Executive summary

Developments in drug law and policies (chapter 1)

This National Report reviews the developments in the drug policy of the Netherlands up to the 7th of November 2013. The Dutch Opium Act places drugs with an unacceptable risk on Schedule I and places other drugs on Schedule II. The Opium Act, the Opium Act Directive and other drug-related Acts and Codes have been subject to changes:

- Since January 2013 qat is placed on schedule II of the Opium Act. The sale of qat is not tolerated.
- 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. This bill was approved by the House of Representatives on 11 October 2013.
- In 2011, an advisory committee advised to classify cannabis with a THC concentration of more than 15% as a hard drug. Implementation was announced in the plans of the new Cabinet (Rutte II) of November 2012. The procedure is still pending.
- On 1 January 2012 two new criteria to which coffee shops must adhere were added to the Opium Act Directive: the private club [B] club criterion and the residence [I] criterion. The Directive stipulated that the enforcement of these criteria should start in May 2012 in the southern provinces of Limburg, North-Brabant and Zeeland. The enforcement of these criteria in the rest of the country should start on 1 January 2013. In November 2012 the new government cancelled the private club criterion. The Opium Act Directive was changed. On 1 January 2013 the residence criterion is in force for the whole country. The enforcement of this criterion at local level may be implemented in phases. The number of drug tourists strongly decreased in the southern provinces of the Netherlands where the criterion was enforced as of 1 May 2012.
- A change in the Code of Criminal Procedure is in preparation which will make it possible for the police to apply compulsory tests of alcohol and drug use on suspects of violent crimes. The use of substances can be an aggravating factor in the sentencing of these cases.
- The Evaluation and Extension Act BIBOB (Public Administration Probity Screening Act) came into force on 18 April 2013.
- A new bill to regulate structural funding of anonymous e-mental health is in preparation.
- Traders in new precursors of synthetic drugs (APAAN and GBL) were for the first time convicted and the combat against organised crime will be tightened.

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. Using cannabis prevalence data from the 2009 population, the total amount of cannabis consumed in the Netherlands per year was estimated between 44 and 69 tons (excluding consumption by drug tourists). The smallest group of intensive (daily or almost daily) users was found to be responsible for the largest part of this amount (77%).

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.

A web survey in spring 2013 among a convenience sample of visitors of parties or festivals and clubs revealed fairly high levels of substance use compared to their age peers

(15-35 years) in the general population (2009 data). For example, last year prevalence rates were about three times higher for cannabis (52% versus 14%), about ten times higher for cocaine (27% versus 2.4%) and about twenty times higher for ecstasy (61% versus 3%). Prevalence of drug use was associated with the frequency of attending parties and festivals, e.g. recent use of ecstasy increased from 10% among those who had not attended a party/festival (but did attend clubs) in the past year up to 78% among those who attended these locations weekly. It is not known which proportion of the total population of young people from 15 up to including 35 years visits parties, festivals, or clubs as much as the young people in the convenience sample.

Several surveys suggest that ketamine is on the rise. New psychoactive substances, such as mephedrone[1], methylone, methoxetamine, 6-APB ("BenzoFury'), spice and 4-fluoramphetamine, are used appreciably less often among partygoers, with the exception of the latter substance (last year prevalence 8.5% in the web survey).

Developments in prevention (chapter 3)

Dutch drug prevention policy is part of a broader scope of public health prevention, co-ordinated by the Ministry of Health, Welfare, and Sport (VWS) and implemented by local government. Recently, a new National Prevention Program (NPP) 2014-2016 was formulated. The main focus remains on prevention among young people. Also central to the NPP are the integration of prevention efforts and cooperation between stakeholders such as health care, employers, schools and local government. Specifically regarding substance use, the NPP focuses on healthy and safe nightlife regarding alcohol, drugs, and tobacco. The minimum age to buy alcohol and consume alcoholic beverages in public spaces is increased (16 to 18 years) as of January 2014. A similar increase in the legal age for buying tobacco is foreseen on 1 January 2014. Also, the smoking ban is extended to bars without personnel (except the owner). Finally, an additional school doctor/nurse visit in adolescence is implemented, to facilitate early identification of problems, including substance abuse.

Drug prevention activities aim to discourage drug use, support early detection, facilitate referral to regular treatment and reduce drug-related health risks. They are focused on young people at school or in nightlife and high risk groups. Examples that were recently updated include the project Healthy School and Drugs and 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. The anonymous drug test service of the Drug Information and Monitoring System (DIMS) still exists, as well as the monitor for drug-related emergencies (MDI), which directly communicate public health risks within their networks to enable fast prevention responses (see also chapter 7). First Aid services at large dance parties also still exist (and provide data for the MDI), as well as the national alcohol and drug information lines. The 'Wiet Check' is a website at which users of cannabis can find information and advice about their cannabis use (www.wietcheck.nl). After a randomized controlled trial evaluating the effectiveness of the Dutch 'Wiet Check', it was implemented in several addiction care facilities and made available online. This preventive intervention is based on the Australian Adolescent Cannabis Check-up (ACCU) for young cannabis users (14-21 year).

[1]Strictly speaking, mephedrone is not a new psychoactive substance after its listing on May 2012 on Schedule 1 of the Opium Act.

The new age limit of 18 years for the sale of alcohol and tobacco and the use of alcohol in public spaces will be communicated through governmental mass media and local campaigns. Moreover, a long term mass media campaign aiming to denormalise alcohol use and smoking under age 18 is funded and implemented by a joint action of health charities, (alcohol) retailers' associations, and national health promoting institutes. This campaign will propagate that alcohol and tobacco use is ‘not done’ for people under 18.

By 1 July 2014, municipalities must have formulated their local alcohol prevention and law enforcement policy. Local authorities may link age restrictions to opening hours, impose restrictions on happy hours and special alcohol offers, and regulate sales of alcohol in sport club canteens and other such venues by local ordinance.

To support coherent and effective local health promotion, the website "www.loketgezondleven.nl" provides information on effective public health interventions for municipalities, schools, and healthcare workers. With regard to the name of the website, "loket gezond leven" means "office or counter healthy living". This website is maintained and updated by the Centre for Healthy Living (Centrum Gezond Leven) of the National Institute on Public Health and the Environment. It includes a database of lifestyle interventions and guidelines, such as the Guideline Healthy Municipality (Handreiking gezonde gemeente), to support municipalities with their prevention policy.

Developments in problem use (chapter 4)

The number of problematic opiate users has been estimated in 2013 at 14,000, implying a decrease of 21% compared to the previous estimate for 2008-2009. This decrease is consistent with other indicators, including a decrease of opiate users in treatment and overall ageing population with low levels of new users recruited.
A very rough national estimate of the number of (dependent) crack users, based on extrapolation of data from three cities to national level, arrives at a number 17 and 24 thousand. This population may overlap to a considerable extent with the population of opiate users as 50% to 80% of the crack users may also consume 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)

On the 18th of June 2012, the Ministry of Health, Welfare, and Sport (VWS) and the providers of mental health care and addiction care signed an agreement aimed to secure the future of mental health care and addiction care in the Netherlands. To keep the mental health care and addiction care affordable in the near future, it was agreed to reduce the number of inpatient units (slots) by a third in 2020 compared to 2008. A third of the inpatient care will then have to be replaced by outpatient care, which will require more self-management from the clients. To put the agreement with the ministry into practice, the National Branch Organization for Mental Health Care and Addiction Services (GGZ Nederland) has issued a vision document that targets a more assertive prevention of drug use; focuses on youth, vulnerable groups, and neighbourhoods at risk; and aims to consolidate the care for chronic addicts.

In 2012, the regular addiction care was provided by thirteen institutes and registered anonymously in the National Alcohol and Drugs Information System (LADIS).

During the past decade, about half of the institutes for addiction care had merged with an institute for general mental health care. With regard to the number of treated clients, the fusions have had no large impact on substance abuse treatment. The total number of drug clients in a year is given by the number of clients that already started treatment in a previous year (the old clients) and the number of clients starting treatment in that year (the new clients). Between 2011 and 2012 the total number of old and new drug clients decreased with 4% from 32,871 to 31,605 drug clients. In the same order of magnitude, the number of new drug clients, as defined by the EMCDDA's Treatment Demand Indicator (TDI), decreased with 5% from 11,341 new drug clients in 2011 to 10,801 new drug clients in 2012. Only the number of GHB clients had increased. The overall small decrease in the number of drug clients in the addiction care might have resulted from the own private contribution which the clients were to pay in 2012. It parallels the stabilization of the number of drug patients in the hospitals during the past three years. All in all, the figures from the addiction care and the hospital care suggest a stabilization of the number of problem drug users.

By 2011, the quality management program Scoring Results had established 27 products, and for 24 of these products it was found that the implementation rate was high for 10 products, moderate for 7 products, and low for 7 products. Based on cognitive behavioral therapy, the protocols for the life-style trainings reached an implementation rate of not less than 100%. Several products which Scoring Results in 2013 added to its quality management products are the "Practice-based recommendations for GHB detoxification", the advisory report "Elderly and addiction", and the quick scan "Scoring results around recovery".

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. Risk behavior (injecting and exchange of injecting material) is (very) low. 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. The disease outcome of HIV in IDUs is however worth than in the other risk groups and the proportion of AIDS patients dying is highest in the risk group IDUs. Also the burden of chronic hepatitis C infection stays high among (current and former) IDUs.

Data on drug-related health emergencies show two trends which are reason for concern. First, there is a substantial increase in the number of people seeking medical treatment at emergency posts at large events for ecstasy-related emergencies. Data from DIMS already showed that the average MDMA concentration in ecstasy tablets has also increased in recent years. In addition, there are indications for a "normalization" of ecstasy use, which may result in less precautions taken while using the drug. Second, we see a general increase in the level of intoxication of emergencies presented, which also points to a more easy use of recreational drugs without taking into account possible consequences. Emergencies related to GHB use are also still relatively frequent. In the hospitals, an increase in the GHB-related emergencies was observed, but not in the other settings (ambulance transportation services, the forensic doctors, and the emergency posts at parties). The level of intoxication in GHB-emergencies is high compared to the other drugs.

New data showed that the prevalence of several mental health disorders (childhood and adult ADHD, externalising disorders, mood, anxiety) is higher among dependent drugs users than in the general population. The mental health condition in non-dependent, but frequent users of cannabis was shown to be similar to that of the general population, with the

exception of externalising disorders. The existence of mental health problems was higher among cannabis dependent patients seeking treatment in addiction care.

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 an increasing percentage of the deceased aged 35 years and above, from 40% during the period 1991 up to including 1995 to 71% during the period 2006 up to including 2012.

Responses to health correlates and consequences (chapter 7)

The monitor for drug-related emergencies (MDI) 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. In recent years, the close collaboration with the Drugs Information and Monitoring System (DIMS) has proven to be very fruitful in the recent disturbances on the ecstasy and speed market (PMMA, 4-MA, high MDMA concentrations). Several other initiatives have provided information to professionals with a public task to inform them about strategies to handle aggression of persons under the influence of drugs, to provide guidelines regarding the "excited delirium", etc.

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 2000 and 2012, although all available signs indicate that those drug users in need of these harm reduction measures have access to them. Injecting drugs is no common practice in the Netherlands at the moment.

Several scientific studies assessed the impact of harm reduction on the prevalence of hepatitis C and HIV. They concluded that harm reduction measures could partly explain the marked decreases in HIV and HCV, but that the impact of the natural epidemic progression and demographic changes should also be taken into account when the benefits of harm reduction interventions are assessed. Another study concluded that the potential for targeted intervention depends on the actual existence and identification of different risk types, but also the willingness of individuals to enroll in intervention programs. These authors found that different strategies have to be applied to effectively minimize the spread of HCV and HIV in IDUs.

Treatment for HCV in IDUs is not yet common practice. However, in 2013 a project was started in which 6 of 11 addiction care institutions participate. The project aims to give a boost to hepatitis C screening and treatment.

Social correlates and social reintegration (chapter 8)

Up to 2011, the Netherlands was still the best-performing economy on the European continent. Nonetheless, in that year Dutch citizens started to notice the consequences of the worldwide economic crisis that started in 2008. Unfortunately, policy interventions targeting social inequality in deprived neighbourhoods had no effect. Nonetheless, together with Finland, the Netherlands was still the only Member State of the European Union in which

homelessness had decreased in the past five years. However, the European Committee on Social Rights had to remind the Netherlands to ensure nationwide access to shelters for homeless people. Access to social relief is a legal right of all homeless people. However, being under the influence of drugs or alcohol was put forward in some shelters as an excuse to refuse social relief.

Although the Netherlands had to be reminded this way about the rights of homeless people, the Strategy Plan for Social Relief did show a success ratio of not less than 64% in 2011. By that year, more than 9,100 former homeless adults had now reached a stable mix of housing, income, and treatment. With regard to finding employment, some former addicts were successfully trained as an Expert By Experience and were employed this way at an institute for addiction care.

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

The number of Opium Act cases dealt with by the police, the Public Prosecution Service and the Courts increased in 2012. Around 8% of all cases in the criminal justice system concerns Opium Act offences. This percentage increased in recent years. There is a decreasing trend in the proportion of cases with hard drugs and an increasing trend in the proportion of cases with soft drugs. This might be related to the intensified enforcement efforts directed at cannabis production and the increased focus of the police on soft drugs dealing outside coffee shops within the framework of the tightened coffee shop policy in 2012.

The majority of the Opium Act cases is submitted to court. There is, however, a decrease in the proportion that is submitted to court. This seems to be caused by the implementation of the disposal of the Public Prosecution Service to impose sentences for certain crime types without referring them to the court, in combination with the increasing number of case dismissals due to policy reasons in 2012.

Court sentences in Opium Act cases constitute mainly of community service orders and/or unconditional prison sentences. In 2012 there are slightly less prison sentences for Opium Act cases and more community service orders than in 2011. Fifteen percent of the detainees on September 30, 2012, were convicted for an Opium Act offence.

The number of arrestees that was classified as a ‘drug user’ in the police registration decreased again in 2012. Their mean age is 42 years. A substantial proportion is a frequent offender. The majority is suspected of a property crime. This picture did not change in 2012 compared to 2011.

In 2012, the private club and the residence criterion for coffee shops were introduced in the Opium Act Directive and enforced in the three southern provinces from May 2012 until 19 November 2012. One of the aims was a reduction of drug tourism and related nuisance. An evaluation study showed that indeed drug tourism had decreased drastically. The degree of the nuisance experienced by people living in the direct vicinity of coffee shops had not changed significantly until November 2012. The nature of the nuisance had changed. It had shifted in nature from nuisance experienced in relationship to coffee shops and coffee shop visitors to nuisance due to drug dealing on the streets. The private club criterion was abolished per 19 November 2012.

Expenditures for Opium Act offences in 2011 are estimated at 395 million euros, of which 287,9 million is spend on hard drug related activities and an estimated 107,2 million on soft drug related activities. Expenditures for Opium Act offences account for 3.1% of the total

expenditures for all kinds of offences. Most of the money is spend to the execution of sentences.

The organized crime in relation to cocaine, heroin, synthetic drugs and the large-scale professional cultivation of cannabis are defined as priority areas for enforcement by the police for the period 2013-2017. In the combat of organized crime the 'barrier' model is applied, which aims at disturbance of the logistic organization and the central processes in the criminal organizations. The confiscation of criminal revenues is a central element in the approach. The combination of administrative and criminal law enforcement and the co-operation of local and regional institutions like the Public Prosecution Service, the municipalities, the police, the Fiscal investigation unit, and the Tax Authorities is an important aspect in the approach. These institutions also organize support from the public and civil society. For municipalities, the main priority is to attack the cultivation of cannabis.

Problematic drug users/drug addicts in the Dutch criminal justice system are subject of case meetings in Safety Houses, where trajectories are set out for them; forensic care and behavioural interventions are offered to them, and Addiction Probation Services carry out several types of assistance. They are a target group for the measure of Placement in an Institution for Prolific Offenders.

Drug markets (chapter 10)

The number of coffee shops, where the sale of cannabis is tolerated under strict conditions, shows a decreasing trend. In 1999 there were 846 coffee shops and in 2011 there were 651 coffee shops. At the end of 2012 there were 617 coffee shops, located in 103 of the 415 municipalities in the Netherlands. In April 2013 there were 614 coffee shops.

In addition to the national criteria the coffee shops have to adhere to in order to be tolerated, the majority of the municipalities with coffee shops applies additional local criteria as well, mostly with regard to the location of the coffee shop (like: not near schools or near youth facilities). Adherence to the tolerance criteria is controlled by municipalities and/or police. In 2012 a total of 56 violations of criteria were recorded (in 2011: 51). Two-thirds (64%) of the municipalities with coffee shops do not experience problems with the coffee shops.

In 2012 5,773 dismantlements of cannabis cultivation sites were reported to the National Police Forces. This number ranges over the years between 5,000 and 6,000 and the number for 2012 does not deviate from this pattern.

In 2012, 42 dismantlements of production locations of synthetic drugs are reported, more than in 2011. Sixty-six storage places of hardware, chemicals or both were discovered by the police and 68 dumpings of chemicals, more than in 2011.

The trend towards increasing purity of tablets sold as ecstasy at retail level increased in 2012. In this year, laboratory analyses revealed an average dose of 107 mg of MDMA per tablet (against 66 mg in 2009). Amphetamine purity strongly fluctuated in the past decade, which may be due to variations in precursor availability. When levels decrease, a compensatory increase in the concentration of caffeine can be observed.

Occasionally (potentially) dangerous substances are detected in samples sold as ecstasy and amphetamine (e.g. PMMA, 4-MA). In 2012 1.4% of the ecstasy samples contained PMMA and this proportion showed a worrying increase to 2.7% in the first half of 2013. The increased MDMA concentration and dangerous 'adulterants' in ecstasy, together

with observations of increased risk behaviour among some subpopulations of (young) drug users, increased the severity of non-fatal emergencies related to ecstasy use (§ 6.3). Notifications of several fatal emergencies related to ‘ecstasy’ use were the reason for seven local and four national warning campaigns.

Several “new psychoactive substances” (or research chemicals) were notified in 2012 in consumer samples. Most common were 4-fluoramphetamine, followed by mephedrone, methylone, methoxetamine and 6-APB (BenzoFury). The number of samples containing 4-methylamphetamine, which was brought under control of the Opium Act in June 2012, dropped from 2012 to the first half of 2013.

The majority of the cocaine samples from consumers still contain medicines, especially levamisole (65% of the samples in 2012). In 2012 the purity of cocaine was higher than in 2011 (58% against 49%).

Between 2005 and 2012 the average concentration of THC in Dutch weed sold as most popular type fluctuated on average between 15% and 18%. A significant decrease was found from 15.5% in 2012 to 13.5% in 2013.