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Stretching the Limits of Drug Policies: An Uneasy Balancing Act

Dolf Tops

Introduction

Organisations for and by hard drug users have been a common phenomenon in the Netherlands ever since the late 1970s. The user organisation in focus in this article, the Amsterdam-based Interest Association for Drug Users or MDHG was founded almost 30 years ago. Unlike most Scandinavian user organisations, the MDHG is neither a self-help group/client organisation, nor closely related to a treatment system or treatment issue. Instead, it proclaims to represent and defend the interests and rights of drug users, and its main goal is a political one, namely the legalisation of hard drugs. This makes the MDHG a particularly interesting case from a Nordic perspective, for such an objective is taboo or would at least not be explicitly declared by user organisations in the Nordic countries.

My purpose in this article is to describe how the Dutch context has made possible the emergence of a relatively autonomous group of user organisations. I will illustrate how user organisations are influenced by general drug policy and by the institutional structure of the political system.

Based on the principles of harm reduction, Dutch drug policy differs quite considerably from the Swedish goals of a drug-free society and therefore provides an interesting backdrop for an analysis of how it influences the modus operandi and goals of user organisations. The harm reduction approach does not focus on illegal drug use as such, but on preventing and reducing the risks of drug use to both users themselves, the immediate environment and society. Reducing the risks for society is the origin of the public nuisance policy that incrementally paralleled the harm reduction approach in the Netherlands and that is targeted at the behaviour of the drug user rather than drug taking as such. The drug-free society approach, on the other hand, is aimed at eliminating illegal drug use altogether, and one of the means of achieving this is by the criminalisation of drug use. Logically, the approach determines the limits for the organisation of users as well as for their aims, strategies, activities and action repertoire.

Apart from drug policy, another important aspect facilitating the emergence of user organisations is the institutional structure of the political system. In this

case, both the Nordic countries and the Netherlands can be characterised as cooperative states with long traditions of involving civic organisations in the policy-making process.

A third relevant factor concerns the constituency of drug user organisations. Although drug use does not necessarily and automatically imply individual or social problems, the constituency of organisations for and by hard drug users usually consist of marginalised people with multiple problems, including drug use, homelessness, psychiatric disorders, etc. This presents a special challenge to these organisations in terms of encouraging users to get involved and to sustain that involvement.

In this article I will be describing the ways in which the MDHG is working to stretch the limits and possibilities imposed by society by focusing on its organisational form, the issues that are raised, its action repertoire and aims in relation to the local context.

Social Movement Organisations and Their Context Structure

The MDHG may be described as a social movement organisation, i.e. an organisation that pursues a political goal by means of collective action. My choice to call it a social movement organisation instead of a social movement is deliberate. According to Tilly (2004, 4), one of the characteristics of social movements in the West is that participants concert public representations of WUNC: worthiness, unity, numbers and commitment on the part of themselves and/or their constituencies. In this sense, the MDHG is not a social movement because even though it promotes the W and the C certainly is present, user organisations do not display numbers (they do not march in ranks) and there are also questions about unity. However, if we regard the emergence of user organisations in Western Europe as a social movement, local organisations are part of this phenomenon and thus social movement organisations. This argument is strengthened by the fact that there exist international networks of user organisations where information about local developments is exchanged and where the action repertoire is emulated. User organisations also support initiatives to set up new organisations where such do not exist.

One way of analysing social movement organisations is via the concept of *context structure* (Rucht 1996). In this concept, conditions external to a movement (or set of movements) either restrict or facilitate the building and maintenance of a movement structure devoted to conducting protest activities (ibid., 189). The most crucial contextual dimensions are the cultural, social, and political contexts:

- The *cultural context* refers to the attitudes and behaviours of individuals who may (or may not) provide support such as money, organisational help, or personal involvement in protest events. This depends on how a movement's issue and demands resonate with the experiences and interests of larger sections of the population. This resonance is a function of the distribution of cultural patterns among certain groups in the population and the framing of the problems at stake. Here both general values and more situationally dependent issue perceptions come into play.
- The *social context* is the embedding of social movements in their social environment. One aspect consists of the social milieu and networks, which either facilitate or restrict the forming of collective identity and the building of movement structures. For example, population density facilitates communication and mobility between networks.
- The *political context* is where conceptions of political opportunity structures are focused, singling out factors such as access to the polity, political alignments, presence or absence of allies, and conflict among the elites (ibid., 190).

In this article I use the concept of context structure to describe the MDHG and its operation. The focus is on what McCarthy (1996, 142), referring to Tilly (1985), described as a key task in the study of mobilising structures, namely to characterise “the social movement” by its typical social location and associated strategic and tactical approaches. In effectively choosing mobilising structures, activists must successfully frame them as usable and appropriate to the tasks of social change they employ. The targets of these framings are both internal – adherents and activists of the movement itself – as well as external, including bystanders, opponents, and authorities. This means that the framing of action is intimately related to the cultural context in which a social movement builds its mobilisation structure (ibid., 149).

The empirical data for the article consist of interviews in April 2005 with three persons working in user organisations and one official from the Department of Social Affairs. The magazine “*Spuut 11*”, published by the MDHG since 1981, and the organisation's annual reports have also provided important sources of information. Additional material has been collected through the Internet.

In the following the main focus is on significant aspects and changes in the Dutch context that have contributed to the emergence of the MDHG and some other user organisations.

From Drug Free to Harm Reduction

One important contextual factor is of course the national drug policy and its impact on possibilities for drug user organisation. Dutch drug policy is characterised by a two-track approach, with separate policies on cannabis products and so-called hard drugs. This principle, as set out in the Opium Act of 1976, has been at the centre of Dutch drug policy ever since. The focus here is on the policy on hard drugs, i.e. heroin and cocaine, for it is precisely these users who are targeted by user organisations in the Netherlands.

Heroin appeared on the Dutch illegal drug market in 1972, presenting the authorities and treatment organisations with a whole new problem. Based on experiences and research from abroad, especially the United States, there were fears of a heroin epidemic, particularly among socially marginalised sections of the young population. These fears materialised sooner than anyone had expected and in 1976, the number of people addicted to heroin in Amsterdam was estimated at 5,000–7,000 (Tops 2001, 123). The number of problem users peaked at 8,800 in 1988, and has declined until 1998.¹ This decline has been explained by the return of German and Italian users to their home countries. The number of problem users of opiates (most of whom also used cocaine) in 2003 was estimated at 4,530. The use of cocaine (coke base) seems to be primarily a big city phenomenon and common among homeless people (Trimbos 2005).

A major shift occurred in national drug policy in the early 1980s. The philosophy and goals of the traditional treatment system were increasingly called into question (not least because of its poor results) by user organisations, left wing parties and progressive treatment professionals. Eventually, the system bowed to the pressure. Instead of taking abstinence as the only goal for treatment, politicians began to accept more differentiated goals. Coming off drugs, for those who were able to, and a policy of “harm reduction” for those who were not (yet) able to quit drugs, were adopted as the leading principle for care and treatment institutions. It was considered a kind of social contract where society, on the one hand provided assistance that enabled drug users to reduce the risks of drug use, for example by low-threshold assistance facilities, and drug users on the other hand would and could behave as common citizens (whatever that might be). This policy became denoted as the normalisation of the drug user and entailed a further categorisation of drug users into socially normalised and integrated users, on the one hand, and those who could not or did not want be normalised, on the other, eventually becoming problem users or extreme problem users.² The latter two categories became the constituency of the MDGH. When compared internationally, the adoption of what later became known as the policy

¹ The number of problematic drug users in the Netherlands was estimated at 32,000 (2001) which compared to most other EU countries is quite low (Trimbos 2004). The number of drug addicts per 1,000 population in the Netherlands was 3.0, in Denmark 7.2, Sweden 4.5, Finland 3.5 and Norway 4.2 (EMCDDA 2005).

of harm reduction, in which the aim was to reduce the risks of drug use to the user and society instead of curing all drug users, took place at a rather early stage.³ One of the consequences was particularly visible: thousands of addicts from abroad (many from Germany) sought and found refuge in Amsterdam. Another part of the social context concerns the period in which drug user organisations emerged. User organisations were one among numerous action groups that emerged in the 1960s and later. In many fields of social life, groups of people felt oppressed and claimed the same human rights as other citizens. To name just some, homosexuals, psychiatric patients and women's liberation movements called for equal rights, squatters for housing, and students for the democratisation of universities. In this pandemonium of protests, drug user organisations were just one among several actors with the same action repertoire, including pamphlets, rallies, demonstrations and occupations of treatment organisations' offices. Their chief goal was not to get better treatment, but rather to be treated like other citizens with the same human rights, even if they were using hard drugs. However, their situation was only made worse by the prevailing drug policy. From the very outset, therefore, user organisations aimed to change Dutch drug policy in terms of drug users having legal access to hard drugs. However, such a fundamental change was a long-term goal; their short-term goal was to improve the living conditions of drug users.

In 1981, "*Junkiebonds*" (Junkie Unions)⁴ emerged in a number of cities across the Netherlands (Spuit 11, No. 3, 1981). The number of user organisations has varied over the years from 15 to 30. Some have closed down, especially those wholly organised by drug users, but many of them have returned with new, often charismatic instigators (Jepsen 2004). In some cities, they are organised in statutory associations or foundations, in other cities they consist of loosely organised user groups.

The Emergence of Local Initiatives

Social problems tend to concentrate in big cities, and drug use is no exception. The Dutch government was concerned that the drug problem might spread from the cities to the rest of the country and therefore closely monitored developments

² Problem use is defined as the use of a substance in such a way that it causes physical, mental or social problems or social nuisance. Problem use does not always imply addiction. "Misuse" is a type of problem use that it still not a matter of addiction (Trimbos 2005).

³ Germany, Belgium and France, for example, adopted elements of harm reduction in their drug policies during the 1990s.

⁴ The adoption of the concept of "junkie" (from junk, meaning rubbish), follows an old Dutch tradition since the 16th century of reclaiming a derogatory name and using it as a positive label of empowerment within one's own movement (Vuijsje & van der Lans 1999). This is a case of framing that it is embedded in the cultural context.

in Amsterdam and the country's three other major cities, Rotterdam, The Hague and Utrecht, collectively known as the 4 G. The 4 G have played a major role in drug policy issues since the 1960s, and they have discussed their local drug problems and drug policies directly with the national government (Tops 2001). This means that local initiatives also have an important impact on national drug policy. Harm reduction practices, such as coffee shops and needle exchange programmes, for example, first emerged in the 4 G before they became part of national drug policy.

Likewise, drug user organisations have jointly pursued actions to influence policy measures on the national level, and there have also been some national drug user organisations.

The MDHG was founded in 1975 in a neighbourhood known as a marketplace and gathering place for opiate users in Amsterdam, on the initiative of a local resident who was convinced there should be viable alternatives to the repressive drug policy (Hondius 2005). Among the other people involved were an outreach worker, physicians, local pharmacists, users, and parents of drug users.

The National Dutch Federation of Junkiebonds (FNJB) was established in 1980 to promote the exchange of information between local user organisations and discussion of developments and events at local and national levels. When necessary, concerted actions were pursued. In June 1980, members of user organisations in Amsterdam, Rotterdam and other cities occupied the premises of the Federation of Agencies for Alcohol and Drugs (FZA), an umbrella organisation for ambulatory drug treatment institutions in Bilthoven (near Utrecht) and demanded to speak with the board in order to discuss its policy on the prescription of methadone (Spuit 11, No. 4, 1981). Another example of the ability of these organisations to carry out orchestrated actions is provided by the conference staged by user organisations in response to the introduction in 1980 of compulsory care for hard drug users by the Lord Mayors of the 4 G. On this occasion 500 participants, among them many drug users, gathered in The Hague (the residence city) to discuss the proposal and to persuade public opinion and politicians (MDHG 1981). Indeed this and other actions probably contributed to the government's decision to reject the proposal. In May the same year, at another conference staged by user organisations, a proposal was floated for the prescription of opiates (including heroin) to heroin users. This, at that time, was a politically impossible option, but it was eventually realised twenty years later, just as compulsory care. It was indeed a distinctive characteristic of national user organisations at this time that they were very much oriented to direct action.

In 1992, another type of national drug user organisation emerged with the foundation of the National Supporting Point Drug Users (LSD). The LSD was established on the initiative of an ex drug user who had been previously involved in a peer-to-peer harm reduction activity. The main goal of the LSD is to support

the creation of local drug user organisations. One of its functions is to mediate between drug users and policy makers at both the local and the national level and to provide advice in conflict situations between user organisations and treatment organisations. It also aims to assist and encourage drug users to organise themselves in local organisations. Other activities include the provision of information about drug use and drug users at juvenile prisons and health care institutions, to political parties, etc. Together with the Trimbos Institute, the national knowledge institute for mental health care, addiction care and social work, it has developed guidelines for the country's 35 using rooms.⁵ In these contexts, drug users should be considered "experience experts".

The LSD received funding for its operation from the Department of Social Affairs (VWS). As far as the VWS is concerned, "the LSD is like any other association of clients, and it is important in the policy making process to know what is happening in the world of drugs and drug users".⁶ However, VWS funding to the LSD had to be discontinued in 2005 due to cutbacks in the national budget. The government's policy today is to withdraw its funding for activities that are a matter for local politics and authorities. How this will affect local user organisations in the future remains to be seen. Organisations in the 4 G have now turned into professional organisations which (for the time being) have stable resources and can survive even without the support of the VWS. Organisations in smaller cities face a more uncertain future.⁷

It is probably because of its stable organisation that the MDHG has played an important role in many of these initiatives on the national level and in networks between local drug user organisations. The text below proceeds to look into the aims and role of the MDHG in closer detail. It starts with a short description of some important developments within the local Amsterdam drug policy.

Public Nuisance and Reducing Risks to the Environment

A significant change in local drug policies that influenced the everyday lives of drug users was the launch of a programme aimed at reducing drug-related public nuisance. The definition of this nuisance reduction policy and the way it was implemented calls for some discussion.

In Amsterdam, an area near the Central Station⁸ was known since the 1960s as a major marketplace for opiates: there were large numbers of opium users in the local Chinese community and therefore the area also attracted opium addicts.

⁵ The term "injection room" is not used in the Netherlands. A large majority of drug users smoke their heroin/cocaine and the premises are therefore called "using rooms".

⁶ Interview with official from the Department of Social Affairs.

⁷ Interview with founder of the LSD.

⁸ This was the area in which the MDGH was established.

When heroin became the most widely used opiate, users began to gather in this area. Heroin was of course available in others parts of the city as well, but the sheer number of drug users here made them more visible. At first, the public nuisance consisted mainly of petty crime, but eventually the mere appearance of drug users was seen as a source of disturbance. Drug-related nuisance was most noticeable around the Zeedijk, a street in the Red Light District, where drugs were sold and used in the open. Local residents and shopkeepers consequently began in the mid-1970s to insist that the authorities take action to intervene. However, the complaints were not unanimous. For example, the present chairman of the MDHG lived opposite the organisation's offices and he initially took an interest in the MDHG as he observed the people visiting the office from his window. Furthermore, a letter from the Lord Mayor in which he advised people in the area not to offer coffee, sandwiches or shelter to drug users, also goes to show that not all local residents experienced the presence of addicts as a nuisance (Sput 11, Winter 2000).

In 1987 the police introduced what is colloquially known as the "Dike prohibition", which has been a thorn in the side of the MDHG ever since. This local regulation gives the police the powers (in the name of the Lord Mayor) to expel people from the area for up to eight hours if they are found consuming drugs, if they are in possession of a drug-using device, or if they gather in a public place in groups of four or more. At the same time, the individual or individuals concerned will be summoned to court, where they will be issued a fine of between 75 and 120 euros or given a five-days prison sentence. In cases where people have received an expulsion order five times within six months, the police can impose an expulsion period of 14 days. Violations may result in prison sentences of six weeks to three months.

Another exponent of the nuisance policy in Amsterdam was the so-called street-junkie project that started in 1989 and that was specifically aimed at a hard core of some 300–400 problem drug users. Drug users who repeatedly committed petty crimes more than four times during one year were given the choice of either going to prison or attending a drug aid programme (Mol & Trautmann 1991).

A third example of the nuisance reduction policy is a penitentiary regulation, SOV (Measure for the Criminal Care of Addicts), that came into force on an experimental basis in 2001. According to this regulation a hard drug user who has received more than three prison sentences and who is re-arrested within five years, may be sentenced to compulsory care during a maximum period of two years.

It is clear then from these examples that there are no grounds whatsoever to the common notion that Dutch drug policy is liberal or permissive. This may be true for cannabis users, but as far as problem users of hard drugs are concerned (and

particularly heroin and cocaine users), public and political attitudes are far from liberal. As Mol & Trautmann (1991) have shown, Dutch drug policy has followed an increasingly repressive course since the late 1980s. This new direction, as we will see, became a major target for the MDHG's action programme, which was based on the view that is the "illegality of drugs" that creates the black drug market and causes nuisance to the environment (Spuit 11, Spring 2001).

MDGH: Working for an Alternative Drug Policy

The MDGH was founded as an alternative to the Netherlands' repressive drug policy in 1975. In a memorandum from 1977, the founder and first chairman of the organisation proposed three starting-points, viz. a generous prescription of substitutes (methadone, heroin and other opiates), ambulatory first line assistance and a neighbourhood-oriented approach (Riemens 1977). When the organisation turned into a union of drug users in 1981, its founder decided to leave because in his opinion this move would lead to a further stigmatisation of drug users (Hondius 2005).

Until 1986, the official name of the MDGH was the Association of Medical-Social Service Heroin Users (MDHG); the name was then changed to the Interest Association of Hard Drug Users (MDHG). The change from "heroin" to "hard drug" users was made because hardly any of the members were on heroin only. Since the 1990s, the organisation has been called the Interest Association for Drug Users (MDHG). As the name of the organisation describes its main target group, it is interesting to note that the MDHG no longer uses the epithet "junkie", a label that its constituency no longer appreciates.

It is the organisation's position that the criminalisation of drugs and repressive drug policy both adversely affect the social position of drug users and constitute a major obstacle to the normalisation of drug users. The organisation conveys this view in its contacts with politicians, the authorities, the public and the media. Its main goal is to promote an alternative drug policy, including the legalisation of drugs, and the normalisation, emancipation and public acceptance of the drug user (MDHG 2004). In the shorter term, the organisation aims to promote low threshold and user-friendly assistance programmes, including methadone and heroin prescription, with a view to improving the everyday life of drug users. Another goal is to work against the prejudice in society towards drug users, especially in neighbourhoods where drug users live or gather.

The interests of the organisation's constituency are promoted in numerous contexts. The "user's voice" is put forward in various fora; in contacts with the judicial system, treatment institutions, the media and the polity. One way to

achieve influence is to get drug users involved in client councils of care institutions, such as the municipal health authority in Amsterdam that runs methadone programmes and the heroin prescription programme. According to the Bill on Client Participation in Care Facilities (WMCZ) from 1996, all care institutions are to have client councils in order to ensure client participation in matters that are of immediate concern to them (NIVEL 2005). Another strategy of gaining influence is through the representation of drug users on advisory boards of projects such as the Measure for the Criminal Care of Addicts (SOV) in Amsterdam.

Below, I describe some of the issues that have been raised by the MDHG as well as activities and actions for and by its constituency. I make a distinction between more or less regular activities directly aimed at the constituency and actions aimed at the public and the policy-making domain. Together, these constitute the organisation's action repertoire.

Policy Challenging Activities

The MDHG is not a single-issue organisation, but its action repertoire covers various aspects of the problems encountered by its constituency. It ranges from challenging actions such as protest marches to the City Hall and occupying institutions to more conventional information activities such as distributing leaflets.

A recurrent issue concerns police activities to reduce drug-related nuisance, or what the MDHG and its constituency regard as "police harassment". Since the 1980s, the City of Amsterdam has been increasingly concerned about its dubious reputation as a mecca for drug users, both in the Netherlands and abroad. In 1987, Amsterdam published its new drug policy in a booklet specifically aimed at foreign drug tourists: "Addicts who are not from Amsterdam are not welcome here. Amsterdam is not a rose garden for junkies" (Amsterdam Information Office 1987). In the opinion of the MDHG, domestic junkies were not welcome either, and the City's message has been a main target for the organisation's activities and actions. Not surprisingly, this also accounts for nuisance reduction actions such as the Street Junkie Project and the Measure for the Criminal Care of Addicts (SOV).

The MDHG works to combat the "hounding junkies" policy in several ways. In winter 1991, the organisation's magazine *Spuut 11* included four pages of information for drug users on how to act in case they were arrested, detailing the procedures as well as the rights and obligations of drug users and police officers. In winter 2000, an allied (star) lawyer (and former member of the board) prepared a standardised form of appeal to be used in case of a police summons for violation of the Dike prohibition. In *Spuut 11* (Winter 2000), drug users are

cautioned not to neglect a summons, but to bring it to the MDHG offices where they will be assisted in filling out the form of appeal.

Another activity through which the MDHG works to combat the anti-nuisance strategy is its “habituation course” for newly arrived police officers in the area, informing them about the situation of drug users. This course imitates the Netherlands habituation course that is obligatory for immigrants, who are supposed to learn the language, the history, and the values and norms of Dutch society. Another illustration of a more light-hearted action is the “Willem Schild (an Amsterdam police officer) Award” for the user-friendliest police officer in Amsterdam, launched in 2001. However, no police officer has been nominated for the award since 2002.

The organisation’s action repertoire also includes more militant actions. On 19 September 2002, a group of 50 drug users entered a room where the Lord Mayor was chairing a commission meeting, to protest against the police practice of “hounding junkies”. The MDHG insists there is need for more using rooms. The Lord Mayor was offered a peace pipe. He listened for a full hour, but rejected an invitation to visit the MDHG for a discussion with drug users (MDHG 2003). As the protesters made their way back, the police booked 15 of them for gathering in the street (De Telegraaf, 20 September 2002).

The MDHG came up with an inventive strategy to circumvent the Dike prohibition in 2004 when it established the Association Meeting Point and claimed it was organising outdoor debates under the constitutional right of meeting. By organising large numbers of meetings, the MDHG hopes to reduce the number of fines issued for gathering. During these meetings, participants wear a button which reads: “Do not disturb – meeting going on”.

Other issues addressed by the MDHG concern treatment arrangements, such as methadone programmes and particularly the control practices and subsequently the sanctions imposed through methadone programmes. It also closely monitors the experimental heroin prescription programme. Complaints about the quality of heroin used in the programme concerned its effects on the lungs when smoked. Accustomed to street quality of diluted heroin, drug users were not used to the purity of the prescribed heroin. Another target of criticism has been the Amsterdam policy on using rooms: there are too few of them, they are far too restrictive (users only have access if they are registered) and they are only open during the daytime.

Self-help as Action

Although the organisation has explicitly stated that it is not a self-help organisation, it does engage in activities that are directly aimed at catering for

the needs of its constituency. The best-known among its self-help activities was the world's first needle exchange programme in 1984. The initiative that started out as a protest against the lack of sterile injection equipment eventually became an integral part of regular drug treatment programmes. Other important activities include practical support for members, for example in the form of assistance with correspondence with social service agencies, making and keeping appointments, finding a place to sleep, applying for an ID card or access to legal aid. These activities are carried out in the streets, at drop-in centres, using rooms or at the MDHG offices.

Another self-help activity is the so-called women's afternoon. On Friday afternoons, female drug users can meet female volunteers to talk about their problems, get a massage, a haircut and smoke a little. This activity started in protest of a decision by the municipality to close down a facility for female drug users.

A more challenging activity that has been organised from the very outset is a drop-in consultancy centre, intended primarily as a means for the organisation to keep in touch with its constituency. Drug users can drop in for information, advice, to complain or just to have a cup of coffee or a smoke. Opening hours and days have been changed several times because of complaints by local residents or orders issued by the police. Visitors represent a cross-section of the drug using population in the area (and the prime target group for police anti-nuisance actions). In addition, wherever drug users meet and consume drugs, drug dealers are not far away. Drugs have been used during drop-in hours and tolerated by the staff. In 2004, however, the drop-in centre turned into an unofficial using room with a daily average of 70 visitors. It was intended as an alternative to established using rooms (nine rooms in 2005), most of which are in the centre of the city, where drug users can smoke their heroin and cocaine. These using rooms are run by assistance agencies, who also select and register the visitors (in some cases visitors are also selected by the police), and their main aim is to reduce the amount of nuisance caused to the general public by drug use. Drug dealing on the premises is prohibited, and an experiment with house dealers was ended in October 2004 when the police raided the MDHG premises on suspicion of drug dealing. In the MDHG action plan for 2005, the drop-in centre ("experimental self-management using room") was described as a success on account of its low-threshold character, and plans were announced for its continued operation. However, not all local residents were pleased and opening hours were reduced to three days a week (MDHG 2005). In April 2005, the police raided the drop-in centre once again. After four months of surveillance, the police had collected evidence of drug dealing, and this time the Lord Mayor took the decision to close the premises. After discussions with the municipality, the MDHG was allowed to reopen its offices on condition that the drop-in centre remained closed.

The examples above show how the MDHG uses self-help activities for purposes of achieving various goals. The women's afternoon started in protest against the lack of facilities for female drug users. The self-management using room, launched as an alternative to the municipal policy on using rooms, was more controversial and met with repressive actions. In particular, the house dealer in hard drugs as a way of regulating not only drug use but also the retail trade of drugs, challenged the very core of the national drug policy on hard drugs. Obviously, in this case the limits were stretched too far.

Information Activities

Another important MDHG activity is the provision of information about the organisation's goals and its constituency to the media, the general public and the authorities. Information is also provided on request, for example to the Police Academy in Amsterdam. Furthermore, the MDHG participates in conferences both in the Netherlands and abroad.

One important instrument in this information function is the quarterly magazine *Spuit 11*, which has been published (irregularly) since 1981. It is edited by MDHG staff and volunteers and it has around one thousand subscribers. The title is rather ambiguous and relates to someone who always comes too late, but "Spuit" is also the Dutch word for syringe. Reports about actions by the MDHG and other user organisations are an important topic. Under the heading of "Sounds of the Street" (or Junk mail), drug users report on their encounters with the police or the treatment system, usually in critical terms. Occasionally, *Spuit 11* contains obituaries of drug users who were actively involved in the MDHG.

Another, now defunct way of informing the public about the everyday life of drug users was the open evening, which until 2005 was held every Thursday evening at the MDHG premises. It was open to anyone interested, often with an invited speaker addressing an issue related to drug use. Sometimes local residents were invited to discuss problems allegedly caused by drug users, and how to address these problems.

A standing subject of conversation at these evenings consisted of reports by drug users about their experiences during the last week. This also provided an opportunity for staff to keep themselves informed. A lawyer was also present to provide advice, free of charge, to drug users who needed advice in legal matters. The service ended last year because this voluntary lawyer retired and it was too expensive to hire a replacement. However, the open evenings were not without their problems because they were not intended as a drop-in for using drugs, but for serious discussions, and these two activities did obviously not mix very well (MDHG 2003). The staff placed a message (Sorry, no smoking, just talking) at the front door, and eventually the open evening moved to Wednesdays (Jezek

2000). In 2005, the open evening was discontinued because it placed too heavy a drain on personnel resources.

Another way to highlight the living conditions of the organisation's constituency is through research. One example of the MDHG's research from a user perspective is provided by a study (*Dope and Detention*) on the situation of detained drug users (MDHG 1994). Furthermore, students from De Hogeschool van Amsterdam conducted a study on the subject of coping with bereavement among drug users. The study explores the question as to how far it is possible to mourn while using drugs and looks at the role of treatment in this process (LSD/MDHG 1999). The MDHG was also involved in a study called *Free heroin... Medical prescription from a users' perspective* conducted by the LSD in five cities where 40 drug users were interviewed (by drug users) about their experiences of the heroin prescription programme (LSD 2002).

As mentioned earlier, the MDHG has also played an important role in national initiatives and in establishing contacts between local drug user organisations. One example is the "four cities consultation" in which representatives of user organisations in Amsterdam, Rotterdam, The Hague, and Utrecht meet four times a year to discuss developments in their cities and in national policies – an analogy to the meetings of the Lord Mayors of the 4 G. Here it is interesting to consider the impact of the social context both on framing activities and on the creation of networks through the high population density, which facilitates communication and mobility. The Netherlands is one of the most densely populated countries in the world; by comparison drug users from Stockholm and Malmö in Sweden, for example, would have to travel 600 km to meet each other.

The MDHG also participated in the preparation of the annual International Drug Users' Day, organised by the LSD until 2003 and financed by the Department of Social Affairs. At this meeting drug user organisations from around 20 countries got together to exchange information and experiences.

In summary, the MDHG's action repertoire is multifaceted, ranging from support to drug users in everyday matters through political actions to research. It is also noteworthy that the issues covered and the activities and actions pursued have been remarkably stable over time. Tensions between what the organisation wants to achieve and the conditions embedded in its structure and social, political and cultural context are discussed below.

Dilemmas of Representation

An important issue in terms of representation is whether a user organisation is organised for or by drug users. Some take the view that only users can represent themselves. Others refer to the circumstances in which drug users live their lives,

very much hampering their ability to run a stable organisation. So what kind of organisation does the MDHG actually represent. Kriesi (1996, 154) outlines two ideal types of organisation that are of interest here. First, there is the grassroots model, which is characterised by a relatively loose, informal, and decentralised structure, an emphasis on unruly, radical protest politics, and a reliance on committed adherents. Secondly, there are interest organisations that are characterised by an emphasis on influencing policies (via lobbying, for instance) and a reliance on formal organisation.

The MDHG describes itself as an interest organisation for and by drug users. Even though it has attempted over the years to encourage stronger grassroots participation, its main feature remains that of a formal organisation. The MDHG is open to drug users, ex drug users, their relatives, and all others who share the goals of the organisation. Non-drug using supporting members do not, however, have a vote at the annual meeting (Spuit 11, Winter 1999). As from 1977, the MDHG has been formally organised as an association with a board consisting of five to seven members. The board is elected by the members every three years. It accounts for its work (and that of staff members) in an annual report submitted at the annual meeting, which is also where questions of policy and activities for the next year are decided. The members of the board are elected on the basis of their commitment to the issue and their professional affiliation; they include lawyers, staff members of drug assistance organisations, scholars, but also parents of drug users. To ensure that the organisation's constituency retains a voice, the board always includes at least two drug users. Among the board's several functions, the most important is to guarantee continuity in the organisation.

A common difficulty for user organisations that hope to be an organisation for and by drug users is how to actively involve users in activities within and outside the organisation. Since the use of hard drugs is illegal, users often find themselves preoccupied by obtaining drugs and therefore have no time for organisational work. On the other hand, if and when users do succeed in obtaining drugs, that may also undermine their ability to work for the organisation. Furthermore, drug users occasionally end up in prison or die. These problems also apply in the case of the MDHG. According to the organisation's director, it is very hard to encourage members of the constituency to attend annual meetings, for example, and consequently drug using members usually are in the minority.

The board also has a responsibility as an employer. The working relation between the board and staff members can vary from a rather distant one to a more active interplay. Today, contacts are close and the director and the board meet every other month. Staff and volunteers who have daily contact with the constituency can address issues that are important to them.

Financial Resources

Financial and human resources are important to the development of a social movement organisation and affect its internal structure. The MDHG depends on the municipality for financial resources, which means that it has to give something in exchange, such as services that the regular assistance system cannot adequately provide. As in other countries, the spread of HIV among drug users has dramatically increased the availability of financial resources for HIV prevention activities (Tops 1991). User organisations suddenly became important allies for public health authorities, for example in peer-to-peer campaigns for the prevention of HIV. In other words, the flow of financial resources very much influences the organisation's activities.

Since 1977, the MDHG has been subsidised by the City of Amsterdam, and it is currently subsidised directly by the Office for Social Development (DMO). One of the office's tasks is to assist district councils in developing and executing services in a number of fields, including the care of drug users. To "earn" this subsidy, the MDHG has to advise the DMO on such matters as when a district is planning to open a using room. Another minor source of income is a subsidy from the Amsterdam Patient and Consumer Platform (APCP), which is based on the number of members. In April 2004, the MDHG had 1,200 members, about half of whom were supporting members.⁹ For 2005, the organisation's budget is 150,000 euros: this has to pay the salaries of full-time staff (director, secretary and assistants), the office rent, the magazine *Spuit 11*, etc. In summary, the MDHG is a formal and professionalised organisation that largely works for its grassroots members, i.e. drug users.

The mode of financing can also bring about a certain level of professionalisation, including staff appointments. MDHG staff consists of a co-ordinator, regular staff members and assistants (usually drug users employed with labour market subsidies from the state or municipality for a maximum period of two years). While daily operations are in the hands of the director and secretary, the assistants are busy with activities directly aimed at the constituency, such as running consultancy hours or visiting drug users in using rooms or in the street. For assistants, the job provides an opportunity to stabilise their drug use and social life. Much of the organisation's activities are based on the commitment of volunteers. However, doing voluntary work in a user organisation is no easy task, and requires the ability to communicate with people who are not always organised or prepared to put the interests of the organisation first (LSD 1998).

⁹ Interview with the director of the MDHG.

Co-optation

After 30 years at the same location, the MDHG moved in September 2005 to new premises. The main source for its subsidies, the Office for Social Development (DMO), stressed that the MDHG should find new offices in affiliation to an assistance organisation.¹⁰ The MDHG, however, preferred to remain independent and finally found a new location on the edge of the city centre district, much against the will of the district council and police authorities: they took the view that assistance agencies should move out of the district because they attracted drug users. However the MDHG was allowed to reopen on condition that it organised no using room activities on the premises. Now, the MDHG has consultancy hours on an individual basis from nine to five every day. This enables the organisation to pursue one of its most important tasks, namely to understand the problems encountered by its constituency. Other ways in which this can be achieved is for staff members to visit drug users at using rooms and other locations.

These latest developments highlight some interesting issues. First, they draw attention to the tension between two elements of the organisation, i.e. its ambition to represent the grassroots members who have only limited ability to organise themselves, and on the other hand its role as a formal professional organisation that works for its constituency, the grassroots. Secondly, they highlight the risk of co-optation, with the organisation becoming ever more closely integrated into the official assistance system and in this way making it harder to criticise the system.

In the MDHG's 2002 annual report, the chairman of the board cautioned against excessive involvement in all kinds of consultations with the authorities, because these consultations can also be exploited to legitimise drug policy decisions. The organisation is at risk of getting bogged down in endless meetings, while the constituency is keen to see action (MDHG 2003).

It is possible that the MDHG will slowly, but obviously not unnoticed, become involved in a process of institutionalisation and formalisation in order to ensure its access to a stable flow of resources. This will obviously influence its internal structure and its integration into established systems of interest intermediation. However, the organisation has managed to avoid some of the consequences of such a transformation: for example, it has neither moderated its goals nor conventionalised its repertoire. Furthermore, it has resisted demands by funding bodies to affiliate with assistance agencies. As for its internal structure, the organisation has shown long-standing stability, presumably due to its structure as an association. However, there are also some signs that at the staff level, things are changing. Today, the co-ordinator has the title of "director", and the 2004

¹⁰ Interview with the director of the MDHG.

annual report of 2004 features the terms “managing director” and “finance director” (MDHG 2004) This professional approach is probably also reflected by *Sput 11*, which today is a glossy magazine. Whether this is simply an adjustment to the changing social structure or a fundamental change in the organisation’s internal structure, is as yet unclear.

Future Challenges: Stretching the Limits

User organisations have been a common social phenomenon in many Dutch cities since the 1970s. Although many of them have disappeared over the years, some have shown great strength of survival and maintained their activities. The MDHG provides a good example. One of the reasons for its strength is that the organisation is an association with a board consisting of both non-drug users and drug users, which has provided a stable structure over time. Secondly, the presence of a professional staff also contributes to stability. Thirdly, a steady flow of financial resources is important for any organisation. The MDHG is an organisation for rather than by drug users, and its main task is to promote the interests of drug users in contacts with the policy-making domain, treatment systems and the media. To achieve these goals, the organisation has to be in close contact with its constituency, either through drop-in consultancy hours, open evenings (until 2005), individual contacts in the street, using rooms, or treatment centres.

Looking at the *political context*, it is clear that local authorities are important actors on the Dutch political scene. Dutch drug policy is largely an outcome of local developments, although it is also constrained by international commitments. Dutch user organisations therefore operate mainly on a local level, because it is there they can make a difference for their constituencies – and hope that their actions can make a difference at the national level as well. The emphasis on local activities can be explained by the historical social context. In the process of state making and in drug policy issues, the largest cities in the Netherlands (the 4 G) have played a dominant role since the 1960s (Tops 2001).

However, as the MDHG itself has found out, it is very hard to gain access to decision-making processes. The MDHG still has no part in commissions that are involved in activities directly aimed at drug users. However, the MDHG can influence the local policy-making domain through its official mission at the Office for Social Development (DMO), namely by putting forward the voice of drug users. Another avenue of influence is through participation in client councils, but here again there is the question as to who represents whom. Even if drug users have a representation in client councils, the difficulty remains as to how to keep in touch with the constituency they represent. A third way of gaining access to decision-making fora is through the professional networks of

board members. A fourth, indirect way is by seeking to persuade politicians through the media. It is of course hard to assess the true influence that the MDHG has on the policy-making process. However, the frequent appearance of the organisation in the media suggests that the MDHG is at least thought to speak on behalf of drug users.

Another intriguing question concerns the rationale behind the municipality's decision to subsidise an organisation that over the years has been one of the fiercest opponents of the City's drug policy, particularly its "hounding junkies" policy. The same applies, until recently, to the national government. There are several possible answers to that question. Firstly, as pointed out by the MDHG chairman, (limited) involvement by the organisation in the local drug policy domain can be exploited to legitimise policy decisions. Secondly, the MDHG performs functions that are not possible for the established assistance system. A third possible explanation relates to the structure of the treatment and assistance system in the Dutch social/cultural context. For historical reasons, the bulk of social and health services are organised and executed by non-governmental organisations, which means that national and local authorities depend heavily on these organisations in pursuing a policy. Consequently, this institution with long roots in the past opens up opportunities for new actors in this sector.

There is yet another salient feature of the Dutch *cultural context* that should be mentioned here. Dutch society is often described as a "consultation nation" where special value is attached to the achievement of consensus between conflicting parties (Andeweg & Irwin 1993; Lendering 2005). The Dutch even have a special word for this that goes back several centuries: "*polderen*" means that relations between central government and the cities, between the cities and their citizens, between employers and trade unions, etc., are dealt with in deliberations between the two parties. This time consuming procedure, which may involve an indefinite number of meetings, might be considered a rather ineffective way of decision-making, but it has in fact proved to be quite effective in reaching consensus. This might explain why the policy-making domain refuses to neglect the socially and politically marginalised minority of problem drug users, but on the contrary finances and consults their organisations. Obviously, the City of Amsterdam seems to be of the opinion that the organisation holds an important intermediary position between drug users and the drug policy domain and the treatment system. Otherwise, it would be hard to understand why it has subsidised the organisation for over 25 years.

One aspect of the *social context* is represented by national and local drug policies. The harm reduction approach adopted in the Netherlands is described as relatively successful when compared to other European countries (VWS 2003).

In 2003, the number of problem hard drug users in Amsterdam was estimated at 4,530 (Trimbos 2004); some 1,000 of them are categorised as extremely

problematic (Amsterdam 2005). The average age of methadone clients in Amsterdam in 2003 was 44 years (32 in 1989), 51 years among drug users born in the Netherlands and 42 years among those born abroad (Trimbos 2004). The mortality rate among problem drug users is relatively low, and consequently a considerable number of drug users are still alive and constitute a residual group of the drug using population. This group consists of people who are homeless, who suffer from psychiatric problems, are in a poor physical condition and use drugs – indeed a very vulnerable group with which neither the drug treatment system nor the police seem to be able to cope. It is clear from this that there is a need for alternative activities such as those carried out by the MDHG and that partly form the organisation's *raison d'être*.

Another relevant social aspect is that many drug user activists belonged to the generation that grew up during the 1960 and 1970s. Most of these first generation activists are now dead or have left the drug scene, a fact that may emphasise the need for a formal user organisation. If the MDHG had been solely an organisation by drug users, it is hard to imagine it would have celebrated its 25-year jubilee.

The MDHG has survived as a social movement organisation without changing its goals and even without making many changes to its means of action. However, it is possible that structural changes in its external environment are forcing changes in its internal structure as well. For example, there is the legal obligation since 1996 for all institutions that provide care or treatment to establish a client council or to have client representatives on their board. This regulation might have the effect of formalising and canalising user influence. The requirement introduced in 1999 that all members be registered in order that the organisation qualifies for subsidy, or the professionalisation of the organisation's management, may also contribute to formalisation. This process also includes the creation of a formal leadership and office structure, leading to professionalisation with a management of directors and paid staff members. However, the staff by means of actions like the self-management using room and conflicts with its financiers, has demonstrated that the process of professionalisation does not necessarily impair the action repertoire.

As regards external structures, the organisation depends on two main sources of income, one of which is also a target for its actions. This puts the organisation in a classic dilemma, that of co-optation. The creation of client councils not only opens up opportunities to influence treatment practices, but may also lead to co-optation. This is something the organisation clearly is conscious of, but which is hard to escape from. Participation in all kinds of councils and working groups can be a double-edged sword. It can provide an opportunity to exert influence and promote the interests of the constituency, but on the other hand the organisation may also be inundated by the flood of meetings and deliberations. It can also make it difficult to take direct action, such as obstructing the police or

occupying offices of treatment organisations. In this situation, the organisation has to decide to take part in legal/illegal actions. In the case of the consultancy drop-in centre that turned into a using room, the MDHG obviously crossed the line and the centre was closed down. At this point, the organisation has to maintain a balance between being both a grassroots organisation and an interest group. The tension between being an interest group and providing assistance to members is also a delicate one because assistance activities such as a large scale drop-in centre takes up a lot of resources at the expense of the interest promotion side.

If the organisation is forced by its political and social context into one type of movement organisation, then it has to decide which direction to take. If it chooses to become a pure formal interest group, then it may risk losing contact with its constituency. However, if it chooses to become a pure grassroots organisation, then it risks losing its financial resources and influence in the policy making process. A delicate balancing act indeed.

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