

LESSONS FOR DRUG POLICY SERIES

Coffee Shops and Compromise

Separated Illicit Drug Markets
in the Netherlands



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in the Netherlands

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Global Drug Policy Program



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Foreword

There is an undeniable shift happening in international drug policy. Lawmakers—sometimes at the urging of voters—are debating regulatory approaches in a number of jurisdictions. Internationally, leaders are bringing these discussions to multilateral forums such as the United Nations and regional institutions like the Organization of American States.

Change is in the air.

These discussions naturally lead to questions about what can reasonably be done and what we can expect to happen if certain policies are introduced. It is popular to inject an air of mystery into any debate about drug policy reform. The truth is that we know more than we think. There are approaches—including those in the Netherlands, Portugal, Switzerland and the Czech Republic—that have put the emphasis in their policies on public health, pragmatism, safety and security. We know what works based on what has been tried. And the Dutch model works.

It may seem paradoxical that a nation famous for its so-called ‘permissive’ approach has had more positive outcomes in controlling the harms of drug use than many other countries that have enacted much stricter policies. While Dutch drug policy may be most renowned for its coffee shops, where cannabis is openly sold and consumed, the reasons behind this policy are less understood.

This Dutch model was introduced as a pragmatic way of protecting cannabis users from exposure to harder drugs. The theory was that indiscriminate prohibition created a sub-culture in which users of drugs with vastly different risks are placed in the same milieu. Moreover, it was thought that saddling young people with criminal records might push them toward using harder drugs. As different drugs create different risks, the government

sensibly surmised that all substances should not be treated the same. This is generally what is understood as a ‘separation of markets.’

A risk considered by Dutch policymakers was that people buying illicit marijuana would be in contact with those selling harder drugs. As designated commercial sources for marijuana evolved, it came to pass that drug users were much less likely to buy harder drugs from their cannabis sources. For example, in Sweden, 52 percent of marijuana users report that other drugs are available from their usual cannabis source. In the Netherlands, only 14 percent of marijuana users can get other drugs from their cannabis source.¹ This is largely because the vast majority of cannabis users buy from coffee shops. In addition, these businesses generate around €400 million per year in tax revenues, according to some conservative estimates.

By a number of indicators, the Dutch drug policy approach has been more successful than more repressive policies. One study found that people who use cannabis in Amsterdam are less likely to use cocaine than are marijuana users in the US. It said: “Only 22% of those [in Amsterdam] aged 12 and over who have ever used cannabis have also used cocaine ... This compares to a figure of 33% for the United States.”²

Furthermore, access to a commercial market for cannabis did not prompt the Dutch to become the world’s most prolific cannabis consumers. On the contrary, cannabis use stayed on par with European averages and remains far lower than in stricter environments like the United States.

This study is not written to cast an exclusively favorable light on Dutch drug policy. While there are many successes, there are also challenges. There have been past public nuisance complaints against coffee shops as well as tension regarding supply of a substance never officially legalized. Yet how these challenges are dealt with is equally instructive. With its regulated approach to coffee shops, the Dutch have been able to rely on regulatory mechanisms to address problems.

However, nothing takes place in a vacuum and the Dutch approach is as vulnerable to politics as any policy. Interparty squabbles in a climate ripe for populism creates fissures that can lead to regressive drug policy approaches. At times, ambitious lawmakers or candidates have used drug policy as a wedge issue and in recent years, there have been various attempts to make the Dutch policy more restrictive. This paper explores some of the political

1. EMCDDA, Further insights into aspects of the EU illicit drugs market: summaries and key findings, European Union, 2013, p. 18.

2. R MacCoun and P Reuter, Evaluating Alternative Cannabis Regimes, 178 *The British Journal of Psychiatry* p. 126 (2001).

dimensions in the Netherlands around these discussions. Nevertheless, proponents of the international status quo would like to exploit any debates about drug policy in the Netherlands as being reflective of an admission of failure on the part of Dutch policymakers. This is a disingenuous attack on what has been a largely successful policy. As this paper shows, the conversations currently underway about marijuana policy in the Netherlands have very little to do with success, failure, public health or criminal justice. They are about politics.

And that is where the main questions about the next steps arise. What comes next may actually not depend on outcomes but rather on leadership. Is there the political will to absorb what we've learned and carry them even further?

This is as true for the Netherlands as the entire international community.

Kasia Malinowska-Sempruch
Director, Global Drug Policy Program
Open Society Foundations

“The Purpose of the State is Freedom”

Baruch Spinoza, Tractatus Theologico-Politicus

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Acknowledgments

We thank our respondents. They helped us making sense of the 40-plus years of dealing with illicit drugs in a humane and pragmatic public health manner. Many of them have taken active roles in shaping Dutch drug policies and practice. Their efforts and those of many others have put the Netherlands, for many years, ahead of the pack in international drug policy.

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Executive Summary

Building on a long history and culture of tolerance, the Dutch responded to illicit drugs with decades of pragmatic measures free of judgment. A central element of modern Dutch drug policy was a crucial decision to establish a legal and practical separation of cannabis—judged to pose “acceptable” risks to consumers and society—from hard drugs associated with unacceptable risk. This policy effectively decriminalized possession and use of cannabis and opened the door for tolerated outlets for small-scale cannabis sales that eventually took the form of the well-known Dutch “coffee shops.” By all measures, the coffee shops succeeded in enabling cannabis consumers to avoid exposure to hard drug scenes and markets. Dutch cannabis consumers have also been spared the profound costs of carrying a criminal record, and the public has not had to bear the cost of incarceration for minor offenses. Drug policy in the Netherlands was characterized by a pragmatic bottom up development in which policies developed through trial and error at a local level often initiated by local officials in consultation with representatives from civil society who were supported by national policy makers.

With respect to heroin and other hard drugs, the Dutch government at national and municipal level put a premium on reduction of individual and social harm. This commitment has been reflected in the government’s investment in comprehensive health and social services. Low-threshold methadone and safe consumption rooms as well as needle exchange programs proliferated earlier and with higher coverage than in most of Europe. Even before these services were established, however, tolerance for sale and consumption of illicit hard drugs in designated “house addresses” greatly reduced the dangers of an open drug scene, including exposure to uncontrolled criminal elements. It also contributed to a preference

for drug consumption not involving injection. The Netherlands was spared the major drug-linked HIV epidemic that devastated drug users and their families in other European countries. An important element of this success, at times, was not only pragmatic national policy but also the degree of autonomy that municipal officials had to exercise of practices that did not conform to the letter of the law.

None of this was without its challenges. For example, while the coffee shops provided a venue for safe and controlled consumption of cannabis without exposing consumers to harmful hard drug scenes, successive governments have not successfully addressed the so-called back door problem—coffee shops being supplied with cannabis by an illegal market. While there were instances of popular support for the complete legalization or government regulation of the cannabis market, which would address this problem, there were always political challenges to securing such a policy. Though confidently preserving the core of their policy and continuing to focus on reduction of individual and social drug-related harm, successive Dutch governments have felt international pressure to not “step over the line” into areas such as legalization and regulation of drugs. In addition, attempts to address drug tourism by making coffee shops exclusive Dutch-only clubs seem to create more problems than they solve, evoking opposition from proprietors, patrons, civil society, legal experts and city mayors alike. Nevertheless, some municipalities continue to complain of drug tourism while enjoying the substantial revenue generated by coffee shops.

This report is an in-depth analysis of the politics and the practicalities that enabled or led the Dutch authorities at national and local levels to make the drug policy decisions that have shaped the lives of people who use or are otherwise affected by drugs in the Netherlands. It is the authors’ hope that it will be of use to those outside the Netherlands, in government and civil society, who seek drug policy solutions that are respectful of human rights and based strongly in science and good public health practice. If there is one lesson to take away from the Dutch experience, it is that when taking steps toward regulating cannabis or other psychoactive substances meant for human consumption, these should include the entire chain of supply, from production to consumption.

1. Introduction

The Netherlands consistently features low prevalence of HIV among drug users, negligible incidence of heroin use, cannabis use among young people on par with the European average and a citizenry that has generally been spared the burden of criminal records for low-level, non-violent drug offenses. How the Netherlands accomplished these goals is a matter of some debate. The Dutch drug policy model is often misrepresented or poorly understood. Its laudable public health programs are too often overshadowed by the publicity surrounding coffee shops, where cannabis is openly sold and consumed (a notable feature of the Dutch model but far from its principal characteristic).

The essence of Dutch drug policy can be traced to one crucial policy change enacted into law in 1976: the separation of illicit drugs into those with “unacceptable” risk (list I, “hard drugs”) and those with “acceptable” risk (list II, soft drugs or cannabis) to the health of the user. This distinction effectively decriminalized the use of marijuana and hashish and initiated the beginning of a cannabis trade severed from the market for “harder” drugs. Around 1980, coffee shops, establishments where cannabis can be purchased and consumed, were opened in Amsterdam, Rotterdam and Utrecht. By the end of the 1990s coffee shops could be found in almost every large or mid-sized Dutch city. The separation of markets also aimed to provide an environment where policies addressing increased heroin-related problems could be more effective. Indeed, within 10 years of the enactment of the 1976 law, the number of new heroin users dropped significantly (Toet, 1990; Grund, 1993; Van Brussel, 1995).

In other words, by its own metrics, the policy worked.

As with any public policy, Dutch drug policy has had both intended and unanticipated consequences. Some of the latter have become highly debated issues in the country. For example, the nuisance from foreign customers around coffee shops in border regions and the involvement of criminal organizations in cannabis cultivation and wholesale supply resulted in the closing of some coffee shops in border towns and overall calls for tougher drug policies. Since 2000, policy has for various reasons shifted away from public health and increasingly toward more punitive approaches. This trend is however not uniform, as this report will document.

1.1 Aims & Objectives

Critically examining Dutch drug policy over four decades, this report aims to:

1. Identify both the successful and less successful ingredients of the 1976 legal change, its overall effect on drug policy and its outcomes; and
2. Analyze these features within the context of Dutch society, history and politics.

The report does not address the use of ecstasy and other so-called “party drugs” that have become common on the Dutch scene, but rather focuses on cannabis and heroin. While this decision is made mainly due to space limitations, the influence of “party drugs” on Dutch drug policy involves a fairly complex set of additional questions that are beyond the scope of this paper.

1.2 Methods

We conducted a thorough review of relevant key policy documents, research publications, scholarly literature, press reports, local, national and international reports, reports by civil society organizations, media publications and other grey literature on Dutch drug policy in general, and policies on cannabis and heroin related issues and on the Dutch “policy of tolerance” in particular. In addition, 20 face-to-face interviews were conducted with key national (drug) policymakers who each played a significant role in several decades of “separation of markets,” as well as with academic experts, civil society representatives, local and national politicians, harm reduction activists, policy advocates, a treatment service provider, a coffee shop proprietor and representatives of law enforcement. Names and affiliations of the interviewees can be found in Annex 1. Relevant policy documents and research publications were reviewed, with an emphasis on important policy changes as well as outcomes of these policies. Policy documents and interviews were analyzed in conjunction.

2. Cannabis Policy

2.1 The Run-Up to the 1976 Law Change

2.1.1 The Dutch and Drugs Before the 1960s

The Dutch relationship with psychoactive substances dates back to shortly after the foundation of the “Vereenigde Oostindische Compagnie” (VOC), or United Dutch East-Indies Company, in 1602. In the 17th century, the Dutch gained firm control over the opium trade in Asia. In response to leakages and illegal trade in opium and to international concerns about the rising use of opium, the Dutch government introduced the “Opium Regie,” in the Dutch Indies (present day Indonesia) in the 1890s (De Kort, 1995). This monopoly regulated the production and trade of opium, reinforcing Dutch control. The revenues from the opium monopoly contributed greatly to the wealth of cities such as Amsterdam and Leiden and ended with the Japanese invasion of the Dutch Indies in 1941.

By the end of the 19th century, their renowned mercantilism led the Dutch to cultivate coca on the island of Java. In 1900, the “Nederlandsche Cocaïnefabriek” (Dutch Cocaine Factory) was established in Amsterdam. Ten years later, the Netherlands led the world’s cocaine market. Officially, cocaine was manufactured solely for medicinal purposes, but Dutch cocaine also ended up in recreational retail and, in particular, military markets (De Kort, 1995). Until the 1950s, few people used illicit drugs in the Netherlands. Hemp and hashish were included in the Opium Act in 1928, but only in 1953 did the possession and production of cannabis become a criminal offence in the Netherlands (Korf, 2002).

As in many other Western countries, the use of psychoactive substances increased rapidly in the 1960s, when young people started experimenting with cannabis, LSD and amphetamines. Dutch law enforcement authorities initially responded forcefully, aiming to repress not only drug trafficking but also drug use itself (Cohen, 1975; Korf, 2002). Drug arrests grew rapidly from 74 in 1966 to 544 in 1969 (Andere Tijden, 2004). According to Dirk Korf, Professor of Criminology at the University of Amsterdam (interview), this repressive approach was widely criticized by the public and some politicians. Enforcement and successful prosecution proved to be both difficult and time consuming and did not result in a noticeable reduction in the availability or use of drugs. In 1969, the Public Prosecutor's office published an enforcement guideline, shifting the focus of policing and prosecution away from cannabis use and towards the trafficking of cannabis and to substances such as LSD, amphetamine and opium (Andere Tijden, 2004).

An important turning point in drug law enforcement came with the Holland Pop Festival in June 1970 in Rotterdam—the Dutch answer to the 1969 Woodstock festival. At this first-ever large-scale outdoor festival in the Netherlands, the police and mayor of Rotterdam opted for a softer approach to policing the crowd of 100,000, which, they noted, posed no immediate threat to public order. They decided just to observe the masses, rather than enforce the Opium Act by arresting every single cannabis-consuming young person. Police officers at the festival observed, firstly, that in the absence of enforcement drug transactions became quite visible, until eventually stalls were set up where drugs were sold. And secondly, different drugs (cannabis, LSD and amphetamines) were sold by different vendors. Apparently, markets in illicit drugs were to some degree already segregated by substance. They saw that it was indeed possible for people to consume substances on a large scale without causing major risks to either themselves or public order. The absence of police arrests at this festival marked the dawn of more tolerant attitudes towards the use of psychoactive drugs, and cannabis in particular. The restrained policing at the festival may be considered the first large scale implementation of the 1969 Public Prosecutor's office enforcement guideline. Subsequently, the authorities also began to tolerate so-called “house dealers” in venues frequented by Dutch young people, which is described in greater detail below.

Until the early 1970s, cannabis sales remained underground and part of the Dutch counterculture, in which users sold to fellow users. Gradually, an informal policy of tolerance emerged around the use and transactions of amounts of cannabis associated with individual consumption. In addition, the attention of the police was soon to be diverted by heroin.

And then there was heroin

By 1972, the Amsterdam police had successfully intervened in the opium trade, mostly by deporting opium traffickers from Asia (Van Riessen, interview). Competing traffickers of

heroin filled the vacuum and, within months, heroin replaced opium in the Amsterdam and Rotterdam drug markets (Grund and Blanken, 1993; De Kort, 1995). The number of heroin users quickly increased as heroin was on its way to becoming the leading drug of concern in the Netherlands.

Meanwhile, an influential 1969 study conducted by medical sociologist Herman Cohen cast doubts on the theory of cannabis as a “gateway drug” which assumes that users are compelled to progress from milder (cannabis) to harder drugs. However, participation in a marginalized sub-culture may familiarize cannabis users with other drugs and encourage their use (Cohen, 1975). A separation of the cannabis scene from that surrounding other drugs, Cohen argued, would prevent the cannabis users from exposure to harder drugs. Thus, the decriminalization of cannabis was greatly influenced by the emerging wave of hard drug use.

A separation of the cannabis scene from that surrounding other drugs ... would prevent the cannabis users from exposure to harder drugs

The “Algemeen Centraal Bureau voor de Geestelijke Volksgezondheid,” the central authority for mental health—a non-governmental but influential advisory body to the government—commissioned a report from a panel dubbed the Hulsman committee. Reflecting on debates about social deviance that became prominent in Dutch academic literature at the time, the committee’s 1969 report proposed abolishing criminal sanctions on all drug use in the long run and to treat drug problems using a public health approach. It further recommended that the intensity of law enforcement be determined by the danger a substance presented to the individual and society. Cannabis was deemed a relatively mild drug. It was the setting, or social context, that determined the amount of risk associated with its use, and the marginalization resulting from criminal prosecution might cause cannabis users to switch to “harder, more dangerous” drugs like heroin (Hulsman Committee, 1969).

A second report from a separate panel, the Baan Committee, proved to be even more influential on government policy and provided the justification for the amendments to the Opium Act four years later. The 1972 Baan report focused mainly on cannabis and, for the first time, made a distinction between substances with an “unacceptable risk” and “other substances.” The committee re-emphasized that the risks particular substances pose to the individual and society ought to determine the severity of penalization (Baan Committee, 1972; Hulsman Committee, 1969). Decriminalization of cannabis was proposed as the eventual goal, while penalties for hard drug trafficking and use were recommended to be increased. According to the Baan Committee, the negative effects of arrest and criminal

prosecution of cannabis users outweighed the possible benefits of punishment, not only to the individual user but also to public order.

Interestingly, the essence of the Hulsman report—the shift from repressive enforcement towards social and public health policies—was already reflected in the 1969 prosecution guidelines. According to Marcel de Kort, there were many links between the Hulsman and Baan committees on the one hand, and both the departments of Public Health and Justice. Professor Hulsman had also worked in and with the Department of Justice in various roles between 1955 and 1980. Decriminalization of cannabis was a widely supported notion, even within the Justice Department, as the prevailing opinion was that law enforcement should be the *ultimum remedium*. This represented an important shift in policy that would remain in force until the end of the 1990s.

Some respondents noted that the government at this time considered decriminalizing and regulating the supply of cannabis as well. Former Minister of Justice (and Prime Minister) Dries van Agt explained that he and Minister of Health, Irene Vorrink, both wanted to go further than just decriminalizing cannabis: “We wanted to fully legalize cannabis and regulate all other drugs” (Van Agt, interview). Because of international pressure the cabinet decided differently and for the same reason possession of cannabis was not legalized, but merely decriminalized. It was not going to risk the relationships with neighboring countries and the international community any further. But it did intend to explore the feasibility of amending agreements, such as the Single Convention in a way that would allow nations to institute, at their discretion, separate regimes for cannabis products (De Kort, 1994).

Once other European nations saw the progress that was made, though, the Dutch government expected that other countries would emulate the policy, at least decriminalizing cannabis use (Lap, Polak, interviews).

2.2 The 1976 Revision of the Opium Act

In 1976, the Opium Act was revised. With this revision, the Dutch government brought all substances classified in the United Nations’ 1961 Single Convention on Narcotic Drugs under the new Opium Act, but introduced two lists of substances:

1. “substances with an unacceptable risk to the health of the user”
2. “cannabis products”

Charges for the possession of 30 grams of cannabis or less would either be dismissed or be charged as a petty offence or misdemeanor (comparable with a traffic ticket) which would not result in a criminal record (De Kort, 1995).

The use of drugs was and still is not a criminal offence in the Netherlands, but possession of any drug remained illegal under the new law, reflecting the government's conviction that use of cannabis was not without some risk. Likewise, in addition to the law's recognition of differing risks another distinction was made between possession intended for personal consumption and possession with intent to distribute. The government intentionally did not reduce mere possession of hard drugs to a misdemeanor, as they wanted to keep open the option of compulsory treatment for heroin-dependent people. The new Opium Act further formalized the policing and prosecution policies reflected in the 1969 enforcement guideline of the Public Prosecutor's office, when the police stopped enforcing possession for personal use of any substance.

The development of drug policy was now formally coordinated by the Ministry of Health. The Ministry of Justice did not aspire to a leading role in drug policy in these days, as it subscribed to the governing view that drug use and addiction should be treated primarily by medical and social approaches rather than criminal justice (thanks to the influence of the aforementioned committees).

2.2.1 Expediency Principle and Political Structures

Shortly after the revision of the Opium Act, in 1977, the guidelines were altered to give the "local triangle" (consisting of the mayor of a municipality, the public prosecutor and the chief of police) the power to decide whether or not to prosecute small-scale sales of cannabis (De Kort, 1995), reflecting what in the Dutch legal system is known as the expediency principle. A public prosecutor in the Netherlands may lawfully decide to forgo criminal prosecution under the expediency principle when it is deemed not opportune, or not in the public interest, and may instruct the police to act accordingly (Korf, 2002). This approach has become the cornerstone of the Dutch approach to cannabis and drug use, as criminal prosecution of cannabis users was judged to not serve the public interest (Korf, 2002). Within the context of drug policy, then, law enforcement yields to public health, but also to public order. The expediency principle paved the way for the coffee shops and other further developments in Dutch drug policy, reflecting the Dutch tradition of pragmatism and tolerance.

Another important aspect of Dutch policy is that the Dutch value individual freedom and open debate, in particular on controversial ethical issues. Influential 18th century statesman Jan Rudolf Thorbecke wrote that "transparency is the great, general school of political education." Since the Dutch feel strongly about inclusion and protecting the public good, there is an extensive system of social and health care in place (Keulen & Van de Mheen, 2008). Importantly, already in the 1960s, this pragmatic, inclusive and non-moralizing attitude to politics and policy making allowed for the input of many voices in the debate

about the country's drug policy—from academics to NGOs and cannabis users themselves.³ The policy of tolerance and the use of the expediency principle were not invented in 1976. On the contrary, the Dutch had ages of experience with tolerating diverging viewpoints and unconventional conduct. Indeed, the 1976 revision of the Opium Act “sanctioned” the practice that had emerged by trial and error in the decade before.

3. The voice of hard drug users was not heard until 1980 when the Rotterdam based ‘Junkiebond’ was founded.

3. Regulating Emerging Practice: Policy Development After 1976

3.1 Cannabis Sales Before the Coffee Shops

3.1.1 Sales in Concert Venues and Youth Centers

The 1960s were an economically prosperous time in the Netherlands and a time of mass secularization, in which traditional cultural and youth associations were no longer of interest to many Dutch adolescents (Bogt and Hibbel, 2000). Illicit drug use first emerged in these middle-class youth cultures. Despite the social upheaval of the late 1960s, most youth cultures were mainstream at the time but the heroin scene appeared among an early post-war underground youth subculture.

If the use and underground trade among people within the 1960s counterculture marked the first phase of cannabis sales in the Netherlands, sale in facilities where young people gathered can be regarded as the second stage (Korf, 2008). By around 1970, soft drugs were used and sold rather openly, although not aggressively, and without substantial police intervention in music venues in Amsterdam, Rotterdam and The Hague. While the government felt that the law ought to be held up, they could not ignore the social reality and feared that enforcing the law by closing youth meeting places could lead to the spread of cannabis dealing to seedier areas of Amsterdam. This might expose cannabis users to

hard drugs, which was deemed an unacceptable consequence (De Kort, 1995). Eventually, as was confirmed by our respondents (Polak, Lap, interviews), the venue staff and its NGO boards tolerated so-called “house dealers,” whom they knew and trusted, renting a table in a corner of these—often government subsidized—youth centers and music venues, where they sold hashish and marijuana. By 1977, the public prosecutor’s office had decided to make prosecuting house dealers a low priority, and the number of house dealers in these venues skyrocketed (De Kort, 1995).

3.2 And Then There Were Coffee Shops

“Coffee shops just originated. I don’t recall this ever being a topic at the Department. They just emerged.” (Engelsman, interview)

While politics focused on the sales of cannabis in pop podia and youth centers, the first commercial cannabis outlets were already emerging. One of the first, in 1972, was a “tea house”⁴ in Amsterdam called Mellow Yellow, where instead of selling from behind a counter, the dealer posed as a customer in front of the bar. The outfit kept a low profile, did not advertise and opened only after 6 p.m. (Schoof, 2008).

In 1975, *Rusland* and *The Bulldog* opened in Amsterdam, the first to be called *coffee shops* (Bruining, 2010). Where Mellow Yellow initially aimed at providing their friends (and friends of friends) with cannabis, Henk de Vries, founder of *The Bulldog*, turned the idea into a commercial concept and started selling cannabis from early morning to late in the evening (Ibid.). As long as cannabis wasn’t traded in an overt manner, the police wouldn’t bother these shops. Meanwhile, shops such as *The Bulldog* actively aimed to avoid becoming a public nuisance in the neighborhoods where they were located. They also soon established house rules, for example against hard drugs.

Coffee shops expanded and became visible only in the early 1980s. Compared to youth centers or apartment dealers, coffee shops had longer, fixed opening hours and a broader, more consistent supply of cannabis. Furthermore, budget cuts during the economic crisis of the early 1980s spurred the closure of many youth centers, which pushed cannabis users to the nascent coffee shops.

4, ‘Tea’ is also a reference to the 1940s slang for marijuana.

The Dutch government would not forcefully respond with regulations for coffee shops until the early 1990s. This reactive and restrained stance allowed for pragmatism in dealing with the emerging coffee shops, which were (and are)—literally—in conflict with Dutch law. It is clear that the appearance of coffee shops was not anticipated by the 1976 Opium Act revisions. When the coffee shops emerged it was decided through case law that the tolerance criteria developed for house dealers would be applied to these new establishments (Korf, 2002). Bos (2008) compared government attitudes toward coffee shops to the tolerance of 17th century underground Catholic churches in the Protestant Netherlands: the government knew what was going on, but as long as they weren't visible to the public, they could be tolerated.

3.2.1 Guidelines and Criteria for Coffee Shops

Used “off-the-record” since 1978 (Blom, 1998), new guidelines for the Opium Act were officially published in 1979 (Korf, 2008). “Police would only interfere if small-scale trade was publicly advertised or otherwise provocatively effectuated” (Staatscourant, 1980). These guidelines generated a special position for house dealers at youth centers, when working “with the trust and under protection of the staff of a youth center” (Blom, 1998). Marcel de Kort (1995) hypothesizes that these new guidelines provided the legal leeway for coffee shops. However, lacking specificity, the guidelines left it unclear under which circumstances and criteria police should enforce the rules (Jansen, 1989). While some coffee shops were mostly left in peace, others were raided regularly (De Kort, 1995). None of this, however, hindered the steady rise in the number of coffee shops throughout the 1980s.

Pioneered in Amsterdam, the AHOJ-G criteria were to be introduced nationally in 1991, but were only officially enacted in 1994 (Staatscourant 1994: 203). The initial AHOJ-G criteria were formulated in rather broad terms, leaving room for interpretation by the municipalities. AHOJ-G is an acronym for the following set of criteria:

- ▶ **A**, no Advertising: no more than (very) low profile signposting of the facility;
- ▶ **H**, no *Hard* drugs: these may not be sold or held on the premises;
- ▶ **O**, no Nuisance (*Overlast* in Dutch): including traffic and parking, loitering, littering and noise;
- ▶ **J**, no sales to under-aged customers (*Jeugdigen* in Dutch) and no admittance of under-aged customers to coffee-shops;
- ▶ **G**, transaction size is limited to ‘personal use,’ defined as 30 Grams per person per coffee shop per day.

When coffee shops started appearing, there was no Dutch-grown marijuana worth speaking of. According to economist Adriaan Jansen (2002) most coffee shops provided high-quality hashish until 1990, and interest in home-grown cannabis was low. With a few exceptions, growing marijuana was not very profitable. However, Dutch cultivators began growing different and more potent varieties, starting with the now famous *Skunk* (Niesink & Rigter, 2012). Indoor cultivation meant year-round harvests, higher yields and lower risk of discovery by police and thieves. Furthermore, breeding new strains was not against the Opium Act, and still isn't. Within a decade "over 80% of the internal demand for cannabis in the Netherlands was met through domestic production" (Jansen, 2002). By 2006, there were an estimated 200 wholesalers and 375 grow shops in the country, and Dutch-grown cannabis acquired an international reputation and market (Maalsté, 2007). These developments were not lost on the government.

4. At the Other Side of the Fence: The Dutch Hard Drug Epidemic, 1972–Present

4.1 Introduction

In the 1970s the focus of Dutch drug policy turned to heroin after it flooded the streets of Amsterdam, Rotterdam and then various provincial capitals. Until then, drug policy discussions focused on decriminalization of all drugs (e.g. the Hulsman committee) or cannabis and the status and health of its users (the Baan committee). The practical imperative of policy soon became to keep young people, cannabis users in particular, away from heroin. Thus, the policy objective became (to reinforce) the separation between cannabis scenes and the evolving street heroin scenes (De Kort, 1995).

This analysis focuses mainly on Amsterdam, the capital of the Netherlands, and, Rotterdam, Europe's biggest harbor, though other cities eventually experienced similar problems. Importantly, the hard drug epidemic in the Netherlands is not a single-drug but a multi-drug epidemic. The problematic use⁵ of heroin and cocaine are intricately interwoven

5. Problem drug use is defined as 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines' (<http://www.emcdda.europa.eu/themes/key-indicators/pdu>).

since cocaine emerged and “nested” in the heroin-using population around 1982 and not within a new age cohort of Dutch youth, previously uninvolved in hard drug use (Grund, 1993). Therefore, when using the term *hard drug use* in this chapter, we refer to problem use of heroin and/or cocaine.

4.2 Interwoven Epidemics of Heroin and Cocaine Use

In the 40-year-old Dutch hard drug epidemic we can distinguish four waves of new users, differing in social-demographic profiles or the social ecology of drug markets. These were: (i) 1972, with the onset of heroin use in the Netherlands; (ii) 1975, when the former Dutch colony Suriname gained independence and a large number of young Surinamese men came to the Netherlands, some of whom become entangled in the problem; (iii) 1980, when drug markets in Amsterdam and Rotterdam started leaving the inner cities and moved into apartments in working class neighborhoods outside the city center and heroin diffused across the country; and (iv) the rise of cocaine smoking within the heroin-using population.

4.2.1 The 1970s: Onset, Incubation and towards Widespread Diffusion of Heroin Use

The emergence of heroin was largely an unintended consequence of the dismantling of Amsterdam’s opium trade. Hard drugs in the Netherlands in the early 1970s were largely situated in the hippie subculture. Among Dutch hippies, experimentation with hallucinogens, amphetamines and other drugs were common, with heroin only emerging on the fringes in the summer of 1972. Subsequently, heroin also popped up in certain nightlife spots in Amsterdam and Rotterdam, attracting new users among working class youth and the first generations of immigrants from Suriname (Janssen and Swierstra, 1982; Grund and Blanken, 1993).

By the second half of the 1970s, heroin was the first drug to be experienced as a social problem in Dutch society and became the object of the first moral drug panic in the Netherlands. At the end of the decade, several Dutch cities housed large open air drug scenes at and around specific bars, street corners, bridges or shopping malls. Frederick Polak, consultant psychiatrist at the Amsterdam Municipal Drug Service between 1990 and 2003, noted: “In Amsterdam, there were repeated raids of users and small dealers on the Zeedijk. The mindset of the police back then was ‘we have to chase them and lock them up’” (Polak, interview). Despite these efforts, street scenes continued to grow and mobilized the wrath of residents of affected neighborhoods. In response, by around 1980, the (local) police started to repress and disperse the large street heroin markets. The heroin scenes then moved to working-

class neighborhoods that were scheduled for urban renewal (Grund & Blanken, 1993; Van Brussel, 1995). This had several unintended consequences—both negative and positive.

4.2.2 The 1980s: Off the Streets and Into Apartments

Nineteen-eighty was a significant year and perhaps even the principal tipping point (Gladwell, 2000) in the Dutch hard drug epidemic. The emerging economic crisis and resulting unemployment hit many adolescents in the same working class neighborhoods where hard drug dealers were settling. The majority of heroin dealers had left the streets and set up shop inside, “renting” a room in the apartments of hard drug users (who were mostly compensated with a daily ration of cocaine and heroin) or moving into abandoned housing. Heroin no longer had to be purchased from an unknown street dealer, but could now be had and consumed in the protected and discrete environment of “house addresses” around the corner (Grund and Blanken, 1993; Grapendaal et al., 1991). This low-threshold situation resulted in heroin rapidly diffusing into these working class neighborhoods, affecting both native Dutch and immigrant families (De Vos, 1984; Grund, 1993; Van Brussel, 1995). Merging with the economic crisis and the urban renewal process, this provoked the third wave of heroin use in the Netherlands (Grund and Blanken, 1993; Swierstra, Janssen and Jansen, 1986; Van Brussel, 1995).

By 1982 powder cocaine also slowly started making its way into the heroin scene and soon both heroin and cocaine could be bought at the same “house address” locations, which also provided the chemicals and utensils necessary to produce crack cocaine (although this term never caught on in the Netherlands) (Grapendaal et al., 1991; Grund, Adriaans and Kaplan, 1991). However, since cocaine was generally consumed indoors with heroin out of public view, the emergence of cocaine smoking became an issue for the drug treatment system only more than ten years later. The introduction of cocaine smoking also qualifies as a tipping point as it prolonged the careers of Dutch hard drug users and attracted new users to the scene, but its effects were moderated by these protective factors (Kaplan et al., 1990). Consumption of heroin and cocaine in house addresses was also dominated by “chasing the dragon,” a method of smoking with comparable effect to injecting but without the harms of injection, such as the transmission of blood borne viruses. Thus, from the early 1980s on, fewer and fewer new hard drug users initiated injecting (Grund, Adriaans and Kaplan, 1991; Grund et al., 1992b). In 2010, only 9 percent of the problem heroin users in Amsterdam inject (van den Brink, 2010), a ratio not very different from elsewhere in the Netherlands.

At the same time, young people in the Netherlands were exposed to many messages in popular culture, including in music, that highlighted the harms of heroin addiction, and they observed for themselves the differences in the hard and soft drug scenes. As Korf (interview) noted: “The visibility of these people [users of hard drugs], since we didn’t send them all to jail, also helped, as it provided negative role models, like ‘I do not want to be like them.’”

Throughout the 1980s, the police continued putting pressure on street markets, but after realizing that the heroin scene had moved inside and resulted in less nuisance on city streets, local governments and police decided to tolerate this situation, an “off the record” practice that would continue far into the 1990s. In fact, in some cities the police and neighborhood organizations actively collaborated with dealers at the house addresses (Blanken and Adriaans, 1993; Grund and Blanken, 1992; Grund, 1993). André Beckers, a former police officer in Arnhem and attorney who specialized in cannabis cases, explains that police officers in neighborhoods with many house addresses developed an unofficial policy of tolerance and discretion, making agreements with the dealers or proprietors in order to contain nuisance:

“The biggest complaint in my neighborhood was that customers rang the wrong buzzer, so I [as the local policeman] agreed with the dealers to affix little stickers next to their buzzer. I rewarded them with clean needles and syringes and also rewarded them when they cleared the playground of discarded syringes. People complain about nuisance, not about the use of drugs.”

4.2.3 The 1990s: From Heroin to Crack and the Demise of the House Addresses

In the second half of the 1980s, the first signs were observed in the larger cities that the heroin epidemic was declining (Toet, 1990; Grund, 1993; Van Brussel, 1995), although it continued to diffuse to smaller cities and rural areas (Korf, Mann & Van Aalderen, 1989; Korf, 1990). During the 1980s and 1990s, house addresses moved from one neighborhood to the other, basically following the agenda of the local urban planners (Blanken and Hendriks, 1996). However, increasing complaints and subsequent police raids resulted in a circular process toward more users on the streets, with associated increases in street-level nuisance (Grund, Adriaans and Kaplan, 1991).

In 1995, the Rotterdam Municipal Health Authority drew up a set of tolerance criteria for small-scale house addresses, where drugs could both be bought and consumed inside (Barendregt, Schenk, & Vollemans, 2001). Using the expediency principle, in the following years the police did not intervene in house addresses that met these criteria (Van de Mheen and Gruter, 2004). After a change in Dutch municipal law in 1997, the Rotterdam mayor could close down residences that created a public nuisance and evict their tenants. Soon thereafter dozens of dealing addresses were closed, which once again moved the drug trade into open air street markets (Barendregt, Blanken and Zuidmulder, 2000). But by then, the population of hard drug users was aging rapidly and combined measures of treatment, care, harm reduction and measured repression helped to get most problematic drug users from the streets and into services and sheltered housing (see 6.2).

5. The Nineties: Continuity and Change

5.1 New Directions in Cannabis Policy

In 1995, the “Purple Government”⁶ published an official policy document called *Dutch Drug Policy: Continuity and Change*. On the one hand, this important inter-ministerial policy paper represented continuity in that it recognized that the separation of soft and hard drugs in policy had been achieved and that the coffee shops were instrumental in this success (TK 24 077 no 3, 1995). It highlighted that this success was directly measurable in the low number of persons, especially young people, addicted to hard drugs compared to the rest of Europe (see also Kuipers, 1993). On the other hand, it was the first national policy document to take up the issue of nuisance associated with coffee shops. The paper emphasized that some coffee shops were under the influence of criminal organizations and that in some places local residents complained about loitering customers, pollution, parking problems, and so on. It asserted that the presence of coffee shops in the vicinity of schools demanded more attention from law enforcement. The government also expressed concern about its international reputation and worried that it could become an “export nation of cannabis.” (TK 24 077 no 3, 1995).

6. A coalition formed by Social Democrat and Liberal parties, the first government without a Christian Democratic Party in 80 years.

Continuity and Change ushered in a tightening of regulations for coffee shops, including a minimum admission age of 18 years nationally. The maximum transaction amount was decreased from 30 to 5 grams per person per day, and a limit was put on the trading stock kept in the shop. While the upper limit was left to the local authorities, a stock of 500 grams or less would not trigger enforcement by national authorities (Korf et al., 1999). According to our respondents, the upper limit was rather arbitrary and not justified by, for example, the level of sales in the shops (Beckers, Bos, interviews; Eerenbeemt & Visser, 1995). In 1995 it was also announced that coffee shops would become “dry” facilities—i.e. alcohol-free—but this rule was implemented only in 2000 (Bieleman et al., 2008). Municipalities in addition obtained the power to add further local directives, such as a minimum distance to schools (e.g. a 250 or 350 meter minimum), or bylaws stipulating business hours and zoning criteria (Bieleman et al., 2006).

5.2 Drug Tourism and International Relations

Many of the new restrictions were passed under pressure from neighboring countries, the UN International Narcotics Control Board (Van der Stel, 1999; Boekhout van Solinge, 2010) and some segments of the media (Wiedemann, 1994).

The Schengen Agreement, a treaty signed in 1985, effectively abolished border controls between many European countries. In subsequent years, cannabis tourism to the Netherlands increased substantially in the border regions with Germany and Belgium, and so did the complaints about nuisance from local residents. Changes, such as the reduction in the maximum allowable amount for daily individual possession and purchase in coffee shops (from 30 to 5 grams), were in direct response to the increasing nuisance and aimed at discouraging foreign drug shoppers.

5.3 Getting Tough

Continuity and Change sought to reduce the influence of organized crime in the supply of the coffee shops as much as possible, by giving small scale, non-professional home cultivation low enforcement priority. In the beginning of the 2000s, however, law enforcement increasingly started focusing on cannabis cultivation, a development that continues as of this writing. When police started deploying anonymous tip-lines and cooperating with, for example, housing associations, insurance companies, electricity companies and banks, can-

nabis cultivation quickly lost its attraction to small-time home growers wanting to avoid a criminal record or home eviction. These steps may have only further pushed cannabis growing into economically less fortunate neighborhoods, where more and more unemployed people grew cannabis to support their income, increasingly managed by criminal organizations. According to Boekhout van Solinge (2010), the government's stricter approach triggered the scale-up and criminalization of the cannabis supply side.

The government's stricter approach triggered the scale-up and criminalization of the cannabis supply side

The Opium Act guidelines regarding coffee shops contained a major ambiguity: a low enforcement priority for possession for personal amounts of soft drugs and a high priority on trade and cultivation of larger quantities. This created the so-called “back-door problem”: coffee shops were exempted from prosecution for the sale of small quantities (the front door), but still liable to criminal prosecution for the purchase of large quantities of cannabis (the back door). Jeroen Bos, long time coffee shop proprietor, summarizes the back door problem as follows: “As proprietor you have to comply with many rules and checks on the one side, while at the other side you hardly have any rights, under the motto ‘you are tolerated, and you knew this when you started your business’.”

Former Minister of Health Hedy D’Ancona explained the lack of regulating the back door in terms of what was politically possible. When the Dutch policy on drugs was being shaped in the 1970s and 1980s, “we were already so happy with what we had, that we did not realize which problems we were also getting” (interview). Besides, coalition parties were never very willing to move forward on this policy file. Dries van Agt, who was Minister of Justice in 1971–1977, said the government first wanted to show that the number of cannabis consumers would not rise drastically and that they could consume their cannabis in a safe environment. The governing idea was that separating the users markets made so much sense that soon other nations would follow (Everhardt, interview). When international pressure was heavier than expected, the idea to regulate cultivation and introduce a closed system for the purchase and sales of hashish and marijuana was abandoned.

The first estimate of the total number of coffee shops in the country, in 1995 (TK 24 077 no 3, 1995), put the number of coffee shops at around 1200, with some 900 additional illegal points of sale, although no official figures exist. This was clearly too much for the government. “The first thing I did in 1995, was to order municipalities to close down hundreds of coffee shops. There were too many, which meant that some started selling hard drugs as well. They apparently lacked revenue due to the high competition” (Else Borst-Eilers, former

Minister of Health, interview). Since then, the number of coffee shops in the Netherlands has been steadily declining, to 846 in 2000 and 666 in 2009 (Bieleman and Goeree, 2000; Bieleman et al., 2005; Bieleman & Nijkamp, 2010). Moreover, in 1996 local municipalities were given the discretionary power to allow coffee shops in their municipality or not. About 69 percent of all municipalities have a so-called “zero policy” (allowing no coffee shops), while about one in four municipalities allow coffee shops (Bieleman & Nijkamp, 2010). Over half (53 percent) of all coffee shops are located in the five largest communities (> 200,000 inhabitants). Although only 5 percent of the national population lives in Amsterdam, the city is home to one-third of all coffee shops in the country (Bieleman & Nijkamp, 2010).

While it moved towards somewhat stricter policies on recreational cannabis use after 1995, the Netherlands did become the first country to legalize cannabis use for medicinal purposes in 2000 (Hazekamp, 2006; Holland, 2010). Since 2003, medicinal cannabis has been available in pharmacies for a number of medical conditions as prescribed by a physician. The prescribed cannabis is produced domestically, overseen by the Office for Medicinal Cannabis.

5.4 Policy Making At Work: Competing Policy Interests & the Politics of Compromise

Drug policy in the 1970s and 1980s was mainly dominated by public health issues, such as heroin injection and HIV. But this only partly explains why steps to further legally regulate coffee shops were not made. The Department of Justice traditionally had little interest in the topic, as coordination rested with the Minister of Health, including chairing the Inter-Departmental Steering Group on Drugs. But, as drug related health problems became more manageable, other issues, such as nuisance and crime, competed for political attention. Furthermore, the Dutch law enforcement sector saw itself increasingly exposed to zero-tolerance attitudes of European countries with much more punitive approaches to drug use.

In the 1990s Dutch drug policy was increasingly characterized by compromise—in international relations but also within political coalitions, most notably during the two Purple Cabinets (1994–2002). Political opposition and the lack of visibility put cannabis legalization, or further regulation, low on the list of policy priorities. Moreover, the main focus of drug policy remained heroin.

With regard to public health and harm reduction, I mostly occupied myself with heroin. This already took a lot of political haggling, as the VVD (Liberal Party) was rather opposed

to heroin assisted treatment. Only after I left did heroin become a registered medicine. Coffee shops were not our priority. Besides, the opinion was that further liberalization is undoable if you can't get neighboring countries to side with you (Borst-Eilers, interview).

Though the focus of policy making shifted to fighting organized crime and nuisance in the second half of the 1990s, the coordination of Dutch drug policy remained within the Department of Health. Only in the 21st century did this “balance of power” in drug policy shift towards the Justice Department.

6. Changing Tides—Dutch Drug Policy in the 21st Century

With the advent of right-wing, populist politicians such as Pim Fortuyn, tolerance for edgy social issues was decreasing. Indeed, the whole idea of tolerance was increasingly questioned. Although Pim Fortuyn was actually in favor of legalizing drugs, populist parties turned their attention to drugs (as well as immigration) as rallying points. In response to the emerging populism, conventional parties, such as the CDA and, in particular, the VVD, not only hardened their positions on immigration, but also on drug policy. The strong performance of the populist parties in the 2002 national elections resulted in greater emphasis on repressive measures both nationally and locally, including on cannabis policy.

After eight years of “Purple” governments, the 2002 Parliamentary elections brought a coalition of right-wing and Christian Democratic parties into power. Between 2002 and 2010, four subsequent Cabinets under Christian Democratic Prime Minister Jan-Peter Balkenende created an increasingly harsh social-political discourse around drugs and coffee shops in particular. The repressive direction of policy was continued by Rutte 1 in 2010—a minority coalition of VVD (Liberals) and CDA (Christian Democrats), tolerated by the Geert Wilders’ populist right wing PVV (Freedom Party).

The first Cabinet, which lasted only 86 days, named its coalition agreement “Towards a Safer Society” and expressed the intent to reduce the presence of coffee shops in the vicinity of schools and border areas as well as criminal involvement in the shops. Although the Ministry of Health was still the lead ministry in name in 2012, in practice the Ministry of Security and Justice took the lead in drug policy (Blickman, 2012).

6.1 (No) Experiments with Regulation

In the 2000 policy paper *Het pad naar de achterdeur* (The Path to the Back Door), the Minister of Justice wrote that the Purple Government had no intention to expand the policy of tolerance towards regulated or legalized cultivation of cannabis (TK 24 077, no. 75, 1999/2000) as that would be incompatible with international treaties and would cause problems with enforcement. Organizing a closed system for the production and distribution of cannabis in an open economy was judged impossible (Van der Stel et al., Everhardt et al., in Van Laar and Van Ooyen-Hoeben, 2009). Shortly thereafter, a parliamentary motion requesting the government develop guidelines for the cultivation of cannabis was accepted by a margin of only one vote (TK 24 077, no. 75, 1999/2000) but never executed by the Cabinet. Likewise, in both 1999 and 2008 a large number of mayors, of all political stripes, requested the Cabinet regulate the production and supply of cannabis to coffee shops. Another combined parliamentary-municipal initiative, the Manifest of Maastricht (09-12-2005), requested the government allow experiments with regulated cannabis cultivation, but was abandoned in June 2006 when the VVD withdrew its initial support. None of these initiatives were supported by the national government (TK 24 077 no. 179, 2006), which cited a study by the Asser Institute (2005) suggesting that international treaties did not leave room for experimentation. Years later, it was questioned in parliament whether a first draft of the report, which stated that such experiments were not at odds with international treaties, was withheld by the government (h-tk-20112012-69-8, 2011/2012). Reportedly, the Department of Justice changed the document to suit the government's position after receiving the first draft of the report (Althuisius & Driessen, 2012; Polak, interview).

6.2 The 2004 'Cannabis Letter'

In 2004, the Ministries of Health, Justice and Internal Affairs issued the "Cannabis Letter," which re-emphasized the three pillars of Dutch drugs policy; the protection of health, combating nuisance, and fighting drug related crime. Importantly, the paper stated that "The primacy of policy lies with the protection of health" but at the same time it declared the intent to focus on reducing street trade, drug tourism and professional cannabis cultivation (MinVWS, 2004). Referring to THC, the principal psychoactive constituent of cannabis, the paper mentioned the option of "moving varieties with higher THC content onto List I of the Opium Act," if these were associated with increased health risks. Decriminalizing and regulating the cultivation and distribution of cannabis were not an option for regulating

THC content, the government wrote, as this would require legalization, which “given the international obligations of the Netherlands is not an option” (MinVWS, 2004).

Coffee shop policy was further decentralized to the local authorities, emphasizing the focus on nuisance. The letter reiterated the desire to further reduce the already declining number of coffee shops—in particular near schools—and appealed to municipalities to use the available enforcement instruments more effectively (Bieleman et al., 2008). This further reduction was to be monitored carefully to prevent the “precarious balance” from sliding to non-tolerated sales of cannabis (MinVWS, 2004).

6.3 The Damocles, Victor and BIBOB Acts

The options for administrative enforcement were significantly increased with the addition to the Opium Act of the Damocles Act (article 13b) in 1999 and the Victor Act in 2002. The Damocles Act gives mayors the power to close down coffee shops—rather arbitrarily—if they fear “disruption of public order by, for example, drug users and drug dealers or when safety or the health of local residents are at issue as a result of drug use or trade” (Bieleman et al., 2008). The Victor Act further facilitated the repressive approach by intensifying the cooperation between law enforcement, energy companies, housing corporations and other arms of the municipal administration, resulting in, for example, evictions or lease terminations where cannabis cultivation is detected.

The “*Wet Bevordering Integriteitsbeoordelingen door het Openbaar Bestuur*,” (Promotion of Integrity Assessments by the Public Administration Act) or “BIBOB” aims to prevent coffee shop permits going to proprietors with ties to criminal organizations. Due to the front-door/back-door paradox, it is unsurprising that many coffee shops do have contacts with criminal entrepreneurs. Lawyers representing coffee shop owners argued that these instruments lack transparency as action can be taken without the intervention of a judge (Beckers, interview).

In 2008, police sources were claiming that 80 percent of the marijuana cultivated in the Netherlands, estimated at 500,000 kg, was grown for exportation. On national TV the Chief of the Taskforce Against Organized Marijuana Cultivation (Aanpak Georganiseerde Hennepteelt) also claimed that the size of indoor growing would cover the province of Utrecht if farmed outside. These claims were reportedly based on a confidential 2006 “study” by the Dutch national police force and were recited numerous times thereafter in media, in Parliament and by the government. These numbers soon became *accepted fact*, “an idea widely accepted as true by both the public and (media) ‘experts,’ but unexamined and [used to] preserve the status quo.” (Galbraith, 1958) Until in 2012, investigative TV journal-

ists (Reporter, broadcast 2 March 2012; Althuisius & Driessen, 2012) got their hands on the KLPD report and proved that the report (KLPD, 2006) in fact suggested that there was not a shred of proof in support of the previously cited numbers and that even the KLPD itself doubted that Europe was overflowing with Dutch cannabis (Buruma, 2008; Reporter, 2012; Althuisius & Driessen, 2012).

Whatever the actual extent of cultivation and export, focusing detection and prosecution on home growers meant that smaller targets in the trafficking hierarchy were caught first, which left the market open to competitors with less to lose from a criminal record and more resources to avoid detection (Boekhout van Solinge, 2010; Bos, interview). This provided both the incentive and leeway for criminal organizations with significantly more means and money to stay ahead of law enforcement. According to several of our respondents this created a self-fulfilling prophesy: the government was apparently reinforcing a problem it was trying to fight— drug-related organized crime.

6.4 Policy Evaluations and Advisory Committees

Two-thousand-nine was a busy year for Dutch drug policy, as three evaluations of the policy were published. The Ministries of Health, Justice and Internal Affairs collectively issued *Geen deuren maar daden* ('No Doors but Deeds'), the report of the Advisory Committee on Drug Policy ('Van de Donk Committee'). The National Institute for Public Health and Environment (RIVM) published *Een ranking van drugs* ('A Ranking of Drugs'). *Evaluatie van het Nederlandse Drugsbeleid* (Evaluation of the Dutch Drug Policy), a study conducted by the Trimbos Institute (the Netherlands Institute on Mental Health and Addiction), was issued by the Ministry of Justice. In the previous year, the "Coordination Unit Assessment and Monitoring of New Drugs" (CAM)⁷ published a new assessment of the risks associated with THC percentages in cannabis.

[S]weeping reforms of current policy measures – e.g. abolishing the coffee shops – were undesirable and potentially harmful to public health

7. The CAM has been part of the RIVM (National Institute for Public Health and Environment) since 2000.

The CAM report asserted that sweeping reforms of current policy measures—e.g. abolishing the coffee shops—were undesirable and potentially harmful to public health. The report concluded that combating organized crime and reducing cannabis-related nuisance are best achieved by regulating the supply side (CAM, 2008). The Van de Donk Committee, basing its conclusions on the Trimbos Institute report, concluded that the main aim of Dutch drug policy—reducing the harms to the health of drug users—had been successful, as coffee shops facilitated the separation of hard and soft drug markets. It further noted that the coffee shops did not contribute to high levels of problematic cannabis use, compared to other European countries, and that the tolerance criteria enabled effective control of nuisances (Van de Donk, 2009).

6.4.1 Coffee Shop Tourism

But the Van de Donk Committee also recommended some changes. It expressed concern about the large, professionally organized coffee shops in the southern border provinces and increased trafficking of drugs across the border, citing public order, safety and international criticism (Van de Donk, 2009). At that time several cities closed down their coffee shops, including Terneuzen, or planned to restrict access of foreigners to coffee shops (VOCM, 2011). The committee called it “an urgent necessity” that coffee shops become small-scale establishments again, restricted to local residents and maintaining the separation of soft and hard drug markets (Van de Donk, 2009). Coffee shops should become closed venues, based on a residence criterion. Notably, the committee also mentioned that if this were to take the form of a club with fixed membership, regulating the production and supply of coffee shops would be worth exploring (Van de Donk, 2009).

6.5 The Weed Pass

Seeking to establish coffee shops as “members only” institutions, in May 2012 the government introduced the *weed club pass* on a pilot basis in the three southern provinces. Two new criteria were added to AHOJ-G: **B** and **I**: coffee shops need to be small and closed (*Besloten*) and include only local residents (*Ingezetenen*) (Aanwijzing Opiumwet, 2012). Several studies evaluated the first months of this experience. In line with an almost daily stream of news articles on the ineffectiveness of the weed pass, Maalsté and Hebben (2012) concluded that local residents had stopped frequenting the “controlled environment of the coffee shop, but instead find their way to the illegal market.” Nuisance related to illegal street sales increased, as did feelings of insecurity (SSC, 2012). Local consumers refused to register for their passes at coffee shops, fearing that their privacy would not be guaranteed (Maalsté and Hebben,

2012; Wouters and Korf, 2011; Nijkamp and Bieleman, 2012). As of this writing, opposition among local governments against the weed pass is growing rapidly. Mayors of the G4 (Amsterdam, Rotterdam, The Hague and Utrecht) and many other municipalities have spoken out against the resident criterion (Volkskrant, 2012). As Mayor Aleid Wolfsen of Utrecht said: “The weed pass is a medication for a disease we do not have” (Posthumus, 2012).

Since the September 2012 elections, a new coalition has been formed of Social Democrats (PvdA) and Liberals (VVD). The new government has abolished the weed pass but, as stated in the coalition agreement, seems to insist on restricting access to foreigners. The new agreement also specifies that implementation of the residence criterion will be done in consultation with the municipalities concerned and, if necessary, in stages. The implementation also depends on municipal coffee shop and security policies in order to allow “a tailor-made approach per municipality,” which essentially means that municipalities will have a lot of leeway in the new guidelines. Nonetheless, mayors, civil society groups and an increasing number of parliamentarians are urging the government to drop the idea of the weed pass altogether and also to start experiments with the controlled cultivation of cannabis. Meanwhile, the cities are again spearheading reform, as municipal plans to effectively solve the “backdoor problem” seem to be sprouting. The city of Utrecht plans to start a scientific experiment with NGO “Weed Clubs,” in which adult consumers can grow their own cannabis collectively. Rotterdam also wants to start its own municipal marijuana farm.

6.6 Local Initiatives

Municipalities have important leeway in making local drug policy. While successive governments have emphasized the importance of local policies and initiatives, they did not always adhere to this “Thorbecke principle” of local autonomy. For the coffee shop checkpoint in Terneuzen, for example, concerns over international relations overruled local efforts to regulate nuisance from cross-border coffee shop clients.

Another example of the tension between national and local policies is the proposed experiment in Utrecht to allow recreational users to form an association to grow cannabis collectively, with monitoring of nuisance and leakage to illicit markets (Reinking, 2011). Minister of Justice Ivo Opstelten forbade the experiment (NRC, 2011), even though, as one Utrecht alderman noted, “[T]here are no valid legal arguments to ban a medical-scientific experiment, nationally nor internationally” (Everhardt, interview). The present Ministry of Security and Justice is apparently willing to let municipalities experiment only with repressive approaches.

6.7 Public Opinion

Finally, public and political support for liberal policies is still widespread. A 2008 poll showed that 75 percent of those municipalities with coffee shops think the national government should regulate the wholesale supply to coffee shops (NRC, 2008). And according to a 2010 public opinion poll, 49 percent of the Dutch feel that cannabis should be legalized while 13 percent believe the current policy should be continued. Prohibition of cannabis is favored by only 26 percent of the population (Blickman, 2012). A poll on May 16 2012, showed that the “cannabis pass” has little support among the Dutch population; 61 percent said it did not agree that its introduction was a good idea and 60 percent favored stopping its introduction. Even among the coalition parties that supported the now defunct right-wing government—the Christian Democrats and the conservative liberal party, the People’s Party for Freedom and Democracy (VVD) of Prime Minister Mark Rutte and Justice Minister Opstelten—only potential voters for the Christian Democrats were really in favor. Among potential VVD voters—the party that became the biggest party after the elections—60 percent did not agree with the pass and 59 percent said its introduction should be stopped. Eighty percent of the people expected that street dealing would increase (de Hond, 2012).

7. The Role of Drug Treatment, Social Care and Harm Reduction Programs

With all of the changes since 2000, the Dutch nonetheless did not fundamentally change the harm reduction approach in place since the mid-1970s. Harm reduction included a policy focus on getting homeless people who use drugs off the streets. Cities experimented with local laws, municipal ordinances, public transport bylaws and a wide range of other measures to ensure public safety. Investments were made in housing for people who used drugs. Some of the housing projects are substance-free facilities; in others hard drug use is allowed according to house rules (Schatz, Schiffer and Kools, 2010). Health and social services for people who use drugs in fact are a bedrock of Dutch drug policy. The 1970s were dominated by ideological debates, e.g. abstinence-based treatment versus health maintenance or harm reduction (Blok, 2011). Unfortunately, there was virtually no communication between abstinence-oriented programs, on the one hand, and social support and harm reduction programs, on the other.

Methadone treatment was introduced in 1968 (Van den Brink, 2010). In 1977, Rotterdam started funding low-threshold methadone treatment that specifically targeted those in the street drug scene. In 1979, Amsterdam followed suit by introducing a methadone bus for Surinamese heroin users (Blok, 2008). In 1981, the *Rotterdam Junkie Union* (RJB) published a “black book” critique of methadone treatment programs in the city (Friedman

et al., 2007) and, after its demands were ignored, the RJB organized a *guerrilla* methadone maintenance program, which lasted almost a year (Blok, 2011). This signified a turning point in the discussion on drug treatment and methadone maintenance programs were rapidly expanded. In the 1980s, methadone maintenance became the first-line approach to heroin addiction in the Netherlands (Van de Wijngaart and Verbraeck, 1991).

As early as 1974, drug injection rooms were available in Amsterdam (Blok, 2008; Amsterdam City Archives, ND), to which the police turned a blind eye. The city of Amsterdam tried to address the street scene by establishing drop-in centers, drug consumption rooms and overnight facilities in various out-of-the-way neighborhoods. However, after two of these facilities were burned down, the city started implementing low-threshold methadone programs on a wide scale (Blok, 2008; 2011).

The early injection rooms in Amsterdam also provided their clients with sterile injecting equipment (Blok, 2011). In response to a local epidemic of hepatitis B, the Rotterdam Junkie Union started distributing syringes on the streets in 1981. A few years later, even after the first studies on HIV among people who inject drugs were published in the US, traditional drug treatment providers remained reluctant to introduce needle exchange. A small Rotterdam outreach program run by activists and volunteers then started a modest needle exchange program in 1985. By the end of the 1980s, syringe exchange programs were offered in most Dutch cities, by a variety of organizations and approaches. In 2010, around 107,000 syringes were distributed in Rotterdam and 153,600 in Amsterdam, a decrease from the approximately one million syringes that were distributed between 1990 and 1993 in the capital (EMCDDA, 2012), representing the declining number of people who inject drugs (PWID) in the Netherlands.

7.1 Chasing and the HIV Epidemic

In 1984, the first HIV case linked to drug injection was identified. HIV prevalence among people who inject drugs in Amsterdam quickly rose to 30 percent in the next two years, declining to 26 percent in the second half of the 1990s. Among people who injected drugs in Rotterdam, 12 percent were found to be HIV-positive in 1986, but prevalence never increased further (Beuker et al., 1999). By then the majority of people using hard drugs in Amsterdam and Rotterdam were no longer injecting their heroin and cocaine and gradually users in the rest of the country followed suit. As a result, HIV never affected hard drug users in the Netherlands as it did in the rest of Europe. In 2008, only 4 percent of the Dutch HIV cases were found among people with a history of drug injecting and 0.3 percent of HIV incidence was due to injecting drugs (Van den Brink, 2010; IDU Reference Group, 2010).

By the late 1980s the Dutch heroin epidemic had stabilized. In subsequent years the coverage of methadone maintenance programs further increased. In the 1990s, approximately 70 percent of the heroin users in Rotterdam were in contact with one or more drug agencies yearly—about 35 percent on a daily basis through participation in methadone programs (Toet, 1990; Grund, 1993), similar to figures in Amsterdam. The low threshold of these programs (e.g. no urine controls or sanctions on the use of other drugs; availability of needle exchange in methadone programs) has, without a doubt, contributed to the large proportion of heroin users in drug treatment.

The *Continuity and Change* policy of 1995, described above, noted the successes of the health-focused policies to that date—including low incidence of overdose and of hard drug use—but also ushered in a greater focus on public nuisance linked to both cannabis and heroin. In the years that followed, public health and public order were approached as closely connected problems, and reducing harms to society became a driver of policy. As Professor Wim van den Brink, director of the Amsterdam Institute for Addiction Research (AIAR), explained, since the 1990s, ideology has decreased quite a bit and the Dutch have increasingly become more pragmatic: “The battles over whether addiction is a social construct or a disease ... is something I actively promoted. It is also a transition from labeling people who use drugs as criminals to labeling them patients ... If they are considered ill, they are not treated as criminals, which means they have a right to treatment and are entitled to compensation for that treatment.”

New services were developed—including consumption rooms, housing; employment and training as well as other activities. Methadone doses were increased and heroin assisted treatment (HAT) was introduced as an experiment in 1998 and approved as a regular addiction treatment in 2006 for poorly functioning, therapy-resistant heroin-dependent persons, although under strict conditions (Blanken, 2010; Fischer et al., 2007). By 2000, the Netherlands had the highest opiate substitution treatment (OST) coverage in the EU except for Spain (EMCDDA, 2002), as an estimated 44 percent of the Dutch heroin users were receiving substitution treatment. In Amsterdam 80 percent received methadone or other substitution drugs in programs and from general practitioners (van den Brink, 2010).

Despite the changed political backdrop and growing calls for zero tolerance, the Dutch continued to build a comprehensive and increasingly integrated treatment and social support system targeting problematic drug users, the homeless and chronic psychiatric patients (Schatz, Schiffer and Kools, 2010). At present, there are around 150 specialist syringe exchange programs across the country (EMCDDA, 2012) and about 37 drug consumption rooms (Schatz and Nougier, 2012; EMCDDA, 2012); specialized health care can be accessed through these and other facilities. Most aging street drug users live in sheltered or supported housing and receive welfare, drug treatment and medical care in integrated service centers.

Most of them use their drugs in a drug consumption room, and the use of substances like crack or heroin is no longer publicly visible (Schatz, Schiffer and Kools, 2010).

The Netherlands has a strong tradition of civil society involvement, and taking care of vulnerable populations was traditionally relegated to NGOs and public health bodies. As a result, calls for tougher policies were translated by civil society and public health authorities into an emphasis on getting drug users off the streets. This was achieved not primarily by policing, but by developing a system of drop-in, housing and outreach services. Nonetheless, the criminal justice system became an increasingly important stick. Over the years, in particular when the four largest cities joined hands with the national government after 2006 (Rijk en vier grote steden, 2006), the Dutch approach to problem hard drug use was developed into an integrated mix of social-medical interventions and measured law enforcement responses, aimed at reducing harms to both the individual and the society (Schatz, Schiffer and Kools, 2010). The combined “carrot and stick” approach seems to have been effective in addressing the needs of an aging population of problem drug users, whose drug careers, perhaps extended by cocaine smoking, were already fading.

8. Drug Policy by the Numbers: Outcomes and Costs

The impact of Dutch drug policy can be seen in the data on prevalence of use and of harms. Overall, cannabis use in the Netherlands is on par with the European average. With the exception of ecstasy, the prevalence of use of all other substances by the general population is lower than the European average and that in the United States (ECMDDA, 2012; NDM, 2012), and even ecstasy use is near the European average. The prevalence of problematic use of crack cocaine and heroin in the Netherlands is respectively at and below the European average.

8.1 Cannabis

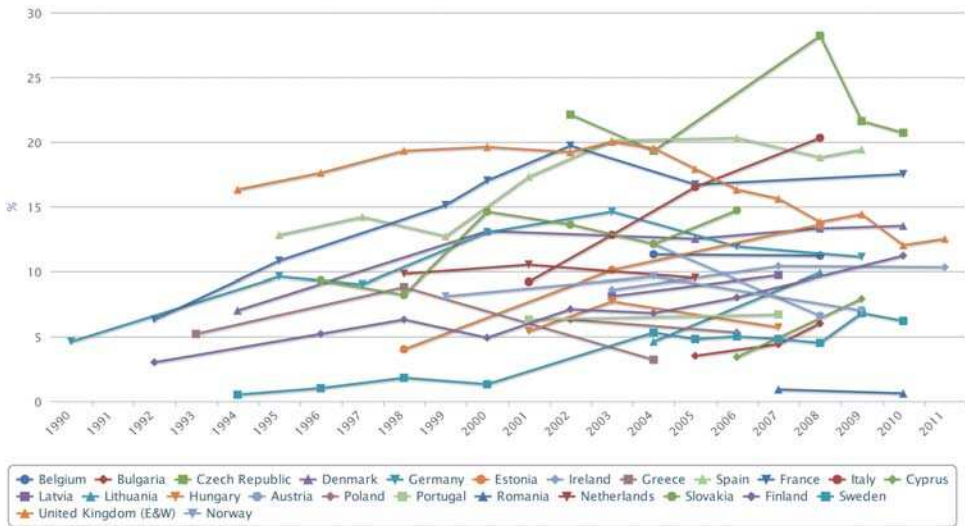
There are no studies to compare the situation before and after the revision of the Opium Act in 1976. Both the lifetime prevalence and recent use of cannabis in the Dutch population between 15 and 64 years (25.7 percent; 7.0 percent) (NDM, 2012) have always been in line with the European average, though the 2011 figures are a bit higher than the European average⁸ (23.2 percent; 6.7 percent) (EMCDDA, 2012). For comparison, the analogous two

8. Which is attributed to variations in measurement.

figures from recent data in Canada were 39.4 percent and 9.1 percent and in the U.S., 41.9 percent and 11.5 percent, well above the Dutch figures (EMCDDA, 2011a; NIDA, 2012; Health Canada, 2011). In comparing the cannabis markets in Amsterdam and San Francisco, Reinerman and colleagues found that neither criminalization (in San Francisco) reduced cannabis use, nor that decriminalization (in Amsterdam) increased cannabis use (Reinerman et al., 2004). Cannabis use in the Netherlands increased between 1997 and 2001, but returned to the 1997 level between 2001 and 2005 (NDM, 2012).

Use of illicit drugs in general among high school students—cannabis no exception—has steadily declined since 1996 (Verdurmen et al., 2012). Recent use of cannabis among young adults (15 to 34 years) in the Netherlands falls within the mid-range in the EU context and is stable (Figure 1; Van Laar, 2009). The variety in cannabis prevalence among EU member states further supports the conclusion that drug policy has little effect on the prevalence of drug use.

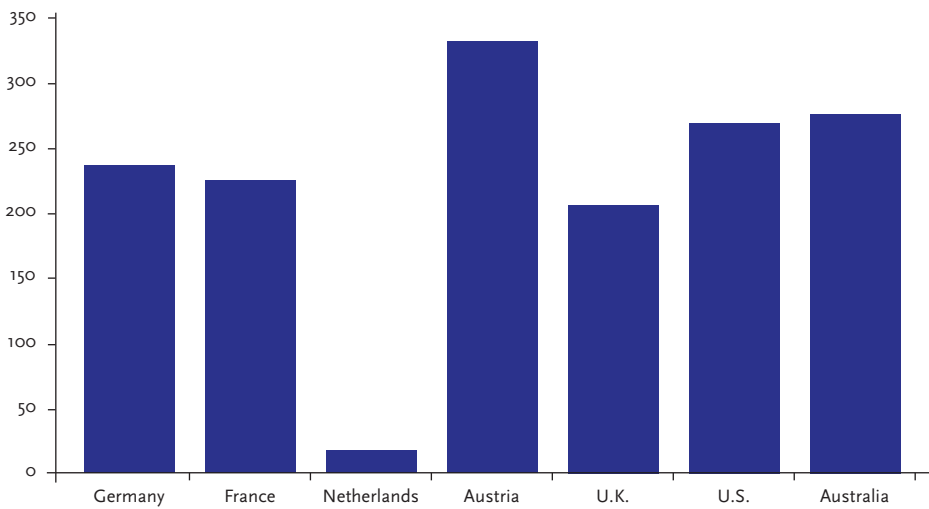
FIGURE 1: Trends in Last 12 Month Cannabis Use among Young Adults, 15–34, in EU Member States and Norway



Source: EMCDDA statistical bulletin 2012 (<http://www.emcdda.europa.eu/stats12#display:/stats12/gpsfig4a>)

The number of treatment admissions with a primary cannabis diagnosis, indicating possible problematic use, tripled between 1995 and 2009 (IVZ, 2011). This increase has been attributed to the increasing potency of *Nederwiet*, but may also be due to the expansion of addiction treatment and care services, targeting cannabis users for treatment, changes in referral policies and changes in the drug choice of problem users (Van Laar, 2009). The increase in treatment for problem cannabis use was also observed in the rest of Europe (EMCDDA, 2011a).

FIGURE 2: ARREST RATES FOR CANNABIS POSSESSION PER 100,000 POPULATION, CA. 2005



Source: The Beckley Foundation (2008), “Cannabis Policy: Moving Beyond Stalemate,” *The Global Cannabis Commission Report* (<http://www.beckleyfoundation.org/Cannabis-Commission-Report.pdf>)

One of the principal motivations for the 1976 revised Opium Act was to prevent the stigmatization and marginalization of cannabis users, of which a criminal record is often the start, as it may be a barrier to employment and educational opportunities. In comparison to other European nations, arrests and convictions for use of illegal substances and possession for personal use are very low in the Netherlands (EMCDDA, 2011a). Figure 2 (source: Room et al., 2008) shows that, beyond any doubt, this aspect of Dutch drug policy has been extremely successful. Arrests, and thus criminal records, for cannabis use or possession are extremely rare in the Netherlands.

8.2 Hard Drugs

Use of hard drugs is not popular among secondary school students (12-18 yrs). With 2.6 percent, ecstasy is the “list 1” drug with the highest lifetime prevalence among students, followed by amphetamine (1.8 percent), cocaine (1.7 percent) and heroin (0.6 percent) (Verdurmen et al., 2012). Among adults, the lifetime prevalence (6.2 percent) and previous year prevalence (1.4 percent) of ecstasy use in the Netherlands (NDM, 2012) are both above European average (3.2 percent; 0.7 percent) (EMCDDA, 2012), but still lower than in the UK (8.3 percent; 1.6 percent) or Australia (10.3 percent; 3 percent) (NDM, 2012). Among 15-35 year old patrons of clubs and large scale dance parties in 2008/9, recent (last year) use of ecstasy was 16 percent and 31 percent, respectively—much higher than in the general population (3 percent) (Van der Poel et al., 2010). But in the same year there were an estimated 600 problem ecstasy users and only 154 actually engaged in treatment (Table 1).

TABLE 1: Number of problem users (estimated) and people in addiction treatment

| Substance | Problem Users ¹⁰ | People in Treatment | Substance | Problem Users | People in Treatment |
|----------------|-----------------------------|---------------------|--------------------------|---------------|---------------------|
| Tobacco | 810.000 | 251 | Amphetamine | 6.000 | 1.504 |
| Alcohol | 477.000 | 36.203 | GHB | 1.200 | 524 |
| Cannabis | 70.000 | 10.971 | Ecstasy | 600 | 154 |
| Powder cocaine | 30.000 | 4.246 | Gambling | 40.000 | 2.673 |
| Crack cocaine | 15.400 | 5.190 | Internet/ Gaming/Chat | 20.000 | 182 |
| Heroin | 17.700 | 12.313 | Other | | 983 |
| | | | Total | 2.002.500 | 76.175 |

The influence of drug policy on the use of Ecstasy may be very limited. In the Netherlands, as elsewhere, the primary drivers of ecstasy use are the electronic dance music culture and nightlife (Nabben, Benschop and Korf, 2012; NDM, 2012; EMCDDA, 2008). Hard drug

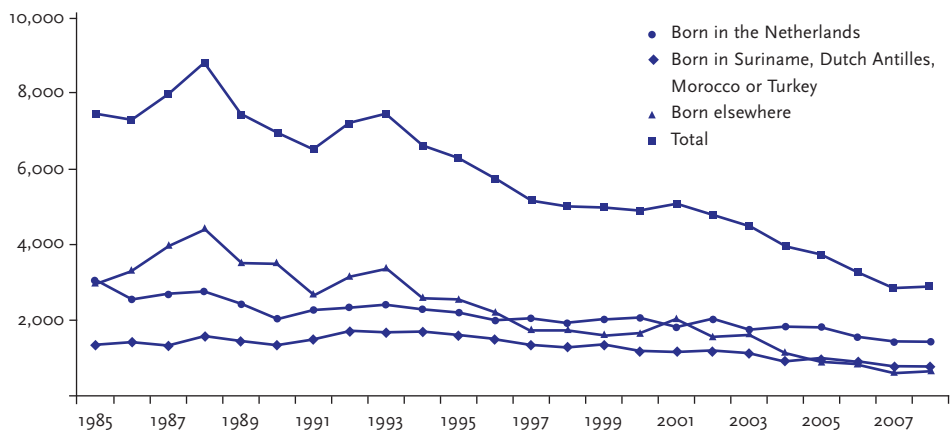
9. The estimates of the number of problem users are based on a number of studies, sometimes based on extrapolations. The numbers of problem cocaine, amphetamine, ecstasy and GHB are deemed “very rough” estimates (Jellinek, 2012).

10. A combination of the DSM-IV diagnoses of dependence and misuse. For example, 82.400 people were diagnosed with alcohol dependence in 2010 and 395.000 with alcohol misuse.

use is higher among cannabis users than in the general population, as is the case virtually worldwide. **Table 1** presents the estimated number of problem cases and people in addiction treatment of various kinds in 2010 and for ecstasy and amphetamine in 2009 (Ouweland et al., 2011).⁹ When compared internationally, the rate of problem drug use is low in the Netherlands, 3.1 per 1000 inhabitants, compared to 9.8 in the UK and 8.5 in Italy and Spain (Van Laar, 2009).

Figure 3 represents the heroin epidemic in Amsterdam between 1985 and 2008. A large number of heroin users from outside the Netherlands came to Amsterdam in the 1980s and 1990s—and still do—making the situation in Amsterdam unique. By 1985, the heroin epidemic had largely peaked and entered into a stage of slow decline (Toet, 1990; Grund, 1993; Van Brussel, 1995). Heroin use remains present in the Netherlands though with minimal incidence and low, slowly declining prevalence (Van Laar et al., 2012; NDM, 2011).

FIGURE 3: Problem Opiate Users in Amsterdam, 1985–2008



Source: Municipal Health Service Amsterdam

The proportion of opiate users between 15 and 29 dropped from 39 percent in 1994 to 6 percent in 2006 (Van Laar, 2009). As already noted, the population of opiate treatment patients is largely middle-aged, average age 45.5, compared to 34 in 1997 (Van Laar, 2009; Wisselink et al., 2012). There are an estimated 17,700 problem opiate users (Cruts et al., 2010), down from 25,000–39,000 in 2002 (Wisselink, Kuijpers & Mol, 2012). About 10

percent of clients in services for opiate users are over 55 years of age. Treatment for heroin addiction increasingly has elements of geriatric care.

8.2.1 Drug Related Harm

Drug injecting continues to decline in the Netherlands. In the last decade, the proportion of recent injectors has halved to a little over 7 percent of all opiate users (Wisselink et al., 2012), the lowest in all of Europe. For example, the proportion in France is 25 percent, the UK 40 percent and Finland 83 percent (EMCDDA, 2009). In recent years, only 4-to-5 percent of HIV infections in the Netherlands are associated with injecting drug use (Van Laar, 2009; Van den Brink, 2010; IDU Reference Group, 2010). With Belgium, The Netherlands has the lowest HIV incidence in Europe (EMCDDA, 2011b).

The Amsterdam cohort study among hard drug users documented a sharp decrease in new HIV and HCV infections between 1985 and 2005 (Lindenburg et al., 2006). Annual incidence of HCV dropped to 2 percent in 2005, compared to 28 percent in the 1980s (Van den Berg et al., 2007). HIV incidence dropped from 8.6 percent in the 1980s to 0 in 2006 and 2007 (Van Laar, 2009).

Although mortality comparisons must be made cautiously because of differing national survey methods, the number of drug-related deaths is relatively low in countries such as Italy, France and the Netherlands (9.5 per one million inhabitants in 2006) and high in Norway, Denmark and Luxembourg (60 per 1 million) (EMCDDA, 2011b). The low number of overdoses among drug users in the Netherlands is the outcome of the low number of people who use hard drugs plus extensive harm reduction and drug treatment services (Van Laar, 2009).

8.3 The Costs of Dutch Drug Policy

Dutch drug policy is definitely not a *laissez faire* approach. Over the years substantial funding went to the social-medical interventions and to law enforcement in particular. In 2003 the Netherlands spent an estimated €2,185 million Euros on drug policy in total, representing 0.5 percent of the country's GDP. About €540 million went to drug prevention, treatment and care services, €42 million for prevention, €278 million for treatment and €220 million for harm reduction. Still, a whopping €1,646 million went to law enforcement and incarceration for drug-related offences (Rigter, 2006).

About €160 million per year goes to the investigation and prosecution of soft drugs crime. At present, the Dutch tax authorities are earning some €400 million a year in corporate taxes from the country's 700 plus cannabis-selling coffee-shops, according to con-

servative estimates by the TV program Reporter in 2008. Further decriminalization and regulation of cannabis production and supply would reduce the pressures on law enforcement and lead to significant cost reductions—up to this €160 million, a Ministry of Finance working group recently calculated. Furthermore, these measures could generate up to about €260 million in tax revenues (Ministry of Finance Working Group, Security and Terrorism, 2010).

9. Conclusions

9.1 The Dutch Applied Tolerance and Informed Dialogue

The Dutch tradition does not shy from controversy. The country has a centuries-long history of taking pragmatic approaches to potentially contentious subjects like abortion, sex work, voluntary euthanasia or use of psychoactive substances. Tolerance and collaboration, despite differences in views or lifestyle, were crucial to the early prosperity of the Netherlands (Bikk, 2007). Early on the state's role was perceived as safeguarding freedom for all of its citizens: "The purpose of the state is freedom," wrote Spinoza in 1670, advocating principal tolerance on all terrains. During the 1960s and 1970s, the Netherlands changed from a rather closed and segregated society, organized along ideological and religious lines, to a more secular and individualized social order. However, the need for pragmatism, tolerance and dialogue did not subside and these qualities remained at the core of Dutch political process.

In spirit, the 1976 Revised Opium Act—effectively decriminalizing possession of cannabis and other illicit substances for personal use and allowing coffee shops to develop—is rooted in the country's early experience with the regulation of opium and cocaine. The development of drug policy in the Netherlands has also largely involved finding middle ground between opposing views and building political majorities around this complex social issue. There was no parliamentary majority for decriminalizing the supply side of the cannabis equation, in 1976 or transactions in drugs other than cannabis, and the Dutch government did not want to risk diplomatic or economic problems with neighboring countries and the international community (Van Agt, interview). During the parliamentary debate in 1976,

D'66 MP Sef Imkamp wanted to go further than the “compromise of Van Agt” because, as he put it: this policy “*is like a lame horse. You have to get on the road with it, but it will not take you far.*” The “lame” compromise eventually allowed consumers safe access to cannabis in establishments tolerated under certain criteria, without securing a regulated and controlled supply to these same tolerated outlets (the back door problem). Nonetheless, this “lame” policy also exemplified responsible use of sometimes underused tools of drug policy—legislative change, reliance on expert committees (although advice is not always followed by government) and civil society, and practical autonomy for local authorities who understood the particular context of drug use in their locations.

Whereas the Dutch did reach compromise and political majorities on a great number of other complex social issues, such as gay marriage and LGBT rights, prostitution, abortion, and assisted euthanasia, no further progress was made on cannabis policy, despite numerous government and civil society initiatives. Dutch politicians dealt with the issue in a pragmatic fashion, illustrated by the words of former Minister of Health Els Borst: “There are policy files where the best approach is to muddle through. It is not a great solution, but I have learned to accept that, while sometimes you cannot defend it on paper, a bit of muddling through is probably the best solution” (interview).

A constant in the history of Dutch drug policy is that it follows practice—from a distance. It is reactive, in the sense that policy follows and reacts to social developments, without proactively taking the lead. Coffee shops are a case in point. They are certainly not a social experiment planned by the government, but the amended 1976 Opium Act opened up the room for local policy and entrepreneurial initiatives.

Although an unanticipated consequence of law and policy change, coffee shops were deemed expedient because they served the goal of preventing heroin use. As the heroin scene faded in the 1980s and 1990s, however, the policy focus inevitably turned to negative aspects of coffee shops, and numerous measures were taken to reduce the number of coffee shops and restrict their room to operate. The key negative side effects of the policy remained unsolved, partly because of the lack of drug policy reform in neighboring countries. Over the years, the influence of criminal organizations in cannabis cultivation and the supply of coffee shops have not subsided, despite enormous investments in law enforcement. Early evaluations and numerous media reports suggest that the weed pass, introduced in 2012, may have reduced the flow of foreign customers to the coffee shops near the borders, but at the cost of increasing drug transactions in the streets and peripheral neighborhoods, while most domestic cannabis users remain reluctant to register at a coffee shop.

9.2 A Positive Balance

The positive outcomes of Dutch drug policies are substantial indeed. Despite the liberal access that coffee shops provide, the prevalence of cannabis use has remained on par with the European average. Cannabis use ceased to be a sign of deviance or part of a subculture in the Netherlands—long before anywhere else in Europe. Most importantly, no Dutch youth will be socially handicapped by a criminal record for the mere possession of consumer amounts of cannabis or other drugs. As summarized in section 6, the remarkable successes in the area of hard drugs include averting a drug-linked HIV epidemic, the virtual disappearance of drug injection, and comprehensive health and social services for the aging problem drug users. Moreover, unlike many other countries in the EU, where overall about 21 percent of inmates have initiated drug injecting in prison (EMCDDA, 2002), Dutch prisons are not transmission hubs for HIV infection.

The successes of Dutch drug policy can perhaps best be explained as an interaction between drug policy—including both health services and law enforcement—and a multitude of other factors. External dynamics, like immigration and urban renewal policies, heavily influenced the outcomes of policy and subsequent changes in drug markets. In addition, some successful outcomes were the result of simple luck. For example, Dutch heroin users were abandoning injecting even before the arrival of HIV, while an extensive system of low-threshold treatment and harm reduction services was already in place. HIV prevention was then inserted into the existing services comparatively seamlessly.

9.3 The Dialectics of Progress

At the end of the 1990s and in the 21st century, Dutch drug policy has clearly been affected by what Dutch historian and journalist Jan Romein (1937) termed the “law of the handicap of a head start.” The initial head start in progressive drug policies became a burden in the long term. Dutch policies have clearly paid off—the hard drug problem has been largely contained, and cannabis use remained within acceptable limits, while cannabis consumers don’t risk acquiring criminal records. Successive Dutch governments had hoped that these demonstrated successes would convince at least neighboring states to implement similar policies. When it comes to hard drug policies, this has in fact happened. HIV prevention measures, substitution treatment and needle exchange are standard practice in most EU member states.

However, as the Dutch were relatively successful in dealing with their own drug problems, they became more vulnerable to those of their neighbors. Without much international

support, the Netherlands struggled with drug tourism from neighboring countries with less liberal policies. At the same time, the Dutch government felt unable to regulate the back door because of alleged potential diplomatic and economic consequences. New generations of politicians seem to have forgotten why many harm reduction measures were taken in the past, and nuisance is nowadays measured by a different, stricter standard.

10. Lessons Learned

10.1 Decriminalization of Individual Possession Does Not Increase Drug Use

Cannabis use in the Netherlands peaked around 1996, after which it declined. The emergence of coffee shops in the 1980s may have resulted in initial increases in use, but these cannot be disentangled from strong social forces, such as the economic crisis and high unemployment rates, music and youth culture, and globalization, to name but a few factors cited by our respondents. The Dutch experience has thus not been a slippery slope towards ever increasing drug problems. To the contrary, the Dutch policy of tolerance is not, as international critics have sometimes suggested, “one of closed eyes or of turning a blind eye, but one of keeping your eyes open, wide open” (Van der Ham, 2011).

The Dutch policy of tolerance is not, as international critics have sometimes suggested, one” of turning a blind eye, but one of keeping your eyes open, wide open.”

One could argue that Dutch policy did not result in decreases in cannabis use. However, this was not the overall aim of the policy, which since the early 1970s has been to protect the health and social wellbeing of both the individual and the public. Moreover, the Dutch hard drug epidemic has been brought under control. Most respondents see this as a

direct consequence of the separation of drug markets, legally sanctioned in 1976, and the public health-driven drug policies developed in the 1970s and 1980s.

10.2 Separating Drug Markets Is Legally and Practically Possible—and Successful

The relatively low level of problem drug use in the country sets the Netherlands apart from other EU countries. Separating cannabis from the then-available hard drugs, as the Dutch pragmatically did in the 1970s, turned out to be an important step in controlling the concurrent epidemic of hard drug use. This suggests that firmly separating drugs with “unacceptable risks” from those with less worrisome risk profiles is good for public health.

10.3 Separated Drug Markets Result in Fewer Criminal Records, Less Social Exclusion and More Controlled Consumption

Arrests or criminal records for the possession of small amounts of cannabis are virtually absent in the Netherlands; although the tolerated amounts differ, the same applies to hard drugs. Nonetheless, many Dutch problem (hard) drug users do have criminal records and have spent time in prison for other—mostly minor—infractions. As in the rest of Europe, many problem drug users come from disadvantaged communities, as do quite a few of the consumption-level heroin and cocaine dealers. These backgrounds are reflected in the prison population. However, as Mario Lap (interview) pointed out, the absence of criminalization has prevented drugs from becoming instrumental in over policing minority communities, as has happened in France, for example. Nor are there “no go” zones in the Netherlands, neighborhoods, typically dominated by drug markets, into which the police cannot venture.

Dutch drug policy does not condone the use of mind altering substances, but these substances are no longer automatically associated with deviance in the Netherlands. Cannabis in particular, but also drugs like mushrooms and ecstasy, have been acculturated and to a large degree normalized, as are—to a large extent—the problems associated with heavy drug use. Drugs like crack cocaine and heroin, however, continue to hold strong stigma—both among the public and medical providers—but they no longer raise moral panic. The 1976 legislative changes and the resulting normalization brought the drug issue in plain

sight, allowing for a more realistic perspective on both recreational and problem drug use and exposing these to mainstream social controls. The Netherlands has the lowest level of problem drug use in the EU (Van Laar, 2009) and the overall prevalence of drug use in the general population is below the EU average and well below that in the United States (ECMDDA, 2012; NDM, 2012).

A substantial proportion of Dutch citizens do use various substances other than alcohol, and for most this is limited to their formative years with differences between the sexes, social economic status and ethnic groups fading.¹¹ As noted, The Netherlands has the lowest level of problem drug use in the EU; the large majority of drug consumers use drugs “recreationally” without many complications and are not locked in into deviant subcultures. The virtual absence of injecting drug use, blood borne diseases and the low number of overdoses among problem drug users finally suggests that even hard drug users seem to be exercising a fair degree of control over their drug consumption (Grund, 1993).

10.4 Keep Expectations Low Regarding the (Immediate) Effects of Drug Policy on Use

The primary objective of Dutch drug policy never was to ban drug use outright, but to contain associated social and medical problems. Given the lifespan of epidemics of addictive drug use and the role of youth culture and nightlife in recreational—mostly unproblematic—drug use, the immediate effects of drug policy on prevalence are a feeble measure of the success of drug policy. “Prevalence [of use] is almost policy-resistant,” as former drug policy maker Marcel de Kort put it eloquently.

“Prevalence [of use] is almost policy-resistant”-- Marcel de Kort

11. Which is likely due to normalization, emancipation, merging musical preferences and other factors.

10.5 Public Health-driven Drug Policy Contributes to Reduction of Drug-related Harm

In contrast to the weak link between policy and drug use prevalence, the effects of drug policy on drug-related harms are more direct, immediate and, furthermore, more meaningful outcomes for society. Problem hard drug users are rapidly aging in the Netherlands and drug-related mortality is relatively low. Refraining from injecting, most have avoided HIV. Leaving problem drug users at home addresses relatively undisturbed—in an effort to contain nuisance—is central to explanations for the comparatively low number of HIV cases or overdose deaths in the country.

10.6 Change Should Be Comprehensive, Regulating Sale to Consumers, Wholesale Supply and Cultivation

Virtually all respondents in our study agree that the failure to regulate the supply to coffee shops and cannabis cultivation is the source of many of the current negative side effects of the Dutch cannabis policy—from the involvement of criminal enterprise to the lack of quality control. If there is one lesson to take away from the Dutch experience, it is that when taking steps toward regulating cannabis (or other drugs), these should include the entire chain of supply, from production to consumption. This prevents engagement with criminal elements and allows for quality control, increased tax income and decreased public spending. Policies should also be reflective of local or regional differences in a country, such as those between large cities and smaller communities. For example, although both Amsterdam and Maastricht deal with drug tourism, their needs and problems are very different. Likewise, coffee shops are not the only model for controlled cannabis distribution, as suggested by the Utrecht proposal for a closed-system growing club, Spanish “cannabis social clubs,” medical outlets in California, and legalized recreational marijuana use in Colorado and Washington in the US. Note that these alternative distribution models were developed at the local or regional (state) level.

Therefore, public health-driven policy in the Netherlands also importantly includes cooperation between different levels of government and a large degree of autonomy for civil society, local health and other officials to respond to situations that they understand best.

10.7 The Human Factor in Policy-making

Finally, as in Csete's study of Czech drug policy (2012), we have noted an important human factor in Dutch drug policy making. Several respondents pointed out that it is not only the party affiliation of politicians and ministers that influences their position on drug policy, but just as much their personal interest in this policy file that determines the priority given to furthering drug policy. Perhaps more importantly, into the late 1990s, the seat of national drug policy making was located in the interdepartmental steering group on alcohol and drugs (ISAD), which was chaired by a senior policy officer of the Ministry of Health. Within the Ministry of Health, the key policy makers included medical doctors, a sociologist and a historian—dedicated people who had healthy doubts about the repression of drug users or prohibition in general. Of special importance has been Eddy Engelsman, who was—as the face of Dutch drug policy until 1992, when he left the MoH drug department—a steady force for rational, pragmatic and balanced policy making in which health is the goal and law enforcement but one of the instruments to achieve it.

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Annex: List of Respondents

Academic experts

- ▶ Wim van den Brink. Professor of Psychiatry and Addiction Care at the Academic Medical Center of the University of Amsterdam (AMC–UvA). Co-founder and director of the Amsterdam Institute for Addiction Research (AIAR).
- ▶ Martin Jelsma. Fellow at TNI (Transnational Institute), Drugs and Democracy Programme Coordinator. Political scientist specialized in Latin America and international drugs policy.
- ▶ Dirk Korf. Director of Bongor Institute for Criminology for the University of Amsterdam (UvA), Professor in Criminology.
- ▶ Nicole Maalsté. Senior Researcher at Law School of Tilburg School of Politics and Public Administration. Investigative journalist and owner at Acces Interdit.
- ▶ Egbert Tellegen. Professor in Sociology and Environmental Studies at the Universiteit Utrecht. Author of “The Utopia of the War on Drugs” (Het utopisme van de drugsbestrijding).

(Former) Government officials and politicians

- ▶ Dries van Agt. Former Prime Minister of the Netherlands (1977–1982), Former Minister of Justice (1971–1977).

- ▶ Dr. Els Borst-Eilers. Former Minister of Health, Welfare and Sport (1994–2002). Former Deputy Prime Minister, former Director of Academic Hospital in Utrecht, former Professor in Evaluation of Clinical Practice. Vice Chair of the Dutch Health Council.
- ▶ Lea Bouwmeester. Member of Parliament for Dutch Labour Party, PvdA (Partij van de Arbeid).
- ▶ Hedy D’Ancona. Former Secretary of State for Social Affairs. Former Minister of Welfare, Health and Culture (1989–1994). Spokesperson on drugs as member of the European Parliament.
- ▶ André Elissen. Member of Parliament for Party for Freedom. Former detective for Central Criminal Investigation Department, specialization in drugs.
- ▶ Victor Everhardt. Alderman for the Municipality of Utrecht (D’66–Democrats 66). Former senior researcher at Trimbos institute, former officer at Ministry of Health, Welfare and Sport.
- ▶ Boris van der Ham. Member of Parliament for Democrats 66 (D’66).

Policy makers

- ▶ Eddy Engelsman. Former senior Policy Officer at Ministry of Welfare, Health and Culture. Former director of ‘Alcohol, Drugs and Tobacco,’ former representative of Ministry of Health for the European Union in Brussels.
- ▶ Marcel de Kort. Senior Policy Officer for International Affairs at the Ministry of Health, Welfare and Sport. Member of EMCDDA Management Board. Former coordinator research and monitoring at the drugs department and programme commission ‘Addiction.’ Also former deputy head of ‘Alcohol, Tobacco and Drugs.’

Civil society representatives

- ▶ André Beckers. Attorney at law. Exclusively focuses on cannabis. Former policeman in the eighties.
- ▶ Jeroen Bos. Partner of coffee shop ‘t Grasje in Utrecht. Involved with PCN (Platform Cannabis Enterprises) in the Netherlands.
- ▶ Jaap Jamin. Team manager Addiction Prevention and Senior Health Education officer at Jellinek Prevention, Amsterdam.

- ▶ Mario Lap. President of the board of Drugtext Foundation. Technical commissioner INPUD (International Network of People who Use Drugs).
- ▶ Frederik Polak. Independent Psychiatrist. Board member of Dutch Drug Policy Foundation, president of ENCOD (The European Coalition for Just and Effective Drug Policies), board member of VOC (Association for the Abolition of Cannabis Prohibition), board member of MDHG (Interest Group for Drug Users).

Law enforcement officials

- ▶ Joop van Riessen. Former Chief Superintendent of Police. Former advisor for the COT Institute for Safety and Crisismanagement. Head of 'Joop van Riessen, Communication & Advice.'
- ▶ Hans van Duijn. Speaker and member of Advisory Board of LEAP (Law Enforcement Against Prohibition). Former chairman of the Dutch National Police Union.

About the Authors

Jean-Paul Grund completed an advanced degree in Clinical and Developmental Psychology at Utrecht University and received a Ph.D. in Social Science from Erasmus University in Rotterdam. He is Research Director at the Addiction Research Centre (CVO) in Utrecht, the Netherlands and a senior research associate at the Department of Addictology, First Faculty of Medicine, Charles University in Prague, General University Hospital in Prague, Czech Republic. Previously he held faculty and research positions at the University of Connecticut and Beth Israel Medical Center, Albert Einstein College, Yeshiva University in New York. He established outreach and syringe exchange in Rotterdam and was a Regional Technical Advisor HIV Prevention and Injecting Drug Use at UNAIDS in Vienna. Dr. Grund was the founding director of the International Harm Reduction Development Program of the Open Society Institute in New York.

Joost Breeksema holds a Master's degree in Philosophy and has worked as a social scientist at the Addiction Research Centre (CVO) since 2007, where he conducted research on compliance with and enforcement of the coffee shop system. He also lectures on Dutch drug policy for several international courses at the University of Amsterdam. Presently he works as project leader for Dutch harm reduction organization Mainline and as chairman and co-founder of the OPEN foundation he actively dedicates himself to stimulating scientific research into psychedelics.

Global Drug Policy Program

Launched in 2008, the Global Drug Policy Program aims to shift the paradigm away from today's punitive approach to international drug policy, to one which is rooted in public health and human rights. The program strives to broaden, diversify, and consolidate the network of like-minded organizations that are actively challenging the current state of international drug policy. The program's two main activities consist of grant-giving and, to a lesser extent, direct advocacy work.

At present, global drug policy is characterized by heavy-handed law enforcement strategies which not only fail to attain their targets of reducing drug use, production, and trafficking, but also result in a documented escalation of drug-related violence, public health crises, and human rights abuses.

Open Society Foundations

Active in more than 100 countries, the Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. Working with local communities, the Open Society Foundations support justice and human rights, freedom of expression, and access to public health and education.

Drug policies that are based on human rights and promote public health are a priority for the Open Society Foundations. Our efforts focus on promoting collaboration and expanding the range of stakeholders committed to drug policy reform, empowering drug users to advocate for their rights at the national and international level and supporting research into the economic and social costs of current drug policies.

Coffee Shops and Compromise: Separated Illicit Drug Markets in the Netherlands is the fourth in a series of publications by the Open Society Foundations' Global Drug Policy Program that documents positive examples of drug policy reform around the world. We hope these case studies will inspire policymakers and advocates in consultation with people who use drugs and others affected by drug policy to design rights-centered policies that are scientifically sound and humane.

The drug policy of the Netherlands—famous for coffee shops where cannabis can be purchased and consumed—exemplifies good decision-making in many ways and has had many successful outcomes. These include low prevalence of HIV among people who use drugs, negligible incidence of heroin use, lower cannabis use among young people than in many stricter countries, and a citizenry that has generally been spared the burden of criminal records for low-level, non-violent drug offenses. *Coffee Shops and Compromise* explains how these results have been accomplished.

In addition to drug policy reform, the Open Society Foundations work around the world to advance health, rights and equality, education and youth, governance and accountability, and media and arts. We seek to build vibrant and tolerant democracies whose governments are accountable to their citizens.

