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by the Reitox National Focal Point**

**THE NETHERLANDS  
DRUG SITUATION 2012**

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**REPORT ON THE  
DRUG SITUATION  
2012**

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## **PREFACE**

The Report on the Drug Situation in the Netherlands 2012 has been written for the European Monitoring Centre for 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 their respective 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. In keeping with the guidelines, the report focuses on new developments in the reporting year. In order to avoid too much overlap, the reader is repeatedly referred to previous National Reports.

This 2012 national report was written by the staff of the Bureau of the Netherlands National Drug Monitor (NDM) at the Trimbos Institute and staff of the Research and Documentation Centre (WODC) of the Ministry of Security and Justice. The NDM was established in 1999 on the initiative of the Ministry of Health, Welfare and Sport. The Ministry of Security and Justice also participates in the NDM. The NDM carries out the functions of the Netherlands Focal Point.

The NDM relies on the contribution of a multitude of experts and input from registration systems and monitors in the Netherlands. In particular, the authors would like to thank the members of the Scientific Committee of the NDM and other expert reviewers for their valuable comments on the draft version of the report.

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## Executive summary

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

This National Report reviews the developments in the drug policy of the Netherlands up to the letter of the 19<sup>th</sup> of November 2012 of the Minister of Security and Justice (TK 24077-293) informing the House of Representatives on the policy consequences of the measures announced in the Coalition Agreement for the Rutte II Administration, that was presented on the 29<sup>th</sup> of October 2012.

The Dutch Opium Act places drugs with an unacceptable risk on Schedule I and places other drugs on Schedule II. The Opium Act and the Opium Act Directive have been subject to changes:

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

- A change in the Code of Criminal Procedure is in preparation which will make it possible for the police to check the use of alcohol and drugs amongst suspects of violent crimes. The use of substances will be an aggravating factor in the sentencing of these cases.

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

There are no new data on drug use in the general population.

Overall, prevalence rates of cannabis and other drug use among pupils of secondary schools of 12-18 years peaked in 1996, decreased afterwards and remained stable between 2007 and 2011. In 2011, 17.6% had ever used cannabis, 2.6% ecstasy en less than 2% amphetamine, cocaine or heroin.

Various indicators strongly point at an increase in the (problem) use of GHB in some subpopulations both in and outside the nightlife scene. Several qualitative and quantitative studies have been carried out in 2011 and 2012 on profiling GHB users. Different user groups have been identified, which can be partly characterised on the basis of their main location of use (users in the nightlife scene, at home users, hanging round youth and marginalized users).

### *Developments in prevention (chapter 3)*

In the Netherlands the municipalities are responsible for carrying out health prevention programs. They are usually carried out in co-operation between prevention departments of the institutes for addiction care and the public municipal health services, schools, neighborhood centers and different health promoting institutes, which support these organisations. The Ministry of Health, Welfare, and Sport (VWS) coordinates the prevention activities, which are part of a broader scope of public health prevention.

In the Netherlands prevention activities are focused increasingly on young people at school or in nightlife and high risk groups. Examples are the project Healthy School and Drugs, the program Open and Alert in the residential child care, youth work, youth custodial institutions, and facilities for people with mild or borderline intellectual disabilities.

On the other hand the Ministry of Health, Welfare, and Sport stopped the funding for nationwide mass media campaigns in 2012. On a local level diverse initiatives are taken like a new GHB-campaign "Fainting is never ok" in Amsterdam.

In 2012, the government announced that in 2013 the minimum legal age for the provision of all alcohol containing drinks will be increased to 18 years. The Secretary of State has a legislative proposal in preparation to increase the minimum legal age for the provision of tobacco from 16 to 18 years. The announced measure to implement a national distance criterion of 350 metres between coffee shops and secondary schools and schools for professional education schools was not mentioned any more in the Coalition Agreement for the Rutte II Administration. In a letter to the Parliament from 19-11-2012 the minister of Security and Justice announced that, because of the choice for tailored local approaches, the distance criterion of 350 metres will not be imposed by national rules – i.c. in the Directive of the Opium Act (T.K. 24077-293). However, municipalities can decide themselves which distance criterion is necessary in the local situation.

Since 2011 the government has a law in preparation to oblige persons to cooperate with the testing on alcohol and drugs in case of violent crimes. The intention of this measurement is to aggravate the sanction in case of the use of alcohol and drugs in violent crimes. This law is expected to be operational in 2013.



#### *Developments in problem use (chapter 4)*

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

While health and treatment indicators point at an increase in the number of problem (dependent) GHB users, the size of this population is not known.

#### *Developments in treatment (chapter 5)*

In June 2012 the major stakeholders agreed on the Governmental agreement future mental health care 2013 – 2014. With this agreement the stakeholders intended to consolidate the quality of care on a high level and to keep the care affordable in the future: the mental healthcare institutes (including addiction care) and the health insurance companies have to make arrangements to reduce the number of beds in residential mental health care, including the addiction care. In the coming years the parties involved will lay emphasis on outpatient care, the General Practitioner and E-health interventions, this with the intention to reduce the demand for residential care.

In 2011 and 2012 the quality management care program Scoring Results for the addiction care continues, this program aims to improve permanently the quality and effectiveness of prevention, treatment and care. In this context a few new guidelines were published in this period.

Benchmarking is considered in the Netherlands as a tool to improve the quality management of health care in general. Therefore diverse measurements are conducted (ROM and CQ-Index) and centrally gathered. Mid 2013 a new quality institute in health care will be installed. The objective of this institute is to improve the client-centricity, quality, safety, effectiveness, and efficiency of care. Until now these tasks are currently administered by different organisations.

In September 2012 three draft versions were published of a treatment protocol for treating GHB addiction, meant for different settings.

Since January 2012, patients of addiction care and mental health care organisations had to pay an own contribution. According to a large part of the care giving organisations, as a result of this measure, more patients stopped their treatment prematurely, fewer outpatients were registered and the number of crisis admissions increased. By the end of 2012, the government made clear that his measure will be withdrawn.

#### *Health correlates and consequences (chapter 6)*

The incidence of HIV and hepatitis B and C among (ever) injecting drug users remains low since many years. HIV is mainly transmitted through sexual contact (both through men who have sex with men (MSM) and heterosexuals) and drug users only play a marginal role in new infections. However, the burden of especially chronic hepatitis C infection stays high.

Since 2009, data are collected on drug-related health emergencies seen by four types of medical services (ambulance transportation services, emergency departments in

hospitals, forensic doctors and organisations with a first aid medical post at large events) in eight regions. The data show large differences in characteristics of the emergencies between the medical services and between regions. Emergencies related to GHB use are relatively frequent, taking into account the rather limited use in the general population. Ecstasy intoxications were the most prevalent acute medical problem after drug use at the first aid medical posts at parties. Although in 90% of these emergencies the level of intoxication was light, there are some indications for an increase in the level of intoxication between 2009 and 2011 (more intoxications in which the level of intoxication is graded as severe), which seems to continue in 2012.

The number of acute drug-related deaths remained low. Between 1996 and 2011, the annual number of recorded drug-related deaths among residents fluctuated between a minimum of only 94 cases in 2010 and a maximum of 144 cases in 2001. In 2011, 103 cases were recorded, including 33 cases relating to opiates, 19 to cocaine and 51 to unspecified substances. The latter category mainly includes death due to multiple substance use, commonly including illicit substances as well as combinations with alcohol and/or medicines.

The ageing of the population of problem drug users is reflected in a decreasing percentage of deceased aged 35 years and younger, from 40% during the period 1991 up to including 1995 to 70% during the period 2006 up to including 2011.

#### *Responses to health correlates and consequences (chapter 7)*

The monitor for drug-related emergencies collects, in a standardized format, information of the incidence and type of acute emergencies related to drug use, and uses this information as direct input for preventive measures, both at the level of the professionals in the field as for policy makers (§ 7.2). With regard to the prevention and treatment of drug-related infectious diseases, a strong decrease in the number of exchanged needles and syringes has been reported between 2002 and 2007, with some fluctuations in the years afterwards. Thirty-seven drug consumption rooms were identified in 2010. The population of drug users who utilize drug consumption rooms has decreased in the past due to increased participation of former homeless drug users in social housing projects and a reduced injecting of drug use (although drug consumption rooms are not restricted to injecting users).

Moreover, the national hepatitis B vaccination program for drug users has been ended as of 31 December 2011, as this population is no longer considered as a (behavioral) risk group (§ 7.3.3). The costs of hepatitis C treatment have been estimated at between 9,900 euro and 28,500 euro, depending on genotype, viral response and treatment outcome.

In 2012, the guideline for education, screening and treatment for hepatitis C in detention was finalised (§ 7.3.4).

#### *Social correlates and social integration (chapter 8)*

Currently, the level of social cohesion in the Netherlands is mainly determined by the degree in which non-Western migrants have become socially integrated. Although in 2011 some indications were found of a structurally better integration of non-Western migrants, stagnation was reported with regard to education, employment, income, and housing. Moreover, migrants are still more involved in crime.

"Social exclusion of drug users" and "drug use among socially excluded groups" are still two sides of the same coin. A literature research and an expert meeting have

confirmed that addiction is associated with disturbances of social relations, dropout from school, homelessness, debts, and domestic violence. Among the homeless in the four largest cities, higher prevalences have been found for the use of drugs like cannabis, crack cocaine, sniff cocaine, ecstasy, amphetamines, and opiates.

The institutes for addiction care have consolidated their efforts for social reintegration. Common treatment programs targeting the social reintegration of addicts are given by supported living, daily activities, work experience, participation of Experts by Experience, Assertive Community Treatment (ACT), Functional Assertive Community Treatment (FACT), and the Community Reinforcement Approach (CRA). More specific programs for social reintegration have targeted female sex workers, victims of lover boys, and undocumented people.

Evaluation research has shown positive results for the Community Reinforcement Approach (CRA) targeting alcohol addicts in the city of Eindhoven. Positive results have also been found for interventional care in three regions in the province of North Brabant, social relief for homeless young people in the city of Rotterdam, and for the passing through from social relief to supported living in the city of Enschede. The positive results of Assertive Community Treatment (ACT) and Flexible Assertive Community Treatment (FACT) have been confirmed by the Psychiatric Case Registers (PCRs) in the cities of Rotterdam, Utrecht, Maastricht, and Groningen.

However, in the city of Groningen it was found that a project for supported living in a neighbourhood will only succeed on the condition that the surrounding habitants are involved in the project from the very start. Another condition is that all stakeholders are involved in the final choice of the location for the supported living.

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

In 2011, the majority of criminal investigations into serious and organized crime were aimed at drugs, mostly at hard drugs, and within hard drugs, mostly at cocaine. This picture is the same as in the years before. The total number of drug law cases dealt with by police and Public Prosecution has increased compared to 2010. The increase is substantial, especially with regard to soft drug cases. The proportion of soft drug cases exceeded that of hard drug cases in 2011. More than half of the cases reported by Public Prosecution (53%) concern soft drugs now.

The majority of Opium Act cases is submitted to court, but the total number of Opium Act cases handled by the Courts decreased. In 2011 the court cases concerned almost as much hard drugs (48%) as soft drugs (47%). The proportion of court cases concerning a combination of hard and soft drugs remained constant (5%). The sanction most often applied in 2011 for Opium Act cases and in first instance is the (partly) unconditional prison sentence.

Expenditures for Opium Act offences are estimated at € 766.3 million, of which € 485.8 million is spent on hard drugs and € 280.4 million on soft drugs. Expenditures for Opium Act offences account for 6% of the total of expenditures for security issues. Opium Act offences rank fifth in amount of expenditures for security issues.

The combat of organized drug production, cultivation and trafficking is a priority area for police and Public Prosecution in 2011-2012. The 'barrier' model is applied with combinations of criminal and administrative and judicial measures and with a crucial role for local and regional institutions. New regulations broaden the options. The confiscation of criminal

proceeds is a central element in the approach. Investigations into the top of criminal organisations involved in cannabis cultivation and exportation are stimulated by a national Taskforce and a Taskforce aimed specifically at the southern region of Brabant.

For offenders with drug problems (and for offenders with other mental health problems) there are interventions available in the criminal justice system: "Safety Houses", forensic care as an alternative to prison, Penitentiary Psychiatric Centres, Addiction probation services, behavioural interventions inside and outside prison and the Measure of Placement in an Institution for prolific offenders. In 2012 there were 41 Safety Houses. These are networks of local organisations working together to reduce crime. Offenders are discussed in case meetings and adequate trajectories are planned.

The number of diversions to care as an alternative for detention is rising. Planned new laws give priority to care as an alternative for or following imprisonment and forensic care for delinquents in institutions outside the prison system is contracted by the Ministry of Security and Justice.

The number of clients of addiction probation services in 2011 did not change compared to 2010. Two-thirds (64%) of the offenders under the Measure for Placement in an Institution for Prolific Offenders (ISD) had addiction problems. Most offenders under ISD participate in trajectories with behavioral interventions or care programs. More trajectories take place outside prison. ISD is effective in reducing criminal recidivism.

#### *Drug markets (chapter 10)*

The number of coffee shops in the Netherlands is gradually decreasing. In 2011 there were 651 coffee shops, located in 104 of the 418 municipalities.

The National Police Agency observed no substantial new developments in cannabis production in the Netherlands. Main destinations for export of cannabis are the UK, Germany, Italy and the Scandinavian countries. In 2011 5,435 cannabis production sites were dismantled. There are no indications that compulsion, intimidation or violence is used against home-growers of cannabis. Foreign hashish comes mainly from Morocco and is transported over sea. This type of crime seems to be conducted in a small world, although the number of players increased.

Cocaine comes from Peru, Bolivia and Colombia, with Western Africa as one of the important transit regions. The trafficking is in the hands of Europeans. Rotterdam and Antwerp are main ports of entry of cocaine. The Netherlands is primarily a transit country. With regards to heroin there are no substantial new developments. No consequences were observed in the Netherlands from the decrease in opium production in Afghanistan in 2010.

In the field of synthetic drugs there were important developments in 2008-2012: new (pre)precursors emerged, MDMA production recovered in 2011 and production sites increased in scale. Several new psycho-active substances seem to be on the market, which are not produced in the Netherlands. In 2011, 30 production locations of synthetic drugs were dismantled.

The internet seems to be of growing importance as a medium for contacts over trading and production of drugs. The Minister of Security and Justice announced steps against this way of drug trading.

In 2011 and the first half of 2012, the purity of ecstasy samples bought by consumers exceeded purity levels in earlier years. Ecstasy tablets analysed in the laboratory contained on average 107 mg in the first half of 2012 (against 66 mg in 2009). Amphetamine purity

strongly fluctuated in the past decade, which may be due to variations in precursor availability. In the first half of 2012 the average concentration of amphetamine was 21% against over forty percent in the second half of 2010. The caffeine concentration increased to 58% in the first half of 2012.

Occasionally (potentially) dangerous substances are detected in samples sold as ecstasy and amphetamine (e.g. PMMA/PMA, 4-MTA). In the first half of 2012, 11% of the speed samples contained 4-methylamphetamine (4-MA). Fatal emergencies related to the use of this substance in the Netherlands, as well as Belgium and UK, were reason for the Minister of Health, Welfare and Sport to commission a quick scan on the risks of 4-MA. The results have led to immediate control of 4-MA on List I of the Opium Act.

The majority of the cocaine samples from consumers still contain medicines, especially levamisole (64% of the samples in 2011). So far no cases of agranulocytosis, associated with the use of levamisole, have been reported. In 2011 the purity of cocaine was 49%, about the same as in 2009 and 2010, but less than in 2002 (68%).

Prices of ecstasy tablets at retail level increased from 2008 to 2010 and remained at the same level in 2011 (on average 4 euro). The price of a gram amphetamine increased from 2010 to 2011 (from 6 to 8 euro on average) and prices of cocaine fluctuated on average between 45 and 52 euro in the past years.

Between 2005 and 2012 the average concentration of THC in Dutch weed fluctuated on average between 15% and 18%. Prices of Dutch weed at retail level increased since 2006. In 2012 the price per gram of Dutch weed sold as most potent type was 11.2 euro and one gram of the most popular type was 9.3 euro.

#### *Residential treatment for drug users in Europe (chapter 11)*

The history of the (residential) treatment especially for drug users in the Netherlands is not going back further than around 1970. By that time the heroin use became epidemic in Amsterdam and it became clear treatment was necessary. Around 1975 the first residential facilities started to open their doors. The dominant vision at that time was that the only meaningful treatment of addiction aims at total abstinence. In the beginning of the eighties, the Dutch government started to change its drug policy. The former treatment goal of "abstinence" was now partly replaced by a plea for easily accessible methadone. Acceptance of drug use and harm reduction now became the leading principles. In the nineties, the collaboration between the addiction care and the mental health care improved. More attention was now paid to patients having dual diagnoses (DD). In 1995 the first outpatient projects for dual diagnosis started, and later on the first clinics were established. Addiction was no longer seen as a superficial behavioral characteristic, but was now seen as a result of abnormal brain processes.

There are thirteen established addiction care organizations in the Netherlands which offer a clinical stay. The majority of these are part of a large mental healthcare organization. Next to these 'established organizations' a growing number of private clinics are founded. There are eleven youth addiction clinics and five forensic addiction clinics and especially in 2012, some of latter clinics were founded.

The stakeholders in the mental healthcare and addiction care agreed in 2012 that a reduction of beds is desirable and many addiction care clinics have developed plans to realize this reduction. The patient flow should be directed from residential care to outpatient care and from specialized care to the general practitioner and E-health interventions.

In 2011 11,675 admissions took place in the residential care (including detoxification) and 5,351 admissions (without detoxification). Cocaine users formed the largest group in residential addiction care (865 persons).

The clinical addiction care offers a wide variety of treatment methods. Especially in the large institutes, many programs are available for different target groups. A majority of the institutes for addiction care offers the common evidence-based psychosocial treatments, like cognitive behavioral therapy, community reinforcement approach, motivational interview techniques, 12-Step approach, and partner and family therapy.

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

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

## ***Part A: New developments and trends***

# 1 Drug policy: legislation, strategies and economic analysis

## 1.1 Legal framework

### *Introduction*

This National Report reviews the developments in the drug policy of the Netherlands up to the letter from the 19<sup>th</sup> of November 2012 of the Minister of Security and Justice (TK 24077-293) informing the House of Representatives on the policy consequences of the measures announced in the Coalition Agreement for the Rutte II Administration that was presented on the 29<sup>th</sup> of October 2012.

In 2011 and 2012 many important drug policy documents and debates and legislative measures can be discerned in the Netherlands. In March 2012 a major drug policy debate took place between the Ministers of Security and Justice and Health, Welfare and Sport and the drug specialists of the Dutch political parties in the House of Representatives. The most important topic was the sharpened coffee shop policy (see also chapter 9). Also, changes were introduced in the Opium Act Directive of the Public Prosecutor, which affect the coffee shops. In addition, some courts pronounced verdicts in cases concerning the coffee shops, new substances were (re)placed on the schedules of the Opium Act, and the government took position on the so-called "generic" approach towards substances.

All recent policy documents state that the Dutch drug policy has two cornerstones - and this was confirmed by the Minister of Health, Welfare and Sport during the major drug debate in the House of Representatives in March 2012: to protect public health and to combat public nuisance and drug-related crime (TK 24077-259; TK Handelingen 69-28 maart 2012). In the current Opium Act Directive the objective of the drug policy is described as: *'The [new] Dutch drugs policy is aimed to discourage and reduce drug use, certainly in so far as it causes damage to health and to society, and to prevent and reduce the damage associated with drug use, drug production and the drugs trade'* (Stc 2011-11134).

### *Laws*

In the Netherlands, only a few laws and regulations are primarily directed towards drugs, but many other laws with a broader scope are important in relation to illegal drugs:

#### *Drug laws and regulations*

- Opium Act (Opiumwet) – (criminal law)
- Opium Act Decision (Opiumwetbesluit) (Royal Decree)
- Opium Act Directive (Directive of Public Prosecution Service)
- Victor Act (Wet Victor) – (criminal law/administrative law)
- Regulation Heroin Treatment – (ministerial regulation)
- Regulation Opium Act Exemptions (ministerial regulation)

#### *Laws and regulations with a broader scope but important for illegal drugs*

- Prisons Act (Penitentiare Beginselenwet) - (criminal law)
- Conditional Release Act – (criminal law)
- Placement in an Institution for Prolific Offenders Act (Plaatsing in een inrichting voor stelselmatige daders – ISD) - (criminal 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)
- Health Insurance Act (Zorgverzekeringswet) - (health law)
- Medicines Act (Geneesmiddelenwet) - (health law)
- Collective Prevention Public Health Act (Wet collectieve preventie volksgezondheid) - (health law)
- General Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten) - (health law)
- Community Support Act (Wet Maatschappelijke Ondersteuning - WMO) (health law)
- Plan of approach for social relief (Plan van aanpak maatschappelijke opvang) (policy letter)
- Forensic Care Act (Wet Forensische Zorg) – (criminal law)
- Compulsory Mental Health Care Act (Wet Verplichte Geestelijke Gezondheidszorg) – health care
- Road Traffic Act (Wegenverkeerswet)

In addition, there are policy letters with regards to the combat of organized crime (Bestrijding Georganiseerde Misdad) and with regards to the drug policy. These letters give the strategic framework for laws and regulations.

### *The Opium Act*

Dutch legislation is consistent with the provisions of all the international agreements which 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, defines the illegal drug-related activities and the sanctions that can be applied. It was fundamentally changed in 1976, when a distinction was made between drugs presenting unacceptable risks (Schedule I) and drugs like cannabis (Schedule II), which were seen as less dangerous. Since then, the Opium Act has been amended on various occasions but its basic structure has been maintained.

There are two procedures to place substances on the Opium Act Schedules: the 'normal' procedure by way of a governmental decree (*algemene maatregel van bestuur*) - which takes at least a few months- and an emergency procedure, giving the Minister of Health the possibility to place a substance immediately on an Opium Act Schedule.

### *New developments in the Opium Act*

On 6 September 2011, the Minister of Health announced that she will follow the advice of the Coordination Centre for the Assessment and Monitoring of new drugs (CAM) to move GHB from Schedule II to Schedule I of the Opium Act. It was advised because of the increasing use of GHB, the large risk of addiction and the risks for the health of the user (in particular losing consciousness) (TK 24077-262). Since 9 May 2012 GHB is placed on Schedule I.

On 5 October 2011, the Minister of Health announced that 4-methylmethcathinon (mefedrone) and tapentadol will be placed on Schedule I of the Opium Act. These decisions were published in the Bulletin of Acts and Decrees on May 8 2012 and have the force of law since then (Stb 2012-201).

By way of an emergency procedure, 4-methylamphetamine (4-MA) was placed on Schedule I on 13 June 2012, after it became clear that four people had died by using

amphetamines which were mixed with 4-MA (Stc 2012-12249).

The government decided to place Qat on Schedule II of the Opium Act. The "normal" procedure is running (TK 33255-1; TK 33255-2). In her explanatory notes the Minister of Health writes that the most important psychoactive substances of Qat are the alkaloids cathinone and cathine. Cathinone has amphetamine-like characteristics and is already placed on Schedule I. Cathine has efedrin-like characteristics and can be found on Schedule II. Qat is mainly used by the Somali community in the Netherlands and 11% of the users can be called problematic users.

In 2011 an advisory committee advised to categorize cannabis with a THC-concentration of 15% or more as a hard drug (Schedule I of the Opium Act) (Expertcommissie Lijstensystematiek Opiumwet 2011). In the plans of the new Cabinet (Rutte II) of November 2012 the intention to introduce a legal limit for the percentage of active ingredients in soft drugs is repeated (VVD en PvdA 2012; see also T.K. 24077-293). A literature review by the Trimbos Institute on the health effects of cannabis and of its main psychoactive constituent, tetrahydrocannabinol (THC) and its isomer cannabidiol (CBD), showed that there are very few studies investigating the protective effects of CBD, although it is believed that CBD can subdue the anxiety arousing potential of THC and the psychosis inducing effects of cannabis as such (Niesink and Van Laar 2012; see also paragraph 10.3).

By order of the Minister of Health, the National Institute for Public Health and the Environment (RIVM) wrote a report on the advantages and disadvantages of generic legislation for new psychoactive substances (Van Amsterdam 2012). It concludes that based on a common chemical structure, the generic approach of new psychoactive drugs seems not feasible, because hundreds of compounds (analogues) will be forbidden. New psychoactive substances, not covered by the generic legislation, will still be developed and introduced to the market. The Ministers of Security and Justice and Health, Welfare and Sport agree with this conclusion (TK24077-288). No generic legislation for psychoactive substances will be initiated in the Netherlands.

In July 2011, a bill to add a new article to the Opium Act was published, including the advice of the Council of State (Stc. 2011-13125; TK 32842-2 and 3). The new article aims at penalization of preparative and facilitating activities for illegal professional large-scale cultivation of cannabis. The *grow shops* are an example of such facilitators of illegal professional and large-scale cannabis cultivation. Until now it was difficult to prosecute these preparatory acts if a connection with criminal organisation could not be proved. From the moment this article comes into force the municipalities are obliged to withdraw the licenses of the grow shops. The discussion in the House of Representatives revealed that many Members of Parliament (MPs) had critical questions concerning the practical consequences of this bill. A key problem is that many products sold by grow shops are normal products which are also sold at garden centres and other 'normal' shops. MP's worry about the responsibilities of personnel of 'normal' shops when they sell materials that could be used for cannabis cultivation. The bill is not in force yet. It was estimated that there were about 275 grow shops in the Netherlands in 2009 (Driessen 2009), but their number may have decreased in the past years.

#### *Other new legislative initiatives in relation to drug law offences and substance use*

The BIBOB Act (*Public Administration Probity Screening Act*) gives local authorities the power to screen certain new applications for permits, operating licenses, tenders or subsidies, in order to prevent them from unwittingly facilitating organized crime. A bill to enlarge the scope of this Act, to improve the information position of the administrative

bodies, to improve the legal protection of the screened persons and to extend the advice period was sent to Parliament in March 2011. On 20 March 2012 the bill was passed in the House of Representatives. In July 2012 the bill was discussed in the Senate. The most important change will be that also the real estate sector, the branches of games of chance and head shops, and firework importers will be brought under the scope of the BIBOB Act. It is still not clear when this new act, the Evaluation and Extension Act BIBOB, will be in force (TK 32676-3).

According to a European study, the prevalence in the Netherlands of the use of alcohol by car drivers is 2.2%, compared to 3.5% average in Europe. The use of cannabis by car drivers (1.7%) is above the European average of 1.3% (SWOV factsheet 2011). According to the Road Traffic Act it is forbidden to drive under the influence of a (illegal) substance affecting one's driving ability. The Ministers of Security and Justice and Transport are preparing a bill to change this Act in order to be better able to detect these drivers. Part of the bill is to give police investigators the authority to use an oral fluid screener as pre-selection method to detect drug use of traffic participants. The legal evidence will remain a blood test. The use of GHB is only detectable with a blood test. Like with driving under the influence of alcohol, threshold values will be defined for driving under the influence of drugs (e.g. 50 microgram per litre for amphetamine and cocaine and 3 microgram per litre for THC). A special commission has proposed limiting blood values per drug in accordance with international practices. Because some substances are occurring in the body and measuring instruments are not sensitive enough, zero limits are not feasible. The present bill uses behaviour-related limits, meaning that a limit is set above which driving skills are affected. There are fewer traffic casualties due to the use of drugs and medicines than to alcohol consumption (T.K. 29398-236; T.K. 32859-3; TK32859-7).

A bill to change the Code of Criminal Procedure was sent to Parliament on August 17 2012. The change aims at pushing back the acts of violence under the influence of substances and would, if accepted, give a legal basis for the police to force violent offenders to a check up with an alcohol and/or drug test. In this way the use of substances could be proved. Committing an act of violence under the influence of substances could raise the sentence.<sup>1</sup>

For more information about the content and impact of these laws and regulations: see our previous National Reports.

### *Forensic Care*

The Forensic Care Act, which creates a new system of forensic care, is not implemented yet. It is the intention of the government to implement this Act in 2013. The Act creates a new system of Forensic Care. On request of the government several agencies, amongst which the Council for Public Health and Care, wrote an advice on how to implement these two Acts successfully. Because the core of the new system is to strengthen the connection between the judicial system, forensic care and the regular mental health care, both the Minister of Security and Justice and the Minister of Health, Welfare and Sport should propagate the same vision on the *care* for persons with a severe mental illness who are also offenders (RVZ 2012).

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<sup>1</sup><http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2012/08/17/wetsvoorstel-memorie-van-toelichting-terugdringen-geweld-onder-invloed-van-middelen.html>.

### *Medicinal cannabis*

The Bureau Medicinal Cannabis (BMC) only delivers the raw material, there is still no official “cannabis medication” produced and registered by a pharmaceutical company. The BMC could be exploited cost-effective in 2010. In 2010, 102 kilograms of medicinal cannabis were delivered to pharmacies and it is estimated that about 558 patients were using it with an average of 0.5 gram per day per each person. Some Dutch health insurance companies reimburse medicinal cannabis in certain circumstances (TK Aanhangsel-2461). According to the Dutch Foundation for Pharmaceutical Statistics was medicinal cannabis in 2010 6,700 times supplied to 1,300 different patients. Every year there is an increase of about 10 per cent.<sup>2</sup>

### *Institution for Prolific Offenders (ISD)*

In 2004, the act ‘Placement in an Institution for Prolific Offenders (Plaatsing in een inrichting voor stelselmatige daders – ISD)’ came into effect (Stb 2004-351) (see also § 9.3). This act refers to all prolific offenders, not only addicts. One can be confined to ISD for at most two years. The primary objective of the ISD Order is to reduce the public nuisance caused by extremely persistent offenders. Another objective is to reduce recidivism by offering treatment and rehabilitation. In order to investigate the effects of the ISD a (retrospective) quasi-experimental research was set up: for four years 554 offenders with an ISD Order were compared with a comparable group of prolific offenders without an ISD Order. Although the recidivism of the ISD-group was very high (72%), it was less high than the recidivism of the control group with regular detention (recidivism rate between 84% and 88%). Just by the fact that they were locked-up for two years about 9 offences each year per ISD-offender were prevented (Tollenaar and Van der Laan 2012). For more detailed information on this subject: see § 9.3.

### *Medical heroin prescription*

In 2012 there are still 740 treatment places for medical heroin prescription operational at 18 units in 16 different municipalities (Regulation Heroin Treatment). Since 15 October 2009 heroin (diamorphine) can be prescribed by physicians working at municipal treatment units for treatment resistant heroin addicts to addicts who are registered at that units. For this reason the Opium Act Decision was complemented with Appendix 2 (Stb 2009-348). Medical heroin prescription is legal on the condition that strict requirements are met. A 4-year follow-up study concluded that the physical and psychological condition of the patients who received heroin treatment was far better and they caused much less public nuisance than the heroin users who withdrew from the treatment (Blanken et al. 2010).

### *Implementation of Laws*

#### *Opium Act Directive in cases of cannabis cultivation*

In June 2011, the Opium Act Directive of the Public Prosecution Office was updated (Stc. 2011-11134). The basic principle of a differentiation between drugs with unacceptable risks and other drugs (listed on schedule I and II, respectively) is still the cornerstone of the Opium Act. One important change is the definition of professional cultivation of cannabis and the rules for prosecution in cases where there are no more than five plants. Until June 2011, if people were caught with five or fewer plants, the Directive ordered that the case should be

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<sup>2</sup><http://www.sfk.nl/nieuws-publicaties/PW/2011/2011-20.html>.

dismissed. The Directive of June 2011 states that when the police detects places where people are cultivating cannabis, the most important criterion to prosecute will be the degree of professionalism according to a checklist which is part of the Directive, and not the number of plants.

#### *Opium Act Directive in cases of stock of coffee shops*

In April 2012, the Court of Zwolle judged that the Public Prosecutor is inadmissible in the case against the owners of the coffee shop Koffie & Dromen (the so-called Blowboot) in the town of Almere. This case was defended by a well-known Dutch criminal lawyer. One of the criteria of the Opium Act Directive by which the selling of cannabis in coffee shops is tolerated, is that at most 500 grams may be in stock (at the coffee shop venue). At two occasions in 2008 and 2009 the police found tens of kilos of marijuana at venues outside the coffee shop, but owned by one of the owners. This was about the stock for one week. According to the Court, the Public Prosecutor should not have prosecuted the owners, because it was known to them (and to the police and the mayor) –and already tolerated for more than ten years- that the coffee shop has between 800 and 1000 costumers each day and they cannot be served with a stock of 500 grams. It was never told to the owners nor by the mayor, the police or the Public Prosecutor that it should not be tolerated to have stashes outside the coffee shop (rechtspraak.nl: BW0879; Spong 2012).

In an appeal case about the closure of the biggest coffee shop of the Netherlands in 2008, Checkpoint in Terneuzen, the Public Prosecutor was also declared inadmissible on 2 February 2012. The judges of the Court of The Hague find that the mayor and the Public Prosecutor had in fact tolerated the supplying of the coffee shops for years. So, the owner and its employees had reasons to trust the authorities that they should not prosecute them (rechtspraak.nl: BV2572). The Public Prosecutor appealed to the court of cassation. In a similar case, the Court of Middelburg declared on 5 June 2012 the Public Prosecutor inadmissible. The judges accuse the authorities of an arbitrary-like legal insecurity, because the stocks of the coffee shop in the town of Goes were confiscated without any warning, although the coffee shop was tolerated for years (rechtspraak.nl: BW7416).

#### *Public Administration Probity Screening Act (Wet BIBOB) (see also chapter 9)*

The scope of the BIBOB Act relates to: 1. The licensing system under the Licensing and Catering Act; 2. Environmental licenses and building permits; 3. Operating licenses for among others hotel and catering establishments, including coffee shops, sex establishments, smart shops and grow shops; 4. Licenses for persons and goods transports by road, opium exemptions, and licenses for the sale of real estate by housing associations. In the near future the scope of this act will be enlarged. The actual screening is conducted by a special central BIBOB-office. This office has access to secured sources such as the police files and the Tax and Customs Administration. The central BIBOB-office cooperates closely with the Regional Centres for Information and Expertise (RIEC's). The BIBOB office not only inspects the antecedents of the applicant, but also checks his or her immediate environment. This may result in a recommendation about the degree of risk. Dutch administrative authorities may refuse contracts, subsidies or permits for organisations and companies if they have serious doubts about the integrity of the applicant. In 2011 the BIBOB-office received an order of the Minister of Security and Justice to carry out a national screening of coffee shops (Bureau BIBOB 2012; EK 32676-C herdruk). See also Chapter 9.

#### *Combating organised crime in the Netherlands*

In line with the BIBOB Act is the Administrative Approach to Organized Crime program which started in 2007 as part of the comprehensive policy to combat organized crime. It is complementary to the criminal justice-based approach, and aims to prevent criminals being facilitated by the government, to prevent intermingling between the underworld and the normal society, and to break up the economic positions of power that are established with capital derived from criminal activities (Olsthoorn and Van Hees 2011). The instruments applied by the administrative approach are monitoring and control, screening, information exchange, policy with regard to the granting and withdrawal of permits, registration mechanisms and measures aimed at guaranteeing government integrity. With the administrative approach the local authorities are supported by the 10 Regional Centres for Information and Expertise (RIEC's). The RIEC's do not only support the administrative approach but also actively facilitate the combat of organized crime by exchanging criminal, administrative and tax information and by advising the authorities on possible interventions. At the end of 2012 94% of the municipalities participated in a RIEC (Nieuwenhuis 2012, see also [www.riecnet.nl](http://www.riecnet.nl)).

In 2011 the Netherlands' National Centre for Information and Expertise (LIEC) was founded. One of the core targets of the RIEC's is aimed at organized cannabis cultivation. According to minister of Security and Justice the RIEC's are important in combating organised crime because they augmented the awareness and expertise of it at the municipal level (TK 29911-60).

The Public Prosecutor of the region of Den Bosch started in 2010 a pilot in which more severe sentences were demanded for exploiting a *dangerous* illegal cannabis nursery. Many cannabis nurseries in private homes endanger the neighbours because they create fire hazard as a consequence of unprofessional installation of electricity. Besides a sentence for cultivating cannabis, six to fifteen more years in prison are demanded (Dubveld 2011).

In July 2008 the ministers of Security and Justice and Home Affairs installed the national Taskforce Organized Cannabis Cultivation. The Taskforce aims to contribute to a visible reduction of large scale cannabis cultivation in the Netherlands. Within the Taskforce there is a specific focus on investigations of criminal networks behind cannabis cultivation, the export of cannabis and facilitators.

In the southern region of Brabant, the Taskforce Approach Organized Crime Brabant (Taskforce B5) was installed in December 2010 to intensify the cooperation between the five largest municipalities in Brabant, the regional police forces, the Public Prosecutor, the tax authorities and the Royal Netherlands Marechaussee to combat organized crime. One of the main targets of the TaskForce is rounding up the criminal cannabis gangs and confiscating criminal proceeds. In December 2012, eleven groups engaged with organized crime in Brabant were tackled and 32 million euro was confiscated. The criminal structures behind the cannabis cultivation are investigated (TK 29911-60).

Central elements in the approach against organised crime are the 'barrier' model and the confiscation of criminal proceeds (TK 29 911-68 and 69, 2012; Inspectie, 2012). See Chapter 9.

The priorities in tackling organized crime are drug-related criminality, money laundering and human trafficking. The aim is that in 2014 the number of criminal organisations tackled by criminal law must be doubled and that 160 million euro's will be confiscated (TK 29911-60). The cooperation between the authorities involved will be further strengthened.

On 18 July 2012 the Minister of Security and Justice reported to Parliament that in 2010 160 million euro's of criminal proceeds were confiscated by using criminal law. Compared to 2009, the number of criminal groups tackled has risen with 20 per cent (TK 29911-70). This is in line with the conclusions of the first evaluation of the recent emphasis on the implementation of structural and comprehensive financial-economic investigations by the Dutch police. However, not all the targets have been realized (TK 29911-68).

'Ndrangheta' (Italian mafia) is involved in several criminal activities in the Netherlands, amongst which drug trafficking, according to an explorative study of the Netherlands Police Agency (KLPD 2011; TK 29911-61). There is not much knowledge about this specific organization yet, but organized crime is a priority area already for the Netherlands Police Agency. A multidisciplinary expert group was installed to collect all the available information (T.K. 2911-70).

In the Netherlands, an increased number of Vietnamese suspects have been found in cannabis nurseries in recent years. Because the police is interested in the nature and development of the Vietnamese involvement in Dutch cannabis cultivation, a research bureau was asked to investigate this issue (Schoenmakers et al. 2012). In 2011 there were about 20,000 Vietnamese migrants in the Netherland, who form a relatively closed community. The Vietnamese criminal groups in the Netherlands are essentially mono-ethnic. Where cultivation necessities and the sale and distribution of cannabis are concerned there is cooperation with people of different descent. For more information on policies concerning combating organised crime: see our former National Reports and in this report chapter 9.

#### *Intensified actions against ecstasy*

Organised crime with regards to synthetic drugs was a priority area for the police and the Public Prosecutor for 2008-2012 (T.K. 29911-17).

In March 2012 the National Crime Squad published its quadrennial analysis of the criminal developments concerning synthetic drugs in the Netherlands. For the reported trends see Chapter 10.

#### *Combating cocaine trafficking at Schiphol Airport* N.N.I.A.

#### *Local coffee shop policies (see also chapter 12)*

At the end of 2011 there were 651 coffee shops in the Netherlands in 104 of the 418 municipalities. That is a decrease of 2.3% compared to 2009 (666 coffee shops). As in the previous years, concentrations of coffee shops are mainly found in the western part of the Netherlands and in the medium-sized cities in the provinces. Of the coffee shop municipalities 83 per cent has a distance or proximity criterion to schools in 2011. According to civil servants, no violations of the AHOJ-G criteria were recorded in 71 per cent of the municipalities with coffee shops. A total of 51 violations were identified leading to the closure of 30 coffee shops of which 15 for a specific time and 15 for an indefinite period of time (Bieleman et al. 2012). See also Chapter 10.

By order of the municipality of Rotterdam Bureau Intraval investigated the nature and size of the visits to coffee shops in Rotterdam in spring 2012. At the moment there are 43 coffee shops ('cannabis cafes') in Rotterdam, which are daily visited by between 22,600 and 25,500 different persons. Of the visitors 82 per cent lives in the city of Rotterdam. The most important reasons to visit a specific coffee shop is the small distance to the home of the

visitor, and the quality of the marijuana or hash. About half of the coffee shop visitors in Rotterdam, who are Dutch residents, indicate that they will not register for an cannabis pass when that will be obliged (Nijkamp 2012).

In the city of Venlo (province of Limburg), on the Dutch-German border, the *Hektor Project* to combat drug-related crime and nuisance at the local level, started in 2001 and was extended several times, first by a combined contribution of the central and municipal government, but since 2010 *Hektor* is only financed by the local government. Its purpose was to diminish public nuisance mostly caused by German drug tourists. The project operated on three levels. One level aimed at diminishing public nuisance by tracking down and closing non-tolerated points of sale (administrative enforcement) and step up action against drug-related crime. The second level had to do with the redevelopment of parts of the city centre to make it more attractive to new investment. The third level of the project concentrated on redefining the local coffee shop policy. In 2007 three illegal drug trade venues were closed. The experienced drug related nuisance diminished significantly in the centre of the town since two coffee shops were relocated in 2005. Because the illegal drug trade shifted to other parts of the town, it was decided in 2007 to extend the *Hektor*-approach to all parts of the town of Venlo. The municipal authorities, the police, the Public Prosecution Service and the Tax and Customs are cooperating to tackle illegal drug trade and public nuisance caused by drug tourists. According to the third evaluation of the *Hektor* project, which was carried out before the introduction of new Dutch coffee shop policy, it is possible to diminish illegal street trade and drug related public nuisance in a Dutch border town by the approach chosen in *Hektor* (Snippe 2012).

Another project to combat drug related nuisance, which started as a pilot project but was continued since 2003, is the Courage Project of the municipalities of Roosendaal and Bergen op Zoom near the border with Belgium in the province of North Brabant. One of the results of this project was that the mayors of both municipalities decided in September 2009 to close down the four tolerated coffee shops. However, the Courage Project was continued among others with a monitor called the *Drugsscan*, in order to follow the developments. Since the closure of the coffee shops 95 per cent of the drug tourists disappeared from the street scene. The Courage Team shifted the emphasis from drug related public nuisance to investigating drug related criminality. In 2011 narcotics for the amount of 7 million euro were confiscated and dispossessions for the amount of 600,000 euro were collected (Courage 2012; [www.courage.nu](http://www.courage.nu)).

#### *Other drug related societal questions*

The Rutte government decided for a fundamental reorganization of the Dutch police. In 2013 one National Dutch Police organization will be realized, centrally managed by the Chief Constable. The operational strengths of the police force of 49.500 fte will be divided between 10 regional units, 43 districts and 1687 basic units. Locally, the influence of the mayor and the Public Prosecutor will not change, though it is not unthinkable that the influence of the Minister of Security and Justice and the (new) police chiefs of the regional units will be become greater in the new National Police Organization.<sup>3</sup>

One of the items of the yearly Integral Security Monitor of Statistics Netherlands is to measure the experienced drug related nuisance. In 2011 only 5 per cent of the respondents reported drug related nuisance, that is about the same as in the previous years. Most

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<sup>3</sup><http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2012/06/27/samenvatting-concept-inrichtingsplan-nationale-politie.html>.



nuisance in the neighbourhoods is reported for hanging around kids (CBS 2011 and 2012). See also Chapter 9.

Safety houses are networks of local organisations working together to reduce crime. Criminal Justice Organisations cooperate with municipalities, the social sector and care organisations to better combine and integrate penal and rehabilitative interventions for offenders. Most of the time the Safety House is also a physical office location. The operational goal is to create more alignment and unity in the approach towards different groups of offenders. Safety houses organize regular case meetings around individual offenders (or specific local safety themes). The first Safety houses started in 2005. Since 2009 there is a nationwide network of regionally operating Safety houses in the Netherlands (Rovers 2011). In 2012 there are 41 Safety houses operative. The Minister of Security and Justice strives to limit the number of Safety houses to 25, namely for each safety region one. Other new aims of the Safety Houses are: they should limit to cases of severe nuisance and repeated offenders, and they should work more multidisciplinary (TK 28684-355). See also Chapter 9.

Many public service professionals, such as policemen, door men, ambulance staff and supervisors, encounter substance related nuisance, aggression and violence, especially in night life settings. It was investigated what the most effective ways are for them to prevent, reduce or end this kind of behaviour (Ferwerda 2012). The way a substance related violent incident evolves depends on the type of substance that was used. People under the influence of stimulants react more explosive than people who have used sedatives. The best way to handle these situations is only common knowledge for a small part of health professionals. Violent incidents develop through one of two tracks. The first track refers to a course in which aggression and violence occur seemingly spontaneously. The second, and much more common, track, refers to a course in which some sort of trigger can be identified. A violent situation is the result of all specific factors involved, relating to the drug someone took, the setting someone is in, and the characteristics of the individual. Some of the suggestions to tackle substance related violence are: 1. Dissemination of knowledge on substance's effects, on identification of substance use and on handling intoxicated people; 2. Implementation of knowledge within existing education; 3. Registration of substance use involved in violent crimes.

## **1.2 National action plan, strategy, evaluation and coordination**

### *1.2.1 National Drug Strategy*

In May 2011, the government announced its objectives for the near future in a special drugs policy letter (T.K. 24077-259). The following advices of the *Advisory Committee on Drugs Policy* from 2009 were endorsed (Adviescommissie Drugsbeleid 2009):

- Use of drugs and alcohol by minors must be tackled far more rigorously.
- Coffee shops need to return to their original purpose: small scale points of sale for adult local users
- Reinforcing the combat against organized crime.

The agreements on a new drug policy of the Coalition Agreement of the Rutte I Administration were specified in a policy letter. Most of the measures were concerned with cannabis.

1. The government intends to make coffee shops closed clubs only accessible for adult Dutch residents with a special club card. Every coffee shop will have a maximum number of members which will be determined by the mayors.
2. The government intends to bar non-residents from the Dutch coffee shops.
3. The use of drugs will be discouraged on schools (T.K. 24077-259).
4. The government will propose a bill to compel schools to register safety incidents, including incidents with drugs.
5. The Public Administration Probity Screening Act (Wet BIBOB) will be used more intensely to screen owners of coffee shops in order to detect connections with criminal organisations.
6. The new Opium Act Directive and a new article 11a of the Opium Act are proclaimed (see § 1.1)
7. Combating organized crime will be intensified: the proportion of criminal organisations against which judicial proceedings will start after investigation shall double from 20 per cent to 40 per cent in 2014. An integrated approach against organised cannabis cultivation is prioritized in Central-Brabant, Amsterdam and Maastricht.
8. The prevention policy of this government will target early detection and treatment of problematic behaviour of young people, including substance use
9. In the field of addiction care the new government will give more emphasis to e-health interventions, to more coherence in the approach of multi problem addicts and to the aftercare and reintegration of addicts finished with treatment (T.K. 24077-259).

### *1.2.2 Major Drug Debate in House of Representatives*

On 1 and 28 March 2012, for the first time in four years, a major drug debate between the MP-spokespersons of the political parties and the Minister of Security and Justice, and the Minister of Health, Welfare and Sport took place in the House of Representatives (TK Handelingen 2011-2012, 58 & 69). Key subjects were the new drug policy plans of the government. In this paragraph we will describe some of the themes discussed in Parliament, the measures promised by the Ministers and some actions taken afterwards. Developments relating to the (new) coffee shop policy are described separately in § 1.2.3.

The Minister of Health stated that the Dutch drug policy is based on two pillars: to protect the public health of the people and to protect the people against public nuisance and criminality (TK Handelingen 2011-2012, 69, p.59).

The statement made by the Taskforce Organised Cannabis Cultivation in 2008 that 80% of the cannabis cultivated in the Netherlands is exported, was questioned by a MP, because in the crime analysis the estimates varied between 15% and 74%. The Minister declared that the figure of 80% is based on an educated guess, and that more specific information will be sent to Parliament.

Another assumption of the police and the Public Prosecutor, namely that the cannabis cultivation in the Netherlands is almost completely run by organised crime, was questioned by a MP with reference to a report of the Tilburg University of arrested home growers of cannabis (Siesling et al. 2011). The key question of this investigation was to explore how many arrested home growers were forced to cultivate cannabis. A total of 295

criminal files were studied, and 8 suspects and 7 experts (i.e. lawyer; public prosecutor) were interviewed. No evidence was found that the arrested home growers were forced to start a cannabis nursery. However, from the files it became clear that in the cases involved the police closed the investigations after dismantling the nurseries, without further investigating the possibility of the involvement of a criminal organisation. The Taskforce Approach Organized Crime Brabant –installed in December 2010- is one of the instruments by which the assumed organised crime behind the home growers is investigated more thoroughly. The Minister emphasized that from the fact that the home growers themselves did not declare to have ties with organised crime it cannot be concluded that the cannabis cultivation is not run by criminal gangs (TK Handelingen 2011-2012 69 p. 42).

The Minister announced that the Public Prosecutor has chosen to approach the so-called drug runners supra-regionally. Although the public nuisance caused by the drug runners is the largest in the city of Maastricht, the court of Maastricht works closely together with the courts of Rotterdam, The Hague and Utrecht (TK Handelingen 2011-2012 69 p.56.). A recent study on the drug runners in Southern Limburg sheds some light on the background of this phenomenon (Van Wijk and Bremmers 2011). A drug runner tries to contact or to recruit foreign drug tourists (mostly from Belgium and France), to direct them to venues where all kinds of illegal drugs are sold. They jeopardize the traffic safety very often and the drug venues they bring their clients to cause much public nuisance. The dealers and runners adapt very quickly to changing circumstances. Many drug runners started to operate in Maastricht since about 2000, because of the repressive approach of the police of Rotterdam, which made it difficult for foreigners to buy illegal drugs in Rotterdam. Most drug runners are young Moroccans from disadvantaged neighbourhoods in Rotterdam, Utrecht or Gouda.

The Minister of Health, Welfare and Sport stated that from the perspective of the protection of the public health the Dutch drug policy has been quite successful. The key issues of the public health aspects of the Dutch drug policy are:

- a. because one of the precursors of GHB –GBL- is much used for industrial purposes, the Minister declared that it is not easy to place GBL on Schedule I of the Opium Act. However, the trade in GBL can be monitored using the Abuse of Chemical Substances Prevention Act;
- b. certain vulnerable groups of young people (such as truants, youngsters in youth care, school drop outs) use cannabis and other substances significantly more often than the average adolescent; targeted prevention to prevent or diminish cannabis use and to augment the resilience of these vulnerable groups is one of the priorities of the Minister of Health; prevention campaigns will use social media to reach the target groups;
- c. projects developing supporting tools for parents to better handle substance use of their children are also financially supported by the Ministry of Health;
- d. the possession of alcohol for adolescents younger than 16 year was made liable to punishment;
- e. the school-based drug prevention programme 'The Healthy School and Drugs' covers 30 per cent of primary educational schools, 70 per cent of secondary educational schools and 50 per cent of intermediate vocational educational schools and is supported by the Ministry of Health;
- f. in 2012 the Minister of Health introduced the rule that everybody using mental health or addiction care facilities is obliged to pay an own contribution of 200 euro

each year, the consequences of this new rule will be monitored; an exception is made for youngster under 18 year, crisis and outreaching care and compulsory admissions. In her reaction to the wish of some MP's to make drugs and alcohol testing compulsory in the working environment, the Minister declared that it is not possible to make drugs and alcohol testing generally compulsory on the work floor, because of the European Convention on Human Rights and the Constitution of the Netherlands; only in certain professions –such as pilots and bus drivers- employers have the right to take drugs and alcohol tests;

- g. the Minister announced that she is preparing a bill making schools legally bound to register all incidents at schools, drugs incidents included, in order to improve the safety at schools;
- h. in the course of 2012 the Minister will take a position on the reimbursement of e-health care in an e-health policy paper (TK Handelingen 2011-2012 69).

### 1.2.3 *The new coffee shop policy*

- Coffee shop related nuisance, drug crimes, and drug tourism have been known issues for quite some time. The drug policy paper of 1995 already mentioned that coffee shops can cause problems and attract customers from neighbouring countries, particularly in border regions (T.K. 24077-3 1995; see also Van Laar and Van Ooyen 2009). The rules and regulations have gradually grown both more numerous and more strict since (Van Laar and Van Ooyen 2009). In 2010, ten municipalities conducted a pilot with the aim of reducing nuisance in relation to coffee shops (TK 24077-256 2010). A total of 3.3 million Euro was made available by the national government, whereas municipalities added also own finances.
- The 2010 coalition agreement 'Freedom and Responsibility' announced several changes to the Netherlands' national drug policy. The Dutch Cabinet led by Prime Minister Mark Rutte stated they intended to combat public nuisance and crime related to coffee shops and the illegal drug market by making coffee shops smaller and more manageable, and by reducing the appeal of the Dutch cannabis market to foreign drug tourists. These new measures were described, explained, and defended through several letters issued by the Dutch Ministry of Security and Justice and the Ministry of Health, Welfare and Sport.
- Of particular importance is the letter issued by the Ministry of Security and Justice and the Ministry of Health from May 27 2011 (T.K. 24077-259), as it introduced the new coffee shop policy:
  - Coffee shops were to become closed clubs, licensing only adult residents of the Netherlands, upon showing a valid coffee shop membership card (commonly known as the 'wietpas').
  - There would be a new minimum distance of at least 350 meters between secondary schools and schools for professional education and coffee shops
  - The Minister would strengthen national policy, and make sure that municipalities use the licenses issued to coffee shops as enforcement tools for the minimum distance criterion and other relevant aspects of the national drug policy. (However, a *national* distance criterion has been skipped in the Coalition Agreement from 29-10-2012 for the Rutte II Administration.)
  - The government would also propose harsher sanctions for the (preparation of) in- and export, growth, and (organised) buying and selling of drugs, and make adjustments to the official distinction between hard- and soft drugs.

- Subsequent letters in October and December 2011 (T.K. 24077, 265/267) further delineated the coffee shop policy. Coffee shops would become closed clubs (closed club criterion, 'B-criterion') where adult residents of the Netherlands would be allowed to purchase cannabis, but only after registering with the coffee shop. Registration would require presenting a valid Dutch ID as well as a recent extract from the Municipal Personal Records database as proof of residence in the Netherlands (the resident criterion, 'I-criterion'). Coffee shops would also become small-scale providers of cannabis by limiting the registrations to 2,000 members per coffee shop per year. The December letter (T.K. 24077-267) also revealed that the new policy would be implemented gradually.
- These two new (B&I) criteria were defined as criteria for non-prosecution in the Public Prosecutor's Directive (Directive Opium Act of the Public Prosecutor 2011A021 2012) January 1<sup>st</sup> 2012, as an addition to the previously formulated AHOJG criteria. The AHOJG criteria are: no advertisement (A), no hard drugs (H), no nuisance (O), no persons younger than 18 (J), and no selling of more than 5 grams of cannabis per customer per day, and having no more than 500 grams of cannabis in supply (G). From January 1<sup>st</sup> 2012, coffee shops would formally have to comply with the AHOJG + BI criteria to qualify for non-prosecution.
- As stated previously, the new coffee shop policy was to be implemented gradually. This entails that although the new rules went into effect January 1<sup>st</sup> 2012, they would not be enforced until later. The closed club (excluding the membership limit of 2,000) and the residence criterion have been enforced since May 1<sup>st</sup> 2012 in the southern provinces Limburg, North-Brabant, and Zeeland. The other provinces were to follow starting January 1<sup>st</sup> 2013, when these two criteria, including the membership limit of 2,000, would be enforced nationally. In November 2012, however, the Minister of Security and Justice announced that the closed-club criterion will be cancelled per January 1<sup>st</sup> 2013. The resident criterion will stay in force, but enforcement of the resident criterion will be implemented in practice by the local authorities, in phases if necessary, and fine tuned to local coffees shop and security strategies (T.K. 24077-293).
- The announced measure to implement a national distance criterion of 350 metres between coffee shops and secondary schools and schools for professional education was not mentioned any more in the Coalition Agreement of the new Cabinet Rutte II. In a letter to the Parliament of 19-11-2012 of the minister of Security and Justice announced that, because of the choice for a tailored local approach, the distance criterion of 350 metres will not be imposed by national rules – i.c. in the Directive of the Opium Act (T.K. 24077-293).
- Extra police capacity was made available by the Minister of Security and Justice in order to combat illegal drug dealing and to take care of a smooth introduction of the new rules.
- An intensive communication campaign in different languages was used ("New rules, no drugs" in English).
- The new coffee shop policy has not been without resistance. Newspapers and other media reported frequently about it and there were questions in the House of Representatives. Main issues were the protection of the privacy of coffee shop members, the responsibilities of municipalities and police in control and enforcement of the new criteria, and the lawfulness of the residence criterion.
- On April 18<sup>th</sup> 2012, the Dutch Data Protection Authority (*College Bescherming Persoonsgegevens*) stated in an advice that control of a schedule of coffee shop members with personal information by authorities is to be seen as interference in the

privacy of the members. Registration of the name, the date of birth, the residence, the date of registration and the expiry date, however, are not unusual for a closed club and can be registered and controlled. It is not necessary to retain the extract from the Municipal Personal Records database. The coffee shop owner is responsible for the correctness of the club member schedule and compliance to the rules.

- Coffee shop compliance with the new rules is assessed primarily by the municipalities; enforcement is primarily a task of the mayor. This was made clear in a letter of the Minister of Security and Justice to the mayors on the 20<sup>th</sup> of April 2012. If a coffee shop does not comply with the rules, sanctions can be applied ranging from a formal warning to permanent closure of the shop and revocation of the coffee shop owner's license. The enforcement protocol should be explicated in dialogue between the mayor, the Public Prosecutor and the local police.
- In subsequent letters to the House of Representatives in the period April-July 2012, the Minister of Security and Justice offered further explanations of the responsibilities and the ways of control of the new criteria (TK 25911-286, 287, 288, 289).
- In June 2012, a first overview of results and side-effects was provided by the Minister, based on the reports of local stakeholders (municipalities and police) (TK 29911-287). He stated that the introduction was running according to plan. There was a substantial decrease of the number of drug tourists. Illegal street dealing increased, but the situation was under control and the police was given it priority with the help of extra capacity. Displacement of coffee shop clients to other provinces was limited, according to the Minister.
- Two social scientists (Maalsté and Hebben 2012) conducted a 'quick scan' amongst coffee shop exploiters regarding the perceived effects of the new coffee shop criteria in the southern provinces of the Netherlands in the first months of implementation. The quick scan was carried out by means of telephone calls and written questionnaires. According to their respondents, Dutch residents don't want to register with a coffee shop due to privacy concerns. They fear their registration may be used against them if their information were to become publicly available. According to a number of coffee shop owners their former clients now purchase their cannabis in coffee shops further north, where they can still purchase cannabis without registering.

The implementation and effectiveness of the new criteria is monitored in evaluation research (TK 24077-289 2012, [www.wodc.nl](http://www.wodc.nl)). This study is ongoing. In the new Coalition Agreement of October 29<sup>th</sup> 2012, the closed club criterion is cancelled. The residence criterion is continued (VVD en PvdA 2012). This is confirmed in the letter of the Minister of Security and Justice to the House of Representatives of 19 November 2012 (TK 24077-293). The Minister decided this on the basis of experiences and advices of municipalities and police in the three southern provinces, who had been implementing both criteria between May 2012 and November 2012. The experiences showed that drug tourists stayed away from the Dutch coffee shops and the municipalities in border regions, but that coffee shop customers who are residents did not register as a member of coffee shops but bought on the illegal cannabis market instead.

- The new national distance criterion (a minimum distance of 350 meters between coffee shops and secondary schools or schools for secondary vocational training) which was intended to go into effect nationally January 1<sup>st</sup>, 2014 (T.K. 24077, 267), will not be implemented. A total of 164 coffee shops would have been affected by this criterion

(Bieleman et al. 2012). This criterion was not mentioned any more in the Coalition Agreement of the new Cabinet Rutte II of 29-10-2012. In a letter to the Parliament of 19-11-2012 of the minister of Security and Justice announced that, because of the choice for tailored local approaches, the distance criterion of 350 metres will not be imposed by national rules – i.c. in the Directive of the Opium Act (T.K. 24077-293).

- The minister of Security and Justice announced the intention to place cannabis with a THC-percentage of 15% or more on Schedule I (hard drugs) of the Opium Act (TK 24077-293).
- The Rutte II administration is against any regulation of the so-called 'back door' (supply of cannabis) and will continue to tolerate the sale of cannabis at allowed coffee shops.

### 1.3 Economic analysis

#### *Introduction*

This paragraph reviews the information that is available for the Netherlands about drug-related expenditures. No integrated studies have been conducted recently into drug-related public expenditures. A study into the criminal justice costs estimated that in 2006 the prevention of drug offences by the police and justice was publicly financed by about 114 million euro (Moolenaar 2009). And preliminary figures reported by Nauta, Moolenaar & van Tulder (2011) show that in 2009 expenditures for Opium Act offences are estimated at € 692,2 x million, of which the majority goes to hard drugs (€ 524,3 x million) (see § 9.1). Nonetheless, new (albeit fragmentary) information is available about the expenditures that are made by the regular institutes for addiction care, some private addiction clinics, and about some medical expenditures. The expenditures made by the regular and private institutes for addiction care refer to the annually self-reported expenditures. Note that these are not labeled beforehand and do not make a distinction between mental health problems and addiction problems, nor between the kinds of addiction problems. It will be shown that the increase in self-reported expenditures made by the regular institutes are larger than inflation and that the expenditures made by the private clinics are becoming substantial. Some people with drug abuse or drug addiction problems also consult a general practitioner or a psychologist-practitioner, but their number remains unknown. Consequently also the expenditures associated with this kind of care remain unknown.

#### *Expenditures on addiction care*

In the Netherlands, an institute for addiction care and/or mental health care is financed in a complex way by several sources. As a rule, regular institutes receive their funding from the Ministry of Health, Welfare, and Sport; the Ministry of Social Affairs and Employment; the Ministry of Security and Justice; the provinces; the municipalities; the health insurance companies; additional temporary funds; and some private funding.

Table 1.3.1 gives an overview of the expenditures of the institutes during the fiscal years 2010 and 2011. From this table it can be estimated that the annual expenditures of the main regular institutes for addiction care, together with the institutes for integrated addiction care and mental health care, in 2010 amounted to 1,545,241,886 euro, which increased with 4.4% to a total of 1,612,533,820 euro in 2011. Given a general inflation of 2.3% in 2011 ([www.cbs.nl](http://www.cbs.nl)), this implies a real net increase of the expenditures by 2%. Unfortunately, it is not directly clear which part of the amounts is spent on treating addiction, let alone drug addiction, and which amount is still missing from the non-merged mental health care.

With regard to the annual growth of the mental health care (including the addiction care), the Minister of Health, Welfare, and Sport in June 2012 signed an agreement with the mental health care that in 2013 and 2014 the annual growth will be reduced from 5% to 2.5% ([www.psy.nl](http://www.psy.nl), 18-06-2012).



Table 1.3.1: Expenditures in the fiscal years 2010 and 2011 by the 13 main regular institutes for addiction care and integrated mental health care and addiction care

Institute, Place of business	Domain of care	Fiscal year	
		2010	2011
1. Stichting Arkin, including Jellinek, Amsterdam	Addiction & mental health	213,664,000 EUR	228,476,000 EUR
2. Stichting Lievegoed Zorggroep, Bilthoven	Addiction & mental health	32,572,930 EUR	35,086,764 EUR
3. Stichting Bouman GGZ, Rotterdam	Addiction*	76,452,601 EUR	79,483,715 EUR
4. Parnassia Bavo Groep B.V., including Brijder Verslavingszorg B.V., The Hague	Addiction & mental health	537,540,545 EUR	549,110,707 EUR
5. Stichting Centrum Maliebaan, Utrecht	Addiction	37,499,550 EUR	39,014,317 EUR
6. Stichting Verslavingszorg Noord Nederland, Groningen	Addiction	61,119,414 EUR	66,616,773 EUR
7. Stichting Tactus Verslavingszorg, Deventer	Addiction	67,488,803 EUR	71,345,386 EUR
8. Stichting IrisZorg, Arnhem	Addiction & social relief	83,801,629 EUR	92,349,487 EUR
9. Stichting Emergis Centrum voor Geestelijke Gezondheidszorg, Goes	Addiction & mental health	87,370,000 EUR	89,911,000 EUR
10. Stichting De Hoop, Dordrecht	Addiction & mental health	30,661,327 EUR	33,459,858 EUR
11. Stichting Novadic-Kentron, Vught	Addiction	70,115,906 EUR	71,547,813 EUR
12. Vincent van Gogh voor Geestelijke Gezondheidszorg, Venray	Addiction & mental health	106,590,181 EUR	105,630,000 EUR
13. Stichting Mondriaan, Heerlen	Addiction & mental health	140,365,000 EUR	150,502,000 EUR
<b>Total</b>		<b>1,545,241,886 EUR</b>	<b>1,612,533,820 EUR</b>

\*Although *Bouman GGZ* offers mental health care as well as addiction care, its actual clients are still mainly addiction clients. Source: [www.jaarverslagenzorg.nl](http://www.jaarverslagenzorg.nl).

#### Costs of addiction care for people with drug problems

On the 5th of July 2012, the Minister of Health, Welfare, and Sport and the Minister of Security and Justice informed the House of Representatives about the total costs of drug addiction care, including the judicial addiction care. For 2011, these total costs were estimated at 226 million euro (in this estimate people with alcohol problems or other behavior with risks on addiction are excluded) (TK 24077-288).

*Private clinics*

Table 1.3.1 above does not yet include the expenditures made by *private* clinics for addiction care and/or mental health care. Some well-known private clinics in the Netherlands are Castle Craig Nederland B.V., CrisCare B.V., RoderSana Holding B.V., SolutionS Center, and U-center B.V. The total expenditures of these five clinics amounted to € 38,771,246 in 2011. The annual expenditures per clinic ranged from € 1,226,434 to € 15,381,728.

## **2 Drug use in the general population and specific targeted groups**

### **2.1 Introduction**

There are several sources to monitor substance among pupils (HBSC, ESPAD, Dutch School Surveys). In the current National Report, new findings from the Dutch School Survey in 2011 are reported. Data from the ESPAD study in 2011 will be described as well since the Dutch findings were not reported in the main report due to late data delivery, which was related to the integration of data collection for the National School Survey and ESPAD. Drug use in the general population is assessed in the National Prevalence Survey on substance use every four years since 1997. The last survey was carried out in 2009 and the data have been reported in the previous National Reports.

Moreover, in the current National Report findings will be described from a study employing an innovative method to assess drug use in the population by means of chemical analyses of waste water samples from sewage systems in several locations in the Netherlands. While this method will not contribute to our understanding of prevalence or individual consumption patterns, it may complement information on trends in the overall amount of drugs consumed within a certain geographical areas and time periods.

In previous reports, information has been included on drug use in a variety of targeted populations. In the current 2012 report, qualitative data will be described from the Amsterdam Antenna survey 2011 on trends in drug use among nightlifers and neighbourhood youth. Moreover, several qualitative and quantitative studies have been conducted to describe populations of GHB users and their consumption patterns and habits.

### **2.2 Drug use in the general population**

There are no new data on drug use in the general population (ST01). In the Netherlands trends in drug use in the general population are monitored every four years since 1997. The surveys showed that recent and current drug use remained overall stable between 1997 and 2005. Prevalence rates were overall higher in the 2009 survey. However, a change in data collection method in 2009 (shift from CAPI to CASI) precluded the determination of trends between 2005 and 2009.

#### *Illicit drug use measured through waste water analysis*

In the Netherlands, illicit drugs and drug metabolites were measured in 2010 in the waste water of the sewage systems of 4 major cities and the international airport of Amsterdam (Bijlsma et al. 2012). Wastewater analysis is a useful and intriguing technique to gain insight into the bulk drug consumption patterns in certain topographic regions which are covered by a wastewater plant. This revealed a diverse picture for the Netherlands in terms of drug use. Results are shown in table 2.1.1.

The samples from Amsterdam showed the highest mean concentrations in cocaine and cocaine metabolites. In fact, cocaine metabolites are the most direct indication of actual

cocaine consumption that can be measured. Cocaine itself could also be the result of a disposal at the toilet or the sewer. MDMA and THC concentrations (not in table) were also highest in the Amsterdam sewage system. These findings are in line with the fact that Amsterdam is an international capital with a great attraction to visitors, both nationally and internationally. The city is renowned for its nightlife, coffee shops and tolerance concerning drug use. In that sense it is not surprising that the city ranks number one in THC concentrations, even if compared to other major European capitals, like Paris or London (Thomas et al. 2012).

In contrast, amphetamine levels were many times higher in the sewage system of the Eindhoven municipality. This is possibly explained by the fact that in this region a lot of clandestine amphetamine production facilities are located (Bijlsma et al. 2012).

Unfortunately, this technique is not yet able to discriminate between amphetamine that has been passed through the body and amphetamine that ends up directly in the wastewater as result of production waste or illegal disposals.

Interestingly, samples from Schiphol airport were found positive for methamphetamine, whereas no methamphetamine was detected at all in any of the other Dutch cities. This might be related to international passengers travelling to or via this airport. There are no signs from any drug survey that methamphetamine is popular in the Netherlands, in contrast with other European cities, which was also confirmed when results were compared internationally (Thomas et al. 2012).

*Table 2.2.1: Mean concentrations of illicit substances in Dutch wastewater plants (adapted from Bijlsma et al. 2012)*

Substance	Utrecht	Eindhoven	Apeldoorn	Amsterdam	Schiphol airport
Concentration (ng/L)					
Amphetamine	98	682	89	88	81
Methamphetamine	<15*	<15*	<15*	<15*	17
MDMA	87	92	<12	140	58
Benzoylecgonine (cocaine metabolite)	1079	862	409	2306	1472
Cocaine	193	118	222	434	559

\*Detection limit

## 2.3 Drug use in the school and youth population

### *Drug use among pupils*

Since 1988, substance use is monitored every four years among pupils of primary education (7<sup>th</sup> and 8<sup>th</sup> grade) and all grades of 'mainstream' secondary education. The most recent survey was conducted in 2011. Among pupils from primary education, questions on illegal drug use were restricted to cannabis. Using a two stage random sampling procedure (schools and classes), data were collected and analyzed for a final net sample of 2,482s pupils of primary education and 7,772 pupils attending secondary education. Response rates of schools were lower compared to previous years (48% against 55%/57% in 2007),

which was mainly due to the fact that schools were (too) often asked to participate in research and because of lack of time. Response rates at the level of the pupils are always high (96% at primary education and 93% at secondary education). As in previous years, data were collected by written questionnaires, administered in the class-room. Period of data collection was October and November 2011.

- The results showed that primary-school children (7th and 8th grade) had little experience of cannabis. In 2011 only 0.3% of them had ever smoked a joint.
- Table 2.3.1 shows the trends in lifetime prevalence and table 2.3.2 the last month prevalence of drug use rates among pupils of secondary education of 12-18 years (see also ST02).
- The percentage of last month cannabis users declined gradually between 1996 and 2003, and remained stable in 2007 and 2011.
- Both lifetime and last month use was higher among boys than girls (lifetime 20.7% and 13.9%, respectively; last month: 10.5% and 4.8%, respectively). No differences were found between the various school levels.
- Almost half (51%) of the last month users smoked joints only one or two times (59% of the girls, 48% of the boys). Fifteen percent of the last month users had used cannabis more than times in the past month. The percentage is higher among boys than girls (18% and 8%, respectively).
- Overall, prevalence rates of the other drugs peaked in 1996, decreased afterwards and remained stable between 2007 and 2011. Lifetime use of ecstasy remained highest and use of heroin remained lowest over all years (2.6% and 0.6%, respectively in 2011).
- Note, however, that even a lifetime prevalence of heroin use as low as 0.6% seems to be questionable given the unpopularity of this substance, especially among young people.

*Table 2.3.1: Lifetime prevalence of drug use among pupils of secondary education (12-18 years)*

	1988	1992	1996	1999	2003	2007	2011
Cannabis	8.6%	15.2%	21.6%	19.5%	18.7%	16.7%	17.4%
Cocaine	1.2%	1.6%	3.0%	2.8%	2.2%	1.7%	1.7%
Ecstasy	n.a.	3.4%	5.8%	3.8%	2.9%	2.4%	2.6%
Amphetamine		2.2%	5.3%	2.8%	2.2%	1.9%	1.8%
Heroin	0.7%	0.7%	1.1%	0.8%	1.1%	0.8%	0.6%

Source: Dutch National School Survey (Verdurmen et al. 2012).

*Table 2.3.2: Last month prevalence of drug use among pupils of secondary education (12-18 years)*

	1988	1992	1996	1999	2003	2007	2011
Cannabis	3.7%	7.8%	11.1%	9.3%	8.6%	8.1%	7.7%
Cocaine	0.4%	0.4%	1.1%	1.2%	0.8%	0.8%	0.8%
Ecstasy		1.0%	2.3%	1.4%	1.2%	0.8%	0.9%
Amphetamine		0.6%	1.9%	1.1%	0.8%	0.8%	0.6%
Heroin	0.3%	0.2%	0.5%	0.4%	0.5%	0.4%	0.2%

Source: Dutch National School Survey (Verdurmen et al. 2012).

In 2011, the Netherlands also participated in the ESPAD survey. The net sample consisted of 138 schools, 220 classes and 2,044 pupils of 15 and 16 years. Table 2.3.3 shows that in this age group, lifetime cannabis use remained at the same level between 2003 and 2011. The prevalence of last month cannabis use (table 2.3.4) was about twice the (unweighted) European average (15% against 7%).

Lifetime use of any other drug (ecstasy, amphetamine, cocaine, heroin, GHB, crack, magic mushrooms) was 5%, which is slightly lower compared to the European average of 6%. After cannabis, ecstasy seemed to be the most common illegal drug. Lifetime use of cocaine decreased between 2003 and 2011. Use of amphetamine remained lowest in all these years.

*Table 2.3.3: Lifetime prevalence of drug use among pupils of 15 and 16 years of secondary schools in 2011*

	2003	2007	2011
Cannabis	28%	28%	27%
Cocaine	6%	4%	2%
Ecstasy	5%	4%	4%
Amphetamine	1%	2%	1%

Source: ESPAD (Monshouwer et al. 2012).

*Table 2.3.4: Use of cannabis among pupils of 15 and 16 years of secondary schools in 2011*

	2003	2007	2011
Last month use	13%	15%	14%
Use of cannabis 6 times or more in the past month	6%	6%	5%

Source: ESPAD (Monshouwer et al. 2012).

### *Secondary school pupils in Amsterdam*

Since 1993, the Amsterdam Antenna combines qualitative and quantitative research methods to monitor substance use among adolescents and young adults (Nabben, Benschop, and Korf 2012). In 2011, the quantitative survey of the Antenna focused on Amsterdam secondary school pupils.

In the autumn of 2011, a total of 840 pupils from 39 classes at 8 Amsterdam secondary schools completed the Antenna questionnaire. To enhance the representativeness of the survey, the data were weighted by school type, age, gender and ethnicity on the basis of population statistics. The vast majority of the adolescents questioned aged 12 to 17 years. Males and females were almost equally represented. Slightly more than one in three respondents (37%) had ethnic Dutch backgrounds, which was defined as having parents born both in the Netherlands.

In leisure time, the pupils mostly went shopping, to the cinema or to parties at the homes of friends. Half of the sample had gone out to a pub, club or event one or more times in the preceding month. One quarter had part-time jobs. Spending money averaged 10 Euros per week. Mobile phones occupied an even more pivotal place than in our last school survey in 2007: 90% reported using telephone, text, ping or other services, averaging about

four hours a day, as compared to three hours in 2007. More than half reported computer gaming, for a median duration of two hours a day. Only a few played poker for money (3%) or gambled on the Internet (1%).

For the different substances, table 2.3.5 gives the lifetime prevalences (LTP) and last month prevalences (LMP) for the first- and second-year pupils, the third-year pupils, and the older pupils.

*Table 2.3.5: Lifetime prevalences (LTP) and last-month prevalences (LMP) for secondary school pupils in Amsterdam in 2011 by substance and grade*

Substance	First- and second-year pupils		Third-year pupils		Older pupils	
	LTP	LMP	LTP	LMP	LTP	LMP
Ecstasy	0.8%	0%	1.5%	0.2%	6.0%	1.6%
Cocaine	0.3%	0%	0.9%	0.6%	1.5%	0.7%
Amphetamine	0.5%	0%	0.4%	0.4%	1.5%	1.3%
GHB	0%	0%	0%	0%	1.5%	0%
Ketamine	0.4%	0.3%	0.1%	0%	1.3%	1.0%
Laughing gas	3.4%	0.5%	5.6%	0.2%	8.3%	2.0%
Magic mushrooms	4.8%	1.7%	1.7%	0.6%	4.8%	0.7%
LSD	0.1%	0%	0.6%	0%	2.1%	0%
Heroin	0.1%	0%	0%	0%	0%	0%
Crack	0.5%	0.2%	0.5%	0.5%	1.1%	0.6%
Ritalin	2.6%	1.2%	2.7%	1.8%	5.8%	2.2%
Tranquillisers/hypnotics	6.6%	2.1%	10.1%	3.8%	8.7%	2.9%
Poppers	0.1%	0%	0.4%	0.3%	0.5%	0.4%

LTP = lifetime prevalence, LMP = last month prevalence. Source: Amsterdam Antenna, Bonger Institute of Criminology, University of Amsterdam (Nabben, Benschop, and Korf 2012).

It comes as no surprise that, in general, the prevalences increase by grade as the pupils grow older. With regard to the different substances, it is striking that laughing gas, Ritalin, and tranquillizers or hypnotics are even more popular than ecstasy. The lifetime use of laughing gas and of tranquillizers or hypnotics was higher among pupils with poorer mental health.

The authors of the Amsterdam Antenna stress that, during the past years, the use of drugs has *decreased* (Nabben, Benschop, and Korf 2012). Among first and second-year pupils, lifetime cannabis use declined from 7% in 2007 to 4% in 2011. Among the third-year pupils, the lifetime cannabis use decreased in this period from 20% to 18%. Moreover, lifetime ecstasy use decreased from 2.9% to 1.5%, lifetime cocaine use decreased from 2.2% to 0.9%, and lifetime amphetamine use decreased from 1.5% to 0.4%. However, among the third-year pupils, the ever use of Ritalin *increased* from 1.3% to 2.7%, and the ever use of tranquillizers or hypnotics *increased* from 6.6% to 10.1%.

## 2.4 Drug use among targeted groups

### *Nightlifers in Amsterdam*

The previous paragraph 2.3 already introduced the Amsterdam Antenna, which combines qualitative and quantitative research methods (Nabben, Benschop, and Korf 2012). The qualitative panel study of the Antenna focuses on nightlifers. In 2011, the panel observed the following with regard to the main drugs:

- For years now, the smoking of *cannabis* in clubs continues to decrease, partly as a consequence of the (tobacco) smoking ban. "It is now exceptional to see a joint smoked in a club, except on reggae nights." Nonetheless: "For many tourists, Amsterdam is still the cannabis Mecca.". Moreover, it was observed that "Smokers who preferred hashish to marihuana were apparently on the increase".
- In about half of the panel networks, *ecstasy* remains the most popular recreational drug. "There was a reported minor increase in ecstasy use in 2010 after the unstable period the previous year"
- The economic recession seems to have tempered the use of *cocaine*, but nevertheless, "cocaine is still a popular drug at home or on the go".
- The "revalorisation in recent years" of amphetamine has continued, and *methamphetamine* remains a marginal drug.
- After years of growth, the consumption of *GHB* has now levelled of. With regard to GHB "concerns are growing about frequent use and loss of consciousness" and "club staff now try to curtail its spread by carrying out more stringent entry searches".
- *Amphetamine, GHB*: "there are some nightlife scenes where either amphetamines or GHB is the second most popular drug", and "amphetamine is apparently undergoing a 'rehabilitation' at present, especially amongst young, educated partygoers", and "this 'speed renaissance' is in line with the expanding alternative partying culture that welcomes pep pills as protest drugs".
- *Mephedrone*: "... A stimulant that gained popularity in a few circles during the recent ecstasy market slump is said to be no match for ecstasy. Despite some positive reports about mephedrone, the negative experiences, such as heart palpitations, nervousness, headache and stiff jaws, seem to predominate".

### *Neighbourhood youth in Amsterdam*

Apart from the nightlifers, the qualitative panel study of the Amsterdam Antenna also monitors the neighbourhood youth. In 2011 it has been observed again that many neighbourhood youth from minority ethnic backgrounds, as part of a street culture, smoke cannabis daily.

### *GHB users*

Recent (pilot) studies into characteristics of GHB users have been conducted by the Trimbos Institute (Voorham and Buitenhuis 2012) and by the Addiction Research Institute Rotterdam (Hammink and Schrijvers 2012). To obtain a better picture of the different groups of GHB users, the Trimbos Institute interviewed 12 key informants from prevention departments and 24 users (Voorham and Buitenhuis 2012). From the 24 GHB users 4 were female and 20 were male, most of them aged 24 to 30 years and most of them were of Dutch origin. It was found that GHB use occurs in many different settings like at home, at after parties, in the gay scene, at mainstream parties, on the street, at drug parties, in pubs, and at hangouts at the



countryside. All in all, the researchers distinguish three groups of GHB users: the nightlifers, marginalized groups, and the at-home users. However, the key informants stressed that it is currently not known how many people use GHB and how many users have become addicted to it but are not seen yet at the addiction care.

Looking for measures to prevent GHB use, the Addiction Research Institute Rotterdam (IVO) carried out a qualitative study on the use of GHB among hang-around youth and at-home users (Hammink and Schrijvers 2012). Interviews were held with 10 key informants, 12 hang-around youngsters and 8 at-home users. The average age of the hang-around youngsters was 20 years, 75% of them were male, and most of them were lowly educated. The average age of the at-home users was 26 years, 50% was male, 63% had a full-time job, and 75% was educated at an average or high level. The at-home users were either recreational users or were addicted users.

With regard to appropriate prevention measures, the researchers conclude that a single prevention measure is not to be found, because even within a subgroup of GHB users there is so much diversity. Therefore, the development of selective prevention measures is needed. The hang-around youngsters will have to be targeted by outreaching prevention workers. The at-home users who use GHB on a daily basis will have to be reached by intensive prevention programmes, possibly by means of a community approach.

As a follow-up to their qualitative exploration (Voorham and Buitenhuis 2012), the Trimbos Institute conducted a web survey among GHB users in the spring of 2012 (Frijns et al. 2012). A non probability sample of 534 GHB users (inclusion criterion was the use of GHB at least once in the preceding 12 months) was recruited online through websites, social media pages and fora focusing on drug information and/or going out, and offline through the distribution of flyers at institutes of addiction care. In total, 406 (76%) male and 128 female participants with a mean age of 29 years completed a battery of questions on their GHB use. The majority of respondents (58%) had used GHB in the past month, but almost half (49%) indicated that they use GHB less than once a month. The remaining respondents used on one (9%) or 2-3 days a month (20%), on one (8%), 2-3 (6%), or 4-6 days a week (2%), or used daily (7%). The majority of respondents used only on weekends (73%) or more often on weekend days than on weekdays (15%). The mean number of doses taken on a typical use day was 2.9, and the average dose was 4.3 ml. The large majority of respondents (81%) were introduced to GHB by friends and, on average, respondents first used GHB when they were 24 years old.

Respondents obtained GHB by (a) getting it from someone else who either buys it (25%) or makes it themselves (20%), (b) buying it from a dealer (20%) or someone else who makes it themselves (17%), or (c) making it themselves (14%). A few respondents buy their GHB at either a smart shop (.6%) or through the internet (1%), or obtain it in various other ways (3%). Most mentioned places of use were respondents' own home (48%) or that of friends (41%), followed by places of entertainment including dance parties (26%), clubs (21%) and after parties (26%). Some respondents use alone (12%), but most prefer to use with others, predominantly with friends (67%) but also with their partner (21%).

Combined use of GHB with other substances was relatively high among this sample of GHB users. When asked whether they had ever combined GHB with other substances, 76% of the respondents indicated that they had. Most often mentioned combinations were GHB with ecstasy (49%), amphetamine (36%), alcohol (32%), cannabis (24%), cocaine (19%) and ketamine (11%).

## 3 Prevention

### 3.1 Introduction

The aims of the drug policy in the Netherlands are, on the one hand, to prevent drug use and, on the other hand, to reduce the risks faced by drug users and their environment. Within this Dutch drug policy, tolerance counts as a leading principle.

Prevention programs in the Netherlands are usually carried out in co-operation between the prevention departments of the institutes for addiction care and the public municipal health services, the schools, the neighborhood centers, the Dutch Centre for Crime Prevention & Safety (CCV), the Trimbos Institute, which is the Netherlands Institute of Mental Health and Addiction, and different other health promoting institutes.

The Ministry of Health, Welfare, and Sport (VWS) coordinates the prevention activities, which are part of a broader scope of public health prevention. The public health prevention targets the risk factors for public health and supports vulnerable groups that are at risk. According to the Public Health Act from 2008 (T.K. 31316-3), the Dutch municipalities are responsible for carrying out health prevention programs, for which they receive funding from the Ministry.

Eight health promotion institutes<sup>4</sup> co-operate within the framework of the National Consultation of Theme Institutes (Landelijk Overleg Thema-instituten, LOT-i). At the LOT-i, these eight health promotion institutes monitor and coordinate their activities. The respective institutes are national expertise centers that each target one of the following themes: smoking, sport and exercise, accidents and safety, food and overweight, alcohol and drug use, depression and mental problems, intercultural relations and ethnic minorities, hiv/aids and other STIs, and homosexuality and health.

The Ministry of Health, Welfare, and Sport (VWS) has asked the LOT-i for advice with regard to the new lifestyle policy for the period from 2012 up to including 2015. Giving its advice, the LOT-i has stated the following:

- The eight health promotion institutes are willing to intensify their co-operation.
- From the 11.4 million Euros, 7.1 million Euros should be reserved for improving the lifestyle and resilience of young people.
- Successful teaching programs must be offered in a common approach.
- Investments should be made in 'inspiring and teaching' in important key development areas where already much and diverse expertise exists like social media, the public-private co-operation, and there should be a focus on the responsibility of parents.

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<sup>4</sup>These eight institutes are: STIVORO, Veiligheid NL, RutgersWPF, SOAAIDS, Voedingscentrum, NIBS, Trimbos Institute, and Pharos.

In December 2011, the LOT-i published a memorandum entitled "Priorities in prevention 2011 -2015". The major advices given in this memorandum are the following:

- Enable citizens to make their own choices.
- Strengthen the integrated approach in the prevention chain as a whole.
- Apply effective interventions.
- Focus more on implementation instead of developing new interventions.
- Target the implementations especially on young people, people with disadvantaged backgrounds, and the elderly.

The Centre Healthy Living (Centrum Gezond Leven (CGL)) is a section of the National Institute for Public Health and the Environment (RIVM). The CGL reinforces coherent and effective local health promotion. Health benefits for citizens is the ultimate goal. For this the CGL supports local health professionals to promote healthy living. Through presenting interventions and sharing knowledge about quality and coherence, the CGL stimulates the use of the appropriate lifestyle interventions. The aforementioned eight health promotion institutes publish their lifestyle interventions on the website [www.loketgezondleven.nl](http://www.loketgezondleven.nl). The CGL maintains this website. On this website, municipalities, schools, and healthcare workers can find effective interventions and related information. The website offers guidelines, actual effective lifestyle interventions, and contains the themes "Healthy school", "Healthy neighborhood", and "Healthy work". The website is being updated continuously with new documents.

To support the municipalities in performing their task, a Guideline Healthy Municipality (Handreiking gezonde gemeente) has been published in 2010 by all relevant stakeholders.<sup>5</sup> This guideline targets the four-year policy cycle of a municipality. This cycle consist of four cornerstones: preparing, formulating, implementing, and evaluating. The guideline includes interventions, examples of best practices, checklists, and advices. The municipalities can apply the guideline to develop their own local health policy.

In the meantime, the Ministry of Health, Welfare, and Sport (VWS) has organized a seminar with the stakeholders to discuss how public health information should be communicated to the public. This has become an issue especially because an information overload threatens the target groups. During the general discussion at the seminar the participants welcomed the idea of a stronger and more prominent role of the central government in the provision of health information (Kooiker et al. 2012).

#### *New developments and trends regarding prevention policies and interventions*

In 2012, the policy measures were effectuated as announced in the two policy papers that were published in 2011: the drug policy letter ("Drugsbrief", T.K. 24077-259), and the broader public health approach ("Health Nearby", TK 32793-2). In "Health Nearby" three general health targets were prioritised, namely overweight, substance use, and risky sexual behaviours. In the drug policy letter, the impetus of the drug policy for the coming years was shifted towards stricter legal measures against cannabis-related crime and towards a stricter policy against nuisance associated with coffee shops (for more details: see chapter 1 and 9). Several measures have been announced (and partly implemented), but not all of them will be continued. In the new Coalition Agreement of October 29<sup>th</sup> 2012, the closed club criterion

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<sup>5</sup>These stakeholders are: STIVORO, Voedingscentrum, NISB, Trimbos Institute, Pharos, Rutgers WPF, Soa Aids Nederland, STAP, Voedsel- en Warenautoriteit (VWA), VeiligheidNL, and RIVM Centrum Gezond Leven (CGL).

was cancelled, but the residence criterion, aiming to restrict cannabis sale in coffee shops to residents only, is continued (VVD en PvdA 2012, Bruggen bouwen). The formerly announced distance criterion between coffee shops and schools – aiming to create a barrier for minors to use cannabis – has been abandoned in the Coalition Agreement from 29-10-2012 for the Rutte II Administration. A (tailored) distance criterion is left to the municipality and is not guaranteed in national rules.

## 3.2 Environmental prevention

### *Introduction*

The Dutch government aims to tackle alcohol abuse and tries to diminish the social and personal costs of alcohol abuse by informing the public about the dangers of alcohol. It is part of the policy to diminish alcohol abuse. The government especially tries to reduce harmful alcohol use by juveniles. The goals of the alcohol policy for juveniles are:

- juveniles don't start drinking before their sixteenth birthday,
- juveniles of sixteen years and older will drink less,
- fewer juveniles will become physically or mentally dependent on alcohol,
- the harmful effects of excessive alcohol consumption will be reduced (in the family, at work, in traffic and when going out).<sup>6</sup>

The government also carries out an anti-smoking policy. The goal of this policy is discouragement and the government aims to decrease the amount of smokers, to support people who want to stop smoking, to protect people against passive smoking, and to prevent juveniles from starting to smoke.

Measures for regulating tobacco use are given by the Tobacco Act. Some important themes are:

- Smoking is prohibited in government buildings, public buildings, hospitals, public transport, schools, cultural- and sport facilities, and in the hospitality industry (hotels, restaurants, cafés, discotheques etc.).
- Everybody can work in a smoke-free workspace.
- It is prohibited to sell tobacco to juveniles younger than 16 years.
- Smoking advertisements are prohibited.
- The Netherlands Food and Consumer Product Safety Authority (Nederlandse Voedsel en Waren Autoriteit, NVWA) can impose penalties on persons who violate the Tobacco Law.<sup>7</sup>

### *Alcohol policies*

In June 2012, a majority was emerging in the Dutch government for increasing the minimum age for selling alcohol to eighteen years. On the 29<sup>th</sup> of October 2012 this has also been included in the Government Agreement. In 2013 the minimum legal age for the provision of alcohol will be increased to 18 years. This will be accompanied by intensive education and adequate law enforcement.

At the moment, juveniles at the age of sixteen years and older are allowed to buy drinks with less than 15% alcohol, such as beer and wine. Juveniles of eighteen years or

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<sup>6</sup><http://www.rijksoverheid.nl/onderwerpen/alcohol/preventie-en-behandeling-alcoholverslaving>.

<sup>7</sup><http://www.rijksoverheid.nl/onderwerpen/roken/roken-ontmoedigen>.

older are allowed to buy liquor with 15% alcohol or more. For supermarkets, liquor shops, sports canteens, pubs and other entertainment facilities it is prohibited to sell alcohol to juveniles below this specified age limit. An initiative law is currently under preparation.<sup>8</sup>

In the meanwhile, some stakeholders have anticipated the forthcoming legislation. A supermarket in the municipality of Bemmelen, for example, has decided not to sell alcohol anymore to the youth of 16 and 17 years old (starting at the 1<sup>st</sup> of September 2012). A local supervisor of the Liquor and Hospitality industry Law reacted positively and hoped that other supermarkets would take the same measures.<sup>9</sup>

In the government there has been a discussion going on for almost nine years about the new Liquor and Hospitality Industry Law<sup>10</sup> (Drank- en Horecawet). As a result, this law will become operational on January 2013. According to the new law, children under the age of 16 years will be punishable if they possess alcohol, in the pub as well as in public places. Sellers of alcohol will face a so-called '3 strikes out measure'. This means that an alcohol selling point (temporarily) can be closed if the company is found to do banned sales three times in twelve months. For the hospitality industry and liquor stores the license may be suspended or revoked. Contrary to the previous law, the enforcement of the new law will be the responsibility of the municipalities.<sup>11</sup>

Until now the Netherlands Food and Consumer Product Safety Authority (NVWA) was enforcing the liquor law, but the possibilities for this authority to perform inspections were rather limited. Therefore, in August 2012, the Ministry of Health, Welfare, and Sport (VWS) and the Ministry of Security and Justice (VenJ) developed a new law, the "Instructions Liquor and Hospitality industry Law for municipalities" to support the law enforcement on a local level.<sup>12</sup> In 2013 the municipalities will be responsible for the enforcement.

In August 2012, the Minister of Security and Justice issued that suspects must be obliged to participate in alcohol or drug testing. According to the Minister, especially in case of violence in entertainment areas or in case of violence against care providers, drunkenness or drug use are often involved. When a suspect tests positive on alcohol or drug use, the Public Prosecutor may require a higher penalty. At the moment suspects often refuse to undergo these tests. Since 2011 the government has a law in preparation to oblige persons to cooperate with the testing on alcohol and drugs in case of violent crimes. The intention of this measurement is to aggravate the sanction in case of the use of alcohol and drugs in violent crimes. This law is expected to be operational in 2013.

The government wants to discourage the use of alcohol. That is why excise duties are imposed on beverages which contain alcohol as well as on intermediate products. These excises are reviewed in table 3.2.1. Excise duty increases are an instrument for discouraging the use of alcohol.

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<sup>8</sup><http://www.nu.nl/politiek/2848333/hogere-leeftijdsgrens-alcohol-lijkt-komst.html>,  
[http://www.eerstekamer.nl/wetsvoorstel/32022\\_terugdringen\\_alcoholgebruik](http://www.eerstekamer.nl/wetsvoorstel/32022_terugdringen_alcoholgebruik),  
[http://www.eerstekamer.nl/behandeling/20120626/brief\\_inzake\\_aangenomen\\_motie/info](http://www.eerstekamer.nl/behandeling/20120626/brief_inzake_aangenomen_motie/info).

<sup>9</sup><http://www.gelderlander.nl/voorpagina/betuwe/11597990/Onder-18-geen-alcohol-bij-Jumbo-in-Bemmel.ece>.

<sup>10</sup>The hospitality industry includes: hotels, restaurants, cafés, discotheques, etc.

<sup>11</sup><http://www.antwoordvoorbedrijven.nl/wetswijziging/wijziging-drank-horecawet>.

<sup>12</sup>[http://www.handhavingdhw.nl/sites/default/files/publication\\_attachments/Handreiking\\_0.pdf](http://www.handhavingdhw.nl/sites/default/files/publication_attachments/Handreiking_0.pdf).

Table 3.2.1: Excise duty imposed on beverages containing alcohol and on intermediate products, litres

Product	2012	2013
Beer	€ 0.245/€ 0.326 <sup>13</sup> (liter)	> 10% + € 0.03
Wine	€ 0.26 (<8,5 % alc.)	> 15% + € 0.08
	€ 0.53 (8,5 -15 % alc.)	
	€ 0.92 (> 15% alc.)	
Sparkling wine and champagne	€ 0.34 (<8,5% alc.)	>6% + € 0.32
	€ 1.80 (> 8,5 % alc.)	
Intermediate products	€ 0.65 (< 15 % alc.)	>6% + € 0.32
	€ 0.92 (> 15 % alc.)	
Sparkling intermediate products	€ 1.80	>6% + € 0.32

In January 2013 the alcohol the excise duty will increase with 10% for beer (0.01€ per bottle of 0.33 liter), with 15% for wine (0.08€ per bottle), and with 6% for other alcohol containing beverages (0.32€ per bottle liquor).<sup>14</sup>

On the 29<sup>th</sup> of October 2012, a next increase in the excise duties for alcohol (and tobacco) has been included in the Coalition Agreement. On 1 January 2014 the excise duties for beer and wine will increase with 14% and the excise duty for spirits will increase with 5%.

#### *Alcohol provision to the youth*

In April 2012, the Monitor alcohol provision youth 2011 was published by Intraval commissioned by the Netherlands Food and Consumer Product Safety Authority (NVWA) and the Ministry of Health, Welfare and Sport (VWS). Every two years more than 3,000 juveniles (13 - 17 years) and 400 entrepreneurs are interviewed for this monitor. Some of the findings are the following:

- In 2011, 23 percent of the youth of 16 and 17 years old tried to buy a beverage with 15% alcohol or more (in 2001 it was 9 percent). The amount of youngsters under 16 who tried to order a beverages with less than 15 percent alcohol decreased to 1 percent (in 2001 it was 4 percent).
- The success rate is given by the probability that a young person under the age of 16 years will succeed to buy a weak alcoholic beverage or the probability that a youngster under the age of 18 years will succeed to buy liquor. The success rate remains high.
- A majority of the alcohol suppliers claims that they ask young people for an identity document if they want to buy alcohol (Bieleman et al. 2011).

#### *Tobacco policies*

On 23 November 2012, the government decided to increase the minimum legal age for the provision of tobacco from 16 to 18 years. A bill to change the Tobacco Act on this matter is expected in the course of 2013.<sup>15</sup>

In the Netherlands, the prevalence of smoking has decreased. In 2011, 24.7 percent of the population was a current smoker, whereas 18.7 percent was a daily smoker. In 2010, about

<sup>13</sup>This depends on the type of beer.

<sup>14</sup>Voorjaarsnota 2012, kenmerk BZ/2012/283M.

<sup>15</sup><http://www.rijksoverheid.nl/nieuws/2012/11/23/leeftijdsgrens-tabaksverkoop-verhogen-naar-18-jaar.html>.

22.5 billion cigarettes and roll-ups were smoked in the Netherlands. Smoking is the most important reason of premature death. In 2010, 19,214 persons over 20 years of age died from the direct consequences of smoking.

The first act especially designed to limit the use of tobacco and to protect the non-smoker was the Tobacco Act from 1988. Since then many amendments were made to the Tobacco Act. Since 2003 it is prohibited to sell tobacco products to persons younger than 16 years of age. Since 2004 employers are legally bound to protect their employees from tobacco smoke produced by other persons. The smoking ban in the hospitality industry was announced on the 1<sup>st</sup> of July 2008. From July 2011 onwards an exception has been made to the smoking ban for small pubs that are run by its owners and have no other employees. Since 2009 there is a comprehensive ban on advertising and promoting tobacco. In 2005 the WHO Framework Convention on Tobacco Control (FCTC) was signed by the Netherlands. Most of the tobacco products are sold by four kinds of retail outlets: tobacco and convenience stores, petrol station forecourt shops, supermarkets, and hospitality industry venues. The market shares of these retail outlets are different for cigarettes, cigars and pipe tobacco. These market shares are given in table 3.2.2.

*Table 3.2.2: Market shares of different retail outlets for the selling of cigarettes, cigars and rolling and pipe tobacco in 2010*

<b>Retail outlet</b>	<b>Cigarettes</b>	<b>Cigars</b>	<b>Rolling and pipe tobacco</b>	<b>Total</b>
Supermarkets	44%	29%	56%	48%
Petrol station forecourt shops	29%	38%	19%	27%
Tobacco and convenience stores	18%	27%	19%	18%
Hospitality industry	3%	1%	3%	3%
Other	5%	5%	4%	4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

In March 2011, the price of a packet (containing 19 cigarettes) of the most popular cigarettes was €5.20. This means that 25 cigarettes cost €6.84. Of this amount €3.90 is excise duty and €1.09 is VAT. Therewith, 73% of the retail price of cigarettes is tax. This is about the average tax rate for tobacco in the European Union. The price of a packet (containing 42.5 grams) of the very popular rolling tobacco was €5.50 in July 2010, of which €3.55 were taxes (that is 64.5% of the retail price).

On the 29<sup>th</sup> of October 2012, a next increase in the excise duties for tobacco (and alcohol) has been included in the Coalition Agreement. On the 1<sup>st</sup> of March 2014 the price of a packet of 19 cigarettes as well as the price of a packet of rolling tobacco weighing 40 grams will increase with €0.09.

The Netherlands Food and Consumer Product Safety Authority (nVWA) is in charge of controlling the observance of the rules of the Tobacco Act. Periodically, the following items are investigated:

- whether tobacco products are sold to youngsters younger than 16 years;
- whether employees are protected against smoke in the working environment;
- whether the smoking bans in the catering industry are being observed.

In 2009, about nine percent of youngsters between 13 and 15 years tried to buy tobacco products. The chance that they succeeded in buying the cigarettes or rolling tobacco was about 90 percent, although 97 percent of the tobacco retail sellers were convinced that they never sell to persons younger than 16 years (Bieleman et al. 2010).

In 2010, about 94 percent of the companies in the Netherlands reported to have introduced the smoking ban on the workplace in a correct way. More companies tend to set up comprehensive smoking bans (Kruize et al. 2011).

The observance of the smoking ban in the hospitality industry is being investigated every year. In 2011, there were no smokers present in 91 percent of the hospitality industry establishments. Smokers were mainly found in (small) pubs and nightclubs (Intraval/nVWA 2011). These pubs also included the small pubs where smoking has become permitted again. It is clear that not smoking has become the rule at workplaces and at nightlife venues.

Most of the smokers who try to quit smoking try to do so by means of self management and by seeking help from their general practitioner. Annually, about a quarter of the smokers try to quit. Between five and twelve percent of the quitters succeed in quitting after one year. Programs to quit smoking are reimbursed by the health insurance companies. However, before 2011, and in 2012, only behavioral support was reimbursed, while in 2011 both pharmacological and behavioral interventions were reimbursed. In 2011, more than 37,000 insured persons made an appeal of reimbursement for a quit-smoking intervention. A population-based study suggested that the introduction of a full reimbursement system was associated with a more than ten-fold increase in telephone counseling for smoking cessation (Willemsen et al. 2013). In 2013 full reimbursement of smoking cessation interventions will be introduced again.

The funding of the Ministry of Health, Welfare and Sport (VWS) for campaigns on smoking, drinking, and cannabis use and other mass media health campaigns has been withdrawn since the end of 2011. The funding has stopped because the national health policy aims to cut 220<sup>16</sup> million euro of subsidies (see the health care policy paper "Health Nearby"; T.K. 32793-2).

#### *National Centre of Expertise on Tobacco Control*

At the request of the Ministry of Health, Welfare, and Sport (VWS), the Trimbos Institute will establish a National Centre of Expertise on Tobacco Control (NET) as of January 2013. The NET has planned to operate in co-ordination with the already existing national expertise centers on alcohol and drugs at the Trimbos Institute. These knowledge centers can support the government, schools, businesses, and communities with their policies and prevention activities. Collaboration with a network of experts and stakeholders is foreseen.

The focus of the NET will be on monitoring trends, developing interventions, investigating these interventions while in operation, providing (international) knowledge in the field of tobacco control, performing preventive activities with an initial focus on youth, and innovating policies and interventions.

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<sup>16</sup><http://www.rijksoverheid.nl/nieuws/2011/05/25/noodzakelijke-bezuinigingen-laten-ruimte-voor-nieuw-beleid.html>.



### 3.3 Universal prevention

The range of prevention programs in the Netherlands is diverse. The aim of an intervention can be to postpone the start of substance use or to reduce the level of (experimental) use. Besides the target groups and the goals of the interventions, the methods and settings within which the interventions take place differ. The measures the government takes can be divided into measures aimed at the supply of the substances and the availability, the price, the age limits, and the marketing.

Universal prevention has a long history in the Netherlands.<sup>17</sup> The relevant parties<sup>18</sup> share their knowledge on alcohol use since 2005 in the Partnership Early detection Alcohol (Partnership Vroegsignalering Alcohol, PVA). The Partnership aims to improve the co-operation between addiction care facilities, specialized mental health care facilities, primary care, schools, leisure centers, community centers, youth centers, and local institutions. In its first phase from 2005 to 2007 the PVA developed a standard product and created support for this product from the primary care and the municipalities. In its second phase from 2007 to 2010 the PVA worked on implementing the developed product in the primary care. Moreover, in the secondary care pilot projects were executed. In the same period an early detection protocol for the youth was developed, and the project "Prevent alcohol-related harm in young people"<sup>19</sup> was executed by the PVA. In its third and last phase from 2011 to 2013 the PVA will emphasize on implementing the developed products, especially the products focused on the secondary care.<sup>20</sup>

In 2013, the PVA will be terminated in order to prevent that it will become an institution that hinders innovations at a local level. The PVA will have achieved the goal that it was created for, namely improved co-operation between the important players. However, in the area of the youth care improvements can still be made. Here the co-operation between the field partners is still insufficient, and more activities are necessary. Therefore the PVA pleads for a Partnership Youth and Addiction<sup>21</sup> (Van der Gaag 2011).

#### *Stepped care*

The prevention policy in the Netherlands is built on the principle of stepped care. According to this principle the prevention activity starts with the least intensive intervention and only steps to a more intensive intervention when necessary. The consecutive steps are: 1) information, 2) testing, 3) self-help, and 4) supported care.

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<sup>17</sup>[http://www.nji.nl/nji/dossierDownloads/Watwerkt\\_middelengebruik.pdf](http://www.nji.nl/nji/dossierDownloads/Watwerkt_middelengebruik.pdf).

<sup>18</sup>These relevant parties are: the Dutch College of General Practitioners (NHG), The Dutch Institute for Healthcare Improvement CBO, The Scientific Institute for Quality of Healthcare of the UMC St Radboud (IQ Healthcare), Association of GGD's (Community Health Services) in the Netherlands, The Trimbos Institute, Reinier de Graaf Gasthuis te Delft (polikliniek Jeugd en Alcohol), and the Foundation Knowledge Center Addiction "Scoring Results".

<sup>19</sup>Developed by the Reinier de Graaf Gasthuis.

<sup>20</sup>[www.vroegsignaleringalcohol.nl](http://www.vroegsignaleringalcohol.nl).

<sup>21</sup><http://www.vroegsignaleringalcohol.nl/~media/Themasites/PVA/Downloads/Themanummer%20Verslaving%202011%20nr%203.ashx>.

### *E-health*

A wide variety of e-health interventions for alcohol and drug use have been developed along the line of stepped care by, or in co-operation with, the addiction care facilities. Some examples of these e-health interventions are the following:

- alcoholdebaas.nl,
- alcoholenik.nl,
- alcoholinfo.nl,
- cannabisondercontrole.nl,
- dealermee.nl,
- drinktest.nl,
- drugsinfo.nl,
- drugsondercontrole.nl,
- minderdrinken.nl,
- testjeleefstijl.nu,
- unity.nl,
- watdrinkjij.nl,
- watwiljijmetwiet.nl,
- wietcheck.nl.

### *School*

The main universal prevention program in the Netherlands is given by the interactive school-based prevention program about alcohol, tobacco, and drugs named "The Healthy School and Drugs" (DGSG, see our former National Reports). The program has been developed for primary schools, secondary schools, and for intermediate vocational education. The DGSG-program consists of four parts: 1) education at school, 2) parent involvement, 3) identifying of problem use and support, and 4) rules and dealing with the rules. The existing E-learning modules are being adapted and improved regularly. The local Public Health Services and the addiction care support the schools in carrying out the program. In 2012, about one-third of the primary schools and 70 percent of the secondary schools were involved in this program. From the 70 schools for intermediate vocational education, 26 schools were involved in the program (on 55 separate locations, personal communication, program Parenting and Education, Trimbos Institute).

The Dutch schools (primary schools, secondary schools, and schools for intermediate vocational education) can call in the assistance of a multidisciplinary Care and Advice Team (ZAT, zorg- en adviesteam). A school can receive such assistance in case there are worries about a pupil who has complex problems. Until now, the addiction care has not been involved yet in all teams and in all schools. The House of Representatives has paid attention to this issue, but a motion to change the situation has been rejected. The goal of the motion was that in every ZAT and on every school a youth addiction prevention worker had to be part of the team.<sup>22</sup>

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<sup>22</sup><http://publitiiek.nl/zoek?q=motie-bouwmeester>.

## *Family*

During the past years, much effort has been made to support parents while they are bringing up their children. Parents will have to teach their children that starting to drink alcohol, smoking, and using cannabis at an early age is not a wise thing to do. In the context of the 2011 lifestyle campaign "How do I help my child to say no against drinking alcohol, smoking and using cannabis"<sup>23</sup> the Trimbos Institute and the National Centre on Tobacco Control (Stivoro) published a guideline for employees of the Public Health Services and the Addiction clinics. This guideline can be applied to organize the local provision of interventions for parents about smoking, alcohol, and drugs. The guideline contains effective and well-documented interventions for parents about the educational topics alcohol, smoking, cannabis, and hard drugs. Furthermore the guideline includes general advises about how to improve the recruitment and guidance of parents for parenting interventions. It also includes an overview of the regional pilots (implementing interventions) that took place in 2011.<sup>24</sup>

## *Community*

### The Drugs Information Line

For more than 15 years the Drugs Information Line (Drugs Infolijn) has been an important reliable source of information for the general public about drugs. The Drugs Information Line is not only a telephone line, but it also covers a chat service, an e-mail service, and it runs a twitter account for knowledge dissemination. It operates the evidence-based website [www.drugsinfo.nl](http://www.drugsinfo.nl), which information on drugs, drug treatment, the law, health, parental issues, and risks of drug use. The website also contains a question and answer section. Moreover, the Drugs Information Line manifests itself through other channels like forums and local and national media.

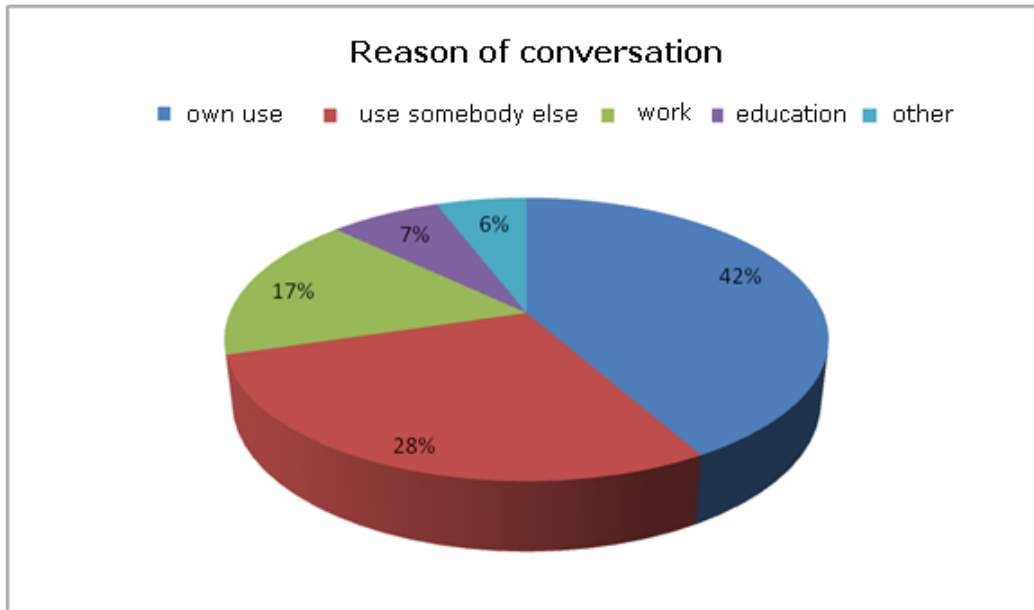
Over the years many help and information lines have seen a decline in the number of phone calls, and this also counts for the Drugs Information Line. People seem to focus more on digital information by means of e-mail and chat, information on the websites of the Trimbos Institute, and specific drugs forums. Figure 3.1 reviews the reasons for contacting the Drugs Information Line in 2011.

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<sup>23</sup> [www.hoepakjijdataan.nl](http://www.hoepakjijdataan.nl).

<sup>24</sup> <http://www.trimbos.nl/webwinkel/productoverzicht-webwinkel/alcohol-en-drugs/af/af1118-roken-drinken-blowen-en-opvoeding>.

Figure 3.1: Reasons for contacting the Drugs Information Line in 2011

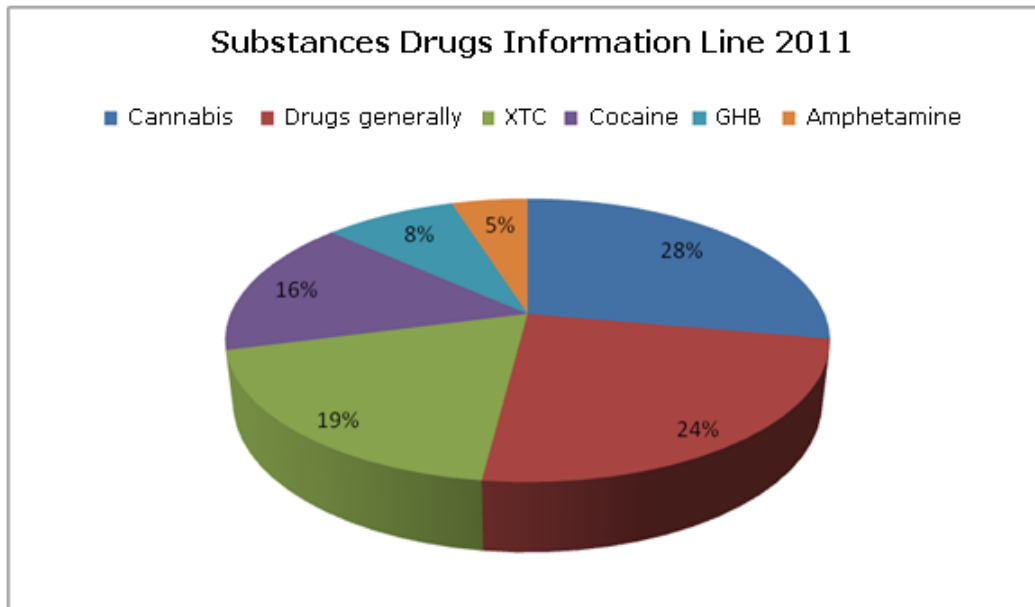


Source: Drugs Information Line, Trimbos Institute.

In 2011, 42 percent of the persons who contacted the Drugs Information Line searched information related to their own substance use, and more than a quarter (28%) searched information for the substance use of somebody close by (family member, partner, or friend). Less than a fifth of the information searches were work-related (17%), and less than a tenth (7%) concerned educational matters or 'other' matters (6%).

Figure 3.2 gives the breakdown by substances for the information requests in 2011.

Figure 3.2: Information requests by substance at the Drugs Information Line in 2011



Source: Drugs Information Line, Trimbos Institute.

In 2011, about a quarter of the information seekers asked questions about cannabis (28%), and about a fifth wanted to know something about XTC (19%). About a quarter asked for

more general information about drugs (24%). Less than a fifth of the information seekers was interested in information about cocaine (16%), and less than a tenth was interested in information about GHB (8%) or amphetamine (5%).

#### Addiction app

A relatively new addiction care facility *Ready for change* launched an Addiction app in October 2012. This app includes a self test, and a button "relapse prevention" with information about self help groups nearby to the user. The app also has an emergency button which immediately makes contact with a caregiver. For persons who have been addicted it contains a program which calculates the "clean time". This indicates for how many days and hours the former addicts have not taken drugs or alcohol. The app also encloses practical information, including information for partners, friends, and family. The app can be downloaded for free.

### **3.4 Selective and indicated prevention in at risk groups and settings**

In the former National Report it has already been explained why in the Dutch situation the distinction between selective and indicated prevention is difficult to make (see National Report 2011 § 3.4). Therefore, in the following, these two types of prevention will be treated together.

In the former years there has been a growing need for a form of prevention that fills the gap between universal and indicated prevention. Therefore, the attention has shifted more and more to selective prevention. The high-risk approach of selective prevention serves as a bridge between the two forms of prevention. Providing preventive services to groups of people with more than one risk factor appears to be a promising strategy. This strategy is promising in terms of improving the health of individuals in a specific risk group and lowering the risk that their problems will become chronic.<sup>25</sup>

In the following text, some examples of selective and indicated prevention activities in the Netherlands will be described.

#### *Open and Alert*

The program *Open and Alert* offers alcohol- and drug prevention in risk settings and aims to prevent (problematic) use of alcohol and drugs by juveniles at these settings. It also aims to support them in the best possible way. It covers projects in the residential child care, youth work, youth custodial institutions, and facilities for people with mild or borderline intellectual disabilities. These are risk settings because problematic alcohol and drug use often occur in these settings. This kind of problematic use worsens the problems of juveniles and grownups in these setting. Due to problematic use, their chances to marginalize increase, and juveniles and grownups in these setting often get socially excluded from the healthcare.

The program has resulted in five factsheets to inform health insurers, municipalities, caregivers, and managers about alcohol and drug prevention in the risk settings mentioned above. Next to that course material, (implementation) manuals, and work books have been developed for caregivers in the different settings.

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<sup>25</sup>Preventie van chronische ziekten in risicogroepen (<http://www.rivm.nl/bibliotheek/rapporten/260221004.pdf>).

### *The Drugs Information and Monitoring System (DIMS)*

Twenty years ago the Ministry of Health, Welfare, and Sport (VWS) founded the *Drugs Information and Monitoring System (DIMS)*. The DIMS explores the chemical content of drugs, the health risks, and monitors trends. The drugs are collected by means of those users who bring their drugs for control to an organisation affiliated with the DIMS. These organisations have weekly office hours. This method of collecting drugs brings along the possibility to exchange information between the personnel at the testing facilities and the users. The user is informed about the composition of the delivered drugs and is warned about the risks. The data that are collected this way are used for education, prevention, and drug policy. Next to this, the data are used to inform the network of organisations participating in the DIMS.

Acute health risks for users can occur, for example in case extra harmful substances are detected in the drugs. In case of such acute health risks, the DIMS will start a national or a regional warning campaign, a *Red Alert*. In 2011, the DIMS warned two times at a national level. The first national warning targeted the risks of using ecstasy pills contaminated with PMMA, and the second national warning targeted pills with a high dose of MDMA. During the first six months of 2012, about 4,000 people visited the consulting hours of the DIMS-facilities, about 160 people every week. In total 4,421 samples were delivered, about 176 samples weekly (DIMS 2012) (see also § 10.3).

At the request of the present Cabinet, the DIMS has increased its tasks with regard to the "Reporting Desk New Drugs" (Meldpunt Nieuwe Drugs, MND). The MND monitors the new psychoactive drugs which appear frequently on the market, like mephedrone, 4-MEC, or MDPV. These new drugs raise questions about who are the users and about the (health) risks. At a special website ([www.meldpuntnd.nl/](http://www.meldpuntnd.nl/)) the users can report new drugs anonymously and eventually can describe their experiences with these drugs.

### *The Monitor Drug-related Emergencies*

In addition to the Drugs Information and Monitoring System (DIMS), the "Monitor drug-related emergencies" (Monitor drugsincidenten) has been established since 2009. By means of this monitor current data are gathered about the nature and extent of drug-related health incidents in the Netherlands. The data are collected on the special website [www.drugsincidenten.nl](http://www.drugsincidenten.nl) by a number of health-care organisations like hospitals, ambulance services, police medical-services, and first-aid services, in different regions of the country. This website enables the exchange of information and supports the professional level of health workers concerning interventions targeting these incidents. In 2011 a total of 3,652 incidents were registered. Between 2009 and 2011 the notification came in 48 percent of the cases from ambulance services, in 32 percent of the cases from the first aid stations on parties, in 14 percent of the cases from the Emergency Departments of the hospitals and in 8 percent of the cases from police doctors (Monitor drugsincidenten Factsheet 2011).

### *Nightlife / going out*

In August 2012, the Trimbos Institute, in co-operation with STI Aids Nederland and the Centre Media & Health, launched the internet film "SndBites".<sup>26</sup> This internet film is about going out and the sensible use of alcohol, safe sex, and the prevention of hearing loss. The film is intended for juveniles between 15 and 18 years receiving Lower and Intermediate Vocational Education.

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<sup>26</sup><http://www.sndbites.nl/>.

### *Going Out: Alcohol and Drugs*

Contracted by the Ministry of Health, Welfare, and Sport (VWS), the Trimbos Institute, in co-operation with several parties in the field of addiction care, runs the program "Going Out: Alcohol and Drugs". This program was started in 1998, and deals predominantly with the prevention of harmful drug use in recreational settings, especially by young people from 16 up to including 26 years. A variety of interventions and preventive instruments has been developed during this project. Some examples are a quick-scan for detecting drug problems, First Aid courses for personnel in recreational settings, factsheets, and a help desk. Stakeholders in the program are, for instance, municipalities, municipal health services, coffee shops, and institutes for addiction care (Croes and Van Gageldonk, 2009, see also several former national reports).

Since 2008, a website has been installed that provides information for people who participate in the nightlife. The website contains information about the effects of drugs and alcohol, the risks that are involved, advices for less risky use, tests for the knowledge about drugs, tests for the level of use, advices for going out safely, advices for first aid per drug type, tips for obtaining general advice, information about drug testing, and links to general information.

In a letter to the House of Representatives the Minister of Health, Welfare, and Sport (VWS) and the Minister of Security and Justice (VenJ) have pledged the grant until 2014 for "Going Out: Alcohol and Drugs". After 2014 the activities of this program must be included in other programs or must be picked up on a regional level<sup>27</sup>.

A complicating factor is the cutting in the budgets for addiction prevention at the level of the municipalities. This has implications for peer-education projects like, for example, Unity. This is a youth-participation project that works with volunteers who are recruited at the entertainment scene. These volunteers are trained by the staff of Unity to become peer educators. Unity aims as much as possible to reduce the risks of the use of recreational drugs. It works in co-operation with the addiction care facilities Jellinek Preventie, Context (part of Parnassia Bavo Groep), Novadic-Kentron, Centrum Maliebaan, Brijder, and Iriszorg. Because of the cuts on the budgets for prevention, Bouman GGZ (region Rotterdam) has finished the activities per 2012 as regards Unity per 2012. Novadic-Kentron has halved the activities for the same reason.

The *Centre Safe and Healthy Nightlife* (Centrum Veilig en Gezond Uitgaan, CVGU) is part of the program "Going Out: Alcohol and Drugs". This centre was initiated by the *Dutch Centre for Crime Prevention & Safety* (Centrum voor Criminaliteitspreventie en Veiligheid, CCV) and the Trimbos Institute. The aim of the CVGU is to offer support to municipalities for constructing a local policy (a mix of measures) to increase the safety in recreational settings by reducing drug and alcohol use. The CVGU is also a centre of expertise for evidence-based interventions and practice- or experience-based activities in this domain. It disseminates newsletters, info sheets, and it organizes thematic meetings. On the 21<sup>st</sup> of November 2012, for example, a meeting was scheduled about how to influence the risk behavior of juveniles in the nightlife. The meeting was meant for professionals working in the health and security domain. Recently two factsheets were published entitled "Health incidents caused by alcohol and drugs, first aid in nightlife facilities and during events" and "Risky use of alcohol and drugs in the nightlife, facts, figures and trends".

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<sup>27</sup>VGP/3121667 Kamerbrief over toezeggingen drugsdebat - Rijksoverheid.nl.

The CVGU now aims to monitor the health- and security effects of different closure times in the nightlife. Therefore, the CVGU is now investigating municipalities that have planned to change the closure times.

#### *Youth and Safety Guide*

The *Youth and Safety Guide* (Wegwijzer Jeugd en Veiligheid) is an initiative of the Ministry of Security and Justice (VenJ), the Ministry of the Interior and Kingdom Relations (BZK), the Association of Dutch Municipalities (VNG), and the Dutch Centre for Crime Prevention & Safety (CCV). The Youth and Safety Guide informs stakeholders about the activities of the government and the municipalities with regard to youth and safety. An overview of these activities is given on the website [www.wegwijzerjeugdenveiligheid.nl](http://www.wegwijzerjeugdenveiligheid.nl). Apart from an overview of national and local policies, this website also offers research findings and best practices. To further support the stakeholders during the policymaking process, a roadmap is also available.

#### *App for (care) professionals*

In July 2012, the prevention department of the institute for addiction care IrisZorg launched a new App for (care) professionals entitled "From alcohol to ecstasy". This App contains easy accessible current information about drug use, the characteristics of different drugs, the risks related to drug use, and the legal matters related to drugs. Until now, this information was presented annually by means of a poster and a book.<sup>28</sup>

#### *Interventions targeted at users of GHB*

In March 2012, the Trimbos Institute published an explorative qualitative study entitled "GHB use(rs) in the picture - A characterization of the GHB users and their accessibility". Another recent study about GHB use has been published by the Addiction Research Institute Rotterdam (IVO) entitled "Prevention of GHB use in the Netherlands". (See § 2.4 for the findings of these studies). It was concluded that there are a few prevention activities which focus on problematic GHB use among juveniles who hang around on the street, and which focus on home users. These groups have an increased risk of (problematic) GHB use and require a selective prevention approach.

It is the task of the youth worker to bring juveniles who hang around on the street into contact with the care providers. At home users, who use GHB recreationally, can be reached probably by the existing prevention services in the nightlife and on the internet. However, those home users who use GHB daily will require a more intensive prevention approach. They can be reached via the social network of those GHB users who are already familiar with the addiction care. Another option to reach them is the development of a smart phone application. Still another possibility to get in touch with this group is given by an intensive community-based prevention approach. Within the framework of this approach a team of prevention workers visits the users in their home environment.

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<sup>28</sup><http://www.psy.nl/psyme/artikel/Artikel/iriszorg-lanceert-app-van-alcohol-tot-xtc>.



## *Interventions for juvenile immigrants*

### Saygi

In 2011, the institute for addiction care Tactus realized the project "Saygi", named after the Turkish word for "respect".<sup>29</sup> This project was initiated because caregivers of Tactus received worrying signs from the Turkish community, the police, and the municipality about substance abuse among Turkish juveniles. Moreover, the care providers were not able to reach the Turkish target group in an adequate way. The goal of Saygi is to obtain more insight into the current situation of the needs and demands of the Turkish youngsters who use drugs in a risky way. When necessary, existing interventions will be adapted or new interventions will be developed.

The project Saygi tries to create a closed chain of youth addiction care by which young (Turkish) migrants can be reached at an earlier stage, early detection of problems is possible, and, when necessary, better and faster referral of these youngsters can be realized. The target group is given by not only the Turkish juveniles who use drugs in a problematic way, but also their parents. The interventions consist of information leaflets, information- and theme gatherings, and parental support.

The experiences with Saygi are collected in a road map meant for professionals at public health services, institutes for addiction care, municipalities, and other interested parties.

### Hulpmix.nl

Another intervention for young immigrants is given by the website [www.hulpmix.nl](http://www.hulpmix.nl).<sup>30</sup> This website offers different interventions for the target group, including help for addiction problems. In June 2011, the Dutch Youth Institute recognized Hulpmix.nl as an effective youth intervention. Therefore, Hulpmix.nl has now been included in the Databank Effective Youth Interventions. Hulpmix.nl has been set up by a co-operation between two (youth) mental health care facilities and three regional child welfare agencies.<sup>31</sup>

Hulpmix.nl is a protected website where visitors can find information about more than 100 subjects. Next to this they can help each other at a forum and they can ask questions (anonymously) by e-mail or chat with a caregiver. The intervention aims to efficiently reach young immigrants between 12 and 21 years with mild mental or social problems in an early stage. By helping them in an early phase or by referring them to another form of treatment, more severe problems can be prevented.

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<sup>29</sup><http://www.tactus.nl/teksten/item/bekijk/id/206>.

<sup>30</sup><http://www.psy.nl/psyme/artikel/Artikel/hulpmixnl-erkend-als-effectieve-interventie/>.

<sup>31</sup>The following institutes have set up Hulpmix.nl: Bureau Jeugdzorg Gelderland, Bureau Jeugdzorg Overijssel, Bureau Jeugdzorg Zuid-Holland, GGZ De Bascule, and GGZ Eindhoven en de Kempen.

### 3.5 National and local media campaigns

By the end of 2011, the Ministry of Health, Welfare, and Sport (VWS) stopped the funding for mass media campaigns. This was one of the measures taken as a result of a cut of 220 million euro of grants (Health Nearby, T.K. 32793-2).

Local parties, like municipalities and public health services, used to participate in the national campaigns and used to apply the available national material. Such material was commonly produced by national health promoting institutes. A concrete example is given by the campaign "More fun by self control" (Meer lol met self control) at the website [www.selfcontrol.nu](http://www.selfcontrol.nu). It is not clear yet what will happen in the future. The material, like the websites, will be available, but the Trimbos Institute will no longer be able to support the local parties.

On a regional level, the addiction care facilities in co-operation with the public health services, the municipalities, and the other stakeholders develop regional projects and campaigns. Some of these campaigns are directed at the use of a specific substance. Other campaigns target, for instance, alcohol use and drug use in general. Some of the campaigns run in small or larger cities, and some of them are running in a region where more municipalities are involved.

In October 2012, a new GHB-campaign "Fainting is never ok" (Out gaan is nooit ok) was launched in Amsterdam. This campaign has been developed in co-operation with the dance scene, the municipal health services, the institute for addiction care Jellinek, the peer prevention organisation Unity, and August de Loor's Drug Consultation Bureau (Adviesburo Drugs). Fainting is a major risk when using GHB. The campaign intends to inform GHB users about responsible use of GHB in order to avoid fainting and losing consciousness. A video clip with a song especially composed by the Amsterdam DJ Boris Werner can be viewed on the campaign website [www.outgaanisnooitok.nl](http://www.outgaanisnooitok.nl).

Another example of a local initiative is the cannabis campaign that started in May 2012 in Zutphen, a small town in the eastern part of the Netherlands.<sup>32</sup> By means of this cannabis campaign the local institute for addiction care Tactus aims to reach as many juveniles as possible at diverse places. Two messages are given in the campaign: "Smoking weed is not normal" and "It's not as innocent as it seems". Different activities are organised. Professionals from Tactus visit schools with a "cannabis bus" and invite pupils to receive information about smoking cannabis. With the same bus the Tactus prevention workers visit the centre of the city where juveniles can receive information about cannabis by peers. Next to that, a theater play about cannabis is performed at a school. For parents an information meeting is organized, and on the website for the youth of Zutphen ([www.zutphen4you.nl](http://www.zutphen4you.nl)) a contest about who knows the most about hashish and weed can be found.

The municipality of Rotterdam started the campaign 'Stay clear' (Blijf helder) in January 2011. This campaign is an element of the 'Battle plan alcohol and drugs' aimed at the scholars of the vocational education. The aim of this project is to reduce the use of alcohol and drug among vocational scholars. This contributes to: - reducing underachievement and school failure, - reducing drug and alcohol related violence and - improving health. The target of this battle plan is: End 2012 the drug- and alcohol use among vocational scholars diminished with 10% compared with 2009-2010. The battle plan includes the implementation of a 'code of conduct alcohol and drugs on school', information provision to scholars and parents, instruction for teachers. In 2011 the campaign was

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<sup>32</sup>[http://www.jonginzutphen.nl/showevents.asp?cat\\_id=-1&web\\_id=143&evt\\_id=13549](http://www.jonginzutphen.nl/showevents.asp?cat_id=-1&web_id=143&evt_id=13549).

executed at six locations, in 2012 at nine locations and in 2013 it will be executed on ten locations. The message is: Alcohol and drug use have a bad influence on the performance at school<sup>33</sup>.

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<sup>33</sup>[http://www.rotterdam.nl/GGD/Document/Jeugd/Aanvalsplan%20drugs\\_alcohol%20op%20ROCs.pdf](http://www.rotterdam.nl/GGD/Document/Jeugd/Aanvalsplan%20drugs_alcohol%20op%20ROCs.pdf)

## **4 Problem drug use**

### **4.1 Prevalence and incidence estimates of PDU**

Compared to the previous national report (Van Laar et al. 2012), no new national estimate has become available about the number of problem drug users in the Netherlands. According to the most recent estimate for 2008, there were about 17,700 more or less problematic opiate users within a 95%-confidence interval running from 17,300 up to 18,100 problem opiate users. This estimate was obtained by means of the treatment multiplier. It has been planned to update this estimate during 2013 for the registration year 2012, also by means of the treatment multiplier.

The majority of the opiate users also consume crack, but treatment registration and field studies also point at the existence of a group of (problem) crack users who do not consume opiates. The size of this population is not known. In the near future, estimates will become available on the total population of crack users (both with and without users of opiates) for the three largest cities of Amsterdam, The Hague and Rotterdam. Some preliminary results on the characteristics of the crack users in these cities have been published (see also the next paragraph 4.2).

A new local estimate of the number of problem opiates users has become available for the city of Enschede for the registration year 2010 (Kruize et al. 2011). In this city, a total of 112 problem opiates users were registered in the local police system, and a total of 226 problem opiates users were registered in the local treatment system. Given an overlap of 39 problem opiates users who were registered in both systems, their total number, by means of a capture-recapture analysis, can be estimated at 649 problem opiates users in the city of Enschede in 2010 (ST7\_2012\_NL\_01). This comes down to 6 problem opiates users per 1,000 inhabitants in the city of Enschede aging 15 up to including 64 years. At a national level in 2008, this figure was estimated at only 1.6 problem opiates users per 1,000 inhabitants aging 15 up to including 64 years.

### **4.2 Data on PDUs from non-treatment sources**

#### *Crack users*

Oteo Pérez, Benschop, and Korf (2012) have studied frequent crack users in the three largest cities of the Netherlands given by Amsterdam, Rotterdam, and The Hague. The researchers investigated whether differences would be found between a respondent-driven sample and two treatment samples. One treatment sample was obtained from low-threshold opiate substitution treatment, and one sample from user rooms.

Starting in March 2009 in Amsterdam and ending in January 2011 in Rotterdam, a total of 1,039 crack users were interviewed, of whom 440 in Amsterdam, 321 in Rotterdam, and 278 crack users in The Hague. Only those crack users were included who currently used crack, at least two days a week. From the 1,039 crack users 81.5% were male, their mean age was 45.1 years, 49.5% were non-Western, 11.6% were homeless, and 44.3% had work. Apart from crack, most respondents also used heroin. The lifetime prevalence of heroin was 89.3% and the last-month prevalence was 72.1%.

With regard to the differences between the respondent-driven sample and the treatment samples, it was found that the crack users in the respondent-driven sample were younger, were less often homeless, and less often used heroin. All in all, the researchers conclude that by means of respondent-driven sampling "a different subpopulation of crack users" is found, and that "different sampling frames and sampling methodologies result in different profiles of drug users".

In a next phase of the present research, the total number of crack users will be estimated, including the hidden population.

#### *Problematic GHB use*

The increase in treatment demand by GHB users (albeit still low compared to other drugs) (see paragraph 5.3) and GHB-related emergencies (see paragraph 6.3) point at an increase in problematic GHB use. There are, however, no figures on the number of problem (or dependent) GHB users in the total population.

Figures on (a proxy for) problem use are only available for a non probability sample of 534 last year GHB users who completed a web survey in spring 2012. Inclusion criterion was the use of GHB at least once in the preceding 12 months (Frijns et al. 2012). Participants were recruited online through websites, social media pages and fora focusing on drug information and/or going out, and offline through the distribution of flyers at institutes of addiction care. Three quarters (76%) of the sample was male and the average age was 29 years. They were classified into three groups on the basis of cluster analysis involving three variables (use in the past month or longer ago, number of use days, and number of doses per use day). These groups were composed of occasional users (no use in the past month, average frequency of use less than once a month and 2.4 doses on an average use day); frequent users (use in the past month, average of 1 to 3 use days per month and 2.4 doses on an average use day) and intensive users (use in the past month, average of 1 to 3 use days per week and 5.3 doses on a typical use day).

Questions included the seven criteria of the DSM IV for dependence. Some 10% of the occasional and frequent users fulfilled three or more criteria, against 46% of the intensive users (mean numbers of criteria fulfilled were .85, .72 and 2.71 for occasional, frequent and intensive users, respectively). Three quarter (76%) of the latter group also reported to have lost consciousness (according to their own perception) after GHB use at least once in their lives, against 30% and 38% of the occasional and frequent users, respectively. Finally, 14% of intensive users reported that they had ended up on the emergency department of a hospital as a result of their GHB use at least once in their lives, against 3% of occasional users and 2% of frequent users

## **5 Drug-related treatment: treatment demand and treatment availability**

### **5.1 Introduction**

Addiction care is offered by thirteen specialized addiction care organisations (see also §11.2.1 for the residential settings), at some 200 locations throughout the country, in co-operation with municipal Public Health Services and other local initiatives. Facilities like drug consumption rooms, medical heroin units and methadone distribution centers fall under the responsibility of the local Public Health Service or the addiction care organisation.

Municipalities organize the addiction care on a local level so the exact appearance differs. In some municipalities one client can obtain care of different addiction care facilities. Therefore these facilities have to work together closely and the coordination of the (individual) care within facilities and between facilities is very important. Usually case managers or so called first responsible caregivers have this coordinating task.

The (addiction) care is financed under three different laws (see for more details §11.1.2): 1- Social Support Act (Wet maatschappelijke ondersteuning (Wmo)), 2- Health Insurance Act (Zorgverzekeringswet (Zvw)) and 3- Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten (AWBZ)). This means, for example, that a stay in a residential setting is financed under another law than a drug consumption room. As a result an addiction care institute can be financed under all of these three laws.

### **5.2 General description, availability and quality assurance**

#### *5.2.1 Strategy/policy*

In the Netherlands, addiction care is part of the mental health care so measures relating to mental health care have direct implications for the addiction care. Partly because many addiction care facilities merged with the mental health care institutions in former years and partly because the funding is equal.

The quality improvement initiatives taken in the addiction care during the previous decades have been consolidated and continued in 2011 and 2012. The main changes in the addiction care in the past year are financial. Next to that the Minister of Health, Welfare and Sport started some initiatives in the organisation of the care for (problematic) GHB-users.

In 2012 patients of the mental health - and the addiction care organisations had to pay an own contribution (see § 8.2 and § 11.1). This measure taken by the Minister of Health, Welfare and Sport should retrench 40 million euro. It created resistance of mental healthcare and addiction care institutes, the police and the municipalities. Even the Secretary of State of the Ministry of Security and Justice expressed his concern that more people, who would

otherwise be treated, will end up in the judicial system. "Persons who don't receive the mental health care they need, according to experts will end up in criminality sooner."<sup>34</sup>

Others emphasize the inequity of this measure: persons with a somatic disease do not have to pay the own contribution. Therefore the nationwide platform mental health care (Landelijk platform GGZ) the umbrella organisation of all client - and family organisations in the mental health care, started a lawsuit for this reason.

The National Branch Organisation for Mental Health Care and Addiction Services (GGZ Nederland) executed two times a quick scan under the member organisations (in February and August 2012).<sup>35</sup> Two third of the member organisations stated the measures resulted in fewer patients in outpatient facilities and a quarter of the institutes report more crisis admissions. In October 2012 these controversial measurements were drawn back.

In June 2012 the major stakeholders in mental health care and the Ministry of Health, Welfare and Sport signed a *Governmental agreement future mental health care 2013 – 2014*.<sup>36</sup> The stakeholders intended to consolidate the quality of care on a high level and to keep the care affordable in the future with this agreement. With this agreement a budget is booked in: € 75 million for 2013 and € 100 million for 2014.

In this document agreements were made on the volume of curative care and at the patient flow: The mental healthcare institutes and the health insurance companies make arrangements to reduce the number of beds in residential mental health care, including the addiction care. Even though addiction care is traditionally especially provided in outpatient settings the existing residential wards have to reduce their beds. In the coming years the parties involved will lay emphasize on outpatient care, the General Practitioner and E-health interventions, this with the intention to reduce the demand for residential care.

In 2012 the mental health and addiction care institutes make arrangements to reduce their beds. For example addiction care organisation Iriszorg announced April 2012 to reduce 40 of the 140 beds and expands on the other hand the outpatient facilities (employees are not dismissed).<sup>37</sup>

In the recent years increasing attention is paid to GHB use and - nuisance. July 2012 the Minister of Health, Welfare and Sport gives a reaction in a Chamber letter to parliamentary questions on this matter. The Minister reports on the investigation in five regions where the GHB-related problems are severe and analyses the problems. The problems with GHB-use are not immense in numbers but complex and severe. Therefore a summary of preventive approaches is given on a national level, aimed at certain target groups like GHB-users who cause nuisance and GHB users who are addicted and need treatment.

Next to that GHB is now listed in category one of the Opium law (the list of hard drugs). Addiction care institutes are working on a detoxification protocol GHB (September 2012 a

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<sup>34</sup><http://www.volkskrant.nl/vk/nl/2824/Politiek/article/detail/3198183/2012/02/23/Schippers-bekijkt-controversiele-eigen-bijdrage-GGZ.dhtml>.

<sup>35</sup><http://www.ggznederland.nl/pa/resultaten-quick-scan-versie-30-03.pdf>  
<http://www.ggznederland.nl/pa/quick-scan-ii.pdf>.

<sup>36</sup><http://www.rijksoverheid.nl/documenten-en-publicaties/rapporten/2012/06/18/bestuurlijk-akkoord-toekomst-ggz-2013-2014.html>.

<sup>37</sup><http://www.iriszorg.nl/nieuws/120413/beddenreductie-en-uitbreiding-ambulante-behandeling>.

draft was published). On the local and regional level attention is paid to spread the expertise and education of the care professionals.<sup>38</sup>

### *Education*

In the fall of 2012, pilots will start to improve the knowledge sharing between vocational education and the mental health care and addiction care.<sup>39</sup> Research shows that teachers in vocational education need mutual knowledge exchange to update the curriculum and to improve the attachment to current issues in mental health care and addiction care. Trainers in mental health also point at the need for a smooth transition from education to professional practice. Often current knowledge does not find its way into education programs. Conversely, the educational sector is working on innovations but these hardly reach the practice (personal communication Sonja van Rooijen, Trimbos Institute).

## *5.2.2 Treatment systems*

### *Organisation and quality assurance*

In the Netherlands there are thirteen specialized addiction care organisations which have a regional function. Next to that, the more than 400 municipalities in the Netherlands have the statutory duty to promote the health of citizens and protect them against diseases and disasters. This task has been deposited with the municipal Public Health Services (GGD). These Public Health Services fulfil an important role in the addiction care and co-operate with the addiction organisations and local initiatives. On a local level these organisations together take care of residential treatment, outpatient treatment, drug consumption rooms, medical heroin units and methadone distribution.

In 2006, the new health care system was implemented and this introduced the free market system in the care sector (see former Reports). New providers of addiction care came up (e.g. SolutionS) and some existing addiction organisations created new, more commercial driven concepts (e.g. Jellinek Retrait on Curacao). In 2012 some turmoil started because patients who are treated on Curacao presented huge bills to health insurers and one of these insurers (DSW) no longer wants to reimburse this luxury rehab resorts. In response to this parliamentary questions have been submitted. The Minister answers that the health insurers can make agreements on the costs of treatment with the caregivers. The insurer can test for suitability and quality of care and there are maximum rates. Insurers do not have to pay the costs which are higher than the market conform prices in the Netherlands (based on the Health Insurance Act).

In the Netherlands E-health instruments are available for different proposes. They can be ordered by the principles of stepped care (starting with the least intensive intervention and only step to a more intensive intervention when necessary). This means 1- Information, 2- Testing, 3- Self-help and 4- Supported care. In the past decade many E-health instruments were developed for self-help and as part of addiction care, like treatment programs to get alcohol- of drug use under control (e.g. [www.alcoholondercontrole.nl](http://www.alcoholondercontrole.nl) and [www.drugsondercontrole.nl](http://www.drugsondercontrole.nl) of the addiction organisation Brijder). Some of the instruments

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<sup>38</sup><http://www.rijksoverheid.nl/ministeries/venj/documenten-en-publicaties/kamerstukken/2012/07/05/kamerbrief-over-toezeggingen-drugsdebat.html>.

<sup>39</sup><http://www.psywerkt.nl/home/nieuwsbericht/article/start-pilots-gericht-op-meer-kennisdeling-mbo-en-ggz/>.



are developed for the general public and some are developed for the clients of addiction care facilities (see § 3.3 for the recently developed e-health instruments).

In the previous paragraph is written about the Governmental agreement future mental health care 2013 – 2014. In this agreement the use of E- mental health interventions is mentioned frequently. For example the support given by the general practitioners can be accompanied by E-health interventions but also next to the treatment in a specialized mental healthcare facility the E-health interventions are gaining more and more ground. In mental health care some e-health initiatives are available for the group of patients with long-term mental health problems, like the portal 'Own control' ([www.eigenregie.nl](http://www.eigenregie.nl)) for people with a vulnerability for psychoses (schizophrenia). The website supports them to regain self control and stimulates empowerment. Till now this kind of E-health methods are not developed to support the group patients with long term addiction problems. It will be a challenge to do so.

Addiction care is also offered to offenders in the criminal justice system. There are, for example, facilities aimed at target groups like forensic addiction care organisations (see Chapter 9 and 11). These organisations offer treatment in closed and open settings and outpatient treatment meant for reintegration in the community.

Eleven addiction care organisations with a probation department form a network organisation (Stichting Verslavingsreclassering GGZ, SVG), which aims to support and reintegrate persons with a judicial status and addiction- and mental health problems. In June 2012 SVG started with 'Electronic Monitoring under own management'. At addiction care organisation Novadic Kentron the first patient was connected to the ankle bracelet with a location commandment. At the addiction care organisation Iriszorg the same happened with a GPS ankle bracelet.

### *Quality assurance*

The quality management program Scoring Results aims to improve permanently the quality and effectiveness of prevention, treatment and care. Scoring Results conducts annually a set of projects, commissioned by in the Ministry of Health, Welfare, and Sport (VWS), the Ministry of Security and Justice or at the request of the institutions for addiction care (See also former National Reports). Recently the program activated an independent website where all the products, news and activities can be found ([www.resultatenscoren.nl](http://www.resultatenscoren.nl)). In 2011 and 2012 a few new guidelines were published, like the Guideline Substance abuse or – addiction and anxiety disorders (addendum Multi disciplinary guideline anxiety disorders). This guideline aims to provide integrated diagnostics and treatment of addiction and anxiety problems. This fits with another goal of Scoring Results, i.e. to improve the co-operation between mental health care and addiction care, since most patients with the combination of these problems have intakes in both types of care. Another new guideline is the Guideline cognitive behavioral therapy youth developed for clinicians, which aims to stimulate young users to change their substance use and gamble behavior. It provides problem solving skills meant for motivation, self control and relapse prevention. This guideline is not substance specific. On the other hand some of the older guidelines were updated like the Guideline Opiate maintenance treatment (Richtlijn opiaatonderhoudsbehandeling, originating 2006). Shortly before this guideline was available a report on implementing this guideline was published.

Benchmarking is considered in the Netherlands as a tool to improve the quality management of health care in general. In former years Consumer Quality Index (CQ-Index) questionnaires

have been created and were implemented in the addiction care and mental health care. This CQ-Index measures the patient experiences in the care (outpatient, short term admissions, long term admissions and sheltered living).<sup>40</sup> The data can be used, for example, by the management of addiction care organisations to improve their care and by insurers to monitor the patient experiences at the facilities they contracted. The addiction care organisations were obliged to use the CQ-Index questionnaires in a sample of their clientele. These questionnaires were created under supervision of the program 'Visible care' (Zichtbare zorg) which was established in 2007 by the Ministry of Health, Welfare and Sport. At the end of 2012 this program will stop and the activities will be continued in the new Quality Institute in 2013. It is not clear if or how the measurements will continue. The new institute is planned to start July first 2013 and the Ministry of Health, Welfare, and Sport is working on a legislative proposal. The objective of the Quality institute is to improve the; client-centricity, quality, safety, effectiveness, and efficiency of care. Until now these tasks are currently administered by different organizations.<sup>41</sup> The Ministry clusters the tasks and responsibilities in the area of quality of care in the new institute which will be part of an existing organisation; the Health Care Insurance Board (CVZ). Besides bundling of these tasks some new functions are added including the ability to take over the control of the development of professional standards (persistence power).<sup>42</sup>

In the Netherlands benchmarking also includes Routine Outcome Management (ROM). Since 2011 it is introduced in mental health and addiction care (see for more details the National Report 2011). The insurers oblige the organisations to deliver the ROM-data for external accountability. The management and professionals fear an increased bureaucracy and have criticism on the unscientific approach: the necessary tools to make justified comparison possible will only be available in a few years.<sup>43</sup>

Noom e.a. (2012) analyzed documentation, policy information and experiences in vivo with the ROM and conclude that it is instructive to compare institutions, both among themselves and with best practices (benchmarking). However, it is important to be aware of the fact that institutions differ in client populations, measurement procedures and – instruments, which hamper a meaningful comparison.

In March 2011 the Platform youth addiction care has been established, in which representatives of addiction care facilities and scientists participate to facilitate the mutual exchange between professionals involved in the care of adolescents with substance use problems. It aims to increase the quality of youth addiction care. One of the tasks is to give support and advice to the development of the MATE Youth (Measurements in the Addictions or Triage and Evaluation, see National Report 2011). The MATE is designed to determine valid and reliable patient characteristics intended for the indication of care and treatment and for the evaluation of the outcomes. Currently a trial version of the MATE-Y is piloted in eight youth addiction care organisations. The pilot will end at the beginning of 2013.

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<sup>40</sup>[www.centrumklantervaringzorg.nl](http://www.centrumklantervaringzorg.nl).

<sup>41</sup>Centrum Klantervaring Zorg, het Coördinatieplatform Zorgstandaarden, kiesBeter, de Regieraad Kwaliteit en het programmabureau Zichtbare Zorg.

<sup>42</sup><http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2012/11/21/kamerbrief-over-later-behandeling-wetsvoorstel-kwaliteitsinstituut.html>.

<sup>43</sup><http://www.psy.nl/meer-nieuws/dossier/Artikel/zorgverzekeraar-straft-ggz-instelling-die-geen-data-aanlevert/>.

Annually the Committee of Scoring Results decides which protocols and guidelines need to be updated. The implementation of protocols and guideline developed in the context of Scoring Results is repeatedly evaluated. The addiction care facilities and other stakeholder are responsible for the implementation. Scoring Results is trying to create good conditions to support the implementation, e.g. by updating guidelines and an active PR. In 2011 for the fourth time a survey is done after the nationwide implementation of the products of Scoring Results.

One of the conclusions of the evaluation of 2011 is that the protocols, guidelines and manuals have actually implemented in the field, but the degree of implementation varies widely between addiction care organisation and type of product (Spits and Schippers 2012). Some examples of widely used protocols and guidelines are; the lifestyle training (100 % use by participating organisations) and the Guideline Detox (72.7 %) and the Guideline Double diagnoses (63.6 %). Some products are used in every institution and some are hardly used. Some institutions implement all the products and some hardly implement any. One of the conclusions is that some of the new products are not known in all organisations. Therefore the recommendation is made the spreading of the products and the PR should be done firmly.

#### *Availability and diversification of treatment*

In the Netherlands addiction care facilities intend to be easy accessible for different problem drug user. In the past decade, new types of drugs and new visions on addiction care brought along new treatment and care methods. Nowadays a broad spectrum of programs, therapies and facilities are available for different types of drug users. In this paragraph attention will be mainly paid to new initiatives in the field of outpatient care, which constitutes the majority of treatment type in the Netherlands. Some of these examples are local and some of them reflect broader (sometimes nationwide) developments. See § 11.2 for an extensive description of residential (treatment) facilities.

In June 2012 the town council of Haarlem agreed on developing a 'unilocation', a building where different care facilities are housed in order to avoid the nuisance of homeless and addicted persons who are wandering between the different locations. Housing at one location supplies a number of efficiency advantages, both in business operation and in the required control in and around the location. The day and night shelter are combined, there will be a methadone distribution center, a drug consumption room, a winter emergency shelter and a walk-in facility. This facility will be developed in co-operation between the addiction care institute (Brijder verslavingszorg), the Salvation Army and the municipality. Next to that Brijder and GGZ Ingeest (mental health care) will establish their Assertive Community Treatment (ACT) teams on this location. These teams are meant for care avoiders and multi-problem patients.

Since decades the mental health care and housing corporations in the Netherlands co-operate in housing persons with severe mental problems. In the addiction care the same initiatives take place. A recent example is the Domus Dordrecht, which opened the doors in October 2012. The facility is initiated by the Salvation Army, the municipality and the housing corporation Trivire. The Domus is a sheltered living facility for persons who are chronically addicted and homeless for a long time, and have mental problems and limited self-awareness and autonomy. This group usually avoids care. In the Domus, 24 persons have their own room and next to that there are a number of shared living rooms and a garden. The residents receive medical support, mental support

and an activity program. Some of the residents are working or receive education.<sup>44</sup> To avoid nuisance of the residents a so called 'control group' is established in which the police is seated. This group organizes for instance the clean team; employees who are making a round a trough the neighborhood few times a week, to clean the waste of the residents. The Domus is situated in a residential area. Therefore the Salvation Army organized information meetings for neighborhood residents to explain the method of working and the measurements taken to decrease the nuisance (like the one mentioned above). An opinion poll showed that 50% of the residents think the neighborhood will deteriorate, especially in the area of safety and nuisance. Shopkeepers fear a decline in patronage. In the spring of 2013 the survey will be repeated to investigate whether or not the expectations did come true.

In the Netherlands the development of internet therapy and online tools aimed at clients of mental health and addiction care facilities is growing fast. In the following two examples of these developments are given.

In April 2012 one of the addiction care organizations (Brijder) introduced the combination treatment, which integrates internet and face-to-face treatment. Patients complete their assignments on the internet and patient and clinician can come to the appropriate treatment much faster. According to Brijder, organizing the care in this way is more effective and efficient. By the end of 2013 the Brijder endeavors to organize all the treatments in this way. A short internet search showed more mental health and addiction care clinics are starting to offer the combination treatment (e.g. Altrecht and Jellinek).

Also the double diagnosis clinic of the mental health care facility GGZ Noord-Holland-Noord recently started to combine face to face treatment with additional internet therapy. There are different internet treatment modules which focus on giving up or reducing substance use: alcohol, cannabis and cocaine. Other modules will be developed. The modules contain information, assignments en exercises. The treatment is tailored to one's personal situation. Attention will be paid to: awareness, self-control, thinking and feeling, learning how to cope with craving and relapse prevention.<sup>45</sup>

#### *The International Cannabis Need of Treatment study (INCANT)*

In 2003 the Government members for Health from Belgium, France, Germany, the Netherlands and Switzerland agreed on priorities for research in the field of cannabis use. The first priority was the treatment program for adolescent cannabis use disorder: the INCANT-study was founded. Since then several publications are published, these were described in the former National Reports (see for example National Report 2011, § 5.3.4).

Recently new results were published on the comparison of Multidimensional Family Therapy (MDFT) and Individual Psychotherapy (IP; or treatment as usual) on five sites in Brussels, Berlin, Paris, The Hague and Geneva (Rigter et al. 2012). Data were gathered five times, at baseline, and 3, 6, 9, and 12 months thereafter. Study participants were recruited at outpatient secondary level addiction, youth and forensic care organisations. The participants were juveniles from 13 to 18 years of age, with a 12 month cannabis use disorder (dependence or abuse) at baseline who had at least one parent who was willing to take part. In total 450 cases were randomized, i.e., 60 from Belgium (30 MDFT, 30 IP), 101 from France (38 MDFT, 63 IP), 120 from Germany (59 MDFT, 61 IP), 109 from the Netherlands

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<sup>44</sup><http://www.rijnmond.nl/nieuws/04-10-2012/wooncomplex-voor-chronisch-verslaafden-geopend>, <http://www.legerdesheils-zwn.nl/pdf/Inloopavond%2028-6-11.pdf>.

<sup>45</sup><http://www.ggz-nhn.nl/nl/internetbehandeling/Overzicht-internetbehandelingen.html>.

(55 MDFT, 54 IP), and 60 from Switzerland (30 MDFT, 30 IP).

There were three primary outcomes: 1- treatment retention, 2- prevalence of a cannabis use disorder and 3- 90-day frequency of cannabis consumption. The results were mainly reported for data from all sites combined. The across-site 12 month follow-up completion rate was 89%.

Results showed that 90% of the MDFT-patients completed therapy and 48% of the IP-patients. The prevalence of cannabis use disorders (dependence and abuse combined) declined from 100% at baseline to 71% (MDFT) and 74% (IP) at 12-month follow-up. The findings suggest a shift from dependence to less severe conditions, namely, abuse or no disorder and the shift was greater for MDFT than for IP. The treatment difference was largest in The Hague. At baseline MDFT and IP adolescents reported an average of 4.1 and 4.0 of the 7 dependence symptoms, respectively. After 12-months, the symptoms average was 2.4 for MDFT and 3.0 for IP. The drop in symptoms was larger in MDFT than in IP and MDFT most strongly diminished the number of cannabis dependence symptoms in Berlin and The Hague.

The frequency of cannabis use at baseline was 61 out of 90 days. At 12-month follow-up, the mean number of consumption days had decreased by 43% (35 days) in MDFT and by 31% in IP. This difference was not statistically significant. On this measure, MDFT did better than IP in the 'high-severity' cannabis consumption group. The authors conclude: "MDFT is labour intensive. For financial reasons, this therapy may not be indicated for all adolescents with cannabis use disorder. When the cannabis use disorder is mild, interventions labelled as IP may be appropriate alternatives to MDFT. However, when cannabis use is heavy and cannabis dependence is severe or (to be reported) associated with mental co-morbidity or family dysfunction, MDFT would appear to be the treatment of choice."

Another study on implementation fidelity of MDFT was published (Rowe et al. 2012). The findings support the implementation fidelity of MDFT in diverse Western European clinical settings, and increased confidence in the internal validity of this family-based treatment as delivered in the INCANT trial (Rigter et al. 2012).

### *Treatment of GHB addiction*

The number of GHB dependent users applying for treatment is growing and so is the need for specialized detox – and treatment facilities. 'Loodds' for example is a ward of the double diagnosis department of Delta mental health care institute. 'Loodds' is specialized in treating GHB dependent users. The treatment consists of detoxification, screening, diagnostics, medication and relapse prevention. Special attention is paid to intensive medical care.<sup>46</sup>

Other addiction care organisations (Novadic-Kentron and Tactus Verslavingszorg) report a shortage of treatment places for GHB addicted persons in the regions of these addiction care organisations. In June 2012 these organisations have established a waiting list.<sup>47</sup>

The addiction care organisation Brijder reports they have a waiting list for two weeks for GHB detoxification in their clinic in Hoofddorp (July 2012) and claims some other clinics have waiting lists of three months. Because of the growing need for treatment places for

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<sup>46</sup><http://www.deltapsy.nl/professionals/buitengewoondelta/dubbelediagnose/Pages/default.aspx>.

<sup>47</sup><http://www.nu.nl/binnenland/2870967/tekort-bedden-ghb-verslaafden.html>.

GHB addicted persons the Brijder planned to open a new facility for GHB detoxification in autumn 2012 in The Hague.<sup>48</sup>

The Ministry of VWS funds the development of a treatment protocol for GHB addiction. In September 2012 three concept versions were published:

1- A detoxification protocol for GHB in a clinical setting, 2- A detoxification protocol for GHB in an outpatient setting and 3- A detoxification protocol for acute GHB abstinence in the hospital. In the meanwhile a survey is conducted among GHB addicted patients of seven addiction care organisations. The survey data aim to provide more information about this addiction and its treatment. Because the detoxification process of GHB is dangerous and delicate, special attention will be paid to the careful detoxification with medical GHB. In 2014, the study will end.

#### *(Function) Assertive Community Treatment*

The capacity reduction of clinical beds brought along more emphasis on outpatient facilities. In the past years, patients with long-term addiction problems are more and more supported by (Function) Assertive Community Treatment (FACT) teams. In the mental health care this method is more common.

In 2011 the Trimbos Institute published the *Model description (F)ACT addiction psychiatry*. The model description is primarily intended to support starting (F) ACT teams. The model contains recommendations with regard to the organisation and implementation of care aimed at clients with addiction problems. In the addiction care some experience has been build up in working with (F)ACT teams. Generally these teams don't focus on the addiction problems solely, but also pay attention to the mental health and other life domains. One of the conclusions is that next to integrated double diagnosis treatment other models and behavioral therapeutic interventions can be applied in (F)ACT, like motivational strategies, relapse management, contingency management, community reinforcement approach and addiction counseling. The teams can apply the variants that are most appropriately tailored to the needs of the clients.

An example of the eastern part of the Netherlands is an ACT team of a mental health care facility (Pro Persona) and an addiction care facility (IrisZorg). The target group of this team consists of persons who have problems on almost all life domains (housing, work, finance, sense of purpose and somatic situation), combined with mental health or/and addiction problems. They have severe social problems and have been in contact with caregivers several times with limited effect. Often there is nuisance in the environment. The patients need, long term care on the life domains and support in coexistence in and with their environment.<sup>49</sup>

The treatment is aimed at:

- harm reduction: to prevent aggravation or relapse;
- to improve the quality of life;
- crisis prevention and intervention;
- to strengthen the social position;
- to improve the living conditions

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<sup>48</sup><http://www.brijder.nl/Nieuws-Algemeen?path=/News/Brijder/korte-wachttijd-ghb-behandeling-bij-brijder>.

<sup>49</sup>[http://www.propersona.nl/Home/!k%20zoek%20een%20afdeling/?address\\_category\\_id=38&mode=goal](http://www.propersona.nl/Home/!k%20zoek%20een%20afdeling/?address_category_id=38&mode=goal).

- to give help on several life domains like housing, work, finances, somatic problems and giving meaning;
- to treat the mental and/or addiction problems.

The treatment provides an active, intensive transmural and outpatient treatment which is strongly outreaching. The starting point is integral care in which all problem areas are dealt with and this happens in close collaboration with other health care providers and agencies (integrated care). The recovery process can take several years to complete. The ACT team makes available prolonged treatment, counseling, empowerment, rehabilitation and monitoring.

### **5.3 Access to treatment**

#### *5.3.1 Specialized addiction treatment*

The National Alcohol and Drugs Information System (LADIS) is the most comprehensive information system in the Netherlands about clients in specialized addiction treatment. The LADIS contains data from the regular institutes for addiction care and has national coverage. Until the registration year 2011, the LADIS also contained data from the probation services for addicts. However, the data for 2011 no longer include the probation clients.

During the past years, most regular organizations for outpatient treatment merged with the regular organizations for inpatient treatment within their region. As a result of these mergers, the majority of clients are now registered at a central intake location. Some private clinics, those institutes for mental health care that have not yet merged with an organization for addiction treatment, and the addiction units in general psychiatric hospitals are not yet represented in the LADIS.

The data in this paragraph are based on the protocol for the Treatment Demand Indicator (TDI) as established by the EMCDDA (Standard Table TDI\_2012\_NL\_06). This means that only those clients who have had at least a second face-to-face contact with an addiction counselor are included.

Moreover, the TDI only includes clients who subscribed in the year of registration. The TDI does not include subscriptions from a previous year that were continued in the registration year. Subscriptions within the registration year include clients that subscribed for the first time in their life for a drug problem (first treatments), as well as clients that re-subscribed in the registration year. The TDI controls for double counting of persons. These criteria are more restrictive than the criteria applied by the holder of the LADIS, the Foundation for the Provision of Care Information (IVZ), to assess the annual LADIS Key Figures. The figures presented here will therefore deviate from the figures reported in chapter 11 and elsewhere (Wisselink, Kuijpers, and Mol 2012).

Some further observations should be made:

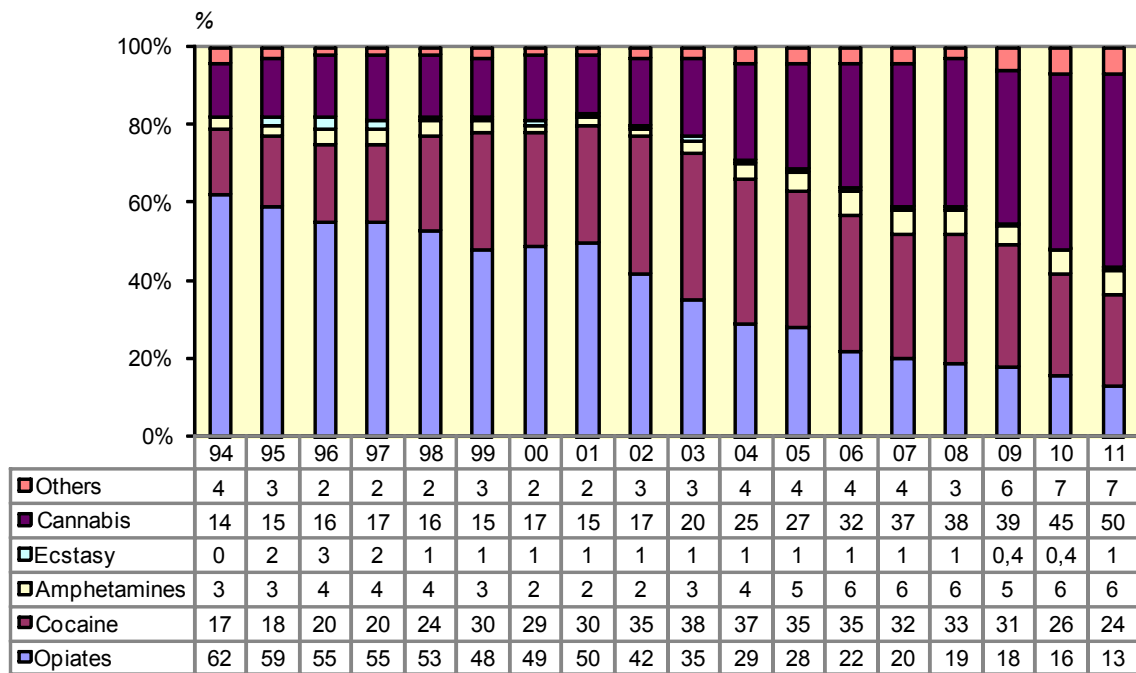
- The data will be reported from 1994 onwards, since this is the first year for which IVZ is able to control for double counting.
- The coverage of the system in terms of the participating institutes for addiction care has improved over the years. The small relative increase in opiates clients from 2000 to 2001 is mainly due to the participation since 2001 of the Public Health Service of Amsterdam (GGD Amsterdam) in the LADIS.

- Cocaine refers to both sniff cocaine and crack cocaine.
- As was already mentioned in the above, the probation clients are no longer included in the data for 2011.

### Trends

Between 1994 and 2011, the annual number of new clients applying for help at the drug treatment services varied between eight and eleven thousand, with no clear trend over the past years. Figure 5.3.1 shows the distribution of the new clients from 1994 up to including 2011 for the drug that was the primary problem for these clients.

Figure 5.3.1: Distribution of clients (%) subscribed in the registration year from 1994 up to including 2011 at the institutes for addiction treatment by primary drug\*



\*Selection of clients based on the EMCDDA TDI protocol. From 1994 up to including 2010, the probation clients are included; but since 2011, the probation clients are no longer included. Source: LADIS, IVZ.

Figure 5.3.1 shows the following:

- The percentage of opiates clients among the new drug clients decreased from 62% in 1994 to only 13% in 2011. The percentage of cocaine clients increased from 17% in 1994 to 38% in 2003, and steadily declined thereafter to 24% in 2011.
- Since 2003, the proportion of cocaine clients exceeds the proportion of opiates clients. It should be noted, however, that these percentages differ from the overall number of clients including the clients who were already registered in the year before the reporting year.
- The proportion of cannabis clients steadily increased from 14% in 1994 to 50% in 2011.
- When taken separately, the ecstasy and amphetamines clients never accounted for more than 6% of the new drug clients. However, the proportion of amphetamines clients increased over the past years, from 2% in 2001 to 6% in 2006 and remained more or less at this level up to including 2011.



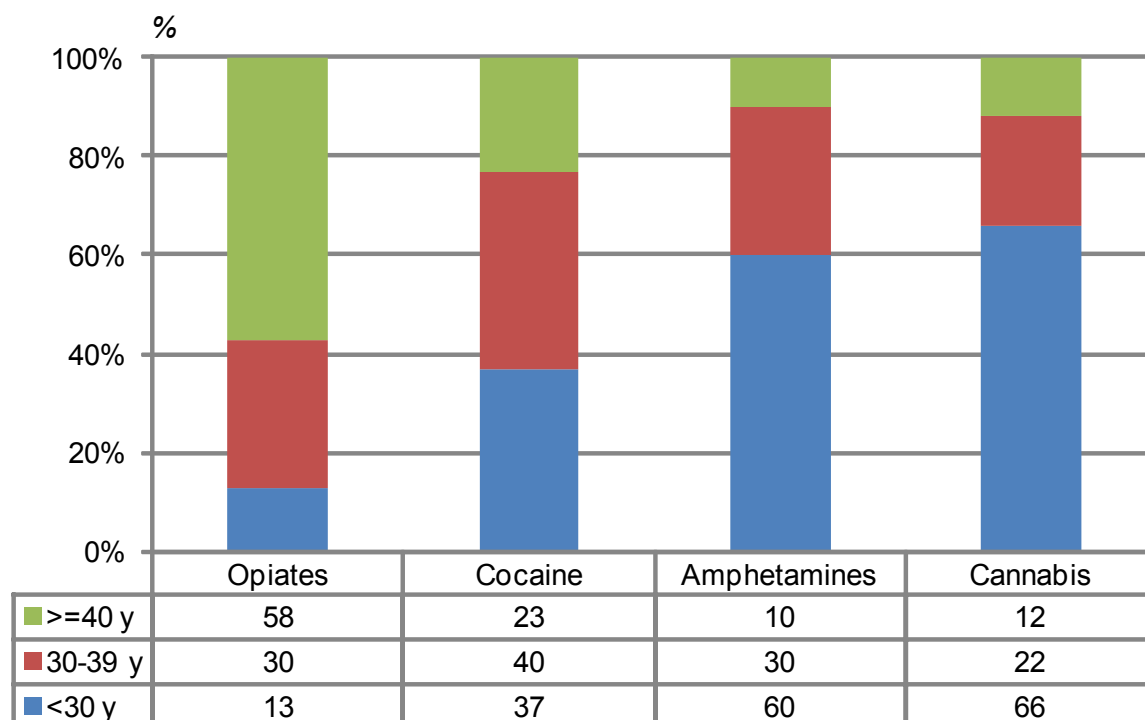
The shift in ratios among the primary drugs is even more visible in clients who have entered treatment for a drug problem for the first time in their life. These first treatments even more reflect the incidence of drug users seeking help, and therefore may even be a better indicator of recent developments in problem use. Among the first treatments in 2011, the proportion of opiates clients was only 6% compared to 20% for cocaine clients and 59% for cannabis clients. The proportion of first treatments for amphetamines was 6%.

The increase in the number of cannabis clients is not only visible in the proportion of the cannabis clients among all drug clients. Also the absolute numbers of cannabis clients strongly increased in the past decade. In the public debate, according to one opinion, the increased treatment demand is linked to an increase in the number of problematic users. This increase is supposed to be due to a relatively high and until 2004 increased THC content of Dutch marihuana. This is the most popular type of cannabis consumed in the Netherlands. However, other explanations are equally likely, such as an increased awareness of the addictive properties of cannabis and/or changes in treatment capacity, quality, or accessibility.

### Age

For the different drugs, figure 5.3.2 shows the distribution over the age groups of the clients in 2011. Clients seeking treatment for problem use of opiates, most often fall in the older age groups. On the contrary, clients who have a primary problem with amphetamines, or cannabis most often fall in the youngest age groups.

Figure 5.3.2: Clients subscribed in 2011 at addiction treatment centers by primary drug and age group\*

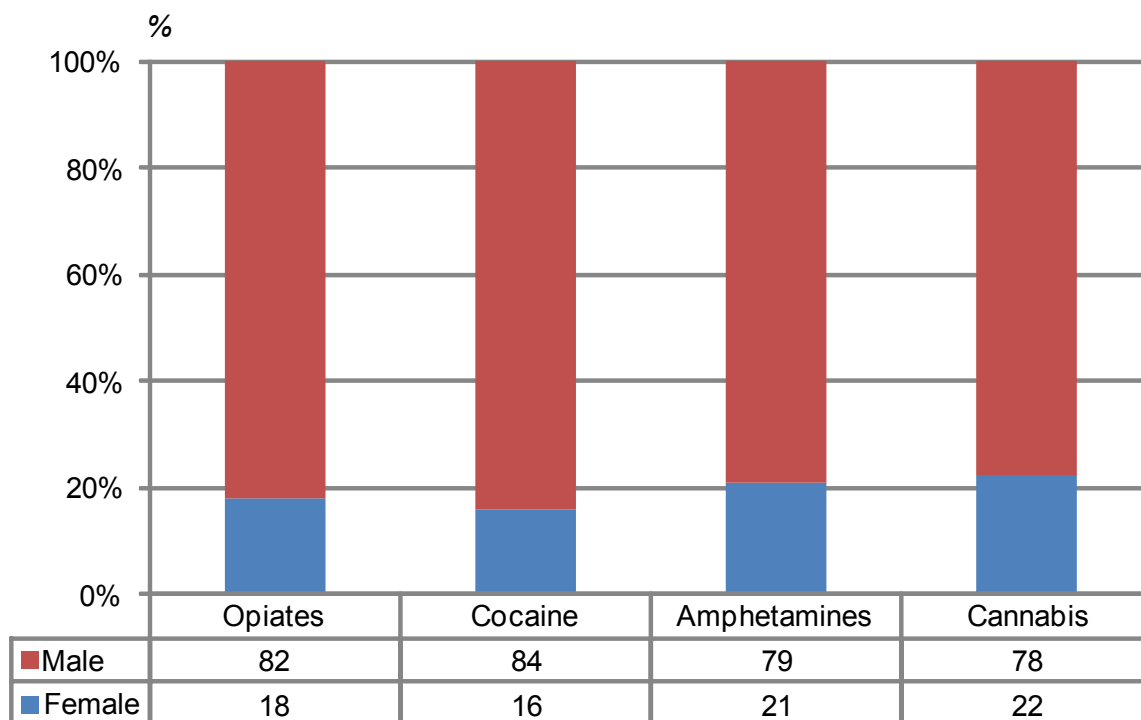


\*Selection of clients based on the EMCDDA TDI protocol, excluding probation clients. Source: LADIS, IVZ.

### Gender

The percentage of females among all the new drug clients has varied over the years between 12% and 21%. Figure 5.3.3 shows the gender distribution by primary drug in 2011. The proportion of females was the highest among the cannabis clients (22%), and was the lowest among the cocaine clients (16%).

Figure 5.3.3: Gender distribution by primary drug of clients subscribed in 2011 at centers for addiction treatment\*



\*Selection of clients based on the EMCDDA TDI protocol, excluding probation clients. Source: LADIS, IVZ.

### Increase of GHB clients

The Treatment Demand Indicator (TDI) does not yet specify the number of GHB clients. However, it should be noticed that the number of GHB clients has increased over the past years. This increasing trend is clearly visible in the total number of clients resulting from summing up the number of clients who subscribed in a registration year and the number of clients who continued a subscription from the previous year. For this total number, the number of *primary* GHB clients increased from 279 in 2009 to 659 in 2011 (Wisselink, Kuijpers, and Mol 2012). In addition, the total number of *secondary* GHB clients increased from 75 in 2009 to 178 in 2011.

### Some regional findings

With regard to the addiction care, there are some findings at regional level that are worthwhile to mention separately:

- In the province of North Holland, the regional institute for addiction care *Brijder*, part of the *Parnassia Bavo Groep*, managed to reduce the waiting list for GHB clients to only two weeks. In general, there is a shortage in units for the detoxification of GHB.<sup>50</sup>
- In the province of North Brabant, the regional institute for addiction care *Novadic-Kentron* signaled an increase in the number of young clients with mild or borderline intellectual disabilities. During 2011 a total of 500 of such young people were registered. Halfway of 2012, already 600 of these young people were registered.<sup>51</sup>

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<sup>50</sup><http://www.brijder.nl/Nieuws-Algemeen?path=/News/Brijder/korte-wachttijd-ghb-behandeling-bij-brijder> [accessed 31-07-2012].

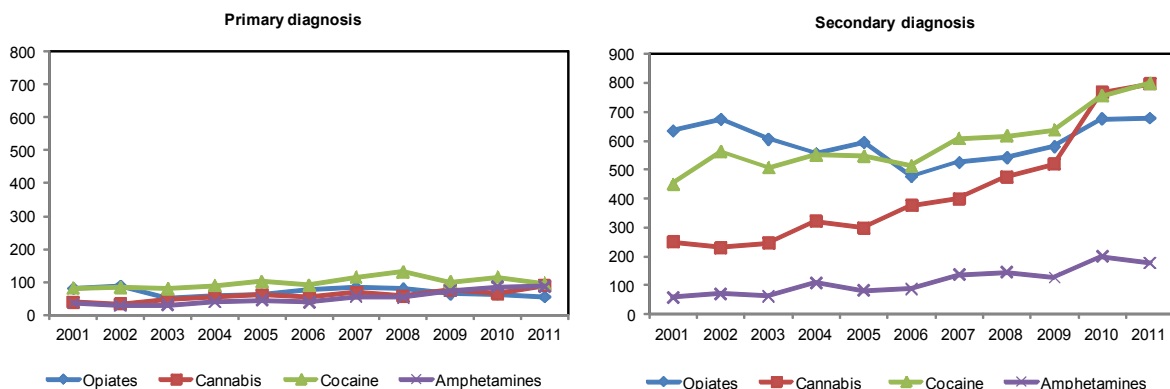
<sup>51</sup><http://www.ed.nl/gezondheid/11610136/Meer-verslaafden-met-beperking.ece> [accessed 29-08-2012].

### 5.3.2 General hospital admissions

Admissions to a general hospital in the Netherlands are recorded via the Dutch Hospital Registration (LMR) held by the foundation Dutch Hospital Data (DHD). Figure 5.3.4 shows the number of clinical admissions to a general hospital because of drug dependence or abuse as a primary or a secondary diagnosis for opiates, cannabis, cocaine, and amphetamines.

- In 2010, the Dutch Hospital Registration (LMR) recorded almost two million clinical hospital admissions. In 2011, drug dependence and drug abuse were recorded only 706 times as a primary diagnosis and 2,973 times as a secondary diagnosis (ICD-9 codes 304 and 305.2-9).
- Within the category of admissions related to drug abuse and dependence, opiates made up 8% of the primary and 23% of the secondary diagnoses. Cocaine made up 14% of the primary and 27% of the secondary diagnoses. Cannabis made up 13% of the primary and 27% of the secondary diagnoses. Amphetamines made up 12% of the primary and 6% of the secondary diagnoses.

Figure 5.3.4: Number of admissions to general hospitals related to dependence or abuse for opiates, cannabis, cocaine, and amphetamines, as primary diagnosis (left panel) or secondary diagnosis (right panel), from 2001 to 2011



Source: Dutch Hospital Registration (LMR), Dutch Hospital Data (DHD).

#### Trends

The number of admissions related to drug abuse or dependence as a primary diagnosis remained rather low over the past years and there were only some minor increases. Stronger increases have been observed for the number of admissions with drugs as a secondary diagnosis. Between 2006 and 2011 the number of admissions increased from 514 to 800 for cocaine, from 476 to 679 for opiates, from 377 to 798 for cannabis, and from 88 to 178 admissions for amphetamines.

Table 5.3.1 summarizes the precise figures for 2011 for the main drugs of abuse.

*Table 5.3.1: Number of clinical admissions to general hospitals in 2011 related to abuse and dependence for cannabis, cocaine, opiates, and amphetamines\**

	<b>Cannabis</b>	<b>Cocaine</b>	<b>Opiates</b>	<b>Amphetamines</b>
Primary diagnoses	89	96	55	86
Secondary diagnoses	798	800	679	178

\*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. Source: Dutch Hospital Registration (LMR), Dutch Hospital Data (DHD).

## **6 Health correlates and consequences**

### **6.1 Introduction**

This chapter describes the fatal and non-fatal consequences of drug use. The focus of this chapter is on problematic drug use. The Netherlands has a long standing tradition on harm reduction and already from the eighties onwards a large package of harm reduction measures have become available, reaching the very majority of those problematic drug users in need of it. As a result, the incidence of drug-related infectious diseases (§ 6.2) as well as overdose death (§ 6.4) has been substantially reduced. The prevalence of all drug-related infections, however, are still (substantially) higher than in the general population.

To a lesser extent, this chapter pays attention to recreational drug users. There is a paragraph on the relation between sexually transmitted infections and recreational drug use in several high risk groups (see § 6.2.4). Further, information is provided on medical emergencies after (most often recreational) drug use and information requests at the National Poisons Information Centre (§ 6.3). In all databases on recreational drug use mentioned in this chapter, we see a slight increase in ecstasy related problems. Further the prevalence of intoxications with GHB is high, especially when seen in relation to the limited use in the general population. Finally, this chapter presents data on the relation between intensive cannabis use and psychiatric disorders (§ 6.3). There are no new data on the prevalence of driving under the influence of drugs available; consult the previous National Report for a summary of the Dutch part of the European DRUID study.

### **6.2 Drug-related infectious diseases**

The most important drug-related infectious diseases include HIV/ AIDS, and hepatitis B and C. They are transmissible through sexual contact (HIV, hepatitis B) and blood (hepatitis C, HIV and hepatitis B). Infectious diseases associated with poor living conditions (such as hepatitis A and tuberculosis) may also have higher incidence and prevalence rates among drug users. The incidence, i.e., the number of new diagnoses, of HIV, hepatitis B and C among injecting drug users is low since many years. The data of the current reporting year point into the same direction. However, there are still indications that the number of chronically infected drug users (i.e., prevalence), and thereby the burden of these diseases, is higher, especially for hepatitis C.

In this paragraph we present prevalence and incidence data on HIV, hepatitis C and B among (injecting) drug users based on the results from the national HIV/ AIDS registry, the Amsterdam Cohort Studies among drug users, regular screening data from drug treatment centres, notification data on hepatitis B and C, and the hepatitis B vaccination campaign. As described in previous reports, the (HIV) sentinel surveillance system among (ever) injecting drug users (IDUs) of the National Institute of Public Health and the Environment (RIVM) has been discontinued and no recent data from national IDU surveillance systems are available.

### 6.2.1 HIV

a. *The national HIV/ AIDS registration of the HIV Monitoring Foundation (SHM) was appointed by the Dutch Ministry of Health Welfare and Sport as the executive organisation for the monitoring of HIV in the Netherlands in 2002. This registration contains data on HIV-infected patients who are seen regularly by HIV/ AIDS treating physicians in one of the 25 collaborative HIV treatment centres throughout the country. It also includes data from a prior project on HIV positive patients treated between 1998 and 2001 (the AIDS Therapy Evaluation Netherlands, or ATHENA, cohort). The longitudinal, anonymous data are used to monitor changes in the HIV epidemic, the natural history of HIV and the effects of treatment (www.hiv-monitoring.nl). In their latest report, the SHM concluded that “injecting drug use is rarely reported any longer as the most probable mode of transmission, which reflects the decreasing popularity of injecting drugs since the 1980s. Also needle exchange programmes and easily accessible dispensing of methadone has contributed greatly to a reduction in the number of new infections in this group.” (Van Sighem et al. 2011).*

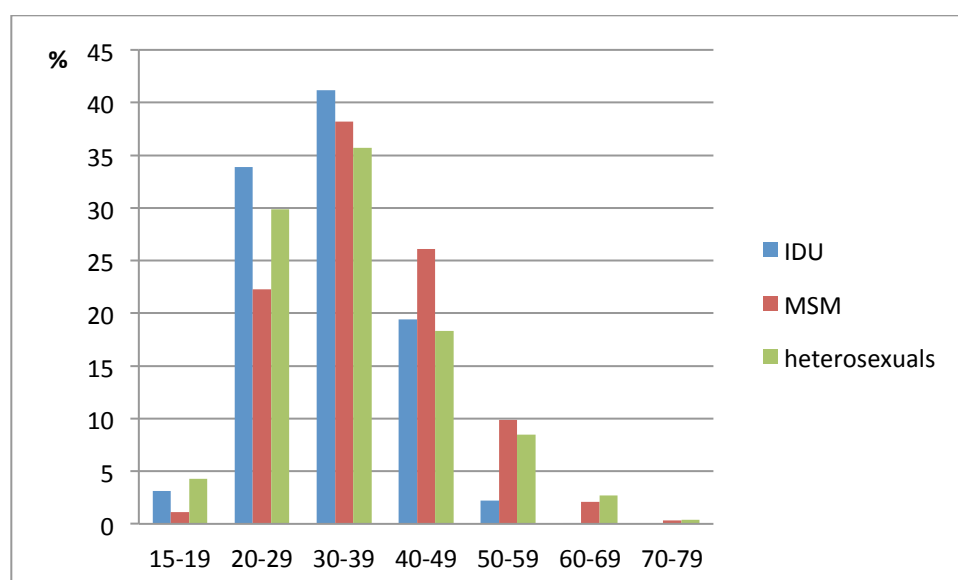
- In 2011, 811 new HIV diagnoses were reported in the treatment centres. In 1 men and 0 women injecting drug use was the most likely route of transmission (table 6.2.1) (Trienekens et al. 2012).
- Up to December 2011 a cumulative total of 19,227 HIV-infected individuals were registered by the treatment centres and the HIV Monitoring Foundation (Trienekens et al. 2012). The percentage of patients infected with HIV through injecting drug use is 3.7 (712 patients). The main route of HIV-transmission in the Netherlands is sexual: through MSM contact in 56% of cases and through heterosexual contact in 32%.
- 41% of all injecting drug users were diagnosed with HIV at an age between 30 and 39 years. IDUs were on average younger than MSM and heterosexuals at diagnosis (Trienekens et al., 2012) (Figure 6.2.1).
- Of the registered HIV positive injecting drug users, 72% originated from the Netherlands and 23% from other Western European countries. This is in sharp contrast to HIV-positives infected through heterosexual contact, of whom only one third had a Dutch origin and almost half originated from Sub-Saharan Africa (table 6.2.1) (Trienekens et al., 2012).

Table 6.2.1: Number and characteristics of recorded HIV infections by route of transmission

Transmission group	Number and percentage of HIV cases diagnosed in 2011	Cumulative number (up to 2011) and percentage of HIV cases	Gender: percentage males (of cumulative number in transmission group)	Region of origin: percentage from the Netherlands (of cumulative number*)
MSM	548 (68%)	10,836 (56%)	100%	85%
Heterosexual contact	205 (25%)	6,058 (32%)	44%	36%
Injecting drug use	1 (0.1%)	712 (4%)	73%	72%
Blood (products)	3 (0.4%)	213 (1%)	63%	54%
Mother to child	2 (0.2%)	231 (1%)	49%	50%
Needlestick injury	3 (0.4%)	38 (0.2%)	74%	Nk
Other/ unknown	49 (6%)	1,139 (6%)	82%	52%
Total	811 (100%)	19,227 (100%)	79%	70%

Figures are adjusted constantly because of reporting delays. \*Only the five most common regions of origin are included. Source: HIV Monitoring Foundation/ RIVM (Trienekens et al. 2012).

Figure 6.2.1: Age distribution at HIV diagnosis in IDUs compared to MSM and heterosexuals, up to 2011



Source: HIV Monitoring Foundation/RIVM (Trienekens et al. 2012).

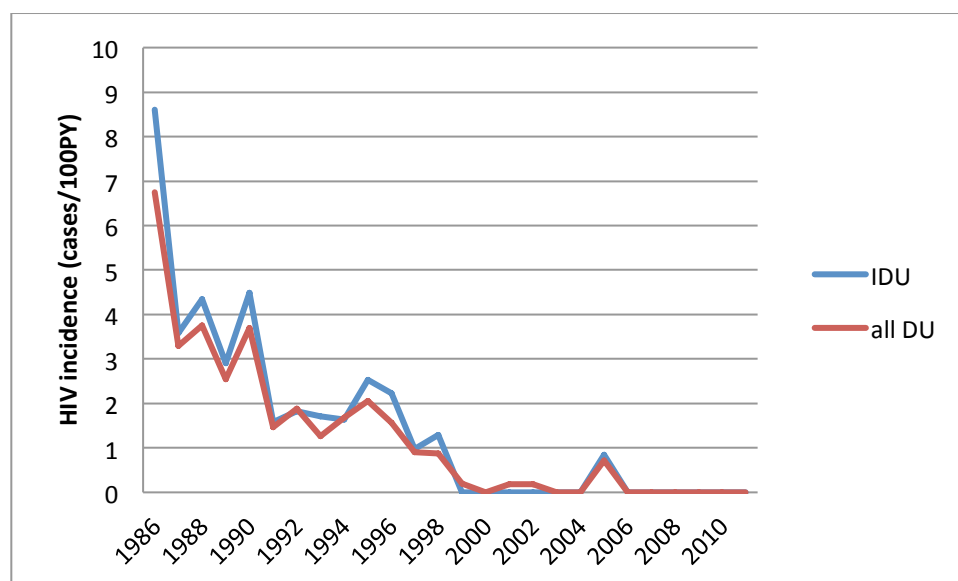
b. The prospective Amsterdam Cohort Studies (ACS) are a collaboration between the Amsterdam Health Service, the Academic Medical Centre of Amsterdam, the Sanquin Blood Supply Foundation and the University Medical Centre Utrecht



([www.amsterdamcohortstudies.org](http://www.amsterdamcohortstudies.org)). The ACS has been carried out since 1984 among homosexual men and since 1985 among drug users. Since 2000, only young drug users (aged <30 years) are allowed to enter the cohort (YODAM). From July 2009 on, also recent injecting drug users (irrespective of their age) are invited to participate. As of December 2010, 1657 (injecting) drug users were included in the ACS (Van Sighem et al. 2011). Drug users are recruited at methadone posts, the STD-clinic for drug-using prostitutes and by word of mouth. The enrolment and follow-up (every four to six months) are facilitated by the well organised health care system for drug users in Amsterdam. Research in the ACS ranges from epidemiology and social science to virology, immunology and clinical medicine.

- At study entry, 322 of the 1657 drug users were HIV-positive (19%) and 98 seroconverted during follow-up (Van Sighem et al. 2011). For comparison, of the 2447 MSM in the ACS 596 were HIV-positive at study entry (24%) and 98 seroconverted during follow-up.
- In 2010, 351 drug users were still followed, of whom 5 had their first study visit in 2010. Of the 351 drug users followed in 2010, 29 were HIV-positive at entry and 16 seroconverted during follow-up. With regard to treatment uptake, 31 of 45 HIV-positive drug users (69%) in 2010 received some combination of anti-retroviral therapy. Of these 31, 29 (94%) had an undetectable viral load ( $\leq 150$  copies/ml) at their latest visit. Of the 14 HIV-positive drug users not receiving HAART, 13 (93%) had an undetectable viral load (Van Sighem et al. 2011).
- HIV incidence rates among ever-injectors dropped from 8.6/ 100 person-years in 1986 to virtually 0 since 2000, with a slight increase to 0.85/ 100 person-years in 2005, when 2 HIV-cases were found (Figure 6.2.2). From 2006 to 2011, no new HIV infections were diagnosed in drugs users (injecting and non-injecting) (Trienekens et al. 2012). For comparison: the HIV incidence rate in MSM participating in the ACS fluctuated during the last decade between 1-2/ 100 person-years.
- The reduction in HIV transmission in IDUs can be partly explained by the decline in injecting and needle sharing (see also § 7.3), although sexual risk behaviour is still occurring.

Figure 6.2.2: Yearly HIV-incidence of injecting drug users (IDU)(≤30 years at entry) and all drug users (DU) included in the Amsterdam Cohort Studies, 1985-2011



Source: Amsterdam Cohort Studies/ RIVM (Trienekens et al. 2012).

c. *Regular screening of infectious diseases* among drug users in treatment settings is recommended in several guidelines and this recommendation is regularly followed, but the test results are not available for monitoring purposes, as the data are stored in individual patient files.

- In Amsterdam, the Public Health Service (GGD) runs most of the low threshold methadone treatment locations. As part of the treatment, patients are regularly offered tests for drug related infectious diseases. However, in practice not all clients are tested. The results may be biased in two directions. First, professionals are more insistent on the screening in case of new clients and those with higher risk behaviour (usually prostitutes), which may result in a slight over-estimation. On the other hand, drug users who are already in HIV (or hepatitis C) treatment will not be tested again. The effect hereof will be a significant underestimation.
- In 2011, 225 clients were tested for HIV antibodies, but only 27 of these were known as ever IDU; in 1/27 ever IDUs (3%) HIV antibodies were found. In the 198 clients not known to have ever injected drugs, 2 positive HIV test results were found (1%) (source: M. de Wit and M. Van Rooijen, GGD Amsterdam). See also Standard Table 09 (ST09).

### 6.2.2 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 this AIDS registration was replaced by the HIV/ AIDS registration of the 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 Disease Control).

- Up to December 2011, the cumulative total of reported AIDS diagnoses was 8,615 and 5,274 HIV infected individuals had died (Trienekens et al., 2012). The annual number of new AIDS diagnoses peaked in the first half of the nineties (around 500 cases per year) and then gradually dropped, to 158 cases in 2011 (Trienekens et al. 2012). The observed decrease since 1996 is related to the availability of HAART, which slowed progression from HIV to AIDS.
- Of the 158 new AIDS diagnoses in 2011, 4 (2.5%) were among injecting drug users (table 6.2.2). In the same year, 122 AIDS patients died, among whom were 10 (8.2%) injecting drug users. Note that the data for 2011 are incomplete due to reporting delay (Trienekens et al. 2012).
- Up until December 2011, 706 registered AIDS patients (8.3% of the total AIDS diagnoses) belonged to the transmission risk group of injecting drug users. The number of AIDS cases related to injecting drug use peaked in 1995 (74), but remained at or below 20 cases per year since 1999 (see table 6.1.2).
- Note that the percentage of IDUs among the total population of AIDS patients (8.3% over all years) is higher than the percentage of IDUs in the total population of HIV patients (3.7%), but that the percentage of IDUs among the AIDS deaths is even higher: 10% or over in the last decade (2011 not included as the data for 2011 are incomplete). This indicates that the disease course in injecting drug users is less favourable than in other risk groups.

*Table 6.2.2: Number and percentage of recorded AIDS patients, by year of diagnosis and by route of transmission*

<b>Transmission group</b>	<b>&lt;=2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011*</b>
MSM	4,625 60%	128 49%	125 49%	119 45%	81 52%
Heterosexual contact	1,781 23%	94 36%	96 38%	115 43%	52 33%
Injecting drug use	683 9%	6 2%	8 3%	5 2%	4 3%
Blood (contacts)	167 2%	6 2%	1 0.4%	1 0.4%	1 0.6%
Mother to child	64 1%	0 0%	1 0.4%	3 1.1%	0 0%
Other/ unknown	351 5%	29 11%	25 10%	23 9%	18 12%
<b>Total</b>	<b>7,671</b>	<b>263</b>	<b>256</b>	<b>266</b>	<b>156</b>

AIDS cases were registered by the Health Inspectorate before 1999 and from 1999 onwards by the HIV Monitoring Foundation. Figures are adjusted constantly because of reporting delays. \* Incomplete data for 2011. Source: HIV Monitoring Foundation/ RIVM (Trienekens et al. 2012).

### 6.2.3 Hepatitis B and C

#### *Notification data*

Notification data are reported by the municipal health services to the National Institute of Public Health and the Environment (RIVM). It is of note that estimating the incidence of hepatitis B and C based on notification data of acute cases will give an underestimation, as a large percentage of new infections remain asymptomatic. However, they may (in the long run) give indications of trends on the incidence of these infectious diseases.

The Netherlands is a low hepatitis B endemic country. In the “Pienter studies” (national representative serological survey held in 1995/1996 (Pienter 1) and 2006/2007 (Pienter 2) in the Dutch population aged 0-79 years), the prevalence of hepatitis B infection was established (Hahné et al. 2012). These studies are the only source of information on the prevalence of HBV infection in the general Dutch population. In 2007, the weighted anti-HBc prevalence was 3.5% (95% CI 2.2-5.5) and the HBsAg prevalence was 0.2% (95% CI 0.1-0.4). The HBV prevalence estimates probably underestimate the true population prevalence, as high risk groups, such as injecting drug users, are likely to be underrepresented. In indigenous Dutch participants, the only risk factors identified were older age and having received a blood transfusion before 1990. A history of injecting drug use was only found in second generation migrants as a risk factor for anti-HBc positivity. However, there was only one second generation migrant reporting injecting drug use and this participant was anti-HBc positive. The power of the study to identify risk factors for chronic HBV was limited because in 2007 only 16 chronically infected individuals were found.

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. The data show that from 1976 to 1981 the incidence of hepatitis B in the population increased (probably due to the introduction of the obligation to notify the disease, the large-scale availability of serological tests and the screening programs among blood donors). Since 1981 the incidence has decreased again, which can be attributed to the availability of a vaccine and the decrease in sexual risk behaviour as a reaction to the aids-epidemic (Rijlaarsdam 1999). In 1995, the number of acute hepatitis B cases among people with injecting drug use peaked with 24 cases, but a sharp decrease has taken place since then. In recent years, injecting drug use plays only a marginal role in newly diagnosed acute and chronic hepatitis B infections.

- In 2011, 157 acute cases of hepatitis B infection were notified (see also [ST09 part 4](#)). The incidence of notified cases of acute hepatitis B in the Netherlands is thereby 0.9/100,000 inhabitants (Trienekens et al, 2012). In the 118 cases with known route of infection, unprotected sexual contact (including MSM and heterosexual) was found to be still the most important risk factor (69% of cases in 2011). There were no notifications of acute hepatitis B in injecting drug users in 2011. Also in the preceding years notifications of acute hepatitis B among injecting drug users were rare: 1 case in 2010, 0 cases in 2009 and 2008 (source: RIVM).
- Chronic infections with hepatitis B were reported in 1,537 cases in 2011. In 3 of the 1,092 (0.3%) chronic infections with known route of infection, injecting drug use was regarded as the vector, comparable with previous years (2010: 13/ 1,112; 2009: 6/ 1,251; 2008: 3/ 1,108) (source: RIVM).

Hepatitis C is 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, with or without clinical symptoms). Since October 2003, this procedure only applies to (suspected) acute or recent infections. As acute infections are often asymptomatic, an unknown rate of missed diagnoses and underreporting is possible.

- The Netherlands is a low HCV-endemic country. The PIENTER-2 study, a national population-based cross-sectional serosurvey performed in 2006-2007, found a weighted national HCV seroprevalence of 0.30% (95% CI 0.05-0.55%) (Vriend et al, 2012). The study finds that most HCV-positive persons (70%) are born in a HCV endemic country. Eight of the 6386 participating individuals reported having injected drugs and three of eight ever injectors were HCV-positive. However, the study concludes that “limited information was obtained on the HCV prevalence among high-risk groups like IDU and HIV-positive MSM. Despite the high number of total participants, the number of HIV-positive MSM and of participants reporting IDU was very small. Moreover, information on (former) IDU and HIV status were missing in 3-10% of the total study population. A possible underrepresentation of these groups could have resulted in an underestimation of the national HCV seroprevalence.” (Vriend et al, 2012)
- In 2011, 65 cases of acute hepatitis C infection were notified. The transmission route of 53 of these 65 cases was reported; in 1 cases (2%) injecting drug use was the most likely route of transmission (see ST09). In previous years, the contribution of the transmission group IDU in the total number of acute HCV infections with known route of infection fluctuated between 3 and 16%. Since 2006, most acute HCV infections are found in MSM (source: RIVM).

#### *Treatment data and other sources*

Screening of drug users in drug treatment on infectious diseases is increasingly part of routine care but test results are only available for a few treatment centres. Note that recruitment site can influence the prevalence point estimates. It has been shown that, among others in the Netherlands, HCV prevalence is significantly higher in IDUs recruited in drug treatment centres, compared with low threshold services and other settings (Rondy et al. 2012).

A rather substantial data source on hepatitis infections in (former) IDUs is the database of the national HIV/ AIDS registration of the HIV Monitoring Foundation (SHM). In total 17,745 HIV-infected patients were tested for a co-infection with HBV and 17,082 for a co-infection with HCV (Van Sighem et al. 2011). In this cohort, the overall prevalence of HBV (defined as presence of HBsAg antibodies) was 8% and of HCV 12%.

- The distribution of HBV infections was equal over the behavioural risk groups. I.e., while 56% of the total HIV cohort was from the risk group MSM, a comparable amount (57%) of all HBV infections was in MSM. The second largest group, heterosexuals, comprised 32% of the HIV cohort, and in heterosexuals 30% of HBV infections were found. Drug users were 4% of the total HIV cohort, and 6% of the HBV infections was found in IDUs. The number of new HBV diagnoses remained stable over time amongst patients infected with HIV through injecting drug use (Van Sighem et al, 2011).
- The distribution of HCV infections, however, was not equal over the behavioural risk groups, with the IDUs heavily affected. Of all 2004 HCV infections diagnosed, 632 (32%) were in IDUs, which is more than 90% of the IDU population co-infected with HIV and

HCV. Previously, it was already shown that injecting drug use was by far the largest risk factor for hepatitis C co-infection (multivariate odds ratio 97.9, 95% CI 70.5-136.0; the reference group is MSM) (Gras et al 2010). In absolute numbers, the IDU population in this HIV cohort was the second largest group with HCV, after MSM. In contrast to the other risk groups, the number of HCV diagnoses in HIV-positive MSM shows a significant increase since 2000 (Van Sighem et al. 2011).

- Data from the SHM showed that progression to liver disease is highest among HIV/HCV co-infected patients (hazard ratio 2.6 (12.4-32.2), and followed by HBV co-infected patients (hazard ratio 10.0 (5.4-18.6), compared to the reference group of HIV mono-infected patients ( $p < 0.0001$ ) (Van Sighem et al. 2011). Note that these figures include all behavioural risk groups.

The Public Health Service of Amsterdam (GGD Amsterdam) collects information on hepatitis B and C infections in methadone clients participating in low threshold services. Patients are tested exhaustive, but not every year. A selection bias in those being tested is certainly the case, e.g., because testing is voluntary and only patients are tested with unknown test result (see also 6.1.1). The data presented for 2011 are limited and have to be interpreted with caution. No substantial changes were observed with previous years (see also [ST09](#)) (source: M. De Wit and M. Van Rooijen, GGD Amsterdam).

- In 2011, HBsAg was not found in any of the 19 IDUs tested. Out of the group of drug users tested in methadone maintenance treatment for whom is unknown whether they ever injected, 1 of 120 (1%) was found to be positive for HBsAg.
- In 19 IDUs tested, 6 (32%) were positive for antiHBc. In the group of tested drug users for whom is unknown whether they ever injected, 32 of 111 (29%) had a positive antiHBc test-result in 2011.
- HCV antibodies were detected in 14 of 28 (50%) tested ever injecting drug users; they were all aged 35 years or over. In the 202 tested drug users with unknown injecting status, 20 were found positive for HCV antibodies (10%).

The open and ongoing Amsterdam Cohort Studies (ACS) among drug users (see above) focuses among others on hepatitis C (but also on hepatitis B, see last bullet). The study generates a wealth of information, which is also described in the previous National Reports.

- The HCV incidence has strongly declined in the last years, both in ever-injectors and in never-injectors. Since 2005, the incidence rate is 0.35 cases/ 100 person years (Grady et al, 2012). In 2010 (latest data available) the HCV incidence amongst injectors as well as in the total group, was 0/100 person-years (van Sighem et al, 2011).
- However, the HCV prevalence is substantial. From January 2005 to July 2009, the DUTCH-C project, part of the ACS among drug users, found HCV antibodies in 267 of 449 (60%) tested drug users (of whom 2/3 ever injected drugs and more than a quarter had also injected in the last 6 months) (Lindenburg et al. 2011). 69% of the drug users with HCV antibodies were also positive for HCV-RNA.
- Based on data of the ACS and surveillance studies, the modelled prevalence of chronic HCV infection in (ever) injecting drug users in Amsterdam ( $n=4353$ ) was 80,7% (Matser et al. 2011).
- Using information of 106 drug users participating in the ACS, with documented dates of seroconversion, it was found that 33% of seroconverters spontaneously clear the virus (Van den Berg et al. 2011). In multivariate analyses, females with a favourable genotype in interleukin 28B (CC at SNP rs12979860; involved in antiviral activity), had the greatest

likelihood to spontaneously resolve HCV (adjusted OR 6.62; 95% CI 2.69-26.13). Also hepatitis B infection and *absence* of HIV co-infection were found to favour HCV clearance (Van den Berg et al. 2011).

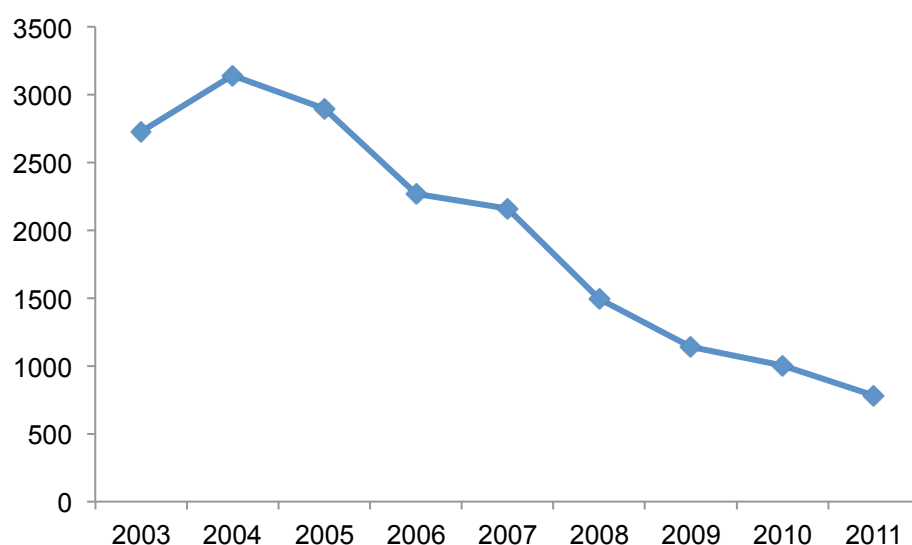
- Also based on data from the ACS, it has been shown that in drug users who have been treated for their HCV infection, HCV reinfection is low in those participating in a multidisciplinary programme (Grady et al. 2012). The observed incidence rate of HCV reinfection was 0.76-3.42 cases/ 100 person years, comparable with reinfection rates in other prospective studies and close to the yearly incidence rate of primary HCV infection among ever injectors in the ACS since 2005 (see above) (Grady et al. 2012).
- Using knowledge of actual risk behaviour from the ACS, a mathematical model was developed to analyse the relationship between HIV and HCV in a population of IDUs (De Vos et al. 2012). The authors conclude that a threshold for HCV prevalence exists at which HIV can invade into an IDU population. The threshold strongly depends on heterogeneity of risk behaviour, as well as on whether sharing is more likely to occur within or between risk behaviour groups. In a previous ecological study, a threshold at around 30% HCV prevalence was found below which HIV was absent (Vickerman et al. 2010). In the ACS, the HCV threshold was found to be 60%, below which HIV did not invade. In the ACS data, two risk groups and proportionate mixing were used in the model, which may explain the higher threshold found. The authors argue that the HCV prevalence can be used as an indicator of risk for successful HIV introduction into an IDU population, provided that information on risk heterogeneity is available (De Vos et al. 2012).
- While evolutionary analysis of the HCV genome sequences found in Amsterdam describes an exceptionally diverse set of HCV genotype 2 isolates, which are traced back to the times of the trans-Atlantic slave trade (1700-1850), the large IDU-cluster (n=45) shows instead low genetic diversity, reflecting the recent and rapid transmission of a HCV-2a lineage among IDUs in Europe (Markov et al. 2012). This genetically less diverse HCV-cluster in IDUs is typical for a recent introduction of a single virus that rapidly spread to IDU communities, in the Netherlands and in neighbouring countries, via a joint transmission network (Markov et al. 2012).
- To gain insight in the proportion of drug users developing chronic hepatitis B after a primary hepatitis B infection, data from the ACS were used (Van Houdt et al. 2012). Sera of 1268 drug users, visiting the centre between 1985 and 2002, were tested retrospectively for anti-HBc, HBsAg, and HBV DNA. After 2003, all participants were vaccinated making further testing unnecessary. During follow-up, 83 drug users sero-converted and 28% became chronically infected, which is unexpectedly high. Being younger was a risk factor for developing a chronic infection, as well as HIV/HCV co-infection.

Since November 2002, the national hepatitis B vaccination campaign is ongoing, after a pilot period in Amsterdam since 1998. The hepatitis B vaccination program targeted behavioural risk groups (MSM, drug users –including never injectors, prostitutes, and until 2007 heterosexuals with multiple sex contacts) (see also § 7.2). The program has been executed by the municipal health services, in close collaboration with several organisations which specifically focus on the target groups. As of January 1, 2012, drug users are excluded from the program and no longer collectively vaccinated. Vaccination of drug users is from now on individual care and the responsibility of addiction care institutes (De Vries 2011).

- From 2002 up until 2011, a total of 17,859 drug users received a first vaccination (not including the 1,125 participants in the pilot phase) (Trienekens et al. 2012). The absolute number of first vaccinations in drug users has shown a decrease over the years (Figure 6.2.3 shows the trend from 2003-2011; 2002 is the starting year and not included because it only comprises 2 months, hampering comparison with full years).
- Of the 17,859 drug users included, 9.0% were found to be immune, which is high compared to the general population. Immunity was also slightly higher in drug users than in commercial sex workers (7.4%) and MSM (8.2%) participating in the hepatitis B vaccination program. In the previous National Report it was already described that the percentage of drug users in the hepatitis B program that are immune is decreasing, from 11-12% between 2003 and 2006, to 8.8% in 2007, 7.8% in 2008, 2.7% in 2009 to 4.0% in 2010. An explanation for this decrease may be that in previous years already the highest risk individuals were included in the campaign. On the other hand, drug users who declare that they were previously infected with hepatitis B are not tested or vaccinated and therefore not included in these figures.
- Chronic carriership was found in 0.8% of individuals (Trienekens et al. 2012). This is higher than in the general population (0.2% carriership) (Hahné 2010). Chronic carriership in drug users was also higher than in MSM and commercial sex workers, where 0.5% was found to be hepatitis B carrier at first consultation (Trienekens et al. 2012).
- Between 2002 and 2011 8,901 drug users received three (or more) vaccinations, which is 50% of those receiving the first vaccination. In MSM, 63% of the more than 36,000 participants finished the vaccination series; in commercial sex workers only 42% of almost 16,000 participants completed the three vaccinations (Trienekens et al. 2012).
- Fifty-nine percent of the drug users who entered the database because they have received a first vaccination are thus no longer susceptible (defined as having had 3 vaccinations, already immune after a previous infection, or chronic carrier).
- With regard to the location of first vaccination, data show the importance of vaccination in the addiction care. Of the 17,859 vaccinations, 42% was done in the public health service, while 35% was first vaccinated at a drug location. Penitentiary institutions were also important, as 17% of all drug users were found here.



Figure 6.2.3: Number of first hepatitis B vaccinations among drug users, 2003-2011



The year 2002 is not included in the figure as the campaign did not take place in the full year. Source: RIVM.

#### 6.2.4 Sexually transmitted infections (STIs)

In total 26 low-threshold STI centres, mostly within the public health services, provide free-of-charge STI/HIV testing and care, targeted at several high risk groups (Trienekens et al. 2012). Although injecting drug use is not among the 8 formulated criteria for high risk, data are available for ever and past 6 months injecting drug use. All attendees are mandatorily offered testing for Chlamydia, gonorrhoea and syphilis. For HIV testing an opt-out policy is in place (Trienekens et al. 2012). The reporting of this national STI surveillance system has been organised in eight regions since 2006 and is coordinated by the RIVM.

- In 2011, 113,180 new consultations were registered. Ever injecting drug use was reported by only 369 cases (139 women; 130 heterosexual men; 100 homosexual men). Another 206 persons indicated they had injected drugs in the past 6 months (74 women; 72 heterosexual men; 60 homosexual men).
- The percentage of positive STI tests among those with ever injecting drug use was relatively low compared to other risk behaviour (such as sexual risk factors and previous positive STI or HIV diagnosis). This may indicate that for the ever injecting drug users, the service is indeed low-threshold.
- With regard to sexual preference, the percentage of positive tests was highest among ever injecting MSM (in ever drug using MSM, around 23% of STI tests had a positive test result, compared to 11-12% in ever drug using heterosexual men and women). This finding is also observed in the other risk behaviour groups (e.g., no condom use at last sexual contact, three or more sex partners in past six months, previous positive HIV test). This indicates that apart from the risk of injecting, also sexual risk behaviour is related to the increased rate of STIs.

The Amsterdam Cohort Studies (ACS, see above) has monitored STIs among their participants since the start of the study in 1986. Although in the first years of the study STIs were found in up to 10% of participants, reports of STI have remained relatively stable at around 5% since the mid-nineteens (Van Sighem et al. 2011).

Another study in Amsterdam assessed the relation between *recreational drug use* during sex and sexually transmitted infections (Heiligenberg et al. 2012). They studied 961 heterosexual men, 673 MSM and 1188 women who attended an STI clinic in Amsterdam in 2008 or 2009. Sex-related drug use in the previous 6 months was frequent, and reported by 23% of heterosexual men, 52% of MSM and 16% of women. In multivariate analyses, sex-related drug use was associated with STI in MSM (any drugs and poppers) and women (GHB and ecstasy). In heterosexual men, no relation was found.

### 6.2.5 Risk behaviour

The ACS has been monitoring risk behavior among drug users in the past 25 years.

- In HIV-negative drug users, injecting and borrowing of needles significantly declined between 1985 and 2010 (van Sighem et al, 2011). While more than 55% of drug users visiting the ACS in 1986 reported injecting, this declined to less than 15% in 2010. In line with that, use of needle exchange also decreased to less than 10% and borrowing was reduced to virtually zero.
- Reports of high sexual risk behaviour decreased before 1996, remained relatively stable until 2005 and further decreased to approximately 35% (of drug users visiting the ACS) in 2010 (van Sighem et al. 2011).

## 6.3 Other drug-related health correlates and consequences

In this paragraph new data are presented on drug-related emergencies (§ 6.3.1), and psychiatric comorbidity (§ 6.3.2).

### 6.3.1 Drug-related emergencies

Data on drug-related emergencies are based on various sources: i) the Monitor drug-related emergencies, which covers several regions of the country, ii) emergency department data (national estimates, based on sample data); iii) ambulance transportation data in Amsterdam (trends), and finally, iv) requests for information on drug intoxications at the National Poisons Information Centre. In general, cannabis remains the most important drug associated with health related emergencies, which may be partly related to its relatively high prevalence of use. Depending on the type of reporting source, cocaine, ecstasy or GHB feature as the second most reported drug associated with emergencies.

#### *Monitor drug-related emergencies*

Since 2009, data on drug-related emergencies are collected from a selected number of regions as well as from several (nationwide operating) emergency posts on dance events by the *Monitor drug-related emergencies* (Monitor Drugs Incidenten, MDI). The number of participating regions increased from four in 2009 to six in 2010 and eight in 2011. The regions are selected in such a way that they are indicative for the situation in the country.

Note however, that they only cover a part of the country and the monitor does not provide an overview of *all* drug-related emergencies that occur in the Netherlands. Cases are reported by ambulance transportation services, emergency departments in hospitals, forensic doctors, and organisations with a first aid medical post at dance parties. In 2011, a total of 25 institutes participated. The collected information includes data on the drugs used, level of intoxication, and demographics. Information of alcohol use is only collected when this took place in combination with drug use. Since the type of emergencies may substantially differ between the participating medical services, data are reported separately where necessary.

- In 2011 3,652 emergencies were reported by the participating institutions in the selected regions (Vogels and Croes 2012) (tables 6.3.1 and 6.3.2). Between 2009 and 2011, the cumulative number of reported cases was 9,029.
- Patients were predominantly male, especially those seen in police custody (90%).
- The majority of patients was 25 years or older, except for the patients at the emergency post at large parties (57% 24 years or younger).
- The level of intoxication was mildest in the patients consulting the medical post at large parties.
- Combination use of drugs or drugs with alcohol was most prevalent in the patients seen by forensic doctors.
- In 2011, 14 patients registered in the monitor died. In two of these it was likely that the presence of PMMA in the drugs used contributed to mortality. In six cases an overdose heroin (by accident or deliberately) initiated death. In the remaining cases, combination use of drugs in addition to individual circumstances were fatal.
- In Amsterdam, tourists had a substantial contribution in the emergency cases. Their problems occurred predominantly after cannabis or mushroom use.

Table 6.3.1.: Characteristics of emergencies registered by the Monitor drug-related emergencies (MDI) by medical service, 2011

	Ambulance transportation service N=2022	Hospital emergency dept N=257	Forensic doctors N=327	Emergency posts at parties N=1046
<b>Sex</b>				
Male	71	70	90	63
Female	29	30	10	37
<b>Age</b>				
0-24 years	31	40	27	57
25+ years	62	60	71	41
unknown	7	0	2	2
<b>Level of intoxication</b>				
Light	39	36	37	73
Moderate	45	33	47	16
Severe	16	32	16	5
Unknown	0	0	0	6
<b>Type of incident</b>				
Intoxication	93	83	91	97
Trauma	8	17	9	4
<b>Deceased</b>	2 patients	1 patient	11 patients	0 patients
<b>Combination of drugs</b>				
Yes	13	16	27	15
No	87	84	73	85
<b>Combination with alcohol</b>				
Yes	37	48	57	50
No	59	36	41	50
Unknown	5	16	3	0
<b>Tourist</b>				
Yes	15	35	6	14
No	37	62	33	80
Unknown	47	2	62	6

In percentages. Due to rounding, percentages do not always exactly sum up to 100. Note that this table includes all drugs and that the distribution of drugs used is not comparable across the medical instances (see next table).

Source: Monitor drug-related emergencies, Trimbos Institute, Netherlands Institute of Mental Health and Addiction (Vogels and Croes 2012).

Table 6.3.2 summarizes the contribution of the separate drugs to the total drug-related emergencies. Note that the figures refer to single drug use, except for the category “combination of drugs”.

- Emergencies after cannabis use are a substantial part of the drug related emergencies in ambulance transportation services and emergency departments of hospitals. The share of cannabis-related emergencies is highest in Amsterdam (in 2011, 40% of all drug-related emergencies in Amsterdam was associated with cannabis use). From 2009-2011, a decrease was observed in the relative contribution of cannabis emergencies to the total of drug-related emergencies (in ambulances: from 42% in 2009 to 33% in 2011; in emergency department in hospitals from 54% to 38%; forensic doctors: from 28% to 18%). In all cannabis cases from 2009-2011, the level of intoxication was severe in 1% (emergency posts at parties) to 15% (forensic doctors).
- Ecstasy intoxications were the most prevalent acute medical problems after drug use on first aid medical posts at parties. From 2009-2011, ecstasy was involved in 63% of drug-related emergencies at these medical posts (as only drug or in combination with another drug). In more than 90% of these patients, the level of intoxication was light. This is in contrast to the level of intoxication in patients with an ecstasy intoxication presenting at the ambulance or emergency department of an hospital, where almost 70% of the ecstasy emergencies had a moderate or severe level of intoxication. From 2009 to 2011, the relative contribution of ecstasy-related emergencies increased in the medical posts at parties from 39 to 55%. There are also some indications for an increase in the level of intoxication (more intoxications in which the level of intoxication is graded as severe), which seems to continue in 2012.
- Compared to the relatively limited use of GHB in the general population, the number of emergencies after use of this drug is remarkably high. One fifth of reported emergencies is related to GHB use, as only drug or in combination with another drug. The level of intoxication is moderate to severe in 50 (medical posts at parties) to 90% (ambulances) of cases, which is higher than in the other drugs monitored. However, this may in part be explained by the definition of level of intoxication used, which highly depends on the level of consciousness, which is easily affected in GHB users.
- Cocaine-hydrochloride is an important drug in the setting of forensic doctors, where this drug (as only drug used or in combination with another drug) was involved in almost one third of drug related emergencies between 2009 and 2011. The level of intoxication here is in two third of cases moderate or severe. In contrast, the level of intoxication in cocaine emergencies at the medical posts at parties is in 98% of cases light.
- Only a limited number of reported emergencies is related to the use of cocaine base or heroine, which are traditionally associated with the hard drug scene.
- Emergencies after mushroom use are limited to Amsterdam.
- Combination use of two or more drugs is associated with more severe levels of intoxication. The monitor shows clearly that the more drugs (and alcohol) are used, the higher the level of intoxication.

Table 6.3.2: *Types of drugs involved in the emergencies documented by the Monitor drug-related emergencies (MDI), 2011*

	Ambulance transportation service N=2022	Hospital emergency dept N=257	Forensic doctors N=327	Emergency posts at parties N=1046
Cannabis	32.9	37.7	18.3	6.9
Ecstasy	3.8	7.8	4.9	55.1
GHB	14.3	16.7	8.0	14.9
Cocaine-HCl	8.3	8.2	19.6	1.1
Amphetamine	1.3	3.1	5.2	2.4
Opiaten	5.4	2.7	4.9	0
Basecoke <sup>1</sup>	0.8	1.2	0.6	0
-Mushrooms	2.3	1.9	2.4	0
Ketamine <sup>1</sup>	0.1	0.4	0	0.8
LSD <sup>1</sup>	0.2	0.4	0.3	0.2
Other/unknown drug	17.6	4.3	9.2	3.4
Combination of drugs	13.0	15.6	26.6	15.2
<i>Total</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>

In percentages. Note that the drugs mentioned refer to single drug use, except for the row "combination of drugs". However, in all drug categories, drug use in combination with alcohol is possible. <sup>1</sup> Because of small absolute numbers, the percentages for basecoke, ketamine en LSD should be interpreted with caution. Source: Monitor drug-related emergencies, Trimbos Institute, Netherlands Institute of Mental Health and Addiction (Vogels and Croes 2012).

#### *Ambulance rides for drug-related non-fatal emergencies in Amsterdam*

The Public Health Service of Amsterdam (GGD Amsterdam) provides trend data of non-fatal emergencies brought to its attention by the *Central Post for Ambulance Transports (CPA)*. Since 2009 these data are also part of the MDI (see before). The link with drug use has been based on case history and circumstantial data; there is no toxicological confirmation. Table 6.3.3 gives the annual number of ambulance rides for drug-related emergencies from 2005 to 2011. The data provided in this National Report replace the data reported in the previous reports. Note that the sum of the rides per drug exceeds the total number of rides per year because more drugs may be involved in one ambulance ride.

- In 2010 and 2011, an increase was observed in the total number of ambulance rides for drug-related emergency assistance. For the moment, it remains unclear whether this reflects a real increase in drug-related emergencies, or whether there is a better registration, increased awareness among personnel, differences in selection, or any other reason (M. Buster GGD Amsterdam, personal communication).
- In 2011, most drug-related emergencies were related to the use of cannabis (involved in 44% of drug-related requests for emergency assistance), followed by heroin/cocaine (17%) and GHB (15%). Emergencies related to amphetamine use were relatively rare.
- Between 2005 and 2011, the percentage of those requesting for assistance who have been actually transported to a hospital (a proxy measure for the seriousness of the emergency) has been fluctuating between 49 and 58%. The proportion of patients requiring transportation to a hospital is lowest for cannabis and highest for GHB.
- It is of note that in 2011 almost two third (66%) of the cannabis emergencies occurred in tourists. In 2009 and 2010 less than 60% of cannabis emergencies were among tourists.

**Table 6.3.3: Number of ambulance rides for emergency assistance for drug-related problems in Amsterdam, 2005-2011**

	2005	2006	2007	2008	2009	2010	2011
<b>Total number of rides*</b>	<b>830</b>	<b>1003</b>	<b>1070</b>	<b>970</b>	<b>986</b>	<b>1192</b>	<b>1454</b>
<i>Patients transported</i>	<b>52%</b>	<b>49%</b>	<b>56%</b>	<b>55%</b>	<b>58%</b>	<b>51%</b>	<b>50%</b>
Cannabis	342	464	444	381	480	617	641
<i>Patients transported</i>	36%	34%	39%	38%	41%	36%	34%
GHB	76	110	110	128	169	194	222
<i>Patients transported</i>	82%	80%	80%	82%	87%	85%	79%
Ecstasy	63	53	67	43	54	64	82
<i>Patients transported</i>	74%	81%	81%	70%	81%	68%	66%
Amphetamine	3	13	17	14	8	19	16
<i>Patients transported</i>	67%	77%	77%	53%	70%	89%	50%
Opiates/cocaine	230	238	220	221	197	165	240
<i>Patients transported</i>	65%	66%	70%	65%	75%	63%	58%
Cocaine					144	130	179
<i>Patients transported</i>					76%	67%	55%
Opiates					71	41	79
<i>Patients transported</i>					77%	68%	67%
Mushrooms**	70	124	149	125	53	69	84
<i>Patients transported</i>	43%	42%	54%	52%	53%	42%	52%
Other/ ill defined/ unknown	46	46	152	118	116	172	229
<i>Patients transported</i>	74%	78%	67%	65%	75%	62%	57%

In absolute numbers. \* Per ride more than 1 drug can be involved, therefore the sum of the drugs per year exceed the total number of rides. From 2009 onward, data for opiates and cocaine are provided both in combination (for comparison with previous years), as well as separated. Due to combination use, opiates and cocaine cannot be summed. \*\* Including the legal sclerotia. Source: Central Post for Ambulance Transports (CPA), Public Health Service of Amsterdam (GGD Amsterdam).

### *Emergency departments in hospitals*

The *Injury Information System* (LetseL Informatie Systeem, LIS) of the Consumer Safety Institute (Stichting Veiligheid.NL) offers information on the number of people treated annually at the emergency departments of hospitals. These data are derived from a selection of hospitals and are extrapolated to yield national estimates. Because of the estimation method and associated error margin data are averaged over a five-years period.

According to the LIS it is estimated that, averaged from 2006 to 2010, about 4,200 people were treated annually at a hospital emergency department following an accident, violent incident or self-mutilation related to drug use. About 17,000 people were treated annually on account of alcohol (Draisma 2011).

- In the patients treated for drugs, 47% was between 20 and 29 years of age and 74% was male.
- Poisoning was the most frequent cause of emergency (74%) and 36% of the patients required hospital admission.
- In 28% of cases, cocaine was mentioned as the most important drug, GHB was involved in 22% of cases, cannabis in 18% and the problems were related to ecstasy use in 8% of patients. In around one fifth of patients, the type of drug was unknown.
- In the period 2006-2010, recorded problems after use of GHB tripled in this database.
- It is likely that patients underreport drug use, and thus these figures may be an underestimate of the true number of emergencies in hospitals related to drugs.

### *Information requests on acute intoxications*

Another source of information on trends in emergencies is given by the number of intoxications about which physicians, health authorities, and others have requested information at the National Poisons Information Centre (NVIC) from the University Medical Centre Utrecht (UMC, Van Velzen et al. 2012). Note that these data are only indicative and do not represent the actual number of acute intoxications. Since 2008, apart from the information requests made by telephone, the numbers also include the intoxications about which information requests were made by the internet.

- Table 6.3.4 shows that the total number of drug-related information requests sharply increased between 2002 and 2005, slightly dropped in 2006, and stabilized thereafter. A possible explanation for the reduction is that physicians have become more familiar with recognising and treating problems related to (specific) drugs, especially if they have been on the market for some time (e.g. ecstasy). This will reduce the need for physicians to consult the NVIC for information.
- In 2011, most information requests were related to use of cocaine, cannabis, GHB/GBL, and ecstasy.
- After the ban on hallucinogenic mushrooms, it was questioned whether there would be a shift towards other hallucinogens. This expected 'waterbed effect' was not observed in the data, except for an increase in the number of information requests for intoxications with nutmeg. These information requests increased from 1 in 2007 to 2 in 2008, 10 in 2009, 31 in 2010 and then decreased to 12 in 2011. Nutmeg has hallucinogenic effects.



Table 6.3.4: Information requests on drug-related intoxications at the National Poisons Information Centre (NVIC)

	2002	2003	2004	2005	2006	2007	2008 **	2009	2010	2011
Cocaine	217	247	227	254	211	231	255	238	243	219
GHB/GBL	194	212	190	241	203	202	218	273	234	211
Ecstasy	184	208	246	217	183	171	185	140	183	205
Cannabis	141	144	191	202	186	178	168	204	164	211
(Meth)amphetamine	39	47	51	128	106	94	125	106	144	161
Opiates*	95	112	112	129	32	47	74	52	75	40
Hall.mushrooms	49	65	52	62	67	68	62	19	37	33
Ephedra/stacker	61	110	127	67	55	26	28	24	31	24
Nutmeg						1	2	10	31	12
Other (smart shop) products	43	65	89	83	103	102	95	92	101	124
Total requests on drugs	1023	1210	1285	1383	1146	1120	1212	1158	1243	1240

\*Due to a change in registration: since 2006 methadone is not counted anymore in the group of illicit drugs but in the group of medicines. \*\*Since 2008, intoxications reported by the internet are included. Source: NVIC, UMC (Van Velzen personal communication).

### 6.3.2 Psychiatric comorbidity

As described in previous National reports drug use disorders are commonly associated with other mental health disorders.

Preliminary findings from the CANDEP study among frequent cannabis users (see § 4.3) indicate that compared to the general population, both dependent and non-dependent frequent cannabis users were at higher risk of having 'any mental disorder' (Van der Pol, 2011). Besides the higher risk of having ADHD in frequent cannabis users compared to the general population, additional analyses showed that ADHD also tended to be more persistent into adulthood. Frequent non-dependent cannabis users were found to have similar levels of DSM IV internalising disorders (mood, anxiety) as the general population, but displayed higher levels of conduct disorder and ADHD. Interestingly, prevalence rates of both internalising and externalising disorders were higher among dependent users, also compared to non-dependent users, while their cannabis exposure was similar. These associations remained significant after controlling for a range of confounders (e.g. sociodemographic, substance use, childhood trauma). More detailed data will be reported in the 2013 National Report.

## 6.4 Drug-related deaths and mortality of drug users

### *National level*

In the Netherlands, statistics on drug-related deaths at national level come available from the General Mortality Register (GMR), or Causes of Death Statistics, held by Statistics Netherlands (CBS). In this register the causes of death are classified according to the International Classification of Diseases, Injuries and Causes of Death (ICD). The 10<sup>th</sup> edition of the ICD has been in use since 1996. The register has national coverage, but in standard form only includes deceased residents of the Netherlands who were registered at a municipal register. However, data on drug-related deaths among non-residents are available from an additional database.

The General Mortality Register (GMR) specifically provides data on acute mortality due to drug use, that is poisoning by drugs, or drug 'overdose'. These are the cases in which death is directly related to drugs. The GMR data do not make a distinction between experimental and habitual drug users, and are not suitable for tracing deaths due to rare toxicological substances like various synthetic drugs. Nonetheless, the registered cases can be selected according to the EMCDDA standard definition of acute drug-related death, as reported for the Netherlands in the Standard Tables ST5\_2012\_NL\_01 and ST6\_2012\_NL\_02.

### *Overall trend*

Figure 6.4.1 shows the number of cases recorded from 1996 up to including 2011. These cases are selected according to the EMCDDA standard selection of ICD-codes. The figure only includes cases from residents that were registered at a municipal register. Among non-residents, an additional 13 cases were registered in 2011 in a separate archive. Between 1996 and 2011, the total number of recorded drug-related deaths among residents fluctuated between a minimum of only 94 cases in 2010 and a maximum of 144 cases in 2001.

Of the 103 cases in 2011, a total of 52 cases were coded to unspecified substances. Although the specific substances are not known in these cases, a previous inquiry at Statistics Netherlands (CBS) revealed that these cases are mostly related to hard drugs and to polydrug use, and are therefore rightly included in the group of drug-related deaths. From 1996 up to including 2010, the number of unspecified cases ranged from 18 in 1996 to 58 in 2008.

Despite some fluctuations over the years, the total number of drug-related deaths in the Netherlands has remained relatively low. This might be explained by a low number of socially marginalized problem drug users, successful prevention measures among the problem drug users, and protective factors, such as the nationwide availability of methadone-maintenance treatment, heroin-assisted treatment, and a low rate of injecting drug use.

### *Opiates and cocaine*

Cases of "opiates" and "cocaine" refer to cases in which these substances were explicitly stated as the primary cause of death on the death certificate. Between 1996 and 2001, opiate intoxications were the most common causes of drug-related death recorded among Dutch residents. In this period, the casualty rate fluctuated between 81 and 75 cases. In 2002, the number of opiate deaths decreased and reached about the same level as the number of acute cocaine deaths, which had slowly increased since the late nineties.

Number

160

140

120

100

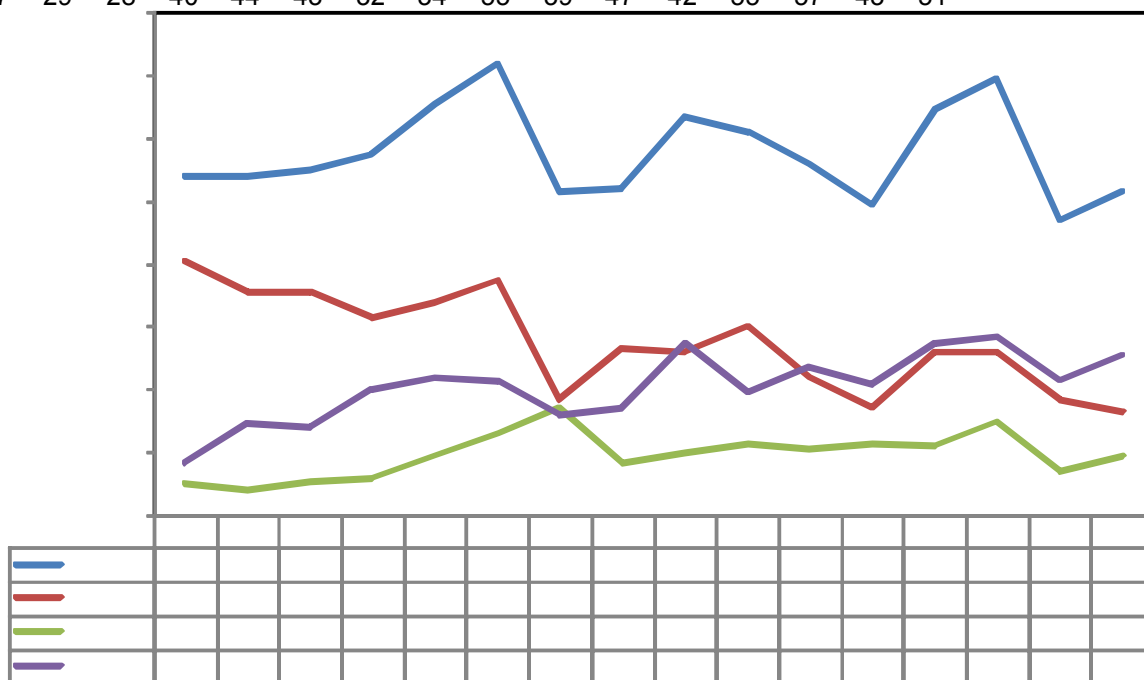
However, since 2003 these trends have diverged again and each year there were more opiates deaths than cocaine deaths.

**Psychostimulants**

In 2011, there were only two cases that were coded to poisoning by psychostimulants (other than cocaine), compared to just four cases in 2009, two cases in 2008, and only one case in 2007 and 2010. Whether these fatal intoxications concerned amphetamines, MDMA, or other psychostimulants is not known.

Figure 6.4.1 1998-2011 Number of acute drug-related deaths in the Netherlands according to the EMCDDA selection of ICD-10 codes from 1999 up to including 2011\*

Total	108	108	110	108	106	104	103	102	101	100	99	99	100	103	104	
Opiates	81	71	71	63	68	75	37	53	52	60	44	34	52	52	37	33
Cocaine	10	8	11	12	19	26	34	17	20	23	21	23	22	30	14	19
Other	17	29	28	40	44	43	32	34	55	39	47	42	55	57	43	51



\*Only residents that were registered at a municipal register in the Netherlands are included. Among non-residents, an additional 13 cases of acute drug-related deaths were registered in 2011. EMCDDA selection of ICD-10 codes: F11-F12, F14, F16, F19; and X42, X41, X62, X61, Y12, Y11 (selected in combination with T40.0-9 or T43.6). Source: Causes of Death Statistics, Statistics Netherlands (CBS).

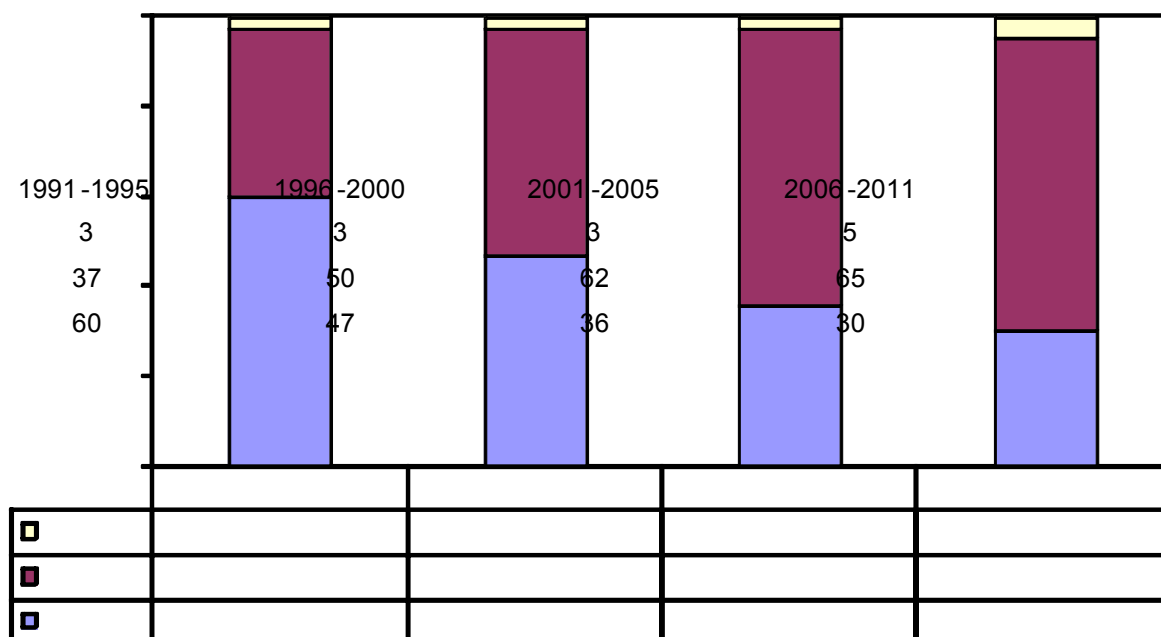
**Age and gender**

The population of problem drug users is ageing, and this trend is reflected in the increasing age of drug users that have died from drugs. Figure 6.4.2 shows that the percentage of deceased aged 35 years and above increased from 40% during the period 1991 up to including 1995 to 70% during the period 2006 up to including 2011.

Between 1996 and 2011, the percentage of female cases varied from 15 to 28% per year, without showing a clear trend. In 2011, the proportion of female cases was 27%.

100%  
80%  
60%  
40%  
20%  
0%  
>=65 y  
35-64 y  
15-34 y

Figure 6.4.2: 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 (CBS).

**Regional level: Amsterdam**

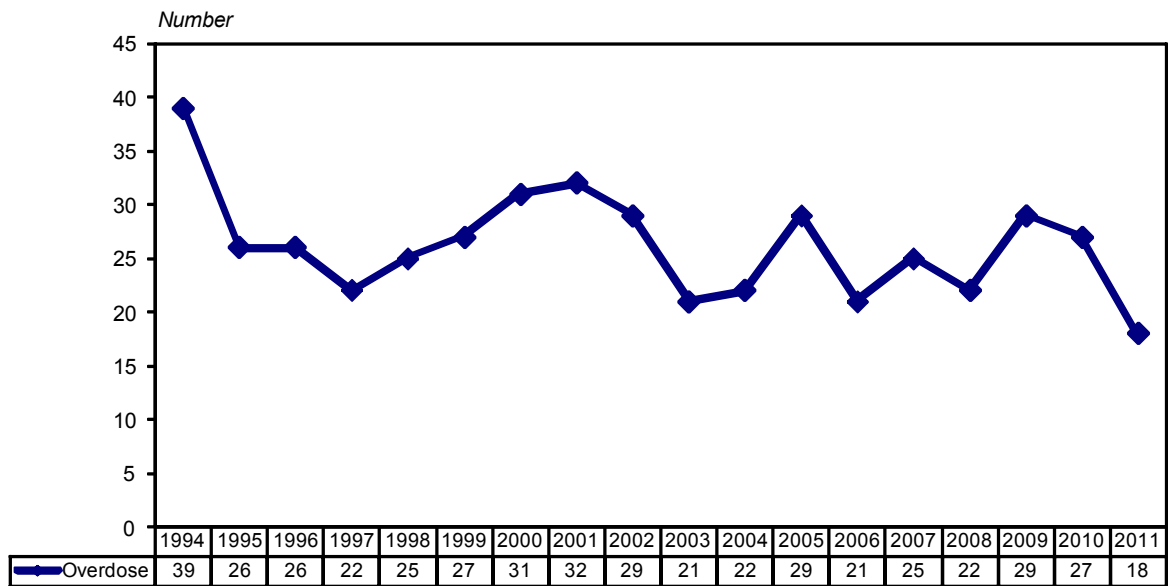
The Public Health Service of Amsterdam (GGD Amsterdam) traces drug-related deaths by means of the Central Methadone Register. This regional monitor is part of the Public Mental Health Care monitor (OGGZ monitor) of Amsterdam (Buster and Van Brussel 2011). The data on the fatal poisonings ('overdoses') from the Amsterdam coroners also include tourists and drug users that stay illegally in the Netherlands and are therefore not included in the Population Registry. Figure 6.4.3 gives the number of acute deaths (overdoses) that were found according to this procedure among the drug users in Amsterdam. Between 2001 and 2011 the number of acute deaths fluctuated around an average of 25 acute deaths per year. The number of 18 cases in 2011 is the lowest number since 1978. Cases of drug swallowers (4 cocaine cases in 2011) are not included in these figures.

From the 18 cases in 2011, 4 were female, 14 were male, and the age ranged from 26 to 67 years, the average age being 42 years. The following substances were found: cocaine (10 times), opiates (10 times), amphetamines/MDMA (8 times), GHB/GBL (5 times), and other medications (10 times).

There were indications of suicide in 9 cases. In 2 suicide cases, among other substances, GHB/GBL was used.

Apart from the fatal poisonings ('overdoses'), no new data have become available from the mortality cohort study in Amsterdam (ST18\_2012\_NL\_01).

Figure 6.4.3: Number of acute deaths (overdoses) among drug users in Amsterdam from 1994 to 2011



Source: Public Health Service of Amsterdam (GGD Amsterdam).

## 7 Responses to health correlates and consequences

### 7.1 Introduction

In this chapter information is provided on prevention of health consequences related to both recreational and problematic drug use. Relevant changes and trends compared to the responses to health correlates and consequences described in our previous National Report include the ending of the national hepatitis B vaccination program for drug users as of 31 December 2011 (§ 7.3.3); the finalization of the hepatitis C guideline in prison (§ 7.3.4); and the "education plan" for addiction care physicians (§ 7.4). Further, new information is provided on the 102etwork102ing102 of drug consumption rooms (§ 7.3.2) and the costs of hepatitis C treatment (§ 7.3.4).

### 7.2 Prevention of emergencies and deaths

#### *Drug-related emergencies*

In 2008, the "Monitor drug-related emergencies" (Monitor drugsincidenten) was developed, and data from 2009 -2011 have been reported (Vogels and Croes 2012; see also §6.3.1). The monitor aims to identify, on an actual basis, trends in drug-related emergencies (via a basic registration), and simultaneously intends to pick up acute life-threatening situations (via case reports). The findings will be used as direct input for preventive measures, both directed at drug users and health care workers, as well as to policy makers. Healthcare workers can report drug-related emergencies online at the website [www.drugsincidenten.nl](http://www.drugsincidenten.nl). The emergencies are registered as light, moderate, and severe intoxications.

The number of participating regions increased from four in 2009 to eight in 2011 (Amsterdam, Brabant-Zuidoost, Enschede, Gelderland Midden, Gelderland Zuid, Groningen, Purmerend, Rotterdam). Cases in these regions are reported by ambulance transportation services, hospitals, forensic doctors and, at a national level, by several 102etwork102ing102g delivering medical first aid at dance parties.

The 'Monitor drug-related emergencies' works closely together with the DIMS project, which besides having a monitoring function also aims to prevent drug-related health problems (for more information: see § 3.3).

#### *Drug-related deaths*

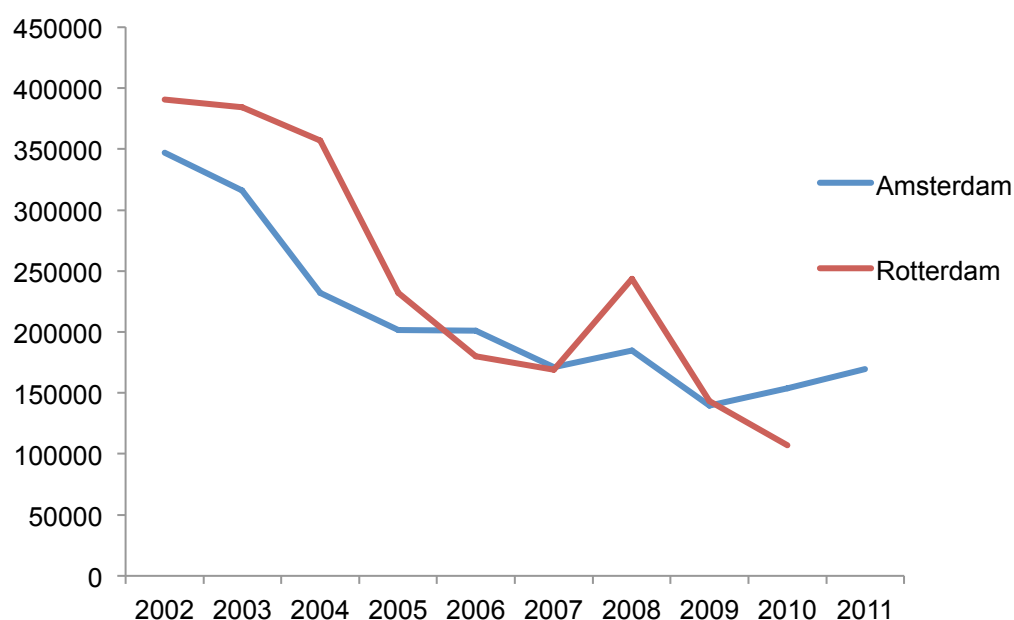
Within the framework of its harm reduction policy, the Netherlands has consolidated in 2010 the prevailing practices to prevent drug-related deaths. There is no specific new information available in addition to the prevention measures that have been reported already in the previous national reports.

## 7.3 Prevention and treatment of drug-related infectious diseases

### 7.3.1 Needle/syringe exchange

Estimates from Mainline (a grassroots organisation for drug users in Amsterdam) and the Trimbos Institute suggest that there are approximately 150 needle/syringe exchange programs in the Netherlands. This is a rough estimate because for some cities it has been reported that pharmacists are also exchanging syringes. There are also reports of merging of several sites as well as closure, which may cut down the estimated number, however, new estimates are not available. In Amsterdam and Rotterdam trend data on the numbers of syringes that were exchanged are available. In both cities, a decreasing trend in the number of exchanged syringes is observed since many years (see figure 7.3.1). The small and unexplained increase observed in 2008 was not continued afterwards. For Rotterdam, there are no data available for 2011, due to a change in the registration system.

Figure 7.2.1: Number of syringes exchanged in Amsterdam and Rotterdam 2002-2011



Source: GGD Amsterdam and GGD Rotterdam. For 2011, no data are available from Rotterdam.

- In Amsterdam, figures are available since 1990. After a steady increase until 1993 (1,082,880 syringes were exchanged in that year), the number of exchanged syringes declined and slightly fluctuates below 200,000 syringes per year since 2007 (169,600 in 2011) (source: GGD Amsterdam).
- In Rotterdam, figures are available since 2000. The number of syringes ordered by the local distribution centres was reduced between 2000 and 2010 from 422,000 to 107,000 (source: GGD Rotterdam). It is noteworthy that in Rotterdam during evening and nightly hours drug users can exchange needles and syringes at several police stations.
- The decline during many years in the number of syringes exchanged can be explained by several factors: a reduction of injecting heroin users in general; a reduction of drug users, often injectors, from neighbouring countries; a reduced popularity of injecting

resulting from experienced health problems, in combination with an increase in the use of crack; and mortality among injectors.

### *7.3.2 Drug consumption rooms*

The first formal drug consumption room in the Netherlands opened in 1994 and since the beginning of this century the number has rapidly increased. An inventory in 2010 among a network of infectious disease experts in all addiction care institutions in the Netherlands identified 37 drug consumption rooms, located in over 25 cities in the Netherlands (Havinga and Van der Poel 2012). In the last decade, due to several developments, the organisation of these locations and the population using them changed. A major impact has had the decrease in homeless drug users. The majority of them is now living in social housing projects, which has reduced drug use on the street and the associated nuisance, including that of drugs dealing. Another important factor has been the decrease in injecting drug use, which further reduced the population using the drug consumption rooms. While in 2003 the average number of visitors per drug consumption room was 36, this has decreased to 22 in 2010. It is likely that several rooms will be closed in the near future (Havinga and Van der Poel 2012).

The majority of Dutch drug consumption rooms is part of a low threshold service. They often distribute needles and syringes. In 2010, six in ten also had medical consulting hours. Most consumption rooms have a different room for smoking and for injecting. In about one third of the rooms, alcohol use is also allowed, either in a separate alcohol room, or in the smoking or injecting room. Three quarters of the rooms is open daily, with an average of 8 hours per day (range 3-15 hours), some also in the evening. The period of stay is limited, ranging from 20-120 minutes. For this limitation, several arguments are used: on an organisational level, there is limited capacity; an argument on health level is that a shorter stay reduces excess drug use (Havinga and Van der Poel 2012).

Drug users have to fulfil several criteria to get access to a drug users room, but the criteria differ locally. Almost everywhere, a minimum age of 18 years is used. In two third of the rooms, the drug users must be registered as a local citizen, sign a contract and being registered at the addiction care institute that runs the consumption room. In half of the cases, the drug users must be in possession of drugs when entering the consumption room (Havinga and Van der Poel 2012).

### *7.3.3 National hepatitis B vaccination campaign*

See also § 6.2.3. The Netherlands is a low hepatitis B endemic country with higher prevalence in specific risk groups. In 2011, the Netherlands started with an universal hepatitis B vaccination strategy. Besides universal vaccination, risk group vaccination will have to be continued for many years. From 1-1-2012 onwards, drug users are no longer considered as a risk group in the free hepatitis B vaccination campaign targeted at behavioural risk groups. This decision is among others based on the decrease in number of vaccinations in this group, which is already going on for years, and the decrease in immunity found among drug users. Also the low number of injecting drug users in the hepatitis B notifications plays a role.

In 2011, RIVM and Trimbos Institute assessed the organisation of hepatitis B vaccination in addiction care (De Vries 2012). The study pointed out that in four of eleven addiction care



institutes, hepatitis B vaccination was systematically and consequently executed in all locations. In four other institutes there was some hepatitis B vaccination, but scattered in time and/ or locations. In the last three institutes, the hepatitis B vaccination programme was not executed at the time of the study.

Both addiction care and municipal health service were involved in the hepatitis B vaccination, but large differences were identified in the assigned tasks. Stimulating factors attributing to a successful vaccination included a motivated leader, extensive compliance and recruitment activities, close collaboration between addiction care and municipal health service and clear description of the tasks. Factors impeding a widespread vaccination were among others a lack of hours or personnel, insufficient support from management, and absence of a hepatitis B vaccination strategy that covered the total institute (De Vries 2012).

#### 7.3.4 Hepatitis C treatment

Thanks to improved identification strategies for hepatitis C infection, more patients are following the expensive treatment. A Dutch study assessed the real life costs of treatment with ribavirin and peg-interferon from a health care perspective (not including indirect costs such as absence from work) (Helsper et al. 2012). Cost-inducing elements used in the study included number of consultations, admission to the hospital, length of stay, medication use, number and type of diagnostic tests performed, use of specialised homecare and other registered use of hospital facilities, from one month before start of treatment to the evaluation of treatment success 24 weeks after treatment. As the study extracted the data from medical files (of 85 patients), the strong point is that it generates a “real life” overview of the costs of hepatitis C treatment, in patients with different relevant lifestyle factors, taking into account factors such as relapse, non-response, genotype and treatment setting.

For all patients, irrespective of treatment outcome, the mean treatment costs were € 12,900 for genotype 1 and 4 and € 9,900 for genotype 2 and 3. For patients with a sustained viral response the costs were respectively € 15,500 and € 10,100; for patients with a relapse € 16,800 and 12,100. Costs per cured patient were € 28,500 and € 15,400. The main component of the treatment costs was the medication. The costs of unsuccessful treatment and those for the treatment of side effects were considerable (Helsper et al. 2012).

Using multivariate linear regression analyses, the study found that treatment duration was the only statistically significant determinant of treatment costs. Genotype, gender, age, treatment setting, somatic or psychiatric comorbidity, severity of liver damage and importantly, injecting drug use, were *not* independently associated with treatment costs (p-value for injecting drug use in multivariate analyses 0.4-0.9) (Helsper et al. 2012).

In 2012, the guideline for education, screening and treatment for hepatitis C in detention was finalised (DJI 2012). This guideline summarises step by step all actions to be taken, including cooperation with other fields (addiction care, hospital, social work, GP). In general, the guideline allows the start of hepatitis C treatment in prison only, when the detainee has a remaining sentence duration that will exceed the length of the hepatitis C treatment.

### 7.3.5 Other prevention activities

The Ministry of Health, Welfare, and Sport (VWS) finances the program Infectious Diseases and Drug Use, a collaborative project of the grassroots organisation Mainline Foundation and the National Support Function Prevention in Mental health and addiction care (Dutch abbreviation: LSP) of the Trimbos Institute. The focus of the program is on education and implementation of harm reduction measures. The program is in close contact with the functionaries at the addiction care institutions whose task is dedicated to infectious diseases. These functionaries, usually nurses, assemble every two months in a network to exchange information. The program developed several websites (e.g., sickofit.nl, hepikhepatitis.nl, both for drugs users with hepatitis C) and a team site for information exchange. Further, it yearly writes comprehensive guidelines and Factsheets on infectious disease and related topics.

## 7.4 Responses to other health correlates among drug users

As described in previous National reports, drug use disorders are frequently associated with other mental health disorders. In the past decade the number of facilities for the treatment of comorbidity in institutes for mental health care, addiction care, and supported living has increased.

Since 2009, a national centre for expertise and implementation has been in operation which offers basic and follow-up training courses in professional development and in-depth courses. The national centre boosts on specific aspects of integrated treatment, and offers advice and coaching on implementation on-the-spot. The centre is called Landelijk Expertisecentrum Dubbele Diagnose (LEDD), which can be translated as: National Centre of Expertise on Double Diagnosis.

In October 2012 an educational network ('work place Dual Diagnosis) was established by the LEDD and the Nijmegen Institute for Scientist-Practitioners in Addiction (NISPA). It aims to develop and improve a comprehensive treatment package for dual diagnosis patients, by organising eight meetings for about 10-16 professionals from mental health and addiction care, who can exchange information, share experiences and will be offered training courses. These include psycho-education, motivational interviewing, outreach work, personality disorders, security issues, demoralisation and recovery, and routine outcome monitoring.

A guideline (on the treatment of) Anxiety and Addiction (Angst en Verslaving) has been published in 2012 (Snoek et al. 2012).<sup>52</sup> It is considered as an addendum to the already published Multidisciplinary Guideline Anxiety Disorders and it targets integrated care for this type of comorbidity.

Also note that many interventions described in paragraph 8.3 (CRA, ACT and FACT) are targeting multiple problem populations, of which a large part has addiction, psychiatric and social problems.

Drug use is also associated with a range of somatic disorders. Most of the somatic problems associated with drug use are not unique for drug users but are common in other risk groups as well or are associated with the aging population in general. Therefore, most interventions are not exclusive for drug users. As a result, it is often unclear whether the treatment of

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<sup>52</sup>[www.resultatenscoren.nl](http://www.resultatenscoren.nl).

somatic problems is the responsibility of the addiction care, the general practitioner or whether they should take place in hospital. In general, the attention for somatic co-morbidity in problematic drug users in the Netherlands is rather low.

The Dutch association of addiction care physicians (VVGN) has written an “education plan” for the physician working in addiction care (VVGN 2011). Six themes were defined that together encompass the work field, both in specific disorders as well as in specific situations or problems that are relevant in, or characteristic for, this field. Theme 4 includes somatic disorders. It describes that the physician in addiction care is central in diagnosing and treatment of relevant somatic disorders, unless explicitly taken over by GP or somatic specialist. This field requires that the physician is pro-active in diagnosing somatic disorders, in periodical physical screenings, takes into account somatic comorbidity in the treatment of the patient, prioritises if necessary, offers (indicated) prevention, e.g., with regard to the metabolic syndrome or lung disease, mentions stop smoking programmes, pays attention to treatment compliance, etc.

Apart from the “medical” competences in this theme somatic disorders, also requirements are formulated on the level of communication skills, collaboration, knowledge and science, organisation, social responsibility and professionalism (VVGN 2011).

## 8 Social correlates and social reintegration

### 8.1 Introduction

By definition, if the level of social cohesion of a society *decreases*, the level of social exclusion of certain vulnerable groups *increases*. Social cohesion and social exclusion are one another's counterparts. For the Netherlands in general, the level of social cohesion is monitored by The Netherlands Institute for Social Research (SCP). In its 2011 Annual Integration Report, the SCP has especially monitored "the structural integration of non-Western migrants into Dutch society" (Gijsberts et al. 2012).

On the one hand, the following indicators of a better integration into Dutch society were found:

- There is a decrease in the proportion of migration marriages.
- The average number of children of migrants is coming closer to that of the native population.
- There is a high reach among migrants following civic integration programmes mandatory.
- The results of the civic integration programmes are largely positive.
- Due to the growing second generation, the educational disadvantage of the migrants is diminishing.
- The learning disadvantage in primary school is diminishing.
- The level of school dropout among migrants has reduced sharply.
- Increasing numbers of migrants are going on to higher education.
- The second generation of migrants is more often in senior positions at the labour market.
- Migrant women are more often in paid work and are more often economically independent.
- The second generation of migrants lives in increasingly high-quality homes.

However, on the other hand, the following indicators of a less successful integration of migrants into the Dutch society were found as well:

- There is a low reach among migrants who follow civic integration programmes voluntarily.
- The language disadvantage in primary school remains stubborn.
- The gap in secondary education is barely narrowing.
- The migrants who are going on to the higher education have less success.
- There is high and rising unemployment among migrants.
- The labour market position of Antillean migrants is weakening.
- The position of young migrants on the labour market is worrying.
- Migrants lag a long way behind in terms of income.
- The benefit dependency is much higher among migrants.
- The income position of migrants is deteriorating.
- There is a growing ethnic concentration in the peripheral municipalities around the major cities.
- Migrants are less satisfied with their housing situation.
- There is a substantial overrepresentation of non-Western migrants among crime suspects, and even two out of three men of Moroccan origin have been crime suspects in their youth.
- Migrants are more often victims of crime and more often feel unsafe.

With regard to the rising unemployment among migrants, FORUM, the Institute for Multicultural Affairs, confirmed that during the first quarter of 2012 the unemployment rate among migrants had increased to 15%, which is 2.5 times as high as the Dutch average (FORUM 2012). Among youngsters the unemployment rate has even risen to 27% among youngsters from Surinamese and Antillean origin, 33% among youngsters from Turkish origin, and even 39% among youngsters from Moroccan origin, compared to only 9% among youngsters from Dutch origin.

## **8.2 Social exclusion and drug use**

By means of a literature research and an expert meeting, the Addiction Research Institute Rotterdam (IVO) has investigated the social consequences of addiction (Hammink et al. 2012). It was found that addiction is associated with disturbances of social relations, dropout from school, homelessness, debts, and domestic violence. In general, these negative social consequences are more severe in case of low income, personality disorders, and living in a multiproblem family.

Involvement in crime counts as one of the most severe forms of social exclusion. With regard to explaining the relation between crime involvement and drug use, Stevens (2011) reviews that Goldstein's tripartite framework has become widely accepted as the best explanation. According to this framework, there is first a psychopharmacological link (e.g. some drugs increase aggression), second an economic-compulsive link (committing crimes to buy drugs), and third a systemic link (violence of the illegal market). Stevens (2011) criticizes that this tripartite framework overlooks that there is an underlying factor of social inequality, which induces problem drug use as well as crime.

Whatever the complex relation may be between drug use, crime, and other forms of social exclusion, this paragraph will review current developments in the Netherlands about, on the one hand, social exclusion of drug users, and, on the other hand, drug use among socially excluded groups.

### *Social exclusion of drug users*

In prior chapters, certain political developments have already been described which signal increased social exclusion in the Netherlands of drug users as well as problem drug users. Chapter 1 above reviewed the more strict guidelines for tolerating 'coffee shops'. As a result of these more strict guidelines, buying and using cannabis in a 'coffee shop' has become less normalized in the Netherlands, although differences may occur at local level. This might imply more social exclusion of the cannabis users.

Moreover, chapter 5 already mentioned the new financial policy for the mental health care, including the addiction care. Just like mental health clients, addiction clients will have to pay an own contribution to receive professional care. Additional contributions will have to be paid for residential treatment. There has been much political and societal debate about this own contribution, and its final version is still unclear. Certain forms of addiction care may circumvent the own contribution or perhaps certain exceptions may be made. Nonetheless, the announcement of having to pay a rather high own contribution counts as increased social exclusion and stigmatizing for people suffering from mental health problems and/or addiction problems. More details about the own contribution will be given in § 11.1.

### *Drug use among socially excluded groups*

The *Coda-G4* is a cohort study among the homeless in the four largest cities of the Netherlands, the G4, including Amsterdam, Rotterdam, The Hague, and Utrecht. This cohort study will monitor 513 homeless people who presented themselves in 2011 to the social relief somewhere in the G4. This cohort will be monitored during 2.5 years (Van Straaten et al. 2012). From the 513 homeless people, 410 homeless were age 23 years and above, and 103 homeless were 18 through 22 years old. From the age group 23 years and above, the adult group, 80% were male and 60% were ethnic, the mean age was 40 years. From the age group 18 through 22 years, the younger group, 60% were male and 63% were ethnic, the mean age was 20 years.

With regard to drug use, 43% in the adult group had used cannabis in the last month, and 63% in the younger age group. In the adult group, the last-month prevalences for other substances were 6.6% for crack cocaine, 3.4% for sniff cocaine, 3.7% for ecstasy, and 3.2% for amphetamines. In the younger age group, this was 1% for crack cocaine, 5.8% for sniff cocaine, 4.9% for ecstasy, and 2.9% for amphetamines. Having a problem with drug use was mentioned as a cause of having become homeless by 10.5% in the adult group and was mentioned as a cause of homelessness by 8.7% in the younger age group.

The use of drugs among the homeless in the G4 is also monitored by the *G4-USER*, the *Urban Social Exclusion Research* (Buster et al. 2012). During the winter of January and February 2012, a total of 2,232 homeless people were sheltered in the G4, on average 991 homeless per day. In a sample of 567 of these homeless people it was found that 90% was male, their mean age was 41 years, 48% was a Dutch national, and 25% had entered the city during the past year. With regard to the use of drugs, it was found that, during the past month, 11% had used cannabis almost daily, 6% had used cocaine, and 11% had used opiates.

The *Tendens* monitors the trends in living, working, and the use of substances in the province of Gelderland (Beurmanjer et al. 2012). With regard to the use of drugs among socially excluded groups, youth workers have observed in 2011 that some young prostitutes abuse cannabis to avoid their problems. Abusing cannabis this way is unfavourable for working on their problems. Cannabis is also used to make the work as a prostitute bearable, which can also be a reason to use cocaine. Also among problem youth it has been observed that cannabis is abused to avoid problems. When using cannabis this way, relaxing with cannabis turns into becoming passive. Ecstasy, amphetamines, and GHB are popular among hang-around youth.

## **8.3 Social reintegration**

### *Programs advertised in annual reports*

As a reflection of the national social relief strategy, institutes for addiction care can be found to advertise in their annual social reports special programs that aim at the social reintegration of drug users. Table 8.3.1 reviews the social-reintegration programs as published in the annual reports. All care institutions in the Netherlands are legally obliged to prepare a social report each year, this on behalf of the Admittance of Care Institutions Act (in Dutch: Wet Toelating Zorginstellingen, WTZi).

In case an institute for addiction care does not pay special attention to a certain rehabilitation program in its annual social report, this does not mean that the institute has no

such program at all. An institute does mention a program in its social annual report in case it has made special efforts to set up or to improve the quality of such a program.

*Table 8.3.1: Programs for social reintegration as published in the 2011 annual social reports of the 13 main regular institutes for addiction care and integrated addiction care and mental health care*

#### **1. Stichting Arkin, including Jellinek, Amsterdam**

- A separate business unit for community-oriented chains of care that implemented the method of "Integrated Dual Disorder Treatment (IDDT)".
- Integration of the units for daily activities.
- Special trademarks "Mentrum" and "Roads" for supported living 2011, incorporating Experts By Experience.
- Function description for Experts By Experience and a better organisational support system for the Experts By Experience.
- Start of 24 units for supported living at "de Witte Kaap".
- Start of 45 units for supported living at the "Woontrainingscentrum".
- Development of the new method "Critical Time Intervention" to offer step-by-step interferential care.
- Quality evaluation of three ACT-teams by means of the measurement instrument "Thermometer".
- Transition from Assertive Community Treatment (ACT) to Function Assertive Community Treatment (FACT).
- Development of a process manual for an integrated chain of care for homeless youth.
- Development of a training program for professionals integrating IDDT, FACT, and supported living, and incorporating Experts By Experience.

#### **2. Stichting Lievegoed Zorggroep, Bilthoven**

- Implementation of solidarity and community spirit from an anthroposophical inspiration.
- Offering integrated care for the whole person at small-scale locations in natural environments, and not just treating an isolated 'disorder'.
- Recognition of daily activities and supported living as essential forms of work.
- Implementation of evidence-based Therapeutic Working Communities at care farms, especially at the care farm "De Hondspol".
- Development of an expansion strategy for self-reliant care farms.
- Special projects for theatre productions at internal and external locations.

#### **3. Stichting Bouman GGZ, Rotterdam**

- Evaluation of supported living within the infrastructure of treatment, living, and working.
- Development of 33 extra units for supported living at the "Romanohof".
- Certification of the FACT-team "Charlois".
- Start of the project "Hillesluis" that creates safe havens of social networks around vulnerable people in the neighbourhood.
- Standard assessment and monitoring of the level of autonomy of a client by means of the AOS-V.

#### **4. Parnassia Bavo Groep B.V., including Brijder Verslavingszorg B.V., The Hague**

- Partnership with "ADO Den Haag in de Maatschappij" by which clients can obtain work experience.
- Participation in the foundation "Samen Sterk Tegen Stigma" to fight stigma.
- A special segment for neighbourhood-oriented social mental health care, including the FACT teams.

#### **5. Stichting Centrum Maliebaan, Utrecht**

- A special unit for social activation including "Bureau Dagloon", "Het Maliegilde", and the team for social support.
- A separate line of care ("Zorglijn") for long-term care.
- Appointment at two departments of two Experts by Experience and facilitation of self-help groups.

#### **6. Stichting Verslavingszorg Noord Nederland, Groningen**

- A separate division for living, working, and clinical care ("Wonen, Werken en Klinische Zorg") to support clients for living and working.
- Recognition of case management and ACT as a core task.
- FACT teams at all main locations, and further professionalization of the FACT teams.
- Start of the FACT team "DOK3" for multiproblem young clients up to 23 years of age.
- Start of 12 units for supported living at "Woontraining Franeker".

#### **7. Stichting Tactus Verslavingszorg, Deventer**

- Separate circuits for social addiction care and support.
- Recognition of small-scale living, labour reintegration, and social activation as core tasks.
- Recognition of social reintegration as a core task in co-operation with the Client's Council ("Cliëntenraad") and the Scientific Committee, with a focus on living, working, daily activities, Experts by Experience, and giving meaning to life.
- Further development of the reintegration program "Tactory" by which clients with certain disabilities can obtain work experience.
- Participation of clients and staff in public sport activities and other public activities.

#### **8. Stichting IrisZorg, Arnhem**

- A separate line of care for relief, living, and work, and recognition of work projects and rehabilitation programs as core activities.
- Recognition of the Community Reinforcement Approach (CRA) as the guiding principle for addiction care, and almost all professionals have been trained in CRA.
- Participation in the national project for rehabilitation work ("Herstelwerk"), and Critical Time Intervention (CTI) to support self-reliant living.
- Separate funding for innovative aftercare for ex-detainees.
- Development of 35 units for supported living in Nijmegen and 25 units in Doetinchem.
- Special projects for Experts By Experience.

#### **9. Stichting Emergis Centrum voor Geestelijke Gezondheidszorg, Goes**

- A special limited to support social reintegration by work ("Demontage Werkplaats Zeeland B.V. (DWZ)").
- Integration of the Foundation Living-room Project for Drug users (Stichting Huiskamerproject voor Druggebruikers, HKPD").
- Special department ("Het Duin") for long-term care and supported living.
- Special department for social relief ("Maatschappelijke opvang").
- Appointment of Experts By Experience and participation in the national project LIVE to appoint Experts By Experience from a national level.
- Special projects for neighbourhood parties and film festivals.



### **10. Stichting De Hoop, Dordrecht**

- Certification of the special department for reintegration "De Hoop Re-integratie", and start of the separate foundation "De Hoop Werk en Re-integratie" that will develop from giving work experience to supporting full reintegration.
- Nomination of the special department for reintegration "De Hoop Grafisch Centrum".
- Integration of the foundation "Stichting CJO Sela" which offers supported living for young people.
- A special department for social relief "Jordaan".
- A special department for living and community "Horeb".
- Start of the program "Freedom" which includes supported living and work experience.

### **11. Stichting Novadic-Kentron, Vught**

- Intensification of social relief and supported living.
- Leadership at national level in offering Community Reinforcement Approach (CRA), and implementation of CRA throughout the whole province.
- Participation with the municipality of Cuijk in the communication protocol for mutual clients to offer optimal self-reliant living.
- Participation in "DOOR!" which offers supported living.
- Development of supported living in the municipality of Roosendaal.
- Participation with the municipality of Eindhoven in the project of sharing information about the homeless to offer integrated care.
- Recognition of self-help groups as important partners.

### **12. Vincent van Gogh voor Geestelijke Gezondheidszorg, Venray**

- A special division for long-term care which pays attention to living, care, and daily activities.
- Using services from the "Cliëntenadviesbureau Noord- en Midden-Limburg (CAB)" that has appointed Experts by Experience.
- Integration of the FACT-teams for short-term care and long-term care into 5 FACT-teams.

### **13. Stichting Mondriaan, Heerlen**

- Development of offering the basic care at community level by means of neighbourhood teams.
- Transformation of clinical care into outpatient care targeting at rehabilitation.
- Ten teams for Functional Assertive Community Treatment (FACT), eight of which have been certified.
- Initiative for a network of rehabilitation groups that covers the whole region.
- Further development of participation of Experts By Experience.
- Small-scale supported living.

Source: <http://www.jaarverslagenzorg.nl>.

From the thirteen regular main institutes in table 8.3.1, eleven institutes mention to have given special attention to supported living, and ten institutes especially mention offering daily activities and work experience. Seven institutes especially mention the participation of Experts by Experience. Assertive Community Treatment (ACT), Functional Assertive Community Treatment (FACT), or Community Reinforcement Approach (CRA) are mentioned by eight institutes.

### *Other interesting initiatives and developments*

Some other interesting initiatives and developments to promote the social reintegration of vulnerable people in the Netherlands were as follows:

- In January 2012, the town council of the city of Arnhem adopted the program *Next Step*, which is a program that motivates addicted female sex workers to quit the prostitution scene.<sup>53</sup>
- In February 2012, the care program *Asja* from the institute *Fier Fryslân* was officially recognized as a theoretically well-based intervention. *Asja* offers social relief and treatment for girls and young women from 12 up to including 23 years who became a victim of a lover boy and were forced into prostitution.<sup>54</sup>
- On the 16<sup>th</sup> of March 2012, the Fontys University of Applied Sciences installed a lectorate entirely devoted to the issue about how to guide people from a social work place to regular work.<sup>55</sup>
- On the 12<sup>th</sup> of April 2012, *Altrecht*, the regular institute for mental health care in the province of Utrecht held a symposium about how to apply Functional Assertive Community Treatment (FACT) in combination with Mentalization Based Therapy (MBT) to clients suffering from severe personality disorders.<sup>56</sup> On the 29<sup>th</sup> of February 2012, *Altrecht* had given its traditional party for the homeless people, which was attended by about 400 guests.<sup>57</sup>
- On the 16<sup>th</sup> of April 2012, the Public Employment Service (UWV) and the National Branch Organisation for Mental Health Care and Addiction Services (GGZ Nederland) signed an agreement to stimulate the work participation of people with mental diseases.<sup>58</sup>
- On the 4<sup>th</sup> of September 2012, *Arkin*, the regular institute for mental health care and addiction care in the city of Amsterdam, together with other institutes started a pilot for a chain of mental health care for undocumented people.<sup>59</sup> These people lack a legal basis to stay in the country.

### *Evaluation research*

With regard to programs for social reintegration, results of evaluation research have become available recently about the Community Reinforcement Approach (CRA) in the city of Eindhoven, interventional care in the province of North Brabant, social relief in the city of Rotterdam, supported living in the cities of Enschede and Groningen, and about Assertive Community Treatment (ACT) and Flexible Assertive Community Treatment (FACT) in four regions.

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<sup>53</sup><http://www.hetccv.nl/nieuws/2012/02/arnhem-zet-in-op-uitstroom-tippelaarsters.html> [accessed 15-02-2012].

<sup>54</sup>[http://www.huiselijkgeweld.nl/nieuws/nieuws/2012/210212\\_zorgprogramma-asja-officieel-erkend-](http://www.huiselijkgeweld.nl/nieuws/nieuws/2012/210212_zorgprogramma-asja-officieel-erkend-) [accessed 21-02-2012].

<sup>55</sup><http://www.tilburg.com/web/Informatie/Nieuws/Nieuws/Lectoraat-onderzoekt-begeleiding-uit-Sociale-Werkvoorziening.htm> [accessed 16-03-2012].

<sup>56</sup><http://www.altrecht.nl/ggz/INT/59/098.html> [accessed 07-02-2012].

<sup>57</sup><http://www.altrecht.nl/ggz/INT/59/221.html> [accessed 29-02-2012].

<sup>58</sup><http://www.ggz nederland.nl/actueel/perslijsten/publiek-pers/uwv-en-ggz-stimuleren-arbeidsdeelname-mensen-met-psychische-aandoening.html?jaar=2012> [accessed 16-04-2012].

<sup>59</sup>[http://www.ggznieuws.nl/2011/index.php?option=com\\_content&view=article&id=4049:pilot-zorgketen-ggz-voor-ongedocumenteerden-van-start&catid=3:verzameld-nieuws&Itemid=1](http://www.ggznieuws.nl/2011/index.php?option=com_content&view=article&id=4049:pilot-zorgketen-ggz-voor-ongedocumenteerden-van-start&catid=3:verzameld-nieuws&Itemid=1) [accessed 04-09-2012].

### *Community Reinforcement Approach (CRA) in Eindhoven*

In table 8.3.1 above, it was reported that the institute for addiction care Novadic-Kentron (no. 11) has stated the ambition to become the national leader in Community Reinforcement Approach (CRA). Novadic-Kentron is the regular main institute for addiction care and treatment in the province of North Brabant. In the city of Eindhoven, located in this province, the CRA offered by Novadic-Kentron has been evaluated (Dijkstra and Roozen 2012, see also the Standard Table EDDRA\_2012\_NL\_01).

The idea behind CRA is that it "assists patients by identifying and capturing their nonsubstance-related reinforcers from the natural environment and by implementing procedures to increase the accessibility of these reinforcers, such as problem solving, systematic encouragement, reinforce access, and reinforce sampling to compete with the reinforcing effects of substance use" (Dijkstra and Roozen 2012).

Between September 2008 and December 2009, 34 alcohol clients from the city of Eindhoven participated in the evaluation of the CRA. Their mean age was 46.1 years, and 61.8% was male. The effects of a 6 weeks CRA program (including detoxification) were measured by the Pleasant Activities List (PAL) and by the CRA Happiness Scale (CRA-HS). Improvements were found on two subscales of the PAL and "the effect sizes of the CRA-HS were even more robust". The authors conclude that especially the CRA-HS, "seems favourable to adopt in a routine outcome measurement procedure to evaluate program effects". Finally, the authors recommend to replicate this evaluation research with regard to illicit drugs and clients with other cultural backgrounds (Dijkstra and Roozen 2012).

### *Interferential care in the province of North Brabant*

The effects of interferential care ("bemoeizorg") have been studied in three regions in the province of North Brabant: the city of Tilburg, the north east region, and the city of Eindhoven (Roeg et al. 2012). Interferential care is given to vulnerable people who do not ask for help themselves, but avoid care institutes. The target of interferential care is to guide these vulnerable people into care. Therefore, contrary to Assertive Community Treatment (ACT), interferential care is given only temporary.

A total of 523 clients receiving interferential care were monitored during three years. Their average age was 45.7 years, and 66.1% was male. On average, the clients were referred for three problems, most often financial problems, psychiatric problems, and addiction problems. Two trials were required on average to come into contact with the client, and on average they received seven months of interferential care.

It was found that, when having finished interferential care as well as at a 6-month follow-up, the quality of life had increased (large effect), the problems were less severe (medium effect), the relation with the care-giver had improved (small effect), and there were fewer problems with referring the clients to the follow-up care (small effect) (Roeg et al. 2012).

### *Social relief in Rotterdam*

In the city of Rotterdam, programs for social relief have been evaluated with regard to programs for homeless young people and night relief for the homeless in general.

During 2009, the Addiction Research Institute Rotterdam (IVO) recruited 55 homeless young people suspected to have severe problems like psychiatric disorders, addiction, or intellectual disabilities (Barendregt et al. 2011). They aged 18 up to including 23 years, their mean age was 20 years, two third of them were male, and 20% of them showed intellectual disabilities. These young people and their nearest counsellors were interviewed

three times during a period of 12 months. In addition, 15 former homeless young people who had obtained stable housing were also interviewed.

It was found that during the period of the interviews the perceived quality of life had increased, that most of the homeless young people had reached a more stable housing situation, and that their psychological problems had decreased. Nonetheless, the use of psychoactive substances remained high, daily activities had not changed, and debts had increased. Moreover, it was found that in about half of the cases the demand for help did not match with the supply. The mismatch between demand and supply was found to have resulted from the severity of the problems, inflexibility of the care, waiting lists for more intense treatment, not enough or too much pressure on the young clients, insufficient treatment of aggression, and lack of co-ordination between different forms of care.

#### *Supported living in Enschede*

Within the framework of the Strategy Plan for Social Relief, the general approach in the Netherlands is to reach homeless people by means of interventional care, social relief, and supported living. The goal is that, by passing through from interventional care and social relief to supported living, the clients will become as self-reliant as possible.

During 2010, in the city of Enschede and its surrounding municipalities, a total of 889 clients received interventional care (Kruize et al. 2011). Their mean age was 39 years, 63% was male, and 47% had an addiction problem. In addition, a total of 832 clients in the region of Enschede received supported living. The average age of these clients was 41 years, 70% was male, and on average they stayed in supported living for 62 months. From 62 clients it could be traced back that they had passed through from social relief to supported living.

#### *Supported living in Groningen*

By the Summer of 2011, the municipality of Groningen failed to find enough bearing surface in a designated neighbourhood to implement supported living for about 30 young adult ex-detainees aging 17 up to including 27 years. Bureau Intraval was asked to evaluate what went wrong and to advise about how to do better in the future (Bieleman et al. 2012). Bureau Intraval interviewed professionals from the involved network and interviewed 345 habitants who lived in the surrounding where the supported living had been planned.

The habitants were asked which target groups, according to their opinion, could be placed in supported living in a neighbourhood. It was found that 97% of the habitants accepted supported living in their neighbourhood for people having visual or acoustic disabilities as well as for people suffering from physical or mental handicaps. However, only 83% would accept former addicts, and only 58% would accept current addicts.

From its evaluation research, Bureau Intraval concluded that implementing supported living successfully in a neighbourhood requires the following:

- involving surrounding habitants from the very start of the process, as soon as a location for supported living is looked for;
- good communication between different departments of the municipality;
- involving all stakeholders, including the habitants, in the final choice of the location;
- recognition of zoning plans ("bestemmingsplannen"), and following proper procedures to change current zoning plans.

### *ACT and FACT in four regions*

In four regions in the Netherlands, all the care received by psychiatric patients is monitored in a *Psychiatric Case Register* (Psychiatrisch Casus Register, PCR). Recently, information has become available from four PCRs about patients having received Assertive Community Treatment (ACT) or Flexible Assertive Community Treatment (FACT) in the cities of Rotterdam, Utrecht, Maastricht, and Groningen (Drukker et al. 2012). These patients suffer from a Severe Mental Illness (SMI), often combined with addictions and a bad physical condition. The targets of ACT and FACT are to reduce the number of clinical admissions, to reduce the duration of clinical admissions, and to keep the patients in contact with treatment.

For the city of Rotterdam, information has become available from 637 measurements from 139 patients who were treated by six ACT-teams between 2003 and 2008. It was found that, especially for the male patients, psychosocial functioning increased during the first months of receiving ACT. Although ACT was not able to always prevent a clinical admission, in case of a clinical admission this did not affect the ACT-trajectory on the long-term.

The ACT-team in the city of Utrecht especially targets people with mental illnesses who avoid treatment. On average, the patients remained in ACT for 24 months, ranging from 5 days to 8.5 years. After the start of ACT as well as after having received ACT, the patients were indeed more often seen in treatment, including supported living and daily activities, which can be seen as a success of ACT.

After the introduction of FACT in the city of Maastricht, the proportion of patients in remission increased from 19% to 31%. However, this only appeared to count for patients suffering from psychosis, and not for patients suffering from additional addictions. Therefore, experts on addiction have now been added to the FACT-teams.

In 2009, a total of 11 FACT-teams were in operation in the city of Groningen. A total of 543 patients who received FACT could be compared to 102 patients who did not receive FACT. On average, the patients in FACT had 27 contacts a year, stayed in FACT for 62 months, ranging from 1 day to 10 years. It was found that the patients who did receive FACT had a better score on the Health of the Nations Outcome Scale (HoNOS). The severity of symptoms decreased when receiving FACT.

Although a hard causal relation could not be proven, the authors all in all conclude that ACT and FACT go together with being in treatment to receive other forms of care, and go together with less psychopathology (Drukker et al. 2012).

## 9 Drug related crime, its prevention, and prison

### 9.1 Drug related crime

#### 9.1.1 Drug law offences

The most important act with regard to drug law offences is the Opium Act, which defines the trafficking, production, cultivation, dealing and possession of illegal drugs as criminal acts, when these activities take place outside of the conditions mentioned in the Opium Act Decision and the Regulation Opium Act Exemptions. The drugs in question are named in schedule I ('hard drugs' like heroin, cocaine, amphetamines or ecstasy) and schedule II ('soft drugs' like cannabis or hallucinogenic mushrooms) of the Opium Act. The possession of drugs is a criminal act and therefore theoretically the use of drugs may be a criminal act as well. This reasoning was part of a verdict of the Council of State (Raad van State 201009884/I/H3 2011). The Prosecutor, however will never prosecute consumption of drugs per se.

Preparative activities for the illegal production, sale or export of hard drugs are also criminal acts according to the Opium Act (article 10a). These imply also possession of substances which are meant to be used for the illegal production of hard drugs (see for instance LJN: BW8614 2012).

The Prevention of Abuse of Chemicals Act is also of importance for the combat of drug-related crime, especially with regard to precursors of synthetic drugs. In addition, administrative law plays an increasing role in the combat of drug-related crime on the local and regional level.

Police and Public Prosecutor give low priority to the investigation of possession of small amounts of a drug for own use. The Opium Act Directive of the Public Prosecutor state that, if the offence concerns possession of small amounts for own use of a hard drug, the drugs will be seized, but normally there will be no custody or prosecution. Diversion to care is the primary aim of custody or prosecution in cases of possession of hard drugs (Directive Opium Act 2011A021 2012, [www.om.nl](http://www.om.nl)). 'Small amounts' of a hard drug are defined as one tablet, ample, wrapple or ball of the drug and in any case an amount of no more than 0,5 grams. With regards to cannabis (categorized as 'soft drug') small amounts are defined as no more than 5 grams and no more than 5 cannabis plants – under the condition that there is no professional or commercial cultivation of the plants (Stc. 2011 – 22936). For hallucinogenic mushrooms, also categorized as soft drugs, the small amounts for own use are defined as 0,5 grams (dried mushrooms) and 5 grams (fresh ones). In cases of possession of small amounts of soft drugs, the drugs will be seized but a dismissal by the police will normally ('in principle') follow, without custody or prosecution.

Paragraph 9.1.1 reports about Opium Act offences, including organised crime in relation to drugs. In the next paragraphs, data are presented from registrations of Police Forces and Public Prosecutor, and the Prison Services. In addition, Crime Pattern Analysis of the Netherlands Police Agency, policy documents en research reports are used as sources of information.

With regard to registration data of law enforcement agencies the following should be noted:

- The figures cover offences that came to notice of the police. They should not be interpreted as a measure of the size of drug markets or as a supply indicator.
- Registration data always depend for a certain part on the activities, priorities and skills of law enforcement agencies. In the observed period (2011) there were several intensified law enforcement activities running with regards to drug crime. First, the enhanced law enforcement on cannabis cultivation is under action. Second, the organised crime in relation to heroin, cocaine and synthetic drugs and the organised large scale cultivation of cannabis have been priority areas for police and prosecution (TK29911-10; Boerman et al. 2008; TK 29911-17). These enforcement priorities influence the numbers of reported offences.
- Databases are adapted and improved in the course of time and figures are cleaned and adapted every year. As a consequence, later versions may differ from former ones. The current (preliminary) updates over 2011 are presented in this chapter.
- In 2008, major changes in information systems and underlying databases of the police and the Public Prosecutor were introduced. The National Audit Office concluded in 2011 that the new police registration system of crime reports (*BVH, Basisvoorziening Handhaving*) was not implemented in a consistent way (TK 29350-10). According to the National Audit Office, figures might be incomplete. Whether this is really the case, and if so, to what extent figures are incomplete is not known. The problem could affect the figures of the Public Prosecutor as well. In September 2011, the minister of Security and Justice announced improvements of the ICT-systems of the police forces in a programme that will be implemented in 2011-2017 (TK 29628-269, attachment, Aanvalsprogramma Informatievoorziening Politie 2011-2014). This programme was running in 2011.
- The national registration systems of police and Public Prosecution do not contain specific information about types of drugs or specific types of drug offences. Only 'hard drugs' (schedule I) and 'soft drugs' (schedule II) can be distinguished. This general distinction between hard and soft drugs will be made in this chapter whenever possible. Categories of offences (production, trafficking or dealing) cannot be distinguished in a meaningful way.
- The Opium Act contains only rough and broad categories of drug offences. Therefore it is not possible to distinguish between offences related to personal use and other offences like production, trafficking and dealing.
- Since 2008, the jurisdiction of the Public Prosecutor to apply sanctions were expanded (Stc 8299, 2012; OM Feitenboekje 2012). The data presented below include the facts which were handled by the Public Prosecutor on the basis of this expanded jurisdiction.

#### *Criminal investigations into organised drug related crime (table 9.1.1)*

Figures on the number of investigations into organised crime come from the Information Services of the Netherlands Police Agency. They make an inventory for Europol, in the framework of European Serious and Organised Crime Threat Assessment (SOCTA). A comparison between figures over the years should be done with caution, because the delivery of figures is done by several different organisations and not all of them deliver each year. We compare figures of 2011 with 2010 and 2009 figures, because 2010 gives an incomplete picture.

- In 2011, 72% of the investigations into serious and organised crime involved drugs. Although this is less than in 2009 and 2010, drug-related investigations still are the majority.
- Most of the investigations involve (also) hard drugs (76%). The proportion of investigations involving hard drugs increased compared to 2009 and 2010. In the long run however, there seems to be no increase.
- Cases with hard drugs mostly concern cocaine (75%). Second are synthetic drugs, (41%), then heroin (27%). Cases related to heroin increased in 2011 compared to 2009 and 2010.
- The proportion of investigations involving (also) soft drugs increased and is higher than in the years before (now 69%).
- There are more investigations into cases which involve hard *and* soft drugs in combination. As is described in Chapter 10 (§ 10.1), combinations of cannabis, synthetic drugs and cocaine were discovered recently.

*Table 9.1.1: Investigations into more serious forms of organised crime, percentage of drug cases and type of drug involved, 2004-2011<sup>I,II</sup>*

	2004	(III)	2005	(IV)	2006	2007	2008	2009	(V)	2010	2011
<i>Total number of investigations (N)</i>	289	...	(176)	...	333	328	352	272	...	(123)	318
- % targeting drugs	69%	...	72%	...	75%	72%	70%	75%	...	77%	72%
<b>N targeting drugs</b>	200	...	(127)	...	250	235	247	203	...	(95)	230
- % cases with hard drugs	84%	...	85%	...	79%	83%	76%	72%	...	73%	76%
- % cases with soft drugs	27%	...	41%	...	60%	67%	65%	67%	...	68%	69%
- % only hard drugs	69%	...	59%	...	40%	36%	35%	33%	...	32%	31%
- % only soft drugs	11%	...	15%	...	21%	20%	24%	28%	...	27%	24%
- % hard & soft drugs	16%	...	26%	...	39%	47%	41%	40%	...	41%	45%
<b>N targeting hard drugs</b>	168	...	(108)	...	198	194	188	147	...	(69)	175
- % cocaine	57%	...	54%	...	68%	77%	76%	78%	...	70%	75%
- % synthetic drugs	39%	...	44%	...	43%	40%	46%	41%	...	51%	41%
- % heroin	18%	...	29%	...	29%	20%	22%	25%	...	20%	27%

I. Investigations may involve more than one type of drug. II. .... Means that figures between years are incomparable due to inconsistencies in data collection. III. Data 2005 concern the period January-November. IV. In 2006 a larger scope of selection was implemented; as a consequence the number of investigations is substantially higher than in the years before, in particular the number of soft drugs trafficking. V. Data 2010 are incomplete and preliminary. Source: KLPD/IPOL 2012.



### *Systemic drug crimes*

Crime Analyses Reports of the Netherlands Police Agency 2012 about criminal organisations involved in drugs contain some information about systemic crimes in the Netherlands (see Chapter 10 § 10.1.2 for a description of these reports).

- In general, no competitive rivalry was observed between criminal organisations involved in production and export of Dutch-grown cannabis (*nederwiet*). There seems, on the contrary, more co-operation than competition between producers and traffickers, probably because the demand exceeds the supply (NND Nieuwsbrief 2012). Violence is only observed at times of harvesting. Because the yield is sometimes stolen, this leads to protective activities in the form of (threat) of violence, mainly directed at persons outside the organisation.
- A number of investigations into cocaine-related criminal organisations reveal systemic violence like blackmailing, intimidation and liquidations (Van der Laan 2012).
- The production and trafficking of synthetic drugs sometimes involves violence, but only as a last resort in conflicts. Threatening with violence is reported and there are indications that violent incidents increase in number (KLPD 2012).

### *Opium Act reports by the Police Forces (table 9.1.2)*

- There is an increase in the total number of police reports of Opium Act offences in 2011.
- There is an increase in both hard and soft drugs reports compared to 2010. The increase in soft drugs exceeds the increase in hard drugs offences. The number of reports of combinations of both hard and soft drugs has decreased. This type of cases forms a minority.
- The proportion of hard drugs and soft drugs offences remained more or less constant compared to 2010. In 2011, there are almost as many hard drugs as soft drugs reports. There is an increase in the proportion of soft drugs offences since 2009. This increase is confirmed by the Netherlands Police Agency, who assume that the increase is a result of the intensified enforcement efforts directed at cannabis production (Nationaal Netwerk Drugsexpertise 2012).
- 7% of all the police reports concern Opium Act offences in 2011. This proportion increased compared to 2010.
- Most arrestees for Opium Act offences are male. Most of the arrestees have more than one criminal report. For 42%, the 2011 offence is the first registered offence (of all possible offences, not only Opium Act offences; not in table).

Table 9.1.2: *Opium Act reports by the Police Forces by drug type (hard-soft), 2004-2011<sup>I</sup>*

	2004	2005	2006	2007	2008	2009	2010	2011
Hard drugs	12,035	11,084	10,978	10,682	9,524	7,746	7,692	7,810
Soft drugs	7,433	8,273	7,973	7,859	7,554	8,163	7,699	8,027
Hard and soft	2,105	2,158	2,708	2,801	2,718	1,901	1,436	1,456
Other/unknown	696	380	349	93	56	1	0	7
Total	22,269	21,895	22,008	21,435	19,852	17,811	16,827	17,300
Hard drugs	54%	51%	50%	50%	48%	43%	46%	45%
Soft drugs	33%	38%	36%	37%	38%	46%	46%	46%
Hard and soft	9%	10%	12%	13%	14%	11%	9%	8%
Other/unknown	3%	2%	2%	0%	0%	0%	0%	0%
Total <sup>I</sup>	100%	100%	100%	100%	100%	100%	100%	100%
% drug related of total number of offences	7,5%	7,3%	7,3%	6,9%	6,8%	6,6%	6,7%	7,0%

I. More than one offence may be reported per suspect. due to rounding numbers, percentages do not always add up to 100. II. Number 2011 are preliminary. III. 0% is <0,5% in cases where the number of other/unknown is >0.

Source: HKS, KLPD/IPOL, extraction from the WODC-Datamart Drugs, 2012.

### *Opium Act cases registered by the Public Prosecutor (table 9.1.3)*

The next phase in the criminal justice chain is the Public Prosecutor. Note that a police report is a different administrative unit than a case registration of the Public Prosecutor.

- In 2011 the number of Opium Act cases increased compared to 2010, especially soft drug cases. The increase is substantial.
- The percentage of soft drug cases increased in 2011, while that of hard drug cases decreased. More than half of the cases (53%) concerns soft drugs now.
- The majority of the Opium Act cases (60%) concerns production, trafficking or dealing of drugs, 40% concerns possession of drugs (not in table). It is not known from the figures what the quantity of drugs was in the cases of 'possession of drugs'. The general guideline for prosecution states that, if possession concerns 'small amounts for own use' police dismissal or prosecution aimed at diversion to care can follow. The drugs will always be seized. But if someone possesses more of a drug than the small amount that is considered 'for own use' – and which might be meant for dealing – or if there is also another, more serious offence involved, arrest and prosecution are the rule. The available data do not allow a distinction between possession of small amounts for personal use or larger amounts which might be meant for supply.
- In cases of hard drugs, 44% concerns production or trafficking and 46% concerns possession of hard drugs in 2011 (not in table). For soft drugs, these fractions are different: 74% concerns production or trafficking and 26% possession (not in table).
- The percentage of Opium Act cases of all cases in 2011 is 7.6%. This is the first increase since 2005.

Table 9.1.3: *Opium Act cases registered by the Public Prosecutor by drug type (hard-soft), 2004-2011<sup>I</sup>*

	2004	2005	2006	2007	2008	2009	2010	2011
Hard drugs	11,974	9,923	9,912	9,471	9,083	7,424	6,891	7,358
Soft drugs	9,249	9,499	9,544	9,207	9,057	8,965	7,365	9,236
Hard and soft	695	716	822	677	671	647	588	659
Other/unknown	32	60	34	53	54	40	61	49
Total	21,950	20,198	20,312	19,408	18,865	17,076	14,905	17,302
Hard drugs	55%	49%	49%	49%	48%	43%	46%	43%
Soft drugs	42%	47%	47%	47%	48%	53%	49%	53%
Hard and soft	3%	4%	4%	3%	4%	4%	4%	4%
Other/unknown <sup>II</sup>	0%	0%	0%	0%	0%	0%	0%	0%
Total <sup>*</sup>	100%	100%	100%	100%	100%	100%	100%	100%
% drug related of total number of cases	8,0%	7,5%	7,5%	7,1%	7,1%	7,3%	7,0%	7,6%

I. More than one case may be recorded per suspect; due to rounding numbers, percentages do not always add up to 100. II. 0% is <0,5% in cases where the number of other/unknown is >0. Source: OMDATA, extraction from the WODC Datamart Drugs, 2012.

#### *Decisions made by Public Prosecutor in Opium Act cases (table 9.1.4)*

- The majority of Opium Act cases is submitted to court. The proportion decreased compared to 2010. This decrease is most visible for cases which involve hard drugs: 68% in 2010, 63% in 2011. For soft drug cases, these percentages are: 64% in 2010 and 63% in 2011. The percentage remained constant for cases involving hard and soft drugs: 84% (not in table).
- 17% of the cases get a transaction by the Public Prosecutor. These transactions include community service orders and financial transactions. In the period 2004 – 2009 the median amount of money in financial transactions of the Public Prosecutor fluctuates between €230 and €270. From 2010 on this value increases from €280 in 2010 to €320 in 2011. This is the highest median value in years (not in table).
- Since February 2008, the Public Prosecutor has the disposal to impose sentences for several crime types without referring to the Court. This is the so called “strafbeschikking” (disposal to impose sentences) and it may imply several sanctions like fines, community service orders and disqualification from driving. This disposal is gradually being implemented. It is meant to replace the transaction entirely in a couple of years. In 2011 the first “Strafbeschikkingen” in relation to Opium Act offences can be found. They form 5% of the total number of Public Prosecutor decisions.
- Relatively small fractions of Opium Act cases are dismissed due to policy or technical reasons. The percentage of dismissals due to policy reasons was high in 2004 because many cases were dismissed as a policy in cases of hard drug trafficking at Schiphol Airport by drug couriers. Non-prosecution was a policy decision and part of the temporary drug oriented approach of drug couriers at Schiphol. Since 1-1-2006, all of these types of cases are prosecuted again.

The other cases ended with joinder of charges, were dismissed for administrative reasons or transferred to another court (last two types not in table).

*Table 9.1.4: Decisions by the Public Prosecution in Opium Act cases, 2004-2011*

	2004	2005	2006	2007	2008	2009	2010	2011
Submitted to court	61%	65%	66%	66%	62%	62%	67%	64%
Transaction	20%	19%	21%	22%	24%	23%	21%	17%
Sentence disposal								5%
Case dismissal due to policy reasons	10%	8%	6%	5%	6%	6%	5%	5%
Case dismissal due to technical reasons	7%	6%	5%	5%	6%	7%	7%	8%
Joinder of charges	2%	2%	2%	2%	2%	2%	1%	1%

Source: OMDATA, extraction from the WODC Datamart Drugs, 2012.

*Opium Act cases submitted to Court (tables 9.1.5 and 9.1.6)*

- The total number of Opium Act cases handled by the Courts decreased. There is a continuous decreasing trend since 2007.
- The proportion of hard drug cases has increased and that of soft drug cases decreased in 2011 compared to 2010.
- In 2011 the court cases concern almost as much hard drugs (48%) as soft drugs (47%). The fraction of hard- and soft drugs remained constant (5%).
- The percentage of Opium Act cases of the total number of cases handled by the court did not change compared to 2010 and is 7.8%.
- Opium Act cases submitted to Court result in first instance in a conviction with a community service order, an (unconditional) prison sentence or a fine. The sanction most often applied in 2011 is the (partly) unconditional prison sentence.

*Table 9.1.5: Number of court sentences for Opium Act cases by drug type, 2004-2011<sup>I</sup>*

	2004	2005	2006	2007	2008	2009	2010	2011 <sup>I</sup>
Number of Opium Act cases	12,140	12,185	13,000	11,797	11,383	10,516	9,358	9,110
Type of drug:								
- Hard drugs	58%	52%	50%	51%	51%	49%	46%	48%
- Soft drugs	38%	44%	45%	45%	45%	47%	49%	47%
- Hard- and softdrugs	4%	4%	4%	4%	4%	4%	5%	5%
- Other/unknown <sup>II</sup>	0%	0%	0%	0%	0%	0%	0%	0%
% drug related on total number of cases	8.3%	8.4%	8.9%	8.5%	8.1%	7.6%	7.8%	7.8%

I. There can be more than one case per person. II. 0% = <0.5% in cases where the number of other/unknown is >0. Source: OMDATA, extraction from the WODC Datamart Drugs, 2012.

Table 9.1.6: Types of sanctions in Opium Act cases imposed by the Courts, 2004-2011<sup>1</sup>

	2004	2005	2006	2007	2008	2009	2010	2011
Community service order	4,389	5,126	5,651	4,694	4,119	3,856	3,362	2,813
(Partly) unconditional prison sentence	5,393	4,845	4,762	4,238	4,283	3,712	3,279	3,008
Fine	2,110	1,830	1,798	1,615	1,658	1,532	1,299	1,072

I. There can be combinations of sanctions. Source: OMDATA, extraction from the WODC Datamart Drugs, 2012.

- The mean number of hours of a community service order is 92 in 2011, somewhat less than in 2010 (97 hours). Since 2004 the number of hours has decreased with 25 (not in table).
- The mean number of days of (partly) unconditional prison sentences is 285 in 2011, which is a decrease compared to 2010 (308 days). Since 2004 the mean number of days has decreased with almost three months (2004: 377 days; not in table).
- The median amount of money of fines is €450 in 2011, €10 higher than in 2010. In 2011 and 2010 the amount is still about €50 lower than in the years 2004 – 2006.

#### *Opium Act offenders in prisons (figure 9.1.1)*

16% of the detainees in the prison system on September 30 2011 were convicted for an Opium Act offence. This proportion did not change much in the last years, it ranged between 17% and 20%. Most detainees are convicted for violent offences, which include violent offences, property offences with violence and sexual offences.

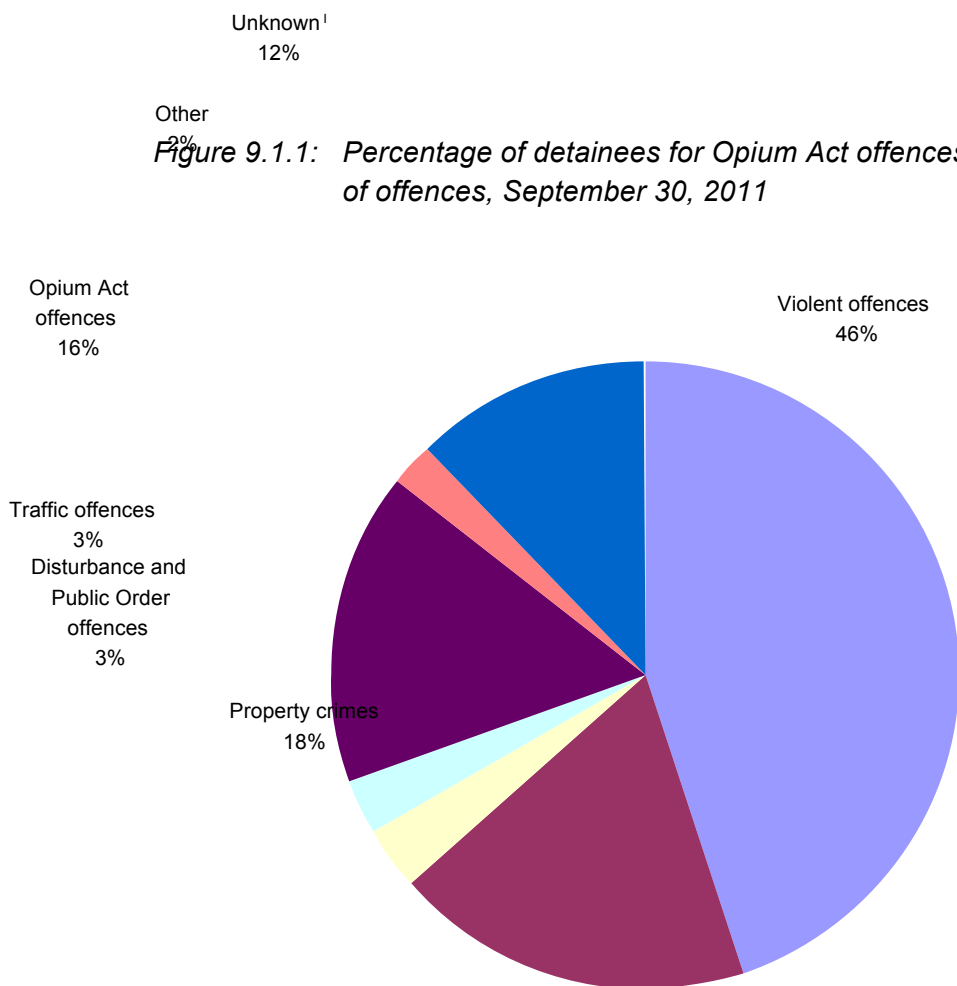


Figure 9.1.1: Percentage of detainees for Opium Act offences compared to other categories of offences, September 30, 2011

I. Unknown because of specific legal residency or other reasons. Source: Van Rosmalen, Kalidien, and De Heer-de Lange, N.E. 2012.

*Other information: expenditures for Opium Act offences*

Moolenaar, Nauta, and Van Tulder (2012) report on expenditures for security issues in 2010. Expenditures for different types of offences – whereby offences are categorized on the basis of the most serious offence – are calculated, amongst which Opium Act offences (table 9.1.7). Figures are preliminary.

- Expenditures for Opium Act offences are estimated at € 766.3 million, of which € 485.8 million is spent on hard drugs and € 280.4 million on soft drugs.
- Expenditures for Opium Act offences account for 6% of the total of expenditures for security issues (including minor offences).
- 3.2% of the money is used for prevention, 0.4% for investigation, 0.3% for prosecution, 0.1% for sentencing, 1.7% for the execution of sentences, and 0.3% for support of offenders and other kinds of support and activities.
- Soft drugs expenditures are highest in the stage of prevention, but hard drugs are higher in all the other activities (not in table).
- Of all types of offences, Opium Act offences rank fifth in amount of expenditures for security issues (see table 9.1.7)

Table 9.1.7: Expenditures for different types of offences, 2010<sup>I</sup>

Types of offences:	Total (in mln €)	Prevention	Investigation	Prosecution	Sentencing	Execution	Other <sup>II</sup>
Property crimes	5,946.2	3,293.4	1,528.8	187.0	89.4	618.8	228.6
Violent and sexual offences	2,241.8	599.2	263.2	164.7	55.5	1,011.0	148.2
Vandalism, disturbance of public order	2,003.3	1,292.2	411.1	61.4	30.5	128.9	79.3
Traffic offences	857.5	121.7	501.6	49.5	34.9	49.2	100.5
Economic offences	176.1	23.7	91.5	17.1	10.3	2.9	30.7
Opium Act offences	766.3	405.4	55.2	42.3	16.0	211.3	36.1
Other offences	224.2	59.7	65.9	30.2	12.1	21.3	35.1
Minor offences	500.4	15.0	41.2	147.7	67.1	229.3	-
Total	12,715.7	5,810.1	2,958.4	699.9	315.8	2,272.7	658.7

I. Figures are preliminary. II. Lawmaking, Inspectorates. Source: Statistics Netherlands (CBS), calculation Research and Documentation Centre Ministry of Security and Justice (WODC).

### 9.1.2 Other drug-related crime (i.e. crimes committed by drug users)

#### Offences committed by drug users

The Police Records System includes a classification 'drug user'. This designation is given to a suspect if he/she may constitute a danger to others due to his or her drug use, if he/she indicates being a drug user or if he/she asks for methadone. The classification is made by the police, but because drug use is not assessed systematically, its validity is disputable. An unknown proportion of drug using offenders is missing in the classification.

The category of drug users who are registered as such by the Police has the following profile in 2011 (not in table; preliminary data):

- 93% is male. They are an ageing population: mean age increased from 37 years in 2003 to 41 in 2011. 95% is over 24 years old.
- Many of them are prolific offenders: 81% was arrested more than ten times before and 25% more than 50 times.

With regards to the type of crime, we can see the following pattern in the registered crime (table 9.1.8):

- Most of the drug using suspects were suspected of property crimes. This fraction increased in 2010 and 2011.
- The proportion of drug users suspected of property crimes with violence decreased.
- Violent crimes (against persons) committed by drug using suspects remained more or less constant.
- Other offences (Opium Act offences, vandalism/disturbance of public order, traffic offences) show decreasing trends in the last years. Especially the proportion of drug users suspected of Opium Act has decreased substantially to 16% in 2011.

Table 9.1.8: Types of crime of suspects classified by the Police as drug users, 2004-2011<sup>1</sup>

	2004 N= 10,504	2005 N= 9,646	2006 N= 8,878	2007 N= 8,307	2008 N= 7,757	2009 N= 6,892	2010 N= 6,324	2011 N= 6,199
Property crimes without violence	56%	53%	50%	49%	51%	50%	52%	53%
Property crimes with violence	10%	8%	8%	8%	7%	7%	7%	6%
Other violence (against persons)	24%	24%	26%	29%	28%	29%	29%	28%
Opium Act offence	23%	24%	25%	21%	21%	19%	16%	16%
Vandalism, disturbance of public order	23%	22%	23%	24%	22%	20%	20%	19%
Traffic offence	11%	11%	11%	12%	13%	13%	11%	11%
Sexual offence	1%	1%	1%	1%	1%	1%	1%	1%
Other	11%	11%	10%	11%	10%	11%	11%	12%

1. Suspects may commit more than one type of offence; percentages do not add up to 100. Source: HKS, KLPD/IPOL, extraction from the WODC Datamart Drugs, 2012.

### *GHB and offending*

- Heavy users of GHB, who were interviewed in the study of Voorham and Buitenhuis (2012), report that, as a consequence of the disinhibitive effect of GHB, users tend to rob, steal and drive under the influence more readily.
- The police is confronted with an increasing number of GHB-users who committed offences (Korf, Nabben & Pronk, 2012). This category of GHB-users is broad and consists of homeless poly drug users with comorbid psychiatric problems, street youngsters, pleasure-seekers and home-users. Korf et al. (2012) estimate that about 420 and 570 times a GHB-users got in contact with the police in 2010 and 2011. This concerned about 320 and 420 unique persons. About 70% of them was detained in a police cell. Sometimes users are sent away although they should be enclosed on the basis of their offence.

### *Prolific offending by drug users*

The Research and Documentation Centre of the Ministry of Security and Justice monitors the population of Very Active Adult Prolific Offenders (VAPO's) since 2005. In 2012 the analysis covers the period 2003-2009 (Tollenaar and Van der Laan 2012). A very active prolific offender is a person of 18 years and older with more than ten police reports in the last five years. The number of VAPOs shows a decreasing trend (table 9.1.8).

- The majority of VAPO's is recorded by rehabilitation services as having addiction problems (table 9.1.9). It is a decreasing majority: in 2003 72,5% was addicted and in 2009 64,3%.
- There is a shift in problems: there are less addiction problems and more mental health problems, relational and financial problems.



Table 9.1.9: *Problem categories amongst very active prolific offenders, according to rehabilitation services, 2003-2009<sup>1</sup>*

	2003	2004	2005	2006	2007	2008	2009
Number of very prolific offenders	5,822	5,989	5,824	5,552	5,402	5,087	4,761
<b>Addiction problems</b>	<b>72.5%</b>	<b>71.7%</b>	<b>70.9%</b>	<b>69.9%</b>	<b>68.1%</b>	<b>66.9%</b>	<b>64.3%</b>
Mental health problems	38.1%	39.4%	40.1%	41.1%	41.2%	42.9%	42.6%
Housing problems	43.0%	44.1%	44.5%	43.9%	44.2%	43.5%	42.3%
Financial problems	43.4%	43.6%	45.5%	46.2%	46.9%	47.6%	47.0%
Problems with physical health	18.3%	19.2%	19.4%	19.2%	18.2%	18.0%	18.8%
Relational problems	35.7%	37.8%	38.8%	40.1%	41.1%	41.6%	42.3%

I. Based on information in intervention plans as registered in the Client Monitoring System of rehabilitation services. Incomplete data corrected by multivariate imputation sampling. Source: Tollenaar and Van der Laan, 2012.

### *Violent offences by drug users*

Hammink et al. (2012) describe the relationship between addiction and domestic violence.

- Cross-sectional studies of children of alcohol- and drug addicted parents show that these children are more often subjected to (threats of) domestic violence than children whose parents are not addicted. According to longitudinal studies there is no causal relationship, however. There seems to be a combination of risk factors.
- Alcohol addiction seems to be a predictor of partner violence and drug addiction a predictor of becoming a victim of partner violence. There are certain predictive risk factors, a.o. seriousness of the alcohol problems, 129network129in in the family and antisocial personality traits.

Goossens (2012) and Ferwerda et al. (2012) show that alcohol, amphetamines and cocaine can have an effect on violent behaviour, especially in the nightlife setting and during events. The effect depends on the dose. Group processes also play an important role. Furthermore, after using a stimulant (amphetamines, cocaine, ecstasy) an excited delirium may occur. Someone experiencing an excited delirium displays random aggression and is almost impossible to constrain by means of physical force.

### *Driving offences by drug users*

See the plans for changing the Road Traffic Act with regards to driving under the influence of drugs (Chapter 1).

### *Drug-related nuisance*

With regards to drug-related nuisance there is information from the annual Integral Security Monitor (CBS 2012). This is a victimization survey based on self report. The latest survey reports a.o. about victimization and feelings of security in the last 12 months of a total of 223,946 Dutch inhabitants of 15 years and older who live in a private household situation. The monitor in its actual form was carried out in 2008, 2009, 2010 and 2011. Respondents filled out questionnaires – via internet, on paper, by telephone or face-to-face. Overall response rate of the total (national and local) sample is 43.2%. One of the issues is the (‘threatening’) nuisance that inhabitants experience in their own neighbourhood.

- 7.0% of the respondents report that public drunkenness was a problem they experienced in 2011 (table 9.1.10). There is no significant difference with 2010 or 2009, but it is significantly more than in 2008.
- 4.9% report drug-related nuisance as a problem in 2011. This does not differ significantly from 2010 nor from 2009 or 2008.
- 2.9% rate drug-related nuisance as the most urgent problem in their neighbourhood and 1.6% rates public drunkenness as such. Drug nuisance ranks relatively low in this respect (15<sup>th</sup> in a schedule of 25 problems). Public drunkenness ranks 18<sup>th</sup> in this schedule). There are no significant changes. Both problems seem of minor importance.
- The drug-related nuisance is, however, significantly more relevant in certain areas of the Netherlands. In the south-east of the country (*Limburg-Zuid*) reports of drug-related nuisance are highest (10%). Second in rank is the region of Amsterdam (7.2%), third is Rotterdam (7.1%).
- Public drunkenness is mainly a problem in the regions of Amsterdam and The Hague (around 11.0%) and Rotterdam (9.2%).

*Table 9.1.10: Percentage of citizens that experience drug-related nuisance and public drunkenness as a problem in the neighbourhood, 2008-2010*

	2008	2009	2010	2011
Drug-related nuisance is a problem	4.8%	4.9%	4.8%	4.9%
Drug-related nuisance is the most important problem	2.7%	2.7%	2.9%	2.9%
Public drunkenness is a problem	6.2%	6.8%	6.5%	7.0% <sup>I</sup>
Public drunkenness is the most important problem	1.5%	1.4%	1.3%	1.6%

I. Statistically significant difference with 2008. Source: Statistics Netherlands (CBS) 2012 ([www.cbs.nl](http://www.cbs.nl)).

As mentioned above, the police reports that they are increasingly confronted with public order problems and offences related to users of GHB (Korf, Nabben, and Pronk 2012). The police have to give assistance when GHB-users lose consciousness, and must cope with their excited behaviour after recovery from loss of consciousness and aggression and confusion after withdrawal from the drug.

The police co-operates with care agencies, but there are differences between regions in this respect, depending on the frequency of occurrence of the problem. The police encounter problems around privacy issues and security and experience a lack of clear definitions and agreements on approaches.

## 9.2 Prevention of drug related crime

### 9.2.1 Prevention of drug law offences

#### *Prevention and combat of organised crime*

##### *Priorities in law enforcement:*

- The combat of network drug production, cultivation and trafficking is a priority area for police and Public Prosecutor in 2011-2012.
- The cultivation of Dutch cannabis is defined in 2012 as an area on which more information is needed (Jansen 2012a). More information is also considered necessary about trafficking of heroin (KLPD 2012c).
- Investigations into the top of criminal networking which are involved in cannabis production and exportation are still very limited, despite the prioritization of this theme at the police (Siesling, Smeets, and Spapens 2011; Jansen 2012). Efforts of the police focus mainly on dismantlements of cultivation sites and less on further investigation (Siesling et al. 2011; Nationaal Netwerk Drugexpertise 2012). In July 2008 the ministers of Security and Justice and Internal Affairs installed the national Taskforce Organized Cannabis Cultivation. The Taskforce aims to contribute to a visible reduction of large scale cannabis cultivation in the Netherlands. Within the Taskforce there is a specific focus on investigations of criminal networks behind cannabis cultivation, the export of cannabis and facilitators. In 2010 the Taskforce Approach Organized Crime Brabant (Taskforce B5) was installed in the southern region of Brabant, after some severe violent incidents related to cannabis cultivation.

##### *Strategies in law enforcement:*

- In the combat of organised crime, the 'barrier' model is applied, which aims at interventions in the logistic organisation and central processes of the crimes. For instance: with regards to cocaine the police aims at prevention of import by 'upstream' investigations into source countries, investigations into financial facilitators and adulterants, and by interfering with the mutual trust between criminals (Van der Laan 2012). Siesling et al. (2011), who studied 295 files of home growers of cannabis, report that there is always mainly a financial motive, making the enhancement of financial risks a likely barrier for home growers of cannabis.
- Local and regional institutions have an important role in the combat of drug-related organised crime. A combination of administrative and criminal laws is applied. Co-operation between administrative and judicial partners is enhanced and supported by so-called Regional Information and Expertise Centres (*RIEC-networks*), that were set up in 2009 in order to support local authorities in their fight against organised crime. They should ensure the connection between administrative and judicial measures and function as an information junction. Public administration, police, Public Prosecutor, Fiscal investigation units and Tax Authorities co-operate in these Centres. A National Centre of Information and Expertise (*LIEC*), which is a shared service centre for RIECs, supports the RIECs since 2011. After a pilot period in 2008-2011, the RIEC's and its national supporting centre LIEC got a structural role in the combat of organised crime per January 1<sup>st</sup> 2012. 88% of the municipalities participate in a RIEC by the end of 2011 (participation is voluntary). Organised cannabis cultivation is one of the main priority areas of the *RIECs*, but the *RIEC's* are also involved in the combat of other drug crimes, like dealing

in the streets and from houses, which causes nuisance (Morée & Hols 2010; TK 29 911-54 2011; Nieuwenhuis 2012; see [www.riecnet.nl](http://www.riecnet.nl)). The minister of Security and Justice reported to the Lower House that the RIEC networks are an important tool in the combat of organised crime because they increased awareness and expertise on municipal level (TK 29911-60). See also Chapter 1.

- A central element in the approach against organised crime is the confiscation of criminal proceeds (TK 29911-68 and 69, 2012; Inspectie 2012). Police forces enhanced their expertise, capacity and efforts in an special programme and a specialized bureau “FinEC” (*Financieel Economisch Opsporen Politie, Financial Economic Criminal Investigation by the Police*; TK 29911-68 2012). According to an Inspectorate Report, this approach of financial economic crime works well – more criminal proceeds are indeed confiscated since 2009 – and should be broadened to the whole police organisation. In order to guarantee this method of criminal investigation in the long term, however, improvements are necessary. These improvements would concern a.o. more prioritization, better registration and feedback of results, and co-operation between police forces, Public Prosecutor, local administrations, tax authorities and other (private) parties (Inspectie [Inspectorate] 2012). The minister of Security and Justice promised improvements and further implementation (TK 29911-68). New acts are in preparation, in which judicial financial economic sanctions are broadened (TK 29911-57 2011) and victims get better options to get financial compensation for the damage caused by suspects (TK 33295-1 2012).
- The Integrity Screening of persons who apply for a license from public authorities is an important tool for local authorities in their combat of organised crime (*Public Administration Probity Screening Act, Wet BIBOB*). The screening determines whether there is a serious danger that a license or authorization will be misused for criminal activities. This tool is a.o. applied on coffee shops and smart- or growshops: 6% of the 171 BIBOB requests in 2011 concerned coffee shops and 3% concerned smart- or growshops. In 2011 the minister of Security and Justice ordered a national screening of coffee shops on the basis of BIBOB. Mayors were asked to pre-select coffee shops where criminal activities might take place, but municipalities are not obliged to co-operate. The screening of coffee shops will last until 2014 (Bureau BIBOB 2012; EK 32676-C herdruk). The legal possibilities to screen certain professional categories in the framework of subsidizing, licensing or authorizing by the *Public Administration Probity Screening Act (Wet BIBOB)* will be broadened (TK 29911-54 and 63; (TK 32676-3). See also Chapter 1.
- The Public Prosecutor of the region of Den Bosch started in 2010 a pilot in which more severe sentences were demanded for exploiting a *dangerous* illegal cannabis nursery (Dubbeld 2011). See also Chapter 1.
- The special Taskforce Approach Organized Crime Brabant (Taskforce B5) was installed in December 2010 See above and Chapter 1.
- ‘Ndrangheta’ (Italian mafia) is involved in several criminal activities in the Netherlands, amongst which drug trafficking, according to an explorative study of the Netherlands Police Agency (KLPD 2011; TK 29911-61). There is not much knowledge about this specific organization yet, but organized crime is a priority area already for the Netherlands Police Agency (see also Aanslag 1985, 2011-2012; T.K. 29911-70 2012). A multidisciplinary expert group was installed to collect all the available information (T.K. 2911-70 2012).

New regulations for law enforcement:

- In pursuance of the Treaty on Illicit Traffic by Sea of January 31<sup>st</sup> 1995 in Strasbourg and in addition to article 17 of the UN Treaty on illicit drug (December 1988), a nationwide act is in preparation (including the Caribbean region: Curacao, Aruba, Sint Maarten; Stc 2012-7745). Although ratification is for the whole of the Kingdom, implementation of the treaty is in national law, including Opium Act and Extradition Act, not in a Kingdom wide act. The other Countries of the Kingdom will have to implement the treaty in their own laws. This Act facilitates operational regional co-operation in the combat of drug trading at open sea. According to the annual report of the coast guard of the Netherlands in the Caribbean region, 827 kilos of drugs were seized in 2011, more than in 2010; 12 drug-related actions were carried out in 2011 ([www.rijksoverheid.nl](http://www.rijksoverheid.nl)).
- The legal status of GHB has been changed, it is categorized now as a hard drug. This change facilitates enforcement of precursors of GHB GBL and 1,4BD under the Opium Act. Both precursors can be used as substitutes for GHB. In addition to the change of the legal status of GHB, the minister of Health, Welfare and Sports started two trajectories to change the status and form of GBL and 1,4 BD: to place them on EU schedules of controlled substances, linked to the Prevention of Abuse of Chemicals Act; and denaturalization. Both measures would ensure the use for industrial purposes but prevent the use as a substitute for GHB.

Future developments relevant for law enforcement:

- According to the Netherlands Police Agency, there are several factors and circumstances that might enhance drug-related crime in the future (KLPD 2012d). A consequence of the financial crisis may have been, for instance, that there are more cannabis cultivation sites in subleased houses which are for sale but not sold yet. Technical equipment like cameras and GSM- or GPS-jammers came available for offenders and criminal organisations. Gaps between laws and policies in different countries and local administrations can be used by offenders.
- The National Network Drugs Expertise (NND) at the Netherlands Police Agency will be continued. Professionalization will be enhanced. The network is a partnership of police, customs, tax authorities, military police, Trimbos-institute, Inspectorate of health care, police academy, Public Prosecutor and ministry of Security and Justice (National Network Drugs Expertise 2012).

*Prevention and combat of crimes and nuisance related to coffee shops*

- As described in chapter 1, two new criteria for licensing en non-prosecution were introduced in the Opium Act Directive in January 2012: the Closed club criterion and the Resident criterion. Coffee shops had to become closed clubs and membership was exclusively for residents of the Netherlands. This measure aimed to reduce nuisance related to drug tourism. Both criteria were enforced from May 1<sup>st</sup> 2012 in the three southern provinces. According to the original plans of the Cabinet, the new rules had to be enforced in the whole country from January 1<sup>st</sup> 2013 on. The new rules are subject of discussion and resistance, a.o. of the mayors of the four major cities. In the new Coalition Agreement of October 29<sup>th</sup> 2012, the Closed club criterion is abolished, but the resident criterion is continued. This is confirmed in a letter to the Parliament of the minister of Security and Justice of November 19<sup>th</sup> 2012 (TK 24077-293). See Chapter 1 for a more elaborate description of the new rules and the developments in 2012.

Some municipalities have additional plans for the combat of nuisance around coffee shops. Maastricht is considering relocation of a total of 7 coffee shops from the centre of the city to the periphery, which is opposed by municipalities, businesses and private persons (Raad van State 201112936/1/T1). Rotterdam is also considering relocation (Gemeente Rotterdam 2012).

### 9.2.2 *Prevention of crimes committed by drug users*

- A change in the Road Traffic Act is in preparation to specify more clearly under which conditions driving under the influence of drugs will be a punishable act (see chapter 1).
- A change in the Code of Criminal Procedure is in preparation which will make it possible for the police to check the use of alcohol and drugs amongst suspects of violent crimes. The use of substances will be an aggravating factor in the sentencing of these cases. See Chapter 1.
- Ferwerda et al. (2012) describe possible indicators of substance use amongst visitors of nightlife evenings and parties, and ways in which public service professionals can handle violence caused by substance use. They suggest that:
  - the existing knowledge on substance's effects, on identification of substance use and on handling intoxicated people should be disseminated more broadly amongst professionals;
  - that substance use involved in violent crimes should be registered (by police and other professionals);
  - that thorough and joint preparation of events or nightlife evenings by diverse categories of professionals should be stimulated;
  - and that a protocol for the handling of excited delirium should be developed.

For the report with a summary in English see [www.wodc.nl](http://www.wodc.nl).

- A four-year follow-up study amongst heroin addicts in the medical heroin prescription programme revealed that the addicts caused much less public nuisance than the addicts who withdrew from the programme (Blanken et al. 2010).

## 9.3 Interventions in the criminal justice system

Except for addiction probation services, there are no interventions in the criminal justice system which are exclusively for drug users or addicts. The target groups of the interventions are broader. Some are applicable for all offenders in the criminal justice system, others are applicable for offenders with problems that can affect their rehabilitation and their criminal recidivism ('criminogenic problems'). Addicts are a relevant target group for the last category of interventions, but also offenders with mental health problems or mild learning disabilities. We will describe the interventions for the broader category of offenders with criminogenic problems.

The following interventions are available:

- "Safety Houses" (see § 9.3.1).
- Forensic care and Penitentiary Psychiatric Centres (see § 9.3.2).
- Addiction probation services (see § 9.3.3).
- Behavioural interventions inside and outside prison (see § 9.3.4)
- The Measure of Placement in an Institution for prolific offenders (see § 9.3.5).

### 9.3.1 Safety Houses

In 2012 there are 41 Safety houses. These are networks of local organisations working together to reduce crime. Offenders are discussed in case meetings. Adequate trajectories are planned. This is an approach for all offenders, but prolific offenders (amongst whom there are a lot of addicts) and offenders with addiction problems are a relevant target group. Rovers (2011) reviewed the existing research on Safety houses. His conclusions are:

- The co-operation between agencies improved and their activities for the target groups are more geared to one another.
- Clients' situations improved, especially those of prolific offenders. This leads to a reduction of criminal recidivism.
- There are, however, considerable problems, which concern for instance the availability of information on cases, the direction and organisation of the Safety house, availability of after care, vague goals or the internal communication.
- As far as results are reported, it becomes clear that it takes time for the Safety houses to produce them. The information about results still is very limited.

### 9.3.2. Forensic Care and Penitentiary Psychiatric Centres

The planned *Forensic Care Act (Wet forensische zorg)* is a broad Act which provides a framework for an adequate connection between care agencies and the justice system (TK 32398-3, 2010). The Act still is in the process of discussion in the Lower House (TK 32398-15; TK 32398-16) and advice trajectories of the Council of State and other organisations (TK 32398-24). The aim of the Act is that offenders with problems – addiction problems, mental health problems or mild learning disabilities – are placed in the just place, that there is enough forensic care capacity, that the care is of good quality and aimed at improvement of the safety in society. Offenders with problems should be diverted to care outside the prison system, in order to stimulate their rehabilitation and to reduce their recidivism. Diversion should take place on the basis of diagnosis and a solid advice. There should be adequate exchange of information. The care should preferably be given by specialized institutions outside the prison system. It can consist of forensic psychiatric clinics, institutes for persons with mild learning disabilities, addiction care agencies, institutions for supervised living and outpatient care facilities. Only those problematic offenders who are not motivated or not suitable for placement in a clinic outside prison will stay in the prison system. These offenders will be placed in Penitentiary Psychiatric Centres, where basic care is provided (*Penitentiaire Psychiatrische Centra, PPC's*). Ultimo September 2011 there were 595 prisoners in these (five) centres (Van Gemmert and Van Schijndel 2012). It is not reported how many of these have addiction problems.

In anticipation of the new act, some elements of it are already implemented according to an Interim Decision Forensic Care, like central contracting of external forensic care under responsibility of the ministry of Security and Justice (Stb. 2010-875; Stc. 2011-191). A revised Interim Decision was introduced on April 1<sup>st</sup> 2012 (Stb. 2012-134; Stc. 2012-6558). Rules for performance-based payment of forensic care will be developed and terminated by 2013 (TK 32398-16). Forensic care might be cut down in 2013 as a consequence of reductions of public expenditures ([www.forensischezorg.nl](http://www.forensischezorg.nl)).

- In 2011, a total of 182 places in specialized forensic addiction care were contracted and realized (Van Gemmert and Van Schijndel 2012). This is slightly less than in 2010 (199 contracted places in addiction care, 197 realized) and in 2009 (198 contracted, 186 realized).

The planned Forensic Care Act in combination with the planned Compulsory Mental Health Care Act contain articles to broaden the possibilities for quasi-compulsory and compulsory care directly in connection with the criminal justice system. The compulsory placement of offenders in psychiatric hospitals directly from the criminal justice system by the criminal judge should be made possible. The Public Prosecutor can consider asking for an authorization for compulsory mental health care instead of, or directly after, criminal prosecution, and the criminal judge can apply such an authorization.

In 136 organizations with the new Compulsory mental Care Act, the options for compulsory care in the penal institutions were broadened also (Stb 2012-410).

Other Acts which are relevant with regard to forensic care are the *Act on Conditional Sanctions* and the *Act on Conditional Release*, which came into force per April 1<sup>st</sup> 2012 (*Wet Voorwaardelijke Veroordeling, Wet Voorwaardelijke Invrijheidstelling*; Stb. 2011-615 and Stb. 2012-5; TK and E.K. file number 32319). These Acts also facilitate the implementation of alternatives to prison, amongst which diversions to care (see also Van Ooyen 2012).

The number of diversions of clients of addiction probation services to care facilities outside prison did increase in 2011: 7,311 times there were activities in the framework of a diversion to care. These diversions took place within the judicial framework of supervision of the probation services. There is an increasing trend in activities for diversions since 2004 (table 9.3.1).

- Most diversions concern non-residential addiction care (outpatient or part-time care): 1,289 times (18%);
- Second is non-residential psychiatric care: 956 times (13%);
- Third are diversions to activating and supporting counseling: 924 times (13%);
- Fourth are diversions to living accommodations: 800 times (11%).
- Residential addiction care and residential mental health care rank fifth: 502 and 269 times resp. (7% and 4%).

There is a rise of diversions to low-threshold nonresidential supporting services compared to 2010 and before. It should be noted that diversions to addiction care also – but to a lesser extent (368 activities) – are carried out by other probation services, which are not specialized in addiction.



Table 9.3.1: Number of diversion activities (diversion to forensic care outside prison) by Addiction Probation Services, 2004-2011<sup>I</sup>

Year	Number of diversion activities
2004	2,254
2005	2,081
2006	3,226
2007	3,684
2008	4,005
2009	4,514
2010	5,046
2011	7,311

I. Diversions within the judicial framework of rehabilitation supervision. An additional 1,186 diversions took place outside this judicial framework (voluntary diversions). Source: Foundation of Addiction Probation Services, 2012.

### 9.3.3 Addiction Probation Services

Addiction Probation Services registered 20,234 clients in 2011, about the same as in 2010 (20,233). Mean age is 36,1 years. The majority is male (92,8%).

Information about the problems of clients is incomplete and will not be reported here.

The activities of Addiction Probation Services in 2011 are shown in table 9.3.2. Due to changes in definitions and criteria for registration, the figures of 2009 and before are incomparable to 2010 and 2011. Only 2010 and 2011 are shown. For 2010, activities based on old and new definitions were added.

- Supervision of clients and the writing of advisory reports for judicial authorities were carried out most often in 2011. This pattern is the same as in 2010.
- Advisory reports are written (partly) by using the standard instrument RISC (Risk Assessment Scales, *Risico Inschattings Schalen*). A RISC-assessment was carried out more than 4,508 times in 2011, less than in 2010. In addition to the RISC, more detailed and deeper screening can be carried out, in order to come to an adequate indication for care or cure.

Table 9.3.2: Types of assistance offered by addiction probation services and number of times the service was provided, 2010<sup>I</sup>

Type of assistance	2010	2011
First visit to arrestee/prisoner in remand	2,122	2,049
Advisory reports (by order of Public Prosecutor, Judge, prison authorities, etc; including reports about the social environment)	10,522	10,722
Referral to care programs (under a judicial measure)	5,046	7,311 <sup>II</sup>
Supervision of clients in the framework of a judicial decision	10,954	11,168
Behavioural interventions	686	542
Supervision of working sentences	4,888	3,510
Judicial case management <sup>III</sup>	-	623

I. No figures on case level, no specification for type of drug/alcohol/gambling. II. Excluding 1,186 referrals to care programmes outside the judicial framework of probation supervision. III. New in 2011. Source: Foundation of Addiction Probation Services, 2012.

### 9.3.4. Behavioural interventions for substance users

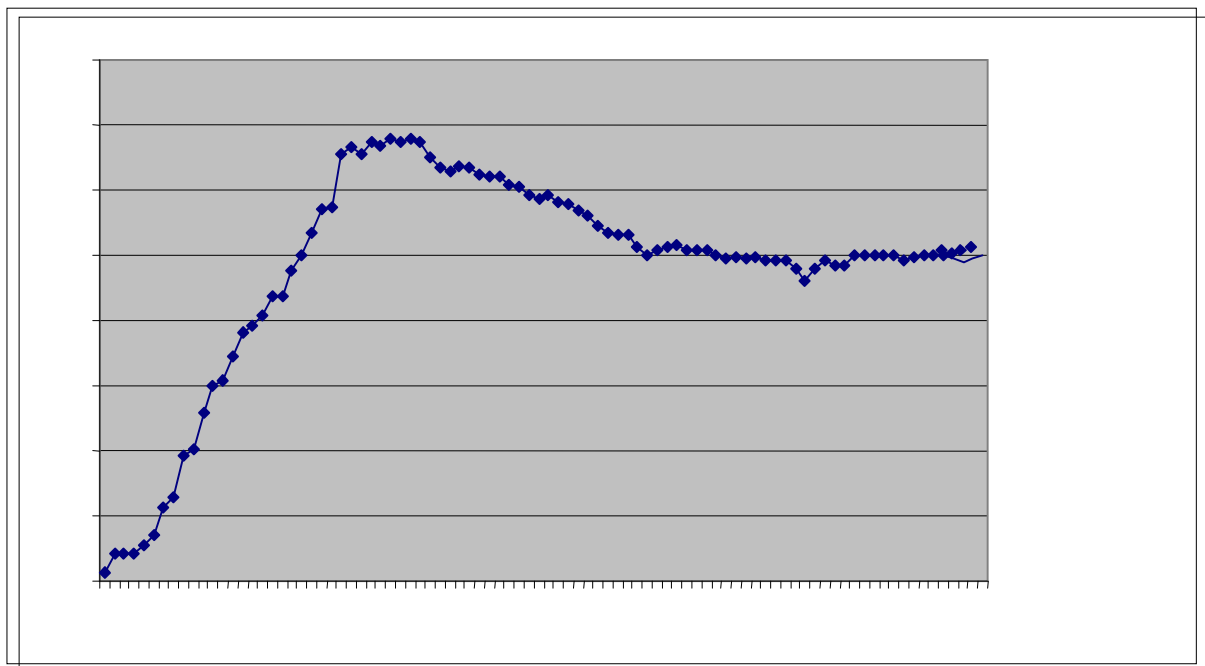
N.N.I.A.

### 9.3.5 Measure of Placement in an Institution for Prolific Offenders (ISD)

The measure of Placement in an Institution for Prolific Offenders (ISD) is a judicial measure for prolific offenders of over 18 years old. ISD can be applied for a maximum of two years, which is a relatively long sentence. The aim of the measure is twofold: to safeguard society from the frequent offences committed by prolific offenders by incapacitation of the offenders, and to improve the individual situation of offenders, in order to reduce their recidivism.

- Tolenaar and Van der Laan (2012) showed that a majority of the group of very active prolific offenders in 2003-2009 is an addict (see table 9.1.9).
- In 2011, there were 479 to 501 persons per month under the Measure of Placement in an Institution for Prolific Offenders (ISD), with a mean of 494. This is about the same as in 2010 (mean: 493), but less than in 2009 (mean: 528) and 2008 (mean: 607). In 2012, the mean number per month is 497 (period January-May 2012). Since 2010, the number of ISD-convicted offenders per month is more or less stable (see figure 9.3.1).

Figure 9.3.1: Number of offenders under the Measure of Placement in an Institution for Prolific Offenders, January 2005-June 2012



Source: Custodial Institutions Agency, 2012.

- Most offenders under the ISD-measure participate in an trajectory with behavioural interventions or care programmes (table 9.3.3). Most of these trajectories take place inside prison, the others outside prison. A minority of offenders under the ISD-measure stays in regular prison regime.
- The proportion of participants in trajectories versus regular prison regime did not change in 2011-2012 compared to 2010.

- The proportion of trajectories outside prison shows an increasing trend.

*Table 9.3.3: Percentage of offenders in different regimes under the Measure of Placement in an Institution for Prolific Offenders, 2009-2012*

<b>Regime:</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012<sup>I</sup></b>
Trajectory outside prison	24%	30%	32%	33%
Trajectory inside prison	57%	55%	52%	51%
Regular prison regime	19%	15%	16%	16%
Total N (mean per month)	528	493	494	497

I. January-June 2012. Source: Custodial Institutions Agency 2012.

Tollenaar and Van der Laan (2012) conducted a study into the effectiveness of ISD. They analyzed the reduction of criminal recidivism as a consequence of the ISD in 2004-2008. A group of ISD-participants was compared to two control groups of very prolific offenders who were detained in regular prisons. Both controls were matched to the ISD-group by propensity score matching on 20 variables. Recidivism during two years after completion of ISD or prison was assessed.

- Criminal recidivism amongst ISD-participants persons is high: two years after completion of ISD 72% relapsed in offending.
- Compared to the controls, ISD is effective. In the control groups the criminal recidivism was 88% and 84%. This is a statistically small effect.
- There is also a significant effect on the mean frequency of offending: ISD-participants offend to a lesser extent than the control groups.
- It is estimated that the longer period of incarceration of ISD-participants compared to control groups prevents 5.7 criminal cases and a minimum of 9.2 offences.

#### **9.4 Drug use and problem drug use in prison**

N.N.I.A.

#### **9.5 Responses to drug related health issues in prison**

##### *Determent policy*

The Dutch prison system aims at a drug-free detention situation. The presence of drugs is considered as a disturbance of order and safety, as causing health risks and not compliant with the aim of using the detention period as a time to kick te habit of drug use and to make a new start after release (DJI 2008; TK 24587-428). There is a determent policy in force for all illegal drugs, alcohol and medication without prescription. The policy consists of:

- Controls at entry into prison by X-ray and – if necessary – physically;
  - Searches of body and clothes of persons who are under the suspicion of possession of drugs;
  - Urine controls of detainees, at random and/or under suspicion. If drugs are detected a sanction will follow, like isolation, refusal of visits or suspension of leaves;
  - Inspectorates of cells and other rooms were detainees stay;
  - Supervision of visitors rooms, if necessary with searches;
  - Drug dogs; these dogs are used for controls of detainees and visitors. After a pilot these drug dogs are now a standard element of the determent policy.
- Personnel of prisons are also subject to controls.
  - The determent policy was evaluated in 2011. It will lead to adjustments in the policy, which will, in the future, be reported to the Lower House. Results are not public yet and adjustments are still only in concept and not definitive.

##### *GHB*

In April 2012, a project was started called “GHB in the criminal justice chain”. Part of this project is the installation of special cells for GHB-addicts, four in total, three in penitentiary pilot locations and one in a police cell pilot location. GHB-addicted detainees and suspects

will be taken care of here, they will be stabilized and detoxified. The prison system is developing methods to detect GHB. In 2012, about 50 GHB-users underwent detoxification during detention (personal communication Prison Services 2012).

### *Hepatitis C in detention*

Because there was an increase of treatments for hepatitis C in penitentiary institutions, a guideline was formulated in which education and information, screening and treatment is described (Eijkenboom 2012). Addicts and ex-addicts are the main risk group. Infection rates amongst this category are high, ranging from 26% to 91% and especially amongst (ever) injecting users (Van Laar et al. 2012). Among prisoners prevalence of hepatitis C is estimated between 2 and 10,7% (Leemrijse, Bongers, Nielen and Devillé, 2010).

## **9.6 Reintegration of drug users after release from prison**

Aftercare – in terms of having an identity card, housing, income and care (if necessary) and settlement of debts – is a responsibility of municipalities and penal institutions. It should be available for all (ex-)prisoners. The municipality should know in a timely manner when a prisoner will be released and what kind of problems he/she has. The Ministry of Security and Justice started a special aftercare programme (Van Duijvenbooden and Plattje 2010). This programme runs under the direction of the Ministry, and penitentiary institutions, municipalities, probation services, mental health/addiction care organisations, housing corporations and organisations that help people to solve their debts, work together.

- At entrance in prison an inventory is made whether detainees have an identification, an income, housing, debts and contact with a care agency (when necessary). When they leave prison, all these items should be organised and present.
- The new approach is monitored in research. In 2012, the third assessment was conducted (Noordhuizen and Weijters 2012, to be published in 2013). This assessment describes the situation of 9,690 ex-detainees who left prison after an imprisonment of at least two weeks between July 1<sup>st</sup> and November 30<sup>st</sup> 2010. The situation at entrance, at release and six month after release from prison is described. Because the sample of municipalities in the monitor is limited (n=8), representativity of results is not optimal.
- Results show that improvements are 141rganiza during imprisonment for about 7 to 29% of the detainees who have no ID, income or housing at the moment of entrance in prison:
  - 15.8% of the detainees had no ID at entrance; of these, 7.4% got an ID during their imprisonment.
  - 29% had no income at entrance; at release, 22% of these detainees have an income at release.
  - 19.1% of the detainees had no housing at the moment of entrance; 29% of those have one at release.
- Results also show that in the period of six months after release almost all the detainees did keep their ID, income and housing. Of those who did not have this at release from prison, between 27 and 70% improved on these aspects:
  - 42.9% receives an ID in the first six months after release;
  - 70.2% gets an income;
  - 26.6% gets housing.
- 13.2% gets in contact with a care agency after release. Almost all detainees kept their debts at the municipalities in the first six month after release..

## 10 Drug markets

It is difficult to get a valid overview of the availability and supply of drugs because of the hidden character of drug production and trafficking and the lack of unambiguous indicators. Production of drugs in the Netherlands is often indoor (for instance cannabis cultivation or production of synthetic drugs) and not directly visible. The data in § 10.1 and § 10.2 are drawn from research reports and Crime Analyses Reports of the Netherlands Police Agency. Data on purity and prices of drugs at retail level (§ 10.3) are monitored by the Drugs Information and Monitoring System (DIMS).

### 10.1 Availability and supply

#### 10.1.1 Availability

##### *Access to cannabis/availability of cannabis*

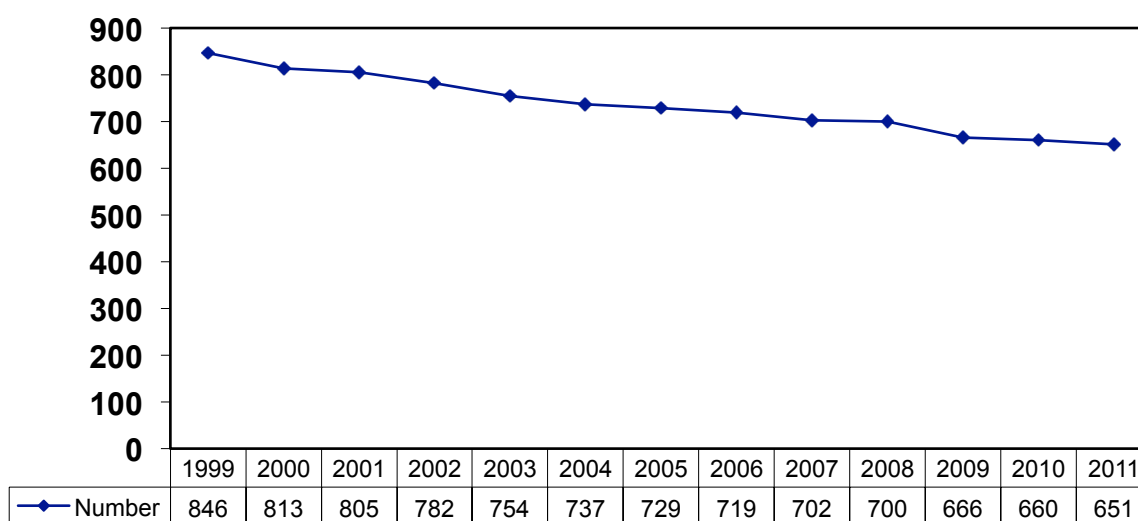
In the Netherlands, the sale of cannabis is largely regulated through coffee shops.

- The number of coffee shops gradually decreased. In 2010 there were 660, in 2011 651 (Bieleman, Nijkamp, and Bak 2012; see figure 10.1.1).
- The reduction has several causes:
  - Rotterdam closed 16 coffee shops because of the introduction of a local minimal distance criterion to schools of 250 metres;
  - Bergen op Zoom and Roosendaal closed (all) 8 coffee shops because of the introduction of a local 'zero-policy', as a consequence of unmanageable nuisance related to drug tourists;
  - in other municipalities closures occurred because of different reasons like: a negative outcome of the screening on the basis of Public Administration Probity Screening Act (*BIBOB*); application of a local 'extinction policy' which implies that when a coffee shop stops no new one will be authorized; or because coffee shops violated the regulations.
- In 2011, the coffee shops were located in 104 of the 418 municipalities. Most municipalities have a 'zero-policy' with regards to coffee shops, which means that they do not permit any coffee shops. 99% of the municipalities with coffee shops apply a 'maximum policy': they limit the number of coffee shops (Bieleman et al. 2012).
- Over half (53%) of the coffee shops is located in the six bigger cities with over 200 thousand inhabitants. In municipalities with coffee shops there are 31,431 inhabitants per coffee shop in 2011 (mean). This is more than in previous years. Amsterdam has the highest coffee shop density per inhabitant: one coffee shop per 3,513 inhabitants.

The political composition of the local council generally does make a difference in the decision of a municipality for or against authorizing coffee shops (Wouters, Benschop, and Korf 2010). The larger the percentage of progressive councilors, the greater the probability that coffee shops are allowed. But it does not make a difference in the number of coffee shops. The latter seems to depend primarily on the scale of the cannabis demand (indicated by population size). In addition, the presence of tourism, nightlife or regional arrangements over coffee shops play a role in the local coffee shop policy.

There were plans to close or relocate coffee shops within 350 metres distance from secondary schools or schools for professional education by imposing a minimum distance criterion as a national rule. The plans were to be effectuated in January 2014 according to the previous Cabinet. Research shows that 164 coffee shops would be affected by this measure (Bieleman et al. 2012). This criterion was not mentioned any more in the Coalition Agreement of the new Cabinet Rutte II of 29-10-2012. In a letter to the Parliament of 19-11-2012 of the minister of Security and Justice announced that, because of the choice for tailored local approaches, the distance criterion of 350 metres will not be imposed by national rules – i.c. in the Directive of the Opium Act (T.K. 24077-293).

Figure 10.1.1: Number of coffee shops in the Netherlands, 1999-2011



Source: Bieleman, Nijkamp, and Bak 2012.

Coffee shops have to comply with certain regulations. Roughly spoken: they are not allowed to advertise (with some exceptions), to have hard drugs or youth under 18 present in their shops, to cause nuisance, to sell more than 5 grams to a customer per day or to have a stock of 500 grams of cannabis or more. Since January 2012, they should also be a closed club, whereby the members should be inhabitants of the Netherlands (closed club and residence criterion; see Directive Opium Act of the Public Prosecutor 2011A021 2012, [www.om.nl](http://www.om.nl)). The new rules are enforced since May 1<sup>st</sup> in the three southern provinces. As far as the residence criterion is concerned other provinces will follow in January 2013, but as of this date the closed club criterion will be abandoned as a criterion in de Opium Act Directive (see also chapter 1). The consequences of the new regulations are monitored in local and national research (see [www.wodc.nl](http://www.wodc.nl)).

- The majority of the municipalities with coffee shops applies additional local regulations as well, mostly with regard to the location of the coffee shop (like: not near schools or near youth peoples facilities). Adherence to all the rules is controlled by municipalities and/or police. If a coffee shop does not comply to the rules, sanctions can be applied, ranging from a formal warning to closure of the shop. The sanction depends on the rule that was violated (presence of hard drugs and youngsters is sanctioned more severely than advertising) and recidivism (repeated violation of rules is sanctioned more severely). The

sanctions are established in a local enforcement arrangement, in which administrative and criminal justice law are combined.

- Compliance with the rules has been evaluated (Bieleman et al. 2012). In 2011 a total of 51 violations of rules were recorded, especially of the maximum stock criterion (20 times) and of the youth criterion (14 times). The advertisement and the 5-grams criteria were violated 6 times each. Compliance to the new criteria has not been evaluated yet.
- Nijkamp (2012) investigated the nature and size of the visits to coffee shops in Rotterdam in spring 2012. In 2012 there were 43 coffee shops ('cannabis cafes') in Rotterdam with 22,600-25,500 visitors per day. The majority (82%) of the visitors lives in Rotterdam. The most important reasons to visit a specific coffee shop are the small distance to the home of the visitor and the quality of the cannabis. See also Chapter 1.
- Several local projects aimed to reduce nuisance related to coffee shops are described in chapter 1.

#### *Illegal selling points for cannabis*

- Cannabis is also available through illegal selling points, e.g. dealers operating by means of mobile-phone; home dealers, who sell drugs from their own home, partly from own cultivation; self-growers, who give cannabis away or sell it; street dealers; and under-the-counter dealers, who sell cannabis in a 'normal' catering place (Korf et al. 2005).
- Research on illegal selling points of cannabis in 2012 is currently ongoing in the framework of the implementation of the residence and closed club criterion (see [www.wodc.nl](http://www.wodc.nl); and prior paragraph).

#### *10.1.2 Supply*

The Netherlands Police Agency conducted updates of their 2008 Crime Pattern Analysis about drug related serious and 144rganizat crime in the Netherlands (to be published in January 2013). The reports concern domestic cannabis (Jansen 2012a), foreign hashish (Jansen 2012b), cocaine (Van der Laan 2012), synthetic drugs (KLPD 2012c) and heroin (KLPD 2012c). The main aim of these reports is to give insight in developments in the criminal phenomena related to serious and 144rganizat crime and to provide an empirical basis for decisions about national strategies and priorities of the Public Prosecutor and the police forces in the combat of 144rganizat crime for the period 2012-2016. It should be kept in mind that the reports are based on information about cases that came to notice of police or customs. Other cases are not included. This selection might cause bias in the results. The information in the reports is sometimes fragmentary and the researchers themselves report serious gaps in the knowledge. But whereas this is the best information about drug-related 144rganizat crime that is available at the moment, it will be presented below. The focus is on developments since 2008.

In addition to the Crime Pattern Analysis of the Netherlands Police Agency, data from research about cannabis cultivation in the Netherlands will be used (Siesling, Smeets and Spapens, 2011).

#### *Domestic cannabis production*

For the Crime Pattern Analysis about cannabis production and trafficking 16 files of regional police investigations were analyzed and registration data of the police were used (Jansen 2012a; Nationaal Netwerk Drugsexpertise 2012). It mainly reports about Dutch cannabis (*nederwiet*). Nederwiet is the dominating type of cannabis used and produced in the



Netherlands. Nederwiet is also the main product that is sold in the coffee shops (see paragraph 10.3).

- The police did not observe any substantial new developments in the production of cannabis in the Netherlands in the recent period. There were, however, minor changes.
- The number of dismantled production sites in temporarily rented houses increased.
- In 2012, a new production method was discovered called *scrogging*, by which the cannabis plants grow more horizontally instead of vertically. This method can be used in low spaces and it seems to make yields more predictable, according to the Netherlands Police Agency. It is not known how often this method is applied.
- The Netherlands Police Agency reported some minor production of *ice*, a type of domestic hashish made of refuse remaining after production.
- Criminal organisations are involved in export of cannabis. The main pattern is that these organisations export only cannabis; there were only a few seizures of combinations of cannabis with other drugs (only synthetic drugs). The organisations consist of Dutch nationals, although there were more Turkish organisations involved since 2008. The organisations are characterized as family businesses. Vietnamese organisations seem to be getting some involvement also (Schoenmakers, Bremmers & Van Wijk 2012).
- Main destinations for export of cannabis in the files and according to the interviews are the UK, Germany, Italy and Scandinavian countries.
- On the basis of the prevalence and frequency of cannabis use reported in surveys amongst Dutch users, it was estimated that about 58-143 tons of cannabis is used per year in the Netherlands: 32-92 tons of Dutch weed, 4-10 tons of imported weed and 22-41 tons of hashish. These are rough estimations.
- It is very difficult to estimate the size of the production of cannabis in the Netherlands, because central factors, like the chance of being caught, are unknown. Furthermore, registrations of seizures and dismantlements are incomplete and unreliable. The Crime Pattern Analysis tries to make an estimate, using the number of dismantlements of cannabis production sites (reported as 5,435 in 2011), the mean number of plants per site (325), the mean yield of cannabis per plant (28.2 grams), the mean number of crops per year is estimated (3-5) and the chance of being caught (4 to 21% with a mean of 10%). This results in an estimation of 187 to 1,196 tons of Dutch cannabis production in 2011, with a middle value of 448 tons. There seems to be an increase since 2008, despite the priority given to investigation and enforcement of cannabis production and export in 2008-2012. The Netherlands Police Agency estimated that most of the produced cannabis (51-97%) is exported and that this proportion increased since 2008. These figures, however, are disputable and not solid (Nationaal Netwerk Drugexpertise 2012). The broad ranges indicate a lot of uncertainty.
- Societal damage of cannabis cultivation (plants) is caused by tapping of electricity, of which the costs are estimated at 180 million euro's. There is also damage from cannabis cultivation caused by fire and deterioration of houses.
- The size of the production of domestic hashish (resin) cannot be estimated because of lack of information, according to the police. There is hardly any evidence that the production of resin in the Netherlands is significant. Most resin seemt to be imported.
- Synthetic cannabinoids (*spice*) are rare on the consumer market in the Netherlands (Niesink and Rigter 2012). There were some seizures of *spice*, but this was meant for export.

Siesling, Smeets, and Spapens (2011) conducted research into home-growers of cannabis in the three southern provinces. They reviewed the literature and analyzed 295 criminal files which were handled by the Court in 2008 and 2009. In addition, they did qualitative analysis on 15 cases in which there were indications of compulsion or violence, observed court hearings of home-growers of cannabis and interviewed experts from the police. The tax authorities provided authorized descriptive data about characteristics of 256 home-growers in the sample over the period 2006-2009.

- A total of 2,212 suspects of illegal cannabis cultivation were handled by the Courts in 2008 and 2009. The majority (73%) has the Dutch nationality.
- There are no indications that compulsion, intimidation or violence is used against growers. All growers started cultivating cannabis voluntarily, it was a decision that they took on their own.
- Home-growers of cannabis are mostly people with a job, but a job that generates little income. Many of them have a debt, mostly of up to 5,000 euro. The earnings from the cannabis are a welcome supplement to their financial situation and the main motive for cultivation is the financial profit.
- There is a subpopulation of growers who is involved in other illegal activities as well, and there is another subpopulation who has only legal incomes beside the cannabis cultivation and who see the cultivation as an easy, risk-free extra income.
- Eighty-two percent was first offender. About 18% had criminal antecedents, which are very diverse: traffic offences, public order offences, property offences, assault, and illegal possession of firearms. Thirteen percent was a recidivist in a cannabis offence, 5% had more than one cannabis antecedent. No differences were found between first offenders and recidivists in cannabis offences. They use the same kind of network around their cannabis cultivation and the same ways of cultivation, and they have the same motive (generating extra income).
- A mean of 200-300 plants was cultivated and the harvest was probably bought by a middleman. Cultivation took place in rented houses (47%), but also in own houses in the cheaper sections of the housing market (37%). The set-up of the plantation was in 47% of the cases organised with the help of others. After that, the majority (66%) operated the plantation on their own. The harvest was sold to own private 'clients' (43%), is said to be for own use (36%), is sold to a growshop (14%) or a coffee shop (7%). 48% sold the harvest on their own, 32% did this with the help of others.
- Main sanctions are community service orders (75%), prison sentences (33%) and/or fines (14%). Recidivists get more often a prison sentence than first offenders, and growers with higher (legal) incomes get more often (also) a fine.

### *Import of foreign hashish*

A *quick scan* of the Netherlands Police Agency focuses on the import of foreign hashish (Jansen 2012b). In 2008, this was not defined as a priority area for the police forces. For the 2012 report, 5 investigation files were analyzed and police professionals were interviewed about 7 investigations. Although fragmentary and casuistic, the general picture is the following.

- In the investigations there are a lot of recurring names, indicating that this type of crime is a small world.
- The main source country of the hashish that enters the Netherlands is Morocco.
- Transport to the Netherlands takes place mainly via sea, often using old fishing boats which are loaded and unloaded by smaller boats (rigid-hulled inflatable boats, go-fasts

and sailing boats) which sail from and to the coast or small harbours. Remarkable is that the fishing boats are often in a bad state and that a lot of problems occur on the way, which can lead to sinking of the boat (and its load).

- The Netherlands are mainly a transit country. The hashish is primarily transported via the road. Destinations are Italy, Denmark, UK and Scandinavian countries.
- The number of players increased. Besides Dutch networks, consisting of persons with a track record in drug trafficking, Moroccans are increasingly involved. Some Moroccans are coffee shop owners as well, or have family members with a coffee shop. Also Dutch nationals from fishing villages in the Netherlands are increasingly becoming involved. Only a small number of experienced captains are available for the long transport over sea.
- There is almost never a mingling with hard drugs. The organisations seem to be specialized in cannabis. In some cases there were also synthetic drugs involved.
- Estimates of the size of the import are impossible because of a lack of concrete information. Information about the connection between the import and the export is also lacking. On the basis of the amount of money that is seized Jansen concludes that it is a lucrative business.

### *Cocaine*

The report about organised crime in relation to cocaine is based on 39 investigation files from the period January 2007-October 2011 (Van der Laan 2012). 10 files of the biggest cases were selected for closer analyses. In addition, information was gathered from professionals who were involved in the investigations, and research reports and strategy documents were studied.

- Source countries of the cocaine are Peru, Bolivia and Colombia. Western Africa is important as transit region, as are other African countries like South-Africa, Kenya and Mauritania. The trafficking here is in the hands of Europeans.
- The most important way of transport to the Netherlands is by boat. Transport is often problematic and can take months or even years. The harbours of Rotterdam and Antwerp are the main points of entry. Antwerp is for Dutch criminals as important as Rotterdam and it seems to become even more important. Sometimes transport takes place via airplanes; this concerns smaller amounts of the drug.
- The cocaine that arrives in the Netherlands is sometimes hidden by mingling or processing it in other substances. It has to be extracted after transport. This is done in secondary extraction laboratories or 'coke laundries'. Between 2003 and 2008 between 1 and 10 of these labs were discovered by the police. Exact figures about 2009-2011 are not available, but according to Van der Laan (2012) "some" big labs were discovered in 2011. Most are small labs in private houses of traffickers. Suspects are Dutch nationals and Colombians. The Dutch are the main suspects.
- 31 of the files contain information of the amount of cocaine that was (being) smuggled to the Netherlands. In 2011, this was a total of 5,116 kilos, transported by 6 criminal groups. Most of this was seized abroad. The Netherlands is primarily a transit country. The cocaine is transported to the UK, Central Europe and Italy. The files do not contain information about stashes in the Netherlands. The files make clear, however, that there are big stashes in Africa, Brazil, Ecuador and Rumania in which Dutch nationals are involved.

- A large number of independent entrepreneurs are active in the trafficking. Dutch nationals are dominant, followed by Surinamese and Colombians. Several other nationalities are involved, but none of the investigations mentioned African organisations.
- Half of the 39 criminal groups is only involved in cocaine, 11 were also involved in other drugs (mainly synthetic drugs, sometimes cannabis, once heroin).
- Van der Laan (2012) expects no big changes in cocaine trafficking in the near future. It is assumed that the market offers enough opportunities for an increase of the number of persons involved without creating extra tension for criminal groups.

### *Heroin*

The report on heroin is based on 9 files of investigations of serious and organised crime in relation to heroin, and 14 interviews with experts (KLPD 2012c). The information about heroin trafficking in the Netherlands is limited, because there is almost no (further) investigation into suppliers, buyers, smuggling routes or criminal organisations. Authors conclude that the intelligence position of the National Crime Squad in this matter declined in the last years.

- The available information indicates that there are no substantial developments with regards to heroin in the last years.
- The National Crime Squad did not observe any consequences of the decrease in opium production in Afghanistan in 2010.
- The Netherlands seem to function as a transit country for heroin. The smuggling route from Afghanistan via Iran, Turkey and the Balkan countries still seems to be the main routes (mentioned in two investigations from 2009), although it is noticed that this route might be less attractive because of the intensified enforcement efforts in Turkey. An alternative is the northern route along the Black Sea, which avoids Turkey (reported in one investigation from 2010).
- Most heroin that is reported in police files is smuggled in sea containers or by couriers who travel by airplane.
- No new criminal groups were observed in the Dutch heroin market, according to the information in the files. Turkish groups are still the big players. The role of Nigerians, which is mentioned by some agencies, is unclear.
- Renewed operational co-operation with Turkey was initiated in 2010 and implemented in 2012, after some years of less intense collaboration.

### *Synthetic drugs*

The report on synthetic drugs is based on 21 files of investigations, expert interviews and (partly confidential) reports, including weekly reports on 125 synthetic drugs investigations and reports of foreign police and custom agencies (KLPD 2012b). In addition, the annual report on synthetic drugs was consulted here (KLPD 2012a).

- There were important developments in the field of synthetic drugs since 2008. Remarkable are
  - the emergence of new precursors (e.g. safrol) and non-controlled pre-precursors (e.g. PMK-glycidate, APAAN),
  - the recovery of MDMA production,
  - the increase in scale of production sites,
  - the emergence of new source countries for chemicals,

- the emergence of new psycho-active substances on the trafficking market (import and export, not on consumer markets in the Netherlands). These new substances, however, are not produced in the Netherlands.
- The criminal organizations seem to aim at circumvention of international laws and minimalizing the risk of being caught, by using new (pre)precursors. On the other hand, PMK and BMK are probably still hard to come by. The production processes needed adaptation and, as a consequence, criminal organizations specialized in the conversion of new precursors or even production of essential chemicals seem to emerge.
- With regard to MDMA, it is reported that pre-precursors like safrol, safrol-rich oils and PMK-glycidate came in place of PMK since 2009. These are imported from China, but also other Asian countries like Myanmar, Cambodia, Laos and Indonesia are important producers and exporters of safrol-rich oils. Production of MDMA is recovering itself in 2011: more production places were dismantled and more tablets of ecstasy contain MDMA.
- With regard to amphetamine, non-controlled derivatives from BMK seem to be on the market, like BMK-bisulfite and 4-methyl-BMK, as well as the non-controlled pre-precursor APAAN, although BMK seems to have been sufficiently available (from China, Lithuania, Poland and possibly Ukraine).
- 4-Methylamphetamine is placed under the Opium Act in 2012.
- The Court decided in 2012 that PMK-glycidate and BMK-bisulfite can be considered as registered substances and as such can only be traded and used with a license, which opens the way to judicial sanctioning (LJN BQ2998 2011; LJN BQ2877 2011; LJN BW8614 2012).
- Poland became more important as source country of chemicals.
- The production capacity of the hardware seems to increase (in general, there are large margins).
- Countries in Asia seem rising as destinations of synthetic drugs.
- GBL and 1,4 BD are used as precursors for GHB. Production and dealing of GHB seems to happen outside the criminal circuit, because it can be made easily by users themselves and the ingredients are cheap (Voorham & Buitenhuis 2012). GBL is a non controlled substance in the Netherlands, however, since GHB is rescheduled from schedule II to schedule I (class A drug), trade in GBL can (under certain circumstances) be prosecuted on the basis of preparatory acts. In the reporting year the trade in GBL increased substantially.
- Raw materials seem to be increasingly bought via the internet. The same seems to be the case for the sale of end products.
- The National Crime Squad expects that the production and export of synthetic drugs in the Netherlands will recover further in the next years. The production of methamphetamine could possibly increase, as well as that of GHB.

#### *Illicit drug sales via internet*

With regards to illicit drug sales via internet within and from the Netherlands, the minister of Security and Justice concluded (T.K. 24077-295):

- Drugs are offered on Dutch websites and this offer seems to be focussed on Dutch users.
- Per transaction it concerns only small amounts of drugs, but in total it could concern large amounts of drugs which are traded this way.

- Internet is also a source of chemicals and precursors like GBL, cannabis seeds and equipment for cultivation of cannabis, and new psychoactive substances.
- The drugs seem to be supplied on usual websites, but also via so-called 'TOR' networks, which are anonymous and secured.
- Several sources mention The Netherlands as an important source country of drug sales via internet.
- The size of the trade, the traders, the buyers and the methods are unknown, a lot is still unclear.

The abovementioned conclusions require further action, which will be taken along the following three lines: increasing our knowledge of the *modi operandi*, making full use of our current and future legal instruments and further developing expertise of the police forces and public prosecutor's office.

## 10.2 Seizures

Figures of 2010 and 2011 are reported in table 10.2.1 (see also ST13). The figures are incomplete, because data from some police regions are lacking. In 2010, four police regions did not report their seizures and in 2011, seven regions did not deliver their reports on seizures. No comparison can be made between years, because they would be invalid.

Table 10.2.1: Drug seizures 2010<sup>I</sup> and 2011<sup>II</sup>

Type of drug	Amount in 2010 <sup>III</sup>	Amount in 2011 <sup>III</sup>
Opiates	13 kilograms	1,1 kilograms
Heroin	+ 550 kilograms and 235 balls	400 kilograms and 370 balls
Morphine	+ 30 ampoules	-
Cocaine	10,000 kilograms and + 400 balls	10,000 kilograms and + 1800 balls
Methadone	700 grams and 16,500 tablets	235 grams and 11,000 tablets
Hashish	3,500 kilograms	1,000 kilograms
Marihuana	4,500 kilograms	5,000 kilograms
Hallucinogenic mushrooms	3.5 kilograms	1 kilogram
'nederwiet'		
- plants	1.6 million	2.0 million
- cuttings	170,000	200,000
- plant tips	110,000	13,000

I. Four out of 25 regions did not report. II. Seven out of 25 regions did not report. III. Figures are truncated and figures of Customs and Military Police are included. Source: KLPD/IPOL, 2012.

Additional information is available in the Crime Pattern Analysis of the National Police (KLPD 2012a, b and c; Van der Laan 2012, Jansen 2012a and b, to be published in January 2013):

- In 2011 5,435 cannabis production sites were dismantled according to the Netherlands Police Agency. This number does not differ substantially from the years before. Siesling et al (2011), who analyzed 295 files of home growers of cannabis, report that the supply of home growers of cannabis is still high and that it is easy for buyers of cannabis in the background to recruit a substitute if a grower is caught by the police. When a home grower is caught, there is no further investigation into other persons involved in the background.

- There are large regional differences in the number of dismantlements. Western Brabant (a southern region) and Rotterdam-Rijnmond region have the highest number. In Western Brabant, where the Task Force Organised Crime is active, 14 groups engaged in large-scale cannabis cultivation were tackled, 10 million euro was confiscated, and 7 persons were arrested because of money laundering from drug trafficking. The criminal structures behind the cannabis cultivation are investigated (TK 29911-60; Nationaal Netwerk Drugsexpertise 2012). For Western Brabant, this might be a result of the high priority that is given there to this type of crime.
- Most of the indoor plantations are detected by anonymous reporting by citizens to the police (52% according to Siesling et al. 2011; see also Jansen 2012a). Other kinds of reporting leads to arrest in 25% of the cases. Discovery at police actions takes place in 18% of the cases. In 8% of the cases, the plantation revealed itself by fire, flooding or heat emission (Siesling et al 2011).

The police is implementing a uniform protocol for registration of seizures of drugs (T.K. 28684 and 29628-343 2012). The Inspectorate of Public Order and Security will conduct a follow up investigation by the end of 2012.

Tables 10.2.2 and 10.2.3 show figures about seizures of precursors and synthetic drugs (KLPD 2012a; KLPD 2012b). These figures come from the special unit for synthetic drugs and precursors of the National Crime Squad. They might not be complete – there is no obligation for enforcement agencies to report figures – but whereas there is central support to regional parties and active gathering of data, it is assumed that these figures give the best possible picture.

- Precursors as well as pre-precursors for amphetamine and MDMA were seized (table 10.2.2). Remarkable is that new types of both are used in 2011 (see above).
- There were no seizures of PMK and less seizures of BMK in 2011.

*Table 10.2.2: Seizures of (pre)precursors for synthetic drug production 2005-2011, in litres*

	2004	2005	2006	2007	2008	2009	2010	2011
BMK	6,280	340	171	-	231	258	334	139
PMK	4,400	1,762	55	20	-	40	-	-
PMK-glycidate		-	-	-	-	-	1,200 (kilos)	100
Safrol		-	-	-	-	20	85	105
(Pseudo-)ephedrine		-	-	-	317 (kilos)	587 (kilos)	508 (kilos)	-
APAAN		-	-	-	-	-	-	2,810
Benzylacetone		-	-	-	-	-	-	1,440
GBL		-	-	-	-	-	-	3,740

Source: KLPD 2012b.

Table 10.2.3 shows seizures of amphetamine and MDMA in the Netherlands. For both drugs, the Netherlands still is an important production country, according to the Netherlands Police Agency.

- More amphetamine was seized in 2011 than in 2010. In 2010 it was a total of 612 kilos and in 2011 1074 kilos. The purity on consumer level decreased.
- More MDMA was seized than in 2010, 2009 and 2008.

Table 10.2.3: Seizures of amphetamine and ecstasy/MDMA in the Netherlands, 2006-2010

	2006	2007	2008	2009	2010	2011
<b>Amphetamine:</b>						
- Powder (kilos)	633	2,805	1,106	1,946	66	530
- Tablets	38,077	1,391	0	0	0	0
- Paste (kilos)	3	40	121	466	546	544
- Oil (litres)	5	241	65	0	57	76
<b>MDMA:</b>						
- Tablets	4,118,252	8,430,043	249,761	172,845	555,401	1,059,534
- Powder (kilos)	664	1,319	84	3.4	66	200
- Oil (litres)	120	1.74	300	0	0	10

Source: KLPD 2012b.

Other synthetic drugs that were seized in the Netherlands in 2011 were:

- mephedrone: 0.5 kilos (in 2010: 109 kilos)
- Synthetic cannabinoids: 190 kilos (in 2010: not known)
- mCCP: 0 tablets (in 2010: 5,200 tablets)
- LSD: 0 stamps (in 2010: 6,430 stamps)
- 2-PEA: 0 tablets (in 2010: 4,000 tablets)
- methamphetamine: 35.4 kilos (in 2010: 44.6 kilos)
- ketamine: 18.6 kilos (in 2010: 5 kilos)
- GHB: 270 litres (in 2010: not known).

These types of drugs, except mCCP, were not reported or not known in 2009.

Thirty dismantlements of production locations of synthetic drugs are reported in 2011, more than in 2010 (table 10.2.4). This number is relatively high.

- At six locations, amphetamine was synthesized, three less than in 2010.
- At four locations, MDMA was synthesized, two more than in 2010.
- Two locations were synthesizing methamphetamine, the same as in 2010. Production takes place on a smaller scale than that of MDMA or amphetamine.
- Five times other or designer drugs were synthesized, about the same as in 2010.
- At eight locations APAAN or safrol was converted. There were more conversion labs discovered than in 2010, especially of APAAN.
- 16 times (also) crystallization took place and seven times (also) tableting (mainly of amphetamine or MDMA).
- Most production locations were situated in the South of the Netherlands (figures available until 2010).
- 50 storage places of hardware, chemicals or both were discovered by the police, nine more than in 2010.
- The number of dumpings is higher than in 2010 (55 times), and there are indications that also other methods of processing of waste are in use.
- The Act for Prevention of Misuse of Chemicals (*Wet voorkoming misbruik chemicaliën, WVMC*) obliges companies to report suspicious transactions with regards to registered chemicals. In 2011, 87 suspicious transactions are reported, more than in the years before (not in table).



Table 10.2.4: Number of dismantlements of production locations for synthetic drugs 2004-2011

	2004	2005	2006	2007	2008	2009	2010	2011
Production locations	29	18	23	15	21	24	19	30
Storage places	14	19	43	44	35	37	41	50
Waste dumpings	81	51	42	50	36	34	35	55

Source: KLPD 2012b.

## 10.3 Purity and price

### 10.1.3 Purity

The Drug Information and Monitoring System (DIMS) of the Trimbos Institute provides detailed information on the quality of 'ecstasy' and other drugs submitted by consumers at test locations of drug treatment services. Some of the submitted tablets can be identified visually on the basis of comparing specific characteristics (colour, logo, weight, diameter etc.) and reaction in the Marquis test with previously analysed tablets. All other samples (non-recognised tablets and all powders and liquids) are sent to the laboratory for chemical analysis.

In 2011 the number of delivered drug samples was 9,959, about the same as in 2010 (8,898), of which 63% were analysed in the laboratory. The majority of drug samples consisted out of tablets (5,587) followed by powders (3,222), and the remainder were capsules, liquids, paper trips and miscellaneous formulations. In general, ecstasy tablets contained a high amount of MDMA, higher than in all previous years.

In the text below, a distinction will be made between tablets or other samples as they were sold to the consumer, e.g. tablets sold as ecstasy, amphetamines or something else. Data on powders (mainly cocaine and amphetamine) are also included in this paragraph. We will first briefly describe the (assumed) composition of consumer samples (tablets) that were identified in 2011 on the basis of the identification lists (without laboratory analysis). Thereafter we will continue with the findings based on laboratory analyses.

#### Tablets identified without lab tests

In 2011 2,950 tablets were recognised (or classified) on the basis of a visual analysis, Marquis test and recognition lists. This is 52% of all tablets delivered to the DIMS (DIMS, 2011). Virtually all tablets were sold as ecstasy or ecstasy-like substance (99%). Whereas in 2009 about one-third of ecstasy tablets did not contain MDMA (or MDEA/MDA), in 2011 this was a mere 4%. Most tablets that did not contain MDMA contained mCPP (2%). Mephedrone has virtually disappeared in 2011 (0.2%).

## Laboratory analyses

### *Ecstasy: very high purity of tablets in 2011/2012*

In 2011, 2,183 tablets sold as ecstasy were analysed in the laboratory. Table 10.3.1 shows the percentage of analysed tablets containing certain substance(s), or a combination of substances. These categories are mutually exclusive.

- The total percentage of ecstasy tablets containing MDMA (and/or an MDMA-like substance, such as MDEA, MDA) as the only scheduled drugs has decreased in 2008 and 2009 and increased again in 2010 and 2011.
- In the first half of 2012, the purity of ecstasy tablets was higher compared to all previous years.
- In 2010 and 2011, both mCPP and mephedrone were detected less frequently than in the years preceding (5% and 4%, respectively for mCPP; 1% and 0.7% for mephedrone). This is indicative of a strong 'recovery' of the ecstasy market.
- DIMS detected the harmful substance PMMA in a number of ecstasy tablets: 29 times (1.2%) in 2010, 28 times (1.3%) in 2011 and 17 times in the first half of 2012 (1.7%). Usually, this substance is detected in tablets which also contain MDMA. Only a few tablets were found which only contained PMMA in a substantial concentration (20 mg or higher), 8 in 2011 and 3 in the first half of 2012. The use of PMMA was associated with several fatal emergencies in 2010 and 2011 (4 with use of PMMA verified, one non-verified), although other substances might also have contributed to death. The number of nonfatal emergencies is not known.
- Subjective ratings of users handing in their ecstasy sample show that tablets containing only MDMA are rated as having the most desirable effects, while tablets (also) containing PMMA or mCPP have comparatively lower desirable and much more adverse effects (Brunt et al. 2012).

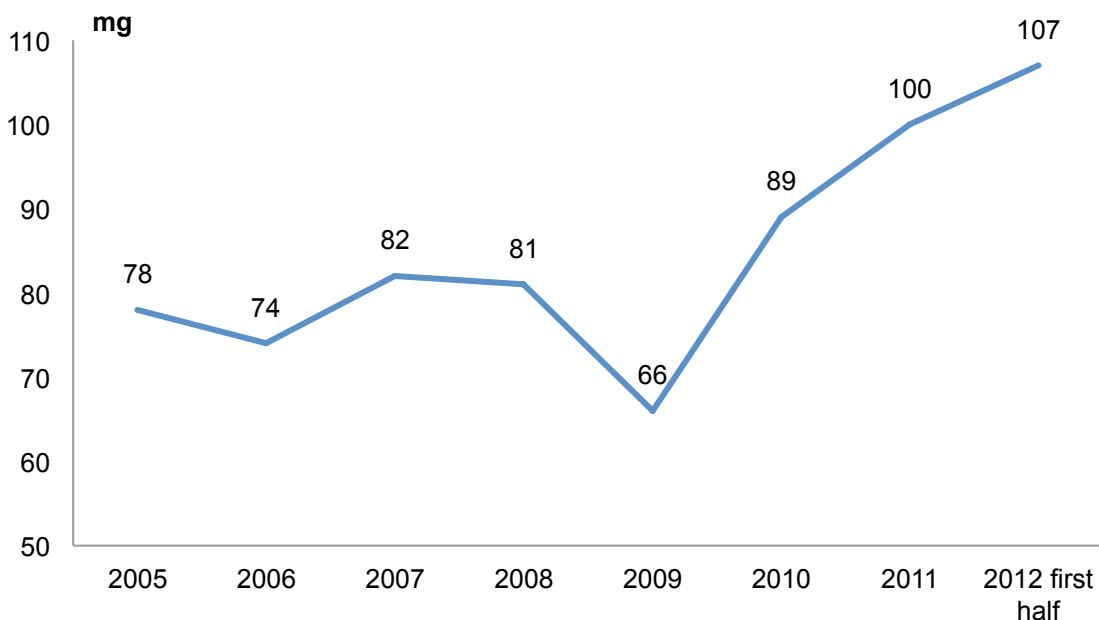
*Table 10.3.1: Content of tablets sold as 'ecstasy' based on laboratory analyses*

	2004	2005	2006	2007	2008	2009	2010	2011
Number of tablets analysed	1,985	2,140	2,523	2,319	2,183	2,181	2,357	2,183
- Only MDMA-like substances	91.9%	88.6%	83.2%	84.6%	70.5%	70.8%	81.9%	90.5%
- (Meth)amphetamine	0.8%	4.0%	1.8%	0.7%	1.1%	4.9%	2.9%	2.3%
- MDMA-like substances and (meth)amphetamine	0.3%	1.4%	2.2%	1.3%	1.40%	1.3%	2.2%	3.0%
- Others *	4.5%	0.3%	4.5%	3.8%	7.40%	1.40%	1.8%	1.0%
- Miscellaneous**	2.5%	5.7%	8.3%	9.6%	17.70%	21.66%	11.2%	3.2%

\* Category 'others' may include samples with MDMA and for example caffeine and other pharmacologically active non-scheduled substances. \*\*In 2009: The category miscellaneous consisted mainly of mCPP (11.60%) and mephedrone (7.4%). In 2010 and 2011 this category consisted mainly of mCPP and caffeine. Source: DIMS, Trimbo Institute.

- The concentration of MDMA in tablets has always shown a wide variation. Excluding ecstasy tablets without any trace of MDMA, in 2011 4% of the ecstasy tablets contained between 1 and 35 mg MDMA, 13% contained between 36 and 70 mg and, 36% between 71 and 105 mg, 25% between 106 and 140 mg and 13% contained a high dose of over 140 mg. 2012 shows a similar pattern. This is a substantial shift towards higher dosed MDMA tablets compared to 2010.
- In general, users subjectively rate doses between 81 and 100 mg as most positive or desirable, while for higher doses the likelihood of desirable effects decrease and the risk of adverse effects increase (Brunt et al. 2012).
- The *average* amount of MDMA in tablets (containing at least 1 mg MDMA) was relatively low (66 mg) in 2009, which is probably due to a shortage of precursors for synthesising MDMA. In contrast, the averaged dose was as high as 107 mg in the first half of 2012 (see figure 10.3.1).

Figure 10.3.1: Average concentration of MDMA in tablets sold as ecstasy\*



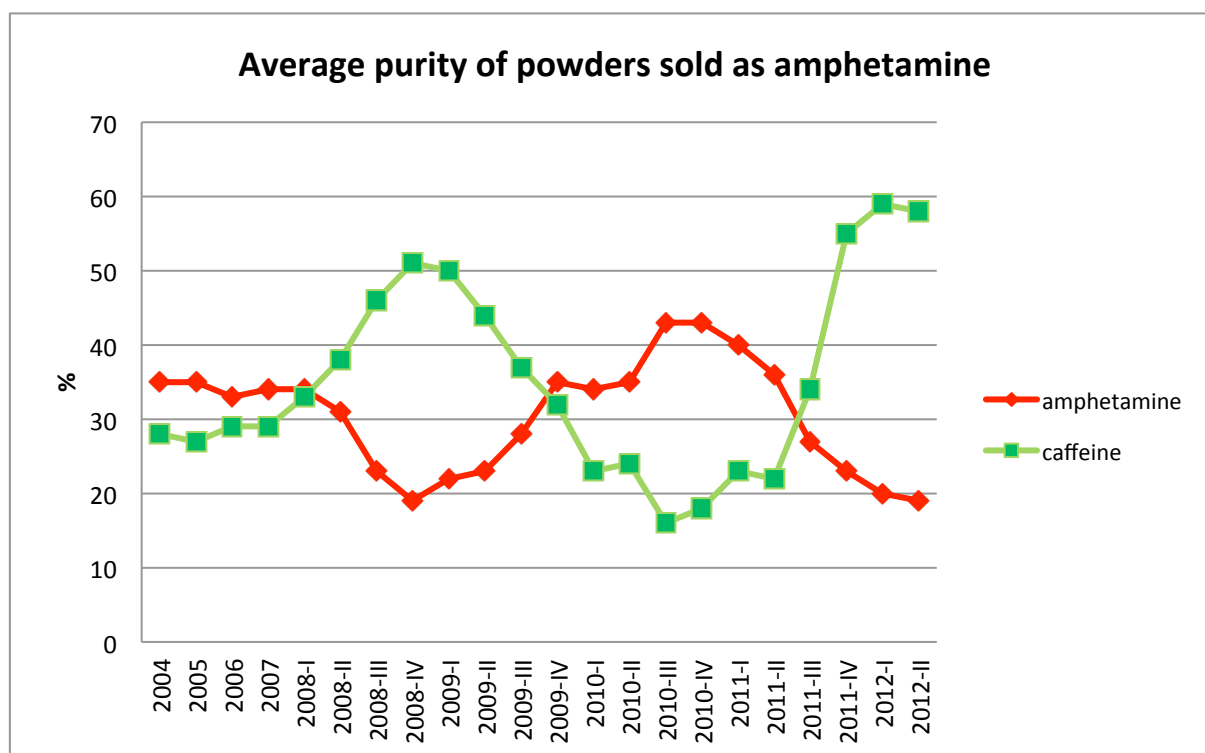
\* Tablets analysed in the laboratory containing at least 1 mg MDMA. Source: DIMS, Trimbos Institute.

#### *Amphetamine:*

Purity of amphetamine powders shows strong fluctuations, which may be associated with (temporary) shortages in precursors. Whenever the content of amphetamine drops in the powders, this is compensated by an increase in caffeine, the most preferred adulterant. In 2011 DIMS received 1,187 powders sold as speed.

- The majority of speed powders (95%) contained amphetamine, with an average concentration of 30%. In the first half of 2012 this has dropped to a concentration of 21% over 790 powders containing at least 1%. Like in 2011, 95% of the powders sold as speed contained amphetamine. Methamphetamine was hardly detected in speed samples in the Netherlands.
- The concentration caffeine in powders containing amphetamine was 46% in 2011 and 58% in the first half of 2012.

Figure 10.3.2: Average concentration amphetamine en caffeine in speed samples\*



\* Data based on a selection of samples containing at least a trace amphetamine (with or without caffeine). Source: DIMS.

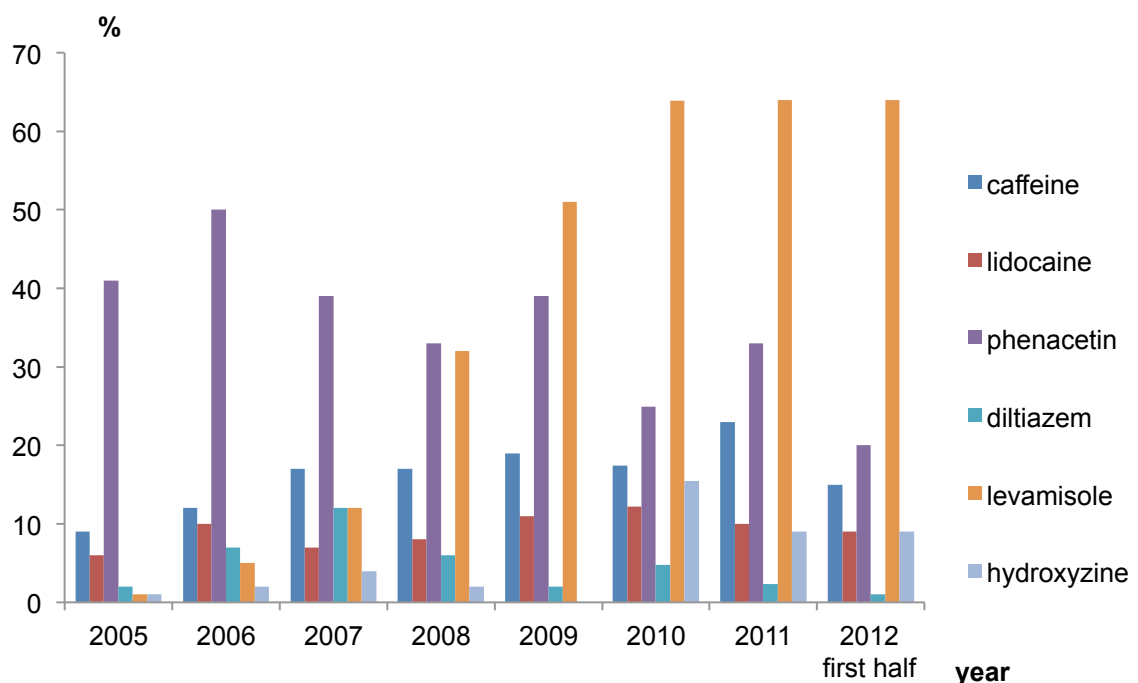
- Figure 10.3.2 shows the percentage of caffeine in all samples containing amphetamine (thus also including samples without caffeine).
- In 2011 and the first half of 2012, about 3% of the speed samples contained the non-controlled substance 4-fluoramphetamine, which is much lower than in 2008 (10%).
- In 2010, 4-methylamphetamine (4-MA) was detected for the first time in 10% of the samples, in 2011 in 9% and in the first half of 2012 in 11% of the samples. It has been suggested that 4-MA is less potent than amphetamine (Wee et al., 2005). Nonetheless, the Netherlands Forensic Institute has associated the use of this substance with several fatal emergencies in the Netherlands in 2010, 2011 and 2012, although the precise role of 4-MA as a cause of death is not yet known. In some cases there may have been severe hyperthermia and there are indications that this drug may cause adverse effects only in particular persons (idiosyncratic reaction). On request of the Minister of Health, Welfare and Sport, a quick scan on the risks of 4-MA was carried out in May/June of 2012 by the Co-ordination Centre for the Assessment and Monitoring of New Drugs (CAM, June 2012). This resulted in the immediate placement of 4-MA on Schedule I of the Opium Act (on June 13 2012).

*Cocaine: continuing large proportion of powders with medicines, especially levamisole*  
In 2011, 1,085 powders sold as cocaine were analysed.

- Almost all (96%) of samples contained cocaine (among other substances), with an average concentration of 49%. Over the past decade, average purity decreased (e.g. 68% in 2002).

- Since 2002, the percentage of cocaine samples containing pharmacologically active adulterants or diluents has strongly increased (see also Brunt et al., 2009). Figure 10.3.3 shows that the proportion of powders sold as cocaine with phenacetin is lower than in previous years (33% in 2011, 20% in the first half of 2012). Yet, the proportion of cocaine powders containing levamisole has strongly increased (64% in 2011 and the first half of 2012). Levamisole is an antihelminticum used mainly for veterinary purposes. It is also used as an anti-cancer drug, but is not officially registered for human use in the Netherlands. The average dose of levamisole was 7.5% in 2011 and 7% in the first half of 2012, with a maximum of 82% in 2011 (this drug sample exclusively contained levamisole).
- In North-America, the use of cocaine adulterated with levamisole has been associated with serious blood diseases. In the Netherlands no such cases are known (CAM 2009).

Figure 10.3.3: Percentage of powders sold as cocaine also containing medicines



\*Source: DIMS, Trimbos Institute.

#### Other substances

- In 2011, substances found relatively often in the *rest of analyzed drug samples* were ketamine (n=79), GHB/GBL (n=139), 4-Fluor-amphetamine (n=24), mephedrone (n=15) and 2-CB (n=35).

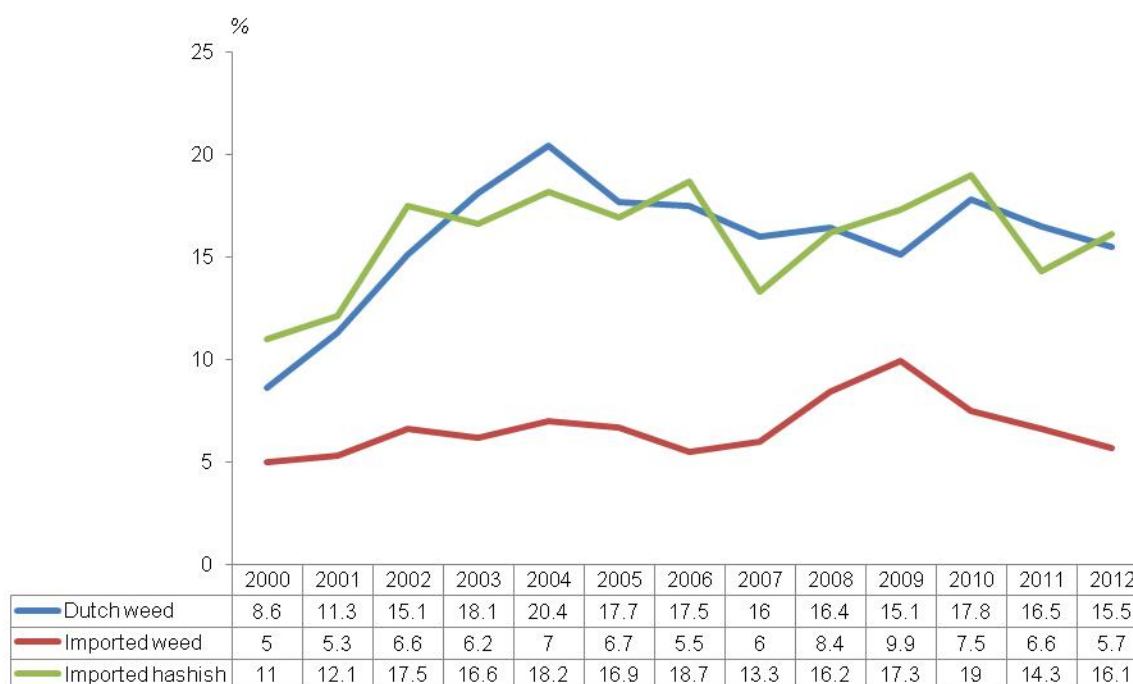
#### Cannabis

Since 1999, a special department of the DIMS™ also monitors the THC content and prices of cannabis. This department of the DIMS™ is called the *THC-monitor*. In 2012 188 samples of different cannabis products (about 1 gram each) were procured from a random sample of coffee shops and chemically analyzed (Rigter and Niesink 2012). Figure 10.3.4 shows the

average concentration of THC in Dutch-grown weed ('nederwiet'), imported weed and imported hashish (see also Standard Table 14). Two types of samples of Dutch marihuana were bought: the most "favorite" variety (normally reported here, unless mentioned otherwise) and the most "potent" variety, according to the perception of owners of coffee shops. In 2010 there was a change in the laboratory assessing the THC concentration, which may have had some impact on the trend data.

- Dutch weed contains almost three times more THC than imported weed.
- Between 2000 and 2004, the percentage of THC in Dutch-grown weed (most popular type) increased significantly from 9% to 20%. Between 2005 and 2012 the average concentration stabilized and fluctuated between 15% and 18%.
- The percentage of THC in Dutch weed sold as 'most potent type' did not differ significantly from that in the most popular type (16.9% against 15.5%).
- The THC concentration in imported weed increased between 2007 and 2009 and dropped again afterwards.
- The percentage of THC in imported hashish dropped from 18.7% in 2006 to 13.3% in 2007, and fluctuated in the consecutive years. These changes are hard to explain.

Figure 10.3.4: Average THC percentage in cannabis products



Source: THC-monitor, DIMS, Trimbos Institute (Niesink and Rigter 2012). Dutch weed: sold as 'most popular' type.

- The relatively high THC content in Dutch weed compared to imported weed is probably due to highly professional cultivation methods, which have been refined more and more during the past years.
- A committee of experts has advised the Minister of Security and Justice and the Minister of Health, Welfare, and Sport to reschedule weed containing more than 15% THC from Schedule II to Schedule I of the Opium Act (Expertcommissie Lijstensystematiek Opiumwet 2011). In 2012, the Minister of Security and Justice announced that this THC limit will be implemented and enforced. (see also chapter 1)

### *THC versus cannabidiol (CBD)*

The potency of cannabis is generally indicated by the concentration of THC. In recent years scientific publications increasingly point at the role of another cannabinoid – cannabidiol (CBD) – in contributing to the (health) effects of cannabis. More specifically, cannabidiol seems to counteract some of the effects of THC that are implicated in, among others, psychosis and dependence. In this regard, especially the ratio between THC and CBD – rather than absolute THC content - seems to count.

Dutch weed contains relatively high average concentrations of THC and very low levels of CBD: in 2012 15.5% versus 0.3%, respectively). For imported weed this balance is slightly better (65.7% versus 0.4%), but here the levels of CBD are also rather low. Imported hashish contains the highest levels of CBD (6.9%), and levels of THC comparable to those of Dutch weed (16.1%).

However, although various studies point at some protective effects of CBD on THC induced adverse health effects, there is insufficient knowledge of the 'optimal ratio' of THC and CBD, and whether the different types of cannabis are indeed associated with different health risks (Niesink and Van Laar, 2012).

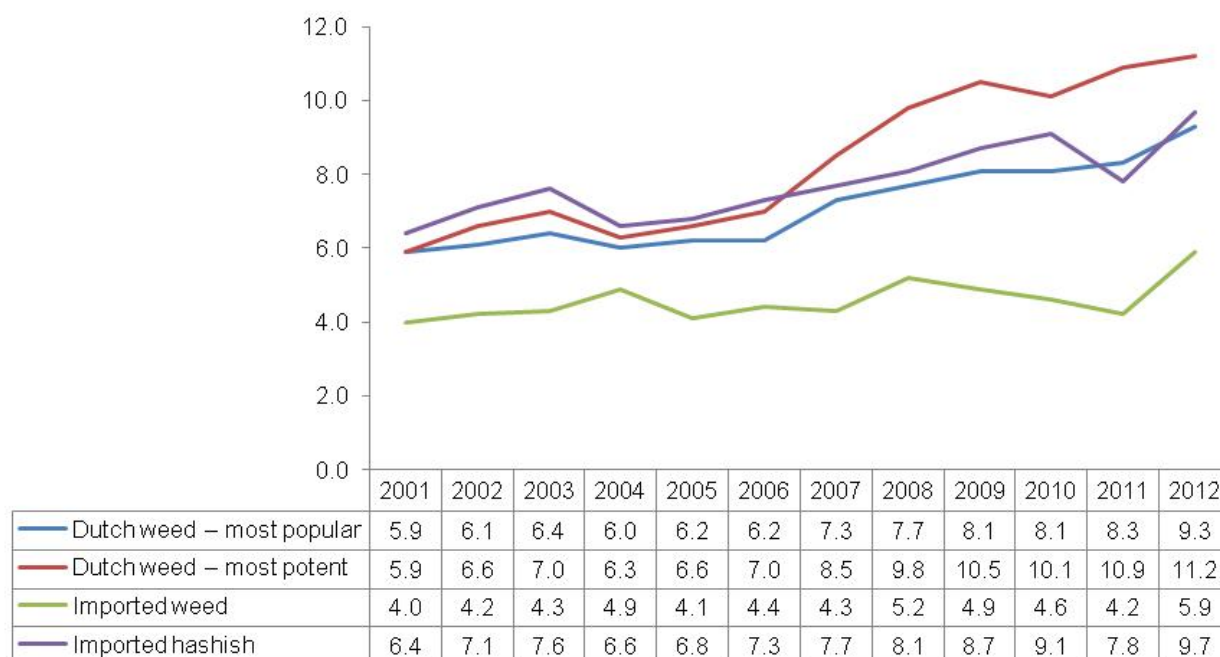
#### *10.1.4 Prices*

Sources on the price of drug samples at consumer level are DIMS/THC-monitor. It should be noted that prices may vary widely between regions (e.g. often higher prices in Amsterdam), but a reliable picture of these differences is not available. Also, prices may vary depending on the amount that is purchased and source of the purchase (Benschop et al., 2009; Doekhie et al., 2010). Prices reported in this paragraph are not corrected for purity (unless mentioned otherwise).

#### *Cannabis*

- According to the THC-monitor, the average retail price of a gram of imported marihuana is consistently lower compared to other cannabis products (Figure 10.3.5; see also Standard Table 16).
- Retail prices in coffee shops are significantly higher for Dutch weed sold as 'most potent' compared to Dutch weed sold as 'most popular' (11.2 versus 9.3 euro in 2012).
- The retail price of Dutch marihuana increased steadily since 2006, with the strongest increases reported for Dutch weed sold as most potent type, although the difference between 2011 and 2012 was not significant.
- Prices of imported hash also slowly increased, from 6.29 euro per gram in 2009 to 9.71 euro per gram in 2012.
- Prices for imported marihuana remained low and stable over the years (5.9 euro per gram in 2012).
- Taking 2012 data for the most potent and popular types of Dutch weed together, a significant correlation was found between prices per gram and THC concentration ( $r=0.45$ ,  $p<.0001$ ).

Figure 10.3.5: Trends in average prices per gram of different types of cannabis



Source: THC-monitor, Trimbos Institute (Niesink and Rigter 2012).

### Prices of other drugs

Retail prices of other drugs reported by users who delivered their drugs sample to DIMS did not change very much over the past three years (see table 10.3.2; Standard Table 16). In 2008 and 2009, the price of an ecstasy tablet varied between 1 and 10 euro. However, the average price per tablet seems to have increased between 2008 and 2010, and remained stable in 2011. In 2011, the average price per tablet was about four euro. The Amsterdam Antenna monitor 2011 reported that price and quality of ecstasy tablets were not correlated (Nabben et al. 2012).

The price of cocaine lies between 25 and 80 euro. The average price per gram cocaine seems to fluctuate around 50 euro, uncorrected for purity. Benschop et al. (2011) reported that prices Amsterdam dealers have to pay for one kilogram of cocaine have increased up to 32,000-40,000 euro in 2009 and 2010, but prices at retail level remained generally stable at between 50 and 70 euro. However, amounts sold to consumers are often lower than 1 gram and increasingly contain adulterants.

Amphetamine is much cheaper than cocaine - one gram generally costs between 3 and 17 euro - which is sometimes mentioned as a reason to use it as a substitute for cocaine. Prices fluctuated in the past years, and increased from 2010 to 2011 (table 10.3.4), which may be related to previously described changes in quality (and availability).

Prices of heroin vary from 15-50 euro, with little changes over the past years. However, note that the number of samples is very low and may not be a representative sample of the heroin available on the heroin consumer market.



Table 10.3.2: Prices (in €; mean and range) of drug samples delivered to DIMS in 2008 - 2011

	2008	2009	2010	2011
<b>Heroin</b>				
Sample size (n)	24	40	24	26
Mean (€)	40	40	41	37
Minimum – maximum (€)	15-60	10-60	15-60	15-50
<b>Cocaine</b>				
Sample size (n)	637	780	979	679
Mean (€)	50	50	45	52
Minimum – maximum (€)	25-70	20-80	30-75	25-80
<b>Amphetamine</b>				
Sample size (n)	843	973	969	843
Mean (€)	6	8	6	8
Minimum – maximum (€)	5-15	1-25	2-15	3-17
<b>Ecstasy</b>				
Sample size (n)	1766	1561	1994	1855
Mean (€)	2	3	4	4
Minimum – maximum (€)	1-10	1-10	1-10	1-16

Heroin, cocaine, amphetamine prices are in euro per gram. Ecstasy price is in euro per tablet. Source: DIMS, Trimbos Institute.

## ***Part B: Selected issues***

## 11 Residential treatment for drug users in Europe

### 11.1 History and policy frameworks

#### 11.1.1 History of residential treatment

To a large extent, this paragraph is based on the study of Gemma Blok (2011), entitled "Sick or weak: History of the addiction care in the Netherlands" (*Ziek of zwak: Geschiedenis van de verslavingszorg in Nederland*).

#### *Medicalization*

In the Netherlands, from 1881 onwards, people who were picked up drunk three times were sent to the *National work facilities* (Rijkswerkinrichtingen). Life was harsh in these labor detention centers, and the results of a stay in these facilities were poor. In response to this hardship the *People Federation against alcohol abuse* and other organisations looked for a more human solution. Partly for this reason the first addiction clinic in the Netherlands was founded in 1891: *Hoog Hullen*, a non-religious asylum for "needy drinkers". This development was in line with the medicalization of alcohol abuse which took place in Europe and the USA in the nineteenth century. The treatment now consisted of first detoxification and after that offering the patients "powerful" food, purifying drinking water, healthy work, hydrotherapy, and sport.

About twenty years later, the first outpatient facility was established: the *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme) in Amsterdam. After that several inpatient mental healthcare hospitals opened special wards for people with alcohol problems. The main reason for special wards was stigma driven. Alcoholics wanted not to be associated with "crazy" people.

The fight against alcoholism and alcohol abuse was not initiated by the government but by different enlightened persons, whether or not religious driven, like doctors, teachers, vicars, professors and factory owners.

Although opiates were used (especially) by the wealthy bourgeois women and morphinism was diagnosed as a disease (around 1900), there were no special clinics for problem opiates users. These women were admitted to sanatoria. Around the same time certain laborers in the industrial centers and farm workers used opiates to release the hardship of their life. At that time opiates were easily accessible medication. It took a time before it was found out that this medication was addictive. Thus, until the sixties of the twentieth century, the addiction care mainly focused on alcoholism and alcohol abuse.

#### *Paradigm shifts*

During the last century, various paradigm shifts have occurred in the perception of addiction. At the end of the nineteenth century alcohol addicts were seen as "sick" instead of "weak" persons. In the first addiction clinic it was tried to help them by curing their disease. About two decades later, damage control was added to the treatment goal in the form of preventing social and financial decay. After that a pendulum movement became visible. Initially, the goal of addiction treatment shifted from total abstinence to damage control. Next, the goals

of addiction treatment shifted back from the acceptance of addiction as a chronic disease and applying harm reduction to efforts to reach total abstinence.

After 1950, a new perspective became prevalent, namely the psychological approach to addiction. According to this new approach, the root of addiction problems was to be found in the addict's childhood. This perspective brought along new therapeutic treatment options. In the same period new medication became available which further broadened the treatment options, like Librium (1960), a benzodiazepine that made craving less severe.

In 1960, the Jellinek clinic was founded, a "Therapeutic community" in the city of Amsterdam especially for alcohol addicts. In the sixties more of these clinics were opened like the Boumanhuis in 1962 in the city of Rotterdam. Many of these clinics originated from a former *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme).

### *New young drug users*

After 1960 a new client population came up: the young drug users. But it was not until 1968 that special care was organized for this group in the form of a consultation hour in the centre of Amsterdam where young drug users could get help and advice. In 1969 the *Medical health center for alcoholism* (Medisch Consultatiebureau voor Alcoholisme), in response to the new drug problem, became the *Medical health center for alcohol and drugs*.

Also in 1969 the first methadone treatment started in the Jellinek clinic. Problem drug users were given methadone according to a schedule by which the dose was reduced in six weeks. After 1972 heroin use became epidemic. It started in the capital city of Amsterdam, and although it was also used in the outside areas, Amsterdam remained the centre of heroin use.

The main group of drug users consisted of people who were frustrated about their position in the Dutch society, like youngsters who did not finish school or only finished low skilled education. They were jobless or only did unskilled work. A disproportionate large number of immigrants from Surinam were addicted. This group had a double disadvantage. On the one hand they already belonged to the weaker groups in Surinam, and on the other hand they emigrated to the Netherlands during an economic recession. Their housing situation was poor and there were not enough jobs available for the newcomers.

The prevailing view in addiction care was that parents are to blame for the addiction of their child. This resulted in the vision that addicted patients must loosen the bonds with their family. This vision collided with the (culturally driven) need of strong family ties and the wish to restore the family relations among the immigrants from Surinam. This collision of values was one of the reasons that an alternative treatment was realized for this group. An example of such an alternative treatment facility was "Wan Pimpel". The Surinam caregivers at this facility were less detox-minded compared to the Jellinek clinic. They helped the addicts with practical issues and gained their trust, and this way they could make the drug use a subject of discussion.

In 1979 the public health services (GGDs) started a "methadone bus" in the major cities in the Netherlands. On fixed times drug users (mostly vagrants) could come to pick up a dose of methadone at certain areas in the city that were visited by the methadone bus. There was no control on the use of other drugs and there were no therapeutic obligations. In the beginning a major part of the methadone clients was of Surinam origin.

### *Residential care*

Meanwhile, the addiction care facilities only reached a small fraction of the drug users. There was a threshold to receive addiction care. The patients had to be motivated and had to

submit themselves to certain rules to be admitted to a therapeutic program. The government supported this approach. The Health Council reported in 1976 that the only meaningful treatment of addiction aims at total abstinence. Every other approach was supposed to stimulate an addicted person to persist in his lifestyle. At that time the addiction care was rather optimistic about the therapeutic possibilities. The Drug-free Therapeutic Communities (DTCs) came up, and the Jellinek opened the DTC "Parkweg". The average stay in this kind of clinic was eight months to one and a half year. In due time, the caregivers noticed that a too liberal and too noncommittal approach led to improper use of the DTC by the patients. Therefore, the caregivers were looking for other approaches.

In the USA a new treatment method came up in the form of the Hierarchically Structured Drug-free Therapeutic Community (HSDTC). This form of treatment was based on the mutual contact between the addiction patients and self help. In 1972 the "Emiliehoeve" was founded in The Hague, it was the first HSDTC in the Netherlands. The treatment program at the Emiliehoeve consisted of therapy, sport, housecleaning, and other tasks. The residents had to work hard and were not allowed to use any addictive substance which was tested by means of urine tests. After this initiative, a few other clinics were founded which applied the same treatment method. By the start of the eighties, a total of 120 treatment units (beds) were available in the HSDTCs in the Netherlands.

In the "Delta Psychiatric Hospital" (Delta Psychiatrisch Ziekenhuis) in Rotterdam an "eclectic" program was developed. It consisted of working hard and sporting, based on the idea that as long as someone is busy he has no time to think about drugs.

Next to this there were various Christian rehabilitation centers and residential communities for drug users. In these institutes daily life was filled with working hard and engagement with faith.

Unfortunately there was a group of extreme problematic drug users that were not reached by the existing care. Many of them were imprisoned on a regular base. Some prisons created special wards for this group, like "Demersluis" (1979) in Amsterdam, where caregivers from the Jellinek clinic assisted these detained patients.

As already mentioned above, the inpatient addiction care treated just a part of the drug users. The outpatient and outreaching care offered by a "Medical health center for alcohol and drugs" and a "Public Health Service (GGD)" reached more people. The Public Health Service (GGD) of the main cities played (and still plays) an important role in supporting the problematic drug users. The methadone distribution in Amsterdam and Rotterdam, for instance, was taken care of by the Public Health Service in cooperation with the addiction clinics.

### *Alternative treatment*

Around 1980 a movement against the traditional addiction care came up. According to this movement the traditional treatment was humiliating, arrogant, and pedantic. Drug addicts should be helped to build up a human life. The basic idea now was that if the addicts can obtain drugs from their general practitioner, and if they have their own house, they can live an independent life. In 1980 the first "Junky Union" (Junkiebond) was set up in Rotterdam and many followed. A vicar became familiar with the drug scene and he opened his church the "Pauluskerk" for the drug users and accepted that they were using drugs. According to the vicar, "Society has to face reality, there are people who need drugs and they buy and sell it".

The discussion now started about heroin on prescription. A small experiment in Amsterdam started with morphine provision, and later an experiment was conducted with

methadone that could be injected. These experiments were not successful yet, partly because the drug addicts were not interested.

In the beginning of the eighties, the Dutch government started to change its drug policy. The former treatment goal of "abstinence" was now partly replaced by a plea for easily accessible methadone. Acceptance of drug use and harm reduction now became the leading principles.

#### *Measures against nuisance*

Notwithstanding the attention that was given to drug users, the public nuisance caused by hard drug users remained. Therefore, in 1993, the government issued the "Policy Document Nuisance" (Nota Overlast). A total of 212 million Dutch guilders (96.2 million Euros) were reserved for care innovations to attack public nuisance. As a result, the "Inpatient Motivation Centers (IMCs)" were set up. The IMCs targeted criminal hard drug users, and put them under judicial constraint to motivate them for treatment. Moreover, the treatment options during imprisonment were extended. The drug users were not forced into treatment, but they were stimulated by rewards and sanctions to make a choice for treatment.

In 1997, there started an experiment with a new stringent measure, the "Judicial Placement of Addicts" (Strafrechtelijke Opvang Verslaafden). This measure was meant for addicted prolific offenders. They had to undergo a long-term forced placement (1.5 – 2 years). The program focused on five areas: work/education, relationships, meaningful leisure activities, housing, and debt settlement. They could still choose to be treated or not. In case they refused treatment, it would lead to imprisonment for two years without privileges.

#### *Collaboration with mental health care*

In the nineties, the collaboration between the addiction care and the mental health care improved. More attention was now paid to patients having dual diagnoses (DD). In 1995 the first outpatient projects started, and later on the first clinics were established. An inventory from 2006 shows that there were at least 20 DD clinics and 19 outpatient treatment programs. These programs were mainly running in the mental health care clinics. The addiction care delivered a third of the total treatment services.<sup>60</sup>

These developments can be traced back to another paradigm shift. Addiction was no longer seen as a superficial behavioral characteristic, but was now seen as a result of abnormal brain processes. For a long time addiction was perceived as an isolated disease which was treated outside the mental health care. In the nineties this view started to change. Addiction care clinics now frequently merged with institutions for mental health care. Nonetheless, the addiction care is still hosted in special wards, circuits, and care programs (Van der Stel, 2010).

### *11.1.2 Strategy and policy frameworks for residential treatment*

#### *Agreement among stakeholders*

On the 18<sup>th</sup> of June 2012, the Minister of Health, Welfare, and Sport (VWS) and the different stakeholders signed a broad agreement for the future of mental health care. The Minister and representatives of caregivers, professional associations, health insurers, and patient- and family organisations agreed about different shifts in the mental health care. Agreement was found about shifting from inpatient to outpatient care, from secondary to primary care,

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<sup>60</sup>[http://www.ledd.nl/index.php?option=com\\_content&view=article&id=7&Itemid=8](http://www.ledd.nl/index.php?option=com_content&view=article&id=7&Itemid=8).

from primary care to the general practitioner (GP), and from the GP to self management.

As a result of the agreement, the health insurers and care providers have planned to reduce the number of inpatient beds with a third compared to the capacity of 2008. The parties approved to strongly stimulate prevention, self management, and the recovery-oriented care. The secondary care will now be financed by "performance funding" instead of "budget financing" (Government Information Service, RVD, 2012-06-18). Although the incentive of the reduction of inpatient beds has a financial origin, all parties agree that it will be an advantage for patients to stay in their own social environment to be treated there.

This agreement pursues the reduction of beds which already started some years ago. In 2007 the mental health care in Belgium and The Netherlands proportionally had the largest inpatient capacity in Europe (Van Hoof et al. 2010). Knowing this, the health insurers issued that therewith a reduction in inpatient beds had become necessary. Since then this has become an issue in the policy of the insurers when contracting mental health care. Since January 2012, the health insurers have significantly decreased the available funding for the inpatient treatment and have increased the funding for outpatient treatment.

Historically, the addiction care has focused more on outpatient treatment facilities. Nevertheless, the addiction care also has its inpatient clinics, and many addiction care clinics have now planned to reduce their beds. The institute for addiction care Iriszorg, for instance, has planned to terminate 40 clinical beds before July 2012. The resulting supernumerary staff has been offered an appointment in a new intensive outpatient team aimed at preventing and reducing clinical admissions.

#### *Own contribution*

Another major change in the mental health care and the addiction care is the own contribution which the patients have to pay since the beginning of 2012. Patients who are treated ambulatory have to pay 100 euro a year, and patients who receive a clinical treatment have to pay 145 euro a month. There are a few exceptions. The own contribution is not charged for patients who are 17 years or younger, patients who are placed compulsory, patients on a crisis admission (maximum 28 days), patients who receive interventional care, and patients with a judicial status.

The own contribution has had implications. Since the beginning of 2012, many patients decided not to be treated or to finish their treatment because of the own contribution. In March 2012, the National Branch Organisation for Mental Health Care and Addiction Services (GGZ Nederland) conducted a quick scan among its 96 member institutes by sending them a questionnaire. A total of 54 member institutes participated in the quick scan, 24 integrated hospitals and 7 clinics for addiction care. Almost 60 percent of the respondents indicated that there were patients who had finished their treatment or had received less treatment, all because of the own contribution.

At the insistence of its "Board of clients" (Cliëntenraad), the institute for addiction care Bouman GGZ decided that in 2012 the institute itself would pay their patients "own contribution". A condition was that the patients should complete their treatment. Reimbursing the patients' own contribution, according to Bouman GGZ, prevents major health damage and social damage among its (potential) patients. It also prevents a long-term increase in the healthcare costs.

During the first months of 2012, the institute for addiction care in Amsterdam, the Jellinek, had 25 percent less new admissions. This was one of the reasons that the town council of Amsterdam decided to pay the own contribution for the mental health care patients having a minimum income. The council expected that public unrest would occur when patients with mental problems and addiction problems would remain untreated. Some officials from justice and the police predicted the same, and many of these stakeholders expressed their concerns through the nationwide media.

Amsterdam is not the only municipality that has decided to pay the patients' own contribution. In June 2012, the municipality of Langerdijk made the same decision. This municipality also reimburses the own contribution for people with a low income. More clinics and municipalities took similar measures.

By the end of October 2012, a new government agreement was reached. As part of the agreement it was decided to skip the controversial own contribution. Until now it is not clear yet what will happen to the contributions which were already paid in 2012.

### *Funding of the addiction care*

In the Netherlands, the care sector is funded under three laws:

1. The Community Support Act (Wet Maatschappelijke Ondersteuning, WMO);
2. The Health Insurance Act (Zorgverzekeringswet, Zvw);
3. The Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ).

#### *Ad 1: The Community Support Act*

Since 1994, giving shelter to the homeless and setting up programs for social reintegration have become a responsibility of the municipality. In 2007, the Community Support Act became effective, and since then the responsibilities of the municipalities have increased. It is probable that in 2013 the *support function* will also have to be funded by the municipality and this will also include the facilities for supported living for patients with chronic addiction problems.

The municipality has the task to fund outpatient care which targets addiction problems and the prevention of addiction problems. Another task of the municipality is to target the nuisance caused by addiction.

The facilities on a local level are funded by the government by means of 43 centre municipalities (centrumgemeenten). These centre municipalities are usually the largest municipality in a region. They make arrangements for the care provision in each community. The care provision on that level is given by the *public health service* (GGD). A public health service is funded at the municipal level, and at the moment there are 28 such public health services, each located in a GGD region. The municipality decides which tasks a public health service will have to execute.

#### *Ad 2: The Health Insurance Act*

The health insurance companies finance that part of the addiction care that targets the curing of the addiction. The inpatient treatment in the addiction care facilities is financed under the Health Insurance Act as long as the treatment duration is less than a year. In the Netherlands everyone is compulsorily insured.

#### *Ad 3: The Exceptional Medical Expenses Act*

Addiction care with a duration of one year or longer is funded under the Exceptional Medical Expenses Act (AWBZ). This form of addiction care includes residence in an inpatient clinical setting as well as supported living in a shelter or a hostel. Almost everyone who lives or works in the Netherlands is automatically AWBZ insured and pays a AWBZ-contribution.

The Ministry of Security and Justice (VenJ) is responsible for specific parts of the addiction care. Especially the forensic addiction care and the probation care for addicts are a responsibility of this Ministry.



On the 29<sup>th</sup> of October 2012, far-reaching measures were announced in the new Government Agreement. It was announced that the health care insurers will become financially responsible for the total mental health care, which will probably include the addiction care. The major change will be that the long-term mental health care and addiction care will be transferred to the Health Insurance Act (Zvw). The plan is that the current inpatient care will be transferred from the Exceptional Medical Expenses Act (AWBZ) to the Health Insurance Act (Zvw) by 2015. A decision still has to be taken whether the facilities for social support will be "hosted" at the municipalities or at the health insurers. For the period from 2015 up to including 2017, an outline agreement will be settled with the insurers and the care providers. As a part of the plan, the health insurance companies will have to be completely risk-bearing by 2017.

## **11.2 Availability and characteristics**

This paragraph will give an overview of the existing treatment facilities in the Netherlands for problematic drug users. First, a description will be given of the addiction care facilities in general, and next three special facilities will be described: addiction care for the youth, the judicial addiction care facilities, and the special care provision.

### *11.2.1 National (overall) availability and accessibility*

It has already been mentioned above (see § 8.3) that, in the Netherlands, all care institutions are legally obliged to prepare a "social report" (maatschappelijk jaarverslag) each year. Among other topics, these social reports give some information about the inpatient capacity of the addiction clinics. This information is reviewed in table 11.2.1. In the former years, many clinics for addiction care merged with clinics for mental health care. These integrated clinics reported the accumulated figures in their social report, including the capacity for addiction care as well as mental health care. Therefore, the figures for only the addiction care facilities were obtained from additional sources (see the footnotes to table 11.2.1).

Currently, there are thirteen established addiction care facilities in the Netherlands which offer a clinical stay (see table 11.2.1). In addition to these established facilities, there are more acknowledged addiction care clinics, but these are not taken into account in this paragraph. The care which these (private) clinics offer, is not accessible for everybody, especially because of a larger own contribution one has to pay. In paragraph 1.4 above, some information was given about private clinics like Castle Craig, CrisCare, RoderSana, SolutionS Center, and U-center. The majority of the established addiction care facilities have now become a department of a larger integrated hospital for mental health care. Here, "integrated" includes different forms of care that can be outreaching care, outpatient care, or inpatient care. From the thirteen established clinics, only five are now left that only offer addiction care.

Table 11.2.1 shows that, in 2011, there were 2,101 beds for inpatient addiction care on the treatment wards. In addition to these beds, there were 862 "other" beds including, for instance, sheltered living facilities. The number of "treatment" beds in an established institute ranged from 16 to 306, sometimes including the beds for detoxification. In total there were 80 clinical units, ranging from 2 to 12 units per institute. There were differences between the units due to different treatment methods and different target groups. The units included, for

instance, youth clinics, specialized facilities like therapeutic communities, and units applying self-help like Jellinek Minnesota or the Tactus 12-Step treatment program.

### *Accessibility*

In different cities or regions in the Netherlands the addiction care is organized in a different way. The specific way of cooperation between an addiction care clinic, a public health service, or a medical health center for alcohol and drugs (in some regions) differs per region. The regional cooperation depends on many factors like the policymaking process on the local level and the presence of certain addiction care facilities in the region. Above, it was already mentioned that in the Netherlands the care sector is funded under three laws. This makes the situation even more complicated. Roughly speaking, it has resulted in the following triple situation:

1. The social support facilities that are organized at the municipal level are covered by the Community Support Act (WMO). For the clients, there is a WMO-counter which organizes the individual access to municipal facilities. However, the funding of the addiction care is based on agreements at a higher level between a municipality and an institute for addiction care, for instance an agreement about the funding of outreaching care.
2. Outpatient addiction care with a duration of less than a year is covered by the Health Insurance Act (Zvw). The general practitioner (GP) is the gatekeeper for the Zvw. A prospective addiction client needs a referral by the GP for being admitted to the addiction care.
3. The inpatient addiction care with a duration of less than a year is also covered by the Health Insurance Act (Zvw), but the care with a duration of a year or longer is covered by the Exceptional Medical Expenses Act (AWBZ). An AWBZ indication for an addiction care clinic is performed by a "Care Indication Centre" (Centrum indicatiestelling zorg, CIZ) or a Bureau for Youth Care (Bureau jeugdzorg). Many integrated clinics now have a central admittance facility, but the addiction care in general has also remained accessible through an own 'entrance'.

Table 11.2.1: Capacity of beds and number of clinical units at the inpatient addiction care facilities in the 13 established institutes in 2011

Institute, Place of business	Domain of care	Capacity of beds addiction care 'treatment'	Capacity of beds addiction care 'other'	Clinical units <sup>61</sup>
1. Stichting Arkin, incl. Jellinek, Amsterdam	Addiction & mental health	134 (incl. 10 DD*-beds) <sup>62</sup>		5
2. Lievegoed zorggroep Arta verslavingszorg, Bilthoven	Addiction, mental retardation & mental health	59	38 SL*	4
3. Stichting Bouman GGZ, Rotterdam <sup>63</sup>	Addiction* & mental health	287	184 SSH*	6
4. Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	Addiction & mental health	281	60 SSH*	12
5. Stichting Centrum Maliebaan, Utrecht	Addiction	152		5
6. Stichting Verslavingszorg Noord Nederland, Groningen	Addiction	214	48 SL*	9
7. Stichting Tactus Verslavingszorg, Deventer	Addiction	201 (incl. 48 FC* and 24 DD*-beds)	134 SSH*	8
8. Stichting IrisZorg, Arnhem	Addiction & social relief	201 (incl. 24 DD* and 34 FC*)	66 SL* 332 HWT*	5
9. Stichting Emergis Centrum voor GGZ, Goes	Addiction & mental health	16 <sup>64</sup>		2
10. Stichting De Hoop, Dordrecht	Addiction & mental health	110		7
11. Stichting Novadic-Kentron, Vught	Addiction	306		12
12. Vincent van Gogh voor GGZ, Venray	Addiction & mental health	44		2
13. Stichting Mondriaan, Heerlen	Addiction & mental health	96 (incl. 28 DD) <sup>65</sup>		3
<b>Total</b>		<b>2,101</b>	<b>862</b>	<b>80</b>

\*DD = dual-diagnosis bed, FC = forensic care, SL = sheltered living, SSH = small-scale living, HWT = housing without treatment. "Units" include youth facilities, judicial addiction care, long-stay facilities, and DD-clinics.

<sup>61</sup>Based on information from the websites of the care providers.

<sup>62</sup>According to Care Institutions Accreditation Act (WTZi), acceptance of Arkin July 2011, <https://zoek.officielebekendmakingen.nl/stcrt-2010-11519.html>.

<sup>63</sup>Since 01-07-2012 Bouman GGZ merged with Delta GGZ: new name Antes.

<sup>64</sup>Merging research report Emergis, [http://www.centraleclieftenraademergis.com/uploads/5/9/2/7/5927248/onderzoeksrapportage\\_fusie\\_\\_boer\\_en\\_croon.pdf](http://www.centraleclieftenraademergis.com/uploads/5/9/2/7/5927248/onderzoeksrapportage_fusie__boer_en_croon.pdf).

<sup>65</sup>According to Corporate Social Responsibility Report 2010 Mondriaan, <http://www.mondriaanzorggroep.nl/upload/1/300/305/MJD%202010%20ZH%20definitief.pdf>.

### *Therapeutic communities*

It has already been mentioned above that, in different units of the inpatient addiction care, different treatment methods are applied. As an example of an important treatment method this paragraph focuses on the *therapeutic community*. Table 11.2.2 gives an overview of the therapeutic communities in the Netherlands, their capacity, and the average stay in these communities.

*Table 11.2.2: Capacity and average stay for the therapeutic communities in the Netherlands*

<b>Therapeutic community (umbrella institute)</b>	<b>Capacity in beds</b>	<b>Average / Maximum stay</b>
De Witte Hull (Lievegoed zorggroep)	20	Average 10 months
Aanzet (Lievegoed zorggroep)	12	Average 8 months
Emiliehoeve (Brijder verslavingszorg)	32	Maximum 1 year
Horeb (Stichting De Hoop)	70	Average 1 – 1.5 year
<b>Total</b>	<b>134</b>	

In the eighties the therapeutic community was a common treatment method. Currently, there are only four therapeutic communities in the Netherlands operated by three institutes for addiction care. The *Emiliehoeve* was the first therapeutic community in the Netherlands, and is still in operation. The other therapeutic communities are part of an anthroposophically inspired institute (Lievegoed zorggroep) or an evangelically inspired institute (Stichting De Hoop).

The total capacity of all four therapeutic communities in the Netherlands comes down to 134 beds. On average, the clients stay in a therapeutic community for a period between 8 months and 1.5 years. This is a longer stay than the average stay of a regular clinical admission. The target group of a therapeutic community consists of patients with addiction problems who need more structure than outpatient treatment can offer. A therapeutic community focuses on abstinence and is directed towards psychological recovery, behavioral change, learning to take responsibility, social rehabilitation, and social reintegration. It is also directed towards improving the relationship of the patient with his or her environment and towards changing the lifestyle of the patient.

### *Data from the National Alcohol and Drugs Information System (LADIS)*

For the Netherlands, the data for the Treatment Demand Indicator (TDI) are delivered from the National Alcohol and Drugs Information System, the LADIS (see Chapter 5 above). Apart from delivering the data for the TDI, the LADIS also contains a separate database about the inpatient episodes related to the admissions for an addiction problem. During 2011, the LADIS registered a total of 38,275 inpatient episodes that had resulted from 11,675 admissions (IVZ, personal communication 30-05-2012). After correcting for double counting, it turned out that behind these 11,675 admissions there were 11,413 unique persons.

To distinguish true residential treatment from merely inpatient detoxification, it was decided to leave out the addiction patients not having had a continued inpatient episode of at least three weeks during 2011. It was assumed that a detoxification would not last longer than three weeks. It was found that from the 11,413 unique addiction clients a total of 5,351 clients had indeed been residentially treated for at least three weeks. From these 5,351 clients, 2,583 clients had been admitted for a primary problem with alcohol, 865 clients for

cocaine, 779 clients for opiates, 649 clients for cannabis, 183 clients for amphetamines or ecstasy, 119 clients for GHB, 71 clients for medicines, and 102 clients for other addictions. All in all, during 2011, a total of 2,666 clients had received residential treatment for a primary problem with a drug (including medicines). Table 11.2.3 shows the proportion of the drug clients having received residential treatment.

*Table 11.2.3: Number of primary drug clients and number and proportion having received residential treatment during 2011*

Primary drug	Total number of outpatient and residential clients	Number of clients in residential treatment	Proportion of residential treatment
Cocaine	7,517	865	11.5%
Opiates	11,315	779	6.9%
Cannabis	10,632	649	6.1%
Amphetamines/ecstasy	1,645	183	11.1%
GHB	659	119	18.1%
Medicines	810	71	8.8%
<b>Total</b>	<b>32,578</b>	<b>2,666</b>	<b>8.2%</b>

Source: LADIS, IVZ (Wisselink et al. 2012).

Table 11.2.3 shows that the group of cocaine clients was the largest group in the residential addiction care, followed by the clients for opiates and cannabis. This order of ranking differed from the total population of the addiction care. In 2011 the largest group in the total population was given by the opiates clients (11,315 persons), followed by the cannabis clients (10,632 persons), and the cocaine clients (7,517 persons). Opiates, cannabis, and cocaine were the three leading substances in residential treatment as well as in the total treatment group, but the order of ranking differed.

For the different drugs, table 11.2.4 shows the distribution of the residential clients over the age categories and gives the percentage of male clients.

*Table 11.2.4: Distribution of residential clients over age categories and percentage male in 2011*

Primary drug	Number of residential clients	10 -20 years	20 -30 years	30 -40 years	40 -50 years	50 -60 years	60 -70 years	% male
Cocaine	865	1.0%	23.8%	36.1%	29.5%	9.1%	0.5%	78.3%
Opiates	779	0.1%	6.3%	24.9%	46.0%	20.9%	1.8%	80.2%
Cannabis	649	16.0%	44.8%	26.2%	10.0%	2.9%		81.7%
Amphetamines/ecstasy	183	8.2%	54.1%	27.9%	6.0%	3.8%		77.1%
GHB	119	2.5%	66.4%	26.9%	4.2%			70.6%
Medicines	71		11.3%	25.4%	33.8%	22.5%	7.0%	53.5%

Source: LADIS, IVZ (Wisselink et al. 2012).

Clients who primarily demanded treatment for opiates use, most often belonged to the older age categories. Clients who had a primary problem with Cannabis, Amphetamines/ecstasy, and GHB on the contrary belonged to the younger age groups.

A majority of the residential addiction clients was male. Roughly speaking, about 80 percent of the primary residential drug clients were male. An exception is given by the groups of GHB clients and medicines clients. In these groups, the percentage of male clients was lower.

#### *Youth addiction clinics*

Before 2005, there were only three specialized youth addiction clinics in the Netherlands, namely the *Mistral* (part of Brijder), and the *Bauhuus* and the *Breegweestee* (part of Verslavingszorg Noord Nederland). In 2006, the Minister of Health, Welfare, and Sport (VWS) designated special funding to tackle the lack of sufficient clinical treatment places in the youth addiction care. Since then, nine extra youth clinics have been founded. The Minister targeted at 300 places. Currently, about 180 extra places have been realized in addition to the places already existing before 2005. Two clinics have planned to realize eight and ten beds extra, but one clinic expects a reduction of three beds before the end of 2012. By then, two third of the targeted places will have been realized.

For the different youth addiction clinics, table 11.2.5 gives their starting year, the number of beds for detoxification and treatment, and the duration of detoxification and treatment. The information in this table has been obtained by personal communication (e-mail and telephone) with professionals from the youth clinics.

Table 11.2.5: Starting year, number of beds for detox and treatment, and duration of detox and treatment for the youth addiction clinics in the Netherlands in 2011

Youth clinic (Umbrella institute)	Starting year	Beds detox (& diagnosis)	Beds treatment	Detox duration (weeks)	Treatment duration (months)
Youz (Bouman GGZ)	2011		28	max. 3	3 – 4
Mistral/ Mistral Detox (Brijder/Parnassia)	2000/ 2007	16 + 1 crisisbed	17	24 hrs to 8	4
DD jeugd kliniek (Dimence)	2009	8 detox	8	4 - 5	4 -6
Jeugdkliniek Paschalis (GGZNML)	2008	16	10**	1 - 4	3 – 4
De Kajuit (De Hoop)	2009		16		4,5*
Jeugdkliniek (IrisZorg)	2010	9	27	1 - 2	0,5 - 3,5
Herten (Mondriaan)	2010		15*	4 - 6	3 – 6 *
Kentra24 (Novadic-Kentron)	2011	Some	22***	2	3
Jeugdkliniek (Tactus)	2010	No detox	16****	No detox	3 - 4
Bauhuus (VNN)	2004	9 (flexible)	7 (max. 8)	4	6
Breegweestee (VNN)	1979	No detox <sup>66</sup>	25	No detox	5-7
<b>Total</b>		<b>About 68</b>	<b>About 192</b>		

Source: personal communication with professionals from the youth addiction clinics. \*including detox, \*\*end 2012 – 3 beds, \*\*\*end 2012 + 10 beds, \*\*\*\*end 2012 + 8 beds.

From the eleven youth addiction clinics, only one clinic has no youth detoxification facility. The duration of the detoxification ranges from 24 hours to 8 weeks. Often during the phase of detoxification the diagnosis takes place as well, which probably explains the differences in the duration of the detoxification. The treatment duration ranges from 2 weeks to 7 months. In two clinics this duration includes the detox phase.

### Judicial Facilities

In the Netherlands there are a few forensic addiction clinics (FACs). Especially in 2012, some of these clinics were founded (see table 11.2.6). One of the reasons for founding FACS was the declining number of patients disposed to be involuntarily admitted to a forensic psychiatric hospital on behalf of the state (TBS-measure). In 2006, the number of 'new' TBS-patients was still 188, which decreased to only 94 'new' TBS-patients in 2010 (DJI 2011).

<sup>66</sup>< 23 years: Bauhuus, > 23 years: adult care.

The decline in the number of these TBS-patients was mainly due to an increase in the number of suspects refusing a forensic psychiatric examination, prior to the judicial process. Without such a psychiatric examination, the TBS-measure cannot be taken. The duration of the TBS-measure is on the rise and now accounts for almost ten years. The duration of the TBS-measure seems to have reached a tipping point. Individuals who have committed offenses worthy TBS, would be more quickly released again after a custodial sentence than after a forensic treatment. Therefore, lawyers advise their clients not to cooperate, also because the duration of a hospital treatment is not always proportional to the original offense. When having only a prison sentence and not the TBS-measure, a convict will be set free sooner, but without having received treatment.

Given the decline in TBS-patients, the TBS-clinics are now looking for alternative care provisions to utilize their capacity and therewith to maintain their capacity. In two cases, the new forensic addiction clinics (FACs) were developed in cooperation between an addiction care clinic and a forensic clinic. In the FACs there was a total of 178 beds.

*Table 11.2.6: Forensic addiction clinics(FACs), participating institutes, founding year, and capacity in beds*

<b>FAC</b>	<b>Participating institutes</b>	<b>Founding year</b>	<b>Capacity (beds)</b>
Basalt	Centrum Maliebaan and Oostvaarders-kliniek	April 2012	24
Piet Roordakliniek	Tactus	Before 2005	60 <sup>67</sup>
FVK De Smaragd	De Kijvelanden and Bouman GGZ	February 2012	24
Triple-X	Palier (Centre for forensic and intensive care)	Before 2007	50 <sup>68</sup>
FPA Roosenburg	Altrecht	± 1990	20
<b>Total</b>			<b>178</b>

### *11.2.2. Types and characteristics of residential treatment units*

The clinical addiction care offers a wide variety of treatment methods. Especially in the large institutes many programs are available for different target groups. All the institutes mentioned in table 11.2.7 offer treatment and support to addiction clients in general. Some of these institutes also offer treatment and support to special groups of clients. Examples of such special groups are young people, patients who prefer a maximum of privacy, and patients who can afford a treatment in a private facility.

In this paragraph, the common treatment methods are reviewed first, and next more detailed information will be given about the treatment methods for specific target groups like young people and clients undergoing judicial measures. The information has been mainly gathered on the websites of the institutes, but some of the websites are not that clear about the treatment that is offered. Therefore, the information reviewed below is not expected to be

<sup>67</sup>Closed setting and open social-reintegration setting.

<sup>68</sup>In the program (clinic and rehabilitation facilities).



complete. No attention will be paid to the clinical detoxification facilities and the treatment methods applied for detoxification are assumed to be known.

In the Netherlands, a majority of the institutes for addiction care offers the common evidence-based psychosocial treatments, like cognitive behavioral therapy, community reinforcement approach, motivational interview techniques, 12-Step approach, and partner and family therapy. In table 11.2.7 the treatments offered by the addiction clinics are listed in alphabetic order. It is remarkable that the established institutes more and more offer the 12-Step approach (Minnesota Model) which has originated in self-help groups like Alcoholics Anonymous.

*Table 11.2.7: Treatment methods offered in the addiction clinics of the institutes for addiction care*

<b>Institute for addiction care, Place of business</b>	<b>Treatment method offered in the addiction clinic of the institute for addiction care</b>
Stichting Arkin, incl. Jellinek, Amsterdam	ART, CBT, CRAFT, LST, MIT, MM, PE, SST
Lievegoed zorggroep Arta verslavingszorg, Bilthoven	MT, RT, TC
Stichting Bouman GGZ, Rotterdam <sup>69</sup>	CRA, PE, RM, SST
Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	CBT, CRA, LST, MM, TC, MDFT, MIT, RM, RT
Stichting Centrum Maliebaan, Utrecht	FT, CBT, LST, PT
Stichting Verslavingszorg Noord Nederland, Groningen	MDFT
Stichting Tactus Verslavingszorg, Deventer	CT, LST, MDFT, PRT, PT, RM, SST
Stichting IrisZorg, Arnhem	CRA, CT, DT, SST
Stichting Emergis Centrum voor GGZ, Goes	LST
Stichting De Hoop, Dordrecht	MM
Stichting Novadic-Kentron, Vught	CRA, DT, FT, LST, MT, PT, RM, SST, ST,
Vincent van Gogh voor GGZ, Venray	FT
Stichting Mondriaan, Heerlen	CT, LST, PT, RM, RT, SST

See Box 1 for an explanation of the abbreviations.

<sup>69</sup>Since 01-07-2012 Bouman GGZ merged with Delta GGZ: new name Antes.

*Box1: Treatment Methods (abbreviations)*

(A)CRA: (Adolescent) Community Reinforcement Approach	MM: Minnesota model (12-Step)
ART: Aggression regulation training	MT: Musical therapy
AT: Assertiveness training	MP: Medical psychiatric therapy
BG: Budget group	OC: Orthopedagogic components
CBT: Cognitive behavioral therapy	PE: Psycho education
CRAFT: Community Reinforcement Approach and Family Training	PG: Parental guidance
CT: Creative therapy	PM: Psychomotorial therapy
DT: Drama therapy	PRT: Partner relation therapy
EBPC: Experiential body-centered psychotherapy (Pessotherapy)	PT: Pharmacotherapy
EMDR: Eye Movement Desensitization and Reprocessing	RM: Relapse management
ERT: Emotion regulation training	RT: Running Therapy
ET: Expressive therapy	SCM: Social competence model
IDDT: Integrated Dual Disorder Treatment	SDM: Shared decision making
LST: Life-style training	SH: Self Help
LM: Liberman modules	SocT: Socio therapy
(MD)FT: (Multidimensional) family therapy	SOT: Solution oriented treatment
MIT: Motivational interview techniques/therapy	SSI: Supporting and structuring interview
	SST: Social skills training
	ST: Systemic therapy
	TASU: Training aggression and substance use
	TC: Therapeutic Community

Many clinics do not specifically mention creative therapy or physically oriented therapies like psychomotorial therapy, although such therapies are usually part of the regular treatment provision. Therefore, it may be assumed that these kinds of therapies will be available in most of the clinics.

*Youth addiction clinics*

Paragraph 11.2.1 above already reviewed the youth addiction clinics in the Netherlands. In this paragraph more specific information will be given about these youth clinics. Table 11.2.8 reviews the respective age groups, the target groups, and the treatment methods. The information in this table has been obtained from personal communication (by e-mail and telephone) with professionals from the clinics.

When excluding the addiction clinic for young adults (Breegweestee from VNN), there are ten youth addiction clinics. In eight of these ten clinics, children from the age of twelve to thirteen years who have an addiction problem are already welcome. In two clinics, sixteen years is the threshold for being admitted. In seven clinics, the maximum age is 23 to 24 years. Two clinics apply 20 to 21 years as the maximum age. In one clinic (Bauhuus from VNN) the maximum age is eighteen years, but young adults from 18 to 30 years are welcome in another clinic at the same institute (Breegweestee from VNN).

Only three clinics present themselves explicitly as a dual-diagnosis clinic (DD-clinic). Nonetheless, almost all clinics indicate that many of their clients suffer from (underlying) comorbid disorders (see table 11.2.8). These clinics usually diagnose the comorbid disorders as AD(H)D and ASD. In addition, depression, anxiety, and ODD are mentioned a few times.

The youth clinics offer a wide variety of treatment methods. In general, a clinic does not favour a specific treatment method, but at one clinic (Kajuit from De Hoop) the 12-Step program counts as the leading treatment method. However, within the approach of this clinic other treatment methods are offered as well.

In general, there are three leading therapeutic methods given by client-centered psychotherapy (e.g. MIT), system therapy (e.g. (MD)FT, ST), and behavioral therapy (e.g. SCM, (A)CRA and CBT). In addition to these leading therapies there are some alternative therapies, but these are hard to categorize. Alternative therapies are, for example, EMDR, IDDT, LST, and SOT. Another leading method, psychodynamic therapy (psycho analysis), is not applied in the (youth) addiction care.

Table 11.2.8 further shows that, by means of different therapies (ST, (MD)FT), a majority of the youth addiction clinics explicitly involves into treatment the system around the young client. The system around the client is given by the family and the parents. The involvement of the young client's system is not surprising. The clients are young people who still need (some) parental guidance. One clinic emphasizes that no clinical treatment is offered at all without the cooperation of the system, that is the parents. Almost all clinics offer some form of behavioral therapy (CBT, (A)CRA). About a third of the clinics offer elements from the client-centered approach in the form of Motivational therapy. It is remarkable that there is only one youth clinic (Kajuit from De Hoop) that offers the 12-Step treatment. De Hoop's 12-Step program is based on its Christian identity. Contrary to the youth addiction care, the established addiction care for adults has now adopted the 12-Step program as a regular treatment method.

Table 11.2.8: Youth addiction clinics, age groups, target groups, and treatment methods

Youth addiction clinic (Umbrella institute)	Age in years	Target group: addiction and other disorders	Treatment method
Youz (Bouman GGZ)	16 - 24	DD & TC <sup>70</sup> , Contra indication low IQ	CRA, MIT and SOT. Group- and individual oriented, aimed at various areas of life (incl. LST), addiction- and CMD - oriented: FT/ST, MIT, CBT, RM, EMDR, PT
Mistral/ Mistral Detox (Brijder/Parnassia)	12 - 20	DD	SCM, ST and basic attitude of MIT
DD jeugd kliniek (Dimence)	12 - 23	DD, CMD <sup>71</sup> (AD(H)D <sup>72</sup> , ASS <sup>73</sup> , ODD <sup>74</sup> , CD <sup>75</sup> , depression, anxiety, bipolar disorder, bonding problems, threatened personality development, traumatization, and disturbed mourning process)	ST, IDDT, MIT, CBT, PE, PG, MDFT, PM, CT, MT, ET, SST, ART, ERT, AT. Group- and individual oriented
Jeugdkliniek Paschalis (GGZNMML)	16 - 24	CD (ADHD, ASD, affective disorders) as long as someone can function in the group	RM, MIT, CBT, SDM, SR, CT, PMT, EMDR, CRA, PT, MDFT, SocT, OC
De Kajuit (De Hoop)	12 - 23	CMD secondary to the addiction problem and treatable in group (ADHD, minor ASD & ODD)	12-Step treatment, within this program SST, CBT
Jeugdkliniek (IrisZorg)	12 - 23	CMD (depression, anxiety, ADHD and ASD). Some come with a judicial status	A-CRA, ST
Herten (Mondriaan)	12 - 21	CD (ADHD and ASD), some come with a judicial status, parent-child problems	SOT, CGT, ST/PG, LST, DT, MT en PM, RT, SST. Group oriented, on indication individual (e.g. CBT)
Kentra24 (Novadic-Kentron)	12 - 23	Attention is paid tot underlying problems. Severe psychiatric problems in cooperation with care circuit.	A-CRA, SCM & ST
Jeugdkliniek (Tactus)	13 - 23	Mild CMD (AD(H)D and ASD)	SOT and structuring and encouraging to go to school and prepare for work
Bauhuus (1)	12 – 18	(1) CD (PDD NOS (ASS), ADHD, borderline and other)	(1) 3 approaches: ST, SOT, CBT, next to this SST, LB, CT,
Breegweestee (2) (VNN)	18 – 30	(2) Young adults, less CD possible because one works according to principles of SH and TC	(2) Principles of TC/SH, next to this, SOT, scheme therapy, group oriented, no 'leading school', RM

<sup>70</sup>DD: Dual diagnosis (mental problems), TC: Triple cripple (mild mental retardation).

<sup>71</sup>CMD: Comorbid disorders.

<sup>72</sup>AD(H)D: Attention Deficit (Hyperactivity) Disorder.

<sup>73</sup>ASD: Autism spectrum disorders.

<sup>74</sup>ODD: Oppositional Defiant Disorder.

<sup>75</sup>CD: Conduct Disorders.

### *Judicial Facilities*

In paragraph 11.2.1 above, it was already reviewed that, in the Netherlands, there are a five forensic addiction clinics (FACs). Table 11.2.9 gives some more information about the target groups of these FACs and the treatment methods which they offer.

*Table 11.2.9: Forensic addiction clinics (FACs), target groups, and treatment methods*

<b>FAC</b>	<b>Target group</b>	<b>Treatment method</b>
Basalt	(Young) adults with psychiatric problems and criminal behavior	CBT, LST, MIT, PRT, SSI, TASU, ST, ADHD coaching/treatment, scheme therapy
Piet Roordakliniek	Males with psychiatric problems and (frequent) criminal behavior	RM, integrated treatment, emphasis on early detection of signals
FVK De Smaragd	Males (>18 years) with (frequent) criminal behavior	CBT, SocT, DT, CT, MT
Triple-X	Adults (>18 yrs) with (frequent) criminal behavior and long-term problems on various life areas	Group therapy, BG, ST, SST, ART, LST, EBPC
FPA Roosenburg	Adults (>18 yrs) with criminal behavior and DD-problems. Mainly psychotic disorders, behavioural problems and severe social problems	CBT, MP and ST, RM, RP, ST, PT, ART, PE, SST, LM, MT, PM

All five forensic addiction clinics (FACs) explicitly offer care to patients who suffer from addiction problems and have shown criminal behavior. In two of the five clinics, only males are admitted. All five clinics treat multi-problem patients. In addition to having shown criminal behavior and suffering from addiction problems, the majority of the FAC-patients also has psychiatric and social problems.

The forensic clinics offer a wide variety of treatment methods. All clinics offer a combination of therapies and in none of them one specific treatment method counts as a leading approach. In all clinics group sessions are part of the program. A majority of the clinics offers cognitive behavioural therapy and system therapy. All clinics try to improve the social situation of their patients. Triple Ex explicitly tries to involve patients in a work program, whereas in some other clinics "doing work" is a regular component of the week program.

### *Special care provision*

This paragraph will present some examples of special care provisions for target groups like the elderly, addicted parents, clients with a mild mental retardation, highly vulnerable clients, employed clients, female clients, and young clients (in a private setting).

### *Elderly*

Each year, the Foundation for the Provision of Care Information (IVZ) reports figures from the National Alcohol and Drugs Information System (LADIS, see also chapter 5). In 2011, 16% of the 69,312 general addiction clients aged 55 years or above (about 11,100 clients), and from the additional 17,453 addiction clients in the probation care 5% aged 55 years or above (about 900 clients). Among these older clients in the general addiction care, aging 55 years or above, 74% were primarily addicted to alcohol and 15% were primarily addicted to opiates. Therewith the addiction care has invested substantially in the elderly with alcohol problems. Most of the treatment is given in the form of outpatient treatment.

During the beginning of the seventies, the use of opiates became epidemic in the Netherlands. Many of the opiates users lived a harsh life. Because of their unhealthy lifestyle, many of these chronic drug users have aged more rapidly. Since 2009, a special facility for this group of users has been established in the form of *Woodstock* located in The Hague and operated by the institute for addiction care Brijder, part of Parnassia. Woodstock can house 33 clients who are homeless; are 45 years or older; have psychiatric problems; are chronic addicts; suffer from an addiction which has been shown to be untreatable; have problems in various fields such as financial management, administration, contact with family, leisure, and (volunteer) work; and who are able to make agreements about their own behavior.

Woodstock assists its clients with managing their finances and administration, restoring the contact with their family, personal hygiene, cooking, and so forth. The residents are also assisted in finding a hobby and (volunteer) work. They are allowed to smoke, drink, and use drugs in their own room. Woodstock is explicitly meant for older chronic addicts. In the area of social services there are more facilities for elderly homeless, and the target groups partly overlap.

### *Addicted parents*

The institute for addiction care Verslavingszorg Noord Nederland (VNN) maintains a special addiction care facility for addicted parents having children ageing 0 to 12 years. This special facility is called *De Lage Kamp*. This clinic has a capacity for twelve families. There are facilities for four pregnant women. The clinical treatment program takes about twelve months, and after the clinical admission the family can obtain an aftercare program. There are individual therapeutic sessions as well as group sessions. De Lage Kamp is accessible for families from all over the Netherlands.

### *Clients with a mild mental retardation*

In 2009, the institute for addiction care Novadic-Kentron opened a special clinic targeting clients of 18 years and older who suffer from an addiction problem in combination with a mild mental retardation (MMR). Although the treatment in this special clinic mainly targets the individual client, therapies are offered in a group of six persons at maximum. The therapy is characterized by often repeating the information that is given to the client. It is a practical form of therapy and it applies a visual approach. The communication in this form of practical therapy is supported by cards with pictograms which help the clients to find words for emotions. Such a card is called a *Sociopicto*.

The aim of the treatment for addicts with a mild mental retardation (MMR) is total abstinence. The treatment therefore pays attention to relapse prevention, increasing the motivation for abstinence, and reducing substance use. Next to this the treatment focuses on

increasing the self-reliance of the clients by means of practical support. Extra attention is given, for example, to housing skills and personal hygiene. The treatment program is further adapted to people with mild mental retardation (MMR) by offering only one intensive therapy component a day. The rest of the day is focused on activities and less on giving information.

#### *Highly vulnerable clients*

In 2009, in the town Veenhuizen in the north of the Netherlands, the institute for mental health care GGZ Drenthe opened a clinic called the *Beter leven kliniek* (Better life clinic). This clinic has a capacity for 30 clients, mainly young adults, having a mild mental retardation (MMR) in combination with psychiatric, social, emotional, behavioral, and addiction problems. In this clinic in the north of the country, those clients from the cities of Amsterdam and Rotterdam are admitted who were already treated in a variety of treatment settings, but without success.

At the *Beter leven kliniek* (Better life clinic) the patients are admitted on a judicial basis for two or three years. The clinic functions within a closed setting, and is built on the grounds of a former penitentiary. During their stay at the clinic the patients learn to socialize; to cope with their problems; to accept help and support; and they learn to live within a daily structure with work, activities, and relaxation. All in all, the treatment aims at learning to live in a sheltered community. During the stay in the clinic, the team of social workers around the patient assesses how much freedom a patient can already handle, conversely how much structure he or she still needs. During the first period of their treatment, the patients will have to stay in the clinic. During the second period, in a programmatic way, the patients are given more and more freedom outside the clinic.

#### *Employed clients*

At the end of 2011, the Jellinek clinic in the city of Amsterdam started a new treatment program targeting clients with medium or severe addiction problems who are employed during the day. This new treatment program is to be followed during the evening hours. This way, the employed clients do not have to interrupt their occupation and they can still profit from the daily structure it gives.

If necessary, the clients first receive a regular clinical detoxification of one week. After that they are admitted for six weeks to the evening program. In this period they also spend the night in the clinic. After working hours, the clients go to the clinic, have a meal in the group, and at seven o'clock PM the group sessions start. The treatment program applies diverse therapeutic methods and components, like cognitive behavioral therapy and relapse prevention. The clients increase their motivation to stop using the substance to which they are addicted and learn how to cope with risk situations.

#### *Female clients*

Some clinics offer a special program for female clients and other clinics have separate wards for male and female clients. As an example, the institute for addiction care De Hoop in September 2011 started the program *Challenge Vrouwen* (Challenge Women). This program starts with a clinical period that takes 20 weeks, followed by a part-time daycare period taking 12 weeks. There are facilities for mothers to stay in the clinic together with their children. The leading treatment method is the Minnesota model.

The Jellinek Minnesota also offers a special program for female clients. There is a capacity of twelve beds, and the female clients are admitted for eight weeks. After that period, those patients who have not yet found a suitable living environment, can be referred to the *Safehouse* where daycare is offered. Again, the Minnesota model counts as the leading treatment method, in the clinic as well as in the *Safehouse*.

#### *Young clients*

In the Netherlands, there are various private clinics. In 2010, the established institute for addiction care the Jellinek opened a new private clinic on Curaçao, one of the islands of the Netherlands Antilles. This new private clinic is called the *Jellinek Retreat*. Usually, clients aging between 30 and 50 years visited this clinic. However, in the summer of 2011, the clinic started a special program for young people aging between 16 and 23 years. The program is offered during the (school) summer holiday. It targets young people who excessively use party drugs, cannabis, or alcohol (binge drinking). It also targets young people who excessively visit the internet, for example to play games. In addition, young adults are also welcome at the Jellinek Retreat if they have to cope with other problems like obesity, ADHD, depression, feeling sad, and apathy.

The leading treatment method at the Jellinek Retreat is given by cognitive behavioral therapy. There are individual as well as group sessions. Next to the therapeutic program the clients can participate in a lot of activities like sporting (boating, snorkeling, hiking, swimming, and mountain biking), sightseeing, and relaxation therapy. The treatment program takes four to six weeks, and the Jellinek institute on its home base in the Netherlands offers the aftercare.

### **11.3 Quality management**

During the past years, the mental health care and the addiction care have given priority to being transparent and benchmarking the quality of their services. In recent years different instruments have been developed and implemented for quality measurement.

#### *Consumer Quality Index*

The *Consumer Quality Index (CQ-I)* is a standardized instrument to measure, analyze, and report the experiences of clients in the health care. For the mental health care four versions of the CQ-I are available for different populations, including the Consumer Quality Index clinical mental healthcare and addiction care. By means of the CQ-I, patients are questioned about their experiences with, for instance, the information they received about the treatment, the attitude of the caregivers, the treatment options that were available, and to what extent they are satisfied with their treatment.

In 2012, the institutes for mental health care and addiction care will be obliged to interview a sample of their clients by means of the CQ-I. The results from these interviews will be used for benchmarking on the level of teams, departments, and institutes. The benchmarking will take place within the framework of the national performance indicators. Different stakeholders, like the health insurers and the Health Care Inspectorate (IGZ) will be able to compare the experiences of the clients. Some addiction clinics publish results from



benchmark research on their website in order to provide information about the quality of their services to their (potential) clients and their family.

#### *Youth thermometer*

Institutes for mental health care that provide care to young people aging 12 to 18 years can apply the *Youth thermometer* each year. This instrument assesses the satisfaction with the received care of the young clients as well as their parents. The Youth thermometer measures the appreciation of the information that was received about the treatment programs, the involvement of the clients in taking decisions, the satisfaction with the care worker, and the appreciation of the results of the treatment. The results from the Youth thermometer are applied in the same way as the results of the Consumer Quality Index (CQ-I) as described in the paragraph above.

#### *Routine Outcome Monitoring*

Benchmarking will also be done by means of *Routine Outcome Monitoring* (ROM, see also previous National Report 2011, § 5.3.1). ROM is a method to clarify, evaluate, and improve a treatment program. The input for the ROM method comes from different sources. A first source of information for the ROM is given by the agreements between patients and professionals about the treatment targets. A second source of information is given by measurements of the problems of the patient, at least at baseline and at the end of treatment. Sometimes there are also measurements available from one or more follow-ups.

The purpose is that the information collected by ROM can be applied at the individual level, at team level, at the level of a whole institute, and at the level of a nationwide benchmark. All in all, the ROM method will have to serve four functions: 1) giving information about the treatment and support programs that are actually followed; 2) learning about how to improve the quality of treatment; 3) conducting research; and 4) giving account about the treatment that has been given. In the future, the data from the ROM can possibly be used in the context of the national performance indicators, for example to measure the outcomes of treatment at a national level.

The data for the ROM are collected at a national level by the *Foundation Benchmark Mental Health Care* (Stichting Benchmark GGZ, SBG). This national data collection by the SBG started in the beginning of 2011. The implementation of ROM is work in process. In 2012, the institutes for mental health care and addiction care will have to deliver their data to the SBG. Consequently, the SBG intends to perform a benchmark on the ROM data during the course of 2012. The insurers intend to use the ROM data for contracting mental health care and addiction care.

In the beginning of 2012, a sharp dispute arose about the ROM. On the one side of the debate position was taken by eleven professors of psychiatry, senior university lecturers, and board members of institutes for mental health care. On the other side of the debate position was taken by the insurers and the SBG. The insurers were putting pressure on the institutes to deliver their treatment outcomes to the ROM data base held by the SBG. If the institutes would not deliver their data, the insurers would cut down their budgets. During the debate, the professors, lecturers, and board members of the institutes complained that the "insurers held hostage of care workers by means of expensive and nonscientific

bureaucracy". They argued that the insurers lacked the instruments to compare institutes in an objective manner. These instruments must be developed, but it can still take years<sup>1</sup>.

### *Patient security*

Funded by the Ministry of Health, Welfare, and Sport (VWS), the Netherlands Association for Mental Health Care (GGZ Nederland) conducts since 2008 the patient security program *Safe care, everyone's concern*. The program is based on the *Security Management System* (Veiligheidsmanagementsysteem, VMS) and the *Safely Reporting of Incidents* (Veilig Incidenten Melden, VIM). The program targets five main themes given by somatic comorbidity, suicide prevention, medication security, fire safety, and reducing coercion and restraint. These are issues about which it is known that there are security risks for the patients.

By means of the patient security program, GGZ Nederland encourages the institutes for mental health care and addiction care to be aware of the risks involved for patients, and to take measures to reduce those risks as much as possible. The program develops standards and tools that support institutes to work towards patient security.

The patient security program *Safe care, everyone's concern* is in line with similar programs for the medical hospitals in the Netherlands, the care for the disabled, the nursing homes, the home care, and the primary care.

In this line GGZ Nederland and the Foundation Harmonization of Quality in Healthcare (Stichting HKZ) have made agreements on the assessment of the security management system for the period from 2012 to 2014<sup>2</sup>. The themes of the security program are part of the Certification schemes for the HKZ. By the end of 2014, all institutes for mental health care and addiction care will have to be certified on the security norms. In the period 2012-2014 the institutes will receive security visitations from an external audit team. The results will be presented to the Health Care inspectorate (IGZ). On the website [www.veiligezorgiederszorg.nl](http://www.veiligezorgiederszorg.nl) (safe care everyone's concern) all information about the patient security program is collected.

### *Audits*

In their annual accountability reports, the institutes for mental health care and addiction care report which audit system they employ (see table 11.3.1). All addiction care facilities apply internal audits and the audits are in line with the HKZ. Three institutes also apply the independent audits from the Center Certification ACT and FACT (CCAF) and the European Foundation for Quality Management (INK-Model/ EFQM).

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<sup>1</sup>[http://www.psy.nl/meer-nieuws/nieuwsbericht/article/zorgverzekeraar-straft-ggz-instelling-die-geen-data-aanlevert/?no\\_cache=1&cHash=1a72f16af92b9d36f4fe80c590614660](http://www.psy.nl/meer-nieuws/nieuwsbericht/article/zorgverzekeraar-straft-ggz-instelling-die-geen-data-aanlevert/?no_cache=1&cHash=1a72f16af92b9d36f4fe80c590614660).

<sup>2</sup><http://www.veiligezorgiederszorg.nl/meerjarenafspraken-hkz-igz-ggznl.pdf>.

Table 11.3.1: Types of quality audits in the thirteen regular institutes for addiction care

Institute, Place of business	Internal quality audits	HKZ <sup>1</sup> - certificate and audits annually	Independent audit CCAF <sup>2</sup>	INK-Model/ EFQM <sup>3</sup>
1. Stichting Arkin, incl. Jellinek, Amsterdam	X	X		Since 2009 EFQM/INK recognition for excellence, 3 stars
2. Lievegoed zorggroep Arta verslavingszorg	X	X		
3. Stichting Bouman GGZ, Rotterdam	X	X	Certification FACT	
4. Parnassia Bavo Groep B.V., incl. Brijder Verslavingszorg B.V., The Hague	X	X		
5. Stichting Centrum Maliebaan, Utrecht	X	X		
6. Stichting Verslavingszorg Noord Nederland, Groningen	X	X		
7. Stichting Tactus Verslavingszorg, Deventer	X	X		
8. Stichting IrisZorg, Arnhem	X	X		
9. Stichting Emergis Centrum voor GGZ, Goes	X	X		
10. Stichting De Hoop, Dordrecht	X	X		
11. Stichting Novadic-Kentron, Vught	X	X		
12. Vincent van Gogh voor GGZ, Venray	X	X	Certification FACT	
13. Stichting Mondriaan, Heerlen	X	X		

<sup>1</sup>HKZ: Harmonization Quality in Healthcare.

<sup>2</sup>CCAF: Center Certification ACT and FACT.

<sup>3</sup>EFQM: European Foundation for Quality Management.

## 12 Drug policies of Amsterdam, Rotterdam and The Hague

### 12.1 Functions and responsibilities of Amsterdam, Rotterdam and The Hague in drug policy issues

#### *Introduction*

Much information concerning drug policy issues in the largest Dutch cities can, although scattered, be found in previous National Reports. In the Netherlands there are four large cities: Amsterdam (±790.000 inhabitants), Rotterdam (± 617.000 inhabitants), The Hague (± 501.000 inhabitants.) and Utrecht (± 316.000 inhabitants.). These four cities are lying relatively close to each other and the region where these cities are situated is sometimes called the 'Randstad Holland', with about seven million inhabitants. As requested by the EMCDDA, this chapter focuses on the cities of Amsterdam, Rotterdam and The Hague.

#### *12.1.1 Relationship between the national government and the local government*

The Netherlands is a unitary decentralized welfare state. Although a municipality is an independent statutory body with a city council and a Board of Mayor and Aldermen, its independence is limited by the central government. The structure and functions of the municipalities are described in the Municipality Act (Gemeentewet). The national government has the power to decide about matters of the political-administrative and democratic design of municipalities and according to the Constitution, the principle of the hierarchy of legislation is applying. Another statutory body in between the central government and the local government is the province, which has no direct responsibilities for the drug policy issues.

The municipal council possesses the supreme power of the city and has the task of setting the political framework of the city and controlling the Board of Mayor and Aldermen (the Board), which can be seen as the executive power of the city. The Aldermen are representatives from political parties and are appointed after the four-yearly elections. The mayor is the official chairman of the municipal council and of the Board. Besides this tasks, the mayor has separate responsibilities and powers. The mayor is primarily responsible for maintaining the public order and can independently act against violations of that public order. According to article 13b of the Opium Act (Act Damocles) the mayor is authorized to close down venues which are used for illegal drug trading (administrative order). The mayor is also member of the administration of the regional fire brigade and of the regional police force.<sup>1</sup> The mayor is appointed by the Cabinet after a recommendation of the city council. In the Netherlands, mayors are not elected.

Since 1980, Amsterdam is not only organized as a municipality, but it has also introduced boroughs to govern the various neighborhoods. At the moment, the city is divided in seven boroughs. Rotterdam has followed this example and has introduced 14 boroughs. However, the central government is preparing a bill to abolish the right of municipalities to set up boroughs.

The largest source of revenue of municipalities in the Netherlands is the general transfer by the national government through the municipality fund, followed by special transfers by the

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<sup>1</sup><http://www.rijksoverheid.nl/onderwerpen/gemeenten/vraag-en-antwoord/wat-zijn-de-taken-en-bevoegdheden-van-een-burgemeester.html>.

national government for social assistance and other tasks. Another source of income for the municipalities are revenues from the sale of goods and services. Only about ten percent of the municipal revenues come from local taxes. In 2013 the total budget for the City of Amsterdam is about 5 billion, for the city of The Hague about 2.2 billion euro. The total budget of the city of Rotterdam for 2012 was 4.4 billion euro.

Amsterdam, Rotterdam, The Hague and Utrecht are also the centre of a city-region, a partnership of major cities and their neighbor municipalities. Because the four major cities have special “metropolitan” problems, they receive extra transfers from the national government. On public health, social, security and other themes ‘the big four’ co-operate in the so-called G4. The four major cities (and 39 other Dutch cities) have also a special task as so-called ‘centre municipalities’. They are among others responsible for the public mental health care and the social relief of problem substance users and homeless people in their region. They receive specific transfers to perform these tasks. Since 2007 the municipalities are legally responsible for all these kind of tasks according to the Community Support Act (WMO). The Community Support Act regulates support and aids for the daily life, as well as welfare services. It replaced the Facilities for Impaired Persons Act (Wet Voorzieningen gehandicapten-Wvg), the Welfare Act (Welzijnswet) and parts of the General Exceptional Medical Expenses Act (AWBZ). One of the nine tasks, mentioned in the Community Support Act, which must be carried out by the municipalities is outpatient addiction care.

The Dutch municipalities are united in the Association of Netherlands Municipalities (VNG), which supports decentralization processes and facilitates decentralized cooperation. Under the guidance of this Association, civil servants of centre municipalities meet each other on a regular base to discuss items of social relief, outpatient addiction care, public mental health and women’s relief (pers. comm. A. Schoorl, civil servant of The Hague). Cooperation between municipalities can officially be arranged with the Shared Arrangements Act (Wet Gemeenschappelijke Regelingen).

In 1993 the municipal and national police forces were replaced by regional police forces. These forces are financed and supervised by the national government. In 2015 these regional divisions will be replaced by the national police. Local matters relating to public security and the use of police resources are discussed and decided upon in so-called tripartite consultations between the mayor, the chief regional police representative and the chief regional public prosecutor.

The system of relatively independent regional police departments has been criticized because of the lack of effectiveness and efficiency in solving crime, safety and security challenges. The national government wants a much bigger say in setting its police programs and priorities. Moreover, the police must be more “tough” on crime and terrorism. This attitude has led to centralization, penalization, and at the local level, ‘responsibilization’, which signifies that a variety of private policing agencies and companies are made responsible for public order maintenance (Das et al. 2007). On security issues the municipalities are supported by the Dutch Centre for Crime Prevention and Safety (CCV), the national expertise centre for information, advice and support for security professionals.

### *12.1.2 Responsibilities of municipal governments for drug-related issues*

Although all kinds of problems related with the use of drugs are taken very seriously in the large Dutch cities, there is not *one* integrated drug strategy or *one* drug action plan in Amsterdam, Rotterdam or The Hague. Because the drug problem has many dimensions, it is covered in different themes. This is also the case on the national level, to the extent that in contrast with most other EU-countries, in the Netherlands there is not one integrated national drug strategy, but in the past fifteen years drug-related policies were mostly developed for specific substances and problems i.e. policy letters to tackle the cannabis problem or synthetic drugs production.

The main responsibilities of municipalities concerning drug-related issues are in the fields of the public order, security of citizen, public (mental) health and health prevention. In the large cities several civil servants have final responsibility for each of the drug-related themes: one for the coffee shop policy, one for the organisation of the social relief, one for the care of problematic drug users, one for permits for major events and one for preventive and educational activities.

In the large cities the drug-related issues are tackled along four tracks:

1. Combating crime and public nuisance. Public nuisance is combated using combinations of administrative and criminal law. Municipalities also participate in Regional Centers for Information and Expertise (RIEC). The RIEC's actively cooperate in the prevention of organized crime by exchanging judicial and administrative information. The local coffee shop policy is mainly based on enforcing the Opium Act Directive. The coffee shop policy has also a public health objective, namely maintaining the separation of the market of cannabis and the hard drug markets (main actors: mayor, police and Public Prosecution Office). This is part of the general (municipal) security policy;
2. Taking care for and relief of (homeless) drug addicts, including providing night shelter and developing special housing facilities (part of municipal task for public mental health); side effect is also decreasing public nuisance (main actors: mental health and addiction care, municipal health service and police);
3. Selective prevention and public health objectives, especially targeted to youngsters at school and in nightlife surroundings; also facilitation of major events and parties (with sometimes specific drugs controls); (main actors: municipal health service, addiction care, and police);
4. Many of these issues are monitored on a regular basis and are often accompanied by research.

### *12.1.3 'Offering care when possible and punishment when necessary': drug-related action plans on the municipal level*

As stated above, there are no broad integrated drug action plans as such, but drug-related problems are covered by policy papers on other themes. In the large Dutch cities, the different drug related issues are covered by periodical and ad hoc policy papers. Since 2002 every four years special Security Policy Papers with concrete targets are published by the municipal Boards of the large cities. Recurring themes in these policy papers are: approaches to tackle prolific offenders, combating public nuisance caused by using alcohol

and/or drugs, dismantling weed nurseries, controlling coffee shops and to maintain security on large events.

Already before the Placement in an Institution for Prolific Offenders Act (ISD measure) came into effect (in 2004) the Municipality of The Hague had started with a special chain approach for this group. It was a collaboration of municipal services, the police, the Public Prosecutor Office, addiction care organisations, addiction probation services and prison services. In the first external evaluation it was concluded that the number of bookings and recidivism of the active and very active prolific offenders had decreased significantly and the narrow collaboration of organisations with such different background was positively assessed (Arts and Ferwerda 2006). The ISD measure was preceded by the measure Judicial Placement of Addicts (SOV), which started in Amsterdam and Rotterdam in 2001. This was also a compulsory care order outside the prison system, mainly directed to drug addicts causing much public nuisance (for more background information: see Van Laar en Van Ooyen-Houben 2009).

Amsterdam was in the frontline of differentiating between addicted prolific offenders and prolific offenders with other characteristics (such as young not substance abusing criminals). It was in Rotterdam that the personal approach scheme to tackle the top 700 addicts who form a public nuisance and who avoid treatment was implemented most quickly (Gemeente Rotterdam, PGA 700, 2004).

The municipalities are responsible for the aftercare for former prisoners. In the case of offenders with an ISD-measure, there are two phases: a residential phase in a penitentiary, often followed by an extramural "aftercare" phase in care-related institutions. The municipal authorities are in charge of this phase, including providing basis needs, such as income and accommodation, to the offenders with an ISD-measure.

In the three large cities –and also elsewhere- the collaboration of the different organisations resulted in the development of Safety Houses where personal trajectories of among others addicted prolific offenders are arranged (see also chapter 9).

In connection with the increasing drug use of certain (vulnerable) groups, the Rotterdam five-year security program for 2010-2014 announces measures to develop a preventive program on substance use in the public space and to develop an own Rotterdam vision on psychoactive substances in cooperation with the Municipal Public Health Service (Gemeente Rotterdam, Directie Veiligheid, 2009)

According to the Public Health Act of 2008 (Wet Publieke Gezondheid), the Municipal Council has to approve every four years a municipal health policy paper, which will actually be prepared by the Municipal Public Health Service (WPG, art. 13, lid 2). Core of this policy is to stimulate the citizen to accept a healthier lifestyle. The obliged Public Health Policy Paper has to be preceded by the collection and analysis of the health situation of the citizen. The four largest cities have developed a comparable survey, which is held every four years (the Health Monitor). One of the questions concerns the use of cannabis and hard drugs. One of the concrete targets of the public health policy is to decrease the use of alcohol and drugs especially by youngsters. The 2008 Public Health Policy Paper of Amsterdam, for instance, states clearly that “..the objective of the Board of Mayor and Aldermen is that the monthly prevalence of the use of cannabis by youngsters will decrease from 20 percent to 15 percent in 2011..”. (GGD Amsterdam 2008). The 2011 Public Health Policy Paper of Rotterdam announces a strong approach to prevent youth up to age 23 from becoming

addicted, sliding off, becoming criminally involved and throwing away their talent (GGD Rotterdam-Rijnmond 2011). This theme was elaborated in a special policy paper about the Rotterdam Program Drugs and Alcohol: the target is to decrease the use of alcohol and drugs for youngsters up to 23 years with 10 percent in 2014 in comparison with 2010. The chosen approach is a combination of strategies in the fields of prevention, care and repression (GGD Rotterdam 2012). This Program partly carries out the targets formulated in the Rotterdam Security Policy Paper of 2009. The Municipal Public Health Service of Rotterdam started in December 2011 with a Plan of Attack against Drug and Alcohol use by pupils of secondary vocational schools (ROCs). The main target is that at the end of 2013 the use of drugs and alcohol among the pupils will be diminished with 10 percent in comparison with 2010 (GGD Rotterdam 2011).

#### **Recent Security Policy papers of three largest cities in the Netherlands (only in Dutch)**

Policy paper Rotterdam: *Vertrouwen in veiligheid: vijfjarenactieprogramma 2010-2014*

<http://www.rotterdam.nl/BSD/Document/Perskamer/VJAP%202010-2014.pdf>

Policy paper Den Haag: *'Doen wat werkt: aan de slag voor een veilig Den Haag': integraal veiligheidsplan Den Haag 2012-2015*

<http://www.denhaag.nl/web/file?uuid=51217185-fa33-4c29-ab57-5d11f2db9f6f&owner=c23b77c3-74ca-478c-b767-eebb1d29690b>

Policy paper Amsterdam: *Regionaal Veiligheidsplan 2012-2014: regio Amsterdam-Amstelland*

[http://www.eenveiligamsterdam.nl/publish/pages/425320/regionaal\\_veiligheidsplan\\_2012-2014\\_amsterdam-amstelland\\_definitief.pdf](http://www.eenveiligamsterdam.nl/publish/pages/425320/regionaal_veiligheidsplan_2012-2014_amsterdam-amstelland_definitief.pdf)

Before the implementation of the Community Support Act (WMO) the large cities had developed specific social addiction care policies for the vulnerable, hard to reach, outpatient addicts. The last specific policy paper on drug-related nuisance and addiction problems of the city of Amsterdam was published in 2006. Since that time this population was covered by several other policies: the Strategy Plan for Social Relief, the target approach of prolific offenders and the four-yearly Community Support Act policy papers.

One important initiative of the four largest cities and the national government, which started a few years (in 2006) after the Placement in an Institution for Prolific Offenders Act came into effect, and which can be seen as a complement of this policy was the Strategy Plan for Social Relief. (See also our NR2011 + this report, chapter 8.) The costs of the Strategy Plan were estimated at € 61 million in 2006 increasing to a total of € 175 million in 2009. The national government takes two-thirds of this amount at the expense of the General Exceptional Medical Expenses Act; the rest is paid by the four cities. The main objective of this Strategy Plan was to improve the living situation of actual and potential homeless people and at the same time to reduce the public nuisance caused by them. A second aim is to prevent the ascend of new groups of homeless people by trying to reduce evictions and to reach released inmates. These groups have a high risk of becoming homeless. A large part of the primary target population is an active prolific offender and addicted to drugs and/or alcohol.



The Strategy Plan is based on two pillars:

1. A person-oriented approach by using individual care program plans and client managers linked to individual persons. This person-oriented approach will cover the roofless and houseless and other highly vulnerable people in the four large cities until January 2013;
2. A comprehensive and guaranteed cooperation of all relevant parties and institutions involved under the direction of the municipality and the care office. This sound co-operation was established at an administrative and executive level. (Planije et al., unpublished). The central direction of this Strategy Plan is executed by certain municipal departments –in Amsterdam the Municipal Department for Housing, Care and Society. The main target for the first four years was to offer to all the estimated homeless people (10,150 persons) a ‘stable mix’, meaning a stable housing situation, regular legal income and stable contacts with care providers (Tuynman et al. 2011). The ‘stable mix’ is the successful result of what starts as an individual trajectory scheme. Table 12.1 show that the Strategy Plan reached most of its aims within five years.

*Table 12.1: Number of homeless persons with an individual trajectory or a ‘stable mix’; January 2011*

	<b>Individual trajectory</b>	<b>Stable mix</b>
Amsterdam	3,966	2,820
Rotterdam	3,634	2,108
The Hague	3,111	1,543
Utrecht	1,725	1,005
<b>Total</b>	<b>12,370</b>	<b>7,506</b>

Persons who reached a stable mix committed on average 54 percent less offenses or misdemeanors, resulting in a significant decrease of public nuisance (Tuynman et al., p. 34). The first phase of the Strategy Plan was concentrating on reducing the number of evictions and on accommodating the roofless and houseless, providing them with an income and establishing contact with social assistance and care. However, some problems did emerge that can threaten the lasting success of the Strategy Plan:

- Despite the success of preventive measures, people are still becoming homeless, in particular young people and people with serious financial problems;
- Some people in a stable mix relapse to homelessness; others stay too long in shelter facilities, stagnating the turnover and outflow to other services;
- There is a lack of available housing and of diversity in accommodation with variants in intensity of support.

The national government and the four cities have signed a letter of intent to continue the Strategy Plan in 2010-2014, phase II. The second phase has to focus on preventing homelessness and promoting that people participate as independently as possible in society (Planije et al., unpublished).

The approach towards vulnerable, multi-problem substance abusers, with the intention of a narrow co-operation between judicial officers and care givers can be summarized with: “offering care when possible and punishment when necessary”.

#### *12.1.4 Cannabis policies in Amsterdam, Rotterdam and The Hague*

The cannabis policy in the large cities consists of three elements:

- Implementation of the coffee shop policy
- Developing programs for health promotion and to prevent the use of cannabis by young people
- Detecting and dismantling illegal cannabis nurseries in neighborhoods.

In the Netherlands, the sale of small quantities of cannabis is tolerated, but only if sold in so-called coffee shops (cannabis cafes), which have to obey to certain rules (the AHOJG-criteria). Officially the Resident criterion is also valid but is not yet enforced. These rules are formulated in the Opium Act Directive. (See also chapter 1 and 9.)

The coffee shop policy is mainly part of the security policy with a public health background. The sale of cannabis is tolerated, because since 1976 cannabis is put on Schedule II of the Opium Act, which means that the legislative decided that the use of that substance has less risks than the hard drugs on Schedule I. The main objective of this policy is to separate the markets of cannabis (soft drug) and hard drugs. The rules and regulations for the coffee shops exist since 1996. The mayor is responsible for the permit and parts of the coffee shop policy may be developed by the tripartite consultations of the mayor, the chief of the regional police and the chief regional public prosecutor. However, the municipal authorities can never take decisions on this matter contrary to the Opium Act or Opium Act Directive or which overlap with the national law. But they can sharpen or expand the minimum criteria.

In December 2011, there were 651 tolerated coffee shops in the Netherlands. More than a third of these coffee shops are located in Amsterdam (222); in Rotterdam there are 44 and in The Hague there are 40 coffee shops.

Most of the cities with coffee shops have a written formal coffee shop policy. Sometimes, updates of coffee shop policy papers are published by the security departments of the (large) cities. The most recent one of the city of Rotterdam dates from October 2007; Amsterdam has published a concept policy paper in November 2008 and a policy vision paper on coffee shops in November 2010. The mayor of The Hague has been accountable of the coffee shop policy in his city in a recurrent letter to the city council under the heading of 'coffee shop monitor', of which the last one was send in July 2008.

In the coffee shop policy vision paper of Amsterdam, there is a reference to the Program Agreement of the Board of Mayor and Aldermen to investigate the possibilities to regulate the growing and delivery of cannabis for the coffee shops (Visiedocument p.6). This is only possible with the approval of the national government. Another pilot project is announced: to investigate the spreading of coffee shops in order to promote a smaller scale, the transparency and the controllability of coffee shops. Another objective of this pilot project, which is co-financed by the national government, is to diminish the public nuisance of coffee shops. Up until now there is a fixed list of addresses of coffee shop venues which were exploited at that address in 1995. According to a valid General Local Bye-law (in Dutch: APV) tolerated coffee shops are not allowed at other venues than on the fixed list, and in the case a coffee shop is closed down, no new coffee shop are allowed to start again at that venue. One of the aims of the ongoing project Pilot Coffeeshops is to experiment with the

relocation of maximum five existing coffee shops to a new location (Gemeente Amsterdam 2012).

In 2009, 310 marijuana cultivation sites were dismantled in Amsterdam with a total of 98,914 plants, a mean of 361 per dismantlement. There were 90 sites with less than 100 plants, 127 with 100 to 500 plants and 57 with more than 500 plants. Most of the (smaller) sites were situated in private houses, regularly rented from housing corporations. 479 suspects were involved. The sites were spread over the city, but some quarters - socially weaker ones - were overrepresented. The organizers behind the cultivation stayed mostly invisible in the police reports, because the enforcement focuses on the persons that grow the cannabis, not on the persons in the background. The coffee shop pilot is still running (Gemeente Amsterdam 2012). The City of Amsterdam had difficulties with the announced distance criterion of 350 meter between a coffee shop and a school. If this new criterion would be strictly implemented, 43 coffee shops would have to be closed down. However, the announced measure to implement a distance criterion between coffee shops and schools has been abandoned by the Rutte II administration. The City of Amsterdam also wants to tighten the Advertising criterion of the AHOJG-criteria. Especially in Amsterdam about one quarter of the foreign tourists appreciates easy access to marijuana and hashish and visits one of the 140 coffee shops in the Centre borough (Amsterdamse coffeeshopbeleid 2008, p.16). In 2010 about 4, 2 million foreign tourists visited Amsterdam.

Referring to the conclusions of an evaluation of the Public Health Service of Amsterdam, which states that more efforts should be invested in the prevention of cannabis use targeted at pupils of secondary vocational schools, the coffee shop policy paper proposes that the coffee shops will be required to inform their customers on the risks of cannabis use (visiedocument, p.10; 15). The dismantling of cannabis nurseries is not explicitly mentioned as a priority neither in the Amsterdam coffee shop policy papers nor in the most recent Security Policy paper of Amsterdam and surroundings (Regionaal Veiligheidsplan 2012-2014). However, under the supervision of the Amsterdam police force, cannabis nurseries are dismantled whenever detected.

The most recent comprehensive coffee shop policy paper of Rotterdam stems from 2007 (Rotterdamse coffeeshopbeleid, 2007). The key objective was to discourage the use of cannabis, especially by schoolchildren and vulnerable groups and to problematize the normalization of the use of cannabis. One consequence of this principle was that it was announced that every coffee shop within a distance of 250 meters from a high school or a primary vocational school should be closed down from 1 June 2009 onwards. Since that time 18 coffee shops have been closed in Rotterdam. Research showed that in areas where coffee shops were closed, there was a decrease both in the occurrence of nuisance, meaning nuisance reported to authorities, from 58 per cent to 42 per cent of 600 respondents living in the neighborhood of the coffee shops *and* in the experienced public nuisance (*for example*: experienced traffic nuisance decreased in areas with closed coffee shops from 51% to 36 % of 600 respondents living in the neighborhood of the coffee shops and remained the same in areas where coffee shop had stayed). The respondents had the impression that the supply of cannabis from illegal selling points had also decreased since the closure of the coffee shops. A possible explanation for this development is that more police force was brought on the street after the closures. After the closures, most of the young cannabis users still got their cannabis through friends who buy it at coffee shops, so

the measures did not seem to have much effect on the availability of cannabis (Bieleman et al. 2010).

Just as in Amsterdam it is impossible to start a new coffee shop in Rotterdam (“dying-out principle”). In Rotterdam every coffee shop owner is obliged to possess a special cannabis prevention certificate. The course connected with this certificate was developed by the Public Health Service of Rotterdam and the Association of Coffee Shop Entrepreneurs of Rotterdam (p. 19). In this coffee shop policy paper is mentioned that it is the target of the Board to dismantle 600 cannabis nurseries each year in the Security region of Rotterdam (p.12). Combating organized crime is the target of the Rotterdam Action Program Societal Integrity 2010-2014, which is a continuation of the Program with the same name from 2007 to 2010 (Gemeente Rotterdam 2010). One of the measures of this Program is that every coffee shop will be controlled ten times each year. Another target is to strive to dismantle a cannabis nursery within six days of a qualified notification. Every year two comprehensive investigations of criminal cannabis networks per district will be initiated (p. 9).

The municipality of The Hague has sharpened its coffee shop policy in the past years resulting in a decrease of the number of coffee shops to 40. The Hague applies an additional criterion for coffee shops, the field-of-vision criterion, meaning that if the front door of a coffee shops is visible from the front door of an elementary school, the coffee shop will be closed. From the Coffee Shop Monitor 2008 of the City of The Hague it becomes clear that a distance criterion of 500 meter between a coffee shop and a school is already applied in that city. Every coffee shop in The Hague can expect a police control twice a year (Gemeente Den Haag 2008).

In the most recent G4 Health Monitor the cannabis use of citizen between 16 and 54 year of the largest four cities are compared: 10 percent of the Amsterdam respondents had used cannabis in the past four weeks, whereas in Rotterdam it was 6 percent and both in The Hague and Utrecht 5 percent.

#### *12.1.5 Municipal nightlife drug prevention activities*

The municipal authorities are responsible for a safe and healthy atmosphere in the nightlife areas and during special licensed events, like dance events, within their cities. Under the direction of the Ministry of Security and Justice a guideline for safely organizing events for municipalities was developed in the last years ([www.infopuntveiligheid.nl](http://www.infopuntveiligheid.nl)). The most important organisations which have to be consulted before issuing a permit are the police and the emergency services (security and public health).

In Rotterdam the emphasis on developing a safe nightlife environment started in 2002 with extra lightning, urinals, camera surveillance, extra trash cans, tit-for-tat policy for aggressive behavior and public drunkenness, and in involving bar-owners and porters in pushing back excessive alcohol and drug use. Some cities apply a zero-tolerance policy with regards to drugs (dealing, possession and use) at certain risky dance-events and night clubs. For every event or dance party a risk assessment is made and security measures are applied in accordance with this risk (NR2011, p.141). In Amsterdam the municipal authorities state clearly: ‘Dance events are culturally and economically important for the city of Amsterdam. However, on dance events there should be no drugs’ ([www.eenveiligamsterdam.nl](http://www.eenveiligamsterdam.nl)). Also, in Amsterdam the Advisory Bureau Drugs is publishing before every major public event, like Queens Day and New Years Eve, a risk assessment for

alcohol and drugs use. This organisation also recommends involving the expertise of drug prevention workers of addiction care treatment centers ([www.adviesburodrugs.nl](http://www.adviesburodrugs.nl)). In The Hague a special New Years Eve approach was developed in which role models of the community are involved, citizen are made responsible for the security of the event ([hetcvv.nl](http://hetcvv.nl)).

## 12.2 Case study: the City of Amsterdam

### 12.2.1 Key features of the drug policy of Amsterdam

Just as the policy of the national coalition government is based on a Coalition Agreement between the coalition parties, in the Dutch cities majority coalitions are formed after the four-yearly elections, resulting in a Program Agreement. In the city of Amsterdam three parties forged a coalition in 2010 with the pretext of "Choice for the city". In it is among others stated: "In 2014 Amsterdam is more safe and free [than in 2010]". The main objective is to enhance the objective and subjective security by decreasing criminality and public nuisance. The results have to be measurable. Concerning the coffee shop policy is formulated that the city of Amsterdam is an advocate of a tolerant cannabis policy, but also intends to combat drug criminality. An active promotional policy on how to use substances in a sensible way is announced.

As stated earlier, the City of Amsterdam has not *one* drug strategy, but different policy papers and coordinators for different themes connected with drugs. There are coordinators (civil servants) for the following themes:

- The coffee shop policy;
- The security policy, including public nuisance caused by drug use; also every borough has its own security civil servants;
- Events and nightlife, including zero-tolerance policy on dance events;
- Youth criminality, including drug using young people;
- Prolific offenders (together with Public Prosecutor Service and Public Health Service of Amsterdam);
- Strategy plan for social relief (together with Public Health Service of Amsterdam) : targeted at reducing homelessness, which are for a large part chronic drug addicts;
- Public mental health, including problematic hard drug users (Public Health Service).

In Amsterdam, there are at least four regular monitors, producing relevant data for policy makers:

- Since 1993, the Amsterdam Antenna combines qualitative and quantitative research methods to monitor substance use among nightlifers and neighborhood and problem youth in Amsterdam. Commissioned by Jellinek Prevention (addiction treatment), Antenna is executed by the Bonger Institute of the University of Amsterdam.
- The Public Mental Health Monitor of the Public Health Service of Amsterdam is published every four years (the last one in 2011). The main themes are: patterns of use of illegal drugs in Amsterdam; developments around chronic opiate and cocaine addicts and the use of recreational drugs.
- The Health Monitor, also of the Public Health Service of Amsterdam. The most recent is based on the four-yearly health survey of a representative sample of the population of Amsterdam. The most recent one was published in 2009. A new survey is running at this moment.
- Since 2008 measurement of the perception of the security of a representative sample of the population of Amsterdam is part of the Integrated Security Monitor (n=19,000). This national report set out Dutch people's perceptions of the livability of their residential

neighborhood, community problems, sense of insecurity, willingness to report crime, experiences with common offences, the public's assessment of police performance, and crime prevention behaviors. In the police region Amsterdam-Amstelland there is an additional annual survey of 12,000 questionnaires, resulting in the Security Monitor Amsterdam-Amstelland. Except for this subjective index, the security policy is also adjusted by objective security figures.

New policy plans and priorities on public health are expressed in the most recent Public Health Policy Memorandum of Amsterdam which was published in December 2011.

The City of Amsterdam co-operates closely with Arkin, the largest care institution in Amsterdam delivering mental health and addiction care. Regular addiction treatment and care for adults and youngsters is offered at six locations in Amsterdam by Arkin's trade mark Jellinek. Arkin is also involved in care and treatment for hard to reach (drug using) outpatients, crisis intervention and former prisoners. In 2011 the municipality of Amsterdam bought services from Arkin for €8 million.

#### *12.2.2 Four areas of the current drug policy of Amsterdam*

Four major areas of drug policy can be discerned in the Amsterdam . These are: a: Local policing strategies against drug scenes; b: Interventions in recreational nightlife settings; c. Low threshold services for problem drug users and d. Responses to smart shops.

##### *a. Local policing strategies against drug scene and drug trafficking*

Since 2007 the city of Amsterdam has its own long term Security Plan Amsterdam. The most recent one covers the period 2012-2014. Aims for different parameters are formulated: on Target Groups, Themes and Areas for Special Attention. Areas for Special Attention are quarters of the city under pressure of criminality and public nuisance. This security plan is integrated in the Regional Security Plan 2012-2014 of the police region Amsterdam-Amstelland. The priorities of the national policy for the police force are integrated in the Security Plan Amsterdam. Top priorities are: a personal approach to tackle the 600 most criminal youngsters and to combat organized crime.

One of the target groups are the (addicted) prolific offenders. Concrete objectives are: a. at the end of 2014 75% of this group has obtained a stable mix of housing, income and care; b. At least 50% of the very active prolific offenders with a Measure Placement in an Institution for Prolific Offenders will commit less serious offences than before the Measure was imposed; c. At the end of 2014 reports of drug-related nuisance will be decreased with 10 percent in comparison with 2010.

In August 2006 the Mayor of Amsterdam and the Minister of Security and Justice agreed on the need for a concerted effort by the Municipality of Amsterdam and the national government to combat serious organized crime in the City Centre District (postal code area 1012, see figure 12.2.1). It was concluded that the only effective way to deal with the problems involved was to target the criminogenic sectors themselves. The goal is to

regenerate the district into a worthy entrance to Amsterdam. This grand plan, Coalition Project 1012, involves a substantial reduction in the number of buildings used for window prostitution (from 477 to 293 windows) and coffee shops (from 76 to 50) and redeveloping the bottom segment of the hotel sector by enabling legitimate investors to buy up dubious hotels. The 1012-area will be tackled by administrative, fiscal and criminal law as well as by spatial and care interventions. This Coalition Project will last at least until 2018. Part of the Coalition Project 1012 is the Emergo project that lasted from July 2007 to July 2011. The main objectives of the Emergo project were: first, to establish a close collaboration between municipality, police force, public prosecutor, Ministry of Security and Justice and Ministry of Finance, supported by research and analysis, to gain an understanding of how criminal power is concentrated and the underlying criminal opportunity structures in the 1012-area, and second, to use the information obtained to take specific action to seize every possibility to break the concentrations of power and opportunity structures, and prevent future recurrence.

*Figure 12.2.1: Postal code area 1012 in Central Amsterdam (Color brown)*



A key finding of the Emergo project was that the criminal groups in the city centre of Amsterdam are no criminal groups with a Mafia- style grip on social life or groups that control certain tolerated or legal economic sectors, in the form of a cartel or otherwise. It is more a picture of individuals and groups who play a key operational or infrastructural role, possibly in a professional or commercial connection, or who assume key positions in serious organized crime. There are no direct signs of remarkable financial or organisational constructions around possession or exploitation of the coffee shops. But there are signs that the shops are



regularly financed out of underhand cash loans and remissions of debts, which poses the question whether these are cases of money laundering. This is, however, not known. 674 employees of the coffee shops in 2010 have no registered criminal antecedents over the last 25 years. 172 employees do have criminal antecedents, but these were only of minor character. The other 145 have a record of relevant criminal convictions. In total, they committed 1,036 offences, of which 221 were drug related (21%; both hard and soft drugs and also production of cannabis), 17,2% concerned driving offences and 10,3% violent offences. Other offences concerned illegal firearms, participation in a criminal organisation or money laundering. A number of owners and managers of coffee shops are part of criminal networks – also outside Amsterdam - and a lot of these persons also exploit other kinds of businesses (like travel agencies, real estate etc.). In general, the coffee shop sector is not in the hands of a few groups of criminals. The criminals that are involved know little envy or competition, notwithstanding the fact that they will defend their position of power with (threats of) violence (NR2011, p.161-62).

Estimates indicate that the 74 coffee shops in the 1012-area traded cannabis for about €38,121,130 in total (in 2007), a mean of about €515,150 per coffee shop. About 25% concerns hashish and 75% weed. It is estimated that 52,221 kilos might have been traded, which could mean that 2,861 customers per day visited a coffee shop. This is a mean of 39 customers per coffee shop. To supply cannabis for this amount of trade a total of 138,884 plants are needed, a 9,259 square meters, and an estimated 380 cannabis production sites (with a mean of 24 square meters) (NR2011, p.162).

In 2009, 310 sites were dismantled in the police region Amsterdam-Amstelland with a total of 98,914 plants, a mean of 361 per dismantlement. There were 90 sites with less than 100 plants, 127 with 100 to 500 plants and 57 with more than 500 plants. Most of the (smaller) sites were situated in private houses, regularly rented from housing corporations. 479 suspects were involved. The sites were spread over the city, but some quarters - socially weaker ones - were overrepresented. The organizers of the cultivation stayed mostly invisible in the police reports, because the enforcement focuses on the persons that grow the cannabis, not on the persons in the background (NR2011, p.164).

In a recent policy paper the Municipality of Amsterdam announced that in co-operation with the Pilot Coffee Shop from 1 September 2012 to 1 September 2015 the toleration permit of 26 coffee shops will be withdrawn (Nota beleidsaanpassing bestemmingsplangebied 1012, Gemeente Amsterdam 2011). Certain streets, like the Warmoesstraat with ten coffee shops, will become coffee shop-free.

Recurrent themes in security and other policy papers of especially Central Amsterdam are the public nuisance caused by (fake) drug dealers and very active prolific offenders. From 2005 to 2009 the police force registered 17,613 drug-related incidents in Amsterdam, of which 26,6 percent concerned hard drug dealing and 28,9 percent fake dope dealing. Especially fake dope dealers approach mainly tourists in an aggressive way. To tackle these persistent problems a special General Local Byelaw came into force on 1 October 2009 which designate certain areas as dealer nuisance areas (*Dealeroverlastgebieden*). For three months the entrance of these areas can be forbidden to certain persons (mostly prolific offenders and drug dealers). After a year the fake dope dealers proved to be active in the adjoining areas of the dealer nuisance areas ('waterbed effect'). In the most recent Security

Plan Centre 2012 2014 it is announced that the expulsion orders will be continued, supplemented with the deployment of 'flying enforcement brigades', a person-oriented approach and targeted communication to tourists on this phenomenon of dealers in fake drugs (Gemeente Amsterdam 2012).

In the same Security Plan it is stated that the very active drug using prolific offenders were combated very successfully in recent years. This is the group of offenders which commits within a period of two years more than ten offenses. They were sentenced to a two year placement in an institution for prolific offenders and/or came into a care trajectory, such as the strategy plan for social relief. Non-Dutch EU-nationals are not entitled to care but just locking them up in an institution of prolific offenders has proven to be very effective. However, other groups not falling under the definition of very active prolific offenders, but causing much public nuisance have emerged. These people are partly tramp, partly drug addict, partly alcoholic, partly with a mental illness, and it is difficult to put in criminal law against them because they commit small offences. The police force, the city departments for security and social services and the public prosecutor office will jointly act against this 'special group' active offenders (Gemeente Amsterdam 2012, p.15).

In September 2010, mental health and addiction care centre Mentrum (a trade mark of Arkin) started a so-called Living Training Centre in Amsterdam for addicts who kicked the habit but have to learn again how to live a normal social life. This is an important in-between facility which can contribute to prevent former chronic drug addicts from relapse.

Another group hard to treat heroin addicts can obtain heroin as a medication on certain conditions (see our previous NRs). In Amsterdam up to 145 addicts can enter the heroin-assisted treatment which is supervised by the Municipal Health Service. However, of the estimated opiate (and crack) addicts in Amsterdam of between 1850 and 3000 persons, this is only a small portion. Anyway, these 145 persons cause much less public nuisance and lead more social lives than before they entered this treatment.

#### *b. Interventions in recreational nightlife settings*

The dissertation of Ton Nabben on the nightlife of Amsterdam from 1988 to 2010 summarizes the changing drug policies of that period: "The drug policies in the Netherlands were long known as pragmatic and tolerant, but they came under increasing pressure in the first decade of the 21<sup>st</sup> century. At the local level this expressed itself in more rigorous zero tolerance policies...The [following] societal trends had repercussions in Amsterdam nightlife. First, after the turn of the century the previous culture of toleration was increasingly superseded by policies that put the emphasis not on disease prevention and health promotion, but on more stringent, normative crime control. Second, Amsterdam experienced a transition from an industrial to a service economy...The third development was the 'safety doctrine' that rose to the top of the local government agenda after a series of incidents inside and outside the nightlife environment. One resulting measure was to confer more responsibilities on the fire department and the municipal health service for approving dance events permits. At the same time, police and [public] prosecution were urging sterner punitive action to gain control over drug dealing and drug use in nightlife. The goal was to subdue the 'partying madness', using criminal sanctions if needed. The initial focus was on the club scene, including more rigorous body searches by door staff and more raids led by the

Amsterdam police department's Horeca Interventie Team (HIT) [Catering industry Intervention Team]. The authorities then turned to dance events. Administrative powers were expanded in order to crack down on the dealing, possession and 'public use' of drugs. The more repressive approach was motivated not so much by 'internal' factors (such as public disorder, large-scale drug dealing or intolerable risk levels at events or nightclubs), but more by an intensifying focus on public order and safety and a desire to heighten the authorities' visibility and proactive law enforcement efforts " (Nabben 2010).

For the past year 2011 the mood in Amsterdam nightlife is characterized by the Antenna monitor as 'new jollity'. Although complaints could still be heard about stringent door policies, drug searches, high entry charges and expensive drinks, there was also enthusiasm for new venues that had recently opened their doors. The nocturnal domain continued its shift to neighborhoods outside the city centre, and night lifers grew increasingly resourceful in organizing festivities of their own. New types of club owners and event organizers, less associated with commercialism were winning the hearts of clubbers and partygoers (Benschop et al. 2011).

With regard to the Amsterdam nightlifers in general it has been observed in the past year that the swift communication by means of the new social media "enables event planners to mobilize their clientele in no time". As a result, more and more not-entirely-legal "park raves now spring up with increasing frequency". For specific substances, several trends have been described in chapter 2 (§ 2.4) (Benschop et al. 2011).

Although the priorities in the most recent comprehensive policy paper Prevention Substance Use Amsterdam 2008-2011 (September 2007) were focused on reducing the use of alcohol and tobacco, clear policy objectives for cannabis, party drugs and hallucinogens were also formulated. For party drugs such as ecstasy and cocaine the objective was to limit risky use as much as possible and to intensify preventive efforts at large scale events such as house parties and dance events. The Board also decided to install a policy platform Going Out and Drugs, which changed its name in Policy Platform for the Prevention of Substance Use. Its main task is to translate available knowledge of (party) drugs to health promotional and preventive messages to in particular young outgoing persons. It is a co-operation of the Public Health Service, the City Department Care and Living Together, JellinekMentrum Prevention (addiction care), City Department Public Order and Security, the police force, the public prosecutor, coffee shop and smart shop entrepreneurs and the Advisory Bureau Drugs. (GGD Amsterdam, 2007; Preventief Verbinden ). The Policy Platform produced two important publications: an Action Protocol on information provision at incidents and an Action Plan GHB.

The background of the Action Plan GHB is the increase in ambulance services caused by GHB use and the addictive nature of GHB when used regularly. GHB users do not seem to be aware of the adverse and possibly also dangerous effects of GHB. The target is to reduce the negative consequences of GHB-use and to support GHB-users and GHB-dependents in relieving the acute problems related to GHB-use. The proposed program of actions contains: (1) monitoring GHB use in the city to get informed about specific target groups (e.g. via existent and if necessary new monitor activities and via focus groups with representatives of risk groups within homosexual scenes and dance events); (2) a public campaign targeting these target groups that is also informing about a website with information on this drug and

its effects; (3) improving support in case of incidents in recreational settings (e.g. a GHB information course for personnel in these settings, for the police and security personnel), and (4) offering low-threshold care for problematic users (based on the results of the current experiments in several organisations of addiction care) (NR2011, p63).

Table 6.3.3 in chapter 6 gives the annual number of emergencies in Amsterdam per drug from 2005 to 2011. The total number of rides is increasing every year, from 830 in 2005 to 1454 in 2011. Transportation to a hospital (patients transported) is a proxy measure for the seriousness of the emergency. For GHB is the transportation percentage almost every year the highest. The regular increase in GHB-related emergencies is consistent with signals of the growing popularity of GHB in some subpopulations.

### *c. Low threshold services for problem drug users*

The most important low threshold services in Amsterdam for problem drug users are methadone substitution treatment programs, syringes exchange facilities, drug consumption rooms and low threshold day and night shelter facilities. Most of these services have *low* thresholds, meaning that the participants have to go through an mild intake procedure. The most important check taking place is to determine whether the participant is a "rightful claimant with a regional bond". For the city of Amsterdam this means: inscribed at the municipal register and receiving a social security benefit. There is *no* threshold for syringe exchange projects and one night shelter project during the winter time (het Stoelenproject).

#### *Methadone substitution treatment programs*

Amsterdam has the oldest methadone treatment program in the Netherlands and the coverage is high but in some subgroups of opiate users the coverage is probably decreasing. Some professionals suppose that opiate users who do not participate in methadone treatment are also for some reasons resistant against this treatment. Factors that reduce participation in these programs are related to the effects of methadone itself, to characteristics of the individual drug user, and to the organisation of the distribution program. To stop with methadone is difficult and (former) users anticipate on this by not participating in a methadone program. Friction is also felt between the free but risky lifestyle of users and the rather strict rules of these programs. The ultimate craving for a sharp 'kick' as a result of heroin use cannot be reached by methadone. Most heroin users that are out of substitution treatment seem to use primarily crack and they often use heroin as a downer. This subgroup of heroin users who do not participate in methadone programs cannot participate in heroin-assisted treatment either (because one of the admittance criteria is participation in a methadone program) so they have to purchase their drugs outside the addiction care. (NR2011, p. 84)

In Amsterdam, the outpatient methadone substitution treatment is provided by the Municipal Health Service, Jellinek Addiction Care or the general practitioner. The Municipal Health Service also delivers methadone to heroin addicted arrestees at police stations. All these treatments are registered at the Central Methadone Register. The total number of participants of methadone programs is decreasing from 3940 persons in 1989 to 2270 in 2010 (OGGZ Monitor 2010, GGD Amsterdam 2011).

### *Syringes exchange*

The Public Health Service of Amsterdam (GGD Amsterdam) actively tries to prevent the spreading of the HIV virus. An important means to obtain this objective is offering an infrastructure of needle exchanges, which is in Amsterdam possible anonymously at all the locations of the Municipal Health Service.

In Amsterdam, figures are available since 1990. After a steady increase until 1993 (1,082,880 syringes were exchanged in that year), the number of exchanged syringes declined to 153,600 in 2010 (see also § 7.3). The decline during many years in the number of syringes exchanged can be explained by several factors: a reduction of injecting heroin users in general; a reduction of drug users, often injectors from neighboring countries; a reduced popularity of injecting resulting from experienced health problems, in combination with an increase in the use of crack; and mortality among injectors. The number of injected drug users is estimated on 200 to 300 persons, that is about 7 to 11 percent of the opiate users in Amsterdam.

### *Drug consumption rooms*

The objectives of a drug consumption room is reduce public nuisance and to reduce negative health effects of the drug user. It is a place where the addict can use his drug in a relatively quiet environment. There are six drug consumption rooms in Amsterdam. On average the number of visitors is declining, partly of the success of the Strategy Plan for Social Relief (Havinga 2010).

### *Low threshold day and night shelters*

In Amsterdam persons sleeping rough will be fined and/or be taken to a night shelter or if this is not available a police cell (Boesveldt 2012). Before entering the social relief shelters or other housing facilities there is a screening of the problems and the 'regional bond' of the person by an office staffed by the municipal Department for Labor and Income and the Municipal Health Service (the so called Intake House). The following social relief facilities are being offered in Amsterdam: night shelter, bridging facilities, 24-hour relief, supported housing and supported independent living. In Amsterdam social relief is delivered by seven specialized organisations. According to a recent report of the Municipal Health Service, about 2500 persons are using these social relief facilities (Runtuwene 2012).

### *d. Responses to smart shops*

In 2008, over 40 smart shops in Amsterdam existed, selling so called 'smart drugs', legal psychoactive substances. Smart shops sell products like "herbal energizers", "aphrodisiacs", and "psychedelic herbs, plants and seeds". In 2012 it is estimated that there are still about 25 smart shops in Amsterdam, whereas municipal civil servants counted 19 smart shops in the Centre of Amsterdam (Nota Beleidsaanpassingen bestemmingsplangebied 1012). The municipality of Amsterdam has the impression that the smart shops are criminogenic and have to die out to at most eight locations in the 1012-area (vlos.nl).

One of the most popular products were the hallucinogenic "magic mushrooms". Magic mushrooms (or 'paddo's' in Dutch), contain psilocin and psilocybin, substances that, when eaten, have strong psychedelic effects. Ever since the Dutch government banned the selling of dried magic mushrooms and fresh magic mushrooms in 2008 by law, some smart shops

had to close according to the national association of smart shop owners (VLOS) (vlos.nl). Although magic mushrooms are now forbidden, there are truffles (sclerotia) available in the smart shops, also called *Philosopher's Stones*, that contain the natural ingredient of psilocybin. These truffles are no mushroom. When eaten, they have a similar effect as magic mushrooms. Smart shops are also selling cannabis seeds which is not against the law.

Table 6.3.3 in chapter 6 shows that the number of emergency ambulance rides has decreased after the prohibition of hallucinogenic mushrooms, but is again slightly rising in 2011. The incidents are probably caused by the consumption of hallucinogenic truffles bought by tourist in smart shops (OGGZ Monitor 2010). Because the smart shops are overrepresented in the 1012-area, the municipal authorities have declared that for them –as for the coffee shops- also applies the 'dying out principle' in Central Amsterdam. In the policy paper Prevention Substance Use Amsterdam 2008- 2011, which was published before the prohibition of hallucinogenic mushrooms, it is announced that special preventive activities, such as distributing health promotional leaflets, targeted to young tourists will be developed by the municipality of Amsterdam.

## ***Part C: Bibliography and annexes***

## 13 Bibliography

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## 13.2 Alphabetic list of relevant data bases

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.ggd.amsterdam.nl](http://www.ggd.amsterdam.nl)

Antenne (Amsterdam Antenna)

Local monitor of the use of alcohol, tobacco, and drugs by school-goers and socialising young people in Amsterdam, conducted by the Bongers Institute of the University of Amsterdam (UvA).

Homepages: [www.jur.uva.nl](http://www.jur.uva.nl) & [www.jellinek.nl](http://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](http://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](http://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.ggd.amsterdam.nl](http://www.ggd.amsterdam.nl)

Cliënt Volg Systeem van Stichting Verslavingsreclassering Nederland, Client Monitoring System of the 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.ggznederland.nl](http://www.ggznederland.nl)

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

Local registration of methadone substitution treatment, conducted by the Municipal Health Service Amsterdam. Homepage: [www.ggd.amsterdam.nl](http://www.ggd.amsterdam.nl)

CPA, Centrale Post Ambulancevervoer, Central Post for Ambulance Transports (CPA)  
Local registration of ambulance transports, including transport due to problem use of alcohol and drugs, conducted by the Municipal Health Service Amsterdam. Homepage: [www.ggd.amsterdam.nl](http://www.ggd.amsterdam.nl)

Database problematische harddrugsgebruikers 2008, Data base problem hard drug users 2008

Data base about a field sample of 572 socially marginalized problem hard drug users. This database is a compilation of databases supplied by the Municipal Health Service Amsterdam, the Addiction Research Institute Rotterdam (IVO) and Bureau INTRAVAL.

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](http://www.trimbos.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 of Nursing & Education Consultancy. Homepage: [www.educaregroningen.nl](http://www.educaregroningen.nl)

Haags Uitgaansonderzoek

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

HBSC, Health Behaviour in School-Aged Children

National monitor on the physical and mental health and well-being of school-aged children, including high-risk use of cannabis, conducted by the Trimbos Institute, Radboud University Nijmegen, and Utrecht University. Homepages: [www.trimbos.nl](http://www.trimbos.nl) & [www.hbsc.org](http://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](http://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](http://www.rivm.nl)

Inbeslagnames drugs, Drug Seizures

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/](http://www.politie.nl/KLPD/)

LADIS, Landelijk Alcohol en Drugs Informatie Systeem, National Alcohol and Drugs Information System (LADIS)

National registration system of addiction care and treatment, conducted by the Organisation Care Information Systems (IVZ). Homepage: [www.sivz.nl](http://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](http://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](http://www.veiligheid.nl)

LMR, Landelijke Medische Registratie, Dutch Hospital Data (DHD)

National registration of admissions to hospitals, including admissions due to problem alcohol and drug use, conducted by Prismant. Homepage: [www.prismant.nl](http://www.prismant.nl)

Monitor gedoogde coffeeshops, Monitor of tolerated coffee shops

National monitor of the number of coffee shops that are officially tolerated by the local municipal policy, conducted by Bureau Intraval. Homepage: [www.intraval.nl/](http://www.intraval.nl/)

Monitor veelplegers (ISD), Monitor prolific offenders (ISD)

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

National Security Monitor, Veiligheidsmonitor Rijk (VMR)

National monitor on the experiences of citizens with crime and security and their opinion about police action, conducted by the Ministry of the Interior and Kingdom Relations (BZK).  
Homepage: [www.minbzk.nl/](http://www.minbzk.nl/)

NEMESIS II, Netherlands Mental Health Survey and Incidence Study

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

NL.Trendwatch

National qualitative panel monitor on the use of alcohol and drugs by young people in the nightlife scene, conducted by the Bonger Institute of the University of Amsterdam (UvA).  
Homepage: [www.jur.uva.nl/criminologie](http://www.jur.uva.nl/criminologie)



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 Addiction Research Institute Rotterdam (IVO). Homepage: [www.ivo.nl](http://www.ivo.nl)

NVIC Monitor, Nationaal Vergiftigingen Informatie Centrum, National Poisons 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](http://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 Security and Justice. Homepage: [www.wodc.nl/](http://www.wodc.nl/)

OCTA, Organised Crime Threat Assessment  
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/](http://www.politie.nl/KLPD/)

GGZ 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 (GGD Amsterdam). Homepage: [www.ggd.amsterdam.nl](http://www.ggd.amsterdam.nl)

OMDATA, Openbaar Ministerie Data, Public Prosecutions Department Data (OMDATA)  
National registration of criminal cases registered at the district courts, including offences against the Opium Act, conducted by the Office of the Public Prosecutions Department. Homepage: [www.wodc.nl/](http://www.wodc.nl/)

Peilstationsonderzoek scholieren, Dutch National School Survey (sentinel stations)  
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](http://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/](http://www.wodc.nl/)

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

TULP/GW, Ten UitvoerLegging van vrijheidsbenemende straffen en maatregelen in Penitentiare 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/](http://www.dji.nl/)

### 13.3 List of relevant internet addresses

*This list contains only a selection of Dutch websites on the subject of substance use.*

#### **URL Websites**

##### ***Research institutes***

<http://www.trimbos.nl/>  
<http://www.wodc.nl>  
<http://www.intraval.nl>  
<http://www.aiar.nl/>  
<http://www.ivo.nl/>  
<http://www.scp.nl/>  
<http://www.nispa.nl/>  
<http://www.rivm.nl/>  
<http://www.sivz.nl/>  
<http://www.prismant.nl/>  
<http://www.zonmw.nl/>  
<http://www.hiv-monitoring.nl/>  
<http://www.jur.uva.nl/criminologieuk>  
<http://www.drugresearch.nl/>

##### ***Ministries/ governmental organisations***

<http://www.rijksoverheid.nl/ministeries/vws>  
<http://www.rijksoverheid.nl/ministeries/venj>  
<http://www.rijksoverheid.nl/ministeries/bzk>  
[http://www.om.nl/vast\\_menu\\_blok/english/](http://www.om.nl/vast_menu_blok/english/)  
<http://www.politie.nl/KLPD/>  
<https://www.riecnet.nl/>  
<http://www.hetccv.nl/english>  
<http://www.cbs.nl/>

##### ***Online information and care websites***

<http://www.drugsinfoteam.nl/>  
<http://www.unitydrugs.nl>  
<http://www.drugsinfo.nl/>

##### ***(Addition) Care institutes***

<http://www.ggznederland.nl/>  
<http://www.ggd.nl/>  
<http://www.boumanggz.nl/>  
<http://www.brijder.nl/>  
<http://www.jellinek.nl>  
<http://www.centrummaliebaan.nl/>  
<http://www.vnn.nl/>  
<http://www.parnassia.nl>

<http://www.novadic-kentron.nl/>

<http://www.tactus.nl/>

<http://www.ggznm1.nl/>

<http://www.mondriaan.eu/home/>

<http://www.emergis.nl/>

<http://www.gezond.amsterdam.nl/>

<http://www.castlecraig.nl/>

<http://www.rodersana.nl/en/home/>

<http://www.addiction-solutions.nl/>

## 14 Annexes

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- Table 2.3.2: Last month prevalence of drug use among pupils of secondary education (12-18 years)*
- Table 2.3.3: Lifetime prevalence of drug use among pupils of 15 and 16 years of secondary schools in 2011*
- Table 2.3.4: Use of cannabis among pupils of 15 and 16 years of secondary schools in 2011*
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- Table 3.2.2: Market shares of different retail outlets for the selling of cigarettes, cigars and rolling and pipe tobacco in 2010*
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- Table 6.2.1: Number and characteristics of recorded HIV infections by route of transmission*
- Table 6.2.2: Number and percentage of recorded AIDS patients, by year of diagnosis and by route of transmission*
- Table 6.3.1: Characteristics of emergencies registered by the Monitor drug-related emergencies (MDI) by medical service, 2011*
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- Table 9.1.7: *Expenditures for different types of offences, 2010*
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## 14.2 List of abbreviations used in the text

4-MA	4-methylamphetamine
ACS	Amsterdam Cohort Studies
ACT	Assertive Community Treatment
ADHD	Attention-Deficit/Hyperactivity Disorder
AIAR	Amsterdam Institute for Addiction Research
AIDS	Acquired Immune Deficiency Syndrome
ASI	Addiction Severity Index
BIBOB	Public Administration Probity Screening Act
BMK	Benzyl-Methyl-Keton
BZK	Ministry of the Interior and Kingdom Relations
BZP	1-benzylpiperazine
CAM	Coordination Centre for the Assessment and Monitoring of New Drugs
CAPI	Computerised Assisted Personal Interview
CASI	Computer Assisted Self-Interviewing
CBD	Cannabidiol
CBS	Statistics Netherlands
CBT	Cognitive Behavioural Treatment
CBO	Dutch Insitute for Health Care Improvement
CBZ	Board of Construction of Facilities for Hospitals
CCBH	Central Committee on the Treatment of Heroin Addicts
CCV	Netherlands Centre for Crime Prevention and Community Safety
CDC	Centres for Disease Control
CIA	Cannabis Intelligence Amsterdam
CIDI	Composite International Diagnostic Interview
CMR	Central Methadone Registration
CPA	Central Post for Ambulance Transports
CRA	Community Reinforcement Approach
CVGU	Centre Safe and Healthy Nightlife
DBC	Diagnosis Treatment Combinations
DHD	Dutch Hospital Data
DIL	Drugs Information Line
DIMS	Drugs Information and Monitoring System
DJI	Department of Judicial Institutions
DNR	National Crime Squad
DNSSSU	Dutch National School Surveys on Substance Use
DOB	2,5-dimethoxy-4-bromoamphetamine
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUTCH-C	Drug Users Treatment for Chronic Hepatitis C
E.K.	Senate
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FACT	Function Assertive Community Treatment
FIOD	Fiscal Intelligence and Investigation Department
GBL	Gamma-butyrolacton



GGD	Municipal Health Service
GG&GD	Area Health Authority
GGZ	Mental Health Service
GHB	Gamma-hydroxy-butyrate
GMR	General Mortality Register
HAART	Highly Active Anti-Retroviral Treatment
HAT	Heroin-assisted treatment
HAVO	Secondary education at middle level
HBV	Hepatitis B virus
HBSC	Health Behaviour in School-aged Children
HCV	Hepatitis C virus
HIV	Human Immune Deficiency Virus
HKS	Defendant Recognition System (of the Police)
HTN	Healthy Nightlife Toolbox
ICASA	International Collaboration on ADHD and Substance Abuse
ICD	International Classification of Diseases, Injuries and Causes of Death
ICT	Intensive Community-based Treatment
IDDT	Integrated Dual Disorder Treatment
IDUs	Injecting Drug Users
IGZ	Health Care Inspectorate
IMC	Inpatient Motivation Centre
ISD	Institution for Prolific Offenders
IVO	IVO, scientific bureau on lifestyle, addiction and related social developments
IVZ	The Foundation for the Provision of Care Information
KLPD	National Police Agency
LADIS	National Alcohol and Drugs Information System
LCI	National Coordination Structure on Infectious Diseases
LCMR	National Board for Substance Registration
LEDD	National Centre of Expertise on Double Diagnosis
LIS	Injury Information System
LMR	National Information System on Hospital Care and Day Nursing
LSD	D-Lysergic acid diethylamide
LSP	National Support Centre for Prevention
LTP	LifeTime Prevalence
LMP	Last Month Prevalence
LYP	Last Year Prevalence
MATE	Measurement of Addiction for Triage and Evaluation
MBDB	N-methyl-1-(3,4-methylenedioxyphenyl)-2-butanamine
mCCP	Meta-chloro-phenyl-piperazine
MDA	Methylene-dioxyamphetamine
MDEA	Methylene-dioxyethylamphetamine
MDFT	Multi Dimensional Family Therapy
MDI	Monitor drug-related emergencies
MDMA	3,4-methylene-dioxymethamphetamine
MIM	Multivariate (Social) Indicator Method

MSM	Men having Sex with Men
NDM	National Drug Monitor
NEMESIS	Netherlands Mental Health Survey and Incidence Study
NHG	Association for General Practitioners
NIGZ	National Institute for Health Promotion and Disease Control
NIVEL	Netherlands Institute for Health Services Research
NNIA	No new information available
NND	National Network Drugs Expertise
NPO	National Drug Use Survey/National Prevalence Survey
NVIC	National Poisons Information Centre
OBJD	Justice Documentation Research Database
OCTA	Organised Crime Threat Assessment
OMC	Office of Medicinal Cannabis
OMDATA	Public Prosecution Department Data
PMA	Paramethoxyamphetamine
PMK	Piperonyl-Methyl-Keton
PMMA	Para-Methoxymethamphetamine
PPC	Penitentiary Psychiatric Centres
RDS	Respondent Driven Sampling
RIEC	Regional Information and Expertise Centres
RIOB	Guideline on Methadone Maintenance Treatment
RISc	Risk Assessment Scales
RIVM	National Institute for Public Health and the Environment
ROM	Routine Outcome Monitoring
SCP	National Institute for SocioCultural Studies
SES	Socioeconomic Status
SHM	HIV Monitoring Foundation
SOV	Judicial Treatment of Addicts
SRM	Criminal Justice Monitor
STI	Sexually Transmitted Infections
SVO	Steering Committee for the Reduction of Nuisance
SVG	Addiction Probation Services
SWOV	Institute for Road Safety Research
TBC	Tuberculosis
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
T.K.	Lower House of Parliament
TM	Treatment Multiplier
TRAILS	Tracking Adolescents Individual Lives' Survey
VAPO	Very Active Adult Prolific Offenders
VBA	Drugfree Addiction Support Unit
VNG	Association of Netherlands Municipalities
VVGN	Dutch Association of Addiction Physicians
VWO	Secondary education at the higher level, pre-university education
VWS	Ministry of Public Health, Welfare and Sport
WHO	World Health Organisation

WODC	Research and Documentation Centre of the Dutch Ministry of Security and Justice
WTZi	Admittance of Care Institutions Act
XTC	Ecstasy
ZonMw	Netherlands Organisation for Health Research and Development

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## Map of the Netherlands: provinces and major cities

# The Netherlands



