Ministerie van Volksgezondheid, Welzijn en Sport – NL

Drug Policy in the Netherlands

Basic Principles and Enforcement in Practice

International Publication Series Health, Welfare and Sport No 18

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This series provides information on the Netherlands policy specifically relating to the health, welfare and sport sectors. In addition, the series reproduces the full text of relevant Acts. The target groups are counterparts of the Ministry of Health, Welfare and Sport (VWS) in other countries, international organizations, embassies of the Kingdom of the Netherlands abroad, foreign embassies in the Netherlands, researchers and other experts.

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Preface

Drug policy in the Netherlands aims to reduce demand for drugs, reduce the supply of drugs and the risks to drug users, their immediate surroundings and society. The Ministry of Health, Welfare and Sport (VWS) is responsible for coordinating policy preparation and implementation.

This booklet provides background information about drug policy in the Netherlands. It describes the various activities and organisations involved in implementing policy.

The aim of this booklet is as follows. In the first part we discuss the basic principles and main outlines of drug policy in the Netherlands. Next, there is a discussion of international cooperation and dissemination of information. The first part concludes with a detailed discussion of the judicial aspects of drug policy. In part two we examine drug policy from the specific perspective of public health and welfare. There is a discussion of care and relief, along with prevention policy. Further, we discuss several scientific experiments and studies. In six separate boxes we provide additional information about several subjects.

Part 1 Drug Policy in the Netherlands

INTRODUCTION

During the 1960s and 1970s the use of drugs (cannabis products, opiates and synthetic drugs) increased sharply in Western Europe and North America. There were fears of large-scale public health problems. It resulted in the development of new national and international policy frameworks.

Consumption of the various drugs is subject to substantial fluctuations. Total consumption has increased. In the Netherlands only a small percentage of cannabis users move on to hard drugs. The number of opiate addicts (such as heroine, morphine and methadone) in the Netherlands is relatively small. Moreover, this number has not increased in years. It is far below the number of cannabis users. There is no evidence that Dutch policy concerning cannabis has fostered the use of hard drugs.

Dutch policy assumes that it is not possible to totally ban drug use by means of firm government policy. Partly as a result of this, the government has formulated realistic aims. To start with, government policy discourages use. For those who nevertheless use drugs, there is a wide range of provisions designed to manage potential social and health problems related to drug use. The justice department and the police concentrate on tackling the supply side of the problem.

1.1 BASIC PRINCIPLES AND MAIN OUTLINES

Risk assessment

Formulation of the main outlines of Dutch drug policy originated early in the 1970s. An advisory group established by the government in 1972 argued that an assessment of the risks of using drugs depended in part on the circumstances under which and the degree to which the use of drugs occurred. The key aims of the chosen policy were prevention and control of social and personal risks stemming from the use of drugs. The government concurred with this view.

The government sees its task as one of preventing (especially youthful) citizens from taking drugs. The aim also focuses on providing medical or social assistance to problematical users. Assistance could result in total abstinence, but also in an improvement of the social and medical condition or in harm reduction.

Dutch lawmakers make a distinction between drugs and unacceptable health risks and cannabis products, whose risks they see as less dangerous. This distinction is known by its separation of hard drugs and cannabis. In this connection, the aim of criminal law is to protect the interests of public health. A further elaboration of Dutch drug policy makes allowances for the potential gravity of damage to health related to the use or abuse of drugs.

Public Health Concerns

In the Netherlands, in keeping with international conventions, the use of drugs is not a punishable offence. Nor is consumption of drugs a punishable offence in other EU and many non-EU countries. In the Netherlands, authorities view hard drug users through the healthcare lens. This has led to the formation of various types of facilities for prevention and aid. The Dutch government continues its efforts to develop better treatment forms for this, often difficult, target group. The starting point of the Justice Department favours medical treatment for addicts rather than imprisonment.

Improving social integration of (ex) drug users is extremely important. To achieve this, expert assistance is available throughout the Netherlands. This also eliminates financial barriers. However, the addict care sector does not focus exclusively on the goal of total abstinence, but also pursues other aims, such as improving medical health and the social functioning of drug addicts.

The Netherlands has created facilities to avoid individual and general risks of drug use, to help addicts get off of drugs and to improve their physical, mental and social conditions. The threshold to addict aid organisations is low. Since drug use does not result in criminal prosecution, users need not fear being stuck with police records when they receive addict care. This does not mean, however, that there is general acceptance of drug use in the Netherlands. Furthermore, the government and agencies pursue a policy of discouraging the use of drugs, pointing out the risks of addictive substances. Educational counselling and media campaigns relate the risks of taking drugs to those of using alcohol and tobacco.

The Legal Framework

There are various laws designed to combat illegal drugs. The primary one is the Opium Act (the law concerning narcotics). The minister of Health, Welfare and Sport (VWS) is responsible for the enforcement of this act. The act went into force in 1919 as a result of international conventions to combat the opium trade. The act underwent revision in 1928 and 1976 in conformance with new treaty obligations or changed attitudes and insights about (combating) the use of drugs. The law states that the possession of, trade in and production of narcotic drugs

is a punishable offence. The minister may make exemptions for medical, scientific and educational purposes.

Criminal Prosecution

Emphasising the concerns of public health goes hand in hand with a strong prosecution policy towards the production of and trade in hard drugs. In particular, due to their organised nature, the Dutch criminal investigation department has placed a high priority on dismantling criminal organisations that trade in cannabis or hard drugs. In doing so, the Netherlands is following the main outlines of the international prevention model, as set forth in the Single Convention on Narcotic Drugs (1961).

Criminal prosecutions place a heavy burden on the police and the public prosecutor. Criminal prosecutions of organised drug dealers have resulted in lengthier prison sentences. Due in part to this, the capacity of the Dutch prison system has expanded considerable over the last 15 years. The government has also reacted actively to disturbances of the peace and nuisance caused by the use of drugs.

Distinction between Cannabis and Hard Drugs

The starting point of the Dutch 'Opium Act' is the health risk for users. Dutch policy takes a different approach to cannabis than it does to hard drugs. While many other countries recognise this distinction, in the Netherlands it is part of the law. The reason for this has to do with differences in health risks. Cannabis (in the form of marihuana and hashish) causes substantially fewer health problems than hard drugs (such as heroine, cocaine and synthetic drugs). Experts consider the risk to health from hard drugs to be unacceptable.

According to the Dutch government, it would be unwise if the government's reaction to the use of cannabis should result in stigmatisation and social marginalisation of users. For this reason, the aim is to keep the social environment of young people who use cannabis separate from those where the use of or trade in hard drugs occurs. In the 1970s, this 'separation of markets' formed the basis for the Justice Department to allow the sale of cannabis in youth houses by licensed dealers. Since the 1980s, so-called coffee shops have assumed this function on a commercial basis.

In contrast to the use of drugs, trade (import/export), sale, production and possession of drugs is a punishable offence. Corresponding to the various risks per category of drugs, police investigating priorities and sentencing also vary, relative to the drugs-related punishable offence. Because of the lower health risks of cannabis, the authorities treat possession of up to 30 grams as a misdemeanour, not a criminal offence.

The Role of the Government

In the Netherlands, in keeping with basic policy assumptions that public health concerns are central to drug policy, the ministry of Health, Welfare and Sport (VWS) is responsible for coordinating drug policy nationally. Further, HWS is responsible for prevention and aid policy. In addition, there are two other ministries closely involved in drug policy: the Department of Justice and the Ministry of the Interior and Kingdom Relations. The Department of Justice is responsible for enforcing drug laws (criminal investigations and prosecutions). The Ministry of the Interior is responsible for issues relating to local authorities and the police.

In recent years, increasingly, the formation of drug policy locally has taken on new meaning. Local authorities have received clearer guidelines for dealing with drug-related nuisance. We discuss this in greater detail in subsection 1.5. Many cities conduct their own coffee-shop policies and have developed policies to control the drug trade. Coordination in municipalities is part of what is called 'three-party consultations'. The three parties are the mayor, the field officer (the Public Prosecutor) and the chief of police. These three officials determine such things as coffee-shop policy within the guidelines of the Public Prosecutor's Office. We discuss this in greater detail in subsection 1.4.

1.2 INTERNATIONAL COOPERATION

Dutch drug legislation conforms to international conventions of organisations with which the Netherlands is affiliated. Examples are the United Nations' treaties of 1961, 1971 and 1988 and various other multilateral treaties relating to drug policy, along with treaties entered in the framework of the EU. The Netherlands believes in making optimum use of the potential afforded by legislation and lawful treaties. The government is receptive to future policy developments. It follows policy developments in other countries closely, particularly in Europe.

Through public information, the Netherlands endeavours to generate a clear picture of its drug policy. In multilateral and bilateral relations, the Netherlands draws attention to the basic assumptions of its drug policy. The integral approach to the issue and the separation of markets receive special mention in this regard. In addition, cooperation focuses on the exchange of knowledge and expertise. This takes place in various ways, by organising international conferences to starting joint projects. Regarding Dutch cannabis policy, we would point out that there are ongoing developments in several EU countries that are in keeping with Dutch policy. There is running international debate about tensions between

BOX 1

PROJECTS AND COLLABORATIVE TIES

The European Union

There are various organisations in the EU concerned with the drug issue. A key one is the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, which specialises in disseminating information about developments in EU Member States relating to drug use. Europol plays a leading role in combating the drug trade. Its head office is in The Hague. Recently, Europol made recommendations to the Member States about registering confiscated drugs. In the Netherlands a central registration system is being set up.

There are various consultative platforms in the EU, such as the Horizontal Group on Drugs, the Precursor Committee and the Working Party on Illegal Drug Trade. The EU has included several projects in the *2000-2004 Drugs Action Plan*, which also concentrates on third-world countries. Other participants from the Netherlands are:

- EU Action Programme on Prevention of Drug Addiction;
- EU-LAC: a collaborative project between the EU, Latin America and the Caribbean region. The action plan focuses attention on reduction of demand, money laundering, alternative development and maritime cooperation. The Netherlands is a pioneer in the area of maritime cooperation;
- Twinning project with Hungary to support the creation of a policy framework for local prevention activities. Implementation is taking place in cooperation with Great Britain;
- Phare Synthetic Drugs Project (PSDP). This EU project, which the Dutch Ministry of Justice heads, concentrates on supporting future member states of the EU in their efforts to adopt and implement 'community experience' in the area of drugs. Special attention is given to synthetic drugs. The participating countries are Bulgaria, the Czech Republic, Estonia, Latvia, Lithuania, Poland, Rumania, Slovakia, Slovenia and Hungary. Albania, Bosnia-Herzegovina and Macedonia also take part in the project. The aim is to encourage all countries to adopt a 'National Synthetic Drugs Plan'. Besides the Netherlands, Germany, Sweden, Great Britain and the EU are helping to implement the project.

The Council of Europe

In the Council of Europe, in the form of the Pompidou group, there are various working party activities in which the Netherlands participates. The aim of the Pompidou group is to make a joint contribution to multidisciplinary, balanced, effective and innovative drug policy. The Pompidou group focuses on:

- research and epidemiology;
- prevention, education and training;

- treatment, rehabilitation and social aspects of drug use;
- legal-criminal aspects.

The United Nations

The Netherlands also takes part in many UN activities. From 2002 to 2005, the Netherlands is a member of the Commission on Narcotic Drugs (CND). This entails cooperation with the International Narcotic Control Board (INCB), an independent body responsible for monitoring compliance with UN treaties on drugs and precursors (raw materials for synthetic drugs). Further, it works with the United Nations Office on Drugs and Criminality (UNODC), the executive body of the UN in the area of combating drugs. De UNODC helps countries implement UN drugs treaties. Further, it contributes to the development of national drug policy and implements projects in poor countries.

Other Forms of Cooperation

There is bilateral collaboration with Germany, France and the United States. Attachés from the ministries of HWS and Justice are stationed at the Dutch embassies in Washington and Paris.

We should also mention the Dublin group. This is an informal forum where, besides EU Member States, the USA, Canada, Japan, Australia, Norway and the UNDCP also participate. There are regular consultations in the Benelux concerning drug policy in relation to public health and the administration of justice. Regional networks have been set up in neighbouring countries to combat drugs tourism. The Netherlands works intensely with Belgium, France and Luxembourg to tackle the activities of drug couriers between these countries and the Netherlands. An exchange of magistrates also takes place with France.

Collaborative projects on prevention and addict care have started with the Netherlands Antilles and Aruba, both of which are part of the Kingdom of the Netherlands. Further, there is cooperation with these overseas territories concerning an effective approach to the drug trade: combating the drug trade via airports, the active deployment of the coast guard, cooperation between criminal investigation departments and, in collaboration with the USA, reconnaissance flights.

Finally, we should point out the activities of the National Police Force Corps (NPFC). This corps has liaison officers or contacts stationed in Thailand, the Antilles, Poland, Spain, Hungary, Russia and the United States. Liaison officers are Dutch police contacts abroad. They form a link in research and operational matters. Conversely, there are police officers from more than 10 countries assigned to foreign embassies in the Netherlands. They maintain close contact with the NPFC.

cannabis policy in practice and international treaty obligations. In that context, the Netherlands has organized two major conferences in collaboration with Belgium, Germany, France and Switzerland (see box 7 in subsection 2.3). In this regard, the aim is to create a breeding ground for international cooperation. It should be noted here that, from an international perspective, Dutch coffee shop policy still occupies an exceptional position.

The issue of potential harmonisation of drug legislation now dominates discussion in the EU. In particular, the outcome of the European Convention will play a major role in this. In the area of drugs, the Dutch government places considerable importance on international cooperation. Besides combating the drug trade, the Netherlands is increasing ties with other countries in the area of public health. For example, the Dutch government subsidises cross-border projects relating to addict care, geared towards the exchange of practical collaboration with institutions in neighbouring countries. In various border regions there are collaborative ties between prisons, aid organisations and social workers on the street. In box 1 we give further details of several international collaborative projects in which the Netherlands participates.

1.3 DISSEMINATION OF INFORMATION

The Netherlands has a well-organised dissemination of information system concerning the use of drugs, the scope of user groups, along with statistics on use-related illness and death. These data serve as comparisons with other countries.

The National Drugs Monitor

Since 1999, the National Drugs Monitor (NDM) is the main authority that collects data for government, about which it reports annually. The establishment of the NDM was an initiative of the Dutch Ministry of Health, Welfare and Sport (VWS). It has a coordinating, harmonising task with respect to gauging and registering the use of stimulants and addiction in the Netherlands. It is also responsible for reporting to the national authorities, the government and international agencies such as European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the WHO.

The NDM has its offices at the Trimbos Institute, the national knowledge centre for mental healthcare and addiction. NDM's reports are preparatory to the obligatory annual reports that the Netherlands must compile for the EMCDDA in Lisbon. Because of the work done by NDM there is good insight in the use of drugs and related problems, the demand for aid, health risks and social harm.

Among other things, NDM reports data on five key indicators established by the EMCDDA on the use of drugs by the general population, estimates of the number of problematical drug users, demand for treatment, death due to drug use and the prevalence of contagious diseases as a consequence of drug use. The NDM also regularly compiles surveys of developments in the drugs-aid sector and coordinates national working parties of experts. Box 2 shows several figures about drug use in the Netherlands.

Trend Watchers

The NDM chiefly uses data supplied by other authorities. However, it could be extremely significant for public health also to use data from direct contacts with user groups. In the Netherlands there are *trend watchers* that serve this purpose. These are agencies that specialise in maintaining contacts with drug users in their own social environments. These are Mainline, the Advisory Foundation for Drugs and the National Drug Users Support Centre. With good access to the world of users, their staff forms an important observation point. They can identify at an early stage whether new drugs have appeared on the market or whether methods of use have changed. They are also in a much better position than more formal authorities to contact new user groups that addict-care agencies still overlook. As an extension of this observation function, they also fulfil a preventive task as information officials or advisers of the users concerned.

In subsection 2.2 we discuss in greater detail the Coordination Centre for Assessment and Monitoring (CAM), which estimates the risks of new drugs.

Registration of Addict-care Data

The Dissemination of Information on Addict Care Foundation (DIAC) collects registration data of ambulatory care agencies. According to a specific plan, the agencies deliver data about the drug users under their care. This provides a fairly accurate determination of the characteristics of this group of clients (drugs used, ages, social backgrounds) and of how demand for aid develops in the Netherlands.

Addict care in the Netherlands distributes alternative drugs for opiate addiction to heroine addicts, such as methadone and, on an experimental basis, also prescribes heroine. This resulted in the establishment of a national registration centre. Its aim is to combat misuse or duplicate issues. Using biomedical methods, it seeks to establish methods of patient identification that would provide maximum security for distribution.

BOX 2

DRUG USE IN THE NETHERLANDS

In its 2001 annual report, the NDM drew the following conclusions about the state of drug use in the Netherlands:

- compared to other EU countries, drug use is not exceptional; however, the Netherlands often ranks above average among the country ratings, especially for cocaine;
- the estimated number of problematical users of opiates is between 25,000 and 28,000;
- cocaine (particularly when it can be smoked - crack) has gained in popularity in recent years with problematical hard drug users. There are also signs that other user groups, especially in nightlife circles, have developed a preference for cocaine. Added to this, the number of clients in ambulatory care with cocaine addiction has increased. Deaths due to cocaine have risen slightly, but the absolute number remains small;
- XTC (ecstasy) is still popular among the pleasure-seeking youth. On further analysis, the pills more often have MDMA (Methylenedioxy-N-Methylamphetamine) as their principal ingredient and less often contain amphetamine. This corresponds to the finding that fewer amphetamine pills are confiscated in the Netherlands and fewer production facilities are dismantled.

In 2002, the Centre of Drug Research at the University of Amsterdam published the findings of a national, representative sampling among the general population aged 12 years and older. Compared to a previous national sampling in 1997, the latest sampling showed the following:

- the number of those who had ever used cannabis rose by 15.6% of the population, to 17.0% in 2001;
- the average age when these Dutch citizens started using cannabis remained the same; both in 1997 and in 2001, the average age was 19.7 years;
- in 1997, there were around 325,000 Dutch citizens who had smoked a joint in the month prior to the survey; in 2001, the estimated figure was 408,000;
- the use of so-called party drugs rose: the percentage of Dutch citizens who had ever used cocaine rose by 2.1% to 2.9% between 1997 and 2001; the use of XTC and amphetamines increased equally; 1.9% of the population used both substances in 1997 at some time; in 2001, the figure rose to 2.9%;
- for all illegal drugs, the 'ever used' category was substantially higher than 'actual use'.

1.4 JUSTICE DEPARTMENT POLICY

In this subsection we discuss how the Netherlands combats drugs and, in particular, the role of the related role of the Justice Department.

Distribution of Responsibilities

In the Netherlands the Minister of Justice takes part in the practice of criminal law. This applies to the field of legislation, to the administration of justice and to enforcement of criminal-law decisions. The Public Prosecutor (PP) is responsible for enforcing the prohibitions in the Opium Act. This agency has established guidelines for investigating and prosecuting infringements. The penal code also applies to cases of organised crime. It makes membership in an organisation with the intent to commit crimes a punishable offence.

The PP has its own responsibilities and jurisdiction, which arise directly from the law. The Attorney General's Council shapes PP policy. The PP falls under the responsibility of the Minister of Justice, who holds political responsibility. The minister has the authority within certain limits to give instructions to the PP, which its members are obliged to follow.

From the point of view of criminal investigations, the following agencies are responsible for implementing drug policy: customs, the 25 regional police forces and their special criminal intelligence departments (CIDs), the National Police Services Corps (NPSC) and the Central Investigative Intelligence (CII), which has a coordinating task in combating the drug trade.

Public Prosecutor Guidelines – priorities and principle of discretionary powers

The Public Prosecutor (PP) decides about instituting legal proceedings. As mentioned previously, the PP has issued a guideline (the PP Guideline) that sets forth the priorities for investigation and prosecution of punishable offences relating to drugs. As a result, compared to several comparable countries, Dutch investigative and prosecution policies are very transparent. The setting of priorities by the PP has its legal basis in the principle of discretionary powers. This is a general principle of Dutch criminal law. It means that the PP has the authority to waive legal proceedings of punishable offences, if it serves the public interest.

Possession of drugs

Possession of more than 0.5 grams of hard drugs is a crime punishable by law, which receives high police priority. Possession of fewer than 0.5 grams of hard drugs for own use is also a criminal offence, but has a low priority in criminal

investigations. On the other hand, possession of fewer than 30 grams of cannabis for personal consumption is a misdemeanour with a low investigative priority. Possession of more cannabis than a small amount for personal use is a punishable offence. Possession of trading quantities of cannabis and hard drugs therefore receives high investigative and prosecution priority.

The sale of drugs
The sale of both hard drugs and cannabis is a punishable offence in the Netherlands. The PP Guideline is more stringent concerning the sale than it is with the possession of small quantities. The sale of any quantity of hard drugs has high priority in investigative and prosecution policies and will receive harsh penalties. In particular, the police and judicial authorities place high priority on the investigation and prosecution of large-scale trade in either soft drugs or hard drugs. Such trade mainly takes place in the form of organised criminality. The supply of cannabis to coffee shops is also a punishable offence. In this regard, there is compliance with all international conventions.

The PP Guideline differentiates with regard to the sale of cannabis. Quantity plays a central role with cannabis; the police will not actively investigate the sale of fewer than 5 grams in coffee shops. The sale of small quantities of cannabis for personal consumption has a low investigative priority because the use of cannabis causes few health problems and little nuisance in the community. The authorities deal harshly with the sale of larger quantities, often for export, There is active investigative policy concerning the sale of cannabis in other catering establishment, on the street or in private dwellings.

In setting priorities for investigating and prosecuting punishable offences resulting from the provisions of the Opium Act, the possession of drugs and retail trade in cannabis products in coffee shops have therefore received low priorities. The background of this is that use of these substances does not entail unacceptable health risks (the principle of discretionary powers). Apart from that, there is ongoing international development in a growing number of European countries concerning the possession of small amounts of cannabis for personal consumption, which no longer automatically results in criminal prosecution. The development towards a low police priority for possession of cannabis lies along these lines.

Combating Drugs-related Crime
The Netherlands conducts active investigative and prosecution policies concerning drug-related crime. However, the starting point of the government is that criminal-law interventions should not result in additional harm to drug users. The emphasis is on combating trade and limiting use.

In the Netherlands, the police always confiscate the drugs found. That applies both to hard drugs and to cannabis, even when it only involves small amounts for personal consumption. However, the PP established its own regulation (the PP Guideline), which allows coffee shops to maintain limited stocks of cannabis for sale to visitors.

The Opium Act is not the only instrument for combating trade in and transit of drugs. There are various other laws that apply to investigations and prosecution. Nowadays, based on the Dutch Penal Code, after being convicted of drugs or related offences, it is possible to take away any unlawful benefit received by convicted persons. This is also called 'pluck them' legislation. This is a measure designed to counter the laundering of money received through illegal trade. Since 1994, pursuant to the Reporting of Unusual Transactions Obligation Act (RUTO), Dutch banks must report all such financial transactions. Further, the PP has established guidelines for circumstances that carry more severe penalties, such as the sale of drugs to vulnerable groups or trade in the vicinity of schools or psychiatric institutes.

Indeed, Dutch regulations relating to penalising drug-related actions are similar to those in many other countries. All preparatory actions for trading in hard drugs and all attempts to import or export drugs are punishable offences. Persons who have repeatedly committed punishable, drug-related offences are subject to a maximum sentence of 16 years in prison or a fine of € 45,000, or both.

The International Drugs Trade

At the end of the last century, the EU opened its internal borders. This meant that joint efforts to combat cross-border drug trade became more important than ever. Both the Schengen Convention and the Treaty of Maastricht therefore contain major provisions relating to this. Controlling 'external' borders is also high on the agenda. In particular, this concerns activities for investigating drug smuggling via the Port of Rotterdam or Schiphol airport. When carrying out inspections or investigations, Dutch customs can make use of the progressively refined analytical techniques of the national Customs Information Centre. Special attention focuses on identifying new smuggling methods (e.g. in car airbags) and improving customs controls (e.g. the use of container scanners). Dutch customs officials place a high priority on working with their counterparts in Germany, France and the United Kingdom. In this regard, they have concluded various agreements.

The Dutch government has formed special teams (HARC teams: Hit and Run Container teams) for combating the cross-border, illegal trade in drugs. These

teams are responsible for investigating drugs at seaports and airports. They consist of specialist tax inspectors from the Internal Revenue (IRTI), the river police, customs and the Public Prosecutor.

Cultivation of Cannabis

Indoor cultivation of cannabis is illegal in the Netherlands. The reason for this is that, in general, the climate in the country makes in difficult to grow cannabis for consumption outdoors. This modification in the law therefore focuses on combating production and preventing the export of homegrown weed. Cannabis cultivation is only permitted in the open air, in the natural soil, for the production of hemp. The maximum punishment for illegal, professional or trade-related cultivation of cannabis has increased from two years in prison or a fine of € 11,250 to four years or a fine of € 45,000.

The Department of Justice places high priority on investigating and prosecuting professional or trade-related cultivation. Due in part to this, in recent years the authorities have dismantled numerous cannabis 'farms'. The quantity of plants confiscated has increased dramatically. Further, in 2000, the Dutch government announced more stringent policy towards illegal indoor cultivation.

Coffee Shops

The sale of cannabis in so-called coffee shops forms a significant aspect of Dutch policy. A 'coffee shop' is a catering establishment that sells cannabis under strict conditions. According to the PP Guideline of 1 January 2001, exemptions from prosecution for the sale of cannabis in coffee shops only applies if the owners meet the following criteria (AHOJ-G criteria):

- coffee shops may not sell more than 5 grams per person per visit;
- coffee shops may not sell hard drugs (including XTC);
- coffee shops may not advertise drugs;
- coffee shops may not constitute a nuisance for surrounding businesses or residents;
- coffee shops may not sell soft drugs to minors (under age 18) and may not admit minors to the premises.

The sale of cannabis therefore remains a punishable offence. If owners and operators of coffee shops break the above rules, they will face administrative procedures (closing of the coffee shops), criminal prosecution or both. As long as owners and operators abide by the rules and do not stock quantities of cannabis in excess of 500 grams, in accordance with the PP Guideline, the authorities will not take action against these establishments.

With the authorisation of controlled retail outlets for cannabis, the Dutch government seeks to establish and preserve separation between cannabis users and social environments in which people use hard drugs. Moreover, this serves to protect cannabis users - including many young people who experiment with soft drugs - from the criminal circuit involving trade in hard drugs. This substantially reduces their risk of getting a police record, which is important for preserving societal integration.

Coffee shops cannot be established freely. Within the framework of the PP Guideline, the three-party consultative body can decide whether a municipality may have one or more coffee shops. Accordingly, approximately 80 percent of Dutch municipalities do not have such coffee shops. In consultation, coffee shops could be required to carry smaller maximum stocks of soft drugs. The mayor has the authority to close unwanted coffee shops if local drug policy so requires. This possibility also exists even when a coffee shop does not cause any 'nuisance'.

Intensification of Enforcement

Dutch cannabis policy encounters both national and international criticism and appreciation. In terms of social acceptance, current policy is regularly a subject of discussion, especially concerning the subject of nuisance. There is also criticism from EU countries, which think that Dutch policy deviates too much from that of other EU Member States.

Since 1995, the government has sought to reduce the number of coffee shops. In this regard, the government wants to monitor stricter compliance with the AHOJ-G criteria established by the Public Prosecutor. In 1997, there were 1,179 estimated coffee shops. By the year 2000, researchers identified 813 coffee shops. This represents a decline of 31 percent compared to 1997. The aim is to keep the number of coffee shops in line with local demand. The authorities have consistently taken effective measures to combat unwanted marginal phenomena such as nuisance, the sale of hard drugs and the sale of cannabis for export.

At present, the cannabis sector is undergoing an economic and organisational investigation, including shops that sell 'smart drugs', 'eco-drugs' or products that could be used for growing cannabis indoors. The purpose of this is to obtain insight into the potential for organised crime to exploit weak areas and, in this way, to infiltrate the sector.

An inconsistency in Dutch cannabis policy concerns the 'backdoor problem' - coffee shops are free to sell small quantities of cannabis to consumers who come through the 'front door', while the authorities actively combat 'backdoor'

activities needed to supply and assure trading stocks. Despite a parliamentary request to the government - in response to a call from a group of mayors - to find a solution to this problem, the cabinet rejected a measure aimed at the backdoor problem. It would conflict with the obligations arising from international conventions. In addition, it would create a hugely disproportionate enforcement effort. In an open economy such as the one in the Netherlands, it is not possible to develop and maintain a closed system.

Instead of rear-door measures for coffee shops, the cabinet decided to intensify enforcement. Particular attention focuses on combating illegal indoor cultivation, the supply of cannabis from abroad and alternative retail outlets. Also, police action to combat the sale of drugs other than cannabis has received high priority.

Synthetic Drugs

Given their status as hard drugs, investigation and prosecution of the production of and trade in synthetic drugs also receives high priority. In recent years, there has therefore been an increase in the number XTC pills confiscated. Trade is usually in the hands or organised criminals. Accordingly, in keeping with Dutch criminal law, the prosecution can demand higher penalties than the maximum sentences applicable to the crime in question.

Investigations are largely international in nature. The Synthetic Drugs Unit (SDU) serves to promote collaboration. Founded in 1997, the SDU has a coordinating national task in combating the production of and trade in synthetic drugs. Coordination focuses on all authorities involved in combating production of and trade in synthetic drugs, including the police, customs, the Public Prosecutor and Internal Revenue Tax Inspectors (IRTI). As a result, the Netherlands can respond more quickly to requests from abroad for information and cooperation on investigations. Over the last five years, the SDU has successfully tackled XTC, both nationally and internationally. In 2000, for example, the SDU rounded up 37 locations producing or processing XTC or amphetamines. This also included confiscation of various raw materials for synthetic drugs.

Various chemical substances are necessary to produce synthetic drugs (precursors), which were freely available until several years ago. Trade in these precursors is now regulated in the Netherlands in the Preventing Misuse of Chemicals Act (the Precursor Act). Otherwise, there is little misuse of precursors for the illegal production of narcotic drugs. The law states that a breach of the law is en economic offence. The maximum penalty for this is six years in prison or a fine of € 45,000, or both. The Economic Control Department (ECD) monitors trade in these substances.

Monitoring of the sale of precursors takes place in close cooperation with other EU countries. The EU has established statutes and directives for this, based on the UN Treaty of 1988. Particular attention is given to a list of 23 substances for the illegal production of drugs. In this regard, the EU has concluded treaties with countries in the Andes (Bolivia, Colombia, Ecuador, Peru, Venezuela). It has also concluded a treaty with the USA concerning exchange of information about trade in precursors.

In 2001, the government further elaborated its policy on XTC. In the form of a five-year plan, there is a substantial intensification in measures aimed at synthetic drugs. These involve confiscation of raw materials and additives, approaches taken towards trade, production and distribution of XTC pills in and outside the Netherlands. Investments in public information to discourage young people from using XTC have also increased.

Drugs Tourism

The Dutch government pursues stringent deportation measures with respect to hard-drug addicts who are in the Netherlands illegally and who commit punishable offences. They are the subjects of targeted investigations, prosecution and sentencing. The Dutch authorities may hand them over to judicial authorities in other countries for criminal prosecution.

Export of any drug, even in small quantities, is always a punishable offence. The phenomenon of foreigners coming to the Netherlands to use or purchase drugs is known as 'drugs tourism'. Nuisance caused by drug tourists is especially evident in Dutch border cities and in large cities. They often come from neighbouring countries. Cannabis tourists create nuisance at coffee shops; hard drug tourism often goes hand in hand with aggressive recruitment methods (drug runners). This results in unacceptable nuisance in residential areas and city centres.

In order to counter the export of cannabis by drug tourists, the authorities restricted the maximum quantity of cannabis that coffee shops could sell without being prosecuted to 5 grams. For several years, there have been more stringent measures against drug tourism and related nuisance. In cooperation with customs, the military police and other services, the police regularly monitor drug tourism. In this regard, the Netherlands works with the neighbouring countries of Belgium, France, Germany and Luxembourg.

Since 2000, supplemental to these actions, the 'A Team' has been called in to limit nuisance from drugs. This entails a collaborative arrangement of three

police regions, the National Police Force Corps (NPFC), the railway police and the internal revenue. The 'A Team' identifies and detains drug runners and drug tourists. The 'A Team' operates daily on the roads and in international trains.

The detained drug runners receive summary proceedings and fines on the spot. Local authorities make every effort to persuade those concerned to take part in re-integration programmes.

Penitentiary and Justice Department Addiction Policy

The Justice Department takes active measures geared towards bringing about behavioural changes in each category of addicts. For judicial authorities, addiction is not a mitigating circumstance. Addicts who commit punishable offences might have an opportunity to choose between treatment and custody (coercion and legal pressure?). For those who opt for treatment, the magistrate could suspend custody temporarily or definitively. Addicts who opt for treatment must satisfy several conditions. If they do not stick to these conditions, they could still be placed in custody. One requirement is that they must be motivated to tackle their addiction problem and prepared to undergo monitoring to see whether they are using drugs. The idea behind this approach is that targeted treatment is necessary for addicts who commit punishable offences, in order to bring about sustainable changes in behaviour in this group. Implementation of this justice department addiction policy takes place in judicial institutions, in cooperation with addict-aid agencies. Among other things, this policy entails measures for convicted addicts: pressurised projects, Addiction Counselling Departments (ACD) and Criminal Prosecution Addict Relief (CPAR).

Experiences with this approach in the Netherlands are encouraging. However, based on an extensive study of international literature, the National Health Council recently concluded that little or no evidence is available for the effectiveness of coercion and legal pressure. However, the Council indicated that there is very little evidence for the opposite conclusion, namely that it could **not** achieve any favourable effect.

A reassessment of penitentiary addiction policy is taking place. The aim is to maximise relief to addicts in custody and to improve links to care facilities. This could lead to a reduction in ACDs and expansion of Individual Counselling Departments (ICD) ICDs are special departments for the growing group of detainees with a 'dual diagnosis' - i.e. they are drug addicts, but they also have serious psychological or psychiatric disorders. The National Health Council, an advisory body of the Dutch government, recently issued recommendations for the improvement of care to drug addicts in Dutch penitentiaries. Currently,

forcing addicts to kick the habit is a regular occurrence. Or penitentiary doctors decide against providing methadone to addicts who received methadone treatment prior to ending up in custody. The National Health Council considers this type of force undesirable, arguing that more attention should focus on harm reduction as a goal. Also, care after being released from custody should receive more attention. In subsection 2.1 we discuss cooperation between the judicial authorities and addict care in detail.

1.5 COMBATING NUISANCE

The public's perception of nuisance and insecurity in their social environments is clearly not solely a consequence of drug trade or drug use, but it forms a significant part of this. A relatively small number of drug addicts are responsible for the nuisance that people and governments experience.

In the Netherlands, there is an integral approach to the problem of public nuisance. Since 1993, the Dutch government has systematically worked to reduce nuisance caused by the trade in and use of drugs. Policy focuses specifically on innovative care (see box 4 in subsection 2.1). The Steering Committee for Reducing Nuisance came into being to further policy formation. In addition, 1995 saw the establishment of the inter-administrative Task Force on Safety and Addict Care. Members of the task force, which had close ties with the aforementioned steering committee, included several ministries, the Association of Netherlands Municipalities (ANM) and cities. The main assignment of the task force was to improve the potential for an administrative approach to drug-related nuisance. Box 3 discusses nuisance policy in greater detail.

BOX 3

COMBATING NUISANCE RELATED TO DRUGS

Drugs premises

Trade in and use of drugs in and around residential areas causes considerable annoyance. New changes in the law (Municipalities Act) authorise mayors to close drugs premises if there is a disturbance of public order around the premises and if there are dangers to the health and safety of local residents.

Use and trade on the street

This provides for administrative legal instruments to combat nuisance caused by trade and consumption on the street. Municipalities can also make use of the general municipal bylaws: prohibition of public gatherings or a prohibition to use public streets for purposes other than those for which they are intended.

Drug-use areas

To combat nuisance from hard drug addicts wandering the streets, several cities have opened 'drug-use areas'. Addicts can use such locations to take their daily doses of drugs. Aid workers are present. Sale or distribution of drugs is forbidden. The main aim is to get the support of local residents and to engage them in consultations about this. The PP approves of such initiatives if the decision fits the approach of drug policy formulated by the three-party consultation. They must safeguard the interests of public health and public order. Another factor here is that consumption of drugs is not a punishable offence in the Netherlands.

The Trimbos Institute compiled a manual in the framework of the 'Getting Results' project for the layout and organisation of drug-use areas. In a recent policy statement, the Ministry of Health, Welfare and Sport indicated that, under certain conditions, drug-use areas could contribute to an improvement in the health and social situations of drug users, while reducing nuisance.

Infringements of the Opium Act

The PP could decide to pursue criminal investigations and prosecution of Opium Act offences punishable in the context of combating drug nuisance. The degree of priority depends on the three-party consultation.

Coffee shops

Under certain conditions, the sale of cannabis in coffee shops is not subject to criminal prosecution. Since 1995, in the framework of nuisance policy, for example, policy has focused on controlling problems centred on coffee shops. Coffee shops cause particular nuisance in border regions, where foreign drug tourists come to buy cannabis, and in certain sections of cities. The authorities have kept close watch on coffee shops for some years and have brought about a decline in the number of coffee shops. Based on various laws, local authorities can take action against nuisance that stems directly or indirectly from the sale of cannabis products in coffee shops. In 1999, the 'Damocles Rule' went into force. This entails an addition to the Opium Act that provides for the use of administrative force against coffee shops (and other public premises and related buildings), where the sale, supply or distribution of hard drugs or cannabis takes place or is present.

With respect to administrative action against nuisance caused by drugs, the three-party consultations between the mayor, the police and the PP are indispensable. The Drugs Support and Information Centre (DSIC) supports administrative policy. It is part of the ANM. Its task is to provide support to municipalities, the police and the PP in implementing local drug policy.

Policy to combat nuisance from drugs has been successful. A study covering the period between 1996 and 2000 showed that drug-related nuisance in the Netherlands has declined slightly in recent years.

Part 2 Drug policy in the context of public health and welfare

INTRODUCTION

Addict care in the Netherlands specifically relates to the use of hard drugs, particularly including an estimated 25,000 opiate addicts. Still, care also covers clients with cannabis-related problems, which currently includes some 3,500 persons. Of the total number of clients in addict care, nearly 20 percent come from migrant origins.

In the first instance, addiction is seen as a health problem. However, some addicts cause serious criminal and societal problems. Dutch policy towards drug users is designed to prevent addiction from resulting in increased health problems, degeneration, the spread of diseases, including via used needles, nuisance for the social environment and criminality. Policy also aims to prevent and combat drug addiction. The aim of addict care is also to prevent addicts from ending up in the criminal underworld.

Getting addicts off drugs is usually a long-term problem. That is why it is important to work towards stabilising addiction when total withdrawal is (not yet) feasible. Addict care is geared towards reaching as many hard-drug addicts as possible. An estimated 70 to 80 percent of opiate addicts have contacts with addict care. This provides insight into the scope of the problem, so that policy can be in tune with the actual situation, wherever possible.

In recent years, the average age of addicts who are in touch with addict aid has risen sharply – now around 35 years. This has increased the need for care. Further, it would appear that there is a high need for psychiatric care within this group.

2.1 CARE AND ADDICT CARE

The Netherlands has an extensive, differentiated network of medical and social facilities geared towards prevention and treatment of problematical abuse of alcohol, drugs and other psychoactive substances, such as medicines. This specialised addict care is part of mental healthcare. Its functions include prevention, consultation, emergency medical and social assistance, counselling, treatment and after-care. All functions are available locally or regionally, performed by networks of agencies working in concert.

A major aim of drug and addict care is to reach a drugs-clean life. Improved physical and social functioning, without being exclusively geared towards ending addiction, is also part of this goal.

Dutch policy focuses on advancing differentiated care services, wherever possible, in tune with the widely varied demand for care services. Close attention goes towards ensuring that care programmes anticipate changes in the problem. That means, for example, that one must be alert in preventing contagious diseases (AIDS, TBC, hepatitis) that often affect these target groups. The drug care agencies pursue an integral approach with attention to the total living situation of each client. This type of care demands a concerted effort within the various addict-care services and between addict care and other agencies, such as general healthcare, the police and judicial authorities.

Although addict care aims to bring about close cooperation between ambulatory and clinical facilities, we will discuss these two facilities separately.

Ambulatory Care

Addict care in the Netherlands comprises 33 agencies, of which 18 offer intramural care (treatment in clinics). Of these 18, 10 agencies offer ambulatory or other type of care.

The Consultation Offices for Alcohol and Drugs (CADs) perform ambulatory care. The municipalities fund this care (23 municipalities have regional functions) and, on a contractual basis, also fund the Netherlands Resettlement Foundation (NRF). This foundation contracts out resettlement work to CADs, if people released from prison undergoing resettlement also have addiction problems.

Traditionally, the CADs have played a role in the area of resettlement. Their work concentrates on addicts who have run into trouble with the police and judicial authorities. The first contact usually takes place at police stations, in order to create a drug or addict care relationship. The resettlement officer issues informative reports to a magistrate and offers guidance to addicts, if necessary, during and following a stint in the penitentiary. Further, this officer is involved in community service punishment and monitors correct compliance with the special conditions set by the court or the PP, with respect to suspended sentences or release (waiver of prosecution).

Most CADs are now part of an addiction centre with both clinical and social emergency services. The main tasks of CADs are prevention, consultation and addict care. The aim of consultation is to further the expertise of care workers in

general healthcare facilities or welfare work and to advise them when they are involved in care to addicts.

CADs offer a wide range of care services. These vary from crisis relief, distribution of methadone, social counselling, help in kicking the habit - to and including social skills training and psychotherapy. Besides addicts, their partners and (other) members of their families also receive assistance.

Since the early 1980s, in cities or in regions where there were many drug-related problems, there have been separate agencies for socially-orientated addict care. The care offered was distinct from more medically-orientated CADs or clinics, since it did not emphasise kicking the habit. CADs started with an 'acceptance model', thereby offering 'low-threshold' care. The social assistance offered often focused on specific local problems and client groups. Concerning the latter, this could refer to migrant addicts or heroine prostitutes. This type of assistance is now part of larger agencies. It currently consists of methadone distribution, social work on the streets, living room projects, assisted domestic living and commuter projects. AIDS prevention (replacing needles) and public information also form part of this type of addict care. In recent years, most low-threshold agencies have merged with the CADs.

In extramural or ambulatory addict care, according to a count in 2000, there were approximately 25,000 people registered for care in the Netherlands due to addiction. Remarkably, the average age of addicts has gradually increased in recent years. The group of opiate addicts has remained stable, although there was an increase in the use of cocaine or crack. Nearly one-fourth involves addiction to cocaine or crack. Apart from that, many registered clients use more than one drug (54 percent of clients use more than three different drugs). In intramural or clinical care, the number of cocaine users has also increased, although there are no accurate figures available. One problem is that there are few specific treatment programmes for these kinds of addiction.

Clinical Care

Clinical facilities offer treatments varying from brief detoxification periods (up to three weeks), short admissions (up to three months) to longer admissions (maximum one year) for intensive treatment programmes. Several clinics offer part-time treatment. Nine addiction clinics also have polyclinics (ambulatory care stations). The main aim of these polyclinics is to provide after-care for clients released from the clinics. The longer admissions often take place in therapeutic communities. Intramural care is particularly geared towards achieving abstinence. Since this requires sufficient motivation, it usually entails a selection

process. Since these are relatively high-threshold programmes, certain client groups are put off. As a result, clinical facilities with less ambitious goals have opened their doors in recent years. There, stabilisation and improvement of the addicts' situations receive greater attention as the basis for future treatment.

Methadone Distribution

Distribution of methadone to opiate (heroine) addicts is another option (free of charge). Some 13,500 persons take place in the annual methadone programme. Methadone is a synthetic opiate (containing opium). Various countries distribute methadone to hard-drug addicts as a drug substitute. Less than half of the estimated number of heroine addicts receive methadone. Distribution takes place on the basis of phased withdrawal and replenishment. In practice, nearly 90 percent of participants receive methadone on a replenishment basis. The primary aim of the replenishment programme is to prevent deterioration in the health of those involved and to promote stabilisation of their addiction. Improving social functioning and reducing criminal activities (stealing to finance their habits) are aspects of support offered by this type of care. Only therapy-resistant heroine addicts can join the methadone distribution programme. Addict care agencies and city healthcare agencies in Amsterdam and Groningen mainly conduct methadone distribution. Methadone is also addictive, but has the advantage over heroine that addicts can take it orally in the form of pills or as a liquid, in precise doses. Moreover, methadone lasts more than 24 hours. The effect of heroine only lasts a few hours. In this sense, medically seen, it is a drug for treating addicts and not a stimulant. Of the addicts known to the aid agencies, some 75 percent regularly take methadone.

An evaluation of methadone distribution over several years in the Netherlands reveals that a relatively high percentage of addicts do have the intended high frequency of contact with aid agencies. Participation also reduces the chances of an overdose. In general, participants show improvement in their social and medical conditions. Deaths among participants are relatively low. There is also a lower frequency of drug use. The large scope of the methadone programmes provides a good basis for other care activities, including prevention of HIV/AIDS or hepatitis. Researchers also found a small reduction in criminality among participants.

Prevention of AIDS and Hepatitis

Prevention of HIV infection and AIDS constitute a separate aspect of drug care. The HIV virus causes AIDS. The infection occurs via the use of injection needles, among other things. Infection with hepatitis can also take place in this way. Currently, only 13 percent of opiate clients inject the drug. Since the mid-1980s, there have been programmes for distribution and exchange of needles. There are

over 130 needle-exchange programmes in the Netherlands in 60 municipalities. These are often components of methadone programmes.

In the Netherlands, with low-threshold care, personal counselling and public information, the reuse of needles by heroine addicts has declined sharply in recent years. The number of drug users or addicts infected with the HIV virus is relatively low. Since the HIV virus is contagious via unsafe sex, public information about safe sex and the distribution of condoms are also preventive measures. In some municipalities, chemist's, or specially equipped buses exchange syringes. Studies show that exchanging syringes does not result in a lowering of the threshold for injecting hard drugs. That threshold remains high.

Prevention of hepatitis B and C also benefits considerably with syringe exchanges. The experiences of several years, which show that between 70 and 80 percent of users in Amsterdam who inject drugs are infected with the hepatitis C virus, underscore the importance of this.

Legal Pressure Policy and Judicial Addict Care

In recent years, the authorities have used legal pressure to get addicts to undergo treatment. One idea behind this is that, in this way, society could try to reduce the nuisance caused by them. Since 1988, the authorities have made increasing use of the opportunities afforded by criminal law. Cooperation between the police and judicial authorities and care agencies is a typical feature of Dutch policy. When the police detain hard-drug addicts for possession of drugs or for criminal activities, they contact aid workers. Addicts who regularly get in trouble with the police and judicial authorities can choose between 'punishment and treatment'. Dutch criminal law provides for several types of 'legal pressure'. For example, in the context of 'early assistance' at the police station, suspects can opt for care based on having their temporary custody suspended in favour of treatment.

Another legal avenue concerns making use of statutory regulations relating to custody. These provide for substituting custody for clinical treatment during the last stages of the punishment. In the Netherlands, since 1981, the prisons have established various drugs-free departments (addict counselling departments, ACD). In these departments, addicts can take part in separate treatment programmes. Cooperation between addict care and judicial authorities has also developed to combat nuisance caused by drug addicts. The number of clinics, ambulatory and judicial facilities has expanded considerably. Since 1993, a range of new (closely-related) facilities and projects has been under development. Box 4 contains additional details on this.

BOX 4

INNOVATIVE CARE INVOLVING LEGAL PRESSURE

Based on positive experience in Amsterdam with the so-called Street Junkie Project, the authorities in the Netherlands developed and implemented the *Early Assistance Intervention System* (EIS). It represents an elaboration of the resettlement function, which is already responsible for addict care. This system endeavours to reduce addict crime and nuisance by improving and intensifying cooperation between the police, judicial authorities and addict care. Intake comes from police cells or prisons. One possible result of these contacts, if the courts give their approval, is to suspend temporary custody of addicts under certain conditions, if those involved opt for treatment instead of (further) detention.

When the courts sentence addicts, they can impose *community service punishment*, based on relatively minor offences with unconditional sentences up to six months. Community service punishment could entail a community-service project, a learning assignment or a combination of both. The development of community service punishment for judicial addicts is the responsibility of the resettlement and after-care service.

If addicts opt for care, the case manager sets up an *individual care track*. This entails specific conditions. Any violations during this track will result in the case being brought back to the courts, where the suspended custody could be reinstated. As a result, the magistrate could still order execution of the sentence.

If addicts opt for care, in most instances admission takes place in an addiction clinic. The aim is to improve physical and social functioning and to motivate addicts to continue or complete the treatment. When sufficiently motivated, the addicts can continue the treatment or counselling voluntarily. Social integration follows completion of the treatment. Finding jobs is extremely important. The *Intramural Motivation Centre* (IMC) provides a low threshold, experimental facilities. Assessment studies have concluded that these facilities meet expectations.

Other experiments include facilities for addict mothers with children, a facility for young addicts, care farms and a *Forensic Addiction Clinic* (FAC). The FAC has served problematic delinquents on an experimental basis since 1998. This involves drug addicts who have committed multiple crimes and have unsuccessfully undergone clinical treatment.

The most recent development in the judicial involvement with addicts concerns the

Criminal Relief for Addicts (CRA). This measure is still in an experimental stage. It concerns a legal measure that went into effect in 2001, empowering the courts to place addicts who are consistently repeat offenders in a special institution charged with criminal relief for addicts. In such cases, the measure cannot last longer than two years and can only be imposed on in the event that other types of addict care have been unsuccessful. The CRA institutions devote considerable attention to schooling, work, leisure time, (supervised) domestic living and managing money. These institutions utilise the expertise of addict care, working closely with services and organisations in the municipalities where the institutions are located. Special CRA institutions have opened in Rotterdam, Amsterdam and Utrecht and in six other medium-sized municipalities in South Netherlands.

Further, there are various kinds of 'busybody care' (actively staying in touch with addicts in their own social environments), facilities for day and night shelter (for addicts that do not yet have stable social situations), educational and work projects, employment mediation and supervised living (for stable ex-addicts), social boarding houses and sheltered dwellings.

Consultation and Alignment

Addiction is a chronic disorder that involves many institutions and professional groups. Proper consultation and alignment of activities are therefore necessary. There are now specific addiction circuits in all regions and cities. These comprise both specialised and general institutions and facilities. General Practitioners form the foundation of these circuits. They have an important role in identifying and providing assistance for addiction problems. For extended treatment, they can refer their patients to specialised addict care.

Addict care receives funding from various sources: at national government level via the General Extraordinary Health Insurance Act (EHIA) and via subsidies from the ministry of Health, Welfare and Sport budget, municipal funding for ambulatory addict care and prevention, based on the Welfare Act; and from the ministry of Justice for judicial addict care and addict resettlement. Since these various financiers conduct their own policies, inconsistencies in policy conduct could arise. For several years, the authorities have sought methods of improving coordination. There are pilot projects geared towards better administrative and financial alignment. The latter form the basis for any changes in legislation and regulations. One bottleneck in particular is the continuity of care between addict resettlement and regular addict care. The reason behind this is that the Justice Department adopts policy centrally and the regions have no say in the financial resources made available in that context.

Quality Improvement

For nearly ten years, systematic attention has focused on improving the quality of drug-related care. The Care Institutions Quality Act went into force in 1996. This Act prescribes that institutions must offer 'accountable care': care that is effective, appropriate and client orientated. This is conditional to systematic monitoring, control and improvement of the quality of the services provided. Because of the complexity of drug addiction, this means that care relies on proper alignment of the various types of care. Further, there are efforts to improve client dossiers, standard records and standard protocols. These safeguard alignment and communication among the various departments and institutions.

Quality improvement also comes about through systematic assessment and treatment programmes with a scientific basis. Institutions develop guidelines for treatment programmes based on scientific insights. For several years, the government has supported the 'Getting Results' programme in which institutions for addict care work on improving the quality and innovation of care service. This also includes prevention, social care and emergency relief for chronic addicts with multiple problems, along with a specific approach for migrant target groups. Social integration plays a major role in drug-related care. It encompasses all activities and programmes geared towards improving the integration of (ex-) addicts in society. Areas of attention here are housing, schooling, leisure time, income and work. The authorities offer these activities integrally, along with more medically-orientated care. Cooperation with authorities not specifically orientated towards addicts is necessary to ensure the success of the care offered. The National Health Council recently issued recommendations about the treatment of addiction with medicines. They stated that treatment of addiction should be in the domain of medical treatment. However, that does not mean that such treatment would only involve doctors. According to the council, addiction is a disorder that entails biological, psychological and social causes. Treatment with medicines should therefore often form part of any integrated treatment, including psychosocial and psychotherapeutic treatment. The council found that, in the Netherlands, such treatment differs appreciably per institution and that there is a clear lack of consensus and guidelines. The ministry of HWS has not yet adopted a position with regard to this report.

2.2 PREVENTION POLICY

Naturally, policy does not solely focus on (problematical) drug addicts. The addict-care institutions and municipal healthcare departments devote considerable attention to primary and secondary prevention. The prevention programmes are geared towards pupils, young people in places of entertainment

or other risk groups. Public information takes place locally and nationally (through the mass media).

The Dutch government sees itself as responsible for creating the conditions for development, implementation and assessment of prevention and public information activities. For the most part, implementation is in the hands of specialised institutions or organisations that maintain close contacts with the target groups. These include schools, facilities for youth work or youth assistance and sports.

There are countless local and regional prevention activities geared towards diverse target groups. Prevention staff mainly work for addict-care institutions. At the Trimbos Institute there is a National Prevention Centre (NPC) for addition and drug use that coordinates the activities of prevention workers. The NPC aims for quality improvement, cooperation concerning the Internet, registration of prevention activities and reinforcement of secondary prevention (geared towards people using problematical drugs). The NPC also works together on scientific development of effective prevention methods, in the framework of the 'Getting Results' project.

The municipalities have policy responsibility for local and regional prevention activities. The national government organises and finances national prevention campaigns.

Public Information Programmes

The Trimbos Institute conducts the 'Clean School and Stimulants' programme. It has done so with considerable success since 1990, along with schools and local agencies. The programme devotes attention to the risks of drugs, alcohol, tobacco and gambling. It focuses on pupils in various age categories, involving both teachers and parents in carrying out the programme. It is important to provide children with public information about specific stimulants when they reach the age that they could come into contact with such drugs. Three-fourths of secondary schools now take part in this project. Most municipal healthcare services and addict-care agencies support it. Many schools have established their own rules relating to stimulants. They are now in a better position to identify the use of drugs, to counsel pupils with problems and to get parents involved at school about this issue. The project has developed its own folders, brochures, exercise booklets, handbooks, posters, postcards and videotapes. Studies show that the project has had a positive effect on knowledge and behaviour. Moreover, it appears that use of stimulants at the participating schools is following a more favourable course.

A comparable project is the 'Going Out & Drugs Project'. The aim of this project is to prevent problematical use of drugs among young people. The idea behind the

project is that prevention is most effective when it reaches young people for longer periods of time, in different ways, at various locations and via different channels. The project focuses on all young people (users and non-users), without limiting itself to one specific drug.

At the Trimbos Institute, the Drugs Information Office has been around since 1995. This office endeavours to improve public information activities relating to drugs. It maintains a data bank with an overview of current public information materials. Information is also available on the Internet and there is a telephone hot line for drugs information, with live operators who answer calls.

The general public receives public information through national agencies - with the support and by direction of the national government. They use mass media, but also ensure support for their campaigns through agencies that operate locally. This increases the scope of the campaigns. For a long time, people thought that it was a good idea to remain aloof to large-scale campaigns about drugs. There was a risk that the problem could be blown out of proportion, with the wrong effects. This view has now undergone revision and, since 1996, reinforces this type of public information about drugs.

Prevention around XTC

XTC (whose chief ingredient is MDMA, see box 2) has become popular (in the Netherlands and many other countries) in a short time, especially among the youth. The substance causes an euphoric effect and is non-addictive. The drug is seen as the ideal way of getting into the right mood at house parties. There are apparent risks of poisoning the nervous system by using XTC, although research in this area is still ongoing. In the wake of the arrival of XTC, other pills came into use whose composition was not clear or dubious, which could sometimes cause acute health risks. In order to learn more about these substances, partly in relation to the circumstances under which they are used, the Dutch government is doing substantial research into the effects of these drugs.

Recently, in a specific policy document devoted to XTC, the Dutch government has given new impulse to prevention and counteraction policy. The policy document ties in with initiatives taken several years previously. In 1997, a campaign started via the mass media about the risks of XTC. The main goals are to improve the health-related behaviour of young people concerning alcohol and drugs, to restrict use and to prevent harmful health effects. The year 2000 saw the introduction of the 'Drugs, don't be fooled' campaign. This aimed particularly at communication about drugs between young people and their parents.

Another type of prevention relating to XTC and other synthetic drugs focuses on furthering the expertise of agencies and local authorities, geared towards controlling the drugs problem in locations or during events for which they bear responsibility. The use of synthetic drugs often takes place during house parties. This frequently involves pills of unknown composition, thereby increasing the risk. For municipalities and municipal services, the measures that they and the house party organisers take are extremely important, in order to prevent accidents. In 1995, a policy document entitled *'Town Hall and House Parties'*, contained recommendations to guide municipal policies in reducing the risks of XTC use at large-scale events and house parties. Further, the advice concentrated on combating nuisance in the residential environment. In this regard, the chief aim was the potential of municipalities for improving the circumstances in which high-risk drug consumption takes place through legislation.

Prevention of drug use is the primary aim of public information about drugs. Still, a substantial number of young people take drugs at house parties and in discotheques. This particularly involves XTC and, to a lessor degree, other synthetic drugs. Until 1999, visitors to house parties could have their pills tested. This activity was part of the so-called *Safe House Campaign*. Visitors could get an indication of the composition of their pills and the possible health consequences. Today, testing of pills is only possible at special testing labs, which are part of addict-care agencies. However, visitors may only offer a limited number of pills for each testing.

The Drugs Information and Monitoring System (DIMS), part of the Trimbos Institute, coordinates these testing opportunities. It has concluded agreements with the PP about the circumstances under which testing takes place. The government considers testing useful for improving public health. The activities of the DIMS provide greater insight into the various drugs markets in the Netherlands and the changes that are taking place.

Current testing opportunities accompany prevention-targeted public information to users, concerning the health hazards of using XTC and other pills. Action is taken immediately if testing reveals pills in circulation that carry serious health risks. In some cases, a warning could go out to all testing labs and care agencies in the Netherlands, along with notification of the press. Further, in such cases, the authorities would spread flyers at places of entertainment and could offer extra testing opportunities.

Monitoring and Estimating Risks

Finally, monitoring of new, dangerous developments and assessment of the risks of drugs is a new aspect of prevention policy. The European Union devotes

systematic attention to monitoring the production and use of new synthetic drugs. The purpose of the 'Early Warning System' (EWS) is to have timely information about developments that constitute serious hazards to public health and, based on this, to issue warnings to the separate Member States. The EMCDDA is in charge of the system. Based on this, the countries can take preventive measures. The Member States have set up 'focal points' and prepare reports for the EMCDDA. Since 1993, the DIMS has served as a *focal point* - housed in the Trimbos Institute.

Supplemental to this, since 1999, the Coordination Centre for Assessment and Monitoring of new drugs. (CAM). It came into being as a high-grade instrument for estimating the risks of new drugs. The Public Health Inspectorate (PHI) houses its secretariat. The aim of CAM is to identify any new drugs (with vegetable or synthetic origins) appearing in the Dutch market, or any new combinations or new applications of known drugs, and to subject them as quickly as possible to *multidisciplinary* risk estimates. The multidisciplinary aspect is necessary to prevent one or two points of view getting the upper hand, which could result in a one-sided assessment. If possible, the CAM also makes recommendations for measures about production and distribution of and trade in the drugs tested. Further, it provides pointers about public information and prevention. The CAM can also recommend continued monitoring of the tested drugs, for example, because there is insufficient data to draw definitive conclusions. This forms the basis for national government policy. If this involves synthetic drugs, the CAM reports this to the EMCDDA. A risk estimate runs its course according to established procedures and criteria. These criteria relate to both (public) health

BOX 5

THC CONTENT OF CANNABIS

Dutch law prohibits the Food Inspection Department from carrying out quality controls on cannabis offered. The law prescribes that only legal substances are subject to quality controls. Nevertheless, the government attaches great importance to having insight in the content of the THC (TetraHydroCannabinol, the active ingredient) in cannabis, because of the accompanying health risks. There is an impression that, due to better refinement and growing techniques, this content has increased considerably in recent years. The government therefore orders periodic testing to monitor the development of the THC content (including seasonal influences) and to determine whether there is a connection between incidents and the THC content. Further, studies are being carried out to determine THC's dosage-effect ratio.

and to public order and safety. There are already risk estimates for 4-MTA (4-methylthioamfetamine), GHB (gammahydroxybutyrate), 'paddos' or magic mushrooms (psilocine and psilocybine) and ketamine. The estimate of PMA (1-[4-methoxyfenyl]-2-aminopropane) and PMMA (paramethoxymethylamphetamine) substances is nearing completion. The government is also keeping a close watch on the development of the composition of cannabis (see box 5).

2.3 EXPERIMENTS AND RESEARCH

The government contributes to improvement in the quality of current addict care. This means that it also contributes to research into new treatment methods for people who until now have received insufficient treatment. In that context, starting in 1997, researchers have gained experience relating to addicts that kick the habit under narcoses. Administration of the substance Naltrexon, which counteracts the effects of opiates, to patients under narcoses for approximately eight hours, results in intensive and acute physical abstinence. Because they are under narcoses, patients do not suffer severe withdrawal symptoms. Several hours after regaining consciousness, patients can leave the hospital. Afterwards, the patient must continue to take Naltrexon in pill form for another six months as part of the follow-up treatment. Supported by HWS, experimental testing of this treatment method has taken place since 1999. The tests show that general anaesthesia has no added value on the effect of rapid detoxification with this kind of anti-opiate agent. Researchers did determine that rapid detoxification is superior to the traditional method of gradual withdrawal from methadone. Research into rapid detoxification without anaesthesia is continuing. Researchers have recommended that the indicated position for rapid detoxification should take place at a single location in the Netherlands.

Another experiment concerns research into 'high doses of methadone'. Standard treatment in the Netherlands limits doses of methadone to 40 grams per day. The hypothesis is that higher doses for specific patient groups could result in more stability or reduce relapses in drug use. It is not yet certain whether these effects are permanent.

Heroine Experiment

In July 1998, the Netherlands started research into the effects - in combination with methadone - of experimental prescriptions of heroine to chronic heroine addicts. The study, under the auspices of the Central Committee for the Treatment of Heroine Addicts (CTHA), focused on long-term addicts, at least 25 years old, for whom current treatment, including taking part in a methadone programme, had little or no effect. Another criterion for participation was weak physical

condition and the occurrence of psychosocial problems. The participants had to be Dutch nationals or legal residents of the Netherlands. They had to be residents of the municipality where treatment would take place for at least three years. A further requirement was that they would have to agree to take part in the study.

BOX 6

CONCLUSIONS AND RECOMMENDATIONS OF A HEROINE EXPERIMENT

The researchers formulated the following conclusions:

- Implementation of the study and analysis of the data went smoothly;
- Controlled treatment with heroine in combination with methadone of chronic, therapy-resistant heroine addicts (who had already received treatment with methadone) is more effective than a continuation of treatment with methadone only; the size of the effect was 25 percent, both for those who injected and those who smoked heroine;
- Controlled treatment of this group of addicts provided clinically relevant health differences; the favourable effects were not limited to reductions in criminality, but there was also improvement in both social functioning and physical and psychological health;
- However, the effects of the controlled treatment of heroine in combination with methadone are especially favourable when treatment continues;
- The combined treatment proved to be practicable to carry out, did not result in any serious medical incidents and only resulted in a limited number of manageable disturbances of the peace;
- The costs of the combined distribution depended on the application method and distribution of the drugs: there should be proper controls and safety precautions for arranging and implementing the medical distribution of heroine.

The researchers made the following recommendations:

- Under compulsory conditions and as final pharmacological-therapeutic intervention, introduce in the Netherlands controlled medical distribution of heroine in combination with methadone as a form of treatment for specific target groups;
- Take a decision at the earliest moment concerning the introduction of controlled distribution of heroine under medical prescription;
- Promote the demand for registration of heroine as a medicine;
- Develop a quality assurance system for heroine under medical prescription;
- Conduct a follow-up study.

Addicts with severe psychiatric disorders or with sufficient aggressive behaviour to disrupt the experiment were not allowed to take part in the distribution. Nor were pregnant women and addicts with specific health problems admitted. The addicts could only take the heroine in the treatment centre.

Preparations leading to this 'heroine experiment' made extensive use of the experiences gained several years ago in Switzerland, concerning experimental heroine distribution. A wide range of international researchers had access to the design, conduct and reporting of the experiment. Further, the International Narcotics Control Board (INCB, part of the UN) and the World Health Organisation (WHO) received extensive briefings in advance.

During the study, researchers examined whether the condition of the participants improved when they received combined treatment, compared to treatment with methadone only. They measured the success of the treatment based on improvements in the subjects' medical condition, use of drugs, changes in criminal behaviour and social functioning. All research subjects received offers of psychosocial assistance during the experiment.

In early 2002, researchers announced the results of two randomised and controlled studies of 12-month treatment effects, with or without medical distribution of heroine. In this regard, they distinguished between (a) treatment that combined methadone with injected heroine and (b) treatment that combined methadone with heroine that can be inhaled. The study also examined possible differences between treatment combining methadone and heroine between six and 12 months. The experiment focused attention on the consequences of a predetermined termination of treatment with heroine. Box 6 contains the conclusions and recommendations of this research group.

The Lower House has decided to continue the experiment. It has proposed that the Dutch government come up with a new proposal within one year, after taking advice from the Central Committee for the Treatment of Heroine Addicts (CTHA).

Medicinal Cannabis

People can also use cannabis for medical purposes. Patient organisations and the general healthcare services have long argued in favour of allowing the use of cannabis as a medicine. Among others, this applies to AIDS and cancer, whereby cannabis can counter negative side effects of the medicines. Patients with multiple sclerosis also use cannabis to relieve symptoms. The Dutch government has recently legalised the controlled cultivation of cannabis for medical applications.

Research

The Dutch government devotes considerable attention to research into addiction, the risks of certain drugs, along with the effectiveness of treatment methods. There is exceptionally high-level research in the Netherlands concerning the drug issue. To a large degree, Netherlands Care Research / Medical Sciences (NCR/MS) carries out the programming and funding of such research. In 1997, this organisation started the Addicts Programme for research and innovative projects in the field of addiction, prevention of addiction and addict care. The programme contains the following main topics: (a) individual sensitivity for addictive substances, (b) relapses into former addictive behaviour and improvement of the effectiveness and appropriateness of care, and (c) prevention and monitoring. Another important initiative concerns international research centred on cannabis. Box 7 provides details of a scientific conference in Brussels in 2002.

BOX 7

CANNABIS CONFERENCE

The West European cannabis conference took place in Brussels early in 2002. It was a scientific conference on cannabis, on behalf of the ministers of Health from Belgium, Germany, the Netherlands and Switzerland. The ministers felt that there should be a scientific basis for policy in this area. Representatives of other West European countries, the USA, Australia and Canada also attended the conference.

The conference members drew up a list of points for which there was scientific agreement. They drew up another list of points about which too little information was available or about which scientific opinions were at odds. They reached a general consensus on the following findings:

- Cannabis could affect one's ability to drive, although not as seriously as alcohol. In particular, the combination of cannabis with alcohol could have an effect in this regard;
- There are effective programmes for preventing the use of cannabis among young people; schools play key roles in this (along with the family and the neighbourhood). Nevertheless, there are ineffective programmes carried out in many countries, which are counterproductive in deterring young people or in bringing them into contact with (ex-) addicts and convicts;
- Many cannabis consumers experience little or no harmful effects from using cannabis. Dependency on cannabis is a possibility. Approximately 10 percent of users in western countries find it difficult to stop or reduce consumption. They also experience withdrawal symptoms or other problems;

- There are promising programmes under development for treating cannabis dependency; however, there is little interest for them in Europe so far;
- Young people usually start by drinking alcohol and experimenting with tobacco; some of them later use cannabis and a small number move on to try hard drugs. In this regard, there is evidence that the use of alcohol, tobacco and cannabis 'could' lead to the use of hard drugs. It seems that hard-drug users often have a previous history (traumatic youth experiences, behaviour disorders) and (partly as a result of this) are more inclined than average towards risky behaviour;
- Legislation and police supervision have little effect on the use of cannabis; countries with widely divergent legislation show no significant differences in the use of cannabis.

The conference members proposed that further research should take place on the following subjects: the effect of policy, epidemiology, the threshold value for driving proficiency, the effectiveness of prevention and various biological aspects. The ministers said that they would institute research programmes and discuss them at the following conference, to be held in Paris.

This would also stimulate international cooperation in this connection. In the Netherlands, there is multiple-year research into the degree of toxicity for the nervous system (neurotoxicity) of XTC, in collaboration with French, American and British (research) institutes. The intention of this medical and pharmacological research is to get a more accurate picture of the risks of XTC and to align public information and prevention activities to such risks. Further, the American National Institute on Drug Abuse (NIDA) and MCR/MS concluded a collaborative agreement.

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The objective of Dutch drug policy is to prevent and limit the risks associated with drug use, both to users, to their immediate surroundings and to society. In this booklet you will find an overview of all aspects of our policy. It explains our integrated approach to drug policy, both at national and local levels.

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