NATIONAL DRUG POLICY: THE NETHERLANDS

PREPARED FOR THE SPECIAL COMMITTEE OF THE SENATE ON ILLEGAL DRUGS

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TABLE OF CONTENTS

CANADA

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NATIONAL DRUG POLICY: THE NETHERLANDS

INTRODUCTION

Dutch drug policy is often misunderstood and misrepresented. Beginning in the 1970s, the Netherlands embarked on a pragmatic harm reduction approach to drugs that has resulted in a system in which priority is given to health care and prevention while, simultaneously, strong enforcement measures are directed against organized crime. This paper provides a brief historical overview of the development of Dutch drug policy, a summary of the current law, and a selection of related statistical data. A synopsis of reports from significant commissions of inquiry is also presented.

This paper is part of a series of country reports prepared by the Parliamentary Research Branch of the Library of Parliament for the Senate Special Committee on Illegal Drugs.

DUTCH DRUG POLICY AND LAWS

A. Historical(1)

The Netherlands' experience with drugs in the 19th century was in some ways unique. Although it was certainly not a drug-free nation, it differed from the United States and other Western European nations in that it did not have the problem of addicted soldiers and there

(1) Sources: Marcel de Kort, "A Short History of Drugs in the Netherlands," in Leuw and Marshall (eds.), *Between Prohibition and Legalization: The Dutch Experiment in Drug Policy*, Amsterdam: Kugler Publications, 1994, pp. 3-22; David F. Duncan, "Dutch Drug Policy: A Model for America?" (1997) 8(3) *Journal of Health & Social Policy* 1, available online at http://bubl.ac.uk/journals/soc/jhasp/v08n0397.htm#1dutch; Dana Graham, "Decriminalization of Marijuana: An Analysis of the Laws in the United States and the Netherlands and Suggestions for Reform" (2001) 23 *Loy. L.A. Int'l & Comp. L. Rev.* 297; *Drugs Policy in the Netherlands: Continuity and Change* (1995), Official Dutch government policy document, available online at http://www.drugtext.org/reports/wvc/drugnota/0/Default.htm; Robert J. MacCoun, "Does Europe Do It Better?: Lessons from Holland, Britain and Switzerland" (1999) 269(8) *Nation* 28.

was little scientific research or public concern regarding addiction. Two key factors shaped the evolution of the Dutch policy on drugs during this period: the development of the modern medical profession, and the immense profitability of Dutch colonial drug operations.

During the last decades of the 19th century, conflict between "primitive-traditional" healing and "rational-scientific" medicine led physicians to see the unrestrained sale and use of opiates and cocaine as a threat to their profession. In essence, the professionalization of the medical occupations resulted in attempts by physicians and pharmacists to monopolize the administration and supply of drugs in the country. As for drug use in Dutch colonies, both opium and cocaine made substantial contributions to the state treasury. By the early 20th century, the Netherlands was the world's largest cocaine producer; huge profits were made first from opium leases – the practice by which the government leased the right to sell opium to local colonial populations – and then later via state monopoly on the sale of opium.

In 1909, on the initiative of the United States, a conference on opium was convened in Shanghai. The U.S. delegation had hoped for official measures restricting opium sales and use; however, the Dutch – along with Great Britain – resisted and a set of recommendations was all that resulted from the meeting. The U.S. crusade continued, however, and another opium conference took place in The Hague in 1911, resulting in the Hague Opium Convention of 1912. Article 9 of the Convention required state parties to enact legislation restricting the production and sale of drugs to medicinal purposes only. Ratification in the Netherlands took some time and it was not until the *Opium Act* was enacted in 1919 that Article 9 was given effect. This Act remains the legislative basis for Dutch drug policy today.

Prior to the Second World War when it began to lose its colonies, the Netherlands' drug enforcement measures were, some suggest, less than genuine. Internationally, the Dutch had economic interests to protect; a government monopoly on opium in the Dutch Indies proved very lucrative until the Japanese army invaded in 1942. Internally, while the *Opium Act* was selectively enforced, for the most part it was simply not considered a law enforcement priority. Some authors, such as de Kort, suggest that unlike the United States, Holland did not have identifiable recreational user groups that were considered problematic. In the United States, three user groups – Chinese, Blacks and Mexicans – were identified with, respectively, opium, cocaine and marijuana; these groups provided crusading law enforcement officials with useful targets. Although Holland had a Chinese community, it was fairly small and

isolated; however, it should be noted that when prosecutions did take place in the Netherlands, they were mainly directed at Chinese opium smokers.

Following WWII, marijuana use became detectable in the Netherlands and a 1953 amendment to the *Opium Act* added cannabis to the list of illegal substances. Prosecution for marijuana offences began, but experts and official agencies soon started to call for a reconsideration of prosecution policies. The excessive use of force by Amsterdam police in response to student riots in 1966 made law enforcement highly sensitive to public opinion and led to more relaxed attitudes towards social issues such as the peace movement and drug use. Policies de-emphasizing marijuana possession arrests resulted.

The changing views of law enforcement with respect to some drugs coincided with a new drug problem in the early 1970s: a violently competitive heroin market. The Dutch government established a Working Party on Drugs which came to be known as the Baan Commission. Its recommendations largely determined the course of the Netherlands' drug policy and resulted in an overhaul of the *Opium Act* in 1976.

B. Goals and Objectives

The core features of the Dutch system were established by the Baan Commission and are rooted in the concept of harm reduction, i.e., the minimization of the risks and hazards of drug use rather than the suppression of all drugs. Using this pragmatic approach, the government sets clear priorities based on the perceived risks of particular drugs; public health is the main concern. The key elements as established in the 1976 parliamentary debate are summarized by Grapendaal *et al.* as:[2]

- the central aim is the prevention or alleviation of social and individual risks caused by drug use;
- there must be a rational relation between those risks and policy measures;
- a differentiation of policy measures must also take into account the risks of legal recreational and medical drugs;

(2) M. Grapendaal, Ed Leuw and H. Nelen, *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam*, New York: S.U.N.Y. Press, 1995, as referred to in Tim Boekhout van Solinge, "Dutch Drug Policy in a European Context" (1999) 29(3) *Journal of Drug Issues* 511, available online at: www.cedro-uva.org/lib/boekhout.dutch.html.

- repressive measures against drug trafficking (other than trafficking of cannabis) is a priority; and
- the inadequacy of criminal law with respect to other aspects (i.e., apart from trafficking) of the drug problem is recognized.

The literature also makes reference to the policy of "normalization." Social control is achieved through depolarization and integration of deviant behaviour rather than isolation and removal, as is typical of the deterrence model. This paradigm also suggests that drug problems should be seen as normal social problems rather than unusual concerns requiring extraordinary treatment.

Another key aspect is the notion of market separation. By classifying drugs according to the risks posed and then pursuing policies that serve to isolate each market, it is felt that users of soft drugs are less likely to come into contact with users of hard drugs. Thus, the theory goes, users of soft drugs are less likely to try hard drugs.

In essence, Dutch drug policy – with respect to the *supply side* of the drug market – in many ways reflects the international repressive norm. On the *demand side* of the equation, however, a unique approach is evident; the Dutch policy approach recognizes that drug use may often just be a youthful dalliance but emphasizes compassion and treatment for those who develop drug use problems.

C. Current Legislation and Enforcement

As noted, the *Opium Act* – also referred to as the *Narcotics Act* – is the Netherlands' main drug legislation. The Act criminalizes possession, cultivation, trafficking and importing or exporting. The 1976 Amendments established two classes of drugs: Schedule I drugs are deemed to present an unacceptable risk to Dutch society and include heroin, cocaine, amphetamines and LSD; Schedule II drugs include "traditional hemp products" such as marijuana and hashish. Further amendments were made following a major government drug policy study in 1995, and a summary of the current state of the law follows.

1. Overview of Penalties

The possession of all scheduled drugs is an offence, but possession of a small quantity of "soft" drugs for personal use is a minor offence. Generally, it is tolerated by law

enforcement, particularly within the regulated coffee shop system, discussed in the following section. Importing and exporting are the most serious offences under the Act. The maximum penalty for importing or exporting hard drugs is 12 years' imprisonment and a fine of Dfl. 100,000 (guilders).[3] Anyone found in possession of a quantity of hard drugs for personal use is liable to a penalty of one year's imprisonment and a fine of 10,000 guilders. The maximum penalty for importing or exporting soft drugs is four years' imprisonment and a fine of 100,000 guilders. Habitual offenders are liable to a maximum penalty of 16 years' imprisonment and a fine of 1,000,000 guilders. Moreover, offenders may be deprived of any money or property gained from their offence.

The Netherlands also has guidelines for sanctions that the Public Prosecutor is directed to seek, based on: the type of drug involved, the amount of the drug, and the specific offence. The following tables set out the current (1996) guidelines.[4]

SCHEDULE I SUBSTANCES ("HARD DRUGS")		
Offence	Amount	Sanction to be Sought[5]
Possession	< 0.5 g or < 1 user unit	Police Dismissal
	0.5-5 g or 1-10 user units	1 week - 2 months
Possession with Dealer Indication (i.e., intent to sell)	<15 g or <30 user units	Up to 6 months
	15-300 g or 30-600 user units	6-18 months
	> 300 g or > 600 user units	18 months - 4 years
Street or Home Dealing	< 1 g	Up to 6 months
	1-3 g	6-18 months
	>3 g	18 months - 4 years
Middle-level Dealing	<1 kg	1-2 years
	> 1 kg	2+ years
Wholesale Trade	> 5 kg	6-8 years
Import and Export	< 1 kg	Up to 3 years
	> 1 kg	3-12 years

(3) 100,000 Dutch gilders = approximately Cdn.$63,000

(4) Source: Staatscourant (1996) as reproduced in Dirk J. Korf and Heleen Riper, "Windmills in their Minds? Drug Policy and Drug Research in the Netherlands" (1999) 29(3) *Journal of Drug Issues* 451, at Table 2.

(5) In addition to imprisonment, fines and property seizure may also result (except for possession).

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought[6]
Possession, Preparing, Processing, Sale, Delivery, Supply, Transporting or Manufacturing	Up to 5 g	Police Dismissal
	5-30 g	Fine of Dfl. 50-150
	30 g-1 kg	Fine of Dfl. 5-10 per g
	1-5 kg[7]	Fine of Dfl. 5,000-10,000 and 2 weeks per kg
	5-25 kg	Max. fine of Dfl. 25,000 and 3-6 months
	25-100 kg	Max. fine of Dfl. 25,000 and 6-12 months
	> 100 kg	Max. fine of Dfl. 25,000 and 1-2 years
Cultivation	Up to 5 plants	Police Dismissal
	5-10 plants	Dfl. 50 per plant (repeat offenders: Dfl. 75 per plant)
	10-100 plants	Dfl. 25 per plant and/or ½ day per plant
	100-1,000 plants	Max. fine Dfl. 25,000 and 2-6 months
	>1,000 plants	Max. fine Dfl. 25,000 and 6 months - 2 years
Import & Export	The Act does not distinguish between quantities, but in practice the prosecutor's sentence recommendation will correspond to the quantity divisions for possession.	Sanctions for possession may be doubled to a maximum of 4 years and a maximum fine of Dfl. 100,000

(6) In the case of recidivism within five years, the sanction requested is increased by one-fourth. For sales to "vulnerable groups" (i.e., minors, psychiatric patients), there is also a minimum fine of approximately Cdn.$475.

(7) Amounts over 1 kg are regarded as dealing.

2. Cannabis

Possession of small amounts of cannabis for personal use has been decriminalized in Holland. The sale of cannabis is technically an offence under the *Opium Act*, but prosecutorial guidelines provide that proceedings will only be instituted in certain situations. An operator or owner of a coffee shop (which is not permitted to sell alcohol) will avoid prosecution if he/she meets the following criteria:

- no more than 5 grams per person may be sold in any one transaction;
- no hard drugs may be sold;
- drugs may not be advertised;
- the coffee shop must not cause any nuisance;
- no drugs can be sold to minors (under age 18), nor may minors enter the premises; and
- the municipality has not ordered the establishment closed.

It is common for municipalities to have a coffee shop policy to prevent or combat the nuisance sometimes associated with these establishments. For example, suspicion of selling hard drugs or locating a coffee shop near a school or in a residential district may result in closure. In April 1999, the "Damocles Bill" amended the *Narcotics Act* by expanding municipal powers regarding coffee shops and permitting local mayors to close such places if they contravene local coffee shop rules, even if no nuisance is being caused. As a result of strict enforcement and various administrative and judicial measures, the number of coffee shops decreased from nearly 1,200 in 1995 to 846 in November 1999.(8)

3. Schedule I Drugs – Heroin, Cocaine and Amphetamines

The risks associated with these drugs have been deemed unacceptable. Heroin can result in dependency relatively quickly and thus its use is more often associated with serious problems such as visible degeneration, poor health and criminality. Significantly, people who lose control over their opiate use often turn to other hard drugs, particularly cocaine and amphetamines.(9)

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(8) Source: National Drug Monitor, "Fact Sheet: Cannabis Policy, Update 2000," Trimbos Institute, 2000.

(9) National Drug Monitor, "2000 Annual Report," Bureau NDM, Utrecht, the Netherlands, May 2001, at part 4.

One of the key elements of assisting Dutch addicts is the free supply of methadone, but as noted in the government's 1995 policy report,(10) this practice has had limited effect, possibly due in part to the fact that methadone lacks the euphoric "flash" of heroin. In 1998, a number of Dutch cities started experimenting with prescribing heroin, in combination with methadone, on medical grounds. Approximately 750 addicts are involved in the comparison of treatment with methadone and treatment with methadone and heroin. The experiment is still ongoing and preliminary results have yet to be published.

To prevent HIV/AIDS and hepatitis B and C, syringe exchange programs were developed in the 1980s; today, 130 programs are operating in 60 Dutch cities and towns.

4. Ecstasy ("XTC" or MDMA)

Ecstasy is the most widely consumed synthetic drug in the Netherlands and is associated with the "clubbing circuit." According to the Trimbos Institute (an independent mental health organization that is partially financed by the Ministry of Health, Welfare and Sports), the drug is not highly addictive, but does present short-term side effects, such as raised blood pressure, heart palpitations, dry mouth and anxiety or excitement, as well as long-term risks such as damage to nerve cells in the brain that relate to functions such as sleep, appetite, memory, depression and aggression regulation.(11) As with other drugs, Dutch policy focuses on a combination of demand reduction and harm reduction, i.e., preventing use by educational campaigns and preventing problems caused by its use through health measures.

Ecstasy was placed in Schedule I of the *Opium Act* by Ministerial decree in 1988 and thus is among the drugs that are given highest priority in terms of investigation and prosecution. In 1997, the Synthetic Drugs Unit was established in response to growing concerns about the drug with the goals of improving national coordination, providing information, initiating policy, and supporting local prosecutions.

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(10) See the "Key Reports and Studies" section of this paper.

(11) Trimbos Institute, "Hard Drug Policy: XTC Update 1999," published by the National Drug Monitor, The Netherlands, 1999. Although the Institute is technically not a government agency, government websites (such as that of the Ministry of Justice) refer to the Trimbos Institute's fact sheets on drug policy as authoritative documents.

D. Why is the Dutch System Different?

It must first be noted that Dutch drug legislation is not unique. Many other nations have laws that look very much like the *Opium Act*, and the Netherlands policy with respect to supply reduction is fundamentally the same as other western countries. What sets Holland apart is its enforcement policy.(12) The official Guidelines for the Investigation and Prosecution of Drug Offences are based on the principle of expediency, i.e., authorities can refrain from prosecution without first seeking permission from the courts. Rather than approaching the issue on a case-by-case basis, there is a systematic application of the expediency principle; as well, whole sections of the penal law are deemed not to warrant judicial proceedings.

In a government publication, the nature of Dutch society is suggested as a rationale for its approach:

> In order to appreciate the Dutch approach to the drugs problem, certain characteristics of Dutch society must be kept in mind. The Netherlands is one of the most densely populated, urbanized countries in the world. It has a population of 15.5 million, occupying an area of no more than 41,526 km2. The Netherlands has a long history as a country of transit: Rotterdam is the largest seaport in the world, while the country has a highly developed transport sector. The Dutch firmly believe in the freedom of the individual, with the government playing no more than a background role in religious or moral issues. A cherished feature of Dutch society is the free and open discussion of such issues. A high value is attached to the well-being of society as a whole, as witness the extensive social security system and the fact that everyone has access to health care and education.(13)

Others point to the fact that the Dutch do not have a tradition of responding to social problems with the criminal law.(14) In any event, the experience of the Netherlands is a markedly relevant example to the world in that it represents a compromise position between the

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(12) Korf and Riper, *supra*, note 4.

(13) "Drug Policy in the Netherlands," Government of the Netherlands, available online at: http://www.netherlands-embassy.org/c_hltdru.html.

(14) T. Boekhout van Solinge, "La Politique de Drogue aux Pays-Bas: Un Essai de Changement" (1998) 22 *Déviance et Societé* 69, at 71.

drug war "hawks" and the legalization "doves."[15] That it is the result of culturally specific factors and not relevant to other nations is unlikely. On the contrary, it would appear to be the rational outcome of political problem-solving, which cannot be said to be an exclusively Dutch trait.

E. The Netherlands and International Commitments

Like Canada, the Netherlands is a signatory to the United Nations drug conventions.[16] As well, it has drug control commitments associated with the Treaty of the European Union[17] and the Schengen Agreement relating to border controls. In the opinion of the Dutch government, the obligations arising from these accords preclude outright legalization of cannabis or indeed any other drug referred to in the treaties.[18]

By maintaining laws criminalizing the drugs enumerated in the international agreements, the Netherlands complies with the letter of international law. Its discretionary prosecution policy is not specifically prohibited by the treaties. When faced with external criticism about compliance with its international commitments, the government states that its role is to rectify the inadequate understanding of what is occurring in Holland.[19]

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(15) CD Kaplan *et al*., "Is Dutch Drug Policy an Example to the World?" in Leuw and Marshall (eds.), *supra*, note 1.

(16) Specifically, the Netherlands has ratified or acceded to: The Single Convention on Narcotic Drugs, 1961, as amended by the Protocol of 1972; The Convention on Psychotropic Substances, 1971; and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. Note that Holland has expressed a reservation with regard to the Trafficking Convention indicating that it accepts the provisions of paragraphs 6-8 of Article 3, which relate to prosecutions for possessing or trafficking drugs, only insofar as the obligations under these provisions are in accordance with Dutch policy on criminal matters.

(17) The Maastricht Treaty provides that EU states will cooperate in the fields of justice and home affairs, and Article K.1 states that preventing and combating drug trafficking is an area of common interest as is combating drug addiction.

(18) In Annex III of the 1995 government report entitled *Drugs Policy in the Netherlands: Continuity and Change*, *supra*, note 1, Professor Schutte of the Legal Service at the Council of the European Union examines the ramifications in international law of Holland legalizing cannabis and determines: (1) the 1961 Single Convention and the 1988 Trafficking Convention would have to be denounced; (2) legalization would conflict with the provisions of the Schengen Agreement and because the 1990 Convention implementing this Agreement cannot be denounced, it would have to be amended which would require the assent of all the EU Member States.

(19) *Drugs Policy in the Netherlands: Continuity and Change*, *supra*, note 1, at part 1.3.

KEY REPORTS AND STUDIES

A. The Hulsman Commission – 1968-1971

In 1968, the National Federation of Mental Health Organizations[20] established a commission with a broad mandate to "clarify factors associated with the use of drugs" and "to suggest proposals for a rational policy."[21] Chaired by criminal law professor Louk Hulsman, the Commission had a diverse membership including law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist.

The commission's final report, presented in 1971, provided an analysis of drug use and the social mechanisms behind drug problems. New approaches were suggested, including:

- The use of cannabis and the possession of small quantities should be taken out of the criminal law immediately. For the time being, production and distribution should remain within criminal law, but as misdemeanors.
- The use and possession of other drugs should temporarily remain in the realm of criminal law, as misdemeanors, but in the long run all should be decriminalized.
- People who have problems with their drug use should have adequate treatment facilities at their disposal.

In recommending the gradual decriminalization of all drugs, the report noted that illicit drugs can be used in a controlled and limited way and that marginalizing drug-using subcultures has significant negative repercussions. Specifically, becoming a member of the "drug scene" may familiarize a cannabis user with other drugs and patterns of use. Although the commission found no evidence of a "stepping stone" sequence of drug use – what in other contexts has been referred to as "gateways" – it accepted the notion that one kind of drug user

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(20) In the Netherlands, Mental Health used to involve a mix of public and private bodies organized along the lines of religious and political denominations. The National Federation of Mental Health Organizations was an umbrella organization.

(21) Louk Hulsman, "Ruimte in het drugbeleid," Boom Meppel, 1971, at page 5, as quoted in Peter Cohen, "The case of the two Dutch drug policy commissions: An exercise in harm reduction 1968-1976" (1994, revised 1996), Paper presented at the 5th International Conference on the Reduction of Drug Related Harm, 7-11 March 1994, Addiction Research Foundation, Toronto, available online at: www.cedro-uva.org/lib/cohen.case.html.

(e.g., heroin user) will contaminate another kind of drug user (e.g., cannabis user) when the two kinds of drug use are forced into one marginalized subculture.

With respect to the issue of law enforcement, the commission concluded that once started, drug policing would have to be constantly enlarged to keep pace with the never-ending escalation of drug use. It referred to the criminal law option of opposing drug use as inadequate and "extremely dangerous," stating on page 51 of its report:

> Time after time it will show that the means will fall short, upon which those who favour punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation…This will boost polarization between the different parts of our society and can result in increased violence.(22)

B. The Baan Commission – 1968-1972

A State Commission was also established in 1968 by the Under Secretary of Health. This commission contained some members of the Hulsman Commission, as well as officials from the Ministry of Justice, the Amsterdam Chief of Police, and additional psychiatrists and sociologists. In 1970, Pieter Baan, the Chief Inspector of Mental Health, assumed the chairmanship of the commission and a final report was presented in 1972.

The report suggested dividing drugs into those with acceptable and those with unacceptable risks. Further research would be needed to create a greater consensus among the experts as to how some individual drugs should be classified, but the report described cannabis products as relatively benign with limited health risks. However, even for those drugs that pose unacceptable risks, the report concluded that use of the criminal law is not an adequate approach. The commission suggested the long-term goal of complete decriminalization once a good treatment system has been created. In the interim, the justice system should just be used as a tool for manoeuvring heavy users into treatment.

Other notable findings include:

- The special characteristics of youth culture are important determinants of drug use and if so-called deviant behaviour is stigmatized by punitive measures, the probability of intensification of this behaviour is a serious danger. This will initiate a spiral that will make the return of the individual to a socially accepted lifestyle increasingly difficult.

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(22) As quoted in Peter Cohen, "The case of the two Dutch drug policy commissions," *supra*, note 21, at 3.

- Much drug use is short-lasting experimentation by young people.
- Cannabis use does not lead to other drug use, but as noted in the Hulsman report, the criminalization of cannabis promotes contact between cannabis users and the users of "harder" drugs.
- Drug users are better served by drug information and prevention efforts than by prosecution.
- The sometimes unusual behaviour of cannabis-consuming youth is more a result of specific subculture norms and ideologies rather than pharmacology.
- Cannabis use when driving or operating machines in factories is not responsible, and the consumption of cannabis without risks to the individual or society can only take place during recreation.

C. "Continuity and Change" Report – 1995[23]

In 1995, the Dutch government published a report entitled *Drugs Policy in the Netherlands: Continuity and Change*. This policy document was sponsored by: the Minister of Justice; the Minister of Health, Welfare and Sport; and the Secretary of State for the Interior.

The report begins by noting that the Netherlands has always attempted a pragmatic approach to drug use. In tackling markets in illegal products throughout the world, government intervention has historically proven to have a limited effect. Thus, the modest objective in Holland is to keep the use of dangerous drugs, as a health and social problem, under control. The 1972 state commission's recommendations still form the basis of this drugs policy in which the government's role is seen as preventing people – particularly young people – from starting to use drugs without knowing enough about them, while providing treatment for those who develop drug problems. As discussed in previous sections, this harm reduction approach has led the Dutch government to distinguish between "hard drugs," i.e., those that pose an unacceptable risk to health, and "soft drugs" such as cannabis products, which although still considered "risky" do not present similar concerns. The underlying assumption made in the Netherlands with respect to cannabis is that people are more likely to make a transition from soft to hard drugs as a result of social factors, not physiological ones. Separating the markets by allowing people to purchase soft drugs in a setting where they are not exposed to the criminal subculture surrounding hard drugs is intended to create a social barrier that prevents people experimenting with more dangerous drugs.

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(23) The report is available online at: www.drugtext.org/reports/wvc/drugnota/0/drugall.htm. A summary of the principal policy intentions from the report are reproduced in the Appendix of this paper.

The report goes on to review the effects of the Dutch drug policy, the treatment of addiction in the Netherlands, and enforcement under the *Opium Act*. Key conclusions and findings include:

- Decriminalization of the possession of soft drugs for personal use and the toleration of sales in controlled circumstances has not resulted in a worryingly high level of consumption among young people. The extent and nature of the use of soft drugs does not differ from the pattern in other Western countries. As for hard drugs, the report states that the number of addicts in the Netherlands is low compared with the rest of Europe and considerably lower than that in France, the United Kingdom, Italy, Spain and Switzerland.
- The number of heroin users under the age of 21 has continued to fall in the Netherlands. The report speculates that is partly attributable to the "loser" image that has come to be attached to addicts. The presence of older addicts in a serious state of degeneration is compelling propaganda against heroin use, and the lack of repressive action by police against addicts prevents the lifestyle from being viewed as socially or culturally rebellious.
- The use of cheaper forms of cocaine (i.e., crack) has not made significant inroads in Holland as had been feared as a result of developments in the United States.
- The tone of public debate in Holland is different than in other countries because drug use is no longer seen as an acute health threat but rather as a source of nuisance. Policies focusing on addiction and care have resulted in less HIV infection; in fact, levels continue to fall. As well, the mortality rate among addicts is low and is not increasing, as it is in other European countries.
- With respect to the legalization debate, the report concludes that with a state monopoly or licensing system, the disadvantages would outweigh the practical advantages. Although the role of criminal organizations would be reduced, such a system would impose a considerable burden in implementation and monitoring, and would probably attract even more "drug tourists" and the nuisance they sometimes cause. Furthermore, the report suggests that this is not something that could be done by the Netherlands in isolation. The international conventions preclude outright legalization and would have to be renegotiated or denounced. As well, even if just soft drugs were legal in Holland but not in the rest of Europe, the Dutch criminal organizations that export drugs would continue to exist and would still require significant law enforcement activity.
- Foreign concerns about the Dutch coffee shop policy have centred not on the use of cannabis in the establishments, but on drug tourists who take cannabis back to their home countries, something that has been particularly easy since the abolition of border controls under the

Schengen Agreement. The report confirms the government's plan to reduce the purchase limit to 5 grams from 30 grams to see what impact this will have on illegal exports.(24)

- Given the lack of sufficient scientific data, the report endorses the 1995 recommendation of the Dutch Health Council that a medical trial into the effectiveness of prescribing heroin to addicts be undertaken.(25)

The report also notes three negative implications that need to be addressed: the nuisance caused by hard and soft drug users; the increasing presence of organized crime in the Netherlands; and the effect of Dutch policy on other countries.

- The criminal and general nuisance caused by Dutch and foreign hard drug users may have the effect of undermining public support for the policy of social integration of addicts. A small proportion of hard drug users commit a large number of property offences in order to buy their drugs. Contrary to expectations, the fact that methadone is easily obtained has scarcely improved the situation. Drug-related crime and anti-social behaviour, such as discarding used needles in public places, has affected the tolerance levels of residents in some socially disadvantaged neighbourhoods in the larger Dutch cities. Nuisance caused by the presence of coffee shops selling soft drugs has also been problematic in some municipalities.(26)
- Another complication has been the rise of criminal organizations involved in the supply and sale of drugs in Holland which has necessitated increased criminal law measures. The prosecution of drug traffickers will continue to be a top priority for the Dutch police and judicial authorities.
- Although the "ideological nature" of some foreign criticism suggests a lack of understanding of Dutch policy and is often based on purported health risks that are not supported in the scientific literature, there are problems in the Netherlands that have international implications. The Dutch, for example, are responsible for more than their proportional share of trafficking in soft drugs, and drug tourists routinely purchase soft drugs in Holland with

(24) As noted in the section of this paper on current legislation, this reduced limit is now in effect.

(25) As noted in the section of this paper on current legislation, trials began in 1998.

(26) This concern was addressed subsequent to the Report by the "Damocles Bill" of 1999, discussed herein, which provides greater powers to municipalities to shut down coffee shops that are a local nuisance.

the intent of transporting them back to their home country. The report suggests that combating these problems will involve continuing and reinforcing current law enforcement activities that prioritize trafficking. As noted, the issue of soft drug tourists taking home their coffee shop purchases is to be addressed by decreasing the amount permitted for sale.

SELECTED DATA

A. Trends and Patterns of Illegal Drug Use[27]

1. Cannabis Statistics

CANNABIS USE IN THE NETHERLANDS BY PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Has ever used	16%
Has used recently	2.5%
Has used for the first time in the past year	1%
Mean age of current users	28 years

(27) The source of these statistics, unless otherwise noted, is: National Drug Monitor, "2000 Annual Report," Utrecht, The Netherlands, May 2001. (Available online at http://www.trimbos.nl/ndm-uk/national_drug_monitor_2000.html.) The National Drug Monitor was established in 1999 by the Dutch Minister of Public Health, Welfare and Sports and has the support of the Dutch Parliament. It is a cooperative effort involving various monitoring institutes and has two functions: (1) acting as an umbrella group for addiction and substance abuse monitoring projects; and (2) reporting to Dutch government authorities and various international and national agencies on the results of such projects.

CANNABIS USE IN THE FOUR LARGE CITIES AND IN SMALLER TOWNS AMONG PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

	Ever use	Recent use
Amsterdam	37%	8%
Utrecht	27%	4%
The Hague	20%	4%
Rotterdam	19%	3%
Smaller towns[a)]	11%	2%

Percentage of users: Ever used in lifetime and in the last month.
[a)] Definition: Towns with less than 500 addresses per square kilometre.

CANNABIS USE BY PEOPLE AGED 16 AND ABOVE IN THREE URBAN AREAS. SURVEY YEAR 1999

	Ever use[a)]	Recent use[b)]
Utrecht	30%	7%
Rotterdam	19%	6%
Parkstad Limburg[c)]	13%	5%

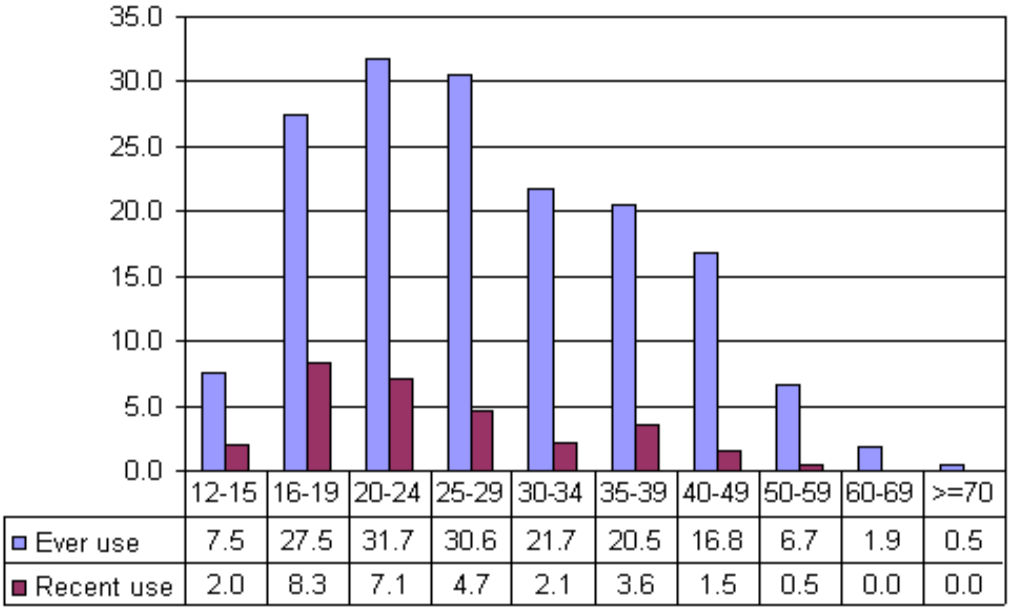
Percentage of users: [a)] 16 to 70 years, [b)] 16 to 55 years. Recent use: last month.

LEVEL OF CANNABIS CONSUMPTION IN THE NETHERLANDS BY RECENT USERS AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Days of use in the last month	*Percentage among recent users*[a)]
1-4	45%
5-8	14%
9-20	15%
More than 20 days	26%

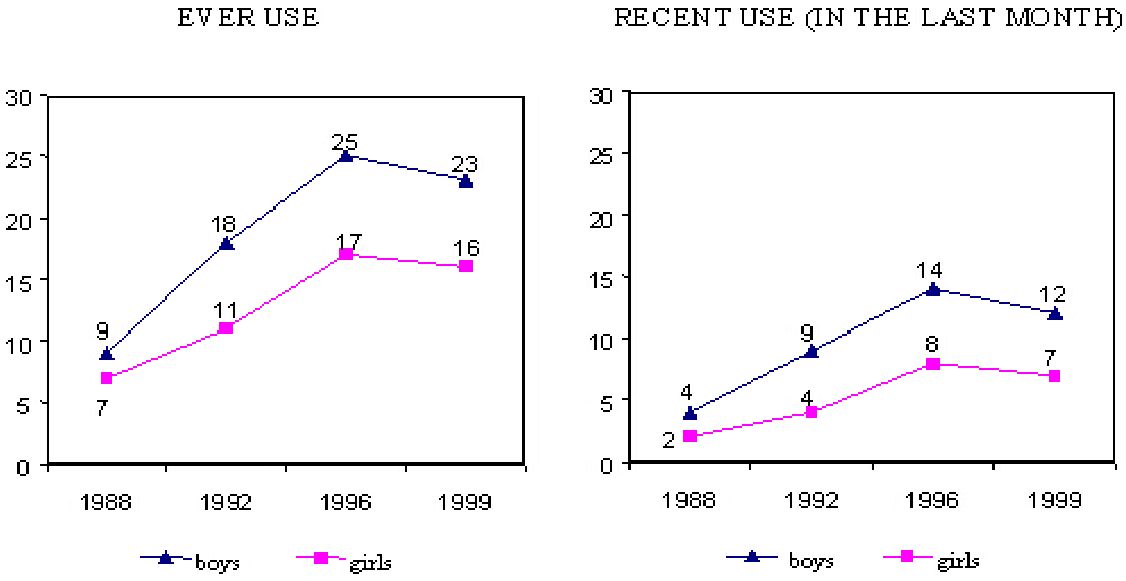
[a)] *Adds up to 100%*

CANNABIS USERS IN THE NETHERLANDS PER AGE GROUP. SURVEY YEAR 1997



	12-15	16-19	20-24	25-29	30-34	35-39	40-49	50-59	60-69	>=70
Ever use	7.5	27.5	31.7	30.6	21.7	20.5	16.8	6.7	1.9	0.5
Recent use	2.0	8.3	7.1	4.7	2.1	3.6	1.5	0.5	0.0	0.0

CANNABIS USE BY STUDENTS AGED 12 YEARS AND ABOVE, SINCE 1988



Percentage of 'ever users' in lifetime (left) and last month users (right).

WHERE DO YOUNG PEOPLE PROCURE THEIR CANNABIS?

	1996	1999
Obtain cannabis from friends	41%	47%
Purchase cannabis in coffee shops	41%	32%
Purchase cannabis from a dealer	11%	11%
Receive cannabis from others	5%	8%
Purchase cannabis at school	3%	1%
Grow it themselves[a)]	-	2%

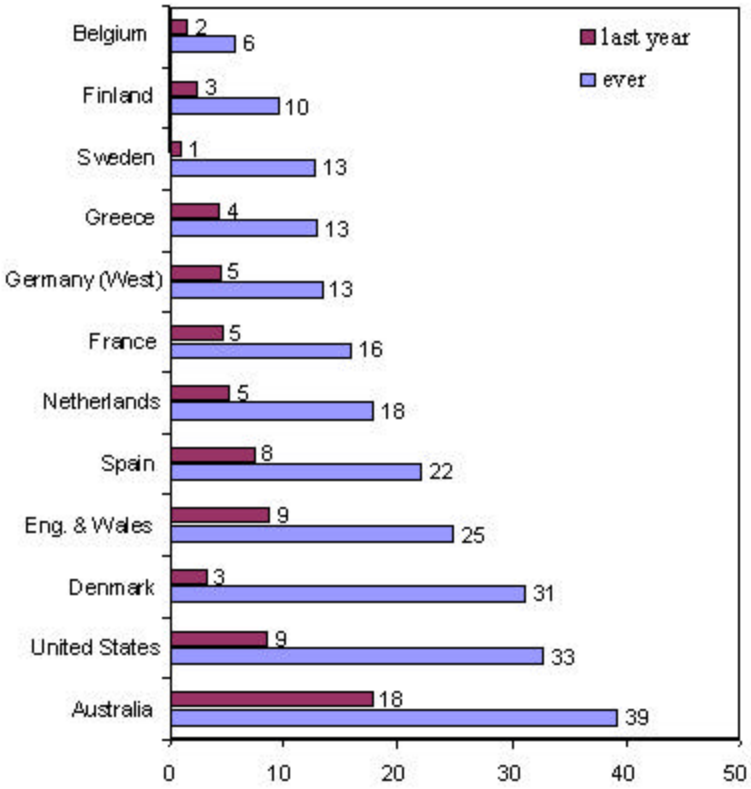
Pupils aged twelve and above in secondary schools (recent users)
[a)] Only measured in 1999

RECENT CANNABIS USE IN SPECIAL GROUPS

Young persons in	*Survey Year*	*Age*	*Recent use*
Special schools for secondary education	1997	12-18	14%
Truancy projects	1997	12-18	35%
Judicial institutions	1995	-	53%
Youth care institutions	1996	10-19	55%
Young drifters	1999	15-22	76%

Percentage of recent users per group.

CANNABIS CONSUMPTION IN WESTERN COUNTRIES IN THE GENERAL POPULATION. SURVEY YEARS 1994-1998



Percentage of users. Age limits range from 14-18 (lower limit) to 59-69 years (upper limit). Figures for the Netherlands: 15-69 years. No information was available for unlisted EU-Member States.

ADMISSIONS IN GENERAL HOSPITALS RELATED TO PROBLEMATIC CANNABIS USE, SINCE 1996

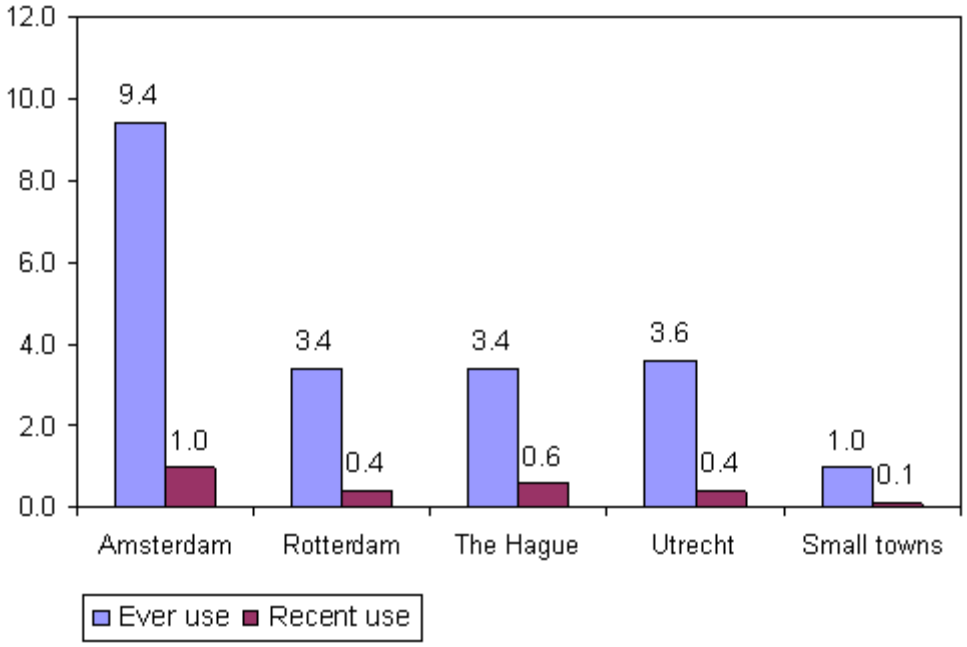
	1996	1997	1998	1999
Cannabis as primary diagnosis	38	26	29	29
Cannabis as secondary diagnosis	154	184	195	247

2. Cocaine

COCAINE USE IN THE NETHERLANDS AMONG PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

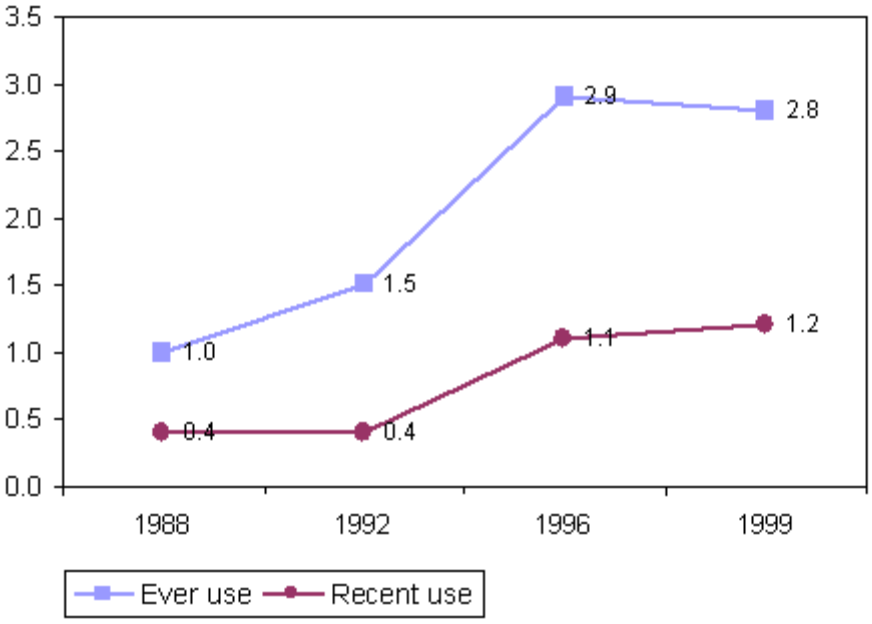
Has ever used	2.1%
Has used recently	0.2%
Has used for the first time in the past year	0.3%
Mean age of current users	29 years

COCAINE USE IN THE FOUR LARGE CITIES AND IN SMALLER TOWNS BY PERSONS AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997



Percentage of users: ever used (in lifetime) and recent use (last month).

USE OF COCAINE BY PUPILS AGED 12 YEARS AND ABOVE, SINCE 1988



Percentage of ever users (lifetime) and recent users (last month).

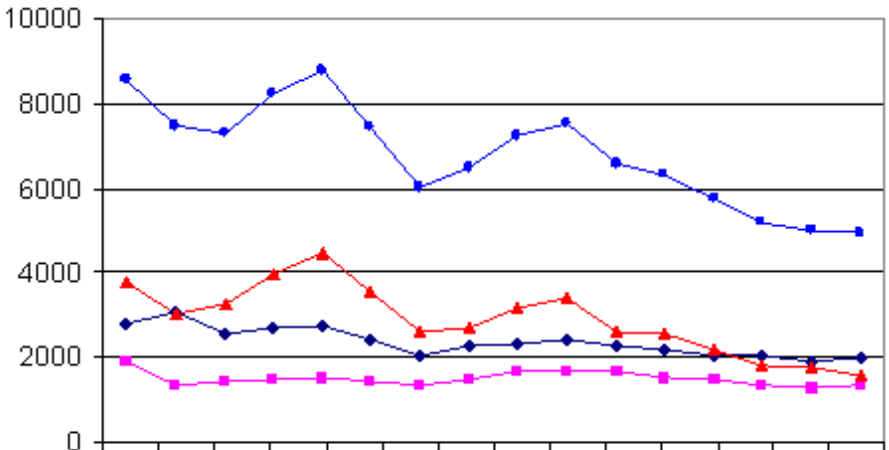
CONSUMPTION OF COCAINE IN WESTERN COUNTRIES IN THE GENERAL POPULATION

Country	*Survey year*	*Ever*	*Last year*
United States	1998	10.6%	1.7%
Australia	1998	4.3%	1.4%
Spain	1997	3.3%	1.6%
England and Wales	1998	3.0%	1.0%
The Netherlands	1997	2.4%	0.7%
Denmark	1994	2.0%	?
Germany (West)	1997	1.5%	0.7%
Greece	1998	1.3%	0.5%
France	1995	1.2%	0.2%
Sweden	1998	1.0%	?
Finland	1998	0.6%	?
Flemish Belgium	1994	0.5%	0.2%

Percentage of users. Age limits vary between 14-18 (lower limit) and 59-69 years (upper limit). Figures for the Netherlands: 15-69 years. No data was available for unlisted EU countries.

3. Heroin and the Opiates

PROBLEM OPIATE USERS IN AMSTERDAM, SINCE 1984



	1984	1985	1986	1987	1989	1990	1991	1992	1993	1994	1995	1997	1998	1999
Native Dutch	2790	3063	2552	2701	2440	2041	2276	2354	2435	2298	2204	2043	1921	2016
Immigrants	1935	1342	1445	1516	1436	1362	1485	1696	1674	1693	1554	1332	1314	1362
Foreigners	3806	3060	3293	3991	3560	2640	2713	3175	3411	2616	2559	1802	1783	1591
Total	8531	7465	7290	8208	7436	6043	6474	7225	7520	6607	6317	5177	5018	4969

METHOD OF USE OF HEROIN

Method of use	*Rotterdam*	*Utrecht*	*Parkstad Limburg*	*Parkstad Limburg*
	1998	1999	1996	1999
Always injects	15%	5%	33%	13%
Smokes and injects	16%	9%	33%	28%
Smokes	65%	86%	34%	58%

Percentage of problem users per method of use. The figures count per column rounded up to 100%.

INJECTING DRUG USERS: HIV-INFECTION AND BORROWING OF SYRINGES

Location	*Survey year*	*Infected with HIV*	*Borrow used syringes*[a)]
Amsterdam	1993 1996 1998	30% 26% 26%	18% 18% 12%
Rotterdam	1994 1997	12% 9%	18% 10%
South-Limburg[b)]	1994 1996	10% 12%	19% 17%
Utrecht	1996	5%	17%
Arnhem	1991-1992 1995 1997	2% 2% 1%	42% 39% 15%
Groningen	1997-1998	1%	11%
Brabant[c)]	1999	5%	17%

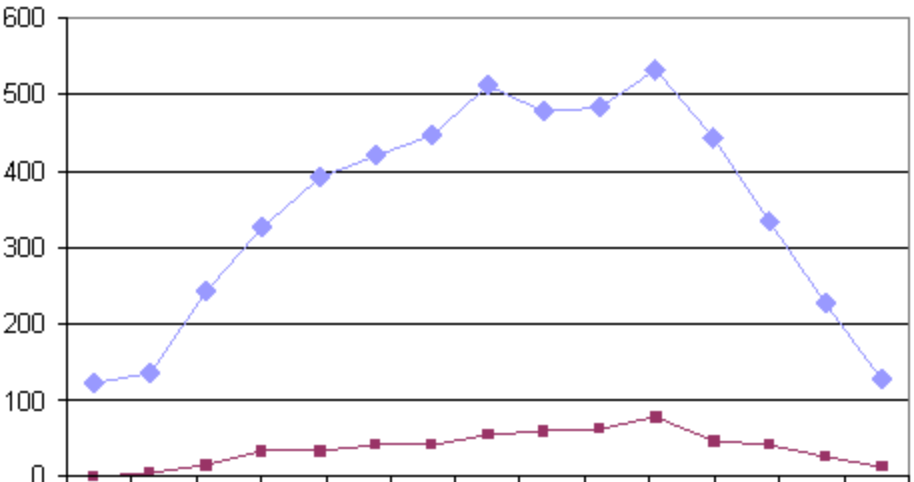
Percentage of users infected with HIV compared with the percentage of HIV-infected people, borrowing syringes. An injector is defined as a person who has injected a drug once or more in his/her life.

[a)] *Once or more often in the past month.*

[b)] *Measurement 1996: Heerlen 16% and Maastricht 3%.*

[c)] *Eindhoven, Helmond, Den Bosch.*

TOTAL NUMBER OF NEW REPORTED AIDS CASES AND NUMBERS RELATED TO INJECTING DRUG USE, SINCE 1985



	1985	1986	1987	1988	1990	1991	1992	1993	1994	1995	1997	1998	1999
Total	122	136	243	325	419	446	511	477	482	533	335	228	128
IDUs	1	6	16	34	41	43	56	59	62	77	43	25	13

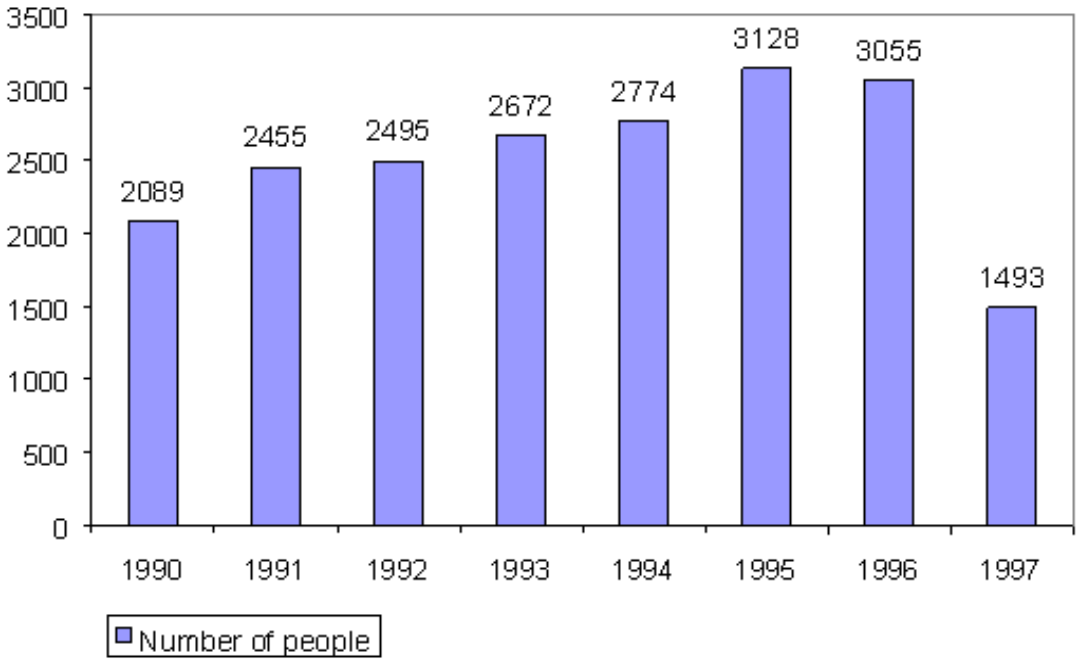
IDU = intravenous drug user

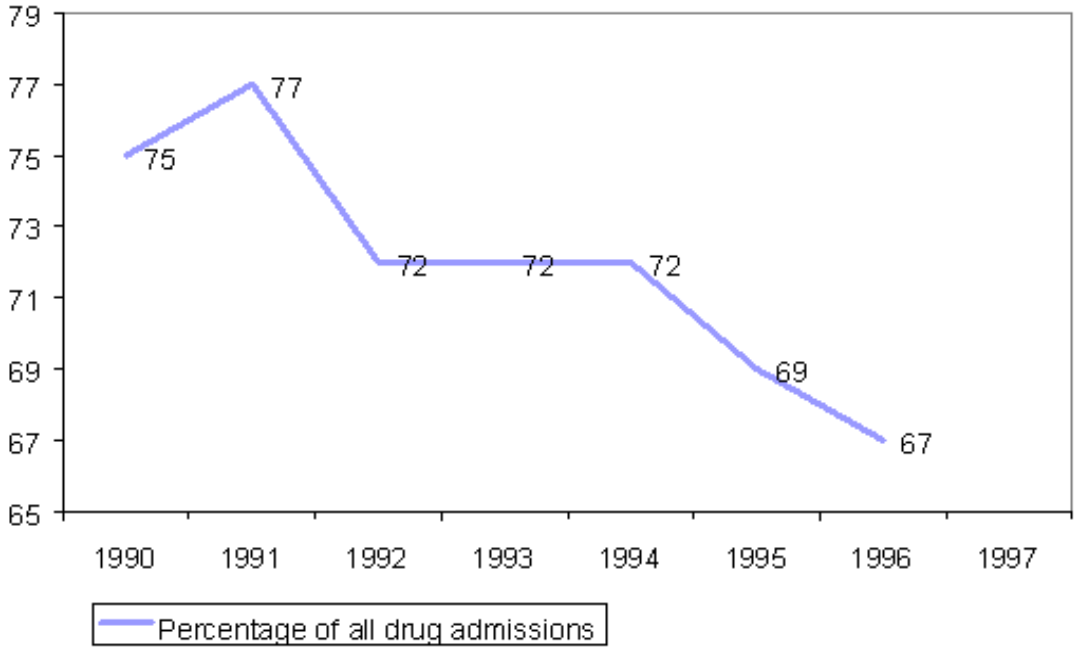
PROBLEM HARD DRUG USERS IN THE EUROPEAN UNION AND IN NORWAY

Country	*Number per thousand inhabitants*
Luxembourg	7.2
Italy	6.4
United Kingdom	5.6
Spain	4.9
France	3.9
Norway	3.9
Ireland	3.8
Denmark	3.5
Austria	3.2
Belgium	3.0
Sweden	3.0
Netherlands	2.5
Finland	2.4
Germany	2.2

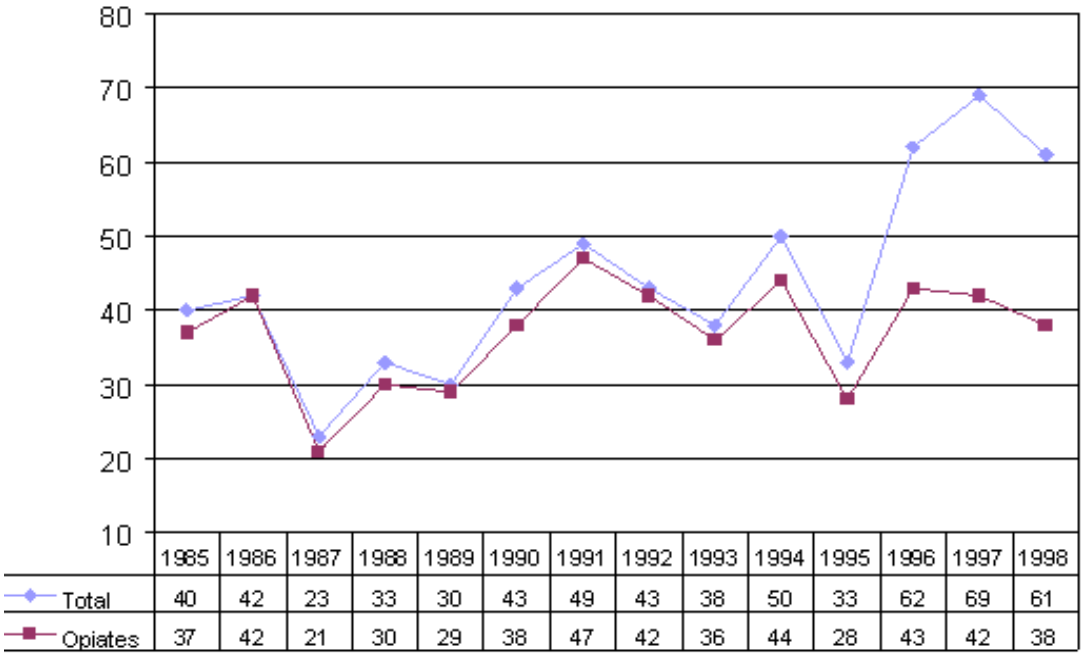
Age limits: 15-64 years. Survey years: 1996–1998. Exceptions: Austria (1995) and Ireland (1995/1996). The figure for Sweden is outdated (1992). No estimates are available for Greece and Portugal.
This deals mainly with opiate users, with the exception of Sweden, where people who inject amphetamines present the majority of cases (at least during the early 1990s).

ADMISSIONS TO IN-PATIENT ADDICTION CARE FACILITIES DUE TO PROBLEMATIC OPIATE USE: ABSOLUTE NUMBERS AND AS PERCENTAGE OF ALL ADMISSIONS FOR A DRUG-RELATED PROBLEM, SINCE 1993





**DEATHS DUE TO DRUG OVERDOSE
IN THE NETHERLANDS, SINCE 1985**



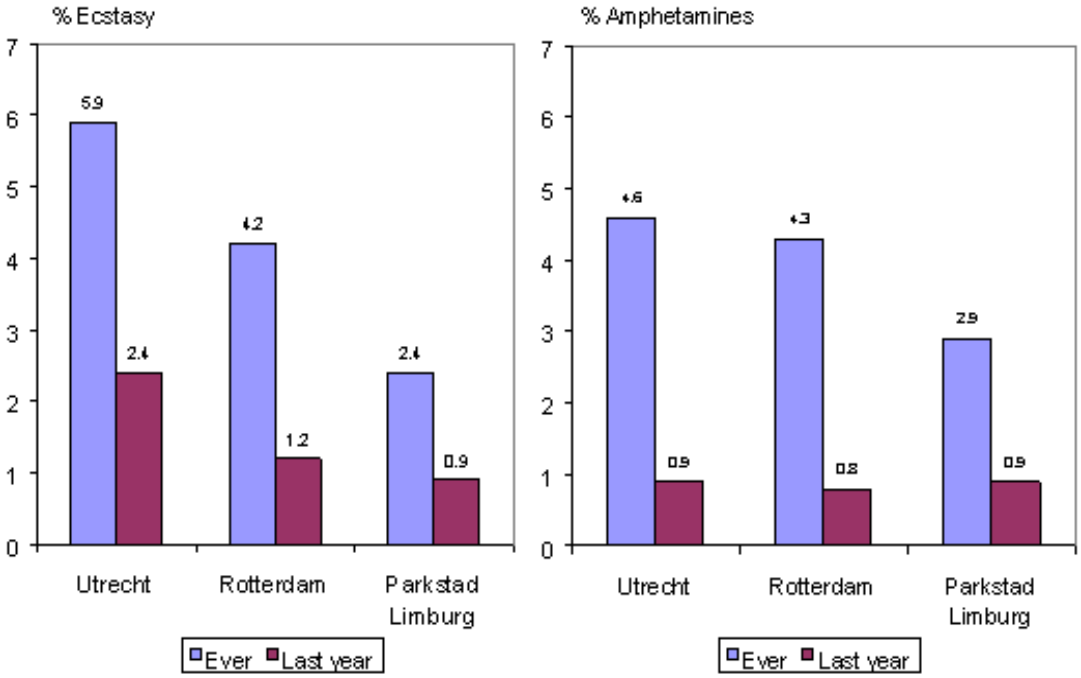
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Total	40	42	23	33	30	43	49	43	38	50	33	62	69	61
Opiates	37	42	21	30	29	38	47	42	36	44	28	43	42	38

4. Ecstasy (MDMA) and Amphetamines

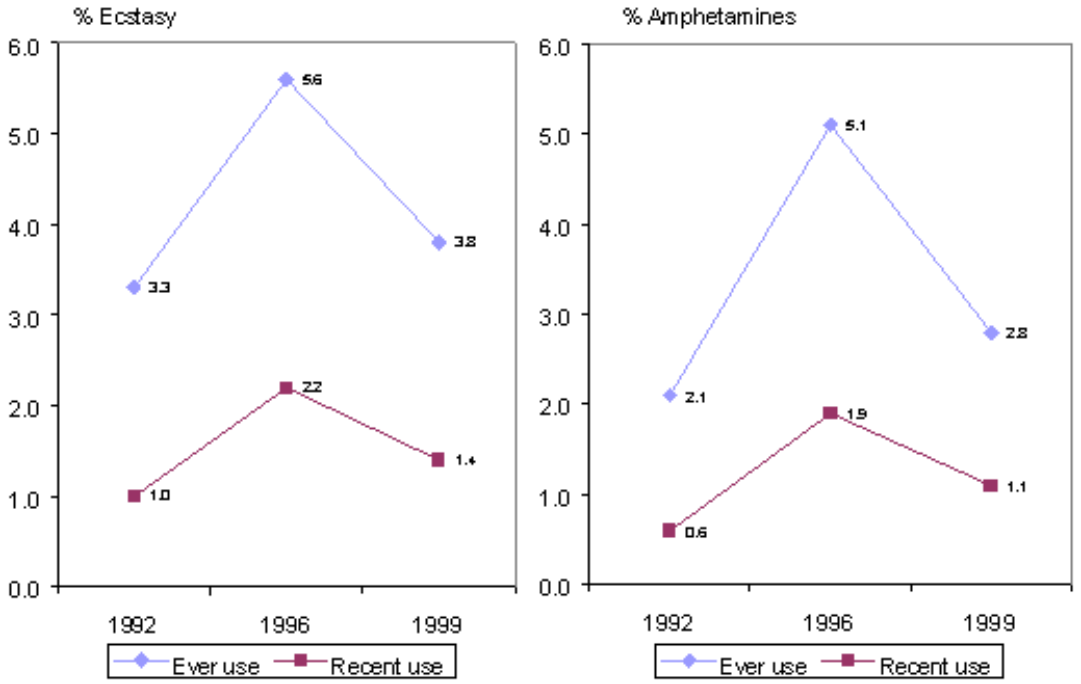
ECSTASY USE IN THE NETHERLANDS BY PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

	Ecstasy	Amphetamines
Has ever used	1.9%	1.9%
Has used recently	0.3%	0.1%
Has used for the first time in the past year	0.4%	0.2%
Mean age of current users	25 years	30 years

USE OF AMPHETAMINES AND ECSTASY IN THREE URBAN AREAS BY PEOPLE AGED 16 TO 70 YEARS. SURVEY YEAR 1999



USE OF ECSTASY AND AMPHETAMINES BY PUPILS AGED 12 YEARS AND ABOVE, SINCE 1992



CONSUMPTION OF ECSTASY AND AMPHETAMINES BY PUPILS AGED 15 AND 16 YEARS IN THE EUROPEAN UNION

Country	*Survey year*	*Ecstasy*	*Amphetamines*
Ireland	1995	9%	3%
Flemish Belgium	1998	6%	4%
Netherlands	1999	5%	4%
United Kingdom	1999	5%	9%
Italy	1999	4%	2%
Denmark	1999	3%	4%
Spain	1998	3%[a)]	4%
France	1997	3%[b)]	2%
Greece	1998	2%	4%
Luxembourg	1998	2%	1%
Sweden	1998	1%	1%
Finland	1995	0.2%	1%

Percentage of ever users
a) Ecstasy including other synthetic drugs
b) Ecstasy including LSD

B. Law and Enforcement Statistics[28]

CRIMINAL OFFENCES AND MAXIMUM SENTENCES[29]

HARD DRUGS	Maximum custodial sentences and/or fine	
Import/export	12 years	Dfl. 100,000
Sale, transport, production	8 years	Dfl. 100,000
Intended import, export, sale, transport, production	6 years	Dfl. 100,000
Preparation of crimes	6 years	Dfl. 100,000
Money laundering	6 years	Dfl. 100,000
Producing and trading in precursors	6 years	Dfl. 100,000
Possession	4 years	Dfl. 100,000
Possession for own use	1 year	Dfl. 10,000
SOFT DRUGS		
Import/export	4 years	Dfl. 100,000
Sale, transport, production, possession of more than 30 grams	2 years	Dfl. 25,000
Sale, production, possession of up to 30 grams	1 month	Dfl. 5,000

(28) The source of these statistics, unless otherwise noted, is: National Drug Monitor, "2000 Annual Report," *supra*, note 27.

(29) Source: "Criminal Justice Factsheet 9: Drugs Policy: The Criminal Justice and Administrative Authorities," Trimbos Institute, 1997 (last updated 12/14/2000), available online at: http://www.trimbos.nl/ukfsheet/fc9uk.html.

The maximum sentence which can be imposed for committing more than one drug offence is a custodial sentence of 16 years and/or a fine of Dfl. 100,000. This fine can be increased to a maximum of Dfl. 1,000,000. A bill has been presented to the Lower House of Parliament which will increase the sentence for growing hemp professionally or commercially. The proposal is that the custodial sentence should be raised from 2 to 4 years.

A total of 4,228 people were convicted of an offence under the *Opium Act* in 1995. Of these, 3,290 sentences were unconditional (i.e., not suspended sentences). A large proportion of them (57%) consisted of short sentences of 0-6 months, and 14% were sentences of between 6 months and 1 year. Sentences of 1-3 years were passed on 23% of convicted defendants, and 3% were given a sentence of 3 years or more.

DRUG ADDICTS IN NORMAL WINGS IN TWO PENAL INSTITUTIONS. SURVEY YEAR 1997

Location	*'Diagnosis'*	*Found in*
Penal Institution Over-Amstel	Addicted to drugs[a)]	44%
	Severely addicted to drugs[b)]	29%
Penal Complex Scheveningen	Drug-dependent[c)]	29%

Percentage of inmates addicted to drugs.

a) Consumption of drugs on three or more days per week for at least two months in the two years prior to the interview, plus a score of at least 4 on the questionnaire section on drugs of the EuropASI.

b) Same as above, but with a score of at least 6 on the list in question.

c) According to DSM-III-R (dependency can be equated to addiction).

RECENTLY COMMITTED OFFENCES BY DRUG ADDICTS IN THE PENAL INSTITUTION OVER-AMSTEL AND THE 'STREET JUNKIE PROJECT' IN AMSTERDAM. SURVEY YEAR 1997

Number of offences in the year prior to imprisonment[a)]	*Voluntary placement in drug-free wing*	*Street Junkie Project*[b)]	*Involuntary placement in drug-free wing*	*In 'normal' custody*
Drug trafficking	35	16	45	40
Property offence	161	336	361	124
Violent offence	1	4	3	2

a) Self-Report. Number of offences in the year prior to detention, or prior to the interview of participants in the 'Street Junkie Project.'
b) Criminal drug addicts, who voluntarily enter treatment outside the prison as an alternative to completing their prison sentence.

NUMBER OF CONFISCATED ECSTASY TABLETS, ATTRIBUTED TO THE NETHERLANDS

	1998	1999
Confiscated outside of the Netherlands	2.5 million	9.7 million
Confiscated in the Netherlands	1.2 million	3.7 million
Total	3.6 million[a)]	13.3 million[a)]

In the first half of 2000, a total of 8.7 million of Dutch tablets were confiscated, 6 million of which were confiscated abroad.
Source: USD (Synthetic Drugs Unit)[108]
a) These figures were rounded down.

Criminal cases brought before court per 100,000 inhabitants aged 12-79[30]					
	1995	1996	1997	1998	1999
Men					
Penal Code	2,142	1,990	1,939	1,893	1,825
• Violent crimes among which	429	427	447	453	463
- rape	18	16	15	14	15
- assault	11	11	12	11	13
- other sexual offences	19	20	19	18	17
- threatening behaviour	57	60	63	68	73
- crime against life	38	36	37	37	38
- maltreatment	193	197	215	218	221
- imputable death and bodily injury	1	1	1	1	1
- theft with violence	83	77	75	77	78
• Extortion	10	10	10	8	8
• Property crimes	1,346	1,178	1,089	1,029	937
• Malicious damage and crimes against public order	337	353	371	368	364
• Other crimes under the *Penal Code*	30	31	32	44	61
Road Traffic Act	625	687	692	666	650
Economics Offences Act	223	184	210	179	162
Drugs Act of which	140	154	167	156	144
- Hard drugs	113	112	112	103	101
- Soft drugs	28	42	55	52	43
Weapons and Munitions Act	68	79	76	73	71
Other acts, decrees, etc.	60	70	76	58	59
Tax law	7	8	7	8	10
Unknown	21	24	34	23	9
Total	3,287	3,196	3,202	3,056	2,931

(30) Source: Statistics Netherlands, Voorburg/Heerlen, 2000, available online at: http://www.cbs.nl/en/figures/keyfigures/krv1522y.htm.

Criminal cases brought before court per 100,000 inhabitants aged 12-79[31]					
	1995	1996	1997	1998	1999
Women					
Penal Code	342	330	322	302	296
- Violent crimes	29	33	35	38	42
- Property crimes	283	261	249	226	215
- Malicious damage and crimes against public order	26	31	32	32	33
- Other crimes under the Penal Code	5	5	5	5	7
Road Traffic Act	51	57	61	59	62
Economics Offences Act	27	20	22	32	33
Drugs Act of which	16	19	21	21	19
- Hard drugs	14	14	14	13	13
- Soft drugs	3	5	7	8	7
Weapons and Munitions Act	4	6	6	7	6
Other acts, decrees, etc.	7	12	17	13	11
Tax law	1	1	1	1	1
Unknown	1	2	3	2	2
Total	450	446	454	436	429

Note: With a few exceptions, criminal court cases deal with crimes under the Penal Code. First offences are tried at the district courts. The Public Prosecutors' Offices and the offices of the district courts of justice and the Supreme Court of the Netherlands report information on registered and disposed criminal court cases. The figures for the district courts are taken from the "Compas," computer registration.

(31) Source: Statistics Netherlands, Voorburg/Heerlen, 2000, available online at: http://www.cbs.nl/en/figures/keyfigures/krv1522y.htm.

Arrests for Drug Offences per 100,000 inhabitants, 1995/1996[32]	
Australia	313
Austria	201
Canada	207
Denmark	166
France	134
Germany	229
Netherlands	43
Sweden	100
UK	162
USA	539

(32) Source: Frans van Dijk and Jaap de Ward, “Legal Infrastructure in the Netherlands in International Perspective: Crime Control,” Ministry of Justice, The Netherlands, Directorate for Strategy Development, June 2000, p. 27.

APPENDIX

PRINCIPAL POLICY INTENTIONS INDICATED IN THE 1995 "CONTINUITY AND CHANGE" POLICY DOCUMENT ON DRUGS

GENERAL

1. Neither hard nor soft drugs to be legalised.

2. Continuation of policy geared to market separation and harm reduction, with a tightening up in certain areas:
   - renewal of care;
   - more action to combat nuisance and crime;
   - organised crime to be tackled;
   - more consultations with other countries.

3. Integrated approach: prevention, care, social rehabilitation and penalties under the criminal law for criminal behaviour and nuisance.

MORE SPECIFIC MEASURES

4. Establishment of national support office to provide information, improve expertise and develop policy on drugs prevention.

5. Statutory provisions on participation in national information collection system to monitor the addiction problem.

6. Research to establish how regional non-residential care for addicts should be financed when the Temporary Act for the Promotion of Social Renewal (TWSSV) comes to an end.

7. Renewal of care for addicts:
   - greater range of residential care to be provided;
   - more attention to be paid to prevention and "socialisation" of addicts;
   - trial involving the provision of heroin to older, untreatable addicts;

- increased capacity in compulsion and dissuasion projects (500 places in consultation with Public Prosecutions Department);
- opening of forensic addiction clinic (70 places).

8. Establishment of Inter-administrative Task Force on Public Safety and the Care of Addicts (central government, municipalities, Association of Netherlands Municipalities), in conjunction with the policy on the big cities.

9. Establishment of panel of experts to assist municipalities in tackling the problem of nuisance using administrative powers and in pursuing a policy on coffee shops:
   - case law studies;
   - development of proposals for local coffee shop policy;
   - offices where nuisance can be reported;
   - exchanges of information.

10. Strict approach to drug tourists who cause nuisance (specifically targeted investigations and immediate deportation).

11. Bill on a criminal law measure allowing addicts who frequently commit offences or cause nuisance to be taken into care compulsorily; trial using such a measure in Rotterdam (100 places).

12. Amount of soft drugs whose retail sale is tolerated in regulated coffee shops to be reduced from 30 grammes to 5 grammes; more monitoring of exports.

13. Inclusion in Public Prosecutions Department guidelines of the amount of soft drugs coffee shops will be permitted to stock for sales purposes (a few hundred grammes).

14. Bill to increase the maximum penalty for the cultivation of cannabis.

15. Priority to be given to the investigation of the large-scale cultivation of Dutch cannabis.

16. No priority to be given to investigating the small-scale domestic cultivation of Dutch cannabis within limits to be set locally.

17. Investigation of criminal organisations to be stepped up (national team).

18. More priority to be given to investigating those who control drug trafficking at local level.

19. Plan of approach to tackle organised crime after completion of enquiry.

20. Promotion of cross-border cooperation between the judicial authorities, the police, administrative authorities and care organisations.

21. Greater attention to be paid to research, monitoring and evaluation:
    - regular user studies;
    - projects on quality;
    - evaluation of preventive measures;
    - future scenarios;
    - coffee shop policy;
    - THC-levels;
    - synthetic drugs.