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The Dutch approach to services for drug misusers

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The Dutch have a tradition of tolerance and pragmatism in the fields of social policy, and nowhere is this better illustrated than in their policy and practice in the field of drug misuse. Indeed often exaggerated accounts of Dutch 'liberalism' are promulgated, and articles in the press have suggested a backlash is now occurring in Holland to these 'progressive' policies (Williams, 1989). The award of a Council of Europe Fellowship gave me the opportunity to spend two weeks in the Netherlands in October 1989, visiting drug services and talking to a wide range of people with responsibilities for such services. I was particularly interested to see how the Dutch were responding to the challenges of HIV infection in drug users (Fleming, 1989).

The Netherlands is a small densely populated country with a population of 14.7 million. It is estimated that there are between 15,000 and 20,000 addicts in the country. Heroin was first introduced into Holland in 1972, and its use spread quite quickly. The purity of black market heroin has remained relatively high (30–40%) and, as a result, the majority of users smoke it – only some 40% inject. The number of heroin users has stabilised in recent years, and the average age of those presenting to services has steadily risen. In Amsterdam, for example, the average age is 31. There is evidence of increasing use of cocaine, often with other drugs, and users with a primary cocaine problem are beginning to present to services.

The key principle lying behind the Dutch policy on drugs is that of 'normalisation' (Engelsman, 1989). The drug problem is seen essentially as a matter of health and social well-being, and not as a problem of law enforcement. The responsibility for co-ordinating the drug policy in the Netherlands lies with the Minister for Health. This contrasts with the United Kingdom, where the lead Ministry is the Home Office. The 1976 Opium Act makes a clear distinction between drugs presenting 'unacceptable risks', such as opiates, cocaine, LSD and amphetamines on one hand, and 'hemp products' such as hashish and marijuana on the other. The aim was to avoid a situation in which consumers of cannabis suffered more damage from any criminal proceedings than from the use of the drug itself. The intention was also to separate the markets in which hard and soft drugs circulate; thus the sale of limited quantities of cannabis in youth centres and coffee shops is accepted (Dean, 1989). In practice, people found in possession of amounts of cannabis less than 30 grams are almost never prosecuted. Surveys have shown that the incidence of cannabis use has not increased.

I found widespread support for this policy of the separation of markets and the *de facto* decriminalisation of cannabis among those working in the drugs field and among administrators in the Health and Justice Ministries. Dr Eddy Engelsman, Head of the Alcohol, Drugs and Tobacco Branch at the Health Ministry, is an articulate advocate of the policy of normalisation. He emphasises that drug taking should be demythologised and deglamourised, and that drug takers should be integrated into society. He points out that the labelling and stigmatisation of drug abusers can paradoxically attract young people to what seems an exciting life-style. Engelsman sees the normalisation policy as a compromise between the 'war on drugs' approach of the United States (and increasingly of our own Government) and the legalisation of drugs. I met one or two advocates of legalisation, but the majority of those I met working in services were against such a policy.

Services for drug misusers in Holland are of several different types (Ministry of Health, 1989):

(a) Out-patient consultation bureaux for drug and alcohol problems (CAD) are usually part of psychiatric services or in some cases are specialist institutes in their own right. The Jellinek Centre in Amsterdam, which is the largest treatment centre for addicts in the country, is an example of the latter. There are some 90 such institutes across the country and they tend to be medical/treatment in orientation, and are staffed principally by social workers.

(b) Municipal methadone programmes are run in 12 cities. These are part of the municipal health services which are funded by, and are answerable to, the local municipality. The largest of these is also in Amsterdam.

(c) Social welfare services are aimed specifically at young people and tend to have a social model.

There are 60 of these and they provide a variety of community based projects, including work, housing and education.

(d) Residential facilities. There are 18 of these; some are run in association with the CAD and some are independent therapeutic communities.

Harm reduction is an integral part of the Dutch approach to drug services, and has been for many years (Buning, 1989). In the late 1970s it was clear that many drug users were unable or unwilling to come off their drugs, and it was accepted that the aim should be to reduce the harm that addicts did to themselves. Low threshold methadone programmes were set up first in Amsterdam, and later in other cities, to encourage addicts into contact with services, to stabilise their life-styles and to encourage those who wished to accept further treatment and detoxification. Perhaps the best known of these low threshold programmes is the methadone bus project in Amsterdam, which has been running for ten years. There are two converted municipal buses that stop in various locations in the city. Addicts (who have previously been assessed at an out-patient clinic) drink their methadone at the bus and can also obtain needles, syringes and condoms. Seven hundred addicts a day get their methadone from the buses, and the service runs 365 days a year. The first needle and syringe exchange scheme was set up in Amsterdam in 1984. Such schemes are now in operation in many cities. An interesting development has been the use of addicts and ex-addicts as outreach workers to spread the health education message, and also to provide clean needles and syringes for drug users who will not come to services. As a result of these more 'user friendly' services a much greater proportion of Dutch drug users are in contact with services than is the case in this country. For example, in Amsterdam it is estimated that at any one time 70% of users are in contact with services, and the proportion is greater in other parts of the country.

A large proportion of the prison population (over 50%) use drugs regularly, and various alternatives to prison have been developed over the years by negotiation with CADs, the Ministry of Justice, and the municipal authorities. I visited two drug-free units in remand prisons in Rotterdam and Amsterdam. Such units have been in existence for some ten years now. They are staffed by CAD employed staff with prison officers who volunteer specially for the work. The unit is separate from the rest of the prison and prisoners enter only *after* detoxification in the main prison. The aim is to prepare inmates for therapy outside prison, and the structured programmes consist of group work, individual counselling, sport and other activities. From one of the units I visited, 50% of inmates went on to a therapeutic community after release from custody.

What can we learn from the Dutch? The best of the services, in Rotterdam and Amsterdam, for instance, provide good models for post-HIV drug services: easy access, low threshold services that are in contact with a high proportion of drug misusers; a variety of treatment options; imaginative outreach programmes, and above all an emphasis on harm minimisation. In this country, the advent of HIV has forced a radical re-thinking of drug policies (DHSS, 1989) and we are only just beginning to move in these directions. The Dutch have a lot to teach us.

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