

ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

5740

HOUSE JUDICIARY

Item 2E

# STATE OF ALASKA THE LEGISLATURE

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## LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

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 Council

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 imposed 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.

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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.

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## 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

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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

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RECEIVED NOV 28 1989

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 responsible 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 drug problems
- 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 intermediaries (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 burnt 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 Antillian 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 counseling); the main objective of the Netherlands treatment policy is to reach as many as possible addicts with aid (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;

### Aids:

- estimate: 800 drug addicts in Amsterdam 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 substitute 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 accessibility 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 J. 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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2

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 me 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 drug abuse 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 reasons 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 marijuana. 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 is 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 is 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 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 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 'harm reduction'. Or more traditionally: as secondary and tertiary prevention. Its effectiveness can only be ensured by low threshold-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 is 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 kick up 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 junkie-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 (junkie-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 Ministry 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- throughout 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 to 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 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.

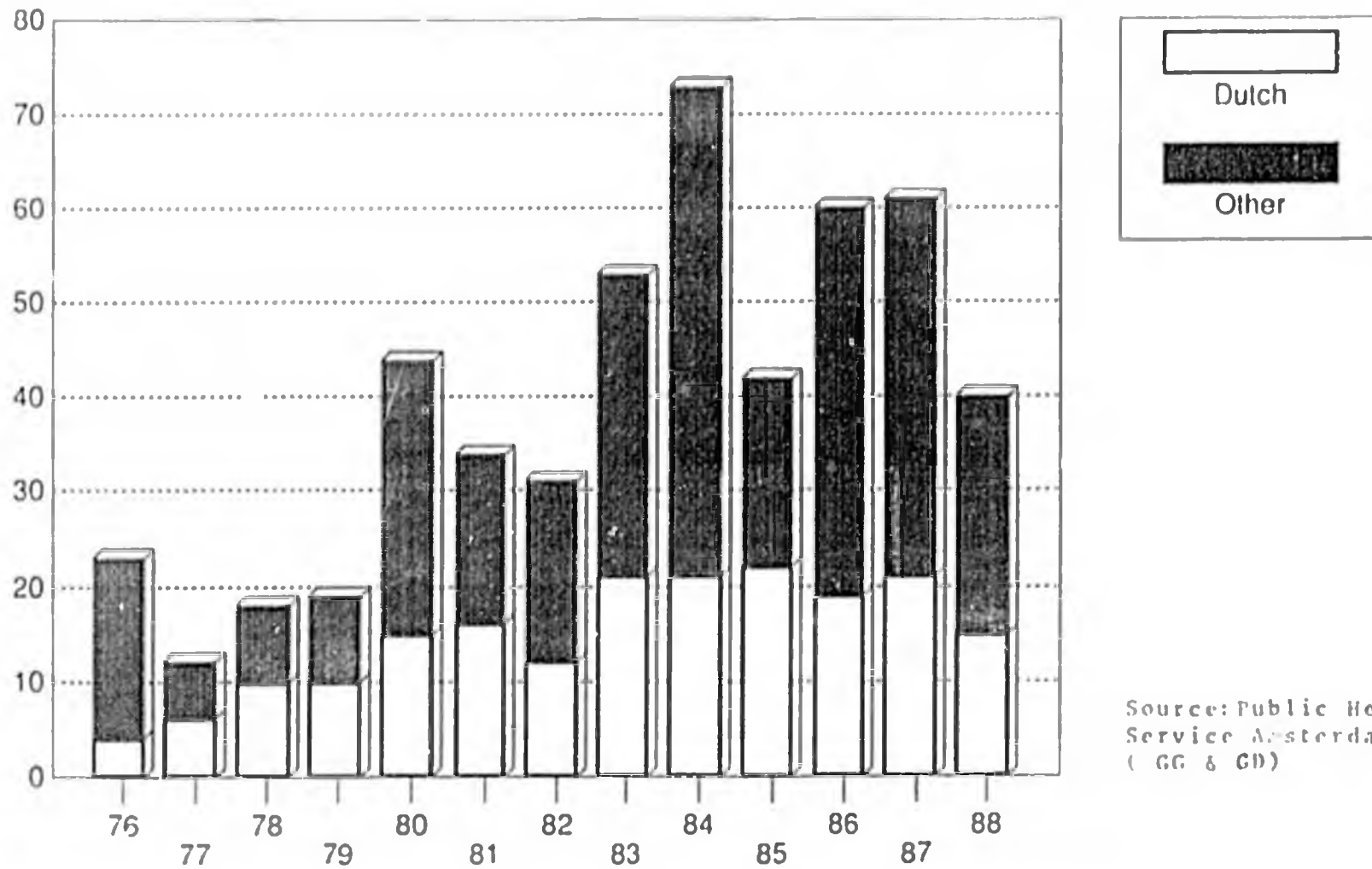
Research data are still scarce but yield signs of positive effects: there is evidence that the growth of the prevalence of H.I.V. seems to be stabilizing and that the intended behavioural changes unmistakably do take place.

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# Death by overdose

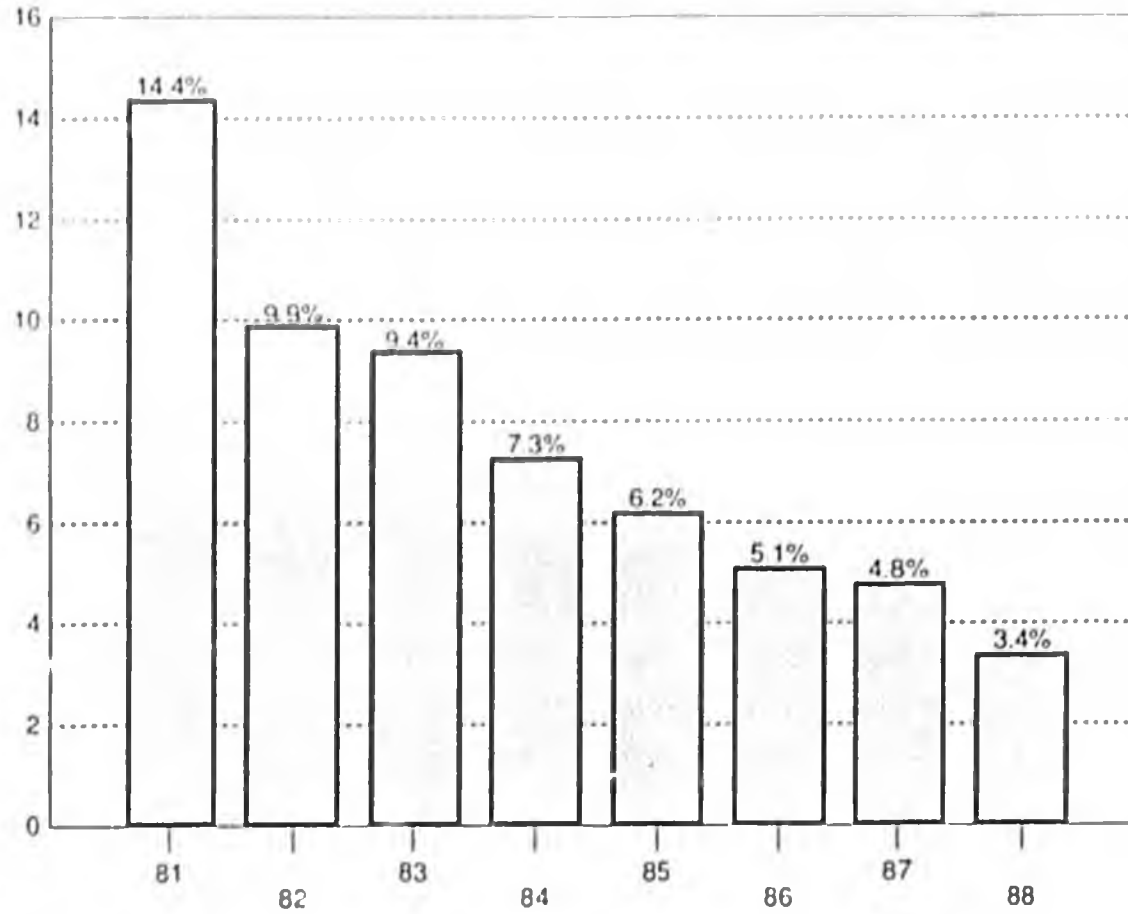
(In Amsterdam, by nationality)



Source: Public Health  
Service Amsterdam  
(GG & GD)

## Percentage addicts under 22 years

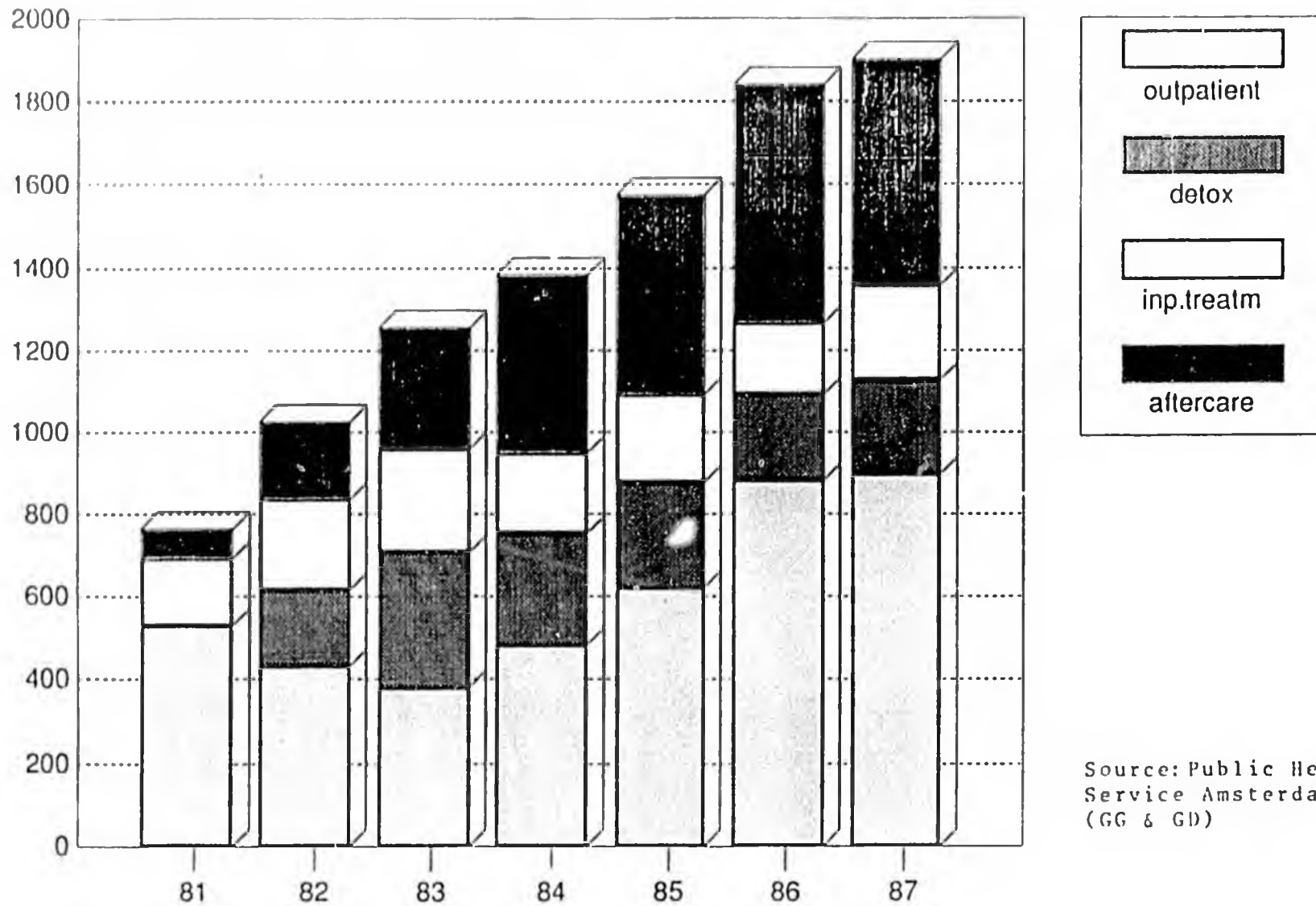
Amsterdam



Source: Public Health Service Amsterdam  
(CG & GD)

# Patient load drugfree treatment

Amsterdam



Source: Public Health  
Service Amsterdam  
(GG & GD)

## 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 it 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 committed 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

October 20 - 23, 1988

Washington, D.C.

Responding to drug problems: Dutch policy and practise

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## 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 minimum 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<sup>1</sup>. That is why responsibility 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

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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,<sup>2</sup>. 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.<sup>3</sup>

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 misinterpreted 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 successful. 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 daily cannabis users appeared to be one in a thousand (nationwide school survey; N = 25,000 ; 1984)<sup>4</sup>.

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<sup>5</sup>. 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<sup>6</sup>. 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<sup>7</sup>.

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 demystifying 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)<sup>8</sup>. 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 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 and are for that reason not considered effective. Publicity sensationalizes the dangers of drugs and may even create curiosity and encourage experimentation 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<sup>9</sup>. 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 threshold-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 disseminate 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-threshold methadone clients as well as "street addicts" have shown that the "typical" addict is in no way an anti-social monster<sup>10</sup>. 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<sup>11</sup>. 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)<sup>13</sup>.

Conclusions from the first evaluation of the needle/syringe exchange programme<sup>12</sup> 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 fight 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 manslaughter 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.<sup>14</sup>

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<sup>15</sup>.

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 treatment.

**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)<sup>5</sup>.

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)<sup>5</sup>. 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<sup>11</sup>.

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<sup>11</sup>.

#### 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.

Paper presented at the annual meeting of  
The Society for the Study of Social Problems  
ATLANTA, Ga, 20 - 23 August, 1988

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## 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-trying 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 of population that is only exceeded by that of Bangla Dosh, being the delta of the Ganges. But Bangla Dosh 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 Britain.

The characteristics 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 consensus 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 dispensation, 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 exaggeration. The city houses an estimated 6,000 dependent drug users of which only a minority of perhaps one thousand are to an extent 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 dependant drug users in Amsterdam is operated especially through busses, public transport vehicles modified into mobile clinics. Originally meant only for methadone dispensation 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 dispensation, syringe-exchange, condom sale, a separate 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). The 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 is dominated politically by a extremely orthodox-protestant 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 criticized 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 July 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 hepatitis 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 it 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 package-deal, consisting of syringes, condoms, education and counselling.

II/ Syringe-exchange is part of a harm-reduction strategy.

III/ Syringe-exchange is part of an integrated drug policy, aimed at the Dutch call the 'normalization' of drug problems.

IV/ Syringe-exchange is carried out by a variety of organizations, and often with the active participation of drug users themselves.

I will now labour these points to some extent.

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 secondary 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 11: 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-friendly' 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 success 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 essential 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 physical 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 behavioural 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 attempts 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 extent 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 Chinese 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 led to the development 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 extent 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 extent that despite the ample availability the prevalence of marijuana use among youngsters 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 tolerate, 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 tailor-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 secondary 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 hepatitis 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 hepatitis epidemic, and more small programs have been operated successfully on a temporary basis in order to control local epidemics. Both professionally and politically these programs have attracted very little attention.

The Municipal Health Service in Amsterdam was not very enthusiastic about syringe-exchange in the beginning. They very reluctantly took over the responsibility 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 existing 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 counselling, 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 until 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 Health Service, they presented at the IVth International Conference on AIDS in Stockholm, last June.

\* 148 IV drug users were interviewed, utilizing a standardized questionnaire;

\* 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 conclusion 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 with 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 appreciate 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 secondary transmission of the epidemic into the general population.

If we want to stem both the epidemic among the drug users and the secondary 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 many 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 extent 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 evidence 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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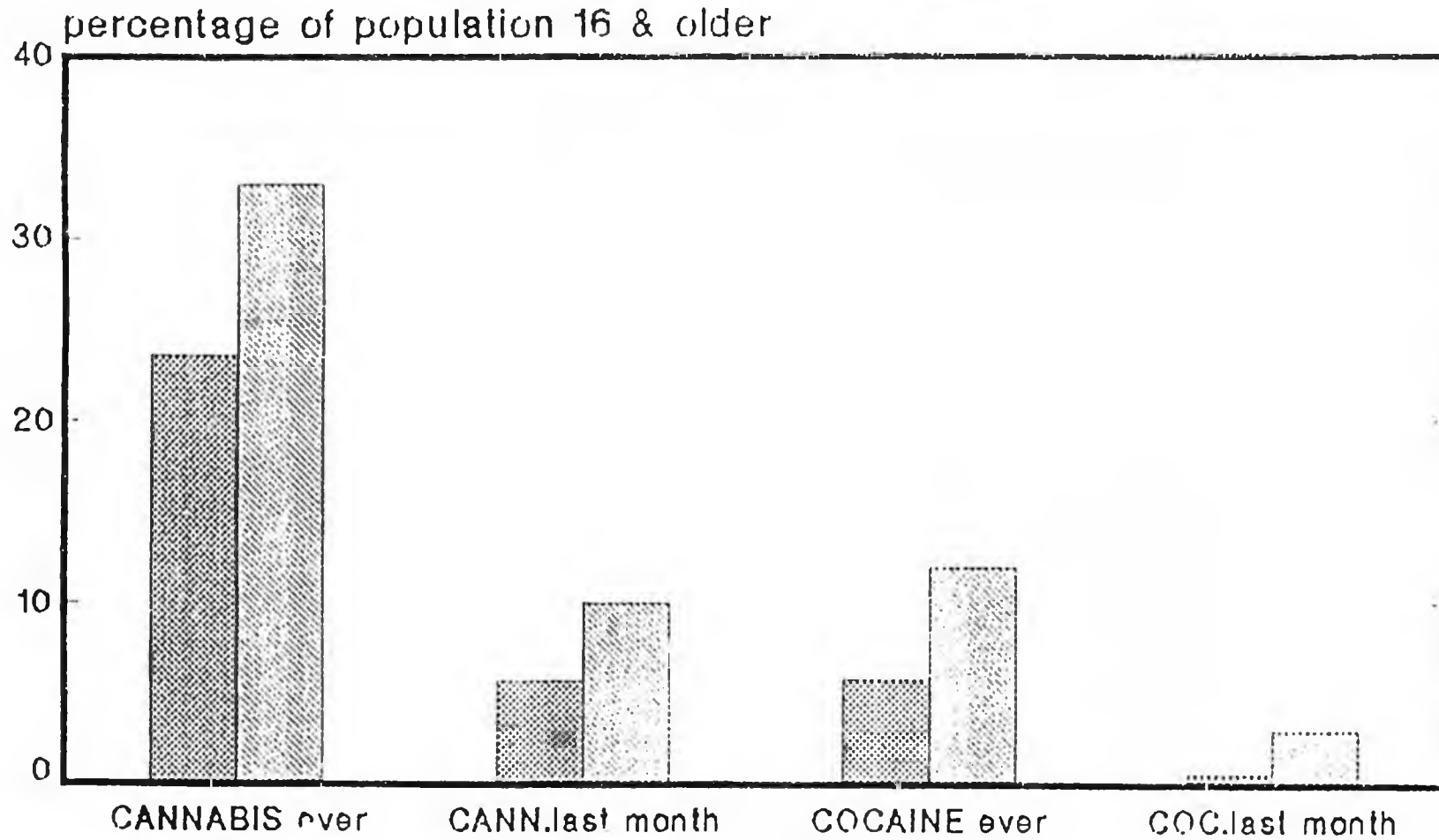
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# DRUG USE

AMSTERDAM )\*  
1987

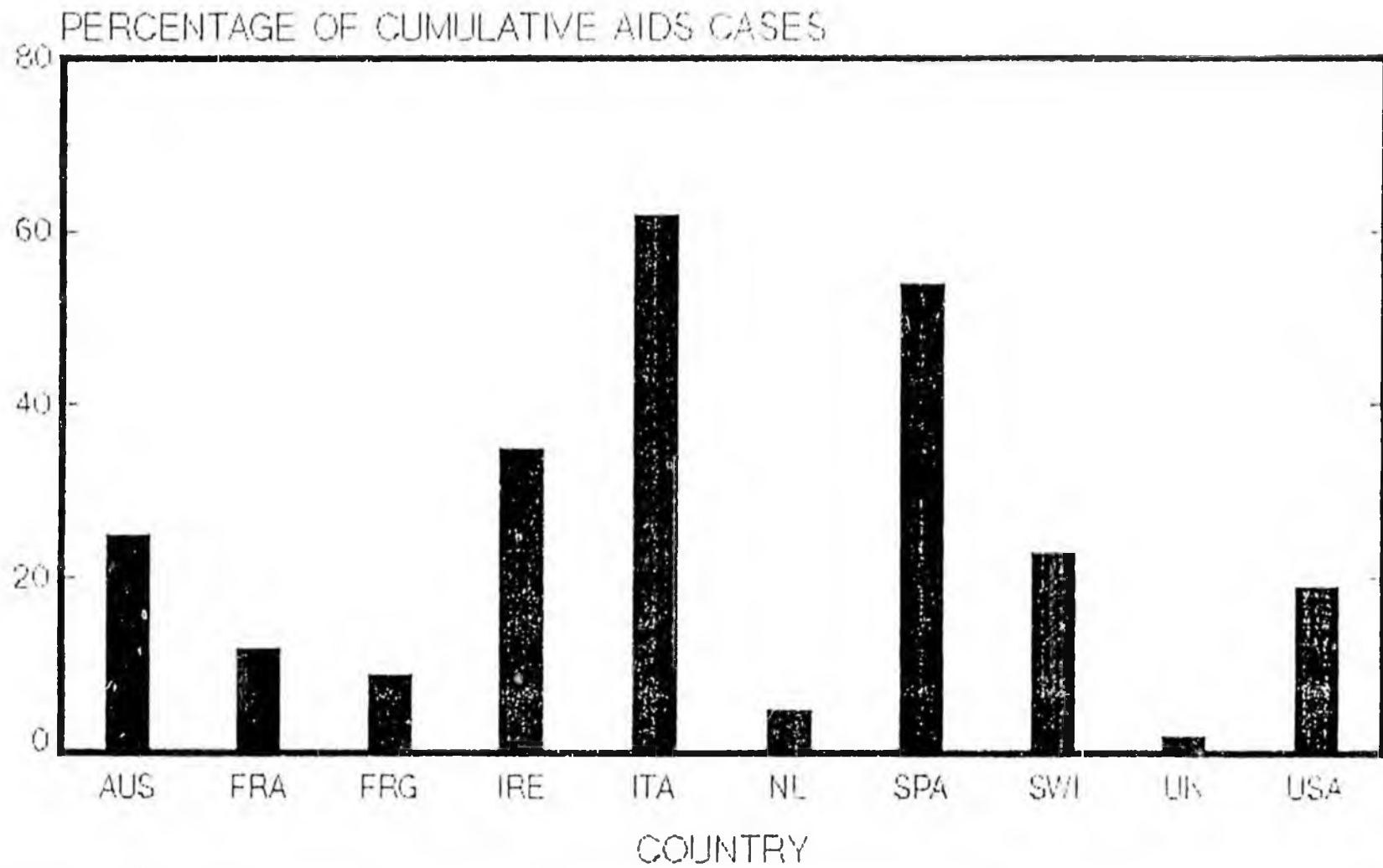
USA  
1985



)\* 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

The Drug Policy Founda' ton  
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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, how 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 <sup>1)</sup> 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 <sup>2)</sup>. 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 <sup>3)</sup>. 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 <sup>4)</sup>. 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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<sup>1</sup> i.e. Marijuana and hashish

<sup>2</sup> See table 1, p. 15.

<sup>3</sup> See table 2, p. 15.

<sup>4</sup> 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 <sup>3</sup>). 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.

Misinter-  
pretations

"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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<sup>3</sup> 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 examples to 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 were separated and the overwhelming majority of marihuana users did not graduate to hard drugs. The experience of over 12 years has shown that - at least within this Dutch context - 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<sup>6</sup>). 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.

<sup>6</sup> 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