

Summary

9.1 Introduction

Court-ordered treatment of drug-dependent offenders (SOV) is a Dutch criminal justice measure that permits the compulsory placement of offenders for up to two years in government-designated secure and semi-secure facilities. The Rehabilitation of Drug-Addicted Offenders (SOV) Act, which took effect on 1 April 2001, had two major aims (Memorie van Toelichting, 1997-1998):

- To reduce serious nuisance resulting from offences committed by drug users
- To resolve or bring under control the individual addiction problems and related problems faced by drug-dependent offenders, so as to enable their return to the community without falling into recidivism.

SOV was launched as an experiment in four different locations – in Amsterdam, Utrecht, Rotterdam and a Southern Region⁸³. The SOV facilities were designed to offer a programme focusing on education and training, employment, leisure time management, money management and independent living.

The primary goals are to deter criminal behaviour, reduce crime rates and improve the manageability of individual addiction problems. SOV is comprised of three stages. In the first, a secure residential stage, the emphasis is on coming off drugs and improving physical health. The second stage is semiopen, meaning that participants may leave the facility for activities such as training, employment, voluntary work or organised sports activities. The third stage takes place outside the facility and concentrates on reintegration. Participants are to have housing and either employment or other structured daily activities available. The participating local authorities are responsible for coordinating, funding and operating the third phase.

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. The process evaluation, reported here, had two aims:

- To describe SOV as intended and as achieved ⁸³The Southern Region involves the local authorities of Arnhem, Nijmegen, Den Bosch, Eindhoven, Maastricht and Heerlen.
- To clarify how and under what conditions SOV was implemented and carried out.

The research questions were as follow:

- Which local actors are engaged in setting up the SOV projects, and what contributions do they promise and deliver (such as expertise, services, funding, facilities or staff)?
- What activities do local actors perform at which points during the process of implementation, how well are these coordinated, how well are intermediate results communicated, and what factors and events both surrounding the projects and within the local implementation teams influence the performance of those activities and responsibilities?

- How does the admission of participants proceed, what activities do the various actors perform in this process, and are these consistent with prior agreements?
- How well are the SOV programmes functioning during the experimental phase?
- What activities do staff perform during the three stages of SOV, and are these subject to change? How do they feel about their daily work?
- In what sorts of group and individual activities do SOV participants take part in the different stages of SOV, and what do their individualised pathways entail? How do they feel about this individual plan? And what opinions do those who refuse to take part in the programme (who were separately detained in the so-called Unit 4) have about SOV?

The following research activities were undertaken to address these questions:

Implementation study

- Review of the written documentation relating to the local implementation and administration of the SOV facilities.
- Group interviews at two points in time (in 2002 and 2004) with local implementation teams in the participating local authorities and court districts. Basic material for the interviews was obtained from a previously administered written questionnaire on commitments, duties and responsibilities.
- Interview with the chair of each local implementation team on the progress in implementing and managing the SOV facilities.

Intervention study

Admission process

- Analysis of admission data from the SOV facilities and other bodies involved in the admission process, including the district public prosecution services and the probation and aftercare agencies for drug-dependent offenders.
- Analysis of criminal files in the district prosecution offices.
- Telephone interviews with police officials, public prosecutors, addiction probation officers, behavioural experts and judges about the admission procedure in general and about the specific course of events in a limited number of examined cases.

Programme

- Review of written documents and reports.
- Interviews with SOV directors on the programme's course of development.
- Working visits to SOV facilities at two points in time (2002/2003 and 2003/2004). During these visits, researchers attended group activities for SOV participants, interviewed project managers and held a group interview with SOV participants. Project managers completed a written questionnaire about the programme.
- Group interviews with probation case managers, focusing on their contributions and experiences and on any issues needing improvement.

Activities and work satisfaction of staff

- Questionnaire for staff members covering qualifications and experience, motivation and viewpoints with regard to the work, new work demands, needs for peer supervision and professional development, control over practice, perceived strengths and weaknesses, remuneration and future perspectives.
- Interviews with staff members about day-to-day work in the SOV facilities.

Health service utilisation and satisfaction among participants

- Questionnaire for SOV participants at four points in time: 1) immediately on admission, 2) after six months, 3) after twelve months, and 4) after eighteen months.
- Group interviews with SOV participants at two points in time (2002/2003 and 2003/2004) concerning their experiences with the programme.
- Analysis of client files to map the individual pathways of SOV participants.

Research activities were carried out in the period from 2001 until early 2004. Improvements made in the course of 2004 are not reported here. Information was collected from a variety of sources, including written reports, admission data, individual and group interviews with parties involved in the implementation and operation of SOV, individual and group interviews with SOV participants, staff and management in the SOV facilities, surveys of staff and SOV participants, and working visits to the SOV facilities.

This process evaluation allows no conclusions about the effectiveness of SOV for the individual drug-dependent participants. Those will be drawn from the results of the effectiveness study to be completed in 2006. The process evaluation does enable conclusions about the implementation and operation of SOV and the factors that influenced those processes.

9.2 Implementation of SOV

Organisational structure

In 1998, the Netherlands Minister of Justice appointed four project groups in Amsterdam, Rotterdam, Utrecht and the Southern Region. Their remit was to draw up preliminary memoranda at the local level working out plans to implement SOV. The Rehabilitation of Drug-Addicted Offenders Act was passed by Parliament in 2001. In the same year, the Justice Minister established the four-level organisational structure for the nationwide implementation of SOV. In the Southern Region, a separate four-level structure was created.

Factors affecting the implementation

Several national- and local-level factors that affected the implementation of SOV were identified in the study.

- Respondents reported a gap between national-level politics and local conditions. The frameworks provided for the implementation were deemed insufficient, as was the management of the process. The directors of the SOV facilities did not always feel supported by the head office of the National Agency of Correctional Institutions (DJI). The Southern Region's organisational structure was considered complex.

- At local levels, cooperation did not always proceed smoothly, for a number of reasons:
 - At the time the SOV facilities became operational, cooperative agreements were reportedly not always put into writing between the local parties involved in the implementation.
 - The chairs of the local implementation teams did not have the power to direct the activities of the various parties represented on their teams.
 - The Forensic Psychiatric Service (FPD), the agency that determines whether contraindications exist for imposing an SOV order, was not sufficiently involved in the planning and implementation of the SOV programme.
 - The commitment shown by the participating local authorities – Amsterdam and Rotterdam in particular – did not live up to expectations. Local authority representatives were not always present at meetings of the local implementation team; the covenant for coordinating, implementing and funding the third, non-residential stage of SOV took some time to get signed, especially in Amsterdam; and not all local authorities promptly designated a coordinator for the third stage, making it difficult to know who, or which department, within the local authority should be contacted in connection with that stage.

9.3 Admission process

An average of 66% of the SOV places in the facilities were occupied during the period from February 2002 to early 2004. The occupancy rate increased steadily during the study period. Just over two years after the inception of SOV, in November 2003, slightly more than 80% of the SOV places in the facilities were occupied. In the Southern Region, with an average occupancy rate of 45%, admissions were slowest to get underway. A range of factors influenced the flow of candidates to the SOV facilities.

Coordination and cooperation

- In most participating local authorities – Amsterdam, Utrecht, Arnhem, Nijmegen, Eindhoven and Den Bosch – an admissions protocol was drawn up containing specific cooperative agreements between parties (such as police, public prosecutors, and probation agencies for drug-dependent offenders).
- The district prosecution services, which were officially responsible for coordinating admissions, did not always take the lead. The Amsterdam prosecution office was an exception.

Lists of SOV candidates

- The numbers of potential SOV candidates were difficult to ascertain in Maastricht, Rotterdam, Arnhem and Nijmegen. The registration systems used by the local prosecuting and probation services made it awkward to obtain personal information on suspects in terms of their criminal records, their care and treatment histories, and whether they had previously been offered quasi-compulsory treatment (QCT).
- Compiling lists of SOV candidates was less difficult in Utrecht, Den Bosch, Eindhoven and Heerlen. These local authorities had lists available of drug-dependent offenders who had previously undergone quasi-compulsory treatment. In Amsterdam, a candidate list was produced rather swiftly after

special efforts were made by the public prosecution service.

Contacts with early intervention services and behavioural experts

- Cooperation with the Forensic Psychiatric Service (FPD) – the agency that determines whether contraindications exist to imposing an SOV order – was not equally smooth in all local authorities. The main reasons were its marginal involvement in the designing and implementing of SOV and the capacity problems of the service. Yet despite this low involvement and less-than-ideal cooperation, the majority of the criminal files that were studied did contain behavioural reports.
- Fewer than half of the criminal files studied contained early intervention reports. Early intervention reports, behavioural reports and social inquiry reports were most often absent from criminal files studied in Amsterdam and Rotterdam.

Public prosecution services

Public prosecutors ran up against three issues in seeking SOV orders:

- Many suspects who were eligible for SOV had one or more short prison sentences outstanding, which they were required to serve beforehand.
- Public prosecutors could seek an SOV order only if capacity was known to be available in the SOV facilities. Prosecutors in the Southern Region were not sufficiently informed about this, as the Utrecht SOV facility had no designated contact point for obtaining the information. In 2002, a staff member was specially appointed in Utrecht for this purpose. Public prosecutors were also unable to claim SOV places that were reserved for another local authority. According to the regulations, potential SOV candidates residing within the area of a participating local authority could be assigned only to SOV places reserved by that local authority in an SOV facility. This arrangement especially caused problems in the Southern Region.
- When a suspect had been detained, the public prosecutors were faced with the choice between initiating an SOV procedure or bringing accelerated criminal proceedings to quickly dispose of the case. The former was a longer process.

The judiciary

- In the Southern Region, not all potential candidates that met the legal criteria for SOV actually received an SOV order. According to our respondents, this could be attributed to three issues:
- Some judges, particularly in the Southern Region, were reportedly less inclined to impose SOV orders.
- For a long time, no location was available in the Southern Region for carrying out the second stage of SOV, so that judges were uncertain whether potential SOV candidates would be able to complete the programme.
- It was not always sufficiently clear to judges whether suspects had previously undergone quasi-compulsory treatment unsuccessfully or had ever been offered such a plan.

9.4 Profile of SOV participants

The 245 persons who received irrevocable SOV orders before 1 March 2004 were long-term drug users (averaging approximately ten years of regular heroin and cocaine use). Both the average age and the average duration of regular substance use were higher for the SOV respondents than for two comparison groups in (a) the nationally oriented Forensic Addiction Clinic (FVK) and (b) the locally oriented Triple-Ex programme in The Hague. These findings suggest that SOV respondents represented a more chronic group in terms of addiction than the two comparison groups.

SOV respondents reported an average of 31 convictions for criminal offences and an average of 67 months of imprisonment. In the year preceding the arrest that led to their SOV order, they reported frequent violations of the law:

- 92% had committed property offences (median 337)
- 32% had committed violent offences (median 3)
- 38% had committed drug offences (median 180).

They were also a problematic group in terms of housing. Only one third had stable living arrangements in the year preceding admission.

SOV respondents had little employment experience and little education, and their social networks largely consisted of other drug users. The vast majority had been receiving social assistance benefit in the three years prior to the SOV order or had resided mainly in controlled environments, usually prisons. In the month preceding admission, 80% reported 'illegal activities' as their largest source of income.

About two thirds of the SOV respondents reported at least one contact with addiction services in the year preceding the SOV order. For half of the group, the professional contact solely involved services such as methadone maintenance or night shelters; the other half had at least one treatment contact in the year preceding the order. Many such contacts occurred in a criminal justice setting (prison addiction support sections [VBAs], quasi-compulsory treatment or probation aftercare). The average duration of treatment in the year preceding the order for the subgroup with at least one treatment contact was just over two months.

In terms of physical and mental health, the SOV respondents scored considerably worse than the general population, but were similar to the respondents in the two comparison groups. Any differences between them and the FVK and Triple-Ex respondents were slightly in favour of the SOV group. Perceived quality of life amongst the SOV respondents in terms of physical health did not differ substantially from that of the general Dutch population, but quality of life in terms of mental health was considerably lower. Particular problems were reported with housing, police, employment, daily routine, leisure time and general well-being.

9.5 SOV programme

Major problems faced by the SOV facilities during the initial period (2002-2003) lay in the fact that the programme had not yet fully taken shape, as well as in the complex, multiple problems of the SOV participants, in staff changes, and in the differing views of staff members. By a later stage (2003-2004), professionalism had improved in the various SOV facilities, there was a more active exchange of information, more programme modules were available, and modules were occasionally developed in conjunction with the addiction services. Nonetheless, the SOV facilities were still

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struggling with their highly changeable programmes, the differing staff viewpoints, and the insufficient knowledge and experience of staff in dealing with the psychiatric and addiction problems of the SOV participants. Moreover, the individual approach had not yet sufficiently materialised, and there was not sufficient knowledge of which programme modules had already been shown effective for this client group. It was further reported that the third stage of SOV was not yet sufficiently operational, and that independent living and employment was a bridge too far for some SOV participants – factors which slowed progression to the third stage of SOV. Several ex-participants appeared to have persisting needs for supervised living and aftercare following the termination of their SOV order.

9.6 Staff

Almost all SOV staff reported they enjoyed beginning their working day and were intrigued by the work from day to day. The majority reported feeling very much at home within the organisation. However, a total of 11% of the questioned staff members appeared to be suffering burnout (in terms of a predefined combination of three dimensions: emotional exhaustion, depersonalisation and reduced sense of personal accomplishment). Average scores of SOV staff on the three dimensions were relatively better than those of staff working in health care services, with SOV staff experiencing lower levels of emotional exhaustion and higher personal accomplishment. SOV staff had similar burnout levels to those working in homeless services, but they had poorer levels than workers in Utrecht's three drug consumption facilities, with higher emotional exhaustion and lower personal accomplishment. To become better equipped for their work in the SOV facilities, almost half of the SOV staff reported they needed additional professional development training in the following areas:

- Dealing with psychiatric and addiction problems
- Rehabilitation and reintegration methodologies
- Provision of first aid
- Provision of help in crisis situations.

9.7 Operational requirements

Client monitoring system

The electronic client monitoring system to keep track of SOV participants' progress was not introduced until 2004 (in Amsterdam and Rotterdam). In the absence of this

system, the staff largely employed paper files, not all of which were accessible to the programme managers. This made it difficult to oversee the participants' progress in the SOV.

Probation case managers

Particularly in the Southern Region and in Rotterdam, it took a long time before enough probation case managers – engaged to ensure continuity in the participants' individual pathways throughout the three stages – had been appointed. Consequently, not all SOV participants had been assigned probation case managers. The job description of the probation case managers also did not provide adequate orientation; an improved job description was finalised in 2003. Neither participants nor staff were clear as to what could exactly be expected from the probation case managers at the different stages of the programme. Cooperation between them and their colleagues in the SOV facility and the addiction service did not go smoothly.

Supervision and support plan

Drawing up the initial plan took longer than the legal requirement of one month. Staff in the SOV facilities therefore decided to use a simpler template that could be signed more quickly.

Exit criteria

Exit criteria are standards relating to key life areas (such as work, housing, addiction, money management and social networks) which SOV participants must fulfil in order to successfully complete their stay in the SOV programme. For a long time, no exit criteria had been formulated. The Probation and Aftercare Foundation for Drug-Dependent Offenders (SVG) and the National Agency of Correctional Institutions (DJI) made a first move in that direction in 2001. Exit criteria were adopted on 23 April 2002 by the National Steering Group, but the concrete details still had to be worked out in relation to programme modules. Staff of the SOV facilities believed these exit criteria were unattainable for some SOV participants.

Policy on medication

The basic premise of SOV was a drugs-free existence. Gradual withdrawal of methadone maintenance was an objective of SOV. During the course of the programme, it proved necessary to re-examine the policy on medication in SOV. In October 2003, the policy was updated on this point by the Ministry of Justice.

Policy on sanctions

Unit 4, the section designated for 'refusers', who decline to take part in the SOV programme, was also used at some locations (Rotterdam and Utrecht) as a punitive measure or a time-out place for SOV participants.

9.8 SOV programme content

Needs and expectations at admission

SOV participants had high expectations when they first entered the SOV facilities.

The placement was more or less in line with their own wishes. The majority thought the SOV programme would help them tackle their drug problem. Their paramount needs lay in housing, drug addiction, money management and employment, and at admission they expected they would receive help in all of these life areas.

Content of the first and second stages

The content of the first stage of the programme, lasting six to nine months, was aimed at improving physical health, teaching participants to control their drug addiction, and providing education and training. Participants had to wait until the second stage (extending from about the ninth to the eighteenth month after admission) to work on the areas of life that they attached the most importance to – work, finances and housing. SOV staff devoted the greatest relative amount of time to helping clients with their drug addiction. Only sporadic help was forthcoming in matters like finding accommodation or sorting out finances. In addition, a lot of time was spent on tasks like keeping order (enforcing the rules in the facility) and on informing participants. Intensive effort was put into creating a positive atmosphere in the SOV facility and ensuring proper registration and file-keeping.

Satisfaction with programme content and perception of improvements

Participants expressed only limited satisfaction with the SOV programme content. Although their general level of satisfaction increased significantly in the course of their stay, participants were still not really satisfied after eighteen months at the facility. Disappointment was indeed great amongst the participants because they had received the least amounts of help in the very areas of life where they had expected it the most (housing and finances). Nor did they generally perceive any real improvement in their own functioning during their stay. The most satisfaction was expressed about the help they received in learning to control their drug dependency, an area in which they perceived a reasonable degree of improvement in their own functioning. After eighteen months of participation, they felt substantially less need for help with their addiction. Participants expressed only limited satisfaction about the help provided in areas they considered the most important themselves (housing, finances and employment), although both their satisfaction and their perceived improvement in their own functioning significantly increased during the course of their stay in the facility. Nevertheless, they still reported strong needs for help in these three life areas eighteen months after their admission to the facility.

Unit 4

Refusers who were assigned to Unit 4, the section devoted to people with SOV orders who were unwilling to take part in the programme, felt their sentencing to SOV was unjustified. They had few positive expectations of SOV and would have preferred to leave it. They perceived no substantial improvement in their situation during their stay, although they did believe their physical and mental health had slightly improved.

9.9 Conclusion

The implementation of court-ordered treatment of drug-dependent offenders (SOV) in the Netherlands could have gone more effectively. The essential problem was the lack of adequate network coordination, given that the experiment had no central coordinating authority at the national level. The process was characterised by a profusion of actors at both national and local levels, engaged in various circuits and frameworks. At the same time, within the many organisations involved, responsibilities and tasks relating to implementation had often been parcelled out over different departments. Coordinating and adaptive mechanisms were diffuse and relatively powerless, and cooperation between the various actors was not ideal.

In the past few years, much effort has been put into implementing SOV. Despite this, a gap still exists between SOV as intended and SOV as achieved – a view that is shared by various parties and stakeholders, including the SOV participants.

The problems highlighted in this study derive from the design of the SOV, the implementation of this legal measure and the development of the programme.