STREET SUPPORT PROJECT

The Netherlands

national report

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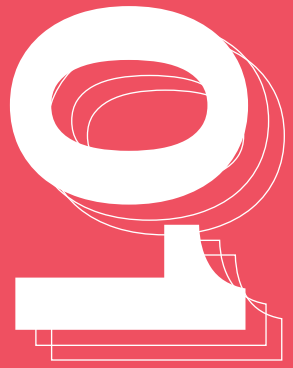


national situation

with regard to homelessness, drug use & public nuisances

1.1. Description of epidemiology

HOMELESSNESS

In the Netherlands, the number of people in homeless situation has increased by 74% in recent years. In 2009, 17.800 people were counted as homeless, and this number raised up to 31.000 in 2015. In 2016, this amount remained somehow stable in 30.500[1] This includes people sleeping rough (EETHOS 1.1), people staying in homeless shelters (EETHOS 1.2), people staying in short-term accommodation (EETHOS 3) and people staying with friends, acquaintances or relatives on an irregular basis (EETHOS 8.1)[2]

1. CBS (2016) Daklozen.

2. FEANTSA (2005) - ETHOS. European Typology of Homelessness and housing

However, when comparing this information with the data gathered by the Federatie Opvang, a discrepancy is observed. According to their monitoring system, 60.120 people were reported having been assisted by the homeless shelters in 2016.[3] This difference of information responds to the diverse definitions that both monitoring systems use. Whereas CBS counts people experiencing homelessness who are registered as such with a local authority, Federatie Opvang, census all people who have requested and received assistance from a shelter organization. Besides this, CBS also registers those persons registered as homeless by the National Alcohol and Drugs Information System (LADIS).

3. Federatie Opvang (2016). Cijfers maatschappelijke

In 2015, 82% of homeless were identified as male and 18% as female. From those, 49% were registered as Dutch nationals, and 51% as foreign born. In general lines, since 2010, the composition of the population experiencing homelessness has remained relatively stable, with the only significant increase in the proportion of foreign born nationals of non-western origins, doubling numbers up to 13.000. Further, regarding the age of this population, CBS' monitor shows that the majority of this population belongs to the category of 30 to 50. And just over 40% of this population was concentrated in the major cities of the country, namely Amsterdam, Rotterdam, Utrecht and Den Haag (known as the G4)[4]

4. CBS (2016) Daklozen.

The factors contributing to this increasing trend are diverse. The majority of people interviewed in the research carried by Coline van Everdingen, 38% reported rental arrears and debts as the immediate cause to homelessness. Beside this main reason, among

others, 20% became homeless after a relationship break, 10% after detention and 13% were expelled from home because they cause too many inconvenience to others.[5]

Further, cuts in the amount of social housing in, together with debt, have created an specific target group for which a new terminology has been coined: the 'new homeless'. According to studies carried by Trimbos Institute, 71% municipal centres signaled in 2013 an increment of requests for help from this target group.[6]

5. Van Everdingen, C. (2015) Verwarde mensen op straat.

6. Tuynman, M. (2015). Dakloze personen zonder OGGz- problematiek en hun ondersteuning.

Poverty and Social Exclusion

In the Netherlands, the factors which are considered when measuring social exclusion cover both immaterial and material living conditions. In the first category, employment, income and material deprivation are considered the most essential. When it comes to social aspects, we find access to basic rights and compliance to the norms as guidelines.

Consequently, social inclusion in this context means citizens having a place in both the socio-cultural and the economic/structural domain. Social exclusion occurs when a person suffers long-term disadvantage in both domains, and where there is no prospect of an improvement in the future[7].

In the last years, parallel to other European countries, the Netherlands has witnessed an increment in the unemployment rate. Whereas, 3,7% of the active population experience a lack of job in 2008, after the crisis, the rate duplicated to 7,4% in 2014. In the last years, even though this amount has been significantly reduced, it still remains higher than in 2008. In 2017, 4,9% of the active population was reported as not having a job.[8]

Compared to the general population, unemployment affects people over the age of 55 more acutely, as well as people with a lower level of education. Once people aged over 55 become unemployed, their chances of finding another job are slim and many of them face long-term unemployment. To a lesser degree, this also applies to those aged between 45 and 55. Although young people are unemployed relatively often, it mostly lasts only for a short period.[9]

Individuals with a non-western background have as well less access to work than people with a Dutch or an EU background. Between 2009 and 2016, the labor market participation of people with a background in all four largest non-western origin groups have declined more than those of persons with a Dutch background. People with a non-western background were almost three times more likely to be unemployed in 2015 than people with a Dutch background, and one and a half times as often as people with a background from the new EU. As a result, the economic conditions of recent years have had more consequences for them[10].

The risk of poverty or social exclusion in the Netherlands is relatively low when compared to the other EU member states. In terms of the three EU indicators used to measure the risk of poverty and social exclusion (EU2020 Poverty Target), 10.4% of the Dutch population finds itself at risk of poverty, 2.5% experience material deprivation and 9.3% of the population constitute a jobless household[11].

Next to this indicators, in an study conducted by Hoff, S. and Vrooman, C. in 2010, it was reported that 7.0% of the population was fairly excluded in social participation, and 7.8% very excluded. Beside this, 8.4% was fairly excluded regarding normative integratio, and 1.8% very excluded. Besides this information, it was also evidence that 5.8% of the Dutch population was fairly excluded in access to basic social rights (1.0)[12]

7. Jehoel-Gijsbersm J. & Vrooman, C. (2007). Explaining social exclusion. A theoretical model tested in the Netherlands.

8. CBS (2018). Arbeidsdeelname en werkloosheid per maand.

9. e Graaf-Zijl, M., van der Horst, A. and van Vuuren D. (2015). Long-term unemployment in the

10. CBS (2016). Jaarrapport Integratie 2016.

11. O (2015). Strategic Social Reporting Questionnaire. Netherlands.

12. Hoff, S. & Vooman, C. (2011). Dimensies van sociale uitsluiting.

Alcohol and Drugs Consumption

Among the general population in the Netherlands, cannabis is the most common illicit substance, followed at a distance by MDMA and cocaine. The use of all illicit drugs is concentrated among young adults aged 15-34 years. Besides this, the gender gap regarding cannabis use remains wide: last year prevalence of cannabis use among young adults was approximately 1.5 times higher among males than among females, while last-year cocaine use is reported to have been three times higher among young males than among females. In 2015, levels of last month cannabis use and last year and last month MDMA use among the general population aged 15-64 years were higher than in 2014.[13]

13. Van Laar, M.W. et al (2017). Nationale Drugs Monitor 2017. Utrecht:

When it comes to high-risk drugs, in the Netherlands this pattern is mainly linked to use of heroin or crack cocaine. The most recent estimate of the high-risk opioid use population suggested that there were approximately 14.000 high-risk opioid users in 2012. The available data indicate a decline in the estimated number of opioid users in the last decade, which coincides with the ageing of this population and the low popularity of opioids among younger PWUD.[14]

14. Van Laar, M.W. et al (2017). Nationale Drugs

Many high-risk PWUD, including opioid users, use crack cocaine and a range of other licit and illicit substances. Although an estimate of crack cocaine users in the Netherlands is not yet available, sub-national studies provide a prevalence rate of 0.51% (95% CI: 0.46%-0.60%) in the Dutch population aged 15-64 years[15].

15. Oteo A (2016) Urban crack users in The Netherlands: Prevalence, characteristics, criminality and potential for new treatments

Another source of information for the study of drug consumption is provided by LADIS. From its monitoring system it is reported that the number of new treatments entrants has remained stable in recent years, following an increase during the period 2006-11.

In 2015 the largest group of first time treatment entrants comprised those who required treatment for cannabis use. Cocaine (crack) is the second most commonly reported primary substance among first-time clients, although the trend indicates a decline in the past decade.

The number of primary heroin users requiring treatment for the first time declined between 2007 and 2013, while an upward trend has been noted since 2013. Overall, heroin users entering treatment are older than other treatment clients. Injected drug use is rare among those entering treatment[16].

16. Wisselink, D.J. et al (2015). LADIS. Key figures

Regarding problematic patterns of alcohol consumption, the number of clients in addiction care with a primary alcohol problem between 2006 and 2015 fluctuated around 32,000 clients. Alcohol addicts still are the largest group within the addiction care services. In 2015, 46% of all requests for help with the addiction care services were alcohol-related. The proportion of people over 55 increased from 20% in 2006 to 28% in 2015. In 2014, (most recent figures), approximately 22,000 people were admitted into general hospitals with alcohol dependence as primary or secondary diagnosis.[17]

17. Van Laar, M.W. et al (2017). Nationale Drugs

Prevalence of infectious diseases

As of May 2017, 26.509 HIV-positive individuals had ever been registered by Stichting HIV Monitoring (SHM). Of those, 25.355 were followed in one of the HIV treatment centres in the Netherlands. The remaining 1.504 were followed in the St. Elisabeth Hospital in Willemstad, Curacao. Of the 25.355 patients, the majority was infected with HIV-1, accounting for a 99%. A small group of patients, 97 in total, were infected with HIV-2, while 60 patients had antibodies against for HIV-1 and HIV-2.

24.413 individual were ever diagnosed with HIV-1 as adults. The age at which individuals are diagnosed with HIV has been slowly increasing over time. In 1996, the median age at the

time of diagnosis was 35 years; in 2016, it was 38 years. Over the entire period from 1996 through 2016, 16% of adults who received a diagnosis of HIV were 50 years or older; in 2016, 27% were 50 years or older.

For a 3%, the reported mode of transmission was related to injected drug use. From the 1900s until 2008, the annual number of new diagnosis has steadily declined. This decline is largely the result of a reduced number of diagnoses in migrant populations. Further, injecting drug use in now rarely reported as the most probable mode of transmission[18], which reflects both the decreasing popularity of injecting drugs and the implementation of harm reduction measures aimed at reducing the risk behaviour of injected drug use.[19] [20]

Infections with hepatitis C virus (HCV) and hepatitis B virus (HBV) are generally uncommon in the Netherlands. It is estimated that 0.1 to 0.4 percent of the total Dutch population has evidence of ever been exposed to HCV, and that the same percentage has ever been exposed to HBV. From the total number of individuals screened for HCV, 82% were male, and for a 30% the virus transmission was related a current or former injecting pattern of drug use

In the Netherlands, 12% of the HIV-1 positive adults in care who were screened for HCV co-infection had a positive result[21], which confirms the far greater prevalence of HCV in the HIV-positive population when compared to the general population.

In 2014, the total number of acute hepatitis C notifications decreased by 20% when compared with data from 2013. Unprotected sexual contact between men remains the most important route for transmission.[22]

From 2008 until 2015, the number individuals newly-diagnosed with Tuberculosis has steadily decreased. However, in 2015 the register of notifications has increased to 900, from 858 in 2014.[23]

18. Van Sighem, A. et al (2017). HIV Monitoring Report

19. De Vos. A et al (2013). Decline in incidence of HIV and hepatitis C virus infection among injecting drug users in Amsterdam; evidence for harm reduction?

20. Van den Berg, C. et al (2007). Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: evidence from the Amsterdam Cohort Studies among drug users.

21. Van Sighem, A. et al (2017). HIV Monitoring Report 2017. Stichting HIV Monitor-

22. Van Oeffelen (2015). Sexually transmitted infections, including HIV, in the Netherlands in 2014. RIVM

23. Bijkerk, P. et al (2016). State of Infectious Diseases in the Netherlands, 2015. RIVM.

Public Nuisance & Criminality

The Dutch term 'overlast' refers to objective - verifiable and observable - nuisance, as well as to nuisance that is subjectively perceived. Although a widely used definition of the term is available, the concept, its measurement and monitoring pose considerable challenges.[24]

As a general trend, in 2016, the proportion of residents who experienced a lot of nuisance in their neighborhood was higher than the national average in the regional units of Amsterdam, The Hague, Rotterdam and Limburg.

In the studies conducted by the Security Monitor of CBS, 1,500 suspects were classified in 2014 as ‚alcohol users'. The reported cases responded to a population classified as men, with an average age of 45, and often with several criminal antecedents. In those cases, 56% was suspected of property crimes, 30% of violence against other people (other than theft with violence or extortion), and 26% of vandalism or offenses against public order.

In 2014, the group of suspects with the classification ‚PWUD' consisted of more than 5,000 people, and were also mostly men. In this group, most people had ten or more criminal antecedents, and the average age was 43 years old.

The majority of drug-using suspects, 63%, was charged in 2014 for property crimes, including theft by force and extortion. Furthermore, 25% of the suspected PWUD are guilty of ‚other violence', 19% of vandalism or public order offenses and 15% of violations of the Opium Act.

24. Garretsen et al (1996). A research perspective on drug related nuisance: Dutch experiences.

When comparing the criminal patterns between these two groups, differences are observed. Whereas the number of alcohol users suspected of criminal activity have remained somewhat stable in the last years, the drug-using suspect population has declined between 2005 and 2014.[25]

25. CBS (2017). Veiligheidsmonitor 2016.

Between 2005 and 2014, the share of PWUD that was suspected of an Opium Act crime decreased, and every year, the Justice refers more than 20,000 people to drug dependence treatment (Verslavings Reclassering).

In 2015, the intake of Opium Act offences with the Public Prosecution Service (OM) decreased. Soft drug and hard drug cases dropped equally, but the number of soft and hard drug cases combined is increasing.

The proportion of Opium Act cases with the Public Prosecution Service and the courts is more or less the same as in 2014. The proportion of soft drug offences still exceeds that of hard drug offences. Most hard drug offences involve the possession of a hard drug. This is different from soft drug offences, which usually involve cannabis cultivation.

In 2015, 18% of all inmates were imprisoned on account of Opium Act offences. Community service orders and (partly) unconditional prison sentences are the most common sanctions with Opium Act cases, followed by financial penalties imposed by the Public Prosecution Service. In 2015, the proportion of (partly) unconditional prison sentences and financial penalties imposed by the Public Prosecution Service was relatively low. Community service orders are mostly imposed in soft drug cases, unconditional Prison sentences are mostly imposed in hard drug related offenses.

1.2. Description of national policy approach

Drug Policy

The Dutch drug policy, since its development starting in 1976, aims to balance the maintenance of public health, public order, and compliance with international law. Based on evidence and pragmatism, while legalisation of drugs is not pursued, attaining a completely drug-free society is not seen as a realistic or feasible goal.

Information, prevention, treatment and harm reduction are the four pillars of the Dutch health oriented policy. PWUD are not seen or treated as criminals, but as patients who need care. The Dutch national policy fosters participation of PWUD in treatment to prevent the individual and/ or social situation from worsening. Whenever abstinence based interventions are not feasible, support is given to reduce the harmful consequences of use.

The responsibility for drugs policy is shared by various ministries. The Ministry of Health, Welfare and Sport (VWS) coordinates the drug policy and works together with the Ministry of Security and Justice and Foreign Affairs. Specifically, the Ministry of VWS bears the main system responsibility for drug policy in the field of public health, drug dependence prevention, and care. This includes the Opium Act.

Table 1 : Official Definitions of Drug Policy goals in the Netherlands[26]

Year	Definition	Source
1976	Prevention and reduction of societal and individual risks case by the use of drugs	Tweede Kamer 1975, p. 5
1985	The drug policy has three aims: protection of (public) health, public order, and the health and welfare of PWUD	ISAD 143-693, 16 december 1985, p. 12
1995	Prevention and containment of the societal and individual risks that result from the use of drugs	Tweede Kamer 1995, p. 4
2007	The primary aims of the Dutch drug policy are: protection of (public) health, counteraction of nuisance and the control of (drug-related) crime	Tweede Kamer, 2007, p. 391
2011	The Dutch drug policy has two pillars: one for the protection of public health on the one hand and the control of nuisance and crime on the other.	Tweede Kamer 2011a, p. 1

26. Adapted from, Van Der Stel, J. et al (2009)Ontwikkeling van het Nederlandse drugsbeleid.

In the Netherlands, The Opium Act which came into force in 1928 and was fundamentally amended to separate the markets of hard and soft drugs in 1976, is the basis for the current drug legislation. Drug policy is based on the central notion that the 'drug problem' is primarily a public health and welfare issue and that risk reduction is its core concept.[27] The Opium Act, as a result, did not define use of drug as an offense. Instead, it defined drug trafficking, cultivation and production, dealing, and possession of drugs as criminal acts.

27. Leuw, E. (1991) Drugs and Drug Policy in the Netherlands

A two-schedule distinction was made in the Opium Act in 1976 on the basis of drugs' risks to the user's health. Drugs in list I (e.g. heroin, cocaine, MDMA/Ecstasy, amphetamines) were considered to offer higher risks to consumers and where classified as 'hard drugs', while drugs on List II (e.g. cannabis, hallucinogenic mushrooms) were considered to offer lower risks and were classified as 'soft drugs'. The regulated sale of soft drugs was allowed in designated places (such as the coffeeshops for cannabis).

Despite its health and social approach to the 'drug problem' approach, the Dutch drug policy discourse in the last years has shifted to an increasing focus on law enforcement. Successive governments have emphasized public order, safety and law enforcement, shifting the policy focus towards containing public nuisance and crime.[28 29]

28. Grund, J.P. C. & Breeksema, J.J. (2017). Drug

29. Van Ooyen, M. & Kleemans, E.R. (2015). Drug Policy: The "Dutch Model"

Alcohol Policy

In the Netherlands, the Drinking and Catering Act (Drank en Horecawet, DHW) is one of the most important legal frameworks for alcohol policy. The DHW is responsibility of the Ministry of Health, Welfare and Sport and is therefore primarily a public health law. The DHW aims to prevent the harmful effects of alcohol abuse and to reduce alcohol-related nuisance[30].

30. De Greeff, J. et al (2014). Gemeentelijke uitvoering van de Drank- en Horecawet: analyse stand van zaken 2014.

A number of important local tasks have been recorded in the DHW:

- Licensing to regulate who can sell alcoholic beverages and where;
- Supervision of compliance with the DHW. An important part of the supervision is the inspection on compliance with the age limit of 18 years for the sale of alcohol;
- Writing and reviewing an alcohol prevention and enforcement plan every four years, with a focus on the prevention of alcohol use among young people.

The Social Support Act 2015 (Wmo 2015) and the Youth Act also set out tasks that have an interface with alcohol policy: preventing problems, timely identification of problems and early use of care and help to prevent more severe forms of social support or youth assistance. Other legal frameworks relevant to alcohol sales and use are the Dutch Penal Code, the Media Act 2008 and the 1994 Road Traffic Act with provisions on public drunkenness, alcohol advertising and drink-driving. In addition, there are parliamentary letters and national prevention programs that can give direction to the implementation of local policy.

The Netherlands has various laws relating to preventive local policy as well. Municipalities are responsible under the Public Health Act (Wet publieke gezondheid, Wpg) for, among others, local health policy, youth health care, and health promotion. This legislation legitimizes preventive local alcohol policy.[31]

31. TK (2014) Kamerbrief over betrouwbare publieke gezondheid: Gezamenlijke verantwoordelijkheid van gemeenten en Rijk.

In parallel to other measures aiming to reduce nuisances in the public space, most municipalities in the the Netherlands have designated areas in the cities in which it is forbidden to consume, or to carry alcohol. Public intoxication it is also prohibited in these areas. These regulations are stipulated in the General Local Regulations (Algemene Plaatselijke Verordening) of each Municipality. Non compliance with this alcohol prohibitions result in fines between 95€ and 380€[32].

32. More information regarding the types and amount of fines can be found in the following database of the Public Prosecution Service: https://www.om.nl/onderwerpen/boetebase/

Social Support Policy

On September 17, 2013 the King of the Netherlands Willem-Alexander delivered his first speech during the State Opening of Parliament. On his speech, he listed as threatened the affordability of public services due to demographic aging, globalization, and the financial and economic crisis started in 2007. At the same time, further on, he emphasized how, in today's information society, people value their independence and the ability to make their own choices more than in the past. As a result of these conditions, he declared that the classical welfare state was slowly but surely moving into a participation society.[33]

33. Royal House of the Netherlands (2013) Speech by His Majesty King Willem-Alexander on the occasion of his investiture

In the last decade, the Netherlands has experienced a deep transformational process to actualize the participatory society model. This process has been rather unique, as this reform have not only triggered a revision process aimed at improving the quality and efficiency of the support systems available, but also involved a strong normative discussion about social and individual responsibility and, therefore, about the relationship between the state and the individual.

Participation, within this context, is understood as the right of citizens to develop their talents, and the duty to use those talents in the service of society. Nowadays, every person involved in the Dutch society has a responsibility and must take an active attitude in order to respond to it. Consequently, active citizenship has become in the last years almost synonymous with decreasing citizen dependence on social services and other welfare arrangements. As a result, citizens in the Netherlands are expected to take responsibility for their employability, health and finances as well as for the social cohesion, safety and 'liveability' of their communities.

In practical terms, this shift in paradigm has triggered a de-centralizing process through which many of the central government responsibilities have been transferred to the regional and local governments. Furthermore, through this legislative process, the self-reliance of the citizens has been rendered crucial. As a consequence, legislation in the last years aimed at organizing the services closer to the citizen, emphasizing informal care, neighbourhood support, and has sought fostering an integrated approach capable to respond to the multidimensional nature of the request for help that the municipalities had to respond to.

Work & Income Support

The 'Participation Act' (Participatie Wet, PW) aims to bring citizens with some form of labour limitation back to work. The act, which was implemented starting from the 1st of January, 2015, replaces the former Work and Social Assistance Act (Wet Werk en Bijstand, WWB), Social Employment Act (Wet Sociale Werkvoorziening, WSW) and parts of the Work and Support for Young people with Disabilities Act (Wet Werk en Arbeidsondersteuning Jonggehandicapten, Wajong).

Under this law, municipalities were rendered responsible for the support to those citizens facing limitations, and for its integration into the labour market. Consequently, municipalities became responsible for providing and organising counselling, support, additional training, supported employment , reintegration trajectories and employment subsidies.

The rationale behind this new legislation is that at local level, more tailored support can be given, arguing that the coordination between the different stakeholders involved in different types of support can be organised more effectively and efficiently. However, besides this official rationalization, it also needs to be mentioned that through this change of legislation a significant cut in public expenditure in social support occurred in parallel, responding to a broader cost-efficiency transformation in the social and health support sector.

Health & Wellbeing Support

In the last decade, a major reform of the Dutch long-term care system has taken place, starting in 2007 with the introduction of the Social Support Act (Wet Maatschappelijke Ondersteuning, Wmo 2007). In practical terms, this reform became the starting point of a decentralizing process of responsibilities within the health support field. This market-oriented reform was directed at fostering efficiency, enhancing citizens' freedom of choice and reinforcing solidarity among citizens, while simultaneously upholding public values such as accessibility of care, quality of care and financial sustainability of the healthcare sector in general.[35]

35. Maarse (2016) Results of the market-oriented reform in the Netherlands: a review.

In contrast to the previous legislation, the Wmo is not constituted as an insurance scheme, but rather as a tax-based scheme. Thus, entitlements under the Wmo are largely influenced by the available funds. Moreover, the execution of this legislation fell on the municipalities, now endowed with a relatively substantial policy discretion regarding the way they execute their responsibilities under the Wmo. As a result of this process, an increased focus was given to informal care provision and the social participation of vulnerable citizens.

Up until 2015, the Dutch long-term care system basically consisted of two pillars. The first pillar included services within the scope of the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ), falling under the responsibility of the national government. AWBZ services included all types of long-term care for people with severe limitations, including personal home care, personal counseling, and residential care.

The second pillar of the Dutch long-term care system consisted of services within the scope of the Wmo 2007, and under the responsibility of the municipalities. Wmo services included the other aspects of social care. In 2015, a renewed version of the Wmo 2007 (Wmo 2005) entered into force. Under the new reform, part of the services that used to be within the scope of the AWBZ were transferred to the Wmo, and therefore fall under the responsibility of the municipalities. These services include those that are directed towards the social participation of people with severe limitations, notably personal counseling services. Next to the long-term care decentralization, municipalities are also responsible in the field of youth care and in the field of labor participation of people with an occupational disability, as it was mentioned before.[36]

36. CPB (2013) Decentralisaties in het sociaal domein

Another part of the ABWZ services was transferred to the Health Insurance Act (Zorgverzekeringswet, Zvw), falling under the responsibility of the health insurers. The Zvw, approved in 2006, makes it mandatory for anyone over the age of 18 who resides or pays payroll tax in the Netherlands to take out a health insurance. All insured persons pay a nominal premium directly to their care insurers and an income-related contribution, which the employer (or state benefits implementing body) deducts from the employee's wages (or state benefit). The insurer has the right to decide the amount of the nominal premium, based on a minimal nationally amount designated.

In case a nominal premium is deemed excessive in relation to the income of the citizen, a possibility for an allowance is articulated through the Health Care Allowance Act (Wet op de zorgtoeslag, WZT). That been the case, the Dutch Tax and Customs Administration pays out the allowances.[37]

37. RO (2001) Health Insurance in the Netherlands.

Finally, concluding this decentralizing process, in 2015 the remaining AWBZ services were transformed into a new act, the Long-term Care Act (Wet langdurige zorg Wlz). However, when compared to the previous legislation, the new Wlz Act only arranges residential care for the most severe cases, thereby abolishing residential care for people with lower care-severity packages.

Public Order & Law Offences

In the Netherlands, guidelines on public nuisance due to alcohol and drug consumption have both a national and a local dimension. Although there is no document that explicitly typifies homelessness as such, in practice, effects of this situation, such as sleeping outside, begging or grouping in public space, are targeted as offenses by the local APS and Gemeentewet. This regulations stipulates that an administrative fine may be imposed for violations of the regulations from municipal ordinances that can lead to nuisance in the public space[38].

38. As a reference, in the following Municipal Ordinance of Amsterdam you can access a list of violations, the administrative fine applied: https://zoek.officielebekendmakingen.nl/gmb-2018-276207.html

The main supervisors of the compliance to these regulations, and therefore also responsible for its enforcement, are the national police and the municipal extraordinary investigating officers (Buitengewoon Opsporingsambtenaren, BOA's). Whereas the police have two statutory tasks - the maintenance of public order and provision of assistance, with the mayor as authority, and investigation, with the Public Prosecutor as authority -, BOA's are municipal agents whose task is to detect criminal offenses and thus supplement the police in maintaining public order in safety. Both are allowed to uphold suspects and write fines.

Opium Act

In the Netherlands, the above mentioned Opium Act is the main legal instrument regarding illegal drug-related activities and its sanctions.

In the Netherlands, criminal investigation and prosecution operate under the so-called 'expediency principle' or principle of discretionary powers (opportuniteitsbeginsel). The Dutch Public Prosecution Service has full authority to decide not to prosecute a crime if it is not in the public interest to do so. They may also issue guidelines for that end.

The Opium Act Directive stipulates when a maximum penalty or a lower sanction is required. Decision criteria are the amount of drug, the kind of drug, the place where the drug was sold, and occasional versus long-term dealing.[39]

The Polaris Tables gives a very detailed elaboration of this principle, and its guidelines are employed in court cases in relationship to the punishment dictated.[4]

The Forensic Care Act

The Forensic Care Act was approved in 2014. The aims of this act is to strengthen the connection between the prison system, compulsory and quasi-compulsory forensic care within the criminal justice framework, the compulsory (after)care and the regular voluntary mental health (after)care. The target group of the Act are people who committed crimes and have psychiatric problems, a drug dependence or mental disabilities .[41]

Public drunkenness and disruption public order

In the Netherlands, the Penal Code regulates the punishability of public drunkenness in Article 453. The article 426 regulates the punishability of drunkenness if there is disruption of public order. The police act against public drunkenness, whether or not in relation to the disruption of public order. Next to this, as mentioned before, at a municipal level, public intoxication and disruption of public order is pushined via administrative fines.

Research on Violent Offenders (Wet Middelenonderzoek bij Geweldplegers, WMG)

From 1 January 2017, the police is allowed to test violent offenders for alcohol and drugs. This is stated in the new Environmental Investigation Act for violent offenders. Whenever the perpetrator consumed alcohol or drugs, the Public Prosecutor can demand a heavier sentence. Normally, this penalty results in a higher fine or longer community service or cell punishment. However, the Public Prosecutor can also demand a conditional sentence. Examples of such a conditional punishment are an alcohol ban, a location ban, a location offer or a training (behavioral intervention).

Further, this new law also establishes alcohol and drugs use objectively, aiming to avoid discussions in this regard in the courtroom.[4]

Habitual Offenders Act (Maatregel Inrichting Stelselmatige Daders, ISD)

Coming into effect in 2004, the ISD is intended for systematic adult offenders with or without drug dependence or mental illnesses. It provides that offenders may be committed to a special institution for intensive treatment for a period of at most two years. The offender's detention is suspended on the condition that he or she undergoes treatment in such an institution.[43]

General Local Regulation (Algemene Plaatselijke Verordening, APV) & Municipalities Act (Gemeentewet)

In the Dutch municipalities, the different drug related issues are covered by periodical and ad hoc policy papers.

The drug policy at the local level, which must comply with national guidelines, is coordinated in consultation between the mayor, the chief public prosecutor and the chief of police, in the so-called tripartite consultations. Examples of recent policies are the Dealers Nuisance

39. etelaars, T. et al (2002) Report to the EMCDDA by the Reitox National Focal Point 2002.

40. taadscourant (2010) Beleidsregels Openbaar Ministerie - Wijzigingen in (Polaris-) richtlijnen voor strafvordering per 31 december 2010 en 1 januari 2011

41. Van Laar, M. W. et al (2014) Report to the EMCDDA by the Reitox National Focal Point 2014

42. RO (2017) Factsheet. Geweld onder invloed wordt zwaarder bestraft.

43. OM (2018) Maatregel Inrichting Stelselmatige Daders.

Areas (Dealeroverlastgebieden, DOG), aimed to provide effective approach towards public nuisance by dealers;[44] the Plan Against Intimidation and Nuisance by (fake)drug dealers (Aanpak van intimidatie en overlast door (nep)drugsdealers) which focus on dealers selling fake drugs to tourists[45].

Every four years, a Security Policy Paper is published with concrete targets concerning prolific offenders who are dependent on drugs, combating public nuisance caused by alcohol and, or drugs, dismantling weed nurseries, controlling coffee shops and maintaining security on large events.

Also, every four years Dutch municipalities have to approve a Public Health Policy Paper preceded by a health survey, in which strategies targeting to decrease the use of drugs, especially among youngsters, are formulated.

44. Gemeente Amsterdam (2016) Bm-besluit. Aanwijzing dealeroverlastgebied Amsterdam Centrum 2.0

45. Gemeente Amsterdam (2016) - Aanpak van intimidatie en overlast door (nep)drugsdealers stadsdeel Centrum.

1.1. Description of the insitutional structure

As a consequence of the ambitious reform process developed in the last years, and aiming at providing a service as integrated as possible, a wide range of institutions have been mobilized. Housing corporations, health insurance companies, healthcare providers, the police and the justice department, among others, have been involved into shaping not only the services themselves, but also the structures of collaboration that support them.

Municipalities, according to the new legislation, are entitled to provide services in whichever form suits best their context. In practice, most of the municipalities have confronted this task collaborating with one another through inter municipal networks. The most significant one, who has provided some help through guidelines, is the Association of Dutch Municipalities (Vereniging van Nederlandse Gemeenten, VNG)

Taking the example of the city of Amsterdam, and considering that most municipalities have implemented a variation on this model, all stakeholders involved in social support have signed a covenant, agreed on common goals, including the provision of financial and human resources. Further, equipped support units have been established in different neighborhoods to provide medical treatment, social support, employment, and day activity programs. This is the so called 'chain approach' (ketenaanpak).

Within this model, the local government has a clear function of management, coordination and controls the financial situation. Within the municipality, an administrative management team (mayor and high level administrative local officers) meets twice a year to reach agreements at the general level.

Beside this team, an interdisciplinary working group, the operational team, has become responsible for the implementation of the program. This group consists of representatives of the local government, representatives of the justice system and the police, and the managers of housing, healthcare and social benefit services. A program manager coordinates the implementation of the project and reports regularly to the working group.

Lastly, a 'veldtafel', consisting of local service providers, has regular meetings to monitor the progress of individual clients and to refer them to the appropriate services. A 'chain

unit', consisting of the police and representatives from the justice department, monitors the clients within the judicial system.

A description of the main stakeholders if offered below.

The National Government

The central government is in charge of articulating the general guidelines trough which social and health support is provided on the national territory. This function has been accomplished through the legislation described in previous sections of this report.

Further, the central government is in charge of providing the necessary funds for the municipalities, as well as remaining responsible for the long care support.

VNG

The VNG supports the regions in the development and implementation of the new regional plans from a national support program. For example, from this platform a quality agenda for shelter and protected living has been set, in which basic standards are developed for specific target groups and facilities. Advising in social care, supported by studies and research, is another of its tasks.

The Municipalities

The responsibility for the organization, implementation, and coordination of care in the Netherlands has been delegated to regional and local authorities and is part of the broader healthcare agenda.

The local governments develop and implement the relevant drugs policies, provide resources for the service providers and organize the collaboration between the different stakeholders, including the mayor, administration for social and health policy, the head of the police, the criminal justice administration, service providers and the municipal health services.

Municipal Health Services

The Municipal Health Service (Geestelijke Gezondheidsdienst, GGD) is the main provider of treatment programs such as clinics for opioid substitution treatment (OST), the heroin prescription program, the treatment of blood-born infectious diseases such as HIV/ AIDS, tuberculosis and hepatitis, and psychiatric treatment.

In Amsterdam, a special GGD unit is responsible for the 'support approach', that is, for coordinating the individual support for clients offered by different agencies such as social benefits, medical care, housing, 24 hours emergency service, etc. (Vangnet & Advies).

Justice Department

The police, the public prosecutor and probation officers are closely involved in the development and implementation of this 'integral approach' towards dependent PWUD. Regular exchange of data and information, direct client monitoring systems within the justice system, coercive treatment programs and detention are part of their role within the system, besides the investigation of criminal offenses, maintenance of public order and assistance to those who need it.

Service Providers

A number of service providers focus on particular target groups or situations: outreach work, low threshold services (including drug consumption rooms, night shelter, supported

housing, daytime activities), drug free treatment (outpatient and clinical treatment facilities), reintegration into the workforce (labor projects, support in finding work, etc.), as well as training and education.

Other Institutions

In addition to the direct partners mentioned above, other institutions related to the municipality are involved in the implementation of the program, including housing corporations, the social benefits agency, the employment agency, health insurance, reintegration services companies and others.

1.1. Description of the social support system

Target Group: from Mental Health Care to Social Care

Until 2015, the public mental health care (Openbare geestelijke gezondheidszorg, OGGz)[46] was explicitly included as such in the law. In this way it was stipulated as one of the tasks of within Public Health Prevention Act (Wcpv), and then the Social Support Act (Wmo).

46. Nationale Raad voor de Volksgezondheid (NRV). 1991. Advies openbare geestelijke gezondheidszorg.

However, since the entry into force of the Wmo 2015, the term public mental health care (OGGz) is no longer reflected in the law. Yet, it remains a municipal responsibility. In the explanatory memorandum of the Wmo 2015 it is stated that the term ‚social support' also covers the prevention of (serious) psychosocial problems and the accompanying of the persons involved. This task is achieved by ‚supporting the self-reliance and the participation of people with disabilities or with chronic psychological or psychosocial problems'.[47]

47. GD-GHOR Nederland (2016) Nieuwe OGGz: handreiking voor DDG'en.

In the last period, as a consequence of the intended integrated approach, and aiming at a more client centered approach instead of one based on categorizations, a new reference framework was published adopting the denomination of 'social care', instead. The target group consists of people at risk of dropout, the dropouts themselves and people who return to care. The group includes young people, adults and the elderly. The majority are single, but there are also families, single-parent families and, to a lesser extent, couples. Is typical for people in the group to be in a situation of simultaneous occurrence of multiple, often strongly interwoven problems. Often there are (combinations of) social isolation, neglect of one's own physical functioning, neglect or abuse of children, problems with (domestic) violence, pollution of the living space and / or the living environment, nuisance, actual homelessness or the lack of stable living space, financial problems and debts, poor physical health and often serious mental illnesses and drug dependence problems.[48]

48. Wolf, J. (2015). Niemand tussen wal en schip. Referentiekader maatschappelijke zorg voor mensen in multiprobleemsituaties.

The frame of reference contains proposals for the organization of social care. It also offers starting points for monitoring the quality of care. However, when municipalities asked about specific recent policy memoranda or covenants regarding the OGGz, almost all central municipalities responded that they prefer an integrated approach, often in connection with 'social relief' (Maatschappelijke Opvang, MO) in which the category OGGz keeps on being employed.

Table 2 – Target Groups

Categorization within MO / BW	
OGGZ	OGGZ includes all activities in the field of mental health, which are not conducted on the basis of a voluntary individual request for help. Persons who have problems in several areas of life, including homelessness, with a minimal psychiatry and / or drug dependence, cognitive problems or inadequate coping behavior and avoidance of care or finding the way to assistance.
GGZ	Persons with mental health problems such as schizophrenia, psychosis, anxiety disorder, depression, bipolar disorder or personality disorder. **Autism, ADHD and drug dependence also fall under the GGZ.**
'New Homeless'	People who have become homeless due to (a combination of) debts, unemployment and / or mortgage payments but who have no (o) GGZ problems
VG & V&V	Persons who, besides psychological problems, also have intellectual disabilities or old age problems and stay in a specialized institution.

Social Relief

Social Relief (Maatschappelijke Opvang MO) includes a wide range of activities: offering temporary shelter, guidance and providing information as well as directing the person towards the right institutions. In concrete terms, and aiming at fostering self-reliability and participation, this means that actual or residential homelessness alone does not happen on its own.

The municipalities are entitled to set the admission criteria and to determine whether the services of Social Relief are necessary. However, in general terms, the users of this service share generally the following characteristicsClients who find themselves in a situation of homelessness;

- Clients who are not self-reliant, or are insufficiently able to meet their own conditions of living (roof above head, food, income, social contacts , self-care);
- Problems in several areas including, for example, the lack of self-care, social isolation, pollution of living space and / or living environment, lack of permanent or stable living space, behavioral problems and addiction problems;
- Not (yet) able to live independently;
- 23 years of age or older ;

- From the point of view of the professional assistance, they do not receive the care they need to maintain themselves in society, and do not have a need for help in the regular care - family neighbors and bystanders usually ask for help - often resulting in unsolicited interference or assistance.[49]

49. Gemeente Amsterdam (2017) Handboek maatschappelijke opvang.

To ensure the national accessibility of social relief in practice, a covenant was drawn up and signed in 2015 by all central municipalities[50]. A Handbook on National Accessibility[51] and regional link to social care has also been made. This guide contains model policy rules for (central) municipalities to determine where a homeless person can receive the best social care.

51. VNG (2014) Handreiking Landelijke toegang maatschappelijke opvang.

50. VNG (2015) Convenant Landelijke Toegankelijkheid Maatschappelijke Opvang

In order to receive assistance by the Social Relief services, clients need to demonstrate a binding with the municipality in which their request for help is collected. The rationale behind this measure is aimed at ensuring self-reliance and participation by accessing services in social context with which they already have a bond with. Normally, this connection needs to have been maintained for at least two years.[52]

52. Gemeente Amsterdam (2013) Een Toegankelijke Opvang voor Dak- en Thuislozen: over regiobinding, sociale binding en bad, bed en brood voor iedereen.

Amsterdam's Example

Although a majority of municipalities in the Netherlands signed a covenant, the implementation of the general guidelines provided by VNG has crystallized in various models that respond to the specificities of its context. In order to gain a better understanding of the social relief program, and aware of the impossibility, within the scope of this report, to account accurately for all of the Dutch municipalities, the model of Amsterdam will be offered as an example.

In Amsterdam, the Social Relief and Protected Living Plan (Maatschappelijke Opvang en Beschermd Wonen) is an integral plan in which related policy fields such as living, poverty, participation and care for the family are a part of. The person who seeks for help, receives a social support offer in the fields of housing, income, debt counseling, day-to-day spending and medical, psychosocial and psychological care.

The program, which aims to offer an independent housing condition within 3 months, is articulated around three main goals:

- To prevent influx from relatively self-reliant people with an increased risk of inflow. This goal is set to be achieved by receiving early signaling and providing early intervention based on sources from the neighborhood, and from establishing cooperation between the basic services, neighborhood teams, informal care and the urban chain for social relief.
- To promote participation when possible, aiming at the independence and integration of the service user into the neighborhood. As a result, it is expected to reduce the amount of 24 hours care provided.
- To secure outflow and to reduce the chance that people fall back and become dependent on the Social Relief system.[53]

53. Gemeente Amsterdam (2016) Koersbesluit maatschappelijke opvang en beschermd wonen.

Access to Help

In Amsterdam, a Central Access (Centrale Toegang CT) point has been established. There, the target group can request e social benefits and/or can apply for shelter or support.

In most cases, people come to the Central Access themselves. However, it is also common that persons have been referred by another service provider or institution (a social worker, night shelter, outreach teams, a hospital, etc.). The Central Access of the Social Relief

system has an integrated approach and works closely with the Municipal Health Service, Healthcare Support from Arkin and Work Participation and Income (WPI). This gives the client an intake process with an integrated approach.[54]

54. Gemeente Amsterdam (2017) Handboek maatschappelijke opvang.

When a client meets the basic access requirements to the services and has demonstrated relevant information that proves a connection to the municipality, the Central Access will file the request and place it for help on a waiting list for an intake process within the 'in-flow' department.

Assessment

After this first procedure takes place, a first screening is done by the GGD. During this interview, the help questions and possibilities of an applicant are discussed. On this basis, the GGD employee completes the self-reliance matrix (Zelfredzaamheid Matrix ZRM). The matrix evaluates a client on the basis of 11 criteria, such as income, housing and drug dependence. Once completed, it, gives an automatic advice whether or not the applicant is self-reliant and is eligible for social support. [55]

55. Lauriks, S. et al (2010) Zelfredzaamheid-Matrix. Amsterdam: GGD.

If the applicant does not meet the conditions for social relief, it is decided that the applicant has no right on reception. The GGD employee must then fill in a form for a rejection decision. This rejection decision will be explained and handed over to the applicant. In addition, the decision is scanned and archived in an online integrated system (Trajectus) by the GGD employee.

If the first screening by the GGD or the digital registration shows that the applicant may be eligible for social relief and also has a demand for a benefit, then a second screening will follow within two to five working days (a so-called ‚integrated intake') on one of the three integrated facilities existing in Amsterdam.

The intake is carried out by an employee of the Central Access of the Social Relief system, the,'intake officer', and a customer manager from WPI. If it turns out that the applicant already has a provision for income, the take-up will be followed up by the intake officer of the Central Access of the Social Relief system only. A decision may also be included in this discussion, which shows that an applicant is not eligible for social relief.

During this conversation, the help questions and strengths of the client are discussed. This process is underpinned by means of an Integral Trajectory Plan. This Plan describes what the help questions are and which help questions are already being addressed. The inflow officer instructs the client on the field table and gives advice for the cluster to which the client will be directed.

All clients are entitled to free client support prior to or during the application process for social care. The client support is independent of care institutions and indication counters and stands up for the interests of the client.

Integrated Facilities

Whenever a person is screened as suffering from a multi-problematic condition that includes a substance dependence, a side-influx process takes place. In these cases, clients can be eligible for a Trajectory at Budget and Income Management Special Target Groups (Budget en Inkomensbeheer Bijzonder Doelgroepen, BIBD), and the intake takes place at one of the Integrated Facilities (Geïntegreerde Voorzieningen, GV). The work of these polyclinic departments consists of drug treatment, psychiatric treatment, or both to OGGZ patients from Amsterdam.

In an Integrated Facility, the City of Amsterdam and the Medical and Health Service (GGD), together with other organizations, provide care and assistance to Amsterdammers with

psychiatric problems and / or a dependence on drugs. The various care providers, such as doctors, nurses, social workers, budget consultants and customer managers work together in one building so that a customer can be helped easily.[56]

56. GGD Amsterdam (2016) Wegwijs in het werk van de GGD Amsterdam.

Substitution treatment includes methadone and buprenorphine dispensing, as well as the medical prescription of heroin. Participation in these services is on a voluntary basis. The GGD stimulates healthy behavior and tries to reduce the risks of infections such as tuberculosis (TB), sexually transmitted infections, hepatitis and HIV.

As mentioned in the Key Statistics, the group of chronic heroin users is steadily getting smaller and older. This means that the average age in 2015 has reached 54 years. In the younger generation, heroin dependence is hardly seen. For the aging generation of PWUD, the long-term use of drugs and cigarettes takes its toll and intensive care is often necessary. For this reason, having a physician is particularly relevant within the facilities assisting this public.

Table 3 - Housing Facilities in Amsterdam

	General Facilities	Specialist Facilities
Shelter	- Crisis Shelter - Paid Night Shelters (Passantenpesions) - Night Shelters, including: - Winter Shelter - Winter Emergency Shelter - 'Stoelenproject' -Drop-in Centers - Alternative Shelters	- 24-hour housing, extra care regular - 24-hour housing, regular - Group housing, regular - Individually assisted housing, regular
Protected Housing		- 24-hour housing, extra care intensive - 24-hour housing, intensive - Group housing, intensive - Individually assisted housing, intensive

Social Benefits

Next to the possibility of receiving housing support, as mentioned before, a client might be entitled to receive social benefits as soon as she or he is able to demonstrate that indeed a homelessness situation is at hand. The Work and Income Department (Dienst Werk en Inkomen DWI) controls this through a form in which the applicants register the places in which they sleep during 10 consecutive days. Further, DWI reserves itself the possibility to check this information with the Night Shelters.

In general terms, the social benefits for a person experiencing a situation of homelessness accounts for half the amount that any family member would receive as social benefit. Further, this amount can be incremented via complements if the client sleeps 15 nights or more in an official Night Shelter, or through the participation in work programs. Participation in a work program is mandatory as a condition for receiving social benefits.[57]

57. Gemeente Amsterdam DWI (2008) Dak- en thuislozen.

Day Activities

In addition to housing, financial assistance and social medical assistance, day activities (Dagbesteding) are an important aspect of the Dutch social support system. The purpose of daytime activities is to structure the daytime of the clients, and to support clients in participating actively in society.

Together with their clients, care providers develop tailor-made offers.

Day spending is a provision that municipalities can use from the WMO 2015 on the basis of the objective of supporting self-reliance and the participation of people with disabilities or with chronic, psychological or psychosocial problems.

Meldpunt Vangnet & Advies [58]

58. GGD Hollands Noorden. Meldpunt Vangnet & Advies. Openbare Geestelijke Gezondheidszorg.

The GGD's Safety Net Department works within the Living Nuisance and Health Registration Point (Meldpunt Zorg and Woonoverlast) together with mental health care, addiction care, housing associations, police and justice, and generally takes care of social or psychological crisis. This can include drug dependence, or mental and behavioral disorders.

In practice, this service targets population that has been experiencing problems for a long time which were never reported before. In this way, this intervention targets many of the citizens that would not, or could not, actively seek help and therefore are under the risk of being considered or becoming a form of public nuisance.

The Safety Net provides activities such as 24-hours crisis services for the police, hygienic housing surveillance, psychosocial assistance in accidents, coordinates the Winter Shelter program, cares for forensic addiction services - including multiple crime offenders with a substance abuse or a psychological condition. In addition to its referral to the appropriate regular health care institutions, the Safety Net also has a service provider role.

Outreach Work

Outreach work - understood as care service provision for those populations who might not, or decide not to have access to more institutionalized offers - has a long tradition in the Netherlands, which dates back to the 1970's.

Since then, several organizations in the city of Amsterdam have been carrying activities that target people experiencing homeless and/or a substance dependence, or that represent a risk for themselves or the society.

Examples of this activities are the ones carried by: Veldwerk Amsterdam, which focus on linking the population to health and care services in the city; Stichting Mainline, a harm reduction organization whose street workers seeks contact with PWUD on the streets, low-threshold facilities and through their 'methadone bus', among others; and Street Corner Work, whose street workers seek to establish contact with young PWUD in their own social context.

02

inclusive interventions

Drug Consumption Rooms

Drug consumption rooms are harm reduction facilities, where PWUD can use drugs in safer and more hygienic conditions. DCR aim to provide an environment for safer drug use, improve the health status of the target group and reduce public disorder.

In the Netherlands, as of February 2017, there are 31 facilities in 25 cities[59]. Here, supervision of drug consumption and health educative advice are some of the services offered. Further, drug consumption rooms provide PWUD with sterile injecting equipment, counselling services before, during and after drug consumption, emergency care in the event of overdose, primary medical care and referral to appropriate social healthcare and drug treatment services.

59. EMCDDA (2017) Drug consumption rooms: an overview of provision and evidence.

The vast majority of drug consumption rooms in the Netherlands are integrated within low-threshold facilities and deliver as well a wide range of auxiliary services. This includes provision of food, showers and clothing to those who live on the streets, prevention materials including condoms and sharps containers, counselling and drug treatment.[60]

60. Woods, S. (2014) Organizational overview of drug consumption rooms in Europe.

The effectiveness of drug consumption facilities to reach and stay in contact with highly marginalised target populations has been widely documented. The main achievement has been an immediate improvement in hygiene and safer use for clients. Next, wider health and public order benefits have been observed, such as reducing public drug use and associated nuisance, and reduction in the number of improperly discarded syringes. Lastly, attitudes in the general population towards PWUD and the DCR's have substantially improved. [61] [62]

61. Potier, C. et al (2014) Supervised injection sites: what has been demonstrated? A systematic literature review

62. Hedrich et al (2010) Drug consumption facilities in Europe and beyond.

The rooms cooperate closely with the local police and neighbourhood committees. Frequently, a committee composed of local residents, service staff, users and representatives of the police and the municipal health administration, meets regularly to address any problems that might arise from the operation of the drug consumption rooms.

Alcohol Consumption Rooms

Alcohol Consumption Rooms (ACR) are a relatively new phenomenon in drug treatment care. In 2015, 18 ACR were available in the Netherlands, most of them set up in the center of a town or village.

An ACR is a care facility where alcohol-dependent people who experience other disorders can use alcohol under professional supervision. As it is the case with DCRs, use in a safe environment and a link with healthcare are central within a ACR[63]

The main objective of alcohol consumption areas is public nuisance reduction. Another important objective is limitation of health damage. Alcohol consumption areas can act as a safety net or as a springboard on which the client can have access to other typologies of social or health care.

Even tough differences exist in the admission criteria, the following ones are regarded as desirable: being alcohol dependent (according to DSM IV), being homeless, being at least 21 years of age, being registered in the municipality, staying legally in the Netherlands and causing nuisance.[64]

63. Van Essen, J. et al (2011). Alcoholgebruiksruimten.

64. Van Essen, J. (2011). Richtlijn alcoholgebruiksruimten.

Table 4 – Characteristics ACR's clients

Characteristics ACR's clients[65]	
Gender (media % man)	90%
Age (media)	44 years old
Origin	76% Dutch
	4% Western
	20% Non-Western
Living Situation	Protected Housing 33%
	Homeless, shelter 48%
	Family, 3%
	Own Home, 16%
Substance Use	Cannabis 88%
	Heroine, methadon 81%
	Cocaine 94%
	Amphetamine, GHB 12%
	Medicines 18%
	Speed 6%

65. Zijlstra-Vlasveld, M. and van der Poel, A. (2015) Alcoholgebruiksruimte in Nederland.

Addiction Care, Low-Threshold Facilities, clients of the ACR, police, and outreach workers are some of the most fundamental entry points into this service. Aiming at an integrated approach, intensive cooperation with other stakeholders - such as social relief services, the municipality, general practitioners and general psychiatry practitioners - is fostered.

Upon entry, by default, clients should blow a breathalyzer to have their alcohol levels determined. However, differences among the facilities exist in the amount of alcohol that is allowed to be consumed, the type of beverage, the periods of use and breaks in between. A few of the alcohol consumption rooms only allow alcohol to be used which is supplied by the institution itself. Some require testing of the alcohol promillage at entrance.

Next to the possibility of consuming alcohol in a safe and supervised manner, ACR offers (free) meals, coffee, tea, access to facilities for personal care and hygiene, recreation and day activities. Next to this services, the assistance offer is proactive and focused on practical matters, such as income, work / day activities and accommodation.

Housing First

Although Housing First (HF) has already existed internationally for at least twenty years, only recently these interventions have received more interest in the Netherlands. Since 2006, various practices have been set up under the umbrella of HF, and on the last three years this initiative has experienced a big increment. At the beginning of 2014, the numerator of practices under the name of Housing First stands at nearly 20.[66]

66. Wewerinke, D. et al (2014) Housing First: principes en praktijken.

This models contrasts to the existing social relief framework, in which the client have access first to a shelter or a low-threshold facility, stays in crisis or 24-hour facilities and protected housing, and from there, if possible, moves on to an (accompanied) independent living. Instead, HF approach grants a housing from the start and, once there, clients are offered support on the spot in overcoming possible barriers in remaining housed. This includes treatment for psychological and/or drug dependence problems, and support for the participants in their process of recovery and social participation, with respect for their own choices.

The Dutch HF model is based on the Pathways to Housing model.[67] HF projects work with rental and payment agreements, and none of the contracts have time limits for its use. Considering that many users of HF programs still have fines open, budgeting of the housing costs and help is a condition for participation, guarantying in this way the payment of the rent. Besides this, income management is not mandatory, but encouraged.

67. Tsemberis, S. and Eisenberg, R.F. (2010) Pathways to housing

As a second condition for admission, the acceptance of guidance in the form or home visits - at least once a week - is compulsory. The focus of this supervision lies on the role of the client as a tenant and the condition in which the home is maintained. This measure is aimed at supporting the maintenance of the independent living condition as long as possible.

Although comprehensive studies on a national level on the results of this projects are still being carried, several local reports give insight into the benefits of HF programs.

When it comes to living conditions and quality of life, a general increment has been reported. In the HF Amsterdam, 91% of the participants have reported an improvement on their living situation, 89% on the general quality of life and 71% on finances. Next to this, 70% experience improvements in their mental condition, 73% on their physical condition, and 70% reported an improvement in their substance use patterns.[68]

68. Wewerinke, D., al Shamma, S. and Wolf, J. (2013) Report of the Evaluation of Discus Housing First, The Netherlands

Results in Den Haag correlate to these findings. Measuring the developments of clients through the ZRM (Self-sufficiency Matrix), although the scores in most areas of life fluctuated somewhat in the intervention period, the scores at the end are higher in all areas than at the start.[69] In the areas of social network and drug dependence, a relatively large increase in self-reliance is visible. A high degree of self-reliance in the field of drug dependence does not mean that the participant does not use any substances, but that this does not lead to problems. In Den Haag, , a (small) increase in self-reliance seems to be visible at each measurement in at least three areas of life. These concern the ADL areas (general daily life activities), social participation and justice.

69. Nieuwenhout, Y. (2016) - Housing First ervaringen en resultaten na 4 jaar.

Reducing public nuisance at large, and specifically within the location in which clients of HF are located, is an important goal of the intervention. All Housing First practices have

developed policies for this and have made agreements with housing associations about the steps to be taken in case this situation arises.

Results on this area point towards a rate of success. Virtually all practices have received complaints about nuisance, and usually these complaints were justified.[70] However, based in the HF in the city of Dordrecht, the case managers indicated in interviews that nuisance is rare and not an issue. The Trivire HF Program in Dordrecht employee also indicates that the amount of nuisance, taking into account the target group, is not high.[71]

In the HF Amsterdam, the relationship between the housing corporations and the programs is regarded as positive, and the employees of housing corporations believed that an investigation into nuisance was not necessary, as participants hardly caused any inconvenience. [72]

Lastly, the rates of maintenance of housing have been reported as positive as well. Of the 123 people experiencing homelessness in Amsterdam who moved into a home between 2006 and April 2011, 83% are still housed after five years. Of the 44 homeless people in Den Haag who have moved into a home between December 2011 and October 2013, 91% are still accommodated after more than one and a half years.

70. Wewerinke, D., al Shamma, S. and Wolf, J. (2013) Report of the Evaluation of Discus Housing

71. Massie et al (2014) Een eigen huis.Tussenevaluatie van het Housing First project Dordrecht.

72. Wolf, J., Maas, M. & Al Shamma, S. (2012). Discus Amsterdam: Housing First. Evaluatie van de werkzaamheid: samenvatting van resultaten.

Amsterdam Underground

Amsterdam Underground[73] is a project which offers (former) homeless people and PWUD meaningful work that links with their knowledge, qualities and skills. They often have had to survive in difficult conditions and now can use the knowledge and skills learned through this process in a positive way. Participants give guided tours on the Amsterdam Red Light District, where they tell their personal story and share their knowledge about life on the streets.

During the walks a dialogue arises with the participants. As a result, by sharing their experiences and contexts, they give insight into the lives of people who experience homelessness, use drugs, or both. In this way, participants in the tours gain a better understanding of their (former) reality and the stigma that they might experience.

The guides are coached by a professional from the Rainbow Group[74]. Once a month there is also a consultation with all guides in which the participant's experience are monitored. Hereby, attention is given to their own ideas and what the project means for the participants. Further, a yearly evaluation complements the monthly meetings.

Before a participant starts working as a guide, an intake takes place in which it is screened whether someone has sufficient substantive knowledge and whether he can deal with telling his personal story to a group. After this step, the upcoming guide walks with the coach and they discuss the story that the guide will tell. The walk is then further practiced with guests, as a group of volunteers. The guide's story consists of personal experiences and anecdotes but always contains a number of fixed themes. For example how the guide became homeless, how he got help and how he experienced it, how he got out and what his wishes for the future are.

This way of daytime activities is valuable for the guides because it suits them well and their mostly negative experience in a positive way. They also come into contact with people who they otherwise would not meet. Because they notice that people are interested in their experiences and appreciate it, the guides get more self-confidence, accept their own history better and gain insight into what they are good at.

The project is designed as to function self-sufficiently. Participants in the tours pay an

73. More information can be found at https://www.amsterdamunderground.org/en

74. More information can be found at: https://www.deregenboog.org

entrance fee so that the activity is cost-effective. The guides receive a small volunteer allowance. There is no subsidy from the municipality for professional guidance from the Rainbow Group. However, the Rainbow group receives a municipal subsidy for overheads such as spaces. Further, the project collaborates with other stakeholders.[75]

75. Van Houten, M. en Verweij, S. (2015) Vernieuwing in dagbesteding: 45 Projecten.

Amsterdam Sports Life

Since 2014, Amsterdam Sports Life[76] contributes to a city where no one is sidelined by using sports as a means towards participation. This project is a network of sports providers, healthcare institutions and volunteers who use the Life Goals Methodology[77] to reach, motivate and empower vulnerable people in Amsterdam.

76. More information can be found at: http://stichtinglifegoals.nl/lokale-sportprogrammas/amsterdam/

77. More information about the Life Goals Methodology can be found at: http://stichtinglifegoals.nl/academie/methodiek/

In the last years in the Netherlands, many social institutions have begun to develop opportunities for their clients to engage in sports and physical activities by increasing their variety of activities, as well as by expanding their scope of structural activities[78]. However, one of the most innovative aspects of this project is how people who experience homelessness, drug use, or both, participate in this project together with neighbors of the north area of Amsterdam. Further, alongside, migrants and asylum seekers are also part of the program.

78. Verwijs, R. & Hermens, N. (2013). Sport en bewegen in de opvang. Resultaten van drie jaar onderzoek.

This sports offer is realized by 12 Social Sports coaches who assist participants in various locations in Amsterdam to partake in weekly sports activities. At the moment, it counts with more than 270 weekly participants. Further, beside the activities, and thanks to its participation within the Life Goals network, the project offers as well the possibility of participating in competitions and events.

Normally, sport monitors are referred to this project through the different stakeholders with this the organization collaborates, such as care providers, WPI and client managers. Next to this, participants in the activities are mostly reached out through the same services, plus neighbourhood centres and information points from the municipality.

The project is designed to function as a low-threshold activity. And, even its aim is not abstinence directed, the use of alcohol and/or drugs right before or during the activities is not permitted. There is not an age limitation when it comes to participating in the activities themselves. However, sport monitors are required to be over 18, be legally residing in the country and have a binding with the municipality.

Before a participant starts working as a sport monitor, an intake takes place in which the expectations, rules and guidelines are explained. Besides this, every three months a meeting takes place in which the individual development is assessed. Based on the core values of the project, joint agreements are made. Particular emphasis is given to themes such a health, respect, cooperation or communication.

Participants in the project have reported improvements in self-esteem, self-care and motivation to take care of their own lives. Further, thanks to the combination of different target groups, the network of the participants is amplified and, in this way, social isolation is tackled.

The funding for the project comes from a diversity of resources, which includes municipal programs in the area, as well as well as contribution from service providers. Next to The Rainbow Foundation, the program is carried by Leger des Heils, Exodus and AVV SDZ.

Peer to Peer

Peer to Peer is a training for people who experience mental health problems and who also have experienced homelessness for a long time, a long-term depression or a substance use disorder.

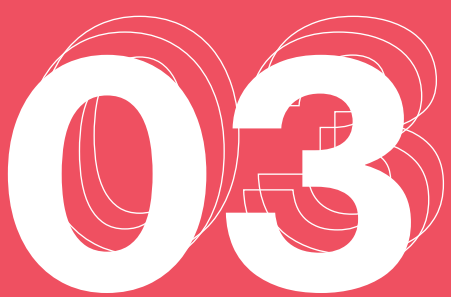
On average, 12 to 16 participants take place in a program that consist of six training sessions per year. The training has weekly meetings of one or two time slots per day (between 3 and 4 hours), depending on the capacity and concentration of the participants. Each training takes place during eleven weeks, and are aimed at helping participants to examine what their passions are and how their network can support them. The aims of the program is to learn how to formulate their own goals, to network, and take actions to achieve results. During the process, step by step, they receive guidance and support by a trainer and an experienced expert in establishing their goals and achieving them..

The success factors of this project are the targeted guidance given during the training, the motivation and learning levels. The training is based on the passions and strengths of the participants which, in return, help establishing connections between other stakeholders in the neighbourhood.

This program is developed by the Centrum voor Dienstverlening, in Rotterdam[79]. It is founded via the Municipal Health Care Budget, and through the Wmo, whenever applicable.[80]

79. More information at: https://www.cvd.nl/clientinformatie/training-en-arbeidsparticipatie/peer-to-peer/

80. Van Houten, M. en Verweij, S. (2015) Vernieuwing in dagbesteding: 45 Projecten.


03

3.1. Participation & self-sufficiency

After the transitional period that followed the changes in legislation, the principles on which the Wmo 2015 is based – independence, participation, broad approach to requests for help, customisation of support, lighter forms of support – seem to be incorporated within the municipal agendas. Proof of it is the inclusion of such a terminology within the dialogues, process and recent evaluations and improvements of the services provided.

However, when the perspective of citizens, clients, and professionals is taken into consideration, research into this transition offers a different light over this subject matter. In this way, a discrepancy arises between the legislation aims and the reality of the practice in neighbourhoods, facilities and programs.[81] Based on the experience of practitioners, participation still remains a challenge when it comes to vulnerable populations such as people who experience an alcohol and/or drug use dependence, people experiencing homelessness or psychiatric problems.[82]

Whereas the policy assumption is that every citizen is capable of achieving and improving their life quality levels with the right support and guidance, the reality of the practice speaks differently. In most cases, clients which are in contact with drug treatment services, social relief or protected housing require continuous intensive supervision in order to maintain themselves. Besides this, it seems that some limits have been reached regarding the capacity support of informal help (e.g. due to embarrassment about asking for help or overburdening of informal care), and the deployment of lighter forms of support (e.g. due to limited availability).

81. bma, T.A.(2016). De tragiek van de transitie. Een filosofische bezinning op de transitie in het sociaal domein.

82. Van der Harm et al (2018) The Wmo 2015 in praktijk.

Contribution to Society at Large

In the society of participation, citizens are expected to contribute, preferably in the form of paid work. In this way, being employable, finding a job and retaining it are rendered as essential attitudes. Participation, under this light, has thus been given an individualistic interpretation, and the socio-cultural and political motivations behind it - more visibility,

control, and space for people who do not meet the norm of healthy, enterprising and economically productive - have fallen out of sight. In this way, feelings of exclusion from society for people who experience homelessness and/or alcohol and PWUD, based on their employment status, are frequent, as being out of the labor force becomes synonymous with not being part of society.[83]

This shift of paradigm, in this way, seems to have a normative effect since a critical reflection on values and norms that hamper or impede participation are not actively addressed on an institutional level. Consequently, participation primarily implies that medical professionals and service providers ought to be the ones who, in practice, need to reflect critically on precisely those values and norms and prejudices that prevent people from participating.[84]

83. WRR (2017) Weten is nog geen doen. Een realistich perspectief op renzaamheid.

84. bma, T.A. (2016). Participaties is geen zelfdrzhaamheid, maar deling van controlling en macht.

Participation & Self-Sufficiency within the care services

As a rational behind the decentralizing reform within the long-term care, are freedom of choice and autonomy in the care they receive. In this way, citizens are offered more control over their options. However, in practical terms, oftentimes this translates as more responsibilities too.

The latest set of reforms in the social and health field seem to be founded on the assumption that the correct knowledge and processes automatically leads to the right goals. Further, it also implies certain levels of control of a person over its own life: capacities to manage and stay out of trouble, skills to deal with problems, and to thrive.[85] However, this is not always the case when it comes to people who experience homelessness and/or alcohol and drug use. Professionals estimate that only half of their clients are able to make the right choices for themselves in the care and support he or she needs.

85. WRR (2017) Weten is nog geen doen. Een realistich perspectief op renzaamheid.

In the agreements with care suppliers it is recognized that service users have a co-determination and participation in any event referred to proposed decisions which are of interest to clients. However, when we refer to this specific population, that is not always the case. At the Social Reliefs access points, for example, it is common that no information is provided regarding the rights and obligations such as the house rules, the provided care and support.[86] Further, clients are also think that there is little regard for their personal needs; they experience, despite the possibility of some involvement in the personal plan, few possibilities to take control again and take ownership of their lives.[87]

In the Netherlands, another possibility for participating in the social & health care system is provided by the Client Participation in Healthcare Institutions Act, which makes mandatory for services providers to count with a Client Council (Cliëntenraad). Client Councils are established as mean towards looking after the common interests of patients and clients and, in this way, they represent an important channel for service users participation.

However, in practice, interaction institutions oftentimes lead to mutual frustration and ineffective interaction. Client councils experience that they are hardly representative, they tend to be constituted in its majority by the 'good' active clients and they have little systematic contact with their diverse constituents. Besides this, it also needs to be considered how their tasks are now more challenging than ever, since the existing inpatient healthcare organizations are getting bigger, and care is more often granted at home.[88]

86. Planije, M. et al (2017) Praktijktest toegankelijkheid maatschappelijke opvang 2017.

87. De Blok et al (2017) Wachten op opvang.

88. Baur, V. & Abma T.A (2011) Resident councils between lifeworld and system: Is there room for communicative action?

Participation in Activities

When it comes to the general population, virtually all municipalities seek to foster independence by focusing in the support of the citizen by its own means, namely by

support of its network, collectives of informal care or its own agency. Further, participation is achieved through neighbourhood and community activities and through civic initiatives and volunteering. However, for those clients that outflow, the range of day activities is still insufficient to prepare them for independent participation. . People from multi-problem families, people in the Participation Act and WMO people participate less than people who do not use a facility. Between 2015 and 2016, no changes occurred in the social participation of any of the groups.[89]

89. Pommer, E. and Boelhouwer, J. (2017) Samenvatting. Overall rapportage sociaal domein 2016.

3.2. Support received

Intakes

Delivering customisation and providing appropriate support are regarded central within the Wmo 2015. However, this notion is not always necessarily translated into practice as 'appropriate support' since the interviews process are not integral enough[90]. People who access the social relief and protected housing programs often report that their life situation is not sufficiently central to the application of the services themselves. When examining the application for social assistance, the process seems to be more directed towards evaluating whether the client meets the eligibility criteria, rather than mapping the need for support.[91]

Although the Wmo 2015 stipulates that social care is accessible nationally[92] and the 'national accessibility' has been elaborated by municipalities in the National Guide accessibility and regional ties to social relief[93], the lack of regional connection features still as one the main reason for which access to the social relief and protected housing services is denied.[94] In 2017 the lack of regional bonding played a role in two-thirds (69%) of the rejections, in 2015 in 59% of the rejections. In 2017, it was the only reason for 43% of the rejections and in 2015, for 34% of the rejections. This situation is particularly adverse to people experiencing homelessness without a proof of registration in the municipal register, former PWUD who wish to escape their drug dealer or find a new community, migrants, as well as people who do not have formal proof of identity.

Regarding the level of knowledge of interviewers on the problems and characteristics of the specific groups that they work with, often times it is self reported as insufficient when it comes to people who experience homelessness and/or use alcohol/drugs. According to the CSP (HLZ-G'16), 41% of the interviewed people consider not to have a sufficient knowledge on this target group (see table next page).[95]

90. Rekenkamer Den Haag (2018) Van de straat. Onderzoek naar de maatschappelijke opvang in Den Haag.

91. De Blok et al (2017) Wachten op opvang.

92. Ministry of Health, Welfare and Sport (2016). Social relief. Letter with reference 1072240-159728-DMO dated 21 December 2016 to the President of the Second Chamber of the States General.

93. VNG (2014) Handreiking Landelijke toegang maatschappelijke opvang.

94. Planije, M. et al (2017) Praktijktest toegankelijkheid maatschappelijke opvang 2017.

95. Feiten en at (2017) Zicht op de Wmo 2015. Ervaringen van melders, mantelzorgers en gespreksvoerders.

Lack of Access

It has been observed in several municipalities that there are too few adequate housing facilities, especially those with guidance.[96] In those existing, it is common to encounter long waiting lists. In Amsterdam, for example, 1.612 requests were collected in 2016. From those, 1.076 were invited for the first screening, out of which 309 made it into the 'inflow' commission. In practice, this means that part of the client group, which has been recognized as in need for care, are faced with no support.

96. Pommer, E. and Boelhouwer, J. (2017) Samenvatting. Overall rapportage sociaal domein 2016.

Table 5 ~ % Level of knowledge of interviewers about the characteristic limitations and problems of specific target groups

	Insufficient	Sufficient	More than sufficient
Interviewee with a mild intellectual disability	16	48	36
Interviewee with a mental or psychiatric disorder	22	42	36
Interviewee with a psychogeriatric disorder (e.g. dementia)	23	40	37
Interviewee experiencing physical limitations due to chronic sickness	15	32	53
Interviewee experiencing sensory limitations	23	52	25
Interviewee with an acquired brain injury	15	50	35
Interviewee experiencing multiple problems such as homelessness, or a heavy addiction.	41	37	22

Source: SCP (HLZ-G'16) 33 Municipalities, 201 respondents.

As described in previous sections, the phase of the first reception is intended as an emergency provision before a suitable facility is accessed. However, the estimated waiting list accounted for 1,2 years in Amsterdam. Similar patterns have been observed in Protected Housing in Amsterdam, and other municipalities in the country.[97] [98] [99] As a result, waiting clients remain staying in emergency shelters when the capacity permits it and, despite the additional support they could get in this phase of the trajectory, their situation generally worsens. [100] Generally speaking, emergency shelters are not properly prepared to respond to the nature of the help request since they cannot respond specifically enough to the diversity of needs of the users.

Further, the outflow process remains problematic due to a lack of enough affordable housing, whether it is (social) rented places or protected housing. As a result, people who could make it into a more suited facility remain in there longer than intended. This process results in bigger delays in the inflow process and, next to this, results in a more expensive service.

97. Planaije, M. et al (2017) Toekomst beschermde wonen.

98. Planaije, M. and Kroon, H. (2017) Opvang en beschermde wonen in Amesfoort.

99. Homan, L. and Schutte S. (2017) Inventarisatie Beschermd Wonen en Maatschappelijke Opvang Regio Holland Rijnland.

100. Pommer, E. and Boelhouwer, J. (2017) Samenvatting. Overall rapportage sociaal domein 2016.

Integrated Approach Services

In general municipalities seek more contact with services providers, link the Wmo to other policy domains and link up with other municipalities in regional partnerships. In recent years, collaboration with health insurers and other parties involved in long-term care has been increased. However, there are also issues, most notably concerning the collaboration between municipalities and health insurers, which is not always functioning smoothly, especially in small municipalities.

On occasions, challenges to the development and implementation of integrated approaches find their cause in the frictions between different policies. Specifically, the Healthcare Insurance Act (Zvw), the Long-term Care (Wlz) and the Participation Act, are less flexible than the Wmo 2015 and therefore offer less scope for delivering customisation.

Informal Support

With the entry into force of the new legislation special attention has been given to the informal support and extra mural care in an attempt to secure the independence and self-reliance of citizens. Although these developments are encouraging, there is still a lot of room for further improvements. Consequently, municipalities and services providers have been developing strategies to increase the use of informal support.

Concerns have been raised regarding the extent to which the potential for new informal care is overestimated.[101] Furthermore, in the last period municipalities are experiencing a decrement in the amount of volunteers which collaborate with associations. Instead, volunteers are turning more often now towards individual requests of support. This decrement is particularly meaningful for people experiencing homelessness and alcohol or drugs patterns of consumption, since their own networks are oftentimes debilitated, or nonexistent beyond the professional care context. Further, people with long term needs that outflow into independent housing encounters a lack of sufficient ambulatory support. Consequently, this decrements their possibilities for maintaining this independence and, in occasions, increments the possibilities for a worsening of their condition.

101. Maarse, H., Jeurissen P. (2016) The policy and politics of the 2015 long-term care reform in the Netherlands.

Next to this, professionals have reported difficulties during the selection of candidates, as this requires a careful approach and demands a great deal of attention. An increment in the number of volunteers needing aid in performing their tasks has been also experienced. Consequently, professional caregivers find themselves spending more time than before in supporting informal caregivers and volunteers. These are not always the kinds of volunteers that organisations are looking for. [102]

102. Van der Harm et al (2018) The Wmo 2015 in praktijk.

3.3. Regulation of public space

In the last years, the Netherlands has witnessed a shift in drugs and social policy in which preventing and controlling public nuisances has been rendered central. Parallel to the broader decentralising process taking place in the social and health fields, nowadays municipalities are also in practice more responsible for the legislation and enforcement of public order.

The decriminalization on begging is a recent example of this shift in responsibilities. In 2000 the Dutch government abolished the nationwide prohibition of begging, arguing that such a prohibition was no longer needed, [103] owing to better economic and social conditions in the country. However, despite this national decriminalization of begging, many local authorities in the Netherlands have introduced their own local regulations which a similar goal, reflecting in this way the economic and social changes that took place after of the

103. Kamerstukken II, 1996-1997 (Explanatory memorandum), 25 436 nr.3, pg 13.

recession 2007, and highlighting the boundaries of what is considered acceptable to the Dutch society.

Besides the criminalization of begging, in the Netherlands other behaviours commonly associated in different degrees to drug and alcohol use, or homelessness are targeted. This would include, among others, sleeping outside, loud noises, urinating in public space, or the disturbance of the normal activities for which public, and private, spaces are intended for. As a consequence, even if this population is not the explicit target of these control measures, the impact of such measures is disproportionately felt by people experiencing homelessness, which might include alcohol users, or PWUD due to their reliance on public space for conducting their day-to-day activities[104].

Oftentimes, these clearing policies, together with the possibility to commute severe penalties with treatment programs, are considered as an helpful instrument when it comes to help and improve the life quality of drug and alcohol users, and people experiencing homeless. Under this light, prohibitions such a sleeping outside function as environmental strategies through which to guide population towards the right institutions and support.[105] [106]

However, such measures are not as effective as intended. As we have seen before, facilities in the Netherlands are not yet prepared to accommodate all of the request for help, or are not accessible to those populations which are not able to proof bonding enough with the municipality that organizes the support. Further, with such practices there is danger of performing a selective targeting by which most vulnerable populations are suppressed their right to the city, which is not explicitly acknowledged.

Pushing alcohol, PWUD and people experiencing homelessness into care, in this way, has a strong linkage with enhancing public order by taking users (and their potential criminal and nuisance behaviors) off the streets. Whenever this happens, the main concern, in this sense, is not necessarily with the individual user, but with the undesirable effects s/he may cause for society at large.[107] It becomes then unclear to what extent the motivations are a structural approach to end homelessness, or rather it was intended to decrease public nuisance as a form of social cleansing.[108] Under this light, questions can be raised up regarding the degree to which harm reduction programs, low-threshold facilities, or OST programs are expected to function as a soft law enforcement strategy.

When an infraction takes place in the Netherlands, the most common form of penalty is a fine. However, considering how people who experience homeless oftentimes find themselves in a poverty situation too, as soon as several fines are accumulated, they are commuted for imprisonment. This approach to law enforcement not only affects certain groups disproportionately, and contributes to stigmatization and discrimination, but also is not effective in reducing the insecurity of population at large and increasing the quality of life of vulnerable populations[109] Alcohol and PWUD who experience homelessness are considered as an 'alternate universe' where the social order is drastically different, and the links between the social structures and the production of these environments is ignored, and removed from everyday experience.

Further, this shift in balance between the social and the penal and the link between insecurity and the 'criminalization of poverty`, reduces the opportunities available to people experiencing homeless and the space for potential solutions to their problems, and contributes to the degradation of homeless policies.[110]

104. Doherty, J. et al (2006) Addressing Homelessness in Europe. Homelessness and Exclusion: regulating public space.

105. De Quadros Rigoni, Rafaela (2017) Double expectations: law enforcement workers and dilemmas on handling drugs use at the street level.

106. Gemeente Hardenberg (2017) Nieuwe APV vanaf 1 januari 2018.

107. De Quadros Rigoni, Rafaela (2017) Double expectations: law enforcement workers and dilemmas on handling drugs use at the street level.

108. Hermans, K. (2012) The Dutch Strategy to Combat Homelessness.

109. College voor de Rechten van de Mens (2017) Jaarlijkse rapportage. Armoede, sociale uitsluiting en mensenrechten.

110. Tosi, A. (2007) *Homelessness and the control of public space - criminalizing the poor?*

04

conclusions & recommendations

Holistic approach or multi-agency approaches?

Within the context of the recent developments in social and health support in the Netherlands, enormous efforts have been made regarding agency collaboration. However, although customized, integral plans in different life domains have been developed and rendered central to the process of support, actions and evaluations are initiated simultaneously by different actors, and service users are oftentimes not given enough agency within this plans.

Contrasting this multi-agency approach, a client-centered one would represent an attempt to better diagnose the situation in which a person finds him/herself, before any task division or action is taken in parallel by any service. Aiming at developing inclusive services by implementing holistic models in social and health services would ensure that people experiencing homelessness and/or alcohol and drug use, are afforded optimum opportunities to engage in the process of planning and action, in which strategies for support can be determined. Consequently, when such an assessment is realized, institutions ensure themselves not to have the person go through the same process several times, as only updates would be necessary, and every agent would be involved right from the start.

Strengthening cooperation

Providing social support is not the only way for states and local authorities to approach homelessness and alcohol and drug use. As we have seen, another common strategy is to respond with repressive measures, many of which are originated within the municipalities through ad hoc laws, aimed at the criminalisation of the so called 'anti-social' behaviour. Homelessness, alcohol and drugs use and nuisance on the streets are often bracketed together. In the last years, the Netherlands have witnessed a simultaneous raise in the number of people experiencing homelessness, along with a shift on policies that aims at controlling public nuisance, targeting in this way the effects of poverty and the use of alcohol and drugs.

In order to provide effective support to those who find themselves in such situations, there is nowadays an urgent need for strengthening the collaboration between social, health and law enforcement institutions in an attempt to understand and address the structural causes

that generate this phenomena. Innovative partnerships and working methods that cut across sectoral boundaries can contribute effectively to policy making practices regarding homelessness and drug, alcohol consumption in the public space.

Information

People experiencing homelessness, and those who use drugs and/or alcohol, do not constitute an homogeneous group as such since their situation oftentimes relates to an intersection of diverse problems. As we have seen before, targeting the needs of this population does not necessarily translates into addressing the roots of their specific problems, causing oftentimes the need for help again. Better information is a crucial condition for increasing both the quality and effectiveness of the care given and to avoid relapses. This is not only relevant for the nature and causes of the problematics experienced by the users of a service, but also for the quality of care experienced and what kind of impact it has on their evolution.

Longitudinal peer and subject review, next to studies performed by evaluators who do not have a vested interest in the results are advisable, as well as qualitative studies who render the person in need central.

Peer Involvement

Much evidence supports that peer-to-peer support is a critical and effective strategy for ongoing social and health support, contributing to the improvement of the life quality of people with long term care needs. Far from remaining only in the service user context, its benefits can be extended to community, organization and societal levels.

Whilst peer-working has been mostly developed to help respond to health needs, it can also play a valuable role in terms of social support for people moving on from homelessness

The base for this is to recognize that experiences of peer support providers, as (former) participants in the same life circumstances that the people they work with, are a valuable source when it comes to service design, implementation and delivery.

Peers have a unique understanding of both the realities of drug and alcohol users, and people experiencing homeless, and the barriers faced when accessing care. Structural inclusion of peers in care services offers the possibility of creating specific and individualized plans of care that secure specific individualized goals. Furthermore, through these programs, a more appropriate and effective support can be offered when compared with generalist volunteers services.

Next to this, peer-to-peer services can become a meaningful space in which life experiences of (former) service users are rendered as a field of expertise through which social inclusion of both the peer support provider and the person in need of help can be achieved. Furthermore, peer-to-peer services can provide professional experience, training and employability gains, as well as personal satisfaction and self-confidence.

Public opinion is key

In the Netherlands, homelessness and alcohol or drug use are oftentimes presented as a public order and safety issue, contributing in this way negatively to the already existing stigma that this population faces. Framing homelessness and alcohol or drug consumption

in terms of public nuisance subtracts its relationship from social policies. Considering how the latest Dutch policies and cultural frameworks have rendered central participation and self-reliance, the emphasis is made on the personal responsibilities for poverty, mental health or substance consumption. This conception generates a high risk of social exclusion, and affects the quality and effectiveness of the services provided.

Challenging these common conceptions is not only urgent, but crucial when it comes to foster inclusion and offering the necessary support. As elaborated previously, PWUD and/or alcohol, who also experience homelessness are far from belonging to a homogenous group. Consequently, strategies that disrupt this misconception are needed.

Approaches that would help are those which discuss the social and economic conditions that shape people experiences, as well as the values that sustain them. By activating both strategies, social accounts as well as individual ones, a more nuanced and clear understanding of what systems are at play arise, and it becomes more clear how they are designed. By understanding how they are constructed, new spaces for collective action and collaboration with people in other fields are open that differ greatly from those in which the problem is de-socialized and efforts are directed towards making invisible PWUD and alcohol, as well as people experiencing homeless

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Drug- and alcohol-related nuisance is an important policy issue in nearly all smaller, medium-sized and bigger cities. Experience and research has shown that this is a pan-European problem which many local and municipal authorities are struggling to address in an effective manner.

A broad range of participatory interventions and prevention activities have been developed to prevent nuisance among youngsters. Intervention, targeting adults however, are limited and mainly based on repressive and sanctionary acts, including arrests, restraining orders and fines. Less is known about inclusive strategies and adult learning opportunities, which provide daily structure and support to this specific group.

The Street Support Project is built on the idea that each person has the potential to learn and to do something meaningful. Adult learning, work and other activities can play a vital role in this context, as long as it is adapted to the specific needs and living conditions of the target group.

STREET
SUPPORT