



PROCESS AND OUTCOME STUDY ON PRISON-BASED REGISTRATIONPOINTS IN BELGIUM

SUMMARY



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IN COOPERATION WITH THE FEDERAL PUBLIC SERVICE OF HEALTH, FOOD CHAIN SAFETY AND ENVIRONMENT
AND THE FEDERAL PUBLIC SERVICE OF JUSTICE



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CONTENT

1. Background and context of the study	1
1.1. Situation in European prisons.....	1
1.2. Drug counselling and treatment in European prisons.....	1
1.3. The Belgian context.....	2
1.4. Gap in the (drug) treatment in Belgian prisons.....	3
2. Methodology	4
3. Conclusions	5
3.1. Inform: Reached Number of clients and client profile (WP1).....	5
3.2. Motivation: What facilitates and impedes the motivation and readiness for treatment? (WP3, WP5).....	6
3.3. Referral: Number of referrals and factors that facilitate or impede referral (WP1, WP3, WP4).....	7
3.4. Signalling as a fourth additional main objective (WP2, WP4).....	8
3.5. The value of a specialized registration point in prison was recognized by all stakeholders (WP1-WP5).....	11
3.6. Essential preconditions for optimal functioning of the registration points (WP2-WP5)...	12
3.7. Research on the practice and continuation of the CRPs for incarcerated drug users.....	12
4. Recommendations for practice and policy	13
4.1. Legislation and current policy context.....	13
4.2. Recommendations regarding disclosure.....	15
4.3. Recommendations regarding the actual practice.....	15
4.4. Recommendations regarding collaboration and networking.....	20
4.5. Recommendations regarding policy.....	20
References	22

Context

This document is an extensive summary of the study entitled “*Process and outcome study on prison-based registration points in Belgium*” (PROSPER) aimed at the evaluation of Central Registration Points (CRPs) for substance users in Flemish, Brussels and Walloon prisons. The study was carried out on behalf of the Federal Public Planning Service Science Policy (BELSPO) and was made possible by the co-financing of the Federal Public Service of Health, Food Chain Safety and Environment and the Federal Public Service of Justice. The study ran from 1 December 2014 to 31 October 2016 and was conducted by Ghent University, Department of Special Needs Education and Department of Criminology, Criminal Law and Social Law and the National Institute for Criminalistics and Criminology (NICC). The aim of this summary is to provide an overview of the main conclusions of the study with an emphasis on the recommendations for practice and policy, based on the research findings. A full research report is available on the BELSPO website.

1. Background and context of the study

1.1 Situation in European prisons

Research indicates the high prevalence of alcohol and/or illegal substance use and abuse in incarcerated offenders (Fazel & Seewald, 2012; EMCDDA, 2012; Van Malderen 2012; Enggist et al., 2014). On average, substance use/abuse is more prevalent among prisoners as compared to the general population (EMCDDA, 2012; Belenko, Hiller & Hamilton, 2013; Enggist et al., 2014). A review study showed that 18% to 30% of detained men and 10% to 24% of detained women use or abuse alcohol. With regard to the use/dependence of illegal substances, the prevalence rates are higher, ranging from 10% to 48% of the male population and 30% to 60% of the female population on entry into prison (Fazel, Bains & Doll, 2006; Fazel & Seewald, 2012). Studies conducted in 15 European countries since 2000 show that between 2% and 56% of detainees have used substances during detention (EMCDDA, 2001). Cannabis is used most frequently, followed by cocaine and heroin (Bullock, 2003). The reciprocal relationship between substance use and involvement in criminal acts has been frequently described in literature (Belenko, Hiller & Hamilton, 2013; Bennett, Holloway & Farrington, 2008; Esbec & Echeburua, 2016; Martin O'Connell, Paternoster & Bachman, 2011). 17% of European prisoners are held in detention for committing crimes related to drug use, drug possession or drug dealing (Aebi & Del Grande, 2013). Furthermore, prisoners who use alcohol or drugs on a regular basis seem to be at greater risk to reoffend and to relapse into substance abuse (Belenko, 2006; Cartier, Farabee & Prendergast, 2006).

1.2. Drug counselling and treatment in European prisons

Detained people often suffer from a great complexity of health or psychological difficulties (Rutherford & Duggan, 2009). Addressing these diverse and often intertwined needs is recognized as a priority within the European Union (EMCDDA, 2012). Substance abuse treatment for detainees may reduce drug use as well as recidivism (Enggist et al., 2014). In 2012 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) presented an overview on available substance abuse treatment in European prisons. This overview made a distinction between interventions focusing on

the reduction of drug use, harm reduction interventions and interventions with a focus on linking with the community.

Interventions focusing on the reduction of drug use include prison-based therapeutic communities, substitution and detoxification interventions, drug-free units and self-help groups. These interventions appear to have positive effects on recidivism and drug use, but are implemented only to a limited extent (Belenko, Hiller & Hamilton, 2013; Galassi, and Mpofu Athanasou, 2015). Harm reduction interventions, including vaccinations, are provided in various prisons, both proactively as well as on request of the detainee. However, disinfectants to 'cleanse' needles are often not present in European prisons and needle exchange within prison is only available in a few countries (EMCDDA, 2012).

Furthermore, in several European prisons, throughcare initiatives are implemented. These initiatives focus on the continuity of care and support between prison and the community and vice versa (MacDonald, Williams & Kane, 2012, 2013). Fox et al (2005, p. 1) describe throughcare as: *“Arrangements for managing the continuity of care which begin at an offender’s first point of contact with the criminal justice system through custody, court, sentence, and beyond into resettlement.”* EMCDDA (2012, p. 23) emphasizes *“the importance of establishing a liaison between prison and community-based programmes in order to achieve continuity of treatment and longer-term benefits”*. The availability of throughcare is reported to lead to less relapse into drug abuse or criminal offenses among former detainees (Stöver, Weilandt, Zurhold, Hartwig & Thane, 2008; Belenko, Hiller & Hamilton, 2013). The UNODC (2008) states that aftercare is basically the last element in effective throughcare. Aftercare is described as a rehabilitation or reintegration scheme which actively supports prisoners after their release from prison (UNODC, 2008). Fox et al. (2005, p. 1) describe aftercare as: *“(…) a package of support that needs to be in place after a drug-misusing offender reaches the end of a prison-based treatment programme, completes a community sentence or leaves treatment.”*

Internationally, through- and aftercare interventions range from specific units with a focus on reintegration (Cox, 2013; Powis, Walton and Randhawa, 2014; Lloyd, Russell & Liebling, 2014), over the continuation of therapy or aftercare after release (Torrens & Ruiz, 2015) to the intensive involvement of family members (EMCDDA, 2001). In addition, peer support is well established in prisons in England and Wales and peer-based interventions appear to be effective in reducing risk behaviour and improve the mental health of the participating detainees (Bagnall, et al., 2015). The exemplary role of as well as the incentive provided by peers prove to be essential in the initiation of commitment and the continuation of participation (Humphreys & Lembke, 2014). The peer-based intervention *‘listener schemes’* relies on experts by experience. Detainees are trained as 'listeners' who give emotional support to fellow prisoners (Jaffe, 2012). Experts by experience offer a great value as they can detect and understand factors that foster or hinder the recovery process in a fast and thorough manner, based on their own experiences (Erp, Boertien, Scholtens & Rooijen, 2011; Weerman, 2013).

1.3. The Belgian context

Belgian prisons cope with a large number of detainees with substance abuse problems. About two-thirds of the detainees used an illegal product during their lifetime. One third of them, indicate to have used an illegal product during detention and 11.7% reported to have used an illegal product for the first time during imprisonment in a penitentiary setting (EMCDDA, 2012; Van Malderen, 2012). Within the Belgian prisons, a number of initiatives are available to reduce drug use and their negative

effects (Permanente Coördinatie Algemene Cel Drugsbeleid, 2010; Van Malderen, 2012). For example, since 2006 detainees with an opiate addiction can follow substitution treatment with methadone or buprenorphine. However, in some prisons this form of treatment only consists of detoxification and is rarely offered in terms of maintenance (Vander Laenen et al., 2013).

In addition, several Walloon prisons set up prevention projects, including 'Boule de Neige', 'Détenus Contact Santé' and 'Prévenez-vous', where detainees are trained on the prevention of risks associated with drug use. Besides prevention-focused interventions, a few interventions in Belgium focus on supporting detainees during the detention period. Since 1995, for example, the 'B.Leave' program, aimed at prisoners convicted for drug offenses or for prisoners who have substance abuse problems, is organized in the prison of Ruselede. The 'Schakels' ("Links") programme was developed complementary to the 'B.Leave' programme and focuses on relapse prevention and social skills training (Van Luchene, 2013). In addition, since 2009, a drug-free wing 'D-side' and since 2012 a 'Short-term drug programme for drug using detainees' is available in the penitentiary complex of Bruges. In the prison of Hasselt, a drug free wing was initiated in 2015 (Vereniging Geestelijke Gezondheidszorg Limburg vzw, 2016).

Since 2011, Central Registration Points (CRPs) for drug users were developed in all Flemish, Brussels and Walloon prisons. For Flanders, the 'Centraal Aanmeldingspunt voor drugs (CAP)' was organized from 1 March 2011 onwards in 14 Flemish prisons by the 'Vlaamse Vereniging Behandelingscentra Verslaafdenzorg (VVBV)' on behalf of the Federal Public Service of Justice, department of Healthcare. By the end of 2011, registration points were also initiated in Brussels (Le Prisme) and Walloon prisons (Step by Step). The CRPs started from the need that detained people experience difficulties in linking with (substance abuse) treatment services at the time of and after release. From a throughcare perspective, the CRPs engage in continuity of care and support between prison and the community. CRP-staff members are treatment providers, who perform a liaison function between the prison and substance abuse treatment outside prison. They support incarcerated offenders with a substance abuse problem in finding adequate treatment after detention. Through individual conversations, at fixed times in prison, the following objectives were pursued: (1) providing information about treatment services; (2) increasing clients' motivation and readiness for counselling or treatment; and (3) referring clients to as well as establishing contact with treatment services in the community.

Since 2011, the Federal Public Service of Justice funded the functioning of the registration points. With the 'communitarisation' of substance abuse treatment services, the CRPs were not transferred to the communities. As a consequence, the Federal Public Service of Justice could not further provide funding and a negative advice of the financial inspection about funding led to the cessation of the registration points. The activities of the CAP were ended on 1 May 2016 and the activities of Step by Step and Le Prisme were terminated in September 2016, due to the lack of funding.

1.4. Gap in the (drug) treatment in Belgian prisons

Despite the development of several initiatives that focus on (substance abuse) treatment for detainees, current treatment only reaches a small number of detained people. Furthermore, the available care services in Belgian prisons are not always sufficiently aligned and continuity of care is often inadequately addressed (De Pauw, De Valck & Vander Laenen, 2009; Favril & Vander Laenen, 2013;

Kazadi Tshikala & Vander Laenen, 2015; Vander Laenen, 2015a; Vanhex, Vandevelde, Stas & Vander Laenen, 2014; Memorandum Zorg en Detentie, 2014). The report of the WHO (2014) indicates that the current provision of prevention, treatment and harm reduction interventions in EU member states prisons is inadequate as compared with community care initiatives developed over the last 30 years (Galea, Enggist, Udesen & Møller, 2014). Until today, international and Belgian through- and aftercare initiatives are insufficiently implemented and aligned with the specific needs of the prison population (MacDonald, Williams & Kane, 2012).

With the recent cessation of the CAP, Le Prisme and Step by Step, a comprehensive (substance abuse) treatment offer for detainees seems to be moving further away. The EU Drugs Strategy (2013-2020) however explicitly states that attention should be given to strengthening and expanding quality care for drug users in prisons, to a level of care which is equivalent to what is offered in the community. The Basic Law of 12 January 2005 concerning the prison system and the legal position of detainees (B.S. 1 February 2005; hereinafter referred to as Basic Law) and the recent recommendations of the UN General Assembly (2016, p13-14) are also clear: *“Ensure non-discriminatory access to health, care and social services in prevention, primary care and treatment programmes, including those offered to persons in prison or pre-trial detention, which are to be on a level equal to those available in the community.”*

2. Methodology

The research project addressed the evaluation and practice of the Central Registration Points (CRPs) in the Flemish, Brussels and Walloon prisons. Up until now, no scientific evaluation of the CRPs has been performed. The following three objectives were tackled:

1. To investigate how the CRPs operate and what the effects are on the trajectories of incarcerated drug users.
2. To document how the CRPs are perceived by different involved stakeholders in terms of functioning, strengths and limitations and future challenges and opportunities.
3. To formulate policy recommendations with regard to the further continuation, expansion and/or modification of the CRPs.

This project consisted of six work packages (WP's) and used a multi-method approach.

WP1 (chapter 1) provides an (inter)national literature review on the availability of care and throughcare initiatives for detained people with substance abuse problems. A secondary analysis of the databases of the CRPs was performed to map the current CRPs practice and to analyse referral trajectories.

WP2 (chapter 3) assesses the relation between different variables (including whether or not support by CRPs was provided) and three recidivism indicators (new criminal record at the level of the prosecutor's office, reconvictions in the 'Centraal Strafrechtregister' and re-incarceration). Using multivariate analyses these indicators were compared within two groups of ex-prisoners drawn from the CRP datasets.

WP3 (chapter 4) describes the results of a qualitative study on the stakeholders' perceptions with regard to the functioning of CRPs. By means of individual interviews, the added value as well as possibly limiting factors with regard to the activities of the CRPs were analysed, also focusing on

potential recommendations for further improvement. Four respondent groups were interviewed: (1) CRP-staff members; (2) staff members from community treatment services that regularly treat CRP-clients; (3) staff members from the justice field that have regular contact with CRP-clients and, in Flanders, staff members from Judicial Social Welfare (JSW, 'Justitieel Welzijnswerk'); and (4) CRP-clients. The interviews were analysed by means of the qualitative software package NVivo.

In WP4 (chapter 2) three standardized registration forms and one follow-up questionnaire, administered by means of interview by phone, were developed. Using a prospective study design, characteristics from newly admitted clients were registered by means of the intake registration forms, mentioned above. These clients were contacted by phone after six months, in order to gain insight into their current psychosocial functioning and the effects of CRPs on their current support or treatment. In addition, the tasks of the CRP-staff members were objectified by means of a client-specific and client-transcending registration form.

WP5 (chapter 5) focused on the development and implementation of a motivational group-based short duration programme 'DRUGS de baas?!' for incarcerated offenders with a substance abuse problem, organized in the prison of Ghent. A feasibility study was conducted concerning the implementation of this programme and the perceptions of different stakeholders were studied. These included (1) the CRP-staff members; (2) staff members from community treatment services that regularly treat CRP-clients; (3) judicial staff members who regularly are in contact with contact with CRP-clients; (4) and CRP-clients who have followed the program.

WP6 integrated the results from the WP's mentioned above. The following topics were addressed: (1) the added value of the CRPs in terms of treatment-related indicators and recidivism; (2) process evaluation based on the perceptions of important stakeholders focusing on strengths, potential pitfalls and future challenges and opportunities; and (3) practice and policy recommendations with regard to the further continuation, expansion and/or modification of the CRPs (WP6).

WP1, WP4 and WP5 were conducted by Ghent University. WP2 was carried out by the NICC and WP3 and WP6 were tackled by both research groups.

3. Conclusions

The conclusions are structured on the basis of the main objectives of the CRPs: (1) providing information about available (substance abuse) treatment services; (2) increasing the motivation and readiness for counselling or treatment; and (3) making contact with and referring to (substance abuse) treatment services. Throughout the study a fourth key objective became clear: signalling, which will be discussed later in this summary.

3.1. Inform: Reached Number of clients and client profile (WP1)

Providing information about available treatment was the first main objective of the CRPs. WP1 revealed that 2182 clients registered for an appointment with one of the CRP-staff members in 2014 (reference year of the study) in Brussels, Wallonia and Flanders. Of these clients, 80.2% had one or more (intake) interview(s). In the years registered (2012-2014), the number of clients that were seen each year remained fairly stable. The Belgian prison population systematically increased within the same period (as the prison population in 2012 increased to 11107 people, in 2013 to 11732 people and in 2014 to 11769 people) (Federal Public Service of Justice, 2016; Statistics Belgium 2015). This

increase was not compensated by an increase in the number of staff members, leading to a significant number of clients (19.8%) who were not seen by CRP-staff members partly due to the waiting time between the time of the registration and the first conversation.

By means of a secondary analysis of available CRP databases, the client profile was analysed. The majority of the clients were between 20 and 35 years old and male. The CRPs appeared to reach a slightly older group and more female prisoners as compared to the general prison population. 78% of the CRP-clients had the Belgian nationality, which is significantly higher than the general prison population (Federal Public Service of Justice, 2015). This may point to difficulties in reaching people with a non-Belgian nationality. The figures of convicted and accused clients were similar across the three registration points (CAP, Le Prisme, and Step by Step). On average, 47.4% was convicted and 46.3% was in remand. The CRPs reached proportionately more defendants and less convicted detainees as compared to the number of defendants and convicted detainees in prison in 2014 (Federal Public Service of Justice, 2015). This finding could be explained by the fact that the participation of the defendant in (substance abuse) treatment can be one of the requirements for a conditional release. In addition, the CRPs reached less internees in comparison with the proportion of internees throughout the prison population (Federal Public Service of Justice, 2015). With regard to the substances that were abused, opiates (both heroin and substitution medication) and alcohol were the most frequently mentioned main products. Also the abuse of cannabis was frequently cited. Amphetamines were mentioned noticeably more at CAP compared with Step by Step and Le Prisme. It is unclear what caused this difference.

3.2. Motivation: What facilitates and impedes the motivation and readiness for treatment? (WP3, WP5)

The CRPs aimed at improving clients' motivation and readiness for treatment. Based on the findings of WP3 and WP5 factors that facilitate or impede motivation were mapped.

The participants (WP3) indicated the CRP-staff members' independent positioning as a strength, as it facilitated a neutral perspective towards clients. From this perspective, CRP-staff members kept focusing on the positive aspects and the capabilities of clients. Subsequently, the CRP-staff members' professional secrecy was experienced as a necessity by various actors. Also clients indicated that the professional secrecy reinforced their confidence in the CRP-staff members. It facilitated open and free communication, which improved the accessibility of the CRPs. In addition, the CRP-clients attached great importance to the personal approach of the staff members. The clients mainly appreciated the caring and emotional support. The empathic, non-intrusive and unprejudiced attitude and practice increased their motivation to start with (substance abuse) treatment.

In addition, treatment providers indicated that the waiting period between the decision for registration by the client, the first conversation and the start of the counselling or treatment negatively impacted the clients' motivation to participate in treatment or counselling. Some clients referred to the waiting period until the first conversation with a CRP-staff member as a motivation-obstructive factor (WP3). A decrease in motivation for treatment also turned out to be associated with a reduced participation in various forms of treatment in another study on the drug treatment court (DTC) (Dekkers & Vanderplasschen, 2013; Vander Laenen et al., 2013; Evans, Li & Hser, 2009).

The results of qualitative interviews with the participants of the short-term motivation programme in prison 'DRUGS de baas?!' (WP5), a programme that was carried out by 'de Kiem vzw' as part of the study, indicated that reasons to participate were very diverse. Doing well for family members, the prospect of a drug free life, and the possibility of parole were formulated as main reasons. A wide variety of topics from the programme were experienced as meaningful, which illustrated the importance of a differentiated offer. The evaluation showed that explicit attention should also be paid to alcohol use and abuse. Interventions aimed at alcohol abuse among detainees are reported to contribute to the reduction of alcohol-and health problems and to reduce recidivism (Galea, Enggist, Udesen & Møller, 2014). The unbiased attitude, professional secrecy and independent positioning of the supervisors also turned out to be essential conditions in order to speak freely during the program. In the majority of the participants, 'DRUGS de baas?!' appeared to affect the readiness to change in a positive way. Being able to share experiences, getting advice on dealing with craving and mutual reflection on possible solutions concerning drug-related problems were perceived as the main strengths of the program. The pursuit of abstinence was not a prerequisite for participation. This promoted, according to the participants, the accessibility of the program. These results showed positive effects of the programme in a detention context. However, the findings should be interpreted with caution given the small sample size.

3.3. Referral: Number of referrals and factors that facilitate or impede referral (WP1, WP3, WP4)

The third main objective aimed to refer clients and to establish contact with substance abuse treatment services in the community. Information relating to the clients' trajectories within (substance abuse) treatment after referral was only available for CAP in Flanders.

Based on WP1, the results indicate that 4807 clients registered at the CAP from 2011 to 2014. 80.4% of the clients were seen by a CAP-staff member and 43% of those who were seen were referred to treatment. More than half of the referred clients started with the counselling or treatment that they were referred to. Nearly half of these clients completed the counselling or treatment in accordance to the treatment goals or were still in counselling/treatment at the time of the survey.

In total 657 clients registered at Le Prisme between 2012 and 2014, for 82.5% of these clients an intake was organized. The database from Le Prisme showed that all registered clients in 2014 were referred to treatment.

From 2012 to 2014, Step by Step received a total number of 1570 registrations, of which 93.3% were seen by a staff member and of which 87.5% were referred. Nearly a quarter of the clients was simultaneously oriented to multiple services. A comparison between CAP, Step by Step and Le Prisme showed a difference in the number of referrals. Besides the fact that Step by Step referred to multiple services, this difference could be explained by a different interpretation of the term 'referral'. CAP only registered a client as referred when an "attestation" for counselling or treatment was obtained. For Le Prisme and Step by Step an attestation for counselling or treatment is not a prerequisite in order to register a client as referred. It is deemed sufficient that the client received information concerning the referral and that the contact with a treatment service is initiated.

The majority of clients were referred to outpatient drug-specific treatment services. A significant number of clients in Flanders and Wallonia were also referred to mental health care services ('GGZ',

both outpatient and residential). Residential drug-specific treatment centres were mentioned as the third most prevalent category to which clients were referred.

Results from WP3 and WP4 indicated several aspects that facilitate or impede the referral to (substance abuse) treatment. The CRP-staff members' extensive expertise and experience about substance use treatment and the organization of (substance abuse) treatment services turned out to facilitate the access to and cooperation with (substance abuse) treatment services. The participants considered this as an important link with reintegration. The staff members' familiarity with (substance abuse) treatment services also facilitated a fluent referral since mutual confidence was already installed. The waiting period between the registration and the first conversation with a CRP-staff member complicated a smooth referral. Also consensus on the function, job content and mandate of the CRPs seemed to be of great importance for a smooth referral and communication between all actors involved. According to the central psychosocial service (PSS), Step by Step experienced an additional challenge as there are no structural agreements with external services that offer services inside prison in Wallonia. Furthermore, several actors from the three CRPs indicated a certain degree of resistance and prejudice with some treatment providers concerning counselling or treatment of detained people with substance abuse problems (WP3). Furthermore, the unavailability of (substance abuse) treatment services was mentioned as an additional difficulty to initiate the most appropriate (substance abuse) treatment.

3.4. Signalling as a fourth additional main objective (WP2, WP4)

The development of standardized registration forms (WP4) made clear that the CRPs fulfilled an important role in signalling. The systematic registration carried out in WP4 enabled comparison of the CRPs, which pointed towards barriers and possible exclusion criteria in the range of available treatment services. This study identified difficulties regarding referral because of limited availability of care services, differences in the expectations of the involved actors about the most appropriate form of care and the willingness of care providers to counsel or threaten people with a judicial status. A challenging referral was also observed among the referral of drug users with additional psychiatric problems, which is consistent with previous research findings concerning persons with dual diagnosis (see e.g. Vandeveldel et al., 2015).

A mutual intake registration form was developed for the three CRPs (WP4). The CRP-staff members reported to experience it as useful, clear, logical and user-friendly. Based on the feedback by the staff members and care providers, some optional open questions and more space for additional information were added. The form was also further aligned with the Treatment Demand Indicators (TDI) (see below) by adding new questions (see Annex 1 'Adjusted Intake Registration form Dutch' and Annex 2 'Adjusted Intake Registration form French').

Furthermore, the standardization revealed some differences in the client profile in comparison with the registration figures from WP1. This emphasizes the importance of using a standardized registration procedure. Clients seemed to experience difficulties in various life domains, next to difficulties concerning substance abuse: physical and mental health, labour, family and social relationships, financial situation and justice. This complexity underscores the importance of care and support focusing on multiple life domains, also after detention. Another important finding showed that one-third of the clients never attended an outpatient or residential service for substance abuse problems in

the past. This illustrates that the CRPs managed to reach a group of clients who were not previously reached by (substance abuse) treatment services.

In addition to the development of a standardized intake registration form, a follow-up registration was conducted. Clients were followed up with regard to referral and admission to treatment, treatment participation and other indicators (e.g. treatment engagement, health and psychosocial functioning) (WP4). The number of completed registrations, however, was limited¹.

The survey by phone, six months after the first contact with a CRP-staff member, also showed the difficulty of systematic registration and monitoring. Although the results should be interpreted with caution because of the limited response, the survey indicated that clients reported a high satisfaction with regard to the practice of the CRPs. These high levels of satisfaction seem to be related to: fluent referrals; the quickly and clearly answering of questions; the experience that the client's choice was taken into account; and the motivational and supporting approach of CRP-staff members.

The importance of the signalling function of the CRPs also became clear in WP2, as the registered recidivism figures were in line with (inter)national research (Robert, Mine & Maes, 2015 ; Mine, Robert & Maes, 2015; Belenko, 2006; De Wree, De Ruyver & Pauwels, 2009; De Wree, Pauwels, Colman & De Ruyver, 2009; Gossop, Trakada, Stewart & Witton, 2005). Concerning (ex-)detained drug users (n= 2758) following recidivism figures were observed: 75,7% committed a new offence based on registration at the level of the prosecutor's office within a maximum period of 4 years and 9 months after their release (regardless of the offence committed and orientation which was eventually given); 39,7% had a new conviction record within this time frame (regardless of the offence committed and the later pronounced punishment or measure); 40,4% was re-incarcerated after release (on electronic surveillance or on one of the various specific forms of 'release') within a maximum period of 3 years and 9 months (regardless of the reason for re-incarceration: non-compliance with conditions, committing new offenses). The first (three) months after release appeared to be associated with a higher intensity of recidivism (in terms of a new, at the prosecutor's office notified, case and re-imprisonment). For example, approximately 30% of the recidivists were back in prison within 3 months after release.

The (bivariate) analyses showed a statistically significant difference regarding the recidivism indicator 're-imprisonment' between detainees seen by the CRPs and detainees who made a notification but had no conversation with a CRP-staff member. Detainees seen by the CRP had a higher rate and intensity of recidivism in comparison with detainees who were not seen. This difference was not observed for the other indicators (new criminal charges and new conviction record). The higher measure of re-imprisonment and recidivism intensity could be explained through the presence of penitentiary antecedents, as this correlation was no longer significant when the number of previous convictions was taken into account. Further analyses seemed to confirm this hypothesis; both penitentiary antecedents and age had a significant impact on recidivism, regardless of the indicator used.

These findings are consistent with the results of the DTC-research (De Keulenaer, Thomaes, Wittouck & Vander Laenen, 2015). DTC-clients were characterized by more criminal antecedents, a longer criminal career, a longer duration of detentions and more heroin use when compared with the

¹ Different explanations may account for this: the limited time in which the forms had to be filled out; the mandate of the CRP-staff members ending at the time of referral; and the difficult working conditions in view of the imminent closure of the CRPs at the time of the study. Furthermore, some treatment providers referred to the professional secrecy as a reason not to share treatment-related information.

probation group. These characteristics correspond to a profile with a higher risk of recidivism (Noppe et al, 2011; De Ruyver et al., 2007). The study conducted by De Ruyver et al. (2007) indicated that being male, aged under 25, heroin use, frequent (more than monthly) use and a criminal record are significant recidivism predictors in drug users.

Results from WP2 also showed that the type of release from prison and the judicial statute at the time of the opening of the dossier had a significant impact on recidivism (in terms of re-imprisonment). Those who leave prison on electronic surveillance or on conditions, had a greater risk of re-incarceration than those who are exempt from conditions. Detainees with a judicial statute within the category 'other' (including a large number of interneers, see chapter 3 figure 3) also had a higher risk of ending up back in prison compared to definitive convicts. Conversely, for the other indicators (new criminal charges or a new criminal record) it appeared that those who left prison on condition were less likely to have a new criminal charge or a new criminal record in comparison with detainees who left prison without conditions. This finding seems to confirm the hypothesis that those who leave prison with conditions are more likely to end up back in prison, since re-incarceration in many cases seemed to be related with the breach of judicial conditions instead of committing new offences². Contrary to what was observed for the first indicator, the results also show that whoever was definitively convicted at the time of release, had a greater chance of a new criminal charge or a new criminal record than those who left prison under another judicial status.

There was no information available regarding clients' care trajectories after referral, which can be seen as a shortage in the recidivism measure. As such, no comparison could be made between the group who was referred and initiated treatment ("successful referral") and the group who was not.

It should be noted that reducing recidivism was not an objective of the CRP-staff members. Their interventions could, at best, indirectly contribute to recidivism reduction, but recidivism figures are not a benchmark to assess the effectiveness of the interventions of the CRPs. Indeed, the recidivism risk could be influenced by several factors beyond the control of CRPs, such as the work situation, support from social network, living situation and mental health (De Ruyver et al., 2007; Somers et al, 2014). These factors were not included in the registration in WP2, because these data were not available. The reported recidivism figures should therefore be interpreted with caution.

The time invested by CRP-staff members with regard to preparing and completing client-specific and client-transcending activities was objectified by means of a client-specific and client-transcending registration form (WP4). This registration showed that the tasks of staff members involved more than only client-specific activities, including conversations with clients (20-32% of working time) and client-supporting activities, including consultations/meetings about clients, administration and preparing and monitoring client files (38-40% of working time) (Figure 1).

A significant part of the working time was registered as client-transcending activities such as trainings and seminars, team meetings, drafting year/activity reports (12-51%) and other activities (9-18%) which are specific for working in a detention context and which cannot be directly linked to individual clients: transfer to prison, checking in and out of prison, waiting for clients before a conversation,...

² Re-incarceration rates explained by committing new facts or by violating conditions were not registered.

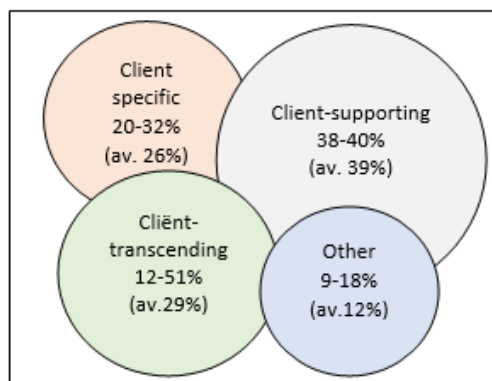


Figure 1: Overview of the tasks of CRP-staff members³

3.5. The value of a specialized registration point in prison was recognized by all stakeholders (WP1-WP5)

The results of the different work packages (WP1-WP5) pointed towards the added value of CRPs for drug users in prison. All interviewed actors, including those of justice, (substance abuse) treatment and welfare services, and clients (WP3) emphasized the added value of the CRPs in terms of informing, motivating and referring prisoners with a substance abuse problem.

Clients reported an overall high satisfaction concerning the CRPs practice, since they felt understood and experienced support and new opportunities. In addition, clients indicated that the CRPs increased their motivation to start with (substance abuse) treatment. Care providers, on their part, stressed the beneficial collaboration with CRP-staff members in terms of a smooth referral. Judicial actors and welfare service providers emphasized the added value of the staff members' attitude, focusing on positive client characteristics and strengths and the belief in a possible referral (WP3). Following elements were mentioned by the different actors:

- The expertise and experience of the CRP-staff members with regard to substance use and with regard to substance abuse treatment services
- The professional secrecy and independent positioning of staff members
- The client-oriented, motivational and unprejudiced attitude of staff members
- The accessible and non-intrusive approach of staff members
- The close, honest and confidential cooperation with (substance abuse) treatment services
- A shared vision and openness to dialogue with (substance abuse) treatment services.

The long waiting period until the first conversation with a staff member was mentioned as an area for improvement by some clients (WP3). Because of the waiting period not all clients who registered had an initial conversation with a CRP-staff member. All three CRPs mentioned the fact that clients were already released before a first conversation could take place, as the main reason why clients were not seen. The low accessibility of detainees with a non-Belgian nationality could also be regarded as an area for improvement. To reach foreign-language detainees they must have access to information regarding available care in a language they understand (Brosens, De Donder, Dury & Verté, 2015).

³ The reported averages (av.) should be interpreted with caution due to missing values (e.g. report 2.3.3.) and since the calculation of averages was not proportionally weighted in relation to the number of staff members at each of the CRPs.

3.6. Essential preconditions for optimal functioning of the registration points (WP2-WP5)

The results from the different work packages revealed a number of preconditions, which were essential to promote the clients' motivation for counselling or treatment and to facilitate the orientation and referral to (substance abuse) treatment services. Essential preconditions to safeguard and to further consolidate a high quality practice, according to the interviewed actors, included:

- An adequate number of staff members and resources
- Consensus about the function, job content and mandate of the CRPs
- Systematic disclosure about the existence and functioning of the CRPs to all new detainees and stakeholders inside and outside prison
- Easy access to detainees in prison
- The provision of a telephone and/or computer for CRP-staff members during waiting periods and/or in meeting areas in prison
- An increased willingness and availability of external (substance abuse) treatment services to consult with or treat detainees
- The further expansion of consultation and treatment options for specific target groups (women, clients on electronic surveillance, foreign-language speakers, people with a non-Belgian nationality) and people with additional problems (intellectual disability, psychiatric disorder).

3.7. Research on the practice and continuation of the CRPs for incarcerated drug users

A survey carried out by the policy coordinators of the Flemish Government (2016) amongst 'JSW' from 'Centra Algemeen Welzijnswerk', 'Psychosocial Service' (PSS, 'Psychosociale dienst'), 'Centra voor Geestelijke Gezondheidszorg (CGG)' and substance abuse treatment services on the effect of the discontinuation of the CAP in daily practice showed a high number of difficulties. This survey was only conducted in Flanders, so no statements about the possible impact of the termination of the registration points in Wallonia and Brussels can be made on basis of this survey.

The respondents indicated that clear guidelines or agreements concerning registration and referral procedures and associated responsibilities are no longer available. Some of the former CAP-tasks are currently taken over by the 'PSS', 'CGG' or (substance abuse) treatment services, which results in an increased workload. These tasks, however, are only carried out for convicted detainees. This is not the case for defendants, which leads to a hiatus for this group. To date, care givers and prisoners can no longer rely on the extensive expertise and experience of the CRP-staff members with regard to substance use and with regard to (substance abuse) treatment services. According to respondents, this leads to delayed referrals and an increased number of refusals from (substance abuse) treatment services. Also the lack of an independent and external positioning, which was seen as an important strength of the CRPs, is perceived as an important shortcoming in the current practice.

4. Recommendations for practice and policy

These findings point out the value and importance of the CRPs regarding the three previously mentioned objectives ((1) providing information about treatment services; (2) increasing clients' motivation and readiness for counselling or treatment; and (3) referring clients to as well as establishing contact with treatment services in the community) for which they were established. The continuation and preferably expansion of the CRPs practice is therefore recommended. Based on the research findings two matters seem to be of paramount importance in the successful CRPs practice: the professional secrecy and specific expertise on (substance abuse) treatment. Given the complex situation of drug users in prison an independent positioning and categorical assistance with drug specific expertise is essential.

This section focuses on concrete recommendations based on the research findings and (inter)national literature. First, these recommendations are presented within the legislation and current policy context. Subsequently, the recommendations will be discussed on various levels: disclosure; actual practice; collaboration and networking; policy. At the level of the actual practice of the CRPs, an additional classification is made in line with the main objectives of the CRPs. Depending on the encountered importance of continuity of care a further key objective is described: case management. Finally, specific policy recommendations are formulated in terms of integrated care provision, aftercare and follow-up (Figure 2).

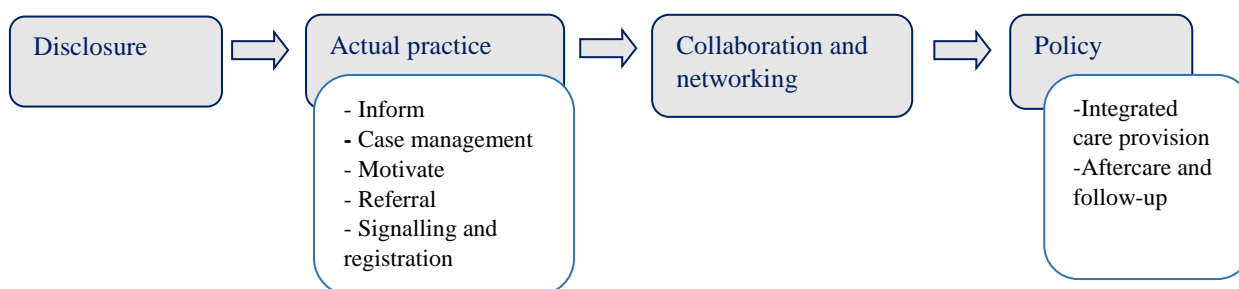


Figure 2: Summary of recommendations for practice and policy

4.1. Legislation and current policy context

Basic law

Currently an inclusive and qualitative (substance abuse) treatment offer for detained drugs users is lacking in Belgian prisons; a fact that has been referred to and criticised multiple times in the literature (Favril & Vander Laenen, 2013; Kazadi Tshikala & Vander Laenen, 2015; Vander Laenen, 2015a; Vanhex, Vandeveld, Stas & Vander Laenen, 2014; Memorandum Zorg en Detentie, 2014). The need for a better organisation of (substance abuse) treatment in prison has also been acknowledged in the policy note for social issues and healthcare of the federal minister of Public Health (Belgische Kamer Van Volksvertegenwoordigers, 2015).⁴

⁴ This note reports that the results of a study for the Federal Resource Centre for Healthcare on (the financing of) penitentiary healthcare shall be awaited (expected at the end of 2016), and that until then, public health authorities 'will not take any further steps' (Belgische Kamer van Volksvertegenwoordigers, 2015: 56).

The Basic Law explicitly determines the right to healthcare in detention and care equality between the community and the prison context. This care should be adjusted to the needs of the detainee (Art. 88 Basic Law). Today, interventions in prisons in EU member states still do not observe the principle of equality as described in international recommendations by the United Nations General Assembly, UNAIDS/WHO and UNODC (Galea, Enggist, Udesen & Møller, 2014; Stöver, 2006). The individual detention plan (Art. 35-40 Basic Law) can be a significant contribution to a meaningful interpretation of the detention trajectory. With the recent cessation of the CRPs, the inequality of healthcare to detainees with substance abuse problems only grows. Within this matter, the implementation of these articles for incarcerated drug users is strongly advised (Snacken, 2015).⁵

Communitarisation

Following the sixth state reform of 11 October 2011, a number of authorisations concerning (substance abuse) treatment were transferred from the federal level to the communities. The institutional agreement determines that rehabilitation agreements for addicts and parts of the 'GGZ'⁶ (mental health care) are now the responsibility of the communities (Federal Government, 2011).

Since 2011, the Federal Public Service of Justice financed the operation of the CRPs. However, during the communitarisation of (substance abuse) treatment, the CRPs for drugs users were not transferred to the communities. The Federal Public Service of Justice reported that they would be unable to further arrange the financial matters, and a negative advice of the financial inspection concerning the further financing led to the cessation of the CRPs. On 1 May 2016 the CAP practice was dissolved, and in September of 2016 the cessation of Step by Step and Le Prisme followed, as its financing ended. Restarting the CRPs will require some extensive arrangements between Justice, Public Healthcare and the communities. Clear agreements should be made concerning responsibilities, as well as on the matter of financing. Pilot projects of which the added value was proven after a thorough academic evaluation should be financed structurally and projects with no real value should be cancelled (Vander Laenen, 2016). Jo Vandeurzen, the Flemish minister of Wellbeing, Public Healthcare and Family, already stated that as of 2017 the CAP financing will be the responsibility of the Flemish authority for support and services to detainees (Vlaams minister van Welzijn, Volksgezondheid en Gezin, 2016). Regarding the further financing of Le Prisme and Step By Step, there was no clarity yet at the end of November 2016 .

Continuity

The European Union Drugs Strategy (2013-2020), the UNGASS resolution (2016) and the recommendations of the WHO (2014) explicitly suggest that special consideration should be given to strengthening and expanding high-quality and continuity of care for drugs users in prisons, in order to reach a care level equal to what is being offered in the community. Employing a permanent CRP-staff member for each prison may contribute to this. In addition, continuity of care improves the confidential relation between staff members and clients, as well as between staff members and care

⁵ The sole exception is art. 98 Royal Decree of 12 December 2005 on the determination of the date of implementation of article 98 of the Basic Law of 12 January 2005 concerning the prison system and the legal position of detainees and concerning the arrangement of the composition, the authorisations and the operation of the Penitentiary Healthcare Council, B.S. 29 December 2005.

⁶ Mainly the meeting platforms of mental healthcare, the mental healthcare clinics and the initiatives for sheltered living.

providers. Furthermore, a wider availability of staff members could also improve the continuity of care.

The most important reason why clients were not seen by the CRPs, is that the client had been released from prison by the time the first meeting could be arranged. Therefore, in the future, waiting times should be reduced in order to refer more clients to (drug)treatment services. With more available staff, more clients could be reached and more intensive trajectories could be carried out with clients who have more complex needs. A higher intensity support could improve their motivation to start with counselling or treatment (Vander Laenen et al., 2013). Additionally, there should always be enough time and space for meetings with various partners of justice, welfare services and (substance abuse) treatment services. The expansion of the mandate of CRP-staff members, to a form of case management, could ensure that the trajectories can be monitored and evaluated after detention.

4.2. Recommendations regarding disclosure

A clearly delineated and transparent task description and systematically organized information or introduction moments for all actors involved can lead to a greater disclosure of the CRPs among detainees. This should be realised with utmost care for the relation to the detention context. In this regard, leaflets, video or service memoranda on practice procedures and cooperation with other services could be used as communication tools. These tools should be short, clear, and developed with attention to foreign-language detainees (MacDonald et al., 2012). Disclosure should be realised both inside (e.g. medical staff, penitentiary surveillance assistants,...) and outside prison (e.g. lawyers, judges,...). As such, it is recommended that regular services outside (substance abuse) treatment, including the ‘Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding (VDAB)’ and the ‘Public Centre for Social Welfare (‘OCMW’), are familiar with the CRPs practice.

4.3. Recommendations regarding the actual practice

Inform

In order to organize constructive information distribution and transfer, good cooperation structures between various services – inside prison and between services inside and outside prison – are required. This is closely linked to an efficient exchange of data. Sufficient time should go out to communication between services, as well as to the clarification of roles, expectations and responsibilities (MacDonald et al., 2012).

CRP-staff members and external care providers can exchange information in the framework of their shared professional secrecy, if this information is required for the quality or continuity of care and if the client has been informed properly on the aim and the content of this exchange and gave his/her permission (Vander Laenen & Stas, 2015). However, judicial actors operate within a different professional secrecy. Therefore there is no shared professional secrecy with care providers (Van der Straete & Put, 2005). These differences between judicial and non-judicial actors do not form a barrier for proper cooperation as long as clear agreements are made on information exchange in regard to the professional secrecy of care providers (Vander Laenen & Vanderplasschen, 2012; Colman, Vander

Laenen & De Ruyver, 2010)⁷. As such, it is important that the judicial actor clearly explains his/her role towards the client and that clear agreements are made both on the client-specific and client-transcending level (Vander Laenen, 2013).

Furthermore, the creation of a common database or horizontal communication process between CRP-staff members and care providers offers the opportunity to increase the quality and efficiency of cooperation. Naturally, the access to this database should be adjusted to the legislation on privacy and professional secrecy. Duplication of effort by both CRP-staff members and care providers in the context of registration and identifications of client-specific and client-transcending data should be kept to a minimum.

Screening, assessment and case management

A general screening by the medical staff upon entry into prison is recommended to detect drug related problems in an early stage. This basic screening should focus on several life domains: physical health, work/education/income, substance use, law/police, family and social relations, and mental and emotional health. The ‘Simple Screening Instrument for Substance Abuse (SSI-SA)’ (Winters & Zenilman, 1994) and the ‘Brief Jail Mental Health Screen (BJMHS)’ (Steadman & Veysey, 1997) are two valid and brief screening instruments, consisting of respectively four and eight questions, that can be used for this purpose⁸. If the screening reveals psychological or drug related problems a more thorough assessment should be organised (Soyez et al., 2007; De Wilde et al., 2007).

Among other objectives, case management operates to ensure continuity of care (Vanderplasschen, Rapp, Wolf & Broekaert, 2004; Vanderplasschen et al., 2011). The case manager acts from a motivating, coordinating and assisting role and provides a wide range of services tailored to the clients’ needs in a systematic and coordinated manner (Hall, Carswell, Walsh, Huber & Jampoler, 2002). Case management becomes more and more common within substance abuse treatment. In Belgium it is mainly used for drug users with multiple and complex problems and to support transitions in care (Vanderplasschen et al., 2011). If the detainee had a case manager before his/her detention, this external case manager could continue to support the client, with consent of the client. If the detainee had no previous contact with (substance abuse) treatment services or had no case manager before, case management can be initiated when appropriate to the clients’ complexity of problems and the request for support. The function of the case manager will then be carried out by a CRP-staff member, if the client agrees. Upon leaving prison, this support will be continued with the client approval. This results in a substantial expansion of the CRPs role, which requires increased staff resources. If the detainee, upon being released, requests a case manager and case management is required in terms of problem complexity, a CRP-staff member may still act as case manager (Figure 3). Unlike support or guidance from a judicial assistant (“justitieassistent”), the professional secrecy of case managers guarantees the confidential relationship with the client.

The implementation of case managers who support and guide detainees after detention is very ambitious when it comes to work intensity and necessary resources. However, this ambitious

⁷ This applies to both meetings with the PSS, during the detention period, and meetings with the judiciary assistant of the client, who protects the observance of the client after their release from prison and forms the bridge between healthcare services and the legal system.

⁸ These instruments are part of a more general screening and assessment procedure that was developed in a previous BELSPO study, “Druggebruik en psychopathologie in gevangenis: Een exploratieve studie tot methodiekontwikkeling” (<https://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR%2F26>) (Soyez et al., 2007; De Wilde et al., 2007).

recommendation seems to be most adequate within the complexity of factors that impede high-quality care for detainees during and after detention. Considering the high recidivism risk during the first three months after detention, case management can play an important role especially during this period. The literature describes various effective forms of case management, which vary in intensity and duration (Vanderplasschen, Wolf & Colpaert, 2004; Rapp, Van Den Noortgate, Broekaert & Vanderplasschen, 2014).

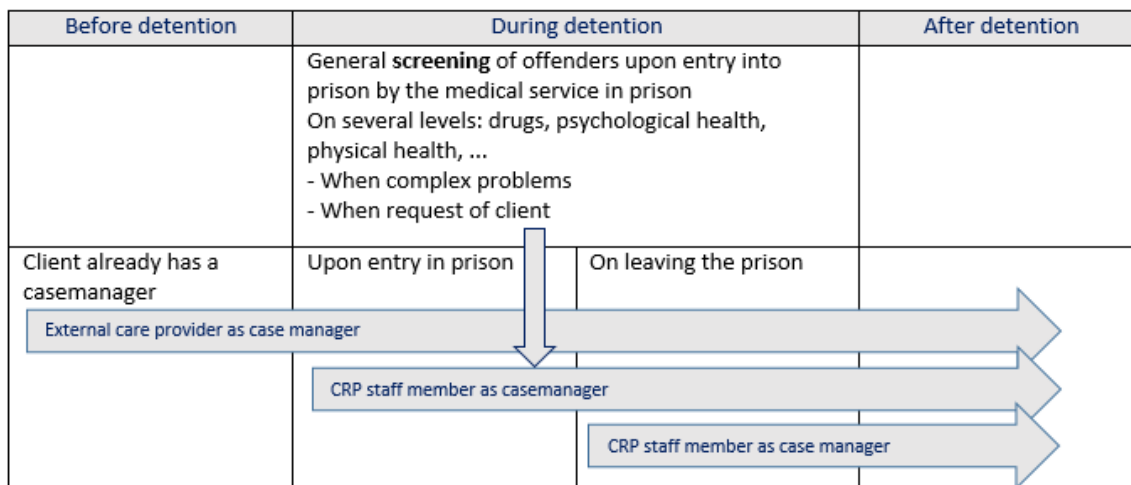


Figure 3: Schematic overview on the potential future organisation of screening, assessment and case management

Motivate

Adjusting and/or reorganising time investments linked to working in a detention context may be a first step towards a more efficient practice. In doing so, the waiting period between registration and the first meeting with a CRP-staff member can be reduced, as this waiting period was experienced as a motivation-obstructive factor. In addition, the staff members' task package should include enough time and space to provide emotional support and to maintain and improve the clients' motivation.

Staff training in terms of motivational interviewing, knowledge of comorbidity and the practice of treatment services is essential to increase clients' motivation. Staff members should, for example, be aware of the possible thresholds that detainees experience during reintegration (MacDonald et al., 2012). Special focus should be placed on specific target groups, such as women, people with an intellectual disability, dual diagnosis, clients under electronic surveillance, and foreign-language speakers. An integrative care provision that goes beyond drug abuse problems and includes strengths and barriers in different life domains is needed (Durcan, 2008; Galea, Enggist, Udesen & Møller, 2014). The realisation of an integrated support assumes that the CRPs practice is integrated in a more general organisation of partnerships with, for example in the Flemish context, 'JSW' and 'GGZ' (see below).

In addition, involving families or broader networks of the client offers opportunities for motivation improvement. International research shows that support by family members plays a vital role in a successful reintegration (MacDonald et al., 2012). Family also appeared to be an important motivation to participate in the 'DRUGS de baas?!' programme (WP5). According to the programme participants, involving experts by experience in the sessions was recommended. They could serve as an example and encourage the participants' motivation for counselling or treatment (Erp, Boertien, Scholtens &

Rooijen, 2011; Weerman, 2013). Limited interference with prison specific activities, such as ‘yard time’, work and visiting hours, may also improve the willingness to participate in the programme. The same barriers were described in a recent study on the participation of Flemish detainees in a vocational orientation programme among prisoners (Brosens, De Donder, Dury & Verté, 2015).

A motivational group-based short duration program: ‘DRUGS de baas?!’ (WP5)

Various findings stress the importance of a further implementation and expansion of a motivational group-based short duration programme for incarcerated offenders with a substance abuse problem. Results from WP5 show that the participants were satisfied with the ‘DRUGS de baas?!’ programme, awarding an average score of 7.7/10. The coaches’ expertise, unprejudiced attitude, professional secrecy and familiarity with the prison context was seen as the main programme strength by participants, coaches and ‘PSS’. Various participants indicated the value of the availability of care in prison that focused specifically on persons with addiction problems. Participants experienced the programme to be important as it could be a first moment of contact with care providers. For some participants it felt like a form of pre-therapy. This programme should be developed complementary to the CRPs practice, and preferably further implemented in various Belgian prisons.

In order to maintain support and increase the programmes’ disclosure it is recommended that detainees are screened during their early stages of detention and that the content of the programme is brought up regularly. It is also advised that programme coaches are familiar with the prison context and that prison staff are informed about the programme content. Additionally, familiarity with the CRPs may be increased by assigning one session to the CRPs practice. Participation in the short duration motivation programme should complement the CRPs practice. Clients can enter the programme through the registration points, but it is not required that they do so. Considering the large number of detainees with alcohol problems, and the scientifically underpinned relation between alcohol, aggression and relapse, it is strongly recommended to spend sufficient attention on alcohol abuse (Coccaro et al., 2016; Beck, Heinz & Heinz, 2014; McCloskey, Berman, Echevarria & Coccaro, 2009).

If the programme is also implemented in French-speaking prisons, sufficient time should be reserved to modify and translate the material. In addition, supervision and intervision and a multiple-day training, adjusted to the needs of the prison context, are recommended for the programme coaches. If the programme is systematically implemented in the wider range of support and services within the prison context, considerable financial savings can be achieved. This implementation requires enough time for meetings, a long-term perspective and sufficient and engaged penitentiary surveillance assistants. Furthermore, all involved actors indicate the necessity of a certain form of support after the programme during the detention period in order to maintain the acquired knowledge and level of change that was achieved. This form of support should focus on: making counselling and treatment opportunities more explicit; assisting with and refining the transition to (substance abuse) treatment; preventing risk situations and harm reduction; and maintaining and improving client motivation. The coaches of the programme are well-positioned to provide this aftercare, since they know the participants and their motivations and can continue working on the content of the programme.

Referral and follow-up

An important condition to reach efficient cooperation and smooth referrals would be a clear and shared description of the CRP-staff members' tasks. In addition, the diversity of the client profile (WP1,WP4) underscores the importance of a client-focused approach. An individual and integrative assessment of needs, from a participatory perspective, is essential to organise this client-focused approach. In addition, it is important that these assessment tools are standardised and adjusted to the specific detention population and context. By doing so, it is possible to monitor and evaluate the achieved aims of the CRPs.

Certain exclusion criteria applied by (substance abuse) treatment services regarding the client profile hinder the referral of CRP-clients. Therefore, awareness is needed concerning the shared responsibility of "challenging referrals" by all actors involved. More expertise among care providers and CRP-staff members on additional problems, such as intellectual disability or psychiatric problems, may be useful to guide an adapted referral. In addition to a good collaboration with (substance abuse) treatment services, a good connection must be made with regular treatment services. Through an integrated care and assistance provision a much greater emphasis should be placed on expanding the bridge between prison and the community. This provision should focus on all major life domains, such as general wellbeing, social network, leisure and work. Active cooperation with organisations such as social housing agencies, social office rental agencies and the 'Public Centre for Social Welfare' is strongly advised (for example, starting with "living wages" or debt mediation during detention) (Vander Laenen, 2015b).

Signalling and registration

When the CRPs practice is continued in the future, the signalling function should be included as an explicit additional task of the CRP-staff members. Adjusting and/or reorganising time investments linked to working in a detention context may contribute to more time and space for the organisation of this fourth aim. Administrative simplification or providing a computer with server access in prison may help organise a more efficient registration procedure.

Belgium has agreed to register key indicators of the European Treatment Demand Indicator (TDI) protocol on a national level, so that priorities for treatment and prevention can be objectified. The registration of TDI by the CRPs creates an important source of information to map the number and profile of new clients addressing (substance abuse) treatment services in terms of care that is tailored to their needs. TDI which were not included in the proposed intake registration form, were added to the modified registration form (Wetenschappelijk Instituut Volksgezondheid, 2016; Antoine, De Ridder, Plettinckx, Blanckaert & Gremeaux, 2016). This modified registration form was included as an appendix in the report (see appendix 1 'Modified Intake Registration Form in Dutch' and appendix 2 'Modified Intake Registration Form in French'). Standardization of registration and comparison between Flanders, Wallonia and Brussels will become possible when the use of these newly developed registration forms is continued after finishing the study.

Follow-up registration is recommended to monitor and evaluate clients' trajectories. When expanding this follow-up registration form, attention should be paid to problems inherent to registration in a detention context, staff members' workload and the (shared) professional secrecy. It is important that CRP-staff members request clients' informed consent for contacting (substance abuse) treatment services to evaluate the clients' trajectory after referral. Therefore, the process of referral can be

monitored and evaluated with the consent of the client, in response to continuity of care. Research showed that a telephone follow-up can prevent relapse and foster recovery (Dennis, Scott & Laudet, 2014). When this follow-up is implemented systematically, it has the potential to expose barriers and gaps in (substance abuse) treatment. In addition, continuity of care can be improved by tackling barriers and gaps, on the client- and structural level (e.g. signalling function).

4.4. Recommendations regarding collaboration and networking

Effective cooperation and networking between services inside prison and with external services is essential in the development of successful trajectories (MacDonald et al., 2012). Team meetings with CRP-staff members within detention must be continued to support each other. In the Flemish context, repeated meetings with employees of 'JSW' and 'CGG', who operate in prison, are recommended in terms of shaping a 'hulp- en dienstverleningsplan' (Polfliet, Vander Laenen & Roose, 2012). In addition to the 'hulp- en dienstverleningsplan', consultations with 'PSS' members are also required in relation to the alignment of a detention plan.

Regarding effective cooperation and referral, it is important that CRP-staff members are involved in network meetings outside detention, both with drug-specific care and 'GGZ'. In this manner, the aims and operation of the CRPs can be clarified on a regular basis and difficulties regarding the cooperation can be discussed. An annual evaluation meeting with CRP-staff members and external care providers, with an emphasis on the process of referral and client trajectories, is recommended. This evaluation moment works towards the professionalization of the CRPs, since elements that contribute to a smooth referral can be further developed. Shared professional secrecy is necessary, if the meetings are not anonymised (see above).

4.5. Recommendations regarding policy

Integrated care provision

A combination of a maximal provision of community care initiatives with (drug specific) treatment offer in prison is desirable in order to realise high-quality care for detainees (Vanhex, Vandeveld, Stas & Vander Laenen, 2014). Maximum effort should be spent on expanding a (drug) treatment offer in each prison, as well as an integrated drug policy. This could be developed through the continuation or restart of the local steering committees drugs. Within these local steering committees, there should be a more active role for CRP-staff members, both in the light of the expansion of an integrated local drug policy during detention and concerning the signalling function. Care and support for detainees should be linked optimally with other care providers attending similar objectives, such as 'JSW' and 'CGG' (Vanhex, Vandeveld, Stas & Vander Laenen, 2014). The communitarisation of drug specific treatment providers offers the opportunity to replace the current performance-focused financing system with a system of envelope financing or personal financing (Flemish Government, 2013; Vander Laenen, 2016), so they can actually provide care and support for detainees (Vanhex, Vandeveld, Stas & Vander Laenen, 2014).

A continuum of interventions is advised in order to expand a form of care that is tailored to the needs of every detainee. These comprehensive and integrated interventions should be based on evidence-based interventions, which include harm reduction initiatives (Galea, Enggist, Udesen & Møller, 2014). A methadone maintenance treatment programme should at least be organised or expanded in all

prisons. Currently, this is not the case (Schiltz, Van Malderen & Vanderplasschen, 2015). The continuation of methadone maintenance treatment during detention proves to contribute to a greater willingness to start with treatment after release, which reduces risk behaviour and the risk of overdose (Rich et al., 2015). A consistent care policy concerning substitution is necessary, unrelated to personal preferences of doctors. Resistance to substitution treatment among some prison doctors can be reduced through additional training (Vanhex, Vandeveld, Stas & Vander Laenen, 2014; Memorandum Zorg en Detentie, 2014).

Aftercare and follow-up

The prevalence of a substance abuse problem appears to increase the risk of overdose and mortality after being released from prison, independent of socio-demographic, criminological or familial factors (Chang, Lichtenstein, Larsson & Fazel, 2015). Aftercare may reduce this risk, since it appears to exert a positive influence regarding recidivism and drug use among individuals in a detention context (Belenko, Hiller & Hamilton, 2013; Galassi, Mpofu, & Athanasou, 2015; Wexler & Prendergast, 2010). Aftercare is mainly important within the first three months after detention, because the risk of recidivism is highest during that period (see WP2). A link between prison and (substance abuse) treatment outside prison walls is very important to achieve continuity of care and long-term effects (Galea, Enggist, Udesen & Møller, 2014). In Belgium, this link is currently missing and is even under more pressure after the closing of the CRPs. International examples, who focus strongly on peer support or experts by experience, can offer inspiration for the implementation of aftercare to support detainees with their reintegration and rehabilitation in the community.

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