DRUGUSERS IN PRISON

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Introduction

Since 1979 several drugtreatment projects have been developed in four houses of detention in the Netherlands.

Though operationally quite different, the major objective of the four projects are the same, *i.e.*, continuity of social services.

One of the joint characteristics is that an external, private drug addiction service works within the penal institution, coordinating the project.

This summary paper will give some general background information on the Dutch penal system. It then describes the Amsterdam project in some detail.

The author is the coordinator of this project. Finally some questions, which may be relevant to this Seminar will be raised.

General information about the Dutch penal system and addiction services

About 14 million people inhabit the Netherlands. There are 19 houses of (pre–trial) detention and 17 prisons.

The average number of incarcerated persons for day is 3500 (including 100 women), of whom about 2000 people are kept in houses of detention. Per 100.000 inhabitants 23 persons are incarcerated (on any day). In 1980, 15369 persons were sentenced to an unconditional term in prison. Of these 85,4 % received a sentence of less than six months, 9,2 % received a sentence between 6 months and a year, and 5,4 % a sentence of one year and longer.

(*) Coordinator drug project in the prisons of Amsterdam.

About 18 % of all pre–trial detainees used hard–drugs. In the lager institutions 30 % to 40 % of the inmates are drugusers. The number of hard–drugusers who were put in custody increased steadily from 259 in 1971, to 1036 in 1975, to 2626 in 1979 and to 3276 in 1981.

One large and three relatively small private organizations deliver probation and parole services. One of the smaller ones is the umbrella organization for 19 consultation centers for alcohol and drugs (*CAD*).

These extra–mural CAD's deal with alcohol and drug clients in general, but are charged in addition with the probation and parole work and pre–sentence reporting for alcohol — and drugdependents who enter the criminal justice system.

In addition to the consultation centers a large number of more and less traditional organizations and institutions deal with drugusers, varying from streetcornerwork, junkie unions, store–front projects, volunteer groups and parents–associations to more structured programmes, religious–oriented organization, special organizations for black people and for moluccans, detoxification centers and a number of intra–mural programmes (therapeutic communities, clinics). In most cities the consultation centers have a coordinating intake and referral function.

Background of the drugtreatment projects in Amsterdam, Rotterdam, The Hague and Breda

While in the very early seventies several government committees were focussing on the alleged dangers of cannibas use and on the (im)probabilities of its decriminalization and lagalization, rather suddenly and unexpectedly the problem of harddrugusing criminal justice clients presented itself. Drugusers became very fast a problematic group of inmates.

Guards and prisonstaff didn't feel equipped to deal with withdrawal behavior and withdrawal symptons. The drugusers and their social workers complained about the bad treatment or the lack treatment at the police stations and in the houses of detention.

As the number of drugdependent criminal justice clients increased steadily, the problems within the penal institutions grew accordingly.

The department of justice and the health department set up working groups which had to inventarize those problems.

The criminological institute of the University of Groningen (1) interviewed drugdependent inmates in six houses of detention about their problems during incarceration, and they compared them with a matched group of non–using inmates.

The major findings were that drugdependent immates were not all that different from non–using inmates as far as social backgrounds, family history and delinquent careers were concerned.

The major difference between the two groups was that most of the non–users had contacts with probation officers or other services, while the majority of the drugdependent inmates did not.

Asked about their experience in jail the drugusers complained most about the poor medical care. They felt at the mercy of the prison physician and medical staff, insufficient medical attention and care was given.

Other research and studies showed, iter alia:

1) that there was no correctional policy on the medical treatment of drugusers; prison physicians developed their own methods according to their own beliefs, or according to the belief of the prisonmanagement;

2) that when unvoluntarily detained drugusers are consulted about their ideas on medical care, they are more inclined to consider a further, psychological, kicking off;

3) that continuity between extra mural and intra–mural addiction services was considered to be very important but in fact completely lacking;

4) that, consequently, there was no systematic effort to divert drugusers from the criminal justice system.

In 1979 the Department of Justice started, under her auspices, two projects in Amsterdam and Rotterdam.

The objectives were *a*) to give adequate medical care and attention to drugusers, particularly during the withdrawal

(*) ERKELENS, L.H., P.J.D. HAAS en O.I.A. JANSSEN: *Drugs en detentie.* Groningen, Criminologish Institut, 1979.

period, *b*) to look for alternatives for futher pre–trial detention and *c*) to link inmates to outside services. Characteristic for both projects was that the local consultation centers for alcohol and drugs (CAD) coordinate the services within the jails and that the guards received a special training.

In late 1980 and 1981 two other projects were developed in Breda and the Hague respectively. The four projects developed in different ways, due to architectural differences, the prevailing network of service on the outside, the diversion possibilities allowed for by the courts and the various ideas of the CAD's.

The jail in Rotterdam, for exemple, is very old and the regime well established. The addiction services, on the other hand, are well structured and regular contacts did already exist between the several components of the criminal justice system and the local consultation center. The court does not easily suspend pre–trial detention.

In Amsterdam a new compound of six houses of detention had just been opened in 1979, the prisonstaff and guards were newly appointed, the addiction services network in Amsterdam was highly disorganized and the court diversion efforts during the pre–trial phase.

The Amsterdam experiment

Within the jail compound there are four houses of detention for adult men. The capacity of the institutions is 120 cells. Each building is divided in five two–floor–units of 24 cells.

One of the houses of detention, called Demersluis, is a reception center, where all pre–trial detainees arrive from the court and where they spend the first fourteen days to three weeks. After this period inmates are transferred to the house of detention for young adults (up to 23 years), to the house of detention for elder people or to the fourth building which houses young as well as elder people.

In the reception center Demersluis one of the five units, Unit I, is reserved for 12 drugdependent inmates who stay there for the first two or three weeks of their detention.

The placement criteria are that inmates speak the Dutch language, that they consider their druguse to be problematic

and that they chose to be placed on Unit I and stick to the rules.

The rules are that Unit I is an open unit (this is unique); inmates are out of their cells all day, but one has to get up in the morning and has to work. There is a permanent team of 12 guards and a headguard.

The CAD unit exists of 5 people, one coordinator, one psychologist and two social workers who work on Unit I and one social worker who deals with the drugdependent inmates who are not placed on Unit I.

The dayprogramme starts at 7 o'clock, between 8 and 9 o'clock inmates clean their cells and the unit.

There are group–meetings four days a week between 9 and 10,30 a.m. The rest of the mornings are spent on standard activities; sport, the shop, medical and dental care, etc.

Inmates, guards and CAD workers eat together, and in the afternoon inmates work. The evening programme ends at 9.15. Twice a week external addiction–services visit Unit I to give information about their respective programmes. They are encouraged to bring ex–addicts who are preferably also ex–inmates. The weekendprogramm is 'low key', with some extra sport and recreation. The CAD work consists of checking with inmates what their contacts are and have been with outside services if any, to screen people for possibilities of an early (conditional) suspension, to give information about services and programmes and to link inmates and services together.

We don't 'push' services, but expose inmates to the various possibilities, in the hope that they will finally opt for some outside contact.

The objective of the groupsessions is to confront people with the situation they are in and their ways of (not) dealing with it. The group–discussions are loosely structured.

They are the most important aspect of our programme and rather popular, to our surprise, among inmates.

After their transfer to one of the other institutions we used to visit our clients individually once every week or fortnight, depending on the contacts made (or not made) with outside services. But as the groupsessions turned out to be rather fruitful we have been setting up regular group-meetings in the other institutions.

The medical approach is that the physician discusses with the inmates whether they want to kick off or not, and if so, how they prefer to do that.

About 70 % of the inmates kick off on a methadon withdrawal programme (starting with 30 mg) within a period of 8 days to about 3 weeks.

Another 15 % kicks off on depronal, librium, valium or sleeping pills.

About 10 % of the inmates receive a methadon maintenance dose. There are mainly older and long–term addicts who partecipate in outside maintenance programmes. Also younger addicts and people who are, or who are likely to become, (pre) psychotic may receive a maintenance dose for the time being.

A small group of drugusers choses to kick off without any medication.

The other drugusers

It turns out that only 50 % of the drugusers who come to the reception center Demersluis are placed on Unit I.

The largest group of the drugusers who are placed on the other units are foreigners (35 %), drugusers who did not want to go to Unit I (12 %), dealers, inmates with restrictions and people who have been placed already twice or three times on Unit I.

The last group is unfortunately increasing. We continue our individual contacts them. When people come in for a fourth of fifth time, placement on Unit I become possible again. Another 25 % were not placed on Unit I for lack of space.

Some outcome data

The projects in Amsterdam and Rotterdam have been evaluated by the research section of the department of justice. An interim report of a client oriented research project was issued last year and confirmed largely the data we had collected ourselves during the first year.

About 400 inmates had been places on Unit I between July 1979 and May 1981. The average age was 23,5 years. The

average length of stay is about three weeks. The average length of destination of inmates from Unit I is about a month shorter than that of drugusers who are placed elsewhere, i.e. 2.11 months.

More than 85 % of the Unit I clients have established a contact with an outside service before the end of their detention. Around 50 % have actually made specific plans, ranging from joining an experimental work–project to admitting oneself to a therapeutic community.

Pre–trial detention was suspended for 37 % of the 400 inmates, 25 % was suspended within three weeks.

From the interviews with 50 clients (after their departure from Unit I but before their discharge) emerged that most people appreciated their stay at Unit I. Particularly mentioned are the relaxed atmosphere, the groupsessions, the contacts with us, the guards and most of all with the fellowinmates.

The more negative comments were, ' you have to get up ', ' you have to participate in groups all the time ', ' you are surrounded by other junkies '.

The only conplaints were still about the medical treatment.

There are no follow–up data available yet. Considering the number of people who show up again in jail, however, and considering the informal information we receive from inmates and fellow social workers, we are convinced that not all that many of the 85 % of the people who got in touch with addiction–services, while in jail, remained ' clean ' outside.

Which means that continuity of services does not necessarily results in immediate change of lifestyle.

Our main objective is, indeed, to provide inmates with information about the available services and programmes and to link them to those services. With the hope that when people are (more) inclined to stop using drugs they will know where to go.

The other projects

None of the other projects has the possibility of a separate unit at its disposition.

In Rotterdam two CAD groupworkers have intake meetings with all the drugusing inmates after their arrival

in jail. They run several group discussions, loosely structured groups and so called interest–groups.

In the Hague a team of four CAD workers, work within the house of detention for young adults (18–21). They have also set up groupmeetings. A therapeutic community runs a series of groups for those inmates who plan to go to this community.

The CAD coordinator in Breda does not see inmates; he coordinates the outside services, which hold group discussions within the jail in collaboration with the jail social work staff.

Continuity of services

One of the problems all four project encounter is that the network of available services is incomplete.

There are no programmes which focus on the young user (18–21) for whom the drugscene is still very attractive.

Nor are their facilities for the older drugaddict (34 +) who knows by now the addictions–services network by heart.

Also for the black–addicts, mostly coming from Suriname and the Antilles, too few structured programmes exist thus far.

Nor are sufficient services available for the increasing number of drugusers coming from other etnic minorities, particularly second generation migrant labourers.

In some cities loosely structured (low–threshold) methadon distribution centers have been developed. They have sofar, however, not contributed to a decrease in the number of drugsers who get in touch with the police.

In various cities the probation services, including the CAD's, are developping a special 'early–aid' system for drugusers who are arrested.

Probation officers visit the drugusers at the police station.

One of the objectives is diversion.

There, also, the major problem is that there are not many opportunities for diversion for people who have lost their apartment, friend, parents, wives, who are in dire need of the next shot.

Another major problem concerning the continuity of services is that many drugusers seem to prefer to go to jail,

rather than go to their social worker, drugaddiction service, streetcornerworker or withdrawal clinic.

Issues and questions

After these years of experience with the care for drugusers in prison a number of more general questions arise, which may be relevant to this seminar.

1. – Is it necessary, and if so, what makes it necessary to provide special services for drugusers in prison? – In the Netherlands it is not a criminal offence to be addicted. People come in touch with the criminal justice system for ordinary offences, often offences committed in order to support their addiction.

As cocaine abuse increases more people are convicted for offences (often agressive ones) directly resulting from a cocaine 'rush' or psychosis. Not all detained druguser commit only offences in order to be able to buy drugs. Many of them (in the Netherlands 30 % to 40 %) were arrested for imprisoned for offences committed prior to their drug use.

The policy of the Department of Justice has been that drugtreatment is not the task of the Justice Department, but the task of the Department of public health.

As great numbers of drugusers are arrested and imprisoned the Department felt obliged however to develop treatment services within the penal institutions.

2. – What should the objectives be of treatment services in penal institutions? – Prisons are not the best places to 'treat' addiction. Of course inmates are more or less forced to kick off in prison. On the other hand the smuggle and use of hard drugs is a wide spread and serious problem in our institution. But should one just provide withdrawal services.

Or should one try to create a surrounding where inmates can prepare themselves for a life without drugs (and criminality?) afterwards.

'Motivation' is a very complexissue. Our experience is that no one is 100 % motivated to lead a 'clean' life.

We try to create a setting and facilities which enhance and support the positive sides in one's motivation.

3. – Medical treatment. – The medical care for drug-users is one of the most controversial issues in the Netherlands. Particularly the use of methadone. The treatment ' philosophy ' of prison psysicians vary enormously.

The department of justice has issued guidelines which allow for the use of methadone in the penal institutions. The guide lines are rather vague. They basically state that it is ' alright ' to administer methadone.

Often the whole issue of ' how to provide services for drugusers in jail ' center on the methadone issue. Of course the issue is much broader.

In our institution the medical approach is an integral part of the treatment or care services for drugusers.

4. – Who should provide services. – For drugusers in prison? The prison staff (e.g. social workers) or a private addiction service?

In the Netherlands seven new projects, similar to the existing ones, are under way.

Other models are also possible. It seems essential that there are at least links between inside and outside services.

One of the problems in the projects in Holland is that penal institutions are not used to have an independent agency which works within their, often bureaucratically and hierarchically organized, institutions.

5. – Treatment in prison is easily considered as ' compulsory ' treatment. – In the Netherlands we don't have compulsory treatment programmes for drugaddicts, in prisons or elsewhere.

As drugaddiction becomes more visible ' compulsory treatment ' has become a public and political issue. (As has heroin maintenance!).

6. – The developing of a policy for the treatment for drugusers in prison is by itself rather complex. – Several departments are involved, particulary justice and public health. In addition prison management and staff as well as addictionservices have to do the actual work. Departments and institutions which have, at worst, conflicting interests, due largely to their essential functions, and to professional differences.

7. – To what extent will the economic recession influence the development of ' drugs in prison? – We started our projects in the Netherlands when there still was sufficient funding. This is no longer so, on the contrary there will be a substantial decrease in funding for all kind of activities and services for inmates. What kind of consequences should be drawn from that situation.

RIASSUNTO

Sin dal 1979 sono stati elaborati in Olanda diversi progetti nei quali i servizi esterni di terapia antidroga curano all'interno degli istituti di detenzione i tossicomani.

Questi progetti si pongono essenzialmente i seguenti obiettivi:

1) Intermediare tra detenuti e servizi esterni (continuità dei servizi).

2) Fornire un trattamento medico personalizzato ai consumatori: il metadone viene somministrato sia ai fini di astinenza che di mantenimento.

3) Deviare i detenuti da un'ulteriore detenzione verso i servizi esterni.

Questo documento tratta in particolare di un progetto sperimentale realizzato negli istituti di detenzione di Amsterdam e solleva alcune questioni in merito ai futuri programmi del dipartimento della giustizia in Olanda.

Il carcere di Rotterdam è, ad esempio, molto antico e le sue direttive sono ormai consolidate. I servizi relativi alla tossicodipendenza, d'altra parte, son ben strutturati e contatti regolari esistevano già tra le varie componenti del sistema di giustizia criminale e il centro consultivo locale. Il tribunale non sospende facilmente la detenzione preventiva.

Un nuovo complesso di 6 istituti di detenzione è stato aperto nel 1979 ad Amsterdam. Il personale carcerario e le guardie sono stati nominati ad hoc, la rete dei servizi antidroga di Amsterdam era molto male organizzata e l'azione del tribunale in tale campo durante la fase antecedente al giudizio non era ancora sviluppata.

Progetto sperimentale di Amsterdam.

All'interno del complesso carcerario vi sono 4 istituti di detenzione per uomini adulti. La capacità delle istituzioni ammonta a 120 celle. Ciascun fabbricato è suddiviso in 5 reparti di due piani ciascuno comprendenti 24 celle. Uno degli istituti di detenzione chiamato Demerluis

è un centro di raccolta dove affluiscono dal tribunale tutti i detenuti in attesa di giudizio e dove essi trascorrono dai 14 ai 21 giorni. Dopo questo periodo i detenuti vengono trasferiti nel carcere per giovani adulti (fino ai 23 anni di età), nel carcere per adulti o nel 4 edificio che ospita detenuti sia giovani che adulti.

Uno dei cinque reparti del centro di Demerluis, ed esattamente il reparto I, è riservato a 12 detenuti tossicodipendenti che vi rimangono per le prime due o tre settimane della loro detenzione.

La scelta dei 12 detenuti si basa sul fatto che gli stessi considerano l'uso della droga un problema, che scelgano di alloggiare nel reparto I, che si attengano alle regole e che conoscano la lingua olandese.

Le regole sono che il reparto I è un reparto aperto (questo è un fatto unico), i detenuti trascorrono l'intera giornata fuori dalla loro cella ma devono alzarsi la mattina presto e lavorare. Esiste una squadra permanente di 12 guardie ed un capo guardia.

L'unità Cad è formata da 5 soggetti: un coordinatore, uno psicologo e 2 assistenti sociali che lavorano nel reparto I e un assistente sociale che si occupa di detenuti tossicodipendenti che non sono alloggiati nel reparto I.

Il programma giornaliero inizia alle 7 e tra le 8 e le 9 i detenuti puliscono le loro celle e il reparto.

RESUME

Depuis 1979, en Hollande, divers projets ont été élaborés parmi lesquels les services externes de thérapie antidrogue qui soignent les toxicomanes en prison.

Ces projets ont essentiellement comme objectifs:

1) créer un intermédiaire entre détenus et services externes (continuité des services);

2) fournir un traitement médical personnalisé aux consommateurs: la méthadone est administrée aussi bien à des fins d'abstinence que de maintien;

3) détourner les détenus d'une détention ultérieure vers les services externes.

Ce document parle en particulier d'un projet expérimental réalisé dans les instituts de détention d'Amsterdam et soulève certaines questions concernant les programmes futurs du département de la justice en Hollande.

La prison de Rotterdam est, par exemple, très ancienne et ses principes directeurs sont désormais consolidés. Par ailleurs, les services relatifs à la toxicodépendance sont bien structurés et il existe des contacts réguliers entre les divers organes du système de la justice criminelle et le centre consultatif local. Le tribunal ne suspend pas facilement la détention préventive.

Un nouveau complexe de six instituts de détention a été ouvert en 1979 à Amsterdam. Le personnel pénitentiaire et les gardiens ont été nommés ad hoc, le réseau des services antidrogue d'Amsterdam était très mal organisé et l'action du tribunal durant la phase précédant le jugement était pratiquement inexistante.

Projet expérimental d'Amsterdam

A l'intérieur du complexe pénitentiaire, on trouve les instituts de détention pour les hommes adultes. La capacité de ces instituts est de 120 cellules. Chaque bâtiment est divisé en 5 sections de deux étages comprenant 24 cellules. Un des instituts de détention, appelé Dermeluis est un centre d'accueil où arrivent les détenus en attente de jugement pour 14 à 21 jours. Après cette période, les détenus sont transférés dans la prison pour jeunes adultes (jusqu'à 23 ans), dans la prison pour adultes ou dans le quatrième édifice qui accueille jeunes et adultes.

Un des cinq départements du centre de Demerluis (la section I) est réservé à 12 détenus toxicodépendants qui y restent durant les deux ou trois premières semaines de leur détention.

Le choix des douze détenus est basé sur le fait qu'eux-mêmes considèrent l'usage de la drogue comme un problème, qu'ils choisissent d'aller au secteur I, qu'ils se soumettent aux règles et qu'ils connaissent la langue hollandaise.

Les règles sont que la section I est une section ouverte (cela est un cas unique), les détenus passent leurs journée hors de la cellule mais doivent se lever tôt et travailler. Il existe une équipe permanente de 12 gardiens et un gardien-chef.

L'unité Cad est composée de cinq personnes: un coordinateur, un psychologue, 2 assistants sociaux qui travaillent au secteur I et un autre qui s'occupe des toxicodépendants n'étant pas logés au secteur I.

Le programme quotidien commence à 7 heures et, entre 8 et 9 heures, les détenus nettoient leur cellule et la section.

SUMMARY

Since 1979 have several projects been instated in the Netherlands, in which external drugaddiction-services work within the houses of detention with drugabusing inmates.

The main goals of these projects is:

1) to intermediate between inmates and outside services (continuity of services);

2) to give individually oriented medical treatment to drug-users: methadone is administered on as well a withdrawel as a maintenance basis;

3) to divert inmates from further incarceration to outside services. This paper discusses in particular an experimental project in the houses of detention in Amsterdam.

And it raises some pertinent questions to the future policy development by the Departement of Justice in the Netherlands.

The jail in Rotterdam, for example, is very old and the regime well established. The addiction services, on the other hand, are well structured and regular contacts did already exist between the several components of the criminal justice system and the local consultation center. The court dose not easily suspend pre–trial detention.

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