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Custody or release: Problem GHB users in police cells, custody, and pre-trial detention

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Gamma-hydroxybutyrate acid (GHB) is a potent depressant of the central nervous system which rapidly enters the bloodstream and produces its effects shortly after ingestion.[1] Since the early 1990's, GHB increasingly became popular as recreational drug, mainly as 'club drug', but GHB cannot be considered safe and reliable. After initial stimulation its use may lead to loss of consciousness. In addition, GHB retains a high addictive potential. First added to Schedule II (soft drugs) of the Opium Act by the Dutch authorities in October 2002, GHB was transferred in May 2012 to Schedule I (hard drugs). From March to July 2012, we conducted a study on encounters between problem GHB users and Dutch police. Our primary source of information consisted of interviews with 49 professionals (mostly police officials and doctors with relevant expertise) located throughout the Netherlands.

Problem GHB users

GHB is a liquid anaesthetic that appears to enjoy growing popularity today in rural parts of the Netherlands, although initially it was taken mostly by drug users in large cities. GHB is now used by different types of people in a variety of settings, both at home and in nightlife venues, at festivals, at after-parties or even in street life. Finding the right dosage of GHB requires a great deal of fine tuning. There is a narrow margin between getting high and passing out, and GHB users may suddenly lose consciousness and need to be rushed to the hospital. There is also growing concern about the addictive effects of GHB and the severity of withdrawal. The numbers of addiction service clients with GHB as their primary addiction are mounting steeply.

'Problem use' of GHB, as discussed in this study, may have different meanings. It can be a *medical* problem (as manifested in loss of consciousness after overdosing or in withdrawal symptoms in addicted users), but such medical problems may also be accompanied by *behavioural* problems, in particular from a police point of view. When a GHB user loses consciousness, the police is often the first to arrive and provide first aid; interference or aggression on the part of bystanders may occur, and unconscious users may become agitated once they come to consciousness. Users who are experiencing withdrawal symptoms may be confused or aggressive, prompting friends, relatives or neighbours to summon police.

A particular focus in this study is on problem GHB users who have committed offences serious enough to be kept in custody, but who nonetheless are released, or must be released, as a consequence of their GHB use.

Box I Background of GHB

Though GHB was marketed as an anaesthetic in 1960,[2] it is no longer applied as an anaesthetic because of its negative side effects and poor control of dosage and duration of effect.[3] GHB is, however, still clinically applied to treat narcolepsy[4] and withdrawal symptoms of alcoholic patients.[5] As GHB also increases feelings such as euphoria, well-being, relaxation, tranquillity, sociability, sexuality and enjoyment of dancing,[6,7] since the early 1990's, it became increasingly popular as recreational drug, mainly as 'club drug'.[8-12] For example, in the Netherlands, the use of GHB gained popularity as recreational drug[13-17] as evidenced by data from a large national survey among clubbers and party-goers in 2008-2009. Prevalence of GHB use among clubbers and party-goers was respectively 6.4%, and 14.3% (life time use); 3.4% and 7.8% (last year), and 1.7% and 4.6% (last month).[18] These rates are significantly higher as compared to the general population (aged 15-64 yrs) with prevalence rates of 1.3% (lifetime), 0.4% (last year), and 0.2% (last month).[19]

However, GHB cannot be considered as a safe and reliable recreational drug, because after initial stimulation its use may lead to loss of consciousness. Moreover, the dose-response margin between stimulation and the loss of consciousness (intoxication) is very narrow.[20] Indeed, several emergency department case studies have reported GHB use as one of the major causes of drug related intoxications.[8,21-26] Due to respiratory depression, GHB use may even be lethal.[8,10] According to figures of the Dutch Drug Incidents Monitor 2011, 740 out of 3652 registered drug related incidents (ambulance called and/or arrived at emergency departments) were related to the use of GHB.[27] In addition to sudden intoxications, GHB retains a high addictive potential. Recently, the number of clients in outpatient care with GHB as their main drug problem sharply increased in the Netherlands from a few dozens in 2007 to 659 in 2011.[28,29]

Four types of problem GHB users in encounters with police

Many different types of problematic GHB users are encountered by Dutch police. There are very young users, but also people in their forties; most are above 18. The vast majority are male and have ethnic Dutch family backgrounds.

From the evidence provided by the informants we spoke to, nine out of ten users in question can be categorised into four main types:

- *Classical hard drug users* are the largest group. They are poly-drug users, may be homeless or roofless, and/or have psychiatric problems, but they are not necessarily addicted to GHB. They are predominantly in their late twenties or thirties (average estimated age: 31). Virtually all are male (as compared to eighty percent of the other three types). 'Classical' users are encountered in most areas of the country; they predominate in urban areas, though not necessarily in all large Dutch cities.
- *Street youth* take second place. They include quite a few teenagers, but also 'over-age adolescents'. Their estimated average age is 21. They constitute the majority of GHB users in rural villages in parts of some provinces (Overijssel, Gelderland, Noord-Brabant, Noord-Holland, Zeeland), yet there are other rural areas where such youthful GHB users are rare to unknown.
- The third type is found in the *nightlife crowd*. Most are in their twenties, averaging around age 25. They constitute the majority of GHB users in parts of Overijssel, Gelderland, Noord-Holland and Limburg – predominantly, but not exclusively, in urban areas.
- *Home users* are the fourth type. Except in parts of some provinces in the northern and eastern Netherlands, they are rare amongst the problem GHB users that get into encounters with police.

In a few provinces, a single type of user predominates, but in most provinces more than one type is seen. There are also remarkable regional variations within a single province, or even between adjacent towns and villages. This suggests that some GHB markets are highly local in nature – especially because dealers, and even users, can fabricate GHB themselves.

Numbers of problem GHB users in police encounters

Our mapping study amongst police and health care professionals throughout the country uncovered a steady rise in the numbers of problem GHB users encountered by police. The perceived increase may, however, be partly due to a growing alertness and earlier recognition of problem users on the part of police and health care staff.

No exact figures can be given, as police forces do not keep systematic records of their encounters with GHB users. To document the scale of the problem, we had to go by what the interviewed experts understood by 'problem GHB users in police encounters'. Some of them could not access records kept for internal use, but most gave reasoned estimates.

On a nationwide basis, the data we obtained revealed not only a larger number of users involved in incidents in 2010-2011 as compared to 2008-2009, but also a clear increase between 2010 and 2011. Regional differences did emerge in the reports, ranging from little or no increase in Zeeland and parts of Noord and Zuid-Holland to sharp jumps in Friesland, Overijssel and Gelderland (or parts of them).

We based our nationwide estimate of the numbers of problem GHB users involved in police encounters on data received from police custody officers; the data was therefore limited to GHB users who had been held in police cells, and did not include those in other police encounters. Extrapolating from data from more than half of all Dutch regional police forces, we arrived at cautious nationwide estimates of 320 unique persons in 2010 and 420 in 2011, and a total of approximately 420 cases (including repetitive incidents) in 2010 and 570 in 2011. A large margin of error should be allowed for in these figures, partly because the scale of the problem varied so widely between regions.

Custody or release

Two basic factors govern whether GHB users are handed over to the custody officer and held in a police cell. From the standpoint of *criminal law*, the nature and severity of the suspected offence (in conjunction with any prior offences) must justify the continued detention. Confinement to a police cell must also be *medically* permissible. In cases of acute intoxication after GHB use or of suspected or known GHB addiction, a forensic medical officer is normally consulted forthwith. Generally speaking, suspects of minor offences such as shoplifting are released after charging. In some cases, though, arrestees charged with minor offences are transferred to the custody unit anyway to sober up, for medical observation or pending arrival of a forensic medical officer. (Similar treatment is given to arrestees who are drunk or otherwise incapacitated.)

On the basis of the custody officers' data, we arrived at a cautious estimate that seventy percent of the problem GHB users arrested by police and referred to the custody officer are retained in custody. Throughout the country, this would mean an estimated 225 unique individuals in 2010 and 295 in 2011, and a total of 295 cases in 2010 and 400 in 2011. Reasons why not all arrestees remain in custody after referral to the custody officer include medical recommendations against continued custody (received at or shortly after transfer) or lack of appropriate facilities for continued custody.

These estimates are hedged with uncertainties. There are some wide regional differences in the likelihood of suspects remaining in custody after referral to the custody unit. These are partly explainable by regional differences in the nature and severity of suspected offences and in the prevalence of GHB addiction among arrestees. There are also strong indications that, in medically comparable cases, forensic medical officers in certain regions are more likely to advise against continued custody than officers elsewhere in the country. It follows that policemen in those regions may have become more selective beforehand in terms of which GHB users they transfer to a cell block, in order to avoid seeing their transferees promptly released on medical grounds after a forensic medical officer's report.

Cell capacity for problem GHB users

The collected data does not allow us to make any precise, empirically substantiated numerical distinction between

problem GHB users released on criminal law grounds and problem users released because of other behaviours, drug consumption patterns or degree of addiction. What we can ascertain is that, both in 2010 and 2011, some GHB users were released who would normally have been retained in custody on grounds of the nature and severity of their suspected offences.

Three dedicated beds for GHB-dependent offenders have been available since early 2012 in Dutch penal institutions (two beds in Zwolle and one in Scheveningen, The Hague). If the experiences in the initial months of the year are an indication for the rest of the year, then approximately 100 GHB-dependent offenders per year could receive treatment in those units. This evidence seems to confirm the need for such specialised facilities. The dedicated beds increase the possibility that in 2012 fewer GHB users than in preceding years will be released from police custody on medical grounds even though the nature and severity of their offence warranted continued custody. That circumstance makes it more difficult to determine whether sufficient cell capacity is now available to accommodate problem GHB users who constitute a medical risk but who should be kept in custody on criminal law grounds. For the time being, however, the conclusion seems justified that no expansion of the number of dedicated beds for GHB-dependent offenders will be needed unless the number of GHB users qualifying for committal to custody continues to increase.

The fact remains that such dedicated beds are no remedy for GHB users who do not qualify for custody but who continue to burden police with their problem behaviour.

Cooperation, hindrances and improvement targets

The interregional differences in the nature and scale of the problems that police forces face with GHB users are broadly mirrored in the extent and types of consultation and cooperation between police and other agencies in those regions. The greater the problems (perceived or real), the more consultation and cooperation there is, and the greater the reported satisfaction with that collaboration. Complaints can be heard in various parts of the country about the pace at which public prosecution services (OM) are engaging with the GHB problems. At the same time, positive experiences are also reported whereby prosecution services play a critical role in a joint strategy.

Health, public order and relapse

In some regions, health problems are the primary concern (in particular the symptoms of GHB overdosage), whilst other regions are more focused on the nuisance caused by GHB users, and in some cases also on the chronic reoffenders. Some individuals that are seriously addicted to GHB could be called 'revolving-door clients' of the police, and at the same time they may be addiction service clients who repeatedly relapse into GHB use after every stay in a hospital or detoxification clinic. Key issues are: How to deal with GHB-using nuisance makers? How can police and justice authorities and the health care sector develop the best possible joint strategy to deal with drug-dependent GHB users, and to deter ex-users from relapsing into GHB addiction?

Privacy-sensitive information

Police staff express the most satisfaction when there is also local cooperation at the level of individual cases. An oft-bemoaned obstacle to collaboration between police and health and welfare agencies stems from the need to protect sensitive personal information about clients or patients. Privacy rules may impede cooperation and limit the exchange of information. In this connection, police officials sometimes complain of a certain lack of engagement and a tendency to pass the buck. Yet, the degree to which such stumbling blocks are experienced varies between police regions. Police forces apparently have much to learn from one another.

Adequacy of medical facilities and safety arrangements

Different views are expressed in different regional police forces as to whether the currently available medical facilities are adequate for safely detoxifying problem GHB users committed to custody or pre-trial detention. There are regional police forces where little or no need exists for such facilities so far; other forces believe they have enough suitable observation cells available, and still others argue that too few dedicated cells are available throughout the country for GHB users experiencing withdrawal. Other reported inadequacies are that police forces have too few specifically designed medical facilities available and too little knowledge and experience in their custody staffs, and that cooperation between police and hospitals proceeds awkwardly.

One specific concern involves the safety of arrestees and police when problem GHB users are transported to police cell blocks or from police cells to prisons. Although protocols and sound working arrangements are in place for such tasks, in practice the police may decide not to transport an arrestee because not enough properly trained personnel are on hand and/or because the trip would be too long.

Medical advice and record keeping

Police staff feel that forensic medical officers do not make consistent recommendations in comparable cases with regard to whether problem GHB users can be kept in custody. The forensic medicine sector needs to investigate this. Forensic expertise will also be essential to the efforts to develop an unambiguous, practicable definition of 'problem GHB use' that can be applied nationwide. Such a definition is also a crucial prerequisite for improving the registration and monitoring of this type of arrestees.

Knowledge needs and knowledge exchange

The less experience police forces have with GHB problems, the greater their need for relevant knowledge, except in forces that seldom encounter problems with GHB users. Most of the reported knowledge gaps were said to involve police custody officers and patrol officers. Some regional police forces that have not yet experienced many GHB problems have initiated proactive consultations and are working together with more experienced forces in joint projects such as the development and implementation of protocols.

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