European Monitoring Centre for Drugs and Drug Addiction

Trimbos instituut
Netherlands Institute of Mental Health and Addiction

Wetenschappelijk Onderzoek- en Documentatiecentrum
Ministerie van Veiligheid en Justitie

Netherlands

Country Drug Report 2017

THE DRUG PROBLEM IN THE NETHERLANDS AT A GLANCE

Drug use

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

Cannabis

16.1 %

10.8 % 21.3 %

Other drugs

MDMA	6.6 %
Cocaine	3.6 %
Amphetamines	3.1 %

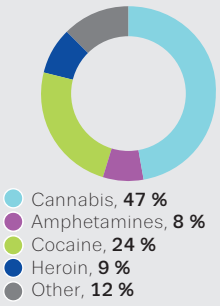
High-risk opioid users

14 000

(12 700 - 16 300)

Treatment entrants

by primary drug



Opioid substitution treatment clients

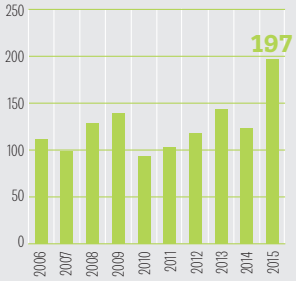
7 421

Syringes distributed

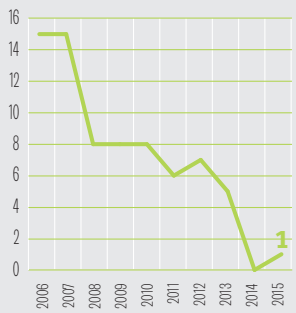
through specialised programmes

237 400

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

20 503

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

11 065 975

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, 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.

About this report

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 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

National drug strategy and coordination

National drug strategy

According to the Opium Act Directive, 'The [new] 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).

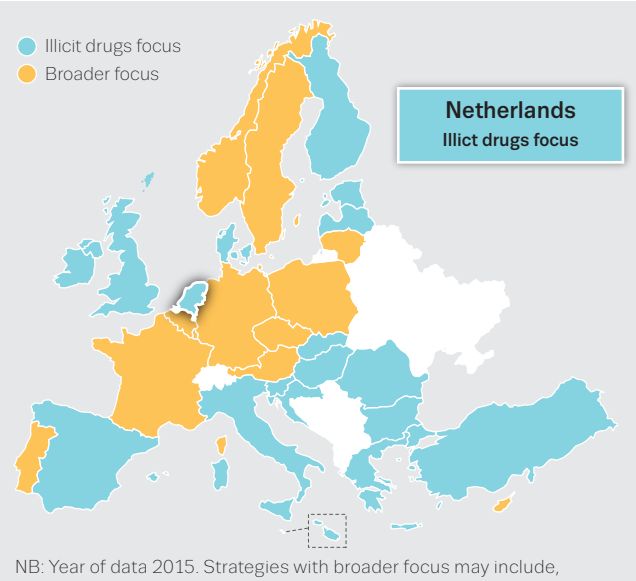
The 1995 white paper 'Drug policy: continuity and change' set out the principles of the Dutch illicit drugs policy. Taking a balanced approach, it continued the distinction between 'soft' (List II) and 'hard' (List I) drugs. It outlined four major objectives: (i) to prevent drug use and to treat and 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 different 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 youth and nightlife (2015) (Figure 1).

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. Though still a criminal offence, the sale of small quantities is condoned if shops adhere to the 'AHOJ-G' criteria (rules and limits on advertising, sales of 'hard' drugs, nuisance, the sales to under aged customers, and personal transaction size and stock limits for the coffee shop in grams).

Like other European countries, the Netherlands regularly evaluates its drug policy and specific issues using routine indicator monitoring and specific research projects. Additionally, in 2009, an external evaluation of the 1995 white paper was completed by the Trimbos Institute.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs 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 Security and Justice is responsible for law enforcement and matters relating to local government and the police. The Ministry of Foreign Affairs is in charge of some other issues, including matters relating to human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), and injecting drug use, on behalf of the government at the international level. Regular coordination takes place through meetings between drug policy managers at the ministries.

Dutch drugs policy aims to discourage and reduce drug use, as 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

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy.

In the Netherlands, no budget is associated with the drug policy documents and there is no review of executed expenditures. In 2006, the results of a study that aimed to estimate overall drug-related public expenditures in the Netherlands was published.

The study estimated that in 2003 total drug-related public expenditures represented 0.5 % of gross domestic product (GDP). Most of the expenditures were attributed to law enforcement (75 %) and the remainder to treatment (13 %), harm reduction (10 %) and prevention (2 %).

The available data do not enable the total drug-related public expenditure in the Netherlands in recent years or trends in spending to be reported.

Drug laws and drug law offences

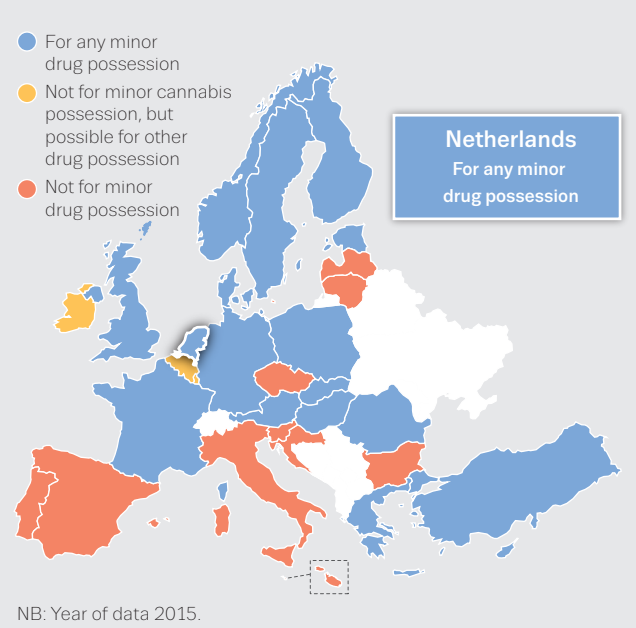
National drug laws

The Netherlands Opium Act, which came into force in 1928 and was fundamentally amended in 1976, 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 List I drugs (e.g. heroin, cocaine, MDMA/ecstasy, amphetamines) and List II drugs (e.g. cannabis, hallucinogenic mushrooms). In 2012, it was proposed that cannabis containing more than 15 % tetrahydrocannabinol (THC) should be placed in List I, but this has not yet been implemented. Furthermore, criteria defining the 'professional cultivation of cannabis' for prosecution purposes were also revised in the Opium Act Directive. New psychoactive substances (NPS) are regulated through amendments to relevant schedules of the Opium Act.

Drug use as such does not constitute a crime in legal terms. However, 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 not subject to targeted investigation by the police. Anyone found in possession of less than 0.5 g of List I drugs will generally not be prosecuted, though the police will confiscate the drugs and refer the individual to a care agency. The threshold amount for cannabis is set at 5 g. However, in 2012, the Opium Act Directive was revised so that, instead of saying 'a police dismissal should follow if a cannabis user is caught with less than 5 grams of cannabis', it now states that 'in principle a police dismissal will follow if a person is carrying less than 5 grams of cannabis'. This leaves open the possibility of arresting and prosecuting individuals in possession of less than 5 g of cannabis in certain circumstances (Figure 2).

FIGURE 2

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



NB: Year of data 2015.

In 2015, a total of 20 503 offences against the Opium Act were registered by the public prosecutor

Drug users are convicted when they have committed a crime such as selling drugs, theft or burglary. A special law — the Placement in an Institution for Prolific Offenders — was introduced in 2004 for the treatment of persistent offenders, of which problematic 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 sets out that supplying drugs (possession, cultivation or manufacture, import or export) is punishable, depending on the quantity and type of drug involved, by up to 12 years' imprisonment. However, the Opium Act Directive sets out strict conditions under which cannabis sales and consumption outlets, known as 'coffee shops', may be tolerated by local authorities. In 2014, there were 591 coffees hops in the Netherlands.

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 2015, a total of 20 503 offences against the Opium Act were registered by the public prosecutor, fewer than in 2014. Slightly more than half of all reports were linked to List II drugs. The majority of offences related to List I was linked to possession.

Drug use

Prevalence and trends

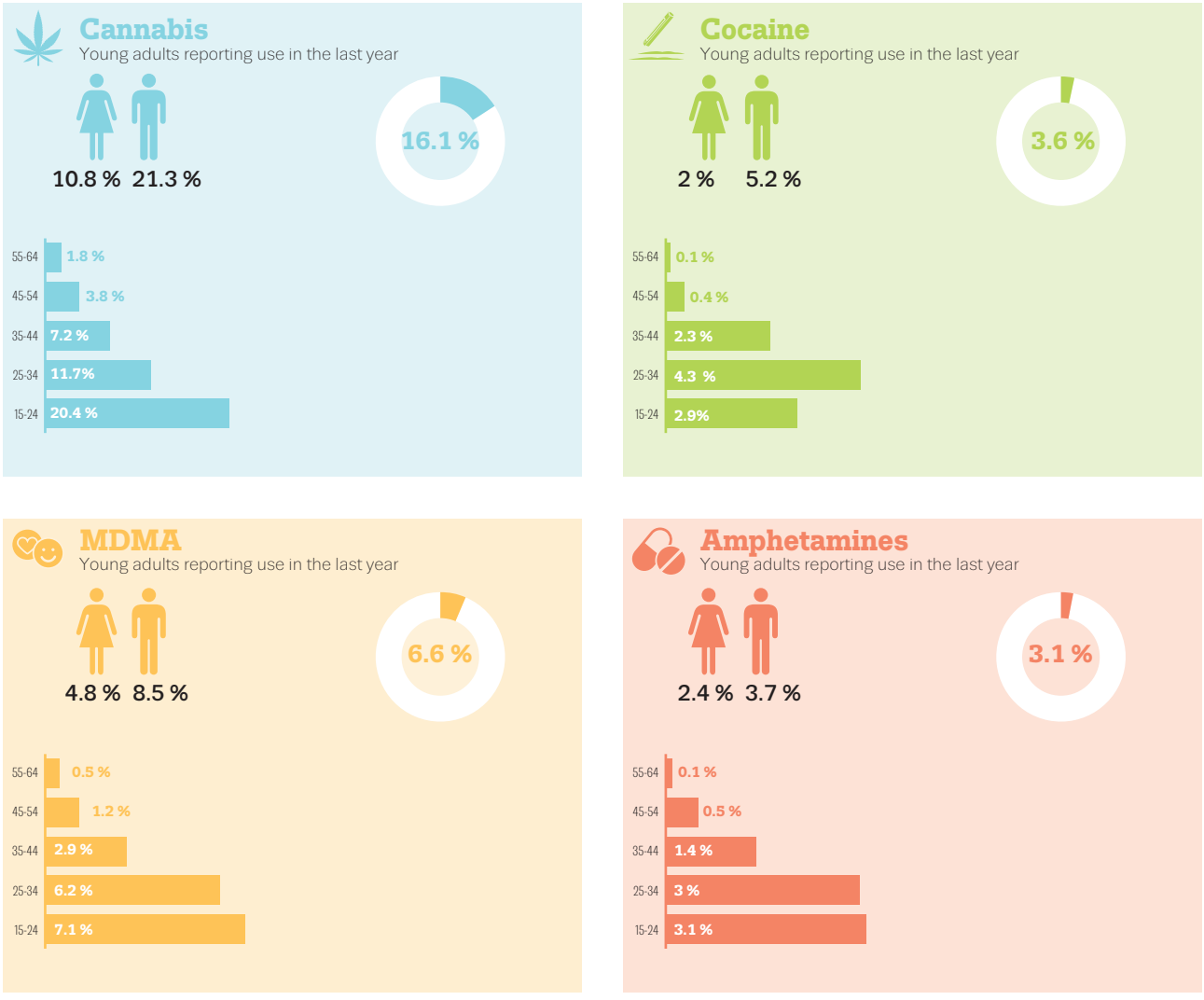
Cannabis is the most common illicit substance used by the Dutch adult general population aged 15-64 years, followed at a distance by MDMA and cocaine. The use of all illicit drugs is concentrated among young adults aged 15-34 years. The gender gap regarding cannabis use remains wide: last-year prevalence of cannabis use among young adults was approximately 1.5 times higher among males than among females, while last-year cocaine use is reported to have been three times higher among young males than among females. In 2015, levels of last-month cannabis use and last-year and last-month MDMA use among the general population aged 15-64 years were higher than in 2014.

Prevalence data from 2014 and 2015 studies are not comparable to those of previous years owing to methodological changes in the latest surveys; however, there are some indications that MDMA use has increased in recent years (Figure 3).

Eindhoven and Utrecht have participated in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a community level, based on the levels of different illicit drugs and their metabolites in a source of wastewater. These data complement the results from population surveys; however, wastewater analysis reports on collective consumption of pure substances within a community, and the results are not directly comparable to prevalence estimates from population surveys. Regarding stimulants, the results indicate an increase in cocaine use in these two cities between 2015 and 2016. Levels of MDMA and cocaine metabolite were higher at weekends than on weekdays. Use of both substances seems to be more common in Eindhoven than in Utrecht. In 2016, methamphetamine levels detected were low, indicating its limited use in both cities.

FIGURE 3

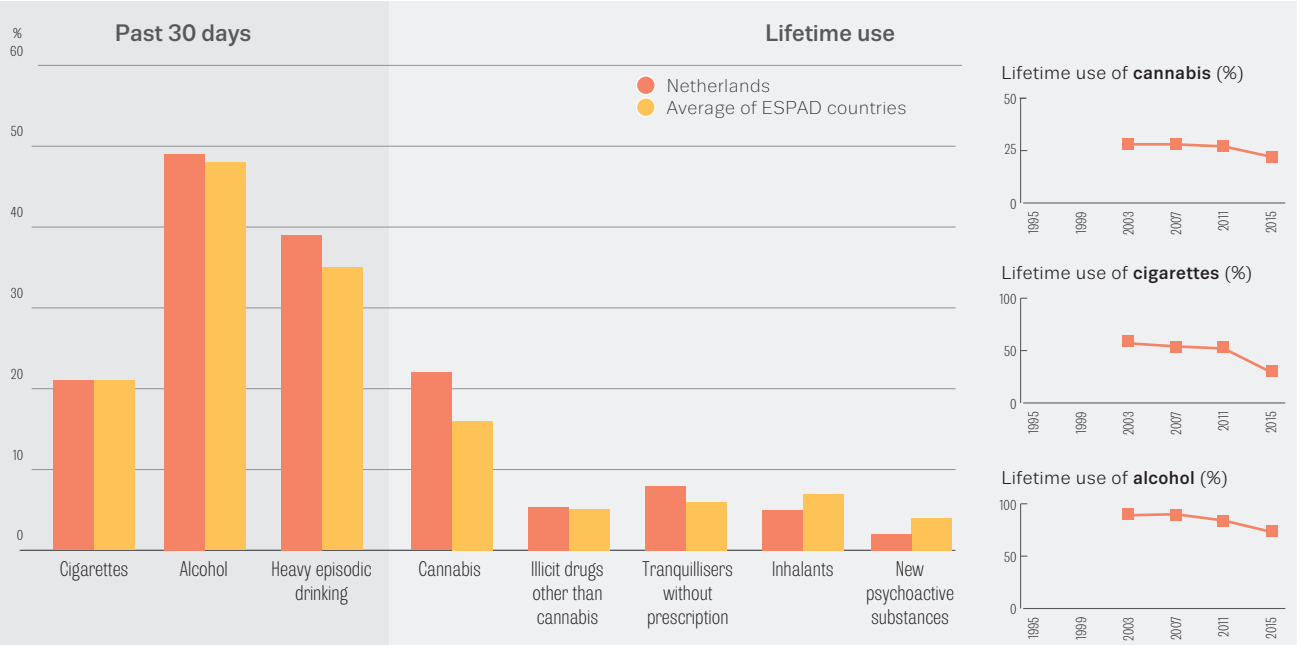
Estimates of last-year drug use among young adults (15-34 years) in the Netherlands



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 4

Substance use among 15- to 16- year-old school students in the Netherlands



Source: ESPAD study 2015.

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, among students in the Netherlands reported lifetime use of cannabis was notably higher than the ESPAD average (based on data from 35 countries) in 2015. Lifetime use of illicit drugs other than cannabis and lifetime use of NPS, however, were more or less in line with the ESPAD average (Figure 4).

Studies among other sub-groups of young people indicate that the use of illicit substances is more common in recreational settings and at music festivals, with cannabis and MDMA being the most popular substances used. Moreover, prevalence of some NPS, such as 4-fluoramphetamine (4-FA), is also gaining popularity among this sub-group and use levels are now similar to those of amphetamine and cocaine, although use of other NPS remains low.

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 the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 6).

In the Netherlands, high-risk drug use is mainly linked to use of heroin or crack cocaine. The most recent estimate of the high-risk opioid user population suggested that there were approximately 14 000 high-risk opioid users in 2012 (Figure 5). Available data indicate a decline in the estimated number of opioid users in the last decade, which coincides with the ageing of the opioid user population and the low popularity of opioids among younger drug users. Many high-risk drug users, including opioid users, use crack cocaine and a range of other licit and illicit substances. Although an estimate of crack cocaine users in the Netherlands is not yet available, sub-national studies indicate that the population of crack cocaine users in the Netherlands might be even larger than the population of opioid users.

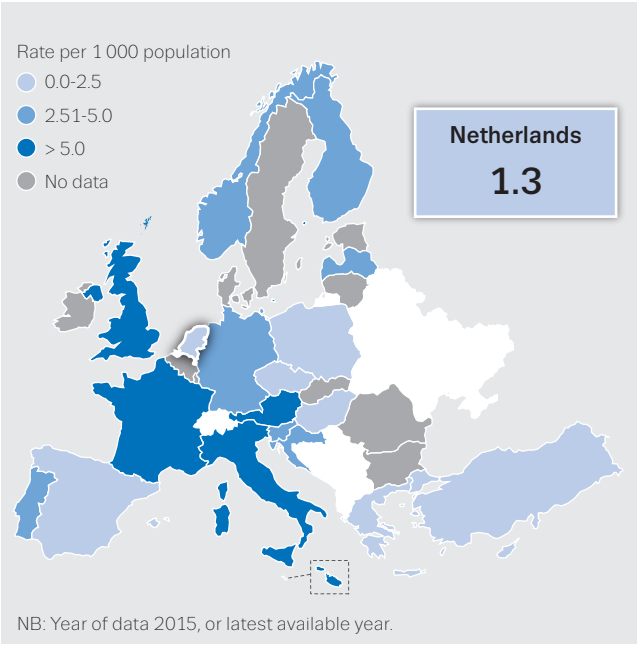
In 2015, a general population survey estimated that 1.5 % of 15- to 64-year-olds in the Netherlands had used cannabis daily or almost daily within the last 30 days, which is an indication of risky use.

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 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 in the past decade.

The number of primary heroin users requiring treatment for the first time declined between 2007 and 2013, while an upward trend has been noted since 2013. Overall, heroin users entering treatment are older than other treatment clients (Figure 6). Injecting drug use is rare among those entering treatment.

FIGURE 5

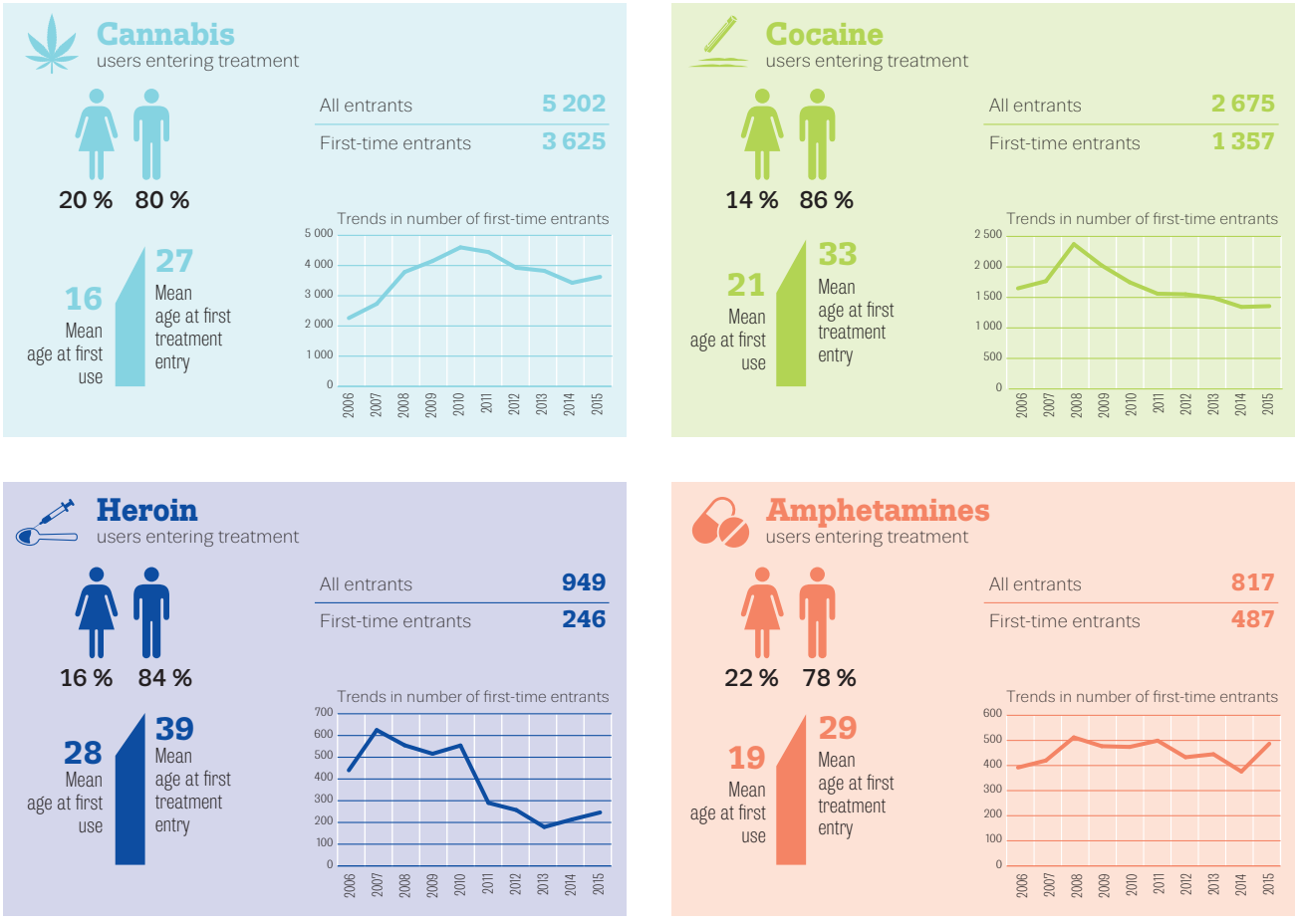
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 6

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



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

Drug-related infectious diseases

The available data suggest that the incidence of HIV, hepatitis B virus (HBV) and hepatitis C virus (HCV) infections among people who inject drugs (PWID) has remained at low levels in the Netherlands; however, prevalence of HCV among this group is higher than in the general population, and it remains the most common drug-related infection in the country (Figures 7 and 8).

A recent study estimated that fewer than one third of the 28 000 people with chronic HCV infection had ever injected drugs. In recent years, men who have sex with men (MSM) and who inject crystal methamphetamine (slamming) are increasingly seen as a high-risk group with regard to new HCV infections. This pattern has been reported for Amsterdam in particular.

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 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, although the prevalence of chronic HBV among PWID is approximately 3-4 %, which is higher than in the Dutch general population. It is estimated that 420-560 opioid users have chronic HBV infection.

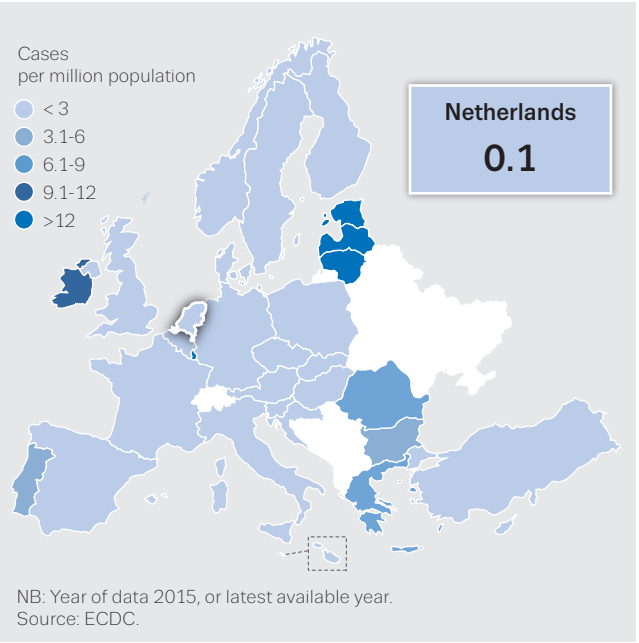
Drug-related emergencies

Although national data on absolute numbers of emergencies are not available, the 'Monitor drug-related emergencies' 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. The coverage of the data collection has changed over the years and remains incomplete. An injury information system collects data from the emergency departments of 14 hospitals.

In 2015, a total of 4 023 drug-related emergencies were registered by the Monitor, while the injury information system recorded 638 cases. At festivals, emergencies are predominantly related to the use of MDMA. Although the proportion decreased in 2015, it remains the case that approximately one third of affected individuals were reported to be moderately intoxicated. Emergency cases involving more than one illicit or licit substance have been reported increasingly frequently. Since 2012, emergencies linked to 4-FA have increased substantially, and the drug is often used in combination with other substances.

FIGURE 7

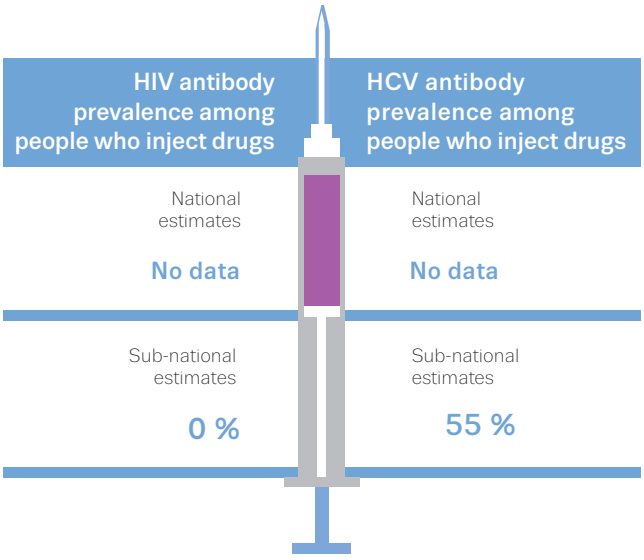
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 8

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

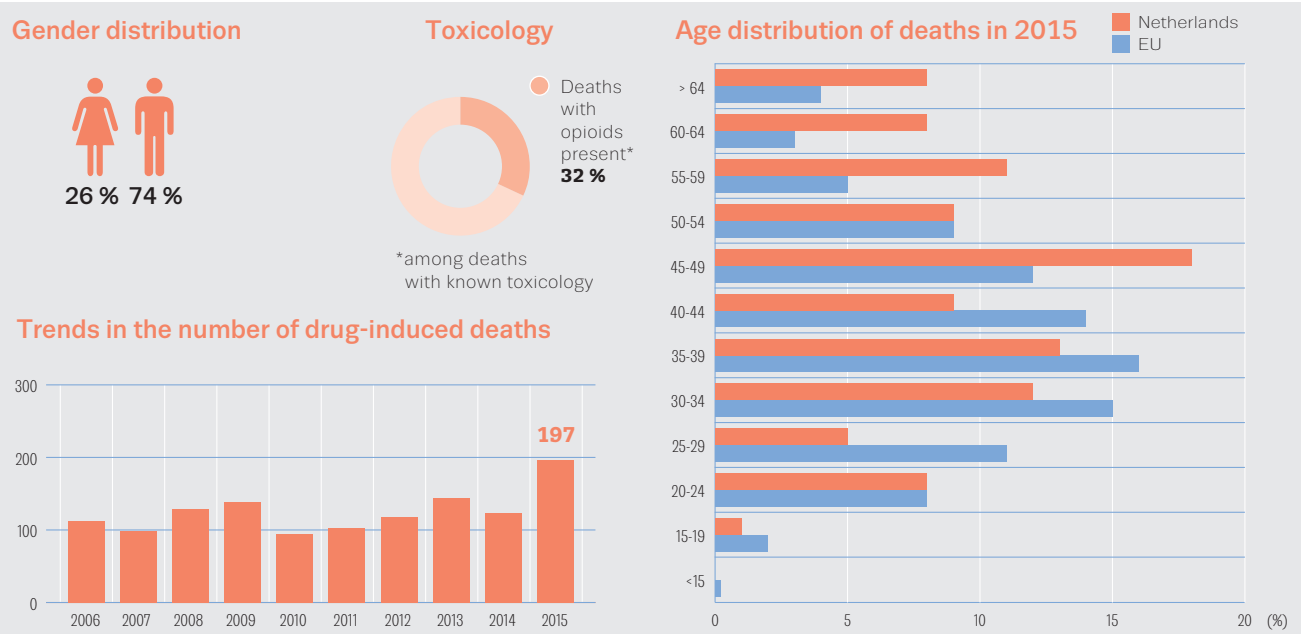


NB: Year of data 2015.

Ketamine intoxications do not form a large proportion in the Monitor, but, in 2015, a small increase was noted, as well as an increase in the severity of gamma-hydroxybutyric acid (GHB) intoxications.

FIGURE 9

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



NB: Year of data 2015.

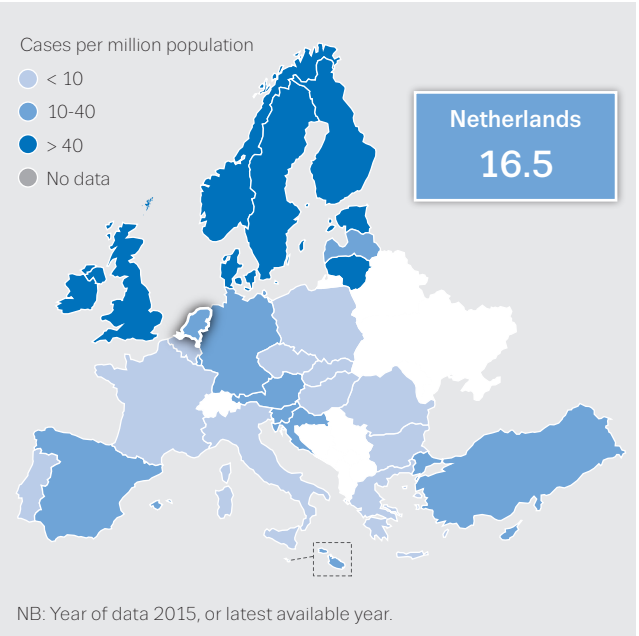
Drug-induced deaths and mortality

In 2015, the general mortality register reported an increase in the number of drug-induced deaths in the Netherlands. The deaths were attributed to opioids in 64 cases, and to cocaine in 40 cases, while in approximately half of cases another substance was involved. The majority of victims were male, and most were aged 40 years or older. The data indicate that there was an increase in deaths linked to all substances, and among both males and females; however, the reasons for the rise in the number of drug-induced deaths remain unclear (Figure 9). Some changes in the registration process of drug-induced deaths in the Netherlands were introduced between 2012 and 2013.

The drug-induced mortality rate among adults (aged 15-64 years) was 16.5 deaths per million in 2015 (Figure 10), remaining, despite the recent increase, lower than the most recent European average of 20.3 deaths per million.

FIGURE 10

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



NB: Year of data 2015, or latest available year.

Prevention

Drug use prevention in the Netherlands is embedded in a broader perspective of a national prevention programme for 2014-16. In the programme, priority is given to high-risk groups and young people; activities in recreational settings, especially those tackling the use of illicit and licit substances, predominate. A new development in the area of prevention is a focus on 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. However, local municipalities are responsible for carrying out the prevention interventions and policies in close cooperation with schools, municipal care services, neighbourhood centres, other organisations involved in substance use prevention and national health promoting institutes.

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 drug 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, with municipalities having an important role in defining regulations.

Universal prevention is carried out in secondary schools through the Healthy School and Drugs programme. Following an evaluation in 2014, the programme was revised to increase the skill-focused components and to provide more intensive interventions on social norms, self-regulation and impulse control, and professional training for educational staff. A Swedish programme, Preventing Heavy Alcohol Use in Adolescents (the Örebro programme), has been effectively implemented in the Netherlands under the name PAS (Figure 11).

Outside school settings, the project Alcohol and Drug Prevention at Clubs and Pubs aims to create a healthy and safe nightlife environment using a healthy settings approach. The focus is on reducing the high-risk use of substances among young people and its related problems. Electronic media and new applications are increasingly used to provide information and counselling on drug-related issues, for example the Drugs Information Line.

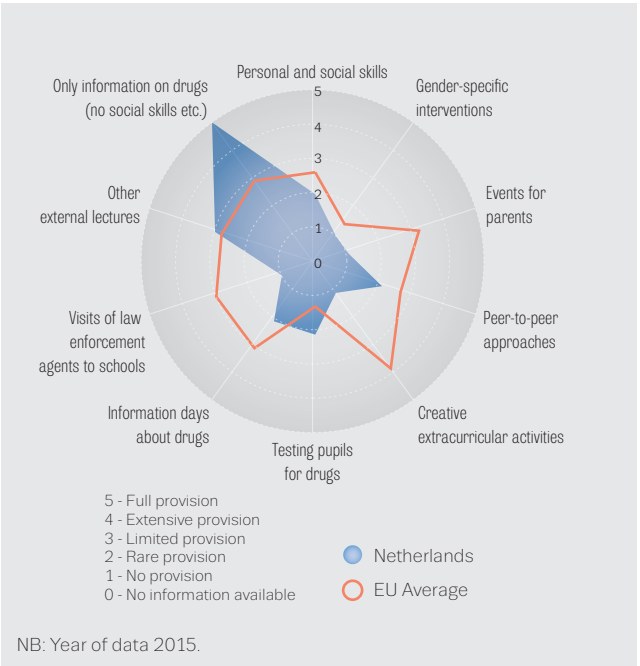
In recent years, more attention has been given to a shift towards selective prevention interventions, although their availability largely depends on the local policies.

These interventions, carried out by non-governmental organisations (NGOs) in cooperation with government services, are mostly targeted at the children of parents with drug use problems, young people with a slight intellectual disability and young people on the streets, from socio-economically deprived neighbourhoods or in special institutional settings (such as child residential care or custodial institutions), and in recreational settings. The projects in recreational settings focus on the implementation of safe clubbing regulations, person-to-person interventions and the testing of substances (often 'club' drugs) at addiction care organisations. They are linked to other nationwide monitoring systems and are particularly important for the rapid sharing of information about new or dangerous psychoactive substances and their hazardous health effects in recreational settings, and for issuing local warnings. These initiatives have recently been complemented with additional interactive tools and mobile applications. An increasing role in selective prevention interventions is played by social neighbourhood teams, developed as part of an ongoing reorganisation of general healthcare. New programmes addressing GHB use and substance use among transgender people have been launched.

In the indicated prevention area, activities focusing on early identification of substance use or dependence are on the increase and some activities target young people arrested under the influence of substances. Several online programmes to prevent and decrease high-risk drug use by means of motivational interviewing techniques have been launched in the Netherlands.

FIGURE 11

Provision of interventions in schools in the Netherlands (expert ratings)



NB: Year of data 2015.

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 interventions

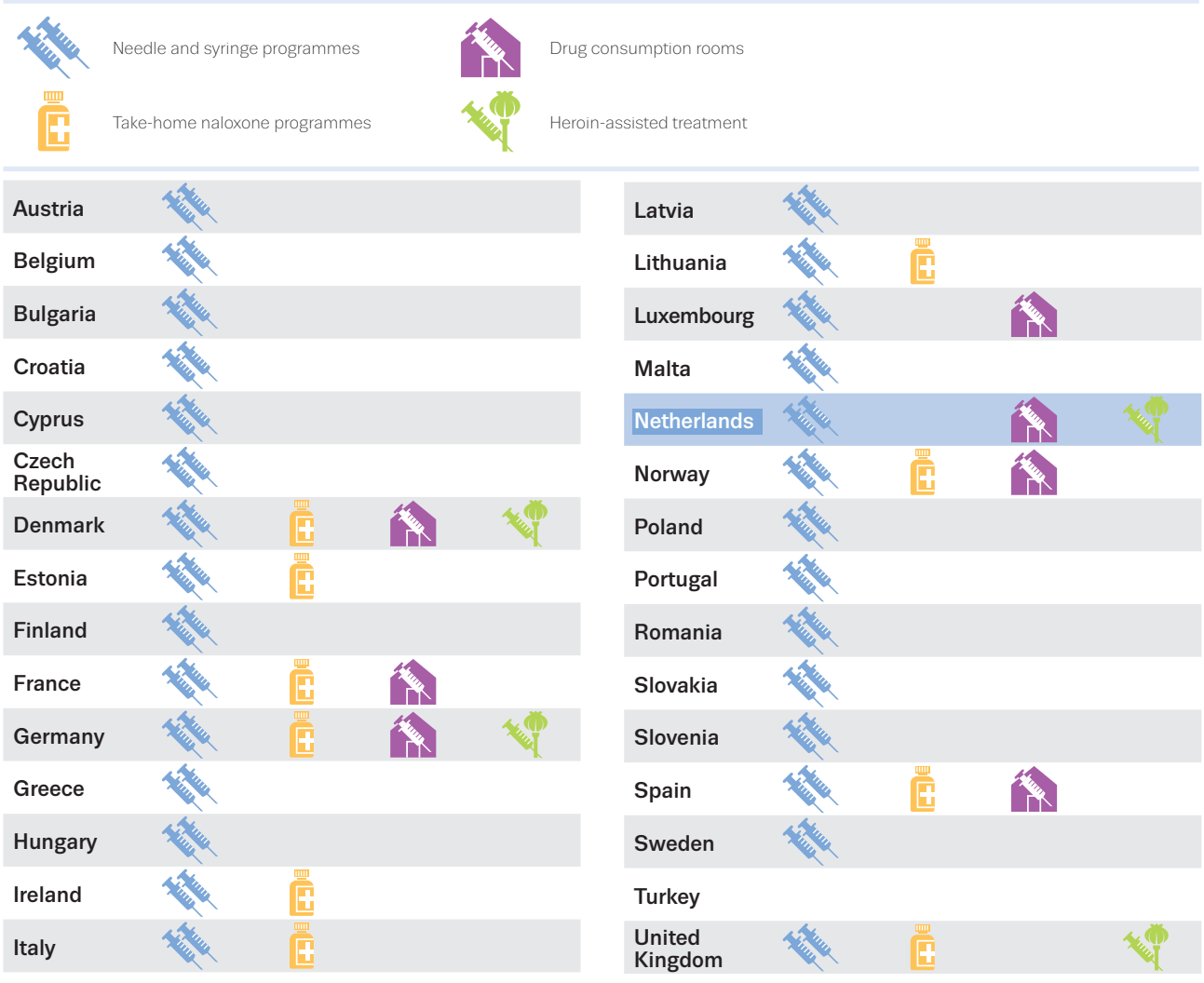
In the Netherlands, harm reduction activities are implemented through outreach work, low-threshold facilities, and centres for 'social addiction care', the main goal of which is to establish and maintain contact with difficult-to-reach drug users. All services attempt to motivate difficult-to-reach drug users to participate in some kind of treatment to prevent their individual and/or social situation from worsening. However, if this is not feasible, support is given to drug users to reduce the harmful consequences of drug use.

Most outreach work is carried out by low-threshold services in outpatient care facilities, targeting street-based problem drug users and drug-using sex workers. Drug consumption rooms offer the possibility of supervised consumption to chronic hard drug users. Other target groups are PWID, high-risk drug users and drug users from foreign countries. Outreach activities also feature in programmes for reducing drug-related public nuisance, which are a collaborative venture between treatment and care facilities, police and civil groups.

Needle and syringe programmes have been established in the Netherlands for more than 20 years and are available in all major cities. These programmes are mainly implemented by street drug workers and at treatment centres. In some cities, pharmacies are involved in needle and syringe programmes, and in Rotterdam needle and syringe exchange is available at several police stations. There is no national monitoring of the number of syringes and needles distributed. Available local data indicate a significant decline in syringe provision since the 1990s,

FIGURE 12

Availability of selected harm reduction responses



NB: Year of data 2016.

which can be attributed to a reduction in heroin use and injecting in general as a result of increasing coverage of opioid substitution treatment (OST), and an increase in the inhalant use of other substances, such as crack cocaine. Therefore, it is assumed that the current level of syringe provision meets the needs for clean injecting equipment among the majority of people who inject drugs.

The first drug consumption room was established in 1994; currently there are 31 drug consumption rooms across 25 cities, servicing people who inject drugs and those who smoke or inhale drugs (Figure 12).

In 2015, HCV treatment availability expanded and the new oral interferon-free direct-acting antiretroviral treatments became reimbursable. A comprehensive hepatitis plan was launched in 2016, and the Health Council advised that drug users should actively be offered HBV and HCV testing. Addiction care institutions were identified as the main players responsible for case finding.

In 2015, more than 31 000 people received drug treatment in the Netherlands, mainly in outpatient settings

Treatment

The treatment system

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

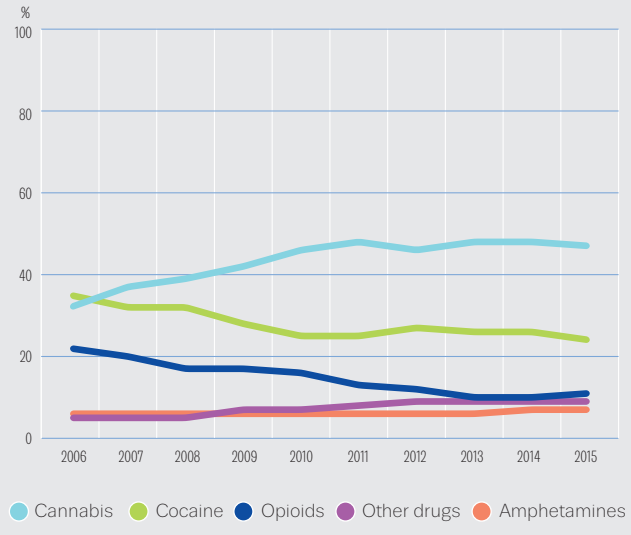
Responsibility for the organisation, implementation and coordination of addiction care in the Netherlands has been delegated to regional and local authorities, and is part of the broader mental healthcare agenda. Drug treatment is provided by 14 regular addiction care and treatment institutes, of which seven have merged with a mental health institutes and one with an institute for social support. 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 start of 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 primary mental healthcare and secondary mental healthcare. Some treatment providers may have 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.

The options for drug treatment interventions in the Netherlands are diverse. OST, complemented by psychosocial treatment, is the treatment of choice for opioid dependence. 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 and crack cocaine and GHB users. In addition, new treatment settings for homeless drug users in several municipalities have been opened.

FIGURE 13

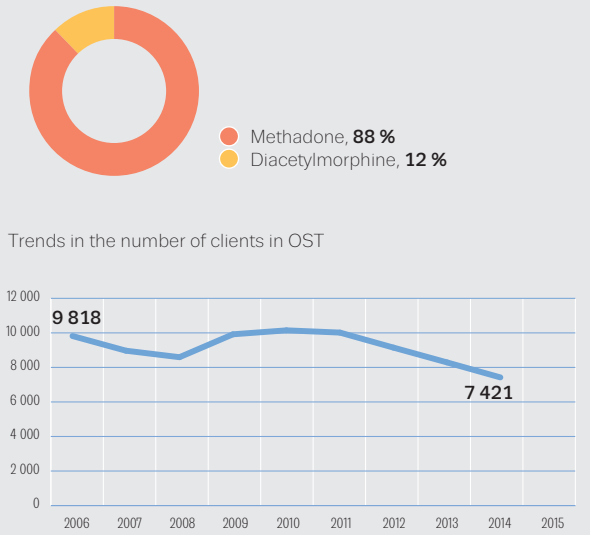
Trends in percentage of clients entering specialised drug treatment, by primary drug in the Netherlands



NB: Year of data 2015.

FIGURE 14

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



NB: Year of data 2014.

OST with methadone has been available since 1968. Heroin-assisted treatment (HAT) was introduced in 1998 and high-dosage buprenorphine treatment in 1999. HAT is provided at 18 outpatient treatment units, while methadone-based treatment is available from various treatment providers, including office-based practitioners and mobile units.

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 (Figure 13).

Fewer than 2 out of 10 treated opioid users entered treatment in 2015, and most of them 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 ageing of the opioid-using population in the Netherlands.

According to the latest available data (2014), 7 421 clients received OST, a large majority of whom were treated in methadone maintenance programmes (Figure 14).

Drug use and responses in prison

There is no recent information about the prevalence of (problematic) substance use among prisoners in the Netherlands, but studies published between 2003 and 2009 suggest that around 4 out of 10 adult Dutch prisoners had substance use problems before being sent to prison.

In general, the prison system has implemented a policy aimed at discouraging the use of drugs, by creating drug-free settings by limiting the availability and use of drugs in prisons.

The Ministry of Security and Justice is in charge of health services in prisons and funds drug treatment in prisons. Continuity of care and equivalent access to health services are basic principles of the treatment of prisoners.

Cooperation between prisons and the drug treatment system was strengthened in 2015. Drug treatment measures in prisons include evidence-based behavioural intervention and mental care services. If needed, prisoners can be referred to treatment services outside prison (as an alternative for imprisonment). Repeated offenders who exhibit drug use problems on entering prison may be placed in an Institution for Prolific Offenders, which also offer several treatment interventions inside and outside the prison system. Those who were in a methadone maintenance treatment before imprisonment can continue the treatment during their imprisonment. Special treatment for those dependent on benzodiazepines or GHB are available. Naloxone is available in every penitentiary institution, in case of an emergency.

After release from prison, treatment and care services should 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. Criminal justice organisations cooperate with municipalities, the social sector and care organisations to better combine and integrate penal and rehabilitative interventions for offenders.

Continuity of care and equivalent access to health services are basic principles of the treatment of prisoners

Quality assurance

The 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 e care have organised the Dutch Association of Mental Health and Addiction Care (GGZ Nederland), which supports the quality management of addiction e care by means of the programme 'Scoring Results' (*Resultaten Scoren*), which was launched in 1999.

The national infrastructure for the governance and coordination of the implementation of best practices is as follows: the Minister and the State Secretary for Health, Welfare and Sport (VWS) are advised by the Dutch Association of Mental Health and Addiction Care (GGZ Nederland), the National Health Care Institute (*Zorginstituut Nederland*) and the Trimbos Institute (Netherlands Institute of Mental Health and Addiction).

In addition, the Minister and the State Secretary can commission further research by the Netherlands Organisation for Health Research and Development (ZonMw), and initiate the development of quality standards and guidelines for best practices by Foundation Scoring Results (*Stichting Resultaten Scoren*) and the Quality Institute (*Kwaliteitsinstituut*). These quality standards and guidelines are implemented by the health insurance companies so that only qualified evidence-based best practices are funded. Subsequently, the Dutch Healthcare Authority (NZa) and the Health Care Inspectorate (IGZ) monitor the actual implementation of the best practices.

The accreditation system is operated by the CIBG Agency, which has been defined by the Ministry of Health, Welfare, and Sport (VWS) as follows: 'The CIBG agency is an executive organisation within the Ministry of VWS which, based on legislation or established policy, makes decisions, registers data, issues permits and permissions, and provides support to committees and boards that have an oversight function in health care.'

Continuing professional development courses are available. In addition, many universities offer undergraduate degrees in addiction e science, and Radboud University offers a master's degree in Addiction Medicine for students who want to specialise in addiction.

Drug-related research

Drug research in the Netherlands is extensive and covers many domains. Public funding of drug-related research is, to a large extent, delegated to intermediary agencies, although ministries and municipalities also directly fund a considerable number of research projects. Many academic institutions are involved in drug research, sometimes in collaboration with researchers from institutes for addiction e care. A national conference has been organised annually for drug researchers to stay informed about recent developments (Forum Alcohol and Drugs Research).

The number of publications in national and international scientific journals is extensive. The development and implementation of multidisciplinary evidence-based guidelines, protocols and training materials are the most important channels for disseminating drug-related research findings from the scientific community to practitioners and decision-makers. Reports on research findings are disseminated through, for example, the websites of the Trimbos Institute (www.trimbos.nl) and Foundation Scoring Results (www.resultatenscoren.nl). 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 were also mentioned.

Research with regard to nuisance and crime is funded both by municipalities and on a national scale. The Ministry of Security and Justice — especially the Research and Documentation Centre of the Ministry (WODC) — is an important player in funding research that is carried out by diverse research institutes and universities. It also conducts its own research (such as monitoring of organised crime and criminal recidivism of offenders). Reports either carried out or funded by the WODC (http://www.wodc.nl) are made public and contain a summary in English.

Public funding of drug-related research is, to a large extent, delegated to intermediary agencies, although ministries and municipalities also directly fund a considerable number of research projects

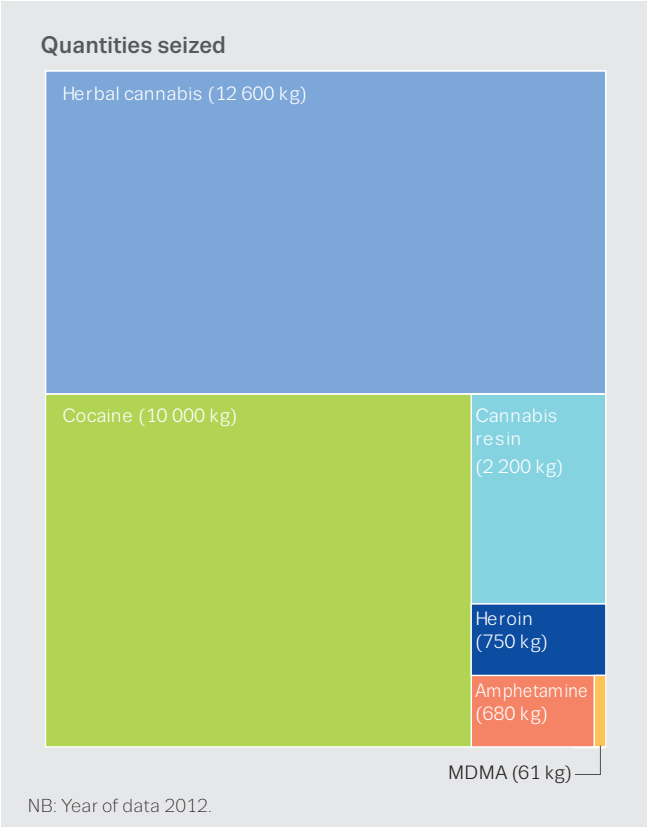
Drug markets

Cannabis cultivated and synthetic drugs produced in the Netherlands are exported to foreign markets; the Netherlands is also a transit country for heroin and cocaine. Cannabis cultivation occurs mainly indoors, and only a small number of open-air sites have been dismantled and reported. In 2015, almost 6 000 cannabis plantations were dismantled, maintaining an increasing trend since 2011.

The number of production units of synthetic stimulants reported to be dismantled has also increased in recent years, and a similar trend has occurred with regard to reports of 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 and/or the conversion of precursors for the production processes, methamphetamine and, most recently, possible mephedrone production activity have also been reported, albeit on a small scale.

FIGURE 15

Drug seizures in the Netherlands: quantities seized



NB: Year of data 2012.

Heroin mainly originates from Afghanistan and is trafficked to the Netherlands via the Balkan route. Turkish crime groups seem to play an important role in the Dutch heroin market.

Cocaine is most commonly shipped directly from South America or via intermediary African countries by sea and, to a lesser extent, by air. The Netherlands is primarily a transit country for both heroin and cocaine.

In recent years, drug trade over the internet has emerged as a new business model. There are a considerable number of online (clearnet) shops offering NPS, although their role may be diminishing. In contrast, the size of illicit drug trafficking on the dark net is increasing; a considerable number of vendors reportedly operate from the Netherlands.

Data on drug seizures in the Netherlands are collected centrally by the National Police Agency. The register includes data from the regional police departments, customs, the Royal Military Police and the Synthetic Drugs Unit (part of the National Police Force). However, not all departments report their data each year, which, in conjunction with the lack of a uniform registration system, hampers data quality. The most complete reporting dates back to 2012 (Figure 15).

The minimum and maximum retail price and purity of the main illicit substances seized in the Netherlands are shown in Figure 16. Data collected on the prices in the coffee shops indicate that the mean price of cannabis resin was EUR 9.20/g in 2015, the mean price of domestically produced cannabis was EUR 10.20/g and the mean price of imported herbal cannabis ('skunk') was EUR 4.90/g. Information available through the drug information and monitoring system indicates the following mean retail prices for other illicit drugs in the Netherlands in 2015: heroin (brown) — EUR 38.70/g; cocaine — EUR 50.80/g; amphetamine — EUR 7.25/g; and MDMA — EUR 4/g. Tackling and counteracting organised crime groups involved in production and trafficking of 'established' illicit drugs is the key priority in supply reduction field; multidisciplinary enforcement activities primarily take place at regional level. Specialised police units and teams are also in place to deal with investigative and enforcement activities related to cannabis cultivation and production of synthetic stimulants, as well as to deal with money laundering linked to illicit drug trade. To address international drug-related crime, the Netherlands has developed close cooperation or joint actions with all neighbouring countries.

FIGURE 16

Price and potency/purity ranges of illicit drugs reported in the Netherlands

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

KEY DRUG STATISTICS FOR THE NETHERLANDS

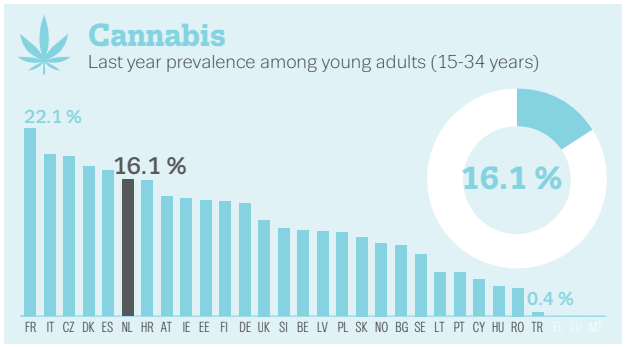
Most recent estimates and data reported

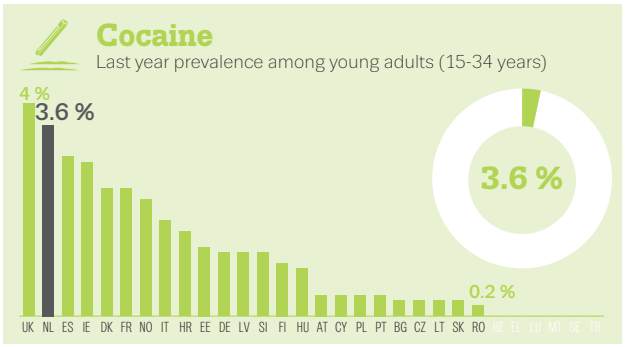
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	22.4	6.5	36.8
Last year prevalence of use — young adults (%)	2015	16.1	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	8.7	0.3	11.1
All treatment entrants (%)	2015	47	3	71
First-time treatment entrants (%)	2015	56	8	79
Quantity of herbal cannabis seized (kg)	2012	12 600	4	45 816
Number of herbal cannabis seizures	No data	No data	106	156 984
Quantity of cannabis resin seized (kg)	2012	2 200	1	380 361
Number of cannabis resin seizures	No data	No data	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	4.5-25	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	1.9-45.4	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	No data	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	No data	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.9	0.9	4.9
Last year prevalence of use — young adults (%)	2015	3.6	0.2	4
Last year prevalence of drug use — all adults (%)	2015	1.9	0.1	2.3
All treatment entrants (%)	2015	24	0	37
First-time treatment entrants (%)	2015	21	0	40
Quantity of cocaine seized (kg)	2012	10 000	2	21 621
Number of cocaine seizures	No data	No data	16	38 273
Purity (%) (minimum and maximum values registered)	2015	1-89	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	10-130	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.4	0.8	6.5
Last year prevalence of use — young adults (%)	2015	3.1	0.1	3.1
Last year prevalence of drug use — all adults (%)	2015	1.6	0	1.6
All treatment entrants (%)	2015	7	0	70
First-time treatment entrants (%)	2015	7	0	75
Quantity of amphetamine seized (kg)	2012	680	0	3 796
Number of amphetamine seizures	No data	No data	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1-73	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	1-50	1	139.8

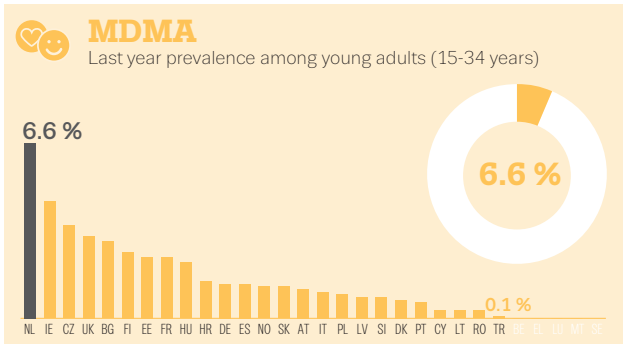
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	3.1	0.5	5.2
Last year prevalence of use — young adults (%)	2015	6.6	0.1	6.6
Last year prevalence of drug use — all adults (%)	2015	3.4	0.1	3.4
All treatment entrants (%)	2015	1	0	2
First-time treatment entrants (%)	2015	1	0	2
Quantity of MDMA seized (tablets)	2012	2 442 200	54	5 673 901
Number of MDMA seizures	No data	No data	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	1-293	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	0.5-10	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2012	1.3	0.3	8.1
All treatment entrants (%)	2015	11	4	93
First-time treatment entrants (%)	2015	6	2	87
Quantity of heroin seized (kg)	2012	750	0	8 294
Number of heroin seizures	No data	No data	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	1-87	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	15-70	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/ million population, Source: ECDC)	2015	0.1	0	44
HIV prevalence among PWID* (%)	No data	No data	0	30.9
HCV prevalence among PWID* (%)	No data	No data	15.7	83.5
Injecting drug use (cases rate/1 000 population)	No data	No data	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	16.5	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2012	237 400	164	12 314 781
Clients in substitution treatment	2014	7 421	252	168 840
Treatment demand				
All clients	2015	10 987	282	124 234
First-time clients	2015	6 529	24	40 390
Drug law offences				
Number of reports of offences	2015	20 503	472	411 157
Offences for use/possession	No data	No data	359	390 843

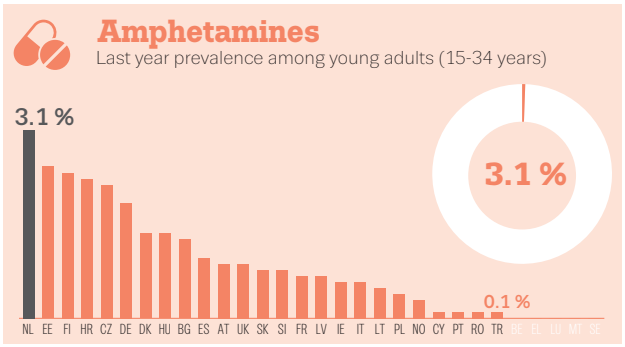
* PWID — People who inject drugs.

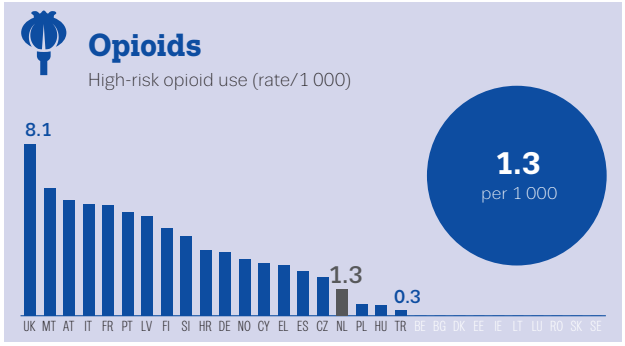
EU Dashboard

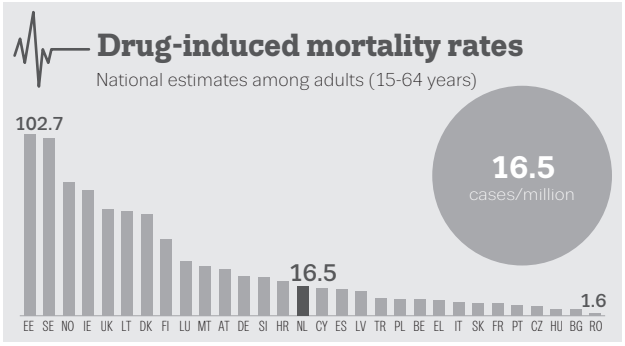


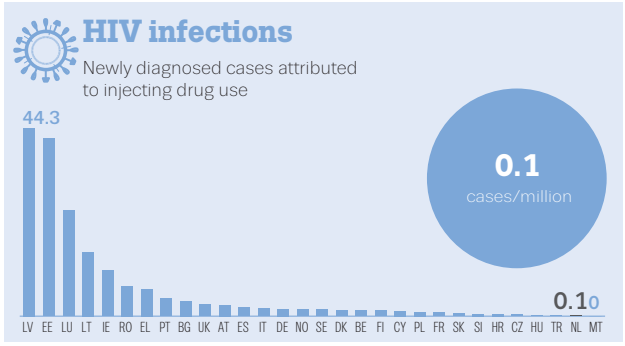


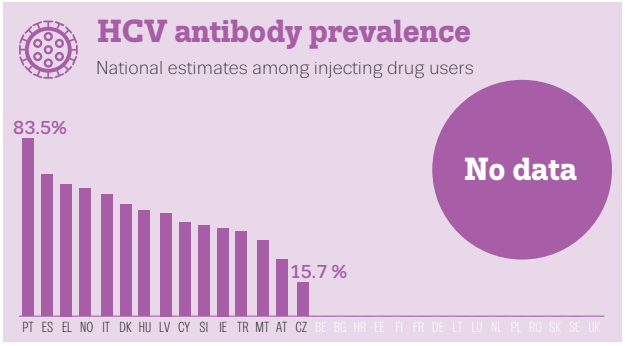












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

Trimbos instituut
Netherlands Institute of Mental Health and Addiction

Wetenschappelijk Onderzoek- en Documentatiecentrum
Ministerie van Veiligheid en Justitie

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.

Trimbos Institute

(Netherlands Institute of Mental Health and Addiction)
Da Costakade 45
PO Box 725
NL-3500 AS Utrecht
Netherlands
Tel. +31 302971186
Fax +31 302971187
Head of national focal point:
Mrs Margriet van Laar — mlaar@trimbos.nl

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EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. +351 211210200 | info@emcdda.europa.eu
www.emcdda.europa.eu | twitter.com/emcdda | facebook.com/emcdda

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