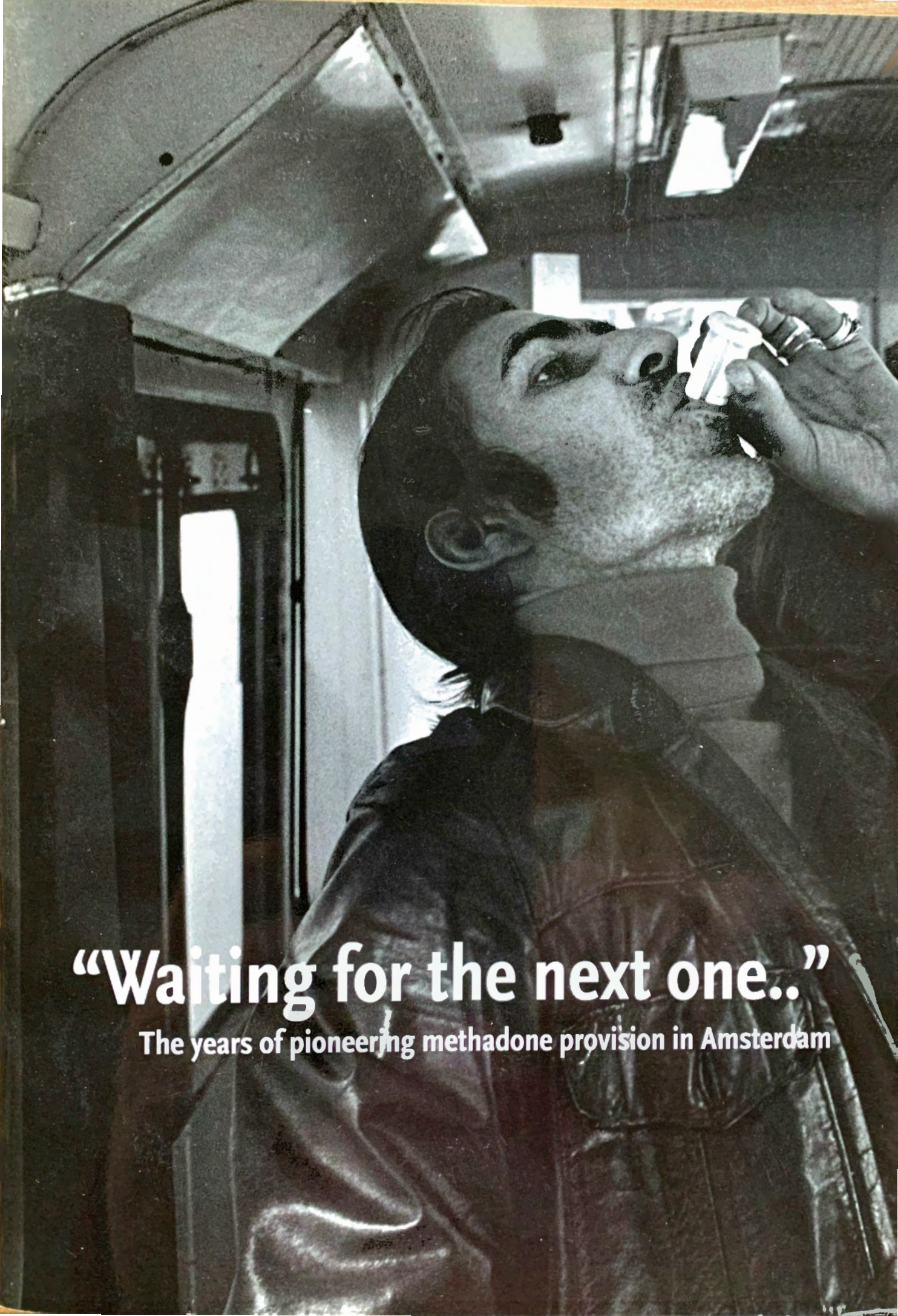


"Waiting for the next one.."

The years of pioneering methadone provision in Amsterdam

"Waiting for the next one.."

The years of pioneering methadone provision in Amsterdam (1975-1985)

The 8th of June 1979. The first day the methadone bus was due to start operations in Amsterdam there was no bus. The Public Health Service of Amsterdam (PSHA) had bought a bus from the City Transport Service for one symbolic guilder (Dutch currency at the time equivalent to around € 0.45), but it first required a thorough makeover. A waiting room for clients, a front desk for nurses, and a heater had to be installed. While they waited, the PHSA provided methadone to clients using a Citroen DS, owned by drug team doctor Gerrit van Santen. They started by collecting cups of fluid methadone at the Slotervaart Hospital, after which the Citroen DS was parked behind Central Station with staff waiting for their first client in great anticipation. All employees from that time remember him: a somewhat older man who used drugs and had formerly been a teacher in Suriname. He had apparently been sent on reconnaissance and was the only client on this first day. According to psychologist Ernst Buning, the methadone bus coordinator, the rumour among people who use hard drugs (PWUD - defined as regular injecting and non-injecting use) at the time was that if you went to the methadone bus, the dealers would punish you by never selling heroin to you again, because they saw the methadone bus as competition.

This wasn't an illogical idea. The first methadone bus in the capital was a response on the part of the City Council and PHSA to an urgent public order issue: a large 'roaming group' of people who regularly used heroin had based themselves around the squat 'De Doelen' on the Kloveniersburgwal. Hundreds of PWUD – estimates vary from six to twelve hundred people, mainly of Surinamese and Antillean descent – came there to buy drugs on a daily basis.[1] People living in the neighbourhood complained of noise, urination, and comatose PWUD found in toilets of local cafes. There was also a lot of related crime in the surrounding neighbourhood: breaking into cars, shop theft, stabbings, street robberies, etc. By offering free methadone, a synthetic opiate, the hope was that these PWUD would have an alternative to heroin, which could pave the way towards getting them into care.

Coordinating methadone provision became a new important task for the Mental Hygiene Department of the PHSA. Over the course of the eighties, Amsterdam started offering low-threshold access to methadone on a wide scale through methadone buses, neighbourhood health posts, and general practitioners (GPs). The PHSA was in charge of its coordination. Methadone provision was at the hart of the City's new harm-reduction policy.

The primary goal was not to stop drug use. The aim was to get into contact with PWUD to inform and support them to avoid further physical or social deterioration. According to the Amsterdam Alderperson for Public Health in 1997, the policy was a great success: "Conditions in the Netherlands and Amsterdam are positive in comparison to other countries." Our country even had an "absolute top position" regarding provision of medical treatment for PWUD.[2]

Low-threshold methadone treatment did not originate as a health measure. It was brought to life by the City Council in the context of 'disaster relief'. The first methadone bus started operations in a pressured environment with urgent public order issues, as part of a wide-ranging scheme to confront the crisis surrounding Surinamese PWUD. Large-scale provision of opioid substitution therapy in Amsterdam was not at the forefront of their minds at the time. The first methadone bus actually had quite a strong 'recovery mentality'. Alderperson for Public Health, Irene Vorrink (PvdA - a Dutch left-wing labour political party), told the City Council in 1979 that the methadone bus was a recovery-focused type of assistance.

The text below describes the origins of methadone treatment: the explosion of heroin use in Amsterdam after 1972, and the disquiet surrounding Surinamese PWUD. In the early seventies only a few hundred young people used opium or heroin, but by 1980 experts estimate the amount of youth using heroin in the city was around ten thousand. Around two thousand of these were of Surinamese descent.

Following this, the mode of operations on the first methadone bus is highlighted, based on a representative sample of 36 case files belonging to the first round of clients for the period 1979-1981. Next, the elevation of methadone treatment to a large-scale City Council policy is discussed. The piece ends with a moral evaluation of methadone maintenance treatment. Is it a measure to keep ill-adjusted citizens in check, or are PWUD actually being spoiled with free drugs?

Kids with spoons and lighters

In 1972, the PHSA's Annual Report mentioned field officers charged with tracking down PWUD. Ten thousand youth, mainly from Germany, the USA, France, Italy, and the United Kingdom, came here to enjoy the easily accessible hash and weed, and enjoy modern entertainment at the 'consciousness-, being-, and meditation centre' Fantasio and pop temples Paradiso and Melkweg. The youth hostels were full and many hippies laid their sleeping bags on the Dam Square.

'Real hippies' and 'holiday hippies' in the Vondelpark, 1971

After the City Council banned sleeping on the Dam in 1971, they moved to the Vondelpark, the largest city park in Amsterdam. To avoid disturbances, Amsterdam provided a luggage depot, bathing facilities, toilets, maintenance, and cleaning facilities. Field officers shared information about the city and responsible drug use. PHSA nurses went to the youth with kilos of aspirin, lice water, cough syrup, vitamin tablets, plasters, and bandages.

Based on a questionnaire conducted among 708 young tourists in the Vondelpark in 1972, Criminologist Ed. Leuw determined that eighty percent of them used drugs. Around fifty percent stuck to cannabis only, while thirty percent also took other substances, mainly LSD. A ten percent minority in the Vondelpark used drugs like amphetamines, opium, and heroin.[3] The latter had been introduced into the scene that year for an affordable price of 25 Dutch guilders per gram (equivalent to around € 11).[4] People in Amsterdam were barely familiar with this substance, which had been brought to market as a coughing and bronchitis remedy in 1898. Early in the twentieth century, heroin was declared illegal in many western countries, including the Netherlands with the Opium Law of 1919.

Heroin is made of morphine, which in turn is made of opium, a substance originating from the poppy. Opiates are known for their pain-relieving and numbing effects. A shot of heroin results in a few seconds of deep pleasure (the 'flash'), followed by a four to six hour high. The person using the drug experiences an intense state of euphoria: pain, sadness, hunger, fear, or cold disappear.

Giel van Brussel, who was a doctor in training at the time and had a side job for the Vondelpark project, witnessed the arrival of this new drug up close.

> It was distributed by American Vietnam veterans and deserters, and was very cheap. There was an information booth under a bridge in the Vondelpark where kids were messing about with spoons and lighters. They had to be sent away. In retrospect that was the start of the heroin era.[5]

In the summer of 1974, the health professionals in the Vondelpark realised there was a serious problem. Every day more PWUD showed up and heroin was still relatively cheap, around fifty Dutch guilders per gram (equivalent to around € 23). For people seriously addicted to heroin this can last a day, for people using a moderate amount or just starting to use it's enough for a few days. Staff from Stichting De Laurier, an alternative support organisation that took in 'strung-out' LSD users, observed what was happening on the spot:

> Especially young kids were in danger of being sought out by drug pushers; this was especially the case for the often very young runaways. It wasn't always a matter of 'pushing'. In reality, all acquaintances of those injecting drugs were in danger: in a group like that there was a large temptation to try heroin. Often it was just a matter of: nowhere to stay, go along with a new acquaintance, his friends come over and have a shot, they don't look ill or emaciated. The new kid hears everyone is doing fine and also, cautiously or not, takes a shot.[6]

Health professionals warned about this relatively unknown drug by emphasising that you get addicted to heroin faster than you think. Whoever uses the substance daily for three weeks already suffers withdrawal symptoms when trying to stop. But the youth didn't believe them. "That's what they used to say about hash too", was the counter argument. The field officers felt like they were lagging behind. By the end of the summer of 1974, they personally distributed a flyer about heroin in seven languages to all those sleeping in the Vondelpark, but it was too late. Heroin use was spreading. In part because of this, the Vondelpark project was brought to a close.

In the Vondelpark, Leuw differentiated between the 'holiday hippies', who only joined the hippie culture during the holidays; the real hippies, for whom the subculture was a lifestyle; and the 'dropouts', who did not belong to society or the hippie subculture. According to Van Brussel, the problematic PWUD on heroin were mainly in the latter subgroup. Van Brussel: "Mentally disturbed people feel at home in a situation where everyone deviates from the norm, because they cease to be different. When everyone is strange, you are no longer strange." For some young people, heroin may have had a self-medicating effect, because it suppresses psychotic symptoms.

When the Vondelpark project stopped and the hippie culture in Amsterdam had passed its peak, Van Brussel said that for the PWUD on heroin it felt "like the draining of a warm bath, and being left sitting there in the cold." After 1974, the City Council subsidised a low-threshold care facility on the Spuistraat in the city centre for the leftover PWUD from the hippie culture's heyday: The Housing- and Welfare Room (In Dutch called the 'Huis- en Uitkeringenkamer' or HUK). A place to take drugs undisturbed, shower, and get a meal. Medical and psychosocial support was also made available.

Detox at the police station

Meanwhile, the PHSA psychiatrists who rode the bus got increasingly occupied working with youth using hard drugs. Their number increased at a "terrifying rate"[7] in the mid-seventies, while the price of heroin increased. The price of a gram of heroin had increased to three hundred Dutch guilders by 1977 (equivalent to around € 136).[8] PWUD were forced to deal, steal, or engage in sex work to provide for their needs. "The amount of consults at the police station related to arrested persons addicted to drugs with possible withdrawal symptoms increased", according to the 1973 Annual Report.[9] Sometimes a quarter of police cells were filled with PWUD.[10] The Mental Hygiene Department spent a lot of time on this group and decided to adopt a targeted approach. From April 1977, the police could have incarcerated PWUD visited twice a day by doctors of the recently created PHSA 'drug team'. The incarcerated PWUD had to detox relatively quickly before being released, sent back to their country of origin, or sent on to prison.

Initially the PWUD detoxed using small doses of methadone, sometimes supplemented with librium and sleeping tablets. Giel van Brussel started working at the PHSA as a doctor to engage specifically with PWUD at the police stations. He remembers having to "defend every methadone tablet 'unto death'".

"They thought I was crazy. You don't give alcoholics gin do you?"[11] The detainees were often in bad health. The "masking effect of the opiates was most certainly partly the cause of frequently observed extensive self-neglect", according to Van Brussel. The PHSA doctors were busy: in 1979 they saw 2,327 clients, who generated a total of 13,643 doctors visits. They were mainly men (83 percent) of around 25 years old. At least one third were Dutch (38 percent), as well as groups of Germans, French, Italians, and smaller amounts of Greeks, Spaniards, and North Africans.

One remarkably large group was the Surinamese using heroin (18 percent). Around the time of Surinamese independence in 1975, tens of thousands of Surinamese came to the Netherlands. This peaked in 1975, when almost 40,000 Surinamese departed for the Netherlands. In 1979 and 1980 at least 18,000 people per year were still coming into the country from Suriname.[12] Our country wasn't prepared for the influx of migrants. Support and housing were in short supply; many Surinamese lived in dilapidated hostels or with family. They had a hard time entering the workforce. Sometimes they discovered heroin through friends, who usually inhaled it by 'chasing the dragon': put the drug on some tin foil, hold a lighter beneath it, and inhale the rising vapours through a small funnel.

A drug supermarket

The Amsterdam police received a lot of criticism from people living in the city centre, who blamed the city government for too accommodating a stance towards PWUD and held them responsible for the drastic increase in crime (shop theft and robberies) and the deterioration of their living environment (among others due to sex work by PWUD). The police decided to take a tougher approach. In 1978 some tolerated drug-using spaces ('heroin cafes') on the Zeedijk were closed because of suspected dealing. Hounded Surinamese moved into the SOSA building on the Herengracht 519, a tolerated squat where Surinamese welfare organisations arranged support. This soon became a place for large-scale dealing. The neighbourhood experienced a lot of disturbance and the building also attracted foreign PWUD.[13] According to Mayor Wim Polak, having a kind of 'drug supermarket' in the inner city was an untenable situation.

In the bitterly cold winter of 1979, the riot police emptied the building. The evangelical Christian foundation, De Regenboog, took charge of providing assistance for the inhabitants, in cooperation with a few Surinamese welfare organisations, united in the so-called Steering Committee 9-2-9. Reverend Wouters of De Regenboog knew of an empty building on the Kloveniersburgwal, close to De Regenboog offices: the building, De Doelen, had been a cultural centre left empty after a fire.

Reverend Wouters helps the roaming group squat De Doelen, 1979

Interior of squat De Doelen

He helped the roaming group squat this building. In an impressive and media-genic tableau the Reverend led the group of Surinamese to De Doelen through the snow.

The City Council tolerated the squat after the Steering Committee promised to keep the situation under control, with a strict admittance policy and registration of visitors. Soon the situation in De Doelen turned out to be just as bad as in the SOSA building. Invited by the Steering Committee, Van Brussel held consulting hours there a few times a week:

> When you entered, you saw a big black hole with three light bulbs, pulled from the Regenboog office. All those Surinamese were sitting there, a mass of people, and there were tables with knives, guns, and dope. Around a thousand people passed by on a daily basis.

Van Brussel saw many horrific cases. People suffered from neglected lung diseases, hepatitis B, and various sexually transmitted infections.[14] A major apparent need during the consulting hours was methadone.[15]

There was a months-long impasse surrounding the situation at De Doelen. It was clear to

everyone this building also had to be cleared, because the dealers were essentially in charge. At the same time it became clear that something had to be arranged for the PWUD who came there daily before it could be cleared, or the problem would simply move elsewhere. In the spring of 1979 heated discussions took place in Amsterdam's City Council. All parties were united in their criticism of the Mayor and Alderpersons, who had demonstrated too little vision regarding drug policy, had been too hesitant in their response to the roaming group, and had left the solution to private initiatives. On the 7th of March, the Mayor and Alderpersons presented a plan of approach.

Culturally uprooted

An important point of focus was strengthening the provision of assistance through subsidising withdrawal programmes for Surinamese. But what could be done about those unmotivated to quit drugs, or who could not yet go to a clinic? The City Council advocated for the setting up of sleeping facilities and daycentres based on a 'spreading-out' or distribution policy. The aim was to create small-scale services throughout the city. The City Council decidedly did not want large centres like De Doelen or SOSA, as such large-scale ways of working would benefit the drug trade by having a lot of people congregated in one location.[16]

In addition, they also advocated for the low-threshold provision of opioid substitution therapy, so long-term PWUD could receive methadone (or even heroin) under medical supervision. The council emphasised that the need to provide this kind of service would be decided on a case-by-case basis by a doctor. "No one is in favour of providing drugs on a large scale", stated the responsible Alderman Irene Vorrink.[17] The Council was unanimous that recovery had to remain central in the provision of assistance. Thus, Ms. Agtsteribbe of the PSP (a Dutch left-wing pacifist political party) said, "people must be motivated to detox voluntarily".[18] Ms. Aerts – de Vries of the CDA (a Dutch right-wing conservative political party) was a great proponent of the "Stichting Srefidensie method, that is to detox without opioid substitution". Her party was of the opinion that provision of opioid substitution therapy should only take place on the basis of reducing doses.[19]

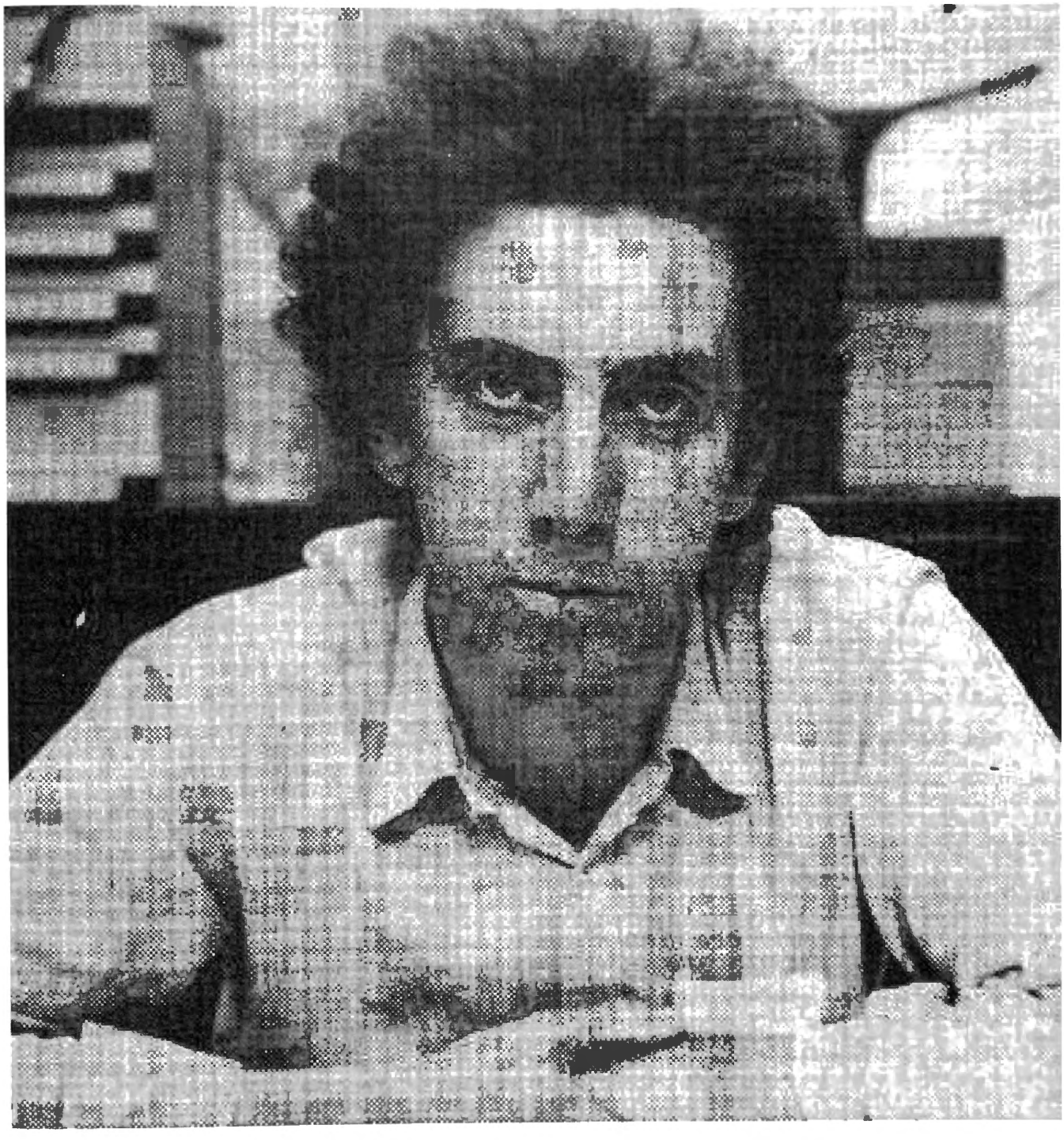
Srefidensie's vision was to have PWUD detox and then migrate back to Suriname. According to them that was what many Surinamese PWUD wanted. They did not feel at home in the Netherlands. Because, as Srefidensie workers wrote bitterly, in the Netherlands Surinamese face "large-scale discrimination".[20] Indeed, negative feelings toward these new compatriots were widespread at the time. According to a population survey, around forty percent of respondents were against the presence of Moluccans, Moroccans, Turks, and Surinamese in the Netherlands. One in three Dutch people thought of 'foreigners' as the greatest societal problem at the time.[21]

Surinamese protesting at Amsterdam City Hall, 1979

Among the Amsterdam City Council there was actually a lot of understanding and sympathy for Surinamese PWUD. Party chairman Jo Horn of the PvdA (a Dutch left-wing labour political party) pointed to a vicious cycle of 'discrimination – segregation – discrimination' faced by the roaming group: "Ascribing low value to a person or people leads to social exclusion; social exclusion leads to social deprivation; which in turn leads to an even more negative valuation."[22] His colleague, Ms. Hoogkamp-Kok (CPN – a Dutch left-wing communist political party) saw the Surinamese PWUD as victims as they had been "culturally uprooted". According to her, dealers actively sought out these kinds of vulnerable groups.[23] Only the VVD (a Dutch right-wing conservative-liberal political party) suggested that forced withdrawal was a possibility, but found little support. Alderperson Vorrink thought there was little point in "having someone who isn't motivated join a withdrawal-programme".[24] No one supported the VVD view on the City Council.

"Waiting for the next one.." Gemma Blok

The authoritative current affairs programme Brandpunt had just broadcast a documentary about forced drug withdrawal in Singapore and Hong Kong. PWUD were isolated in camps and on islands, where with shaved heads they had to do forced labour.[25] Ghastly, said the horrified City Council members. PWUD were people going through a pool of misery. It was their decision when and whether they wanted to rid themselves of their addiction, whether or not encouraged by various support services.[26] For many Dutch in the seventies and eighties, the idea of forced detox evoked associations with authoritarian states.



Giel van Brussel in De Waarheid, 1984

PHSA doctor Van Brussel, for example, spoke with disapproval of West Germany and Sweden, where there was close cooperation between addiction-care and the justice department. "In these countries the problem is tackled in a totalitarian, I would almost say fascist, way", he argued in the communist newspaper *De Waarheid*.[27]

In short: a tough approach of the roaming group was not an option for the majority of Amsterdam city politicians. Large-scale care facilities weren't either. So the Mayor and Alderpersons put the inhabitants of the capital to the test: the PWUD were spread across the neighbourhoods, where they would be cared for in 'café-style spaces'. Dealing would not be permitted, but the Surinamese PWUD could use drugs and spend their days here. The questions would now be answered as to whether "Amsterdam is the tolerant city it professes to be", said PvdA-Council member Horn.[28]

A name that stank like a rotten fish

Next, responsibility for the methadone bus project had to be assigned. In some ways, Jellinek was the obvious choice. It was the oldest addiction-care facility in the capital, having been involved in treating alcoholism since 1909. Since the fifties, Jellinek also started caring for PWUD. In addition, it had been offering methadone in its outpatient treatment of people who injected opium since 1969.[29] However, over the years, with the explosion of the heroin epidemic, Jellinek rules regarding methadone treatment had become stricter. Whoever wanted to enter the methadone programme, had to promise to turn up on time to drink their methadone, hand in a urine sample, and take part in group therapy. Heroin withdrawal had to be completed within six to eight weeks. In that time, clients had to change their lifestyle and build up a 'meaningful daily routine'. The Jellinek methadone programme was very selective: in 1978, for example, 472 PWUD signed up, but only 134 were accepted.[30] This was, moreover, the approach favoured nationally. The Health Council of the Netherlands turned down provision of methadone that "merely satisfies needs" on principle.

As such, Jellinek was not interested in coordinating the methadone bus. Jellinek director, Dees Postma, did not think his institution should become a drug dealer on behalf of the state.[31] Methadone treatment had to stay as high-threshold as possible. This view was criticised from many sides. Members of Parliament asked questions about the so-called 'hold on patients' Jellinek had instituted. Giel van Brussel remembers well how unpopular Jellinek was from the conversations he had with PWUD at the police station.

> I have never seen an institution have such a bad name with its own target group. 'The road to happiness via the gutter', was what they'd say. The PWUD descended into the gutter en masse and Jellinek's name among them evoked the stink of a rotten fish.

Ernst Buning called Jellinek's treatment offer "quite quixotic". There did not seem to be any realisation of the explosive growth in heroin use at the time.[32]

Neurologist Wijnand Mulder, then head of the Mental Hygiene Department at the PHSA and head of the drug team, was willing to take charge of the methadone bus. He saw it as the City Council's responsibility to do something about the growing hard drug problem in the centre of Amsterdam. According to Buning, Mulder said to his staff: "We as the PHSA are responsible for safeguarding public life." The fact that Mulder was willing to provide methadone also had to do with his view on drug use. Mulder saw addiction as a life phase issue. In his book Addiction, drug use among youth (1969), Mulder described the young PWUD he met as consulting psychiatrist at Jellinek, as "artistically and academically gifted persons" who were restricted by "lightly neurotic inhibitions". The youth were anxious and confused, especially in the post-war years where Weltschmerz (a sense of world-weariness coming from the German Welt 'world' and Schmerz 'pain') was unusually high due to the aftermath of the Second World War, said Mulder. They numbed feelings of fear and insecurity with drugs.[33]

According to Mulder, research showed that sooner or later forty percent of PWUD healed spontaneously. Health services were tasked with ensuring these people got through their phase of intense drug use with as minimal damage as possible to themselves or others. The Drug Department's 1983 Annual Report includes this basic assumption: hard drug use was "merely a phase in someone's life".[34] Buning thought this was a convincing "professional formulation" regarding the use of methadone provision:

The idea was: Ok, we have people here who are dumb enough to use drugs, but that can't be a death sentence for them. So we will help them through this phase. Ensure they don't get infected with scary diseases, are not malnourished, can keep their housing and don't end up on the street. Then at a certain point they will – hopefully – come to the conclusion that: this is terrible, this life as an addict.

Mulder also thought methadone provision was a good fit for the PHSA's "epidemiological attitude". He thought the fast increase in heroin usage was an epidemic and a disease of which you had to prevent further spread. All in all, Mulder was the right man to take charge of this important new step of setting up a low-threshold system of methadone provision.

Send them all back to Suriname

For Alderperson Vorrink, idealistic motives were also involved. She wanted to counteract stigmatisation and rejection of PWUD.[35] But the tolerance she hoped for did not come. Vorrink and Mayor Polak went into the neighbourhoods with PHSA workers to announce and defend the new policy. Van Brussel was present at some of these informational meetings.

> We were heavily criticised in those neighbourhoods. You'd be sitting at a table with a spokesperson, Vorrink, a few police officers to keep order, and the people did not like her plans. In Amsterdam South it got completely out of hand, there was a real 'lynching atmosphere'. Vorrink had to be taken away in a service vehicle, lying down between front- and backseat covered by a raincoat. It was quite a spectacle.

Polak responded to the popular anger with horror. He heard pronouncements like: "Send them all back to Suriname", or: "Put them in a work camp in the new polders (spaces of reclaimed land)". These kinds of things were said by "primitive souls", stated Polak. "Thankfully we don't live in a dictatorship" here in the Netherlands. People can't "simply be deported for being addicted".[36] For Vorrink the meetings were "a martyrdom", according to De Telegraaf newspaper.

She was obviously not popular in Amsterdam. As Minister for Health she had been partly responsible for the change in the Opium Law in 1976, which declared cannabis products as 'soft drugs'. Her son Koos Zwart, a classic hippie with long black hair, denim suit and cowboy hat, was a Dutch celebrity at the time. He read out 'stock exchange news messages' with weekly prices for hash and weed. And now this grand lady of the left was sinking due to the hard drug issue, wrote De Telegraaf with barely veiled Schadenfreude. "What are you wining about woman? The fact that your son is addicted is not our problem. Get out of here" was the message she heard from Amsterdammers.[37]

Other pronouncements were blatantly threatening, like a young woman who yelled through a café space: "This is going on fire and I will keep going till the last stone has fallen."[38]

Alderperson Irene Vorrink defends the Amsterdam drug policy, 1979

This met with loud applause in the room. Vorrink left her position as alderperson due to health reasons in August 1979. Her successor, Wim Polak Emzn continued to carry out the City Council policy. In addition to a large subsidy of over three and a half million Dutch guilders (equivalent to around 1.6 million euro) for Srefidensie in 1979 and double that in 1980 for setting up recovery farms, fieldwork, day facilities, aftercare, and education,[39] six café-style spaces were set up in the neighbourhoods. A methadone bus started doing the rounds, specifically targeting Surinamese and Antillean PWUD.[40]

A serious attempt to detox

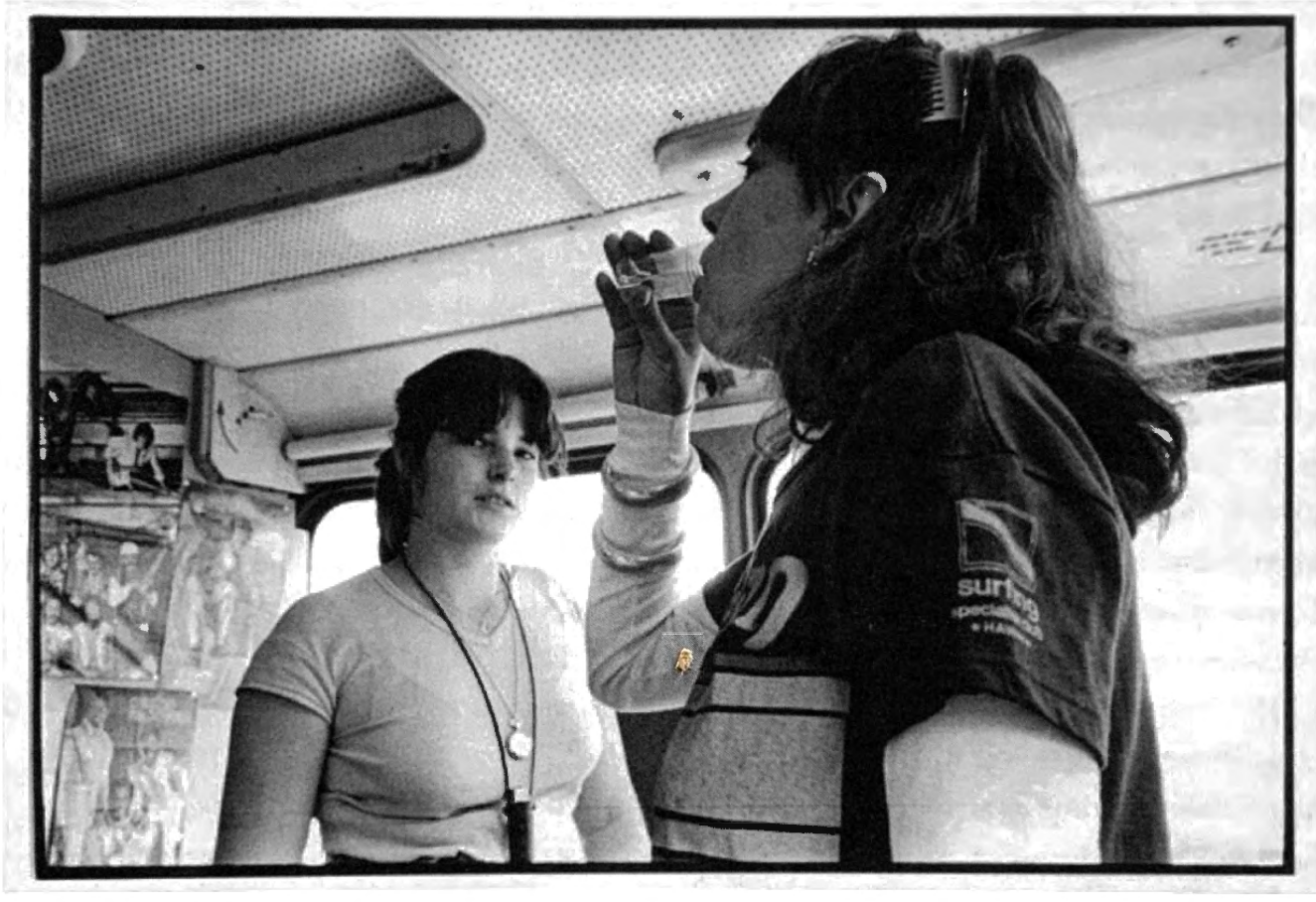
PWUD in Amsterdam could visit the methadone bus starting Friday 8 June 1979, just eleven days before the closure of De Doelen, which went smoothly. The bus project was developed by the PHSA in cooperation with the foundations: Streetcornerwork, De Regenboog, Srefidensie, Kontaktsentra (of the HUK), and the Jellinek Centre drug team. This was the start of a coordinating role on the part of the PHSA for methadone provision in the capital. Amsterdam was incidentally not the first to have a bus: both Rotterdam and The Hague had had methadone buses since 1978.

The methadone bus at the Moses and Aaron Church, 1981

The bus went to several locations in Amsterdam on a daily basis: Central Station, Amstel Station, and Marnixstraat. Later other locations were added and changed over the years. The idea of mobile provision was to prevent any disturbances around the bus, leading to irritation and possible aggression by local inhabitants. At the end of October 1979, 352 clients had been to the bus, mainly men (261).[41] By the start of June 1981, over 1,200 intakes had been completed.[42] Clients were told about the existence of the bus if they ended up at the police station for a drug-related incident, or when taken into hospital for physical ailments or an overdose. The PHSA also tried to support PWUD there and tell them about the bus. Whoever came to the bus was given a temporary dose of methadone, but had to complete an intake within three days. A nurse did the intakes and a doctor examined clients for sexually transmitted diseases, hepatitis, and their level of drug use. After that the dosage was determined. Sometimes syringe abscesses and skin diseases had to be treated, and occasionally clients were psychotic. A consulting psychiatrist was connected to the bus, and some client files say they received Haldol (anti-psychotics). Women were given birth control; pregnant women could receive support in having an abortion.

The majority was of Surinamese descent, besides a few Antillean and Moluccans. Most were between twenty and thirty years old. They also had 21 Dutch women registered as visiting the bus, married or living with a non-Dutch PWUD. They also had access to the programme.

A special group were the female sex workers who used drugs. They were treated with methadone by request from the PHSA's STI clinic. Buning thought they also deserved a spot on the bus, "seeing as both the physical and psychological state of sex workers is often dismal en they generally are in a 'double bind', with heroin and their pimp". [43]



A female PWUD sex worker drinking methadone on the bus

Of note is that even though methadone provision was low-threshold, there was a fairly recovery-focused attitude on the bus. That was also the City Council's wish. On 20 June 1979, Irene Vorrink was questioned by the City Council about the methadone provision on the bus. Was this maintenance or recovery? According to Vorrink "currently only withdrawal doses of methadone are being [...] provided."[44] In practice, just like at the Jellinek, clients could come to the bus either for a detoxification programme (a schedule of reducing doses) or a "slow detoxification programme or maintenance programme". At the end of August, 75 clients were in a detoxification programme, five clients had become clean. [45]

First drink, then hustle

During the intake, clients were asked about their desire to detox. The majority wanted to get off of heroin. They hated the "daily grind of having to find heroin", or they wanted to "live a normal life". One man said he wanted to stop because he had started "swindling a good friend". Another had had enough of all the problems with the law. Of course there is a chance clients answered in a way they thought was desirable. However, their files indicate they had often attempted to quit heroin several times. Some tried at home, 'cold turkey' or with the aid of methadone bought on the black market. Others had been to a recovery farm in France or tried to get clean in a monastery.[46]

Some nurses on the bus encouraged clients to stop doing drugs. The PHSA partly recruited nursing staff from the Surinamese community, thinking they would have a better connection with the target group. They had trained as A-nurses and often had no experience working with PWUD. Marlène McDonald was one of them. "The clients had a hard time with me", according to McDonald, "because I wanted them to stop doing drugs. 'Oh no, is she on the bus again today!', they would say to each other. 'I'll come back when she's not here!' (she laughs)". The compassion McDonald felt for her countrymen on drugs was soon paired with frustration. She often found them rude. McDonald:

> The way they spoke to the white people, the doctors. I would say to them in Surinamese: "You are bringing shame on me. I can't keep working here if you act this way". Then they would be meek. Sorry, sorry, they would say. Because you said it in their own language. They still had respect for that.

McDonald didn't see addiction as a disease, she says looking back:

> You have nothing, you start using, and then you can't do without. That isn't a disease. When you have AIDS you are sick. No, you can't come tell me it's a disease. They want things and then go do them. Lust. That is more what it is.

According to Buning and Van Brussel the desire to detox mainly came from the clients. The doctors found it a complicating factor about working on the bus. "The consequence of a low-threshold methadone programme is, after all, accepting heroin use in addition to the methadone dosage", they wrote in a note.

"However, it appeared that many clients were making serious attempts to detox with the help of methadone". The mix of clients that kept using heroin in addition to methadone, and those wanting to become clean, was an "issue that was hard to deal with".

Around a hundred people came to collect their drink on a daily basis, but they didn't all come to the bus regularly. Some came a few times, only to disappear from view. Others only came during difficult periods. A large portion visited the bus when they didn't have the means to buy heroin.[47] McDonald: "When they didn't have energy to hustle they came and drank methadone with us. Then they'd go back to hustling."

Methadone as bread, crack as spread

Possibly, then, this first methadone bus attracted users for whom a 'normal' life was somewhat in sight, the files from the random sample examined for this piece suggest.[48] For example, clients who had children or a non-using partner, who had their own home, and who hoped there was a way out of addiction. For most of the clients their lives had not completely gone off the rails. They lived with their spouse or partner, with or without children. For other clients their lives were in the late stages of disarray; they had lost their homes or had never had their own place to live. Some lived with family or acquaintances. One client lived with another user in a "disgusting shack", another in a home where people used and dealt drugs. A minority of the first group of bus clients were homeless. The random sample also confirms that a pretty large portion of the first group of methadone clients used cocaine in addition to heroin. From other rapports it also appears that almost half of the clients on the first methadone bus used cocaine in addition to heroin.[49]

Crack cocaine had entered the scene in the Netherlands. Van Brussel brought the phenomenon up during a 1982 symposium on drug policy. "Freebasing", he determined, was a technique observed among PWUD in the capital and had a "disastrous" effect for those who did it. "Within a few weeks you see these people going downhill", he said. Maybe cocaine was physically even more damaging than heroin. The room asked what 'freebasing' was exactly: cocaine is first cooked and put in a freezer, "in that liquid some small lumps appear of free pure cocaine". Those lumps are mixed with strong alcohol, heated and inhaled through, for example, a water pipe.[50]

The phenomenon was relatively unknown in our country at the time. The City Council also indicated a worrying increase in the phenomenon in 1984. Freebasing cocaine was especially on the increase among Surinamese PWUD.[51]

Now we know that 'crack' works much faster and intensely than normal cocaine. The effect starts within seconds and lasts a maximum of a few minutes. Straight after smoking crack the user feels intensely happy, but this quickly turns into a sense of irritation and discomfort. Experts call it the 'flash' and the 'crash' that pushes a person towards constant use. One of the methadone client files from the time was of a man who already smoked crack cocaine in 1980. "He freebased every day", health professionals wrote in his file, "had pain in his chest and fever two days ago. When client throws up, a yellow green slime comes up".[52]

It is possible, then, that the first methadone bus partly attracted clients who were (mentally) addicted to cocaine in addition to heroin. With this expensive drug use pattern, free drugs were likely welcome. A cynical conclusion is that the methadone provision did not only help clients continue their heroin addiction, but also allowed them to use more cocaine. As one methadone client said it: "For many addicts methadone was the bread; we scored our own spread'.[53]

Because Buning and Van Brussel assumed that many clients would continue to use other drugs, they provided methadone in relatively low doses. The American pioneers of methadone maintenance treatment, Vincent Dole and Marie Nyswander, recommended a dose of between eighty to a hundred mg per day, or even higher if necessary, because the high doses would block the euphoric effect (the flash) of heroin. The starting dose on the Amsterdam methadone bus varied between five to seventy five mg per person per day. Most clients received between twenty and fifty mg. According to Buning and Van Brussel, research showed that users also kept using other drugs with higher doses. They added that methadone could also be dangerous, certainly in combination with alcohol or other drugs.

Now truly motivated to lead a better life

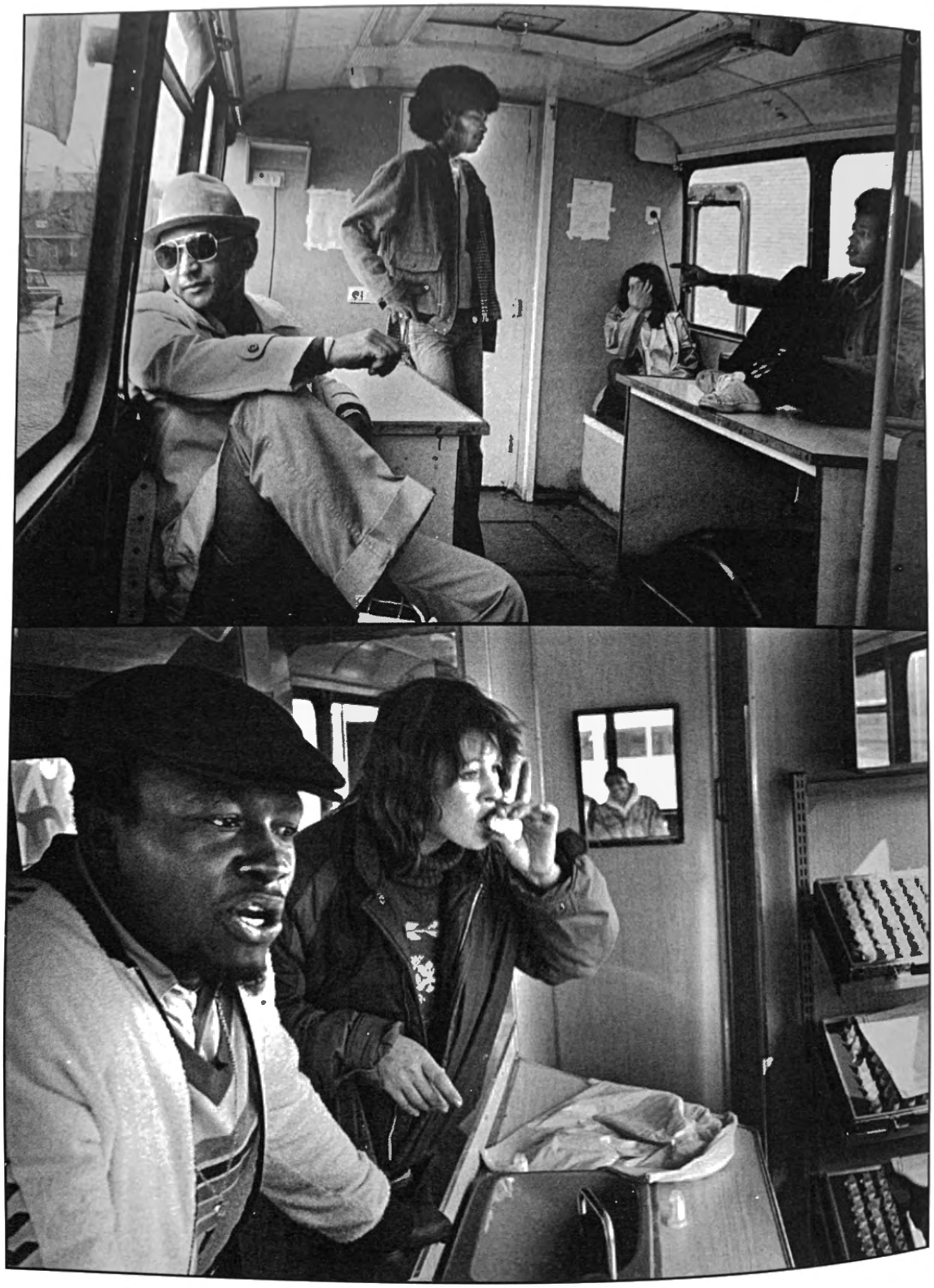
According to the PHSA workers, methadone therapy was "more dependent on good psychosocial support, than a gigantic dose of methadone". Mulder wrote in 1979 that the methadone bus may function well as "part of the measures to manage the crisis", but did not solve the social problems that drove clients to drug use.

Social support for methadone clients was done by a PHSA social worker and field officers from De Regenboog, Streetcornerwork, and Tjandu (a Moluccan charity). They arranged things for clients like health insurance, housing through the City Housing Corporation, and social security through Social Services or debt-support.

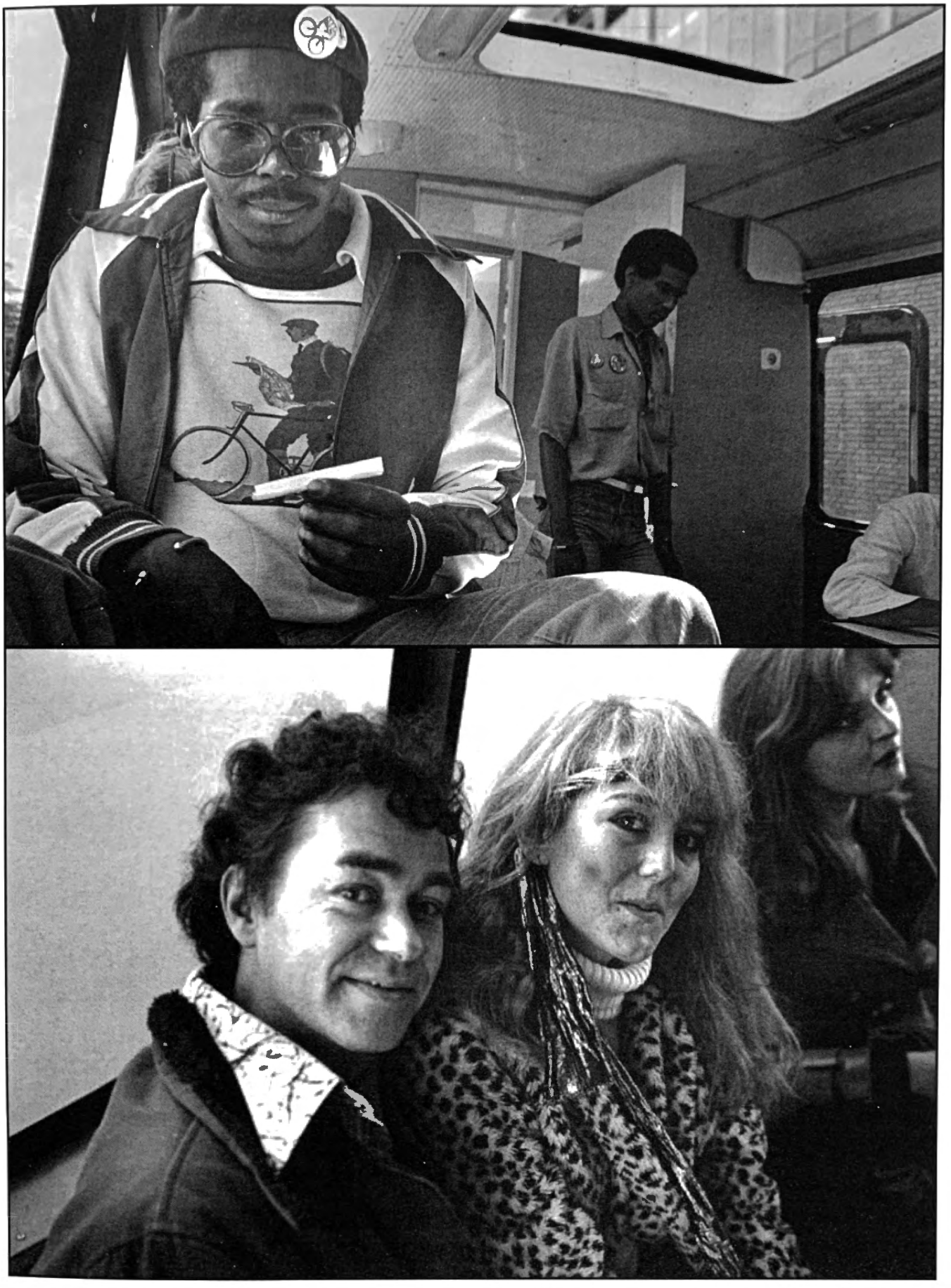
Sometimes the offered support went beyond this. For a client living in Flevoland who struggled to settle there, new housing was arranged in Amsterdam and he and his family were helped with the move. When the man was held for a drug-related crime, a PHSA social worker wrote a letter to the prison director asking whether his sentence could be shortened. His client could finally go to a therapeutic community, which had a long waitlist, and was now truly motivated to improve his life. In another case, a social worker wrote to a Justice officer requesting that a fine for soliciting clients for sex work be removed. She had just started doing so well, only using methadone, and the big fine confronted her with her past in a "very unpleasant way".

There was great involvement with clients. During these pioneering days the hope clearly was present among some health professionals that they could save their clients from the junkie existence. They went to places where PWUD gathered, trying to convince them to start using methadone. Marlène McDonald says: "I wanted to help them. That's why I was attracted to this work." At the beginning she and her colleagues sometimes gave hungry bus clients some money when they didn't have anything to eat. Later they stopped doing this. In the early eighties McDonald and her social work colleagues tried to set up an assisted living project. They bought all the pans, pots, a television, and stove on the Waterlooplein. But "within no time they sold everything and the houses became drug dens".

The atmosphere on the bus was also good, says Steef Meyknecht, who was studying anthropology at the time. He had a side job driving the bus on the weekends. "We had a lot of contact with clients", he remembers. "When we were parked somewhere, I would always go sit in the waiting room in the back." He felt sorry for the Surinamese clients. Meyknecht: "Of course when they migrated here they didn't intend to become addicted bus clients." From their stories he gathered they often became addicted without being aware. "The Surinamese saw heroin as nothing but a slightly more dangerous version of hash. Only later on once they exhibited withdrawal symptoms, did they realise they were addicted." Meyknecht, who was a photographer and later documentary maker, organised a photography course for clients and shot an impressive series of pictures of people who came to the methadone bus in 1989 and 1980.



"Waiting for the next one.." Gemma Blok



When clients had children, they tried to support the family as much as possible so children could remain at home. Children sometimes came to the bus with their parents. It was a contentious issue: children were not meant to be on the bus, but it did happen on occasion. Health professionals discussed the question: was it humane or irresponsible to have children living with their addicted parents? The approach at the time was to ensure parents and children stayed together as much as was possible, says PHSA doctor Gerrit van Santen. It was thought a PWUD also has a right to life. Furthermore, if the parents were still capable of taking care of them, it was better for children to be with their parents.[54] Still, the case files show that the policy could also lead to tragic situations. The youngest child of an addicted couple thought the methadone supplies were sweets and ended up in hospital with severe neurological damage.[55]

It seems the atmosphere around the methadone bus became bleaker over the years. Aggressive behaviour increased, even though it had always been present. Marlène McDonald: "I took so many knives from clients. They would be in their trousers. I would just take them out of their pockets. 'No knives here', I would say. 'You can only be planning bad things with those'". Sometimes stones were thrown through the bus windows, or people jumped over the counter to grab methadone. In June 1981 the methadone bus was robbed. Two small vans drove up to the bus. The drivers were recognised as two Stichting Srefidensie employees. They entered the bus, threatened the staff, and disappeared with hundreds of methadone doses. Giel van Brussel, who was now head of the PHSA Drug Department, was angry: at City Hall they had been aware of the threat and were supposed to provide police protection, but this did not materialise.[56]

"Amsterdam is going to banish heroin with methadone"

This was the headline of Het Vrije Volk (a Dutch social-democratic daily newspaper) on 17 October 1981. An important shift occurred that year: Amsterdam moved to a drug policy where less was left to private initiatives. The policy from the seventies had failed, admitted Alderperson Polak Emzn. The drug trade was flourishing in the café-style spaces, as well as at the HUK. This had nothing to do with healthcare, he thought. A few cafes were hardly used anymore, while others attracted many PWUD as drug dealers hung out there. Two cafes had mysteriously burned down, one of the fires resulted in visitors having to be admitted for burn treatment at the main burn unit in Beverwijk.

Arson was strongly suspected. The Srefidensie withdrawal centres had also failed; the charity that had been involved in managing the cafes was declared bankrupt in 1981. The City Council discovered the organisation had a five million-guilder deficit (equivalent to around 2.3 million euro). In retrospect Van Brussel said: "We were doing business with dealers. Give criminals money and you'll never see it again. We went to one of those withdrawal clinics and it seemed to be fully operational. Later it appeared they had arranged it for that one day."[57]

Like the heroin cafes, the HUK was also closed. Instead, an expansive network was set up for the provision of methadone. An extra bus, also open to Dutch users, started operations. Four neighbourhood posts were created in the East, West, Centre, and South districts of the city, where methadone was given to clients who were managing their addiction. A neighbourhood post was also created in the proper van Baerlestraat area. Van Brussel: "The ladies from the brasserie next door asked: Gosh, what is this going to be? A drug post, we said. In the evening the sophisticated South threw stones through the windows. We had to put synthetic material on the windows that made the stones bounce back, and stayed."[58]

The buses and drug posts allowed for distribution of around a thousand doses of methadone per day. The posts were manned by staff from various organisations: Jellinek, De Regenboog, and Streetcornerwork. PHSA doctors and nurses were in charge of medical coordination. All engaged parties came together in the Stichting Vervangende Middelen (Dutch for 'opioid substitution foundation'), ranging from the Jellinek to the advocacy organisation for 'intensive drug users' MDHG (Dutch acronym for 'medical services for heroin users'). For the former HUK population and other clients with behavioural problems, there was a separate methadone post for 'extremely problematic PWUD'. The central idea of this methadone circuit was to offer multifaceted and flexible care: a client will not need the same forms of support throughout their time using drugs, was the idea, so they should be able to flow easily from one form of support to another within the circuit.

This is how the City Council placed methadone provision at the hart of Amsterdam's drug policy in 1981. The PHSA had the central role of setting up the methadone circuit. They managed the registration of all methadone clients in Amsterdam and provided most of the methadone. The amount of PWUD receiving methadone increased significantly, from 1,466 in 1981 to 3,887 in 1984.[59] In the meantime the focus on recovery reduced. In 1984, the Amsterdam City Council wrote in its Note on Hard Drugs:

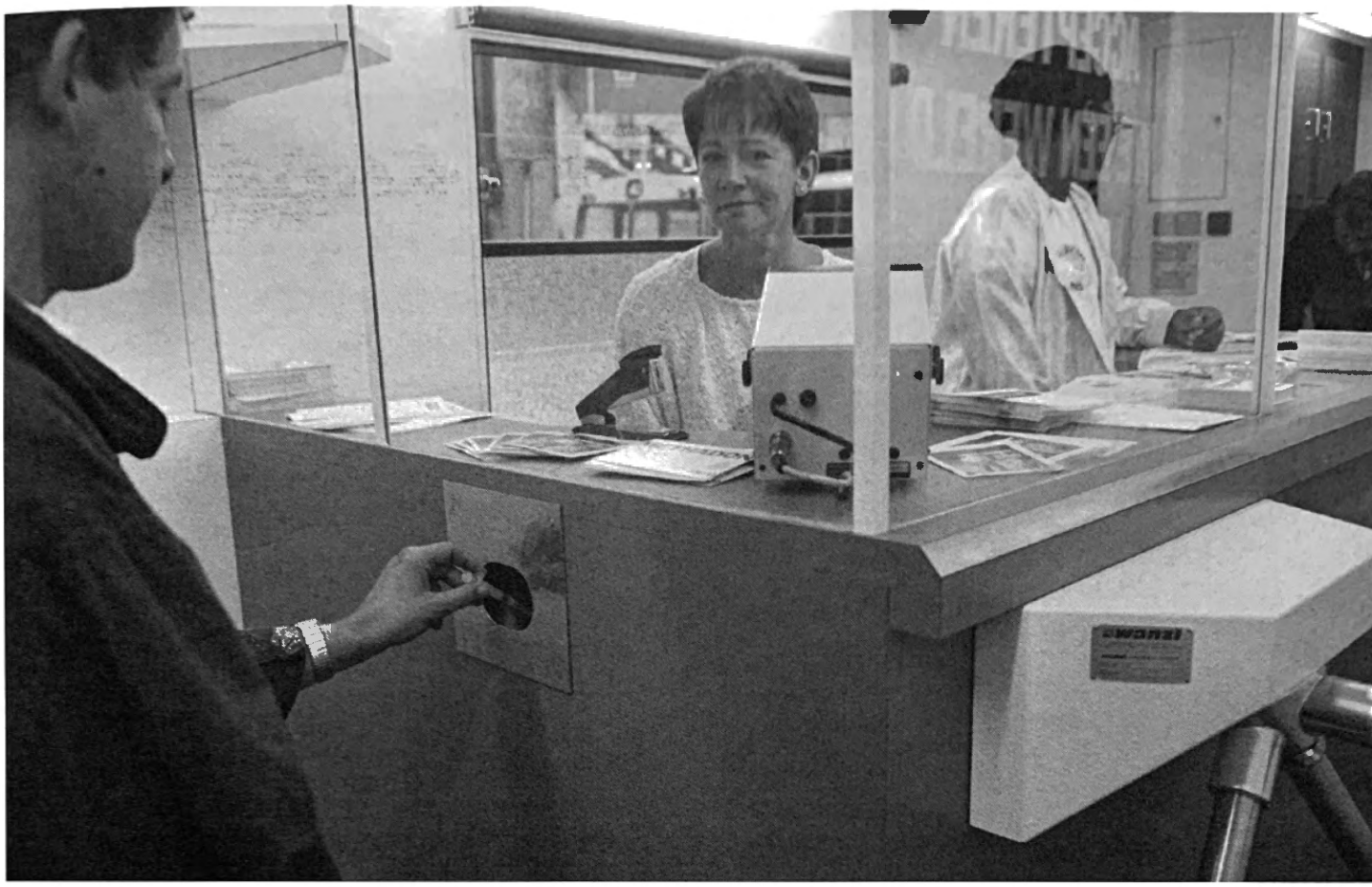
Initially healthcare activities were mainly directed towards withdrawal and bringing the PWUD back into society. When this appeared to be too ambitious, the emphasis was moved towards improving societal and physical functioning of PWUD on hard drugs.

After 1981, the intake forms for methadone treatment no longer included desire to detox or history thereof. The PHSA's focus on damage control became increasingly more explicit. Care and reducing disturbance for the general public could go hand in hand, argued director Henk Rengelink in 1984. For those PWUD who could not stop using, he advocated for care aimed at reducing physical, psychological, and social damage associated with their addiction. However, he thought the goal of medical treatment could not be made subservient to maintaining public order.[60]

Encouraging doctors to prescribe

Private initiatives remained of great importance in the development of the harm-reduction approach. This is how needle exchange came into existence – the possibility for PWUD to exchange used needles for clean ones, to prevent the spread of infectious diseases and abscesses – not through the City Council, but 'bottom-up'. The Van de Meulen pharmacy on the Gelderse Kade, near the Zeedijk, had already been selling needles to PWUD on a large scale. At the height of the heroin epidemic in 1982, they ceased to do so. The demand and thus the pressure on the pharmacy became too big. MDHG took over and started a systematic exchange system, conceived by the PWUD. Whoever handed in a needle, got a free clean one back. If you didn't hand one in, you paid fifty cents.[61]

According to the MDHG, the PHSA helped in the disposal of dirty needles, but otherwise was not sufficiently involved. At the same time there was concern within the PHSA: would a large-scale supply of clean needles not mean an increase in injected needles on the streets? There was also scepticism at City Hall, according to Van Brussel: "Policy makers thought handing out clean needles was just pampering."[62] When the AIDS epidemic started spreading, this argument quickly ceased. After 1986, needle exchange was available on the methadone buses and the system expanded in later years, among others through needle exchange machines at strategic locations in the city. At any time of day, PWUD could insert a used needle into these machines and take out a clean one. In 1992 over a million needles were distributed in Amsterdam.[63]



Needle exchange on the methadone bus, 1989

Amsterdam was not always in agreement with the national government regarding this new course of damage control. In March 1981, the National Health Inspection wrote a letter to all doctors in the Netherlands, with guidelines regarding out-placement treatment of PWUD in general practices. A general practitioner (GP) could only provide methadone if done daily in fluid form. There was to be a working cooperation with a PWUD care facility, a check on additional drug use, and participation in a central methadone register.

The letter caused great consternation in Amsterdam. All drug care providers in the capital soon met to discuss its contents, including Jellinek, the PHSA, the MDHG, and Streetcornerwork. Both Alderperson Polak Emzn and Rengelink of the PHSA feared this letter would scare GPs from prescribing methadone for patients. This hampered Amsterdam's very efforts to get more GPs to prescribe methadone. With these guidelines it would be challenging as daily provision would place a burden on their practice.

At the time, fourteen doctors in Amsterdam prescribed methadone for around 450 people. Polak Emzn wrote a letter to the Inspection, explaining that Amsterdam was striving for a targeted neighbourhood care approach. He thought it was a shame the National Health Inspection seemed to be discouraging GPs' participation. Rengelink sent a letter to all Amsterdam GPs, emphasising the city's addiction care institutions were not in agreement with the National Health Inspection. GPs could also play an important role in the provision of methadone.[64]

In cooperation with Streetcornerwork and the MDHG, the PHSA started supporting GPs who provided methadone, through visits and advice. They also offered a 24-hour safety net if there was a relapse. More and more GPs dared to prescribe methadone. In 1995, 151 Amsterdam GPs treated PWUD with methadone. Together they prescribed this for 747 persons. The government also gradually changed its stance. In 1983, the State Secretary for Public Health and Culture, J.P. van der Reijden, wrote there should be more room for care not aimed at breaking addiction, but improving the societal and physical functioning of PWUD.[65]

Still, there was a lot of criticism regarding the provision of methadone in the early eighties. During the parliamentary debate on drug policy, representatives from the CDA and VVD called methadone a form of "illusory help", because most addicts kept using additional drugs and did not change their lifestyle. They were also apprehensive about the magnetising effects of large-scale methadone provision.[66] The AIDS epidemic played a crucial role in strengthening the case for methadone provision in the eighties, in the Netherlands and abroad. The felt need by all to combat this epidemic, that affected many PWUD, in addition to men who have sex with men, meant controversial measures like needle exchange and methadone provision were more easily accepted.[67] In addition, Van Brussel remarks that it was impossible to care for a PWUD suffering from AIDS in a hospital or social care facility without the use of methadone.[68]

No tablets for family weekend

Meanwhile, methadone has been studied extensively. Studies have shown methadone to have a favourable effect on reducing criminal behaviour of drug users.

The use of illegal opiates declines with the provision of methadone, now an integral part of the harm-reduction approach towards PWUD in many western countries. But how should we value this treatment in a moral sense? This is still subject to debate.

Critical scientists, often inspired by the French philosopher Michel Foucault, have described methadone provision as a 'power game' and a way of disciplining deviant citizens.[69] Methadone is used to keep people who do not want to live a composed, productive and sober life, dumb and docile. The maintenance treatment also has a stigmatising effect. Clients experience humiliation having to wait in line for the methadone or having to negotiate with health professionals on the amounts they can have, when they need to collect and take it, the urine checks, and the question of whether they can take the methadone home in tablet form. These scientists claim the strict rules of methadone provision work against PWUD re-socialisation.

The controversial British psychiatrist Theodore Dalrymple disapproves of methadone provision for very different reasons. He thinks it is rewarding bad behaviour. "When self-indulgent actions, such as taking heroin, are deprived of some [of] their worst consequences, it is hardly to be wondered at that they spread like wildfire," he wrote in his book Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy (2006). Methadone treatment has the result that it infantilizes the subject and treats him as if he were not responsible for his own actions.[70]

The client files confirm this idea of methadone provision as a power game. They show a constant battle for power between health professional and client. Over the course of the eighties the regulatory nature of provision increased. In the methadone provision circuit that came to being after 1981, health professionals had more options available to regulate their clients' behaviour. Rewards could be granted for 'good' behaviour: no additional drug use, a cooperative attitude towards the health professionals, a certain measure of cleanliness and maintenance of their living space, taking care of a partner and family if that was the case, and potentially even work or study. The reward was that people did not have to come to the bus to drink methadone there, but could go to a neighbourhood health post, with the option of taking pills home to last them a few days or a week, and even longer for vacations.

Whoever worked, studied, or had caring responsibilities, could also collect their methadone in the evenings. When clients were well regulated for a longer period – they had to have a home, be signed up for public health insurance, stick to appointments, be heroin-free, and work – they were referred to the GP.[71]

For many clients that was the most pleasant option. Not only was the GP often closer to home, nobody could see why you were there.[72] With undesirable behaviour, the opposite occurred. Using additional drugs, aggression, uncooperative behaviour, lying and deceiving were punished by putting people back on the bus. Whoever did not behave on the bus could be punished by not being provided with tablets for a family weekend away or a vacation.

Clients often went from bus to neighbourhood health post and back. Typical outcomes of client meetings were: "Send to bus", "Can go to neighbourhood post", or "No more exceptions. No more pills to take home!". Or: "Can take a few tablets home if he: 1. Makes an appointment with the social worker 2. After urine check. Otherwise bus!!"[73] Not cooperating with medical check-ups could also have consequences. Strict procedures were in place for their own protection. For example, PWUD are at high risk of contracting tuberculosis, which poses a significant threat to vulnerable HIV-infected PWUD. For someone who had not had their annual chest X-ray taken, they wrote: "He is going tomorrow, knows that if he doesn't go, he won't get anymore methadone".[74] Another point of conflict between health professionals and clients were the methadone bus times. Where the first bus had a large waiting room, the second bus had a smaller one, and the third bus had none. Clients increasingly had to wait for their methadone outside.

Advocacy organisation MDHG was incredibly frustrated about the 'abuse of power' by staff on the methadone bus. The bus was often late, but if clients were late the bus would drive away right in front of them. One PWUD described the methadone provision as "junk-degrading". The "sad line of poor devils" who "preferably were left waiting on a windy square or drafty corner for the methadone bus" reminded him of soup kitchens during the hunger winter experienced during the war. Nurse Marlène McDonald confirms that the bus coming late was a point of conflict. "They of course were never late. No, we always left too early." This conflict was not limited to Amsterdam. Methadone buses were operational all over the Netherlands. The phenomenon even led to the number one hit by the Höllenboer duo in 1995, "Busje komt zo (eventjes geduld nog...)" which translates to: "The bus is coming (Waiting for the next one... / just have a little patience...)".

A game without a winner

The effect of the disciplinary measures was, however, limited. The basic principle of low-threshold methadone provision, thought Buning and Van Brussel, was of course that few demands were placed on clients. The point of departure was "maintain contact with the client as long as possible, even if it is not going well". Methadone provision, wrote Marian Commandeur, a Jellinek social worker at the neighbourhood post in the East, was firstly "an entry into

care." She saw it as an opportunity to "get into contact with PWUD and offer medical, social, and psychological support".[75]

From the desire to stay in contact with clients, the health professionals let them return again and again to the bus or neighbourhood post, especially if they had a family or a job. They often received the benefit of the doubt. For example in the case of a man who came to a neighbourhood post, a health professional wrote: "Is not taking any steps, does not come to appointments. Meanwhile his girlfriend and child are ill and he is considering giving up his job. Proposed to give him till the 28th and otherwise still have him leave post and send to the methadone bus". As such there was also a lot of negotiation with clients. Another file said: "Doesn't want to go to bus. Can try one more week at the neighbourhood post".[76] Only rarely were clients suspended for a few weeks or months, because of cheating or when double dose provision was found out. But after a while these clients could also come back for a re-intake.

Indeed methadone use was a power play between health professionals and clients, but the question is who was the winner, and particularly, whether there even was a winner. What is especially apparent from the files is the powerlessness of both the health professionals and the clients. In the short term the health professionals definitely had the power to provide tablets or not, or send people to the bus. In the long term the power lay more with the clients – or better said, with their addiction. That ultimately dominates the game. The provision of care can do little more than follow and try to shift its course. There is no obvious winner in this power game. It seems more like a constant negotiation, sometimes ending in a win-win for both parties.

As an example there is the story of a client, here called Romeo, with whom there had been years of back and forth as described above. He eventually stabilised to fifty mg of methadone in the mid-nineties. He also regularly used cocaine, heroin, and valium, but could afford this out of his social security payments. Aside from small infections, he was in good health. He lived with a fellow PWUD, sometimes went to a sex worker and for this the PHSA gave him a condom for protection.[77] Dalrymple would probably think this a case of extreme spoiling, Romeo had a good thing going: health professionals facilitating his use of drugs and visits to a sex worker. However, this spoiling had a positive effect on both the client and society. Romeo did not experience the deterioration that may have happened without contact with the health professionals. In addition, he would not be responsible for spreading sexually transmitted diseases and was not bothering society with criminal behaviour.

Besides, the theories about disciplining PWUD through methadone do not sufficiently take into account the attitude of the health professionals. They were also struggling with the matter of whether they were too much of an instrument for maintaining public order. In a note about the methadone provision circuit the involved parties wrote: "Is it ethically justifiable that the State is keeping people calm through an opiate, namely methadone, in the name of maintaining public order?"[78] As a response to this moral dilemma, they concluded that psychosocial support was an essential factor in methadone provision.

Thus, when striving for public order got in the way of psychosocial care provision, there were also protests. In 1984, field officers from De Regenboog were urgently put into action when police was trying to clean up the Zeedijk, the PHSA wrote an angry letter to the Alderperson for Public Health, Tineke van den Klinkenberg. City Hall neglected to discuss things with the PSHA, they reproached. The relationship between the PHSA and the City Council wasn't always smooth. Constant tensions between these entities occurred, where the City Council often prioritised maintaining public order, while the PHSA emphasised the need for proper care.[79]

The 'Dutch approach'

In the nineties, Dutch politicians and policy makers were proud and satisfied. The heroin epidemic our country had been struggling with after 1972 seemed to be under control. Few young PWUD were added. The average age of an Amsterdam PWUD on heroin had gone up from 26.6 years in 1981 to 36.2 years in the mid-nineties. The low-threshold methadone provision may have contributed to this. The view of PWUD around buses did not give opiate use a particularly sexy image. As Giel van Brussel once said: "Heroin is for the sad sap who needs to go to the PHSA".[80] Victim numbers also went down. In 1984, at the peak of the epidemic, there had been 74 drug-related deaths in the capital, by the mid-nineties there were 'only' 32. The amount of HIV infections among PWUD had also stabilised.[81] According to top civil servant Eddy Engelsman, who worked for the Ministry of Public Health and Culture, the harm-reduction approach was an expression of a historical Dutch cultural identity. The Dutch were a "sober and pragmatic" people. Which is why they chose a realistic and practical approach to the drug problem, rather than a "moral or overly dramatized" approach.[82] Not only the Dutch were proud of 'the Dutch approach', it also earned a reputation worldwide among health professionals, policy makers, and researchers.[83]

With these rose-tinted stories it may appear that with the changes to the Opium Law in 1976, the Netherlands not only introduced a tolerant policy of cannabis, but also set an intentional course of harm-reduction in its approach to PWUD on heroin. This is a retrospectively romanticised view. As shown, the Dutch road of embracing a harm-reduction approach was much messier than that. PWUD may have been called patients in the Opium Law of 1976, but a recovery-focused approach was initially dominant. PWUD on heroin had to be discouraged from continuing their destructive lifestyle, was the government's view.

Only in the eighties did we gradually change course, where it was not the national government but often local initiatives that seemed to be leading the way. The crisis around De Doelen was the direct impetus for low-threshold methadone provision in Amsterdam. The methadone bus initially started operations in 1979 as part of City Council damage control. In later years methadone treatment developed as a healthcare measure. But there was also resistance, from local politicians and State Health Inspection, who thought stopping drug use had to be front and centre in the provision of care. Meanwhile, Amsterdammers complained about the soft and ineffective City policy. The famous 'Dutch approach' was definitely not celebrated by all Dutch.

The fact that methadone provision did not mean the end of heroin- and cocaine use by clients was quickly apparent. Methadone provision was mainly used to get clients into care, but also to encourage them to lead a more regular and productive life. Still, it seems there was only limited 'medical power'. The stubbornness of addiction ultimately decided the game. The files confirm that the dominant picture in current addiction science is of addiction as a chronic-like illness, where relapse is more the rule than the exception and where it is hard to predict whether or when people are able to leave their addiction behind. More than power, powerlessness seems a relevant analytical category as far as methadone provision is concerned.