Executive summary

Developments in drug law and policies (chapter 1 and 9)

This National Report reviews the developments in the drug policy of the Netherlands up to the letter of the 19th of November 2012 of the Minister of Security and Justice (TK 24077-293) informing the House of Representatives on the policy consequences of the measures announced in the Coalition Agreement for the Rutte II Administration, that was presented on the 29th of October 2012.
The Dutch Opium Act places drugs with an unacceptable risk on Schedule I and places other drugs on Schedule II. The Opium Act and the Opium Act Directive have been subject to changes:
• Since May 2012 mephedrone is placed on schedule I of the Opium Act.
• GHB was categorised as a hard drug (schedule I) under the Opium Act (Stb 2012 – 201). GHB was categorised as a schedule II drug before.
• 4-MA, a precursor of amphetamine, was brought under the Opium Act as a hard drug (schedule I) because of the high health risks (see also chapter 10).
• Qat will be placed on schedule II of the Opium Act; legislation is in preparation.
• A new article to the Opium Act is in preparation (article 11a), which aims at criminalisation of activities that prepare or facilitate the large-scale professional illegal cultivation of cannabis. The article aims especially at so-called grow shops.
• In 2011, an advisory committee advised to classify cannabis with a THC concentration of 15% or more as a hard drug. Implementation is announced in the plans of the new Cabinet (Rutte II) of November 2012 and in a letter of the minister of Security and Justice (T.K. 24077-293).
• No generic legislation will be initiated for new psychoactive substances.
• In reaction to a verdict of the Council of State, which stated that the use of cannabis implies the possession of cannabis and as such is an offence according to the Opium Act, the Opium Act Directive is changed: instead of decreeing that a police dismissal should follow if a cannabis user is caught with less than 5 grams of cannabis, it says now that *in principle* a police dismissal will follow in these cases. This opens the way to arrest and prosecute persons who possess less than 5 grams of cannabis (for instance: drug dealers who could not be prosecuted before because they carried only a small amount of cannabis).
• Since June 2011 the Directive states that when the police detect cannabis cultivation sites, the most important criterion to prosecute will be the degree of professionalism and not the number of plants. Before, if people were caught with five or fewer plants, the Directive ordered that the case should be dismissed.
• The Opium Act Directive was extended with two new criteria for coffee shops: the closedclub criterion and the criterion that club members must be inhabitants of the Netherlands. The criteria were enforced since May 2012 in the three southern provinces. Enforcement in the other provinces was envisaged for January 2013. After the Coalition Agreement – in November 2012 - the minister of Security and Justice announced that the closed-club criterion will be cancelled, but that the resident criterion will be introduced nationwide by the 1st of January 2013. Enforcement will be implemented in consultation with the municipalities and, if necessary, in phases.
• A change in the Code of Criminal Procedure is in preparation which will make it possible for the police to check the use of alcohol and drugs amongst suspects of violent crimes. The use of substances will be an aggravating factor in the sentencing of these cases.

Developments in drug use in the population and specific target groups (chapter 2)

There are no new data on drug use in the general population.
Overall, prevalence rates of cannabis and other drug use among pupils of secondary schools of 12-18 years peaked in 1996, decreased afterwards and remained stable between

2007 and 2011. In 2011, 17.6% had ever used cannabis, 2.6% ecstasy en less than 2% amphetamine, cocaine or heroin.
Various indicators strongly point at an increase in the (problem) use of GHB in some subpopulations both in and outside the nightlife scene. Several qualitative and quantitative studies have been carried out in 2011 and 20012 on profiling GHB users. Different user groups have been identified, which can be partly characterised on the basis of their main location of use (users in the nightlife scene, at home users, hanging round youth and marginalized users).

Developments in prevention (chapter 3)

In the Netherlands the municipalities are responsible for carrying out health prevention programs. They are usually carried out in co-operation between prevention departments of the institutes for addiction care and the public municipal health services, schools, neighborhood centers and different health promoting institutes, which support these organisations. The Ministry of Health, Welfare, and Sport (VWS) coordinates the prevention activities, which are part of a broader scope of public health prevention.
In the Netherlands prevention activities are focused increasingly on young people at school or in nightlife and high risk groups. Examples are the project Healthy School and Drugs, the program Open and Alert in the residential child care, youth work, youth custodial institutions, and facilities for people with mild or borderline intellectual disabilities.
On the other hand the Ministry of Health, Welfare, and Sport stopped the funding for nationwide mass media campaigns in 2012. On a local level diverse initiatives are taken like a new GHB-campaign "Fainting is never ok" in Amsterdam.
In 2012, the government announced that in 2013 the minimum legal age for the provision of all alcohol containing drinks will be increased to 18 years. The Secretary of State has a legislative proposal in preparation to increase the minimum legal age for the provision of tobacco from 16 to 18 years. The announced measure to implement a national distance criterion of 350 metres between coffee shops and secondary schools and schools for professional education schools was not mentioned any more in the Coalition Agreement for the Rutte II Administration. In a letter to the Parliament from 19-11-2012 the minister of Security and Justice announced that, because of the choice for tailored local approaches, the distance criterion of 350 metres will not be imposed by national rules – i.c. in the Directive of the Opium Act (T.K. 24077-293). However, municipalities can decide themselves which distance criterion is necessary in the local situation.
Since 2011 the government has a law in preparation to oblige persons to cooperate with the testing on alcohol and drugs in case of violent crimes. The intention of this measurement is to aggravate the sanction in case of the use of alcohol and drugs in violent crimes. This law is expected to be operational in 2013.

Developments in problem use (chapter 4)

Various indicators point at a decreasing number of problem opiate users in the past decade (18,000 in 2008). The majority of these users also consume crack (basecoke). Similarly, a study among crack users in the cities of Amsterdam, Rotterdam and The Hague showed that almost three-quarters had also consumed heroin in the past month. There is no national estimate of the absolute number of crack users, including those who do not use opiates.
While health and treatment indicators point at an increase in the number of problem (dependent) GHB users, the size of this population is not known.

Developments in treatment (chapter 5)

In June 2012 the major stakeholders agreed on the Governmental agreement future mental health care 2013 – 2014. With this agreement the stakeholders intended to consolidate the quality of care on a high level and to keep the care affordable in the future: the mental

healthcare institutes (including addiction care) and the health insurance companies have to make arrangements to reduce the number of beds in residential mental health care, including the addiction care. In the coming years the parties involved will lay emphasize on outpatient care, the General Practitioner and E-health interventions, this with the intention to reduce the demand for residential care.
In 2011 and 2012 the quality management care program Scoring Results for the addiction care continues, this program aims to improve permanently the quality and effectiveness of prevention, treatment and care. In this context a few new guidelines were published in this period.
Benchmarking is considered in the Netherlands as a tool to improve the quality management of health care in general. Therefore diverse measurements are conducted (ROM and CQ-Index) and centrally gathered. Mid 2013 a new quality institute in health care will be installed. The objective of this institute is to improve the client-centricity, quality, safety, effectiveness, and efficiency of care. Until now these tasks are currently administered by different organisations.
In September 2012 three draft versions were published of a treatment protocol for treating GHB addiction, meant for different settings.
Since January 2012, patients of addiction care and mental health care organisations had to pay an own contribution. According to a large part of the care giving organisations, as a result of this measure, more patients stopped their treatment prematurely, fewer outpatients were registered and the number of crisis admissions increased. By the end of 2012, the government made clear that his measure will be withdrawn.

Health correlates and consequences (chapter 6)

The incidence of HIV and hepatitis B and C among (ever) injecting drug users remains low since many years. HIV is mainly transmitted through sexual contact (both through men who have sex with men (MSM) and heterosexuals) and drug users only play a marginal role in new infections. However, the burden of especially chronic hepatitis C infection stays high.
Since 2009, data are collected on drug-related health emergencies seen by four types of medical services (ambulance transportation services, emergency departments in hospitals, forensic doctors and organisations with a first aid medical post at large events) in eight regions. The data show large differences in characteristics of the emergencies between the medical services and between regions. Emergencies related to GHB use are relatively frequent, taking into account the rather limited use in the general population. Ecstasy intoxications were the most prevalent acute medical problem after drug use at the first aid medical posts at parties. Although in 90% of these emergencies the level of intoxication was light, there are some indications for an increase in the level of intoxication between 2009 and 2011 (more intoxications in which the level of intoxication is graded as severe), which seems to continue in 2012.
The number of acute drug-related deaths remained low. Between 1996 and 2011, the annual number of recorded drug-related deaths among residents fluctuated between a minimum of only 94 cases in 2010 and a maximum of 144 cases in 2001. In 2011, 103 cases were recorded, including 33 cases relating to opiates, 19 to cocaine and 51 to unspecified substances. The latter category mainly includes death due to multiple substance use, commonly including illicit substances as well as combinations with alcohol and/or medicines. The ageing of the population of problem drug users is reflected in a decreasing percentage of deceased aged 35 years and younger, from 40% during the period 1991 up to including 1995 to 70% during the period 2006 up to including 2011.

Responses to health correlates and consequences (chapter 7)

The monitor for drug-related emergencies collects, in a standardized format, information of the incidence and type of acute emergencies related to drug use, and uses his information

as direct input for preventive measures, both at the level of the professionals in the field as for policy makers (§ 7.2). With regard to the prevention and treatment of drug-related infectious diseases, a strong decrease in the number of exchanged needles and syringes has been reported between 2002 and 2007, with some fluctuations in the years afterwards. Thirty-seven drug consumption rooms were identified in 2010. The population of drug users who utilize drug consumption rooms has decreased in the past due to increased participation of former homeless drug users in social housing projects and a reduced injecting of drug use (although drug consumption rooms are not restricted to injecting users).
Moreover, the national hepatitis B vaccination program for drug users has been ended as of 31 December 2011, as this population is no longer considered as a (behavioral) risk group (§ 7.3.3). The costs of hepatitis C treatment have been estimated at between 9,900 euro and 28,500 euro, depending on genotype, viral response and treatment outcome. In 2012, the guideline for education, screening and treatment for hepatitis C in detention was finalised (§ 7.3.4).

Social correlates and social integration (chapter 8)

Currently, the level of social cohesion in the Netherlands is mainly determined by the degree in which non-Western migrants have become socially integrated. Although in 2011 some indications were found of a structurally better integration of non-Western migrants, stagnation was reported with regard to education, employment, income, and housing. Moreover, migrants are still more involved in crime.
"Social exclusion of drug users" and "drug use among socially excluded groups" are still two sides of the same coin. A literature research and an expert meeting have confirmed that addiction is associated with disturbances of social relations, dropout from school, homelessness, debts, and domestic violence. Among the homeless in the four largest cities, higher prevalences have been found for the use of drugs like cannabis, crack cocaine, sniff cocaine, ecstasy, amphetamines, and opiates.
The institutes for addiction care have consolidated their efforts for social reintegration. Common treatment programs targeting the social reintegration of addicts are given by supported living, daily activities, work experience, participation of Experts by Experience, Assertive Community Treatment (ACT), Functional Assertive Community Treatment (FACT), and the Community Reinforcement Approach (CRA). More specific programs for social reintegration have targeted female sex workers, victims of lover boys, and undocumented people.
Evaluation research has shown positive results for the Community Reinforcement Approach (CRA) targeting alcohol addicts in the city of Eindhoven. Positive results have also been found for interferential care in three regions in the province of North Brabant, social relief for homeless young people in the city of Rotterdam, and for the passing through from social relief to supported living in the city of Enschede. The positive results of Assertive Community Treatment (ACT) and Flexible Assertive Community Treatment (FACT) have been confirmed by the Psychiatric Case Registers (PCRs) in the cities of Rotterdam, Utrecht, Maastricht, and Groningen.
However, in the city of Groningen it was found that a project for supported living in a neighbourhood will only succeed on the condition that the surrounding habitants are involved in the project from the very start. Another condition is that all stakeholders are involved in the final choice of the location for the supported living.

Drug-related crime, prevention of drug-related crime and prison (chapter 9)

In 2011, the majority of criminal investigations into serious and organized crime were aimed at drugs, mostly at hard drugs, and within hard drugs, mostly at cocaine. This picture is the same as in the years before. The total number of drug law cases dealt with by police and Public Prosecution has increased compared to 2010. The increase is substantial, especially with regard to soft drug cases. The proportion of soft drug cases exceeded that of hard drug

cases in 2011. More than half of the cases reported by Public Prosecution (53%) concern soft drugs now.
The majority of Opium Act cases is submitted to court, but the total number of Opium Act cases handled by the Courts decreased. In 2011 the court cases concerned almost as much hard drugs (48%) as soft drugs (47%). The proportion of court cases concerning a combination of hard and soft drugs remained constant (5%). The sanction most often applied in 2011 for Opium Act cases and in first instance is the (partly) unconditional prison sentence.
Expenditures for Opium Act offences are estimated at € 766.3 million, of which € 485.8 million is spent on hard drugs and € 280.4 million on soft drugs. Expenditures for Opium Act offences account for 6% of the total of expenditures for security issues. Opium Act offences rank fifth in amount of expenditures for security issues.
The combat of organized drug production, cultivation and trafficking is a priority area for police and Public Prosecution in 2011-2012. The 'barrier' model is applied with combinations of criminal and administrative and judicial measures and with a crucial role for local and regional institutions. New regulations broaden the options. The confiscation of criminal proceeds is a central element in the approach. Investigations into the top of criminal organisations involved in cannabis cultivation and exportation are stimulated by a national Taskforce and a Taskforce aimed specifically at the southern region of Brabant.
For offenders with drug problems (and for offenders with other mental health problems) there are interventions available in the criminal justice system: "Safety Houses", forensic care as an alternative to prison, Penitentiary Psychiatric Centres, Addiction probation services, behavioural interventions inside and outside prison and the Measure of Placement in an Institution for prolific offenders. In 2012 there were 41 Safety Houses. These are networks of local organisations working together to reduce crime. Offenders are discussed in case meetings and adequate trajectories are planned.
The number of diversions to care as an alternative for detention is rising. Planned new laws give priority to care as an alternative for or following imprisonment and forensic care for delinquents in institutions outside the prison system is contracted by the Ministry of Security and Justice.
The number of clients of addiction probation services in 2011 did not change compared to 2010.Two-thirds (64%) of the offenders under the Measure for Placement in an Institution for Prolific Offenders (ISD) had addiction problems. Most offenders under ISD participate in trajectories with behavioral interventions or care programs. More trajectories take place outside prison. ISD is effective in reducing criminal recidivism.

Drug markets (chapter 10)

The number of coffee shops in the Netherlands is gradually decreasing. In 2011 there were 651 coffee shops, located in 104 of the 418 municipalities.
The National Police Agency observed no substantial new developments in cannabis production in the Netherlands. Main destinations for export of cannabis are the UK, Germany, Italy and the Scandinavian countries. In 2011 5,435 cannabis production sites were dismantled. There are no indications that compulsion, intimidation or violence is used against home-growers of cannabis. Foreign hashish comes mainly from Morocco and is transported over sea. This type of crime seems to be conducted in a small world, although the number of players increased.
Cocaine comes from Peru, Bolivia and Colombia, with Western Africa as one of the important transit regions. The trafficking is in the hands of Europeans. Rotterdam and Antwerp are main ports of entry of cocaine. The Netherlands is primarily a transit country.
With regards to heroin there are no substantial new developments. No consequences were observed in the Netherlands from the decrease in opium production in Afghanistan in 2010.
In the field of synthetic drugs there were important developments in 2008-2012: new (pre)precursors emerged, MDMA production recovered in 2011 and production sites increased in scale. Several new psycho-active substances seem to be on the market, which

are not produced in the Netherlands. In 2011, 30 production locations of synthetic drugs were dismantled.
The internet seems to be of growing importance as a medium for contacts over trading and production of drugs. The Minister of Security and Justice announced steps against this way of drug trading.
In 2011 and the first half of 2012, the purity of ecstasy samples bought by consumers exceeded purity levels in earlier years. Ecstasy tablets analysed in the laboratory contained on average 107 mg in the first half of 2012 (against 66 mg in 2009). Amphetamine purity strongly fluctuated in the past decade, which may be due to variations in precursor availability. In the first half of 2012 the average concentration of amphetamine was 21% against over forty percent in the second half of 2010. The caffeine concentration increased to 58% in the first half of 2012.
Occasionally (potentially) dangerous substances are detected in samples sold as ecstasy and amphetamine (e.g. PMMA/PMA, 4-MTA). In the first half of 2012, 11% of the speed samples contained 4-methylamphetamine (4-MA). Fatal emergencies related to the use this substance in the Netherlands, as well as Belgium and UK, were reason for the Minister of Health, Welfare and Sport to commission a quick scan on the risks of 4-MA. The results have led to immediate control of 4-MA on List I of the Opium Act.
The majority of the cocaine samples from consumers still contain medicines, especially levamisole (64% of the samples in 2011). So far no cases of agranulocytosis, associated with the use of levamisole, have been reported. In 2011 the purity of cocaine was 49%, about the same as in 2009 and 2010, but less than in 2002 (68%).
Prices of ecstasy tablets at retail level increased from 2008 to 2010 and remained at the same level in 2011 (on average 4 euro). The price of a gram amphetamine increased from 2010 to 2011 (from 6 to 8 euro on average) and prices of cocaine fluctuated on average between 45 and 52 euro in the past years.
Between 2005 and 2012 the average concentration of THC in Dutch weed fluctuated on average between 15% and 18%. Prices of Dutch weed at retail level increased since 2006. In 2012 the price per gram of Dutch weed sold as most potent type was 11.2 euro and one gram of the most popular type was 9.3 euro.

Residential treatment for drug users in Europe (chapter 11)

The history of the (residential) treatment especially for drug users in the Netherlands is not going back further then around 1970. By that time the heroin use became epidemic in Amsterdam and it became clear treatment was necessary. Around 1975 the first residential facilities started to open their doors. The dominant vision at that time was that the only meaningful treatment of addiction aims at total abstinence. In the beginning of the eighties, the Dutch government started to change its drug policy. The former treatment goal of "abstinence" was now partly replaced by a plea for easily accessible methadone. Acceptance of drug use and harm reduction now became the leading principles. In the nineties, the collaboration between the addiction care and the mental health care improved. More attention was now paid to patients having dual diagnoses (DD). In 1995 the first outpatient projects for dual diagnosis started, and later on the first clinics were established. Addiction was no longer seen as a superficial behavioral characteristic, but was now seen as a result of abnormal brain processes.
There are thirteen established addiction care organizations in the Netherlands which offer a clinical stay. The majority of these are part of a large mental healthcare organization. Next to these 'established organizations' a growing number of private clinics are founded. There are eleven youth addiction clinics and five forensic addiction clinics and especially in 2012, some of latter clinics were founded.
The stakeholders in the mental healthcare and addiction care agreed in 2012 that a reduction of beds is desirable and many addiction care clinics have developed plans to realize this reduction. The patient flow should be directed from residential care to outpatient care and from specialized care to the general practitioner and E-health interventions.

In 2011 11,675 admissions took place in the residential care (including detoxification) and 5,351 admissions (without detoxification). Cocaine users formed the largest group in residential addiction care (865 persons).
The clinical addiction care offers a wide variety of treatment methods. Especially in the large institutes, many programs are available for different target groups. A majority of the institutes for addiction care offers the common evidence-based psychosocial treatments, like cognitive behavioral therapy, community reinforcement approach, motivational interview techniques, 12-Step approach, and partner and family therapy.

Drug policies of Amsterdam, Rotterdam and The Hague (chapter 12)

In the large Dutch cities, the different drug related issues are covered by periodical and ad hoc policy papers. Every four years Security Policy Papers are published with concrete targets concerning prolific drug addicted offenders, combating public nuisance caused by alcohol and/or drugs, dismantling weed nurseries, controlling coffee shops and to maintain security on large events. Also every four years Dutch municipalities have to approve a Public Health Policy Paper, preceded by a health survey, in which strategies targeting to decrease the use of drugs, especially among youngsters, are formulated. In the four-yearly Community Support Act policy papers, specific social addiction care policies for the vulnerable outpatient addicts are presented. The Strategy Plan for Social Relief is an important initiative in which the four large cities and the national government co-operate to improve the living situation of homeless people. Amsterdam, Rotterdam and The Hague –and other cities with coffee shops- have specific Coffee Shop Policy Papers. The large cities have regular monitors producing relevant data for policy makers.