

PAMPERING “NEEDLE FREAKS” OR CARING FOR CHRONIC ADDICTS? EARLY DEBATES ON HARM REDUCTION IN AMSTERDAM, 1972-82

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Abstract. During the 1970s, the Dutch were suddenly confronted with an epidemic of heroin use. This article analyzes the initial reactions to this epidemic in the Dutch capital of Amsterdam. First of all, this case-study makes clear that many ideas and practices that are now labelled as “harm reduction” were already present in the 1970s. This developing new paradigm in addiction treatment clashed with the old-established “abstentionism.” Heated debates over the proper use of methadone and the overall treatment of heroin users dominated addiction treatment in the 1970s. The Dutch approach to hard drug users at the time was ambivalent. The notion that the addict was a patient, not a criminal, was the foundation of national and local drug policy. A closer look at the actual treatment addicts did receive, however, shows that many “patients” were left uncared for and the implicit moral approach to drug use was still strongly present. Around 1980, the tide began to turn in favour of harm reduction methods and principles. Yet it was public order problems associated with addicts that led to the “victory” of this modern paradigm.

The Netherlands are famous for “window prostitution” and Rembrandt but perhaps most of all for its tolerant attitude toward drug use. In any city one can freely buy and smoke marijuana in a legal, tax-paying coffee shop. Moreover, “harm reduction,” to use the term now in vogue, in the treatment of heroin addicts is widely accepted. Almost half of all hard-drug users are on methadone maintenance, while several hundred take part in heroin-maintenance projects. Seventy percent of all known hard-drug users receive some form of addiction treatment; this is a high number in comparison to, for instance, the United States, where 25 percent of all addicts receive treatment.¹

Initially, however, the explosion of heroin use in the Netherlands after 1972 led to a clash between two paradigms in the treatment of addicts: the old, established abstinence-oriented paradigm (“abstentionism”²) and the modern paradigm of harm reduction. Abstentionism can be defined as a form of addiction treatment aimed primarily at creating a drug-free life for the addict. In

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contrast, Diane Riley and Pat O'Hare have aptly defined harm reduction as "an attempt to ameliorate the adverse health, social or economic consequences of mood-altering substances without necessarily requiring a reduction in the consumption of these substances."³

Harm reduction is often thought to have started in the 1980s. However, in the Netherlands many of the ideas and practices that are now ranged under this banner, such as needle exchange, drug-consumption rooms, and methadone maintenance, were present earlier. More important, a growing number of therapists and relief workers before the 1980s expressed the opinion that chronic heroin addicts deserved help and support even if they did not want to – or were unable to – "kick" the habit. The notion of harm reduction was not yet in use at the time. Some addiction therapists used the term "tertiary prevention" to refer to interventions meant to prevent complications and deterioration of an addiction. Other precursors of harm reduction were labelled "alternative addiction treatment."

Still, the new paradigm in addiction treatment that was gradually taking shape did not gain acceptance as easily as one would expect. This article will focus on the debate on "treatment" versus "relief" in Amsterdam during the 1970s. Who were the spokesmen for both positions and what were their arguments? How did harm reduction become more accepted over the years? The conflict between the two approaches, it will be argued, complicates the general picture of the intrinsically tolerant Dutch.

THE "MAGICAL CENTRE OF THE WORLD": RISE AND FALL, 1955-80

One reason why the Netherlands is now known as a forerunner in the domain of harm reduction might be the fact that the use of hard drugs exploded in this country quite suddenly during the 1970s, a period of great cultural change in which liberalism dominated the ideological terrain and anti-authoritarian sentiment was widespread in society at large. The Netherlands, and especially Amsterdam, had to deal with a large public-health and public-order problem at a time when taking more rigorous action against drug users would have been completely against the prevailing cultural and political mood.

On the eve of the heroin epidemic, Amsterdam was famous worldwide as the "magical centre of the world." According to the Dutch "hippie" poet Simon Vinkenoog, Amsterdam was to become a crucial site for all those who "wanted to end the aggressive, destructive, paranoid and frustrated tendencies in our society."⁴ His fantasies seemed to come true. From 1969 onward, Amsterdam was flooded by tourists from Europe and North America, many of whom slept in large numbers on the Dam square or in the Vondelpark. About one-quarter of all "Vondelpark sleepers" used LSD one time or more during their stay in the park.⁵ Many more of them smoked marijuana and some used speed or opium. Big attractions for the tourists were the youth centers Paradiso, Fantasio, and the Melkweg (Milky Way). Music, theater, macrobiotic food, and yoga were on the daily menu of these establishments. Visitors used

and sold drugs quite openly.⁶

By then it would have been hard to imagine that the use of drugs was in fact a relatively new phenomenon in the Netherlands. After 1945, American soldiers stationed in Germany had discovered Amsterdam to be a good place to spend leave time. In bars along the Zeedijk (an infamous street near Amsterdam Central Station), the Leidseplein, and the Rembrandtsplein, they mixed with immigrants from the Dutch colony Surinam and musicians from the United States, enjoying jazz, marijuana, and prostitutes. Still, until the early 1950s, recreational drug use was mostly confined to outsider groups, such as Chinese immigrants in the big cities (who smoked opium), and prostitutes, pimps, and seamen.⁷ This situation started to change around 1955, when Amsterdam began attracting growing numbers of students and artists who wished to escape the suffocating social atmosphere in post-war Netherlands.

After the chaos of the Second World War, the Dutch nation had reverted to traditional Christian values. During the reconstruction period, hard work and decent behavior were prized. Alcohol use was low, as were the numbers of divorces and illegitimate births. The Dutch “beatniks” of the 1950s, however, read Jean-Paul Sartre’s *Nausea* and Jack Kerouac’s *On the Road*. Using marijuana and amphetamines (“speed”) fit in well with their desire to separate themselves from the “squares.” During the 1960s their drug use expanded to include LSD and opium. According to informal law, the Amsterdam Chinese were allowed to smoke opium in their dens, as long as no young Chinese men or white people joined in.⁸ Some Chinese, though, started to sell opium to the Dutch. They even delivered at home, as one user later recalled: “We ordered some Foe Young Hai and they brought it to our door, along with a block of opium.”⁹

By the late 1960s, roughly two types of drug “scenes” had come into existence in Amsterdam: in one, characterized at the time as “psychedelic,” people often engaged in countercultural activities while using such mind-altering substances as cannabis and LSD; and in the other, the injection of amphetamines or opium, or both, was common.¹⁰ By 1969, the latter scene included some 250 chronic users.¹¹ In contrast to those using psychedelic substances, the amphetamine and opium users were mainly from a lower-class background and often poorly educated.¹²

From the viewpoint of public health and public order, opium and speed use was potentially the most worrying. In the media, however, during the 1950s and early 1960s, much concern was also expressed about the drugs cannabis and LSD. Both were strongly condemned as “evil,” poisonous, and sure pathways to insanity and moral degradation.¹³ The justice system at the time was quite strict in its dealings with drug users as well. The possession of one “joint” could result in a prison sentence of up to eight months.¹⁴

Nevertheless, by the end of the 1960s, the tide was turning. A growing number of criminologists, psychiatrists, sociologists, and politicians started to speak in support of the “maladjusted” youngsters who were using drugs.

Psychiatrists Wijnand Mulder and Peter Geerlings were among them. Both worked at the Jellinek Institute, the main institution for addiction treatment in Amsterdam, where they treated young drug users. Initially, these were referred to the Jellinek Institute through the justice system, but later on they came voluntarily.

In 1969 Mulder published a book entitled *Verslaving. Druggebruik bij jongeren* [Addiction: Drug Use among Young People]. He claimed that, in most cases, drug use was part of the identity crisis and “self-actualization” process of “artistically and scientifically talented” young people.¹⁵ Sympathetic remarks like these were characteristic of the permissive attitude the Dutch elite came to adopt toward youth culture at the end of the 1960s. Some scientists and policy makers put young people on a pedestal as a source of new vitality that would benefit the entire society.¹⁶

It may have been that the appreciative attitude of the elite was facilitated by the nature of Dutch counterculture, which was more playful and less political than that in the United States, France, or Germany. Besides, modernity and prosperity came to the Netherlands quite suddenly during the 1960s. In the course of one decade, the Dutch were confronted with economic prosperity, the rapid expansion of television, feminism, the sexual revolution, secularization, counterculture, and the growing visibility of youth culture and recreational drug use. Combined, all of this generated a feeling of inevitable change, especially after 1973 when a reform-minded, centre-left government was elected.¹⁷

With regard to drug use, things were changing as well. A turning point was the pop festival at Kralingen forest in Rotterdam (1970). The police were waiting outside the fences, ready to intervene if things grew violent. But they didn't. In fact, the atmosphere was so good, one officer remembers, that “we just could not continue to preach that marijuana was evil.”¹⁸ Around 1970, psychiatrists Wijnand Mulder and Peter Geerlings participated in two expert committees which advised the Dutch government on the issue of drug policy.¹⁹ The radical Hulsman committee, of which Geerlings was a member, issued a report in 1971 which proposed to decriminalize all drug use. Criminalization, the committee argued, resulted in a harmful stigmatization and marginalization of drug users. In the media, Geerlings expressed his fierce criticism of American drug policy. In his opinion, the “War on Drugs” led to the “bizarre situation that one can be sent to jail for years for the possession of marijuana – a substance less dangerous than alcohol according to many experts – while anyone can walk around freely with a Sten gun, that so-called symbol of manliness and freedom.”²⁰

The more moderate Baan committee expressed a wish to decriminalize cannabis as well, but it stated that punishment through the justice system could be beneficial to those young people who were just starting to use drugs. In the end, the reports of both committees contributed to the famous Dutch distinction between “soft drugs” (cannabis products) and “hard drugs” (opiates,

cocaine, and amphetamines), which was put into operation in 1976 when the centre-left government adjusted the *Opiumwet* [Drug Law].

The Dutch criminologist Ed Leuw makes the important point that drug use came to public consciousness in the Netherlands “against the backdrop of a relatively mild dispute about lifestyles and values systems, not against a background of criminality, pathology, and deep rooted social conflict.”²¹ The young people who were using cannabis at the time were mostly well educated and came from an upper-middle-class background.²² They were not considered to be a serious threat to the social order and the elite adopted a strategy of accommodation.

The Amsterdam city council generously subsidized youth centres like *Paradiso*, *Fantasio*, and the *Milky Way*. In 1971 the “Vondelpark Project” was started, providing people sleeping in the park with free medical care, showers, and toilets. Additionally, the city financially backed countercultural initiatives for young people, such as the JAC, a ring of shelters offering support to runaways, and the *Laurier* [Laurel], where people could recover from a bad “acid trip” in a special “flip-room.”²³

In the summer of 1972 events took a turn for the worse. In that year, an estimated 36,000 people slept in the Vondelpark, 70 percent of them foreigners. Many came from the United States, where the use of heroin had already exploded. When President Richard Nixon started his War on Drugs in the early 1970s, the supply of heroin to the United States stagnated. Some users took refuge in Amsterdam; about 15 percent of the American youth tourists who visited this city in 1972 and 1973 were already using heroin before their arrival.²⁴ This made Amsterdam a lucrative market for heroin dealers.

At the same time, the supply of opium in the Dutch capital ran dry. In 1972 the police invaded the opium dens²⁵ and carried off all users and dealers to prison.²⁶ A new heroin mafia of Singapore Chinese brought “brown sugar” from Southeast Asia into the Netherlands.²⁷ These Asian dealers started selling cheap, good-quality heroin in Amsterdam and by 1974 the number of addicts in the Dutch capital had risen to around 5,000.²⁸ By then, the price of heroin had become much higher as well. The population of the Vondelpark now consisted of a sad army of “homeless people, runaways, drop-outs from Holland and abroad.”²⁹ The Vondelpark project was cleared, an operation that passed off without incident. The youngsters were quietly escorted from the park and advised to go to a Christian shelter or a cheap youth hostel.³⁰

At the beginning of the heroin epidemic, most users were veterans of the old drug scenes of the 1960s. As one of them recalled: “For years, I had been using ten guilders of opium daily. Within three months, this had changed to three hundred guilders of heroin.”³¹ But soon new groups of clients emerged: young boys – and, to a much lesser extent, girls – from the workmen’s quarters surrounding the Amsterdam city center. Heroin struck hardest in the lower strata of Amsterdam and Dutch society as a whole. An important group of victims were immigrants from Surinam.

Ever since the nineteenth century, inhabitants of Surinam had been migrating to the Netherlands for the purpose of education or to fill gaps in the Dutch job market. In 1975, when Surinam gained independence from the Netherlands, the Surinamese could choose to adopt Dutch nationality. Many of them did, believing the Netherlands to be a land of milk and honey. By 1978, about 135,000 Surinamese were living in the Netherlands, a number that represented about one-third of the total population of Surinam.³²

In many ways, the Surinamese immigrants who turned to heroin in the 1970s resembled the African Americans who fled the South during the 1930s and 1940s. The historian David Courtwright writes that the American black heroin users of the 1940s and 1950s in cities like New York and Chicago were “disoriented and demoralized... exposed to narcotics in a way they had never been before.”³³ The same could be said about the immigrants from Surinam. They had to adjust to a new environment and, since decent housing was in short supply, they often lived in crowded apartments. Moreover, the recession of the 1970s led to high rates of unemployment.³⁴ Discrimination was common; Surinamese were increasingly denied entrance to bars and clubs along the popular Rembrandtplein and Leidseplein.³⁵ They resorted to the Zeedijk, where people from Surinam traditionally went to listen to jazz and smoke marijuana.

When heroin dealers started their activities in Amsterdam, the disappointed Surinamese were likely targets. By 1980, the number of heroin addicts in Amsterdam lay somewhere between 8,000 and 10,000.³⁶ Approximately 2,500 of them were Surinamese.³⁷ In the Netherlands as a whole, there were some 25,000 hard-drug users at the beginning of the 1980s.³⁸

DRUG TREATMENT UNDER SCRUTINY: THE COURSE OF THE DEBATE

The Dutch approach to hard-drug users at the time was characterized by ambivalence. The notion that the addict was a patient, not a criminal, was the foundation of national and local policy³⁹ and had been expressed as early as 1969 by Amsterdam mayor Ivo Samkalden.⁴⁰ However, if we take a closer look at the actual treatment that addicts did receive, it becomes clear that many of them were left uncared for and that the implicit moral approach to drug use was still strongly present. For instance, in 1976 the Dutch National Health Council (a consultative government body) stated that “the only treatment for drug addicts that makes any sense is 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.”⁴¹ The choice of words is significant. Apparently, addiction was regarded as a lifestyle of choice.

Freeing the addict from drugs was the central purpose in Amsterdam addiction treatment as well, a field dominated by the Jellinek Institute. When the Jellinek was founded in 1909 – it was then called the ambulatory Health Center for Alcoholism – its goal was to minimize the use of alcohol in Dutch society and to strive for total abstinence on the part of alcoholics. Temperance

societies had enjoyed strong support in the Netherlands during the nineteenth and early twentieth centuries, and Dutch addiction treatment stemmed more from a temperance background than from a medical one. The social workers and doctors working at the Amsterdam Health Center for Alcoholism tried hard to convince their clients that they could “choose to overcome their weakness.”⁴² As the leader of the center, the former school teacher Th. Van der Woude, put it in 1937, his aim was to “educate the alcoholic to become a human being filled with the wish and determination to free himself from his miserable situation... someone who felt responsible for his family, his work, his society.”⁴³

Van der Woude did realize that only a minority of his clients reached this goal. Many of the center’s activities were actually aimed at helping the wives and children of alcoholics. They were provided with interest-free loans, food, clothes, sometimes even with a divorce attorney. Although this early form of harm reduction was quite important in daily practice, officially abstentionism counted as the only acceptable and most important purpose of addiction treatment.

Even if the explicitly moralistic approach had faded after the Second World War, the emphasis on abstinence remained strong at the Jellinek Institute (as the Health Center for Alcoholism came to be called in 1964). In fact, abstentionism grew more pronounced as clinical treatment became possible during the 1960s and more therapeutic methods were available, such as Antabuse and various forms of psychotherapy. As Henk Krauweel, managing director at the Jellinek, admitted in 1973, chronic alcoholics were neglected by his institute: “It is so much easier to work with people by whom one can gain credit.”⁴⁴ Chronic alcoholics ended up in run-down hostels or in psychiatric clinics, or were left to be cared for by the ambulatory psychiatric service of *Gemeentelijke Geestelijke en Gezondheids Dienst* (GG & GD) [Municipal Health Services]. This organization was instituted and owned by the city of Amsterdam. It functioned as a refuge for the “lost cases” of addiction treatment.⁴⁵

After Krauweel left in the early 1970s, a new director, Dees Postma, entered the picture. A former lawyer and recovered alcoholic, during the 1960s he had achieved sobriety with the help of the Jellinek Institute and Alcoholics Anonymous. Postma experienced his recovery as a rebirth. Addiction was an escape, in his view, and treatment an opportunity for personal growth.⁴⁶ Postma declared to the press that the Jellinek Institute offered treatment only to those who “formulated a clear wish to be helped.” The criterion for admission was “a desire to fight one’s addiction.”⁴⁷

In the treatment of the new clientele of drug users, this abstentionist approach was continued. In 1969 the Jellinek established a therapeutic community for twenty hard-drug users. Encounter and scream therapy were the main forms of treatment. Clients were admitted only if they were truly motivated to overcome their habit and their psychiatric problems were minimal. A relapse into drug use or aggressive behavior could result in expulsion from the com-

munity. In 1977 the Jellinek's capacity for the clinical treatment was increased to sixty beds.

Moreover, in 1968 psychiatrist Peter Geerlings had established an outpatient clinic for drug users at the Jellinek Institute. Consultation was possible on a voluntary basis.⁴⁸ In 1971 seven hundred drug users were registered at the clinic; a quarter of them regularly attended consultation sessions.⁴⁹ Almost from the start, Geerlings used methadone, first in the treatment of twenty-five of his clients. Having read about the work of the American pioneers Vincent Dole and Marie Nyswander, Geerlings tried to wean his patients from their opium addictions. "I wanted to use methadone as a foundation for larger changes in lifestyle," he says looking back.⁵⁰ In 1970 he reported that the treatment seemed to be successful. After eighteen months, ten clients no longer used opium. Some had got married or started a job. The others used opium only occasionally.⁵¹

Soon, Geerling's consultation sessions were flooded with drug users from all over the Netherlands and even the rest of Europe. The news about methadone spread like wildfire, and many people came to the Jellinek in search of this new "medication."⁵² As this trend accelerated even more after 1972, Geerlings, appreciating the possible medical dangers of methadone use, remained cautious. In reaction to the heroin epidemic, the methadone program at the Jellinek outpatient clinic was expanded; it also came to include slow detoxification, long detoxification, and maintenance programs. In addition, Geerling continued to choose his patients carefully. For instance, in 1978, 472 addicts applied for help at the Jellinek outpatient clinic, but only 134 of them were admitted into one of the methadone programs.⁵³ On average, during the 1970s, only about a hundred clients at a time took part.⁵⁴ These are small numbers, considering the scale of the heroin epidemic in Amsterdam at the time.

Methadone clients at the Jellinek were closely monitored, for medical and psychological reasons. A treatment where nothing was required from the client supposedly continued and even worsened the addiction.⁵⁵ Besides, Geerlings believed that a therapist providing methadone should be in full control of the relationship with his or her clients.⁵⁶ In order to gain entrance into the methadone program, the user had to promise to avoid the drug scene and focus on rehabilitation, visiting the clinic every day in order to receive methadone and to have his or her urine tested. Moreover, the provision of methadone was accompanied by regular talks with a psychotherapist.⁵⁷ If a client broke these rules, or misbehaved in the waiting room, the provision of methadone could be stopped. The Dutch government supported this selective approach. For example, in 1975 it stated that methadone should be given only to a small group of addicts. The government did not want to take responsibility for a "methadone program that did nothing but satisfy the needs of the user."⁵⁸

In these years, many drug users ended up in prison or in a psychiatric hospital. During the 1970s, approximately 2,500 persons a year were imprisoned in the Netherlands for drug-related petty crime. Some prison directors allowed

their inmates to use methadone as part of a detoxification program. Many did not.⁵⁹ Some six hundred people a year were admitted to the university psychiatric clinic of the University of Amsterdam because of drug-related problems. Most of the time, their stay in this clinic was short. As soon as their acute symptoms were controlled, patients were referred to the Jellinek Institute or another institution for addiction treatment outside Amsterdam.

Since the Jellinek did not admit clients with psychiatric problems, many addicts fell back on the care offered by charitable religious organizations, such as the *Leger des Heils* [Salvation Army], the evangelical *Vereniging tot Heil des Volks* [Association for the Good of the People], and the Protestant organization *de Regenboog* [Rainbow Foundation]. They all invited young people into their hostels and coffee bars and approached them on the streets. Several of these organizations founded treatment farms in the Dutch countryside.

During the 1970s, next to the Jellinek, the Municipal Health Center and the Christian organizations, an influential alternative sector for addiction treatment grew into existence in Amsterdam. Alderman Harry Verheij of Youth and Health Affairs gave out large sums of money to private institutions entering the field of addiction treatment, many of which were strongly linked to the Amsterdam counterculture. Those working in this new sector would become leading players in the debate about addiction treatment, giving voice to the new paradigm of harm reduction.

The leading alternative institution for addiction treatment was the HUK, which opened its doors in 1974 as a drug-consumption room generously supported by the local government. At the HUK, addicts could cash their unemployment benefits and then openly take their drugs, get a meal, shower, and buy more drugs from the house dealer. Needle exchange and medical care were available as well, and those working at the HUK tried to assist the addicts in finding decent housing or legal assistance. A doctor working at the HUK aptly described the shelter as “a trendy Salvation Army.”⁶⁰ Even though the HUK was not very big (it was visited by some 35 to 70 people a day and kept files on about 150),⁶¹ it was outspoken and extremely controversial.

A journalist accused the HUK of “putting a bounty on drug use”⁶² and pampering addicts. The police and the Jellinek claimed that the shelter was dominated by a criminal atmosphere. Sending a person to the HUK felt like “giving up on them,” an Amsterdam police officer said in 1977.⁶³ In 1978 the city of Amsterdam installed a new committee to evaluate the existing forms of assistance to addicts. This committee stated that the work of the HUK could not be considered relief work, let alone proper addiction treatment, because it was too unconditional and too caring.⁶⁴ Many agreed. “Needle freaks are not helped by providing unpretentious 24-hour care and shelter,” stated a leading organization of youth-relief workers.⁶⁵

Yet, according to Eric Fromberg, founder and director of the HUK, his drop-in center was the only refuge for the majority of addicts: those whose behavior was fickle and whose problems were chronic. He criticized the

Jellinek for its elitist work method, claiming that it welcomed only humble, apologetic people who were capable of compliance with paternalistic rules and a psychotherapeutic approach – in short, the most “normal” and healthy ones among the addicts. Fromberg stated: “We are the last stop for those who are thrown up by everyone, literally everyone.”⁶⁶ He continually argued that “most addicts do not want to kick their habits at all. Our aim is to offer them help and care in spite of that.” The coordinator of another alternative institution offering assistance and shelter to addicts, the Princenhof, fully agreed. It wanted to give “love and care” to chronic addicts who did not want to quit their habit or who had tried to but failed. The starting point was to offer them respect and solidarity.⁶⁷

These debates about the fundamental question of “treatment” versus “relief” were fuelled by a variety of ideas. The alternative relief workers, for instance, felt that the Jellinek rejected many drug users simply because of their hedonistic lifestyle. Several of these workers were recreational drug users themselves and claimed that the people who treated addicts at the Jellinek did not really understand them. Moreover, the alternative relief workers stated that drug abuse was not a problem in itself unless the user experienced it as such. They tended to believe in the possibility of controlled drug use.

Besides, anti-authoritarian and anti-psychiatric sentiments were strong in the Netherlands during the 1970s.⁶⁸ These sentiments clearly resonated in the discussion on the treatment of heroin addicts. Many of those working in the field of alternative-addiction treatment did not have a medical background; most of them were volunteers, social workers, or psychologists. The Jellinek was regarded as an instrument of the state’s power over non-conformist individuals. The Amsterdam street-corner workers, for instance, complained that the Jellinek and the justice system worked too closely together. This turned the drug user into both a patient and a criminal offender, a person who had to learn to adjust to the values of non-users.⁶⁹

When Peter Geerlings of the Jellinek, together with several other psychiatrists, wrote a report defending the forced treatment of homeless addicts with psychotic symptoms, those working in the alternative field bombarded this approach with criticism. Fromberg, the HUK director, stated that “to put people in prison, if society considers them to be dangerous, is at least more honest than committing them to some beautiful white building where they would be medically sedated under the show of psychiatric care.”⁷⁰ Another group of alternative relief workers declared: “If one does not know what to do with a client, then at least let him keep his civil liberties. Carrying him off somewhere is not a solution. Besides, it is brutal.”⁷¹

So, while Geerlings was considered progressive in the late 1960s, when he was an advocate for decriminalizing marijuana use, ten years later his views no longer coincided with the countercultural point of view. Geerlings had never actually taken part in Dutch counterculture; he sympathized with it but was a doctor first. As a doctor, he believed that in some cases forceful treatment

was for the good of the patient. Furthermore, he felt that panicky behavior was no solution to the heroin problem. Instead, he believed that the scale of Dutch addiction treatment should gradually be enlarged to encompass a variety of tools, including inpatient and outpatient detoxification, methadone use, residential care, and therapeutic communities. Only after a multilayered operation had been functioning for a while should large-scale, low-threshold methadone or heroin maintenance be considered, as a last resort in cases where all other forms of treatment had failed. This rational call for patience and caution conflicted with the heated feelings of concerned citizens, relief workers, and users.

In 1977 a new drug-users lobby group was founded: the *Medisch-Sociale Dienst Heroïne Gebruikers* (MDHG) [Medical-Social Service for Heroin Users]. This organization, which still exists today, became another important advocate of the harm-reduction paradigm. Although many drug users joined the MDHG, the service was initiated by a concerned citizen living near the Zeedijk, the fifty-seven-year-old left-wing politician Johan Riemens.⁷² Riemens pitied the addicts he observed every day. He described them as “hungry tigers running around in their cages, without getting any help from the outside.”⁷³ Heroin users deserve our care, Riemens proclaimed. “They are not pieces of trash; they are the minister’s son, the notary’s daughter, or the black sheep of the Smith family.”⁷⁴ Wanting to mobilize drug users themselves, he put an advertisement in a leading Dutch newspaper, *de Volkskrant* [The People’s Paper], inviting “heroinists” to his house for a meeting. Only one person reacted to the invitation: street-corner worker August de Loor. He sat there for two hours listening to Riemens’s ideas, amazed that someone could put into words so well what he felt on the streets every day.⁷⁵ Riemens lobbied for a “third way” in the treatment of addicts. At that time, he argued, there were only two ways in which drug users were treated: with force by the justice system, or with the aim of abstinence by addiction treatment. Riemens abhorred the harsh mentality of this “clique” of police and therapists. According to him, addiction treatment rested on a philosophy of neglect: do not offer addicts too much help and care, for that will only reinforce their lifestyle. Instead, let them land in the gutter, at which point the motivation to overcome their habit would “originate of itself.”⁷⁶

A third way, Riemens argued, would consist of a fundamental acceptance of and respect for addicts in spite of their drug use. Together, Riemens and De Loor founded the MDHG, which lobbied for community treatment and large-scale methadone-maintenance programs. Urine testing should not be used as a condition for acceptance in such programs, nor should the continuation of illegal drug use be a reason to stop the methadone supply. Methadone would offer addicts a chance to escape the madness and misery of the streets, and might keep them out of prison.

With regard to methadone, the attitude of the MDHG was different from that of the HUK. In the eyes of the people working at the HUK, methadone

was a symbol and instrument of the medical model of addiction, which they rejected.⁷⁷ But, at the end of 1976, the HUK was forced to change its opinion. For some reason, heroin was in very short supply in Amsterdam for a while. Since the HUK was known for its house dealer, addicts flocked to the facility hoping to get their hands on some heroin. This high concentration of drug users became a problem to the neighbors.⁷⁸

When the supply of heroin picked up again at the beginning of 1977, a lot of dealing was taking place around the HUK. Since clients were not allowed to deal inside the shelter, they moved their activities to nearby alleys. This was too much for those who lived in the area, and they complained to the city government. Around this time, the HUK started to hand out methadone to its clients. Whether this was done to silence the growing concerns in the neighborhood, or because the staff felt pity for addicts suffering from withdrawal symptoms in a period of heroin shortage, is not clear. In any case, the HUK staff decided to set aside their objections to methadone. And, once they had started, it was impossible to stop. The HUK did stress, however, that its methadone program was very different from that offered at the Jellinek Institute. The dosage of methadone was low, because it was assumed from the beginning that clients would continue to use heroin and other drugs on the side. Also, the HUK did not perform urine checks, and, when clients did not arrive to collect their daily dosage, they were not kicked out of the program. Staff regularly gave clients a week's supply of methadone to take home. They emphasized that the client was responsible for his or her own drug use. Any unnecessary dependence by clients on the institution that supplied their "medicine" was to be prevented.⁷⁹ The HUK staff quickly discovered that methadone maintenance was of great use in improving the lives of their clients.

The debates in Amsterdam regarding addiction treatment were further heightened by growing public-order problems. In 1977 two leading Amsterdam police officers published an article describing the situation in their city. A lot of pressure was being brought to bear upon the police and the city government by Amsterdam citizens and shopowners, who demanded that drug-related crime be reduced.⁸⁰ The matter truly became urgent when, in 1979, a large group of Surinamese addicts began wandering the streets of Amsterdam, much to the alarm of its citizens and the city government.

Addicts of Surinamese origin seldom went to the Jellinek Institute, the HUK, or the Princenhof voluntarily, for they did not feel at home in any of these institutions.⁸¹ Dutch addicts who frequented the HUK mostly injected their heroin; the Surinamese addicts preferred to inhale heroin using a technique called "chasing the dragon" (or, in Dutch, "*chinezen*"). According to their native Winti religion, the body, as one of them expressed his feelings, was the "chair of the soul": the sacred medium that could put one into contact with one's ancestors. One did not put a needle in the body, which should be treated with respect.⁸² At the HUK, white opiate users sometimes discriminated against the Surinamese.⁸³ They did not respect addicts who did not "shoot

up.”

Surinamese addicts felt discriminated against by the police as well. Relations between the police and the Surinamese had been tense ever since 1972, when a young man from Surinam had been shot while resisting arrest. He died as a result.⁸⁴ The officer responsible was acquitted: the dead man had been carrying a knife and some cannabis, so the shooting was regarded as self-defence.⁸⁵ Later, since Asian heroin dealers used the Surinamese as intermediaries,⁸⁶ every day about four hundred Surinamese dealers populated the Zeedijk.⁸⁷ Relations in that neighborhood between the immigrants and the police, to say nothing of those between immigrants and non-immigrants, became very tense.

On top of this, in addiction treatment a cultural gap existed between the native Dutch and the Surinamese. For instance, a female addict from Surinam claimed that she had to learn to speak differently at the clinic. She recalls: “The Dutch junkies kept bitching about my accent. They said it made them crave for heroin.” This woman also had a hard time relating to the therapeutic climate in the community, with its emphasis on individualistic values like self-development and autonomy. “The therapists kept saying that I was too dependent on my family,” she remembers. “I had to stand up for myself and break away from my parents. I did not understand this; family ties are very important in my culture.” Instead, she wanted to talk to her therapists about racial discrimination and unemployment. This was not possible, she claims.⁸⁸

In 1975 the city created a working group to study the problem of the many Surinamese addicts in need of care; their number was estimated to be from 1,000 to 1,500.⁸⁹ The meetings of this group did not produce any concrete solutions, so the SOSA (a Surinamese welfare organization) went on to establish a shelter. After 1977 the SOSA was transformed into a new organization called Srefidensie, which from 1977 to 1981 managed several detoxication farms in the Dutch countryside.

At the shelter run by the SOSA, criminal and drug activities became interwoven.⁹⁰ Things reached a crisis point when the police, in a desperate attempt to curb the trouble at the Zeedijk, raided a couple of Surinamese drug bars in 1978. Many dealers fled to the SOSA building. The Amsterdam government decided that this was an untenable state of affairs. In the bitterly cold winter of 1979, the SOSA building was cleared by the Riot Squad.

A sad procession of homeless addicts then wandered the streets until they ended up in the Doelen Building, an empty and desolate structure in the center of town – directly opposite, in fact, the home of Willem Polak, mayor of Amsterdam since 1977. From his window, Polak could watch addicts plundering parking meters and breaking into cars.⁹¹ Still, the city of Amsterdam decided to let the group stay in the building for a while. Within four days, 1,100 Surinam drug users had registered to live there.⁹²

It soon became clear that the Doelen Building posed a serious inconvenience to people in the neighborhood. In June 1979 this building, too, was

cleared. To compensate the Surinamese, Srefidensie was offered an extra sum of money to expand its therapeutic activities. Also, the city tried a new strategy: to spread the wandering group of addicts more widely by creating drop-in sites and temporary housing for them in various parts of town away from the city center. This strategy nearly caused a popular uprising.

Members of the city council were shocked by the “fascist remarks” made by residents during a hearing. Some Amsterdam citizens proposed to expel all addicts to labor colonies or an island somewhere in the ocean. Others wanted to transport all people from Surinam back to their own country. Some threatened to stone Surinamese addicts or burn them alive. Two new drop-in centers meant for Surinamese addicts were in fact burnt to the ground.⁹³ The alderman responsible for health affairs, Irene Vorrink, eventually resigned. Then, in 1981, Srefidensie collapsed because of an internal corruption scandal. The city decided to take action. Large-scale, low-threshold methadone maintenance had to save the day.

The Jellinek still did not want to do it. “Addiction therapists are not supposed to be reduced to drug dealers in service of the state,” Jellinek director Postma said in 1982.⁹⁴ “We wanted to help people who wanted to change, to fight their addictions,” he explains retrospectively. “It was not our task, I felt, to maintain public order.”⁹⁵ The Jellinek did not stand alone in this opinion. The editors of a leading liberal Dutch newspaper, the *NRC-Handelsblad*, felt the same way: they likened methadone maintenance to the offering of “human sacrifices” in order to diminish drug-related crime and meet public-order concerns.⁹⁶ Still, since a local health-care system was already in place in the form of Municipal Health Services, the desire of the city government to restore order in the city could easily be satisfied. In fact, Municipal Health Services had already taken the initiative.

As soon as the Doelen Building was evacuated in 1979, members of the drug team of Municipal Health Services set up a low-threshold methadone program for Surinamese addicts. In June 1979 the first “methadone bus” – at which addicts could pick up their methadone at fixed hours – started to function in Amsterdam. Within a year, 632 addicts had applied for this program, mostly people from Surinam.⁹⁷ For the first time in Amsterdam, methadone maintenance was used with the explicit aim of entering into contact with heavy drug users known for their “care-avoiding behavior.”

In the period between 1977 and 1979, field worker and psychologist Ernst Buning had met many of those “care-avoiders.” As a member of the drug team of Municipal Health Services, Buning was “knocking on the doors of squatters, talking to people who were asking me what the hell I wanted from them.” He met with many drug users who had been to a therapeutic-treatment program and relapsed again. Talking to them, Buning started to realize the importance of harm reduction, or “tertiary prevention,” as the drug team then called it: “What can we do for drug users who are not motivated to give up their drug use? How can we integrate interventions for this group in our

public health activities? How do we communicate this change to our local politicians?"⁹⁸ One of Buning's colleagues, Dr Giel van Brussel, was on the same track. When the Surinamese group had taken up residence in the Doelen Building, van Brussel started offering consultation sessions there. When he asked the drug users he met what they wanted, many of them answered: we want methadone, but without any pressure to undergo treatment.⁹⁹

After 1981 a broad system of methadone maintenance was created in Amsterdam, involving general practitioners, special community centers for the distribution of methadone, and methadone buses. The number of methadone users in Amsterdam increased from about 1,000 in 1980 to some 4,000 in 1983.¹⁰⁰ Municipal Health Services coordinated the project and also started to register drug users in the city. Its director expressed the philosophy underlying the new harm-reduction paradigm in 1984, when he wrote in a renowned Dutch medical journal:

When treatment fails, we simply set ourselves a new goal: diminishing the harm caused by an addiction: the physical, mental and social harm... Of course, we cannot allow medical actions to be made subordinate to the maintaining of public order. However, health care and public order can work together in achieving a common goal: diminishing the uncontrolled nature of existing addictions.¹⁰¹

In 1982 the Dutch government, too, had adjusted its goals with regard to addiction treatment. Abstinence was impossible to achieve for many addicts. Treatment should focus more on harm reduction or, in the government's words, "improving the social and physical functioning of the addict through 'coaching.'"¹⁰²

CONCLUSION

Many ideas and practices that today would be labelled "harm reduction" were thus already in place almost from the start of the heroin epidemic in Amsterdam. The HUK, the MDHG, and street-corner and other relief workers all stated that drug users who were unable or not motivated to kick their habit deserved attention, support, compassion, and low-threshold methadone maintenance.

Retrospectively, the tolerant and accommodating attitude of the Amsterdam city council toward the counterculture and drug use was an important factor in the rise of this new harm-reduction paradigm. The generous funding of the HUK and other alternative institutions enabled the critics of abstinence to make their voices heard and experiment with a different approach to hard-drug use. Furthermore, an open drug scene existed right in the middle of Amsterdam's city center. The reality of the heroin epidemic was not concentrated in distant city ghettos; it was there for all to see. The sight of the users swarming the streets sparked compassion in the hearts of some observers, like Johan Riemens, who felt that heroin addicts condemned to a life on the streets were utterly pitiable.

Harm reduction was controversial at first, but it turned into local policy

when the heroin epidemic got out of hand at the end of the 1970s. The growing acceptance of large-scale methadone maintenance was the result both of a growing compassion for chronic heroin addicts and of a need to restore social order in Amsterdam. Since the city had its own health service, the new approach could easily be put into practice. Municipal Health Services had originally been set up in the nineteenth century to fight epidemics like cholera and tuberculosis; now it had to fight the heroin epidemic.

The Netherlands were thus quite early in its acceptance of the harm-reduction paradigm. In France, by contrast, a repressive drug policy and abstinence dominated until the end of the 1990s. In 1993 only fifty-two people received substitution treatment, a number that had expanded to 90,000 by 2002.¹⁰³ In Germany, after a long debate, a methadone-maintenance treatment was introduced in 1987. The number of clients was low at first, because of strict admission criteria. It increased considerably in the 1990s.¹⁰⁴

Yet the case of Amsterdam is not unique in all respects. Abstinence was quite strong in the Netherlands, too, in addiction treatment as well as in popular opinion and even national health policy. In the end, the leftist government of Amsterdam used methadone to fight drug-related crime and diminish social unrest, much like the conservative American president Richard Nixon did in New York. In short, the story of the heroin epidemic in Amsterdam, and the reaction to it, moderates the image of the Netherlands as an intrinsically liberal country.

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ENDNOTES

1. Femke Pijlman, "Waar Nederland sterk in kan zijn," *Mediator* 15 (March), 25.
2. A term used in James A. Inciardi and Lana D. Harrison, eds., *Harm Reduction: National and International Perspectives* (London: Sage, 2000), 2.
3. Diane Riley and Pat O'Hare, "Harm reduction: history, definition and practice," in Inciardi and Harrison, eds., *Harm Reduction*, 7.
4. Simon Vinkenoog, "Amsterdam, magisch centrum van de informatie-explosie of reflecties op de kinderkruistocht der 70-er jaren," *Vrij Nederland* 28 (March).
5. Stadsarchief Gemeente Amsterdam (SGA), Archive number 5320 B (Secretarie Afdeling Jeugdzaken en Volksontwikkeling), inventory number 55, SDI, *De Amsterdamse drugsmarkt zomer '72* (Amsterdam, 1973), 16.
6. Lutgard Mutsears, *25 jaar Paradiso. Geschiedenis van een podium, podium van een geschiedenis 1968-1993* (Amsterdam: Jan Metz, 1993), 32-3; *De Amsterdamse drugsmarkt zomer*.
7. Marcel de Kort, *Tussen patiënt en delinquent. Geschiedenis van het Nederlandse drugsbeleid* (Hilversum: Uitgeverij Verloren, 1995), 121-27; S. Snelders, "De psychedelische revolutie in Nederland," in *De psychedelische (r) evolutie. Geschiedenis en recente ontwikkelingen in het onderzoek naar veranderende bewustzijnsstaten*, ed. Hans Bogers, Stephen Snelders and Hans Plomg (Amsterdam: Bres, 1994), 52.
8. Cees Zwart, *Diender in Amsterdam. De beproevingen van een politiekorps 1966-1999* (Hilversum: Balans, 1999), 185.
9. Piet Piryms and Kees Schaepman, *Verslaafd in Nederland. Over drugs, dealers en gebruikers* (Amsterdam: Van Gennep BV, 1982), 13.

10. Herman Cohen, *Drugs, druggebruikers en drug-scene* (Alphen a/d Rijn: Samson, 1975).
11. P.J. Geerlings, "Ambulante hulp voor druggebruikers in Amsterdam," in *Drugs in Nederland*, ed. W.K. van Dijk and L.H.C. Hulsman, (Bussum: Paul Brand, 1970), 160.
12. Cohen, *Drugs*, 93 and 144.
13. Nicole Maalsté, *Het kruid, de krant en de kroongetuigen* (Rotterdam: Stichting WGU, 1993).
14. Zwart, *Diender in Amsterdam*, 226-27; Snelders, "Psychedelische revolutie," 53.
15. W.G. Mulder, *Verslaving. Druggebruik bij jongeren* (Amsterdam: Wetenschappelijke Uitgeverij, 1969), 159.
16. G. Blok, "'Tall, spanking people': The idealization of adolescents in a Dutch therapeutic community," in *Cultures of Child Health in Britain and the Netherlands in the Twentieth Century*, ed. M. Gijswijt-Hofstra and Hilary Marland, (New York and Amsterdam: Rodopi, 2003): 256-87.
17. J.C. Kennedy, *Nieuw babylon in aanbouw. Nederland in de jaren zestig* (Amsterdam: Boom, 1995).
18. This quote comes from a Rotterdam police officer, who was interviewed for a Dutch documentary television program in February 2004, *Andere tijden*, that examined the history of the Dutch drug policy. The full text of the program can be found on the Internet at <http://geschiedenis.vpro.nl>
19. Marcel de Kort, *Tussen patiënt en delinquent*, 189-97.
20. Geerlings quoted in *Het Parool*, July 31, 1968.
21. Leuw quoted in Tim Boekhout van Solinge, *Dealing with Drugs in Europe: An investigation of European drug control experiences: France, the Netherlands and Sweden* (The Hague: Pompe Reeks, 2004), 119.
22. Cohen, *Drugs*, 136-49.
23. *Het Parool*, August 7, 1971.
24. Stichting Kontakt Sentra (SKS), *Verslag over 1975 en 1976* (Amsterdam, 1976), 7.
25. Zwart, *Diender in Amsterdam*, 185.
26. Louis de Jonge, *Belangenvereniging druggebruikers MDHG 1977-1997. 20 jaar in een roes van overwinning* (Amsterdam: MDHG, 1997), 20.
27. SKS, *Verslag over 1975 en 1976*, 7.
28. Ed. Leuw, "Door schade en schande. De geschiedenis van drug-hulpverlening als sociaal beleid in Amsterdam" *Tijdschrift voor Criminologie* 8 (1984), 153.
29. *Gemeentebld Amsterdam*, January 2, 1975, 9.
30. Zwart, *Diender in Amsterdam*, 176-77.
31. Emma Verhey, "De Binnenbantammerstraat," *Vrij Nederland* 43 (1983).
32. Stichting Srefidensie, *Het gebruik van heroïne onder Surinaamse migranten in Nederland* (Amsterdam: Srefidensie, 1978), 46.
33. David Courtwright, Herman Joseph, and Don des Jarlais, *Addicts Who Survived: An oral history of narcotic use in America, 1923-1965* (Knoxville: University of Tennessee Press, 1989), 17.
34. Piet de Rooy, *Republiek der rivaliteiten. Nederland sinds 1813* (Amsterdam: Mets en Schilt, 2002), 268.
35. Margreet Luning, "Politie en Surinamers. Een attitude-onderzoek bij de Amsterdamse ge-uniformeerde politie in 1974-1975," (Master's thesis, University of Amsterdam, 1976), 1; SGA, Archive number 5320B, Inventory number 70, *Nota inzake opvang en begeleiding van drug-dependent Surinamers* (Amsterdam, 1976), 3.
36. B.T. de Koningh, "Structurele aanpak van lokale drugshandel in Amsterdam," *Algemeen Politieblad van het Koninkrijk der Nederlanden*, 26 (1984), 571.
37. *Amsterdams Drugtijdschrift*, March 1988, 11.
38. *Dagblad Zwolle*, March 7, 1981.
39. De Kort, *Tussen patiënt en delinquent*, 241-43.
40. *Gemeentebld*, 1969.
41. *Nederlands Tijdschrift voor Geneeskunde*, 120 (1976), 1351.
42. J.C. van der Stel, *Drinken, drank en dronkenschap. Vijf eeuwen drankbestrijding en alco-*

- holhulpverlening in Nederland* (Hilversum: Uitgeverij Verloren, 1995), 211.
43. Th. W. van der Woude, *Werk onder dronkzuchtigen* (Amsterdam: Medisch Consultatiebureau voor Alcoholisme, 1937), 5.
 44. Hans Smits, "Eredoktoraat voor een verslavingsbevrijder," *Vrij Nederland* 33 (January).
 45. C. Akkermans, *Aanspoelen aan de Achtergracht. Maatschappelijke ontwikkelingen, cliënttelevorming en de psychiatrische patiënten van de Amsterdamse GG en GD [1933-88]* (Amsterdam: Uitgeverij Aksant, 2006), 139.
 46. Interview with Dees Postma, November 13, 2007.
 47. *De Tijd*, June 29, 1979.
 48. P.J. Geerlings, "Ambulante hulp voor druggebruikers in Amsterdam," in van Dijk and Hulsman, eds., *Drugs in Nederland*, 157-58.
 49. "Hard drugs," *Het Parool*, August 7, 1971.
 50. Interview with Peter Geerlings, November 20, 2007.
 51. Geerlings, "Ambulante hulp," 165.
 52. Bani de Lima, interview with Peter Geerlings, *Omummer* 3 (January).
 53. Jellinek Institute, *Annual Report 1978* (Amsterdam, 1979).
 54. Stichting Itoba, *Hulp en dienstverlening aan druggebruikers: deelonderzoek in de regio Amsterdam* (Amsterdam: Stichting Itoba, 1979), 106.
 55. P.J. Geerlings, "Medische aspecten van de heroïneverslaving," *Nederlands Tijdschrift voor Geneeskunde* 123 (1979): 1148-54.
 56. P.J. Geerlings and E. Ch. Wolters, *Verslaving. Een handboek voor arts en hulpverlener* (Utrecht: Wetenschappelijke Uitgeverij Bunge, 1980), 158-59.
 57. SGA, Archive number 5320B, inventory number 77, *Concept-nota drugs in Amsterdam* (1976), 7.
 58. De Kort, *Tussen patiënt en delinquent*, 239.
 59. MDHG, *Dope en detentie. Interviews met (ex-)gedetineerde druggebruikers* (Amsterdam, 1994); De Jonge, *Belangenvereniging druggebruikers*, 10.
 60. Piryns and Schaepman, *Verslaafd in Nederland*, 23.
 61. SKS Report, *Geïntegreerde hulpverlening* (Amsterdam, 1977), 12.
 62. *Elsevier*, April 3, 1982.
 63. J.C. van Riessen and R.P.J. Gräeve, "Iets over riskant druggebruik in Amsterdam," *Algemeen Politieblad* 24 (1977): 583-85.
 64. *Nieuws van de Dag*, February 15, 1978.
 65. *Volkskrant*, January 13, 1973.
 66. *Nieuws van de Dag*, 1978.
 67. Stichting Itoba, *Hulp en dienstverlening*, 83.
 68. Gemma Blok, *Baas in eigen brein. 'Anti-psychiatrie' in Nederland, 1965-1985* (Amsterdam: Uitgeverij Nieuwezijds, 2004); Gemma Blok, "Madness and autonomy: the moral agenda of anti-psychiatry in the Netherlands," in *Psychiatric Cultures Compared: Psychiatry and mental health care in the twentieth century* ed. Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijseelaar and Hugh Freeman (Amsterdam: Rodopi, 2005): 103-16.
 69. SGA, Archive number 5320B, inventory number 75.
 70. SGA, Archive number 5320B, inventory number 61, KODA meeting, May 10, 1974.
 71. Itoba, *Hulp en dienstverlening*, 175.
 72. De Jonge, *Belangenvereniging Druggebruikers*, 4-6.
 73. Johan Riemens, "De heroïne epidemie. Een aanklacht en een recept," unpublished (Amsterdam: 1978), 7.
 74. De Jonge, *Belangenvereniging Druggebruikers*, 4.
 75. Geja Roosjen, *30 jaar scoren, 30 jaar drugscene, 30 jaar MDHG 1977-2007* (Amsterdam, 2007), 6.
 76. De Jonge, *Belangenvereniging druggebruikers*, 8.
 77. De Kort, *Tussen patiënt en delinquent*, 240.
 78. SKS, *Jaarverslag HUK 1977* (Amsterdam, 1977), 20.
 79. *Ibid.*, 32.
 80. Van Riessen and Gräeve, "Riskant druggebruik in Amsterdam," 586.

81. Srefidensie, *Gebruik heroïne onder Surinaamse migranten*.
82. Douwe N. Wouters, *Zorg op straat. De Regenboog 25 jaar* (Amsterdam: Stichting De Regenboog, 2000), 39.
83. Ton van Dijk, "De junkies van het HUK," *Haagse Post* 1978.
84. Luning, *Politie en Surinamers*, 57-62.
85. Margreet Luning, "Politie en Surinamers," 4.
86. De Jonge, *Belangenvereniging druggebruikers*, 20.
87. Van Riessen and Gräeve, "Riskant druggebruik in Amsterdam," 585.
88. Unknown author, "Surinaamse vrouwen en harddrugs," *Amsterdams Drugtijdschrift* 2 (1986), 2/3.
89. SGA, Archive number 5320B, Inventory number 72.
90. Leuw, "Door schade en schande," 160.
91. Dirk Wolthekker, ed., *Een keten van macht. Amsterdam en zijn burgemeester vanaf 1850* (Amsterdam: Uitgeverij Balans, 2006), 227.
92. Leuw, "Door schade en schande," 162.
93. Ibid.
94. *Elsevier*, April 3 1982.
95. Interview with D. Postma, November 13, 2007.
96. Editorial, *NRC-Handelsblad*, February 2, 1977.
97. G. Sijbiling, *Methadon – GG en GD Amsterdam* (Amsterdam: GG en GD, 1981), 3.
98. Ernst Buning, "Fifteen years of harm reduction: A reflection." This article can be found on the Internet at <http://www.drugtext.org/library/articles/923411.html>
99. Giel v. Brussel speaking at the MDHG conference, Amsterdam, August 30, 2007.
100. *Elsevier*, June 11, 1983.
101. H. Rengelink, "Hulpverlening aan drugsverslaafden," *Nederlands Tijdschrift voor Geneeskunde* 128 (6), 259-60.
102. De Kort, *Tussen patiënt en delinquent*, 261.
103. Van Solinge, *Dealing with Drugs in Europe*, 92.
104. Ilja Michels, Heino Stöver and Ralf Gerlach, "Substitution treatment for opioid addicts in Germany," *Harm Reduction Journal* 4 (2007). <http://www.harmreductionjournal.com/content/4/1/5> (last accessed June 20 2008).