

AMSTERDAM



AMSTERDAM DELEGATION

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Police Department
- ERNST BUNING,
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- DUS FABIUS,
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**PAUL VASSEUR, Drugs Coordinator
AMSTERDAM**

On behalf of the city of Amsterdam I wish all of you a lot of strength and wisdom to develop a drug policy which is convenient to your city.

My name is Paul Vasseur, I'm the drugscoordinator of the city of Amsterdam and I brought with me three experts: on my left hand is Mr. Ernst Buning, he works at the Municipal Health Department and far away on my left hand is Mr. Dus Fabius from the Townhall of the City of Amsterdam.

Our contribution to this conference is to tell you about our integrated drug policy. As you know we have a drug policy which is working since 1979 and our policy can be characterized as pragmatic and non-judgemental. In the period of 1979 to 1984 the drug policy was based on

- obtaining into the scope and characters of the heroin problem by contacting as many drug users as possible and by setting up a registration system.
- Reducing the risk of hard drugs use for those users who are not capable or willing to give up their drug use.
- Motivating drug users to enter drug-free treatment programmes and/or resocialization programmes.
- Cooperation between the police, the helping-system, and the neighbourhoods whenever drug issues were at stake.

With respect to the responsibilities of the police for public order issues and the helping systems for public health matters a central coordination was installed in the townhall. Since the drug problem had a clear effect on the living circumstances of the Amsterdam citizens, those aspects were adopted in this integrated drug policy as well.

In the period of 1984 to 1989 AIDS-prevention measures were integrated into the existing drug policy. The first goal was to prevent a further spread of HIV among injecting drug users by various prevention interventions.

The second goal was to organize good care for injecting drug users with AIDS. This care is integrated into the existing helping organizations and aimed at avoiding further discrimination and marginalization. "Case management" is a keyword in this regard.

Like I told you, our contribution will be to tell you about our experiences of the last decade. For that I would like to ask Mr. Ernst Buning to tell all of you about our helping systems and another important thing is the research behind that. Thank you.

**DR ERNST BUNING, Municipal Health Department
AMSTERDAM**

This is the central station of Amsterdam. Probably all of you know this place because it is the first you see when you come in by train. This is the beautiful Amsterdam as a lot of tourists see it. About two minutes from here is the red-light districts where we have all the prostitutes and where we have a lot of drug users hanging around. There is a big difference between one area and the other so close by each other.

Of course I'm going to talk about the drug problem. I first try to give you an idea about drug use in Amsterdam. A researcher from the University of Amsterdam - Sandwijk - and others had a large household survey where they ask people what sort of drug they have been using over the last month and the last year. And as you can see, the alcohol score is quite high, the cannabis score is not extremely high and the opiates and cocaine score is very low.

Actually 1.2 % of the people who were interviewed admitted having used opiates in the last month. If you calculate this 1.2 % on the total population of Amsterdam, that would be about 7.000 drug users. What is quite interesting is that the sort of calculation that my department does - which is a very different method. It is called the "capture-recapture" method where you look at populations that you see in different places and you look at the overlap. It is quite technical, but anyway, we come up with the same calculation: between 5.500 and 7.000. Quite interesting: out of these 7.000 people a lot are not injecting. In that respect Holland is very different from a lot of other countries. About 60% of the drug users are what we call "chasing the dragon" (inhaling the vapour of heroin/cocain smoke). In terms of AIDS-prevention this is extremely important and in sort of other illnesses - abcesses etc. it is also very important.

A lot of people ask: why are people not injecting? There are basically a couple of answers to that. One answer is that the black drug users in Amsterdam respect their body so much that they never inject. That is a cultural thing and they have a rather high position in the drug scene in terms of that drug users look up to these black drug users and they imitate the habits of the black drug users. That is one reason. Another reason is that the price of heroin is relatively low if you compare it to the prizes we have heard earlier today and also that the purity of heroin is quite constant and also reasonably high - about 30 to 40 % pure heroin. In this condition you can afford to smoke heroin. You don't have to inject. Later on in the discussion we can maybe see how police action is counterproductive to the purity and the prize of heroin and therefore stimulates people to inject and is then

again counterproductive to AIDS-prevention. There you may have very conflicting reasons to do something. Out of the drug injectors about 1/3 is seropositive.

As Paul Vasseur already mentioned we have an intergrated drug policy and I think today is a very very good example of how integrated drug policies are now all over Europe. People are going to see that this is really very important - you have to cooperate - there is not one group of people who can deal with the drug problem you have to cooperate. The police, the helping system and the people who are living in the city itsself. We have established this system in 1984, it was not easy - especially from my point of view as being from the helping system to start a cooperation with the police because we had certain ideas about the police. But when you work together for a longer period of time you realize that you share a lot of goals. You all share the goals that you don't want people to die, you want to reduce all the misery that drugs are causing and you can find a lot of common denominators in that sense.

Pragmatic, non judgemental, non moralistic - that's what we try. Pragmatic means, that we are very open minded to any solution. Today methadone seems to work in Amsterdam . If somebody comes up tomorrow with something that works better than methadone we are willing - hopefully, but I mean that 's the whole idea - we are willing to give up methadone and change to a totally different policy. That's what we mean by "pragmatic": see what works and try to stay away from a lot of ideology and a lot of ideological warfare between different institutions or different political parties. We don't think you gain a lot with that.

Because we have this pragmatcal approach we also have a whole variety of different helping istitutes and helping projects. Because we say there is not one certain solution that works for every drug user - if you have 100 drug users you probably need 100 different approaches. You can't afford it, it is too costly, but at least you can have 10 different approaches.

I talk about the helping system and I do that along four clusters.

1. How do we contact drug users?
2. What can we do to reduce the harm that drug users cause to themselves and their environment?
3. What do we have in terms of helping people to kick the habit, to stop using drugs?
4. What do you do once people have kicked the habit and as the peolpe from Zurich said this morning you have to look what they do in their spare time - you have to look at jobs etc. etc.

1. Contact.

Where do we contact drug users? We go to the police station - doctors from the Municipal Health Service - we have a team of people that go to the Municipal Health hospitals. These are five medical nurses who contact different wards in the hospitals in Amsterdam and of course we have outreach workers, streetcorenr workers who go out into the drug scene. This is an example of one of our doctors, Miss van Arnheim, who is visiting a drug user in a police station. Our doctors see every year about 2.000 different

drug users who have been arrested by the police. This gives us a very good opportunity to tell people about the helping system, to give them information about AIDS and to get an insight into the drug using population.

We also go into hospitals there we see every year about 350 drug users and again it gives you a very good opportunity to meet drug users who are not going to the drug helping systems themselves. Because the fact that they are in a hospital was not their own decision. Something happened - some medical disaster and then they were in the hospital. Very good opportunity to try to get somebody into more drug related treatments.

Finally we do streetcorner work. This is a picture of addicted prostitutes behind the central station. We have female outreach workers, and we have black outreach workers and then also white outreach workers. But we try that the outreach workers are very close to the group we want to contact.

2. harm reduction

We never knew the word "harm-reduction" until, I think, 5 years ago. We were always using the term "primary care" but then somebody from England said, when we explained what we were doing that this is called harm reduction, what you are doing. So since then we are using this term harm reduction. Where we say that if you cannot treat somebody for his drug addiction, that could be your first goal but you realized it's very difficult. Then at least you should try to minimize the harm that the drug user is causing to himself and his environment. We include the environment in our definition of harm reduction as well. And how do we do it? We do it with a lot of medical and social care. We use methadone in our harm reduction programmes and needle exchange programmes are a perfect example of harm reduction interventions. Medical care is so important - we have all eaten, so I think it's o.k., - but this is the sort of things that you see when people come to this low threshold harm reduction programmes. You need very skilled medical personnell to take good care of that. For example you can offer people to do an AIDS test as well in these programmes.

This is a person who sleeps in the train. What do you do about people who don't have a home - we think that even if people are still very active on drugs they have the right to have a proper place to live.

I was also talking about methadone as part of the harm reduction program. When someone is using methadone there is no need for this person to use other drugs. I'm not saying they are not doing this but there is no physical need to do so. What we find out is that drug users who are on methadone have a much more relaxed existence and are more open minded to other possibilities than people who are on heroin. If they are only on heroin and cocain they have a one way vision at life and this is what it is all about. They are just chasing their drugs and getting their money. When somebody is on methadone, this person is much more relaxed. So in terms of harm reduction, methadone plays a very important role.

We give it in fluid form - they have to drink it on the bus. Every bus has for example 300 people a day and in total we have 1.000 people a day we prescribe methadone to. Tablets are also possible but only if people are a little bit better regulated, otherwise we are afraid that they will sell all the tablets on the black market.

This is the number of people in our methadone program on a yearly basis: we see about 3.500 people a year in our methadone program. So half of the estimated population of hard drug users in Amsterdam is actually seen in our methadone program. That's a very good way of making a lot of contacts. Also, we involve the general practitioners (Hausärzte) in Amsterdam. Out of the 400 general practitioners 170 are prescribing methadone and in total they have about 1500 drug users a year who make use of the general practitioners. This is a very good system - it's very close to the person, it's his own general practitioner and he goes there once a week, gets his prescription for one week. Not all drug users can handle this situation. There are drug users whose lives are such a mess that they get the methadone and they sell it or whatever. But there are quite a number of drug users who manage to lead quite a regulated life with methadone from a general practitioner.

We have a central methadone registration system. In Holland that gives no problems. I realized that when you mentioned that in Germany the Municipal Health service sets up a central registration that you have a lot of trouble. But we don't have that sort of a trouble because the history of our Municipal Health Service is very well and we are trusted by the population. If we say that we have the medical secrecy then people believe that we actually will not violate this secrecy.

Another issue of course is AIDS, the needle sharing, and that's why we have the needle exchange. This is a very neat and clean system. People throw the needle through this little tube and then it falls on this gadget and the nurses can see how many needles have been thrown in. It is a one to one exchange system. We distributed 800.000 needles last year. It is a lot, but it is probably still not sufficient for the whole group of injectors. We also did some evaluation on the needle exchange. The conclusion was that a lot of drug users who were participating in the needle exchange had a low level of risk taking behaviour and they were able to maintain that low level for a long period of time. So it is very useful for a certain group of drug users. We didn't see any increase in injecting among people who are using the needle exchange. Especially people who have been injecting for a long time and who are injecting every day were the people who were using the needle exchange. Young people or people who would just use once a week would not use the needle exchange so much. Especially young people were still at risk for borrowing needles from others. That was very important for us to realize that the needle exchange is not the final answer, it is not a panacea for the whole AIDS program. It's one of the things that you can do but it's not the final solution.

3. Therapeutic treatment

We have in Amsterdam the Jellinek Centre - it's a very large alcohol and drug treatment centre. They have a high equipped staff

there and they have in-patients programmes and out-patients programmes to assist people who want to stop, who want to kick the habit. It is very important that you have it in the city and I think, a lot of people tend to oversee that we have that in Amsterdam, because everybody comes to the methadone bus and looks at the needle exchange or at the coffee-shops or whatever. We have a very good therapeutic treatment system in Amsterdam as well and also two foundations who are involved in resocialisation with work projects, with activity projects and they reach quite a lot of people and do very interesting work.

What we wanted to find out was if the moment we started to prescribe methadone drug users would no longer be interested in coming to drug-free treatment centres. Because that's what a lot of people who were working in the drug free treatment centres were saying. They said: if you start with methadone, we will be unemployed. We looked at the figures and we actually see another effect: more and more people are making use of the drug-free treatment facilities. I think this is very important also for the discussion in Germany about how methadone can be used. I don't think that people working in "Langzeittherapien" have to be afraid that they won't see any clients any more.

I will also talk briefly about AIDS prevention among drug users. The total number in the Netherlands is about 1400 patient and out of the 1400 patients about 130 are drug injectors. The percentage is almost the same as the percentage in Germany.

This is the AIDS and drug policy that we have where we say that we contact drug users first. Then we give give them information about safe sex, about safe drug use and about other risks of AIDS. By doing so we hope that they will change their attitude, that they are willing to behave in a safer way. And then we say that this will only lead to safer behaviour if those things in the blue box are fulfilled - like condoms, drug-free treatments, methadone programmes and the needle exchange. If those conditions are not there - I mean, you can talk to a drug user for 5 days and tell him that he should use condoms, but if there are no condoms available they will not use them. If you talk to a drug user and say: you have to use clean needles and there are no needles available - why are you doing it? Again, you have to look at the possibilities of change among every individual. For one person it may be possible because of his fear for AIDS to stop using drugs - then he should go to a drug free treatment centre. But somebody else may not be ready for this sort of treatment and be only motivated to use clean needles. But then they have to be available - that's very important. We contact a lot of drug users every year - 70 %. This is the information we give them: this was actually a video about safe sex where we showed exactly how condoms should be used. We showed this to clients several times and then they didn't want to see it any more, because they said this is pronography. So, we had some problems there.

This is a leaflet about safe drug use - he has a needle and syringe behind his ear. Condomes as I said are very important. The drug free treatment and methadone plays a very important role in our eyes in AIDS prevention, because first of all it makes it possible to contact a lot of drug users. Only then you can give them the AIDS information. You have to contact them first and

methadone is a very easy tool of getting in touch with a lot of drug users. Secondly it regulates their drug use, so they are not so uptight that they have to get that shot. They can wait a little bit longer. They can manage their injecting behaviour much better. And finally methadone can be very useful in helping people to get off drugs totally.

I will give you some data about people who died after an overdose. These are not drug related deaths - that is much more. It includes AIDS or TBC or other things. You can see that the highest number was in 1984, when we had almost 80 people who died of an overdose. Last year it was 41 or 42. The majority of the people who died of an overdose last year was not of Dutch origin. These were mainly people from countries like Germany and Italy. They are coming to Amsterdam, they don't know the purity of the drugs, they take an overdose and die. This is very sad, but still the number is much lower than for example here in Frankfurt.

The average age of our drug users that we see every year - and this is based on about 5000 people - has been going up and at the moment the average age is 32. That means that you have people there who may be 50 or 55 and this slide shows the percentage of people who are very young - 21 years and younger - and that number is quite low. About 4 1/2 percent and in absolute numbers it is going down more and more. You always have to be careful with this sort of data but it seems as if the problem is over its highest point.

A very brief statement about the visits we get to the drug department. This is a totally different thing, but because we are talking here about building a network - how can we exchange information what can we learn from one another? We thought it might be useful just to give you an idea of who is coming to Amsterdam besides the drug users from abroad.

We have a lot of visitors, experts from abroad. In total in the last 1 1/2 year we had 1320 people visiting my department. These were 153 different visits. Now if you only look at the people from Germany it is 520 people from Germany who visited my department in the last 1 1/2 year. That is quite a lot of people. In this sense we seem to play a role as a centre for the exchange of information.

If look at where you can cooperate with European organizations there are three groups: first of all it is the European Community itself, they have various different departments - one in Luxemburg, others in Brussels, one is looking more into safety and into AIDS and the other is looking more into research issues. We cooperate with all these different departments of the European Community. For example the department of Safety is financing Elisabeth van Berg, who is the coordinator for the study visits in my department. In that sense they help us with this building of a network of information exchange. Another very important organization is the WHO - Section Europe in Copenhagen and we work quite a lot with them in terms of preparing papers, going to meetings, giving advice etc. And finally the Pompidou Group which should be known to most of you, but I'm afraid, it is probably not. That is a group of the Council of Europe and they do a lot of comparative research amongst cities in Europe. For example at the

moment Amsterdam is involved in a study where we look at people who are going for treatment for the first time and there are 14 European cities participating - two cities for example from Switzerland. From Germany only Hamburg is looking into the possibility of participating. I think this sort of opportunity is great for a lot of German cities to participate in something like that because it helps to get comparacing data and to really exchange information.

Finally, what are we doing in Amsterdam at the moment for building a European network? First of all we have a pool of experts. All those people who come to us and that we meet at other meetings. We try to make some sort of a data base with names of experts and their expertise and their willingness to give consultation so that if somebody needs help we know who to contact. We also have a lot of information and we are going to put it in a data base like what we call the grey literature, like papers that are given on conferences that you will not find in official books or official publications. We are going to organize a couple of workshops next year with people who have visited Amsterdam. We ask them to come back to see what they have actually done with the information from Amsterdam and what can we learn from them. And finally there are plans, but they are still very elementary, of meaking a newsletter on AIDS and drugs. Again, to stimulate the exchange of information.

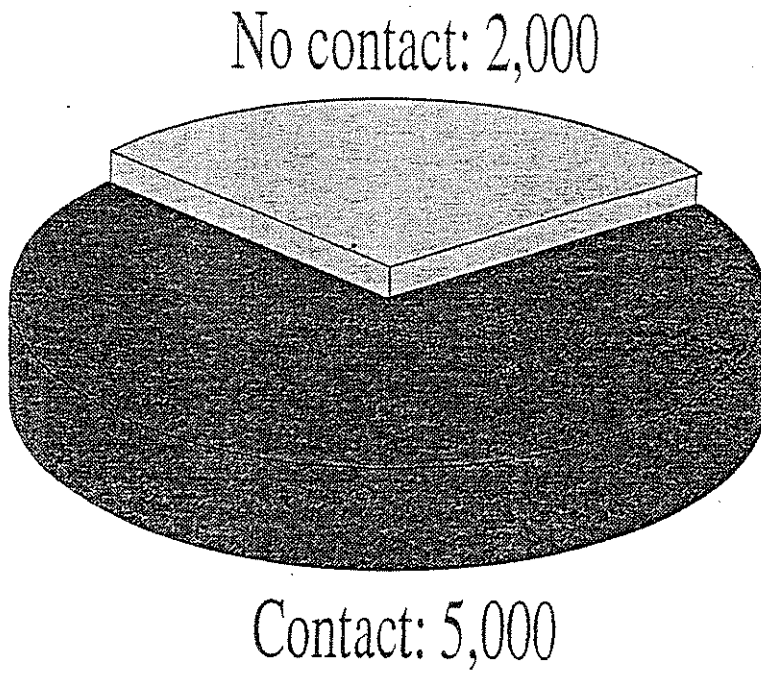
Integrated drug policy

co-operation between:

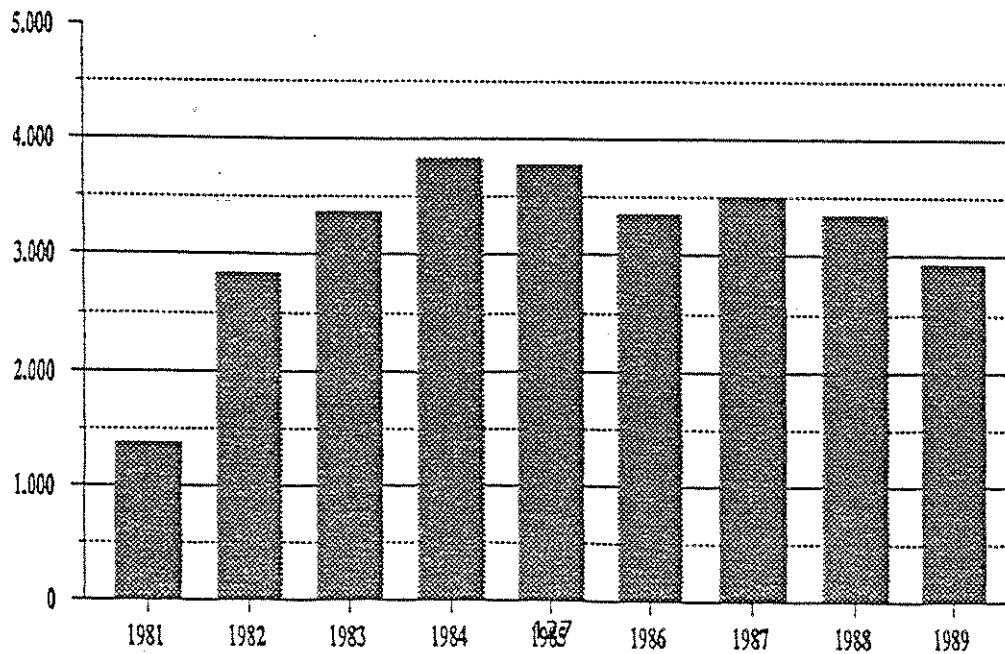
- **police**
- **neighbourhoods**
- **helping system**

central co-ordination in townhall

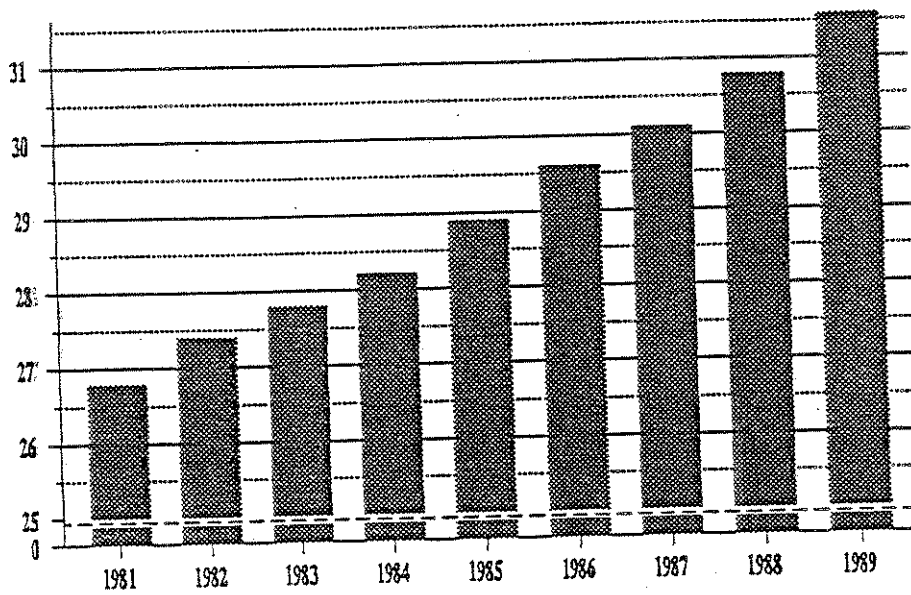
Reach of Amsterdam helping system



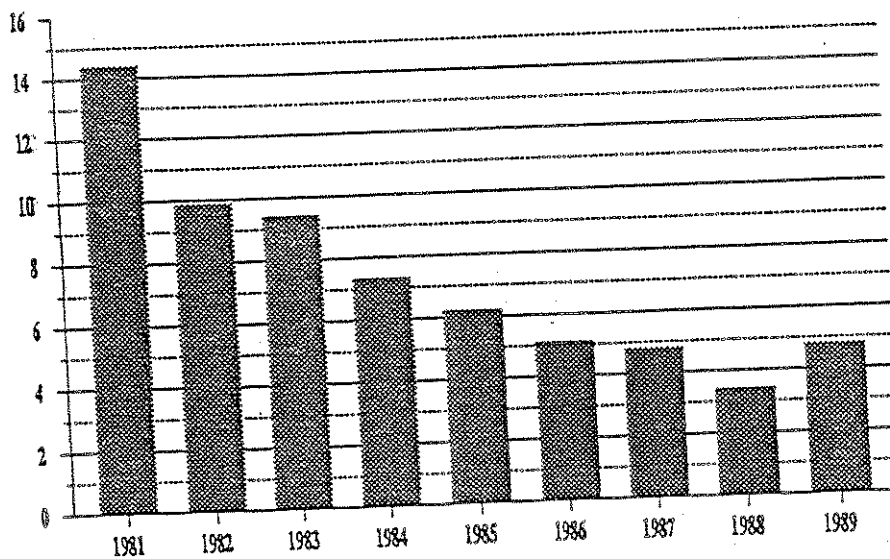
Clients in methadone program



Average age addicts in Amsterdam



Percentage addicts under 22 years



**BERNHARD SCHOLTEN, Police Department
AMSTERDAM**

I noticed this morning that there were frequent and strong reactions in the direction of the police. This is perfectly natural, in my opinion. We in the police in Amsterdam have had experience of the drug problem for many years - I could go back as far as the 60s. Our experience has been that there is frequent and very violent criticism of the police. Actually that's inherent in what the police must do for society. Let me say this to my fellow policemen in the hall: we've gone through a lot, not everything has been given a positive evaluation, and yet we have had some success. I'd also like to say that we needed time to achieve whatever we did achieve and we're going to continue needing time, I'm convinced of that.

If I'm going to say anything about the way the Amsterdam police work on and try to counter the drug problem, then I think it's important to say something about the background. At the end of the 60s and the beginning of the 70s we had "Flower Power" when large numbers of young people came to Amsterdam in the summer to enjoy themselves. They came from all over the world. No one in our city got upset about the presence of such a large group of people, and the reason is that the people of Amsterdam are really pretty tolerant. If you've got a tolerant society then it's easier for people to accept that we've got a group of young people from Holland and other countries are living and sleeping in the parks and on the Damplaat and in the city centre, etc.

This went on for several years, and at the same time these people started to consume drugs. At first no one in the city was upset or concerned. At first we hardly noticed it, but then it really started, not just in Amsterdam but in other countries too.

In Amsterdam we've got used to the situation that we're sharply criticised by other countries. We nevertheless believed, and still believe, that we have a good policy, and at the moment we are pleased that so many foreigners come to Amsterdam, as Ernst Buning has already said. Many visitors are our guests. On the other hand the development is an international one, and we're trying to do something about the drug problem.

In Holland we have really always accepted the problem of drugs. We've never claimed that there isn't a drug problem. If you accept that there's a problem you've got a chance of doing something about it. That is the Amsterdam situation, and we don't claim that our way of dealing with the drug problem is the best there is. But it is our way, and it is

rooted in our laws and our social system. Thus we can live with it and work with it.

In 1976 a Drugs Act was passed that differentiated between soft and hard drugs. When there's mention of the drugs situation in the Netherlands, many people think that drugs have been legalised. That's a misunderstanding. Both soft and hard drugs are illegal under the law, but the law does differentiate between hard and soft.

A fundamental difference is that the consumption of soft drugs does not harm the body. In our system the user of soft drugs can have up to 30 grammes of soft drugs on his person for his own use (not, by the way, 50, as reported, incorrectly, by the Frankfurter Stadtrundschau). This is also accepted by the police. For me and my colleagues it is no problem that there are people in the city with up to 30 grammes of soft drugs on them. One reason this is so is that we apply the principle of expediency to drug law enforcement. For the police this means that we have an enormous amount of scope for living with the drug problem and working on it. And we make full use of that scope.

In Amsterdam people can buy soft drugs virtually anywhere, e.g. in one of the so-called coffee shops. Trade in these drugs is a system that really regulates itself. It's in the interest of the buyer that there is a system and that it works. But it's also in his interest for it to be regulated. For us in the police, that's a situation that we find easy to accept.

The assumption was uttered this morning that this system of selling soft drugs enables us to make predictions about hard drugs as well. In our city there is no merging of soft and hard drugs. As far as we know, the coffee-shop owners make very sure that there is no mixing of the two, because as soon as that happens we have a problem, and then of course the police have got to take action.

The consumer of soft drugs is not really seen as a problem in our society, which means, for the police, that he's not a criminal either. When we talk about drug addiction in Holland we often compare it with the alcohol problem. In our society the alcohol problem is much worse than the problem of soft drugs. For example last year, nation-wide, we had 1,456 people killed in traffic accidents, 10% of them - that is, 145 - because of the excessive consumption of alcohol. Last year 13,600 people were injured badly enough to have to go to hospital; 1,200 of these injuries were related to the consumption of alcohol. There were also another 36,000 people injured but not hospitalised, and more than 2,200 of these injuries were due to excessive consumption of alcohol.

When we talk about the drug problem in connection with Amsterdam and the situation in Holland, then we're really talking about the problem of hard drugs. In our diagrams and

so on we don't even deal with soft drugs any more.

In 1987 we registered 35 deaths due to an overdose of drugs. The figure for 1988 was 30, and for 1989 32. Just compare that with the alcohol statistics, and what have we got to talk about? The consumption of hard drugs is always very closely tied to the question of illegality.

In our society we distinguish between hard and soft drugs. The consumption of soft drugs is no problem for society, as is generally accepted. By contrast, the consumption of hard drugs is a gigantic problem because, as I said a moment ago, it is an illegal activity. Nevertheless our basic attitude - and it's one that was reflected this morning in the words of our Zürich colleagues - is that a drug user is someone who needs help; anyone who can help should do so.

Secondly - and this is also the opinion of the police - the hard-drug user is a criminal. In Holland, and I think this is a worldwide phenomenon, the drug user says why he is addicted and there is only one person who can decide how to solve the problem and that is the drug user himself. He (or of course she: this applies to the pronoun throughout, in this context) can only say: I want to stop using drugs and I need help. We in the police understand that to mean that as long as there are drug users we'll never be able to solve the problem. It is an aspect of our society. The drug user has a problem, and society should help him solve the problem.

When we in the police do something about it, then it is always in collaboration with the courts, the local authorities and the health department. Ernst Buning has already spoken about that. Our experience of police work in isolation has been negative; there's no success that way. One's always got to work in cooperation with the appropriate institutions.

We use a special narcotics department to handle the drug problem. It's quite a big department, and it operates throughout the city and the country, and internationally too. As far as I know that's the same set-up as with other police organisations.

In practice the way we tackle the drug problem is that we divide up the city into sections and then deploy very small groups of officers - we call them teams - each team being responsible for a specific section. Each team, consisting of 60 to 90 officers, has got to be aware of everything that is happening in its section. Thus these officers are directly confronted with the drug problem, and they have a great deal of latitude because our law enforcement is subject to the principle of expediency. There are many police officers, e.g. from Germany, who come to study our situation and I always hear them say. "We've got a law and that law obliges us to act willy-nilly, whether it's hard or soft drugs." Our system of expediency gives us a wide range of possible action. That applies to drug users and also to aid associations etc.

I may have been giving you the impression that in general the problem of drugs is accepted by the police. That is not strictly speaking accurate. Of course we are not satisfied with the situation and we are trying to do something about it. What we're doing at the moment is trying, every day, to make things as unpleasant as possible for the drug users on the streets. We keep on moving them along because we've got a drug scene on the streets of our city that no one really wants. So we try to break up the scene, to disperse the drug users.

At the beginning of 1989 we launched a project called "Straat-jungenprojekt". It is aimed at drug users who live on the streets. It involves cooperation with aid associations etc. and it has two pillars:

The first pillar is the judicial one. We have a group of 300 to 400 drug users who keep our courts and the police continually occupied. They are hauled into the police stations so often that they constitute a major problem for us and the courts.

The second pillar has to do with people addicted to hard drugs whose behaviour on the streets is a nuisance to the general public. An attempt is being made to get them to behave differently, so as to reduce the problem slightly.

At first our intention was to integrate the two pillars. But we were not successful. Ernst Buning has just said something about the cooperation between the police and the Health Department - but that too was very diffident to start with. At the moment, however, it is working very well. The aid associations asked themselves at first whether they should even try to collaborate with the police and the courts: our objects are after all very different. We feel that the real reason for this uncertainty was that the liaison mechanisms didn't work very well. But we still carried out the project, and I would like to tell you something about it:

The target group consisted of 300 to 400 drug users who are well known to us. The procedure that we applied to this group was that as soon as they had been arrested five or more times in the last twelve years they were given the alternatives prison or therapy. This was a measure that we decided on in collaboration with the courts. 250 of these users, who live on the streets, were warned, and 126 of them were given the offer of going into a Detox clinic or having outpatient treatment. 56 of them accepted the offer, 51 going to the clinic and 5 choosing an outpatient programme. It is a success for this project (which started at the beginning of 1989) that 45% of the 126 left the clinic clean. However, that means 55% of them did not. At the moment we are still investigating the reasons why not. The other 70 could not be involved in the system - partly because of our limited funds. Either there weren't enough beds available, or the courts were not able to support the recommendation. As Amsterdam is an international city, there was the occasional language difficulty. There were also psychiatric problems in certain

cases. 45% means only 27 people, and our critics say that's very few. But for us, the police, and for the public it does mean that more than one third of this group of 300 or 400 people have not been on the streets for several months. The best success for us is that these drug users are no longer in the drug scene for a considerable period of time.

I'd also like to say something about the operation of the law in connection with hard and soft drugs. We have made the following decisions jointly with the courts:

- If someone has up to 30 grammes of soft drugs on him for his own consumption, we accept it. If we arrest such a person, we make a note of it and nothing else.

But if the amount is more than 30 grammes, charges are laid.

There are many foreigners who know very well that there are more than 30 grammes available in the coffee shops. But we haven't enough personnel to check out every coffee shop for the amount of drugs sold there.

- The police are far more interested in the trade in soft drugs than in consumption. That's because the trafficking brings us closer to the criminal elements, and if we can counter these, then perhaps we will make real progress.

- As far as trafficking in soft drugs is concerned, charges are laid even if the quantity is less than 30 grammes. If it's more than 30 grammes, then of course the courts must also act.

- If a user has less than half a gramme of hard drugs on him for his own consumption, we make a note of it but do not press charges.

- For quantities of one half to one gramme, charges are laid.

- Between one and three grammes the case is without exception brought to court.

- Between three and twelve grammes the case is also brought to court, and those found guilty are sentenced to a maximum of 6 months.

- For more than 12 grammes the sentence can be more than 6 months.

- Trafficking in hard drugs is again another matter for us. Regardless of the quantity, charges are always laid and the case is discussed with the public prosecuting authorities. As I said before, we are not so interested in what the users do - though of course we've got to take action in cases of acquisitive crime and public nuisance - but if you're going to solve the problem of drugs on the streets then you're confronted with a long chain of distributors and middlemen, and if you don't take some kind of effective action on them

the problem will always remain acute. We know that the distributors work in highly organised syndicates that are active worldwide. In Amsterdam we say: These criminals drive about in big Mercedes and when we want to catch them we have to do the chasing in a tram.

In 1988 there were more arrests than in 1989. The reason is that we are not so interested in the drug users on the streets. We try to make contact with them and to get information on the dealers and the distribution system.

I mentioned before that we are not so interested in soft drugs. We still managed to confiscate 9 million grammes of hashish in 1989, as the result of a single raid on a large-scale dealer.

In connection with acquisitive crime we registered 31,628 car burglaries in 1988; the 1989 figure was 26,000. The figures for handbag thefts are about the same. Car break-ins declined from 1988 to 1989 - possibly because we now patrol the city with small police squads 24 hours a day. This makes a contribution to the feeling of public security.

We have also tested public opinion on police action. In 1989 the public felt that they had fewer problems with burglaries and theft than in the years before. Other problems with drug users, as experienced and assessed by the public, declined in 1989 compared with the years before.

This morning we heard that in Zürich too there is discussion of prevention strategies. In Amsterdam too we are trying to do something in this field. We have a programme which was instituted by a colleague of mine. It involves bringing schoolchildren between the ages of 6 and 12 in contact with drug users. We started the project 3 or 4 years, and it hasn't exactly had a universal welcome. We've kept it going all the same, and we offer it to all primary schools in the city. We feel that at that age the children are particularly sensitive, and as a rule have had no contact with soft or hard drugs. Of course there are certain conditions applying to the drug users that have to be met: they must be prepared to take part voluntarily, and they must be able to express themselves clearly, so as to make it clear why they took to drugs and what dependence on drugs in fact means. So they must also be prepared to pay a certain psychological price. For the children too participation is entirely voluntary, and of course their parents have to give permission. At school the children have to be prepared very carefully for the meeting with the drug user. So there must be classroom discussions of the drug problem - and also the problems of alcohol and tobacco. The response we've had to the programme has been very positive - from children and parents, teachers and drug users; the police too. Meetings of this kind make it possible for people to understand better the problems of drug users.

Ernst Buning has already mentioned the cooperation between the police and the Health Department. When we have a drug

user in a police cell we always enlist the cooperation of the Health Department. For example a doctor can come twice a day to give the drug users methadone. In our view there are two important reasons for this cooperation. Firstly, drug users in police custody must receive methadone, otherwise we can't work with them. When possible we also take part in the syringe exchange programme. Of course the people in custody have no drugs on them, but when they leave the cells and ask for a clean syringe, they get one from us. We see that too as a prophylactic measure.

Of course we are not completely satisfied with what we are achieving in the drug problem in Amsterdam, but are trying to work to the limit of our capacity. We have conducted surveys among the people of Amsterdam to find out whether they are satisfied with the conditions under which they live. Our findings are that they believe that the social situation in the city has improved in recent years.

To conclude my talk, may I thank you for the attention you have given me.



DISCUSSION



Russel Newcombe
Liverpool:

Can some of the members of the Amsterdam delegation explain the reasoning behind the apparent agreements of the Amsterdam authorities not to prescribe injectable methadone to drug addicts as it is done in parts of Britain?

Ernst Buning
Amsterdam:

Well, I think it is good that you bring this question about prescribing injectable drugs. We have had a small programme with the prescribing of injectable morphine that involved 38 people who needed a medical or psychiatric indication. Basically it meant that if our doctors had the idea that these drug users were injecting heroin as a form of self medication - that means for people who have a lot of psychiatric problems i.e. who have a high level of anxiety or who are psychotic - they realized that by using heroin they could reduce the symptoms of the psychiatric problem. In that case we could look at morphine - we were not allowed to give heroin - as something with a medical indication to prescribe it.

So we had an experiment with 38 people, but it turned out that out of these 38 people about half of them reacted very well on injectable morphine. Their whole situation was much better, they were much more coherent, they managed to keep the same house for a long time, they were eating better, they looked after themselves much better. The other half did not react very well - some said: I don't like morphine, I prefer to use heroin. Others said, they didn't want to be dependent on a doctor and go there all the time to collect their injectable drugs. Others said they preferred methadone and a small group of people sold their morphine. We knew that, because we had a system where we prescribed about 80 milligrams of morphine - these were four ampoules of 20 mg morphine and there would be a substance in one of the four ampoules that was traceable in the urine. People had to give their urine 2 or 3 times a week and this substance had to be in the urine. That was the only way we could prove that this person was actually using the morphine that he was prescribed. If we did not find this substance in the urine we would talk very seriously with this person and ask them what they were doing and sometimes we would find out that they were selling it and then we would stop the prescription.

At the moment we have a discussion about prescribing injectable methadone. We do that, because we realize that in the methadone programmes there are people who managed to be clever enough to take their fluid methadone with them. They have a trick: they have an old cup somewhere in their pocket and they get the other cup from the nurse and they switch it quickly and do as if they drink it. But they take it home and inject it at home.

There are two ways you can react to this: to can give them methadone to drink and say: you should drink it and if you don't drink it we stop giving you methadone. We did that for a while.

Another way of handling this is to say that obviously these persons are so much involved in injecting that we might as well give them proper injectable methadone. But you need a lot of discussions for that - especially among the doctors who always say: "I am a trained doctor and I am not a dealer. So if I prescribe a certain drug I have to have the feeling that this person is going to benefit from my prescription in one way or another". There is the professionalism of the doctors and also the Opium-Act, there is a medical inspection who controls what doctors are doing. You can have all sorts of examples for dangers and that is what the doctors are afraid of: that they would prescribe too much drugs and somebody would die and the parents would take them to court and they would lose their license.

But the discussion about injectable drugs has not been closed in Amsterdam. It is still one of the options.

**Margarethe Nimsch
Frankfurt:**

Could I add a short question here? You said that the black people don't inject heroin so much but tend to smoke it, and that that was a matter of cultural heritage - which seems logical to me. What I don't understand is why the central Europeans and the Americans are, by comparison, so aggressive towards their own persons, feeling they've got to have the drug by injection. Has any research been done into this?

**Ernst Buning
Amsterdam:**

It was basically the self-aggression I was puzzled a little bit with. I now realize what you mean. It is a bit complicated. I think, if you look at reasons why people are using drugs you find a lot of different reasons. If I take ten of the people that I know and try to figure out the ten different reasons who they started using drugs I will actually find that with some people they have a very low self-esteem or what you may call self-aggression. The black drug users in Amsterdam started taking drugs much more out of social reasons. If you look at the history: in 1975 half of the population of Surinam moved to Holland. 300,000 out of the 600,000 people moved to Holland. That was just before Surinam became independent. Especially people without many perspectives i.e. good jobs, high income moved out of Surinam. So it was the lower income group who came to Holland but arriving there they realized there was no work and that the Dutch people - although we may be appear very friendly with everybody - had trouble to accept that there were all of a sudden 300,000 black people coming to the Netherlands. So they didn't feel accepted.

The police just before 1975 were very successful in getting all the Chinese heroin dealers off the street. And the Chinese were looking for people who could do the dealing on the street level. Among the black males who were unemployed and had no future they found very good victims to start selling drugs on the street. That is basically how the drug problem among black people started. It was not because they were hating themselves or because they wanted

to hurt themselves with injecting but it was part of a whole social movement and in that group it was normal to use hard drugs. Because they were selling on street level they got a very high acceptance by the white people because they had to buy their drugs from them. The white drug users were looking up to the black people and started to imitate their behaviour of not injecting.

Guus van der Upwich
Bremen:

I have four questions on points I didn't understand:

At one point you said that you had 60 to 90 personnel per section of the city engaged in the war on crime. Either I understood it wrong, or you must have got an extraordinarily good bunch of people. Perhaps you could clarify that.

You also said that charges are always preferred in cases of dealing, regardless of the quantity. Does that apply to the consumer-dealer too?

Then I have a question on the dispensing of syringes to people in custody. I find that very interesting, because it's something that gives us a lot of headaches in Bremen. Does that apply only to people who are in police custody, or also to people who have been sentenced and are in prison?

How do your police and courts deal with foreigners who are professional drug dealers after the conclusion of court proceedings against them?

Bernhard Scholten
Amsterdam:

The first question was about the number of police officers. We have a total of 3,600 working in the city. They are distributed over 8 districts, in which there are 22 groups, each responsible for one small section. The earlier system was to have 8 large units, each working on one eighth of the city area. At the moment we prefer to use small groups for small sections of the city, and we are achieving two kinds of result. The police officers enjoy their work more because they've got to deal with everything they encounter in their sections, which means that they have more and better contact with the public. Secondly, the public also get a strong impression that public safety and order are in better condition.

There are people who only consume and also a large group who both consume and deal. In our view the latter are also dealers.

Drug users are not given a syringe in the cells, but only when they leave the police station and ask for it.

Gijs van der Upwich
Bremen:

A short question: what point has been reached in debate on the dispensing of syringes in prisons? Could you give us a brief comment there?

Bernhard Scholten
Amsterdam:

I have no information on syringe dispensing in the prisons. Could one of my colleagues help there?

Ernst Buning
Amsterdam:

We have had discussions about that. We don't have needles available in the prisons in Holland. The main argument for that is that the people who work in the prisons are afraid that needles can be used as weapons and I think that is a very solid argument. We have methadone available in prisons there are condoms available and we know of course, like anywhere in prisons in the western world, that there are drugs. But because we have the alternative of smoking which is also accepted by the drug users, our impression is that if hard drugs are used in prison a lot of people smoke instead of injecting.

Bernhard Scholten
Amsterdam:

The fourth question was about the foreigners. Sometimes there is the impression that all foreigners can participate in one of our methadone programmes. That is not the case. To do so you've got to be registered and living in the city legally. Our policy for drug users who are illegal aliens is to send them home as quickly as possible. But of course there have to be legal proceedings, which can't always be rushed through. Nevertheless we try to get it done as fast as possible. Still, we have the same problem that was mentioned earlier by the Frankfurt police. When we get the drug users over the borders and into Germany or Belgium, they're usually back in Amsterdam quicker than the police. Of course that's very frustrating for the force, but it's a situation we can't alter.

Dr Hofmeister-Wagner
Frankfurt:

I'd like to get back briefly to the morphine programme. The results haven't exactly been wonderful. Could that be because the setting for the project was a lot more strictly controlled than is the case for methadone dispensing in Amsterdam? It occurred to me that presumably in Amsterdam you are not used to implementing a project like that very strictly, and this

could have have contributed to the fact that the results were not very satisfactory.

Ernst Buning
Amsterdam:

Yes, I absolutely agree with you. This was basically after a long political discussion about a heroin prescription programme for a large group of people. I think, a lot of people - politicians and people from the medical professions - were quite happy that they found a solution for a very complicated political situation where they said: "Well, let's try this first for a very small group of people". A lot of people told us - especially people from the Junkie-Union - already what the outcome of this programme will be. It will be that it has no success. I think a lot of people realized that and what we've learned from it is that we have given out hundred thousands of injectable doses of morphine. This group of people have injected themselves with drugs that were prescribed by us and there is not one case of a deadly overdose in that group. People have died in that group, but they have died of Aids or other causes. That is at least one positive lesson that we have learned from it.

Mr Lange
Hamburg:

I have a question for Mr Scholten. You said that the police carry out dispersal measures when there are too many junkies concentrated in one place and they constitute a nuisance, or a presumed threat, to the public. How do the police justify these measures? Are they only present there, or do they actually push them away, telling them "What you're doing is illegal"? What are the precise tactics you use? In Hamburg we've made similar attempts.

Mr Scholten
Amsterdam:

Actually we only have practical measures. We try to make things as uncomfortable for the drug users on the streets as possible. We go up to them and say "Clear off, you're not allowed to be here", things like that. And we keep it up every day. One success we have as a result of this basic approach is that the drug users don't enjoy being in groups quite as much. We've had a lot of problems with the concentration of drug users at particular points, including the problem of public reaction to the feeling of being under threat, or likely to be molested, etc. In a situation like that you've got to keep on trying to attain a reasonable balance. It's always a struggle between what's good for the drug users and what's good for the community. We don't like them being concentrated together and we try to shift the drug scene into the city centre.

Kurt Lange
Hamburg:

Could we look at the matter of separating the markets for soft and hard drugs? It's clear enough to me what you do at street level and in the coffee shops, but what about trafficking and smuggling in quantities of more than one kilogramme? Are there different ethnic groups running the large-scale import of cannabis products from those putting e.g. heroin on the market? Have you any information on profits and profit margins? Which dealer groups in fact make more money: those whose trafficking remains illegal although nothing is done about prosecuting small-quantity consumers, or those who are prosecuted because they import on a large scale but on the other hand have a safe sales network because of the system of coffee shops and the general policy of toleration?

Bernhard Scholten
Amsterdam:

As far as we can tell it's the big bosses that make the money, not the dealers on the streets. When we confiscate hard drugs - whether it's one kilogram or 30 - that has no effect on the prices on the streets. So there's a lot in circulation than we know about. The big dealer organisations have much more money than we know about. That's where money is really made. The people hit are the ones on

Mr Waser
Zürich:

Just a very short question for Mr Scholten. Your quantity for hashish and heroin. Is this quantity when someone is taken into custody, or is he allowed to keep it?

Mr Scholten
Amsterdam:

It is confiscated. We take it away from them.

Mike Ryan
Liverpool:

If the Dutch police see a consignment of Cannabis to the coffee-shop, how do they deal with that?

Bernhard Scholten
Amsterdam:

If it's a dealer related to the selling of soft drugs, of course we go to that man and arrest him. But we have a system that is not divided in a soft drug and a hard drug system, it is combined. If we arrest a dealer he is always part of a big "Mafia".

Mrs. Serafinowska-Gabryel
Wrozlaw:

I have a question concerning the same problem. How do the coffee-shops get the Cannabis? Do you close your eyes when they get in and once they are inside everything is alright?

Bernhard Scholten
Amsterdam:

They get it from a trafficking system and although it is illegal according to our law, but at the same time we have a system of pragmatism so we accept the system like it is there. Although the law says you shouldn't do so, in our society nobody makes any complaint and we can all live with it. Moreover, doing it in this way it is decriminalizing the soft drug user and that is a very positive aspect.
