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Drugs and drug policy in the Netherlands by Ed. Leuw

The Dutch parliament enacted the revised Opium Act in 1976. This penal law is part of the Dutch drug policy framework that includes tolerance for nonconforming lifestyles, risk reduction in regard to the harmful health and social consequences of drug taking, and penal measures directed against illicit trafficking in hard drugs. This multifaceted approach established the basic principles and operating practices of contemporary social and criminal drug policy in the Netherlands. Dutch

drug policy is pragmatic and nonmoralistic. It has been conceptualized within a 'normalizing' model of social control, aiming at depolarisation and integration of deviance as opposed to a 'deterrence' model of social control, aiming at isolation and removal of deviance (Van de Wijngaart, 1990, pp. 83-104). Within this ideology of normalisation, illegal drugs are seen as a limited and manageable social problem rather than an alien threat forced upon an otherwise innocent society.

Dutch drug policy has resulted in the explicit liberalisation of soft drugs (marihuana and hashish). This may be understood as partial decriminalisation of use and small scale trade by decreasing the penal law status of these activities to misdemeanours. In social practice however, there exists an all but full decriminalisation of these manifestations of cannabis. 'Decriminalizing' cannabis primarily aims at separating the social worlds of soft and hard drugs. At the same time it communicates the intention of Dutch drug policy to confront the objective harms of psychoactive substances, rather than their social or moral symbolism.

Penal drug laws and law enforcement policy

The revised Opium Act of 1976 is a compromise between outright prohibition and social integration of illegal drugs. The partly decriminalised status of cannabis (marihuana and hashish) being the most explicit expression of the normalising approach, as is reflected in the differentiation of the Act in two schedules. In schedule I a number of substances (among which opiates, cocaine, amphetamines, LSD etc.) is listed under the heading 'drugs presenting unacceptable risks'. Schedule II mentions cannabis only, without the qualification of nonacceptability. Penalties for forbidden actions pertaining to schedule II are considerably lower than for those for schedule I. The general trend of the 1976 penal law revision includes the following:

- a reduction of all penalties regarding soft drugs;
- a reduction of penalties for possession for own use (for instance possession for own use of hard drugs could be penalised by maximally 4 years under the old Opium Act of 1928 compared to 1 year under the present Opium Act);
- a differentiation of maximum penalties for different aspects of drugs trafficking;
- an increase of maximum penalties for trafficking hard drugs, from 4 years to 12 years.

Laws in practice are, however, more relevant than law in books. The social reality of penal law involvement with illegal drugs may be described as de facto abolition in regard to (possession for own) use of all illegal substances. Normally there are no investigation, arrest or criminal prosecution for the use of hard drugs, no more than for the use of soft drugs. In the last case there has been a de facto legalisation of the retail market. Hashish and marihuana are officially permitted (though not officially 'licensed') to be traded in limited quantities. During the last decade this has mainly taken the form of small commercial outlets, 'coffee-shops', which operate openly and undisguised, similar to 'normal' bars or coffee-shops.

For commercial trafficking in hard drugs, Dutch policies and practices resemble those of most Western countries. The Dutch drug policy conforms to the international agreements to combat drug trafficking: importation, exportation and transportation.

Law enforcement policy in the Netherlands operates within the framework of the more comprehensive social drug policy except for wholesale drug trafficking where law enforcement agencies act autonomously. In other realms of the drug problem, such as the control of street markets for hard drugs, meeting-places for drug users and the supervision over commercial establishments for the sale of soft drugs, crime control interests are coordinated with other interests of public order, public health and welfare. Typically police authorities will take part in local drug policy formulation under the responsibility of the city administration, thus attempting to integrate law enforcement activities into the central priorities of (local) drug policy. In such real-life situations the interest of enforcing criminal (drug) laws may be considered secondary to public order or public health interests. This has for instance resulted in an agreement of the Amsterdam police to refrain from investigating or arresting criminally suspected methadone clients in the vicinities of the methadone posts. The necessary flexibility of law enforcement to be integrated in the general social drug policy is warranted by the 'expediency principle', that authorizes the prosecution office to decide whether to prosecute or initiate criminal investigation. Those decisions can be made 'in the public interest'. They are ultimately based on the political responsibility of the Minister of Justice.

In 1976 guidelines for the investigation and prosecution of drug offences were issued by the Ministry of Justice. They thus form a translation of the intentions of drug policy to the practical execution of law enforcement. These guidelines direct the law enforcement actions of the public prosecutor and of the police. The prosecutor is instructed with a summoning and penalty demanding policy. On his part the Head Prosecutor has the authority to direct the police investigation activities within his district by stipulating the priorities of police actions in regard to specific violations of the law. For instance the police operates on the basis of the 'stumble principle' when small (30 grams or less) but commercial amounts of cannabis are involved. The police will not initiate investigations on having knowledge of such violations. But it may act if it happens to stumble on such an amount. In 1987 the commissioner of the police in Amsterdam wrote a letter to all 'coffee shop' keepers in the city, warning them of possible police actions if they traded in quantities larger than 30 grams.

The guidelines give prosecutors some latitude in reacting against small scale dealers of hard drugs who provide for their own use. Those cases are intended to be met by demands of imprisonment, although no standard for length of imprisonment is specified. For all other trade offences involving hard drugs the guidelines stipulate police and prosecutorial actions, including minimum terms of imprisonment to be demanded by the prosecutor. Under the guidelines simple use or no trade related possession of hard drugs do not require specific police investigation, nor pre trial detention or prosecution.

Starting in 1976 law enforcement practices have developed on the basis of these guidelines. Prosecution policies are illustrated by a study of 1042 drug offences that came to the knowledge of the public prosecutor in 1982 (Rook and Essers, 1987). It was observed that prosecutionary practices, for both

soft and hard drugs, were more lenient than was intended by the guidelines. Of all possession-for-trade-cases in which unconditional demands for imprisonment were made, 64% was below the one year term designated by the guidelines. 'Manufacturing hard drugs' is intended by the guidelines to be met with a demand for imprisonment of at least two years. In 73% of these cases the actual demand was less. Similarly 56% of the demands for international hard drug trafficking were more lenient than the two years of imprisonment intended by the guidelines. In many cases the leniency of these prosecutionary practices could be explained in terms of the small quantities of hard drugs (i.e. less than 10 to 50 grams) (ibid., p. 39). The study included 63 cases of trafficking cannabis in amounts exceeding 3000 grams in which an unconditional demand of imprisonment was made by the prosecutor. In 50% of those cases the demanded prison sentence was less than 3 months (ibid., p. 37).
Very large cases of international cannabis trafficking, for instance amounts over 1000 kilograms will normally be met with a demand/conviction of about 2 to 4 years imprisonment. Large-scale international trafficking cases involving hard drugs will be met by prison sentences of about 6 to 10 years. Obviously, these figures should be compared to Dutch sentencing standards; in that context, they are severe. In recent years the median length of unconditional prison sentences in the Netherlands has been about 2 months. Prison sentences of more than 1 year occur in only 10% of all prison sentences.
In 1984 a working group appointed by the assembly of heads of prosecution offices concluded that the guidelines for prosecution and criminal investigation of drug offences should be revised. The report reaffirmed the policy of partial decriminalisation and the restrained application of law enforcement in regard to drug problems as formalised by the revised Opium Act. The working group proposed that the official guidelines be brought more in line with the more lenient practice that had evolved.

Extent and nature of illegal drug taking in an international context

Epidemiology of illegal drug use

The number of drug addicts has increased sharply from 1974 until the present level was reached in 1980. According to all estimates there are between 15,000 and 20,000 'addicts' who use opiates, cocaine or both. This number has been stable for the last 10 years and the average age of this population has substantially increased (Van de Wijngaart, 1990, p. 56). This indicates that fewer young people are becoming drug addicts and that earlier cohorts are ageing.
National drug policy officials in the former West Germany estimate between 60,000 and 70,000 drug addicts in that country. In England the estimate ranges between 60,000 and 80,000. Converted to rates, these numbers suggest 100 to 133 addicts per 100,000 population in the Netherlands, the German rate of 99 to 115 is slightly lower; the English rate of 106 to 140 is essentially similar to the Dutch. It has to be noted, however, that the Dutch figure is probably substantially inflated by the inclusion of foreign drug addicts. Due to the relatively 'friendlier' Dutch situation for drug addicts the 'foreign element' is certainly more significant than in the other countries.
The few sources available suggest that epidemiological developments in several European countries have been as comparable as the levels of prevalence (Hartnoll, 1986). The stabilisation of the number of drug addicts may have occurred somewhat earlier in the Netherlands than elsewhere. For instance drug addiction in Italy, the former West Germany and England sharply increased until the middle of the nineteeneighties (ibid.). The Dutch prevalence figures for deviant drug use are probably reasonably reliable because of the easy accessibility of socio-medical agencies for drug addicts. This makes it unlikely that the Dutch figures are an underrepresentation relative to other countries.
In Europe, although cocaine has become more widely available since the beginning of the last decade, deviant drug use is still primarily a matter of opiates. There is a strong concurrence of heroin (methadone) and cocaine use in the Dutch junkie scene. A recent field study on drug use and income patterns in Amsterdam, based on a sample of 150 problematic hard drug users showed that 70% of frequent heroin users (thus excluding those who stick to their legally supplied methadone) also used cocaine (Grapendaal, 1989). There is, however, very little indication of addicts in the subculture of hard drug use who use only cocaine to the exclusion of heroin. This suggests low levels of primary deviant cocaine use (addiction) in the Netherlands - a conclusion that is probably also true for other European countries. Deviant, subcultural and marginalised use of cocaine seems to be restricted to a portion of the heroin addict population.
This deviant form of cocaine use is to be distinguished from recreational patterns of cocaine use. Those two worlds are strictly apart in terms of ways of use, patterns of use, meanings of use and the structure of the users' market for cocaine. Non-deviant cocaine use is part of a lifestyle characteristic of some, mainly young, urbanites who spend many of their evenings and nights in socializing in private settings or fashionable discobars. A recent study in Amsterdam concluded that among this partying population the substance is used almost exclusively by way of snorting, in contrast to the junkie scene where cocaine is either injected or free based. Cocaine is traded in this same (semi) private settings, whereas the junkie market for cocaine is integrated in the deviant hard drug market. This same study found that non deviant use of cocaine is characterised by generally well controlled frequency and intensity of use patterns. Social or (mental) health consequences of this modality of cocaine use were found to be relatively limited and nonproblematic.
The highest figures for prevalence of cocaine use in the general population may be expected to be found in Amsterdam. A recent population survey on drug taking in Amsterdam showed a month-prevalence of cocaine use (use at least once a month) of 0.6% in the total sample (n= 4371) and a month-prevalence of 1.2% in the 20-29 years age group, where cocaine use appeared to be most common (Sandwijk et al., 1988). This is a very low figure compared to the recently published week-prevalence of almost 1% of the general population of the U.S. (Staff Report to the U.S. Senate, 1990). Finally, but not unimportant, until now there seems to be no crack on the Dutch or other European drug markets.
For both theoretical and practical reasons comparative figures for cannabis use in the Netherlands and some comparable countries may be of paramount interest. One major question

is whether the pseudo legalisation of cannabis in the Netherlands has produced relatively higher prevalence figures than in other countries. A recent analysis combined the results of more than 20 Dutch 'ever used' prevalence studies since 1970. The figures were compared with the results of comparable studies in Norway, Sweden and the U.S. (Driessen et al., 1989).
Taking the results of the time analysis over the last 20 years into account the authors arrive at the general conclusion that 'the results of the analysis show that the prevalence of cannabis use since 1970 decreased, whereas the policy became more tolerant. Since 1979 a slight increase in the use of cannabis can be observed. A comparison with data from countries with a more restrictive policy reveals that the use of cannabis in the Netherlands is on the same level as in Sweden and Norway (around 10% to 15%), but far lower than in the U.S. (exceeding 50%). However, the downward trend in these three countries since 1984 did not occur in the Netherlands' (ibid., p. 11).
The use of other psycho-active substances apart from conventional, legal luxuries such as alcohol and tobacco, should be viewed within the contexts of deviant versus non deviant (sub)cultures. It concerns consumption patterns of a wide array of substances: speed (amphetamines), tranquillizers and sleeping pills, hallucinogenics (such as LSD and XTC) and inhalants (for instance as contained in dissolvents like tri).
In the Netherlands drug consumption levels of this kind seem to be low. With a possible exception of the 'soft hallucinogenic' XTC, the use for 'kicks' of medical pills, speed or other substances mentioned has never become popular among 'normal' Dutch cohorts. High school pill parties or pubescent glue sniffing are virtually unknown phenomena, even as incidental reports in the Dutch mass media.
Within the Dutch deviant subculture of drug addiction, however, a high level of consumption exists of any kind of medically prescribed, but often non-medically obtained, substances. Medical pills, along with cannabis and large quantities of alcohol are fairly typical for this poly-drug using subculture.

Drug related social problems

Judged from the figures quoted above the extent of the drug problems may be basically unaffected by the repression directed against it. But what about the intensity of (individual) drug problems as may be indicated by marginality, health conditions, criminality and the consequences for public health, public order and general livability?
A majority of Dutch drug addicts (60% to 80%) is estimated to be in regular contact with (specialised) health and welfare institutions (Wever, 1989). This may have some relevance for the general observation of many foreign visitors of the Dutch drug field that Dutch addicts appear relatively well and sound. In itself this is, of course, very hard to substantiate and can only be taken at face value.
Mortality of drug users is a firmer indication for the level of socio-medical problems in connection with the use of hard drugs. Between 1979 and 1986, an average of 38.4 Dutch citizens died each year from an overdose of heroin. In (the former) West Germany the corresponding number is 377.1. Adjusted for population size, deaths by overdoses are 2.3 times as probable in Germany as in the Netherlands (6.2 versus 2.7 per 100,000). This ratio may very well be related to the conventions of the hard drug culture in the Dutch context that may promote safer ways of using. In the Netherlands 'only' 40% of heroin users is estimated to use intravenously. Among comparable groups of heroin addicts in Germany and in the U.S. this proportion may be estimated as at least twice as high (Berger et al., 1980; Anglin et al. 1988). Different socialisation processes of drug use in Germany and the Netherlands may also be indicated by the fact that 'drug deaths' among Germans in Amsterdam are about 6 times as probable as among Dutch users.
The relatively low levels of intravenous drug use in the Netherlands may be expected to have beneficial effects on the AIDS epidemic. Among 11 countries of the European Economic Community the Netherlands rank eighth with 2.7 IV drug using AIDS patients per million inhabitants, the mean number for those countries being 9.4 (Buning, 1989).
The immense threat of diffusion of HIV infection by drug users has recently overshadowed the long standing concern for drug related criminality as a harmful consequence of drug use for society. There is a close connection between addiction to illegal drugs and income-producing criminality. People addicted to expensive illegal substances normally just can not provide for them by legal means. According to records of the Ministry of Justice in 1987 more than one third of the imprisoned population were known by the medical prison services to be problem users of hard drugs before incarceration. Dutch users are no exception to the rule of strong coincidence of drug problems and delinquency. According to recent figures of the Amsterdam probation office, which organises assistance to drug addicts among arrestees in police-cells, about 35% to 40% of this population must be considered as users of hard drugs. This figure may be compared to an average level of 60% to 75% in east coast cities of the U.S.
The social context of illegal drug taking, which to a large extent is produced by the nature of its social control, may have important effects on the level and nature of drug related criminality. The results of the little relevant empirical data available suggest that Dutch as well as foreign addicts resort to relatively less socially harmful ways of income provision. Comparing income provision data of Amsterdam and New York drug addict populations which were gathered by similar methodologies, it appears that hard drug addicts in Amsterdam rely more on welfare cheques and the drug market as major sources of income, while their New York counterparts derive relatively more income from predatory crime. In New York 43% of the total yearly cash income was derived by this socially most threatening means compared to 24% among Amsterdam drug addicts (Grapendaal, 1989; Johnson et al., 1985; Leuw, 1990).
One other dimension of criminality related to the illegal drug problem in the Netherlands should briefly be mentioned. It has been widely observed that, along with the generally rather low level of (criminal) violence in the Netherlands, the Dutch drug market is rather peaceful. The use of guns is rare and practically limited to some incidents among competing groups of higher level drug traders. During the 8 years period of 1980 to 1988 in Amsterdam, 15 homicides (out of a total number of 135) were attributed to conflicts (liquidations) in the drug distribution system. In another 32 cases there was a possible connection with the illegal drug market.

Even more important in regard to public order and livability is the low level of violence on the Dutch consumers market for hard drugs. During the last eight years there have been only two fatal injuries of Amsterdam policemen in connection with the drug scene. Commonly only fist fights and some incidental knife fights (in the inevitable process of 'ripping') occur in the marketplace of street-dealers and drug addicts. A candid display of soft drug use and sometimes even of hard drug use seems as typical of the Dutch drug situation as low levels of violence.
The relative tolerance for the consumers market of hard drugs in the Netherlands offers a probable explanation. The police are not especially interested in small time street dealers. Police practices such as undercover purchases ('narco's') or 'contracting' junkies as police informers ('snitches') are normally not employed at the retail level of the hard drug market (Van Gemert, 1988). Consequently the paranoia and retaliation so characteristic for drug scenes and copping areas elsewhere exists to a moderate degree only.

Ideological principles and some consequences of pragmatic drug policy

Rejecting a 'War on Drugs'

During the parliamentary debate on the revised Opium Act of 1976 Irene Vorrink, the Minister of Public Health, summarised the major elements of the governmental drug policy. These essentials of Dutch drug policy have been upheld till the present day, although at times practical policy measures have been reconsidered and adapted.

- The central aim is the prevention and amelioration of social and individual risks caused by the use of drugs.
- A rational relation between those risks and policy measures.
- A differentiation of policy measures which will also take into account the risks of legal recreational and medical drugs.
- A priority of repressive measures against (other than cannabis) drug trafficking.
- The inadequacy of criminal law with regard to any other aspect of the drug problem.

A broad conviction exists in Dutch society that the real problems of drug use are far too serious to tackle with a single-minded 'War on Drugs'. The importation of the American crack epidemic would be deplored, but no more than the importation of the U.S. drug policy model, primarily based on law-enforcement (Wisotsky, 1986).
This basic societal attitude to the problem is not to be misunderstood as a highly disputed outcome of antagonistic political and moral forces in Dutch society. Apart for a short period preceding the adoption of the revised Opium Act in 1976 illegal drug use has never been a moral or political issue in the Netherlands. Consequently it has not served as a means of promoting political or moral power, nor has it served the specific institutional interests of law enforcement agencies. Political speeches elaborating on the abhorrence of illegal drugs have seldom been staged. They would appear as quite misplaced in the Dutch political culture. Consequently there are no votes to be won or positions to be conquered by rallying on the anti drug theme.
In a comparative analysis of the development of drug policies in the Netherlands and (the former) West Germany it was concluded that 'a low degree of politicalisation of the issue was the most important prerequisite for successful decriminalisation' (Scheerer, 1978, p. 603). In the decisive years for setting the tone of drug policies, around 1970, the general public in both countries was assumed to be quite similar in its (moral) rejection of drug (cannabis) use. Thereafter, according to Scheerer, social policy reactions departing from this public attitude strongly diverged. In Germany the political parties, the police and the medical profession used the drug issue to further their own institutional objectives by a process of problem amplification. A contrary process of problem relativisation occurred in the Netherlands. The social democrats were allowed to realise their 'liberal' interests in moral issues because their Christian Democratic partners in the coalition cabinet did not choose to use the drug issue 'as a self-serving sociopolitical symbol' (ibid., p. 595).
By adopting a pragmatic drug policy the basic contradictions of any attempt to reach practical solutions can be readily appreciated. A study on 'the Dutch Approach' observed that within the Ministry of Public Health that carries the primary responsibility for national drug policy formulation there is no pledge of 'solving the problem'. Instead, policy efforts are understood as pragmatic attempts to cope, meaning the management and if possible the minimalisation of the risks and the damaging effects of the drug phenomenon and preparing society to optimally live with it. On the one hand this pragmatism requires the recognition of moral and life style pluralism of modern western society, on the other it requires a clear dissociation from the stringent moral reductionism of the radical prohibition ideology. Dissociation from this perspective opens a wider choice of societal solutions. Policy options need no longer be based on moral rejection and (forceful) repression.
Perhaps most importantly within this pragmatic and non-moralistic model of social control the ultimate paradox of all drug policy can be accounted for. Attempts to limit the availability of drugs tend to increase its damaging (social) effects as well as its psychological and economic attractions. The more drugs are tabooed and forcefully repressed, the more its users will become marginalised, criminal, bearers and sources of diseases and the more the world of drug use will offer attractive perspectives for earning money and living a meaningful life in deviant subcultures. Thus the real challenge of pragmatic drug policy may be perceived as striking a balance between limiting the availability of 'dangerous substances' and augmenting their secondary risks.
One important ideological legitimation of the rejection of the War on Drugs has been pointedly expressed in the statement that: '(...) the theories underlying the "War on Drugs" are seen as oversimplified and (...) escapist, in that they seek to off-load responsibility for a wide spectrum of social problems on to chemical substances' (Van de Wijngaart, 1990, p. 101). Pragmatic drug policy allows for a problem concept where blame is not onesidedly fixed to drugs, drug takers or even drug dealers but is justly returned to society itself. As long as gross socio-economic, ethnic and cultural injustices so obviously coincide with drug taking and drug dealing, combatting drug problems will practically and ethically be irresponsible without at least recognising the conditions that co-determined the problem in the first place.
In the 'Program towards an integrated approach to hard drugs' of the city of Amsterdam, (Gemeente Amsterdam, 1985) the drug problem has been put into the context of social

rehabilitation programs for poor neighbourhoods. In the most troubled drug area of Amsterdam, more intensive police surveillance has been put into practice to contain the presence and the impact of the street market for hard drugs within manageable limits. At the same time an extensive program for renovation of houses for local citizens and for economic rehabilitation are being carried out.
Ultimately, it has to be recognised that the social order will not be recasted in such a way that basic structural and cultural tensions within any given society are solved for the sake of solving symptomatic consequences like drug problems. This means that basic limitations of (national) drug policy have to be accepted.
As yet, the Dutch approach has not gone beyond certain clear limits. There is a continuing debate on the feasibility of radical abolition of all criminal law interference with drugs. This option has some prominent proponents for instance among penal law professors, law enforcement authorities and local politicians (Rüter, 1986). Nationally and officially, however, the flexibility of Dutch drug policy has stopped short of formal legalisation or even further practical decriminalisation of illegal drugs. A comparative study of the national drug laws of several Western European countries concluded, perhaps surprisingly, that apart from the partially decriminalised status of cannabis, the Dutch Opium Act is not the most liberal. The penal law positions of 'possession for own use' in Italy, Spain and Switzerland were observed to be more liberal than in the Netherlands.

The impact of pragmatic drug policy on the appearance of drug problems

The precedence of health or welfare interests over the criminal law has important consequences for the ways in which drug problems surface in Dutch society. The purposely restrained role of 'the law' has led to high visibility of manifestations of drug use, problematic or otherwise. This has strongly shaped the image that has internationally been established of the nature of drug problems and drug policy in the Netherlands, an image which may be quite misleading when its backgrounds are not understood or ignored. Visibility signals failure if maintaining a decent front is an important aim of drug policy. It may indicate success however if drug policy aims at preventing drug addicts from marginalisation as much as possible.
The hard drug manifestations are considered to be the price that Dutch society has to pay for a policy that will not marginalise problematic drug users more than is necessary, a policy that will not push the problematic drug takers to move underground, where they will drift out of reach of health institutions and where their subcultures may uncontrollably 'infect' other local or social areas in the city. Similarly, Dutch policy will not allow street markets of hard drugs in any other part of the town than where it is expected and can be contained within certain limits by the permanent presence of the police. This social control policy towards hard drug manifestations is not different from and serves the same ends as the long existing policy towards the traditional forms of prostitution in the Netherlands.
In case of the soft drug manifestations it is even simpler. They can be bought in normalised retail outlets, the 'coffee shops', that are closely monitored by the police and the city-adminstration for not dealing anything else than soft drinks and soft drugs. Legally operating, hash cafes can be found throughout the country. In Amsterdam approximately 300 such small scale commercial establishments exist.

Public health and welfare policy in response to drug problems

Reaching the limits of tolerance

In Dutch society there has been some illusion that hard drug problems could be handled in a similar way as soft drugs problems, an illusion which has been rather typical for the decade of the seventies and which specifically manifested itself in Amsterdam. In this historical context a strong distinction existed between a more or less traditional medical approach for dealing with problematic drug users and an approach that was based on the views of newly professionalised social work and relief groups. According to the medical perspective, addicts were sick people who should be medically treated until their addiction was cured. According to the social work point of view, persons addicted to hard drugs should be supported, cared for, and shielded from the moral and social expulsion of conventional society. Especially this last approach originally gained much influence and may in its extreme form very well be considered as the Dutch version of madness in drug policy.
Countless groups of providers of social assistance and care for problematic drug users succeeded in convincing local or national authorities that they really understood the addicts and that consequently they should be subsidised to lead them to rehabilitation while in the meantime liberating society from the nuisance caused by the addicts. Especially in the (drug) capital of Amsterdam this led to the establishment of several day-care centres, 'drug cafes' and social clubs for hard drug users. The use of hard drugs was officially tolerated in these facilities, while hard drug dealers were officially banned from the premises. In practice (of course) dealers soon displaced the social workers from control of the daily course of events. The drug cafes were meant to be shelters where the junkies could find rest and protection that would enable them to reverse their path. However, it soon appeared that these fashionable so called 'alternative' settings were often exploited by the addicts. The addicts were not so much directed towards rehabilitation by those facilities as reinforced in lifestyles of deviant drug use. It took several years for the institutions themselves and for the municipal and national authorities to find out that this approach of 'limitless tolerance' was a failure (Downes, 1988). It had allowed an uncontrolled increase of expensive but inadequate help providing institutions, which in retrospect have functioned to ritually fulfil the illusions of integrating deviance. In the end this approach could however not survive the confrontation with the harsh realities of increasing numbers of hard drug users, increasing drug related crime and, perhaps most importantly, the threat of hard drug scenes to public order and the livability in the cities.
After some years both rather optimistic policy models for the realisation of risk-reduction had to be reappraised: the traditional medical institutions were basically unable to even reach the addicts and the 'alternative' institutions were partly aggravating the problem. In the early years of the nineteeneighties, this rather sad situation was officially recognized and new ways of pursuing the risk reduction aim

were attempted. It was recognized that the social strategy of tolerance and full integration that had worked so well in the case of cannabis could not as easily be applied to hard drugs. The concept of risk-reduction as the core of drug policy addresses three sets of risks: to the addicts themselves, to their immediate environment and to society as a whole. The last two elements may broadly be understood as undesirable effects on public order, livability, public health and drug related criminality. The reconsideration of drug policy in the early eighties resulted in a more sober and less idealistic outlook. The first element of risk-reduction lost the predominance over the other two that it had enjoyed in practice. The daycare centres, social clubs for addicts and the like of them were abolished under a pledge of 'never again'. The officially redefined drug policy in Amsterdam was proclaimed in 1983 as a 'two track policy', which meant that the interests of society would be considered equal to the interests of the addicts. To put it in less abstract terms: it indicated that addicts would receive some well defined assistance, that they would not be chased by the police, unless they would cause nuisances for their environment.

Reformulation of social drug policy: towards a cultural integration of drug problems

In a letter to parliament the more sceptical and less idealistic primal aim of social drug policy in the eighties was phrased as follows: 'The basic aim has not been to combat drug use itself or to prosecute persons because they are drug users, but to reduce these risks' (State Secretary for Welfare, Health and Cultural Affairs, 1983, p. 2). For the implementation of this aim there has been a heavy reliance on existing or especially created social work and medical institutions. Due to the traditions of the welfare state and to the booming economy of the sixties and early seventies there existed an extensive, easily accessible network of medical and social assistance facilities in the Netherlands. Inexpensive and comprehensive (public) insurance covers the expenses for virtually all people. The letter to parliament argued that aiming at abstinence and complete rehabilitation was generally unrealistic and inefficient because: 'Addicts who do not, or do not primarily, feel the need to "kick the habit" or are not capable of doing so will remain beyond the reach of assistance' (ibid., p. 7). The Secretary stated that effective social policy aiming at reduction of the risks of drug use will have to acknowledge that deviant drug use has important functions for the addict. Thus, conceiving no alternative for a (provisional) acceptation of drug use (addiction) as matter of fact in many individual cases, the letter stated that '(...) there must be increasing scope for forms of assistance which are not primarily aimed at curing the addiction as such, but at improving the social and physical functioning of addicts' (ibid., p. 7).

Based on this perspective, in recent years a stronger accent has been put on operating so called low threshold facilities which offer limited but easily accessible services for a broad population of drug addicts. Basically those programs offer unconditional support, based on the acceptance of drug addiction as an explicit individual choice. They include shelter projects, free methadone maintenance, free needle exchange programs, material support (free meals, housing projects), social guidance programs and psycho-medical care. Methadone programs form the core of most help providing institutions for drug addicts. Registration figures of the ministry in charge indicate that the strategy of establishing regular, frequent contacts between the hard drug using population and socio-medical institutions has been rather successful.

According to estimates of the Amsterdam Public Health Service on a yearly basis about 70% of the cities drug addict population is reached by the drug addiction agencies. This is mainly realised by the mobile and stationary methadone maintenance facilities that cover the city. They provide daily doses of methadone averaging around 50 milligrams. The institutions do not expect clients to be abstinent. In fact within this same context of methadone provision used needles are being collected and exchanged for new ones. Likewise the methadone providing agencies do not question the deviant junkie lifestyle. Next to this a relatively wide array of more demanding and ambitious programs exists which aim at recovery from addiction and social rehabilitation. They operate on the assumption of the addict's own and unrequested motivation to break away from the life style of deviant drug addiction.

The prominent role of methadone provision in the present Dutch drug policy may be understood as an expression of the rather modest and sober 'normalisation' approach which recently has been adopted as an official model for directing social policy. The concept of normalisation has been elaborated in the official policy report of 1985 Drug Policy in Motion; towards a normalisation of drug problems (ISAD, 1985). The report draws on the conclusions of a sociological study concluding that deviant drug users have 'good reasons' for their problematic drug use and that those reasons for and functions of drug use are closely linked to and even materialised by moralising, stigmatising and making social reactions criminal acts (Janssen and Swierstra, 1982). Drug users were found to use drugs 'because', in comparison to their expectations of conventional society, a drug life offered attractive alternatives which mainly exist under the conditions of criminalisation: adventure, excitement, friends and (illegal) economic perspectives.

The policy report Drug Policy in Motion adopted the fundamental conclusion of this study that 'a gradual cultural integration of heroin use' will be a rational and feasible aim of social drug policy (ISAD, 1985, p. 13) This implies that drug use will have to be accepted as a reality in modern society which can not be eradicated, but which can 'be reduced to a problem of individual addicts' (ibid., p. 20).

This objective is to be attained by the 'normalisation of drug problems'. In practice this means a policy of consistently aiming at reducing the secondary drug problems as well as the secondary attractions and rewards of illegal drug use. Secondary problems are considered to result primarily from the (level of) criminalisation of drugs. They are '(...) the price that has to be paid for limiting primary (trafficking and the consumption of drugs) drug problems' (ibid., p. 9). The reduction of secondary problems involves a process of destigmatisation, whereas the reduction of secondary rewards and attractions calls for a process of demythologisation. The policy report proposes a sober and unemotional attitude towards illegal drug taking in which users are as far as possible not morally judged, minimally criminalized and minimally marginalised. They can expect to receive assistance attuned to their motivation and ability to rehabilitate or even kick the habit. The report explicitly states that, under those

conditions, addicts should be held responsible for their own choices. Assistance will be offered on the basis of reciprocity and addiction will not exempt individuals from responsibility for their acts.
This pragmatic and non-moralising drug policy has operated between rather clear limits, although these limits have at times been seriously challenged. The policy report reaffirms once more the basic positions that have been taken since the introduction of the new Opium Act. Three possible alternatives for the proposed cultural integration of illegal drug use are mentioned: forced treatment of drug users, large scale (medical) prescription of heroin and legalisation. They are all rejected as not fitting in with the basic philosophy of Dutch drug policy.

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