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Netherlands Institute of Mental Health and Addiction

Evaluatie van het Nederlandse drugsbeleid

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Trimbos-instituut, Utrecht, 2009
WODC, Den Haag, 2009

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Colofon

Opdrachtgevers
Ministerie van Volksgezondheid, Welzijn en Sport
Ministerie van Justitie

Financiering
Ministerie van Volksgezondheid, Welzijn en Sport
Ministerie van Justitie

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Omslagontwerp
Ladenius Communicatie BV Houten

Vormgeving binnenwerk
Troost communicatie Utrecht

Productie
Ladenius Communicatie BV Houten

Tekstredactie
Bureau Schrijf Schrijf Utrecht

ISBN: 978-90-5253-643-9

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De integrale tekst van het rapport is gratis te downloaden van www.wodc.nl

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1 Summary

On 6 March 2008, drug policy in the Netherlands was debated in the Dutch Parliament. During this debate the Ministers for Justice, Health, and the Interior pledged to draft a new drug policy paper. In preparation for this policy paper, the Ministries of Health and Justice have requested the Trimbos Institute and the Scientific Research and Documentation Centre (WODC) to conduct an evaluative study and to provide a joint, integrated report on its findings.

The primary aim of the study is to establish the extent to which the main objective of Dutch national drug policy has been achieved. This objective, as formulated in the 1995 Drugs Policy Paper prioritises the protection of public health: prevention and management of the threats to individuals and society that ensue from drug use. In addition, the study will examine the relevant secondary objectives of Dutch drug policy regarding the following areas:

- Market separation and the policy on coffee shops (Chapter 6)
- Prevention and harm reduction (Chapter 7)
- Health care and treatment (Chapter 8)
- Drug crime (Chapter 9)
- Offences committed by drug users (Chapter 10)
- Drug-related public nuisance (Chapter 11)
- International collaboration (Chapter 12)
- Research and monitoring (Chapter 13)

This evaluative study starts by analysing the reasoning behind the policy. For each of the above policy areas, a description is provided of the underlying principles, the proposed approach and the envisaged outcomes of policy. Furthermore, the study examines whether the proposed approach was realised in practice and whether the outcomes are in line with expectations. Only to a limited extent can pronouncements be made about the 'effects' of policy, and then only with regard to some aspects of policy areas. The main starting point for the evaluation is the 1995 Drugs Policy Paper, with the situation in recent years forming the benchmark for outcomes. Documents analysed included policy documents, scientific publications, doctoral theses, research reports; data from existing registrations were examined as were secondary analyses of research data, as well as information obtained from experts in sounding board meetings.

Development of Dutch Drug Policy (Chapter 4)
This chapter outlines in chronological detail the main developments of recent decades in Dutch drug policy. After a brief historical introduction, a description follows of how the amendment of the law came about in 1976. This statutory change was a direct consequence of the reasoning that the risk posed by a substance to the user and to society should form the main premise for policy making. On the basis of a number of recommendations, including those of the Baan Commission, a distinction has been made ever since in drug policy between substances containing an unacceptable risk to public health (hard drugs) and cannabis, a substance that poses less of a threat to public health. Furthermore, it was agreed that stigmatisation and criminalisation of drug use should be avoided. In the late 1970s, the government initiated a debate on the issue of innovation in drug treatment. This was the precursor to the introduction of methadone and other treatment methods that are now known collectively as "harm reduction". This development was further intensified by the emergence of the HIV/AIDS epidemic. Furthermore, from the mid-1980s the Netherlands was confronted with a new type of recreational drug – ecstasy. Besides the increasing use of this drug in the social scene, the Netherlands became an ecstasy producing and exporting country.

The publication of the Policy Paper on Continuity and Change – the 1995 Drugs Policy Paper – heralded a new policy approach. The fundamental principles of Dutch drug policy were not up for discussion. However, the Policy Paper did give rise to a range of innovative approaches to specific groups of addicts, as well as to matters related to the production, trafficking and use of drugs. The Policy Paper also called for a more integrated approach to the ways in which national government, municipalities, departments, authorities and countries separately tried to define the problems and seek solutions. A number of main aspects of this policy development are further described in this chapter. For instance, policy on cannabis and coffee shops has been further modified and regulated via a constant stream of measures and legal amendments. This chapter also focuses on the

development of a wide range of treatment options, both in non-compulsory addiction care and in compulsory addiction care (by court order). We also look specifically at how the increasingly large-scale and professional illegal cannabis cultivation and the illegal production of synthetic drugs are being combated. A further important development since 1995 is that the set of legal, administrative and judicial instruments has been further modified to enable local authorities in particular to tackle prevalent local drug crime and drug-related public nuisance. Finally, we outline the investments that have been made in the area of research and monitoring, and dwell on the efforts made in the area of international collaboration. This chapter can thus be regarded as an introduction to the further analysis of drug policy as detailed in the following chapters.

Statistics: Developments in drug policy and international comparison (Chapter 5)
The seriousness of the drugs problem can be measured on the basis of five key epidemiological indicators which have been established by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). These are the prevalence of drug use in the general population and among the school-going population; prevalence estimates of problem drug use; demand for treatment on account of drug use; (infectious) diseases related to drug use; and drug-related deaths. For all drugs, with the exception of ecstasy, the Netherlands scores below the European average for prevalence of use in the general population, and lower than prevalence rates in the US. Among secondary school-goers a slightly declining trend in drug use can be seen since 1996 in the Netherlands. Nonetheless, cannabis use among school-goers of 15 and 16 years old scores well above the international average. This is true both for the percentage of current users and the more frequent users of cannabis. With regard to the number of problem hard drug users, (opiates and often also crack cocaine), the Netherlands obtained a low average score, although differences in definitions and methods did not permit precise comparisons. There are relatively few new opiate addicts in the Netherlands, and the average age is rising. It is not known whether the numbers of primary crack users who don't use opiates are increasing. This also applies to the question whether crack use leads to chronic problems to the same extent as opiate use.
Trends in the number of treatment requests in the Netherlands (a decline in opiate clients and an increase in the number of cocaine and cannabis clients) are similar to those seen elsewhere in Europe. In the Netherlands the increase in the number of cocaine clients (particularly crack users) has recently levelled off. Such trends cannot be interpreted as reflecting an increase or decrease in the problem itself. The percentage of injecting opiate clients is the lowest in the Netherlands of all EU-15 countries. It is thought that this factor plays a part (among others) in the relatively low number of drug-induced deaths (overdoses) in the Netherlands. Some older data show pronounced regional variation in the prevalence of HIV infection among injecting hard drug users. The annual incidence of new HIV infections in this group has declined sharply since the epidemic of the early 1980s, and remains low by comparison with other countries. Likewise, the growth of new Hepatitis C cases has declined, although prevalence among injecting drug users is high. We may conclude that the Netherlands scores 'average to well' on the indicators of the EMCDDA. However, with regard to ecstasy use in general and cannabis use among youngsters, the Netherlands scores in the higher echelons.

Market separation & policy on coffee shops (Chapter 6)
Since the 1970s, policy in the Netherlands has focussed on combating the marginalisation and criminalisation of cannabis users and minimising the likelihood that they will become hard drug users. By tolerating small-scale selling of cannabis and clamping down on hard drug dealing, it was hoped to achieve a separation between the soft drug and hard drug markets. This policy was based on the principle that the risks attached to cannabis were rated much lower than those related to hard drugs. While cannabis was sold to consumers in the 1970s mainly through house dealers, from the late 1980s it was chiefly sold in coffee shops. In 1995 policy on coffee shops started to focus on reducing the public nuisance factor (including drugs tourism) and criminality associated with coffee shops and cannabis cultivation. This took the form of measures such as stricter application of legislation, improved monitoring of compliance and expansion of administrative measures.

Has the proposed approach been realised? In some respects the proposed approach has been realised, but in other respects it has not. In 1976 the laws were changed in order to reflect the differences in the risks involved in cannabis compared to hard drugs. A policy of tolerance was adopted in relation to the sale of cannabis in coffee shops, subject to conditions that are laid down in the national guidelines of the Public Prosecutor (the AHOJ-G criteria). These criteria have been extended and intensified over the course of time. At local level further criteria were added to the list, such as a mandatory minimum distance from schools. Compliance with the national and local criteria is monitored, sanctions may be imposed, and municipalities can receive advice and support from an expert agency. The scope for taking action against non-sanctioned cannabis sales outlets has been expanded. On the other hand, however, little use has been made of the legal instruments available, and possible criminality associated with the coffee shops has only started to receive attention in recent years. In principle, the

criteria are being adhered to, but at the same time, the criteria themselves contain loopholes that make it difficult to detect violations. The policy on coffee shops has been decentralised. At local level, various initiatives have been taken to combat public nuisance as well as drugs tourism.

Have the envisaged outcomes been achieved? As intended, cannabis users are seldom arrested for possession of the drug, and as such they remain outside criminal law. In other Western countries, there is a far greater likelihood of being arrested for possession or use of cannabis, but there is no consensus on the extent to which this has negative (social) consequences for the user. Often those arrested are fined or cautioned.

Research among cannabis users has shown that coffee shops are the major direct or indirect source for purchasing cannabis. They are not, however, the only source, even in municipalities where coffee shops are located. There is a market everywhere for non-sanctioned sales outlets. Underage youngsters can easily procure cannabis, particularly through friends; and some also manage to buy the substance in coffee shops. On the other hand, there is a low risk that they will be exposed to hard drugs in the coffee shops. This is also generally true for adult cannabis users. When cannabis is sold through other, illegal channels, there is a greater risk of exposure to the hard drugs market, depending on the type of supplier. On balance, it may be concluded that the markets for hard and soft drugs remain largely separate in the Netherlands.

Since there are countless factors that may influence the use of (hard) drugs, it remains difficult to make definite assertions about the effects of market separation. A positive effect of the coffee shop system on the use of hard drugs cannot be demonstrated convincingly; nor can it be ruled out. In so far as international comparisons are feasible, there are many countries that have higher, similar or lower prevalences of hard drug use among cannabis users. However, the use of hard drugs, with the exception of ecstasy, among the general population is relatively low in the Netherlands.

There are no indications that the coffee shops have led to an inordinate rise in cannabis use, at least among adults. Compared to other western countries, cannabis use in the general Dutch population is relatively low. However, the same cannot be said for underage school-goers. Despite an overall levelling off in use, they score relatively highly for cannabis use in the Netherlands, compared to their peers in other European countries. It is unclear whether this is linked to the existence of coffee shops (greater availability – albeit indirectly; greater acceptance of use) or other factors. Among certain groups of more vulnerable youngsters the use of cannabis is the rule rather than the exception. Furthermore, there has been a sharp rise since the mid-1990s in the numbers of cannabis users seeking treatment from addiction care, as is the case in numerous other European countries. However, it is not known whether this development is indicative of an increase in problem usage.

The number of coffee shops in the Netherlands is declining steadily, although the number of municipalities that tolerate coffee shops has remained stable. As a rule, coffee shop proprietors try to comply with the rules and conditions, and are generally successful in this. The most common violations are those concerning age limit and maximum sale quantities. Compliance with the ‘no sale of hard drugs’ rule is high, as this is seen to be essential for the continued functioning of the coffee shop system. Nonetheless, a certain risk prevails that the aims of coffee shop policy will not be entirely achieved, as a result of grey areas and difficulty in policing some rules.

On a nationwide basis, not many formal breaches of the prevailing public nuisance criteria for coffee shops are registered. Research has shown that in 2007, these criteria were sometimes breached in the case of over 40% of coffee shops, and that in 2004 and 2007 these criteria were violated more often than other criteria. Specific details about the extent of the breaches and about national trends are unavailable. A number of border municipalities experience serious nuisance from drugs tourism. In this regard, the policy objectives have clearly not been realised. The role of criminal consortiums and criminality surrounding coffee shops has only come under the spotlight in recent years. By intensifying policy it may be possible to combat criminality among coffee shop proprietors, but not the organised crime behind cultivation and trafficking. Over time, the coffee shop sector has become increasingly more commercialised. This is remarkable in view of the fact that policy is based on the thinking that the sale of cannabis should be small-scale and non-commercial.

Prevention and Harm Reduction (Chapter 7)

The main objective of Dutch policy on drugs is “the prevention and management of the risks to individual and society arising from drug use”. In the 1995 Drugs Policy Paper, this aim is further described as preventing the country’s youth in particular from starting to use drugs, and providing problem users with the medical and/or social support needed to alleviate their distress. This objective prioritises public health considerations, whereby limiting the harm of drug use takes precedence over punishing offences. It is a fundamental principle which has engendered a policy that emphasises prevention and harm reduction.

The policy of prevention and harm reduction of the past 30 years has evolved in reaction to various developments in society. Firstly, the 1980s saw an increase in the public nuisance caused by problem drug users, particularly in the major cities. Equally important was the HIV epidemic among injecting drug users. In the 1990s

there was a rapid rise in the popularity of ecstasy and other synthetic drugs, especially in younger age groups. There was increasing scientific evidence for the harmful effects of ecstasy use, both in the short term and the long term. In addition, concern was growing about the effects of cannabis, particularly in relation to the increased THC content, the rising demand for treatment and the association between cannabis use and psychiatric disorders.

Has the proposed approach been realised? It was proposed that a broad approach to the area of prevention should be taken, encompassing a comprehensive and varied range of prevention activities aimed at public awareness, as well as monitoring the user and supply markets, plus scientific research. Furthermore, coffee shop policy, administrative measures and judicial interventions all ultimately contribute to the prevention of use and of the problems associated with drug use. The proposed prevention activities, such as those described in the 1995 Drugs Policy Paper, the 2001 Policy Paper on Joining Forces against XTC, and the 2004 Cannabis Report have largely been realised. Between 1996 and 2008 large-scale public awareness campaigns were conducted on a virtually annual basis. In 1996 a telephone information line (the Drugs Infoline) was set up. It operates 24 hours a day, providing scientifically founded information and also has a website (www.drugsinfo.nl). Since the early 1990s, a prevention programme (The Healthy School and Drugs) has been integrated into the curriculum for pupils in the higher classes of primary school and the lower secondary school classes, and is updated regularly. Prevention efforts in recreational outlets and in coffee shops are embodied in the project 'Drugs and the social scene'. Public information about cannabis has been stepped up through the project 'Prevention in the Coffee Shop'. And a national support centre (The National Support Centre for the Prevention of Addiction and Substance Use (LSP)) has been set up to improve the quality of prevention activities and promote clarity and coordination regarding these.

Furthermore, activities proposed under policy on ecstasy have been realised, or are being developed. Information activities have been aimed at potential ecstasy couriers; the user market is being monitored through qualitative and quantitative research, and the supply and composition of drugs are being monitored by the Drugs Information and Monitoring System (DIMS). Dutch Parliament called a halt to the testing of pills at recreational sites. Training and courses about first aid and prevention of accidents are available to staff at recreational venues; the target group is reached through channels such as peers and informative websites.

The most recent public information campaign on cannabis took place in 2006. There are prevention modules for drug use among youngsters in hang-outs and in youth centres, and a training course has been developed for youth workers (Open and Alert). The proposed 'less non-committal public information' in coffee shops has resulted in the development of a new leaflet for coffee shop frequenters and a course for coffee shop staff. Most of the prevention activities proposed in the 2004 Cannabis Report have been realised, with the exception of specific activities aimed at people suffering from a psychiatric disorder.

The envisaged approach to the area of harm reduction has largely been realised. Thanks to the Strategy Plan for Social Relief, low-threshold relief for the homeless (and those threatened with homelessness) has been given a major boost in the four major cities. The majority of this target group are drug users. As a result, the number of user areas has increased, needle exchange has been widely available for a number of years – although demand for this facility has declined on account of the dwindling popularity of injecting – there is a free Hepatitis B vaccination for hard drug users, and in the autumn of 2009, a mass media public awareness campaign on Hepatitis C will take place.

The degree of focus on vulnerable groups depends on developments in societal attention to such groups. In former years, immigrant groups were the focus of many prevention activities; however, following mergers in addiction care, these activities have become considerably less marked. There are now other interventions, targeting, for example, young people inside and outside the social scene, young people in institutions, children of addicts and youngsters with mild mental disabilities.

Have the envisaged outcomes been achieved? Universal preventative interventions have shown at most only minor effects on attitudes to drugs, and have no or only short-lived impact on use. In fact, even a counter-productive effect has been described. However, knowledge about drugs has been found to have a positive effect. This has been shown both in the findings of Dutch drug prevention projects, and in international scientific literature. Preventative interventions targeting groups with an above average risk of developing a drug problem (selective and indicated prevention) appear to be able to reduce drug use somewhat. There are indications – although no proof – both in national and international scientific literature, that combining various strategies can intensify the preventative effect of such measures. In the Netherlands, various acknowledged "best practice" interventions are in use. These include the "home party", aimed at immigrant families and families in disadvantaged neighbourhoods, an intervention aimed at the children of addicts, and the Theater2daagse, a drama production targeting immigrant youth. Insufficient research has been conducted to establish whether these interventions are achieving the desired results.

In the area of harm reduction, there is more tangible evidence of the envisaged outcomes. Nationally, there has been a strong decline in the number of newly diagnosed HIV infections among drug users. In so far as data are available, the high rate of HIV infection among drug users appears to be restricted to Amsterdam, and possibly Heerlen. In recent years, there is also evidence of a decline in new Hepatitis C diagnoses, although in the meantime, many injecting drug users have become infected with this virus. Hepatitis B infection has also remained limited. Research in Amsterdam shows that these relatively favourable outcomes can partly be attributed to the widespread availability of harm reduction measures. The decline in the prevalence of injecting drugs has also contributed to these results. Individually, the interventions show only a slight effect. The favourable effects can chiefly be attributed to the combination of measures.
By international standards, the drug-related death rate is low in the Netherlands. Amsterdam-based research has found that both the decline in drug-related deaths in general and the decline in deaths through overdose are linked to participation in methadone maintenance programmes and needle exchange projects.

Care and Treatment (Chapter 8)
Addiction care in the Netherlands offers a combination of "cure" (treatment aimed at abstinence) and "care" (treatment aimed at stabilising the problems). At the time the Drugs Policy Paper was being drafted in the mid-1990s, the available treatment resources proved insufficient in a number of areas, which became manifest in a considerable public nuisance factor caused by drug use. Policy therefore concentrated on expanding the treatment resources, to enable a suitable and integrated treatment path to be drawn up for each individual drug addict. It was also aimed to improve the quality of care. This strategy was based on the premise that providing high quality care would have the effect of reducing public nuisance.

Has the proposed approach been realised? The proposed approach has been implemented to a large degree. Resources have been expanded in the areas of both cure and care. With regard to the treatment of opiate addicts, the emphasis on the "care" aspects of treatment has increased, because both practice and research have shown that in these cases sustainable abstinence is rarely an achievable goal. The Strategy Plan for Social Relief that was signed by the G4 and the Dutch government in 2006 has provided a significant contribution to social relief for the homeless (and those threatened with homelessness) causing public nuisance. Although the capacity of treatment resources has been increased, it is unclear if capacity is sufficient, because the total numbers of drug addicts (including those addicted to cannabis, cocaine and other substances) are not known. The (limited) data available from waiting list registers indicates that demand for treatment is fairly well matched by supply. However, it is typical of drug users that they often don't come forward to seek help. There are consistent indications that the care supply for double diagnosis patients is too limited and that follow-up in after-care projects is insufficient. A second limitation consists in the fact that there is no overview of the resources for vulnerable groups, such as immigrant groups. And the extent of the problems in vulnerable groups is unknown.

Various developments have contributed to an improvement in the quality of care. The long-term programme, Scoring Results, financed by the Health Ministry and launched in 1999 gave a substantial boost to the quality of addiction care in the Netherlands. Furthermore, research on care and treatment was promoted by two programmes focussing on addiction, funded by the Netherlands Organisation for Health Research and Development (ZonMw). Also of importance to the quality of addiction care are the introduction of benchmarking and the set of performance indicators to which the sector has committed itself. Further evidence of quality improvement in addiction care can be seen in the widespread familiarity with and increasing implementation of resources, guidelines and protocols for various treatments (including detoxification and maintenance treatment), which have been developed within the context of the Scoring Results programme.

Have the envisaged results been achieved? Treatment resources for opiate addicts have been expanded and improved. The average prescribed methadone dose was increased, after Dutch research showed that a higher dose achieved a greater effect. In addition, addicts who benefit little from methadone may be prescribed heroin under strict conditions. Medically prescribed heroin has been found to have positive effects on the health of the addict, and reduces the public nuisance factor. However, this approach has been adopted in only a limited number of countries, with the Netherlands playing a leading role. Focussing on housing, employment or daily occupation, finances and debt reduction is an integral part of medical care for addicts. Centres have been set up to coordinate this integrated care. There are indications that this resolute approach has greatly reduced the public nuisance caused by drug users in the major cities. However, there are no hard data to support this.

Resources have also been expanded to tackle problem use of other substances, although the emphasis in addiction care remains largely on problem opiate addicts. Various guidelines have been developed for the psychosocial treatment of cannabis and cocaine addiction. For a long time there were no specific treatment resources for minors; however in the early 1990s a number of special facilities were set up for this target group,

offering an integrated treatment approach. Expansion of resources has also taken place or is currently ongoing for other vulnerable groups, such as people with mild mental disabilities who have an addiction problem. Drug addicts with psychiatric comorbidity can be treated in special double-diagnosis clinics. Internet interventions (currently chiefly aimed at cannabis problems) can reach groups of patients who were not being reached before. The same can be said for the increasing number of private clinics for addiction treatment. By contrast, it appears that treatment resources for immigrants have been reduced, partly because some of the specific relevant expertise was lost at the time of large mergers.

It may be concluded that the envisaged outcomes in terms of realised resources have been reasonably well attained. Hard drug users have a relatively favourable profile in care, partly thanks to low-threshold, accessible treatment; the health of problem hard drug users is relatively good; deaths from overdose and the number of drug-related infectious diseases are relatively low by international standards. These outcomes all indicate that Dutch policy on treatment and care for addicts has been reasonably successful.

Drug Law Crime (Chapter 9)
'Supply reduction' is one of the cornerstones of drug policy in the Netherlands. Combating the smuggling, production, trafficking and possession of drugs takes place within the framework of international agreements. In this respect, Dutch policy is based on the premise that drug production and trafficking cannot be eliminated, but can be managed. There is a tougher policy for hard drugs than for soft drugs, and policy also varies according to the type of offence. It is aimed to combine law enforcement with administrative and financial or economic interventions. The Drugs Policy Paper envisages an intensification of international collaboration on stepping up measures to combat the production and trafficking of hard drugs (including ecstasy).

Has the proposed approach been realised? The two-track policy on investigation and prosecution is reflected in the application of the Opium Act by police and the courts. In recent times, drug offences have been tackled more severely thanks to the expansion of legal instruments and the intensification of investigative and prosecution efforts. Consequently, the number of drug offences being dealt with by the courts has increased. This can partly be explained by the tougher approach taken, especially to hard drugs. Accordingly, in 2009, drug law crime constitutes a greater burden, on both resources and finances, for the criminal law system.

Additional measures have been taken to reduce the production and export of ecstasy and imports of cocaine. Although not all plans proved feasible, and in some cases drastic measures caused serious problems, the situation improved nonetheless. In order to ensure that the problem does not return in full force, these measures have been made permanent.

Combating organised crime in relation to cocaine, heroin and synthetic drugs remains a priority for police and the courts. However, there is considerable variety in how these crimes are investigated and in the intensity of the investigations. Commercial cultivation of cannabis has been tackled more intensively since 2004. Here too, the focus has increased on the organised crime behind the cannabis plantations, although this is still in the process of being developed.

Increasingly, a more integrated approach to tackling drug crime is being adopted: a combination of administrative law, criminal law and financial instruments is used, and several organisations work together. Increasing use is made of the administrative law instruments, however, financial investigations are progressing more slowly. A more comprehensive approach is being taken to the entire drug chain from precursors and production up to and including dealing. International collaboration plays an important role in this respect. On balance, the proposed approach has been put into practice.

Have the envisaged outcomes been achieved? On the supply side, changes have taken place since 1995. With regard to cannabis, domestic cultivation has burgeoned and has become more professional. In 2008 the supply of Dutch-grown weed appeared to show some decline. It is not known whether this has to do with the intensified clamp-down or with other factors. Although criminal consortiums are involved in the cultivation, the extent of this remains unclear. There are recent signals that this involvement may be on the increase.

Until 2008, ecstasy appeared fairly widely available on the Dutch consumer market. However, recently, (late 2008, early 2009) there appears to have been a substantial deterioration in the purity of the substance, which is attributed to a shortage of precursors. This is also true for amphetamine. It remains unclear to what extent anti-drug measures have caused this. It is also difficult to ascertain whether production is currently still taking place on Dutch soil. It would appear to be spread across a number of countries, accompanied by a decline in the international role of the Netherlands in this respect.

Cocaine production in the South American countries of origin continues unabated. Despite changes to trafficking routes, possibly because of intensified investigations, the availability of cocaine on the Dutch market

does not appear to have changed greatly. The consumer market for cocaine, however, does show some changes, but no great changes. The price decreased slightly since the nineties and the proportion of cocaine samples with adulterants increased in the past years. The Netherlands continues to play an important role as a transit country for the drug, although apparently somewhat less prominently. The Netherlands is also a wholesale market for heroin. The heroin market in the country itself appears relatively stable and comparatively small.
Criminal consortiums at national and international level are still involved in drug law crime.

It can be concluded that some policy objectives have been realised in a number of areas. The commercial growing of cannabis at home seems to have declined, there are fewer body-packers or drug swallowers smuggling cocaine into the Netherlands via Schiphol airport, and the role of the Netherlands in the production and export of ecstasy appears to have lost prominence. On the other hand, the Netherlands continues to play an important role as a transit country for cocaine and heroin. Furthermore, a shift has been observed in trafficking routes and production locations, with the production techniques of both cannabis and cocaine becoming more efficient.

Offences committed by drug users (Chapter 10)
Since the 1980s, the Netherlands has battled with the problem of high criminal recidivism among a group of long-tem problem hard drug uses. Drug policy is based on the assumption that a reduction in the crimes committed by these problem drug users can only be brought about if the users receive help for their problems and their addiction. This principle is also set out in the 1995 Drugs Policy Paper. The proposed approach consists of a combination of care, detention and rehabilitation, with the emphasis on improving the progression to care after detention, cooperation between police, the courts, municipality and penitentiary institutions, as well expanding the facilities for compulsory and quasi-compulsory treatment.

Has the proposed approach been implemented? The approach has largely been realised. New measures and care provisions have been created for the target group. The scope for imposing a compulsory care order – outside the prison system – has been expanded by measures including the Forensic Addiction Clinic (FVK) and suspended sentencing. More stringent measures have also been adopted, such as the Judicial Placement of Addicts (SOV) and the Placement in an Institution for Prolific Offenders Act (ISD). Under these measures, drug users can be placed in (special) penitentiary institutions. The judicial addiction care has evolved alongside mainstream care for problem drug users.

In recent years, criminal law has been applied more consistently to this target group. There is also greater emphasis on a person-oriented approach instead of a case-oriented approach. This means users can be detained for longer periods, screened systematically for individual risk factors and can be more stringently selected for behavioural interventions. However, this development has not taken place specifically for tackling drug users. It is a general societal trend which is also evident in relation to other target groups. Tackling problem drug users who have a high level of criminal recidivism has acquired a place within security policy.

Initially there was a difference in approach between the SOV and the ISD. The SOV clearly had a dual objective: besides protecting society, it was also hoped to improve the situation of the addict. By contrast, the primary aim of the ISD was incapacitation. However, over time, a shift has taken place in the objectives of the ISD, and there is now more emphasis on rehabilitation. The judiciary played an unmistakeable role in this development, not only via judicial reviews, but also by exerting pressure to place greater emphasis on care, since the ISD groups were proving exceptionally difficult.

Remarkably, all the above approaches – compulsory treatment, FVK, SOV and ISD – have so far encountered similar problems. The scope for compulsory treatment in the target group remains limited, the numbers receiving treatment are often lower than expected, and the target group typically often exhibits complex problems and limited mental capacity. The demands made on the competencies of personnel are greater than expected, and the existing care resources and behavioural interventions require modification. These problems tend to be tackled on an ad hoc basis. Some have been resolved, others have not. It is not clear what these problems can be attributed to. Currently several improvement projects are ongoing with regard to compulsory treatment, aftercare and the ISD. The important thing is that collaboration between care organisations, police, the judiciary, municipalities and penitentiary institutions have improved in recent years, having sometimes been fraught with difficulty in the past.

Have the envisaged outcomes been achieved? Currently, developments in the area of criminality are going in the right direction. The crime rate has dropped, particularly property crime. This appears to a certain extent due to a decrease in crimes perpetrated by problem opiate users. We can partly explain this by the fact that this group is ageing and getting smaller, and also because addicts from other western countries are leaving the Netherlands according as facilities in their own countries are improving. Further reasons for the lower crime rate

include the improved support for addicts in the Netherlands, methadone and prescribed heroin programmes and intramural detention in the ISD, where some 600 mostly prolific offending addicts are detained every month. On the other hand, there has been an increase in violent crimes among drug users. This may be linked to the use of cocaine/crack. However, little is known about the nature and cause of these offences.

Chronic hard-drug using prolific offenders form a complex target group. Neuro-biological research of recent years has shown that their functioning has been affected by years of drug use. They are battling not only with long-term addiction problems, but often too with underlying psychiatric disorders and sometimes reduced intellectual capacity. The path to a stable, independent existence in society seems to be attainable for very few.

Research has shown that compulsory and quasi-compulsory treatment under the SOV measure has a greater effect on substance use, living situation and criminal behaviour than detention alone. Likewise, prescribed substances (heroin) may be effective in reducing criminal recidivism. However, the effects of compulsory and quasi-compulsory treatment lessen over time. Research findings show that long-term follow up and aftercare as well as low-threshold interventions are necessary to reduce the criminal nuisance factor associated with this group.

Drug-related public nuisance (Chapter 11)
In the 1995 Drugs Policy Paper, drug-related public nuisance is seen as a serious problem, requiring special attention. The proposed approach to this problem consists of a combination of measures – preventative, administrative and legal. Drug users causing public nuisance are dealt with by means of both detention and treatment. Public nuisance caused by drugs is understood to include criminal, public order and audio-visual disturbance. Subjectivity plays an important role in defining public nuisance. Most of the nuisance is associated with hard drug use and dealing, followed by coffee shops and large-scale hemp cultivation in houses. The latter contributed to the intensification of anti-cultivation measures which were announced in the 2004 Cannabis Report.

Has the proposed approach been implemented? A large number of measures have been taken to combat the public nuisance caused by hard drugs. These tend to have a two-pronged goal: the reduction of nuisance on the one hand, and an improvement in the situation of those causing the nuisance on the other hand. Virtually all municipalities in the Netherlands take a broad approach, with detention and treatment – relief, support, housing, user rooms - going hand in hand. The local authorities make various legal instruments available.

Nuisance surrounding coffee shops chiefly involves parking and traffic problems, followed at some distance by the disturbance caused by youngsters hanging around and noise. Nuisance involving coffee shops occurs chiefly in a number of small border towns, and to a lesser extent in the other municipalities that have coffee shops. In a number of border areas large number of drugs tourists from Belgium, Germany and France cause a considerable amount of public nuisance. This type of nuisance is tackled by imposing and policing national and local criteria for coffee shops. Special, broader projects have also been conducted in an attempt to reduce this kind of nuisance.

Large-scale cultivation of hemp in houses has been tackled. In recent years, thousands of nurseries, particularly in houses, have been dismantled.

In combating public nuisance, local factors are central. Local authorities have the scope to customise their approach to suit local conditions. Accordingly, they seek to find their own solutions to problems that arise. Consequently, there is considerable variation in the solutions, such as relocating coffee shops (Venlo), restricting the number of coffee shops (Terneuzen) or closing them down (Roosendaal and Bergen op Zoom).

Have the envisaged outcomes been achieved? With regard to the public nuisance caused by hard drug users, it appears that some measures, such as user rooms and street-clearing orders have contributed positively to a reduction in disturbance, although some relocation effects have been identified. In general, nuisance caused by hard drugs has declined since 1996, particularly in highly urban areas. This decline can chiefly be attributed to a reduction in the use of public spaces by users and street prostitutes.
With regard to public nuisance surrounding coffee shops and drugs tourism, the projects have had varying degrees of success. In some border municipalities drugs tourists continued to cause serious problems in 2009; this problem has not disappeared.

Although the integrated approach has led to the dismantling of thousands of hemp farms, it is not exactly known to what extent this has reduced the nuisance factor.

The solutions found by municipalities for coffee shop tourism would sometimes appear not to be entirely compatible with the principles of national policy, specifically where the creation of large coffee shops is concerned.

International Collaboration (Chapter 12)
As far as Dutch international policy is concerned, the priority was to ensure that the Netherlands could direct its own drug policy, despite the international pressure being exerted on the government to modify its policy. The objectives of the Netherlands in its international policy have largely not been explicitly set out, but can generally be understood from comments on formal policy papers and from the activities carried out or supported since 1976. Given this underlying general objective, and the envisaged outcome of Dutch international action, various forms of collaboration were sought in the different areas of policy. Details of these policy objectives were further elaborated in the 1995 Drugs Policy Paper:

- To prevent international criticism and improve the image of the Netherlands by providing correct information about the country's legal framework, policy and practice as well as an explanation of the underlying principles and objectives.
- To start an international discussion about the pros and cons of legalising soft drugs and make this subject debatable.
- To reduce cross-border public nuisance problems by combating (a) drugs tourism and (b) the export of cross-border/overseas drug problems to the Netherlands.
- To reduce cross-border (organised) crime related to drug trafficking and production, by joining forces with other countries and international agencies in combating this problem.

Two developments have played an autonomous, yet important role in whether these goals were achieved. First, the HIV/AIDS epidemic made many governments more amenable to the principle of 'harm reduction', one of the main cornerstones of Dutch drug policy. Second, the expansion of the European Union has meant that Dutch policy has to be viewed in an ever stronger European context.

Have the envisaged outcomes been realised? It may be concluded that the Netherlands has succeeded in pursuing the key elements of its policy, despite much criticism and pressure from abroad. Only in respect of the amount of cannabis permitted for own use has the Netherlands succumbed to international pressure, by reducing the limit from 30 grams to 5 grams. At the same time, we may assert that a number of Dutch principles have been adopted by other countries. This applies both to the decriminalisation of amounts of drug possession for own use and to harm reduction measures such as treatment with drug replacement therapies, needle exchange programmes and viewing treatment as an alternative to prison. An international debate about the pros and cons of the legalisation of soft drugs has never been conducted openly in a meaningful way. On the other hand, some elements of the cross-border public nuisance problem, caused by foreign heroin users, have been resolved. In contrast to this success, drug tourism around coffee shops in a number of border municipalities remains a daily issue. Accordingly, Dutch coffee shop policy remains a major focus of international criticism, particularly at political and administrative level. There has been some success with regard to tackling cross-border trafficking. However, no data are available to suggest whether improved collaboration has succeeded in reducing drug-related crime from an international perspective. Finally, some improvement has taken place in the international image of the Netherlands, partly thanks to the above-cited elements that have been incorporated in the policies of other countries, and partly due to the international anti-drug crime efforts of the Dutch Justice Ministry. These factors have contributed to a reduction in the volume of international criticism.

Research and Monitoring (Chapter 13)
One of the aims of the 1995 Drugs Policy Paper is to seek scientifically founded ways to improve and update addiction care through research and the development of guidelines and protocols. The poorer than expected results of some types of treatment as well as the emergence of new groups of drug users mean that scientific research on new prevention and treatment strategies is necessary. A further aim of policy is to create conditions permitting the discussion on the effects of Dutch drug policy both at national and international level, to be based more than formerly on scientific knowledge and sound statistical estimates. This is necessary, because Dutch drug policy, with its culture of tolerance, and emphasis on harm reduction, has been regularly in the line of (international) fire throughout the years. It is therefore of great importance to the Netherlands that reliable data should be made available about the nature and extent of drugs use over time, as well as the negative effects and developments in supply, in the light of health considerations as well as judicial matters.

Has the proposed approach been realised? In the 1995 Drugs Policy Paper, the 1994 XTC Policy Paper (which led to the National Working Group) and the 2004 Cannabis Report (containing a cannabis-deterrent policy) a series of measures was proposed. These included proposals to expand the research area to include more programmes, while also focussing on specific aspects; keeping track of drug use and its consequences via monitors; and setting up registration systems and large-scale population studies. Most of these proposed activities

were indeed carried out. New, fairly comprehensive activities were launched (such as the Netherlands National Drug Monitor (NDM), the Scoring Results programme and the ZonMw-research programme); a number of existing activities were supported – sometimes with certain modifications, or were continued (e.g. the Drugs Information and Monitoring System (DIMS), the National Alcohol and Drugs Information System (LADIS) and public anti-cannabis campaigns).

Have the envisaged outcomes been achieved? The 1995 Drugs Policy Paper would appear to have gone some of the way towards addressing the stated lack of data. The NDM publishes an annual report on the nature and extent of drug use in the Netherlands and on drug-related crime. Moreover, with the guidelines and protocols which have largely been published by the Scoring Results programme, a basis has been laid for evidence-based work in addiction care. Furthermore, considerable effort was put into the implementation of evidence-based interventions, although some obstacles still remain. Although organisations are often well informed of knowledge products, various problems need to be overcome in order to actually introduce new interventions on a sustainable basis. This is not always successful. Currently, these efforts are taking place in the form of the earlier cited Diagnosis Treatment Combinations, via Benchmarking of certain elements of addiction care and by means of GGZ mental health care performance indicators, which also apply to addiction care.

Municipal policy regarding coffee shops, numbers of coffee shops and breaches of the AHOJ-G criteria are monitored on a national basis via research. Drug-related organised crime is monitored separately. Furthermore, both small-scale and large-scale evaluation research is conducted on judicial policy and behavioural interventions. Drug-related public nuisance is covered by the State Safety Monitor, although this only generates a very general picture.

It is important for the success of guidelines and monitors that figures are regularly updated, since otherwise the results may become outdated or show gaps. Apart from the danger of becoming outdated, essential data may be left out or be of insufficient quality. This applies to data on the size of the group of problem cannabis and cocaine users, the extent of public nuisance caused by drug users and other forms of drug-related public nuisance, the prevalence of infectious diseases (HIV, Hepatitis B and C), trends in (risky) recreational drug use among youngsters and the registration of the effects of specific treatments and care. There is also insufficient understanding of developments in the problems (mental, social and health-related) among problem drug users. Finally, we do not yet know who participates in the "new" treatments that are offered via internet or in private clinics. And data on drug law crime often lack specificity.

Research on ecstasy, prompted by the rise in synthetic recreational drugs has highlighted the risks of using ecstasy, as a result of which policy initiatives were adopted to reduce these risks.

Virtually all proposed research activities related to the objectives of the Cannabis Report have been carried out, although not all the questions that are of importance for cannabis-deterrent policy have been addressed.

Conclusions and Discussion (Chapter 14)

In this chapter we conclude that the approach proposed in Dutch drug policy, i.e. a combination of measures targeting a reduction of demand, harm and supply, has broadly been adopted in practice. Nonetheless, this evaluative study has identified a number of problems related to implementation and capacity as well as gaps and loopholes.

It may also be concluded that policy has not prevented an increase in drug use between the late 1980s and the mid-1990s, particularly among minors. Nonetheless, compared to other European countries and the US, drug consumption in the Netherlands in the general population is average or low, with the exception of ecstasy, and the situation is stabilising. With regard to managing individual (health) risks, policy appears to have been fairly successful. At the same time, it must be acknowledged that high-risk drug use is more common among vulnerable groups of youngsters. There has also been a rise in the demand for treatment for cannabis problems from addiction care services; however it is unclear whether this indicates an increase in problem use. Where crime among long-term problem hard drug users is concerned, there is a perceptible decline in property crime, which can (partly) be attributed to a decline in criminality among opiate addicts. However, there are signs of a rise in violent crimes committed by drug users. In the recent period criminality associated with drug production and trafficking as well as drug-related public nuisance received greater attention than might have been expected on the basis of the 1995 Drugs Policy Paper. There has been some success with intensified policing of cocaine, ecstasy and cannabis. Although recent data indicate that these developments are going in the right direction, certain shifts in drug production and supply have been noted, and the involvement of organised criminal consortiums operating both on the domestic market, but especially internationally, continues unabated. In some border communities, coffee shop tourists cause serious public nuisance.

It may be asserted that Dutch drug policy has been reasonably successful, even by today's standards, in achieving the goals set out, although certain problems continually require renewed attention.