



HR4Homelessness

Integrating Harm Reduction in Homeless Services

COUNTRY REPORT NETHERLANDS

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Erasmus+

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1. Data & Prevalence

a. Homelessness

In the Netherlands, the number of people experiencing homeless has more than doubled between 2009 and 2018.¹ According to the Central Agency of Statistics [CBS], the latest number accounts for a total of 39.300 people. This number 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

However, when comparing this information with the data gathered by the Federatie Opvang, a discrepancy is observed. According to their monitoring system, almost 70.000 people were reported having been assisted by the homeless shelters. 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).

In recent years, the Netherlands has witnessed a change in the profile of people experiencing homelessness. What is striking about the figures is the large increase in young homeless people - three times as much as in 2009. These are, for example, young people who can no longer count on youth assistance by reaching the age limit of 18 and after leaving an institution or foster families fall between two stools (Wolf et al. 2015).⁵ In addition, it is noticeable that over the half of the number of estimated homeless people have a non-western migration background (CBS 2019b). It concerns people who have a valid residence permit. Hereby first and second generation migrants are included. Becoming illegal homeless people as mentioned, not counted. The number of homeless people with a western migrant land is estimated at 4,100, of which 2,500 to 3,000 are homeless from Central and Eastern Europe (CBS 2019b; Barka 2019).

Health of people experiencing homelessness

When compared with the general population, the health of people experiencing homeless people is concerning: mainly affected by skin diseases, respiratory infections, neck, back and joint pain, dental problems, foot and walking problems. Substance dependence is also found above average among people experiencing homelessness (van Laere, Sloekers & van den Muijsenbergh 2017). In addition, a relative

a larger number of homeless people experience need for mental health support (CBS 2018; van Laere, Sloekers & van den Muijsenbergh 2017). 40% are dealing with serious or long-term mental health problems

(Movisie 2017; Movisie 2019). This also applies to younger people experiencing homelessness, from which between 20% - 30% have been identified needing middle mental health support (Movisie 2017; Smulders et al. 2018).

¹ CBS (2020) - Daklozen

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

b. Prevalence of Substance Use

General Population

Among the general adult population in the Netherlands, cannabis is the most common illicit substance used in 2018 [7.5%], followed at a distance by Ecstasy [2.8%] and cocaine [1.6%] (Van Laar, 2019). 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: the prevalence of cannabis and ecstasy use was approximately twice as high among male identified young adults than among female identified, while cocaine use is reported to have been three times higher.

Although heroin use is uncommon in the general population, according to data from health insurers, the number of people with severe medical opioid use problems (such as oxycodone and fentanyl) has aroused in the last years.

It is also worth noting how Amphetamine use in the Netherlands is the highest in Europe [1.1% of the Dutch population ages 18 and older]. New Psychoactive Substances, 4-FA and 2C-B are the most used, with a 0.9% and 0.6% of the adults in the Netherlands had used in 2018

When it comes to high-risk substance use, 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 (Cruts, Van Laar, & Buster, 2013). 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 population. 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 (Oteo Perez, 2016)

People Experiencing Homelessness

In 2018, the use of cocaine has increased among people experiencing homelessness, especially in four biggest cities of the country (G4). In Rotterdam, cocaine was the most consumed substance among this population, with 18% of them reporting use dependence behind their experience of homelessness (Kruize et al., 2019). In Amsterdam, from the population who made use of the Winter Shelter facilities in 2016, 8,7% of them reported using cocaine (Buster & Oosterveer, 2017).

Use of cannabis is frequently encountered among young people experiencing homelessness in the G4. In 2011, 63% had used cannabis in the previous month of the study conducted in this area (Van Straaten et al., 2012). This number remained somewhat stable in the measurements of the following year. Studies in Rotterdam in 2018, offer a similar estimate, with a 51% of this population having consumed cannabis on the previous year (Kruize, De Muijnck, & Schoonbeek, 2019).

According to older studies, and signals from the field, the use of GHB is also relatively frequent among young people experiencing homelessness (Van Straaten et al., 2012 | Kepper et al., 2009; zie ook Van Laar et al., 2016). There have been signals of use of NPS among people experiencing homelessness (Van Laar et al., 2019).

c. Prevalence of Infectious Diseases

General Population

In the Netherlands, there has been since 2008 a decreasing trend in the annual number of newly-diagnosed HIV infections. This decreasing trend continued in 2018, with an estimation of 320 cases. The majority of these infections [66%] were in men who have sex with men. As of 31 December of 2018, a total of 20.104 people living with HIV were known to be in care in one of the HIV treatment centres (van Sighem et al. 2019).

Infection with Hepatitis C virus [HCV] and Hepatitis B virus [HBC] is generally uncommon in the Netherlands. It is estimated that 0.1 to 0.4 percent of the general Dutch population has been exposed to HCV, and the same percentage to HBC (van Dijk et al., 2019)

People Who Use Substance

In the Netherlands, the number of new and reported cases of HIV and Hepatitis B and C among injecting drug users has been low for years. The number of newly diagnosed HIV cases among injecting drug users per million inhabitants is one of the lowest in the EU-15. In 2018, only two new cases were registered (van Laar et al., 2019).

From the total of people living with HIV in 2018, in 3% of the cases the transmission was reported to be related to drug use/drug injection, the same percentage as the one found in people with an active HBV infection. This contrasts greatly with percentages on HCV, with 34% of transmission cases being reported to be related to drug use/drug injection. (Smit et al., 2019).

2. Relevant Strategies and Policies Tackling Homelessness, Housing Exclusion & Substance Use

In this chapter, the most relevant strategies and policies targeting people experiencing homelessness and people who use substances are presented. These include (1) housing exclusion & homelessness (2) substances (3) social security (4) legal & judicial (5) professionalization of experiential expertise.

a. Housing Exclusion & Homelessness

In the Netherlands, there are five main strategies addressing:

National Housing Agenda 2018-2021

This agenda broadly aims at reducing the shortage of housing in the Netherlands, and improving the quality of housing and neighborhoods (Ministerie van BZK, 2019).

This agenda consists of three parts: (1) *building more housing*, with the key objective of 75.000 houses constructed every year until 2025; (2) *affordability of housing*, including promoting accessibility to social housing, and making rent allowances more broadly available; (3) and *improvement of utilization of current housing supply*, with an important section on providing adequate housing for the so-called vulnerable groups. Emphasis is made on enabling people living in shelters and protected housing to access independent housing [see also Multiannual Strategy].

Multiannual Strategy for Protected Housing & Shelter

In the Netherlands, the responsibility for and decision making on construction of housing falls under the municipalities and housing corporations³. Next to this, within the WMO [see number section/page here] municipalities are also responsible for providing shelter and assistance.

Announced in 2018, this national and integrated⁴ strategy urges municipalities and other stakeholders to strive towards social inclusion through independent ‘regular’ housing, and articulates support as being aimed towards recovery and self-reliance. It states that support should move from the ‘staircase model’, to an Housing First model [see also HF Stimulation Program] with flexible support. Further, it urges municipalities to cooperate with service providers to better respond to the complex needs who make use of shelter and protected housing [including, but not only, substance dependence, different physical abilities, or mental health support].

Homeless Youth Action Plan 2019-2021

As seen before, the number of young people experiencing homeless has increased dramatically in recent years. Within the Multi Annual Strategy, this specific action program aims to tackle homelessness among people aged 18-27 (Ministerie van VWS, 2019).

To do so, the program articulates five lines of action: (1) prevention, long-term support and coordination, focusing on early identification of young people at risk of experiencing homelessness; (2) provision of financial security, aiming at an early identification of problems in this areas by the municipalities; (3) support of development, education and training; (4) development of specific shelter and housing solutions, separately from adult people experiencing homelessness; and (5) revision of legislation and rules that may hinder the work of professionals supporting youth experiencing homelessness.

Housing First Netherlands Stimulation Programme⁵

Although this program does not constitute a national strategy as such, the HF Netherlands Stimulation promotes the development of HF initiatives, and research on the effectiveness of these initiatives. Commissioned by the Ministry of Public Health, Welfare and Sport, the programme is aimed primarily at people with a substance dependence, or experiencing need for psychiatric support.

‘Weer Thuis!’ Action Programme

Starting in 2017, and continued in 2019, the Association of Dutch Municipalities teamed up with several organizations⁶ in the field of housing, social and health support provision. The main goal of the programme is to facilitate access to independent housing from shelters and protected housing. To do so, the Action Programme has implemented several regional Pilot Projects, while at the same time fosters cooperation and knowledge-sharing among municipalities, housing associations and service providers, both at local and national level.

³ Most social housing in the Netherlands is owned by housing associations.

⁴ The Multiannual Strategy written with the involvement of client representatives, municipalities, healthcare organizations, housing corporations, Ministries of the Interior, Justice and Security, Social Affairs and Employment, and Public Health, Welfare and Sport.

⁵ More information, and access to publication, through the following address <https://housingfirstnederland.nl/>

⁶ The ‘Home Again’ program was initiated together with the Association for Housing Associations (AEDES), the Federation of Shelters (Federatie Opvang), the Alliance of Assisted Housing (RIBW Alliantie), the Dutch Association of Mental Health and Addiction Care (GGZ Nederland) and the Salvation Army (Leger des Heils).

b. Drug policies

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.

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.

In the Netherlands PWUD are not seen or treated as criminals, but rather as patients who need care and support. 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, or sought out, support is given to reduce the harmful consequences of use.

Despite its health and social approach to the 'drug problem' approach, the Dutch drug policy Climate in the last few years has shifted to a more moralizing and conservative discourse, with an increased focus on law enforcement, and abstinence, sometimes at the expense of the health approach where acceptance of use is essential (de Gee & van der Gouwe, 2020). In recent years, successive governments have emphasized public order, safety and law enforcement, shifting the policy focus towards containing the so-called public nuisances, and crime (Grund & Breeksema, 2017).

The Netherlands doesn't count with a Drugs National Plan, or an equivalent overall drug strategy coordinating document. Instead, complementing the above mentioned legislations and documents, aspects of Dutch drug policy are elaborated in specific strategies, policy notes or letters to the parliament⁷.

The Opium Act

The Opium Act came into force in 1928 and was fundamentally amended to separate the markets of hard and soft drugs in 1976. As such, it is the basis for the current drug legislation. As mentioned above, the Dutch 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. (Leuw, 1991) The Opium Act, as a result, did not define use of drugs as an offense. Instead, it defined drug trafficking, cultivation and production, dealing, and possession of drugs as criminal acts.

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 were 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 coffee shops for cannabis)

⁷ Examples include the white paper 'A combined effort to combat ecstasy' (2001) 'The medical prescription of heroin' (2009) or the 'Police and the Public Prosecution Office policy letter' (2016).

c. Social Security System

Social Services

Participation Act [Participatie Wet, PW]

The PW aims at supporting every citizen with some capacity to work to incorporate into the labour market. Introduced in 2015, this Act puts into practice the idea that every individual has to make a contribution in a participatory society. Participation means, in the context of the law, having a paid job. To achieve so, the PW includes aspects of income support, compulsory activities in return for benefits, and labour market reintegration. The Participation Act assumes that people can be self-reliant in the search for paid work and that the government only offers support where their own strength falls short.

The PW sets out the frameworks for this, articulating as well the decentralization of all relevant social assistance to the local communities. As a result, local authorities have the freedom to determine how they wish to guide people into work and which instruments they deploy to this end. Further, the PW integrated several assistance schemes for “special target groups”. This includes among others the Sheltered Employment Act [Wet sociale werkvoorziening - Wsw] - who targets physical, intellectual or mental disabilities who prior to the implementation of the Participation Act were able to find adapted employment in sheltered working environments - and the Supplementary Benefits Act (TW) - meant to support the income of people who receive social benefits from the UWV, because of long-term illness, unemployment, a disability or an income that is below the social minimum -.

Health and Social Insurance Services

Health Insurance Act [Zorgverzekeringswet, Zvw]

The ZVW makes it mandatory to take out health insurance [or basic package of care] with a care insurer to all residents or payroll tax payers in the Netherlands above eighteen years old. Through the ZVW, the central government defines which care is included in the basic package of care, which conditions apply to this care, and the obligations of the healthcare insurance companies, healthcare service providers, and so forth. Within the specified package set by the government, health insurers have freedom to organise, within the parameters set, who provides the care and where it is to be provided. The Zvw combines elements of public and private insurance.

Under the Health Insurance Act, all insured persons together contribute to the total costs of all care. This is done through a ‘nominal’ premium paid by the citizens directly to their health insurer, and through 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 specified amount designated by the central government. In case a nominal premium is deemed excessive in relation to the income of the citizen, a possibility for support is articulated through the Health Care Allowance Act (Wet op de zorgtoeslag, WZT). That being the case, the Dutch Tax and Customs Administration pays out the allowances.

Long-term Care Act (Wet langdurige zorg Wlz)

Introduced in 2015, the Wlz functions as general insurance for people with severe, long-term care needs such as elderly people and people with severe disabilities, chronic illness or disability that need close all day intensive care or supervision. Long-term care can be provided in an institution or at home.

The Wlz is administered by special long-term care administrators at the behest of the central government. These administrators have transferred the actual implementation to healthcare administration offices; these are offices designated in each region which are closely affiliated to a health insurance company. They organise the way the healthcare services are provided.

Public Order & Law Offences

Opium Act

As mentioned above, the Opium Act is the main drug policy, and also the legal instrument regarding its sanctions. In the Netherlands, criminal investigation and prosecution operate under the so-called 'expediency principle' or principle of discretionary powers (opportuiniteitsbeginsel). 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 (Ketelaars et al., 2002) 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 (Staatscourant, 2010).

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.

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

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 space⁸

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

⁸ 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>

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.

d. Professionalization of Experiential Expertise in the Field of Mental Health and/or Addiction Care

In the Netherlands, the NZa [Dutch Healthcare Authority] has allowed the professionalization of experiential expertise in the field of mental health and/or addiction care under special conditions.

In 2015, GGZ Nederland [Mental Health and Addiction Care in NL] applied to the NZa to include 'experiential experts' as a profession in the NZa occupational table. After a positive assessment by the Quality Development, the NZa Technical Sector adopted the new profession with the following conditions: (1) the profession will be denominated as 'Ervaringsdeskundige GGz' (Experiential Expert GGz); (2) professionalizing courses for experiential experts must be standardized based on the available Professional Competence Profile⁹, and differentiated according to the level of education [technical & university levels]; (3) it must be established that there is an independent action in the context of the treatment plan, the recovery process and self-management.

In 2018, the profession 'Ervaringsdeskundige GGz' was included in the legal framework of the ZVW [Healthcare Insurance Act, specifically within specialized mental healthcare (Rijksoverheid, 2018).

Professional Competency Profile for Experiential Experts

The "Professional Competency Profile for Experiential Experts"¹⁰ aims to capture the essence of the professional employment of experiential expertise (van Bakel et al. 2013). It differentiates professional work levels and settings, and helps distinguish the various tasks and functions for people with lived experience. As such, the document serves as a base for healthcare, and social institutions that want to employ experiential experts. It also serves as a reference for educational institutions to create professionalizing courses for Experiential Experts.

3. Service Provision for People Experiencing Homelessness and/or Use Substances

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 in 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

⁹ The 'Professional Competence Profile' of the Experiential Experts includes the following activities: supporting self-help activities and recovery processes of individuals and groups; coaching of regular supervisors, practitioners and experience experts; schooling and organizing expertise promotion for clients, regular counselors and practitioners, experiential experts and other stakeholders; advising on the organization of restorative support care, care programs and policy; offer multidisciplinary, outreaching outpatient treatment where the intensity can vary depending on the situation of the client; doing research from the perspective of experiential expertise; developing and coordinating vision formation and policy based on experiential expertise; and developing anti-stigma activities.

¹⁰ Available at <http://tiny.cc/ihr0oz> (in Dutch)

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. 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 characteristics

- Clients 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 don't 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.

To ensure the national accessibility of social relief in practice, a covenant was drawn up and signed in 2015 by all central municipalities. A Handbook on National Accessibility 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.

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.

A Case Study: Amsterdam

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.

Access to Help

In Amsterdam, a Central Access (Centrale Toegang CT) point has been established. There, the target group can request the 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 it 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.

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.

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.

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.

General Facilities		Specialist Facilities
Shelter	<ul style="list-style-type: none"> - Crisis Shelter - Paid Night Shelters (Passan- tenpesions) - Night Shelters, including: - Winter Shelter 	<ul style="list-style-type: none"> - 24-hour housing, extra care regular - 24-hour housing, regular - Group housing, regular - Individually assisted housing, regular
Protected Housing	<ul style="list-style-type: none"> - Winter Emergency Shelter - 'Stoelenproject' - Drop-in Centers - Alternative Shelters 	<ul style="list-style-type: none"> - 24-hour housing, extra care intensive - 24-hour housing, intensive - Group housing, intensive - Individually assisted housing, intensive

Table x- Housing Facilities in Amsterdam

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 participation in work programs. Participation in a work program is mandatory as a condition for receiving social benefits.

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.

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.

b. Example of Successful Harm Reduction Interventions for People Experiencing Homeless and/or Use Substances.

Drug Consumption Rooms

Drug consumption rooms [DCRs] are harm reduction facilities, where PWUD can use drugs in safer and more hygienic conditions. DCRs 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. Here, supervision of drug consumption and health educational 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.

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.

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.

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

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 though 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.

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 in 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

This model contrasts to the existing social relief framework, in which the client has 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, guaranteeing in this way the payment of the rent. Besides this, income management is not mandatory, but encouraged.

As a second condition for admission, the acceptance of guidance in the form of 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 these 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

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. 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.

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.

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.

4. Barriers to Access Harm Reduction Services & Support

a. 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 interview process is not integral enough. 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.

Regarding the level of knowledge of interviewers on the problems and characteristics of the specific groups that they work with, oftentimes 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), There is a mismatch between generalist social workers, and specific needs of people experiencing homelessness and/or drug use. 41% of the interviewed people consider not to have sufficient knowledge on this target group.

Next to this, it has been observed how 'self-reliance' is occasionally activated as a criteria during intakes. In practice, this means that people experiencing homeless who do not experience substance dependence and/or mental health support needs, will tend to be not granted access to social relief facilities / services as long as they are regarded as being able to take care of themselves. As a result, problems must worsen before help can be provided. However, not all municipalities agree with this reasoning, so the criterion is also not strictly enforced everywhere in the Netherlands.

b. Lack of Equal National Coverage

Although the Wmo 2015 stipulates that social care is accessible nationally and the 'national accessibility', 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. In studies from previous years, the lack of regional bonding played a role in two-thirds (69%) 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 take distance from problematic relationships or to find a new community, migrants, as well as people who do not have formal proof of identity.

Although local governments are in charge of providing shelter and protected housing, these organizations are not present in all municipalities, but geographically clustered in certain parts of the Netherlands. This is fundamentally in contradiction with what the law stipulates - services close to the citizen and of inclusive nature.

Following this, at the moment, the distribution of budget for shelters and protected housing is dictated by where provision is available, instead of where the people who need it live. Within this model, people experience homeless moving towards larger cities in which more services and opportunities are available, resulting in higher costs for these municipalities. As a result, this system gives municipalities incentives to refer people in need to other municipalities and/or countries. Examples of this have been how municipalities in the Netherlands have been known to hire organizations to 'help' non-dutch people experiencing homeless to go back to their countries, or municipalities paying people experiencing homeless for the costs of moving somewhere else in the country.

c. Lack of Sufficient Capacity

It has been observed in several municipalities that there are too few adequate housing facilities, especially those with guidance. 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 of care, are faced with no support.

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. 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. 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.

d. Cooperation

In general municipalities seek more contact with services providers and big results have been accomplished in recent years. However, municipalities still struggle to link the Wmo to other policy domains and to 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.

Further, when it comes to the development of Housing First programs, and a sufficient housing offer, municipalities still tend to struggle to develop adequate partnerships with housing corporations, despite this been promoted by both the multi-annual strategy for protected housing and shelter, and the 'Homeagain' action programme.

e. Limits of 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 decrease in the amount of volunteers which collaborate with associations. Instead, volunteers are turning more often now towards individual requests of support. This decrease is particularly meaningful for people experiencing homelessness and/or use substance, 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.

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.

f. Emphasis on Public Order

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.

Although in 2000 the Dutch government abolished the nationwide prohibition of begging, many local authorities in the Netherlands have introduced their own local regulations with a similar goal, reflecting in this way the economic and social changes that took place after the 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.

Although these measures, together with the possibility to commute severe penalties with treatment programs, are often enacted as environmental strategies through which to guide population towards the right institutions and support, their effects are not as successful as intended. As we have seen before, facilities in the Netherlands are not yet prepared to accommodate all of the requests 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 selective targeting by which most vulnerable populations are suppressed their right to the city, which is not explicitly acknowledged.

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. Next to this, this approach to law enforcement not only affects certain groups disproportionately, but contributes to stigmatization and discrimination.



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