if taken as an overdose should be withheld and issued to them on an individual dose-by-dose basis.
- 49 In consultation with the competent pharmaceutical adviser, the prison doctor should prepare, as necessary, a comprehensive list of medicines and drugs usually prescribed in the medical service. A medical prescription should remain the exclusive responsibility of the medical profession, and medicines should be distributed by authorised personnel only."

3.1.2 Constitutional basis of the right to health care

According to Article 22(1) of the Dutch Constitution, "The government shall take steps to promote the health of the population." This Article has given rise to a fundamental social right to health care. The citizen cannot directly derive any additional rights from a fundamental social right, which should be regarded rather as a 'standard instruction' directed at the government that affords it the necessary freedom to determine which steps should be taken and when. The right of the citizen is only realised once the government has established a system for the delivery of care services. In fact, Leenen has pointed out that the fundamental social right to health care is currently assuming a stronger legal character (Lee96).

A key question to be answered here is the extent to which the fundamental social right to health care also applies in the detention situation. According to Article 15(4) of the Constitution, detainees may be restricted in the exercise of fundamental rights in so far as the exercise of such rights is not compatible with the deprivation of liberty. From this constitutional provision, it is inferred that violations of fundamental rights should be kept to a minimum and are permissible only if they are inherent to the deprivation of liberty (the principle of minimum restriction). Quite clearly, it is not possible to infer any need to restrict the fundamental social right to health care merely from the fact that someone has been deprived of his liberty (Kel98). Proper medical care is, after all, perfectly compatible with deprivation of liberty. We may therefore assume that this fundamental right is also fully applicable in the detention situation: detainees are, in general, just as entitled to health care as any other citizen (the principle of equivalency). According to Kelk, deprivation of liberty sometimes actually necessitates that extra care be taken over the health of the detainee (Kel98).

The principle of minimum restriction is also enshrined in Section 2, sub-section 4 of the Custodial Institutions Act (PBW), whereby detainees are "not subjected to any restrictions beyond those that are necessary for the purposes of deprivation of liberty or

in the interests of maintaining order or security in the concerned institution". As far as prison health care is concerned, this principle implies that all health care-related regulations and standards will be applicable to detainees, unless they are incompatible with the detention situation.

The medical care of detainees is regulated in a number of provisions to be found in the Custodial Institutions Act (in force since 1 January 1999), notably in Section 42, and in the Penitentiary Order (PM), which governs such issues as the detainee's right of complaint on medical matters. More detailed practical information (for example, the institutional physician's surgery hours) should be set down in the internal rules of the penal institutions themselves, taking into account the model internal rules established by the Minister of Justice (Section 5, subsection 1 of the PBW). In addition, the Minister of Justice issues general policy rules and regulations that are announced by circular.

3.1.3 Custodial Institutions Act (PBW)

Section 42 of the PBW lays down rules for the medical care of the detainee. According to Section 42, sub-section 1, the detainee is entitled to receive care from a physician, or his replacement, attached to the institution. Section 42, sub-section 2 of the PBW grants the detainee the right to consult, at his own expense, a physician of his choosing, with the location and timing of the consultation to be determined by the institution's director in discussion with the selected physician.

The right to a free choice of physician now applies to all categories of detainees. The fact that the detainee has a statutory right to consult a physician from outside the prison does not, however, necessarily mean that he can also be treated by this doctor in the penal institution*. The Explanatory Memorandum to the Custodial Institutions Act states that "It is incompatible with good prison practice for a doctor who is not attached to the institution to interfere with the medication policy of the institutional physician". The visiting external physician will need to discuss the proposed treatment with the institutional physician. In the event of a difference of opinion over the treatment, the external physician will need to convince the institutional physician that his treatment advice is appropriate, since it is the institutional physician who ultimately decides which medicines are issued to the detainee.

In the past, problems have notably arisen in this respect with regard to the provision of methadone to detainees, since doctors have differing opinions on the correctness of providing – or continuing to provide – methadone in a penitentiary setting. According to Dute, the institutional physician must not simply substitute his own professional opinion

* Regulation no. 98 of the European Prison Rules does indeed give prisoners in preventive detention the right to be *treated* by their own physician or dentist.

for that of the doctor who is prescribing methadone, since to do so would virtually obviate the detainee's right to a free choice of physician (Dut97). If new circumstances arise that, in the view of the institutional physician, necessitate an adjustment of the detainee's methadone prescription, then it would, at least, be appropriate to consult the doctor who is prescribing the methadone.

Sub-sections 3 and 4 of Section 42 of the PBW summarise the director's duties of care in respect of medical services. The director must, for example, ensure that the institutional physician holds regular surgeries in the institution and, if necessary, that he is also present in the institution at other times. Furthermore, he must ensure that the prescribed medication and diets are, in fact, provided and that the treatments prescribed by the physician do, indeed, take place. Should it prove necessary to transfer the detainee to a hospital or to another institution, then it is the director who must ensure that this occurs. The fifth and final sub-section of Section 42 of the PBW contains a reference to an Order in Council that governs the right of the detainee to complain about decisions made by the institutional physician. This regulation can be found in Articles 28–34 of the Penitentiary Order (see below).

3.1.4 Penitentiary Order

Among the topics covered in the Penitentiary Order (PM) are the Penitentiary Programme (Articles 5-10), compulsory medical procedures (Articles 21-23) and appeals against medical interventions by the institutional physician, nurse or other care providers involved in the medical care of the detainee (Articles 28-34). We briefly consider the appeals against medical interventions here. The Penitentiary Programme and compulsory medical procedures are discussed in sections 3.5 and 3.4.

Under Section 42, sub-section 5 of the PBW and the Penitentiary Order, the detainee has been granted a specifically medical right of complaint (Moe01b) in addition to the general right of complaint. This medical right of complaint means that, after the Medical Adviser of the Ministry of Justice has made a (mandatory) attempt to mediate and this mediation has failed to produce results, the detainee may file a notice of appeal with the Medical Appeals Committee of the Central Council for the Application of Criminal Law(now known as the Council for the Application of Criminal Law and Youth Protection (RSJ)). The medical profession is strongly represented on this committee (two physicians, one chairman-cum-legal expert). The standard against which the Committee makes its assessment is defined in Article 28, para. 2 of the PM. There must be no question of any act or omission that is contrary to the duty of care that medical practitioners owe to prisoners, nor of any act or omission that is not in accordance with good individual health care practice.

Research (Moe01b) showed that less than 10% of all mediation cases resulted in an appeal. The mediation procedure took a total of six months or longer in two-thirds of the cases. This is because the Medical Adviser and the Appeals Committee both frequently take longer to handle the matter than was intended. In 60% of the cases, the mediation phase involving the Medical Adviser was twice as long as was foreseen in the legislation (according to Article 29, para. 4 of the PM, the target period is four weeks). The subsequent Appeals Committee procedure lasts for three months or longer in 60% of the cases, whereas Article 32, para. 1 of the PM states that the Committee must deal with cases as swiftly as possible. An additional delaying factor in some cases is the fact that the complainant himself has waited several weeks or more before turning to the Appeals Committee. In practice, therefore, it will not be unusual for the detainee to have already been released by the time the Appeals Committee makes its decision.

3.1.5 Guide to Methadone Provision

The Guide to Methadone Provision in Prisons, issued by the Ministry of Justice's former Medical Inspectorate (in a letter dated 13 December 1996, reference dM/96268) indicates the cases in which addicted detainees may be considered for methadone. It should be noted that this guide has the legal status of a guideline/protocol, which is not binding on the institutional physician. The Ministry of Justice Medical Adviser's letter of 16 July 1997, which can be regarded as a more detailed supplement to the Guide, is likewise non-binding. Both of these documents are, nevertheless, guidelines/protocols that can be considered to represent the standard of professional medical care with regard to methadone provision in detention. Their contents may thus indeed have a bearing on the assessment that is made (following mediation) by the disciplinary tribunal, the interim injunction court and the Medical Appeals Committee of the Council for the Application of Criminal Law and Youth Protection.

Previous Appeals Committee decisions indicate that the Guide is more than simply non-binding advice; in fact, this should be a guideline for medical practice with regard to the provision of methadone (Moe01b). As of 1 February 2001, the Appeals Committee had issued ten decisions with regard to methadone: eight of them related to reductions in the dose of methadone, one concerned with the low daily dosage of methadone provided, and one involved with the unsolicited prescribing of methadone. These decisions are listed in Annex C of this advisory report. Deviation from the Guide and from the Medical Adviser's letter can easily pave the way to an upholding of the appeal.

3.2 Patient rights

According to Article 7:464 of the Civil Code, the provisions of the Code concerning the contract to provide medical treatment – i.e. the Medical Treatment Agreements Act (WGBO) – are applicable to medical actions *mutatis mutandis* when the treatment relationship is not based on an agreement (unless the nature of the legal relationship dictates otherwise). The entry into force of Article 7:464 of the Civil Code was initially postponed until 1 May 2000. A Decree of 13 March 2000 (Bulletin of Acts and Decrees 2000, 121) listed the situations for which this Article would come into force later than 1 May 2000. Deprivation of liberty in connection with the execution of a custodial sentence is not among these situations.

The consequence of all of these factors is that the provisions concerning the contract to provide medical treatment are, since 1 May 2000, also applicable in the treatment relationship between the detainee and the institutional physician. This applies even though this relationship cannot be described as a contract to provide treatment, since the detainee has, in a manner of speaking, been 'sentenced' to the care that the institutional physician extends to him (Gro00). It is precisely in such situations of dependency as those encountered in the detention situation that patient rights have a pre-eminently protective function. In principle, therefore, the detainee essentially has the same rights (and duties) vis-à-vis the institutional physician as the patient in the community has with regard to his attending physician.

As far as the applicability of WGBO provisions is concerned, the key consideration is that a medical action must be deemed to take place. Decisions to test a detainee's urine or to transfer him to a hospital are cited in the Explanatory Memorandum accompanying the Decree as examples of measures that are not covered by the term 'medical action' and to which the provisions of the WGBO do not, therefore, apply. Procedures that are not performed by a physician or dentist, but by prison personnel or nurses, only fall within the scope of the WGBO in so far as they are aimed at assessing the health status of the concerned individual. Procedures that are performed in connection with the order and security of the institution are not aimed at assessing health status and do not, therefore, fall under the WGBO.

Thus although the provisions of the WGBO are, in theory, applicable to medical actions performed in the detention situation, this applicability may be limited in two respects.

First, there is, in the detention situation, legislation in force that contains provisions that deviate from the WGBO, namely the Custodial Institutions Act and the Penitentiary Order. A case in point is the regulation of the use of compulsory medical treatment. Section 32 of the PBW contains provisions that explicitly deviate from the WGBO in this

regard. Since they are classed as *lex specialis*, these provisions take precedence over the general provisions of the WGBO – in this case, the requirement of consent.

Second, Article 7:464 of the Civil Code states that the WGBO provisions are applicable "insofar as the legal relationship permits". There are, in fact, statutory regulations that do not actually constitute an explicit deviation from the WGBO, but that, given their content, may well be deemed to be *lex specialis* as far as the WGBO is concerned. Such regulations can be said to flesh out the rules laid down in the WGBO, or else provide a rule that deviates from them (Gro00).

The institutional physician's involvement with instruments of control (such as body searches, use of mechanical equipment and isolation) is governed by special rules in penal legislation, which deviate from the WGBO. In such cases, there can be no question of the physician being required to obtain consent from the detainee, since these measures are imposed by the director of the institution.

Assessments made by the institutional physician with regard to detainees' fitness for work and sport can, however, be regarded as medical procedures. The provisions of the WGBO will apply here, since penal legislation contains no specific rules in this regard.

In principle, the WGBO is applicable to the normal primary care that the institutional physician provides to the detainee. But even then, according to the Explanatory Memorandum accompanying the Decree, situations can arise in which the WGBO engenders tension, notably in relation to the physician's duty of confidentiality. One example is the fact that penal institution workers (PIWs) can be entrusted with the medical care of detainees. These social workers would not be able to perform this work properly if the institutional physician were to be bound to his duty of confidentiality in his dealings with them. They must therefore be regarded as being involved in the treatment, so that the physician is released from his duty of confidentiality with regard to them and can, where necessary, inform them about the state of health of the concerned individual.

In principle, the applicability of patient rights in the detention situation means that the detainee is entitled to be informed about his health status by the institutional physician, that medical treatment requires the consent of the detainee (an exception is compulsory medical treatment in very particular situations; see Section 32 of the PBW), that the physician must provide the detainee with sufficient information in this regard (informed consent), that he must keep records that are, in theory, available for inspection by the concerned individual, and that information may only be divulged to third parties under certain conditions. In view of the detainee's situation of dependency, the institutional physician will need to consider it part of his responsibility to take good care of, and possibly to seek alternative solutions for, detainees who refuse a necessary treat-

ment. This responsibility exists where it is possible and necessary, in consultation with the director and/or other non-medical care providers who are involved in the care and support that is being extended to the detainee at that time (Kel98).

3.3 Content of the right to care: supervision or treatment

In this section, we examine the question of how the detainee's right to care is to be concretised.

The right to proper medical care includes the right to the necessary psychiatric and psychological assistance. Moreover, the detainee's right to social care and support is enshrined in Section 43, sub-section 1 of the PBW. According to Kelk, there is now a consensus that these rights also include the right of the addicted detainee to receive treatment for his drug addiction, albeit it that this right may be restricted where it threatens to disturb the order and calm in the institution – a potential restriction that is in accordance with Article 15, para. 4 of the Dutch Constitution – or where the physician would be unable to reconcile this with his medical code of practice (Kel98, p. 83).

The detainee's right to proper care has its corollary in the duty of care of the institution. How high a standard of care should the institution be obliged to provide? It has already been noted that this should, in principle, be equivalent to the standard of care that obtains outside the institution. The government may, nevertheless, have grounds for making exceptions to this principle of equivalency (in a positive sense) – as occurs, for example, in the case of dentistry (detainees receive more dental care than they would be entitled to outside the penitentiary setting).

It is, however, a long-established principle within the Dutch prison system that offenders are not 'treated', but 'supervised', based on the underlying principle of Dutch penal law that distinguishes between punishment and treatment. This principle implies that a custodial sentence must not be used in order to make someone undergo psychiatric treatment. In the Explanatory Memorandum pertaining to Article 21 of the Penitentiary Order (Bulletin of Acts and Decrees 1998, 111, p. 35), it is formulated – without further explanation – as follows: "In principle, treatment for a psychiatric disorder does not take place within the prison system." This merely paves the way for exceptions to the principle.

However, Vegter made the observation in his introductory lecture that these exceptions are, in fact, made in abundance (Veg99). For example, he drew attention to the Penitentiary Programmes as specified in the Custodial Institutions Act – a means of executing a prison sentence outside the walls of the prison which can involve following a treatment programme – and to the recent statutory underpinning of compulsory treatment. By including the possibility of compulsory treatment in the Act, Parliament is said

to have implicitly acknowledged that treatment with consent need not be considered impossible in the context of the execution of a custodial sentence.

The Forensic Care Working Group pointed out (WFZ96, p. 30) that the term 'supervision' is consistently used in the prison system for many procedures that can also be designated as treatment. The working group noted that the distinction adopted in the prison system between supervision and treatment hinges, in particular, on the intention behind the action. Supervision aims to prevent the detainee's condition from deteriorating or else to stabilise it, whereas treatment is aimed at effecting a cure and can, in some situations, be made compulsory. Vegter says that it is artificial to regard an intervention that is aimed at effecting a cure as treatment and an intervention that aims to stabilise the individual's mental state as supervision (Veg99). Because it is, in his opinion, difficult to draw a distinction between treatment and supervision (the same procedures are often involved in practice), he recommended adopting a broad interpretation of the term 'treatment' and having it cover interventions that set out to achieve therapeutic effects, i.e. prevention of new pathology, stabilisation or a cure. This approach is endorsed by the Committee (see also section 1.5).

In the prison system, however, there is a tendency to place as narrow an interpretation as possible on the term 'treatment'. Vegter concluded that there is definitely room for treatment in the context of a prison sentence, both from a legal perspective and in view of the existing need. In his opinion, it would also be advisable to make treatment a goal (albeit a subsidiary one) when executing a sentence.

In the policy document *Taak en toekomst van het Nederlandse gevangeniswezen* (The future task of the Dutch prison system) (Second Chamber, 1981-1982 session, 17,539, no. 1) the prison system was given a threefold task: *1*) to seek to enforce detention in a humane manner, *2*) to prevent (or at least limit to the maximum possible extent) the harmful consequences and effects of detention, and *3*) to prepare detainees for their return into the community by creating possibilities and opportunities for them to work on their personal development and to resolve any psychosocial problems that they might have.

In the context of the debate over the content of the institution's duty of care, the second and third aspects of the task – i.e. the limitation of harmful consequences and the principle of resocialisation – are particularly important. The resocialisation principle was first articulated in Section 26 of the former *Beginselenwet Gevangeniswezen* (Custodial Institutions Act). The progressive belief that a prison sentence can be used in order to resocialise detainees prevailed within the prison system in the 1950s, but little of this optimism remains. The principle is, nevertheless, still enshrined in Section 2, sub-section 2 of the PBW, where it is formulated as follows: "While maintaining the

character of the custodial sentence or measure, its execution is, as far as possible, subordinated to the task of preparing the concerned individual for the return into the community."

Nowadays, the principle of resocialisation is interpreted in a restrictive manner. At present, the official objective of the prison system – besides secure custody – is to prevent, or at least limit, the harmful consequences of detention (see the policy document *Taak en toekomst van het Nederlandse gevangeniswezen* (The future task of the Dutch prison system)). This emphasis on the harmful consequences of detention gives rise to an extremely limited interpretation of the principle of resocialisation (Veg99, pp. 6, 7).

The policy document *Werkzame detentie* (Effective detention) (1994), which has, in part, formed the basis for the new legislation and remains the point of departure for policymaking, confines the principle of resocialisation to detainees who are accordingly motivated. In addition, this document cites specific groups that qualify for special care that is specifically geared towards promoting integration into society following detention. Among the groups mentioned in this connection are drug addicts who wish to break with their drug-related criminal lifestyle and detainees with mental disorders who require intensive supervision. Officially, what takes place in the wings that are specially designed for the care of these groups (see section 4.1.4) is not characterised as treatment, but as supervision. Where treatment is required, the official position is that this will have to take place outside the prison system by means of a transfer.

3.4 Pressure and compulsion

This section explores the legal options for using pressure or compulsion on suspected or convicted offenders with addictions.

Pressure

Criminal law affords various possibilities for admitting suspected or convicted offenders who are addicted to drugs into a programme that can tackle their drug addiction. A common denominator in virtually all of these options is the fact that they involve imposing conditions with regard to behaviour. The suspect/convict is always faced with the choice of either submitting to the normal criminal proceedings and undergoing the punishment or else participating in a particular treatment programme. If someone chooses the latter option, then the criminal proceedings are suspended during their participation in the programme. Should that individual stop participating in the programme, then the criminal proceedings are resumed. Because the suspect/offender is given the choice between either pursuing the due process of law and undergoing the punishment or else opting for treatment, the term applied in these cases is pressure (and not compulsion).

For *suspected* offenders, the first option is conditional dismissal under Article 244, para. 3 of the Netherlands Code of Criminal Procedure (Sv). In this case, the Public Prosecutor decides not to prosecute on the condition that the suspect agrees to undergo treatment (in the community) for his drug addiction. The second option is a conditional suspension of pre-trial detention (Article 80, para. 1 of the Sv). The pre-trial detention of a suspected offender can be suspended on the condition that the suspect agrees to undergo treatment (possibly in a clinic) for his drug problems. Thirdly, there is the (actually seldom used) possibility of suspending the trial (Article 281 of the Sv), in order to give the suspect the opportunity to undergo a treatment.

The possibility of treatment for drug problems may still arise even for a *convicted* offender, namely as a condition of a (partially) suspended sentence (including a prison sentence) under Article 14a of the Netherlands Criminal Code (Sr). In this case, the court will stipulate a probationary period (Article 14b, para. 1 of the Sr) of no longer than three years (Article 14b, para. 2 of the Sr). The condition may include "admission of the offender to a institution of care" for a maximum period of three years (Article 14c, para. 2(2) of the Sr). This may include treatment of drug addicts in a clinic, but such a condition can also mean treatment in the community, also for a maximum period of 3 years (Article 14c, para. 2 (5) of the Sr). In the case of this treatment modality, the treatment may be linked to the unconditional part of the custodial sentence, in which addiction treatment may also be given (e.g. in an Addiction Support Section (VBA)), so that some degree of continuity of care is achieved.

Compulsion

There are only limited legal options for making justiciable addicts undergo treatment. Unlike 'pressure', compulsory treatment leaves the concerned individuals with no choice: they have to submit to treatment, regardless of whether or not they are in agreement with it.

Compulsory treatment (or, to be more precise: the obligation on the part of the detainee to tolerate a particular medical procedure) is included in Section 32 of the PBW (on the compulsory administration of medication in the penitentiary setting; see Moe01a). As was stated earlier, this is an exceptional provision pertaining to the Medical Treatment Agreements Act (WGBO). Owing to the applicability of the WGBO, the administration of a medical treatment in detention requires (in principle) the consent of the detainee. An exception can be made to this principle providing that the grounds specified in Section 32 of the PBW are satisfied, in which case the treatment may even be administered without the detainee's consent. According to Section 32, sub-section 1 of the PBW, "The director can oblige a detainee to submit to a particular medical procedure if, in the opinion of a physician, that procedure is necessary in order to avert a seri-

ous risk to the health or safety of the detainee or of others. The procedure is performed by a physician or, on his instructions, by a nurse." Sub-section 2 of the same provision states that further rules will be laid down by Order in Council concerning the application of sub-section 1.

The legal basis for compulsory treatment is therefore that this must be necessary in order to avert a serious risk to the health or safety of the detainee or of others. By emphasising the need for compulsory intervention, Parliament has sought to give expression to the legal principles of subsidiarity, proportionality and suitability. Thus the criterion for compulsory treatment in the Custodial Institutions Act closely resembles the criterion for compulsory treatment in the Psychiatric Hospitals (Compulsory Admissions) Act (BOPZ). Unlike the BOPZ Act, the Custodial Institutions Act vests the authority to make decisions on compulsory treatment in the director, whereas the physician will be required to assess the need for the compulsory treatment.

Further rules concerning the toleration of a medical procedure are to be found in Articles 21, 22 and 23 of the PM. These are regulations governing such matters as careful decision-making, reporting and record-keeping, and the need to end the compulsory treatment as soon as possible.

A review of the Custodial Institutions Act performed by the Catholic University of Nijmegen shows that no medications were administered compulsorily in three-quarters of the penal institutions in 1999 (Lae01, pp. 53-58). In the facilities where this practice did occur, it was limited to just a handful of occasions. On the other hand, it took place on 43 occasions in 1999 in the Secure Psychiatric Observation and Treatment Unit (FOBA) alone. No forms of compulsory medical procedure other than injections were reported. Virtually all of the reported cases involved a disturbance of the mental faculties.

Detainees engaged in lawsuits have argued in the past that the withholding of methadone against their will, or the provision of a lower maintenance dose than they request, should be regarded as an unlawful form of compulsory treatment, since it compels the detainee to come off the drug. These cases took place prior to the entry into force of the Custodial Institutions Act, at a time when there was still no formal legal basis for compulsory treatment in detention. Although various courts acknowledged at the time that such situations could, indeed, be deemed to constitute unlawful compulsory treatment, the Amsterdam Court of Appeal rejected this approach – according to Dute (Dut97) – without advancing any valid arguments to support this finding. For the time being, therefore, this question remains legally unresolved.

The Committee is of the opinion that the replacement of an existing methadone maintenance treatment with a treatment based on abstinence (detoxification), without having first obtained the patient's consent to this change of treatment, amounts to compulsory treatment – both in essence and by dint of its repercussions – even if no higher

court has made an official decision to this effect. If this practice were also to be judicially deemed to be compulsory treatment, then it might nonetheless still be capable of legitimisation under the regime specified in the Custodial Institutions Act, if the requirements of Section 32 of the PBW were satisfied. The discontinuation of medical management against the patient's will by replacing methadone maintenance treatment with a treatment based on abstinence would then have to be absolutely necessary in order to avert a serious risk to the health or safety of the detainee or of others. The Committee finds it difficult to envisage such a situation arising.

Finally, we must consider what place the Penal Care Facility for Addicts (SOV) occupies on the pressure-compulsion scale (see section 4.2.5 for a description of the SOV). Since the SOV involves compulsory care in a specially designated facility, it essentially amounts to a *compulsory placement*. The SOV does not, however, legitimise compulsory *treatment*, even though considerable *pressure* may well be exerted on the addict to submit to the treatment. This pressure consists of the threat of having to remain in an austere regime for a maximum of two years if one does not go along with the treatment. The SOV can thus be said to involve *compulsory placement* on the one hand and *pressured treatment* on the other.

3.5 Continuity of involvement

This section identifies penal means that can be utilised in order to bring about continuity of involvement with the addicted detainee. It has already been previously noted that a certain measure of continuity of care can be achieved by linking a treatment that is performed in connection with a conditional portion of the punishment to the execution of the unconditional portion of the punishment. Before 1986, conditional release provided a further means of achieving continuity of care. Since the abolition of conditional release in 1986 and its replacement with early release, detainees (with certain exceptions) have been entitled to be set free after having served two-thirds of their custodial sentence, without any possibility of further conditions being attached with regard to their future behaviour. Conditional release is therefore no longer available to be used as a means of achieving continuity of care.

There are, however, plans to re-introduce the attachment of conditions to early release, as is apparent from the Ministry of Justice's policy document *Sancties in perspectief* (Penal Sanctions in Perspective) (San00). In autumn 2001 the Minister of Justice promised to submit a Bill to the Second Chamber in 2002 in which the practice of early release after two-thirds of the term has been served will be replaced with a form of conditional release. A detainee can then choose between returning to the community and participating in a follow-up care programme or serving the full term of the sentence. A follow-up care programme may, for example, consist of psychiatric treatment, regular

contacts with the probation service, and a ban on alcohol and drugs (Second Chamber, 2000-2001, 27834, no. 4).

One possible way of ensuring that a supervision/treatment programme that has been started in detention is continued in the community (with a view to achieving some degree of continuity in the provision of care) is now available in the form of the Penitentiary Programme. The PP is a means of executing the custodial sentence outside prison (see Rei01 for a description of the role of the PP under the regime specified in the Custodial Institutions Act). We read in Section 2, sub-section 1 of the PBW that there are two ways of executing a custodial sentence, namely: *a*) through confinement in a penal institution and *b*) through participation in a Penitentiary Programme. The PP is regulated in Section 4 of the PBW and in Articles 5-10 of the PM.

The Penitentiary Programme fits in with the prison system's task of preparing detainees for their return into the community. Partly in order to underline the fact that custodial sentences are still being enforced, electronic monitoring as part of the phased detention project has become an essential component of Penitentiary Programmes since 1.1.1999. Further details can be found in the regulation governing Penitentiary Programme accreditation.

Participation in a Penitentiary Programme is possible for convicted detainees who have received a sentence that includes an unconditional custodial term of one year or more. The detainee must have served at least half of this custodial sentence in a penal institution. The programme must last for a minimum of six weeks and a maximum of one year (Section 4, sub-section 2(a, b & c) of the PBW). In practice, a maximum duration of six months is currently applied, though it is possible that Penitentiary Programmes with a duration of up to one year may be introduced with effect from 2002 (San00, p. 17).

Participation in a Penitentiary Programme is not a right, but a privilege. Permission to take part can only be given to detainees whose behaviour warrants their inclusion. The director of the institution nominates a detainee for participation, whereupon the probation service and the Public Prosecution Service issue a recommendation and the selection official makes the decision. Among the factors that this official should consider in making his decision is the motivation of the concerned detainee (Article 7, para. 3(b) of the PM). A positive decision is not possible unless the detainee has declared his willingness to participate in the programme and satisfy the associated conditions. The selection official is also able to terminate participation in a Penitentiary Programme if the detainee fails to abide by the imposed conditions, in which case the detainee must serve out the remaining portion of the custodial sentence in the conventional manner.

A Penitentiary Programme comprises a minimum of 26 hours per week of *compulsory* activities (Article 5, para. 1 of the PM). Article 5, para. 2 of the PM describes the

possible content of a PP. Reference is also made to the offering of special care (such as addiction treatment or mental health care) to the participant.

Participation in the Penitentiary Programmes was disappointing in 1999 and 2000 (Rei01). The shortfall is for the most part blamed on unfamiliarity with these programmes. Because the selection criteria for the Penitentiary Programmes also include the motivation and suitability of the participants, the majority of participants are, in practice, individuals who are socially functional – that is to say people who would probably also manage outside prison without a Penitentiary Programme. Addicts seldom take part in a Penitentiary Programme. A debate is currently in progress as to whether the target group should be broadened (Rei01). More addicts might well qualify for participation if motivation and/or willingness were dropped as participation criteria and if monitoring/control of compliance with the conditions were tightened up.

A further possible means of achieving continuity of care is by transferring the concerned detainee from a prison or remand prison into the care of the mental health services. In cases of inadequate development of, or pathological illness in, the detainee, the selection official can decide that the detainee will be transferred to a psychiatric hospital that has been designated for compulsory admissions under the BOPZ Act, where treatment will continue for as long as is deemed necessary (Section 15, sub-section 5 of the PBW). Section 15 can therefore justify transferring an addicted detainee with an accompanying psychiatric disorder into the care of the mainstream mental health services. Transfer to a TBS clinic (under Article 13 of the Sr) is a further possibility. This is, though, only a theoretical possibility, since such a transfer is impossible in practice owing to the lack of space in the TBS clinics. Those detained on remand can also be transferred for observation to a psychiatric hospital or clinical observation centre (Article 196 of the Sv). The reasoning here is that the suspect's mental capacity needs to be investigated and that this can only be accomplished by means of such a transfer.

One other possible means of achieving continuity of involvement with addicts is to place them in an addiction clinic under Section 43, sub-section 3 of the PBW, which states: "The director is responsible for transferring the detainee to the designated place if the care and assistance specified in sub-section 1 (that is to say, social care and support) necessitate this and if such a transfer is compatible with the deprivation of liberty." The Explanatory Memorandum to the Custodial Institutions Act indicates that this provision was also intended to include placement in an addiction clinic. According to Section 31 of that Act and the accompanying *Toelichting van de Regeling Selectie, Plaatsing en Overplaatsing van Gedetineerden* (Explanation of the Regulations on Selection, Placement and Transfer of Detainees: number 5042803/00/DJI), placement in an addiction clinic pursuant to Section 31 is intended for detainees who wish to receive treatment in lieu of detention in the final phase of their prison sentence, where a positive assessment has been made of the detainee's motivation as well as the desirability and feasibility of

the treatment. An important indicator of a detainee's suitability for placement in an addiction clinic is that he has given the impression of being motivated and capable of tackling his addiction problems in an Addiction Support Section (VBA, see section 4.1.4). Detainees who do not yet satisfy the criteria for participation in a Penitentiary Programme may also qualify for placement in an addiction clinic if such a transfer is considered to be indicated and socially responsible.

Chapter 4

Organisation, policies and practical implementation

This chapter describes the organisation, policies and practical implementation of care for addicts in prisons. It discusses the various penitentiary regimes (4.1), the penitentiary policy on addicted detainees, and what happens in practice (4.2). Finally, the organisation, policy and practical implementation of probation services are examined (4.3).

Much of the information on regimes provided in section 4.1 applies to all detainees and not specifically to addicted detainees. Nevertheless, the information is important for a proper understanding of the situation in which addicted detainees find themselves.

4.1 The penitentiary regimes and their treatment options

4.1.1 Differentiation and selection

The implementation of the Custodial Institutions Act brought about a new system of differentiation in institutions and the selection of detainees in the prison system. The system is roughly described below on the basis of the Ministerial Selection Regulations on the placement and transfer of detainees, the accompanying Explanatory Memorandum (5042803/00/DJI), and articles from the Custodial Institutions Act (PBW) and the Penitentiary Order (PM).

Various factors play a role in the selection of a detainee for a particular institution. Each institution or section is assessed to determine if it is intended for:

- use as a remand centre or prison
- male or female detainees
- special care.

The level of security and the regime are also determined for the institution or section. A distinction has to be made between the level of security, the regime and special care. The most suitable institution for the detainee can be determined by combining these factors. The decision on a detainee's placement or transfer to another institution or section is first checked against the security criterion. The level of security appropriate to the detainee's risk profile determines the further indication of the regime and institution or section in which the detainee should be placed. Determining selection for a specific institution or section involves combining the criteria for the level of security, regime and any special care, even though it is sometimes impossible to make a clear distinction between the level of security and the regime. For example, the right to regime leave is linked to placement in a half open institution (HOI) or open institution (POI). The starting point for this leave is that it is allowed within the scope of social integration, which is mainly given shape in the final period of detention (detention phasing). The remaining period of imprisonment therefore forms part of the selection criteria for placement in a half open or open institution or section. The integration of certain safety measures in the regime of the Extra Secure Institution is another example of how the aforementioned factors (namely the level of security and regime) cannot be readily separated. Placement in an institution of this kind therefore implies placement in the reinforced security unit restricted group regime, without the regime being used as a separate selection criterion for placement.

In practical implementation, only a limited number of possible combinations of the individual factors will be attributed to institutions or sections. It is therefore possible that the indicated combination of factors based on the implemented policy may not exist for the detainee. In such cases, an institution will be selected with a security level that at least complies with the level of security indicated for the detainee. An institution or section is then chosen with a regime that is most appropriate for what has been indicated for the concerned person.

Implementation of the Custodial Institutions Act provided a basis for increasing a prisoner's maximum stay at a remand centre (HvB) from one month to three. This enables the execution of short sentences (remaining period of imprisonment < 91 days) in remand centres. A consequence of this policy change is that available remand centre capacity needs to be increased. This has been taken into account in determining capacity requirements and the allocation of remand centre capacity to the districts (Bes00).

4.1.2 *Level of security*

The starting point for selection is that detainees will be placed in an institution with normal security, unless the concerned person qualifies on the basis of the stipulated criteria for placement in an institution or section with a different security level. Open institutions or sections are used to accommodate detainees who are in the final phase of detention or the final phase prior to a Prison Programme and who are suitable and motivated to work on returning to society. The half open institutions or sections are intended for detainees who present a limited escape or social risk and who qualify for regime leave.

The criteria for placement in a reinforced security unit have thus far not been further specified. For the time being, it has been decided to designate the Secure Individual Supervision Section (BIBA) and the national sections for detainees who are difficult to manage as the reinforced security unit or section. As these institutions or sections are also designated as institutions or sections with an individual regime, the current selection criteria for the regime or the special care (Individual Supervision Section (IBA)) will mainly determine whether a detainee qualifies for placement in these institutions or sections.

The reinforced security unit (EBI) is intended to be used as accommodation for detainees who are extremely likely to attempt to escape. Only detainees in the highest category of escape or social risk qualify for placement in the reinforced security unit.

4.1.3 *Regimes*

Types of regimes

Section 19 of the Custodial Institutions Act distinguishes between a general group regime (section 20), a restricted group regime (section 21) and an individual regime (section 22). In a general group regime, detainees are placed together in accommodation and workspaces, or take part in joint activities. Detainees in a restricted group regime are given the opportunity to take part in joint activities. Detainees in an individual regime are given the opportunity to take part in activities, but the governor determines the degree to which they will take part individually or jointly.

According to section 3, subsection 2, of the PM, the daily programme in a general group regime lasts at least 78 hours per week and at least 48 of those hours per week must be associated with activities and visits. According to section 3, subsection 3, of the PM, the restricted group regime distinguishes between a standard regime, in which the daily programme lasts at least 78 hours per week (with at least 43 hours per week spent on activities and visits), an austere regime, in which the daily programme lasts at least 56 hours per week (with at least 38 hours per week spent on activities and visits), and a

regime for reinforced security units, with a daily programme of at least 78 hours per week and at least 18 hours per week spent on activities and visits. According to section 3, subsection 4, of the PM, the Minister would draw up further rules on the various regimes that would apply in the institutions. This occurred in the aforementioned Selection Regulations on the placement and transfer of detainees.

The starting point for unconvicted detainees is that they qualify for placement in a standard restricted group regime, unless the concerned person qualifies for placement in another regime. Because no remand centres with a general group regime have been designated, the standard restricted group regime will apply to the majority of pre-trial detainees. The starting point in prisons is that detainees will be placed in a general group regime wherever possible. Prisons will therefore only contain those in a restricted group regime who, owing to their personality and/or behaviour, are incapable of staying in a general group regime.

The reinforced security unit is a variant of the restricted group regime, whereby the security measures required for the accommodation of detainees who are extremely likely to attempt to escape are integrated in a highly structured regime. The reinforced security unit does not concern a separate selection criterion but is directly coupled to placement in a reinforced security unit or section.

The individual regime can be seen as a type of detention somewhere between a period in solitary confinement and in a restricted group. This regime is intended for detainees who, owing to their personality or the circumstances of the concerned person, present a permanent control risk for fellow detainees, members of staff or themselves, and are consequently unable to function in a group regime.

The nature of the regime and shape given to it may differ between institutions because management boards implement their own policy within the indicated statutory framework.

The standard regime and the austere regime are discussed below. As mentioned, the standard and austere regimes are part of the restricted group regime. Because addicted detainees usually receive fairly short custodial sentences, most of them will serve their punishment in a remand centre, especially now that the maximum stay in a remand centre has been increased from one month to three. In addition, they will be placed in either a standard restricted group regime, or an austere restricted group regime, insofar as they are deemed to be in what is referred to as the nuisance category.

Standard regime

The standard regime, otherwise known as the ‘standard accommodation section’ or ‘standard detention’, without special care, applies to the majority of detainees in the Netherlands. During the day, detainees in the standard regime perform work with the fellow

detainees, they follow educational courses or relax, and spend the nights in their cells. Detainees receive standard care in accordance with the prison system's duty of care, as laid down in various instructions and regulations. This care is provided by penal institution workers (PIWs), the Social Services Bureau (BSD), and the probation and medical services (Psycho-Medical Team: PMT). A limited basic package of psychosocial and medical care is provided in the standard regime. Special care, such as care focused on addiction problems, is currently not available in the standard sections; this type of care is only provided at the Addiction Support Sections (VBAs) discussed below. A detainee in a standard section may qualify for this special care by following an Addiction Support Section admission and orientation programme.

The standard regime is not suitable for all detainees. Special care is also provided in addition to this regime. The special care for mentally disturbed persons and addicts is especially important within the scope of this advisory report (see section 4.1.4).

Austere regime

A relatively recent development in the prison system was the establishment of the 'austere regime' (not to be confused with the standard regime). This is intended for people under arrest (held for the execution of a basic custodial sentence), for alternatively imprisonment detainees and for what are known as the 'nuisance categories'. The latter group includes people with a severe drug-addiction problem who will receive a short-term sentence in accelerated criminal proceedings. The regime involves a daily programme of eight hours, without an evening programme and without activities that specially focus on social integration. This means that these people are locked up in their cells for long periods, without any possibility of contact with fellow detainees, and without being able to contact friends and family by telephone. People are only permitted to stay in the austere regime for up to 60 days, unless subsequent sentences are imposed, in which case the maximum stay in the austere regime is 90 days. The austere regime has been introduced into a number of institutions since 1 November 1996.

The austere regime has always been subject to criticism. The criticism concerned the humaneness of the austere regime and also involved doubts about the prospect of resocialisation. Kelk refers to the practice of the austere regime as distressing (Kel98). In his view, the people affected are usually people who have been extremely psychologically and physically neglected, and who are not always permitted to take part in work at the institution, so they have to spend even longer in almost complete isolation (only one hour out of the cell per day). The Forensic Care working group also pointed out that many mentally disturbed people find themselves in the austere regime (WFZ96). The percentage of addicts in the austere regime is estimated to be 70 to 75% (Bie99).

In a letter of 5 June 2001 to the Second Chamber (TK 2000-2001, 27400 VI, no. 66), the Minister of Justice presented arguments calling for the austere regime's discontinuation. Discontinuing the austere regime and placing these detainees in standard remand centres would offer a better guarantee that a responsible level of care would be provided. This is partly because of the broader possibilities for individual help and admission and orientation for special facilities, such as a special care unit. Moreover, discontinuing the austere regime would help considerably in terms of the flexibility and efficiency of capacity utilisation. However, discontinuation would involve extra costs because people in the nuisance category, people under arrest and alternatively imprisoned detainees would then come under the regime that normally applies in remand centres, for which the standard price is higher. The Minister stated in the letter that the extra costs required for this are not currently available. The Minister wrote that discontinuation of the austere regime would be taken up again in the future, when new possibilities arise. However, the number of places in the austere regime in remand centres will be reduced from 1,708 to around 800, owing to a reduced capacity requirement.

4.1.4 Special care

Only those institutions/sections for special care that are relevant to the subject of this advisory report, namely the special care for mentally disturbed persons and addicts, are discussed below. It is also important here to pay attention to the care provided for mentally disturbed persons because approximately half of all detainees with drug-use problems meet the criteria for at least one other disorder covered by the DSM psychiatric classification system (see section 2.3).

Special care for mentally disturbed persons: Special Care Section (BZA),Individual Supervision Section (IBA, Penitentiary Selection Centre (PSC),Forensic Observation and Supervision Section (FOBA)

Various Special Care regimes with increasing levels of care, individualisation and security have been established in penal institutions for detainees that are unsuitable for the standard regime owing to their mental condition. The various regimes are discussed below, more or less in order of the increasing intensity of care provided.

Some penal institutions have Special Care Sections (BZAs) intended for detainees who are vulnerable (for example, owing to their introverted disposition) and who (temporarily) need more individual care than can normally be provided in a standard regime. These sections are only used by the institutions themselves and are not exclusively intended for detainees with psychiatric disorders. The level of care in a Special Care Section is higher than that provided in sections with a standard regime. Although no extra psychological help is

available, some institutions have more PIWs, so that individual programmes can be provided. In 2000, 548 places were available in Special Care Sections (Zor01).

Some remand centres and prisons also have an Individual Supervision Section (IBA). These sections consist of one or more units. A unit has up to 12 places and is completely separate from the rest of the institution. It primarily has a regional function. The total number of places assigned to Individual Supervision Sections in 2000 was 190, distributed between remand centres (109), prisons (68) and female institutions (13). The number of places was due to be increased (Bes00, pages 12 and 13), but the expansion had still not taken place in 2001. Individual Supervision Sections are intended exclusively for detainees with psychiatric disorders who require more specific care than can be provided in a Special Care Section. Nevertheless, the special care provided in an Individual Supervision Section is, by nature, primarily related to social welfare (more individual attention from PIWs). Only limited medication-based psychiatric treatment is possible.

Placement in an Individual Supervision Section is arranged through a national Placement Advisory Committee (the Individual Supervision Section Selection Advisory Committee), which is mainly composed of behaviour specialists. The length of stay is generally eight weeks. Detainees whose psychiatric disorder is primarily the result of the addiction problem do not generally qualify for placement in an Individual Supervision Section (section 15, subsection 2, Selection Regulations on the placement and transfer of detainees). Research showed that Individual Supervision Sections in 1999 included many mentally disturbed persons who had an addiction problem (Vru00). The Drug Policy Progress Report indicated that Individual Supervision Sections are intended for detainees with (minor) psychological problems and disorders, and for detainees with a dual diagnosis (addiction plus other psychiatric disorder) (Dru01).

There is also the Penitentiary Selection Centre (PSC) in Scheveningen. The PSC is a national psychological advice centre for detainees with non-acute psychiatric disorders. The PSC also conducts clinical psychological research; during the last one and a half years of their sentence, detainees receive psychotherapeutic or sociotherapeutic supervision and receive temporary care in connection with a psychosocial crisis. This modality of special care is generally not intended for detainees whose psychological problem is dominated by the addiction problem (section 18, subsection 2, Selection Regulations on the placement and transfer of detainees).

Finally, there is the Forensic Observation and Supervision Section (FOBA), a special remand centre in Amsterdam. This is the prison system's crisis centre, where detainees in a penal institution who are suffering a severe psychiatric disorder can be temporarily admitted. It is for psychotic patients with a severely disturbed perception of reality and/or who are severely withdrawn. They usually suffer from schizophrenic psychosis and often refuse to undergo the indicated medical treatment because they fail to realise that they are sick. The centre is also for patients with a personality disorder and associated

disturbed states of mind, such as depression, patients who are impervious to approaches by the institutions staff, patients with an organic psychosyndrome and patients with drug-induced psychosis. Besides a psychiatric disorder, many patients in the Forensic Observation and Supervision Section have major social problems (low education level, no job, no home, poor social contacts, etc.) and the number of patients includes many people from ethnic minority populations (WFZ96). In line with its function as a link to facilities outside the prison system, there is a high flow-through rate at the Forensic Observation and Supervision Section. It also has its own consultant psychiatrist, physicians, psychologists and psychiatric nurses. The Forensic Observation and Supervision Section had room for 60 detainees in 2000. There were plans to considerably expand the capacity in 2000 by opening another Forensic Observation and Supervision Section elsewhere in the Netherlands. The increase in capacity had still not taken place in 2001, although an additional six places for women were created in the Forensic Observation and Supervision Section.

Special Addiction Support Section (VBA)

Addiction Support Sections (VBAs), formerly known as Drug-free Sections (DVAs), are specifically intended for addicts. An Addiction Support Section comprises one or more units. A unit has up to 24 places and is completely separate from the rest of the institution. It primarily has a regional function. The total number of places assigned to Addiction Support Sections was 443, distributed between remand centres (292), prisons (91), half open institutions for men (31) and female institutions (29) (Bes00). The number of places was originally increased within the scope of the nuisance reduction policy, but the decision to reduce Addiction Support Section capacity by 25% was taken in 2000 (see also section 4.2.4). The plan for 2002 is to reduce the number of Addiction Support Section places from 347 to 325, which represents a reduction that is, in fact, not even 10%.

The Addiction Support Sections are intended for addicts who are motivated to stop using drugs and who therefore qualify for admission to a treatment centre outside the field of law. Urine tests are an extremely important part of the Addiction Support Section regime. Any use of hard drugs or non-prescription substances is likely to result in sanctions, such as transfer to another wing (for a given period) or temporary denial of certain programme components. Disciplinary punishments may also be imposed.

To qualify for placement in the Addiction Support Section, detainees must be capable of making use of the provided supervision of the addiction problem and must have successfully completed the admission programme (section 20, subsection 1, Selection Regulations on the placement and transfer of detainees). Placement is not available for, among others, detainees with an acute psychiatric disorder and detainees whose command of

Dutch is insufficient (section 20, subsection 2, of the same Regulations). In the present policy, methadone use is a contraindication for placement in an Addiction Support Section.

The Addiction Support Section is characterised by a group approach based on communal groups of approximately eight to ten detainees (Zor00). The communal groups facilitate learning processes and behaviour changes. The programme is phased, with the initial phase involving working out the help that is required and determining goals. The emphasis is on basic issues, such as structure, regularity, self-discipline and self-care. Work in the middle phase is on achieving the goals set out in a plan of approach. The final phase is mainly concerned with preparing for the period after the Addiction Support Section (Zor00). The starting point for Addiction Support Sections has to be the perspective of the request for help from the addicted detainee. Demand for this help is varied and, therefore, the help the Addiction Support Section provides has to be customised. Another reason for this is that there is a large variation in the length of stay of detainees at an Addiction Support Section, in particular due to differences in remaining periods of imprisonment.

An important task of Addiction Support Sections is to promote the outflow of addicts to external treatment facilities. According to the constituent project group Regime of the Effective Detention Project (Wer94b), Addiction Support Sections should mainly be deployed at the start and finish of detention. The fact is that the initial phase often provides a good starting point for motivating addicted detainees to work on their problems. Addiction Support Section facilities will have to be available in the final phase as a closing part of a process that has already been set in motion, and as preparation for external care. Insofar as the initial and final phase do not join up (in the case of longer sentences), the interim phase of detention in the standard regime has to provide special facilities to ensure drug-free detention and to maintain motivation for the treatment.

However, the Addiction Support Section outlined here is an idealised picture. Addiction Support Sections are not a great success in practice. There is relatively little motivation among detainees to be placed in an Addiction Support Section; the Addiction Support Section utilisation rate in 1999 was approximately 65%. In 1999, 1,210 detainees were placed in an Addiction Support Section. The average length of stay was 12.8 weeks. A possible explanation for the number of vacancies is that there are so few detainees that are sufficiently motivated to actually stop their use of drugs.

4.2 The penal addiction policy and practical implementation

First, a description of the penal addiction policy's objectives is provided(4.2.1). This is followed by details of specific parts of the policy, namely the drugs policy in detention (4.2.2), the policy on methadone (4.2.3), the policy on the Addiction Support Sections

(4.2.4), and the policy on pressure and compulsion (4.2.5). Where details are available, we also examine the degree to which the policy is implemented in practice.

4.2.1 *Objectives*

The objectives of the present penal addiction policy are set out in the Preliminary Memorandum on developing the vision of the penal addiction policy, dated 10 January 2001 (Ministry of Justice, Dutch Agency of Correctional Institutions, Prison System Sector Agency). The memorandum describes the objectives as follows. The penal addiction policy arises from the policy on effective detention and government policy on reducing the nuisance caused by drug addicts. The operational policy framework is set out in two constituent reports on care for addicts (Wer94a and Wer97), within the scope of effects of effective detention. In line with the objectives of effective detention and the nuisance reduction policy, the penal addiction policy is intended:

a to discourage drug use during detention with a view to promoting a drug-free environment
b to limit the risks of drug use (for users and their environment) and to offer addicted detainees complete (medical) care, and
c to admit addicted detainees to specific care facilities and programmes, via Addiction Support Sections, after, or in the final phase of, detention.

4.2.2 *Drugs policy in detention*

Drugs (including soft drugs) are prohibited in penal institutions. The official policy in institutions is the Drugs Discouragement Policy (DOB). The core of the policy is that the entry, presence and use of drugs must be prevented as far as possible. Instruments for achieving this include cell inspections, urine tests, examinations of clothing, examinations of (and inside) the body, and (disciplinary) punishment.

The Drugs Discouragement Policy serves several goals, the first of which is the uninterrupted execution of the deprivation of liberty. It must be ensured that the struggle to obtain the daily portion of drugs does not become a preoccupation of detainees, reinforcing this lifestyle and thereby continuing to be a source of nuisance in the institution. Moreover, the policy aims to provide safety and protection to non-users and addicted detainees who are motivated to kick the habit, but who cannot yet be placed in an Addiction Support Section. Finally, the Drugs Discouragement Policy aims to contribute to the resocialisation of addicts. Drug use is at odds with the aim of resocialisation; discouraging drug use creates a situation in which addicts are confronted with questions about their drug use, which can in turn motivate them to opt for supervision/treatment.

The following applies to the Drugs Discouragement Policy's implementation in practice. According to the report referred to as the *Stok achter de deur* (Big Stick Report (Bie99)), institutions often still fail to do enough to implement the Drugs Discouragement Policy. This is possibly accounted for by the fact that they have not received a separate budget to do so. The fact is that preventing drugs from entering penal institutions is hardly (if at all) feasible in practice (see section 2.4). This would only be possible with rigorous inspections and repressive measures, owing to the ingenuity employed in getting around existing inspections. The managing boards of institutions often believe there would be too high a price to pay for this (hardening of attitudes and the climate in the institution).

4.2.3 *Methadone policy in detention*

Supervision, medical or otherwise, of drug addicts in penal institutions is characterised by differences, as is that provided in non-penal drug-treatment services. Policies on methadone provision are particularly divergent in the institutions, whereby the individual opinions of institutional physicians and governors are not infrequently the deciding factor. It even occurs that an addicted detainee has to kick the habit 'cold turkey' (which means immediately ceasing to use addictive drugs). As long as the detainee only had the institutional physician to rely on for methadone treatment, the same addict might have been provided with the daily maintenance dose of methadone in one institution but not in another. This presented detainees with an uncertain and confusing situation, which had the unmistakable characteristic of arbitrariness (Kel98). Now that both remand centre and prison detainees are entitled to consult a physician outside the institution (see section 3.1.3), there must be at least a collegial consultation between the external physician and the institutional physician. This may have made policy differences between institutions less extreme, but differences have by no means vanished (IGZ99).

Attempts were made as early as the mid-nineteen-eighties to achieve greater consensus on methadone provision in penal institutions. In 1985 the then Ministry of Justice's consultant for addiction affairs, Dr PA Roorda, sent a memorandum to all institutional physicians. A distinction was made in the memorandum between the category of detainees serving a short sentence that return after detention to the methadone programme they were following, and the detainees serving a long sentence, who are transferred to a prison after sentencing. The advice was that there is no point in withholding the methadone maintenance treatment of detainees serving a short sentence, whereas this will generally be the aim, after a gradual reduction, in the case of detainees serving a long sentence. This advisory report was indeed supposed to have brought about greater unity in the medical line of conduct.

On 11 December 1986 the Association of Medical Officers (now the Association of Penitentiary Physicians), with cooperation from the Central Advisory Body for Peer Review

(CBO), organised a Consensus Meeting on the Medical Policy on detainees addicted to opiates (Con86). A draft protocol on the medical treatment of addicted detainees was discussed at the meeting. The protocol certainly won no prizes for its simplicity and it is difficult to say whether this initiative has helped create a more uniform policy. In any case, the Van Dinter Committee, which had the task of advising government on the organisation of medical care in penal institutions, thought it was necessary to once again call for greater uniformity in the methadone policy in 1995 (Din95).

Detainees brought a number of interlocutory proceedings in the mid-1990s that were intended to ensure the continuation of methadone provision in the institution, as it had been prescribed outside the institution. It could be inferred from the court's decision that the detainee must be given the opportunity to consult a physician from outside the institution for a methadone prescription. The right to consult an external physician was, in the meantime, anchored in the Custodial Institutions Act of 1 January 1999.

In December 1996, the (former) Medical Inspectorate of the Ministry of Justice drew up a guide on methadone provision for detainees (Letter of 13 December 1996, reference dM/96268). The guide indicated the cases in which detainees qualify for methadone. The guide indicated that detainees who did not use heroine or methadone during the two weeks prior to their custody should not receive methadone and that short-term detainees (shorter than four weeks for example) who did receive methadone may be provided with a maintenance dose of methadone, if required. The guide did not distinguish between pre-trial detainees and sentenced detainees, so the four-week term applies to both categories*. Mainenance treatment with methadone may be started or continued for detainees who are also suffering from HIV infection, some other severe infectious disease (such as tuberculosis), or those who are pregnant. Addicts with a psychiatric syndrome, and those with extremely long-term addiction and methadone use (e.g. longer than 15 years), may, in consultation with the physician providing treatment, also have their maintenance treatment continued after consultation with the treating physician. All other addicts must kick the habit by means of a gradual reduction programme. It is stressed that decisions on whether or not to provide methadone must be based on individual considerations. There is no place in the guide for an all-or-nothing policy.

According to the guide, there must be a reduction of the methadone dose of detainees that have a custodial sentence of more than four weeks and do not have concomitant ailments. The health lawyer, Dute, wondered whether this is at odds with case law from interlocutory proceedings (Dut97). After all, these detainees may attempt to obtain their maintenance dose of methadone by consulting a physician outside the institution. In a letter dated 16 July 1997, the Ministry of Justice's medical adviser therefore went a step further than the

* Application of the four-week term can cause problems in practice with pre-trial detention because the duration of detention is uncertain for this

guide. According to him, the possibility of "a number of physicians who are not familiar with the detention circumstances, having a significant effect on the penal institution" must be avoided. The adviser therefore "urgently requests institutional physicians (..) not to deny methadone in this period to detainees who used methadone before the detention period, unless this is agreed on in negotiations with the concerned person". There must always be consultation with the clinic for alcohol and drug abuse, the Municipal Health Services, or the prescribing general practitioner. It was pointed out in section 3.1.5 that neither the guide nor the letter was binding for the institutional physician. However, the content does play a substantial role in the judicial review and the review in the case of a complaint concerning the actions of the institutional physician.

The report *Zorg achter tralies* (Care Behind Bars), by the Health Care Inspectorate and the National Institute of Public Health and Environmental Protection (IGZ99, provides an impression of current methadone policy practice. It shows that the methadone policy in penal institutions can be roughly divided into gradual reduction and maintenance. A few institutions have a 'no provision' policy because there is only entrance of transferred detainees who have had their dose 'gradually reduced' elsewhere. Almost 20% of institutional physicians and nurses said that methadone is issued (under certain conditions) on a maintenance basis. However, there was no single medical service where all institutional physicians and nurses said that methadone is issued on a maintenance basis. At 60% of medical services, all institutional physicians and nurses indicated that the methadone dose of all detainees is gradually reduced. Especially in the larger institutions, they unanimously said that methadone is not issued on a maintenance basis. Opinions differ sharply among institutional physicians on what the maximum methadone dose should be at the start of the gradual reduction. They also have very different opinions about the length of the gradual reduction period. Because the implemented policy is actually still dependent on the institutional physician's choice, there are differences in the way in which methadone is gradually reduced per medical service. They sometimes start with a fixed (maximum) dose for all detainees and sometimes the starting dose is determined per detainee. A few institutions even appear to use the 'cold turkey' method, possibly in combination with paracetamol. Medications other than methadone are hardly used at all for gradually reducing heroine addiction.

Methadone is issued in liquid form. One medical service indicated that it has not 'dissolved' methadone since 1 January 1998, following a circular from the Ministry of Justice's pharmaceutical adviser (dated 4 September 1997, reference 583936/96/DJI). The circular stated that medications should not be dissolved in advance in connection with the possibility of decomposition and conversion into (toxic) by-products. The concerned advisory report obviously relates to medications that are unavailable in liquid form. However, methadone is available in both tablet and liquid form. Choosing the liquid form is in no way in breach of the circular, as the aforementioned medical service apparently

assumed it was. According to 82% of institutional physicians and nurses, detainees are supervised during the methadone gradual reduction period. Supervision is usually provided by the CAD or the medical service, and consists of talks, examinations of the detainee and/or medication. The PIW member of staff also has a supervisory and controlling function in the Addiction Support Section.

Interviews with medical services revealed that the policy on issuing methadone has recently been made more flexible at some institutions. Although maintenance doses are sometimes given, the policy is generally still concerned with gradual reduction. Care Behind Bars deems this to be in conflict with the prevailing opinion of society and that sanctioned by the courts, which is that detainees should also be able to continue their treatment for addiction during their stay in a penal institution (IGZ99). The recommendations of the Dutch Agency of Correctional Institutions (DJI) of the Ministry of Justice, which is responsible for the guide and letter, are therefore only very partially followed up in practice. See also section 3.1.5, as well as Annex C containing the statements of the Medical Affairs Appeal Committee of the Central Council for the Administration of Criminal Justice.

4.2.4 Addiction Support Section policy

The duty of the prison system to lead addicted detainees to standard care for addicts arises from the nuisance reduction policy. An important link in this is the addiction supervision process. The process is ultimately aimed at placing the addict in a care facility outside the penal institution. This process is described as follows in the report by the Addiction Support Process Improvement working group (Wer00) on the basis of the two constituent reports on care for addicts (Wer94a and Wer97).

The first step in the process is to determine the problems upon admittance. The second step is to provide detainees with information on the types of care that are available for addicts in the institution, including the provision of special care in the Addiction Support Sections. The third step consists of offering a group admission and orientation programme. This is intended to further encourage detainees, to test their motivation and to develop insight into the addiction problem. Insight is also obtained during the programme into the nature and availability of the required follow-up care.

Once the detainee has successfully completed the admission and orientation programme, the institution can submit a proposal - in the form of an advisory report on selection - to the regional selection officer for placement in an Addiction Support Section. The proposal indicates the extent to which the selection criteria have been fulfilled for the Addiction Support Section (see section 4.1.4 under Special Addiction Support Section (VBA)). The selection officer then carries out a formal review and decides on the placement. If the selection officer's decision is affirmative, then detainees in an institution without an Addiction

Support Section are transferred to an institution with an Addiction Support Section. The Addiction Support Sections therefore play a supralocal function. According to the Addiction Support Process Improvement working group, placement in an Addiction Support Section is in order in the final phase of detention. After all, it is only then that the Addiction Support Section can make preparations for outflow to a care facility or into the community.

While in the Addiction Support Section, the detainee is prepared for the external care facility. Preparations take place in a drug-free/opiate-free environment, on the basis of a group approach, a phased programme, and individual customised care at the indicated facility. Ideally, the transfer to an external care facility takes place within the scope of treatment that replaces detention, as this enables the care for the concerned person - who is still under the supervision of the judicial authorities – to be intensified in a non-judicial setting. A properly functioning Addiction Support Section is deemed to exist if it conducts the activities that are required for the best possible preparation for follow-up care. The Addiction Support Process Improvement working group believes this may be deemed to have been successful if a detainee can be designated for follow-up care after, or in the final phase of, detention.

In 2000 the Ministry of Justice instructed the Addiction Support Process Improvement working group to delineate practices in the Addiction Support Sections, by means of a questionnaire sent to the institutions and making use of monitoring data from the Netherlands mental health care service. In practically all the institutions investigated, the aspects of the admission and orientation for the Addiction Support Section – determination of addiction problem, information, admission and orientation as well as selection – have been implemented. Approximately three-quarters of institutions that have implemented an admission and orientation programme have done so on an individual rather than group basis. Seventy percent of institutions apply demonstrable gradual reduction of drug use as a selection criterion, but they differ in the explanation they provide of it. Half the institutions consider ‘preparation and suitability for (external) follow-up care’ to be an important selection criterion for admission to an Addiction Support Section. A third of institutions – especially institutions with an Addiction Support Section – select and place people without making use of the selection officer.

There are major differences between remand centres in the degree to which they arrange for the admission and orientation for an Addiction Support Section. Addiction Support Section places in the remand centres are 80% filled with local detainees, whereas the Addiction Support Section places in prisons are 78% occupied by detainees from other institutions. The supralocal function of the Addiction Support Section in remand centres, as opposed to that in prisons, has therefore not been achieved. Almost 60% of detainees who follow the admission and orientation programme normally complete it and receive an affirmative recommendation. Of these detainees, at least 85% are actually placed in an Addic-

tion Support Section. Therefore, 50% of those who start an admission and orientation programme finally end up in an Addiction Support Section. Practically all detainees who are placed have followed an admission and orientation programme. The Addiction Support Sections differ with regard to the nature of the structural separation from the rest of the institution and they also use different programme modules to enable them to provide customised services.

Around 1,200 detainees are placed in an Addiction Support Section each year. Almost 45% of them stay there for two months, at most. The average length of stay at an Addiction Support Section in a remand centre is 12 weeks, whereas the figure at an Addiction Support Section in a prison is 16 weeks. In total, the target group vacancy level is 25%. When divided according to remand centres and prisons, vacancy levels are 31% and 8% respectively. The vacancy level is therefore mainly accounted for by the Addiction Support Sections in remand centres. Forty percent of detainees who leave an Addiction Support Section in a remand centre are provided with follow-up care at a care facility. Ten percent are transferred to another Addiction Support Section. Almost 60% of detentions finished in a prison Addiction Support Section are 'followed by a care process'. The latter probably only means that people have indicated they would follow a care process. The percentage that actually followed this through was probably much lower.

These findings were insufficient for the Addiction Support Process Improvement working group to reach agreement on what the precise problem is and where improvements should be sought. Some members of the working group sought the reasons for the vacancy level mainly in poor implementation of the policy that has been set in motion. However, other members believed that the current policy fails to provide sufficient returns. The former members of the working group called for the actual implementation of the Drugs Discouragement Policy, the materialisation of proper admission and orientation, and measures to tackle under-utilisation by probation officers for addicts. The latter members of the working group sought the reason for the inadequate, if any, supralocal functioning of the Addiction Support Section in a lack of motivation among addicted detainees. This was apparently clear from the fact that there was also little interest in the low-threshold admission and orientation programme. Improvement measures were not expected to do much good. These members of the working group thought that care of addicts should be transferred to the level of the clusters. Besides an offer of a limited established Addiction Support Section to a specific group of the addict population, the institutions in the clusters should be free to give shape to the remaining care offered to the other group of addicts.

Owing to the urgency of improvement measures and given the different opinions, the Addiction Support Process Improvement working group recommends, for the short term, that Addiction Support Section capacity should be reduced by a total of 25%.

Analogous with the results of the survey, the reduction should be in the ratio of around 31% in remand centres and around 8% in prisons. For the long term, the working group recommends working towards a policy framework that establishes a shared vision of care for addicts in prisons and the policy objectives that arise from it.

In a memorandum dated 14 March 2000, the Ministry of Justice's Director of Prisons informed those attending the meeting of Governors of the prison system that, on the basis of the working group's report, he soon intended to reduce total Addiction Support Section capacity by 25%. He also intended to arrange for research to be conducted into what was actually needed in the range of programmes available to addicted detainees to enable them to successfully complete the admission and orientation process for the standard care for addicts. The role of Addiction Support Sections would also have to be investigated. This would enable a decision to be taken within no more than two years on the advisability of continuing Addiction Support Sections in any form. The meeting of Governors approved the proposals in April 2000. Reduction of Addiction Support Section capacity by 25% has since been laid down in the Drug Policy Progress Report (Dru01). The released capacity will be used for expanding Individual Supervision Sections and the admission and orientation process for Individual Supervision Sections. However, the reduction in Addiction Support Section places scheduled for 2002 is not even 10% (see section 4.1.4, under Special Addiction Support Section (VBA)).

4.2.5 *Pressure and compulsion*

Pressure

The 1988 government policy document *Dwang en drang bij de hulpverlening aan verslaafden* (Compulsion and Pressure in Help for Addicts) contained the first description of how pressure could be used to reduce the level of nuisance caused by drug addicts. The *Nota Vermindering Overlast (*Nuisance Reduction Policy Document) was published in December 1993 and described government policy for the period 1994 to 1997. The interdepartmental *Stuurgroep Vermindering Overlast* (Nuisance Reduction Steering Committee, Dutch acronym, SVO) was set up to implement the policy. The Dutch Association of Addict Care and Treatment Centres (NeVIV) started a nationwide project in 1994 to contribute to the policy from the viewpoint of care of addicts. The *Drang op Maat (*Appropriate Pressure Project), subsidised by the Ministry of Health, Welfare and Sport, was concerned with addicts who come into contact with the criminal justice system, otherwise known as justiciable addicts. Organisations providing care for addicts carried out all kinds of projects as of 1994 under the umbrella of Appropriate Pressure, with the aim of arranging for addicts who came into contact with the police and judiciary to undergo treatment under pressure of a penal sanction (see also section 3.4). The treatment was concerned with

dealing with the addiction problem and integration/reintegration in the community. Inflow was possible at various times in the criminal law chain, for example during the preliminary investigation (conditional dismissal, suspension of pre-trial detention period), in the case of sentencing (suspended sentence), and during the execution of the punishment (Addiction Support Sections, Penitentiary Programme).

To make customised care possible, various types of facilities were started that helped with the target group's social integration and with reducing recidivism. Among other things, this included the development of the Early Intervention Arrest Referral Scheme (VIS), which involved the probation officer at the police station systematically offering suspects a choice between a place in a care facility or a prison, the development of Addiction Support Sections, Penitentiary Programmes (PP), Motivation Centres (i.e. low-threshold clinical facilities intended for addicts who are a persistent nuisance and who do not wish or are unable to immediately go to standard addiction clinics), a Forensic Addiction Clinic (FVK), and projects within the scope of Social Rehabilitation. These last-named projects included housing supervision and supervision with finding worthwhile ways of spending time.

These projects were evaluated after five years (Dra98). One conclusion was that pressure had still not been implemented as an instrument everywhere to the same extent and as systematically, which meant that the instrument's added value could not be adequately assessed. Nevertheless, initial results were promising. The people with final responsibility for the Appropriate Pressure project therefore decided that there was no reason in the year 1999 to switch to the more forceful instrument of compulsion.

Compulsion: Demersluis, Ossendrecht, Penal Care Facility for Addicts

Prior to the introduction of the Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act (SOV, see below), there was only one judicial facility in the Netherlands where justiciable addicts could be compelled (thus, against their will) to enter a drug-free/opiate-free regime, with compulsory urine tests, namely Pavilion 2 at Demersluis remand centre in Amsterdam. This section, with 24 places, was used as of September 1994 for the compulsory placement of what are known as street junkies who have been given a custodial sentence. The placement was intended to confront the addicts with a drug-free/opiate-free regime and to encourage them through pressure (sanctions/privileges) to participate in an individual care programme. Addicts who produced uncontaminated urine every day and actually made use of the care programme were given extra freedom and activities (basic-plus regime). Refusal to undergo urine tests and/or presentation of contaminated urine (i.e. indication of drug use) and/or refusal to work on the therapeutic programme were punished with a restriction or withdrawal of liberties and privi-

leges (austere regime). The aim was to arrange for as much care as possible immediately following the programme, after detention.

The decision not to continue with Pavilion 2 and to gradually reduce the number of placements was taken in mid-1998. Evaluation of the experiment by the Amsterdam Institute for Addiction Research (AIAR) (Jon97) showed that the group that was most receptive to the pressure component (inflow in the basic-plus regime) was the group of people with a custodial sentence of three to six months. However, owing to the tit for tat policy, the average length of stay of clients in Pavilion 2 was shorter than three months and therefore too short to motivate them to enter into treatment (Baa98b). The evaluation results showed that at least three months is required for this.

Prior to the introduction of the Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act, a start was made in Rotterdam in 1995 on treating addicts detained in Ossendrecht according to a judicial measure that made it possible for certain recidivist addicts to be compulsorily placed for two years in an institution for the care of addicts. Until the Compulsory Treatment of Addicts Act created a statutory basis for compulsory placement, the inflow and outflow of detainees in this experiment was voluntary. The design of the experiment was very similar in content to the design of the Forensic Addiction Clinic (FVK). There were three phases with an increasingly open character in which social integration and the ability to function independently were the final goal. As with the FVK, the programme lasted eighteen months to two years.

The project's evaluation showed that the results were positive in terms of confidence in the programme and the reduction in social harm (Kon98). However, one of the most important distinguishing features of the future Compulsory Treatment of Addicts Act, namely compulsory placement, was not tested in this experiment because placement was still voluntary. The positive evaluation of the project at Ossendrecht could indicate that there is no need for compulsory placement of the kind introduced by the Compulsory Treatment of Addicts Act. However, the legislator did not draw this conclusion.

The Compulsory Treatment of Addicts Act (Bulletin of Acts and Decrees, 2001, 28) came into force on 1 April 2001. It introduced a new sanction provision in the Penal Code, namely the measure of placing recidivist addicts in an institution for the care of addicts. The measure can be imposed provided that the following four requirements are adequately met: *1*. the offence the accused has committed concerns a criminal act for which pre-trial detention is permitted; *2*. the accused must have been irrevocably sentenced at least three times during the preceding five years in connection with criminal acts, and there must be a likelihood of recidivism; *3*. the accused must be addicted to hard drugs, and the criminal acts committed and the likelihood of recidivism must be related to the addiction; *4*. the safety of persons or goods must demand the measure's imposition. The Explanatory Memorandum (Upper House, session 1999-2000, 26023, no. 215b, page 3) names the following as objective criteria for determining the target group: “three irrevocable sen-

tences during the past five years; male; legally resident in the Netherlands and no dominant psychiatric disorder". An additional criterion is stated as "unsuccessful previous participation in drug rehabilitation programmes provided within the scope of care for addicts".

The Compulsory Treatment of Addicts Act measure may also be imposed conditionally, in which case an operational period of three years must not be exceeded. In that case, conditions are set for the offender's conduct, which may entail the person undergoing outpatient or inpatient treatment. In such cases, the period for which the person is admitted into an institution must be a maximum of two years. This condition is only set if the offender has indicated willingness to undergo the treatment.

The Explanatory Memorandum to the bill states the measure's main objectives: *1*, to reduce serious nuisance resulting from offences committed by drug addicts; and, *2*, to solve, or at least make manageable the individual addiction problems of the addicted offenders, with their return to the community and ending recidivism in mind. According to the Explanatory Memorandum, the justification for implementing the measure does not lie solely in the seriousness of the offences committed (usually theft, theft preceded by forcible entry and/or handling stolen property). The justification lies on the one hand in the serious social nuisance the criminality causes (a series of offences) and, on the other hand, in the interest of ensuring that addicts receive an integrated range of care that focuses on social reintegration and ending recidivism.

The measure's maximum duration is two years. The court may prematurely terminate the measure if it believes further execution is no longer required or if this is the offender's request. It was not the legislator's intention that addicts who are subject to a Compulsory Treatment of Addicts Act measure and that fail to cooperate in the treatment are able to get of scot-free through premature termination.

The proposed facility involves compulsory care in an institution intended specifically for that purpose (compulsory placement). It has no provisions for compulsory treatment, but does have provisions for pressure in the treatment. The pressure will consist of the threat of placement in an austere regime if the addict does not wish to cooperate in the treatment (see also section 6.1). According to the government, compulsory care may create the conditions under which the addict becomes motivated to undergo treatment. The care consists of various phased stages: closed, half open and open. The first two stages will be executed in a specific institution, while the third – outpatient stage – will occur in the region where the nuisance was caused and the perpetrator lives. The possibility of methadone use is not excluded at this third stage (Decree of 27 March 2001, Explanatory Memorandum, Bulletin of Acts and Decrees, 2001, 159, bottom of page 12).

The Compulsory Treatment of Addicts Act focuses on provision of an integrated and differentiated range of care and a single process supervisor who works in the probation services and supervises the concerned person for the entire duration of the measure. The measure envisages a great deal of involvement by the participating local authorities

in, and joint responsibility for, the creation of follow-up facilities (education, job counselling, housing). The intention is for the local authorities to stand as guarantors for housing facilities and jobs when the concerned persons have successfully completed the process.

The Compulsory Treatment of Addicts Act's target group is people addicted to hard drugs, whose (frequently) long-term addiction is combined with constant and steadfast criminal behaviour that causes a great deal of nuisance. It concerns offenders who usually have a long criminal record. Addiction is central to their problem but they have proved to be incapable of breaking out of the spiral of addiction and crime. They also lack the motivation to use existing care facilities. They have been unable to benefit sufficiently from existing compulsory interventions and the associated possibilities for opting for care facilities. The sentences for the crimes concerned are often too short to enable pressure to be effectively used on the offenders. Compulsory interventions intended to coerce offenders into opting for care facilities that are provided immediately after intervention are only partially used because the 'big stick' is too small. In summary, the judicial contacts and care facilities have thus far had too little of a grip on this category of people. According to the government, this new penal instrument's introduction is justified by the persistence of the nuisance, the personal problems that are at the root of it and the inadequacy of existing instruments for the concerned group of addicts.

For the time being, the Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act will be in the form of an experiment* that will be subject to evaluation and will be conducted in Amsterdam, Rotterdam, Utrecht, Arnhem, Nijmegen, 's-Hertogenbosch, Eindhoven, Maastricht and Heerlen. The last six of the aforementioned cities will be incorporated into a 350 place Penal Care Facility for Addicts known as SOV Zuid. Given the capacity that will become available in the course of 2001 and the next three years, the Ministry of Justice expects an inflow of no more than 700 addicts into the Penal Care Facility for Addicts.

4.3 Organisation, policy and the practical implementation of probation

The present organisation and structure of probation date back to 1995, when SNR, a national probation foundation, was established. Three national probation bodies participate in the service: the probation section of the Salvation Army (for homeless justiciables), the addict probation section of the mental health care service (for addicts) and the Dutch Probation Service (for all other justiciables). The qualitative distribution of clients between the organisations in 1998 was 10% for the Salvation Army, 20% for the Dutch mental

* From a legal point of view, the term 'experiment' is an unfortunate choice for the Penal Care Facility for Addicts because a measure for which a statutory basis has been created can hardly be referred to as 'experimental'.

health care service and 70% for the Dutch Probation Service (Kal00). Sixteen bodies with probationary powers carry out probation work for addicts; they provide care for addicts and are supported by a national staff office. The central government has now taken over the entire funding of probation. The central government, that is the Ministry of Justice, is therefore also responsible for the extent to which and the way in which probation work is executed.

The key tasks of probation are described in article 8 of the Probation Regulations of 1995. The tasks are:

a to provide help and support
b to conduct research and provide information for the Ministry of Justice, and
c to prepare and supervise community service sentences and other judicial decisions, and to supervise their implementation, which includes reporting on this to the competent authorities.

Contrary to what is often thought, providing follow-up care after the execution of a sentence or measure is not one of the statutory tasks of probation. The probation service is not allocated a government subsidy for providing follow-up care. The government sees the provision of this care as a task of normal social work or the standard care for addicts.

The Social Services Bureau, which exists in all penal institutions, is concerned with assisting detainees. The probation service also has a task in this area. Whereas the BSD's focus on tasks in the area of what is known as 'detention planning', employees of the 'penitentiary probation service' (i.e. probation officers working in a penal institution) are mainly occupied with helping detainees with their tangible and intangible problems, such as debt rescheduling, rent arrears, problems with work, benefits or relationships, or other difficulties connected with detention. Ordinary prisons have one probation worker for every 96 detainees. Supervision of addicts at Addiction Support Sections (VBAs) is a special form of assistance that is provided by a probation service employee. There is one probation officer for every 12 addicted detainees (Kal00).

The tasks of providing assistance and information are considered as coordinating tasks in the Probation Regulations of 1995. It is assumed that a trained probation officer should be capable in practice of properly combining these tasks with each other in consultation with the client. The information report for the prosecution and trial is the most important, but not the only, report that the probation service prepares. Another category of report is concerned with the way in which the accused or offender complies with the conditions imposed by the court or Public Prosecutor, in the case of, for example, a conditional dismissal, a conditional suspension of pre-trial detention, a suspended sentence, a community service order, a conditional hospital order or a Penitentiary Programme. The Public Prosecution Service is formally responsible for implementing these provisions and for

their inspection, but the actual supervision of compliance and the provision of assistance and support are left to the probation service.

Unlike with the information report, it is impossible to take the middle way when considering coordination. In the field of tension between behaviour control and assistance, the probation officer will be unable to escape the primacy of behaviour control. If the accused or offender fails to comply with the conditions, then the probation officer will have to report the details to the body that imposed the sentence. A negative report of this kind may have serious consequences for the concerned person, such as continuation of the prosecution, the accused's return to custody or the implementation of a suspended sentence, community service order or Penitentiary Programme, and execution of the imposed punishment or measure. It is not the probation service that formally takes a decision of this kind, but the probation report does form the basis of any such decisions.

Because the merging of assistance and control place pressure on the contact with the client, the mutual relationships, expectations and obligations are laid down beforehand in a protocol that both parties sign, so that the client is aware of his relationship with the probation officer. Clients who do not agree with the report or the decision may contest it by instituting special proceedings with the national complaints committee or the body that is responsible for taking the subsequent decision (Kal00).

The Dutch mental health care service published a Penitentiary Probation Officers Policy Document in 1998 (PRA98). It described the mission of judicial care for addicts as the provision of 'customised care' to the entire population of addicted detainees.

The aim was to provide a range of care that was in line with the possibilities and wishes of the individual client, varying from harm reduction to abstinence. It was pointed out that the aim for judicial care for addicts with this is broader than that set by the prison system, which was a policy that focused on achieving abstinence among drug addicts.

To achieve this broader aim, they are attempting, on the one hand, to strengthen the existing penitentiary probation that is provided and, on the other, to modernise the care provided in this field. Ideas for achieving this include: *a*, the development of services that focus on follow-up care, with a lower threshold than the present Addiction Support Section, in which the emphasis is on harm reduction and social rehabilitation (methadone maintenance programmes), *b*, working on reaching the growing group of addicted detainees with psychiatric problems and the group of addicts from ethnic minorities, and *c*, developing a specific range of probation services for addicted detainees with psychiatric problems, as this group is not properly reached with the present range of services.

In the same period as that in which the Penitentiary Probation Officers Policy Document was published, the addict probation section of the mental health care service commissioned a national survey by Intraval consultants into practical problems that occur in achieving

the probation service's objectives and into possible solutions to those problems (Bie99). The survey showed that penitentiary probation officers have to operate in a considerable field of tension. There is by no means always agreement between the institution's management board and the penitentiary probation service on the objectives and target groups of the care for addicts in prison policy. For example, institution management boards believe that the probation service should mainly pay attention to motivated detainees, whereas the probation service would also like to involve non-motivated addicts in its activities. The detainees themselves mainly need to arrange practical matters, customised care and proper follow-up care. Some institution management boards believe that the probation service should also contribute to making the situation in the penal institution manageable and that it is best to provide care for detainees after detention.

The recommendations of researchers are concerned with, among other things, institution management boards and probation workers achieving a better match between target groups and the objectives of care for addicts in prisons, and with the quantitative and qualitative expansion of the care provided for addicts in prisons. More supervision facilities should be created for the probation service in the standard and austere regime. The services should be more differentiated (more customised care) and, with continuity of care in mind, supervision should be carried out while taking more of a path-based approach.

The survey revealed that the stumbling block in achieving a coherent policy is the lack of constructive cooperation between penitentiary probation workers (the penitentiary probation service), the external probation service (the institutions for care for addicts with a probation order), the three probation partners and the penal institutions. The transition to follow-up care is often far from optimal owing to the difficulties in cooperation between the penitentiary probation service and the external probation service. The probation partners (Salvation Army, Dutch Mental Health Care Service and Dutch Probation Service) more or less compete with each other, while the penitentiary probation worker is in effect often stuck between the institution management board and the care for addicts. More direct consultation between the management boards of the organisations and the management boards of the institutions would be advisable, also with a view to improving the probation worker's position in the institution. It is currently often the case that the penitentiary probation worker himself/herself consults the institution's management board, while the worker actually has little authority to take decisions and is therefore unable to act as a proper counterbalance to the management board. It would generally be better for penitentiary probation officers to be supported by their own organisation. Consultations between the organisations providing care for addicts and the penal institution should be intensified at the management board level, and agreements should also be reached on mutual responsibilities, in accordance with the recommendations of Intraval consultants.

Chapter 5

Current knowledge

5.1 Introduction

This chapter sets out what is known about the effectiveness of treating drug addiction in detention. Most research into effectiveness has been conducted in the United States.

The effectiveness of treatment for cocaine addiction is first briefly discussed below (5.2). Current knowledge of the effectiveness of treatment, especially methadone treatment, for opiate addiction is then discussed both in general and in the detention setting (5.3). This is followed by a discussion of what is known about the effectiveness of treatment programmes for drug addiction in detention (5.4). The effectiveness of judicial pressure and compulsion in the treatment of drug addiction is then examined (5.5), as is the effectiveness of follow-up care programmes after confinement (5.6). Finally, we summarise the research conducted into the effectiveness of treatment for drug addiction in detention and discuss the relevance of the research for the Netherlands (5.7).

5.2 Effectiveness of treatment for cocaine addiction

A chapter on current knowledge of the treatment of drug addiction in detention cannot avoid a discussion of the treatment of cocaine addiction. Chapter 2 indicated that most drug-addicted detainees in the Dutch penitentiary setting are, by far, polydrug users (mainly cocaine and heroin). A small group of an unknown size is composed of people who only use cocaine. However, in all probability, very few of those detainees who only use cocaine

would have been treated by the addiction treatment and care system prior to their detention (see section 2.2).

Withdrawal symptoms are much less of a problem with cocaine addiction than with addiction to opiates, benzodiazepines or alcohol; there are no severe (physical) withdrawal symptoms, although justiciable users do 'crash' a short time after ceasing to take the drug. This usually occurs in the police cell and symptoms can include dysphoria, fear and agitation. However, the likelihood of 'crashing' has usually passed by the time the cocaine user is transferred to the remand centre or prison. There are no acute indications for treatment of people in the penitentiary setting who only use cocaine or who use it in addition to other drugs. No effective pharmacotherapy is currently available for treating cocaine addiction. Possibilities for effective psychosocial treatment of cocaine addiction are limited. For details of current knowledge about pharmacotherapeutic and psychosocial treatment of cocaine addiction, see the advisory report of the Pharmacotherapeutic Interventions in Drug Addiction Committee (GR02).

5.3 Effectiveness of treatment for opiate addiction

The Pharmacotherapeutic Interventions in Drug Addiction Committee recently delineated the general effectiveness of the treatment of opiate addiction. It is sufficient here to present a few quotations from the Committee, while referring to the complete advisory report (GR02).

In its Executive Summary, the Pharmacotherapeutic Interventions Committee distinguishes between the objectives of cure of addiction *(cure:* the achievement of stable abstinence), care/stabilisation *(care:* maintenance treatment, risk minimisation/harm reduction) and palliation (the reduction of symptoms and attenuation of suffering). The particular objectives that are important for the present advisory report are cure and care/stabilisation. In the case of care/stabilisation, i.e. curbing use by means of maintenance treatment, there is the additional objective of maintaining regular contact with treatment providers. This is because it creates opportunities for intervention directed at improving (or preventing any deterioration of) the patient's physical and mental health, and helping with social problems.

The aim of care and stabilisation is also referred to as risk minimisation or harm reduction. This objective has gained ground in care for addicts as a result of the growing realisation that addiction is a condition with a tendency towards chronicity that is extremely difficult to cure, and also owing to the necessity of combating the spread of HIV/AIDS and other severe disorders among (intravenous) drug users. It is certainly not always realistic to aim for abstinence among long-term opiate addicts, and therefore a cure, as the initial treatment objective. However, the latter is usually the aim in penal institutions (see chapter 4). The treatment objective for a particular patient may change over time from stable abstinence to care and stabilisation, if it becomes clear that abstinence is too high a goal. It is essential for the objective of a given treatment to be made clear beforehand.

Abstinence

The achievement of stable abstinence (i.e. cessation of the use of all illegal opiates) occurs in two phases: actual detoxification followed by relapse prevention. Actual detoxification is not the main problem in treating opiate addicts; the problem is stopping the patient from using opium again after detoxification. The greatest likelihood of success – long-term abstinence from opiate use – is when abstinence is set as a treatment objective at a moment when the patient is 'ready for' this and when personal circumstances are favourable. Psychosocial support is essential in both detoxification and relapse prevention.

The Pharmacotherapeutic Interventions Committee believes that detoxification is contra-indicated when there is no prospect of proper relapse prevention, not only because of the risk of overdosing with renewed use but also because of the likelihood that the continuity of care will be interrupted.

According to the Pharmacotherapeutic Interventions in Drug Addiction advisory report, the preferred choice for detoxifying opiate addicts is methadone. Its effectiveness in detoxification has been studied extensively in other countries, in both inpatient and outpatient situations. The best results are obtained by replacing heroin with methadone and gradually reducing the dose in an inpatient setting over a period not exceeding three weeks. If withdrawal symptoms occur despite a sufficiently high initial dose and (individually determined) gradual dose reductions, then these can be treated symptomatically. It is also possible to arrange for patients to acutely stop all opiate use (cold turkey). In the aforementioned advisory report, the Committee's opinion is that an approach of this kind, combined with a heavy withdrawal syndrome lasting for days, is unprofessional and not in the interest of the patients. Moreover, the results of this patient-unfriendly approach do not appear to be any better, and may in fact be worse, than when other methods are used, even when any withdrawal symptoms that may occur are treated symptomatically (as advised by the American Psychiatric Association).

Various methods may be used to try to prevent a relapse after detoxification. According to the Pharmacotherapeutic Interventions in Drug Addiction advisory report, currently available pharmacotherapeutic options can offer no effective method for preventing the relapse of opiate addicts. Naltrexone, an opiate-antagonist, is the only medicine available for this purpose. However, adjusting to naltrexone after gradually reducing intake of intoxicating opiates requires an opiate-free period of several (2-10) days. There is a major likelihood of a relapse in this period. This can be avoided by prescribing alpha$_2$-adrenergic agonists (such as clonidine) to treat withdrawal symptoms while gradually reducing opiate intake. Patients can then be started on naltrexone alongside, or immediately after, medication of this kind. Combined treatment of this kind must, in connection with possible side effects, be provided in a clinical setting (or at least in an outpatient set-

ting). Naltrexone only works properly if patients are motivated; the vast majority of patients prematurely stop treatment.

A proper follow-up care programme that provides sufficient psychosocial support can help limit the dropout rate. Pharmacological relapse prevention should generally be continued for a year, starting from the last relapse. Although antidepressants are used in relapse prevention to reduce craving, behaviour therapy appears to currently be the most promising way of achieving this objective. However, most patients in practice opt for long-term treatment with a maintenance dose of methadone.

Stabilisation and care

When abstinence proves to be unfeasible, the treatment objective shifts to stabilisation and care. Maintenance treatment is then indicated. For the time being, methadone – in adequate, individually determined doses – is the preferred substance. When treatment is concerned with ending the use of illegal opiates, doses will practically always have to be high (> 60-80 mg/day) to avoid the occurrence of withdrawal symptoms and to prevent craving.

It is generally accepted (in situations other than detention settings) that drug use does not change; a lower dose of methadone will then suffice (< 60 mg/day). The aim is to keep the patient's use of drugs under control. They are also encouraged to integrate into the community as much as possible, to improve their welfare and to at least prevent a deterioration in their physical, psychological and social situation. The term used for this type of treatment objective is risk minimisation or harm reduction.

Experience shows that additional use of illegal opiates fades into the background when these patients receive a flexible, high dose. However, methadone appears to have no effect on the use of other additional substances (cocaine and benzodiazepines).

The treatment goals of risk minimisation and harm reduction also apply to long-term addicted patients for whom no single treatment has been effective over the course of the years. An important secondary goal is to maintain regular contact with treatment providers, as this creates opportunities for intervention directed at physical and mental health improvements, the prevention of hepatitis, tuberculosis and HIV, and the provision of assistance for social problems (housing, finances, daily activities). In situations of this kind, heroin or heroin-equivalent intoxicating opiates are prescribed – experimentally and under strict conditions – as an *ultimum refugium* (last resort) for heroin addicts.

Maintenance treatment generally has to be continued long term, often for many years. According to the Pharmacotherapeutic Interventions in Drug Addiction Committee, replacing maintenance treatment with treatment that focuses on abstinence (stopping or gradually reducing the methadone dose) against the patient's wishes has to be categorised as compulsory treatment. Because experience in the field shows that not all patients respond optimally to

methadone, there is a need for alternatives (buprenorphine, heroin). The Committee refers to the Pharmacotherapeutic Interventions in Drug Addiction Committee's advisory report for a discussion of these alternatives.

Maintenance treatment in the penitentiary setting

The information that emerges from the international scientific literature on the effectiveness of methadone (maintenance) treatment in the penitentiary setting is particularly important within the scope of the present advisory report. Two review articles by the same authors were found in the literature (Dol96, Dol98a). The articles showed that very few prison methadone programmes existed anywhere in the world in 1995.

Eight countries had programmes in one or more prisons in which methadone was used to detoxify detainees when they entered prison, namely in Australia (South Australia, Victoria, Queensland), New Zealand, Portugal, England/Wales, Scotland, Ireland, the Netherlands and Sweden. Selected detainees in six of these countries were also issued methadone on a maintenance basis. Methadone maintenance programmes in prisons existed in seven countries where this sometimes concerned only a single prison, namely Australia (New South Wales), United States (New York), Spain, France (Paris), Switzerland (Basel), Germany (see also Stö98) and Denmark.

One of the reviews (Dol98a) mentioned some well-documented programmes, namely Riker's Island, New York (Mag93 and more recently Tom01) and New South Wales, Australia (Hal93 and more recently Dol98b). Both programmes dated from 1986 and comprised a detoxification programme (Riker's Island) and a 'pre-release program' (New South Wales), respectively.

Methadone maintenance programmes must obviously be evaluated in relation to their objective. Only the programmes of Riker's Island and New South Wales had clearly described and documented objectives (Dol98a). However, it is difficult to evaluate the programmes because their set-up and goals have changed over the years. Nevertheless, it is possible to draw conclusions. The programme in New South Wales has resulted in a lower rate of drug use in the prison and less involvement in drug dealing by the detainees there. The maintenance programmes in both New South Wales and New York were designed to reduce criminal recidivism. In this respect, no differences were found in New South Wales between the treated group and a control group. However, it is questionable whether this finding can be generalised, given the fact that the most disadvantaged detainees were over-represented in the study group. Research into the effects of outpatient methadone maintenance programmes have reliably indicated that these programmes reduce crime.

Intravenous drug users who followed a maintenance programme on Riker's Island contacted the care services more often after their release than those who had only under-

gone detoxification. However, many of them had left the outpatient methadone maintenance programme again after a year. This applied to detainees in Australia, as well as those in New York, who had followed a methadone maintenance programme in prison.

The first results have meanwhile also been published on the evaluation of methadone maintenance programmes in prisons in Madrid and Barcelona (Veg98, Arr00). The English summary of the Madrid study showed that, throughout its duration, the programme's results included a reduction in drug use, less risky behaviour and fewer conflicts between detainees (Veg98). The English summary of the study in Barcelona showed a significant reduction in cocaine and cannabis use, but an increase in the use of alcohol, nicotine, benzodiazepines and 'designer drugs' during the course of the programme (Arr00).

It can be concluded that the impacts of the few methadone maintenance programmes that prisons provide have only been studied to a limited degree. Current research is more concerned with programme implementation than impacts. There is therefore a lack of scientific evidence that methadone maintenance programmes in the prison setting are as effective as those outside. Not a single reference was found to a randomised controlled trial in the references, although one was announced, namely in the aforementioned review article (Dol98a), but it has apparently so far not led to a publication. However, it would be going too far to conclude from the lack of strictly scientific evidence that such programmes are not justified; there are sound arguments for implementing programmes of this kind in prisons. Dolan and Wodak mention, for example, the creation of a better link between outpatient programmes (continuity of care), promotion of tranquillity and order in prison, and prevention of the transfer of infections by reducing risky behaviour, such as syringe sharing (Dol96). It is pointed out that syringe sharing hardly, if ever, occurs in the Dutch penitentiary setting because drugs are rarely injected (Haa97)*.

Finally, it is important to mention that the meta-analysis of Pearson & Lipton (Pea99) discussed below in section 5.4 sees methadone maintenance treatment in detention as a promising treatment, at least in terms of helping to prevent or limit relapses into illegal drug use. The treatment thus looks promising from this point of view.

5.4 Effectiveness of treatment for drug addiction in detention

Pearson & Lipton (Pea99) recently conducted an extremely thorough meta-analysis of the effectiveness of drug-addiction treatment in detention within the scope of a major research project, the Correctional Drug Abuse Treatment Effectiveness (CDATE) project, financed the by American National Institute on Drug Abuse (NIDA). A data-

* Moreover, the percentage of seropositive drug users in the Netherlands is relatively low (see sections 2.3 and 2.4). Alongside this, it can be noted that the effects of syringe-exchange/syringe-distribution programmes on transmission of hepatitis B and C have never been demonstrated; there is a lack of research into this.

base developed within the scope of this project used data from evaluation research conducted between 1 January 1968 and 31 December 1996. They attempted to collect and evaluate all published and unpublished studies of the effectiveness of judicial interventions. To find the data, they used a few dozen automated databases, manually screened the main journals, consulted monographs of the two main libraries and wrote to authors and organisations in many countries, including many non-English-speaking countries, such as Germany, Sweden and the Netherlands. The total number of studies identified came to 1,606; they contained 2,176 comparisons of experimental groups with control groups. Only 30 of these were concerned with the effectiveness of interventions among addicts who were in detention at the time of intervention.

Following an assessment of the methodological quality of these 30 studies, not a single study was appraised as 'excellent' (large degree of confidence in the outcome), only one study was deemed to be 'good' (a measure of confidence in the outcome), 15 studies scored 'moderate' (little confidence in the outcome) and the remaining 14 studies were appraised as 'poor' (very little confidence in the outcome and a high likelihood of the impact being overestimated in the experimental setting).

The 30 studies covered a large number of different interventions, of which only three were evaluated in at least five studies, namely 'boot camp' (six studies), therapeutic community (seven studies) and group counselling (seven studies). The cumulative evidence for the effectiveness of these interventions was studied in a meta-analysis. The effectiveness of the remaining interventions could only be verified on the basis of anecdotal evidence.

All the studies of the effectiveness of boot camps (military style discipline)were deemed to be of 'poor' quality. Four studies indicated a (small) positive impact and two indicated a (slight) negative impact. The meta-analysis showed a very limited and statistically insignificant positive impact ($r=0.053$; $p=0.163$).

In the studies of the effectiveness of therapeutic communities in prison, the quality of one study was considered to be 'good'; three were appraised as 'moderate' and three as 'poor'. Six of the seven studies revealed a clear positive impact, whereas only one (which was deemed to be poor) indicated a negative impact. The meta-analysis showed a clinically relevant and statistically significant positive impact ($r=0.133$; $p=0.025$). The average weighted magnitude of effect over the studies can be described as a difference of approximately 13% in the percentage of recidivists between the experimental and control group. Only one of the seven studies considered relapses into illegal drug use in addition to criminal recidivism. In this study, which was appraised as moderate, the relapse percentage in the experimental group was 17% lower than in the control group. Unfortunately, there was a lack of clarity about the voluntariness of placement in the programmes, as the summary made no distinction between voluntary and compulsory placements.

Of the studies into the effectiveness of group counselling in prison, five were deemed to be of 'moderate' quality and two of 'poor' quality. Only two of the seven showed a clearly positive impact and the meta-analysis showed that the weighted average effectiveness was low and not statistically significant (r=0.036; p=0.054). An additional problem in these studies was that the description of intervention was not very specific in many cases. Each study involved a group approach that was different from that which used a therapeutic community.

Of the remaining studies, four covered the effectiveness of methadone maintenance treatment (of which three used criminal recidivism as the measure of effectiveness and three (also) used relapse into the use of illegal drugs), two focused on addiction education and four were studies with subjects such as individual counselling, individual cognitive therapy, and studies concerned with the effectiveness of preparing for participation in narcotics anonymous (NA) following the end of detention. The authors concluded, with the necessary caution, that methadone maintenance programmes do appear to have a future in preventing a return to drug use, but not in preventing criminal recidivism. The authors are even more cautious about addiction education and individual cognitive therapy, although they can imagine cognitive behaviour therapy and 12-step programmes contributing, as part of a broader approach, to the effectiveness of treatment programmes for drug addicts in prison.

The general conclusion of this overview study has to be that there is currently only evidence of the effectiveness of therapeutic communities in the treatment of drug addicts in prison, and that even in that case the results are limited. Boot camps appear to have no future and the future of group counselling also appears unpromising. Methadone programmes in prison could be important in reducing relapse into illegal drug use after release from detention (see also Dol96). The meta-analysis conducted by Pearson and Lipton therefore supplements the information provided in section 5.3 on the effectiveness of methadone maintenance treatment in detention.

In their foreword to the special edition of The Prison Journal, which published the Pearson & Lipton meta-analysis, Simpson *et al*. (Sim99) once again stressed the often poor quality of the studies conducted so far and the risk of the impacts of experimental interventions being overestimated in poor studies. They also emphasised the favourable results that have thus far been achieved with the therapeutic-community model but warned against disappointment if good programmes during detention are not combined with intensive follow-up care after discharge from detention (see also section 5.6).

Finally, it must be pointed out that the successful American therapeutic-community model discussed here differs to a great degree from the therapeutic communities that exist in the Netherlands. American prison TC is organised on a strictly hierarchical basis. It covers a complete treatment environment that focuses on changing the addicts' behaviour, attitudes, emotions, standards and values. The aim is to create a new drug-

free lifestyle through repetition and confirmation in daily life in the therapeutic community. Treatment staff members include former addicts who have completed TC treatment. A period of 9 to 12 months is considered the ideal length of stay in a therapeutic community, preferably followed by work release (a form of freedom restriction under which the offender performs paid work in the free community but is obliged to spend any other time in an institution) and parole (the American version of conditional release) (Mar99).

5.5 Efficacy of judicial pressure and compulsion in the treatment of addicts

Our account of current knowledge on the effectiveness of judicial pressure and compulsion in the treatment of drug-addicted detainees is based on two secondary sources, namely the literature review by Baas (Baa98a) and the critical literature study by Rigter (Rig98). As mentioned above, the meta-analysis by Pearson & Lipton (Pea99) made no distinction between voluntary and compulsory treatment. We can assume that there is a large overlap between the material they analysed and the research studied by Rigter and Baas.

Baas' literature review was intended to provide information that could be useful in the parliamentary discussion of the legislative proposal for the Compulsory Treatment of Addicts Act (SOV) and to help with preparations for the evaluating the effect of the Act. Apart from two Dutch studies (Jon97; Kon98, see section 4.2.5), the author examined evaluation research in the United States, Germany and Sweden. Compulsion facilities are used in Sweden and Germany, whereas pressure and compulsion facilities are used in the United States. She believes that the pressure facilities in the United States (which frequently involve long-term detention) have more in common with the compulsory placement of the Compulsory Treatment of Addicts Act (SOV) than with the Dutch pressure facilities.

On the basis of her literature review, Baas concludes that addicted offenders can profit from entering or continuing treatment under compulsion or pressure. The literature showed that compulsion upon entering into treatment often has a positive impact on drug use and (offender) behaviour, at least insofar as older drug users, with a long history of addiction, are concerned. In any case, entering into treatment under compulsion does not appear to have a negative effect on treatment results. This corresponds with the finding of Van den Hurk (Hur98, page 173) that criminal recidivism among offenders who are under a court order to participate in intervention – therefore involuntarily – is no more likely than it is among motivated participants who take up the offer voluntarily.

According to Baas, a possible explanation for this is that the duration of treatment has a major effect on treatment results. Addicted offenders have to undergo treatment for long enough to become motivated to change their lifestyle. Much evaluation research shows

that people who are involuntarily placed in a treatment programme tend, on average, to stay in treatment for longer than those who enter treatment voluntarily. The Committee believes this would obviously be the case, as they are not permitted to leave. The Committee would also like to relativise the importance of time in treatment as a factor in the treatment's success; this is not so much a matter of a causal relationship as of a selection bias, as the people who are most motivated tend to stay in treatment the longest.

Baas also found indications that combined participation in an inpatient and an outpatient programme consisting of various phases was more effective than participation in just an inpatient or an outpatient programme.

Rigter (Rig98) largely based his study on the same literature as Baas, but his conclusions are more balanced and cautious. He believes Baas' overview of the literature presents a true picture of what the authors she cited wrote on the effectiveness of pressure and compulsion measures, but he believes it is questionable whether these authors were entitled to claim what they claimed. He believes the answer should often be that they were not. Practically all the studies described in the references were characterised by methodological shortcomings, such as the lack of a comparable control group, a retrospective instead of a prospective set-up, deficient sampling, follow-up periods that were too short, a large drop-out rate from treatment and study, a large loss to follow-up, etc. His opinion on this point is in line with the findings of Pearson & Lipton (Pea99) discussed in section 5.4.

Rigter concluded that pressure projects generally have a modest impact, which is only achieved and maintained through long-term deployment of resources. With regard to penitentiary compulsory treatment, there is so much amiss with the scarce research that has been conducted that there is no evidence of the usefulness of this approach. Use of compulsion cannot, therefore, be justified by invoking the supposed effectiveness of this approach. On the other hand, it cannot be said that compulsory treatment is ineffective.

5.6 Effectiveness of follow-up care programmes for ex-detainees

The term follow-up care programme is used here in the sense of a care programme in the community that follows the care programme provided in the penitentiary institution*.

There are no review articles or meta-analyses on the effectiveness of follow-up care for detainee drug users. However, research has been conducted in the United States on the effect of separate follow-up care projects. These follow-up care projects usually follow on from – successful – treatment programmes in prison in accordance with the Therapeutic community (TC) concept. The idea soon arose that the effect of these successful pro-

* Unlike the case with the Pharmacotherapeutic Interventions in Drug Addiction Committee, the Committee does not distinguish between follow-up care and aftercare, but uses the terms more or less synonymously.

grammes could be strengthened by linking them to follow-up care. After all, the transition from prison to the free community is a major step for ex-detainee drug users. There is every likelihood that detainees will fall back into old habits again once they have returned to their former social environment, in spite of the new attitudes and skills acquired in the prison TC. The need to look for ways to continue to support ex-detainees in this crucial phase of transition to freedom therefore seems obvious.

Recent primary sources from America on the impacts of follow-up care programmes are discussed below. Details were found in the literature of one randomised controlled trial of follow-up care (in this case assertive case management, in the state of Delaware) that had little effect. The authors attributed this mainly to the reluctance of participants to make use of the services offered (Inc94). However, follow-up care set up according to the American TC model, combined with prison TCs that have proven to be successful, did indeed appear to be effective. The most recent research into the effects of these programmes was concerned with the situation three years after the end of confinement. The results of the three studies, all three of which were published in the same edition of The Prison Journal (September 1999), are provided below.

The first study was concerned with a project in the state of Delaware. The starting point was an integrated (coercive) approach. The TC treatment in Delaware can be subdivided into three stages, namely, *1*, the prison TC (KEY); *2*, work release (semi-outpatient: nights spent at the Crest Outreach Centre, days spent working elsewhere), referred to as CREST; and *3*, parole or similar form of community supervision (living in the community, supervision by TC counsellors, including counselling, group therapy and family meetings). The measures of effectiveness used in the study of this integrated approach (Mar99) were criminal recidivism (arrest) and remaining drug-free.

Criminal recidivism had dropped significantly one year after work release among those who had only followed the first and second stage of TC treatment. However, these effects had largely disappeared three years after release. The essence of this study was the effects of the second and third stages, three years after release. Four newly formed groups were compared: a control group, Crest dropouts, Crest completers and Crest completers who had also completed the third stage. The impacts of treatment were permanent for the last two groups. Those who completed Crest appeared to do better (in terms of not being arrested and remaining drug-free) than the control group or the CREST dropouts. Those who also completed the third stage of care did even better. These results support the continuum model of TC treatment for offenders with severe drug problems. However, it should be stressed that the analysis of the results was conducted among 'treatment completers', not in accordance with the principle of intention to treat. This suggests a need for caution in interpreting the study results.

The second study concerned a project in California. A follow-up care programme that was linked to the Amity prison TC (Wex99) was studied. Participants in the prison TC were recruited at random, but participation in follow-up care was voluntary, which does not exclude self-selection. Caution is therefore also necessary in interpreting the results. The prison TC covered a period that varied from eight to twelve months. Those who completed this TC programme could opt for a community-based TC treatment programme that lasted no more than a year. The main question of the study was whether the favourable results achieved after 12 and 24 months were still apparent after 36 months. A limitation of the study was that dropouts from follow-up care were not studied.

Three-quarters of the control group had returned to prison after three years, against only 27% of those who had completed follow-up care. There appeared to be a strong positive relationship between the number of days people received treatment and the time until recidivism occurred. However, the results found after 12 and 24 months among those who had completed TC treatment in prison but had not taken part in follow-up care appeared to have disappeared after 36 months. Nevertheless, the positive effect still existed after 36 months among those who had completed the follow-up care programme. Those who had completed prison TC as well as follow-up care displayed a reduction in recidivism varying from 42 to 53%. Although self-selection could play a role here, the researchers believed there were sufficient indications that follow-up care can be effective. It was not possible to accurately determine the effect of the follow-up care, and the effect of the combination of prison TC and follow-up care, in this study.

The third study (not a randomised control study!) was concerned with a follow-up care programme combined with a prison TC of nine months. This was established in Texas and was set up in accordance with the New York Stay'n Out model (Kni99). The attached parole period consisted of semi-outpatient treatment (compulsory internal residence) for three months with work release, followed by 12 months of compulsory outpatient counselling. Participants were required to take part in monthly urine tests during the parole period. Those who completed the TC programme in prison and also the follow-up care programme returned least often to prison (also owing to breaches of parole agreements) (only 25%, as against 64% of the dropouts from follow-up care and 42% of the (untreated) control group). The most striking effects of follow-up care were found among those with the most severe drug problems who had also completed the follow-up care programme; only 26% of them were sent to prison again, as against 66% of the dropouts and 52% of the control group. If one only takes into account reconfinement owing to new offences, then these percentages come to 6% of completers, as against 22% of dropouts and 19% of the control group. The Committee points out here that the achieved results may actually be a consequence of selection. According to the researchers, it is mainly offenders with a severe drug problem who benefit from prison TC, particularly

when the treatment is followed by compulsory participation in an outpatient follow-up care programme.

A study aimed at the expenses for the judicial system and based on the same research data also showed that the costs were higher for the 'non-completers' than for the 'completers' (Gri99).

The researchers drew two conclusions on the basis of the Texan study: *1*, follow-up care has to form an integrated part of the treatment of drug-addicted offenders; *2*, the people who benefit most from an intensive TC programme in prison are those with a severe drug problem; if the entire programme is followed, then the effect of treatment remains for up to three years after their release. The favourable figures do not apply to persons with less severe problems.

All these study results relate to different detainee populations, diverse TC treatment and follow-up care programmes, and various geographical areas. All the studies discussed here were subject to some criticisms about methodology. We must therefore be careful when drawing general conclusions. Nevertheless, it seems clear that even with successful internal treatment programmes, such as the American prison TC, the effects on criminal recidivism and the maintenance of a drug-free lifestyle decline after a year in the absence of sufficient follow-up care. To ensure that the results of the programmes continue in the long term, they could be combined with a given period of(compulsory) follow-up care in the free community.

5.7 Conclusion

Current knowledge of the treatment of drug addiction (in detention) can be summarised as follows. No effective pharmacotherapy is currently available for treating cocaine addiction and there are only limited possibilities for effective psychosocial treatment of cocaine addiction. It is necessary when treating opiate addiction to distinguish between the objective of cure (achieving stable abstinence) and care/stabilisation (curbing use by means of maintenance treatment). Achieving stable abstinence involves two phases: detoxification and relapse prevention. Methadone is the preferred means of detoxifying opiate addicts. If there is no prospect of proper relapse prevention, then detoxification is contra-indicated.

When abstinence is not feasible, the treatment objective shifts to stabilisation and care. Maintenance treatment is then indicated. For the time being, methadone – in adequate and individually determined doses – is the preferred substance for opiate addiction. There is still too little scientific evidence that methadone maintenance programmes in the penitentiary setting are as effective as those outside. However, treatments of this kind look promising for helping to avoid or limit relapses into illegal drug use. The only penitentiary

treatment programme for drug addiction for which there is any evidence of effectiveness is the (American) therapeutic community.

The impact of pressure in the treatment is generally modest and can only be achieved and maintained through long-term deployment of resources. With regard to the effects of penitentiary compulsory treatment, there is so much amiss with the research that there is no evidence of the usefulness of this approach.

Even with successful internal treatment programmes, such as the (American) prison TC, the effects on recidivism and maintaining a drug-free lifestyle decline after three or so years in the absence of sufficient follow-up care. To ensure that the results of the programmes continue in the long term, they should be combined with (compulsory) follow-up care in the free community for a given period.

Most research into the effectiveness of drug-addiction treatment in detention has been conducted in the United States. The Committee makes the following final comments on the relevance of this research for the Netherlands.

An addict in the United States is more likely to end up behind bars earlier and for a longer period than an addict in the Netherlands. Simply using drugs can lead to long-term detention in the United States. Addicts in Dutch prisons presumably face more severe addiction problems, in general, than addicted detainees in the United States. The population of heroin users in the Netherlands is different from that in the United States (the average heroin user in the Netherlands has been addicted for a longer period) and the 'risk of arrest' for drug addicts in the Netherlands is much smaller than in the United States. Moreover, most addicted detainees in the United States only come into contact with care services when they enter prison. This is unlike in the case of many addicted detainees in the Netherlands, who have already spent a considerable time receiving help from the care services (see section 2.2).

The setting in which treatment programmes in the United States are provided is also different from that in the Netherlands. Conditions in American prisons are austere and the regime is hard. They exert a great deal of pressure on the detainee to undergo treatment by offering particular improvements in the conditions under which the sentence has to be served, for example transfer from a cell for several people to an individual cell. These treatment incentives would be difficult to reconcile with the Dutch penitentiary system (although placement in the austere regime is used as a (negative) means of exerting pressure in the Penal Care Facility for Addicts).

It is impossible to conclude anything other than that programmes that have proved successful in the United States will not necessarily be as successful in the Netherlands. Results achieved in other countries cannot simply be transferred to the Dutch situation. The studied populations and settings in which treatments are provided are in fact only partially comparable with the situation in the Netherlands.

Chapter 6

Possibilities and limitations

This chapter discusses the possibilities and limitations in treating drug-addicted offenders, with the main focus on the detention period. Most treatment possibilities that involve stipulating behavioural conditions (see section 3.4) are not discussed here. After all, limitations that are inherent in the detention setting do not apply there. This subject is taken up again at the end of this chapter (6.3).

6.1 Opportunities and possibilities

Detention can be modified to encourage drug addicts to work (or continue working) on their addiction problem. Detention can serve as a moment of crisis, with an associated time for reflection for addicts. The fact that detainees are compelled to live in an environment with few, if any, drugs, confronts them with the consequences of their problematic drug use. This can provide the ground upon which the motivation to stay away from drugs can grow. The Drugs Discouragement Policy (DOB, see section 4.2.2) is intended to maintain or create such an environment. Moreover, the detention setting provides addicts with the necessary protection against leaving the programme early, which is one of the main problems in the care for addicts (Hur98, page 182).

If the detainee is already motivated, then motivation can be kept up by continuing in the detention setting the treatment that was started in the free community. When motivation for treatment is created (or recreated) in detention, treatment for outside the detention setting can be prepared in the penal institution. In both cases, contact has to be established with those providing treatment in the free community. In the first case, contact is neces-

sary to ascertain the nature of the present treatment, so that treatment provided in detention can follow on from it as far as possible. In the second case, contact is necessary to enable arrangements to be made with external treatment providers for the addict's placement in an external treatment programme.

Motivation is essential. Addicts themselves ultimately decide the extent to which they will make use of the opportunities and possibilities that are provided. If addicts have no desire to work on their addiction problems, then there are no means available to compel them to do so in detention. It would obviously be possible to put considerable pressure on the addict to enter an Addiction Support Section (VBA), by, for example, threatening him with the denial of certain rights or with placement in an austere regime. Apart from the ethical and legal objections to this, threats of this kind would not have the intended effect. Addicted detainees who are not motivated to go to an Addiction Support Section would probably opt for a denial of rights or placement in an austere regime in preference to the Addiction Support Section. The Committee believes the entry threshold to the Addiction Support Section could be lowered by including harm reduction (methadone maintenance) in the Addiction Support Section's objectives. The Addiction Support Section is currently based solely on abstinence.

Although the opportunities practically all revolve around voluntariness, this does not exclude the possibility of the institutional physician insistently confronting detainees with the detrimental consequences of their lifestyle and with the damage to health it will eventually cause. Insistent conversations of this kind, in which the aim is indeed to influence the addict, leave the final choice to the concerned individual.

The *pressure* that can be imposed in detention is only concerned with compelling the concerned person to live in an environment with few, if any, drugs. Even the Compulsory Treatment of Addicts Act (which, like detention under hospital order, is a deprivation of freedom measure) only legitimises compulsory placement, not compulsory treatment. According to section 32 of the Custodial Institutions Act, compulsory treatment is only permitted in exceptionally unusual situations. The Committee repeats its standpoint on denying methadone to detainees against their will: any replacement of current methadone maintenance treatment against the patient's will by abstinence-oriented treatment (detoxification), may, in terms of its content and consequences, be deemed to be compulsory treatment, even if this issue has apparently still not been settled from the legal point of view (see section 3.4).

However, within the context of the Compulsory Treatment of Addicts Act, considerable *pressure* will be exerted on addicts to get them to undergo treatment: if people sentenced to a Compulsory Treatment of Addicts Act measure do not wish to cooperate in treatment, then they will be kept for no more than two years in a closed institution and subjected to an austere regime, whereas addicts who cooperate in the treatment may be allocated certain freedoms as early as the second and third phase of the measure's imposition

(see also section 4.2.4). The question obviously remains as to whether this type of pressure has the intended effect, which will have to be addressed in the evaluation of the Compulsory Treatment of Addicts Act. The literature only mentions minor impacts in different populations with different programmes.

The time of entering the institution is the most favourable moment for supervising/treating addicts. Intake interviews with a penal institution worker (PIW), the (addiction) probation worker and the institutional physician occur upon the detainee's entry. It is mainly the PIWs, the probation service and the medical service that can play a role in offering opportunities to addicted detainees. Probation officers are currently available at practically every closed institution, although the degree of availability may vary per institution. The tasks of these social workers include conducting individual interviews and group interviews with detainees about their addiction problem, and also talking with external contacts in aid of treatment after detention.

If not already apparent from the file received on the detainee, then the interviewer must ascertain during the intake interview whether the concerned person has an addiction problem. The person conducting the intake interview should, in any case, ascertain whether an addicted detainee is aware of the existence of possibilities for treatment. The prison regulations issued to detainees upon arrival can draw their attention to the possibility of their contacting the probation service themselves. The Committee believes it would be advisable to hold intake interviews on the basis of a standard list of points that could be ticked off. The points that should in any case be included in an intake interview are: financial status, domestic situation, most recent contact with treatment providers, addiction problems (which medical practitioner provided treatment and which medication was provided), psychiatric contacts (which medical practitioner provided treatment and which medication was provided), physical health, and the necessity of getting in touch with external treatment providers.

The Committee's impression is that some opportunities are unexploited in practice, particularly in the intake of addicted detainees. For example, upon their arrival at the penal institution, steps are by no means always taken to ensure that the rental payments on their accommodation are kept up by arranging for 'special assistance'. This involves completing a slip of paper for the social services department. This could in due course mean one fewer homeless person in the community, and it only takes around five minutes.

What are the possibilities for providing treatment, once the addicted detainee has had the intake interview? In the first place, the possibility of continuing any methadone programme that has already been started could be considered, more on the grounds of continuity of care and equivalence than on the basis of scientific evidence. Second, as described in sections 4.1.4 and 4.2.4, thought could be given in the context of participation during detention to an admission and orientation programme and placement in an

Addiction Support Section. Third, the initiative could be taken to start treatment outside the penitentiary setting during detention. As the Committee believes there is insufficient information about this last possibility, the sections of the law that offer this possibility are summarised below. In the first place this concerns:

a suspension of pre-trial detention (section 80, subsection 1, Netherlands Code of Criminal Procedure), subject to the special condition of participation in addiction treatment, by means of admission to, for example, an institution for the care of addicts.

Another possibility for treatment outside the penitentiary setting is provided by:

b section 43, para. 3, of the Custodial Institutions Act. This article offers the governor of the penal institution the possibility of transferring the detainee to an appropriate location for social care and assistance. In the case of an addict, this could entail placement in an addiction clinic. Placement of this kind is intended for addicted detainees who wish to receive treatment that replaces detention in the final phase of their prison sentence, preferably following on from a period in an Addiction Support Section (see article 31 of the Selection Regulations on the placement and transfer of detainees, dated 15 August 2000). In recent years, less rather than more use has been made of the possibilities referred to in article 43, para. 3, of the Custodial Institutions Act.

The following is another possibility for treatment outside the penitentiary setting:

c participation in addiction treatment within the scope of a Prisons Programme (PP) (section 4 of the Custodial Institutions Act and articles 5 to 10 of Penitentiary Order (PM)). This framework also includes the possibility of participation in an outpatient treatment. However, addicts rarely participate in PPs in practice (see section 3.5).

Finally, there is

d the possibility, pursuant to article 15, para. 5, of the Custodial Institutions Act, of transferring addicted detainees who are also psychologically disturbed to a psychiatric hospital.

Placement in an Addiction Support Section is currently only possible in a remand centre or closed prison. There are generally no Addiction Support Sections in a half open institution or open institution, as they do not provide the protected environment that the current Addiction Support Section philosophy deems to be essential. (An exception to this is the Drug-free Care Facility, a half open institution with 31 places, which is part of De Kruisberg, in Doetinchem.) Urine tests are an important part of the present Addiction Support Section regime and are intended to assist in achieving a drug-free lifestyle. In its conclusions and recommendations (chapter 7), the Committee proposes giving a different shape to the

Addiction Support Section programme from the one that is generally in use at the moment. The Committee also examines the question of the extent to which this new shape can be reconciled with the regime of half open and open institutions.

Another moment that is just as important from the point of view of continuity of care as the offender's moment of arrival at the institution is the moment of departure (discharge). The Committee believes much better use could be made of this moment. However, the Committee points out that the moment of departure can often occur rather unexpectedly, especially for pre-trial detainees in a remand centre, which makes proper preparation hardly, if at all, possible. The Social Services Bureau receives the discharge notice from the court or Public Prosecutor. Although the detainee would not be particularly open to an extensive exit interview on the day of departure, it should at least be possible to provide the detainee with details that are essential for follow-up care, such as the name and address of the probation officer, who could then be contacted, if required. After all, follow-up care should start at the moment a person is discharged from the penal institution. The importance of follow-up care in the supervision of addicted detainees and the approach taken there is discussed further in chapter 7.

6.2 Limitations

The nature and duration of detention, the regime, the type of treatment and the nature of the phenomenon of addiction all place limitations on the treatment of addicted detainees.

The nature of the detention or regime presents the first limitation. As mentioned earlier, the government's official standpoint is still that (psychiatric) treatment will not generally be provided in the prison system, even if increasingly more treatment is being provided in practice under the name of 'supervision' or 'pre-treatment'. This limitation is therefore partially more ideological than actual. However, the Committee believes there is also a real limitation. A penal institution differs substantially from a treatment institution. Penal institution workers (PIWs) are generally not trained to treat detainees. Even if a lot of work is currently done inside the prison walls that should rightly be called treatment, treatment will not soon become the penal institution's core business. Moreover, the ideal treatment environment is different from that of a penal institution. There is a certain tension between what is necessary for security (on the grounds of order and control!) and what is good for treatment. In the event of a conflict between these two factors in the penitentiary setting, the requirements of security and control prevail. This is probably one of the reasons why Addiction Support Sections are given shape in the form of separate departments that are spatially separate from the rest of the institution.

One type of regime is more suitable than another for providing supervision/treatment. The institution's level of security may also play a role. Treatment possibilities in the standard regime, and certainly in the austere regime, are limited, which gives rise to the question of whether this is an inherent feature of the regimes or the result of external factors, such as limited staffing in the probation service. However, admission and orientation programmes are actually implementable within these regimes.

The imposed length of the deprivation of liberty also places a limitation on the treatment. In the Netherlands, the offences drug addicts commit are not usually those that incur long custodial sentences. Drug addicts are mainly involved in (repeated) petty property-related crimes, such as theft, theft preceded by forcible entry, and handling stolen property. According to the TULP register, 50% of drug-addicted detainees are detained for periods shorter than two months and 75% of addicted detainees have left the penal institution within four months (see section 2.5). This limited period of detention imposes limits on the expectations of what can be achieved with addiction treatment in detention. Evaluation studies of compulsory placements at Demersluis II (Jon97) showed that at least three months was required to create motivation to work on addiction; until three months had passed, motivation appeared only to decline. It is therefore realistic not to have any high expectations of any (initial) treatment of addicts who are serving sentences that are shorter than three months. This is not to say that such people should not be offered treatment, but only that no miracles should be expected of the treatment. Continuity of care during detention and the follow-up process after discharge from detention will be all the more important for the success of the treatment of detainees who are serving a short sentence.

The nature of the treatment of addiction, in interaction with the detention setting, also limits the possibility of treatment. Detoxification is certainly possible in the penitentiary setting, but is only a start on treatment. The main part of treatment involves learning to deal with and exercising options and becoming resistant to temptations. Detention offers few possibilities in this area, as few options or temptations exist in penal institutions. The former Ministry of Justice's consultant for addiction affairs, Dr. PA Roorda, pointed this out as long ago as 1987. He stressed that a complete programme for treating addiction during detention (with the objective of stopping drug use) is ‘impossible’, owing to the nature of the setting, although he thought the detention period could actually be used to bring about positive changes in addicts who were receptive to them.

Finally, another limitation is the nature of the phenomenon of addiction. Addiction is a condition that is exceptionally difficult to treat, especially if the goal is abstinence. It is often the case that addicted detainees deny their illness: “There's nothing wrong with me. I could

stop if I wanted to." No matter what they are offered, people with this attitude will not be able to benefit; a realisation of the disease is essential for (starting) addiction treatment. What also occurs is that addicted detainees sincerely resolve to continue working on their addiction and to give their lives another direction. However, as soon as they return to the free community, they are confronted with the availability of drugs and the whole of the drug scene. After a period of abstinence, there is a great temptation to use drugs again. They then often change priorities and fall back into old habits that they had only recently renounced. The use of certain coercive measures in the follow-up care process could help support the addict's motivation. However, this requires legislative possibilities after detention to legitimise pressure in that situation, and these are only available to a limited extent.

The difficulty of treating addiction is also a reason for being realistic about what cannot be achieved. The goal of abstinence is often too high. However, it is also extremely important to achieve a degree of harm reduction, through methadone-maintenance treatment, for example, even if it is not possible to completely stop the addiction and the associated criminal activity. Whereas methadone can be prescribed as an effective maintenance treatment for addiction to opiates, no such medication is available for addiction to cocaine. However, withdrawal symptoms after using cocaine are, after all, much less of a problem than those that occur after using opiates. The result is that there are no indications for acute treatment of addiction to cocaine in the detention setting. Furthermore, the possibilities for effectively treating cocaine addiction are generally extremely limited (GR02).

There is an impression that cocaine use by some detainees is only a means of facilitating their criminal behaviour and that the comorbidity in these cases appears to be limited to the antisocial personality disorder. If this impression is correct (something that will first have to be corroborated by scientific studies), there is little point in developing treatment options in detention for this particular group of drug addicts.

6.3 Conclusion

The Committee concludes that a detention period can and should be used to motivate drug addicts to start or continue working on their addiction problem. However, we must acknowledge that there are few possibilities in the penitentiary setting for doing much to treat drug addicts. The limitations are found in the nature and duration of detention, the regime, the type of treatment and the nature of the phenomenon of addiction. However, the possibilities that do exist should be fully utilised.

Under present penitentiary policy, these possibilities are mainly combined with abstinence. However, the Committee believes that these opportunities could be considerably expanded. Horizons could, in particular, be widened beyond mere abstinence to include harm reduction

It is necessary to note here that the situation in the case of opiate addiction is substantially different from that of cocaine addiction. Whereas methadone can be prescribed as an effective maintenance treatment for addiction to opiates, no such medication is available for addiction to cocaine. Treatment possibilities for cocaine addiction are very limited. Continuity of care may provide less of an indication of how to treat detainees who are addicted to cocaine than it does for detainees who are addicted to opiates; this is because very few cocaine users receive treatment for cocaine addiction under care for addicts programmes prior to their detention. Most drug-addicted detainees are, for that matter, poly-drug users. In their case, treatment by the institutional physician will usually focus on opiate addiction.

From the treatment point of view, treatment possibilities outside the penitentiary setting, particularly those that involve stipulating behavioural conditions, are preferable to treatment opportunities in the penitentiary setting. After all, treatment in the detention setting involves limitations that are not linked to treatment provided within the framework of stipulated conditions. Moreover, the associated operational period of a maximum of three years puts pressure on the addict to continue the treatment (the 'big stick' of rescinding the decision taken subject to conditions).

Treatment in the detention setting is mainly concerned with offering (new) opportunities, providing continuity of care and initiating treatment that can be followed up after discharge from detention. The Committee believes that the possibility of introducing certain coercive elements into follow-up care procedures, to nurture and support the motivation for treatment that developed during detention, should be considered . This is discussed in further detail in section 7.3.

Chapter 7

Conclusions and recommendations

The Committee sets out its conclusions and recommendations in this chapter. These are, as far as possible, based on the results of scientific research and take into account the limited possibilities that are available for treating drug addiction in detention and the limited period of detention that addicted detainees serve. The following issues are then discussed in sequence: methadone treatment (section 7.1), Addiction Support Sections (VBAs) (7.2), follow-up care (7.3), psychiatric comorbidity (7.4), continuity of care (7.5) and the Compulsory Treatment of Addicts Act (7.6).

7.1 Methadone treatment

7.1.1 Conclusions on the state of affairs

Methadone is a medication with a function in the treatment of opiate addiction. However, no effective pharmacological products for treating cocaine addiction exist. A great deal of (American) research has provided results on the impact of methadone treatment in the free community, with the objective of either abstinence (opiate-free) or harm reduction (by means of maintenance treatment). There is abundant evidence that harm reduction based on methadone treatment is worthwhile. However, the situation is different with regard to achieving abstinence. Methadone is effective in detoxification, but methadone reduction programmes do not help addicts achieve stable abstinence.

However, little research has been conducted into the effects of methadone treatment in a penitentiary setting. Methadone is distributed in some prisons in other countries, such

as Australia, the United States (New York), Spain, Switzerland and Germany, just like it is in a few places in the Netherlands. Some research has been conducted in these countries into the impacts of distribution. However, this scanty research has provided insufficient scientific substantiation of the beneficial effects of methadone treatment in detention. The Committee believes that there are no reasons for assuming that the beneficial effects achieved through distribution in the free community would not also occur if methadone were to be distributed in the penitentiary setting. The Committee adds to this that evidence for the effectiveness of medications is generally found at the population level. This implies that not every individual will benefit from the treatment that has been studied.

There is variability in the opinions of institutional physicians and the Association of Penitentiary Physicians regarding methadone treatment in detention. Research has shown that some places still fail to comply with the Guide to methadone provision issued by the former Medical Inspectorate of the Ministry of Justice (letter of 13 December 1996, reference dM/96268) supplemented by a letter of 16 July 1997 written by the medical adviser to the aforementioned Ministry. There are major variations in the practice of methadone treatment in Dutch penal institutions. The Committee believes this is an undesirable situation and has examined the possibilities for achieving consensus on this question.

7.1.2 Recommendations

Guide and letter

The Committee assumes that the prescription of methadone is a medical matter, because methadone needs to be seen as a medication. The Committee accepts the ideas set out in the Guide and supplementary letter of the Ministry of Justice. These take into account, on the one hand, the scientific evidence for the effectiveness of methadone medication and, on the other hand, the principles of equivalence and continuity of care. The Committee points out that the Health Council of the Netherlands has previously subscribed to the import of this, namely in the advisory report *Onderzoek op druggebruik* (Testing for drugs of abuse) (GR98). The Guide and letter provide institutional physicians (and detainees) with security and a foothold. This is still necessary, not least because medical decision-making, except in a disciplinary procedure, can be tested in specific appeal proceedings. The clarity that has been provided means that it is now less necessary for physicians to be in conflict with detainees. Moreover, it has been established that stopping current methadone treatment may be harmful. This provides a powerful call for continuity of care not only during, but also after, detention.

The Committee would like to supplement some of the points presented in the Guide and letter. This is first in connection with the start of methadone maintenance treatment

in the detention setting. According to the Guide, the start is only called for if there is a special medical indication on the part of the addict (pregnancy, serious infectious disease). The Committee believes that, subject to a careful diagnostic examination by the institutional physician, it should also be possible for a motivated drug addict to start maintenance treatment in the detention setting in the absence of these indications (see GR02 on starting maintenance treatment). Obviously, the conditions would have to be created for continuing maintenance treatment after detention. Second, the Committee uses a much broader interpretation of the concept of 'short term', in the sense of 'short-term detention', than that used in the Guide. This is explained below.

Abstinence process

Besides being prescribed for maintenance treatment, methadone may also be prescribed as part of an abstinence process, namely as a means of kicking the habit. The Committee points out that in situations in which the addict has to be detoxified, detoxification should take place in the penitentiary setting under humane and medically responsible conditions. This is obviously not the same as cold turkey. For a further discussion of the responsible conditions, see the Pharmacotherapeutic Interventions in Drug Addiction Committee's advisory report (GR02), which mentions alternatives to methadone for kicking the habit. It also emerged from the scientific literature that abstinence programmes must be maintained for at least nine months (up to 12 months) if they are to be effective (Wex90). It may therefore be worthwhile to impose abstinence on people in detention, but only insofar as the detention period is long term in the Dutch sense of the phrase, namely around nine months. Addicts rarely receive sentences of this duration (see section 2.5).

The Guide recommends continuing maintenance treatment with methadone if the detainee already used methadone in the free community and will be resuming treatment after short-term detention. Short-term detention is defined as, for example, a period shorter than four weeks. The Committee believes it would be advisable to review this period in the light of the fact presented in the preceding paragraph. The Committee suggests that this term should be considerably extended, with which it distinguishes between people who are in pre-trial detention and people who have been sentenced. This distinction is important from the point of view of this advisory report because the duration of detention for pre-trial detainees is, by definition, uncertain. The Committee believes maintenance treatment with methadone for pre-trial detainees should always be continued, whereas the gradual reduction of methadone for sentenced detainees should only take place if detention will last longer than, for example, six months. The Committee is aware that the latter will only apply to a few addicts in standard detention.

The Committee makes the following comments on the gradual reduction of the methadone dose in the detention setting. As indicated in the Guide, gradual reduction of the

methadone dose should always be possible for detainees who say that they are motivated to work on that. Under the regime of the Medical Treatment Agreements Act (WGBO) and the Custodial Institutions Act, the stopping of current maintenance treatment and implementing of an abstinence process requires that the institutional physician obtain the informed consent of an addict whose detention will last for longer than six months. The Committee believes that any replacement by the institutional physician of current methadone maintenance treatment against the detained patient's will, by abstinence-oriented treatment (detoxification), may be deemed in terms of its content and consequences to be compulsory treatment, even if this issue has apparently still not been settled from the legal point of view (see section 3.4). The Committee believes it would be difficult to imagine that the legal grounds for compulsory treatment set out in article 32 of the Custodial Institutions Act would have been fulfilled in such a case. There would be no prospect of adequate relapse prevention for patients who were unable to reconcile themselves to the gradual reduction policy. The Committee also repeats that the scientific literature repeatedly mentions the occurrence of fatal overdoses in the free community following detoxification in penal institutions (Sea98).

The Committee points out in connection with this that ceasing to prescribe methadone requires just as much care and attention as prescribing it. The physician cannot simply make do with a single informational interview with the detoxified patient, but must carefully prepare for the person's discharge from the outset, therefore from the time the decision to start detoxification is taken. This calls for regular contact between the patient and the institutional physician.

Guidelines

The Guide and letter constitute, in fact, guidelines for the institutional physician's actions. The guidelines have thus far only made a limited contribution to achieving consensus among professionals. The great diversity of viewpoints on addiction and the care of addicts is presumably an obstacle to achieving consensus. The Committee assumes that addiction is a condition that tends towards chronicity and is extremely difficult to cure. The Committee believes professionals should set about achieving consensus on methadone medication, so that professionally supported guidelines on methadone medication can be established. The Committee refers here to the results of the Royal Dutch Medical Association's (KNMG) drugs project, and explicitly to the policy document of the project's Steering Committee (KNM99), which stated that the concerned professionals should attend to the systematic and structural development of protocols, standards and/or guidelines.

An obvious step would be to establish a link with the Results Scores process, which is coordinated by the Dutch mental health care service and the Ministry of Health, Welfare

and Sport. The aim of the process is to improve the quality of care for addicts and to start innovative developments in the field of prevention, cure and care. In connection with this, it is also important that the Ministry of Health, Welfare and Sport's policy proposals for 2001 - 2003 mentioned reinforcement of medical care for addicts (Alcohol policy document, page 50). The guidelines due to be drafted could provide details of current knowledge (indications, directions on frequency, doses, use in special circumstances (detention), interaction with other substances, alternatives, etc.). The Committee refers to the Pharmacotherapeutic Interventions in Drug Addiction Committee's advisory report (GR02) for aspects raised in connection with this. Although it is unusual to produce a guideline concerning one specific medication, the Committee believes there are grounds for doing so in this case in view of the lack of available knowledge.

Given the number of professional associations and bodies that would be involved in producing guidelines that they could all support (National Association of Penitentiary Physicians, Association of Addiction Specialists, Psychiatry and Addiction section of the Dutch Association for Psychiatry, Dutch mental health care service/Results Scores, Royal Dutch Medical Association (KNMG), Institute for Health Care Quality Control, Central Advisory Body for Peer Review (CBO), etc.), coordination of the activities that are undertaken will be essential. This could be a task for the Steering Committee on the Development of Multidisciplinary Guidelines in Mental Health Care.

Obligation to provide an account and reasons

Before taking a decision in a specific case on the continuation of methadone medication, the institutional physician is obliged to consult the physician who previously prescribed methadone. However, after consulting that physician, an institutional physician who decides to continue methadone medication is not released from the obligation to inform the addict of the reasons for the decision. This obligation arises from the Medical Treatment Agreements Act (WGBO): the physician must obtain the patient's informed consent, which also means that, besides information on the proposed treatment, the physician must provide the patient with information on alternative treatments and their pros and cons, so that the patient can make a well-considered decision. In other words, an institutional physician who acts in accordance with the aforementioned guide and letter is under an obligation to provide an account and reasons. In the event of departing from the policy set out in the Guide and letter, this obligation to provide an account and reasons applies even more forcefully. In connection with this, the Committee repeats its standpoint that the replacement of current methadone maintenance treatment by abstinence-oriented treatment (detoxification) without the patient's consent may be deemed to be compulsory treatment in terms of its content and consequences.

Safe provision

The Committee has also examined the question of how methadone can be safely provided in the detention setting. It recommends providing liquid methadone in such situations, which is already the usual practice in most institutions. If methadone is provided as tablets, there is always a risk that the tablets will be saved and dealt, which can lead to a great deal of disquiet and other risks (overdosing) in a penitentiary setting. The likelihood of misuses is furthermore reduced by ensuring that liquid methadone is taken under strict supervision. Adherence to the Guide and letter – and this Committee's recommendations – could, apart from that, also drastically reduce the attractiveness of methadone as a commodity. Methadone would then be available to many people, as a result of which there would be less interest in dealing it.

More research

Finally, the Committee again points out the gaps in scientific knowledge on the effects of methadone treatment in the penitentiary setting. The gaps need to be filled. With this in mind, the Committee recommends that further research should be conducted into the effects of methadone treatment in the detention setting.

7.2 Addiction Support Sections (VBAs)

7.2.1 Conclusions on the state of affairs

It has been established that the external inflow (i.e. the inflow from other penal institutions) to Addiction Support Sections is poor and that these departments had a high vacancy level, at least in 1999-2000. The effectiveness study of Addiction Support Sections failed to provide sufficient clarity. The working group with the task of advising the Minister on the continuation of Addiction Support Sections was divided in its conclusions; some members believed on the basis of the study results that the functioning of the existing Addiction Support Sections could be considerably improved, whereas others concluded on the basis of the data that it would be better to dispense with Addiction Support Sections entirely. The Ministry of Justice has now decided to gradually reduce a quarter of Addiction Support Section places (the equivalent of the vacancy level) and to keep the remaining places for the time being. However, the programme's scheduled reduction for 2002 is below 10%.

Although there is also scepticism in the Committee about the effectiveness of the current provision of ‘supervision’ in the Addiction Support Section, the Committee believes the

existence of an Addiction Support Section has, in any case, an indirect positive impact; it ensures a certain structuring within the institution. Taking this and the fact that the Addiction Support Sections will continue to exist into account, the Committee has decided to make suggestions for improving Addiction Support Section results. The suggestions are mainly concerned with the conditions under which the supervision is provided.

7.2.2 Recommendations

The Committee wants to list, and make more precise, the conditions under which the Addiction Support Section could be successful: lower thresholds, revised programmes, improved implementation of the admission and orientation programmes, longer stays in the Addiction Support Section and an expansion of the opportunities for mandatory follow-up care. These conditions are individually discussed below.

Lower thresholds and revised programmes

First, having lower thresholds is one of the conditions for making Addiction Support Section provisions more successful. Lowering thresholds entails expanding the Addiction Support Section's objective and changing the admission criteria accordingly. The Committee recommends not having abstinence as the sole objective but also including harm reduction through maintenance treatment with the aid, for example, of a maintenance dose of methadone. The Committee therefore links its recommendations on Addiction Support Sections to its recommendations for methadone treatment. Besides abstinence (handing over 'clean' addicts), which is an exceptionally high aim for many drug addicts, the Addiction Support Section's objective could also be harm reduction: handing over addicts stabilised on methadone.

A switch of this kind could make admission and orientation programmes easier, as placement in the Addiction Support Section would become more attractive to addicts. This would also mean that Addiction Support Section provisions in the penitentiary setting would be more in line with socialisation practices that are used elsewhere in care for addicts.

A consequence of this is that there will be two types of Addiction Support Sections: one focused on abstinence and one focused on maintenance treatment with the aid of methadone. It follows from the Committee's previous recommendations that the abstinence-oriented Addiction Support Section will be intended for detainees serving a long sentence and that the Addiction Support Section providing maintenance treatment will be for pre-trial detainees and detainees serving a short sentence.

The programmes available in the Addiction Support Section will have to be adapted to bring them into line with this new objective. In connection with this, the Committee calls for a practical, down-to-earth approach (e.g. continue rental payments on the addict's home, make arrangements for debt repayments, provide social skills training, resocialisation). The Committee's comments on programme content are limited to noting that some short-term behavioural programmes, such as those that have been developed in the care for addicts programmes and that can be provided under the regime of a stepped-care indication, are suitable for this purpose. Programmes of this kind contain elements of psycho-education and simple self-control methods. In the case of polydrug use or cocaine addiction, the Committee recommends paying a great deal of attention to the role of cues in relapses (GR02).

The Committee believes that the model of the abstinence-oriented prison TC, which was successful in the United States, would be difficult to reconcile with the penitentiary system in the Netherlands, which has no treatment prisons. Moreover, the average length of detention for addicted detainees in the Netherlands is shorter than is necessary to achieve success using this model. The Committee also repeats its earlier conclusion (see section 5.7) that successes achieved in the United States with this model cannot simply be transferred to the Dutch situation, where the treated population and the treatment setting are different.

Improving admission and orientation programmes

The Committee's second recommendation concerns the general improvement of admission to the Addiction Support Sections. Admissions to the new Addiction Support Section can be expected to increase owing to the more attractive Addiction Support Section programme, but actual orientation could also be considerably improved. Research has shown that the practical implementation of admission and orientation programmes still leaves a lot to be desired. The admission and orientation programme will have to be provided in every institution. This is currently not the case in most institutions; where this is because of a lack of funds or structural facilities, the obstacles will have to be removed.

Longer length of stay

Third, the selection of addicts for the two types of Addiction Support Sections will need to pay more attention to the expected length of stay in the Addiction Support Section. It emerged from the literature that abstinence-oriented treatment programmes are only effective in the case of a certain minimum length of stay (around nine months). As pointed out in chapter 2.5, many drug addicts only serve short-term custodial sentences (sentences of 7 to 16 weeks). No miracles can generally be expected when detainees serving

such short sentences are placed in the Addiction Support Section. As a rule, the success of treatment will increase as the length of stay in the Addiction Support Section increases. A longer stay in the Addiction Support Section can be arranged by starting the selection process for the Addiction Support Section earlier and by allowing the addict's stay in an Addiction Support Section to last until the end of detention. This calls for better gearing of programmes in prison to those in the remand centre. It would also be possible in the case of detainees serving longer sentences to make more use of Penitentiary Programmes and the possibility of placement in an addiction clinic following the period in the Addiction Support Section (section 43, para. 3, Custodial Institutions Act).

Compulsory follow-up care

The Committee's fourth recommendation concerns follow-up care and the limited possibilities for making it obligatory. There are indications that the success of interventions among addicted detainees is largely dependent on the follow-up care provided after detention (see section 5.6). This care will have to be long term, intensive and, especially, also not voluntary, particularly if an abstinence process is implemented, as addicts are not always motivated to continue treatment at later stages. As long as they are 'inside', detainees promise themselves and those around them the earth and the moon. But, when they are 'out', they may not be able to withstand the temptation of drugs and the drug scene, and their priorities may change. The Committee therefore only expects the three recommendations made above to bear fruit if the legal possibilities for making follow-up care compulsory are increased. See also the Committee's recommendations on follow-up care (section 7.3.2).

Addiction Support Sections in open and half open institutions

Finally, the Committee points out that the present abstinence-oriented Addiction Support Section is difficult to reconcile with the regime in half open and open institutions. These institutions therefore generally have no Addiction Support Sections. However, if Addiction Support Sections also had the objective of harm reduction, they would be reconcilable with the regimes that apply in those institutions.

7.3 Follow-up care

Conclusions on the state of affairs

There are indications that the success of interventions among addicted detainees largely depends on follow-up care after detention (see section 5.6). The follow-up care should

continue immediately after the detention period and should form an integrated part of the entire approach. This applies to a long-term (i.e. several years) intensive, mainly practical (housing, employment) follow-up care process, with considerable obligations and checks (urine tests), because most addicts are simply not able/willing to stay off drugs under their own volition. Such a follow-up care process exists in the United States in the form of parole, a statutory possibility that currently (2002) has no equivalent in the Netherlands. The conditional release was discontinued here and replaced by early release, which is not subject to conditions.

The key tasks of probation are described in article 8 of the Probation Regulations of 1995. There are three tasks:

a to provide help and support
b to conduct research and provide information for the Ministry of Justice
c to prepare and supervise community service sentences and other judicial decisions, and to supervise their implementation, including reporting on this to the competent authorities.

Providing follow-up care after the execution of a sentence or measure is not one of the statutory tasks of probation and the probation service is not allocated a subsidy for providing that care. Although contact with the probation service may also occasionally continue on a voluntary basis after execution of the sentence or measure, the government does not consider provision of follow-up care as a task of the probation service. The official government standpoint is that follow-up care is more a task of normal social work or the regular institutions for the care of addicts.

Although follow-up care is not one of the subsidised tasks of the probation service, part of the (addiction) probation worker's core task of providing help and support is to make preparations for the follow-up care process and to establish contacts with normal care institutions in consultation with the detainee. The *Stok achter de deur* (Big Stick Report) (Bie99) describes the options that the probation service has to offer and the problems that occur. Cooperation between penitentiary probation workers, the external probation service, probation partners and the penal institutions leaves a lot to be desired. Moreover, under pressure from cutbacks, most time and energy is spent on the detainees who are most likely to succeed and those for whom prospects of treatment exist. This means that many addicted detainees lose out on opportunities.

There are inadequate statutory arrangements in the Netherlands for enabling addicts to follow particular addiction programmes under pressure after detention. The only possibility that exists at the moment is the combination of an unconditional and a suspended sentence. A long operational period may be attached to the conditional sentence, thereby making it possible to continue addiction treatment under pressure.

It was once possible in the Netherlands, as in other European countries and in the United States, to impose behavioural conditions on addicts for a considerable period after their detention and thereby create possibilities for treatment under pressure, namely conditional release. This possibility was discontinued in the 1980s in the Netherlands and was replaced by early release, which is not subject to behavioural conditions.

Possibilities now exist within the framework of a Penitentiary Programme (PP) for keeping addicted detainees in a particular (outpatient) addiction programme under pressure (return to prison if agreements are not kept). However, pressure ceases to apply as soon as the detention period has expired. The 'big stick' that the Penitentiary Programme offers is, therefore, much too short for effecting compulsory follow-up care. In practice, little use is made of the possibilities that the Penitentiary Programme offers. This is because of the strict criteria for admission on the one hand and the electronic supervision it involves on the other. Participation in the Penitentiary Programme is voluntary. There is an impression that many detainees generally prefer to spend the remaining period of imprisonment in an open or half open institution, rather than be confronted with the daily freedom restrictions that electronic supervision involves. The Minister of Justice intends to submit a bill in 2002 that will reintroduce conditional release.

The Committee believes that the inadequate possibilities for providing or imposing follow-up care in the existing system in the Netherlands are a major problem. Most addicted detainees are polydrug users. The Committee believes admission to follow-up care after detention is particularly important for polydrug users, owing to the high risk of quickly relapsing under the influence of the cues that exist in the free community.

7.3.1 Recommendations

The Committee recommends that the obstacles to implementing effective types of follow-up care should be removed and that conditions should be created under which the follow-up care can still be provided. This will demand the necessary time and effort, as it involves a complex of factors. The Committee makes the following suggestions for this.

Legal preconditions

The legal obstacles should be removed first. The Committee envisages *a*, expanding the legal possibilities for making follow-up care compulsory and *b*, assigning a statutory monitoring role to one or more organisations in the area of follow-up care, so that those organisations can be held to account for this task's further implementation. The Committee realises with regard to point *b* that a task of this kind cannot be assigned without the associated structural funding.

The Committee adds the following comment with regard to point *a*. The only possibility available at present for making follow-up care compulsory is the combination of an unconditional and a suspended sentence. The introduction of other possibilities could also be considered alongside this. In connection with this, the Committee endorses the Minister of Justice's proposed reintroduction of conditional release. By attaching special conditions to the detainee's release, the concerned person could be compelled to follow a particular programme and to periodically undergo urine tests. Compliance with the conditions should be regularly checked and non-compliance should result in the concerned person being sent or returned to the penal institution. However, the introduction of possibilities other than conditional release, such as a combination of a sentence and compulsory contact with the probation service that occurs in some other countries, is also conceivable.

If conditional release is reintroduced, then the Committee believes that the possibility of earlier conditional release should be considered. In the past, when the Dutch penal system still included conditional release, it came into effect two-thirds of the way through the sentence. Earlier conditional release would be appropriate for offenders for whom a follow-up care process was particularly advisable, such as addicts.

The duration of the imposed operational period would also need to be reviewed in the event of reintroducing conditional release. In the system that was discontinued, this period was calculated by adding one year to the duration of the remaining sentence. Imposing an operational period of two years or more even in the case of relatively short custodial sentences would considerably increase the possibilities for compulsory follow-up care for addicts. The Committee believes the possibility of doing so should be investigated.

Organisational problems

The second point is that organisational problems need to be tackled: shortcomings in the chain during preparation and implementation of follow-up care for addicted detainees need to be removed. The various organisations that are or could be involved (the social services bureau, the penitentiary probation service, the external probation service, the probation service, etc.) must cooperate better. Data transfer from one organisation to another needs to be improved and more thought should be given to continuing contacts with the clients after their discharge.

In connection with this, the Committee stresses the importance of the moment of departure from the institution, which sometimes occurs suddenly, leaving little, if any, time for preparation. It should at least be possible to use the moment of departure as an opportunity to provide (ex)detainees with the name and address of the probation officer, who could then be contacted in the free community, if desired. The Committee suggests making a single (unit

of an) organisation responsible for the proposed monitoring of detainee follow-up care. The obvious body to consider for this is the probation service

Fixed supervisor

Third, the Committee believes that all addicted detainees/ex-detainees should be assigned a fixed supervisor. This contact person should at least have the task of ensuring that addicted ex-detainees follow the treatment programmes that were set as a condition for their release. This official should have the task of reporting to the competent authority if an ex-detainee fails to fulfil the agreements that had been made. There would obviously have to be consequences for any such failure.

7.4 Psychiatric comorbidity

7.4.1 Conclusions on the state of affairs

Research has shown that around half of addicted detainees have a mixed pathology: around half of them suffer from one or more other psychiatric disorders. The conclusion has to be that addicted detainees require a relatively high level of psychiatric attention and care.

The principle of equivalence dictates that the psychiatric care provided in penitentiary institutions must be subject to the same (therefore not a higher or lower) quality requirements as those that apply to psychiatric care in the free community. The Committee is unable to assess the general quality of psychiatric care in penal institutions, owing to a lack of data. The availability and quality of care undoubtedly differ in different institutions and regions. The Committee has no reason to believe that psychiatric care for addicted detainees is generally poorer than that provided for detainees in general. Nor does the Committee have any reason to believe that psychiatric disorders (particularly depression and anxiety disorders) remain undetected or untreated for longer in the penitentiary setting than in institutions in the free community.

7.4.2 Recommendations

The relatively high percentage of addicts among detainees, in combination with the relatively high percentage of detainees suffering from psychiatric disorders, means that medical services and penal institution staff need to be aware of the occurrence of psychiatric disorders among (addicted) detainees. In penitentiary situations, more so than elsewhere, the possibility that individuals may be suffering from psychiatric disorders should be borne in mind and more psychiatric care should be available. The requirement

for the extra facilities flow from the principle of equivalence. After all, the idea that more facilities need to be provided where there is a need for more facilities of a certain kind also applies in the free community.

The Committee recommends that professionals – in this case the National Association of Penitentiary Physicians in consultation with the Forensic Psychiatric Service – should develop numerical standards for the provision of such facilities, similar to the numerical standards that exist for general practitioners and nurses in penal institutions (1 full-time physician for every 300 detainees, 1 full-time nurse for every 50 male detainees and 1 full-time nurse for every 30 female detainees). The Committee's starting point is that the diagnosis and, if necessary, treatment of a psychiatric disorder should not be subject to delays, regardless of its cause or the context in which the disorder occurs.

Addicted detainees with an acute psychiatric disorder do not currently qualify for placement in an Addiction Support Section (section 20, para. 2, Selection Regulations on the placement and transfer of detainees, number 5042803/00/DJI). These individuals are generally placed in a Special Care Section or Individual Supervision Section (see section 4.1.4 for further details). The Committee believes there are generally no good grounds for denying them stabilising medication such as methadone within the scope of their treatment for addiction. If appropriate, they can continue to receive a maintenance dose of methadone while in a Special Care Section or Individual Supervision Section. The question arises of whether it should be possible to place dual-diagnosis patients (that is to say, patients who, in addition to being diagnosed as 'drug dependent' have also been diagnosed as having a concomitant psychiatric condition) in an Addiction Support Section with the aim of harm reduction. The pros and cons of placement in a Special Care Section/ Individual Supervision Section or Addiction Support Section should be assessed on an individual basis. The best place for a particular individual largely depends on the individual's problems. In any case, the possibility of transfer from an Individual Supervision Section/Special Care Section to an Addiction Support Section should not be excluded.

7.5 Continuity of care

7.5.1 Conclusions on the state of affairs

Continuity of care is an exceptionally important principle in the medical supervision of detainees, particularly those addicted to opiates. This is less of a guiding principle in the treatment of cocaine addicts in the penitentiary setting because few addicts would have been receiving treatment for cocaine addiction under a care for addicts programme prior to their detention. Anyway, there are only a few effective possibilities for treating cocaine addiction.

Besides unity in the chain, one of the preconditions for achieving continuity of care is adequate transfer of information from one care provider to another. However, it has already been pointed out that there is little unity in the chain with regard to the care of addicted detainees/ex-detainees in the Netherlands. The Committee discusses transfer of information in this section.

There is no question that a care provider is under an obligation to ensure that medical information is transferred to the next care provider or to request medical information from the previous care provider. Nevertheless, the Committee has the impression that information is not always transferred in the case of addicts. The Committee believes that the cause of this lies with the patient/detainee, on the one hand, and with the care provider, on the other.

If patients deliberately fail to inform their care provider that they have to spend time in a penal institution, they cannot expect the medical practitioner to transfer information to the institutional physician. Another possibility is that the addict no longer knows who the medical practitioner is. Many addicts 'go shopping' from one care provider to another and, in doing so, lose track of where they have been in the world of care provision. This can make it difficult for an institutional physician requiring information from the previous medical practitioner to achieve the goal of continuity of care.

Nevertheless, the Committee has also received signals indicating that the actual care providers are a major obstacle to continuity of care. They are sometimes disinclined to pass on or request information on their addicted patients, especially on patients that they only expect to treat for a short time. The Committee has gained the impression that it is the institutional physicians in remand prisons in particular who feel that collecting and passing on information about their addicted patients does not have a high priority. The situation is different in prisons, perhaps also because long-term detainees often press the institutional physician to request or pass on their medical information.

7.5.2 Recommendations

The Committee realises that continuity of care may be difficult to achieve in remand centres, particularly for pre-trial detainees and detainees serving short sentences. After all, some pre-trial detainees are likely to be suddenly discharged, with the result that the institutional physician is also suddenly faced with the person's departure, and no longer has an opportunity to transfer information. Although the Committee realises that this also makes the transfer of collected information difficult, it again stresses how important such transfers are. The Committee therefore recommends that institutional physicians should assign greater priority to this transfer of information.

The Committee points out that this exchange of data between medical practitioners could perhaps be promoted in future by the introduction of a national registration system:

the National Central Medicine Register (LCMR). If implemented, institutional physicians could use the National Central Medicine Register to check whether addicts were already receiving treatment elsewhere. It would, though, be inadvisable for physicians to base their treatment policy solely on the data that this system provided.

7.6 Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act (SOV)

7.6.1 Conclusions on the state of affairs

The Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act is a sanction provision in the Penal Code, which enables drug-addicted recidivists to be compulsorily placed for up to two years in an institution for the care of addicts. The Penal Care Facility for Addicts does not involve a custodial sentence, but is instead a judicial measure like detention under hospital order. The Committee's advisory report could not play any part in the parliamentary discussion of the legislative proposal for the Compulsory Treatment of Addicts Act because it had not been completed at the time of the discussion. The Committee notes that parliament accepted the legislative proposal for the Compulsory Treatment of Addicts Act and that the Compulsory Treatment of Addicts Act entered into force on 1 April 2001. This meant the Penal Care Facility for Addicts was a fact. The Committee concludes that there is no role for the fundamental question of whether the Penal Care Facility for Addicts is required. However, this does not prevent the Committee from making a number of comments on the Penal Care Facility for Addicts.

Insufficient evidence

The Committee doubts whether the Penal Care Facility for Addicts will provide any real solutions to the problems it is intended to tackle. The Penal Care Facility for Addicts has two objectives, namely; *1*, to reduce crime or nuisance and *2*, to reduce the addiction problem. The Committee notes that the two objectives do not always complement each other and are sometimes at odds with each other. The Committee has doubts about the measure's effectiveness, particularly with regard to the reduction of addiction problems. The Committee believes that the report of the scientific research and documentation centre (WODC) (Baa98) is too optimistic about the effectiveness of regimes like the Penal Care Facility for Addicts. In this regard, the Committee shares the doubts that Rigter expressed on this subject in his literature review (Rig98).

Very little research has been conducted into the effectiveness of judicial pressure and pressure in the treatment of addiction. Most of the (scarce) research that has been conducted is characterised by methodological shortcomings. Recidivism, rather than a reduc-

tion in the addiction problem, is often the measure of the effect. Insofar as the studied interventions proved to be effective in this respect, the extent of the identified effects was extremely limited (around 15%). Moreover, it is questionable whether the conditions under which the results were achieved are comparable with those that will exist in the Penal Care Facility for Addicts. The Committee doubts that the studied populations are comparable with the target group envisaged for the Penal Care Facility for Addicts, namely (older) opiate addicts who are persistently guilty of (petty) property-related crimes. In short, the Committee has the impression that the research – which is partly characterised by methodological shortcomings – on which the scientific research and documentation centre (WODC) has based its findings often concerns different populations in different countries and under different conditions. It is thus questionable whether, or to what extent, the findings also apply to the Penal Care Facility for Addicts in the Netherlands.

There is therefore insufficient evidence that the Penal Care Facility for Addicts will have a beneficial effect. It is particularly unclear to what extent the addicts themselves will benefit from the measure. As things stand, it is necessary to ask whether the Penal Care Facility for Addicts might also have detrimental effects and even whether it might be harmful to those involved. Before further discussing this potential harm, the Committee points out that addiction is a psychiatric disorder that requires treatment. Perhaps partly because the term 'treatment' is not used, the Committee is unclear, on the basis of the material that it has available on the Penal Care Facility for Addicts, as to what range of treatment will be provided. The Committee believes it is extremely important that addicts have, prior to their entry into the facility, clarity about the nature of the care they will receive in the Penal Care Facility for Addicts. The Committee repeats that the Medical Treatment Agreements Act applies not only to the normal detention setting, but also to the Penal Care Facility for Addicts. The Medical Treatment Agreements Act stipulates that proper information must be provided with a view to obtaining the patient's informed consent. It is known that there is a correlation between the degree to which patients feel they are able to exert control over the situation and the effectiveness of medical intervention, which justifies an attempt to achieve shared decision-making (RGO00). Moreover, addicts must be prevented from saying afterwards that they were lured under false pretences into accepting the treatment provided by the Penal Care Facility for Addicts.

Potential harm

The Committee would now like to point out the possible drawbacks of the Penal Care Facility for Addicts. First, there is the risk that addicts' motivation to do something about their addiction problems might be weakened rather than boosted by their compulsory placement in the Penal Care Facility for Addicts. This would produce exactly the

opposite effect to the one intended, namely that addicts reject the provision of care even more than before. In connection with this, the Committee reiterates the objections that have been raised to the legitimacy of the Penal Care Facility for Addicts. It is conceivable that addicts confronted with the Penal Care Facility for Addicts might feel they have been unjustly treated because others have been deprived of their freedom for less time by being given shorter sentences. At the least, it will do nothing to encourage addicts to make an effort. All of this has the potential to make the relationship of trust with the care provider more difficult, as the addict will bear a grudge against the care provider for being part of an unfair system. The Committee believes that a feeling of having been treated with unreasonable harshness could harm addicts' trust in the care providers and organisations associated with the Penal Care Facility for Addicts. The failure of the Penal Care Facility for Addicts could undermine addicts' trust in organisations providing care for addicts that are associated with the Penal Care Facility for Addicts, which could be potentially extremely harmful to the provision of care for addicts as a whole.

Second, the Committee points out the risk of arbitrariness or incorrect decisions. Documents on the Penal Care Facility for Addicts indicate that the existence of a 'dominant psychiatric disorder' or 'severe psychiatric problems' is a contra-indication for the Penal Care Facility for Addicts. The Committee assumes it is the consultant behavioural specialist (psychologist or psychiatrist, see Second Chamber, session 1999-2000, 26023, no. 9, page 2) who will have to examine whether any such contra-indication exists in an individual case. The Committee takes the starting point that only a psychiatrist has sufficient training to determine the existence of problems of this kind. A difficulty here is that the legislator does not provide a precise definition of 'dominant psychiatric disorder' or 'severe psychiatric problems'. Would it be correct to assume from this that patients who, besides being addicts, have 'minor' psychiatric problems would qualify for admission to the Penal Care Facility for Addicts? Until there is clarity about which psychiatric disorders are deemed to be severe and which are deemed to be minor, specialists referring patients to the Penal Care Facility for Addicts will have different opinions on this subject. This will be made even worse by involving non-psychiatrists in the situation, with the risk of arbitrariness playing a role in admissions or incorrect decisions being made. This will certainly not increase confidence in the opportunities that the measure offers among those who are subjected to it. Incidentally, the Committee assumes that those who are not admitted to the Penal Care Facility for Addicts will be provided with proper care for their psychological problems in detention.

Third, the Committee points out that insufficient attention has been paid to the special dynamics of the relationship between those involved in the Penal Care Facility for Addicts. This refers not only to the relationship between addicts and those treating them, but also to interactions between the addicts themselves. Little information is available about what the pressure/pressure features of the Penal Care Facility for Addicts will

signify for these contacts. Because addicts will not be able to leave, tensions may arise that are released in acts of violence. Any such reactions may spill over to other detainees. The occurrence of reactions of this kind should be delineated within the framework of the evaluation of the Penal Care Facility for Addicts.

Fourth, the Committee requests attention for the potential damage to the health of those who are placed in the austere regime for a long period because they prefer this to participation in the programme provided by the Penal Care Facility for Addicts. This point is all the more important as an austere regime is generally not permitted to last more than 90 days, whereas the period in the case of the Penal Care Facility for Addicts may be as long as two years. The Ministry of Justice itself recognises that confinement in detention is harmful in principle; after all, the prison system has the task of arranging the stay in a penal institution so that it minimises the harm that is done. However, there are few possibilities for such reductions of harm in the austere regime. The Committee therefore believes there is a considerable risk of detainees' mental or physical health being harmed. Those who are involved in the measure's implementation also have a heavy responsibility in this respect.

Fifth, the Committee has doubts about the follow-up care in the resocialisation phase of the Compulsory Treatment of Addicts Act. The fact that this has been placed in the hands of the local authorities means that there is no guarantee of a comprehensive care chain. For example, Amsterdam's local authority has said it will only be willing to pay for the employment and accommodation of addicts covered by a Penal Care Facility for Addicts measure if they are residents of Amsterdam and are younger than 25.

Sixth, the Committee reiterates the risk of overdosing after addicts have kicked the habit, compulsorily or otherwise. Kicking the habit results in a reduction of an addict's tolerance to the drug. If the addict then takes the previous dose again after being discharged, then the consequences may be disastrous, and in the worst case, fatal. It is the responsibility of those who implement the Compulsory Treatment of Addicts Act measure to provide proper preparation for the addict's return to the community.

Recommendations

Before presenting recommendations, the Committee would like to make a few preliminary comments. Some members of the Committee believe that the lack of sufficient evidence for the effectiveness of the measure and the aforementioned lack of clarity and risks are such important factors that they expect little good to come from the Penal Care Facility for Addicts. These members also have doubts about the legal-ethical basis of the measure; the question remains as to whether addiction, even when it leads to exasperating nuisance factors, entitles the government to attempt to change the course of undesirable behaviour through pressure in a direction that is against the wishes of the concerned

individual. In spite of the lack of evidence and the demerits, other Committee members are willing to give the Penal Care Facility for Addicts the benefit of the doubt for the time being. This decision is based on the persistent or exasperating nuisance factors that result from addiction, the relatively small size of the group that creates the nuisance and the failure of pressure projects among this group. These Committee members point out that insofar as relevant research has been conducted, it has not produced any indications that the Penal Care Facility for Addicts will be ineffective.

Notwithstanding the above, the Committee is unanimous in its recommendations. The Committee has made proper note of the fact that the Minister of Justice views the measure of the Penal Care Facility for Addicts under the Compulsory Treatment of Addicts Act as an experiment that he has promised to evaluate, although the proposed legislation for the Compulsory Treatment of Addicts Act has since entered into force. The Committee believes that such an evaluation is essential. It is pleased to hear that the evaluation study will be conducted by an independent research organisation. Rather than focusing solely on reductions in criminal behaviour, any evaluation of this kind must also address the issue of reduction of the addiction problem itself in the long term. In addition, the evaluation study should also clarify the issue of possible, previously identified, adverse effects. The Committee considers the effective registration and analysis of possible disasters to be of the utmost importance.

The Committee would like to point out here that its general recommendations on supervision and treatment of drug addiction in detention also apply to the Penal Care Facility for Addicts. This particularly implies that its recommendations on harm reduction and methadone treatment also apply to the Penal Care Facility for Addicts; methadone maintenance treatment should also be a subject of negotiation between the physician and the addict in the Penal Care Facility for Addicts. The effects of methadone treatment on addicts who are subject to a Penal Care Facility for Addicts measure could be delineated within the framework of the evaluation of the Penal Care Facility for Addicts.

Finally, the Committee would like to emphasize the subsidiarity of the Penal Care Facility for Addicts, which is by far the most draconian measure within the range of pressure and pressure that the state can apply to delinquent addicts. It should therefore only be used for delinquent addicts as a last resort, provided it can be demonstrated that more moderate means (pressure applied by means of special conditions) have been tried and have failed for these individuals. The Committee has in mind here the armamentarium of special conditions, because their value has been proven in the treatment of addicted offenders. The Committee strongly supports the view that the state should maintain or create this range of more moderate means, which it believes could be made more effective. This advisory report identifies the conditions under which this might be possible and the way in which this could be tackled. The Committee considers the introduction of pres-

sure in the area of follow-up care (for example, in the form of re-introduction of the conditional release) to be of crucial importance in this regard.

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A Request for advice

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Annexes

Annex **A**

Request for advice

On 23 February 1998, the Minister of Health, Welfare and Sport wrote to the President of the Health Council of the Netherlands (letter reference GVM/Vz/98734):

Since the early 1980s, problems concerning the care, treatment and medical supervision of addicts have increasingly been the focus of attention of my predecessors in office and of the Minister of Justice. This has led to a number of policy documents and debates in the Second Chamber. In particular, related policy decisions were intended on the one hand to improve the physical, psychological and social situation of the involved addicts and, on the other hand – particularly recently – to also reduce the social nuisance that addicts sometimes cause. Definite results have been achieved in both areas. However, my colleague, the Minister of Justice, and I recognise that the situation could be further improved on certain points.

A direct result of endeavours to reduce social nuisance is that there are now more addicts in penal institutions. According to an estimate by the Van Dinter working group (*Zorg ingesloten* [Care of detainees], Ministry of Justice, 1995) more than half of all detainees in these institutions have addiction problems of one kind or another. The Dutch Association of Addict Care and Treatment Centres (NeVIV) published a similar estimate in 1996. Although the exact number of drug addicts is difficult to determine precisely, 'as there is no clear definition of addiction and the figures are based on detainees' own statements' (Van Dinter), rough estimates of the number of detainees held in detention on an annual basis – for either short-term or long-term sentences – is approximately 18,000*. Treating these detainees often presents the judicial system with considerable problems.

* Because drug users are often recidivists, allowances have to be made for a considerable number of double counts.

The diverse opinions that exist throughout the country on medical supervision of hard-drug addicts during detention are reflected in the various penal institutions. This results in there currently being no unambiguous answer to – for example – the question of whether it is advisable to prescribe or continue prescribing methadone to addicted detainees. There is likewise no clear answer to the question of whether the start of detention could form a provocation for changes in the addict's medical supervision.

My colleague, the Minister of Justice, and I therefore require an overview of current knowledge on the medical supervision of drug addicts in different penitentiary regimes.

The starting point should be the impact that the various detention settings can have on different categories of drug addicts; the policy adopted by the institution, the interrelatedness of the various medical and penitentiary regimes, and the duration of detention must be taken into account. This would make it possible to say what current insights reveal about the existing prospects for treating addicted detainees.

By different categories of drug addicts, I mean differences in the nature, severity and duration of addiction, taking into account any existing (psychiatric) comorbidity. The different categories will probably require a different approach for different penitentiary regimes.

I imagine 'treatment possibilities' including pharmacotherapeutic as well as non-pharmacotherapeutic treatment modalities. It will be relevant for you to also examine the impact of various forms of pressure and pressure under which treatment can be provided; this is especially relevant when keeping in mind the possibility of using the detention period as a positive moment for change. I realise that the medical and penitentiary regime are closely intertwined with this.

Finally, I request you to pay attention to the possible importance of continuity of care before, during and after the detention period. I assume that you will take into account that a body of knowledge has also developed in recent years on subjects such as 'care' and the 'implementation of care'.

We believe it will be important to involve advisors from the concerned departments of both ministries in the formulation of your replies to these questions. I therefore request you, also on behalf of the Minister of Justice, to report on these matters in the course of 1999, within the scope of the 1998-1999 working programme.

I look forward to receiving your reply.

The Minister of Health, Welfare and Sport,
(signed) Dr E Borst-Eilers

Annex **B**

The Committee

- Professor HGM Rooijmans, *president*
  emeritus-professor of psychiatry; chairman of Health Research Council, The Hague
- CM Boeij
  general governor of Toorenburgh Penal Institution, Heerhugowaard
- Professor W van den Brink
  professor of clinical epidemiology in the field of care for addicts;
  University Medical Centre, University of Amsterdam
- GHA van Brussel
  public health physician; Municipal Health Service, Amsterdam
- M van Doorninck*
  health information official; Netherlands Institute of Mental Health and Addiction,
  Utrecht
- MA Goppel, *adviser*
  Health Council, The Hague
- AK van der Heide, *adviser*
  public health physician; Ministry of Justice, The Hague
- Dr AM van Kalmthout
  senior university lecturer on criminal law; Catholic University of Brabant, Tilburg
- Professor HJC van Marle, *adviser*
  professor of forensic psychiatry; Ministry of Justice, The Hague

* Mr M van Doorninck died on 8 March 2002.

- Dr LM Moerings
  senior university lecturer; Willem Pompe Institute for the Criminal Sciences, Utrecht
- EA Noorlander
  psychiatrist; De Kijvelanden Forensic Hospital, Rhoon
- Professor GM Schippers
  psychologist/psychotherapist; researcher at Amsterdam Institute for Addiction Research, extraordinary professor of addiction behaviour and health care evaluation; University Medical Centre, University of Amsterdam
- JMLP Sieben
  general practitioner; Amsterdam
- AAM Vloemans, *adviser*
  physician/epidemiologist; Ministry of Health, Welfare and Sport, The Hague
- RH Zuijderhoudt
  psychiatrist and health lawyer with independent practice in The Hague
- Dr CJ van de Klippe, *secretary*
  Health Council, The Hague

Annex **C**

Verdicts of the Central Council for the Administration of Criminal Justice

The Medical Affairs Appeal Committee of the Central Council for the Administration of Criminal Justice, now known as the Central Council for the Application of Criminal Law and Youth Protection, issued ten verdicts between 1 January 1999 and 1 February 2001 in complaint proceedings on methadone provision. The verdicts are summarised below in chronological order.

- BC 6.9.1999 no. A 99/655/GM. Reducing methadone prescription during a detention of approximately nine weeks and in the absence of contra-indications is in accordance with the guide published by the Ministry of Justice and is therefore not in breach of the standard set out in section 28 PM. Appeal dismissed.
- BC 6.9.1999 no. A 99/751/GM. Reducing methadone prescription during a detention of approximately 11 weeks and in the absence of contra-indications is in accordance with the guide and is not in breach of the standard set out in section 28 PM, although a different policy is conceivable for detainees with a long history of addiction who are not deprived of their liberty for a long period. Appeal dismissed.
- BC 18.1.2000 no. A 99/1135/GM. The complainant had been an addict for many years and had used methadone in recent years as part of the programme supervised by CAD. He had originally agreed during his detention of more than 13 months to a reduction in the provided dose of methadone, but failed to fulfil the agreement. Not prescribing him methadone is not the obvious step to take, given the letter of the Ministry of Justice's medical adviser as an explanation of the guide and his new insights on this subject. Appeal upheld.

- BC 17.2.2000 no. A 99/1201/GM. Reducing methadone in the case of a long-term addict in short-term detention (six months, in this case), against the advice of her CAD practitioner, is inadvisable according to the guide and supplementary letter. Appeal upheld. Compensation for inconvenience suffered is NLG 250.
- BC 17.2.2000 no. A 99/1133/GM. According to the guide and supplementary letter, reduction of methadone against the advice of the addiction physician providing treatment is inadvisable for an extremely long-term addict in short-term detention. Appeal upheld. Compensation for inconvenience suffered is NLG 250.
- BC 25.5.2000 no. 00/447/GM. Complaint against rapid reduction of methadone provision. It was shown that the reduction started at the complainant's request, that complete reduction did not take place and that the institutional physician had consulted fully with the complainant about the reduction process. Appeal dismissed.
- BC 21.8.2000 no. 00/864/GM. Reducing methadone to a daily dose of 20 mg, against the advice of the addiction physician providing treatment, for a person who received a short-term (three months) sentence and has been addicted to hard drugs for an extremely long period, is in breach of the guide and explanatory letter. Appeal upheld. Compensation for inconvenience suffered is NLG 250.
- BC 21.8.2000 no. 00/986/GM. Complaint against prescription of small daily dose of methadone (30mg). Complainant was transferred from another institution, where the institutional physician had decided (contrary to guide and letter) to reduce the maintenance dose from 70 mg to 30 mg. Complainants appeal could only concern the actions of the institutional physician at the second institution. This physician decided to prescribe the same maintenance dose of methadone that the complainant had received in the preceding period. This action is not in breach of the standard set out in section 28 PM, although it would have been conceivable for the institutional physician to prescribe the complainant a (slightly) higher dose in view of his imminent release. Appeal dismissed.
- BC 11.12.2000 no. 00/1300/GM. Complaint against unrequested prescription of Symoron (methadone). Complainant said he had taken Symoron on the physician’s advice, without knowing that it was methadone, whereas he had previously deliberately reduced his use of methadone. The key question is whether the complainant knew that Symoron was the brand name of methadone. The Committee gave complainant the benefit of the doubt because he had reduced his use of the drug as soon as he became aware of what it was. Appeal upheld: institutional physician failed to provide complainant with sufficient information.
- BC 11.12.2000 no. 00/1874/GM. Complaint against reduction (halving) of methadone maintenance dose after 40 mg of methadone (saved residual amounts) were found in the detainee’s cell. Without further investigation of the complainant and solely on the basis of the small supply of methadone found, the physician should not have decided to halve

the dose, in view of the medical indication on which the daily maintenance dose had been provided up to that point, particularly the complainant's susceptibility to psychosis, and in view of the care with which the size of the dose had been determined. Appeal upheld. Compensation for inconvenience suffered is NLG 250.