

Summary

Effect evaluation of the Rehabilitation of Drug-Addicted Offenders Act (SOV)

The Rehabilitation of Drug-Addicted Offenders Act (SOV) was launched on April first 2001. This law permitted the compulsory placement of criminal addicts for up to two years in government-designated secure and semi-secure facilities. To meet several objections raised pertaining to proportionality and subsidiarity of the law, SOV was launched as an experiment which should be evaluated within six years. After this period the SOV would only be continued in case of a favourable outcome of the evaluation. In 2001, the Research and Documentation Centre of the Netherlands Ministry of Justice (WODC) commissioned the Trimbos Institute and the Amsterdam Institute for Addiction Research (AIAR) to evaluate the functioning of SOV. Trimbos carried out the process evaluation and AIAR the effectiveness study. This report presents the outcome of the effectiveness study.

Quasi compulsory (diversion) and compulsory treatment of criminal addicts

In the Netherlands quasi compulsory treatment is seen as an important way to reduce public nuisance. Specifically criminal nuisance caused by addicted offenders. In this approach the criminal addict is offered a choice between treatment and detention. This legal pressure is considered important because this group of criminal addicts is not believed to enter treatment on a purely voluntary basis. Marlow's behavioural model, however, shows that several other sources of pressure may act upon the criminal addict in addition to legal pressure. This raises questions about the voluntary character of voluntary treatment control groups in effect evaluations.

Since quasi compulsory treatment takes place at the boundary between criminal law institutions and addiction treatment, its aims are both a reduction of criminal offences and improvement of the mental, physical and social situation of the offender. The latter by changing or stabilizing his drug taking behaviour. To accomplish these goals it is required that the criminal addict enters treatment, participates in the treatment in such a way that the treatment goals may be accomplished and does not drop out of treatment prematurely. An evaluation of the Dutch quasi compulsory treatment programmes on these characteristics showed that only a small part of the target group actually entered treatment, the effect of legal pressure on treatment retention was marginal and an effect of quasi compulsory treatment on psychosocial problems, addictive behaviour and criminal offences was difficult to prove. The level of legal pressure in the quasi compulsory treatment setting in the Netherlands, however, is low compared to other countries. This was considered an important cause for these findings.

Until the SOV act was launched, compulsory placement in a treatment programme was only possible in case of danger, either to oneself or to others. Compulsory treatment or placement in a treatment programme was not allowed in the context of reducing criminal nuisance. Compulsion could be used in case of danger, quasi compulsion could be used in case of criminal nuisance. The SOV changed this situation. Although officially danger (to persons or goods) is still a requirement for compulsory placement in a treatment setting, the SOV act made it easier to apply compulsion in strictly criminal nuisance cases. This compulsory placement was seen as a probable solution to the low level of coverage and the limited effect on treatment retention of the quasi compulsory alternatives. It is important to realise, however, that SOV is not compulsory treatment but merely compulsory placement in a treatment setting.

Research design and research questions

The evaluation focuses on the main aims of SOV: 1) reduction of criminal recidivism, 2) reduction of addiction problems and 3) improvement of social functioning. The Dutch Minister of Justice stated the following effect criterion: Comparable outcome to intensive quasi compulsory treatment, significantly better outcomes than regular detention and a reduction in criminal recidivism of 15 to 20%. Based on this criterion the following research questions were formulated:

- 1 Among hard core criminal addicts, does SOV result in at least a comparable reduction in criminal recidivism compared to intensive quasi compulsory interventions and a larger reduction in criminal recidivism compared to regular detention?
- 2 Among hard core criminal addicts, does SOV result in at least a comparable reduction in addiction (related) problems compared to intensive quasi compulsory interventions and a larger reduction in addiction (related) problems compared to regular detention?
- 3 Does SOV, compared to intensive quasi compulsory interventions, result in at least comparable outcomes on social functioning?
- 4 Is SOV successful in terms of a composite criteria based on criminality, addiction and social functioning?
- 5 To what extent did respondents change during their stay in SOV?
- 6 What are the expectations, experiences and satisfaction of respondents with respect to SOV and the quasi compulsory treatments?
- 7 What intervention and respondent characteristics are related to a successful outcome within the SOV population?

To answer these questions we used a quasi experimental design with three comparison groups two quasi compulsory treatment groups and a third group of detained criminal addicts. The former 2 control groups

comprised 1) clients of the forensic addiction clinic (FVK), and 2) clients of Triple-Ex.

FVK clients are criminal addicts who are considered treatable but for whom, given their addiction, the severity of the offence, their personality structure and their treatment history, admittance in regular addiction treatment centre seems not a fruitful option. Triple-Ex (ex addict, ex criminal ex unemployed) is a quasi compulsory treatment setting and is part of the Parnassia psycho-medical centre in The Hague.

This chapter ends with the operationalization of success. First for each aim (criminality, addiction and social functioning) a success criterion was developed. Reduction in criminality was operationalized in two ways: 1) a decrease in the percentage of respondents committing crimes (criminality prevention) and 2) a reduction in the number of crimes committed (criminality reduction). With respect to addiction we restricted ourselves to use of illegal opiate and stimulant use and heavy alcohol use (defined as more than five glasses a day). Social functioning comprises three domains (housing, work and finances) combined to one criterion.

The partial criteria were combined into so called composite criteria. Because information on social functioning was not available for the regular detainees, composite success criteria for comparisons with this control group were only based on a combination of the success criteria for criminality and addiction.

Baseline characteristics of the experimental and control groups

All study groups (SOV, FVK en Triple-Ex) reached part of their target group: heavy criminal chronic hard drug users. The detained criminal addicts control group was comparable to SOV in terms of addictive behaviour and severity of addiction. The overall majority in all study groups were already addicted to opiates, stimulants or both for many years. Most respondents reported contacts earlier in their lives with addiction treatment. About three quarter of the SOV respondents did enter clinical treatment at some point in their life. It is not known whether they did actually complete this earlier treatment(s). We do know, however, that these treatments did not solve their criminal behaviour neither their addictive behaviour. All respondents had an impressive criminal history, spent a large part of their lives in prison and had a large number of earlier convictions. All study groups can also be considered problematic in terms of work experience and educational level. The latter was low and respondents had more experience with being unemployed than with having a job.

Despite the similarities the study groups did show substantial differences in primary substance of abuse (SOV and regular detainees more often opiates, FVK and Triple-Ex more often stimulants), treatment history (SOV respondents more often started treatment at some point in their

life), criminal history (SOV had more convictions and spent more months in detention, SOV and regular detainees reported more often property crimes, FVK and Triple-Ex more often violent crimes), work experiences (SOV and regular detainees less favourable), and mental health care history (lifetime, SOV respondents had comparable mental health problems but received less often mental health treatment).

The effect evaluation statistically controls for these initial differences by including the following covariates in the analyses: age, work status, primary substance of abuse, years hard drug use, former addiction treatment, number of months detained lifetime, former mental health treatment, and suicide thoughts at some point in their life.

Changes during their stay in SOV (research question 5)

Soon after the start of SOV, respondents reported a substantial improvement of perceived physical and mental health and self esteem. This improvement sustained when SOV ended. Reported changes in self efficacy and mastery were less pronounced and pertained mainly to the perceived ability to withstand environmental pressure to use substances.

The effectiveness of SOV (research questions 1 to 4)

In all comparisons both SOV respondents and respondents from quasi compulsory settings showed higher observed success rate than regular detained criminal addicts. Both in terms of observed (raw) success rates and in terms of (for initial differences) adjusted odds ratios. Based on adjusted odds ratio's SOV was somewhat effective in terms of criminality prevention compared to FVK and Triple-Ex, comparable in terms of criminality reduction to FVK and better than Triple-Ex, comparable to FVK and better than Triple-Ex in terms of addiction (when the entire follow-up period is taken into account, else comparable to both FVK and Triple-Ex), and comparable to FVK and better than Triple-Ex in terms of social functioning. See table s1 for the success rates.

Table s1 Observed success rates (% succes)

Criteria and domains	SOV	FVK	Triple-Ex	Reg. det.
Criminality prevention	23	18	24	7
Criminality reduction	43	33	31	9
Addiction (30 days)	49	42	48	a
Addiction (follow-up period)	45	32	30	10
Social functioning	43	41	30	a
Work	25	13	16	a
Finance	47	57	48	a
Housing	58	55	46	a

a No data available.

The answer to research question 1 (reduction of criminal recidivism) depends on whether one takes a criminality prevention or a criminality reduction perspective (see tables s2-s5). From a criminality prevention perspective SOV is somewhat less successful than both quasi compulsory treatments but substantially better than regular detention. From a criminality reduction perspective SOV did somewhat better than both quasi compulsory treatment groups and substantially better than regular detention. The answer to research question 2 depends on the time frame (30 days prior to the interview or the entire follow-up period). In the first case SOV had comparable outcomes to FVK and Triple-Ex but does substantially better than regular detention. In the latter case SOV did better than FVK and Triple-Ex and did substantially better than regular detention. In terms of social functioning (research question 3) SOV had comparable outcomes to FVK and better outcomes than Triple-Ex.

Table s2 Observed success rates (%), composite criteria stratified to study group (criminality prevention perspective)

Success in terms of	SOV (n=154)	FVK (n=87)	Triple-Ex (n=50)	Reg. det. (n=72)	p
Criminality and addiction	18	12	20	4	0.004
Criminality	23	18	24	7	0.002
Criminality or addiction	51	39	34	13	<0.001

Table s3 Observed success rates (%), composite criteria stratified to study group (criminality prevention perspective)

Success in terms of	SOV (n=154)	FVK (n=87)	Triple-Ex (n=50)	p ²
Criminality and addiction and social functioning	12	10	16	0.231
Criminality and addiction ^a	16	15	22	0.171
Criminality ^a	22	17	22	0.448
Addiction and social functioning ^a	28	23	26	0.981

a Deviations with previous tables caused by prerequisite that situation on social functioning is not deteriorated and the fact that the success criterion for addiction is different.

Table s4 Observed success rates (%), composite criteria stratified to study group (criminality reduction perspective)

Success in terms of	SOV (n=151)	FVK (n=80)	Triple-Ex (n=48)	Reg. det. (n=71)	p
Criminality and addiction	28	20	19	4	0.002
Criminality	43	33	31	9	<0.001
Criminality or addiction	58	43	38	11	<0.001

Table s5 Observed success rates (%), composite criteria stratified to study group (criminality reduction perspective)

Success in terms of	SOV (n=151)	FVK (n=80)	Triple-Ex (n=48)	p
Criminality and addiction and social functioning	21	18	17	0.861
Criminality and addiction ^a	28	26	27	0.762
Criminality ^a	40	30	30	0.918
Addiction and social functioning	28	24	21	0.779

a Deviations with previous tables caused by prerequisite that situation on social functioning is not deteriorated and the fact that the success criterion for addiction is different.

To take into account that SOV has goals in term of criminality, addiction and social functioning, outcomes on these three areas are combined into composite outcome measures, SOV as well as the two quasi compulsory treatment groups did substantially better than regular detention on these composite outcomes (both in terms of observed success rates and adjusted odds ratio's). Using the most strict composite criterion (success both in terms of criminality and addiction) absolute success rates were relatively low (between 12% and 28%), despite the fact that both SOV and quasi compulsory treatment did a much better job than regular detention. In relative terms the success rate of SOV was about 4.5 to 7 times higher than the success rate for regular detention. When comparing SOV with both quasi compulsory treatments SOV did somewhat better from a criminality reduction perspective and the quasi compulsory control groups did somewhat better from a criminality prevention perspective. The absolute success probability, however, seemed to decrease over time.

Predictors for success (research question 7)

To what extent is the probability of success related to 1) perceived coercion, 2) primary substance of abuse, 3) cognitive level and 4) time in treatment? The answer to this question may offer information for treatment matching.

In our study perceived legal coercion was neither related to actual legal coercion neither to success rate. The small (non significant) relation found suggests a decrease in success rates with an increase in

perceived legal pressure. Primary drug of abuse was also not statistically significant related to success rate. Respondents reporting stimulants or a combination of stimulants and opiates as their primary substance of abuse, had a somewhat higher (non significant) success rate compared to respondents with opiates as primary substance of abuse. Success rate was not related to level of cognitive capacities. We did find, however, a strong positive relation between treatment duration and success rate. That is, composite criteria success rate increased with an increase in treatment duration. To statistically adjust for this potentially confounding effect treatment duration was included as covariate in all analyses.

The respondent opinion (research question 6)

There was much consensus among SOV, FVK and Triple-Ex respondents about areas of life in which they were in need of help. Most help was needed for housing, work, finance, drug use, activities of daily living and socializing. Help was considered relatively less important by respondents for physical and mental health problems, social contacts and surprisingly, criminal behaviour. The proportion of respondents expecting the treatment facilities to be able to actually supply help on specific areas of life was lower than the proportion of respondents in need of help on these areas of life. Only a minority of the respondents reported during follow-up to have received 'considerably' or 'a lot of help' on specific areas of life. Areas of life which were most frequently mentioned as areas for which 'considerably' or 'a lot of' help was received were housing, drug use and physical health. There was no area of life, however, for which more than 50% of the respondents received 'considerably' or 'a lot of' help.' Compared to the quasi compulsory treatment facilities, SOV did specifically well in terms of housing. Less than one third of the SOV respondents received 'considerably' or 'a lot of' help with respect to criminal behaviour. FVK and SOV did better on this subject but even here, less than half received 'considerably' or 'a lot of' help for their criminal behaviour. In all three treatment groups less than one third received help for work and finance. Only a majority was satisfied with the help they received on specific areas of life and less than half of SOV and FVK respondents thought the help received adequate for their problems. Among Triple-Ex respondents this was slightly more than half (54%).

Conclusion

Based on the research findings, SOV has significantly better outcomes with respect to addictive behaviour and social functioning than regular detention and comparable outcomes to two intensive quasi compulsory treatment programs: the forensic addiction clinic and Triple-Ex. Consequently, our final conclusion is that SOV fulfils the required criteria. Success rates are however relatively low and decrease over time.

Given the limited amount of treatment places and its long duration, the impact of SOV on national crime figures, perceived criminal nuisance and the burden of criminal addicts on legal institutions will probably be limited. This also applies, however, to quasi compulsory interventions. Some qualifying remarks have to be made on the study design. Firstly, in the Netherlands both judges and public prosecutors will never agree to a random allocation of suspects to the different experimental conditions (jail, quasi compulsory treatment or compulsory placement in a treatment program). This ruled out the possibility of an experimental design with random allocation. Consequently we had to select the best alternative: a quasi experimental design with three control conditions: two quasi compulsory treatment groups and a regular detention group. The former (FVK and Triple-Ex) have criminal addicts as their target group. Compared to SOV, FVK aims at a slightly more problematic patient group in terms of psychiatric problems. Triple-Ex aims at a comparable group of criminal addicts as SOV. The latter control group consists of detained criminal addicts. Data of this group were about three years older than data of the other three groups. As a consequence, it cannot be ruled out that we are partly looking at a period or a cohort effect.

The quasi experimental design has consequences for the final conclusion. The most important being that causal statements like 'SOV caused more improvement than the control conditions' are formally not allowed. However, the internal validity of the findings can be considerably enhanced by statistically correcting for initial differences between study groups. Allowing for tentative 'effect' statements. This is what we did in this evaluation.

Only a minority of the respondents was satisfied with the help they received. With the exception of housing SOV did less well than both quasi compulsory control groups, specifically with respect to drug use. On average respondents rated SOV on a scale from 1 to 10, 4.7 (phase 1), 5.1 (phase 2) and 5.2 (phase 3), Triple-Ex 5.7 and FVK 6.5. People were more satisfied about received information, say and counselling than about the effect of the treatment. Less than half of the SOV and Triple-Ex respondents and slightly over one half (54%) of the respondents of FVK thought the treatment they received adequate for their problems.