



N D M N A T I O N A L E
D R U G M O N I T O R

**REPORT TO THE EMCDDA
by the Reitox National Focal Point**

**THE NETHERLANDS
DRUG SITUATION 2004**

FINAL VERSION

REITOX

REPORT ON THE DRUG SITUATION 2004

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The Report on the Drug Situation in the Netherlands 2004 has been written for the European Monitoring Centre of Drugs and Drug Addiction (EMCDDA). Each year, national centres of expertise on drug-related issues in the member states of the European Union ('Focal Points') draw up a report on the national drugs situation, according to guidelines provided by the EMCDDA. These reports form the basis of the "Annual Report on the State of the Drug Problem in the European Union" compiled by the EMCDDA.

This 2004 national report was written by the staff of the Bureau of the National Drug Monitor (NDM) located at the Trimbos Institute and staff of the Scientific Research and Documentation Centre (WODC) of the Ministry of Justice. The NDM was established in 1999 on the initiative of the Ministry of Health, Welfare and Sports. The Ministry of Justice also participates in the NDM. The NDM carries out the functions of the Focal Point.

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Executive summary

Part A New developments and trends

1. National policies and context

The most important policy document published April 2004 is the white paper on cannabis policy. With this paper the Government expressed the intention to tighten the Dutch policy on cannabis. The main policy intentions are: National Action Plan to Discourage Cannabis Use, intensified enforcement of the laws and regulations on cannabis, more severe measures to curb drug tourism and firm action to curb large-scale production of cannabis.

The new act 'Placement in an Institution for Prolific Offenders – ISD' came into effect on 1 October 2004. This act refers to all prolific offenders, not only addicts. The Judicial Treatment of Addicts will operate as a separate programme within the ISD-programme. In order to combat drug trafficking, a complete control of all flights from the Netherlands Antilles started in December 2003 and is still operational. The 100%-control of flights from Surinam started in February 2004.

The Government decided that, for a selected group of chronic treatment resistant opiate addicts, treatment units for medical prescription of heroin can be extended from 300 to 1000 participants.

2. Drug use in the population

General population surveys show that drug use increased between 1997 and 2001, at least in the population above age 15. According to a series of national school surveys among pupils between 12 and 18 years, drug use increased between 1988 and 1996 and overall stabilised in 1999 and 2003. Among boys, the last month prevalence of cannabis use significantly decreased from 14% in 1996 to 10% in 2003. There was no significant change in cannabis use among girls (LMP 8% in 1996 and 7% in 2003). The percentage of pupils using other drugs, such as ecstasy, cocaine, amphetamine or heroin, peaked in 1996 and stabilised or decreased since then. In 2003, 4.5% of the pupils had ever tried one of these drugs and 1.5% had currently used.

Compared to the general (school) population, drug use is much more common among specific populations, such as young people in recreational settings. Recent quantitative and qualitative studies indicate that ecstasy remains the main illicit drug (after cannabis) in the nightlife scene, although a moderation of its use and 'ecstasy weariness' have been noted. Cocaine has gained popularity throughout the country. Among visitors of clubs in Amsterdam, drug use seems to have decreased between 1998 and 2003.

3. Prevention

There are no major new developments in drug prevention but several new reports were published. Some older projects (the Drugs Info Line, Educare, the Healthy School and Drugs, the Drugs Information and Monitoring System, and Unity) are continued. Several new projects were reported. A public campaign targeting cannabis use among youth outside school, was not particularly successful. Knowledge about this drug only increased among cannabis users and information seeking did not change at all. The results of a local school-based project favoured drug use instead of imposing a negative attitude towards drugs. The results of a peer project on four locations in Amsterdam were mixed. The third study is an analysis of registration data. The outcomes refuted general prejudice about large numbers of serious drug casualties in recreational settings. This study shows that since 1996, serious

trouble appears to be rare in these settings. Finally, various studies, amongst which one systematic review of Dutch authors, initiated a scientific discussion on possible causal links between cannabis use and psychotic disorders. Such a link could have consequences for future cannabis prevention activities.

4. Problem drug use

The number of problem opiate users in 2001 was estimated at some 32,000, which is not significantly different from previous estimates in 1996 and 1999. Converted to population rates, there are about 3 problem opiate drug users per 1000 inhabitants between 15 and 64 years. Most of these users also consume crack cocaine and other substances. An estimate on the total number of problem cocaine users (crack users as well as cocaine sniffers) is not available, nor are there any recent and/or reliable estimates available on the number of problem users of cannabis, ecstasy and amphetamines.

According to outpatient treatment data, the proportion of cocaine and cannabis clients among all drug clients has strongly increased in the past ten years, amounting to 38% and 20% in 2003, respectively. The proportion of *new* cocaine and cannabis clients among all drug clients applying for help for the first time (first treatments) is even more pronounced (41% and 32% in 2003, respectively). The average age of the population of drug clients has increased from 29 years in 1994 to 33 years in 2003. There are no major changes in gender distribution. The percentage of injecting drug clients decreased in this period from 12% to 5%.

5. Drug-related treatment

Some studies illustrate a lack of insight in what type of interventions for substance use problems are used in daily practice, but registration and reporting has improved in the past years. A critical review of the international literature offers the latest evidence for effectiveness of interventions. The attention in addiction care is increasingly towards evidence-based or 'good' practice. Although the effectiveness of self help groups cannot be determined, these groups are perceived to improve retention and to reduce relapse rates, when added to (or after) regular treatment. Recent Dutch experiments have opened possibilities for effective treatment or harm reduction modalities: medical heroin prescription, rapid detoxification and after care with naltrexone, and higher doses of methadone. Still, much remains to be improved. Recently published reports from the National Court of Audit and the National Inspectorate of Health are critical about the Dutch system of addiction care. Criticisms relate to funding arrangements, the organisation, actual cooperation with other organisations and the quality of care.

6/7. Health correlates and consequences

The *total* number of recorded drug-related deaths doubled from 70 cases in 1995 to 144 in 2001, and decreased again in 2002 and 2003 (103 and 104 cases, respectively). The increasing trend can be attributed to the change from ICD-9 to ICD-10 in 1996 (whereby more cases are included according to the ICD-10) and the rise in acute cocaine deaths, which seems to parallel an increase in problem use. Moreover, besides deaths due to opiates and cocaine, a growing number of deaths since 1996 were coded as 'accidental poisoning by other and unspecified dysleptics' and 'poisoning by other and unspecified narcotics'. These deaths may be related to poly drug use, but there might be some 'contamination' by psychoactive medicines and alcohol.

HIV prevalence among injecting drug users varies between 26% in Amsterdam to 1% in Arnhem and Groningen. In most cities, prevalence rates remained fairly stable in the past decade. There are no new data on the prevalence of HCV and HBV among random samples of injecting drug users. Early 2004, an outbreak of hepatitis A was observed among homeless problem drug users in Rotterdam.

Many initiatives to prevent and treat drug-related infectious diseases started several years ago. In the reporting year, drug consumption rooms and hepatitis B vaccination for high risk groups were continued. Moreover, a study investigating the feasibility of hepatitis C screening and treatment of hard drug users was started. A survey showed the diversity of syringe exchange practices in the Netherlands. These data may support activities for improving the quality of these programmes.

A recent literature review concludes that chronic ecstasy use is associated with long lasting impairment of cognitive functions, although the effects are probably also due to the poly substance use that is typical for the population of ecstasy users. Moreover, ecstasy induced hyperthermia (and probably the degree of brain damage) is associated with the amount of the drug ingested and the ambient temperature during use. Information communicated by the Drugs Infoline and various information leaflets on ecstasy will be adjusted according to the conclusions of this report. Various experimental studies also suggest that ecstasy may interfere with specific psychomotor abilities relevant to driving, but the results are mixed.

8/9. Social correlates and consequences

A distinction can be made by Opium Act crimes and crimes committed by drug users. Opium Act crimes increased in 2003 to more than 17,000. The increase can be seen from (registrations of) first police contacts to those that were released from prison. The increase might partly be due to the enhancement of law enforcement efforts, which were in 2003 especially aimed at the investigation and prosecution of the import of cocaine and export of synthetic drugs via airplanes and at rolling up locations where marijuana plants are grown. In 2003, there were also more investigations into serious forms of organised crime; drug law offences form a growing proportion of these investigations. The majority of cases concern hard drugs.

The number of crimes committed by drug users was just as high in 2003 as it was in 2002. There were about 10,000 offenders classified as drug users by the police in 2003. The majority has a long history of hard drug use and high rates of recidivism. Most of them are suspected of property crimes without violence. Of prison inmates, 79% indicates to have used drugs ever prior to imprisonment and 40% report serious or very serious problems with their drug use, mainly with use of hard drugs. Repeat offenders are a target of the recent Dutch safety policy; drug addicts form a considerable proportion of these repeat offenders.

For drug using offenders several types of assistance are available. Assistance is aimed at re-integration of offenders into society and - by this - prevention of recidivism. Addiction Rehabilitation Services are active in all phases of the criminal justice system. Several services are offered, from early visits to detainees in remand custody to supervision of clients in the framework of a judicial decision. Drug addicts in prisons can choose to participate in an Addiction Counselling Department or a penitentiary programme at the end of the detention period. In addition, there is the possibility of compulsory participation in Judicial Treatment of Addicts (SOV), which can be applied by the Judge as a judicial measure with a maximum of two years. On 31 July 2004 there were 148 participants in SOV, 67.5% of the 219 available places were occupied.

There are important political developments going on with respect to the assistance to drug users in prison. The prison system is focused towards a higher effectiveness and efficiency in the execution of sentences, with a more differentiated and selective use of prison capacity and a more systematic and stringent selection of detainees for programmes. Participation in aftercare rehabilitation programmes will be stimulated. New experiments are carried out in this framework.

An important development is the new Act ' Placement in an Institution for Prolific Offenders ', which facilitates sentencing offenders to an imprisonment in a sober regime for a maximum of two years. This Act has been in force since October 2004. Because most drug addicts belong to the category of repeat and prolific offenders, this Act will have high impact on drug addicts.

10. Drug markets

The composition of 'ecstasy' pills delivered by consumers at test locations has been fairly stable in the past years. Over 90% of the tested pills contained only MDMA or an MDMA-like substance (MDEA and/or MDA). However, there is a slight increase in the proportion of pills with a high dose of MDMA (>140 mg), i.e. from 1% in 1997-1999 to 6% in 2003.

The concentration of THC in Dutch marihuana has increased from 9% in 1999/2000 to 20% in 2003/2004, which is probably related to improved cultivation methods. The Ministry of Health has launched a research programme to investigate the health consequences of these increasing THC percentages.

The number of coffee shops sharply declined between 1997 (1179) and 2000 (813). Since 1999, annual reductions were smaller. In 2003, 745 coffee shops were counted. They were located in 21% of all Dutch municipalities.

Part B Selected issues

11. Buprenorphine

In the Netherlands, buprenorphine is used in low dosages for several purposes, also as a treatment for drug addicts. It is not forbidden by law, but higher doses are now registered to facilitate payments by assurance companies. Traditionally, pharmacotherapy for opiate addicts has been and still is done with methadone. Buprenorphine for detoxification and maintenance treatment is used by a minority of professionals in addiction care, mainly concentrated in one regional organisation of addiction care. The National Health Council has suggested to make buprenorphine available in higher dosages. Recently, an import license for the higher dose preparation of buprenorphine (Subutex®) has been realised and registration is underway. The number of physicians certified to prescribe buprenorphine is insufficient in the Netherlands and additional courses in buprenorphine treatment methods have been initiated. Contrary to methadone, there are no up-to-date statistics on buprenorphine use.

12. Alternatives to prison targeting to drug using offenders

Drug treatment can be an alternative to imprisonment. There are several legal options under which diversion from the criminal justice system to care programmes can be effectuated. Most are quasi-compulsive in nature, which means that the addict has a choice between treatment and imprisonment. Since 1988 the Netherlands has pursued an explicit policy aimed at alternatives to prison. It is seen as an instrument to improve drug and other problems and to prevent recidivism. Quasi compulsory treatment is normally provided by

regular addiction care facilities. Addiction Rehabilitation Services function as a bridge between the justice system and the care system. Recent research shows that treatment as an alternative to imprisonment works best for addicts with a basic motivation for change and in clinical, low threshold, long term, skill-oriented facilities. In recent years, several of these facilities have become available, especially for hard drug addicts. Diversion to treatment as an alternative to imprisonment will be part of the policy in the near future.

13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies

The concept of “drug nuisance” is diffuse. In general, nuisance is defined in terms of a wide range of human behaviours that are either inadmissible according to objective norms or subjectively inconveniencing. In 1993, national policy was developed on drug-related nuisance. By then, most municipalities had already developed some kind of local policy. Drug-related nuisance and criminality are being counteracted, firstly, by administrative measures for maintaining public order. Secondly, measures are taken based on criminal law, providing also for qualitative improvements in the care for (hard)drug addicts.

The national government leaves the implementation of nuisance measures largely to local municipalities, while stipulating limiting conditions and intended results. In the measures against (drug) nuisance a broad distinction can be made between: 1) Measures targeting the public domain, such as maintaining guidelines for the toleration of cannabis sale in coffee shops, and counteracting drug tourism; 2) Measures targeting subgroups causing public nuisance, such as judicial treatment of addicted offenders, and opening of drug consumption rooms for homeless addicts with a license.

Between 1996-2002, the figures on drug-related nuisance in large cities give evidence of a downward tendency. Over the years 2002-2004, however, the Police Monitor Population reports an almost constant drug-related nuisance rate of well over 6% in residential areas. In July 2004, 148 places for the Judicial Treatment of repeat offending addicts (SOV) were occupied (occupation rate of 67.5%). Between 2000 and 2002, the number of small scale consumption rooms for drug addicts increased from 20 to 32 throughout the country.

Part A: New developments and trends

1 National policies and context

In accordance with the EMCDDA guidelines, this chapter focuses on new developments after 2002 and does not give an exhaustive picture of the legal framework and the national drug policy in the Netherlands.

1.1 Legal framework

Laws

The use of drugs is not penalised in the Netherlands, unlike the production, trafficking and possession of drugs. The framework for prosecuting unlawful activities, especially the production and trafficking of drugs, and for sentencing criminal drug users has been gradually expanded in the past decade and now involves an extensive set of laws and other legal instruments.

In the Netherlands, the most important laws on drugs are:

- Opium Act (*Opiumwet*) – (penal law)
- Prisons Act (*Penitentiaire Beginselenwet*) - (penal law)
- Judicial Treatment of Addicts (*Strafrechtelijke Opvang Verslaafden*) - (penal law)
- Act Temporary Measures for Penitentiary Capacity for Drug Couriers (*Tijdelijke Wet Noodcapaciteit Drugskoeriers*) - (penal law)
- Closing Drug Premises Act (*Wet Sluiting Drugspannen*) - (administrative law)
- Abuse of Chemical Substances Prevention Act (*Wet Voorkoming Misbruik Chemicaliën*) - (chemical precursors – administrative law)
- Public Administration Probity Screening Act (*Wet bevordering integriteitsbeoordelingen door het openbaar bestuur or Wet Bibob*) - (money laundering – administrative law)

Changes relating to these laws will be described below. For further information: see our National Reports of 2002 and 2003.

The Opium Act

Dutch legislation is consistent with the provisions of all the international agreements the Netherlands has signed, i.e. the UN Conventions of 1961, 1971 and 1988, and other bilateral and multilateral agreements on drugs. The Dutch Opium Act (1928), or Narcotics Act, is a penal law. It was fundamentally changed in 1976. Since then, the Opium Act has been amended repeatedly but its basic structure has been maintained.

For more detailed information, see our National Report 2002.

Since September 2003, physicians can prescribe cannabis for medical reasons, and pharmacies are allowed to supply this drug. The price of medical cannabis is much higher than in the tolerated coffee shops. A governmental agency, the Office of Medicinal Cannabis (OMC), regulates the whole process of production, delivery and quality control of medical cannabis. It has been estimated that 104 kilos of medical cannabis will be sold in 2004 (T.K.29800XVI/2). The OMC can grant opium exemptions for cannabis and cannabis resin and has the exclusive legal rights on the import and export of cannabis and cannabis resin.

About half of the Dutch health insurance companies reimburse medical cannabis for their clients.

The maximum penalties in the Opium Act remained unchanged (see National Report 2002).

Institution for repeat offenders

On 1 April 2001 the Judicial Treatment of Addicts (*Strafrechtelijke Opvang Verslaafden-SOV*) intervention was introduced. It allows the courts to commit repeat offenders, who are addicted to drugs and who have failed to respond to other forms of treatment, to a special institution for up to two years (see also chapter 9). Originally, it was decided that further implementation of the law should await the outcomes of an evaluation for three to four years (to be expected in 2006). The experiment runs in four institutions – in Amsterdam, Rotterdam, Utrecht and the 'Southern municipalities' -, totalling 219 places. The aim of this initiative is to reduce public nuisance and to stimulate behavioural change of the offenders.

In the reporting year, a new act 'Placement in an Institution for Prolific Offenders (*Plaatsing in een inrichting voor stelselmatige daders – ISD*)' came into effect on 1 October 2004 (Stb 2004/351). (see also chapter 9.1). This act refers to all prolific offenders, not only addicts. It has been estimated that there are about 6000 very high frequent prolific offenders (Wartna et al. 2004b). Until 2007, thousand places will be created for these offenders, excluding the addicted offenders. The Judicial Treatment of Addicts will operate as a separate programme within the ISD-programme. About 20 percent of these compulsory treated offenders are expected to give up committing crimes after completion of this programme (E.K.28980/B). (see also chapter 9.1). This new Act is one of the measures of an extensive programme of the present Government to tackle the feelings of insecurity in Dutch society. This programme is called Towards a Safer Society (*Naar een veiliger samenleving*) (T.K.28684/1-2).

Prisons Act

In July 2004, the Prisons Act was changed to make it possible to place more than one prisoner in a prison cell (Stb 2004/350). This will only be practised after a careful assessment and matching of the prisoners. Addicts are not qualified for placement in a group cell (E.K.28979/B).

Laws implementation

Opium Act Directive

In the Netherlands, criminal investigation and prosecution operate under the so-called 'expediency principle' or principle of discretionary powers (*opportuïteitsbeginsel*). The Dutch Public Prosecution Service has full authority to decide whether or not to prosecute and may also issue guidelines. The most recent set of comprehensive guidelines for enforcing the Opium Act was the Opium Act Directive of 2000, which is valid from 2001 until 2005 (Stc 2000/250). For more information see our National Report 2003.

The sale of cannabis is illegal, yet coffee shops are tolerated to sell cannabis, if they adhere to certain criteria: no advertising, no hard drug sale, not selling to persons under the age of 18, not causing public nuisance and not selling more than 5 grams per transaction (AHOJ-G criteria). In recent years, the government policy has aimed to reduce the number of coffee shops. The estimated number went down from almost 1200 in 1997 to 754 in 2003 (Pardoel

et al. 2004). It is still uncertain whether this has resulted in increased supply of cannabis through channels outside coffee shops. Eighty percent of the Dutch municipalities do not have a coffee shop. There are major differences between municipalities concerning the enforcement of the coffee shop guidelines. (See also chapter 10.1 and 13.3)

In 2005, a pilot project will start in Maastricht to investigate the possibility to bar non-residents from the tolerated coffee shops in that city by means of a pass holder system.

Drug-related nuisance

An important pilot project to combat drug-related crime and nuisance at the local level is the *Hektor Project* in the city of Venlo. Its purpose is to diminish nuisance caused by German drug tourists who buy cannabis mostly at 'illegal' coffee shops, i.e. coffee shops not tolerated by the local authorities. The project has a three-line approach: 1. Low tolerance towards nuisance in the public space; 2. Revision of the coffee shop policy; 3. To combat the infiltration of the real estate market by organised crime. By creating special teams, the local government, the regional police, the Public Prosecution Service and the Fiscal Intelligence and Investigation Department (FIOD), succeeded in closing many drug dealing premises and illegal coffee shops. Also, a substantial amount of black money has been confiscated. The Hektor Project runs from 2001 to 2005 and will be evaluated by an independent research institute (Ministerie van Volksgezondheid 2002). Most political parties asked for a continuation of this project during a regular meeting with the Minister of Justice (T.K.24077/137). A similar project, *Operatie Hartslag*, runs in the city of Heerlen. It is characterized by multidisciplinary cooperation between the local authority, the Police, the Public Prosecution Service, care institutions, transport companies, residents and entrepreneurs. The project combines law enforcement and care in combating drug-related nuisance. In September 2004, this project won a prize as the most successful approach in improving safety in the inner town. Other important projects run in Utrecht, Rotterdam and Roosendaal. See chapter 13 for a more extensive description of drug-related nuisance.

Intensified actions against ecstasy

In 2001, the national government announced measures against the production, sale and use of ecstasy in the white paper "A combined effort to combat XTC", also known as "Uniting against XTC" (T.K.23760/14). This action plan costs € 18.6 million each year and is evaluated by an independent research institute. The first measurement was taken in 2003, the second will be taken in 2004, and the final evaluation will be conducted in 2006. The first evaluation of the implementation of the announced measures was sent to Parliament in March 2004 (T.K.23760/17). In this report (Snippe et al. 2003) it was concluded that the targets had been realised, e.g. increase in ecstasy seizures and increase in the number of dismantled production locations. In 2002, six million ecstasy pills were seized, against 4.6 million the year before. Also, in 2002 43 ecstasy production locations were dismantled against 37 in 2001. In 2002, 105 persons accused of ecstasy-related offences were arrested. Because of the continuation of the intensified action against ecstasy, the researchers expect a decrease of the dismantling of ecstasy production units and seizures of pills in the coming years. In 2003, 36 production units were dismantled, a slight decrease as was predicted in the evaluation report. The most important export markets for ecstasy pills are the USA, the UK, Belgium and Germany. The investigation services of these countries report a decrease in the seizure of assumed Dutch ecstasy pills.

Drug trafficking

In January 2002, the government accepted the "Plan of Action for Drug Trafficking at Schiphol", which intended to intensify the existing two-line approach to combat cocaine smuggling from the Netherlands Antilles and Aruba, and Surinam (T.K.28192/1). The first line comprises measures to prevent drugs transports to the Netherlands, and the second line is directed at ensuring that intercepted drugs are confiscated and judicial intervention against couriers will follow.

Since early 2003, a special law court with prison facilities has been operational at the airport. In October 2003, the fifth progress report concerning "Drug Trafficking at Schiphol" was sent to Parliament by the Minister of Justice (T.K.28192/23). The number of arrested drug couriers had increased from 1303 in 2001 to 2176 in 2002. From January 2002 to July 2003, 4012 couriers were sentenced by the law courts. The most important envisaged measures announced in the fifth progress report were:

- A complete control of all flights from the Netherlands Antilles. This action started on 11 December 2003 and is still operational. The *100%-control* of flights from Surinam started on 11 February 2004. From 11 December 2003 until 24 June 2004, 788 drug couriers were arrested at Schiphol (T.K.Aanhangsel/2249), although it is known to them that it is almost not possible to pass the control without detection. According to the Minister of Justice this can be explained by the continuing pressure from the criminal organisations on the couriers to meet their debts to them. Most of the actual drug couriers at Schiphol swallow the pellets of cocaine. The Department of Justice claims that before the 100%-controls started about 30 to 50 drug couriers per flight came to the Netherlands from the Antilles, against 3 to 6 couriers after the implementation of this measure (T.K.28192/29). So, this approach is seen as a success. In the near future the 100%-controls will be extended to all flights from South America.
- All the efforts are directed towards preventing drugs from entering the country via Schiphol Airport and confiscating the cocaine. Apart from 100% controls other measures are being applied to combat the smuggle of cocaine. Since this is very labour-intensive the authorities temporarily dropped the principle to prosecute every courier. Prosecution is now concentrated on more severe cases, like those smuggling substantial amounts, recidivists, and those using minors to perform the job. This implies that certain groups are not being prosecuted at the moment. However, to prevent other smuggle attempts several measures were taken. Names of all persons being caught smuggling cocaine will be put on a black list, which will be disposed to airliners. It has been agreed that those persons will not be transported by the airliners during a three year period. This black list is available for authorities in other countries on formal request. Arrested foreign couriers are removed from the country and are denied acces to the Netherlands.
- Improved collaboration between the authorities of the Netherlands Antilles and Aruba, and international collaboration within the European Union. A special Anti-Drug Team on the Antilles will be financed by the Netherlands. The efficacy of the Antillian Coast Guard is enhanced: in 2002 almost 2000 kilos of cocaine were intercepted against 5000 kilos in 2003. The intention of the Dutch government to intensify the collaboration with other European countries in the fight against drug trafficking was expressed by the organisation of a European Cocaine Conference in The Hague in June 2004.
- As a possible consequence of the 100%-controls at Schiphol, it was anticipated that the trafficking of cocaine might be shifted to the harbour of Rotterdam. So, more custom staff was deployed there (T.K.Aanhangsel/2295).

1.2 Institutional framework, strategies and policies

The national drug policy in the Netherlands has three major objectives:

- To prevent drug use and to reduce harm to users.
- To diminish public nuisance caused by drug use (the disturbance of public order and safety in the neighbourhood).
- To combat drug-related criminality.

This policy was reconfirmed in the white paper on cannabis policy (see below) (T.K.24077/125). For more detailed information on national drug policy: see National Reports 2002 and 2003.

In the reporting period no *major* changes in the objectives of the national drug policy were formulated by the government.

The most important policy document was the white paper on cannabis policy, which was sent to Parliament on 23 April 2004. With this paper the Government expressed its intention to tighten the Dutch policy on cannabis. In the field of criminal justice, the aim of the white paper is to combat the negative side effects of the Dutch cannabis policy more severely and coherently. The main policy intentions are:

- National Action Plan to Discourage Cannabis Use.
The main elements of this Plan are:
 - Research into the possible health risks of cannabis with high THC-levels. If this research shows that cannabis with high THC-levels has serious health risks, the Government will consider the consequences for policy and penal law. As a last resort the upgrading of cannabis with high THC-levels to a class I drug (drugs with unacceptable risks) cannot be excluded.
 - Research into the link between cannabis use and mental disorders has been prioritised.
 - The annual mass media campaign will be focused exclusively on the discouragement of cannabis use.
 - Prevention targeted towards high-risk groups will be intensified.
 - Actions will be taken to improve the use of evidence based treatment for cannabis dependence.
- Intensified enforcement of the laws and regulations on cannabis. The possibilities for the local authorities will be enhanced to apply administrative coercion in case of serious disturbance of the public order caused by drug-related nuisance. Also, the local authorities are asked to enforce a minimum distance between schools and coffee shops and (in border towns) between the border and coffee shops.
- More severe measures to curb coffee shop tourism. In accordance with the EU Framework Decision on Illegal Drug Trafficking close cross-border police operation in this field will be encouraged.
- Tougher action against cannabis cultivation with a special focus on large scaled production. The Government wants a combined approach of more severe administrative coercion and criminal prosecution.

Medical Heroin prescription

The Government decided that the treatment units for medical prescription of heroin for chronic treatment resistant opiate addicts can be extended from 300 to 1000 (T.K.24077/137). This will be a special treatment for a limited group in the setting of the specialized addiction care. The procedure to register heroin as an official medicine was initiated by the Government. Most of the treatment costs for this special group are supposed to be paid by the local municipal authorities. (See also chapter 5)

Evaluation of addiction care

Information on strategies in relation to drug related treatment can be found in chapter 5. Two important studies are worth mentioning here:

- The results of a policy programme to improve the quality of addiction care and drug prevention (*Resultaten Scoren* or 'Achieving Results') were published in the reporting year (Van Es 2004).
- Another evaluation of the care for addicts (of alcohol and opiates) with multiple problems organized in the Netherlands was carried out by the Netherlands Court of Audit (T.K.29660/1-2). The main conclusion is that the activities of the addiction care institutions and general care facilities for housing, finance, general health and day care should be better geared to one another. The advice of the Netherlands Court of Audit is to give the addiction care a coordinating role in this process. In his reaction to this report the Minister of Health announced that he would not develop a separate vision for the addiction care, but these problems should be tackled by the future local social support systems.

1.3 Budget and public expenditures

Last year, an attempt was made to estimate how much money is spent on drug policy in the Netherlands (Rigter 2003). Estimates of the official public expenditures are presented. Besides these costs, other societal costs as a result of drug use -more indirect costs- can be discerned but these are not included in this report.

Table 1.1: Estimated expenditures on drug policy in the Netherlands in 2003 (x million Euro)

Target	Estimated expenditure
• Prevention	42
• Treatment	278
• Harm reduction	220
• Law enforcement	1,646
Total	2,186

Source: (Rigter 2003)

Drug policy in the Netherlands is multifaceted. It involves a variety of parties and funding arrangements. The estimates are based on the budget proposals for the year 2003 from the national ministries, white papers published by the ministries on drug-related topics, and personal contacts with civil servants. The available data were often not drug-specific and various methods were applied to parcel out the drug "component" of the general figures.

The figures of table 1.1 have to be taken with caution, but do give an indication of the budget that is spent on drug policy. About 75 percent of the budget is spent on law enforcement in a broad sense (police, prosecution, detention), whereas two percent is spent on prevention.

In the study by the Netherlands Court of Audit mentioned above, the expenditures for addiction care in 2003 were estimated at € 154 million (T.K.29660/1-2). The difference between this figure and the estimated expenditure for treatment by Rigter (€278 million), can be explained in that the latter figure includes treatment in judicial settings.

1.4 Social and cultural context

Public attitudes

There are no recent general surveys or opinion polls concentrating on attitudes towards the drug problem (see National Report 2002). Information on attitudes towards drug-related nuisance can be found in chapter 13.

Cannabis in the mass media

- The increase in THC-concentration in cannabis cultivated in the Netherlands ('nederwiet') (see chapter 10) caused a lot of discussion in the mass media among scientists and professionals on the possible health consequences associated with this rise.
- The possible relationship between cannabis use and the onset of mental disorders, in particular schizophrenia, was often discussed in the mass media in the reporting year.
- In order to present the state of science (and practice) on the above mentioned and other issues related to cannabis, the Trimbos Institute organised the National Cannabis Conference in May 2004. Care givers, scientists, policy makers, cannabis users and coffee shop owners exchanged views about a.o. the pros and cons of the Dutch cannabis policy, the care for young cannabis users, efficacy of the addiction care, the treatment of cannabis problems and possible consequences of cannabis use for physical and mental health.
- Some City Councils and mayors openly discussed the possibility of legalising the cultivation of cannabis in order to regulate the supply (the so-called backdoor) of the coffee shops, but the Government is strongly against this idea.
- The round up of large scale illegal cannabis farms, in particular in some caravan camps, which are known as 'no go areas', caused a lot of commotion in Parliament and the mass media.

2 Drug Use in the Population

2.1 Drug use in the general population

There is no new information on drug use in the general population at the national level. The national surveys in 1997 and 2001 among the population of 12 years and older showed that drug use had generally increased in this period, at least among people above the school age. A new round is foreseen in 2005/2006. For more detailed information, we refer to the National Report 2002.

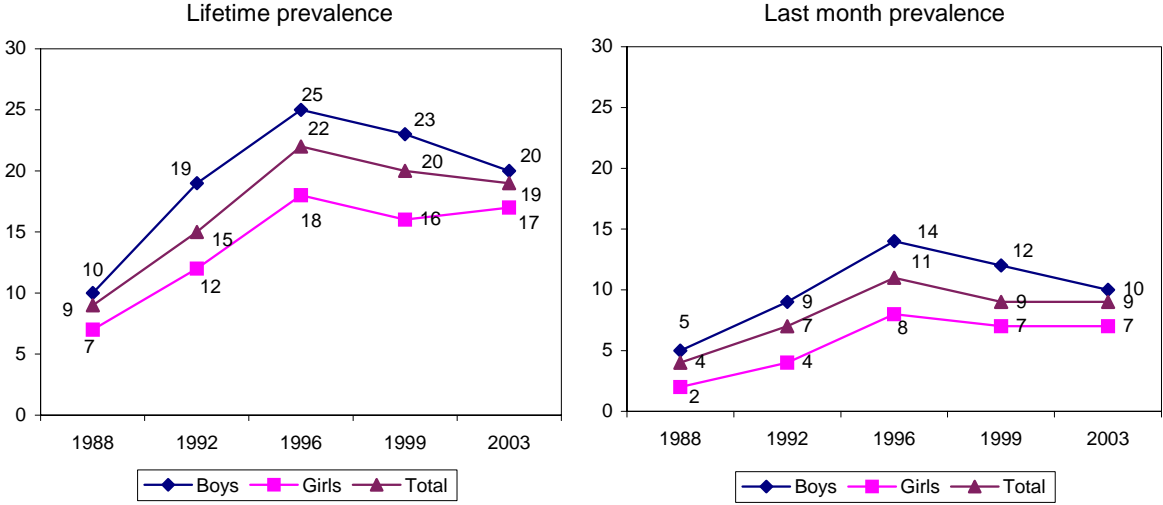
2.2 Drug use in the school and youth population

In this section we describe trends in drug use among pupils. Data on other youth are included in section 2.3 (special groups).

There are new data from the *Dutch National School Survey* (Monshouwer et al. 2004). This repeated cross-sectional study gives insight into the development of drug use among pupils of 10 -18 years. Surveys were held in 1984, 1988, 1992, 1996, 1999 and 2003. Data from the 1984 survey will not be presented because the methods differed from those of the other surveys, which hampers comparability of results. In each survey, pupils completed written questionnaires in the classroom. Pupils from primary schools were only questioned about lifetime cannabis use (as far as questions on drugs are concerned). Therefore, only figures were present on drug use among secondary school pupils between 12-18 years¹. In 2003, random sampling occurred in two stages (first at school level, second at class level). The 2003 final (net) sample of respondents consisted of 7,883 pupils from secondary schools. In order to analyse trends, data were weighed with respect to gender, school type and school year.

¹ In 2003 only 0.6% of the primary school pupils had ever tried cannabis.

Figure 2.1: Trends in lifetime and last month use of cannabis (%) by gender among pupils of 12-18 years



Source: Dutch National School Survey, Trimbos Institute (Monshouwer et al. 2004)

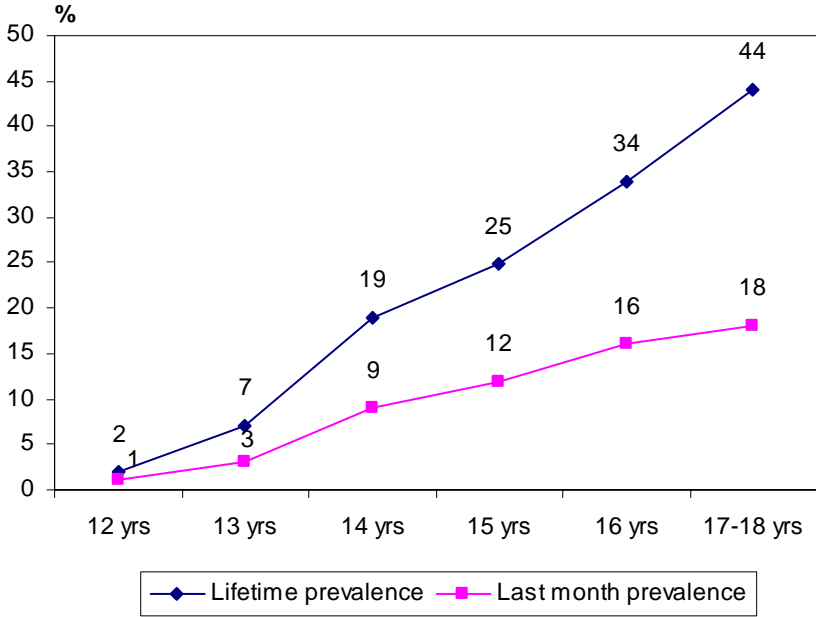
Trends in cannabis use

- Figure 2.1 shows that the lifetime and last month prevalence rates of cannabis use increased steadily between 1988 and 1996.
- Between 1996 and 2003, lifetime use stabilised. The decrease among boys observed in figure 2.1 was not significant. Last month rates significantly declined among boys and remained at about the same level among girls.
- Until 1999, cannabis use was more common among boys than it was among girls. However, in the 2003 survey the lifetime prevalence of use was not significantly different between boys and girls any more. Last month prevalence rates had also converged in 2003 but the gender difference was still significant.

Cannabis use by age (of onset)

- Cannabis use increases with age (see figure 2.2). Note that above age 16, school attendance is not compulsory in the Netherlands. Therefore, data for age 17 and 18 are not representative of Dutch youth in general.
- According to the 2003 survey, only few pupils of 13 years have ever tried cannabis (7%). Most pupils use cannabis for the first time when they are between 14 and 16 years. At age 16, about one-third of the boys (36%) and girls (31%) said to have used cannabis at least once.
- According to a recent study based on a survival analysis, the age of onset was significantly lower in 1996 and 1999 compared with 1988 and 1992: 14 and 15 years, respectively (Monshouwer et al. 2004). For illustration: in 1988 two in ten lifetime users had started use at age 13 or younger against four in ten in 1999. The analysis did not include the 2003 data.

Figure 2.2: Lifetime and last month prevalence of cannabis use (%) by age among pupils in 2003

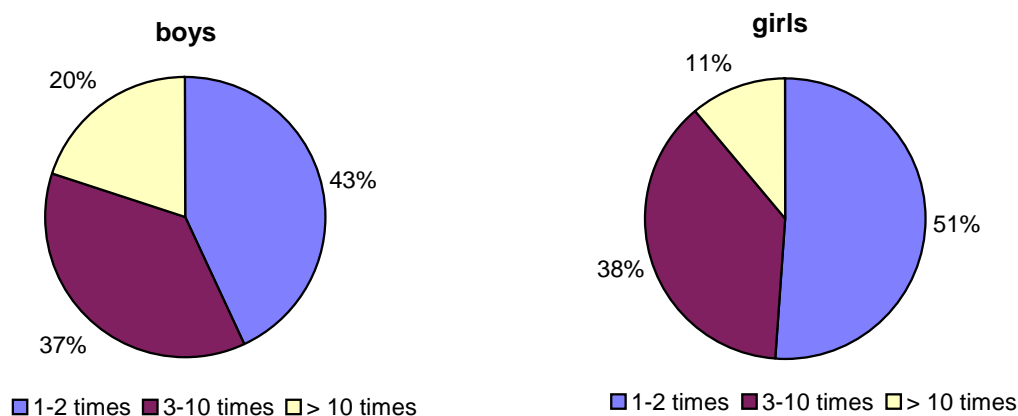


Source: Dutch National School Survey, Trimbos Institute (Monshouwer et al. 2004)

Frequency and intensity of cannabis use

- Although lifetime and last month prevalence rates tended to converge between boys and girls, the 2003 survey still showed a pronounced gender difference as far as the frequency of use was concerned. About half of the current users had consumed cannabis 1-2 times in the past month: girls 51%, and boys 43%. Heavy use (more than 10 times in the past month) was appreciably more common among boys (20%) than girls (11%) (see also figure 2.3).
- Almost half of the current users (46%) reported to smoke less than one joint per occasion (presumably sharing) (54% for girls, 40% for boys). Smoking 3 or more joints per occasion was more common among boys than among girls (27% and 15% of the current users, respectively) and more common among lower educated pupils than among higher educated pupils.

Figure 2.3: Percentage of current cannabis users (pupils 12-18 years) by frequency of use in the past month



Source: Dutch National School Survey, Trimbos Institute (Monshouwer et al. 2004)

Cannabis use by ethnic origin

- An analysis of cannabis use by ethnic origin² showed that the percentage of last month users was lower among Moroccan pupils (mainly girls) compared with Dutch pupils (4% against 9%). Prevalence rates of Surinamese, Antillian/Arubean and Turkish pupils did not differ from those of Dutch pupils (Monshouwer et al. 2004).

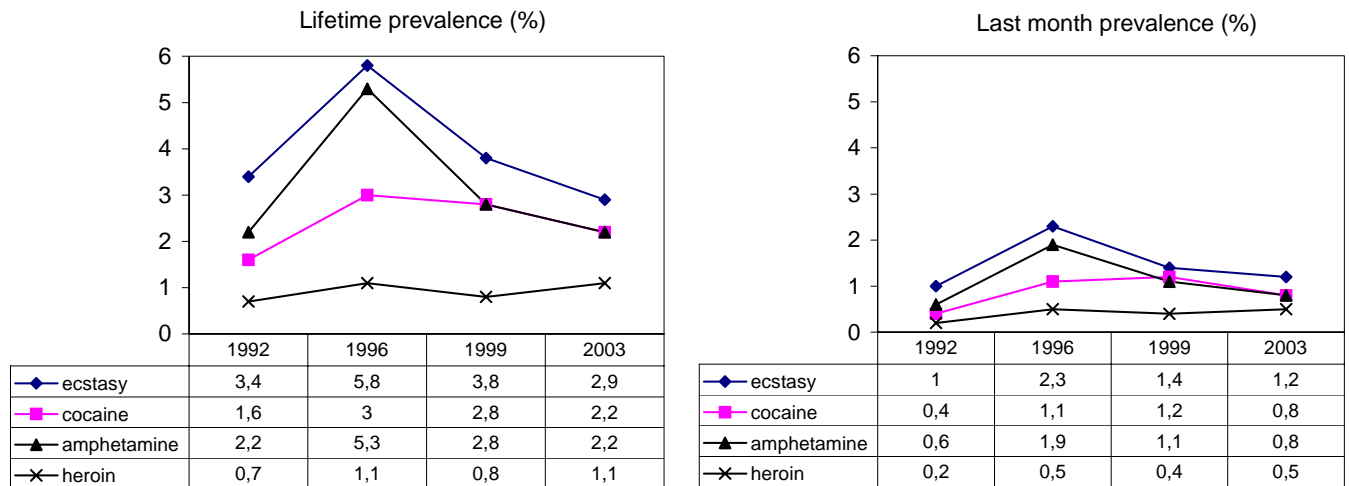
Other substances

The percentage of pupils using other drugs, such as ecstasy, amphetamine, cocaine or heroin, is much lower (see figure 2.4).

- In 2003, 4.5% of the pupils had ever tried one of these drugs, while 1.9% had currently used. Ecstasy was most popular, followed by amphetamine and cocaine and heroin.
- The percentage of pupils using these drugs peaked in 1996 (with the exception of heroin) and declined since then. The decrease in the lifetime use of amphetamine and ecstasy from 1996 to 1999 reached statistical significance. Use rates tended to decrease even further between 1999 and 2003 but these differences were not significant.
- As expected, more boys than girls used these drugs. However, the expected increase in use with increasing age was apparent only for boys (as of age 15).
- Experimenting with 'any hard drug' was more common among pupils of the lowest school type (VMBO-p) than pupils of the highest school type (VWO) (LTP 5.7% against 2.6%).

² Based on country of birth of respondent, mother and father. Non-Dutch origin: if a respondent was born abroad or when his or her mother and/or father was born abroad.

Figure 2.4: Trends in the lifetime and last month prevalence (%) of ecstasy, cocaine, amphetamine and heroin use among secondary school pupils



Source: Dutch National School Survey, Trimbos Institute (Monshouwer et al. 2004)

- The consumption of hallucinogenic mushrooms was fairly uncommon. In 2003, three percent of the pupils had ever tried these drugs and less than 1 percent (0,8%) had done so in the past month. Since 1996, prevalence rates have declined but this trend is not significant.

It is hard to explain these – generally stabilising – trends in drug use among young people. Perhaps the reported developments reflect the influence of (school) prevention programmes or just a ‘ceiling or saturation’ effect in drug use. As far as cannabis use is concerned, the reported stabilisation/decrease may also be associated with the strong decrease in smoking (LTP, LMP and daily smoking) between 1996 and 2003 (Monshouwer et al. 2004). This could be a fairly direct relationship given the fact that cannabis is usually smoked in the Netherlands, or an indirect relationship mediated by another variable predicting both cannabis use and smoking.

Another hypothesis explaining the recent stabilisation or decrease in cannabis use among young people refers to changes in the demographic characteristics of the school population, i.e. the relative increase of pupils of non Dutch ethnic groups that are known to have lower use rates³. Moreover, it can be hypothesised that the increase (in 1996) of the age limit from 16 to 18 years for admission to coffee shops might have affected use rates. In a study casting light on these issues, trend data from the school surveys mentioned above (1992, 1996, 1999) were analysed in detail (Korf et al. 2001). It was expected that a possible effect of raising the age limit would be present among pupils of 16-17 years, who had access to coffee shops before 1996 but not after this year. Multiple regression analyses, correcting for changes in the distribution of age, gender and ethnicity of the samples, were carried out. The results showed that the increase in cannabis use between 1992 to 1996 remained significant

³ Between 1992 and 1999, the percentage of non-western pupils in national school surveys doubled from 10% to 20%.

and that use rates between 1996 and 1999 remained stable. These findings indicate that after raising the age limit, the increasing trend in use was indeed broken. This does not imply, however, a causal relationship. A second finding revealed that, after 1996, pupils were more likely to buy their cannabis *outside* coffee shops, from friends or family. Thus, raising the age limit does not seem to have affected the availability of cannabis but rather resulted in a displacement of the cannabis market at the user level.

2.3 Drug use among specific groups

Compared with the general population, drug use is more common in special settings, such as the nightlife scene and coffee shops, and in special groups, such as the homeless, psychiatric patients, youth in correctional institutes and detainees. In this report we focus on findings from new studies. For other data: see previous national reports.

Substance use among school drop-outs

Data from a national school survey in 1997 indicate that substance use is fairly common among pupils of special schools and school drop-outs participating in special 'truancy projects' (Stam et al. 1998). For example, the prevalence of last month cannabis use in these groups was 14% and 35% respectively. These findings are corroborated by preliminary data from a recent study among pupils of special schools and participants of truancy projects in Amsterdam (Wouters et al. 2004). One in three young people was a current cannabis user (LMP 32%).

Visitors of clubs, discotheques and (house) parties

Monitoring of substance use in various youth scenes, including the nightlife scene, has a relatively long tradition in Amsterdam. A similar initiative has recently started in The Hague (since 2002) and the province of Gelderland (pilot in 2003; only qualitative data, not reported here). Moreover, in 2003 a national panel study was launched (see later).

Results from the Amsterdam Antenna Monitor 2003 (Korf et al. 2004a) became available just at the launch of this national report. Briefly, the data showed that drug use among visitors of clubs (and parties) in Amsterdam increased between 1995 and 1998 and decreased from 1998 to 2003 (corrected for differences in demographic characteristics of the samples). An exception to this trend is the increasing lifetime use of GHB⁴ between 1998 and 2003, and the stable current use of this drug. The last month prevalence rates of use of the main drugs in 2003 were: cannabis 39%, ecstasy 19%, cocaine 14%, amphetamine 7%, hallucinogenic mushrooms 10%, poppers 7% and GHB 4%. The decrease in ecstasy use is consistent with signals about 'ecstasy weariness'. Elsewhere in the country, a stabilisation or moderation of ecstasy use has also been reported on the basis of observational (but not quantitative) data (see later in this paragraph). More details will be given in the next National Report.

Monitoring of substance use in the nightlife scene of The Hague started in 2002. Just as in Amsterdam, this monitor incorporates both quantitative (survey) and qualitative (panel study, field work) methods. In the summer of 2003 634 questionnaires were distributed among young people of 15-34 years at different locations in The Hague (mainly dance parties,

⁴ There was also no decrease in the use of energy drinks and alcohol.

outside dance events and student's data market). The response rate was high compared with the 2002 survey: 68% against 15%. This high response is explained by the more active and personal way of approaching respondents, of whom most completed the questionnaire in the presence of the investigators. Table 2.1 shows the prevalence rates for the main drugs. The prevalence data are not comparable with those of 2002 because respondents were recruited at different locations in both surveys and immigrants were over-sampled in 2003.

Table 2.1: Drug use among young people in the nightlife scene of The Hague in 2003

	LTP	LMP
Cannabis	57%	37%
Cocaine	23%	10%
Ecstasy	35%	17%

Response rate was 64%. Source: (Van Gelder et al. 2004).

- As expected, cannabis was the most popular illicit drug. One out of three respondents had smoked the drug in the past month.
- Ecstasy was the second most popular drug. According to the panel, the use of ecstasy has gained general acceptance in the nightlife scene, while a spread to other scenes has also been observed in the past years.
- Cocaine (sniffing) was also popular. Panel members observed an increase in the acceptance and normalisation of the use of cocaine in the nightlife scene. Cocaine use has been associated with aggressive behaviour. The prices seem to have increased.
- Use of GHB, amphetamine, LSD, ketamine and hallucinogenic mushrooms was infrequently reported, while heroin, methadone and crack cocaine were hardly or not consumed. GHB was clearly less popular than in Amsterdam, although some informants (Nabben et al. 2004) have noted an increase in The Hague as well (see below).
- Combining substances (simultaneously or in succession) was common. Mixing cocaine and alcohol was most favourite, followed by alcohol/ecstasy and ecstasy/cannabis.

Additional information on possible trends (signals) in substance use in the nightlife scene comes from a qualitative panel study with a national scope named Trendwatch. In the first round of this study, key informants involved in a wide range of club and party scenes (including health professionals and police) were recruited throughout the country and interviewed about developments in dance cultures and patterns of substance use (Nabben et al. 2004).

- The results of this study suggest that the use of cocaine has spread rapidly throughout the country in various networks and locations (clubs, discotheques, cafes and at home). As also noted in the Hague, mixing cocaine and alcohol seems to be very popular.
- Ecstasy remains the most popular stimulant on (dance) parties but its consumption tends to stabilise and the incidence of related health emergencies at parties has decreased. Ecstasy is less popular in clubs than parties. In general users appear to be aware of the health effects of ecstasy and have moderated their consumption. However, a slight increase in the popularity of ecstasy has been observed in the eastern part of the country (big discotheques in rural areas).
- Amphetamines are the least popular stimulants in the regular nightlife scene but they are relatively more common in 'alternative scenes' (punk, electro, trance, underground, rock, techno) and hardcore parties.

- GHB use seems to have spread from smaller closed networks into the regular nightlife scenes and from specific geographical locations, such as Amsterdam and the 'Zaanstreek', to other regions in the country. The number of GHB related health emergencies at dance parties seems to be on the rise (no figures available), suggesting an increase in the consumption of this drug.
- Familiarity with ketamine seems to increase in Amsterdam, although at a low level. Also, on a national level this anaesthetic is less popular than GHB.
- Hallucinogens are not common in regular club and party scenes.

The 'stabilisation' or moderation of ecstasy use mentioned above seems to be partly in line with findings of a recent study on the expected outcomes of using ecstasy in users and non-users (Engels et al. 2004). The sample consisted of 844 visitors of 7 parties (clubs, festivals) in the Netherlands. The majority of the visitors was defined as an ecstasy user (65%). The results showed that negative outcomes most strongly distinguished users from non users. That means, visitors who perceived the physical (headache, dizziness) and emotional (feeling depressed or anxious) consequences as strong apparent after taking ecstasy were most likely to refrain from using. Moreover, those who thought ecstasy would provide them with more self-insight and would improve communication were more likely to use ecstasy. Unexpectedly, negative outcomes were not related to the intensity and duration of use.

Visitors of coffee shops

The average THC concentration in Dutch marihuana (nederwiet) has increased in the past years (see chapter 10) but little is known about the possible health consequences of the consumption of such 'strong' cannabis. Main problem in this regard is the question whether or not users titrate their dose, i.e. do they reduce the amount of cannabis smoked and/or adjust their smoking technique when the THC concentration is high in order to attain a stable 'internal dose'? The Ministry of Health has launched a research programme to elucidate this issue. In a first qualitative study, Korf et al. (Korf et al. 2004b) investigated cannabis use patterns among over 400 coffee shop visitors, who were current consumers of cannabis. The sample was not representative of all cannabis users. Frequent visitors of coffee shops (probably also the more frequent users) were more likely to be included in the sample than occasional visitors. Moreover, for the purpose of the study it was necessary to obtain a heterogeneous sample in terms of use history (ranging from starters to chronic users) and cannabis preference (ranging from strong hashish to mild marihuana).

- These data did not suggest that users – in general - titrated their dose. From a series of cluster analyses, the authors drafted three types or profiles of cannabis consumers:
- The first type of user prefers the "strongest high". This group consists of relatively young users who often consume cannabis with a high concentration of THC (and in fairly great amounts), inhale deep and tend to smoke a whole joint straight off. They have a greater risk of dependence compared with the other types of users.
- The second type prefers a 'stable high'. These users are as a rule aware of their behaviour, have a moderate consumption pattern aimed to attain a certain 'high'. In a certain way they tend to titrate their dose. Thus, they compensate for the concentration of the cannabis by increasing or decreasing the amount they smoke.
- The third type prefers a stable amount of cannabis (regardless of the 'strength'). This group consists mainly of older, male, solo users who have developed a stable use pattern over time, independent of the strength of the cannabis.

Note that this study is largely based on self-reported smoking behaviour, not on objective measures. Moreover, the study does not provide information on the prevalence of these types of users. Nonetheless, the results give some important cues for further research and provide information on target groups relevant for preventive activities (especially type 1 users).

Amphetamine users in Amsterdam

Uitermark and Cohen have investigated patterns of use and modes of self-regulation among a community sample of 109 experienced (15 times or more) and recent (< 2 years) amphetamine users in Amsterdam (Uitermark et al. 2004). They were asked about the evolution of amphetamine use in the 12 months before the interview (or the last 12 months of their career by those who had quit) according to the use patterns adapted from Morningstar and Chitwood (Morningstar et al. 1983). The most common pattern (nr 4) reported by four in ten respondents was that of up-to-down, which means that their use had gradually increased over time but after reaching a peak it had gradually diminished. A variable pattern ranked second (nr 6). In a follow-up interview two years later (among 68 respondents), the two most common patterns were up-to-down (nr 4) and a gradually diminishing pattern (nr 1).

The investigators also investigated problem use in terms of DSM IV criteria for dependence. The lifetime prevalence of amphetamine dependence was 57% and the last year prevalence was 27%. There were strong correlations between the amount of use (in grams) and the number of DSM-reported items. The data suggested that many respondents had ever experienced at least some problems associated with amphetamine use but these problems often did not seem to be chronic or worsen over time, as indicated by the much lower LYP compared with the LTP of dependence. Most users applied implicit rules of self-regulation by restricting use to specific situations and locations - mainly at parties, when going out and with friends – and by not using when they had to work or study. Explicit rules of self-regulation to minimise harmful effects of use (e.g. not too much) were reported by 76% of the respondents.

2.4 Attitudes to drugs and drug users

There are no recent studies assessing attitudes towards drugs and drug users in the Netherlands. Chapter 13 on Public Nuisance gives information on a related subject, drug-related public nuisance as experienced by citizens.

3 Prevention

There are no new developments and trends in preventive interventions and quality assurance but two studies may have implications for preventive actions.

A systematic review has been published on the effectiveness of Dutch preventive interventions for psychological problems among young people. These problems include substance abuse and addiction, criminality, truancy and drop out, unemployment and social exclusion in general (Verdurmen et al. 2003). The authors of this study conclude that many projects in this broad domain (youth care) have been realised but project evaluation is still rare or of low quality. Projects that study the applicability and/or necessary adaptations of foreign studies in our country are a *sine qua non* for developing effective national prevention programmes. A major change in developing and evaluating prevention projects in the Netherlands is necessary in order to improve existing practice.

Secondly, several Dutch and foreign publications triggered discussions about the risks of psychotic disorders among cannabis users and the validity of a causal relationship between the two (Arseneault et al. 2004; Smit et al. 2004a). During a recent cannabis conference in Amsterdam, organised by the Trimbos Institute, these issues were discussed. The causal links are still not quite clear. Future studies in causal biological mechanisms may solve this uncertainty. In the meantime prevention activities targeting young people (the group that most frequently uses cannabis) are gaining importance in public debate.

3.1 Universal prevention (school, family and community)

As we mentioned in our previous National Report (2003), there are more than 30 local applications of the programme The Healthy School and Drugs. We could trace one publication on effectiveness of a local *school-based* drug prevention project (Laurens 2004). This classroom project (*Bijdrage*) targets raising the awareness of primary school pupils and their parents of the effects of drugs and drug use. During the first years of secondary school (experimental) drug use among pupils increases sharply, thus drug education (tobacco, alcohol and cannabis) during the last year in primary school may be most effective in preventing drug use afterwards. However, after the project, their attitude changed in an undesired direction. The attitude of pupils on substance use was less negative than before. This was mainly because they thought it was nice and cosy to smoke, drink alcohol or use cannabis. They also thought it was more difficult to refuse a smoke, a drink or a joint, especially when friends or peers were around. Social influence appears the most crucial factor. Finally, parent communication about substances and substance use with their children was not changed significantly after the project intervention.

In the past year, there were little new developments in Youth programmes *outside school*. The old public campaign 'Drugs, don't fool yourself' became more specific: "There is much more to know about cannabis". This initiative was based on registration data from the Drugs Info Line (see below) indicating that many young people do not know enough about cannabis (the most frequently used illegal drug), e.g. its characteristics and its effects. The focus was on the age group 12-18 years and on the risks of cannabis use. Targets were increasing knowledge about cannabis, increasing information needs and information seeking behaviour. An independent evaluation of the effects of the campaign showed that "knowledge" did not

change between pre- and post-test for the majority of nonusers (78% believes cannabis is hazardous for one's health), but increased in the user group from 39% to 51% (Van den Putte et al. 2004). The need for information about cannabis did not change. Almost 20% of the target group needed more information before and after the campaign. During the year before the end of the campaign 14% of a sample of 955 pre-tested young people had searched for information about cannabis, and 64% of this group said that they did it during the campaign. The internet was most frequented for information (10%), school, parents and friends are second. The national Drugs Info Line (see under 'community prevention') is well known. Nearly half of all young people know it, and its website is known by more than 40% of the young people.

Family-based prevention

In our National Report 2002 (8.2 and 9.3) we presented data on family-based prevention projects. These data dealt with addicted parents, parent meetings on drug use (*home parties*), self help groups for parents, and a therapeutic community (*the Herberg*). Several older drug prevention projects for immigrant parents have been evaluated (Terweij et al. 2004). This study is part of the five-year policy programme for increasing the quality of addiction care and drug prevention "Achieving Results" (see National Report 2002). Facilitating and limiting factors of these projects were reported. Some highlights: a theory-based problem analysis is often missing; motivating participation rates is a long-term endeavour and necessitates networking, success factors are offering one standard intervention combined with recruiting via immigrant networks; separating women from men increases participation rates of Moroccan families.

Community prevention

Daily knowledge on drugs and drug use is often based on prejudice instead of facts. The National Drugs Information Line (*Drugs Info Line*) aims to reduce this by offering neutral, objective information, free leaflets and a counselling service (cf. National Report 2002, 9.4). Nowadays a website is in operation with the same objective. From 1996 to 2001 the number of telephone calls increased from more than 26,000 (the initial target was set at 25,000 calls) to more than 35,000 in 2000 (a hundred calls a day). In 2001 - 2003 this number declined from 32,000 to 24,900 to 20,600 (all these numbers are round offs). This is probably due to the success rate of the website and because less publicity was organised compared to previous years (Kok et al. 2003; Kok et al. 2004). In 2003 most questions came from drug users (32%). Second are partners, family or friends (17%).

3.2 Selective/indicated prevention (recreational settings, at risk groups, at risk families)

Recreational settings

Drug use is most prominent among young people in recreational settings (in general experimental use). The difference between indicative prevention and harm reduction is fuzzy.

The *Drugs Information and Monitoring System (DIMS)* analyses drug samples of consumers delivered at drug treatment services. The largest part of these consists of pills sold as ecstasy (see chapter 10.3). In the past years, the proportion of ecstasy pills containing 'other' psychoactive substances in addition to an MDMA-like substance has decreased. National

warning campaigns to inform users and professionals about dangerous substances were not necessary in 2003 (Drugs Informatie en Monitoring Systeem 2004).

The project “Outsider and confederate” (*Buitenstaander en Bondgenoot*) is part of the programme Going Out and Drugs of the Trimbos Institute. This project targets networking as a necessary condition for drug prevention to cooperate with owners of recreational settings (including coffee shops) and other professionals. Cooperation is a prerequisite for preventive action in these settings. The process evaluation showed some limiting factors in developing such a network (Bolier et al. 2004). The period needed for the first phase, getting into contact with important professionals within recreational settings (owners, barkeepers, doorkeepers, etc.), should not be underestimated. In most cases this will take a fairly long period. A preliminary guideline gives answers to questions such as: “How to start networking?, What is interesting for professionals in recreational settings? How to maintain contacts? What do you offer them?”.

A third project consists of courses for trainers (train the trainers) in First Aid activities meant for drug accidents in recreational settings (*Eerste Hulp Bij Drugsincidenten*). Professionals in organisations of addiction care and Municipal Health Services are trained as an education course leader. Completers are able to train other professionals in recreational settings e.g. owners of and personnel working in these settings, in security agencies and in the police force.

An organisation in the North-western part of the country hires youngsters for drug prevention activities among tourists along the coast. This is part of the activities of the *Drugs and Alcohol Info Team*. This team also offers a website (www.drugsinfoteam.nl) with information on drugs, online therapy, early warnings (high dose ecstasy pills), questions and answers, and an invitation to have pills tested by the regional organisation of addiction care.

Unity is an educational peer project (volunteering drug users) for visitors of dance parties in Amsterdam and its environment that started in 1996 (Van Bakkum et al. 2003). The target is a party that is as safe as possible. At this moment 45 volunteers are working for this project, who signed a contract for at least 4 hours of work per week. The project takes care of basic training and coaching of newcomers. After this training, knowledge is tested by means of a quiz. The 2003 recommendations for peer education are: improving registration of educational talks during parties, cooperation with the university of Amsterdam (Antenna study), increasing attention for alcohol abuse, continued attention for ecstasy, increasing attention for cocaine use, poly drug use and tobacco. Unity has its own website (www.unitydrugs.nl) with 200,000 hits monthly and an English do-it-yourself guide, which provides a conceptual framework on how to develop, implement and evaluate a peer led intervention, e.g. its rationale, efficacy, and its limitations (Bleeker et al. 2003).

Cannabis Intelligence Amsterdam (CIA) is a peer prevention project targeting at normalising cannabis use among immigrants. This project is working in a network of 48 locations, 77 group meetings have been organised, and 1500 youngsters have been reached. Cooperation is started with schools and youth care. This two-year pilot phase is now evaluated and the results will be published at the end of 2004 (personal communication M. Sijes).

A second (experimental) peer project targeting immigrant drug users is Youth with a message (*Jeugd met een boodschap*). The prevention method was developed, evaluated, and described in a handbook (Kroneman et al. 2003). A course book for training the peers was also published (Lok et al. 2004). From April 2003 to April 2004 three training courses are realised, each for minimal eight persons. The method was experimentally implemented in four locations, two in two very different regions. In one region the target group consisted of Turkish youth and youngsters from the Dutch Antilles. In the second only young Moroccans were reached. Unfortunately, peer projects could not be started in all locations. Only one project fitted the initial criteria from the handbook. This illustrated the importance of experimenting and evaluating this type of projects before implementing them on a larger scale. An important conclusion was that peer projects for young immigrant groups is difficult and many pitfalls may hamper a successful realisation of it. Up to date, the implementation targets for April 2005 are: knowledge on the existence of the handbook and the training is present in 80% of the prevention workers in organisations of addiction care and of those in municipal health services, and in 60% of youth workers in local welfare work.

Studies on selective and indicated prevention activities

A still vivid assumption is that pill testing at parties stimulates drug use in these settings. This assumption has been refuted in an international study that was mentioned in our previous national report (Benschop et al. 2002).

Pijlman et al. analysed registration data of Educare, the organisation which takes care of First Aid services during big dance parties (Pijlman et al. 2003). This study analysed data of the past six years and concluded that the public image of big dance parties mainly consists of prejudices (i.e. frequent drug abuse and many victims who come to the First Aid facility). During the past six years there were hardly any serious drug related accidents on big parties where Educare was present, while the total number of visitors in this period was around two million. More than 90% of the visitors who came to the First Aid site did so because of little physical wounds or because they became unwell. Moreover, since 1996 more than 16,000 visitors were recorded at the First Aid desk, 142 of whom were taken to hospital by ambulance. The strong impression is that visitors and organisers of these parties behave considerably more responsible on illegal drugs than expected. Most drug incidents are still related to ecstasy; amphetamine related health complaints have decreased. Alcohol misuse on the other hand, was mentioned more often as a reason for First Aid. An important assumption underlying different preventive activities for recreational drug use is that systematic registration improves estimates of health risks, enables targeted surveillance during parties and offers better opportunities to evaluate these activities. This study confirms that systematic recording of incidents is also necessary to correct the public and political opinion on drug use (the “debunking” function of registration).

4 Problem Drug Use

4.1 Prevalence estimates

Cannabis

There is no recent estimate of the number of problem cannabis users, which is in part related to the lack of consensus over the definition of problematic cannabis use. Problem cannabis use may include dependence. According to an outdated estimate of 1996, some 0.3-0.8 percent of the general population of 18-64 years is dependent on cannabis (last year prevalence of a DSM-III-R diagnosis of dependence). This translates into about 30,000 – 80,000 persons.

Ecstasy and amphetamines

The number of problem users of these drugs is not known. Ecstasy has no strong dependence potential. In spite of this, a minority of persons has a compulsive use pattern with associated psychological and somatic problems. As described in chapter 2.3, amphetamine use may be problematic and give rise to dependence and health problems, although in the long run most users seem to gain control over their use (Uitermark et al. 2004). The number of ecstasy and amphetamine users applying for help at treatment centres is fairly low. However, there is no information on the 'hidden' part of the population of problem users of these drugs staying out of the reach of treatment services.

Opiates and/or cocaine

The number of problem opiate users in the Netherlands was estimated several times in the past years (table 4.1). For the last (preliminary) estimate, three methods were used: a multivariate social indicator method (MIM) (or regression imputation), a multiple imputation method (on the same data) and a treatment multiplier (TM). The results are shown in table 4.1. These methods yielded a central estimate of about 32,000 problem drug users. Converted to population rates, the TM resulted in 3.0 problem drug users per 1000 inhabitants of 15-64 years (range 2.4 – 3.6), the MIM/regression in 2.9 cases/1000 (range 2.0 -3.9) and the multiple imputation in 3.1 cases/1000 (range 2.3 -3.9).

Taking the large confidence intervals into account, the outcomes did not differ significantly from the previous estimate (1999) of 2.7 per 1000. Note, however, that MIM and multiple imputation were based on local estimates, some of them being fairly outdated (e.g. Rotterdam). Therefore, in contrast to the multiplier method, this estimate does not accurately refer to '2001'.

Table 4.1: National estimates of the number of problem hard drug users*

Site	Year	Method	Case definition*	Estimates (lowest – highest value)	Source
National	1993	Multiple	Problem opiate users	28,000	(Bieleman et al. 1995)
National	1996	Treatment multiplier	Problem opiate users	25,000-29,000	(Toet 1999)
National	1999	MIM Treatment multiplier	Problem opiate users	27,000 25,970-30,298	(Smit et al. 2001)
National, preliminary estimate	“2001”	MIM Treatment multiplier	Problem opiate users	29,213 25,718 – 39,118	(Smit et al. 2004b)
		MIM Multiple imputation	** **	21,720 – 41,819 24,683 – 41,603	

MIM=Multivariate (social) indicator method. *Mainly opiate users who also consume crack cocaine (and other substances) **Variable case definitions of local estimates (anchor points) used by MIM. Mainly problem opiate users. Yet, some anchor points – especially of the latest estimates - may also include small numbers of primary crack cocaine users who do not consume opiates.

Table 4.2 gives an overview of the methods and outcomes of estimates of the number of problem hard drug users in various Dutch cities and regions. Note that the capture-recapture method may slightly overestimate the number of problem users because of violation of the closed population assumption⁵ and underreporting of hard drug users in the Police Records System HKS (often used as one of the sources).

Figure 4.1 on local estimates shows that the highest concentrations of problem hard drug users per 1000 inhabitants of 15 – 64 years are found in the three largest cities (Amsterdam, Rotterdam, and The Hague). New estimates for The Hague and Rotterdam will be available in due time.

⁵ For illustration, estimates in Amsterdam based on a 3-months observation period (with less risk of migration, death etc.) yield lower numbers of problem opiate users than estimates based on a 1-year observation period (ref).

Table 4.2 Local and regional estimates of the number of problem hard drug users

Site	Year	Method	Case definition*	Estimates (lowest – highest value)	Source
Amsterdam	2003	2-sample C-RC	Problem opiate users	4,778	Municipal Health Service Amsterdam (pers. comm. M. Buster)
Rotterdam	1994	Truncated Poisson		3,500 – 4,000	(Smit et al. 1997)
The Hague	1998	2-sample C-RC	Problem hard drug users	2,586 – 2,740	(Burger et al. 2001)
Groningen**	1993/ 2002	Treatment multiplier	Problem opiate users	1,000	(Bieleman et al. 1995)
Utrecht (province)**	1999	Treatment multiplier (a.o.)	Problem hard drug users	1,300	(De Graaf et al. 2000) (personal comm. J. Toet)
Friesland*** (province)	2001	2-sample C-RC, treatment multiplier	Problem opiate users	1,007	(Biesma et al. 2003)
Enschede	2003	2-sample C-RC	Problem opiate users	600	(Bieleman et al. 2004)
Stedendriehoek* ***	2000	2-sample C-RC, treatment multiplier	Problem opiate users	750 (561-948)	(Bieleman et al. 2002b)
Zuid- Limburg **	1999/ 2002	1-sample C-RC (Chao's estim.) (a.o.)	Problem hard drug users	1,100	(Coumans et al. 2002);(Hoebe et al. 2003)

* Problem opiate users often consume other substances as well (especially cocaine). Problem hard drug users consume opiates and/or cocaine and also other substances.

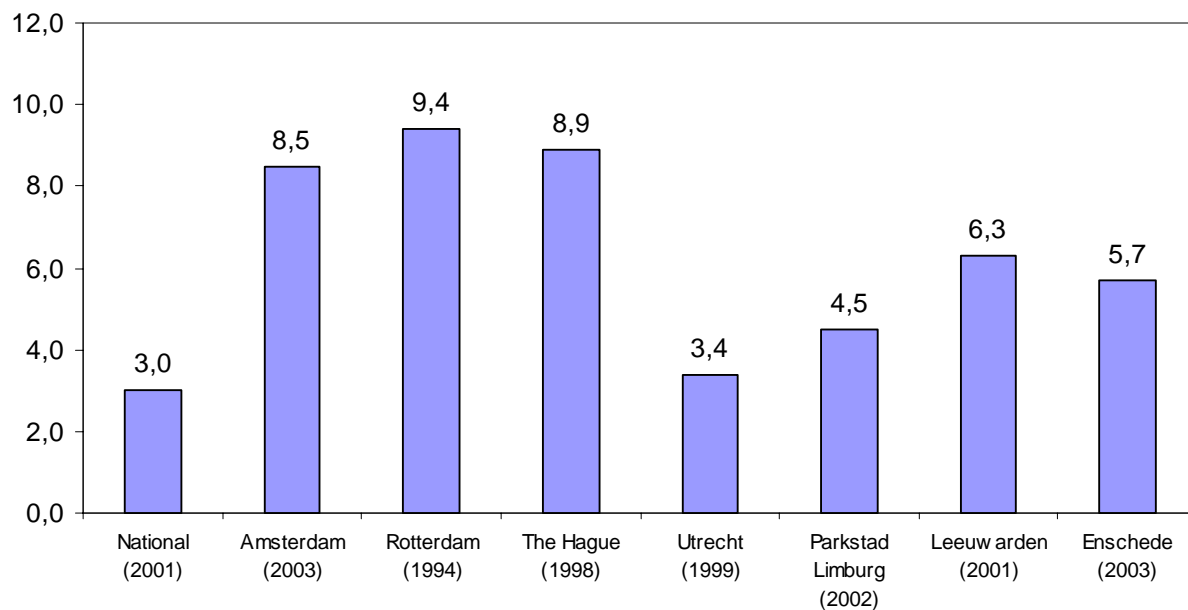
** Estimates for the regional/province are based on extrapolations from local estimates (cities). City of Utrecht: 570; Parkstad-Limburg: 800.

*** Leeuwarden: 389; North-Friesland: 135; South-West Friesland: 169, Friese Wouden: 314.

**** Deventer, Apeldoorn, Zutphen.

C-RC=capture-recapture. Samples are from treatment and police data.

Figure 4.1: Estimated number of problem users of hard drugs per 1000 inhabitants (15-64 years) in the Netherlands



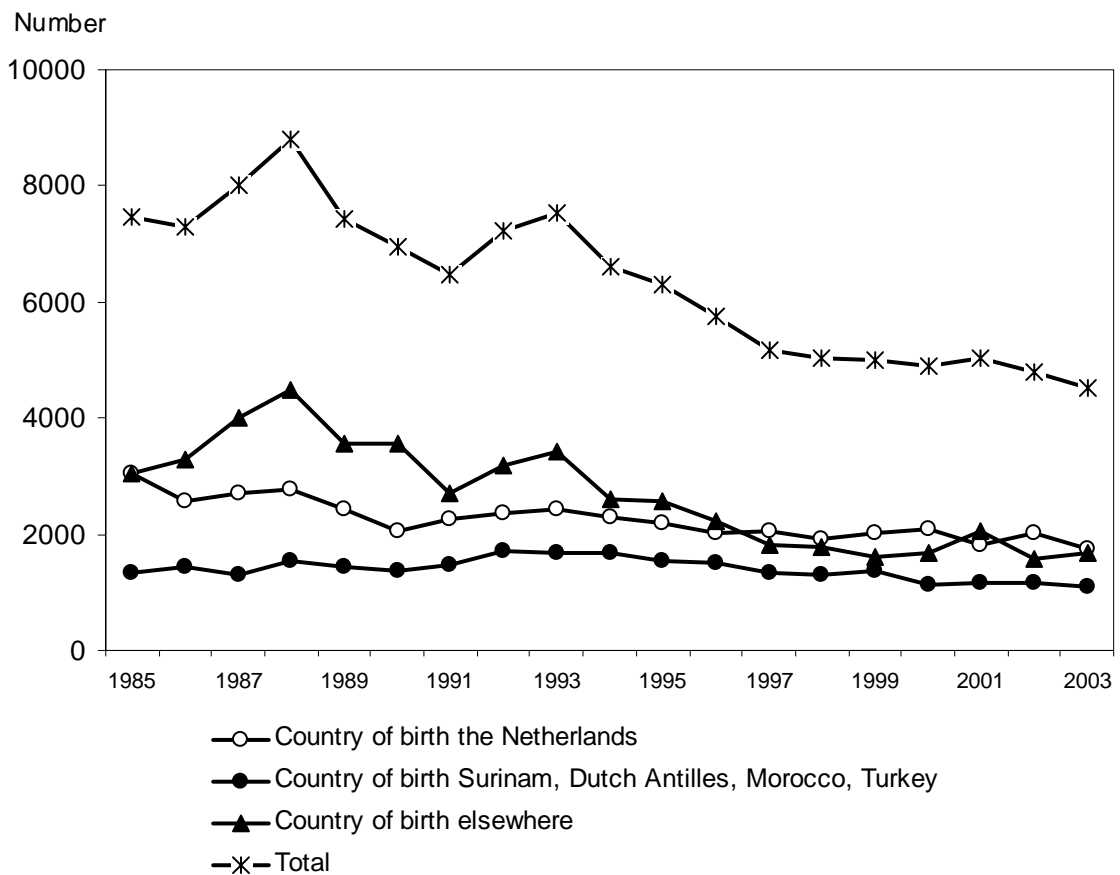
Average values of lowest and highest estimates. Sources and definitions: see table 4.1 and 4.2.

Stable number of opiate addicts in Amsterdam

Estimates for Amsterdam are available since 1984. Figure 4.2 shows the estimated number of (problem) opiate addicts broken down by country of origin.

- Since 1988 the estimated number of addicts has declined. This trend is largely explained by the decrease in the number of foreign drug users (category 'borne elsewhere', including Italians and Germans). The number of Dutch and ethnic-Dutch users remained relatively stable throughout the years.
- In 2003, the number of opiate addicts was estimated at 4,530, including 38% persons who were born in the Netherlands, 25% persons in Surinam, the Netherlands Antilles, Morocco and Turkey, and 37% who were born elsewhere. Addicts of the first and second subgroup usually have a residence permit and maximum access to (methadone) treatment.

Figure 4.2: Estimated number of opiate addicts in Amsterdam by country of origin



Problem opiate users: those who have medical and/or judicial problems and/or have difficulties controlling their addiction. Estimates based on 2-sample capture-recapture applied to data from the Central Methadone Register (CMR). Source: Municipal Health Service Amsterdam.

4.2 Profiles of clients in treatment

Specialised outpatient treatment

LADIS is the most comprehensive information system in the Netherlands on clients in the drug treatment system. It contains data from outpatient drug treatment services, including probation services, and has a national coverage. Data on inpatient services will be included in the future when the new information management system of the Dutch Mental Health Service, ZORG-IS, will be fully operational.

In contrast to previous years, the data in this paragraph will be based on the TDI protocol. This means that only clients who have had at least a second direct (face to face) contact with the therapist / treatment facility are included. Moreover, the TDI only includes data on clients starting treatment in a year ('new clients', including also first treatments) instead of all clients who had been recorded in a year. These criteria are more restrictive than the criteria used to select cases normally by the holder of LADIS (IVZ) and figures may deviate from those reported before.

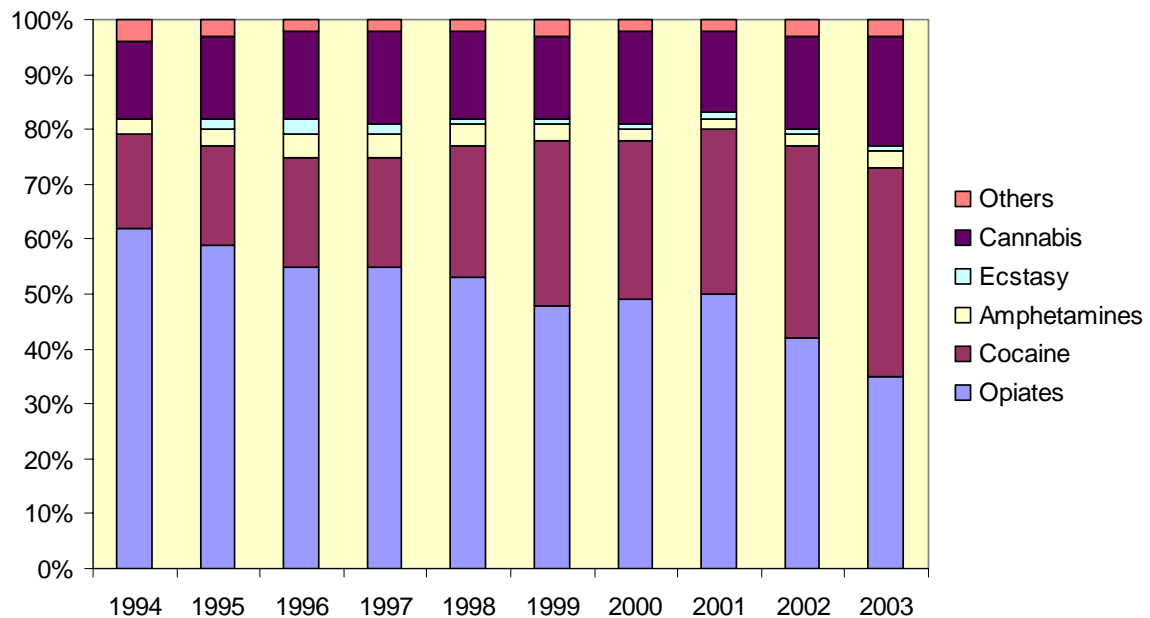
Some other remarks:

- Data will be reported of 1994, the first year for which IVZ could control for double counting of persons.
- The coverage of the system in terms of participating services has improved over the years. The small relative increase in opiate clients from 2000 to 2001 is mainly due to the participation of the Municipal Health Service of Amsterdam in LADIS.
- Cocaine refers to both cocaine HCL and cocaine base.

Trends

The annual number of new clients applying for help at outpatient drug treatment services varied between eight and eleven thousands, with an increasing trend (although with some fluctuations) over the years.

Figure 4.3: Distribution of new clients recorded in 1994-2003 at outpatient treatment centres by primary drug*



* Selection of clients based on the TDI protocol. Source: LADIS, IVZ.

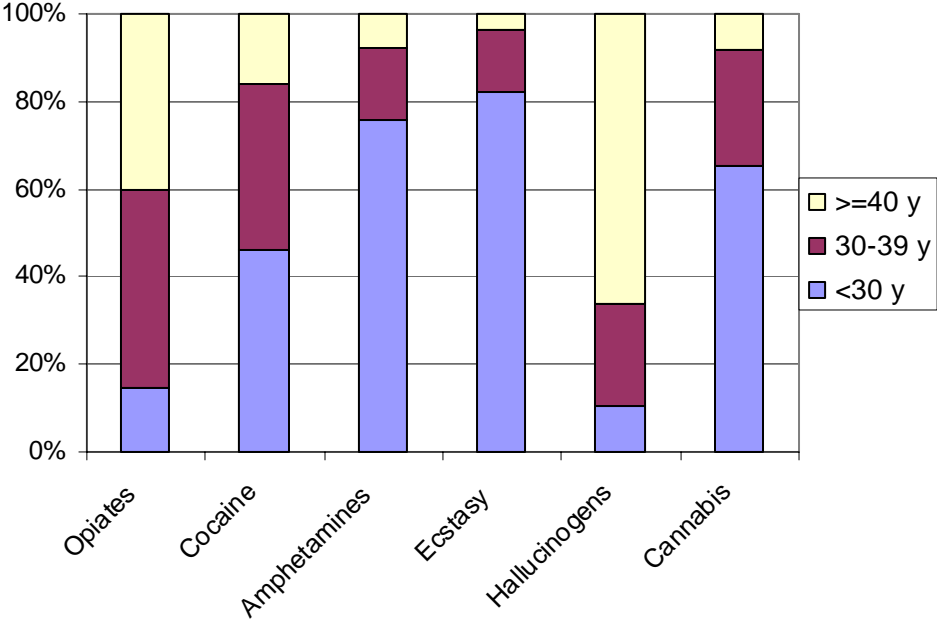
- Figure 4.3 shows that the percentage of opiate clients among all new drug clients strongly decreased over this period (62% in 1994, 35% in 2003), while the percentage of cocaine clients showed an increasing trend.
- In 2003, the proportion of primary cocaine clients even exceeded that of the opiate clients (38% against 35%).
- There was also a relative increase in the proportion of cannabis clients from 14% in 1994 to 20% in 2003.
- Ecstasy and amphetamine clients accounted separately at the most for 4% or less of all drug clients across these years.

The shift in proportions of primary drug clients is even more visible in data on clients who enter treatment in LADIS treatment centres for the first time. These first treatments reflect the incidence of drug users seeking help and may be a better indicator of recent developments in problem use. Among first treatments in 2003, the proportion of opiate clients was only 16% while cocaine clients made up 41% of the first treatments and cannabis clients 32%.

Age

The average age of all drug clients combined increased from 29 years in 1994 to 33 years in 2003. Figure 4.4 illustrates that hallucinogen and opiate clients are on average the oldest, followed by cocaine clients. Cannabis and amphetamines clients are on average youngest.

Figure 4.4: Number of clients recorded in 2003 at outpatient treatment centres by primary drug and age group*

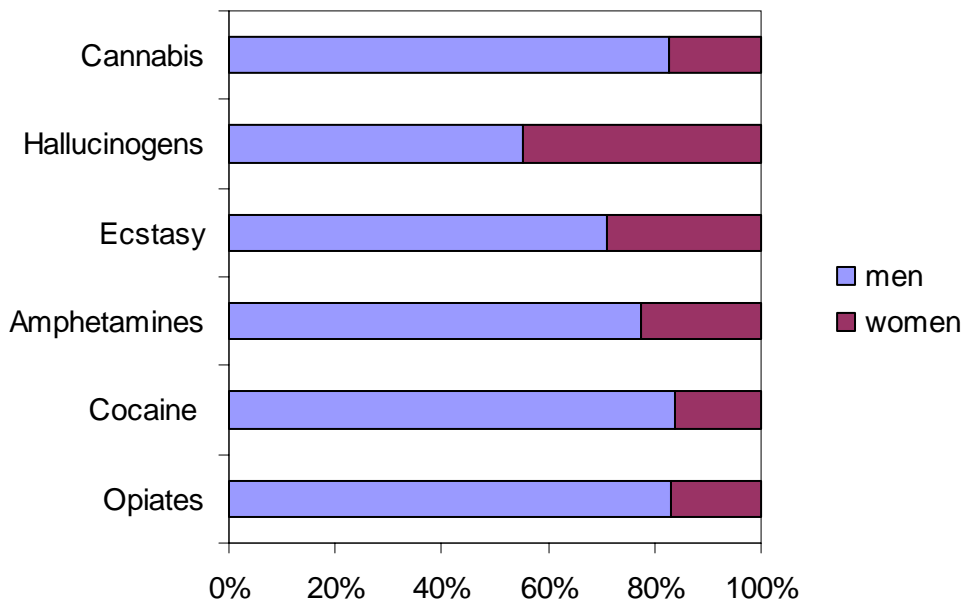


* Selection of clients based on the TDI protocol. Source: LADIS, IVZ.

Gender

The percentage of females among all drug clients varied over the years between 17% and 19%. Figure 4.5 shows the gender distribution by primary drug in 2003. The proportion of females was highest among hallucinogen clients (45%) and lowest among cocaine (16%), cannabis (17%), and opiates clients (17%). Ecstasy and amphetamines fell in between these extremes (29% and 23%, respectively).

Figure 4.5: Gender distribution by primary drug of clients recorded in 2003 at outpatient treatment centres*



* Selection of clients based on the TDI protocol. Source: LADIS, IVZ.

Route of administration

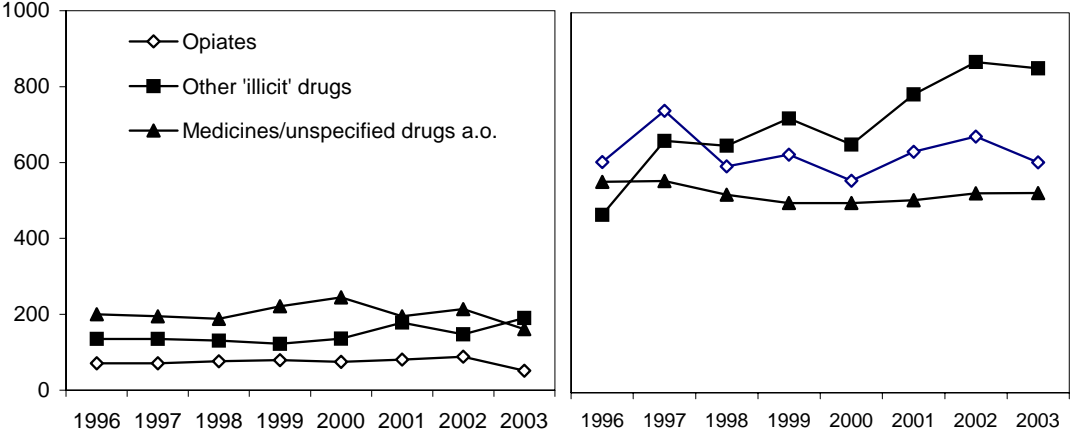
According to the TDI (LADIS, IVZ), injecting drug use strongly decreased from 12% in 1994 to 5% in 2003 for all primary drugs combined. Among opiate clients a decrease was found from 16% to 10%. In 2003 the main route of administration for opiates was smoking/inhaling (77% of the opiate clients). This also applied to cocaine (58% smoking/inhaling) although more than one-third of the cocaine clients sniffed this drug (37%). Probably this distinction refers to two different groups of problem users, the problem crack-cocaine users (who often also consume other hard drugs, such as opiates) and the 'recreational' cocaine users who have run into problems because of compulsive sniffing. Cannabis is mainly smoked (97%), while amphetamines are both sniffed (59%) and swallowed (30%).

General hospital admissions

Figure 4.6 shows the number of admissions to general hospitals because of drug dependence or abuse as a primary or secondary diagnosis.

- In 2003, the LMR recorded a total of almost 1.6 million hospital admissions. Drug dependence and drug abuse were counted just 402 times as a primary diagnosis and 1,986 times as a secondary diagnosis.
- Within the category of admissions related to drug abuse and dependence, opiates made up 13% of the primary and 31% of the secondary diagnoses. Other illicit drugs accounted for 47% and 43% of the primary and respectively secondary diagnosis related to drug problems. In this category, cocaine ranked as most frequent drug, followed by cannabis. Psychoactive medicines (e.g. benzodiazepines) and unspecified substances accounted for 40% of the primary diagnoses and 26% of the secondary diagnoses.

Figure 4.6: Number of admissions to general hospitals related to drug dependence or nondependent drug abuse (ICD-9 codes 304 and 305.2-9) as primary diagnoses (left) or secondary diagnoses (right)



Other 'illicit drugs' : cocaine, cannabis, amphetamines, hallucinogens.
 Source: LMR, Prismant.

Trends

The number of admissions related to drug abuse or dependence in general as primary diagnoses remained low over the past years. The number of admissions with 'other illegal drugs' as secondary diagnoses increased since 2000. This trend was mainly attributable to cocaine and to a lesser extent to cannabis. More specifically, cocaine dependence and abuse as secondary diagnoses increased from 246 in 1996 to 562 in 2002 and slightly decreased to 506 in 2003. The number of cannabis related admissions was lower and more variable over time, although a slight increase in secondary diagnoses was observed (from 160 in 1994 to 246 in 2003). Trends in admissions related to opiates were fairly stable.

Table 4.3 gives some more details about admissions related to the main drugs of abuse.

- In accordance with data from outpatient drug treatment services, the average age of patients admitted to general hospitals was the highest for opiates and lowest for cannabis and amphetamines.
- The average number of days hospitalised was the highest for cannabis problems and lowest for amphetamine problems (as primary diagnoses).

Table 4.3: Clinical admissions to general hospitals related to drug abuse and drug dependence in 2003*

	Cannabis	Cocaine	Opiates	Amphetamines
Number of primary diagnoses	46	80	51	30
• Average number of days	10.8	4.6	6.8	3.2
Number of secondary diagnoses	246	506	606	63
Number of persons**	262	522	533	89
• Average age (years)	29 years	34 years	39 years	30 years
• Percentage male	79%	74%	69%	72%

* ICD-9 codes: cannabis 304.3, 305.2; cocaine 304.2, 305.6; opiates 304.0, 304.7, 305.5; amphetamines 304.4, 305.7. These ICD-9 codes are not 100% specific with regard to the drugs in question. Clinical admissions do not include one-day admissions. ** Number of persons who were admitted at least once because of a drug-related disorder assigned as a primary or secondary diagnosis. Source: LMR, Prismant.

4.3 Main characteristics and patterns of use from non-treatment sources

Substance use

Most problem hard drug users are poly-substance users, with tobacco, cocaine and opiates featuring most prominently. This is illustrated by data in table 4.4. Amphetamines, ecstasy and hallucinogens are not very popular in this population.

Table 4.4: Substance use among a sample of problem hard drug users in Rotterdam in 2003

	Current use (%)	% of (almost) daily users among the current users
Tobacco	98%	100%
Cocaine	96%	78%
Heroin	80%	71%
Cannabis	60%	48%
Methadone	58%	78%
Psychoactive medicines	26%	30%
Alcohol, > 5 units	24%	58%
Ecstasy	2%	-
Amphetamines	1%	-
Hallucinogens	1%	-

N=201. Source: IVO Rotterdam (Van der Poel et al. 2003)

- In a field study in Parkstad Limburg among a street sample of hard drug users, the number of cocaine users among a sample of problem hard drug users had increased from 80% in 1999 to 88% in 2002. The percentage of heroin users did not change much (88% in 1999 and 86% in 2002) (Coumans et al. 2002).
- In a similar field study in Rotterdam (see table 4.4), cocaine use was more prevalent than heroin use. The percentage of heroin and cocaine users remained stable between 1998 and 2003. Today, an increasing percentage of younger problem hard drug users start their career with cocaine (and at a decreasing age), while the older users almost all started their career with opiates.

Route of administration

Chinesing or basing is the most common route of heroin administration, and basing the most common route of cocaine administration, among problem hard drug users in the Netherlands⁶. Injecting drug use has steadily decreased over the past years.

- In 1998, 28% of the problem hard drug users in Rotterdam had (sometimes) injected heroin or cocaine in the past six months, whereas in 2003 only 16% were reported to do so (Van der Poel et al. 2003).
- In Parkstad Limburg, the percentage of injectors decreased from 39% (1999) to 31% (2002). According to field workers and observational data, this trend might be attributed to several factors. These include: fear of aids and hepatitis, increasing health messages on the dangers of injecting, low prices of heroin on the Dutch market and associated easy availability, which makes injecting (a relatively more efficient route of administration than smoking) less important.
- In 2003 a field study was carried out in the southeast of Amsterdam among 184 opiate/crack-cocaine users recruited at street and at methadone treatment. Preliminary findings indicate that 9.5% was an injector (14% inside treatment and 4% outside treatment). This percentage is probably not representative (lower) for all problem drug users in Amsterdam, since the percentage of Surinamese drug users, who have low injection rates, was relatively high (personal communication Marcel Buster, Municipal Health Service Amsterdam).
- According to another field study in 2001 in Amsterdam, reported motives for not starting injecting by young hard drug users were: fear of needles, barrier/no way to return, fear of not finding veins and fear of getting abscesses or other diseases. Reported motives to start injecting were: increased kick, curiosity, more economical (efficient), not dangerous, healthier (Witteveen et al. 2003).

Demographic and social characteristics

- Most problem hard drug users are male (70 to 80%).
- There is an aging trend. Field studies in Rotterdam and Parkstad Limburg among problem hard drug users revealed a current average age of 39 years (Coumans et al. 2002; Van der Poel et al. 2003).
- Seven in ten (72%) problem hard drug users in Parkstad Limburg (2002) were born in the Netherlands against 47% in Rotterdam (2003). In Rotterdam the second most common group was born in Surinam (23%).
- The majority lives on social security (e.g. about eight in ten users in Parkstad Limburg). Other sources of income are obtained by 'assisting a dealer', property crime, prostitution (women) etc.
- The majority has some form of debt (70-90%). In 2003, problem drug users in Rotterdam had 4 debts in average with an average amount of 6,770 euro (ranging from 30 to 72,600 euro).

Risk behaviour: unsafe injecting behaviour and unsafe sex

There are no new data on risk behaviour since the previous National Report. As was stated in the previous paragraph, most drug users in the Netherlands do not inject. Table 4.5 gives the proportion of injecting drug users who borrowed (used) needles or syringes from their fellows, and who had unsafe sex in the past six months. The data are part of the HIV

⁶ These routes of administration of heroin and cocaine are jointly referred to by 'smoking' in this report.

surveillance among local samples of injecting drug users (see chapter 6.2). In all cities where repeated assessments have been carried out, the borrowing of needles or syringes has decreased (Amsterdam, Rotterdam, South-Limburg, Arnhem). However, rates of between 8 and 30% are still reported.

Table 4.5: Injecting and sexual risk behaviour among injecting drug users (%)

Region	Year of survey	Borrowing ^{II}	Condom use ^V steady partner	Condom use ^V casual partner	Condom use ^V clients
Amsterdam	1996	18%	24%	60%	70%
	1998	12%	15%	53%	71%
Rotterdam	1994	18%	9%	53%	80%
	1997	10%	16%	46%	69%
	2002/2003	8%	15%	57%	68%
South Limburg ^I	1994	19%	14%	39%	87%
	1996	17%	13%	61%	83%
	1999	10%	11%	51%	75%
Utrecht	1996	17%	16%	55%	83%
Arnhem	1991/1992	42%	na	na	60%
	1995/1996	39%	10%	49%	79%
	1997	16%	4%	47%	78%
Groningen	1997/1998	11%	11%	43%	76%
Brabant ^{III}	1999	17%	12%	39%	83%
The Hague	2000	21%	16%	27%	60%
Twente ^{IV}	2000	30%	8%	32%	50%

An injecting drug user is defined as a person who has intravenously injected a drug once or more times in his or her life. I. Heerlen and Maastricht. II. The percentage of IDUs who borrowed needles from somebody else on one or more occasion(s) in the last six months. III Eindhoven, Helmond, Den Bosch. IV Almelo, Hengelo, Enschede. V. Always using condoms in the past six months. na = not available. Source: RIVM (Van de Laar & Op de Coul, 2004).

Unsafe sexual behaviour, i.e. not always using condoms with steady partners, remains high in most cities. In the most recent survey in Rotterdam (2002/2003), 85% of the respondents did not always use condoms with steady sexual partners, while the corresponding percentage for casual partners and clients was 43% and 32%, respectively (De Boer et al. 2003). Given the fairly high (8%) HIV prevalence and high sexual risk behaviours, there is a theoretical risk of transmission of HIV among the population of injecting drug users and to the general population.

5 Drug-Related Treatment

5.1 The treatment system: studies on evaluation and quality assurance activities

Treatment supply in Dutch addiction care is highly diverse and may vary from kicking the habit to drug consumption rooms, from voluntary to (quasi-)compulsory treatment modalities, or from outpatient to inpatient. Drug treatment in the narrow sense refers to (branches of) institutions of addiction care, providing help to people with substance abuse problems. In some cases (i.e. psychiatric hospitals) this is also done as part of the Mental Health Service (GGZ). Drug treatment in a broader sense entails facilities in the narrow sense *and* other institutions and services (the prison system, probation services, the general health care sector and social services, self-help groups).

In 2000, the Netherlands had 32 drug treatment providers, diverse in type, with an estimated 231 facilities:

- 144 facilities for outpatient treatment or counselling
- 22 facilities for day-treatment or counselling
- and 65 facilities for intramural treatment.

Most people with problems due to drug use are helped in outpatient addiction care. Methadone maintenance is predominantly an outpatient treatment arrangement. According to a national registration office (*Prismant*), drug services in the narrow sense had 1552 beds at their disposal in 2000 for intramural treatment and 270 places for semi-mural treatment. For client data (numbers, characteristics) we refer to 4.2..

Social addiction care includes a wide range of services, to name just a few:

- Boarding houses, hostels or sheltered accommodations
- Drop-in Centres for (drug-dependent) street prostitutes in various towns
- Drug consumption rooms

We refer to our previous national reports for more details on these services. In-depth information on judicial addiction care and on addiction probation services is presented in chapter 8 and 9. For alternatives to prison for drug users we refer to chapter 12.

An important development concerns the increasing number of mergers between organisations of mental health care and addiction care, and in some cases also between different organisations of addiction care during the past five years (Van den Berg et al. 2004). Besides arguments of coping with budget cuts, expenditures and cost-effectiveness, an important reason for some of these mergers is the growing knowledge from research that addiction is related to psychiatric disorders. Besides, comorbidity (the co-prevalence of addiction and psychiatric disorders) appears to be more frequent than initially thought (Brook et al. 2002) (Nolten 2004). A result of these mergers is that the number of organisations of addiction care has become somewhat smaller during the past years, but the amount of facilities in each region remained largely the same (cf. (Trimbos-instituut 2003; Van der Wilt et al. 1998).

The results of a five-year policy programme to improve the quality of addiction care and drug prevention (*Resultaten Scoren* or 'Achieving Results') were published recently (Van Es 2004)

(cf. National Report 2002, 8.2.1). The evaluation report marks the end of the first phase of five years of activities with 50 publications: e.g. literature studies, instrument development studies, guidelines and protocols. The focus in the coming two years will be on the improvement of medical and nursing interventions, on further developing protocols, on the implementation of guidelines and on contacts with professional training and education in order to improve expertise of future professionals (Van Es 2004). Besides protocols and guidelines, this programme, and the programme of the Care Research Centre of the Netherlands (ZonMw), funded various other activities. These included a descriptive study on monitoring systems in the Netherlands (Cruts et al. 2004); the development and implementation of an electronic management information system; initiatives to stimulate professional training and education in addiction care; and possibilities of education and treatment via the internet.

A positive finding of another evaluation is that the products of the policy programme *Achieving Results (Resultaten Scoren)* have reached 85% of the professionals in addiction care and that all products have been appreciated by the target group (Mulder et al. 2004). There are also some points of concern because it remains unclear which strategies and means are most effective. Since most successfully implemented are (half-)products that can be adapted by the organisations, there is a risk that after some years of implementation the protocols will change on the basis of local insights. This might undermine their effectiveness. Yet, the best implemented guidelines are those on evidence-based life style training for addicts and these guidelines are fully developed products. Thus, the relationship between these factors should be further explored. Another point of concern is that activities targeting the development and maintenance of quality of care are still insufficient. Finally, there is no registration of interventions applied to specific clients. Thus it remains unknown what the costs and what the effects are of newly implemented interventions. Finally, medically assisted treatment (pharmacological interventions) has been neglected in the first phase of this programme. Such treatments will receive more attention in the second phase.

Several other reports that were published recently are targeting addiction care in general. A report of the National Court of Audit described the results of an evaluation of the organisation of addiction care and its facilities, especially in relationship to 'multiple problem clients' (T.K.29660/1-2). Most clients of addiction care have also other problems, such as criminality, unemployment and psychosocial problems. Therefore, they need the support of different services ("integrated care"), preferentially working via an interdependent network of working relationships targeted in a coordinated manner for individual clients. However, cooperation between these actors is still largely unstructured. Case consultations and consultations with crisis intervention centres often tend to be ad hoc. Few agencies responsible for providing financial, housing or reintegration services, have the expertise to deal with addicted clients. In some agencies, case managers appear to be more effective, but a funding system for case managers is non-existent. Other examples of shortcomings that have been mentioned by the Court are a lack of supported housing projects for addicts and a lack of knowledge on addiction among professionals in general health care and among professionals working in projects aiming at the habituation of addicts to working schedules.

The annual report of the Health Care Inspectorate presents general evaluative data on legal and organisational aspects of mental health care, care for the mentally handicapped, and addiction care. Congruent with the National Court of Audit, it also stresses the fact that most patients of addiction care have multiple problems. Still, roughly one third of the organisations

in this field work with multidisciplinary teams, with specified treatment targets and plans, and with evaluative actions for improvement. Most patient records are not systematically recorded and lack specified treatment targets. However, in most organisations of addiction care, clients are in some way able to inspect and correct their own records (Inspectie voor de Gezondheidszorg (IGZ) 2004). More than 10 years after the first legal arrangements for quality care in mental health care, quality care is still not systematically organised and accompanied by a quality committee in 80% of the organisations of addiction care. Furthermore, existing committees are not representative of the professional groups that are working in the organisation. Thus, the range of faults and shortcomings reported by such committees remains smaller than necessary. However, mistakes are being reported and most organisations adapt their working processes even without a committee (Inspectie voor de Gezondheidszorg (IGZ) 2004).

As mentioned in the introduction of this chapter, the mergers in the addiction and mental health care were partly meant as solutions for the problems mentioned above. However, much work still has to be done and therefore it is still too early to conclude that these operations were not successful.

Another report describes an evaluation of the quality and feasibility of regional cooperation circuits that were set up in three regions, namely Arnhem, Rotterdam, Limburg (Doornink et al. 2003). These circuits were developed at the start of a policy programme in 2000 (Addiction Care Re-assessed: *Verslavingszorg Herijkt*) based on an advisory paper from the National Council for Public Health and Care (1999). The evaluation shows that the initial targets of the policy programme were hardly realised. It was considered important that no region had succeeded in setting up a policy instrument for developing a long-term, regional funding policy. The evaluation further suggests that it is hardly possible to stimulate voluntary cooperation between funding organisations. The evaluators conclude that non-coercive cooperative arrangements appeared to be a serious limiting factor in reaching the targets and that a policy programme aiming at national addiction care as a whole was probably too ambitious. Funding systems of addiction care are partly delegated to the municipalities (see also National Report 2002, 14), and the reality of municipal policy is directed at short-term issues that may be inconsistent with longer term national targets. The separation line between the two main sources of funding (the Special Medical Expenses Act and the Public Welfare Act) are vague, which regularly leads to exchanges between these funding sources. The vast differences between the funding system of judicial arrangements for addiction care, probation etc. (via the Ministerial budget) makes cooperation with “the other part” of addiction care impossible. Furthermore, the main funding systems are not exclusively dedicated to addiction care. On the contrary, addiction care or drug prevention is only a small part of the financial targets of the three funding sources mentioned before, and these cover a small part of their target population. This reduces their commitment to this type of care. During the past years there has been growing attention for specific target groups (children of addicted parents, youth frequently causing nuisance, repeatedly offending addicts, etc.). These bottom-up initiatives necessitate intra-regional cooperation and will probably generate specified funding in the longer run.

A fourth report is a background study of the National Drug Monitor (NDM) comprising a systematic review of international studies on the efficacy of interventions for problem drug use (Rigter et al. 2004). This report is an update and improvement of an earlier systematic

review study (Van Gageldonk et al. 1997). In the past years, most progress has been achieved in the psychosocial treatments of cannabis and cocaine abuse. There are some promising results of American and Australian studies which will most probably be elaborated in the near future. Although the report mentioned above indicates which treatments are proven effective, it is not known to what extent these treatments are actually applied in the daily practice of the Dutch addiction care. There is no uniform registration system on interventions. During the past years catalogues have been published by organisations of addiction care which present “products-in-use” in descriptive categories: programmes, treatments, their target groups, targets, etc.. These catalogues or reports differ considerably in quality and are still largely incomparable due to differences in the description of the categories used. This is in part due to differences in historical development of separate addiction care agencies. On the initiative of the policy programme Achieving Results the quality and comparability of these catalogues is increasing.

5.2 Drug free treatment (inpatient and outpatient)

A valid overview of availability, financing, and organisation of delivery of drug-free treatment services does not exist. Drug-free treatment (including psychosocial support, motivational interviewing or counselling) is also used as an added component to medically assisted treatment, dependent in the first place on the existence of drug treatment modalities. For cannabis, cocaine and amphetamines, effective drug treatments do not (yet) exist (Rigter et al. 2004). The main objective of drug-free treatments is to complement drug treatments in order to increase the duration of effectiveness and reducing relapse rates (Schippers et al. 2002).

Criteria of admission to drug-free treatment

Specific criteria are not used for drug-free treatments. Drug treatment is not systematically complemented with drug-free treatments in Dutch addiction care. Instead the picture is diverse without a general pattern of treatment habits (Rigter et al. 2004). If possible, partners and/or family members should be involved, dependent on the phase of addiction of the client and the objectives agreed upon (Van den Brink et al. 1999b).

Evaluation results, statistics, research and training

A literature study dealt with the efficacy of self help groups and 12-steps programmes in addiction care. This study was meant as support for constructing guidelines for narrowing the gap between addiction care and self help groups (Geelen 2003). Most studies are from the US and targeting Alcohol Anonymous groups as a type of after care. Target groups in recent studies are increasingly poly-drug users. In the Netherlands AA-groups are less well known compared to the US, and the mean number of participants is much lower. The author reports a gap between addiction care and self help groups in our country. Unlike in America, AA-groups are generally not used as a type of after care. Combined with professional after care, AA-groups are most efficacious. However, drop out rates are high (95% within a year), but seem to be much lower when professional treatment explicitly prepares for AA-groups. Other studies (also predominantly from the US) show that 12-steps programmes are in general just as efficacious as other interventions (in most cases cognitive-behavioural therapy). Published information about self help is still insufficient for suggesting clear indications to refer clients to this type of help. Generally, dual diagnosis patients may be less fit for self

help groups, and addicts with a social network that supports alcohol use may be better off with self help groups, but supporting evidence for these observations is small.

5.3 Medically assisted treatment

Medical heroin co-prescription

In earlier reports we already mentioned the experiment with medical co-prescription of heroin (see National Report 2002, 10c) based on successful Swiss experiments with heroin prescription. Medical heroin prescription for treatment-refractory chronic opiate addicts on methadone is supposed to reduce the use of other illegal drugs (mainly cocaine) and drug related public nuisance. Measured effects are psychological, physical, social, and public (nuisance or criminality). In the final report, the effects during treatment and after 12 months have been compared (Van den Brink et al. 2002). The effects of stopping prescription have also been evaluated. The main finding of this study was that methadone plus heroin is more effective than exclusively methadone distribution, irrespective of the route of administration, the population in the analysis (intention-to-treat-analysis versus exclusively treatment completers), the outcome parameter 12 months after randomisation (response on the multi-domain outcome index; sustained response on the multi-domain outcome index; no longer meeting inclusion thresholds for the trial); and study site. The effect size differed considerably between the experimental and control group: 25% for injectors (OR = 2.99) and 23% (OR = 2.99) among inhalers of heroin. No significant differences were observed between month 10 and month 12, indicating that anticipation effects in the experimental group cannot be held responsible for the observed effects after 12 months. Similar positive effects were observed across the Netherlands. Both drug injectors and 'smokers' (inhalers) can benefit from this treatment option (Van den Brink et al. 2002). A current study aims at determining the additional effects of psychosocial treatment. Another (cohort) study evaluates the health and social situation of the participants of the experimental study three and six months after the start.

Withdrawal treatment

There is no overview of withdrawal treatment (detoxification) activities. Five years ago Van den Brink (Van den Brink et al. 1999a; Van den Brink et al. 1999b) wrote two articles about medications used in addiction care (see National Report 2002). These publications did not clarify what was actually done in the Netherlands and how. As part of the programme Achieving Results, protocols on this subject are underway which highlight two aspects: treatment of withdrawal symptoms and the choice of the setting. A literature study was meant to support the construction of these protocols (De Jong et al. 2004). After the first phase, detoxification under anaesthesia was stopped because its side effects and higher costs. The focus was turned to follow-up treatment (naltrexone maintenance combined with a specified and standardised psychosocial treatment). Of the 272 patients that entered detoxification, 235 (86%) finished the last follow-up measurement (12 months after finishing detoxification). Eighty percent of the anaesthesia-group did not use opiates during the first month after treatment. For the non-anaesthesia-group this percentage was 77. During the 16-months period after detoxification, patient scores improved remarkably. One quarter of this group remained abstinent during the whole period (16 months, including the first phase). All secondary outcomes improved (craving, use of other drugs, psychological complaints, health, quality of life index).

Substitution treatment

The conclusions of the study of Loth et al. (see National Report 2003) were confirmed in the more recent report of the National Inspectorate for Health Care (2004). Methadone distribution is not meant in first instance to reduce drug-related nuisance, but during the past decades this target has grown more important. Loth et al. further suggested that it is by no means certain that criminality among opiate addicts is reduced when they participate in methadone programmes (Loth et al. 2003). The initial target was to give medically assisted treatment, targeting abstinence or stabilisation c.q. harm reduction. Therefore it should be applied, according to the Inspectorate, in a medically justified way. Registration and treatment planning do not coincide with legal norms. There is no consensus on prescription methods for methadone. Doses and frequencies differ too much. The same author published reports of problematic situations in methadone maintenance in one regional organisation of addiction care. She also mentioned solutions for these problems and gave suggestions for innovation and evaluation of outpatient methadone distribution and a model for diagnosing problems and support by specialised nurses for methadone clients (Loth C.A. 2003a;Loth C.A. 2003b).

The Inspectorate will be more strict and intense in its inspections for the coming years (Inspectie voor de Gezondheidszorg (IGZ) 2004). Possibly high doses may be used more commonly in addiction care following the positive results of an experiment with such high doses for methadone clients (Driessen et al. 2003;Rigter et al. 2004).

6 Health Correlates and Consequences

6.1 Drug-related deaths and mortality of drug users

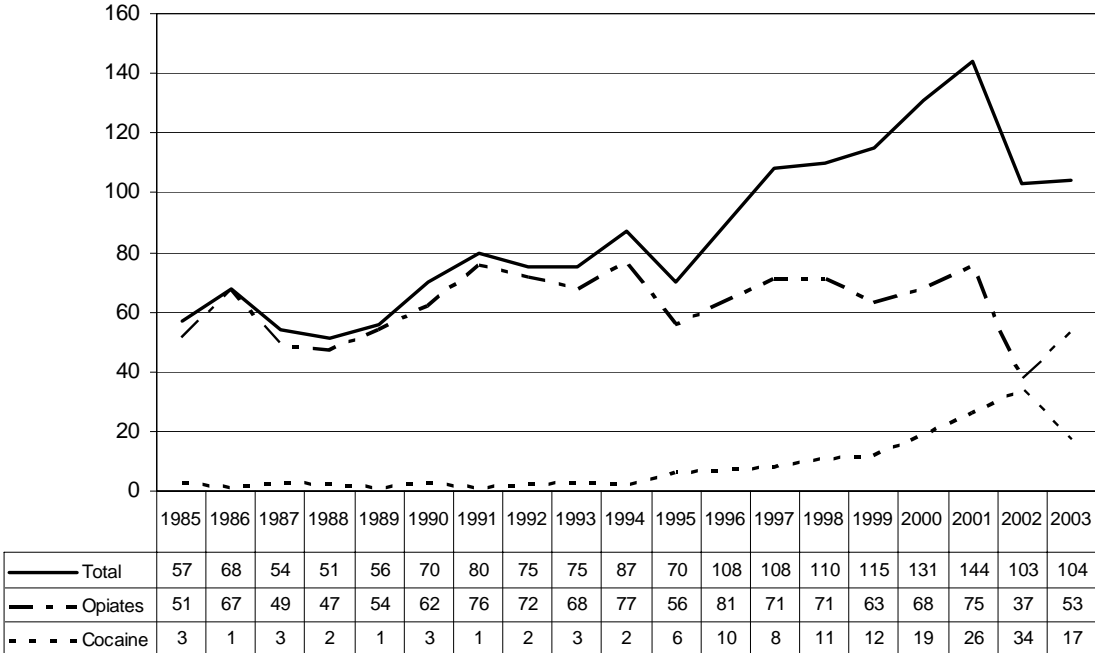
General Mortality Register: direct deaths

The main source for the official Dutch statistics on drug-related deaths is the General Mortality Register (GMR) or Causes of Death Statistics held by Statistics Netherlands (CBS) (Bonte et al. 1985). Causes of death are classified according to the International Classification of Diseases, Injuries and Causes of Death (ICD). The 9th edition was used from 1979 through 1995, and the 10th edition since 1996. This register has national coverage, includes only residents of the Netherlands and provides data especially on acute mortality due to drug use. Cases refer mainly to direct or acute deaths (drug 'overdose'). The GMR data do not make a distinction between experimental and habitual drug users, and are not suitable to trace deaths due to rare toxicological substances (e.g. various synthetic drugs).

Trend

- Figure 6.1 shows the number of cases recorded from 1985 through 2003 according to the EMCDDA selections of ICD-codes. Between 1985 and 2001, opiate intoxications were the most common causes of death recorded among Dutch residents. In this period, the casualty rate fluctuated between 47 and 77 cases. In 2002, the number of opiate deaths dropped and reached about the same level as the number of acute cocaine deaths, which had slowly increased since the late nineties. However, in 2003 these converging trends diverge, i.e. the number of cocaine deaths slightly decreased and the number of opiate deaths slightly increased.
- The *total* number of recorded drug-related deaths increased between 1995 and 2001 and seems to have decreased since then. The increasing trend can be attributed to various factors, such as the change from ICD-9 to ICD-10 in 1996 (whereby more cases are included under the ICD-10 standard) and the rise in acute cocaine deaths, which seems to parallel an increase in problem use. Moreover, besides deaths due to opiates and cocaine, a growing number of deaths were coded as 'accidental poisoning by other and unspecified dysleptics' and 'poisoning by other and unspecified narcotics'. It is not clear which drugs – or combinations of drugs - were involved in these latter two categories of deaths. A preliminary investigation of information on death certificates suggests that many of these cases involve 'hard drugs' but there 'might be some contamination by alcohol and psychoactive medicines. The drop in the total number of deaths in 2002 is due to opiates and from 2003 to both opiates and cocaine.
- Despite fluctuations over the years, the total number of drug-related deaths in the Netherlands remained relatively low. This might be explained by protective factors, such as the nationwide availability of methadone maintenance treatment and the low rate of injecting drug use in the Netherlands. There are, however, some indications that not all cases of drug-related deaths are recognised in the GMR (De Zwart et al. 2001).

Figure 6.1: Number of acute drug-related deaths in the Netherlands according to the EMCDDA selection of ICD-9 codes (1985-1995) and ICD-10 codes (1996-1998).



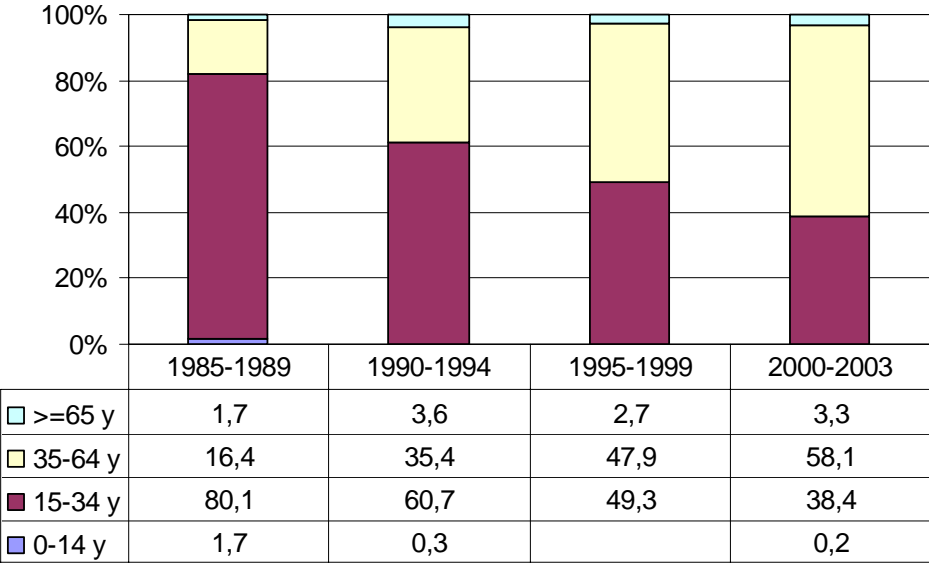
ICD-9: 292, 304.0, 304.2-9, 305.2-3, 305.5-7, 305.9, E850.0, E850.8, E854.1-2, E855.2, and E858.8, E950.0, E950.4, E980.0, E980.4 (selected in combination with N965.0, N968.5, N969.6 or N969.7). **ICD-10:** F11-F12, F14-F16, F19; and X42, X41, X62, X61, Y12, Y11 (selected in combination with T40.0-9, T43.6). Source: Causes of Death Statistics, Statistics Netherlands.

Age and gender

The population of problem hard drug users is ageing and this trend is reflected in the increasing age of drug users dying from drugs. Figure 6.2 shows that the percentage of victims in age group 35-64 years increased from 16% in the late eighties to 58% in the beginning of this century.

Between 1985 and 2003, the percentage of female cases varied from 10 to 27% per year, without showing a clear trend.

Figure 6.2: Trends in age distribution of cases of acute drug-related deaths in the Netherlands, according to the EMCDDA definition

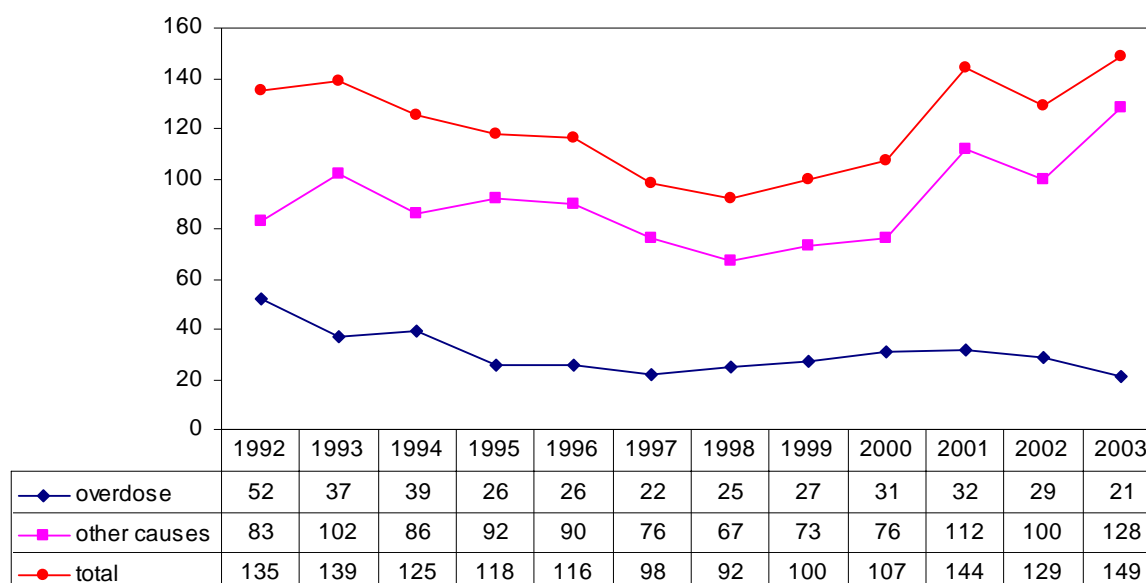


Source: Causes of Death Statistics, Statistics Netherlands.

Mortality among drug users in Amsterdam

Each year the Municipal Health Service of Amsterdam traces drug-related deaths by combining data from the Central Methadone Register, the municipal registrar’s office, the municipal coroners, hospital records, and the police. Data on overdoses from Amsterdam coroners *also* concern tourists and illegal drug users not included in the Population Registry. This is in contrast to the GMR, which only includes residents of the Netherlands who are recorded in the Population Registry. Moreover, in addition to direct deaths (or ‘overdoses’), the registration also includes ‘indirect’ causes of death.

Figure 6.3: Number of deaths among drug users in Amsterdam



* Including, among others, infectious diseases, violent deaths, accidents and suicide. Cases are counted among all drug users who have (ever) been registered in the Central Methadone Register of the Municipal Health Service Amsterdam. This may result in an overestimation of the number of cases in the category 'other causes'. In 2003, 37 deaths were recorded among 'clients' who had not been seen by the Municipal Health Service for more than five years Source: Municipal Health Service Amsterdam (M. Buster; T Sluijs).

Trend

- The total number of deaths slightly decreased in the late nineties and has slightly increased since then.
- The contribution of overdose declined from 39% (in 1992) to 14% (in 2003). This trend is largely explained by the decreasing number of foreign drug users in Amsterdam, who commonly inject their drugs⁷.
- Most drug users died from other causes of death than overdose and their number has slightly increased in recent years (figure 6.3).
- The contribution of other pathology, such as respiratory, liver and cardiac diseases, in causing deaths grows with the ageing of the population of drug users.

Characteristics of the drug-related deaths in Amsterdam in 2003

- Sixty percent of the cases were residents of Amsterdam, forty percent came from elsewhere.
- The mean age was 48 years. Overdose victims were on average 37 years against 50 years for drug users dying from other causes.
- Little is known about the nature of the substances involved in overdose cases, because toxicological data were usually not available. Of the four youngest drug users (between 15-24 years), three foreigners had consumed heroin and cocaine and one (Dutch boy) had taken ecstasy. Most older drug users probably died from a mixture of drugs, usually involving opiates, cocaine and other substances. Various somatic disorders often

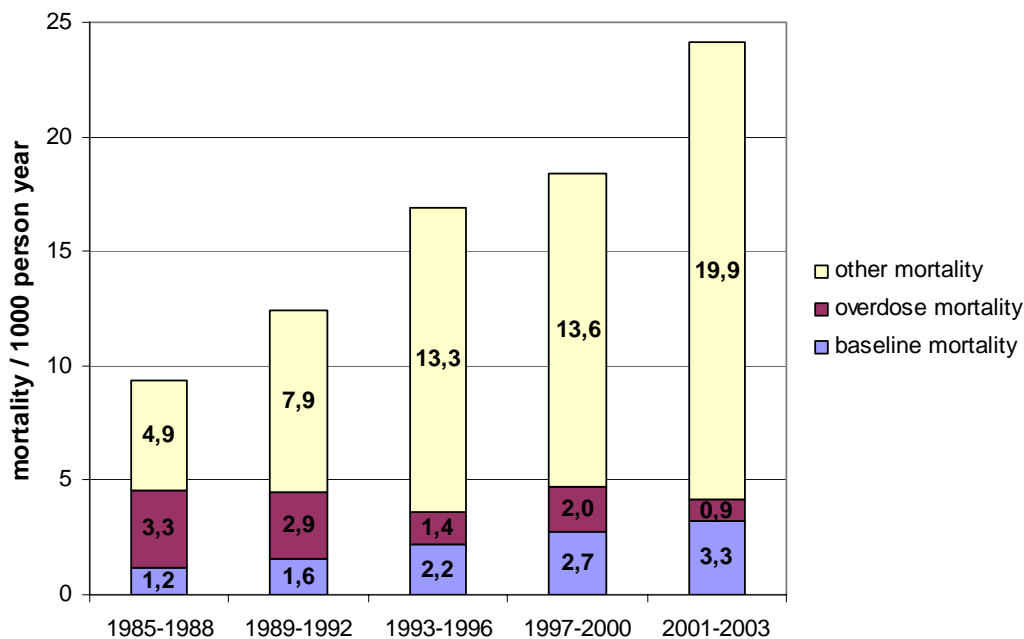
⁷ The number of fatal overdoses peaked in 1984 with over 70 cases and declined since then.

complicate the picture.

- Twenty persons in the category 'other causes' were HIV infected, but this infection was not always the cause of death.

The Municipal Health Service also investigates mortality rates among methadone clients (data provided by Marcel Buster). In order to have a proper follow-up of drug users, only methadone clients who were likely to stay in Amsterdam are included (i.e. who had a known address in the city and were born in the Netherlands, Surinam, Netherlands Antilles, Turkey or Morocco).

Figure 6.4: Mortality per 1,000 person years among Amsterdam methadone clients



Baseline mortality indicates the mortality among the Amsterdam population of the same age. Source: Municipal Health Service Amsterdam (M. Buster).

- In 2003, 24 persons per 1000 methadone clients died. Figure 6.4 shows that the overall mortality has increased since the eighties. Across these years, the relative mortality among methadone clients remained about 7 to 8 times higher than the mortality among the Amsterdam population in the same age group.
- The increase in other mortality may be related to the ageing of the population. The overdose mortality remained low, which may be related to the low rate of injection. The main increase is seen in the category 'other causes of death', including aids, liver cirrhosis, cancer, respiratory diseases, endocarditis, suicide and violence.

Deaths related to the use of ecstasy, GHB or other (synthetic) drugs

The number of persons in the Netherlands who died after using ecstasy or other synthetic drugs is not known, since there is no central registration of these cases. Moreover, full toxicology (and autopsy) is required to determine the exact cause of death. However, this is no routine procedure in the Netherlands. The National Forensic Institute is working on a

publication of 'ecstasy' deaths investigated over the past years, taking toxicological and pathological data into account. The results are not yet available.

According to the Causes of Deaths Statistics, 7 people died in 2003 from an acute psychostimulant intoxication. The precise nature of the involved drugs is not known (e.g. amphetamine, MDMA).

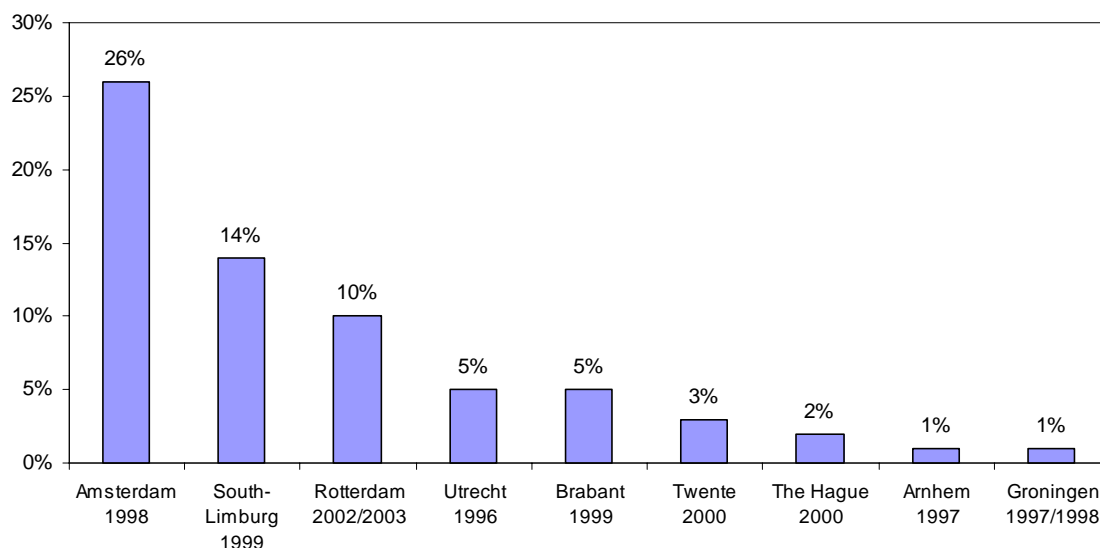
6.2 Drug-related infectious diseases

The (HIV) sentinel surveillance system among injecting drug users of the National Institute of Public Health and the Environment (RIVM) is the main source of information on the prevalence of HIV and hepatitis B and C. Other sources include the HIV/AIDS registration (HIV treatment data), notification data (hepatitis B and C; reported by the RIVM) and data from a local (Amsterdam) screening and treatment programme on infectious diseases among methadone clients. For various reasons, the latter sources do not give unbiased estimates of prevalence rates, but they may (in the long run) give additional indications of trends on the incidence of infectious diseases.

HIV

The Dutch HIV surveillance involves repeated surveys among drug users in four fixed cities (Amsterdam, Rotterdam, Heerlen/Maastricht en Arnhem) and two optional cities. Since 2001, one fixed city has been studied per year. In these surveys, frequent hard drug users (heroin, cocaine, methadone, amphetamines) are recruited in methadone centres and on the street. Saliva samples are collected and tested for HIV antibodies. The last survey was held in Rotterdam in 2002/2003.

Figure 6.5: HIV-prevalence among injecting drug users*



* Injecting 1 time or more in lifetime and using hard drugs on at least one day per week in the past 6 months. The figure includes only the most recent prevalence rates. South-Limburg: Heerlen: 11% (1994), 16% (1999), 22% (1999) and Maastricht: 8% (1994) 3% (1996), 5% (1999).

Figure 6.5 shows that the pattern of HIV prevalence among (ever) drug injectors across the Netherlands is quite heterogeneous. HIV prevalence is highest among drug injectors in Amsterdam, followed by Heerlen and Rotterdam. In most cities where repeated surveys were held, HIV prevalence remained fairly stable, with the exception of Heerlen. In this city, the percentage of HIV infected injecting drug users increased from 11% in 1994 to 22% in 1999.

Treatment data

Another source of information is the national HIV/AIDS registration of the HIV Monitoring Foundation (SHM), which has operated since 2002. This registration includes data on HIV diagnosed patients who contacted one of the 22 official HIV treatment centres (including 24 hospitals) in the Netherlands. This registration also includes data from a prior project (ATHENA) on HIV positive patients treated between 1998 and 2001. The data are used in a prospective observational study to monitor changes in the HIV epidemic and the effect of treatment of infected patients with antiretroviral combination therapy.

In August 2004, the SHM recorded a total of 9,767 persons (23% females). The percentage of injecting drug users was low and fairly stable in the past years (1 to 2%). In a previous report, the average percentage of injecting drug users among HIV infected patients up to 1996 was still 10%, dropping to 5% in 1997 and 2% in 1998 (Op de Coul et al. 2003).

Table 6.1: Number (%) of recorded HIV infections by year of diagnosis and transmission group

Transmission group	<=2000	2001	2002	2003
Homo/bisexual	3671 (56%)	386 (46%)	416 (46%)	374 (44%)
Heterosexual	1768 (27%)	372 (44%)	394 (44%)	373 (44%)
Injecting drug use	477 (7%)	15 (2%)	11 (1%)	16 (2%)
Blood (products)	103 (2%)	9 (1%)	8 (0.9%)	7 (0,8%)
Mother to child	26 (0,4%)	0 (0%)	0 (0%)	0 (0%)
Needle stick injury	15 (0,2%)	1 (0,1%)	5 (0,6%)	2 (0,2%)
Other/unknown	441 (7%)	65 (8%)	64 (7%)	75 (9%)
Total	6501	848	898	847

'Year of HIV diagnosis' refers to the date of the first HIV positive blood sample known by the HIV Monitoring Foundation. Figures are adjusted constantly because of reporting delays. Source: HIV Monitoring Foundation/ RIVM [RIVM report 441100020/2004, HIV and sexually transmitted infections in the Netherlands in 2003. An update: November 2004]

Note that this source of information does not concern a representative sample of drug users. Moreover, trends in newly diagnosed HIV infections may be influenced by various factors, such as the number of HIV tests (e.g. availability of HAART, more active testing policy) or retrospective inclusion of cases in the registration (Op de Coul et al. 2003).

The Municipal Health Service Amsterdam has recently carried out a pilot study on the implementation of a screening programme for HIV, hepatitis and other infectious diseases among clients of an Amsterdam methadone clinic. In 2003, 115 clients were tested, including 32% ever injectors (18% current; 14% ex-injector). The prevalence of HIV was 3% (Van Santen et al. 2004).

Aids

Until 2001 aids cases meeting WHO criteria were registered in the national Information System on AIDS Statistics, maintained by the Health Care Inspectorate (IGZ). In 2002 the Aids registration was replaced by the HIV/AIDS registration of the HIV Monitoring Foundation (SHM) mentioned above. As the IGZ data appeared to be incomplete since 2000, the data below are based on the IGZ registration until 1999 and the SHM data from 2000 onwards. The year of AIDS diagnosis refers to the date of the first CDC-C diagnosis (classification C according to the Centres for Diseases Control).

- On the first of January 2004, the cumulative number of reported AIDS diagnoses was 6,331. The annual number of cases peaked between 1992 and 1995 (between 480-533 cases) and then dropped to some 230-280 cases in the last years. The decrease since 1996 is related to the availability of HAART, which slowed progression from HIV to AIDS.
- The number of cases related to injecting drug use peaked in 1995 (74) and dropped to 8 cases in 2003. The proportion of injecting drug users varied between 2% and 14%.

Hepatitis B and C

The HIV surveillance system of the RIVM mentioned above among local samples of injecting drug users does not systematically test for HBV and HCV. Occasional local assessments carried out between 1994 and 2000 revealed high infection rates of HBV and HCV, varying between 35% and 67% (HBV) and between 47% and 79% (HCV). Data from a study in Amsterdam in the late eighties revealed that HCV infections are not exclusively found among injecting drug users; 10% of a sample of *non-injecting* drug users tested positive for HCV (van den Hoek et al. 1990).

Notification data

Since 1976 acute hepatitis B infections have to be notified to the Health Care Inspectorate (IGZ). In April 1999, newly diagnosed chronic and subclinical HBV infections also became notifiable diseases. Between January 2001 and December 2003, a total of 5,181 HBV infections were reported to the IGZ. Fifteen percent of the cases concerned an acute infection, 76% a chronic infection and for 6% of the cases the nature of the infection was not known. The total number of reported HBV infections (especially acute infections among males) rose between 2001 and 2003.

Table 6.2 shows the number of cases by the route of transmission. Injecting drug use was among the least important transmission routes (in 2003 3.1% of the acute cases and 1.9% of the chronic cases with a known transmission route). Note that the percentage of cases with an unknown transmission route is high.

Table 6.2: Notifications of HBV chronic and acute infections by route of transmission

Chronic infections	2001		2002		2003	
	N	%	N	%	N	%
Injecting drug use	17	1.4	23	1.6	17	1.2
Accident. exposure incidents	5	0.4	7	0.5	10	0.7
Mother to child	463	38.0	604	41.7	630	43.6
Sexual contact	70	5.7	87	6.0	150	10.4
Other	112	9.2	84	5.8	86	6.0
Unknown	552	45.3	643	44.4	552	38.2
Total	1,219	100	1,448	100	1,445	100

Acute infections	(2001)*		2002		2003	
	N	%	N	%	N	%
Injecting drug use	4	1.9	4	1.5	7	2.2
Accident. exposure incidents	2	0.9	2	0.8	7	2.2
Mother to child	-	-	-	-	2	0.6
Sexual contact	114	53.8	157	59.3	194	60.8
Other	27	12.7	35	13.2	19	6.0
Unknown	65	30.7	67	25.3	90	28.2
Total	212	100	265	100	319	100

Source: RIVM (Koedijk et al. 2004a; Koedijk et al. 2004b; {Haks, Bosman, et al. 2002 590 /id})

Hepatitis C has been a notifiable disease since April 1999. Until October 2003 both chronic and recent HCV infections had to be reported to the Health Care Inspectorate within 24 hours after the diagnosis (positive test for HCV or HCV-RNA-PCR). Since October 2003, this procedure only applies to (suspected) acute or recent infections.

The figures mentioned below should be interpreted with caution. As acute infections are often asymptomatic, an unknown rate of missed diagnoses and underreporting is possible. Underreporting also occurs because until 2004 data from the Municipal Health Service of Amsterdam are lacking. The registration system also changed in 2002, which hampered the analyses of data even further, and the transmission route is missing for quite a few cases.

Between April 1999 and December 2002, a total of 2,172 HCV infections (3.1% acute, 85% chronic and 12% unknown) were reported to the Health Care Inspectorate (Op de Coul et al. 2003)⁸. For 86% of the cases additional epidemiological information was obtained, including the likely route of transmission. Injection drug use was the most probable transmission route in 44% of the cases; 'other routes' accounted for 11.4% and no information on risk group was available for 45% of the cases.

Among persons with an *acute* infection (57) between 1999 and 2002, injecting drug use was reported as the most likely transmission route (49%). A slightly (non-significantly) higher percentage was found among *chronic* cases (54%). In 2003, a total of 10 acute hepatitis C infections were notified, including 7 cases with known transmission route. Four acute cases were related to injecting drug use (data provided by the RIVM).

Treatment data (hepatitis B and C and other diseases)

Screening of drug users in treatment is no routine procedure, but various pilot studies assessing the feasibility of screening and HCV treatment programmes are running (see also chapter 7.2). According to a pilot project of the Municipal Health Service of Amsterdam (see above, under HIV), 26% of the methadone clients tested in 2003, including 32% ever injectors (18% current, 14% ex-injector), had HCV antibodies (Van Santen et al. 2004). When analysed according to injection status, prevalence rates were higher among ever (ex) injectors compared with current injectors (see table 6.3).

Table 6.3: Prevalence of HBV and HCV among 116 clients of a methadone post in Amsterdam

	Current injectors	Ex-injectors	Never injectors
HBV ever*	85%	55%	27%
HCV	77%	90%	10%

Immune through (current) infection, window-phase. Percentages refer to all infections (old, chronic and active). Source: Municipal health Service Amsterdam (Van Santen et al. 2004).

Serologic testing for hepatitis B (HBsAg, anti-HBc, anti-HBs) showed that 50% had ever been in contact with HBV, including 2% active infection; 18% immune by past infection; 3% immune by vaccination. Prevalence rates were higher among current injectors compared with ex-injectors. This study also tested for Lues (% active infection, 10% immunity).

⁸ This figure also includes cases from Amsterdam (obtained from Annual Reports of the Municipal health Service).

In a recent letter, the National Health Council (September 2004), advised the Minister of Health to improve information and educational activities about the approved treatment modalities for HCV. For drug users, screening and treatment at drug treatment services was emphasised. Moreover, the Council stressed the importance of epidemiological research into the prevalence and risk factors of HVC (See also paragraph 7.2.)

TBC

The number of recorded tuberculosis (TBC) cases among problem hard drug users and the homeless in Rotterdam has tripled over the past ten years (De Vries et al. 2003). In 2002 a total of 26 hard drug addicts and 6 homeless persons with hard drug problems were diagnosed with TBC (note that the number of hard drug addicts is about 3,500 and the number of homeless persons without hard drug problems is estimated at 1,000). In 2002, the incidence of TBC was very high: 743 per 100,000 for problem hard drug users.

Until recently, the Municipal Health Service of Amsterdam recorded some 14-15 cases of TBC among methadone clients each year. In 2002 12 cases were counted and in 2003 only 6. Since TBC among drug addicts is strongly related to HIV, this drop might be due to the declining number of HIV/AIDS clients among drug users (personal communication M Buster). The lower TBC prevalence in Amsterdam (244 per 100,000 for methadone clients in 2001; (De Vries et al. 2003) compared with Rotterdam is probably explained by the existence of systematic screening programmes among risk groups, such as hard drug users, implemented in Amsterdam many years ago, while such programmes were terminated in 1996 in Rotterdam for financial reasons (De Vries et al. 2003).

Hepatitis A

On the 7th of February 2004 the Municipal Health Service of Rotterdam reported an outbreak of hepatitis A among homeless problem drug users (De Vries et al. 2004). Between February and mid April 2004, a total of 15 cases were reported among this population. In order to prevent further spread among the homeless and transmission to the general population, a large-scale vaccination campaign was launched. A total of 1515 homeless people were vaccinated as well as 1197 professionals working at various social services and treatment centres.

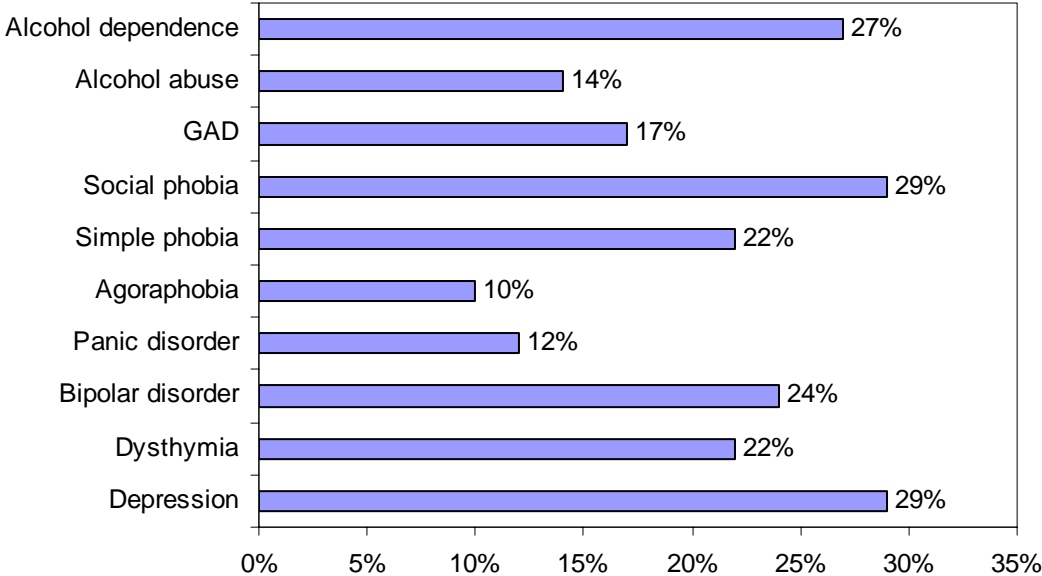
6.3 Psychiatric comorbidity

Recent data on the prevalence of psychiatric comorbidity are not available. According to local field studies, psychic problems are fairly common among problem hard drug users. In Rotterdam (1998), 37% of this group reported to have had psychic problems in the past month (7% mild, 9% moderate and 21% severe) (Jansen et al. 2003). Most common were depression, aggressiveness and anxiety/phobias. In Parkstad-Limburg (2002), more than half (51%) of the problem hard drug users reported to have psychic problems (45% depression, 15% severe anxiety, 16% concentration problems) (Coumans et al. 2002).

According to international studies, the comorbidity of ADHD and substance use disorders in treatment settings appears to be high (30-50%; Gordon et al., 2004). No reliable prevalence data are available yet for the Netherlands. According to a preliminary tentative estimate, some 20% of the clients of drug treatment services can be diagnosed with ADHD (pers. communication G. vd Glind).

Nemesis provides information on the comorbidity of mental disorders based on DSM-III-r diagnoses in the Dutch population of 18-64 years in 1996 (figure 6.6). Comorbidity is defined here as the occurrence of more than one disorder in a person within a given time frame. Drug dependence is highly comorbid with alcohol dependence (OR=10.3), bipolar disorder (OR=26) and dysthymia (OR=11).

Figure 6.6: One-year prevalence of mental disorders (%) among drug dependent persons (in 1996)



Odds ratios between 3 and 26. Source: Nemesis (Ravelli et al. 1998).

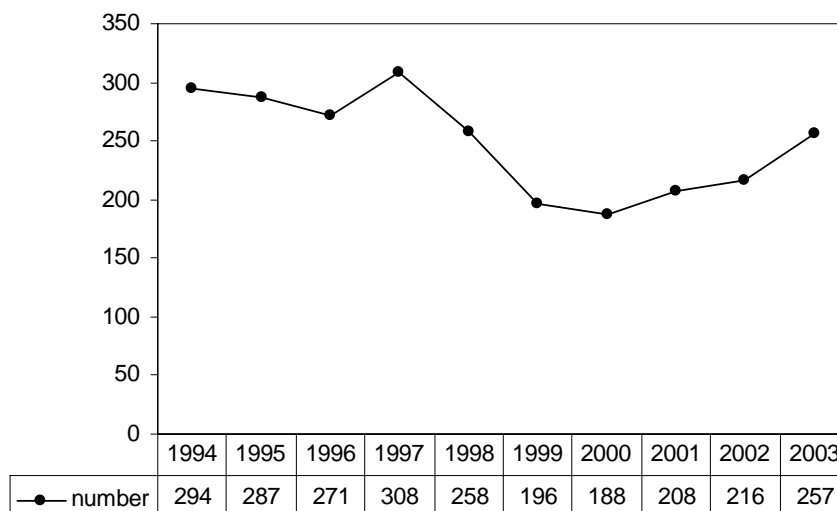
In the past year, there has been scientific and political debate on the association between cannabis use and mental disorders (see also chapter 3). A national study and various international studies (Arseneault et al. 2004; Smit et al. 2004a; Van Os et al. 2002) tend to provide converging evidence on the etiological role of cannabis in the onset of psychotic disorders. In general, the findings suggest that cannabis use increases the risk of the incidence of psychosis in the ‘general population’ with a factor 2 on average. This risk increases with the intensity of use and is much higher among vulnerable people with a history of psychotic disorders. These findings have been confirmed recently in a cohort of young people (Henquet et al., 2004). Despite the many methodological pitfalls and the impossibility to definitely infer causal relationships on the basis of epidemiological research (as argued by (Van Amsterdam et al. 2004)), the bulk of evidence suggests a possible etiological mechanism. Less is known about the relationship between cannabis use and other mental disorders, such as mood and anxiety disorders.

6.4 Other drug-related morbidity

Drug-related non-fatal emergencies in Amsterdam

The Municipal Health Service of Amsterdam keeps a record of nonfatal emergencies brought to their attention (Central Post Ambulance Transport). The more serious emergencies require transportation to the hospital by ambulance. The link with drug use has been based on case history and circumstantial data; there is no toxicological confirmation.

Figure 6.7: Number of non-fatal emergencies due to hard drug overdose recorded in Amsterdam*



* Includes heroin and cocaine. Source: Municipal Health Service Amsterdam.

- The annual number of requests for emergency assistance related to the use of opiates and cocaine varied between 200 and 300 (see figure 6.7).
- In 2003, 467 emergencies were related to 'recreational drugs' (amphetamines, cannabis, GHB, LSD, mushrooms, ecstasy) (table 6.4).
- More than half (55%) were due to the consumption of cannabis (including 61 space-cake cases), which may sometimes lead to panic attacks and other untoward reactions, particularly in inexperienced users.
- Second most common were emergencies related to GHB and hallucinogenic mushrooms. The number of emergencies related to these drugs tended to increase in the past years.

Table 6.4: Number of non-fatal emergencies* due to recreational drugs recorded by the Municipal Health Service of Amsterdam

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Cannabis	210	223	258	135	139	141	289	285	257
Hall. mushrooms	2	5	37	44	26	24	49	50	60
Ecstasy	38	66	41	35	43	36	42	39	39
Amphetamine	6	1	7	7	7	30	6	5	7
LSD	1	1	2	2	1	2	3	1	1
GHB	-	-	-	-	-	25	69	67	74
Unknown	-	-	-	3	13	20	37	38	29

Source: Municipal Health Service Amsterdam.

Information requests on acute intoxications

Another source of information on trends in emergencies is the number of information requests from physicians, health authorities and others on acute intoxications recorded by the National Poison Information Centre (NVIC) of the RIVM. Note, however, that these data are just indicative and do not reliably represent the actual number of acute intoxications.

Table 6.5: Information requests on drugs at the National Poisons Information Centre in 2000 and 2003

	2000	2003
Ecstasy and amphetamine	206	255
Cocaine	150	247
Cannabis	71	144
GHB	91	212
Others	138	352
<i>Total drugs</i>	<i>656</i>	<i>1,210</i>

Source: NVIC, RIVM (Van Gorcum et al. 2003); Meulenbelt personal communication).

- From 2002 to 2003 the total number of requests almost doubled (see table 6.5). Relatively strong increases were found for GHB, cannabis and cocaine.
- Moreover, in 2003, 112 questions were related to opiates, 110 to ephedra, 65 to hallucinogenic mushrooms and another 65 to other smart drugs.

Drugs and driving

According to an international review of epidemiological and experimental studies, cannabis use increases accident risk in a dose-related manner in drivers who are under the influence of this drug (Ramaekers et al. 2004). Recent experimental studies carried out by the University of Maastricht also suggest that ecstasy (MDMA) has the potential to interfere with complex performance, including driving, but the results are more mixed (Lamers 2004).

- In acute doses of 75 mg, MDMA improved aspects of psychomotor function, such as tracking performance under both single and divided task conditions, and movement time. However, object movement estimation was impaired. Moreover, MDMA levels in various bodily fluids (blood, sweat, urine, saliva) were significantly associated with changes in psychomotor performance.
- In a subsequent study, an attempt was made to examine whether MDMA has lasting effects on driving performance, beyond the intoxication phase. A group of MDMA users (>10 times, 37 times on average) who also used cannabis – but were abstinent at the time of testing - was compared with a group of (abstinent) cannabis only users and a

group of non-drug using controls. The results showed that abstinent MDMA /THC users and abstinent THC users performed as well as controls on measures of attention and processing speed. However, in a simulated driving test MDMD/THC users severely increased their risk of accidents by entering a collision with a much higher speed as compared to non drug users. A non-significant increase was also found in THC users. The interpretation of the results of this study (and most studies assessing the impact of long term substance use) is hampered by the fact that the three groups were not matched for the intake of alcohol (more use in both drug groups). Moreover, the role of other (premorbid) confounding factors can not be excluded.

Health effects of ecstasy

In a recent report, Pennings et al. (2004) - toxicologists of the University of Leiden - reviewed the international literature on the health effects of chronic ecstasy use (Pennings et al. 2004). Their main conclusions indicate that impairments of attention, memory and mood impairment were found in chronic ecstasy users, up to one year after cessation of use. However, given the characteristics of the population of ecstasy users, it is likely that such effects are not only related to ecstasy but also to other substances (alcohol, cannabis, amphetamines). Moreover, (partial) recovery of functional impairment is possible, but this is a slow process and it is not known whether full recovery is possible. The link between serotonergic damage of the brain and hyperthermia after MDMA, as found in animal studies, may hold for humans too. Changes in serotonergic parameters (serotonin transporter density) seem to be (partially) reversible but changes in cognitive functions do not recover at the same pace (more long lasting). The risk of hyperthermia (and probably serotonergic damage) is associated with the amount of ecstasy ingested and the ambient temperature during ecstasy use.

The University of Amsterdam carries out a *proprospective* study among 200 coffee shop visitors with a two-years follow-up among 50 incident and 50 continuously ecstasy naïve subjects (www.zonmw.nl). Measurements will include various brain imaging techniques and clinical and cognitive assessments. This study will allow to determine the causality of the relationship between (patterns of) ecstasy use, brain damage and functional impairments. This study will also demonstrate whether short term use causes brain damage.

7. Responses to Health Correlates and Consequences

There is no national policy on this subject but many local or regional initiatives to prevent or reduce negative drug-related health effects have been realised during the past years. There are First Aid courses for workers in the drug treatment system and the general health care system to manage drugs incidents in recreational settings. These courses focus on knowledge about recreational drugs, possible health consequences and First Aid interventions. Pill testing also aims to prevent health incidents (see chapter 3.2). As far as training is concerned, pill testing professionals are trained in techniques of chromatography, spectrometry, and paramedical interventions.

7.1 Prevention of drug-related deaths

The initiation of drug consumption rooms is part of harm reduction policy and these are (amongst other targets) meant to prevent overdoses and other drug-related health consequences.

7.2 Prevention and treatment of drug-related infectious diseases

Over a period of three years the National Coordination Structure on Infectious Diseases (*LCI*) published many protocols on infectious diseases, including HIV and hepatitis B and C. The last version (3rd edition) is from 2004 (Van Steenberghe et al. 2004). In these publications, which are primarily meant for health professionals, many aspects of infectious diseases have been made explicit, e.g. general preventive measures, possibilities for reimbursement of treatment costs, searching the sources, infection rates, duty to report, vaccination activities etc.

Many preventive activities started some years ago, some are to be continued, a few are new (see National Report 2003, 10.1, and earlier ones). Examples are: peer support for drug using immigrants, HIV tests, HIV treatment, Hepatitis C tests, HAART, and prophylactic vaccination of early stage syphilis among (drug using) street prostitutes. In this paragraph we only mention new developments.

Hepatitis B vaccination

The hepatitis B vaccination programme of high risk groups will be continued until 2006 (GGD Nederland 2004). In 2003 all 40 municipal health services participated in this project and more than 10,000 participants were registered (Waldhober 2003). This free of charge vaccination campaign focuses on high-risk groups for hepatitis B: i.e. men with homosexual contacts; hard drug users; heterosexuals with multiple sex-partners; including prostitutes and their clients. Targets are: increasing the coverage of a national immunisation campaign (vaccination and health education); reducing virus transmissions among target groups; and reducing virus transmissions among others who are in close contact with the target group. Combining vaccination with health education increases participation considerably compared with vaccination without health education. This especially counts for people who are not well-informed, less easy to reach, and less motivated (in most cases these are heterosexuals).

Treatment hepatitis C

Treatment of hepatitis C among drug users has been tried out recently (Ter Haar et al. 2004). Pilot studies testing the effectiveness of interferon treatment in methadone clients showed that patient compliance was (unexpectedly) very high. The treatment was given at methadone posts under supervision of a hepatologist. Almost all patients finished this heavy treatment. Therefore, the National Hepatitis Centre proposed a feasibility study to investigate whether this treatment could be implemented for all drug users. A project plan was approved and funded by the Foundation on Public Health Care. In three regions of the Netherlands, eligible drug users were selected and treated. Specialised physicians and nurses cooperated in solving logistical problems. Specific problems mentioned by leaders of this project were related to funding, available working hours of physicians and nurses, and organisational factors. These factors should be solved when implementing this treatment programme in all regions.

In 1997, the recommended therapy for hepatitis C was interferon. Some 20% of the treated individuals improved permanently. Today, a 48-week treatment with ribavirine and polyethylen-glycolinterferon results in a permanent elimination of viruses of the genotype 1. For patients with viruses of types 2 or 3, a permanent improvement of the clinical situation was realised in 80% of the patients with a 24-week treatment. These results apply to patients who had never been treated before (Orlent et al. 2003; Seeff et al. 2002). Trials which try to find an explanation for these positive results are still running. The National Health Council reported earlier on vaccination with interferon for hepatitis C. Based on the much better results of vaccination with the new combination mentioned above, the National Health Council has reported a new advice to inform high risk groups about the improved effectiveness of the new medication ((Gezondheidsraad 2004), see also paragraph 6.2).

Syringe exchange

A recent survey study (Otto et al. 2004) examined data on syringe exchange in the Netherlands to support activities to enhance the quality of this type of harm reduction. Of the 115 locations of syringe exchange that were approached, 79 participated in this study (somewhat less than 70%). The level of syringe exchange activities in the Netherlands is considerable considering the reduction of injecting drug users in our country during the past decades. However, exchange programmes differ much in several aspects (e.g. settings, opening hours, conditions) and are not based on guidelines. These programmes are present in all regions and big cities. It could not be determined how many syringes are exchanged annually. The authors also conducted a literature review on syringe exchange activities, but could not find any recommendations for quality assurance measures. One of their conclusions is that syringe exchange does reduce risk behaviours (such as syringe sharing), and is associated with a reduction of HIV infections. This decreases societal costs of this disease. Unfortunately, the transfer of hepatitis has been studied much less frequently (Otto et al. 2004).

Drug consumption rooms

Drug consumption rooms are low-threshold services targeting a reduction of drug related harm, including negative health consequences. Services offered are shelter, advice and support, food and drinks, medical treatment, safe use counselling, and syringe exchange. Between 2001-2004 three drug consumption rooms in the city of Utrecht were evaluated. Changes were measured between six and fifteen months after their opening. The target

group consisted of drug addicts among the down and out in the streets of Utrecht and environment. Participants were selected by a committee and the drug consumption rooms use specific "passports" in order to avoid an influx of drug users from other cities. The capacity did not change during the evaluation period, that is three to five professionals working in the room, open all week for 16 hours a day, offering not only a drug consumption room but also a room for relaxation where drug use is not permitted. Only one drug consumption room had a shower facility, two had rooms for medical care and First Aid services in case of accidents. In general there was a shortage of space for these added facilities. Drug use, physical and psychological health did not change. The participation rate in health assurances among participant drug addicts increased (from 70 to 82%), and the amount of nights per month sleeping rough decreased. From the estimated 410 drug addicts in the streets of this city, 220 participated actively (i.e. passport owners using these facilities) and 80 remained inactive after receiving this passport. Although other facilities (health care, social work, etc.) knew about these rooms, there were hardly any contacts between drug consumption rooms and regular care. However, compared with regular care the daily violence rate and theft among participants was higher in these rooms and the atmosphere was more restless than it was initially meant to be (a shelter where drug users can peacefully use their drugs without being bothered by the hectic of the street scene). Drug users themselves judged these rooms very positively (Hulsbosch et al. 2004). (See also paragraph 9.1 and 13.4.)

Shelter facilities for homeless people

Municipalities of several big cities have initiated 24-hour shelters for homeless people, included drug addicts. In these "hostels" the target groups have their own room, find support and care and they can spend their time. Evaluation among 300 inhabitants of the neighbourhood of each of two hostels in one city showed, that the safety in the two neighbourhoods did not change from six months before to six months after the start. Inhabitants had a slightly more favourable attitude towards these hostels afterwards. In a currently running second study of shelter facilities in the city of Utrecht, the first three of these hostels (a total of six are planned) are being evaluated. The number of inhabitants of these shelter facilities are permitted to range from 15 to 25.

Interventions related to psychiatric comorbidity

Somatic comorbidity

No new developments are present in this domain. We refer to our previous National Reports.

8. Social and legal correlates and consequences

8.1 Social exclusion

The Laeken European Council of December 2001 issued 18 indicators to monitor poverty and social exclusion (The Social Protection Committee 2004). For the Netherlands, poverty and social exclusion are monitored on these indicators by the Poverty Monitor. Among low income, unskilled labour, poor health, immigration, low education level, dropout, gender inequality, discrimination and racism, old age, divorce, alcoholism, and living in a problem accumulation area, the Dutch Poverty Monitor identifies "drug abuse" as a risk factor for social exclusion (Vrooman et al. 2004).

Social characteristics

Chapter 4.3 gives some information on social correlates related to problem drug use. Table 8.1 gives data on social characteristics of a street sample of problem hard drug users in Rotterdam.

Table 8.1: Social characteristics of a street sample of problem hard drug users in Rotterdam in 2003

Characteristic		%
Cultural origin	Dutch	47%
	Surinamese	23%
	Moroccan	9%
	Antillean/Aruban	7%
	Others	14%
Residence in the Netherlands	Legal	97%
	Illegal	3%
Living situation	Alone	70%
	With others**	30%
Housing situation	Homeless/drifting	40%
	Independent/self supporting	28%
	Shared living	32%
Main income males	Social benefit	51%
	Paid job	15%
	Others***	34%
Main income females	Social benefit	36%
	Prostitution	39%
	Others**	25%

N=201. * According to the perception of the drug user. ** Partner, children, family, others. *** Property crime, drug dealing, selling newspapers, street performance, renting accommodation etc. Source: IVO Rotterdam (Van der Poel et al. 2003).

The relation between indicators of social exclusion and drug abuse also becomes apparent in the social characteristics of outpatient drug clients. Table 8.2 shows some social characteristics of outpatient drug clients for the years 1994 and 2003.

Table 8.2: Social characteristics of outpatient drug clients in 1994 and 2003

Characteristic	Cannabis		Opiates		Cocaine (incl. crack)		Ampheta- mines		All drugs	
	1994	2003	1994	2003	1994	2003	1994	2003	1994	2003
Ethnic*	18%	21%	29%	33%	32%	29%	6%	5%	27%	29%
Secondary or higher education	40%	44%	28%	33%	32%	37%	30%	37%	30%	37%
Employed	30%	42%	21%	21%	35%	37%	35%	43%	24%	30%
Cohabitation	62%	57%	59%	44%	59%	52%	71%	61%	59%	49%

*According to the perception of the client. Source: LADIS, IVZ.

In 2003 only 37% of the primary drug clients had finished secondary or higher education, a minority of 30% was employed, and 49% did not live alone but with a partner or children. Compared with clients having a primary problem with cannabis, cocaine, or amphetamines, clients having a primary problem with opiates show a more unfavourable position in terms of higher education, employment and living situation. The proportion of ethnic minorities was highest among the opiates clients and lowest among amphetamines clients.

Compared with 1994, the social position of the drug clients in general seems to have improved in 2003. The proportion of drug clients that finished secondary or higher education and the proportion of drug clients having a paid job increased in this period. However, the work situation did not improve for the opiates clients.

Ethnic minorities

In previous reporting years it was already signalled that in outpatient addiction care ethnic minorities show higher dropout rates (Vrieling et al. 2000). For ethnic minorities more information has now become available about barriers to receive inpatient addiction care.

In a cohort study over four years, Verdurmen et al. (2004) followed 742 primarily heroin-dependent clients that entered methadone treatment in the greater Rotterdam area in 1996 (Verdurmen et al. 2004b). Besides the 491 native Dutch clients, this group consisted of 251 ethnic clients, 69 of whom were Moroccan/Turkish clients and 182 of whom were Surinamese/Dutch-Antillean clients. Although no differences were found in the use of outpatient treatment, ethnic minorities appeared to be under-represented in the methadone programme. Moreover, people of Moroccan and Turkish descent were under-represented in inpatient treatment. In a qualitative study, Verdurmen et al. (2003) revealed the barriers to service access among Moroccan drug users (Verdurmen et al. 2004a). Barriers were found to consist in language problems, not knowing where to obtain inpatient treatment, not seeing the use of talking about feelings, too strong rules, and too few counsellors from the same ethnic origin.

Tjaden et al. (2003) followed 214 clients from April 1999 up to August 2000 in three different inpatient settings (Tjaden et al. 2003). From the 214 clients, 150 clients were native Dutch and 64 were ethnic. The inpatient settings were located in the city and the province of Utrecht and in the city of Amsterdam. It was found that 25% of the ethnic clients did not show up for a planned inpatient treatment, compared with only 9% of the native Dutch clients that did not show up. Further research by Tjaden et al. (2004) revealed that although differences in values do not effect the result of treatment, these differences decrease the quality of the

working alliance with the addiction counsellor and lead to less satisfaction with treatment (Tjaden et al. 2004). Differences were found in that, compared with their counsellors, ethnic clients attribute greater value to safety for the family, politeness, respect for their family and the elderly, and respect for tradition. Given these results, the authors do not plead for a culture-specific form of addiction treatment. A culture-sensitive form of addiction treatment is recommended in which there is sufficient communication regarding the differences in values between clients and counsellors.

8.2 Drug-related crime (drug offences)

The Scientific Research and Documentation Centre (WODC) of the Ministry of Justice presents statistics on registered drug related crime and responses to this crime in the Annual Report of the National Drug Monitor. Data in this paragraph are drawn from the WODC-chapter of the Annual Report.

Drug offences

The criminal justice system in The Netherlands has to deal with several thousands of drug offences each year. The drug offences consist of *drug law crimes* - specifically offences against the Opium Act - as well as *crimes committed by drug users*. Where drug users commit Opium Act offences, the two components overlap.

The number of Opium Act crimes increased in 2003. All phases of the law enforcement chain saw more Opium Act cases. This may partly be due to the enhancement of law enforcement efforts in recent years. Efforts on both synthetic drugs and cocaine trafficking via airplanes were intensified (A combined effort to combat XTC/Samenspannen tegen XTC, 2001; Plan to combat drug trafficking at Schiphol/Plan van aanpak drugssmokkel Schiphol, 2002). In addition, the Dutch cabinet launched proposals to intensify enforcement on cannabis crimes in April 2004 (T.K.24077/125).

The number of crimes committed by drug users did not increase in 2003; there were about 10,000 drug using offenders, the majority of whom has high rates of recidivism. The type of offence committed by drug users is mainly property crimes without violence. Since 2002, special efforts are made to reduce the recidivism of these repeat offenders (T.K.28684/1-2; T.K.28684/29).

Offences against the Opium Act

An indicator for offences against the Opium Act is the number of Opium Act cases recorded by the Public Prosecution Service. The data are shown in table 8.3.

- In 2003, the total number of Opium Act cases increased to more than 17,000. About half of the recent increase is related to cases in the 'arrondissement Haarlem', which includes Schiphol Airport. These cases largely represent drug couriers, especially swallowers or body packers of cocaine.
- The majority of the Opium Act cases (58%) concerns hard drugs, 36% soft drugs and 6% both hard and soft drugs. 2003 did not show any relevant changes in these proportions.
- Offenders are mainly male and most of them are between 25 and 35 years old.

Table 8.3: Number and percentage of Opium Act cases recorded by Public Prosecutions Service 1999-2003

	1999	2000	2001	2002	2003
Hard drugs	6,407	6,397	7,672	9,246	9,989
Soft drugs	4,380	4,324	5,059	5,832	6,156
Hard and soft drugs	888	792	827	770	942
Total	11,675	11,513	13,558	15,848	17,087
Hard drugs	55%	56%	57%	58%	58%
Soft drugs	38%	38%	37%	37%	36%
Hard and soft drugs	8%	7%	6%	5%	6%
Total	100%	100%	100%	100%	100%

Source: OMDATA, WODC. Note that more than one case may be recorded per suspect and that cases may have been 'filtered' at the level of the police (only cases with a reasonable chance of being prosecuted will be sent to the public prosecutor).

Organised crime

Efforts of law enforcement organisations have been focused on more serious cases in recent years; this is reflected in figures from the National Investigation Information Services. In 2003 there were more investigations into more serious cases of organised crime (a total of 221) and drug law offences form a growing proportion of these (see table 8.4).

- 66% concerned drug-related crime, which is slightly more than in 2002.
- 40% of all cases concerns only hard drugs and 11% only soft drugs, 14% concerns both soft and hard drugs.
- In 62% of the drug related investigations there is only one type of drug involved. The other cases concern more than one type of drugs.
- 60% of the investigations on hard drugs involve cocaine, 54% synthetic drugs and 17% heroin. The number of cases with cocaine increased strongly. This might be caused – partly - by the more intense checks at Schiphol Airport.
- The soft drugs are mostly 'nederwiet' (marihuana cultivated in The Netherlands; 53%) and concern trafficking as well as production.
- In 2002, the criminal groups under investigation were more often involved in transport and trafficking than in production. For 2003, these specifications cannot be made.

Table 8.4: Investigations into more serious forms of organised crime: proportion of drug law criminality and type of drug involved 1999-2003

	1999	2000	2001	2002 ¹	2003
Number of investigations	118 (100%)	148 (100%)	146 (100%)	185 (100%)	221 (100%)
Number and % of drug law criminality	75 (64%)	78 (53%)	90 (62%)	117 (63%)	146 (66%)
• Hard drugs	24 (20%)	35 (24%)	53 (36%)	64 (35%)	89 (40%)
• Soft drugs	9 (8%)	14 (9%)	15 (10%)	20 (11%)	25 (11%)
• Hard and Soft drugs	42 (36%)	29 (20%)	22 (15%)	33 (18%)	32 (14%)

I. Due to changes in registration, the number of investigations since 2002 are not directly comparable to the years before. Source: KLPD/DNRI, group Research and Analysis.

Convictions and court sentences for Opium Act offences

Most of the Opium Act cases (68%) are taken to court. Of the hard drug cases 74% is taken to court, of the soft drug cases 57%, of the cases with hard and soft drugs 80%.

Table 8.5 shows a selection of sentences imposed by the courts for Opium Act cases where there is a verdict of guilty, and of transactions offered by the prosecutor.

Table 8.5: Number of irrevocable sentences in Opium Act cases imposed by the courts 1999-2003^I

	1999	2000	2001	2002	2003
Community service order ^{II}	2,129	2,138	2,382	2,985	4,008
Unconditional prison sentence	3,578	3,341	3,523	4,641	5,155
Financial transaction	911	838	1,568	1,884	1,797
Fine	1,634	1,350	1,393	1,522	1,547
Dispossession	74	73	46	58	105

I. There can be combinations of sentences. II. This order applies to relatively minor offences. It can consist of work, treatment, education or a combination of these. Source: OBDJ, WODC.

- The number of community service orders and unconditional prison sentences increased in 2003 by 34% and 11% respectively. The number of dispossession cases almost doubled in 2003.
- The mean duration of the community service is 119 days in 2003, mean duration of prison sentences is 357 days; this is slightly less than in 2002. Median amount in dispossessions is 2,616 Euro in 2003, more than in 2002.
- The number of financial transactions and fixed penalties did not change very much in 2003.

Prison data

There is a growing number of – mostly lengthy – custodial sentences for drug law cases. The extension of the Dutch prison system, which has been carried out recently, was necessary partly because of these sentences. Merely to cope with the inflow of cocaine couriers, there has been an increase of detention capacity of about 1300 places, which is an extension of 10%.

- 16% of all custodial sentences concern Opium Act cases, predominantly hard drug cases (table 8.6). There is a slight increase in 2003.
- The proportion of imposed detention years for Opium Act cases increased from 28% in 2002 to 31% in 2003, again this concerns predominantly hard drug cases.

Table 8.6: Number of custodial sentences and number of detention years 1999-2003^I

	1999	2000	2001	2002	2003
Number of custodial sentences	25,220	25,851	27,413	30,994	34,380
Opium Act total	13%	11%	12%	14%	16%
- hard drugs ^{II}	12%	10%	11%	13%	15%
- soft drugs ^{II}	1%	1%	1%	1%	1%
Other criminal cases ^{III}	87%	89%	88%	86%	84%
Detention years ^{IV}	9,100	9,086	10,079	12,025	12,204
Opium Act total	27%	24%	23%	28%	31%
- hard drugs ^{II}	25%	23%	22%	27%	30%
- soft drugs ^{II}	2%	1%	1%	1%	1%
Other criminal cases ^{III}	73%	76%	77%	72%	69%

I. Excluding youth detention. II. Cases involving a soft drug offence as well as a hard drug offence are classified as hard drug cases. III. 'Other criminal cases' contain all crimes committed by drug users. IV. Detention years are calculated by adding all unsuspended parts of sentences and deducting early releases. Source: OBDJ, WODC.

Recidivism of Opium Act offenders

Opium Act offenders have a slightly higher rate of recidivism compared with other offenders. Figures from the Monitor on Recidivism from the WODC show that (see table 8.7):

- In the first year after their first Opium Act offence, 25% of the offenders came into conflict with the law again (any offence). In the following years the percentage went up to 34, 40 and 43%. Five years after the first offence 45% had offended again. This is higher than in the total population of criminal offenders.
- Opium Act offenders also show a slightly higher percentage of severe recidivism (new offences for which detention on remand is applicable). This severe recidivism occurs in 15% of the cases after 1 year and in 29% of the cases after 5 years. More often than other offenders, these offenders end up with a relatively long custodial sentence after recidivism.
- Special recidivism (new Opium Act offences) occurs in 10% of the cases within 1 year, up to 22% in 5 years.

Table 8.7: Percentage of recidivists after an Opium Act offence, cumulative figures

	Observation period									
	1 year		2 years		3 years		4 years		5 years	
Type of recidivism:	oa	total ^{II}	oa	Total ^{II}	oa	total ^{II}	oa	total ^{II}	oa	total ^{II}
General	25%	22%	34%	31%	40%	36%	43%	39%	45%	42%
Severe	15%	14%	21%	19%	25%	23%	28%	25%	29%	26%
Special: Opium Act	10%	-	15%	-	18%	-	20%	-	22%	-

I. Opium Act offenders who have been in contact with the justice system in 1997 (oa). II. All offenders who have been in contact with the justice system in 1997. Source: Monitor on Recidivism, WODC.

Offences by drug users

The Police Records System includes a classification "drug user". This notification is made if the suspect may constitute a danger to others due to his or her drug use. The classification is made by the police and its validity is disputable. However, it gives a rough indication of drug using suspects and their characteristics. The police statistics for 2003 are preliminary. They show that:

- An estimated 10,000 suspects (individuals) are classified as drug user, 90% of them is male. There are no relevant changes in these figures when compared to those of 2002.
- 44% lives in the larger cities (more than 250,000 inhabitants). Mean age is 37 years.
- 11% is also classified as having problems with alcohol use and 21% has problems with other drugs (e.g. medicines).
- These suspects have a high rate of recidivism: 72% has more than 10 records of an offence in his or her criminal career; 20% even more than 50.
- A recent research report shows that an estimated 71% of a group of 6,000 repeat offenders - defined as being in contact with the criminal justice system more than 10 times in a 5 year period - is a regular hard drug user (Wartna et al. 2004b;Wartna et al. 2004a).

Types of offences

- Most drug users (58%) are suspected of property crimes without violence; this was 63% in 2002 and 23% is suspected of 'other violence' and 22% is suspected of an Opium Act offence. Both these figures show a slight increase. Property crimes with violence is reported for 11% of suspects; there is no relevant change compared to 2002.

Table 8.8: Types of offences committed by suspects classified by the police as drug user, 1999-2003

Type of offence ¹	1999	2000	2001	2002	2003
Sexual offence	1%	2%	1%	1%	1%
Other violence (against persons)	19%	20%	20%	22%	23%
Property crimes with violence	12%	12%	12%	12%	11%
Property crimes without violence	63%	63%	63%	63%	58%
Vandalism, disturbance of public order	20%	21%	21%	22%	22%
Traffic offence	10%	11%	11%	10%	10%
Opium Act offence	20%	18%	19%	19%	22%
Other	10%	11%	10%	10%	10%

I. Suspects may commit more than one type of offence; percentages do not add up to 100. Source: HKS, KLPD/DNRI, group Research and Analysis.

8.3 Drug use in prison

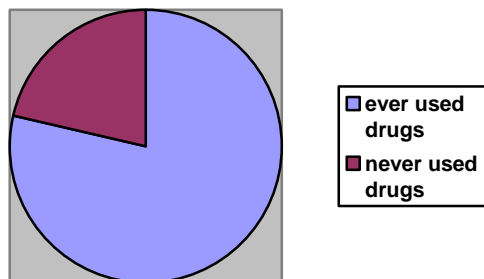
Although drug use in prison is not yet monitored systematically in the Netherlands, it is studied occasionally. Drug use among detainees was investigated at a police station (Van den Broek et al. 2000), see national report 2001), in regular remand houses and prisons (Koeter et al. 1998;Schoemaker et al. 1997); see previous national reports), and in youth detention centres. It was also studied among detainees receiving compulsory treatment. In the Netherlands, compulsory treatment is given to offenders who are legally not accountable for their offence, because they committed the offence under the influence of a psychological disorder. In Dutch, this proceeding of compulsory treatment is called "terbeschikkingstelling", abbreviated as "TBS".

The most recent research which provides data on *pre-prison* drug use by prison inmates was published in April 2003 (Vogelsang et al. 2003). This study In this study a representative sample of 355 male prisoners out of the total population in the entrance/intake departments of 8 Dutch prisons were interviewed. The aim of the study was to detect the prevalence of

“criminogenic needs” of prisoners. Criminogenic needs are defined as “features and circumstances of offenders (including their surroundings) which contribute to offending behaviour, and therefore can be used to determine the risk of recidivism”. Substance misuse is considered as one of the (12) criminogenic needs. The study describes self reported drug use prior to imprisonment. It shows that a reasonable proportion of prisoners have problems with drug use.

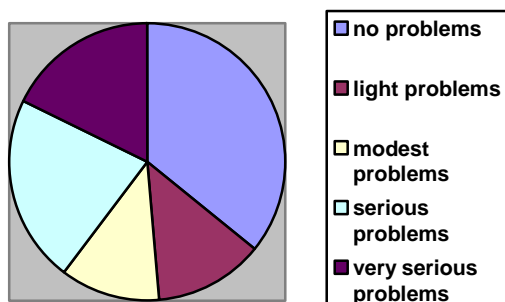
- 79% of the inmates in the study indicate that he or she ever used drugs (see figure 8.9). 61% of the inmates used hard drugs in the 6 months before imprisonment, 39% used soft drugs.
- 33% used soft drugs daily before their imprisonment, 32% used cocaine/crack on a daily basis, 21.4% heroin. Other drugs were used less frequently.
- 40% of the users report serious or very serious problems with their drug use; mostly these problems have to do with hard drug use. Only 36% of those who report drug use have no problems with their use; the majority has problems, in most cases of a serious or very serious character (see figure 8.10).
- Inmates that used hard drugs before their imprisonment are significantly less motivated to change the drug using behaviour than those that used soft drugs.

Figure 8.9: Percentage of prisoners that ever (79%) or never (21%) used soft or hard drugs prior to imprisonment



Source: (Vogelsang et al. 2003)

Figure 8.10: Percentage of prisoners that ever used drugs prior to imprisonment with no problems (36%), light, modest, serious and very serious problems (64%)



Source: (Vogelsang et al. 2003)

In the Netherlands there are nine youth detention centres. Bulten (1998) studied male detainees between 18 and 24 years in one of these detention centres (Nieuw Vosseveld), whereas Vreugdenhil et al. (2003) investigated the population of six other detention centres⁹(Bulten 1998;Vreugdenhil et al. 2003). Bulten (1998) assessed drug dependence according to DSM III criteria, and found a lifetime prevalence of drug dependence of 58%, and a last year prevalence of 49%. For the investigated six other youth detention centres, Vreugdenhil et al. (2003) found 30% to have suffered from cannabis dependence during the last 6 months before detention, and 14% to have suffered from cannabis abuse. The lifetime prevalence of drug use appeared 86% for cannabis, 21% for cocaine, 5% for heroin and opiates, and 21% for ecstasy/amphetamines.

According to the TBS-proceeding, psychologically disordered offenders who are legally not accountable for their offence, receive compulsory treatment in eleven specialised clinics. On a sample of detainees from these eleven clinics, by means of DSM IV and ICD-9 diagnoses, Van Emmerik and Brouwers (2001) assessed problems with substance use (Van Emmerik et al. 2001). At the time of the criminal offence, 31% of the compulsory treated showed problems with cannabis, and 27% showed problems with hard drugs.

The studies reviewed above have applied different definitions of drug use, ranging from broad definitions like "lifetime use" and "last year use" to stricter definitions as "daily use" and "dependence". To a large extent the different percentages that were found will be due to these differences in definitions. Notwithstanding the deviating definitions, different studies show a similar pattern in that cannabis shows the highest percentage of use and problem use, followed by cocaine/crack, then by opiates/heroin, and then by amphetamines.

8.4 Social and economic costs of drug consumption

There are no recent estimates of the social and economic costs of drug use. Recent estimates of public expenditures on drug policy amount to a total of €2,186 million (Rigter 2003). Enforcement makes up 75% of this budget.

⁹ Den Heyacker, Eikenstein, de Hartelborgt, het Jongeren Opvang Centrum, het Nieuwe Lloyd, and Teylingereind

9 Responses to Social Correlates and Consequences

9.1 Social integration

The aim of providing social care to drug-dependent persons is *harm reduction*: the prevention of (additional) harm to the drug user's health and outlook on life. This kind of help is mainly offered by community and private social care organisations, but — without a clear division between 'drug treatment' and 'social care for drug-dependent persons' — social care is also provided by many drug treatment services. (See also paragraph 5.1.)

Social care for drug-dependent persons includes a wide range of services, for example:

- *Boarding houses or hostels*
- *Drop-in Centres* for (drug dependent) street prostitutes in various towns
- *Drug Consumption Rooms*, where drug dependent persons can use drugs in safe surroundings without being harassed by the police. The objective of such modalities is to reduce the level of nuisance that might be caused otherwise, and prevent (additional) harm to the drug user's health by providing information as well as medical and social care. In November 2000, 20 drug consumption rooms were operational in the Netherlands: thirteen of which were integrated in a larger facility with more services, and seven of which operated independently. Nowadays this number has increased to 32. Integrated drug consumption rooms are cheaper to run and less stigmatising for the visitors. (See also paragraph 13.4.)

9.2 Prevention and reduction of drug-related crime

For drug using offenders - and also for other persons with addiction problems in the criminal justice system - several types of assistance are available. The general aim of the assistance is to improve reintegration in society by reducing drug problems and other problems drug users have to cope with, in order to reduce drug-related crime. Hard drug users have the most serious problems (Vogelsang et al. 2003). Not only drug use and criminal behaviour are a problem, but also housing, finances, work and social contacts (Van Ooyen-Houben 2004b). An important development is the political movement towards more safety in society. Many changes in the criminal justice system are being carried out to this end (T.K.28642/1;T.K.28684/29). These developments have an important influence on the responses to the criminal behaviour of drug users, whereas one of the main targets of the new policy concerns repeat offenders (T.K.28684/10), a majority of whom are regular hard drug users (Wartna et al. 2004a).

Addiction Probation Services

For addicts in the criminal justice system, assistance from addiction probation services is available within budgetary and political limits. Addiction Probation Services form a national foundation (Stichting Verslavingsreclassering GGZ Nederland) and addiction probation officers are employees of regular addiction care organisations in every part of the country. Addiction probation officers are active in all phases of the criminal trajectory: from police custody until release from detention. They visit arrestees when in police custody or in remand custody, to gather knowledge about the situation of addicts in the early phases of the criminal justice system and to be able to give advice about the best possible approach. They report about suspected and imprisoned persons and their circumstances, and advise judges and other organisations about the best approach for a reduction of problems and a decrease

of recidivism. They supervise working and learning sentences and are involved in referral to care programmes when appropriate, ultimately to be decided by the judge.

Table 9.1 gives an overview of the services delivered by addiction probation services in 2002 and 2003. The overview comes from the registration system about clients “Client Volg Systeem” which was introduced in 2001.

Table 9.1: Types of assistance offered by addiction probation services to drug using offenders, and number of times the service was provided, 2002 and 2003^I

Services	2002	2003
First visit to arrestee/prisoner in remand	3,629	4,305
Report to judge with advice regarding continuation remand imprisonment	995	922
Devising, coordinating and evaluating a plan of approach following a systematic method ^{II}	10,048	9,156
Referral to care programmes	1,568	2,115
Supervision of clients in framework of judicial decision	2,407	3,726
Reintegration training programmes	1,696	2,566 ^{IV}
Supervision of working sentences	3,382	4,098
Supervision of learning sentences	139	217
Advisory reports	7,587	8,746
Diagnoses ^{III}		10,615

I. No figures on case level, no specification for type of drug/alcohol/gambling II. Service is discontinued in 2004. III. Newly defined service in 2003. IV: predominantly Drug Counselling Units in prisons. Source: Foundation of Addiction Probation Services.

- Most activities show an increase in 2003.
- Diagnostic activities are carried out most frequently: more than 10,000 times in 2003. This is a service that was redefined and extended in 2003. A new standard instrument has been developed for diagnosis: the RISC. This instrument focuses on criminogenic factors and will be scientifically tested. It was adopted from “what works” approaches in, amongst others, Great Britain. It is under validation in The Netherlands right now. It will be used by addiction probation and prison officers in different phases of the judicial chain.
- Early visits to addicted arrestees and prisoners in remand custody also occur with a reasonably high frequency: 4,305 times in 2003.
- Devising, coordinating and evaluating a plan of approach occurred more than 9,000 times. This service is discontinued in 2004.
- Diversion to care programmes took place more than 2,000 times.
- Supervision activities and delivery of reintegration programmes occur with high frequency.
- Advisory reports were made more than 8,000 times; these consist of written information to the judge or (judicial) organisation in consideration of a specific question or a decision about prosecution, sentencing or the execution of a sentence. A report has been made 922 times during remand imprisonment.

New developments

The position of addiction probation services in the criminal justice system is subject to redefinition and rethinking (T.K.29270/1). This process should result in a more effective and efficient approach by probation services. Examples of new ways of working which are being developed are:

- Financing of services of addiction probation by the Ministry of Justice will only be possible if this service is ordered by the justice system (prosecutor, judge or prison authorities).
- There will be a more stringent selection of cases. Efforts will be aimed more strictly at those addicts with a high risk of recidivism who have a reasonable chance of success in a behavioural care programme and whose problems are severe. For addicts who have no chance of success, imprisonment in a sober regime will be applied.
- Selection of addicts to be assisted will take place in a systematic way. An instrument has been developed for assessing risk factors, the RISc (see previous paragraph).
- New protocols for cooperation between the prison system and addiction probation services will be developed. In the future, addiction probation services and the prison system will be co-responsible for the re-integration trajectory of an addicted detainee.
- Addiction probation services face quite a task implementing the consequences of the new policy.

Assistance for drug users in prison

During their stay in prison, drug users can make use of or can be forced to make use of special programmes.

- In 2003, addicts chose to stay in a Drug Counselling Unit (Verslaafden Begeleidingsafdeling, VBA) 680 times. These are drug-free units which offer a programme for addicts who are motivated to stop their drug use and who are, as such, eligible for a programme preparing them for treatment outside detention.
- Substitution treatment is possible for short-term detainees who already used methadone before imprisonment (T.K.24077/112). However, daily practice is variable and whether detainees receive methadone depends on prison physicians.
- Participation in penitentiary programmes is possible at the end of the detention period. However, addicts scarcely participate in these programmes.
- The experiment with the measure of compulsory placement of addicts in the Judicial Treatment of Addicts (Strafrechtelijke Opvang Verslaafden, SOV) is still going on. It started in 2001 and will be continued until the end of 2006. This placement is mandatory and executed in special prison units in Utrecht, Amsterdam and Rotterdam. The aim of the SOV is twofold: a reduction of severe drug related criminal nuisance and resolving or reducing individual addiction problems in combination with reintegration in society. Adult frequent offenders with a hard drug addiction form the target group of SOV.
- SOV has 219 places available. In July 2004, 148 places were occupied (occupation rate 67,5%).
- Drug users in SOV follow a stepwise reintegration programme into society. There is a first closed phase (day-and-night in SOV), followed by a second half-open phase (outside during daytime, in SOV during the night) and a final open extramural phase. Each phase lasts 6 to 9 months.
- In 2003 the first participants left the programme on a regular basis. The first participant left on the 22nd of April 2003. Since then, the outflow has been continuous.

New developments

The focus of the prison system is changing towards a higher effectiveness and a higher efficiency in the execution of sentences, with a more differentiated and selective use of prison capacity and a more systematic and stringent selection of detainees for programmes. These changes will have a strong impact on the assistance to drug users in prison.

- From 2002 until end of 2004 three special projects are carried out to improve protocols and instruments for diversion of addicted detainees in the phase of remand custody (Bouman 2002). There are pilot projects going on, which will be evaluated by the Institute for Applied Social Sciences of the Radboud University Nijmegen under supervision of the WODC. Results will be available by the end of 2004. Addiction probation services, prison authorities and addiction care centres are involved. The projects are part of the broader programme "Reduction of Recidivism" (Terugdringen Recidive) that affects all prisoners (not only drug users) and is being executed by the Ministry of Justice since 2002, to improve the implementation of sanctions. The programme "Reduction of Recidivism" aims at improving the diversion into care programmes by a more effective screening of detainees and assessing their chances of success, and improving the implementation of effective interventions and the cooperation between police, prosecutor, prisons and probation services.
- Recent policy documents on security and criminality focus on the target group of repeat offenders. Since 2002, special efforts are made to reduce the recidivism of these offenders (T.K.28684/1-2;T.K.28684/10;T.K.28684/29). Specific measures are carried out for the 'hard core' of this group of over 18 years old. One of the measures is the new law "Placement in an Institution for Prolific Offenders" (Stb 2004/351;T.K.28980-1-2;T.K.28980/16;T.K.28980/3), which has been in force since October 2004. This law facilitates sentencing a person to imprisonment in a sober regime for a maximum of two years. New is the focus on the person and not on the case (mostly minor crimes). ISD-places are made available stepwise, from 272 places in 2004 to a total of 1,000 places in 2007, at first in Amsterdam, Rotterdam, The Hague and Utrecht, later in other larger cities. ISD is for all repeat offenders. However, because a large part of them are drug users (71% according to Wartna, Baas & Beenackers, 2004 (Wartna et al. 2004a)), the ISD law will affect drug users specifically. An interesting point is that the measure of compulsory placement of addicts (SOV) is incorporated in the new ISD-law. Those who get a measure of ISD will get an assessment. The outcome can be either the placement in programmes geared at behavioural change - like SOV or a less intensive or extramural programme - or the placement in a sober basic regime with the focus on incarceration. Starting point is the basic regime.
- At the same time, the prison system is changing its strategy. There are proposals in which programmes geared at behavioural changes will no longer be offered to all detainees, but only to those detainees who are in the prison system for a longer period and who are motivated and have a reasonable chance of success. Other detainees will get a set of basic activities during their stay in prison. The new plans were presented at the end of 2003 (Ministerie van Justitie 2003). Follow up versions are expected in 2004.
- A recent report showed that aftercare is badly organised (T.K.29660/1-2). Local authorities and health care should play an important role in assisting with the reintegration of released offenders. Policy makers will take action on this by developing covenants with local authorities and organisations, to improve after care and stimulate re-integration of ex-detainees.

- The Minister of Justice is proposing a re-introduction of the legal possibility of conditional release. By keeping ex detainees under the supervision of judicial authorities and – at the same time – stimulating participation in extramural re-integration programmes, it is assumed that recidivism can be reduced.

Alternatives to prison for drug users

The Netherlands have options for drug treatment as an alternative to imprisonment. On a political level, these options mainly refer to highly criminal long-term users of hard drugs. This group causes a lot of nuisance and is a major burden on society and the justice system. They are repeatedly sentenced to short-term custodial sentences. Ever since the end of the nineteen-eighties, the Netherlands have an explicit national policy to divert drug users to care programmes (T.K.20415/1). The idea behind this is that recidivism of drug users can be reduced when they participate in a care programme. The criminal justice system offers a unique possibility to bring criminal drug users in contact with care programmes. By exerting pressure provided by law, drug using offenders can be pushed in the direction of care (Van Ooyen-Houben 2004a). More information: see chapter 12.

10 Drug Markets

10.1 Availability and supply

Availability

Information on perceived availability of illegal drugs and the actual sources where young people obtain cannabis is available from the last school survey in 2003 (Monshouwer et al. 2004). Table 10.1 shows that cannabis is overall perceived as the most easily available substance, followed by both ecstasy and cocaine. More boys than girls rate these drugs as being easily or very easily available. Moreover, perceived availability strongly increases with age.

Table 10.1: Perceived availability of cannabis, cocaine and ecstasy by secondary school pupils in 2003. Percentage of pupils indicating 'easily and very easily available'

	12-15 years			16-17 years			18 years			Total		
	Boys	Girls	Tot.	Boys	Girls	Tot.	Boys	Girls	Tot.	Boys	Girls	Tot.
Cannabis	26%	19%	23%	59%	45%	52%	94%	69%	83%	34%	25%	30%
Cocaine	8%	6%	7%	21%	11%	16%	55%	21%	40%	12%	7%	9%
Ecstasy	9%	6%	8%	24%	13%	19%	62%	23%	44%	13%	8%	10%

Source: Dutch National School Survey, Trimbos Institute (data analysed on request by K. Monshouwer).

Table 10.2 shows that two in three pupils obtain cannabis through friends; one in three pupils obtains cannabis in coffee shops. Dealers and indirect sources are mentioned by one in ten pupils. Friends are a more important source for girls than for boys while coffee shops are more important for boys than they are for girls. Quite some pupils between 15 and 17 years report to buy cannabis in a coffee shop, while the age limit for entrance to a coffee shop is 18 years (see also chapter 2.2). However, it is possible that some pupils indicated this source, while in fact they meant that others had bought cannabis for them in a coffee shop. The importance of coffee shops as a source for obtaining cannabis increases with age. In 2003, eight in ten boys and almost six in ten girls of 18 years reported to buy cannabis in coffee shops.

Table 10.2: Cannabis procurement sources of secondary school pupils by age and gender in 2003. Percentages among current users*.

	12-15 years		16-17 years		18 years		Total		all
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	
Friends	60%	78%	64%	77%	40%	69%	60%	78%	67%
Coffee shops	22%	22%	57%	37%	81%	56%	40%	27%	35%
Dealers	17%	6%	15%	12%	9%	0%	16%	7%	12%
Indirectly, through other people,	16%	9%	6%	2%	0%	0%	11%	6%	9%
Other	7%	6%	2%	8%	4%	0%	5%	6%	6%

* More than one source could be indicated. Source: Dutch National School Survey, Trimbos Institute (Monshouwer et al. 2004).

Coffee shops

Cannabis can be obtained in coffee shops adhering to certain criteria (AHOJ-G; see chapter 1). From 1995 onwards, Dutch policy has focused on controlling public nuisance problems

associated with coffee shops. As a result of strict enforcement and various administrative and judicial measures, the number of officially tolerated coffee shops has decreased in the past years (table 10.3).

- This trend was most pronounced between 1997 and 1999 (28%), especially in the smaller towns and Rotterdam.
- Since 1999, the annual reduction in number of coffee shops was smaller: 4% from 1999 to 2000, 1% from 2000 to 2001, 3% from 2001 to 2002 and 4% from 2002 to 2003.
- Coffee shops are present in 105 municipalities. This is 21% of all municipalities, about the same level as in previous years. Thus, almost eight in ten municipalities do not have coffee shops.
- The majority (52%) of all coffee shops were located in the big cities with more than 200 thousand inhabitants.
- The relative distribution of coffee shops by number of inhabitants was fairly similar since 1999.

Table 10.3: Number of coffee shops in the Netherlands

Number of inhabitants	1997	1999	2000	2001	2002	2003
< 20,000	±50	14	13	11	12	12
20-50,000	±170	84	81	86	79	73
50-100,000	±120	±115	109	112	106	104
100-200,000	211	190	168	167	174	168
>200,000 (totaal)	628	443	426	413	411	394
- Amsterdam	340	288	283	280	270	258
- Rotterdam	180	65	63	61	62	62
- The Hague	87	70	62	55	46	41
- Utrecht	21	20	18	17	18	18
- Eindhoven**			16	16	15	15
Total	1,179	913	813	805	782	754

* Estimated number of coffee shops. ** Eindhoven has passed the limit of 200,000 inhabitants in 2000. This partly explains the slight decrease in the number of coffee shops in cities with 100-200,000 inhabitants. Source: IVA, University of Tilburg (Pardoel et al. 2004).

As argued elsewhere, the reduction in the number of coffee shops does not mean that there has been a similar reduction in the (perceived) availability of cannabis.

Supply

Due to its position as an important trading country with a large harbour (Rotterdam) and a busy airport (Schiphol), The Netherlands are vulnerable to trafficking of drugs within the country as well as from and towards other countries.

In 2003, three major problems existed:

- The production of ecstasy in laboratories in The Netherlands. For this problem, an action started in 2001, which will be continued until the end of 2006 ((T.K.23760/14)). The first results of an evaluation of this plan showed that the planned activities were all carried out after two years (Snippe et al. 2003). (See also chapter 1.) More pills were confiscated, more labs dismantled and other results in line with the plan. A second evaluation is currently running.

- The production of 'nederwiet' is a major concern. Focused actions have been going on recently, which will be continued in the near future (T.K.24077/125); see also chapter 1).
- The import of cocaine, mainly at the airport of Schiphol. Focused actions have been implemented in recent years (T.K.28192/1).

10.2 Seizures

Figures about seizures 1999-2003 are available from the National Police Forces (De Miranda et al. 2004). However, only 18 out of 25 regional police forces are included in the figures. This causes unreliability of the information and makes it difficult to interpret the figures. De Miranda and Van der Werf substitute estimates for the regions that are not included. According to the authors the figures do not allow conclusions about developments and trends. De Miranda and Van der Werf report a total number of 5,752 seizures in 2003. They give the following descriptions:

- "The recorded seizures of heroin were lower in 2003 than in the years before. In 2003 417 kilogrammes were recorded, in 2002 1,122, a decrease of 63%.
- With regard to cocaine there has been an increase compared to the years before, especially seized by Customs and Royal Military Police. There was an increase of more than 120% compared to 2002.
- The amount of seized amphetamine (in kilograms and tablets) increases from 2002 to 2003. For the first time there was a seizure of amphetamine in fluid form.
- The amount of ecstasy seized (kilograms, tablets) in The Netherlands decreased.
- With regard to LSD there have been no remarkable amounts of confiscations.
- Cannabis (hashish, nederwiet and Dutch grown cannabis): there was a decrease from 2002 to 2003. There was an increase in the amount of hemp plants confiscated and in the number of hemp production places that were dismantled."

10.3 Price/purity

The Drugs Information Monitoring System (DIMS) of the Trimbos Institute provides detailed information on the quality of 'ecstasy' and other drugs delivered by consumers at test locations of drug treatment services. Part of the samples is identified on the basis of specific characteristics (colour, logo, weight, diameter etc.) and reaction in the Marquis test¹⁰. Samples which can not be identified at these test locations are sent to the laboratory for chemical analysis. As the number of delivered samples progressively decreased over the years¹¹, DIMS also started to report on drug samples confiscated by security services of clubs (since 2003). If these data are given in this paragraph, it will be mentioned explicitly. DIMS is used here as to refer to the testing system for consumers at treatment services.

Ecstasy

The number of pills sold as ecstasy that were identified at test locations strongly decreased from 4320 in 1997 to 688 in 2003. The number of pills tested in the laboratory remained more

¹⁰ The Marquis test gives an *indication* of the composition of a sample based on a colour reaction.

¹¹ This trend is probably related to the discontinuation of the Safe House Campaign (on the spot testing at parties organised by the Stichting Adviesburo Drugs), the increased confidence of users in the fairly stable content of pills and the reduction of the numbers of pills users were allowed to provide for testing (Pijlman et al. 2003).

stable. Table 10.4 shows the percentage of analysed pills containing certain substance(s), or combination of substances. These categories are mutually exclusive.

- The total percentage of ecstasy pills containing only MDMA (or an MDMA-like substance, such as MDEA, MDA) has increased over the years, while the percentage of pills containing other psychoactive substances has decreased.
- In 2003, 95% of the pills only contained a MDMA like substance (MDMA, MDA, MDEA), while 2% of the pills containing a MDMA-like substance also contained another psychoactive substance.
- The percentage of pills sold as ecstasy containing amphetamines has decreased since 1997.

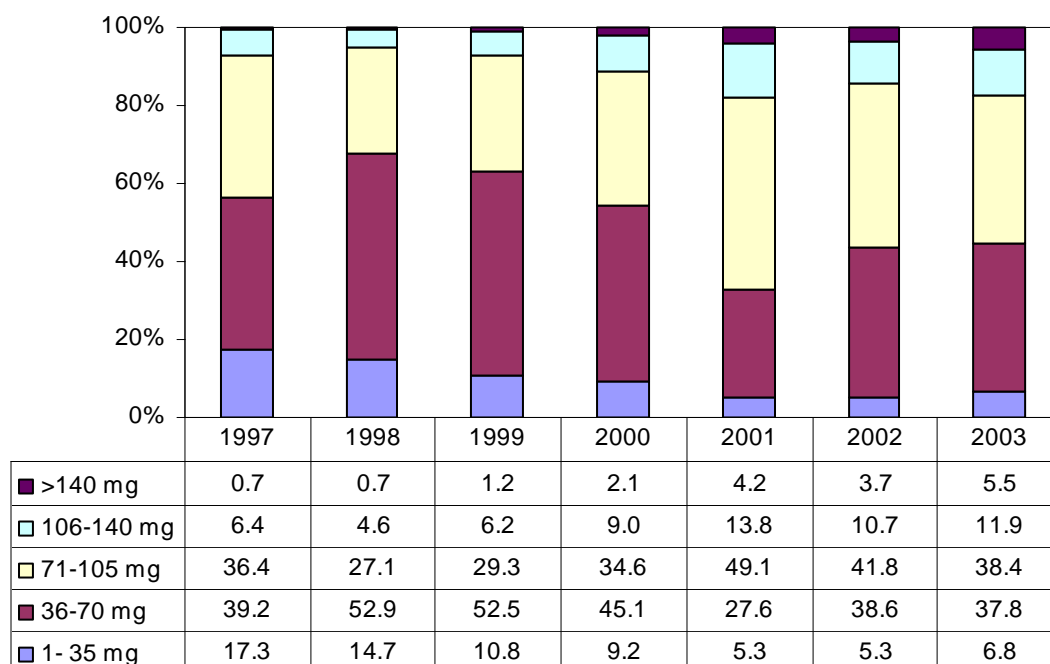
Table 10.4: Content of pills sold as 'ecstasy' tested by DIMS, since 1997

Substances (% of pills)	1997	1998	1999	2000	2001	2002	2003
MDMA	44.6	75.2	82.0	89.5	91.4	88.7	91.2
MDEA	8.2	1.3	1.4	0.9	1.2	0.4	0.5
MDA	1.5	2.2	2.8	2.0	0.7	1.4	0.9
Combination MDMA, MDA and/or MDMA	2.6	1.6	1.0	3.0	3.0	1.7	2.1
Combination MDMA, MDA and/or other psychoactive subst. ¹	9.0	4.3	3.3	1.2	0.9	3.7	2.1
<i>Tablets without MDMA, MDEA and/or MDA:</i>							
Amphetamine ²	15.5	6.5	3.9	0.9	1.0	1.7	1.0
Methamphetamine						0.3	0.3
Other psychoactive substance ¹	14.7	4.5	2.7	1.6	1.2	1.3	0.7
No psychoactive substance	3.9	4.3	2.9	0.8	0.5	0.8	0.8
Total number of pills analysed	2,434	2,713	2,306	2,497	2,402	2,149	2,187

Percentage of pills containing a certain substance, or combination of substances. Categories are mutually exclusive. ¹ E.g. 2-CB, MBDM, DOB, PMA, caffeine, ephedrine etc. ² Until 2002, no distinction was made between amphetamine and/or methamphetamine. Source: DIMS.

- Figure 10.1 illustrates that the concentration of MDMA in pills has always shown a wide variation, but there is a trend towards an increasing proportion of high dose (>140 mg) MDMA pills: 1% in 1997-1999 against 6% in 2003. The average amount of MDMA (78 mg in 2003) remained relatively stable.

Figure 10.1 Percentage of ecstasy pills by content of MDMA (mg)



Source: DIMS, Trimbos Institute. Only ecstasy pills tested in the laboratory and containing at least 1 mg MDMA or more have been included.

Amphetamines

In 2003, DIMS analysed 393 powders bought as 'speed'.

- The majority (85%) of the powders contained (at least) amphetamine with an average concentration of 33%; 3% contained both amphetamine and methamphetamine and 3% contained just methamphetamine. The average methamphetamine concentration was 18%.
- Eight percent contained only another psychoactive substance, usually caffeine and 2% contained no psychoactive substance at all.
- The proportion of caffeine containing speed powders increased from 32% in 2002 to 54% in 2003.

Cocaine

In 2003, DIMS analysed 229 powders that were bought as cocaine (generally cocaine HCL).

- The large majority (95%) did indeed contain (also) cocaine, with an average concentration of 65%, while 4% only contained another psychoactive substance and 1% contained no psychoactive substance at all.
- The percentage of cocaine powders containing fenacetine (an analgesic withdrawn from the Dutch market because of serious kidney damage in chronic use of high therapeutic doses) almost doubled from 8.5% in 2002 to 16.2% in 2003.
- Other commonly detected substances were lidocaine (10%) and (traces of) cocaine 'co-products', such as tropacaine and norcocaine (83%).

Fenacetine was also found in 23% of the cocaine powders confiscated by security services. It is not likely that the doses of fenacetine used by sniffing cocaine cause any serious health

damage, i.e. these doses are much lower than the therapeutic doses known to cause kidney damage. However, little is known about the risks of smoking (and heating) crack cocaine adulterated with fenacetine. Therefore, the Minister of Health has asked the Dutch Committee on the Assessment and Monitoring of New Drugs (CAM) to provide an expert report on this issue.

Other substances (based on DIMS and 2003 security)

Many 'other' psychoactive substances that entered the market since 1997, seem to have largely disappeared in the past years (e.g. atropine, DOB, MBDB, PMA). In 2003, DIMS detected 2 pills containing 2C-B and 3 with ketamine. 4-MTA was not detected in 2003. Occasionally a new substance is seen.

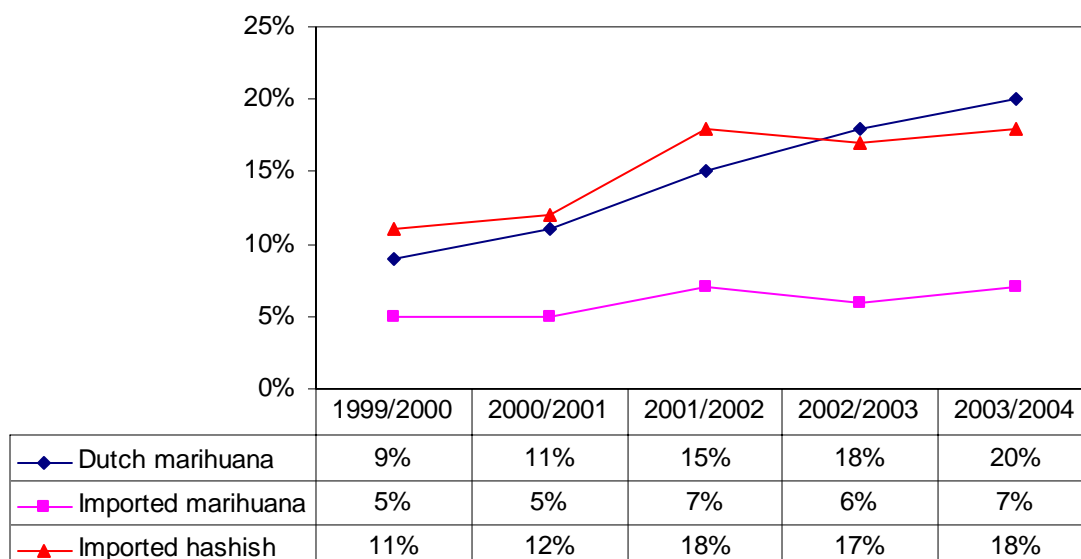
Samples containing GHB are still delivered to DIMS: 102 in 2001, 72 in 2002 and 72 in 2003.

Cannabis

Since 1999 the Trimbos Institute also monitors THC content and prices of cannabis (THC-monitor). Samples of different cannabis products (about 1 gram each) are regularly procured from a random sample of 50 coffee shops and chemically analysed. Figure 10.2 shows the average concentration of THC in Dutch marihuana ('nederwiet'), imported marihuana and imported hashish.

- Nederwiet contains more THC on average than imported varieties.
- Since 1999, the percentage of THC in nederwiet increased progressively each year.
- The THC concentration in imported marihuana did not change significantly over the years. Imported hashish contained on average more THC in the past 3 years compared with the first two years.

Figure 10.2: Average THC percentage in cannabis products



Source: THC-monitor, Trimbos Institute (Niesink et al. 2004).

- Improved and highly professional cultivation methods probably explain the increasing trend in THC content in home grown cannabis products.
- These high THC levels are not exclusively found in the Netherlands. Relatively high and increasing THC concentrations have also been found in special kinds of American cannabis ('sinsemilla').
- The health consequences of cannabis with higher percentages of THC are not known. The Ministry of Health has recently launched a research project to investigate the pharmacokinetic and pharmacodynamic effects of three doses of THC in a randomised controlled trial in healthy volunteers. The range of the selected dose is wide, encompassing also doses in excess of those investigated in international studies.

Prices

No major changes have been noted in the retail prices of cannabis over the past years (see table 10.5). According to the THC-monitor, the average retail price of a gram of nederwiet was slightly but significantly higher in 2002/2003 compared with 1999/2000 and 2000/2001 but this trend did not continue in 2003/2004. The price of imported marihuana was higher in 2003/2004 compared with the 1999/2000 and 2000/2001. Imported hashish was more expensive in 2001/2002 compared with 2000/2001, but less expensive in 2003/2004 compared with 2002/2003.

Table 10.5: Average retail price per gram of cannabis products (in €)

	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004
Dutch marihuana (nederwiet)	5.83	5.86	6.28	6.45	5.97
Imported marihuana	3.87	3.80	4.16	4.32	4.86
Imported hashish	6.29	6.36	7.14	7.56	6.46

Source: THC-monitor, Trimbos Institute (Niesink et al. 2004).

According to DIMS, the average retail price of an ecstasy pill is 3.5 euro (range 1 to 7.5 euro). The price of 1 gram cocaine (powder) was 45 euro on average (range 40 to 50 euro). The price of 1 gram amphetamine (powder) was 6 euro (range 4 to 10 euro).

Part B – Selected Issues

11 Buprenorphine, treatment, misuse, and prescription practices¹²

In the Netherlands, the use of buprenorphine is not forbidden by law. Buprenorphine is sold as Temgesic® sublingual tablets of 0.2 and 0.4 mg and as injection fluid (Gezondheidsraad 2002b). It is registered as an analgesic and is mainly, although not exclusively, used for postoperative pain. The National Central Register of Substances has not formally registered this drug and an overview of annual prescription rates does not yet exist. Buprenorphine is used on a regular basis in only one Dutch organisation of addiction care (the Brijder Foundation).

Traditionally, Dutch addiction care was primarily focused on opiate addicts, for whom methadone was the main treatment, i.e. since the sixties for detoxification and later also for maintenance treatment. Since then, Dutch drug addiction care has been “built” on methadone maintenance and a quick large-scale change to other substitution treatments is unlikely, even when buprenorphine have clear advantages or would be equally effective compared to methadone (cf. Rigter et al., 2004). Up to date, buprenorphine for detoxification and maintenance treatment of opiate addicts is used by a minority of professionals in addiction care. In fact only one drug treatment organisation uses this substance on a more systematic basis. Initially, buprenorphine was exclusively used in a low dosage variant because the high dose preparation Subutex® (2 mg) is not for sale in the Netherlands, but this may change in the near future. In an advisory paper, the National Health Council suggested to make buprenorphine available in higher dosages for treatment of opioid addicts (Gezondheidsraad 2002b). An important limiting factor is that the higher dosage variant of this substance is not officially registered yet. Therefore, the costs of prescribing this substance for clients in addiction care are not reimbursed by insurance companies. The Dutch Association of Addiction Physicians (VVGn) published an official letter to support an import license and the registration of Subutex (*Standpuntbepaling*). Recently, an import license for Subutex has been realised by the National Health Care Inspectorate and registration is underway.

In 2003, the Dutch Association of Addiction Physicians made the following recommendations. Buprenorphine treatment should be:

- a treatment option for detoxification, next to methadone
- a second choice for clients who do not respond to methadone
- prescribed by specially trained addiction physicians

There are criteria (medical grounds) for eligibility.

It should be avoided in case of:

- pregnancy and lactation
- hypersensitivity for this substance
- respiratory insufficiency
- liver insufficiency
- (acute or general) psychiatric diagnoses

¹²We appreciated personal communication contacts on this subject with the Chairman of the Dutch Association of Addiction Physicians (VVGn), Mr. R. ter Haar, and with Mr. J. Vrasdonk, First addiction physician of the Brijder Foundation.

In the only organisation of addiction care that uses buprenorphine on a regular basis, this treatment is indicated for:

- all new clients using opiates (methadone not included)
- opiate addicts who want to stop using additional illegal drugs and who respond inadequately to methadone
- clients who want to detoxify of methadone maintenance use and for whom a slow reduction of the methadone dose is difficult
- clients who already use buprenorphine (Temgesic®).

In Dutch addiction care, physicians and psychiatrists are responsible for drug treatments. A specific training and accreditation is needed. At this moment very few physicians are certified to prescribe buprenorphine. Those who were certified have been trained in the US or followed a Continued Medical Education course of the International Society of Addiction Medicine in Amsterdam. The number of certified physicians to prescribe buprenorphine is insufficient in the Netherlands. The Dutch Association of Addiction Physicians (VVGN) initiates further activities in order to realise courses in buprenorphine treatment methods for its members.

Annual numbers of clients treated with buprenorphine are not published. It is estimated that these numbers are constant or only slowly increasing. There are no evaluation studies planned on the effects of buprenorphine. As far as known a black market for this substance is non-existent, and buprenorphine-related deaths are highly unlikely.

In the US, buprenorphine has also gained increasing attention from addiction workers. The drug was been approved by the US Food and Drug Administration (FDA) late 2002. A recent publication describes how this medication works, its efficacy, and safety profile (Doot et al. 2004; Jones 2004). In several community programmes, professionals are enthusiastic about the application of buprenorphine in medically assisted treatment modalities (Casadonte et al. 2004).

In the only regional organisation using buprenorphine on a regular basis, it has been a treatment option for detoxification and maintenance treatment for ten years already. However, Subutex, the most effective higher dose, is not yet used. Instead, many pills with a lower dose are used (sublingually). Other organisations do not use this substance or only occasionally. Buprenorphine was introduced in the Brijder Foundation after an (unpublished) internal descriptive study targeting detoxification of opioid addicts. Subjective and objective withdrawal symptoms were measured. The outcomes suggested that the tolerance for detoxification had increased and that former methadone clients preferred buprenorphine treatment (Van Waveren, 2002).

During the past decade buprenorphine has been distributed exclusively to clients with a health insurance. Clients also have to sign an informed consent paper. If clients are no longer insured, the pharmacist will try to arrange this.

Warnings against misuse of this substance (by injecting the fluid substance) have been reported as a serious possibility in the regional guideline for addiction physicians. When misuse is traced, a combination with naloxon is suggested (combi-injection), causing withdrawal symptoms, thus reducing misuse of this cocktail.

Special attention should be paid to clients who already use medication for pain reduction (sedatives) and for those with dependence on sedatives (including alcohol and benzodiazepines).

Treatment route

Detoxifying heroin users

Detoxification is indicated after a minimum of six hours abstinence in order to get the first withdrawal symptoms. At that moment buprenorphine will be used: 2-4 mg for low opioid tolerance, and 6-8 mg for clients with high tolerance. During detoxification and maintenance, frequent urinalyses are necessary to control for the use of other drugs, but urinalyses cannot trace buprenorphine misuse.

After buprenorphine detoxification

Clients should be stabilised at least two weeks and then be transferred to maintenance treatment (preferred frequency: three times per week under strict supervision).

In case of methadone use

Clients should be stabilised on methadone of 30 mg or less for at least one week. In these cases, treatment should also wait for the first withdrawal symptoms (usually after 24-36 hours of abstinence). Thus, clients must stay within reach and activities should be well planned in order to be able to set the most appropriate individual dose.

12 Alternatives to prison targeting to drug using offenders

12.1 Political, organisational and structural information

Translation of Dutch terms

The Dutch language makes a subtle but crucial distinction between "dwang" and "drang". "Dwang" means compulsion, i.e. compulsive treatment by which an addict is actually forced into treatment. "Drang" means that an addict is not yet forced but is still given "the choice between care and a penal sanction", hoping that the addict will choose care (Van Ooyen-Houben 2004a). "Drang" is sometimes translated as "coercive treatment", but in this section it is translated as "quasi compulsion", or "quasi-compulsory treatment", which expresses the choice-aspect better than 'coercion'. These terms are coined by QCT Europe, a project funded by the European Commission on "Quasi-Compulsory and Compulsory Treatment in Europe" (Stevens 2004).

National policy

In the Netherlands, drug treatment as an alternative to imprisonment has been part of a national policy since 1988. In this year, a policy document was published entitled "Compulsion and Quasi Compulsion in the treatment of addicts" (T.K.20415/1). This document described alternatives to prison for drug using offenders to reduce criminal nuisance and criminal recidivism, which were explicitly mentioned in national policy documents (Bouman 2002; Ministerie van Volksgezondheid 1995; Ministerie van Welzijn 1993; T.K.24077/112). In recent years repeat offenders, for whom alternatives to prison are considered one of the possible solutions, became a topic in the political discussion.

Coordination

The Ministry of Justice as well as the Ministry of Health, Welfare and Sports are in charge. The Ministry of Justice coordinates the activities in the justice system; the Ministry of Health coordinates the care system. Addiction probation services form a bridge between the two systems. These are financed by the Ministry of Justice and are employed by addiction care centres. Local authorities play a role on a local level.

Legislation

The Dutch law provides opportunities to put pressure on addicts to enter care and finish the care programme. Legal options for quasi compulsion exist in the pre-trial, trial and post-trial phase (during imprisonment). Table 12.1 gives an overview. Suspension of pre-trial imprisonment under the condition of treatment is most often used, or suspension of the sentence.

Public debate

Quasi compulsion is not a subject of public debate, but there has been a lot of debate on compulsion, which was introduced as an experiment in 2001. The Ministry of Justice collects all newspaper items on these themes. An online database with newspaper items is available.

Implementation structure

Many organisations are involved in diversion and quasi compulsion. Addiction probation services have an important role as a bridge between the justice system and the care system. They visit addicts in the justice system, make up reports for the prosecutor, the judge and

prison authorities, with an advice for an individual trajectory, which may involve diversion to an alternative to imprisonment, and they lead the addict into care. The prosecutor has some decisive options in the suspension of prosecution. The (remand) judge decides about diversion during court proceedings. Prison officials decide about alternatives during imprisonment. Care facilities carry out the treatment, mostly on a local level.

Table 12.1: Options for entry into drug treatment as an alternative to imprisonment during different phases of the judicial process

Phase in judicial process:	Options under criminal law:
During police custody without extension (police phase)	No legal pressure possible; voluntary entry into care programme
During pre-trial imprisonment	<p><i>Quasi-compulsion:</i></p> <ul style="list-style-type: none"> • (Conditional) decision not to prosecute by the Public Prosecutions Department (Article 167 of the Code of Criminal Procedure [<i>Wetboek van Strafvordering</i>]) • Suspension of pre-trial imprisonment under certain conditions (Article 80 of the Code of Criminal Procedure)
During court hearings	<p><i>Quasi-compulsion:</i></p> <ul style="list-style-type: none"> • Stay of court hearing/postponement of judgment delivery (Article 281 of the Code of Criminal Procedure and Article 346 of the Code of Criminal Procedure) • Imposition of (partially) suspended sentence, subject to completion of a care programme proposed during the court hearing (Articles 14a and 14c of the Criminal Code [<i>Wetboek van Strafrecht</i>]) <p><i>Compulsion:</i></p> <ul style="list-style-type: none"> • Imposition of measure providing for the Compulsory Admission to the Judicial Treatment of Addicts (SOV) (art. 38m Criminal Code)
During imprisonment	<p><i>Quasi-compulsion:</i></p> <ul style="list-style-type: none"> • Participation in a care programme, where necessary outside the penal institution in an institution intended for this purpose (non-custodial treatment; Section 43 of the Prisons Act [<i>Penitentiaire beginselenwet</i>] ¹³) • Participation in a Penitentiary Programme (Section 4 of the Prisons Act)
After imprisonment	No legal pressure possible; voluntary entry into care programme ¹⁴

¹³ This possibility will be applied more intensively in the future.

¹⁴ The introduction of legal options for conditional release is under action; participation in a care programme can be a special condition.

12.2 Interventions

Treatment modalities

There are several treatment modalities which function as an alternative to prison. The majority belongs to the regular care system. Some are paid by the justice system. Most quasi compulsory programmes are inpatient and aimed at reintegration. Abstinence is mostly part of it. In recent years, long term programmes for the target group of offenders addicted to hard drugs have been developed. They have a closed phase, a half-open phase and an open phase, have a total duration of one-and-a half to two years and are more skill oriented than therapeutic. All regular facilities are accessible for clients under quasi compulsion. Table 12.2 shows the facilities that are normally used for quasi compulsion. These are often offered in combination with substitution treatment (methadone) or medical co-prescription of heroin, which is available in a limited number of locations.

Table 12.2: Normal facilities for clients subject to quasi-compulsion*

Facility:	Description according to objective:
Addiction clinic	Geared towards abstinence and stability in terms of psychological and social performance. Therapeutic, also crisis intervention.
Intramural motivation centre	Low-threshold facility, geared towards motivating clients to enter follow-up care programmes or towards the improvement of their welfare and well-being. Not geared towards abstinence and therapy. Programme duration 3-4 months. IMC-facilities will be increased (brief van de Minister van Justitie aan de Koningin, 52113/03/06, juni 2003).
Long-term, phased programmes (SOV-quasi-compulsion, Triple-Ex)	Aimed at reintegration (work/training, leisure time, accommodation, finances, and social relationships), abstinence (if feasible) and a reduction in the nuisance and crime committed by participants. Phased structure: closed-half open-open phase, duration 16-18 months.
Forensic addiction clinic	Clinic with a national function. Phased structure. Strict security during the first, closed phase. Geared towards abstinence, social stability and improved functioning. Therapeutic. Duration 6-18 months.
Sheltered accommodation projects	Small-scale projects in which clients are trained and coached in aspects relating to housing, learning and working. The aim is to prepare addicts for life in independent accommodation (where possible). Often in combination with learning/working pathways.
Ambulant and part-time addiction care programme	Aimed at the improvement or stabilisation of a client's situation by means of (various forms of) guidance and counselling.

* Often in combination with medical treatment: substitution treatment (methadone) or medical co-prescription of heroin, which is available in a limited number of locations.

Implementation

There are no exact figures. Research shows that an estimated 7-37% of the target group entered treatment in the period of ten year's of implementation of quasi compulsion. Diversion of addicts by addiction probation services takes place about 2000 times a year (including alcohol and other addictions). Addiction probation services do not record the specific addiction. Judicial authorities do not record specifically for drugs, care facilities do

not record specifically for quasi compulsory clients; they do record who is diverted by Justice officials. Thus, registration could be improved.

Main obstacles for implementation include: not all addicts of the target group are offered an alternative; addicts do not choose treatment above imprisonment; the threshold for treatment is too high; the threat of a sentence is not strong and realistic enough; the addict is not motivated; there is a waiting list for the care programme (see (Van Ooyen-Houben 2004a)).

Funding

By the Ministry of Justice (probation services), Ministry of Health, Welfare and Sports (some care facilities), local authorities (local care programmes).

Treatment is provided by non-profit agencies and by social workers, group workers, psychologists, and medical staff.

Monitoring

Addiction probation services report to the court about the progress in individual cases. Non-adherence to the care programme does not have immediate consequences (Van Ooyen-Houben 2004a). The police and the prosecutor carry out the prosecution and impose the sentence when the addict is caught again.

Specific target groups

Although legislation on quasi compulsion can be applied to every addict, the main target group consists of male addicts; 93% of drug using offenders are male.

Specific projects

Current projects aim at improving referral to care programmes from remand custody. These projects are initiated by the judicial system (Bouman 2002). They are geared at the development of more systematic methods for diversion of addicts into care programmes. Pilot projects are running to develop new ways of screening and diagnosis, effective interventions, and better ways of co-operation between police, addiction probation services, prisons and care programmes.

12.3 Quality assurance

Guidelines

In the judicial system people work according to strict procedures. In the care system there is a law on quality, which is being implemented. Professionals have to be registered; education and follow up education is a must for registration.

Evaluation and Research

There are several ad hoc studies available about quasi compulsion. These studies apply drug use, improvement of the living situation, health, housing and crime as outcome indicators. Recently, a synthesis of these research studies has been made (Van Ooyen-Houben 2004a). This review shows that most studies do not use control conditions. Entry into care of the target group of frequent offending drug users ranges from 7 to 37%; drop out ranges from 20 to 100% (mostly 50-60%). Those who finish the programme do better than the drop outs with respect to housing and working, drug use and criminal behaviour. Results show that legal pressure is not applied consistently. Results also show that – in general - alternatives to prison under quasi compulsion work best if:

- the addicts are motivated for treatment
- they are actively and intensively approached and advised to go into treatment
- care facilities are clinical, low threshold, non- therapeutic, practically oriented and allow for reduction of drug use at an individual's own pace
- facilities have enough staff and qualified staff
- there is a feeling of a heavy threat of punishment
- there is close co-operation between judicial authorities and care programmes.

Aftercare is important. A new development is that policy makers want to draw up covenants with local authorities to improve aftercare and guidance after release from detention on a local level. Also, a re-introduction of conditional release is considered, in order to keep ex detainees longer under the supervision of judicial authorities and to be able to stimulate their re-integration.

In order to make quasi compulsion work, conditions should be created with many negative and positive external incentives, combined with a certain intrinsic basic motivation of the drug user.

Training programmes

Methods for counselling and treatment under conditions of compulsion and quasi compulsion are being developed. The national foundation of probation services has recently published a book on this theme.

The "Reduction of Recidivism" programme of the Ministry of Justice, within which compulsive and quasi compulsive programmes are carried out, applies criteria for the quality of the programmes.

13 Public nuisance: definitions, trends in policies, legal issues and intervention strategies

13.1 Definition

The concept of “drug nuisance” (“drugoverlast”) is diffuse. In general, nuisance is defined in terms of a wide range of human behaviours that are either inadmissible according to objective norms or subjectively inconveniencing (cf. Garretsen et al. 1996). The subjective inconvenience of behaviours is partly influenced by the varying levels of tolerance in society as a whole. In everyday life, “kinds of nuisance” and “effects of nuisance” are often muddled up (Intraval: buro voor onderzoek en advies 1996). A concept mapping-study in 1995 identified 11 significant forms of drug-related nuisance:

- Violence and intimidation;
- Annexation of public space by drug abusers and dealers;
- Crime against property;
- Decay of moral principles and corruption, causing citizens to take the law into their own hands;
- Antisocial and objectionable behaviour;
- Intrusive verbal contact by drug abusers and dealers;
- Threat to public health and social assistance;
- Nuisance and irritation about drug-related behaviours, individuals and scenes;
- Undermining of the family as cornerstone of society;
- Diffusion of crime and violence;
- Vulnerability of children in relation to addicts and drug dealers (Schouten et al. 1995).

As a concept “(drug)nuisance” shows an overlap with various other related concepts which are used as an alternative to some extent. In Dutch public debate and policy the following concepts are also important:

- Social safety;
- Quality of life;
- Public order.

Like drug nuisance, the latter concepts are interpreted both objectively and subjectively. Between local municipalities as well as in national politics, differences of definition and priority of nuisance occur. Local variables partly correspond to socio-geographical differences (e.g. population size and composition, city location, industry and trade). In general, a distinction can be made between:

- a. The four largest cities: Amsterdam (739,104 inhabitants), Rotterdam (598,923 inhabitants), The Hague (469,059 inhabitants), Utrecht (270,244 inhabitants); confronted with e.g. multi-problem residential areas, extremely miscellaneous population groups;
- b. Medium-sized cities such as Leeuwarden (91,354 inhabitants) or 's-Hertogenbosch (133,511 inhabitants), having a regional function and related (drug-)nuisance problems (Gemeente 's-Hertogenbosch 2004);
- c. Smaller municipalities such as Edam-Volendam (28,194 inhabitants), a municipality with special cultural or religious characteristics and confronted with e.g. (drug-)nuisance problems by (sub)groups of youngsters (cf. (Stoele et al. 2004);

d. Border towns such as Venlo (92,094 inhabitants), because of nuisance by coffee shop tourists and drug runners.

Differences are further related to features of political movements. Since 2000, right wing political parties such as the LPF (Lijst Pim Fortuijn) started to emphasize the priority of “social safety” and “quality of life”. At present, the policy of dealing with these issues is widely supported by political parties. From the outset of the second Balkenende government (in 2003), “norms, values and the nuisance of behaviour”, including alcohol, tobacco and drug-related behaviour, feature the political agenda (Wetenschappelijke Raad voor het Regeringsbeleid 2003).

13.2 Genesis

In the mid 1970s, increasing numbers of heroin users of Dutch and foreign origin, including heroin prostitutes began to cause inconvenience in the cities of Amsterdam and Rotterdam. During this period, local-level drug policy was focusing on health and well-being of users, e.g. by setting up programs for needle exchange and methadone supply, opening drug consumption rooms, and arranging streetwalking zones. The publication of the *White paper on the subject of policy aiming at reducing nuisance caused by addicts* in 1993 was the start of national policy making against drug nuisance. By then, most municipalities had already developed nuisance projects and some kind of nuisance policy (Bröer et al. 1999). In 1995, drugs policy received a new impulse by the document *Drugs policy. Continuity and change* (Ministerie van Volksgezondheid 1995). Drug-related nuisance undermining public support for drug policy was a main reason for national government involvement. Local municipalities were held responsible for the implementation of the nationally proposed measures. The control and guidance of measures and projects were assigned to the official *Steering committee Reduction Nuisance* (SVO), installed by the Ministry of Health, Welfare, and Sport (VWS), the Ministry of the Interior (BZK), and the Ministry of Justice. Other initiatives started at local level and were next taken over at national level. Operation Victor, for example, originally started in Rotterdam to target drug tourists causing nuisance in neighbourhoods (T.K.24549/5).

In 1995, the national government also launched a policy for making the cities vital, safe and livable: the Large-cities’ policy (Grotestedenbeleid). Large-city problems called for a joint effort of public and private partners. Mid 2004 the national government had entered into covenants with 30 medium-sized and large cities. Participating cities are urged to adopt a result-oriented and integral approach. “Result-oriented” means: agreeing on concrete targets in advance and collecting data with regard to target realization. “Integral approach” means: gearing activities of local municipalities and sector-oriented institutions for one another. The responsibility of the national government consists of formulating and monitoring policy lines, and providing additional funds. During the first period of the Large-cities’ policy (1994-1998), the *Steering committee Reduction Nuisance* (SVO) mentioned above worked together with municipalities in pushing back drug nuisance.

Since the 1990s, repressive measures gained more and more priority on the political agenda. Linking addiction care to repression became a guiding principle of drug nuisance policy. The most recent policy document *Working together for the powerful city. Elaboration of the system Large-cities’ policies 2005-2009* (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2004) contains two files related to (drug) nuisance. One of the targets of

the File *Off the street and safe* is to increase the proportion of drug users reached by the outpatient addiction care. Targets of the File *Towards a safer society* include the reduction of criminality committed by repeat offenders and the realization of a chain of social relief and assistance facilities for nuisance-causing persons. To give shape to the partnership between the national government and the municipalities a *Strategic Council Safety* (Strategisch Beraad Veiligheid) was installed mid 2004. In this council, related ministries and municipalities periodically confer on the development and implementation of safety measures, including measures against public drug-nuisance.

13.3 Measures taken

In general, Dutch drug policy is based on three pillars: prevention of drug use and reduction of harm to users; reduction of (drug) nuisance; and combating drug-related crime (see Chapter 1). Drug-related crime can be divided into two (partly overlapping) components: 1. Drug crime, as defined by the drug laws or related to those laws; and 2. Offences committed by drug users and addicts (see Chapter 8). Drug-related nuisance and criminality are being counteracted by two main lines of policy. The first line consists of *administrative* measures for maintaining public order. In addition, measures are taken *based on criminal law*. The second line of policy provides for qualitative improvements in the care of (hard)drug addicts. By offering an opportunity for social re-integration, problem drug users are to be reached more effectively.

As mentioned above, the implementation of nuisance measures is largely a responsibility of municipalities. Local measures have to be carried out within the conditions and intended results stipulated by national policy (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2004;T.K.28684/1-2). At the local level, maintenance of public order and assistance/care is a responsibility of the mayor(s). The Public Prosecutor is in charge of the investigation of penal acts. The Dutch police force is subdivided into 25 corpses. Therefore, one mayor in a police district is corps administrator. In each district a “tripartite consultation” (driehoeksoverleg) consisting of the corps administrator, the senior public prosecutor and the corps chief confer on developments, policies and results.

To realise more coherence in the policy against (drug) nuisance and related problems, priority is given to an integral or chain approach in which prevention, repression and assistance are geared for and supplement one another (cf. (2004)).

This means that in practice various actors have to work together, such as the outpatient addiction care, social relief services, Community Health Services (GGD), and police and justice.

Measures against (drug) nuisance can be distinguished into:

1. Measures targeting the public domain;
2. Measures targeting subgroups causing public nuisance.

Ad 1. Measures targeting the public domain

First we will explicitly give attention to cannabis and nuisance. Secondly, we will subdivide between the following three public domains, both related to cannabis and hard drugs: 1. residential areas, 2. areas of entertainment, 3. shopping areas and public transport including

stations. For each type of domain appropriate measures against (drug) nuisance are taken and/or developed. The most notable measures are discussed below.

Cannabis and nuisance

Since 1976, Dutch policy makes a distinction between hard drugs and soft drugs (including cannabis). The sale of cannabis is under certain conditions not prosecuted in coffee shops. The interpretation of coffee-shop policy is a local affair. The “tripartite consultation” (mayor, public prosecutor, and police) formulates a concrete policy and establishes priorities in the daily maintenance. The national government is responsible in case coffee-shop policy affects public health, the combat of crime, or international relations (T.K.24077/125). In 1991, the national government specified the so-called “AHOJ-G criteria”. The capital letters refer to the different official guidelines for the toleration of cannabis sale: no overt Advertising; no Hard drugs; no Nuisance (Overlast); no under-age clientele (Jongeren); and no Large quantities per transaction (Grote hoeveelheden). In the application of these criteria various adjustments were made, such as a stock maximum of 500 grams. In 1996, the Public Prosecutor also decreed that local “tripartite consultations” could make further decisions. In 1999 article 13b was added to the Opium Act. This so-called “Damocles regulation” qualifies the mayors of municipalities to act administratively in case a coffee shop does not comply with the local rules. By the end of 2000, the national Board of Attorneys-General sharpened up the AHOJ-G criteria as follows:

- No advertising;
- No hard drugs being present or sold;
- No nuisance, including parking, noise and pollution; and visitors hanging around;
- No under-age clients and no admission of minors (under 18 years) to coffee shops;
- No large sale quantities of cannabis per transaction, not larger than appropriate for own use, up to a maximum of 5 grams. A “transaction” is defined as: all buying and selling to the same client in one coffee shop within one day’s time.

At the local level, priority is given to the criteria “no under-age clients”, “no nuisance”, and “no hard drugs” (Bieleman et al. 2003;Korf et al. 2001;Pardoel et al. 2004).

A more recent measure is the Public Administration Probity Screening Act (Wet Bibob) becoming effective in June 2003. Its purpose is to prevent the inadvertent facilitation of crime by providing public contracts, funds or licences. Local authorities can seek advise from the Office Bibob about the risk that a public facility might be misused. The government also argues for the use of the Bibob-instrument in relation to coffee shops which are considered to be potentially vulnerable for crime (T.K.24077/125).

Distinct but related nuisance problems are caused by cannabis farms. In 2003, the national government intensified the combat against the (home) cultivation of cannabis. In the *Action Plan to Discourage Cannabis Use* two related policy lines were proposed: *administrative* to counteract nuisance; and *criminal* to prosecute endorsing organisations. Enforcement is mainly dependent on the effort of local authorities (T.K.24077/125).

Dutch cannabis coffee shops attract tourists from abroad. Main factors in the nuisance caused in border towns are the magnitude and the uncontrollability of the stream of cannabis buyers and the appearance of non-tolerated outlets. Coffee-shop tourism also has a negative effect on relations with neighbouring countries. The following measures were taken (T.K.24077/125):

- *Adaptations of municipal rules and policy measures.* Possible local measures are: suspending or refusing a licence in case too many tourists visit a coffee shop; limitations on the numbers of clients; and restrictions on opening hours.
- *Counteracting non-tolerated outlets and illegal drug runners.* The local-level policies of Rotterdam (Project Alijda, which also targets harddrugs) and Venlo (Project Hektor) are considered to be examples of a successful cooperation between local administrations, the police, and public prosecutors in combating non-tolerated outlets and related nuisance. Project Hektor consists of an intensified policy against non-tolerated outlets of cannabis sale, illegal drug running and trafficking (Project Hektor 2003). Project Alijda was started in 1998 to counteract drug runners. Its main purpose was a coordinated approach against nuisance and crime caused by drug runners and dealers in the city of Rotterdam (Snippe et al. 2000).
- *Pragmatic cooperation with neighbouring countries against drug tourism.* In counteracting drug tourism, judicial authorities of Belgium, France and the Netherlands already cooperate in a structural way for a long time. Between investigation departments exchange of police officers is also taking place. In Dutch border regions with Germany a comparable approach is followed (T.K.24077/125).

Measures against drug-related nuisance in residential areas

Many local municipalities and districts have put into operation a centre (Meldpunt drugsoverlast) to which citizens can pass their complaints about drug use, drug trafficking, deal houses, drug tourists, and drug-related crime (cf. (Gemeente Bergen op Zoom et al. 2003; Gemeente Helmond 2004). It should be noted, however, that not all complaints appeared to be drug related (Gruter et al. 2002). By virtue of article 174a of the Municipality Act, since 1999 mayors have had the authority to counteract drug nuisance in residential areas by nailing up deal houses. Large cities also indicate areas (“hot spots”) with an accumulation of problems, a.o. in order to remove as many problem users as possible. This action partially results in an overspill of addicts to other residential areas (“waterbed effect”)(Gemeente Nijmegen 2004).

Measures with regard to areas of entertainment

In the second half of the 1990s, a number of violent incidents in night-life areas, often related to alcohol abuse, aroused much debate. The national government announced a structural approach. A main target was a local-level cooperation of the municipality, the catering industry, the police, the public prosecutor, and others, outlined in a Covenant Safe Entertainment (Convenant Veilig Uitgaan). In 2002, local partners of 72 municipalities (out of a total of 163 municipalities with more than 25,000 inhabitants) had formulated and signed a kind of covenant. In most agreements, the objective appears to be broader than combating violence. Many measures also aim at counteracting drug-related and other kinds of nuisance (T.K.29661/2) .

Measures with regard to shopping areas, stations and other public areas

One frequently taken measure against drug-related nuisance and crime in public areas consists of some form of surveillance, such as video cameras. At railway, subway and other traffic stations additional entrance checks are carried out (T.K.28642/1) In notorious drug-nuisance areas, municipalities can also act on the basis of General Local Acts (Algemeen Plaatselijke Verordeningen, APV) to send away causers of nuisance for 8 hours up to 14

days (street prohibition). Other frequently enforced measures are a gathering prohibition and a knife prohibition (De Bie et al. 1997).

Ad 2. Measures targeting subgroups causing public nuisance

In first instance, the measures to target problem users are taken by the regular addiction care. In addition, special measures are taken. Drug users and dealers are not the only causers of public nuisance. As a consequence, various target groups, such as psychiatric patients, alcoholics and homeless persons, overlap. Furthermore, it is common practice to separate adults from minors.

Repeat offenders

In 2001, the Judicial Treatment of Addicts (SOV) became effective as a specific measure whereby repeat offending addicts pass under coercion through a programme of two years at the most (see Chapters 9 and 13). The aim of the SOV is twofold: 1. reducing nuisance caused by offending drug addicts; 2. treating the individual problems of addicted criminals, so that re-entry in society becomes possible. In the whole range of coercion and compulsion measures against addicted offenders, the SOV is by far the most severe measure (Gezondheidsraad 2002a). In 2004, the government issued a law to place not only addicted but also other repeat offenders for 2 years at the most in Institutions for systematic offenders (ISD). Until further notice, ISD-placement is limited to the 4,000-5,000 criminals with the highest offences rate (see Chapter 9 and 13). Repeat offenders, however, do not compose an uniform target group (Ferwerda et al. 2003;Wartna et al. 2004b). In the *Policy letter persistent offenders* a global difference is made between offenders with an addiction or psychiatric background or a combination of both on the one hand, and criminal illegal immigrants; and others (T.K.28684/10), on the other.

Drug addicts with psychiatric problems and/or homeless drug addicts

Drug addicts with psychiatric problems and/or homeless drug addicts are mainly dependent on the regular facilities of the addiction care and the centres for the homeless (cf. (De Bruin et al. 2003)). The treatment of drug addicts with psychiatric problems (comorbidity) is a responsibility of both the addiction care and the Mental Health Care (GGZ), but substantial efforts are still required to fully implement this common responsibility. As an additional measure, many cities decided to open one or more small-scale user rooms where long-term hard-drug addicts are able to use drugs without being chased after (see Chapter 7). Besides counteracting inconvenience, drug consumption rooms are a relief facility in order to improve the living conditions of mostly homeless addicts (Barendregt et al. 2002;Hulsbosch et al. 2004;Meijer et al. 2001). The broadest range of care is supplied in integrated consumption rooms, supervised by the addiction care. In Rotterdam, the opening of consumption rooms was in 1998-2001 part of a programme *Safe Clean* reducing nuisance in selected neighbourhoods while simultaneously improving the health situation of homeless users. Besides creating housing for 200 homeless users, 4 consumption rooms for 20-30 visitors (with a pass) were realised (Spijkerman et al. 2002). However, drug consumption rooms can never fully diminish drug-related nuisance, because the buying of drugs is not allowed. That means that nuisance caused by traffic (buying and selling of drugs) will still take place in the public domain.

Nuisance caused by (groups of) youth and risk youth

Various (sub)groups of youth give evidence of problematic drug use while causing public nuisance (cf. (Sociaal en Cultureel Planbureau 1998)). In *Youth at the right place/Jeugd Terecht. Action program against youth criminality 2003-2006*, the government makes a distinction between: “disturbing”, “causing nuisance” and “criminal” (groups of) youngsters. Disturbing and nuisance causing youngsters are considered to be a public-order problem, including a.o. excessive alcohol use and/or illegal drug use. As to criminal youth, the police focus surveillance and investigation on persistent offenders and hardcore youth as well as on high-crime urban areas (Ministerie van Justitie 2004). With regard to repeatedly offending youngsters, a person-oriented approach already started in the early 1990s, presently known as *Individual Trajectory Guidance* (ITB). ITB consists of two different trajectories for 1) hardcore youth (ITB-HK); and 2) low-rate criminal immigrant youth (ITB-CRIEM) in disadvantaged positions. A main difference with the judicial treatment of adult persistent offenders is the stronger emphasis on (secondary or tertiary) prevention and/or integration into society (Ferwerda et al. 2003).

Funding

Since 1994, the implementation of facilities for social relief and addiction care are a responsibility of municipalities. At the time, 48 so-called “centre municipalities” (centrum-gemeenten) for social relief were allocated and 25 for the addiction care. To this end, these municipalities were funded by the national government. Since 2001, all together 43 centre municipalities are responsible for both social relief and addiction care. In addition, clinical addiction care institutions are financed on the basis of the Exceptional Medical Expenses Act (AWBZ) and come under the Ministry of Health, Welfare, and Sport (VWS). Within the framework of the Large-cities'-policy 2005-2009 coordinated by the Ministry of Interior, the separate funding by ministries is changed into three Broad Target Payments (Brede Doeluitkeringen). Previously, dozens of distinct arrangements were in use. Further, municipalities can formulate their own measurable results within the framework of their own Long-range Development Programme (Meerjaren Ontwikkelings Programma). To this end, municipalities are allowed to follow their own approach, leaving more room for local adaptations and priorities (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2004).

13.4 Results/Evaluation

Availability of statistics

Monitoring and research are important instruments within the framework of Dutch drugs policy. Since 1996, repeated surveys were carried out to assess trends in drug-related nuisance in Dutch cities (Bröer et al. 1999; Snippe et al. 2002).

With regard to social security and (drug-related) criminality in cities, three data sources can be distinguished, namely: 1) police sources; 2) recurrent population surveys; and 3) occasional empirical investigations (2004). The police are a main provider of data about (drug-related) crime and nuisance. In the Police Records System (HKS) all booked criminal offences are stored, mainly for the purpose of prosecution. On the basis of the HKS-database, e.g. Biesma et al. (2002) concluded that 28 (62%) out of 45 addicted persistent

offenders within the Rotterdam region committed no criminal act any more after finishing their entire period of Judicial Treatment (SOV)(Bieleman et al. 2002a).

Periodic population surveys, such as the Police Monitor Dutch Population (2004), are an important supplement (see also below)(Uitvoeringsconsortium Projectbureau Politie monitor 2004). Apart from monitor studies and surveys being held at a national level, many cities have their own local monitors and/or surveys carried out (cf. (Gemeente Amsterdam 2004; Gemeente Nijmegen 2004); see also (Cruts et al. 2004).

Many data on drug-related crime are produced by occasional empirical investigations. The third type of research is guided by specific questions and carried out by universities, government services, or private institutes.

Results of measures taken

Drug nuisance in public areas

Between 1996-2002, drug-nuisance figures in the larger cities give evidence of a downward tendency. In the years 1998-2000, subjective inconvenience decreased, particularly in residential areas with the severest nuisance (category I) (Snippe et al. 2002). After 2000, however, the reduction did not continue. In residential areas with comparatively low drug nuisance, rates were stabilising or slightly increasing. Over the years 2002-2004, the Police Monitor Dutch Population (2004) reports an almost constant drug-nuisance rate of well over 6% in residential areas. In 2004, compared to drug nuisance, slightly more respondents mentioned "drunken people" as an important cause of nuisance, while "nuisance by groups of youngsters" was on top of the list with 13% (see table 13.1). The figures in table 13.1 represent the public nuisance that is subjectively felt throughout the country.

Table 13.1 Serious nuisance in residential areas*: percentage “occurs often” for the Dutch population, 2002-2004

<i>Kinds of nuisance:</i>	2002	2003	2004
Nuisance by groups of youngsters	13.9%	13.2%	12.8%
Drunken people out of doors	8.0%	7.4%	7.2%
Drug nuisance	6.4%	6.2%	6.3%
People are being hassled out of doors	3.4%	2.8%	2.6%

*Public nuisance that is subjectively felt throughout the country. Source: Police Monitor Dutch Population 2004.

Closures of houses and public establishments

Since 1997, local authorities can appeal to Article 174a of the Municipality Act to counteract non-tolerated cannabis outlets or hard-drug sale in houses. Until 2001, local authorities did hardly enforce Article 174a, the exception being the border town of Venlo where 52 cannabis outlets were closed (Gemeente Venlo 2003;Korf et al. 2001;Smits et al. 2002). In 1999, Article 13b of the Opium Act against public establishments came into operation. Until 2001, Venlo again showed the highest closure rate compared to other cities (see table 13.2). In some cities, Article 13b was applied to “smarthops” selling non-traditional drugs. The number of closures in tabel 13.2 accounts for only part of the actual decrease in the number of coffee shops in the same period.

Table 13.2: Number of closures 1999-2001 on basis of Article 13b Opium Act in some municipalities*

<i>Number closures:</i>	<i>Municipalities:</i>
1-2	Arnhem; Groningen; Leeuwarden; Terneuzen
5-9	Heerlen; Rotterdam
10-20	Amsterdam
40-45	Venlo

*Not complete for all municipalities. Source: (Smits et al. 2002).

Subgroups causing drug nuisance

Judicial Treatment of addicted repeat offenders

In 2001 the Judicial Treatment of Addicts (SOV) was set up for a provisional period of 6 years, the process being evaluated in 2004 being followed by an effect evaluation in 2007. On 31 July 2004, all together 219 SOV-places were available with an occupation rate of 67.5%. In 2004 the instrument of the Judicial Treatment was extended to all so-called "repeat offenders" (veelplegers) with more than 10 summons in their life-time (T.K.28684/1-2). The total number of repeat offenders in the Netherlands is estimated at 18,000-19,000 ((Wartna et al. 2004b); see also Chapter 8 and 12).

Drug consumption rooms for addicts with psychiatric problems and/or being homeless

In 2000, all together 20 small scale drug consumption rooms were available for addicts throughout the country (Linssen et al. 2002). Within two-years' time this number increased to 32, but consumption rooms were mostly not integrated with other services resulting in lacking follow-up assistance (Bransen et al. 2004).

Contestations about measures taken

AHOJ-G criteria for cannabis sale in tolerated coffee shops

The enforcement of "AHOJ-G criteria" to cannabis sale in coffee shops (see above) still raises questions. The criterion "no Advertising" is still indefinite because the criterion "restricted advertising" is not described in detail. The 5 gram norm per transaction with the same customer on the same day is hard to control for coffee-shop owners. At the local level, the latter norm has low priority (Pardoel et al. 2004). As one of the undesirable side effects, tourists could go shopping in different coffee shops. Empirical research, however, does not conform such behaviour in border towns (Korf et al. 2001).

Combating nuisance versus individual assistance to addicts

The Ministry of Health, Welfare, and Sport (VWS) is responsible for the funding of municipalities with a centre function in their region (centrumgemeenten). Municipalities are responsible for outpatient addiction care and prevention. Officially, municipalities are also responsible for individual, medical outpatient addiction care, such as methadone supply programmes. The Large-Cities' policy memorandum 2005-2009 (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties 2004) makes mention of municipalities focusing themselves more and more on combating nuisance and social relief of addicts, disregarding individual assistance. According to this policy document, municipalities should also focus on subgroups, such as cocaine addicts who are reached insufficiently. For that matter, the Amsterdam policy document *Drug nuisance and addiction problems* draws attention to a

subgroup of “new users” who look well but use free-base cocaine and are highly criminal (Gemeente Amsterdam 2003).

Contrasting perspectives on repeat offenders and illegal drug use

The correlation between illegal drug use and high rates of crime is not unequivocal. According to research and policy documents (Ferwerda et al. 2003; Grapendaal et al. 1991; Meijer et al. 2003), three main perspectives on this correlation are relevant for policy making, namely: 1) A person’s addiction to illegal drugs causes crime; 2) A person’s involvement in a crime scene facilitates his/her use of illegal drugs; and 3) The use of illegal drugs is a main characteristic of persons leading a deviant style of living.

Part C – Bibliography, Annexes

14 Bibliography

14.1 References

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14.2 Alphabetic overview of relevant data bases

(Source: Cruts et al. 2004)

Amsterdamse cohortstudie, Amsterdam Cohort Study

- Local cohort study on mortality among methadone clients registered at the CMR (see below), conducted by the Municipal Health Service Amsterdam. Homepage: www.gggd.amsterdam.nl

Antenne

- Local monitor of the use of alcohol, tobacco, and drugs by pupils and outgoing young persons in Amsterdam, conducted by the Bonger Institute of the University of Amsterdam (UvA). Homepages: www.jur.uva.nl & www.jellinek.nl/

Causes of death statistics

- National registration of causes of death, that is the Dutch General Mortality Register (GMR), including deaths due to drugs, conducted by Statistics Netherlands (CBS). Homepage: www.cbs.nl

CBS Politiestatistiek, Statistics Netherlands (CBS) Police Statistics

- National registration of the number of police reports on offences against the Opium Act, conducted by Statistics Netherlands (CBS). Homepage: www.cbs.nl

Cliënt Volg Systeem Amsterdam, Client Monitoring System Amsterdam

- Local registration system of treatment given by the Municipal Health Service, Addiction Care, and Public Mental Health Care, including treatment for drug users. Homepage: www.gggd.amsterdam.nl

Cliënt Volg Systeem van Stichting Verslavingsreclassering Nederland, Client Monitoring System Foundation of Addiction Probation Services

- National registration of probation services offered to drug using offenders, conducted by the Foundation of Addiction Probation Services. Homepage: www.ggz nederland.nl

CMR, Centrale Methadon Registratie, Central Methadone Register (CMR)

- Local registration of methadone substitution treatment, conducted by the Municipal Health Service Amsterdam. Homepage: www.gggd.amsterdam.nl

CPA, Centrale Post Ambulancevervoer, Central Post Ambulance Transport (CPA)

- Local registration of ambulance transport, including transport due to problem use of alcohol and drugs, conducted by the Municipal Health Service Amsterdam. Homepage: www.gggd.amsterdam.nl

DIMS, Bureau Drugs Informatie en Monitoring Systeem, Drugs Information and Monitoring System (DIMS)

- National survey on the contents of synthetic drugs, conducted by the Bureau of the Drugs Information and Monitoring System (DIMS) at the Trimbos Institute. Homepage: www.trimbos.nl

DMS, Drug Monitoring Systeem, Drug Monitoring System (DMS)

- Local monitor on problem drug use and living conditions of marginalised hard drug users in the cities of Rotterdam and Utrecht, and the region of Parkstad Limburg, conducted by the Addiction Research Institute Rotterdam (IVO). Homepage: www.ivo.nl

Educare monitor

- National monitor on first aid given at house parties, including first aid for problem alcohol and drug use, conducted by Educare Ambulant, Foundation Nursing & Education Consultancy. Homepage: www.educaregroningen.nl

Haags Uitgaansonderzoek

- Local monitor on the use of alcohol and drugs by outgoing young persons (16-35 years) in The Hague, conducted by the Research Committee Monitoring & Registration (MORE). Homepage: www.denhaag.nl/

HBSC, Health Behaviour in School-Aged Children

- National monitor on physical and mental health and well-being of school-aged children, including the risky use of cannabis, conducted by the Trimbos Institute, Radboud University Nijmegen, and Utrecht University. Homepages: www.trimbos.nl & www.hbsc.org

HIV/aids-registratie, HIV/aids Registration

- National reporting system for diagnoses of HIV and aids assessed by doctors, including HIV and aids due to injecting drug use, conducted by the HIV Monitoring Foundation (SHM). Homepage: www.hiv-monitoring.nl

HIV-surveillance among drug users

- Local surveys in different cities of HIV-infection among injecting drug users, conducted by the National Institute of Public Health and the Environment (RIVM) and the municipal health services. Homepage: www.rivm.nl

Inbeslagnames drugs, Seizures drugs

- National registration of drug seizures, conducted by the Research and Analysis Group of the National Criminal Intelligence Service of the National Police Agency (O&A/dNRI/KLPD). Homepage: www.politie.nl/KLPD/
- LADIS, Landelijk Alcohol en Drugs Informatie Systeem, National Alcohol and Drugs Information System (LADIS)
- National registration system of outpatient addiction care and treatment, conducted by the Organization Care Information Systems (IVZ). Homepage: www.sivz.nl

Landelijke Jeugdmonitor CBS-SCP (POLS), National Youth Monitor CBS-SCP (POLS)

- National monitor on the living conditions of young persons (12-29 years), including drug use, conducted by Statistics Netherlands (CBS) and the Social and Cultural Planning Office of the Netherlands (SCP). Homepage: www.cbs.nl

LIS, Letsel Informatie Systeem, Injury Information System (LIS)

- National survey on injuries treated at emergency departments of hospitals, including injuries due to alcohol and drugs, conducted by the Consumer Safety Institute. Homepage: www.veiligheid.nl

LMR, Landelijke Medische Registratie, Dutch Hospital Registration (LMR)

- National registration of admissions to hospitals, including admissions due to problem alcohol and drug use, conducted by Prismant. Homepage: www.prismant.nl

Monitor gedoogde coffeeshops, monitor tolerated coffeeshops

- National monitor of the number of coffeeshops that are officially tolerated by the local municipal policy, conducted by Bureau IntraVal. Homepage: www.intraval.nl/

National Investigation Information Services (Opsporingsonderzoeken Georganiseerde Criminaliteit)

- National survey on organised crime, including offences against the Opium Act, conducted by the Research and Analysis Group of the National Criminal Intelligence Service of the National Police Agency (O&A/dNRI/KLPD). Homepage: www.politie.nl/KLPD/

NEMESIS, Netherlands Mental Health Survey and Incidence Study

- National cohort study on the general population (16-64 years) focussing on mental disorders including the abuse of and the dependence on alcohol and drugs, conducted by the Trimbos Institute. Homepage: www.trimbos.nl

NPO, Nationaal Prevalentie Onderzoek, National Prevalence Survey (NPO)

- National survey on the use of alcohol and drugs in the general population aged 12 years and older, conducted by the Centre for Drug Research (CEDRO) of the University of Amsterdam (UvA). Homepage: www.cedro-uva.org

NSO, Nationale Scholierenonderzoek, National School Survey (NSO)

- National survey on alcohol and drug use among pupils in relation to their physical and mental health, conducted by the National Institute for Family Finance Information (NIBUD). Homepage: www.scp.nl

NVIC Monitor, Nationaal Vergiftigingen Informatie Centrum, National Poison Information Centre (NVIC)

- National registration of information requests for poisonings, conducted by the National Institute of Public Health and the Environment (RIVM). Homepage: www.rivm.nl

OBJD, Onderzoeks- en Beleidsdatabase Justitiële Documentatie, Research and Policy Database Judicial Documentation (OBJD)

- National registration of criminal cases registered at the Public Prosecutions Department (OM), including offences against the Opium Act, conducted by the Research and Documentation Centre (WODC) of the Ministry of Justice. Homepage: www.wodc.nl/

OGGZ Monitor Amsterdam, Public Mental Health Care Monitor Amsterdam

- Local monitor on marginalized inhabitants of Amsterdam including problem drug users, conducted by the Municipal Health Service Amsterdam (GG&GD Amsterdam). Homepage: www.gggd.amsterdam.nl

OMDATA, Openbaar Ministerie Data, Public Prosecutions Department Data (OMDATA)

- National registration of criminal cases registered at the county court districts, including offences against the Opium Act, conducted by the Office of the Public Prosecutions Department. Homepage: www.wodc.nl/

Peilstationsonderzoek scholieren, Dutch National School Survey

- National survey on alcohol and drug use among pupils (10-18 years), conducted by the Trimbos Institute and the Municipal Health Services. Homepage: www.trimbos.nl

Police Records System (HKS)

- National identification system for the police, including drug use of suspects, conducted by the Research and Analysis Group of the National Criminal Intelligence Service of the National Police Agency (O&A/dNRI/KLPD). Homepage: www.wodc.nl/

Politiemonitor Bevolking, Police Monitor Dutch Population

- National survey on safety and public nuisance due to alcohol, drugs and other sources, conducted by a consortium of the B&A Groep Beleidsonderzoek & -Advies B.V. and Intomart GfK B.V. Homepage: www.politie.nl/Overige/Documentatie/politiemonitor_bevolking.asp

SOV-onderzoek, Strafrechtelijke Opvang Verslaafden, Judicial Treatment of Addicts (SOV) Survey

- National registration of addicts receiving Judicial Treatment of Addicts (SOV), conducted by the Amsterdam Institute for Addiction Research (AIAR). Homepage: www.aiar.nl

SRM, Strafrechtmonitor, Criminal Law Monitor (SRM)

- National in-depth survey on a sample of criminal cases, including offences against the Opium Act, conducted by the Research and Documentation Centre (WODC) of the Ministry of Justice. Homepage: www.wodc.nl/

THC-monitor

- National monitor on the concentration of THC in cannabis products sold in coffeeshops, conducted by the Bureau of the Drugs Information and Monitoring System (DIMS) at the Trimbos Institute. Homepage: www.trimbos.nl

TULP/GW, Ten UitvoerLegging van vrijheidsbenemende straffen en maatregelen in Penitentiaire inrichtingen, Execution of detentions in penitentiaries (TULP/GW)

- National registration of detentions, including detentions for offences against the Opium Act, conducted by the Judicial Detention Service (DJI). Homepage: www.dji.nl/

USD monitor, Synthetic Drugs Unit (USD) Monitor

- National registration of seizures of synthetic drugs, precursors and production locations, conducted by the Kernteam Zuid-Nederland/Synthetic Drugs Unit. Homepage: www.politie.nl/Overige/Overigepolitieorganisaties/

WODC-Recidivemonitor, WODC Monitor on Recidivism

- National registration of suspects and convicts that repeat the offence, including offences against the Opium Act, conducted by the Research and Documentation Centre (WODC) of the Ministry of Justice. Homepage: www.wodc.nl/

14.3 List of relevant internet addresses

This list contains only a selection of websites in the Netherlands on the subject of substance use.

Website	Contents
http://www.trimbos.nl/	Netherlands Institute of Mental Health and Addiction
http://www.minvws.nl/	Ministry of Health, Welfare and Sports
http://www.justitie.nl	Ministry of Justice
http://www.wodc.nl	Research and Documentation Centre of the Ministry of Justice
http://www.drugsinfoteam.nl/	Drugs and Alcohol Info Team of Brijder Addiction Care
http://www.unitydrugs.nl	Unity: educational peer project in Amsterdam
http://www.jellinek.nl	Jellinek Addiction Care Amsterdam
http://www.cedro-uva.org	Centre for Drug Research, University of Amsterdam
http://www.intraval.nl	Intraval. Bureau for Research and Consultancy
http://www.aiar.nl/	Amsterdam Institute for Addiction Research
http://www.drugsinfo.nl/	Objective information on drugs for general public
http://www.sidv.nl/	Information Point Drugs and Safety for local authorities
http://www.ivo.nl/	Addiction Research Institute Foundation, Rotterdam
http://www.gggd.amsterdam.nl/	Municipal Health Service of Amsterdam
http://www.cbs.nl/	Statistics Netherlands
http://www.ggznederland.nl/	Netherlands Association for Mental Health Care
http://www.rivm.nl/	National Institute for Public Health and the Environment
http://www.sivz.nl/	Care Information Systems Foundation
http://www.hiv-monitoring.nl/	HIV Monitoring Foundation (HMF)
http://www.politie.nl/KLPD/	National Police Agency
http://www.prismant.nl/	Prismant: Consultancy agency for the Social Care Sector
http://www.scp.nl/	Social and Cultural Planning Office of the Netherlands

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15.3 List of Abbreviations used in the text

2C-B	4-bromo-2,5-dimethoxyphenethylamine
4-MTA	4-methylthioamphetamine
ADHD	Attention-Deficit/Hyperactivity Disorder
AIAR	Amsterdam Institute for Addiction Research
AIDS	Acquired Immune Deficiency Syndrome
BZK	Ministry of the Interior and Kingdom Relations
CAM	Coordination Centre for the Assessment and Monitoring of New Drugs
CBS	Statistics Netherlands
CBZ	Board of Construction of Facilities for Hospitals
CEDRO	Centre for Drug Research
CMR	Central Methadone Registration
DIMS	Drugs Information and Monitoring System
DOB	2,5-dimethoxy-4-bromoamphetamine
DSM	Diagnostic and Statistical Manual of Mental Disorders
E.K.	Senate
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FIOD	Fiscal Intelligence and Investigation Department
GGD	Municipal Health Service
GG&GD	Area Health Authority
GGZ	Mental Health Service
GGZ Nederland	Netherlands Association for Mental Health Care
GHB	Gamma-hydroxy-butyrate
GMR	General Mortality Register
HAART	Highly Active Anti-Retroviral Treatment
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immune Deficiency Virus
HKS	Defendant Recognition System (of the Police)
ICD	International Classification of Diseases, Injuries and Causes of Death
IDUs	Intravenous Drug Users
IGZ	Health Care Inspectorate
IMC	Inpatient Motivation Centre
ISD	Institution for Prolific Offenders
IVO	Addiction Research Institute Foundation
IVV	Foundation of Information on Addiction Care
IVZ	Care Information Systems Foundation
KLPD	National Police Agency
LADIS	National Alcohol and Drugs Information System
LCI	National Coordination Structure on Infectious Diseases
LMR	National Information System on Hospital Care and Day Nursing
LSD	D-Lysergic acid diethylamide
LTP	LifeTime Prevalence
LMP	Last Month Prevalence
LYP	Last Year Prevalence
MBDB	N-methyl-1-(3,4-methylenedioxyphenyl)-2-butanamine

MDA	Methylene-dioxyamphetamine
MDEA	Methylene-dioxyethylamphetamine
MDMA	3,4-methylene-dioxymethamphetamine
MIM	Multivariate (Social) Indicator Method
NDM	National Drug Monitor
NEMESIS	Netherlands Mental Health Survey and Incidence Study
NIGZ	National Institute for Health Promotion and Disease Control
NPO	National Drug Use Survey/National Prevalence Survey
NVIC	National Poisons Information Centre
OBJD	Justice Documentation Research Database
OMC	Office of Medicinal Cannabis
OMDATA	Public Prosecution Department Data
PMA	Paramethoxyamphetamine
RIVM	National Institute for Public Health and the Environment
SCP	National Institute for SocioCultural Studies
SHM	HIV Monitoring Foundation
SOV	Judicial Treatment of Addicts
SRM	Criminal Justice Monitor
SVO	Steering Committee for the Reduction of Nuisance
TBC	Tuberculosis
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
T.K.	House of Representatives
TM	Treatment Multiplier
USD	Synthetic Drugs Unit
VVGN	Dutch Association of Addiction Physicians
VWO	Pre-University Education
VWS	Ministry of Public Health, Welfare and Sports
WHO	World Health Organisation
WODC	Research and Documentation Centre of the Dutch Ministry of Justice
XTC	Ecstasy
ZORG-IS	Registration System on Mental Health Care

15.4 Map of the Netherlands: provinces and major cities

The Netherlands



