



Ministerie van Volksgezondheid,
Welzijn en Sport

Drug Policy in the Netherlands





About me

- Drugs researcher/sociologist Trimbos Institute NL, program Drug Monitoring & Policy
- National coordinator Dutch Harm Reduction Network
- Coordinator C-EHRN expert group new drug trends

Main field of work:

Drug checking (DIMS) and online drug markets

International project promoting harm reduction and evidence-based policies

Evaluations of National Drug Strategies: HU, LUX (3 X), HR (2X), CY

Evaluation of harm reduction interventions: SI, HR

Evaluation of Dutch drug policy (2009)



1. Objectives and principles





Objectives of Dutch drug policy



To reduce:

- drug demand (→ information, prevention, treatment)
- drug-related harm (→ health protection, care)
- public nuisance related with production, trafficking and use of drugs
- drug supply (→ combatting production, trafficking, dealing)

To combat drug-related serious crime (e.g. organised crime, money laundering)

This presentation focuses on demand reduction, the domain of the Ministry of Health, Welfare and Sports





Principles of Dutch drug policy

- Approach: balanced, integrated and evidence-based
- Fact-based: Importance of research, evaluation and monitoring
- Drug problem primarily a (public) health issue
- Health promotion and harm reduction key concepts in effective demand reduction efforts
- Pragmatic rather than principle-based: do what works best





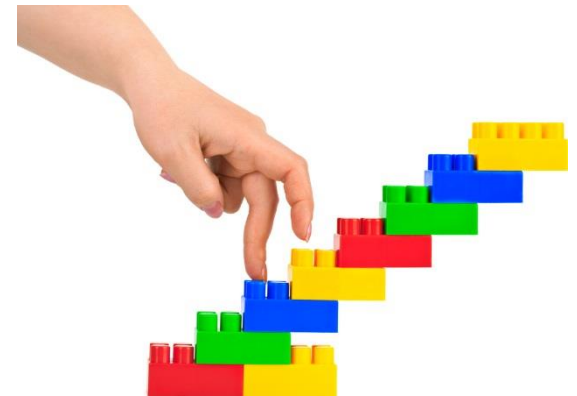
Integrated approach: division of tasks

National level: Collaboration between

- Ministry of Health, Welfare and Sports
- Ministry of Justice and Security
- Ministry of Foreign Affairs

Local level: local drug policy tailored through consultations between

- the mayor
- the chief of police
- the chief public prosecutor





2. Legislation and regulations





Legislation and regulations

Main law: Opium Act

- Differentiation to separate the markets

I

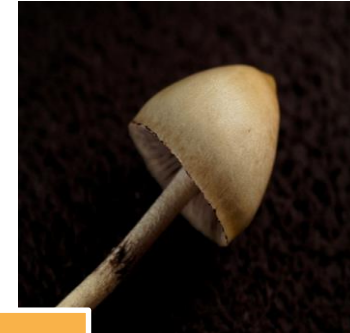
Hard drugs

- Schedule I
- Drugs posing an unacceptable risk to user and society

II

Soft drugs

- Schedule II
- Drugs that pose a less serious risk to user and society



- Use of illicit drugs is not a criminal offence (to avoid marginalisation and facilitate access to services)
- Possession is a criminal offence (to allow for seizing the drugs)





Recent adaptations of the Opium Act

I Hard drugs

- Since May 2017: 4-fluoroamphetamine (4-FA/4-FMP), α -PVP, acetylfentanyl
- Since April 2018: 4-MEC; 5F-APINACA; acryloylfentanil; butyrfentanyl; ethylon; ethyl-fenidaat; furanylfentanyl; methiopropamine (MPA); MDMB-CHMICA; pentedron; U-47700; XLR-11

II Soft drugs

- *Since 2008: hallucinogenic mushrooms*
 - *Since 2013: khat*
 - *Since May 2017: phenazepam*
- *Since March 2015: preparatory acts for cannabis cultivation punishable*
- *Since 1 January 2019: extension of closing powers mayors (art. 13b Opium Act)*





Expediency principle

Public Prosecutor has the discretionary power to refrain from prosecution of criminal offences if this is judged to be in the public interest

Priorities laid down in the Opium Act Directive of the Public Prosecution Service:

- Highest priority: large-scale dealing in and production of hard drugs
- Low priority: possession of small quantities for personal use (<0,5 g hard drugs; <5 g cannabis)
- No priority: Selling of cannabis products through coffee shops complying with the public prosecutor's criteria





< 1 unit/dose/pill synthetic drugs:

- substance confiscated
- under 18: community service 20-40 hrs |
100-200 EUR fine

< 0,5g heroin, cocaine, speed, MDMA powder etc:

- substance confiscated
- under 18: community service 20-40 hrs |
100-200 EUR fine



Up to 5g cannabis:

- sepot – no further research done
- substance confiscated
- < 18yrs: possession is forbidden: community service 12 hrs | 60 EUR

Between 5 and 30g cannabis:

- 75 euro fine
- substance confiscated
- Recidive?: higher penalties
- < 18: community service 16-30 hrs | 80-130 EUR



Use of soft drugs (Schedule II) where it is not allowed

95 EUR

Use of hard drugs (Schedule I) in public

390 EUR



3. Coffee shops: policy and practice





Coffee shop policy: national

AHOJ-GI Criteria

- A** no **A**dvertising
- H** no sale of **H**ard drugs
- O** no public nuisance (**O**verlast) in and around the coffee shop
- J** no entry or sale to young (**J**ong) people (< 18 yrs)
- G** no sale of large (**G**root) quantities per transaction (max. 5 grams); maximum stock for selling is 500 grams
- I** admission and sales only to residents (**I**ngezetenen) of the Netherlands (local adjustments in implementation are allowed)



Additional criteria may be added by local authorities





Coffee shop policy: local competences

Municipal authorities are entitled to:

- Decide on the permission and number of coffee shops
- Define a minimum distance between coffee shops and secondary schools (ranging from 250 to 350 meters)
- Prohibit cannabis use in public spaces (to reduce public nuisance)
- Close down a coffee shop when it does not adhere to the criteria of the municipality





Coffee shop policy: recent developments

- Tightening up the rules for coffee shops (e.g. only residents)
- Closing big coffee shops and coffee shops in border towns to reduce public nuisance
- Intensified police actions against (large scale) cannabis growing and facilitation of growing: each year 5,000 cannabis plantations dismantled



Coalition agreement of Rutte III cabinet (2017): There will be experiments in 6-10 municipalities with tolerated cannabis production by approved cannabis growers



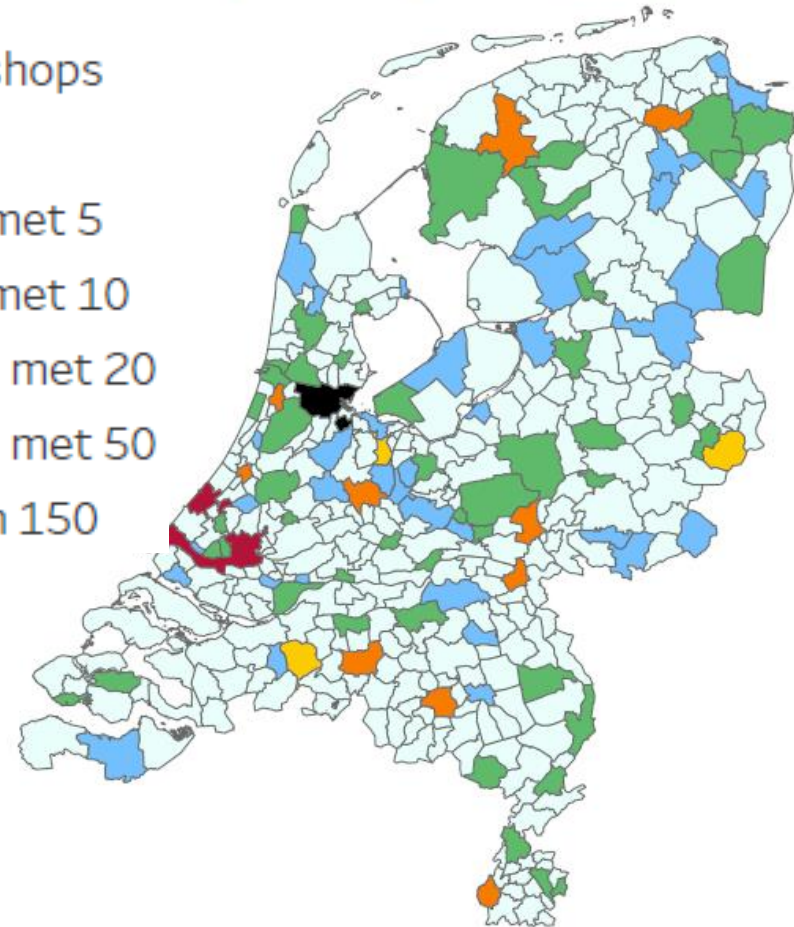


Coffee shops in the Netherlands

March 2019: 570 coffeeshops shops in total, compared to 591 in 2014 and 719 in 2006

43% are located in Amsterdam, Rotterdam, The Hague

70% of all municipalities have implemented a zero tolerance policy regarding coffee shops



Source: Intraval (2019) *Coffeeshops in Nederland*





4. Drug statistics





Key facts and trends











Cannabis is the most prevalent illegal drug in the general population aged 15-64, followed by ecstasy and cocaine

- Current cannabis use among Dutch students aged 15-16 is almost twice the European average
- Use of ecstasy among the 15-64 aged population has increased compared to 2014
- Heroin use continues to decline
- Low prevalence of GHB use, but relatively high risk of acute incidents and of relapse in addiction treatment
- Use of new psychoactive substances (NPS) relatively low, except for 4-fluoroamphetamine (Note: controlled substance since May 25, 2017)





Substance use in the general population (2017)

	Last year use (%) 18+	Last month use (%) 18+	Trends 2014/5 - 2017 18+ or 15-64 years
 Alcohol	79.5	-	Decrease 18+, 2014-17
 Tobacco	-	23.1	Decrease 18+, 2014-17
 Cannabis	7.2	4.5	Stable 18+, 2015-17
 Ecstasy	2.7	0.8	Increase 15-64, 2014-17
 Cocaine	1.8	0.6	Increase 15-64, 2014-17
 Amphetamines	1.4	0.5	Increase 15-64, 2014-17
 GHB	0.4	0.1	Fluctuations 18+, 2015-17
 Heroin	0.1	<0.1	Stable 18+, 2015-17

Source: Health Survey/Lifestyle Monitor CBS, RIVM and Trimbos Institute, 2017.

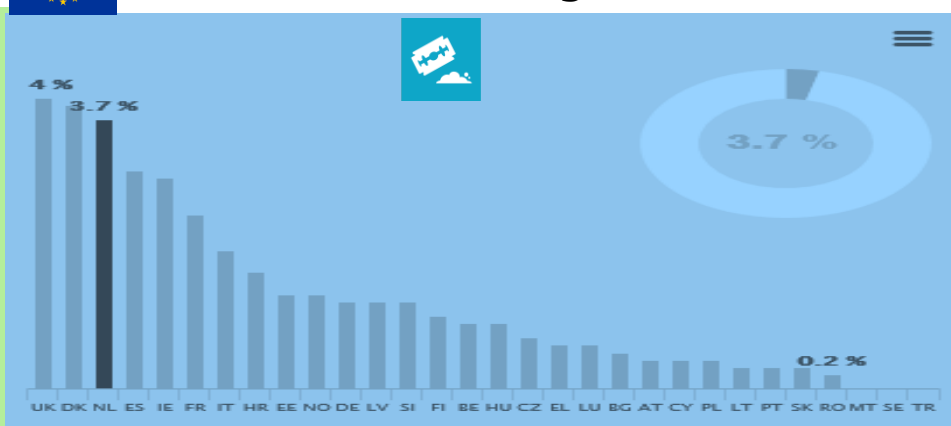
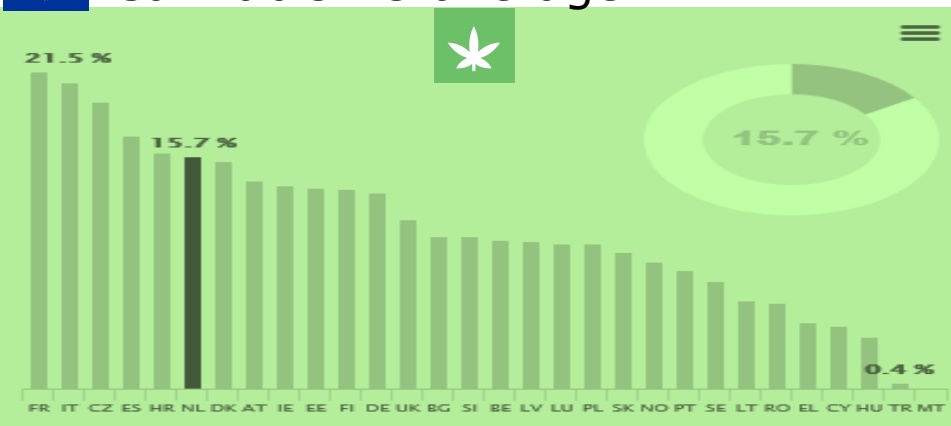




European comparison: Last year use 15-34 years

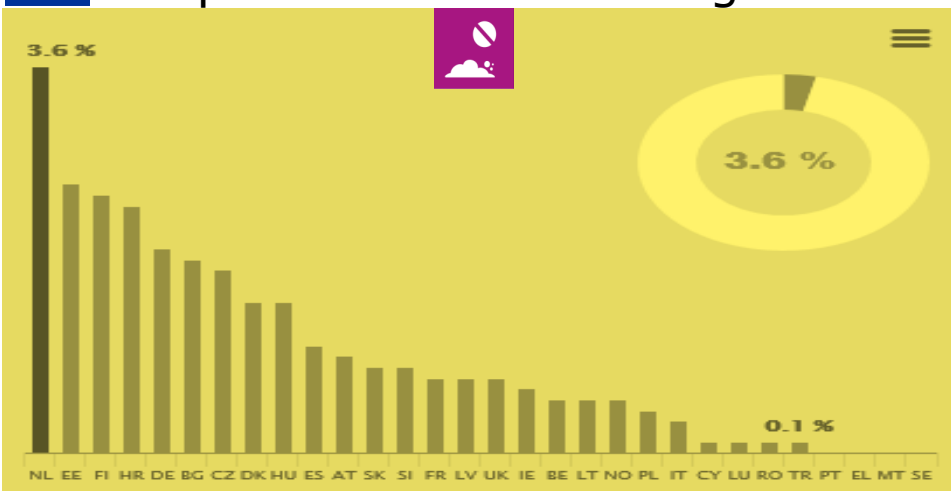
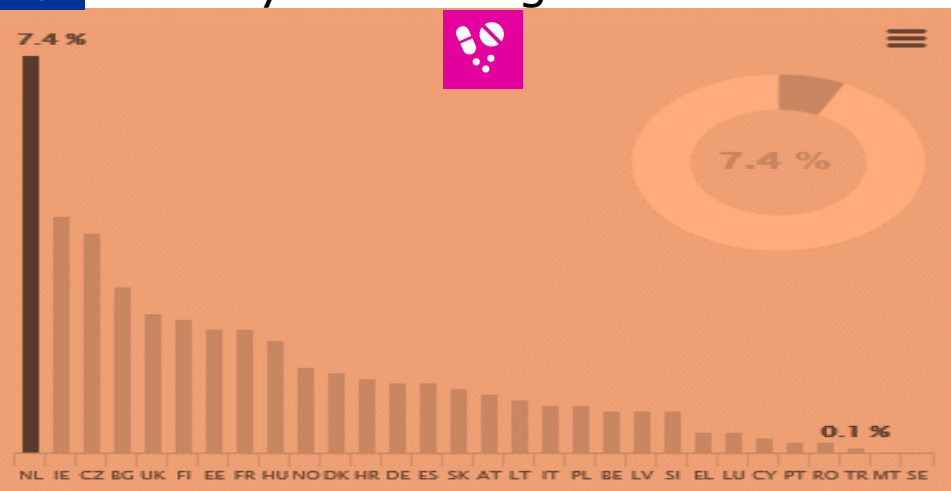
Cannabis EU average: 14.1

Cocaine EU average: 1.9



Ecstasy EU average: 1.8%

Amphetamines EU average 1.0%



Source: European Drug Report 2018. This report uses 2016 Dutch drug prevalence data.












In 2017, last year prevalence of use were: cannabis 17.5 %, cocaine 4.5%, ecstasy 7.1%, amphetamines 3.9%.



International Comparison

Last year use in the general population

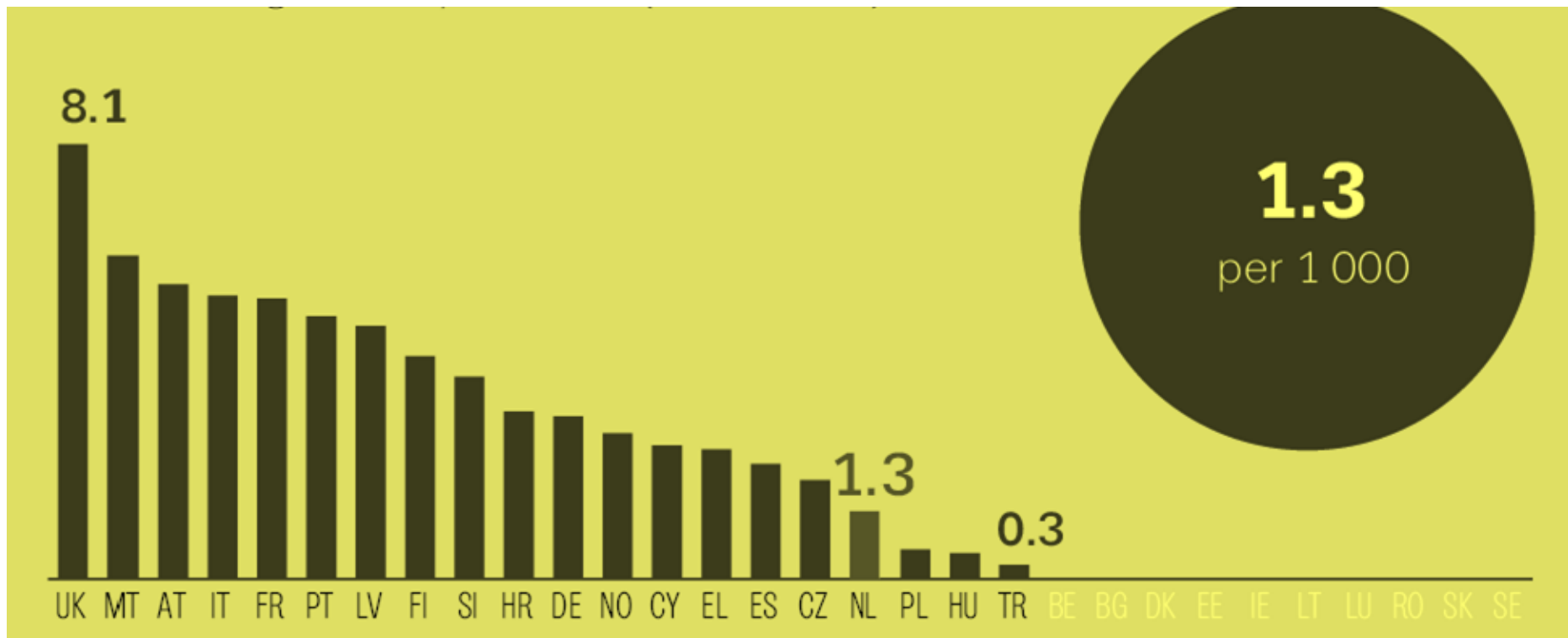


							
	NL	EU-27	U.K.	Germany	US	Canada	Australia
	(2017)	(2016)	(2016)	(2015)	(2017)	(2015)	(2016)
	15-64	15-64	16-59	18-64	18+	15+	14+
 Cannabis	9.2%	7.0%	6.6%	6.1%	15.3%	12.3%	10.4%
 Cocaine	2.2%	1.0%	2.6%	0.6%	3.0%	1.2%	2.5%
 Ecstasy	3.3%	0.8%	1.3%	0.6%	0.9%	0.7%	2.2%
 Amphetamines	1.8%	0.5%	0.5%	1.0%	0.6%	n.a.	1.4%

Source: National Drug Monitor – 2018 Annual Report, Trimbos Institute



European comparison: high risk opioid users (number per 1000 inhabitants, 2016)





International Comparison

Problem opiates users

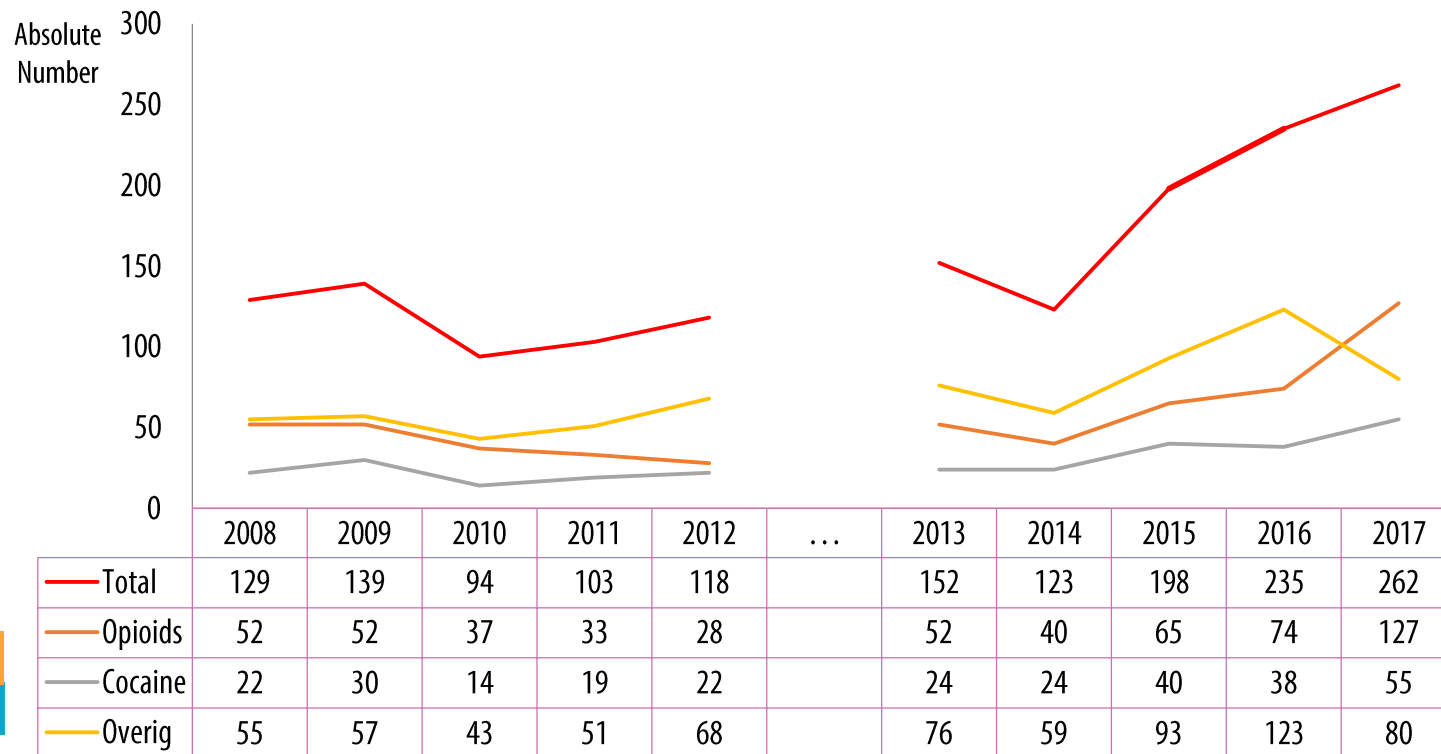


Country	Year	Number per ten thousand inhabitants 15-64 yrs	
		Mean estimate	lower - upper limit
United Kingdom	2010/2011	81	79 - 84
Luxembourg	2007	59	50 - 76
Austria	2015	55	53- 56
Italy	2015	52	46 – 58
Finland	2012	41	38 – 45
Germany	2014	-	27 – 33
Norway	2013	27	20 – 42
Greece	2015	24	21 – 28
Spain	2014	21	16 – 26
Netherlands	2012	13	12 - 15

Source: National Drug Monitor – Annual Report 2018, Trimbos Institute



Deaths from drug overdose in the Netherlands (2007-2017)



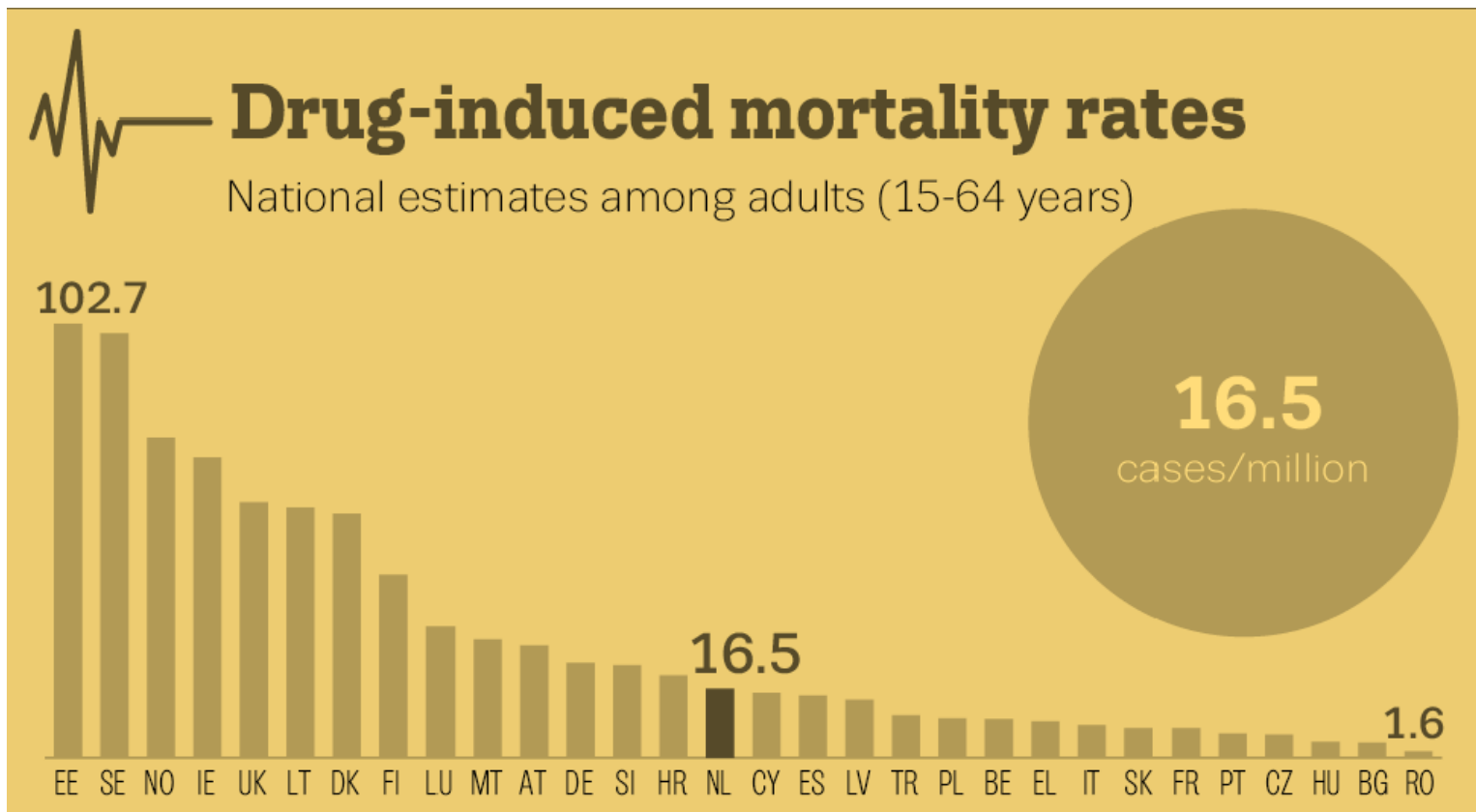
Source: National Drug Monitor – Annual Report 2018, Trimbos Institute





European comparison: overdose mortality

Number of deaths per million inhabitants (2016)





Infectious Diseases

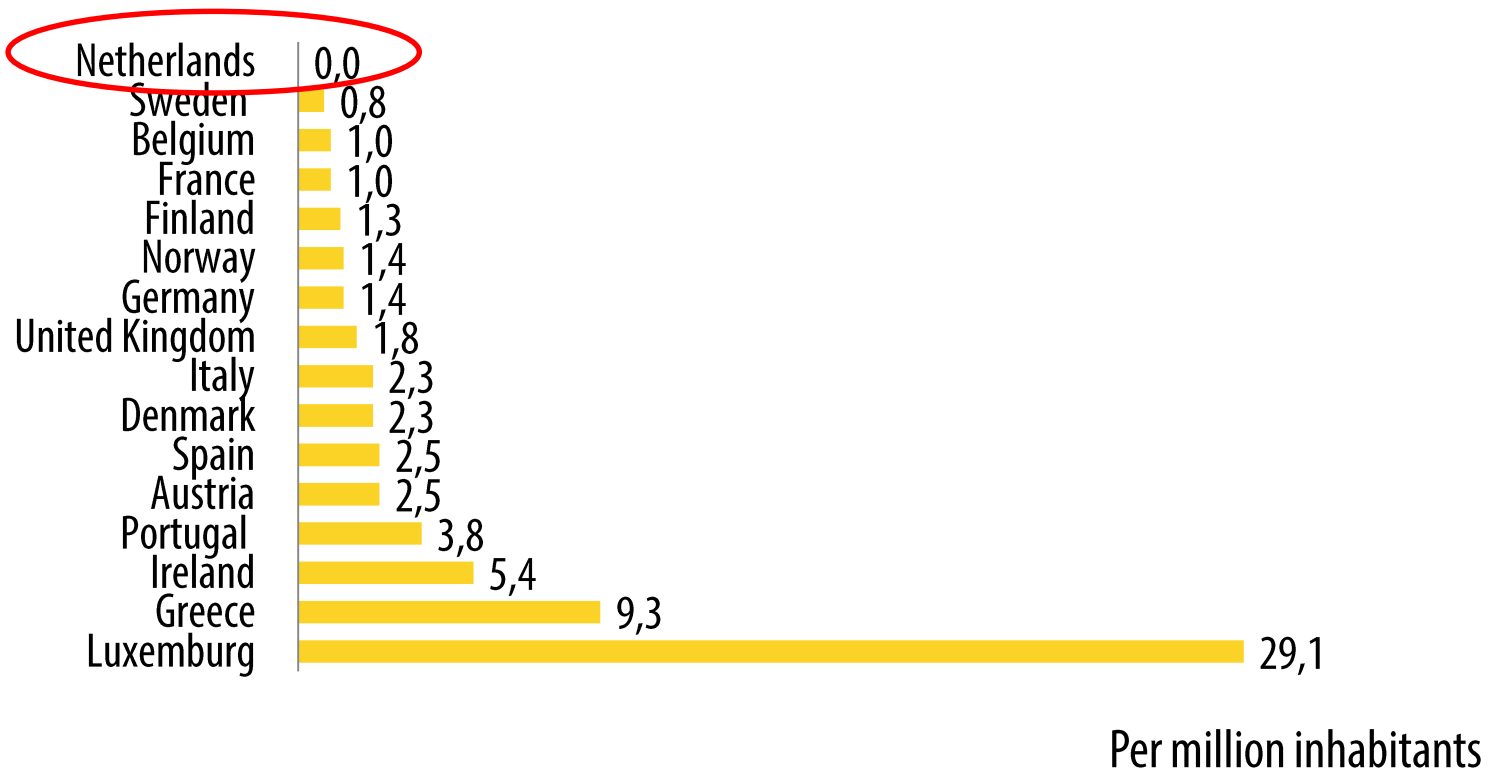
- **Estimated number of injecting drug users:** <1000 (2015)
- Decreasing trend in injecting drug use
- **HIV:** low incidence and prevalence among injecting drug users
 - Virtually 0% of all registered new HIV infections annually are related to injecting drug use
 - Largest group of HIV+ patients: men having sex with men (MSM)
- **Hepatitis C (HCV)**
 - Estimation ever injected drug users infected with HCV: 1/3
 - Largest group of HCV+ patients: first generation migrants
 - Treatment with the highly effective new DAA-medication is available for ALL patients (with all stages of liver damage)





Number of newly diagnosed HIV cases

among injecting drug users per million inhabitants in the EU-15 and Norway, survey year 2014



Source: ECDC and WHO, 2015





9. Conclusions

Is Dutch drug policy effective?





Evaluation of drug policy in the Netherlands (2009)

To assess the implementation of drug policy plans since the last comprehensive drug policy strategy (1995)

- Public health targets overall reasonably well realised
- Less 'effective' in the area of supply reduction
- Hard and soft drugs markets mostly separated
- Role of coffee shops with regards to cannabis use prevalence is unclear
- Health situation drug users relatively positive, e.g.: mortality rate, infectious diseases, problematic hard-drug use, addiction care coverage, harm reduction measures





New challenges

- Relatively high prevalence of stimulant use (linked to nightlife settings)
 - Changing markets: emergence of New Psychoactive Substances; high potency drugs (cannabis, ecstasy)
 - Low, but possibly increasing number of drug-related deaths
-
- Monitoring is important for responding to new drug problems
 - So does evaluation of national drug strategies



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