European Monitoring Centre for Drugs and Drug Addiction

Netherlands

Netherlands Drug Report 2018

This report presents the top-level overview of the drug phenomenon in the Netherlands, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2016 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

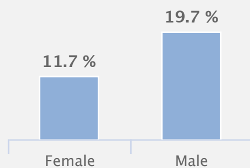
THE DRUG PROBLEM IN THE NETHERLANDS AT A GLANCE

Drug use

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

Cannabis

15.7 %



Other drugs

MDMA	**7.4 %**
Amphetamines	**3.6 %**
Cocaine	**3.7 %**

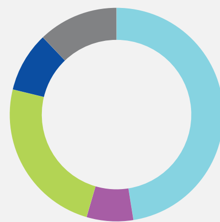
High-risk opioid users

14 000

(12 700 - 16 300)

Treatment entrants

by primary drug



- Cannabis, **47 %**
- Amphetamines, **7 %**
- Cocaine, **24 %**
- Heroin, **9 %**
- Other, **12 %**

Opioid substitution treatment clients

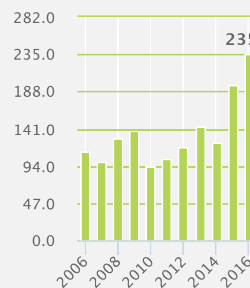
7 421

Syringes distributed

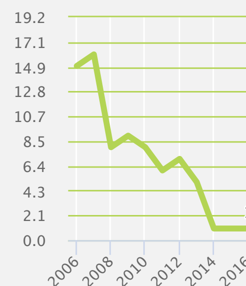
through specialised programmes

No Data

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

21 118

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

11 094 040

Source: EUROSTAT Extracted on: 18/03/2018

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law o?ences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

National drug strategy and coordination

National drug strategy

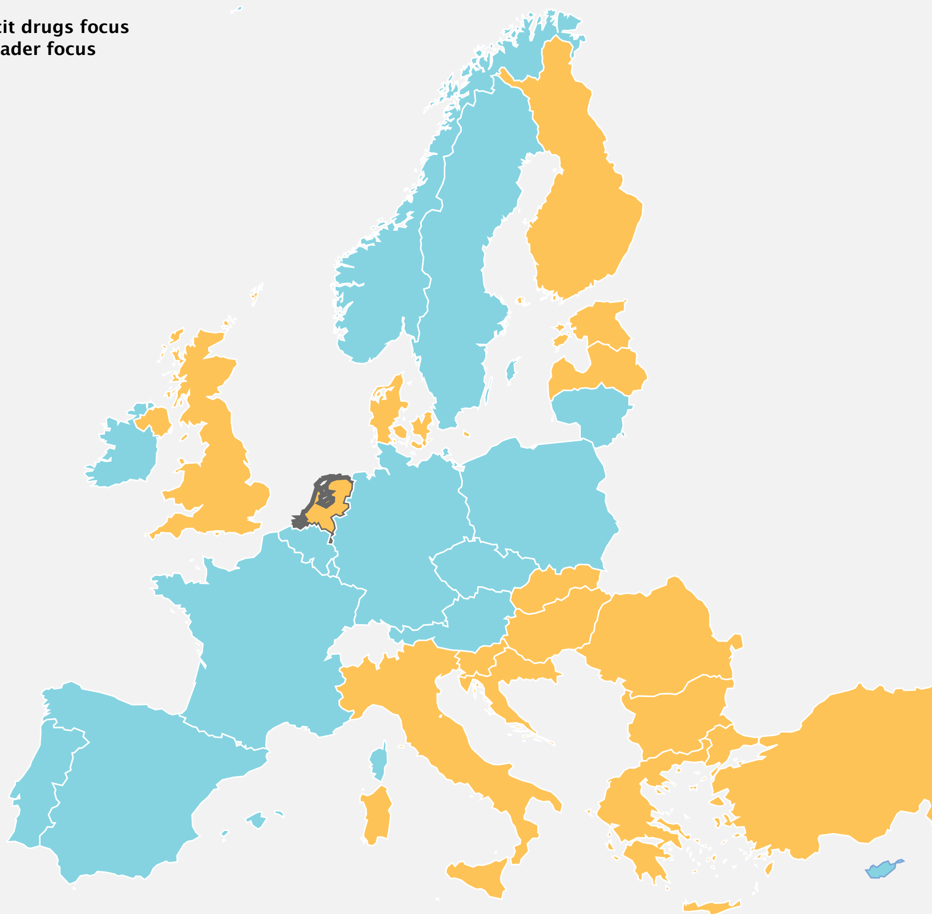
According to the Opium Act Directive, 'The Dutch drugs policy aims to discourage and reduce drug use, certainly in so far as it causes damage to health and to society, and to prevent and reduce the damage associated with drug use, drug production and the drugs trade' (Stc 2011-11134). The 1995 white paper 'Drug policy: continuity and change' sets out the principles of the Dutch illicit drugs policy. Taking a balanced approach, it continued the distinction between 'soft' (List II) and 'hard' (List I) drugs. It outlined four major objectives: (i) to prevent drug use and to treat and rehabilitate drug users; (ii) to reduce harm to users; (iii) to diminish public nuisance caused by drug users; and (iv) to combat the production and trafficking of drugs.

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

Specifically, Dutch cannabis policy has been elaborated in a series of policy letters. The 'Letter outlining the new Dutch policy' (2009) placed an increased emphasis on prevention and use reduction, and it amended the 'coffee shop' policy. The expediency principle holds that the public prosecutor has the discretionary power to refrain from prosecuting a criminal offence if this is judged to be in the public interest. This approach provides the basis for the coffee shop policy, which allows users to buy cannabis in coffee shops, preventing them from coming into contact with hard drugs. Though still a criminal offence, the sale of small quantities is condoned if shops adhere to defined criteria introduced in 2013, which mayors are responsible for enforcing: no advertising, no sale of hard drugs, no public nuisance in and around the coffee shop, no admittance of or sale to minors, no sale of large quantities per transaction (maximum 5 g), maximum in-store stock for sale 500 g, and admittance and sales limited to residents of the Netherlands.

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

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2016. Strategies with broader focus may include, for example, licit drugs and other addictions.

National coordination mechanisms

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

Public expenditure

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

A study using 2003 data suggested that total drug-related public expenditure represented 0.5 % of gross domestic product and that the majority of the expenditures were attributed to law enforcement (75 %) and the remainder to treatment (13 %), harm reduction (10 %) and prevention (2 %). Recent estimates suggest that the public sector spent EUR 84 million to implement the Opium Act in 2015.This budget was spent on prevention, police investigation, prosecution, sentencing, implementation of sentences, supporting offenders and victims, and judicial services.

Drug laws and drug law offences

National drug laws

The Netherlands Opium Act, which came into force in 1928 and was fundamentally amended in 1976, is the basis for the current drug legislation. It defines drug trafficking, cultivation and production and dealing in and possession of drugs as criminal acts. The Act and its amendments confirm the distinction between List I drugs (e.g. heroin, cocaine, MDMA/ecstasy, amphetamines) and List II drugs (e.g. cannabis, hallucinogenic mushrooms). In 2012, it was proposed that cannabis containing more than 15 % tetrahydrocannabinol should be placed in List I, but this has not yet been implemented. The Opium Act is implemented by the national Opium Act Directive to prosecutors, which is periodically revised; for example, criteria defining the ‘professional cultivation of cannabis’ for prosecution

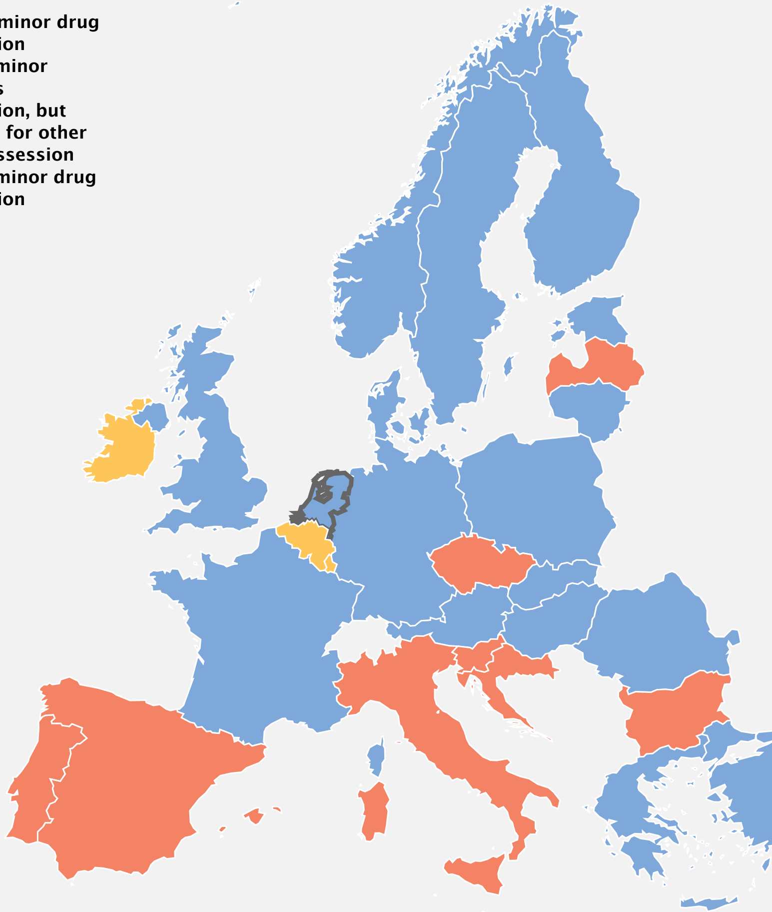
purposes were revised in the Directive in 2016. New psychoactive substances are regulated through amendments to relevant schedules of the Opium Act. For example, in May 2017, 4-fluoroamphetamine was listed as a List I drug, because severe emergencies and deaths related to this drug had occurred.

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

Drug use as such does not constitute a crime in legal terms. However, there are situations when the use of drugs is prohibited at the local level for reasons of public order or to protect the health of young people, such as at schools and on public transport. It is up to the responsible authorities — not the national government — to regulate this. The possession of small quantities of drugs for personal use is legally punishable by imprisonment, but is not subject to targeted investigation by the police. Anyone found in possession of a small amount of drugs for personal use will generally not be prosecuted, though the police will confiscate the drugs and refer the individual to a care agency. The threshold amount for cannabis is set at 5 g. However, in 2012, the Opium Act Directive was revised to leave open the possibility of arresting and prosecuting individuals in possession of less than 5 g of cannabis in certain circumstances: instead of 'a police dismissal *should* follow if a cannabis user is caught with less than 5 grams of cannabis', it now states '*in principle* a police dismissal *will* follow if a person is carrying less than 5 grams of cannabis'.

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

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



NB: Year of data 2016. The possession of small quantities of drugs for personal use is not subject to targeted investigation by the police. Anyone found in possession of less than 0.5 g of List I drugs will generally not be prosecuted, though the police will confiscate the drugs and refer the individual to a care agency

Drug law offences

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

In 2016, a total of 21 118 offences against the Opium Act were registered by the public prosecutor, more than in 2015. Slightly more than half of all reports were linked to List II drugs. The majority of offences related to List I was linked to possession.

Drug use

Prevalence and trends

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

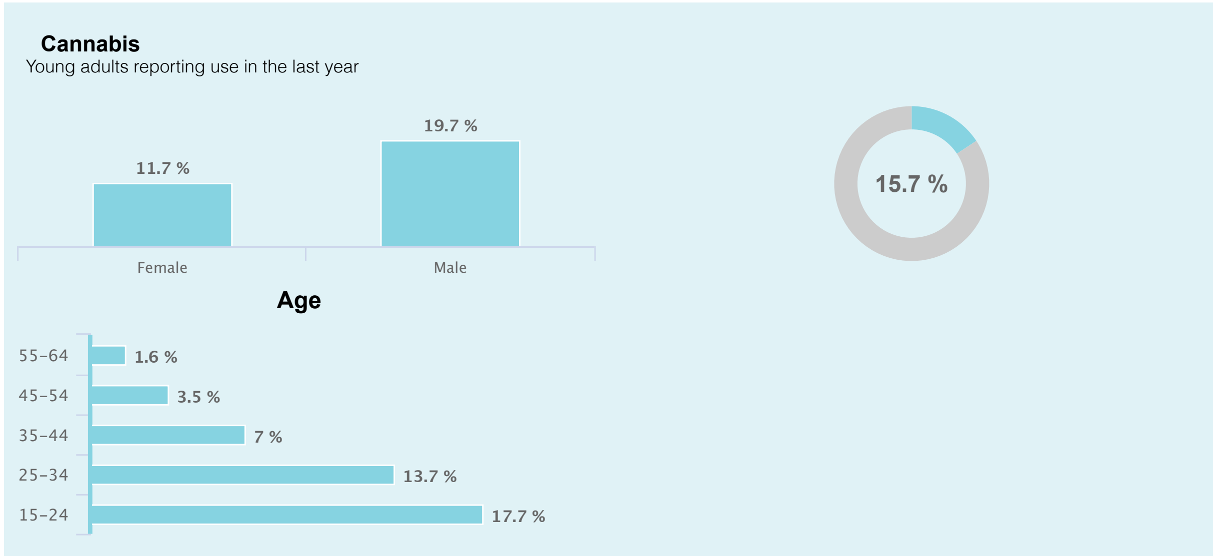
The available data suggest an increase in stimulant use among the general adult population, and young adults in particular, in recent years.

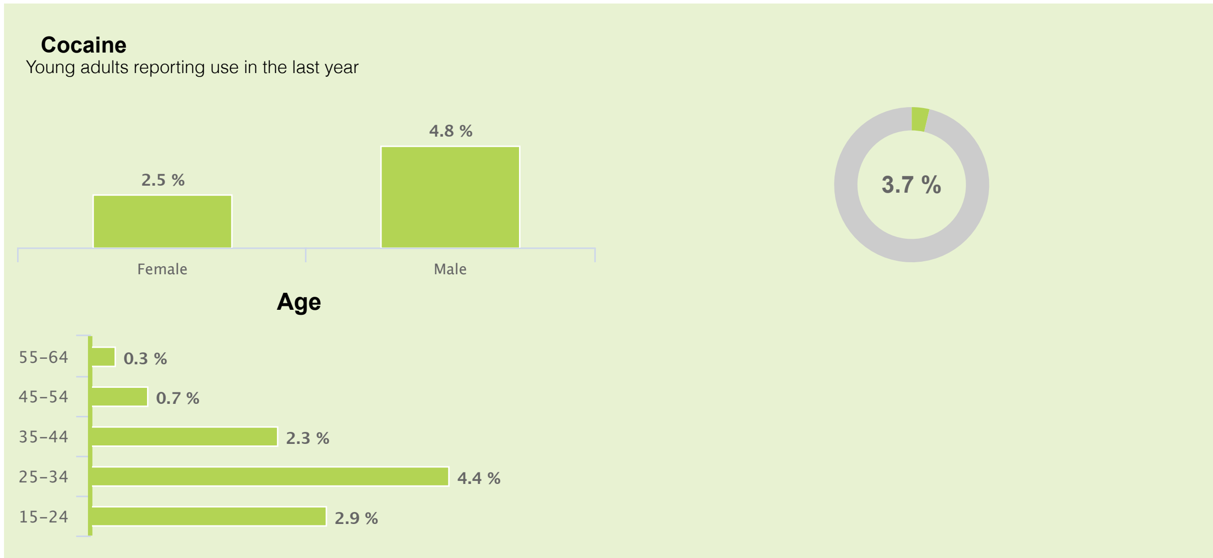
Data on the use of illicit substances among students aged 15-16 are reported in the European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been carried out regularly in the Netherlands since 1999 and the most recent data are from 2015. The ESPAD studies indicate a decreasing trend in lifetime cannabis use among school-age children over the period 1999-2015. Nevertheless, among students in the Netherlands reported lifetime use of cannabis was notably higher than the ESPAD average (based on data from 35 countries) in 2015. Lifetime use of illicit drugs other than cannabis and lifetime use of new psychoactive substances (NPS), however, were more or less in line with the ESPAD average.

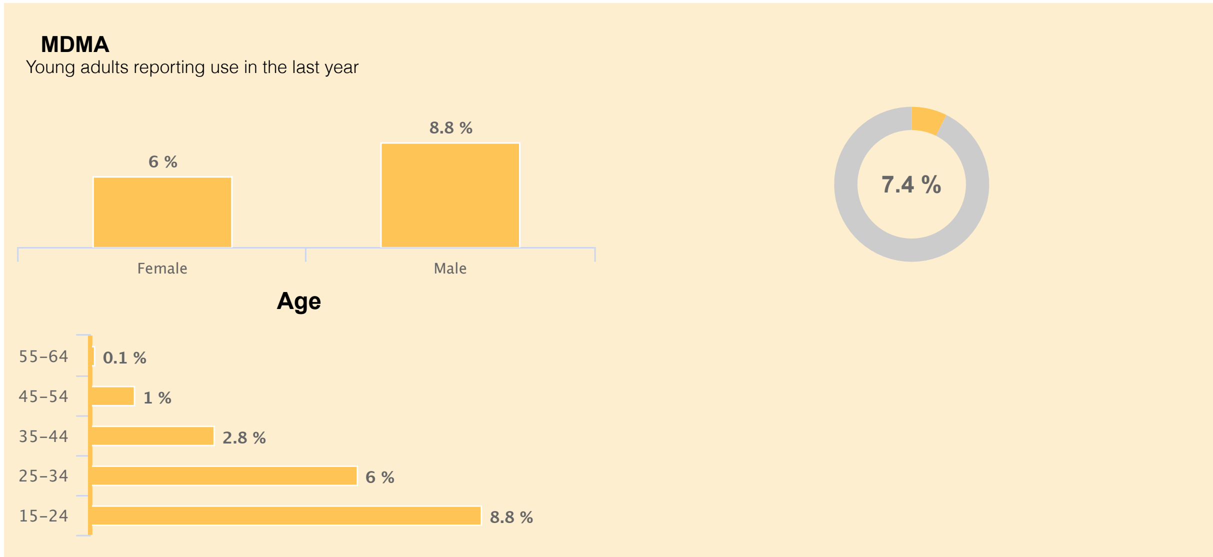
Studies among other sub-groups of young people indicate that the use of illicit substances is more common in recreational settings (where cannabis is the most popular substance consumed) and at music festivals (MDMA). Moreover, some NPS, such as 4-fluoroamphetamine (4-FA), are also gaining popularity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

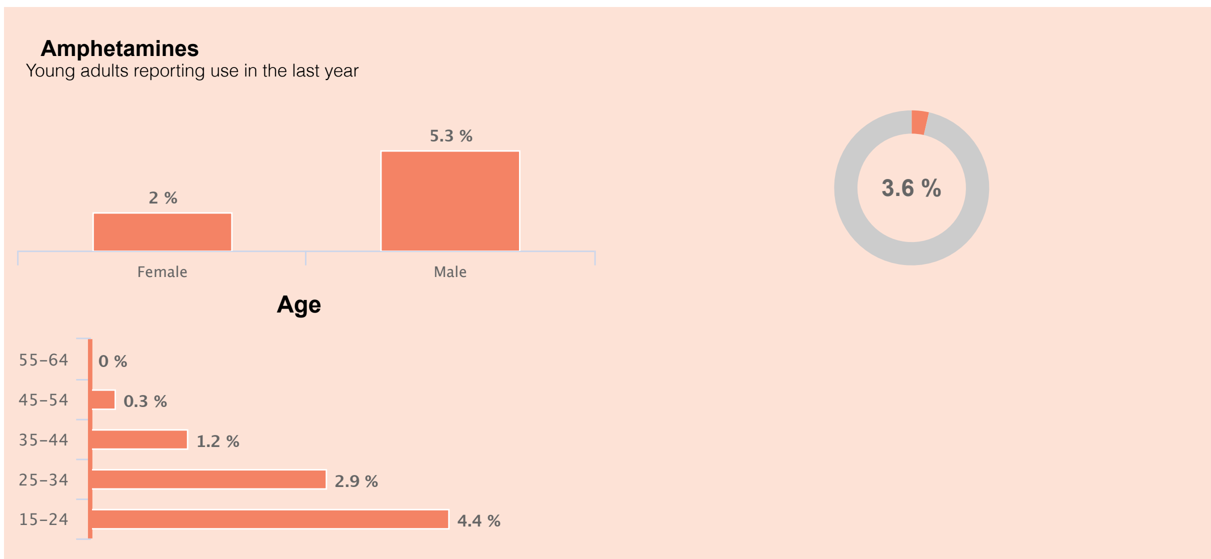
Wastewater analyses can complement the results from population surveys, by providing data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. As part of the Europe-wide Sewage Analysis Core Group Europe (SCORE) analyses, Eindhoven and Utrecht indicate a decrease in cocaine between 2016 and 2017. On the other hand, in Eindhoven MDMA levels were higher in 2017 than in 2016. Use of MDMA and cocaine seems to be more common in Amsterdam and Eindhoven than in Utrecht.

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

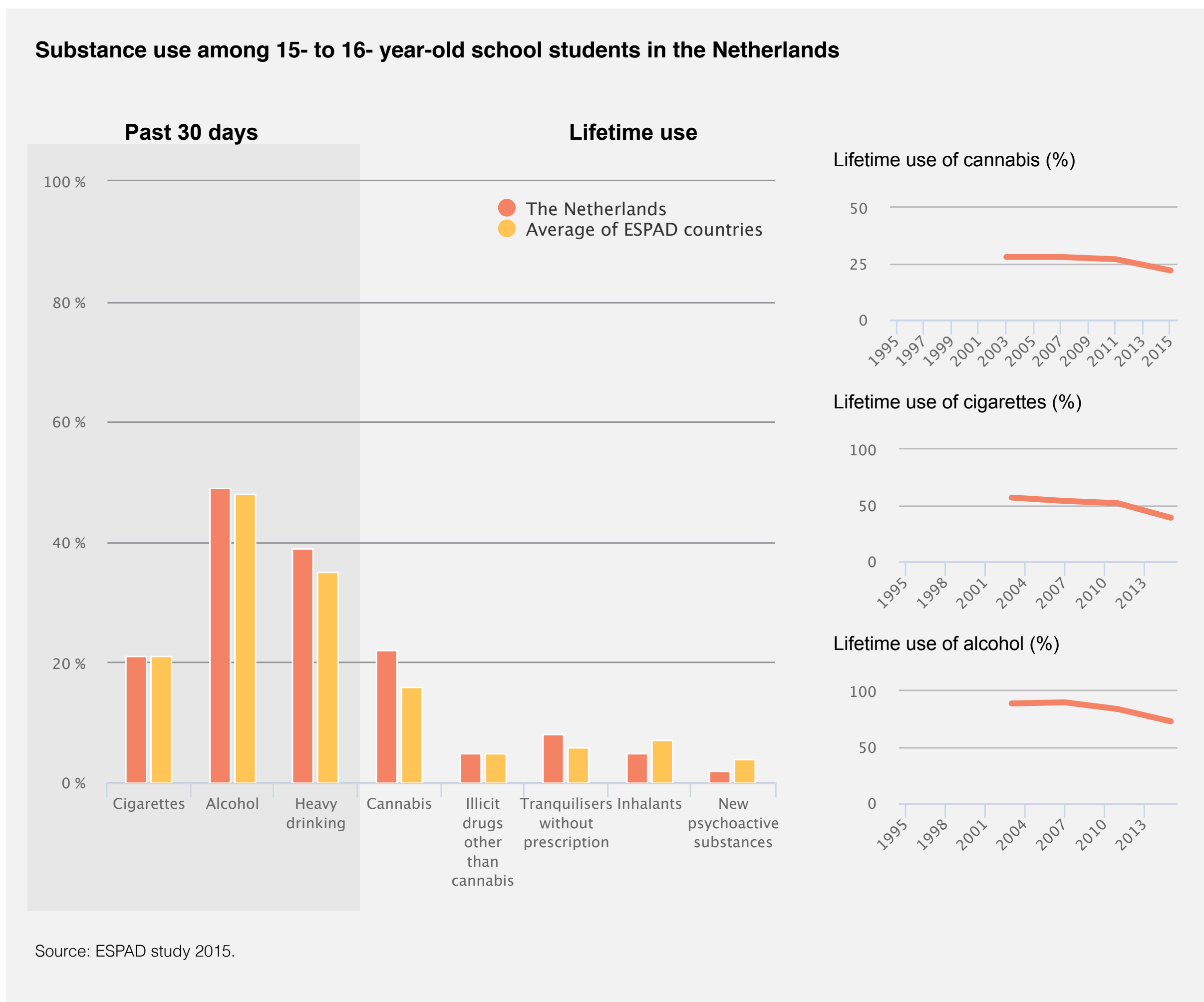








NB: Estimated last-year prevalence of drug use in 2016.



High-risk drug use and trends

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

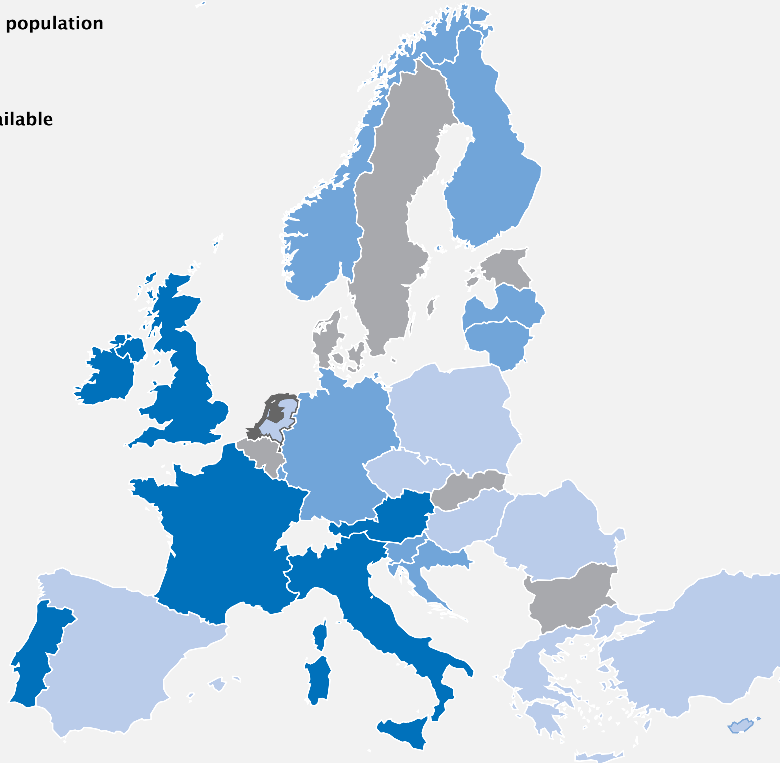
In the Netherlands, high-risk drug use is mainly linked to use of heroin or crack cocaine. The most recent estimate of the high-risk opioid user population suggested that there were 14 000 high-risk opioid users in 2012 (1.3 per 1 000 inhabitants aged 15-64 years). Available data indicate a decline in the estimated number of opioid users in the last decade. Based on a study in the three largest cities, the prevalence of crack use ranged between 1.6 and 2.2 per 1 000 inhabitants aged 15-64 years in 2013. Many high-risk drug users, including opioid users, also use crack cocaine and a range of other licit and illicit substances.

In 2016, a general population survey estimated that 1.4 % of people aged more than 18 years in the Netherlands were high-risk cannabis users.

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

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

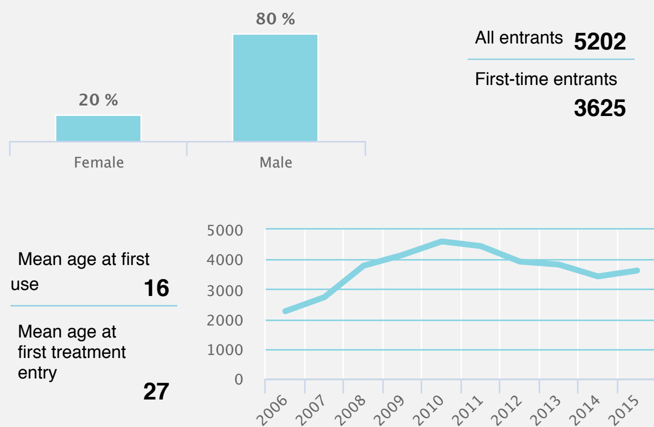
National estimates of last year prevalence of high-risk opioid use



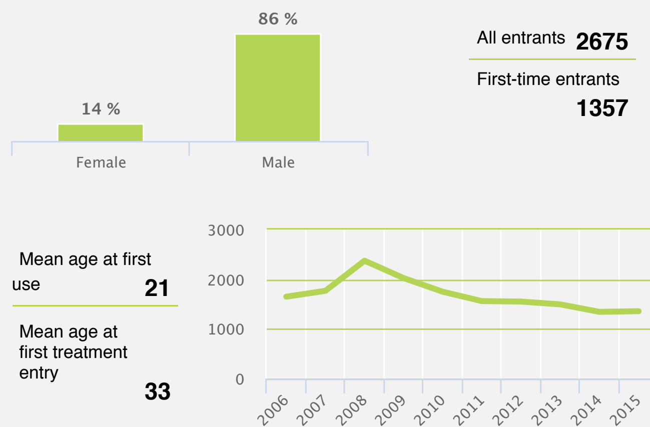
NB: Year of data 2016, or latest available year

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

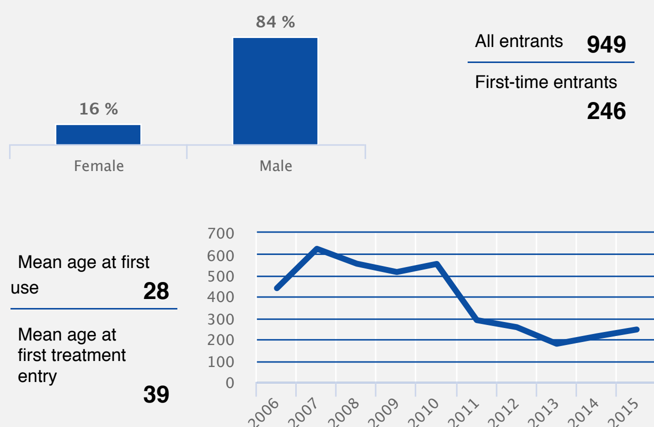
Cannabis
users entering treatment



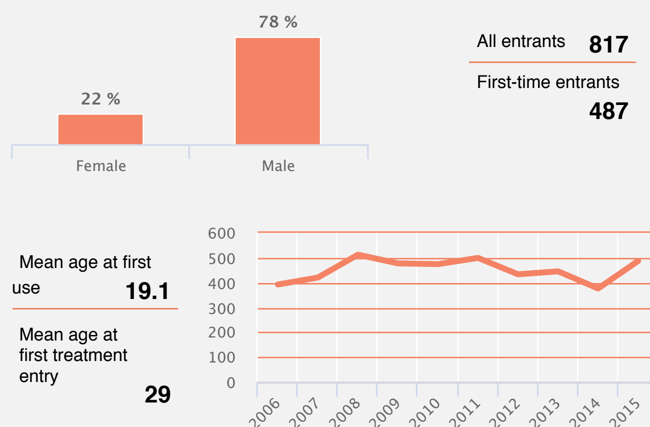
Cocaine
users entering treatment



Heroin
users entering treatment



Amphetamines
users entering treatment



NB: Year of data 2016. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

Drug-related infectious diseases

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

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

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

region	HCV	HIV
National	:	:
Sub-national	76.2	3.8

Year of data: 2016

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

Drug-related emergencies

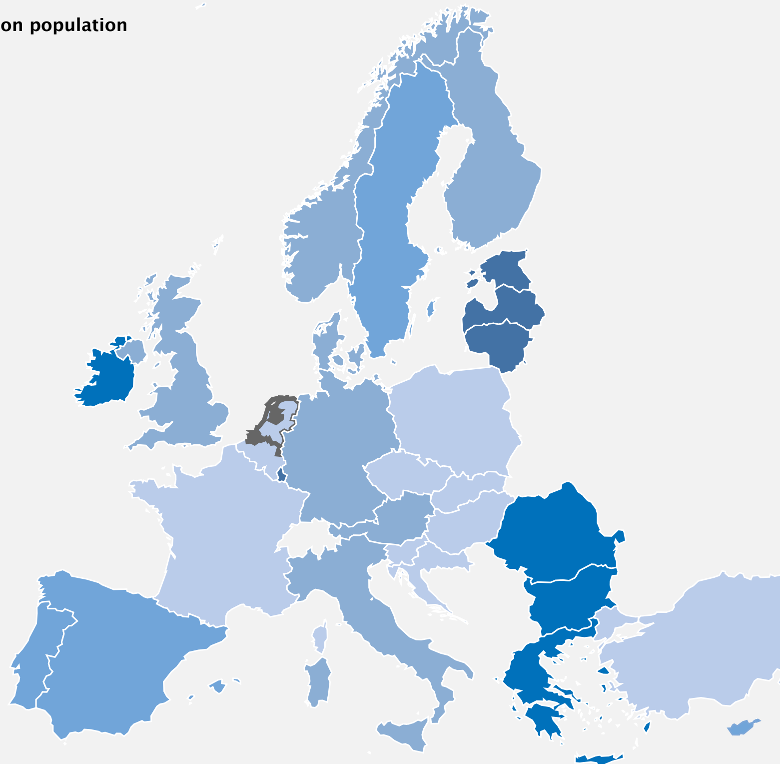
Although national data on absolute numbers of emergencies are not available, the ‘Monitor drug-related emergencies’ has been collecting information from a number of sentinel regions and emergency posts in dance and festival events since 2009, providing an insight into drug-related acute intoxications in sentinel centres. A second source on drug-related emergencies is an injury information system collecting data from the emergency departments of 14 hospitals.

In 2016, a total of 4 894 drug-related emergencies were registered by the Monitor, while the injury information system recorded 760 cases. In recent years, the percentage of moderate to severe intoxication with MDMA/ecstasy (as the only substance present) has increased, and is probably explained by the availability of high-concentration MDMA tablets on the market: in 2016, more than half of ecstasy pills tested by the Drug Information and Monitoring System (DIMS) contained more than 150 mg MDMA.

Emergency cases involving more than one illicit or licit substance have been reported increasingly frequently. Since 2012, emergencies linked to 4-fluoroamphetamine (4-FA) have increased substantially, and the drug is often used in combination with other substances. Whereas no emergencies related to the use of 4-FA were recorded before 2012, 272 emergencies with 4-FA as the only drug were recorded in 2016, and another 184 patients had used 4-FA in combination with at least one other drug. The majority presented at the first aid posts. Ketamine intoxications do not form a large proportion in the Monitor, but, in 2015, a small increase was noted, as well as an increase in the severity of gamma-hydroxybutyrate (GHB) intoxications.

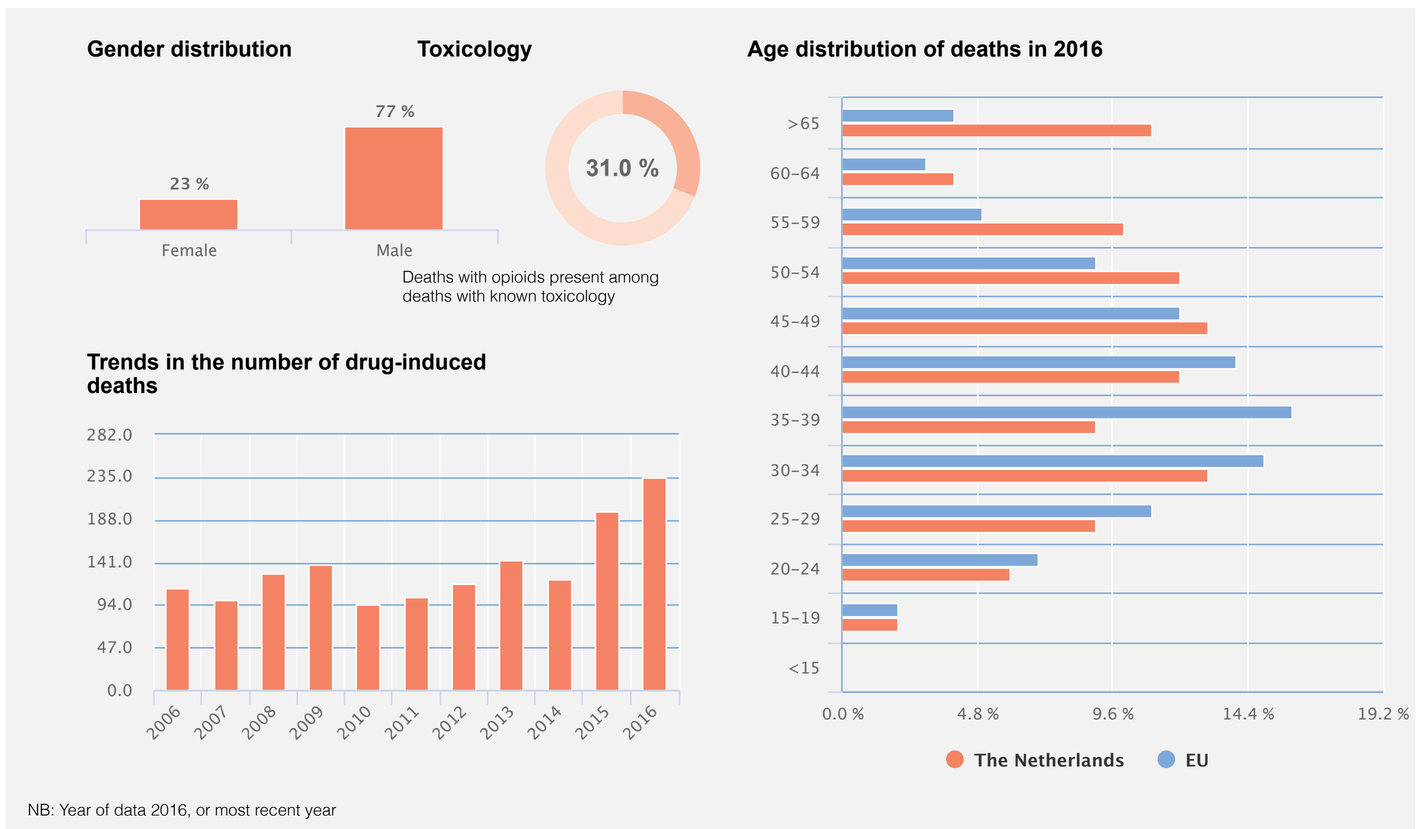
Newly diagnosed HIV cases attributed to injecting drug use

Cases per million population
- <1.0
- 1.0–2.0
- 2.1–3.0
- 3.1–8.0
- >8.0



NB: Year of data 2016, or latest available year. Source: ECDC.

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

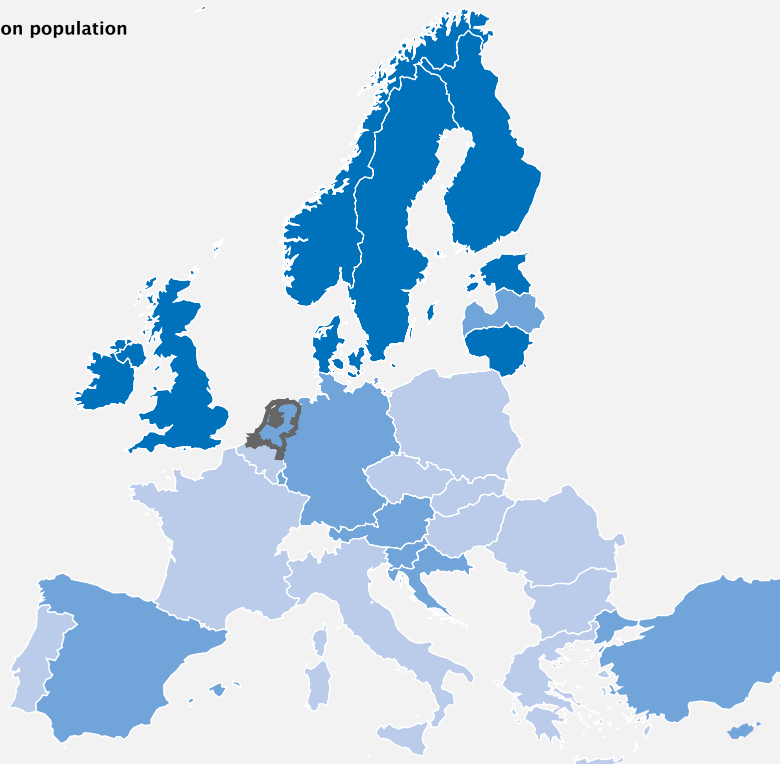


NB: Year of data 2016, or most recent year

Drug-induced deaths and mortality

In 2016, the general mortality register reported a further increase in the annual number of drug-induced deaths in the Netherlands. The majority of victims were male, and the mean age was 41.5 years. The reasons for the rise in the number of drug-induced deaths remain unclear, although ageing of the drug users, changes in drug use and emergence of medicinal opioids including oxycodone use could play a role, as well as changes in registration of drug-induced deaths.

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



"NB: Year of data 2016, or latest available year. Comparison between countries should be undertaken with caution. Reasons include systematic under-reporting in some countries, different reporting systems and case definition and registration processes."

The drug-induced mortality rate among adults (aged 15-64 years) was 18.84 deaths per million in 2016. This remains lower than the most recent European average of 21.8 deaths per million.

Prevention

Drug use prevention in the Netherlands is embedded in a broader perspective of a national prevention programme for 2014-16, which was renewed in May 2017. In the programme, priority is given to high-risk groups and young people. Activities in recreational settings predominate, especially those tackling the use of illicit and licit substances. In recent years, emphasis has been given to counteracting the normalisation of recreational drug use in nightlife settings.

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

Prevention interventions

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

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

Universal prevention has been carried out in secondary schools through the Healthy School and Drugs programme for the last 20 years. This programme targets students from the second-last year of elementary school to vocational education, as well as parents and teachers. Following an evaluation in 2014, the programme was revised to increase the skill-focused components and to provide more intensive interventions on social norms, self-regulation and impulse control, and professional training for educational staff. A Swedish programme, Preventing Heavy Alcohol Use in Adolescents (the Örebro programme), has been effectively implemented in the Netherlands under the name PAS. A new programme, ‘Toolkit alcohol and drugs prevention for students’, targets higher professional education and academic education. It offers an integrated approach that addresses all phases of educational experiences. Outside school settings, the project Alcohol and Drug Prevention at Clubs and Pubs aims to create a healthy and safe nightlife environment using a healthy settings approach. The focus is on reducing the high-risk use of substances among young people and its related problems. Electronic media and new applications are increasingly used to provide information and counselling on drug-related issues.

In recent years, more attention has been given to selective prevention interventions, although their availability largely depends on local policies. These interventions, carried out by non-governmental organisations in cooperation with government services, target various at-risk groups: children of parents with drug use problems and the parents themselves; frequent users of cannabis not yet in treatment; tourists; young people with learning disabilities; young people on the streets, from socio-economically deprived neighbourhoods or in special institutional settings (such as residential child care or custodial institutions); and young people in recreational settings.

The projects in recreational settings focus on the implementation of safe clubbing regulations, person-to-person interventions and the testing of substances (often ‘club’ drugs) at addiction care organisations. The nightlife projects aim to link up with parents, municipalities, schools, professionals, club owners and event organisers. These projects are connected to the Drug Information and Monitoring System (DIMS). They monitor drug-related emergencies and are particularly important for the rapid sharing of information about new or dangerous psychoactive substances and their hazardous health effects in recreational settings, and for issuing local warnings. These initiatives have recently been complemented with additional interactive tools, campaigns, conferences and mobile applications such as the ‘Red Alert App’, by which recreational drug users can receive an alert when there are especially dangerous drugs on the market, and can find general information about drug-testing services.

Social neighbourhood teams play an increasing role in selective prevention interventions, as part of an ongoing reorganisation of general healthcare.

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

Harm reduction

Harm reduction is a central feature in the Dutch drug policy and is aimed at reducing drug-induced deaths and drug-related infectious diseases, as well as at preventing drug-related emergencies. Methadone and heroin programmes, needle and syringe programmes, supervised drug consumption rooms, sheltered living projects and treatment of drug-related infectious diseases are widely available for people with problem drug use patterns.

Harm reduction interventions

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

Most outreach work is carried out by low-threshold services in outpatient care facilities. Drug consumption rooms offer the possibility of supervised consumption. Outreach activities also feature in programmes for reducing drug-related public nuisance, which are a collaborative venture between treatment and care facilities, police and civil groups.

Needle and syringe programmes were established in the Netherlands over 30 years ago and are available in all major cities. These programmes are mainly implemented by street drug workers and at treatment centres.

There is no national monitoring of the number of syringes and needles distributed. Available local data indicate a significant decline in syringe provision since the 1990s, which can be attributed to a reduction in heroin use and injecting in general, and an increase in the inhalant use of other substances, such as crack cocaine.

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

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

Availablity of selected harm reduction responses in Europe

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

Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

The treatment system

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

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

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

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

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

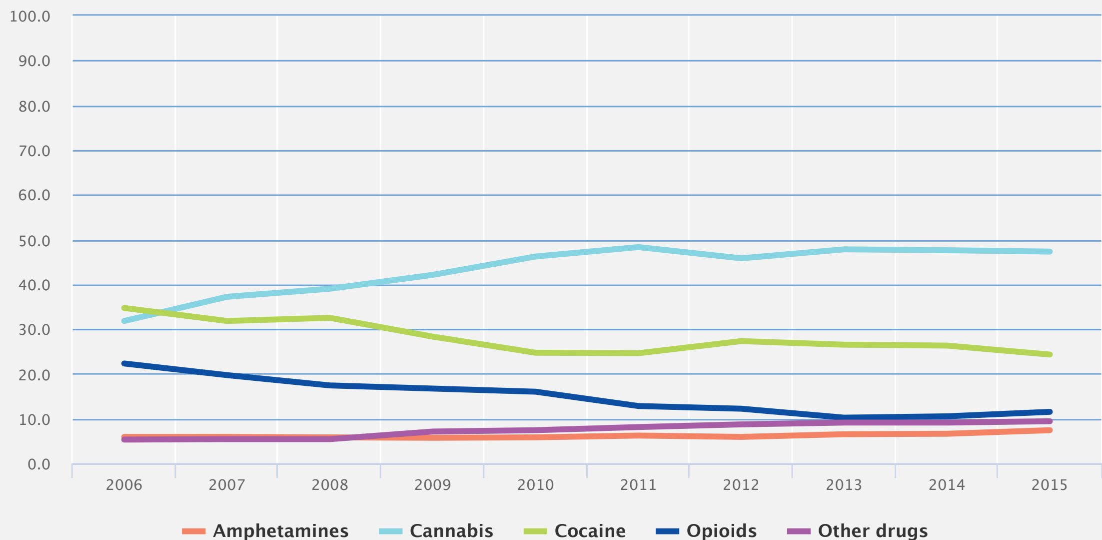
Treatment provision

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

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

Fewer than 2 out of 10 treated opioid users entered treatment in 2015, and most of them were already in long-term treatment programmes, such as OST. Moreover, the number of new treatment entries attributable to opioid use has reduced and the mean age of opioid treatment clients has increased, indicating ageing of the opioid-using population in the Netherlands. According to the latest available data (2015), 5 241 clients received OST, a large majority of whom were treated in methadone maintenance programmes.

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

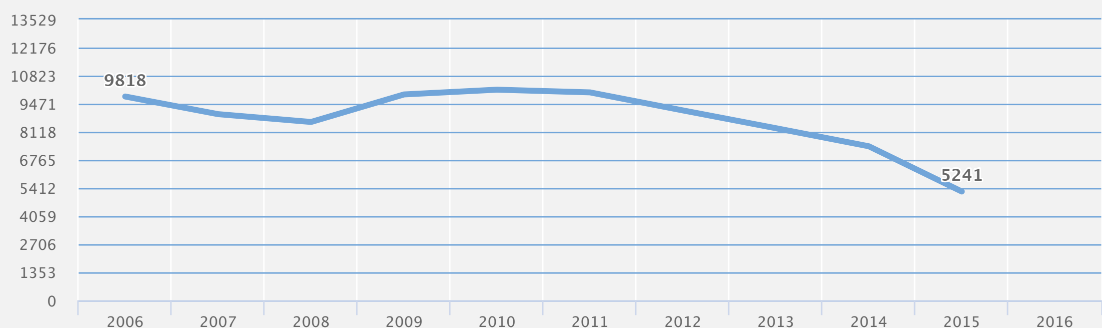


NB: Year of data 2016.

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

Methadone, **100 %**

Trends in the number of clients in OST



NB: Year of data 2015.

Drug use and responses in prison

The data on prevalence of (problem) substance use among prisoners in the Netherlands date back to 2009 and suggest that around 4 out of 10 adult Dutch prisoners had substance use problems before being imprisoned. In general, the prison system implements a policy aimed at discouraging the use of drugs, by creating drug-free settings, limiting the availability and use of drugs in prisons. Continuity of care and equivalent access to health services are basic principles of the treatment of prisoners.

The Ministry of Justice and Security oversees health services in prisons and funds drug treatment in prisons. Drug treatment measures in prisons include evidence-based behavioural intervention and mental care services. If needed, prisoners can be referred to treatment services outside prison (as an alternative for imprisonment). Repeated offenders who exhibit drug use problems on prison entry may be placed in an Institution for Prolific Offenders, which also offers several treatment interventions inside and outside the prison system. According to the guidelines on 'medical treatment of detained opiate addicts', those in methadone maintenance treatment prior to being incarcerated can continue their treatment during imprisonment.

Special treatment for those dependent on benzodiazepines or gamma-hydroxybutyrate (GHB) is available. To reverse overdose due to use of heroin and other opioids, naloxone is available in every penitentiary institution.

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

Quality assurance

The national policy envisages that all treatment interventions, irrespective of their provision, should be evidence based and comply with prevailing guidelines.

Together with the institutes for mental healthcare, the institutes for addiction care are organised within the Dutch Association of Mental Health and Addiction Care (GGZ Nederland), which supports the quality management of addiction care by means of the programme 'Scoring Results' (Resultaten Scoren), which was launched in 1999. In 2017, the Dutch Addiction Association (DAA, Verslavingskunde Nederland) was formed. It is a network that includes institutes for addiction care, client organisations, knowledge centres, and the GGZ Nederland and Resultaten Scoren. Its mission is to increase the impact of addiction expertise, to raise the profile of the field of addictions, and to increase the quality of recovery oriented care.

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

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

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

As of 1 January 2017 all providers of mental healthcare (including general mental healthcare and specialised mental healthcare, which include addiction care) are obliged to disclose a quality statute. This statute will be reviewed by a board every 2 years.

Every professional working in the healthcare sector and in contact with patients has to be registered in the 'BIG registry' (Beroepen in de Individuele Gezondheidszorg; professions in individual healthcare). In order to maintain registration, one has to fulfil criteria both on the level of hours worked in contact with patients and on the level of refresher courses.

Academic curricula, continuing education programmes and refresher courses for professionals are offered by research universities, universities of applied sciences, institutes for international education and other institutes for specific higher education, and degrees can be obtained at BSc and MSc levels. Since 2007, there is a specific master's degree in Addiction Medicine (MiAM) at Radboud University.

Drug-related research

Drug research in the Netherlands is extensive and covers many domains. Public funding of drug-related research is mainly delegated to intermediary agencies, although ministries and municipalities also directly fund research projects. Many academic institutions are involved in drug research, sometimes in collaboration with researchers from institutes for addiction care. An annual Forum on Alcohol and Drugs Research is organised for drug researchers to stay informed about recent developments. A study is ongoing to identify research gaps in Dutch addiction care, which could serve as a basis for a research agenda for the coming years.

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

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

The Netherlands Organisation for Health Research and Development coordinates the European Research Area Network on Illicit Drugs (ERANID).

Drug markets

Dutch drug markets are extensively monitored in the long-running chemical toxicological monitor Drug Information and Monitoring System (DIMS) (drug composition) and the tetrahydrocannabinol (THC) monitor (analysing cannabis from 'coffee shops'). After a decline, the average level of THC in Dutch-grown herbal cannabis (the most popular variety of cannabis) has risen gradually since 2013. It remained at the same level in 2016 and 2017. The level of THC in imported hashish has also risen slightly in the last few years. In 2017, at 20.8 % it was more potent than Dutch-grown weed and was at the highest level since monitoring started. Dutch-grown weed contains low levels (0.3 %) of cannabidiol (CBD), which was 8.4 % in imported hashish. The average price of herbal cannabis was EUR 10.20/g and for resin EUR 9.90/g in 2017.

Most cocaine powders are cut with other substances. However, in 2016, a reduction was seen in the proportion of consumer cocaine powders that contained levamisole (an animal dewormer). Still, the purity remains high, at 69 % (percentage weight) in 2016. This was 44 % for amphetamines. In 2016, the average concentration of MDMA in ecstasy pills rose to 157 mg.

Tackling and counteracting organised crime groups involved in production and trafficking of 'established' illicit drugs is the key priority in the Netherlands; multidisciplinary enforcement activities primarily take place at regional level. Specialised police units and teams deal with investigative and enforcement activities related to cannabis cultivation and production of synthetic stimulants, as well as with money laundering linked to the illicit drug trade. To address international drug-related crime, the Netherlands has developed close cooperation or joint actions with all neighbouring countries.

Cannabis cultivated and synthetic drugs produced in the Netherlands are exported to foreign markets. Cannabis cultivation occurs mainly indoors, and only a small number of open-air sites have been dismantled and reported. In 2016, around 5 500 cannabis plantations were dismantled, fewer than in 2015.

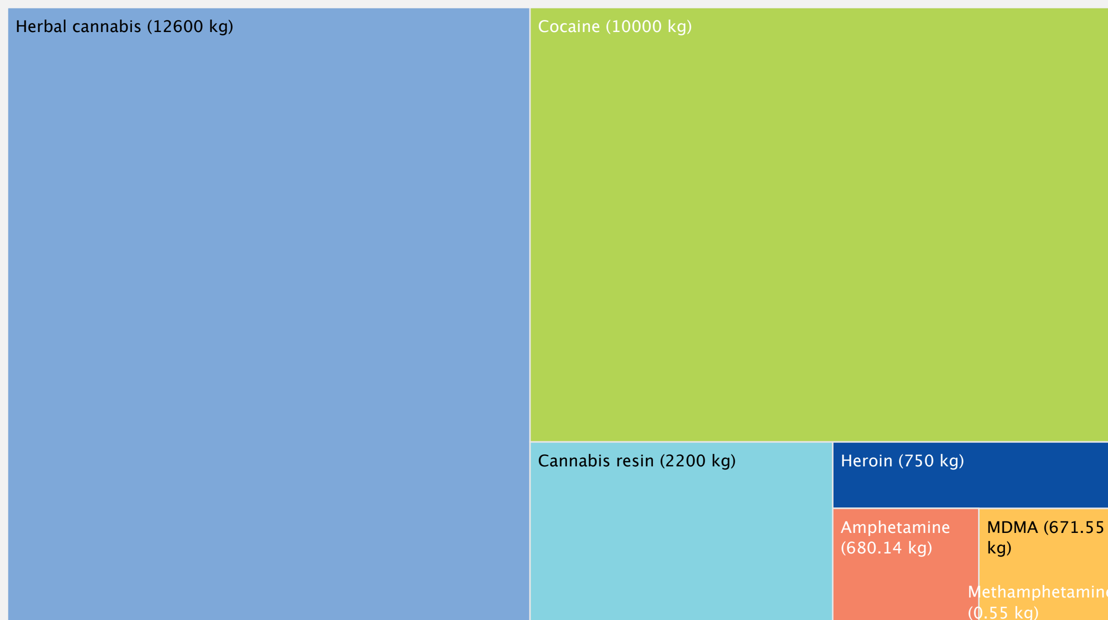
The Netherlands is primarily a transit country for both heroin and cocaine. Heroin mainly originates from Afghanistan and is trafficked to the Netherlands via the Balkan route. Cocaine, originating in South America, is most commonly shipped directly from Central American countries by sea and, to a lesser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

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

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

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

Drug seizures in the Netherlands: quantities seized



NB: Year of data 2016

Key statistics

Most recent estimates and data reported

	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	22.37	6.5	36.8
Last year prevalence of use - young adults (%)	2016	15.7	0.4	21.5
Last year prevalence of drug use - all adults (%)	2016	8.4	0.3	11.1
All treatment entrants (%)	2015	47.3	1.0	69.6
First-time treatment entrants (%)	2015	55.5	2.3	77.9
Quantity of herbal cannabis seized (kg)	2012	12600	12	110855
Number of herbal cannabis seizures	n.a.	n.a.	62	158810
Quantity of cannabis resin seized (kg)	2012	2200	0	324379
Number of cannabis resin seizures	n.a.	n.a.	8	169538
Potency - herbal (% THC) (minimum and maximum values registered)	2016	2.2 - 25	0	59.90
Potency - resin (% THC) (minimum and maximum values registered)	2016	1.9 - 45.8	0	70.00
Price per gram - herbal (EUR) (minimum and maximum values registered)	2016	n.a.	0.60	111.10
Price per gram - resin (EUR) (minimum and maximum values registered)	2016	n.a.	0.20	38.00
Cocaine				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	1.9	0.9	4.9
Last year prevalence of use - young adults (%)	2016	3.7	0.2	4.0
Last year prevalence of drug use - all adults (%)	2016	2	0.1	2.3
All treatment entrants (%)	2015	24.3	0.0	36.6
First-time treatment entrants (%)	2015	20.8	0.0	35.5
Quantity of cocaine seized (kg)	2012	10000	1.00	30295
Number of cocaine seizures	n.a.	n.a.	19	41531
Purity (%) (minimum and maximum values registered)	2016	1 - 89	0	99.00
Price per gram (EUR) (minimum and maximum values registered)	2016	30 - 200	3.00	303.00

Amphetamines				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	2.4	0.8	6.5
Last year prevalence of use - young adults (%)	2016	3.6	0.0	3.6
Last year prevalence of drug use - all adults (%)	2016	1.7	0.0	1.7
All treatment entrants (%)	2015	7.4	0.2	69.7
First-time treatment entrants (%)	2015	7.5	0.3	75.1
Quantity of amphetamine seized (kg)	2012	680.1	0	3380
Number of amphetamine seizures	n.a.	n.a.	3	10388
Purity - amphetamine (%) (minimum and maximum values registered)	2016	1 - 73	0	100.00
Price per gram - amphetamine (EUR) (minimum and maximum values registered)	2016	2.8 - 40	2.50	76.00
MDMA				
Lifetime prevalence of use - schools (% , Source: ESPAD)	2015	3.1	0.5	5.2
Last year prevalence of use - young adults (%)	2016	7.4	0.1	7.4
Last year prevalence of drug use - all adults (%)	2016	3.6	0.1	3.6
All treatment entrants (%)	2015	0.7	0.0	1.8
First-time treatment entrants (%)	2015	1.0	0.0	1.8
Quantity of MDMA seized (tablets)	2012	n.a.	0	3783737
Number of MDMA seizures	n.a.	n.a.	16	5259
Purity (MDMA mg per tablet) (minimum and maximum values registered)	2016	20 - 266	1.90	462.00
Purity (MDMA % per tablet) (minimum and maximum values registered)	2016	n.a.	0	88.30
Price per tablet (EUR) (minimum and maximum values registered)	2016	1.9 - 10	1.00	26.00
Opioids				
High-risk opioid use (rate/1 000)	2012	1.2	0.3	8.1
All treatment entrants (%)	2015	11.5	4.8	93.4
First-time treatment entrants (%)	2015	6.2	1.6	87.4
Quantity of heroin seized (kg)	2012	750	0	5585
Number of heroin seizures	n.a.	n.a.	2	10620
Purity - heroin (%) (minimum and maximum values registered)	2016	23 - 71	0	92.00
Price per gram - heroin (EUR) (minimum and maximum values registered)	2016	10 - 60	4.00	296.00
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to Injecting drug use -- aged 15-64 (cases/million population, Source: ECDC)	2016	0.1	0.0	33.0
HIV prevalence among PWID* (%)	n.a.	n.a.	0.0	31.5
HCV prevalence among PWID* (%)	n.a.	n.a.	14.6	82.2
Injecting drug use -- aged 15-64 (cases rate/1 000 population)	2015	0.08	0.1	9.2
Drug-induced deaths -- aged 15-64 (cases/million population)	2016	18.8	1.4	132.3
Health and social responses				
Syringes distributed through specialised programmes	n.a.	n.a.	22	6469441
Clients in substitution treatment	2014	7421	229	169750
Treatment demand				
All entrants	2015	10987	265	119973
First-time entrants	2015	6529	47	39059
All clients in treatment	2014	31115	1286	243000
Drug law offences				
Number of reports of offences	2016	21118	775	405348
Offences for use/possession	n.a.	n.a.	354	392900

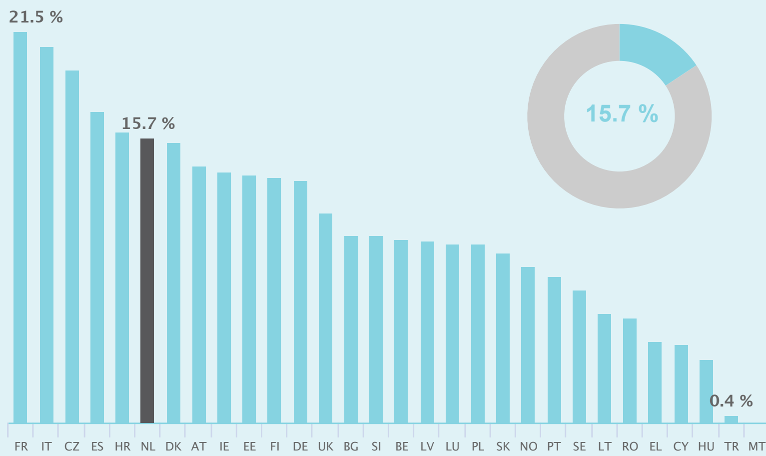
* PWID — People who inject drugs.

Average purity and cannabis prices are reported in the Drug Market section. Avarage prices for other substances: 1 MDMA/XTC pill: EUR 4.1; 1 gr cocaine: EUR 48.25; 1 gr amphetamine: EUR 7.25

EU Dashboard

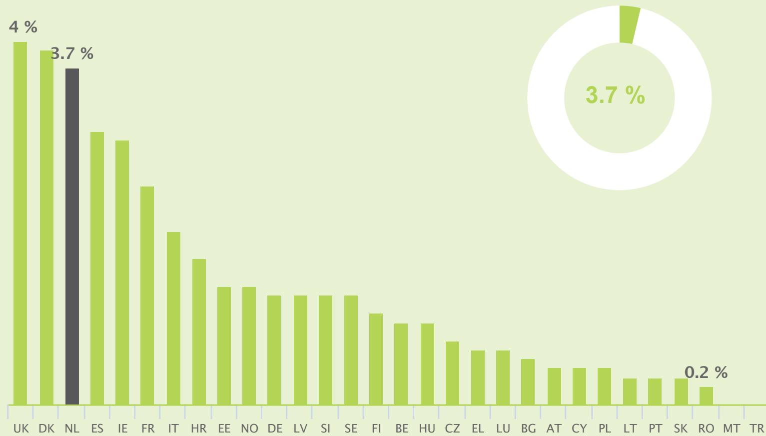
Cannabis

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



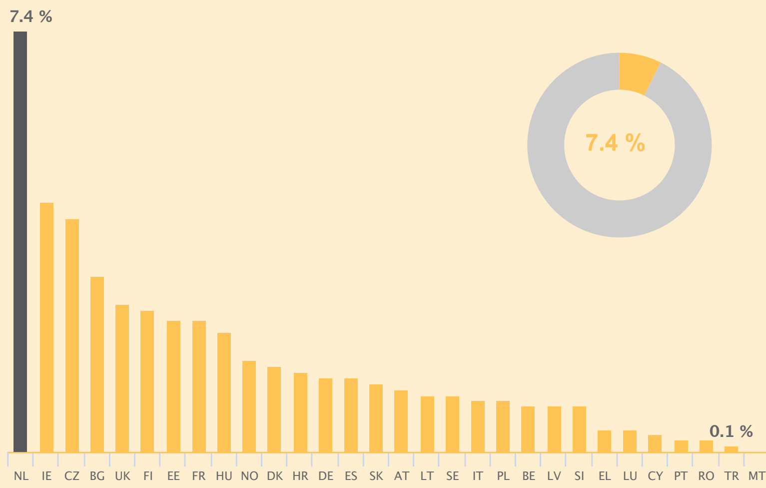
Cocaine

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



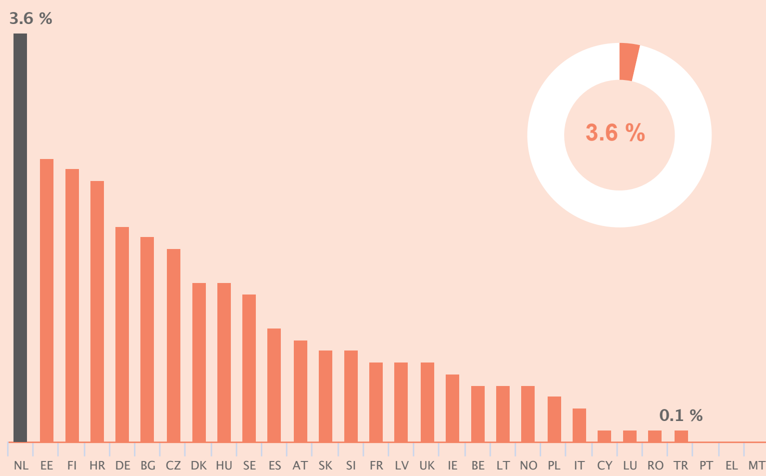
MDMA

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



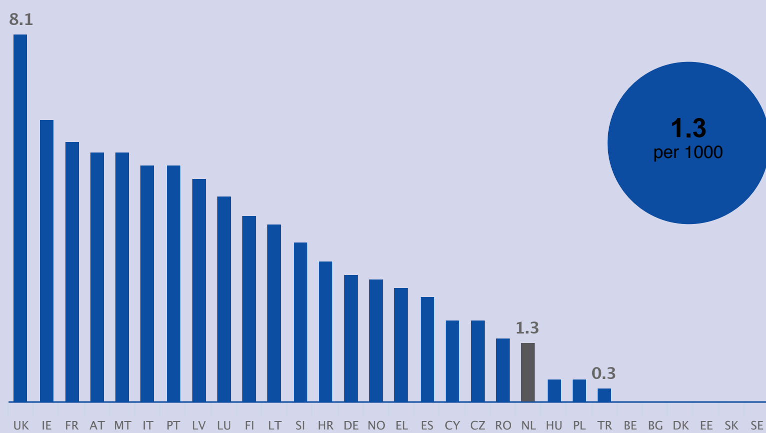
Amphetamines

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



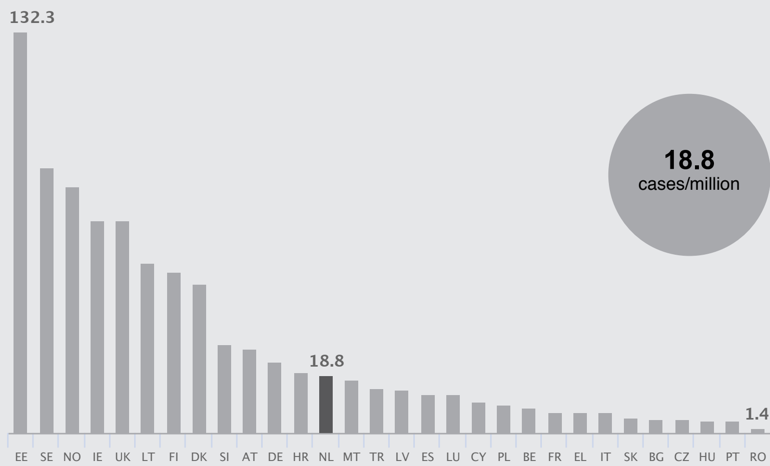
Opioids

High-risk opioid use (rate/1 000)



Drug-induced mortality rates

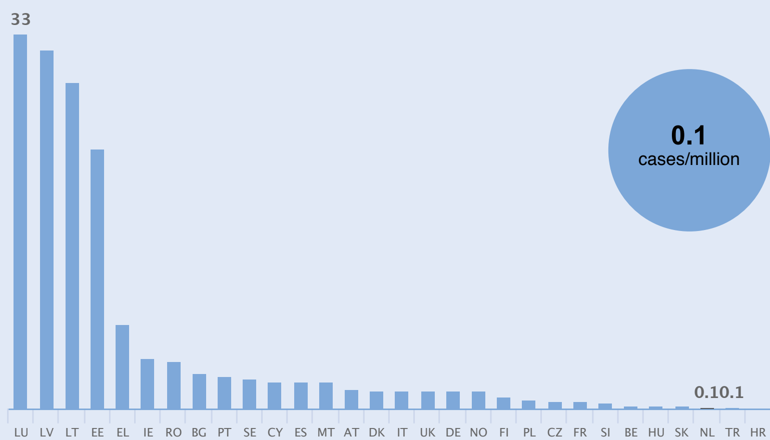
National estimates among adults (15-64 years)



18.8
cases/million

HIV infections

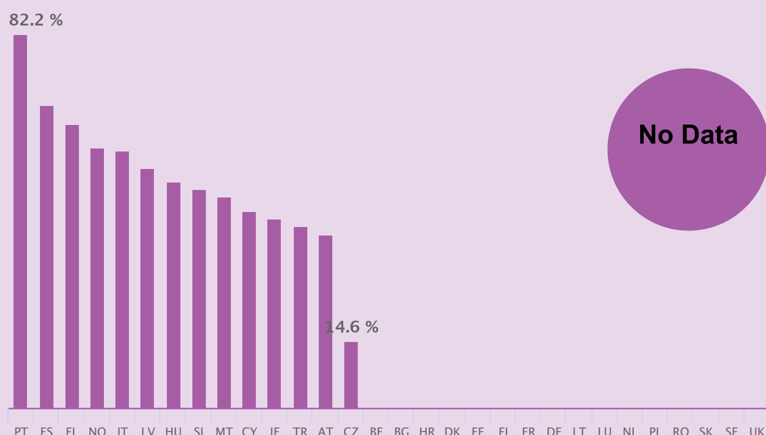
Newly diagnosed cases attributed to injecting drug use



0.1
cases/million

HCV antibody prevalence

National estimates among injecting drug users



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

About our partner in the Netherlands

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

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