Knowledge gained through experience in young problem drug users: reflections on interventions and change
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Chapter 1

General introduction
This thesis reports on a number of studies that were conducted at the Public Health service of Amsterdam. The introduction in chapter 1 situates these studies within a broader perspective. First I give some background information on the characteristic drugs used by the Amsterdam problem drug using population. Then, prevalences of the Netherlands and Amsterdam problematic drug using populations are given, followed by a description of the consequences of use. Finally, an overview of the main interventions is given. The second part elaborates on the emergent (1,2) and complex method of qualitative research. To cope with the problems of drug use behaviour, to my opinion it is also important to use the expertise of drug users themselves. Knowledge gained through experience therefore is important and qualitative research is ideally suited to explore their lived experience of drug use. Part three of the introduction describes the objectives of the thesis, followed by the thesis’ structure. Then the specific research questions are described.

1.1 Problem drug use

A brief historical outline
In this thesis it is predominantly spoken about problem drug use. In 1998, a working group of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defined ‘problem drug use’ as ‘injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. Ecstasy and cannabis are not included’ (3).

The use of natural opium and coca has a long history. Stories of the ancient Greeks and the native inhabitants of Latin America already refer to the use of opium and coca leaves (4,5).

Until the 19th century, opium and coca leaves were used without many restrictions (6). From then these substances gradually were introduced into official medical practice. Opium and later morphine and heroin were increasingly used as painkiller, calming agent and because of the effect of feeling high and pleasant. Coca and later cocaine were used as a stimulant, as a cure for alcohol and opiate addiction, as a local anaesthetic and because of its energetic, active and sociable effect. At the end of the 19th century the use of these substances became more popular and a growing fear of addiction developed among the public (7). International legislation and the availability of alternative medication gradually reduced the medical use of heroin and cocaine in the first quarter of the 20th century (8). Nevertheless, none of the bans on heroin and cocaine have been successful in convincing users to abstain and from then use of illicit drugs still persisted.

Heroin and cocaine can be swallowed, snorted, inhaled and/or injected. Although injecting drug use was introduced at the end of the 19th century problematic injecting use of mainly heroin, was first seen in the early 1960s in North America and a few years later in Europe (6). At present roughly 60% of problem drug users in Europe are drug injectors, i.e. around 750.000 (9). The proportion of injectors in Europe varies considerably between countries and has changed over time, with levels of injecting falling in almost all countries during the 1990s. In recent years, problematic injecting drug use has spread especially in developing or transitional countries like south-east Asia, eastern Europe, parts of Latin America and West Africa (10).
In the Netherlands, before 1972, opium had been used on a small scale. Thereafter, the number of heroin users and the concomitant problems escalated rapidly. Heroin was introduced in Amsterdam in 1972 when the withdrawal of US forces from Vietnam forced south-east Asian syndicates to seek new markets for their heroin production (11). In this period it was mainly injected. In 1974, there was a second wave of heroin users among emigrants from Surinam. Single male Surinamese adolescents came to play a major role in the heroin street trade, and many became users themselves. As a result of initial contacts with Chinese dealers and users they preferred to smoke the heroin by heating a tin foil from underneath and inhaling the vapour. This mode of smoking (chasing the dragon) is indicated in Dutch as ‘chinezen’. In Amsterdam, the third wave occurred in approximate 1977 among native socially disadvantaged young people. Half of this group used their drugs by injection, the other half adopted the Suriname practice. An additional problem was the large number of illegally resident foreign drug users (mainly Germans), who took heroin intravenously (12). Nowadays, the vast majority of heroin users in Amsterdam and other parts of the Netherlands administer the drug by ‘chinezen’. Only recently the prescription of heroin for chronic treatment-resistant heroin addicts experiences an upsurge in the Netherlands (13).

The history of methadone is much shorter. For lack of opium this synthetic substance was developed for analgesia prior to World War II in Germany (14). After the war Isbell and Vogel found that methadone could be used effectively as a substitute for heroin. They replaced heroin by methadone and slowly reduced it. Because more than 90% of the patients relapsed to heroin again alternative forms of treatment were looked for (14). A treatment in which methadone dosages were maintained was developed by Dole and Nyswander in 1964 (15). High dosages of methadone has been proved to reduce heroin use and has become the main treatment for heroin addiction. Nowadays in Europe, approximately 275,000 heroin users are treated with methadone (9).

Although coca has been used for thousands of years and cocaine for about hundreds, American cocaine users started smoking crack or freebase since the 1970s (16). Crack is smokeable cocaine. It gained its name from the ‘crackling’ sound it makes when heated. Because cocaine powder (cocaine hydrochloride) vaporizes at the high temperature of 195° Celsius, it was impossible to smoke. So it was necessary to change the chemical composition. This process of converting cocaine powder into crack entails the use of baking soda or ammonia, water and heat. Crack melts at a much lower temperature (98° Celsius) and can be smoked in a base pipe (basing) or from aluminium foil (‘chinezen’ / chasing the dragon). When crack is smoked, it enters the bloodstream quickly, providing an almost instant and powerful ‘rush’ within approximately six seconds. Its highs are higher and its lows (crash) are more severe than if snorted or injected. Crack provokes excessive and compulsive use. The fierce crash almost immediately demands for renewed use. Crack was a ‘marketing innovation’ (16). Because of the pharmacokinetic properties of the drug, the ease of administration, availability of ready-to-use substance and relatively low cost per dose, basing cocaine appears to be attractive to many hard drug users and epidemics soon were reported in many large American (17) and European cities (18). The scene is changing because of crack use, and knowledge about these populations is still scarce. Through this new substance the climate in the traditional opiate circuit became tougher and more aggressive. Freebase and associated behaviour turned out to be violent,
harmful, and difficult to control. In combination with no food or sleep, a base binge can lead to total exhaustion and contributes to the process of marginalisation.

In the Netherlands, the inhaling of base cocaine entered the traditional opiate circuit in the early 1980s (19). In the beginning users themselves prepared base coke from cocaine powder. During the 1990s, however, ready-to-use base coke or crack was increasingly available on the streets.

Prevalence of problem drug use
Although most experimenters with drugs are unlikely to maintain use or to experience drug-related problems, a substantial minority will develop problem drug use. However, due to the nature of illicit drug use behaviour, the degree of dependability of current estimation methods and data quality, exact incidence and prevalence numbers are difficult to obtain.

The EMCDDA reports changes in estimates, suggesting increases in problem drug use since the mid-1990s (9). Out of 16 European countries, eight report higher estimates of problem drug use (Germany, Spain, Italy, Luxembourg, Finland, Sweden) or injecting drug use (Belgium and Norway) during the 1990s. The highest rates are reported in Italy, Luxembourg, Portugal and the United Kingdom (6-10 per 1000 inhabitants aged 15-64). Rates are lowest in Germany, the Netherlands and Austria, each with about 3 problem drug users per 1000 inhabitants aged 15-64. Probably around 60% of problem drug users in the EU are drug injectors, i.e. around 750 000 of the EU’s estimated 1 – 1.5 million problem drug users.

For the Netherlands estimates show a number of 33.000 problem drug users in 2001 and declining numbers of injecting drug use (20). Heroin use has been in decline over the past few years and the epidemic seems to be in its final phase. Cocaine use, however, is increasing in the last few years and especially sniffing coke has become more prevalent. Although mainly in large cities and principally among primary opiate users the relatively high prevalence of crack cocaine use is causing increasing concern in the Netherlands.

Over the past few years the number of problem drug users in Amsterdam has stabilized and the total for 2005 was calculated at about 4000 persons (21). The injection method has been virtually abandoned, and current estimates indicate that only 10% of users use their drugs intravenously (22). Since 1990, the heroin population in the city has stabilized. Not only the number of foreign users (Germany) has reduced, but also the number of Dutch users from out of town. The number of young heroin users has fallen dramatically and the average age of the heroin population is rising quickly. Amongst young people, heroin has gained the image of a taboo drug for ‘losers’ (22). In Amsterdam, however, cocaine use is widespread. A study reports that 10 percent of the citizens of 12 years and older have used cocaine at some point, and that 1.2 percent used cocaine during the last month (22). A population study shows that current use of cocaine among subgroups rises till 14% in 2003 (23). The majority of support requests received by the addiction intervention agencies concern smoking cocaine base or crack. The users of cocaine base mostly are members of minorities and the use often coincides with contacts with the judicial authorities. The street drug users who smoke cocaine base usually combine this with heroin (24).
Consequences of problem drug use
Injecting drug use or long duration/regular use may lead to severe problems on many levels.
Damage to physical health includes accidental injury, disability, or even death; perhaps when driving, or at work, or by being involved in violence, drowning, burning or fatal falls (25). Problem drug users also have considerably higher risks for morbidity than the general population (26). Physical complaints, which at first appear to be innocent, can lead to a serious problem within a relatively short time. In a hard-pressed existence in which getting and using drugs is the primary objective, bodily care mostly has a low priority. Health problems therefore are often associated with self-neglect and a reduced resistance. The damage to physical health includes serious weight loss, exhaustion, diminished resistance, lung and heart complaints, and chronic infections. Data from EU countries show that 60% of problem drug users use their substance of choice intravenously. This goes hand in hand with the fact that an increasing number of heroin users are also injection cocaine users, taking numerous injections each day. This results in extremely high levels of risk for infectious disease transmission. Estimates suggest that in the EU, HIV prevalence within injection drug user populations in different countries ranges from 0.5 – 32%, and that the majority of injection drug users are Hepatitis B and C infected. Injecting drug users have a mortality rate 12-22 times greater than their peers (25). In the European Union, the total number of acute drug-related deaths was estimated to be 7.419 in 1996, having increased from 6.819 in 1992 (9).
There may be mental health problems as well (25). Depression, lack of emotion, restlessness, nervousness, sensory hallucinations, aggression, anxiety, paranoid behaviour, and acute psychosis. Family problems are common, as parents and relatives find it increasingly difficult to cope with a person who persists with substance misuse. Finally, research has indicated that the majority of problem drug users have social problems. There is often evidence of a complex marginalisation process; most problem drug users are unemployed, use welfare benefits, and are homeless. The need to obtain funds to purchase substances for misuse often leads to criminal behaviour and legal problems. Criminological estimates suggest that a considerable share of property crime, especially in urban areas, occurs in the form of acquisition crime committed by problem drug users (27,28). Self-report data from users indicate that drug purchasing expenses often accumulate to 100 – 200 Euro each day.

Prevention, cure and care of problem drug use
Societies differ in their approach to problem drug use. Three major orientations are criminalization, medicalization, and harm reduction (29). The first approach means prohibition of possession and distribution of drugs and needles. Medicalization defines the problematic use of drugs as a chronic relapsing disease. In the pragmatic, public-health-oriented harm reduction approach “one should try to minimize drug-related health damage, reduce deaths, and mitigate public nuisance” (9).

In most European countries a combination of medical and harm reduction interventions have been developed for heroin dependent patients, including prevention programs (universal and targeted prevention), crisis intervention, abstinence-oriented interventions (detoxification and relapse prevention), low-threshold methadone maintenance, the recently (1998) implemented trials with the medical prescription of heroin to chronic
treatment resistant heroin dependent patients, and other harm reduction measures as there are needle exchange programs (NEPs) and the various forms of users rooms. When looking to the efficacy of mentioned interventions one can say that only a handful of mainly targeted prevention programs are of proven effectiveness (25,30). Crisis intervention can be effectively handled with naloxone for patients with an overdose. Abstinence-oriented interventions are effective only for a very small group of motivated patients in stable living conditions who have adequate social support (31). We also can say that many patients do not benefit sufficiently from low-threshold methadone treatment because improvement or even stabilization is not possible (32). The results of the maintenance treatment trials with medically prescribed heroin show some improvements in the areas of physical and mental health and criminality (33). However, patients remain strong dependent on methadone and heroin prescription and mostly patient are not able to work.

Particularly in the United States, where crack cocaine use appeared approximately ten years earlier then in the Netherlands, efforts have been made to develop an efficacious pharmacotherapy for cocaine dependent patients. Several of these treatments were reviewed and from the findings it was concluded that no effective medication has yet been identified (33). Psychotherapeutic interventions for cocaine addiction also produce modest results. An American study by Rawson et al. (34) recommended a behavioural approach resulting in several new potentially effective interventions, including methadone maintenance combined with contingency management, community reinforcement approach with vouchers for cocaine free urines, and co-prescribed heroin and methadone supplemented with contingency management. However, support for its effectiveness in severely addicted crack cocaine users is limited.

The majority of European countries have included in their drug strategies a variety of additional interventions. Some of these new concepts developed in the Netherlands and especially in Amsterdam are mentioned here (22).

Many problem drug users have severe psychiatric problems. Realizing compulsory admission (RM) to mental health care in the framework of the Psychiatric Hospitals Act (Wet BOPZ) is possible. Another intervention in the justice setting is the institution for repeat offenders (ISD). Persistent offenders receive an order for two years. In the field-specific co-ordination (Support) patients are tracked on their care pathway through the agencies, with a treatment plan focused on the individual as the starting point and proper care and social functioning as the objectives.

Other care agencies, such as care-in-the-community agencies for homeless people and rough sleepers, the Jellinek clinic, the Street-corner work foundation (SSCW), Amoc, and the Regenboog are also involved with providing help for problem drug users. A relatively new partner is the Amsterdam Department for Work and Income (DWI).

Current interventions mainly seem to stabilize and reduce harm primarily for opioid dependent patients and problem drug use seems very difficult to prevent and cure. The disquiet about the consequences of drug use continue to exist.
1.2 Qualitative research

Knowledge gained through experience
Problem drug use seems very difficult to prevent and cure and interventions mainly stabilize and reduce harm. Looking at the lack of effectiveness of interventions, it is notable that for a long time the vast majority of efforts deployed to reduce substance misuse are supplier-driven, top-down, and mainly based on ideas and opinions. Perhaps this explains why interventions have failed to impact on rising trends in substance misuse. To develop rational policies and effective interventions maybe one should more often deploy consumer-run interventions and use the experience of drug users themselves to address their health, safety, and legal problems.

In the past 10 years, the imbalance in health care between a supplier-driven demand and a consumer-run demand slowly seems to change in favour of the consumer, till they become more assertive (empowerment) and better informed (knowledge gained through experience) (35). This change has come about due to people living with a disability or condition, who were confronted with the fact that the supply did not meet their demand, on a daily basis, and who were no longer willing to accept that. The people concerned organized themselves in client organizations to make their lives more pleasant by using their knowledge gained through experience. In the Netherlands ZonMw (36) and several research institutes including the Trimbos-instituut, the NIZW, and the Verwey-Jonker Instituut (37), work together with these client organizations.

To my opinion, drug users are the experts on their lived experiences of drug use and their story of experience is a rich source of knowledge. It offers a way of understanding drug use behaviour and related matters because it provides insight in the meanings, perceptions and contexts in relation to their ‘world of drugs’. A story of experience will, however, be told from the viewpoint of the first person and will have a strong personal and subjective character.

By purposely examining several stories of drug user experience, comparing them with others, by identifying common principles, through abstraction, reflection and connection, arises knowledge gained through experience. This knowledge, however, comes about differently to common scientific knowledge, which is arrived at by means of the empirical cycle. Questioning the validity and reliability of knowledge by experience is therefore relevant. We need to avoid arriving at conclusions which are unfounded.

Knowledge gained through experience and any advice resulting from it will only be of value if it is arrived at in a systematic, transparent, reproducible manner and if it can be tested. The qualitative research method is pre-eminently suitable for the assembly of knowledge gained through experience. This research method focuses on the stories of the experiences of addicts, with their meanings, perceptions, processes and contexts of the ‘world of drugs’. It offers ways of understanding drug use behaviour, patterns and related responses. The qualitative researcher pre-eminently tries to become an expert by experience in the subject of its research. Qualitative researchers use a framework of concepts relevant to people’s individual experiences, and in this framework a distinction is made between ‘emic’ as opposed to ‘etic’, ‘induction’ as opposed to ‘deduction’ and ‘verstehen’ as opposed to ‘explaining’ (39). Qualitative researchers have an eye for
people’s motives for making particular choices, as well as for the experiences people have personally lived through with all associated aspects and attributed meanings. Qualitative methods therefore are ideally suited to understand the lived experience of drug use from drug users’ perspectives.

In the next two paragraphs I elaborate on the qualitative research method. First a summary of the theoretical perspective is given, followed by a description of qualitative research practice.

Theoretical perspective of qualitative research
The beginnings of qualitative research on drug use behaviour started more or less with De Quincey’s *Confessions of an English opium eater* (1822). The origins of qualitative research may be traced to symbolic interactionism in sociology, which emerged in the 1920s and 1930s, led by the Chicago school. This major sociological perspective (paradigm) on human behaviour has a long intellectual history, beginning with the German sociologist Max Weber (1863-1920) and the American philosopher, George H. Mead (1863-1931). Herbert Blumer (1900-1987), a student and interpreter of Mead, is responsible for coining the term, ‘symbolic interactionism’, as well as for formulating the most prominent version of the theory. Blumer notes:

*The term ‘symbolic interaction’ refers, of course, to the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or ‘define’ each other’s actions instead of merely reacting to each other’s actions. Their ‘response’ is not made directly to the actions of one and another but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use symbols, by interpretation, or by ascertaining the meaning of one another’s actions. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behaviour* (38).

Other perspectives, such as ethnography and phenomenology also influenced qualitative research. All of them emphasized the socially situated nature of individual action, and demonstrated the value of qualitative methods to understand the subjective meanings and socially contexts of behaviour.

In his handbook ‘Strategies for qualitative research’ F. Wester describes mentioned perspectives and offers a simplified summary, concentrating on points of convergence (39).

1. Qualitative researchers base their theoretical perspective on their image on humans, rather then on their image of society and focus on the subjective aspects of social life.
2. For qualitative researchers, humans are pragmatic actors who continually must adjust their behaviour to the actions of other actors. We can adjust to these actions only because we are able to interpret them, i.e., to grant meaning to the actions of other actors, to their behaviour. Interaction and meaning are closely related. ‘Human beings act on basis of the meaning which they grant to the situations in their world’ (39). The object of social sciences therefore is the already pre-interpreted reality of the actors and not something like the ‘real reality’ which precedes the interpretation of the actors.
3. To study behaviours of people as meaningful actions the research worker must see the world from the insider’s perspective. ‘The primary task of the research worker is to gain access to the actor’s point of view to reconstruct his reality’ (40). In the terminology of
Mead this ‘role taking’ means the capacity to move yourselves in the position of another one. In this context the term ‘emic’ is used. An ‘emic’ account of behaviour is a description of behaviour in terms meaningful and familiar to the actor. In this way the researcher tries to understand (‘verstehen’) the actor.

4. Important is the ‘direct examination of the empirical world’ by which Blumer (1969) means that the researcher, with a global idea (sensitising concept) in his head has to look for direct contact with the studied social reality. In this context it is that Glaser & Strauss (41) talk about ‘grounded theory’. Theories and terms must emerge from this direct contact with social reality.

5. What most differentiates qualitative research from much other research is that it is explicitly theory emergent (inductive approach). It does not test a hypothesis, it is driven by the data in such a way that the final shape of the theory is likely to provide a good fit to the situation. The aim is to understand the research situation by ‘discovering the theory implicit in the data’ as Glaser & Strauss (41) framed it. Induction enables the discovery of plural, and competing, interpretations of drug use.

6. The meaningful reality of the studied actors must be objectified in terminology. The core of the qualitative analysis lies in this process of reconstruction to objectivation. In qualitative analysis practice this objectivation is reached on by passing cyclical again and again through data collection and analysis, refaction and testing.

**Qualitative research practice**

Each research begins with a research situation. Within that situation, the task of a researcher is to understand what is happening there. He/she is doing this by formulating one or more research questions.

Next, the researcher has to make a choice out of a variety of data collection methods such as; participant observation, direct observation, case studies and semi-structured in-depth interviewing. In the qualitative studies described in this thesis was chosen to work with the last one. Semi-structured in-depth interviewing was considered more suitable. First, our primary objective was to achieve an understanding of drug use behaviour and information about motives, reasons and processes was needed. Second, finding respondents was considered very difficult, when you find one you must collect your data immediately. Finally, although the researcher has some core questions, there is only a semi-formal protocol and the interviewer is free to move the interview in any direction of interest and explore in-depth the topic (39).

The researcher then tries to put together as diverse a sample as possible. Mostly a small initial sample of about 4 to 6 respondents is enough. According to a semi-structured protocol the researcher poses open-ended questions facilitating the free expression of feelings, perceptions, and beliefs during these interviews. To minimize recall bias, the researcher may attempt to assist the interviewees by using a chronological interview structure and by referring to biographical landmarks as they recall early behaviour. During the interviews the researcher may note down the key issues, ‘note taking’. However, speaking for myself I think it is very important to concentrate on the interviews without making any ‘notes and recommends tape recordings and word-by word transcripts.

To interpret phenomena in terms of the meanings people bring to them the transcripts are used for the content analysis (42). With the research question(s) in his head the researcher reads the interview transcripts for the first part of the analysis. He takes a
sentence at a time and examines it. The task of the researcher then is to identify
categories and their properties (in effect their sub-categories) and asks himself; what
possible answers to the research question(s) are suggested by that sentence? In effect, a
category is a theme or variable which makes sense of what your informant has said. It is
interpreted in the light of the situation the researcher is studying. Identified categories
are coded by the researcher and checked over by a second researcher for inter-
subjective reasons.
In this first part of the analysis constant comparison is important. The researcher
compares interview to interview and codes the second transcript with the coded
categories from the first transcript in mind. Then the researcher again compares and
codes the subsequent transcripts each with the already coded categories in mind. New
categories also emerge from the transcripts and the first transcripts have to be analysed
again with these new categories in mind. During this cyclical process ideas and rapport
develop and certain theoretical propositions will emerge to the researcher. These may be
about links between categories, or about a category which appears central to the study,
a core category. As the categories and properties emerge, they and their links to the core
category provide the theory.
While analysing an idea occurs to the researcher, he pauses in what he is doing and
writes himself notes about it, memoing. A memo is a note to yourself about some
hypothesis you have about a category or property, and particularly about relationships
between categories.
After cycles, categories will be found to emerge with high frequency of mention. If they
can be connected to the other categories which are emerging we call them core
categories. It is hazardous to choose a core category too early in the data interpretation.
When a core category has been identified, the researcher stops coding any sentences
from the transcripts which do not relate to it. In most instances the coding rapidly
becomes more efficient as the analysis progresses. The researcher now only codes for
the core categories, connected categories and their properties. As the coding proceeds
the researcher records any identified connections between categories in memos.

The researcher continues the described analysis process, adding to the sample as
necessary, until the transcripts add nothing to what he already knows about the
categories, their properties and their relationships. The researcher then seeks to add to
the sample through theoretical sampling. This is purposive sampling which increases the
diversity of the sample. It is a search for new core categories and their properties with
the purpose to strengthen the emerging theory. When theoretical sampling no longer
produces new core categories, or add to the already found ones, their links and their
properties, saturation is achieved and the researcher no longer adds new transcripts to
the sample. For the researcher this is the sign to group his memos.

Memoing continues in parallel with data collection and analysis, and in time the core
category and the categories related to it will have saturated the researcher will have
accumulated a large number of memos. Between them are memos who capture the
important aspects of the theory which has emerged from the data.

In short, in using the prescribed methodology the researcher assumes that the theory is
concealed in the data for him to discover. Coding makes visible some of its components.
Memoing adds the relationships which link the categories to each other.
The next task is the sorting of the coded categories and their properties. One may use cards with the categories and properties written on them. Speaking for myself I prefer to group on paper the different properties with their transcripts under their subsequent categories. This provides the basis for writing the report, which follows.

Having done all this -coding, memoing, sorting- the writing of the ‘results’ mostly is not a difficult job. The sort structure is the report structure.

In the qualitative studies described in this thesis, I followed this methodology; identifying informants who directly experienced the phenomenon in question, interviewing them at length so that they tell their story, then analysing the interviews, code, checking over, compare and finally, determine what the generalizable themes may be.

**Qualitative research and Dutch drug policy**
Till the 1970s Dutch drug policy was mainly based on a priori ideas and opinions. However, from then on drug policy has been based more and more on scientific research. Mostly of epidemiological, sometimes of a social scientific nature (43). The 1972 report of the Baan Committee for instance, broke through by identifying and using existing social scientific research. This report, had its impact on Dutch drug policy and culminated in the revision of the opium act in 1976. The revision led to decriminalisation of cannabis and to higher penalties for ‘drugs with unacceptable risks’ (hard drugs). The ‘separation of markets’ concept aimed at keeping experimenting young users away from drugs like heroin. The revision declared drug concerns foremost as a public health problem.

In 1985, the Dutch Government published another policy paper, ‘Drug policy in motion: towards a normalization of drug problems’, in which guidelines were formulated for the period 1985-95. This policy paper was based on a study by Janssen and Swierstra (44). These authors concluded that the existing policy measures for reducing supply and demand were unsuccessful. They proposed alternative interventions, ranging from legalization of drugs to compulsory treatment. Although the Dutch Government did not accept all recommendations made, the study had an identifiable impact on Dutch drug policy. The leading concept in this revised policy was ‘normalization’ which means the admission that illicit drug use has obtained a firm foothold in society and unrealistic to eradicate drugs and related problems. It appeared more realistic to try to contain the damage caused by drugs and abuse, to cope with attendant problems and to manage them. “With regard to illegal drugs, this meant government would fight organized crime, drug trafficking and the retail trade, while simultaneously integrating or encapsulating drug users in ‘normal’ society” (45).

Because of drug-related public nuisance in Amsterdam, a new policy paper was formulated in 1993. This paper was based on a study of the lifestyle and economic behaviour of opiate users by Grapendaal et al. (46), using quantitative and qualitative methods.

Another example I mention here is the 1995 policy paper, ‘Dutch drug policy: continuity and change’. In the list of references many qualitative studies are mentioned.

Even today, qualitative methods influence Dutch drug policy, I mention two important projects for monitoring and prevention purposes. The Drugs Information Monitoring System (DIMS) which is coordinated at national level and has two objectives: to monitor which drugs are in circulation and to prevent health damage owing to their use. The
Amsterdam Antenna project analyses four kinds of data and formulates policy recommendations for preventive interventions and local drug policy.

### 1.3 Objectives, structure and research questions of the thesis

**Objectives**
The main objective of this thesis is to enhance the understanding of problem drug use behaviour for developing rational policies and effective interventions with the help of knowledge gained through experience of problem drug users and the qualitative research methodology. By focusing on six more specific problems of particularly the new generation of drug users, I also want to make a contribution to the solution of problem drug use in Amsterdam. Finally, I hope to encourage a wider appreciation of the contribution that qualitative research can make.

**Structure**
The core of this thesis are six chapters, each of which includes an independent study about a more specific drug problem in Amsterdam. All studies are published or submitted for publication in national and international scientific journals. Since each of the chapters include in essence a complete study with an abstract, introduction, method, results and discussion some overlap exists in the description of the methodology. It concerns one epidemiological study and five qualitative studies. The epidemiological study and the first three qualitative studies concern drug use behaviour, the other two qualitative studies focus on health care.

**Research questions**
The Amsterdam drug problem has primarily been interpreted as a heroin problem. Both treatment services and research are mainly focused on heroin users and, during the 1980s, with the spread of HIV more specifically on injecting drug users. However, since the 1990s the heroin epidemic of Amsterdam has started to decline and as in other European countries cocaine use is in the rise and has gradually become more dominant (47). A recent study among young problem drug users in Amsterdam revealed that crack cocaine was the most popular substance (48). In chapter two we try to find an answer to the question whether these crack cocaine users are at risk to start using heroin or change their mode of administration towards injecting?

In Amsterdam the current situation is still alarming, mostly because of a substantial minority of about 4.000 problem drug users (21). These users mostly live a highly marginalized existence as indicated by inadequate housing, high levels of criminality and detention, bad health status, polydrug use, and high levels of prostitution and psychiatric co-morbidity (49). Among them a relatively new group of primary crack-addicted young users, for whom there are only few treatment facilities. To reduce the use of drugs, new strategies using information about the perceptions and purposes of initiation from the perspectives of young problem drug users are to be developed. In chapter three therefore we look for new answers to the question: which factors facilitate the initiation of cocaine and heroin among problem drug users?
Additionally, we see injecting drug users (± 10% of 4000) (22) who are at increased risk of a range of health problems. Reducing the number of injecting drug users therefore is of utmost importance. Although the number of injecting drug users is decreasing (50), some level of risk seems hard to prevent and injecting continues in Amsterdam, especially among young drug users. Twenty to thirty percent of the reduction in injecting drug use in Amsterdam can be attributed to death and migration of drug users (50). In addition, mentioned study has shown that not commencing injecting drug use and especially cessation of injecting drug use are causative factors in reducing the number of injecting drug users in Amsterdam. Therefore, it is important to really understand injecting drug use and in chapter four and five we look to find an answer to the following two questions: (1) what are the motives of young drug users for initiation into injecting and for not injecting? (2) what are the motives and methods of drug users in relation to cessation of injecting drug use.

Amsterdam has long-standing and accessible health care services. There is nevertheless evidence that there are some problems. A number of young marginalized users stay out of contact with these services. Anecdotal indications from young problem drug users and workers in the field reveal a variety of unmet needs and obstacles to health care use. This seems particular true for primary crack-addicted young users, for whom there are few treatment facilities (49,51). Knowing how problem drug users view the factors that deter them from health care use, should enable future interventions to be targeted more precisely at issues that are personally relevant for them. In chapter six therefore we want to find an answer to the following two questions: (1) what are the most important health care needs among young adult problem drug users? (2) what are their help-seeking experiences and the barriers to health care use that they perceive?

Finally, in chapter seven we address another important health care problem. The current highly active antiretroviral therapy (HAART) allows for long-term suppression of HIV-replication (52,53). It is essential however, that prescribed nutritional guidelines, combination and amount of medicines and administration times are rigorously adhered to. Imperfect adherence may be HAART’s Achilles’ heel. With HAART, however, the threshold of therapy to be effective is at 90% (52), or even at 95% (54) according to a recent study. This high minimum threshold for HAART has important consequences for problem drug users because they are relatively often excluded from therapy in advance, due to the fact that they are expected to show poor adherence (55,56,57). The problems drug users have in relation to HAART, need to be resolved urgently. Therefore, it is important primarily: to gain more insight into the extent of adherence to HAART, and secondly, to take a closer look at factors which may impede or facilitate adherence, in order to develop strategies for improvement.

**Amsterdam cohort study**

All studies presented in this thesis are performed as part of the Amsterdam cohort study among drug users. This is an open cohort study, which started in December 1985. Recruitment and follow up are ongoing. Participants of this original cohort were recruited via the methadone programs, through the special STD clinic for drug using prostitutes (until 1997) and to a lesser extent by word of mouth. Those who enroll are asked to return every six month for follow-up visits, at which time a questionnaire is completed.
and blood is collected for testing and storage. As an incentive, participants are paid eleven euro.
Because the problem drug using population in Amsterdam has changed in the late 1990’s, it was important to invite a new generation of problem drug users to participate in this study. New data was needed and the YOung Drug users in AMsterdam (YODAM) study was set up in the year 2000 so that specialized programs may be developed that address the needs of these younger users.
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