DRUG DECRIMINALIZATION IN PORTUGAL

LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES

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Executive Summary

On July 1, 2001, a nationwide law in Portugal took effect that decriminalized all drugs, including cocaine and heroin. Under the new legal framework, all drugs were "decriminalized," not "legalized." Thus, drug possession for personal use and drug usage itself are still legally prohibited, but violations of those prohibitions are deemed to be exclusively administrative violations and are removed completely from the criminal realm. Drug trafficking continues to be prosecuted as a criminal offense.

While other states in the European Union have developed various forms of de facto decriminalization—whereby substances perceived to be less serious (such as cannabis) rarely lead to criminal prosecution—Portugal remains the only EU member state with a law explicitly declaring drugs to be "decriminalized." Because more than seven years have now elapsed since enactment of Portugal's decriminalization system, there are ample data enabling its effects to be assessed.

Notably, decriminalization has become increasingly popular in Portugal since 2001. Except for some far-right politicians, very few domestic political factions are agitating for a repeal of the 2001 law. And while there is a widespread perception that bureaucratic changes need to be made to Portugal's decriminalization framework to make it more efficient and effective, there is no real debate about whether drugs should once again be criminalized. More significantly, none of the nightmare scenarios touted by preenactment decriminalization opponents—from rampant increases in drug usage among the young to the transformation of Lisbon into a haven for "drug tourists"—has occurred.

The political consensus in favor of decriminalization is unsurprising in light of the relevant empirical data. Those data indicate that decriminalization has had no adverse effect on drug usage rates in Portugal, which, in numerous categories, are now among the lowest in the EU, particularly when compared with states with stringent criminalization regimes. Although postdecriminalization usage rates have remained roughly the same or even decreased slightly when compared with other EU states, drug-related pathologies—such as sexually transmitted diseases and deaths due to drug usage—have decreased dramatically. Drug policy experts attribute those positive trends to the enhanced ability of the Portuguese government to offer treatment programs to its citizens—enhancements made possible, for numerous reasons, by decriminalization.

This report will begin with an examination of the Portuguese decriminalization framework as set forth in law and in terms of how it functions in practice. Also examined is the political climate in Portugal both pre- and postdecriminalization with regard to drug policy, and the impetus that led that nation to adopt decriminalization.

The report then assesses Portuguese drug policy in the context of the EU's approach to drugs. The varying legal frameworks, as well as the overall trend toward liberalization, are examined to enable a meaningful comparative assessment between Portuguese data and data from other EU states.

The report also sets forth the data concerning drug-related trends in Portugal both pre- and postdecriminalization. The effects of decriminalization in Portugal are examined both in absolute terms and in comparisons with other states that continue to criminalize drugs, particularly within the EU.

The data show that, judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success. Within this success lie self-evident lessons that should guide drug policy debates around the world.

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Portugal is the only European Union state explicitly to "decriminalize" drug usage.

Introduction

Around the globe, countries approach drug policy in radically different ways. In Communist China and various Muslim nations, drug traffickers and, in some instances, even those found guilty of possession of narcotics, receive draconian prison sentences and are even executed. At the other end of the policy spectrum, most people think of the Netherlands, which has long been perceived as leading the way in drug liberalization and, at least in Amsterdam, has long maintained a drug-tolerant culture, though it has never legalized drugs. Most countries, of course, fall somewhere in between. In the 1980s, the global policy trend was toward harsher criminalization approaches, even at the user level. In recent years, however, as drug policymakers have attempted to formulate policy recommendations for how best to manage drug-related problems exclusively on empirical grounds, there are signs that countries in every region of the world are reversing course.[1] This study will focus on one such reversal in Europe—Portugal's dramatic 2001 decriminalization policy.

Decriminalization, Depenalization, and Legalization

On July 1, 2001, a nationwide law in Portugal took effect that decriminalized all drugs, including cocaine and heroin. Since the enactment of that law, Portugal is and remains the only European Union state explicitly to "decriminalize" drug usage. The statute, in Article 29, uses the Portuguese word *descriminalização*—decriminalization—to describe the new legal framework it implements. "Decriminalization" applies to the purchase, possession, and consumption of all drugs for personal use (defined as the average individual quantity sufficient for 10 days' usage for one person).

Even in the decriminalization framework, drug usage and possession remain prohibited (i.e., illegal) and subject to police intervention. But "decriminalization" means that infractions have been removed completely from the framework of the criminal law and criminal justice system. Instead, they are treated as purely administrative violations, to be processed in a noncriminal proceeding.

It is important to distinguish between "decriminalization," the de jure scheme enacted by Portugal, and mere "depenalization," the prevailing framework in several EU states that have not decriminalized drug usage. The central agency of the European Union for coordinating drug policy data is the European Monitoring Centre for Drugs and Drug Addiction and in 2005, that agency promulgated the following definitional distinction between "decriminalization" and "depenalization":

> "Decriminalisation" comprises removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within the framework of the criminal law.
>
> [By contrast],"depenalization" means relation of the penal sanction provided for by law. In the case of drugs, and cannabis in particular, depenalization generally signifies the elimination of custodial penalties.[2]

In sum, "decriminalization" means either that only noncriminal sanctions (such as fines or treatment requirements) are imposed or that no penal sanctions can be. In a "depenalized" framework, drug usage remains a criminal offense, but imprisonment is no longer imposed for possession or usage even as other criminal sanctions (e.g., fines, police record, probation) remain available. "Legalization"—which no EU state has yet adopted—means that there are no prohibitions of any kind under the law on drug manufacturing, sales, possession, or usage.

As set forth below, several EU states have developed either formal or de facto forms of depenalization, particularly for personal cannabis usage. But no EU state other than Portugal has explicitly declared drugs to be "decriminalized."

Portugal's Decriminalization Regime: How It Works

The 2001 Portuguese decriminalization statute was enacted to revise the legal framework applicable to the consumption of all narcotics and psychotropic substances, together with what the European Monitoring Center for Drugs and Drug Addiction describes as "the medical and social welfare of the consumers of such substances without medical prescription." The statute's operative decriminalization clause is set forth in Article 2(1), which provides:

> The consumption, acquisition and possession for one's own consumption of plants, substances or preparations listed in the tables referred to in the preceding article *constitute an administrative offence*. (emphasis added)

The referenced preceding article encompasses "narcotics and psychotropic substances" and includes a table of all "plants, substances or preparations" that were previously criminalized.

The key phrase—"for one's own consumption"—is defined in Article 2(2), as a quantity "not exceeding the quantity required for an average individual consumption during a period of 10 days." Decriminalization does not apply to "drug trafficking," which remains criminalized and is defined as "possession of more than the average dose for ten days of use."[3]

No distinction is made between the types of drug (so-called hard drugs or soft drugs), nor does it matter whether consumption is public or private. Personal possession and consumption of all narcotics, no matter where they occur or for what purpose, are now decriminalized in Portugal. As noted, "decriminalization" is not synonymous with "legalization." Drug usage is still prohibited under the law of Portugal, but it is treated strictly as an administrative, not a criminal, offense.

Thus, Article 15 of the law, entitled "Penalties," sets forth the authorized administrative sanctions for violations. In lieu of criminalization, the Portuguese law, in Article 5, establishes "Commissions for Dissuasions of Drug Addiction," the body solely responsible for adjudicating administrative drug offenses and imposing sanctions, if any. The first section of the law's penalty section, Article 15, provides, "Non-addicted consumers may be sentenced to payment of a fine or, alternatively, to a non-pecuniary penalty." Article 17, entitled "Other Penalties," provides in Section (1) that "instead of a fine, the commission may issue a warning."

In theory, offenders can be fined an amount between 25 euros and the minimum national wage. But such fines are expressly declared to be a last resort. Indeed, in the absence of evidence of addiction or repeated violations, the imposition of a fine is to be suspended.

While the Dissuasion Commissions are not authorized to mandate treatment, they can make suspension of sanctions conditioned on the offender's seeking treatment. This is typically what is done, though in practice, there are very few ways to enforce the condition, since violations of a commission's rulings are not, themselves, infractions of any law.[4] In fact, Dissuasion Commissions are directed by Article 11(2) to "provisionally suspend proceedings"—meaning to impose no sanction—where an alleged offender with no prior offenses is found to be an addict but "agrees to undergo treatment."

Where the offender is deemed to be a non-addicted consumer of drugs and has no prior offenses, the commissions are *mandated* by Article 11(1) of the decriminalization law to "provisionally suspend proceedings," whereby no sanction is imposed. Article 11(3) vests the commissions with discretion to "provisionally suspend proceedings" even for an addict who has a prior record, provided he or she agrees to undergo treatment. Alternatively, under Article 14, a commission, in the case of an addict with a prior record, can impose sanctions but then immediately suspend them contingent on ongoing treatment. In the event that treatment is completed and there is no subsequent offense, the proceeding will be deemed closed after a specified time period.

In theory, the Dissuasion Commissions are able to impose on offenders found to be

Personal possession and consumption of all narcotics, no matter where they occur or for what purpose, are now decriminalized in Portugal.

addicts a wider range of sanctions under Article 17, including suspension of the right to practice a licensed profession (doctor, lawyer, taxi driver); a ban on visiting high-risk locales (nightclubs); a ban on associating with specified individuals; requiring periodic reports to the commission to show there is no ongoing addiction or abuse; prohibitions on travel abroad; termination of public benefits for subsidies or allowances; or a mere oral warning.

Article 15(4) sets forth a variety of factors the commissions should consider in determining what sanction, if any, should be imposed. Such factors include the seriousness of the act; the type of drug consumed; whether consumption was public or private; and whether usage is occasional or habitual. The commissions are vested with the sole discretion to determine the extent to which these factors should be considered and how they should determine the appropriate disposition of cases.

Minors who are cited for drug possession or usage enter the same process and, pursuant to Article 3, are aided by a legal representative, who is authorized to make decisions for the minor. But furnishing drugs to a minor (or people with mental illness) continues to be forbidden by the general law that regulates drug issues and is considered an aggravating circumstance to the ongoing prohibition on "trafficking and other illicit activities," which is punishable by imprisonment of between 4 to 12 years.

Decriminalization in Practice

Pursuant to the 2001 law, each of the 18 administrative districts in Portugal established at least one Dissuasion Commission to oversee the administrative process for those cited for drug usage or possession (large districts, such as the one encompassing Lisbon, have more than one). As provided for by Article 7 of the decriminalization law, each commission consists of three members—one who is appointed by the Ministry of Justice and the other two members appointed jointly by the Minister of Health and the government's coordinator of drug policy. The member appointed by the Ministry of Justice will have a legal background, while at least one of the other two members (usually both) will have a medical or social services background (physician, psychologist, social worker).

Even in the decriminalization framework, police officers who observe drug use or possession are required to issue citations to the offender, but they are not permitted to make an arrest. The citation is sent to the commission, and the administrative process will then commence. The cited offender appears before the commission within 72 hours of the citation's issuance. If the commission finds compelling evidence of drug trafficking, it will refer the case to criminal court.

The effect that the decriminalization regime has had on police conduct with regard to drug users is unclear and is the source of some debate among Portuguese drug policy experts. There are, to be sure, some police officers who largely refrain from issuing citations to drug users on the grounds of perceived futility, as they often observe the cited user on the street once again using drugs, leading such officers to conclude that the issuance of citations, without arrests or the threat of criminal prosecution, is worthless.

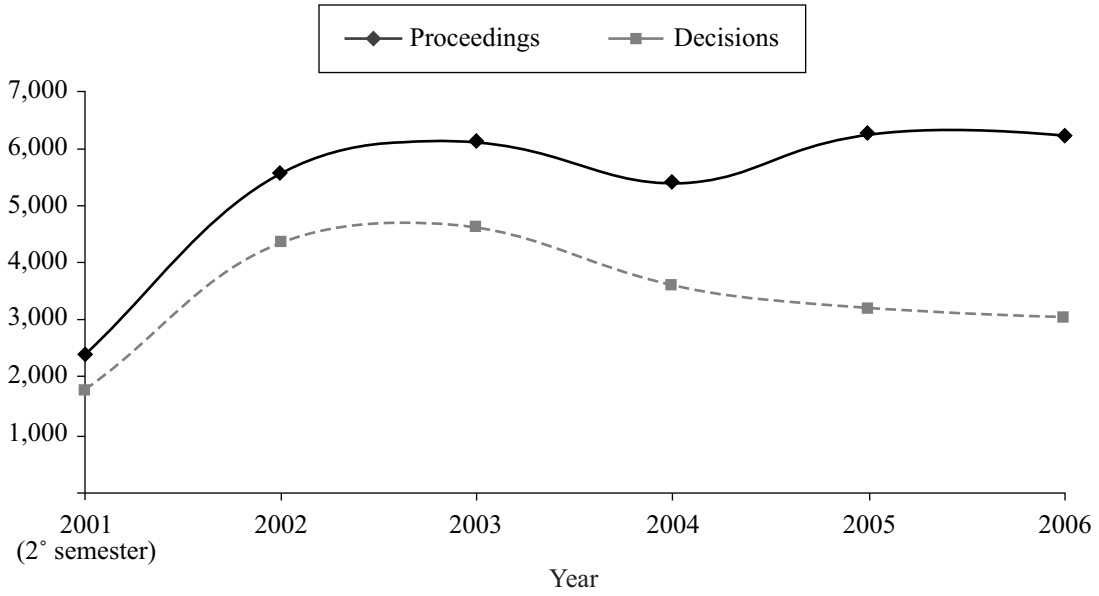
Other police officers, however, are *more* inclined to act when they see drug usage now than they were before decriminalization, as they believe that the treatment options offered to such users are far more effective than turning users into criminals (who, even under the criminalization scheme, were typically back on the street the next day, but without real treatment options). One 2007 paper contended:

> The law enforcement sector was seen as supportive of the reform, particularly because they perceived decriminalization and referral to education and treatment as offering a better response to drug users than under the previous legislative approach. Key informants asserted law enforcement have embraced the more preventative role for drug users.[5]

Some Portuguese drug officials believe this dichotomized reaction among police officers to be split largely along generational

Furnishing drugs to a minor (or people with mental illness) continues to be forbidden by the general law.

Figure 1
Administrative Infraction Proceedings and Decisions, by Year*



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 35.
*Year in which the deed punishable as a misdemeanor occurred. Information gathered as of March 31 of the year after the occurrence of the deed punishable as a misdemeanor.

lines: older officers are inclined to believe that the decriminalization scheme makes issuing citations a waste of their time, whereas younger officers view the administrative process as the best hope for containing addiction. The inability to quantify negative events—that is, officers who refrain from issuing citations on the grounds of perceived futility—renders anecdotal evidence the most reliable for assessing police behavioral reaction to decriminalization.

What is clear is that the number of cases referred to the administrative process has increased slowly and more or less steadily since the enactment of decriminalization in 2001, suggesting (without proving) that officers are issuing citations at least at the same rates, if not more enthusiastically, than when the law was first enacted (see Figure 1).[6]

In theory, under Article 3 of the decriminalization law, both private and government physicians are permitted to notify the Dissuasion Commissions if they have reason to suspect drug use in their patients. In reality, however, such reporting is extremely rare for several reasons, including the widespread belief among physicians that such reporting violates doctor-patient confidentiality.

As noted, the decriminalization law sets forth numerous criteria that Dissuasion Commissions are to consider in determining the proper disposition of each case. Article 10 of the decriminalization law directs the commission to hear from the alleged offender and to "gather the information needed in order to reach a judgment as to whether he or she is an addict or not, what substances were consumed, the circumstances in which he was consuming drugs when summoned, the place of consumption and his economic situation." Which of these are to be weighed, and the weight they are to receive, are left to the sole discretion of the commission members. The alleged offender has the right to request

Many physicians believe that reporting suspected drug use to the authorities would violate doctor-patient confidentiality.

Fears of "drug tourism" have turned out to be completely unfounded.

that a therapist of his choice take part in the proceedings and/or that a medical examination be conducted to aid in determining the various factors the commission might consider.

Portuguese and European officials familiar with the Dissuasion Commission process emphasize that the overriding goal of that process is to avoid the stigma that arises from criminal proceedings. Each step of the process is structured so as to de-emphasize or even eliminate any notion of "guilt" from drug usage and instead to emphasize the health and treatment aspects of the process.

The alleged offender, for instance, can request that notice of the proceedings not be sent to his home in order to preserve privacy. Commission members deliberately avoid all trappings of judges, and the hearing is intentionally structured so as to avoid the appearance of a court. Members dress informally. The alleged offender sits on the same level as the commission members, rather than having the members sit on an elevated platform. Commission members are legally bound to maintain the complete confidentiality of all proceedings. At all times, respect for the alleged offender is emphasized.

In determining what, if any sanction, should be imposed, the commission often takes account of the seriousness of the drug that was used. The EMCDDA identifies the probable sanction for possession of cannabis as "suspension of sanction with probation."[7]

In 2005, there were 3,192 commission rulings. Of those, 83 percent suspended the proceeding; 15 percent imposed actual sanctions; and 2.5 percent resulted in absolution.[8] That distribution has remained constant since the law's enactment.[9] Of the cases where sanctions were imposed, the overwhelming majority merely required the offenders to report periodically to designated locales.[10]

Cannabis continues to be the substance for which the greatest percentage of drug offenders are cited. The percentages for the other substances remain roughly the same (see Figure 2).[11]

Before the enactment of the decriminalization law, opponents insisted that the proposed change in law would make Portugal a center of so-called drug tourism. Paulo Portas, leader of the conservative Popular Party, said: "There will be planeloads of students heading for [Portugal] to smoke marijuana and take a lot worse, knowing we won't put them in jail. We promise sun, beaches and any drug you like."[12] Such fears have turned out to be completely unfounded.[13] Roughly 95 percent of those cited for drug offenses every year since decriminalization have been Portuguese.[14] Close to zero have been citizens of other EU states (see Table 1).[15]

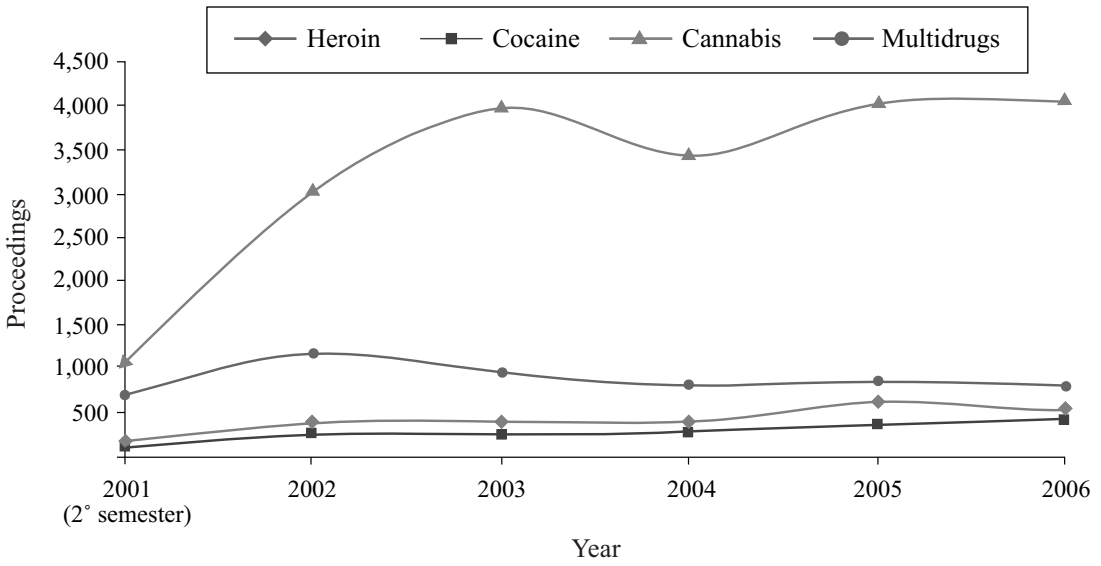
Political Climate in Portugal Pre- and Postdecriminalization

The political impetus for decriminalization was the perception that drug abuse—both in itself and its accompanying pathologies—was becoming an uncontrollable social problem, and the principal obstacles to effective government policies to manage the problems were the treatment barriers and resource drain imposed by the criminalization regime. Put another way, decriminalization was driven *not* by the perception that drug abuse was an insignificant problem, but rather by the consensus view that it was a highly significant problem, that criminalization was *exacerbating* the problem, and that only decriminalization could enable an effective government response.

In fact, Portuguese decriminalization occurred only after extensive study by an elite commission, Comissão para a Estratégia Nacional de Combate à Droga (the Commission for a National Drug Strategy). That commission was created "in response to a rapidly rising drug problem in the 1990s, principally, but not exclusively, involving heroin use."[16] Notably, the 2001 change to the Portuguese legal framework was intended to implement "a strong harm-reductionistic orientation," and "the flagship of these laws is the decriminalization of the use and possession for use of drugs."[17]

In its 1998 report, the Portuguese commission ultimately recommended decriminalization as the optimal strategy for combating Portugal's growing abuse and addiction problems. The commission emphasized that the

Figure 2
Administrative Infraction Proceedings, by Year,* by Type of Drug



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2005 Annual Report (2006), p. 37.
*Year in which the deed punishable as a misdemeanor occurred. Information gathered as of March 31 of the year after the occurrence of the deed punishable as a misdemeanor.

objective of its decriminalization strategy was to *reduce drug abuse and usage*. Thus, as its report stated, its recommendations were intended to

- redirect the focus to primary prevention;
- extend and improve the quality and response capacity of the health care networks for drug addicts so as to ensure access to treatment for all drug addicts who seek treatment;
- guarantee the necessary mechanisms to allow the enforcement by competent bodies of measures such as voluntary treatment of drug addicts as an alternative to prison sentences.[18]

The commission concluded that legalization, as opposed to mere decriminalization, was not a viable option due, in large part, to the fact that numerous international treaties impose the "obligation to establish in domestic law a prohibition" on drug use. Decriminalization was consistent with that obligation as Portuguese law continued to prohibit usage, but simply no longer classified violations as a criminal offense.

Following issuance of the commission's report, the federal government's Council of Ministers, in 1999, approved the commission's report almost in its entirety. In 2000, the council produced its own policy recommendations, which were consistent with the commission's, including recommending full-scale decriminalization.

With both the expert commission and the government's council agreeing on the need for a harm-reduction approach generally, and decriminalization specifically, the proposal encountered relatively little political resistance. Thereafter, in October 2000, the Portuguese Parliament, supported by the national president, enacted legislation implementing the council's recommendations in full, and decriminalization took effect on July 1, 2001.

Interviews with Portuguese drug officials confirmed that before decriminalization, the most substantial barrier to offering treatment to the addict population was the addicts' fear

In its 1998 report, the Portuguese commission recommended decriminalization as the optimal strategy for combating addiction problems.

Table 1
Individuals* in Misdemeanor Case, according to Year, Country of Nationality**

Country of Nationality	Year				
	2001 (2nd half)	2002[a]	2003[a]	2004[a]	2005
Europe	2,113	4,923	5,445	4,844	5,556
European Union	2,104	4,910	5,426	4,825	5,533
Germany	6	13	10	16	13
Spain	6	14	16	18	12
France	26	36	17	22	25
Netherlands	..	2	..	1	3
Portugal	2,057	4,831	5,372	4,751	5,461
United Kingdom	6	6	5	10	8
Other EU countries	3	8	6	7	11
Other European Countries	9	13	19	19	23
Ukraine	4	7	9	14	13
Others	5	6	10	5	10
Africa	55	143	135	114	203
Angola	24	64	66	59	72
Cabo Verde	8	39	37	23	63
Guinea-Bissau	4	11	11	12	24
Mozambique	13	14	14	9	29
São Tomé and Principe	2	2	..	2	1
Others	4	13	7	9	14
America	15	41	29	29	46
Bolivia	..	..	1	..	..
Brazil	10	26	17	21	40
Colombia	..	1	1	..	1
Venezuela	1	4	4	4	2
Others	4	10	6	4	3
Asia	2	7	2	4	8
Oceania	..	1	..	..	..
Unknown	19	8	4	7	11
Total	2,204	5,123	5,615	4,998	5,824

Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2005 Annual Report (2006), p. 99.

*Individuals acquitted and repeat offenders (repeat offenders are only entered one time for the year in question) are not included for analysis purposes.

**Year in which the deed punishable as a misdemeanor occurred.

[a]Information gathered as of March 31 of the year after the occurrence of the deed punishable as a misdemeanor. Between March 31, 2002, and March 31, 2003, commissions entered 282 more cases from the courts, with a date of occurrence of the deed punishable as misdemeanor referring to the year 2001; between March 31, 2003, and March 31, 2004; 496 more cases from the courts referring to the year 2002; between March 31, 2004, and March 31, 2005, 725 more cases from the courts referring to 2003, and between 3/31/2005 and 3/31/2006, 770 more cases from the courts referring to 2004.

The most substantial barrier to offering treatment to the addict population was the addicts' fear of arrest.

of government officials as a result of criminalization. João Castel-Branco Goulão, the chairman of Portugal's principal drug policy agency, the Institute on Drugs and Drug Addiction (Instituto da Droga e da Toxicodependência—or IDT), emphasized that before the 2001 decriminalization law, his principal challenge was drug addicts' fear of seeking treatment—

particularly from the state agencies offering it—because they were afraid of being arrested and prosecuted. One prime rationale for decriminalization was that it would break down that barrier, enabling effective treatment options to be offered to addicts once they no longer feared prosecution. Moreover, decriminalization freed up resources that could be channeled into treatment and other harm-reduction programs.

A related rationale for decriminalization was that removal of the stigma attached to criminal prosecution for drug usage would eliminate a key barrier for those wishing to seek treatment. Even in those nations where drug users are not typically punished with prison—such as Spain—the stigma and burden of being convicted of a criminal offense remain. "It is this stigmatization that the Portuguese policy explicitly aims to prevent."[19]

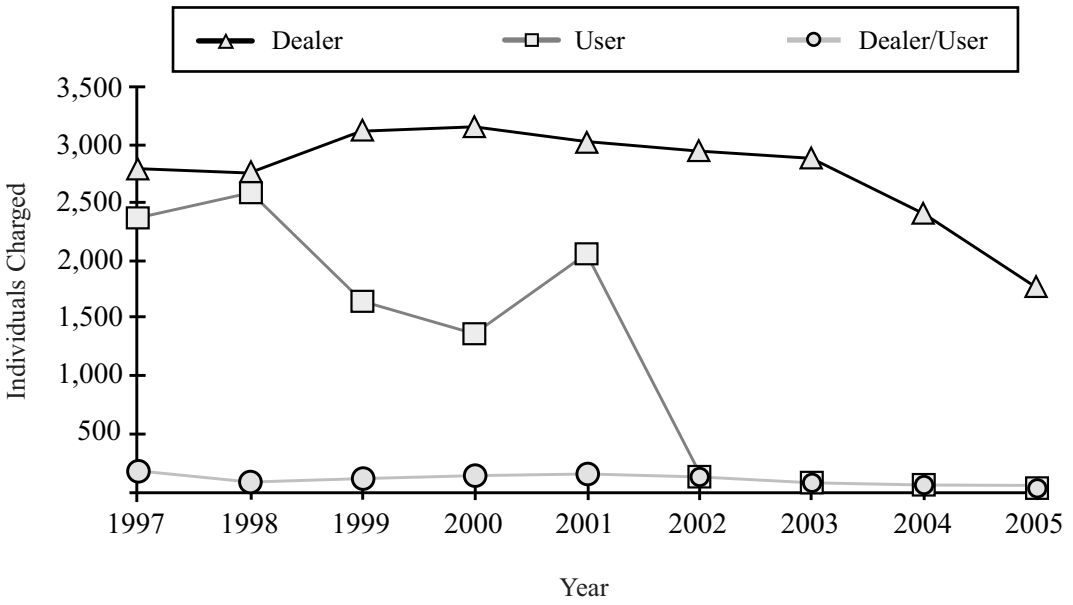
Even before decriminalization, prosecution—and certainly imprisonment—for mere possession or use were rare, but not unheard of. At times, the use of the criminal process against those accused solely of usage approached the levels of those accused of trafficking (see Figure 3).[20] The citizenry's fear of being identified as a user was thus immense, and the stigma attached to such accusations was substantial, even in the absence of a prison sentence.

Indeed, interviews with Portuguese political officials and drug policy experts confirm that they did not embrace decriminalization *despite* their belief that it would lead to increased usage. Rather, they embraced decriminalization as the best option for minimizing all drug-related problems, including addiction:

> Decriminalization is not expected to increase the amount of drugs available or the use of new types of drugs. However, there is a general belief that decriminalization increases the need for prevention, for example, to com-

The citizenry's fear of the stigma attached to such accusations was substantial, even in the absence of a prison sentence.

Figure 3
Individuals Charged, By the Year and Drug-Related Status



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2005 Annual Report (2006), p. 150.

> municate to the public that decriminalization does not condone drug use. . . . There is a consensus that decriminalization, by destigmatizing drug use, will bring a higher proportion of users into treatment, thereby increasing the need for treatment.[21]

Put another way, Portuguese decriminalization was never seen as a concession to the inevitability of drug abuse. To the contrary, it was, and is, seen as the most effective government policy for reducing addiction and its accompanying harms. For that reason, the *National Plan against Drugs and Drug Addictions for 2005–2012* (prepared in 2004) centers on ongoing strategies for prevention, demand reduction, and harm-reduction, as well as maximizing treatment resources and availability for those who seek it.

Portuguese decriminalization was never seen as a concession to the inevitability of drug abuse.

The Institute on Drugs and Drug Addiction remains the leading agency in Portugal for overseeing drug policy. It continues to define its core mission, and the core purpose of the decriminalization law, as follows:

> This law reinforces the resources in the context of demand reduction by sending to treatment drug addicts and [includes] those that are not addicts but need a specialized intervention. With this Law, we expect to contribute to the resolution of the problem in an integrated and constructive way, looking at the drug addict as a sick person, who nevertheless must be responsible for a behavior that is still considered an offense in Portugal.[22]

As the institute puts it, "Demand reduction is clearly IDT's central task."[23]

Portugal Viewed in the Context of the European Union

Although there is still wide variance in drug policy among the EU states, there are certain clear trends that have emerged in the EU generally, particularly with regard to how the law ought to deal with personal drug consumption. Although many EU states continue to emphasize criminal aspects in dealing with drug users, many states are increasingly moving toward a health-based approach, viewing personal drug usage as a health problem rather than a criminal one.

Danilo Balotta, the institutional coordinator for the EMCDDA, uses the French term "healthification" to describe the clear trend in the EU's consensus approach to drug policy. Specifically with regard to cannabis, a de facto move away from criminalization is virtually unanimous. The EMCDDA's 2007 annual report put it this way: "A general trend in Europe has been to move away from criminal justice responses to the possession and use of small amounts of cannabis and towards approaches oriented towards prevention or treatment."[24] An excerpt from the EMCDDA's 2005 paper, *Illicit Drug Use in the EU: Legislative Approaches,* observes:

> In the EU Member States, notwithstanding different positions and attitudes, we can see a trend to conceive the illicit use of drugs (including its preparatory acts) as a relatively "minor" offence, to which it is not adequate to apply "sanctions involving deprivation of liberty."[25]

Despite this, the agency warns that "it would be a mistake to define [these changes] as a trend in a 'relaxation' or a 'softening' of the drug laws in Europe."[26] Even where there is a strong de-emphasis on incarceration and other criminal sanctions for drug use, the aim in most EU countries is merely to formulate more efficient and proportionate sanctions—not legalize drug use.

The ongoing generalized belief in criminalization notwithstanding, all EU states have agreed within the last several years to broad principles for formulating drug policy. The EMCDDA refers to this consensus as GBE: a global, balanced, evidence-based ap-

proach to drug policy. In this formulation, "global" designates an acknowledgment that all aspects of drug policy—prevention and anti-trafficking efforts—require international efforts. "Balanced" requires a sense of both proportion and a roughly equal emphasis on supply reduction and demand reduction. "Evidence-based" requires that all policy judgments be grounded in data and exclude moral and ideological considerations.

This trend is evident not only in the slow de facto movement away from criminalization of small amounts of cannabis, but also in the increasing acceptance across the EU of even more controversial "harm reduction" policies. As EMCDDA's 2007 annual report documented:

> Historically, the topic of harm reduction has been more controversial. This is changing, and harm reduction as a part of a comprehensive package of demand reduction measures now appears to have become a more explicit part of the European approach. This is evident in the fact that both opioid substitution treatment and needle and syringe exchange programmes are now found in virtually all EU Member States. . . .[27]

In 10 years, the availability of harm-reduction measures, such as opioid substitution treatment, has increased tenfold across the EU.[28]

As noted above, other EU nations have adopted what amounts to de facto decriminalization, but have not explicitly declared drug usage "decriminalized." In Spain, for instance, "a drug consumer will still be judged by a criminal court, although he or she will never be sent to prison for drug consumption alone."[29] Moreover, a gap in Spain's drug laws exists whereby *public* drug consumption is prohibited, but *private* drug usage is not, and Spanish legislatures have left this gap standing.

Other forms of de facto decriminalization have occurred in Germany, where a court ruled that imprisonment for petty drug possession offenses implicates constitutional concerns, and in Luxembourg, which only permits punishment by a fine for cannabis usage. Nonetheless, Portugal remains the only EU state to decriminalize explicitly, and the criminalization framework continues to predominate in the EU for most drug offenses.

Effects of Portuguese Decriminalization

Since Portugal enacted its decriminalization scheme in 2001, drug usage in many categories has actually *decreased* when measured in absolute terms, whereas usage in other categories has increased only slightly or mildly. None of the parade of horrors that decriminalization opponents in Portugal predicted, and that decriminalization opponents around the world typically invoke, has come to pass. In many cases, precisely the opposite has happened, as usage has declined in many key categories and drug-related social ills have been far more contained in a decriminalized regime.

The true effects of Portuguese decriminalization can be understood only by comparing postdecriminalization usage and trends in Portugal with other EU states, as well as with non-EU states (such as the United States, Canada, and Australia) that continue to criminalize drugs even for personal usage. And in virtually every category of any significance, Portugal, since decriminalization, has outperformed the vast majority of other states that continue to adhere to a criminalization regime.

Effects Viewed in Absolute Terms

Usage Rates. Since decriminalization, lifetime prevalence rates (which measure how many people have consumed a particular drug or drugs over the course of their lifetime) in Portugal have *decreased* for various age groups. For students in the 7th–9th grades (13–15 years old), the rate decreased from 14.1 percent in 2001 to 10.6 percent in 2006.[30] For those in the 10th–12th grades (16–18 years old), the lifetime prevalence rate, which increased from 14.1 percent in 1995 to 27.6 percent in 2001, the year of decriminalization,

Prevalence rates for the 15–19 age group have actually decreased in absolute terms since decriminalization.

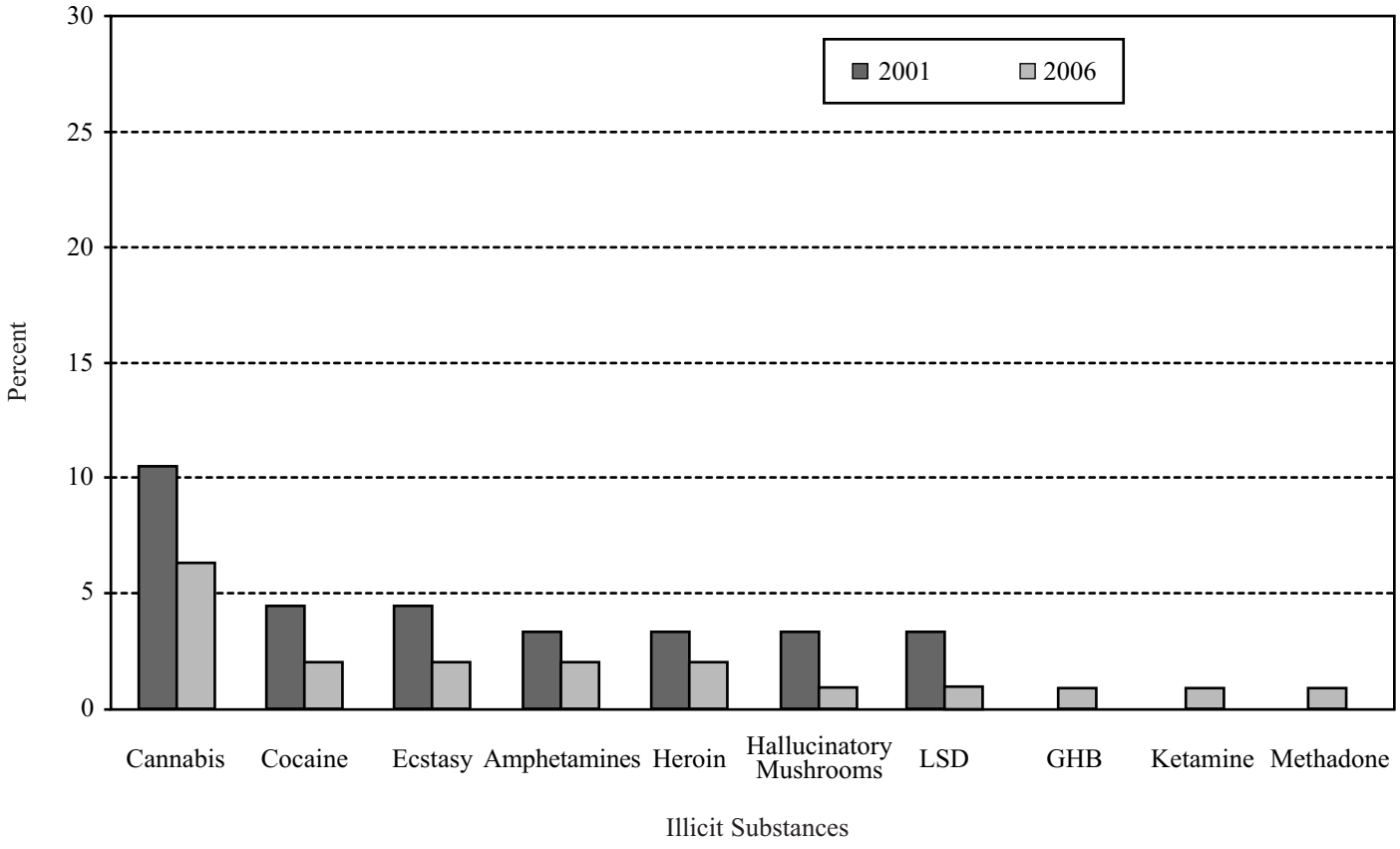
has decreased subsequent to decriminalization, to 21.6 percent in 2006.[31] For the same groups, prevalence rates for psychoactive substances have also decreased subsequent to decriminalization.[32]

In fact, for those two critical groups of youth (13–15 years and 16–18 years), prevalence rates have declined for virtually every substance since decriminalization (see Figures 4 and 5).[33]

For some older age groups (beginning with 19- to 24-year-olds), there has been a slight to mild increase in drug usage, generally from 2001 to 2006, including a small rise in the use of psychoactive substances for the 15–24 age group,[34] and a more substantial increase in the same age group for illicit substances generally.[35] For other age groups of older citizens, increases in lifetime prevalence rates for drugs generally have ranged from slight to mild. Such an increase in lifetime prevalence rates for the general population is virtually inevitable in every nation, *regardless of drug policy and regardless of whether there is even an actual increase in drug usage*. The IDT's Goulão explained why:

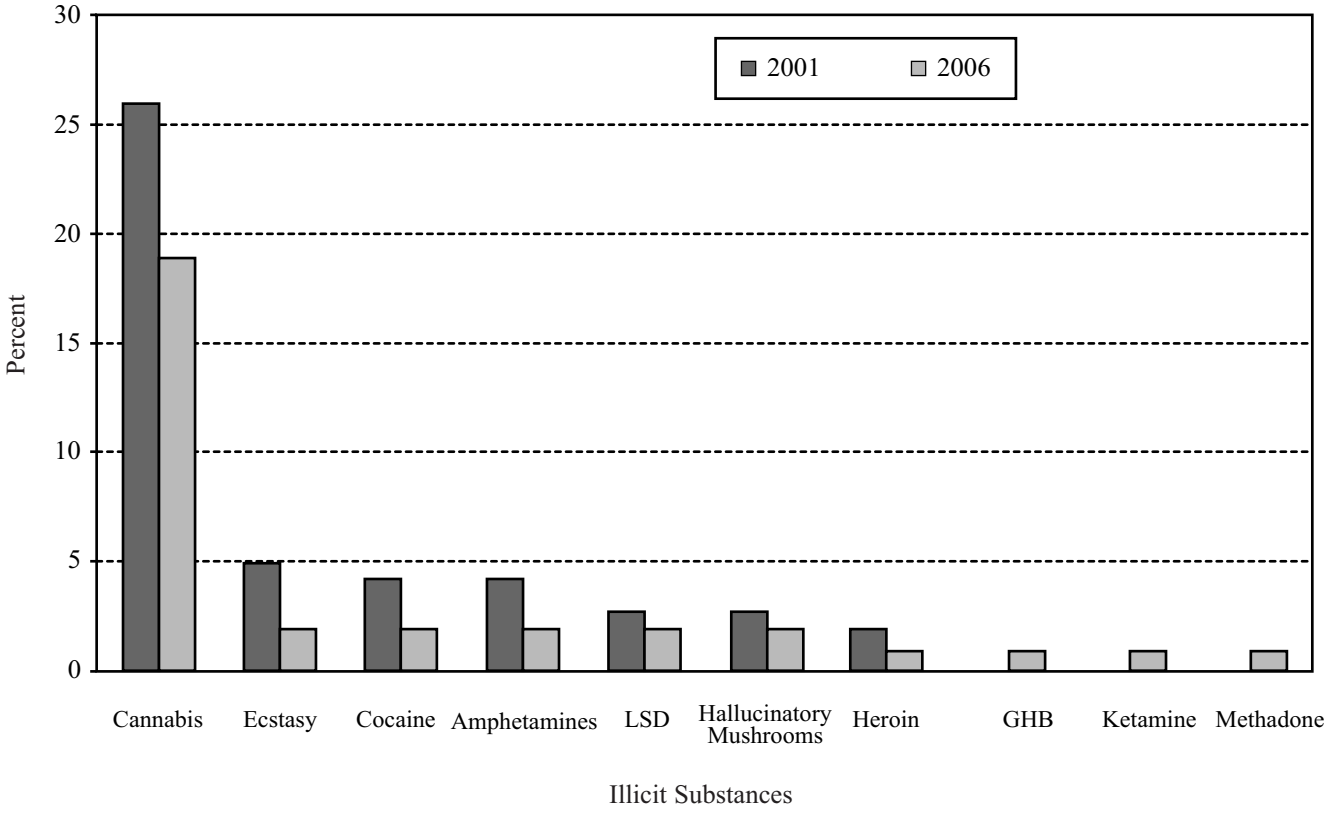
> This is an expected result, even when there is not an increase in drug use, because of the cohort effect (in the sample, from one study to the other, older people that never try drugs are replaced for a new generation among whom a significant percentage already had that experience).[36]

Figure 4
National Investigation in School Environment, 2001 and 2006, 3rd Cycle (7th, 8th, and 9th years), Portugal, Prevalence Over Entire Life



Source: Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 13.

Figure 5
National Investigation in School Environment, 2001 and 2006, Secondary (10th, 11th, and 12th years), Portugal, Prevalence Over Entire Life



Source: Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 14.

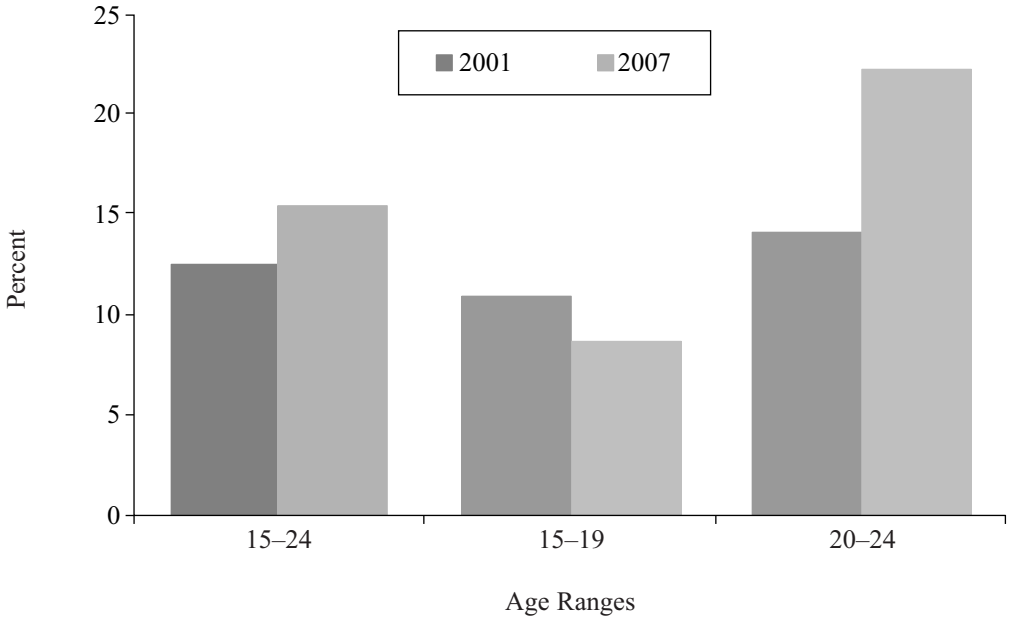
When it comes to assessing the long-term effects of drug policy and treatment approaches, Portuguese drug policy specialists, like policy specialists in most countries, consider the adolescent and postadolescent age groups (15–24) to be the most significant. The behavior of those younger age groups is widely considered by drug policymakers around the world to be the most malleable, and trends that appear during those years are far and away the most potent harbingers for long-term behavioral changes. The University of Michigan's Lloyd Johnston, the principal researcher behind a 2003 study revealing some increasing trends in the drug usage rates among American youth, put it this way:

> The 8th-graders have been harbingers of change observed later in the upper grades, so the fact that they are no longer showing declines in their use of a number of drugs could mean that the declines now being observed in the upper grades also will come to an end soon.[37]

A 2008 study of drug usage trends in 17 nations on five different continents similarly found that the late adolescent years are key in determining future, lifelong drug usage:

> In most countries, the period of risk for initiation of use was *heavily concen-*

Figure 6
Portugal, 2001 and 2007, General Population (15–24 years old), Lifetime Prevalence (any illicit drug)



Source: Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 8.

> *trated in the period from the mid to late teenage years*; there was a slightly older and more extended period of risk for illegal drugs compared to legal drugs.[38]

As one would expect, then, Portuguese officials emphasize the dramatic trends seen in these younger groups since the decriminalization law was enacted. Prevalence rates for the 15–24 age group have increased only very slightly, whereas the rates for the critical 15–19 age group—critical because such a substantial number of young citizens begin drug usage during these years—have actually *decreased in absolute terms since decriminalization* (see Figure 6).[39]

Perhaps most strikingly, while prevalence rates for the period from 1999 to 2005, for the 16–18 age group, increased somewhat for cannabis (9.4 to 15.1 percent) and for drugs generally (12.3 to 17.7 percent), the prevalence rate decreased during that same period for heroin (2.5 to 1.8 percent),[40] the substance that Portuguese drug officials believed was far and away the most socially destructive:

> At the time of introducing decriminalization the Portuguese drug problem was notable due to a high level of problematic drug use and drug-related problems. This was associated primarily with use of heroin, with a particular problem of injecting drug use and the related risks of HIV/AIDS and viral hepatitis.[41]

These postdecriminalization decreases were preceded by significant increases in drug-related problems in Portugal in the 1990s. Throughout the 1990s, the number of arrests for drug offenses generally, and heroin use specifically, rose steadily.[42] By 1998, more than 60 percent of drug-related arrests were for use or possession, rather than for sale or possession to sell. The amount of drugs seized during that decade rose significantly as well.[43]

In almost every category of drug, and for drug usage overall, the lifetime prevalence rates in the predecriminalization era of the 1990s were higher than the postdecriminalization rates.

In almost every category of drug, and for

drug usage overall, the lifetime prevalence rates in the predecriminalization era of the 1990s were *higher* than the postdecriminalization rates.[44] Moreover, the level of drug trafficking, as measured by the numbers of those convicted of that offense, has steadily declined since 2001 as well (see Figure 7).[45]

Drug-Related Phenomena. As predicted, and desired, when Portugal enacted decriminalization, treatment programs—both in terms of funding levels and the willingness of the population to seek them—have improved substantially.[46] That, in turn, has enhanced the ability of local and state government officials to provide disease-avoiding services to the population:

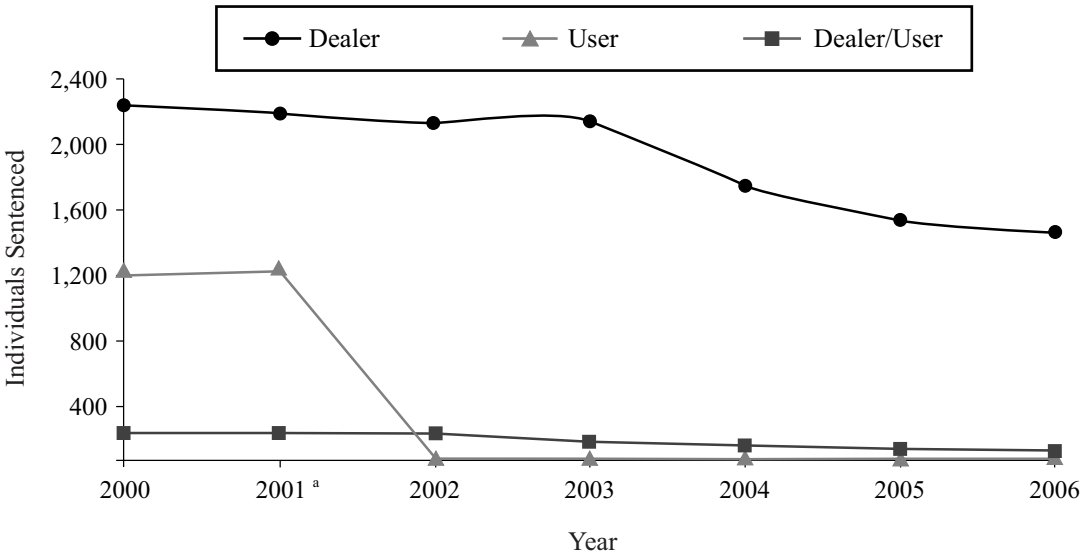
> The number of people in substitution treatment leapt from 6,040 in 1999 to 14,877 in 2003, an increase of 147% . . . . The number of places in detoxification, therapeutic communities and half-way houses has also increased. . . . The national strategy has led directly to increases in the scale of treatment and prevention activities in Portugal.[47]

While proponents of criminalization sometimes depict an increase in the number of individuals seeking treatment as indicative of worsening drug problems, empirical evidence suggests that the opposite is almost certainly true. Between (a) addicts who are afraid to seek treatment due to fear of criminal penalties and (b) addicts who freely seek treatment in a decriminalized framework, the latter option is clearly preferable, as such increased treatment decreases the amount of addiction and, as important, enables the management and diminution of drug-related harms. For precisely that reason, as treatment enrollment has increased in the postdecriminalized setting, drug-related harms have decreased substantially.

According to the 2006 report of the Institute on Drugs and Drug Addiction of the Portuguese Health Ministry, "Available indicators continue to suggest effective responses at

The number of newly reported cases of HIV and AIDS among drug addicts has declined substantially every year since 2001.

Figure 7
Individuals Sentenced by Year, and by Drug-Related Status



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 53.
[a]With the entry into effect, starting July 1, 2001, of Law no. 30/2000 of November 29, the use of illegal drugs was decriminalized and became a misdemeanor. However, growing drugs—as provided under Article 40 of Legislative Decree no. 15/93 of January 22—continues to be considered a felony.

Drug-related mortality rates have decreased as well.

treatment level . . . and [at] the harm reduction level."[48] Moreover, the percentage of drug users among newly infected HIV-positive individuals continues to decline.[49] Since 2004, general infection rates for HIV have remained stable—a positive trend, which, according to the 2006 report,

> may be related . . . to the implementation of harm reduction measures, which may be leading to a decrease in intravenous drug use . . . or to intravenous drug use in better sanitary conditions, as indicated by the number of exchanged syringes in the National Programme "Say no to a second hand syringe."[50]

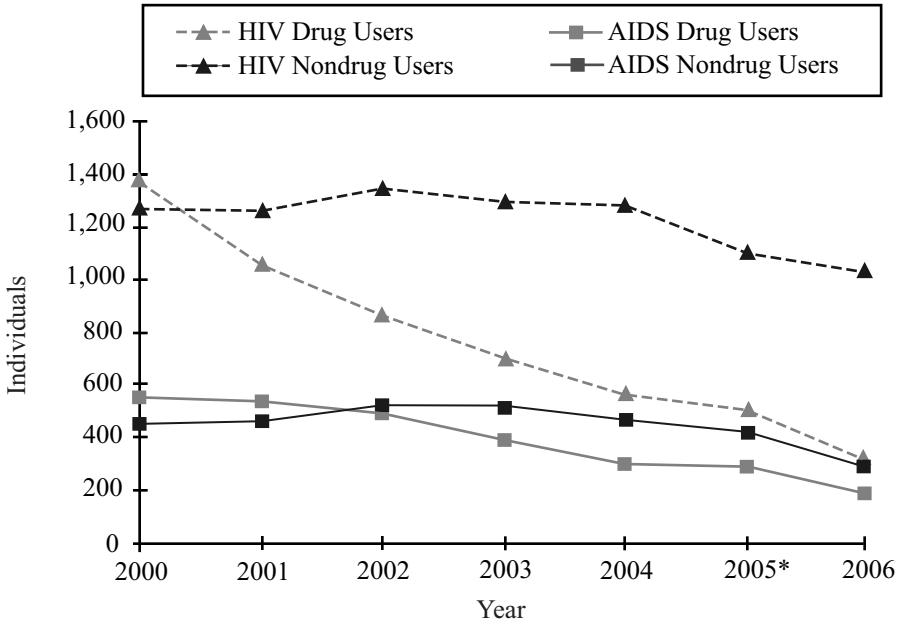
Most significant, the number of newly reported cases of HIV and AIDS among drug addicts has declined substantially every year since 2001 (see Figure 8).[51]

The percentage of newly diagnosed HIV and AIDS patients who are drug addicts has steadily decreased over the same time (see Figure 9).[52]

Likely for the same reasons, there has been, since 2000, a mild decrease in the rates of new hepatitis B and C infections nationwide,[53] all of which are attributed by analysts to the enhanced treatment programs enabled by decriminalization:

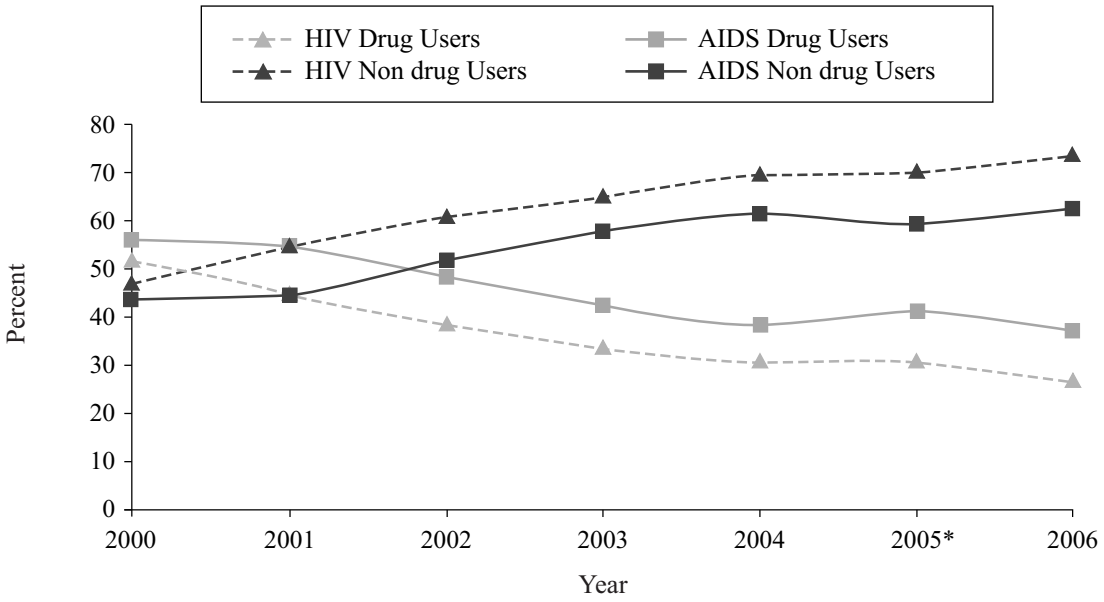
> With its relatively high rates of heroin use by injection, Portugal has had a serious problem with the transmission of HIV and other blood-borne viruses. For example, in 1999 Portugal had the highest rate of HIV amongst injecting drug users in the European Union . . . . This is a major target of a public health approach to drug use, with opiate substi-

Figure 8
HIV/AIDS Notifications: Drug Users and Nondrug Users, by Year of Diagnosis



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 26.
*Infection by HIV was integrated into the list of diseases of mandatory declaration.

Figure 9
HIV/AIDS Notifications, Percent Drug Users and Nondrug Users, by Year of Diagnosis



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation relating to Drugs and Dependency," 2006 Annual Report (2007), p. 26.
*Infection by HIV was integrated into the list of diseases of mandatory declaration.

> tution treatment and needle exchange being an important element of the Portuguese response. *Between 1999 and 2003, there was a 17% reduction in the notifications of new, drug-related cases of HIV . . . . There were also reductions in the numbers of tracked cases of Hepatitis C and B in treatment centres*, despite the increasing numbers of people in treatment.[54]

Beyond disease, drug-related mortality rates have decreased as well. Although the number of toxicological exams undertaken as part of postmortem investigations has increased substantially every year since 2002, the number of positive results is far lower than the levels during 2000 and 2001 (see Figure 10).[55]

In 2001, for instance, 280 toxicological tests found a positive result (out of 1,259 tests undertaken). In 2006, the number of positive results was only 216 (out of a much higher 2,308 tests undertaken).

In absolute numbers, drug-related deaths from 2002 to 2006 for every prohibited substance have either declined significantly or remained constant compared with 2001. In 2000, for instance, the number of deaths from opiates (including heroin) was 281. That number has decreased steadily since decriminalization, to 133 in 2006 (see Figure 11).[56]

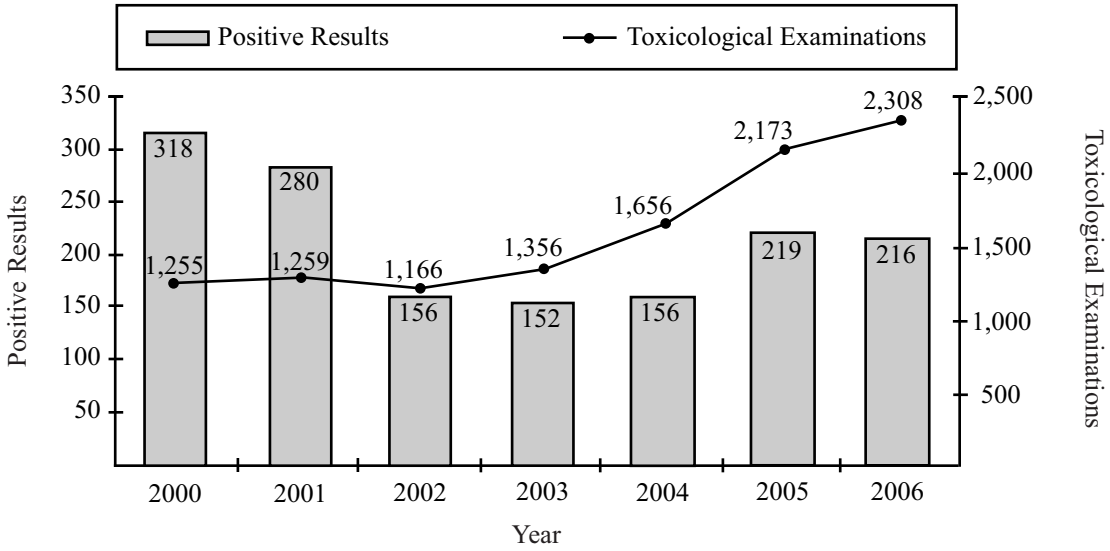
As is true for drug usage rates, these post-decriminalization decreases were preceded by significant increases in drug-related problems in Portugal throughout the 1990s. Throughout the predecriminalization 1990s, the number of acute drug-related deaths increased every year, increasing more than tenfold from 1989 to 1999, reaching a total of almost 400 by 1999 (see Figures 12 and 13).[57]

The total number of drug-related deaths has actually *decreased* from the predecriminalization year of 1999 (when it totaled close to 400) to 2006 (when the total was 290).

Like drug-related deaths, predecriminalization drug-related AIDS cases skyrocketed throughout the 1990s,[58] while the prevalence

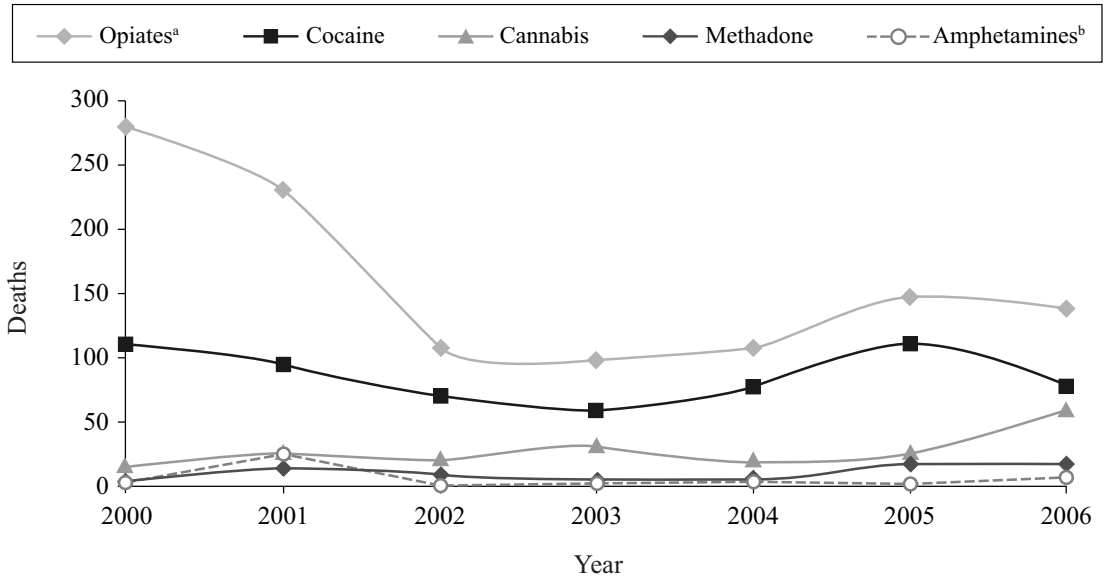
The total number of drug-related deaths has actually *decreased* from the predecriminalization year of 1999 (when it totaled close to 400) to 2006 (when the total was 290).

Figure 10
Toxicological Examinations and Positive Results, by Year



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 30.

Figure 11
Deaths,* by Year, by Substance



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 31.
*Cases of death with positive results in toxicological exams of drugs or narcotics conducted in the National Institute of Legal Medicine.
[a]Includes heroine, morphine, and codeine.
[b]Includes amphetamines, methamphetamines, MDA, and MDMA.

rates for HIV and hepatitis were far higher.[59] Thus, even in those drug-related categories that have worsened in absolute terms since decriminalization, those categories compare quite favorably with predecriminalization trends in the 1990s.

Although education and awareness efforts in the 1990s began to stem the tide of HIV infection and those of other sexually transmitted diseases even before decriminalization, these trends, as demonstrated above, accelerated even more favorably postdecriminalization. Researchers who interviewed numerous drug policymakers in Europe generally and Portugal specifically found unanimity in support of the view that these positive trends were due to decriminalization, and specifically to Portugal's ability to provide more extensive and effective treatment and education programs:

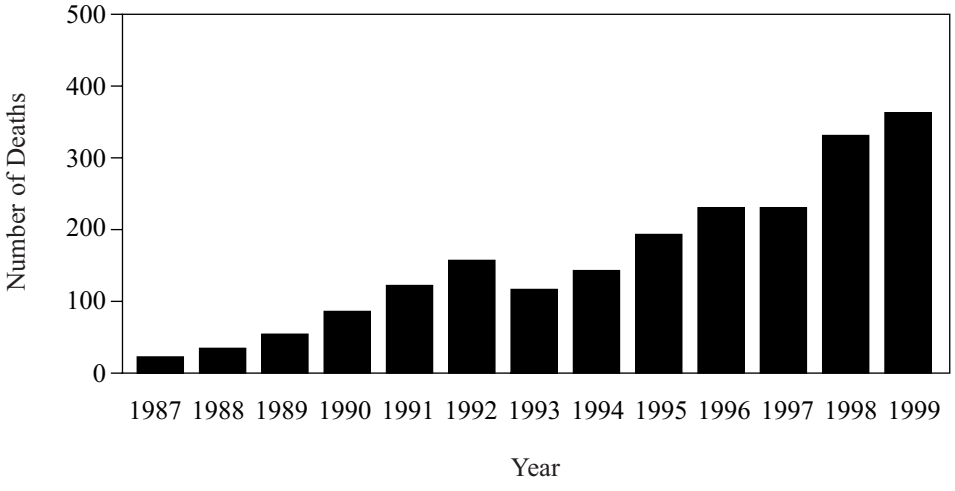
> All the interviewees agreed that decriminalization has been beneficial for existing drug users, principally because decriminalization has resulted in earlier intervention and the provision of more therapeutic and targeted responses to both drug and drug-related problems. Through providing problematic drug users with a better system of detection and referral to treatment, the [Dissuasion Commissions] increase the ability to address the causes of and harms from problematic drug use.[60]

Decriminalization Effects Viewed in Context of Trends in the European Union

Beyond comparing postdecriminalization trends in Portugal with predecriminalization trends, the effects of Portuguese decriminalization should be assessed in the context of trends in Europe generally during the same period. There is, however, a serious difficulty in undertaking such a comparison. Although the EMCDDA is tasked with coordinating the compilation of uniform drug statistics among EU states, its lack of compulsory authority, as well as the lack of resources in many EU states, means that there is very little real reporting uniformity. Many EU states, particularly the poorer ones, often allow many years to elapse before undertaking

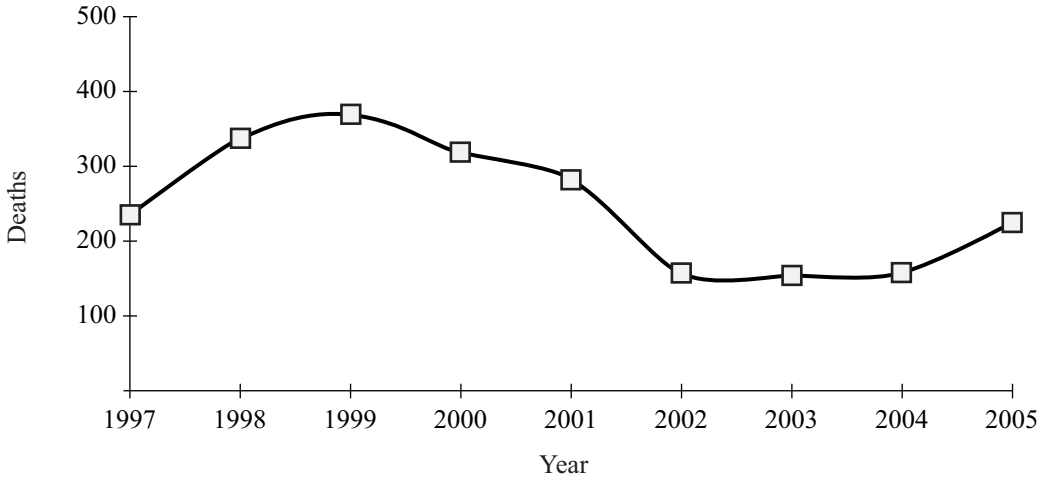
The effects of Portuguese decriminalization should be assessed in the context of trends in Europe generally during the same period.

Figure 12
Number of Acute Drug-Related Deaths, 1987–1999



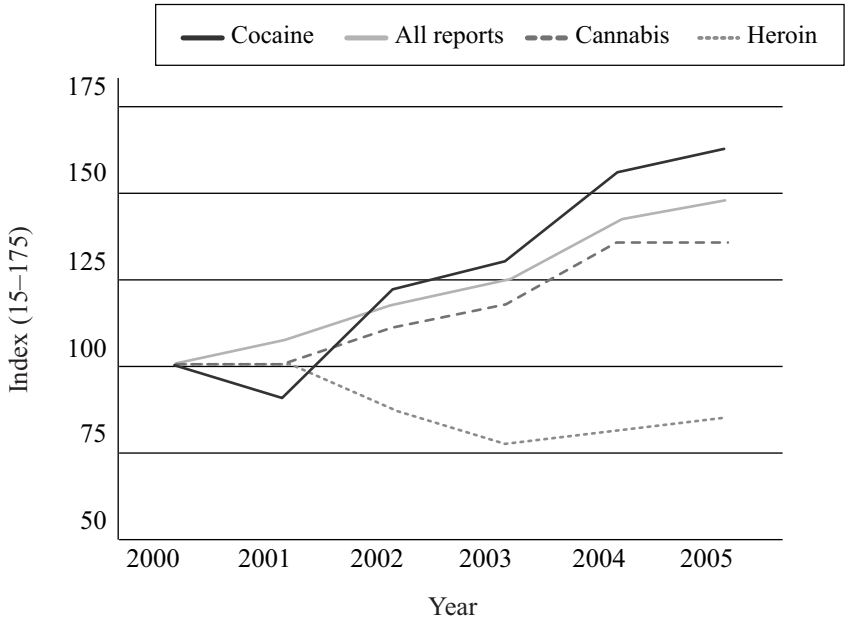
Source: Mirjam van het Loo, Ineke van Beusekom, and James P. Kahan, "Decriminalization of Drug Use in Portugal: The Development of a Policy," *Annals of the American Academy of Political and Social Science* 582, Cross-National Drug Policy (July 2002): 53.

Figure 13
Deaths,* According to Year



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2005 Annual Report (2006), p. 71.
*Cases of death with positive results in drug toxicological exams conducted in the National Institute of Legal Medicine.

Figure 14
Indexed Trends in Reports for Drug Law Offenses in EU Member States, 2000–2005



Source: European Monitoring Center for Drugs and Drug Addiction, "The State of the Drug Problem in Europe," Annual Report (2007), p. 25.

comprehensive drug-related surveys, and even those states that report more regularly often measure metrics that are slightly different—when compared with both prior metrics they surveyed and the metrics surveyed by other EU states.

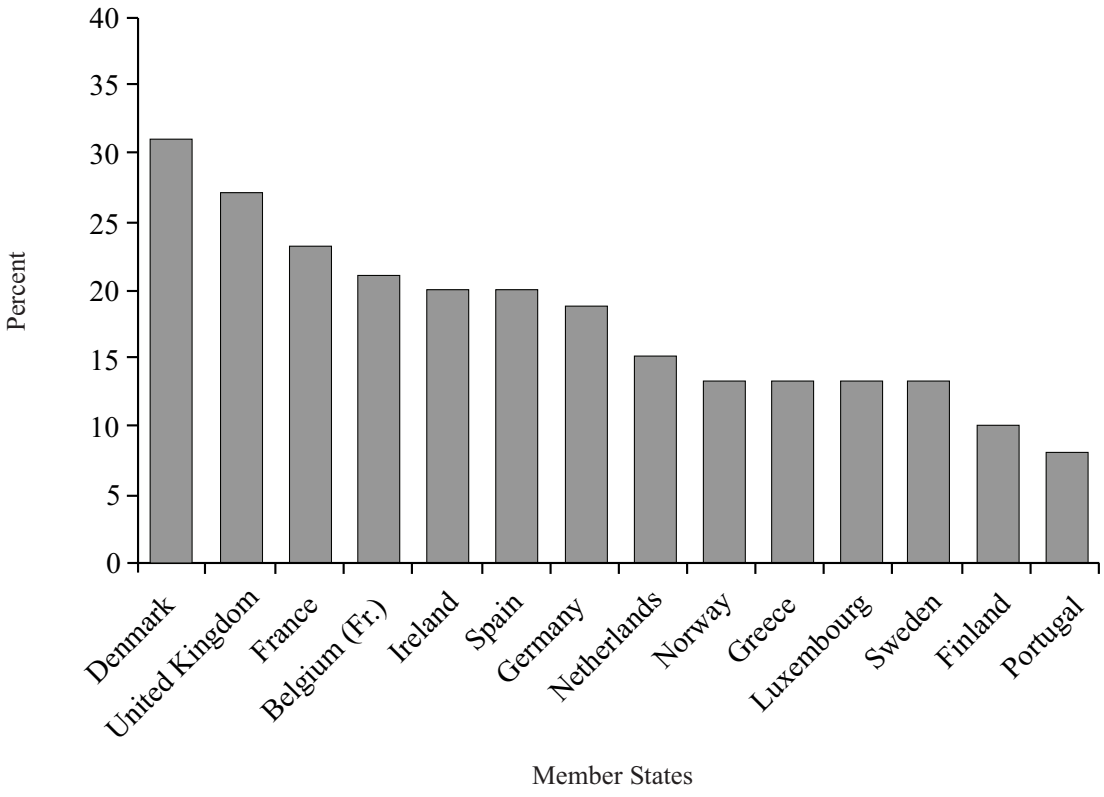
Despite these difficulties, some meaningful comparisons can still be made. Drug statistics rarely change radically from one year to the next. Thus, comparisons between EU states of metrics such as prevalence rates and drug-related social problems can still be useful even if they are taken from different years or measuring population clusters that are defined slightly differently. Comparisons with slightly different statistics lack mathematical exactitude, but they still afford substantial analytical utility.

Across EU states, according to the EMCDDA's 2007 annual report ("The State of the Drug Problem in Europe"), "drug use in general remains at historically high levels, but it has stabilised in most areas, and in some areas there are even signs that merit cautious optimism."[61] That EU trend of historically high usage rates can be seen for cannabis and cocaine, the two most widely used drugs in the EU, respectively (followed far behind by ecstasy and amphetamines; usage of crack cocaine remains negligible in the EU).[62] Across the EU, the number of drug offenses in absolute terms has risen steadily since 2000 (see Figure 14).[63]

For cannabis usage, "current levels are by historical standards very high" ("although only a relatively small proportion of cannabis users are using the drug on a regular and

Despite difficulties, some meaningful comparisons can still be made.

Figure 15
European Union (2001–2005), General Population (15–64 Years), Cannabis, Prevalence over Entire Life



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), Draft 2007 Annual Report, slide 9.

The majority of EU states have rates that are *double and triple* the rate for post-decriminalization Portugal.

intensive basis").[64] For cocaine, it is estimated that in 2007, 4.5 million Europeans used it, up from 3.5 million the year before.[65] All metrics point to an "upward trend" in cocaine usage across the EU.[66]

In the context of these EU-wide trends, usage rates in postdecriminalization Portugal are notably low. Indeed, as a 2006 report on Portuguese drug policy concluded, five years after decriminalization, "The prevalence of drugs in Portugal, both in general and the school populations, is *below EU average*."[67]

For the period 2001–2005, Portugal—for the 15–64 age group—has the absolute lowest lifetime prevalence rate for cannabis, the most used drug in the EU. Indeed, the majority of EU states have rates that are *double and triple* the rate for postdecriminalization Portugal (see Figures 15 and 16).[68]

Similarly, for usage rates of cocaine (the second-most commonly used drug in Europe) for the same period and the same age group, only five countries had a lower prevalence rate than the Portuguese rate. Most EU states have double, triple, quadruple, or even higher rates than Portugal's, including some with the harshest criminalization schemes in the EU (see Figure 17).[69]

Indeed, subsequent to decriminalization in Portugal, for almost every narcotic, the lifetime prevalence rates—the percentage of adults who will use a particular drug over the course of their lifetime—is far lower in Portugal than in Europe generally. For cannabis, compare the 2006 lifetime prevalence rate for Portugal (8.2 percent)[70] with the rate in Europe generally (25 percent).[71] Indeed, the 8.2 percent *lifetime* prevalence rate in Portugal (meaning 8.2 percent of Portuguese citizens in the studied age range consumed cannabis at least once in their life) is almost the equivalent of the prevalence rate for EU states *just from the last year alone* (7.1 percent) (meaning that 7.1 percent of EU citizens have consumed cannabis in the last year).[72]

Country-by-country prevalence rates in the EU for amphetamine[73] and ecstasy usage similarly show Portugal with among the lowest usage rates in the EU (compare, for instance, Portugal's ecstasy prevalence rate [1.6 percent] with the higher rates in virtually every EU country).[74] One finds the same conclusions for the EU country-by-country prevalence rate for heroin and injection usage (compare the 2006 prevalence rate for students for heroin use in Portugal of 2.6 percent[75] with the several EU countries with substantially higher rates; see Figure 18).[76]

For cocaine, the lifetime prevalence rate for the student age group in Portugal is 1.6 percent whereas for Europe generally, it is substantially higher—4 percent.[77] As the EMCDDA reported in its 2007 report, "Based on recent national population surveys in the EU and Norway, it is estimated that cocaine has been used at least once . . . by more than 12 million Europeans, representing almost 4 percent of all adults."[78]

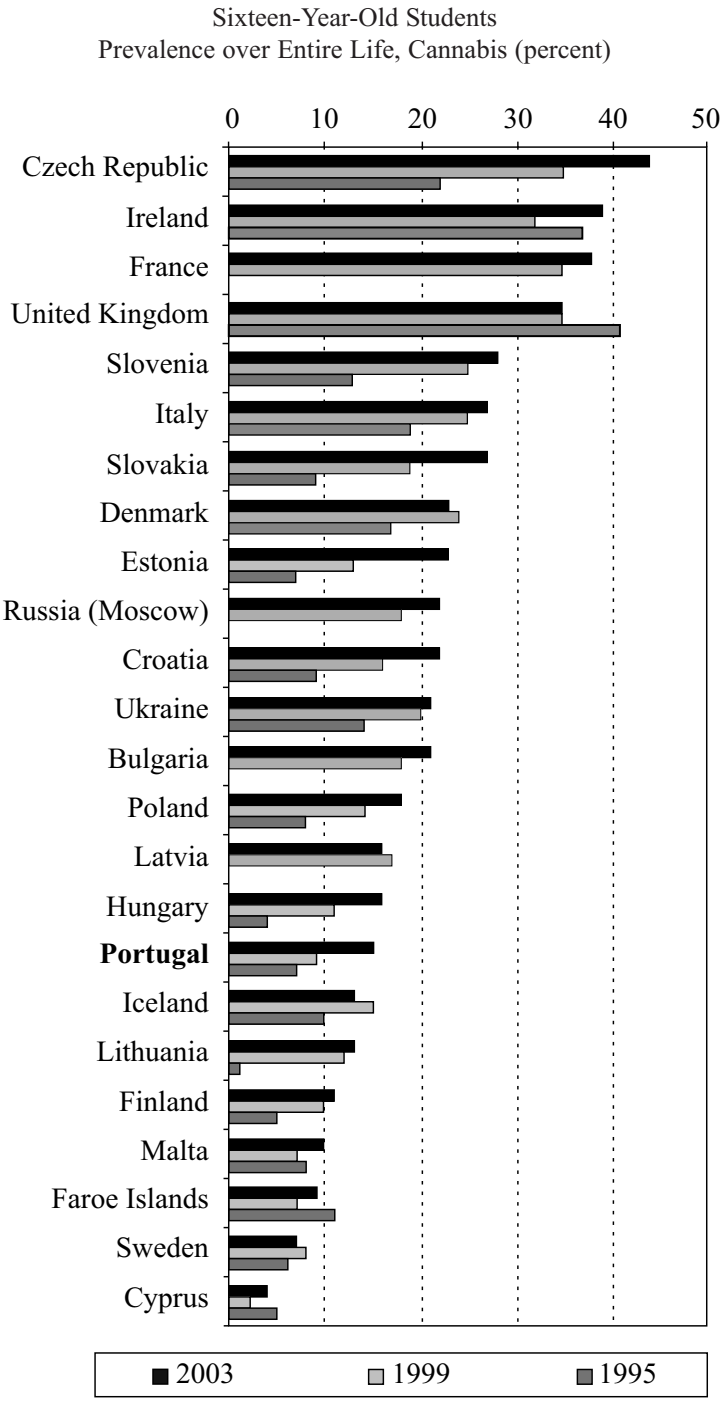
Again, postdecriminalization, Portugal—with 1.6 percent—is near the bottom of prevalence rates, whereas across the EU, "national figures on reported lifetime use range from 0.2 percent to 7.3 percent, with three countries reporting values of more than 5 percent (Spain, Italy, the United Kingdom)."[79] For cocaine usage, Europe is generally experiencing an "overall increase in use."[80] Increases (in the 15–34 age group) can be seen in most EU states (see Figure 19).[81]

By and large, usage rates for each category of drugs continue to be lower in the EU than in non-EU states with a far more criminalized approach to drug usage:

> Estimated cannabis use is, on average, considerably lower in the European Union than in the USA, Canada or Australia. As regards stimulant drugs, levels of ecstasy use are broadly similar worldwide, although Australia reports high prevalence levels, and, in the case of amphetamine, prevalence is higher in Australia and the USA than in Europe and Canada. The prevalence of cocaine use is higher in the USA and Canada than in the European Union and Australia.[82]

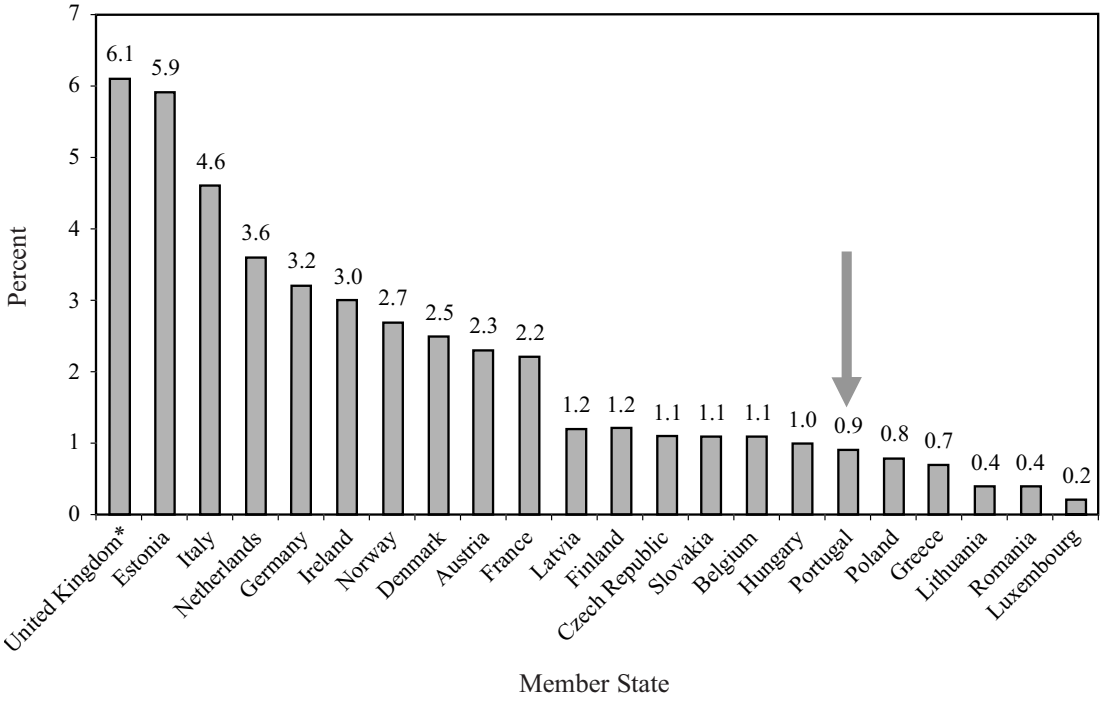
Indeed, a 2008 survey of drug usage among Americans found that the United States has the

Figure 16
European School Survey Project on Alcohol and Other Drugs



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "Os Adolescentes e a Droga" ("Adolescents and Drugs"), 2003, p. 6.

Figure 17
European Union (2001–2005), General Population (15–64 Years), Cocaine, Prevalence over Entire Life



Source: Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), Draft 2007 Annual Report, slide 10.
*Excludes Scotland and Northern Ireland.

highest level of illegal cocaine and cannabis use in the world. The findings were the result of surveys conducted in 17 countries, in the Americas (Colombia, Mexico, and the United States), Europe (Belgium, France, Germany, Italy, the Netherlands, Spain, and Ukraine), the Middle East and Africa (Israel, Lebanon, Nigeria, and South Africa), Asia (China and Japan), and Oceania (New Zealand).[83] As reported by *Science Daily* on July 1, 2008:

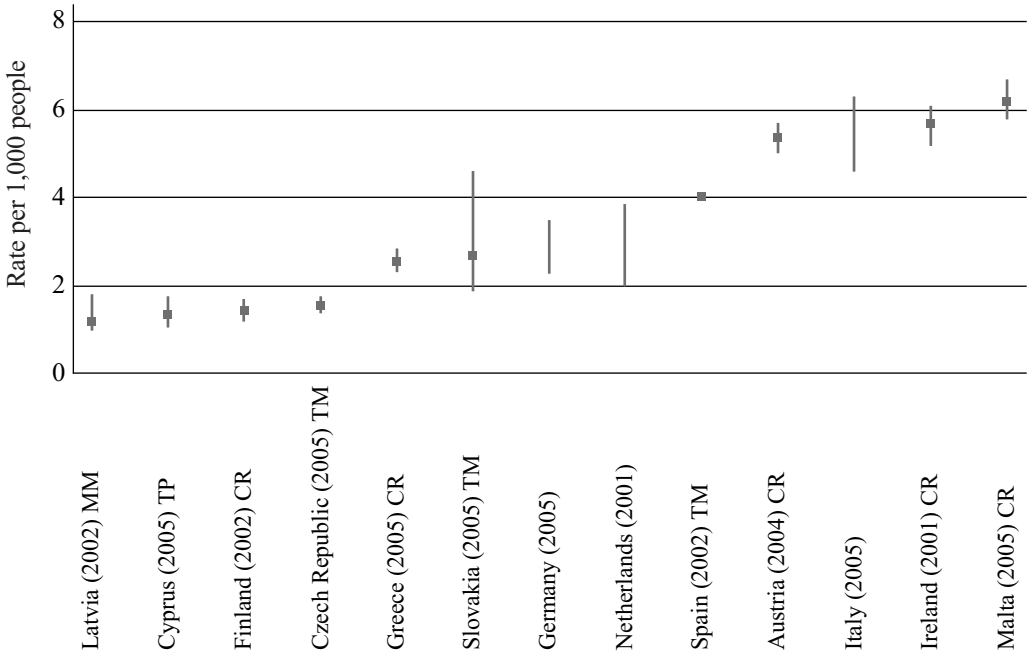
> A survey of 17 countries has found that despite its punitive drug policies the United States has the highest levels of illegal cocaine and cannabis use. The study, by Louisa Degenhardt (University of New South Wales, Sydney, Australia) and colleagues, is based on the World Health Organization's Composite International Diagnostic Interview (CIDI) and is published in this week's Plos Medicine.
>
> The authors found that 16.2% of people in the United States had used cocaine in their lifetime, a level much higher than any other country surveyed (the second highest level of cocaine use was in New Zealand, where 4.3% of people reported having used cocaine). Cannabis use was highest in the US (42.4%), followed by New Zealand (41.9%).[84]

By and large, usage rates for each category of drugs continue to be lower in the EU than in non-EU states with a far more criminalized approach to drug usage.

The prevalence rate for cocaine usage in the United States was so much higher than the other countries surveyed that the researchers formally characterized it as an "outlier":

> The US was an outlier in lifetime cocaine use, with 16% of respondents reporting that they had tried cocaine at least once compared to 4.0%–4.3% in Colombia, Mexico, Spain, and New Zealand, and

Figure 18
Estimates of the Prevalence of Problem Opioid Use, Ages 15–64, 2001–2005



Source: European Monitoring Centre for Drugs and Drug Addiction, "The State of the Drug Problem in Europe," 2007 Annual Report (2007), p. 65.
Note: The symbol indicates a point estimate; a bar indicates an estimation uncertainty interval, which can be either a 95% confidence interval or an interval based on sensitivity analysis. Target groups may vary slightly owing to different estimation methods and data sources; therefore, comparisons should be made with caution. Where no method is indicated, the line given represents an interval between the lowest lower bound of all existing estimates and the highest upper bound of them. Estimation methods: CR = capture–recapture; TM = treatment multiplier; TP = truncated Poisson; MM = mortality multiplier.

> extremely low proportions in countries in the Middle East, Africa, and Asia.[85]

The study also found that "the proportions of respondents who ever used cannabis were highest in the US (42%)."[86] The magnitude of the United States' drug usage rates compared with every other country surveyed is illustrated in Table 2, which shows the lifetime prevalence rates for cannabis and cocaine for each.

A similar table (Table 3), reflecting prevalence rates in each country among the nations' youth (15 years and younger and, separately, 21 years and younger), also reflects the vastly higher rates in the United States.

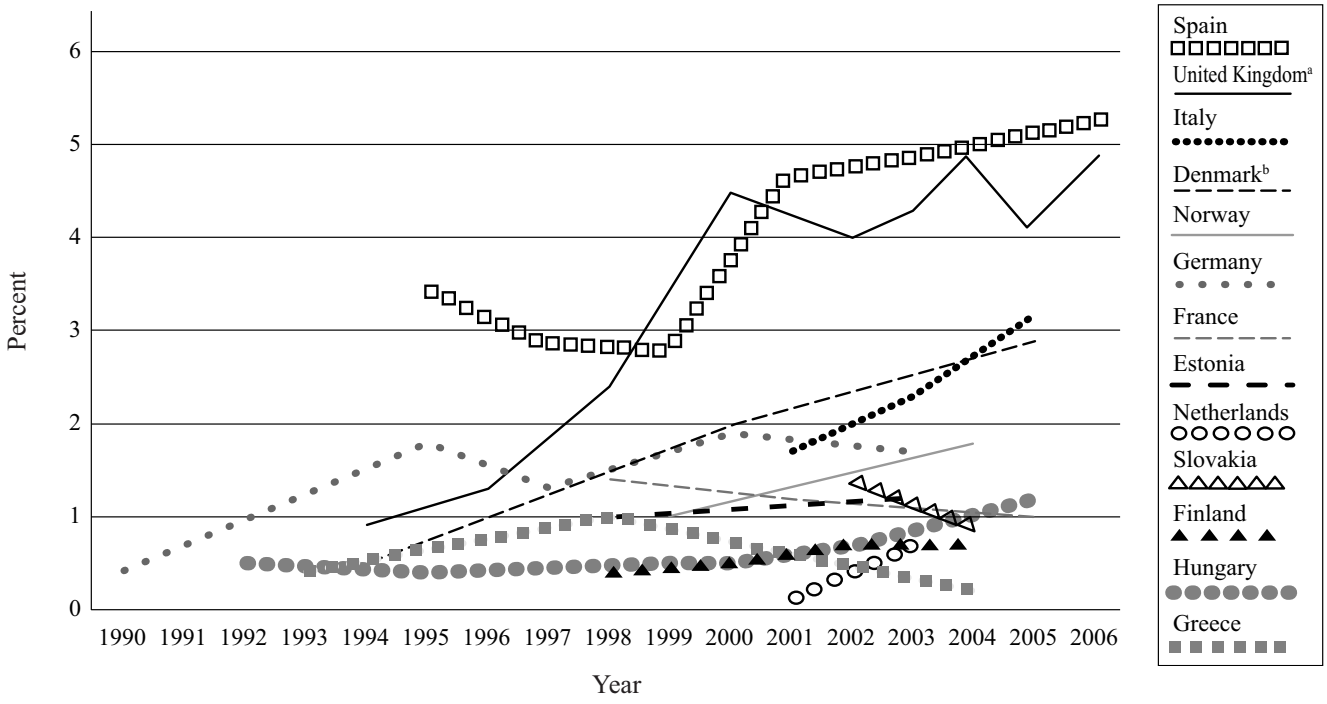
The report explicitly found that stringent criminalization laws do not produce lower drug usage, and that some data suggest the opposite may be true:

> Countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies. In the Netherlands, for example, which has more liberal policies than the US, 1.9% of people reported cocaine use and 19.8% reported cannabis use.[87]

A draft of this Cato report was submitted to several U.S. drug policy officials—in the U.S. Drug Enforcement Administration's headquarters, the DEA office in Madrid (which has jurisdictional responsibility for interacting

A 2008 survey of drug usage among Americans found that the United States has the highest level of illegal cocaine and cannabis use in the world.

Figure 19
Trends in Last Year Prevalence of Cocaine Use among Young Adults, Ages 15–34



Sources: European Monitoring Centre for Drugs and Drug Addiction, "The State of the Drug Problem in Europe," Annual Report (2007), p. 59.
[a]England and Wales.
[b]In Denmark, the value for 1994 corresponds to "hard drugs."

Table 2
Alcohol, Tobacco, Cannabis, and Cocaine Use in Selected Countries, 2008

Region	Country	Unweighted *n*	Alcohol		Tobacco		Cannabis		Cocaine	
			Percent	SE	Percent	SE	Percent	SE	Percent	SE
Americas	Colombia	4,426	94.3	0.5	48.1	1.2	10.8	0.6	4.0	0.4
	Mexico	5,782	85.9	0.6	60.2	0.9	7.8	0.5	4.0	0.4
	United States	5,692	91.6	0.9	73.6	1.2	42.4	1.0	16.2	0.6
Europe	Belgium	1,043	91.1	1.8	49.0	2.2	10.4	1.6	1.5	0.6
	France	1,436	91.3	1.2	48.3	2.1	19.0	1.6	1.5	0.4
	Germany	1,323	95.3	0.9	51.9	1.9	17.5	1.6	1.9	0.5
	Italy	1,779	73.5	1.8	48.0	1.3	6.6	0.8	1.0	0.3
	Netherlands	1,094	93.3	1.4	58.0	1.9	19.8	1.3	1.9	0.2
	Spain	2,121	86.4	1.1	53.1	1.8	15.9	1.3	4.1	0.7
	Ukraine	1,719	97.0	0.6	60.6	1.8	6.4	1.0	0.1	0.0
Middle East and Africa	Israel	4,859	58.3	0.8	47.9	0.7	11.5	0.5	0.9	0.1
	Lebanon	1,031	53.3	3.0	67.4	2.6	4.6	0.9	0.7	0.3
	Nigeria	2,143	57.4	1.6	16.8	1.1	2.7	0.5	0.1	0.1
	South Africa	4,315	40.6	1.2	31.9	1.1	8.4	0.6	0.7	0.3
Asia	Japan	887	89.1	1.6	48.6	2.0	1.5	0.4	0.3	0.3
	China	1,628	65.4	1.8	53.1	1.8	0.3	0.1	0.0	0.0
Oceania	New Zealand	12,790	94.8	0.3	51.3	0.7	41.9	0.7	4.3	0.3

Source: Louisa Degenhardt and others, "Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys," *Public Library of Science Medicine* 5, no. 7 (2008): p. 1057.

Table 3
Alcohol, Tobacco, Cannabis, and Cocaine Use for Youths 15 Years and Younger and 21 Years and Younger in Selected Countries, 2008

Region	Country	Unweighted *n*	Alcohol				Tobacco				Cannabis				Cocaine			
			By 15 years old		By 21 years old		By 15 years old		By 21 years old		By 15 years old		By 21 years old		By 15 years old		By 21 years old	
			Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE	Percent	SE
Americas	Colombia	4,426	57.4	2.3	92.2	1.2	12.3	1.3	37.5	1.9	2.9	0.6	10.2	1.2	0.8	0.3	3.1	0.8
	Mexico	5,782	29.0	1.9	77.5	1.2	21.4	1.4	52.5	1.6	2.2	0.5	8.0	1.1	0.6	0.3	4.1	0.7
	United States	5,692	50.1	2.5	93.1	1.3	43.6	2.4	71.6	2.8	20.2	1.8	54.0	2.8	2.5	0.8	16.3	1.6
Europe	Belgium	1,043	67.0	8.3	88.5	6.1	—[a]	—	—[a]	—	4.7	2.5	22.2	6.6	0.0	0.0	0.6	0.4
	France	1,436	68.2	3.2	94.5	2.2	—[a]	—	—[a]	—	15.3	4.3	44.1	5.3	0.0	0.0	1.9	1.3
	Germany	1,323	82.1	3.2	97.8	1.1	—[a]	—	—[a]	—	13.0	3.3	41.0	4.8	0.0	0.0	6.1	2.7
	Italy	1,779	44.9	3.6	76.3	3.6	—[a]	—	—[a]	—	3.3	1.1	13.7	2.5	0.0	0.0	0.9	0.6
	Netherlands	1,094	59.6	7.7	89.7	6.4	—[a]	—	—[a]	—	7.0	3.0	34.6	7.1	0.0	0.0	1.0	0.6
	Spain	2,121	52.8	4.8	92.1	2.1	—[a]	—	—[a]	—	8.5	2.6	27.7	4.4	0.1	0.1	5.3	1.8
	Ukraine	1,719	39.3	3.9	98.5	1.1	46.0	4.9	72.1	3.9	1.3	0.7	12.3	2.6	—[b]	—	—[b]	—
Middle East and Africa	Israel	4,859	15.2	1.2	62.7	1.6	8.9	0.9	43.2	1.6	0.3	0.2	13.7	1.1	0.0	0.0	0.5	0.2
	Lebanon	1,031	24.3	5.2	45.8	6.5	18.0	2.8	51.1	6.4	0.4	0.3	5.7	2.7	—[b]	—	—[b]	—
	Nigeria	2,143	31.4	3.2	52.5	3.1	6.9	1.7	10.1	1.7	0.2	0.2	1.9	0.9	—[b]	—	—[b]	—
	South Africa	4,315	9.4	1.4	39.5	2.0	11.0	1.6	31.0	1.6	1.6	0.5	11.0	1.4	—[b]	—	—[b]	—
Asia	Japan	887	30.4	6.7	91.9	5.8	—[a]	—	—[a]	—	—[b]	—	—[b]	—	—[b]	—	—[b]	—
	China	1,628	31.7	5.1	73.6	5.2	15.2	3.7	54.7	5.0	—[b]	—	—[b]	—	—[b]	—	—[b]	—
Oceania	New Zealand	12,790	74.1	1.5	94.1	0.9	—[a]	—	—[a]	—	26.8	1.4	61.8	1.5	0.1	0.1	5.0	0.8

Source: Louisa Degenhardt et al., "Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys," *Public Library of Science Medicine* 5, no. 7 (2008): 1059.
[a]Not asked in this country.
[b]Fewer than 30 persons in the entire sample of this country used this drug, so estimates have not been produced.

with Portuguese drug officials), and the Office of National Drug Control Policy—along with a list of specific questions for which a response was requested. Those questions focused on the rationale for the U.S. approach to drug criminalization in light of the far higher drug usage rates among Americans, trends that, in general, appear to be worsening, contrasted with the far better rates in decriminalized Portugal. Despite repeated requests, none responded to those questions.

According to EU drug policy officials, the United States has displayed very little interest in understanding the improving trends in Europe generally, and in Portugal specifically, that have clearly resulted in an environment of drug liberalization and decriminalization. Quite the contrary, over the last two decades, the United States has single-mindedly agitated for greater criminalization approaches and appears, at least to EU officials, interested solely in enforcement actions, rather than empirically vindicated policy changes at the user level designed to manage usage rates and ameliorate drug-related harms.

Around the world, it is apparent that stringent criminalization policies do not produce lower drug usage rates. If anything, the opposite trend can be observed. The sky-high and increasing drug usage rates in the highly criminalized United States, juxtaposed with the relatively low and manageable rates in decriminalized Portugal, make a very strong case for that proposition.

Conclusion

None of the fears promulgated by opponents of Portuguese decriminalization has come to fruition, whereas many of the benefits predicted by drug policymakers from institut-

There is no serious political push in Portugal to return to a criminalization framework.

ing a decriminalization regime have been realized. While drug addiction, usage, and associated pathologies continue to skyrocket in many EU states, those problems—in virtually every relevant category—have been either contained or measurably improved within Portugal since 2001. In certain key demographic segments, drug usage has *decreased in absolute terms in the decriminalization framework*, even as usage across the EU continues to increase, including in those states that continue to take the hardest line in criminalizing drug possession and usage.

By freeing its citizens from the fear of prosecution and imprisonment for drug usage, Portugal has dramatically improved its ability to encourage drug addicts to avail themselves of treatment. The resources that were previously devoted to prosecuting and imprisoning drug addicts are now available to provide treatment programs to addicts. Those developments, along with Portugal's shift to a harm-reduction approach, have dramatically improved drug-related social ills, including drug-caused mortalities and drug-related disease transmission. Ideally, treatment programs would be strictly voluntary, but Portugal's program is certainly preferable to criminalization.

The Portuguese have seen the benefits of decriminalization, and therefore there is no serious political push in Portugal to return to a criminalization framework. Drug policymakers in the Portuguese government are virtually unanimous in their belief that decriminalization has enabled a far more effective approach to managing Portugal's addiction problems and other drug-related afflictions. Since the available data demonstrate that they are right, the Portuguese model ought to be carefully considered by policymakers around the world.

Notes

1. See Elisabeth Malkin and Marc Lacey, "Mexican President Proposes Decriminalizing Some Drugs," *New York Times*, October 2, 2008; Helen Popper, "Argentina Eyes Legalizing Paco," *Toronto Sun*, August 19, 2008; "Swiss Voters Back Legalized Heroin," *New Zealand Herald*; and "Canadian Government Tries Anew to Decriminalize Marijuana," Reuters, November 2, 2004. Note also Jose De Cordoba, "Latin American Panel Calls U.S. Drug War a Failure," *Wall Street Journal*, February 12, 2009.

2. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), "Illicit Drug Use in the EU: Legislative Approaches," 2005, p. 4.

3. Mirjam van het Loo, Ineke van Beusekom, and James P. Kahan, "Decriminalization of Drug Use in Portugal: The Development of a Policy," *Annals of the American Academy of Political and Social Science* 582, Cross-National Drug Policy (July 2002): 59.

4. Ibid.

5. Caitlin Hughes and Alex Stevens, "The Effects of Decriminalization of Drug Use in Portugal," Briefing Paper no. 14, the Beckley Foundation Drug Policy Programme, December 2007, p. 6.

6. Instituto da Droga e da Toxicodependência de Portugal (IDT), "The National Situation Relating to Drugs and Dependency," 2006 Annual Report (2007), p. 35.

7. EMCDDA, "Illicit Drug Use in the EU," (2005) p. 27.

8. Instituto da Droga e da Toxicodependência de Portugal (Institute on Drugs and Drug Addiction of Portugal), "The National Situation Relating to Drugs and Dependency," 2005 Annual Report (2006), p. 87.

9. IDT, "The National Situation," (2007) p. 88.

10. IDT, "The National Situation," (2006) p. 35.

11. Ibid., p. 37.

12. Quoted in Daniel McGrory, "Portugal Police Won't Arrest Drug Takers," *Times* (London), July 14, 2001.

13. Fernando Negrao, a former police chief and the head of Portugal's Institute on Drugs and Drug Addiction, says, "There were fears Portugal might become a drug paradise [for tourists], but that simply didn't happen." Quoted in Alison Roberts, "How Portugal Dealt with Drug Reform," *BBC News*, December 29, 2007.

14. IDT, "The National Situation," (2006) p. 39.

15. Ibid., p. 99.

16. Van het Loo, van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," p. 54.

17. Ibid., p. 49.

18. Ibid., p. 54.

19. Ibid., p. 58.

20. IDT, "The National Situation," (2006) p. 150.

21. Van het Loo, van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," p. 60.

22. Instituto da Droga e da Toxicodependência de Portugal, pamphlet intended for public consumption by the citizenry.

23. Ibid.

24. European Monitoring Centre for Drugs and Drug Addiction, "The State of the Drug Problem in Europe," 2007 Annual Report, pp. 12–13.

25. EMCDDA, "Illicit Drug Use in the EU," (2005) p. 22.

26. Ibid.

27. EMCDDA, "The State of the Drug Problem in Europe," (2007) p. 13.

28. Ibid., p. 33.

29. Van het Loo, van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," p. 58.

30. Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 3.

31. Ibid., slide 4.

32. Ibid., slides 5–6.

33. Ibid., slides 13–14.

34. Ibid., slide 7.

35. Ibid., slide 8.

36. Communication with author, July 2008.

37. Quoted in Bob Curley, "Youth Drug Use Declines, but Alcohol, Future Trends Are Concerns," *Join Together*, December 19, 2003.

38. Louisa Degenhardt, Wai-Tat Chiu, Nancy Sampson, Ronald C. Kessler, James C. Anthony, Matthias Angermeyer, Ronny Bruffaerts, Giovanni de Girolamo, Oye Gureje, Yueqin Huang, Aimee Karam, Stanislav Kostyuchenko, Jean Pierre Lepine, Maria Elena Medina Mora, Yehuda Neumark, J. Hans Ormel, Alejandra Pinto-Meza, José Posada-Villa, Dan J. Stein, Tadashi Takeshima, and J. Elisabeth Wells, "Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys," *Public Library of Science Medicine* 5, no. 7 (2008): e141 DOI, 10.1371/journal.pmed.0050141 (emphasis added).

39. IDT, Draft 2007 Annual Report, slide 8.

40. L. V. Tavares, P. M. Graça, O. Martins, and M. Asensio, "External and Independent Evaluation of the 'National Strategy for the Fight against Drugs' and of the 'National Action Plan for the Fight against Drugs and Drug Addiction—Horizon 2004,'" Portuguese National Institute of Public Administration, Lisbon, 2005.

41. Hughes and Stevens, "The Effects of Decriminalization of Drug Use in Portugal," pp. 2, 5.

42. Van het Loo, van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," p. 52.

43. Ibid., p. 53.

44. Ibid.

45. IDT, "The National Situation," (2007) p. 53.

46. IDT, "The National Situation," (2006) p. 3.

47. Hughes and Stevens, "The Effects of Decriminalization of Drug Use in Portugal," pp. 2, 5.

48. IDT, "The National Situation," (2006) p. 3.

49. Ibid., p. 4.

50. Ibid.

51. IDT, "The National Situation," (2007) p. 26.

52. Ibid., p. 26.

53. IDT, "The National Situation," (2006) p. 4.

54. Hughes and Stevens, "The Effects of Decriminalization of Drug Use in Portugal," p. 3.

55. IDT, "The National Situation," (2007) p. 30.

56. Ibid., p. 31.

57. Van het Loo, van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," p. 53; IDT, "The National Situation," (2006) p. 71.

58. Van het Loo, van Beusekom, and James P. Kahan, "Decriminalization of Drug Use in Portugal," p. 52.

59. IDT, "The National Situation," (2006) pp. 59–60.

60. Hughes and Stevens, "The Effects of Decriminalization of Drug Use in Portugal," p. 6.

61. EMCDDA, "The State of the Drug Problem in Europe," (2007) p. 5.

62. Ibid., p. 14.

63. Ibid., p. 25. The figures refer to cited offenses—the number of people ticketed or arrested for drug law violations, not convictions.

64. Ibid., p. 13.

65. Ibid., p. 14.

66. Ibid.

67. IDT, "The National Situation," (2006) p. 2.

68. IDT, Draft 2007 Annual Report, slide 9; IDT, "Os Adolescentes e a Droga" ("Adolescents and Drugs"), (2003) p. 6.

69. IDT, Draft 2007 Annual Report, slide 10.

70. IDT, "The National Situation," 2007, p. 63. The last study to determine lifetime drug prevalence rates for the general population of Portugal was undertaken in 2001. The 2006 study referenced here examined the prevalence rates for students 18 years old or younger. Typically, the prevalence rate for the general population is *slightly lower* than the prevalence rate for the student population.

71. EMCDDA, "The State of the Drug Problem in Europe," p. 12.

72. Ibid.

73. Ibid., p. 51.

74. Ibid., p. 53.

75. IDT, "The National Situation," (2007) p. 69.

76. EMCDDA, "The State of the Drug Problem in Europe," (2007) p. 65.

77. Ibid., p. 13.

78. Ibid., p. 57.

79. Ibid.

80. Ibid., p. 14.

81. Ibid., p. 59.

82. IDT, Draft 2007 Annual Report, slide 11.

83. Degenhardt and others, "Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use," p. 1053.

84. *Science Daily*, July 1, 2008, http://www.sciencedaily.com/releases/2008/06/080630201007.htm.

85. Degenhardt and others, "Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use," p. 1056.

86. Ibid.

87. *Science Daily*, July 1, 2008, http://www.sciencedaily.com/releases/2008/06/080630201007.htm.

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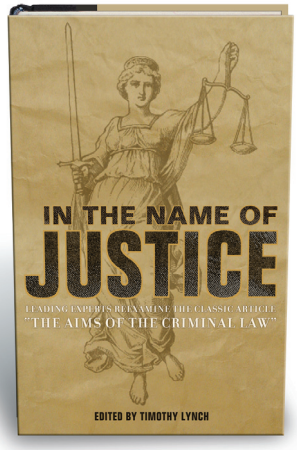

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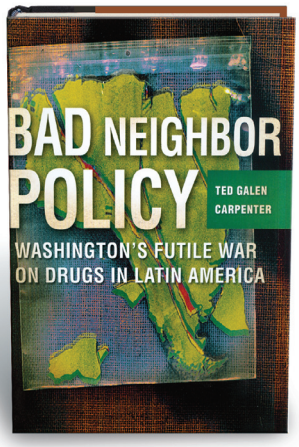

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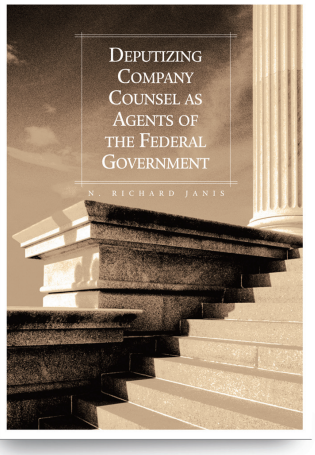

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