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The politics of intoxication. Dutch junkie unions fight against the ideal of a drug-free society, 1975–1990

Gemma Blok

Introduction

In 1982, in the Dutch city of Rotterdam, a local 'junkie union' organized a guerilla methadone programme. The junkies wanted to offer an emergency provision of this synthetic opiate to the large number of destitute heroin users in the streets, who often suffered acute withdrawal symptoms when they did not have the means to buy heroin. With the help of a sympathetic doctor and pharmacist, the junkie union was able to get three hundred pills of methadone each week. Two union members constantly carried an emergency stock, which they handed out to drug users whom they encountered in the streets, in buses or in trams, at any time, day or night. Ever since its foundation in 1980, the Rotterdam Junkie Union had argued for an unconditional supply of methadone. According to the union, the methodology in addiction treatment was 'outrageous' because of its one-sided insistence on abstinence.

Historically, in Dutch addiction treatment, the ties between professional carers and self-help groups of addicted clients had always been quite close. Before the Second World War, self-help organizations for alcoholics, such as the International Order of Good Templars, were actively involved in the institutional care for alcoholics. After 1945, Dutch institutions for addiction treatment worked closely together with the Alcoholics Anonymous. During the 1970s and 1980s, however, the relationship between the providers of addiction treatment and its new group of drug-using clients was rather strained.

At the time, organizations for drug users sprang up in various cities in the Netherlands. In the mid-1980s, there were some 15 to 20 groups, although some of them were quite small and were still at a formative stage.[1] They joined forces under the umbrella organization known as the Federation of Junkie Unions.[2] The biggest and most active organizations were, not surprisingly, based in Amsterdam and Rotterdam. These were the largest cities in the Netherlands with the largest number of drug users. The use of heroin was also quite visible in both cities.

During the 1970s and 1980s, an 'open drug scene' existed in Amsterdam and Rotterdam, where certain streets in the city centres were almost completely taken over by dealers and users. These streets were regarded as 'no-go

1 International Institute for Social History Amsterdam (henceforth IISG), MDHG archive, inv. no. 17. The folder 'Amsterdamse Junkiebonden' contains a leaflet listing all known junkie unions in existence between 1981–1987.
2 In Dutch: Federatie van Junkie Bonden (FJB).

areas' by many Dutch citizens.[3] In 1977, the 'Medical and Social Service for Heroin Users' (Medisch-sociale Dienst voor Heroïne Gebruikers, MDHG) was founded in Amsterdam, followed by the Junkie Union (Junkiebond) in Rotterdam in 1980. Both these interest groups for drug users are still very active today.

Compared to many other European countries, the Netherlands seem rather unique in that they had an active drug-user movement quite early on. Apart from Sweden, where a movement of drug users was already present during the latter half of the 1960s[4], there were few interest groups for drug users in other European countries before the 1990s. In Germany, the Dutch example inspired the institution of the first 'Junkiebund' in Kassel in 1982. Several others soon followed. However, this turned out to be a short-lived phenomenon; the 'Bünde' failed to attract a substantial constituency and withered away within a couple of years.[5]

British drug users did not really become visible until the mid 1990s, when they formed their own groups, were represented in various statutory organizations involved in the delivery of treatment services, and published magazines such as *The Users' Voice*.[6] In France as well, groups of drug users entered the stage at around 1990, in the wake of the HIV-Aids epidemic. Concern about this new public health problem greatly stimulated the formation of interest groups for drug users, who were especially vulnerable to infection with the HIV virus when they shared syringes to inject heroin.

This article will examine the views and actions of the Dutch junkie unions during the peak of heroin use in the Netherlands, roughly between 1975 and 1990. First of all, the origins and context of the early movement for clients in addiction treatment facilities will be sketched. What kind of therapies were the clients of addiction treatment exposed to during the 1970s, and how did the various drug user organizations come into existence? What caused the estrangement between carers and client organizations in addiction treatment?

To answer these questions, the main objectives and activities of the leading drug-user groups will be analysed. What exactly did they want to change and what kind of alternative health practices did they themselves experiment with? Finally, an attempt will be made to assess the influence of drug-user groups. Did they succeed in their efforts to transmit their views on the nature of intensive drug use and the best way to handle addicts based on their subjective expert experiences to policy-makers and professionals working in addiction treatment?

3 The Zeedijk in Amsterdam and the Kruiskade in Rotterdam.
4 Laanemets (2006).
5 Schmid (2003), p. 188.
6 Mold (2008), pp. 136 and 147.

Birth of the Dutch junkie unions during the 1970s

The Dutch approach to hard-drug users during the 1970s and early 1980s, when the drug-user groups were founded, was characterized by a strong ambivalence. The notion that the addict was a patient, not a criminal, had become the foundation of national and local policy by the mid 1970s. However, if we look at the actual treatment the addicts received, many of them were left uncared for. The existing institutions for addiction treatment were quite small and still trying to adjust to the explosion of drug use that was taking place at the time. Besides, treatment in the field strongly focused on abstinence. The temperance tradition in Dutch addiction treatment still reverberated in mission statements calling for a 'fight against addiction'.

The primary reaction of those in the field of addiction treatment to the new group of patients, the opiate addicts, was two-fold. Methadone was introduced in Holland during the late 1960s for the small number of people who had started to inject opium. At first, these programmes were quite liberal and non-committal, but as the heroin epidemic started to spread after 1972, the methadone programmes were transformed into stricter reduction programmes. A small number of therapeutic communities for addicts was created in addition to these methadone programmes.[7]

The national government supported the abstinence approach in addiction treatment. According to a consultative government body on health care and drug abuse, in a report from 1976, the only treatment of addicts that made any sense was 'one that principally aims to free the addict from drugs. If one offers the addict shelter and food, this only stimulates him to continue his lifestyle.' This choice of words is significant; implicitly, addiction was regarded not as a disease but as a lifestyle of choice.[8] The main Amsterdam institute for addiction treatment, the Jellinek, stated that addiction was 'an opportunity for personal growth'. The institute noted that it wanted to help only those who 'expressed a clear wish to be helped'.

Many addicts expressed no such wish and were not in contact with any form of addiction treatment. Instead, they lived in squats and shelters, or were forced to stay in prisons or psychiatric hospitals where they had to kick the habit. There is no legislation in the Netherlands that can force addicts to commit to institutional addiction treatment. The only way to have them committed against their will is through the Insanity Law, or through the legal system. Some prison directors were willing to provide addicted inmates with methadone, others were not. In Rotterdam there were about 3,000 to 3,500 drug users around 1980. An estimated 720 of them were taking part in a methadone programme, while 150 addicts were in a clinic or therapeutic community.[9] In Amsterdam, during the 1970s, only a couple of hundred clients a year took

7 About 10 therapeutic communities for drug addicts existed in Holland around 1980.
8 Blok (2008), p. 248.
9 Rotterdamse Junkiebond (1981).

part in one of the methadone programmes offered by the Jellinek. Taking into consideration that the population of addicts amounted to about 8,000–9,000 people in Amsterdam around 1980, this number is not very high. Nationally, the number of heroin addicts was estimated to be around 20,000 at the time. Some 3,000–4,000 of them were on methadone.[10]

Care and shelter for homeless addicts was offered by private individuals who often came from a countercultural background themselves. They created drug consumption rooms, soup kitchens and day or night shelters. Their work was commonly referred to as 'alternative addiction treatment'. Charitable religious organizations were quite active in creating this type of care for drug users as well. Many of these private and religious initiatives for addicts were financially supported by local town councils.

Looking for a 'third way'

The founding meeting of the MDHG took place on 2 May 1977 in the inner city of Amsterdam. The setting was the home of concerned citizen and former politician Johan Riemens. In the 1960s, Riemens had been the co-founder of the Dutch Pacifist Socialist Party (PSP), a party that tried to escape from the Cold War dichotomy between capitalism and communism. They campaigned, amongst other ideals, for nuclear disarmament and advertised using a poster that depicted a cheerful blond girl running naked through a meadow, surrounded by cows. Now, sitting on a small platform, the ageing idealist Riemens spoke to the small group of people who had gathered in his house. They had come there in response to an advertisement that Riemens had placed in a national newspaper about the formation of a platform to help Amsterdam's drug users.

At the meeting, Riemens talked about the misery of the heroin users he observed around his house every day. He wondered whether professionals working in addiction treatment had ever witnessed the degrading, tragic daily lives of drug users. Did they even know what kind of life these people were forced to live? Riemens accused the Dutch society in its approach to addiction treatment of applying a philosophy of neglect. According to him, the implicit assumptions ran something like this: Let's not affirm drug users in their lifestyle by helping them too readily. If they refuse to cooperate, then just let them end up in the gutter. That will motivate them to quit the habit. The addict was thus caught between the police and prison on the one hand, and an abstinence-oriented addiction treatment on the other. There should be a third way here as well, Riemens argued: integrating hard-drug users back into society; supporting them whether they were using hard drugs or not; treating them

10 IISG, Federatie van Instellingen voor de Zorg voor Alcoholisten (FZA) archive, inv. no. 210, 'Bezetting FZA gebouw door Junkiebonden'.

like 'normal' persons with specific problems, instead of stigmatizing and excluding them.[11]

Riemens' plea was received with great enthusiasm by the young and ambitious street-corner worker, August de Loor, who had been working in the populous neighbourhoods of Amsterdam since the beginning of the 1970s. He had closely witnessed the quick spread of heroin use amongst young people with little education and few prospects. The atmosphere in those days, he remembers, was one of doom and disappointment. The flower power mood of the 1960s had faded, and the younger brothers and sisters of the 'provos' (activists) and hippies had to deal with rising unemployment and housing shortages.

In those days, a new group of people was discovering drugs, not sitting on the grass in the Vondelpark, but hanging out in snack bars in the under-privileged parts of town. For a short while in 1972, heroin was handed out to potential new clients almost for free, as new dealers from South-East Asia tried to enter the Dutch market. De Loor could see the results of the criminalization of drugs around him every day. De Loor: 'These young people using drugs were not the "lucky few"; they were the children of divorced parents, unemployed fathers, the employees of illegal contractors and adolescents who had run away from home. Their drug use was not financed by their parents. They had to pay for it themselves, by legal or illegal means.'[12]

The fourteen individuals present at the founding meeting of the MDHG in 1977 were a mixed group of people. Some of them were physicians and volunteers working in 'alternative' addiction treatment facilities, such as night shelters and walk-in centres. Others were members of interest groups for immigrants from Surinam. Some were actual drug users. In those early days, the input from solicitors speaking on behalf of drug users was also quite important at the MDHG.[13] The new organization worked from the home of Johan Riemens, who put the ground floor of his upmarket canal-side house at the disposal of the MDHG. For several decades, the MDHG held its meetings, consultations and walk-in hours at this house.

In Rotterdam, developments took exactly the opposite course: the initiative to form a junkie union was taken by drug users themselves, especially its chairman Nico Adriaans (1957–1995), who then started to approach possible supporters and sympathizers. One of his most successful alliances was with the reverend Hans Visser, who was minister at St. Paul's Church in the centre of Rotterdam, quite close to the central railway station. The station was struggling to deal with the influx of drug users and others on the fringes of society, such as psychiatric patients, alcoholics and prostitutes. Adriaans simply approached Visser one day, asking if his church wanted to join forces with the Junkie Union. Visser and Adriaans became close friends and together they

11 Riemens (1977).
12 Jonge (1997), p. 6.
13 Roosjen (2007), p. 7.

would initiate and coordinate many new activities for drug users. The Junkie Union also had its office at St. Paul's Church.

Visser described his friend, who died of AIDS in 1995, as a 'cultural rebel whose drug use was part of his resistance against the capitalist forces in society. Unfortunately, he was forced to discover that his resistance had resulted in a heroin addiction.'[14] According to him, Adriaans hated hypocrisy, bureaucracy, dishonesty and cheating.[15]

Both the Rotterdam Junkie Union and the MDHG were very active in securing support, making contact with national and local politicians, making good use of the media, and cooperating with universities. For example, in 1981, the Junkie Union was a guest of the Netherlands' most popular radio station for ten Fridays in a row, explaining its view on drug use and addiction treatment. Adriaans was in close contact with researchers working at the Institute for Preventive and Social Psychiatry at the Erasmus University in Rotterdam.

One of these researchers, Jean-Paul Grund, remembers how 'Nico saw his role as that of the tribesman who helped the scientist access and understand tribal culture. When I started working at the institute two years later, I was happy to be that scientist and Nico taught me a lot. For several years Nico worked on my study into the drug-taking rituals of heroin and cocaine users.'[16] Together with several other left-wing academics, Adriaans and Grund founded the 'United Front for the Renewal of Drug Policy'. In 1986, Adriaans left the Junkie Union to become a 'community field worker' at the Institute for Preventive and Social Psychiatry.

At the MDHG office in Amsterdam, students and academics from various universities were regularly welcomed as well to conduct research into the habits and lifestyles of drug users, and to transmit the expert knowledge about intensive drug users to researchers in the academic world. The drug-user groups also operated in close contact with each other. The MDHG and the Junkie Union held meetings together at Riemens' canal-side house, worked on publications together and coordinated their actions. All Dutch drug-user groups, moreover, were united under the banner of the above-mentioned Federation of Junkie Unions. Besides, both the MDHG and the Rotterdam Junkie Union also managed to gain financial support from their local city councils within a couple of years.[17] Meanwhile, smaller unions, such as those in Nijmegen and Groningen, were struggling to survive.

14 Visser (1996), p. 10.
15 Visser, 'Nico Adriaans 1957–1995', at http://www.aidsmemorial.nl (last access: Dec. 11th 2010).
16 Grund, 'Letter for Nico', at: http://www.ibogaine.desk.nl/adriaans.html (last access: Dec. 11th 2010).
17 Jonge (1997), p. 6; IISG, MDHG archive, inv. no. 17, folder 'Amsterdam Junkie Unions'.

Central themes and issues in the user groups

When looking at the writings and actions of various Dutch user groups of the 1970s, 1980s and early 1990s, it becomes obvious that their themes were quite similar. The main goals, which will be elaborated below, can be summarized as follows:

1. Acceptance of drug use and the drug user
2. Respectful treatment of drug users
3. More 'care' instead of 'cure' in addiction treatment

To start with the first goal: the dominant motive, the umbrella covering all activities, was the promotion of the 'acceptance model' (*aanvaardingsmodel*) of the drug user, as it was called back then. The term, which came into vogue at around 1980, is comparable to the German concept of 'akzeptierende Drogenarbeit', introduced there a decade later, at around 1990.[18] Today, we would probably speak of 'harm reduction' to describe similar views on the treatment of intensive drug users.

According to the drug-user groups and their sympathizers, modern society was to accept the fact that there would always be people who enjoyed drugs and who wanted to use them, just as it had come to accept the fact that people drank alcohol. A drug-free society was considered to be a utopian ideal and the 'War on Drugs' the cause of many problems for heroin users.

The junkie unions constantly fulminated against the police, especially after 1984, when more and more attempts were made to sweep the inner cities of Amsterdam and Rotterdam clean. Drug users told stories about being thrown into police vans and transported to plains outside of town.[19] The addicts also complained about being physically searched by the police in a rude and aggressive manner. The dope that was found in their possession was often thrown into a canal or otherwise destroyed. Comparisons with the Middle Ages were often made in the drug user groups' pamphlets. 'Back in the old days,' they wrote, 'whores, beggars, lepers and vagrants had to stay outside the city gates. Today, junkies are the outcasts of society.'[20]

Finally, according to the junkie unions and the MDHG, the Dutch government and the citizens of the Netherlands had to accept the fact that not all intensive drug users were willing, or able, to stop using drugs. As Nico Adriaans put it in 1982:

> A junkie is not as deviant as many people think. There are many similarities between a junkie and a housewife addicted to Valium. But she does not need to go out and 'score' her dope, because her addiction is tolerated and even supported by her environment. Therefore, she does not become a 'junkie', while the user of illegal drugs does. A junkie

18 Schmid (2003), p. 204.
19 Visser (1996), p. 13.
20 MDHG/Junkiebond (1984), p. 2.

is not destroyed by heroin, but by everything else that comes along with the use of heroin.[21]

An anonymous user stated in 1978: 'Nobody is willing to accept the fact that if a "junkie" were able to obtain his daily portion of dope in a normal fashion, he or she would be able to work and function just like anybody else. Many users would like that very much.'[22]

There were heated debates on the issue of accepting or countering opiate use. For instance, the Rotterdam Junkie Union organized a series of talks with psychiatrist Martien Kooyman, a well-known proponent of therapeutic communities for heroin addicts. They wanted to know, amongst other things, his views on Valium addiction in the Netherlands. Why were Valium addicts so easily supported in their habit by their doctors while heroin addicts could not be supplied methadone from their local General Practitioners (GPs)? Kooyman replied that he thought the phenomenon of Valium addiction was quite harmful as well. So why add another problem to it?

It seems that for many people at around 1980, it was still too early to accept the fact that heroin was there to stay. For instance, in a current affairs programme on Dutch television 'Here and now' (*Hier en nu*), reverend Hans Visser, the Protestant minister from Rotterdam and strong supporter of the local junkie union, discussed the Dutch drug policy with the Rotterdam head of police, J.A. Blaauw.[23] Visser argued that heroin use should be accepted as a given.

'It just happens,' he said. 'There are people who have their reasons for using it, just as there are people who use alcohol or Valium. They often suffer from hidden problems in their personal biography. Why should alcohol use be legal, and heroin use illegal?' Blaauw objected that alcohol abuse was a big problem in Dutch society as well. He asked: 'Just because we already have one big problem, do we have to accept the fact that we have another one as well, a heroin problem? Are we to surrender to this without resistance? That would be an admission of weakness.'

Visser reacted by stating that a dignified existence for all people should be the goal of all action. Heroin users deserved this as well, even if they continued to use drugs. We should accept the drug user and his deviant lifestyle, Visser argued, and support him so as to prevent social and physical degradation. Blaauw countered that according to him, it was not very dignified to simply give up on people. 'We do *not* give up on them!', Visser replied with pent-up rage. 'We want to save them from a life in the gutter.'

Other Protestant ministers supported this acceptance model of drug use and the drug user as well, possibly because it linked into their long tradition of religious philanthropy. Evangelical Christians had been active in the Netherlands since the nineteenth century in what they referred to as 'active Christianity': trying to offer relief to the poor and the homeless by opening shelters in under-privileged areas and paying house visits to destitute families. The 'soldiers' working for the Salvation Army (which has been active in the Netherlands since 1887), for instance, and relief workers from comparable Protestant organizations, had always protested against the social exclusion of deviant groups. During the nineteenth and early twentieth century, they had taken mercy upon former prisoners and alcoholics. Now, they turned to a new group of people who were at the bottom of society's pecking order: heroin addicts.

21 Rotterdamse Junkiebond/MDHG (1982), p. 15.
22 Stichting Streetcornerwork Amsterdam (1978), p. 16.
23 Instituut Beeld en Geluid, Hilversum, *Hier en Nu*, Nov. 28th 1983.

In Amsterdam, reverend Douwe Wouters and his colleague Jelle van Veen strongly sympathized with the drug users flooding the streets of the Dutch capital at the time. They both worked for the Regenboog Foundation, a Protestant organization based in the city centre offering shelter to various groups of people, such as prostitutes and the homeless. Van Veen stated in 1979 in the local newspaper *Het Parool*: 'In order to be a good fieldworker, one should be able to shift one's boundaries and adjust to the addict's environment. This means, first of all, accepting his drug use. If a user does not want to kick the habit, then start by introducing some regularity into his life. A helper should not press an addict to stop using drugs.'[24]

In short, the root of the communication problem between 'official' addiction treatment and its clients, according to the 'junkies', was the result of Western society's drive for Utopia. Society, so they said, was trying to realize two impossible goals – the first to create a drug-free society. The second to save addicts from their disease.

Humour and respect

One of the aspects the junkie unions and the MDHG disliked most about addiction treatment was the way in which they were approached by those working in this field. In general, the members of the drug-user groups experienced the attitude of the professionals in addiction treatment as humiliating, arrogant, and full of pedantry.[25] The atmosphere, they reported, was one of distrust and seriousness; there were many complaints about the care-givers' lack of humour.[26]

One of the continuing complaints was a lack of knowledge about and understanding of the lifestyle and experiences of the drug user. Professionals, addicts claimed, behaved as 'office workers' with no feeling or sympathy for their clients. The official addiction treatment centres, such as the Jellinek, were experienced by many as strongholds of medical power and quite remote from their own lives.

24 *Het Parool*, August 3rd 1979, 'Hulpverlener moet afkicken niet opdringen'.
25 Rotterdamse Junkiebond/MDHG (1982), p. 4.
26 Jezek (2000), p. 17.

Some psychiatrists working at the Jellinek or other institutions for addiction treatment were themselves quite young in the 1970s. Several *did* make an effort to enter into contact with the growing drug scenes in their cities at the end of the 1960s, for instance, by offering them practical advice on the long-term physical effects or combinations of drugs. A couple of psychiatrists working in addiction treatment in Amsterdam were even quite active in the Dutch campaign to decriminalize cannabis products.[27]

Still, although the gap between professionals and clients was not always as wide as the drug-user groups claimed, in many cases there probably were differences in age, gender and cultural background between the clients of addiction treatment and the professionals working in the field. In the 1970s, many social workers were (older) middle-class women, while many of the clients were (younger) men from a counter-cultural or lower-class background. One drug user remembered how he had to educate his social worker on drug abuse; she knew only alcohol and alcoholics. Together, they read the same book on drugs and addiction. Others were confronted by doctors who asked them whether they injected their cannabis, or who believed that LSD was as addictive as opium.[28]

A huge blemish for the junkie unions was the introduction of the term 'junkie syndrome', used to describe a pattern of behaviour ascribed to the chronic heroin addict. He would lie, cheat, steal and manipulate in order to get his hands on some dope. He was 'unbelievably cheeky and immodest', one psychiatrist wrote, 'and could never be trusted'.[29] In choosing the name 'Junkie Unions', heroin users re-appropriated the stigmatizing term 'junkie' and used it in a defiant manner.

The wish to keep a safe distance from the heroin-using client is certainly quite tangible in the manuals and articles of psychiatrists writing on addiction at around 1980. Much was written about the need for the therapist to stay in control in the therapeutic relationship. He was never to allow himself to be manipulated by the addict. Possibly, professionals working in addiction treatment were feeling a bit overwhelmed at the time because of the growing number of clients requesting help, or methadone.

Meanwhile, many drug users felt unjustly feared and distrusted. They did not deny the reality of this 'junkie behaviour', which indeed was quite common, as they admitted. However, this type of behaviour was caused not by the use of heroin itself, or by the inferior character of the addict, but mostly by the degrading life a heroin user was forced to live in a country where his drug of choice was forbidden, and thus quite expensive and hard to come by.

The junkie unions laid the blame for another type of unattractive behaviour of drug users at the door of addiction treatment. As professionals in the

27 This campaign was successful: the Opium Law of 1976 turned the possession of small amounts of hash and marihuana into an offense instead of a crime. Blok (2008), pp. 245–258.

28 Stichting Streetcornerwork Amsterdam (1978), pp. 8, 10.

29 Epen (1981), p. 56.

field had noticed as well, many 'junkies' would adopt the role of victim as they presented themselves to therapists or social workers. They told them tearful stories about their troubled lives and awful parents, and assured them that they really desperately wished to escape their horrible addicted existence.

The junkie unions noticed this kind of behaviour amongst their fellow drug users as well, with much dislike. Instead of regarding it as 'typical addict behaviour', they considered it to be a reaction to the therapeutic climate in addiction treatment. These clients were simply being strategic: they told their therapists exactly what they thought they wanted to hear. Didn't professionals in therapeutic communities always want to hear about hidden emotions and troubles in the family? Did they not stimulate their clients in 'scream therapy' sessions to get in touch with their suppressed anger towards their dominant fathers or cold mothers?

According to the MDHG, some users actually suffered from a 'detox syndrome'. For years they wandered from one therapeutic community or crisis centre to another. In this way, they learned exactly what to say – and what not to say – during an intake, how to behave during therapy sessions, and so on.[30] One thing they learned was not ever to admit that they were not completely convinced, deep down, that they wanted to stop using drugs for good. They knew that if they said that, all help would soon be withdrawn from them. According to the MDHG, this was the one big taboo in therapy-land. This created much deception on the part of the addict, who was constantly required to 'prove' his motivation to be helped.

Fighting for a 'low-threshold' methadone supply

The wish for more accessible and large-scale methadone maintenance was the central uniting issue for all drug-user groups. Junkies wanted care instead of cure. The 'treatment industry' was considered by them to be too one-sided in its focus on the promotion of abstinence. This resulted in a situation where the majority of addicts was forced to remain in the cold.

Many heroin users were critical of existing forms of addiction treatment. Methadone programmes often involved many rules such as urine testing, a prohibition of the use of other drugs, limited opening hours, and an obligation to partake in a reduction programme or psychotherapy. Therapeutic communities for addicts, in particular, were extremely unpopular. Clients felt humiliated and degraded by the hierarchical system in these institutions. On arrival, they were washed in a wooden laundry bowl, completely naked. This ritual was meant to clean them from their former junkie existence. Additionally, clients had to cut their hair, hand in their clothes and jewellery, wear an overall, and clean the kitchen and toilets. Any contact with friends or family members was not allowed for weeks or even months.

30 Stichting Streetcornerwork Amsterdam (1978), p. 24.

Meanwhile, they had to endure a continuing stream of critical and confrontational remarks on their behaviour by therapists and fellow-patients. These remarks were meant to break down their 'junkie identities'. In the opinion of the therapists, clients were often hiding behind a stereotypical 'character armour': the pathetic victim, or the tough street boy. The aim was to free the vulnerable person concealed within by shattering the addict's resistance to change and stimulate him to show his hidden emotions. Some clients reacted positively to this approach: they managed to run through the whole therapeutic programme and graduate after one or two years. Some graduates even became co-counsellors in a therapeutic community.

Quite often, on the other hand, the result of the intense regime was that people became agitated, depressed, scared or annoyed. Many clients ran away after one or two weeks. According to the junkie unions, there were many 'freaked-out' runaways, who felt desperate and confused after their stay in a therapeutic community. Some, they claimed, were even suffering from suicidal tendencies.[31] One of these runaways remembers how, during his short stay in a therapeutic community, he felt as if he were being dragged through the mud for the duration of his time there. 'My pride was hurt too much'.[32] Another person recounts with horror how he had to go through a shaming ritual that was often used in these therapeutic communities. It consisted of wearing a wooden 'sandwich board' around his neck for a couple of days, with the following text written on it: 'I am a creep because I am too scared to look into other people's eyes.'

Quite a few heroin users experienced these communities as a form of brainwashing, as legalized terror, or as a religious cult, where 'dope' was the enemy and where hysterical shouting and swearing at the drug-using 'sinners' served to exorcise this Devil.[33] Not all communities were as bad, however, according to the addicts. Whereas in some communities even a simple aspirin for a headache was completely taboo, in others a slow methadone reduction programme was possible. However, all communities had in common what addicts considered to be a very elitist regime. It favoured extrovert and eloquent clients, while many drug users were introverts or even slightly sociophobic.

'Alternative' forms of addiction treatment

The junkie unions worked hard to formulate and experiment with alternatives to this psychotherapeutic climate in addiction treatment. A soup kitchen for drug users was established in St. Paul's Church in Rotterdam, as well as day and night shelters.[34] In Amsterdam, the MDHG organized open consultation

31 Rotterdamse Junkiebond/MDHG (1982), p. 5.
32 Stichting Streetcornerwork Amsterdam (1978), p. 25.
33 Stichting Streetcornerwork Amsterdam (1978), p. 26; Rotterdamse Junkiebond/MDHG (1982), p. 5.
34 Visser (1996), p. 10.

hours a couple of nights a week, where drug users could get non-committal practical advice and support.

Christians and alternative addiction treatment workers further led initiatives such as walk-in shelters and drug consumption rooms, where addicts could buy drugs from house dealers, buy clean needles, get a medical check-up by a licensed doctor, and find a cheap and healthy meal and a warm bed. The MDHG had mixed feelings, however, as to these alternative initiatives. Although these places did serve as useful and necessary relief opportunities for many addicts who were out on the streets, they quite often turned into 'ghettos' and 'training institutes for junkies', according to the MDHG[35], which aimed at total liberation of the drug user from both the justice system, addiction treatment, *and* the drug scene. Ideally, in its view, a socially-adjusted drug user would be able to consume his methadone at home and live a normal life, independent of drug dealers, therapists and anti-social fellow users.

One of the first actions taken by the MDHG was to invite a group of local GPs to its office. These doctors came to be known as 'Doctor Ten'. Together, they supplied hundreds of heroin users with methadone. One of the Amsterdam 'methadone doctors', a psychiatrist called Hardenberg, described his views on addiction in an elaborate letter to his fellow doctors and psychiatrists in town on the occasion of his retirement from office in 1988.[36] At the end of the 1970s, Hardenberg had started prescribing methadone to some of his patients, because he had become 'convinced that heroin addiction truly was a disease that can afflict people of all kinds of character and from any social background'.

Methadone, according to Hardenberg, was a 'primary necessity of life' for addicts. This medicine enabled them to restore their confidence and gradually learn to control their addiction. Hardenberg considered it unjust that this category of patients was often treated by professionals with 'disgust, distrust and prejudice'. He argued that patients reacted to this hostile attitude with antisocial and egocentric behaviour. He concluded by saying that as a doctor, he had always tried to offer his addicted patients a stopping place in their chaotic lives instead of trying to 'discipline them with rules and regulations, like a police officer". He had wanted to offer them help and care 'without making judgements'.

Initiatives such as those described above were strongly discouraged at the time by institutions for addiction treatment, by the Royal College of Pharmacists, and by governmental health inspectors. They feared double prescriptions and overdosage. According to the junkie unions, however, what was known as the 'treatment industry' wanted to safeguard its monopoly on addiction treatment. An anti-institutional and anti-medical mentality was strongly present in the new social movements of drug users.

35 Stichting Streetcornerwork Amsterdam (1978), p. 38.
36 IISG, MDHG archive, inv. no. 11, Letter by L. Hardenberg, October 3rd 1988.

The idea of the MDHG was that 'Doctor Ten' would act as a lobby group to convince their fellow GPs that they should also start prescribing methadone to addicts. When this plan was unsuccessful, the MDHG managed to convince two doctors working for the Municipal Health Service to take up this task. These two doctors visited many local GPs to plead for more understanding for the plight in which addicts found themselves. Thousands of Amsterdam's heroin users were thus placed in general practices over the next couple of years.[37] In 1982, Stivema was founded. This organization was responsible for the registration of methadone clients and the prevention of double prescriptions. All parties involved in prescribing methadone took part in Stivema, such as the Jellinek, the Municipal Health Service, and various institutions for alternative addiction treatment. The MDHG was a member as well.

The MDHG then took on pharmacists, since they had to be willing to actually carry out the doctors' prescriptions. A group of lovely-looking ladies was selected from volunteers and social-workers-in-training, to hand out leaflets in Amsterdam's pharmacies about the nature, use and benefits of methadone. According to the leaflet, methadone enabled addicts to participate in society again as well as reducing aggression and criminality. The MDHG was hoping that pharmacists would be more willing to listen to these ladies than to 'a rough fellow in a squatter's outfit'.[38]

In Amsterdam, the relationship between the local city government, the Municipal Health Service and the MDHG seems to have been quite fruitful in the beginning, at least until the middle of the 1980s. The alderman for health affairs, Wim Polak, even invited August de Loor, as a representative of the MDHG, to advise him on the introduction of 'community methadone centres' in various neighbourhoods in Amsterdam. These centres were established by the Municipal Health Service from 1982 onwards in order to offer heroin users the opportunity to collect their methadone close to their homes, and receive advice, guidance, social and medical support at the same time. In some areas, these new centres met with stiff resistance from the inhabitants, who did not like the idea of 'junkies' in their neighbourhood. De Loor was able to bring some calm to this heated atmosphere, providing realistic information to these worried citizens, and thus became a valued advisor to the city council.[39]

In Rotterdam, the Junkie Union and the city council had a more rocky relationship. In 1981, the union met with the (socialist) mayor, André van der Louw, and an alderman of the city. At first, this meeting seemed to have positive results. The mayor himself paid a visit to a shelter for young prostitutes, along with the director of the Rotterdam Municipal Health Service. Soon after, an accessible methadone maintenance programme was set up at this shelter, but it was not nearly enough to service all heroin users in the city. Renewed efforts to expand the low-threshold methadone programmes were less

37 Jonge (1997), p. 10.
38 Jonge (1997), p. 8.
39 Jonge (1997), p. 9.

successful. The Junkie Union then occupied the office of the Rotterdam city council's advisor on drug affairs. This was the start of a long and troubled relationship between the city and the Junkie Union.[40]

In Nijmegen, much to the annoyance of the local junkies, the only methadone programme around was run by the psychiatric wing of a local general hospital. It consisted of a short-term reduction programme. The client would get his methadone for a period of twelve days only, in decreasing amounts. He had to go to the clinic every day to take his methadone pills under supervision. This programme, according to the local junkie union, was only effective for a very small group of drug addicts. Others lied and cheated, faking motivation to stop using drugs in order to get into the programme – to at least get their hands on some methadone in times of need. Many clients travelled to Amsterdam to score methadone on the black market.

Local doctors in smaller Dutch towns were often afraid to prescribe methadone because they were unfamiliar with addiction treatment or because they feared an increase of addicts and possible accompanying aggressive behaviour. This fear was not unjustified. In Arnhem, for instance, a venturesome doctor and pharmacist had actually had bad experiences in prescribing methadone. They started to experiment with this at the end of the 1960s, in order to help the small group of opium addicts in the area. However, when the number of heroin users started to increase, they suddenly had to deal with a problem on a different scale, as well as with impatient and aggressive clients. Besides, the large number of drug users in the doctor's waiting room and in the pharmacy began to scare away other customers.[41]

Still, in the course of the 1980s, methadone prescription steadily became more common. The Dutch government changed its views as well. Sometimes, it was now argued by policy-makers and health inspectors, another approach made sense in addiction treatment, besides that of freeing the addict from his drug abuse. Prevention of social degradation, it was argued, could also be a legitimate goal of treatment. By the early 1990s, methadone had become a cornerstone of Dutch addiction treatment. In part, this has been the result of the lobbying by the drug-user groups of the 1970s and 1980s. Junkies closely cooperated with the local Municipal Health Services, with sympathetic general practitioners, and with volunteers and professionals who were experimenting with an alternative kind of addiction treatment. Together, they made a strong plea for an acceptance model in drug-addiction treatment, with low-threshold methadone maintenance. Certainly, this had an impact on local and national policy. But the move towards harm reduction methods was the result of other considerations as well, such as the need to reduce drug-related crime and inconvenience for Dutch citizens and curb the growing unrest in cities such as Amsterdam and Rotterdam.[42]

40 Visser (1996); Bos/Jong/Kleer (1983), pp. 8–11.
41 Blok (2007), pp. 175 and 176.
42 As is argued in Blok (2008).

Conclusion

After 1977, Dutch interest groups for drug users thus dedicated themselves to transmitting practical, emotional and subjective knowledge about drug abuse and addiction which, in many ways, questioned the existing specialist knowledge in addiction treatment. The new socially-minded Dutch movement for drug users was very active during the 1980s. This was the result of the dedication shown by many persons involved, both the drug users themselves and those who sympathized with them. However, the support which the junkie unions encountered in the Netherlands was probably crucial as well. Many citizens, journalists, individual doctors and politicians lent an ear to the call of the junkies, in contrast to Germany where the 'Junkiebunden' withered away quite soon. The German junkies had presented themselves at several conferences held by institutes for drug research and addiction treatment, but their appearance only evoked irritation.[43]

In the Netherlands, the results of the many meetings and contacts with institutions, professionals and politicians certainly were not always satisfactory, in the opinion of the drug-user groups. Still, they did find a sufficiently large audience to keep going and feel at least a little encouraged. At least here, the junkies were invited to offer their opinions and attend meetings. In the large cities, they were supported financially. They encountered many like-minded people amongst left-wing academics and 'alternative' relief workers in addiction treatment. Besides, the user groups were willing to cooperate with each other as well. Thus, they proved to be very active and successful in gathering support and making their voices heard.

The junkie unions and the MDHG presented themselves as trade unions. Looking back on their views and actions now, this label seems rather limited. During those pioneering days, the user groups can truly be considered as 'new social movements'. They argued for a broad social change: the Opium Law was to be abolished and the stigmatization and social exclusion of drug users had to end.[44] Their views, issues and constituency were largely rooted in the counter-cultural movement of the 1960s, and they concerned themselves with the common themes of many other new social movements of the day: advancing individual freedom and well-being. In this sense, they can be compared to the women's movement, the movement for more humane psychiatric treatment and the gay liberation movement.

One very important goal of the junkie unions and the MDHG has been reached: methadone maintenance has become very accessible. Even before the AIDS epidemic created a panic, the number of methadone programmes and doctors willing to prescribe methadone had started to rise. By 1990, almost half of all hard-drug users was on methadone and the new philosophy of 'harm reduction' was becoming quite popular. According to this philosophy,

43 Schmid (2003), p. 188.
44 Rotterdamse Junkiebond/MDHG (1982), p. 2.

the aim of treatment is not to put an end to drug use, but to ameliorate the adverse social, medical and psychological effects of drug use. Today, about 12,500 people are enrolled in a methadone programme. This is almost half of all known problematic hard-drug users in the Netherlands, the number of which seems to have stabilized at about 25,000 people. Many methadone clients combine their use of methadone with regular or occasional use of cocaine, base-cocaine, heroin, alcohol or benzodiazepines. About 600 people partake in a heroin maintenance project.

In retrospect, the main cause for the estrangement between clients and healers in addiction treatment in the 1970s and 1980s, was the fact that both parties did not agree on the aim of addiction treatment. Most professional healers were working from the paradigm of abstentionism, while many clients felt they needed help and support even if they continued their drug use. The drug user groups at the time were fighting for an acceptance model of the drug user, a forerunner of the modern harm reduction paradigm. In this way, the junkie unions and the MDHG differed from traditional client organizations like the International Order of Good Templars, the Alcoholics Anonymous and Narcotics Anonymous. These organizations were strongly in favour of abstentionism as well.

Today in 2010, the heroin epidemic in Holland has passed its peak. The number of young new users is quite small and those who started their careers as addicts in the 1970s and 1980s are in their fifties or even sixties now. Many have died from an overdose, AIDS, or other health problems. With the average age of the Dutch hard-drug user rising, the number of deaths is on the increase as well. The coordinator of the National Support Group for Drug Users[45] – a national organization which has existed since the early 1990s – is now in training to arrange funerals.[46] In several places, hostels exist especially for elderly drug users, who are allowed to use their rooms. Heroin is provided for them by the hostel personnel. The occupants are allowed to go out, score some cocaine, and use this at home.

Care is now officially just as important in Dutch addiction treatment as cure. The chronic nature of addiction has become accepted and 'formulating a strong wish to be helped' is no longer a basic criterion in the selection of clients. Addicts who avoid care are considered to be a legitimate group of clients as well. The new socially-minded movement for drug users did not succeed, however, in putting a stop to the War on Drugs, or end the use of force against addicts by the police and the justice system. On the contrary, in the course of the 1990s, the possibilities in the Netherlands for the forced treatment and imprisonment of troublesome addicts have grown.

Furthermore, a new and quite different type of client movement in addiction treatment today suggests that perhaps the most fundamental goal of the junkie unions was never reached: the acceptance of drug users as free persons

45 In Dutch: the 'Landelijk Steunpunt Druggebruikers' (LSD).
46 Gerritsen (2009), p. 10.

with their own agency. Interestingly, nowadays in the Netherlands, a growing criticism from drug users is that methadone maintenance excessively dominates addiction treatment. Users complain that they are brushed aside when they indicate that they want to give it a try and stop taking drugs altogether. One former hard-drug user, Keith Bakker, has even filed a complaint against the Jellinek for refusing to help him properly. The only treatment they offered was methadone maintenance, he claims, when he came asking for their help in trying to stop using drugs. He went to an English rehabilitation clinic and did manage to stop his drug abuse, after almost twenty years of living on the streets, using heroin, alcohol and cocaine. He now runs his own private institute for addiction treatment, which is very successful in the Netherlands.[47]

The final aim of the junkies, in retrospect, was to create a completely different approach to addiction treatment, where the client is in charge and professionals adopt a helpful and empathetic attitude. Basically, the message the junkie unions and the MDHG were sending to addiction treatment facilities was that they should accept intensive drug users for who they *really* were, in their own view: drug users who had once had their reasons for starting to experiment with intoxication; who were now entertaining an intense love-hate relationship with their drug of choice, over which they have lost control; but who would get out of this dysfunctional relationship on their own terms only and in their own time. Pressure to change was futile and did not help in shaping a constructive therapeutic relationship. However, help should be on offer when the addict himself felt ready to change. But only the drug user could save himself – or not. Of course, this was asking a lot from a field which was created to convert addicts into new abstainers and was by its nature geared towards interventionism like all health care.

Many who were active in drug-user groups, however, did not regard drug abuse as an illness. According to them, drug abuse was not simply a terrible affliction one desperately wanted to get rid of. The situation was much more complex. Intensive drug use was a habit with which users often had a love-hate relationship.[48] On the one hand they desperately wanted to stop using drugs; on the other, they didn't. In spite of this tiresome predicament, many intensive drug users did not want to be regarded either as patients or as poor wretches. Today, however, addiction is seen in the Netherlands and elsewhere as a genetically and neurologically-based disease, tending towards chronicity. The user groups did not succeed in changing this medical paradigm of addiction.

They did succeed, however, in convincing people that junkies can be accepted as equal interlocutors deserving a say in the shaping of health knowledge and health practices in addiction treatment. The junkie unions were able

47 Bakker/Verdonschot (2008).

48 IISG Amsterdam, MDHG archive, inv. no. 12, 'Zo ken ik er nog wel een paar', memorandum on forced treatment, 1984.

to show, by their actions and writing, that hard-drug users could do much more than cheat, lie, steal and manipulate.

Grund, a close friend and colleague of Nico Adriaans, remembers meetings they had with representatives of all political parties in the Dutch parliament and with high-ranking officials within the Ministry of Health.

> They were flabbergasted … They had never engaged in a serious conversation with a drug user before […] Now, here, they were confronted with an eloquent speaker, who debunked dangerous 'junkie syndrome' mythology, taught them the basics of street life and demanded sensible, pragmatic policies and services, such as 'low threshold' methadone maintenance. […] Yet, he was … ahum ah … well … a junkie.[49]

In all probability, the junkie unions represented the 'elite' of the addict population. They were often better educated or more eloquent and probably less troubled by other psychiatric problems compared to some of their fellow users. Still, for this reason, they were able to improve the image of the heroin user and contribute to one of their main goals: the destigmatization of the drug user.

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49 Grund, 'Letter for Nico', at: http://www.ibogaine.desk.nl/adriaans.html (last access: Dec. 11th 2010).

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'Give them practical lessons': Catholic women religious and the transmission of nursing knowledge in late nineteenth-century England[1]

Carmen M. Mangion

> Be particular about the Nursing lectures. Make them learn by heart and also give them practical lessons, putting on leeches, going to bed to be poulticed, sheets changed, etc.[2]

Introduction

Nursing knowledge has sharply divided medical and nurse practitioners in the past and continues to challenge educators and historians in the present. In the latter half of the nineteenth-century, nurses, medical men and philanthropists in England bickered over what sorts of knowledge was necessary for nurses. These debates hinged on differences of opinion with regards to the professionalisation of nursing, gendered ideals of womanhood and authority in hospital spaces. Central to these debates was the concept of vocation which implied that nursing was more than an occupation, but a calling. Many accepted that good moral character was the keystone of a good nurse and that training in obedience as well as nursing tasks was necessary. But the medicalisation of nurse training was a point of marked divisions. Those who sought a more professional nursing status fought for a medicalised and scientific nursing education and a registration process that would identify nurses who had passed through a rigorous process of examination. Others opposed professionalisation on the grounds that nursing was a vocation and a medicalised education and registration would turn nursing into a 'mere' occupation. Medical practitioners faced another set of concerns as they feared that their own authority and power on the wards would be challenged by more formally-trained nurses. The emotive rhetoric of these debates persistently surfaced in the medical and the nascent nursing press, sometimes spilling over into the national press.[3]

1 I would like to express my gratefulness to the religious institutes and archivists that allowed me access to the private archives of their congregations: Little Company of Mary Congregational Archives; General Archives of the Union of the Sisters of Mercy of Great Britain; Central Congregational Archive of the Poor Servants of the Mother of God; Archives of the Poor Servants of the Mother of God 'Instituto Mater Dei', Rome; Archives of the Daughters of Charity of St Vincent de Paul; Archives of the Filles de la Croix.
2 Little Company of Mary Congregational Archives (henceforth LCM), Book I, Undated letter from Mary Potter to M. Rose (Mary) Moules, p. 107.
3 Baly (1973); Dingwall/Rafferty/Webster (1988).