

When a group of students from Stoke of Trent College visited Amsterdam, they had a chance to see at first hand how policy and practice compared with their experiences back home. Outreach worker Brian Street describes highlights of the study visit.

The Netherlands has been unafraid to address its drugs problems in ways that have often seemed, to us in the UK, to be too permissive. It was therefore tremendously exciting for us to have the chance to see how things worked practically and at ground level.

As part of our course and underpinning the theoretical aspects we cover in class, our group spent three days in Amsterdam visiting projects relevant to the work we do at home. Members of our group work with various aspects of drug dependency in the UK, and the projects we visited enabled us to compare the Dutch approach to our own.

We spent time at the KDO project which dealt with the children of addicted parents; visited the drug free unit in Overamstel prison; looked at the Amsterdam heroin prescribing unit; and saw a project concerned with the protection of women involved in the vice industry. Most of these projects were operating with the approval of, and benefiting from, funding by their government. The exception was the drug free prison facility, run by Jellinek (an umbrella organisation that uses different approaches to provide treatment options for drug and alcohol users). On the final day of our

visit, we had time with Dr Peter Cohen from Amsterdam University, who gave us an unorthodox view of the Dutch drug scene and much to consider and evaluate on our return home.

Amsterdam is a small but cosmopolitan city, with diversity of culture and until recently, a liberal and tolerant municipal governing body. It is a city that is comfortable with itself and unafraid of trying unusual methods to address the problem of illicit drugs. Their decriminalisation of cannabis and its availability in the 'coffee shops' is interesting, in that it has not resulted in an increase of cannabis use. We were told that presently, the Netherlands has the lowest rate of cannabis use in Europe and much lower than that of the USA.

Amsterdam's liberal attitude is not always the case in other Dutch cities and their approach to drugs and other social problems varies from region to region, much as it does in the UK.

The Netherlands has a total population of 16 million and of these 25,000 are considered problematic drug users. In the past decade, the main drug of choice has changed from heroin to crack cocaine.

Outreach project for prostitutes

The project started in 1988 and was later extended to help illegal women immigrants who had been trafficked.

The evolution of the sex industry in Amsterdam saw a change from a majority of Dutch women workers to women of different ethnic origins. Project workers from the same ethnic backgrounds, or who had previously worked in the sex industry, had the language to communicate and could empathise with clients.

Legislation in the year 2000 made brothels legal and required owners to fulfil certain requirements before applying for a licence. Women employed in licensed brothels were safer, more accessible to project workers, and had better access to health provision. Illegal immigrants, however, were unable to work in licensed brothels and they moved to alternative places of work.

At this time there was an official tolerance zone existing in Amsterdam, which saw a big increase in the number of women working there, as the new legislation came into force. Numbers of women in this small area increased to 130 and numbers of customers kerb crawling could be as many as 600 cars per night. The problems this caused the city, combined with increased criminality in the area, forced the mayor to close down the tolerance zone in 2001. Many women subsequently moved to other cities, escort agencies or alternative unlicensed working areas, where it was difficult for the project workers to make contact.

Even women living legally in the country were

often reluctant to work in licensed brothels for various reasons. Some were reluctant to pay tax or social benefit contributions; others did not want to be listed officially as prostitutes and many of these women were opposed to the new legislation.

When asked if the police had a positive attitude to complaints from working women, project worker Theresa said that this was generally the case. Difficulties arose when women in the country illegally were asked to pursue cases further, as this meant disclosing names and personal details, risking expulsion from Holland. At one point, the project employed seven peer educators, who jointly spoke 14 different languages.

Theresa felt that it was advantageous to work with the police. She also felt that although some agencies in Holland considered collaboration with brothel owners wrong, she considered it necessary to gain access to the women working there.

Prison drug free unit

Overamstel prison (known locally as the 'Bijlmer Bajes') was built to a new design and opened in 1997. A central corridor and a low-lying building, which houses offices and admission facilities of six tower blocks, connect the layout, with capacity for 670 inmates.

Our party visited the drug free unit, which offers help to 24 inmates. The unit has two Jellinek drug workers who help prison staff to treat addiction problems. We were told that 70 per cent of the

prisoners have an addiction problem of drugs, alcohol or gambling and that treatment is now being offered for smoking and medication addictions.

Inmates applying for treatment are referred by the judiciary, who ask Jellinek for an assessment as they enter the remand system. Help is designed to prepare inmates for treatment after release, or a continuation programme after detention.

New inmates are given medication to help withdrawal symptoms, and methadone prescriptions are provided after release. Inmates on the drug free unit are tested daily for drugs. A positive test for soft drugs will result in a five-day suspension for the first offence and a seven-day suspension for a second offence. Positive testing for hard drugs will mean suspension of the programme and a return to one of the normal prison towers. The inmate will then need to re-apply for a place on the drug free unit.

During treatment in this unit, inmates will participate in group therapy, which includes examining the reasons for lapsing. They are encouraged to engage in 'positive thinking' sessions, examining their social structures outside prison and how best they can make changes to address their drug problems.

The provision of care after release is determined at meetings between Jellinek staff and outside support workers, who jointly agreed an aftercare plan for the inmates. We were told that in Holland, addiction is considered a 'chronic disease'.

'Although this facility is very modern by UK prison standards, I felt it to be an institution of social

exclusion. Tall tower blocks, accessed by internally connected passageways, surrounded by a wall and a moat, made it almost medieval in concept. Had we been examining prison structures instead of drug treatments, any ideas of Dutch liberalisation would have been stretched to breaking point.

'We were told that there is a care plan in place for those inmates returning to mainstream society. Hopefully they will be more progressive, far reaching and reflecting the needs of the clients than the vision we were offered during our visit.'

Brian Street, voluntary outreach worker

Heroin prescribing project

In 1997, the government initiated a heroin-prescribing project, which began operations in the following year.

Applicants to the programme are at least 25 years of age, have a five-year addiction and are resident in Amsterdam. (Illegal immigrants are excluded, as they have no medical insurance.)

Clients are referred by either doctors or other methadone outpatient programmes, and there is no direct access or self-referral. Those that are accepted are likely to use heroin or methadone 12 times a month or more.

The entrance to the treatment facility leads to the methadone-dispensing machine, and from there clients move to either the injecting or smoking rooms. Both rooms are starkly functional, with stainless steel surfaces. The injecting room also has a low sink for clients who are injecting in their legs or feet. Large windows give an uninterrupted view of the rooms from the central office, and it is from here that ready prepared doses are administered. Injecting clients are required to place used syringes into a bin in order for project staff to check that doses have been used. Time for these clients to complete their treatment is limited to 30 minutes, after which they are required to leave.

After 12 months, treatment is discontinued and clients return to their original treatment regimes in order to observe the effects of the programme. Heroin prescribing is considered more cost effective than normal methadone only prescription, as it has been shown to result in less associated crime and anti-social behaviour.

It is the object of the programme to promote the recognition of heroin prescription as an effective treatment and to register it as a medicine for the treatment of addiction.

'After visiting the experimental service provision for heroin prescribing, my attitude totally changed. My expectations were of clients using heroin in rooms full of other clients in a very sociable setting. As a practitioner I didn't know where I sat with this. The visit totally changed my view; it was very clinical and followed the medical model. It was for about 75 clients who had long histories of drug use. There were two rooms; one for injecting and one for smoking, and in the middle were the supervising staff. There was an intense routine, which involved attending up to four times a day. This method would not be appropriate for

a lot of people, but I think there should be a choice of treatment available; this must be the way forward.'

Claire Pattison, women's worker (with prostitution) at a voluntary agency

Support project for children of addicted parents

This project operates to co-ordinate the support network for parents and children and avoid 'ad-hoc' working practices. It acknowledges that vast numbers of parents who use drugs are coping well, but that some support opportunities are missed when agencies do not work together. The project seeks to fill that gap and encourages basic care, and aims to support parents in bringing up their own children.

'I found the level of compassion towards drug users in Amsterdam a real eye-opener. I feel that society sees drug users as the lowest of the low, which I think is mainly due to ignorance.'

'Visiting the project for children of drug users left me with a quote from the manager, that I know that I will never forget: 'they are parents with a problem - not drug

users with children'. I think this sums up the difference in attitudes I have encountered here and in Holland.'

Vikki Kent, counsellor

The Btec Professional Diploma in Management of Addiction course, at Stoke on Trent College, offers a progression route from a range of popular courses in General Drugs Awareness and Addiction. The courses are mapped to DANOS, with assessment of practical workplace competence throughout, and at Level 4 provide evidence for FDAP registration and accreditation.

Second year students are offered an opportunity to visit projects and treatment providers in the UK and in Europe. They meet with fellow drug workers and discuss practice and policy.

For further information about the courses, contact the course team leader, Jane Rowley, at Stoke on Trent College, tel: 01782 208208; email: jrowl1sc@stokecoll.ac.uk

Jane would be interested to hear from any projects that would be willing to meet with small groups of students and discuss their work.

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