

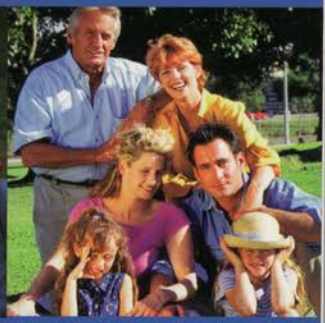

PARENTS

A Natural Preventive Against Drugs

THE DUTCH EXPERIENCE

By Renée Besseling

Parents

A Natural Preventive Against Drugs

The Dutch Experience

By Renée Besseling

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This book is dedicated to all supporters of the
United Nations International Drug Conventions

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Preface

In 1982, the grocery store on the corner of my street was replaced by a "coffee shop." For me, a mother of two young children, this was reason enough to delve into the matter of drugs. Children, who earlier might get an apple from the store owner, were now suddenly greeted by a hemp leaf in the window. For them, in the beginning, this only meant that we had to go some place else to get fruits and vegetables, but it also quietly introduced the drug-selling "coffee shop" into their world. Yesterday's child is grown up today, and will be tomorrow's parent.

Since that time I have closely followed the "coffee shop" and societal development that accompanied it, and it turned into quite a quest. I wondered how the sale of hashish and marijuana came to be, practically overnight, without a similar development in the countries surrounding us. It turned out that the drug policies and the world of the users of illegal drugs were as complex as the different drugs in circulation, and that our politicians complicated the matter even more with a blatant disregard for the legal standards that had for a long time been codified in the Opium Law and the various international treaties.

In this book, I wish to share my experiences and the knowledge I gained during my quest with other parents, because as long as the use and sale of drugs are tolerated, the drug problem will only continue to increase. Drug use is a problem not just for the child who uses, but also has far-reaching consequences for those who don't use. An ever-increasing burden is placed on the shoulders of those children. To show that we should not and can not give up the fight against drugs, I decided to write this book.

I owe a debt of gratitude to a great number of people. I wish to thank Michel Aaij, Ph.D., for his energy and professionalism in the translation

of and research for the English edition. The following people, a list by no means inclusive, have helped me greatly in explaining different aspects of the use and trade of drugs in a comprehensive and intelligible manner: writer and researcher Jonas Hartelius, psychologist and researcher Thomas Lundqvist, professor K.L. Täschner, social worker and drug counselor Anders Eriksson, Allan Rubin, Joop Verbeek, J.D., social worker Gun Zacharias, K.F. Gunning, M.D., the late Eth de Marees van Swinderen, J.D., and president of EURAD and drug counselor Grainne Kenny—as well as all others who have shared with me their material findings and insights. Thanks also to Nelly Oostland-Veldhuis, for illustrating the book, and to Frode Wikesjö, for his technical support. Special thanks go out to the Swedish Carnegie Institute, Stephanie Haynes and the Northwest Center for Health & Safety for their financial support of the English translation. My deepest admiration goes out to the late professor Nils Bejerot, for disseminating his enormous knowledge and insight, for his encouraging words, and for his will to solve the drug problem.

I reflect with fondness and respect on all the wonderful people of many different nationalities who have so generously shared their knowledge and expertise. With many of them I share the idea that our children should have a protective and drug-free environment, that drugs are harmful and therefore illegal—and that this should remain so.

Renée Besseling

Introduction

"The future is definitely not to be found in hydro-electrical power, oil fields and natural resources. The future depends on the priority we give to our children. They embody our capital assets. They are the ones who in the near future will have to support their elders, but they also will have to look after the younger generation. They ensure society's development and progression, and this is often forgotten," says child psychiatrist and author Olof Ulwan. "As a rule we only notice how much money they need, but they are an investment, and investment means that a company's capital is reserved for the sake of interest and profit. That's what children are, they are an investment. Their development is important not only for their future, but for that of all of us."[1] Drug abuse slows down this development—sometimes to a complete stop.

It is often said that we must learn to live with drug abuse. Education is useless, and the prohibition of drugs is senseless. But is this really true? Opinions differ on drugs, especially concerning hashish and marijuana. Some say that marijuana is less harmful than alcohol and tobacco and wish to decriminalize its use and production, while others say that its use is positively damaging: it is indeed possible to die from the abuse of marijuana. Some want to destroy these illegal crops, others will do everything to preserve them—with the prospect of enormous profit. Dependent persons say they want drugs to be freely available, but really they want to be free of drugs. If the sale of marijuana is legalized, so will be the trade in hemp products, which will increase to enormous proportions. What is the danger of this? Hemp will possibly be used in products for everyday use and even as ingredients in food products. The cannabis leaf will be featured on such products, indirectly advertising the smoking of cannabis. There will be a competitive race between the legal and illegal market towards the consumer. Finally, legalization of marijuana will lead the way toward legalization of other drugs. The Dutch Opium Law prohibits the growth, manufacture, import and

export, trade, distribution, and possession of narcotics, but not their use. In the Netherlands, the sale of marijuana in "coffee shops" is tolerated, but not its purchase by dealers, unless in quantities of no more than five hundred grams.

Crime and nuisance caused by drug abuse make our citizens feel unsafe. However, the former Dutch government called its drug policies a success—and the new government, elected in 2002, seems unwilling to ensure fundamental change. Abroad, some are influenced by Dutch so-called success stories, but some foreign governments loudly bemoan the all-too-liberal drug policies of the Netherlands.

A result of an inconsistent Opium Law, coupled with contradicting directives, scientific material, information and opinions, creates the risk of misleading parents and youngsters, who start experimenting "so they can judge for themselves." There are "drug experts" who use drugs and then tell young people that drugs are harmful, saying one thing and doing another. Others proclaim proudly how they manage to use drugs properly—trying to legitimize their use. In all likelihood, their drug habit is so strong that they are convinced "proper management" of that use will reduce the harm caused by drugs. That a person can use drugs and not become a slave to them is a conviction that can be transmitted to non-users. What they don't want to admit is the risk of being under the influence of and dependent on drugs is high, and while everybody has their own limits, these limits are hidden until they are exceeded—and a person becomes dependent.

Many municipal councils in the Netherlands tolerate places where drugs can be used and support, under the guise of "harm reduction," the sale of (home produced) drugs. At the same time, they try to act against the visible consequences of drug abuse such as prostitution and other social ills. Such passive-aggressive policies are unreliable and contradictory, proving that those who first tolerate drugs and then complain about the nuisances they cause have not understood cause and effect. Too often they intervene only when the abuser is dependent, exhibits criminal behavior, prostitutes him or herself or finally lies ill or dead in the street. The highly visible manifestations of the drug problem do not fit the image of a successful drug policy: drugs and public health simply do not go hand in hand. Liberal drug policies do not serve the best interest of children or families. Drugs influence users' personalities, dominate their way of thinking and distort their emotional world. In short, drugs affect our society's safety and future.

Why a book on drugs from a Dutch perspective?

The reputation of the Netherlands abroad, especially among young Americans from high school to college age, is based to a great extent on the image of liberal Dutch drug policies as portrayed in the American press and entertainment industry[2] as well as in more scholarly books and articles that seek to undermine the war on drugs.[3] However, Dutch drug policies send mixed messages. On the one hand, the Dutch government ratified both the 1961 and 1971 United Nations treaties banning the illegal production and distribution of drugs, and the 1988 United Nations treaty banning drug-related activities, such as money laundering, drug tourism and the production of materials used for making drugs. On the other hand, local and national governments in the Netherlands allow and regulate various kinds of illicit drugs, effectively decriminalizing the use of and trade in those drugs. Through the distribution of methadone and other "harm reduction" measures, health organizations fail to combat the causes of drug dependence, leaving dependent persons to their own devices. Sending these wrong signals amounts to inviting new users to become dependent themselves. While ostensibly marching in step with other countries and ratifying United Nations treaties, Dutch drug policy advertises a use of certain illicit drugs which have been deemed "safe" or "recreational," inviting users from abroad to try the wide selection of drugs available in Amsterdam and other cities and exporting a tolerance detrimental to children everywhere.

Discussion in the United States is heating up. While the federal government actively wages the "war on drugs" in the United States and abroad, voter-supported initiatives on city and state levels seek to decriminalize the use of some drugs, especially of marijuana, and to install programs in inner cities distributing methadone and syringes to dependent persons. Such proposals are often modeled after current Dutch drug policies. Nevertheless, they are detrimental to society, fail to help dependent persons, and provide a bleak prospect for our children by effectively advocating use of illegal drug. This is the main issue of this book.

For whom is this book intended?

In the first place, this book is meant for parents, educators and alarmed citizens to aid them in the debate on drugs. It aims at a better understanding of the mechanisms of dependence and the prevention of

drug abuse, but it is also meant to strengthen the position of parents and educators who often find themselves ill-equipped in discussions with so-called experts. For many families, drugs and drug abuse raise questions and cause disquiet or profound misery. This book also is intended for people who want to know more about the drug problem, how dependence develops and what can be done about these things. It is also useful for those who want to consider the drug problem from a different perspective than that of "tolerance," and for those who are interested in the background of the Dutch drug policy and why the ban on drugs is not enforced. Hopefully, the book will be useful as a second opinion for those who are responsible for creating national and local drug policies to counter the simplistic and irresponsible propaganda supporting tolerance and "harm reduction."

What can we do?

Parents, educators and others responsible for the well being of our youth and public health play a very important role in preventing—or maintaining—drug abuse. Fighting the traffic and trade in drugs is the responsibility of police and government, but parents may be able to decrease their children's demand for drugs. To anyone responsible for the development of our youth, a good relationship with the child and a knowledge of drugs are equally important. Answering children's questions and guiding their development requires knowledge, common sense and clear rules. But these alone often do not suffice. We also should be well informed about the strategies of those who want to liberate the drug trade. Their aim is to get drugs legalized, for whatever reason and in whatever manner. The new consumers, the younger generation, are easily influenced. They are promised the possibility of buying freedom, a heightened consciousness and excitement wherever and whenever they like, for an affordable price—at least initially. The pro-drug movement is active globally and is considered credible by many people. Their message is communicated by sympathetic scientists, farmers, users and the media, who pave the way for a liberal outlook on drugs and drug abuse. Many governments contribute to this process by allowing shooting galleries, "coffee shops," needle handouts, methadone clinics and head shops—even by giving out heroin to dependent persons.

It is not hard to identify those who propagate liberal attitudes to drugs. The trade in drugs is always accompanied by enormous profit

and social unrest, and, more or less unwittingly, legalization proponents align themselves with drug traders and terrorist movements throughout the world. On the other hand, it often seems as if only families are concerned about the wellbeing and the protection of children, and it is of eminent concern to the family to ban drugs from the child's surroundings.

A "drugs democratorship"

Debate on the drug problem should not be left to experts and users of illegal drugs. If we allow them to dominate the discussion, our own voices will not be heard. This provides "experts" with liberal ideas about drugs with the opportunity to spread their thoughts, promoting a "drug democratorship," a democracy that dictates which opinions in any given debate are given credit.[4] Those experts provide too many young people with excuses like "tobacco is more harmful than marijuana," or "the risks of cannabis are acceptable," or "it's my body and I can do with it what I like." It is high time that parents and others who are responsible for the weal and woe of our youngsters expose the tolerance policy for what it is: a danger to our children and our future. Many people think that the drug problem is insoluble. They believe that acceptance, decriminalization, or even the legalization of some or all drugs will manage the problem. The dependence producing nature of drugs and the profits of drug trade ensure, however, that managing the problem in such a way is a utopian dream. As author and former drug user William S. Borroughs put it, "The junk merchant does not sell his product to the consumer, he sells the consumer to his product."

Tolerating drug use leads to accepting destructive behavior and sends the wrong signals to young people who are not yet depended. The largest percentage of drug users use drugs "recreationally." "Recreational" users of drugs are the habitual customers of the drug industry and living, walking advertisements for an ever-increasing assortment of drugs. In return for their money, the "recreational" users get everything, from a high to a psychosis. The money made by the drug industry finances wars, civil conflicts, terrorism, weapons purchases, bribes and more drugs.

New customers are found among the teenagers who year after year leave the bosom of their families to establish their lives independently. Their role models are the "recreational," everyday users they see in college, on TV and in Hollywood. Parents who want to prevent drug use

among their children wage an uneven battle with the "glamorous" world of drug use, but this battle must be waged and won. History shows that tolerance for drugs creates the opportunity for drug use. Public health, peace and security are not just the government's responsibility. They are family matters also. If we can prevent our own and our children's drug use we stand to gain much. However big the supply of drugs may be, if demand decreases and finally dries out, drugs become worthless and we can erase drug-related crime, dependence and children dropping out of school and society. If we really want to see the problem for what it is, we can find a solution—even for the drug problem.

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1. Ulwan, Olof. Kan Man Förebygga Missbruk? [Can We Prevent Abuse?]. Lecture, Kontraktnätets Rikskonferens, Rosenbad, 27 April 1998, Stockholm. http://webbhotell.c3l.com/teamsmart/olof.htm. Retrieved 16 July 2002. [Tr. note: "Kontraktnätet" is a Swedish organization of volunteers aiming to promote healthy, drug-free living to school children, organizing courses comparable to American DARE programs. Dr. Ulwan was the keynote speaker for their annual convention in 1998.]

2. Quentin Tarantino's movie *Pulp Fiction* describes at length the supposed Dutch policies regarding police authority in drug cases, advocating the legal use of marijuana. Almost weekly, reports on seizures of XTC originating from the Netherlands further the reputation of the Netherlands as a free haven for drug users and manufacturers.

3. For instance, the recent book by Robert J. MacCoun and Peter Reuter, Drug War Heresies: Learning from Other Vices, Times, and Places (New York: Cambridge UP, 2001), esp. "Cannabis Policies in the Netherlands" (pp. 238-64) and "Evaluating the Harm Reduction Approach: The Netherlands" (pp. 272-78).

4. The word was used by Eduardo Galeano in his essay "Democratorship: Latin American Democracy Held Hostage" to describe the Latin American semi-democratic dictatorships after the Second World War: democratorship is "democracy mortgaged by dictatorship—democracy nullified, bent double, watchdogged, submitted to a regime of conditional freedom under the shadow of bayonets." We Say No: Chronicles 1963-1991. Translation Mark Fried et al. New York: Norton, 1992, p. 194.

Chapter One

PARENTS

Wisdom, experience, and intuition—these elusive sources of knowledge nowadays seem to be dismissed or at best supplanted. All that "old-fashioned stuff" seems to be replaced by experts, therapy and drugs. Nevertheless, man and his environment do not change that quickly, even though it may appear that way. Parents are still the most important people in a child's life. Competition increases as the child grows up, but despite outside influences, parents remain role models and counselors who set boundaries, empathize and care. Raising a child may seem simple, but it is probably the hardest job in the world. It always has been, and even more so now. To find equilibrium between freedom and restraint, rights and duties, and a parent's responsibility and a child's development requires a balancing act between parent and child. Swedish child-development specialist Bengt Grandelius said, "Many adults are unclear about their norms and values. We get lost in the plethora of information about what is good and what is evil, and have lost the connection with our inner child as well as confidence in our own judgment. The worst that can happen is when parents set aside their function as a role model. Feelings of guilt and the need to compensate in the case of a family falling apart are very common."[1]

Establishing rules is never a simple task; enforcing them without being overzealous or stubborn may be even more difficult. But setting boundaries cooperatively with the child makes rules intelligible and clear to the child even if they are broken.

How do you care without interfering; how can you worry without controlling, admonish to be careful without nagging, give assurances without limiting freedom?

—Thord Wallen, The Most Beautiful Words about Children

Lifestyle

The choice of a lifestyle always happens in a social context. "It is the interaction between people that enables a self-image and an identity to come into being and allows the expression of a choice for a certain lifestyle."[2] "The choice of lifestyle provides insight into what teenagers experience, who they are and where they belong."[3] This development is adjusted constantly through experience, but also in connection with different groups and different friends. Besides parents, the child's surroundings, new experiences and new friends all exert their influence. During puberty, teenagers process the psychological pain of maturation. Substances that take away or cover up this pain disturb the process. Experimenting with substances during puberty slows down the process of growing up.

Growing up

> "Before the age of 12, children have the ability to deal with the most terrible and difficult experiences by using fantasy, daydreams and magic. They lose this gift during adolescence. In large part, the emotional pain they experience during the teen years is connected to this loss. They experience marijuana as a painkiller and substitute for this lost ability to imagine. This chemical enables one to be relieved of reality for a while and extend childhood. This is a welcome discovery for many. It is seen as the ultimate escape from the inevitability of growing up, which creeps up on people whether they like it or not. The use of cannabis is a protest against time and growing up, not always against parents or society. Time stands still and childhood endures."[4]

In other words, the psychological development of the growing child comes to a stop.

This is what Dr. Peter Paul Heinemann, a Swedish expert on child behavior, calls "Truancy from life" in his book of the same title.

Certainly, in some respects, children do want to grow up and become adults quickly. However, the accompanying rights, duties, and responsibilities must be learned and accepted slowly.

Parents' roles

Children observe their parents and surroundings from their earliest moments. Father and mother are their first source of information and their first role models, also in matters related to alcohol, tobacco, medications and illicit drugs. In general, parents and educators have more influence on children than they may realize, and parents' opinions play a significant part in the decision to use or not use both legal and illegal substances.

In 1996, in the Dutch seat of government, The Hague, the regional health care department conducted a study among 62 groups of K-12 students to assess drug use. The study concluded that high prevalence coincided with friends' use of drugs, an active nightlife and criminal behavior, whereas low prevalence was tied to parents disapproving of drugs: "Living at home with both parents coincides with low prevalence of drug use."[5] Thus, the presence and participation of adults matter considerably, and they don't always have to be two parents. To set boundaries, to set an example, to show respect and love, to know what the child is doing and with whom, to know what substances are on the market and to think logically, these are all important. Thinking logically leads to the conclusion that drugs were not invented for children's benefit, but that drugs derive from the desire for power, greed for money and self-interest.

For parents, there should be no reason to support or tolerate neither drug liberal politicians, criminals worldwide nor the local drug dealer by accepting the use of drugs in the family. Parents have every right to tell their children that they would be disappointed if their children used drugs. State your concern calmly, but insistently, when neither parent nor child is stressed A child will listen when told, "Using marijuana hinders your concentration, damages your memory, your motor skills and your motivation. That will lead to lower grades in school and harm your future prospects."

Substances that obscure the pain of adolescence or take it away altogether disrupt the process of growing up.

A few tips

In preventing drug use, your own views on the various drugs available are extremely important. The following guidelines can help you establish your own role in prevention.

- Provide rules and draw clear boundaries.
- Be(come) an active listener.
- Become knowledgeable about what goes on with teens.
- Encourage discussion within the family.
- Discuss advertisements and products intended for young adults.
- Provide love and affection.
- Discuss how you deal with stress and disappointment.
- Encourage your child to develop a positive self-image.
- Promote your child's interests rather than his/her peers' interests.
- Make time for your child!
- Point out the positive aspects of adulthood.
- Discuss the role young people can play in making the world a better place.
- Ask what your child wants, what his/her goals are.
- Promote natural highs, such as sports, nature, drama, literature, love and music.
- Get to know your child's friends and their parents.
- Support your child's efforts, and don't criticize unjustly.
- Respect your child's choices, but be clear when you disagree with those choices and why you disagree.
- Find out what your community is doing to prevent drug use.
- Find out if this prevention entails "responsible drug use" or focus on the prevention of drug use altogether.
- See if there is a volunteer organization in your neighborhood, or start one if there isn't.
- Check into the guidelines for drug use set by your community's school, athletic club and other youth organizations.
- Find out if your public library has books on drug use and young adults.
- Become knowledgeable about all kinds of drugs.
- See if counselors are available if you should have questions.

Does this seem easier said than done? It may, but consider what you already do without thinking too much about it. We all know that growing children don't always want to consider what their parents tell them. They want to, and have to, find their own way. There will be occasions when other family members or adults are in a better position than parents to listen to the child or discuss problems. Don't hesitate to encourage this, and don't get miffed or hurt should this need arise. It is normal. In some parts of the world, children who can't get along with their parents or keep getting into trouble with them move out of the immediate family to stay temporarily with an aunt or an uncle. This may create space for both parent and child and will improve the relationship. Never let a contrary teen take over the family. It is not always automatically the case that prohibition doesn't work or that forbidden fruits are the sweetest. Drug use never should be allowed "to keep the peace." Drugs are forbidden fruit not because they are sweet, but because they are harmful. Of course, children will do on occasion what they're not supposed to do, but when the rules are clear, the child will know what is and what isn't allowed. Children like to test boundaries to see how serious parents are about those boundaries. In this way, they test how much you care for them. Give your child the proper attention even when your child doesn't ask for it or is reluctant. If we don't give them positive attention, they will find it in other, harmful, ways, or withdraw from communication altogether.

> ***Everyone wants to be loved, or if love is lacking, to be admired, or in the absence of admiration, feared, or, if fear is lacking, despised and detested.***
>
> *—Hjalmar Söderberg. Doctor Glas, 1905*

How to identify a drug user

Drug use often coincides with puberty, a period in which teenagers go through changes anyway. Often, it is not easy to tell if a certain change in behavior is just a normal result of puberty or caused by drugs. Parents, friends and others close to the child play an invaluable part in the discovery of drug use, and can intervene early to prevent the development of a habit. But they can only do this if they pay attention to the early signals, can diagnose the symptoms, have moral support and are not afraid to act. In the case of alcohol and tobacco, a keen sense of smell and a conversation often suffice. This is not so simple for illicit

drug use, since the symptoms of a beginning dependence are harder to recognize. Each symptom alone may not be so meaningful, but when observed in combination, these symptoms should trigger the appropriate response.

- New, unknown friends
- Truancy
- Continuous coughing and chest infections
- Delayed reactions
- Deteriorating short-term memory
- Increased pulse
- Red eyes
- Poor depth perception
- Cravings for sweets (especially "munchies" after marijuana use)
- Fatigue
- Nightmares
- Decreased powers of concentration and memory
- Blackouts and hallucinations
- Lowered interest in school, sports and hobbies
- Mood swings
- Depression and a sullen attitude
- Development of unrealistic thoughts and ideals
- Shifty eyes and jittery handshake
- The disappearance and borrowing of money, expensive objects being sold
- The appearance of drug-related paraphernalia (cigarette papers, marijuana scales, marijuana leaves on clothing, CD covers and comic books)
- Criminal behavior
- Radical change in personality and behavior
- Difficulties in school

This list is not complete. Individuals react differently to change. Some symptoms are not necessarily related to drug use. What is important is to look at the broader picture, to check for as many of these symptoms as possible and to approach the situation with a healthy dose of common sense and care. Don't be fanatical, but be clear—which shouldn't be so difficult if it involves your child, grandchild, kid next door or student. Above all, do not hesitate to broach the subject. If these symptoms occur, and you don't act on your suspicions, you may be made aware of your child's drug use by school, police or friends. Don't dismiss their concern. Ask them for help.[6]

What can you do if your child uses drugs?

Be informed, first of all. Also:

- Don't panic.
- Don't go into denial.
- Remain a parent: stay involved.
- Examine carefully and calmly the indications of drug use.
- Wait until the high has passed.
- Confront the child with the evidence.

The key is to listen, to ask your child what's happening in his or her life. Are there problems in school? Make an appointment with the school, and ask them if they have noticed anything unusual.

And don't be manipulated—"I'll stop using if you don't tell mom or dad." Make and enforce reasonable rules related to going out, coming home, having friends over. Involve the other family members, and don't neglect them or yourself. Get help to stop your child's drug taking.

What really matters is not what you know about drugs, but what you know about alternatives for drugs.

Bad parents?

In his 1989 book on drug dependence and drug policy in the Netherlands, *The Dutch Method*, Arthur Baanders wrote, "Almost everyone I spoke to agrees that the source of heroin use is rooted in the family background. Most say so very emphatically and explicitly."[7]

This attitude remains popular, but drugs can take over anybody, anywhere. This has become clear to me over the many years when I supported a parent self-help group. Everybody makes mistakes. Parents and educators aren't perfect. But should parents therefore be blamed for their children's drug use? Parents of drug dependent children carry a heavy burden, always looking for the answer to the question "why?" They don't need to add more guilt to their burden. On the contrary, they need support. Parents of children who don't use drugs often have more energy to engage in the struggle against drugs, especially on city and

county levels, than parents whose children are struggling with dependence.

Looking at parents of drug dependent children around the world, we'll see that background and color don't matter. Such parents can be black or white, rich or poor, well educated or not, single or not, religious or non-religious. But it certainly is a lot easier to blame the parents than government policies. And not often do we hear about how drugs came to be in the child's environment. The drug industry, popular artists and actors who use drugs and the trend toward liberalization all exert enormous pressure on young adults. At the same time, parents' lives have not become any simpler or calmer. Children are working hard to prepare themselves for adult life. Such work is intensive and tiring, but also exciting and challenging. Drugs lead them away from those goals and steal their teen years from them. "Drugs are everywhere, and easy to get," we hear many teens say, and that is the problem. "Bad parents" must have been around since Adam and Eve, but drugs used to be hard to find, and certainly were not as plentiful and varied as they are now. There used to be social control mechanisms to support parents who now find themselves alone too often. The situation now confuses children and parents alike. Don't blame parents for a drug culture where drugs are tolerated and young people exposed to drug abuse! Blame incompetent and uninterested politicians for their passivity! Blame the legalizing movement for hazardous, propaganda, misleading young people into believing that drugs can be used "recreationally" with no or little risk to their health.

Tolerating drugs is hostile not only to children, but also to parents.

Who is codependent?

"For a while the drug addict in my life completely dominated our house and our happiness. He caused me to feel anxious, to suffer sleep depravity, to be angry and afraid. He reacted aggressively to situations which didn't please him and abused my weakness."[8] The person telling this story is codependent.

What is codependency?

The term is mostly and regularly used in treatment programs and in self-help groups. These groups are usually based on the Twelve Step

program developed by Alcoholics Anonymous. A person is codependent when they tolerate or excuse dependence behavior and thus support it. "A codependent person is one who has let another person's behavior affect him or her, and who is obsessed with controlling that person's behavior."[9] While one would rather have the person drug-free, one can always find excuses to allow it for this one last time, or to think that it really may not be so bad. The codependent's life more and more goes out of control, until it finally becomes possible that the codependent person is as bad off as the dependent person.

The codependent person will often go through the same stages as the dependent person before accepting the facts and the situation for what it is. These five stages are:

1. *Denial* — One first denies the existence of a problem. Often, codependents are the last to realize that the family contains an addict, sometimes they realize it even later than the addict. Of course, there is a nagging, uncomfortable feeling that something is wrong, but parents usually suppose their children do not lie and do not use drugs.

2. *Anger* — The second stage often involves blame. One can blame society, the addict, God or life itself. One has attempted, unsuccessfully, to gain the addict's confidence or control their behavior. Embittered, the question comes to mind, "What did I do to deserve this?" This anger is normal, but if it isn't overcome, the addict will continue to dominate you're the codependent person's life. In this rage, codependents have committed the most desperate acts, from murder to suicide, remaining stuck in and controlled by uncontrollable rage, or, perhaps most commonly, being deadlocked by endless, terrible destructive resentment.

3. *Bargaining* — In this stage, codependents try to make the best of their situation and convince themselves that it's not so bad yet. Perhaps, if he is helped just once more, it will all go away. Perhaps his addiction will stop if he gets this job, or that house or this gift.

4. *Depression* This is the stage where the codependent person realizes they are completely helpless, overpowered by the other's addiction.

5. *Acceptance* Acceptance does not mean approving of drug use. It does involve the realization that one still cares for the user, but is powerless in some matters, such as drug use. Acceptance also entails the realization that, as a codependent, one also needs help. No matter what happens to the addict, recuperation is necessary. One has to be able to let go of the problem, so that the addict can come to realize the consequences of his/her actions and addiction. This stage can be reached with the help of the Twelve Steps.[10]

Besides the meetings organized by AA (Alcoholics Anonymous), NA (Narcotics Anonymous) and GA (Gamblers Anonymous), other support groups now come together to support families, friends and teens. Families Anonymous (Al-Anon) and Alateen and others offer help to those whose lives have become unbearable as a result of someone else's drug problem. To check for codependency, Melody Beattie, whose *Codependent No More* was a breakthrough in the public's awareness of codependency in the 1980s, developed the following questionnaire. She discusses codependents of alcoholics. Since alcoholism and drug dependence are so much alike, I have adapted her questionnaire. Should you answer yes to three or more of the following 20 questions, you may want to consider contacting one of the organizations above. There are more organizations than just those who provide assistance to codependents. Make sure that the group doesn't support the "harm reduction" ideology, in which case they may do more harm than good. A considerable number of help organizations are, according to the definition of codependency, codependent themselves.

Questions to determine codependency

1. Are you worried about how many drugs someone else uses?
2. Do you have money problems because of someone else's drug use?
3. Do you tell lies to cover up for someone else's drug use?

4. Do you feel that using drugs is more important to your loved one than you are?
5. Do you think the drug user's behavior is caused by his or her companions?
6. Are mealtimes frequently delayed because of the drug user?
7. Do you make threats, such as, "If you don't stop using drugs, I'll leave you?"
8. When you kiss the drug user hello, do you secretly sniff for signs of drug use?
9. Are you afraid to upset someone you suspect is using drugs for fear it will set off another episode of drug use?
10. Have you been hurt or embarrassed by a drug user's behavior?
11. Does it seem as if every holiday is spoiled because of drug use?
12. Have you considered calling the police because of drug-induced behavior?
13. Do you find yourself searching for a drug stash or paraphernalia?
14. Do you feel that if the drug user loved you, he or she would stop using to please you?
15. Have you refused social invitations out of fear or anxiety?
16. Do you sometimes feel guilty when you think of all you've done to control the user?
17. Do you think that if the drug user would stop using, your other problems would be solved?
18. Do you ever threaten to hurt yourself to scare the drug user into saying, "I'm sorry," or "I love you"?
19. Do you ever treat people (children, employees, parents, co-workers, etc.) unjustly because you are angry at someone else for using drugs?
20. Do you feel that there is no one else who understands your problems?[11]

Letting go

Some codependents have a hard time letting go and ceasing to exercise control. The following statements may enable you to realize that you don't have to stop *caring*, but that neither you nor the addict benefit from your attempts to control the situation.

> When you stop exercising authority, you don't stop caring; it simply means you cannot make decisions for someone else.
>
> Letting go of your authority means to accept your lack of power, that you cannot control someone else's life.

Letting go of your authority means to stop nagging, arguing or screaming at a person, and instead to realize the uselessness of those reactions. Letting go of your authority means not to judge, but to be human.[12]

In a nutshell, letting go means that the dependent person must take full responsibility for his or her dependence. To loved ones, it can be excruciating to watch another loved one bearing this burden alone, but often enough the dependent person does not realize he or she needs help until his or her family realizes the dependent's problem and the family's own helplessness. The dependent person will see that the parents are powerless, or that they simply refuse to maintain the dependent person by bailing him or her out time and again. A parent who accepts the situation is far from weak. Such a parent is strong, draws the line when necessary, and as a result has more peace of mind. Such a parent can help a child get help and can say, "As a person, you are always welcome, but your drugs are not." At that moment, dignity is restored.

In the Old Wild West, highwaymen used to put a pistol in their victim's face and demand, "Your money or your life." Drugs are worse than those old-fashioned robbers: They take both.[13]

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Chapter Two

OVERVIEW OF DRUGS

Drugs are commonly divided into classes based on their general pharmacologic effects.

Narcotics (Opiates)

The origins of opiates date back to around 4,000 years ago, when ancient Mesopotamia, the area between the rivers Tigris and Euphrates, saw the first cultivation of opium. It was considered a divine gift whose use was strictly regulated, not a drug for use by just anyone. Before 1600, use in China and elsewhere was only medicinal, as an extract or tonic. Smoking opium to get high came into being only after Europeans introduced smoking tobacco.[1]

Opiates are narcotic, pleasure-inducing, painkilling, and sedating drugs that have been used in countless products over time. "Poppy syrup," also called "sleeping syrup," was used for many different ailments. Laudanum, a mixture of opium and alcohol, was quite commonly consumed instead of gin to alleviate the conditions of the working man.[2]

Common to every opiate is physical tolerance. Each time they are used, the dose must be increased to achieve the same effect. Opiates are both physically and psychologically dependency producing. Many users of opiates become indifferent and careless and, finally, depressed, which can lead to suicide.

Opium

Opium (*Papaver Somniferum L.*)* is the dried sap of unripe poppy heads or poppy straw. Raw opium alkaloid (approximately 40) contains 4-21 percent morphine, besides other opiates such as codeine (0.7-3 percent), papaverine, and thebaine. They sedate, calm and suppress cough. Growing opium is legal only for medicinal and scientific purposes. Its culture is, like all other drugs, regulated by the International Narcotics Control Board in Vienna, a subsidiary organization of the United Nations. Poppy straw is all parts of the opium poppy (except the seeds) after mowing, namely the dries upper part of the stem and the poppy plant.

Morphine

Morphine is an alkaloid extracted from opium or poppy straw used as painkiller, medicine and narcotic. The German pharmacist F. W. Sertürner was the first to derive morphine from opium 1803. Raw opium can be purified as a morphine base into ranges from off-white to dark brown powder, which forms the basis for the production of heroin. In extreme cases, and by developing tolerance, a morphine dependent person can increase his or her dose up to 50 times, an amount lethal to a non-user, and more than a few hundred times the usual dose in medical use (0.01 gram).[3] The morphine used in hospitals is a highly refined white powder and is still the most commonly used painkiller for severe conditions.

Morphine was initially used to help opium dependent persons kick their habit, but it was soon discovered that morphine also was highly dependent producing. This prompted further research for a non-dependent producing substitute painkiller. Heroin was the result of the search.

Heroin

Heroin (Diacetylmorphine) is a semi-syntetic opiate synthersized from morphine. Four stages in the production of heroin can be distinguished: 1. crude morphine, 2. heroin base prior to its conversion to the hydrochoric salt, 3. smokable form containing 25-45 percent heroin hydrochloride, 4. injectable white powder with a purity up to 98 percent. Brown heroin is crude heroin base when uncut 40-60 percent.

*Papaver Somniferum L. L. for Linné

Like morphine, heroin rarely comes to the market in its pure form. Rather, it is cut and mixed with a variety of materials such as baking soda, sugar, caffeine powder and rat poison.* Purity levels vary widely: in the Netherlands, street heroin contains 20 to 80 percent heroin."[4]

Heroin as a miracle cure?

Heroin was produced in 1874 by English researcher C.R. Wright. When he tested the drug on dogs, he found it caused side effects such as agitation, anxiety, drowsiness and vomiting, causing him to quickly stop his experiments. Twenty years later, a German researcher rediscovered the drug. After six months of lab tests, the pharmaceutical company Bayer introduced heroin to the market in 1898. It was presented as a non-dependent producing drug at least as powerful as morphine and sold as a cough suppressant and painkiller. Despite agreement among many researchers in 1910 that heroin actually was dependent producing as well as a ban on narcotics (the 1914 Harrison Narcotics Act), Eli Lilly & Co. introduced four more such cough suppressants to the US market in 1919. Millions of bottles of elixir and pick-me-ups were sold. The result was widespread heroin dependence, especially so in the United States because heroin was touted as a miraculous cure for morphine dependence.[5]

Heroin is injected, snorted/sniffed or smoked mixed with tobacco or, inhaled (chasing the dragon) similar to freebasing, when heroin is heated and the fumes are inhaled. It immediately causes feelings of deep satisfaction and contentment, blocking pain and, at least initially, providing great euphoria (a "kick"). Heroin does not cause immediate physical dependence, but the rush it provides inevitably invites a second dose. The first injection can be so intense that psychological dependence precedes physical dependence. Repeated use, even of small doses, quickly enhances dependency.

> ***The junk merchant does not sell his product to the consumer, he sells the consumer to his product.***
>
> *—William S. Burroughs, Naked Lunch (1959)*

All use of heroin is poisonous, including freebasing and smoking. After numerous alarming reports about an increase in AIDS among illegal drug users who share needles, smoking and particularly inhaling

*Rat poison allows the heroin to leave the body more quickly and forces the addict to visit the

heroin became more and more popular, increasing the number of heroin dependent persons with severe lung problems—often caused by years of smoking tobacco and then aggravated by inhaling heroin fumes. Those who shoot up risk HIV infection, and often do serious damage to their veins. Just as heroin was expected to help morphine dependent persons kick their morphine habit, so was methadone expected to help people beat their heroin habit. Of course, both "cures" merely supplanted one dependence for another.

> ***Opiate dependence damages health and diminishes sexual appetite. Despite decreased physical capabilities, dependence persons often prostitute themselves, engage in crime and become homeless. These dependence persons do things they never wanted to do and really are incapable of doing. The drug controls their behavior; society tolerates it.***

Synthetic opiates

Synthetic opiates, also called opioids, are created chemically. The best known are methadone, palfium, levo-alpha-acetyl-methadol (LAAM), buprenorphine (Subutex®), Temgesic®, Buprenex®). Legally, they can only be used as painkillers. Increasingly, physicians and scientists, but also parents, social workers and former users warn against these substitutes. Usually, they are prescribed for users of illegal drugs by physicians and at rehabilitation clinics. They often are distributed by volunteers and social workers and subsidized by the Government. However, the majority of prescriptions only serve to add to a user's arsenal of drugs. Some of them are resold illegally on the streets, where they are as popular among drug users as many other synthetic sedatives and tranquilizers, such as Flunitrazepam (Rohypnol®), Lorazepam (Temesta®), oxazepam (Seresta®), diazepam (Valium®), Mogadon®, and Librium®.

Methadone

Medicinally, methadone is used both as a painkiller and as a detox agent under careful medical supervision during the detoxification of opiate dependent persons. In methadone programs, however, it is used as a substitute for various drugs. Methadone, usually taken orally, is effective much longer than heroin, 24 to 36 hours, compared to heroin's

two to three hours. This longer effectiveness increases the risk of accumulation of methadone in the body.[6]

Taken orally in precisely measured doses, it causes neither craving nor a "kick" and thus prevents withdrawal symptoms. But its withdrawal symptoms last much longer and are more painful than those of heroin. In the Netherlands, methadone is placed on the list of substances covered by the Opium Law, along with heroin, but because its use is medically accepted, it is treated differently by criminal law. Possession for other than personal medical use is punishable by probation of one week to one month, whereas possession of heroin for other than personal use is punishable by a maximum six months in prison.[7]

History of methadone

Methadone was developed just before the Second World War under the commercial name Dolophine, named for Adolf Hitler at Bayer pharmaceutical company.[8] Researchers were looking for an alternative to morphine, because morphine was in short supply in Germany. Methadone was introduced to the United States at the end of the war. Immediately at the end of World War II in Europe, a Lilly research chemist named Dr. Ervin C. Kleiderer joined the Technical Industrial Intelligence Committee of the State Department which was investigating Nazi drug companies. Kleiderer's team brought methadone to the US. Two years later, Lilly marketed Dolophine cough medicine, thereby retaining the Nazi brand name for methadone.[9]

Methadone experiment

With a growing epidemic of i.v. heroin abuse, a solution had to be found for America's drug problem. Psychiatrist Mary Nyswander and scientist Vincent Dole, in a 1965 article, proposed methadone treatment for heroin dependent persons. They were committed researchers looking for an antidote to what seemed an incurable dependence, and were exploring pharmaceutical interventions. Dole was convinced that heroin dependence was caused by a metabolic disorder for which methadone would be the cure.[10]

> *In 1963 [Dole] began experimenting with long-acting methadone treatment of a number of young heroinists, "street addicts" from slum districts in New York. Dole*

administered successively increasing doses of methadone (mixed in orange juice and taken under medical supervision) during a six-week period, and in this way he saturated the heroinists with this long-acting morphine substitute. As a result even large injections of heroin no longer had an euphoric effect. Not even the methadone doses themselves gave a euphoric effect when the doses were increased slowly, or later when the saturation dose was kept constant, and the original mood and personality of the patients returned. Many of the patients soon started working again and could give up the criminal life they had been forced to follow in order to finance their dependence and their kicks. By the spring 1967, about 400 heroinists had been treated according to Dole and Nyswander, with complete success. Very few had interrupted the program which, after a six-week period of adjustment in hospital, consisted of daily visits to the outpatient department to drink a glass of methadone juice. By means of regular urine tests, there was a check on whether the patients abused heroin or other pharmaceutical preparations. Even the social rehabilitation was reported to have been very successful for the whole group.[11]

This sincere experiment led to the conclusion that methadone could decrease drug abuse and crime. The program was exported in the mid 1960s to Europe and to Australia in 1969. Initially, these programs were carefully monitored by medical experts in the manner of Dole and Nyswander. In Sweden, this program is applied even today in its strictest form.

HIV and methadone

Since most drug dependent persons did not want to lose the kick heroin provided, Dole and Nyswander's model did not gain popularity among them. Soon a "political" model, aimed at reducing drug-related nuisances and guided by politicians' efforts to show well-intentioned resolve, became fashionable—often against expert advice. The onset of HIV was used to again push methadone and needle exchange programs

to prevent HIV and AIDS. This infection was new and lethal, and all possibilities were examined to prevent the disease. According to Dr. Mary Jeanne Kreek, a professor at the Laboratory of the Biology of Addictive Diseases at Rockefeller University, where methadone maintenance programs started, "Heroin dependence is a chronic disease from which few are cured. Because of HIV and AIDS, methadone is now experiencing a worldwide renaissance."[12]

Professor Karl-Ludwig Täschner, chief physician of the psychiatric clinical hospital in Stuttgart (part of the academic hospital of the University of Tübingen), an internationally renowned expert on drug dependence, questions if distributing methadone helps to counter HIV. "As experiments in Spain and Italy show, methadone substitution programs that are only loosely controlled do not help to curb the spread of HIV. Even more strictly controlled methadone programs, such as that in Switzerland until the summer of 1987, do not help to stop the spreading of the disease. In Switzerland, the relative number of AIDS patients among drug addicts is five times higher than in Germany. American experiments likewise indicate that such programs do not reach those spreading HIV."[13] Similarly, experimentation in the Netherlands also failed to show positive results.

Methadone in the Netherlands

In the Netherlands, methadone distribution started on a small scale in 1968 in Amsterdam's Jellinek clinic. The experiment aimed at abstinence and disallowed the use of any other drug except methadone. The use of heroin spread rapidly in the early 1970s, which in turn led to changes in the methadone program. Methadone became increasingly important, causing large groups of drug dependent persons to crowd the distribution points where they created an immense nuisance. They wanted free methadone in case they ran out of heroin but did not want to cure their dependence. Social and medical workers reacted with despondency to the failure of the rehabilitation program, and the result was more methadone programs with low thresholds. Wherever the threshold was raised, an addict had to be motivated to kick their habit and was removed from the program in case other drugs were used.[14]

According to William Twiss, social worker at a consultation agency in Friesland, the Netherlands, methadone is like a sweetener, fitting perfectly with a strategy of buying time without curing users of illegal

drugs or preventing dependence. "By handing out a substitute like methadone, social services actively work toward maintaining opium dependences among those whom they want to assist in living without compulsive use of opiates."[15] In the words of a former addict: "When I wanted to kick my heroin habit they offered me methadone. When I asked when the dose would be decreased, the social worker told me: 'That's not necessary. You can function quite well on methadone.'"

Expansion

Despite the harmful effects and the lack of scientific study into the long-term effects of methadone, methadone programs were put in place all over the world. This process is called the medicalization of the drug problem. Methadone *maintenance programs* pose no time constraints or demands. Concurrent use of other drugs is allowed, increasing the risk of overdose. Drug dependent persons are rarely required to kick their habit, though they're free to do so.

The beneficial effects of methadone still haven't materialized. Methadone's impact on public nuisance and crime caused by users of illegal drug is next to none. In fact, for many dependent persons the daily dose of methadone becomes the essential precondition for continuing their drug habits and its associated life of crime.[16] Nor does methadone decrease the demand for drugs. Ninety percent of methadone users also use heroin and cocaine.[17] On the other hand, methadone is a money-maker: annually, Dutch dependence treatment centers and physicians prescribe around two and a half million doses of 50 milligrams of methadone[18]—a $5 million business.

Besides, no scientific studies have been done in the Netherlands testing the efficacy of methadone programs. The only study currently underway compares a group of methadone users with a group using both methadone and heroin. It is a study to test the heroin program, not the efficacy of methadone substitution.

Different programs are conceivable. Methadone programs could *phase out* illegal drug use with the ultimate goal of complete independence by slowly decreasing the dose. Unfortunately, current methadone programs do not pose this as a goal.

We know that every drug affects the unborn child, and methadone is no exception: "The most bizarre and horrible effects of methadone withdrawal occur in infants born to mothers who are addicted to

methadone," according to Michael Smith. He quotes a study done in the Bronx showing that "methadone babies died of crib death at 17 times the normal rate."[19] In hindsight, methadone appears to have become the pillar of Dutch drug policy on the basis of dubious evidence as to its efficacy and its consequences. Interestingly enough, drug dealers never interfere with methadone distribution points, even though they should be a direct threat to their livelihood. Methadone distribution has no impact whatsoever on the heroin trade. The state supplies the methadone and keeps an eye on the community of illegal drug users. Illegal drug dealers benefit from the presence of methadone distribution, because few methadone users take only methadone. As long as the state continues a policy of "harm reduction," it maintains illegal dealers through maintaining drug dependent persons to the detriment of both the user of illegal drugs and society.

Effects of methadone use

Ross I. Goodridge, a barrister who researched the Australian methadone program and was instrumental in putting methadone maintenance programs and their negative effects on the political agenda, listed the following short- and long-term effects of methadone.

Short-term effects:

- sweating and intensified body odor
- analgesia (blocking of sense of pain)
- myosis (contracted pupils)
- sexual dysfunction
- nausea and vomiting
- respiratory problems
- intense constipation
- abnormally lowered body temperature
- slow pulse, palpitations, low blood pressure
- poor blood circulation

Long term:

- weight increase (due to fluid retention or diet changes)
- tooth decay (due to reduced saliva production)
- impotence or delayed ejaculation in some men
- loss of libido for some women

- disrupted menstrual cycles
- reduced fertility
- increased danger for people with liver and kidney ailments[20]

Advocates and opponents of methadone

Advocates feel that methadone should be used when other treatments against dependence have failed. This is based on the principle of "harm reduction," that those who are not yet willing to kick their habit will cause as little harm as possible to themselves and to society. According to these advocates, methadone brings regularity into the life of the dependent person.

Opponents, on the other hand, believe that the use of methadone reinforces, rather than counters, dependence. Methadone enters the illegal market, and the use of other drugs besides methadone is the rule rather than the exception. Methadone is harmful and more easily obtainable than counseling on how to kick a drug habit. Moreover, methadone programs have thresholds and demands that are too easily met. Withdrawal from a methadone habit is more difficult than from a heroin habit. Dependent persons find themselves feeling doomed to remain drug dependent indefinitely.

Control?

Who hasn't heard this: "If we give out methadone, addicts don't have to engage in criminal activities to get money for their habit," or, "Addicts are under the care of social services, and know what they get—and we control the situation." From statements such as these, giving out methadone to dependent persons came to be seen as a positive factor in aiding and preventing dependence. Citizens trusted the experts.

Methadone programs are still in place without much criticism or control. E. Engelsman, who headed the department for Drugs, Alcohol and Tobacco at the Dutch Department of Health expressed such faith in methadone programs in the following terms: "Abroad, addicts are often seen as dangerous monsters. When we have foreign visitors, sometimes they are even afraid to enter the vans from which methadone is distributed. What we try is to make contact with addicts. We do research in the field to gain insight into how addicts do over the course of a number of years."[21]

But such a mentality, of merely observing without ever acting has brought many a parent to despair. It reminds me of the time I participated at a conference in Noordwijkerhout in 1986. After a presentation on drug policy in the Netherlands, a Canadian researcher told me, "What is happening in the Netherlands sounds like an interesting experiment." When I responded that this wasn't equally "interesting" to parents and their children, he agreed with me, but told me that as a researcher he was more interested in this experiment with tolerance, implying that the human cost was less interesting.

> ***A so-called humane drug policy, formulated to give these sorry dependent persons what they need, is basically an inhumane drug policy. This, in fact, increases the number of people who function in society under the influence of opiates.***
>
> *—Europe Against Drugs (EURAD)*

"Euro-methwork"

Ernst Buning of the Amsterdam Municipal Health Department, while a coordinator in 1993, had a large share in founding the European methadone network, "Euro-methwork." They collect and disperse information, assist in setting up programs and organize workshops at international conventions. Their goal is to integrate methadone into national drug-policies, aiming at "harm reduction."

But not everyone accepts these methods without doubt. In Australia, after years of methadone distribution, an investigation was started into the use of methadone and its consequences.[22] When the methadone program was started in Australia, its proponents claimed it was a program designed to aid dependent persons in kicking their habit. But since then, people failed to reduce their drug use and the problem increased. Ross Goodridge summarized the following myths regarding methadone:

- The government and doctors work together to reduce drug dependence.
- The government distributes methadone to drug addicts as part of a program to help reduce their drug dependence.
- The government prosecutes all drug pushers.

- The law prosecutes illicit drug use.
- Methadone is prescribed in smaller and smaller doses until an addict is cured.
- Government supplied methadone is not sold on the streets.
- Methadone is easier to give up than heroin.
- Methadone and heroin don't mix.

However, these are myths and have no basis in fact. After several interviews, Goodridge concluded that methadone programs;

- do not diminish the use of drugs,
- do not help addicts kick the habit,
- do not stop heroin consumption,
- do not lower the sales of heroin on the streets,
- were not helpful in aiding addicts regain their independence,
- do not discourage patients from selling drugs,
- do not prevent the Government from being unwitting supplier of illegal drugs on the streets.

On the other hand, methadone programs do:

- provide a substantial source of income for some doctors;
- take away the hope of many addicts that they might receive medical assistance with their attempts at drug withdrawal;
- provide addicts with an illegal source of income (when selling excess methadone) with which they are able to buy more drugs;
- provide a system within which the use of heroin is tolerated and not prosecuted;
- inflict upon patients a lifetime of health risks and complaints.

According to Goodridge's numbers, the medical profession gains three million Australian dollars (around USD $1.5 million) for every 500 dependent persons in methadone programs. By selling some of their methadone, users of illegal drug can make 200 to 330 EUR a week. No taxes are paid, of course. The police pay hardly any attention to the sale of methadone, which is acquired for free by the sellers. In this context, it would be interesting to have an independent person or institution investigate the methadone situation and the consequences of methadone programs in Europe.

Deaths resulting from the use of methadone

By 1979, we had heard many stories about the dangers of methadone. According to Dr. John Habison, an Irish state pathologist: "The drug methadone is itself a potential killer and is certainly not a safe opiate."

Little children who swallowed methadone tablets or drank orange juice mixed with their parents' liquid methadone have died as a result. In Denmark, Allan Rathjen, a 24-year old politician who was not a known drug user, died from an overdose of methadone and acquired his methadone illegally.[23] In the United States, a crackdown on oxycodone (the active ingredient in OxyContin®) has led to an increase in methadone-related deaths. "Forty-four people died from methadone overdoses last year in the western half of Virginia," said Dr. William Massello, assistant chief medical examiner in Roanoke. "We're theorizing that perhaps because of the bad publicity that OxyContin® has received, there are physicians who are switching to methadone to treat pain," Massello said. "The pharmaceutical black market is driven primarily by 'doctor shoppers' who fake ailments to obtain drugs from multiple physicians and then sell them on the street."[24]

A first step towards normalization

A community that gives efficient information and acts proactively has little or no need for methadone programs. Methadone programs in a liberal drug climate are doomed to fail, since it is issued on a large scale without the goal of drug rehabilitation. Often it is a first step to normalize illegal drugs by medicalization. Large-scale methadone programs bring more people into such programs for longer periods of time, taking away their motivation to kick their habit. Nowhere in the world have large-scale methadone and needle exchange programs (part and parcel of "harm reduction" policies) successfully managed to prevent or decrease illegal drug use, HIV, hepatitis, traffic accidents, drug deaths or crime. The risk of infection, besides being caused by sexual contact, starts with the first injection. Prevention must be first and foremost. "We learn from history that no country has ever decreased its drug problems by making it easier to use drugs."[25]

> ***The further the boundaries of tolerance are gradually stretched, the greater the need to manage the problem rather than solve it.***
>
> *—EURAD*[26]

Stimulants

Stimulants come in varying degrees of strength. Coffee, tea and tobacco provide a moderate stimulus and amphetamine, speed and cocaine a strong stimulus. Artificially produced stimulants are called "pep" or "speed" on the street. Other stimulants are cathine, cathinone, khat, methcathinone ("cat"), phenmetrazine Preludin® and methylphenidate Ritalin®. Ecstasy also is a stimulant. All of these stimulants can be swallowed, chewed, smoked, injected and snorted. The effect on anyone using these stimulants is first a boost and then exhaustion.

Cocaine

History

Archeological finds indicate that in 2000 BCE. coca (*Erythroxylon coca*) was grown in the Western coastal valleys of South America. More than 200 kinds of coca grow naturally on the continent as bushes or small trees. The leaves are used both as stimulant and as medicine. They are also used in religious ceremonies, parties and family events by native cultures in the Andes. Coca leaves are mixed with certain fruits, ashes, or chalk and then chewed. Its contents are absorbed through the mucous membranes. This manner of intake produces a high but not a kick. When the Spanish, during the 16th century, forced the native population into slavery in the mines and on the plantations, they took advantage of the dependence on coca by paying in coca leaves.[27] Coca leaves were often used to endure hard labor and to prevent feelings of cold and hunger.

Freud

In 1860, the alkaloid cocaine was isolated, which prompted Sigmund Freud's curiosity. Freud was young and looking for novelty. He experimented with cocaine on himself and others. Enthused by those preliminary observations, he published an article "Über Coca" ["On Coca"], in 1884. Freud advised taking cocaine as an aphrodisiac and to combat various physical and psychological ailments. Presumably, Freud considered cocaine to be an excellent local anaesthetic, and he advocated the use of cocaine to treat morphine dependence. In the 1880s, cocaine was introduced into modern medicine.

However, even though Freud was one of cocaine's most outspoken advocates, in his 1887 article "Desire and Fear of Cocaine," he admitted that cocaine should no longer be used to treat morphine dependence, "because of its rapid psychological and physical degeneration, it poses a much more significant threat to a patient's health than morphine."[28] Before the advent of other anaesthetics, cocaine found widespread use as a local anaesthetic, and it is still popular among ophthalmologists for small surgeries.

From leaf to base

The dried leaves of the coca plant contain at least 14 different alkaloids. The most important of these is cocaine, which makes up 86 percent of all the leaves' alkaloids. The coca leaves are treated chemically with gasoline, among other ingredients, and made into a paste (coca paste is often used as a drug in countries that produce coca leaves). Afterwards, it is purified to make pure cocaine—a white, odorless, bitter, crystalline powder. Base, or freebase, is the alkaline form of cocaine, pressed into a cake and broken into pieces. When heated, it crackles, hence the name "crack." With a bong or crack pipe the fumes of the heated cocaine base are inhaled, a process called basing. This process produces rapid absorption of cocaine into the bloodstream, causing an intensive kick within seconds. This is how a crack user described his experience with crack cocaine:

> *You can smoke enough freebase to kill yourself without even realizing it, because the base congests your lungs so you can keep inhaling it. After that first hit, you spend all night trying to repeat that kick. You keep hoping that the next hit will be as intense as that first one, but it never, I mean never, is that good. Nothing compares to that first kick.*

The effects

Cocaine stimulates the central nervous system and is highly psychologically dependent. The threshold separating an occasional user from a compulsive user differs from person to person. The combination of being administered in an uncomplicated manner (by sniffing) and the intense feelings of pleasure after small doses have created the myth that cocaine is the perfect party drug. Cocaine makes the dependent person

feel like he's not dependent, and all-powerful. The kick lasts only a few minutes, the high from 15 to 30 minutes. One loses all feelings of hunger and exhaustion and feels reckless and confident until the high has passed. During the high, one can experience intense pleasure, euphoria, emotional instability, heightened intellectual awareness, extravagant sexual behavior and a tendency for violence. The user judges these experiences as worthwhile and actively pursues them. Often forgotten are situation-related hazards and the emotional breakdown, which follow the use of cocaine. Cocaine withdrawal symptoms are initially mainly psychological, with a "crash" (depression) after the "high."

Adverse physical effects of using cocaine are not easily connected to its use. Usually, users think the cocaine is not to blame for their failing health. They blame an unhealthy lifestyle or the substances mixed in with the cocaine as a cause for sleeping disorders, general weakness, muscle pains, weight loss, headaches, damage to the fetus, breathing problems, shivers, damaged mucous membranes, dental problems, loss of vision, irregular heartbeat, epileptic attacks, unconsciousness and death. The risk of a heart attack increases 23-fold in the first hour after cocaine use, according to Dr. Murray Mittleman, director of cardiovascular epidemiology at Boston's Beth Israel Deaconess Medical Center.[29] Thus, cocaine greatly increases the risk of heart attacks among people who otherwise would have a low risk. Moreover, long-term crack and cocaine use can lead to cerebral damage.[30]

Also, both male and female cocaine users may, in the long run, lose their sexual drive. Taking cocaine as an aphrodisiac, as Freud advised, is based on the desire for cocaine rather than a means to increase sexual appetite. In the words of the late professor Kerstin Tunving: "They are only interested in themselves and their own pleasure. The cocaine high is more desirable than intercourse. These seemingly contradictory effects result from the fact that cocaine first stimulates the area in the brain that governs lust, leading to exhaustion, and finally to deadly exhaustion and chaos."[31]

The psychological effects of cocaine dependence have been well-documented. The psychological complications are divided into three categories, namely, cocaine euphoria, cocaine depression and cocaine psychosis. Also possible are symptoms that resemble Korsakoff's syndrome,* and cocaine dementia.[32] Users are susceptible to unease and

psychosis. Other psychological consequences are depression, dejection, irritability, apathy, difficulties concentrating, anxiety and guilt, insomnia and suicidal behavior. Delusions may occur, preceding cocaine psychosis. The user feels like insects ("coca bugs") or ice crystals are embedded under his or her skin. He or she hears the "sound of coke" and suffers from paranoia.[33]

Amphetamines

Amphetamine-type drugs (speed, pep, methamphetamine, phenmetrazine, ice, crystal methamphetamine) are synthetic drugs. They dramatically affect the central nervous system giving a physiological and psychological response similar to that of adrenalin. They are swallowed, sniffed or injected and sometimes smoked. As with other stimulants, amphetamines can cause dependence, and its use results in physical and psychological problems. An amphetamine high lasts longer than a cocaine high and is much cheaper.

During the Second World War, amphetamines routinely were given to soldiers and seamen in most forces as a help to stay awake in extreme situations. The use of amphetamines and other drugs is known also from the war in Lebanon in Vietnam and the former Yugoslavia. After the Second World War, amphetamines and similar drugs were used in weight-loss programs. Very quickly, abuse of the drug became widespread, but it took quite some time, until 1971, before the abuse was addressed internationally. In the Netherlands, amphetamines were banned in 1976.

Methamphetamine

Methamphetamine works by stimulating the release of specific brain chemicals-neurotransmitters. These are dopamine, noradrenaline and serotonin. The release of these neurotransmitters boosts central nervous system activity leading to increases in physical activity, heart rate, breathing, blood pressure and body temperature, but there is a decrease of appetite and the need for sleep. It is said that the very first pleasurable experience associated with methamphetamine use is locked in the subconscious memory and is the "driver" to keep a "user" using. It is this pleasure-seeking behavior, associated with the release of high levels

*Also known as Korsakoff's psychosis and as the Wernicke-Korsakoff syndrome, Korsakoff's syndrome, prevalent among long-time alcoholics (due to thiamine deficiency), involves loss of memory function, dementia and decrease of psychological functionality.

of dopamine that makes methamphetamine such a depending producing drug. The drug is potentially explosive, it is toxic, and it damages the environment.[34]

Khat, cathine, cathinone

Khat leaves come from the khat tree (*Catha edulis*), which grows naturally in tropical Africa but is cultivated mainly in Eastern Africa, the Arabian peninsula and on Madagascar. Khat comes under a wide variety of names, such as Qaad (Somalia), Murungi (Kenya), and Thad (Ethiopia), as well as qat, kath, kat.[35]

The leaves contain 0.5 percent of the active ingredients cathinone and cathine, related to ephedrine,* which are all dependence producing. The plant's leaves are not illegal in the Netherlands, but cathinone and cathine are. Pharmacologically, khat most closely resembles amphetamine. Khat has been on the World Health Organization's list of "dependence-producing drugs" since 1993 but it is not yet covered by any United Nations treaty. Because of growing concerns and increasing knowledge about khat, more and more people, especially from Somalia, one of the world's largest importers of khat, and khat-producing countries such as Kenya, are demanding an international ban on khat.

Khat must be used fresh. During transportation, it is wrapped in plastic bags or banana leaves, and sprinkled with water to preserve its freshness. In Scandinavia, Italy, France and most recently Germany, khat is prohibited, but not in England and the Netherlands, which puts great burdens on the surrounding countries. Planes full of khat fly into British and Dutch airports. "Khat is big business for airlines," a British customs officer, who preferred anonymity, told me at a recent conference, "and that hinders efforts to deal with the problem."

Khat enters the Netherlands through Schiphol Airport near Amsterdam and is distributed mainly to refugee centers all around the country. An especially disconcerting recent development is the advent of khat houses, derelict buildings used to chew khat. Khat chewers, who are often East African, become noisy and exited an annoying element in their environment, which contributes to discrimination. The limited financial resources of many asylum seekers are strained even more by the demand for khat. Chewing khat thus cuts into the primary needs of the family, indirectly affecting health and social life. The integration of khat in the Dutch drug scene

*The active alkaloid of the Efedra plant.

is well underway; following other European countries, the Netherlands would do well to prohibit all khat products.

The consequences

The health consequences of chewing khat are well documented: migraines, insomnia, irritability, continually recurring depressions, paranoia, acute psychosis, mental confusion, radical personality changes, deliriums, hallucinations, aggression, stomach pains, liver damage, constipation, hemorrhoids, cardiovascular disease, high blood pressure, as well as other problems such as weight loss, anemia, and dental complications. Chewing khat causes intensive thirst. As a result, khat chewers drink enormous amounts of soda and tea with large quantities of sugar. To prevent insomnia, khat users drink alcohol and take sedatives and sleeping pills. Babies born to mothers who chew khat are very likely to have a lower than average birth weight and an increased chance of being stillborn.

Research by the Vienna Institute for Cancer Research indicates that khat causes genetic mutations in the mouth which can lead to cancer.[36] Similarly, khat chewing has been linked to cancer of the stomach and the esophagus.[37] And as all drug use impedes driving skills, the use of khat also increases the risk of road accident fatalities.[38]

Methcathinone

The main ingredient of methcathinone is ephedrine, which is also used in the production of methamphetamine. It is a synthetic and highly addictive drug, and also called cat, jeff, crank, ephedrine or speed. The Russian physician Voronin reported that physical dependence is reached in two to four weeks, and psychological dependence is immediate.[39] Often, methcathinone users consume the drug intensively for days on end without rest. Methcathinone was discovered in Russia in the early 1930s, and later patented in the United States by Parke-Davis Pharmaceuticals in 1957 as medication for weight loss and possibly as an antidepressant. These plans backfired when the drug proved to be highly addictive, with users reporting seizures, heart palpitations and hallucinations.[40] Methcathinone is easily made at home (which explains one of its street names, "bathtub speed") and contains a multitude of dangerous ingredients, especially harmful acids.[41]

Ritalin®

These days Ritalin® is prescribed for children with ADHD and is a highly contentious issue. Ritalin (methylphenidate) is a drug that has many long-term physical consequences for those who take it and considerable potential for abuse.[42] The use of Ritalin® by hyperactive children has risen alarmingly. In the US, 11 million prescriptions for Ritalin® are written annually, primary for school-age children. Medical literature often points to nutrition as a cause for hyperactivity, and when Ritalin® is prescribed, that cause is often overlooked.[43]

Psychedelic Drugs

Psychedelic drugs alter the user's perceptions of the world. Sooner or later hallucinations have drastic consequences on the user's mode of thinking, sense of time and emotions.

In earlier days, opium was widely used by writers and artist for inspiration, but since the publication in 1821 of Thomas De Quincey's *Confessions of an Opium Eater*, which describes problems caused by opium use, some in that community of users lost interest in opium. Their attention then focused on *Cannabis sativa*. They hoped, as increasing numbers of users of illegal drugs do now, that hashish and marijuana would help bring their dreams and creativity to fruition. French physician, psychologist and scientist Jacques-Joseph Moreau de Tours involved a group of writers and artists in an experiment testing the effects of hashish, the results of which he published in 1845 under the title *Du Haschisch et de l'Alienation Mentale* [*On Hashish and Mental Illness*].[44] Moreau's contemporaries regarded his experiments with interest and placed some faith in the medical application of marijuana.[45] Moreau compared the feelings of a hashish-induced high to those experienced by psychiatric patients.[46] While he and his contemporaries had enough reason to believe his efforts to cure patients using hashish a total failure, they still argued for the acceptance and/or legalization of the drug.

Cannabis sativa L.

Cannabis sativa L. is the Latin name for hemp. This plant yields hashish, marijuana and cannabis extract. Cannabis contains many interesting and complicated ingredients. THC (Δ-9-tetrahydrocannabinol) is the most important. Also effective are cannabidiol (CBD), which changes into THC when smoked and thus enhances the high, and cannabinol CBN.[47] Cannabis contains 483 chemical substances, 66 of which are cannabinoids.[48] THC and other cannabinoids are unique to the hemp plant and dissolve in fat. THC occurs in all parts of the plant, but is especially concentrated in the flower buds and the upper shoots.

Hashish

The hemp plant is covered in glandular hairs that secrete a resin, which is scraped off, dried and pressed into what is commonly called hashish. Colors vary from light brown to black. Nuggets of that cake are broken off and mixed with tobacco, which reduced the temperature of the smoke. The most common method of ingestion of both hashish and marijuana is smoking—rolled into a cigarette (joint), put inside a cigar (blunt) or in a hashish pipe (bowl, water pipe). Hashish can also be consumed by eating. Amsterdam is famous for its "spacecake," pound cake with hashish in it, and hashish candy, made by mixing hashish with figs, dates and other sweets.

Marijuana

Marijuana (Mary Jane, bud, kind bud, pot, weed, etc.) consists of dried and pressed parts of the plant and looks like dried grass with leaves and seeds in it. Its smell is characteristically sweet. Marijuana is smoked pure at a high temperature, which results in its smoke containing more than 2,000 different components. Some of those are highly toxic and known cancer agents, such as carbon monoxide, ammonia, and benzene. They not only endanger the health of active smokers but also that of passive smokers.

Cannabis extract

Cannabis extract is the syrupy extract of hashish, with a high THC content—sometimes more than 50 percent. The higher the THC content, the more dangerous the drug is. It is dripped onto tobacco and smoked.

THC content in cannabis

Hashish and marijuana from the 1960s and 1970s contained between 0.1 percent and 2 percent THC, enough to get the flower generation of

that period sufficiently high. Improved hemp plants now render hashish and marijuana with THC contents between 5 percent and 25 percent, averaging around 8.5 percent. Dutch homegrown marijuana ("nederwiet," or "Netherweed") peaked in the year 2000, at 11.3 percent THC. There is no reason whatsoever to call cannabis a "soft" drug, especially considering the increase in THC content. As in the case of XTC, the Netherlands have acquired a worldwide reputation for its high-quality marijuana sold under names like "northern light" and "skunk."

> ***Marijuana is one of the three most important gateway drugs. It is imperative that we teach everyone how dangerous and addictive it is and that it is never to be used. Marijuana combines the carcinogenic effects of tobacco with the intoxicating effect of alcohol.***
>
> *—Steve Gersten, Attorney*

Is cannabis a gateway drug?

Professor Täschner had this to say about cannabis as a gateway drug: "Whoever tries cannabis and continues to use it is liable to move on to stronger drugs. Cannabis is a drug that seduces a user into using stronger drugs, because after a while an increased dose does not produce an increased effect. To produce a stronger effect one must use stronger drugs, such as mushrooms, XTC and LSD, followed by heroin to calm down with, and so on."[49]

Is cannabis "soft"?

It is often said that cannabis is a simple, innocent, and useful natural product, and that problems caused by its use are controllable and uncomplicated. "Cannabis 'soft'? That is a dangerous expression," says professor Täschner:

> *If the associations of "soft" are pleasant, maternal, friendly, delicious, and good, and those of "hard" unpleasant and damaging, then all focus becomes concentrated on so-called dangerous "hard" drugs to the neglect of "soft" drugs. To divide drugs into "hard" and "soft" is to divide them into good and bad drugs. But there are no good drugs. All drugs endanger a user's health. Whether you take hashish, LSD, the so-called party drugs, cocaine or alcohol, they are all drugs with health risks.*

From years of experience with users of cannabis, Täschner refuses to use the terms "hard" and "soft," considering "the disturbed thought processes and delusions, the amotivational syndrome and the addictive qualities of cannabis."[50]

What are THC's effects on the body?

According to biochemist Julie Ikomi-Kumm, "THC is poisonous. One could say it impedes many bodily functions directly and indirectly." Because of its high solubility in fat, THC is quickly absorbed by fatty tissues, such as the brain, bone marrow, intestines, kidneys, testicles, muscles, etc. THC sticks to those tissues, and like grease spots on clothes, is hard to get rid of. The biological explanation for the fact that cannabis smokers often are less capable to draw abstract and logical conclusions is the tendency of THC to remain stuck to the gray brain matter, the seat of logical thought and decision making.[51] Concentration and learning potential decrease, rendering a user incapable of driving a car, performing in school or doing well at work.

> ***The only thing "soft" about "soft drugs" is how softly, slowly and sneakily they creep into your life. "Soft drugs" are so treacherous because their consequences only become apparent years later.***
>
> *—Sander, former cannabis addict*[52]

THC is absorbed into the body's fatty tissue and then released into the blood, a process that may take weeks. The more you smoke, the more THC remains in the body. This remaining THC slowly but surely affects thought processes. According to professor Täschner, all ability to think complex thoughts is affected during use. These changes occur slowly without the user even realizing them. But such effects do not remain hidden. Those in the user's environment realize fairly quickly that the cannabis user undergoes serious personality changes, which the user will typically deny. Dr. Peter-Paul Heinemann described the effects of hashish on young users:

> *Hashish is a very hard drug, probably the hardest until cocaine became widely popular. It has a violent influence on the experience of the young person's reality and has the power to create a world no longer shared with others. The user moves in*

a circle that does not allow for change and where time stands still. That makes hashish a serious drug. Hashish is catastrophic for the lives of our youth.[53]

Passivity and detachment are characteristic of cannabis use. It slowly renders the private hazy world of the user into a real, meaningful world, while the real, outside world in which others live is experienced as stressful and strange.

—Psychiatrist Kerstin Tunving and journalist Thomas Nordengren[54]

Use of cannabis is catastrophic for youth and society. By now, it is obvious that users of illegal drugs and non-users no longer live in the same world, that they interpret norms, values and laws differently. Users of illegal drugs try to force this imaginary world upon outsiders by political decrees and by sneering at those who don't accept the use of cannabis. Increasingly, current international treaties and laws become less and less accepted. This makes way for anarchy.

Alcohol and cannabis the day after

A joint's chemicals don't leave the body the day after as dramatically as alcohol does, because the active ingredients of hashish and marijuana remain in the body fat. This means that a user of cannabis isn't hung over like a drinker would be. The subjective experience is that cannabis is not physically dependent, less damaging and a more controllable substance than alcohol.

Dependence

While participating in a radio debate in Amsterdam in 1980, a representative from the Jellinek clinic, which treats dependence, told me there was no such thing as a marijuana dependence. But earlier he had given me a brochure about their clinic that stated they also treated marijuana addicts. When I pointed out the contradiction, he said, "Well, there are only a couple of them." In 1993, it was four cases a week. According to the Dutch National Alcohol and Drugs Information System, the demand for help with cannabis dependence rose from five percent of the total number of requests in 1990 to eleven percent in 1998. In 2000, one in eight clients who sought help from drug services had a primary cannabis problem. Over two-thirds (69 percent) of all

cannabis users who sought help in 2000 were new outpatients, meaning that they had not sought help from drug services before. Cannabis was also regularly reported as a secondary problem.[55]

More and more, people are beginning to realize that hashish is dependency producing. "I don't care what they say," said a veteran user, "hashish is addictive."[56] And professor Täschner adds, "About as many people become dependent on cannabis as to alcohol. The risk of dependence is just about the same."

Longing for the high

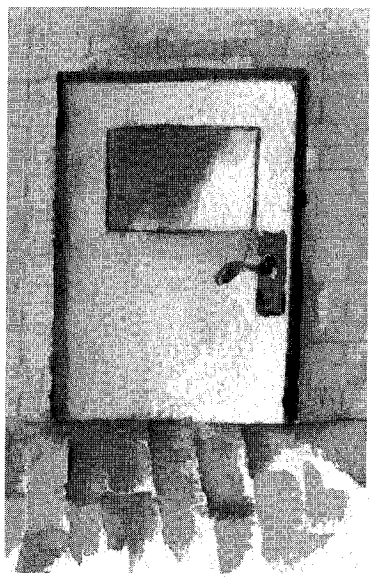
The marijuana smoker utilizes basic psychological mechanism to escape from reality. Whereas a normal drug free person can slip in and out of a dream world, and still recognize the different stage. A marijuana smoker after repeated highs has difficulties holding on to reality.

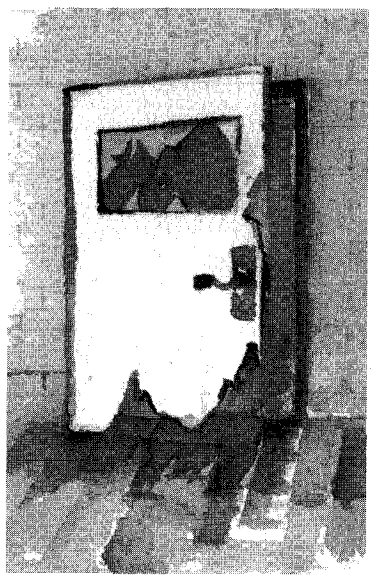
What happens to our everyday impressions?

Peter-Paul Heinemann describes what happens to our everyday impressions at length in his book *Truancy from Life*, and I paraphrase and summarize his account:

Every day we collect impressions. Processing and storing all these impressions goes on in a wonderfully organized fashion. When we sleep, the day's impressions are processed and neatly filed away in our consciousness and our subconscious, where bad memories are concealed. For example, learning how to ride a bicycle is accompanied by bruised knees and scratches. In learning how to swim one may get water inside one's lungs or take a dunking. All these unpleasant memories are either forgotten or buried deep in the subconscious and are not usually recalled. Usually, one doesn't think about these painful events when one bikes or swims. You can't even remember; it is hidden. Less deeply buried are the very private memories we'd like to forget. The knowledge and experience we have acquired are filed in our consciousness and can be recalled upon reflection. The pleasant and everyday experiences we need more often are kept on the surface. When we dream, we stroll through our inner surroundings and check to see if everything is all right. The dreamer walks around and makes sure all the doors are locked

and bolted. At night, the dreamer maintains his personal organization. When things go wrong, the wrong door opens up and a nightmare comes out, waking up from which is the biggest possible relief.[57]





THC disrupts this normal pattern, opening up wrong doors all the time and not closing them again. It's like living in an unending nightmare.

Cannabis: mind-expanding and creativity-inducing?

Cannabis allows the user to wander off in his mind, which is experienced as a revelation. This is the feeling friends enthusiastically share about their drug-induced experiences during pot smoking as a creative and mind-expanding experiment. In the Netherlands, since the 1976 Opium Law, such risky experimentation is considered acceptable. According to Heinemann, "All active drugs have side effects, but those of cannabis are among the most sneaky and destructive. During a mild high, and in the first stages of cannabis use, a 'well-trained' user is usually capable of guiding such a high and its dreams. The user can quit smoking the drug if he goes too far, but at some point in time he will lose that freedom of choice."[58] Hashish makes holes in the wall

separating consciousness from the subconscious, breaking down the mind's safety mechanisms. Sooner or later, the accumulated effects of cannabis create a nightmare from which there is no relief by waking up. The nightmare has become an ongoing reality as long as the drug keeps working. Your personality is torn apart, you hallucinate, fear takes a hold on you, your head is a chaos, you freak out.[59] These are the images we see in drug magazines, images that frighten or boggle a non-user. And the more a user smokes, the more his personality is affected. Cannabis is not mind-expanding but mind-destroying; rather than enhance creativity, it creates anxiety and compulsion.

In countries with century-old traditions of cannabis use, some 35 percent of psychiatric patients are admitted as a result of smoking cannabis. In the Netherlands there has been an increase of psychiatric problems following hashish use. H. Kramer, psychiatrist at the Psychiatric Institute in Castricum, the Netherlands, comments:

It is remarkable to see how crazy hashish or weed can make you. I guess that five percent, or perhaps more, of all the mandatory admissions in our hospital result solely from cannabis use. About twice that amount are admitted because of cannabis-induced psychosis but are dismissed after three days.[60]

When he received his training, Kramer was taught that cannabis was about as dangerous as candy. Oddly enough, indoctrination about cannabis's harmlessness outweighs experience, because despite everything, Kramer still supports the legalization of cannabis: "I am opposed [to cannabis use] only at work." Unfortunately, Kramer is not the only one who doesn't learn from experience. The drug propaganda spouted since the 1960s has deep roots.

What follows is an overview of the possible effects of cannabis use on the user's health.

Respiratory system

Hashish and marijuana smoke causes extensive damage to the respiratory system, acute and chronic bronchitis, emphysema, pneumonia and lowered resistance to lung infections. Cannabis smoke contains four times as many carcinogens as does tobacco smoke. Cases have been reported of young cannabis smokers who didn't smoke tobacco and were diagnosed with cancer of the mouth, tongue, larynx,

jaw, neck and lungs. Tobacco smoke has been proven to cause cancer when inhaled passively and so might cannabis. According to sociologist and author Dr. Kees Neeteson, traces of the active ingredients of cannabis have been found in the urine of non-users who were present when cannabis was smoked. Professor Sidney Cohen of UCLA said in 1986, "Cannabis contains tars, we find, and in these tars are cancer producing agents. We have not yet come to a point where cancer has been proven in people who smoke cannabis—this takes 20 or 30 years—but I am afraid we're going to have an epidemic of lung cancer due to cannabis in time to come."[61]

Most people don't think about marijuana in relationship to cancer. The carcinogens in marijuana are much stronger than those in tobacco. The big message here is that marijuana, like tobacco, can cause cancer.

—Dr. Zuo-Feng Zhang, Jonsson Cancer Center, UCLA[62]

An analysis of the smoke of one pure marijuana cigarette reveals the presence of the following carcinogens:

Vinyl chloride, ng*	5.4
Dimethylnitrosamine, ng*	75
Methylethylnitrosamine, ng*	27
Benz(a)anthracene, ng*	75
Benzo(a)pyrene, ng*	31

Other toxics in one marijuana cigarette:

Carbon monoxide, mg*	17.6
Carbon dioxide, mg*	57.3
Ammonia, µg*	228
HCN, µg*	532
Cyanogen, µg*	19
Isoprene, µg*	83
Acetaldehyde, µg*	1200
Acetone, µg*	443
Acrolein, µg*	92
Acetonitrile, µg*	132
Benzene, µg*	76

Toluene, µg*	112
Phenol, µg*	76.8
o-Cresol, µg*	17.9
m- and p-Cresol, µg*	54.4
Dimethylphenol, µg*	6.8
Catechol, µg*	188
Cannabidiol, µg	190
D9-THC, µg	820
Cannabinol, µg	400
Naphtalene, µg*	3
1-Methylnaphthalene, µg*	6.1
2-Methylnaphthalene, µg*	3.6

*(mg = milligram 1/1.000 of a gram; µg = microgram 1/.1000.000 of a gram; ng = nanogram 1/1.000.000.000 of a gram; *also occurs in tobacco smoke)*[63]

Heart

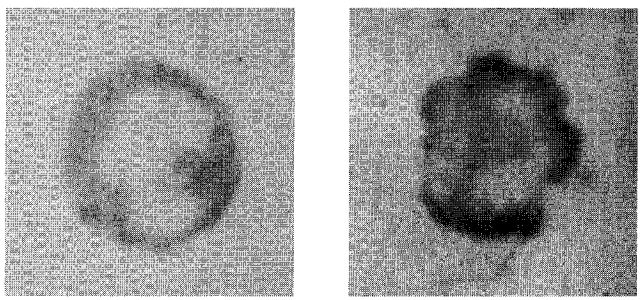
Smoking cannabis leads to an increased heart rate and risk of a heart attack, according to research presented at the American Heart Association's 40th Annual Conference on Cardiovascular Disease, Epidemiology and Prevention. "We found that during the first hour after use, the risk of a heart attack is 4.8 times higher than during periods of non-use," says Dr. Murray A. Mittleman, director of cardiovascular epidemiology at Boston's Beth Israel-Deaconess Medical Center. "In the second hour, the risk drops to 1.7 times higher than during periods of non-use. This indicates a rapid decline in the dangerous effects of marijuana on the heart, but the short-term risk is considerable, especially for patients (such as elderly smokers) with other risk factors."[64]

Growth

Animal research has clearly proven that cannabis stunts growth. This is caused by some of cannabis's effects, such as a lessened appetite and a disturbed hormone balance—or both. Researchers find that cannabis is especially harmful to the fetus, to infants and to rapidly growing teenagers.[65] Research also has shown that young adults who use marijuana regularly have an IQ 4.1 points lower than non-users.[66]

Cells

Every living body is made up of cells consisting of cytoplasm surrounded by a membrane. The nucleus of the cell carries genetic information in the form of DNA. The cell's membrane is made of fats. Because THC is fat soluble, when it reaches the fatty nucleus, it does its damage there. Damage to DNA is especially disastrous. Researchers have shown that intensive marijuana use over long periods of time causes damage to cells that result in clinical symptoms of sickness.



Cells of chronic cannabis users. The membranes and nucleui of these cells have suffered deformations: The cannabinoids living in the fatty "skin" of the cell make the cell look like this.[67]

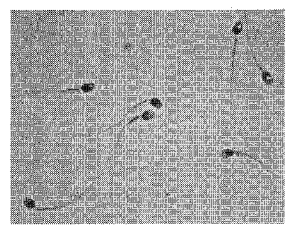
(Image source: Peggy Mann, Pot Safari Slide Series.)

The immune system

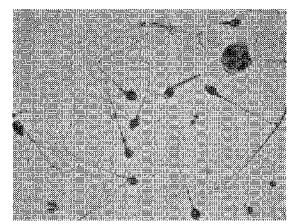
The immune system is damaged by long-term ingestion of THC, because THC sticks to the body's tissues. For example, THC is absorbed quickly into bone marrow, which is high in fat, and slowly released. When the concentration reaches dangerous levels, cells become damaged. Bone marrow plays an important role in the immune system, and damage to immune cells lowers resistance to disease. Regular use of marijuana results in serious illnesses, and cannabis use increases the risk of HIV to run its full course. Lungs are especially susceptible to damage caused by marijuana smoking: White blood cells from the lungs of persons who smoke marijuana have decreased ability to engulf and kill bacteria and tumor cells, and they produce less substances necessary for the immune response.[68] More and more, cannabis smokers seek help for diseases of the respiratory system—-while the pro-drug movement organizes campaigns to demand marijuana be available as medicine.

Sperm

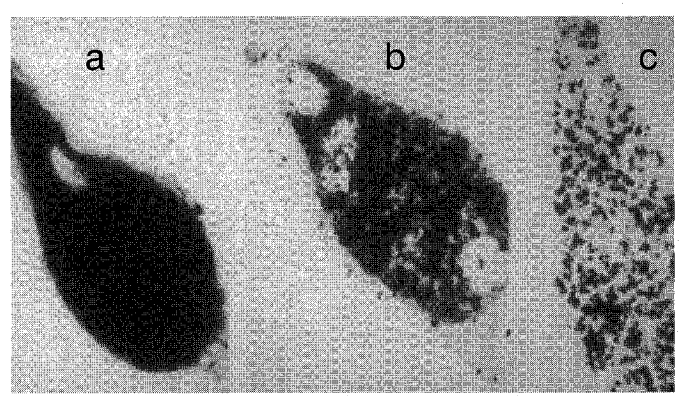
Cannabis affects the sperm maturity at many levels, releasing sperm which had no business being out of the testes. If such sperm did penetrate an egg, there probably would be a natural aborting because the sperm cell is not normal.[69] "The sperm from marijuana smokers were moving to fast early," according Dr. Lani J. Burkman from the University of Buffalo. "These sperm will experience burnout before they reach the egg and would not be capable of fertilization." Burkman noted that many who smoke cannabis have fathered children. "The men who are most effected likely have naturally occurring borderline fertility potential, and THC from marijuana may push them over the edge into infertility,"[70] she said. If fertility potential returns when smokers stop, using marijuana hasn't been studied enough.



a. Normal sperm of a 20-year-old male who smokes one pack of cigarettes a day.



b. Sperm of a 20-year-old male who smoked five to ten joints a day for three weeks.



a. Sperm of a non-smoker. The dark contents are hereditary material, or genes. Here they are well protected by a membrane. b. and c.: Sperm of chronic marijuana smokers. These sperm are incapable of fertilizing the egg.

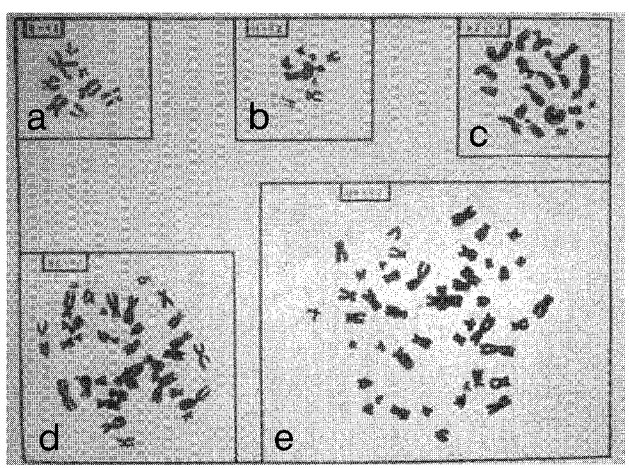
(Image source: Peggy Mann, Pot Safari Slide Series.)

Pregnancy

If marijuana is smoked during pregnancy, even if "only" a few times a week, the risk of a low-birth-weight baby increases dramatically. Cause of this is probably the higher percentage of carbon monoxide in cannabis smoke. Damage may be done to the fetus (fetal marijuana syndrome) comparable to that done by the consumption of alcohol during pregnancy (fetal alcohol syndrome). Babies born to mothers who use marijuana during pregnancy have an eleven-fold increase in non-lymphoblastic leukemia.[71] Children exposed to marijuana before birth display increased behavioral problems, and their vision, language skills, concentration and memory are affected, concludes Dr. Peter Fried of the Department of Psychology at Carleton University in Ottawa, who has researched the effects of prenatal marijuana exposure extensively.[72] THC is carried in mother's milk. A mother who nurses her child while smoking marijuana deposits the harmful substances directly into her baby.

Sexuality

Those who use drugs say that their sexual experiences improve when on drugs. But all drug use after some time leads to sexual problems and to the detriment of the intimate and emotional aspects of sexuality.



a. Forty-six chromosomes in a normal cell. b. Twenty-four chromosomes in the cell of a drug user. Some are dead, broken or distorted. c., d., e. Cells with even fewer chromosomes.

(Image source: Peggy Mann, Pot Safari Slide Series.)

In males, marijuana smoking causes a lowered production of testosterone (the hormone responsible for the reproductive drive), as well as loss of virility and decreased quantity and quality of semen. Long-term use of cannabis negatively affects the production of hormones and semen. In women, the menstrual cycle can become disordered and the ova damaged. The genetic balance in sex cells also is damaged by THC's disruption of the fatty tissue to which it sticks. The result is delayed production in the cell's nucleus of DNA, RNA and protein. Dr. Akira Morishima of the Columbia Presbyterian Medical Center remarked, "In my 20 years of research on human cells, I have never found any other drug, including heroin, which came close to the DNA damage caused by marijuana."[73]

Kidneys

The amount of evidence of marijuana use adversely affecting the kidneys is growing. Lambrecht et al reported in 1995 on a 29-year old male with major kidney failure causedby marijuana use (every other factor was excluded). Their report proves again that, because of marijuana's complicated chemical contents and functions, smoking pot can cause a variety of physical problems, as was pointed out in a comment on their report by Drug Watch International:

> This report is the first one showing clotting off of an artery to the kidney resulting from acute marijuana smoking. The cardiovascular effects of marijuana are well-known and include dilation of peripheral blood vessels resulting in blood pressure changes and reflex, speeding up of the heart rate. If the heart rate is inadequate, there may be drops in blood flow to organs such as the kidney with resulting thrombosis of small arteries. Marijuana is known to be associated with myocardial infarction and stroke (Zachariah SB, Stroke 22:406-409, 1991; Charles et al. Clinical Toxicology 14:433-438, 1979). It is also possible that the marijuana damaged the blood vessels directly, as has been suggested for other drugs of abuse, such as amphetamines (Baden et al New England Journal of Medicine, 284:111-113, 1971). It is clear from this case report, however, that a previously healthy male with acute ingestion of marijuana can clog the blood vessels of a major organ.[74]

Brain

THC stored in brain tissue disrupts the transmission of information and the execution of brain commands. It lessens the blood flow to the brain, even 12 days after smoking marijuana. If the brain does not receive enough blood, it cannot function at full capacity. Short-term memory is affected negatively. The ability to properly evaluate situations and the perception of space and time decline. Normal dream activity decreases. Users develop insomnia, hallucinations, panic attacks, social withdrawal, disturbed sensory perception, loss of motor skills, personality changes, despair, delusions, disorientation and aggressiveness. THC worsens the symptoms of mania, depression and schizophrenia. Marijuana users have a probability of developing schizophrenia at six times the rate of non-users. Manic depression is diagnosed among many (former) marijuana users as a result of chemical imbalances in the brain. In the many conversations I had, it became clear that, for some people, their psychological problems and fears occurred after they started smoking marijuana, but usually they didn't seek help for these problems and didn't admit marijuana use as a cause. However, they did say that marijuana use changed them drastically, for the worse. One wonders if their parents know that this is a possible outcome of marijuana use. According to the late Professor Kerstin Tunving, the majority of marijuana smokers have suffered anxiety and panic attacks. In fact, these attacks are so common that psychiatrists usually treat acute psychological reactions of marijuana users as a panic reaction to the drug until further investigation points to other sources. A former hashish user told me the following about her experiences with hashish:

> *I started smoking hashish when I was 18. After the third time, I flipped out. It was a terrible experience. The next day I had no feeling at all in the right side of my head. They took x-rays of my head but couldn't find anything. I couldn't even feel the needles they stuck into my head. I suffered like that for half a year. Then, I felt this one-inch square on my head, like it was dead. The sensation was terrifying and frustrating. It felt like a liberation when, after 10 years, it finally went away. Now, 23 years later, I have grown children. I have told them how dangerous smoking hashish can be, even if you only do it once. As an example, I tell them of the risk my friend and I took when we put our heads in the toilet bowl and flushed it so we could better hear the wonderful sound of streaming water. In other words, it's lethally dangerous.*

Psychoactive substances don't just cause a high: a growing number of marijuana users suffer psychologically from using the drug. This is not just a personal tragedy, since these users may also cause harm to others, and mentally disturbed drug users have become a visible part of city life. The upshot of the report "Madness in the City, the City a Madhouse?,"[75] written for the city of Amsterdam, was that a city like Amsterdam, with high numbers of pot smokers, cannot provide enough psychiatric relief, and no one seems to know how to organize the treatment of psychiatric patients or how to prevent people from becoming psychiatric patients because of drug use.

Amotivational syndrome/burn-out syndrome

Amotivational syndrome is probably the best-known chronic effect of cannabis use. The father of a hashish-smoking son explained to me how he witnessed his son's lack of motivation and consequent withdrawal from active life:

> *My son wanted to live healthfully and ecologically. He rented a little summer house in the spring, bought seeds and left. It turned out that, come autumn, he still hadn't sowed his seeds. In all those months, he didn't do anything. This unmotivated behavior is characterized by sullenness, apathy and an altered perception of time. He withdrew from society and during this period failed to develop mentally, physically or socially.*

People suffering from amotivational syndrome are passive, introvert and inert. Of course, there are people who don't smoke cannabis and still lack motivation, but this type of reaction can be seen as a direct effect of cannabis smoking, making it hard or impossible to work, to learn, to grow. In his book *Hashish and Marijuana*, Kees Neeteson writes, "Cannabis use has a negative effect on the capability to think logically and on the ability to solve problems and to concentrate." He continues, "Learning new things is rendered more difficult, everyday occurrences become illogical because connections appear missing."[76] Cannabis users simply do not connect to course of events within and around themselves

and fail to recognize this. The mother of a grown former hashish smoker explains this phenomenon as follows:

> *We are now going through the puberty she skipped during her youth, when she was smoking hashish and everything was postponed. And it's not just puberty she has to go through now; everything she should have learned during that period must be repeated.*

With burn-out syndrome, users no longer get high. They only get stoned, desensitized to outside signals. They can no longer engage in conversation, being unable to listen. While people around those users may call this a burn-out, the users themselves don't experience it as such. They are caught in their own petrified world, doing nothing, thinking nothing—but without understanding their own situation.

> ***Saying nobody ever died from smoking marijuana is like saying that nobody ever died from smoking tobacco.***[77]

Cannabis and sudden death

In 1990, a rescue team found two adults and four children in a Stockholm apartment who had been killed by gas. "The person concerned had been taking hashish for twenty years, but there was no evidence of the use of alcohol or any other type of drug. Prior to death, he had shown increasing symptoms of paranoia and had been very aggressive. The case was known to the police and the social welfare authorities, but they were unable to intervene in time."[78]

The department of forensic medicine in Stockholm has been researching drug-related deaths for years. In the beginning, they didn't intend to investigate the relation between cannabis and deaths, since cannabis was supposed to be a rather innocent drug that led to passivity and apathy but not to violence. When the first death from hashish use was reported, they didn't really know what to do with it, but during the investigation more and more bodies were brought in whose blood and urine contained traces of THC but not of any other drug. In five years (1985-1990), the investigators confirmed, to their surprise, no fewer than 24 deaths resulting from cannabis use. Ten of those 24 had committed suicide, one died of natural causes, eight in accidents, and five had been murdered. These deaths related to cannabis use, regardless of the immediate causes of death, were all characterized by impulsive and

unforeseen violent acts. While heroin users typically die of an overdose and alcohol and amphetamine dependence typically lead to violence and accidents, cannabis users statistically died much more often of suicide. Recently, methods to trace cannabis (post-mortem) in blood and urine have become much more sophisticated even though they remain complicated and expensive. They are not done routinely, but only after certain specific indicators.[79] In Sweden, these and all other deaths involving drug use are reported as narcotics-related. In a country like the Netherlands they are not. One should not be surprised, therefore, that cannabis does not show up in Dutch statistics as a cause of death. Statistics from the different countries cannot be compared on a one to one basis.

In the past years, six men in their 30s have died in Norway as a direct result of cannabis use, according to the forensic toxicological institute in Oslo. This report caused quite a stir nationally and internationally. When asked, "Can you die from smoking hashish?" the director of the institute, Jørgen Mørland, replied: "We cannot say that it is life-threatening, but these results show that hashish can be a strong contributing factor in premature death."[80] The young men did not suffer from cardiovascular disease and should not have died so young.

> ***Drugs take you to all kinds of exciting places, such as police cells, jails, psychiatric hospitals, morgues and cemeteries.***
>
> *—Students, age 16-19 at the Danderyd Gymnasium, Danderyd, Sweden*

Mental disorders

"Every kind of use of cannabis, including experimental and recreational, may result in panic, anxiety, discomfort, delusions and altered perception, even situations bordering on paranoia and the feeling of losing your mind," writes Kees Neeteson.[81]

Mental disorders such as schizophrenia and other psychoses are serious afflictions that can be caused, accelerated or emphasized by cannabis use.

Schizophrenia

Schizophrenia acquired its name in 1911, deriving from the Greek word "schizein-phren," that is, split personality. Patients feel divided

inside, guided and manipulated by some other entity than their normal self. Schizophrenia is a disease that usually reveals itself between a person's teenage years and early 30s. Often, schizophrenia is a life-long handicap with a fluctuating clinical picture. If a schizophrenic person goes into psychosis, a world of fear and unreality opens up.[82] About 25 percent of patients are free of symptoms between psychotic attacks. Others have to deal with lingering symptoms continually. Fortunately, symptoms decrease with age. We don't know a great deal about the causes of schizophrenia, but there is agreement that hereditary factors are involved. Schizophrenia is not just a serious illness because it's chronic. It is a severe handicap to the emotional and social functioning of the patient. It is also a very expensive disease, requiring intensive treatment and expensive medication. Thus, we have every reason to curb this disease wherever we can. Schizophrenia is categorized under psychosis, distinguishing itself by its longevity.

Psychoses

Psychoses are psychological situations characterized by a loss of attachment to reality. A person in a psychosis has different behavior and language—colloquially such a person is called "crazy," "insane," "delusional." Such patients also suffer from altered perception, in the form of hallucinations, and altered thoughts, as delusions, to such an extent that their can no longer be in touch with reality or with their own personality. Paranoia often occurs during psychosis. There are different types of psychosis, with various causes and characteristics. For instance, accidental, acute psychosis may arise as a reaction to severe trauma or poisoning, such as drug poisoning.[83] "Certain types of drugs, especially alcohol, cannabis, hallucinogens, and stimulants like amphetamines, can cause psychotic symptoms without there having been a prior mental illness."[84]

People who think there is no connection between cannabis and mental illness simply don't know what they're talking about.

—Ulf Rydberg, Professor and Chief Physician, Magnus Huss Clinic, Karolinska Hospital, Stockholm

Cannabis and schizophrenia

It is clear that the development of schizophrenia can be jump started by cannabis use. According to researcher Sven Andréasson:

> We suspect that cannabis can play a part in a variety of causes for schizophrenia. Experimental studies found that:
>
> 1. THC has a profound impact on the brain, especially on the limbic system,* which plays a central role in the experience and expression of emotions, behavior and memory;
> 2. The distribution of THC in the brain stimulates the production acetylcholine, the signal distributor of the brain, localized in the hippocampus and part of the limbic system. Various studies have shown that certain schizophrenic behavioral distortions occur in the hippocampus;
> 3. It is well known that cannabis smoking dramatically deteriorates the condition of schizophrenic patients, because cannabis blocks the effects of neuroleptic medication necessary for the treatment of psychosis.[85]

"It is very important that those who have mental problems never smoke cannabis, because that can increase the illness," warns researcher Peter Allebeck.[86] When I interviewed psychiatrist Björn Nylander, who has more than 20 years of clinical experience with treating psychosis and other psychological diseases, he stressed his concern over the future of cannabis users. When I asked him if we can expect more mental illness if cannabis use increases, he simply answered, "Yes."

Cannabis is made out to be very exciting and innocent by users of illegal drugs, in drug magazines and on the internet. They will tell you that the high is great but not dependent producing, colors become more intensive, music is experienced much more deeply. High on hashish, you laugh and laugh, get the munchies, cross every boundary and inhibition and your imagination runs wild and free. In reality, all such drug-induced states of mind are dangerous to your mental health. It's like playing Russian roulette with your brain.

Is it possible to kick a cannabis habit?

Yes, one can kick a cannabis habit and altogether stop using the drug. Hashish users who don't realize the seriousness of their drug

*The part of the brain responsible for regulating behavior, emotion, motivation, and involuntary functions like heartbeat and breathing.

taking are usually forced to get help by those near to them. Users who seek help on their own initiative, usually do so because of complications arising from cannabis use, such as panic reactions or anxiety. Therapists who treat cannabis use must be aware of the special damage done by cannabis and adjust treatment. Thomas Lundqvist has been active in researching cannabis use and treatment since 1975. He compares cannabis use to a cheese-dish cover, covering over the brain of the user. He says: "One can end 15 or 20 years of cannabis use if one gets professional help while kicking the habit. It is not impossible to repair the damage done. Of course, the person must totally give up cannabis. Some of them will remain slightly paranoid at least five years after giving up the drug. Cannabis is the most treacherous of all drugs. Hashish smokers live in a psychological prison without ever even realizing it."[87]

Hashish smokers live in a psychological prison without ever even realizing it.

—Psychologist and researcher Thomas Lundqvist

THC's dual effect on the human cognitive function

A major obstacle is that most users are not aware of the effects of cannabis on their mind and health. "A Guide to Quitting Marijuana and Hashish," by the Drug Dependence Treatment Centre of the University Hospital in Lund, Sweden, states that "Cannabis has two effects on human cognitive functioning, an acute effect (1) and an additional chronic effect (2). 1. The acute intoxication consists of two phases.; 2. The chronic influence is established after a period of regular heavy use. You who are a regular user will probably not recognize the description of the acute intoxication, but you may remember how it was several years ago." The "Guide" goes on to describe these effects in detail:

1. Acute intoxication

Phase one

After about ten minutes, and up to 45 minutes after smoking, the user will experience a "high" (after smoking approx. 4-5 times) but initially also some physiological symptoms:

- Palpitation, dizziness, coughs, feeling of increased pressure inside the head, increased pulse, dryness in the eyes, mouth, and throat.

- You are also red-eyed and sensitive to light.

Psychological symptoms of the subjective "high" are:

- A feeling of being mentally active and environmentally-oriented.
- A tendency to become giggly and talkative (for experienced smokers this is unusual).

Phase two

Phase two is self-oriented with a feeling of being mentally active. It will last for about three to four hours.

You who are an experienced smoker probably have a shorter period of acute intoxication (an hour and a half) and are thereby urged to smoke more often to achieve a "high."

This phase is mainly focused on the inner-self (like turning up the volume on your senses):

- You have an increased train of thoughts and you have a lot of associations to your thoughts.
- The colors you are looking at are more intense and your sense of smell makes the smells more salient.
- Details of an entity you earlier neglected are now more conspicuous.
- You like to sit and listen to music, watch videos or just hang around.

In the acute intoxication, you find the positive reasons for smoking cannabis. Cannabis preparations influence your feelings in the same way as turning up the volume on the radio.

Everything you experience becomes more intensive. In this condition, it is easy to deny the negative effects (chronic influence) of cannabis.

The acute intoxication gives you the following sensations:

- It gives you a feeling of being more calm and relaxed.
- It improves your social sensitivity.
- It enhances your sexual experiences.
- It enables you to cope better with difficult situations or persons.

- It serves to improve or enhance self-awareness.
- It increases your understanding of you and others.
- It gives you more insight and tolerance about what is going on around you.

2. Chronic influence

Clinical observations show that the use of cannabis more often than about every six weeks (elimination time of THC) for approximately two years leads to changes in cognitive functioning. These changes create a new state of consciousness which can be described as a "cannabis state dependent" effect. This effect may result from the release of stored THC.

It can be described as follows:
Experimenting with cannabis, you are frequently acutely intoxicated and experience this state in relation to a normal non-intoxicated state of consciousness. The after effects are a passive, unreflecting, and blunt state of consciousness, lasting a day or two. If you smoke again within a period of six weeks or less, these after effects last longer. You have gradually adjusted to this altered state of awareness and it will be your new normal state of consciousness. After a period of regular use you then experience the acute state of intoxication in relation to the effect of the chronic influence (being passive and blunt).

After a critical period of chronic use, the acute state of intoxication is then perceived as one which creates a feeling of being capable and normal. This state lasts for two to three hours and is reported as weaker than day-to-day capacity in the non-intoxicated state. The effects vary with the doses used over time. Acutely intoxicated you will experience a feeling of capacity and a sense of being normal and thereby enabled to perform different tasks.

In the beginning, you smoke to get stoned, but after a while (individually) you have to smoke to be normal and to get a nice feeling.[88]

Cannabis and operating a moving vehicle

Smoking a joint in the evening gets you high for a while, but the next morning, with THC still remaining in your body, are you able to drive a car? Pilots were given one joint to smoke, and after 24 hours they were tested by performing a landing in a flight simulator. All thought they had landed perfectly, but a check of their results showed otherwise.[89] After 24 hours, while "sober" and able to fly safely, they still performed all of the landing errors as they did while intoxicated. Those who operate a moving vehicle while high can experience the guard rail and the center line as winding snakes. Their delayed reactions and skewed perception endanger themselves and those around them. Driving under the influence of drugs is illegal everywhere in Europe and the United States, but according to the British Royal Automobile Club, young adults are passengers in cars driven by people under the influence of drugs twice as often as by drivers who drank too much. "When you combine cannabis with moderate alcohol use, your risk of an accident is multiplied with a factor 10," says Dr. Johan de Gier of the University of Utrecht.[90]

> Two pot smokers were driving down the road and got to an intersection. The light was red, but the driver ran right through it. So the one pot smoker thought, "I could have sworn that was a red light," but didn't say anything to the driver. They ran two more red lights, and finally the passenger said, "Hey, bud, do you know you just ran three red lights? You could have killed us!" The driver said, "Dude, am I driving?"

Other hallucinogens

Marijuana is not the only psychedelic drug widely available to young adults. Other psychedelics, or hallucinogens, have become increasingly popular. They cause users to "trip," to go on a journey through uncharted territory with destination and time of arrival unknown. They are usually distinguished into two categories:

1. Natural hallucinogens, such as mushrooms and plants, and
2. Synthetic hallucinogens, created in laboratories.

Hallucinogens alter perception and can cause panic attacks and hallucinations. This category contains drugs such as MDMA, MDA, LSD (acid), PCP (phencyclidine), mescaline, psilocine, and psilocybine.

LSD

The psychedelic effects of LSD (lysergic acid diethylamide) were discovered by the Swiss researcher Albert Hoffmann. LSD is a semi-synthetic drug synthesized from lysergic acid, which is a component of the mold of ergot (*Claviceps purpurea*), a fungus that forms on rye grain. LSD, or "acid," has no color, smell or taste, and is so powerful that it only takes a quantity the size of a grain of salt to be effective. It is sold in little brightly colored pills, or infused onto a stamp-size piece of paper with appealing designs—on it such as fruits, car logos, cartoon characters or religious symbols. A user's tolerance for LSD increases quickly and decreases rapidly when not used. Psychedelic after effects can linger for months or years, reoccurring as flashbacks, when least desired or expected.

Trips

LSD is difficult to control. An average trip may last four to twelve hours, but up to 24 hours in the case of a high dose. Tripping on "acid" is very risky and may cause serious psychological damage, such as anxiety, out-of-body experiences, disorientation, depression, insanity and rapid mood changes. Sensory perception (vision, hearing, smell and taste) become intensified. Space and time perceptions disappear, apparent surroundings are altered and the user experiences everything radically different from reality. A person high on acid may feel light enough to fly—even from a window. Anxiety and panic attacks, which may last many hours, result from "bad trips." If a user loses all touch with reality, he may be caught in his trip, a truly horrifying experience.

> *It was a weekend. I was about to go out. The night was clear and invited adventure. A bit excited, I took the acid and went clubbing. On the way over, I started tripping and everything changed—the colors, the sounds. I was seeing with different eyes. It's hard to describe. When I got to the club, my friend got me a beer. My attention was drawn to the fluid movements of the crowd on the dance floor. It was a very busy night, and I noticed a lot of oddly dressed punk rockers around the dancing crowd. The music was, as usual, loud and penetrating rock. I stood there, petrified, just watching. The punk rockers and the freaks, the smoke and the strobe lights, the drums increasing the rhythm and egging on the dancers. And like you can focus the lens on a camera, I started seeing frightening shapes in the shadows, demonic figures increasing in number and size. They seemed to enjoy what was going on. They had arms with black scales and claw-like hands, and, grinning, they admonished the crowd with hand gestures. With salivating jaws they grinned like predators licking their chops over a prey they had already caught. I noticed how most individuals in the crowd were connected to these monsters by dark rays that emanated from them. Then, I realized intuitively that these demonic powers were executing a premeditated plan, a plan to tie them down, to make them do ridiculous things that would lead to the destruction of their young lives, so that they could completely possess their souls in eternal torture. At that moment, I heard this witch-like laugh, and sharp as a knife was the realization that for a long time I also had been caught in their sticky webs.*[91]

Most users of psychedelic drugs can tell of similar experiences. Drug cartoons often depict the "third eye," capable of seeing dragons, witches, devils, angels, skeletons and evil monsters. Psychoactive substances enter into the subconscious, and users of these drugs open up a Pandora's box, causing a storm to rage through the mind until the drug wears off. Nobody who goes through such an experience remains untouched or unaltered. The only support in these often bizarre experiences are other users—or psychiatric emergency wards.

Among the physical consequences of use are nausea, muscle weakness, suppression of hunger, raised body temperature, widened pupils, hearing disorders, overly quick reflexes, vomiting, raised blood pressure and increased heart rate. Intestinal problems, such as diarrhea, stomach cramps and constipation are very common side effects.

The 1960s in the United States saw the creation of an LSD culture, led by university professor and psychologist Timothy Leary. LSD has in recent years made a comeback, especially in the club circuit.

Mushrooms

Toxic mushrooms are called "magic mushrooms" or "shrooms" in the drug world. These "magic" mushrooms are for sale, fresh or dried, in

special shops, often called "smart shops." Mushrooms are openly for sale in many countries (companies, some of which operated from the Netherlands, allow customers to mail-order mushrooms over the Internet). Mushrooms contain psychotoxic substances that alter the perception of space, time, color and sound. Most toxic Mushrooms have a bitter taste, and often they are processed with honey, cake, drinks or XTC pills. These mushrooms, most often of the *Psilocybe*, *Conocybe*, and *Stropharia* families, contain psilocine, psilocybine or a related compounds. The preparation, processing, sale, trade and possession of these substances is illegal.

Mushrooms, as well as substances derived from cacti (especially mescaline, prepared from the peyote cactus), can cause relaxation, a feeling of creativity and a sharpening of the senses, all of which easily turn into hallucinations, paranoia and depression. Physical effects include nausea, vomiting, muscle weakness, yawning, drowsiness, tearing, facial flushing, enlarged pupils, sweating, sullenness and lack of coordination, as well as dizziness, diarrhea, dry mouth, and restlessness, often within 20 minutes of taking them and lasting as long as six hours.[92] According to the Dutch Trimbos Institute, which has a liberal view on drug use, mushrooms are not the proper drug for youngsters, pregnant women, drivers, people in poor physical condition and people with medical problems and mental illnesses—apparently, their hidden assumption is that mushrooms are safe to use for all other people. And in the opinion of the Coordinating Agency for assessment and Monitoring (CAM), which conducted a study into the risks of mushroom use by commission of the Dutch Health Department, these mushrooms are not harmful to the user's health, not addictive and as yet not attractive to organized crime. If we add all of this up, we can conclude that:

- Mushrooms are not to be used by young people, but they are freely available to them.
- Mushrooms are not seen as a problem in the CAM risk analysis, but they are harmful to the user's health;
- Mushrooms are used as a "magic" potion to alter the user's mood and, as such, are dependence producing.

No wonder parents sometimes get confused and can't see the forest for the trees when supplied with contradictory information by government-supported agencies. The danger, obviously, is that one may

trust this misinformation or become hopelessly confused by it and fail to act properly. Complacency and confusion among parents create even more difficulties for young adults who encounter drugs. These ambiguities are typical of liberal policies. The result of these policies and can be witnessed in the "smart" shop named Rembrandt in Amsterdam. They not only sell mushrooms, but also run a home-grow and seed operation. Also, in this shop they can instruct you on what to take if you don't feel well. This concern for the costumer is based on the knowledge that a dead or sick customer is a bad customer, even in the drug business.

"Smart drugs," "smart products," and "eco-drugs"

The terminology can be confusing. "Smart drugs" is really a general name under which a wide assortment of drugs is classified. The original smart drugs were prescription drugs used by certified doctors to combat a variety of illnesses, most often for afflictions like Alzheimer's and Parkinson's diseases, and they typically aid in memory retention and concentration. They are available only with a prescription, and are not for sale in "smart shops." What is for sale, sometimes quite openly, are so-called "smart products," usually a mixture of ingredients containing stimulants such as ephedrine, caffeine, kava and guarana, and "eco-drugs," usually containing only one active ingredient, often herbal.

"Smart" drugs contain stimulants ranging from mild to strong; the strong stimulants are often advertised as "legal XTC" or "amphetamine substitutes." Popular active ingredients are psilocybe mushrooms; black nightshade (*Atropa belladonna*) and other plants, such as henbane (*Hyoscyamus niger*); thorn apple (*Datura stramonium*) and *Brugmansia* plants, containing atropine, hyoscyamine, and scopolamine alkaloids; cacti and seeds containing mescaline; kava kava (mashed and fermented parts of the Polynesian shrub *Piper methysticum*); yohimbe (from the inner bark of a West-African tree); nitrous oxide (laughing gas); and ephedrine. Classifying these products is a difficult matter. Some are classified as drugs under the U.S. Controlled Substances Act. Others are not and may be sold under the Federal Food, Drug, and Cosmetic Act. What is not difficult is the name given to these products. "Smart" and "eco" are terms hijacked by the drug world to make these drugs sound positive and appealing. The names, together with the false claims that these non-addictive drugs will make the user more intelligent, are clever marketing ploys.

The US Food and Drug Administration (FDA) do not control vitamins, minerals, teas, infusions, and herbs. Clever, internationally operating drug traffickers have used this to create a new market, since the European counterparts of the FDA don't really seem to know how to regulate these substances and are now allowing them to be sold over the counter and internet. It appears that after XTC, "smart" drugs are becoming important exports for the Netherlands and other European countries.

Ecstasy, XTC

Ecstasy is a street name for MDMA (3,4-**m**ethylene**d**ioxy**m**eth-**a**mphetamine), a hallucinogenic amphetamine causing strong emotional reactions. These days XTC isn't just MDMA; often it consists of substances such as MDEA, MDA, MMDA, MBDB. They often are given "happy" names such as EVE or ADAM, which are all sold as XTC. These substances are frequently mixed with other drugs, such as LSD, caffeine, speed, antihistamines, paracetamol, heroin, morphine, strychnine and methadone. While XTC manufacturers have control over the drug's contents, they rarely pay much attention to purity or quality. More interesting to them is which substances it contains. If a Dutch XTC manufacturer wants to stay on the right side of the law, he'll use substances to make his products that are not yet under the Opium Law. Knowledge and contacts, access to recipes and chemical products and the popularity of certain substances also factor into the manufacturer's decisions on how to maximize profits. According to one XTC manufacturer, "With speed, $5,000 meant it was a good week. With XTC, you could add a zero."[93] This manufacturer's view on quality control is simple. If you want to keep making profit, the product should be of decent quality, because a dead customer never comes back. The big XTC producers no longer like to produce in the Netherlands, since the traffic attracts too much attention and the police are now actively targeting XTC production. They move part of their operation to, for instance, Spain, Belgium and Eastern Europe. This is easily done, according to the same XTC manufacturer, since people need to eat, they will have to cooperate.

History

MDMA was first developed in 1914 by the German pharmaceutical firm Merck as an appetite suppressant but was never manufactured commercially. In 1953, MDMA was tested by the United States armed forces but was found useless. In the 1970s, on the American West Coast, some psychiatrists used it to treat marital problems, psychological damage caused by rape, and war syndrome, with the goal of increasing empathy between patients. It was regarded as a miracle cure. "A five-hour session can be equivalent to five months of regular therapy," according to one psychologist, writing in 1984.[94] Very quickly, though, the negative effects of XTC became clear, and the "miracle cure" was denounced by the medical establishment—but not by the pro-drug movement. According to Dr. Robert DuPont, former chief of the National Institute on Drug Abuse, "The people behind permissive use of MDMA today are the same ones who gave us LSD and pot and who flirted with coke. They are just looking for a safe high."[95] Dutch tourists discovered the drug in a hippie community on the island of Ibiza and brought it back to Amsterdam, where it created interest among yuppies and club visitors. They quickly introduced it to clubs, and there it become so popular it created an instant market. The Netherlands is currently the world's largest producer of XTC. Young people have died as a result of taking the drug. In 1998, after politicians were confronted by the parents of victims, XTC was placed on the list of most dangerous drugs under the Dutch Opium Law. In 1985, the United States placed MDMA on Schedule 1, the same category that includes heroin and LSD. In 1986, the United Nations followed suit.

What does an XTC-user experience?

As with every other drug, the effects of XTC also depend on dosage, how the drug is consumed, whether the user is allergic to one of its substances, and the user's tolerance level. XTC can keep the user awake for long periods, enabling them to dance non-stop for hours. It temporarily postpones fatigue, but this returns, much intensified, after the effects of the drug wear off. XTC also causes hallucinations and altered perception. Because of its eroticizing effects it is also known as the "love drug." XTC is associated particularly with house parties and raves, where some of the partygoers take the drug to attain a positive state of mind, and to feel loved by themselves and others; XTC is mainly a party and club drug.

The negative effects of XTC use

Dance and music are very important to humans, especially among youth. People will dance in hot and stuffy clubs and house parties, and, usually, they drink alcohol. Added to that is the multitude of pills now available that promise happiness and more energy to young people. The danger level is now increased.

When taking XTC, serotonin is pumped into the body, causing exaggerated feelings of happiness and intimacy. However, in the long run, XTC can destroy the serotonin mechanism. The brain consists of billions of nerve cells that communicate with each other by way of chemical messengers, or neurotransmitters. Serotonin is a neurotransmitter and is jump started by XTC, which forcefully releases it from the brain cells that contain it. It determines such functions as impulse control, the ability to react to stimuli, fear, mood, appetite, logical ability, sensory perception, body temperature and sexuality. A heightened serotonin level deregulates the body temperature and can cause body temperatures as high as 115°F (46°C), a life-threatening temperature. The body's fluid and mineral balances are forcefully disrupted, risking intoxication. The lack of salts and minerals and kidney malfunction causes brain cells to swell. Toxicologist Dr. Ed Pennings, of the Leiden University Medical Center, says: "The user risks a brain edema. Too much water enters the head, which causes the brain to become jammed."[96] To maintain their fluid and mineral equilibrium, young users, at the advice of "harm reduction" campaigns, make an effort to drink a lot of water or sport drinks and eat things like salt peanuts, in an effort to prevent toxification in their bodies.

Dr. W. van den Brink, professor of dependence therapy and president of the AIAR (Academic Institute for Research on Dependence), says people using XTC will have to deal at an earlier age with memory-loss symptoms associated with old age.[97]

Long-term damage includes memory loss. The more XTC is used, the more difficult it becomes to store memories. XTC lowers the levels of serotonin and damages the brain cells that contain dopamine, and, while these may regenerate, they don't do so in the right way. The result is brain damage.[98] According to professor A. Cohen of the Centre for Human Drug Research, long-term effects are, among others, muscle atrophy, liver problems, neurotoxicity and Parkinson's disease. He says, "I wouldn't be surprised if fifteen years from now we will have to deal with a completely new form of dementia." He continues, "If you start taking pills that were concocted by crooks with the bare minimum of chemical expertise in the back of a garage, you shouldn't be surprised if the result is serious damage.[99]

According to Dr. Freek de Wolf, professor of toxicology at the universities of Leiden and Amsterdam, Netherlands, "Based on study of the medical and toxicological literature as well as animal experiments, we believe that XTC in humans in the long run will lead to brain damage. Even if you have stopped using years ago, the damage can already been done."[100] Another study, by Liesbeth Reneman, M.D., a researcher at the Academic Medical Center in Amsterdam and recipient of the Marie Curie prize from the European Association of Nuclear Medicine, indicates that using XTC permanently damages memory.[101] These are only some of the statements made by scientists and researchers over the past few years who have all come to the same conclusion: XTC is a very serious and harmful drug, certainly not a party drug suitable for experimentation or legalization.

Drugs in the XTC family are widespread among those looking for human contact and empathy. The boundaries of the individual can dissolve, so that they can be absorbed into a larger community. It is also widely known that people under the influence of XTC are more open to sexual contact, a situation easily abused by others. The effects of XTC increase with physical activity, since dopamine, another neurotransmitter, is released when XTC enters the body.

Direct effects of XTC are increased blood pressure and increased heart rate. Heavy perspiration and increased body temperature can lead to dehydration. A variety of other effects, such as dry mouth, tension in the jaw and facial muscles, destruction of muscle tissue, shivers, exhaustion and heart palpitations can lead to anxiety and panic attacks. Frequent use can lead to depression, loss of sense of reality and psychosis, as well as to problems such as kidney failure. The effects of XTC are serious and all encompassing, especially considering its effects on the central nervous system and the brain.

European Governments, organizers of house parties and raves, young adults and health services are aware of all these risks, but one wonders if parents are. At many parties there are chill-out rooms, a first aid station, ambulances nearby, and anti-dotes are sold. The visitors are

dressed for the evening's purpose and prepared. They drink sport drinks and discus the qualities of the various pills with the cute logos. Taking XTC is like playing Russian Roulette, and the participants in the game are well aware of it.

The Dutch Government on XTC

In a brochure entitled, "XTC: The Answers. What does the Government do?", the Trimbos Institute writes: "The government is realistic, and bases its actions on the realization that a legal ban, the investigation and prosecution of manufacturers and dealers and public information campaigns about the risks of XTC are in themselves insufficient to prevent the use of XTC. Therefore, the government is having research done and promotes public information." Nevertheless, what the government does not do is act. The Government looked into the problem how XTC should be used without too many problems. Before Parliament put a hold on XTC testing the preventive measure was testing pills at raves and parties. This fits in with the official policy of "harm reduction." However, considering the amount of knowledge science has produced about the harmful effects of XTC, it is very far-fetched to call testing XTC pills for quality a means to reduce the harm done by those pills.

The tests done on-site, at raves and parties, are not done with equipment sufficiently sophisticated to discover new ingredients. They are relatively simple and can only recognize ingredients and substances already known. Testing XTC pills is misleading, and, in fact, reports on "findings" in a format of statistical analysis, giving the young users and their parents a false sense of security. At the most, a prevention worker may give a warning, or a "harm-reducing" advice. They reason that prohibition serves no purpose, and so they shift all responsibility to the often very young users and their parents. These specific measures, which aren't measures at all, in fact benefit the manufacturers and dealers:

> *For organized crime, it is important to invest in "marketing" and "quality control." Cooperation with organizers of house parties and others who promote the spread and use of these drugs is of the utmost importance. The marketing is in fact very misleading with respect to the innocent symbols printed on the candy-colored pills, symbols such as cars, love symbols and animals.*[102]

The trade in XTC

The profits in the XTC-trade are enormous. A pill will cost between $2.50 and $7.50 in Europe; abroad, buyers often pay double. Manufacturers have machines that can produce sometimes up to a few hundred thousand pills per hour. According to the Dutch Central Investigation and Information Service, the Netherlands excel in the mechanized, professionally organized production of and trade in XTC and amphetamine pills. When asked how the Netherlands have achieved this prominent position, District Attorney Hans Pieters, who leads the Dutch effort against synthetic drugs, answered: "It is a combination of mercantile spirit, experience with drugs and technical insight. Also, the Netherlands had the first house parties, as a market from which manufacturers could gain profit. The export followed suit."[103] Reports in American newspapers confirm this on a weekly basis—around 80 percent of the world's XTC is produced in the Netherlands.

For years, politicians, law enforcement and citizens have alerted the Dutch government to this alarming situation. Finally, the patience of Benk Korthals, the former Dutch Attorney General, ran out, and they started to hunt down the XTC mafia. With extra funding and 100 more special officers, he aims to deal with the manufacture of and trade in XTC in cooperation with law enforcement agencies abroad. Experience has shown that enforcement actions can lead to the confiscation of considerable amounts of XTC and can corner manufacturers. The Unit for Synthetic Drugs, or USD, founded in 1997, has proven that. These police officers operate in a world of increasing violence, where firearms and the risk of explosion from the chemicals used in the production of synthetic drugs create great risks for the police officers as well as for innocent bystanders. We can only hope that the attorney general has chosen this proactive approach not only because of influence by foreign political and diplomatic pressure, but also because of concern for the youth of the Netherlands. The establishment of a special "party police," which intervenes and confiscates the drugs, would be one step in the right direction if this approach is to be viable. If the demand for XTC isn't halted one way or the other, the Attorney General can hardly hope to argue for special funding and halt the trade in XTC.

I believe in education, but I also believe in prosecution. If you can't show them the light, at least you can make them feel its heat.

—Paul Walsh, DA, Bristol County, New Hampshire[104]

Intensive care is not for parties

According to neurologist Dr. C. L. Kraaijeveld, the various campaigns aiming to inform the public about the dangers of alcohol and tobacco have been clear and successful. Smoking in public places becomes increasingly more difficult and is less and less socially acceptable. Underage young people also are no longer allowed to buy alcohol and tobacco. But the information on the damaging consequences of XTC and the enforcement of possession leaves a lot to be desired — not to mention that the substantial amount of money spent on treating illness caused by drug abuse leaves less for people who have fallen ill through no fault of their own. In Kraaijeveld's opinion, intensive care is not for parties. Commenting on a house party that landed six persons in the intensive care unit, Kraaijeveld said, "It is highly questionable whether it's such a smart idea to throw parties requiring medical supervision."[105] The intensive care unit is not the only medical resource burdened by XTC use. The Red Cross and ambulances are also required to treat patients suffering from overheating, dehydration, respiratory arrest and loss of consciousness. In between intensive care and on-site medical attention, are emergency room visits. In the United States, the Drug Abuse Warning Network (DAWN) estimated that the year 1999 saw more than 10,000 emergency department (ED) mentions of MDMA, 5,000 for LSD, 3,000 each for ecstasy and GHB, 500 for Rohypnol, and just under 400 for ketamine.[106]*

Many deaths caused by XTC

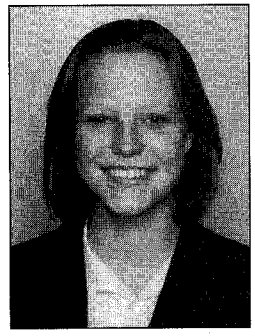
The use of XTC in the club and dance circuit endangers the lives of many young adults. Parents have to deal with more than the non-fatal consequences of these drugs. Many parents have lost children to party drugs. The trade in XTC is boosted by the glib talk of drug pushers who say that the harmful consequences of drug use are limited and controllable. These sad lies circulate throughout clubs and parties, claiming victims around the world.

*DAWN notes that these numbers cannot simply be added to yield a total; one emergency room

In England, young Paula Carrier died in 1992 as the result of an "EVE pill." Her mother and her mother-in-law traveled to the Netherlands to offer the petition "One Pill Can Kill" to members of parliament, asking that the Dutch government put a stop to the export of XTC. At that time, EVE was legal and selling in great quantities. The Netherlands banned the use of EVE on July 2, 1993.

But other versions of XTC continue to claim young victims, often leaving parents nothing but the struggle to warn others of the dangers of XTC. Angela Wood, mother of young Australian Anna Wood, who died at age 15 of a single XTC pill, wrote me the following letter:

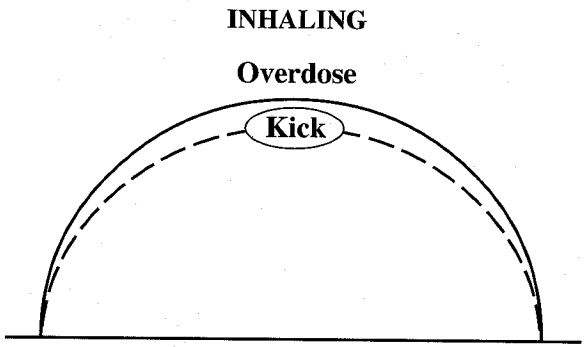
Anna Wood died at age 15 on October 24, 1995, after taking a single tablet of ecstasy (methylenedioxymethamphetamine) at a dance party in Sydney. Anna's drug education was limited but she had been told that Ecstasy was a safe drug but that, if using it, she should NOT mix it with alcohol, use any other drugs and drink plenty of water. These are typical harm-reduction strategies as promoted for this particular type of substance. None of these strategies was going to save her life. She was officially declared brain-dead three days after taking the drug. The coroner's report recorded that Anna Wood died as a result of ingesting the drug ecstasy (MDMA). Also in his findings were references to the fact that no other substances were found in her body, she had no physical illness. She was fit and healthy.[107]



Inhalants

Inhalants generally are used by young children, beginning as early as seven or eight years of age. What is being inhaled are everyday substances such as glue, acetone, lighter fluid, gasoline and aerosols. Particularly popular in the United States is inhaling the nitrous oxide from cans of whipped cream or "whippets." Sniffing glue is best known from television images of homeless children but is a popular and risky way of getting high around the world. The rush is felt when the body is

close to an overdose, at which point breathing arrest or heart failure may occur. Long-term effects are memory and concentration problems, irritability, intellectual numbness, lowered sex drive, anxiety and depression and damage to internal organs such as the lungs, the kidney and the liver.



The kick comes when the body is close to overdose, where breathing arrest and heart failure occur.

There are many other drugs such as barbiturates, benzodiazepines, or GHB on the international illegal market.

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Chapter Three

HOW DOES DEPENDENCE DEVELOP?

"In life, we encounter things and experience moments that make us feel good and which we like to remember and re-experience. It's that mechanism that can cause a person to become dependent. If we find something that makes us feel bright and happy, it's hard to stay away from it, even though we may know it's harmful."[1]

We'd like to believe drug dependence happens to others, not to us and our families. But the risk of drugs influencing and destroying the life of someone close to us is ever present. Looking for positive experiences, relaxation, not feeling any pain or anxiety, satisfying curiosity, partying, there are so many different things drug users look for. And of course everyone knows of the dangers of drug use. Everyone has seen what happens to drug dependent persons, so why do people ever begin using drugs? Two main components play into the development of a dependence: being unprotected and being receptive.

Being unprotected

This involves external factors, such as:

- access to drugs (how easy it is to get them);
- price of the day (the cheaper, the more easily tried);
- lack of law enforcement (police presence, legal deterrence);
- peer pressure;
- lack of adult supervision;
- norms and values in society and within the group.

Being receptive

A person's receptiveness depends on various internal factors, such as:

- curiosity;
- uncertainty;
- feeling insecure;
- the need to impress others;
- enterprising mindset;
- inability to cope with reality;
- genetic factors (dependence in the family tree);
- influence of other drugs (for instance, first smoking pot under the influence of alcohol)

In the use of drugs, being *unprotected* and being *receptive* work hand in hand and may lead to the development of dependence. While pro-drug lobbyists are quick to point out that all people supposedly are receptive to dependency, there can be no dependency if drugs are not present. Thus, before World War II, drug dependence was a rare occurrence in European cities simply because few drugs were available for "recreational" purposes. It is a new social phenomenon in many European cities and communities that dependence-producing drugs are abundant and drug users everywhere. Similarly, there was no tobacco smoking in Western Europe before Columbus. Discussion on the legalization of drugs was not a part of public discourse until the pro-drug lobby got organized in the 1980s.

Of course, there were receptive persons, but they were not exposed to drugs or influenced by drug propaganda. They were, in a way, protected. Inversely, in Amsterdam today a lot of people don't use drugs even though they are easily available. Their individual protection still works.

Many studies have shown that individual receptiveness to drugs is hard to influence or control. On the other hand, a child can be protected against drugs, the influence of other drug users and the pressure of the drug market. These outside influences can be influenced by a strategy characterized by a societal consensus based on the laws governing drugs in each country.

The more drugs are offered and the less using drugs is seen as a deviation from the norm, the greater the risk that drugs will be used even more widely. This also increases the risk that curiosity, in itself a positive quality, may lead to experimentation with drugs. The process, which leads from trying drugs once to becoming dependent person, may look like the following.

A drug user's career

Let's assume a hypothetical average person. We'll call him Andrew. He is still in school and reasonably happy with his life, a life that rolls along normally. His parents have discussed drugs with him on more than one occasion, and so has the school. He knows something about the possible harm caused by some drugs. In the next few pages, we'll sketch how a person like this can possibly end up as a drug dependent person. The process develops over four stages.

Stage 1 — Honeymoon stage

Andrew has been offered drugs a few times, but has always declined. After being asked for the umpteenth time—and after a few beers—he does try. No one notices anything at home. So, every now and then, Andrew smokes a joint and occasionally buys it himself. In the beginning, his experience is naive, but quickly his friends enlighten him and teach him various techniques and drug effects. His or her reaction in stage may show the following outward signs actions.

- He leads a normal life and goes to school.
- He doesn't tell his parents he's using.
- He doesn't look like a junkie, and no one notices or says anything about him.
- He uses drugs to feel good.
- He reasons, "If drugs make you feel good one time, they'll do so the next time."
- He consciously tries to deny any bad feelings about his use.

By now, he now wants to re-experience the feeling of that first high. By taking those drugs again and again, he goes through a chemical learning process. In this stage, Andrew learns:

1. To use a drug to feel good instead of doing the things he used to do to feel good: play sports, dance, develop his interests.

2. That it's easy to feel good wherever and whenever he wants to, and that it doesn't require too much effort.
3. That drugs provide instant gratification.
4. To explore the variety of drug effects.

Because no adults know about his behavior and he gets no other response to his new habit, Andrew considers his behavior as accepted. In this stage, everything is free and easy, like a honeymoon, and there is no incentive whatsoever to stop using. Drug users develop this frame of mind very quickly. Andrew denies warning signals and imagines his habit being normal. By now, he has learned that drugs alter his mood, and, in his enthusiasm, he involves others in his habit, inviting friends to share in his new found joy. He knows drugs aren't legal and that there is a reason they're not but wants to show his friends drugs are not harmful. He builds a wall of denial around himself. In this stage, kicking the habit would be relatively easy. The intervention of parents, teachers, local law enforcement, social services and/or friends usually suffices to put a stop to drug use. By now, perhaps two years have passed since the first joint.

Stage 2 — Searching for the right mood

In this stage, continuing use has led Andrew to place more importance on drug use.

- Andrew now actively buys drugs.
- He still goes to school, but his grades are down.
- Slowly he develops a double life, sometimes lying at home, stealing grocery money and selling his own stuff.
- He shows the first signs of the amotivational syndrome with lethargy, loss of energy, and deluded thinking.
- He no longer needs his friends to get high.
- He takes drugs to feel good and now also to repress unpleasant thoughts.
- He "medicates" himself trying to find the right mood.
- He doesn't like living at home and notices that his earlier ambitions are now fading away.
- He thinks he controls his own drug use.
- He fails to meet promises or appointments, fails to pay off debts.

If someone calls attention to his behavior, Andrew tries to talk his way out of it, with excuses like "everyone oversleeps occasionally," or "I'll pay that debt next week." The user convinces himself that the situation is under control and that he can stop using drugs anytime he wants to. In this stage, the user actively seeks the mood changes learned in the first stage. In this second stage, it is still possible for the outside world to intervene and help a user quit. These first stages, during which the user still experiences positive effects from his use, are also the most dangerous for others: dependence is spread, like a contagious disease, when drug use is experienced positively.

Stage 3 — Drugs are taking over

Serious changes mark the difference between stages two and three.

- Drugs become even more important.
- Andrew is high or intoxicated even more often.
- Drugs no longer provide the same kick they did before. However, he continues to take them.
- Andrew more often uses other drugs. His tolerance levels increase more and more, which means that the body demands larger or more doses of the same substance to feel good.
- Tobacco, alcohol and cannabis are used for a background, while heroin, LSD, XTC and cocaine are used to enhance the high.
- The first overdose occurs, although, from the beginning, he has run the risk of hallucinations, anxiety, confusion and psychosis.
- Andrew no longer feels it's necessary to hide his habit.
- He doesn't care what his parents say.
- He breaks off contact with his old friends, or they break off with him.
- If he hasn't already, he'll come into contact with law enforcement in this stage.
- He sells drugs to support his own habit.
- He is registered at needle exchanges and methadone distribution centers.

Andrew experiences feeling bright and in control when he's on drugs, but he only imagines that. He becomes a loner. It doesn't mean he uses drugs constantly, but it does mean that planning for the next drug use controls his daily activities and, to a great extent, his mind and thinking. Perhaps he wants to quit, but that is hard to do on one's own at in this stage. Parents at this stage cannot help him by themselves. Both the user and his immediate family need professional help and support groups. By now, the choice between kicking the habit or doing time in jail looms on the horizon. In this stage, drugs have taken over, and all control is lost.

Stage 4 — Dependence develops

This is the full-blown stage.

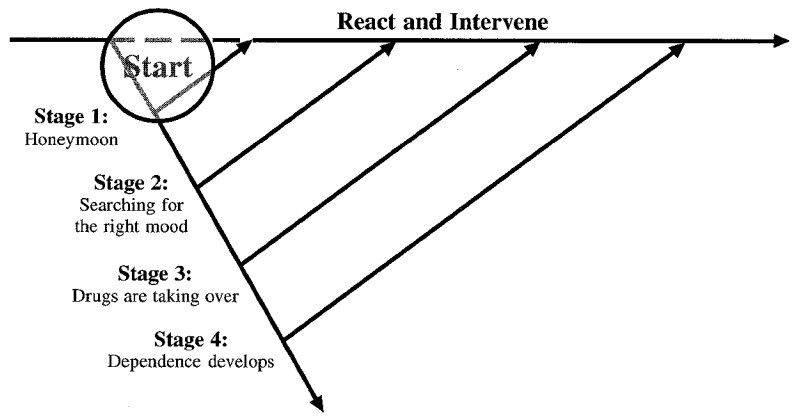
- Consequences are huge and clearly visible.
- Drugs no longer give the feeling they did in the beginning.
- If it hasn't occurred before, Andrew injects drugs into his veins.
- If he hasn't already, Andrew contemplates and attempts suicide.
- Drugs are no longer used to feel good but to feel "normal."
- Drugs are needed to counter withdrawal symptoms: the body now demands drugs.
- The final destination is reached: full-fledged dependence is established.*

In this stage, users look for assistance to kick their habit or control the damage done. When they recuperate a bit, they feel they have earned that new drink or that fresh joint or shot. But using drugs is no longer fun. "The drug dependent person starts to believe that he is a problem, rather than he's having a problem."[2]

Some say that users must go through all these stages before they realize that drugs have completely taken over and develop the motivation to kick their habit. That attitude is disastrous. Do we want a child to go through this whole process before we intervene? Only a minority go through all four stages. Most stop using earlier by themselves or with help from others. Moreover, it is not the chronic drug dependent person, in stage four, who ensure the future of drug dependence by recruiting the next generation, it's the occasional drug users, the friends and the acquaintances of future users—and this group is much too numerous.

* These four stages were described by Milton Newton and Beth Polson in Not My Kid, and adapted by Anders Eriksson in a brochure on preventive education.

HOW DOES DEPENDENCE DEVELOP?



The "I figure"

"Slowly the user loses control over his behavior, but, long before that, he loses his inner control. In his heart of hearts, the user knows that he is changing. He develops a new personality alongside the old one. The old, healthy personality, the 'I-figure,' grows worried from time to time, wondering what is happening. He thinks to himself that his use of drugs has continued longer than he intended and has become much more important to him than initially was foreseen. In the meantime, something has changed. Another personality, the "dependent person," has taken up lodging in the user's psyche, saying, 'It's alright. Have that beer,' and 'Of course you can stop anytime, don't worry,' or 'Hey, as long as you're not injecting you're fine, you're not addicted.' This dependent person more and more takes over from the I-figure, using all available arguments to take over control. It knows precisely how to manipulate common sense and dupe the user. If the user runs into school counselors, law enforcement or social workers, often the dependent person is the one speaking. The I-figure remains silent. It is very difficult to breach these walls.[3]"

Almost all people, addicts as well as moderate users, have rules governing their drug use, their gambling, their eating disorders. They say no drinking during working hours, don't steal money from the kids, don't use up all the money. The dependent person begins to do things he said he never would.

—Drug therapist Gunnar Bergström

Drug consumers

The consumers, buyers, sellers and/or advocates of drugs:

- are largely responsible for the recruitment of new users;
- do the "legwork" for organized crime;
- help organized crime increase its capital, ensuring its steady growth in power and influence;
- are the customers of "coffee shops", XTC sellers, khat cafes, "smart shops" and crude marijuana as medicine;
- degrade their norms and standards and easily lose track of their earlier ideals;
- take enormous risks with their own lives while endangering public health;
- use welfare allowances to buy drugs;
- waste their opportunities for an education, and thus a future;
- become isolated;
- crowd the prison system;
- cause the grief, anger and contempt of their associates;
- create, through an increasing demand for drugs and the problems that brings, a feeling of helplessness, which in turn is employed in the campaign to liberalize drug legislation;
- stimulate the production of cocaine, poppies and marijuana in developing countries;
- stimulate the growth of cannabis and production of XTC in the Netherlands;
- are exploited and displaced;
- provide financial support for wars, civil conflicts and terrorism;
- are indirectly responsible for the deaths and injuries of law enforcement officers engaged in the battle against drugs;

- spread diseases like AIDS and hepatitis;
- are the subjects of disastrous heroin and methadone experiments;
- increase the general public's feeling of insecurity;
- endanger themselves and others while operating motor vehicles;
- may be "drug experts," civil servants or even elected officials, making decisions about our lives.

If you are alarmed by one or more of these consequences of drug use, you are not alone. Maybe it's high time we ask who is truly responsible for the drug epidemic and how to stop it before it's too late? Do individuals have a role and, if so, what is the part we can play in stemming the drug problem around us? Only we can answer that question.

Drug culture

Every continent has or had its own drug culture. Throughout the ages, drugs have served as popular medicine, as a religious catalyst, to enhance the battle prowess of soldiers and for getting high. Drugs that cause hallucinations were not just used by peaceful priests and shamans to enable communication with the divine during rituals. Warlords and fanatical tyrants have used drugs to create a new state of mind in soldiers in order to increase violence and bloodshed.

Drug advocates like to point out how shamans, priests and medicine men exceeded their human limitations by using psychoactive substances, but they fail to mention that this use was only for a select few, not for the many. Such cultures knew very well what the consequences of drug use were and how they could influence a person, and, therefore, did not allow their use by the general population. According to Allan Rubin, an expert on the symbolic qualities and effects of hallucinogens and their religious use:

> Indigenous peoples performed their trance-inducing dances and occasionally used hallucinogenic drugs according to strictly formalized programs. Inner voices were taken seriously. The voice of the gods was the law of the people. Because these rituals were taught from one generation to the next, no one went

> unprepared into trances with the gods. Often, they wore masks or painted their faces, when they got ready to meet the gods. If you compare those masks and painted faces with the record sleeves of bands like Kiss, you can't see much difference. The same drugs were used with the same compulsion to use make-up, and one wonders whether primitive behavioral patterns will be repeated when the same primitive drugs are used.[4]

The old hallucinogens, such as mescaline and cannabis, are still used in Western society. They are ancient herbal products known among native tribes and religious leaders. Drugs, previously used only during religious ceremonies after the prospective user was carefully prepared and under strict supervision, are now let loose on our youth.

Spiritual confusion

In the 21st century, the Western world has many spiritual options besides the Judeo-Christian faiths, Islam and Buddhism. Mysticism, occultism, witchcraft, Satanism and the acid-inspired philosophy of the followers of jam bands have all found a place alongside the more traditional denominations. One wonders, though, whether the attraction of such spiritual movements derives from true interest in alternative philosophy and theology or from the effects of psychedelic drugs. More and more, these drugs creep into everyday life, with their users convinced that their use should be legal or at least demanding their decriminalization. Mind-altering substances such as XTC, LSD, mushrooms and pot, are now commonly used, conjuring up occult thoughts, psychoses and spiritual confusion—leaving parents to wonder what is happening to their children. It may be worthwhile for adults to look into the music our children listen to. Listen to these lyrics of rap artists who talk about what their world looks like. Look at T-shirts, jewelry, tattoos, record sleeves, movies and magazines containing distorted drawings, marijuana leaves, skulls with eyes and brains popping out, images of violent sexuality, demons and snakes crawling out of bleeding mouths and brains. These frightening images are part and parcel of a youth culture that parents generally abhor. As drugs have integrated into society, the cultural world has grown. It contains song lyrics that glorify the use of illegal drugs and images of violence and mysticism. Crude sexist drawings and music videos create a distorted

image of sexuality all too often associated with drugs. Since the '60s, teenagers have become inundated with drug-friendly lyrics—from Peter Tosh's "Legalize It," Cypress Hill's "I Want to Get High" and "Bales of Cocaine" by the Reverend Horton Heat, to practically every single song on Dr. Dre's "The Chronic." In the 1970s, punk culture was launched by icons who were experimenting with hallucinogens or killing themselves with them, as did Sid Vicious. Earlier writers like Jack Kerouac and artists like Andy Warhol also contributed to the glorification of drugs. Young fans emulate the lifestyle of their icons, mutilating themselves with safety pins stuck through their cheeks and ears and copying their behavior and their drug use—for shock, for fun, for excitement.

According to Rubin, cannabis users are fascinated by the cosmos, mythology, mystic religion, meditation, peace and the environment. In itself, there is nothing wrong with that. On the contrary, who is not looking for the meaning of life or the source from which life springs? It is important, though, that entering a deeper level of consciousness is done under the guidance of a teacher, leader or experienced master, so that meditation can help a novice attain a deeper knowledge of the world, of nature, of the self. Looking for the meaning of life, working for peace and a cleaner environment or investigating the subconscious is not to be done while high on hashish or "acid" or from within a drug culture. Whenever I see a cannabis smoker sporting the peace sign, I often wonder if they realize that wars all around the world, terrorism, crime and violence are paid for by drug money and often engaged in under the influence of drugs. Cocaine labs in the Amazon region, XTC labs in the Netherlands and crystal meth labs in the Midwest and southern United States dump tons of chemical waste into the environment without regard for it. Drug use is a pollutant for the soul, the peace, the environment.

Rubin thinks that those using cannabis should know that the drug changes brain functions, allowing users to think things they otherwise never would. Hallucinogens allow the crossing of mental boundaries so that a hallucinatory, magical world can be unlocked. It may sound exciting and enticing, but using hallucinogens disturbs the chemical balance and renders their user susceptible to psychological illness. The drug world is a separate world with its own language and norms. A drug user's world can be far removed from everyday life. The gap between those worlds invites trouble.

Is the use of illegal drugs a class struggle?

In 1997, forty prominent Dutch artists, journalists and scientists signed a petition asking for the legalization of "hard drugs." One of those who initiated that particular movement, sociologist Erik van Ree, wrote quite strikingly: "Not everyone can handle drugs. But why should we deny so obstinately that it is quite possible to enjoy drugs sensibly and enjoyably? Most users never have to seek professional help."[5]

So, a committee was established to plead for the "recreational" use of drugs, re-igniting the discussion on illegal drug use. This group consists of intellectuals, some of whom use illegal drugs, some of whom don't. Often, they are knowledgeable on drugs or on the drug world. Their way of dealing with drugs can be compared to doctors prescribing medication. If side affects occur, the dosage is adjusted, a new drug prescribed or the medication is stopped altogether—all in agreement between patient and doctor. But entertainers and intellectuals, speaking from their safe and secluded world, think that damage-controlling measures for drug use can be converted into a successful national drug policy. Children whose parents are affluent and influential are able to cover up the negative effects of their drug use longer than other children are. These affluent youth often receive professional help before other children. How many children from parents less well off have that opportunity?

Practically speaking, everyone can become dependent on drugs, but a depressed, jobless or lonely person will feel the negative effects of drugs sooner than the self-assured, secure and wealthy person. Drug-using celebrities and their supporters, under the guise of "harm reduction," force their politics of liberalization or legalization onto the general population. This is doomed to fail. "Harm reduction" measures can delay problems, sickness or death, but sooner or later drug use demands its toll, even from those who think they can outsmart drugs.

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Chapter Four

DRUG USE, ABUSE AND DEPENDENCE

In the Netherlands, when referring to even illegal drugs, the term used most often to describe consumption is "drug use." This term has become part of accepted everyday language, even though it is misleading. It suggests that drugs can be used in the same way as bread and butter. This, of course, is not the case. The World Health Organization (WHO) and the international drug treaties adopted by the United Nations in 1961 and 1971 limit the acceptable uses of controlled drugs, allowing their use only for medical and scientific purposes. Using drugs to get high is explicitly illegal, and the proper term for such use is *abuse*. Morphine carefully prescribed by a licensed physician is *used*; morphine used any other way is *abused*.

Drug abuse can be distinguished in many ways, such as according to the substances abused. Another way of distinguishing is based on the origin of drug abuse, because they differ significantly with respect to prevention and control. Swedish professor Nils Bejerot (1921-1988), psychiatrist and specialist in social medicine, classified them in five different categories.

Therapeutic drug abuse

Therapeutic drug abuse usually involves older, socially stable individuals, who have developed a dependence through an unfortunate

exposure to dependence producing drugs during medical care. They rarely draw others into their dependent behavior. When they run out of morphine, for instance, they are not likely to start using cocaine. In most cases, opiates are prescribed after severe accidents, to cancer patients and for other very painful illnesses. In terminal cases, patients receive morphine according to need. As long as the daily dose remains below a certain individual maximum, pain is removed without causing dependency. The medication is used to ease suffering and pain, not to induce a high.

A more recent development is doctors prescribing sedatives (such as benzodiazepines) for patients when there is not enough time to make a thorough assessment of a patient's problems. Sometimes, patients experiencing psychological or social problems, often in combination with financial difficulty, receive such medication instead of proper psychological and social counseling. Patients who continue using such drugs after the original course of treatment, or experiment on their own with increased doses risk dependency. This situation can easily lead to abuse.

Professional drug abuse

Professionals such as hospital staffers, dentists, doctors and pharmacists with access to medications run a high risk for self-medicating with pharmaceuticals and then abusing them. The public authorities that license medical professionals should address this type of dependency.

Endemic drug abuse

This type of drug abuse is based on socially tolerated use of intoxicants, even though they may not be legal. All or major parts of society are exposed to the risks. In the Western world, alcohol and tobacco are the prime examples of dependence producing and accepted drugs. Certain endemic traditions among native populations are rooted in pre-historic times, such as chewing coca leaves in South America and smoking tobacco in North America. Alcohol use was accepted in Christianity from its very beginning, while for a long time, Islam and Buddhism, for religious reasons, was safeguarded from this dependence.

Ritual use

In some cultures, shamans, priests and similar closed groups have taken drugs as part of religious ceremonies. Such ritual use of drugs is

regarded as a way of seeking knowledge and to "see" what otherwise cannot be seen, not to escape into a fantasy world.[1] In these cases, the use of such drugs breaks no laws and violates no norms. Despite the fact that rites govern the use of these drugs, serious dependency is possible. What *has* changed is that such drugs are now widely available to anyone, and that the use of these drugs leads to ritual ceremonies, even to ritual murder when "evil spirits" had to be expelled.

These three types must be distinguished from the fourth type of dependence, which runs a very different course, namely epidemic drug abuse.

Epidemic drug abuse

Non-medical drug use is epidemic in many countries, in the sense that the drug taking behavior spreads rapidly from person to person. A new user can become "infected" by coming into contact with a more experienced user—a kind of "psycho-social contagion." Every new user is introduced to the world of drugs by a friend. The first cigarette, or joint is usually offered and demonstrated by an acquaintance. Typically, this drug advocate is a relatively new initiate to this world and full of zeal about the effects attainable with drugs. No novice learns the sophisticated smoking and injection techniques without help from a more experienced user. Nils Bejerot says, "This is the newest form of contagious infection by contact," giving a new meaning to the word "contagious."[2]

A distinguishing feature of drug abuse epidemic is its inception in bohemian circles, where romantic dreamers and adventurous, unconventional types experiment with exotic or new intoxicating substances in the search for novel experiences. Such drug use may be contained within limited circles for a long time but will slowly spread to other groups, usually through personal contacts with others on the fringes of society, such as criminals. They do not consider taking drugs as breaking a norm. Later, when drug use and its problems become visible and publicized, after which drug consumption spreads throughout society, acquiring the character of a wide spreads epidemic. Inquisitive, insecure, impulsive young people are highly sensitive to peer pressure and easily follow their idols and heroes. Teenagers watching bohemians and artists use drugs often imitate their habits. But by the time teens have learned the mechanics of one type of drug use, their role models

have moved on to other drugs, fallen ill, quit using drugs or have already died as a result of their use.

> ***Epidemics are not restricted to bacteria and viruses. In the case of drug abuse, a new user can become "infected" by coming into contact with a more experienced user.***
>
> *—Nils Bejerot*

Regardless of the drug in question in whatever country, epidemic drug habits share a number of characteristics.

Dissemination

Epidemic drug abuse spreads almost exclusively through personal contact between novice and user, usually with friends, acquaintances, family members or sexual partners. Most likely, this infection is spread in the first stage of dependence, the honeymoon phase, before the negative effects of drug become apparent. Drug propaganda, users, head shops, books and magazines, advertise and arouse curiosity. The constant flow of drugs into society is guaranteed and facilitated by home growers, the internet, drug shops and user clubs, and street-corner dealers. The chances of a child coming into contact with drugs are considerable. Personal contact with dealers doesn't enter the picture until later, when they will ensure the maintenance of existing drug use and dependence.

Explosive growth

Drug epidemics often spread rapidly. In countries where controlled substances are distributed legally, growth is explosive. In England, for instance, there was no epidemic heroin dependence prior to 1959. But when six Canadian heroin dependent persons immigrated to England, having been promised a legal prescription for heroin by psychiatrist Lady Frankau, this situation changed drastically.* Between 1959 and 1968, the number of heroin dependent persons in England doubled every six months. The heroin users sold part of their heroin, thus providing the drug to novices who became heroin dependent. In 1968, England had about 1,200 heroin dependent persons, and the program providing heroin

* Another well-documented case is that of Chet Baker, the famous jazz trumpet player, who was prescribed heroin and cocaine by Lady Frankau in 1962. Even after his extradition to France, intermediaries provided him with heroin and cocaine from Lady Frankau. See Chet Baker's recently

prescriptions was stopped—but not before it had created a market for heroin large enough for a profitable illegal trade in that drug. Similarly, Sweden prescribed synthetic stimulants as well as opiates from 1965 to 1967, but was forced to stop the experiment after a significant increase in drug use among both young and older citizens and after two persons died from prescribed drugs in this program.

Historical and ethnic limitations

For a long time, drug epidemics were contained when drug use remained within religious, ethnic, cultural or geographic boundaries. For instance, Jews in the Middle East cohabited with hashish-smoking Muslims for hundreds of years without adopting that particular habit. Jewish youths only started smoking cannabis when American Jews who smoked cannabis visited Israel, bringing their habit with them.

Experiences from earlier epidemics

The first well documented drug epidemic occurred in Ireland, when ether, a new chemical substance used in industry, proved to be highly dependent producing. In the beginning of the 19th century, its use spread to England, France and Germany, where tens of thousands abused this substance. Strong restrictions banning the substance ended the epidemic.[3] Restrictions also played a decisive role in China's struggle with opium dependence. An American heroin epidemic was detected in 1914. Strict control drastically reduced supply and demand. A cocaine epidemic in Germany was halted in the 1920s in much the same way. The Japanese amphetamine problem after the Second World War started when the military supply of the drug found its way to jazz musicians, artists, barflies, bohemians and prostitutes, after which it quickly spread to the rest of society. The Japanese government enacted measures to stem the tide, but they came too late and were inefficient. The height of the epidemic was 1954, when it was estimated that of 100 million Japanese, 2 million had used amphetamines "recreationally," and that there were 600,000 cases of heavy, mainly intravenous, abuse. Restrictions were put in place, laws became tougher and raw materials for the production of amphetamines were controlled as tightly as the drug itself. Possession of amphetamines led to a jail sentence of three to six months, dealing to between one and three years and five years for illegal production. In the first year of the campaign, 55,600 people were

arrested on amphetamine-related charges. By 1958, that number had diminished to 271. The amphetamine epidemic was over. The Government intervened for around ten percent of intravenous amphetamine users. All the others stopped using amphetamine when they found out that the government was prepared to enforce the laws all the way. Interestingly enough, these measures received broad popular and political support.

Bejerot's fives steps

In a series of books and articles, Bejerot pointed to the strong tendency among drug abusers to spread their drug habits to friends and acquaintances by manually instructing them in the technique of injecting heroin, snorting cocaine, smoking cannabis, etc. In order to stop the epidemic he advocated an epidemiological action program in four steps, in one version also expanded to five steps.

1. Elimination or weakening of agents, i.e. the dependence producing drugs. Substances such as phenmetrazine could be eliminated completely from medical practice, and substances such as heroin could be replaced by modern analgesics. Also, the illegal production of drugs should be suppressed.
2. Control of the mechanisms of spreading of agents. This should include strict control of medical prescription of dependence-producing drugs, and police and customs action to stop illegal trade and distribution of drugs.
3. "Immunization" of populations at risk. This could include proper information on drug effects to explain the risks involved.
4. Treatment of the people already afflicted.
5. Quarantining of the chronic cases, to prevent further spread of the drug habits.[4]

Bejerots program has never been fully implemented in any Western nation.

Pandemic drug abuse

Pandemic, or world-wide, drug abuse is best exemplified by the smoking of tobacco and nicotine dependence. In 1967, at the first

Scandinavian socio-medical conference in Gothenburg, Sweden, Karl Evang, a Norwegian expert from the World Health Organization, said:

> "In a quickly shrinking world with increasingly intensive means of communication of different kinds, we have arrived at a stage of intensive expansion of different endemic forms of use which used to occur in geographically delimited areas, [and which were] unchanged for thousands of years. These types of use are now taking on an epidemic character in new cultural contexts, as evidenced by the rapid spread of our Western use of alcohol all over the world. At the same time, smoking hashish and marijuana is entering the area of alcohol use. The question is hardly whether one type of toxic use is replaced by another. Actually, a new drug has entered the field."[5]

Every continent had its own drug and used it in a more or less traditional manner. These were rarely combined with other drugs, and the relatively small number of full-blown dependent persons caused no permanent damage to societies. But when North American natives began to drink European alcohol, disease and misery began to disrupt families and even whole tribes. This same process occurs when family members start taking drugs or whole neighborhoods degenerate as a result of drug use. By "shrinking the world" we have not traded one drug for another. We have merely added different drugs to the existing stock.

Economic growth

Evang is of the opinion that powerful economic interests lie behind the intensive internationalization, or globalization, of endemic use. Everywhere we see individuals and groups who push for the global acceptance of drugs. But what exactly might happen if the use of cannabis becomes endemic all over the world? Karl Evang was convinced that if cannabis use becomes as widespread as alcohol use, then public life as we know it will cease in a few decades. The director of the UN narcotics laboratory, Dr. Olov Brænden, said in the 1960s: "Hashish is the greatest threat to man and society." Cannabis is the most common illegal drug in the world. Many today feel that society is declining, that politicians are more interested in economic growth than in citizens, society and our environment. During the European Union

summit held in Stockholm in March of 2001, the economy, armed conflicts and employment were prominently on the agenda. Surprisingly, even while Sweden held the presidency of the EU, during all these meetings the problem of drug abuse was hardly ever addressed, not even after the anti-drug movement had forcefully argued to put drugs on the agenda. This passive attitude, this lack of interest, this social alienation and the growing consumption of drugs in Europe, are an odd with basic values of prosperity, democracy and justice in a society. On the contrary, these attitudes enhance workplace and school absences, unemployment, insecurity and anarchy.

Economically speaking, it is evident that small business owners can hardly compete with those who launder drug money. Financial pressure also comes from the many crimes committed by drug users who rob and steal to support their dependence. In general, citizens no longer feel safe or protected and have no reason to feel encouraged when their government tells them, as in certain European countries, that cannabis can be decriminalized. In reality, the widespread use of hashish is not just a personal but also a societal catastrophe that Evang and Brænden foresaw in the 1960s. The same foresight was in the mind of the Egyptian scientist, Dr. Mohamed Abdel Salam El Guindy, who warned about the same thing at the Second International Opium Conference in Geneva in 1924.[6]

The dependence mechanism

This is a murky area, in which technical terms such as habit, tolerance, habituation, dependency, craving and addiction cause confusion among citizens, media and professionals. Adding to the confusion is that these issues often overlap. Translators often experience great difficulty in converting these terms correctly from one language to another. The dependence mechanism applies to any kind of dependence. If users claim to take dependence producing drugs only every once in a while and to have complete control over it, in which phase of dependency are they? Different habits, different substances, how often, how much, the environment, but especially *the intensity of the experience*, are all factors in development of a dependence. What precisely are we talking about when we talk about dependence? The following discussion limits itself, as much as possible, to alcohol and illegal drugs.

Habits

We all have habits and routines that we are accustomed to and make us feel secure. If we exaggerate our habits, or fail to act according to our routine, we may cause anxiety. To walk back into the house three times to check if we turned off the stove, or worrying over whether the door is really locked, may seem normal to us but might surprise another person, who thinks we're compulsive neurotics. If this is brought to our attention, or if we realize that we're overdoing it, we can check the habit that has gotten out of control. However, if no one responds, and we continue our behavior, such habits may become compulsions.

The first steps into the world of drugs

The first step into the legal and illegal world of gambling, alcohol and illegal drugs is seldom taken with the express purpose of developing a dependence. Travelers are lured by promises of freedom, excitement, spirituality and happiness in an environment that is off the beaten track and away from the mundane. There are warnings about the consequences of drug use, but at the same time, people are told how to "safely" use drugs if they want to. No wonder both young adults and parents are getting confused. Without clear guidelines set by parents and other authorities, people are more easily disposed to experimentation. All initial steps take getting used to, such as the smoke, the taste, having to swallow pills, a new environment, the reactions, impressions and new friends. Comic or terrifying drawings and photographs and other literature aimed at the young user's mind are intended to make drug use extra "enjoyable." For the novice, this psychedelic imagery is often exciting. For the more experienced user, it is different. It has become a part of his reality. The user's world is like a roller coaster you can step in or out of before it starts, but once the ride is underway, it is hard to stop it. The foundation for possible future habituation and social interaction in the drug circuit is laid in this first stage.

> ***The intense experience of a high is confused by many young users with intimacy, love and comfort. They fall in love, not with another human being, but with the high.***
>
> *—Drug counselor Gunnar Bergström*

Tolerance or habituation

The genetic make-up of an individual, the level of his tolerance and his trigger-level (the level at which a reaction is triggered which causes sickness) are unique to each person. Everyone has some level of biological risk, or trigger level, for developing lifestyle-related health problems. This is a risk we cannot change and is true for heart disease, cancer and alcoholism. Lifestyle-related health problems are triggered by quantity/frequency choices, which are risks we can change.[7] We can't change our genetic predisposition for dependence. A possible heightened risk caused by hereditary factors is beyond our control. What we can do, by ensuring proper preventative measures, is prevent a possible genetic risk from blossoming. In the case of alcohol and other drugs, that's easy: don't start.

According to the Prevention Research Institute (PRI), we are all born with an innate tolerance level that is determined first by genetics and biology and next by behavior. Initial tolerance to alcohol is raised by drinking to the point of impairment (the tolerance level) and then a little beyond. When a person drinks beyond the tolerance level, the body automatically raises tolerance so that the next time he drinks, he can drink a bit more without becoming impaired. This automatic protective device raises tolerance over time, and this acquired tolerance allows a person to drink increasingly more before becoming impaired.[8]

There are those who claim proudly that they can drink a dozen beers without getting drunk. They may have created or inherited a relatively high tolerance level and will drink more, and more intensively, with all of the risks associated with that behavior. This increases the risk of becoming dependent, becoming an alcoholic. Increased tolerance is seen as a license—"I can handle it," or "It doesn't affect me"—instead of as a warning signal. The tolerance level is raised even more until it goes too far and the trigger-level is reached. Nobody knows before experimenting what his or her trigger level is. For many drugs, such as cocaine or heroin, the trigger-level for psychological dependence can be reached at the first exposure to the drugs effects. According to the PRI, the body's ability to accept drugs is much lower than its ability to accept alcohol.

- Everyone's trigger-level for addiction to most other drugs is much lower than for alcoholism.
- There is no research available that shows any specific quantity/frequency of illegal drugs to constitute a low risk for anyone.

- The strength and the purity of a "dose" of illegal drugs is not predictable. People never know for sure what they are getting.
- Most adults can have a drink, or "standard dose," of alcohol without impairment. But the "standard dose" for illegal drugs is generally enough to cause impairment.

Decreased use of drugs lowers the tolerance level. When use is stopped altogether, it returns to the original level. The brain remembers and recognizes the substance. Therefore, when the drug is taken again, the tolerance level will rise more quickly than it did before, because now the body is pre-programmed to accept the substance. For someone who has kicked a drug habit and acquired a lowered tolerance level, taking an amount of drugs comparable to what he used before poses considerable risk of an overdose. The tolerance of any addicted person is unpredictable, because the central nervous system and the liver have sustained permanent damage.

Tolerance development, or habituation, means the tolerance level becomes raised. The more intensive the behavior or usage and the quicker the tolerance level is reached and surpassed, the sooner the tolerance level will be raised to approach trigger-level.

The question for parents is, What possibilities does today's drug policy offer my child to heighten his/her tolerance level, and what can that lead to?

Psychological dependence

According to the Trimbos Institute, "We can distinguish between physical and psychological dependence. Physical dependence occurs when the body protests if the use of a certain substance is stopped (withdrawal symptoms). Mental dependence means that the user's desire for a substance increases, and they can't feel well without it."[9]

We are all *psychologically dependent* on something or someone who supports us or whom we love. We would rather not change anything about that situation. A good connection and relationship with friends and family is positive and is guided by unwritten rules that allow people to protect and support each other in daily life. Should we have to do without those persons, a psychological and emotional emptiness is the result, often intruding deeply into the life of the subject. Being mentally dependent on alcohol, cigarettes, gambling or drugs is also a kind of emotional relationship.

Drugs never protect or support anybody. They only shield the user from reality. The more intensively and frequently one takes drugs, the sooner one has to pay a high price, or is driven from home and from one's ideals. The irony is that at first a person thinks he or she has "chosen" to do drugs, but then is controlled by them. Looking in a mirror, one probably asks oneself, "What am I doing?" Psychological dependency leads to a defense of drug abuse and reliance on drugs in daily life to the detriment of relationships with people on which one can and should rely. In this phase, many parents can only watch, powerless as their children sink deeper and deeper into the grasp of the drug industry and "harm reduction" ideology.

Psychological dependence is probably more widespread than we think, as we can see in the club circuit, where so many different drugs are used. It seems that a large group of especially young adults don't believe anymore that they can dance, feel empathy, have fun, talk, make love or simply have a nice evening without using drugs. How quickly this dependency develops depends on the factors mentioned above. The younger a person is when they start using drugs, the sooner they will develop compulsive behavior, because a young person physically and psychologically is not full-grown yet. As long as a user stays below his trigger-level, he hasn't yet become dependent upon alcohol or drugs, but he is dependent on a substance or a behavior. Despite the dependency and its associated problems, in order to be able to return to health without developing the diseases of alcoholism, nicotine addiction, bulimia, anorexia, gambling addiction or drug addiction requires outside help.

Craving

"Craving" is a term used when describing the emotional bonding of a drug abuser to his or her drugs. It was adopted at an expert group meeting, organized by the United Nations International Drug Control Program (UNDCP) and the World Health Organization (WHO) in Vienna in January 1992. Attendees agreed upon the following definition:

> *Drug craving is a desire for the previously experienced effect(s) of a psycho-active substance. This desire can become compelling and can increase in the presence of both internal and external cues and with perceived substance availability. It is characterized by an increased likelihood of drug-seeking behavior and, in humans, of drug-related thoughts.*[10]

The UN and WHO definition was followed by "Drug Policy: The Third Way Against Drugs—Demand Restrictive Policy,"a conference sponsored by the European Commission and organized by Europe Against Drugs (EURAD). Jonas Hartelius, a Swedish expert on drugs, further explained in the conference proceedings the concept of drug craving and how to recognize it, especially as it relates to dependency and availability:

> *The concept "drug craving" focuses on the strong desire for the drug effects as the driving force. It is independent of any underlying causes, such as personality disorders or psycho-social deviance or of withdrawal reactions. In clinical and social work the concept of drug craving will be easier to use than the established concept of drug dependence. To show that a patient or client has developed a drug dependence, a doctor must have a long observation time and be able to point to several relapses. If a doctor wants to investigate whether a drug abuser has developed craving, the doctor needs only ask the patient about his or her relations to the drug effects: whether the drug abusers desire them, has gone to lengths in order to acquire drugs, thinks a lot about drugs, etc. Positive answers to one or several of these questions indicate a drug craving. One important consequence for drug control is that the new definition of craving stresses the role of perceived drug availability. It recognizes the importance of public drug control policy, also in the prevention of relapse. The concept of drug craving will not replace that of drug dependence in all areas, e.g., it is not likely in legal texts. But using "drug craving" is useful both in counseling and education. The concept may be useful for explaining to a patient or to other groups that the longing for the pleasurable effects of a drug will drive an abuser to continue the drug taking even under adverse conditions."*[11]

Drug users build such enticing castles in the air to protect their habit that they'll even move in and live in them.

—Drug counselor Gunnar Bergström

Dependence

According to the WHO, the definition of dependence is "the compulsion to use a drug because of its psychological effects." How serious a dependence is can be gauged from the extent to which an abuser will forsake his duties and make sacrifices to continue drug use, despite the negative consequences. Dependence starts when a person consumes a drug in such a dose that the brain, often by stimulation of the pleasure zone, is influenced. This causes feelings of pleasure that the user wants to experience over and over again. By repetition of use to relive that high, sooner or later this repetition will raise the user's tolerance level, which will cause dependency and finally pass the trigger level to cause full-fledged dependence. A dependence will continue to exist, albeit in a dormant state, as long as the person lives—even after detoxification Renewed contact with the drug will cause the dependence to reassert itself. Even after detoxification, one remains dependent upon alcohol or drugs, albeit a sober one. It takes a strong network, such as AA and NA, to stay sober.

The brain's pleasure center doesn't care what it is dependent upon. Unchecked desire, heightened tolerance and withdrawal symptoms if desire isn't fulfilled, define dependence. A dependent person is generally not able to break the circle, despite their realization that such behavior is self-destructive.

Withdrawal symptoms

The body reacts very powerfully when an unfamiliar substance enters it—for example, when people first smoke a cigarette, drink an alcoholic beverage or takes a hit from a bong, most will feel nauseous. If a person doesn't heed this first warning and continues to use, the body surrenders and accepts the poison. Then, if it is withheld the poison to which it has become accustomed, the reaction consists of symptoms such as transpiration, nausea, shakes, dizziness, impaired speech and vision, pain, diarrhea and cramps. Withdrawal symptoms are the body's reaction when a user stops taking drugs. These symptoms go away as soon as the drug is taken again. If the drug isn't taken, they usually diminish within ten days and then disappear altogether. The body has a tremendous ability to detoxify itself if no new poison is added. It is understandable that an dependent person try to avoid this physical

detoxification, even if it lasts only briefly. This is often the reason not to detoxification, and to participate in heroin or methadone programs that don't require them to kick their habits. It is a well-known medical fact that physical detoxification in many cases can be managed in an intensive care unit. Mental detoxification, on the other hand, is much more difficult. These mental detoxification symptoms are an unchecked need and desire for the drug, and they are aggravated by reality intruding upon the mental sphere of the drug abuser.

Dependence is not just a symptom, but a force in its own right

Whether a person's first exposure to drugs is a hit, pill or drink is dependent on a person's background and living habits, as well as the accessibility of drugs. This is the *cause* and the *beginning* of drug use and a possible drug career. *Continuing* toward and *recognizing* drug dependence is a different matter. Professor Nils Bejerot calls dependence an "acquired behavior" or "an artificially induced drive" to emphasize that they were not natural drives (such as hunger) and that they had had developed through external factors, such as the repeated administration of drugs for intoxication purposes. He is of the opinion that, from a biological, pharmaceutical and psychological perspective, there is no difference between nicotine, caffeine, alcohol, medicine or illegal drug dependence. They all result from acquired behavior, regardless of which specific factors led to the first use of the substance.[12] Of course, these substances vary enormously in regard to toxicity, potential harm and potential for dependency. Some are strong narcotics, other have a mild stimulating power and weak dependency—such as refined sugar and chocolate.

If a 13-year old smokes his first cigarette or joint out of curiosity or because he was pressured by his friends, the cause is curiosity, peer pressure or a desire to imitate grown-up behavior. If he is a chain-smoker or pothead at age 35, it's because he bravely coughed himself through the ensuing packs of cigarettes or joints before he got used to them and became dependent. Smoking is then kept going by the desire for nicotine or THC and has nothing to do anymore with the earlier curiosity or the badge of bravado gained by lighting up in front of his friends. Bejerot calls this "an acquired desire and behavior that has taken on a compulsive character and strength."[13] He calls it compulsive because common sense and intellectual, rational

reasoning are almost powerless compared to compulsion. Everyone knows how harmful smoking is and how difficult it is to quit. Compulsion in dependence behavior is a characteristic in all addictions. The fixation of dependence resides in the memory and often remains there for life.[14]

If we are to help someone overcome his or her dependence, it's of little use to look for the reason that caused the first hit or drink, just as it's of little use to look for the cause of a fire when the house is burning down. The fire must first be put out.

Everyone knows how harmful smoking is, and how difficult it is to quit. Compulsion is a characteristic of all dependencies. The fixation of addiction resides in the memory and often remains there for life.

—Professor Nils Bejerot

Between 1850 and 1950, widespread traditional epidemics were countered by prevention. The known contagious diseases were studied, cures were sought out and preventive measures were taken. Alcohol and narcotics problems also were tackled, and in many countries, preventive action was taken against alcohol and illegal drugs. International treaties were drawn up to prohibit drugs, organizations were founded to counter drug and alcohol abuse and drug dependent persons received help. Since the 1960s, this has definitely changed in the Netherlands. This new era saw treatment of those already dependent coupled with the freedom to use dependent producing substances as the most pragmatic and correct way to treat the drug epidemic. But no epidemic has ever been halted by such measures. For drug abuse, just as for HIV, there is no vaccine (yet) that can stem this epidemic, but both can be slowed down considerably or even halted with preventive measures. We know and must continue to remember that the current drug problem is essentially an epidemic, an epidemic in which the user's desire is the driving force, the drug industry and drug pushers deliver the merchandise, the pro-drug movement "informs" the population and politicians adopt inconsistent and permissive attitude of tolerance or "harm reduction." It is impossible to treat the effects of a drug epidemic with detoxification, methadone and therapy. In the words of Nils Bejerot: "Treating drug epidemics via individual treatment is like fighting malaria by hunting mosquitoes. It can keep a lot of people employed but the effects are negligible."[15]

To counter the drug epidemic, just as with earlier epidemics, we must act preventively, if we are to stop the fast-growing destruction of our youth and our society.

Treating drug epidemics via individual treatment is like fighting malaria by hunting mosquitoes. It can keep a lot of people employed but the effects are negligible.

—Nils Bejerot

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Chapter Five

DRUG PREVENTION

Drug prevention means more than just preventing the use of drugs. It is a positive, proactive approach that promotes a society's social well-being, living conditions and welfare. Prevention also includes respect for the law, the promotion of respect for the law and communication. This can be done through mass media, education and discussions in groups and individually. Drug prevention incorporates all types of action that prevent and diminish the consumption of drugs.

Prevention is more than just education. "Prevention differs from education by setting goals and boundaries and working within the social context; in effect fostering a culture in which the desired situation is more likely to occur, to be willingly chosen," according to Peter Stoker, director of the British National Drug Prevention Alliance. "Prevention must engage the whole society. This requires a substantial shift in attitude for several professions, given that we are by nature symptom-focused and reactive."[1] Focusing on symptoms is a natural reaction, but does not prevent problems from happening. Effective prevention must be understood as an ongoing process to curb problems. "Suggesting, for example, that prevention should be limited to those 'at risk' is like limiting contraception to the pregnant," says Stoker.[2]

Suggesting that prevention should be limited to those "at risk" is like limiting contraception to the pregnant.

—Peter Stoker, British National Drug Prevention Alliance

Two perspectives on prevention

No consensus exists concerning the nature of the drug problem and whether and how we must prevent drug abuse. There is, however, widespread agreement that an ounce of prevention is worth a pound of cure. There is agreement also that people do not have responsibility only for themselves but must also share responsibility for others. In practice, we can distinguish between two different perspectives on drug prevention:

1. The prevention strategy *against* the use of drugs.
2. Prevention strategy *favoring* the use and integration of drugs.

Prevention strategy *against* the use of drugs

This strategy is based on the assumption that the use of drugs, alcohol and tobacco is a problem for society and public health even if drugs are not used by anyone in the immediate family or community. The minimalization of alcohol and tobacco use is of great importance if this strategy is to succeed. Research indicates that abstaining from these legal stimulants may stop or delay the initial use of illegal drugs. We can distinguish between three aspects of prevention.

1. *Primary prevention* means preventing any appearance of drug use or any other kind of unwanted behavior. Primary prevention compares to fire prevention involving smoke detectors and fire safety education. The aim is to prevent fire and possible causes of fire. Drug prevention can be attained by strong city policies in combination with the aid of parents, teachers, community leaders, church leaders, YMCA and other groups that organize sports for kids (from Little League to soccer) and local police, using relatively small-scale economic measures and prohibitions. The following are possible elements of a primary prevention strategy: the supervision of children after school, a non-smoking policy in public spaces, drug-free clubs and bars, honest information about various drugs and their consequences, improvement of a child's surroundings, extra attention when risk of drug use increases and dispelling the myth that everyone uses drugs. This last factor especially must be stressed since it may decrease peer pressure. A generally agreed-upon prevention strategy and course of action implemented in the home and the community has a strong likelihood of success.

2. *Secondary prevention* requires every possible effort to detect and stop drug use at the earliest possible stage. In fire prevention, this consists of rapid intervention with fire extinguishers etc. In a similar way, early action is of the utmost importance, preferably before others are introduced to the use of drugs and before the user and the user's environment become either accustomed to or affected by the habit. Measures may include diagnosis of suspected illegal drug use, counseling, tracking of contacts etc.

3. *Tertiary prevention* involves the limiting of drug-related problems often called "harm reduction." In fire prevention this may involve letting the primary fire burn it self out, while protecting other houses. The goal is to save the dependent persons' lives, to help their families and to rehabilitate users so they can return to society.

Considering the enormous drugrelated costs to the individual, the neighborhood, the focus of preventive measures must be on the primary and secondary stages.

The advantage of distinguishing the various elements and stages of a prevention plan is that everyone, from parents to community leaders, realizes their respective responsibilities and can act accordingly in the different stages of dependence and prevention.

Stages of Prevention

Stage	**Keyword**	**Fire prevention** (examples of measures)	**Drug prevention** (examples of measures)
Primary	Prevent (Prophylaxis)	Smoking ban Fire precautions Fire-proof materials	Drug education Administrative drug control in pharmacies etc.
Secondary	Stop (Intervention)	Fire alarms Fire extinguishers Rapid deployment	Detection and diagnosis Early intervention Relapse control
Tertiary	Limit (Damage control)	Stopping the spread of fire to other houses Evacuation	Medical treatment of health consequences Methadone maintenance etc.

Prevention strategy *favoring* the use and integration of drugs

Not everyone uses the word "prevention" primarily with an intention to prevent all non medical use of drugs. Rather, they intend to prevent the risks associated with excessive drug use. But informing people about the dangers of drugs to prevent abuse, while ignoring laws and accepting experimentation, is inherently contradictory. Adherents of this strategy realize that abuse of all drugs can lead to abuse but accept and even supervise the "use" of drugs. Only when public nuisance, crime and health damage become visible, proponents of this strategy with refer to drug use as a problem. At the same time, they will admit that excessive drug use occurs among some groups. "Harm reductionists" and groups endorsing legalization support and implement these strategies, but they are joined also by a great many well intentioned and hardworking people. They say "prevention," but mean "damage control." One must, therefore, be cautious as to what kind of prevention is intended. "Harm reduction" is steadily gaining ground. The interpretation of drug prevention as "harm reduction" has come to be more and more popular inside as well as outside Europe. It has been supported actively since the 1970s by Dutch policy makers and politicians.

> ***Everyone wants to prevent drug problems, but not everybody wants to prevent the use of illegal drugs. Wherever disagreement exists about what the precise goal of prevention is, the prevention of the use of drugs becomes an impossible task.***

Prevention and the law

The Dutch Opium Law is very clear. This is important to both the user and to prevention efforts, outlining the legal limits and the consequences of breaking those limits. The Dutch drug policy, however, is unclear. Besides the Netherlands, other countries have attempted to liberalize drug laws. Sweden between 1965 and 1967 and the United States, Alaska (1975) and other states have tried liberalization. Because of a growing number of dependent persons and drug-related deaths, and pressured by public opinion, politicians were compelled to retighten legislation in Sweden and the United States.

Unfortunately, the Dutch have not learned from history, as became clear recently at a conference on cannabis policies in Europe. In early

2001, the then minister of Health of the Netherlands, Ms. Els Borst, together with her colleagues from Germany, Belgium, France and Switzerland, initiated a series of conferences on establishing a unified European cannabis policy, the first of which was organized by the Department of Justice in Utrecht, the Netherlands. A scientist on cannabis from Sweden, who attended the second conference, "Scientific Conference on Cannabis" in Brussels, Belgium, filed a protest because the reports discussed were handed out only the day of the conference so that none of the delegates could study them. Objective discussion was made impossible, as was reported in the newsletter of European Cities Against Drugs (ECAD). Ms. MaLou Lindholm, former Member of the European Parliament and deputy director of Hassela Nordic Network, a Swedish organization advocating restrictive drug policy, attended both conferences and noted how the organizers, rather than objectively discussing cannabis, were pushing their agenda to create more understanding for the liberal Dutch drug policy. When addressing a seminar at a conference in Reykjavik, commemorating the end of a successful five-year program dedicated to a drug-free Iceland, she remarked, "One of the main issues that was discussed at the conference [on the scientific aspects of cannabis] was: *How to circumvent the UN conventions on illicit drugs.* The conventions are seen as obstacles for 'a pragmatic cannabis policy.'"[3] There is no doubt. When politicians from countries with liberal drug laws say "pragmatic," they mean "liberal." They are not concerned with the scientific evidence or with the unification of European guidelines—they simply want to decriminalize or even legalize marijuana and other drugs. And it looks like their tactics are working. More countries have recently enacted or are working on laws for the liberalization of drugs, e.g. the United Kingdom, Canada, Portugal and Belgium.

Where laws are enforced and attention is paid to primary prevention, drug problems decrease. "In the United States, the use of alcohol and other drugs among teens and young adults decreased dramatically between 1980 and 1992. The combined effort of police officers and school teachers accomplished this, in cooperation with municipal prevention councils and with the financial support of the federal government and staffed by parent volunteers and other concerned citizens," says prevention specialist Edward Ehman. "Consumption of alcohol and use of other drugs usually are very important factors in family problems, juvenile crime, suicide among youths, unwanted

pregnancy, rape, truancy, school drop-outs, domestic abuse, incest, lessened potential, health impairment, drowning, injury or death in traffic crashes and other life-threatening activities."[4]

The case of Iceland shows similar results. For the last five years, Iceland has worked hard to make drug-free Iceland a reality. At a drug prevention conference in Stockholm (May 2002), Thorolfur Thorlindsson, professor of sociology at the University of Iceland, presented data that showed conclusively that drug and alcohol use in Iceland had decreased as a result of dedicated campaigning. "Iceland showed decreasing statistics in regard to all drug issues. Less young people tried illicit drugs, the debut with alcohol came later, frequency of alcohol consumption had gone down."[5]

Tobacco, alcohol and marijuana form a combination in which they reinforce each other and are a gateway to the experience of chemical highs. Once acquired, users wish to experience those other kicks also, especially if the initial high no longer fulfills expectations. Tobacco, alcohol and marijuana are the most commonly used drugs, not just in the Netherlands but around the world. Prevention of their use, therefore, has enormous consequences for public health, lowering the number of drug users and decreasing drug-related incidents and crime. The law is an important tool in preventing drug use. Liberalization, or decriminalization, on the other hand destroy efforts towards drug prevention.

Tobacco, alcohol and marijuana are the most commonly used drugs, not just in the Netherlands but around the world. Prevention of their use, therefore, has enormous consequences for public health, lowering the number of drug users and decreasing drug-related incidents and crime.

Parents and prevention

The then health minister of the Netherlands, Ms. Els Borst, started an educational two-week campaign to prevent drug use in November 2001, "Drugs, Don't Be Fooled by Anyone." The campaign focused on communication between parents and children about drugs and drug use.

"Sooner or later children will be faced with the option to smoke cigarettes, drink alcohol or use drugs. Very often parents do not know how to handle that option. Children find it difficult to discuss these options with their parents. Research has shown that nearly half of all young adults do not wish to tell their parents that they use or want to use drugs."[6]

While this statement appears to be a good start to a useful campaign, the organizers' true intentions surfaced very quickly. According to the Dutch health department, communication between parents and children is important *to prevent problems arising from experimentation with drugs*, not to prevent drug use itself. That a Dutch prevention campaign would have such a goal is no surprise. For years, the government has tried to get parents to accept and accommodate (or supervise) the "recreational" use of drugs. The booklet "Your Child and Drugs," published by the Trimbos Institute (one of the organizations co-sponsoring the 2001 campaign), aligns their goals with those of the government. Under the heading "Education and stimulants," three ambiguous and leading questions are proposed for parents to ask.

- How can you prepare your child to handle stimulants?
- What can you do when your child starts experimenting?
- How do you know if your child engages in risky behavior, and what can you do about it?[7]

Answers to these questions are hardly comforting. The Trimbos Institute advises against prohibition during the experimentation phase. Instead of banning drug use, they propose the following. "Together with your child, try to come to agreements regarding the extent and the occasion of drug use. For instance, only (and moderately) on the weekends, not in combination with homework, school, work or driving."[8] For a government-sponsored institute to propose this to parents is scandalous. Instead, the only realistic prevention approach is that parents must refrain from cooperating with and encouraging their children's drug use. Why?

- Children can create or be the victim of accidents related to drug use.
- After drug use on the weekend, they are tired, aggressive, depressed or unmotivated and cannot function well in school.
- They are liable to get hallucinations and nightmares.
- They can experience paranoia.
- Their health is jeopardized.
- A child may involve siblings or peers in experimenting.
- It's hard to tell if the child continues to use drugs.
- The child may die as a result (one dose of XTC can be deadly).

What parent would willingly take these risks in allowing their child to experiment? The brochure's message is, "Keep in contact with your child, do not be alarmed if they seem to experiment, don't go around prohibiting or warning, but continue to engage in conversation." It seems there is no need for parents to be alarmed about or warn their children about drug use. They must keep on talking. This is the ultimate stupidity, but this is not all of it. "Young adults who experiment with drugs are usually well-informed about them, so you don't have to tell them anything," according to "Your Child and Drugs." "Moreover, you lose your credibility if your opinion turns out to be based on incorrect information."[9] The institute has, however, not considered the risk of itself losing credibility when found to have promoted "incorrect information."

In information spread by public health organizations, not much has changed since 1997, event though all fact information about drugs is available to day. It seems that providing parents with the tools they need to keep their children of drugs is not the primary goal.

Children may know a lot about drugs, but they do seldom understand the consequences of drug use for themselves. The gap between knowledge and understanding must be filled in by parents. Children are taught by parents and educators according to guidelines regarding such as right and wrong, just and unjust, healthy and unhealthy. From early on, parents have had to warn their children about space heaters, cigarette butts, door locks, child molesters and power outlets to explain dangers and to prohibit dangerous behavior. Drugs are no exception. If the child is unwilling to listen, then parents must act in a meaningful and effective manner. Parents are still responsible for their children and their future. "A young adult's experimenting will not easily go astray if he or she is not bored, is self-reliant, knows how to say 'no,' and can accept setbacks," according to the brochure. This may be a comforting message, but will not prevent the use of illegal drugs. It is a well-known fact that teenagers have no qualms about saying "no," however, they do not always say it at the right moment.

"Experimenting" with dependent producing stimulants is not a matter of self-decision for young people, and in fact encourages neglecting rules and laws. Concerned parents who voice their worries are always credible, but they are often characterized by "harm reductionists" as overly dramatic, old-fashioned, and cranky. Despite such ridicule, a parent's opinion and decisiveness do matter to the child,

and the sooner the child gets this message, the better. Prohibition may anger a child, but at least the child knows where he or she, and the parent stand on the issue. The 2000 National Household Survey on Drug Abuse in the United States has shown that among youngsters with parents who "would strongly disapprove if they tried marijuana once or twice," 7.1 percent of children "reported use of an illicit drug in the past month." Among youngsters whose parents "did not strongly disapprove," 31.2 percent reported use in the past month.[10] Other research shows similar results. Most recently, a PRIDE (Parents' Resource Institute for Drug Education) survey, conducted post 9/11 (2001), indicated that heightened drug awareness and more communication among parents and teachers and students led to the lowest percentage of drug, alcohol and tobacco use in fifteen years. Use of any illicit drug among students in grades six through twelve dropped by nine percent use of alcohol by three percent, and use of cigarettes by thirteen percent. "Following 9/11 Americans seemed to refocus on family, community, spirituality and nation. That renewed awareness shows up in the data. More students said their teachers and parents cautioned them about drug use, fewer joined gangs, more participated in extra-curricular school activities and more attended religious services," according to Thomas Gleaton, author of the study.[11] So, parents, don't be fooled by the pro-drug lobby. To clearly say "no" is fully within your right and is proven to be effective.

> ***The government listens only to the "pros," who are plentiful these days. But this libertarian ideal disregards the compulsion of dependence.***
>
> *—Wil Waaning, treasurer of EURAD*

Obstacles to prevention and possibilities

One obstacle to successful prevention is the drug habits of some parents'—smoking, drinking and the occasional use of drugs. Another obstacle is left over from 1960s rhetoric: "I used drugs in the old days; they aren't all that harmful," or, "I turned out alright and still use occasionally; why prohibit my child from using drugs?" But this generation of pot smokers is now showing, for instance, higher incidence of cancer related to pot smoking. Moreover, where pot used to contain between .5 percent and 3 percent THC, it now averages around 8.5 percent. Many more, and more powerful, drugs are available to

children now than in the 1960s. In their hearts, children want their parents to protect them from harm. Young adults want the truth—not parents to beat around the bush. Dutch research on a recent anti-alcohol campaign, "Are you stronger than alcohol?," has shown that according to young adults, the images of a bleeding victim of a drunk-driving accident was powerful and convincing. Also successful were the images of a young girl throwing up violently after drinking too much.[12] Such hard truths also come from drug dependent persons and former drug users, who discuss how they became dependent and what it really means to be dependent. Their stories, if told truthfully and honestly, are cause for reflection. They inform and deter. When not told honestly, they allow former drug abusers to be viewed as exciting characters with an enviable experience. Parents of drug dependent children also can be a valuable source of information and insight for both parents and their children.

Experimenting with narcotics is no business for young adults. It encourages disregard for laws and rules.

Prevention is a process

Primary prevention requires more than the occasional project, TV ad or motivational speaker at a meeting. In the last decades, many voluntary prevention projects against drug use have been started. Despite the sincerity of the efforts, results have not always lived up to expectations. Changing behavior is a slow process. Understanding the following obstacles may prevent despondency when trying to prevent drug use. Some recurring problem of prevention are:

1. There is rarely agreement about, let alone the willpower to engage in, primary prevention. There is a serious lack of prevention workers, preventive thinking and financial means to prevent drug use.
2. The use of marijuana is tolerated in too many countries. This wipes out clear boundaries, goodwill and a legal argument to prevent experimenting.
3. Prevention is all too often a matter left to social workers, teachers and police. In practice, this means that prevention is only a small part of their daily work, without sufficient financial and manpower resources. These professionals can make an important contribution. They have abundant knowledge, motivation and willpower, but if they are not part of a coordinated effort, much of their effort goes to waste.

4. Dutch politicians simply do not believe in solving the drug problem. If the Dutch want to make a serious effort to tackle the drug problem, it is necessary that:
   - primary prevention becomes as important in the discussion as treatment, crime, punishment and alternative drugs;
   - there be a budget for prevention work aimed at preventing and decreasing gateway drugs use;
   - more attention be given to prevention as a profession;
   - every city and county have its own well-educated and highly motivated primary prevention workers;
   - prevention not be a project separate from other public health initiatives, but rather a coordinated and concentrated effort;
   - policy makers not give up on the fight against drugs;
   - volunteer organizations receive all the assistance they need;
   - there be no tolerance for the use and distribution of illegal drugs;
   - young people, parents and concerned citizens become involved.

Prevention must be seen as a process and not as a one-time event to be organized when problems get out of hand.

Municipalities

"Of 538 municipalities in the Netherlands, 105 have one or more coffee shops. Of the remaining 433 municipalities, 72 percent have an official "zero tolerance' policy."[13] But in many cases of smaller municipalities with zero tolerance policies, they border on larger neighboring municipalities where "coffee shops" supply the whole region with drugs in accordance with regional "soft drug" policies. In the Netherlands, where the official drug policy is permissive, local perspectives and policies are individualized and goals unclear. In countries that endorse and enforce zero tolerance, individual perspectives may still proliferate, but there is broad agreement on the goal of a drug-free society. In Sweden, for instance, a poll conducted by the country's largest newspaper revealed that 96 percent of the population supports the government's restrictive drug policy that aims to rid society of drugs.[14] This goal is supported at local levels of

government. In the Netherlands, 25 percent of the population supports the government's drug policy, 43 percent rejects it, 21 percent see both positives and negatives and twelve percent do not care. This research also showed that "coffee shops" are a source of much irritation.[15]

While it is often said that the pragmatic approach, which is how the permissive Dutch policy wants it to be seen, is broadly supported by the population, the numbers belie this. I have often asked residents of various municipalities why they don't react against the advance of drug trade and use. "We don't understand it," is the usual reply. What one doesn't understand is preferably left alone.

Prevention is a cheap and effective means of curbing drug use and is broadly supported if only for financial reasons. "For every dollar spent on prevention, municipalities can save $4 to $5 on treatment and counseling," according to Bill Walluks of the Department of Justice in Wisconsin.[16] A study in the Midwestern United States revealed even more impressive numbers. "Results from the Midwestern Prevention Project—a comprehensive, National Institute of Drug Abuse-funded prevention study that was conducted in Kansas City, Kansas; Kansas City, Missouri; and Indianapolis, Indiana—indicated that every dollar spent on prevention programs saved $68 per affected family in health and social costs."[17] Parents and youngsters, but also city officials, law enforcement, HMOs and insurance companies should welcome and support serious prevention programs.

Prevention initiatives in practice

Such prevention programs are implemented in two large cities, namely Rio de Janeiro, Brazil, and Stockholm, Sweden. According to the former Special Secretary for the Prevention of Chemical Dependence of the City of Rio de Janeiro, professor Mina Seinfeld de Carakushansky, their effort involves the 11 million citizens living in the metropolitan area; in Stockholm, it affects 1.5 million residents. In spite of the huge problems that Rio has to face daily with criminality and violence in part due to drug trafficking, Rio de Janeiro's motto in all its prevention efforts over the last six years has been. "Rio says NO to drugs!"[18] Stockholm has been able to advance even further because the city council's determination to create a drug-free Stockholm is reinforced by the national government's intention to have the whole country be drug-free. In Rio as well as in Stockholm, a central coordinating drug prevention office was established (a Special Secretariat in Rio and a

Prevention Center in Stockholm) with a staff who work on many projects in various neighborhoods, all geared toward drastic reduction of drug use. The enormous courage, vision and motivation underlying these efforts ensure pragmatic and economic success. They aim to reduce the total cost for police and health care and to shield society and families from the ravages of dependence. Sweden has become a classic example of the success that can be attained when drug use is not tolerated. Countries like Sweden and Brazil do not condone drug use. Rio de Janeiro, plagued by drug-related murders, addiction, poverty and exploitation, now offers the poor a chance to become self-sufficient and seek a life far from drugs. More than 1,000 municipal schools work together with city councils and the Special Secretariat. This road is long, and small but important steps are being taken. Other large cities, such as Buenos Aires and Seoul, also have chosen primary prevention as an essential tool in decreasing drug trade and use. But in Dutch cities and municipalities, primary prevention will always be hampered by regional "soft-drug" policies. Tolerance for what are seen as "soft" drugs, which are artificially separated from other drugs, greatly hinder any implementation of preventative measures.

Preventive work in the Netherlands

The National Organization for the Prevention of Addiction and Stimulant Use receives a subsidy from the Department of Health and Human Services. Its task is to promote the cooperation between local, regional and national organizations. They support the dissemination of information, professionalism and innovation. They are also involved in the project "The Healthy School and Stimulants" of the Trimbos Institute, together with regional organizations and municipal health services. The goal of this project is to support K-12 schools that want to make a structural effort to inform children about stimulants and gambling. A brochure entitled "Drugs and Gambling," intended for fifth- and sixth-graders, has the following information on hashish and marijuana, under the heading "Soft and hard drugs":

> The use and sale of drugs is prohibited in the Netherlands. It says so in the law. The law consists of rules that people in the Netherlands must obey. In the Netherlands, rules for soft drugs are different from rules for hard drugs. This is because people think that soft drugs are less bad and harmful than hard drugs.

Hard drugs can make people really sick, so sick that they can't have a nice life anymore.

The only other thing mentioned about marijuana is the various names by which it is known and how it is used. There is no mention of the harmful effects of this drug. These children, eleven and twelve years old, are open to anything that comes their way and are very susceptible. Concerning "coffee shops," these children were told:

"Soft drugs are also banned in the Netherlands. Yet it is still allowed a little bit to sell and use soft drugs. This happens in coffee shops. These are the reasons the government allows this:

- People will use soft drugs anyway, even if you make them illegal.
- They will no longer be sold on the street.
- In coffee shops, people can be educated about soft drugs.
- In coffee shops, they don't mess around with the contents of the drugs, so dangerous things are not in them.
- They can't sell soft drugs and hard drugs at the same time."[19]

What does this teach children?

First..... that they don't have to live by the law.

Second..... that drugs are sold legally indoors and illegally outdoors.

Third..... that "coffee shops" are decent shops; which have their customers' best interest at heart and need to be trusted rather than feared.

Fourth ..... they learn that marijuana does not contain anything dangerous.

The assignment following the text contained the following questions:

1. Write down which of the government's arguments to allow the sale of soft drugs you think is best.
2. Which argument do you think is least good?[20]

What was not asked was whether they might perhaps disagree or what intensified drug treaties oblige the Dutch government to do in the area of drug control. This is indoctrination under the guise of prevention, a scandalous practice. No wonder so many drugs are used by

increasingly younger children. How many parents are aware of these educational methods? Who protects the children from being brainwashed?

Nightlife prevention

By commission of the Department of Health and Human Services, the Trimbos Institute is also responsible for implementing the program, "Drugs and Going Out 1998-2001," which is directed toward the "creative" use of stimulants by young adults when they go out and party.[21]

In the country's various regions, courses are organized on drug education and prevention for employees of "coffee shops". The course teaches "coffee shop" employees, among other things, how to give their customers good information on cannabis.[22] With the government's assistance, the drug pusher has now become a respectable shop owner. At school, children are taught to take their questions to the drug seller. (Oddly, "coffee shops" are really not that popular in the Netherlands: nine percent of the population is in favor, 35 percent want them closed and 52 percent want their opening hours limited.[23])

Organizations of drug promoters and users, such as Mainline, Drugs Consultancy, and the National Platform of Drug Users, receive support and advice from the Department of Health. Volunteer organizations that aim to prevent drug use are neglected. Apparently, to the Department of Health, the pro-drug movement matters more than organizations that advocate restrictive policies. Information spread by pro-drug organizations is used in "prevention," in developing social policies and in monitoring drug trends. In this way, the Department of Health can prove it works pragmatically and listens to "drug experts," who disseminate advice, not warnings, on various drugs.

Courses on drug information and prevention are organized throughout the country for employees of "coffee shops." They certainly are not likely to dissuade people from the use of marijuana.

Public opinion

Professional gatekeepers in the media control the spread of information. Whether economic, political or religious, all power must be supported by the people. Every kind of power in a democracy must be

supported by public opinion. Opinions can be created and manipulated. Opinions about drugs are no exception. Despite scientific research and the obviously negative effects of drugs, propaganda works. As early as 1933, the Swedish writer, philosopher and mass media specialist Alf Ahlberg wrote:

> [Propagandists exert] an invisible influence which radiates to us through thousands upon thousands of different ways, through the press, radio, books, movies, posters and public meetings. [This pressure is] even more refined as it creates an illusion of being one's own thoughts. One imagines oneself to be thinking one's own thoughts, expressing one's own opinions, reaching one's own judgments, acting one's own acts, and still, basically, one thinks, expresses, judges and acts as the blind instrument of social suggestion.[24]

The central question in any democracy is and will always be, who steers public opinion? The public's support is necessary for the creation of a liberal drug policy and the creation of commercial markets for drugs. Wealthy individuals and organizations establish think tanks for analyzing problems, developing strategies and honing arguments. Somewhat crassly, this can be said to produce ideology, i.e. thought structures and philosophies useful to the principals.[25]

The question remains, who determines what is publicly discussed and which policies are implemented? Since 1976, professional opinion makers have been very successful in exploiting drug commerce. Despite the Opium Law the United Nations and international treaties—and against the will of a large part of the population—the trade in and export of drugs continues to blossom in the Netherlands. Through the media, selective statistics and official research are presented to the public. Very rarely is this information checked for accuracy. For the policy makers responsible for the liberal Dutch drug policy, it has proven a rather simple task to present their views in a credible manner. Moreover, they have ample financial means and are able to participate in international conferences to find support for their views and expound them.

From the point of view of primary prevention, the Dutch drug policy is a disaster. Primary prevention groups that aim to prevent drug use are denied access to the public by a strong and closely-knit pro-drug lobby, as they are denied access to financial support from the Government. Despite all such opposition, such anti-drug organizations continue to work in schools, PTAs and in local communities to inform children about drugs and to promote discussions about drugs. Their goal is to reduce the use of drugs in the Netherlands. Active since the 1970s, the anti-drug movement has been opposed by a hostile Government and the growing commercialization of drugs.

The twelve Cs

"Prevention doesn't happen in a vacuum. Primary prevention in schools requires the support of parents, students and society if it is to be successful," says Anders Eriksson, a drug advisor who is responsible for the PreCens drug prevention office in Stockholm. He compiled the following list of factors necessary to guarantee successful prevention, a list now in use in prevention programs in Stockholm and Rio de Janeiro.

The twelve Cs of drug prevention

1.	Consensus	Agreement among all those who are working together regarding the work that is going to be done for the prevention of use of drugs among target groups.
2.	Context	It is not enough to have just prevention, treatment and enforcement, but a plan must involve social programs and, for instance, social services and police.
3.	Control	It is impossible to prevent drug use if drugs are easily available, cheap and socially accepted.
4.	Combination	Prevention must be done at the three levels simultaneously—primary (before the start of a problem), secondary (early intervention) and tertiary (treatment).
5.	Complexity	Primary prevention has to operate on both the demand and supply.
6.	Communication	Through mass media, to groups, and individually.
7.	Complementarity	Strategies aimed at the whole population, complementary with special attention for risk groups.

8. Continuity	Prevention is a long-term endeavor, a process that has to be repeated, continuously for all age strata.
9. Cooperation	One of the most important pillars of prevention, since prevention is too complex to be done by isolated actors. The work has to capitalize on the strengths of many different individuals and organizations.
10. Competence	It is essential to have up-to-date knowledge about drug issues, almost in real time.
11. Credibility	There must be trust that each one of the proposed objectives will be attained.
12. Concreteness	There is little use for theories if they can not be put into practice.[26]

Prevention is a complex issue. If we really want to solve the drug problem we must aim at decreasing the drug use of the coming generation. Good primary prevention can prevent young adults from being sucked into the drug scene. We have to start somewhere if we and our children are to believe that an ounce of prevention is indeed worth a pound of cure.

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Chapter Six

THREE DIFFERENT PERSPECTIVES ON DRUGS

Various factions compete for the public support of their particular philosophy regarding drugs and drug control. The perspectives of these groups can be generalized into three categories: repressive, permissive and restrictive.

1. Repressive perspective

The main idea in the repressive perspective is that organized crime and the drug problem must be battled and held back by powerful police and military operations and tough jail sentences. Tough legal measures are the oldest means of combating the drug problem. Nowadays, the approach is often called "War on Drugs."

Basic philosophy

The repressive perspective is based on the presumption that the drug problem is caused by illegal supply. If society destroys drugs as soon as they are illegally produced, or manages to stop drugs from reaching the market, then no drug abuse will arise, nor will there be an illegal trade in drugs. This perspective was the basis for the first international anti-drug convention in 1912. Wherever drugs are produced illegally, the crops or laboratories are destroyed or impounded by police and military, who

attempt to stop production and distribution by targeting syndicates, triads, cartels and drug dealers. This requires dedicated, determined law enforcement officers, who must often work undercover, as well as huge sums of money and technical know-how—for radar supervision of land and sea frontiers, air surveillance of drug-producing areas and wire tapping. Often, law enforcement must ally itself with certain criminal elements, such as when informers are given lesser penalties for telling on their accomplices or when illegal drugs are placed on the streets deliberately by undercover agents.

Proponents of the repressive perspective

Proponents are found among chiefs of police and conservative politicians, as well as among ordinary citizens. Some countries, such as China and Malaysia, punish drug dealers with the death penalty. In Malaysia, the distribution of more than 200 grams of cannabis, 1,000 grams of opium, or more than 15 grams of heroin or morphine is punishable by death.[1] Such a "hard line" approach also may be used as an excuse to counter guerilla activities. But support for the hard line also is found on a local level in the Western world, wherever drug abuse has caused problems. There are many examples of neighborhoods where tough police action has caused dealers and dependent persons to move out. In addition, sometimes communities run drug dealers out of their neighborhoods. In Naples, Italy, for instance, a drug dealer was literally swept out of a neighborhood by a succession of "housewives, each sweeping their doorsteps" and keeping a watch on what the drug dealer was doing. Acting against dealers people gives a sense of safety and control of their own communities.

Obstacles

The repressive approach faces various problems.

1. Stopping illegal production and trade is very difficult, because many drugs can be produced easily in simple laboratories or even at home. New production methods and new routes for smuggling drugs are developed continually.
2. The unilateral war against the supply of drugs does not reduce the demand for drugs and, in fact, creates huge profit margins. The possibility of great financial reward entices many to take great risks and get involved in drug production and trade.

3. Get-tough policies lead to more violence. Many begin to wonder whether this battle, in which police officers take great personal risks, is worth the sacrifices called for.
4. Provoking someone to engage in criminal activity in order to catch a drug dealer is at odds with the judicial principles of most Western countries. Recently, an expansive drug operation in the Netherlands, in which the police went beyond the boundaries prescribed by the law to catch drug dealers, led to a widespread revision of police methods.
5. The presence of police and paramilitary forces in countries where narcotics are cultivated and at customs checkpoints poses as a pretext for simultaneously trying to stop guerilla activities (as in the South American jungle) or illegal immigration (as along the Mexican-American border).
6. Those who want to liberalize drugs loudly proclaim that the war on drugs has failed and use this as an excuse to propose a permissive drug policy.
7. Constant police action isn't feasible as a method to prevent drugs from coming to the market and control the trade in drugs.

2. Permissive perspective

The main objective of those who hold this point of view is to abolish the ban on the personal use of illegal drugs. This perspective comes in different forms, but all of them promote a tolerant attitude toward the non-medical use of narcotics. Often, a permissive view on drugs goes hand in hand with permissive views on other societal issues, such as prostitution, pornography and trade in humans.

Basic philosophy

The permissive perspective is based on the idea that illegal drugs, when used in a safe environment and in a "controlled" or "moderate" manner, cause only a limited danger and, therefore, should not be forbidden but regulated. Proponents claim there is no difference between the excessive use of legal and illegal drugs and that the war on drugs cannot be won.

Some basic concepts

Legalization or *liberalization* of drugs is a very general term for different attempts to lessen the regulation of controlled substances. The term may cover a variety of legal and other measures, such as the change made in the Netherlands in 1976 when drugs were separated into categories of "acceptable" and "unacceptable." It may also apply to practices such as allowing Dutch district attorneys to choose whether they want to prosecute or not, when illegal acts have been committed.

The "harm reduction" philosophy states that excessive use of drugs and damage caused by drugs must be prevented as much as possible. Under the guise of prevention, children and their parents are taught:

1. to see drugs as an acceptable element of society;
2. how to use drugs in such a way as to reduce withdrawal symptoms, disease, and crime;
3. that checking XTC pills at clubs is a preventative measure;
4. that drugs bought in a "coffee shop" or from a known dealer are safe;
5. not to prohibit drugs;
6. to recognize the benefits of drugs and to minimize the harm they do with public discussion and medical action;
7. to see dependence as a result of a disturbing event in a person's life;
8. to accept and tolerate an individual's right to get high;
9. that sterile syringes reduce HIV and other infectious diseases;
10. how to handle syringes, drugs, and drug use;
11. how to deal with an overdose.

"Harm reduction" may seem to work well enough for the user at least for a while. That person receives health and drug education, psychological counseling, screening for HIV and STDs and medical referrals. "Harm reduction" proponents believe that this service to the user should be available wherever the user travels. This belief is one of the reasons the "harm reduction" movement is on the move globally. At the same time, proponents of permissive policies can only hope that users of illegal drugs will not commit crimes, use impure drugs from the street, sell drugs, share needles or die from an accidental overdose.

Anti-prohibition: Proponents of permissive policies are quick to say that prohibition is a violation of human rights. They aim to inform the public about existing legislation and treaties and how they limit the individual's rights and thus harm society. On local, national and international levels, they organize to end prohibition policies.

Normalization is the attempt to "normalize" drug policy, that is, to create a so-called "humane" drug policy that doesn't criminalize the use of drugs. It is smoke-screen for decriminalization.

Decriminalization aims to make drug possession and use a non-prosecutable act. Decriminalization is defended with the argument that police and the legal system should not bother with what proponents of this philosophy consider petty crime. The police should concentrate on bigger drug dealers, they say, since drug use only harms the user. They don't think that drugs should be illegal because they are harmful. They think that laws, not drugs, cause harm to users and turn them into criminals.

The *legal prescription of drugs* means that doctors, within medical specific guidelines or programs, may write prescriptions for illegal drugs to known patients who are physically or psychically dependent on drugs. Underlying this concept is the idea that it is more humane to give a dependent person the drug legally than it is to acquire their drugs illegally or to force them to stop. In reality, this means that society has given up hope.

Legalization refers to relinquishing public control over drugs, making trade and use legal. The basic idea is that citizens should make their own decision on whether to use drugs and should assume responsibility for their own actions. Users of illegal drugs are seen as victims of prohibition. Proponents of legalization believe that prohibition is the cause of the growing drug problem. Oddly, however, they also believe in regulation that would ensure age limits, drug quality and strength, testing for drugs on highways and taxation. Legalization will open up a wealth of possibilities that traders will exploit. Only international treaties prevent this development, as well as (most) politicians, police, doctors and the (all too silent) majority of the population.

Proponents of the permissive perspective

There are several groups of proponents, who want to legalize drugs or liberalize drug control for different reasons and with different goals.

Libertarians think that citizens have an innate right to use drugs, with which no government should meddle.

Drug romantics and *mystics* claim drugs provide them with a positive, deeper experience of a religious and cosmic character and that they have a right to use and enjoy them.

Green anarchists and others tell us that the consumption of drugs is a way to protest against bourgeois society and that drug users may be a force in the battle against the establishment.

Professionals with a somewhat romantic attitude toward their clients are found among criminologists, sociologists, psychologists, doctors, nurses, judges and therapists who have identified with their clients. They want their individual clients to be freed from societal control over drugs, yet they don't support whole scale legalization.

A *drug industry*, which has an increasingly global presence, includes not just the criminals and major smugglers and importers of drugs, the semi-legal "coffee shops," home-grow shops, home growers, chemists manufacturing XTC, hashish museums, and smart shops, but also ordinary plant nurseries and hardware stores, carpenters, electricians, drivers, and lawyers who benefit from the production of and trade in drugs.

Civil servants who no longer have supervision and control over the situation and can't handle it. Some bureaucrats within the police force would prefer to occupy themselves with more prestigious cases, such as high-profile organized crime, rather than what they consider to be petty crime.

Users of illegal drugs who don't consider themselves criminals or a potential dangers to others.

Liberal psychologists who look at dependence as a result of some trauma and drugs as a comfort for their clients' discomfort.

Opportunists in the media who use the liberal perspective as an opportunity to gain media exposure and to increase the circulation of their magazines, their prestige and their salaries.

Pro-drug organizations

European pro-drug organizations have joined the wide variety of American organizations that support decriminalization of legalization of illegal drugs. The following list, by no means complete, details some of them. Some of the most well known or influential are or have been the following:

European Movement for the Normalization of Drug Policy (EMNDP)

The first anti-prohibition group in the Netherlands was the European Movement for the Normalization of Drug Policy, founded in April 1987 in Rotterdam. The first steps toward a new European movement were made on April 6, 1986, by psychiatrist Wijnand Sengers, formerly a professor at the Institute for Preventive and Social Psychiatry at the Erasmus University in Rotterdam, and three sociologists, Wouter de Jong, Hans van Mastrigt and Peter van den Valk. The EMNDP is an international association whose purpose is to normalize drug policy in West-European countries.[2] The UK was the first European country targeted by the EMNDP, with a conference in Liverpool on August 24, 1988. With the prospect of a single European market without boundaries, from January 1, 1993, the EMNDP worked at a European policy of normalization. They were afraid that the liberal Dutch policies would have to be adapted to more strict legislation in other countries and that drug users would be stigmatized, criminalized and persecuted. As they phrased it themselves, they wanted to contribute to a more humane kind of drug policy and to stop the "war on drugs."

Their coordinator, Wijnand Sengers, asked quite cynically if tobacco should fall under the Opium Law: "In the Netherlands, every year 100 people die from heroin use, but 6,000 die from alcohol and 18,000 from smoking."[3] What Sengers doesn't seem to realize is that if "only" 100 people die annually from using heroin, it is clear that the prohibition of that drug is effective to some extent. So why this urge to normalize the use of heroin if its prohibition under the Opium Law is such a success?

According to Wouter de Jong, "Drug users are still being stigmatized. People who are stigmatized become isolated and thus degenerated. Besides, drug users are criminalized. Just look at the number of addicts in prison."[4] That drug users in the Netherlands end up in prison, even though drug use is legal and petty crime is no priority for police officers, speaks volumes—it proves that those drug users have been guilty of particularly heinous crimes. This is not stigmatization of any person. It is only a measure of their criminal behavior. A person on drugs changes behavior all too often, as well as values and norms.

According to Hans van Mastrigt, another EMNDP activist, "Language has deteriorated. For instance, we talk about 'heroin prostitutes,' when we really should call them 'heroin policy

prostitutes.'"[5] Van Mastrigt hardly knew what he was talking about, even as a co-founder of EMNDP. Heroin prostitution is the result of the normalization policy the EMNDP propagates. This normalization, also called "pragmatic policy" in the Netherlands, has created areas where prostitution is allowed, allowing terrible, disgusting and heartbreaking scenes to take place right in front of those unfortunate enough to live in those neighborhoods. After popular protest, city zoning lead to prostitutes doing their business on the outskirts of town. In some towns, this business is conducted on industrial sites. In others, little sheds are set up that look like a bus stop or a car wash. There have been proposals to privatize these areas. Many of these zones are so far outside the city that no public transportation is available, leaving the prostitutes at the mercy of their last client of the night for a ride home. Privatization, of course, would create the option of running a private bus from the city to these zones, creating yet another business opportunity.

Peter van der Valk, the third sociologist who co-founded the EMNDP, said concerning the motivation and future plans of his organization: "We are most interested in collecting strengths. It is very important that people in Europe who think logically know that they're not alone. They often feel isolated. We are trying to get to the level where drug policy is made."[6] EMNDP has in fact succeeded in that objective, together with representatives of well-known American organizations such as the National Organization for the Normalization of Marijuana Laws (NORML) and the Drug Policy Alliance (DPA).

Pro-drug activities occur mainly in and around universities, where they can become very influential. Activists disperse information, organize conferences, write legal propositions, defend drug dealers and users, give lectures and explain their liberal perspectives to a new generation of college graduates and use them to propagate their ideas. Many of these academics are connected to a wide range of legalization movements. A considerable number use drugs or have used illegal drugs. Their lobbying with politicians and the media is extensive and aggressive. A number of them advise politicians and provide the press with information and misinformation.

EMNDP and European organizations looking for loopholes

It is no coincidence that one year after the EMNDP was founded (1987), a conference was held at the Catholic University in Tilburg, the Netherlands, organized by that university's law school and the Max Planck Institute for Foreign and International Penal Law based in Freiburg, Germany. The conference was called "The Dutch Drug Policy from the Western European Perspective" and brought together people from 15 different countries in a closed, three-day session to discuss the criminal and legal aspects of the growing problems related to the use of and trade in narcotics. Several prominent international proponents of liberalization attended: Nils Christie, professor of criminology at the University of Oslo, Norway; Jose Luis Diez-Ripolles, vice-president of the International Antiprohibitionist League and professor of criminal law at the University of Malaga, Spain; and Steven Wisotsky, member of the Drug Policy Alliance, Washington, D.C., and professor of law at Nova University Law Center in Fort Lauderdale, Florida. J. Wiarda, chief of police, in Utrecht, the Netherlands, talked about drug policies in Western Europe: "The first misunderstanding is that I am not serious enough about keeping the rule of law. On the contrary, keeping the law is a matter of such importance in a democratic society that it is irresponsible to stick to rules of law that cannot be kept."[7] The central tenet of the closed session was explained to those attending the public, one-day session in the following terms: "The central objective is to find, internationally, alternatives for the current approach to the drug problem and to look for options to arrive at a normalization of that problem."[8]

To those who attended the fourth, open day at the conference, it became clear very quickly that the group during the three previous days had been searching for loopholes in national laws and international treaties. However, these treaties proved to be too tight, and the group concluded that Europe was not yet ready for normalization or legalization. The group's recommendations included the notion that national laws should differentiate between "soft" and "hard" drugs and that the use of drugs and all its attendant activity should not be punished by law.[9] As a result, television, radio and newspapers reported that "Experts Advocate Legalization of Drug Use."[10] Legalization via legal means proved impossible, and so the drug libertarians agreed to avoid the laws by simply ignoring them. They would attempt instead to arrive at a more tolerant attitude toward drugs in Europe, with the main objective of undermining the UN treaties on narcotics, drugs and psychotropic substances.

To attain this goal, each representative was to return to his or her own country and look for people and opportunities that would allow them to help spread the ideas of EMNDP's. This started a media

offensive in which the liberal Dutch policies were praised and other countries' more repressive and restrictive policies were denounced. Slowly but surely, all EU countries became inundated with "harm reduction" projects and ideas, and the drug question started to center around the medical use of marijuana. Anti-prohibition propaganda helped liberalize the EU's younger generation in countries such as Belgium, Switzerland, England and Portugal. Governments and parliaments began to discuss the prohibition and especially the possession of drugs, most importantly marijuana, and to liberalize those policies according to the Dutch model. In all European countries, the rate of increase in drug use is related to the perspective on drugs. While the EMNDP is no longer active, other organizations have taken over their philosophy and their goals.

Radical Party (RP)/Transnational Radical Party (TRP)

This political party was founded in December 1959 in Rome, Italy, by well-known public figures such as Nicolo Carandini, Leopoldo Piccardi, Mario Pannunzio, Leo Valiani and Bruno Villabruna. Marco Panella, the current president, was present at its first meeting, and he has argued for the liberalization of drugs since 1974. The RP "denounces the impotence of regressive laws against the dissemination of prohibited drugs."[11] Since then, the RP has evolved into the Transnational Radical Party with members on its council who wield considerable influence in their own countries. The TRP gathered forces from all over the world to disseminate their ideas internationally. While their headquarters are still in Rome, they now have offices in Russia, New York and Brussels and are active on every continent. They actively engage in all kinds of political questions and rally against, for instance, the death penalty, dictatorships, oppression, drug prohibition, environmental pollution and other issues of interest to large groups of people worldwide. They view the TRP as a worldwide organization that promotes democracy. The drug problem and lifting the drug prohibition is high on their agenda, even though they have shifted the actual application of their ideas to two related organizations, CORA and IAL (founded in 1988 and 1989, respectively), assisting these organizations wherever possible. Together, they keep the public's attention focused on lifting drug prohibitions by disobeying the law. First it was CORA, and now the IAL who, in cooperation with organizations around the world, are organizing and co-

sponsoring conferences.* They do this by directly lobbying politicians, physicians, lawyers and the press concerning the use of drug-injection rooms, "harm reduction" measures, crude medical marijuana, hemp marijuana as raw material for consumer goods and all other matters related to drug prohibition. The TRP feels that drugs are harmful because they are prohibited, not the other way around.

Since 1995, the TRP is a non-governmental organization (NGO) with general consultative status with the Economic and Social Council of the United Nations (UNESCO) and claims it is dedicated to the globalization of freedom and the enforcement of democracy all over the world through Gandhian nonviolent means. Moreover, they claim to be "a trans-divisional cross-party that does not endorse political candidates nor run for national or international elections."[12] Despite that last claim, the TRP aims to become globally active in politics, and hopes that a European Radical Trans-Party for the United States of Europe and America affiliated to the Transnational Radical Party may be created in time for the 2004 European Elections.[13] Portraits of Gandhi are featured prominently on TRP material. When it comes to nonviolent action against drug prohibition, most of their actions involve civil disobedience by handing out marijuana in public spaces, for example, which burdens the legal system and creates media attention for the legalization of marijuana. They focus particularly on the UN Conventions against narcotics, which, they argue, "establish global measures for the prohibition and repression of illicit drugs"—a thorn in the TRP's side. They abuse Mahatma Gandhi's name (he was actually a total abstainer from alcohol and other drugs) and his non-violent reputation in their efforts to advocate liberalizing drugs that cause violence, damage and enormous suffering. If using Gandhi's name to legalize drugs sounds confusing, that's because it is—and this is precisely the TRP's strategy, to convince by causing confusion.

Coordinamento Radicale Antiprohibizionista (CORA)

CORA, or Radical Anti prohibitionist Coordination, is a non-profit association of the Radical Party that aims to abolish the prohibition of drugs. It was founded in 1989 by Marco Panella specifically to focus on drugs. For years, CORA abused the European Union to propagate its

*Such as the International Conferences on the Reduction of Drug-Related Harm, sponsored by the International "harm reduction" Coalition in partnership with the "harm reduction" Network; "Out From the Shadows, Ending Prohibition in the 21st Century: For the Anti prohibitionist Reform of the UN Conventions On Drugs," European Parliament, Brussels, 15-16 October

ideas, until, after many protests, the offices of the European Parliament and the offices of members of parliament and various committees were closed to them in January 1999. This blow may have led to CORA being put on hold in 2002. Its main activities are now taken over by the Parliamentarians for Anti-Prohibitionist Action (PAA), by the European NGO Council on Drugs and Development (ENCOD), and the International Anti-Prohibitionist League (IAL).

International Anti-Prohibitionist League (IAL)

The IAL was founded in Rome in 1989, on the initiative of the Radical Party and CORA. Its first president was Canadian RP member Marie Andrée Bertrand*, who has advocated the legalization of marijuana and the controlled distribution of heroin since the early seventies. The IAL has among its members lawyers, criminologists, economists, politicians, psychiatrists, anthropologists, police officers, civil servants, doctors, journalists and district attorneys from all corners of the globe. It lobbies in the European Union and its various committees through universities, media, national politicians and international organizations to have drugs removed from the penal code and to introduce "harm reduction" as a cornerstone of official drug policy.

The IAL's Dutch co-founders are to be found in high positions in universities, government departments and local governments, but the IAL is truly international. Its new president is Arnold Trebach, an American professor emeritus from American University, Washington, D.C., who was appointed to the position in October 2002 during a conference held at the European Parliament called "Out From the Shadows: Ending Prohibition in the 21st Century." In his inaugural speech, he said: "I assume that we in the IAL stand for full legalization of drugs. I certainly do, all of them. Even crack and PCP. By that I mean that I do not see any value in attempting to control these powerful chemicals through the criminal law. We should seek to convince people not to use these two drugs, but we should not send the police to arrest them if they do."[14]

The IAL is basically an anti-prohibitionist movement that considers the "war on drugs" a failure. One of its brochures says, "Prohibitionism has changed our great cities into battlefields without being able to

*Also a member of the Canadian governmental committee which in 1972 published the "Cannabis Report of the Commission of Inquiry into the Non-Medical Use of Drugs," known in Canada as the "Le Dain Report," which became one of the documents on which the Dutch

protect those whom it intended to safeguard. The person who is tempted by hard drugs falls into crime and disease, with AIDS being the worst one. Occasional users find themselves risking imprisonment, while regular users turn to crime to finance their habit."[15] Of course, it doesn't take much to realize that drugs cause misery and that the law must be upheld—but the IAL is not so concerned with the law.

What the IAL doesn't mention is:

- Middle- and upper-class users often buy drugs from dealers coming from the less affluent parts of town, thereby maintaining the status of poorer neighborhoods as battlefields.
- All drugs can lead to disease, crime and death for any user.
- Occasional users are the main customers of drug dealers, undermining legislation and maintaining the problem.
- Despite widespread ignorance and disobedience of the Opium Law, all drug sales are still illegal in the Netherlands.

Those who want to liberalize drugs nationally and internationally can count on IAL's support. Among them are chiefs of police who have openly argued for legalization, because they feel they have already lost the battle against drug crime.

Parliamentarians for Anti-Prohibitionist Action (PAA)

The PAA is another CORA initiative and was launched in July 1996. In November of that year, it gained its first political achievement when eighteen of its members, all of them European Parliamentarians, drafted a recommendation to the Council of the European Union in which they denounced the failure of prohibitionism and asked for publicly controlled sale of drugs. The recommendation was signed by 61 members of the European Parliament. The PAA works inside and outside the European Parliament to abolish drug prohibition through political means and to revise the international treaties on drugs.

There is close cooperation between the TRP, IAL and the PAA as evidenced by their joint organization of the conference in October 2002. Planning was done cleverly. The conference was hardly publicized, and the more conservative MPs were away at their parties' national conventions. During that conference, the IAL was re-energized by receiving support from activists of CORA and many other participants of the conference. Outside criticism came only from a few representatives of European organizations who had

managed to gain access to the conference and issued a joint press statement:

> The purpose of the conference—to end prohibition—seriously violates the contents of the UN Conventions on Drugs, which aim to protect citizens worldwide from the scourge of drugs. The devastating consequences of pro-drug amendments to any or all of the UN Conventions on Drugs should not be underestimated but, on the contrary, should make any responsible politician worried about the future, safety and health of all citizens in their countries, especially young people.[16]

Europe is often a trendsetter in the international debate on drugs and carries considerable weight in the United Nations, which in 1998, set as one of its goals a significant reduction of drug demand and supply within 10 years. The TRP, IAL and PAA fully realize the power of Europe internationally and have decided to start the anti-prohibitionist campaign in the European Parliament—the heart of the European Union on Brussels—with the intention of reforming international institutes, especially the United Nations.

In 2002, the PAA had 65 members. Most of them are members of the European Parliament. Others are from parliaments outside the EU. All of them are responsible for the well being and safety of those they were chosen to represent. Instead, they belong to PAA—a force whose sole purpose is to subvert the legislation and international treaties that attempt to safeguard us and our children from the destruction caused by drugs.

European Cities on Drug Policy (ECDP)

Founded in 1990, the ECDP is best-known for its "Frankfurt Resolution" that rejects narcotics legislation, the legalization of cannabis and the decriminalization of possession of other drugs. They propose the legal prescription of narcotics and support methadone programs, as well as "harm reduction" programs. The first signatures for the ECDP came from Amsterdam, Hamburg, Frankfurt and Zurich. By 2001, it had 34 members. In the Netherlands, this group includes, besides Amsterdam, the cities of Rotterdam, Arnhem and Venlo. The ECDP made an agreement with the Conceil des Communes et Régions d'Europe (Council of European Communities and Regions) to support and promote the aims of the ECDP, especially toward the European Union.

They spread their liberal ideas through annual city conferences, conventions for drug coordinators of the cities and regions, exchanging evaluations of various programs, scientific evaluation programs, regular publication of the ECDP newsletter and by organizing study visits to ECDP member cities for everybody who was responsible for or interested in the drug issue. Since 2002, the ECDP is no longer active.

Euro-Methwork

Euro-Methwork is a "harm reduction" organization for those active in methadone programs. With its roots in Amsterdam, it began in the early 1990s in the wake of the Frankfurt Resolution. Their publication, "European Methadone Guidelines," states:

> Methadone has proved to be an effective means for keeping people in treatment and, hence, averts heroin use when in treatment . . . Methadone treatment has also proved to be cost effective. The British NTORS study found that for every £1 spent on treatment, there is a return of more than £3 in terms of savings associated with victim costs due to crime. Moreover, methadone treatment reduced demands upon the criminal justice system.[17]

With much rhetorical power, perceived professionalism and creatively presented "evidence," Euro-Methwork works toward the integration of a "harm reduction" perspective inside and outside Europe, using slick presentations aimed at politicians and policy makers. It works behind the scenes with the organizations mentioned above. In essence, Euro-Methwork offers cheap, temporary solutions to policy makers who lack the will to solve the drug problem.

European Parliament (EP)

The European Parliament, when it instituted an Investigative Committee on Drug Problems in the 1980s, showed its interest in the drug question within the EU. The committee's report, advocating dealing with the drug problem in a European context, was accepted by an overwhelmingly majority in the European Parliament. However, soon thereafter, the then Dutch Member of the European Parliament, Hedy d'Ancona, informed professor Sengers, co-founder of the EMNDP, of the restrictive measures proposed by the committee and approved by the

EP. After Sengers lobbied extensively in Parliament and attempted to hijack the report, the voting members of the Investigative Committee who were not in favor of the restrictive propositions wrote a minority opinion. The committee's chairman was forced to include this minority opinion in the back of the report. In one place it states:

> *Instead of simply fighting drugs, we should prioritize the normalization of society's attitude toward drug use and the unfortunate existence of drug dependence. Drugs and their use have a history of thousands of years and that will not be any different in the future.*[18]

But this is precisely the problem. For thousands of years, people have been murdered, drugs have been abused, children have been sexually abused and people have been forced into prostitution. There was a time where perpetrators of such acts could do so with impunity. Now we have laws that prevent and punish such actions, but they can only work if they are upheld and respected. Protection from drug crime is one of the slowly gained democratic rights which these anti-prohibitionists, under democratic guise, wish to take away from us.

The most dangerous combination consists of politicians working together with the pro-drug movement, those who believe that "European drug policy should allow for multiple perspectives and that the European Committee should develop European drug policy."[19] This was the first drug-liberal blow struck in the European Parliament by the predecessors of the IAL and the PAA. They were responsible for the anti-prohibitionist attack on drug policy in Europe and have attempted many times to subvert existing European legislation, especially in relation to the UN conventions. Only the concerted effort of anti-legalization organizations and politicians has managed to keep the European drug policies in line with the UN treaties on drugs.

NGO Council in Drugs and Development (ENCOD)

ENCOD started in March 1993; this coalition of 14 European NGOs is based in Antwerp, Belgium. Those who created ENCOD were active in the field of development cooperation and decided to strengthen the voice of the growers of illicit crops in the southern part of the world. Their aim was to promote political alternatives for drug-producing countries. In 1992, Marco Panella, who helped found the Italian Radical Party, was one of a group in the European Parliament who, in a motion for a

resolution (B3-1090/92), "call[ed] for coca to be legalized and support given to set a legal market in 'soft' coca derivatives, tea, medicines, toothpaste and tooth powder, etc.; call[ed] for UN conventions to be revised with a view to making coca consumption legal outside Bolivia."

In the early nineties, the concept of "harm reduction" measures wasn't as accepted in Europe as it is now; especially France despised the liberal Dutch drug policy and tried to force the Dutch to return to a more repressive policy, causing headlines in the Dutch media and arousing the anger of Wim Kok, then Prime Minister, who rejected the French criticism.

In 1997, a first meeting took place between members of ENCOD and some organizations of European cannabis consumers. There, the idea emerged to create an international coalition of organizations that would address the UNGASS (United Nations General Assembly Special Session) of June 1998 in New York under the guise of the International Coalition of NGOs for a just and effective drug policy (ICN). Jan van der Tas, former ambassador of the Netherlands in the UK and active for the legalization of all drugs, was one of the organizers who initiated petitions and collected signatures against drug prohibition. They did not succeed in their effort to change the international treaties. Instead, UNGASS finished with the slogan "a drug free world, we can do it!," specifying 2008 as a deadline and 2003 as a halfway mark.

On March 4, 2003, ENCOD organized a conference in the European Parliament, assisted by the PAA, "Vienna 2003: A Change for the World." During this meeting, we heard several academicals from different European countries propagating a liberal drug policy, surrounded by drug users' organizations and pro-drug activists. I remember Manuela Carmena Castrillo, a penal judge from Spain, and her one-sided argumentation very well. During the conference, she said: "In Spain, since 1995, 32,000 people have died as a result of AIDS. Of them, 55 percent were infected as a consequence of sharing syringes for the injection of heroin. We can say unfortunately 17,000 people died. Not because they consumed heroin, but because they were not allowed to use a drug to which they were addicted in a legal and aseptic way. We can affirm without a doubt that at least 10,000 people died in this same period as a result of adulteration, overdoses, etc. These deaths were not caused by the drug itself but by the uncivilized and unsafe way in which the consumers are taking them. Kids have died not because of drug use but of drug prohibition."

Drug Policy Alliance (DPA)

The Drug Policy Alliance, formerly known as the Drug Policy Foundation, is one of the best-known and most heavily sponsored legalization organizations in the United States, and thus one of the best organized and most influential groups. It has contacts all over the world. Their power comes from their ready access to money provided by liberal lobbyists: "Key to the foundation's expansion is new support from internationally known financier and philanthropist George Soros. Mr. Soros has made an initial three-year commitment of up to $3 million for DPF [now DPA] operations."[21] With the help of Soros and other philanthropists, such as Richard J. Dennis from Chicago, the DPA has been able to organize conferences on both sides of the Atlantic, fund programs geared at legalization and hand out grants. One of the grant recipients was the medical sociologist and then high-ranking civil servant at the Department of Health and Social Services, Eddy Engelsman, who received a $10,000 award from the DPA in 1990. In the US, Engelsman is known as the architect of the liberal Dutch drug policy, and he is now a diplomat for the European Union. The power of money should never be underestimated. It is estimated that George Soros has contributed more than $30 million toward the liberalization of drugs, having funded the Lindesmith Center with $4 million and the Drug Policy Foundation with $6 million.

President and founder of the DPA is Arnold Trebach, whom we met before in his capacity as president of the Anti-Prohibitionist League. "The foundation has worked hard at establishing credibility and becoming a 'respected, responsible center' of opposition to the nation's drugs laws and policy. Although the initial board included many of NORML's [National Organization for the Reform of Marijuana Laws] former board members, the DPF [now DPA] only selected those with proper academic credentials. While NORML seeks to energize pot smokers, the DPF focuses its appeal to the media and intellectuals."[22]

The DPA concentrates its activities mainly at universities and directs its efforts toward academically trained potential members. They organize conferences and informational seminars, write proposed legislation, offer legal assistance to drug dealers and users and explain their liberal views to the new generation of leaders and professionals. Many of these academics are themselves associated with legalization movements. A number of their associates and supporters use drugs themselves.

The above mentioned organizations are symbiotic with other pro-drug organizations, which have mushroomed inside and outside Europe since the 1980s. It seems as if choosing the easiest route, that is, non-prohibition of and non-interference with drug use and trade, appeals to these people. The attraction of money, power, drug use and privilege without responsibility, apparently is so great that common sense, scientific fact and empathy for our youth is easily forgotten.

Obstacles

Even though some of the permissive arguments may sound well founded and humane, they are misleading. A permissive drug policy in fact will lead to an increased drug problem—it will mean that more drug users will drive or operate motorized vehicles, be in school as students or teachers, treat patients and make decisions under the influence of drugs. Many of those in the pro-drug movement are occasional users, while dependent persons sink deeper and deeper into drug misery and are left to their own devices. The liberalization of drugs with the goal of "harm reduction" as the benefit to users of illegal drugs is nothing more than a facade that covers up a dilapidated system that only leads to more misery.

The principal goal of "harm reduction" policies, the minimalization of damage caused by drugs, is unrealistic: namely, that society will come to think that using drugs is OK and that the medical profession will solve any problems they may cause for those who become dependent on them.

Since the permissive attitude leads to increased drug use, the risk is that other problems will increase, as well. So, with the demand that the state provide sterile syringes and methadone, comes a request that the state then also provide heroin, amphetamine and morphine. A clean, empty syringe is of no use to a drug abuser. Likewise, we have heard demands for nursing homes for drug dependent persons. Those users who age prematurely time must be taken care of by the state. Is this what governments and users had in mind when they allowed users to smoke joints in "coffee shops"? At any rate, it is proof that the stepping-stone theory is in fact correct, and that "harm reduction" does maintain people's dependence. But some proposals for legalization go much further than tolerating "coffee shops." Government officials in the Netherlands have proposed everything from a state monopoly on drug sale to the public, to a system of permits for the production and sale of cannabis. The main conclusions of those with a permissive attitude are

that cannabis may come first and other drugs will follow, and "harm reduction" is paving the way for the legalization of drugs. This populist formula traps not only young adults, but also politicians—and they should know better.

Health care

Syringe exchanges and methadone programs have by now become accepted in most European countries. These measures, proposing to help drug users but really keeping them in an-extended state of dependence, are conscious efforts toward the acceptance of drugs. Anti-prohibitionists want to shift responsibility for the drug problem to the health care system. Such vaguely defined proposals focus on the drug abusers welfare and, thus, often elicit positive responses, as if the drug trade, the supervision of drug policies, prevention, social problems and dependency can all be solved by doctors and nurses. Really, for whom is our already overburdened and expensive health care system intended and who pays for these "harm reduction" policies? If, within the context of such "harm reduction," a doctor or nurse dispenses information, tests drugs, hands out syringes or prescribes drugs, it might appear that something is being done about the drug problem. However, the only message given to drug users is that they can continue their use without too many risks. It may also mean that the health care system has given up on drug users, that there is no cure for their problem, only maintenance of it and that they are now forced to live the rest of their lives under the yoke of drug dependence.

The practice of permissiveness

From 1965 to 1967, after an impressive media campaign, Sweden tried the legal prescription of drugs for personal consumption. Indirectly, this led to the legalization of the petty trade in drugs. After two years, the result was a rapid increase in drug use, sometimes resulting in death. Neither crime nor illegal trade diminished, and so the legal prescription of drugs was stopped. After this unhappy experiment, Sweden chose a restrictive approach that is still strongly supported by the Swedish population. In 2001, it was approved by 95 percent of the population. While this restrictive approach has not shielded Sweden from internationally organized liberal pro-drug propaganda, it has slowed down the growth of drug use. While drug liberals, such as Dutch former

secretary of state Hedy d'Ancona, call the Swedish policy moralistic and legalistic, the Swedes themselves—politicians and population alike—view their own drug policy as humane and realistic.

3. Restrictive perspective

The restrictive perspective is often called "the third way." The restrictive perspective can coexist with the demands of the modern legal and welfare state with the objective of striking a balance between the privileges and responsibilities of society. The restrictive and the repressive view share the opinion that narcotics are acceptable only for medical and scientific purposes.

Basic philosophy

Proponents of the restrictive perspective stress the need for cooperation and consensus between prevention, early intervention, legal supervision, treatment and aftercare. The restrictive approach bases itself on the UN treaties on narcotics, which allow for the use of narcotics only for medical and scientific purposes. Every other kind of use is regarded as abuse. The goal is to create a drug-free society, an easy goal to agree with, because everyone's family, place of work, school or neighborhood is part of that society.

The most influential thinker of the restrictive approach was the Swedish professor Nils Bejerot. He described contemporary drug use as an "epidemic," to emphasize how drug users have a tendency to pass on their drug habits to others. The most important characteristic of epidemic use is this social contagion, because it identifies the user as the most important link both for the marketing of drugs and for the maintaining of the drug market and industry. Every user pumps money into the drug industry, which, along with the arms industry, trafficking, and oil industry, is among the biggest businesses in the world. Small amounts spent by occasional users add up to a billion-dollar industry that is powerful enough to send the whole world into turmoil. That is why, according to Bejerot, private use, whether big or small, must be halted by prevention, early intervention and, if all else fails, mandatory treatment. Support and supervision on every level are the two most important elements in a restrictive drug policy. Life for a recovering drug user can be very difficult, and feelings like guilt and shame are very common. By themselves becoming active in prevention or

treatment, users can, after having had problems for many years, regain their self-confidence and become an asset to society. Most important is their return to society drug-free, and that they become accepted into it.

Cooperation

Engagement, support, and grassroots initiatives, in cooperation with government agencies, are necessary to prevent and stop drug abuse. Because most parents do not want to see their kids on drugs, such willingness, especially when encouraged, shouldn't be too hard to find. Those who support the restrictive approach believe there are plenty of opportunities to create drug-free environments. Support groups for young adults, information for parents, practical activities and clear guidelines and messages against drugs from adults and from the law are important ingredients in this process. Such projects have already been successful in Europe, where local initiatives have prevented "coffee shops," head shops, and drug cafes from being established in towns and cities.

Proponents

Countries such as Iceland, Norway, Sweden, Finland, Italy and the United States are enacting restrictive drug policies. Permissive tendencies elsewhere create difficulties for the firm establishment of restrictive policies, but, fortunately, these countries also have a fair number of organizations focused on restrictive philosophies. European organizations have become very active and are operating internationally. Following is a description of some of these groups.

Europe Against Drugs (EURAD)

EURAD (www.eurad.net) is a grassroots movement comprised of parents, young adults and concerned citizens' organizations, cooperating to prevent drug abuse. EURAD is a member of the NGO Committee on Narcotic Drugs at the United Nations Office in Vienna and holds consultative status with the Council of Europe. EURAD was launched officially on October 25, 1988, in the European Parliament in Strassbourg. EURAD seeks to promote humane, restrictive drug policies of prevention and early intervention against drug abuse in order to prevent further damage to individuals and society. They work to prevent any form of liberalization or

legalization of drugs, recognizing the 1961, 1971 and 1988 UN conventions on narcotic drugs as basic platforms for current and future drug control. EURAD works closely with scientists and experts in the field of drug abuse. EURAD improves European cooperation in support of families with drug problems and promotes the education of parents, youth and other concerned citizens about all matters concerning drug abuse through accurate, relevant and up-to-date information and research findings.

European Cities Against Drugs (ECAD)

During a meeting in Stockholm, Sweden, in 1994, 21 cities, of which 16 were national capitols, signed the "Stockholm Resolution." ECAD (www.ecad.net) actively opposes the legalization of drugs and bases its ideas on the UN Conventions. Europe has become a center for the trafficking, distribution and consumption of drugs, according to ECAD. "There can be no other goal than a drug-free Europe. Such a goal is neither utopian, nor impossible. Too often, however, politicians and others seem to act according to what they think is possible to do, rather than what is necessary to do."[23] In 2003, ECAD grown to include 264 Municipalities in 30 countries, representing some 70 million Europeans. So far, the city of Hulst is the only city in the Netherlands to have signed the resolution. While some Dutch cities sent their congratulations to ECAD in 1994, they have not signed the resolution.

Hassela Nordic Network (HNN)

The Hassela Nordic Network (HNN) International Centre (www.hnnsweden.com) is a global network dispensing information regarding drugs and related matters. Based in Gotland, Sweden, HNN is a non-political, non-religious organization for the national and international exchange of drug-related information. They also organize lectures, conferences and seminars to support a restrictive drug policy. They operate a communication center, and their website serves as a clearinghouse for drug-related information and anti-drug action. It has a searchable database of more than 20,000 documents. HNN provides theoretical and practical knowledge, supports a restrictive drug policy to counteract efforts to legalize drugs and increases knowledge about organized crime, money laundering and other drug-related issues.

Rainbow network

The Rainbow International Association Against Drugs started in 1995. These international volunteers share a firm conviction that the use of any drug whatsoever is not simply a matter of personal action, a civil right, or a free choice. It is the dramatic result of a cultural disease. The grip drugs have on so many young people leads to the destruction of the individual, their family and friends and finally to the basic structure of society. Society does not have the obligation to guarantee selfish individualism, cynicism and pseudo-liberalism by allowing and propagating a right to use drugs. Rainbow's main goal is to counter those who wish to legalize "soft" drugs or distribute "hard" drugs to drug dependent persons. A very active organization on a truly international scale, Rainbow also provides practical information on their website at (www.rainbow-network.org.)

Obstacles

While the restrictive perspective is broadly supported by practical experience and scientific study, it still is not broadly accepted for a variety of reasons.

First, there are psychological and political problems. A restrictive drug policy holds the user responsible for his illegal activities, which is becoming less and less attractive to the common European citizen and his still individual and extremely liberal world view. That world view says a drug user must be seen as someone who has a disease, is going through a difficult time, is the victim of drug dealers or has grown up under troubled circumstances. This is called "symptom theory" regards drug abuse or drug dependence only as a "symptom" of underlying psychological problems—not as problems of their own. At the same time, some say that the dependent person is in fact responsible for his actions, but should not be stigmatized.

A second difficulty is a general unwillingness to force someone who is not mentally ill into treatment.

Third, a restrictive approach necessitates action, whether or not drugs have led to damage or dependence. This requires a great deal of engagement, leadership, love, courage and knowledge. In any restrictive approach, this investment is an important aspect of prevention.

A fourth problem is that a lot of people consider the idea of a drug-free society as moralizing or utopian. Still, to strive for such a positive goal from the point of view of the family and of society is only normal.

The official goal of the Dutch drug policy is to strive for public health—but it's that goal that becomes utopian when drugs are legal to use and freely available.

Any restrictive drug policy will entail five separate but connected elements:

1. Prevention of drug use.
2. The earliest possible intervention to stop drug use.
3. Law enforcement to uphold the law, investigate crimes and operate preventatively.
4. Treatment to make the drug dependent person drug free.
5. Aftercare to help the person remain drug free and reintegrate into society.

The restrictive approach sets clear limits and imposes upon the citizen rights and duties. If clear boundaries exist, everyone will know when they are crossed.

The Future

How the various perspectives will fare in the future is an open question. In 1991, Mr. J. C. M. Leijten, professor of law and advocate general for the Dutch Supreme Court, said in an interview that the trade in drugs should no longer be prohibited, because the majority of the prison population is there for violations of the Opium Law, and they take up too much space. "We must abolish punishment of those offenses. That will take the fun out of that trade, when a few grams of that stuff is as cheap as a beer." Unfortunately, he forgot to mention how widespread is the trade, use and damage caused by alcohol. The drug industry is directly opposed by parents, scientists, young adults and the United Nations Treaties. Tax money should finance the work against drugs, not, as in the current situation, the "harm reduction" approach and the movement to legalize them. The clamorous proponents of the permissive perspective must encounter strong opposition of those who favor the repressive and restrictive view.

> ***Groups advocating legalization or decriminalization of drugs were misguided. The truth is that there are no safe ways to abuse drugs. Governments should not be intimidated by a vocal minority that wants to legalize illicit drug use.***
>
> *—Dr. Philip O. Emafo, President of the International Narcotics Control Board (2003)*

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Chapter Seven

HEMP FOR WHOM?

Both fiber and drug hemp are *Cannabis sativa L.* and contain THC.

Cannabis hemp

The term hemp refers to a variety of plants including sisal, jute, kenaf, Manila hemp and true hemp, whose stems can be used for producing hard fibers.

Cannabis hemp used for industry contains 0.3 percent THC, the psychoactive ingredient in marijuana. In the EU, since July 2002, a THC percentage of 0.2 is the absolute limit. At least 30 percent of the total acreage must be checked for THC content.[1] Hemp with a low THC content cannot, with the naked eye, be distinguished from plants with high THC content. The tie-in between cannabis hemp and marijuana smoking is now being used by proponents of the pro-drug movement as a marketing tool. The pro-drug movement's voice is loud and noisy, promoting *Cannabis sativa* for a variety of products.

All of a sudden, there are claims that hemp (*Cannabis sativa L*) is to be treated as any other agricultural product. It is said to be a valuable resource which can supply us with the raw material for rope, vegetable oil, fuel, cattle feed, paper, food and textiles. Cannabis is said to be the best, cheapest and most environmentally friendly agricultural product. These arguments, however, fail to consider some very basic facts:

- The shipping industry was more than pleased when it could

replace hemp with superior nylon rope.
- Plastic and synthetic fibers already exist that are cheaper to manufacture and provide better market results.
- Many plants, such as corn, sorghum and alfalfa, produce more biomass per acre and are more soil-friendly than hemp.
- Ethanol and rapeseed are already used for alternative fuel.
- Like any other crop, hemp also requires pesticides and fertilizers.
- Hemp seed is expensive.

Better alternative products exist. This lack of economic advantage means that, for instance, paper made of cannabis hemp has a high processing cost and a very limited market. "Hemp is a novelty product with limited sustainable development value even in a novelty market,"[2] according to a report by the Office of the National Drug Control Policy (ONDCP). "Hemp growers in Canada," says William S. Walluks, Chief of the Strategic Intelligence Section, Division of Narcotics Enforcement, at the Wisconsin [US] Department of Justice, "have had a tough time due to vast oversupply. According to a June report 2002 from Health Canada, the government's hemp-growing licensing agency, and a related farming newspaper article in August, farmers there are still reeling from the glut in supply. Acreage and numbers of licenses issued for cultivation in 2001 are very low in comparison to 1999. Only a little more than 3,000 acres are planted—less than one-tenth of that in 1999. A primary hemp-buying company went bankrupt and growers who had contracted with it were left with millions of kilograms of hemp grain that threatened to flood the market."[3]

There are plenty of problems for these hemp growers:
- The market for low THC hemp isn't big enough.
- Alternatives to hemp are cheaper and do not cause controversy.
- Hemp with low THC is attractive as an intoxicating drug for beginners who are not interested in high THC pot.
- Farmers of the fiber-bearing plants referred to as "hemp" can be forced to rent out to cultivate hemp with high THC.
- Their incentives to grow hemp, an illegal crop and controlled by the UN Convention on Narcotic Drugs (1961), are presented under false pretences.

On the other hand, those hemp growers who grow for the drug industry make enormous amounts of money on hemp (in the

Netherlands, an estimated 600,000 pounds of cannabis was grown in 1997), while easing their conscience with the assertion that cannabis is a useful and environmental product.

In the Netherlands, "coffee shops," home growers, patient organizations, etc. do business with cannabis. The government isn't exactly happy with it but is unwilling to stop the ever growing drug industry. Cannabis is a billion-dollar industry, providing the state with tax revenue, which it has to spend immediately to cope with the consequences of drug abuse. Besides the pro-drug movement, certain companies now also realize the commercial value of cannabis. The founder of the Body Shop, Anita Roddick, said at a pro-drug conference in London 11th December, 1997 (which she co-sponsored) that for people suffering from AIDS, glaucoma and other illnesses, marijuana "would bring desperately needed relief and dignity to their lives." Her timing for her statement was quite ironic given that at the same time she introduced the Body Shop's new line of hemp products now sold around the world—and advertised by putting the marijuana leaf in bathroom and teenage bedrooms.

> ***Both fiber and drug hemp are Cannabis sativa L., and contain THC, the drug that gets people high. In fact, the marijuana smoked at Woodstock contained "industrial hemp" levels of THC (1.0 percent or less).***
>
> *—Jeanette McDoughal Hemp Committee, Drug Watch International*

Hemp in the food-cosmetic supply

Most plans to use hemp fiber in other than niche markets have largely failed because hemp is neither economically viable nor technically feasible. Hemp seed for food and cosmetics, however, is easier to process than hemp for fiber, and this seed is now being heavily promoted for use in food, nutraceuticals (so-called nutritional supplements for humans), and cosmetics. This is in spite of the seeds containing THC (tetrahydrocannabinol—the main psychoactive ingredient in hemp/marijuana) and other bioactive cannabinoid residue.

Since THC and other cannabinoids found in hemp are fat-soluble, a very small amount may be damaging, especially if ingested regularly. The only important substance that exceeds THC in fat solubility is DDT. The European Union (EU) is concerned about any inclusion of hemp

products in food, stating in their regulations, "*Hemp* seed has one traditional but limited application as food for fish and birds but there is no nutritional justification for this."[4]

A U.S. Food and Drug Administration official also states that there is no definitive information about THC in food and cosmetics. The hemp risk assessment done for Health Canada (the national health agency) found that "new food products and cosmetics made from hemp—the marijuana plant—pose an unacceptable risk to the health of consumers." It says hemp products may not be safe because even small amounts of THC may cause brain and sexual developmental problems in the developing fetus, nursing infant, the young child and adolescents.[5]

Allowing toxic chemicals in our food and cosmetic systems through use of THC-containing industrial hemp products is dangerous and unthinkable. Our young people and future generations must be protected from health and genetic hazards.

> ***There are disturbing indications that fields where cannabis with a low THC content are allegedly cultivated for industrial purposes are in fact used for the cultivation of more potent cannabis destined for the illicit market.***
>
> *—Report of the United Nations International Narcotics Control Board for 1999*[6]

Marijuana for the sick?

Discussion on legalization of cannabis for medical purposes is going on worldwide. The sick and suffering are enlisted to promote demand for crude cannabis as medicine.

Through a smoke screen

In the United States, discussion on the legalization of cannabis started early in 1970. In 1972, the National Organization on Reform of Marijuana Laws (NORML) offered petition to the Bureau of Narcotics and Drugs (now the Drug Enforcement Administration, DEA) to move marijuana from Schedule I to Schedule II, a move that would allow doctors to prescribe marijuana to their patients. The DEA, however, saw no reason in 1979 or in 1989 to change its policy. In 1993, NORML, together with the Alliance for Cannabis Therapeutics and the Drug Policy Foundation (now known as the Drug Policy Alliance), tried it again; the US Court of Appeals for the District of Columbia, however, confirmed on February 18, 1994 that marijuana should remain a Schedule I drug.[7] This did not deter the medical marijuana movement, which spread all over the United States. The founder of NORML, Keith Stroup, even said that the move to legalize medical marijuana was only a smoke screen, a red herring to gain public opinion in the move towards the legalization of marijuana in general.[8] His successor at NORML, Richard Cowan, was equally clear: "Medical marijuana is our strongest suit. It is our point of leverage which will move us toward the legalization of marijuana for personal use."[9] California's Proposition 215 hid behind its title, "Compassionate Use Act of 1996," but this proposition would make marijuana available to *any* Californian who *feels* that smoking a joint might relieve any problem.[10] Voters were asked, in voting for Proposition 215, for the legalization of marijuana as a medicine. Most voters had no idea that the major contributors to Proposition 215 are affiliated with drug legalization organization, not with medical or scientific organizations.

NORML always made clear it sees the medical application of marijuana as an opportunity to legalize its use. They would even exploit illnesses such as AIDS, MS (multiple sclerosis), cancer and glaucoma for their own agenda. During a 1997 decriminalization campaign for cannabis in England, drug users were enlisted to add vocal support to the legalization of medical marijuana. Patients do report benefits from smoking cannabis, but those benefits are limited. The alleviation of pain that comes with a high is clearly pleasant, but when the high is over, the body has even more problems to deal with—the toxins found in marijuana when smoked. In the United States, millions of dollars, supplied by billionaires like George Soros, Peter Lewis and John Sperling, are spent in campaigns to convince politicians and voters that smoking marijuana is wonderfully medical. In the Netherlands, even the former health minister was actively involved in the effort to bring marijuana to the market under the guise of medicine.

> ***If the tobacco industry asked physicians to support making smoked tobacco available by prescription to treat obesity and anxiety, would anyone pay any attention? We know that marijuana smoke is far more toxic than tobacco smoke, so why is medical marijuana even being discussed? Marijuana is addictive, affects the brain, behavior, the unborn, the***

respiratory system, hormonal system and immune system. Using it medically, as some suggest, is 18th century medicine.[11]

—Eric A. Voth, MD, Chairman, The Institute on Global Drug Policy

Is hemp a medicine?

Studies into the medical use of cannabis led to the US Food and Drug Administration's approval of dronabinol for cancer patients suffering from symptoms such as nausea and weight loss and who didn't respond well to other medication. Dronabinol is synthetic THC, marketed under the name Marinol®. Like most modern medications, it is produced in a laboratory, not extracted from plants. Marinol is not particularly popular as a medicine and is seldom prescribed, mainly due to its side effects. In recent studies, patients preferred smoking the natural product over chemically produced THC, which is taken orally.[12] Biochemical research has indicated that some of the cannabinoids may have anti-inflammatory characteristics. Should that be the case, then current regulations allow the development of those substances into medications such as a pill or a spray. But synthetic cannabinoids are completely different from crude marijuana as a medicine.

Office of national opium agencies

According to the Single Convention on Narcotic Drugs of the United Nations, each country must produce an annual report on how much narcotics it needs for medical and scientific use and research, followed the next year by an assessment of how much was actually used. That report has to be sent to the International Control Board (INCB), the control organ from the United Nations. Governments who ratified the 1961 convention are responsible for this being done in agreement with article 23 from the Single Convention, about national opium agencies: "This treaty means that a country may only allow the growth of cannabis if it has a national agency that governs production and has a monopoly on trade. This agency is also required to buy the total production of those growing cannabis."[13] Since 2001 this is the job of the Dutch Office of Medicinal Cannabis, BMC, a national agency responsible for the oversight of cannabis production under the auspices of the Ministry of Health.

Dutch health policy and the BMC

Mario Lap, a lawyer and active within the International "harm reduction" network association Drugtext and the Foundation on Drug Policy and Human Rights, argued in 1993 for "some kind of licensing system regulating both the production and sale of cannabis in The Netherlands."[14] His motivation is to make the trade and purchase of cannabis to be legal, because "coffee shop" owners and hemp growers are protesting against the illegality of their business. A licensed act, according to Lap, can control the production and sale of cannabis products; only then, in his opinion, can the cannabis market be pulled away from criminal circles. He also proposes a duty on tobacco similar to that on alcohol: "These revenues could cover the expenses made for the supervision of the cannabis-market by a National Bureau for Cannabis as suggested." In order to do so, the Opium Law needs to be changed, and the sale of cannabis would be comparable to that of alcohol. With a licensed act, information and other prevention measures can be made obligatory, "In this manner potential consumers will have better knowledge of the dangers of very frequent and/or excessive cannabis use and a better contribution to the restriction to sensible use patterns can be achieved." The Trimbos Institute, working from a similar ideology, invited owners of "coffee shops" to workshops that encouraged prevention—it is, of course, highly doubtful if a single user was ever convinced not to use marijuana.

In October 1994, a judicial workgroup came together, including representatives from the judiciary, the police, trade and industry, health care, and the aforementioned Mario Lap. According to this workgroup, there is a need for a national drug office, capable of operating 150 hard drugs shops in the Netherlands where users of illegal drugs can buy heroin or cocaine for five or ten euro a day. According to this plan, every Dutch citizen above eighteen years old can get a chip card that registers (while keeping in line with privacy regulations) their purchase of hard drugs. If a user consumes more than is deemed acceptable, the appropriate agencies are contacted. If he or she wishes to use more than the predetermined amount of drugs, aid workers will contact the user to "advise [him or her] on safe(r) use, and will determine the appropriately higher amount for that individual user.[15] It is the responsibility of aid agencies to supervise that drugs are not acquired illegally; hard drug shops will be staffed by workers in the service of the National Drug Agency which operates non-commercially. The workgroup further

proposes that the sale of cannabis should be liberated and legalized for customers over sixteen years old, the same age limit for alcohol (another proposal would raise both these age limits to eighteen years). The National Drug Agency would also control the production of cannabis, and the distribution and sale thereof via 1,500 proposed "coffee shops." In their opinion, prices should be lowered to take the illegal market out of operation. In other words: the Dutch have learned from history how to operate a drug monopoly, but they have not learned what history teaches them about the consequences.

The results

In 2000, former Dutch Health minister Els Borst proposed setting up a national agency to regulate the growth and sale of marijuana for scientific and medical purposes. She wanted a BMC to do serious research into possible benefits of cannabis. Writing to the speaker of the Dutch House of Representatives, she said: "Doing clinical research into the effects of medical marijuana is necessary because until now there has not been any systematic and scientific research into precisely what its effects are."

The BMC was founded in 2001, and one of its first goals is to select growers who will be allowed to grow marijuana for the BMC. Interestingly enough, scientific research to be done before seriously ill people are allowed to buy cannabis products was not discussed. One could only hope that she would have had independent research done into the effects of cannabis as medicine; the rigorous testing procedures required before a medical drug is available on the market should apply to *Cannabis sativa* also. She also planned for current users, who now get their marijuana from "coffee shops," to be placed under medical supervision. What kind of medical supervision the minister intended is not at all clear. Borst said, "To allow for distribution to patients, the Opium Law must be changed."

By motion of the Department of Health, and in conjunction with the Department of Justice and the Department of Agriculture, in 2002 the Opium Law was changed, and made into law in April 2003. Since then the Department of Health has assumed the sole authority to import and export cannabis and cannabis extract. Until 2003, it was illegal for doctors to prescribe cannabis

In the Netherlands, the BMC is responsible for the production of cannabis for medical and scientific purposes, by mandate of the

Department of Health, and has a monopoly on trade, import, and export; the BMC decides who may be exempt for possession. It distributes cannabis for defined purposes:

- medicinal, only for doctors, pharmacists, and veterinarians;
- scientific;
- import and export of cannabis and cannabis resin;
- other purposes, permitted under the exemptions of the Opium Law

Two different products are supplied by two certified growers, the Institute of Medical Marijuana (SIMM) and Bedrocan. Cannabis flos variety Bedrocan (5 gram costs 50,00 euro) and is approximately 20 percent stronger than the Cannabis flos variety SIMM18 which costs 44,00 euro. These products are made from extracts of the plant *Cannabis sativa L.* and not synthesized.

The growth of this cannabis is governed by the rules laid down for Good Agricultural Practice (GAP). The strength of the active ingredients is determined in certified laboratories. The Dutch pharmacist who fills a prescription makes around $6 per prescription, and the government earns 6 percent in sales tax. While all pharmacists can order cannabis, not all of them want to make money in the drug business—a Dutch health insurance company has already determined that "medical" cannabis has no role to play in "rational pharmaceutical therapy."

To whom is cannabis prescribed?

The BMC proposes the use of cannabis for those suffering of MS (multiple scleroses), cancer, HIV and AIDS, chronic pain, and Tourette syndrome. Patients with a prescription written outside the Netherlands can get their cannabis from a Dutch pharmacy. If a person doesn't live in the Netherlands and would like to bring the drug home, he or she needs to have a so-called "Schengen declaration"* from the authorities in their home country. If the buyer is living in (or coming from) a country outside the Schengen area, then he or she needs a declaration from their own country. This can also be obtained from the authorities in the Netherlands. In Schengen countries the Inspector for Health Care already provides a Schengen-notification. The goal of this policy is clear: through close cooperation and political negotiation, the Dutch government is launching an international effort to prescribe cannabis.

*Schengen: named after the city in Luxemburg where the first Schengen agreements were signed, which guaranteed the free movement of persons within the European Union. France, Germany, Belgium, Luxemburg, and the Netherlands decided in 1985 to create a territory without internal borders; other member states are Italy, Spain, Portugal, Greece, Austria, Denmark,

Maripharm

The Maripharm foundation, which has been selling cannabis in a semi-legal manner via prescription for years, can continue to do so, even if the BMC is courteous enough to point out that the two varieties sold by them have a higher dronabinol content than Maripharm's product—SIMM's product is about 50 percent more potent, and Bedrocan's about 80 percent. The BMC does note that the purchase of BMC products can lead to side effects—like getting high.

The 2002 elections

The coalition government that supported Borst when she was Minister of Health and proposed a change in policy lost by a landslide-margin in the 2002 elections. The parties forming a new coalition were said to be more reluctant to push the Netherlands even further into legalization of drugs, a legalization that includes as an essential element the medical use of marijuana.

However, this promise proved vain. Pro-drug activists inside and outside the government follow the pattern established by Mario Lap and others. In effect, the desire to control drugs repeats the old colonialist dream of a monopoly. It is irresponsible to let the BMC be run by the Department of Health, a department which has proved time and time again it cares little for the ban of narcotics and protection of the individual's health and the society as a whole. They give ample opportunity to everyone who wishes to consume drugs, of whatever strength, to do that in all peace and quiet. The population is fooled; the Department of Health belies its name. One wonders what the UN will do for the Dutch population, since Dutch government officials have fooled the UN also. When will we hear that enough is enough, and that strong disciplinary measures will be taken by the international community?

To investigate whether the hemp plant contains substances that might be applicable in medicine is not difficult. It becomes problematic when such research is initiated and supervised by someone like Minister Els Borst. A former Minister of Health who claims that smoking marijuana is less dangerous than smoking cigarettes, that cannabis is a "soft" drug, that the higher THC content of cannabis now is no cause for worry and that cannabis has not yet been systematically and scientifically investigated has lost all touch with reality. A member of government who proposed the BMC in the year 2000, nominates

growers in the year 2001 and wants the drug to become available to patients with severe illnesses in 2002, and have the drug available in 2003 is simply irresponsible. No serious scientific study related to medical purposes seems to have been scheduled.

When will we hear that enough is enough, and that strong disciplinary measures will be taken by the international community?

Truth and lies about medical marijuana

Many statements circulate concerning marijuana, statements that too often are taken for truth at face value. Drug Watch International drew up a list of such propositions and effectively countered them.

Lie: Marijuana is an effective medication for nausea associated with cancer chemotherapy.
Truth: Oncologists overwhelmingly reject the idea of prescribing smoked marijuana. Crude marijuana contains more than 400 different chemicals. THC, the main active ingredient in crude marijuana, is available as the prescription drug Marinol® for the treatment of nausea associated with chemotherapy; however, safer and more effective anti-emetic medications are available and preferred by oncologists.

Lie: Marijuana is a beneficial treatment for glaucoma.
Truth: There is no scientific evidence that marijuana prevents the progression of visual loss in glaucoma. While marijuana, as well as alcohol and a host of other substances, can lower intraocular eye pressure, the medication must be carefully tailored to the individual to prevent further eye damage. Besides numerous adverse side effects of smoking marijuana, the dose cannot be controlled.

Lie: Crude marijuana is effective in treating the wasting syndrome associated with AIDS.
Truth: Smoking marijuana compromises the immune system and puts AIDS patients at significant risk for infections and respiratory problems. Current scientific studies show that Marinol® (oral THC), which is available to treat AIDS wasting syndrome, is effective in increasing appetite but is ineffective in increasing weight gain.

Lie: The government is withholding medicine from suffering patients by not allowing the prescribing of marijuana.
Truth: Crude marijuana does not meet the scientific requirements for efficacy, quality, purity and safety necessary to be considered medicine. It is neither compassionate nor medically responsible to prescribe harmful, impure substances to ill people.

Lie: Smoking marijuana reduces the spasticity associated with multiple sclerosis.
Truth: In a recent double-blind scientific study, the latest high-tech electronic monitoring equipment was used to determine if smoked marijuana had any benefit in treating spasticity in patients with MS. The study found that all patients receiving marijuana, rather than a placebo, perceived their spasticity to be lessened, when in actuality, it was made worse.

Lie: Many doctors want crude marijuana available so they can prescribe it to their patients.
Truth: Most doctors want the best medicine possible for their patients. Although synthetic marijuana (THC) in a pure and standardized form is available by prescription, it is often the last choice of doctors, because many better medicines are available. The American Medical Association, the Federal Drug Administration, the National Multiple Sclerosis Society, the American Glaucoma Society, the American Academy of Ophthalmology and the American Cancer Society have all rejected the use of smoked marijuana as a medicine. Marijuana is not recognized as a medicine in generally accepted pharmacopeia, medical references or textbooks.[16]

Dr. Carlton Turner, of the Research Institute of Pharmaceutical Sciences at the University of Mississippi, has collected, read and summarized more than 6,500 scientific articles on cannabis published all over the world. According to Dr. Turner, "Not one of those papers gives cannabis a clean bill of health."[17] It has never been proven to be a harmless, safe or effective medicine. On the other hand, one couldn't say that all studies indicated harmful consequences, because not all studies investigated how marijuana affected health. Some are simply studies into the rate of use, test methods, identification of substances.

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Chapter Eight

THE BACKGROUND OF INTERNATIONAL DRUG TREATIES

International treaties are the foundation for national drug laws in all countries that signed and ratified the United Nations treaties. Nations have agreed that the struggle against drugs must be handled in an international context, prohibiting the legalization of drugs and protecting their citizens. In the last few decades, this protection has been undermined by a pro-drug movement working to change the UN drug treaties. This movement, with significant financial power, organizes anti-prohibitionist conferences. Conference agendas include pressuring the European Parliament to work forward this change in the UN legislation. Restrictive groups opposed these efforts, defending the UN drug conventions and § 33 of the Convention of the Rights of the Child.*

To understand why we have the current international drug laws, an outline of their history is helpful.

England and China

In 1773, the British government gave the British East India Company, founded in 1600, a monopoly on the opium trade in India and China. In return, the British government received ten percent of the company's profits.

*The most recent of such conferences, "For the Anti-prohibitionist Reform of the UN Conventions on Drugs," organized by different prohibitionists groups and the members of the PPA (Parliamentarians for Anti-Prohibitionist Action) took place on Oct. 15-16, 2002, at the Brussels offices of the European Parliament.

At that time, trade in porcelain, tea and silk from China was lively and profitable. However, because China did not desire foreign merchandise, Chinese wares were paid for with silver. This lowered the company's profit margin and caused its directors to seek ways to boost their profits. Bringing opium on the company's ships that made port in China and then selling that opium to the Chinese illegally was the solution—a solution with consequences that would be felt around the world.

To supply the opium, the company turned to one of its colonies. Bengal in India (modern-day Bangladesh) was under British rule, and its farmers who already grew opium were coerced into growing more poppy plants (*Papaver somniferum*) for low prices.

The Tartars introduced opium smoking to China in the 17th century but it was British merchants and the British treasury that would eventually profit from that initiation—even though the British government did not condone opium use for its own people.

The Chinese referred to opium as "foreign mud" peddled by barbarians. Even some people in England realized the dangers of opium trade and attempted to stop it because they saw it as an embarrassment to the British Empire:[1a] "The British viceroy of India described opium as a "detestable luxury item, not to be used for any other purposes but foreign trade."[1] Opium had to be smuggled into China since the Chinese government did not condone the use of opium for intoxication. Wholesale smuggling started in 1781 by way of Canton. Opium trade increased rapidly. In 1831, 10,000 chests of opium entered China; in 1837, that number had risen to 39,000.[2]

The emperor repeatedly prohibited the trade in opium and its use for intoxication, even ordering, in 1838, native drug traffickers to be executed summarily. But the use of the drug spread rapidly. He appointed a special commissioner, Lin Tse-hsu, to enforce the prohibition and stop the trade in opium. Lin, who confiscated opium and torched warehouses that stored opium, wrote a letter to the British Queen, Victoria, that even today is memorable and relevant.

> *A communication: magnificently our great Emperor soothes and pacifies China and the foreign countries, regarding all with the same kindness. If there is profit, then he shares it with the peoples of the world; if there is harm, then he removes it on behalf of the world. This is because he takes the mind of heaven and earth as his mind...*

> *The profit from trade has been enjoyed by them continuously for 200 years. This is the source from which your country has become known for its wealth.*
>
> *But after a long period of commercial intercourse, there appear among the crowd of barbarians both good persons and bad, unevenly. Consequently there are those who smuggle opium to seduce the Chinese people and so cause the spread of the poison to all provinces. Such persons who only care to profit themselves, and disregard their harm to others, are not tolerated by the laws of heaven and are unanimously hated by human beings. His Majesty the Emperor, upon hearing of this, is in a towering rage. He has especially sent me, his commissioner, to come to Kwangtung [Guangdong], and together with the governor-general and governor jointly to investigate and settle this matter.*
>
> *All those people in China who sell opium or smoke opium should receive the death penalty. We trace the crime of those barbarians who through the years have been selling opium, then the deep harm they have wrought and the great profit they have usurped should fundamentally justify their execution according to law. We take into to consideration, however, the fact that the various barbarians have still known how to repent their crimes and return to their allegiance to us by taking the 20,183 chests of opium from their cargo holds and petitioning us, through their consular officer [superintendent of trade], Elliot, to receive it. It has been entirely destroyed and this has been faithfully reported to the Throne in several memorials by this commissioner and his colleagues...*
>
> *We find your country is 60,000 or 70,000 li [three li make one mile, ordinarily] from China. Yet there are barbarian ships that strive to come here for trade for the purpose of making a great profit. The wealth of China is used to profit the barbarians. That is to say, the great profit made by barbarians is all taken from the rightful share of China. By what right do they then in return use the poisonous drug to injure the Chinese people? Even though the barbarians may not necessarily intend to do us harm, yet in coveting profit to an extreme, they have no regard for* injuring *others. Let us ask, where is your conscience? I have*

heard that the smoking of opium is very strictly forbidden by your country. That is because the harm caused by opium is clearly understood. Since it is not permitted to do harm to your own country, then even less should you let it be passed on to the harm of other countries — how much less to China! Of all that China exports to foreign countries, there is not a single thing which is not beneficial to people: they are of benefit when eaten, or of benefit when used, or of benefit when resold: all are beneficial. Is there a single article from China which has done any harm to foreign countries? . . . . Nevertheless, our Celestial Court lets tea, silk, and other goods be shipped without limit and circulated everywhere without begrudging it in the slightest. This is for no other reason but to share the benefit with the people of the whole world. The goods from China carried away by your country not only supply your own consumption and use, but also can be divided up and sold to other countries, producing a triple profit. Even if you do not sell opium, you still have this threefold profit. How can you bear to go further, selling products injurious to others in order to fulfill your insatiable desire?

Suppose there were people from another country who carried opium for sale to England and seduced your people into buying and smoking it; certainly your honorable ruler would deeply hate it and be bitterly aroused. We have heard heretofore that your honorable ruler is kind and benevolent. Naturally you would not wish to give unto others what you yourself do not want. We have also heard that the ships coming to Canton have all had regulations promulgated and given to them in which it is stated that it is not permitted to carry contraband goods. This indicates that the administrative orders of your honorable rule have been originally strict and clear. Only because the trading ships are numerous, heretofore perhaps they have not been examined with care. Now after this communication has been dispatched and you have clearly understood the strictness of the prohibitory laws of the Celestial Court, certainly you will not let your subjects dare again to violate the law.

We have further learned that in London, the capital of your honorable rule, and in Scotland, Ireland, and other places,

originally no opium has been produced. Only in several places of India under your control such as Bengal, Madras, Bombay, Patna, Benares, and Malwa has opium been planted from hill to hill, and ponds have been opened for its manufacture. For months and years work is continued in order to accumulate the poison. The obnoxious odor ascends, irritating heaven and frightening the spirits. Indeed you, O King, can eradicate the opium plant in these places, hoe over the fields entirely, and sow in its stead the five grains [millet, barley, wheat, etc.]. Anyone who dares again attempt to plant and manufacture opium should be severely punished. This will really be a great, benevolent government policy that will increase the common weal and get rid of evil. For this, Heaven must support you and the spirits must bring you good fortune, prolonging your old age and extending your descendants. All will depend on this act.

Now we have set up regulations governing the Chinese people. He who sells opium shall receive the death penalty and he who smokes it also the death penalty. Now consider this: if the barbarians do not bring opium, then how can the Chinese people resell it, and how can they smoke it? The fact is that the wicked barbarians beguile the Chinese people into a death trap. How then can we grant life only to these barbarians? He who takes the life of even one person still has to atone for it with his own life; yet is the harm done by opium limited to the taking of one life only? Therefore in the new regulations, in regard to those barbarians who bring opium to China, the penalty is fixed at decapitation or strangulation. This is what is called getting rid of a harmful thing on behalf of mankind.

Moreover we have found that in the middle of the second month of this year [April 9] Consul [Superintendent] Elliot of your nation, because the opium prohibition law was very stern and severe, petitioned for an extension of the time limit. He requested an extension of five months for India and its adjacent harbors and related territories, and ten months for England proper, after which they would act in conformity with the new regulations. Now we, the commissioner and others, have memorialized and have received the extraordinary Celestial grace of His Majesty the Emperor, who has redoubled his consideration and

compassion. All those who from the period of the coming one year (from England) or six months (from India) bring opium to China by mistake, but who voluntarily confess and completely surrender their opium, shall be exempt from their punishment. After this limit of time, if there are still those who bring opium to China then they will plainly have committed a willful violation and shall at once be executed according to law, with absolutely no clemency or pardon. This may be called the height of kindness and the perfection of justice.

Our Celestial Dynasty rules over and supervises the myriad states, and surely possesses unfathomable spiritual dignity. Yet the Emperor cannot bear to execute people without having first tried to reform them by instruction. Therefore he especially promulgates these fixed regulations. The barbarian merchants of your country, if they wish to do business for a prolonged period, are required to obey our statues respectfully and to cut off permanently the source of opium. They must by no means try to test the effectiveness of the law with their lives. May you, O King, check your wicked and sift your wicked people before they come to China, in order to guarantee the peace of your nation, to show further the sincerity of your politeness and submissiveness, and to let the two countries enjoy together the blessings of peace. How fortunate, how fortunate indeed! After receiving this dispatch will you immediately give us a prompt reply regarding the details and circumstances of your cutting off the opium traffic. Be sure not to put this off. The above is what has to be communicated.[3]

Because the English declared war on the Chinese, this letter was probably never sent. Nevertheless, Lin's arguments, even today, call attention to the widespread social and economic problems caused by drug dependence and illegal drug trade. It even shows the role a country can play in the spread of drug abuse and how others need to defend themselves against the aggressors.

First Opium War

When the enormous opium stocks in British warehouses in Canton were destroyed, the British declared war on China. It was 1839. The goal was to convince the Chinese government that the opium trade should be

legalized. The British beat the undisciplined Chinese army, aided by traitors who chose opium over their country. The capitulation was signed in Nanking in 1842, and Hong Kong ceded to the British. The Chinese paid recompense for the destroyed opium and put five harbors at British disposal, which profited other countries also. Drug dependence, slave trade and widespread misery followed the opium trade, but this misery made no impact on the thriving drug trade. The emperor's power was diminished, his representatives in the provinces became corrupt, and soon poppy was cultivated on the estates of the landed gentry. Draconian measures were imposed to curb opium dependence, such as an edict that allowed dependent person's lips to be torn. But when the emperor's corrupt administration and brutal strategies did not stop Western exploitation, violent opposition ensued in various parts of the country.

The T'ai P'ing revolution of 1851-1864 spread to other provinces and a strong army was amassed. They fought the feudal government and vehemently opposed prostitution, opium smoking and corruption, confiscating property and sharing it with the poor and dispossessed. Internal conflicts stagnated the revolution after 15 years, but the British, Americans and French had already seized the opportunity to establish their influence on the now severly weakened Chinese dynasty.[4]

Second Opium War

When the Chinese captured and impounded an opium-laden ship named Arrow which sailed under the British flag, the British declared the Second Opium War in 1856, with the French following suit.[5] Because the British were fighting an Indian uprising that had started in 1857, the British could not send additional troops to China until after the Indian uprising had been quelled. They eventually shelled Canton, and when they reached Tien-tsin, 100 miles from Beijing, the emperor surrendered. The Anglo-Chinese Treaty, which also involved the United States and Russia, opened more harbors to Western trade, forced the Chinese to pay damages and legalized the opium trade. The war ended in 1858, but the treaty was not ratified because the emperor feared popular revolt. England and France resumed the war in 1860 and forced the emperor to sign the treaty. After legalization, more opium was imported, and the Chinese began growing their own after 1860.[6] The provinces of Sichuan and Yunnan grew so much poppy that they had enough to export. Lin's hypothetical argument, "Suppose there were people from

another country who carried opium for sale to England and seduced your people into buying and smoking it; certainly your honorable ruler would deeply hate it and be bitterly aroused," became reality. The cultivation of poppy in Yunnan then has reached into the future to affect today's heroin use. Yunnan borders on Burma (today called Myanmar), Laos and Tonkin (North Vietnam)—the area we now call "The Golden Triangle." The mountainous region, where borders are unclear, has for long periods provided large quantities of the world's heroin.

The Chinese efforts to stop the import and dependence on opium met with sympathy from other countries. Around 1880, the United States stopped trading in opium with the Chinese. However, the humanitarian gesture didn't give the U.S. expanded trade in other Chinese goods. But this was not the only reason American companies failed to make much headway doing business with the Chinese. Many Chinese were dissatisfied with the treatment their fellow countrymen received in the United States and boycotted U.S. trade. When the Americans won the Philippines from the Spanish in 1898, they inherited a thriving smuggling operation and other opium-related problems. A commission (1909) was formed to investigate means of countering the drug problem in the Philippines, and this commission concluded that the use of opium should be limited and finally prohibited. The commission's report was the basis later for the first international conference aiming to regulate opium trade internationally, the 1909 International opium Commission meeting in Shanghai. The first formal Conference was held 1912 in the Conference of The Hague.

Popular revolt in China against foreigners, which was secretly supported by some at the royal court, led to the Boxer Uprising. On June 21, 1900, the Dowager Empress Tz'u-hsi decreed that all foreigners be killed. When a relief expedition of British, French, Japanese, Russian, German and American troops occupied Beijing on August 14, 1900, the Boxer Uprising effectively ended. China had to begin yet another campaign against the "foreign junk," opium.

1911-1917

Between 1911 and 1917, all foreign opium became prohibited and the legal import of opium put to a halt. The British were forced to support this campaign officially. However, because the Chinese banned all production of opium and there was still a market for it now that so many had become dependent to it, the British continued to profit by

smuggling into China opium from India. Another sad historical note is that Western missionaries were known for their adamant campaign against opium. But they tried to cure opium dependency with morphine. During this period, "Jesus' opium" became a nickname for morphine.[7] In America, but also in England, protests against the opium trade in China were organized by organizations such as the Anti-Opium League and Friends of China.

In 1835, China had more than 2 million opium users. In 1949, that number had risen to between 20 and 30 million. Morphine entered the country from the United States and Europe via Japan. Until the Second World War, opium, morphine and heroin flooded China, despite all attempts to halt the use of those drugs. During the Japanese occupation, Japanese and Chinese generals traded in opium, and General Chiang Kai-shek supported his army with profits from opium sales. When communist forces won the civil war in October 1949, Chiang Kai-shek's troops fled, some to the Golden Triangle.[8] One of the communist government's first measures was to ban the cultivation of poppy and all non-medical and non-scientific use of opium and its derivatives. Some 60,000 people many of them were opium smokers, fled to Hong Kong: "Among these refugees were the crooks, gangsters, secret Triad members, drug traffickers, dealers and addicts. From 1950 on, the major drug of dependence in Hong Kong was and still (1991) is heroin."[9] The British were now faced, in one of their colonies, with the result of their own pro-opium policies.

"In China, anti-opium committees were formed. They reported on opium users and dealers and shut down opium dens. Most users wisely stopped using opium. Those who didn't were executed or put to work in drug-free places. After only a few years, widespread opium use no longer occurred. In general, the people of China gave up opium use to get high. The people associated opium use with violence, treason and repression. Its use was accepted only by the corrupt elite as a source of pleasure and by the poorest as an escape."[10]

The perspective of the Chinese people is relevant not only to China. The people of other countries similarly refuse to accept being exploited by drugs. The free trade in and liberalized use of drugs is still the dream of a select group of business persons, but also of those who are paid for by the people on whom they prey. The Golden Triangle, reportedly supplied 60 percent to 80 percent of the heroin exported to the United States in the 1980s and 1990s, but other countries in the Far East and

Southeast Asia are affected also. From Bhutan and Nepal to India, from Afghanistan to Vietnam, the common people pay the price of the drug habits supported by remorseless traders. The old British opium policy in the East guides drug traffickers today: A large profit can be made from those forced into the production of the drug and those dependent on it. Their former disastrous opium policy in the East comes very close to their policies now, which aim to accept prescription of heroin and the sale of cannabis. This new policy will hit their own people hard; the British should have learned more from their own history.

The Netherlands and Indonesia

VOC

In 1602, the Dutch East India Company (Verenigde Oost-Indische Compagnie, or VOC) was founded in the Netherlands. They governed trade with the archipelago now called Indonesia. Besides sailors and civil servants, the company also included an army. The VOC was granted the exclusive right to trade with the East, trading in many other things besides the spices for which the Far East was noted: Chinese articles such as silk, porcelain and tea; Japanese lacquer ware and copper; Persian silk; indigo and textiles from the Coromandel Coast (present-day southeastern India) as well as Bengal and India. Ivory was traded from Ceylon, which was completely controlled by the company.[11]

Opium was already sold in the Moluccas, and the VOC was quick to jump on that bandwagon. Initially, the VOC was involved only with import. Distribution and sales were left mainly to the Chinese who resided on Java.[12] The monopoly on opium import resulted in a flourishing trade. In 1612, the Governor-General for the Netherlands Indies prohibited the private trade in opium and noted how in the Moluccas the annual opium trade had grown to 200 pounds. For years, prohibition of private trade, was seen as the answer to this problem. In 1678, for instance, notices were posted around Batavia, the capital of the colony that no opium was to be sold unless it came from company warehouses.[13] Severe punishment, even the death penalty, was meted out to offenders in 1680 and 1683.

The trade in opium became very lucrative for the Dutch: in 1640, 187 pounds of opium were imported, mainly from British India, to the Indonesian islands. By 1670 import had increased to 67,444 pounds. Despite this increase, the governing body of the VOC complained about

smugglers who were moving into their territory. Even when smugglers were severely punished, illegal trade did not abate. Then, in 1743, the Governor-General proposed liberalizing the opium trade with the intent to end smuggling, but these efforts also failed. The answer, for the Dutch colonial traders, was to be in regulation.

> ***During the reign of the VOC, profits were to be maximized by attaining the highest possible turnover. Later this goal was to be achieved without necessarily increasing turnover.***[14]

Regulation of the opium trade

Regulation started in 1745 when the Opium Society was founded with the dual goal of halting the smuggling of opium and increasing profits for the Company. Opium was treated like any other product from the East. The Company was to guarantee the import and transportation of opium, while the Opium Society ensured supplies and a fixed price. Most members were civil servants, and they had a right to sell their share of opium. In 1776, the statutes were changed so that Society members, apart from having to pay the fixed retail price, also had to pay half of their profits to the company. As a result, prices rose, illegal trade was unaffected, and the projected profits were never attained. The VOC handed over her responsibility to the state in 1798 and went into bankruptcy on January 1, 1800. Governor-General H. W. Daendels forcefully reintroduced the opium monopoly in 1808. Slowly, it became clear that the trade in opium had negative effects on its consumers. In 1815, Thomas Stamford Raffles, Lieutenant Governor during the British occupation of Java, tried to curb opium use on that island, but was prevented by opium traders from Bengal.

Leasehold system

Daendels introduced the leasehold system, which gave designated manufacturers and merchants the right to produce opium and sell it in small quantities, the equivalent of the modern-day home grower who sells his product in "coffee shops." All trade in opium was controlled by the Government so as to attain maximum profit from a small number of people. The leasehold system was considered a success, but it produced serious, negative consequences. By leaving the retail trade to Chinese opium growers, those lessees were able to build tightly-knit, closed organizations, or cartels, in their dominions. Their roles extended beyond the limits of opium distribution to allow Chinese opium lessees

to become influential enough to affect the authority of the Dutch administration.[15] The smuggle of illegal opium did not diminish as a result of the leasehold system, which led Dr. L.W. de Roo to conclude that the cause of smuggling was not the leasehold but the monopoly system in combination with high prices for the consumers and the economical crisis on Java, the main island in the Indonesian archipelago. He proposed opening up the opium import and trade on Java to stop smuggling. It was estimated that smuggling brought in twice as much opium as did legal import. The biggest smugglers, in fact, were the lessees, since they had to pay more to the Government for the privilege of producing opium than they could make on selling it. All this led to a thorough revision of the old system.

Tiban-Siram system

In the mid-nineteenth century, Tiban-Siram system was introduced, also known as the system of "maximum and unlimited distribution." Tiban was the term for the amount of opium of a certain composition and price to be bought from the governor's office and Siram was the term for the extra amount an opium trader could acquire if he had fulfilled his Tiban quota. A fundamental problem was that it was not known how much opium would be in demand at any given time. If the authorities did not supply enough opium to the market, stocks were supplemented by smugglers; if they released too much, the drug problem increased—a marked similarity to today's situation, where, despite efforts to limit legal amounts of drugs, and crops, age limits and numbers of "coffee shops," it remains impossible to regulate the drug market.

Panto Engan system

The Tiban-Siram system was quickly replaced, around 1885, by the Panto Engan system, which entailed the cooperative sale and gradual consumption of a certain amount of opium for use in restricted opium dens, the so-called "Panto Engan" houses. Only those who bought opium from an official trader could use opium inside those houses, which is reminiscent of modern-day regulations regarding state-distributed heroin and methadone. The dens were not allowed to store more than one "thail," about 1.5 oz.[16] Just like "coffees shops" in the Netherlands today, stores are only allowed a limited supply and it can be used only in this place. The Panto Engan system never worked properly due to its double standard. The idea was to limit the use and negative effects of

drug use while still making money on it—a strategy similar to the current official Dutch policy regarding drugs. In 1886, a Dutch civil servant for the Indonesian colonies, J. A. B. Wiselius, commented on this policy: "Without wanting to act as an apologist for opium, we must make peace with the spirit of the times, which promotes the spread of this article on all five continents. On this matter, going against the current would not only fail to accomplish the desired result, but would also lead to financial loss. Moreover, it is more sensible if the state were to attempt to maximize its profit from this increasingly popular habit."[17]

Opium Regie

The state monopoly made possible the wholesale exercise of government control on all aspects of the opium trade. Opium was packaged in cylinders to prevent tampering with the contents and packaging. Buyers were registered. The middle man was eliminated and replaced by civil servants with fixed salaries, eliminating the cartels, the equivalent of the newly started Bureau for Medicinal Cannabis. During the monopoly, greater quantities of opium were sold than under the leasehold system. Profits were immense but curbing the drug use was a total failure.

Because the cultivation of poppy was prohibited in the Netherlands-Indies, raw opium was procured from British India. In a small factory, opium was refined and packaged for the market, first in Madoera on a small scale, and later (in 1920) for the entire region. The idea was to slowly decrease the use of opium, but some considered the state monopoly an official legalization of opium use. Still others wanted a more serious effort to combat drug use. However, "a wholesale prohibition on drug use was not considered useful," according to De Kat Angelino, a labor-inspector in colonial Indonesia, "because a popular bad habit is not to be ended by bureaucratic measures, especially not in a society which is not inclined to popular protest, and which, moreover, is indifferent toward such abuses."[18]* The state monopoly did not achieve its intended results. A decline in drug use was noted, but this was probably due to the worsening economic conditions of the 1920s and

*In the United States, Dr. Siddarth Chandra, Assistant Professor at the School of Public and International Affairs at the University of Pittsburgh, publishes on and researches the Opium Regie. See, for instance, his article "What the Numbers Really Tell Us About the Decline of the Opium Regie" (Indonesia 70 (October 2000): 101-123); he presented a paper, "The Opium Regie in the Netherlands Indies: Colonial Cash Cow or Drug Policy Triumph?", at the Economic History Association's 61st Annual Meeting, Philadelphia, 2001. Prof. Chandra received a grant to compare the 'opium regie' to modern policy efforts to halt cigarette smoking; see his grant

1930s, when opium dependent persons could not afford the expensive government opium.

The trade monopoly of the East India Company had developed into a state monopoly. Ostensibly the economic motivation for the opium trade was lessened, but its profits and overall size were not. The drug still was allowed and supplied by the state.

Anti-opium league

The Dutch Anti-opium league was founded in 1890. It was a reaction to the growing dissatisfaction with the problems opium dependence caused and to prevent opium dependence in future generations. They wanted to counter opium abuse in the colony and to decrease use in general, as well as to stir the conscience of the Dutch population and criticize the government's opium policies in the Netherlands-Indies. Around the turn of the century, a growing interest in opium problems gave rise to an extensive literature on opium use and abuse such as the book *The Opium Curse on Java,* published by the Anti-Opium League. This public outcry against government policy coincided with the establishment of anti-opium organizations in the Netherlands-Indies, who protested the state's opium monopoly. Again it was the voice of the people, a voice not listened to often enough by politicians, that caused policy to change for the better—a useful lesson from the past.

End of the legal opium era

The Netherlands, like other countries, profited immensely from trade with the Orient, and the drug trade, as we now know, was particularly profitable. Various countries defended their trade monopolies in the East with naval force, opium wars, and the suppression of the native population in their colonialized territories. Nothing was sacred in the attempt to retain control over opium plantations or to keep harbors and open up new ones. This tyranny left in its wake widespread misery, dependence, and slavery. Ellen La Motte wrote in 1920, "Drugged peoples are usually docile and submissive—perhaps that is the secret of much of the successful colonizing."[19] Colonizers were convinced that their subjects in the East could not live without opium; at the same time the use of opium was carefully restricted during this time for the people of the white race but not for Oriental races. None of the self-governing

colonies of European countries—Australia, New Zealand, and Canada—permitted the traffic at home. Neither did Japan, which was never subjugated by a European nation. And, for instance, when America acquired the Philippines, they eliminated the opium traffic. Internationally, slowly but surely the opium trade and its effects came to be criticized; W.E. Gladstone, the British statesman, called it "morally indefensible." The first steps toward international regulation were taken in Shanghai, China, in 1909. In 1912, the first International Opium treaty was signed, in The Hague, the Netherlands. This treaty was aimed at stemming the supply of drugs; buying and selling drugs became illegal except for well-defined, mainly medical and scientific, purposes.

International treaties

"Treaties are written arrangements between states and international institutions that are binding for all citizens and governments of the countries that signed them. They are the highest legal authority, superseding any national legislation. Treaties apply to states only after they have officially bound themselves to them. In most countries such treaties, since they override their own legislation, must be ratified by a parliamentary procedure.[20] This summary of the legal force of international treaties comes from the website of the Dutch State Department." It seems that they know very well that the United Nations drug treaties supersede Dutch national legislation, but a quick look at the history of Dutch drug legislation proves that the Government is not concerned about applying the State Department's definition of treaties to their drug policies.

The Netherlands ratified and signed the 1912 treaty; the Dutch Opium Law, which came about in 1919, is based on this treaty. New drugs and new circumstances caused regular international discussion, and resulted in changes to national law. Afterwards, one international conference followed another, resulting in new treaties, and as a result, international and national drug legislation became a patchwork. To replace existing treaties, the Single Convention on Narcotic Drugs was signed in New York, 1961, under the auspices of the United Nations. Ever since, it has seized as an international drug control constitution. The Netherlands became a party to the treaty, and ratified it in 1964. From then on, "parties to the treaty were obligated to take legislative and administrative measures deemed necessary to limit the production of,

trade in, and possession of drugs strictly to medical and scientific purposes. All activities not aimed at these goals are illegal and must be punished accordingly."[21] No drugs, including marijuana, are acceptable to use for intoxication, and their trade is likewise rendered illegal by national and international legislation. The law assumes that if *possession* of drugs is illegal, then its use will stop; they do not obligate to render the *use* of drugs illegal. Some countries, such as Russia, Norway, Finland, and Sweden are much more clear on this issue, and have made the use of drugs explicitly illegal in their national legislation.

Fact Sheet

The Single Convention on Narcotic Drugs (1961)

The drug constitution from the United Nations is the International Single Convention on Narcotic Drugs from 30 March, 1961. It limits the use of narcotics drugs exclusively to medical and scientific purposes. It does not allow "recreational" or religious purposes. It does not permit free sale of narcotic drugs or free use of illegal narcotics. Each country may decide what measures to take against drug abuse and what penal sanctions to apply for drug crimes. It may adopt measures, which are more severe than the minimum ones give by the convention. In this Convention, only the classic drugs like opiates, cannabis (hashish and marijuana) and coca leaves and cocaine, are controlled. So far, 179 nations have adhered to the convention.
A protocol amending in 1972 provides rules for measures against drug abuse and drug crime, and social and medical measures for the rehabilitation of drug abusers.

The Convention on Psychotropic Substances (1971)

The Convention on Psychotropic Substances (1971) provides rules for the handling of more recent narcotic drugs and psychotropic substances, such as LSD, mescaline, amphetamine, barbiturates, psilocybine, methaqualone, and other tranquilizers. THC is governed by this convention and not by the 1961 convention as the substance was identified only in 1965. The participating countries should limit the use of the controlled substances to medical and scientific purposes. This Convention is signed by 174 nations.

The Convention Against Illicit Traffic in Narcotic and Psychotropic Substance (1988)

The 1988 convention is aimed at promoting international co-operation against drug crime. The convention makes it possible to extradite suspects and seize narcotic drugs, technical equipment use in drug crime as well as proceeds of drug crime or any property acquire by means of such proceeds, to conduct searches etc. also in countries other than that in which a suspect is on trial. A total of 168 nations have signed the 1988 convention. [22]

The Convention on the Rights of the Child

§ 33 stats: States parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

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Chapter Nine

THE DUTCH DRUG POLICY

A way of their own

The Dutch have their own interpretation of the international drug treaties. After years of often difficult but fruitful international discussion on drugs and a number of treaties, the Netherlands parted ways with the international community and chose their own way on 1 November 1976. Since then, the Dutch Opium Law "distinguishes between two kinds of drugs: those with unacceptable risks, and those with less grave risks."[1] Part of this Opium Law is a set of two lists categorizing the various drugs, differentiating between what are called "hard" drugs and "soft" drugs. Thus, via official legislation and publications by the Justice Department, the terms "hard" and "soft" are instilled in the minds of legislators, the media, and the users of illegal drugs and their environment, as well as exported. At the same time, the prohibition on consuming drugs was taken out, rendering the use of illegal drugs no longer illegal, however, the possession, production, preparation, sale, delivery, dispersion, and transportation of drugs remained illegal and therefore punishable.

Guidelines from the Public Prosecutor's offices follow the Opium Law. It strives the greatest possible unification as to investigation, prosecution, and sentencing to maintain. But the prosecutor has the authority to prioritize certain illegal activities over others; the 1976 law

was specifically designed to give the highest priority to the (large scale) trade in drugs, and the lowest priority to possession.

Many people think that the Netherlands legalized drugs, but that is not formally correct. However, the differences between punishable and not punishable, legal and legalized may be defined formally, but they are nevertheless difficult to enforce in a practical way. A Christian-Democrat member of Parliament, Wim van de Camp, explained the differences in the following way:

> Not punishable: Not formally punishable according to the law; this does not mean that the government applauds its use;
>
> Legal: more positive than 'not punishable,' but here also the government does not stimulate drug use;
>
> Legalized: an active stance by government; legalization as an active stance legitimizes the use of 'soft' drugs as something positive.[2]

The judicial situation regarding personal non-medical use of drugs in the Netherlands is confusing and contradictory. On one hand, it is not permitted under the international drug conventions, but on the other hand there is no specific legal sanction (punishment) against it. In practice, the home growing, buying and selling, and the possession and non-medical use of drugs are permitted, at least tolerated. As the police and courts put no effort into stopping the low-level trade and handling of drugs, the drug conventions are not enforced. Thus the Dutch government has succeeded in creating a very wide "grey zone" for drugs. The zone expands steadily and has created a fertile soil for "weed" (marijuana growing). When the gardener does not attend to his garden, the weed creeps all over.

> ***Nothing is more dangerous than active ignorance.***
>
> *—Goethe*

How could this happen?

Drug treaties only create the obligation to legally prohibit drugs, but they still respect the state's sovereignty and legal principles. Law enforcement and prosecution in the Netherlands operate under the principle that the prosecutor need only prosecute those crimes deemed important and relevant given the circumstances. The Single Convention lists heroin and marijuana the same way, because each is harmful in their own way, but it allows national legislation to sanction that prohibition more or less severe, that is, to ban outright or to enforce severe restrictions. Since the Dutch Opium Law is the product of the treaty, the Dutch government cannot deviate from these norms too much, yet Dutch politicians decided in 1976 to liberalize the Opium Law, abusing the terminology of "more or less severe."

According to the reigning government in 1976, the differentiation of drugs into two separate categories was enabled by translating the Single Convention to the benefit of liberalization. The treaty, however, was never intended to be weakened by through individual states' judicial freedom, with the aim of making certain drugs accessible for "recreational" use or their production, sale, and availability.

This national Dutch policy started widespread confusion, and its dual approach opened the door for the drug industry. Like alcohol and tobacco, marijuana products got their own points of sale, the "coffee shop." Those who operate "coffee shops" have to pay income taxes.

An old sales slogan from the days of the opium trade is revitalized in the "coffee shops": "They say that it is not harmful—if taken in moderation. They even assert that it is no more objectionable than alcohol or tobacco."[3]

This is not to say that the trade in hashish and marijuana is totally unregulated. "Coffee shops" are allowed to do business as long as they adhere to certain conditions set by the Public Prosecutor:

- no advertising; this means also that "coffee shops" can only have the most limited of signs outside advertising its business;
- no "hard drugs" are allowed on the premises;
- no public nuisance, including noise pollution, littering, or loitering;
- no sales or access to anyone under the age of eighteen, considering the increasing use of cannabis by youths;
- no selling of large volumes, that is, no sale is to be larger than appropriate for personal use.

The sale of more than five grams of hashish or marijuana, enough for about ten joints, is illegal, but tolerated under the prosecutor's guidelines. For all practical purposes, prosecution only takes place if the owner or operator of a "coffee shop" does not adhere to the guidelines

mentioned above. Law enforcement may also act if the neighbors complain about public nuisance.

A factsheet called "The Dutch Drug Policy," published in 1999 by the Trimbos Institute, the Netherlands Institute of Mental Health and Addiction, summarizes the government's current position on drugs: "The use of drugs is not made illegal. The point of departure is the prevention of drug users from ending up in illegality, where it is more difficult for prevention and social services to reach them."[4] However, if the use of illegal drugs is legal but its trade illegal, a user of illegal drugs will automatically end up in illegal circles. What the government really means is that in a climate of tolerance, under some measure of government control, a drug user will use tolerated drugs in a semi-legal location, and therefore does not have to come into contact with the illegal trade. Since drug users in "coffee shops" are "present" and "accessible," the Dutch Trimbos Institute organizes courses for owners of "coffee shops," under the guise of prevention and social assistance—but not with the aim of preventing drug use. Despite ratified treaties, the drug trade in the Netherlands is moving toward a state monopoly.

Limited retail trade of hashish?

The Opium Law prohibits the growth of *Cannabis sativa* for consumption. Despite this prohibition, the Dutch Internal Revenue Service tracks down hemp plantations and taxes them. They are, however, not obligated to report their findings to the Justice Department.

The government contributes in many ways to the drug trade—by allowing five grams of marijuana for "personal use," by not prioritizing possession of less than 30 grams, by allowing "coffee shops" to have a stash of up to 500 grams of cannabis, and by allowing home growers to have up to five plants. Since the drug market revolves around the consumer, this policy of tolerance has enormous consequences: a user may not buy tons of drugs each time, since they are happy with their couple of grams when they want to light up, but hundreds of thousands of users make all these few grams add up to tons.

When an offense is noted, the Opium Law dictates that all drugs, from both categories, must be confiscated. This creates an opportunity for early intervention, but because of priority policies this is rarely used. According to Joop Verbeek, author of the report *The Possibility or Impossibility of Drug Legalization: Regulated Types of Dispersal,* "The

Opium Law offers no room for a maximum on the amount a trader may have in stock. Besides, the policy is not aimed at suggesting to a "coffee shop" owner how many customers he may serve at any given moment."[5] Despite the Opium Law, since 1996 'coffee shops' may have up to 500 grams of cannabis in store for sale. When sales are good, they may then sell up to 182.5 kilos a year, which is probably more than most sell "legally". A more realistic number is 150 kilos a year per "coffee shop," of which there are around 800; this adds up to the legal sale of around 120 tons of marijuana a year, or around 240 million joints a year—a whopping sixteen joints per Dutch citizen per year. These numbers, as high as they may seem, do not yet account for other points of sale (about 1,450 of them) or for sales above 500 grams a day. During a lecture at the Erasmus University, Rotterdam, the former leader of the Dutch Christian-Democratic party and former minister of foreign affairs Jaap de Hoop Scheffer, stated that the Netherlands attracts drug tourism, and has managed to rank among the world's biggest traders and producers of illegal drugs. He estimated that the annual Dutch trade in drugs to be around eight billion dollars, seven billion of which are profits from export—the Netherlands is now a major drug exporter.

There is another way to demonstrate what enormous market potential is created by allowing the legal possession of five grams of marijuana. According to the NIAD, the Netherlands Institute for Alcohol and Drugs, there are around 675,000 cannabis users in the Netherlands.[6] The Trimbos institute claims a lower number, between 300,000 and 600,000. However, according to numbers from inside the trade, in 1986 there were already between 800,000 and one million users.[7] Let us accept the NIAD estimate of 675,000 regular users accepting the tolerated limit of five grams. If this group would daily exercise their legal privilege, each of them would buy 1,8 kilos of cannabis per year; as a whole, they would buy 1,200 tons a year, enough for 2,4 billion joints. Since a gram of hashish costs between five and ten dollars (but more if the THC content is higher), this represents 25 billion dollars per year—almost three times the Gross Domestic Product of a country like Bolivia. There is nothing "small" or "soft" about these numbers; there is no "small" or "soft" cannabis trade in the Netherlands.

Home growers with their allotment of five plants for "personal use" produce on average 1,5 kilos per plant per year—that is 3,000 joints per year, or eight per day per person. Since plants can be harvested four times a year, this totals 12,000 joints per person; there are between

35,000 and 50,000 home growers, producing up to 600 million joints a year. If a Dutch joint sells for around three dollars, this creates a trade of almost two billion dollars—hardly a small "personal" supply. Much of this production isn't for personal use, though; it generates extra income through sale and barter trade. Many home growers are connected to "coffee shops" that they supply with nederwiet, Dutch home grown marijuana. But the Departments of Justice, Interior, and Health and Social Services, who are responsible for drug policies display a strange way of reasoning and an astonishing naivete: "A coffee shop with a wide assortment offers various kinds of marijuana, hashish, and nederwiet. The entire chain of production and distribution is thus safeguarded from the influence of criminal organizations."[8]

These departments estimate that around half of the trade in cannabis stores consists of nederwiet, which they consider beneficial in decreasing the smuggle of drugs from abroad. It is pretty obvious that these politicians and civil servants do not have much respect for the Opium Law: all possession, production, preparation, sale, delivery, and transportation of drugs is explicitly forbidden. Whether home grown or imported, the Opium Law prohibits any and all trade in drugs.

As a result of dubious legislation, Amsterdam has developed into an international hub for all kinds of drugs. Former chief of police R.H. Hessing thinks that the policy of tolerance has contributed pre-eminently to a crisis among law enforcement and prosecution: "In the beginning, we tolerated youth centers [where 'house dealers' sell drugs to youngsters], then we tolerated criminals taking possession of these centers for financial profit, and then we practically allowed the emergence of organized crime."[9] An official declaration on the policy of tolerance can be found in *The Dutch Drug Policy, Continuity and Change,* a publication of the Departments of Justice, the Interior, and Health and Social Services:

> "The official policy of tolerance does not rest on a more liberal, let alone positive attitude toward the use of soft drugs. Its basis is the consideration that allowing the sale of soft drugs under clearly defined conditions decreases the use by young adults of more dangerous drugs. The Dutch coffee shop policy also is characterized by *harm reduction.*"[10]

Since 1976, by allowing what is essentially illegal, the government has itself entered illegality. They have contorted themselves into an untenable position fraught with contradictions, and to avoid difficult questions they call this "pragmatic" policy—leaving many to wonder what the real goal is of drug policy in the Netherlands.

The official goal of Dutch drug policy

According to the fact sheet published by the Trimbos Institute, outlining Dutch government policy, these are the official goals:

1. The central aim of Dutch drug policy is the protection of the individual's health, his direct environment, and society as a whole. Protection of vulnerable groups, especially the youth, is of prime importance.
2. Policy is aimed, on the one hand, at the reduction of the demand for drugs, and on the other hand, at the reduction of its supply. The demand for drugs is discouraged by a policy of social care and prevention; the supply of drugs is countered by combating organized crime.
3. The policy consists of efforts to counter the nuisance caused by the use of drugs, and maintaining the peace.
4. The demand for drugs is discouraged by an active policy of care and prevention.[11]

Let us see what has become of these lofty goals. Since 1976, the Netherlands has reaped:

- Hemp and hashish museums.
- Nederwiet, produced in cooperation with the Agricultural University at Wageningen.
- A Sensimilla Fanclub (1985) for Dutch cannabis growers and smokers.
- Unions for junkies.
- A temp agency by and for drug abusers, who get paid in drugs.
- Organizations of users and traders that are active in politics.
- Cannabis games, with prizes to whom grows the finest weed.
- Positronic stores where home growers get their hardware and advice.
- Pollinators, a kind of spin-drier allowing a greater yield of hashish from hemp plants.
- Home-grow greenhouse models, delivered with no assembly required.

- The Epaphras Institute, which supports Dutch citizens in foreign prisons on drug charges; they are financially supported by the Sensimilla fanclub.
- "Coffee shops" where cannabis products are sold and used.
- Head shops, for the sale of drug paraphernalia.
- Wiet shops offering advice and selling products for the growth of "*Cannabis sativa L.*"
- Grow shops, which deal in young hemp plants and offer advice to home growers, as well as serving as buyer and seller for the home growers' products.
- Shroom shops which sell hallucinogenic mushrooms.
- "Smartshops" which sell hempwine and herbal XTC.
- "Ecoshops" which sell, among other products, mushrooms and cacti with hallucinogenic properties.
- Khat cafes where khat is sold and chewed.
- Maripharm, the institute for the rights of abusers of medical marijuana; the institute buys cannabis from different growers, to distribute them for "reasonable" prices among patients with various ailments. They have no medical license but are tolerated.
- Areas for drug abusers where they can prostitute themselves under the watchful eye of local health services.
- The ability to have your XTC tested to see if you got what you paid for (officially, this program was temporarily cancelled in 2002).
- Widely known house parties where drugs are taken.
- A reputation as the largest provider of XTC and 'nederwiet' in the world.
- A hemp trade show for traders, merchants, and customers.
- Official "user spaces," around twenty or so, where drug dependents can inject and smoke their drugs. The standard outfit of such a space includes free paraphernalia, clean syringes, food and drink, recreational activities, and bathrooms.
- The distribution of heroin and methadone by the state to dependent persons.

- Syringes and needles handed out to abusers.
- Large pot plantations.
- Home growers who may semi-legally grow up to five plants, but according to the trade organization usually have twenty to fifty plants.
- A wholesale distributor in seeds and paraphernalia, selling to the many head, "smart," and grow shops.
- Mail order and internet business that sell and advertise seeds, paraphernalia, and drugs.
- The "Magic Mushroom Growkit," a do it yourself kit to grow psychedelic mushrooms at home.
- A messenger service for drugs.
- Hashish and mushroom taxi cabs that deliver the goods at home, accompanied by "some solid and responsible information."
- Coops distributing drugs to paying members.
- A national trade organization for "smartshops" with up to 125 members.
- City councils subsidizing the unemployed to work in the cannabis industry.
- Proposed drive-throughs, where customers can get cannabis products without having to leave their cars.
- A "Peace House" working for the international legalization of cannabis.
- Internet listings for headshops and "coffee shops."
- International declarations and conferences, organized by the national government, which aim at gaining support for further liberalization and legalization abroad, and were initiated by the former Minister of Health and Social Services, Ms. Els Borst.
- Civil servants explaining the liberal Dutch drug policies abroad and to foreign visitors as an alternative to a repressive approach.
- Semi-official proposal to legislation the regulation of the trade in drugs.
- Local governments giving permits to "coffee shops," amounting to the acceptance of selling, buying, and consuming.

- A "coffee shop" policy firmly in the context of "harm reduction."
- The reduction of public nuisance as the only goal of local governments' drug policies.
- Physicians and pharmacies prescribe and sale "medical marijuana" to patients supplied by the state.
- Guns, drugs, and large sums of money found on a regular basis at home growers.
- Underprivileged people harassed into giving up parts of their living quarters for growing hemp.
- *Highlife*, a bimonthly magazine for the growers and users of marijuana.
- "Canna," a national and international producer and trader in products especially geared toward growing cannabis, and registered with the Chamber of Commerce.
- A planned "Hemphotel," "where one can sleep, bathe and clothe in hemp and have a hemp oil massage."
- Foundation Legalize.
- Street raves for a "healthy" drug policy.

Before 1976, there were no "coffee shops" in the Netherlands; now there are 800, as well as 1450 other points of sale, besides the already existing places where drugs are sold. The result? Even according to the Trimbos Institute, which is not known to advocate a restrictive policy, the use of drugs in the Netherlands has increased.[12] Formally, the legalization of drugs is impossible, and an overwhelming majority of the Dutch population opposes it. Despite this, drugs are abused semi legally and parts of the trade in drugs tolerated.

The central tenets, mentioned above, of the Dutch drug policy can never be attained with this policy of tolerance, nevertheless the slogan "Go Dutch" is still popular among the advocates of legalization. This would involve the introduction abroad of such great Dutch achievements as "coffee shops," needle-exhange programs, headshops, heroin programs, and XTC tests. The occasional abuser, the small-time drug dealer, the home grower, the regional "coffee shop" policy, these are all contributors to a snowball set in motion in 1976, and now pushed around the world by a well-organized and wealthy pro-drug movement.

The Dutch drug policy is a fiasco

Jan Walburg is the manager of the Jellinek clinic, one of the most well known and heavily subsidized (by the Department of Health and Social Services) centers for the prevention and treatment of dependence in the Netherlands and an active participator in the international drug debate. The Jellinek institute received the highly desired ISO certification for quality in January 1999, which gives them an advantage over similar organizations to draw international projects, such as PHARE* and various EU-sponsored initiatives. In 1996, the Jellinek institute received a recommendation for quality in the Netherlands. Walburg is the chairperson of the Advisory Committee on Quality and, since 1996, professor of Quality Management in Health Care at the Eindhoven University of Technology.[13] During a debate on Dutch national television, in a program called "The Washout of Twenty-five Years of Tolerance," 12 March 2000 he said: "So far, almost no investigations have been made about the effects of cannabis and about the consequences of increasing the active element, THC, in cannabis. We don't know exactly what the consequences are of these new types of cannabis. There are almost no investigations in the field of the relationship between psychiatric problems and the use of cannabis, although we badly need such knowledge to understand what it means to tolerate cannabis in our society."

When asked why so little research is being done, Walburg answered: "Well, the problem is not experienced as such, is not named as such and you simply don't research issues you don't experience or name as problems."[14] But if so little research has been done on such a well-known topic, then why are people allowed to buy illegal hashish and marijuana so easily? And on what studies, if any, is the open sale of marijuana in the Netherlands based? Is it rather not the case that, if you don't research and don't listen to critics, you don't see the need to change existing policy? And what happens to all the information collected in Jellinek's many information and ISO-certified treatment centers, all supported with taxpayers' money? As the manager of one of the first rehabilitation centers in the Netherlands, Walburg must be more knowledgeable than he appeared in the debate. Can he really be serious when he claims that since 1976 there still hasn't been enough research into the relationship between psychiatric problems and cannabis use? Of

*A program geared at developing drug strategies for countries becoming part of the European Union, in which the Jellinek's international department, the European Addiction Training Institute

course, that research is there, but if their results were acknowledged by the Jellinek clinic, cannabis would no longer be tolerated by society. Then the government would be forced to face the facts and cut off subsidies to institutes that support "harm reduction" and tolerance policies. Until then, we are saddled with the Jellinek clinic's little leaflet on "Hashish and marijuana," which claims, for instance:

> "Cannabis is not a risky drug as long as it is used in moderation. But it is not entirely innocent. If you know someone who uses a lot of (or too much) cannabis, it is important to find out how much and why they use. The sensible thing is not to apprehend that behavior immediately, but to ensure that cannabis is (again) used in as safe as possible a way. To achieve that, you can..."

This is followed by a list of nonsense too ridiculous to be copied here. If you'd rather make up your own mind than listen to so-called experts, "The Marijuana Connection" (a list compiled by the Canadian group Lambton Families in Action for Drug Education) offers a comprehensive database of scientific research into the consequences of cannabis use.[15]

> ***Hashish and marijuana are like a fish trap: you swim in so easily. You swim deeper and deeper, until you are hopelessly trapped.***
>
> *—Dutch National Board of Drug prevention 1981*

Still, in 2003, this fish trap is wide open for our young people and the rest of the population. Isn't it time we close it for the next generations?

The sea and the dike

A Swedish mother asked me recently whether Dutch children were immune to drugs. "Why would you think that?," I responded. "It seems," she said, "that no one notices whether kids are using cannabis or not, and now our children think that they can safely use illegal drugs. They travel to the Netherlands, walk into a "coffee shop," and can smoke as much cannabis as they want to. Their reasoning: if it's legal in the Netherlands, then it can't be all that dangerous. This is sad." Tourists traveling to the Netherlands may be amused when a police officer gives them a light when presented with a joint, but in reality, the tolerance towards drugs

bears an uncanny resemblance to the age-old battle the Dutch have waged with the sea. If the dikes are not checked, if they are not maintained and periodically reinforced, water will start to seep through them. Without further action, the hole will increase and the country will flood—and no "Dutch boy's finger" will be able to stem that tide. Drugs work likewise.

First, came youth centers where marijuana was sold to those who thought they had found a niche to fit into. This grew into a drug industry offering a wide variety of drugs to a wide variety of customers. The drug trade has exploited tolerance into a gigantic money-making industry, flooding the Netherlands with drugs—just as the country has been flooded with water several times in Dutch history, leaving its ugly marks.

To allow the public to ignore such unpleasant predictions, users of illegal drugs and their supporters attempt, with playful but frivolous public demonstrations, to make the general population forget that drugs have serious negative effects. Amsterdam has often been the stage for such demonstrations: 2000 young people demonstrated there in June of 2001, where they denounced the "War on Drugs." Which war that was remained unclear, because no such war is waged in the Netherlands. Demonstrators were addressed by notable writers, politicians, and even some religious leaders, and were treated to a bong serving 64 smokers simultaneously. It is not known how many grams of cannabis made it to the demonstration, since for the occasion the usual regulations of the Opium Law were not enforced. The next day, newspapers reported on the protest: all was quiet, there was no excessive public nuisance. What we didn't read was how many traffic accidents were caused by people driving intoxicated, how many people failed to show up for work the next day, how many new users were initiated, how many illegal acts were committed; we didn't read of any comment at all about celebrities advocating drug use.

It's all about money

According to former police officer and now lawyer André Beckers, who in 1991 started a Dutch agency providing legal and business advice for shops in the drug industry ("coffee shops" and grow shops), a grow shop, if business is good, can average annual sales of around a half a million dollars; a moderately successful "coffee shop" can average around a quarter of a million dollars. Growing hashish and marijuana in

the Netherlands has also created a market for administrative services, agricultural equipment, ventilators, security systems, advertising, and for all those involved directly and indirectly with growing this drug—from manual laborers to electricians and plumbers. Knowingly or unknowingly, all these people are now part of a network that has reached all levels of society.

The trade and use of illegal drugs, however, give rise to more than just a high, a wad of cash, or employment—there are victims also. With increasing frequency, Dutch newspapers report on the consequences of this trade—such as a woman recruiting mentally handicapped people to deliver drugs,[16] or a gang coercing people into giving up their bedroom for $100 per week, so criminals can grow marijuana in it.[17] Three square meters of marijuana plants can easily make a grower 20 to 30 thousand dollars a year, according to dr. F. Bovenkerk, criminologist from the University of Utrecht. People who want to make an extra buck often make their house available for homegrowth, but then have to face the consequences when higher-ranking members of drug organizations intimidate and threaten them, telling them how to act when the police raid the house, and informing them that they are financially responsible if the police remove the plants. A vicious cycle has begun: to pay off the debt owed to a criminal organization, they will have to grow more marijuana.[18]

In the past 27 years, this semi-legalization of cannabis has strengthened crime, and made the weakest members of society even weaker—besides the innocent victims mentioned above, there are of course thousands of young people who, since 1976, dwell in a drug-inundated culture or have died in it. The Netherlands have been compared to Colombia; surely it is no coincidence that the Dutch have once again received international recognition as the largest producer of XTC in the world. It is impossible for the Dutch drug industry to have grown this much without the tolerant attitude of the government and other policy makers; it cannot be disputed that the cannabis industry has been jumpstarted by the government's negligence. To propose differentiating the market into two separate spheres, one of "soft" drugs and one of "hard" drugs, and to maintain this differentiation after 27 years is cynical, unfounded, and nonsensical. And to those who may argue that if we don't tolerate the use of "soft" drugs, its trade and use will go "underground," I ask: Are we pretending that the police currently have any kind of control over the drug problem, or that closing our eyes

to the situation is better than maintaining basic respect for the law? Legislation for a restrictive drug policy may create the possibility of penal action, but consider the consequences of the serious application of strong legislation:

- a sizeable segment of drug users will cease their habit;
- the profits made in the drug trade will become illegal and therefore uncertain;
- the business sector making money from drugs will be problematized;
- selling will become much more difficult;
- government sends a clear signal that drugs are not acceptable;
- everyone will know when boundaries are crossed, and what the consequences might be;
- international treaties will be respected, and the international consensus against drugs bolstered;
- a government can no longer tolerate the use of drugs among its people;
- the demand for drugs will decrease;
- parents will have a much less difficult time preventing and stopping drug abuse among their children;
- drug dealers can finally be arrested and put away.

Drug problems affect most people. Human beings are more than just statistics, number in opinion polls and subject groups, votes, and problems. They possess a power which, when unified, can move mountains—if the people in question realize their potential influence. A permissive drug policy cannot engender the motivation necessary to stem the rising tide of drug dependence. The drug trade is still a very lucrative business, and will remain so until we take preventive and proactive measures, show our determination, demand clarity from our elected officials, and respect the international treaties. The Dutch drug policy is not repressive, permissive, or restrictive: it is neither fish nor flesh, and only tolerates and ignores—only when the neighbors complain about a public nuisance does law enforcement act. But the existence of this drug "subculture" irritates most citizens: in the most recent elections, the Dutch voters revealed themselves to be sick and tired of crime, misdirected tolerance, and the degeneration of society; they voted for a more strict policy. The voters' wish was translated into

budget increases for law enforcement and the prison system—but without attacking the root cause of these problems: the Dutch drug problem will never be solved as long as the 1976 measures remain intact and drugs are tolerated.

The Netherlands must choose from one of three options:

1. Maintaining the policy of tolerance, and selling this nationally and internationally via propaganda. That will keep their present policy going.
2. Supporting the international legalization movement, thereby undoing the 1961, 1971, and 1988 treaties and opening the international market to drugs.
3. Changing the 1976 policy into a restrictive drug policy that respects and enforces the requirements of the UN treaties. No difference can then be made between marijuana and heroin as "soft" and "hard drugs."

According to the International Narcotics Control Board, only the rich profit from the worldwide drug trade, whereas it destroys any chances of sustainable development in developing countries.[19] By drawing up two lists of drugs, "soft" and "hard," hoping that users of illegal drug will only use drugs on one of those lists, is utopian. Once the genie comes out of the bottle, there is no pushing it back in, and this drug specter is already haunting the Netherlands. Hopefully, the Dutch experience may serve as a warning to other countries, as a caution that we must protect our society and our children when drugs can play such an important role in daily life that they disturb families, the environment, business, and peace. Why the treaties governing narcotics came about is clear; it is now up to us to stop the demand in drugs, so the supply will dry out. If our children cannot depend on us to protect them, what kind of future do we face?

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Our Future Depends on Our Children

Any parent or concerned citizen with an awareness of the drug problem should really ask themselves a number of questions about drugs:

- Do you accept that your child takes drugs for non-medical purposes?
- Do you think it normal that drugs are freely available?
- Do you want your child to be used by drug dealers?
- Is the Dutch drug control policy really as successful as the Dutch Government believe?
- Do you want to help your child stay off drugs?
- Do you want to know what 27 years of the "new" Dutch drug control policy has lead to?
- What can be done to prevent and stop drug abuse?

Parents A Natural Preventive Against Drugs helps you find your own answers to these and many other questions regarding drugs. The book gives an overview of the main drugs, the dependence mechanism and the role of the United Nations in international drug control. It explains the dangers caused by drug abuse. It provides the necessary information to explain drug hazards to young people.

About the Author

The author, Renée Besseling, is a mother of two children. For the last 20 years she has been involved in the struggle for a restrictive drug control policy in the Netherlands and Sweden. She is co-founder of Europe Against Drugs (EURAD), and currently the International Secretary of the organization. She is a local chapter chairperson of Swedish Immigrants Against Drugs (SIMON) and an international delegate to Drug Watch International (USA).

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