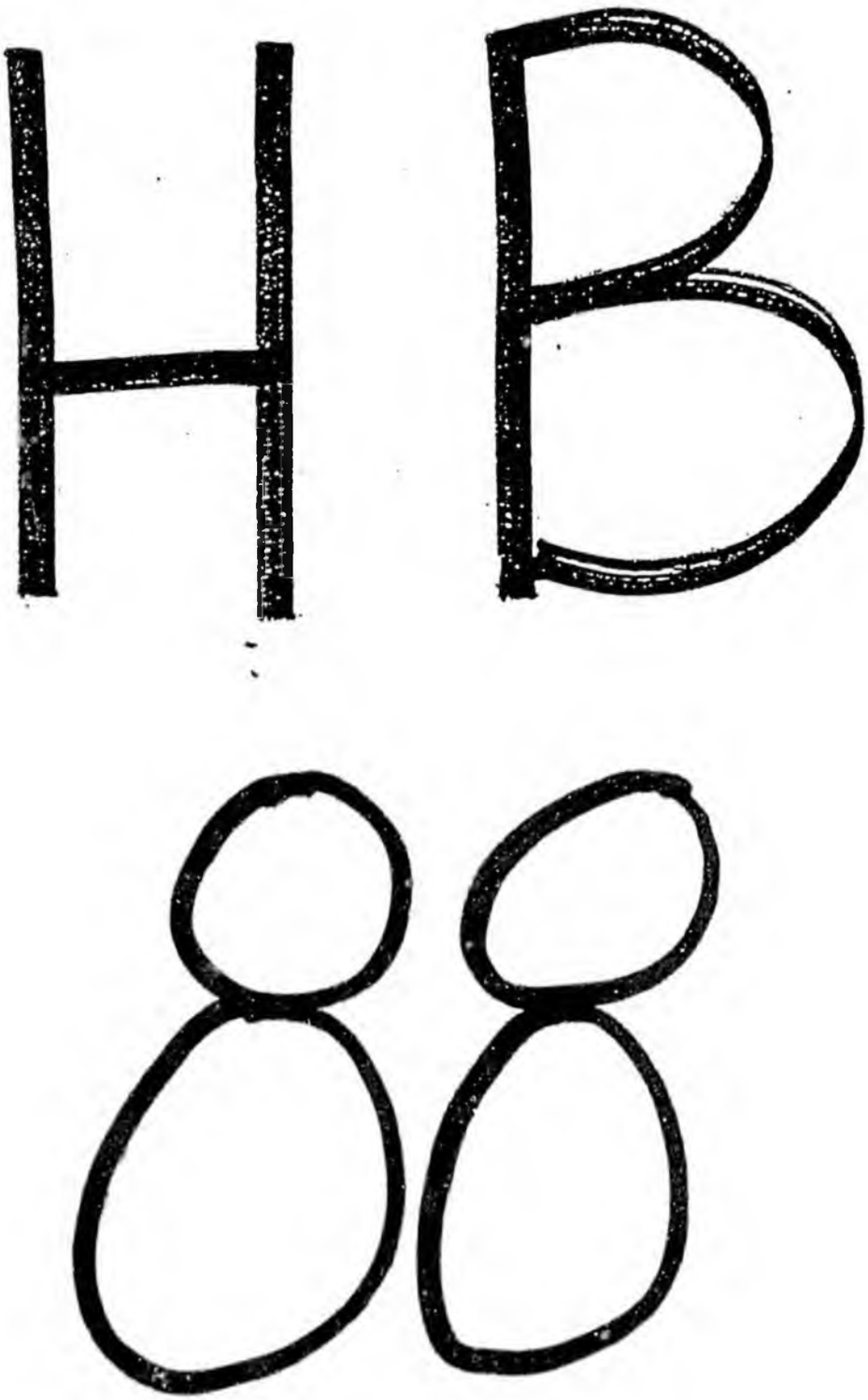
HB
88

HOUSE COMMITTEE ON STATE AFFAIRS

RECAP OF
HB 88

Making Possession of Marijuana Illegal

Received January 18, 1989
by The State Affairs Committee

Heard January 31, 1989 (Work Session)
Heard February 21, 1989
Heard March 16, 1989
Heard April 4, 1989
Heard April 5, 1989

Committee Substitute adopted April 5, 1989

Passed Out of Committee April 5, 1989
5 Do Pass
1 No Recommendation

TABLE OF CONTENTS

HB 88: Making Possession of Marijuana Illegal

HOUSE COMMITTEE REPORT

(5)

Date Referred: January 18, 1989 FURTHER REFERRALS: JUDICIARY

Date of Committee Action: ________

The STATE AFFAIRS Committee recommends that:

HOUSE BILL NO. 88 [MAKING POSSESSION OF MARIJUANA ILLEGAL]
"An Act amending the definition of the offense of misconduct involving a controlled substance in the seventh degree to make possession of less than four ounces of marijuana illegal as a violation, and relating to the disposition of offenses of misconduct involving a controlled substance in the seventh degree."

[X] be replaced with CSHB88(SA) [ ] the same title [X] a new title

[ ] have attached amendment(s)

[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[X] additional referral to the Finance Committee

ADOPTS: House State Affairs letter of intent

ATTACHES NEW FISCAL NOTE(s):

[X] fiscal impact w/analysis by Dept of Law
[ ] zero fiscal note
[ ] zero with analysis

APPROVES PREVIOUS:

[ ] fiscal note(s) published: ________

[ ] zero fiscal notes(s) published: ________

SIGNING DO PASS:

[signatures]

SIGNING OTHER THAN DO PASS:
(Do Not Pass, No Recommendation, Amend)

[signature] "PASS ONLY WITH FUNDING FOR LAW ENFORCEMENT, DRUG RESEARCH AND PREVENTION + INTERVENTION PROGRAMS FOR FAMILIES AND YOUTH"

[signature]
Chairman's signature

Item 1B

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M April 6, 1989

SUBJECT: CSHB 88 (State Affairs), relating to marijuana -- sectional analysis

TO: Representative H.A. "Red" Boucher, Chair
House State Affairs Committee

FROM: Jack Chenoweth
Legislative Counsel

CSHB 88 (State Affairs), adopted by the committee, addresses the subject of possession of marijuana in small quantities. Possession of marijuana in quantities of less than four ounces in other than a public place is not now subject to state criminal law. */ Under the principal changes proposed in this bill, possession of one ounce or more up to four ounces would be

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*/ Under current law,

-- possession of eight ounces or more of marijuana anywhere is a class A misdemeanor; AS 11.71.-050(a)(3);

-- possession of four ounces or more of marijuana is a class B misdemeanor; AS 11.71.060(a)(4);

-- possession in a public place of one ounce or more but less than four ounces of marijuana is also a class B misdemeanor; AS 11.71.060(a)(1).

Also, under current law, possession of less than one ounce of marijuana in a public place constitutes "misconduct involving a controlled substance in the seventh degree," a violation. AS 11.71.070. A "violation" is an offense that is not a crime. For conviction of a violation, no jail sentence may be imposed. See AS 11.81.900(a)(56). A fine may be

made a class B misdemeanor, while possession of less than one ounce would be defined as an offense and treated as a "violation."

Principal provisions of CSHB 88 (State Affairs):

The bill's title and purpose section, bill section 1, provide a summary of the principal features of the legislation.

Bill sections 2 - 5 directly relate to the disposition under state criminal law of possession of small amounts of marijuana.

Bill section 2 redefines possession and makes it an element of the offense of "misconduct involving a controlled substance in the sixth degree," a class B misdemeanor, if one "uses, displays, or possesses" one or more ounces but less than four ounces of marijuana. For a person's first offense of use, display, or possession of between one and four ounces (and for a minor's first offense of use, display, or possession of any amount less than four ounces), imposition of a term of imprisonment is not authorized. Rather, bill section 3 directs that, for these first offenses, the court may require participation in a drug abuse treatment program or performance of community service.

Bill section 4 redefines possession, adds to it the elements of "use" and "display," and makes those three the elements of the offense of "misconduct involving a controlled substance in the seventh degree," a violation, if one uses, displays, or possesses less than one ounce of marijuana. For committing that violation, bill section 5 authorizes imposition of a fine of not more than $300 (repealing the

---

imposed. While, generally, the maximum fine for a violation may not exceed $300, AS 12.55.035(b)(5), under current law applicable to possession of small amounts of marijuana, the fine may not exceed $100. AS 11.71.-070(b).

Finally, because there is no statute that declares it illegal, possession of less than four ounces of marijuana other than in a public place is not currently defined as a criminal offense.

current maximum fine of $100 applicable to violations involving possession of marijuana).

Bill sections 6 and 7 authorize and direct the use of citations as the means of handling and disposing of violations under AS 11.71.070. Bill section 6 adds a new section, AS 11.71.075, to authorize the use of citations (rather than arrest warrants) for these offenses. Bill section 7 amends AS 12.25.190(c) by adding this proposed AS 11.71.075, which relates to the offenses that constitute misconduct involving controlled substances in the seventh degree, to the list of the types of complaints that may be resolved and disposed of through the use of citations. The net effect of this pair of changes is that persons who possess less than one ounce of marijuana may be cited (rather than arrested), and may dispose of their citations by payment of bail in lieu of fine in an amount determined in a bail schedule by court rule.

Finally, bill sections 8 and 9 make technical changes to two existing sections that contain references to prosecutions brought under those statutes that define crimes of misconduct involving controlled substances. The changes are necessary because of the addition of new material in proposed AS 11.71.075.

*

As this measure was developed, I thought it useful to try to summarize within the text of the bill the elements of it that relate to the change in the treatment of small amounts of marijuana proposed by this bill. To do that, I included bill section 1. That section briefly notes the significant change in the treatment accorded possession of a small amount of marijuana made by bill sections 2 and 4, the violation penalty amendment made by bill section 5, and the use of citations, authorized by bill sections 6 and 7 as a primary means of enforcement of that change in treatment.

JBC:kb
wkk3/071

Enclosure

Item 1C

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

April 5, 1989

HOUSE STATE AFFAIRS COMMITTEE

LETTER OF INTENT
For
CSHB 88(SA)

Compared to other states, Alaska rates high in the use of marijuana and other drugs by youth. Expert testimony and research reveals, however, that legislation alone cannot solve this drug problem. The House State Affairs Committee respectfully requests that the legislature, in considering the passage of legislation to criminalize the use and possession of marijuana, adequately fund drug enforcement agencies, drug research activities, and state programs providing drug prevention/ intervention to families and youth victimized by drug abuse.

Representative Ann Spohnholz

Representative Curt Menard

Representative Eileen MaClean

Representative Alice Hanley

Representative Jim Zawacki

Representative H.A. "Red" Boucher
Chair, House State Affairs

Item 1D

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: CSHB 88 (St Aff)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: April 3, 1989
Title: "An Act amending...offenses... involving a controlled substance..."
Sponsor: House State Affairs
Requestor: House State Affairs

Agency Affected: Department of Law
BRU: Prosecution

Components: Third District, Fourth District, Crim. Appeals & Spl. Prosc., Criminal Justice Litigation

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES		133.6	137.6	141.7	146.0	150.4
TRAVEL		3.6	3.7	3.8	3.9	4.0
CONTRACTUAL		72.7	74.9	44.3	45.6	47.0
SUPPLIES		10.8	7.4	7.6	7.8	8.0
EQUIPMENT		12.5	-0-	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	233.2	233.6	197.4	203.3	209.4

CAPITAL						

REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	233.2	233.6	197.4	203.3	209.4
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	2	2	2	2	2
PART-TIME	-0-	1	1	1	1	1
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Please see the attached analysis.

Richard L. Pegues

Prepared by: Richard I. Pegues, Director — Phone: 465-3672
Division: Administrative Services — Date: April 3, 1989

Richard L. Pegues /FOR/

Approved by Commissioner: Douglas B. Baily, Attorney General — Date: April 3, 1989
Agency: Department of Law

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

The committee substitute for HB 88 recriminalizes the possession and use of small amounts of marijuana. The bill would make possession of one ounce or more but less than four ounces of marijuana a class B misdemeanor, and the bill would make possession of less than one ounce of marijuana a violation. The maximum penalty for such a violation would be raised from $100 to $300. The legislature is also considering a joint resolution proposing a constitutional amendment at the next general election in November of 1990, which would provide that an individual's right to privacy does not extend to the possession or use of controlled substances. The bill would be effective 90 days after it becomes law, or sometime during the summer of 1989, if it is approved.

The passage of CSHB 88 will have a fiscal impact on the Department of law in three general areas: (1) the cost of processing additional new criminal cases; (2) the cost of educating the public about the new law; (3) approval of the proposed constitutional amendment will have the effect of repealing the Alaska Supreme Court's decision in Ravin. However, because the bill would be effective about 18 months before the constitutional amendment would become effective, it is anticipated that the bill will come under a vigorous constitutional challenge.

1. New Criminal Cases

Much of the behavior that the bill would classify as either a class B misdemeanor or a violation is not now an offense of any kind. In the past, some law enforcement officers who work primarily in the drug enforcement area indicated that recriminalizing marijuana could potentially result in "thousands" of new criminal cases a year. The police now doubt this but, nonetheless, a large number of the new cases would arise from situations where law enforcement officers now commonly discover small amounts of marijuana (as when an officer responds to a domestic disturbance call and sees some marijuana plants in a person's home, or when a person is arrested for a minor offense and a routine search for weapons reveals some marijuana cigarettes in the person's pocket, for example). Incidents of this sort occur frequently now, but do not generally result in any criminal prosecution for the marijuana possession. Many of these cases are likely to be referred for criminal prosecution if CSHB 88 becomes law because police officers will not ignore evidence of wrongdoing that is in plain view. Many of these defendants are middle-class people who can be expected to vigorously resist having a criminal record. Class B misdemeanors entitle a defendant to a jury trial and court-appointed counsel. Although the bill provides that possession of less than one ounce of marijuana will be handled as a violation, some unknown yet substantial number of these lesser offenses can be expected to be disputed, requiring attorney time to prosecute.

Prosecutors generally predict a substantially lesser number of new potential criminal cases under CSHB 88 than the "thousands" that were once predicted. Once the public becomes aware of the new law, some people are likely to become more careful about not allowing marijuana or smoking paraphernalia to be exposed in plain view in their homes; for example. Judging from the number of minor marijuana offenses prosecuted prior to the Ravin decision in 1975, prosecutors still expect at least a "few hundred" new criminal cases a year. Possession of small amounts of marijuana for personal use has been legal since the Ravin decision in 1975. Consequently, there is no accurate way to predict the number of new offenses that will occur when this current behavior is outlawed. Nor is there any accurate means to determine, in advance, the number of new offenses that will constitute class B misdemeanors, as opposed to violations. All of the department's prosecution offices are working at maximum capacity. Past budget cuts have left little time available to handle minor offenses, and the department has had to focus its remaining resources on major offenses, particularly crimes of violence. Prosecution of a whole new block of crime, although relatively minor, simply cannot be undertaken without some additional resources. The department's current estimate of a "few hundred" offenses is very conservative. The actual number of new cases may be significantly higher. It certainly will not be less.

Class B misdemeanor cases and disputed violations which are accepted for prosecution will require attorney time both at trial and in preparation for trial (i.e., preparation of search warrants, response to defense motions, evaluation of results of laboratory analysis, pretrial witness preparation, etc.). To handle screening of the expected case referrals, and to prosecute the additional misdemeanors and disputed violations, the criminal division will require the addition of at least one Attorney III position and one Legal Secretary I position in Anchorage. It is anticipated that a half-time attorney will also be needed in the Fairbanks District Attorney's office.

2. Public Education

In order to inform the public of the changes in the law, the Department of Law will develop and disseminate public notices explaining the new law. These notices will include newspaper ads and brochures, and will be modeled upon the public education notices which were distributed statewide in connection with the new drug law in 1982 and the new DWI and drinking age laws in 1983. Based upon experience with these earlier notices, approximately $25,000 will be needed to cover the costs of writing, layout, typesetting, publication, and distribution.

In addition to the costs explained above, it is anticipated that the passage of this bill will result in increased costs to other components of the criminal justice system, including law enforcement, the courts, the public defender agency, the Office of Public Advocacy, and corrections.

3. Defending the New Law

In 1975 the Alaska Supreme Court in the case of Ravin v. State, 537 P.2d 497 (Alaska 1975), ruled that under Art. I, Sec. 22 of the Alaska Constitution the state could not prohibit possession of marijuana by adults in their own homes for personal use. The court held that the state had not demonstrated the existence of a legitimate state interest which was strong enough to justify the regulation of this conduct.

Since passage of CSHB 88 would make it a crime for an adult to possess any amount of marijuana anywhere, including in his or her own home, the constitutionality of the new law is certain to be challenged. An appellate court will have to decide whether the state has proved that there is a "compelling state interest" in the prohibition of the use of marijuana which is sufficient to outweigh an individual's right to privacy under the state constitution. It is extremely important, therefore, that the legislature's consideration of this bill include extensive public hearings, debate on the social policy merits of the proposal, and the collection of the results of the most recent scientific, medical, and pharmacological studies regarding the physical, emotional, and social effects of marijuana usage.

In addition to the necessary legislative hearings, evidentiary hearings at the trial court level can be expected when a challenge to the new law is filed. Challenges to the new law will most likely arise in the context of a defendant's pretrial motion to dismiss a criminal prosecution. When responding to such a defense motion, the prosecutor would, in essence, have to convince a court to reverse the ruling in the Ravin case. In order to demonstrate that the result in Ravin is no longer correct, the prosecutor would have to present convincing, scientifically accurate, evidence that the effects of marijuana usage are so injurious to a person's mental and physical health as to justify the legislative decision to totally prohibit use of marijuana by anyone at any time (as opposed to use by minors or use by a person who is operating a motor vehicle--both of which are already prohibited under current law).

The presentation of this convincing evidence will require the prosecution to present expert testimony from authorities who have conducted recent research in this area. Out-of-state witnesses in medical and scientific fields charge a fee for their services. These fees will vary from individual to individual, but are expected to average at least $150 per hour. This would include services for consultation, witness preparation and actual testimony. Costs will be incurred for expert witness transportation, food and lodging, and other incidental expenses. Additionally, there will be some costs for preparation of exhibits and written reports. To the extent possible, the Department of Law would attempt to present written testimony in situations where it is not feasible to fly a person to Alaska to testify

in person. We estimate that a minimum of six expert witnesses will be required to attempt to successfully defend the new law at the trial court level.

Hearings at the trial court level can reasonably be expected to take several days. A substantial commitment of attorney time will be required for scientific and legal research in preparation for the hearings, actual court time, legal briefing, and the preparation of proposed findings of fact. Since prosecutions under the new law will occur statewide, defense challenges may be raised at the same time in different parts of the state. The extensive hearings described above may have to be held in more than one judicial district in the state.

Regardless of which side prevails at the trial court level, the lower court ruling would almost certainly be followed by an appeal. At a minimum, such an appeal (or appeals) would require additional legal research, a thorough review of the record, the drafting of briefs, and oral argument before the appellate court and the Supreme Court.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Fiscal Analysis - (cont'd)

1. New Criminal Cases

Third Judicial District - Anchorage

	Atty III (PFT)	Legal Sec I (PFT)	Total
Total			
Personal Services	63.8	32.9	96.7
Travel - Witness travel subsistence, atty. travel	1.8	-0-	1.8
Contractual Services			
office commo. equip. repai	2.4	1.2	3.6
copy - postage	1.2	1.2	2.4
Office Space rent/lease	4.0	2.2	6.2
			12.2
Commodities - Ongoing			
office consumables	1.8	1.2	3.0
Law library	1.2	-0-	1.2
Commodities - one time			
New position materials	1.2	1.2	2.4
			6.6
Equipment - one time			
New position equipment	2.0	8.5	10.5
	79.4	48.4	71.1

Costs beyond FY 90 include a 3% inflation factor, less one-time items.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Fiscal Analysis - (cont'd)

Fourth Judi ial District - Fairbanks

	Atty. III (PPT)	Total
Personal Services	36.9	36.9
Travel - Witness travel subsistence, Atty. travel	1.8	1.8
Contractual Services		
office commo., equip. repair	2.4	2.4
copy - postage	1.2	1.2
		3.6
Commodities - Ongoing		
office consumables	1.8	1.8
Law library	1.2	1.2
Commodities - one time		
New position materials	1.2	1.2
		4.2
Equipment - one time		
New position equipment	2.0	2.0
		48.5

Fiscal Analysis - (cont'd)

2. Public Education

Criminal Justice Litigation Component/Prosc. BRU

Object	Total
Contractual Services - one time writing, layout, typesetting, publication and distribution of public notices and information brochures describing the changes in the law.	25.0
	25.0

3. Defending the New Law

Criminal Appeals & Special Prosecution Component/Prosc. - BRU

Object	Total
Contractual Services - Professional fees scientific experts 120 hrs. X $150 =	$18,000
Experts' staff support, preparation of exhibits, written testimony 50 hrs. X $60 =	3,000
Experts' travel to attend hearings and offer testimony	
6 trips X 4 days X $80 = $1,920 subsistence	1,920
6 trips X $1,500 = $9,000 travel	9,000
	$31,920

This amount will be required for both FY 90 and FY 91, to cover both trials and appeals.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Summary of Expenses (All Components)

	Defending the new Law	New Criminal Cases	Public Education	Total
Personal Services		133.6		133.6
Travel		3.6		3.6
Contractual	31.9	15.8	25.0	72.7
Commodities		10.8		10.8
Equipment		12.5		12.5
	31.9	176.3	25.0	233.2

Position Title	No. of Positions	Range/Step	Barg. Unit
Attorney III	1	22A	PX

Time Status	Staff Months	Location	Election District
PFT	12	EBA - Anchorage	8

Type of Expenditure		Amount
1	2	3
Salary	49,140	
Benefits	14,657	
Premium Pay		
Other		
Total Personal Services		63,797
Travel		1,800
Contractual		7,600
Commodities		4,200
Equipment		2,000
Other		
Total Cost		79,397

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	79,397
I/A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This full-time attorney position is required at Anchorage to handle the influx of new cases that will result when marijuana possession or use is recriminalized. Prosecutors expect that at least a few hundred such offenses will occur each year as a result of the enactment of this bill. This position will be responsible for prosecuting those new cases that are brought in the Third Judicial District and handling appellate briefs and appeals hearings. Because these new cases will be classed as misdemeanor offenses and violations, allocation of the position to the Attorney III level is appropriate.

Request For New Position

Agency: Department of Law

BRU: Prosecution

Component: Third Judicial District.

Revised Date

FY 90

Position Title	No. of Positions	Range/Step	Barg. Unit
Legal Secretary I	1	10P	GGU

Time Status	Staff Months	Location	Election District
PFT	12	Anchorage	8

Type of Expenditure		Amount
1	2	3
Salary	22,716	
Benefits	10,220	
Premium Pay		
Other		
Total Personal Services		32,936
Travel		-0-
Contractual		4,600
Commodities		2,400
Equipment		8,500
Other		
Total Cost		48,436

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	48,436
I-A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This Legal Secretary I position will be needed to handle the paperwork and scheduling requirements for the influx of new trials that will occur when the possession or use of small amounts of marijuana is outlawed. At the least a "few hundred" new offenses are expected. This estimate is very conservative, and the actual number of new cases may be somewhat higher. It certainly will not be any less. The support staff in the Anchorage District Attorney's Office was cut severely in FY 87, and any additional caseload will require an increase in support staff. Allocation to the Legal Secretary I level is appropriate because of the legal and trial documentation necessary to try these cases.

Request For New Position

Agency: Department of Law

BRU: Prosecution

Component: Third Judicial District.

Revised Date

FY 90

Position Title	No. of Positions	Range/Step	Barg. Unit
Attorney III	1	22A	PX

Time Status	Staff Months	Location	Election District
PPT	12	JBA - Fairbanks	16

Type of Expenditure		Amount
1	2	3
Salary	28,122	
Benefits	8,826	
Premium Pay		
Other		
Total Personal Services		36,948
Travel		1,800
Contractual		3,600
Commodities		4,200
Equipment		2,000
Other		
Total Cost		48,548

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	48,548
I-A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This permanent part-time position at Fairbanks is required to handle the influx of new cases that will result when the use or possession of small amounts of marijuana is recriminalized. Prosecutors expect that at least a few hundred offenses will occur each year as a result of the enactment of this bill. This position will be responsible for prosecuting those new cases that are brought in the Fourth Judicial District. Because these new cases will be classed as misdemeanor and violation offenses, allocation of the position to the Attorney III level is appropriate.

Request For New Position

Agency: Department of Law
BRU: Prosecution
Component: Fourth Judicial District

Revised Date

FY 90

Item 1E

UNIVERSITY OF ALASKA, ANCHORAGE

3211 Providence Drive
Anchorage, Alaska 99508

CENTER FOR ALCOHOL
AND ADDICTION STUDIES

March 31, 1989

Rep. Red Boucher
House State Affairs Committee
PO Box V
Juneau, AK 99811

ATT: Dennis Burns

Dear Rep. Boucher:

I am writing to thank you for your efforts to combat drug abuse in the State of Alaska. The rationale viewpoint with which you have approached the problem will help to create an atmosphere in the state to eradicate the problem.

To this extent I would like to express my full support for the Letter of Intent that accompanies House Bill 88. The requests are more than reasonable, and without appropriate funds the problem will continue unabated. The direction set fourth in the letter are very appropriate, and you can count on me to assist in any way possible to help to reduce the problem of drug abuse in the state.

Very truly Yours,

Bernard Segal

Bernard Segal, Ph.D., Director
Health Sciences, and The Center for
Alcohol and Addiction Studies

Item 1F

Proposed Committee Substitute for HB 88: Making Possession of Marijuana Illegal

Representative H.A. "Red" Boucher

Findings

There is no Alaska law that makes possession of 4 ounces or less of marijuana (VIA controlled substance) in the home a crime. As such, the public perception is that possession of marijuana in the home is legal in Alaska. Technically, possession of marijuana anywhere is illegal by federal law. That difference in state and federal law creates confusion -it sends the wrong message to adults, youth and children in Alaska and elsewhere that we condone its use.

Sub-Committee Preliminary Report

The sub-committee on HB 88 (Item 1A) - composed of Representatives Hanley, Spohnholz, Swackhammer, Shirley Warner (APOA) and a public member Sandy Spargo - have met and discussed with Legislative Legal Services attorney Jack Chenoweth the issues outlined at the "work session" held on January 31, 1989. Our focus has centered on three questions:

1) Should small quantities of marijuana be illegal?

2) If we make small quantities illegal, what is the appropriate penalty?

3) Does Alaska's Constitution preclude prohibition of small quantities of marijuana?

In our discussions and review of the provisions in HB 88, we have tentatively come to the conclusion that HB 88 may not go far enough in addressing the concerns of the subcommittee and the testimony we have heard to date. Consequently we are considering a committee substitute based on the following considerations:

Small Quantities

Testimony has shown that one ounce of marijuana is roughly equal to 40 or 50 joints with a street value of between $250 and $300. Possession of 4 ounces of marijuana has an estimated street value of $1400 in Juneau. Like most products, however, value is dependent upon availability.

Taking into consideration current Alaska law regarding possession of less than one ounce in a public place (treated as a 7th degree violation) and the street value of this substance, defining a "small quantity" of marijuana as less

than one ounce seems reasonable.

The subcommittee generally agreed that possession of one to four ounces of marijuana, in other than a public place, should not be viewed as a "small quantity" as defined above.

Appropriate Penalty

Item 3D compares current law with HB 88 and a proposed committee substitute (Item 3C). This comparison was prepared by Jack Chenoweth and modified for the purpose of this memorandum. As Jack Chenoweth notes, the committee substitute combines a criminal provision for possession of one to 4 ounces (a class B misdemeanor) with a non-criminal provision for possession of less than one ounce (a violation), and it eliminates the public/private distinction.

Constitutional Issues

The committee substitute (Item 3C) discussed above does not include a comprehensive set of medical findings as are found in SB 18 and HB 22 (Item 2A,B). It is my understanding that we must demonstrate a need based on proof that the public health or welfare will suffer if controls are not applied to marijuana's use. While I personally believe there are sufficient social and medical/health reasons to recriminalize marijuana, it is not clear we are yet at a point where "findings" could withstand a court test - findings such as those listed in SB 18 and HB 22.

You will also note there is a companion bill - a constitutional amendment (Item 3A) - which proposes to amend article I, section 22 of the Alaska Constitution to exclude from the right to privacy a person's possession or use of marijuana. This would allow the legislature to regulate without the concern for a violation of the constitutional right to privacy. The effective date of the proposed committee substitute (Item 3C) is tied to passage of the constitutional amendment.

Penalties For Possession Of Marijuana

Place	Amount	Classification	Penalty Up To
Current Law			
Anywhere	> 8 oz	A misdemeanor	$5,000/1 yr
Anywhere	> 4 < 8 oz	B misdemeanor	$1,000/90 days
Public	> 1 < 4 oz	B misdemeanor	$1,000/90 days
Public	< 1 oz	7th degree violation	$100
Private	< 4 oz		no penalty
HB 88			
Anywhere	> 8 oz	A misdemeanor	$5,000/1 yr
Anywhere	> 4 < 8 oz	B misdemeanor	$1,000/90 days
Anywhere	up to 4 oz	7th degree violation	$100/citation
Proposed CSHB 88			
Anywhere	> 8 oz	A misdemeanor	$5,000/1 yr
Anywhere	> 4 < 8 oz	B misdemeanor	$1,000/90 days
Anywhere	> 1 < 4 oz	B misdemeanor	$1,000/no jail time for first offense *
Anywhere	< 1 oz	7th degree violation	$300/citation

Note: possession of up to 4 oz. of marijuana anywhere is a violation, enforceable only by a fine, using a citation system

Note: this approach combines a criminal provision for possession of 1 to 4 oz. - class B misdemeanor - with a non-criminal provision for possession of less than 1 oz. - a violation - and eliminating the public/private distinction

* subsequent offenses may result in jail time up to 90 days, drug treatment/community work service at the discretion of the court

Jan. 93

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM January 12, 1989

CB 55

SUBJECT: Work order 6-~~0469~~A -- sectional analysis

TO: Representative H.A. "Red" Boucher, Chair
House State Affairs Committee

FROM: Jack Chenoweth
Legislative Counsel

The work draft addresses the subject of possession of marijuana in small quantities. Possession of marijuana in quantities of less than four ounces in other than a public place is not now subject to state criminal law. Under one of the changes proposed in this bill, that possession would be made an offense and treated as a "violation."

Other sections provide for the disposition of offenses involving possession of small amounts of marijuana that are classed as violations.

Background:

The following information may be useful.

Under current Alaska law, a person's possession of less than one ounce of marijuana in a public place constitutes misconduct in the seventh degree. Misconduct in the seventh degree is an offense, specifically a violation.

An offense is defined or regarded as a "violation" when it carries no jail sentence and is punishable wholly by payment of a fine. AS 11.81.900(a)(56). State law sets a maximum fine for a violation of $300. AS 12.55.035(b)(5). However, under AS 11.71.070(b), the maximum fine for a violation involving marijuana is set at $100.

A person's possession of less than four ounces of marijuana in a place other than a public place is not a crime.

Principal provisions of the bill:

Bill section 2 affects the status of possession of marijuana. That section redefines possession and makes it an element of the offense of "misconduct involving a controlled substance in the seventh degree", a violation, if one possesses less than four ounces of marijuana in other than a public place.

Bill sections 3 and 4 authorize and direct the use of citations as the means of handling and disposing of violations under AS 11.71.070.

Bill section 3 adds a new section, AS 11.71.075, to authorize the use of citations (rather than arrest warrants) for these offenses. Bill section 4 amends AS 12.25.190(c) by adding this proposed AS 11.71.075, which relates to the offenses that constitute misconduct involving controlled substances in the seventh degree, to the list of the types of complaints that may be resolved and disposed of through the use citations.

The net effect of these changes is that persons who possess less than one ounce of marijuana in a public place or who possess less than four ounces of marijuana in other than a public place may be cited (rather than arrested), and may dispose of their citations by payment of bail in lieu of fine in an amount determined in a bail schedule by court rule.

Finally, bill sections 5 and 6 make technical changes to two existing sections that contain references to prosecutions brought under those statutes that define crimes of misconduct involving controlled substances. The changes are necessary because of the addition of new material in proposed AS 11.71.075.

*

As this measure was developed, I thought it useful to try to summarize within the text of the bill the elements of it that relate to the change in the treatment of small amounts of marijuana proposed by this bill. To do that, I included bill section 1. That section briefly notes the significant change in the treatment accorded possession of a small amount of marijuana made by bill section 2, and the use of citations, authorized by bill sections 3 and 4, as the primary means of enforcement of that change in treatment.

*

If this memorandum or the bill to which it relates prompts questions, please contact me.

Enclosure

JC:gc:kb
WKG5/080

Item 12

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 88
PUBLISH DATE:

FISCAL NOTE
REQUEST:

Revision Date:
Title: Making possession of marijuana illegal
Sponsor: House State Affairs
Requestor: House State Affairs

Agency Affected: Public Safety
BRU: Alaska State Troopers
Component: Detachments, C.I.B. and V.P.S.O.

EXPENDITURES/REVENUES: (Thousands of Dollars) (Inflation not included)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

This bill makes possession of small amounts of marijuana (less than four ounces) a "violation", punishable by a fine. The "bail amount" (fine) will be set by the state supreme court by court rule.

It is anticipated that the majority of new criminal cases under this bill would arise from situations where a State Trooper contacts a person on another matter, and the use or possession of marijuana is discovered during the contact. For this reason, we believe the fiscal impact of these additional cases can be absorbed within existing resources.

Prepared by: Francis C. Allan
Division: Alaska State Troopers
Phone: 269-5691
Date: 01/27/89

Approved by Commissioner: Arthur English
Agency: Department of Public Safety
Date: 1/30/89

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: H.B. 88
PUBLISH DATE: 1-18-89

FISCAL NOTE

REQUEST:

Revision Date:
Title: "An Act amending the definition of the offense of misconduct."
Sponsor: State Affairs Committee
Requestor:

Agency Affected: Department of Corrections
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This legislation will have no fiscal impact on the Department of Corrections.

Susan E. Knighton

Prepared by: Susan E. Knighton, Director
Phone: 465-3376
Division: Administrative Services
Date: 2-1-89

Approved by Commissioner: Susan Humphries-Barnett
Date: 2-1-89
Agency: Department of Corrections

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 88
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: "An Act ... making possession of less than four ounces of marijuana illegal..."
Sponsor: House State Affairs
Requestor: House State Affairs

Agency Affected: Department of Law
BRU: Prosecution
Components: All

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Please see the attached analysis.

Richard I. Pegues

Prepared by: Richard I. Pegues, Director
Phone: 465-3672
Division: Administrative Services
Date: January 30, 1989

Richard I. Pegues /FOR/

Approved by Commissioner: Grace Berg Schaible, Atty. Gen.
Date: January 30, 1989
Agency: Department of Law

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 88

This bill amends AS 11.71 by making the personal possession of less than four ounces of marijuana illegal as the offense of misconduct involving a controlled substance in the seventh degree. Misconduct involving a controlled substance in the seventh degree is, under current state law, a violation punishable by a fine. The bill also provides that a law enforcement officer who stops or contacts a person for possession for a small amount of marijuana may issue a citation for that offense, and the person who receives the citation may waive a court appearance and remit a payment as satisfaction of the offense. This bill will not have a fiscal impact on the Department of Law because prosecution of violations does not usually involve the department's staff resources.

Item 2D

Alaska State Legislature

House of Representatives
COMMITTEE ON STATE AFFAIRS

TO: Jack Chenoweth
Legal Services

FROM: Dennis J. Burns, Committee Aide
House State Affairs Committee

DATE: January 26, 1989

RE: HB 88 Making Possession of Marijuana Illegal

I have been requested to ask the following questions regarding HB 88:

1) If possession of marijuana in the home under HB 88 is a violation, would it be subject to constitutional (court) review? If so, would it stand?

2) If HB 88 passed, what affect would it have on the attached proposed initiative/bill?

Room 102 Capitol Building, P.O. Box V, Juneau, Alaska 99811 (907) 465-4931

I

Marie G. Majewske, Chair
Marijuana Initiative Committee
4002 Kingston Drive
Anchorage, AK 99504
(907) 333-0717

The Honorable Stephen McAlpine
Lieutenant Governor, State of Alaska
P.O. Box AA
Juneau, AK 99811

STATE OF ALASKA
RECEIVED
DEC 16 1988
LIEUTENANT GOVERNOR

Dear Lt. Governor McAlpine:

We are enclosing an application proposing an initiative which relates to repeal of personal usage of marijuana, and a $100.00 deposit. Under AS 15.45.30 this application must include and does include:

1) The proposed bill. 2) A statement that the sponsors are qualified voters. 3) The designation of an initiative committee. 4) The signatures and addresses of sponsors, with additional signatures to be received in the next two weeks. 5) A resolution requesting repeal of the existing law.

Inasmuch as there has been a tremendous amount of concern about the permissive statute that allows consumption of marijuana in the home and its potential harmful effects on individuals, and the cost to society within the family and outside the home; and inasmuch as we feel that the Legislature for over four years while having bills to correct the problem has failed to act according to the vast majority of the people of Alaska; and whereas numerous local governments and community representative groups have asked the Legislature to repeal the law that condones personal possession and usage; we now ask your approval of this initiative for the people of the State of Alaska to vote on this issue.

We are aware that you and the Governor have expressed support for affirmative action on this issue by the Legislature, and therefore we find it necessary to request your cooperation in approving this application, and expediting the issuing of the petition booklets through the Director of the Division of Election.

It is our understanding that should this not be proper form for certification you could assist us in conforming to the Constit..ion and proper statutes. We would most appreciate any help or advice you would offer.

Sincerely yours,

[illegible signature] Sponsor	Marie G. Majewske Sponsor
[illegible signature] Sponsor	Sandra K. Spargo Sponsor
- Edward P. Young	- Linda Douglass "Just Say No!" Alaska Area Organizer
- David P. Renkoski	- Marsha L. Haas
- [illegible signature]	- Alyce A. Hanley
- Terrence H. Martin	-
- [illegible signature]	-

A Bill Enacted By The People of The State of Alaska Under Their Authority Granted By The Constitution Article XI Section 1, 2, 3, and 4; Alaska Statute AS 15.45.010

A BILL

For an Act entitled: "An Act relating to marijuana."

BE IT ENACTED BY THE PEOPLE OF THE STATE OF ALASKA:

Sec. 1 AS 11.71.060(a) is amended to read:

(a) Except as authorized in AS 17.30, a person commits the crime of misconduct involving a controlled substance in the sixth degree if the person

(1) uses or displays any amount of a schedule VIA controlled substance or possesses one or more preparations, compounds, mixtures, or substances of a aggregate weight of <u>less than one-half pound</u> containing a scheduled VIA controlled substance; or

(2) refuses entry into a premises for an inspection authorized under AS 17.30.

Sec. 2 AS 11.71.070 is repealed.

Item 2E

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M January 30, 1989

SUBJECT: Questions pertaining to House Bill 88

TO: Representative H.A. "Red" Boucher, Chair
House State Affairs Committee

FROM: Jack Chenoweth
Legislative Counsel

House Bill 88 makes possession of small amounts of marijuana in other than public place a violation.

I

You have asked if a citation and payment of the penalty imposable under HB 88 would be subject to constitutional review. The answer is "yes". Whether or not a constitutional attack would succeed is a separate, albeit significant, question.

Suffice to say that the court decision in Ravin v. State, 537 P.2d 494 (Alaska, 1975) is helpful, but not definitive. In Ravin, you may recall, the court concluded that there was

> . . . no adequate justification for the state's intrusion into the citizen's right to privacy by its prohibition of possession of marijuana by an adult for personal consumption in the home. The privacy of the individual's home cannot be breached absent a persuasive showing of a close and substantial relationship of the intrusion to a legitimate governmental interest. . . . [M]ere scientific doubts will not suffice. The state must demonstrate a need based on proof that the public health or welfare will in fact suffer if the controls are not applied.

Ravin, at 511. Nothing in the intervening 13 years suggests that the court has modified the requirement enunciated in the last sentence.

Unlike the other measures to "recriminalize" marijuana, this bill is not accompanied by a comprehensive set of findings. If possession of small amounts of marijuana is to be made a crime, as those bills would do, the inclusion of findings "to demonstrate a need based on proof that the public health or welfare will in fact suffer if the controls are not applied" is essential to sustain the bill. To meet the requirement of the Ravin test, the committee may want to prepare findings for inclusion in HB 88.

Review of the testimony offered to marijuana-related legislation during the last legislative session suggests a genuine division of opinion as to whether or not the public health or welfare suffers by uncontrolled possession of small amounts of marijuana for personal use. One cannot conclude as to marijuana, as the court has done with reference to cocaine in State v. Erickson, 574 P.2d. 1 (Alaska, 1978), that the substance represents a substantial threat to public welfare and safety. As to marijuana, there still seems to be no firm conclusion.

Still, in the years intervening since the Ravin decision, society's tolerance for use of certain products has diminished. Laws affecting sale of tobacco and alcohol have been amended, in part out of a greater appreciation of the debilitating effects of those products to significant numbers of people within society.

HB 88 makes possession of small amounts of marijuana in other than a public place illegal, but punishable only as a violation (i.e. by payment of a fine), not as a crime (with the possibility of a jail sentence). Arguably, the absence of findings is not necessarily fatal to a defense of this bill. Enactment of HB 88 seems predicated on an implicit legislative determination that possession of less than four ounces of marijuana "involve[s] conduct [that is] inappropriate to an orderly society, but which [does] not denote criminality in [its] commission". AS 11.81.250(a)(6). In defense of the bill, one may argue, I think, that the legislature was determining only that possession of marijuana in small quantities for personal use was inappropriate, but not so wrong that, as a matter of law, more serious legal consequences should attach. The proposal to make that possession a violation permits the legislature to reach that conclusion.

II

You have asked whether adoption of HB 88 would have an affect on a proposed initiative.

If submitted to the voters and approved, the proposed initiative would make the conviction for possession of less than one-half pound of marijuana a class B misdemeanor, a crime.

If certified for inclusion on the November, 1990, ballot, the lieutenant governor may thereafter withdraw the certified initiative (or, alternatively, not certify its inclusion on the ballot) only if, "before election, substantially the same measure has been enacted". Article XI, section 4, state constitution. The test of substantial similarity is established in Warren v. Boucher, 543 P.2d 731 (Alaska, 1975), a case involving an initiative relating to regulation of campaign contributions and related legislation:

> If in the main the legislative act achieves the same general purpose as the initiative, if the legislative act accomplishes that purpose by means or systems which are fairly comparable, then substantial similarity exists.

Warren v. Boucher, at 736. The approaches used need not be exactly similar, and some allowance must be made for complexity of the subject matter of the two measures:

> It is not necessary that the two measures correspond in minor particulars, or even as to all major features, if the subject matter is necessarily complex or if it requires comprehensive treatment. The broader the reach of the subject matter, the more latitude must be allowed the legislature to vary from the particular features of the initiative.

Ibid. Applying its test, you will recall, I am sure, the majority of the court determined that the initiative and the legislated measure were substantially similar, and that you were correct in withholding the initiative from the forthcoming election ballot:

> Viewing the two measures as a whole we find that they accomplish the same general goals. They adopt similar, although not identical, functional techniques to

> accomplish those goals. The variances in detail between the measures are no more than the legislature might have accomplished through reasonable amendment had the initiative become law. Nothing is present here to suggest that the act was a subterfuge to frustrate the ability of the public to obtain consideration and enactment of a comprehensive system to regulate election campaign contributions and expenditures.
> . . . .

Warren v. Boucher, at 739.

Procedurally, as you know, the determination is assigned by AS 15.45.210 to the lieutenant governor, who acts "with the formal concurrence of the attorney general".

I hesitate to say what those officers would conclude on the question. Chief among the factors they would consider would surely be the fact that (1) the initiative would "recriminalize" possession of small amounts of marijuana, while the proposed legislation would make that possession illegal but not criminal, (2) the penalties imposable under HB 88 and the initiative petition would lead to the imposition of penalties that were significantly different, and (3) the initiative and the bill are mutually exclusive in that adoption of the initiative, making possession of marijuana a misdemeanor, would essentially supersede or "swallow up" the bill making marijuana a violation, were it enacted.

JC:kb
wkk1/089

ROYAL NETHERLANDS EMBASSY
Office of Health and Environment
4200 Linnean Avenue, N.W., Washington, D.C. 20008-3896
tel. 202-244-5300, telex 248336 or 89494, telefax 202-362-1859

Mrs. Barbara Pritchett
Office of Representative Peter Goll
P.O. Box V
Juneau, Alaska 99811

No: VMA/av/433/89111608

November 16, 1989

Re: Drugpolicy in The Netherlands

Please find the enclosed document(s):

X For your information

X With reference to your request

Dr. Bert Metz
Counselor for Health
and Environment

Drug policy in the Netherlands

Main aim of drug policy

The "official" aim of drug policy in the Netherlands is to contribute to the prevention of and to deal with the risks that drug abuse presents to individuals themselves, their immediate environment and society as a whole.
The general point of departure of Dutch drug policy is health protection and prevention. We always bear in mind that the drug abuse problem is basically and principally a matter of health and social well-being. It is not in our view primarily a problem of police and justice. The role of the criminal justice system is supportive to this.
Therefore the State Secretary of Health is responsable for the coordination of the Netherlands drug policy.

We are fully aware of the necessity to prevent as much as possible a situation in which more harm is caused by criminal proceedings than by the use of the substance itself.

Four measures are used:
a. to diminish the availability of illicit drugs
b. to prevent drugproblems
c. to reduce the risks of drug use for the consumers
d. to alleviate the negative effects for society
In the Netherlands a pragmatic balance is sought between these different approaches. We do not ignore the fact that there are problems related to the illegal nature of the drugmarket (such as high prices of drugs and therefore drug-related crimes, increased risks of infection, malnutrition, social rejection). Our care and treatment policy is partly aimed at alleviating the unintended negative effects of measures aimed at limiting the supply of drugs.

re a. diminishing availability

The highest priority is given to the fight against the international and national trafficking of hard drugs such as heroin and cocaine, and the international trafficking of cannabis products (hashish).
Because the Netherlands traditionally is a transit-country for many (licit and illicit) goods international cooperation in the field of law enforcement is essential and has been strengthened during the past years.

re b. prevention

Prevention takes place in three ways:

1. information and education to risk groups (in schools, youthclubs: there is a wide network of prevention facilities, nationally supported)
2. reducing supply (separate the illicit markets of hard and soft drugs in order to prevent soft drug users from becoming hard drug users). The use of drugs (hard and soft) is at least stabilizing in the Netherlands!
3. information to intermediairies (parents, doctors, teachers, see 1.)

re c. aid and treatment

Between 50 and 75% of the 15000 - 20000 heroin addicts has regular contacts with an aid institution.

Two main aims of aid policy are:

- to increase the accessibility of aid services (methadone programmes, streetcornerwork, "walk-in-centres") in order to reach as many as possible addicts with drug kind of aid
- to promote resocialisation (projects in the field of housing, education, work); this is not after-care but should start at the beginning of treatment.

There are four types of aid services:

- residential drugfree treatment centres (900 beds)
- ambulatory treatment centres (70 regions)
- municipal methadone maintenance programs (10)
- facilities for social care (60 regions)

There is a coherence between the criminal justice system and the welfare and health care system:

- the ambulatory treatment centres (Consultationbureaus for Alcohol and Drugs) have a probation task
- the criminal justice system diverts addicts to medical drug treatment centres (suspended sentence by putting pressure on addicts to go into treatment).

Results

- a stabilization of the use of heroin and cannabis, especially among minors (15000-20000 heroin addicts)
- the average drug misuser is older than some years ago
- the age on which youngsters start drug use has become higher
- an improvement of the physical functioning of addicts
- a separation of heroin and cannabis markets
- a relatively low percentage of "drug deaths" (compared to other European countries: 50% lower)
- a relatively low prevalence of AIDS among intravenous drug users (Netherlands: 4% of the AIDS cases are drug users; Europe: 17%

Fact sheet on the Netherlands drug situation

- in the Netherlands population (14,5 million) the number of hard drug addicts (heroin and/or cocaine) is about 15,000 to 20,000;

- a minority of addicts (circa 40% = 6,000 to 8,000) uses hard drugs intravenously; the remaining 60% "chases the dragon" (inhales the vapour of the burned drug);

- 70% live in the four larger cities: Amsterdam, Utrecht, The Hague, Rotterdam;

- 70% of the addicts are male, 30% female;

- average age of addicts in the Netherlands: between 25 and 35 years; average age in Amsterdam is increasing: 1981: 26.7 years; 1986: 29.6 years;

- the population of addicts of 21 years of age and younger has decreased from 14.4% in 1981 to 5.1% in 1986;

- ethnic minorities (people from Suriname, Dutch Antilles and Morocco) are overrepresented;

- in Amsterdam the prevalence of addiction among people of Surinamese and Antillion origin is estimated to be 3 to 4 times higher than among Dutch people;

- only about 4% of addicts from ethnic minority groups inject their drugs; the others chase the dragon;

- the Amsterdam Municipal Health Service estimates that from the 6,100 to 6,800 drug addicts in Amsterdam, 60 to 70% has been reached by any kind of aid (treatment or couseling);
the main objective of the Netherlands treatment policy is <u>to reach as many as possible addicts with aid</u> (drug free, methadone or other forms of assistance);

- on July 1, 1987: to about 6,000 addicts methadone has been prescribed on a daily base;

- in Amsterdam: since 1981 the number of addicts treated in drug free treatment has doubled;

<u>Aids:</u>
- estimate: 800 drug addicts <u>in Amsterdam</u> are seropositive; 55% is a foreigner)
- of the 420 Aids-cases (dead and alive) reported up to December 31, 1987, 16 cases were among intravenous drug addicts and 5 among homosexual man also using i.v. drugs = 5%;
- in 1987 about 800,000 clean needles/syringes have been changed for used ones (Aids-prevention);

Recent development:
the State Secretary and the Ministry of Justice sent a government paper to the parliament on the legal possibilities to put more pressure on addicts to accept treatment as an alternative or subsitute for punishment (this is not compulsive (dwang)treatment!).

MINISTRY OF WELFARE, HEALTH AND CULTURAL AFFAIRS

a national policy outline on Aids and drug use

1. The main target of our Aidspolicy is limiting the spread of the Human Immunodeficiency Virus (HIV) by means of reducing the behavioral risks involved. With regard to intravenous drug users changes of life style towards safe sex and safer use are necessary.

2. Risk reduction means feasible changes of lifestyle. Therefore if a reduction of sexual behaviour is not possible drug addicts need to learn safe sexual techniques. When quitting drug use, or taking drugs in a non-intravenous way, cannot be reached, i.v. drug users need to learn to inject their drugs safely. Health education should therefore be accompanied by the availability of condoms and sterile needles and syringes.

3. Since drug users form high risk groups all efforts should be directed to reaching these groups. This implies a high degree of accessability of drug treatment services (geographically and with regard to the offer of services, for instance methadone maintenance), an outreaching approach of these services (streetwork, fieldwork in hospitals and jails, low threshold "open-door-centres") and realistic, pragmatic treatment aims (not primarily be directed to kicking the habit but to risk reduction).
   Maintaining this treatment approach is a primary condition for effective Aids policy.

4. In the Netherlands the out-patient drug treatment services fulfill a central role in Aidsprevention.
   - They form a dense network all over the country (60 cities, more than 100 out-patient services).
   - They have contact with most of the drug addicted population. It is estimated that at least 60% of the addict population (20.000) maintains a contact with a treatment agency.
   - They are confronted with clients who are concerned with Aids.
   - They are experts in dealing with drug addicts.

5. A large group of i.v. drug users remains to be out of reach for the ordinary drug treatment services. Therefore other ways should be found for getting the health message across. One of those ways is the use of organised consumer-groups, the so-called "junkie-unions". In 1987 there were junkie-unions in 31 cities; most of them however are very weakly organised.

6. Compulsory measures are believed to be counterproductive. The result of such measures might be that less addicts are willing to contact treatment services voluntarily.

7. The following groups deserve special attention:
   - streetprostitutes and addicts belonging to ethnic minorities, because they are difficult to reach;
   - children of addicted parents, because of the risk of perinatal infection;
   - drugaddicts from neighbouring countries, who are afraid to be sent back.

8. Other aspects of Aids policy which should be dealt with are:
   - preventive action in police-stations, jails and prisons, because a large group of drugusers consists of offenders of the Penal Code;
   - health protection measures for personnel in the criminal justice system and in the addiction treatment system;
   - improving the knowledge of treatment personnel about Aids and Aidsrelated issues, such as death, sex and drug use;
   - strengthening the opportunities for local consumer groups (junkie-unions) for health education;
   - improving the psycho-social and medical care of addicted Aidspatients.

9. What is the role of national government?
   Its policy instruments are funding, legislation and information.
   Funding:
   - the Netherlands Institute on Alcohol and Drugs stimulates preventive measures by local treatment agencies (health education, sterile needles and syringes, condoms). The Amsterdam experiences form an important example;
   - the Federation of Netherlands Junkie Unions stimulates health education through local consumer groups (health education, sterile needles and syringes and condoms);
   - municipalities are financially stimulated to take action towards local preventive approaches;
   - epidemiological and evaluation research is undertaken, in order to gear our policy towards the right direction.

   Legislation:
   no legislative measures are planned except for an explicit directive towards Aidsprevention in the Government Financing scheme for out-patient treatment facilities (the so-called consultation bureaus for alcohol alcohol and drugs).

   Information:
   by means of clear policy statements and a realistic approach towards

the Aidsproblems irrational and ineffective societal reactions are prevented, onorthodox measures such as the needle-exchange-programs are promoted and the central role of drug treatment agencies is stimulated.

10. In close cooperation with the national representative organisations of all agencies and persons concerned the Ministry of Welfare, Health and Cultural Affairs has designed a special action and funding programme for Aidsprevention among drug users in 1988. Now over 30 cities have initiated prevention programmes, including needle-exchange-facilities, together with drug treatment institutions. In all cities with some concentration of addicted streetprostitutes low-threshold open-door-centres, sometimes together with streetcornerwork has started or will start.
Experiments with an improved out-patient psycho-social and medical care of addicted Aidspatients will start in Amsterdam and will be stimulated -where necessary- throughout the country.
For the measures described above additional funds of Dfl. 3 million yearly have been made available.

L.J.S. Wever
Alcohol, Drug and Tobacco Branch

TESTIMONY OF

EDDY L. ENGELSMAN

HEAD ALCOHOL, DRUGS AND TOBACCO BRANCH
MINISTRY OF WELFARE, HEALTH AND CULTURAL AFFAIRS

THE NETHERLANDS

BEFORE THE U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

FOR HEARINGS ON AIDS AND THE INTRAVENOUS USE OF DRUGS

WASHINGTON, D.C.

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P.O.Box 5406
2280 HK Rijswijk
The Netherlands
Tel. 31-70-406937
Fax. 31-70-405048

THE NETHERLANDS' POLICY ON AIDS AND ... ABUSE

Syringe exchange programmes: not a panacea but an integral part of a comprehensive preventive approach

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Introduction

For a long time there has not been any medical disorder that has such an emotional and dramatic impact on society like AIDS. It renders many of us powerless, since AIDS is an incurable disease.
We know, however, that AIDS is not a natural disaster that just happens to people but a disease caused by the Human Immunodeficiency Virus (H.I.V.) which is transmitted by means of human behaviour. Human behaviour can be influenced if we are determined to do so and if we try to influence it in an appropriate way.
It is a fact that one of the principal modes of transmission of H.I.V. is needle sharing by intravenous (I.V.) drug users. In addition to needle-sharing some intravenous and non-intravenous drug users engage in unsafe sexual activity.
The aim of my contribution is to address the possibilities to change addicts' behaviour, the role of syringe exchange programmes with that and above all the many social and health conditions which must be satisfied in order to achieve these changes.
Dutch measures for tackling the AIDS problem in relation to drug users can only be understood in the context of our pragmatic drug policy, whilst Dutch measures for controlling drug problems can only be understood in the context of history and culture, combined with the policy of social security based on solidarity.
Let my clarify some backgrounds.
The Netherlands is a small country. It covers a land area of almost 13,000 square miles - about one fourth of the size of New York State. Within this territory live more than 14.7 million people, including some 600,000 foreigners, making the Netherlands one of the most densely populated countries of the world.
In the past hundred years the country has developed into a modern industrial society.

> The city of Rotterdam (the second city of the Netherlands) exemplifies importance of foreign trade. Thanks to its huge transit traffic, it is the largest port in the world.
> The fact that the Netherlands finds itself continuously on the receiving end of what for the United States is its biggest trade surplus with any of its foreign trading partners (some $ 4 billion in 1987) does not unduly worry us. To a great extent our imports from the United States find their way into new products manufactured in the Netherlands, often for export. The Netherlands is the second largest foreign investor in the United States, with a total amount of approximately $ 50 billion, and the United States is the largest foreign investor in the Netherlands, with $ 14 billion.

Even such a seemingly unhistoric factor as geography should be interpreted in the light of history and culture. In the case of the Netherlands, this is particularly obvious, as borne out by the proverbial statement that God made the world, but the Dutch made Holland' of course with the help of God. Indeed, a great deal of the physical landscape is literally man-made, about a third of the country, consisting of former swamps, lakes or even patches of sea drained one by one and turned into valuable polder land. To foreign observers the most striking feature of the Netherlands has always been the abundance of water: water constituting both a threat and a means of livelihood, necessitating the building of dams and dikes, and drawing the people toward seafaring and trade. The Dutch have never conquered the sea but succeeded in controlling this enemy. Surely this factor of natural environment has provided an important stimulus to a realistic and pragmatic attitude to life in general, in particular to Dutch drug policy.

Social security system

Although Dutch society is a close-knit, distinctive whole, there are also many differences, both geographical and culturally: Amsterdam is not representative of the country as a whole.

The conscious commitment to the values of both unity and diversity is one of the key aspects of Dutch society. Expressed in the idea of tolerance, this twofold commitment has always been a prominent tenet in the national ideology.

The concept of unity is also expressed in the system of social security. It guarantees a minimum income to every citizen by supplying old age, widow's and orphan's pensions, family allowances, and insurance benefits in case of sickness, disability, or unemployment. It sets minimum standards of housing and food and sees to it that these standards are met and it sponsors a system of medical care covering health insurance for all wage earners below a certain income level. The state further provides school education at minimum costs, and it grants scholarships if necessary.

All these arrangements are not regarded as acts of charity but as inalienable attributes of social justice. Undoubtedly, the high level of social security contributes to the overall efforts in containing the level of addiction and contributes to the relatively good health of Dutch drug addicts.

I cannot help emphasizing this since the international drug strategy and the approaches of many countries are, in my opinion, too sectoral in nature.

They address mainly <u>drug abuse</u> as the social evil. However, drug abuse does not stand alone. Although the etiology of substance abuse varies with the individual, important and close associations exist with unemployment,

boredom, and general lack of perspectives for the development of life-styles which contribute to economic and social development. Extreme poverty, discrimination of ethnic minorities, social tensions between the rich and the poor, lack of access to social and health services - all of these constitute a breeding ground for economic and social instability. In such unfavourable environments, sectoral approaches to the prevention of drug abuse, to the reduction of illicit demand, have little chance of succeeding. Such approaches will assume a symptomatic character and may even be seen by affected groups as a diversion from addressing basic faults in society. Even the supply of methadone and clean syringes may be seen as 'sops' in such social circumstances. It goes without saying, that in such societies even massive efforts to suppress illicit trafficking will not have lasting effects.

These last reflections are not intended as critical comments. They are intended to show that the sectoral approaches to curbing and containing drug abuse as a health and social problem cannot provide solutions in themselves. If conducted with appropriate regard for the prevailing socio-cultural climate, they will generate positive results at low cost. The extent to which they will generate lasting effects, is determined by socio-political and socio-economical factors which are controlled elsewhere.

General principles of Dutch drug policy

Dutch drug policy should not be seen as a specific policy that is totally different from policies on other areas in society. It is just an example of the way in which the Dutch try to control or to solve their (social and health) problems. This approach fits into Dutch culture and society and that is why it works in the Netherlands. The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic and overdramatized one.
The drug abuse problem should not be primarily seen as a problem of police and justice. It is essentially a matter of health and social well-being. That is why responsibility for coordinating drug policy lies with the Minister for Welfare and Public Health.

The risks involved in drug use are well taken into account. They are mainly categorized according to the properties of the substances taken. Differences in risks are expressed in the Dutch 'Opium Act'. But the -social- background of the users, and -as explained before- the circumstances in which the drugs are taken, the subjective expectancies and the reasons why people use drugs are at least as important as the pharmacological properties. Especially the <u>reasons</u> of use are of decisive

importance as it makes a big difference whether one takes a drug for relaxation and recreation or with the aim to overcome problems or to cope with a hard life (think of alcohol and marijuana). The effects are also different.

The Dutch do care about drug related health hazards and therefore try to address the obvious question: what policy could lead to the containment of drug misuse?
In the first place they adopted drug legislation which penalizes the possession of drugs, including hashish and marijua Secondly, the Dutch prove very pragmatic and try to avoid a situation in which consumers of drugs suffer more damage from the criminal proceedings than from the use of the drug itself.
This requires a restrained attitude towards users on the part of the state. The application of criminal law implies such a pragmatic prosecution policy. If criminal proceedings against drug users do not eliminate the drug problem but aggravate it, law enforcement steps aside.
This practice prevents young people from going underground and provides possibilities for voluntary modes of aid and treatment.
This Dutch practice should not be misinterpreted as a lenient policy. It is, on the contrary, a well-considered and a very practical policy. Dutch do not want to hide the problems of their society as they do not want them to get out of control. This pragmatic approach implies a strict distinction between enforcement policies applied respectively to drug takers and drug traffickers.

Current drug situation

Dutch policy does not produce more drug use. The use of hashish and marijuana by young people has remained stable in recent years. In 1984, 4.2% of the 10 to 18 age group has used these substances at least once and half of them still do so occasionally. One in 1,000 is a daily user (WAL, van der, 1985).
The findings of a survey held in Amsterdam in December 1987 revealed that 23.6 % of persons over the age of 12 had at some time used hashish. Last-month prevalence of cannabis use (people who have used cannabis once or more often in the previous month) appeared to be 5.5%; the highest last month-prevalence was found in the age bracket of 23 and 24 years: 14.5 %. 0.4 % has used opiates once or more often in the month prior to the interview; this last month-prevalence was 0.6% for cocaine (Sandwijk et al, 1988).
As is well-known the prevalence of drug use is always highest in metropolitan areas. So, the situation in Amsterdam is not representative for the rest of the country.

It has been estimated that there are between 4,000 and 6,000 heroin addicts in Amsterdam out of a population of about 700,000. Reliable estimates for 1989 put the number of addicts in the country as a whole at between 15,000 and 20,000 out of a total population of 14.7 million.

A number of general trends have emerged:

- the extent of the overall problem appears to be stabilising and is even decreasing in some cities; the number of overall drug deaths is stable (64 Dutch citizens, 1987); the number of deaths by overdose is considered a good indicator for the state of health of the drug using population, for example in Amsterdam this figure has been stabilized (see Annex 1);
- over the years drug abuse seems to have increased among groups in a relatively disadvantaged social and economic position, particularly among ethnic minorities;
- some of the heroin users tend not to restrict their use to heroin, but combine all manner of substances, including cocaine, psychotropic substances and alcohol;
- cocaine use in increasing, though not alarming so; since cocaine use (apart from the poly drug users' scene) is embedded in non marginalized social settings, some kinds of use-control rules could be developed; 82.2% of the respondents in a recent field study had ever had a period of abstinence of one month or longer; (Cohen, 1989);
- the average age of users is rising and today lies between 25 and 35; people are older when they take drugs for the first time;
- the percentage of addicts under 22 years in Amsterdam went down; (see Annex 2).

Intentional and unintentional effects of drug policy

In drug policy the objectives are sometimes conflicting.
Due to the direct (psychotropic) effects, governments try to discourage use through the penal system and health education. The direct effects form the primary problems, and are seen as the initial reason for passing international conventions. Nowadays we see addicts affected by additional medical and social problems. Medical problems are increased by risks of infectious diseases such as AIDS, prostitution and social ostracism and these complications are caused by pushing drugs into the illegal sphere. On the social level, additional problems have arisen from the intensified law enforcement approaches toward drug trafficking, and the adoption of new far-reaching legal measures, which have contributed to the nourishing of criminal organizations.
These additional problems -both medical and social- form the secondary problems, the unintended side-effects of drug policy.
It would be a mistake to confuse the primary and secondary dimensions of drug misuse. It is not always easy to differentiate between these effects because the appearance of the secondary problems, e.g. criminality and certain health problems, has overshadowed the 'original' health problems.

The primary effects, however, must remain the basis for drug policy including the legal measures.

The Dutch middle course: normalization

Some countries opt for an intensified war on illicit drugs, which is one extreme option. At the other extreme there are groups that favour legalization. It is stressed that there is no significant political support for the legalization of any drug in the Netherlands and the Netherlands government wants to fulfil its obligations stemming from the international drug conventions.

The Dutch have adopted their own, alternative middle course, within the boundaries of the international prohibitive approach. This orientation is a desirable approach in the socio-cultural circumstances of the Netherlands. The Dutch government wants to contain the additional (secondary) problems as much as possible, especially by means of a public health approach.
A gradual process of controlled integration of the drug abuse phenomenon in society may teach its members to cope better with this happening. The addiction problem will continue to exist but it could be reduced from one on a collective, social level to one on the individual level. It is another way of looking at drugs, not by denying that drug addiction may cause severe individual and family problems, but by demystifying the popular views on drug abuse. Integration does not mean acceptance. But discouragement of abuse is not identical with criminalizing the consumer. This approach could be compared to the alcohol- and tobacco-control policies and particularly to Dutch policy on cannabis.
Out of 14.7 million inhabitants in the Netherlands in 1987 about 18,000 people died from smoking, about 2,000 deaths were directly related to alcohol abuse, and only 64 Dutch citizens died from drug abuse. The reaction of society to the high death rates is rather surprising. It is able to cope with alcohol and smoking problems without emotional overtones and fear that the survival of our civilization is at stake, but it is not prepared to accept drugs as the cause of a relatively small number of deaths.

The aforementioned line of thought has been adopted by the Government. A process of normalization of the drug abuse phenomenon is pursued, which could lead to a de-stigmatization of drug users. This does not mean that this phenomenon has been spirited away. But it has been put in another perspective in order to enable society to face the problems from a realistic point of view, unobscured by moralistic colouring.
The process of normalization implies a change of climate. The pragmatic

aspects of drug policy must be emphasized: that it a more factual and realistic approach instead of an over-dramatized one.

Normalization and prevention

In drug abuse policy we encounter an often underestimated process. Part of the process of criminalization is the labelling and stigmatization of drug abusers. Paradoxically some young people are attracted by the exciting and glamorous life-style of being a deviant person. It is difficult to find a social position to which society would pay so much attention as to that of a drug consumer. The police hunt them, treatment personnel quarrel about the most appropriate approach, educators try to warn or deter them, some politicians consider drug addicts as the plague of the twentieth century and the population is scared. Could they themselves ever wish for more attention? And attention is what many youngsters need and want. The rejection of addicts by society may encourage or reinforce such life-styles. Repression towards experimenters and users will have the same effect.

Prevention should therefore eliminate the fascination with and misplaced idealization of a user. Being a 'junky' should be de-mythologized and de-glamourized. By pursuing drug abuse policy in the way at present favoured by many countries, a specific 'meaning' is attached to drug use. The less 'meaning' authorities attach to the drug phenomenon, the less 'meaning' it generates for addicts.

This indicates that drug takers or even addicts should neither primarily be seen as accomplices to drug traffickers, nor as dependent patients or victims, but as 'normal' citizens of whom we make 'normal' demands and to whom we offer 'normal' opportunities. Addicts may have certain (health and social) problems, but they should not be treated as a special category. The policy of normalization is based on well-considered strategic planning and does not favour or indeed allow a laissez-faire approach.

Concern must not however be accompanied by exaggerated attention. The health risks have neither been ignored nor minimized. The mere thought that cannabis is smoked with tobacco provides a reason for concern. Much attention to cannabis is paid in education programmes, albeit as a part of an integrated approach aimed at a healthy life-style. Learning how to cope with risk involving behaviour (including alcohol and tobacco use) and how to be responsible for one's behaviour and choices, is better than simply deterring and warning people. Most mass media campaigns miss direction at specific at-risk target groups and are for that reason not considered effective. Publicity may easily sensationalize the dangers of drugs and may even create curiosity and encourage experimentation with drugs.

Policy on treatment

What are the implications of normalization for the treatment of addicts? Now I enter into the foundations of Dutch AIDS prevention. Present treatment policy is a mixture of the public health approach and of traditional medical practice as well as a recognition of the importance of social background. Furthermore treatment policy fits into the more general principles and structure of social and health care. It also acknowledges the fact that our drug policy unintentionally produces additional health and social problems.

In the seventies aid facilities required the patient's willingness to become abstinent. Consequently, addicts who did not feel the need to 'kick the habit' or were not capable of doing so, remained beyond the reach of the health care system. This led to further social isolation and degradation.

In the eighties a new treatment philosophy emerged which stressed the socially backward position of drug addicts. Increasing encouragement by the Government has been given to forms of aid wich are not primarily intended to end addiction as such, but to improve addicts' physical and social well-being and to help them to function in society in a more stabilized way. 'Care' mostly precedes 'cure'. I emphasize that the number of treatment slots for drug free treatment have increased as well. The result is a differentiated national network of treatment facilities, ranging from crisis-detoxification centres, residential drug dependence units, drug free therapeutic communities, and out-patient facilities with a variety of methods used, such as psychotherapy, group therapy, family therapy, material assistance, counseling, and advising parents and other peer groups.

The (new) kind of assistance may be defined as 'risk minimization' or 'har reduction'. Or more traditionally: as secondary and tertiary prevention. Its effectiveness can only be ensured by low treshold-facilities and accessible help, which are the key concepts in Dutch drug policy. This takes the form of: outreach field work on the street, in hospitals and in jails, open-door-centres for prostitutes, the supply of the medically prescribed substitute drug methadone, material support, and social rehabilitation opportunities. Financial and geographical easy access are essential to attract drug addicts.

The supply of methadone which is free of charge (e.g. in the rebuilt city buses, in Amsterdam run by the Public Health Service of the city) is only possible after having been examined by a doctor and on medical prescription. In Amsterdam the conditions for participation are a regular contact with a medical doctor, the introduction into the central methadone registration and no take home dosages.

The so-called 'junkiebonden', a sort of informal trade-union of addicts, have been promoting their interests and have been contributing to a serious attitude of local and national authorities towards addicts.
The Junkie-unions are able to reach those addicts who cannot be reached by any 'official' aid service. This is very important in relation to AIDS prevention. They receive a subsidy from the Ministry of Health and local authorities as a stimulus for self organization and to disseminate leaflets on 'safe sex' and 'safe drug use' and to counsel fellow-addicts.

The fact that the Government wants to encourage assistance to addicts who are not able or do not -at least for the time being- want to establish a drug free life style, is indicative of the realistic and pragmatic Dutch approach. It also shows the determination not to leave drug addicts in the lurch. Failure to provide care of this type would simply increase the risk of the individual and society. This type of assistance has neither the intention to coddle people, nor does it legitimate or encourage drug use. Nevertheless the treatment personnel must always bear in mind the need to consider where to set the limits in their approach. The life-style led by an addict must never become his profession. Field studies carried out by Kaplan and De Vries (1988) in Rotterdam of low-threshold methadone clients as well as 'street addicts' have shown that the 'typical' addict is in no way an antisocial 'junk'. The studies have shown that the majority of addicts' time allocation is engaged in social activities, such as self-care and leisure (watching TV, going to disco etcetera).
The function of junky unions in this behaviour is to insert as a significant stimulus for adoption of a socially more acceptable lifestyle a community member as a peer who is representing a positive social activity, i.e. political action and organizational responsibility.
I quote: 'The preliminary results of this research is underlying the importance of protective factors as primary mobilizers of health and harm reduction. The Dutch policy of normalization seems to have produced a context where the addict seems more to resemble an unemployed Dutch citizen than a monster endangering society. The Rotterdam studies are documenting a large prevalence of 'social buffering' in which addicts spend a lot of their time at home in the company of others engaging in non-drug-seeking behaviours. Society seems to be being used as a buffer against their compulsions' (unquote). This sounds optimistic. Drug addicts seem to be able to bear some responsibility for their own behaviour.

Policy on AIDS and drugs

In the preceding part of my testimony I have tried to make clear that a discussion on preventive instruments should be related to the conditions in which these instruments are to be used.

The main target of our AIDS policy is limiting the spread of the H.I.V. by means of reducing the behavioural risks involved. With regard to intravenous drug users this requires change of life-style towards safe sex and safe drug use.
I realize that these are not easy messages to get across. Politicians promoting them may be accused of condoning or even promoting illegal and unhealthy behaviour, of breaking fundamental commitments to a drug-free society or to drug-free treatment, of violating peoples' private lives. Above all: some might say that drug users are not interested at all in their own health - let alone in the health of their fellow-citizens.
The answer to these questions is that experience with the Dutch treatment approach proves that the social and physical functioning of those addicts involved in the treatment system can be improved; in Amsterdam more addicts apply for drug-free treatment than ever. Since the introduction of the methadone buses and the out-patient methadone clinics (in 1981) the patient-load of drug free treatment and resocialisation has more than doubled. (See Annex 3).
Most of the clients from these facilities have been clients in methadone programmes before they entered drug free treatment. In addition the syringe exchange programmes did -on balance- not lead to more drug use and people are indeed willing to change their behaviour and take precautions.
A more principal and politically relevant answer might be that the spread of H.I.V. is a greater danger to individual and public health than drug misuse. This requires immediate action.
If we would pretend to have high moral and ethical standards and aim at a total banishment of all drugs, we must realize that whatever governments may wish or do, very far from all young people are deterred by the threat of punishment, or indeed by the health hazards. Neither can present drug education efforts keep thousands of young people from using these substances. The question is how to deal with these facts and which policy could lead to the optimal result.
In 1988 the implementation of a more comprehensive national policy programme on AIDS and drug use has been started.

Research shows that approximately 40% of the drug users in our country uses intravenously. However, I.V. drug use among ethnic minorities is a rare phenomenon. This is an important fact. The rather low percentage may be seen as a result of Dutch drug (health) policy.
On April 1, 1989 the cumulative number of AIDS patients in the Netherlands was 791. 8.1% (64 cases) of them were drug users. One child having AIDS has been infected via perinatal transmission by an I.V. drug using mother. Compared with the situation in other European countries and the United States this percentage is relatively low. The mean percentage of drug users

with AIDS in Europe was 28 (5,219 cases) on December 31, 1988. For the USA this figure was 27% (23,617 cases) on January 31, 1989.

More important for AIDS prevention are figures on the prevalence of H.I.V. The figures give a differentiated picture.
Since Amsterdam has the largest concentration of drug addicts, it is not surprising that the contamination with H.I.V. among I.V. drug users started in this city. Most information on AIDS as well as most of the experiences with AIDS prevention comes from this city.

According to an overview of Houweling (1987) of several samples, in 1983-1984 3.4% of the drug users entering a methadone programme in Amsterdam were seropositive. In 1985 - 1986 this figure was 27.1 %. Among the I.V. drug using group this figure was 32.7%. In 1987 the sero-prevalence was the same: 27% respectively 3%. The figures in other parts of the Netherlands are much lower. In Rotterdam: 9.7% in 1986. In Arnhem, Heerlen and Breda: 3.6 % in 1985.
In The Hague, the third city of the country, in a sample of 144 addicts in an in-patient clinic the prevalence of H.I.V. appeared however to be zero (1988).
The figures of Amsterdam -where the situation is worst- do seem to suggest that the epidemic is not growing so fast. The prevalence of H.I.V. among I.V. drug use in a follow-up study remained stable over the years 1986 - 1988 at approximately 30% (See also page 15 for evaluation data).

Conditions for appropriate AIDS prevention

Three important conditions favoured a quick start of AIDS prevention among drug users.
Firstly, the already described extensive network of accessible drug aid services made it unnecessary to build bridges to addicts. Secondly the willingness to take unorthodox measures. And thirdly the cooperation of the organizations concerned. When AIDS was introduced in the Netherlands, all health and welfare organizations joined hands in order to take coordinated action. This started in Amsterdam. At the national level in all parts of the country regional platforms were installed, mostly under the auspices of a regional or municipal health service. As to drug addiction, most of the treatment services felt responsible for drug related issues such as AIDS.
It was fortunate that in the cities of Amsterdam and Rotterdam some experience existed with the supply of sterile syringes as an unorthodox measure, in relation to the prevention of hepatitis. The supply of sterile syringes has always been a legal activity. Licensing is not required by law. These syringes were sold to drug users by pharmacists and by the

beforementioned junkie-unions. Although in many cities syringes could be obtained easily from pharmacists, in Amsterdam a syringe exchange programme was set up by the junkie-union itself in a part of the city where the availability was restricted. So, in the beginning no official aid agency was involved in syringe exchange; the exchange programme could easily be developed in 'smooth waters'. A few years later it was taken over by the municipal health service and other treatment services, mainly embedded in their methadone programmes. The health authorities were of the opinion that the supply of clean syringes should be complemented by the returning of the used ones. As a consequence, the contacts with addicts could be utilized for other preventive measures. Furthermore the national federation of drug treatment services (now called the Netherlands Institute on Alcohol and Drugs) started a prevention programme, financially supported by the Health Ministry.

The Dutch non-moralistic, low-threshold aid system (treatment and counselling) treats addicts respectfully, has a good reputation among addicts, is 'user-friendly', is free of charge, has no waiting lists, has a high degree of geographical accessibility, and is therefore able to reach a major part of the total population of drug addicts. In Amsterdam about 70% of the heroin addicts are being reached by any kind of assistance. This is higher in less urbanized regions since the situation in smaller cities is less problematic and much more surveyable. This high rate of contact has to be seen as a very positive development, especially since keeping in contact with addicts ia a prerequisite for AIDS prevention.
These three conditions -an infrastructure of aid services (60 cities, more than 100 outpatient services), consensus on preventive measures and cooperation- were important for the implementation of an AIDS prevention programme among drug users on a national scale.

Aids and drug use: preventive measures

As stated before, the main target of Dutch AIDS policy is limiting the spread of H.I.V. by means of risk reduction. Risk reduction implies safe sex and safe drug use. Risk reduction means that changes of life style become feasible. If a reduction of unwanted behaviour is not possible, safer techniques should be learned, as well as with regard to sexual behaviour as with regard to drug taking. When abstention from drug use cannot be achieved, taking drugs in a non-intravenous way should be learned. And when this is not feasible - as practice often shows- safe injection methods should be promoted. Health education should therefore be accompanied by the availability of sterile needles and syringes, as well as condoms (Cramer, 1986).

Since drug users form high risk groups all efforts should be directed to reaching these groups. Once again: this implies a high degree of accessibility of drug aid services, an outreaching approach of these services (streetwork, fieldwork in hospitals and jails, low threshold "open-door-centres", especially for prostitutes) and realistic, pragmatic treatment aims (not primarily directed to kicking the habit but to risk reduction). Maintaining this treatment approach is a primary condition for effective AIDS policy.

In the Netherlands the out-patient drug treatment services fulfill a central role in AIDS prevention.
Although the majority of drug addicts remains in contact more or less regularly, a group of I.V. drug users is yet out of reach for the 'official' drug aid services. In spite of the 'non-bureaucratic' help of the existing services they likely hide themselves from all official institutions and sometimes even from their original communities.
Therefore other ways must be found for getting the health message across. One of those ways is the use of organised consumer-groups, the so-called "junkie-unions". There are junky-unions in about 30 cities; most of them however are very weakly organised and operate in an isolated way and on a small scale.

Other aspects of Aids policy which are dealt with are:
- preventive action in police-stations, jails and prisons, because a large group of drug users consists of offenders of the Penal Code; (there is growing number of police-stations in which arrested drug addicts receive sterile syringe when they are released; only if the police find a used syringe at the moment of arrest);
- health protection measures for personnel in the criminal justice system and in the addiction treatment system;
- improving the knowledge of treatment personnel about AIDS and AIDS related issues, such as death, sex and drug use;
- strengthening the opportunities for local consumer groups (junky-unions) for health education;
- improving the psycho-social and medical care for addicted AIDS patients.

What has been and is the role of national government?
Theoretically its policy instruments are legislation and its enforcement, funding prevention, treatment and information. In the Netherlands we do not believe that legislation and enforcement are a useful instrument in order to reduce behavioural risks. Legislation would always mean a restriction of human behaviour. As to drug addicts we fear that any restrictive measures would decrease the high level of accessibility of our treatment system.

This would mean a decrease of the frequency and voluntary character of communication with drug users. Therefore the use of funding prevention, treatment and information as policy instrument is stressed.
In close cooperation with the national representative organisations of all agencies and persons concerned the Miniatry of Welfare, Health and Cultural Affairs has started a special action and additional funding programme for AIDS prevention among drug users in 1988, which has been continued in 1989. The following measures have been taken:

1. Now over 30 cities have initiated prevention programmes, including needle-exchange-facilities, together with drug treatment institutions.
2. In all cities with some concentration of addicted street prostitutes low-threshold open-door-centres, sometimes together with streetcorner-work, have started or will start; these facilities offer medical and social care;
3. Experiments with improved out-patient psycho-social and medical care for addicted AIDS (case management) patients have started in three cities and will be stimulated -where necessary- thr ;hout the country.
4. The (National) Netherlands Institute on Alcohol and Drugs stimulates preventive measures and expertise of local treatment agencies (health education, provision of sterile needles, syringes and condoms). This institute also develops and distributes material and experiences as to prevention among ethnic minorities;
5. The Federation of Netherlands' Junky Unions stimulates health education through local consumer groups (health education, sterile needles and syringes and condoms);
6. Epidemiological and evaluation research is undertaken, in order to gear our policy towards the right direction.

Furthermore by means of clear policy statements and a realistic approach towards the AIDS problems irrational and ineffective societal reactions are prevented, onorthodox measures such as the needle-exchange-programs are promoted and the central role of drug treatment agencies is stimulated.
For the measures described above additional funds of Dfl. 3 million (± US $ 1.5 million) yearly have been made available. In 1989 this has become Dfl. 4 million.

Implementation and evaluation

With regard to the implementation of preventive measures we have t) face some problems. For the drug treatment staff AIDS prevention could mean promoting the use of clean syringes where they discouraged I.V.-drug use before. Furthermore AIDS imposes problems, for instance with regard to facing death and promoting safe sex, which have not been dealt with before. By increasing the expertise of the staff on AIDS and by showing the

positive perspectives those problems can be met. The issue of conflicting treatment aims -in the case of syringe exchange they seem obvious- can be solved by using the concept of risk reduction. AIDS is a risk -one of the most important problems- of the staff's clients. Since those risks are related to drug use they cannot be denied. It would be unwise to miss a chance to take effective measures.

How effective are these measures? First of all, the full implementation of the national action programme only started in 1988. Secondly, we need more research data. The data available show a wide variety of changes in addicts' behaviour. In the forthcoming years research will be carried out as to the epidemiology of H.I.V. among drug users and the effectiveness of our preventive efforts. In this regard the role of the needle-exchange-programs and the junky-unions will be studied in more detail.
In the past few years some evaluation research has taken place. The main results can be summarized as follows.

I n f o r m a t i o n

Two studies have been undertaken in which the effectiveness of information campaigns for female drug addicts is dealt with (Van den Putte, 1986, Keesmaat, 1989). Both studies conclude that the mere provision of information leaflets in drug treatment services, such as night shelters, is not effective at all. Drug addicted prostitutes seem to obtain most information from friends and mass media, such as women's magazines. In order to get behavioural effects the medical and social workers should play a more active role: more face-to-face communication and the supply of condoms and syringes is necessary.
In addition, information for specific risk groups should be designed in such language and pictures that their (sub-)cultures are taken into account and that the information is compatible with the modes of transmission of information of these risk groups.

S y r i n g e e x c h a n g e p r o g r a m m e s

The syringe exchange programmes have been and are studied in four cities now.
Kaplan (1986) found in a sample of 50 addicts that syringe-exchangers are more integrated into both their communities and their respective treatment systems than the non-syringe exchangers. The syringe-exchange programme is used in a different way: 28% of the clients use it daily, 20% three times a week, 20% two times and 24% once a week. 80% of the exchangers reported a change of life-style: safer sex: 40%; less injecting: 20%.

Another study (Hartgers, Buning et al, 1988) shows that exchangers are older, use longer, are more often in contact with aid services and live in a more stable way. It appears that most of the exchangers use their needle and syringe only once; 10% is still sharing, while non-exchangers use their equipment more times; 24% of the non-exchangers is still sharing their syringes. The exchangers do not enter situations so often in which they possess drugs but no sterile syringe. There are no indications that the majority of exchangers tend to inject more often.
38% of the exchangers use less drugs compared with six months ago; 35% of the non-exchangers used less. 29% of the exchangers used more than six months ago, whereas 50% of the non-exchangers used more. According to treatment experts an increase of use is a 'natural' phenomenon in the drug using career of many addicts. The given percentages however show a levelling off of such increased use by exchangers in comparison with the non-exchangers.
No change of use reported 33% of the exchangers, 18% of the non-exchangers didn't change their drug use. (See Annex 4).
Hartgers and Buning also found that exchangers have better contact with treatment agencies than non-exchangers. For 25% of the exchangers the needle exchange programme serves as first contact moment with a treatment agency. This means that the exchange programme is able to attract addicts not visiting regular health care facilities. The exchange programmes enable those addicts who want to use safely to get their sterile equipment.

In 1988 the Municipal Health Service in Amsterdam registered an 86% 'return-rate' of used syringes in 11 outlets. Number of supplied syringes: 722,800.
Recent (preliminary) data from a longitudinal follow-up study among I.V. drug users in Amsterdam also show that there is evidence for a reduction of injecting risk behaviour in this group. The highest risk reduction was found in those I.V. drug users who received counselling, and this indicates that the availability of clean needles and syringes should be supplemented by intensive counselling and other preventive measures, such as directed information and health education (from 'outside') as well as efforts to improve self-protection measures (from 'inside'). These are absolutely necessary to induce a significant change of behaviour.
The prevalence of H.I.V. among I.V. drug users in this study remained stable over the years 1986-1988 at approximately 30%. The figures should be interpreted with caution as it is not known what the selection bias is of those I.V. drug users, who participated in the study (Van den Hoek, 1989)
Recent studies in The Hague and Heerlen support the findings of the Amsterdam studies.

The study carried out in The Hague showed that 33.3% of the addicts (N = 54) decreased the frequency of injecting since they entered the exchange programme.
The decrease of needle-sharing was -statistically- significant.
The Heerlen study showed a decrease of daily injecting compared with 2 years ago: 26.4% respectively 52%.
It appeared also that in the previous year relatively more respondents never shared syringes than one year earlier: 47% respectively 25%. A negative result is that still 54% had at least shared a syringe once a month during the year prior to the interview.

The overall results show that efforts to reduce at-risk behaviour do have beneficial effects.

Summary and conclusion

In The Netherlands a comprehensive and national AIDS policy including specific approaches towards drug users has started, aimed at risk reduction by changes of life-style. A realistic approach is taken in which written and oral information is channelled through the existing network of treatment services and accompanied by the material conditions for life-style changes, i.e. condoms and sterile syringes. To establish contacts with as many as possible addicts through a network of treatment of facilities is a prerequisite for long term effects of AIDS prevention.
The supply of sterile syringes is not a panacea for AIDS prevention, but an important and integral part of the comprehensive preventive strategy.
Special attention is paid to street prostitutes, children of addicts and addicts who are not reached by drug treatment services such as addicts belonging to certain ethnic minorities.
Research data are still scarce but yield signs of positive effects: there is evidence that the growth of the prevalence of H.I.V. seems to be stabilizing and that the intended behavioural changes unmistakebly do take place.

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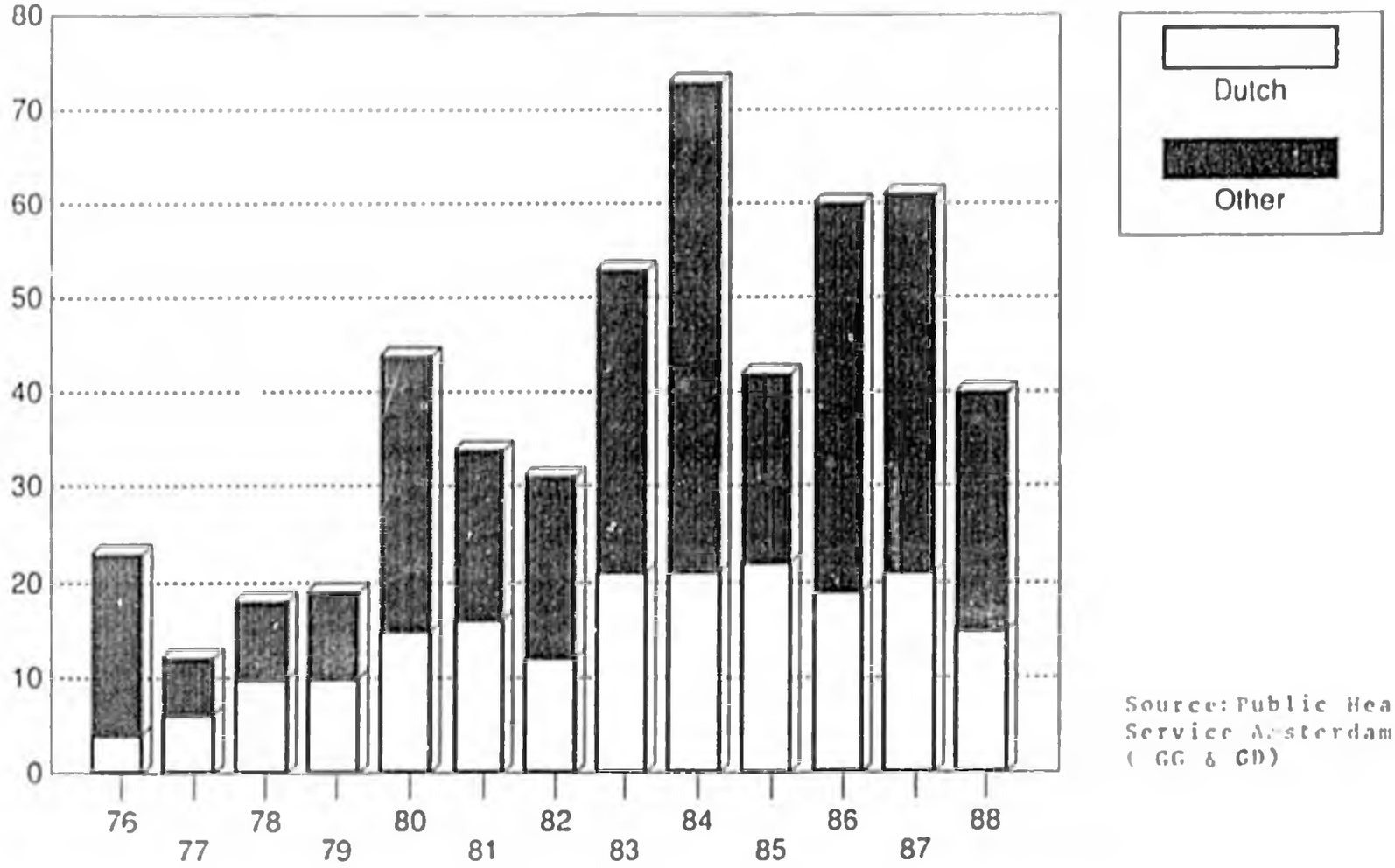
ANNEX I

Death by overdose

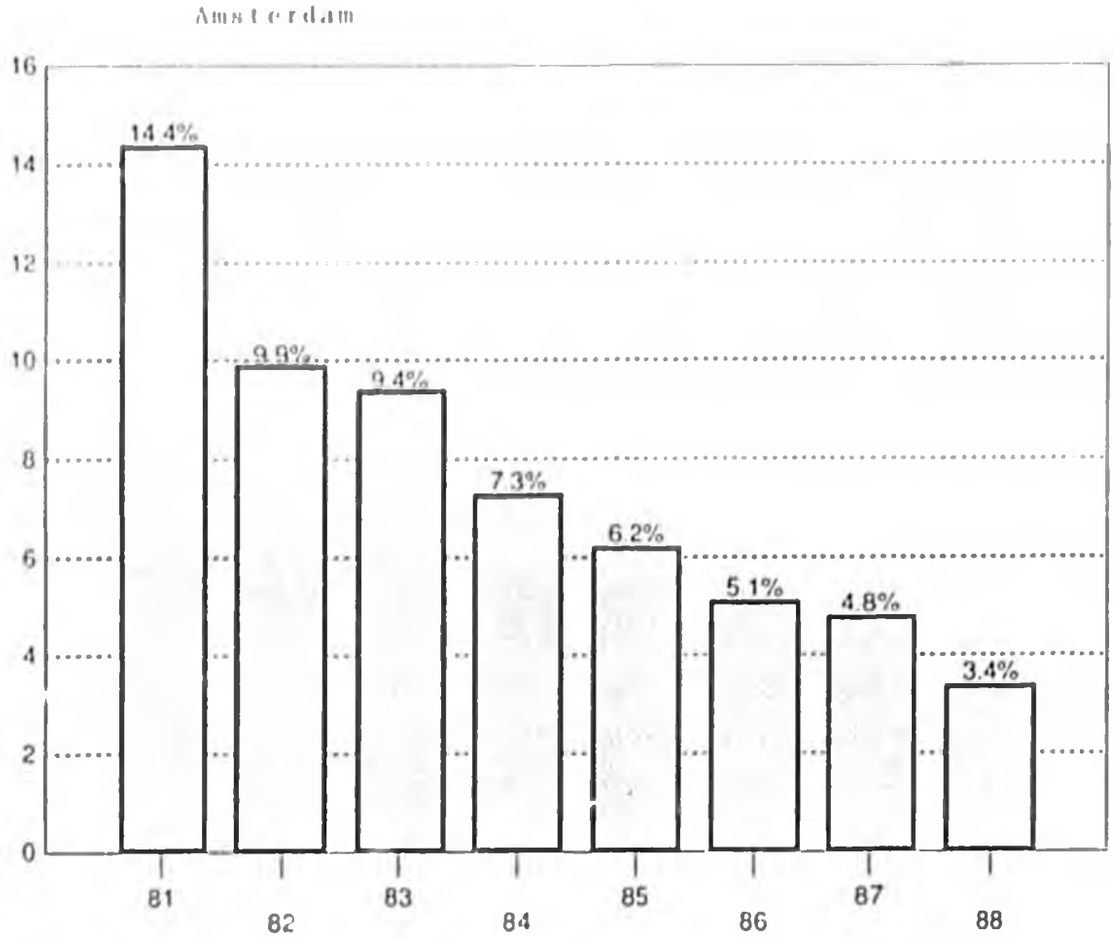
(in Amsterdam, by nationality)



Source: Public Health Service Amsterdam (GG & GD)

ANNEX 2

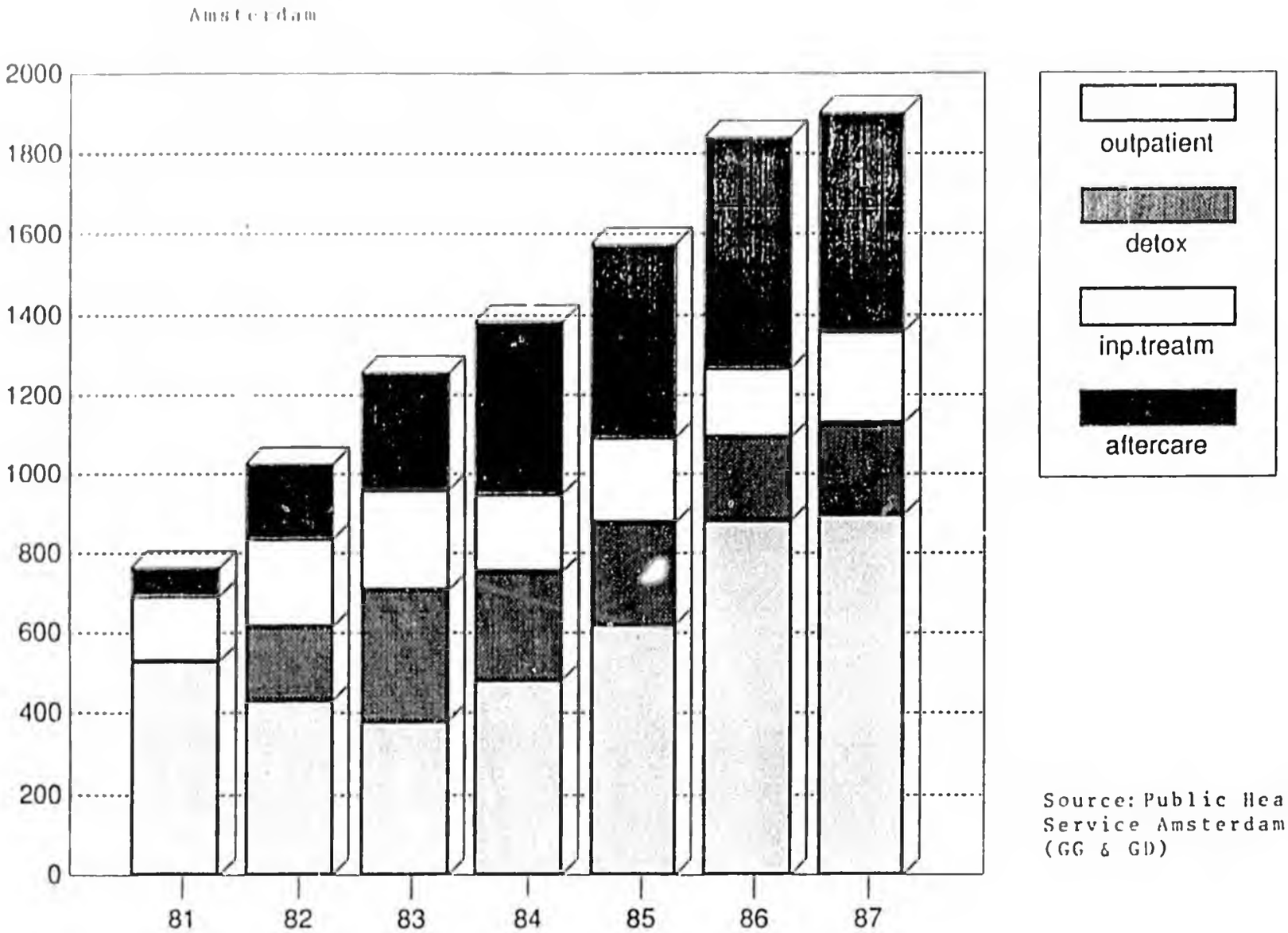
Percentage addicts under 22 years



Source: Public Health Service Amsterdam
(GG & GD)

ANNEX 3

Patient load drugfree treatment



Source: Public Health Service Amsterdam (GG & GD)

ANNEX 4

Results *

Amsterdam 1987

table 1:

general characteristics of 148 IVDU's

	male n=105	female n=43	total n=148	significance p
Dutch origin (%)	48	40	46	n.s.
average age	30.1	28.4	29.6	n.s.
average length of drug use	11	9	10	< 0.05
average length of i.v. drug use	9	7	8	< 0.05

table 2:

Characteristics of "exchangers" and "non-exchangers"

	exchangers (n=73)	non-exchangers (n=75)	significance p
males(%)	66	76	n.s.
average age(years)	31.1	28.1	< 0.001
average length of drug use(years)	12	9	0.001
average length of IV drug use (years)	9	7	< 0.05
Dutch origin (%)	55	37	0.05
no contact with methadone programme in last 5 years (%)	25	50	< 0.05

Current drug use compared with six months ago: (df = 2, p<0.05)

	exchangers	non-exchangers
more(%)	29	50
same(%)	33	15
less(%)	38	35

High-risk situation: no clean needle but drugs in possession: (df = 3, p < 0.001)

	exchangers	non-exchangers
never(%)	50	31
at least once a month(%)	25	21
at least once a week(%)	22	20
daily(%)	3	28

Needle sharing: (df = 3, p < 0.05)

	exchangers	non-exchangers
never(%)	34	21
not last 2 year(%)	31	20
not last month(%)	25	35
still sharing(%)	10	24

Risk level last month: (df = 2, p < 0.001)

	exchangers	non-exchangers
no sharing, single use of needle(%)	74	27
no sharing, re-use of needle (%)	16	49
still sharing(%)	10	24

*
- 148 intravenous drug users (ivdu's) were interviewed utilizing a standardized questionnaire
- Participation was on a voluntary basis
- No blood samples were taken

The interviewed ivdu's were recruited at the 11 "exchange-locations",as well as other places where no exchange is possible (police stations, hospitals and consulting hour for addicts from abroad)

Policy on drugs in the Netherlands

1. General

The principal aim of policy on drugs in the Netherlands is to prevent the risks associated with the use of drugs to users, their families, friends and society at large and to deal with the effects of drug abuse. It is a pragmatic policy, a down-to-earth problem-solving approach in which four elements can be distinguished:

a. reducing the availability of drugs;
b. preventing drugs-related problems;
c. limiting the risks to/damage which can be suffered by users;
d. combating the negative effects on society.

Considerable attention is given to finding the correct balance of measures in the various fields.

2. Policy

a. Reducing the availability of drugs

High priority is accorded to combating trafficking in drugs with an unacceptable risk (e.g. heroin, cocaine, LSD, amphetamines, hash oil); particular attention is devoted to international trafficking.

International cooperation

Traditionally the Netherlands - the gateway to Europe - has always been a country through which goods pass in transit and as a result it is easy for the relatively small quantities of drugs involved to be hidden among large quantities of legal goods. To combat this phenomenon international cooperation among detection services is of great importance. The Netherlands was one of the first countries to station detectives in the producing and transit countries (with officers in Bangkok, Islamabad and Lima) and also welcomes drugs liaison officers from abroad. A successful system for

the identification of suspect consignments of goods has been developed.

Special detection techniques

Special detection techniques are used, in a responsible manner, in the fight against illegal trafficking. These include controlled delivery and undercover operations, which are often conducted jointly with foreign detection agencies.

Combating illegal production

High priority is given to combating the illegal production of drugs in the Netherlands. This primarily involves the destruction of cannabis plants and the occasional LSD or amphetamine laboratory. The Netherlands is in favour of reducing the production of cocaine and heroin in the traditional producer countries and supports the development of policies within the EC to that end; the government helps fund the UN Fund for Drug Abuse Control and is also willing to participate in crop substitution projects such as the UNFDAC project in Pakistan (to which is has contributed Fl. 2.76 million).

New legislation

Under the provisions of the Netherlands Opium Act it is not only trafficking which is an offence, but also any activity preparatory to trafficking in drugs with an unacceptable risk. The Dutch courts also have jurisdiction over offences aimed at the Netherlands which are commi .ed abroad by foreigners.

Prosecutions

In 1985 prison sentences were imposed in 1,428 drugs cases, of which 1,317 concerned trafficking in/possession of hard drugs and 111 involved soft drugs offences. In 1986 there were 3,478 arrests for drugs offences, 60% of suspects being foreigners. Half of the prison population in the Netherlands is serving sentences for drugs offences and 50% of those concerned are again foreigners.

b. Preventing drugs-related problems

There are three ways of preventing drugs-related problems:

1. information campaigns directed at potential drug users (risk groups);
2. influencing the supply;
3. information campaigns directed at and support services for key figures involved with actual or potential drug users (parents, teachers, G.P.s etc).

Information campaigns

Information campaigns in the Netherlands are not generally conducted via the mass media as experience has shown that such publicity has little positive effect on drug abuse and may indeed have the opposite effect to that intended. Information is provided as part of general health education at primary schools, however. A nationwide network of dozens of experts provides teachers, parents and other people involved with young people with information on the risks of using drugs. In this way it is hoped that problems can be prevented and/or recognised at an early stage, before they escalate and become insoluble.

Influencing supply

If young people experimenting with cannabis products, which are relatively speaking less dangerous, have to rely on a black market which also deals in drugs with an unacceptable risk, there is a considerable danger of them changing over to the more dangerous drugs. Policy is therefore directed at separating the markets for the two kinds of drugs by adopting a lenient stance towards small-scale dealing in cannabis products (in "coffee shops" for example) while at the same time taking every measure possible to restrict trafficking in drugs with an unacceptable risk. This approach largely keeps cannabis out of the serious crime sphere and is believed to help break down the mythology surrounding the use of drugs so that they become less attractive to young people. The situation in which users "go underground" can then be avoided.

c. Limiting the risks to users

Nowhere in the world possesses such an accessible and differentiated network of support services for drug users as the Netherlands. Help can be obtained in all 60 localities where there are drug problems of any note. Between 50 and 75% of the 15 to 20 thousand drug addicts make regular use of the services on offer. Radical methods of treatment, such as the free supply of heroin and compulsory detoxification, have been rejected for legal and practical reasons. The national government has never considered the free distribution of heroin; the extensive publicity the subject has received was the result of discussions by Amsterdam municipal executive of the consequences of an experiment involving a limited number of carefully selected "hopeless addicts".

The Netherlands is unsurpassed in the accessibility of its support services, of which there are four types, some of which also exist in other countries:

a. drug dependency clinics;
b. out-patient detoxification programmes;
c. methadon maintenance programmes;
d. social help and support services.

The aim of a. and b. is to get addicts to kick their habit completely and permanently. Approaches c. and d. are also widely used in the Netherlands, however. Their aim is not immediate detoxification, but to give addicts time to break out of the downward spiral of drug abuse - social rejection - crime etc. Research has moreover revealed that methadon maintenance programmes which are not directly aimed at immediate detoxification result in an 86% drop in heroin abuse. This down-to-earth approach is suitable for use where there are large groups of addicts. Methadon is only supplied to addicts who are being treated by a doctor on a regular basis. "Drugs tourists" from abroad are thus not supplied with methadon for example.

AIDS

A down-to-earth approach is also appropriate in combating the spread of AIDS among and by addicts who inject heroin. Medical care for addicts provides an opportunity to publicise the importance of personal hygiene and offering addicts the chance to exchange used needles for new, sterile needles and syringes is an effective way of helping to prevent AIDS infection. An additional effect of such exchanges may even be that the continual confrontation with the threat of AIDS may persuade addicts to reduce their use.

The approach of the judicial authorities to addicts and that of the support services are linked through Alcohol and Drugs Clinics. These clinics, which are part of the mental health services, also have a probation and after-care function. Some 30% of clients report to the clinics via the judicial authorities. Thus the diversity in the forms of treatment available to drug addicts is enlarged.

The following measures also help limit the risks to users.

a. The possession of small amounts of drugs for personal use is not generally the target of active investigative work and does not generally lead to prosecution, though it is an offence as such. As a consequence addicts do not need to hide and the barriers to their seeking help and medical care are therefore lowered.

b. Where opportunities to do so exist under the law attempts are made to persuade addicts to undergo some form of treatment or supervision. They may be offered incentives to agree to this, such as having remand orders suspended, being given suspended prison sentences or being allowed to interrupt a sentence for treatment or counselling.

c. In some municipalities agreements have been reached by the police and the support services whereby addicts who are arrested can see an aid worker almost immediately.

d. Combating unacceptable effects on society

Organised international drug trafficking is one of the most serious forms of criminal activity and every effort is therefore made to combat it. Furthermore, drug abuse all too often results in crime of all kinds and the disturbance of public order, sometimes to the extent that normal life becomes impossible in certain streets or neighbourhoods. This is what happened in parts of the centre of Amsterdam. In addition to removing the drugs-related culture from such places, which have been badly affected by drug trafficking and drug abuse, attention is increasingly being given to making such areas, which are often generally run down, more attractive to live in in other ways too.

Medical and social aid to addicts also helps limit the level of crime and reduce health risks for non-users.

3. Results

The multidisciplinary approach adopted in the Netherlands is based on many years of research and positive reaction to the developments which have been observed. It appears to be producing results.

The separation of the markets for cannabis products and hard drugs is largely complete. The use of drugs with an unacceptable risk has stabilised, partly as a result of this, and is restricted to between 15 and 20 thousand addicts. The use of the most dangerous drug, heroin, is falling.

In the international context there is relatively little use of cannabis among young people in the Netherlands, and among the most vulnerable group (up to the age of 19) such use is continuing to fall considerably. According to a study conducted in 1984 only 2.4% of young people in this age group had ever used cannabis. Only 0.1% used it daily. Figures from 1983 indicate that 12% of people between the ages of 15 and 24 have experimented with cannabis products.

Use of "designer drugs" such as amphetamines and LSD is negligible in the Netherlands; in Scandinavia, the UK and the USA it is these drugs that are causing concern. Cocaine abuse is also at a much lower level than in the USA, though it has increased somewhat.

Deaths as a result of drug abuse are 50% less frequent in the Netherlands than in other countries.

The incidence of AIDS among heroin addicts who inject is an indication of unhygienic living conditions. In the Netherlands 2% of AIDS sufferers inject heroin. In Europe as a whole the figure is 11% and in the USA it is 17%.

The 1985 report of the International Narcotics Control Board provides details of the drugs problem and drugs policies in all countries.

DRUG POLICY FOUNDATION

International Conference on Drug Policy Reform

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Washington, D.C.

Responding to drug problems: Dutch policy and practise

drs.E.L.Engelsman, Head Alcohol, Drugs and Tobacco Branch,

Ministry of Welfare, Health and Cultural Affairs,

P.O. Box 5406,

2280 HK Rijswijk,

the Netherlands.

Telephone: 70 - 40 69 37.

Introduction

The aim of this paper is to elaborate on the principles of drug policy in the Netherlands. To many people this policy may seem radical or at least controversial. The aim is to shed some light on the objectives and practical experiences acquired in this country.

The Netherlands drug policy is in essence not different from drug policies of most other countries. The Single Convention on Narcotic Drugs has been ratified and the Dutch adopted drug legislation which penalizes the possession of drugs, including hashish and marijuana. However, the Netherlands is reputed for the individual character of its drug policy. Unfortunately, this reputation is sometimes based on misconceptions of Dutch legislation and legal practice, if not of Dutch culture as a whole.
Dutch measures for controlling drug problems can only be understood in the context of history and culture combined with the policy of social security based on solidarity.
Let me therefore clarify some backgrounds.
The Netherlands is a small country. Bounded by the North Sea on the West and North, by Germany on the East, and by Belgium on the South, it covers a land area of almost 13,000 square miles - about one fourth of the size of New York State. Within this territory live more than 14.5 million people, including some 600,000 foreigners, making the Netherlands one of the most densely populated countries of the world. In the past hundred years the country has developed into a modern industrial society.
The city of Rotterdam (the second city of the Netherlands) exemplifies the importance of foreign trade. Thanks to its huge transit traffic, it is the largest port in the world.
Even such a seemingly unhistoric factor as geography should be interpreted in the light of history and culture. In the case of the Netherlands, this is particularly obvious, as borne out by the proverbial statement that 'God made the world, but the Dutch made Holland'. Indeed, a great deal of the physical landscape is literally man-made, about a third of the country, consisting of former swamps, lakes or even patches of sea drained one by one and turned into valuable polder land. To foreign observers the most striking feature of the Netherlands has always been the abundance of water: water constituting both a threat and a means of livelihood, necessitating the building of dams and dikes, and drawing the people toward seafaring and trade. The Dutch have never conquered the sea but succeeded in controlling this enemy. Surely this factor of natural environment has provided an important stimulus to a realistic and pragmatic attitude to life in general.

Social security system

More than three and a half centuries of national existence have made the Dutch society a close-knit, distinctive whole. There are also many differences, both geographical and culturally: Amsterdam is not equal to the country as a whole. The differences have been jointly incorporated in the institutional pattern of Dutch society, safeguarding unity as well as diversity. Indeed, the conscious commitment to the values of both unity and diversity seems to be one

of the key aspects of Dutch society. Expressed in the idea of tolerance, this twofold commitment has always been a prominent tenet in the national ideology.
The idea of tolerance is matched by the idea of orderliness. Nonconformity in thought and behaviour, such as prostitution and homosexuality, is tolerated as long as it does not harm other citizens, with a relative absence of penal law. The concept of unity is also expressed in the system of social security. The State has been charged with the social rights. Today it guarantees a minimum income to every citizen on the basis of the National Assistance Act and on the basis of several other Acts by supplying old age pensions, widow's and orphan's pensions, family allowances, and insurance benefits in case of sickness, disability, or unemployment. It sets minimum standards of housing and food and sees to it that these standards are met.
It sponsors a system of medical care covering health insurance for all wage earners below a certain income level. The state further provides school education at mimimum costs, and it grants scholarships if necessary.
All these arrangements are not regarded as acts of charity that might be revoked at will, but as inalienable attributes of social justice. The more a society succeeds in protecting its members from poverty and hopelessness, being a breeding ground for drug use, the more it will succeed in reducing the demand for drugs.

General principles of Dutch drug policy

Dutch drug policy is often considered as an 'experiment' by foreign people. Although Dutch drug policy is deliberately designed, it should not be seen as a specific policy that is totally different from policies on other areas in society. It is just an example of the way in which the Dutch try to control or to solve their (social and medical) problems. This approach fits into Dutch culture and society and that is why it works in the Netherlands. If the Dutch would give up their drug policy, they would give up their historical and cultural identity. The Dutch being sober and pragmatic people, they opt rather for a realistic and practical approach to the drug problem than for a moralistic or overdramatized one. The drug abuse problem should not be primarily seen as a problem of police and justice. It is essentially a matter of health and social well-being[1]. That is why reponsibility for coordinating drug policy in the Netherlands lies with the Minister for Welfare and Public Health.
It should be emphasized that the role of the penal system and law enforcement in the Netherlands is not as prominent as in many other countries. Dutch people favour a policy of encirclement, adaptation and integration. Although Dutch drug legislation is still a part of criminal law, it is generally considered as an instrument of social control, the results of which should be assessed with each case, and it should not be considered as a mouthpiece for passing moral judgement. Drug legislation remains supplementary to the (informal) social control, which has for centuries been established on traditionally tight family structures conforming with a Calvinistic life-style.
Although this paper is written by a health official, it will devote some space to aspects of the reduction of drugs supply. It is a well-known fact that demand and supply reduction are not two separate worlds, but are closely related. The effects of repressive law

enforcement towards drug users and illicit traffickers influence the nature and the magnitude of the health and social problems of drug addicts to a large extent. It is very often forgotten that drug dependence syndroms as they appear to treatment and counselling staff are partly the product of the repressive control-of-supply policy. Moreover the nature and the extent of the harmfulness of drugs are often misinterpreted as they are based on these clinically described dependence problems and not on drug use experiences outside the treatment system.

Present-day drug policy in the Netherlands has largely been determined by the 1972 publication of the recommendations of the Narcotics Working Party, entitled: Backgrounds and Risks of Drug Use,[2]. The Working Party concluded that the basic premises of drug policy should be congruent with the extent of the risks involved in drug use. These risks, or the likelihood of harmful effects, are categorized according to the properties of the substances taken. However the -social- background of the users, the circumstances in which the drugs are taken, the subjective expectancies and the reasons why people use drugs are at least as important as the pharmacological properties. Especially the reasons of use are of decisive importance as it makes a big difference whether one takes a drug for relaxation and recreation (think of alcohol and marijuana) or with the aim to overcome problems or to cope with a hard life, as a form of self-medication. The effects are also different.
The penal approach should be left aside as much as possible and ought to be substituted by other methods of prevention, such as health education.

The 1976 Opium Act and the prosecution policy

The differentiation in risks is reflected in the amended 1919 Opium Act, which came into force in 1976. Thus the Amended Opium Act draws a distinction between "drugs presenting unacceptable risks" such as opiates, cocaine, LSD, amphetamines on the one hand, and "hemp products", such as hashish and marijuana on the other hand. The maximum penalties for illicit trafficking in drugs with an unacceptable risk were considerably increased to a maximum of 12 years imprisonment and/or Dfl. 1 million fine; (under certain conditions, e.g. when a crime was committed more than once, this maximum may go up to 16 years or higher). Maximum penalties for possession of small quantities (up to 30 grams) of cannabis preparations for personal use were reduced from an offence to a misdemeanour, that is one month detention or Dfl. 5,000 fine.
The Dutch do care about the related health hazards and therefore try to address the next obvious question: what policy could lead to the lowering of drug consumption? In this regard the Dutch prove very pragmatic and try to avoid a situation in which consumers of cannabis suffer more damage from the criminal proceedings than from the use of the drug itself.
This requires a restrained attitude on the part of the state and the pragmatic intentions enable such attitudes to events in practice. Prosecutors are empowered to refrain from instituting criminal proceedings if there are weighty public interests to be considered. New guidelines with priorities have therefore been established for investigating and prosecuting offences under the Opium Act. Investigation of the import and export of "drugs presenting

unacceptable risks" takes priority above investigation of the possession of "hemp products" for personal use.
In a nutshell, the application of the expediency principle implies a pragmatic prosecution policy. If criminal proceedings against cannabis users do not eliminate the drug problem but aggravate it, the law steps aside. The same principle accounts for the sale of limited quantities of hashish in youth centres and coffee shops. This aims at a separation of the markets in which hard drugs and soft drugs circulate. According to the Minister of Justice this restraint policy succeeds in keeping the sale of hashish out of the ambit of "hard" crime as much as possible.[3]
This practice also prevents young people from going underground. If that were the case, the social surroundings in which hashish circulates and those in which heroin and cocaine appear, would mix up. This somewhat controversial Dutch practice should not be misinterpretated as a tolerant or lenient policy. It is, on the contrary, a well-considered and a very practical policy. The Dutch do not want to hide the problems of their society as they do not want them to get out of control.

Results of cannabis policy

The policy of de-facto decriminalization of cannabis does not produce more drug use and has proven to be very succesful. The prevalence of cannabis use in the Netherlands is low. In the age bracket between 10 and 18 years, 4.2 per cent have ever used cannabis (life time prevalence). Among them 1.9 per cent are still using occasionally. The number of dai'y cannabis users appeared to be one in a thousand (nationwide school survey; N = 25,000 ; 1984)[4].
As is well-known the prevalence of drug use is always highest in metropolitan areas. Therefore the Dutch carried out a household survey in Amsterdam, in December 1987 (N = 4370) among respondents of 12 years and older[5]. The average life time prevalence of cannabis use was 22.8 per cent. The so-called last month-prevalence of cannabis use appeared to be 5.5 per cent. The highest last-month-prevalence was found in the age bracket of 23 and 24 years: 14.5 per cent. These percentages include even people who have used cannabis only once in the previous month.

THE DUTCH ALTERNATIVE: NORMALIZATION

On the international level most states have always pretended to have high moral and ethical standards and have aimed at a total banishment of all drugs. Last year during the UN Conference on drugs most countries were prepared to take far-reaching law enforcement measures and this escalation has been going on for years[6]. In reality, whatever governments may wish or do, very far from all young people are deterred by the threat of punishment, or indeed by the health hazards. Neither can present drug education efforts keep thousands of young people from using these substances. The question is how to deal with these facts and which policy could lead to the optimal results. In answering this question one should take into account the national socio-cultural circumstances and the cost-effectiveness of any proposed solutions. The present attempts in the UN to merge national drug policies into a single global approach are bound to prove counterproductive for many countries.

Such a universal approach neglects cultural, economic and legal differences among all member countries: the drug problem in individual countries would only be superficially dealt with.

Intentional and unintentional effects of drug policy

In drug policy the objectives are sometimes conflicting.
Due to the direct (psychotropic) effects, governments try to discourage use through the penal system and health education. The direct effects form the primary problems, and are seen as the initial reason for passing international conventions. Nowadays we see addicts affected by additional medical and social problems. Medical problems are increased by risks of infectious diseases, prostitution and social ostracism and these complications are caused by pushing drugs into the illegal sphere. On the social level, additional problems have arisen from the intensified approaches toward drug trafficking, and the adoption of new far-reaching legal measures, which have led to increasing corruption of the police, the judiciary and government authorities in some cities and states. All this leads to a "war on drugs" that enhances the escalation of criminal activities. These additional problems - both medical and social- form the secondary problems, the unintended side-effects of our drug policy.
It would be a mistake to confuse the primary and secondary effects of drug abuse. It is not always easy to differentiate between these effects because the appearance of the secondary problems, e.g. criminality and certain health problems, has overshadowed the "original" health problems. The primary effects, however, must remain the basis for drug policy including the legal measures. This pragmatic approach implies a strict distinction between enforcement policies applied respectively to drug takers and drug traffickers.
The possibility of conflicting consequences stemming from drug policies imply a social dilemma that needs discussion and which cannot be ignored on the international level. In any case more and more people get involved in such a debate in the Netherlands.
Is there any room for adjustments?

Legalization?

An intensified war on illicit drugs is one extreme option. At the other extreme there is legalization of the availability of drugs. It is clear that one may advocate legalization without having any compassion for drug addicts or without taking into account the addict's interests. The mere apprehension of the threat to the civilized legal system or the fear of an escalating arms-race between police and traffickers, may provide arguments that sound realistic. A plea for legalization does not mean that the harmful physical effects of drug use are denied or ignored. In fact, the health issues are of primary concern. The problem is indeed severe, but the cure (that is, the current drug policy) could be worse than the disease[7].
It is unrealistic to assume that with legalization international criminal organizations would terminate their illegal practices, at least in the short term. Alcohol prohibition in the USA nourished such mafia-type-organizations. Opportunity made the thief. Other illegal criminal activities started after the abolition of the prohibition. However, thinking the unthinkable, it is possible that in the long term legalization of drugs could lead to a lower crime rate.

Furthermore it is unknown to what extent drug use will increase or decrease in such circumstances. However, the nature of the addiction problem could in a decriminalized or depenalized situation, which is totally different from a "free" situation, take on a less malign character. I will come back to that. At this moment there is no major political support for the legalization of drugs in the Netherlands. The Netherlands government does not find itself on an island and wants to fulfil its obligations stemming from the international drug conventions.

Compromise between a "war on drugs" and legalization

Nevertheless, the Dutch have adopted their own, alternative way within the boundaries of the internationally prohibitive approach. It is a compromise between legalization and the war on drugs. It should be stressed that this orientation is a desirable approach in the cultural circumstances of the Netherlands.
The Dutch Government feels the need to contain the additional (secondary) problems as much as possible. A gradual process of controlled integration of the drug phenomenon in society may teach its members to cope better with this happening. The addiction problem will continue to exist but it could be reduced from one on a collective, social level to one on the individual level. It is another way of looking at things, not by denying that drug addiction may cause severe individual and family problems, but by demistifying the popular views on drug use. Integration does not mean acceptance, but discouragement of use is not identical with criminalizing the consumer. This approach could be compared to the alcohol- and tobacco-control policies and particularly to Dutch policy on cannabis. Out of 14.5 million inhabitants in the Netherlands in 1986 about 18,000 people died from smoking, about 2,000 deaths were directly related to alcohol abuse, and only 64 Dutch citizens died from drug use. The reaction of society to these figures is rather surprising. It is able to cope with alcohol and smoking problems without emotional overtones and fear that the survival of our western civilization and society are at stake, but it is not prepared to accept drugs as the cause of an even insignificant number of deaths. The Dutch Government wants to remain credible and does not want to encourage messages to youngsters such as "your drugs are killers, but ours are pleasures". Young people are very sensitive to such moral double standards.
The above mentioned line of thought was worked out in the memorandum of the Interministerial Steering Group on Alcohol and Drug Policy, entitled: Drug Policy in Motion: Towards a Normalization of the Drug Problem (1985)[8]. This policy has been adopted by the Government. A process of normalization of the drug phenomenon was advocated, which could possibly lead to a de-stigmatization of drug users. This does not mean that this phenomenon has been spirited away, but it has been put in another perspective in order to enable society to face the problems from a realistic point of view, unobscured by moralistic colouring. The process of normalization implies a change of climate. The pragmatic aspects of drug policy must be emphasized: that is a more factual and realistic approach instead of an over-dramatized one. A sound approach also means that the drug problem should not be considered as a specific social issue.

Normalization and prevention

In drug policy we encounter an often underestimated process. Part of the process of criminalization is the labelling and stigmatization of drug abusers. Paradoxically some young people are attracted by the exciting and glamorous life-style of being a deviant person. It is difficult to find a social position to which society would pay so much attention as to that of a drug consumer. The police hunt them, treatment personnel quarrel about the most appropriate approach, educators try to warn or deter them, some politicians consider drug addicts as the plague of the twentieth century and the population is scared. Could they themselves ever wish for more attention? And attention is what many drug consumers need and want. The rejection of addicts by society may encourage or reinforce such life-styles. Repression towards experimenters might have the same effect. Prevention should therefore eliminate the fascination with and misplaced idealization of a user. The phenomenon of drug use should be shorn of its sensational and emotional overtones and be made more amenable to an open discussion. Being a "junkie" should be de-mythologized and de-glamourized. By pursuing drug policy in the way at present favoured by most countries, a specific "meaning" is attached to drug use. The less "meaning" authorities attach to the drug phenomenon, the less "meaning" it generates for addicts. This indicates that drug takers or even addicts should neither be seen as criminals, nor as dependent patients, but as "normal" citizens of whom we make "normal" demands and to whom we offer "normal" opportunities. Addicts should not be treated as a special category. The policy of normalization is based on well-considered strategic planning and does not favour a laissez-faire approach.
Concern must not accompanied by exaggerated attention.
The health risks have neither been ignored nor minimized. The mere thought that cannabis is smoked with tobacco provides a reason for concern. Much attention to cannabis is paid in education programmes, albeit as a part of an integrated approach aimed at a healthy life-style. Learning how to cope with risk involving behaviour (including alcohol and tobacco use) and how to be responsible for one's behaviour and choices, is better than simply deterring and warning people. Most mass media campaigns miss direction and are for that reason not considered effective. Publicity sensationalizes the dangers of drugs and may even create curiosity and encourage experimention with drugs.

A "normalized" treatment policy

What are the implications of normalization for the treatment of addicts? Present treatment policy is a mixture of traditional medical practise and a recognition of the importance of social background. Furthermore treatment policy fits into the more general principles of the social and health care. It also acknowledges the fact that our drug policy unintentionally produces additional health and social problems.
In the seventies treatment concentrated too much on ending addiction without necessarily meeting the needs of the heroin addicts or helping them to function within society.
Treatment was carried out in outpatient facilities and addiction clinics, the latter being mainly drug free therapeutic communities. These facilities required the patient's willingness to become abstinent.

Consequently, addicts who did not feel the need to "kick the habit" or were not capable of doing so, remained beyond the reach of the health care system. This led to further social isolation and degradation.
The philosophy of abstinence was heavily criticized by the larger municipalities, as they were confronted with addicts who were not accepted by the community and who caused annoyance in some neighbourhoods, ranging from streets crowded with prostitutes and their customers to areas frequented by drugs dealers.
In the eighties a new treatment philosophy emerged which stressed the socially backward position of most drug addicts. Increasing encouragement by the Government has been given to forms of aid which are not primarily intended to end addiction as such, but to improve addicts' physical and social well-being and to help them to function in society. At this stage the addicts' (temporal) inability to give up drug use was being accepted as a fact[9]. This kind of assistance may be defined as harm reduction or more traditionally: secondary and tertiary prevention. Its effectiveness can only be ensured by low treshold-facilities and accessible help, which are the key concepts in Dutch drug policy. This takes the form of: field work on the street, in hospitals and in jails, open-door-centres for prostitutes; the supply of the medically prescribed substitute drug methadone; material support; and social rehabilitation opportunities.
The supply of methadone (including in the rebuilt city buses, for instance in Amsterdam) is only possible after having been examined by a doctor and on medical prescription. In Amsterdam the conditions for participation are a regular contact with a medical doctor, the introduction into the central methadone registration and no take home dosages.
The so-called "junkiebonden", a sort of trade-unions of addicts, have been promoting their interests and have been contributing to a serious attitude of local and national authorities towards addicts.
The Junkie Unions are able to reach those addicts who cannot be reached by any "official" aid service. This is also very important in relation to Aids-prevention. They receive a subsidy from the Ministry of Health to dissiminate brochures on "safe sex" and "safe drug use".
The fact that the Government wants to encourage assistance to addicts who are not able or do not - at least for the time being - want to establish a drug free life-style, is indicative of the realistic and pragmatic Dutch approach. It also shows the determination not to leave drug addicts in the lurch. Failure to provide care of this type would simply increase the risk to the individual and society. This type of assistance has neither the intention to coddle people, nor does it legitimate or encourage drug use. Nevertheless, the treatment personnel must always keep asking the question where to set the limits in their approach. The life-style led by an addict must never become his profession. Field studies carried out by Kaplan and De Vries in Rotterdam of low-treshold methadone clients as well as "street addicts" have shown that the "typical" addict is in no way an anti-social monster[10]. The studies have shown that the majority of addicts' time allocation is engaged in social activities, such as self-care and leisure (watching TV, going to disco). Compared to control groups of "normals", they are alone less and spend more time with significant others. They are with other people 70 percent of the time. Their drug activities seem to be functional substitutes for what in a "normal" control group are work and study activities.

Significant others are often dealers and "partners"/peers. The function of junky unions in this behaviour is to insert as a significant other a community member who is representing a positive social activity, i.e. political action and organizational responsibility. "The preliminary results of this research is underlying the importance of protective factors as primary mobilizers of health and harm reduction. The Dutch policy of the normalization seems to have produced a context where the addict seems more to resemble an unemployed Dutch citizen than a monster endangering society. The Rotterdam studies are documenting a large prevalence of "social buffering" in which addicts spend a lot of their time at home in the company of others engaging in non-drug-seeking behaviours. Society seems to be being used as a buffer against their compulsions."

AIDS and treatment policy

The result of the Dutch health policy is that the Dutch aid system (treatment and counselling) obviously is able to reach a major part of the total population of drug addicts. In Amsterdam about 60 to 80 per cent are being reached by any kind of assistance[11]. This percentage is certainly higher in less urbanized regions. This has to be seen as a very positive development, especially since keeping in contact with addicts is a prerequisite for AIDS-prevention. AIDS-prevention aims at changes of life-style. It teaches addicts to 'use safely', that is to say not intravenously, and to have 'safe sex'. Needle-exchange programmes fit into this practical approach as it is an established fact that many drug users are using intravenously and share needles. Only 8 per cent of all 605 Dutch AIDS-patients are drug addicts (October 1, 1988). In Europe this is 23 per cent (June 30, 1988) and in the United States 26 per cent (September 26, 1988). The prevalence of HIV in a non representative sample of high risk intravenous drug users in Amsterdam was approximately 30 per cent (1987). Outside Amsterdam in three smaller cities the infection rate was 3.6 per cent (1986)[13].
Conclusions from the first evaluation of the needle/syringe exchange programme[12] in Amsterdam should be drawn very carefully since the data are based on reports made by addicts. No testing on HIV was done and a follow-up has not yet been carried out.
The present data show that:
- differences were found between 'needle-exchangers' and 'non-exchangers' on a number of characteristics,
- no increase in drug use was reported by the 'needle-exchangers',
- the exchange schemes stimulated a certain group of IV drug users to take drugs in a safer way with regard to HIV infection,
- the exchange schemes contact addicts not visiting regular health care facilities.

No negative side effects, such as an increasing number of IV drug users,an increase in drug use or reduced interest in drug free treatment, were reported in the study in Amsterdam.
On the basis of the Amsterdam experience no definite answer can be given to the question whether needle/syringe exchange schemes are effective tools in the tight against the further spreading of Aids. Although safer drug use has been reported by a large percentage of the IV drug users in Amsterdam, some addicts are still (occasionally) involved in needle sharing.

Other results of drug policy.

Apart from the positive effects of normalization described above, there is also the effect of prohibition, which is still in existence. Some addicts commit crimes, mainly thefts, but addiction is never an excuse for committing a crime.
The policy of normalization did not produce higher crime rates. After an increase, registered crime has been stabilized since 1984. In comparison with many other European countries crime is even lower.

Registered crime per 100,000 inhabitants

Year	Netherlands	England	France	W.Germany	Sweden
1984	6850	7047	6817	6755	10160
1985	6906	7258		6909	
1986	6910	7707		7154	
1987	6998			7269	

Source: Ministry of Justice, Scientific Research and Documentation Centre.

The number of murder and menslaughter cases in the Netherlands is also lower than in some other countries. These cases are mainly not drug related. Last year this figure was 1.11 per 100,000 inhabitants for the whole country, whereas this figure was 8.3 in the United States; England: 1.23 (1986); W. Germany: 1.4 (1987).

In Amsterdam, with 640,000 inhabitants, this murder rate was 5 per 100,000, namely 33 cases. The city of Washington which has a smaller population (622,000) had 225 murder cases. Boston, also with a much smaller population (575,000) than Amsterdam, had 76 cases.

About one third of people who are detained are drug addicts. In the western part of the country this figure goes up to 50 per cent. These people are incarcerated for drug related crimes and not for offences against the Opium Act.[14]
This situation was unacceptable for the Minister of Justice. In collaboration with the Health Minister he sent a memorandum to parliament about Compulsion and Pressure in the Treatment of Addicts[15].
No new legal proposals were made but both the judiciary and the treatment system were urged to make more creative use of the existing legal possibilities to put pressure upon addicts to undergo treatment as an alternative for imprisonment.
Involuntary treatment is not possible in the Netherlands. Although the Government stresses the importance of the treatment alternative the Ministry of Justice seeks to develop treatment facilities in special wards within the prison system as well. To my mind, such facilities are an undesirable and confusing mixture of punishment and treament.

Some data

Reliable estimates on the number of drug addicts in the Netherlands vary between 15,000 and 20,000 out of the total Dutch population of 14.5 million; although the size of the overall problem appears to be

stabilising and in some cities to be decreasing, treatment staff suggest more mental disorders among addicts.
Over the years drug abuse seems to have increased among groups with a relatively disadvantaged social and economic background (ethnic minorities).
Estimates about the number of drug addicts in Amsterdam, the biggest city of the country, vary from 4,000 to 7,000 (population: 640,000).
To give an indication for heroin use: prevalence of heroin use in Amsterdam is estimated at 0.4 per cent (household survey among 12 years and older; 1987)[5].
The use of cocaine has stabilized; "crack" use is a rarity. Prevalence of cocaine use in Amsterdam has been put at 0.6 per cent (12 years and older; 1987)[5]. The highest (last month-)prevalence (1.7%) was found in the age bracket between 25 and 29 years.
A study carried out by Cohen on cocaine use in Amsterdam in non deviant subcultures shows that the average age of users is 30 years and the age on which people start is 22 years. About 50 per cent of the cocaine users never use more than half a gram a week. The users do not underestimate the negative effects, which mainly occur at a level of use of 2.5 gram a week.
86.2 per cent of the users reported to have stopped for more than a month, against 11.9 per cent who never did since they started cocaine use. Since the use is embedded in a social setting, without any marginalization, some limiting rules have been developed.

Many heroin users do not restrict their use to heroin but combine various substances, including alcohol and psychotropic substances, such as benzodiazepines.
The average age of users is rising (in Amsterdam from 26.8 to 30.1 years between 1981 and 1987) and people who take drugs for the first time tend to be older. In Amsterdam the proportion of drug users of 21 years and younger continues to decrease: from 14.4 per cent in 1981 to 4.8 per cent in 1987[11].
In spite of the wide availability of medically prescribed methadone (to 6300 addicts in the Netherlands on Jan. 11, 1988, an average day) there has never been so many drug addicts asking for detoxification and drug free treatment as at present. In Amsterdam this number doubled between 1981 and 1986[11].

Conclusion

In this paper I have outlined the dilemma of creating new problems while solving others. I realize that some people will also feel that there is a dilemma in setting the limits between being realistic and being indulgent in treatment. To my mind these dilemmas can only be dealt with in an open exchange of ideas. Critical questions on drug policies should be asked over and over again.

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SYRINGE-EXCHANGE; AIDS-PREVENTION AND DRUG POLICY IN THE NETHERLANDS.

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HENK JAN VAN VLIET

Metropolink • Zeeburgerpad t.o. 38 • NL 1018 AK Amsterdam
tel (0)20 - 6681337 • Hollandse Koopmansbank nr 653113880 • K.v.K. S 207290 Amsterdam

SYRINGE-EXCHANGE, AIDS-PREVENTION AND DRUG POLICY IN THE NETHERLANDS.

1. Introduction.

Intravenous (IV) drug users are one of the main groups at risk for contracting HIV and AIDS, especially via contaminated syringes and needles. Because of the illegality of drugs, the purchase of (sterile) shooting-equipment is often illegal too, like in most US-states with a high incidence of drug use. In a number of other countries, in Europe and elsewhere, there is a limited availability, sometimes combined with an active destruction policy by the police. These situations account for fundamentally unhygienic practices of administering drugs. Moreover, needle-sharing for social or ritual reasons is quite common in many countries.
Due to their sexual activity, often involving non-users, IV drug users and their heterosexual partners can become the main bridge across which HIV enters the general population.

For these reasons, a WHO-conference held in Stockholm in October 1986, noted that in the short term it was more important to stop drug users injecting than it was to put an end to their drug use, and if this could not be achieved then they should be persuaded to use sterile equipment, never to share equipment and to adopt safer sexual practises. The report states: "This advice is meaningless unless it is supported by the availability of sterile equipment.." 1).

Although little scientific evaluation on these programs has been done yet, syringe-exchange programs are considered to be the most effective attack at the main AIDS-risk of drug injection, needle-sharing.

In this paper I will give some facts and arguments regarding syringe-exchange in the Netherlands in the context of this country's drug policy and its anti-AIDS strategies.
In paragraph 2. I will sketch very briefly some characteristics of the Netherlands that are important for the understanding of Dutch society, Dutch drug policy and Dutch syringe-exchange programs.
In paragraph 3. I will give a survey of syringe-exchange programs.
In paragraph 4. I will make some preliminary point about this survey and comment on them.
In par 5. I will go into the discussions accompanying the introduction of syringe-exchange programs and present some evaluation data, especially from the Amsterdam Municipal Health Service.
In par. 6. I will make some points for discussion.

2. Some remarks about the Netherlands' society and the position of drug users and drug policy.

"Because no other country has reached the compactness and complexity of the Netherlands' society there are no well-tried recipes yet for the accomodation of various new kinds of business activity and society. They will have to be invented in the

Netherlands itself." 2). This seemingly chauvinistic statement of a famous Dutch lawyer and business consultant in relation to corporate activities in the late 1980's hold for many more social activities in the Netherlands, I think, and among them for many activities related to drugs and to AIDS.

Being the delta of three rivers, Rhine, Meuse and Scheldt, the Netherlands have a density op population that is only exceeded by that of Bangla Desh, being the delta of the Ganges. But Bangla Desh is an extremely poor and vulnerable country, while the Netherlands are among the ten wealthiest industrial nations of the world, very highly organized and the home base of multinational corporations such as Philips, Shell and Unilever. The Netherlands represent a type of society in which it has been proven possible to procure a very reasonable level of living for a nation of almost 15 million people, living very close together on a small territory. Every citizen is surrounded by many neighbours and it is almost impossible, geographically speaking, to hide yourself from them or from society. Many Dutch people stress this fact by always keeping their curtains wide open at night.
Yet the Netherlands is not an Orwellian society; it is a very old and stable democracy. Government bureaucracy plays a rather moderating role in society; it is often hard to please of course, but on the whole it is quite less a Big Brother than the bureaucracies in bigger European countries such as the Federal Republic of Germany, France or Great Brittain.

The characterics mentioned here apply not only to economic activities and to the population in general, but to the activities in the justice, health and drug fields as well. Drug users are officially and by an impressing social concensus considered and treated as a part of society, as deviant neighbours rather than as outsiders - although almost everybody complains, but that's another national trait. Drug users are stimulated to participate in social activities and to contribute to social coherence. If specific obstacles prevent them from these participation and contribution, then these obstacles should be dealt with by specific measures.
Thus for drug users - like for other groups at risk of dropping out of society - the Netherlands provide not only general social, health and judicial facilities, but also specific and specialized ones. Fundamentally, syringe exchange is just one measure out of a set of measures, both general and specific, meaning to implement the Netherlands social, health and judicial policies.

Long before the AIDS-crisis, and particularly in the urbanized areas, general and specific services for drug users already existed. Several government levels, the government-subsidized private services in the social and health fields and the judicial system were already strongly intertwined. The AIDS-crisis thus far did not undermine or disrupt drug policy; the crisis thus far has been kind of absorbed by the helping systems - although it produces considerable social change.

3. A short survey on syringe exchange programs.

In a series of slides I will show you some examples of health and social facilities in which syringe-exchange is part of the services delivered. I start in the West of the country, in the

metropolitan areas of Amsterdam and Rotterdam, where an estimated 2/3 of the country's 15,000 to 20,000 dependent drug users live. It is important to know that only about 40% of them - 6,000 to 8,000 - administer their drugs intravenously.

Rotterdam, where we start our survey, is the world's largest commercial port and one of the main gateways to Europe. It is part of a metropolitan area of more than 2 million people and houses an estimated 3,000 dependent drug users.

(Slides 1/5) - An outpatient methadone clinic in one of Rotterdams late 19th century labour quarters, one of the programs of the Bulldog foundation. The program consists of methadone dispension, especially on maintenance, primary health care and syringe-exchange. This syringe-exchange service has been added to the already existing services some years ago.

(Slides 6/10) - The Rotterdam street prostitution zone, and the street-level service centre 'The Shed', also part of the Bulldog foundation. Mainly heroine-dependent prostitutes come here to sit and relax for a while during the night, to take a shower, have a bite and a soda, talk to the staff, see the doctor and supply condoms and syringes. Here again the syringes are just added to the existing offer of services.

Amsterdam, our next stop, is the capital of the Netherlands, and the heart of a metropolitan area of about 1.5 million people. Because of Schiphol Airport the city is another main gateway to Europe. It is considered one of Europe's "drug capitals", both for the use and for the trafficking.
Particularly as regards the use of drugs this is an exageration. The city houses an estimated 6,000 dependent drug users of which only a minority of perhaps one thousand are to an extend responsible for this "drug capital"-image. This is largely due to the situation that they are quite visible, sometimes when dealing in drugs, in the old downtown area, which is also Amsterdam's main tourist attraction.
Another reason for this bad image are the "coffee shops", where cannabis is sold. It is the visibility of the drug problem in the Netherlands and especially Amsterdam that is shocking. If all this can happen in public what must go on in secret? is the question of many foreigners coming from countries where drug users are underground. The answer is quite simple: not very much 3). The big traffickers are underground, of course, and the police are particularly dedicated to and succesful in chasing them. But the users and street and house dealers usually live in the open. There is little need for them to go underground, generally speaking, because they are not a primary target for law enforcement agencies. And there is no strong pressure from the public to force them to go underground as well. As I said before, the Dutch do not and cannot hide the problems of their society. We have to and want to deal with our social probems in the open, and particularly not by making them taboos.

Amsterdam may indeed be an important centre of international drug trafficking, but this holds for Rotterdam too, like it does for other gateways to the European continent such as Frankfurt Airport, London Heathrow and Madrid's Barajas Airport.

(Slides 11/14) - The outreach work for dependent drug users in Amsterdam is operated especially through busses, public transport vehicles modified into mobile clinics. Originally meant only for methadone dispension to drug users referred by the central intake facility, nowadays also serving as syringe-exchange clinics for drug users without referral.
Another advantage of these busses is that they are hardly to be distinguished from the other city busses; generally they do not cause much sensation in the neighbourhoods where they stay only for one hour a day.
The busses contain a small but fully equipped clinic for methadone dispension, syringe-exchange, condom sale, a seperate room for first aid medical care and counselling. They are operated by the Municipal Health Service.

Now we leave Holland, the western part of our country, and go to the provincial town of Ede, some 60 miles east of both Amsterdam and Rotterdam (Slides 15/27). They drug programs in towns like Ede are quite different from those in the west, mainly because there are not so many dependent drug users there; they tend to move to bigger towns.
What is so special about Ede is that it it dominated politically by a extremely orthodox-prostestant and right-wing party. This party is opposed to almost everything that makes the Netherlands a modern and open industrialized nation and a relatively relaxed place to live. Yet there is a syringe-exchange program in Ede as well.
It is not a very good program, I think. When it was presented on a national syringe-exchange conference last May, it was heavily critisized as an example of a missed opportunity. The very unpersonal approach bars the possibilities for medical checks and for personal information on AIDS and drug prevention (supplier and customer cannot see each other and can only speak through an intercom).
I show you the slides particularly because the program very strongly emphasizes staff security. This makes it a possible example in a technical sense for the more harsh American circumstances.

I will end this survey by giving some data about the syringe-exchange situation in the Netherlands in general.
By Juli 1, 1988 in 36 towns syringe-exchange programs were in operation, many of them operating services on more than one location, all over the country.
In February 1988 some 70,000 syringes were exchanged, the vast majority in Amsterdam. In the year 1988 about 1 million syringes will be dispensed and most of them will be returned safely into special bins and be destroyed.
Almost 50% of the programs are subsidized by both the national and the local authorities. One third of the programs has applied for subsidies and 20% operates without any public money.
Almost 2/3 of the programs are operated by the drug treatment system, 1/4 by municipal health services and the rest by pharmacists and junky unions. Most programs cooperate with all kinds of other health, social and sometimes criminal justice facilities.
Generally, syringe-exchange programs are small-scale, open for some hours a day, mostly in the afternoon, and five days a week. Most of them both exchange and sell syringes (usually in a limited number, but occasionally by the box), hand out or sell

condoms and provide information on safe use, safe sex and drug treatment.

Many pharmacists sell syringes too. Unfortunately some of them stop this when a syringe-exchange program comes into operation. In Amsterdam, and perhaps also in other cities, sex shops and head shops sell sterile shooting equipment as well.
The Netherlands Federation of Junky Unions, which is partly subsidized by AIDS-funds of the Netherlands Health Ministry, operates an kind of mail-ordering business for syringes and condoms.

Some of the most interesting exchange programs in the Netherlands are or were carried out by drug users themselves or in close cooperation with their organizations.
Actually, the Amsterdam syringe-exchange system was started by the local Junky Union in 1984, not because of AIDS but because of a hepathitis B epidemic. The Municipal Health Service was very reluctant, in the beginning, to support - let alone take over - this program. But they did, of course, because is was the only logical and epidemiologically sound decision.
Until last november, when the Junky Union stopped syringe-exchange in their office, they alone supplied and exchanged 40% of the total turn-over - and I am not sure whether the remaining, professional programs can completely make up for this loss.
The Junky Union did not only exchange on a one-to-one basis but also by supplying boxes of syringes to people who deliberately re-supplied them, as a dealer or just to the friends who might drop by at their homes. And it is characteristic of the confidence that we can have in the Dutch drug users in general that the return rate of this kind of exchange programs by is no means less than in the professional, individualized programs. On the contrary: preliminary results of the evaluation of one of the street-level programs in Rotterdam show that the return rate of syringes, sold by the box and meant for re-supply, is higher than for the individual syringes. For a simple reason: people are committed.

4. Some preliminary points.

Some preliminary points can be made now as to Dutch syringe-exchange programs in general (Transparency 1).
I/ Syringe-exchange is part of a <u>package-deal</u>, consisting of syringes, condoms, education and counselling.
II/ Syringe-exchange is part of a <u>harm-reduction strategy</u>.
III/ Syringe-exchange is part of an <u>integrated drug policy</u>, aimed at the Dutch call the 'normalization' of drug problems.
IV/ Syringe-exchange is carried out by <u>a variety of organizations</u>, and often with the active participation of drug users themselves.

I will now labour these points to some extend.
ad I: That syringe-exchange be part of a package-deal is the most obvious of the four points. Not only the intravenous route is a transmission route for HIV; unprotected sex is another one and this route may even be of greater importance in the longer run as to the secundary spread of AIDS. Education, both oral and through written information, on safe use and safe sex is essential. Delivered in a language that is comprehensible to people of various cultural backgrounds and with often a limited education,

it is a necessary amplification of the message carried out by the availability of both syringes and condoms in order to make progress towards changing the drug using and sexual behaviour. Behavioural change cannot be achieved without persuasive and ongoing counselling either. Especially counselling on sexuality is a difficult task for the drug professionals, who are hardly experienced in this field.
General health education and information on drug treatment must be available too.

ad II: The harm-reduction point requires some more explanation but is not a less obvious prerequisite of an AIDS-prevention strategy among intravenous drug users than the selling of a package-deal.
The concept of harm-reduction essentially is based on the conclusion that it is not sufficient to rely on primary prevention and drug treatment alone; there should also be a range of strategies to minimize the harms inflicted upon those dependent drug users who are unable or unwilling to achieve abstinence. By setting up 'user-fiendly' and often outreaching services that are confidential, non-judgemental and not aimed at achieving immediate abstinence, professionals begin to see drug users who would otherwise stay beyond the reach of any drug treatment agency. They then can begin to achieve some succes in minimizing actual and potential harm to both the community and society.

In the Netherlands an estimated 70% of the dependent drug users is known to the assistance and treatment systems. In most countries of the world, however, only a minority of the dependent drug users are in treatment, in prison or in any other place where they can be reached with AIDS preventive activities in an effective way. In the USA the helping system is said to reach a maximum of 20% of the dependent users and in many European countries these figures are about the same. Therefore it is esential to bridge the gap between 'normal' society and the drug users' subcultures.
In most of the countries and cities I visited the past few years and that are reasonably successful in attracting drug users to AIDS-programs, it has become clear that most drug users certainly are interested in protecting themselves and others, and that they will seriously engage in AIDS-prevention and AIDS-containment, if they are treated respectfully - and that means in their identity as drug users as well - and if these programs offer an access to health and social services, not being drug free treatment or imprisonment, but harm-reduction programs.

The Monitoring Research Group that evaluates all 15 syringe-exchange programs in the UK (the only other country that operates these programs nationwide though generally in a different way) said in a first report that user-friendliness seemed to be the key factor for attracting clients. The report also found the general health situation of many British drug users to be very poor 4).
Direct access to health and social services in order to reduce the fysical and psychological harm caused by illegal drugs are considered essential by both these British and other experts in order to keep the clients and thus to be able to work on effective and lasting benavioural change.

Ad III: The issue of an integrated drug policy I think is a typical example of the kind of innovative policy-making the Dutch were forced to develop because of the characteristics of their society. Without at least attemps to coordinate and integrate the various interests at stake in drug control: criminal justice system, health systems and communities, Dutch society would have been disrupted by the drug problems of the past decades to a far higher extend than it has been disrupted now. (Slide C shows the drug policy coordination structure in the city of Amsterdam as an example.)

Actually the Netherlands government started a form of integrated policy making on the drug issue in the late sixties, when the obvious social reaction to drug problems, law enforcement, began to run out of hand. Until then, there was no drug problem in the Netherlands, we only had an Opium Act and a handful of opium-eaters in the Chines communities. When the Opium Act was placed in position against the 'hippy-type' marijuana users it had more devastating effects on society than the marijuana use had itself. To make a long story short: this social debate has lead to the developement of the first corner stone of Dutch drug policy in 1976: the "separation of (drug) markets". Essentially this means that the use and to a certain extend the retail sale of marijuana-products is decriminalized (NOT LEGALIZED!), explicitly in order to prevent Dutch youth experimenting with marijuana to step over to more dangerous and addictive drugs. This policy has been successful to the extend that despite the ample availability the prevalence of marijuana use among younsters in the Netherlands is among the lowest in the Western world, and that only a very small proportion of Dutch youth are attracted to heroin and cocaine.
(In particular the very limited attractiveness of cocaine until now is remarkable: it is widely available at rather low prices, and traffickers have in vain tried to market it as crack. May be this has something to do with the actual policy towards cocaine use which looks rather like the marijuana policy than like the heroin policy.)

In the late seventies, when the heroin problem began to take a threatening shape in the urbanized parts of the country, "harm-reduction" developed as a second corner stone of Dutch drug policy; not the fight against drugs as such but the minimization of harm caused by illegal drugs to the drug user and to society was adopted as the official starting point for the government's policy.

In the early eighties a third corner stone was developed: the policy-concept of "normalization of drug problems" 5).
Normalization of drug problems essentially means the admission - as a government, as a society - that extensive drug use (both legal and illegal) has obtained a firm footing in society, as already is the case with alcohol and tobacco. Worldwide it has proven to be an unrealistic option to try to eradicate drugs and drug use completely, like it has been proven unrealistic with regards to alcohol and tobacco.
These efforts primarily have generated an enormous increase in international organized crime and in the spread of illegal drug use. It is far more realistic to aim at the reduction of drug use, at the containment of the damage caused, and at the

management of the problems. Basically, this is the same policy-concept as we use with respect to alcohol and tobacco.
In effect this means: to fight organized crime, drug trafficking and obtrusive retail trade, and to integrate - or encapsulate if you like - the drug users in 'normal' society. It also means that society makes itself clear as to what it can and cannot, will and will not tolerat , and as to the rights and obligations of drug users as members of society.
This is not kind of a 'soft' way of dealing with drug use and drug users; it is a pragmatic way of coping with a social problem, using social rather than legal coercion.

When the AIDS-crisis broke out, it found the Netherlands prepared so to speak, to cope with at least its initial effects. I won't go that far as an American friend who said that the Dutch drug policy was taylor-made for coping with the AIDS-epidemic, but we were able to integrate the necessary prevention strategy for IV-drug users and the general AIDS-prevention strategy from the very beginning (Transparency 2). Representatives of the drug assistance system took part in the activities of the National AIDS Task Force long before the first IV-AIDS case was detected, and soon after the organized drug users - the Netherlands' Federation of Junky Union - began take part in the AIDS policy-structure.
These ways of integration and cooperation and the strategies developed and implemented will inevitably change the face of Dutch drug policy again. The AIDS-crisis has the power to change the whole paradigm of traditional and less traditional drug control. I think, however, that the starting position of the Netherlands for controlling AIDS as a social problem is less uncomfortable compared to that of many other nations.

Ad IV: Syringe-exchange programs can be operated by a variety of organisations. I already mentioned that although the drug assistance system plays a mayor role in the organization of these programs, other organizations cannot be neglected, especially not when it comes to the qualitative aspects.
AIDS among IV-drug users and the secundary transmission of HIV can only be prevented and controlled if the users themselves change their behaviour, and drug users have to be convinced of their crucial importance to society in this respect. I said before that they are interested in protecting themselves (AIDS is a horrifying way of dying, it is not just an overdose!) and others by changing their behaviour if they are treated respectfully - which includes their identity as a drug user. Therefore we not only have to involve them in policy making and in the implementation of AIDS-prevention. For quite a large part we are have to rely on them, on their willingness and ability to carry out AIDS-prevention and AIDS-containment activities in the drug scenes, and especially in those corners and pockets where nobody of us can go. We have to provide them with the tools but they themselves have to make their possibly decisive contribution to AIDS-prevention and containment for society at large.

5. Syringe-exchange: arguments and evaluation.

The introduction of programs such as syringe-exchange caused some discussion in the Netherlands, of course. Two main arenas of debate can be distinguished: the political and the professional.

Important factors in these discussions have been the facts that a/ syringes have always been sold legally by pharmacists and in some street-level drug assistance facilities, and
b/ syringe-exchange was not 'invented' because of AIDS. I already mentioned that the Amsterdam Junky Union started its syringe-exchange program as a counter-measure against a hepathitis B epidemic in 1984. And there had been starts before. Since already 1980 the municipal health service of Den Helder, the home base of the Royal Dutch Navy, has been operating a small-scale program that also started because of a hepathitis epidemic, and more small programs have been operated successfully on a temporary basis in onder to control local epidemics. Both professionally and politically these programs have attracted very little attention.

The Municipal Health Service in Amsterdam was not very enthousiastic about syringe-exchange in the beginning. They very reluctantly took over the responsability from the Junky Union in 1985, when the program of the latter grew too big for them to handle it alone. But they had no choice, not only because the size and shape the program had already taken, but also for medical and political reasons. And thus syringe-exchange was integrated in the existing harm-reduction programs and the programs rapidly expanded. From 25,000 syringes in 1984, 100,000 in 1985, 400,000 in 1986 to more than 700 000 in 1987.
This increase, and the absence of serious negative side-effects, created a situation in which the stimulation of syringe-exchange became a logical step for the national government as well.

When we organized the first national conference on AIDS and IV drug use in January 1986, we asked the Director-General for Public Health to make an opening statement and, if possible, to stress the importance of syringe-exchange programs in the context of the exixting drug policy - and he did so. This statement did not cause any parliamentary discussion and attracted only little media attention and public debate.

The situation in the assistance and treatment system was different, logically: the professionals had to implement the programs nationwide. The main arguments pro and contra syringe-exchange can be summarized as follows (Transparency 3):
Contra:
- syringe-exchange will encourage IV drug use,
- syringe-exchange will recruit new IV users,
- syringe-exchange will undermine the prevention of drug use and the treatment of drug dependence.

Pro:
- syringe-exchange will reduce needle-sharing and thus slow down the spread of HIV infection,
- syringe-exchange will give the opportunity to reach IV users outside the assistance system,
- syringe-exchange will be an opportunity for councelling, advice and referral,
- syringe-exchange will stimulate the return of contaminated injection equipment.

The discussions about these arguments, more vehement in treatment agencies than in harm-reduction agencies, last untill today, and still bar the introduction of syringe-exchange in some places. The involvement of general public health facilities in these programs sometimes is the result of the refusal of the specialized drug agencies to cooperate. Yet in general the attitude of both public health and drug assistance system is to push for and to evaluate syringe-exchange.

Not very much research has been done until now.
In 1985 Kaplan et al. did a small scale comparative research project in Rotterdam into characteristics of IV drug users who did and did not participate in syringe-exchange 6).
In Amsterdam, the Municipal Health Service (the "GG en GD") started an evaluation study in the summer of 1987. This study 7), which is to be continued and coupled with an existing prevalence research project of the same organization 8) presents a preliminary answer to most of the pro's and con's of in the syringe-exchange discussion mentioned above.

Some other studies are under way or in preparation.
Here I present the summary of the study of the Municipal Healt Service, they presented at the IVth International Conference on AIDS in Stockholm, last June.
* 148 IV drug users were interviewed, utilizing a standardized questionaire;
* participation was on a voluntary basis, and
* no blood samples were taken
The interviewed IV drug users were recruited at the 11 exchange locations and at other places where no exchange was possible, such as police stations, hospitals and the consulting hour for drug users from abroad.
73 IV drug users who exchange regularly ("exchangers") were compared with 75 IV drug users ("non-exchangers") who never exchange or do so irregularly.

(Transparency 4) Table 1 - general characteristics of 148 IV drug users: less than half of them is of (white) Dutch origin, they are about 30 years of age and they use drugs for quite a long time, the males have longer drug histories than the females.
Table 2 - characteristics of exchangers and non-exchangers:
exchangers are older and have a longer history of drug use; they are more often of Dutch origin and have much more contacts with the assistance system.
(Transparency 5) Current drug use: especially the difference in the percentage of people who use more drugs is striking.
High risk situations: exchangers expose themselves considerably less to high risk situations than non-exchangers do.
Needle-sharing: exchangers engage considerably less in needle-sharing, but still 10% do.
Risk level last month: the risk-level of exchangers is much lower than that of non-exchangers.
(Transparency 6) Reasons for sharing:especially the sharing with the sexual partner is a reason for concern because many partners of drug users appear to be non-users themselves.
Frequency of sharing with others than partner: still 9 out of 25 'sharers' share more than once.

Conclusions from the study (Transparency 7):
These concl sion should be drawn very carefully since the data are

based on self reports, no HIV-testing was done and a follow-up has not yet been carried out.
Based on the present data the Municipal Health Service can say:
- differences were found between exchangers and non-exchangers on a number of characteristics;
- no increase in drug use was reported by the exchangers;
- the exchange programs help a certain group of IV drug users to use drugs in a safer way with regard to HIV infection; and
- the exchange programs contact IV drug users outside the methadone programs.
Negative side effects such as an increasing number of IV drug users, an increase in drug use or reduced interest in drug treatment were not found in Amsterdam 9).

The Municipal Health Service thinks it is questionable if findings from an Amsterdam study can be generalized to other cities and countries with drug policies that are primarily repressive and pay less attention to treatment and harm-reduction.
On the basis of the Amsterdam experience, no definitive answer can be given whether the exchange programs are effective tools in the fight against the spread of AIDS. Although safer drug use has been reported by a large percentage of users, some are still (occasionally) involved in needle-sharing.
From a public health point of view every measure that can prevent the spread of AIDS from IV drug users to the general population need sincere consideration. Reducing the number of contaminated needles in the environment is one important aim of the syringe-exchange.
For many Amsterdam IV drug users themselves the exchange plays an important role in staying sero-negative and (if already infected) in preventing them to infect friends and partners.
This as regards the Amsterdam data.

Data from other countries than the Netherlands are very limited available.
The already mentioned Monitoring Research Group evaluates the 15 syringe-exchange programs that exist in the UK. They presented their results at the Stockholm conference as well 10).
The MRG interviewed 769 IV drug users. Differences with the Amsterdam sample are: a lower average age (< 2 years), a shorter period of drug use (> 2 years), and amphetamines (that are practically not used in the Netherlands) are an important drug of choice.
Other important data are:
• 47% had no previous contacts withe the drug assistance system,
• an average of 78% of the needles and syringes had been exchanged.

Follow-up data (N=106) show a decrease in needle-sharing, but 8 people reported to have started IV use after the first interview. No

needle sharing (interview I and II)	66% (70)
Stopped needle sharing	16% (17)
Still needle sharing	11% (11)
Started needle sharing	7% (8).

Other countries that I know of who operate syringe-exchange programs are:
• Sweden - a small scale program in the city of Lund: no seroconversions during participation in the program, and almost all participants underwent HIV-testing, which the Swedes very highly appriciate 10).
• Switzerland - an experimental syringe-exchange program in the high-security prison of Lenzburg: no data available yet.
• France - a pharmacy-based exchange program in Paris: .....11).

* and Australia, of which I know nothing more than that something exists.

6. Some points for discussion.

a/ IV drug users are one of the groups most at risk for contracting HIV and AIDS, and they also play a crucial role in the secundary transmission of the epidemic into the general population.
If we want to stem both the epidemic among the drug users and the secundary transmission, it is vital:
* that the measures for prevention and containment reach the IV drug users, and
* that the IV drug users change their behaviour.

As IV drug users, generally speaking, are social marginals or outcasts, and very often engage in criminal behaviour, they are likely to hide themselves from open society and - sometimes - from their original communities. Even with the best attempts of the treatment system and the criminal justice system, in every country only a minority of drug users are either in treatment or in prison. So you might say that drug users are difficult target-group to reach. And as their risky behaviour, in particular injecting and unprotected sex, is often closely related to the dependence of drugs, this behaviour is very hard to change.

So anti-AIDS strategies among IV drug users have to focus on two issues:
1. to build bridges between society and the drug users in order to engage almost everyone of them in AIDS prevention and containment programs, and
2. to provide very specific and powerful measures for profound and lasting behavioural change.

b/ These two focal points together mean little less than the need for society to forge an alliance with the drug users for a joint battle against AIDS; as long as society continues to treat drug users primarily as junk and as objects of criminal justice, drug treatment and AIDS prevention, it will fail in reaching them and committing them to behavioural change. Any alliance will only work when it is profitable for both sides.
For namy people and institutions working with drug users, and also for countries as a whole, this means both a change in attitudes and in instruments.

It is not enough to develop a non-judgemental attitude towards drug users, it is also necessary to treat them as fellow citizens.
For many working with drug users it has already become clear that drug users are interested in protecting themselves and in protecting others and that they seriously engage in AIDS prevention and containment if they are treated as ordinary citizens. But if we really want to protect them and ourselves drug users have to do the major parts of the job themselves. They themselves have to change their behaviour, and we will only convince them if we give them the confidence, if we give them the tools and if we give them the credits.
There is clear evidence from eg. the Netherlands and the United Kingdom that harm-reduction services are an essential prerequisite for attracting and keeping drug users to engage in AIDS prevention and containment. But if we really want to change their behaviour on a lasting basis we will have to provide them amply with instruments to practice safe sex and safe use, which means: condoms and syringes.

c/ We do not know yet whether the ample availability of syringes and condoms will stop the spread of AIDS. But we all know that unprotected sex and contaminated injection equipment are responsible to the highest extend for the spread of the epidemic.
There is no evidence that the propaganda for safe sex, including the supply of condoms, did or does increase promiscuity; on the contrary. And there is no evendence as well that propaganda for safe drug use, including the supply of syringes, did or does increase IV drug use.

I strongly believe, because of what I have seen and experienced in my own country and abroad, that the availability of syringes in the context of comprehensive AIDS prevention, harm-reduction and a balanced drug policy can make a major contribution to saving the lives of many drug users and other citizens.
The first step on this long way is to clear it from the many moral and legal barriers. Or in other words: we have to stop the war on drugs before we can think of winning the war on AIDS.

henk jan van vliet
August 4, 1988.

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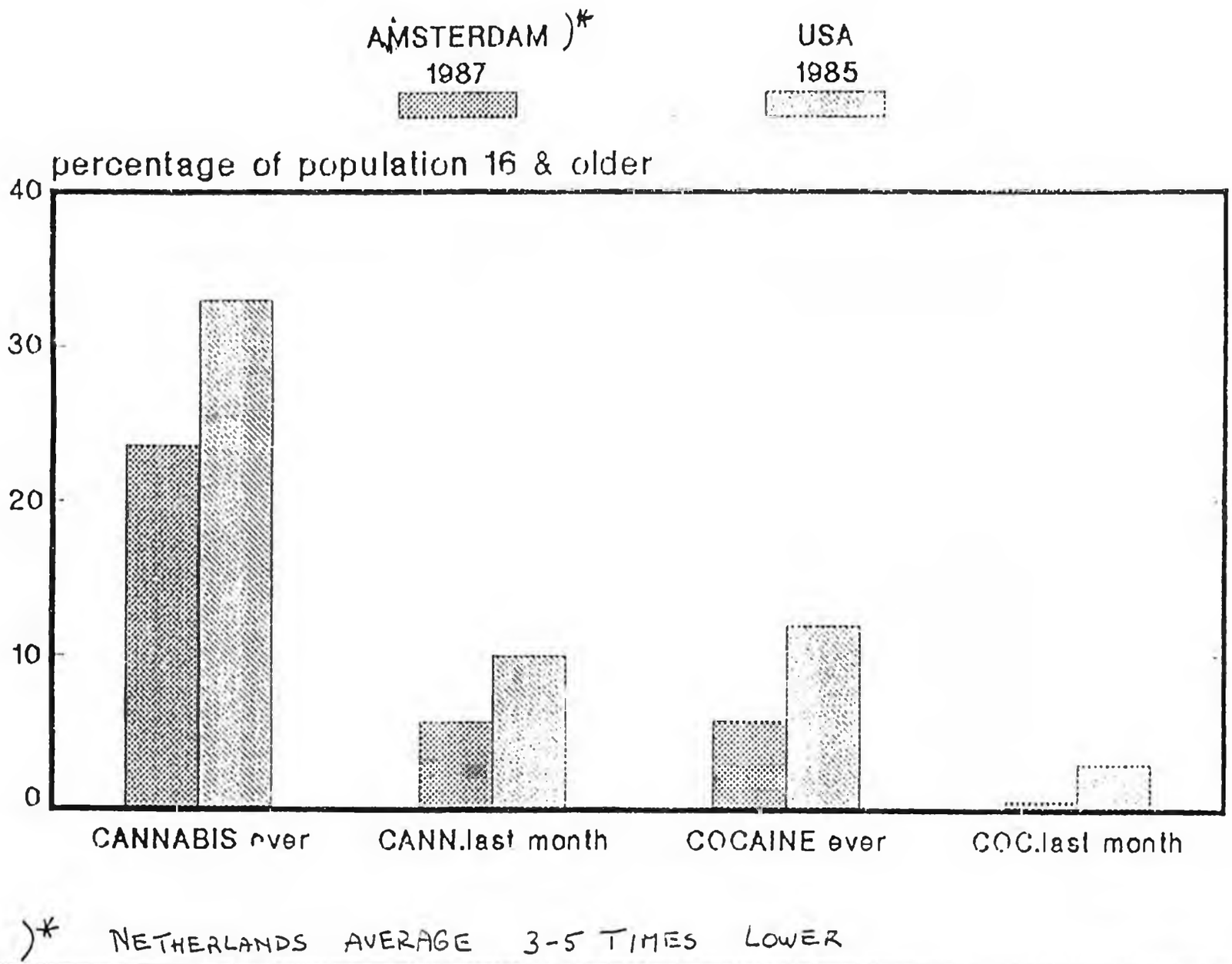
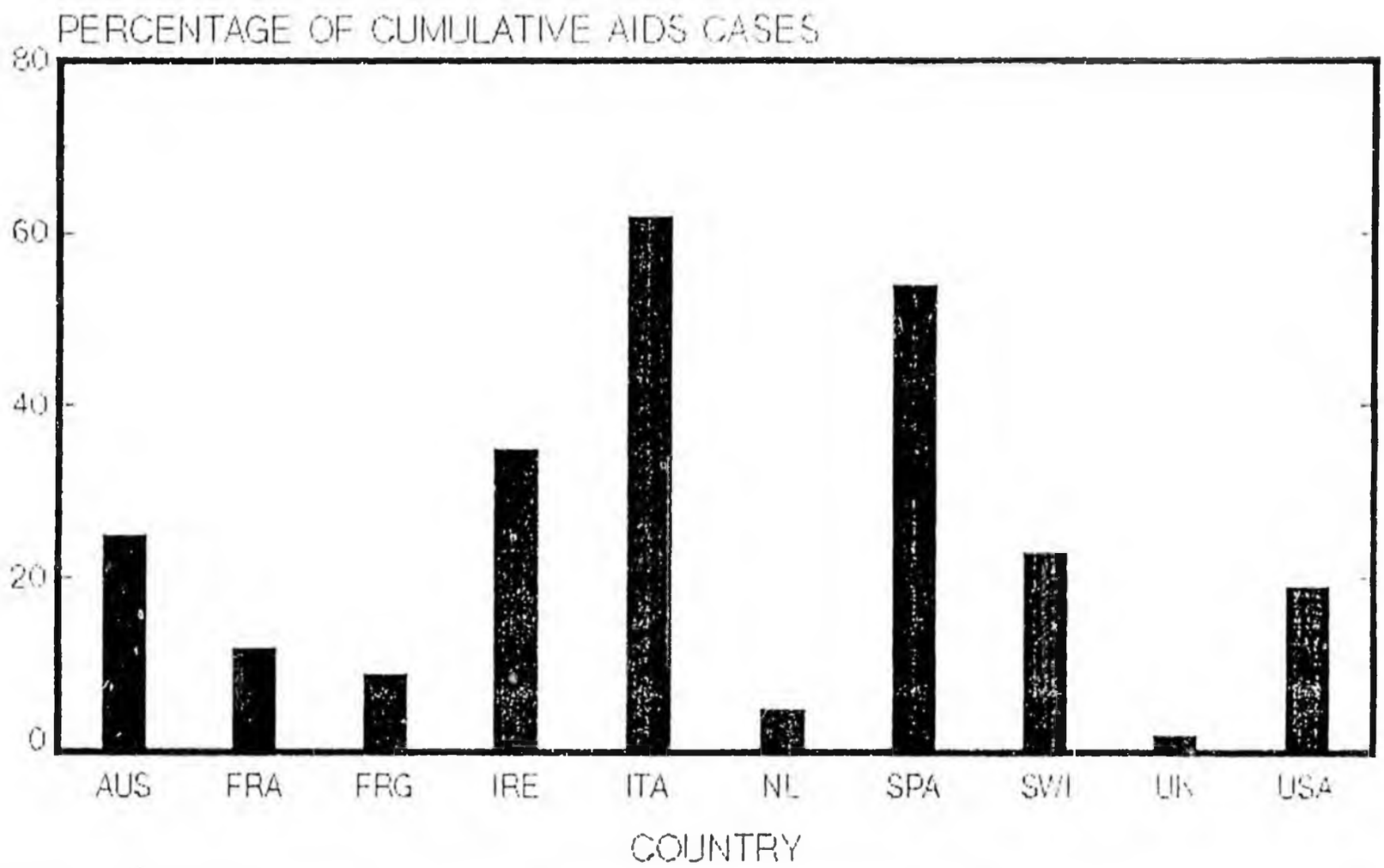
DRUG USE



)* NETHERLANDS AVERAGE 3-5 TIMES LOWER

AIDS CASES THROUGH IV DRUG USE

situation per 31 March 1988



THE DRUG POLICY FORUM

THE PRAGMATIC DUTCH APPROACH TO DRUG CONTROL: DOES IT WORK ?

Lecture held by Prof. Dr. Frits Rüter
University of Amsterdam, The Netherlands

on Wednesday May 25, 1988, 4:00 p.m.
Room B369, Rayburn House Office Building, Capitol Hill
Washington, D.C.

Sponsored By

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NOTE:

The views expressed in this speech are those of Dr. Rüter only and are not necessarily shared by the Netherlands Government

THE PRAGMATIC DUTCH APPROACH TO DRUG CONTROL: DOES IT WORK?

Ladies and Gentlemen,

Let me start by quoting someone whose views are far more interesting and important than mine:

Basis of Dutch Policy

> "The protection of health and social well-being in general and the improvement of the health of those who are already addicted must be our primary aim. We always bear in mind that the drug abuse problem is basically and principally a matter of health and social well-being. It is not, in our view, primarily a problem of police and criminal justice. ... We are fully aware of the necessity to prevent as much as possible a situation in which more harm is caused by criminal proceedings than by the use of the substance itself."
>
> "We give high priority to services directed primarily at improving the health and social functioning of the addict, without necessarily ending addiction, because a lot of addicts are not, or not yet, capable of kicking the habit."

These quotations are not from a pamphlet of Libertarians or even from - what the British call - the lunatic left. They are from the speech delivered last year to the U.N. Conference on Drug Abuse and Illicit Trafficking by the Dutch Minister of Justice, a member of a conservative government, belonging to the traditional right-of-center party whose members include our captains of industry, bankers, judges and conservative professors like myself. This is the voice of the Dutch establishment.

The Minister's statement reflects the basis of the policy now pursued for more than 15 years by successive Dutch ministers of justice and ministers of health, and supported by a broad majority in Parliament. As such it reflects

* the deeply felt concern of the Dutch people and government about the use of dangerous drugs and the level of drug-related crime,
* the limited possibilities, financial, legal and practical, for restraining effectively trafficking and the use of illicit drugs,
* our international obligations, and last but not least
* our humanitarian and moral obligations to minimize the damage to the society as a whole and the harm to the addicted individual.

Dutch policy pragmatic, not liberal

The biggest mistake one could make - and some members of the U.S. House of Representatives, visiting Holland in August 1987 appear to have made that mistake - is to regard this policy as the fruits of an overpermissive society. The Dutch policy on drugs is not a "laissez faire" policy, nor is it a liberal or lenient one.

It is, in American eyes, perhaps strange and unorthodox. But it is, above all, pragmatic and undogmatic. It is a fairly coherent, multi-disciplinary policy which attaches a high priority to the cost-benefit ratio.

This is perhaps the right moment to stress that I have not come to this country to recommend the Dutch drug policy as the perfect approach to the drug problem for all nations. No two societies are the same. What works well in Holland might be a disaster in your country - and vice versa. It is normal that countries tackle their problems in different ways. And there are good reasons to do so. Criminal law and the level of law enforcement are very much influenced by national tradition and the social and cultural structure of each society.

Astonishment at War on Drugs

On the other hand, I have to confess to some astonishment at the American handling of this problem. In my country the American nation is renowned, indeed almost notorious for its veneration for a business-like value-for-money approach to almost every problem of life. At the same time, it is admired for its high standard of constitutional freedom and its willingness to support its European friends in keeping or regaining their independence and civil liberties. It is to you, that we owe our freedom. In World War Two you liberated us from the Germans, today you protect us against the dangers from the East.

Your present War on Drugs and your pressure on foreign nations to join you in that battle does not fit easily into this traditional picture of your country. I have, however, no intimate knowledge of the American social and cultural setting and I am not familiar with the power structures in your country. Perhaps that is why I keep asking myself how it is possible that you handle the problem of drug abuse in such an unbusinesslike way. Any company that ran its affairs like that would have gone bankrupt long ago. And why it is that the American War on Drugs gives us the impression of a fatal marriage between Iranian fundamentalism and Communist economics. Is it because the American nation occasionally tends to choose the wrong allies ? Why are you embarking on a policy that leans so much on an ally like law enforcement which is by definition weak and inadequate ? And why are you not using the forces, which made the U.S. the biggest and most successful industrial nation in the world ? I am referring of course to the moral strength of the American people in general and of the American family in particular and the advantages of your capitalist system ?

Before you tell me that this clearly shows that I understand as little about the U.S. as you do about Holland, I shall quickly switch back to the subject of this lecture: the Dutch policy on drugs.

Approach of the Problem

Does it work ? And what exactly is this policy, in other words, <u>how</u> does it work ?

I shall deal with these questions in the order I have indicated, since I hope that the results will sufficiently impress you to wish to learn more about our procedure.

But first of all, a word of warning. I do not regard myself as an expert on drugs. I am not a doctor, sociologist, psychologist or the like. Although marihuana is sold in a so-called coffee shop just around the corner from my Criminal Law Institute and hard drugs on the bridge across the canal on which the Institute is situated, I have never used or even seen soft or hard drugs. Because I am just an ordinary Dutch citizen, you can be sure that I will keep it that way. If I am an expert at all, I am an expert in the field of criminal law and law enforcement. Not, I hasten to add, because of any unfortunate personal experience. Although I and my family have lived and worked in the centre of Amsterdam for almost 30 years, we have never been the victim of any drug-related crime. My expertise is based on a combination of academic study, good advice from other experts and professional experience gained as a judge of Amsterdam Criminal Court and Chairman of the Police Complaints Board of the City of Amsterdam. I will, therefore, approach the problem not from the angle of narcotic drugs but from the angle of the criminal law and as someone who considers the use of dangerous drugs to be one of the many forms of undesirable behaviour in our society.

Let us now move on to the first question:

Does it work ?

in other words, is Dutch policy successful ? As always, the answer depends on your objective. Of course we all would like not a single drug to be used any more by anyone. But that is, at least at present, not a very realistic objective. In this respect I quote again the Dutch Minister of Justice:

> "One may have a high standard of morals and ethics about the banishment of all drug use. But whatever governments may wish or do, the reality is that not all young people- obviously - are deterred by the threat of punishment or health hazards and that our present efforts ... cannot keep thousands of them from using drugs".

If, however, given this reality, your present objective is to reduce the use of drugs, to bring down the number of new users to the drugscene, to minimize the damage to society, to keep the drug users alive, to let them mature out and to promote social rehabilitation not only in the after-care stage but also during treatment as an inseparable part of that treatment, the answer is different. If that is your objective and you would ask me whether the Dutch policy is successful, the answer is simple: yes, it is. Or, to put it rather more modestly: it is less unsuccessful than the drug policies of at least some other modern Western societies, including, perhaps, the U.S.

Figures and Facts

I will present to you the best possible estimates concerning drug use in the Netherlands, coming from reliable sources. However, as we all know such estimates are never fully accurate although the Dutch might be in a somewhat better position than many other countries, because the Dutch drug users are generally not underground and most addicts have been registered.

As far as cannabis [1]) is concerned, the number of new users has decreased shortly after the government decided on the decriminalisation of cannabis in 1976. Today about 4% of the Dutch young people between the ages of 10 and 18 years admit to ever having used cannabis (lifetime prevalence). But over 55% of them stopped using it before their 19th birthday [2]). The estimated number of heroin addicts has stabilised in recent years at between 15,000 and 20,000. That is 0.14% of the 14 million people living in Holland [3]). The average age of the addicts is increasing during the last 5 years. Experts infer from this fact that the number of addicts is slowly decreasing. The use of Cocaine has been growing very slowly. But in Amsterdam the number of new users has hardly been growing since 1982. It has remained fashionable only in a very limited part of society. The use itself normally does not provide serious social problems, as most cocaine users are quite well integrated in society and manage to live with their habit. The use of free base cocaine is a rarity. Ready made free base cocaine ("crack") has not been spotted in Holland. The use of amphetamines and LSD has always been exceptionally low. There have been no reports of the use of solvent or of new types of illicit drugs. The needle exchange program, providing free clean needles to intravenous drug users, which has operated on a large scale for many years, may be responsible for the fact that the number of AIDS-patients that are addicts is one of the lowest in the western world [4]). Because the possession of hard or soft drugs is not subject to prosecution and punishment although it is legally still a criminal offence, the users are not driven underground. Moreover, it is the official policy of the Dutch government to provide different forms of aid, which are not primarily intended to end addiction as such but to improve the addicts' physical well-being and help him to function in society, the inability of giving up drug use being accepted as a fact for the time being. Obviously the long-term objective is to help addicts lead a drug free life. But failure to provide medical and social aid would be worse as it would simply increase the risk to the individual and society. This kind of assistance may take the form of field work, initial reception, the supply of substitute drugs like methadone, material support and social rehabilitation support. This policy is successful. The majority of addicts have, in one way or another, contact with medical and social services. And generally they are in relatively good health; the death rate among addicts is around 0.5%, which is quite low compared with most other countries. Some of the addicts are members of so called Junky Unions. They thus have a means of making their views known to all kinds of government officials, which is not a bad thing if you are in need of an effective drug policy. Drug-related crime is still a matter of grave concern, both to the general public and to the government. But it is mostly non-

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[1] i.e. Marijuana and hashish

[2] See table 1, p. 15.

[3] See table 2, p. 15.

[4] See table 3, p. 15.

violent property crime. And the crime rate in Holland has not risen since 1984. In Amsterdam, the city in which the majority of drug users live, it even dropped last year. The drug use in Amsterdam is of course higher than in the smaller towns and the rural areas of Holland. Nevertheless it is not only lower than the use in New York or Washington but even lower than the use in the U.S. taken as a whole [3]). And the graphics on page 17 - 20 show, that the development of drug use in Amsterdam during the last decade has been anything but dramatic.

Misinterpretations

"That can't be true. I was in Amsterdam myself. I saw a number of "coffee shops" where cannabis was sold and I saw people dealing in hard drugs quite openly."
This is the usual reaction of foreigners, confronted with the figures and facts I have just mentioned. They make the mistake, as we all do when we are abroad, of judging foreign countries, societies and their social phenomena by our own, national standards. For visitors from countries, where drug users are underground, the visibility of the drug problem in Holland is shocking. If this can happen in public, what must go on in secret ? The answer is quite simple: not very much. Of course, the big traffickers are underground as the police are chasing them, but the small dealers and the users are generally not. There is no need for them to be, because they are not the primary target of the law enforcement agencies. And there is no strong social pressure from the public to go underground. The Dutch do not hide the problems of their society. Not only because they do not want them to get out of control, but mainly because Holland is a small, very old and stable democracy, in which we - the people - decide how we should solve our problems. And you cannot solve them by making them a taboo. So we tend to let our problems come to the surface and discuss them nationwide. Although this is good for our society, it does have the disadvantage that it occasionally gives Holland bad international publicity.

There is, as I said, no need for users and small dealers to go underground, because they are not the primary target of the law enforcement agencies. This brings us to the role of law enforcement in the fight against illicit drugs and to my second question:

How does the Dutch drug control policy work ?

One aspect of Holland which strikes most foreigners is the low level of law enforcement, both in general and in so far as illicit drugs are concerned. Nonetheless, both our countries started from the same point: the international drug treaties concluded at the beginning of this century.

Legislation

The first criminal legislation on drugs was introduced in Holland as early as 1919. Neither this Act nor the 1928 Act which replaced it and remained virtually unchanged until 1976 was

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[3] see the table on p. 16 and compare it with the National Household Surveys on Drug Abuse of the U.S. National Institute of Drug Abuse.

introduced, however, in response to a drug problem in Holland. Indeed, until 1965 no such problem was evident. The illegal use of opium was virtually restricted to the Chinese community. As long as the drug was restricted to this community, no action of any note was taken. Until 1966 the number of convictions averaged 23 a year, which is around 1% of the present figure. Originally, the maximum sentence was 1 year's imprisonment. Until the sixties political interest was extremely limited. The reason for this legislation on drugs must therefore be sought in the drug treaties, instigated by the U.S., and not in our own problems.

In 1961 the Single Convention expanded the number of illicit drugs and laid great emphasis on law enforcement. When Holland was shortly afterwards confronted with a substantial increase in the use of marihuana and later of hard drugs, we leaned, at first, very much on Law Enforcement and the police and the judiciary dealt severely with drug users. But soon it became clear that this approach was essentially incompatible with the country's traditional way of combating undesirable behaviour.

Role of Criminal Law

In Holland the role of the criminal law is a relatively minor one. The Dutch prefer a policy of encirclement, adaption, integration and normalisation, rather than a policy of social exclusion through criminalisation, punishment and stigmatisation. Furthermore, they have no exaggerated expectations of law enforcement. And finally, the Dutch see the criminal law less an instrument for expressing moral values and more as an instrument of social control, whose results must be assessed from case to case.

When it was faced with the task of fighting the increasing drug use, the Dutch government became trapped between on the one hand the international conventions on narcotic drugs and the pressure exerted by states where criminal law plays a much greater role and on the other the traditional Dutch views on the limited task, role and scope of criminal law. Between these conflicting premises, the Dutch government steered a middle course trying to reconcile its international commitments (prohibition, law enforcement) with the traditional national commitment towards institutional plurality and social experimentalism.

The 1976 amendment legislation and in particular the guidelines for the prosecution bear the traces of this policy. This legislation contained a clear signal, namely that Holland was prepared to bring its legislation on hard drugs into line with the international trend. The maximum penalties were increased considerably. Despite pleas from various quarters for the legalisation of marihuana, this did not come about, the government making express reference to the Single Convention. However, the maximum penalties for marihuana were set at a lower level than those for hard drugs. And in 1985, a whole series of preparatory acts were made criminal offences in order to combat international drugtrafficking.

Criminal Justice Policy

As far as its legislation is concerned, Holland is undoubtedly in line with its international commitments and to a large extent with the international trend as well. But legislation is not

necessarily the same as the criminal justice policy which is in fact implemented. The Dutch criminal law provides considerable latitude for such a policy, because, by virtue of the so-called "expediency principle", the Public Prosecutions Department is empowered to refrain from bringing criminal proceedings if that is in the public interest. It is a matter of policy whether the Prosecution will act and, if so, what it will do. This policy is laid down in so-called Guidelines for Investigation and Prosecution. To know what the law in action is like, you need to know what these Guidelines say.

Guidelines

In 1976 the Minister of Justice issued guidelines for the investigation and prosecution of drug offences. In these guidelines the Dutch government translated the international trend into the less prohibitionist, less retributive and less punitive criminal justice policy traditionally pursued by the Dutch, in an attempt to reconcile its international obligations with its national commitments and national political options.

In line with the international trend, the guidelines give top priority to the investigation and prosecution of production, import, export and large scale trafficking. In such cases, prosecutions are brought and the sentences demanded by the Prosecution at the trial must as a rule exceed the statutory minimum by a number of years.

The guidelines specify a milder approach in the case of four categories:
a) users who deal in hard drugs in order to provide for their own needs or who are found in possession of more than a small quantity: in such cases the public prosecutor must demand a prison sentence, but is free to determine the length of the sentence to be demanded;
b) possession of a small quantity of hard drugs for personal consumption: no specific police investigation, no pre-trial detention and as a rule no prosecution.
c) dealing, possessing and producing a maximum of 30 grams of marihuana: no specific police investigation, no pre-trial detention and as a rule no prosecution.
d) sale of marihuana in small quantities by a reliable person in a youth centre (known as a house dealer): no prosecution unless the dealer trades provocatively or openly advertises his wares.

Today's Practice

From these guidelines evolved a practice which was summarised by the Minister of Justice nine years later, in 1985, as follows:

> "Hard drugs: criminal investigation and prosecution are directed against trafficking. No criminal proceedings against users."

Consequently no person is subject to imprisonment or prosecution solely because he or she uses drugs. Instead users are, in accordance with the government policy set out before, approached by organisations of a multi-functional network providing financial, social and medical assistance to addicts.

> "soft drugs: the small dealers and users are left undisturbed by the police."

In practice this means that the police do not interfere with marihuana sales in coffee shops, unless the dealers are selling

to persons under 16, selling large quantities or advertising. I give you two example .o illustrate the present situation:
(1) A coffee shop owner filed a complaint against the Amsterdam Police with the Police Complaints Board for raiding his shop although he had observed these rules. My colleagues and I held that the complaint was justified and the police admitted they had been wrong. (2) As from January of this year the Dutch Ministry of Finance is taxing the profits which the coffee shops make on soft drug sales.

Reasons

For many foreigners this is a somewhat confusing state of affairs: the law formally declares certain acts to be punishable but the law enforcement agencies do not prosecute them in practice. According to Dutch Penal Law, this is legal. But still you may ask, why the Dutch prosecute some crimes like murder and rape and yet leave others unpunished. The answer is that the Dutch have a pragmatic value-for-money approach. Otherwise we would not, as a small country, be able to run the biggest port in the world and have a number of well-known multinationals like Shell, Unilever and Philips. After defining their objective therefor, they take a close look at the means at their disposal to achieve that objective. The objective of Dutch drug policy is to restrict the risks of the use of dangerous narcotic drugs as effectively as possible. Is criminal law in that context an ally or an enemy ? Sometimes it is an enemy. Take for instance the cannabis situation in Holland before 1976.

Until then no legal distinction was made between marihuana and hard drugs. This meant that marihuana was forced into the criminal sphere in common with hard drugs and that it was sold in the same places and frequently by the same dealers. It was, in other words, fully integrated into the hard drugs scene. The Dutch Government decriminalised the possession and trading of small quantities of marihuana because it feared that the unintentional effect of law enforcement might be that marihuana would act as a stepping stone to hard drugs. This decriminalisation policy was intended to separate the markets for marihuana and hard drugs and to remove the sale and consumption of marihuana from the hard drugs scene.

Marihuana Policy successful

This policy was successful: the markets <u>were</u> separated and the overwhelming majority of marihuana users did <u>not</u> graduate to hard drugs. The experience of over 12 years has shown that - at least within this Dutch contetxt - the gateway (or stepping stone) theory is not true. And this policy had another positive result: the number of new users has decreased shortly after the government decided on the decriminalisation of cannabis in 1976 despite the fact, that since then marihuana became more freely available in Holland [6]. This is even more remarkable when compared with the situation in West Germany, our neighbour, where the sale and possession of marihuana are a criminal offence and prosecutions are brought: the percentage of young Germans who admit to ever having used cannabis (lifetime prevalence) is approximately twice as high as in Holland.

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[6] See table 4, p. 15.

Law enforcement a suitable instrument for the fight against illicit drugs ?

This is, in a nutshell, the Dutch drug control policy and the way it works. You may like it or dislike it. It is true, we have not managed to attain a drug-free society. But what country has ? On the other hand, the low level of law enforcement has not - to say the least - resulted in a higher level of drug use than in other Western democracies. And even 12 years of decriminalisation of marihuana have not increased its use. And finally, we have managed to keep our drug users in relatively good health and to limit the number of addicts with AIDS.

Rethinking Criminal Law

In my view, the importance of Dutch drug policy and its results is that it encourages us to rethink the role of criminal law and law enforcement in coping with drug use. There is ample reason to do so. And this applies equally to the Dutch situation. Hence, although the role of law enforcement may - as the Dutch Minister of Justice put it - be only a "supportive" one, and less important than in many other countries, it is still a meaningful factor in the Dutch drug control policy. This seems to be connected above all with the fact that the general public considers that drug trafficking should carry heavy penalties.
But: this does not in itself mean that law enforcement is a suitable instrument for the fight against drug trafficking. Until now there has been no evidence of this. Is this due to an inadequate level of investigation and prosecution, to light sentences, to a lack of powers for the police or to deficient international cooperation ? Or is criminal law, instead structurally unsuitable for the fight against drug trafficking ?

Allow me to end this lecture by stating my personal views on this question.

Law Enforcement unsuccessful

For nearly 30 years penal provisions and law enforcement have clearly proved unable to prevent a situation in which illicit drugs are sold on a large scale and are used by millions and millions of people all over the world.
I put it to you that this is not surprising because it follows from the very structure of the criminal law. And I also put it to you that law enforcement is not our ally in the fight against the use of drugs. These are my arguments:

Reasons

The goal of law enforcement is to prevent undesirable behaviour. We punish wrongdoers in the hope that they will not repeat their behaviour (individual deterrence) and that others in turn will be scared off (general deterrence). And we punish by way of retribution. The degree of retribution takes into account the extent of the criminal's guilt. We may not exceed the bounds of what is a well-deserved punishment, given these factors.

Users

This rule of criminal law is common to all civilised nations. However, it is precisely this rule which creates the first structural weakness of the criminal law in its fight against illicit drugs. If one only uses illicit drugs, the perpetrator and victim are to a large extent one and the same person. There

is therefore precious little reason for retribution or accordingly for punishment. If the punishment were to be substantially increased, this would not only violate the principle of a humane and just criminal law. Substantially heavier sentences have scarcely any extra deterrent effect because the threat of the criminal law does not have much impact on the lifestyle of the addict, who often is not allowed to do anything else but pursuing drug use in the margins of society.

Traffickers

Nowadays the criminal law concentrates on traffickers, imposing heavy sentences as retribution for unscrupulously earning money from the misfortunes of others. We have therefore made punishable an almost never-ending sequence of acts, such as cultivation, production, distribution, delivery, transport, importation and exportation. All of these acts would leave us completely unmoved if the drugs thus obtained were not consumed. The principle underlying this approach is the assumption that drug use cannot continue without supply. But this is true only if the supply of the drug itself or of its basic materials is <u>completely</u> cut off. This is where the criminal law fails miserably, despite extensive penal provisions, intensive law enforcement and severe penalties and becomes counterproductive.

Criminal Law must fail

And criminal law must fail because of two simple and well-established truths. First, demand creates supply and thus provides the impetus to do what, in the case of illicit drugs, the law prohibits. Second, never in the history of mankind has the criminal law succeeded in completely eliminating proscribed behaviour. Not even when the law was backed by almost universal public understanding and support. We all know that.
We have become accustomed to the idea that the criminal law can never prevent more than a given proportion of crime. Theft, rape and murder will always be with us. And yet no one argues that these acts should be decriminalised because the criminal law has failed to eliminate them entirely. We accept the deficient operation and limited success of the criminal law because the position that has been reached is the best one possible in the circumstances. But: things are different in the case of drug use because the deficient operation of the law takes us even further away from our goal.

What happens after all ? The trafficker sells drugs in order to make money. If his profits were to dry up or be exceeded by the costs he incurs, he would go out of business and drugs would no longer be supplied.

Seizure of drugs

In theory, his profits could dry up if it could be ensured that the drugs do not reach the customer. Naturally, the criminal law is not needed for this purpose. Any agency could confiscate illicit drugs. Yet it might be supposed that the law enforcement agencies with all their resources and powers, would have a great success rate in the seizure of drugs. This, however, is not true. A 10% seizure rate is the most optimistic estimate.

Costs passed on

The other course of action would be to allow the cost to rise so much that the traffickers have to work at a loss. This too cannot be effected through law enforcement. Of course, law enforcement measures push up the costs for the trafficker, but they have little effect because he simply passes the extra costs on to the

consumers, who in turn pass them on to the general public. The latter are forced to finance the drugs market as the victims of theft, embezzlement, burglary, robbery and other drug-related crimes. So the price mechanism simply does not work.

Enormous Profits

The seizure of drugs and the arrest of traffickers have little effect because both drugs and traffickers are quickly replaced. The enormous profits ensure that there is never any shortage of recruits. Even worse when a young person can make 2,000 a day dealing, this influences the behaviour of his peer group much more strongly than any drug education program can possibly do.

Seizure of Profits

Seizure of the profits from the drug trade, which is at present the subject of international consultations and draft conventions can succeed only if there is worldwide solidarity. Unfortunately this is in short supply. I need only say "Switzerland", "The Bahamas" or "Panama" and you will know what I mean.

Law Enforcement not an Ally

So far we have seen that law enforcement is a weak highly overrated and grossly overpaid ally. That is, as we all know, dangerous enough when you are waging a war relying almost exclusively on that ally. But the situation is worse. When we take a second look, it becomes obvious that law enforcement is not an ally at all. The inevitably deficient operation and limited success of the criminal law transforms the drug trade into an entrepreneurs' paradise, creating and maintaining a black market that guarantees huge tax free profits, and stabilising the supply and price. Law enforcement does not, therefore, deter the trade. Instead it encourages drug trafficking at every possible level and it is indeed crucial to its survival. Law enforcement, therefore, is not an ally. It is a traitor.

Side effects

Before this audience, there is, I trust, no need to describe all the counterproductive and negative side-effects of law enforcement in this field in any detail.

Criminal Justice System in Peril

As a lawyer, however, I should like to draw your attention in particular to the risk that we may lose the criminal law as a means of social control in those cases in which it still does work (albeit not perfectly) and in which it is indispensable for a just and peacable democratic society.

By attempting to use the criminal law to attain the unattainable, we are burdening the criminal justice system with such problems that it can no longer satisfactorily discharge its role in limiting the other forms of crime. First of all, this is a quantitative problem. Our criminal justice system is being flooded by drugs cases. It is getting blocked up.

Quantitative Problem

It is estimated that the Dutch police spend half their time on investigating drug trafficking and drug-related crimes. Over 75% of the suspects taken into police custody in Amsterdam are connected in some way with drugs, and 70% of the persons remanded in custody by the examining magistrate are either drug traffickers or involved in drug-related crimes. In our prisons nearly 50 percent of the inmates are drug addicts. Even in the prisons, which are of course the most secure places in the criminal

justice system, it has proved impossible to eradicate the possession and use of drugs. The other prisoners too are under pressure to use drugs and the prison officers are under pressure to help provide them. Hence there is a very real danger that the prison staff will be corrupted. And similar problems are evident outside the Netherlands. Almost everywhere in Europe we see overcrowded prisons.

I recognize that it is normal that some offences are given a higher priority than others in law enforcement. After all, no country has ever been able to provide sufficient money and manpower to enable its law enforcement system to deal with all offences. It has always been necessary to make choices and set priorities. But the devotion of huge resources over such a long period to just one kind of offence inevitably means that other offences are neglected. As a consequence, there is tension and dissatisfaction both among the general public and in the police force itself. Slowly but surely, the police are losing the essential support of the public and even of part of their own organisation and of the politicians. A recent survey showed that 40% of the inhabitants of Amsterdam considered that the protection afforded by the police was insufficient. Not because the police pay too little attention to drug abuse but because they do too little to prevent bicycle theft, burglary, vandalism and hooliganism. These are all offences to which the general public accords a higher priority than drug abuse. And again this not a typically Dutch phenomenon either. In 1985 Harald Körner, a public prosecutor and well known expert on drugs in West Germany, noted a similar development in his country.

Quality seriously at risk

But in addition to this quantitative problem the quality of the criminal justice system is also seriously at risk. The decision to use the criminal law in the fight against undesirable behaviour is taken not because this is the easiest path but because we wish to conduct the fight in accordance with the rule of law. The value of the criminal law lies primarily not in its function of combating crime but in the requirement that this function should be fulfilled in accordance with the law. Because of the strong pressure to score, in other words to win the war on drugs, there is an increasing tendency to alter the order of priority: success becomes more important than observing the rules of law.

This is exceptionally dangerous for a democratic society. First, because private individuals no longer have any inducement to obey the law if law enforcement officers themselves ignore the law whenever it suits them. This harms rather than benefits crime prevention. Second, law enforcement organisations which decide to operate outside the bounds of the law when need arises are in fact out of control. Since they have lost their integrity, they are susceptible to widespread corruption. In this way they become a greater threat to a democratic society than the very evil they were trying to eradicate.

Fostering the Maffia

But this is not all. We are fostering an international maffia whose immense income, highly developed criminal organisation and far-flung interests (including interests in gambling, prostitu-

tion, firearms and the trade in women) are enabling it to extend its sphere of influence into legitimate business, into government circles and even into law enforcement agencies. According to police officials, quoted in Newsweek of last March 14, these organisations are superbly organized and can buy off anybody they want, including law enforcement officers. The very roots of our society are threatened by this corruption. If we wait much longer, we will no longer be able to rid ourselves of them.

I have not told you anything new. You know the facts, I know the facts and governments know the facts. And we would all act accordingly if we were prepared to handle the problems in an unemotional and professional way. But most of us, and in particular governments, do not like to make the choices, which are now needed [7]).

If there were no Law Enforcement

Suppose for a moment that the acts in question were not criminal and that law enforcement was consequently not involved. We would then have a situation in which there would be no black market, no monopoly, no tax-free profits and no reason for "pushing". The international maffia would see its profits from narcotics dry up overnight. Its economic potential and its corrupting influence on governments and in society at large would decline. Drug-related crime would as good as vanish. The number of prisoners would decrease and addiction in the prisons would no longer play such a significant role. Enormous resources would be released to fight drug use by other means and to combat other crimes. And the quality of criminal law as a legal instrument could be restored.

By continuing to apply the criminal law we are placing ourselves on the horns of a dilemma. We know the alarming counter-productive effects. But what we do not know is whether drug use would increase if the criminal law were to withdraw from the scene. On the other hand, the Dutch experience of dealing with marihuana over the last 13 years indicates that the situation might get not worse, but better without law enforcement. This is not as surprising as it may seem at first sight. First, because everyone who wants to use illicit drugs can get them even now, albeit illegally [8]). And second, because it is a severe underestimation of the moral stability of young people in general to believe that they will all use drugs the moment this would no longer be a criminal offence. But it is true: we shall never know this for

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[7] "An absolute worthiness or fault approach has proved remarkably stable in some areas of criminal law (like drug addiction), when there is good reason to believe other approaches would be less costly were it not for the stark clarity of the tragic choices they would necessitate". Guido Calabresi and Philip Bobbitt, Tragic Choices - The conflicts society confronts in the allocation of tragically scarce resources. New York, 1978, p.75.

[8] For the availability of illicit drugs in the U.S. see: the National Narcotics Intelligence Consumers Committee Report on the supply of illicit drugs to the United States from foreign and domestic sources in 1985 and 1986.

certain until we try it. No government likes to take this kind of decision. But we will have to. The day cannot now be far away when an increasing number of states will be unable or unwilling to meet the costs of the negative effects of a drug policy dominated by law enforcement. In Holland for instance, members of the "Law Enforcement establishment" like judges and police chiefs advocate a gradual withdrawal of the criminal law from this field. And in some other European countries the possession of small quantities of hard or soft drugs for personal use is no longer a criminal offence.

A Black Friday for the Traffickers!

Mayor Ed Koch of New York City was quoted by Time Magazine some months ago as arguing in favour of massive military interdiction and saying that "the political aim of the drug traffickers is to make addicts of all of us". But even great men make mistakes. It's not a political but a financial aim. Hence, we should not fight them with the army or the police. The use of drugs is too serious to leave it to them. We should utilize those forces in our society, which have always been victorious in the past. I am refering to the forces of our capitalist system. What we need is a black Friday for the traffickers. The U.S. could bring this about by giving up its unhappy alliance with the criminal law. And why should not it ? Unless, of course, it has no confidence in the moral strength of the American People and Nation.

Table 1. The use of cannabis in Holland 1984 (School survey among 25,000 young people 10 - 18 yrs)		
age group:	10 - 18	17 - 18
tried but no longer used	2.3%	5.6%
still using	1.9%	6.5%
└——› One per thousand used it daily		

Table 2. Estimated number of hard drug addicts		
Country	Maximum	% of total population
Holland	20,000	0.14 %
West Germany	109,000	0.19 %
Denmark	10,000	0.20 %
Italy	250,000	0.45 %

Table 3. Proportion of Aidspatients, that are addicts	
Country	%
Holland	3 %
Great Britain	5 %
Western Germany	15 %
City of New York	17 %
Italy	20 %
Switzerland	35 %
Austria	45 %
Spain	50 %

Table 4. The use of cannabis in Holland before and after its decriminalisation		
age group	before (1976)	after (1985)
15 - 16 yrs	3 %	2 %
17 - 18 yrs	10 %	6.5 %

Drug prevalence in Amsterdam (1987)

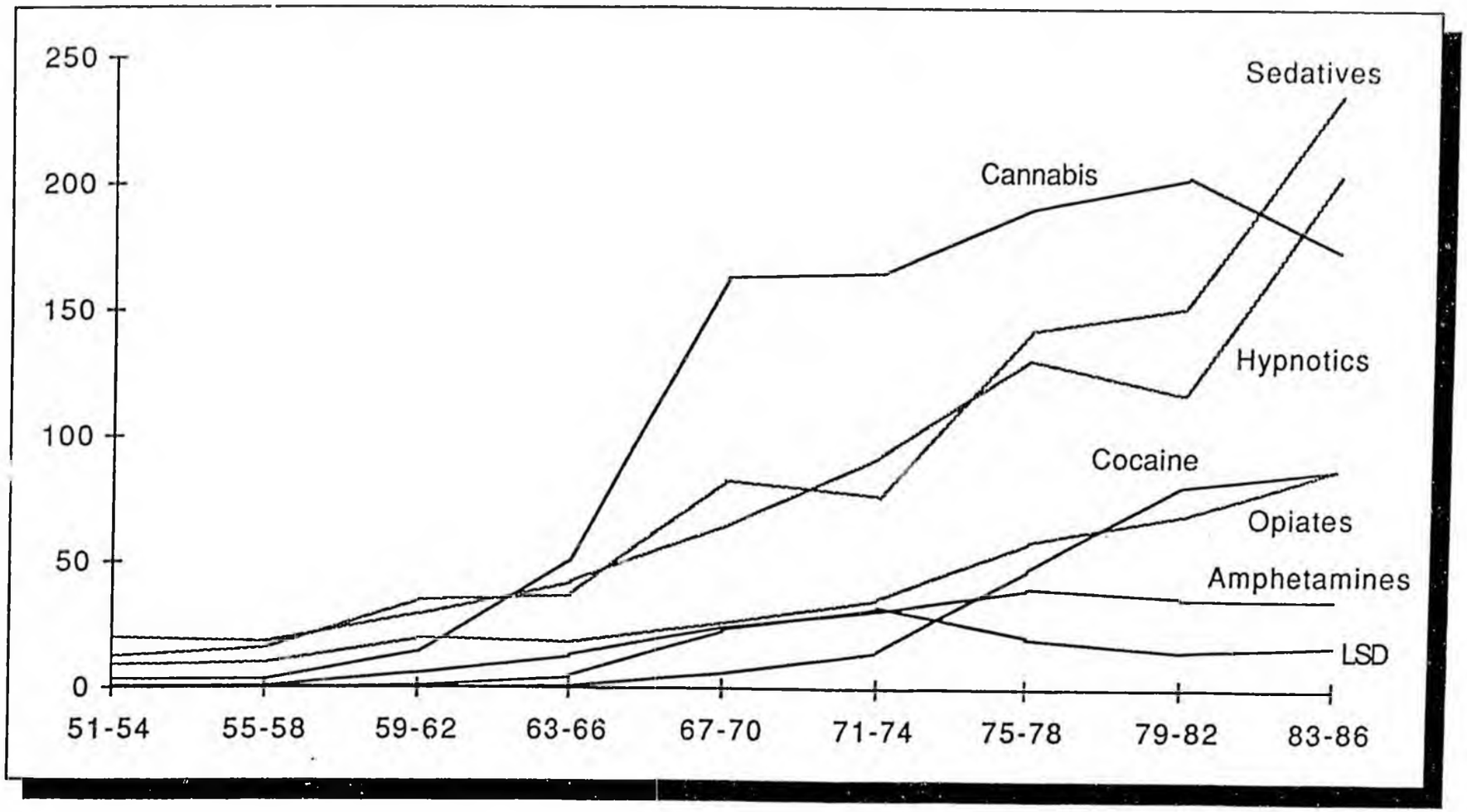
Household survey (representative sample of 4202 respondents of 16 years and older)

	life time prevalence		last year prevalence		last month prevalence						
					total (month)		on presciption		without prescr.		
drug	n	%	n	%	n	%	n	%	n	%	N
tobacco	3091	73.6	2147	51.1	1994	47.5	-	-	-	-	4200
alcoho.	3733	89.0	3373	80.4	3081	73.5	-	-	-	-	4194
hypnotics	863	20.6	487	11.6	357	8.5	306	7.3	58	1.4	4196
sedatives	965	23.0	467	11.1	319	7.6	246	5.9	77	1.8	4198
cannabis	988	23.6	403	9.6	241	5.7	-	-	-	-	4194
cocaine	245	5.8	68	1.6	27	0.6	-	-	-	-	4195
amfetamines	192	4.6	27	0.6	13	0.3	-	-	-	-	4190
opiates	400	9.6	105	2.5	49	1.2	29	0.7	13	0.3	4187
(heroin)	-	-	14	0.3	11	0.3	0	0.0	7	0.2	4187
lsd	118	2.8	5	0.1	1	0.0	-	-	-	-	4194
other hallucinogens	102	2.4	17	0.4	4	0.1	-	-	-	-	4194
inhalants	43	1.0	10	0.2	6	0.1	-	-	-	-	4191

The opiates contain a.o. opium, morfin, heroin, codein, palfium, methadone.
Codein is largely used on prescription, heroin without prescription and methadone both.

Source: Musterd,S., P.Sandwijk & I.Westerterp: "Drug use in Amsterdam" (1988, forthcoming)
Department of Social Geografy, University of Amsterdam

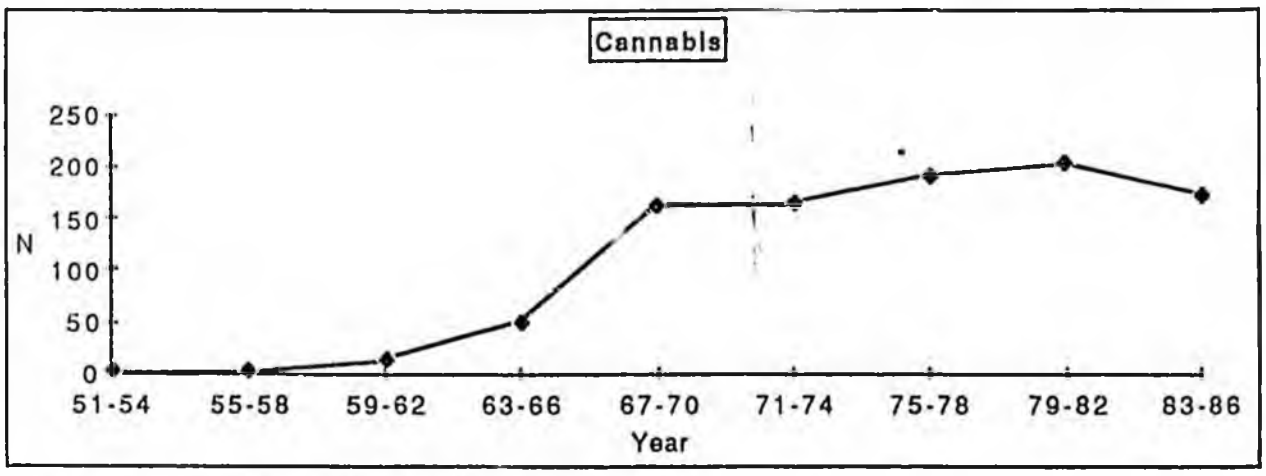
Graphic: Year of first use of several drugs in Amsterdam
Household survey (representative sample of 4202 respondents of 16 years and older)

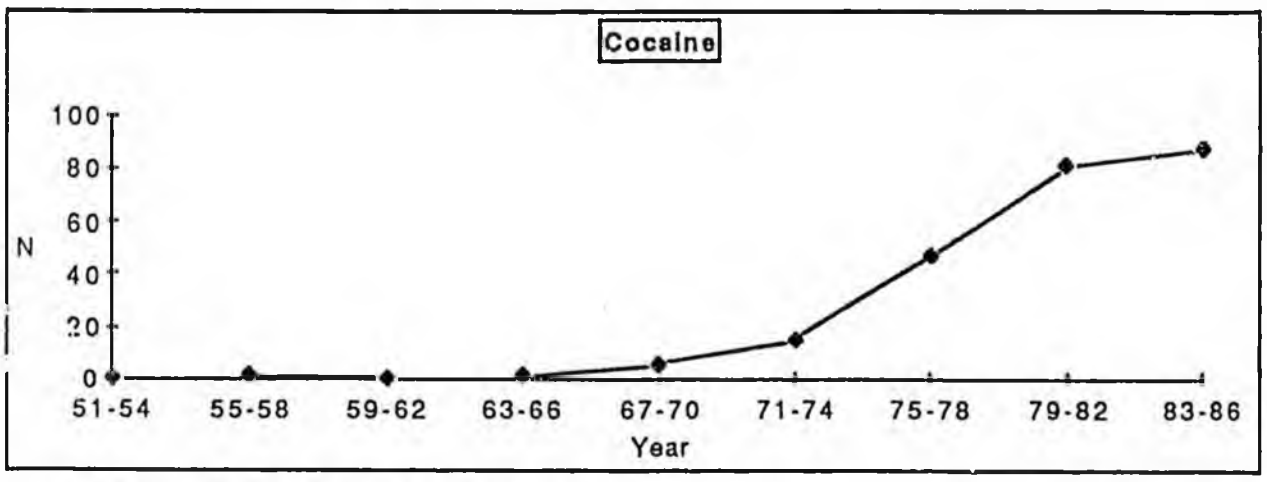


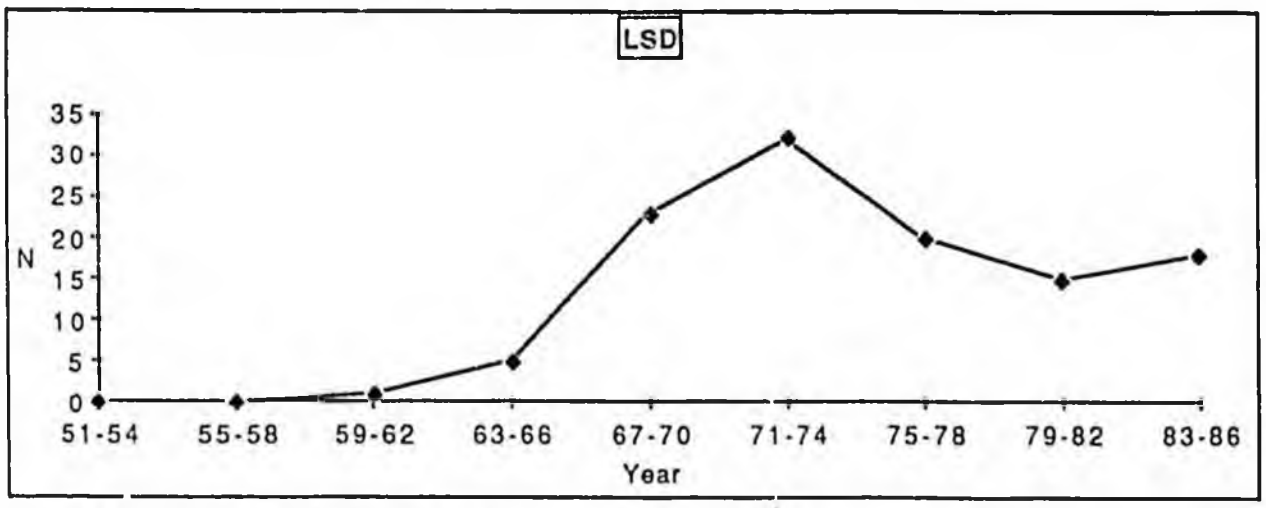
Graphics: Year of first use of several drugs in Amsterdam

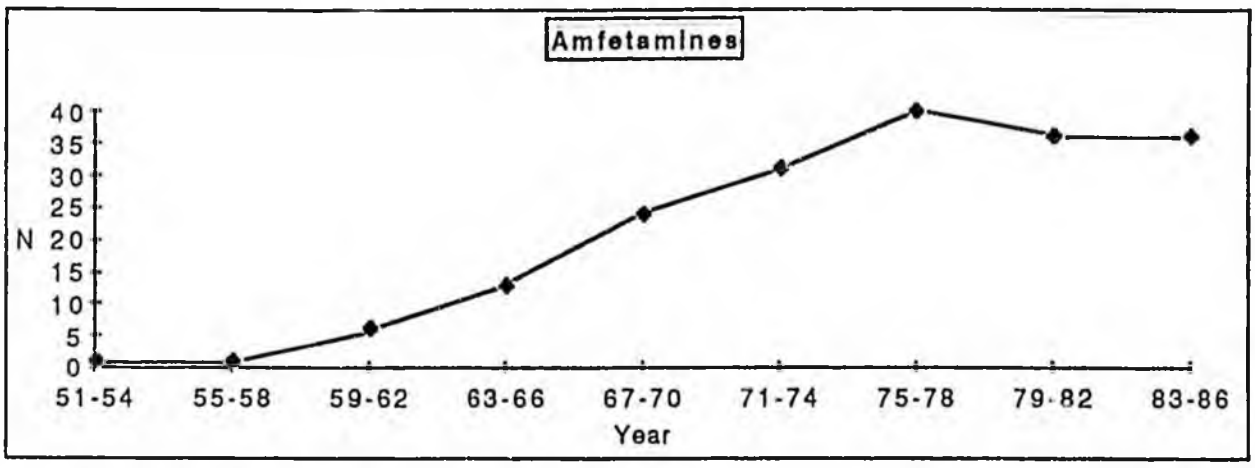
Household survey (sample of 4202 respondents of 16 years and older)

N.B. Heroin: only those respondents who still used heroin in the last year before the interview (1987)









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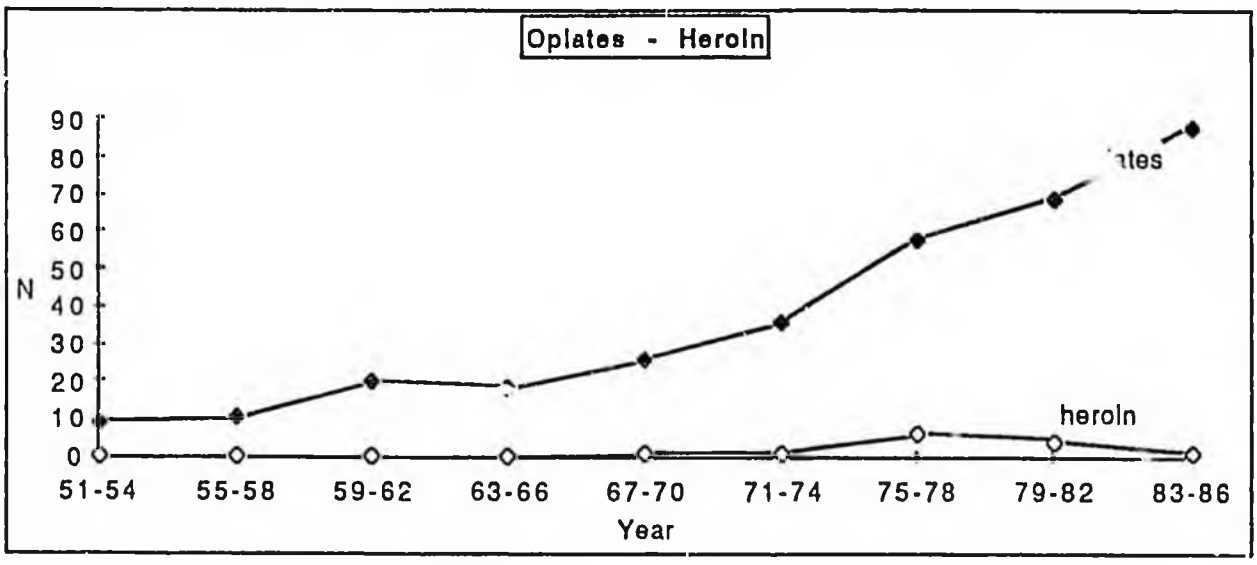

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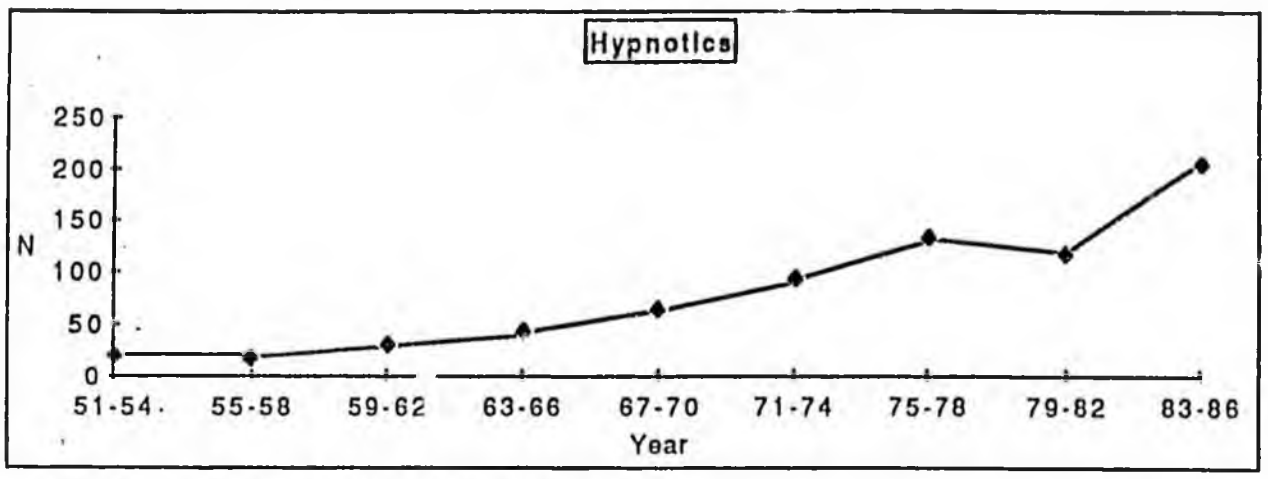

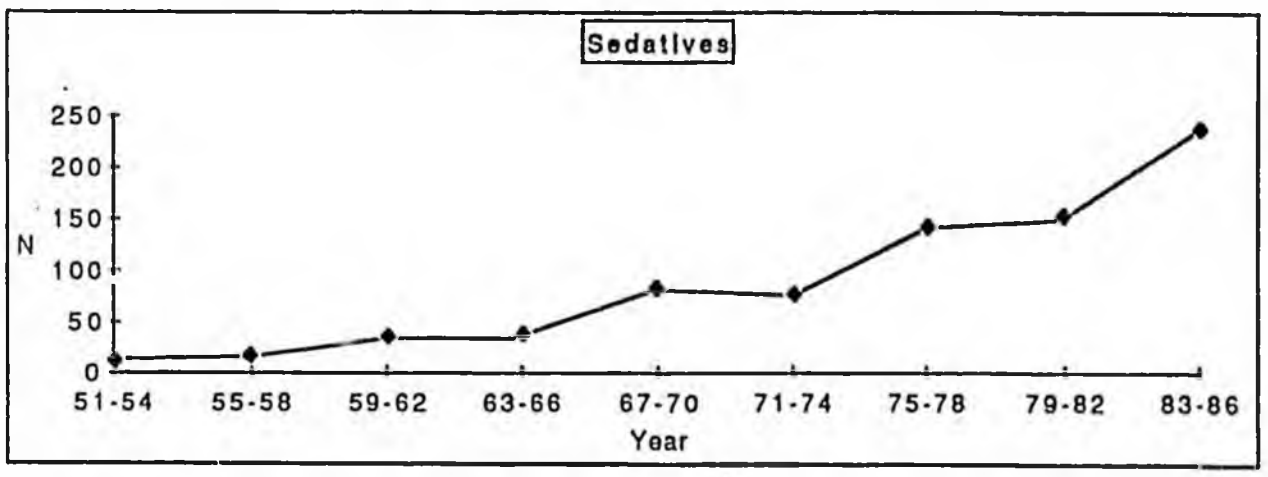

Source: Musterd,S., P.Sandwijk & I.Westerterp: "Drug use in Amsterdam" (1988, forthcoming) Department of Social Geografy, University of Amsterdam

I am greatly indebted to
Peter Cohen, Director of Drugs Research, City of Amsterdam
Eddy Engelsman, Ministry of Health, The Hague
Arnold Heertje, Professor of Economics, University of Amsterdam
Ed. Leuw, researcher, Scientific Research and Documentation Centre, Ministry of Justice, The Hague
S. Musterd, P. Sandwijk and I. Westerterp, Department of Social Geography, University of Amsterdam
Henk Jan van Vliet, former researcher, National Federation for Alcohol and Drugs
for information, the use of their published and unpublished material and their expert advice.

Frits Rüter, born 1938, graduated as a lawyer at the University of Amsterdam in 1962. From 1962 to 1966 he studied at the Max Planck Institute for foreign and international criminal law in Freiburg im Breisgau/West Germany.
Ph.D. Amsterdam 1973.
Since 1973 he has been a senior professor of criminal law at the University of Amsterdam and director of its criminal law institute.
He is a deputy judge at Amsterdam Criminal Court, a member of the Benelux Commission for the Unification of the Law, chairman of the Police Complaints Board of the City of Amsterdam and a member of the International Advisory Board for the publication of the Nuremberg Trials. As official representative of Amnesty International/London he has attended several trials and taken part in various investigative missions, mainly in Eastern Europe.

Publications: "The Prosecution and Trial of War Crimes and Crimes against Humanity" (1973); "Justiz und NS-Verbrechen", a complete collection of West German war crimes trials (22 vols); The Tokyo Judgement (2 vols); books on Dutch criminal law and various articles on Dutch criminal procedure, international cooperation in penal matters, drugs and the criminal law etc.

Decoration: "Bundesverdienstkreuz 1. Klasse" of the Federal Republic of Germany

Address: Universiteit van Amsterdam, Kloveniersburgwal 72, Amsterdam/Holland

HB 32
HB 88
SB 66

TANANA CHIEFS CONFERENCE, INC.
Board of Directors
Resolution No. 89-1

SUPPORTING NATIVE ELDERS IN THEIR FIGHT AGAINST ALCOHOL AND DRUGS

WHEREAS, there are many problems which threaten our survival as a people, but none have such a devastating impact on our [illegible] and families as does the problem of alcohol and drug ab...

WHEREAS, the use of alcohol and drugs offers nothing to our [illegible] villages but broken spirits, broken families, pain [illegible] suffering and death; and

WHEREAS, the use of alcohol and drugs never has been and never [illegible] of any value to our Native culture and Native people; and

WHEREAS, since its introduction from other cultures, Native elders [illegible] warned their villages that alcohol and drugs are the greatest threat to health, life and cultural values; and

WHEREAS, as the keepers and teachers of Native culture, the elders [illegible] today speak stronger than ever against alcohol and drugs and have committed themselves to bring their message against alcohol and drugs to their villages; and

NOW THEREFORE BE IT RESOLVED that the Tanana Chiefs Conference Board of Directors request that Governor Steve Cowper and every Alaska State legislature and member of Alaska's delegation in Congress support the efforts of the Interior villages in their fight against alcohol and drug abuse; and

BE IT FURTHER RESOLVED that the Tanana Chiefs Conference Board of Directors direct TCC to pursue state, federal, local, and private sector funding to institute comprehensive region wide alcohol and drug prevention programs utilizing elders, concerned village volunteers, village councils and youth in each village and that these concerned village teams be afforded training and ongoing support; and

BE IT FURTHER RESOLVED that the Village Councils and village courts pass ordinances against alcohol and drugs and strictly enforce these ordinances through their village courts; and

BE IT FURTHER RESOLVED to protect our children and families, Village Councils and courts strongly consider the use of traditional Native justice mechanisms and banish bootleggers and drug pushers from our village; and

BE IT FURTHER RESOLVED each school in each village includes a comprehensive drug prevention to their curriculum and actively implement preventive education at every grade level; and

BE IT FURTHER RESOLVED as an example to our children and to each other no alcohol is to be served at any TCC function from this day forward; and

389-222.1

BE IT FURTHER RESOLVED any TCC employee determined to have a drug [illegible] problem be given the option to receive treatment or be [illegible]ately terminated from employment; and

BE IT FURTHER RESOLVED each Native person of strong body and mind [illegible] hand to help their elders and village leaders in this most serious task; and

BE IT FURTHER RESOLVED for the spiritual well being of our children, families and for the survival and strengthening of our [illegible] from this day forward, let it be known that the elders of the Athabascan Nation have declared war on all those [illegible] associated with alcohol and drug abuse.

CERTIFICATION

I hereby certify that this resolution was duly passed by the Tanana [illegible] Conference, Inc. Board of Directors on March 16, 1989 at Fairbanks, Alaska [illegible] a quorum was duly established.

Daisy Northway
Secretary-Treasurer
Tanana Chiefs Conference, Inc.

Submitted by: Executive Board

389-222.2

September 20, 1989

David L. Baumeister
Era Aviation, Inc.
6160 South Airpark Drive
Anchorage, AK 99502

Dear Mr. Baumeister:

Thank you for your letter in support of the recriminalization of marijuana possession for adults.

The House Judiciary Committee is in the process of collecting data and studies on substance abuse in Alaska. The committee has two studies of its own in progress. One looks at the social costs of substance abuse in the state, and the other compares the latest scientific data on marijuana with the information available to the Supreme Court in making the "Ravin decision".

I will make sure that your letter is included in the member's files on HB 88 which is the bill currently in our committee.

Sincerely,

Peter Goll

re: written test
Sent

Era Aviation, Inc.

September 8, 1989

Mr. Peter Goll
House of Representatives
Room 122, Capitol
P. O. Box V
Juneau, Alaska 99811

Dear Mr. Goll,

I am writing to encourage you to make "the recriminalization of the possession of marijuana for personal use", your priority as the next session is called to order. Let us face some facts.

1. This country is in dire trouble as a result of drug problems.

2. Some say Alaska is a leader with its marijuana laws. In fact it is 20 years behind the times.

3. We business people who are trying to make our workplace safer are faced with the comment by employees that marijuana is legal in Alaska.

4. Fact is, Alaska stands to loose millions in Federal Funds as a result of our current laws. In these economic times, that is just foolhardy.

5. The majority of the Alaskans who elected you want this law changed.

I look forward to hearing your views on this issue.

Sincerely,

David L. Baumeister
President

6160 South Airpark Drive, Anchorage, Alaska 99502. (907) 248-4422, Telecopier: (907) 266-8350, Telex: 25324

THE WAR ON DRUGS

DRUG POLITICS

"I wonder if when this war on drugs is over, if we'll get veteran's benefits?"

-anonymous Kentucky marijuana grower

Prohibition ended because it created uncontrollable crime, violence and corruption.

Alaskan Marijuana Coalition, Box 80611, Fairbanks, Alaska, 99708

The AMC does not advocate the use of any recreational drugs we believe.

(1) prove Alaskan marijuana laws are effective

(2) Alaska cannot afford the cost of prohibition enforcement

(3) that both tobacco and alcohol are more addictive and biologically damaging than marijuana

(4) Alcohol is associated with most domestic violence

(5) re-criminalization sends a dishonest message to kids about the comparative dangers of recreational drugs

Paula Williams
Chairman, AMC

ALASKA PTA
P.O. Box 142095
Anchorage, AK 99514-2095
907-279-9345

Elrita Magoffin, Chm.
Health/Safety Comm.
Box 80322
Fairbanks, Ak., 99708

April 25, 1989

Rep. Peter Goll
Chairman
House Judiciary Committee
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Representative Goll:

As a representative of the Alaska PTA, I am contacting you with regard to HB 88, "Making Possession of Marijuana Illegal." Please enter this testimony into the Commitee's official record on this legislation.

With a current membership of 18,000, Alaska PTA is the largest educational group concerned with the health, education and juvenile justice of Alaska's youth. We want you to be aware of Alaska PTA's stand on this issue. At our 1987 convention, we unanimously passed a resolution recommending the recriminaliztion of marijuana. On April 1, at our 1989 convention in Anchorage, we reaffirmed the recriminalization of marijuana as a top legislative priority.

The state of Alaska currently sends a harmful and mixed message to the youth of our stat by having a law which allows the use and possession of marijuana in the home. We believe that the passage of HB 88 or a very similar bill is critical to send an anti-drug message to Alaska's youth. Further, we know that federal funds for drug abuse programs have been placed in jeopardy because of this liberal drug law. These funds are essential to Alaska's many drug and alcohol abuse programs.

We urgently request that you, as chairman of this committee, do all possible to bring HB 88 to the floor for debate and to be voted on and passed in this session.

Sincerely,

Elrita J. Magoffin

Elrita J. Magoffin
Health/Safety Commission, Chm.

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

FINAL HOUSE HESS COMMITTEE REPORT:

HEARINGS ON CSSB 32 (HESS)
Penalty for the possession of marijuana

The House Health, Education and Social Services Committee completed six hearings, four in full committee and two in subcommittee, on CSSB 32 (HESS), relating to the possession of marijuana. It was the recommendation of a majority of the members of this committee that this bill should not be passed from committee due to serious flaws in the findings section of the bill, which deals with the health effects of marijuana.

SUPREME COURT DECISION

To understand the reason for the Committee's decision, background information is essential. In 1975, the Alaska Supreme Court decided in Ravin v. State that marijuana possession by adults, at home, for personal use, was constitutionally protected. Writing for the Court, Chief Justice Rabinowitz stated:

> "We conclude that no adequate justification for the state's intrusion into the citizen's right to privacy by its prohibition of possession of marijuana by an adult for personal consumption in the home has been shown."

Rabinowitz continued:

> "The privacy of the individual's home cannot be breached absent a persuasive showing of a close and substantial relationship of the intrusion to a legitimate government interest."

Most importantly, to the legislature, Rabinowitz continued:

> "Here, mere scientific doubts will not suffice. The state must demonstrate a need based on proof that the public health or welfare will in fact suffer if the controls are not applied." (underline added)

The Court left open the possibility of a reversal of the decision based on the presentation of new proof of the danger posed by marijuana to the public health. Section one of CSSB 32 (HESS) is a series of medical findings which, clearly, is written in response to the Court's offering. Thus, this Committee took as our primary task-at-hand, fully within our purview, and appropriate to our area of specialization, the review of these findings.

REVIEW OF THE FINDINGS

Most of the findings in CSHB 32 (HESS) are not new. Many were previously taken into consideration by the Court before the 1975 decision through a thorough review of the medical literature on marijuana's effects. For example, in his opinion Rabinowitz noted the relatively undisputed evidence of short-term physiological effects such as: the impairment of psychomotor control, increase in the pulse, and the tendency to produce drowsiness, lethargy, timidity and passivity. Typical psychological effects such as distorted time perception and the impairment of immediate past-memory facilities were also noted. Taken into account were the "occasional" cases of anxiety and depression; "rare" cases of excessive nervousness and panic reaction; and "extremely rare" instances of psychotic reaction. Also considered were studies that have been "extensively criticized by other qualified medical scientists", claiming deleterious effects on the body's immune defenses, chromosomal structures and testosterone levels.

The bill does have some new findings, not considered by the Court, most of which were criticized as medically unsupported by a majority of the experts who testified before our Committee. These findings include: "it is possible for a human being to overdose from the use of marijuana"; "marijuana may cause schizophrenia"; "one marijuana cigarette a day may cause lung cancer in three years", "marijuana use may result in deformed or undersized offspring"; and "physical reactions to marijuana include irreversible changes in the brain".

MARIJUANA IN PERSPECTIVE

It is undisputed that there are negative health effects due to marijuana use, and that its use should be discouraged. The question is a matter of degree. Just how bad is this substance given society's tolerance of other unhealthy substances such as tobacco and alcohol, and to what lengths does the state have the right to control its use? The Supreme Court originally drew this connection in the Ravin decision stating that:

> marijuana is "far more innocuous in terms of physiological and social damage that alcohol and tobacco"; and further by stating, "it appears that the effects of marijuana on the individual are not serious enough to justify widespread concern, at least as compared to the far more dangerous effects of alcohol, barbiturates and amphetamines."

In sum, we found that some of the medical findings were supported by valid medical research, but most of these were already considered in the Ravin decision. The rest were either irrelevant, overstated, misleading or false. Most were inconclusively proven. This bill would have failed miserably

in proving to the Court any new evidence of marijuana's dangers. To send this bill through the legislative process would have been an abrogation of this committee's duty to act responsibly and authoritatively within our given health area of specialization.

CONCERN FOR CHILDREN: COMMITTEE ACTION ON ABUSED SUBSTANCES

The significant level of public concern, both pro and con, regarding this legislation was taken gravely by this committee. We were especially impressed with and sympathetic to the widespread concern about drug abuse by young people in this state. But, the illusion that this bill was a panacea appears to have been promoted through misinformation and oversimplification. To pass a seriously flawed bill just to escape political pressures, only to have it overturned by the court, would have been a gross disservice. The court most certainly would have struck down this legislation as unconstitutional. We are supported in this view by opinions from both our Legislative Legal Counsel and from the Counsel to the Senate Judiciary Committee.

The Committee did pass three bills designed to specifically address substance abuse by young Alaskans. Senate Bill 339 raises the legal age for the purchase of cigarettes and prevents the sale of cigarettes from unsupervised vending machines; HB 361 limits the driving privileges of minors convicted of offenses involving drugs and alcohol and; HB 265 provided for community service and substance abuse treatment for minors who violate laws. HB 361, known as the "use it and lose it" bill, was sponsored by our Committee and is now state law. SB 339 is also now state law.

COMMITTEES' DELIBERATION

It is unclear to us why CSSB 32 (HESS), after being in the Senate for 13 months, passed with such problems. The sponsor of the bill is the Chairman of the Senate HESS Committee, the committee with primary purview. Yet, after several hearings in the Senate HESS Committee (attended by House HESS members), the findings remained largely unsupported. Research material made available to Senate HESS was specifically requested to show only that evidence which supported the findings; no evidence which could refute them was included. Upon receipt of the bill we requested comprehensive background information from the House Research Agency both supporting and refuting the findings and began our hearings shortly after receiving this information. Before and after the hearings we contacted the sponsor and requested specific documentation for each of the findings in the bill, but none was received.

While the committee spent most of its time on the health aspects of this bill, legal and fiscal issues were also touched upon. Further deliberation on legislation of this kind would need to include discussion of the appropriateness of the penalties, the effectiveness of the deterrence intended by the legislation, the issue of whether or not the new law would be enforced, and the civil liberties issues associated with possible selective enforcement. In addition, the nearly $1 million annual fiscal impact to the state would need to be weighed. Issues of federal funding and federal enforcement regarding drugs were not relevant to this committee's review of the medical findings, especially given the burden of proof charged to the state by the Supreme Court regarding the constitutional implications of Alaska's marijuana laws.

LEGAL QUESTIONS

Alaska's constitution, as originally written in 1955 and accepted by a vote of the people of Alaska, placed greater emphasis on personal individual liberty than does the constitution of any other state. This was reaffirmed and further strengthened by a specific amendment (ART I, Section 22) affirming an Alaskan's right of privacy, passed by vote of the people in 1972. These constitutionally mandated individual rights severely limit the legislature's power, even when the legislature attempts to act within the constitution and for the public interest, as in the local hire and longevity bonus cases. Legislation cavalierly passed in disregard of the warnings of the Legislature's own legal counsel as to its unconstitutional nature, would only be demolished in the courts with great expense to the public. A legislator's oath of office binds him/her to support the Constitution of the State of Alaska and should be taken seriously.

Constitutional questions are properly the purview of the Judiciary Committee. Any legislation that seeks to prohibit an Alaskan's private right to possess marijuana must be carefully examined as to its effect on other personal private rights (home education, possession of literature, firearms, etc.) and on the degree of proof needed to establish that an overwhelming state interest exists in a given case. Further the line between the interest and responsibility of the government of the State of Alaska, functioning under its Constitution, and the powers and functions of the Federal Government and its officers must be clearly delineated. The State of Alaska, although part of our Federal system, is not an arm of the Federal Government, but an instrument beholden to the people of this state and operated in their interest. Unless the Congress of the United States decrees, and the US Supreme Court agrees, that all states must uniformly enforce a specific federally mandated law in regard to marijuana, Alaska must find its own way in this regard. Currently, no uniformity exists: the State of Louisiana does fine an individual $500 for personal possession of marijuana, but personal

possession in Louisiana is defined as possessing up to 100 pounds (!) rather than being limited to 4 ounces as in Alaska. It is clear that the legal questions may produce more testimony and debate than the questions of the public health impact of marijuana that occupied the time of the House HESS Committee.

CONCLUSION

Perhaps the most representative statement regarding the adequacy of this bill was written by Dr. Bernard Segal. Dr. Segal is the Director of the Center for Alcohol and Addiction Studies at the University of Alaska. He has documented high levels of drug and alcohol use by Alaskan adolescents and is a leading Alaskan authority on the prevention of drug abuse. In his statement on CSSB 32 (HESS) he wrote:

> "In summary, it is my professional and personal opinion that this legislation, if passed in its present form, cannot be supported in court. The preponderance of research findings points to conclusions that are contrary to most of the allegations in the bill. Moreover, passing the legislation as is would contribute, in my opinion, to an impression that Alaska is operating in a climate similar to that of the 1930's, one which may convey a message to scientists and others that emotions rather than rationality prevail. As such, I urge that the present legislation be deferred. If the Legislature retains its interest in recriminalization of marijuana, then it has to prepare more factual and more rational legislation, which accurately reflects what is known about the adverse effects of marijuana. A more objective approach would then allow the courts to weigh the arguments for or against, rather than dismiss poorly conceived legislation 'out of hand'."

Finally, since a bill similar to SB 32 has been in the Legislature for the past five years it is likely to be reintroduced again, (SB 32 is identical to HB 698 from the Thirteenth Legislature - 1984). To supporters of that possible future legislation we suggest that objective and authoritative information be sought to support assertions of health effects. In this regard, articles from the Readers Digest will not suffice, nor will the testimony of individuals who have developed a reputation of advocacy, and often an income, for either side of this issue. Any future review of the medical effects needs to be depoliticized, unemotional, rational and comprehensive. Pursued in this light, we are confident that all the members of this committee would be willing to devote their efforts.

July, 1988

Rep. Niilo Koponen, Co-Chair, House HESS Committee
Rep. Johnny Ellis, Co-Chair, House HESS Committee

RECEIVED MAY 4 1989

FAMILIES IN ACTION
FOR A DRUG FREE COMMUNITY
P.O. BOX 1188
PETERSBURG, AK 99833

HB 88

April 24, 2989

The Honorable Peter Goll
Alaska State Legislature
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Goll:

I am writing to you on behalf of an organization called Families In Action For a Drug Free Community. Our group consists of 70 members of the community, who are concerned with the progress of SB18 and its companion bill HB22 - Recriminalizing marijuana. We would like to urge you to please support passage of these bills.

By tolerating even a small amount of marijuana in the privacy of ones own home, Alaskans are putting the seal of approval on this dangerous drug for their children. Do we want to give our children the impression that this drug is okay as long as you use it at home? The Nation as a whole is trying to instill "Just Say No" into our children's vocabulary. Should this mean, "Just Say No To Everything Except Marijuana"?

In the late 1950's fewer than one percent of American teenagers had ever tried marijuana or any other illegal drug. As of 1980, more than 60 percent were experimenting with drugs. Today we are seeing an even higher percentage, with the average age of users dropping from 19 years old, to 12.

According to information put out by the Benevolent and Protective Order of Elks, marijuana is viewed as "The Gateway Drug". This means that once a person has used marijuana, it is easier for them to go on to harder drugs. Among pot smokers, a shocking 60% progress to harder drugs. Conversely, if young people do NOT smoke pot, the odds are 98 to 1, that they will NEVER try any other illicit drug. According the Elk's survey, among high school seniors, 27 percent try stimulants, 16 percent sedatives, 16 percent cocaine, 9 percent LSD, and 6 percent PCP. Nearly all of them started with POT.

Two years ago, a survey was conducted of 420 students in Petersburg schools, grades 6 - 12th. 35% of these students were using marijuana regularly, and had been since age 10 or younger. This survey also reported that their "first time" had been at home and provided by a family member...alarming isn't it? Is this really what we are encouraging for our

youth? Can Alaskans continue to deny the fact that drugs are becoming an increasing problem among teens? State legislators predict that passing SB18 and HB22 would cost the state approximately $750,000.00. That may seem like a lot, however, what dollar amount can we place on Alaska's future leaders? And how many of our children's lives will eventually be ruined or lost due to this "legal" drug?

Again, please support these bills. Recriminalizing marijuana is a step towards making a better future for Alaskan children.

Thank you for the opportunity to comment.

Sincerely,

Beth Rhoden

Beth Rhoden
Secretary

cc: Juneau Empire
Anchorage Daily News
Chilkat Valley News
Southeastern Log

HB 88

Wagstaff, Pope, Rogers & Clocksin
Lawyers

Robert H. Wagstaff
Don Clocksin
912 West Sixth Avenue
Anchorage, Alaska 99501
(907) 277-8611

Douglas Pope
David E. Rogers
124 West 5th Street
Juneau, Alaska 99801
(907) 586-4151

Affiliated with:
Hobbs, Straus, Dean & Walker
1819 K Street N.W. Suite 800
Washington, D.C. 20006
(202) 788-5100

March 19, 1987

Steve Cowper
Office of the Governor
P.O. Box A
Juneau, AK 99811

Re: Our File No. 2027.01

Dear Steve:

As we predicted last fall, the Legislature has introduced several bills calling for the "recriminalization" of marijuana with a number of unfactual alleged findings of fact. Enclosed please find a point by point rebuttal of all the purported "new" facts regarding marijuana.

In summary, nothing has changed as far as marijuana scientific evidence since the Ravin decision in 1975. Indeed, the ultimate bottom line is that people all over the world have been using marijuana in various quantities for over 3,000 years and nothing has happened yet.

The issue presented in such legislation transcends marijuana. It deals with the right of privacy, the right of the people to be let alone to do what they want, so long as it doesn't affect anyone else. Please let me know if you would like any additional information or if I can be of any other assistance. We are not releasing the contents of this letter generally at this time.

Very truly yours,

Robert H. Wagstaff

RHW:ksg/01

NATIONAL ORGANIZATION FOR THE REFORM OF MARIJUANA LAWS

NORML

2001 S STREET, NW, SUITE 640, WASHINGTON, D.C. 20009 • (202) 483-5500

February 26, 1987

Robert Wagstaff
912 West 6th St
Anchorage, AK 99501

Dear Mr. Wagstaff:

I have examined the findings reported in House Bill #55 of the Alaskan Legislature and have found them flawed and inaccurate. Here is a point by point rebuttal of the findings. References to the National Academy of Sciences refer to their publication Marijuana and Health which reports their 1982 study of marijuana related research.

1) "THC, the mind altering ingredient in marijuana, is not soluble in water, but goes into the fatty tissues of the brain, testicles, ovaries, and other internal organs, and takes 30 days to be eliminated from the body;"

Actually, THC is broken down by the body soon after ingestion. It's metabolites stay in the body for up to 30 days, but these metabolites are non-psychoactive. Any toxicologist can confirm this. Urine testing advocates exploit the confusion between THC which is the active ingredient and is metabolized relatively quickly, and its metabolites (chiefly 9-carboxy-THC) which have no psychoactive effect but linger in the body for a month or so.

The following quote is from a recent article by Chemical & Engineering News (6/2/86). "Marijuana is the most commonly abused drug and the kinetics of its metabolism have been studied extensively. It is also an unusual drug in that it can be detected in urine for a long time. Very little of the original drug, Delta-9-tetrahydrocannabinol or THC, goes into the urine. The chemical is absorbed from the blood into body fat tissue where it is eliminated as it is slowly metabolized. . . (metabolites) can be found in urine for longer than a month . . ."

The following quote is from a Center for Disease Control MMWR Report (9/16/83). "Studies involving humans indicate that 80% - 90% of the total dose of Delta-9-THC is excreted within 5 days - approximately 20% in urine and 65% in feces."

Most experts claim that the metabolites disappear 10 to 14 days after ingestion in most cases. Urine tests detect these metabolites, which is why the manufacturers are required to point out that they are tests to indicate recent use, not intoxication or impairment. If THC remained in the system for 30 days, and remained active, the urine tests would be marketed as a way to indicate impairment. They aren't.

2) "the buildup of THC in the body causes the user to smoke more marijuana to achieve the desired high and may result in loss of sleep, appetite, and initiative, as well as moodiness and depression;"

The "buildup of THC" is actually tolerance to the drug, a physiological response humans and animals have to any drug. It occurs not because of the THC buildup, but because of other complex biological factors.

The symptoms mentioned accompany cessation of marijuana use in some individuals, not the buildup in the body. A majority of marijuana smokers experience no side-effects from cessation of use. If these symptoms indicate anything, they indicate the relative lack of serious side-effects from cessation of use, unlike those associated with alcohol and opiate withdrawal.

3) "it is possible for a human being to overdose from the use of marijuana, especially if it is used in conjunction with alcohol, because it increases the effects of alcohol;"

There is no record of anyone ever dying from an overdose of marijuana. It is one of the least toxic drugs known to man.

Raphael Mechoulam, who isolated the main ingredient of marijuana (THC) has edited Cannabinoids as Therapeutic Agents which includes an article by Mark Segal on Marijuana's potential as an analgesic. He reports that marijuana has promise as a pain killer because it is non-addictive and does not depress the respiratory tract (unlike opiods.) Marijuana's promise as a pain-killer is reported by the National Academy of Sciences, and by Roger Roffman in the book Marijuana as Medicine; its promise rests on the fact that finding #3 is essentially false.

Marijuana is a mild intoxicant, and as such should not be used in conjunction with other intoxicants. Whether marijuana increases the effects of alcohol, or complicates them, or just how one would subjectively describe the effects of mixing the two, is beside the point that multiple drug use provides multiple safety concerns. Marijuana, though, has far less severe cross-reaction with alcohol that barbituates or tranquilizers such as valium. Once again, a good toxicologist can provide confirmation of these points.

4) "the THC content of a marijuana cigarette 10 years ago was one percent, but is as high as 10 percent per cigarette today;"

Proponents of jailing people for marijuana use have been using this argument as if to suggest that marijuana is ten times more dangerous than it used to be. The premise that an increase in potency demonstrates an increase in danger is logically unsound. As with alcohol, consumers compensate for higher potency by consuming smaller doses. Anyone who counsels alcoholics will confirm that beer is no less dangerous than whiskey simply because it has a lesser potency.

The government has been trying to sell the increased potency argument for some time. The enclosed press release refers to a New York Times report in 1986 that marijuana had increased to an average potency of 3.5%, and that this was an alarming increase over the seventies. However, in 1980, The Times ran a similar story, only at that time they claimed that marijuana had an average potency of 4%. So, marijuana has actually decreased in potency, if you believe The Times.

5) "Marijuana causes schizophrenia, illusions, and hallucinations, including a dulling of the senses, creating the possibility that the user is unable to respond to body signals, such as pain;"

There is no clinical evidence that marijuana causes schizophrenia. The National Academy of Sciences found that drug abuse was more often than not a symptom rather than a cause of mental problems. Illusions and hallucinations are often subjective phenomena influenced by an individuals mental state and the power of suggestion. Individuals succeptible to lapses in their grasp of reality will compound their mental problems with the use of alcohol, marijuana, or other drugs.

Marijuana users do not hallucinate. They do experience an alteration of their space perception, and an apparent enhancement of colors. These, combined with impairment of motor coordination, are reasons why marijuana should not be used while driving a motor vehicle. However, to call these effects of marijuana "hallucinations" is misleading if not untruthful. Individuals who take LSD hallucinate. Individuals detoxifying from alcohol addiction hallucinate. Hallucinate means the individual sees something that isn't there. Marijuana users do not hallucinate.

The National Institute on Drug Abuse's pamphlet, "Marijuana", is far from being the best source on marijuana's effects. However, it's claims are based far more on actual research than popular myths. It makes no mention of hallucinations, illusions, or schizophrenia resulting from marijuana use.

Marijuana's promise as a pain killer is referenced above. However, the dose required to render an individual oblivious to body signals such as pain far exceeds standard levels of use. A sufficient dose to accomplish this would also put the subject to sleep. It is unlikely that this presents any danger to the individual or to society.

6) "although it may take a heavy cigarette smoker as long as 20 years to develop lung cancer, one marijuana cigarette a day may cause lung cancer in three years;"

Marijuana is used daily by over 6 million Americans, according to the National Institute of Drug Abuse. Marijuana has been a popular recreational drug used by a large percentage of young Americans since 1965. There is no record of case histories to document this finding. If this finding were true, we would have millions of case histories of young individuals with lung cancer from marijuana use. The case histories don't exist because the statement is false.

The National Academy of Sciences decided that marijuana smoking and tobacco smoking can not be compared because the methods of ingestion differ so greatly. Marijuana smokers smoke far less materials a day than tobacco smokers (up to 2 cigarettes a day compared to 20 - 60), but they inhale the smoke far deeper into the lungs. On the other hand, many marijuana smokers use a waterpipe (or "bong") which filters out many, but not all, of the tars that contribute to lung cancer.

Claims that marijuana is more carcinogenic than tobacco are compelled by a logic that dictates that because marijuana is illegal (except in Alaska) it has to be more dangerous than tobacco (or in other cases, than alcohol). The claims are based on the undisputed fact that marijuana contains more tar than tobacco, but ignore the differences in ingestion and dosage that make comparisons inaccurate. Marijuana smoke is bad for the lungs, it does

contribute to the formation of lung cancer, and I am convinced that by the year 2000 we will begin to hear of case studies of individuals who have lung cancer as a result of long term marijuana use.

Nonetheless, it is not true that a marijuana cigarette a day for three years will cause lung cancer. I offer my own lungs and continued health as proof.

7) "THC affects eggs, sperm, sexual hormones, and the development of a fetus, and marijuana use may result in deformed or undersized offspring;"

There are no documented cases of marijuana use causing a genetic deformity. I challenge anyone to provide one.

In April, 1984 Ralph Hingson delivered a paper at a NORML conference on "Effects of Marijuana Use on Pregnant Women". Dr. Hingson's conclusion was that marijuana use during pregnancy may result in a smaller birth weight for the fetus, but in an allowable range (similar to the smaller birth weight for babies from nicotine or alcohol using mothers.) NORML has been publicizing this since 1984. We regularly hear, though, from mothers who used marijuana during pregnancy who delivered babies of normal weight.

Laboratory tests have indicated that under some conditions, large doses of THC affect the eggs, sperm, and sexual hormones of rats and other animals. There is evidence that THC inhibits sperm mobility. However, the effects of marijuana on fertility seem to be negligible - as millions of marijuana smoking parents will attest to.

The National Academy of Sciences report affirmed that marijuana use has no effect on chromosomes or fertility.

8) "other physical reactions to marijuana include irreversible changes in the brain, sinusitis, pharyngitis, bronchitis, emphysema, increased heart rate, and decreased blood circulation;"

Marijuana use does not cause brain damage. NIDA recently announced proof that it does. My office contacted the researcher. His data actually suggested that a does of 50 marijuana cigarettes a day for 30 years would not cause brain damage. What NIDA based their comments on was his finding that 136 marijuana cigarettes for 30 years would cause slight premature senilia. An individual would have to smoke a marijuana cigarette every 8 minutes for 16 hours a day, for thirty years, to suffer any brain damage - if this study is conclusive. The enclosed NORML press release cited above re: marijuana potency contains more details of this study.

Smoking contributes to lung and sinus problems, and marijuana smoking is no different. Marijuana does increase the heart rate and/or blood pressure in some individuals; NORML cautions against marijuana use by individuals with cardiovascular problems.

9) "other psychological reactions to marijuana include loss of memory; impairment in thinking, reading comprehension, and verbal and arithmetic problem solving; impairment of perception of distance and time; and anxiety, panic, paranoia, psychosis, and psychological dependence."

People use marijuana because they enjoy the mild impairment of the senses marijuana contributes to. This impairment is short term, and wears off two to three hours after ingestion. There is no evidence of prolonged impairment from marijuana use. The effects described above up to but not including anxiety are the short-term effects desired by the marijuana user.

The danger of teenage marijuana use is that many teens are prone to mix relaxation and studying, meaning they think it is okay to study while high on marijuana or while drinking beer. Impairment limits the ability to learn, especially the acquisition of learning skills. This is why it is essential to deter adolescents from marijuana use, and a primary reason why NORML advocates legalizing marijuana for adults (and shutting down the black market that will sell to students.) However 90% of marijuana smokers are adults whose learning skills are unimpaired by their occasional, moderate marijuana use.

Marijuana produces a condition similar to stress on the human body (for example, the increase in heart rate.) Most users find this pleasurable (ironically even the ones who claim they use marijuana to alleviate stress), some first time users do not. This is what accounts to reports of anxiety attacks by new or inexperienced users of marijuana. No everybody who tries marijuana likes it, nor does everyone who uses it does so without ill-effect. People with pre-existing mental problems, as mentioned above, are succeptible to drub abuse. They are the source of reports of panic, paranoia, and psychosis resulting from marijuana use.

The issue of psychological dependence has been hotly debated for twenty years. Obviously, millions and millions of Americans use marijuana regularly. I contend they do so because they enjoy using marijuana. Whether they are psychologically dependent or not is a moot point. Marijuana is not an addictive drug, nor a dangerous one. Psychological reactions to it are cultural, not medical or biological. Once again, to belabor the point, some people with psychological problems abuse marijuana and other drugs. As with anxiety, panic, paranoia and psychosis, psychological dependence is not an observed side-effect in the overwhelmingly majority of marijuana users.

Additional Comments

To be to the point, these findings at best constitute horrible distortions and exaggerations of existing research findings. At worst, they are deceptive lies and half-truths designed to mislead the legislature of Alaska.

The National and International Drug Law Enforcement Strategy of the National Drug Enforcement Policy Board (NDEPB) (Jan. 1987) states that "because the decriminalization of marijuana possession undermines the standard of the unacceptability of drug use, the 11 states (which includes Alaska) that have decriminalized marijuana possession should recriminalize this offense." This document also indicates that the Attorney General is now in charge of all anti-drug efforts, including drug-education plans.

Many of the claims represented in the above findings replicate claims in the NDEPB's Analysis of the Domestic Cannabis Problem and the Federal Response, (8/86). The source cited was a Drug Enforcement Administration

report "The Health Implications of Marijuana Use." It is rift with phrases such as "research suggests," "have been observed," "marijuana may," and other cautious terminology which avoids making a direct conclusion. It is my opinion after studying these claims that the represent law enforcement's best attempt to justify the laws which they are obligated to enforce.

Social bias often interferes with sound scientific reasoning. The notion that marijuana is illegal so it must be dangerous is the driving rationale behind the ludicrous comments about marijuana above. The strategy of the NDEPB is to justify their increasing budget requests by turning drug education programs into law enforcement propaganda.

Please let me know how I can be of service in bringing the truth about marijuana to the people of Alaska.

Sincerely yours,

Jon B. Gettman
National Director

cc: Chris Hamre
enclosures

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSHB 88 (SA)
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: Making possession of marijuana illegal
Sponsor: House State Affairs
Requestor: House Judiciary

Agency Affected: Public Safety
BRU: Alaska State Troopers
Component: Detachments, B.D.E. and V.P.S.O.

EXPENDITURES/REVENUES: (Thousands of Dollars) (Inflation not included)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER/PROG RCPT						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

This bill makes possession of small amounts of marijuana (less than four ounces) a "violation", punishable by a fine. The "bail amount" (fine) will be set by the state supreme court by court rule.

It is anticipated that the majority of new criminal cases under this bill would arise from situations where a State Trooper contacts a person on another matter, and the use or possession of marijuana is discovered during the contact. For this reason, we believe the fiscal impact of these additional cases can be absorbed within existing resources.

Prepared by: Francis C. Allan
Division: Alaska State Troopers
Phone: 269-5691
Date: 12/19/89

12/22/89

Approved by Commissioner: Arthur English
Agency: Department of Public Safety
Date: 1-8-90

Page 1 of 1

RESOLUTION 89-6 OF THE GREATER JUNEAU CHAMBER OF COMMERCE

A RESOLUTION IN SUPPORT OF INITIATIVE NO. 88MARI REGARDING THE RECRIMINALIZATION OF MARIJUANA BEING PLACED BEFORE THE VOTERS AT THE NEXT STATE-WIDE ELECTION.

WHEREAS, marijuana has been found to be physically and mentally addictive and significantly impairs learning for individuals under the influence; and

WHEREAS, Alaska is the only state in the union with a permissive statute for personal possession of marijuana; and

WHEREAS, the supreme courts of other states and the United States Supreme Court uphold state statutes prohibiting the use and possession of marijuana; and

WHEREAS, current Alaska state statutes are not in conformity with federal drug enforcement laws and International Treaties; and

WHEREAS, conflicts between federal and state laws pertaining to marijuana create barriers for law enforcement officials in providing protection to the public; and

WHEREAS, marijuana use affects business through high absenteeism, tardiness, high injury and accident rates, thefts of equipment, money and merchandise, poor workmanship, low productivity, high workers' compensation rates, low morale of workers and increased errors and mistakes; and

WHEREAS, current Alaska law indicates to Alaska youth that the use of marijuana is an acceptable adult behavior contrary to federal laws making possession of marijuana a crime; and

WHEREAS, representatives of 60 Alaskan high schools at the Alaska Association of School Governments' Annual Conference in 1986, unanimously passed a resolution to repeal the current marijuana law and make the drug in all its forms illegal in Alaska; and

WHEREAS, Alaska currently receives federal monies in fiscal year 1989 for: drug enforcement; drug-free school programs; juvenile justice; alcohol, drug abuse, and mental health administration to the total of $5,175,000,;and

WHEREAS, continued receipt of these funds is jeopardized by Alaska's failure to conform its marijuana laws to national standards; and

WHEREAS, one of the major purposes and objectives of the Greater Juneau Chamber of Commerce is to "improve the business climate and to make this community a more desirable place to live and work";

NOW, THEREFORE, BE IT RESOLVED BY THE GREATER JUNEAU CHAMBER OF COMMERCE:

That the Greater Juneau Chamber of Commerce 1. urges the Alaska State Legislature to revise the statutes relating to marijuana to conform to the national standards, and 2. supports Initiative No. 88MARI being placed on the next state-wide ballot to give the residents of Alaska the choice of whether or not to recriminalize marijuana, and 3. urges Alaskans to vote to recriminalize marijuana during the next state-wide ballot on Initiative 88MARI.

Effective date. This resolution shall be effective immediately upon adoption.

Adopted this 22nd day of September, 1989

John C. Gucker, President

Attest:

Judy Gilmore, Office Manager

Len Karpinski
810 E. 42nd Pl. #16
Anchorage, Alaska 99503-6110
(907) 562-7985 (home)
(907) 265-6833 (work)
5 November 1989

Rep. Peter Goll
Pouch V
Juneau, Alaska 99811

RECEIV[illegible]
1989

Dear Rep. Goll:

You are to be commended for your stand so far in support of the Constitution regarding the marijuana issue. I believe that children are already prohibited from having marijuana as with alcohol and tobacco. The entire thrust of those who favor recriminalization (often called "reform" in an interesting use of Newspeak) is to protect children, when their intent is to impose their personal preferences on adults regarding a substance that is less harmful than alcohol or tobacco.

I and other like-minded registered voters will always remember your stand for our Constitutional rights.

Sincerely,

Len Karpinski

Wylie Allen
P.O. Box 8362
Ketchikan, Ak. 99901

Representative Cheri Davis, Ketchikan.

Representative Walt Furnace, Anchorage.

These are your representatives who do not consider marijuana enough of a menace to your children to pass a bill out of their committee to recriminalize it.

Ask them why. Ask them why they don't actively support this urgently needed reform. Ask them why they don't publicly state their support for recriminalization, or the reason why they do not want it recriminalized.

Please let them know how you feel about their decision. The Legislative Information Office will relay your comments to your legislator.

ROBERT H. SHIPLEY
Anchorage

Marijuana

EDITOR, Daily News:

I hope the voters of Alaska remember the following names.

Representative Johnny Ellis, Anchorage.

Representative Mark Boyer, Fairbanks.

Representative [redacted]

Representative Max Gruenberg, Anchorage.

Representative George Jacko, Kodiak.

Letters

The Ketchikan Daily
letters to

November 8, 1989

Dear Legislator,

The above letter to the Ketchikan Daily News was published recently, and I welcome the opportunity to be able to identify and thank you for being a voice of reason and moderation in the current anti-drug hysteria that is being generated by a vocal MINORITY of our citizens. Not only do I find this type of legislation repugnant from a civil liberties point of view, I really resent being grouped with other people's children as needing to be supervised by law enforcement in my own home. Children are not supposed to smoke marijuana, nor tobacco, nor consume alcohol, nor engage in certain sexual activities before a certain statutory age, plus a myriad of other activities that are reserved for adults who accept the responsibilities of their actions(hopefully).The laws are already on the books to protect children from harmful activities, and since I long ago ceased being a legal 'child', and pay my bills and take care of my responsibilites, I don't need Mr. Shipley or any others of his ilk deciding how I need to live my life.

This state is supposedly the 'last frontier', a place where an individual can hopefully feel freer from the constraints of government and society's dictates and perhaps be allowed to live the old adage: Live and let live. This push for re-criminalization of smoking pot in one's own home is just another step in Big Brother government intrusion into individual private lives, and it is very ominous..

Thank you again for recognizing the dangers behind this legislation.

sincerly,

"sniff parties," destroying "its victims more swiftly and surely than opium." In the *Century Magazine*, Charles B. Towns, a national anti-drug activist, issued a grave warning: "The most harmful of all habit forming drugs is cocaine. Nothing so quickly deteriorates [sic] its victim or provides so short a cut to the insane asylum."

As early as 1887, the states had begun enacting their own (largely ineffective) laws against cocaine and other drugs. In 1913, New York passed the toughest statute to date, completely outlawing cocaine, except for certain medical uses. By the beginning of World War I, all 48 states had anti-cocaine laws on the books. Fourteen states also inaugurated "drug education" programs in the public schools.

And what role did the federal government play? A small one, at first. According to the Constitutional doctrines of the day, Washington had virtually no power to police the drug trade directly. The federal Pure Food and Drug Act of 1906 merely required labelling of any cocaine content in over-the-counter remedies. But official Washington was jolted by the effects of the cocaine "epidemic" in its own backyard, much as it has become alarmed today by hundreds of crack cocaine-related killings in the Federal District. For years, the District of Columbia's chief of police, Major Sylvester, had been warning Congress (which then governed the city directly) of cocaine's horrifying effects. "The cocaine habit is by far the greatest menace to society, because the victims are generally vicious. The use of this drug superinduces

A NEW COCAINE UNDERCLASS?

After the anti-cocaine reaction of the early 20th century, only a few Americans continued to use the drug. Today, as journalist Michael Massing recently warned in the New York Review of Books *(March 30, 1989), a different "two-tier" system may be emerging, with a large, permanent "underclass" of crack cocaine users.*

Contrary to the popular notion that narcotics are used throughout American society, drug use seems to be developing along well-defined class lines. On the one hand, the consumption of cocaine by the middle class has been steadily falling. Once considered glamorous and safe, cocaine is now widely viewed as a menace. The newsweeklies, movies, TV commercials, [and] books . . . all send the same message: Cocaine can kill. Educated Americans are responding. Recently, for instance, the Gordon B. Black Corporation of Rochester, New York, in a survey of 1,461 college students, found only 6 percent acknowledged "occasional" use of cocaine in 1988—down from 11 percent in 1987. Those who said they had friends who used cocaine socially dropped from 36 percent to 31 percent. Citing such surveys, the *Washington Post* concluded that "use of cocaine and marijuana among many segments of the population, particularly middle-class professionals and college students, has declined sharply."

In the inner cities, the story is very different. There the use of drugs—especially crack—is soaring. Three years ago, crack was sold only in large cities like Los Angeles and New York; today, it's available in places like Kansas City, Denver, and Dallas—everywhere, in fact, with a large minority population. Cocaine, once popular in Hollywood and on Wall Street, is fast becoming the narcotic of the ghetto. Mark Gold, founder of the nation's first cocaine "Hotline" six years ago, told the *Washington Post* that, when the service was introduced, most callers were whites with college degrees and high salaries; now, more than half are unemployed and only 16 percent college educated . . . . As drug use comes to be associated more and more with minorities, public support for treatment could dry up, giving way to renewed demands for more police, more jails, and harsher sentences—none of which . . . has much promise of reducing the demand for drugs.

An Open Letter To Bill Bennett

Dear Bill:

In Oliver Cromwell's eloquent words, "I beseech you, in the bowels of Christ, think it possible you may be mistaken" about the course you and President Bush urge us to adopt to fight drugs. The path you propose of more police, more jails, use of the military in foreign countries, harsh penalties for drug users, and a whole panoply of repressive measures can only make a bad situation worse. The drug war cannot be won by those tactics without undermining the human liberty and individual freedom that you and I cherish.

You are not mistaken in believing that drugs are a scourge that is devastating our society. You are not mistaken in believing that drugs are tearing asunder our social fabric, ruining the lives of many young people, and imposing heavy costs on some of the most disadvantaged among us. You are not mistaken in believing that the majority of the public share your concerns. In short, you are not mistaken in the end you seek to achieve.

Your mistake is failing to recognize that the very measures you favor are a major source of the evils you deplore. Of course the problem is demand, but it is not only demand, it is demand that must operate through repressed and illegal channels. Illegality creates obscene profits that finance the murderous tactics of the drug lords; illegality leads to the corruption of law enforcement officials; illegality monopolizes the efforts of honest law forces so that they are starved for resources to fight the simpler crimes of robbery, theft and assault.

Drugs are a tragedy for addicts. But criminalizing their use converts that tragedy into a disaster for society, for users and non-users alike. Our experience with the prohibition of drugs is a replay of our experience with the prohibition of alcoholic beverages.

I append excerpts from a column that I wrote in 1972 on "Prohibition and Drugs." The major problem then was heroin from Marseilles; today, it is cocaine from Latin America. Today, also, the problem is far more serious than it was 17 years ago: more addicts, more innocent victims; more drug pushers, more law enforcement officials; more money spent to enforce prohibition, more money spent to circumvent prohibition.

Had drugs been decriminalized 17 years ago, "crack" would never have been invented (it was invented because the high cost of illegal drugs made it profitable to provide a cheaper version) and there would today be far fewer addicts. The lives of thousands, perhaps hundreds of thousands of innocent victims would have been saved, and not only in the U.S. The ghettos of our major cities would not be drug-and-crime-infested no-man's lands. Fewer people would be in jails, and fewer jails would have been built.

Colombia, Bolivia and Peru would not be suffering from narco-terror, and we would not be distorting our foreign policy because of narco-terror. Hell would not, in the words with which Billy Sunday welcomed Prohibition, "be forever for rent," but it would be a lot emptier.

Decriminalizing drugs is even more urgent now than in 1972, but we must recognize that the harm done in the interim cannot be wiped out, certainly not immediately. Postponing decriminalization will only make matters worse, and make the problem appear even more intractable.

Alcohol and tobacco cause many more deaths in users than do drugs. Decriminalization would not prevent us from treating drugs as we now treat alcohol and tobacco: prohibiting sales of drugs to minors, outlawing the advertising of drugs and similar measures. Such measures could be enforced, while outright prohibition cannot be. Moreover, if even a small fraction of the money we now spend on trying to enforce drug prohibition were devoted to treatment and rehabilitation, in an atmosphere of compassion not punishment, the reduction in drug usage and in the harm done to the users could be dramatic.

This plea comes from the bottom of my heart. Every friend of freedom, and I know you are one, must be as revolted as I am by the prospect of turning the United States into an armed camp, by the vision of jails filled with casual drug users and of an army of enforcers empowered to invade the liberty of citizens on slight evidence. A country in which shooting down unidentified planes "on suspicion" can be seriously considered as a drug-war tactic is not the kind of United States that either you or I want to hand on to future generations.

Milton Friedman
Senior Research Fellow
Hoover Institution
Stanford University

Flashback

This is a truncated version of a column by Mr. Friedman in Newsweek's May 1, 1972, issue, as President Nixon was undertaking an earlier "drug war":

"The reign of tears is over. The slums will soon be only a memory. We will turn our prisons into factories and our jails into storehouses and corncribs. Men will walk upright now, women will smile, and the children will laugh. Hell will be forever for rent."

That is how Billy Sunday, the noted evangelist and leading crusader against Demon Rum, greeted the onset of Prohibition in early 1920.

We know now how tragically his hopes were doomed.

Prohibition is an attempted cure that makes matters worse—for both the addict and the rest of us.

Consider first the addict. Legalizing drugs might increase the number of addicts, but it is not clear that it would. Forbidden fruit is attractive, particularly to the young. More important, many drug addicts are deliberately made by pushers, who give likely prospects that first few doses free. It pays the pusher to do so because, once hooked, the addict is a captive customer. If drugs were legally available, any possible profit from such inhumane activity would disappear, since the addict could buy from the cheapest source.

Whatever happens to the number of addicts, the individual addict would clearly be far better off if drugs were legal. Addicts are driven to associate with criminals to get the drugs, become criminals themselves to finance the habit, and risk constant danger of death and disease.

Consider next the rest of us. The harm to us from the addiction of others arises almost wholly from the fact that drugs are illegal. It is estimated that addicts commit one third to one half of all street crime in the U.S.

Legalize drugs, and street crime would drop dramatically.

Moreover, addicts and pushers are not the only ones corrupted. Immense sums are at stake. It is inevitable that some relatively low-paid police and other government officials—and some high-paid ones as well—will succumb to the temptation to pick up easy money.

Legalizing drugs would simultaneously reduce the amount of crime and raise the quality of law enforcement. Can you conceive of any other measure that would accomplish so much to promote law and order?

In drugs, as in other areas, persuasion and example are likely to be far more effective than the use of force to shape others in our image.

Correcting Carter's Ethiopian Disaster

Former Cabinet official calls for legalized drugs

By TERENCE HUNT
THE ASSOCIATED PRESS

WASHINGTON – Former Secretary of State George Shultz is being lampooned by the White House for suggesting that cocaine and other drugs should be legalized.

"Whoa, he's been out on the West Coast too long, hasn't he?" White House Press Secretary Marlin Fitzwater said Monday. "The guy slips into retirement and right away he starts saying things that are strange."

More seriously, Fitzwater said, "Clearly, we do not believe drugs should be legalized. President Bush feels very strongly that that is the wrong direction at the wrong time; that it is not a moral position for the United States to take; and that it makes no sense whatsoever."

Shultz said legalizing drugs is something that "everyone is scared to talk about. No politician wants to say (it) ..."

His views were published in The Wall Street Journal Oct. 27 in an adaptation of remarks he made to an alumni gathering at the Stanford Business School in Palo Alto, Calif., on Oct. 7.

He said that attacking drugs with a criminal justice approach "is not likely to work."

Shultz said, "It seems to me we're not really going to get anywhere until we can take the criminality out of the drug business and the incentives for criminality out of it.

"When you do that you wipe out the criminal incentives, including ... the incentive that the drug pushers have to go around and get kids addicted, so that they create a market for themselves."

11/7/89 Empire

Tolerance, not prison, will engender social responsibi

By David Morris

Holland. Every conservative's nightmare come true. Legal prostitution. Coffee houses that sell marijuana to teen-agers. Free abortions on request. Free needles for heroin addicts. Special rooms for prisoners to conduct liaisons with outside partners, even of the same sex. Euthanasia in hospitals.

To Americans, such policies represent a moral breakdown. They are a prescription for social anarchy: promiscuity, drug addiction, family breakdown, AIDS. To Amsterdam Judge Frits Ruter, such policies are "above all, pragmatic and undogmatic." You cannot solve social problems "by making them taboo," he insists.

The Dutch don't drive their human weaknesses underground. Amsterdam's Utopia coffeehouse, where you can choose among 10 kinds of hashish and grass for about $6 a gram, is five doors from the neighborhood police station. The Royal Symphony Hall backs into a red-light district that houses not only prostitutes in well-lit windows, but also sex shops that would make Hugh Hefner blush.

The minister of justice of Holland's conservative government explains: The aim is to "prevent as much as possible a situation in which more harm is caused by criminal proceedings than by the (activity) itself." Legalization allows the government much more flexibility than criminalization. Prostitutes must undergo regular health examinations. One result is an astonishingly low rate of AIDS infection: less than 1 percent, compared to 30-40 percent among America's illegal but probably equally plentiful hooker population. Clean needles for intravenous drug users slows AIDS transmission among a group that now accounts for half the AIDS population in New York. Allowing prisoners sex with loved ones reduces prison tension and curbs in-prison aggressive homosexuality.

> The Dutch treat prostitutes, drug addicts, teen-age pot smokers and the terminally ill with respect.

As for drugs, allowing the sale of marijuana gives the government much more credibility when it warns the young about the dangers of hard drugs. Indeed, says the Dutch secretary of drug policy, "Cannabis used to be the symbol of the youth culture — it was attractive because it was forbidden. Our aim was to turn it into an unsensational item." It worked. The proportion of Dutch teen-agers using marijuana has dropped substantially. It is a fraction of U.S. use.

All Dutch schools teach sex education. A year's worth of birth control pills costs about $10. Yet Dutch girls are no more sexually active than American girls. And 90 percent of those teen-agers who are active use contraceptives. Holland's teenage pregnancy rate is one-seventh that of America's. American teen-agers have 12 to 14 times more abortions than Dutch teen-agers.

The Dutch treat prostitutes, drug addicts, teen-age pot smokers and the terminally ill with respect. Not surprisingly, respect breeds responsibility, not license.

Where does this sense of mutual respect and collective responsibility come from? Historian Simon Schama looks to Dutch history in "The Embarrassment of Riches." In the 1600s, tiny Holland was the most prosperous nation on Earth. Riches bred a "collective conscience" that demanded generosity for the needy and tolerance for those with different religions and different habits. Obligations to community, to society came first.

Today the Dutch continue that 300-year tradition. They know the most fertile breeding ground for irresponsible behavior is the slum. Thus they offer the world's most comprehensive social support programs. Medical care is free; child care plentiful. Unemployment insurance is nearly forever. Amsterdam suffers a housing problem incomprehensible to American city planners. Sufficient housing exists for those of modest means, but there's not enough for the rich.

Such generosity of spirit and purse has not undermined Dutch prosperity. They live longer than Americans. Their economy is robust; their businesses fiercely competitive.

This prosperous country of 14 million has much to teach us, for tolerance has never been an American trait. We have a long history of demanding moral purity of our neighbors and eagerly locking them up if they transgress. We rely on force to solve our social problems, not wisdom. Why we do so is up to the historians and sociologists to ponder. That we do so seems not to be in question. Today America imprisons a larger proportion of its citizens than any country except South Africa, and President Bush now vows to double the number of federal prisoners.

The Dutch watch our descent into social anarchy in amazement. They cannot understand why a nation would willfully destroy itself to control its citizens' personal behavior. After seeing how well tolerance and mutual respect work, neither can I.

David Morris writes for the St. Paul Pioneer Press Dispatch.

The Associated Press

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Shultz support may help moves to legalize drugs

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Nevertheless, legalization proponents are trumpeting an October speech by Shultz that appeared in adapted form in The Wall Street Journal as a major step toward moving the once-radical viewpoint into the mainstream.

Associated Press
Shultz

The political mix of legalization advocates is already broad. On the conservative side are Shultz, who headed President Reagan's State Department and President Nixon's Treasury Department, economist Milton Friedman and political commentator William F. Buckley.

The liberal side includes Democratic Mayor Kurt Schmoke of Baltimore, a former prosecutor; Hodding Carter III, journalist and chief State Department spokesman in the Carter administration; and former Attorney General Ramsey Clark.

"The liberal-conservative definitions keep crumbling," Princeton University's Ethan Nadelmann said. "Each is split into libertarian and social control groups."

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"It seems to me we're not really going to get anywhere until we can take the criminality out of the drug business and the incentives for criminality out of it," Shultz wrote.

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"I predict with some confidence that within the next nine to 12 months, you're going to see a lot more George Shultz-type people coming out," Nadelmann said at a recent conference on legalization arranged by the Drug Policy Foundation.

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STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: CSHB 88 (SA)
PUBLISH DATE: HOUSE 4/6/89

FISCAL NOTE

REQUEST:

Revision Date: April 3, 1989
Title: "An Act amending...offenses... involving a controlled substance..."
Sponsor: House State Affairs
Requestor: House State Affairs

Agency Affected: Department of Law
BRU: Prosecution

Components: Third District, Fourth District, Crim. Appeals & Spl. Prosc., Criminal Justice Litigation

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES		133.6	137.6	141.7	146.0	150.4
TRAVEL		3.6	3.7	3.8	3.9	4.0
CONTRACTUAL		72.7	74.9	44.3	45.6	47.0
SUPPLIES		10.8	7.4	7.6	7.8	8.0
EQUIPMENT		12.5	-0-	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	233.2	233.6	197.4	203.3	209.4
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	233.2	233.6	197.4	203.3	209.4
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	2	2	2	2	2
PART-TIME	-0-	1	1	1	1	1
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Please see the attached analysis.

Richard L. Pegues

Prepared by: Richard L. Pegues, Director — Phone: 465-3672
Division: Administrative Services — Date: April 3, 1989

Richard L. Pegues /FOR/

Approved by Commissioner: Douglas B. Baily, Attorney General — Date: April 3, 1989
Agency: Department of Law

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

The committee substitute for HB 88 recriminalizes the possession and use of small amounts of marijuana. The bill would make possession of one ounce or more but less than four ounces of marijuana a class B misdemeanor, and the bill would make possession of less than one ounce of marijuana a violation. The maximum penalty for such a violation would be raised from $100 to $300. The legislature is also considering a joint resolution proposing a constitutional amendment at the next general election in November of 1990, which would provide that an individual's right to privacy does not extend to the possession or use of controlled substances. The bill would be effective 90 days after it becomes law, or sometime during the summer of 1989, if it is approved.

The passage of CSHB 88 will have a fiscal impact on the Department of law in three general areas: (1) the cost of processing additional new criminal cases; (2) the cost of educating the public about the new law; (3) approval of the proposed constitutional amendment will have the effect of repealing the Alaska Supreme Court's decision in Ravin. However, because the bill would be effective about 18 months before the constitutional amendment would become effective, it is anticipated that the bill will come under a vigorous constitutional challenge.

1. New Criminal Cases

Much of the behavior that the bill would classify as either a class B misdemeanor or a violation is not now an offense of any kind. In the past, some law enforcement officers who work primarily in the drug enforcement area indicated that recriminalizing marijuana could potentially result in "thousands" of new criminal cases a year. The police now doubt this but, nonetheless, a large number of the new cases would arise from situations where law enforcement officers now commonly discover small amounts of marijuana (as when an officer responds to a domestic disturbance call and sees some marijuana plants in a person's home, or when a person is arrested for a minor offense and a routine search for weapons reveals some marijuana cigarettes in the person's pocket, for example). Incidents of this sort occur frequently now, but do not generally result in any criminal prosecution for the marijuana possession. Many of these cases are likely to be referred for criminal prosecution if CSHB 88 becomes law because police officers will not ignore evidence of wrongdoing that is in plain view. Many of these defendants are middle-class people who can be expected to vigorously resist having a criminal record. Class B misdemeanors entitle a defendant to a jury trial and court-appointed counsel. Although the bill provides that possession of less than one ounce of marijuana will be handled as a violation, some unknown yet substantial number of these lesser offenses can be expected to be disputed, requiring attorney time to prosecute.

Prosecutors generally predict a substantially lesser number of new potential criminal cases under CSHB 88 than the 'thousand' that were once predicted. Once the public becomes aware of the new law, some people are likely to become more careful about not allowing marijuana or smoking paraphernalia to be exposed in plain view in their homes, for example. Judging from the number of minor marijuana offenses prosecuted prior to the Ravin decision in 1975, prosecutors still expect at least a "few hundred" new criminal cases a year. Possession of small amounts of marijuana for personal use has been legal since the Ravin decision in 1975. Consequently, there is no accurate way to predict the number of new offenses that will occur when this current behavior is outlawed. Nor is there any accurate means to determine, in advance, the number of new offenses that will constitute class B misdemeanors, as opposed to violations. All of the department's prosecution offices are working at maximum capacity. Past budget cuts have left little time available to handle minor offenses, and the department has had to focus its remaining resources on major offenses, particularly crimes of violence. Prosecution of a whole new block of crime, although relatively minor, simply cannot be undertaken without some additional resources. The department's current estimate of a "few hundred" offenses is very conservative. The actual number of new cases may be significantly higher. It certainly will not be less.

Class B misdemeanor cases and disputed violations which are accepted for prosecution will require attorney time both at trial and in preparation for trial (i.e., preparation of search warrants, response to defense motions, evaluation of results of laboratory analysis, pretrial witness preparation, etc.). To handle screening of the expected case referrals, and to prosecute the additional misdemeanors and disputed violations, the criminal division will require the addition of at least one Attorney III position and one Legal Secretary I position in Anchorage. It is anticipated that a half-time attorney will also be needed in the Fairbanks District Attorney's office.

2. Public Education

In order to inform the public of the changes in the law, the Department of Law will develop and disseminate public notices explaining the new law. These notices will include newspaper ads and brochures, and will be modeled upon the public education notices which were distributed statewide in connection with the new drug law in 1982 and the new DWI and drinking age laws in 1983. Based upon experience with these earlier notices, approximately $25,000 will be needed to cover the costs of writing, layout, typesetting, publication, and distribution.

In addition to the costs explained above, it is anticipated that the passage of this bill will result in increased costs to other components of the criminal justice system, including law enforcement, the courts, the public defender agency, the Office of Public Advocacy, and corrections.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

3. Defending the New Law

In 1975 the Alaska Supreme Court in the case of Ravin v. State, 537 P.2d 497 (Alaska 1975), ruled that under Art. I, Sec. 22 of the Alaska Constitution the state could not prohibit possession of marijuana by adults in their own homes for personal use. The court held that the state had not demonstrated the existence of a legitimate state interest which was strong enough to justify the regulation of this conduct.

Since passage of CSHB 88 would make it a crime for an adult to possess any amount of marijuana anywhere, including in his or her own home, the constitutionality of the new law is certain to be challenged. An appellate court will have to decide whether the state has proved that there is a "compelling state interest" in the prohibition of the use of marijuana which is sufficient to outweigh an individual's right to privacy under the state constitution. It is extremely important, therefore, that the legislature's consideration of this bill include extensive public hearings, debate on the social policy merits of the proposal, and the collection of the results of the most recent scientific, medical, and pharmacological studies regarding the physical, emotional, and social effects of marijuana usage.

In addition to the necessary legislative hearings, evidentiary hearings at the trial court level can be expected when a challenge to the new law is filed. Challenges to the new law will most likely arise in the context of a defendant's pretrial motion to dismiss a criminal prosecution. When responding to such a defense motion, the prosecutor would, in essence, have to convince a court to reverse the ruling in the Ravin case. In order to demonstrate that the result in Ravin is no longer correct, the prosecutor would have to present convincing, scientifically accurate, evidence that the effects of marijuana usage are so injurious to a person's mental and physical health as to justify the legislative decision to totally prohibit use of marijuana by anyone at any time (as opposed to use by minors or use by a person who is operating a motor vehicle--both of which are already prohibited under current law).

The presentation of this convincing evidence will require the prosecution to present expert testimony from authorities who have conducted recent research in this area. Out-of-state witnesses in medical and scientific fields charge a fee for their services. These fees will vary from individual to individual, but are expected to average at least $150 per hour. This would include services for consultation, witness preparation and actual testimony. Costs will be incurred for expert witness transportation, food and lodging, and other incidental expenses. Additionally, there will be some costs for preparation of exhibits and written reports. To the extent possible, the Department of Law would attempt to present written testimony in situations where it is not feasible to fly a person to Alaska to testify

in person. We estimate that a minimum of six expert witnesses will be required to attempt to successfully defend the new law at the trial court level.

Hearings at the trial court level can reasonably be expected to take several days. A substantial commitment of attorney time will be required for scientific and legal research in preparation for the hearings, actual court time, legal briefing, and the preparation of proposed findings of fact. Since prosecutions under the new law will occur statewide, defense challenges may be raised at the same time in different parts of the state. The extensive hearings described above may have to be held in more than one judicial district in the state.

Regardless of which side prevails at the trial court level, the lower court ruling would almost certainly be followed by an appeal. At a minimum, such an appeal (or appeals) would require additional legal research, a thorough review of the record, the drafting of briefs, and oral argument before the appellate court and the Supreme Court.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Fiscal Analysis - (cont'd)

1. New Criminal Cases

Third Judicial District - Anchorage

Total	Atty III (PFT)	Legal Sec I (PFT)	Total
Personal Services	63.8	32.9	96.7
Travel - Witness travel subsistence, atty. travel	1.8	-0-	1.8
Contractual Services			
office commo. equip. repai	2.4	1.2	3.6
copy - postage	1.2	1.2	2.4
Office Space rent/lease	4.0	2.2	6.2
			12.2
Commodities - Ongoing			
office consumables	1.8	1.2	3.0
Law library	1.2	-0-	1.2
Commodities - one time			
New position materials	1.2	1.2	2.4
			6.6
Equipment - one time			
New position equipment	2.0	8.5	10.5
	79.4	48.4	71.1

Costs beyond FY 90 include a 3% inflation factor, less one-time items.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Fiscal Analysis - (cont'd)

Fourth Judicial District - Fairbanks

	Atty. III (PPT)	Total
Personal Services	36.9	36.9
Travel - Witness travel subsistence, Atty. travel	1.8	1.8
Contractual Services		
office commo., equip. repair	2.4	2.4
copy - postage	1.2	1.2
		3.6
Commodities - Ongoing		
office consumables	1.8	1.8
Law library	1.2	1.2
Commodities - one time		
New position materials	1.2	1.2
		4.2
Equipment - one time		
New position equipment	2.0	2.0
		48.5

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Fiscal Analysis - (cont'd)

2. Public Education

Criminal Justice Litigation Component/Prosc. BRU

Object	Total
Contractual Services - one time writing, layout, typesetting, publication and distribution of public notices and information brochures describing the changes in the law.	25.0
	25.0

3. Defending the New Law

Criminal Appeals & Special Prosecution Component/Prosc. - BRU

Object	Total
Contractual Services - Professional fees scientific experts 120 hrs. X $150 =	$18,000
Experts' staff support, preparation of exhibits, written testimony 50 hrs. X $60 =	3,000
Experts' travel to attend hearings and offer testimony	
6 trips X 4 days X $80 = $1,920 subsistence	1,920
6 trips X $1,500 = $9,000 travel	9,000
	$31,920

This amount will be required for both FY 90 and FY 91, to cover both trials and appeals.

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. CSHB 88

Summary of Expenses (All Components)

	Defending the new Law	New Criminal Cases	Public Education	Total
Personal Services		133.6		133.6
Travel		3.6		3.6
Contractual	31.9	15.8	25.0	72.7
Commodities		10.8		10.8
Equipment		12.5		12.5
	31.9	176.3	25.0	233.2

Position Title	No. of Positions	Range/Step	Barg. Unit
Attorney III	1	22A	PX

Time Status	Staff Months	Location	Election District
PFT	12	EBA - Anchorage	8

Type of Expenditure		Amount
1	2	3
Salary	49,140	
Benefits	14,657	
Premium Pay		
Other		
Total Personal Services		63,797
Travel		1,800
Contractual		7,600
Commodities		4,200
Equipment		2,000
Other		
Total Cost		79,397

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	79,397
I-A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This full-time attorney position is required at Anchorage to handle the influx of new cases that will result when marijuana possession or use is recriminalized. Prosecutors expect that at least a few hundred such offenses will occur each year as a result of the enactment of this bill. This position will be responsible for prosecuting those new cases that are brought in the Third Judicial District and handling appellate briefs and appeals hearings. Because these new cases will be classed as misdemeanor offenses and violations, allocation of the position to the Attorney III level is appropriate.

Request For New Position

Agency: Department of Law
BRU: Prosecution
Component: Third Judicial District

Revised Date

FY 90

Position Title	Legal Secretary I	No. of Positions	1	Range/Step	10B	Barg. Unit	GGU
Time Status	PFT	Staff Months	12	Location	Anchorage	Election District	8

Type of Expenditure		Amount
1	2	3
Salary	22,716	
Benefits	10,220	
Premium Pay		
Other		
Total Personal Services		32,936
Travel		-0-
Contractual		4,600
Commodities		2,400
Equipment		8,500
Other		
Total Cost		48,436

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	48,436
I-A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This Legal Secretary I position will be needed to handle the paperwork and scheduling requirements for the influx of new trials that will occur when the possession or use of small amounts of marijuana is outlawed. At the least a "few hundred" new offenses are expected. This estimate is very conservative, and the actual number of new cases may be somewhat higher. It certainly will not be any less. The support staff in the Anchorage District Attorney's Office was cut severely in FY 87, and any additional caseload will require an increase in support staff. Allocation to the Legal Secretary I level is appropriate because of the legal and trial documentation necessary to try these cases.

Request For New Position

Agency: Department of Law
BRU: Prosecution
Component: Third Judicial District

Revised Date

FY 90

Position Title	No. of Positions	Range/Step	Barg. Unit
Attorney III	1	22A	FX

Time Status	Staff Months	Location	Election District
PPT	12	JBA - Fairbanks	16

Type of Expenditure		Amount
1	2	3
Salary	28,122	
Benefits	8,826	
Premium Pay		
Other		
Total Personal Services		36,948
Travel		1,800
Contractual		3,600
Commodities		4,200
Equipment		2,000
Other		
Total Cost		48,548

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	48,548
I-A Receipts	1006	
CIP Receipts	1061	
Other		

Justification

This permanent part-time position at Fairbanks is required to handle the influx of new cases that will result when the use or possession of small amounts of marijuana is recriminalized. Prosecutors expect that at least a few hundred offenses will occur each year as a result of the enactment of this bill. This position will be responsible for prosecuting those new cases that are brought in the Fourth Judicial District. Because these new cases will be classed as misdemeanor and violation offenses, allocation of the position to the Attorney III level is appropriate.

Request For New Position

Agency: Department of Law
BRU: Prosecution
Component: Fourth Judicial District

Revised Date

FY 90

NATION

The Associated Press

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Tolerance, not prison, will engender social responsibility

By David Morris

Holland. Every conservative's nightmare come true. Legal prostitution. Coffee houses that sell marijuana to teen-agers. Free abortions on request. Free needles for heroin addicts. Special rooms for prisoners to conduct liaisons with outside partners, even of the same sex. Euthanasia in hospitals.

To Americans, such policies represent a moral breakdown. They are a prescription for social anarchy: promiscuity, drug addiction, family breakdown, AIDS. To Amsterdam Judge Frits Ruter, such policies are "above all, pragmatic and undogmatic." You cannot solve social problems "by making them taboo," he insists.

The Dutch don't drive their human weaknesses underground. Amsterdam's Utopia coffeehouse, where you can choose among 10 kinds of hashish and grass for about $6 a gram, is five doors from the neighborhood police station. The Royal Symphony Hall backs into a red-light district that houses not only prostitutes in well-lit windows, but also sex shops that would make Hugh Hefner blush.

The minister of justice of Holland's conservative government explains: The aim is to "prevent as much as possible a situation in which more harm is caused by criminal proceedings than by the (activity) itself." Legalization allows the government much more flexibility than criminalization. Prostitutes must undergo regular health examinations. One result is an astonishingly low rate of AIDS infection: less than 1 percent, compared to 30-40 percent among America's illegal but probably equally plentiful hooker population. Clean needles for intravenous drug users slows AIDS transmission among a group that now accounts for half the AIDS population in New York. Allowing prisoners sex with loved ones reduces prison tension and curbs in-prison aggressive homosexuality.

> The Dutch treat prostitutes, drug addicts, teen-age pot smokers and the terminally ill with respect.

As for drugs, allowing the sale of marijuana gives the government much more credibility when it warns the young about the dangers of hard drugs. Indeed, says the Dutch secretary of drug policy, "Cannabis used to be the symbol of the youth culture — it was attractive because it was forbidden. Our aim was to turn it into an unsensational item." It worked. The proportion of Dutch teen-agers using marijuana has dropped substantially. It is a fraction of U.S. use.

All Dutch schools teach sex education. A year's worth of birth control pills costs about $10. Yet Dutch girls are no more sexually active than American girls. And 90 percent of those teen-agers who are active use contraceptives. Holland's teenage pregnancy rate is one-seventh that of America's. American teen-agers have 12 to 14 times more abortions than Dutch teen-agers.

The Dutch treat prostitutes, drug addicts, teen-age pot smokers and the terminally ill with respect. Not surprisingly, respect breeds responsibility, not license.

Where does this sense of mutual respect and collective responsibility come from? Historian Simon Schama looks to Dutch history in "The Embarrassment of Riches." In the 1600s, tiny Holland was the most prosperous nation on Earth. Riches bred a "collective conscience" that demanded generosity for the needy and tolerance for those with different religions and different habits. Obligations to community, to society came first.

Today the Dutch continue that 300-year tradition. They know the most fertile breeding ground for irresponsible behavior is the slum. Thus they offer the world's most comprehensive social support programs. Medical care is free; child care plentiful. Unemployment insurance is nearly forever. Amsterdam suffers a housing problem incomprehensible to American city planners. Sufficient housing exists for those of modest means, but there's not enough for the rich.

Such generosity of spirit and purse has not undermined Dutch prosperity. They live longer than Americans. Their economy is robust; their businesses fiercely competitive.

This prosperous country of 14 million has much to teach us, for tolerance has never been an American trait. We have a long history of demanding moral purity of our neighbors and eagerly locking them up if they transgress. We rely on force to solve our social problems, not wisdom. Why we do so is up to the historians and sociologists to ponder. That we do so seems not to be in question. Today America imprisons a larger proportion of its citizens than any country except South Africa, and President Bush now vows to double the number of federal prisoners.

The Dutch watch our descent into social anarchy in amazement. They cannot understand why a nation would willfully destroy itself to control its citizens' personal behavior. After seeing how well tolerance and mutual respect work, neither can I.

David Morris writes for the St. Paul Pioneer Press Dispatch.

Paul K

House Judiciary Committee

April 6, 1989

Julie Tenison called from Anchorage She opposes HB 88 and would like the opportunity to testify via teleconference should the bill be scheduled She will also be sending written testimony for inclusion in the committee packets.

Her address

Julie Tenison
7830 Kiana Circle
Anchorage, AK 99507
Phone: 522-8573

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