Progress Report on the Drug Policy of the Netherlands

2001-2002

Ministerie van Volksgezondheid, Welzijn en Sport – NL

The Hague, december 2002

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Contents

1 Introduction

The primary aim of the Netherlands' drug policy is to prevent or limit the risks of drug use to individuals, their immediate environment and society. To reduce the demand for drugs and the dangers of drug use to individuals and their immediate environment, we pursue a policy of professional care and prevention. To inhibit the supply of drugs, we actively combat organised crime. Our policy is also aimed at maintaining public order and tackling nuisance occasioned by drug use. The Ministries of Health, Welfare and Sport, of Justice, of the Interior and Kingdom Relations, of Foreign Affairs and of Finance (Customs) are involved in this policy.

The present report is a follow-up to the progress report for the years 1999-2001[1] and can be seen as a concluding summary of drug policy over the last few years. It is sent to the Parliament in October 2002 (Lower House, 2002-2003, 24077, nr. 110).

The most important developments are summarised below:

Drug use
Drug use has increased since 1997. The rate of use is stable among 12 to 15-year-olds and is increasing slightly in the older age groups. This trend does not appear to set the Netherlands apart from other European countries. We occupy a position halfway up the scale for cannabis use in the EU and a position in the top five for other drugs. The number of problem users of hard drugs in the Netherlands is the lowest in the EU.

Prevention
The Netherlands devotes effort to the prevention of drug use in many different ways. Primary responsibility for this rests with the municipalities, schools, parents and institutions, supported by a national infrastructure and by national projects. The effort devoted to the prevention of recreational drugs is being intensified.

Addict care
A number of studies, including the experiment with heroin dispensation on prescription, have been completed. The heroin dispensation experiment shows that patients who are treated with a combination of methadone and heroin function better both physically, mentally and socially, coupled with a fall in the crime rate in this group.

[1] Lower House Non-file document 2001-2002, Ministry of VWS 0001255

Cannabis

Following a marked decline in the number of coffee shops between 1997 and 2001, this number has now stabilised. The results of the latest measurements of THC levels in cannabis will be released later this year.
The Netherlands has been involved in two international conferences on cannabis; one on the urban problems and one on the scientific aspects of this drug.
A growing number of European countries are intending or have already begun to refrain from prosecuting people automatically for the possession of small quantities of cannabis.

Drug nuisance and justice department addict care

Drug-related nuisance declined between 1996 and 2000, and has stabilised since then. Around a hundred people are currently detained in the Penal Care Facility for Addicts [Strafrechtelijke Opvang Verslaafden - SOV]. Further decisions about this penal approach will be made after an evaluation has been carried out.

The fight against drug crime

Cocaine smuggling by couriers through Schiphol increased in the second half of 2001. Various measures have been introduced to combat this, including more stringent checks at the airport. The white paper, 'A combined effort to combat XTC' ['Samenspannen tegen XTC'], is also being implemented. More effort will be put into enforcement and international cooperation within the framework specified in this white paper.

International collaboration

The Netherlands has close collaborative partnerships with various countries. The most important of these are with our neighbour countries, with France and with the USA. We also collaborate within the framework of the EU Action Plan on Drugs, 2000-2004.

2 Drug use: trends, monitoring and assessment

2.1 TRENDS IN USE

In 2001 the Centre for Drug Research [Centrum voor Drugsonderzoek - CEDRO] of the University of Amsterdam carried out the second National Prevalence Study among the general public aged twelve or above. This study includes statistics about drug use, which it compares with the situation in 1997 when the first measurement was carried out. It not only looks at the use of drugs at least once in the respondent's lifetime ('ever use'), but also at use in the year and in the month prior to the measurement date. The latter figure is particularly important because it gives an indication of the current level of drug use among the general public.

The latest statistics show that cannabis is the most widely used drug of all: 17% of the survey respondents reported that they had tried cannabis at least once in their lifetime, 5% had done so during the previous year and 3% had used it during the last month. The rates of use for hard drugs (cocaine, ecstasy, amphetamines, heroin and hallucinogenic mushrooms) are significantly lower. However, there has been an increase in the use of both soft drugs and hard drugs since 1997 (see Table 1).

Table 1: Substance use by the general public aged 12 and above: 1997 and 2001

	Ever used the substance		**Used the substance in the last month**	
	1997	**2001**	**1997**	**2001**
Cannabis	15.6	17.0 *	2.5	3.0 *
Cocaine	2.1	2.9 *	0.2	0.4 *
Amphetamines	1.9	2.6 *	0.1	0.2
Ecstasy	1.9	2.9 *	0.3	0.5 *
Hallucinogens	1.8	1.3	0.0	0.0
including LSD	1.2	1.0	—	—
Mushrooms	1.6	2.6 *	0.1	0.1
Heroin	0.3	0.4	0.0	0.1

* Significant change from the previous measurement

Source: National Prevalence Study. Abraham, Kaal, Cohen, 2002

When these figures are broken down by age, the majority of drug users fall into the 20 to 24-year-old age group. The biggest increase has also occurred in this age group. From the age of thirty upwards the prevalence of drug use starts to decrease again. Drug use in the youngest age group, 12 to 15-year-olds, is limited and has scarcely changed since 1997.

Table 2: Last month use of cannabis and hard drugs by age group: 1997 and 2001

	Cannabis		**Harddrugs***	
Age	**1997**	**2001**	**1997**	**2001**
12-15	2.0	2.2	0.2	0.2
16-19	8.3	8.6	1.4	1.9
20-24	7.1	11.2	1.8	3.5
25-29	4.7	6.6	1.3	1.4
30-34	2.1	3.6	0.3	1.1

* Cocaine, amphetamines, ecstasy, hallucinogens (excluding mushrooms), heroin

Based on the prevalence figures for drug use in the last month, the numbers of current drug users have been estimated as follows:

Table 3: Estimated numbers of drug users (2001)

	Estimated numbers*
Cannabis	375.000 - 443.500
Cocaïne	43.300 - 68.900
Amfetamine	21.700 - 40.700
Ecstasy	54.400 - 82.700
Hallucinogens	900 - 7.600
including LSD	300 - 5.800
Mushrooms	6.800 - 18.800
Heroin	5.300 - 16.300

* 95% reliability intervals

Source: National Prevalence Study. Abraham, Kaal, Cohen, 2002

GHB

In mid-2001 the Ministry of Health, Welfare and Sport received reports from various sources of a rise in the use of GHB (gammahydroxybutyric acid), originally a narcotic. Recreational use of this drug was associated with accidents and people who went into a coma. Incidents of sexual abuse where the victim was said to have been intoxicated with GHB were also reported.

These reports prompted the Ministry to commission a study of the distribution, use and risks of GHB. The study, which was carried out by the University of Amsterdam, reveals that GHB use and the number of accidents linked to GHB are both rising in the Netherlands.[2] The number of unwanted sexual contacts in which GHB plays a role appears to be greater than was previously assumed.
A pilot study has also been carried out into the nature and scale of accidents resulting from the use of GHB, and we shall also need to consider more closely how the available data is to be interpreted.
Users find that the substance mainly has a pleasant effect and causes almost no 'hangover' afterwards. Even if they 'pass out' after using GHB - that is, lose consciousness - they still feel remarkably fit on the following day. But the biggest danger posed by GHB lies in the fact that users do sometimes pass out. The main reason for this is that it is difficult to get the dose right; the toxic properties of GHB itself are relatively slight.
The risk that an individual will consume GHB involuntarily (because someone mixes the drug surreptitiously into their drink) is small, due to the substance's salty taste. Most users get hold of GHB through their friends or acquaintances; a few get it from a dealer. Ten percent of the users surveyed have made GHB themselves at some point; in virtually every case they order the ingredients through the internet
The findings of the study prompted us to ask the National Support Centre for Prevention [Landelijke Steunpunt Preventie - LSP] to develop proposals for intensifying our GHB prevention programme as soon as possible, in consultation with the prevention sector. GHB has recently been added to List II of the substances controlled by the Narcotics Act [Opiumwet].

2.2 MONITORING AND SURVEILLANCE

Monitoring recreational drugs

Since 1992 users have been able to get their drugs tested or hand them in at 25 testing centres, most of which are addict care institutions and municipal medical and health services. These institutions are participants in the Trimbos Institute's Drugs Information and Monitoring System [Drugs Informatie en Monitoring Systeem - DIMS]. The drugs monitor makes an important contribution by providing support with a solid and responsible scientific basis for national and local drug policy. The DIMS observes the developments in the drugs market and draws attention to drugs that pose an acute risk to public health, so that warning campaigns can then be initiated. When users are given the test results

[2] Korf, D., Nabben, T., Leenders, F. en Benschop, A. (2002). GHB: Tussen extase en narcose

[Between ecstasy and narcosis]. Amsterdam: Rozenberg Publishers.

they are also supplied with extensive information about the health risks. The message they are given is that drug use is never risk-free, even after the drugs have been tested by the DIMS.

Identifying pills is becoming harder due to the growing diversity of the products now available. The proportion of pills that are recognised immediately at the participating organisations' offices has fallen sharply in the last few years.
A further problem is that the number of samples submitted to the testing centres has been falling for some time. Because of this, the value of the monitor is decreasing. Carrying out testing inside entertainment venues could be a means of increasing the representativeness of the sampling scheme. This possibility was rejected in a Lower House motion in January 2002. The same position was adopted in the Strategic Agreement.
The University of Amsterdam has been asked to investigate the value of a number of alternative approaches to on-site testing. The alternatives are:

a Expanding the facilities available for testing pills at the participating organisations' offices;
b Testing drugs that have been seized;
c Carrying out testing at separate locations in the entertainment districts (without carrying out tests in places where the pills are actually used).
The study started in July 2002 and is expected to announce its findings in May 2003.

In 2000 agreement was reached with the Public Prosecutions Department [Openbaar Ministerie - OM] as to the circumstances in which tests can continue to be conducted in the interests of public health. The details of this agreement were laid down in the Public Prosecutions Department Drugs Act Guideline [OM richtlijn Opiumwet, registration number 2000A019] by the Board of Attorneys-General [College van Procureurs-generaal], which came into force on 1 January 2001. Agreements have also been made with the participants in the Drugs Information and Monitoring System (institutions which have created a facility where people can submit drug samples) governing the quantity and nature of the substances to be tested. These have been recorded in a protocol.

'Red Alert' protocol

The details of what to do when a worrying substance or situation is detected in the drug market have been laid down in a protocol. This protocol specifies the 'Red Alert' actions to be taken in respect of institutions, potential consumers, professional groups, DIMS participants and the media. The Minister of Health, Welfare and Sport has final responsibility for carrying out 'Red Alert' actions.

The Minister consults a core team of advisors before deciding on the most desirable steps to take when a worrying substance or situation involving recreational drugs has been detected.

2.3 ASSESSMENT

Coordination Centre for the Assessment and Monitoring of New Drugs [Coördinatiepunt Assessment en Monitoring Nieuwe Drugs – CAM].
The CAM was established within the Health Care Inspectorate [Inspectie voor de Gezondheidszorg] at the request of the Minister of Health, Welfare and Sport to implement a decision of the European Council. It has been operating since 1 January 1999. The aim of the CAM is to carry out a multidisciplinary risk analysis as soon as possible on new drugs (of botanical or synthetic origin), and new combinations or new uses of familiar substances which appear on the Dutch market. Fixed procedures (protocols) and criteria are used to perform a risk analysis. These criteria cover aspects both of (public) health and of public order and safety. When it comes across a synthetic drug, the CAM will report this to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

In recent years risk analyses have been published on 4-MTA, GHB, hallucinogenic mushrooms and cetamine. Following the performance of a European risk analysis, the Council of the European Union decided to ban 4-MTA. In the Netherlands this drug has now been put on List I of the substances controlled by the Narcotics Act [Opiumwet].

The recommendation for GHB was that use of this substance should be monitored and that a new risk analysis should be conducted as soon as a discernible change occurred in the situation. Since GHB has been brought within the scope of the UN treaties, it has also recently been put onto List II of the substances controlled by the Narcotics Act [Opiumwet].
In the case of hallucinogenic mushrooms (which contain the substances psilicone and psilocybine), the CAM recommended that quality standards should be drawn up for the product (covering aspects such as standardisation, purity, labelling) and for its sale (including responsible information provision). This should help to limit the availability of hallucinogenic mushrooms. According to the CAM, no legal ban is needed. In view of the limited extent of use, it has recommended that no additional measures be taken for cetamine. The final stages of a risk assessment for PMMA are now being carried out. In the meantime, in response to an EU decree PMMA has been added to List I of the substances controlled by the Dutch Narcotics Act [Opiumwet].

3 Prevention

3.1 ORGANISING THE PREVENTION FUNCTION

The most effective form of prevention probably takes place in the immediate surroundings of (mainly) children and young people; in their upbringing, their education and their leisure activities. Various institutions are active in this area: they include more general bodies, such as the Municipal Medical and Health Services [Gemeentelijke Geneeskundige en Gezondheidsdiensten – GGDs] and the youth care organisations, and, more specifically, the regional addict care and mental health care institutions. Under the terms of the Public Health Collective Prevention Act [Wet Collectieve Preventie Volksgezondheid], municipalities and their municipal health services are responsible for carrying out collective prevention activities. The 1994 Welfare Act [Welzijnswet] stipulates that municipalities are responsible for outpatient addict care. Information provision and preventive activities in respect of drugs and drug use also fall into this area of responsibility. Specialised institutes are generally given responsibility for conducting these campaigns, and they develop regional activities for the purpose.
The Ministry of Health, Welfare and Sport is responsible for a number of aspects of national policy on information provision and prevention. On the one hand, it supports activities which, due to their national scale, would not otherwise take place. On the other, the activities concerned are organised in such a way as to ensure that they can provide support for the activities which are carried out on a regional or local scale.

3.2 ACTIVITIES WITH NATIONAL FUNDING

National public education campaign
In the autumn of 2001 the Trimbos Institute collaborated with over 60 regional addict care institutions and municipal medical and health services to organise a campaign entitled *'Drugs: don't be fooled'* [Drugs, laat je niks wijsmaken]. This campaign continued the work started in the campaign conducted in the autumn of 2000 under the same name. Its aim was to encourage and to improve communication about drugs between young people and their parents, and to influence the information-seeking behaviour of young people.

Drug Information Line [Drugs Infolijn]
The Drug Information Line has now been operational for six years and it plays a key role in the provision of information about drugs and drug use. The line is

open for calls 24 hours a day. Callers can be sure of receiving clear, reliable information. They can choose to be sent printed information about drugs, or to have a personal talk with a member of the Drug Information Line's staff. 11,017 callers - 34% - opted for a personal talk in 2001, compared with 9,816 (28%) in 2000. The drugs about which the largest number of questions were asked were hashish and cannabis; these were followed by XTC and then cocaine. Most of the questions were about the risks. Of the callers who were referred elsewhere, one quarter (25%) were referred to an addict care institution. Referrals to general practitioners came second (16%). 12% of the callers had heard about the Drug Information Line through an intermediary institution, 11% had called it before at some point, and 10% called after finding out about it from a leaflet. In 2001 the line was called most frequently in January, February and November. The peak number of calls in November was connected with the aforementioned public education campaign, *'Drugs, don't be fooled'*. The number of the Drug Information Line appeared prominently in all the campaign publicity materials.

'The healthy school and stimulants' ['De gezonde school en genotmiddelen']
This programme is presented in three quarters of secondary schools, so it reaches at least 350,000 school students a year. More than 90% of the addict care institutions and municipal medical and health services participate in this project. Even after eleven years, the schools' interest in the programme has not diminished and more schools are continuing to join. The project is based on five key elements: lessons about stimulants; agreements that are made within the school; the identification of problem use and the pro vision of guidance for these users; parental involvement; and a steering group which monitors the activities for consistency.
The project has recently been updated and its scope has been expanded. The support offered in the five aforementioned areas has been completely revised and redesigned. Various new interventions have also been added. One example of these is 'No deal!', which provides schools and support institutions with guidelines for collaborating with the police to combat drug dealing in and around schools. Another project is *'Active Pupils'* [Actieve leerlingen], which fits in with the trend towards the use of pupil-mentor relationships in the education sector.

'Achieving Results' [Resultaten Scoren]
The aim of the 'Achieving Results' programme is to improve the quality and innovativeness of the addict care and drug prevention programmes. To this end, the organisations in this sector are collaborating in three development centres (see also section 4.2). One of these is the Prevention development centre, within which a number of addict care institutions work closely together. The National Support Centre for the Prevention of Addiction and Substance Use [Landelijk

Steunpunt Preventie van Verslavingen en Middelengebruik - LSP] advises and chairs the development centre's working group. Its activities in 2002 have included studying and publishing effective marketing and communication strategies, developing a plan of action for creating and introducing an electronic prevention file, research into methods of recruitment among young Turkish people, developing and evaluating an approach for supplying information at home to parents with adolescent children who are difficult to reach, and developing protocols for the prevention of addiction. These protocols will be tested and brought into use in 2003. The centre also plans to start providing clients with interactive information through the internet. It will follow a phased plan of action to do so, starting by setting up the first phase of the prevention file with a minimal data set and making this available to the institutions. This will serve as a much-needed expansion of the mental health care and addict care registration system.

3.3 PREVENTION AND RECREATIONAL DRUGS

In response to the white paper, 'A combined effort to combat XTC' ['Samenspannen tegen XTC'], extra funding has been made available for an intensified programme of prevention, monitoring and research into recreational drugs over the period from 2002 to 2004. After completing a survey and evaluation of the existing interventions in the area of information provision and prevention, a plan of action has been drawn up. Promoting an evidence-based and innovative approach is a priority in this plan of action. As much use as possible will be made of the existing organisation and infrastructure when implementing the plan. It includes the following elements:

Investigating the risks of XTC
In order to update the information messages and materials accurately, an authoritative scientific report must first be compiled on the risks of XTC. This report is now being drawn up by the Leiden University Medical Centre. It will include a summary of the current status of national and international research into the short-term and long-term risks. Extra effort will also be devoted to studies of the neurotoxicity of XTC. Finally, the feasibility of a study into the relationship between XTC policy, drug use and health (a causality study) will be examined.

Improving prevention methods
Innovative methods will be used to approach the target groups. For example, these could include experiments with evidence-based interactive information provision, the creation of an authoritative information centre, and improving,

expanding and standardising information materials. To encourage municipalities, addict care institutions and other interested parties to make XTC prevention a higher priority and to promote an integrated approach, the assistance of the Support and Information Centre for Drugs and Safety [Steun- en Informatiepunt Drugs en Veiligheid - SIDV] and the National Support Centre for the Prevention of Addiction and Substance Use [Landelijke Steunfunctie Preventie - LSP] will be sought.

Monitoring

Since the advent of XTC in the late eighties we have seen rapid changes in the user market. Not only are new substances or new versions of substances constantly appearing on the market, but the quality is also continually fluctuating. The user groups, the locations where the drug is used and the purposes and risks of use are apt to change quickly. To keep track of these rapid changes, partly to enable better preventive action to be taken, we plan to intensify our monitoring of the user market and the supply side. We shall improve our monitoring of the user market by setting up a system which will allow trend watchers to deliver and exchange knowledge and experience from time to time. Monitoring of the supply side will be improved within the framework of the Drugs Information and Monitoring System (DIMS).

3.4 SUPPORTING THE PREVENTION FUNCTION

Drug prevention activities are carried out by a wide variety of institutions, such as schools, local or regional addict care institutions, municipal medical and health services, the police and a number of national institutions.
Cooperation between these institutions and the implementation of programmes that have proved effective is encouraged by the National Support Centre for the Prevention of Addiction and Substance Use [Landelijk Steunpunt Preventie van Verslavingen en Middelengebruik - LSP]. The LSP carries out activities for the benefit of workers in the field, policy-makers and researchers. Programmes of work are coordinated in consultation with the heads of prevention departments and priorities are specified for development, standardisation and research. The LSP ensures that there is a coherent relationship with prevention activities in the field of mental health care; it has close links with the National Prevention Support Centre for the Mental Health Care Sector [Landelijk Ondersteuningspunt Preventie voor de geestelijke gezondheidszorg - LOP]. It also cooperates with other prevention sectors and the public health care sector. The LSP is collaborating with the municipal medical and health services to implement the Hepatitis B vaccination programme among risk groups, including drug users. Preparations for this commenced in 2002, and the execution of the programme

will mainly take place between 2003 and 2005. Three interventions aimed at the children of parents with a psychiatric disorder and children of parents with an addiction were standardised in 2002. National standardisation of an intervention is a highly complex process, and one that requires national direction and support. The LSP collaborates with the Prevention development centre and the Social Policy on Addiction development centre within the framework of the 'Achieving Results' programme (see section 4.2).
The LSP's help desk and database appear to be an indispensable source of information for many prevention workers, researchers and policy-makers. An annual survey is conducted to provide an up-to-date overview of the prevention projects currently taking place in the Netherlands in the areas of addiction and mental health care. Work is currently being carried out in collaboration with various bodies, including the National Institute for Health Promotion and Disease Prevention [Nationaal Instituut voor Gezondheidsbevordering en Ziektepreventie - NIGZ] and the municipal medical and health services of the Netherlands, to create a link between the data collections of other prevention sectors and an internet version.

4 Addict care

4.1 MANAGING AND FUNDING ADDICT CARE

Enhanced addict care [Verslavingszorg herijkt]

The 'Enhanced addict care' project was started in response to the recommendations issued under that name by the Council for Public Health and Care [Raad voor de Volksgezondheid en Zorg] and the Council for Social Development [Raad voor de Maatschappelijke Ontwikkeling]. The centrepiece of this project comprises three pilot projects which seek to improve the administrative and financial coordination of addict care.

The pilot project in Amsterdam is called 'Support' and is targeted at the category of extremely problematic individuals. Its aim is to provide these people with shelter, an activity to occupy their time, medical care and access to a protected environment where they can use drugs (user room). To achieve these goals, each client is assigned a mentor (social worker). These mentors and clients use the facilities of the various institutions and organisations. This demands collaboration and coordination on the part of all the parties involved. A consultative body comprising the mayor, representatives of the police, the chief public prosecutor and the alderman responsible for care has been established for this purpose, and a long-term policy framework has been drawn up. In addition, a coalition representing all the collaborating parties at the managerial level has been set up. The option of expanding this coalition to include the Care Office [Zorgkantoor] is currently under discussion.

The Limburg pilot project covers the regions of North and South Limburg. Administrative coordination teams, in which the parties concerned are represented, have commenced operations in both regions in the past year. Both coordination teams have decided to give priority to the issues of mental health care, social relief and addict care ['maatschappelijke opvang en verslavingszorg'], and youth care and addict care. The policy framework for this project is expected to be finalised in late 2002. One of the action points in this long-term framework will be the formation of an operational committee of budget administrators and a mathematical framework.

To promote an integrated approach to the management of addict care in Rotterdam, the City Council, addict care institution and care office have set up a regional project group and signed a joint starting document. This has been prompted by the desire to develop a shared vision of addict care in the region, based on which production agreements can be made between the funding agencies in question. To this end, the project group has chosen to designate the

central Rotterdam municipality as a reference area. The group has not yet succeeded in involving the addict rehabilitation sector in this project, and has therefore now decided to focus on municipal addict care and addict care funded under the Exceptional Medical Expenses Act in the first instance and to involve the addict rehabilitation sector at a later stage. A 'quick scan' will be carried out to obtain information about the dividing line between the care provided by the justice department's addict care programme and the addict care provided by the municipalities or funded under the Exceptional Medical Expenses Act. This survey will also identify any gaps and problem areas.

In 2003 (when the pilots will end), it will be possible to assess whether better administrative and financial coordination of municipal addict care and addict care funded under the Exceptional Medical Expenses Act has been achieved, or whether legislation and regulation will need to be modified. The Ministry of Health, Welfare and Sport will use the information from the 'quick scan' in Rotterdam to conduct further discussions with the Ministry of Justice.

4.2 DEVELOPMENTS IN ADDICT CARE

'Achieving Results' [Resultaten Scoren]

'Achieving Results' is a quality and care innovation programme for addict care and the prevention of addiction. Three development centres have been created, within which the addict care organisations work together closely: they focus on Quality and Innovation of Care, Prevention (see 3.2), and Social Policy on Addiction respectively. 'Achieving Results' is a long-term programme; it was originally scheduled to finish at the end of 2003 but will probably then be extended by another year. This is to ensure that the new protocols and methods of treatment are actually introduced and established as part of the system. The Ministry of Health, Welfare and Sport provides 'Achieving Results' with an annual subsidy of 0.7 million euros. The Netherlands Association for Mental Health Care [GGZ-Nederland] is responsible for implementation, in consultation with the Ministry of Health, Welfare and Sport. The activities to be undertaken by the Quality and Innovation of Care development centre in 2003 include developing and testing protocols for detoxification, self-help and dual diagnosis, and communicating them to workers in the field. The Social Policy on Addiction development centre will focus on writing client profiles for the sector. In addition, the regional learning networks which were set up this year will be expanded further. In this way the knowledge and the products generated by the 'Achieving Results' programme will be maintained and exchanged by the sector itself.

Improved care for alcoholics

The goal of the policy of alcohol moderation described in the White Paper on Alcohol (Alcoholnota) is to reduce the number of problem drinkers. One of the ways in which this can be achieved, in addition to a change in the rate of excise duty and more effective enforcement, is by providing more extensive care. Starting in 2002, the funds available for this purpose will be increased structurally by an extra 7.7 million euros per annum. The Netherlands Association for Mental Health Care [GGZ-Nederland] has drawn up an Alcohol Care Action Plan [Actieplan Alcoholzorg]. One of its aims is to extend the reach of the outpatient care facilities from 22,500 to 29,000 alcoholic clients per annum within three years. This year the main focus has been on expanding the existing outpatient care for alcoholics. In 2003 it will also need to reach new target groups and to offer new forms of care, such as setting up groups for children whose parents are alcoholics and offering consultations and holding surgeries through general practitioners. The addict care institutions will report annually, through GGZ-Nederland, on the uses to which the funds for the alcoholic care sector have been put. A possible way of improving the accessibility of care facilities for alcoholics is currently being tested in a pilot project involving evening opening in three regions. These pilot projects are being funded from the Ministry of Health, Welfare and Sport's budget. They commenced in October 2001 and will run for three years.

Experimental facilities

New experimental facilities have been established as part of the addict care financed under the terms of the Exceptional Medical Expenses Act [AWBZ] with the aim of reducing nuisance but also to improve the accessibility of care and to help target groups that are not properly reached. The most notable example of these facilities are the Inpatient Motivation Centres [Intramurale Motivatie Centra – IMC]. Evaluation reports on the ten IMCs were published at the end of 2001. Based on the findings, the Ministry of Health, Welfare and Sport has now decided to allow the IMCs to continue operating (a further temporary licence has been granted to one of the IMCs). The most significant conclusion to emerge from the evaluations of the IMCs is that IMCs do succeed in reaching the long-term problematic hard drug addicts who cause nuisance; people whose motivation is low and who have little hope of cutting down quickly and completely on their drug consumption. Almost without exception, both the clients and those who refer them to the IMCs are enthusiastic. After attending the IMC, a large proportion of the target group chooses to attend outpatient follow-up facilities where the emphasis is on practical assistance with housing and work rather than clinical therapy.

Collaboration with the Department of Justice and coordination with follow-up

addict care facilities still needs further improvement (a tighter fit between the links in the chain). As the methodology is developed further, we shall need to work out how the IMCs are to deal with clients who can stop using drugs altogether, as well as chronic addicts for whom stabilisation and resocialisation are more realistic goals.

User rooms

In April 2002 the Lower House was informed[3] about the results of the policy in respect of drug possession and use in a protected environment ('user rooms') as promised in the General Consultations of 23 May 2001. On 2 May of this year, in response to two studies conducted by the Trimbos Institute[4], information about user rooms was supplied to the House for information. The studies show that user rooms have a positive effect on the state of health of those using them, that they lead to a reduction in nuisance and that they increase the reach of the addict care services. User rooms allow drug users to use drugs under the supervision of social workers, in a hygienic manner and in a stress-free environment. Setting up these user rooms is a matter for the relevant local authorities. The dispensation or sale of drugs - including quantities for personal use only - in and around these user rooms is expressly prohibited. This ban also applies to so-called house dealers. These user rooms must not be confused with private initiatives, many of which are set up by users and dealers, such as the so-called crack cellars of Rotterdam.

LADIS register

Each year the Foundation for the Provision of Addict Care Information [Stichting Informatievoorziening Verslavingszorg - SIVZ] supplies details from the National Alcohol and Drugs Information System [Landelijk Alcohol en Drugs Informatiesysteem - LADIS], in which virtually all outpatient addict care institutions participate. Until the end of 2000 these records also covered patients of the addict care system who were undergoing rehabilitation. Since 2001, however, the details of these patients have been recorded in the Patient Monitoring System [Cliëntvolgsysteem – CVS] maintained by the Netherlands Rehabilitation Foundation [Stichting Reclassering Nederland]. This system is not compatible with LADIS. To prevent any loss of data in LADIS, which could lead to a break in the trend, since the start of 2002 the parties concerned have been working hard to enable the necessary details of 2001 to be transported between the two systems. Various problems have arisen in the process, and as a result the reports on outpatient addict care are delayed this year.

[3] Lower House 2001-2002, 24077 nr.105

[4] Lower House 2001-2002, VWS 0200599 (non-file document)

ZORGIS register

Data on clients and on the provision of assistance in the clinical addict care sector have been incomplete for several years due to the development of a new Care Information System [Zorg Informatie Systeem – ZORGIS]. This system is intended to replace the Patient Records for Inpatient Mental Health Care [Patiëntenregister intramurale Geestelijke Gezondheidszorg – PiGG] system, which is considered to be too limited. Although numerous general psychiatric hospitals are already linked to the system, the addiction clinics have barely started to participate as yet. However, the Netherlands Association for Mental Health Care [GGZ-Nederland], the umbrella organisation for the mental health care and addiction care institutions, and the developer of the system, Prismant, expect all the addiction clinics to participate in 2003. Once ZORGIS is running properly in all the institutions, a wealth of information about the patients, the care provided, the results achieved, performance comparisons between the institutions, etc. will become available. However, the addict care sector will have to wait until at least mid-2004 before the first data becomes available.

The National Centre for Substance Registration [Landelijke Centrale Middelen Registratie – LCMR]

The LCMR concentrates mainly on appropriate biometric methods for identifying patients and caregivers, and on national reference indexes. This information system is designed to facilitate a proper and secure form of individual addict care using substitution treatment for opiate addiction (including methadone and heroin). On 13 March 2002 the Ministers of Health, Welfare and Sport and Justice approved the introduction of the LCMR. The technical aspects of the system's introduction nationwide will be handled by the Foundation for the Provision of Addict Care Information [Stichting Informatievoorziening Verslavingszorg - SIVZ]. This is expected to be completed in mid-2004.

Cocaine patients

Last year the details supplied by the outpatient addict care organisations revealed a rapid increase in the number of individuals who applied to the care services for help with problems arising from their use of cocaine.
At the request of the Ministry of Health, Welfare and Sport, the SIVZ is now carrying out an analysis of the characteristics of cocaine patients and the care that they have received. It is comparing them on these points with opiate users in the outpatient care sector. The Netherlands Association for Mental Health Care [GGZ-Nederland] is conducting a 'quick scan' survey to find out to what extent addict care institutions have developed, or need, a specific range of treatments for cocaine patients.

Waiting lists for addict care

In the second survey (1 January 2002) of the number of people on the waiting lists and waiting times in the mental health care system, the independent institutions and addict care institutions in the regular mental health care system were only asked to supply the number of patients who were waiting for treatment. This was because it emerged from the first survey (1 January 2001) that no clear picture could be obtained of the number of people on waiting lists at the registration or evaluation stages, due to the different entry points to the system (registration and symptom identification) and the lack of separation between the funding sources. The total number of individuals waiting for addict care rose by 135 between 1 January 2001 and 1 January 2002, to a figure of 1.264.[5]

4.3 METHODS OF TREATMENT

To improve the treatment of heroin addicts, the Ministry of Health, Welfare and Sport commissioned research into the effectiveness of three methods of treatment: dispensation of high doses of methadone, detoxification with the aid of naltrexon, and dispensation of heroin on medical grounds for those addicts for whom detoxification (even with high doses of methadone or naltrexon) is not successful. Based on the findings of these three studies, the government's position on this question was submitted to the House on 12 March 2002.

Heroin experiment

The study entitled Heroin on Medical Prescription [Heroïne op Medisch Voorschrift] was completed in February 2002. The study was praised highly by international experts in this field. The results of the experiment showed that treatment with a combination of heroin and methadone was more effective than treatment with methadone alone. This was reflected both in improvements in the patients' physical and mental condition and in improvements in their ability to function socially, including a reduction in criminal behaviour. Moreover, heroin on medical prescription also led to a small decrease in cocaine use. The study also showed that heroin dispensation on medical prescription was safe and manageable, and did not cause any additional nuisance.

5 For a General report on waiting lists and waiting times for mental health care, see the letter to the Lower House (Lower House 25 424, no. 42, 6 May 2002).

6 Lower House 24077, no. 102

On 27 June 2002 the government decided that the existing treatment units should be allowed to continue with the combined treatment. A decision about a possible expansion of the programme has yet to be made. A number of issues will be explored in detail in preparation for this decision. A working group comprising (doctors from) the treatment units, the participating care institutions, the municipalities and the Foundation for the Provision of Addict Care Information [Stichting Informatievoorziening Verslavingszorg - SIVZ] will shortly start collaborating with the Central Committee for the Treatment of Heroin Addicts [Centrale Commissie Behandeling Heroinverslaafden] to develop a protocol for diagnosing all patients who participate in heroin treatment. This protocol will include an obligation for all patients to register with the Health Care Inspectorate [Inspectie voor de Gezondheidszorg].
In addition, a large number of aspects of implementation still need to be examined, particularly in the areas of organisation and funding. An independent committee will be set up for this purpose: the Committee for the Introduction of Heroin Addiction Treatments [Commissie Invoering Behandelingen Heroïneverslaving - CIBH]. The CIBH's brief will be to submit a proposal to the government within six months for introducing heroin treatment in the Netherlands in a durable, high quality and responsible manner that will yield results that can be evaluated. The conditions under which the heroin treatment is to be carried out must be specified in the proposal.

EDOCRA/detoxification under anaesthetic
n the EDOCRA study high-speed detoxification was carried out with the aid of the opiate antagonist naltrexon. A general anaesthetic was also administered to the control group in a general hospital. After this, both groups received 10 months of outpatient treatment. The study will continue in 2003, but the short-term results indicate that detoxification with naltrexon under anaesthetic is no more effective than detoxification with naltrexon alone; however, it is more expensive and slightly less safe. Next year it will become clear whether this effect is also evident in the long term.

Large doses of methadone
The study into the effects of large doses of methadone has demonstrated that addicts who received a large dose of methadone (more than 85 mg) were using less heroin two years later and were also in better health and felt better mentally than addicts who received a small dose. The treatment does not produce any clear social benefits; it has a favourable effect on the addict's social network, but not on criminal behaviour, housing or participation in work.
The treatment with large doses of methadone fits in with the regular treatment of heroin addicts. Although large doses of methadone clearly produce better

results, the treatment is not completely risk-free. Near-accidents, such as near-overdoses, were slightly more common in the experimental group. Because of this, the researchers' recommendations concerning protocol development and a monitoring system to prevent (near) accidents must certainly be taken to heart. This year the addict care sector will work within the framework of the 'Achieving Results' [Resultaten Scoren] programme to review the methadone programmes and develop protocols in this area. The recommendations of the study on large doses of methadone will be incorporated into these protocols.

Medical addict care

In addition to the specific issues mentioned above, more general and structured attention is also being devoted to medical care for addicts. The Health Board [Gezondheidsraad - GR] recently published its recommendations concerning medical care for detained addicts. A position on this will be sent to the House in the autumn.

The Health Board also recently published its recommendations concerning medicinal intervention in cases of drug addiction. A position on this will be announced in January 2003. The Ministry of Health, Welfare and Sport is also subsidising the Medical Addict Care project run by the Association for the Medical Rehabilitation of Addicts [Vereniging voor Verslavingsgeneeskunde - VVGN] and the Netherlands Association for Mental Health Care [GGZ-Nederland]. The project is concerned with two preliminary studies which examine the medical and nursing functions in addict care and the opportunities for professional development in the field of addiction medicine. The project will be completed in September 2002. Based on the findings of these preliminary studies, the Ministry of Health, Welfare and Sport will then go on to discuss ways of professionalising addiction medicine with GGZ-Nederland and the VVGN.

ZonMW Addiction Programme

The ZonMW (Netherlands Organisation for Health Research and Development) Addiction Programme started in 1998, initially for a period of three years. When the programme ended in 2000 it was extended by the same amount of time. The main aim during this second period is to further encourage the progress that has already got under way in the areas of research, development and evaluation, and also, most importantly, to concentrate on implementing usable results. With the aid of implementation projects, the introduction of evidence-based innovation into day-to-day practice on a larger scale can be encouraged and evaluated.

The programme has three central themes:

1 Individual sensitivity to addictive substances
2 Backsliding in addiction behaviour, cravings
3 Improvement and innovation in the areas of prevention, care and monitoring.

In principle, the projects carried out within these topic areas are concerned with all potentially addictive substances. In practice most of the projects are concerned with drug use, and with alcohol or tobacco use to a lesser extent. A total of 50 projects were started up by the end of 2001, roughly half of which have now been completed.

A four-year research project on the neurotoxicity of ecstasy also started in the autumn of 2001. Not only do a wide variety of Dutch research groups cooperate in this longitudinal project, but they also exchange expertise with foreign scientists: through the National institute on Drug Abuse (NIDA), for example. Additional funds from the budget of the white paper, 'A combined effort to combat XTC' [Samenspannen tegen XTC] have been allocated to this project so that a number of subsidiary studies can be conducted.

5 Cannabis policy

5.1 COFFEE SHOPS

A study conducted by the research centre Intraval found that the number of coffee shops fell by 32% between 1997 and 2001. Almost all - 31% - of this decrease occurred between 1997 and 2000. The decrease was only 1% between 2000 and 2001.
At the end of 2001, out of a total of 504 municipalities[7], 105 municipalities had 805 officially tolerated coffee shops between them. The number of coffee shops in the Netherlands' four biggest cities fell by 3% between 2000 and 2001 (from 426 in 2000 to 413 in 2001). 95% of the 504 municipalities have formulated policies to regulate the number of coffee shops. The number of municipalities without such a policy in respect of 2002 appears to have fallen in 2001; there were 396 of them in 2000 and 370 in 2001. However, this fall is in fact due to the regrouping of the municipalities which came into effect on 1 January 2001. There was almost no change in proportionate terms.

Table 4 Number of coffee shops in the Netherlands

Number of inhabitants	1997 [a]	1999	2000	2001
< 20.000	± 50	14	13	11
20 - 50.000	± 170	84	81	86
50 - 100.000	± 120	115	109	112
100 - 200.000	211	190	184	183
> 200.000:				
Amsterdam	340	288	283	280
Rotterdam	180	65	63	61
The Haque	87	70	62	55
Utrecht	21	20	18	17
Total	**1.179**	**846**	**813**	**805**

a. These are estimates

Source: Intraval (Bieleman et al., 1997; Bieleman and Goeree, 2000; Bieleman and Goeree, 2002)

[7] Due to regrouping of the municipal boundaries, the number of municioalities fell from 538 in 2000 to 504 as of 1 January 2001.

5.2 CANNABIS POLICY DEVELOPMENTS

'Quick scan' of young people

One of the outcomes of the National Youth Debate, which took place in April 2001, was a promise to perform a 'quick scan'. This survey would give a picture of cannabis use among young people, and would concentrate on the 16 to 17-year-old age group. The survey focused primarily on the prevalence of cannabis use among young people, how they got hold of cannabis, whether young people only buy cannabis from their sales outlets or also buy other drugs, and whether they come into contact with dangerous criminal situations at those sales outlets. The results of this quick scan will shortly be discussed with the National Youth Debate Foundation (Stichting Nationaal Jeugddebat) and with a number of young people, after which the Lower House will be informed.

Count of non-tolerated sales outlets

Research into the count of the number of coffee shops is carried out annually. A promise to see to what extent a method can be developed to count the number of non-tolerated sales outlets has been made to the Lower House (letter dated 3 October 2001, just000779 non-file document). A study of the feasibility of counting the number of non-tolerated sales outlets has now started.

Monitoring the THC content of cannabis

The third survey of the THC content of cannabis was carried out in September 2001. It found that the average THC content of Dutch home-grown cannabis was 10.1%. This was a limited survey which only measured the THC content of samples of Dutch cannabis, the most widely used type of cannabis. The previous surveys, which were carried out in 1999/2000 and in 2000/2001, revealed an increase in the average concentration of THC in Dutch cannabis from 8.6% to 11.3%. This increase thus did not continue in 2001, but it is too soon to draw any conclusions about the present trend.

A promise was made in the progress reports for the 1999-2001 period to increase the frequency of the measurements. In addition to the extensive annual measurement of the strength of Dutch and foreign marijuana and hashish, Dutch cannabis is now also monitored on its own once a year. The statistics maintained by the Amsterdam Municipal Medical and Health Services (Gemeentelijke Geneeskundige en Gezondheidsdiensten – GG&GD) were consulted for signs of a possible correlation between the number of incidents involving cannabis and the level of the THC content. The capital city's main ambulance control centre publishes an annual summary of accidents involving drugs and alcohol. The number of cannabis incidents in 2001 was double the number that occurred in 2000. However, the GG&GD does not regard this as evidence of a link with stronger cannabis. The number of admissions to general hospitals in connection

with cannabis use also remains low. Preparations for a study into the dose-effect relationship of THC are now almost complete. This study is expected to start in September. The National Support Centre for Prevention [Landelijke Steunpunt Preventie - LSP] and the Support and Information Centre for Drugs and Safety [Steun- en Informatiepunt Drugs en Veiligheid - SIDV] have been asked to recommend ways of improving the information provided in the coffee shops.

5.3 INTERNATIONAL DEVELOPMENTS IN CANNABIS POLICY

In the previous Progress Report[8] we reported that growing numbers of European countries are switching over to a policy under which the possession of small amounts of cannabis no longer automatically results in criminal prosecution. This trend has continued. Last year the government of the United Kingdom proposed a number of changes to its drugs policy, including the reclassification of cannabis. The UK's drugs legislation distinguishes between three categories of drugs: Lists A, B and C. Drugs such as heroin and cocaine are on List A, while cannabis is on List B, together with drugs such as barbiturates and amphetamines. In March of this year, the Advisory Council on the Misuse of Drugs (ACMD) recommended that cannabis should be put onto List C, which currently includes drugs such as Valium and anabolic steroids. This is expected to mean de facto decriminalisation of the possession of small amounts of cannabis. The Home Affairs Select Committee (HASC) recently made the same recommendation, along with a large number of other recommendations designed to improve the UK's drugs policy. Damage limitation is an important factor in these recommendations. The UK government has now decided to put cannabis onto List C.

5.4 INTERNATIONAL CONFERENCES

On 6-8 December 2001 the European Cities Conference organised by the Netherlands Ministry of Justice took place in Utrecht. This conference was attended by some 120 representatives from 50 cities in 20 countries. The theme of the conference was putting cannabis policy into practice in an urban setting. The report on the conference, which was submitted to the House, reveals that de facto decriminalisation of the possession and use of small amounts of cannabis has occurred in an increasing number of European cities. In this respect there are many more similarities than differences between the cities of Europe. The conference came to the conclusion that cannabis policy must be formulated primarily at local or regional level. Administrators need to be able to pursue a

8 Lower House 2001-2002, Ministry of VWS 000125 (non-file document)

policy that provides practical solutions for practical problems. The present situation is characterised by a discrepancy between formal policy and actual practice. In the longer term, this undermines the authority of the authorities. A further important conclusion was that the public is entitled to a clear policy on cannabis, and one which is actually enforced. The conference revealed a need for continued cooperation between the cities and countries which share these conclusions. This cooperation should not be of a political nature in the first instance, but should concentrate on further analysis of the problem and on formulating possible approaches to a solution.

On 25 February 2002 the Scientific Conference on Cannabis took place in Brussels. The initiative to organise this event was taken by the Dutch Minister of Health, together with her fellow Health Ministers from Belgium, Germany, France and Switzerland. A summary of the collection of articles published on the occasion of this conference and of the conference's recommendations was also submitted to Parliament. It is striking that the most significant conclusions tally to a large extent with the findings of the authoritative French research institute INSERM (November 2001) and with those of the aforementioned report by the UK's Advisory Council on the Misuse of Drugs. The essence of these conclusions is that cannabis cannot be regarded as a harmless substance, but there are also no grounds for classifying it as a dangerous drug. Moreover, the consequences of using cannabis are less serious in many respects than those of using tobacco and alcohol.

The Netherlands Minister of Justice and the aforementioned five Ministers of Health have decided to look into ways of following up these activities. An official steering committee has drawn up a programme of work to achieve this. The programme focuses on a combination of the recommendations and findings of the European Cities Conference and the Scientific Conference. In particular, it focuses on answering a number of follow-up questions and on developing models with solid scientific support for future cannabis policy. A proposal is now being prepared for this follow-up project.

6 Nuisance and justice department policy on addiction

6.1 DRUG-RELATED NUISANCE

Public nuisance occurs in many different forms and is usually intractable in nature. Hard drug addicts are not the only group guilty of behaviour resulting in nuisance. The behaviour of other groups (the psychologically disturbed, criminals, the homeless) also contributes to public nuisance. For this reason the concept of 'nuisance' must be interpreted broadly.
Public nuisance is an important theme in the white paper, 'Towards a safer society' [Naar een veiliger samenleving]. Further details of a comprehensive approach to drug-related nuisance will be worked out within this context.

In order to collect data for the Comprehensive Safety Reports [Integrale Veiligheidsrapportages], the Ministry of Home Affairs (Ministerie van Binnenlandse Zaken en Koninkrijksrelaties - BZK) instructed the research institute Intraval to conduct studies into drug nuisance experienced by residents. Surveys were carried out in a number of neighbourhoods, mainly disadvantaged areas, in 13 municipalities spread across the whole country. These surveys took place in 1996, 1997, 1998, 2000 and 2002 and a total of over 19,000 residents were surveyed. In general it is possible to conclude that the drug-related nuisance experienced by the respondents decreased between 1996 and 2000, especially in the so-called 'nuisance districts'. This decrease does not appear to have continued after 2000. The analyses of trends also show that the different forms of drug-related disturbances of public order and audio-visual nuisance primarily decreased between 1998 and 2000. Since 2000 there has been a further decrease in the nuisance caused by the appropriation of public space by drug addicts, and also in the nuisance caused by street prostitution. On the other hand, the nuisance caused by buildings where dealing takes place has remained unchanged between 2000 and 2002, while the amount of nuisance occasioned by the pollution of public space by drug addicts and by the coffee shops in the thirteen 'nuisance districts' together is showing a slight increase.
The study compares the 'nuisance districts' with so-called 'reference districts' which can be regarded as average in terms of their composition, their infrastructure and their social problems. Compared with the 'nuisance districts', the 'reference districts' show a relatively small decrease in drug-related nuisance. This has to do with the fact that the level of drug-related nuisance in these districts is low, as it already was in 1996. Drug-related nuisance in the 'reference districts' appears to be stabilising or increasing slightly after 2000. Thus the

nuisance caused by buildings where dealing takes place and by the pollution of public space by drug addicts has increased slightly since 2000. The nuisance experienced by residents due to the appropriation of public space by drug addicts and the nuisance caused by coffee shops has remained unchanged between 2000 and 2002.
A downward trend is also evident in the consequences of drug nuisance. Here, too, the biggest decrease occurred between 1998 and 2000; after that, the decrease did not continue in 2002. This was true both of the neighbourhood problems that occurred in the districts surveyed and of the lack of safety that residents experienced.
This situation coincides with the findings of the Police Population Monitor [Politiemonitor Bevolking]. The survey conducted in 2001 revealed that drug-related nuisance had declined in relation to those conducted in 1997 and 1999. The findings of the Intraval study will be included in the 2002 Comprehensive Safety Report.

Support and Information Centre for Drugs and Safety [Steun- en Informatiepunt Drugs en Veiligheid - SIDV]
The SIDV is subsidised by the Ministries of Justice, of the Interior and Kingdom Relations, and of Health, Welfare and Sport, and by the Association of Municipalities of the Netherlands [Vereniging van Nederlandse Gemeenten – VNG]. The task of the SIDV, which has been placed under the control of the VNG, is to provide support to municipalities, the police and the Public Prosecutions Department in the implementation of local drug policy. In mid-2002 the SIDV's website was completely renovated and updated. The SIDV is currently putting the finishing touches to the 'Smart Shops' report. This document (Lower House 2001-2002, 24077 no.97) describes the available tools and hence provides practical assistance with the development of a comprehensive approach to enforcement at local level. The report is primarily aimed at municipalities. On the instructions of the Ministry of Home Affairs, the SIDV has collaborated with the SGBO, the VNG's research and consultancy agency, to carry out research into the application of Article 174a of the Municipalities Act (closure of homes) and Article 13b of the Narcotics Act (closure of premises open to the public, such as catering establishments, shops and tolerated coffee shops). The findings of this evaluation will shortly be published on the SIDV's website.

6.2 JUSTICE DEPARTMENT ADDICT CARE

The progress reports for 1999-2001 referred to specific facilities for drug addict offenders. These facilities, which constitute a three-stage process, are as follows:
1 Dissuasion projects

2 Addiction Counselling Departments [Verslaving Begeleidings Afdelingen - VBAs], and
3 Penal Care facility for Addicts [Strafrechtelijke Opvang Verslaafden - SOV].

The plans announced by the Justice Department to enhance its policy on addiction in penitentiary institutions are now being implemented as part of a much wider Justice Department policy on addiction. The changes mainly affect the first two stages of the three-stage process. The Ministry of Health, Welfare and Sport has also set up dissuasion facilities: the Forensic Addiction Clinic [Forensische Verslavingskliniek - FVK] operates on the borderline between the justice department and the addict care sector. The FVK is a new facility intended for individuals with a severe addiction and a criminal record. In some cases these addicts also have psychiatric disorders. The Ministry of Health, Welfare and Sport recently commissioned an evaluation of the FVK. This independent study will take almost four years to complete. The same evaluation structure has been chosen as that used for the SOV, so that the results will be comparable wherever possible.
The Ministry of Justice is working on an innovative cooperative venture between the rehabilitation and prison services. The details of this have been formulated in the programme 'Reducing Recidivism' [Terugdringen Recidive]. The goal of this programme is to reduce the rate of reoffending by the effective reintegration of offenders. One of the priority groups for this programme is frequent offenders, a group which contains many addicts. A policy group on Justice Department Addict Care has been set up in connection with the 'Reducing Recidivism' programme. This policy group, which includes representatives both from the partners in the Justice Department chain (the prison service, the Public Prosecutions Department, the addict rehabilitation service) and from the Ministry of Health, Welfare and Sport, has set itself the goal of leading drug addict offenders towards a socially acceptable existence, based on the underlying idea that the rate of reoffending will also decrease as a result.
A start has been made on the development of a policy with the following aims:
- To determine for each detained addict what points of departure there are for an intervention with a good chance of success
- To have a differentiated set of effective interventions available, both during and after detention
- To optimise the collaboration between the relevant partners in the criminal justice chain (police, Public Prosecutions Department, prison service, rehabilitation service) and in the care chain (care facilities, municipalities, etc.).

In developing the Justice Department policy on addict care, the review of the sanction system and the recommendations of the Health Council

[Gezondheidsraad] concerning the treatment of detained drug addicts will also need to be taken into account. The results of the three pilot projects described below, which are being carried out under the responsibility of the prison service, will also be taken into consideration.

- The 'Front Door' ['Voordeur'] pilot study, which is concerned with the development of assessment and diagnosis in the Grave penal institution.
- The 'Comorbidity' ['Co-morbiditeit'] pilot study, which focuses on leading detained drug addicts with psychiatric problems to the care facilities in a collaborative project between the Haaglanden penal institution and the Parnassia Centre for Psychiatric Medicine in The Hague.
- The 'Care Chain' ['Ketenzorg'] pilot study, which aims to lead detained drug addicts to the care facilities more effectively by getting the different partners in the care chain to adopt a systematic approach. This pilot is being carried out in the Arnhem penal institution in collaboration with the 'De Grift' Addiction Centre in Gelderland.

Penal Care Facility for Addicts [Strafrechtelijke Opvang Verslaafden - SOV]. The SOV, which is intended to act as the final link in the three-stage chain of intervention, currently has the status of an experiment and is undergoing evaluation. This consists of a process evaluation and a study of the effects which is being conducted under the responsibility of the Centre for Scientific Research and Documentation [Wetenschappelijk Onderzoeks- en Documentatiecentrum - WODC]. Based in part on the results of this evaluation, a decision will be made as to whether the SOV facility should be introduced more widely, modified or discontinued.

The state of affairs with regard to the SOV (as of May/June 2002) can be summarised as follows. All the facilities are operational, with the exception of Phase Two in the case of the southern municipalities, and the admission process is running smoothly. In Amsterdam 33 participants on whom this order has been imposed are now taking part in the first (closed) stage, and 10 participants have now moved on to the second (semi-open) stage. In Rotterdam 21 participants under this order are now in the first stage and 7 in the second. There are 17 participants in Utrecht, none of whom has reached the second stage yet. Finally, the southern municipalities have 10 participants in the first stage. In all, 98 participants on whom this order has been imposed are now resident in the SOV facilities. So far, 2 participants have refused to take part in the programme offered to them. In the case of one participant, the order was reimposed upon appeal; however, this individual has since lodged a further appeal in cassation.

7 Combatting drug-related crime

7.1 DRUGS AND CRIMINAL LAW

The annual report of the National Drug Monitor (NDM) now also includes a chapter which presents various facts about the judicial side of drug policy. It should be noted that only certain sub-aspects are covered in this chapter's first appearance, and that it is only concerned with crimes that have been solved. Despite these limitations, the chapter reveals a number of interesting facts:

- One in twenty criminal cases concerns an offence under the Narcotics Act [Opiumwet]. One in eight of the (unconditional) custodial sentences imposed each year concerns a case under the Narcotics Act. Together, these cases account for roughly one quarter of the detention time imposed on offenders.
- The majority of police investigations carried out into more serious organised crime are concerned with drug cases, and particularly with drug production, transport and dealing. Drug-related crime often seems to be mixed up with other forms of organised crime.
- Custodial sentences imposed for offences under the Narcotics Act which are carried out as part of an organised group - to which Article 140 of the Penal Code applies - are significantly longer (by an average of 1,000 days) than the sentences imposed for regular offences under the Narcotics Act.
- The combined length of the custodial sentences imposed for Narcotics Act cases amounts to over a quarter of the total number of years in custody imposed for all offences. After decreasing from 1998 onwards, this figure rose again from 24% to 27% in 2001. In is striking that the district of Haarlem - which contains Schiphol Airport - accounted for 10% of the total number of years in custody imposed on narcotics offenders in the Netherlands in 2001.
- No specific register of the group of criminal drug addicts is maintained at present. However, an indicative picture of this group can be obtained by entering the keywords 'drug user' into the police's Suspect Recognition System [Herkenningssysteem - HKS] and combining the results with details from the Criminal Law Monitor [Strafrechts Monitor - SRM]:
- Half of the group live (or are staying) in one of the Netherlands' four biggest cities.
- The probability of re-offending is very high in this group. Three quarters of the drug users arrested in 2001 already had a previous criminal history of more than 11 recorded offences, while a third had as many as 21 to 50 previous offences on their criminal records.
- Criminal drug addicts are by far the most frequently arrested (in 63% of cases) for non-violent property offences. Lagging far behind this category is violence

against persons (19% of cases) and offences falling into the category of vandalism and/or public order offences.

Since the record-keeping systems of the organisations concerned do not yet make sufficient provision for this, this annual report cannot yet give a comprehensive picture of the drugs problem from the judicial viewpoint. However, this is the ultimate goal. The scope of the judicial sector's contribution to the NDM annual report will gradually be expanded over the next few years.

7.2 DRUG SEIZURES

Addendum I contains details of the drugs seized during the period from 1998 to 2001. Once again this year, as in previous years, it is not possible to derive a trend from the figures in this report . This is because when looked at in isolation, the figures are difficult to interpret. The amounts of drugs seized can vary according to the amount of effort devoted to drug investigations, the number of cases presented, the changes that occur in the market, and/or the records that are kept on drug seizures.
Bearing these caveats in mind, it would appear that the number of XTC pills seized in 2001 was significantly lower than the number seized in 2000. The upward trend in the number of cannabis plants seized and the number of cultivation centres dismantled continued throughout 2001. Heroin appears to be stabilising.
There was a massive increase in cocaine smuggling through Schiphol by couriers in the second half of 2001, which attracted a great deal of attention. Special measures were introduced to combat this, including stricter checks carried out at the airport by Customs and Royal Military Police officials. However, smuggling by air only accounts for part of the total amount of cocaine that is brought into the Netherlands. Other organisations are therefore also involved in tackling this problem (see Section 7.5 of the plan of action on drug couriers who swallow small packages of drugs). A total of 8,389 kilos of cocaine were seized in 2001. Customs and Royal Military Police officials seized 1519 kilos in the port of Rotterdam. This included a single large haul of 416 kilos. The remaining seizures were spread among numerous different police forces. The biggest seizures were made by the Haaglanden Core Team, with 470 kilos, and the Rijnmond Regional Police Force and Core Team, with 1763 kilos.

7.3 ENFORCEMENT

Supply and demand reduction
A study of the Netherlands' international obligations in respect of drug supply

and demand reduction, including harm reduction, was carried out to fulfil the promise made by the Minister of Justice to Parliament on 21 December 2001. The study was completed on 1 September 2002. It looked at the obligations arising from the UN treaties on drug control and at the decisions that have been made so far at EU level (especially joint actions). Other relevant treaties, such as the 'Schengen' treaty, were also included in the study. It emerged that the texts examined by the study contain few provisions that include an element of harm reduction. The study also concluded that the obligations laid down by European law mainly serve as a supplement to the national policy of the member states, while the UN treaties are of a mandatory nature. Parliament will be informed of the findings of this study in a further report.

Venlo

The four-year project codenamed Hektor, which aims to reduce drug-related crime and nuisance by 35%, started in Venlo on 1 January 2001. This project comprises three lines of policy: an enforcement programme (aimed at drug-related nuisance and crime), a real estate programme (aimed at acquiring real estate that is owned by building contractors), and modification of the coffee shop policy. The Ministry of Justice is subsidising the enforcement programme for four years. A baseline measurement for the purposes of the evaluation was completed in April 2002 by the Intraval research institute.
The first annual report on the Hektor project was also approved by the Municipal Executive in April 2002 and submitted to the municipal council. In the enforcement programme the municipality is collaborating closely with the Public Prosecutions Department, the District of Roermond, the regional police force, the tax department and the Inland Revenue
Intelligence and Investigations Department [Fiscale Inlichtingen- en Opsporingsdienst - FIOD], so that a comprehensive approach can be taken to drug-related crime and nuisance. A special on-the-street police team has been set up to combat nuisance on the streets, and an investigation team which carries out short-term investigations of drug-related crimes. The municipality is also focusing on the area of administrative enforcement by closing buildings down, carrying out building inspections and checking catering, drinking and operating licences. Excellent results have been achieved in this area. Out of a total of 60 to 100 illegal drug sales outlets, 50 buildings have been closed. The street team has also made 672 arrests, which have been followed by accelerated criminal proceedings in 195 cases. The residence permits of 152 drug runners have been withdrawn, and 43 weapons and a substantial quantity of drugs have been seized. The investigation team has made 58 arrests, 14 of which have led to the individuals concerned being remanded in custody. Finally, more than 1.3 Dutch guilders have been confiscated by means of forfeiture orders.

The annual report shows that no evidence has been found to support the fear that drug-related crime and nuisance will move to other districts or towns. The number of drug-related incidents appears to be decreasing in the region of Limburg North as a whole.

Drugs and the Internet

The project 'Drugs and the Internet' got under way in 2001. This project, which contributed to the implementation of the Van der Staaij motion (Lower House 1999/2000, 24077 no. 80), involved a 'quick scan' of the supply of and advertising for soft and synthetic drugs through the Internet. The scan was completed in May. It also examined the methods that are being, or could be, used to enforce a prohibition on these activities. The findings of the 'quick scan' were submitted to Parliament. They revealed that 103 coffee shops in the Netherlands have a website (as at the end of 2001), but do not offer soft drugs on it. Each website was examined to see whether it infringed the prohibition on advertising laid down in Article 3b of the Narcotics Act. In those cases where there is a clear violation of the guidelines on advertising and sales of these drugs, the Public Prosecutions Department will instigate further criminal investigations. In the case of synthetic drugs, the scan concluded that it had found no evidence of large-scale trafficking in ready-to-use synthetic drugs on the Internet. A number of the sites encountered by the scan, which appeared to be intended to provide information about synthetic drugs and/or medicines, could be characterised as dubious. The scan also showed that raw materials (precursors) for synthetic drugs were offered for sale on a large scale on the Internet. Although these substances can be used for legitimate purposes, in many countries extensive restrictions apply to the use of these substances and to trading in them. Information about the large supply of precursors was submitted to the various investigation and surveillance departments.

7.4 A COMBINED EFFORT TO COMBAT XTC

As well as acting as a transit country and a sales market, the Netherlands is also a manufacturer of synthetic drugs. In May 2001 the Dutch government decided to intensify its battle against synthetic drugs. Within the framework set out in the white paper, 'A combined effort to combat XTC' ['Samenspannen tegen XTC'][9], numerous services and departments are working together to bring XTC production and trafficking to an end. The implementation of this white paper on XTC will take place over the period from 2002 to 2006. In April 2002, on behalf of the Ministries of Justice, Home Affairs, Defence, Economic Affairs, Finance and

[9] Lower House 2000-2001, 23 760 no. 14

Health, Welfare and Sport, the Minister van Justice submitted a report on the implementation of the white paper to the Lower House.[10]

A central role in the implementation of the white paper on XTC will be played by the Synthetic Drugs Unit [Unit Synthetische Drugs - USD]. The USD is a multidisciplinary collaborative partnership made up of staff from a wide range of departments and services: the police, the Public Prosecutions Department, the Economic Surveillance Department of the Inland Revenue Intelligence and Investigations Department [Economische Controle Dienst van de Fiscale Inlichtingen- en Opsporingsdienst - FIOD-ECD], Customs, the Royal Military Police, the Transport division of the Inspectorate for Traffic and Water Management [Inspectie Verkeer en Waterstaat divisie Vervoer], and the National Investigations Information Service [Dienst Nationale Recherche Informatie] of the National Police Agency [Korps Landelijke Politiediensten – KLPD]. The USD will perform its own operational task in the fight against XTC-related crime, and will serve as a point of contact and a centre of knowledge and expertise.

The white paper on XTC envisages an integrated approach to XTC production and trafficking. Besides intensifying our enforcement efforts and increasing our knowledge of XTC, the Netherlands will also invest in various studies and in international collaboration.

Intensifying the Netherlands' enforcement efforts and capacity
In 2002 five special XTC teams will join the strength of the police force (90 extra full-time employees). These teams will be responsible for carrying out investigations and fulfilling requests for mutual assistance from other countries. The teams will be attached to the South Netherlands, Amsterdam-Amstelland, Rotterdam-Rijnmond, Haaglanden-Central Holland and North and East Netherlands Core Teams. The operational XTC teams and the USD will collaborate closely to coordinate the different activities. The Public Prosecutions Department and the judiciary will be expanded to enable them to deal with the extra cases that the XTC teams will bring to them. The Netherlands Forensic Institute [Nederlands Forensisch Instituut - NFI] will help the investigation departments to dismantle laboratories and assist them with other studies. The NFI will also expand its research activities, which will help to strengthen the NFI's position as a national/international centre of knowledge about the production methods and precursors of XTC.

[10] Lower House 2000-2001, 23 760 no. 14

Surveillance of exports of XTC (end) products from the Netherlands has been intensified. Ten investigating officers have been added to the Customs and Royal Military Police team at Schiphol Airport, and the Royal Military Police's judicial department at Schiphol has also been enlarged. The strength of the Customs Department was increased in 2001 by expanding the Customs Information Centre. An additional scanner for carrying out checks on outgoing postal packets is also being put at the Customs Department's disposal, together with the staff to operate it, and extra sniffer dogs and handlers at Schiphol, Eindhoven and Rotterdam.

The FIOD-ECD is responsible for monitoring compliance with the Chemical Abuse Prevention Act [Wet Voorkoming Misbruik Chemicaliën - WVMC]. This act endeavours to prevent the movement of chemicals from legal channels into the illegal circuit by regulating chemical imports, exports and transits. Monitoring of the WVMC is being intensified by increasing the size of the ECD's staff and by improving the methods used to carry out this monitoring. In addition, the FIOD-ECD is going to support the Customs Department and other enforcement organisations more actively by supplying relevant information, contributing to risk analyses and acting as a centre of knowledge about precursors. The FIOD-ECD also has its own task to perform; that is, investigating the illegal production of, or dealing in, chemical substances. The ECD's investigation capacity will be increased by 6 full-time employees for the period from 2002 to 2006. In 2000 the Public Prosecutions Department made a number of agreements with the FIOD-ECD about intensifying the investigation of illegal drug precursors.

Intensifying international collaboration

The Synthetic Drugs Unit [Unit Synthetische Drugs - USD] and the Public Prosecutions Department are intensifying their collaboration with countries that play an important part in the XTC trade. For example, these include countries which supply the raw materials, countries that have a large XTC sales market, and transit countries. The USD organises international internship weeks for foreign investigation departments. These internship weeks are supported by the European Commission.

Article 12 of the UN Treaty of Vienna makes it compulsory to supply *administrative* details. The Dutch government has decided to supply the administrative details of seizures of precursors to the International Narcotics Control Board [INCB] and to the country which has exported the precursors (usually China). The Vienna drugs treaty does not make cooperation in criminal matters compulsory. Article 7 of this treaty stipulates that mutual assistance in *criminal* matters can be refused if there is reason to suspect that fundamental interests of the country investigated will be harmed as a result. This is the case,

for example, if there is a real risk that flagrant violations of human rights will occur as a result of mutual assistance in criminal matters and the death penalty may be imposed. Because of this, the government does not propose to enter into a relationship of mutual assistance in criminal matters with China, for example.

7.5 EXTERNAL BORDER CONTROLS

Larger amounts of marijuana and cocaine were intercepted in 2001 than in 2000. The largest hauls of marijuana were found in the port of Rotterdam (7,823 kg) and the largest hauls of cocaine at Schiphol (4,085 kg). During the course of 2001 the Netherlands saw explosive growth in cocaine smuggling by couriers through Schiphol. A plan of action to tackle drug smuggling at Schiphol[11] was submitted to the Lower House at the beginning of 2002. This plan involves creating additional cell capacity, expanding the Public Prosecutions Department and the judiciary, expanding the Schiphol team and the number of Customs officers, carrying out pre-flight checks and more stringent checks in the Netherlands, the Netherlands Antilles and Aruba, conducting investigations into the organisations behind the drug smuggling activities, and international cooperation. Progress reports are being submitted to the Lower House (Lower House 2001 – 2002, 28 192, nos. 8, 12 ,13 and 16) to keep it up to date with the implementation of the plan of action. The measures that have been introduced have led to the arrest of over 1,300 drug couriers between January and September 2002. Since this is not solely a Dutch problem, the Netherlands has pressed for a joint approach to drug smuggling through airports within the existing EU working groups (on drugs). It has also done so at a Pompidou Group symposium attended by British representatives, during a joint presentation on the cocaine smuggling problem. The Netherlands and the UK have taken a joint initiative to organise an EU meeting on this problem before the end of this year.

'Operation Mercury' ['Mercure']

The 'Mercury' international customs control operation took place from 20 to 26 March 2002. The aim of this control operation was to combat smuggling of synthetic drugs by airline passengers leaving Europe for destinations in the United States, Canada and Australia. The Customs departments of all the member states of the European Union (apart from the UK), Switzerland, Iceland, Australia, Canada and the US took part in this operation. The operation was organised by the Dutch Customs department, in collaboration with the French and German Customs departments. International coordination of the operation was carried out in the Netherlands. Representatives from the US, Canada and Australia participated actively in this coordination unit throughout the whole operation.

[11] Lower House 2001-2002, 28 192 no. 1

8 International aspects

8.1 PROVISION OF INFORMATION

The aim of the Netherlands' policy on the provision of information internationally is to give an unambiguous picture of Dutch drug policy, to ensure that it is understood, and to achieve international collaboration. The interdepartmental Steering Committee for the Provision of Drugs-related Information Abroad [Stuurgroep Coördinatie Drugvoorlichting Buitenland] provides the individuals and organisations who implement our policy in an international context with the right information and tools. This means, for instance, that special fact sheets have been drawn up on new topics for specific conferences such as the 45th meeting of the United Nations Commission on Narcotic Drugs (CND).
The brochure entitled 'Q & A Drugs, A guide to Dutch Policy', published by the Ministry of Foreign Affairs, is an important source of information about the Netherlands' drug policy. This brochure deals with more than thirty questions about Dutch policy on drugs. This interdepartmental brochure (Foreign Affairs, Health, Welfare and Sport, Justice, and the Interior and Kingdom Relations] is published in several languages and can also be found on the website of the Ministry of Foreign Affairs[12].

8.2 NETHERLANDS ANTILLES AND ARUBA

Collaboration Protocol
On 3 June 2002 the Ministers of Health for the Netherlands and the Netherlands Antilles signed a collaboration protocol for addict care. The purpose of this protocol is to encourage cooperation between NGOs [Non-Governmental Organisations]. The protocol should be understood in the context of the two conferences held between Dutch and Antillean professionals in 1999 and February 2002. A number of different collaborative projects between NGOs have now got under way. In the first instance the Netherlands' collaboration with Aruba will focus on the training of care workers. The knowledge and expertise currently available is not sufficient to allow us to provide the different institutions with adequate assistance. We intend to sign a collaboration protocol with Aruba as well.

Joint Investigation Team [Recherchesamenwerkingsteam – RST]
The Joint Investigation Team has been established in order to combat organised crime and to exchange information in the field of financial investigations in

[12] www.minbuza.nl/english under 'Ethical issues'.

particular, as well as channelling and acting on requests for legal assistance from the Netherlands. The team is a collaborative venture between the three countries which operates under the auspices of the local Public Prosecutions Department. On 30 November 2001 the three countries signed a formal protocol which provides a formal basis for this team. The Joint Investigation Team has developed good international contacts, with investigation authorities in the United States and France amongst others, and has an up-to-date criminal profile of drug smuggling to Europe via the Antilles and Aruba. The team is currently investigating a number of major drugs cases in collaboration with the Antillean, Aruban and Dutch investigation departments, and has achieved good results in the past.

The Netherlands Antilles and Aruba Coastguard [Kustwacht voor de Nederlandse Antillen en Aruba]

Coastguard plays a central role in the prevention and investigation of drug landing in the Antilles and Aruba. 4,645 kg of cocaine were intercepted in 2001, and this figure does not include the hauls that the Royal Navy intercepted on the open seas. In late 2001 the participating countries decided that 80% of the Coastguard's efforts should be devoted to the fight against drugs. The Coastguard has now been in operation for six years and has considerable authority in the region and among the international partners. To achieve good results, collaboration with neighbouring countries and a good information position are essential. An interim evaluation of the Coastguard in 2002 yielded a number of recommendations for increasing its efficiency and effectiveness still further. Replacing part of the fleet is one of the most important steps that need to be taken to achieve this.

Joint working party to combat drug smuggling through airports

This working party advises the three Ministers of Justice of the Kingdom of the Netherlands on the prevention of, and the fight against, drug smuggling through the three national airports. This also covers the smuggling of XTC from the Netherlands to or through the Netherlands Antilles and Aruba, although the scale of these activities is still small in comparison with cocaine smuggling. The working party's recommendations in the areas of information exchange, the compilation of criminal profile analyses and preventive measures (e.g. airport security) have been implemented or are in the process of being implemented. A number of investigations have been instigated on the basis of the information collected by the working party. As part of the implementation of the Plan of Action to tackle Drug Smuggling at Schiphol, the Antilles and Aruba have also been supplied with equipment to enable them to limit the transit of drugs.

8.3 BENELUX

In response to the recommendations made on 27 November 1998 by the Interparliamentary Advisory Council of the Benelux countries [Raadgevende Interparlementaire Beneluxraad] for the prevention of drug-related problems, the provision of assistance, and the fight against them, the Benelux Steering Group on Drugs [Benelux Stuurgroep Drugs] was set up in 2001. This steering group has met three times since September 2001, and has discussed policy issues of mutual interest to the members at an official level. More specifically, its members have exchanged information about new developments in policy on drugs and relevant legislative changes in the three countries, studies that have been carried out, the white paper on XTC, the Plan of Action against cocaine smuggling at Schiphol, and the EU framework decision on Illegal Drug Trafficking.

8.4 POMPIDOU GROUP

The Pompidou Group has initiated numerous activities in order to obtain comparable data at the European level, such as the multi-city project and school surveys (ESPAD). Studies of this kind will help to ensure that the debate about drug policy in Europe is conducted on a more scientific basis in the future. In the coming years more attention will also be devoted to translating the data into the development of a rational drug policy. Internationally, more effort is also being directed towards 'evidence-based policy'. In order to provide support for this, the Ministry of Health, Welfare and Sport has made funds available for a (Dutch) secretary of the research and epidemiology working party for three years. The group, which is currently chaired by the Irish, is now preparing for the ministerial conference in 2003.

The Airport Control working group is among the bodies which fall under the Pompidou Group. As we have mentioned in section 7.5, in this working group the Netherlands and the UK have combined forces to press for a joint European approach to drug smuggling through airports.

8.5 EUROPEAN UNION

EU Action Plan on Drugs

Within the EU, collaboration is taking place in the context of the EU Action Plan on Drugs 2000-2004. This plan of action represents the concrete execution of the EU's strategy on drugs (2000-2004), which the European Council adopted in Helsinki. The plan covers all aspects of drug policy, and also focuses on promoting cooperation with other countries, especially the candidates for

membership of the EU. In December 2002 the Commission will evaluate the progress of this plan of action.

Commission Proposal on the Health Aspects of Drug Policy

The Commission has put forward a proposal for a Council recommendation concerning the prevention and limitation of the risks of drug addiction. The main aim of this is to help the member states to achieve the second objective of the EU's drugs strategy (2000-2004) in respect of public health: that is, to bring about a significant reduction in the incidence of drug-related health damage (HIV, hepatitis B and C, tuberculosis, etc.) and in the number of drug-related deaths, within a five-year period.

There are four elements to this recommendation:

1 To adopt the prevention of drug addiction and the reduction of risks as objectives for public health policy.
2 To reduce drug-related health damage (HIV, hepatitis, TB, etc.) and deaths by means of harm reduction measures, such as information provision, street corner work, user rooms, peer prevention, substitution treatment, hepatitis B vaccination, and needle exchange schemes.
3 To base the foregoing measures on scientific research, thorough evaluation, quality criteria, monitoring and exchange of experiences.
4 To publish a report to the Commission on the execution of the recommendation at the end of two years, and upon request by the Commission after that.

Framework decision on illegal drug trafficking

In May 2001 the European Commission submitted the draft Framework Decision on Illegal Drug Trafficking. The aim of this was to harmonise the minimum requirements for the component parts of offences relating to drugs, and also to decide on the minimum level of maximum penalties in the member states of the Union. This Framework Decision implements Articles 34 and 31 of the EU Treaty. The central element of the proposal is a fairly extensive definition of illegal drug trafficking and the sanctions to be applied to it. No provision is made for personal use; this falls outside the scope of the Framework Decision..

For the Netherlands this decision means that the maximum punishment for offences involving large amounts of cannabis (both within the context of organised crime and outside it) and for offences involving precursors and/or hard drugs in the context of organised crime will have to be increased substantially. In addition, the punishment for small amounts of cannabis not intended for personal use will have to be increased from 1 month to 1 year. This will mean that the other member states can submit requests for legal assistance in cases of this kind.

The Netherlands has adopted the position that the scope of this proposal should be limited to those areas where there is added value to be gained from a joint approach within the context of the EU. Based on this consideration, the Netherlands is able to support the harmonisation of component parts of offences relating to organised international drug trafficking. However, this added value is not present in the approach to small-scale national dealing. Because of this, the Netherlands has adopted the position that, from the viewpoint of subsidiarity and proportionality, transactions involving small amounts of soft drugs should be subject to a lower maximum penalty than the maximum sentence of at least one year's imprisonment. The Dutch government was able to agree with the wording of the framework decision when the Spanish chairmanship put forward a proposal that offered a compromise with respect to small amounts of soft drugs. However, at the Council (of Ministers of Justice) meeting in Luxembourg on 13 June 2002, it emerged that three other member states were unable to agree to this proposal. As a result, no agreement could be reached on the Framework Decision. The Danish chairmanship is expected to put forward new proposals.

Working party on drug trafficking

Under the auspices of the EU Working Party on Drug Trafficking, the CASE pilot project (Comprehensive Action against Synthetic drugs in Europe) got under way in December 2001. The aim of this project is to combine forensic information (composition, contamination of seized synthetic drugs with other substances) with more traditional police information. This may help to clarify the links between drugs seized on different occasions and in different locations and so assist investigations. The working party has now been disbanded. Its activities will be discussed in other Council working parties.

Phare Synthetic Drugs Project (PSDP)

The Ministry of Justice was the primary contractor for the European Commission's Phare Synthetic Drugs Project I (PSD I). This project's purpose was to assist the 10 candidate member states, and also Albania, Bosnia-Herzegovina, and the former Yugoslavian Republic of Macedonia, with the adoption and implementation of the EU Acquis on synthetic drugs. The project was completed in late 2001 with satisfactory results. In all, more than 100 activities took place, most of them in the candidate member states themselves. The esteem in which this project was held is also evident from the European Commission's positive response to the proposal to integrate the Phare Precursor Project, which had been running since 1993, into the follow-up Phare Synthetic Drugs and Precursors Project (PSDII). This project got under way at the start of 2002, and will run until the end of 2003. Once again, the Ministry of Justice is the primary

contractor. The project is being carried out by a consortium, in which the Netherlands, Germany, Sweden and the UK are participating. This project is confined to the candidate member states: Romania, Bulgaria, Hungary, Poland, Slovakia, Slovenia, the Czech Republic, Estonia, Latvia and Lithuania. Its broad aim is to assist these countries with the conversion, implementation and execution of the EU Acquis and to exchange practical experiences from the field of synthetic drugs and precursors. The emphasis is on reducing the illegal production and smuggling of synthetic drugs, combatting the diversion/re-routing of precursors (from the legal circuit to the illegal circuit), and early recognition and identification of new synthetic drugs.

EU-LAC

The plan of action drawn up in Panama in 1999 for a joint drug control programme involving the EU, Latin America and the Caribbean (LAC) made provision for collaboration in the areas of demand reduction, combatting money-laundering, promoting alternative development and maritime affairs. A high-level meeting was again held between the participating countries this year. Unfortunately, this collaboration mechanism has yielded few concrete results as yet.

However, the Netherlands' efforts within this context to arrive at a regional Maritime Collaboration Agreement on drug control in the Caribbean region are now beginning to bear fruit. The treaty is intended to supplement the existing bilateral and sub-regional treaties and to provide a legal framework within which the limited maritime resources available can be deployed more effectively. Under the co-chairmanship of Costa Rica, Caricom (a collaborative partnership between Caribbean states which has the goal of creating a common market and enhancing regional integration) and the Netherlands, consensus was reached on the wording of the agreement during the negotiations in Aruba in April 2002. It was hoped that the signing ceremony would take place before 1 October 2002. The intended signatories included the countries of Central and South America, the Caribbean region, and the UK, France, the Netherlands and the US.

EU-Central Asia

In 1999 Europol carried out a study of the growing drug problem in Central Asia and its consequences for the EU. The decision was made to draw up a plan of action for collaboration between the EU and Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan in the area of drug control. Turkmenistan decided not to participate. This plan of action will concentrate on policy development, among other areas, and on supporting organisations that can be used to tackle the relevant problems. Although the plan has not yet been formally signed, the political priorities and guidelines laid down in it already play an important role in

various current European programmes in the region. For example, Customs officers at airports and ports are being trained to intercept drugs and supplied with technical equipment. A regional database containing information about drug use and drug trafficking has also been set up.

EU-Central and Eastern Europe

As part of the efforts aimed at admitting Central and Eastern European countries to the EU, a second seminar will be held on the theme of 'Drug Policy in the European Context'. This seminar will be financed with funding from the Social Transformation [Maatschappelijke Transformatie – MATRA] pre-admission programme, 'Accession-oriented Dutch European Proficiency Training' (ADEPT). The seminar is being organised by the Trimbos Institute and Jellinek/Eati under the auspices of the Ministries of Health, Welfare and Sport, of Justice, and of the Interior and Kingdom Relations. Its primary aims are to provide information about the background to and current state of European action against drug-related problems, and to stimulate the development of policy in line with the EU Plan of Action on drugs.

The Netherlands, in collaboration with the UK, has also entered into a 'twinning' arrangement with Hungary. In this partnership, the Trimbos Institute and the UK organisation Drugscope will provide Hungary with technical assistance in a number of areas. The purpose of this assistance is to help Hungary to comply with the requirements of the Acquis Communautair.

8.6 UNITED NATIONS

Commission on Narcotic Drugs (CND)

The 45th meeting of the CND, of which the Netherlands has been a member since January of this year, took place from 11 to 15 March 2002. The Netherlands was particularly actively involved in the debates on the topic of demand reduction, in close cooperation with like-minded partner countries such as Switzerland, Canada and Portugal. Recent developments in Dutch policy on XTC were discussed in detail in the plenary session, as was the plan of action on cocaine smuggling through Schiphol Airport. The debate about the liberalisation of cannabis in western countries also formed an important part of the meeting.

International Narcotic Control Board (INCB)

In March the INCB, which is responsible for monitoring compliance with the UN treaties on drugs, presented its annual report. One of the central topics of this report was the sale of medicines and narcotics through the Internet. The report found that this phenomenon is most prevalent in the Netherlands, the UK and Switzerland. The INCB reiterated its criticisms of Dutch policy on cannabis, as it

does every year, this time including alleged plans for a so-called 'drive-through' coffee shop in Venlo. In response, the Netherlands stated that we are going to tackle the problem of drugs and the Internet in collaboration with other countries. As far as the uproar over the alleged 'drive-through' coffee shop in Venlo is concerned, we made it clear that the report is based on a misunderstanding. The rumour has been fuelled by inaccurate reporting about the new plans of action designed to tackle drug tourists who cause nuisance in the centre of Venlo.

United Nations International Drug Control Programme (UNDCP)

The UNDCP is the UN's executive body in the fight against drugs. It helps countries to implement the UN drug treaties and develop national drug policies, and it executes projects, particularly in developing countries.
In 2001 the Netherlands suspended its voluntary contribution to the UNDCP. The reason for doing so was our deep concern about the performance of the UNDCP management. Since then, however, we can confirm that a drastic process of reform has taken place within the UNDCP during the past year and is now complete. Most of the recommendations made last year by the independent internal UN inspection service have been put into practice. Furthermore, the last meeting of the CND decided - partly at the Netherlands' insistence - that the member states should play a larger role in managing the programme. Antonio Costa has now taken up his post as the new executive director. Despite the continuing suspension of our general contribution to the programme, the Netherlands did provide financial support for the UNDCP's 'Caribbean drug control Coordination Mechanism' (CCM) since we had previously promised to do so. This project started in 1997 and was completed in December 2001. The aim of the CCM was to improve the effectiveness of drug control efforts in the Caribbean region by means of better coordination.

8.7 BILATERAL COLLABORATIVE VENTURES

France

The collaborative relationship between France and the Netherlands is continuing to improve steadily. There now seem to be more similarities than difference between the two countries' drug policies. This was evident at the thirteenth high level meeting of the Franco-Dutch working party on drugs, in February 2002. Both countries confirmed that further intensification of the Franco-Dutch collaborative partnership is still needed, because the scale of the drug problem is not diminishing. This collaboration covers numerous different fields. In the field of public health, for example, the Netherlands and France exchange expertise and experience in areas such as methods of treatment and prevention

approaches. Liaison staff have been appointed in both countries to keep each other informed about the judicial policy currently being pursued. The collaboration within the joint investigation teams needs to be improved. Operational information is exchanged between both countries' police departments, while the collaboration between the Customs departments includes exchanges of staff and information, both at the operational level and in the context of mutual assistance.

Ms Maestracci, chairperson of the Interministerial Mission for the Fight Against Drugs and Addiction [Mission Interministérielle de Lutte Contre la Drogue et la Toxicomanie - MILDT] visited the Netherlands in July 2001. Her visit lent an additional impetus to what was already a good cooperative relationship in the field of public health. During the discussions, it was decided that this cooperation should take the following forms:

- On the research front, a continuation of the present exchange of information between Dutch and French research teams.
- Exchange of experts and experience in the area of substitution methods, and more generally in the area of treatment of drug addicts (including addicts detained in penal institutions).
- Exchange of experience in the area of prevention of psychoactive substance use (including alcohol and tobacco), especially in schools.
- Intensification of European collaboration to enable us to monitor new substances and new methods of use.

Germany

In the autumn of 2000 the German Minister of Home Affairs, Oskar Schily, took a joint initiative with his colleagues from the Dutch Ministries of Justice and Home Affairs to promote better collaboration between the different investigation agencies in the fight against cross-border drug trafficking. Europol was then asked to coordinate a three-stage project. The first stage consisted of a strategic analysis of collaboration between the relevant departments in the two countries. This was carried out with the assistance of the Dutch National Police Agency [Korps Landelijke Politiediensten – KLPD] and its German counterpart, the Bundes Kriminal Amt (BKA). In the second stage of the project, two specific investigations conducted by the investigation agencies in the two countries were monitored in order to identify the problem areas. The project is now in the third stage, during which the two countries are carrying out a concrete police investigation together. Germany is also involved in organising a meeting of experts, which will take place as part of the implementation of the Plan of Action to tackle drug couriers at Schiphol.

United Kingdom

The collaboration in judicial matters between the UK and the Netherlands is going well. The creation of two discussion forums has helped to strengthen this collaborative relationship. Structured collaboration between the Netherlands and the UK takes place through the Anglo Dutch (Operational) Forum (ADF) at the operational level, and through the Structured Dialogue at the policy level.
The ADF is a bilateral consultative body which has been meeting annually since 1996; at these meetings, the UK and the Netherlands discuss international legal assistance. After focusing specifically on collaboration in the area of drugs in the past, the ADF's scope has now been expanded to include operational collaboration and collaboration in matters of penal law in a broad sense. At the most recent meeting in March 2002, it emerged that the white paper on XTC has had a very good reception in the UK. The two countries intend to cooperate closely in the fight against XTC. The UK is particularly interested in the controlled passage of hard drugs. The two countries will also exchange information about the problem of 'internal couriers' (drug couriers who swallow small packages of drugs). Many internal couriers travel to the UK from Jamaica in particular. The Netherlands will study the UK's action plan on internal couriers more closely.

In December 2001 a delegation from the Department of Justice paid a visit to the British Home Office. Since the operational viewpoint has priority in the ADF, the two countries decided to set up a forum for structured dialogue in which they could exchange ideas about the implementation and consequences of national and international policy developments, such as the Framework Decision on illegal drug trafficking. The UK said that it wanted to continue with this dialogue and to arrive at a joint approach to the fight against drug trafficking in which the Customs authorities must also be involved. A proposal to hold a small joint seminar in the second half of 2002 was also put forward during the talks. This seminar would involve both the policy side (Structured dialogue) and the implementation side (Anglo Dutch Forum), and should focus specifically on ways of tackling hard drug trafficking.

A-team

The Netherlands, Belgium, France and Luxembourg collaborate within the framework of the Hazeldonk consultations, with international operational campaigns designed to reduce drug tourism and to reduce the nuisance caused by drug runners on the highways. In addition to these campaigns, the A-team has been operational since November 2000. This team hunts down and arrests

drug runners and drug tourists on the A-16 motorway and on trains from the Netherlands to France and Belgium on a daily basis. The A-team is a collaborative venture between three police regions, the National Police Agency, the railway police and the Tax Department. Individuals who cause nuisance are dealt with in accordance with uniform accelerated criminal proceedings. During the one-year pilot period, the A-team carried out checks on 2,395 individuals, 1,271 of whom proved to be drug runners. Many kilograms of drugs were also seized. At the end of a year the A-team was evaluated. The collaboration between the different investigation agencies can be described as exceptionally good. A number of French agents participated in the team for several weeks during the first year. In the light of the excellent results, it was decided that the A-team should continue. As of 1 September 2002, the French investigation services (police and Customs) will start collaborating on a structural basis with the Dutch police services. This will mean that French investigation agencies are actually present in the Netherlands, under the direction of the A-team.

Joint teams

Delegations from France and the Netherlands have met twice since the end of 2002. Two pilot investigations to combat drug crime have now been completed. In one of these investigations, arrests were made outside the Netherlands. In the other, two arrests were made in the Netherlands and two suspects were extradited to France.

Collaborating in a joint team structure has proved to be expensive and labour-intensive. An investigation must therefore fulfil certain criteria before a decision can be made to collaborate on it as a joint team. The official delegations will meet again in December 2002 to consider what additional measures appear to be needed to enable the investigators to operate jointly in investigation teams.

United States

A follow-up to the bilateral law enforcement talks, which were held for the first time in Washington in April 2001, will take place in the Netherlands this autumn. The main focus of attention in this second round of talks will be the fight against terrorism, but drug control and cyber crime will also be discussed. More generally, the talks will cover various aspects of operational collaboration; between the police, for example, and in the case of requests for extradition or legal assistance.

The Netherlands has also made considerable efforts in the past two years to improve cooperation with the United States on the staffing front. The Health, Welfare and Sport attaché already at the Dutch embassy in Washington has been joined by a Police and Justice Department advisor. Police liaison officers have now also been posted to Miami and Washington DC.

Addendum 1 Narcotics Seized in the Netherlands

The following table lists the drugs seized in the Netherlands in the period 1998 - 2001. The amounts are specified in kilograms unless otherwise stated.

	1998	1999	2000	2001
Heroin				
- Weight	784	770	896	739
Cocaine				
- Weight	8,998	10,361	6,472	8,389
Amphetamines				
- Weight	1,450	853	293	579
- Pills	242,409	45,847	-	20,592
XTC[1]				
- Weight	310	*****	632	113
- Pills	1,163,514	3,663,608	5,500,000	3,684,505
Methadone				
- Weight	-	50	16	-
- Pills	4,093	186,437	5,543	8,968
LSD				
- Trips	35,964	244	9,829	28,731
- Pills	1,826	2,423	143	-
Hashish oil				
- Litres	150	1	-	-
Cannabis				
- Hashish	70,696	61,226	29,590	10,972
- Marijuana	54,582	47,039	9,629	21,139
- Dutch cannabis	881 +	2,076 +	701 +	1,308 +
Total weight	**126,159**	**110,341**	**39,920**	**33,419**
Number of plants (Dutch cannabis)	353,178	582,588	661,851	884,609
Number of marijuana cultivation centres	616	1,091	1,372	2,012

Sources: National Police Agency, NRI, Regional police forces, Customs, the Royal Military Police, the Synthetic Drugs Unit (KLPD/NRI (2002), 'Drug seizures in 2001'). It is known that these figures are incomplete.

\- Indicates that there were no (known) seizures.

***** These are the annual figures of the Synthetic Drugs Unit (USD). In 1999 the USD only specified the number of pills as the unit of measurement. For this reason no weight was specified in kilograms.

[1] This includes MDMA, MDEA, MDA, PMA and 2C-B pills.

Addendum 2 List of abbreviations used

ADEPT	Accession-oriented Dutch European Proficiency Training
AIHW	Australian Institute of Health and Welfare
AWBZ	Algemene Wet Bijzondere Ziektekosten [Exceptional Medical Expenses Act]
BOPZ	Special Admission to Psychiatric Hospitals [Bijzondere Opname Psychiatrische Ziekenhuizen]
CAM	Coördinatiepunt Assessment en Monitoring Nieuwe Drugs [Coordination Centre for the Assessment and Monitoring of New Drugs]
CCBH	Centrale Commissie Behandeling Heroïneverslaafden [Central Committee for the Treatment of Heroin Addicts]
CCLEC	Caribbean Customs Law Enforcement Council
CEDRO	Centrum voor Drugsonderzoek [Centre for Drugs Research]
CND	Commission on Narcotic Drugs
DIMS	Drugs Informatie en Monitoring Systeem [Drugs Information and Monitoring System]
ECD	Economic Surveillance Department [Economische Controle Dienst]
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPPD	Elektronisch Preventie Project Dossier [Electronic Prevention Project File]
ESPAD	European School Survey on Alcohol and other Drugs
EU	European Union
EWS	Early Warning System
FIOD	Fiscale Inlichtingen- en Opsporingsdienst [Inland Revenue Intelligence and Investigations Department]
FOL	Forward Operating Locations
HDG	Horizontale Drugs Groep [Horizontal Drugs Group]
IBAs	Individuele Begeleidings Afdelingen [Individual Supervision Departments]
IMCs	Intramurale Motivatie Centra [Inpatient Motivation Centres]
INCB	International Narcotics Control Board
INSERM	National Institute for Health and Medical Research [Institut National de la Santé et de la Recherche Médicale]
IVP	Integraal Veiligheidsprogramma [Comprehensive Public Safety and Security Programme]
IVV	Foundation for the Provision of Information on Addict Care [Stichting Informatie Voorziening Verslavingszorg]
KLPD	Korps Landelijke Politie Dienst [National Police Agency]

LADIS	Landelijk Alcohol en Drugs Informatie Systeem [National Alcohol and Drugs Information System]
LCMR	Landelijke Centrale Middelen Registratie [National Centre for Substance Registration]
LOP	Landelijk Ondersteuningspunt Preventie voor de geestelijke gezondheidszorg [National Prevention Support Centre for the Mental Health Care Sector]
LSP	Landelijk Steunpunt Preventie van Verslavingen en Middelengebruik [National Support Centre for the Prevention of Addiction and Substance Use]
MATRA	Maatschappelijke Transformatie [Social Transformation Programme]
MILDT	Interministerial Mission for the Fight Against Drugs and Addiction [Mission Interministérielle de Lutte Contre la Drogue et la Toxicomanie]
NDM	Nationale Drug Monitor [National Drug Monitor]
NIDA	National Institute on Drug Abuse
NPO	Nationale Prevalentie Onderzoek [National Prevalence Survey]
NWO	Nederlandse Organisatie voor Wetenschappelijk Onderzoek [Netherlands Institute of Scientific Research]
OM	Openbaar Ministerie [Public Prosecutions Department]
PiGG	Patiëntenregister Intramurale Geestelijke Gezondheidszorg [Patient Records for Inpatient Mental Health Care]
PSDP	Phare Synthetic Drugs Project
Rfv	Council for Financial Relations [Raad voor de financiële verhoudingen]
RMO	Council for Social Development [Raad voor de Maatschappelijke Ontwikkeling]
RVZ	Council for Public Health and Care [Raad voor de Volksgezondheid en Zorg]
SAMHSA	Substance Abuse and Mental Health Services Administration
SAVVN	Special Session of the United Nations General Assembly [Speciale Zitting van de Algemene Vergadering van de Verenigde Naties]
SIDV	Steun- en Informatiepunt Drugs en Veiligheid [Support and Information Centre for Drugs and Safety]
SOV	Strafrechtelijke Opvang Verslaafden [Penal Care Facility for Addicts]
UNDCP	United Nations International Drug Control Programme
USD	Unit Synthetische Drugs [Synthetic Drugs Unit]
VBA	Verslavings Begeleidings Afdeling [Addiction Counselling Department]
VNG	Vereniging van Nederlandse Gemeenten [Association of Municipalities of the Netherlands]
WHO	World Health Organisation

WODC	Centre for Scientific Research and Documentation [Wetenschappelijk Onderzoeks- en Documentatiecentrum]
WOG	Medicines Act [Wet op de Geneesmiddelenvoorziening]
ZON	Zorg Onderzoek Nederland [Health Research and Development Council]

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December 2002

The progress report on drug policy gives a broad picture of developments in the drug policy of the Netherlands. It provides information about drug use, monitoring, prevention, addict care, the fight against drug-related crime and international collaboration. This progress report is produced annually in cooperation between the ministries involved in this area: Health, Welfare and Sport; Justice; the Interior and Kingdom Relations; Foreign Affairs; and Finance.

Ministerie van Volksgezondheid, Welzijn en Sport – NL

DVC 03-0030