European Monitoring Centre for Drugs and Drug Addiction

Netherlands

Netherlands Country Drug Report 2019

This report presents the top-level overview of the drug phenomenon in the Netherlands, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

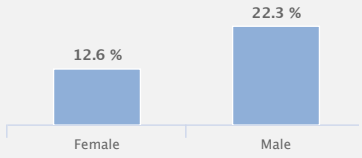
THE DRUG PROBLEM IN THE NETHERLANDS AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

17.5 %



Other drugs

MDMA	7.1 %
Amphetamines	3.9 %
Cocaine	4.5 %

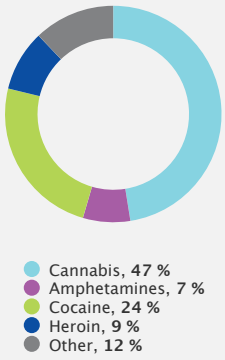
High-risk opioid users

14 000

(12 700 - 16 300)

All treatment entrants

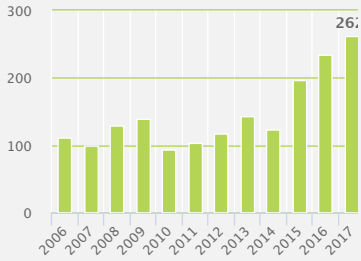
by primary drug



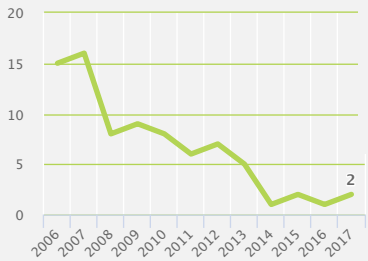
Opioid substitution treatment clients

5 241

Overdose deaths



New HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

18 687

Top 5 drugs seized

ranked according to quantities meas
kilograms

1. Cocaine
2. Herbal cannabis
3. MDMA
4. Heroin
5. Cannabis resin

Population

(15-64 years)

11 140 079

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin. Data for clients in opioid substitution treatment are incomplete and does not represent the national picture. Data for clients in opioid substitution treatment are from 2015 and do not represent the national picture. Data on quantity of seizures c include all relevant law enforcement units and should be considered partial, minimum figures; cocaine seizures are assumed to represent the majority of large seizures. Further details on the scope of supply data ma found in the methodological note.

National drug strategy and coordination

National drug strategy

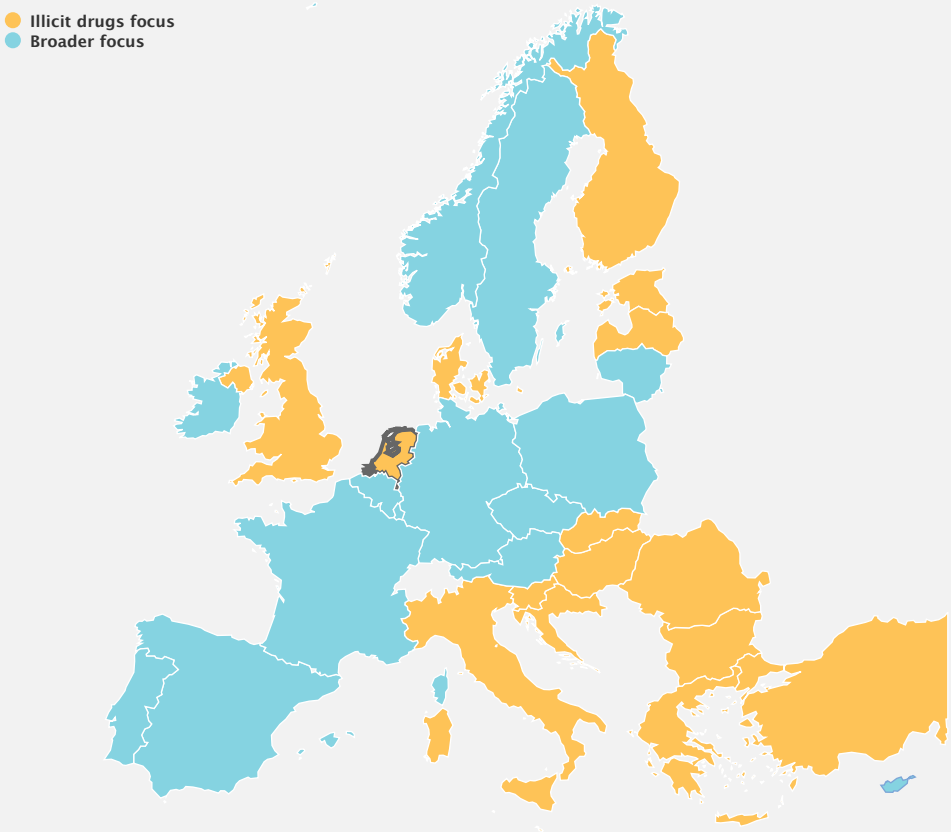
Since 1976, it has been a basic principle of Dutch drug policy to pursue the separation of the markets for ‘soft’ and ‘hard’ drugs. The Opium Act Directive states that the ‘Dutch drugs policy aims to discourage and reduce drug use, certainly in so far as it causes damage to health and to society, and to prevent and reduce the damage associated with drug use, drug production and the drugs trade’ (Stc 2011-11134). The 1995 white paper ‘Drug policy: continuity and change’ sets out comprehensively the principles of the Dutch illicit drugs policy. Taking a balanced approach, it recognises the distinction between ‘soft’ (Schedule I) and ‘hard’ (Schedule II) drugs. It outlines four major objectives: (i) to prevent drug use and treat and rehabilitate drug users; (ii) to reduce harm to users; (iii) to diminish public nuisance caused by drug users; and (iv) to combat the production and trafficking of drugs.

Since 1995, other aspects of Dutch drug policy have been elaborated in a number of issue-specific strategies and policy notes or letters to parliament. These have included the white paper ‘A combined effort to combat ecstasy’ (2001), the ‘Plan to combat drug trafficking at Schiphol airport’ (2002), the ‘Cannabis policy document’ (2004), the ‘Medical prescription of heroin’ (2009), the ‘Police and the Public Prosecution Office policy letter’ (2008-12 and 2012-16) targeting drugs and organised crime, and a policy view on drug prevention addressing young people and nightlife (2015).

Dutch cannabis policy has been elaborated in a series of policy letters. The ‘Letter outlining the new Dutch policy’ (2009) placed an increased emphasis on prevention and use reduction, and it amended the ‘coffee shop’ policy. The expediency principle holds that the public prosecutor has the discretionary power to refrain from prosecuting a criminal offence if this is judged to be in the public interest. This approach provides the basis for the ‘coffee shop’ policy, which allows users to buy cannabis in coffee shops, preventing them from coming into contact with hard drugs. Since 1996, the sale of small quantities has been tolerated if coffee shops adhere to the following criteria: no advertising, no sale of hard drugs, no public nuisance in and around the coffee shop, no admittance of or sale to minors, no sale of large quantities per transaction (maximum 5 g) and a maximum in-store stock for sale of 500 g. In 2013, another criterion was added: admittance to coffee shops and sales are limited to residents of the Netherlands, although local adjustments in the implementation of this criterion are allowed.

Like other European countries, the Netherlands regularly monitors and evaluates its drug policy and specific issues using routine indicator monitoring and specific research projects. Long-standing monitoring systems include the Drug Information and Monitoring System (drug composition), the tetrahydrocannabinol (THC) monitor (cannabis potency) and drug-related emergencies monitoring (presentations at festival first aid stations and medical services in eight Dutch regions). In 2009, an external evaluation of the 1995 white paper was carried out by the Trimbos Institute.

Focus of national drug strategy documents: illicit drugs or broader



NB: Data from 2017. Strategies with a broader focus may include, for example, licit substances and other addictions.

National coordination mechanisms

The responsibility for Dutch drug policy is shared among several ministries. The Ministry of Health, Welfare and Sport is tasked with coordination, while the Ministry of Justice and Security is responsible for law enforcement and matters relating to local government and the police. With regard to the dissemination of effective policies at the international level, including matters relating to human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and injecting drug use, the Ministry of Foreign Affairs is in charge. Regular coordination takes place through meetings between drug policy managers in these ministries.

Public expenditure

While understanding the costs of drug-related actions is an important aspect of drug policy, there are no recent data available on the total drug-related public expenditure in the Netherlands or trends in spending. No budget is specified and allocated in the drug policy documents, and there is no recent overall review of executed expenditures.

The most recent estimate of total drug-related public expenditure in the Netherlands is from 2003; at that time, it amounted to 0.5 % of gross domestic product. Recent estimates suggest that the public sector spent EUR 384 million to implement the Opium Act in 2015. This budget was spent on prevention, police investigation, prosecution, sentencing, implementation of sentences, supporting offenders and victims, and judicial services.

Drug laws and drug law offences

National drug laws

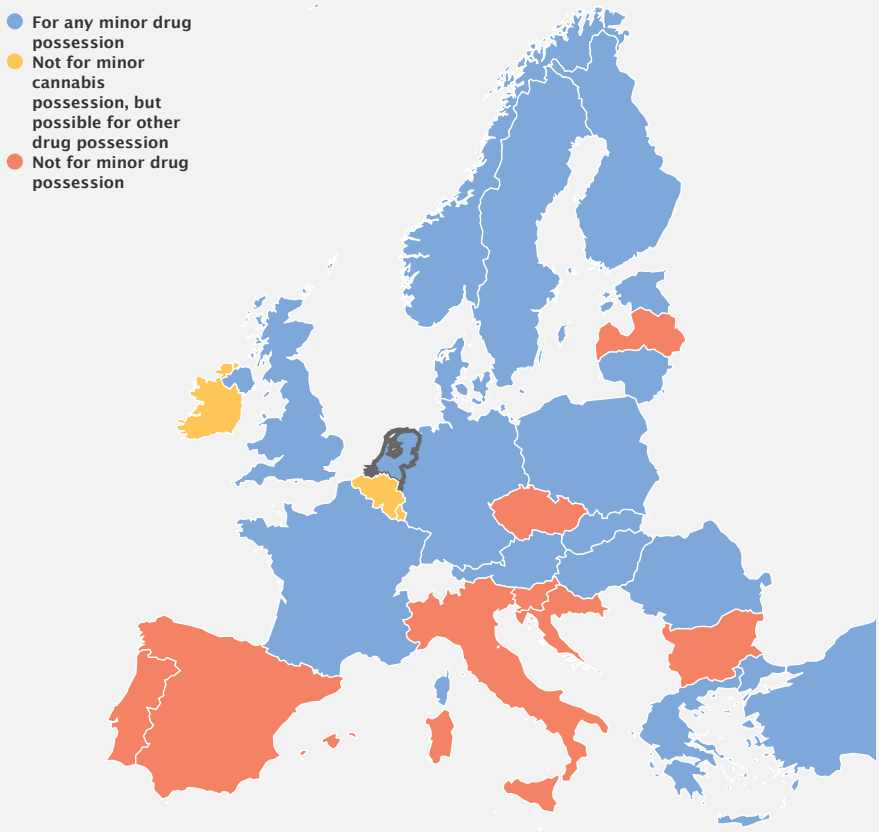
The Netherlands Opium Act is the basis for the current drug legislation. It defines drug trafficking, cultivation and production and dealing in and possession of drugs as criminal acts. The Act and its amendments confirm the distinction between Schedule I drugs (e.g. heroin, cocaine, MDMA/ecstasy, amphetamines) and Schedule II drugs (e.g. cannabis, hallucinogenic mushrooms). The Opium Act is implemented by the national Opium Act Directive to prosecutors, which is periodically revised; for example, since 2018, prosecutors have been asked, when appropriate, to consider (partially) replacing community service and prison sentences with a fine. New psychoactive substances are regulated through amendments to relevant schedules of the Opium Act.

Drug use itself is not specified as a crime, though there are situations when the use of drugs is prohibited at the local level for reasons of public order or to protect the health of young people, such as at schools and on public transport. It is up to the responsible authorities — not the national government — to regulate this. The possession of small quantities of drugs for personal use is punishable by imprisonment, but, in practice, it is not subject to targeted investigation by the police. Anyone found in possession of a small amount of drugs for personal use will generally not be prosecuted, though the police will confiscate the drugs; prosecution is considered only to refer an individual to a care agency. The threshold amount for cannabis is set at 5 g. Since 2012, the Opium Act Directive has left open the possibility of arresting and prosecuting individuals in possession of less than 5 g of cannabis in certain circumstances.

People who use drugs can be convicted when they have committed a crime such as selling drugs, theft or burglary. Since 2004, a special law — the Placement in an Institution for Prolific Offenders Law — has enabled the treatment of persistent offenders, of whom problem drug users constitute a major proportion. The measure consists of a combination of imprisonment and behavioural interventions and treatment, which are mostly carried out in care institutions outside prison.

The Opium Act states that supplying drugs (possession, cultivation or manufacture, import or export) is a crime punishable by up to 12 years' imprisonment, depending on the quantity and type of the drug involved. However, the Opium Act Directive also sets out strict conditions under which cannabis sales and consumption outlets, known as 'coffee shops', may be tolerated by local authorities. In March 2017, there were 567 'coffee shops' in the Netherlands.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Data from 2017. In the Netherlands, the possession of small quantities of drugs for personal use is not subject to targeted investigation by the police. Anyone found in possession of less than 0.5 g of Schedule I drugs will generally not be prosecuted, though the police will confiscate the drugs; prosecution is considered only to refer an individual to a care agency.

Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

In 2017, around 18 700 offences against the Opium Act were registered by the public prosecutor, less than in 2016. Slightly more than half of the offences reports were linked to Schedule II drugs. The majority of offences related to Schedule I were linked to possession.

Drug use

Prevalence and trends

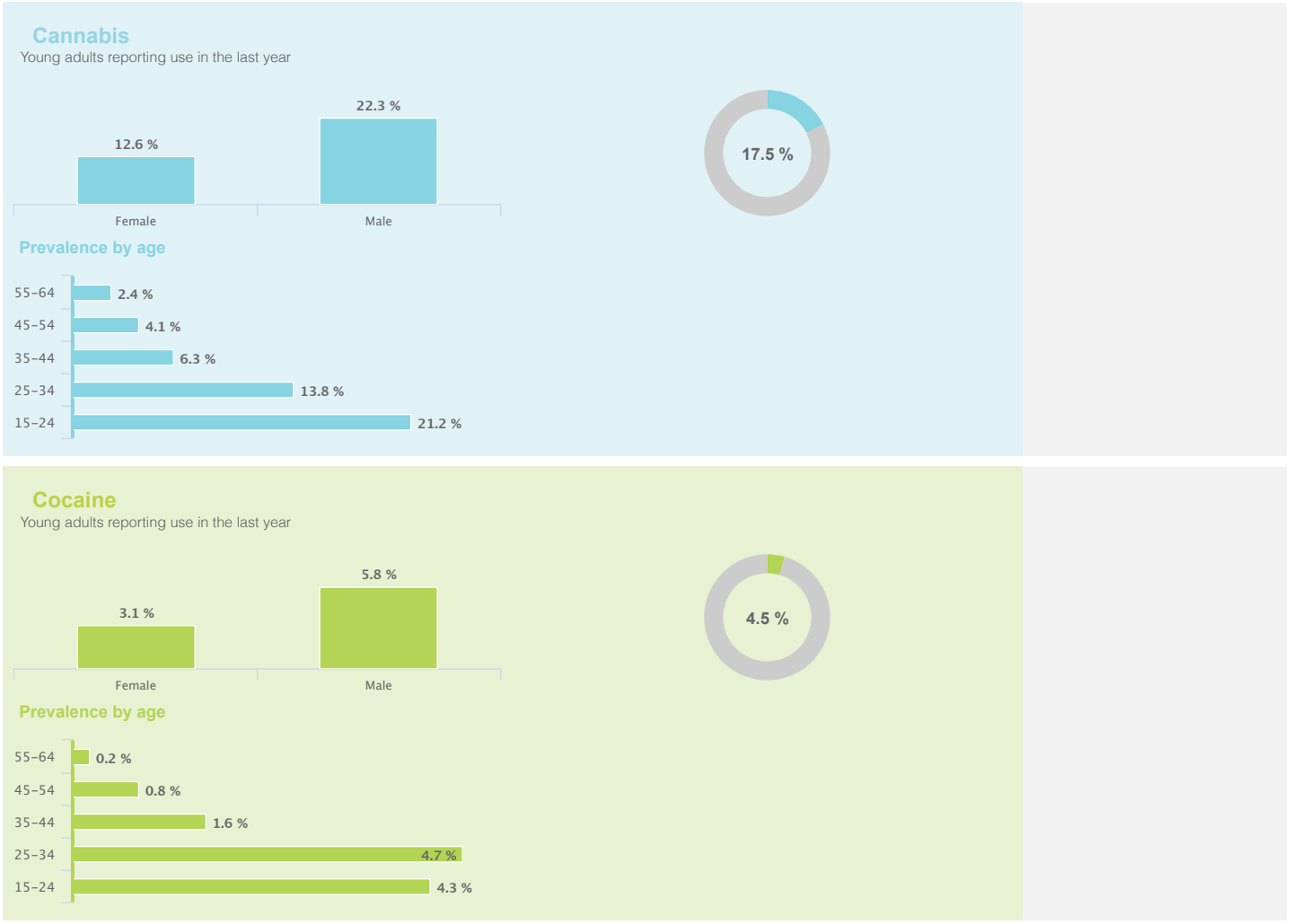
Cannabis is the most common illicit substance used by the Dutch adult general population aged 15-64 years, followed at a distance by MDMA/ecstasy and cocaine. The gender gap regarding cannabis use remains: last year prevalence of cannabis use among young adults was approximately twice as high among males as among females. The use of all illicit drugs is concentrated among young adults aged 15-34 years.

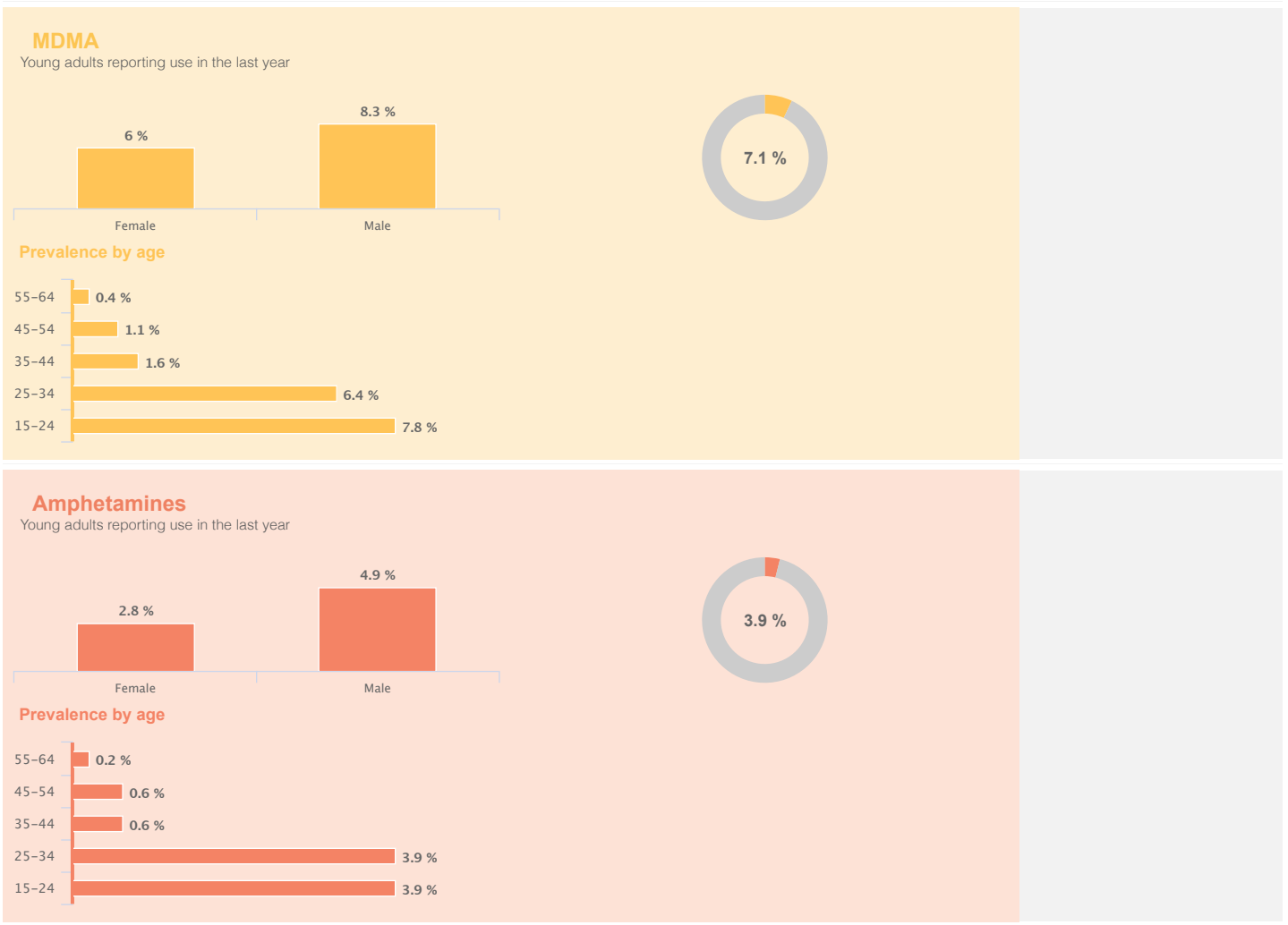
The increasing trend in ecstasy use seems to have halted, at least in the general population, but prevalence rates remain high among young adults. In school-age children, the use of ecstasy decreased between 2015 and 2017. Available data suggest an increase in recent years in cocaine and amphetamine use among young adults in particular and in cocaine use among the general population. There is also some evidence that rates of cocaine use increased among Amsterdam clubgoers.

Studies among other sub-groups of young people indicate that the use of illicit substances is more common in recreational settings, especially in clubs and at festivals. Moreover, some new psychoactive substances (NPS), such as 4-fluoroamphetamine (4-FA), have gained popularity among this sub-group, although use of other NPS remains low.

Wastewater analyses can complement the results from population surveys, by providing data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. As part of the Europe-wide Sewage Analysis Core Group Europe (SCORE) analyses, analysis of wastewater in Eindhoven indicates that cocaine use remained stable between 2017 and 2018. In contrast, the results for Amsterdam point to an increase in cocaine use. The use of MDMA and cocaine seems to be more common in Amsterdam and Eindhoven than in Utrecht.

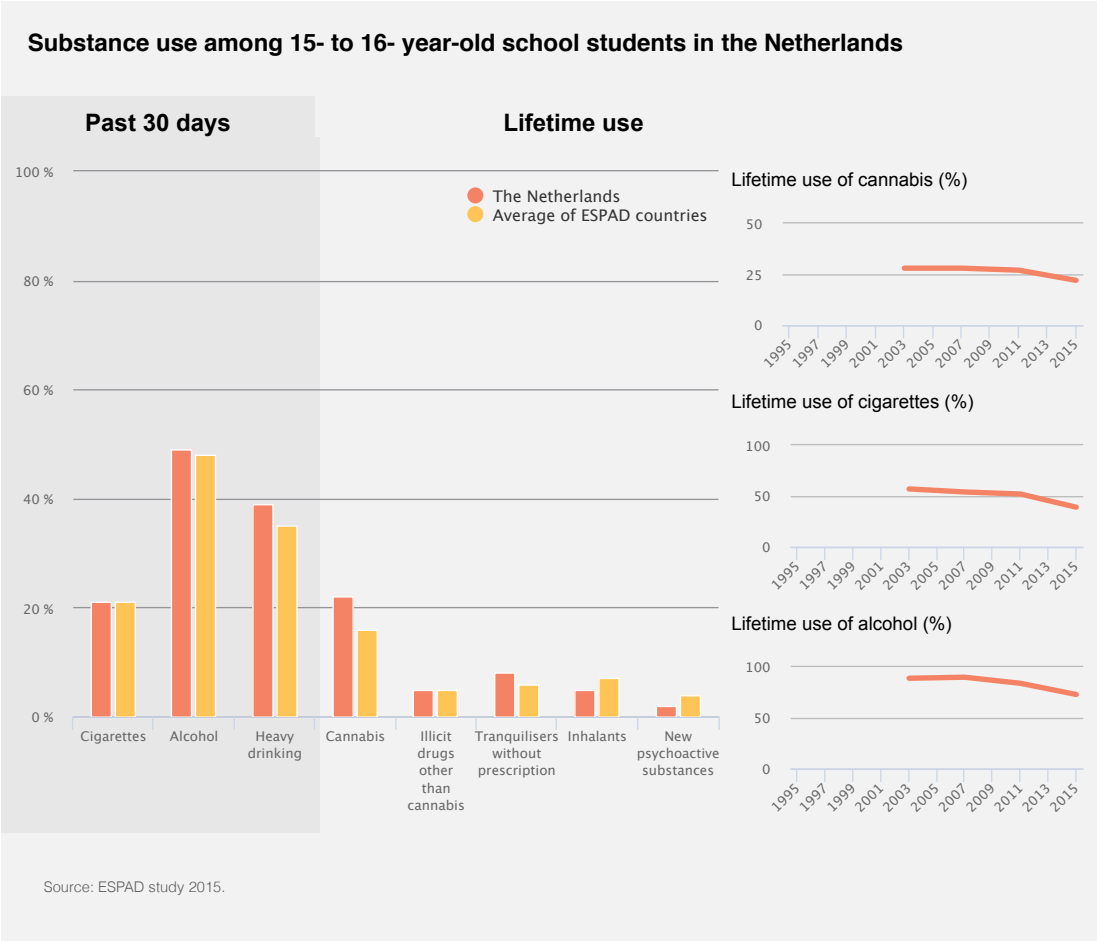
Estimates of last-year drug use among young adults (15-34 years) in the Netherlands





NB: Estimated last-year prevalence of drug use in 2017.

Data on the use of illicit substances among students aged 15-16 are reported in the European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been carried out regularly in the Netherlands since 1999 and the most recent data are from 2015. The ESPAD studies indicate a decreasing trend in lifetime cannabis use among school-age children over the period 1999-2015. Nevertheless, in 2015, lifetime use of cannabis among students in the Netherlands was notably higher than the ESPAD average (based on data from 35 countries). However, lifetime use of illicit drugs other than cannabis and lifetime use of NPS were more or less in line with the ESPAD average. Data from the 2017 Health Behaviour in School-aged Children (HBSC) study also showed a decrease in lifetime prevalence of cannabis use among students aged 12-16 years from 16.5 % in 2003 to 9.2 % in 2017.



High-risk drug use and trends

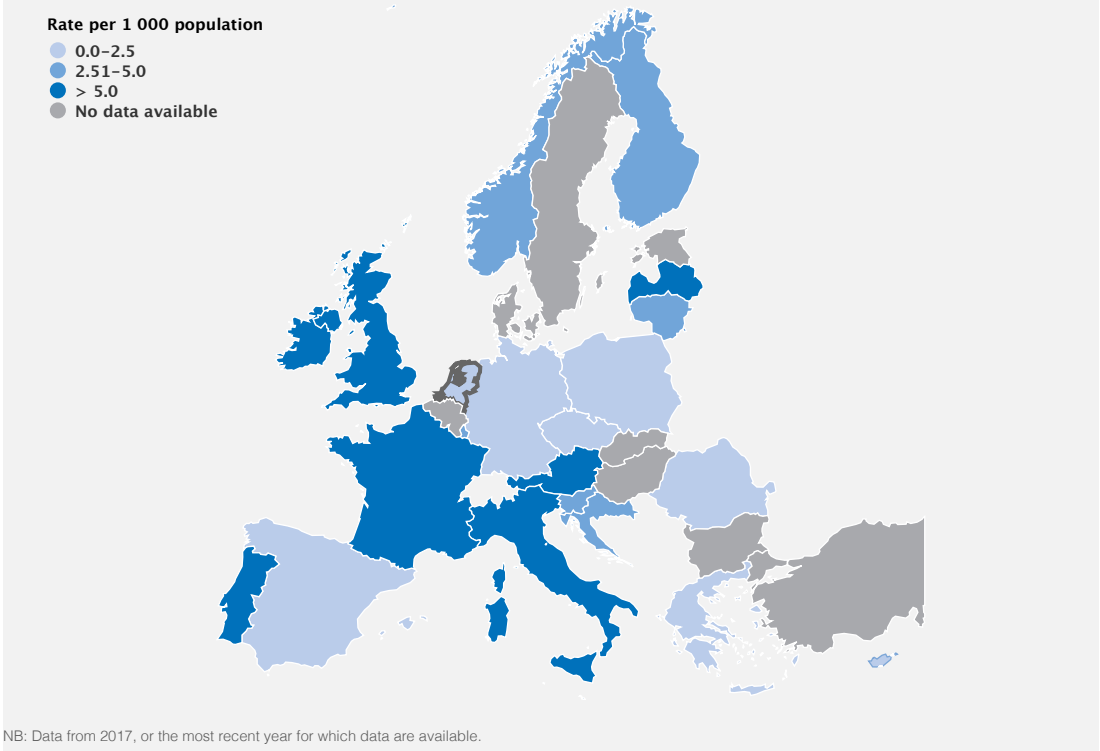
Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

In the Netherlands, high-risk drug use is mainly linked to use of heroin or crack cocaine. There are also reports of dependent gamma-hydroxybutyrate (GHB) users, but their total number is unknown. The most recent estimate suggested that there were 14 000 high-risk opioid users in the country in 2012 (1.3 per 1 000 inhabitants aged 15-64 years). Available data indicate a decline in the estimated number of opioid users in the last decade. Based on a study in the three largest cities, the prevalence of crack cocaine use ranged between 1.6 and 2.2 per 1 000 inhabitants aged 15-64 years in 2013. Many high-risk drug users, including opioid users, also use crack cocaine and a range of other licit and illicit substances. In 2016, a general population survey estimated that 1.4 % of people older than 18 years in the Netherlands were high-risk cannabis users.

Data from specialised treatment centres indicate that the number of new treatment entrants has remained stable in recent years, following an increase during the period 2006-11. In 2015, the largest group of first-time drug-treatment entrants comprised those who required treatment for cannabis use. Cocaine (crack) is the second most commonly reported primary substance among first-time clients, although the trend indicates a decline from 2008.

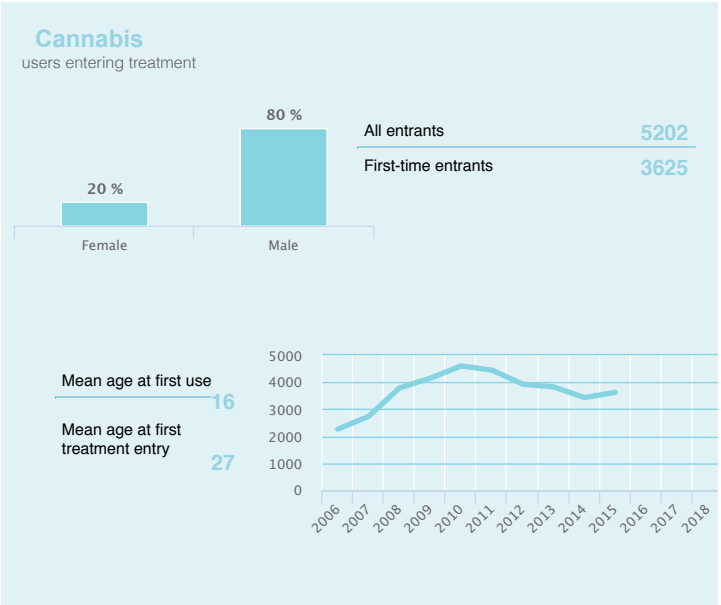
The number of primary heroin users requiring treatment for the first time has declined since 2007 and has remained relatively stable since 2012. Overall, heroin users entering treatment are older than other treatment clients. Injecting drug use is rare among those entering treatment.

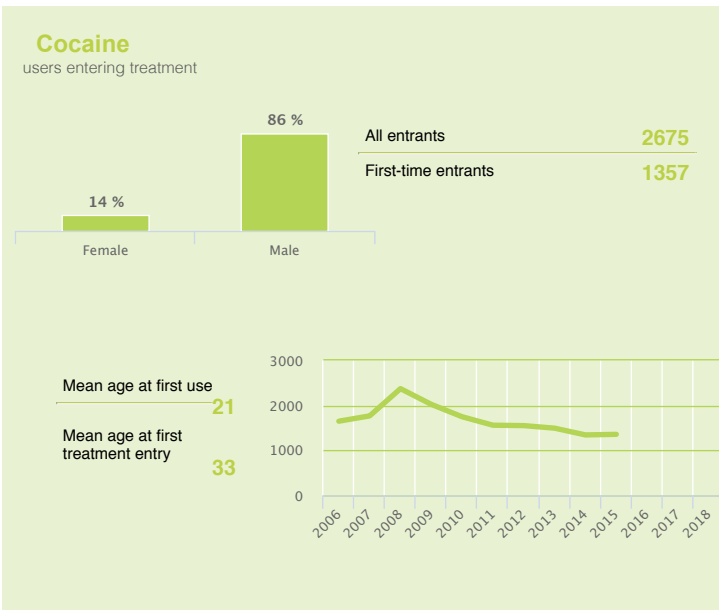
National estimates of last year prevalence of high-risk opioid use

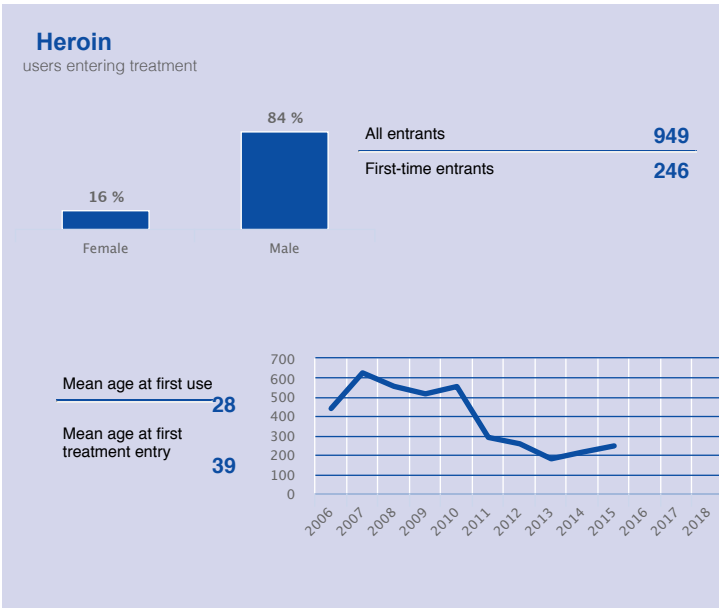


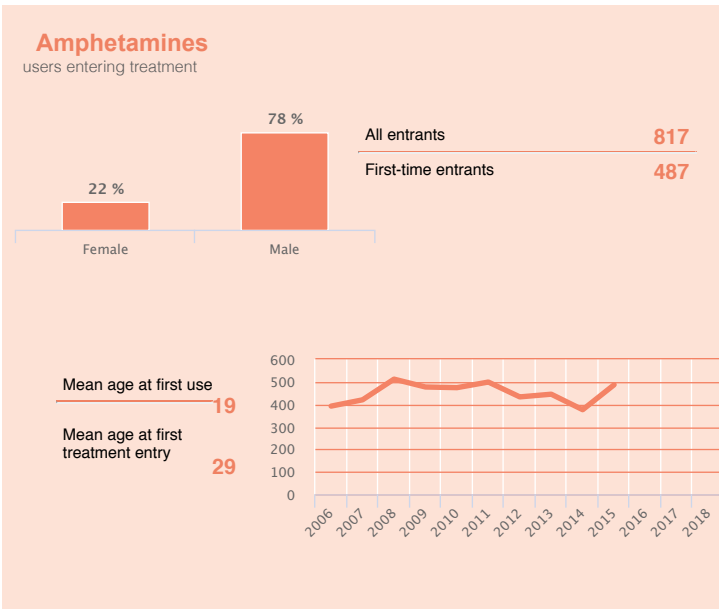
NB: Data from 2017, or the most recent year for which data are available.

Characteristics and trends of drug users entering specialised drug treatment in the Netherlands









NB: Data from 2015. Data are for first-time entrants, except for the data on gender, which are for all treatment entrants.

Drug-related infectious diseases

The available data suggest that the incidence of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) infections among people who inject drugs (PWID) has remained at very low levels in the Netherlands. Still, prevalence of HCV among this group is much higher than among the general population, and it remains the most common drug-related infection in the country. However, in recent years, men who have sex with men (MSM) have been increasingly seen as a high-risk group with regard to new HCV infections. Special concern exists about the risk of infection in MSM who inject in the context of chemsex (slamming), although the size of this group is unclear. This pattern was reported initially in Amsterdam, but it has also appeared in other larger cities more recently.

Prevalence of HIV and HCV antibodies among people who inject drugs in the Netherlands (%)

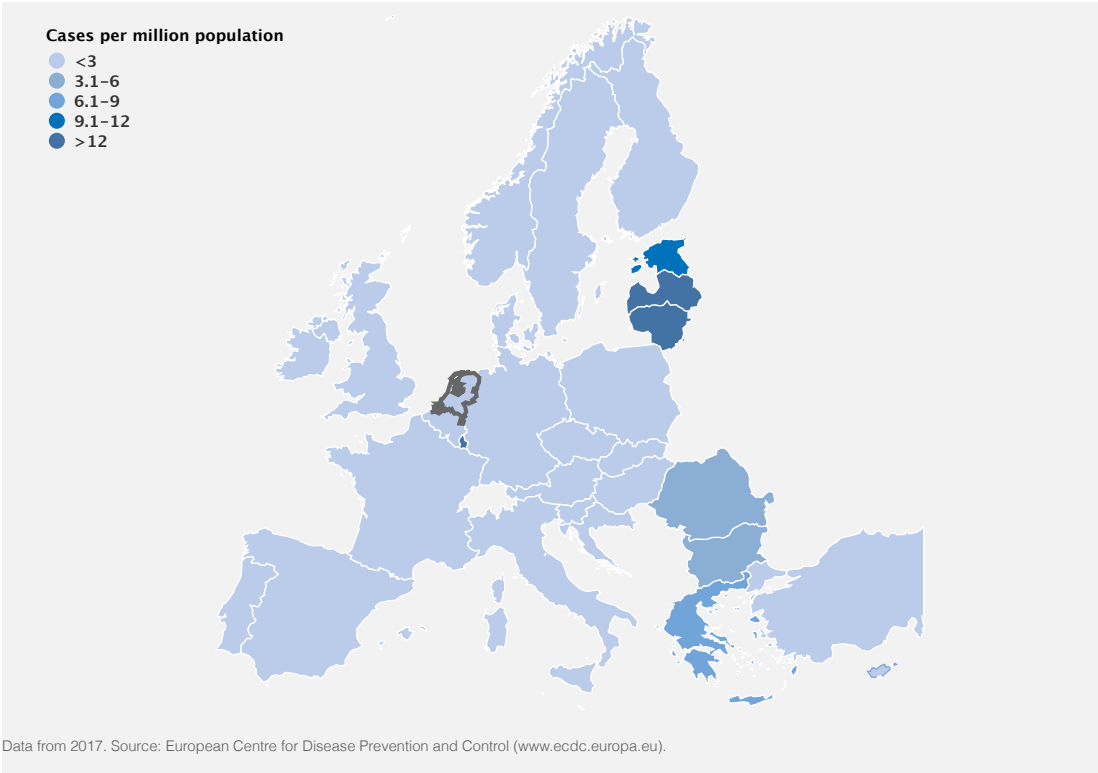
	Region	HCV	HIV
	National	:	:
	Sub-national	85.7	0

Data from 2017. Data are from Amsterdam.

New HIV cases linked to drug injecting remain rare. For example, the Amsterdam Cohort Study, initiated in 1985, had recruited 1 661 (injecting) drug users by the end of 2012, but no new cases of HIV infection were reported after 2006. In addition, the presence of PWID in HIV treatment centres has declined over the years.

The Netherlands is considered a low-prevalence country for HBV infection, although the prevalence of chronic HBV among PWID is approximately 3-4 %, which is higher than in the Dutch general population.

Newly diagnosed HIV cases attributed to injecting drug use



Data from 2017. Source: European Centre for Disease Prevention and Control (www.ecdc.europa.eu).

Drug-related emergencies

Although national data on absolute numbers of emergencies are not available, the Monitor Drug-related Emergencies (MDI) has been collecting information from a number of sentinel regions and emergency posts in dance and festival events since 2009, providing an insight into drug-related acute intoxications in sentinel centres. A second source on drug-related emergencies is the Injury Information System (LIS), which collects data from the emergency departments of 14 hospitals.

In 2017, 5 117 drug-related emergencies were registered at the MDI and 788 emergencies were registered at the LIS. Despite the ever-increasing concentration of MDMA in ecstasy pills (in 2017, around 65 % of ecstasy pills tested by the Drug Information and Monitoring System (DIMS) contained more than 150 mg of MDMA), the contribution of ecstasy-related emergencies at first aid posts is decreasing and the level of intoxication is stabilising (and recently decreasing).

Emergency cases involving more than one illicit or licit substance have been reported more frequently. Since 2012, emergencies linked to 4-fluoroamphetamine (4-FA) have increased substantially, and the drug is often used in combination with other substances. Although no emergencies related to the use of 4-FA were recorded before 2012, 189 emergencies with 4-FA as the only drug were recorded in 2017, a decrease when compared with the 272 cases reported in 2016. 4-FA was placed on Schedule I of the Opium Act in May 2017.

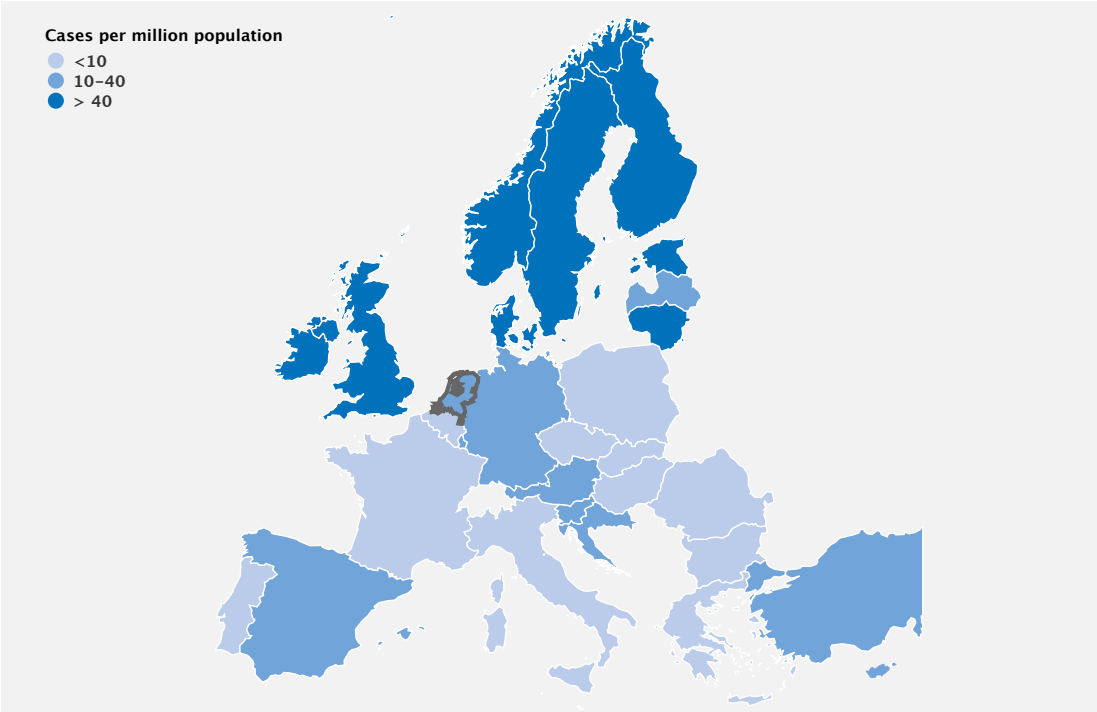
In 2017, 22 % of the 5 905 emergencies were related to the use of gamma-hydroxybutyrate (GHB), alone or in combination with other drugs. The patients very often had a moderate or severe level of intoxication.

Drug-induced deaths and mortality

In 2017, the general mortality register reported a further increase in the annual number of drug-induced deaths in the Netherlands. The majority of victims were male. The reasons behind the rise in the number of registered drug-induced deaths remain unclear, although the ageing of drug users, changes in drug use and the emergence of medicinal opioids including oxycodone use could play a role.

Although post-mortem toxicology is not performed in all cases of unexplained death in the country, there are indications that more drug-induced deaths are now detected because of increasing use of 'less invasive toxicological analyses'. There are also indications that more drug-induced deaths are now registered because of the development of facilities for the electronic registration of such deaths. The drug-induced mortality rate among adults (aged 15-64 years) was 22 deaths per million in 2017, in line with the most recent European average of 22 deaths per million.

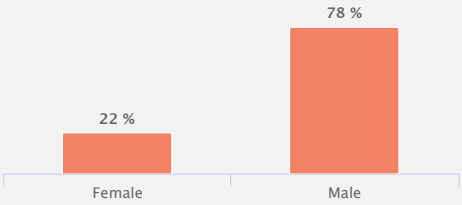
Drug-induced mortality rates among adults (15-64 years)



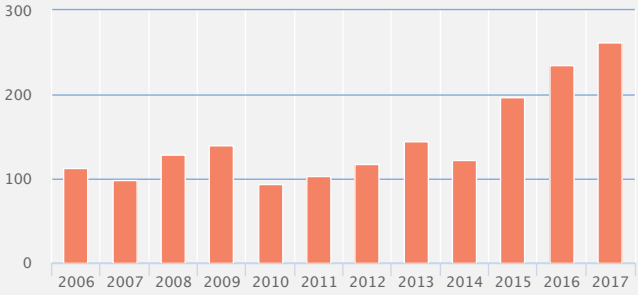
NB: Data from 2017, or the most recent year for which data are available. Comparisons between countries should be undertaken with caution. The reasons for this include systematic under-reporting in some countries, and different reporting systems, case definitions and registration processes. Data for Greece are for all ages.

Characteristics of and trends in drug-induced deaths in the Netherlands

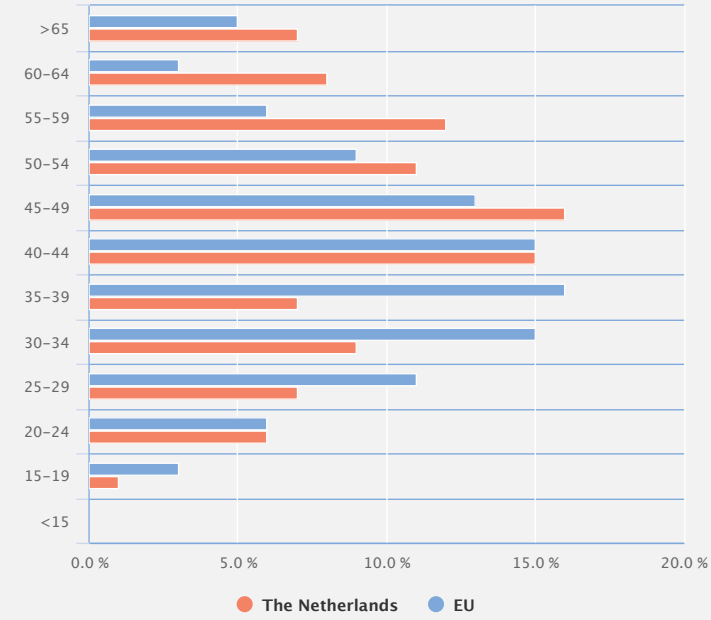
Gender distribution



Trends in the number of drug-induced deaths



Age distribution of deaths in 2017



NB: Year of data 2017

Prevention

Drug use prevention in the Netherlands is embedded in a broader perspective of a national prevention programme for 2014-16, which was renewed in May 2017. The Dutch drug use prevention policy primarily aims to discourage drug use and reduce the risks for drugs users themselves, for their families and for society as a whole. The national drug use prevention policy has been shaped along five objectives. In recent years, emphasis has been given to counteracting the normalisation of recreational drug use in nightlife settings.

Prevention activities are coordinated and funded mainly by the Ministry of Health, Welfare and Sport. Local municipalities are responsible for carrying out the prevention interventions and policies in close cooperation with schools, municipal care services, neighbourhood centres and other organisations involved in substance use prevention.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

In the Netherlands, environmental prevention activities are mainly concerned with regulating and controlling the availability of alcohol and tobacco. The enforcement of these measures is decentralised to municipalities.

Universal prevention is carried out in schools through the Healthy School and Drugs programme. This programme targets students from elementary school to vocational education, as well as parents and teachers. It was revised to increase its skill-focused components and to provide more intensive interventions on social norms, self-regulation and impulse control, and professional training for educational staff. Outside school settings, the project Alcohol and Drug Prevention at Clubs and Pubs aims to create a healthy and safe nightlife environment. Electronic media and new applications are increasingly used to provide information and counselling on drug-related issues.

In recent years, more attention has been given to selective prevention interventions in the Netherlands, although their availability largely depends on local policies. These interventions, carried out by non-governmental organisations in cooperation with government services, target various at-risk groups: parents with drug use problems and their children; frequent users of cannabis; tourists; young people with learning disabilities; young people from socio-economically deprived neighbourhoods or in special institutional settings; and young people in recreational settings. Projects in recreational settings focus on the implementation of safe clubbing regulations and person-to-person interventions. These initiatives have recently been complemented with additional interactive tools, campaigns, conferences and mobile applications such as the ‘Red Alert App’, through which recreational drug users can receive alerts about especially dangerous drugs on the market or find general information about drug-testing services. The government, healthcare providers and funding institutions support the involvement of social districts teams in universal and selective preventive mental health care to improve early detection; in several municipalities, teams are being trained to identify excessive alcohol or drug use.

In the indicated prevention area, activities also focus on early identification of substance use or dependence. Indicated prevention is mostly carried out by general practitioners or primary care assistant practitioners.

Harm reduction

Harm reduction is a central feature in the Dutch drug policy and is aimed at reducing drug-induced deaths and drug-related infectious diseases, as well as at preventing drug-related emergencies. Harm reduction services for users of traditional drugs (mainly heroin) consist of a combination of care and support, while services for recreational users focus on the prevention of drug-related health emergencies, including drug-related deaths. Methadone and heroin programmes, needle and syringe programmes (NSPs), supervised drug consumption rooms, sheltered living projects and treatment of drug-related infectious diseases are widely available for people with problem drug use patterns.

Harm reduction interventions

In the Netherlands, harm reduction activities are implemented through outreach work, low-threshold facilities and centres for 'social addiction care', the main goal of which is to establish and maintain contact with difficult-to-reach drug users.

Most outreach work is carried out by low-threshold services in outpatient care facilities. Drug consumption rooms offer the possibility of hygienic and supervised consumption. In 2018, there were 24 drug consumption rooms across 19 Dutch cities servicing people who inject drugs and those who smoke or inhale. At some Regional Institutes for Protected Living, the use of drugs is also tolerated. Outreach activities also feature in programmes for reducing drug-related public nuisance, which are a collaborative venture between treatment and care facilities, the police and civil groups.

NSPs were established in the Netherlands over 30 years ago and are available in all major cities. These programmes are mainly implemented by addiction care and some municipal health services, and syringes are available through street drug workers and at treatment centres. There is no national monitoring of the number of syringes and needles distributed. Available local data from Amsterdam and Rotterdam indicate a continuous decline in syringe provision between 2002 and 2017 to one fifth of the original number; the decline is attributed to a reduction in heroin use and injecting in general and an increase in the inhalant use of other substances such as crack cocaine.

In 2015, the new oral interferon-free direct-acting antiretroviral treatments for hepatitis C virus (HCV) infection became reimbursable. Such treatment is offered to all HCV patients, irrespective of the level of fibrosis. A comprehensive hepatitis plan was launched in 2016, and the Health Council advised that people who use drugs should actively be offered hepatitis B virus and HCV testing. Addiction care institutions were identified as the main players responsible for case finding in this risk group. Several projects implement chain of care pathways to lead HCV-positive drug users into treatment in hospital centres. In addition, retrieval projects in several parts of the country aim to find patients previously diagnosed with chronic HCV, including people who use drugs, to offer them treatment with direct-acting antiretroviral drugs.

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

The treatment system

The Dutch national drug treatment strategy places an emphasis on the empowerment of clients and their reintegration and self-regulation.

Responsibility for the organisation, implementation and coordination of addiction care in the Netherlands has been delegated to regional and local authorities and is part of the broader mental health care agenda. Drug treatment is provided by specialised addiction care organisations. Municipal public health services, general psychiatric hospitals, several religious organisations and some private clinics also offer care for people with substance use problems. Since the reorganisation of mental health care in 2014, drug treatment has been provided in a three-step approach: frontline support from a general practitioner or a general practice mental health worker, followed by generalist primary mental health care and specialised mental health care. Some treatment providers deliver inpatient treatment programmes.

In general, funding for drug treatment is provided by health insurance, while the public budget for social support at the national and local levels funds specific programmes, such as heroin-assisted treatment and supported living.

The options for drug treatment interventions in the Netherlands are diverse. Opioid substitution treatment (OST), complemented by psychosocial treatment, is the treatment of choice for opioid dependence, and OST with methadone has been available since 1968. Heroin-assisted treatment (HAT) is provided at 17 outpatient treatment units in 16 cities (668 treatment slots), while methadone-based treatment is available from various treatment providers, including office-based practitioners and mobile units. In case of gamma-hydroxybutyrate (GHB) dependence, treatment with medical GHB is available, and research is being done into relapse prevention by means of baclofen.

Available psychosocial treatments in drug treatment centres include motivational interviewing, relapse prevention techniques, cognitive-behavioural therapies, and family, community and home-based therapies. New treatment options have been introduced for young cannabis users, people with multiple (dependencies and mental health) problems, crack cocaine users and GHB users. In addition, new treatment settings for homeless drug users in several municipalities have been developed.

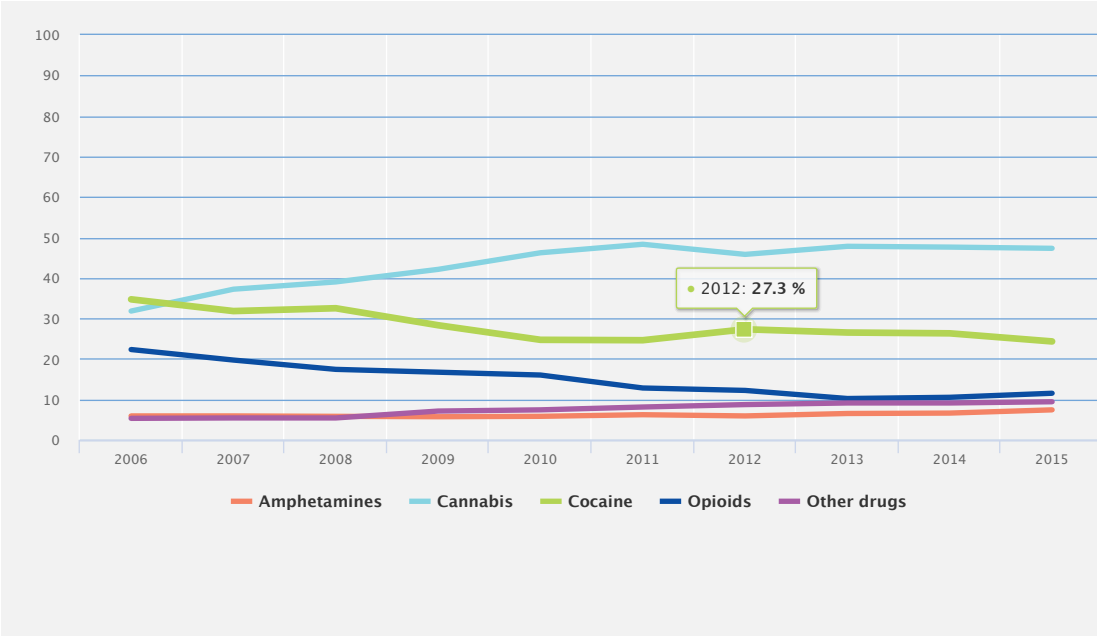
Treatment provision

In 2015, more than 31 000 people received drug treatment in the Netherlands, mainly in outpatient settings. Around one third of them were treated for primary cannabis use, while opioid users constituted the second largest group of treatment clients, followed by cocaine users.

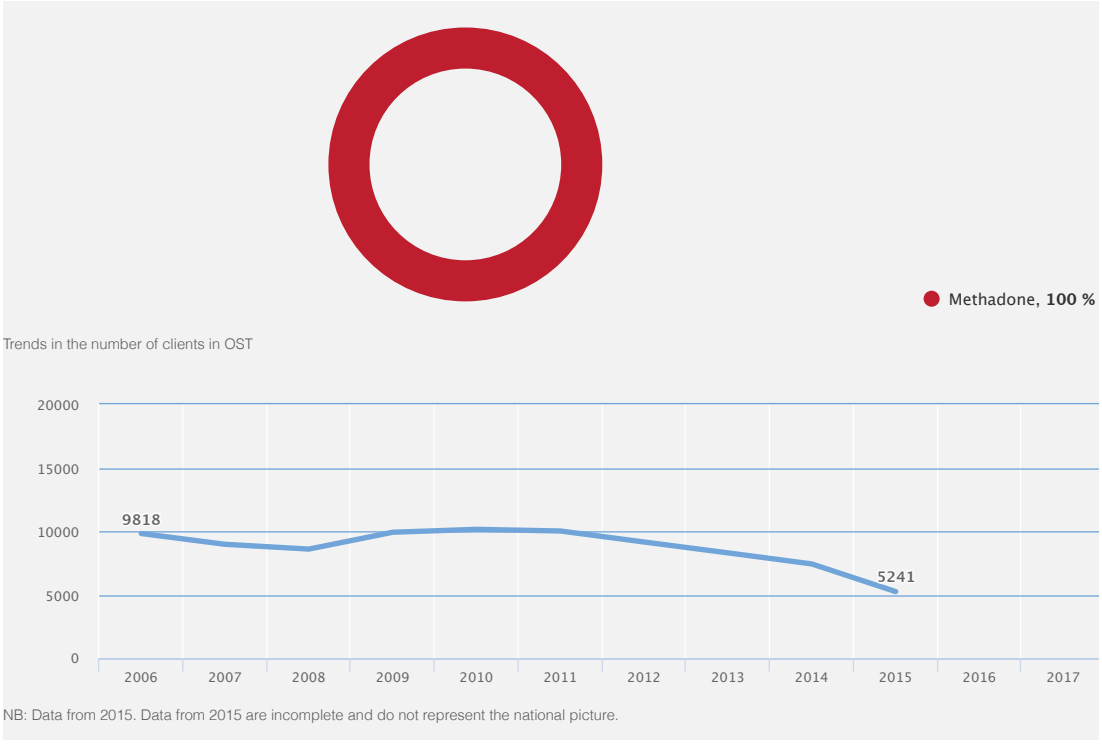
Cannabis users also formed the largest group among those who entered treatment in 2015. Primary cocaine users were the second largest group, followed by primary opioid users.

Fewer than 2 out of 10 treated opioid users entered treatment in 2015, and most were already in long-term treatment programmes, such as OST. Moreover, the number of new treatment entries attributable to opioid use has reduced and the mean age of opioid treatment clients has increased, indicating an ageing of the opioid-using population in the Netherlands. According to the latest available data, in 2014, close to 7 500 clients received OST, a large decrease from 2011. It should be noted that the steep decrease after 2011 is probably related to changes in registration. All OST clients were treated in methadone maintenance programmes, some of which also received heroin-assisted treatment.

Trends in percentage of clients entering specialised drug treatment, by primary drug, in the Netherlands



Opioid substitution treatment in the Netherlands: proportions of clients in OST by medication and trends of the total number of clients



NB: Data from 2015. Data from 2015 are incomplete and do not represent the national picture.

Drug use and responses in prison

More than one fifth of around 26 000 inmates entering the regular prison system in 2017 were imprisoned for a drug-related crime. However, drug users are predominantly imprisoned for other types of offences than drug dealing, such as property crimes. A recent study shows that less than 20 % of prisoners have a serious drug dependency.

In general, the prison system seeks to discourage the use of drugs by creating drug-free settings and limiting the availability and use of drugs in prisons. Continuity of care and equivalent access to health services are basic principles of the treatment of prisoners.

The Ministry of Justice and Security oversees health services in prisons and funds drug treatment in prisons. Drug treatment in prisons includes behavioural intervention and mental care services. Every prisoner is screened for health and social issues, including dependency problems. Prisoners can be referred to treatment services outside prison, as an alternative to imprisonment. Repeat offenders who exhibit drug use problems on prison entry may be placed in an Institution for Prolific Offenders, which also offers several treatment interventions inside and outside the prison system. The guidelines on 'medical treatment of detained opiate addicts' stipulate that inmates who were receiving methadone maintenance treatment prior to incarceration can continue their treatment in prison. Special treatment for those dependent on benzodiazepines or gamma-hydroxybutyrate (GHB) is available. Naloxone is available in every prison to reverse opioid-related overdoses.

After release from prison, treatment and care services continue to be implemented by municipalities. Addiction probation often plays a supervising and helping role in this process. 'Safety houses' are networks of local organisations working together to reduce crime. To better combine and integrate penal and rehabilitative interventions for offenders, criminal justice organisations cooperate with municipalities, the social sector and care organisations.

Since 2015, prison staff have been trained to improve their knowledge about substances and dependencies. Recently, efforts have been developed to improve the cooperation between penitentiary institutions and regular addiction care; in every penitentiary institution a contact person for drug dependency is appointed. The use of care outside prison is promoted.

Quality assurance

Dutch national policy envisages that all treatment interventions, irrespective of their provision, should be evidence based and comply with prevailing guidelines. Together with the institutes for mental health care, the institutes for addiction care are organised within the Dutch Association of Mental Health and Addiction Care (GGZ Nederland), which supports the quality management of addiction care by means of the programme 'Scoring Results' (Resultaten Scoren). In 2017, the Dutch Addiction Association (DAA, Verslavingskunde Nederland) was established, a network that includes institutes for addiction care, client organisations, knowledge centres, and the GGZ Nederland and Resultaten Scoren. The DAA attempts to enhance the quality of addiction care in the Netherlands. The development of quality standards and registrations is partly performed by the Foundation Quality Standards Mental Health Care. This foundation developed and published guidelines for the treatment of opioid addiction (2017) and guidelines for the treatment of non-opioid drug abuse (2018).

The national infrastructure for the governance and coordination of the implementation of best practices comprises the Minister and the State Secretary for Health, Welfare and Sport (VWS), who is advised by GGZ Nederland, the National Health Care Institute (Zorginstituut Nederland) and the Trimbos Institute.

In addition, the Minister and the State Secretary can initiate the development of quality standards and guidelines for best practices by the DAA and the Quality Institute. These quality standards and guidelines are implemented by the health insurance companies so that only qualified evidence-based best practices are funded. The Dutch Healthcare Authority (NZa) and the Healthcare Inspectorate (IGZ) monitor the implementation of the best practices. The accreditation system is operated by the CIBG Agency, an executive organisation within the VWS. Every professional working in the healthcare sector and in contact with patients has to be registered at the 'BIG registry'. As of 1 January 2017, all providers of mental health care are obliged to disclose a quality statute. This statute will be reviewed by a board every 2 years.

Academic curricula, continuing education programmes and refresher courses for professionals are offered by universities and institutes for higher education, and degrees can be obtained at BSc and MSc levels. There is a specific master's degree in Addiction Medicine at Radboud University.

Drug-related research

Drug research in the Netherlands is extensive and covers many domains. Public funding of drug-related research is mainly delegated to intermediary agencies, although ministries and municipalities also directly fund research projects. The Ministry of Justice and Security has a special department for conducting and funding social and statistical research, the Research and Documentation Centre (Wetenschappelijk Onderzoek en Documentatie Centrum (WODC)). The WODC funds large and smaller research projects mostly on drug policy and drug supply, which are carried out by different institutes and universities. Fundamental university research is funded by the Netherlands Organisation for Scientific Research. Many academic institutions are involved in drug research, sometimes in collaboration with researchers from institutes for addiction care. Conferences and training courses are organised every year for drug researchers to stay informed about recent developments.

Researchers from the Netherlands publish their work in national and international scientific journals. Research findings are translated into practice through multidisciplinary evidence-based guidelines, protocols and training materials. Reports on research findings are disseminated through various websites, such as those of the Trimbos Institute, Foundation Scoring Results and the Dutch Association of Practitioners of Addiction Medicine, and the WODC.

Recent drug-related studies mainly focus on aspects related to the consequences of drug use, responses to the drug situation and prevalence, incidence and patterns of drug use. Studies on the mechanisms of drug use and their effects, methodology issues, and supply and markets are also carried out. The Ministry of Justice and Security and the WODC in particular fund research carried out by various universities. The WODC also conducts research (focusing on monitoring of organised crime and criminal recidivism of offenders).

The Netherlands Organisation for Health Research and Development coordinates the European Research Area Network on Illicit Drugs (ERANID). Dutch researchers are involved in seven EU research consortia.

Drug markets

The Netherlands is known to be a country of domestic production (and export) of cannabis and synthetic drugs and a transit country for cocaine and heroin. Cannabis cultivation occurs mainly indoors, and only a small number of open-air sites have been dismantled and reported. In 2017, almost 4 700 cannabis plantations were dismantled, fewer than in 2016. Domestically cultivated cannabis and synthetic drugs produced in the Netherlands are exported to foreign markets.

The number of synthetic drug production labs reported to be dismantled has increased in recent years, and a similar trend has occurred with regard to storage places and dumping sites for chemicals used in the production of synthetic drugs. While most of the dismantled laboratories were involved in the production of amphetamine and MDMA/ecstasy and/or the conversion of precursors for the production processes, methamphetamine and, most recently, possible new psychoactive substances production activity have also been reported, albeit on a small scale.

In 2017, several production facilities for heroin were dismantled. The production of heroin in the Netherlands is a new phenomenon. The Netherlands is primarily a transit country for both heroin and cocaine. Heroin mainly originates from Afghanistan and is trafficked to the Netherlands via the Balkan route. Cocaine originating in South America is most commonly shipped directly from Central American countries by sea and, to a lesser extent, by air.

In recent years, drug trade over the internet has emerged as a new business model. With the amount of illicit drug trafficking on the darknet increasing, a considerable number of vendors reportedly operate from the Netherlands.

Tackling and counteracting organised crime groups involved in the production and trafficking of ‘established’ illicit drugs is the key priority in the Netherlands. Specialised police units deal with investigative and enforcement activities related to cannabis cultivation and the production of synthetic drugs, as well as with money laundering linked to the illicit drug trade. To address international drug-related crime, the Netherlands has developed close cooperation or joint actions with neighbouring countries.

Data on the purity of the main illicit substances seized are shown in the ‘Key statistics’ section.

Drug seizures in the Netherlands: quantities seized

NB: Data from 2017. There are no data available on the number of seizures. Data on quantity of seizures do not include all relevant law enforcement units and should be considered partial, minimum figures. Cocaine seizures are assumed to represent the majority of large seizures. Further details on the scope of supply data may be found in the methodological note.

Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	22.37	6.51	36.79
Last year prevalence of use — young adults (%)	2017	17.5	1.8	21.8
Last year prevalence of drug use — all adults (%)	2017	9.2	0.9	11
All treatment entrants (%)	2015	47.3	1.03	62.98
First-time treatment entrants (%)	2015	55.5	2.3	74.36
Quantity of herbal cannabis seized (kg)	2017	3 104	11.98	94 378.74
Number of herbal cannabis seizures	n.a.	n.a.	57	151 968
Quantity of cannabis resin seized (kg)	2017	942	0.16	334 919
Number of cannabis resin seizures	n.a.	n.a.	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	2017	2.5 - 11.8	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	2017	7.9 - 44.8	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.94	0.85	4.85
Last year prevalence of use — young adults (%)	2017	4.5	0.1	4.7
Last year prevalence of drug use — all adults (%)	2017	2.2	0.1	2.7
All treatment entrants (%)	2015	24.3	0.14	39.2
First-time treatment entrants (%)	2015	20.8	0	41.81
Quantity of cocaine seized (kg)	2017	14 629	0.32	44 751.85
Number of cocaine seizures	n.a.	n.a.	9	42 206
Purity (%) (minimum and maximum values registered)	2017	1 - 89	0	100
Price per gram (EUR) (minimum and maximum values registered)	n.a.	n.a.	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.41	0.84	6.46
Last year prevalence of use — young adults (%)	2017	3.9	0	3.9
Last year prevalence of drug use — all adults (%)	2017	1.8	0	1.8
All treatment entrants (%)	2015	7.4	0	49.61
First-time treatment entrants (%)	2015	7.5	0	52.83
Quantity of amphetamine seized (kg)	2017	122	0	1 669.42
Number of amphetamine seizures	n.a.	n.a.	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	2017	15 - 75	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	n.a.	n.a.	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	3.1	0.54	5.17
Last year prevalence of use — young adults (%)	2017	7.1	0.2	7.1
Last year prevalence of drug use — all adults (%)	2017	3.3	0.1	3.3
All treatment entrants (%)	2015	0.7	0	2.31
First-time treatment entrants (%)	2015	1	0	2.85
Quantity of MDMA seized (tablets)	2017	n.a.	159	8 606 765
Number of MDMA seizures	n.a.	n.a.	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2017	2 - 278	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	n.a.	n.a.	1	40
Opioids				
High-risk opioid use (rate/1 000)	2012	1.26	0.48	8.42
All treatment entrants (%)	2015	11.5	3.99	93.45
First-time treatment entrants (%)	2015	6.2	1.8	87.36
Quantity of heroin seized (kg)	2017	1 110	0.01	17 385.18
Number of heroin seizures	n.a.	n.a.	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	2017	16 - 78	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	n.a.	n.a.	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	0.1	0	47.8
HIV prevalence among PWID* (%)	2017	n.a.	0	31.1
HCV prevalence among PWID* (%)	2017	n.a.	14.7	81.5
Injecting drug use (cases rate/1 000 population)	2015	0.08	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2017	21.81	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	n.a.	n.a.	245	11 907 416

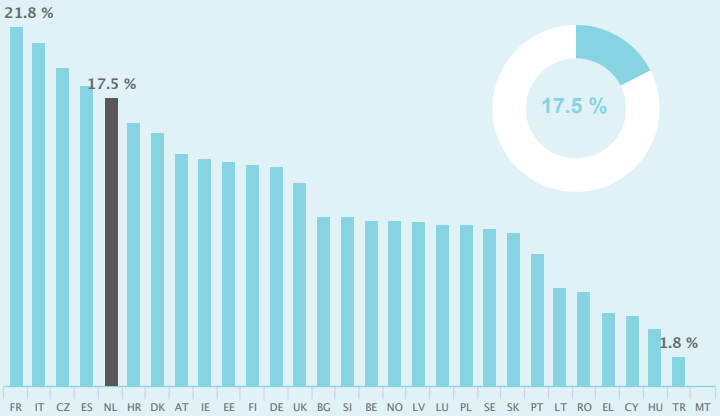
Clients in substitution treatment	2015	5 241	209	178 665
Treatment demand				
All entrants	2015	10 987	179	118 342
First-time entrants	2015	6 529	48	37 577
All clients in treatment	2015	31 115	1 294	254 000
Drug law offences				
Number of reports of offences	2017	18 687	739	389 229
Offences for use/possession	n.a.	n.a.	130	376 282

There are no data available on the number of seizures. Data on quantity of seizures do not include all relevant law enforcement units and should be considered partial, minimum figures. Cocaine seizures are assumed to represent the majority of large seizures. Further details on the scope of supply data may be found in the methodological note . The potency - Herbal (% THC) refers to imported cannabis; the purity of domestic grown weed, also called Nederwiet ranges between min. 4, max. 57 and purity of domestic grown Hashish, also called Nederhasj ranges between min. 0.8, max. 60.4. Mean price per gram of herbal cannabis is estimated at € 4.04, and the mean price of cannabis resin at € 9.43. Purity amphetamines correspond to FT-IR results. The number of Clients in opioid substitution treatment is incomplete and does not represent the national picture.

EU Dashboard

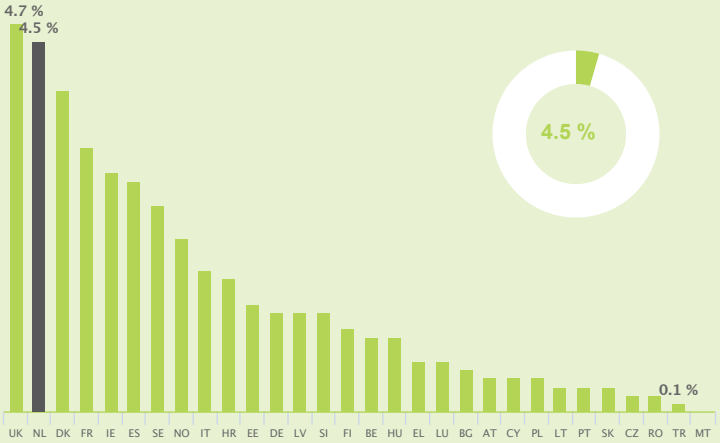
Cannabis

Last year prevalence among young adults (15-34 years)



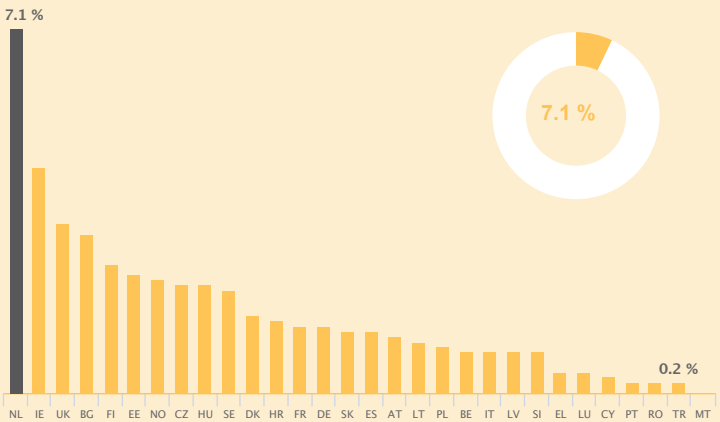
Cocaine

Last year prevalence among young adults (15-34 years)



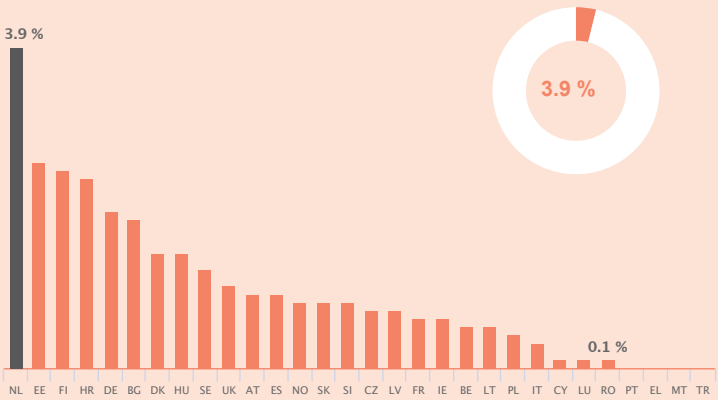
MDMA

Last year prevalence among young adults (15-34 years)



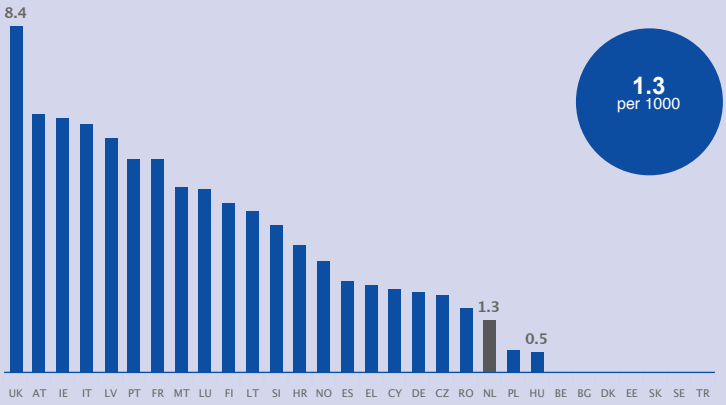
Amphetamines

Last year prevalence among young adults (15-34 years)



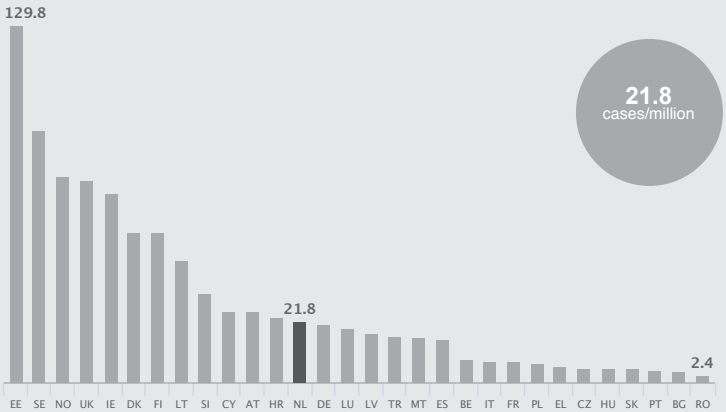
Opioids

High-risk opioid use (rate/1 000)



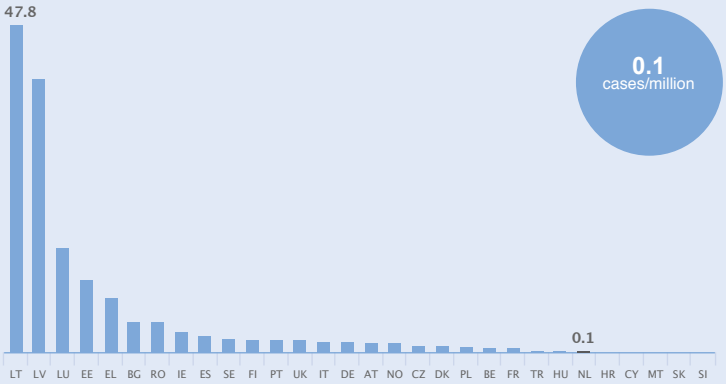
Drug-induced mortality rates

National estimates among adults (15-64 years)



HIV infections

Newly diagnosed cases attributed to injecting drug use



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in the Netherlands

The national focal point in the Netherlands is located within the National Drug Monitor, which was established in 1999 by the Minister of Health, Welfare and Sport in order to evaluate and review registration and survey research data at the national level and to report these data to the Lower Chamber of Parliament, concerned ministries and other stakeholders both nationally and internationally. The national focal point is part of the Drug Monitoring and Policy Department of the Trimbos Institute, the national research institute for mental health care, addiction care and social work, which is tasked with informing policymakers and politicians about the mental health issues that concern the Dutch population. There is close collaboration with the Research and Documentation Centre of the Ministry of Security and Justice.

Click here to learn more about our partner in the Netherlands .

Dutch national focal point

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Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin .