Chapter 13

Alcohol and Drugs: Use, Problems, Prevention and Treatment

H.F.L. Garretsen, I.A.M. van de Goor, V.M. Hendriks and J.A.M. van Oers

1 INTRODUCTION

In this chapter we look at the services for the care and treatment of addicts in the Netherlands, a separate sector with both non-residential and residential facilities, a wide range of services, and a complex structure and funding system. Before discussing prevention and the health and social services, we provide an overview of the use of alcohol and other drugs, the problems connected with their use, and Dutch government policy. The Netherlands does not occupy an extreme position as regards the use of either alcohol or other drugs; consumption is higher in many countries and lower in many others. The situation is rather different when it comes to the problems related to the use of hard drugs in particular – the number of hard drug users with serious health problems such as AIDS is relatively low. Government policy may well play a role in this. Government policy on alcohol can be characterized as a policy of moderation, not rigorously enforced. The policy on illegal hard drugs is repressive in principle and pragmatic in nature, with the focus mainly on limiting the harm to users themselves, heir immediate environment and society as a whole. The authorities have not always operated an entirely clear and unambiguous policy concerning the care and treatment of addicts. However, this area has grown considerably in recent years, both in size and the range of services provided.

Section 2 examines developments in the use of legal and illegal substances, while Section 3 looks at problems related to their use. Government policy and prevention activities are the subject of Section 4, while Section 5 discusses the nature and structure of the addiction services. The whole field of care and treatment is in a state of flux – it is a dynamic sector. In this context, various fundamental discussions are going on about both government policy and the performance of the addiction services. The last section examines some of the main issues involved.

2 TRENDS IN SUBSTANCE USE IN RECENT DECADES

Since the Second World War there have been major changes in the use of various substances. Such changes are not new, however. Throughout the centuries societies have differed in their use of substances, while great

differences can be observed in the same society at different times. For example, a few centuries ago the Netherlands could be characterized as a country where coffee-drinking was opposed and few people smoked tobacco or drank alcohol (Garretsen 1995a). Nowadays legal substances such as tobacco and alcohol are widely used: around 38% of Dutch men and some 31% of Dutch women aged 15 and above smoke tobacco. Alcohol is consumed at one time or another by 80-90% of men and 60-80% of women (Smit et al. 1993). The percentage of men who smoke fell considerably between 1958 (when 90% smoked!) and a few years ago, with some fluctuations; the percentage of female smokers was rising rapidly until a few years ago. Where alcohol is concerned, the period between 1960 and 1975 is striking for the more than threefold increase in alcohol use per head of population (from 2.6 litres of pure alcohol per head of population to 8.7 litres in 1975). Since 1975 alcohol use has tended to stabilize and fall slightly. The same tendency can in fact be seen in many Western and Southern European countries, as illustrated in Table 1 (De Zwart 1995a).

Table 1 Use of alcoholic drinks per head of population in EU countries (in litres of pure alcohol)

	1975	*1980*	*1985*	*1990*	*1993*
The Netherlands	8.9	8.9	8.5	8.1	7.9
Germany	11.3	11.4	10.8	10.6	10.4
Belgium	10.1	10.8	10.5	9.9	9.1
Luxembourg	10.5	10.9	12.1	12.2	12.6
France	16.1	14.9	13.3	12.6	11.5
Great Britain	6.8	7.3	7.4	7.6	7.3
Ireland	7.7	7.3	6.8	7.6	8.3
Denmark	9.1	9.1	9.9	9.9	10.0
Portugal	13.3	11.0	13.1	10.1	10.4
Spain	14.2	13.6	11.6	10.8	10.0
Greece	5.3	10.2	8.9	8.6	9.2
Italy	12.8	13.0	10.6	9.2	8.6

Source: De Zwart 1995.

The number of people using illegal drugs is smaller than the number of alcohol and/or tobacco users. It is far more difficult to obtain reliable data for these drugs; much of the data available consists of estimates based on figures from the addiction services or statistics such as police records (Toet & Garretsen 1992). Data on the use of soft drugs (cannabis products, hashish and marihuana, drugs with an 'acceptable risk' according to the Dutch authorities) are sometimes also obtained from surveys. However, there is no broad tradition of research, so little is known about historical trends. In general it is fair to say that there was little or no use of the current illegal drugs in the period immediately after 1945. Large-scale use of these drugs dates from the mid sixties. Initially LSD and amphetamines were the main drugs used. In the seventies heroine dominated the scene (together with cannabis), while later there was also increasing use of cocaine. Now very popular drugs are heroine, cocaine, amphetamines and Ecstasy. Most people use several substances together and are multi-drug users.

Spruit and De Zwart (1995) discuss the results of several studies examining the use of soft drugs. Nowadays about 675,000 Dutch people are said to use soft drugs with varying degrees of frequency. Use among young people of school-going ages (aged 12-18) is better documented. The lifetime prevalence (those who have ever used drugs) rose from 4.8% in 1984 to 13.6% in 1993; use in the four weeks preceding the interview rose from 2.3% in 1984 to 3.0% in 1988 and 6.5% in 1992. The majority only use drugs occasionally. Data on young people aged 13-24 are also available from the Quality of Life Survey by the Netherlands Central Bureau of Statistics (CBS). This shows that the number of people using soft drugs increased from 2% in 1979 to 5% in 1993, while the number who say they have ever used soft drugs rose from 4% to 9% (on average there were higher percentages for older users in the age group and lower percentages for younger ones).

As we have said, the number of hard drug users is difficult to estimate but seems to have been fairly stable for some years. At present it is estimated that approx. 27,000 people in the Netherlands are 'heroine addicts' (Het Nederlands Drugsbeleid 1995). By international standards, this number does not make the Netherlands exceptional. Even in relative terms, the number of users is neither extremely high nor extremely low.

3 PROBLEMS RELATING TO DRUG USE

The different substances are associated with different problems. In the case of tobacco, these include lung cancer, COPD (chronic obstructive pulmonary disease) and cardiovascular disease. For example, the incidence of death from lung cancer is 22 times higher among male smokers and 12 times higher among female smokers than among non-smokers (Smit et al. 1993). Excessive alcohol use is also associated with many health problems, such as alcoholic cirrhosis of the liver and alcohol psychosis. In addition there are other problem areas. A term often used is 'problem drinking', which covers both excessive drinking and problems in one or more of the following areas: psychological dependence on alcohol, symptomatic drinking (behaviour indicating physical dependence and loss of control over drinking), social problems, for example with one's partner/family, police/criminal justice authorities and at work, health problems, accidents and finally frequent drunkenness/hangovers (Garretsen 1983, Garretsen & Knibbe 1983). The increase in alcohol use after 1960 described in Section 2 is associated with an increase in the number of alcohol-related problems (see Figure 1).

By comparison, the use of soft drugs is associated with relatively few problems. The specialized addition services still encounter few people who are in trouble mainly because of soft drug use (Spruit & De Zwart 1995). Several of the hard drugs can lead to some degree of dependence, as well as creating other problems. However, many problems are associated not with the effect of the substances themselves (as opposed to dependence on the drugs) but rather with the way they are used (complications from injecting, infectious diseases, AIDS), the lifestyle of users (which is dominated by drug use; some users neglect

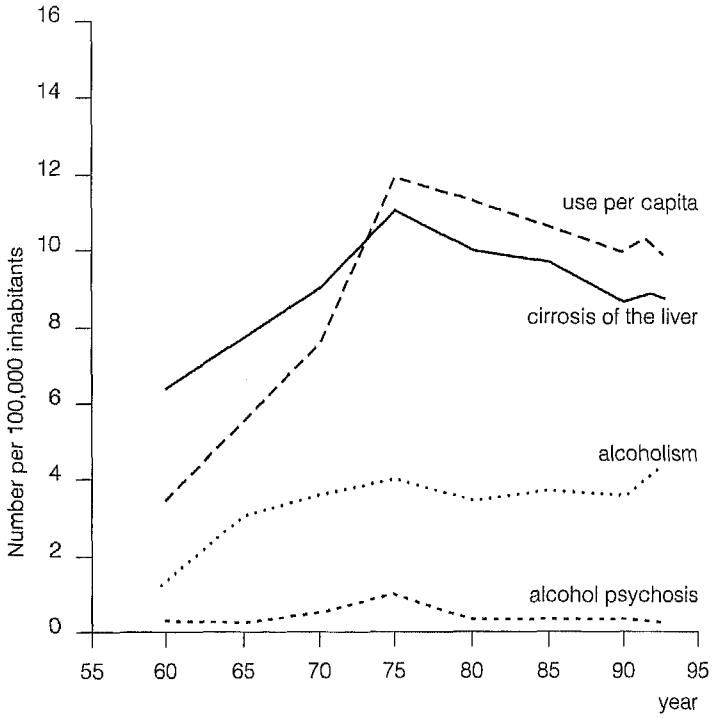

Figure 1 Alcohol: mortality per 100,000 inhabitants aged 15 years and older in the period 1960-1994
Source: IVV 1995.

personal hygiene and/or fail to eat properly) or with complications resulting from adulteration (Garretsen 1985). The lack of quality control and great variations in the purity of black market supplies of drugs such as heroine also result in people unwittingly taking fatal overdoses. Drug users are the second largest risk group for HIV and AIDS (see Figure 2)

The first case of AIDS diagnosed in an intravenous drug user in the Netherlands was in 1985 (Spruit & De Zwart 1995). About 10% of AIDS diagnoses in the Netherlands involve intravenous drug users, a figure that is far below the European average of around 40%.

4 GOVERNMENT POLICY

A great difference can be seen between government policy on legal substances such as alcohol and the policy on illegal drugs. Government policy on alcohol concentrates on encouraging moderation and preventing certain negative effects and problems such as road accidents. This policy more or less reflects the ambivalent attitude to alcohol use in the Netherlands: drinking is allowed/is fine and problem drinking is not allowed/must be prevented. There have been no really major changes in recent decades. In 1975 the then Minister of Health and

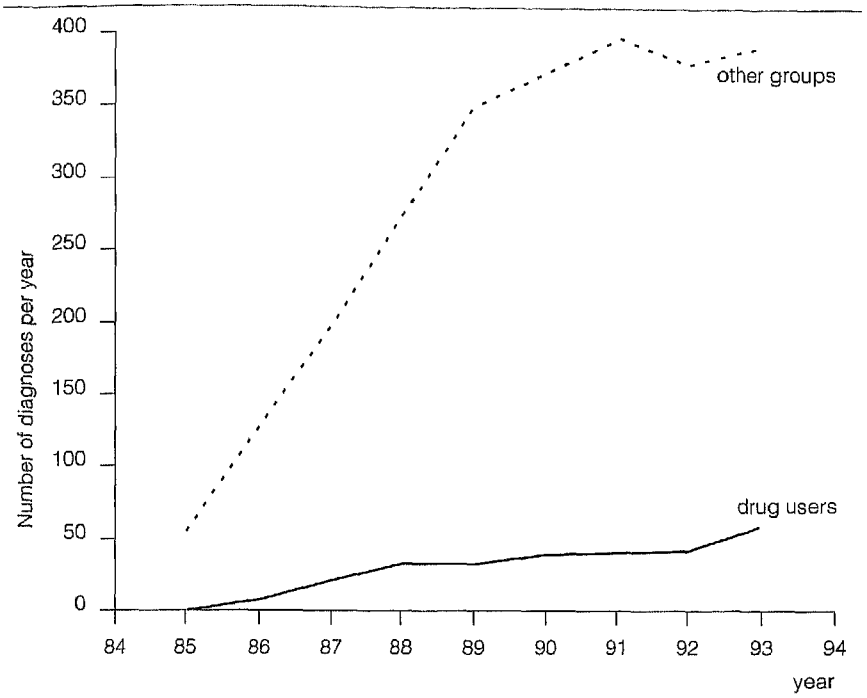

Figure 2 Number of AIDS diagnoses among drug users and other groups in the period 1985-1994

the Environment propagated a policy of discouraging alcohol use, which was regarded by the Minister as a risky habit, although one with positive aspects. The policy document 'Alcohol and Society' (Tweede Kamer 1986) also focused on reducing alcohol use. This and other policy documents published by the Ministry of Welfare, Health and Cultural Affairs from the early eighties onwards always featured prevention prominently, taking the view that the existing structure of institutions with particular tasks and functions is adequate to give shape and substance to the policy of prevention. However, it is debatable whether sufficient funding is available to implement such a policy (Kuipers 1995).

A distinction can be made between primary and secondary prevention. The first involves the prevention of problem use, while the second entails the early detection of problems related to use and intervention to deal with these. The Government sees the implementation of secondary prevention as a task for the non-residential services for addicts (CADs, or Alcohol and Drugs Clinics; see Section 5). For successful primary prevention, it is obviously important to understand the possible causes of excessive and/or problem use. These causes may lie within the person him/herself, in the immediate surroundings (family, work, school, and the like), as well as in society as a whole (availability of substances, social norms, and the like). Strategies for prevention can also be directed at these different levels. As regards the macro level, the level of society as a whole, the government policy of prevention is certainly essential. At the

same time it is often assumed that restricting the availability of the substance is a useful element in this (Garretsen 1983; Knibbe & Van de Goor 1988; Van Oers & Garretsen 1995). The usual ways of achieving this are a policy of higher excise duty on the one hand and measures such as restricting the points of sale and opening times on the other. Incidentally, the effect of some kinds of intervention (such as higher excise duty and setting age limits) has been clearly demonstrated (Lau 1985; Skog 1986). This cannot be said (at least at present) of some other types of intervention (e.g. restricting the number of points of sale). Tough economic and financial measures have never been introduced in the Netherlands, partly because of opposition from other ministries which, have an interest in revenues from excise duty, and partly because of opposition from business (alcohol producers, the catering industry) and the influence of European policy (Hoekstra & Derks 1993). Legislation on the issuing of licences to serve and sell alcohol has been in preparation for a long time. Local government also has an important role to play in this. It can prohibit the sale and/or use of alcohol at certain times, in certain places and/or in certain districts (Garretsen 1986). Besides these measures directed at the supply side, it is also important to reduce the demand for alcohol. A prime example of this is the interdepartmental policy to prevent drunken driving and publicity campaigns such as 'Drink can wreck more than you think'.

Government policy on illegal drugs such as heroine and cocaine is very repressive compared with the policy on alcohol. For example, all sales of drugs (including cannabis) are prohibited. Nevertheless the repressive nature of the policy has always been the subject of discussion, particularly since the sixties. This is because the fact that drugs are illegal creates problems: it restricts the availability of drugs for some addicts, leading to higher prices and hence crime to obtain the drugs, and it results in international trafficking, uncontrolled and unstable use, and a lack of quality control. However, at the same time there is recognition that relaxing the law or even legalizing drugs could also create problems, such as drugs tourism, pressure on international relations, an increase in use and problems in the absolute sense (Garretsen et al. 1996). The recent policy document 'Dutch Drugs Policy, Continuity and Change' (1995) therefore firmly rejects the option of legalization.

The policy on drugs has developed on a continuum between repression and tolerance (Wever 1995). The interdepartmental policy document 'Drugs Policy in a State of Flux' (1985) introduces the idea of 'normalization' as the starting point for policy where hard drugs are concerned; branding users as criminals and stigmatizing drug use and users should be resisted. In general it is fair to say that the Netherlands has operated a pragmatic policy, focusing mainly on limiting the risks for users themselves, their immediate environment and society as a whole (NIAD 1995). Harm reduction is an important principle of Dutch policy, which sees the limitation of risks to health as its objective, without concentrating exclusively on ending the addiction. Many activities have been developed, such as needle-exchange programmes and easy access to methadone supplies.

The policy focuses not only on harm reduction but also on reducing the supply. On the supply side, the authorities are trying to get a grip on the traffic

in hard drugs, using a rigorous policy of investigation and prosecution (Hoekstra & Derks 1993). The measures used to reduce demand are not very repressive and drug use as such is not suppressed. Incidentally, as regards reducing demand, there has been no attempt in the Netherlands to educate the public about drugs via media campaigns (as in the case of alcohol). The cornerstone of Dutch policy on drugs is the distinction between soft drugs (drugs with an 'acceptable risk') and hard drugs. The authorities attempt to keep the two markets separate by being more tolerant not only of drug use but also to some extent of the trade in soft drugs (the sale of soft drugs is tolerated in many 'coffee shops', which have to meet a number of strict criteria). People are able to obtain soft drugs without coming into contact with the black market for hard drugs. This policy has resulted in a comparatively large number of soft drug users, a small number of users of hard drugs and a comparatively small number of users with problems.

5 CARE

De Zwart (1995) states that '...despite the lack of consensus on policy, funding, organization and the nature of care, the specialized services for addicts have grown sharply in recent years, both in size and the diversity of the services provided'. When even experts point out the complexity of the addiction services sector, patients are bound to have problems in finding the right help: this also applies to legal substances such as alcohol. Receiving help early improves the prognosis for recovery. However, many people with use-related problems do not know where to go to obtain care and treatment. The information is not readily available. The family doctor tends to be in a central position – however, patients often do not mention their problems with alcohol use and family doctors often do not recognize the signs. This is because many symptoms are not specific to alcoholism and the patient may conceal problems because of shame, fear or lack of motivation. On the other hand the doctor may not want to spoil the relationship with the patient, may have insufficient expertise or may not be sufficiently motivated him/herself (Van Oers & Garretsen 1995; Cornel 1994). Family doctors can provide help themselves or refer patients elsewhere. In many cases patients will be referred to either another health care institution or to the CAD (Ambulant Centre for Alcohol and Drugs), the central organization for non-residential (specialized) care. The patient may also be admitted to a crisis centre or another residential institution. A number of users, particularly alcoholics and gamblers, eventually receive the help they need from self-help groups such as Alcoholics Anonymous (AA).

The specialized services for addicts in the Netherlands include about 70 institutions: 17 CADs (with 102 branches and 33 counselling addresses), around 30 institutions concentrating on social work (at some 50 locations) and 20 addiction clinics, about half of which are attached to a psychiatric hospital (De Zwart 1995b). The main functions of the services for addicts are prevention and information, counselling, AIDS prevention, medical care, social work, guidance and treatment. There are many different institutions, with various organizational

structures; attempts to coordinate intake and counselling in regions have not been successful (Hoekstra & Derks 1993). At the national level, the Netherlands Association of CADs and the Association of Social Work Services for Addicts merged in 1993 to form the Netherlands Association of Institutions Providing Services to Addicts (NeVIV). Talks are again taking place between the NeVIV and other umbrella organizations of mental health institutions about a larger merger.

The non-residential services for addicts are being funded until 1 January 1997 under the 'Temporary Social Regeneration Act'. After that, the funding is supposed to come from the Municipalities Fund; however, conditions will be attached to this, because otherwise the money would be split up over 633 municipalities (Financial Review of the Care Sector 1996). Funding will therefore take place through government grants, not through the AWBZ (the Exceptional Medical Expenses Act, see Scheerder, Chapter 15) despite the fact that this pays for clinical care for addicts. Most CADs were set up in the thirties and forties as centres for alcoholism, initially as probation and after-care institutions. In 1969 they were given the additional task of providing help relating to drugs. The institutions concentrating on social work with addicts were mostly created in the eighties for specific, often very local problems and groups of clients. Their functions often included the provision of methadone, street corner work, day centres and walk-in centres, crisis intervention, projects to provide education, work and housing, etc. (see Hoekstra & Derks 1993). In 1994 a total of 50,053 people were registered with the non-residential services for addicts, including over 20,000 with mainly alcohol-related problems, more than 20,000 with mainly drug-related problems and 6,000 or more with mainly gambling problems. Since 1988 the number of alcohol clients has declined slightly, while the number of drugs clients has increased and the number of gambling clients has grown sharply (IVV 1995).

Addiction clinics are funded under the AWBZ: the norm is 0.08 beds per 1,000 inhabitants (the beds are also available for outpatient and part-time treatment). Treatment ranges from detoxification, short courses of in-patient treatment (up to three months), and longer periods of in-patient treatment, to outpatient and part-time treatment. On average there were 808 patients at the nine independent addiction clinics in 1994.

In addition to professional help, self-help is also important. Where alcohol abuse is concerned, the list includes (De Zwart 1995b): Alcoholics Anonymous (approximately 160 groups in the Netherlands), Al Ateen (for children of alcohol-addicted parents), Al-Anon (for partners) and self-help groups for family members of patients with Korsakoff's syndrome. There are also groups for people addicted to medicines, and for gamblers. Another active organization is the National Foundation for Parents of Drug Addicts. There are many good contacts between the self-help organizations and the professional services (Hoekstra & Derks 1993).

6 CURRENT DEVELOPMENTS AND DISCUSSION

In the previous sections we have described the main developments in use, government policy and services. The situation is in a state of flux and various fundamental discussions are going on regarding government policy and the performance of the services. In this section we mention some of the main issues.

As has so often been the case in recent decades, the government policy on drugs is attracting more discussion than its policy on alcohol. This no doubt has to do with public opinion and the perceived nuisance connected with illegal drug use. It is fair to say that the Dutch policy on drugs is pragmatic in nature, as mentioned in Section 4, and this has produced positive results in terms of public health. Comparatively few users have major health problems. On the other hand, a (comparatively small) number of drug users is creating a nuisance in the form of violence and threatening behaviour, crime and objectionable conduct. This nuisance aspect has remained a problem up to the present and public acceptance is declining. The attitudes of politicians themselves are often far from repressive but public opinion is changing. The government is reacting to this in various ways, including allowing many municipalities to carry out projects designed to reduce this nuisance. However, more far-reaching measures are being considered and the question is how far they will go. For example, public opinion is calling for the closure of 'coffee shops' and 'tolerance zones', areas where the authorities allow drug use. It is debatable whether this will reduce the overall nuisance (probably not), while it is certain to be at the expense of public health. Closing areas or premises where drug use is tolerated means that there will be less control over the 'scene' and fewer harm reduction activities will be possible (such as needle exchanges and check-ups for infectious diseases, etc.). The closure of too many 'coffee shops' would eliminate an important element in the separation of the soft and hard drug markets referred to earlier.

The social services will also be increasingly involved; new initiatives will emerge involving persuasion and coercion in the treatment of drug users. This raises the questions whether the individual and public health aspects will be sacrificed to the public order aspects and whether there will be too much use of the social services to solve problems of public order. Some of the above issues are important at local government level. And this leads on directly to the next subject of discussion: the role of central government, in view of the fact this is handing over its job increasingly to private funding and local government. There is discussion about the decentralization and regulation of services for addicts (as well as cutbacks). Most suggestions have had a lukewarm reception from the institutions providing services, partly because of the frequent association with spending cuts.

The relative emphasis on drugs rather than alcohol and gambling is also having a negative impact on the range of services available. The number of people with alcohol problems is far greater than the number of drug addicts but the services and programmes for drug addicts are more extensive and varied. From the point of view of public health, the number of services for alcohol clients is currently too low and too static.

Another important subject of discussion is the performance and quality of the current services. Kok (1995) claims that there is too little information about their performance and too little attention is paid to the quality of care. Although many quality projects have started in the sector providing services to addicts, no proper overview exists and their impact is still unclear. What applies to the performance of services for addicts certainly applies to prevention. Kuipers (1995) claims that those working to prevent addiction have unfortunately too long avoided broadening the type of work involved and there is a need for more detailed analysis and a research programme. Here too central government needs to decide on its position and create the proper conditions.

REFERENCES

Cornel, M. (1994), *Detection of problem drinkers in general practice*. Dissertation. University of Limburg, Maastricht.

Drugbeleid in beweging, (Drug Policy in a State of Flux) (1985), Interdepartementale Stuurgroep Alcohol- en Drugsbeleid, Den Haag.

Financieel Overzicht Zorg, (Financial Review of the Care Sector) (1996). Tweede Kamer 24.404.2, 1995-1996.

Garretsen, H.F.L. (1983), *Probleemdrinken*, (Problem drinking). Dissertation. Swets & Zeitlinger, Lisse.

Garretsen, H.F.L. (1986), 'Mogelijkheden voor een gemeentelijk alcoholpreventiebeleid', (Options for a municipal alcohol prevention policy). In: *Alcohol en Drugs* 12, pp. 17-21.

Garretsen, H.F.L. (1995a), *Droge tijden, natte tijden – alcohol en drugs: toen en nu*, (Dry times, wet times – alcohol and drugs: then and now). Desiderius Dies Lectures 1994. Erasmus Alumni Office, Rotterdam.

Garretsen, H.F.L. & R.A. Knibbe (1983), *Alcoholpreventieonderzoek in Rotterdam en Limburg*, (Research into prevention of alcohol abuse in Rotterdam and Limburg). Ministry of Welfare, Health and Cultural Affairs (WVC), Leidschendam.

Het Nederlands drugsbeleid: continuïteit en verandering, (The Dutch Policy on Drugs: continuity and change) (1995-1996). Parliamentary session 1995-1996. Tweede Kamer 24077.2.3. Staatsuitgeverij, The Hague.

Hoekstra, M.J. & J.T.M. Derks (1993), *Verslaving en verslavingszorg in Nederland*, (Addiction and treatment in the Netherlands). In: Handboek Verslaving, (Addiction Handbook), A 2000-3–A 2000-22, supplement. Bohn Stafleu Van Loghum, Houten.

IVV (1995). *LADIS key figures for 1994*, IVV, Utrecht.

Knibbe, R.A. & L.A.M. van de Goor (1988), 'Modellen voor alcoholpreventie', (Models for prevention of alcohol abuse). In: J.C. van der Stel & W.R. Buisman (eds.), *Alcoholpreventie*, (Prevention of alcohol abuse). Samsom, Alphen aan den Rijn.

Kok, A.F.W. (1995), 'Mogelijkheden en beperkingen van de drugshulpverlening', (The possibilities and limitations of drug addiction services). In: *Ned. Tijschr. Geneesk.*, 139, pp. 2632-2635.

Kuipers, S.B.M. (1995), 'Verslavingspreventie', (Prevention of addiction). In: *Jaarboek Verslaving 1994*, (1994 Addiction Yearbook), NIAD, Utrecht.

Lau, H.H. (1985), 'Costs of alcoholic beverages as a determinant of alcohol consumption in the Netherlands 1958-1981'. In: *British Journal of Addiction* 80, pp. 411-419.

NIAD. (1995), *Fact Sheet 2: Harddrugsbeleid*, (Policy on hard drugs). Utrecht.

Oers, J.A.M. van & H.F.L. Garretsen (1995), 'De spiegel van onvrede: verslaving aan alcohol en andere stoffen', (The mirror of discontent: addiction to alcohol and other substances). In: E.H. Nuy & E.H. van de Lisdonk, *Leerboek Medicus en Maatschappij*,

(Textbook on the Doctor and Society). SWP Utrecht.
Skog, O.J. (1986), 'An analysis of divergent trends in alcohol consumption and economic development'. In: *Journal of Studies on Alcohol* 47, pp. 19-25.
Smit H.A., (1993), 'De bijdrage van determinanten aan de huidige gezondheidstoestand'. In: RIVM, *Volksgezondheid Toekomstverkenningen*, (Future Directions in Public Health), Bilthoven.
Spruit I.P. & W.M. de Zwart (1995), 'Middelengebruik en kansspelgedrag', (Substance use and gambling behaviour). In: *Jaarboek Verslaving 1994*. NIAD, Utrecht.
Toet J. & H.F.L. Garretsen (1992), 'Epidemiologie', (Epidemiology). In: W.R. Buisman & J.C. van der Stel (eds.). *Drugspreventie, achtergronden, praktijk en toekomst*, (Prevention of drug abuse, the background, practice and future). Bohn Stafleu Van Loghum, Houten/Zaventem.
Tweede Kamer (1986), *Alcohol en samenleving*, (Alcohol and society.) (Vergaderjaar 1986-1987). 19243.2.3.
Wever, L.J.S. (1995), 'Vijfentwintig jaar drugsbeleid van de Nederlandse overheid: terugblik en evaluatie', (Twenty-five years of policy on drugs by the Dutch government: a review and evaluation). In: *Handboek Verslaving*, A4000-3–A4000-31, supplement. Bohn Stafleu Van Loghum, Houten.
Zwart, W.M. de (1995a), 'Epidemiologie van alcoholgebruik in Nederland', (Epidemiology of alcohol use in the Netherlands). In: *Handboek Verslaving*, A5000-1–A5000-23, supplement. Bohn Stafleu Van Loghum, Houten.
Zwart, W.M. de (1995b), 'Ontwikkelingen in de hulpverlening', (Developments in the social services). In: *Jaarboek Verslaving 1994*, NIAD, Utrecht.