BETWEEN PROHIBITION AND LEGALIZATION

THE DUTCH EXPERIMENT IN DRUG POLICY

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IX. THE DEVELOPMENT OF A "LEGAL" CONSUMERS' MARKET FOR CANNABIS: THE "COFFEE SHOP" PHENOMENON

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"Coffee shop": place where one may buy small quantities of hashish and marihuana for personal consumption.

1. Introduction

This chapter focuses on the uniquely Dutch institution of the "hash coffee shop". Hash coffee shops represent a commercialization of the cannabis trade - a trade which, although in principle still a penal offense, is in practice tolerated at the retail level. The commercialization of cannabis sales - especially when conducted in establishments comparable to traditional bars or "normal" coffee shops, played an extremely important role in the gradual acceptance by Dutch society of cannabis as "just another stimulant", comparable to alcohol.

As this chapter will show, the commercialization of cannabis took place only gradually and under conditions imposed by the government. Soft drug policy in the Netherlands, as in many other countries, was fairly repressive throughout the 1960s. The 1970s showed the beginning of more tolerance towards the use of soft drugs, culminating in the revised 1976 Opium Act. In Amsterdam, as in other large Dutch cities, there were initially numerous frictions between the operators of the coffee shops and the authorities. Gradually, a policy of "toleration" developed, characterized by fairly strict conditions imposed on the operation of the coffee shops.

This chapter describes how Dutch drug policy has been fairly successful in the integration of soft drugs into Dutch society. The semi-legal entrepreneurs running the coffee shops, without ever losing sight of their economic interests, have been important contributors to the achievement of one of the main aims of Dutch drug policy: a strict separation between the trade in soft and hard drugs.

After a brief discussion of developments in Dutch soft drug policy, the chapter provides a description of Amsterdam hash coffee shops. After that, we attempt to account for the fact that the "hash coffee shop" appears to be a phenomenon which exists only in the Netherlands. Finally,
the “success story” of the hash coffee shops should not blind us to the fact that there still exist many cases of misunderstanding, ignorance, and ambiguity concerning cannabis in the Netherlands – the focus of the last section of this chapter.

2. Soft drugs policy and the emergence of coffee shops in the Netherlands

By the 1980s, drug use had become such a pervasive phenomenon in the Netherlands that law enforcement priorities had to be set, resulting in prosecutorial guidelines even more lenient than originally envisioned by the 1976 law. The development of guidelines with regard to the investigation, prosecution and sentencing of drug offenses is based on one of the basic foundations of Dutch criminal procedure: the expediency principle. This principle (Van Vliet 1989:8) empowers the Public Prosecutor’s Office to refrain from initiating criminal proceedings “on grounds derived from public interest”. In 1980, the Ministry of Justice issued a set of guidelines for the investigation and prosecution of offenses under the Opium Act. These guidelines are interpreted at a local level in the different judiciary districts of the country through a process of “triangular consultation” (i.e., consultation between the Public Prosecutor, the Mayor, and the Chief of Police). This decentralized approach results in a variable prosecution policy, ranging from rather strict to lenient. Typically, the policy is less strict in major cities than in the smaller towns and villages, reflecting differences in community standards, extent of drug problem, and so on. Generally speaking, soft drug policy is most tolerant in the urbanized western part of the Netherlands.

Soon after the “Guidelines for the investigation and prosecution of offenses under the Opium Act” had been issued, the Mayor of Amsterdam announced that “relatively low priority” would be given to the investigation of the commercial retail trade in cannabis products taking place in “certain places”, provided that some conditions were met. Two of the more important conditions were a ban on public advertising, and absolutely no sale of hard drugs. Violation of the latter condition would not only result in possible incarceration, but in economic sanctions as well: the establishment would be closed immediately. In this manner, the city of Amsterdam used both a “carrot” and a “stick”: the opportunity to make a profit and to conduct business in a relatively undisturbed way represented the carrot; a relatively harsh penalty when violating the ban on the sale of hard drugs represented the stick. This policy which essentially condoned and “normalized” the use and retail sale of soft drugs, was a
weighty factor in the rapid proliferation of hash coffee shops in the larger Dutch cities.

The “coffee shop” was not newly invented just for the consumption of cannabis (Korf 1990). To the contrary, the “koffiehuis” is one of the traditional Dutch public places—a place where one goes to have coffee, eat, read a newspaper, and meet friends. It is an alcohol-free cafe. Compared to places with a liquor license, there are virtually no rules or regulations regarding its establishment. In the late 1970s, the owners of some of these coffee shops tolerated the occasional sale of soft drugs by small dealers. The sale of soft drugs gradually became an essential part of the income of coffee shops. Coffee shops that were selling soft drugs in the pre-regulation days soon established “house rules”: No hard drugs allowed. No dealing in stolen goods. No violence. In case of violation of any of these rules, the police would be called. Sometimes a square-shouldered person was hired to enforce compliance with the house rules, and these “enforcers” were anything but superfluous: keeping hard drugs out of the soft drug use and trade was not accomplished without, literally, striking a blow.

This means that the local interpretation of the expediency principle in the city of Amsterdam (as well as in other cities) was more or less determined by existing practice: a number of coffee shops, serviced by a
(small) number of soft drugs dealers, tradesmen who were soon considered as “personifications of the “separation of markets”-policy” (Van Vliet 1989:9). After the policy shift of 1980, the number of hash coffee shops rapidly increased: “House rules” were mass-produced (Fig. 1). In a fashion, these “house rules” represented a form of “hidden advertising”, since they indicated the availability of soft drugs at certain establishments. In the 1980s, the Amsterdam hash coffee shops had found numerous other ways of evading the official ban on advertising (see Jansen 1991).

3. Hash coffee shops in the center of Amsterdam

At the time of this writing, more than 1,000 hash coffee shops exist in the Netherlands. In Amsterdam alone, more than 300 of these coffee shops are currently in business. Not surprisingly these establishments are mainly to be found in the cities. In the smaller towns and villages, hash coffee shops do not exist; these places lack an economic (and possibly a social) basis necessary for their subsistence. Dealing from private houses is still common practice for these areas.

I have studied the gradual emergence of the soft drugs retail business in the inner city of Amsterdam (comprising some 110 coffee shops, see Fig. 2) during the 1980s. In the second half of the 1980s I visited coffee shops on a regular basis. Whenever possible, I would initiate conversations with dealers and customers; on other occasions, I simply observed. My observations always included a registration of the amount of drugs changing hands during a half-hour period. (At that time, all coffee shops in the inner city of Amsterdam carried out their trade quite openly – due to the formally stated “low priority policy”. It was typically fairly easy to register the exact amount of drug sales.) A random sample of 887 observations of half-an-hour each during the 1985-1989 period provides the basis for the following conclusions.

First of all, it appears that the policy aimed at the (spatial) separation of the sale of hard drugs and the sale of soft drugs was very successful. In a relatively short period of time, the sale of hashish and marihuana on the streets became comparatively insignificant and was taken over by the “established” trade of the coffee shops. Over 95% of the sale of soft drugs in downtown Amsterdam now takes place in coffee shops, where it is, incidentally, as absurd to ask for hard drugs as it is to ask for a zebra steak at the average butcher’s. It is not known to what extent this spatial division of the worlds of soft and hard drugs has also occurred outside the inner city of Amsterdam.
A second conclusion concerns the importance, both economically and socially, of hash coffee shops. In the inner city of Amsterdam (as in other larger cities), there now exists a large variety of coffee shops. There are coffee shops with a youthful public as their major patronage, and there are coffee shops which are mainly frequented by somewhat older people. There are coffee shops visited mostly by people from Surinam, or from
Turkey, or from the richer neighborhoods of Amsterdam. And there are
coffee shops mainly for tourists. There are coffee shops which are viewed
as “take-out” places, and there are coffee shops which function as youth
centers, where visitors spend hours playing chess, table football, or pool.

The 1980s not only showed a strong growth in the number and types
of coffee shops; they also showed an increase in the variety of cannabis
products for sale. Within a period of less than ten years, cannabis was
imported from virtually all cannabis-producing countries in the world.
Most hash coffee shops in the inner city of Amsterdam offer more than
five types of marihuana and more than five types of hashish. Neither the
variety, nor the price of the goods in coffee shops are influenced by oc-
casional confiscations of shipments of cannabis by the police.

In a social sense, hash coffee shops increasingly resemble those other
establishments in Dutch culture which exist mainly because of the prof-
itability of another psychotropic substance: alcohol. From a social scien-
tific perspective the social functions of pubs and bars may easily be
viewed in positive terms. A Dutch sociologist concluded his study of the
“public house” throughout history with the statement that the quality of
life of a society may be inferred from the quality of its pubs (Jansen
1976). As the integration of soft drugs into Dutch culture progresses,
G.H. Jansen’s criterion of a “liveable” society might include the quality
of its hash coffee shops.

The most recent developments in the soft drug sector in Amsterdam
show that the original spatial separation between the coffee shops selling
hashish and the public establishments with a liquor license, is now
fading. At this moment, approximately 25% of the hash coffee shops in
the inner city of Amsterdam also offer alcoholic beverages. In addition,
we see an increase in the number of pubs where the use of cannabis is
tolerated, although the substance is not sold by or in the establishment.
In other words, there is some evidence that the soft drugs sector is “dis-
solving” into the long existing world of liquor establishments. Whereas
in the 1980s the profitability of the hash coffee shop was almost entirely
based on the sale of cannabis, we now see more establishments where
cannabis is but a part of its income.

The “dissolving” of the soft drugs sector has yet another dimension:
the “sinsemilla guerilla”. From the early 1960s, people in the Nether-
lands have been experimenting with the growing of cannabis. As a result
of these experiments, over the years a home-grown brand of “Nether-
weed” has entered the market. Most of it is “sinsemilla” (a Spanish ex-
pression indicating that the marihuana does not contain seeds). This soft
drug can easily win a quality contest with imported marihuana; the price
of Netherweed in coffee shops is, therefore, higher than that of imported varieties. According to Dutch law, the growing of cannabis seed is allowed; however, not with the intention to grow a crop of marihuana. It is not forbidden to deal in cannabis seed, nor is it illegal to deal in cannabis plants. This is the basis for what has become known as the “sinsemilla guerilla”. The initiators of this “guerilla” promote “home growing” as a means of removing the marihuana trade from the hands of large-scale dealers who, in effect, are violating the Opium Act by importing drugs. High quality seeds or “clones”, in combination with an instruction manual for outdoor or indoor growth (Cervantes 1984; Wiet 1983; Wernard 1987), enable a financially attractive small-scale production.

It is impossible to pinpoint exactly where and how the available amounts of Netherweed have been produced. However, since almost every Amsterdam coffee shop is selling Netherweed, it is reasonable to speculate that the commercial production of Netherweed has reached a considerable volume. The same conclusion may be drawn from the lowering of the price of Netherweed: during 1990, the price has been sliced in half. It should be noted, however, that the same holds true for most imported kinds of hashish.

4. An explanation of the “coffee shop culture”

The hash coffee shop is a phenomenon which only exists in the Netherlands. An obvious question remains: Under what conditions did the Dutch “coffee shop culture” develop? Clearly, the legal distinction between soft and hard drugs has been of strategic importance for the development of the phenomenon. However, the Netherlands is not the only country which has introduced a legal distinction between soft drugs and hard drugs (e.g., Spain, Denmark). Is it then perhaps the expediency principle as applied in Dutch criminal law which facilitated the emergence of the Dutch hash coffee shops? The expediency principle made it possible that in the Netherlands, against the stated intentions of the law of 1976, in certain places a cautious beginning could be made with the commercialization of the cannabis trade. However, since the expediency principle is characteristic for criminal law in many European countries (Van Vliet 1989), this could not explain the uniqueness of the Dutch hash coffee shops.

We have to understand how the expediency principle interacted with what was happening in the Netherlands during the 1970s - a period which may be described as “a strange and brief time when middle-class kids had involved themselves in illegal business and felt they were doing
the right thing” (Warner 1986:264). The 1970s was the decade of challenging authorities by rebellious (middle-class) youngsters becoming involved with a relatively new phenomenon in their culture: drugs. In cities like Amsterdam (and other university towns in the Netherlands) the protest movements were more powerful than in many other European cities, which may explain why Dutch local authorities were willing to make a rather tolerant use of the expediency principle.

Another factor to consider is that the 1980 prosecutorial guidelines leave considerable leeway for local interpretation. The Dutch have a “built in” aversion against a too strong central power (Schama 1987). The history of policies with regard to hashish and marihuana in Amsterdam confirms this tradition: Differences of opinion between the mayor of Amsterdam and the Minister of Justice in the Hague did not always get resolved in favor of the Minister.

Although the coffee shop culture came into being against the stated intentions of the 1976 revised Opium Act, it should be noted that there was already sound public support for a more tolerant policy with regard to soft drugs. As has been pointed out by Van Vliet (1989) and Engelsman (1989), the changing of the law in 1976 took place in a stable democracy where the changed law was the tail end of a wide public debate.

Our brief discussion of the uniquely Dutch circumstances associated with the emergence of the hash coffee shop culture implies that the Dutch experience cannot easily be generalized to other countries. The primary importance of the hash coffee shop may be the fact that it expresses the possibility of cultural integration of the use of illegal (be it soft) drugs into mainstream society. Over the last few decades, some of the marginality typically associated with drugs has been removed from cannabis in the Netherlands. At this point, cannabis is put in the same category as alcohol: simply another stimulant, rather than an illegal drug. The Dutch government, by (somewhat reluctantly) allowing a legal outlet for the use and purchasing of soft drugs, has taken an active role in the redefinition of cannabis as an ordinary product subject to the demand/supply mechanisms of the legal economic marketplace.

5. Cannabis in the Netherlands in the 1990s: Still some unresolved issues

During the first part of 1990, several interesting events involving cannabis took place in the Netherlands. For example, in early February, the 24-year-old manager of a hash coffee shop in Groningen reported to the police the theft of her entire supply of hashish intended for sale at the
coffee shop. The newspaper reporting the event (Haarlems Dagblad, February 5 1990) quotes a spokesman of the Groningen Police Department as saying that such information is rarely received because trafficking in hashish is still officially forbidden. This remark is only partly correct. True, possession of hashish "for retail purposes" is officially prohibited, but it is not true that informing the police of a robbery of hashish or marihuana is such a rare occurrence. It may seldom happen in Groningen, a city in the agricultural northern part of the Netherlands, but in Amsterdam it is not unusual at all for the police to receive a report of a robbery involving hashish or marihuana. As a matter of fact, the Amsterdam police take these (armed) robberies very seriously.

In the same month that the above incident was reported in local newspapers, 45,000 kilos of hashish were confiscated on the premises of an international transportation firm (Volkskrant, February 26 1990). According to the newspaper, it was the largest shipment ever discovered in the Netherlands. The police remarked that the shipment represented a "street trading value" of 450 million guilders (about 230 million dollars). The police comments on this case were rather peculiar. First, they exaggerated the total value of the shipment (which was worth 360 million guilders at the most). However, this form of official exaggeration is the rule rather than the exception and appears to be an almost universal characteristic of law enforcement agencies anywhere in the world. Secondly, the use of the term "street trading value" is odd in the Dutch context where dealing in hashish and marihuana on the streets is virtually a relic of the past. With the establishment of coffee shops, the sale of hashish and marihuana has been taken off the streets and has literally become the domain of "established business".

A few weeks earlier, a remarkable demonstration had taken place in the center of Amsterdam. This demonstration focused on the proposed unification of Europe in 1992 which, in the view of many, forms a direct threat to the liberal Dutch drug policy. Under the proposed plan, European Community member states would no longer be separated by national boundaries, thereby greatly facilitating international trafficking between countries. Concern about the consequences of the Schengen Agreement caused several hundred soft drug users (including coffee shop owners) to demonstrate to express their support of the Dutch drug policy. National television broadcasted the Amsterdam demonstration during the evening news. During the demonstration, a picture was taken of a few police officers accepting marihuana cigarettes from the public. This picture appeared in newspapers and weekly magazines in France, Germany, and Great Britain – doubtlessly reinforcing the popular foreign image of
Amsterdam as the “drug mecca” of the world. During the press conference held in conjunction with the demonstration, the mayor of Amsterdam, in a video-taped interview, emphasized his intentions to do whatever was necessary to preserve the liberal soft drug policy in his city. His main argument was that neither hashish nor marihuana are addictive substances.

Another significant event, though much less publicized, was the ruling by the Dutch High Court that growing hemp plants for their fibers and their seeds is not in conflict with the Opium Act. A grower of 555 hemp plants was acquitted by this ruling. Although this ruling was reported in a very brief notice by a few papers (e.g., NRC-Handelsblad, March 8 1990), this High Court decision will have far-reaching consequences for the production of cannabis in the Netherlands: the production of seeds practically coincides with the production of marihuana. For several years, the Dutch police has routinely confiscated hundreds of kilos of hemp plants growing in garden plots, hothouses, homes, and on roof gardens. In the Dutch context, however, this 1990 High Court ruling does not automatically put an end to this practice. To this very day, even very small “home growers” occasionally see their plants destroyed by the police. Again, the expediency principle can be referred to for explaining this remarkable practice. It should be noted, though, that currently confiscations of small productions do not normally result in imprisonment; a fine is more likely.

Another hallmark of the gradual acceptance of soft drugs into mainstream Dutch culture was an extensive report about the phenomenon of the hash coffee shop published by Elsevier, a middle-of-the-road, if not somewhat conservative widely read weekly magazine, in March of 1990. The article speaks of the “success story of a democratized stimulant”. In this article, coffee shop owners are not depicted as criminals, but rather as worried shop keepers and small business entrepreneurs, afraid of the consequences of a United Europe. For this article, interviewed coffee shop owners no longer tried to conceal their identity – openly stating their names and so on.

The Elsevier article includes some evidence that the Dutch soft drug policy is still not a perfect success story. For example, the owners of an Amsterdam coffee shop “The Golden Stamp” were taken to court in the early months of 1990 because 10.3 grams of hashish and 1.2 grams of marihuana were confiscated during a police raid. The possession of up to 30 grams of cannabis is permitted under current prosecutorial guidelines and therefore not ordinarily a valid reason for criminal prosecution. Rather, the real reason for the prosecution was the fact that the coffee
shop displayed stickers on its windows with a picture of the hemp leaf and with the text “Amsterdam Hash It”. In November of 1987, Amsterdam authorities began to place restrictions on advertising by coffee shops. This more restrictive policy was the result of pressure from abroad (particularly Germany) where concerns were expressed that coffee shop fronts decorated with pictures of a hemp leaf were too enticing to young tourists visiting “Europe’s Drugs Center Number One”.

The Elsevier article quotes a psychotherapist of the Amsterdam Jellinek Center (an alcohol and drug treatment clinic) who notes an increase in the number of people treated for an addiction to cannabis: approximately 200 cannabis users contact the clinic for help each year. Typically, it is the better educated cannabis users who enter therapy: students, doctors, lawyers, journalists. Only seldom do cannabis users from a lower socio-economic background report to the clinic for treatment of their cannabis addiction. Self-reported prevalence statistics on cannabis users (Kersloot and Musterd 1987) suggest that this psychotherapist has touched upon a hidden problem. In the Netherlands – and presumably abroad (Warner 1986) – a relatively greater number of cannabis users are found among the lower socio-economic classes. Although there is no reason to believe that there is cause for alarm, it suggests that the democratization of the “new” stimulant needs to be accompanied by a democratization in the education about the effects and problems of this stimulant. The opinion of one of the psychotherapists of the Jellinek Center is well worth mentioning here:

“As far as I am concerned, hash and weed may be legalized. We should not act as hypocritically as those who feel that a joint is worse than a beer, and hash is as bad as heroin. Parents do not have to worry if their child smokes a joint from time to time; nor if the child drinks a beer once in a while. But with both products they have to fulfill their parental duty and explain the risks. More information is required. If they can talk about being addicted to television, why then can’t they talk about hash addiction? Marihuana – it is just too good not to be a problem.”

The Dutch press reports on hashish and marihuana in a rather businesslike manner, unlike the very sensational type of reporting on drugs typically found in the American mass media. These Dutch newspaper stories show that the philosophy behind Dutch drug policy, based on “the necessity to integrate the drug phenomenon into Dutch society” (Engelsman and Manschot 1985:61 in the official explanatory note accompanying the new Opium Act) has slowly become a well-accepted reality, par-
particularly with respect to cannabis. On the same token, however, the discussed events also reveal the often chaotic, ambiguous and contradictory nature of Dutch soft drug policy. Indeed, despite a certain degree of cultural acceptance of marihuana and hashish, the behavior of the police and the Department of Justice at times may be characterized as thoughtless, inconsistent, and unfortunate. The lack of clarity with regard to the policy on soft drugs is to a large extent explained by the aforementioned expediency principle. In the view of many, the Dutch soft drug policy is obscure and as tricky to figure out as a cryptogram (Smits 1987:4).

In another context I have called the Dutch soft drug policy an “accidentally intelligent policy” (Van Harten and Meijer 1990:13). This is not meant as a pejorative term, dismissing Dutch drug policy as a failure. On the contrary, in spite of its shortcomings and ambiguities, the soft drug policy in the Netherlands is more reasonable, more humane and more effective than in any other European country. What I do mean is that Dutch drug policy is not solely the result of a preconceived policy goal, rather it reflects the process of “muddling through”, a process of trial and error. The particular shape of a drug policy in a democracy is influenced by a number of different “forces”, conflicts between authorities at the legislative and executive levels, and conflicts between national and local authorities. In addition, both soft drug dealers and consumers, through their method of “civil disobedience” constitute another important force in the shaping of the Dutch drug policy. As a result of the interplay between these different interest groups, cannabis use has been redefined during the last several years in the Netherlands: it is increasingly considered to be one of the available (legal) stimulants, instead of a (illegal) drug.

A final observation. Although the Dutch soft drugs policy, when compared with virtually all other countries in the Western world, is less repressive, this policy has not resulted in an explosive increase in the use of soft drugs. As a matter of fact, between 1970 and 1979 - a period of growing tolerance of soft drug use (Driessen et al. 1989) - the use of cannabis among youngsters showed a slight decrease. Since 1979, the use of cannabis has shown a minor increase, and if the full period (1970 to 1987) is considered, it appears that the use of cannabis has remained stable. Prevalence figures for Norway and Sweden - countries with a considerably more strict soft drugs policy - are about at the same level as those in the Netherlands. Comparable figures for the United States are significantly higher. In the Netherlands, the use of marihuana among school-age youth (between 10 and 18 years of age) amounted to 6.1% in 1989 (cf. Plomp, Kuipers and Van Oers 1990).
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X. THE DRUG-RELATED CRIME PROJECT IN THE CITY OF ROTTERDAM

Bert Bieleman and Jolt Bosma

1. Introduction

This chapter describes the Rotterdam Drug-Related Crime (DRC) Project, a program funded by the Dutch government emphasizing cooperation between local city government, the District Attorney’s Office, police, and drug assistance agencies. The DRC Project functioned as an umbrella for four smaller programs aimed at the prevention of drug-related criminality. The following four DRC programs were implemented within a three-year time period (1988-1990): a research study describing the extent and nature of the Rotterdam drug-using population; a work project aimed at the re-integration of addicts into society; a “target hardening” project to reduce drug-related property crime in parking garages; and a shelter for addicts near Central Station aiming at the reduction of nuisance associated with the concentration of drug addicts in that area.

2. Development of the Rotterdam drug policy

Rotterdam, the second largest city of the Netherlands (575,000 inhabitants) has been the world’s largest harbor for quite some time; for example 20,000 containers pass through this large harbor every day. Rotterdam is situated near the mouth of the Rhine, which is one of Europe’s most important waterways. This river divides the city into two very distinct sections. The center of the city is in the northern part. At the start of the Second World War, German bombardments virtually destroyed the center of Rotterdam. After the war the city had to be rebuilt, thereby significantly changing its character. Narrow streets with old fronts were replaced by wide traffic arteries and high rises. Whereas Amsterdam is considered to be the cultural center of the Netherlands, Rotterdam’s reputation is more that of a blue-collar city. Rotterdam has fewer foreign European drug users than Amsterdam. Most of the foreign European drug users in Rotterdam come from neighboring Belgium. Additionally there is a notable influx of Moroccan drug users from (through France) Belgium.
Up until the mid-1970s Rotterdam's drug problem was virtually nonexistent. However, starting in 1976, the nuisance created by drug users and drug dealers began to increase sharply. To pressure city government into dealing with the problems in the area, downtown citizens started an action group ("the Old West"). By the end of the 1970s, the city of Rotterdam published its first reports on the drug problem. These reports clearly indicated that the city did not view addiction as a disease, rather it was seen primarily as a social problem. The problem exists because the addicts behave themselves in a manner which the community experiences as alarming. This troubling behavior is due, at least in part, to the fact that drugs are illegal and are subject to very high prices on the black market, which in turn leads to the so-called "junkie syndrome": stealing, lying, blackmailing, manipulating, and an inability to take responsibility for one's actions.

Dealing with the problems experienced by the addicts is primarily the task of social service and treatment agencies. On the other hand, dealing with the problems caused by addicts is considered to be the primary responsibility of the police and the criminal justice system. The city has no illusions about solving the drug problem. Consequently, the city should focus its efforts on "containing addicted behavior within the social dimension and, if possible, eliminating it" (Gemeente Rotterdam 1980). The city expressed this premise in the three objectives of its drug policy:

- to prevent the onset of drug use by non-users which may lead to addiction;
- to offer assistance to those who want to overcome their drug habit;
- to offer assistance to those who wish to continue their drug habit by establishing programs which enable addicts to live a socially acceptable life (the so-called low-threshold assistance programs).

In these reports, the city requested more prevention, more low-threshold assistance programs and more after-care and rehabilitation programs. Programs and facilities for assistance and treatment aimed at Surinamese addicts, who are typically in a socially disadvantaged position and who are often beyond the reach of social service agencies, need to be adjusted and expanded. The delivery of services should be based on the so-called "circuit notion". The circuit principle implies that the city must offer a large variety of assistance provisions and programs; every program or agency fulfills one or more partial function in the circuit. The activities of the different agencies should not overlap, but rather complement each other. In addition, there should be a well coordinated referral system of clients throughout the agencies. It is this particular organiza-
tional framework which will provide the basis for the Rotterdam (and other Dutch cities’) drug assistance services. A drug policy coordinator should be appointed to support local drug policies and to coordinate drug-related services. In addition, an advisory commission should be established to report to the mayor and the city council. Representatives of drug-related assistance programs, criminal justice agencies (police, court, District Attorney’s office), and city government should participate in the advisory commission. There should also be routine consultations with the staff of the various methadone programs. These programs get their methadone supply from the city pharmacy, which is part of the Municipal Public Health Service.

In spite of the implementation of the city’s drug policy plan, drug-related problems persisted into the early 1980s. Residents of urban renovation projects such as “the Old West” continued to exert pressure on the city to address the problem. In the Old West neighborhood clearly visible street drug dealing continued to flourish. Local residents complained about neighborhood decline and criminality. Previously concealed (i.e., latent) feelings of discrimination became apparent (i.e., manifest) which further complicated and intensified the problem. Street trafficking of heroin was partly in the hands of (often addicted) Surinamese. The many Surinamese residents of the neighborhood were often automatically identified with heroin dealers by the autochthonous residents. This perception threatened to escalate into an open conflict in the Old West. The action group “the Old West” pursued a variety of actions, such as refusing to pay rent and appealing to the (local) mass media to pressure the city. The city’s response to this public pressure was two-pronged. On the one hand, police become more active, resulting in dispersing the drug-related problems and making the dealers more cautious. On the other hand, more drug-related assistance programs were established to ensure that the user would not become the victim of the increased law enforcement efforts. These newly created drug-related assistance programs catered to the needs of specific categories of addicts (i.e., Surinamese addicts, chronic psychotic addicts and very young addicts).

In sum, in the early part of the 1980s, the city policy emphasized combating drug dealing, decreasing drug-related nuisance problems and drug-related crime, as well as establishing comprehensive, easily accessible assistance programs with relatively limited emphasis on programs aimed at breaking the drug habit. The circuit principle remained the organizing framework for delivery of services. Treatment services aimed at abstinence were considered to be very costly in terms of both money and efforts, and were viewed as relatively unsuccessful. Therefore, the
emphasis shifted more from a concern with the termination of addiction to an acceptance of addiction. Increased attention was given to the improvement of the social and medical conditions of addiction. Drug-assistance agencies relied heavily on methadone-maintenance programs. The belief was that methadone, in conjunction with social work and rehabilitation programs, would enable drug users to lead more normal lives.

By the late 1980s, city officials agreed that Rotterdam had a sufficient number of drug-related services. There was a consensus that the emphasis should shift in the direction of maximizing the efficiency of the existing circuit of services.

In order to administer and coordinate the methadone programs, the Rotterdam Drug Information System (RODIS) was established in 1988. The city no longer attempted to develop assistance programs specifically designed for minority groups (i.e., Surinamese users). The working assumption was that these groups made sufficient use of existing social service programs and that they were no longer at a disadvantage compared to autochthonous users with regard to access to assistance and treatment. There remained one minority group, however, which still appeared to be virtually beyond the reach of the existing network of services; the users from Morocco. Policy makers decided that the position of the Moroccan addicts would get extra attention within the existing constellation of services, without establishing separate programs for this particular group.

3. Background and origins of the Rotterdam Drug-Related Crime Project

The Rotterdam Drug-Related Crime Project was a local pilot project in the context of the administrative prevention of criminality. In a way the Rotterdam project was an outcome of the social policy plan of the 1983 Government Commission on Petty Criminality (also referred to as the Commission Roethof). The concept of administrative prevention followed from the Commission's conclusion that the sharp increase in criminality was probably related to post World War II developments such as the increased freedom of movement, urbanization, increased anonymity, de-pillarization, decreased importance of traditional authority relationships, and increased prosperity. The Commission listed several additional criminogenic factors: unemployment; alcohol and drug use; decreased personal supervision in many public or semi-public areas, such as department stores, train stations, public transportation, parking
garages, apartment buildings. Schools exerted less control over the adolescent population, as demonstrated by an increase in truancy and the increased tendency to cancel classes. The Commission noted that social control had lessened in conjunction with a decrease of functional supervision. To complicate things further, Dutch society witnessed a transition from traditional family life – where parents imposed strict norms on their children – to negotiation-based families – where norms are established in mutual interaction. This shift placed a significant and often unrealistic demand on the ability of youth to exert self-control. All too frequently, educators and parents failed to clearly establish normative boundaries and to provide positive examples.

The 1985 government policy document, “Society and Criminality” referred to the work of the Commission Roethof for the prevention of frequently occurring “petty” crime. The policy plan specified integration and supervision as the core elements of the required prevention strategy for frequently occurring petty crime.

At the same time it stressed the importance of administrative prevention policy instead of police-based preventive measures. Thus Society and Criminality distinguished the following three main components:

- Strengthening the social bonds (family, school, work and leisure) of the young.
- Expanding functional supervision of potential law-breakers by security guards, store personnel, and for instance athletic coaches.
- Designing the material environment in such a manner that supervision is facilitated and criminality is inhibited.

The government document emphasized that alleviating petty criminality required a certain degree of decentralization and local government bodies and social organizations took on tasks which were formerly the domain of the national government. In 1985, administrative prevention was still a fairly novel policy concept and the government felt that a certain amount of experimentation was necessary to establish its utility. Initiatives for such experiments were expected to come primarily from local administrations. For this purpose, the national budget provided 45 million guilders to stimulate local pilot projects. In 1987, the Rotterdam Drug-Related Crime Project was funded as one of the local pilot projects.

The main objective of the project was to deal with the nuisance, public order and crime problems, associated with drug use. The project was also intended to convince local citizens that the city was doing something about the problem of hard drugs. The Rotterdam DRC Project consisted of four smaller projects. First, there was a research component which studied the incidence and seriousness of deviant drug addiction in Rot-
terdam. This research would provide the necessary baseline for further local drug policy actions. Second, the DRC Work Project attempted to find a way of breaking the vicious circle of social decline connected to deviant drug addiction. For a small experimental group legal procedures were adapted to allow better opportunities for re-employment and further re-socialization. Third, increased supervision and security measures were installed to prevent thefts from cars in parking garages. Finally, a shelter for drug addicts was placed next to the Central Station in order to decrease the visual nuisance associated with the concentration of drug addicts near the train station. The DRC Project was completed within two years (1988 and 1989). The four project components will be discussed further in the next sections.

4. Research component of the Rotterdam Drug-Related Crime Project: The current situation on hard drug use in Rotterdam

The first extensive drug study in Rotterdam was primarily intended to provide information to City Hall, the Police, the Prosecutor's Office and other agencies dealing with drug use and its related problems. The research documents the dispersion of drug use and drug dealing in the city; provides a typology of Rotterdam drug users; and speculates about future developments.15

In this study quantitative and qualitative methods of social-scientific research were combined. Several key informants (i.e. police officers, drug and youth social workers, street-corner workers) were interviewed about the local hard drug situation. On the basis of this information Rotterdam was divided into several districts, each with their own characteristic features. This provided insight into how to obtain the best possible sample of drug users within each district. Most respondents were identified by using the technique of snowball sampling. Some of the in-depth interviews were conducted by drug aid agencies and drug dealers. Furthermore, participant observation was used: two researchers worked for a period of time in the portable cabin (designed to function as a shelter for drug users) next to the Central Station; several meeting places of drug users were frequently visited (i.e., the St. Paulus Church, the homes of dealers); and some addicts were visited in their own homes. The estimation of the extent of heroin use and the number of heroin users was based on different calculation techniques like the nomination technique. Use has been made, for example, of figures from drug care agencies and police files. Finally, in order to obtain a general notion of the amount of crime committed by drug users, police files were analyzed.
4.1 Dispersion of drug use and drug dealing in Rotterdam

The study (conducted in 1988) suggests that heroin use is dispersed over the entire city of Rotterdam. Of course, there are a few locations in the city where use and dealing in hard drugs is more prevalent than in other areas. For example, in the immediate proximity of the Central Station (CS) is a so-called “street scene”, which consists of about 250 hard drug users who hang out or buy drugs. This group is quite diverse with respect to drug use: the majority are opiate-addicted poly-drug users who also use a combination of cannabis, alcohol, cocaine and sleeping pills and/or tranquilizers. An estimated 500 users come to the CS on a regular basis (on average once a week) to sell methadone or to buy drugs. Remarkable is the relatively large proportion of Moroccans and Surinamese hanging out in the Central Station area. There is a rather intensive trade in methadone and in sleeping pills and tranquilizers, particularly Rohypnol and Valium. Heroin and cocaine dealing takes place primarily inside buildings near the CS. The Central Station drug scene is the most visible and disquieting part of the Rotterdam drug problem.

In the lower-class residential district of West Rotterdam, drug dealing and use are concentrated in four neighborhoods. A fairly large number of Surinamese are part of the street scene in this area. These neighborhoods have a significant number of “deal houses”. It is estimated that about 700 drug addicts live here. In the district of North Rotterdam, the drug problem is concentrated in four other neighborhoods. This region does not have a real “street scene”; dealing and using mostly occur inside private dwellings. About 600 hard drug users live in this area. Roughly the same situation exists in the South Rotterdam district. However, in this last district drug addiction is more scattered among a fairly large number of small, closely knit groups of individuals. It is estimated that approximately 700 hard drug users live in this part of the city.

4.2 Typology of hard drug users

Using the dimension of drug use/criminality, three categories of opiate users were empirically distinguished in Rotterdam.16

4.2.1 Non-criminal users

These users did not commit any crimes before their addiction, nor did they get involved in crime while they were addicted. Less than 10% of drug users belonged to this crime-free group. Interestingly, this category
did not include any Dutchmen. The socio-economic position of the users’ family was typically good. Few had completed their education. For most of the users in this group, the motives for initiating heroin use were either boyfriend troubles (for the females) or the difficult adjustment to Western society (for the non-Dutch users). About half of this group indicated less heroin use and a more regular and relaxed life during periods of methadone treatment. Nearly all respondents in this group received some form of public assistance sufficient to support their (moderate) heroin use.

4.2.2 Drug delinquents

This category includes users who developed a criminal pattern of illegal and semi-legal activities after they initiated hard drug use. Approximately half of the users fit this category. The socio-economic background of the parents typically varied between unskilled laborer to middle class. It appears that as much as two-thirds of the users in this group had a rather unhappy childhood, for example, because of alcohol problems of one or both parents. Associating with (older) friends who were either already using or experimenting with different drugs was the reason for first involvement with drugs for half of the respondents in this group. Approximately half of these users indicated that their lives were much more relaxed and their involvement in drug-related property crime virtually non-existent during periods of involvement with methadone programs. The frequency of illegal and semi-legal activities depended strongly on the extent of heroin use. All of the respondents in this group had been involved with the police during their addiction. Approximately half of the users in this group were married or lived with a partner, who was usually an addict. Two-fifths of this group had one or more children; however, only the two respondents with a non-using partner raised their child(ren) themselves.

4.2.3 Original criminal drug users

This category includes users who committed crimes both prior to and during their drug use. Their drug use was an extension of an already-developed criminal lifestyle. About one-third belonged to this category, which consisted primarily of autochthonous Dutch people. The socio-economic position of the parents varied from unskilled workers to (lower) middle class. Nearly half of the respondents spent the largest part of their youth in youth homes. More than half were habitual truants and
many of them first became involved in criminal behavior while truant. Only very few had no contact with the police prior to heroin use. Over one-third had been detained at least once prior to heroin use. Initiation of involvement in heroin use was consistent with a criminal lifestyle and environment. For over half of this group, the use of methadone produced positive results allowing them to live a more quiet and normal life. The extent of drug use was largely determined by the amount of illegal income; the causal link between drug use and income for this group of offenders is thus exactly the reverse of the drug use/income link for drug offenders. The large majority had received one or more prison sentences. Three-quarters of the users committed violent crimes. Almost one-third of the respondents lived with a partner or was married. One-third had one or more children. Again, only those users who lived with a non-using partner raised their own children.

4.3 Recent increase in hard drug use

The study further suggests that an increase in hard drug use in Rotterdam may be expected to come from the following categories (not included in the previous typology):

- Juvenile delinquents: They become involved with drugs because they associate with (juvenile) delinquent peers. Prior to their opiate use, they have committed all types of crimes. Once they start using, their criminal activity accelerates significantly.

- Moroccans: For most of the group of Moroccans, the marginalization process began in their homeland. For a variety of reasons, they did not complete their education there and they frequently had family problems. After arrival in the Netherlands, their social disadvantage only increased, primarily because they speak very little or no Dutch. In the Netherlands, the Moroccan marginalization process is speeded up because they lack the knowledge and competence to take advantage of the opportunities offered by the different social agencies. Furthermore, as a rule, the re-unification of the family in the Netherlands causes additional problems. Young Moroccans frequently have problems with their father. In a few cases, this results in family conflicts of such magnitude that the youth runs away from home prior to his or her introduction to hard drugs. In short, at the time of their first heroin use, most of these respondents already find themselves in a problematic social situation. When their parents find out about the drug use, serious conflicts usually result. The amount of criminality varies considerably. Prior to first heroin use, Moroccan youths are relatively unin-
volved in illegal activities. Following the onset of heroin use, however, about half of this group violates the law on a regular basis.

To conclude this section, a few remarks about cocaine use are necessary. It seems that cocaine use among youths is on the increase. The research suggests that, outside the circles of opiate addicts, there appears to be a category of youths who heavily use soft drugs, drink alcohol, experiment with cocaine or even use cocaine on a regular basis. Cocaine use takes place primarily at discos and youth centers and other places where youths regularly meet.

5. The other three components of the DRC Project

In addition to the provision of information about the nature and extent of hard drug use, the DRC Project developed some experimental measures to remedy drug-related problems. While trying to reduce drug-related problems, the DRC Project also aimed at improving the social position of criminal drug users by employing an alternative criminal justice approach. A program was initiated to introduce incarcerated drug users to a legitimate job. This project was referred to as the DRC Work Project.

In order to alleviate drug-related crime and public order problems a project was initiated to improve the security of parking garages, which are very vulnerable to criminality: the Functional Surveillance Parking Garage Project. Also, an already existing drop-in shelter for drug users in and around the Central Station was incorporated as part of the Drug-related Crime Project: the Central Station Project.

In addition to the desire to do something about drug-related crime, the DRC Project had another objective: to encourage the cooperation between the various agencies involved in working with drug use and its problems. Over the last few years, an awareness has developed that the only way to reduce nuisance problems caused by drugs is through joint efforts.

National government is very supportive of this notion of teamwork. It should be noted that while the inter-organizational cooperation was of primary importance in the DRC Project, it was also the source of most of its problems. 17

5.1 The DRC Work Project

In Rotterdam there was a sense of dissatisfaction with the typical criminal justice approach to drug-related crime. Incarcerated addicts usually do not kick their habit when detained; upon release from custody they
often go straight to the dealer and are forced to fund their drug use by criminal means. The DRC Work Project was conceived in an attempt to break this vicious circle. By means of a getting-used-to-work project, an alternative was created for a small number of users. The goal was to motivate the drug users to adopt a socially better integrated lifestyle, without criminality and drug use. The experiment consisted of several stages; participation in the labor market was one of its central objectives. This project was considered the showpiece of the DRC Project, absorbing most of the efforts and finances. It represents a rather unique example of cooperation between law enforcement, city government, rehabilitation, and drug-assistance agencies.

The foundations of the work project were: (1) drug use was not allowed (the exception being a maintenance dose of methadone); (2) in addition to work and restoration of a daily routine, there was room for education and training; (3) if a participant did not follow the rules, he/she would be incarcerated once again. The project was meant for incarcerated drug users in the Rotterdam House of Detention who had been sentenced to an unconditional prison sentence of between five months (minimum) to 12 months (maximum). The DRC Work Project consisted originally of three phases:

1. A residential stage. For about six weeks, the clients sailed on an inland vessel. This arrangement was devised as a transition phase between a closed system (House of Detention) and an open system (society).
2. A training stage. This stage consisted of a stay of approximately three months in a training center to get used to a normal daily routine.
3. A work stage. The clients participated for about 18 months in different work projects, thereby increasing their chances on the labor market.

5.1.1 Selection

Several organizations cooperated in the selection of participants: the Rotterdam House of Detention, the District Attorney and the Courts, the Rehabilitation Division of the Consultation Office for Alcohol and Drugs, and the leaders of the project. In 1988, the Rotterdam jail agreed to participate only with inmates from the drug-free wing (D wing) of the jail\(^8\). As a result of this restriction, only 22 offenders were recruited for the project, instead of the 40 originally planned for the first year of implementation (1988). Selection was continued in 1989 on a less restrictive basis. Detainees from other than the drug-free wings were included. The new participants in the Work Project had generally been sentenced to a lesser jail sentence of between three and six months, instead of the
sentence of between six and 12 months for the old participants. For those participants who started in 1989 the residential and training stage was skipped. They started immediately with the work stage. Forty-three participants were selected in 1989.

5.1.2 Work projects

Finding a location and suitable projects was a very time-consuming enterprise. It was not until May 1988 that an old building belonging to the Holland-America Line was found which could serve as the main location. Attracting appropriate projects took even more time. In the fall of 1988 the first work project was initiated: the assemblage of small "sound houses". These are wooden frameworks containing all kinds of noise-making objects, used for music education in schools and hospitals. During 1989 several outdoor projects were taken on, such as the construction and painting of playgrounds and the reinforcement of the foundation of a small Rotterdam island. Some of the participants fixed up the portable cabin for the drop-in shelter for drug users near the Central Station.

Other re-socializing activities included vocational and educational courses. A course on "bureaucratic competence" (i.e., how to deal with organizations, how to write letters, and so on) was one of the most popular activities of the work project. Organizations such as the Municipal Labor Service and the drug team of the Municipal Social Service were utilized to help participants (re-)enter the regular labor market.

5.1.3 Enforcing the rules

Rule violation, usually illegal hard drug use, was the main reason for termination of the program in the first year (1988). However, during its second year of operation (1989), departure from the program was primarily on the participants’ own initiative. The drop-out rate was high especially during the first week of the program. The sudden change from prison conditions to the new work-oriented environment, without much time for adjustment, was probably too much of a problem. In 1989, the program coordinators began to adopt more flexible rules. However, at the insistence of the District Attorney and the court, the more stringent rules with regard to drug use soon were re-introduced.
5.1.4 Results

Six of the 22 participants selected in 1988 completed the program; five of them were able to find a job in the labor market. This means that for 27% of the 1988 participants the project was successful. Incidentally, this percentage is significantly higher than that typically obtained in prisons and therapeutic drug treatment centers (with an average success rate of around 10%). Eighteen of the 43 offenders who started the project in 1989 successfully completed the program by early 1990 (a 42% success rate). Five of these 18 program graduates were able to secure employment on completion of the program. The higher success rate in 1989 can be attributed to the fact that the selection in 1989 was less restrictive, as mentioned before, and to the adoption of more flexible rules during some months of 1989.

5.1.5 Organization and cooperation

The project had an advisory commission consisting of representatives of all participating organizations and the project manager, who was in charge of the daily management of the project. At times, cooperation left something to be desired. This was partly the result of the project's complexity, where the activities of a diversity of agencies had to be coordinated. Sometimes the most unanticipated complications occurred during the selection process of the project participants. Inter-agency problems resulted in the initial selection of a smaller number of participants than was originally intended. To some extent the participating organizations had divergent views on how to deal with drug use and the problems associated with drug use. For example, drug assistance and drug treatment organizations aim at the improvement of the health of the individual (ex-) user, while criminal justice personnel are primarily interested in enforcing the law. It is not surprising that these divergent positions at times result in conflicting assessments of certain situations. This, for instance, led to different ways of compiling information on the participants, disputes over the desirability of supplying methadone, and a late discussion on sanctions on drug-using participants.

5.2 Functional surveillance parking garage

In the two remaining DRC Projects, the notion of "surveillance", a concept re-introduced by the Commission Roethof, plays a crucial role, albeit in two different ways. While the preventive effect of functional
surveillance was particularly important in the Functional Surveillance Parking Garage Project, in the Central Station Project informal control was much more important. In the first project the emphasis was on simple technical “target hardening”. The latter project, however, dealt with the much more complicated issue of containing the undesirable social behavior of a group of highly problematic street addicts within certain limits.

The municipal parking garage in question, with a capacity of more than 600 cars, is located in the city center (Sint Jacobsplaats). Because of its many entrances and exits, and due to the absence of any form of surveillance, the garage was very vulnerable to crime. According to 1987 data collected by the municipal police, breaking into cars occurred about twice a week. As the garage’s lack of security was well known to the public, its level of occupancy was fairly low (64% in 1987). To counter the problems of theft and visual nuisance associated with drug users, several changes were made in the parking garage. Guards were employed during the most vulnerable hours (especially in the evening, at night and during weekends). Only one entrance and one exit were made available. A closed-circuit monitoring system was installed consisting of 12 cameras and monitors. The garage was (partially) repainted and the lighting was improved.

According to police records the results of this project are very encouraging: the 1987 number of 99 thefts from cars decreased between April and December 1988 to 12, and in 1989 only two thefts from cars were reported to the police. In addition, the number of thefts from cars in the six neighboring streets decreased from 286 in 1987 to 99 in 1989. (The total volume of thefts from cars throughout Rotterdam did not decrease during this period.) A 1989 evaluation study indicated that feelings of insecurity were strongly reduced among the users of the garage. The occupancy figures also increased. In 1987 about 50% of the places were reserved for parkers with a long-term permit; in 1988, 80% and in 1989, 90%. The total occupancy rates also increased. The project may be seen as one of the rare and happy occasions where all parties benefit from establishing functional supervision. The garage became a safer and more attractive place for car owners, supervision could largely be financed by higher occupancy rates and, last but not least, job opportunities were created for the unemployed.

5.3 Project Central Station

As in many other cities, Rotterdam’s central railway station is a popular hang-out for various kinds of marginal groups in the population. Ad-
dicted hard drug users form no exception to this rule. For some years the entrance hall to the railway station, the area just in front of the railway station, and the corridors leading to the metro functioned as one of the most important meeting and coping areas for the Rotterdam drug scene. Due to the rather isolated setting of this public transport complex the drug scene was highly conspicuous. Not unexpectedly, the (growing) presence of this problematic subculture led to more and more complaints from travellers and consequently to growing concern by the city administration regarding the crime and public order situation in this critical city area. That this concern was warranted is borne out by police figures on public order and crime problems in this area. According to the police the criminality has been slightly reduced in and around the Central Station but not, however, the nuisance caused by marginal groups.

As an attempted remedy (but certainly no cure) for this inevitable city problem, a shelter for drug addicts was established at the east side of the Central Station. It consisted of a portable cabin which provided drug addicts (who, at the same time, are often alcoholics, homeless persons or ex-psychiatric patients) with an opportunity to sit down, have coffee or tea and spend some time together. The shelter was opened from two p.m. to eight p.m., from Monday to Saturday. All kinds of games could be played and some activities, such as drawing and painting, were organized. It was also possible to exchange dirty needles for clean ones. From the preventive point of view, this arrangement was meant to supervise and regulate the social behavior of this group. The project used two part-time professionals and about ten volunteers. In the portable cabin, better known as “Perron Nul” (“Platform Zero”), several house rules existed, of which, as the most important rule, the prohibition of the use and dealing in drugs or alcohol and the selling or buying of goods. Furthermore, the police were always allowed to visit the shelter. The establishment of “Platform Zero” was supported by the municipal police and by the St. Paulus Church, one of the main social assistance organizations caring for city drop-outs in Rotterdam. This parish has, under the charismatic leadership of Reverend Visser, acquired a national reputation for opening its doors to illegal immigrants, junkies and other down and out city dwellers. Welfare workers from this church organization participated in the daily management of Platform Zero. Support for this project has not, however, been unequivocal. Many railway travellers, people working in offices in the vicinity of the railway station, and occasionally the local mass media remained critical. The Dutch Railways were rather ambivalent about the shelter project. They expressed concern that Platform Zero would attract more addicts than would normally be present.
In the early stages of the project, the problems which were mainly encountered were with those people who work in the direct proximity of Platform Zero, such as cab drivers and employees of the Station's Currency Exchange Office. Due to the intervention of the municipal police and workers from the St. Paulus Church there were only a few incidents. The visitors consisted mainly of young addicts of ethnic minority groups, Surinamese, Antilleans and Moroccans. In later days people from other problematic marginal groups, such as the homeless and ex-psychiatric patients, began to frequent Platform Zero in increasing numbers. The professional employees were mainly involved with the strenuous task of the daily management of the shelter. Recruiting and coaching volunteers was another important element of their task. In 1989, the portable cabin was remodelled, the rest room was closed and volunteers were no longer recruited from among the visitors. All of these measures contributed to a more favorable atmosphere, less aggression and fewer violations of house rules. A local work group was established which formulated proposals to improve the Central Station and its surroundings. Since 1990, the Central Station Project has been funded in full by local government.

Until this day the shelter is still in existence, despite the occasional but inevitable crises, such as its co-existence with the outside world, the continuous frictions regarding the enforcement of house rules, the heterogeneity of its visitors, the growth in the number of its visitors, and the problems with recruitment of capable volunteers. In 1992, the shelter was made an integral part of a comprehensive plan for the whole area. It was moved to another site in the vicinity of the railway station, next to the police post, which serves as a base for surveillance of the area.

6. Conclusions

The main aim of the DRC Project was the prevention of drug-related crime and public order problems through several smaller projects in which city administration, District Attorney's office, police, and drug-assistance agencies cooperated. Although the project has not accomplished all its objectives, the project has contributed substantially to the reduction of drug-related nuisance. To summarize, the most significant positive effects of the project are the following:

1. Increased insight into opiate use: The research component has provided valuable information regarding the extent and nature of opiate use in Rotterdam. Attention has been focused on the extent of criminality by drug users, drug use amongst Moroccans and the danger of drug use by youths. In addition, the growing use of cocaine in Rotter-
dam has been recognized.

2. Actual reduction of nuisance: Improving the security ("target hardening") of the parking garage Jacobsplaats resulted in the most visible reduction of nuisance: the number of larcenies from cars was drastically reduced. The occupancy rate of the garage increased and the public appears to feel more relaxed than before the start of the experiment. Project Central Station has contributed, in all probability, to keeping the situation around the Central Station manageable. Finally, the DRC Work Project has provided some ex-addicts with the opportunity to break out of the vicious circle of drug use, criminality, detention, using, and so on. This project has acquired a more permanent organizational and financial footing during the most recent years.

3. Symbolic function: In addition to the actual reduction of drug-related nuisance, the DRC Project also served another function: it showed the public that policy makers are seriously interested in doing something about drug-related criminality. Of course, this symbolic function only keeps its value in the long run if it is accompanied by an actual decrease in nuisance resulting from drugs: a ritual alone does not work (anymore).

4. Improved cooperation between agencies: Finally the project has promoted cooperation between several agencies at the level of (drug) policy. Presently there is, for instance, a more concerted effort to make the Central Station and its surroundings more livable and several organizations are attempting to improve the situation for the Moroccans. In its inventory of prevention and intervention channels, the final DRC Project report argues in favor of increased field work, keeping drug users out of the criminal justice circuit as long as possible, and increasing inter-agency cooperation. The main contribution of the DRC Project has possibly been the role it has played as a pioneer in interorganizational coordination of drug-related services.

Endnotes

1. The authors thank drs. P.M. Koedijk and G.A.P. Spierings for their comments on an earlier draft of this chapter.
3. Young Moroccan (North-African) males, who either migrated themselves or who are the children of recently migrated parents, have become a new marginal minority group in some West European countries.
9. In the 60s and 70s, in addition to workers from Turkey, large numbers of Moroccans were hired for the Dutch labor market. During that time, there was a shortage of workers for low-paid and manual work. They were primarily people from the Mediterranean area who came to the Netherlands for this type of manual labor. It is the children (born in the Netherlands or in their home country) of these workers who sometimes have drug problems.
10. "Administrative" crime prevention refers to control activities not primarily based on law-enforcement activities. For more information, see articles in Justitiële Verkenningen 13 (August), 1987.
12. Until the Second World War, Dutch society could be described as a "pillarized" society. A pillarized society is comprised of groups (pillars) that (1) each have their own politically relevant philosophy, religion, or ideology; (2) have little mutual contact; (3) are internally tightly organized. This separation was evident in all facets of social life (social, political, religious, educational, media). After World War II, this was radically changed; Dutch society was no longer characterized by these pillars. The process leading up to the abolishment of the pillarized society is called "de-pillarization". De-pillarization implies de-confessionalization (i.e., the weakening of religion as such and as a factor in politics), de-ideologization, increasing social conication and contacts, and the loosening of ties between the different pillar organizations (political parties, interest groups, mass media, and so on). For a more detailed description, see Lijphart, A.: The Politics of Accommodation; Pluralism and Democracy in the Netherlands. Berkeley: University of California Press, 1975.
14. We may distinguish three types of nuisance: (a) Criminal nuisance: This is experienced by victims of a crime committed by drug users, for example, theft, pick pocketing, burglary and robbery. (b) Public order nuisance: This refers to the nuisance directly resulting from drug dealing and drug use. It disturbs the physical conditions of every day life. For example, interrupted sleep because of activities in a neighboring house where drug dealing takes place, or used needles on the street. (c) Visual nuisance: This refers to observations of norm-violating behavior which may instill feelings of unsafety.
18. The D wing has about 30 cells for inmates who consciously have chosen to live in a section of the institution where drug use is not present, and where urine tests are used to check for drug use. The inmates of this wing are subdivided into three categories: recent arrivals (group 3); those who want to be involved in therapy (group 4); and those who do not want to be involved in therapy, but who do want to remain drug-free (group 5). The Consultation Bureau for Alcohol and Drugs (CAD) is in charge of the treatment provided in this wing.

PART III

INTERNATIONAL AND SUPRANATIONAL DIMENSIONS
XI. DRUG PREVENTION IN THE NETHERLANDS: A LOW-KEY APPROACH

Ineke Haen Marshall and Chris E. Marshall

1. Introduction

This chapter describes Dutch policies aimed at the prevention of substance use and the reduction of harm resulting from use. We examine three components of prevention policy: (1) the philosophy of drug prevention as expressed by Dutch policy makers and drug experts; (2) the major types of drug prevention programs; and (3) the organizational structure of drug prevention. In the last section of the chapter, we briefly contrast the Dutch approach to drug prevention and education to that of the Americans. Since these policies are so sharply different, this contrast serves well to illuminate important aspects of each.

2. Philosophical foundation of Dutch drug prevention

The basic tenets of Dutch drug policy have extensively been discussed in earlier chapters. It is obvious that drug prevention efforts reflect the philosophical assumptions of drug policy in general. A complication arises when examining drug prevention policy: there is not one, single Dutch drug prevention policy carried out everywhere and every time consistently and uniformly (Van Amerongen 1987:91). However, it is possible to identify five key tenets guiding virtually all Dutch drug prevention programs. (The following discussion of the philosophical foundation of Dutch drug policy draws from Marshall, Anjewierden and Van Atteveld 1990.)

2.1 Tenet 1: Drug use is primarily a public health problem

The government commission instrumental in designing the basic outlines of current Dutch drug policy stated in its 1972 report that the goal of the government’s drug policy should be “.... to contribute to the prevention of drug use as a component of the general public welfare approach” (Baan 1972:66). This statement continues to portray the basic philosophy of Dutch drug policy and suggests two important things: drug

The authors thank Wim Buisman for his expert review and helpful suggestions.
use is a public health problem and drug use cannot be effectively controlled by criminal justice measures. In a public health model of drug use, prevention is of primary importance and is best served by education and more information. A Dutch drug expert comments, "Learning how to cope with risk-involving behavior (including alcohol and tobacco use) and how to be responsible for one's behavior and choices, is better than simply deterring and warning people" (Engelsman 1988:15).

Since use is viewed as a health problem, the Opium Act assigns the main responsibility for drug policy to the Minister of Welfare, Health, and Cultural Affairs (WHC), and prevention is exclusively the responsibility of the Ministry of Welfare. The Opium Act regards the contribution of the Minister of Justice as complementary and as focused primarily on combatting (international) drug trafficking (Reitsma 1989). Furthermore, a public health approach to drugs implies that education about illegal drug use should be integrated into more general education issues of developing a healthy lifestyle and making healthy choices (Buisman 1988:17; Becherer and Zwinderman 1990:111).

Selective attention to the issue of drugs, particularly in education would result in a credibility gap because youth is very sensitive to the double standard of adults: "your drugs are killers, but ours are pleasures". Therefore, specialized organizations for drug education do not receive government funding. The premise of drug prevention policy is that education about drug use must not be separated from education about other forms of risky behavior (e.g., alcohol and tobacco use and sexual practices) (Engelsman 1992:146).

Dutch drug prevention education does not consider heroin and cocaine as separate, "dangerous" drugs; rather, alcohol and psychopharmaceuticals are also counted as hard drugs along with tobacco in a comprehensive approach to drug prevention (Van Amerongen 1987:91-92; for examples of this approach see pamphlets distributed by Stichting Nederlandse Onderwijs Televisie 1974; Stichting Preventieprojekt Drugs 1986; CAD Haarlem 1984). A typical example of this approach is a comic strip for youth and their parents about "risky behavior and forms of addiction", where in addition to hard drug use also alcohol, tobacco, eating disorders, and addiction to television are discussed (Geene and Zweverink 1987).

2.2 Tenet 2: Drug use should be normalized and demythologized

In 1985, "normalization" became the key concept of governmental drug policy. In that year the Interministerial Steering Group on Alcohol
and Drug Policy (ISAD) published a memorandum titled Drug Policy in Motion: Towards a Normalization of the Drug Problem. The concept of normalization entails a gradual process of controlled integration of the drug phenomenon into society. The 1985 report makes a set of recommendations for a “heroin policy aimed at socially integrated use” (ISAD 1985:32). While integration does not mean acceptance of drug use, the recommendation that drug use should be “shorn of its sensational and emotional overtones” (Engelsman 1988:15) is emphatic in this report. In order to accomplish this, one of the things needed is the “demythologization of heroin and heroin users through a more carefully balanced transmission of information” (ISAD 1985:32). Thus, ISAD endorsed the importance of a differentiated and rational education of the drug phenomenon.

Normalization requires great public interest in the drug problem: it is only through this interest that the desirable degree of acceptance and normalization can be attained. Paradoxically, a substantial part of the drug problem is the overwhelming public and media attention that is paid to the “drug problem”. Public interest should not be roused by dramatic campaigns because “dramatization does not draw closer, but results in expulsion [of the drug user]” (Van Amerongen 1987:92). The ISAD report pointed out that, although most Dutch people have not been directly confronted with drug use, they do have an opinion about it – an opinion shaped mostly by the media which tend to focus mainly on “deviant” cases. In this manner, opinions and myths develop about drugs which influence ordinary social institutions and contribute to the processes of social exclusion. An early government report (Commissie Hulsman 1971) already stressed the importance of providing the public with correct information and preventing selective attention to the drug phenomenon. This report noted that high-level government officials play an important role as opinion-leaders. It is essential, in the view of this report, that they are continuously supplied with objective and complete information. “It should be possible to clarify misunderstood statements” (Commissie Hulsman 1971:56).

Current drug policy is explicitly aimed towards trying to remove the exciting, the dramatic, and the deviant images of drug use and users; instead, it emphasizes that the drug user is, first and foremost, a normal citizen who has to be responsible for the consequences of his actions. Consequently, drug prevention efforts try to de-emphasize the “differentness” of the drug user; they aim to portray drug use as a not very dramatic, exciting event. The drug phenomenon should remain outside the realm of the emotional, sensational, and negative atmosphere (Engelsman
Drug prevention programs are, therefore, characterized by a matter-of-factness about drugs and its effects; they present information in a businesslike, objective fashion. Dutch experts commonly denounce the often emotional language used by the American mass media and stress that Dutch drug prevention does not want to use such language: "In our present-day linguistic usage terms like narcotics brigade, drug team and war on drugs are used much too easily" (Van Amerongen 1987:92). One should avoid these terms because they evoke fear and emphasize the negative aspects of drug use (Van Amerongen 1987:92-93). It is important, therefore, to have ".... no horror stories, no threats, no strong emphasis on dangers of using substances because it is supposed that this will lead to more experiments with drugs" (Buisman 1988:17).

Normalization does not imply condoning drug use; indeed, drug use should be discouraged, but preferably through measures other than the criminalization of the user. Normalization represents some type of compromise between decriminalization and legalization on the one hand, and a repressive "war on drugs" on the other (Engelsman 1992:144). Normalization suggests that drug use, although not viewed as "normal" or acceptable, has become an integral part of society - a "normal" social problem, one among many. Engelsman (1992:144) draws a parallel with alcohol: it continues to exist, but it has been reduced from a collectively experienced, social problem to an individual problem. A similar result may be achieved through the demystification of drug use.

One of the results of the normalization approach and the tolerant approach to drug use and addiction is that people in the Netherlands are quite accustomed to the sight of disheveled looking addicts walking the streets, apparently oblivious of police presence. It may be argued that this highly visible addict population, in some fashion, conveys a message to the public more powerful than any educational program. Exactly what this message is remains an open question: is it that using drugs is not very glamorous, or that drugs, even though illegal, may be used without any fear of formal police intervention?

2.3 Tener 3: Major goal of drug policy is harm reduction

In its 1985 report, the ISAD stated that there was ambiguity concerning the objective of Dutch prevention policy: should the objective be to prevent the use of drugs, or to prevent problems with use (p 11)? Consistent with the notion of normalization, it is now generally accepted that the second objective should be the guiding principle:
"... The general aim of drug policy should be the reduction of drug problems. In that context, preventive policy has as its aim to prevent the emergence of drug problems among people or to prevent that already existing problems get worse...." (ISAD 1985:38)

It is not expected that it will be possible to stop all people from using or trying illegal drugs; rather, the explicit aim is to minimize the risks associated with drug use including those risks to the user, the environment, and society. (See, for example, Van der Stel 1992:127.) Consequently, the emphasis of prevention programs is on the need to make choices, and to make these choices as a well-informed person. Importantly, it is not implied that the only right choice is never to try any illegal drugs; education programs allow for the fact that some people will make the choice to use particular drugs. Prevention programs aim to provide the (potential) user with clear and useful information that allows the person to use or experiment (if he/she chooses to do so) with drugs in a manner that minimizes the risks to themselves and their environment.

Buisman and Geirnaert (1992:78) represent the prevalent Dutch view that promoting absolute abstinence ignores the reality of the "drug taking society" in which we live; a more realistic policy goal is responsible drug use where an individual makes a personal and socially responsible choice with respect to use, varying from non-use, delay of use, to use under certain conditions. The Dutch have generally accepted this policy goal with regard to soft drugs and XTC.

A good example of the harm reduction emphasis is a recent pamphlet on XTC, published by the Institute for Alcohol and Drug Prevention Amsterdam (IADA 1991). The drug XTC (also known as "Ecstasy"), is since 1988 on the list of illegal drugs. In practice, this means that the production of and trade in this product are illegal. The five-page pamphlet describes the chemical properties of the drugs, the effects (physical, psychological), and the risks. The pamphlet provides tips for safer use: "If you don’t want to run any risks, do not use XTC. XTC remains a drug you must be careful with. If you decide you want to use it anyhow, it is good to keep the following in mind...." Then follows a list of recommendations to reduce risks associated with XTC use: ".... XTC is illegal. Therefore, you are never sure what it is you are buying. If you buy XTC you may prevent unwelcome surprises by not buying it on the streets or in a disco, ask other users for "good" pills and a reliable dealer, try the pill you bought by first taking only one-quarter or half a pill.... Like any other drug, the effect of XTC is partly determined by the conditions and mood of the user and the setting in which you use it. Make sure that you feel well physically and mentally and that you are around the right people..."
in a comfortable atmosphere.... Use selectively (not more than one monthly).... Don’t combine it with alcohol, medicine, or other drugs.... Carry condoms with you....” (IADA 1991).

One implication of the harm reduction emphasis for prevention programs is that they tend to shy away from the absolutely-never-under-any-condition approach. In a recent publication intended for users who experience problems with drug use, it is made clear that, for some users, complete abstinence is an unrealistic or undesirable choice; instead, the pamphlet stresses the need to realistically and rationally compare the costs and benefits of complete abstinence. It suggests that for some users “controlled use” may be the preferred approach: “If you can reduce your dependency to such a degree that you can live with it reasonably, that is also progress” (Posma 1991:19). This particular pamphlet is a good example of the practical implementation of the normalization approach; it attempts to show how to integrate drug use in a normal life pattern in such a way as to minimize any harmful effect.

2.4 Tenet 4: Soft drugs and hard drugs are two different things

Dutch drug policy aims to keep users of soft drugs (i.e., drugs with “acceptable risks” such as hashish and marihuana) separate from users of hard drugs (i.e., drugs with “unacceptable risks” such as heroin, cocaine, LSD, amphetamines). This policy is reflected in the de facto decriminalization of trading and possessing small quantities of marihuana and tolerating the sale of soft drugs in “coffee shops”. The policy with regard to the pseudo-legal retail trade aims to prevent the blending of hard and soft drug markets.

Consistent with this policy, drug prevention efforts stress that the risks of using soft drugs are lower and more acceptable than the risks of using hard drugs. Rather than arguing that not taking any drugs is the only acceptable alternative, Dutch drug prevention efforts tend to stress the difference between soft drugs and hard drugs, thereby implicitly rejecting the “stepping stone theory” of drug use. Actually, most Dutch experts do not view the occasional use of soft drugs as any kind of problem; consequently, prevention efforts do not place much emphasis on marihuana and hashish. The differentiation between soft and hard drugs appears to have had great preventive utility: today, for most Dutch people there is a qualitative difference between soft and hard drugs - that is a line not to be crossed lightly (cf. Van der Stel 1992:15). This conscious differentiation between soft drugs and hard drugs is reflected in the government’s “message” on heroin and cannabis:
“Heroin - a quickly and intensively addicting substance. Any experimenting must be dissuaded.... Cannabis - a psychotropic substance, and consequently not without risks.... No panic about experimental and functional-recreational usage. Encouragement to cannabis usage is ill-advised” (Van Amerongen 1987:94).

2.5 Tenet 5: Dutch drug policy is pragmatic, not moralizing

Current Dutch drug policy is pragmatic and mainly guided by cost-benefit principles (see Marshall et al. 1990:393). This is not to say that moral considerations have never played an important role in Dutch public policy with regard to mind-altering substances. To the contrary, drug prevention efforts had to break away from strongly moralistic concepts, in which moral theology played a predominant role (Van Amerongen 1987:93). In its early years, drug education was an extension of rather old-fashioned information about alcohol. For a long time, Dutch alcohol information showed a very rigid and threatening character, in which the main lines were drawn by total abstinence (Van Amerongen 1987:93). Paralleling information about alcohol, drug education initially focused on information in combination with warnings and moral remarks. But presently there is support for the notion that young people, knowledgeable young people, who want to experiment should get the latitude to do so and not be thought immoral having made that choice.

Today's drug prevention programs aim to steer away from moralizing practices. For example, Buisman (1988:16) states that there is a consensus among prevention officials that there should be “.... less emphasis on moral aspects, more on individually accountable choice of risky substance and risky habits”. Consistent with the pragmatic philosophy, most drug education efforts are devoid of moralizing messages and value judgements; rather, they stress the need to be able to rationally calculate the “costs” versus the “benefits” of using drugs. In a recent discussion of an American education program (“Skills for Adolescence”), Akveld and Buisman (1992:160) conclude that, although generally speaking this appears to be a solid program, the part concerning drugs reflects the very moralizing American background: “This segment definitely needs further adjustment for the Dutch situation.” (Akveld and Buisman 1992:160)

This non-moralizing stance is a cornerstone of government policy. However, whether this formal policy is always reflected in actual practices, is, of course, another matter. In this context, it is useful to distinguish between official government policy (pragmatic, non-moralizing) and the beliefs of “John Q. Public”. The Dutch public is not necessarily
as tolerant, understanding, and open-minded as formal policy would suggest. The public is tolerant with regard to cannabis; however, there is a fairly widespread disapproval of hard drugs, particularly in the big cities. Thus, as the ideas and values of prevention efforts “trickle down” from government policy makers, scholars, and legislators to individual police officers, school teachers, and health education staff, a substantial part of their non-moralizing character is often lost. It seems only reasonable to expect, then, that value judgements of individual health workers, counselors, teachers, and police officers are inevitably incorporated in the final “messages” transmitted to the audience (see, for example, Van Amerongen 1987:93 for a discussion of moralizing by the police); these value judgements may be closer to the American “drugs are evil” ideology than the Dutch may like to think.

3. Types of prevention programs in the Netherlands

Policies aimed at the demand side of drug use draw heavily from medical (public health) literature, which makes a distinction between primary prevention efforts and secondary prevention efforts (cf. Mulder 1978:98). Primary prevention interventions are those designed to reach individuals before they have developed a specific disorder or disease. Dutch drug policy’s primary objective is minimalization of risk and harm associated with drug use, rather than to prevent any use or experimentation. Therefore, translated into Dutch drug policy terms, primary prevention programs are those designed to reach individuals before they have developed problems with drug use. We may further distinguish between (1) primary prevention efforts aimed at the total population (particularly the young), and (2) primary prevention efforts aimed at high-risk groups.

Secondary prevention interventions are those designed to decrease the number of existing cases with the “disease” in a particular population (Botvin 1990:465). Applied to the Dutch situation, secondary prevention programs are designed to prevent drug abuse problems among (high) risk groups who are not current users, but who are likely to start using or abusing drugs (e.g., immigrants, school dropouts, children of addicted parents, youngsters in residential youth care facilities, unemployed youth), or groups that (already) have adopted a rather high and risky pattern of drug consumption, which could lead to severe drug abuse in the near future (Buisman 1992). The general aim is to decrease the number of users who experience harmful consequences of their use.
3.1 Prevention efforts aimed at total population (mostly youths)

Primary prevention efforts targeted at the total population by means of mass media campaigns are not common in the Netherlands. It is commonly believed that programs aimed at a general audience are unnecessary and not justified in cost-benefit terms. It is also thought that these kinds of programs may cause several unintended negative side effects. Because the main target group of young people at risk is probably no greater than 10% of the total population, experts believe that there are more appropriate prevention methods available to risk groups than the execution of big mass media campaigns (Buisman 1988:22). Although, unlike the English and American situations, there is not much support for high profile mass media campaigns in the Netherlands (Buisman 1988:22), a large mass media drug information campaign was initiated in 1980 by a non-profit group (SIRE) which lasted for more than five years. Akveld and Buisman characterize this campaign as a “low profile” campaign (1992:166). The campaign consisted of advertisements in newspapers and magazines urging frank, open discussion about drugs and to become as well informed as possible. Headlines in the ads included: “Fear is a bad advisor” and “Ignorance does not help”. The readers were invited to cut out a coupon entitling them to a free booklet “What everybody should know about drugs” (Buisman 1988:21-22; also Buisman 1990). A total of more than 500,000 booklets were distributed in this manner. The main targets for this media information campaign were parents, teachers, youth workers, and health professionals. The effect of this campaign was evaluated in 1985, and it was found that mostly well-educated people and people who already were involved in the topic asked for the pamphlet. Mostly the campaign was effective in increasing knowledge and interest in drugs (Van Berkum et al. 1986) (For more information on this campaign, see Buisman and Kok 1983.)

There have been some other small-scale, fairly simple campaigns with as a common denominator that they are informative, slightly cautionary, but not threatening or judgmental (Akveld and Buisman 1992:167). However, after the SIRE campaign, there have only been two other broad-based mass media drug-related education programs. First, in 1986, the Ministry of Welfare, Health and Cultural Affairs initiated a national anti-alcohol campaign with as slogan, “Be honest.... how much do YOU drink....?” (see: Van de Vrie 1988; Zandbergen 1987 for more details). More recently, a comprehensive media campaign was initiated on the HIV virus and AIDS.
The recent media campaigns on AIDS clearly illustrate how the Dutch attempt to avoid negative approaches, included those intended to have emotionally charged shock effects. As compared to American and British campaigns, the Dutch are more explicit in their campaigns and humor is often used to get people's attention (Cohen 1989:15). For example, "I do it with...." posters (showing prominent Dutch public figures) convey the double meaning of having sex using condoms as well as the suggestion that one is about to reveal the identity of one's sex partner. The focus of Dutch media campaigns is "less on what not to do and more on what you can be doing" (Cohen 1989:15).

Perhaps the Dutch approach to drug prevention is best characterized as "low-key". This low-key approach is not only reflected in the relative unimportance of general mass-media anti-drug campaigns, but also in the low priority given to drug education to school-age youth. Buisman, a leading Dutch expert on drug prevention, argues that alcohol and tobacco education should be started in primary schools, at the age of ten (1988:17). These educational efforts should be repeated in the first year of junior high, and at this time cannabis education should be included in the curriculum. In the higher classes of secondary schools, tobacco and cannabis education should be repeated, possibly including other drugs at this time; however, alcohol education at all times should continue to be an integral aspect of the education plan (Buisman 1988:17). Consistent with this advice, there are some examples of broad-based programs integrated in general health education programs, but drug education ".... is far from completely integrated into the regular school curriculum" (Cohen 1989:11). A WHO (World Health Organization) survey of 29 countries with regard to prevention programs for drugs, indicates that school drug education in the Netherlands was merely "incidental" (Smart et al. 1988: Table 2). (It should be noted that this survey was conducted in the early eighties and employed very global and rough measures.) Curriculum education, teacher training, and teacher counseling training for primary and secondary school children are not uniformly incorporated in schools throughout the Netherlands, although more than 60% of the high schools pay attention to drug education during 2 hours a year on the average (Mesters and Buisman 1987).

The National Institute of Alcohol and Drugs (NIAD) has developed the main primary school program at a national level, targeting 11- and 12-year olds. Some of the school-based programs have been evaluated. Included among these is the evaluation of the effect of drug and alcohol education on fifth and sixth graders which shows an increase of knowledge, but no change in attitude (Jessen and Winkel 1989). Also, Becherer
and Zwinderman (1990) found that a drug prevention project in high-
school affected knowledge, but not attitudes about drugs.

A number of Dutch cities run their own local programs, sometimes
adapting the NIAD materials and involving police and addicts (Cohen
1989). Involvement of police in school drug education remains contro-
versial in the Netherlands. Beginning in the 1970s, numerous police of-
icers started to provide drug education to schools. Typically, education
by the police tended to emphasize the sensational tale and the horror-sto-
ries of drug use (Van Harten 1988). Concerned with the possible negative
effect of police involvement in drug education, the Education and Pre-
vention branch of the former FZA (Federation of Institutions for Alcohol
and Drugs, the former government-funded umbrella organization for drug
programs) formally protested against police involvement in drug educa-
tion. Consequently, an agreement was reached in 1984 between the Min-
istry of Justice, the Ministry of the Interior (in charge of local police),
and the Ministry of Welfare, Health and Cultural Affairs to distribute an
order designed to end police involvement in education. For reasons not
entirely clear, this order was never executed and Dutch police continue
to actively participate in drug education. For example, in 1986 the
Amsterdam police initiated a prevention project for 12-year-olds (6th
graders) which involves a confrontation with a drug addict in jail (De
Keijser 1989). In 1988/1989 about 75% of all Amsterdam schools partic-
ipated in this program. In Rotterdam a policeman organizes programs
with primary schools in his area. It includes talks by the police and ad-
dicts. It should be noted that Dutch experts continue to strongly reject
police education as being “counterproductive” (see also Buisman

3.2 Prevention programs targeted at high-risk groups

Most Dutch experts agree that drug prevention efforts are most effi-
cient if focused on specific high-risk target groups, rather than aiming at
a broad-based audience (e.g., media and school programs). Indeed, in the
Netherlands today, the main focus has shifted from primary prevention
to specific (secondary) drug abuse prevention (Buisman 1992:6). From a
cost-benefit analysis, general primary prevention (expensive, with
limited success) is not as useful as a more focused prevention targeted
at high-risk groups where more intense intervention may be planned with
a greater chance of a positive result (Buisman and Geirnaert 1992:79).
Some Dutch prevention programs are aimed at such high-risk target
groups as those already experimenting, which makes it hard to make a
clear distinction between primary prevention programs aimed at high-risk youth and secondary prevention programs. Other high-risk groups are those in youth homes, or those already involved with social service agencies. Buisman (1988, 1992) and Buisman and Van der Stel (1992) list prevention programs aimed at adolescents who have left school, youngsters who go out a lot at night, migrant children, cannabis users, children of addicted parents, as well as hard drug users. In this context, the term “marginalized youth” (randgroepjongeren) is used to refer to youths (16-25 years) who are socially disadvantaged in several ways. It is this category of youths who are at high risk for problematic drug use (Akveld and Buisman 1992:162). The policy objective for these high-risk groups is to prevent premature exclusion from assistance programs, school, community centers, and other significant reference groups and, relatedly, to prevent marginalization and stigmatization (Borghuis 1990:21). Furthermore, the primary goal of these programs is to prevent problematic use or to promote the sensible use of alcohol and drugs (ibid. p 21).

One of the first programs of this kind was the Amsterdam Stichting Preventieproject Drugs which targets high-risk youths between the ages of 12 and 20. Another example of recent preventive work with high-risk youths is the Prevention Alcohol and Drugs (PAD) team in The Hague where youth centers now have permanent prevention workers. This worker makes weekly visits to the center and develops specially adjusted programs for these centers. Program methods vary from distribution of pamphlets and posters, and unstructured conversations about the topic, to showing videos, organizing information evenings, a competition in fixing alcohol-free drinks, and beer tasting contests (including, of course, alcohol-free beer)(De Ruijter 1989:10-11).

In his recent overview of Dutch (secondary) prevention programs, Buisman (1992) describes a program aimed at cocaine use among high-risk youths (Amsterdam youngsters between 14 and 21 years, low-income, poorly educated, frequent disco and coffee shop visitors): the Amsterdam Cocaine Prevention Campaign conducted by the Jellinek Institute for Alcohol and Drug Prevention Amsterdam in 1986-1988. Activities in the first stage of the campaign were aimed to change the general belief among the target group that cocaine is a safe drug when used carefully. The slogan of “Coke, the white hammer” was displayed on eye-catching posters, and information booklets (in both Dutch and English) were distributed to disco’s, coffee shops, and youth centers. In the second stage of the campaign the notion was challenged that use of cocaine increases your status among your peers. Other posters and booklets were distributed with the slogan: “Cocaine, the illusion of being
strong”. The last stage of the program involved three videos specially designed for the target youths. Although no formal evaluation study has been conducted, there are reasons to believe that the campaign had some positive effects. Different groups requested campaign materials (including bar-owners who like to hang the posters on the doors of the toilets). People are no longer openly using cocaine in disco toilets. The campaign slogans are still favorite and frequently used. The prevalence of cocaine use in Amsterdam was reduced from 1.6 in 1987 to 1.3 in 1990. (For more details on this program, see Jamin 1991.)

Special efforts are made to communicate with young foreign tourists visiting Amsterdam, a notoriously high-risk group because of the international reputation of this city as the low-threshold access drug capital of the world. A special pamphlet is available in places where these young visitors tend to congregate, providing information and caution on drug use in this city. [Amsterdam Institute for Alcohol and Drug Prevention, IADA] Because it is well known that young migrants (i.e., Surinamese, Antillians, Moroccans, and Moluccans) have an increased risk of problematic drug use, a small number of prevention programs targeting these groups have been developed (Akveld and Buisman 1992:164).

Of course, AIDS has added a special urgency to programs aimed at the reduction of the harmful consequences of drug use. Since the mid-eighties, the Dutch have developed a very pro-active AIDS prevention policy – a policy explicitly trying to effect realistic changes in the lifestyle (i.e., safer drug use and safer sex) of as many drug users as possible, as quickly as possible (Kerssemakers and Kramer 1992:195). Needle exchange has been a mainstay of AIDS prevention. The Dutch have been pioneers of street/outreach work around drugs issues. One advantage is that drug use in the Netherlands, with more facilities where drug-using people may openly congregate, is much less underground than in either the US or UK (Cohen 1989:17). An example of an innovative outreach program is project “NO Risk” where drug users are used as “paraprofessionals” who, for pay, do outreach work focused on drug using prostitutes and other users (Kerssemakers and Kramer 1992).

In addition, training programs have been developed for police officers, community workers and volunteers. In collaboration with the Foundation of Parents of Drug Addicts, special training programs are carried out for counseling and guiding of self-help groups of parents of drug addicts. These programs are supported with educational and audio-visual materials, developed and distributed by national organizations (Buisman 1988:23).
4. Organizational structure of drug prevention programs

The Netherlands is an economically rather healthy and prosperous country with one of the world's best developed systems of social welfare and health services. It is thus not surprising to find that a large variety of organizations and individuals are involved in "doing something about drugs". It is estimated that there are about 100 full-time prevention officials, engaged in preparation, development and management of educational and preventive programs (Buisman 1988:18). Often, prevention and treatment services are integrated in that the same organization employs specialists in both fields (Cohen 1989:8). Several hundreds of health education officials attend to drug education as part of a more comprehensive general health education program. Additionally, an unknown number of other professionals like doctors, community workers, youth club workers and volunteers are conducting education programs having strong components of drug prevention (Buisman 1988:18).

It is not simple to provide a comprehensive overview of all organizations involved in drug prevention in the Netherlands since both governmental organizations and non-governmental organizations (usually subsidized by the government) consider prevention of drug-related problems one of their responsibilities. In the following, we will limit our discussion to only the most important national and regional organizations. Part of alcohol and drug information is given by organizations with ideological principles, namely, the National Committee against Alcoholism, originally a total abstinence organization, and the People's League against Excessive Drinking, a temperance organization (Van Amerongen 1987:95). Prior to 1940, a great part of the assistance and treatment of alcoholics was in the hands of volunteers and these volunteers were mostly strong opponents of alcohol use (Otto 1984:120). After World War II, volunteers almost completely disappeared, and alcoholism came to be viewed as a disease - a disease best attended to by "experts". Presently, by far the greatest part of alcohol and drug instruction is planned and carried out by the CADs (Consultation Bureaus Alcohol and Drugs). These CADs utilize virtually no volunteers. They are non-governmental organizations, but fully subsidized by the Ministry of Welfare, Health and Culture. There is a network of CADs in the Netherlands; nearly all large and medium-sized towns have a CAD. The initial CAD activity was assistance to people with alcohol problems. Since 1970, these CADs also have taken responsibility for assistance to drug addicts. Today, the main tasks are: ambulant care and treatment for people with alcohol and drug
problems, probation supervision for those convicted of drunken driving or drug offenses; and, since 1979, prevention (Van Amerongen 1987:95).

While prior to 1979, CADs did some prevention work, it was not done systematically. Pioneering work in prevention was done by the FZA (Federation of Institutions for Alcohol and Drugs, the government-funded umbrella organization to which all CADs and alcohol and drug clinics belonged). In 1973, the FZA appointed three people to travel through the country and educate agencies about prevention (Van Dalen 1987:55). It was not until 1975 that the CADs started to pay attention to systematically organized prevention activities. In 1979, funding was provided for CDAs to appoint their own prevention staff (Van Dalen 1987:55). At that time, the job of prevention workers was not fully described; the role had developed by way of trial and error. In 1981, there were five professional prevention staff at the FZA, and 36 at the CADs; in addition, general CAD staff was expected to spend 10 percent of their time on prevention activities (Otto 1984:122).

Since 1979, the FZA has assigned primary responsibility for local and regional prevention projects to the CADs. In the early 1980s, emphasis was placed on secondary prevention (i.e., the promotion of early recognition of addiction problems). In 1987, the FZA ceased to exist as an independent organization. Together with two other institutions it merged into the NIAD (National Institute for Alcohol and Drugs). Its activities, in the field of promoting, developing and evaluating alcohol and drug prevention programs were continued within this new organizational context.

In addition to CADs, the GGDs (Municipal Health Departments) play an important role in drug prevention. Operating within these GGDs are departments of Health Education (Gezondheidsvoorlichting en Opvoeding – GVOs) that focus on drug education and prevention. The exact role of CADs and GGDs varies from area to area and is further complicated by recent re-organization and the involvement of a number of voluntary organizations in the field. Ideally, the preventive activities of the CADs and GGDs complement each other.

5. American drug prevention

As described earlier, the Dutch view drug use or abuse as a public health issue. With this view, the Dutch expect that most policy emphasis be placed upon the following: (1) recognition of the need to normalize and demythologize drug use; (2) harm reduction; (3) a sharp distinction between soft drugs and hard drugs; and (4) maintenance of a pragmatic,
not moralizing drug policy. As we have seen, the Dutch have, by and large, attempted to seriously incorporate these basic elements in their prevention programs.

Present drug policy in the United States reflects sharply different goals and premises than those of Holland. The difference between these countries lies in large part with the apparatus which each country sets loose on the “problem”: in Holland, the choice is social workers, psychologists, physicians, prevention professionals, and community workers; in the United States the choice is police, judges, and lawyers. Rather than viewing drug use as a public health matter, Americans tend to see these activities as a moral/legal issue. Based upon this moral/legal perspective, American drug policy emphasizes: (1) repression of all drug use even to the point of “zero tolerance”; (2) moral stigmatization of all involved with drugs from suppliers to users; (3) dramatization of the negatives of the lives of those involved with drugs by means of media, government propaganda, or any other vehicles available; (4) blurring the distinction between soft and hard drugs so as to simplify the moral message to “hate all drugs”; and, finally (5) use of the criminal justice apparatus rather than public welfare and medicine to deal with the problem of drug use.

5.1 The “war on drugs”

Both Musto (1987) and Conrad and Schneider (1980) have provided detailed and interesting histories of narcotic control in the United States. The pre-1914 attitude of most Americans was one in which no stigma was attached to opiate use or addiction (Conrad and Schneider 1980:116). The Harrison Act of 1914 was the first major effort to place narcotics use under federal control. It was a tax act and not a direct prohibition of narcotics. The intent of the bill was to place opiates and addicts completely in the hands of physicians. However, in placing the enforcement of the act in hands of the Treasury Department, the implementation of the Act quickly took on the character of a moral crusade and resulted in harassment of physicians and druggists (Conrad and Schneider 1980:124). Moreover, two Supreme Court decisions, Jin Fuey Moy vs United States (1920) and United States vs Behrman (1922), continued to take away the control of the medical profession over opium use and distribution.

Another significant event in the history of narcotic control in the United States is the creation of the Federal Bureau of Narcotics (FBN) in 1930 within the Justice Department. Henry J. Anslinger, a former Prohibition official, became the head of the FBN and an archetypical “moral
entrepreneur”. His efforts to cause the public through major propaganda efforts to view narcotic addiction as clearly a criminal problem and the addict as a moral degenerate are legendary. Anslinger and his agency had an enormous effect upon national drug policy for 30 years; he finally resigned in the early 1960s and national drug policy began to shift away from the law enforcement model toward the treatment model (Abadinsky 1989:66-67). In the late 1960s and early 1970s, there was greatly expanded funding of drug rehabilitation programs and also a growing popularity of the “therapeutic community” approach – for example, Synanon in California and Daytop Village, Phoenix House, Odyssey House, and others in New York – to addiction (Rouse 1991).

Thus, the law enforcement approach to drug control has not always dominated American drug policy. For example, President Carter, in an address to Congress in 1979, expressed his support for lessening the law enforcement approach to drug policy:

“Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed. Nowhere is this more clear than in the laws against possession of marihuana in private for personal use” (Carter 1979:66-67).

President Carter’s narrow electoral victory in 1976 was a premonition of the increasing general conservativism in the country, including its views of drug use. Ronald Reagan’s landslide presidential victory in 1980 completed the cycle. President Reagan and his administration aimed at the supply of drugs in the United States with increased appropriations for law enforcement. Moreover, Nancy Reagan represented the “zero tolerance” attitude by directing disdain at the demander/user of drugs. She states: “Each of us has a responsibility to be intolerant of drug use anywhere, any time, by anybody…. We must create an atmosphere of intolerance for drug use in this country”.

In the view of some, the drug war attempted to create a new morality, one with a clear “right” and “wrong”. It is arguable that the American loss of the Vietnam War and the frequent questions of moral impropriety regarding the actions taken during its conduct left a country in need of moral guidelines upon which to rely. The drug war, then, was an attempt, through federal, state, and local policy to “create” a morality in what was perceived to be a moral void. The perceived crisis of drugs provided the perfect vehicle for the badly needed moral crusade. Other important factors arose in the decade of the 1980s. First, in 1981, the acquired immune deficiency syndrome (AIDS) was discovered. This fatal disease could be transmitted by contaminated needles which were used to inject drugs. Secondly, in 1985, “crack”, a smokeable and relatively cheap form of
cocaine, appeared in several areas of the US (Musto 1987:274). These two developments were used as political justifications for the Anti-Drug Abuse Act of 1986. As Musto describes the political aspects of this act: "..Congress and the President vied with one another to show their hatred of drugs and to state how much money they were willing to pit against the drug issue" (ibid. 1987:274). The first debate regarding the Act occurred in August 1986 at which time a public furor over cocaine had peaked; the Act was signed into law by Reagan shortly before the November elections. This Act authorized $4 billion for the battle against drugs and most of this was directed at law enforcement. (It should be noted that the AIDS argument was used similarly – as a political justification – but with the opposite effect in the Netherlands: not to increase law enforcement efforts, but as a legitimization of pragmatic drug policy.)

A few years ago, the White House issued the report: National Drug Control Strategy (1989) which sets forth the Bush Administration's policy regarding illegal drugs: "The main thrust and heart of the report, measured by proposed expenditures and emphasis, centers largely upon law enforcement, interdiction efforts, and increased and heavier penalties for convicted offenders" (Kittel 1992:107). This report recommends a vast expansion of the criminal justice system at both the state and federal levels. Specific recommendations include more street-level drug law enforcement; expanded efforts to eradicate the domestic marihuana crop; drug testing of arrestees, prisoners, and individuals under court supervision; more judges, prosecutors, and police; more vigorous prosecution of misdemeanor drug offenders by the states; greater coordination of federal, state and local efforts; and massive increase in prison space (Kittel 1992:113).

Drugs are viewed as one of the primary causes of street crime in the United States, where fear of crime is at an all-time high. In American society, people's fear of crime, now more so than ever before, appears to focus on racial minorities, African-Americans in particular. Many people associate gangs, drugs, assault and public disorder with black inner city violence. The "war on drug" pictures the drug user/addict as a violent person, to be feared:

"Reflecting on the earlier wave of drug intolerance, one cannot help but be concerned that the fear of drugs will again translate into a simple fear of the drug user and will be accompanied by draconian sentences and specious links between certain drugs and distrusted groups within society, as was the case with cocaine and Southern blacks in the first decade of this century" (Musto 1987:277).
In the US drugs have become a highly politicized issue, a central focus of the mass media and a main concern of the public. Because of its perceived links with violence, crime, and deteriorating race relations, the war on drugs was one of the main campaign issues in the 1992 presidential platforms. In the US, drug abuse is a very salient, high profile issue - much more so than in the Netherlands; this is reflected in the much more intense efforts to prevent and combat drug use. In 1992, the American federal budget for drug control was 12 billion dollars; approximately 70% of the drug control budget was allocated to law enforcement and other supply-reduction strategies. It should be noted, however, that President Clinton, the Democratic successor of George Bush, has called for a re-evaluation of the current drug war, with increased emphasis on treatment alternatives.

5.2 American drug use prevention programs

Although the American national preoccupation with drugs is of a more recent origin, the US has been experimenting with substance abuse prevention programs for more than two decades. (The following description draws from Botvin 1990.) A large variety of programs exist. Many of these prevention programs focus on school populations. As in the Netherlands, in the US, information dissemination is the most widely used approach. These approaches generally focus on the provision of factual information concerning the nature and pharmacology of specific substances, the ways in which these substances are used, and the adverse consequences of use (Botvin 1990:474). School programs involve the teaching of factual information in drug education classes, school-wide assembly programs featuring guest speakers (frequently police officers or health professionals), and films. In some programs, student involvement has taken the form of organizing a showing of film strips, conducting poster contests, developing anti-drugs public service announcements, or producing anti-drug plays and skits (Botvin 1990:475).

As Botvin points out (1990:475), in contrast to approaches designed to merely disseminate factual information, some have attempted to emphasize and even dramatize the risks associated with tobacco, alcohol and drug use. The underlying assumption is that evoking a simple, visceral fear would be more effective in repressing use than would volumes of “facts” and information about drugs. There is a clear and unambiguous message that drug use is dangerous, and those individuals foolish enough to disregard warnings by parents, teachers and health professionals will be left to suffer the consequences (Botvin 1990:475).
There is no doubt that the fear arousal approach is a mainstay of American drug prevention policy and has become more prominent over the last few years.

Another approach, frequently combined with information dissemination, involves attacking the problem of drug use from a moral perspective (Botvin 1990). This prevention strategy involves “preaching” to students about the evils of smoking, drinking, or using drugs and exhorting them not to engage in those behaviors (Botvin 1990:475-476). Often in conjunction with the above-mentioned fear arousal emphasis, the moral component has recently become increasingly important in drug prevention programs.

American programs have also approached drug education as a process designed to increase affective skills. The focus of affective education programs is on values clarification, teaching responsible decision-making, increasing self-esteem, and promoting participation in alternatives (Botvin 1990:477). (See also Tobler 1986.)

Many current educational programs incorporate a number of the above-discussed approaches (i.e., information dissemination, fear arousal, moral appeal, and affective education.) Two programs which have received considerable attention are SPECDA (School Program to Educate and Control Drug Abuse) in New York City and DARE (Drug Abuse Resistance Education) in Los Angeles. These programs are remarkably similar in objective and assumptions about the precursors of adolescent drug (ab)use (De Jong 1987:21). Both of these involve the close partnership of the schools and the police as a vehicle to intervene and mediate peer, relative, and sibling pressure – these thought to be the key to drug and alcohol use among adolescents. Both SPECDA and DARE are aimed at fifth and sixth graders. The curricula of the programs include such units as: (1) factual information on alcohol, tobacco, and drugs and the consequences of use; (2) promoting self-awareness and self-esteem; (3) assessment of risks and decision-making skills; (4) media and peer influence that encourage substance use; (5) techniques for resisting peer pressure; and (6) positive alternatives to substance use (De Jong 1987:17).

A recent DARE “graduation ceremony” of fifth graders in a public school in a midwestern city provides a good illustration of the importance and nature of drug education in American public schools. Students, dressed up in their best clothes, were called by name, one by one, to come to the front of the auditorium to receive their “diploma”. Emphasizing the importance of this event was the presence of several uniformed police officers, a high-level representative of the school administration,
the school principal, parents, and other friends and relatives. The fifth
graders signed a certificate, promising never to use drugs. Several children
had written brief skits for this special occasion. These skits were perhaps the
most convincing evidence of the “success” of the DARE program: one took
place in a cemetery (drugs kill!!), and several others made it clear that any
experimenting with any type of drug (including alcohol) was bound to result in
disaster.

While these programs have received much attention and many schools
across the country continue to emulate the original ones, systematic eval-
uation of their success is limited (Moore and Kleiman 1989:11). Botvin
(1990:478) notes that, overall, these approaches have not been shown to
be effective.

With regard to the role of the mass media, most of these have relied
on information-dissemination and/or fear-arousal strategies (Botvin
1990:503; Buisman 1990). Many opinion leaders in the United States in-
cluding politicians, sports, media and music stars have begun to re-
tepeatedly convey the message of the new drug morality: “Just Say No!”
The mass media also frequently emphasize the fear arousal aspect. A
good example is a television add showing a fried egg: “This is your brain
on crack!”

Another important aspect which distinguishes the US from the Nether-
lands is its grass-roots support of drug prevention programs. As Botvin
points out, a growing force in substance-abuse prevention in recent years
is the Parents’ Movement. This is essentially a grass-roots movement in-
volving concerned parents from communities throughout the country who
have organized themselves into local parents groups. The main function
of these groups is to provide support for concerned parents, to provide a
mechanism for becoming educated about drugs, to increase the awareness
of the parents throughout the community, and to serve as a catalyst for
change in their communities (Botvin 1990:504). More recently, many of
these local parent groups have been drawn under the umbrella of the
National Federation of Parents for Drug-Free Youth (NFP), formed in
1980. Another example are Mad Dads, a self-help community group con-
sisting of African-American males whose main purpose is to rid their
neighborhood of drug use and violence; an important aspect of their work
consists of talking to schools and community organizations about the
evils of drugs. In addition to community volunteers, professional asso-
ciations such as the American Bar Association, the American Medical
Association, the American Public Health Association, and the American
Psychological Association have all begun taking a greater leadership role
in the area of substance-abuse prevention (Botvin 1990:504).
Burden (1990) identifies six major youth groups which, in different ways, are trying to do something about problematic drug use. The Boy Scouts of America, for example, has since 1987 distributed more than 13 million copies of an 18-page brochure, “Drugs: A Deadly Game”; also available from the BSA is a video and a wall-size chart showing the effect of drugs, alcohol, and smoking on the human body, and a discussion guide for parents and teachers. The New York City Police Department’s drug awareness efforts have utilized the BSA materials (Burden 1990:9). Other youth organizations which have initiated similar programs include the Boys Clubs of America; the Girl Scouts of the USA (“Take the Lead: Fight Drugs”); Girls, Inc. (“Friendly Peer-suasion”); Camp Fire for Boys and Girls (“I’m Peer-Proof”); Key Clubs, the youth arm of Kiwanis International (Burden 1990).

Finally, the US has several comprehensive community-based prevention projects. Botvin (1990:507-510) describes project STAR (Student Taught Awareness and Resistance) as an exemplary program of comprehensive community-based prevention. The most recent comprehensive community-based drug prevention program is the federally funded “Seed and Weed” program, a program designed to “weed” out drugs and crime in high-crime areas and “seed” these neighborhoods with positive alternatives (i.e., employment, decent housing, and so on).

6. Conclusion

Although there are undeniably parallels between prevention strategies in Holland and the US, they differ in several important ways. First, the national pre-occupation with drugs in the US makes substance use control and prevention a higher priority item. The American mass media, public, politicians, and educators appear to devote considerably more resources and energy to issues related to drugs prevention than is the case in Holland. Differences in intensity of prevention efforts reflect fundamental differences in the definition of drugs as a social problem in the US and the Netherlands: In the US, drugs are viewed as a terrible evil to be fought with heavy arms (both in terms of prevention and repression); in the Netherlands, from a policy maker’s viewpoint, drugs are viewed as a “normal” social and health risk controlled by minimal measures or even ignored (e.g., cannabis, XTC). In the Netherlands, both law enforcement and prevention are kept low-key and minimal; in the US, both law enforcement and prevention are more intense. Relatedly, American prevention programs employ fear arousal and moral appeals in a higher degree than in Holland. And finally, there is much more reliance
on volunteers, self-help and grass-roots involvement in the US than in Holland.

Our overview of Dutch and American drug prevention programs further suggests the need for a careful evaluation of the role of media and media campaigns: "...the net effect of public service announcements designed to prevent substance abuse... can only be characterized as infinitessimal compared with advertisements promoting tobacco, alcohol, and drug products" (Botvin 1990:502-503). Indeed, "an overwhelming majority of mass media drug abuse prevention programs have failed to change behavior" (Flay and Sobel 1983, cited by Botvin 1990:503). Moreover, media campaigns can do damage: emotional anti-drug campaigns "inevitably increase the ostracism of drug users, further alienating them from society" (Rhodes 1990:16). As pointed out by Buisman (1988:20), although mass media campaigns have been shown to be non-effective, mass media definitively can have a function in the process of drug communication, because through them it is possible to direct the topics about which people think and talk. This so-called "agenda setting" function is extremely important in raising the proper public concern for the problem (Buisman 1988:21). Importantly, one should not forget that the media play a significant role in the constant glamorizing of drugs.

Further, in view of the fact that drug use is primarily viewed as a lower-class, minority phenomenon, particularly in the US, it is ironical that there seems to be a lack of appropriate preventive means to communicate with these risk groups. The most common preventive means such as booklets, audio-visual materials, and so on are very middle-class oriented and often are of limited utility for members of ethnic minority groups (Buisman 1988:28-29). This problem is also noted to be true for the American situation (Botvin 1990). Interventions are focused primarily on white, middle-class populations. A key question remaining unanswered concerns the efficacy of these programs with high-risk groups (Botvin 1990:510).

The relative success of the Dutch vis-à-vis the American approach to prevention may be judged in at least two different manners. The first is through evaluation studies which have been conducted in both countries. (See Botvin 1990, for a listing of American studies.) Interestingly, both Dutch and American studies seem to consistently indicate the relative ineffectiveness of traditional school-based prevention programs in changing attitudes and behavior. We have to be realistic in our expectations concerning the positive preventive effects of drug education programs, particularly in schools: "If our educational system, that is for almost 100% cognitively oriented, would pretend to be able to prevent a behavioral
problem with relatively few cognitive aspects such as drug abuse, through education (i.e., teaching), it would show very little sense of reality” (Van Amerongen 1982:143; see also Buisman and Geirnaert 1992:83). Unfortunately, evaluation studies in both countries suffer from methodological shortcomings and few prevention programs have a built-in evaluation component. At this point, therefore, evaluation studies cannot be used as the basis for our assessment.

A second way of assessing the relative merits of different approaches to substance use prevention is by comparing facts on drug use in the population. In Holland, drug use among young people is lower than in the US. Alcohol use among young Dutch people has increased over the last decade (Reijneveld 1990) while drug use has remained constant or even leveled off. However, cocaine use in the Netherlands is viewed as a growing problem among young people and adults. In the US, according to recent reports, drug use in general has been declining; experimental and casual use have been declining sharply (Kittel 1992:108). However, it is notable that frequent drug use by the poor in inner-city areas is either remaining constant or increasing (Kittel 1992:108). Although one might quibble about the exact figures and statistics, most experts would agree that drug abuse is currently a more pressing social problem in the US than in Holland.

We agree with Engelsman (1992:138) that a pragmatic and problem-oriented policy works better than an emotional, dogmatic approach. The Dutch pragmatic approach has prevented the use of radical measures such as forced treatment, drug testing at the work place, and fear-inducing information campaigns—"solutions" which may give the appearance of a tough approach, but which frequently cause more problems than they solve. Engelsman (1992:149-150) lists several additional accomplishments of Dutch drug policy: addicts are not forced to live an isolated life of social exclusion; the drugs phenomenon is more public and visible and thus controllable; social service agencies are able to reach the majority of users; the social and physical functioning of users is reasonably good; only a relatively small proportion is actively involved in crime; and users have become more cautious in their drug-taking and sexual practices.

It is, however, naive to conclude that this suggests that Dutch prevention programs should be adopted by the United States. Both the nature and extent of the drug problem and society's response to it reflect the larger structural and cultural conditions of society. Structural factors conducive to problematic drug use—especially poverty and racism—exist to a greater degree in the US than in Holland. Compared with the US, people in the Netherlands suffer fewer economic hardships, there is less
systematic exclusion based on race or ethnicity, there is less polarization of the population into the “haves” and the “have-nots” – all of which are structural causes of persistent hard drug use. The low-key Dutch prevention programs reflect the lower urgency of drug problems, the higher level of social security, the lower incidence of drug-related crime, the lower level of violence, and the more tolerant attitude to drug use.

It does seem that Holland has accomplished a much closer approximation of former President George Bush’s “kinder and gentler society” in the area of drug policy than has the United States. However, we should note in concluding that one issue which has remained outside the focus of our analysis in this chapter is the differential roles of Holland and the United States in the world-wide political and economical community and the potential impact of these different roles upon the domestic drug policies and practices of the two countries.

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XII. LEGALIZATION, DECRIMINALIZATION AND THE REDUCTION OF CRIME

M. Grapendaal, Ed. Leuw and H. Nelen

1. Introduction

Although the debate on the possible effects of legalization of illicit drugs can be characterized as somewhat murky at times and definitely polemic, both sides agree on one thing: the expected decrease of drug-related crime after legalization. In this chapter we will have a closer look at this assumption. We will do so on the basis of an empirical study conducted among Amsterdam opiate addicts. Because this study was done in the relatively decriminalized context of illegal drug use in the Netherlands, its conclusions cannot be generalized to other countries.

The chapter starts with an outline of the general pros and cons of legalization. The next section contains a review of theoretical assumptions about the different hypothetical links between drug use and predatory crime. These theoretical models allow for different predictions about the influence of legalization on the level of criminality among drug users. We will present results of the Amsterdam study that are relevant to both the theory of drug-related crime and the possible effects of legalization.

2. Pros and cons of legalization

After decades of a vigorous but futile fight against the use and trafficking of illegal drugs, a discussion has developed about the advantages and disadvantages of legalizing or decriminalizing illicit drugs (Nadelmann 1991; Inciardi and McBride 1989; Karel 1991; Trebach 1982, 1987, 1989; Szasz 1991; Schmidt-Semisch 1990; Miller 1991; MacCoun 1991; Michaels 1991 and many others). In this discussion a limited number of topics invariably surface.

When making the case for legalization people argue that crime will decrease substantially; both crime related to trafficking and dealing, and criminality by users who commit crimes to maintain their addiction. The price of drugs would fall significantly (Nadelmann 1991) and so would the profits from the illegal trade. This would make trafficking in drugs less and less attractive. Users would be able to buy their desired drug at reasonable prices and would no longer be forced to commit crimes.
The focus of the pro-legalization argument is not only on crime, however; the health consequences of legalization are also addressed. Typically, advocates of legalization foresee a significant improvement of the physical condition of drug users. Because sterile needles and syringes would become readily available for IV users, the spread of contagious diseases like AIDS and hepatitis would slow down. The quality of the drugs would improve and the danger of adulterants would diminish.

There is also a philosophical side to the debate. Referring to John Stuart Mill’s essay “On Liberty”, those in favor of legalization argue that the state may not interfere with individual behavior that does not harm other individuals or, for that matter, is not detrimental to society at large.

Apart from the primary pharmacological risks in terms of addiction and toxicity, all secondary negative effects of drugs (crime, marginality of users, insecurity produced by violent drug markets, drug-related infections, and so on) are linked to the illegal status of the drugs. There is no inherent property to illegal substances themselves that causes these negative outcomes of drug use. According to the legalization argument, abolishing the illegal status of drugs would reduce the harmful effects to a level comparable to legally available stimulants such as alcohol and tobacco. Contrary to popular belief, it may be very hard to decide whether these legal drugs are potentially less harmful to health and society than the illegal drugs (Byck 1987). The pro-legalization side argues that the supposedly exceptional danger of illegal drugs is a culturally determined, social construction for which there are no good, valid or objective arguments.

Alternatively, proponents of legalization may point to social-scientific and historical analyses, which demonstrate that prohibition of drugs primarily serves moral value and political power interests (Gusfield 1966; Musto 1987; Scheerer 1992; Williams 1991). The historical prohibition of alcohol in the United States serves as a case in point.

More pragmatically, legalization is favored because of the costs of prohibition. The government spends huge amounts of money to fight the war on drugs with no apparent success. While the “war on drugs” may have had some constraining effects on recreational drug use by the conventional middle class (youth), there is no indication that decennia of fierce law enforcement has had any effect on the spreading of deviant, addictive and problematic drug use in marginal segments of society (Reuter 1992). After legalization resources could be re-allocated to more sensible targets: treatment, education, prevention.

And last but not least, because the powers of law enforcement authorities and other government officials have been substantially extended in
order to better “fight” the war on drugs, citizens’ civil liberties are in danger. The very nature of the drug problem causes law enforcement agencies to apply an aggressive and pro-active approach. This problem of increasing violation of civil liberties is debated most in the United States, where the war on drugs undoubtedly is fought with the most perseverance.

In the case against legalization, authors primarily warn against the possibility that the number of users would increase markedly. The higher the availability of a commodity, the more it will be used, they argue. In a free market, manufacturers and sales companies would launch advertisement campaigns to attract potential users. Because drugs are dangerous this is an undesirable situation. Not only do drugs inflict physical harm – one can die from an overdose of heroin for example – they also impair the social, productive and responsible behavior of users. In this respect drug use itself, but also the policy option of legalization is deemed to be inherently immoral.

A more practical consideration concerns the argument that proponents of legalization fail to recognize the complexities of the matter at hand. A concrete and specific proposal on how to legalize and under which conditions drugs may be produced, sold, and used has yet to be formulated. According to a common objection, legalizers oversimplify the subject in presenting legalization as a panacea for all problems revolving around drug use, drug violence and drug trafficking.

A few words on the relation between legalization and decriminalization are in order. Regardless of additional restrictions and other practical considerations (licensing, minimum consumption age, level of government control, quality demands etc.), legalization would imply that formerly illegal drugs would get the same legal status as alcohol and tobacco. Decriminalization means that drugs remain illegal, but that the use of drugs, and to a certain degree possession of drugs are not prosecuted as a criminal offense. Both concepts indicate the degree to which penal law control is removed. More importantly, in both concepts societal normalization is the central issue. Normalization may be understood as a social process in which informal social control by moral rejection, stigmatization and exclusion is diminished. Because the relaxation of penal law control is only one element of normalization, legalization does not necessarily indicate a higher level of social “acceptance” than decriminalization.

On the Dutch demand side of the drugs problem there is a substantial degree of decriminalization. Using hard drugs is not prohibited by law. The police and the Public Prosecutor’s Office are explicitly instructed
not to act against possession of hard drugs for personal use. This means that only those Dutch drug addicts who are involved with dealing and/or trafficking are caught up in the criminal justice system (not counting drug-related property crimes, of course). In a broader sense, decriminalization of drug addiction and drug use in the Netherlands may be understood as a manifestation of increased integration and acceptation of illegal drug use and addiction as a “normal” social adversity (Leuw 1991; Van den Wijngaart 1991).

The more tolerant social conditions of illegal drug use and addiction in the Netherlands are relevant for the issue of legalization and its possible effects on drug-related crime. As will be discussed later in this chapter, to some extent the results of our study concerning the issue of drug-related crime might be a function of ongoing social processes in the Netherlands - social processes of which legalization is the final stage.

3. Theoretical perspectives on the drug-crime nexus

The possible benefits of legalization with regard to the predicted reduction in drug-related criminality can only be addressed sensibly in the context of theoretical models for explaining the relation between illegal drug use and criminal behavior.

The existence of a close relationship between illegal drug use and criminality has been proven time and again (Parker 1989; Dobinson and Ward 1985, 1987; Dobinson 1989; Korf 1990; Ball 1982; Hammersley and Morrison 1987; Hammersley et al. 1989). At the same time it has widely been recognized that criminality is no more than a secondary characteristic of illegal drug consumption. Perhaps apart from some very specific instances, there are no inherent effects of illegal drugs which force its users into delinquency. This implies that criminality, along with most other social and health consequences connected to illegal drug addiction, is essentially not related to the pharmacological properties of the substances, but to the social conditions surrounding this kind of drug taking. Acknowledging the secondary character of drug-related criminality has not solved basic interpretational issues of the empirical evidence of its existence.

There are three major theoretical positions. According to the first model, drug addicts are driven to criminal behavior because they have to pay large sums of money for their drugs. This model assumes that addicts are physically dependent on their drugs and if they do not receive the required amount every day they will become sick. This position is widely known as the “inevitability hypothesis” (Goldman 1981) or enslavement
theory (Inciardi 1991).

In contrast, the second model holds that drug use is caused by crime. According to this perspective, involvement in delinquency provides the context, the reference group and definitions of the situation that are conducive for subsequent involvement with drugs (Clayton and Tuchfield 1982).

The third model maintains that drug use and criminality are mutually reinforcing expressions of deviance. Deviance is viewed as the result of individual and collective reactions to the fundamental social-economic and cultural conditions of society. In this theoretical context, drug-related crime is partly explained in terms of the moral status of drug use and the social conditions under which illegal drug use has materialized. The perceived roots of evil are shifted from alien substances to the fabric of culture and social-economic structure (Inciardi 1974; Leuw 1986; Parker 1989).

Each of these theoretical models probably will prove to have some validity for some types of users and for certain circumstances and conditions. Important though, is that each model predicts a different effect of legalization on the level of crime among addicts.

Assuming that the crimes committed by drug addicts are purely instrumental and serve no other purpose than to provide money to buy drugs, the "inevitability hypothesis" predicts that legalization would have a major impact on the level of crime as the price of drugs would fall substantially. This is exactly the same result that was expected from large scale methadone supply to addicts. If addicts are able to substitute an expensive drug (heroin) for a free or cheap one (methadone), there would no longer be any necessity to steal and rob.

According to the second and third models, the effect of legalization on the level of crime would be more ambiguous. If crime does cause drug use, it can not be expected that drug users will immediately cease to commit crimes when their preferred drugs are legally available. Similarly, the impact of legalization on the level of crime is questionable when, according to the third model, both the use of drugs and criminal behavior are integral components of a deviant lifestyle.

To establish an empirical basis to evaluate these theoretical viewpoints, we need answers to specific questions: At which point in time did drug addicts start their criminal career, was it before or after their first drug use? Does methadone supply reduce criminal activity? How (in)elastic is the demand for drugs? In other words, do drug addicts need a fixed amount of drugs at fixed time intervals? Do drug addicts cease to commit crimes in periods of abstinence? Do all drug addicts engage
in serious criminal activity?

The study we conducted in Amsterdam was not in the first place intended to solve basic theoretical issues, but rather to gain insight in the economic behavior of heroin addicts. Nevertheless, the study provides enough information to answer the questions mentioned above. Consequently, we are able to provide the empirical basis to address the issues raised in this chapter.

4. Design of the study

The fieldwork of the study started mid 1987 and ended two years later. The sample consisted of 150 hard drug users. Respondents were recruited from the hard core of the Amsterdam (street) junkie scene. In line with population estimates, the sample was divided so that two-thirds of the subjects were ambulant methadone maintenance clients. The remainder were not involved in methadone prescription. The first subsample was randomly approached on the premises of the methadone maintenance agencies, while the second subsample was recruited by snowballing techniques, mostly starting in the drugs area of Amsterdam: central Amsterdam which also includes the red light district. This is a relatively small and well-defined area where drug use and the retail trade in drugs are clearly visible.

The design allowed for a maximum of seven interviews of each respondent, over a period of about 13 months, about drug taking and economic behavior (i.e., how they obtained and spent money). All standard interviews referred retrospectively to the preceding seven days. The first three interviews took place in the first three weeks after initial contact, the next four quarterly. Respondents were interviewed in a field station, a bar or - depending on the weather - on a bench in the street. In addition to collecting quantitative information, a life history interview was conducted. Respondents were asked about their family backgrounds, peer group, criminal and drug careers and their motivation to maintain their deviant lifestyles. The field workers and researchers also spent considerable time observing the daily activities on the streets of central Amsterdam. The experiences and observations were recorded in a personal diary.

The design of the study is much like the Johnson et al. study, conducted in New York (Johnson et al. 1985). The major differences are the number of - and time intervals between - the interviews and the emphasis on qualitative data. In the Amsterdam study we paid more attention to the life history interviews and participant observation.
5. Empirical evidence

5.1 The start of a criminal career

One of the major questions to be answered concerns the point in time at which the criminal career starts, relative to the onset of drug use. Many researchers addressed this question (Korf 1990; Swierstra 1990; Erkelens et al. 1979; Intraval 1989; Johnson et al. 1985; Stephens and McBride 1976; Nurco et al. 1985; Inciardi 1986). Especially in the Dutch literature there seems to be strong consensus about the percentage of drug addicts who committed crime before they started using drugs: All (Dutch) studies report a figure of about 50%. This is not different in our study: 51% of our respondents engaged in crime before they started using drugs. For 8% drug use and crime occurred simultaneously, 20% eventually started committing crimes after they first used drugs and 21% says that they never engaged in criminal activity despite their obvious addiction. Moreover, when we take a closer look at the recent criminal behavior of our subjects, we find that the respondents who display pre-drug criminality belong to the most criminal group in our sample. This suggests that there exists a certain continuity in the lifestyle and crime patterns people develop before they start using drugs.

Logically, the paradigm that criminal behavior is caused by drug use (the first model), can only be true for the relatively small proportion in our sample that began committing crime after they started using drugs. A remarkable finding is that 21% never engaged in (property) crime either before or after initiation into drug use. This finding is not uncommon in Dutch literature (see for an overview: Korf 1990) and perhaps typical for the Dutch situation. Because popular belief tends to be that every drug addict at some stage in his career commits at least some crime, this finding needs some explanation. The Netherlands have a rather elaborated system of social welfare. Everyone who is not able to work is, under certain conditions, entitled to a monthly governmental support that amounts to the Dutch equivalent of approximately $600. A large proportion of our sample receives a monthly welfare check. In addition they often do odd jobs. Given the fact that many addicts save money on the more conventional expenses, such as housing, heating, meals, clothes and so on, they can spend almost their complete monthly income on drugs. Considering the price of one bag of heroin or cocaine (about $15 for one-tenth of a gram, enough to make it through the day at a moderate level of use combined with methadone supply) some addicts can maintain their habit with a relatively low budget and without crime.
5.2 Methadone maintenance and the reduction of crime

The next important question is whether or not methadone maintenance results in a reduction of property crime committed by drug addicts. In fact, methadone is a legal opiate. According to the classical psycho-physiological theory of methadone maintenance this "treatment" should remove the major drive for criminal behavior of heroin addicts. The Amsterdam case, where about two-thirds of the addict population is estimated to be registered with methadone programs, may be especially suitable to test the impact of this mode of "legalization".

During the first years of methadone maintenance programs in the United States, spectacular successes were claimed. Clients were said to improve dramatically. Not only did abstinence or a serious reduction of illegal drug intake occur in most clients of methadone maintenance programs, it was also estimated that between 50% and 85% showed marked progress in social functioning (Senay 1985).

In later years, news from America on methadone maintenance became more moderate in tone, but there remained a relatively strong consensus that methadone maintenance programs lead to a reduction in the use of illegal drugs and to a (connected) reduction in illegal income acquisition (Edwards 1979; Sechrest 1979; Anglin et al. 1981).

The predominantly positive results of evaluations of methadone programs on drug-related crime in the US should be approached with caution. Two points should be considered: (1) reliability of reported illegal drug use and delinquency and (2) selectivity of participants in methadone maintenance programs in the US. There is an extensive literature on the reliability and validity issue, but here we will limit ourselves to questioning the reliability of (self-report) data on illegal drug use and crime, obtained within the context of (criminal justice) maintenance programs that attach severe penalties to illegal drug use and undesirable social behavior (Ausubel 1983).

The reported success of methadone maintenance in the United States would certainly fade considerably once the question of double selectivity is taken into account. The "double selectivity" refers to both the criteria to be admitted into the methadone maintenance program, as well as the requirements addicts must meet to stay in the methadone maintenance programs. Certainly in comparison to the situation in the Netherlands (Amsterdam), methadone maintenance programs in the United States have a high threshold and impose a large number of conditions. For example, one of the most important programs in Baltimore only takes clients who have been employed for at least two years. Using illegal
drugs (besides methadone) or committing criminal offenses usually are grounds for refusing admittance to the program or removal from the program. To a certain extent, therefore, a decrease in crime rates should be regarded as an artefact of the strict criminal justice context of many methadone (maintenance) programs in the US. In this context, they could be compared to the successes often claimed by drug-free therapeutic communities. Addicts who are able to remain in such programs for any length of time indeed do have a good chance to improve. But then we are talking about an extremely small selection from the population of drug addicts.

To conclude simply that the reduction in crime reported for the American clients of methadone programs has no meaning at all would be unwarranted. However, the results do imply that the relationship between methadone and crime needs more careful consideration. Before we may conclude that there is a biological-causal link between methadone maintenance and reduced criminality, more careful research in other social settings needs to be conducted.

What about the Amsterdam situation of methadone prescription? Perhaps most importantly, the threshold to participate in a methadone maintenance program in Amsterdam is much lower than in the US. The distribution of methadone in Amsterdam is mainly in the hands of the drug department of the local health authorities (GG&GD). There are several different modalities of distribution, each with its own character. First, there are the methadone buses. Initially, old public transportation buses adapted for use as methadone maintenance centers were used, but in the spring of 1989, new specially designed buses were put into service. Seven days a week, two of these buses follow two separate routes through the city, making stopovers at special bus stops at set times for set periods.

These buses provide the lowest threshold service available in Amsterdam. There are barely any requirements that a client has to meet to be able to register with a methadone bus program: there are no urine tests for illegal drugs, addicts are not required to show up every day and they are not expected to change their lifestyle. If a client at one of the buses is “functioning well”, he may be promoted to a community station. The three community stations are situated at the edge of the old city center. They are open on working days; clients are given pills for the week-end. The community stations differ substantially from the buses. Their explicit aim is abstinence from illegal drugs. To that end, urine tests are conducted twice a week, contact with doctors and social workers is mandatory and active support is available wherever possible and necessary.
Apart from the Municipal Health Service, some general practitioners in Amsterdam also provide methadone. The family doctor occupies the highest rank on the promotion ladder of methadone maintenance: addicts may be promoted from bus to community station, and from community station to GP.\(^5\) Doctors give prescriptions that addicts can take to the pharmacy in order to obtain methadone pills. In general, a client may pick up a prescription every two weeks. This places a heavy demand on the patient's own responsibility, for on the street two weeks' worth of methadone fetches between $115 and $170.

The different forms of methadone distribution in Amsterdam may be differentiated according to the requirements that clients have to meet: these may vary from almost none to obligatory abstinence from illegal drugs; from very low threshold to high(er) threshold modalities.

First we shall examine the relationship between property crime and methadone maintenance in a more general way. In order to examine the relative importance of methadone maintenance as a determinant of criminality, a multiple regression analysis was performed, using amount of crime-generated income as the dependent variable. The total number of independent variables used in the analysis was seven (cocaine consumption, heroin consumption, gender, age, duration of opiate use, receipt of social benefits, and registration with a methadone maintenance program). The percentage of explained variance is small (20%) but statistically significant (\(p<0.001\)). Four variables explain 20% of the variance in individual gain from income-generating crime. These variables are, in order of importance: cocaine consumption (the more cocaine one uses, the higher the income from crime), gender (men earn more money through crime than women), age (the younger one is, the more income from crime one has) and heroin consumption (the higher the consumption, the more crime-related income). More important, though, the results show that the influence of methadone programs relative to other variables is virtually negligible. This result is not surprising in view of the fact that the bivariate correlation between criminal gain and methadone distribution is very weak (\(-.08\)). Registration with a methadone program nor duration of opiate use, nor the receipt of social benefit make any difference in the amount of gain from income-generating crime.

*In general* then, participation in a methadone program does not seem to influence the level of criminality. These results may be interpreted as a rejection of the reduction-in-crime hypothesis based on the orthodox, metabolic theory of methadone maintenance. However, as we have seen above, there are important differences between methadone maintenance programs (both in terms of admission and retention criteria). Further
analysis is needed to examine whether participation in a methadone program under certain circumstances may be related to a decreased level of criminality.

We distinguish between three conditions: (1) high threshold programs (i.e., community stations), (2) low threshold programs (i.e., buses), and (3) no registration with a methadone program. Table 1 shows how clients from the three groups differ from each other in terms of profits from crime: there is a clear relationship between the type of methadone program and income-generating crime.

Table 1. Methadone programs and monthly profits from acquisitive crime

<table>
<thead>
<tr>
<th>Programs</th>
<th>High threshold</th>
<th>Low threshold</th>
<th>No program</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No crime</td>
<td>60%</td>
<td>33%</td>
<td>41%</td>
<td>69</td>
</tr>
<tr>
<td>$1 - $285</td>
<td>24%</td>
<td>31%</td>
<td>34%</td>
<td>43</td>
</tr>
<tr>
<td>$ &gt;285</td>
<td>16%</td>
<td>36%</td>
<td>25%</td>
<td>36</td>
</tr>
<tr>
<td>N</td>
<td>62</td>
<td>42</td>
<td>44</td>
<td>148</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 9; \text{df} = 4; p < 0.05 \]

Especially noteworthy is that more clients from the low threshold programs (the buses) commit criminal offenses than the other two groups. Two-thirds (67%) of the users involved in a low-threshold program are involved in income-generating criminality, as compared to 59% of those not involved in a program and 40% of those registered with a high-threshold program. Table 1 also suggests that the low-threshold category is more likely to be involved in more lucrative crimes (over $285.00) than the other two groups. In other words, not only has the hypothesis that methadone maintenance always leads to a reduction in crime been falsified, more of those who obtain methadone from the buses commit crime (67%) than those not on methadone maintenance (59%), and clients of low-threshold programs are also more likely to be involved in the more lucrative crimes. We may view this phenomenon as an important indication that the most relevant factor is not the methadone, but the addict's lifestyle. A brief description of the three different groups may illustrate this conclusion.

Most clients of the high-threshold community stations are at the end of the line of their drug career and want to moderate their deviant lifestyle. They are drug addicts whose ferocity and socially destructive energy has tapered off. They may be typed as retired or pacified junkies. They cut down on the use of expensive illegal drugs and especially keep
away from cocaine. They do commit some crime, but generally at a low frequency and with little financial gain. The pacified junkies succeed in taking illegal drugs within a non-criminal lifestyle by cutting their expenses for “normal” daily subsistence to an extremely low level. They do not spend much money on food or clothing, nor do they pay for public transportation. Their friends and family do not expect the money borrowed to be returned. Some of these drug users make extra money by doing odd jobs for shop keepers: they sweep the pavement, help to unload vehicles, clean windows. Others collect used syringes and needles, exchange these paraphernalia at one of the drug agencies and sell new “shooting equipment” on the street.

Prescription methadone fulfills an important role within the lifestyle of the pacified junkie. The daily use of this synthetic opiate not only prevents the well-known withdrawal symptoms but has social-psychological functions as well: the fact that a client has to show up every day structures his life. He has a reason to get out of his bed, he meets friends at the community station and regularly stays for a chat. If he has problems, he can contact the professionals – both doctors and social workers – who are present at the station.

Turning to the low threshold programs (i.e., the methadone by bus project), we observe a totally different kind of client. These drug users are often hyperactive addicts, who are still fascinated by the deviant lifestyle. They are poly-drug users with a predilection for cocaine. Their visits to the methadone bus are characterized by irregularity and speed. Methadone serves as an insurance against the feared withdrawal symptoms when they have difficulty in obtaining other drugs. At these “bad” moments they will rush to the bus, drink their methadone and leave at once. They do not have time to hang around; they have to go to “work”. In the vocabulary of hyperactive addicts, “work” is synonymous to “committing crimes”. A large proportion of their income is generated from property crime.

Most of the drug users who do not subscribe to any methadone program are active on the drugs market, either as a small-time dealer, a lookout or a middleman. These drug users are commonly being paid in drugs, thus they require less (cash) money than other drug users.

5.3 Inelasticity of demand

The third question pertaining to the legal availability of opiates and criminal behavior concerns the widespread belief that drug addicts need a physiologically and pharmacologically fixed amount of heroin each
day. In other words, the demand for opiates is said to be invariable and inelastic. The idea is that the use of (in this case) heroin over a long period of time causes physical tolerance of the drug to increase until an individually determined optimum has been reached. This level is thought to determine the daily amount of opiates necessary to prevent withdrawal symptoms and to function normally. Legalization may be expected to have more impact on drug-related crime if the demand for heroin is indeed as inelastic as the psycho-physiological theory of heroin addiction implies.

Data from our study reveal that the level of consumption of drugs varies widely. We developed a method of measuring the extent to which drug use varies. A calculation was made for each respondent of the average drug use for all of the days in the first interview cycle (e.g., the first three weeks). Subsequently, variability in consumption - expressed as the standard deviation from the daily average - was calculated. As the standard deviation increases, so does variability in consumption. To allow for large variations in absolute size of daily amounts, the standard deviation was expressed as a percentage of the daily average (variability=$s/m*100$; in which “$s$”=standard deviation and “$m$”=daily average).

Table 2 shows the frequency of deviation percentages of heroin use.

<table>
<thead>
<tr>
<th>Deviations</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant*</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Deviation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1- 25%</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>26- 50%</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>51- 75%</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>76-265%</td>
<td>63</td>
<td>43</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>100</td>
</tr>
</tbody>
</table>

*: no heroin use (n=13) or constant use (n=10)

The apparent large variability in consumption of the illegal drug heroin is partly explained by a strong relation with participation in a methadone program. A relatively easily accessible distribution network for methadone in Amsterdam offers drug users a way of replenishing opiate deficiencies on “bad days” with this synthetic opiate. Due to the availability of free methadone as an insurance against sickness, addicts obviously have much latitude to obtain or not to obtain heroin.

Addicts do indeed cut their coats according to their cloth (Grapendaal 1992). They will obtain the amount of illegal drugs depending on their daily fortunes. This is likely to be the result of the limits they set on
activities they are prepared to undertake in order to obtain heroin and/or money. In this sense, a beneficial effect of methadone prescription on crime may not necessarily be a lower individual level, but a reinforcement of individual limits to criminal behavior. "Everybody" including the drug addict, has his (moral) restrictions with regard to his (criminal) behavior. Availability of free methadone helps addicts to respect these personal normative limits. In similar vein, we may hypothesize that legalization of heroin will put some limits to "excessive" criminality.

5.4 Reduction of crime in periods of abstinence

Criminalization of using and selling drugs inevitably implies that drug users must cross the normative borders of legality. In many respects they must also cross the social borders of deviance. It is quite inconceivable that persons who are "forced" to enter an illegal subculture will not lose constraints against criminal behavior. Therefore, in this broad societal sense, legalization may be expected to decrease criminal behavior. On the other hand, the present study (as well as other ethnographic studies of deviant drug users) suggests that criminal behavior offers its own attractions to drug addicts. To a large extent this attraction depends on the lifestyle of the addict, and the particular stage he is at in his career of deviance. If a drug addict is heavily involved in a deviant lifestyle, abstinence will be less conducive to a decrease of criminal behavior. In this case, drug use or addiction is no longer an incentive or catalyst for criminal behavior, but criminal behavior remains motivated by other deviant interests. In other words, a devoted junkie, deeply involved in an absorbing and rewarding deviant lifestyle, cannot be expected to be transformed into a conventional law-abiding citizen, once his drug taking has stopped.

We will now turn to the relevant empirical results of our study. Periods of abstinence or seriously reduced use were calculated for those respondents with complete information for an entire year (n=85). The level of crime during these periods was compared with the level of crime during periods in which a high level of drug use was reported (of more than two grams a week).

We were able to identify 51 respondents (i.e. 60%) with at least one such period of abstinence in the course of the research project. For our analysis, we compared income from crime by means of a t test for paired samples. In a week during which they used a lot of heroin, these 51 respondents generated four times as much income from crime as they did in a week during which they used little or no heroin. When using a lot of heroin, the average income from crime was $95.00; in the low-use
week, the average income was reduced to $22.00 ($t=2.30; p=0.03). This difference is statistically and substantially significant.

For cocaine, the picture is more or less identical. There were 59 respondents with periods of abstinence or greatly reduced cocaine use. During such periods, income from crime for this group averaged $30.00. During the period of heavy cocaine use, the average climbed to $85.00. The corresponding $t$ value (2.29) has a level of significance of 0.03.

The conclusion will be obvious: during periods of abstinence, considerably less income is generated from acquisitive crime than during periods of drug use. This finding is consistent with the results of Anglo-Saxon research (Nurco et al. 1985, 1988; Dobinson 1989). However, finding a clear link between the use of hard drugs and the level of crime does not necessarily imply that more drug use leads to more crime, or conversely, that less drug use results in less crime. It might well be that the mechanism described in the previous section is also operative here: the abstinent addicts are generating less money – for whatever reason – and are therefore using less or no drugs.

The big difference between our study and other (foreign) research is that drug users in other countries show a proportionately much larger decrease in criminal activities during periods of abstinence. This may be partly explained by the different operationalizations of the concepts of crime and abstinence. In the present study, crime was defined in the narrow sense of acquisitive crime (excluding drug dealing), while our “abstinence” category also includes some periods of a very limited and strongly decreased drug use.

A more theoretically relevant explanation for the difference in results may be found in the social circumstances of Dutch society. Because of the relatively generous social welfare system, Dutch addicts are less dependent on crime as a source of income anyway; this is suggested not only by the (lower) percentage of crime-generated income, but also by the (smaller) number of addicts who commit criminal offenses (Grapendaal et al. 1991). It is likely that this is partly (or even mainly) due to the system of social security. As dependence on crime as a source of income decreases, there will, by definition, be smaller fluctuations in criminal activity.

In Table 3 a comparison of three studies (Johnson et al. 1985; Parker et al. 1988) with regard to the level of crime among drug users is offered. This table shows that Dutch addicts commit less crime than their foreign counterparts. It is plausible that in case of legalization the reduction of crime would be less in countries where addicts are less dependent on crime as a source of income.
Table 3. An international comparison

<table>
<thead>
<tr>
<th>Source of income</th>
<th>This study</th>
<th>Johnson et al. 1985</th>
<th>Parker et al. 1988</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welfare check</td>
<td>29%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Salary</td>
<td>4%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Drugs market</td>
<td>20%</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Prostitution</td>
<td>15%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Property crime</td>
<td>24%</td>
<td>43%</td>
<td>65%</td>
</tr>
<tr>
<td>Others</td>
<td>8%</td>
<td>12%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Applying, committing crimes is less typical of drug addicts in the Netherlands than in some other countries. In a deeper sociological sense this may not only be contingent on available sources of income. A weakened link between drug use and crime may also be explained by the relatively more decriminalized and (therefore) less deviant circumstances of hard drug use in the Netherlands. As has been suggested above, the effect of drug use on criminal behavior may depend on the extent that more general deviant interests are served by this illegal drug use. This would imply that legalization may only result in a strong reduction of criminal behavior when this occurs under the conditions of severe repression and stigmatization of illegal drug use. It is reasonable to speculate, therefore, that legalization might thus result in a considerable decrease of criminal behavior in the USA, while it would have less impact on criminality in the Netherlands.

6. Discussion

The results presented above cannot be fully explained by one of the causal theoretical models. It is not tenable that drug use does cause crime (or vice versa), it is more likely that drug use intensifies and perpetuates criminality. We find the strongest support in the observation that drug addicts do commit less crime in periods of abstinence, but that an important proportion continues to commit crime at a lower level. The results do confirm, however, the notion that there is a strong relationship between drug use and crime. This relationship can best be explained by applying the theoretical approach that both drug use and crime are expressions of an underlying dimension, related to both crime and drug use.

We will consider the possible effects of legalization on crime committed by addicts in the light of the deviant career perspective that we found to be the most plausible explanation for the results of this study.
The perspective implies that hard drug users play an active role in beginning and continuing a life with drugs, that they make choices and that they are usually well aware of the (direct) consequences of such choices. There are both theoretical and empirical reasons for maintaining that, in a sense, they aspire to a deviant existence, because it provides a solution to individual problems that concern both social position and personal development. The illegality of the drugs used, and the illegality that therefore surrounds a life with drugs, is not a coincidental property of a drug that is sought after solely for its pharmacological effects. In other words, people who are attracted to illegal drugs are looking not only for dope, but also for illegality.

Logically, of course, this is a strong argument in favor of minimizing penal repression. However, for precisely the same reason, it is not a compelling argument for totally doing away with penal repression. Legalization may remove one of the elements of a deviant lifestyle, but it will not influence the "search", the motivation, and the (social) conditions that underlie that lifestyle. Nowadays, an interest in deviance may be satisfied by taking drugs, thanks to legislation, moral codes and fashion. In this sense, being an addict is no more, nor less, than an historical form of deviance; a bed along which a river of criminal behavior flows. A different fashion or change in legislation may divert the course of the stream, but this does not necessarily imply that it will run dry.

The results of this study show that addicts, at a certain stage in their development, are able to live "quiet" lives (having periods of abstinence, participating in high threshold methadone programs, not committing crime at all) despite the current illegal status of hard drugs. It seems that an optimal reduction of drug-related crime can be achieved if the criminalization of drug addicts is as moderate as possible. From the point of view of crime prevention, legalization is not necessary for those who have had enough of an illegal existence, and not enough for those for whom that existence still fulfills many functions. The assumption that legalization would immediately reduce drug-related crime derives from the same causal assumption underlying the (rejected) hypothesis that methadone maintenance in and of itself will lead to a reduction in crime rates.

The most relevant arguments for and against legalization concern the tension between primary and secondary prevention of drug addiction. This theme is especially relevant to social drug policy and only partially affects penal policy. For that reason we shall deal with it very briefly. In the Netherlands, social drug policy has two aims: (1) restricting the spread of drug-taking, and (2) limiting the adverse effects of drug-taking
that is already established. It is highly likely that legalization would have contradictory effects on these important policy goals. Lifting the prohibition on drugs will reduce the taboo on drug-taking and increase the availability of drugs through different channels. One needs only look at the (pseudo) legalization of pornography and cannabis in the Netherlands. They are offered for consumption very much more frequently than they were in the days when they were still banned, and the ban was enforced. There is no reason at all to suppose that things would be different for heroin and cocaine.

Legalization would not only increase the availability of drugs, it would also lead to changes in the attraction and significance of hard drugs. It is difficult to estimate what changes in the functions of hard drug use would take place and to what extent these would result in changes and increases in the consumer population. At least two important factors are at work here. On the one hand, drugs would be less attractive as an expression of a deviant style of life, and this could mean that the number of users would decrease. Or, as Nadelmann (1991) puts it with regard to Dutch cannabis policy: “The policy has succeeded (...) in making drug use boring”. On the other hand, greater accessibility could lead to more experimental users. However, experimental use needs not to become problematic use (Zinberg 1984; Cohen 1990). The greatest social (public health) risk attached to legalization may well be the greatly lowered threshold (both practical and psychological) for “normal” populations. We do not really want adolescents, at odds with school, their parents and themselves, to be able to escape too easily to a pharmacologically created other world. The “coffee shops” are already a place of asylum for some of these kids. The question of whether horse and coke would appear there on the menu after legalization is not just a figment of the imagination.

By the same token, it is indisputable that the problems faced by hard drug users would be greatly diminished after legalization. The illegality and marginality of being an addict would largely disappear. The significance of drug scenes would be greatly diminished. The quality of drugs would be controllable, the conditions under which they are taken more hygienic and developments around infectious “drug diseases” such as hepatitis B and AIDS more easily monitored.

On the demand side, the social problem of drugs can be defined as the product of two variables, the number of drug users and the extent of the problems per user. The question then arises as to the necessity of making concessions to the primary prevention of hard drug use for the sake of the secondary prevention of risk. There are many reasons for assuming that there is no great need to legalize drugs in the Netherlands. From an
epidemiological point of view, problematic drug use is a reasonably restricted and stable phenomenon. Pragmatic Dutch drug policy allows a variety of control strategies. Legalization is the obvious option if the “war on drugs” is lost. Contrary to the United States, there is, fortunately, no such war in the Netherlands.

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**Endnotes**

1. In the study we made a conceptional distinction between property crime, drug offenses and prostitution. In the Netherlands, prostitution is neither a criminal offense, nor a misdemeanor; therefore, this activity is not included in the crime figures. Since dealing in drugs is a crime without victims, drug-dealing offenses are also excluded from the figures we are about to present.

2. The used conversion rate for Dutch Guilders to US Dollars is 1.75.

3. Eighty-seven percent of the sample received at least part of their income from the social security system.

4. Information obtained from Richard Lane, executive director of this program.

5. Recently, the system of distribution has been changed drastically. Urine tests at the community stations have been stopped. This means that the health authorities have moved away almost entirely from the graduated model. Community stations are now meant to cater to addicts who need extra attention, the extremely problematic cases. The special station which previously existed to deal with these highly problematic cases has been abolished. In principle, clients of both buses and community stations must submit to a (social) medical examination once every three months. Because the data for this study were collected at a time when the health authorities still adhered to the promotion system, the results should be viewed in that context.

6. “Paired samples” means that we are not dealing with independent samples, but with a comparison of two values for the same respondent, namely income from crime during two different weeks. The differences between these values provide the so-called $t$ value.
XIII. THE FUTURE OF THE DUTCH MODEL IN THE CONTEXT OF THE WAR ON DRUGS

Tom Blom and Hans van Mastrigt

1. Introduction

From the beginning of this century, various international treaties have been closed aimed at a uniform drug policy in all countries of the world. The most important recent agreement in this respect is the Single Convention of New York. Virtually every country in the world (including the Netherlands) is now a party to this treaty. Beginning in the mid-seventies, the Netherlands started to deal with drug problems in a manner quite different from elsewhere in the world. Because of its unique drug policy, the “Dutch model” has attracted international attention. Often, the international opinion was negative, and the Dutch tolerance was met with an apparent lack of understanding. Over the last few years, however, more positive assessments of Dutch drug policy are heard more frequently.

Although respect for the Dutch model is certainly growing, there are several developments – particularly internationally – which possibly may threaten its continued survival. In this chapter, we describe a number of these developments. First, we place Dutch policy as it has developed since the mid-seventies in the context of the Single Convention. Then we describe a number of recent international developments in the United Nations and Europe. Finally, we summarize our discussion and speculate about the likelihood that the Dutch Model will survive in the international War on Drugs. In our discussion, we also include relevant domestic developments in the Netherlands.

2. The Dutch model and the Single Convention

Recent Dutch drug policy has been developed within the context of the Single Convention of 1961. This United Nations convention replaced the nine international drug-related treaties which existed prior to 1961 and is generally considered to be the foundation of both national and international developments in this area.
2.1 The Single Convention of New York

As is clearly stated in the preamble, the main goal of this convention was to protect humanity from the evil of drugs:

"The Parties, Concerned with the health and welfare of mankind, (...). Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind, (and) Conscious of the duty to prevent and combat this evil, (and) Considering that effective measures against abuse of narcotic drugs require coordinated and universal action, (and ...) calls for international co-operation."

Article 4 of the convention lists several general obligations of the parties to the treaty. The parties must take the legislative and administrative measures needed to put into operation and implement the stipulations of this convention, and must, consistent with the clauses of this treaty, limit "...the production, manufacture, export, import, distribution of, trade in, use and possession of drugs..." to medicinal and scientific purposes only. Parties to this convention are not only required to take legislative action but also to take an active role in its implementation. Supervision over the execution of the obligations of the convention is in the hands of the International Narcotic Control Board (INCB) - which has the right to conduct local inspections (Article 14, 1c) - and the Commission on Narcotic Drugs (CND). By its very nature, the Single Convention primarily targets the supply side of the drugs problem. Through administrative controls and criminal sanctions it aims to combat production and distribution of illegal drugs, thereby preventing people to get involved with illegal drugs. In addition, the Convention allows countries to "...take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends...".2

2.2 The Dutch latitude to maneuver

A direct consequence of the convention is that it restricts the latitude of the parties to the treaty to develop their own policies. However, Article 36, paragraph 4 of the Convention provides some room to develop unique, national emphases in prosecution and penalization policy:
"Nothing contained in this article shall affect the principle that the offenses to which it refers shall be defined, prosecuted and punished \textit{in conformity with the domestic law of a Party.}" (Emphasis added)

It is this provision the Netherlands used in its 1976 Revised Opium Act with regard to the de facto decriminalization of the possession of cannabis and a limited amount of other illegal drugs for personal use. Prior to the 1976 revision, the Netherlands had always acted in complete conformity with the manner in which other countries had implemented the Single Convention.

The drafters of the Revised Opium Act of 1976 did realize that the Netherlands should not expect much international understanding for the liberalization of its drug policy, which represented a more lenient approach to drug users in particular. The legislature feared negative international economic consequences, especially from its neighbor Germany, a country of extreme economic importance to the Netherlands. It was partly because of this reason that the revised legislation introduced a substantial increase of the maximum sentences for (inter)national trafficking in hard drugs; there should be absolutely no question that the Netherlands would be backing out of its international obligations. Consequently, the guidelines with regard to the investigation of drug offenses assigned the highest priority to the trafficking in hard drugs (and the large scale trafficking in hemp products). In this manner, the Netherlands met its obligations of the Single Convention, while at the same time creating some latitude to develop its own policy. The (partial) departure from the dominant international repressive ideology with regard to cannabis and the use of illegal drugs in general was thus compensated by the absolute conformity to the letter and the spirit of the international drugs legislation with respect to illegal drug trafficking.

These legislative adjustments did not insulate the Netherlands from foreign pressure and threats to give up its "tolerant" policy. For example, a rapidly escalating conflict developed when the Dutch town of Enschede decided to tolerate a small dealer in hemp products on the premises of the youth center "de Kokerjuffer". Germany, in particular, objected to the presence of a pseudo-legal dealer close to its border with the Netherlands. In response to this conflict, the International Narcotic Control Board visited the Netherlands to determine if the provisions of the Single Convention had been violated. They took no action, however; they accepted the argument that this component of Dutch policy was trying to prevent that youth would get involved in more dangerous and harmful drug use.
Germany was also twice involved in a conflict about the prosecution and punishment of Harm Dost, a Dutch small-scale dealer in soft drugs operating in Arnhem (a city close to the German border) who sold hashish to youth from Germany. On the insistence of German authorities Harm Dost was prosecuted and convicted for these facts in the Netherlands. However, when Harm Dost was on a vacation in Spain, West Germany requested and obtained his extradition from Spain because of his dealing in illegal drugs in Arnhem. In Germany he was tried and convicted to 10 years incarceration for the very same offenses for which he already had been tried and convicted in Holland. High-level diplomatic protests against the kidnapping and unlawful conviction of a Dutch citizen were of no avail. Dost had to serve many years of his prison sentence. Not only was he incarcerated in Germany for offenses that were exclusively committed in the Netherlands, but for actions which were typically not prosecuted under Dutch legal practice.

In spite of conflicts with its neighbors, the Netherlands managed to continue its unique drugs policy and thus built its unique reputation abroad. In 1985 the notion of “normalization” was introduced to provide a philosophical foundation for the policy; at the same time, a high priority was assigned to convincing other countries of the effectiveness and legitimacy of the Dutch model.3

3. Recent international developments

Policy developments at the international level have not remained at a standstill since the Single Convention in 1961. Within the same United Nations context new treaties important for national drug policy - and thus also for the Dutch model - have been developed.4 In addition to these developments at the global level, several things have happened in Europe. The obvious starting point for our discussion of European developments is the European Community (EC). Within the European Community framework, drug policies are developed and implemented. The EC has a parliament which has the authority to make decisions concerning the European approach to drug problems. Furthermore, within the EC context treaties are developed which may have a direct impact on the legislation and practices of the member states. Finally, a substantial number of groups concerned with policy making, coordination, information exchange, and so on, in the field of drug problems have emerged in Europe. To an important degree, these forums have been developed within the framework of the EC; some function within other international contexts, such as the Council of Europe.5
3.1 International drugs legislation within United Nations context

Since 1961 two important treaties have been developed within the context of the United Nations: The Convention on Psychotropic Substances of 1971 and the Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances of 1988. The Convention on Psychotropic Substances of 1971 may be viewed as a further expansion of the criminalization of substances not included in the Single Convention. The Convention against Illicit Trafficking focuses specifically on the legal means to combat the illegal drugs economy and may be viewed as the formal legal codification of the current War on Drugs.

The Netherlands had always taken the position that it was not necessary to enter into the Convention on Psychotropic Substances because the most important non-medical products (hallucinogens and amphetamines) of this agreement were already included in Schedule 1 of the Dutch Opium Act. With regard to the remaining drugs included in the 1971 Convention (barbiturates and tranquilizers), the Dutch did not see a need to participate in this particular international treaty; they considered the existing non-penal regulation of these drugs through the Medicine Act sufficient. However, pressured from several sides (the Schengen Agreement discussed later in this chapter, European Parliament, and the Convention against the Illicit Trafficking), the Netherlands has revised its earlier position on this matter and has entered the Convention on Psychotropic Substances. The legislative proposal to revise the Opium Act to make it consistent with this development is currently discussed in the Dutch parliament. A peculiar development is that, because the Netherlands has to abide by the conditions of the 1971 Convention, barbiturates and tranquilizers will be included in Schedule 2 of the Opium Act, while formerly, schedule 2 exclusively included solid blends of the cannabis plant.

The Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances is an instrument aimed against the illegal drugs economy. This agreement focuses on the law enforcement attack of trafficking in illicit drugs, in particular international cooperation with regard to international trafficking. The core of the Convention is Article 5. This article obliges all parties to the treaty to take the necessary measures to allow forfeiture of all profits from actions deemed illegal by this Convention.

To a large degree, the Convention against the Illicit Trafficking definitions are consistent with the current Dutch Opium Act. However, a new element is the obligation to criminalize the so-called laundering of prof-
its from drug trafficking. Although the Convention still has to be ratified, the Minister already has proceeded to implement it in a number of new legislative measures. These new legislative provisions include: the creation of a criminal financial investigation to determine the amount of the illegally obtained profits; the introduction of the seizure of the suspect’s property as security, to ensure that upon conviction the high monetary fine or required amount to compensate for illegally obtained profits is paid; a sentence of maximally six years of incarceration may be imposed in those cases where there is no possibility of redress on property; the separation of the procedure to determine guilt or innocence from the procedure to determine the amount of profits (in the latter procedure the burden of proof is based on a “balance of probabilities”); the possibility to seize anything that somehow was obtained illegally, independent of the charges and convictions.

The Dutch minister has been severely castigated for the manner in which he wants to implement this convention. Critics focus on the proposed violation of the legal principle that only one judicial body deals with the entire legal case; the violation of the praesumptio innocentiae in the procedure to determine the amount of illegal profits; and the reduction of the role of the Public Prosecutor to only represent the government’s interests in this procedure. Many fear that a substantial portion of Dutch criminal procedural law will be turned upside down because of the War on Drugs. Yet, it appears likely that the Netherlands will ratify the Convention, and that parliament will accept without much resistance the legislative proposals associated with this treaty.

3.2 Developments in Europe

At the European level, the European Community (EC) is of course of special importance. In order to secure the envisioned future economic, monetary, and (partly) political unification in the year 2000, EC countries desire extensive mutual cooperation in a multitude of areas. The desire for unification is formalized in the Treaty on European Union (February 7, 1992), also referred to as the Maastricht Treaty. This Treaty contains several interesting statements concerning the organization of future European drug policy; however, it appears at present that the chance that this Treaty will survive is highly uncertain. Therefore, for the present situation in Europe, other developments are currently of more importance.

In the section which follows, we discuss two European Parliament reports completed in the last several years. Although formally its powers
are limited, the discussion in the European Parliament is important because it serves as a good indicator of how, at the level of (party-)politics, the individual member states think about drug policy. Next, we discuss the Schengen Agreement and how it deals with drugs problems. At the conclusion of this section we focus on a number of groups within the EC and the Council of Europe, and their concern with drugs.

3.2.1 The European Parliament (EP)

The European Parliament has twice occupied itself with drug problems, resulting in two reports: the Stewart-Clark Report (1986) and the Cooney Report (1991). First, in October 1986 the British conservative Sir Stewart-Clark presented the report of the investigative commission on the drug problems in the EC. Then, in early 1991 the EP established another investigative commission to study the increase of organized crime in the member states of the EC associated with illegal drug trafficking. At the end of the same year, rapporteur Cooney presented a report of its findings. Because the Parliament in plenary session has taken positions different from those discussed in the report, the Presidium of the EP no longer allows distribution of the report. In this chapter, we use the Dutch version of the report. Neither commission has succeeded in presenting to parliament a unanimous final report; both have final reports with a majority and a minority opinion.

The Stewart-Clark Report: The Stewart-Clark Commission started its work on drug problems in Europe in October 1985; exactly one year later Parliament was able to evaluate its final report. The report consists of a majority position (with as its central focus the repressive approach to drugs), and a minority position (linking the emergence of organized illegal drug trafficking primarily to existing repressive policies). Although both parties agreed on a strict enforcement policy with regard to illegal large-scale dealing, the minority allowed for the possibility that legalization could be an effective tool to control this problem.

The Dutch policy was discussed in the debate concerning the desirability of legalization of heroin and cocaine. The majority referred to the Netherlands – together with Spain and Sweden – as an example of the failure of a “brief period of greater liberalization (with an) attendant high increase in the number of addicts”. The majority position referred also explicitly to the Netherlands in its discussion of the possibility of legalization of cannabis: As one of the arguments against legalization is mentioned that it is illogical to keep
dealing in cannabis illegal while decriminalizing its consumption. Yet, the report admits that the Dutch approach has not resulted in an increase in the number of users, and that "psychological problems connected with those illegally consuming the drugs have disappeared" (p 48).

For the minority in the Stewart-Clark Commission, the Dutch model shows that it makes sense to consider the legalization of certain drugs. The minority favors decriminalization of use, possession, and small-scale dealing. They argue: "It is incomprehensible that possession, use, manufacture, cultivation and marketing should be criminal offenses in the case of one drug and not in the case of another, when (illegal drugs and alcohol, nicotine, and mind-altering pharmaceutical drugs) are equally damaging to health..." (p 93).

After a lengthy debate, the European Parliament agreed to organize a European conference on drugs policy; at this conference the effects of the existent approach would be discussed. In addition, it was decided to recommend educational programs and the establishment of research centers. Finally, the report recommended the improvement of the coordination of police activities of the member states, and the establishment of a European Narcotics Brigade. Now, six years later, the proposed Narcotics Brigade is about to become reality.

**The Cooney Report:** On January 24, 1991 the European Parliament decided to establish an investigative commission specifically focusing on illegal drug trafficking. The commission started its work in February and finished its report on December 2, 1991. Again, the commission was divided, with a minority report signed by six members (among others, Stewart-Clark and rapporteur Cooney) and a majority position (nine members). Chair was the British Bowe.

Consistent with its specific assignment, the commission focused on how to approach organized illegal drug trafficking; in doing this, it beats its usual repressive drum. Police and customs must increase their cooperation; they argue in favor of the establishment of the European Drug Intelligence Unit (EDIU), and the establishment in each individual member state of a national Office of Narcotics, including a special department for financial crimes to investigate money laundering. They further favor mandatory registration for project development companies, the tourist industry, construction, and the arts because it is assumed that considerable money laundering takes place in these areas.

However, in several of its sections, "Dutch" ideas surface. For example, the report discusses a distinction between categories of drugs, varying from "ultra-hard" to "ultra-soft". Drug addiction is viewed pri-
arily as a public health problem, and next to cracking down on dealers, the report gives the highest priority to prevention, and assistance of addicts: "...The key to a definitive victory in the battle against drugs is at the level of demand..." (p 50). In the opinion of the majority there would need to be a more even balance between the expenditures for demand reduction and supply reduction. More facts would need to be collected about AIDS, social and medical problems and how to lower demand for drugs. Free treatment, needles and sometimes substitute drugs should be available. The recommendations even noted that, in view of harm reduction, a pragmatic approach needs to be followed where drugs in pure form are available in the right doses. However, the report rejects legalization of presently illegal drugs, partly because the United Nations (i.e., "the world") has declared drug use and drug trade illegal because these substances are harmful to body and mind, and disrupt family and society. The EC - itself a constitutional union - must accept and appreciate this (p 51). Nevertheless, in its recommendations an important breakthrough surfaces: Possession for personal use should no longer be viewed as an offense.

Again, a European conference is proposed in order to examine, not only the phenomenon of drug trafficking, but also the consequences (for democracy, and the safety and freedom of the citizens) of drug enforcement itself, including the harmonization of legislation resulting from the far-reaching economic unification as originally anticipated by the end of 1992 (but now postponed to the end of this decade). Finally, the CELAD (discussed later in this chapter) has to develop an integrated program of education of the population of all EC countries. At the same time, initiatives must be taken to provide drug information through the radio, television, and press.

Actually, the minority position deviates from the majority position in only one aspect, namely with regard to the decriminalization of possession for (own) use. The minority considers a certain degree of repression of users appropriate and feels that possession for private use should remain illegal. Furthermore, the minority believes that "...against the backdrop of a common EC policy (...), we must put a halt to the illogical policy that currently exist in a number of countries where trade in and supply of cannabis are illegal, but where the sale and possession of small amounts of cannabis are legally permitted..." (p 70).

At the parliamentary discussion of the resolutions on May 11, 1992, the majority opinion was rejected. The resolution that is finally accepted states that one does not believe "...that any form of legalization offers a practical solution for the drugs problem..." and one "...reaffirms support
for the legal order as expressed in the UNO treaties and the legislations of the member states...” Incidentally, the Dutch model is also used as a (usually terrifying) example during the plenary session. A French delegate (Lehideux) referred to the Cooney report as “scandalous”: “Through the lax measures it advocates in the direction of the Dutch model, it has sadly proven itself. It trivializes drug use and it facilitates drug trafficking...” (preliminary verbatim report of proceedings, Strasbourg, May 11, 1992, p 36). Another delegate believed that the Dutch (and the Spanish) government should realize that the lenient approach has devastated the lives of many young people and their families, among others because one believed that soft drugs were harmless. In the opinion of this delegate, there was now conclusive evidence that the use of soft drugs will lead to experimentation with hard, addictive drugs (ibid. p 33).

As the preceding discussion shows, opinions within the European Parliament with regard to drug policy remain greatly divided. However, it appears that the general tendency within this supranational organ is predominantly prohibitionist, and support for the preservation of the Dutch model or its spreading to other European countries is not to be expected from this side, at least not in the near future.

3.2.2 The Schengen Treaty

It goes without saying that the European Parliament is an important organ within the EC. However, it is definitely not very powerful, it is often internally divided, and it is probably mostly of symbolic significance. This is different for the treaties that have been made (and are still being made) in the context of European unification. We already referred briefly to the Maastricht Treaty, but the importance of this agreement for practical Dutch drug policy remains, for the time being, purely theoretical. This is definitely not the case for the more regionally oriented cooperation between several EC countries with regard to border traffic. In an agreement between Belgium, the Netherlands, Luxembourg, Germany and France entered into on June 14, 1985 (the so-called Schengen Treaty), the gradual abolition of checkpoints at the common border crossings was advocated. The treaty was meant to be a precursor of European unification in 1992.

The 1985 treaty devotes much attention to the potential negative consequences of the abolition of customs inspection at the borders. It proposes measures to prevent illegal drug trafficking across national borders. In 1985, the parties to the treaty had committed themselves to a more efficient coordination of drug enforcement (Article 8), including
the exchange of information about capital movement (Article 9). At the same time, it was agreed that, eventually, the participating countries would strive towards harmonization of legislation, specifically in the area of drugs (Article 19). Finally, the parties committed themselves to an exchange of all information useful “...to the coordination of their actions to combat the trade in narcotic drugs...”28

In the view of Dutch government officials, the treaty posed no special threat to the continuation of a specific “Dutch” drug policy. They were of the opinion that the Opium Act revised in that same year (Revised Opium Act of 1985) had satisfied Article 8, through the criminalization of illegal preparatory acts (Article 10a) and expanded judicial powers with regard to the prosecution of preparatory acts committed by foreigners abroad (Article 13). In their interpretation, Article 9 merely encouraged exploration of intensification of existing forms of cooperation. Finally, the explanation accompanying Article 19 noted that the Single Convention already provides the necessary foundation. Since all Schengen parties have entered into the Single Convention, the legislation is already harmonized, or so the Minister seemed to think.29

Since 1985 the countries involved have been in continued deliberation to work out the Schengen Agreement. The semi-annual reports indicate that the other Schengen partners view the Dutch cannabis prosecution policy as problematic. Germany, in particular, takes exception to the coffee shops, particularly in the border regions. Meanwhile, in order to escape this foreign pressure, the Netherlands has proposed a variety of measures to prevent foreigners from taking advantage of its relatively mild legal and penal climate. An example is the proposal to bar foreigners from Dutch drug assistance agencies. Incidentally, in some cities this policy has already been implemented: in Amsterdam, for instance, only in acute emergencies is methadone provided to foreigners who are not Amsterdam residents. Another Dutch concession is that coffee shops would no longer be allowed to sell soft drugs to “...subjects from other Schengen countries as well as foreigners in general...”30 This condition would be added to the already existing requirements for coffee shops: no dealing in hard drugs, no sales to minors, no advertising, no significant nuisance problems for the neighborhood.

After five years of talks, in 1990 the Schengen Implementation Agreement31 came about. On June 25, 1992, the Dutch parliament concurred. The Agreement rests on two pillars. The parties to the agreement are responsible for their own national policy, but they share responsibility for the consequences of this policy for the other Schengen countries. With respect to drug policy, this notion is reflected as follows: “...
one of the Parties in the context of its national policy regarding the prevention and treatment of addiction to narcotic drugs deviates from the principle established in Article 71, paragraph 2 (i.e. the administrative and legal prevention of illegal export, sale, provision and delivery of those substances - added by authors), all parties will take the necessary legal and administrative measures in order to prevent the illegal import and export of these substances (...).

The Dutch minister has interpreted this clause to mean a need for increased domestic control of drugs in order to compensate for the elimination of the border controls. Consistent with this view, he has already announced that the policy with regard to coffee shops will be strictly enforced.

The most important provisions in the area of drug policy are Articles 70-76 (narcotic drugs) and 39-47 (law enforcement cooperation). In these stipulations, the Agreement creates several obligations, such as the intensification of the scrutiny of border-crossing persons, goods and means of transportation to prevent the illegal import of narcotic drugs (Article 71, paragraph 3); provisions to confiscate the monetary gains from illegal drug trafficking (Article 72), and finally, provisions allowing the use of undercover drug agents and "controlled delivery" (provided that these tactics do not violate the national constitution and legal order). 32

Of importance for the investigation of violations of the Opium Act are also Articles 40-43 of the Agreement regulating the conditions under which observation and pursuit of suspects may cross national borders. The authority to follow suspects is restricted to a list of serious offenses, including the illegal trafficking in narcotic and psychotropic drugs. Except in emergencies, drug enforcement agents are required to obtain prior permission of the national authorities of the country where the pursuit takes place. Under certain conditions are drug enforcement authorities allowed to continue the pursuit on foreign territory of drug dealers caught red-handed in their jurisdiction. Clearly, these provisions expand to a considerable degree the freedom of foreign law enforcement agents to work on Dutch territory.

In addition to increasing repressive measures, the Agreement also pays some attention to the treatment aspect of drug problems. In Article 71 (paragraph 5), the Parties commit themselves to do whatever is in their power to prevent and counteract the negative effects of the illegal demand for drugs. However, it remains a matter of individual responsibility of the parties to determine exactly how that obligation is to be realized.

The joint statement accompanying Article 71, paragraph 2 obligates
the Netherlands to make sure that the Schengen partners are not inconvenienced by Dutch drug policy. According to the Dutch ministers, this means a thorough surveillance of the sales points of drugs, in particular in the border regions where many foreign addicts come to buy their drugs. The already mentioned stricter guidelines with regard to sale of cannabis to foreigners in coffeeshops reflects this effort. On the other hand, it remains Dutch prosecutorial policy not to turn over to foreign authorities criminal cases which would not be prosecuted in the Netherlands, for example for possession of user amounts of illegal drugs. In spite of this principled decision of the top officials of the Office of Public Prosecution, the Minister of Justice did establish a working group to develop guidelines on this matter.

Apart from the just discussed changes, the harmonization of drugs legislation and policy anticipated with so much fear by the Dutch, has not (yet) become reality. Harmonization has definitely taken place with regard to illegal trade in and possession of weapons; however, with regard to drugs, the emphasis has primarily been on improving cooperation. The question remains, however, whether the threat to the continued survival of the Dutch model indeed has past. Only experience will be able to tell the true extent of mutual tolerance between the parties.

3.2.3 European advisory groups

Finally, it is important to discuss the variety of groups (both inside the EC as well as those independent of the EC) where drug problems are under discussion. After all, decisions formally taken at the European level, for example by the Council of Ministers, often may be the result of discussions held in these forums in an earlier phase.

Figure 1 provides a schematic overview of the different organizations involved directly or indirectly in the debate concerning the drug policy in Europe.

Historically, the Council of Europe has been the most important forum for the shaping of European criminal justice cooperation, exchange of information and harmonization of regulation. It was within this structure that in 1971 the first European-level advisory group was established by George Pompidou (commonly referred to as the Pompidou Group). Presently, this advisory body has grown to include ministers of public health and justice from over 25 countries.

This body devotes attention to all aspects of the drugs problem, such as prevention, epidemiology, repression, law enforcement and juridical cooperation. As part of the Pompidou Group’s activities, there is an an-
Fig. 1. Schematic overview of drug advisory bodies in Europe.
nual conference of chiefs of police in charge of international airports, where the participants keep each other informed of recent developments in the area of smuggling methods and routes, as well as efficient investigation techniques and equipment.

There exist additional advisory bodies and ad hoc working groups in the field of drug problems within the European Community context. Unfortunately, these groups present a rather muddled picture. Since 1976, there is the Trevi Group whose goal it is to combat international terrorism (resolution of the EC ministers of June 29, 1976). In 1985 her task was expanded to include the exchange of information about law enforcement techniques and tactics for the combating of other serious forms of (organized) criminality with international aspects. The purpose here was not only to improve the infrastructure of the investigation through exchange of information and expertise but also the development of repressive and preventive strategies. At the suggestion of the Trevi ministers, the European Summit of Maastricht decided in 1991 to establish Europol. For the time being, Europol consists only of a European Drugs Unit (formerly referred to as the European Drugs Intelligence Unit (EDIU)), which is currently without any executive tasks. Using information provided by the member states, this agency would analyze information about internationally organized, serious drug criminality, to improve and coordinate the joint investigation.

Apart from the Trevi Group, drug problems are also discussed in other groups. For instance, there is the group Toxicomanie, associated with the Council of Ministers of Public Health. Over the past years, this group has been involved in activities related to the ethical and technical aspects of urine testing, drug use prevention, establishment of a European data network, development of alternatives for incarcerated addicts, and so on.

In addition, there is a group named Juridical Cooperation, another one by the name of Mutual Cooperation, and a group named RELEX, which involves itself with drug-related "relations extérieures".

In order to impose some semblance of order in this gamut of advisory bodies, the Comité Européen pour la Lutte Anti-Drogue (CELAD) (the European Committee for the War Against Drugs (proposed by French President Mitterand), was established in 1989. This intergovernmental coordinating group is directly accountable to the European Council (consisting of government leaders and heads of state). However, more and more the CELAD is operating as yet another new club developing its own activities. In 1990, CELAD drafted a European plan against drug addiction accepted by the European Council (in Rome). Although this plan is primarily targeting the supply side of the drugs problem, it does raise
the issue of the desirability of providing a more central place to harm reduction in view of the AIDS epidemic. In addition, CELAD has worked to establish a European Drugs Monitoring Centre; in its Guidelines for a European Plan to Combat Drugs (May 1990), CELAD clearly indicated that it did not want to limit itself to “social and health aspects, but also other drug-related aspects, including trafficking and repression”. The criminal justice component, in particular, encountered considerable resistance, among others in the Netherlands. As a compromise, agreement was reached that in the first years the data network will primarily include data concerning use, prevention, and assistance. It concerns scientific data on epidemiology, assistance (number of clients, types of assistance and organization) and data on (national) policy. The Center will obtain these data by means of an infrastructure of one or more national centers (so-called Focal Points), named REITOX (European Information Network on Drugs and Drug Addiction). The intention is that every EC country participates, under the jurisdiction of the Council of Ministers.

Trying to characterize the activities and focus of these advisory groups, it becomes very clear that they are mostly oriented towards aspects related to the coordination, cooperation, and organization of the combatting of illegal drugs trafficking. Of much less concern are prevention and assistance or treatment – the public health aspects which are of primary importance in the Dutch model. Furthermore, there is no question that the great diversity of groups and the unclear authorities and procedures are definitely unconducive to the effectiveness of the whole.

4. The chances of survival of the Dutch model

So far, we have described several international developments which may have an effect on the chance of survival of the Dutch Model in the international War on Drugs. In order to speculate about the preservation of the Dutch drug policy within an increasingly uniform international political system based on prohibitionism, we have to consider two issues. On the one hand, we have to estimate the power of international forces in shaping Dutch policy; on the other hand, we have to assess the degree to which the Netherlands can muster the internal power and force to resist these international pressures.

4.1 International pressures

The effects of the previously described supra-national developments are hard to estimate. For instance, it is hard to predict the consequences
of the Maastricht Treaty for European drug policy. The role of the European Parliament is also hard to place in this respect. Its two commissions (Stewart-Clark and Cooney) and the two plenary sessions devoted to their reports stood out through their contradictions, with alternating positive and negative opinions about elements of the Dutch model. And although the majority opinion in the recent Cooney report appears to take a step forward (particularly in comparison to the majority opinion of the Stewart-Clark report), the European Parliament in its plenary meeting was not able to arrive at a majority position.

Other developments, however, leave no doubt that the Dutch model has come under severe international pressure. Many countries have joined the American War on Drugs. The War on Drugs has been transformed from an American war into a world war, increasing international pressure on the Netherlands to adjust its drug policies. Dutch participation in the international fight against drugs trafficking, started in 1976, has continued even stronger in the early 1990s. The Convention Against Illicit Trafficking has been completely endorsed by the Netherlands, and has already resulted in severely criticized legislative proposals. And, although the original reasons for non-ratification have not changed, the Convention on Psychotropic Substances has also been signed by Holland.

Two spearheads of Dutch drug policy, the allowance of possession of small amounts of cannabis for own use, and coffee shops, appear most vulnerable to international pressures. For example, the problems surrounding coffee shops and drug-related public order problems in the Dutch-German border region seriously impaired negotiations related to the Schengen Agreement. In order to arrive at uniform policies several cities in the Dutch-German border area have recently started deliberations about the best approach to drug addiction.

Although the impact of the Schengen Agreement does not necessarily have to be detrimental to present Dutch drug policy, it is an undeniable political fact that the Netherlands is dependent on the tolerance of its neighbors, Germany in particular. The Kokerjuffer and Harm Dost incidents discussed earlier are not encouraging in this respect. Also, entering into the Convention on Psychotropic Substances further complicates matters: while previously (from 1976) the drugs in the Opium Act were listed on two separate lists allowing separate policies for hemp products and other illegal drugs, now the list for hemp products (Schedule II) has been "polluted" by all kinds of barbiturates which in practice will fall under another policy. This muddling of the waters makes the legitimation of the policy - both nationally and abroad - more problematic.

Finally, danger also lurks from the institutional context of the Single
Convention. In 1992, the INCB - the investigative organ of the Convention - paid another visit to the Netherlands aimed primarily at Dutch cannabis policy. This was triggered by the frequent stories in the international press concerning the greenhouse cultivation of high quality Dutch varieties of the hemp plant. In its annual report, the INCB concludes that the Dutch policy is not “in conformity” with United Nations conventions, in particular with respect to possession of cannabis for personal use. The Commission also questioned whether the Dutch policy indeed has resulted in the intended separation of the illegal markets in cannabis and other illegal drugs (e.g., heroin). The Commission did ask the Netherlands to reconsider its policy in view of the feared negative repercussions for the international community. In response, the Netherlands referred to the positive effects (i.e., low rate of fatalities, relative decline in number of minors addicted to drugs). The Dutch did consent to sharpen the control of coffee shops.

4.2 Dutch domestic developments

Whether the Netherlands ultimately will be able to resist international pressures generated by the War on Drugs depends also on developments on the home front, in particular the extent to which the Dutch model is able to preserve its national support. We are somewhat disheartened by recent developments. The primacy of public health aspects in the Dutch model implies that the Ministry of Public Health functions as coordinator of Dutch drugs policy; theoretically at least, an integrated policy is guaranteed through the Interdepartmental Steering Group Alcohol and Drugs Policy (ISAD), with representatives of the Departments of Justice, Public Health, and Foreign Affairs. It characterizes current developments in the Netherlands that this coordinating commission has not met for years; recently it was even discovered that this commission has ceased to exist altogether. This is consistent with the observation that in national debates on drugs the law enforcement approach is becoming more important, at the expense of the public health approach.

Several factors are involved in this shift in policy debate, but there is no question that the international developments described in this chapter play a substantial role. After all, the War on Drugs is primarily prepared and executed by the justice departments of the different countries. Although occasionally, the Ministry of Public Health has participated in international discussions, primarily the officials and political leaders of the justice department are the persons who have been instrumental in shaping the role of the Netherlands in international developments. There is an
increasing quest for more intensive international cooperation, particularly in the field of trafficking in illegal drugs. This is quite different in the area of public health, where international coordination is limited and there is much less striving towards a uniform policy. That is why internationally the public health approach has been more and more pushed to the background, and the initiative is primarily in the hands of the departments of justice. Not surprisingly, the international leadership position of the justice departments has ramifications for the position of the Ministry of Public Health in the Dutch government bureaucracy.

The position of the Ministry of Public Health is further undermined by other developments in general government policies. For example, recent budget cuts spared judicial agencies and law enforcement, unlike the "soft" areas of public health and welfare. Indeed, several budget cuts have affected the Public Health Department responsible for drug problems over the last several years. Furthermore, the central government now assigns high priority to decentralization of authority (including budgets) to the local level. Consistent with this policy, substantial amounts of money—occasionally earmarked for particular purposes—have been deposited in general funds from which individual municipalities receive their budgetary allotments. It is quite likely that future funds for assistance and treatment of drug addicts will be distributed in this manner. This means that the budget—and thus an important administrative tool in the setting of policy—of the Ministry of Public Health will be strongly reduced. Within certain boundaries, municipalities will be able to determine their own policy with regard to the public health aspects of the drug problems. In some cases this may provide an impetus for daring experiments consistent with the Dutch model. However, without central government intervention through budget restrictions, other local governments may start implementing policies much less concerned with harm reduction. In view of this, it is not unlikely that Dutch drug policy may begin to develop in a very fragmented and locally differentiated manner.

A recent change of personnel in key positions of the Ministry of Public Health may also affect the current shift in emphasis: two of the architects of the Dutch policy of normalization have left for other public health fields. In one fell swoop, a wealth of experience has disappeared, including expertise related to drug-related negotiations with the Ministry of Justice.

In sum, it seems that the Ministry of Public Health is losing its grip on developments in drug policy to the Ministry of Justice. It appears likely that its future role will be restricted primarily to funding of
national experiments, research, training and provision of information. If we are correct, and the formulation of drug policies becomes primarily the domain of the Department of Justice, then it becomes of vital importance for the survival of the Dutch model that the political and official leaders of this ministry genuinely support this policy model. However, recent international and national reports, policy plans, and memos reflect a different spirit among Ministry of Justice officials: a more forceful attack of illegal trafficking, no matter what the costs.

Next to the priority assigned to drug trafficking (and organized crime in general), increasing importance in the Dutch national debate is given to the fighting of public order problems - primarily a local responsibility - resulting from drug dealing and use. Amsterdam has played a leading role in this area, which is not surprising in view of the relatively large number of users (also from abroad) residing in this city. An additional powerful impetus to the national debate were the disturbances (in 1989) in the neighborhood of Klarendal in Arnhem (a town close to the German border) where most of the drug-related nuisance was blamed on (German) drug tourists. In part as a response to the problems in Arnhem, in 1990 a national working group was established to take inventory of available administrative and legal means to deal with drug-related nuisance and public order problems. In January 1991 this group presented a report including both an inventory and a set of recommendations. Central to this report (titled “Drugs and Nuisance”) is an “integrated approach”, favoring a policy which employs a combination of criminal law, civil law, alien law, and administrative law. This report is significant because of its proposal to make use of criminal justice measures in order to control drug-related public order problems - including when it involves people who only possess small amounts of illegal drugs. Significantly, the Working Group thinks no distinction should be made between soft drugs and hard drugs; they argue that for the citizens who experience nuisance problems it is irrelevant whether the problems are caused by the use of hard drugs or soft drugs. This report recommends almost exclusively repressive measures as solutions for public order problems, with particular emphasis on a harsh approach to foreigners.

Although the recommendations of the Working Group have not yet been translated into actual policy, the final report is a good illustration of the present philosophy of the Ministry of Justice - a philosophy which takes more and more distance from the policy foundations aimed at normalization expressed in the 1985 document “Drug Policy in Motion”. The Department of Justice now questions important assumptions of the Dutch model (e.g., protection of users by allowing possession of small amounts
for personal use). There is, incidentally, yet another reason why this particular Working Group exemplifies our pessimistic expectations with regard to the future of the Dutch model: the group spent a whole year studying public order problems and drug use, while the Ministry of Public Health (still the formal coordinator of Dutch drug policy) was never even informed of the existence of this commission.

As a final indication of the trend in Dutch drug policy, we mention the statements repeatedly made by the political leadership of the Ministry of Justice. In statements to the press, making reference to the need to develop policies consistent with neighboring countries, the Minister of Justice has expressed the desire to "sharpen" Dutch policy. Although these statements have rarely been translated in actual policy, they create a climate more and more receptive to changes in current policy. A recent example is a speech by the Minister in December 1992, arguing in favor of the introduction of mandatory "afkick programs" as well as a harder approach to the growing and trading of "nederwiet" and other hemp products. He stated: "The Netherlands cannot afford to become the laughing-stock of Europe in this already very delicate area of policy."60

5. Concluding comments

It should be obvious by now that our general expectations concerning the future of the Dutch model are bleak. Dutch drug policy is in real danger of changing into a war on drugs (aimed primarily at drug dealing and public order problems). The likely negative impact of this repressive policy on users of illegal drugs (as explained in the 1985 policy document favoring normalization) appears to play a slowly diminishing role in the decision-making process. Indeed, it seems that the containment of public health problems associated with drug use is no longer the center piece of Dutch drug policy; instead, drug trafficking and public order problems are gradually becoming the focal concerns of Dutch policy.

Yet, we want to conclude this essay with a few more hopeful signs, for not all international developments need to be interpreted as a threat to the Dutch model. A recent interesting development is taking place at the level of European cities. In order to develop a channel to influence (international) drug policy, a policy advisory consortium for cities was established in 1990. The thought behind this development is that drug policy is developed internationally and nationally, while drug problems mostly are concentrated in big cities - cities that typically are not able to exert a real influence on policy. Meanwhile, this consortium has drafted a proposal to decriminalize the purchase, possession and use of
hemp products and the non-prosecution of use, purchase, possession and consumption of small amounts of other illegal drugs. Together with Frankfurt (Germany), Hamburg (Germany) and Zurich (Switzerland), Amsterdam was among the first to endorse this proposal; recently the Dutch cities of Rotterdam and Arnhem also signed the resolution. Perhaps this initiative provides a new impetus to preserve or further expand the Dutch model at the local level. To compensate for the declining influence on local policy of the Ministry of Public Health, this organization of municipalities may stimulate Dutch cities to more innovative experiments. Rotterdam, for instance, for some time now has had “user rooms”, and there has been talk about initiating experiments with the supply of heroin. 

Internationally, there are also signs indicating a growing support for the Dutch model. In the past, the international opinion of Dutch policy was mostly negative, and “the Dutch tolerance” was met with incomprehension. However, lately more positive accounts of Dutch drug policy are voiced in the international arena. An important example of this growing understanding is Germany, formerly one of the staunchest adversaries of Dutch policy. There are a number of developments in Germany which reflect a partial adoption of the Dutch way of thinking. In particular after the AIDS epidemic, a number of the German federal states have started experimenting – albeit on a small scale – with methadone. In several German states, needle exchange or needle supply programs have been established, including needle machines, and German officials have expressed a desire to integrate elements of Dutch drug policy into the German approach to drugs. Illustrative of the recent change in climate was the admission of a government delegation of Bundesland Reinland-Westfalen that in the past Germany often had unjustly criticized Dutch drugs policy. This comment was made at a press conference during a visit to the Netherlands. Primarily because of the efforts of the SPD (German Socialist Party) which favors a more liberal policy, politicians have begun to question German drug policy. Furthermore, in 1992 an important development has taken place in German jurisprudence: the Lubeck court challenged the constitutionality of the punishability of cannabis relative to the absence of legal penalties for more dangerous substances such as alcohol and nicotine.

Finally, even within the United Nations some encouraging signs may be noted. For example, in the final statement of the 1990 World Ministerial Summit to Reduce Demand for Drugs and to Combat the Cocaine Threat held in London under the auspices of the United Nations, the participating ministers stated that demand reduction (prevention, treatment
and assistance, re-socialization) must have the same priority as supply reduction, and that, therefore, more funds should be allocated to the former. Also, in 1991 the Commission on Narcotics Drugs formally assigned a high priority to demand reduction (possibly reflecting the fact that the Commission was under Dutch chairmanship).

It is even possible to detect encouraging signs in the official United Nations Documents, which are not able to ignore some of the positive aspects of the Dutch model. For example, the 1991 Annual Report of the INCB mentions the Netherlands in one of its few positive references when describing the world drug problem: “The Netherlands is one of the few countries in Europe where the number of drug-related deaths continues to decline.”

In conclusion, internationally the Dutch model is under pressure, particularly because of developments in the field of law enforcement with regard to drugs trafficking. It appears that in this respect, the Dutch want to follow the repressive UN model, with all its negative consequences, including those for the position of users. As a countervailing trend, however, we see developments suggesting that more and more people outside the Netherlands are convinced that the War on Drugs does not provide a realistic solution to the drug problem; other countries have proposed (and sometimes even actually implemented) components of the Dutch model as realistic alternatives. The ultimate fate of the Dutch model will depend on the interplay between these two opposing developments.

Endnotes

4. At the global level, in addition to the United Nations, other organizations concerned with drug use exist; for instance, within the context of the so-called G-7 Conference. The G-7 Conference consists of six important industrialized countries from the West, (US, Canada, UK, France, Germany and Italy) and Japan. The G-7 Conference has two Task Forces dealing with drug-related issues: the Financial Action Task Force and the Chemical Action Task Force both of which deal with the trade in chemicals necessary for the production of particular drugs. The present paper excludes these groups from further discussion.
5. The Council of Europe consists of approximately 25 countries that cooperate in the areas of culture, public health, criminal justice and social welfare. The European Community, on the other hand, consists of three coalitions historically united by predominantly economical interests: the European Community for Coal and Steel, European Economic Community, and European Community for Atom Energy. Presently, the European Community has 12 member states (France, Germany, Great Britain, the Netherlands, Belgium, Luxembourg, Italy, Spain, Denmark, Ireland, Portugal, and Greece).


8. Minutes of the Dutch Parliament, 1990-1991, 22090, nos. 1-3. It should be noted that the guidelines will not tolerate the sale of barbiturates in the coffee shops.

9. It concerns the new legislation to supplement the Criminal Code and Criminal Procedure with provisions to fight fencing, and the expansion of the conditions under which illegally obtained profits may be seized.

10. The judge may base the probability that illegal profits are involved on the prosecution's (proven) argument that the convicted person has considerable material goods which reasonably cannot be assumed to result from his legal income, and the convicted person cannot present a plausible claim that his profits were obtained in a legitimate manner.

11. This is possible if a special criminal-financial investigation shows that it is reasonable to assume (i.e., it is not necessary to prove it) that additional illegal acts somehow resulted in illegal profits for the convicted person.


13. This principle implies that every person, prosecuted for a criminal offense, is presumed to be innocent until proven guilty by law.

14. In the inquisitorial system of the Netherlands, the role of the Public Prosecutor is broader than in the adversariaI American legal system. First, the Dutch Public Prosecutor functions as an administrator whose central concern must be to protect the government's interests. An example of this prosecutorial task is found in the prioritizing of prosecution of violations of the Opium Act (possession for personal use versus large scale dealing). Second, the Public Prosecutor functions as a magistrate, whose obligation it is to represent the interests of all parties involved in a case - including those of the accused. This two-fold responsibility even allows for the possibility that a Public Prosecutor requests acquittal. The proposal under discussion will minimalize the importance of the magistrate role of the Public Prosecutor.


16. The Maastricht Treaty includes, in addition to the establishment of the Council of Ministers of Home Affairs and Justice (K3) and the Coordinating Group (K4), the creation of the European Police Office (Europol) (Art. K.1 paragraph 9) and the European Drugs Intelligence Unit (EDIU). The Council of the Ministers of Justice and Home Affairs has been assigned an important role in the fight against drug addiction and unlawful drug trafficking. However, this topic is also discussed in the section on Public Health (title X, Article 129), where drug dependence is the only "major health scourge" explicitly referred to. (This may be related to the fact that the final text was formulated under Dutch chairmanship.)


19. To illustrate our point: during the last meeting of the Stewart-Clark Commission (September 1986), the recommendations were finally passed with 300 amendments.

20. We have absolutely no idea to which "brief period" the Commission refers.

21. The other two arguments concerned the fact that the cannabis trade still remains in the hands of criminal organizations, and the danger that more potent varieties will be cultivated, or that chemical substances (e.g., PCP) will be added.

22. They somewhat over-differentiate between ultra-hard (heroin, crack), hard (morphine, cocaine, methadone), medium-hard (amphetamine, LSD, barbiturates), medium-soft (opium, hashish, tobacco, distilled alcohol), soft (cannabis, fermented alcohol, mushrooms, tranquilizers) and ultra-soft drugs (tea, coffee, chocolate) (p 9).

23. Unfortunately, it remains unclear exactly what the commission has in mind with this.

24. Apparently the members of the commission believe it is no longer possible to be critical or to conduct a rational analysis simply because the United Nations has taken particular decisions in the past.

25. The minority position opposes this majority viewpoint based on the argument that in most of the rest of the world possession for personal use is illegal.


27. Meanwhile, the following countries have joined the Schengen agreement: Italy, Spain, Portugal and Greece. Only the EC member states of Denmark, UK and Ireland have not (yet) joined the Schengen Agreement.

28. Appendix 3 of the treaty: "Measures concerning the fight against drugs trafficking."


31. Treaty to implement the agreement between the Netherlands, Belgium, Germany, France and Luxembourg of June 14, 1985. Schengen Agreement with regard to the gradual abolition of the check points on common border crossings; June 19, 1990.

32. In view of the jurisprudence on the agent-provocateur and the secret pursuit of people, the Dutch judge is unlikely to object to this method.

33. Minutes of the Dutch Parliament 1991-1992, 22140, no 12, p 28. Although it concerns users of cannabis, the minister talks about "addicts" - a label considered inappropriate by most Dutch policy makers since the 1970s.


35. The intergovernmental consultation of the EC ministers who are responsible for domestic security and combating of crime.


37. An important point of debate is where this agency will be located. The Netherlands would like to house this prestigious agency. Of course, the image of Dutch policy abroad is an influential consideration. France - not entirely coincidentally also interested in housing this agency - complained [through the Minister of the Interior (Quiles)] that the Netherlands has a lax drug policy and therefore would not be suitable to provide the seat for this agency. This comment resulted in a diplomatic scuffle between the two countries.

38. The group is strongly law-enforcement oriented. An official of the Ministry of Justice represents the Netherlands, the Ministry of Welfare, Public Health and Culture provides the substitute.
39. European plan to combat drugs. DOC CELAD 126, November 22, 1990. In June 1992 the European Council instructed the CELAD to present a report about the implementation of the program before the end of that year.

40. Consists presently out of more than 25 countries which cooperate in the areas of culture, public health, criminal justice and social welfare.

41. This is the consulting body of the ministers of Public Health and Justice within the Council of Europe. This body devotes attention to all aspects of the drugs problem, such as prevention, epidemiology, repression, law enforcement and juridical cooperation.

42. Consists of three unions: The European Community for Coal and Steel, The European Economic Community, and the European Community for Atom Energy.

43. Consulting body between government leaders and ministers of Foreign Affairs.

44. Comité Européen pour la Lutte Anti-Drogue, established by the European Council in 1989 in order to coordinate the activities of the EC member states in the area of prevention, health, social policy with regard to addicts, and the combatting of (international) drugs trafficking. In 1990 they drafted the European Plan to Combat Drugs. It is this committee that originated the plan to establish a European Drug Observation Post and a European network for information about drugs and drug addiction (REITOX).

45. Working group of the Council of Ministers of Public Health. This group has been involved in activities related to the ethical and technical aspects of urine testing, drug use prevention, establishment of a European data network, development of alternatives for incarcerated addicts, and so on.

46. Existing since 1976, this advisory body of the ministers in charge of police and security, has been organized outside the EC organs. Initially it was established to fight international terrorism; however, since 1985 its task was expanded to include the exchange of information about law enforcement techniques and tactics for the combatting of other serious forms of (organized) criminality with international aspects, such as drugs trafficking. In June 1990 in Dublin, Trevi initiated the proposal for “national drug units”, which resulted in the establishment of the EDIU (European Drug Intelligence Unit), later renamed to Europol Drugs Unit.

47. The Commission presents her plans to the Council of Ministers and ensures that the decisions of the Council are implemented. In addition, the Commission may propose directives and regulations. A directive obligates the member states to adjust their national legislation according to that particular directive (for example, the Directive of October 6, 1991, on the prevention of the use of the financial system for the purpose of money laundering - 91/308/EEC). An ordinance is even more far-reaching. It replaces national legislation (for example, Regulation (EEC) No 3677/90 of December 13, 1990 mandating measures to be taken to discourage the diversion of certain substances to the illicit manufacture of narcotic drugs and psychotropic substances).

48. The institution which involves the citizens of the member states in the activities of the community. It plays only a modest role. It can give non-binding advice to the Council of Ministers and the European Commission (e.g., the reports of the commissions Stewart-Clark and Cooney).

49. Agreement signed by almost all EC members (except Denmark, Great Britain and Ireland) states to abolish the internal borders between the participating countries.


52. See, for instance, the relevant articles in the Schengen Agreement (Article 71, paragraph 5) and the Single Convention (Article 38), and the statements in the commission reports of the European Parliament.
53. At present, a (temporary) transitional provision (the so-called TFV - Temporary Financial Regulation Addiction Care) is in effect which still offers the Ministry (some) power to direct local or regional policy.

54. This opinion was also expressed in a recent interview of Eddie Engelsman, the former head of the division of the Public Health Ministry responsible for drug policy (NRC, July 2, 1992).

55. We refer here to Eddie Engelsman, (former) director of the Division of Alcohol, Drugs and Tobacco, and Léon Wever, (former) head of the section policy development (both in the Ministry of Public Health).


57. For several years now, a few areas in the center of Amsterdam have been declared emergency zones, which authorizes the police to prohibit people to be in these areas during a certain period (from 8 hours to 14 days). In addition, the police can take action against the possession of users' amounts of drugs and all paraphernalia related to drug use, such as lighters, spoons, and so on. Because of AIDS prevention, an exception is made for clean needles.


59. “Drugs and Nuisance”, p 6. In our view this undermines the rationale for drug-specific regulations in the realm of public order; it would be sufficient to employ general public order (local) ordinances. However, the Working Group does not follow this reasoning. See for a more extensive discussion of this report: “Kroniek rechten en criminologie: Drugs en overlast”. Blom, T. and Van Mastrigt, H, Tijdschrift voor Alcohol, Drugs en andere Psychotrope Stoffen 1991 17(5):183-188.


61. In September 1992, the annual report of the Rotterdam municipal police argued in favor of experiments with heroin distribution in the context of public order and criminality prevention.

XIV. AN ECONOMIC VIEW ON DUTCH DRUGS POLICY

D.J. Kraan

1. Introduction

In this Chapter, a description and analysis is given of Dutch policy with respect to illegal drugs from an economic perspective. However, in contrast to previous explorations in this direction (Stigler and Becker 1977, Pommerehne and Hartmann 1980, Becker and Murphy 1988, Pommerehne and Hart 1991), the focus will not exclusively be on drug consumers or drug producers and dealers, but also on the politicians and agencies who are responsible for the shaping and execution of drugs policy. In this approach these officials will not be treated as benevolent outsiders who seek to improve the outcomes of market behavior in accordance with some conception of the common good, but rather as participants in a system of politico-economic interaction on their own behalf. This can be characterized as a "public choice" approach to public policy, as opposed to a welfare-theoretical approach.

The analysis focuses on three different illegal drugs: cannabis, cocaine and heroin. Although there are many other illegal drugs, these three are the most important in terms of both market turnover and costs of government involvement. The analysis is based on already existing information. Availability of quality data is usually a problem in research on illegal drugs. Fortunately, in the Netherlands there is a relative wealth of data compared to other countries. On the one hand, data are collected by the care-providing institutions as part of their regular tasks; on the other hand, a small but very valuable empirical research tradition has developed in universities and specialized institutes, which aims at data collection among the drug users themselves. However, the relative abundance of data does not apply to all relevant behavior. As far as the drugs markets are concerned, much more is known about the demand side than about the supply side. Obviously, this reflects the higher degree of repression at the supply side.

The Chapter is organized as follows. First, I provide an economic characterization of the instruments of Dutch drugs policy. The next section describes the markets for cannabis, cocaine and heroin, first for the city
of Amsterdam (where most data are being collected), and subsequently for the Netherlands as a whole. The descriptions include the regulatory regime which the government has put in place for each market. Thereafter, a description follows of the services which the government supplies in the areas of law enforcement and health care, as well as a cost estimate of these services. The next section describes the net benefits of the regulation of the drugs markets and the provision of law enforcement and health care services to politicians and the public. Subsequently, I discuss the ways in which the improvement of information about costs and benefits may alter the nature of public policies, given the objectives of decision makers and given the prevailing decision rules. In order to provide an international perspective, the next section compares some important economic characteristics of Dutch drugs policy with those of the radically different drugs policy of the USA. The final section presents some conclusions.

2. An economic characterization of the instruments of drugs policy

From an economic point of view, the instruments of Dutch drugs policy may be distinguished into (1) the regulation of markets and (2) the provision of services.

In a formal sense, in the Netherlands "regulation of markets" implies, for each of the three drugs, the extreme case of complete prohibition in all markets (import, export, distributive and retail markets). However, according to Dutch criminal law (i.e., through the so-called "expediency principle"), there is a certain latitude for discretion in the sphere of law enforcement. Since this latitude is frequently used, for all practical purposes the nature of regulation must be identified on the basis of the factual prosecution policy. This policy is partially determined by the prosecution guidelines for which the Minister of Justice is politically responsible. The guidelines have the status of recommendations to the prosecutors associated with the district courts. These prosecutors consult with the local mayors and the chiefs of police about the application of the guidelines. As will be explained below, as a consequence of this arrangement the nature of regulation is strongly dependent on local circumstances. Furthermore, it differs for each of the three drugs, with a particularly marked difference between "soft" drugs (cannabis) and "hard" drugs (heroin, cocaine).

Publicly provided services in the area of drugs policy can be distinguished into (1) enforcement of the regulation of drugs markets (i.e., law enforcement), and (2) health care services for drugs consumers. Law en-
enforcement services can be characterized as public goods. Furthermore, these services are produced by public agencies and funded by public means. They should be distinguished from the enforcement of common criminal law and the repression of public nuisance among the consumers of drugs. It will appear below that, from an analytical point of view, this distinction is rather important because of a strong interdependency of the benefits of both kinds of law enforcement services.

Health care services can be characterized as private goods with strong “external effects” (effects on the welfare of people other than the primary beneficiaries of the services). The drug consumers are the primary beneficiaries. Health care services are funded entirely by politicians from public means. Furthermore, in the Netherlands they are produced by health care institutions outside the government.

3. The drugs markets

3.1 Cannabis

3.1.1 Prevalence in Amsterdam

Table 1 presents prevalence data for cannabis consumption in Amsterdam, as estimated in a recent survey.

<table>
<thead>
<tr>
<th>Percentage of population of 12 years and over</th>
<th>Number of consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last month prevalence</td>
<td>6</td>
</tr>
<tr>
<td>Last year prevalence</td>
<td>9.9</td>
</tr>
</tbody>
</table>

(From: Sandwijk et al. 1991; last column computed by the author.)

In the present Chapter, “current consumption” is interpreted as “last month” prevalence. According to this survey, in 1990 the estimated number of current consumers of cannabis in Amsterdam was 35,500.

3.1.2 Turnover and prices

It is estimated that the largest part of the total turnover at the retail stage can be attributed to the so-called (hashish selling) “coffee shops” (Jansen 1991:60). The remainder is sold by “house dealers”. Street dealing has virtually disappeared. In 1990 there were 110 coffee shops in the city center and about 300 in Amsterdam as a whole (Jansen 1991:60). On
the basis of systematic observation, total sales in the city center were estimated at approximately 42 million guilders in 1990 (Jansen 1991:56). Assuming that the average turnover in coffee shops outside the center is comparable to that of shops in the city center, total sales in Amsterdam in 1990 may be estimated to have been about 115 million guilders.

Coffee shops typically sell hashish and marihuana from various countries and of different qualities (Moroccan, Columbian, Dutch sinsemilla, and so on). Prices vary accordingly. Most brands sell for between four and 15 guilders per gram. The average price is eight guilders per gram (Jansen 1991:61,67). Given the estimated turnover of about 115 million guilders, the total physical turnover of the coffee shops in Amsterdam can be estimated at 14,000 kilograms per year. Since buying from coffee shops rather than from house dealers has clear advantages from the point of view of quality reliability and price information, it is generally assumed that in recent years the turnover of the coffee shops has surpassed the retail turnover by house dealers by far. If the house dealers would still sell half as much as the coffee shops - which in view of the mentioned development is probably an inflated estimate - the total physical turnover in the retail market of Amsterdam would amount to 21,000 kilograms of cannabis, and a total monetary turnover of 170 million guilders per year.

On the basis of prevalence studies, it is estimated that the total number of current consumers of cannabis in the Netherlands is presently about 400,000 (Stichting Informatievoorziening Verslavingszorg 1993). Assuming that the average use per consumer outside Amsterdam is equal to that of the average consumer in Amsterdam, the turnover of drugs in the Netherlands as a whole would be 11 times the turnover in Amsterdam. This would amount to a national estimate of about 230,000 kilograms and about 1900 million guilders per year.

3.1.3 Structure of the retail branch

The retail sector for cannabis in the center of Amsterdam consists of large, intermediate and small enterprises. The four largest enterprises exploit ten coffee shops with a total market share of about 30%. The 12 intermediate enterprises manage 18 coffee shops with a total market share of about 25%. The 71 small enterprises exploit 82 coffee shops with a total market share of approximately 45% (Jansen 1991:78).

Typically, coffee shops are set up by former street dealers who have become “sedentary” (Jansen 1991:64). In 1980, the number of coffee shops was still less than 20 (Cohen 1981). At the present time, a stage
of complete commercialization has been attained. Competition is strong but focuses on quality assortment, mode of delivery (weight variety of prepacked portions, possibility of weighing out on the spot), location and atmosphere, rather than on price. This type of competition is comparable to that of the sector of bars and pubs.

The profit margin of successful coffee shops is probably comparable to that of bars and pubs: about 50% (Jansen 1991:62). This would amount to total gross profits of the coffee shop sector in the Netherlands of about 950 million guilders. While cannabis, in itself, being an illegal substance, cannot be taxed, the profits of the coffee shops are subject to income tax.

3.1.4 Regulation of the retail market

Formally, the possession of small quantities of cannabis is a misdemeanor; possession of larger quantities is a felony. Materially, because of the expediency principle discussed earlier, there are considerable differences depending on local circumstances. Important factors determining the local law enforcement response are the tolerance of the population (which tends to be greater in big cities than in smaller towns and villages), and the presence of a hard drug problem (which draws attention away from cannabis). Furthermore, the personal preferences of district court prosecutors or judges (i.e., lenient or strict), represent an important factor.

In the big cities, the possession or sale of less than 30 grams of cannabis is materially “legalized”. In 1987, Amsterdam tightened its policy. Now the limit of 30 grams is taken more seriously than before. The Amsterdam police has occasionally raided coffee shops in order to check their inventory. However, it cannot be said that, at the present time, the limit of 30 grams is strictly enforced in Amsterdam or elsewhere. Much depends on the good relations of coffee shop owners with the neighborhood and the responsible police officers.

3.1.5 Structure and regulation of markets for import, export and distributive trade

Much less is known about the import, export and distribution of cannabis than about its retail trade. It is assumed that 10 to 20% of the turnover in the retail market is produced domestically (“nederwiet”; Jansen 1991:145). This would amount to 18,000 to 36,000 kilograms per year. Production takes place in greenhouses in the country and, more and more, indoors using artificial light. The quality of the domestic product has im-
proved markedly in recent years. Accordingly, its retail price has risen to as much as 25 guilders per gram (for the top quality of Dutch sinsemilla), which is considerably higher than the normal prices of the imported variety.

Next to nothing is known about import, export and transit of cannabis. In some publications, estimates are based on quantities seized by the police and customs office (84,292 kilograms in 1991). This quantity is then multiplied by a factor of ten in order to obtain an estimate of total sales (export, transit and retail) in the Netherlands. This estimation method must be considered entirely arbitrary and unreliable. It is likely that quantities seized are strongly dependent upon the priority given to police investigation in this area and that strong random factors are involved.

Most imported cannabis enters the country by ship. The import trade is thought to be interwoven with the international trade in legal products, such as oranges and furniture. The Netherlands is an important transit country for cannabis from Morocco destined for Germany, Denmark and England (Driessen and Jansen 1991:31).

In view of the severe risks involved, activities in the higher levels of the trade column will be more profitable than the exploitation of coffee shops or dealing at the retail level. Possibly, profit margins are comparable to those of large-scale trade in cocaine and heroin, which in some studies have been estimated at 200 to 300% per independent trader (Cachet 1990).

3.2 Cocaine

3.2.1 Prevalence in Amsterdam

Table 2 presents prevalence data for cocaine use in Amsterdam, as estimated in a recent survey.

<table>
<thead>
<tr>
<th>Percentage of population of 12 years and over</th>
<th>Number of consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last month prevalence</td>
<td>0.4</td>
</tr>
<tr>
<td>Last year prevalence</td>
<td>1.3</td>
</tr>
</tbody>
</table>

(From: Sandwijk et al. 1991; last column computed by the author.)

The survey from which these data were taken was not directed at the group of "problematic consumers"; that is, consumers with a problematic pattern of drug consumption indicated by involvement in health care
3.2.2 Turnover and prices

The number of problematic drug consumers in Amsterdam is estimated at 7000 (De Zwart 1992). A substantial part of this group consists of so-called poly-drug users (users of more than one drug). Seventy-five percent of this group uses cocaine in combination with heroin. This adds approximately 5000 consumers of cocaine to the 2500 non-deviant current users that can be extrapolated from the Sandwijk et al. (1991:54) survey, bringing the total of current consumers of cocaine in Amsterdam to about 7500.

3.2.2 Turnover and prices

The most reliable method of estimating the turnover of cocaine for domestic consumption is probably to deduce it from the level of use per consumer. On the basis of a recent study, it may be estimated that the average use of a non-problematic current consumer of cocaine in Amsterdam amounts to 2.4 grams per month (Cohen 1989). The average level of use of the problematic consumer has been estimated at 14.6 grams per month (Grapendaal et al. 1991:128). Given the estimated numbers of consumers (2500 non-problematic; 5000 problematic), this amounts to a total physical turnover of approximately 950 kilograms per year for consumption in Amsterdam (70 kilograms (7%) by non-problematic consumers and 880 kilograms (93%) by problematic consumers).

There is a considerable variation in price. This is typical of a market of a strongly repressed consumption good, where supply is irregular and strongly dependent on the random factor of seizures in all chains of the trade column. A 1987 study suggests that prices may vary between 120 and 220 guilders per gram, with an average of 180 guilders per gram (Cohen 1989). Given this average price and the already mentioned estimated physical turnover, total monetary turnover for cocaine consumption in Amsterdam amounts to 170 million guilders per year.

On the basis of prevalence studies, it is estimated that the number of consumers of "hard drugs" (cocaine, heroin) in the Netherlands as a whole is three times that of Amsterdam (De Zwart 1992). Assuming an equal average use per consumer, this amounts to an estimated physical turnover of 2850 kilograms and a monetary turnover of 510 million guilders per year for domestic consumption.

3.2.3 Structure of the retail market

A recent study shows that 21% of non-problematic consumers buy cocaine from dealers in bars and discos (who make a profit), 34% from
other dealers (who also make a profit) and 45% from "friends" (who do not make a profit) (Cohen 1989). Assuming that the "friends" buy it from dealers in bars and discos and from other dealers in the same proportion as the consumers not buying it from friends, this would amount to a market share of 38% for dealers in bars and discos and of 62% for other dealers. As far as the group of problematic consumers is concerned, it seems plausible to assume that the role of bars and discos in the retail market is smaller, and that most of these consumers buy it either from other dealers or from friends.

In view of the comparable risks, the profitability of retail dealing in cocaine may be similar to that of dealing in heroin, which in some studies has been estimated at about 20 to 30% (Cachet 1990); this would amount to 100 to 150 million guilders in the Netherlands as a whole.

Due to the relatively lenient judicial policy towards the possession of small quantities of cocaine, the retail trade is quite dispersed. There is a relatively large group of consumers who can make a living out of street dealing and related mediation services concerning cocaine and heroin. The later discussion on heroin will expand on this.

3.2.4 Regulation of the retail market

Regulation of the retail market is strongly dependent on local circumstances. Formally, the possession or sale of any amount of cocaine is a felony. Practically, repression by law enforcement is focused on large-scale trade and on consumers who are causing a nuisance (usually problematic consumers). However, when cocaine or heroin consumers are arrested in possession of small quantities, apparently for own consumption or small-scale street dealing, no further steps are taken and often the cocaine or heroin is not even seized.

3.2.5 Structure and regulation of markets for import, export and distributive trade

Very little is known about import, export, production and distributive trade in cocaine. Since rumors about coca cultivation in glass-houses are probably untrue, it may be assumed that the entire domestic turnover is imported, almost exclusively from South America. Again, the estimates of transit based upon quantities seized by the police and customs service (4288 kilograms in 1990) must be considered entirely unreliable. The Netherlands is thought to be an important transit country but, according to a recent study, its transit share is diminishing as a consequence of
increasing repression (Driessen and Jansen 1991). At the present time, Dutch judicial policy with respect to large-scale trade is comparable to that of other West European countries and in some respects even more repressive. Obviously, the presence of a large harbor in Rotterdam remains an important determinant of transit trade, but other European countries also have large harbors (Hamburg, Bremen, Antwerp, Marseille, Le Havre, Bilbao, Lisbon). To the extent that the consumption of cocaine in the hinterland of those harbors will increase, the relative importance of Rotterdam will diminish. Another important factor consists of the traditional ties that the Netherlands has with the Latin American country of Surinam. A substantial proportion of the Surinam population has relations with the Surinam community in the Netherlands. The significance of Surinam for the Dutch cocaine trade depends partially on the regulatory policy and the effectiveness of law enforcement in that country. At the present time, new forms of cooperation in the area of law enforcement are being developed between the Netherlands and Surinam.

It is characteristic of the lack of knowledge about large-scale trade in cocaine that key experts hold widely divergent views about the relative importance of large criminal syndicates (Driessen and Jansen 1991; Korf and De Kort 1990). According to one view, large-scale trade in cocaine and heroin is predominantly in the hands of permanent, large or medium-sized organizations consisting of one or two leaders, a group of five to ten insiders and a larger group of associates available for temporary jobs. In this view, some of these organizations may be connected to the large Columbian drug cartels such as “Medellin” and “Cali”. According to an opposing view, the trade of cocaine and heroin is largely in the hands of transient small groups and family enterprises. According to this view, there is a minimum of organization and the recruitment of assistants is often arranged around the preparation and execution of a particular deal.

According to an internal memorandum from the Dutch Criminal Investigation Information Service, 130 drug trading groups are known to the police (Driessen and Jansen 1991). At most, 25 of these groups are believed to include from 20 to 30 people and no more than 20 include more than 30 people. These numbers do not provide a conclusive answer to the opposing views about the market structure of the large-scale trade. It seems undeniable, however, that at the level of import and export trade a large number of small, poorly organized and primitively operating groups are in business alongside a number of more sophisticated organizations. This is obvious from the large numbers of poorly dressed, foreign traffickers, often women, who are picked up from international flights and arrested with relatively small quantities of packaged cocaine
and heroin in their luggage, clothing or stomachs.

There is more agreement among experts that the large-scale trade in drugs is horizontally diversified: trading groups specialize in drugs, and often deal only in one single type of drug (Driessen and Jansen 1991:16). The cocaine trade is mainly in the hands of Dutch groups (although recently some small-scale networks of South American traders have been observed). However, in order to spread risk and to protect the import and export networks, the trade column serving the domestic retail market is vertically rather diversified. There will often be two or more distributive traders between the importer and the retail trader. Each trader will only know his immediate supplier but is kept ignorant of the higher chains in the trade column.

In view of the comparable risks, the profit margins in the large-scale trade of cocaine are probably similar to those of heroin, which in some studies have been estimated at 200 to 300% per independent trader (Cachet 1990).

3.3 Heroin

3.3.1 Prevalence in Amsterdam

Little is known about heroin consumption outside the group of “problematic consumers”. Furthermore, in typical survey studies, the consumption of heroin appears to be virtually non-existent, in contrast to cocaine. It may be the case that heroin consumption outside the problematic group is relatively insignificant. Whatever the case may be, for the purpose of estimating prevalence and market turnover, it is appropriate to work with data about the relatively well-researched heroin consumption patterns in the problematic group. The number of current problematic consumers of heroin in Amsterdam is estimated at about 7000 (De Zwart 1992), which amounts to 1.2% of the population of Amsterdam of 12 years and over.

3.3.2 Turnover and prices

As was true for cocaine, the most reliable method for the estimation of the total turnover for domestic heroin consumption is probably to deduce it from the level of use per consumer. In a recent study, the average use per consumer was estimated at 7.7 grams per month (Grapendaal et al. 1991:128). Given the estimated 7000 consumers of heroin, this would amount to a total physical turnover of about 650 kilograms per year in Amsterdam.
Retail prices of heroin, like those of cocaine, are rather volatile, due to the strong repression of the entire heroin trade sector. The Criminal Investigation Information Service reported an average retail price ("street value") of 92.50 Dutch guilders per gram in 1987 (Driessen and Jansen 1991). Given this price and the estimated physical turnover of 650 kilograms per year, the total monetary turnover for heroin consumption in Amsterdam would amount to 60 million guilders.

Given an estimated number of consumers of "hard drugs" in the Netherlands as a whole of approximately three times that in Amsterdam (De Zwart 1992), and assuming an equal average use per consumer, the physical turnover for heroin consumption in the Netherlands would amount to approximately 2000 kilograms per year, and the monetary turnover for heroin would be about 180 million guilders. 4

3.3.3 Structure of the retail market

In the seventies and early eighties, a large part of the heroin retail trade in Amsterdam took place in the so-called heroin cafés on the Zeedijk and their immediate environment (the "drug scene"). Because of the increasing nuisance these establishments were creating in the neighborhood, concerted action was taken by the police and the municipal authorities in the mid-eighties to improve the situation. The heroin cafés were shut down and the police intensified its surveillance of the neighborhood. As a consequence, the heroin retail trade moved to the streets. Since street dealing in a closely patrolled area requires quick and simple transactions with a minimum of risk per transaction, this policy definitely enhanced the dispersion of the heroin retail trade.

A recent study provides a sketch of the typical trading practices in the drug scene of Amsterdam (Grapendaal et al. 1991). Two or three times a day the principal dealer appears on the market. In a safe place, he divides his stock among a small number of trusted street dealers, who usually obtain the merchandise on consignment. Each street dealer receives between ten and 20 rolls of "brown" (heroin) or "white" (cocaine). A roll consists of either a tenth or a quarter of a gram. The street dealer usually earns one roll for himself for every five rolls he sells. He can use his earnings either for his own consumption or sell it on his own account. The next time the principal dealer appears, the street dealer hands over the money and receives the new merchandise. The street dealers often work for more than one principal dealer at the same time. In general, they have a busy life (one of the attractions of the drug scene for otherwise unemployed adolescents). In order to spread the risk further, the street
dealers often make use of assistants as package carriers and lookouts. Package carriers carry the rolls of white and brown for the street dealers (and thus run the risk of arrest), but are not allowed to handle money. Lookouts are stationed in the vicinity of where deals are taking place and warn the street dealers when the police is approaching. Package carriers and lookouts are paid in kind by the street dealer, just as he himself is paid in kind by the principal dealer.

The drugs market provides an income not only to street dealers, package carriers and lookouts, but also to service branches such as “garbage men” and lessees of “shooting galleries”. Garbage men collect used needles and exchange them for new ones at health care posts. Shooting galleries are safe places for using drugs. In all, around 15% of the problematic consumers of heroin earn a living from street dealing and mediation services in the drugs market.

Principal dealers typically do not consume heroin themselves. In contrast to coffee shop owners, they have low costs, but the risks of arrest and imprisonment are much higher. In some studies, profit margins at the heroin retail level have been estimated at 20 to 30% (Cachet 1990), amounting to 40 to 60 million guilders in the nation as a whole.

3.3.4 Regulation of the retail market

Just as for cannabis and cocaine, heroin regulation is strongly dependent on local circumstances. Although formally the possession of any quantity of heroin is a felony, materially repression is targeted on large-scale trade and on those consumers who cause a nuisance. The possession of small quantities heroin for personal consumption or small-scale street dealing is not prosecuted. Criminality to property by heroin consumers is prosecuted, but only a minority of the problematic consumers engages in such behavior (Grapendaal et al. 1991: Ch. 6). In general, no judicial action is taken against the majority of problematic consumers who do not harm other people. Nevertheless, there is a grey area in the sphere of repeated and extensive petty drug peddling, in combination with creating a public nuisance; local circumstances determine the kind of response these drug consumers face.

3.3.5 Structure and regulation of markets for import, export and distributive trade

Generally speaking, what has already been said about the structure and regulation of the large-scale trade markets for cocaine applies to heroin
as well. Here too, there is a strongly diversified trade column serving the domestic heroin market and a mixture of more or less sophisticated trading groups for distribution, as well as for import and export. The quantity of heroin seized by the police in 1990 was 532 kilograms. A major difference is that, while the large-scale trade in cocaine is mainly a Dutch business, the large-scale trade in heroin has traditionally been in the hands of Chinese, Turkish and Pakistani nationals. At lower levels in the heroin trade column, many people of Surinam descent are also active (Driessen and Jansen 1991:20).

4. The costs of regulation and collective services

4.1 Real and apparent costs

One of the basic premises of the economic theory of bureaucracy is that in public agencies the incentives to improve the efficiency of production are much smaller than in private enterprises. In particular, it is very likely that in public agencies there will be a discrepancy between the real costs of services (“opportunity costs”) and the financial means which are actually spent to produce the services. The latter may be termed “apparent costs”. The difference between apparent and real costs is known as “managerial discretionary profit”. From a normative point of view, this margin can be considered pure waste. If the margin is zero, production is technically efficient, otherwise the technical efficiency of production can be improved. In general, administrators of public agencies will seek to enlarge managerial discretionary profit because this can be used for discretionary purposes, for instance, a larger work force than necessary to produce the services or luxurious office equipment (Migué and Bélanger 1974).

Not all collective services are supplied by public agencies. In the area of drugs policy, law enforcement services are mostly provided by public agencies, but in the Netherlands publicly funded legal assistance and the entire cluster of drug-related health care services are provided by private agencies. From an economic point of view, supply by private agencies has two advantages. Firstly, a private agency has a better incentive to produce efficiently, because it is allowed to keep its exploitation surplus even when this cannot be transferred in the form of “profit” to private “residual claimants” (shareholders or owners); take, for instance, private foundations in the sphere of ambulant health care which can keep and re-invest their exploitation surplus. Secondly, it is much easier to open up the market for competition. Often, there are various agencies in the
same area which can supply the same services. In that case the govern-
ment can grant the contract to the agencies which offer the services at
the lowest costs. Furthermore, even when agencies hold a regional mo-
nonopoly, it is possible for government to compare performances and to
equalize public financial contributions at the lowest level. This implies
that profits in private agencies tend to be eliminated either by competi-
tion or by governmental action and that the apparent costs of these agen-
cies can be used as a reasonable approximation of real costs.

4.2 The costs of regulation and law enforcement services

The following approximation is based on the assumption that there are
no other costs of regulation than enforcement costs; in other words, it is
assumed that the costs of decision making about regulation are negli-
gible. The enforcement of regulation involves: (1) police services; (2)
judicial services (prosecution, adjudication and legal assistance); and (3)
penitentiary (i.e., correctional) services.

With the exception of legal assistance, all these services are provided
by public agencies in the Netherlands. The discussion in the previous sec-
tion suggests that apparent costs, as reported in governmental budgetary
documents, may substantially exceed real costs (i.e., contain waste). In
view of the fact that the political demand for enforcement services in the
area of drugs is probably inelastic, it is likely that the agencies supplying
these services are able to extract a margin of managerial discretionary
profit that is even higher than average among public agencies.

No information is available about the real costs of law enforcement
services (with the exception of a few specific studies about particular
agencies). Therefore, apparent costs will be estimated in order to obtain
an idea of the financial burden related to drugs policy. The estimates in
Table 3 are based upon the following assumptions:

a. The apparent costs of the police for the enforcement of drugs laws
amount to 7% of the total apparent costs relating to the enforcement
of all criminal law; this percentage is based on the estimate that the
police devotes 28% of its time on the investigation of felonies; in turn,
the investigation of felonies accounts for 26% of the time devoted to
the enforcement of all criminal law.\(^5\)

b. The following divisions of the police are seen as being involved in the
enforcement of criminal law: the Criminal Investigation Information
Service, the Corps National Police, the Advisory Center for the Admi-
nistration of Police Vehicles, the Police Communication Service, the
Police Logistic Service and the municipal police; 7% of the special
national budget for criminal prevention projects by the police is taken to be the apparent costs of these branches.

c. The apparent costs of the offices of the public prosecutors, judiciary and bar for the enforcement of drugs laws account for 3.6% of the total apparent costs of these agencies, relating to the enforcement of criminal law; this percentage is the proportion of the total number of final dispositions regarding violation of sections 10 and 11 of the Opium Law.6

d. It is assumed that 44% of the salary costs of judges, 32% of the salary costs of supporting court personnel, and 40% of the material costs of the courts are apparent costs of the judiciary, relating to the enforcement of criminal law; the cost of criminal procedures (i.e., costs of bailiffs, witness examinations, and so on) are also taken into account. These figures are estimates of the proportion of the total apparent costs of the judiciary, relating to the adjudication phase of criminal procedures.7

e. The apparent costs of the penitentiary services relating to the enforcement of drugs laws represent 18% of the total costs of common public correctional institutions (not including institutions for pathological delinquents), public institutions for juvenile delinquents, and private institutions for juvenile delinquents; this percentage represents the proportion of the institutionalized population convicted for violation of sections 10 and 11 of the Opium Law on 30 September 1990.

Table 3. Costs of the enforcement of drugs laws

<table>
<thead>
<tr>
<th>Services</th>
<th>Costs (in million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>266</td>
</tr>
<tr>
<td>Judicial services</td>
<td></td>
</tr>
<tr>
<td>- offices of public prosecutors</td>
<td>7</td>
</tr>
<tr>
<td>- judiciary</td>
<td>9</td>
</tr>
<tr>
<td>- legal assistance</td>
<td>3</td>
</tr>
<tr>
<td>Penitentiary services</td>
<td>125</td>
</tr>
<tr>
<td>Total</td>
<td>410</td>
</tr>
</tbody>
</table>

(Computed by the author on the basis of the state budget for 1992 and the assumptions mentioned above.)

4.3 The costs of health care services

In the Netherlands, the following drug-related health care services are available:
1. Twenty clinics and departments of general psychiatric hospitals for addiction treatment with 1060 beds.
2. Sixteen Consultation Bureaus for Alcohol and Drugs with 105 offices.
3. Thirty-six regional agencies for social and medical care to drug users with offices in 45 municipalities.
4. Methadon programs at seven municipal health care services.
5. Three clinics for addiction treatment of special groups.
6. Three institutes for research, information and development of expertise.
7. An action program for projects and experiments in the sphere of prevention (including prevention of AIDS), addiction among ethnic minorities, associations of users, research and international cooperation.

All these services are provided by private agencies and fully funded by the central government. The clinics and hospital departments mentioned under subsection 1 are paid for by income-dependent premiums on the basis of a social insurance law which covers special medical services. The social and medical services mentioned under subsections 2, 3 and 4 are provided by private agencies and municipalities and are funded by grants-in-aid to the municipalities. The clinics and institutes mentioned under subsections 5 and 6, and the action program mentioned under subsection 7, are funded directly by the central government.

The cost estimates in Table 4 for the services of clinics and departments of general hospitals for addiction treatment, the Consultation Bureaus for Alcohol and Drugs and the national institutes for research, information and development of expertise, are based on the assumption that 48% of the total costs of these agencies can be attributed to drug-related services (the remainder is for alcohol-related services).

Table 4. The costs of health care services for drug users

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics and departments of psychiatric hospitals</td>
<td>36 million</td>
</tr>
<tr>
<td>Consultation Bureaus for Alcohol and Drugs</td>
<td>36 million</td>
</tr>
<tr>
<td>Regional agencies for social and medical care</td>
<td>56 million</td>
</tr>
<tr>
<td>Municipal methadone programs</td>
<td>7 million</td>
</tr>
<tr>
<td>Clinics for addiction treatment of special groups</td>
<td>3 million</td>
</tr>
<tr>
<td>Institutes for research, information and development of expertise</td>
<td>5 million</td>
</tr>
<tr>
<td>Action program</td>
<td>4 million</td>
</tr>
<tr>
<td>Total</td>
<td>157 million</td>
</tr>
</tbody>
</table>

(Computed by the author on the basis of the cost data provided by the Minister of Welfare, Public Health and Culture and the Minister of Justice in the "Memorandum Problems of Addiction" ("Nota Verslavingsproblematiek" 1992) and the above-mentioned assumption about the percentage of drug-related services of the Consultation Bureaus for Alcohol and Drugs.)
5. The net benefits of regulation and collective services

5.1 The net benefits for politicians

The standard methodology of cost-benefit analysis exclusively takes into account the costs and benefits of public policy to the population at large. However, the population does not decide on public policy. Politicians do. A positive analysis must, therefore, focus on the preferences of politicians rather than on those of the population.

Public choice theory distinguishes two main kinds of political motivation: "followers" attempt to maximize votes and "leaders" attempt to maximize their own gain from public policy. Accordingly, followers will consider primarily the net benefits for the electorate; leaders will look primarily at their own net benefits. However, leaders cannot entirely neglect the benefits for the electorate because they, too, have to win elections in order to get their favorite policies implemented. The main difference between followers and leaders is that leaders will spend more time on policy advocacy in order to influence the preferences of the electorate, and will have less interest in a larger than necessary majority for re-election.

The prevailing political views on the net benefits of drugs policy are partially reflected in official statements which appear in electoral programs and governmental policy documents. As far as the government is concerned, the official objectives of drugs policy are stated as the advancement of public health and the prevention of common criminality. In the Netherlands, reduction of drug consumption is not a policy objective per se. Consequently, there is no official policy with respect to non-problematic drug consumption. This is typical of Dutch political culture, which is consensus-seeking and averse to conflict. Also, it is possible that socially conservative politicians, who in principle would favor such a policy, refrain from advocating it because they have been convinced of either its non-feasibility or its huge costs.

Obviously, the prevailing agreement about the officially stated objectives of drug policy does not imply that all politicians (or even the politicians in the cabinet coalition) hold identical views about the desirable nature and extent of governmental activities. There are continuous discussions about such things as coercing criminal drug users to accept treatment, imposing more conditions on participation in methadone programs, the controlled supply of heroin, and legalization of production and domestic trade of cannabis. These discussions show that, below the sur-
face of general agreement on the stated general objectives, there are considerable differences of opinion on objectives at a more specific level of policy development. These differences are due to two factors. Firstly, there is a lack of knowledge about the relation between repression and the policy objectives of public health and prevention of criminality. Secondly, a political motive exists which is not reflected in the official policy objectives, namely the motive to attain electoral gains from a “tough stand” on drugs.

As far as the knowledge of politicians is concerned, the most common prejudices overstate the effectiveness of repression in relation to the policy objectives. Therefore, well-informed politicians tend to hold more tolerant attitudes than their less-informed colleagues. In the next section, the most harmful prejudices and the role of information in this respect will be dealt with further.

As far as the electoral gains from a “tough stand” on drugs are concerned, much depends on the intensity of external effects (other than on health and crime), such as public nuisance and the visible presence of a “drugs scene”. In general, the benefits for the public from drug policy will parallel those for politicians. They, too, will be interested in public health and prevention of criminality. A conservative group may also consider drug consumption as an evil in itself which ought to be suppressed by government, regardless of its effects on health and crime. However, apart from these preferences and convictions, many inhabitants are annoyed by the nuisance caused by some forms of drug consumption and by confrontation with the non-conformist lifestyles of drug consumers. Furthermore, because of the greater lack of knowledge among the general public, support for the repression of supply is greater among the population at large than in the political community. These circumstances cause permanent tension between politicians and the public. Often, politicians are exposed to the temptation of submitting to public sentiment. In the Netherlands, politicians usually do not give in to this temptation. Informal understandings between politicians preclude electoral polarization in this area. On the other hand, the very existence of a discrepancy between the prevailing views of politicians and the public exerts an immobilizing effect on policy in which politicians cannot afford to deviate from existing policy in the direction of less or more repression. Deviation in the direction of less repression is punished on election day and deviation in the direction of more repression is excluded by informal agreements that decent and responsible politicians are expected to honor. It is the paradox of drug policy that while the best way to reduce the social isolation of drug consumers and to eliminate the lack of knowledge in the population
would consist of full legalization for supply, the very existence of this isolation and ignorance impedes such a step from being taken.

6. The role of information in political decision making

Information can have an impact on public policy when it enables politicians and the public to gain better insight into the costs and benefits of the choice alternatives. It is the responsibility of the research community to provide such information. The impact of information will be greater to the extent that it reaches lesser informed people, and to the extent that it focuses on themes where the prevailing misunderstandings are more serious.

Two of the most serious and harmful misunderstandings are: (a) that consumers of "hard drugs" are generally "addicted" and that they will therefore engage in criminality to property when they lack the necessary means to pay for their drugs; and (b) that additional investment in the repression of supply contributes to public health and the prevention of criminality to property through its effect on the number of drug consumers.

The idea that consumers of cocaine or heroin will engage in criminality to property when they lack the necessary means to pay for their needs is based upon an oversimplified causal model of drug-related criminality. Firstly, there is growing evidence that the demand elasticity of cocaine and heroin is much higher than the very concept of "addiction" suggests. Most cocaine and heroin consumers are able and willing to adjust their average consumption to their current income. In general, average individual consumption is subject to large fluctuations due to changes in external circumstances (Hoekstra 1984; Cohen 1989; Grapendaal et al. 1991). This does not only apply to income changes but also to other occurrences, such as changes in the pattern of personal relationships or in living conditions. Methadone programs are helpful because they can provide for partial compensation of fluctuations in consumption of heroin. The "grey" (illegal) methadone market fulfills a similar function. As far as criminal consumers are concerned, the connection between drug consumption and criminality to property is more complicated than one way causality. Although it is true that drug consumption may contribute to the degree of criminality of a certain group, most criminal consumers have been in contact with the police or the judiciary before they started consuming drugs. Models in which participation in a criminal subculture is conceived as a possible cause of drugs consumption, or in which factors of social and psychological deprivation (chronic unemployment, bad housing, alcoholic parents, violence in the family, and so on) are pro-
posed as the common causes of both participation in a criminal subculture and drugs consumption, are more realistic than models that hypothesize on an exclusive one-way link between drugs consumption and criminality to property.\(^8\)

The idea that additional investment in the repression of the supply of drugs will contribute to the policy objectives of crime reduction and health improvement through its effect on the number of consumers, is inconsistent with available evidence. We now know that the problems of health and criminality stemming from drug consumption are concentrated in a subgroup of problematic drug consumers who are not affected by repression of supply. Furthermore, studies suggest that the relation between the repression of supply and the number of consumers is not linear. Only when repression becomes so severe that any possession of an illegal drug involves a sizable risk of arrest and imprisonment will the number of non-problematic consumers decline. In particular, recent experience in the USA indicates that consumption among school-age youth is probably affected in this way.\(^9\)

On the other hand, repression has a large effect on price. Therefore, it tends to increase rather than decrease the extent to which those drug consumers who are not deterred by the risk of arrest commit crimes against property. Not only must criminal drug consumers obtain more money to pay for their needs, but also the repression of supply criminalizes everybody who possesses drugs, thereby diminishing the threshold between common criminality and mere possession.\(^10\) The additional common criminality caused by an increase in repression of supply involves huge social costs to society. Furthermore, an increase in repression tends to reduce the number of cocaine and heroin consumers who can pay for their needs out of revenues from street dealing and mediation services (see above). When criminality to property becomes a safer way to collect income than drug-related mediating services, a number of suppliers will probably opt for criminality to property. Finally, the retail market will become more concentrated and will be taken over by individuals and organizations which are willing to take the higher risks involved. This will not only contribute further to property crime but also encourage the more serious forms of violent criminality related to the very risky large-scale trade.

Once a process of normalization has set in, the chances are high that it will be self-reinforcing. On the one hand, normalization changes the characteristics and environment of drug consumption. On the other hand, normalization will improve available information about the costs and benefits of repression. When this information is provided to growing
numbers of politicians and inhabitants, the panic will tend to subside; existing forms of regulation will be eyed with increasing skepticism until they are finally restricted or abolished. In the Dutch case, the history of cannabis is exemplary in this respect.

7. An international comparison

Reuter has made a useful distinction between three kinds of political attitudes towards the drug problem: those of hawks, doves and owls (Reuter 1992). “Hawks” consider the nature of the drug problem as one of amorality of consumers and sellers and they seek the solution in the repression of supply. “Doves” see the nature of the drug problem in the bad effects of prohibition and they seek the solution in legalization and information. “Owls” see the nature of the drug problem in addiction and disease and they seek the solution in prevention and treatment while maintaining prohibition. Heroin and cocaine drug policy in the Netherlands appears to fit in the “owl” category, whereas it wavers between that of owls and doves with regard to cannabis. The clearest example of a country where drug policy is in the hands of hawks is the USA. From a comparative point of view, it is illuminating to look at some conspicuous differences between policies in these two countries, as well as at the consequences of these differences for costs and net benefits.

As far as regulatory policies are concerned, the differences between the USA and the Netherlands are moderate. Owls and hawks both support prohibition. Only the dove-like quasi-legalization of cannabis in the Netherlands contrasts with the federal regulatory regime in the USA, which does not discriminate between “hard” and “soft” drugs. The major contrasts are regarding law enforcement and health care services. The intensity of law enforcement has increased enormously in the USA during the last decade. Table 5 presents some data on convictions and imprisonments for both countries.

It should be noted that the data are presented per 1000 inhabitants (per capita *1000); presentation per consumer c.q. seller would be more appropriate. In view of the non-reliability of drug use prevalence data, however, the current presentation is preferable.

Table 5 shows that the number of convictions and prison sentences per 1000 persons is more than five times higher in the USA than in the Netherlands; the USA per capita prison population (incarcerated for drug felonies) is even sixteen times higher than the proportion of Dutch persons incarcerated for drug felonies. It should be noted that the latter ratio partially reflects longer terms of imprisonment.
Table 5. Convictions and imprisonment sentences on account of drug felonies\textsuperscript{11} in the USA and the Netherlands

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>total</td>
<td>per capita *1000</td>
</tr>
<tr>
<td>Convictions</td>
<td>225,000</td>
<td>0.90</td>
</tr>
<tr>
<td>Prison sentences</td>
<td>155,000</td>
<td>0.62</td>
</tr>
<tr>
<td>Prison population</td>
<td>400,000</td>
<td>1.60</td>
</tr>
</tbody>
</table>

(Computed by the author on the basis of estimates by Reuter (1992) for the USA and on the basis of data from CBS (1991) for the Netherlands. The data for the USA concern convictions and imprisonment sentences by state courts (1988) and the prison population in federal, state and local prisons (1990). The share of federal courts in convictions and imprisonment sentences is relatively small. However, in view of the severity of federal offenses, the share of total expected prison time generated by the federal courts is not small: 50,000 years compared to 150,000 years generated by the state courts (33%) in 1988.)

As far as health care services are concerned, in the USA there is less emphasis on the prevention of AIDS among drug consumers and on methadone and needle-exchange programs. The scale of health care activities can best be judged from cost data. Table 6 presents some data about apparent costs of both health care programs and law enforcement.

Table 6. Some data on apparent costs of publicly funded health care and law enforcement services per inhabitant in the USA and the Netherlands

<table>
<thead>
<tr>
<th></th>
<th>USA</th>
<th>The Netherlands</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>$ millions</td>
<td>$ per capita</td>
</tr>
<tr>
<td>Law enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>federal/central</td>
<td>7157</td>
<td>29</td>
</tr>
<tr>
<td>(USA 1991, Netherlands 1992)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>state and local/local</td>
<td>5240</td>
<td>21</td>
</tr>
<tr>
<td>(USA 1988)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care</td>
<td>898</td>
<td>4</td>
</tr>
<tr>
<td>federal, state and local/central and local (USA 1989, Netherlands 1992)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Sources: USA: Bureau of Justice Statistics 1992; the Netherlands: see source description Table 3. For the health care services in the USA, only the publicly funded part (52%) of the total reported treatment costs is presented. The figures for these services are underestimates, mainly due to a lack of response from 22% of known drug and alcohol treatment and prevention units in the annual survey from which the data are taken. The cost data for the Netherlands are presented in dollars on the basis of the average dollar exchange rate in 1992, which was Dfl. 1.75. Costs cannot be totalled because the methodologies and years differ.)
programs in the USA and the Netherlands, taken over all levels of government.

These data indicate that the absolute amount of dollars spent per person for law enforcement is much higher in the USA than in the Netherlands. Even if the volatility of the dollar exchange rate is taken into account, it can safely be concluded that per capita costs for law enforcement are more than four times as high in the USA as in the Netherlands. On the other hand, the costs of publicly funded health care services are of the same order of magnitude (note that the health care figures for the USA are underestimates because of the lack of response mentioned in the source description).

It also appears from Table 6 that the ratio of law enforcement to health care costs is very different in both countries. Even if the fact that health care costs for the USA are underestimates and that they refer to a different year than the law enforcement costs, is taken into account, it seems plausible that they make up less than 15% of the total public budget in the area of drug control. In the Netherlands, health care services made up circa 30% of the total public budget for 1992 in this area. This difference is remarkable, the more so if the fact that, due to relatively favorable living conditions in Dutch prisons, the costs of imprisonment per inmate in the Netherlands are about twice as high as in the USA, is taken into account.13 If Dutch imprisonment costs were equal to those in the USA, the ratio of health care to law enforcement costs would still increase by about 3%.

The prevailing political views on the net benefits of drug policy in the USA are very different from those in the Netherlands. The USA has a long tradition of political activism against drug consumption. This tradition has its roots in puritan religious beliefs of a socially conservative nature, and in the ideas of progressive emancipation movements among working class people and women at the beginning of the century. The essence of these beliefs is that the consumption of drugs is, in principle, a morally degrading and evil activity; it is not only the right but also the obligation of the government to repress such an activity, regardless of the effects that this repression exerts on other persons. There is a straightforward and well-documented connection between the political movements which were responsible for the alcohol prohibition of 1919, and the narcotics and marihuana prohibitions of 1914 and 1937.14

Moreover, the political culture in the United States is in general less averse to conflict and less consensus-seeking than in the Netherlands. As a consequence, there has always been an open political debate between prohibitionists and libertarians about the means and objectives of public
drug policy. Another explanatory factor may be that, compared to their Dutch colleagues, American politicians are typically less afraid of the large costs involved in public endeavors deemed morally worthy. Thus, the restraint of political polarization that is characteristic of Dutch drug policy does not exist in the USA. Moreover, the American two-party system and the pressure on Republicans with libertarian views to hold the ranks closed, has contributed to the enormous escalation of repression which occurred in the Reagan and Bush eras and which resulted in the bizarre situation that in 1990 400,000 American men and women (40% African-Americans) were incarcerated under extremely problematic penitentiary conditions for drug-related felonies (see Table 6).

Although the Democratic camp in the presidential election of 1992 has not openly distanced itself from the raging “war on drugs”, the Clinton administration is clearly willing to take a fresh look at prevailing policies. There are indications that there now is a certain retreat from the hawkish approach in a more moderate direction. Although anti-drug activism is deeply rooted in American political culture, the history of alcohol prohibition (and its subsequent defeat) shows that American policy makers are able and willing to bring about a fundamental policy change as soon as they become convinced of its advantages and moral acceptability. It is hard to predict whether such a fundamental policy change will occur with respect to drug policy in the near future. However, it does seem clear that the huge costs of the hawkish approach, in combination with its apparent lack of success, will keep the debate alive in the years to come.

8. Conclusions

This Chapter was written from a “public choice” perspective, which focuses attention on the motivation and behavior of public officials, especially of politicians. Decisive for the development of drug policy are the costs and benefits of regulation and collective services as they are perceived by politicians and the public. Costs have to be paid for out of taxes and social security premiums. Benefits lie in the sphere of prevention of criminality, public health, and low visibility of a small and unpopular subculture.

Information can have an important impact upon policy. To that purpose, information should particularly be directed at existing prejudices and misunderstandings. The single most important theme in this respect relates to erroneous beliefs about the effect of the repression of supply on property crime and on forms of professional criminality. Step-by-step
reduction of suppression is a learning process that tends to be self-reinforcing because it enhances the dissemination of information about the reality of drug use.

It is important that the trend towards normalization predominant in Dutch drugs policy for some decades should be extended to the areas of cocaine and heroin. One may only hope that new forms of international cooperation do not pose unwanted barriers in this respect.

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Endnotes

1. A report from the Criminal Investigation Information Service of August 1992 reports that in 1991 the police identified 37 rural cannabis farms with a total annual production capacity of 8160 kilograms of hashish and marihuana (NRC Handelsblad 19 August, 1992).

2. A drug-related felony is a felony against a drug law or other felony in which the consumption, production or trade of drugs is presumed to contribute to the offence (e.g.: theft in order to acquire money to be spent on drugs, or violence among drugs traders).

3. For an international comparison, see Huisman 1984.

4. Estimates for earlier periods were much higher. For example, Hoekstra estimates a monetary turnover of 650 million in the Netherlands in 1982 (Hoekstra 1984; see also, Cachet 1990). The differences are mainly due to the higher prices of heroin prevailing at the beginning of the eighties (Hoekstra assumes 300 guilders per gram in 1982).

5. These percentages were computed by the Social and Cultural Planning Bureau on the basis of the report by the Project Quantification Police Work (Social and Cultural Planning Bureau 1989).

6. These percentages were computed by the author on the basis of data collected by the Central Bureau of Statistics (Central Bureau of Statistics 1989).

7. These percentages were computed by the author on the basis of data provided by the Ministry of Justice.

8. For discussions on the validity of the models discussed, see Grapendaal et al. 1991 and Korf 1990.

9. According to general population surveys, 11% of high school seniors reported using marihuana on a daily basis in the previous month in 1978; less than 2% of seniors reported such use in 1991 (Reuter 1992). The decline has been spread evenly between age, sex and race groups.

10. The connection between drug prices and damage by criminality to property is well established in empirical studies. Some of these are cited in Cachet 1990 and in Pommerene and Hart 1991. See also Hoekstra 1984.

11. In both countries, distribution offenses are always felonies, possession offenses can be either felonies or misdemeanors.

12. In view of the discrepancy in the data base mentioned in the source description in Table 6, the difference between the ratios for imprisonment sentences and prison populations cannot exclusively be attributed to longer terms of imprisonment.
13. The costs per inmate in federal prisons and correctional institutions contracted by the Federal Bureau of Prisons were $23,000 in 1991 (National Drug Control Strategy 1992). The costs per inmate in Dutch penitentiary institutions (including institutions for juvenile delinquents) were Dfl. 82,000 (circa $47,000) in 1992.

XV. IS DUTCH DRUG POLICY AN EXAMPLE TO THE WORLD?

C.D. Kaplan, D.J. Haanraadts, H.J. Van Vliet and J.P. Grund

1. Introduction

The papers in this Volume have provided an understanding of the socio-historical factors which have led to the construction of the Dutch definition of drug problems. This final Chapter moves from inspection and introspection to the more risky work of projection. The first sections of this Chapter set the stage for a flight into the future of international drug policy development. This flight is directed towards a deceptively simple question: Is Dutch drug policy an example for the world? As a point of departure, this question could be answered by specifying and evaluating what can be drawn from the Dutch experience that is relevant in the new era of international drug policy development. This era has been signalled by the pronouncements for demand reduction at the Vienna convention of 1988.

In our view, the Dutch experience (with some local adaptations of course) is indeed a markedly relevant example to the world. Support for our view stems from a number of local, national and international movements which are rallying under the banner of public mental health/crime prevention reforms to respond to a perceived failure of the international control system. This movement involves a compromise position between what Peter Reuter (1992) has recently termed the replay of the post-Vietnam war international relations scenario of the “hawks” versus the “doves”. The war on drugs movement represents the hawks while the movement for legalization plays the role of the doves. In this deadlock nothing really pragmatic for the resolution of the drug problem can be suggested and a policy collapse not unlike the debacle of the Vietnam war is a real possibility. What Reuter proposes is a new kind of bird on the horizon. Drawing from the book on the prevention of nuclear war edited by Nye, Allison and Cornesale, he sees the ascendant bird as an owl. The owl offers a public mental health/prevention intervention alternative. Reuter views the European drug policy development as the prototype of the owl alternative. Within this international “owl” movement, the official drug policy of the Netherlands has played a definitive
role simply because it was the first clear and consistent commitment of a government to a change in the direction of international drug policy development. The recent appointment of Professor Hamid Ghodse, Chairman of the Addiction Research Department of St. George's Medical School in London, a psychiatrist and scientist, as Chairman of the International Narcotics Control Board is a significant sign of the emergence of an alternative way of controlling the international situation; formerly, this position was routinely given to a professional international diplomat.

The importance of a single nation's experience in turning the tide of international drug policy cannot be underestimated. For example, in the inaugural Thomas Okey Memorial Lecture, Jerome H. Jaffe, first architect of America's national strategy on drugs, provides a personal perspective of the American experience which indicates how a single national experience can provide the pivot on which to move world drug policy in a different direction (Jaffe 1987). Situating his analysis of the American strategy in terms of its "British origins", he shows how British drug policy was able to influence the American national response through the forum of the World Health Organization. The prestigious World Health Organization Expert Committee on Drug Dependence provided a mechanism whereby leading British ideas could obtain an international legitimacy and influence. This process - the use of official international bodies for legitimating and extending national interests - has been characteristic of international drug policy development from its beginning (see Stein 1985; Escochado 1989; Musto 1973). Therefore, it is not surprising that Jaffe (1987:598) bases his lecture on the seminal idea of the WHO working paper that "all the elements making up a national response ... are always in a state of dynamic equilibrium" and that this equilibrium involves a process of subtle international relations. Thus, the international character of drug policy makes a national response an action that usually has consequences far beyond its legal borders.

The formation of drug policy at the international level always involves an uneasy consensus of competing interests (see Kaplan 1984). Nevertheless, as Jaffe (1987:598) recommends, the best approach for achieving consensus is based upon an open-minded, "learning" attitude to drug problems.

"It would be presumptuous to assume that those in other countries can learn important lessons from a so brief and personal perspective on the American national response. Yet nations do not usually have the capacity to conduct controlled experiments with alternative national responses to drug problems. If they are to reduce the costs of drug use and misuse,
they must learn either from their own history or from the experiences of other nations."

A rigid and dogmatic state of mind will normally lead to the isolation of a national approach and, eventually, as a result of international pressure, readaptation to the fragile, albeit legitimate international standards. In contrast, and significant for the arguments put forward in this Chapter, in order for a nation to start the essential development of opening another nation’s mind, research that takes a self critical look at the origins and consequences of the historical experience of that nation’s drug use must be set in motion. Along with this fundamental critical attitude, scientific curiosity must be stimulated as to how the experiences of other nations may function as comparison and control conditions.

In an earlier paper Jaffe (1983) presented a fundamental conceptual framework in which he scientifically situated the assessment and international comparison of drug problems and policy responses. The first step was the stimulation of multidimensional information systems about drug users, the drugs they use and the real effects these drugs have on the user and society. The next step was to situate this information in a qualitative context of the history of the social response to drug use and the functions drug use has in society and culture. Once this work has been done, finer distinctions such as that between drug use and drug abuse can be made.

Conceptually, the physician Jaffe argues in his paper for “the limited relevance of the pharmacological dimension”. In an age where biological psychiatry is making major pharmacological breakthroughs, this limitation may be forgotten. Thus, the important pharmacological scientific results have their practical relevance mainly as adjuncts to the evolving social systems of drug use and control. In Jaffe’s own research of a wide variety of national experiences documented in the case studies of a major WHO collaborative study, the only common factors to be identified were “deviance” and “impairment”. Thus, in Jaffe’s conception, the dimension of the social definition of drug use is at least as important as the pharmacological dimension in formulating an appropriate “international response” to the wide variety of national experiences. Jaffe (1983:110) clarifies his position:

“Firstly, a pattern of drug use is seen as a problem when it deviates from a traditionally accepted or an emerging cultural norm. And, secondly, it is seen as a problem when it impairs health or social functioning... Developing appropriate responses requires an understanding of the
specific society, its history, its dynamics and its aspirations: factors that must be understood at least as thoroughly as we understand pharmacology and specific drug-induced pathologies."

2. The Dutch definition

The statements of Jerome Jaffe, urging a multiple and multidimensional approach for responding to international drug problems, is familiar to Dutch scientists as well as to cabinet members. For example, the former Minister of Justice of the Netherlands, Frits Korthals Altes, addressing the United Nations International Conference on Drug Abuse and Trafficking in Vienna urged that "international cooperation is indispensable. However, an attempt to reach an internationalization of drug policies in the sense of a single, non-differentiated approach is bound to be counterproductive for many countries..." (cited in Van Vliet 1990:463). This commitment to finding a "cooperation in diversity" has been a cornerstone in the development of the national drug strategy in the Netherlands. This policy approach has also been a significant contributor to the dynamic equilibrium of the international drug control system. Much like the earlier influence of the British through international organizations, the Dutch have maintained an influential role despite the widespread opinion that the Netherlands is somehow in violation of the existing international order. Going beyond this popular and at times official misconception, the Netherlands was one of the signatories of the 1988 Vienna agreement and contributes significantly to its mandate (Article 14) for the adoption of appropriate measures for eliminating and reducing demand. The newly defined international emphasis on demand reduction is not at all strange or even innovative with reference to Dutch national policy. Demand reduction has been the self-conscious aim of Dutch drug policy for the last two decades. This definition provides the basis for the controversial Dutch drug policy innovations of the separation of drug markets and the normalization of drug problems (Van Vliet 1990).

The current Dutch definition did not develop in a social vacuum. On the contrary, the Dutch experience in drug use control can be found in the context of broad civilization and collectivization processes which have a global scope, but have always been openly and clearly expressed in Dutch society. Dutch drug policy can be seen as part of a broad sociohistorical movement which the Dutch sociologist Abram de Swaan (1988:244) termed "the collectivization of arrangements for coping with adversity and deficiency" which has characterized all modern industrial-
ized societies. the Netherlands has always had an historical role as a fore-
runner of Western social development. It was the Netherlands which
pioneered the great social transformation of civilization from the Middle
Age feudal structure to the modern capitalist structure, the so-called “civ-
ilization offensive”. Politically, the United Provinces of Holland became
an example for a variety of modern state organizations, such as the
United Kingdom, the United States of America and the French Union. In
the contemporary world, the Netherlands can be seen to be pioneering
the social development of the immense and gradual shift from modern to
post-modern society – a phenomenon that only very recently has been
measured and evaluated by social scientists.

Despite this unique historical role, it would be mistaken to conclude
that, as a society, the Netherlands is an exception to “the rule”. Rather,
Dutch society represents a particular national adaptation to broad
sociocultural processes that are omnipresent in the world. The tendency
of the Dutch to define drug problems as they do is not a unique idiosyn-
crasy, but rather a re-organization, selection and retention of social
potentials that exist in different degrees and combinations in contem-
porary societies. Despite obvious national differences, De Swaan
(1988:244) can conclude that these processes have even become quite
irreversible:

“The underlying consensus about the basis of the welfare state is still
so encompassing that it remains largely unnoticed ... Even determined
conservative regimes, such as Thatcher’s or Reagan’s, have not undone
the basic tenets of collectivization and transfer capital accumulation. The
“welfare backlash” has been more of an ideological exercise in verbiage,
than an effective or consistent policy.”

Of course, there is a great amount of diversity in these irreversible
processes. The “welfare backlash”, for instance, in the United States, be-
came a dominant ideological pillar for the former Republican adminis-
tration, with the result that real changes in society were made. But these
changes were perceived to increase the social misery of the American
people. This may have contributed to the defeat of the Republicans in
1992 and the election of a Democratic administration which was more
likely to get America back on a progressive ideological track. Under the
Republican administration, substantial social investment was made in
drug control. In the Republican decade of 1981 to 1991 federal govern-
ment spending on drug control increased almost seven-fold, growing
from $28 million to $1.016 billion (Bureau of Justice Statistics 1992:130).
Funds for drug enforcement increased 14-fold while funding for drug treatment only increased four-fold. Spending on drug prevention, however, had the greatest relative growth over the decade, increasing 17 times. However, despite this relatively high increase in the funding of law enforcement, its share of the entire drug budget had leveled off after the early 1980s to a modest increase of from around 60% of the budget to around 70%. This supports the "irreversibility" hypothesis of De Swaan: lots of ideological noise, very modest real reversals. The real loser in the decade was drug treatment which fell from just under 40% of the budget in 1981 to just over 20% in 1991, but this decline was compensated by a relatively high increase in drug prevention to almost 20% of the budget.

The American "war on drugs" rhetoric did have a modest material base in that drug problems were being used to channel the accumulation of transfer capital away from classical welfare state institutions to new "warfare" state experiments. Thus, drug problems were used to stimulate the growth of the federal prison program and the military. Federal prisons were budgeted in 1988 for $445.9 million, raised to $630.7 million in 1989 and $1 billion and $476.5 million in 1990. The Department of Defense, which had always been very ambivalent about the drug problem, were given the incentive to become involved in the drug war with their budgetary allowance growing in the interdiction category from $94.7 million in 1988, to $308.3 million in 1989 and $313.2 million in 1990, and in the international category from zero funding in 1988 to $117.5 million in 1990. To European thinking, the use of military and prison institutions to provide "warfare" alternatives to welfare state functions is almost unthinkable, but this has been a persistent mechanism both in North and South America for maintaining social control. For example, in traditional American society, delinquent youths were frequently given the choice after apprehension by the police of either going to jail or joining the army. A more modern form of this American practice is illustrated by the emergence of "boot camps" for first-time violators of drug laws. These camps, largely organized by the prison system, have been termed "shock incarceration" and involve the combination of "personally challenging" military-like basic training with some sort of drug treatment (Center for Substance Abuse Research 1993; Mackenzie 1990). By March 1992 there were 41 correctional boot camps in 25 states, including one run by the Federal Bureau of Prisons. These programs have the wide support of the American people (49% in a recent Associated Press survey) and can be said to represent the legacy of the war on drugs in the decade of the 1990s (Bureau of Justice Statistics 1992:96). In short,
in the Netherlands, problematic drug users tend to be provided with social and medical services while, in the United States, they are more likely to be dealt with through the criminal justice system.

The Dutch definition can also be seen as an expression of certain global historical cultural changes which have been characterized as the shift from “materialist” to “post-materialist” value orientations (Inglehart 1977, 1990; see also Van Deth 1983a, 1983b for critical remarks pertaining to the Netherlands). These value orientations involve a continuum of basic commitment to the maintenance of national order (“materialism”) to setting the priority on freedom of expression (“post-materialism”). The Netherlands has perhaps the strongest intact tradition of relative tolerance, pragmatic compromise and social welfare and can be seen as the earliest national forerunner of the post-materialist value orientation. The living Dutch tradition springs from the ethical norms of gentleness, temperance, kindness and the pursuit of knowledge and spiritual development expressed by the early 16th Century Rotterdam scholar and humanist Erasmus. During the Dutch “Golden Age” these norms were upheld by the ruling orders of the urban patriarchate against the rigidness of the Calvinistic clergy and the so-called uneducated masses. They provided the means for the crystallization of a distinct Dutch value system built upon orientations beyond the materialist transformations which were changing the global social structure.

This humanitarian value system was not, however, simply idealistic. It was tied to a commitment to utilitarianism and value pluralism that was the basis of Dutch mercantilism. This attitude allowed for experimentalism in both social ends and means. For example, unlike many other prosperous nations, riches was not seen as an end in itself to be displayed in ostentatious status symbols, but rather as an “embarrassment” to be subsumed under other ends such as sobriety and modesty (see Schama 1988). With this value system in operation, the immense prosperity during the 17th Century of the Republic of the United Netherlands enabled the absorption of different ethnic cultures, religions and traditions. For example, persecuted Jews from Spain and Puritans from England were offered refuge in the Dutch Republic in the interests both of utilitarianism and humanitarianism. They were permitted and encouraged to maintain their original backgrounds and cultures. It was expected that these tolerated groups would provide Dutch culture with the most beneficial intellectual and material parts of their own without fundamentally changing the Dutch status quo. In exchange, their traditions and cultural practices were tolerated. Dutch tolerance then as today means not only freedom of religion but also the allowance of different
expressions of lifestyle, attitudes and behavior in accordance with one’s ethical beliefs. To use a metaphor, in order for Dutch society to expand its prosperity, the mainstream needed fresh input from new springs which reinforced the strength of the current.\textsuperscript{5}

Roughly summarizing the last century of societal development in the Netherlands, four groups based either on religion (mainly protestantism and catholicism) or ideology (socialism and liberalism) created their own so-called “pillars” of institutions of education, religion, leisure activities and media. These pillars gave a distinctive identity to their members while, through a democratic process of persistent compromise, created a modern welfare state. This system of institutional “living-apart-togetherness” imploded after the Second World War under the influence of secularization, the “cultural revolution” of the 1960s and the process of “global villagization”. Traditional community life and social control gave way to new waves of urbanization and immigration and the development of individualized lifestyles. During the “cultural revolution” of the 1960s, patronizing control over people’s personal lives by religious, political and community leaders was rapidly replaced by self-determination at the family and individual levels. This shake-up in individual and social values impacted on all Western countries in one way or another. Yet this effected the Netherlands some years earlier (in 1965) and in a more playful way than most of its neighbors. Moreover, the social shake-up contributed to new forms of national consciousness and social responsibility, rather than dividing society along the simple lines of young/old, left/right and pro/contra. When the violent protest movements of the late 1960s shook the world, the Dutch had the advantage of having already renovated their social and cultural infrastructure. Filling the gap left by the implosion of the pillar system, a strong national welfare state in cooperation with many professional and interest groups emerged as the end result of what Abram de Swaan (1988:210) has called “a long sizzle and a late bang”. This “caring state” left intact the strongly knitted fabric of social, economical and mental interactions between citizens and institutions, preventing major tensions and disruptions. On the foundations of prosperity and enlightenment laid down in the 1960s, the Dutch government and society further developed the welfare state towards what the Dutch called the “well-being state” (\textit{welzijn}) in the 1970s. By adding a general “quality of life” criterion to a renovated welfare state apparatus, the new Dutch well-being state provided a critical departure from the rigid and ineffective welfare state bureaucracies which were already rotting in many Western societies. This renovation prevented the growth of anti-welfare state ideologies such as Thatcherism and Reaganomics.
The well-being state, while providing basic material prosperity and security for all through an extensive system of social security, medical care and educational programs, was still not considered sophisticated enough for the management of the growing complexity of Dutch society. Citizens should be embedded in an encompassing structure in which intra-personal, interindividual, group and class conflicts are preferably solved by the “soft policing” of social, youth, cultural and community workers and neighborhood policemen, instead of by harder legal, administrative or even military interventions. Although this type of social management was increasingly criticized and was partly dismantled in the 1980s on financial and ideological grounds, the well-being state continued in its function as a social manager appointed by its citizens.

Although Dutch drug policy is not currently dominated by moral overtones, it does not necessarily mean that morality has not played a part in response to certain substances. Similarly to many other countries which were adapting themselves to the new demands of industrialization of the mid-19th century, the Netherlands’ “fight” against the “evils” of alcohol paralleled other European countries which moved in the direction of temperance in contrast to the prohibition of alcohol. In southern Europe, alcohol became completely normalized and integrated in the fabric of society. This broad European response became the analogue for policies towards other drugs.

Comparing the success of American and European temperance movements, the major difference was that in Europe the anti-alcohol reform movement did not lead to national legal prohibition like the 18th Amendment to the American constitution. Thus, although local Dutch regulations restricting opening times and locations of bars were issued, legislation was not used as the major tool to fight alcohol. Instead, the emphasis was put on improving the living and working conditions of the people who were most likely to be unable to control their drinking habits. The analogy between alcohol and drug policies is that regulation of the problem was preferred to aggressively fighting it. Policies based on creating fear for the dangers of drugs, on forcing drug users into illegality or incarcerating them are considered in the Netherlands to be counter-productive and costly – to be bad policies and therefore immoral in their consequences.

The rising global concern for drug abuse and trafficking should be viewed embedded in this particular sociopolitical context. Compared with most other countries, room was created for experimentation with different policies including those aimed at incorporation and control rather than aggressive attack and elimination. Dutch social life and legal
regulations are strongly oriented towards normalcy. Dutch tolerance and permissiveness are based on a strong desire by state and citizens alike to be able to see what your fellow citizen is doing, where he is doing it and why. This highly sophisticated form of social control grew out of the desire for social equality. Groups or individuals who act deviantly are under constant pressure to become part of the normal mainstream. The much vaunted "typical" Dutch tolerance and permissiveness are, in reality, a generally accepted public policy strategy of holding a juicy carrot in front of groups, promising them the tolerance of their existence, providing them an identity and even financial support, if (and only if) they are willing to subscribe to some basic unwritten rules: as far as possible to act openly and, in public, not to force differing beliefs and lifestyles upon anybody else – implying the acceptance of the moral and legal dominance of the mainstream. Consistent with this, current Dutch “drug problems” are not centered so much around the pharmacological negative effects of drug use, but rather around the reluctant attitude of “extremely problematic” drug users to become controllable by the social and healthcare systems. Much of drug problem solving, therefore, is referred to in a pragmatic and tolerant model of society which manages social experiments in realizing its collectivization and civilizing goals. This response is consistent with an experimental attitude that has been applied to the management of virtually all types of social problems including drugs as well as other tricky, moral issues, such as homosexuality, abortion, euthanasia and age of sexual consent.

3. The shift to different goals strategy: the grand experiment of the Netherlands

As the American political scientist Ronald Inglehart (1990) maintains, in times characterized by an increasing gap between aspiration levels and the perceived situation, two kinds of adaptations are possible – a “more of the same” adaptation strategy or a “shift to different goals” strategy. The pronouncements at the conference in Vienna 1988 have opened a new era in the international drug field in which this credibility gap becomes the pivotal point of future proceedings. The conference simultaneously adopted a “more of the same” strategy in focusing upon narco-trafficking; that is, supply reduction which had become the calling card of the American approach. At the same time, the conference adopted a “shift to different goals” by recognizing the fundamental importance of demand reduction; that is, prevention and treatment services, interventions and experiments. The convention has provided the frame of ref-
ference for a new socio-historical era where multiple and different goals for international drug policy can be defined. The uneasiness in the new period is precipitated by the inherent tensions between the two strategies. The old era's aspiration of achieving consensus on drug control through supply elimination and containment strategies does not fit well in a situation of a continuous and steady growth in the world market of psychoactive drugs. The emergence of the new strategy of demand reduction becomes intelligible as a necessary adaptation to the world market situation.

The Netherlands was an early representative in the international community of nations of this “shift in different goals” strategy. The Dutch strategy, built on a post-material value orientation, involves a process of incorporation rather than alienation of the social groups linked to drug-related problems. As a recent Dutch ministerial white paper contends, the national strategy should seek to depoliticize the drug problem by reconceptualizing the problem as one of individual responsibility instead of mass public concern (Engelsman 1989, 1990). The Netherlands exemplifies a concrete case of a government interpreting its international obligations in the framework of a public mental health and prevention perspective fundamentally grounded on a shift to the new and different goal of demand reduction. Underlying this commitment is the wish to maintain a stable and controllable society through the provision of services friendly to drug users and minimizing the potential harm of drug abuse.

The concern for unintended effects of overly repressive national drug policies that would alienate illegal drug users into uncontrollable, enclosed subcultures was one of the main reasons for reforming the Opium Act in 1976. These reforms provided for the strategic principle of the separation of markets for drugs with an acceptable risk (e.g., cannabis) from other drug markets (e.g., heroin, cocaine, amphetamine). This reform allowed public exposure of soft-drug use in the “normal” environment of the coffee shops. These coffee shops functioned as public places where cannabis users could meet, buy and smoke without being threatened by police (Jansen 1989). This principle is founded upon the view that certain “new” (and illegal) drugs such as cannabis had gained a firm footing in everyday life in post-modern society comparable to alcohol, tobacco and coffee in earlier times. In such a situation, legally to “favor” alcohol and tobacco while prohibiting cannabis is akin to an act of civil rights discrimination (see Ehrenberg 1991). The consistent conclusion from this analysis is that to build a policy on the prohibition of illegal drugs is neither realistic nor conducive to a modern democratic society. Rather, a strategy of “normalization” is a more adequate legal
fundament; a shift (consistent with provisions regulating legal drugs) attempting to find formulas for the conditional integration of drug users in society in order to minimize the harm caused by their drug use.

In contrast, these Dutch strategic goals can be compared to an opposing strategy which has also been highly visible within the community of Western industrialized nations. The United States *National Drug Control Strategy* drafted under the Bush Administration (The White House 1989) represents, in a most sophisticated form, the “prohibitionist expectancy” underlying the international drug control order (see Kaplan 1984; Van Wijngaart 1991). The current American “war on drugs” response is a concrete example of a countervailing strategy in which the situation is “hyper politicized” and the government attempts to mass mobilize its population towards supporting a “more of the same” adaptation to the increasing credibility gap. In direct contrast to the Dutch strategic principles, the American strategy tends towards “unifying” drug markets by arguing for uniform criminal and social sanctions across all drugs. Within this strategy, the prohibitionist expectancy logically is extended to the socially acceptable drugs of alcohol and tobacco. The current American anti-smoking and drunken driving campaigns can be seen as preliminary attempts to *criminalize* tobacco and alcohol use. And the American policy of “user accountability” and “zero tolerance” can be seen as being diametrically opposed to the normalization of the drug problem principle. Here the drug user is singled out by the government for segregation from society despite the rhetoric of treatment. Drug users’ civil and social rights are made contingent upon their willingness to alter their drug preferences. In this way, the power of public definition is being mobilized to raise the thresholds of social tolerance to the point where the very act of using a drug is tantamount to *immoral* behavior - what might be called the “abnormalization of drug problems”.

In choosing an adaptive strategy of “shift to different goals”, the drug policy in the Netherlands is demonstrating itself to be in accord with the “experimentalist expectancy”, the countervailing pillar of the prohibitionist expectancy, beneath the international drug control order. The American social psychologist Donald T. Campbell (1988) has coined the phrase “the experimenting society” to describe a society founded on the principles of “applied social science, on treating the ameliorative efforts of government as field experiments” (Campbell 1988:291). The image of such a society is “...one that would vigorously try out possible solutions to recurrent problems and would make hard headed, multidimensional evaluations of outcomes, and when the evaluation of one reform showed it to have been ineffective or harmful, would move on to other alternatives.”
In the experimenting society, there must be a spirit of social learning with the goal of knowing more about innovations decided upon by political decisions. Thus, Campbell (1988:301) can conclude: “To learn about the manipulation of relationships one must try out manipulation. The scientific, problem-solving, self-healing society must be an experimenting society.” The apparent uniqueness of the Dutch drug policy is largely the outcome of applying the principles of the experimenting society to drug problems. This can be contrasted with many other countries which may provide lip service to experimentation and policy evaluation, but which still decide their policies towards drug problems primarily on “ends idealism”; i.e., morality. The experimenting society, in contrast, places the premium on “means idealism”. Thus, to cite one cogent example, in the early 1970s, the Netherlands’ and the United States’ governments independently established expert commissions to provide recommendations on drug policy issues. The Baan Commission in the Netherlands developed the risk criterion which was the basis for the 1976 policy reforms. In the United States, the Shaffer Commission came to many similar conclusions and recommendations. In the American case, these scientifically grounded recommendations were tabled and “ends idealism” prevailed. The new Republican American government under the leadership of Richard Nixon instead declared a war on crime and drugs, an expedient alternative to the collapse of the former Democratic administration’s “war on poverty” in the wake of Vietnam.

An experimental laboratory is in most cases rather small and simple compared to overall reality and the Netherlands is a small country compared to most others. This compactness coupled with a thorough registration system needed for the management of the Dutch well-being state has provided the Netherlands with optimal conditions to experiment in the drug policy field. These optimal conditions have been recognized in all sectors of Dutch society; from the business community to the social services.6

The design of the Dutch drug policy experiments has largely been in the form of field trials and program evaluations rather than clinical trials and laboratory experiments. Following Campbell’s (1988:308) principle of “means idealism”, these social policy experiments have focused on policies and programs which can be applied in more than one setting (e.g., in different cities) and not on the evaluation of persons and clients. Social experiments are not real social experiments unless the people affected comply. In laboratory animal experiments, the animals have no choice in the matter. In contrast, true social experiments are based on volunteerism and informed consent which function, in turn, as basic de-
sign conditions. Thus, with regard to drug policy, social experimentation requires an acceptable level of compliance of drug users themselves - the program must be user friendly. The real challenge is to design experiments that are sensitive to drug users; that involve, in operation, a real research alliance between the subjects and the researchers (see Kaplan et al. 1990). This "volunteerism" principle in social experimentation requires specific and special methodologies. Campbell (1988:307-308) has described these methodologies as evaluations legitimated and facilitated by non-professional participants and professional observers.

4. An evaluation of the Dutch approach

Recently, the application of evaluation methodologies to national drug policy has become a top level scientific priority further emphasizing the critical importance the issue has gained in the contemporary world. For instance, the prestigious American journal Science has published an article by two highly regarded emeritus professors of pharmacology with long experience in the field of drug abuse (Goldstein and Kalant 1990). In this article an evaluation of American drug policy is presented with a cost-benefit analysis based on pharmacological, toxicological, sociological and historical facts. This article represents an important milestone in the development of a rational valuative approach to assessing a national drug strategy. The choice of a cost-benefit analysis, however, is only one of a variety of options available for conducting evaluation research (see Rossi and Freeman 1985). Cost-benefit methods of evaluation have the limitation of relying upon accepted "net benefit" formulas combining sufficiently reliable quantitative indicators. Furthermore, in terms of Campbell's criteria for social experimentation, the cost-benefit analysis may be sufficient in terms of scientific independence, but insufficient from the viewpoint and interests of the drug users themselves. Without this additional methodological constraint, the evaluation may lose in concreteness and sensitivity what it gains in abstractness and objectivity.

To calculate their net benefit function, Goldstein and Kalant rely upon the indicators of the availability of alcohol in the general population and of opiates to the medical professions. Using these indicators, they are able to demonstrate that alcohol prohibition in the United States did indeed result in a decrease in the use of alcohol and, on the other hand, the ease of availability of opiates by the privileged medical profession can account for their higher use of these prohibited drugs. On the basis of this cost-benefit analysis, they then conclude that "the practical aim of drug policy should be to minimize the extent of use, and thus to min-
imize the harm” and “that radical steps to repeal the prohibitions on presently illicit drugs would be likely, on balance, to make matters worse rather than better” (1990:1513).

However, drug policy need not necessarily adopt the means of minimizing the extent of use in reaching the goal of minimizing the harm of drugs. An alternative (and not necessarily contradictory) means of reaching the same goal of demand reduction is changing the nature of drug use itself. For example, changing the nature of drug use from injection and “basing” to more slowly working forms of self-administration of cocaine, can also minimize the harm and reduce demand (see Bieleman et al. 1993). In this case, the extent of use may remain the same, but an unsatisfactory situation would be improved and the dimensions of the problems relating to cocaine would be reduced.

Evaluation of the ideal means for changing the nature of drug use requires a different sort of evaluation methodology. Thus, Goldstein and Kalant’s quantitative indicators as suitable measures relevant for an analysis of demand reduction need to be cross-validated with complementary global qualitative standards which relate to the nature of drug use in society. This turn in evaluation methodology leads to a critical question. How much of the decrease in alcohol use during the American Prohibition indicates a real reduction in demand and a real improvement in an unsatisfactory condition? Could not the overall demand of drugs have even increased during Prohibition as new substitutes, such as coffee and cigarettes, were found (i.e., the extent of alcohol was reduced without the underlying nature of drug using behavior being effected)?

An alternative methodology to cost-benefit analysis for drug policy evaluation is the cost-effectiveness method. With cost-effectiveness analysis, the output is primarily qualitative. With this method, the criterion is not net benefit, but the effectiveness of a policy in improving the quality of life. In this regard, the evaluation of Dutch drug policy has been more concerned with cost-effectiveness; the outcome criteria are not so much reducing demand by decreasing the extent of use, but rather by improving the quality of life of both drug users and their communities in such a way that the nature of use changes in the direction of reducing harm. To cite one concrete example, the low threshold methadone programs do not aim at blocking all heroin use, but at substituting acceptable drugs (e.g., methadone) and activities (contact with a social medical professional) for unacceptable drugs (e.g., heroin) and unacceptable activities (contact with criminal dealers). These objectives are not realized abstractly, but at certain strategic moments in the daily lives of drug users (see Kaplan et al. 1990; Grapendaal et al. 1992). Thus, the end of
demand reduction is reached not by directly lowering the prevalence of heroin use, but, rather by improving the nature of drug use through a re-organization of the daily and weekly routines of heroin addicts in such a way that the time devoted to the acquisition and self-control of illegal drugs is reduced. Furthermore, with regard to Campbell’s recommendation that programs rather than clients should be evaluated, a number of Dutch studies do not look myopically at only the drug user, but also at the relational context created by the impact effect of specific policy innovations (Verbraeck 1988). In summary, the reduction of demand can be globally assessed as the reduction of the negative quality of life conditions that stimulate demand and produce harmful drug use behavior. In this regard, the Dutch use of methadone can be evaluated as a social management innovation aimed at improving the general quality of life in neighborhoods where drug users reside.

Karl Popper’s advice, essential for a proper climate for evaluation of “letting our ideas die instead of ourselves”, has characterized the pragmatic approach of Dutch policy-oriented research (quoted in Campbell 1988:292). Overall and in terms of its own ends, the drug policy in the Netherlands is seen as functioning positively. The goal of relatively reducing the secondary effects of drug abuse (for example, AIDS, violence) is being reached. For instance, Peter Cohen’s (1989) study of cocaine use in non-deviant social groups in Amsterdam, and Intraval’s (1992) study of the nature and extent of cocaine in Rotterdam, both provide hard and sound evidence that patterns of use need not necessarily lead to negative secondary or, for that matter, primary effects. These studies provide support for a cocaine policy that is more differentiated than that of other hard drugs. The longitudinal study of Swierstra (1990) of 91 heroin addicts demonstrates that the normalization policy has been effective for diverting the career of heroin addicts from criminal to conventional, but has been less effective in getting heroin users clean. Recent survey data from Amsterdam have shown that the current separation of markets strategy has not led to an increase in cannabis use despite the expansion of the coffee house circuit (Sandwijk et al. 1992). However, the preliminary findings of the Netherlands Institute on Alcohol and Drugs from a national survey of 11,000 high school students where alarming increases in cannabis use have occurred over the last eight years are counter-indicative. These results document the limits of tolerance and, therefore, current attention is being placed on the abuse of the coffee house system, and on new programs which focus on the potentially harmful effects of excessive cannabis use in the young. Thus, the coffee house system itself is in need of a comprehensive re-evaluation. On-going evaluations of
clinical programs for addicts concentrating on outcomes, retention and the place of psychopathology in the provision of a wide array of treatment services are yielding results which help to improve the care system (Kooyman 1992; Van Limbeek et al. 1992; Hendriks 1990). The efficacy of needle exchange as it relates to AIDS’ prevention, migrant drug policies and drug prostitution policies has been evaluated with generally positive results (Van Gelder and Sijtsma 1988; Van der Hoek et al. 1989; Grund et al. 1992).

Finally, all Dutch programs have a built-in mechanism to assess the efficiency of their functioning - the so-called advisory commission, made up of independent experts who monitor most research and intervention programs. The standard procedure for establishing such a commission for every evaluation research project is a unique mechanism which bridges the gap between independent researchers and program managers. These commissions are chaired by a respected expert and are appointed to reflect divergent and often conflicting interests. They meet periodically and issue written minutes of their deliberations. Thus, these commissions function, to use the terminology of evaluation research, as “shadow controls” (Rossi and Freemann 1985:266).

5. The manageable bits of Dutch drug policy

To begin the final approach to answer the question posed by this paper, Dutch drug policy needs to be reformulated in terms of technology transfer. The global themes of Dutch drug policy already outlined in this Chapter would be merely an interesting oddity, if they could not be transformed into a relatively context-free set of tools which could be used elsewhere. In order to do this, the policy must be de-constructed into its “manageable bits” which are transferable singularly or in sets to other social situations. Thus, a corollary to this Chapter’s general question is: what specific bits of Dutch drug policy would be transferable to other countries? The transferability of the drug policy of the Netherlands is consistent with its experimental nature. Again, as Campbell emphasizes, the evaluation of programs rather than persons requires a methodology that searches out multiple sites in varying contexts in order fully to assess the program of interest. An answer to this question of transferability starts with the realization that complex and seemingly inextricable social problems (including drugs) must be broken down into discrete areas. By so doing, we do not solve all the problems at once, but we do create situations that can be analyzed separately or in their contexts, that can be managed in a number of cases, and that can be solved sometimes
and to a certain extent. Thus, it also becomes possible to break down the
so-called “drug problem” into a matrix of microproblems concerning a
variety of very different substances, with very different risks involved,
to which different sets of rules, measures, instruments can be applied to
achieve certain distinct aims. The solutions to these microproblems once
packaged and operational become the manageable “bits” of the drug
policy. Managers can learn the “bits” of Dutch problem-solving and use
them in their own situations.

Table 1. The manageable bits of Dutch drug policy

<table>
<thead>
<tr>
<th>Problem-solving responses</th>
<th>Problematic factors</th>
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<tbody>
<tr>
<td>Pharmacology</td>
<td>impairment</td>
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<tr>
<td>Social definition</td>
<td>deviance</td>
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<td></td>
<td>low threshold methadone</td>
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<td></td>
<td>normalization</td>
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The manageable bits of Dutch drug policy are schematically represented in Table 1. The common problematic factors defined by Jaffe (impairment and deviance) have been cross-classified by the dimension of problem-solving responses (pharmacology and social definition) also posited by Jaffe. The manageable “bits” of Dutch drug policy can, in turn, be assigned to the cells of the cross-classification, representing four distinct problems faced by policy-makers and four distinct responses made by them to solve these problems. From a dynamic point of view, they also depict four distinct stages of policy development in the Netherlands.

The earliest “bits” appear in the cell pharmacology/impairment. In the 1970s, the pharmacology of drugs was assessed by a government-appointed work group chaired by Dr. Baan, the Head of the Mental Health Inspectorate. The Baan Commission proposed the criterion of socially acceptable risks. By the application of this criterion cannabis was found to be properly classified as pharmacologically acceptable while heroin was not. In order to deal with the impairments associated with heroin use, low threshold methadone programs were established based on community psychiatric models set up in Chicago and London (Trimbos 1973). Thus, at first Dutch drug policy focused on the classical terrain of medicine defined by the impairment/pharmacology cell and designed a novel response through the use of easily accessible methadone.

In the later 1970s, Dutch drug policy developed the “bit” represented in the cell of pharmacology/deviance. In accordance with the differential pharmacology of different drugs, separate markets needed to be created.
The “soft” drug (cannabis) market had to be separated from the “hard” drug (heroin, unacceptable risk) market in order to minimize the social deviance caused by illegal drug use. The Ministry of Justice guidelines created a situation where the deviance associated with cannabis use was officially seen as different from that of heroin use deviance; separation of the markets was devised.

The third cell (impairment/social definition) was filled in by the development in the early 1980s of the normalization of drug problems. Normalization recognized that much of the impairment in social functioning of heroin users was the result of the social definitions they had of themselves and which society supported. Junkie unions and other forms of drug user self-help organization were created in order to provide drug users with the resources to take more responsibility for their own impairments and to define the kind of help they needed. In this way, drug users were coaxed into a process of normalizing their problems and seeking solutions in the sphere of the conventional rather than the criminal world.

The late 1980s saw the developments in the fourth cell (social definition/deviance). In line with the pronouncements of Vienna 1988, the section of differentiated criminal law policy was created in order to provide the means for lowering the intensity of law enforcement on the hard drug user while, at the same time, increasing the intensity of action against international drug trafficking. The result of this can be seen in actions as diverse as the creation of “tolerance zones” by the police, where open small scale drug dealing is allowed, and the cooperation between the Dutch navy and the American armed forces in patrolling the Caribbean to intercept international drug traffic.

6. Conclusions

The two macrosocial science theories of De Swaan and Inglehart have been consulted in order to provide support for the proposition that Dutch society presents a compact adaptation of broad socio-historical processes which all modern societies are now undergoing. Given the above discussion on the socio-historical background of Dutch drug policy, it makes no sense to argue, as has been done on numerous occasions, that Dutch policy works for the Dutch, but is so culturally specific that it could not work in other more “representative” places. This would provide the answer to our question “is Dutch policy an example to the world?” with simply a clear “No”. However, if the preceding arguments can be accepted and Dutch drug policy is indeed the rational outcome of conscious
political decision-making and problem-solving, then Dutch drug policy could be an example to the world. Dutch drug policy is an example to the world insofar as Dutch society is a forerunner in the "shift to different goals" strategy for solving social problems. Dutch society, therefore, functions as the example of a new and innovative well-being state which, in the words of De Swaan (1988), collectivizes treatment, education and caring, extending civilization to the lower social strata while changing the ways emotions are managed and controlled. For the purposes of our analysis, De Swaan provides a view of the basic condition for the transfer of the technology of the manageable bits of Dutch drug policy – the existence and recognition of a well-being state as both a collectivizing and civilizing conglomerate. The emotional component of the well-being state as expressed in its post-material value orientation as well as a set of institutions collectivizing the helping services are integral conditions necessary for the effective transfer of the technology of the manageable bits. In Inglehart’s analysis of the results over the last two decades of the Euro-Barometer surveys and other national political value surveys, a clear albeit gradual shift in world culture, from materialist to post-materialist values can be measured. Thus, the emotional and cultural conditions for the technology transfer of Dutch drug policy are indeed becoming widespread. Furthermore, these value orientations have been found in a German national survey to have an “extremely orderly relationship” with drug-related attitudes (Kaplan 1987). The measures used in this survey were adopted from Inglehart’s theory using a slightly different terminology. In the study of a national sample of Germans, those holding the equivalent of materialist values (and to a lesser degree a mixed value orientation) had significantly different views on drugs from those who held on to post-materialism.

Focusing on the emotional component, the analysis of the German national sample showed that “fear of the future” was an important variable. The post-materialists were more likely to articulate the emotion of fear of the future in society. This recognition of fear provides a reasonable functional explanation for the widespread use of drugs and makes this use understandable and somewhat acceptable. Thus, at a deep political psychological level, drug policy can be seen to be related to the recognition of fear of the future in society. When fear becomes tied to massive declines in political and interpersonal trust, basic orientations can radically shift (Abramson 1983). The instinct of American politicians to capitalize on this new emotional complex allowed substitution of the war on drugs for a more gentler variety of response. American policy can be seen as a novel attempt to exploit the post-material fear of the future...
sentiment and separate its association with casual contacts with drug users.

It has become a worn-out truism to argue that drugs play the role of a scapegoat in society (Szasz 1974; Alexander 1990; Reinarman and Levine 1989). Drugs, as Goldstein and Kalant convincingly argue, are indeed potentially dangerous. But fear of the dangerous is no basis for the formulation of a rational and effective policy. There are sufficient international initiatives to draw on for inspiration that are both more optimistic and consistent with Dutch drug policy. One such example is the WHO/EURO program “Health for All in the Year 2000”. This document emphasizes positive action and provides a way beyond fear-based thinking. The document notes that “the WHO concept of health as a state of physical, mental and social well-being and not only the absence of disease and disability, views health as a positive condition involving the whole person in the context of his/her situation”. The target of reducing health-damaging behavior including illicit drugs by 25% (i.e., demand reduction) is tied to a social context whereby “health-damaging practices should not be thought of as discrete forms of behavior, but rather as aspects of a cultural life, often one of several interacting problems. Risk behaviors can be a way in which people try to resolve conflicts within themselves and between themselves and society”.

In the drug area there is a general call “to develop innovative approaches to prevention, taking into consideration a broad range of possible resources in different sectors”. In line with the WHO targets, Dutch drug policy includes the mobilization of resources from the broadest possible range of society including active drug users themselves. A primary care orientation with greater degrees of general practitioner and community involvement, more responsibility to the drug user and sensitivity to the conflict resolution function of drugs in a fearful world, has also brought Dutch drug policy in line with other international initiatives such as UNESCO’s “preventive education” approach to drug abuse.

In conclusion, broad socio-historical processes can be seen to determine the national response to the drug problem. While every society is unique, the transferability of Dutch drug policy “bits” will be feasible in a country where the value orientation of post-materialism is ascendant; i.e., a priority is placed on social and self-actualization needs of esthetics, intellect, belonging and esteem. In any case, since these cultural orientations are now broadly distributed over the globe and are gradually expanding, Dutch drug policy, as an outcome of this value orientation cannot be considered a deviant case with no real transfer potential. Thus, while it is indeed true, as Jaffe (1983:111) maintains “...that the characteristics of society itself are essential elements in developing a useful
classification of drug problems ... drug problems need to be defined in the context of the society in which they occur”, it is equally true that an international definition of the drug problem must reflect the emergent general characteristics of society. There is still much creative work to do in the future. The limitations of the Dutch and, for that matter, of the American examples of drug policy “for the world” are that neither has struck the right balance between prohibition and legalization, between a “drug free” and a “free drug” society. It will surely take a new bird (call it an owl) to make the flight into the wild blue yonder of future drug policy beyond those now tiring hawks and doves.

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Cohen, P.: Cocaine Use in Amsterdam in Non-Deviant Subcultures. Amsterdam: University of Amsterdam, 1989


Endnotes

1. The Vienna United Nations International Conference on Drug Abuse and Trafficking in 1987 elaborated on a new Convention on Drugs in November/December, 1988 to be ratified by member states. This global effort stands in the tradition of international cooperation begun in 1912 with the signing of the The Hague Convention. Since the founding of the United Nations after the Second World War several protocols and conventions have been adopted to respond to the drug problem. The 1961 Single Convention on Narcotic Drugs amended by a 1972 Protocol moved to modernize the earlier international accords. In 1971 the Convention on Psychotropic Substances attempted to broaden and move forward the international drug control system. By 1981 the UN had accepted the International Drug Abuse Control Strategy which authorized international cooperation in fighting drug abuse and drug trafficking. In the UN Assembly’s 1984 Declaration on the Control of Drug Trafficking and Drug Abuse, the drug problem became a maximum international priority. That same year a new convention was proposed that would treat those aspects of the problem not sufficiently covered by the existing instruments. The Vienna Convention is especially significant in that it marks the beginning of the “post-modern” period that goes beyond the terms of the “modernizing” process since the Second World War. This is signalled by its articles on demand reduction which turn the momentum of the instruments away from production and distribution and towards consumption. This is especially important because it promises to unravel an essential paradox noted by Stein (1985:5) that “much of the history of national and international narcotics control can be written without addicts or addiction”. The Vienna Convention also signals a new style of work that fits into the post-modern mode: consensus is to be sought through the stimulation of increasing numbers of conferences, meetings, seminars and workshops at all levels and in all regions attended by representatives.
from multidisciplinary and multisectorial backgrounds.

2. For another recent and politically informed statement by the Mayor of Baltimore, see Schmoke 1990.

3. See Ghodse et al. (1990) for a volume debating drug policy options in the UK and the Netherlands.

4. Perhaps because their enlisted corps consists of predominantly young males who are traditionally the highest users of illicit drugs (see Kaplan 1986).

5. This kind of gentleman's agreement of mutual respect did not work for all groups. For instance, the prosperity and tolerance of the Republic became an affront to the group of Puritans who had fled from England. As a result, in 1620 they set sail for the New World to establish a new, isolated society based on "pure" Protestantism, protecting themselves and their children from the corrupting influence of worldly temptations. After several years in the "new Providence" frightened by their own insignificance, these "wayward Puritans" resurrected the witch hunt in Salem that had died away in Europe with the civilization offensive (Erickson 1966).

6. Coppes (1988), a business consultant, puts it this way in a newspaper story: "Because no other society has reached the compactness and the complexity of the Netherlands' society, there are no well tried recipes yet for accommodation of various new kinds of business activity and society. They will have to be invented in the Netherlands itself."

7. This has become the model for a later European Community study (Bieleman et al. 1993).

8. Materialists were highly unlikely to know a drug user, while half the post-materialists did. The generally more permissive attitudes of the post-materialists to drug users is associated with their greater familiarity with them. This finding was independent of the drug use of the post-materialists which was not much higher than the materialist Germans. However, the post-materialists were nine times more likely to experiment in their lifetime with drugs than the materialists. The post-materialists found drugs more easily available, but, at the same time, found them to be more harmless. Post-materialists also displayed a more differentiated view of drugs having different attitudes than materialists for both cannabis and heroin. Post-materialist Germans seem quite receptive to the "separation of markets" bit while not going so far as the endorsing of the legalization of cannabis.