Coalition of Alcohol and Drug Educators

Dalgarno INSTITUTE

Portugal Drug Policy – A Review Of The Evidence!

Portugal Drug Policy Highlights Many Problems that Make it Unsuitable for Australia

Dalgarno Research Report (DRR)

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ABSTRACT

"The war on drugs and attempts at prohibition have failed."

This statement frames virtually every public drug debate and is the core defence for pushing everything from the legalisation of recreational marijuana to every illicit drug... The 'evidence' to support these changes appear numerous but most often include the mention of Portugal's drug policy. In 2001 this small European nation of nearly 10 million people decriminalised illicit drugs for personal use. Since then it has captivated media headlines and policy makers around the world as the poster nation for purportedly reducing drug use, decreasing overdose deaths and better public health outcomes.

What often gets missed in the hype is that while lobbyists vaguely talk about Portugal's decriminalisation they are in fact advocating legalisation. But there's a huge difference. Portugal did not make illicit drugs legal...Further, it did not alter the criminal penalty that prohibits the production, distribution and sale of drugs. Whereas, legalisation would not only remove every criminal penalty associated with using and trafficking but also give governments a stake in the regulation, production and taxing of illicit drugs.

Report Title:

PORTUGAL DRUG POLICY IS PROBLEMATIC AND UNSUITABLE FOR AUSTRALIA

> **THE WAR ON DRUGS AND ATTEMPTS AT PROHIBITION HAVE FAILED.**

This statement frames virtually every public drug debate and is the core defence for pushing everything from the legalisation of recreational marijuana to every illicit drug, including, *The Global Commission on Drug Policy*, a grantee of George Soros' *Open Society Foundations* that released its first major report condemning the war on drugs as a failure and recommending major reforms to the global drug prohibition regime.[1]

The 'evidence' to support these changes appear numerous but most often include the mention of Portugal's drug policy. In 2001 this small European nation of nearly 10 million people decriminalised illicit drugs for personal use. Since then it has captivated media headlines and policy makers around the world as the poster nation for purportedly reducing drug use, decreasing overdose deaths and better public health outcomes.[2]

In Australia, Senator Leyonhjelm[3], the Reason Party (formerly Sex Party) and the Greens[4] have all backed either partial or full legalisation of illicit drugs citing Portugal as their raison d'etre. And in July this year, the Queensland government sent out an information gathering delegation to this small nation.[5]

However, pro-drug lobbyists never explain in any meaningful detail what actually happened in that country, which is crucial if policy changes from one country are adopted by another.

What often gets missed in the hype is that while lobbyists vaguely talk about Portugal's *decriminalisation* they are in fact advocating *legalisation*. The media have led the charge with misleading headlines such as this *Huffington Post* piece, *What Happened After Portugal Made All Drugs Legal?* Even the conservative magazine *Quadrant* seems to have muddled the distinctions publishing this article, *Should We Legalise Drugs?*[6]

But there's a huge difference. Portugal did not make illicit drugs legal, it merely removed criminal sanctions of small quantities for personal use and kept in place administrative penalties. Further, it did not alter the criminal penalty that prohibits the production, distribution and sale of drugs. Whereas, legalisation would not only *remove every criminal penalty* associated with using and trafficking but also give governments a stake in the regulation, production and taxing of illicit drugs.

THE PORTUGUESE CONTEXT – PRE AND POST DRUG DECRIMINALIZATION

What is also frequently misunderstood is that Portugal did not introduce a radical policy transformation after an exhaustive but failed hard line war on drugs. Headlines such as, *Portugal Won the War on Drugs by Giving It Up*,[7] make such claims by relying on the reader's lack of both historical and drug policy knowledge. The Portuguese story is far more historically nuanced.

For nearly fifty years Portugal had lived under authoritarian rule (1926 to 1974). It is considered the longest dictatorship on the European stage[8] and therefore unique in understanding the nations subsequent surge in drug addiction, particularly heroin.

The only wars Portugal lost was in its former colonies. The military coup of 1974 and the nations subsequent withdrawal from Angola, Portuguese Guinea, and Mozambique bought the majority of Portuguese troops – nearly 140,000 out of 204,000 were posted overseas8 — and bureaucrats' home, most with no work to return to but bringing in loads of drugs including cannabis, heroin and cocaine from distant lands. Historian Luis Vasconcelos, who teaches at the *ISCTE University* at Lisbon, believes what happened in Portugal wasn't so different from the rest of Europe, where heroin burst onto the national scene following the pull towards drugs during the liberal countercultural hippy movement of the mid-1960s and 70s.[9]

Added to that, Portugal is surrounded by nations that are key drug trafficking routes. "As international drug traffickers discovered a new market in Lisbon, they also realized that the Iberian Peninsula was an ideal gateway to Europe. Portugal became a transit point for the distribution of cocaine from South America, heroin from Spain, and hashish and marijuana from Morocco and other African countries".[10] [11]

It was a potent mix.

As Dr. João Goulão, who fronted the 1998 Portuguese drug addiction program explains,

> *"Many Portuguese people awoke from a reign of dictatorship in the mid 70s, eager to experiment with the things that had been forbidden for so long — chief among them were drugs."*

This sudden openness also made way for a heroin epidemic.

Lisbon's Casal Ventoso neighbourhood, was home to many unemployed dockworkers and soldiers and the centre of the new drug scene. *The Institute of Drugs and Drug Addiction (IDT)*, characterized this district as "the biggest supermarket of drugs in Europe".

Reports include that of junkies openly injecting themselves, dirty syringes piling up, streets reeking with garbage and HIV and soaring Hepatitis infection rates.

It's interesting that delegations visiting Casal Ventoso today see an area barely recognisable to the chaotic drug scene described. But that's because according to various accounts, the government ordered a district makeover as bulldozers ploughed through the neighbourhood, adding new streets, closing others, taking down or bricking up shacks, adding apartment blocks and moving addicts out.[12]

This is once again in direct contradiction to the popular story of Portugal's switch from its so-called tough on drugs governmental campaign. Goulão goes on to explain:

> *"We were completely naive about drugs. The country had been closed off and drugs had been controlled for decades and suddenly the doors were wide open.*
>
> *Everyone was trying stuff without the risk of consequences... Drug use and alcohol abuse was tolerated, or even incentivized."*[13]

Portugal's history follows more closely, but not directly, the events leading up to US alcohol prohibition, which remains an unfortunate misnomer for a period that didn't actually outright prohibit alcohol. A lesser known fact left out about this historic legislation (Volstead Act), is that it **did not specifically forbid the purchase or consumption of intoxicating liquors in a private residence** and allowed for **stockpiling of alcoholic beverages**. Since the act took a year to come into effect – there was **plenty of time to accumulate liquor**.

The US landscape prior to 1920 was one where with alcohol and opiate addiction were both tolerated and widely used (and misused) for well over a century. As historian Thomas Noel points out, "Western cities were modelled on eastern ones and often had more in common with the urban East than the frontier West."[14]

The book *Dark Paradise: A History of Opiate Addiction in America*, by David Courtwright lives up to its title. Starting as far back as the Revolutionary War, the author gives substance and statistics

about opioids in the United States. The book clearly shows that America has had one ongoing opioid crisis for its entire history. Courtwright begins with the premise that, "Over and over again the epidemiological data affirms a simple truth: those groups who, for whatever reason, have had the greatest exposure to opiates have had the highest rates of opiate addiction."

And as modern medicine was still in its infancy, doctors widely prescribed opiates such as morphine, laudanum, paregoric and codeine. They were used for coughing, toothache, tuberculosis, headaches, depression, menstrual cramps, sleeplessness, a soothing baby tonic and even as a cure for alcoholism.

There was no sudden onset of moral panic that brought about the Prohibition but a reaction to extensive substance abuse that had finally reached the point of becoming a national concern.

As the authors of the book, *Drug Heresies: Learning from Other Vices, Time & Places* make clear, Prohibition did not include criminal penalties for the possession of alcohol, only for the purchase and sale. Prohibition was actually much like what is called "decriminalization" in the current drug debate. Next, they argue that enforcement of Prohibition was never very intense. At the peak of enforcement, they suggest there were 80,000 *alcohol-related* convictions (this would include alcohol as one of two or more charges) annually, but prior to the stiffening of penalties in 1929, the average punishment was a prison term of only 35 days and a $100 fine. Therefore, number of people incarcerated on *alcohol-related* charges at any one time was about 8,000 prior to 1929.

Even after the clampdown in 1929, the number of alcohol-related the number of alcohol-related prisoners was less than 40,000 at any point in time. And finally, alcohol was a previously legal good that became illegal.

Given this social background, the decriminalization changes to Portuguese law in 2001 could not in and of itself produced the overwhelming changes pro-drug lobbyists suggest, simply because the nation already had in effect practiced drug decriminalisation for decades earlier.

Furthermore, Portugal's policy shift was not as profound as some authors and media suggest. With the exception of the creation of the *Dissuasion Commission*, decriminalisation merely brought the nation roughly in line with the drug policies of other EU countries. Both Spain and Italy ceased imposing criminal sanctions for possession of small quantities of any psychoactive substances decades earlier. The *European Monitoring Centre for Drugs and Drug Addiction* (EMCDDA) notes that the trend for Europe since the 70s was a movement toward "an approach that distinguishes between the drug trafficker, who is viewed as a criminal, and the drug user, who is seen more as a sick person who is in need of treatment".

Page nine summarises most of the progressive drug policies Portugal introduced including:

- 1963 - Introduction of mental health law mentioning treatment of 'drug addiction',
- 1973 - Marks the opening of the first addiction treatment service,
- 1976 - The first mention in a legal document of the decriminalisation of drug use,
- 1977 – introduction of opium substitution drug - methadone,
- 1983 - Criminal law recognises the drug user as a person in need of medical care and
- 1999 - Buprenorphine and buprenorphine/naloxone combination made available.[15]

MORE LIES, DAMNED LIES & CONFOUNDING STATISTICS: PORTUGAL'S MIXED OUTCOMES

THE CATO STUDY – GLENN GREENWALD

The most widely circulated favourable report on Portugal's drug decriminalisation titled, *"Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies"*, by Glenn Greenwald, was commissioned by the *Cato Institute* and paid by the Marijuana Policy Project.[16]

FEAR OF INCREASING 'DRUG TOURISM'

The opening pages of the Cato report makes this bold statement, "None of the nightmare scenarios touted by pre-enactment decriminalisation opponents – from rampant increases in drug use among the young to the transformation of Lisbon into a haven for "drug tourists" – has occurred."

Greenwald quite often places this type of subjective story-telling carefully scattered among various graphs and statistics. The report subtly builds a picture of hard-line anti-decriminalisation opponents plagued with irrational fears and an austere pre-decriminalisation environment towards drug addicts. This is despite the fact that resistance to decriminalisation was minimal and barely worth note, as the paper later goes on to describe the governmental mood on page seven where the commission's decriminalisation recommendations were approved by Federal Ministers "almost in its entirety" and "encountered relatively little political resistance."

Hannah Laqueur's paper, *Uses and Abuses in Drug Decriminalisation in Portugal* deals extensively with the social-political background of pre-decriminalisation in Portugal and contradicts much of Greenwald's findings. Interestingly, compared with the widespread media coverage of Greenwald's paper, Laqueur's report barely raised any questions.

Unfortunately, it is left to a few to closely scrutinise the many contradictions, assumptions and unquantifiable suggestive statements, beginning with the so-called "fears of drug tourism" statement referred to earlier. This phrase is parroted almost verbatim by Peter Reuter, a criminologist at the *University of Maryland*, "It did not lead to Lisbon becoming a drug tourist destination," Reuter states.

Yet, a quick scan at travel websites and reviews of actual tourists who have visited the area since decriminalisation presents a somewhat different image.

> *"One thing to note, drug tourism is still treated seriously. The police will hassle people obviously not Portuguese. Quite the most bizarre part is the heavy police presence in the major drug market in Lisbon. Dealing is still illegal, but the cops are there to protect the buyers, not to arrest the dealers. And drug dealers seem indifferent even when they're knowingly being filmed."*[17]

This traveller's cautionary advice from 2015,

> *"Don't go to Lisbon, I have just returned from a weekend in Lisbon. Consistent harassment from people selling drugs. I would say I was approached 30 - 40 times over the weekend. Sitting outside drinking a coffee at lunchtime, must have been approached 5-6 times in one hour. Sitting inside a pub one night beside a window, pushers would approach the window making signs if I wanted drugs. Would never go back to Lisbon, much nicer cities in Europe."*[18]

This type of experience is backed up with the following account,

> *"Another thing which really bothered me is that in the most touristy area of Lisbon, around the Praça do Comercio, the police tolerates drug dealers in Lisbon. That's right. We walked passed a man on the street who offered us marihuana while there was a police man standing only two meters from us. Nothing happened. I think we got offered drugs at least five times the first day we were in Lisbon and after a while you can just spot the dealers from afar, but they'll still talk to you. It's possible that they especially addressed us as we're a young couple."*[19]

Furthermore, a recent report bringing together Portugal's drug experts demonstrates the effortless access to drugs during the opening of drug smartshops (later shutdown), "The NPS (New Psychoactive Substances) market in Portugal can be divided into two distinct periods of time: before the closure of all smartshops in Portugal, from February 2007 until April 2013; and after, from April 2013 until now...According to many of the respondents, the geographical location of Portugal is one of the major reasons for the ease of access and availability of all substances in the country. Additional factors appear to influence the islands of Azores and Madeira, making these regions distinct from the rest of Portugal. In continental Portugal, nearly all substances can be purchased on the street..."[20]

However, pro drug legalisation activists point to the numbers of drug users appearing before Portugal's *Dissuasion Commission* (the centre dealing with drug users) as proof of decreasing drug activity in public streets, "Whilst some feared that Portugal might become a drug paradise, this has simply not been the case. Approximately 95% of people sent to 'dissuasion groups' were of Portuguese origin."[21]

Here it seems the concern is more about public visibility of drug users and dealers than an actual decrease in numbers. As this 2016 Belgian article, *The Drug Zombies are out of Lisbon*, describes addicts from the Casa Ventoso district. "Drug addicts put a syringe in their arm every day in the Casal Ventoso district, outside the eye of the world."[22]

However, what is left out of the 'nine-five percent' statement is that the *Dissuasion Commission* was set up under the nation's public health scheme for Portuguese citizens, so of course this

would be the group predominantly represented before authorities. Furthermore, prosecutions are rarely enforced and recommendations for treatment *remain voluntary*, as drug users are seen as sick patients in need of treatment. Therefore, just like other patients for example, a diabetic, cannot be coerced into treatment, the same attitude is adopted toward drug addicts.[23]

Furthermore, the commission makes the distinction between "non-addicted" and "addicted" users, with the former freely dismissed. Therefore, the *95 percent* appearing before the *Dissuasion Commission* could easily find themselves back among the general populace using and buying drugs. Of course, the other major assumption is that 95 per cent actually represent the entire cohort of Portuguese drug users.

In fact, a likely scenario is that a significant percentage of drug users are simply not reported. This is briefly touched upon in page five of the Cato report. "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."

MacCoun and Reuter in *Drug War Heresies*, note that drug user data often relies on self-reporting and surveys both of which do not accurately reflect actual long term or dependent users' trends because, among other factors, "they lead erratic lives, are less likely to provide truthful responses and more likely to be found among non-household populations". Such observations were backed up with another study that concluded, "This procedure reveals extensive heroin and cocaine use frequency underreporting...Drug use frequency underreporting appears substantial and might constitute an important threat to the validity of some treatment outcome evaluations."[24]

These restraints are important to underscore as the *rates of drug use* are often seen as the linchpin to determining the success or failure of drug policy.

As the case for decreased drug use after Portugal's decriminalisation is a point Greenwald strenuously tries to demonstrate despite his extensive explanations for drug use rates not being the primary focus for the nation's policy makers.

Greenwald's interview with *Time* magazine explains why he considers this so vital.

> *"The Cato report's author, Greenwald, hews to the first point: that the data shows that decriminalization does not result in increased drug use. Since that is what concerns the public and policymakers most about decriminalization, he says, "that is the central concession that will transform the debate."*[25]

RATES OF DRUG USE —AN INCOMPLETE PICTURE

Beginning from about page four, Greenwald begins to set the scene for the legal and political motivations behind Portugal's decriminalisation. While there are passing references to decreasing drug use, the policy objectives clearly centre on the mental and physical wellbeing of drug users and their ease through every level of the decriminalisation process. A message that is firmly reiterated. "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-emphasise or even eliminate any notion of 'guilt' from drug usage and instead to emphasise the health and treatment aspects of the process…at all times, respect for the alleged offender is emphasised." The legal code codifies these convictions, as noted here, "the Portuguese legal framework was intended to implement 'a strong harm-reduction orientation' and 'the flagship of these laws is the decriminalisation of the use and possession for use of drugs'".

Despite this emphasis, Greenwald goes on to make his case for the supposed much-improved decreasing rates of drug use. Beginning in the Executive Summary following the opening statement of unfounded drug tourism fears he continues, "Post decriminalisation usage rates have remained *roughly* the same or even decreased *slightly* when compared with other EU states…".

Roughly the same and *decreased slightly* are not accurate metrics to judge a policy but this does not stop Greenwald from making audacious claims. "The data show that, judged by virtually every metric, the Portuguese decriminalisation framework has been a resounding success."

However, the "decriminalisation framework" success is quite a separate objective to decreasing drug use. The policy framework can only be judged on the framer's original purpose which was to "implement a strong-reduction orientation" – that is, get more addicts into treatment. By that metric it certainly has met its goal. Yet most media coverage has interpreted this as meaning decriminalisation has successfully decreased drug use, including *The Report for the Global Commission for Drug Policy Reform.* "In July 2001, Portugal became the first European country to decriminalize the use and possession of all illicit drugs. Many observers were critical of the policy, believing that it would lead to increases in drug use

and associated problems. Dr Caitlin Hughes of the University of New South Wales and Professor Alex Stevens of the University of Kent have undertaken detailed research into the effects of decriminalization in Portugal. Their recently published findings have shown that this was not the case, replicating the conclusions of their earlier study and that of the CATO Institute."

In fact, most scholars agree that drug decriminalisation i*ncreases drug use* but are unsure on how much.[26] Furthermore, Greenwald explicitly states after interviews with Portuguese political officials and drug policy experts that they went ahead with decriminalisation despite their "belief that it would lead to increased drug usage." (Cato report, page 9)

As mentioned earlier, 'smartshops' selling NPS were initially allowed, and these would not have subsequently been closed down if there was little demand for their product. But they also highlight the difficulty and conflicting messaging of decriminalising personal drug use without legalising its supply (distribution and trafficking).[27]

The other limitation of Greenwald's analysis on drug usage rates is that he insists the best measure of Portugal drug usage rates is through comparison with EU nations that criminalise personal drug use.

> *"The true effects of Portuguese decriminalization can be understood only by comparing post decriminalisation 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."*

But this is either outright false or at best a misleading equivocation between decriminalisation verses actual criminalisation, since the majority of European nations (excluding a minority such as Russia) practice personal drug use decriminalisation, although still in legal code, and for much longer periods than Portugal.[28]

As Greenwald also points out. "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 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.' An excerpt from the EMCDDA 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.'"

This same practice of de facto decriminalisation holds true in Australia and the United States.

The other problem is the issue of averages particularly the "average of averages", which have clear restraints in meaningful data interpretation.

> *"It could take account of the size of the target population in each participating country or it could be computed as a simple 'average of averages', which in practice involves assigning each country the same weighting of one. The latter means that each country influences the average to the same extent, regardless of whether it is a small or large country. Such country averages have been used in all previous ESPAD reports, and this practice has been retained also for the 2015 presentation. Country averages presented in the tables do not include Latvia, Spain and the United States (explained later)", and qualified here, "that average number is completely skewed the data by smoothing out the distribution."*[29]

Added to this is the problem of inconsistency of nation participation rates year on year and the accuracy surrounding self-reporting as discussed earlier.

So, while comparisons are helpful, limitations also need disclosing.

Paradoxically, despite Greenwald's emphasis in EU comparison, he then proceeds to criticise data collected through the EU. "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."

Greenwald then makes his declining drug use success case predominately relying on an entirely different data source from the *Institute on Drugs and Drug Addiction* (IDT), Draft 2007 Annual Report.

DRUG USE DATA 2001 – 2007

The IDT (replaced in 2011-12) under the Ministry of Health was the main body charged with implementing drug treatment and statistical collection— and is the source for most of Greenwald's data analysis. However, the IDT did not begin its data collection until 2001 and there were no national population studies conducted prior to this date.

Furthermore, there is also the possibility of a conflict of interest. The IDT depended on government funding to implement the 2001 recommendations for drug treatment (requiring a doubling of public finances) and as noted by some observers there is an inherent interest to ensure their statistics are favourable, not only for ensuring ongoing finances but for its sudden global standing as a model drug policy as witnessed by the steady flow of international policy makers studying the 'Portuguese model'.

However, from data that can be gleaned, Portugal *had and continues to have* low rates of drug use in the general population compared with the US and many EU nations.[30] However, Portugal surpassed many nations in drug-related AIDS and ranked second in HIV prevalence.

When these factors are considered alongside the historic lenient policing of drug users prior to decriminalisation, in effect this strongly suggests that any shift in the nation's drug statistics post

2001 make it unlikely the direct effects of the decriminalization statute, as "the law focuses on the wrong date for measuring any impact."[31]

The actual statistics on Portugal's drug users are rather difficult to determine. Depending on the data selection criteria for years, ages, outcomes and the particular studies cited, the statistics can prove or disprove increase or decreases in drug usage.

So while the report from *The Global Commission on Drug Policy*, referenced earlier, gives the *Cato* report an emphatic endorsement, also citing researchers Hughes and Stevens, they seemed to miss (along with a large part of the media) a key statement from an *earlier* Hughes and Stevens briefing, *The Beckley Foundation Drug Policy Programme (2007)*, that makes the following observations, "On the other hand there are concerns that decriminalization has contributed towards a rise in new drug use, particularly use of cannabis and ecstasy. While the drug trends clearly illustrate a rise in cannabis use amongst youth, key informants raised a number of possible explanations:

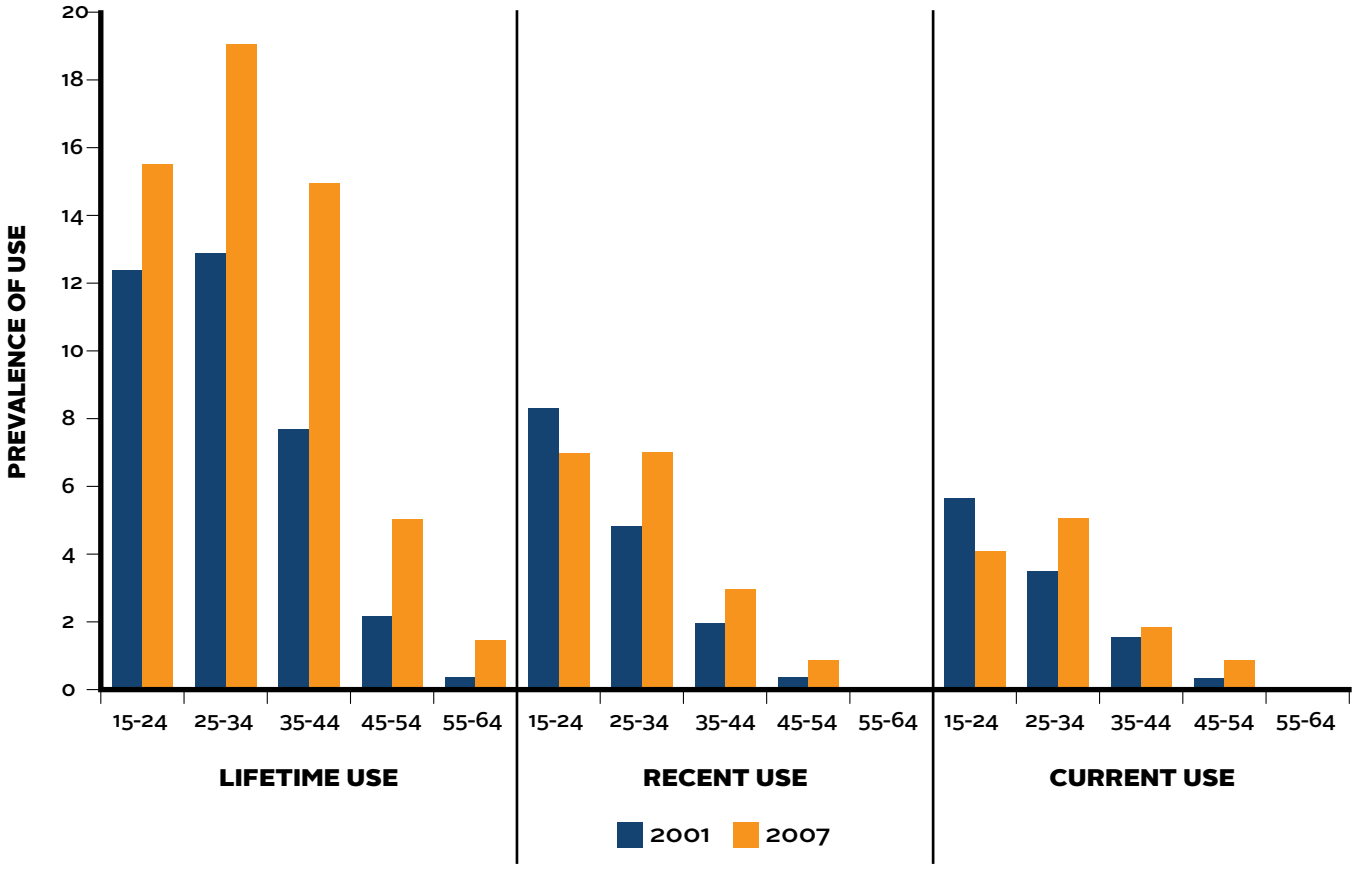
- increased self-reported use due to less stigma surrounding drug use
- increased use as part of a European trend
- increased use due to the decriminalization and perceived tolerance of use."[32]

The first explanation for the rise seems unlikely because as already pointed out, de facto drug decriminalisation was already practiced well before 2001 as witnessed with open-air drug markets and public use of drugs.[33] This makes it highly doubtful that drug users increased drug use simply because government merely altered its legal code. The second explanation of course is unboundedly a factor and the third would be a reasonable deduction but would be summarily dismissed from harm reduction proponents because it would not suit their narrative.

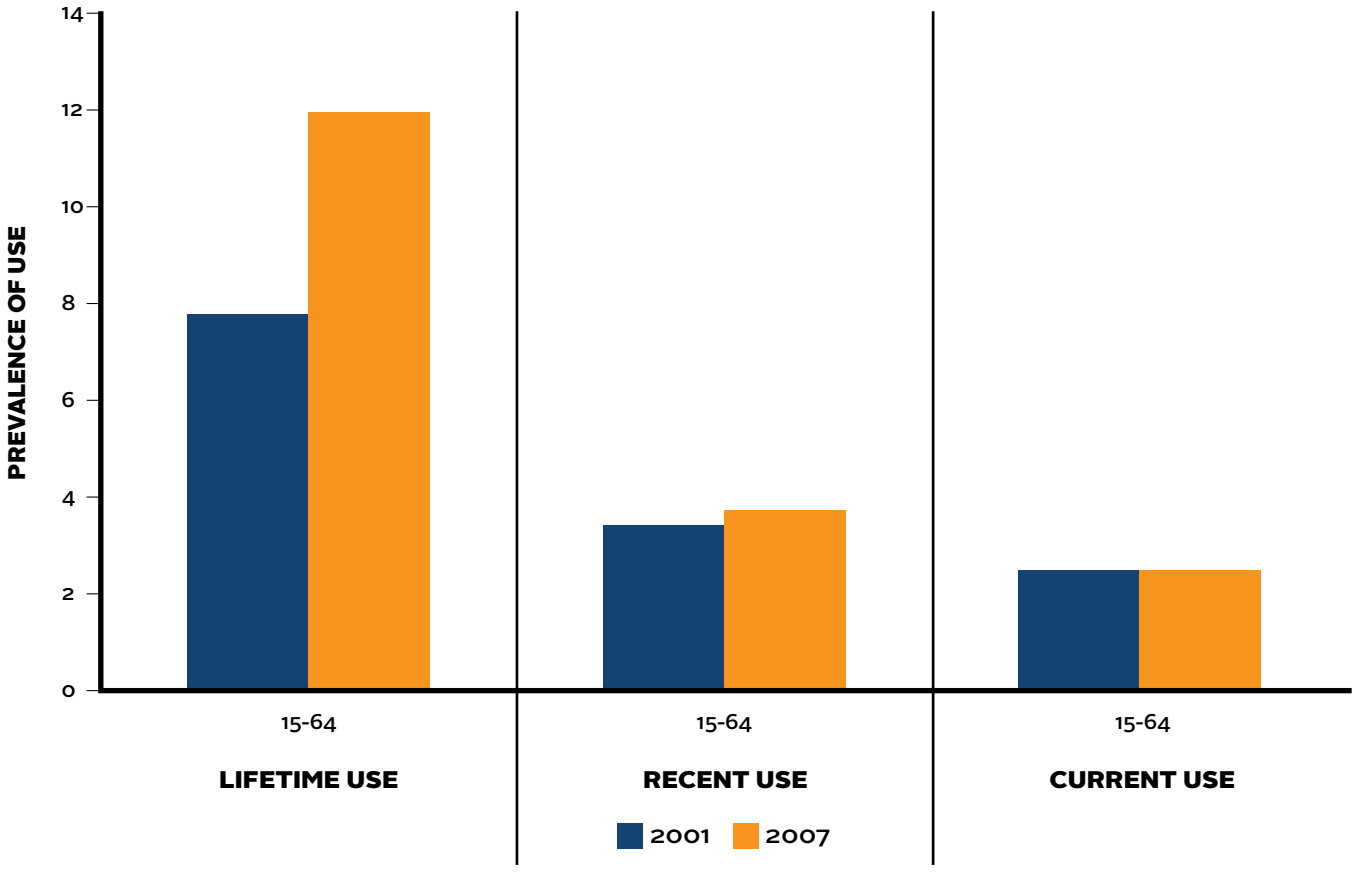
However, even a later Hughes and Stevens 2012 report that re-examined the data stated, "Examining the trends in the general population, there were clear increases between 2001 and 2007 in reported lifetime use for most age groups and most illicit substances." Increases were also noted in the general population for recent use (12 months) and were stable for current use (30 days).[34] Given these figures the authors conclude that, "...the *Cato* report was overly optimistic."[35]

Hannah Laquer's report also offers a different set of statistics.

These graphs below summarise the findings:



Prevalence of lifetime, recent (last 12 months) and current (last month) use of any illicit drug in Portugal, by age group in 2001and 2007. Source: Balsa et al. (2004, 2007)



Prevalence of lifetime, recent (last 12 months) and current (last month) use of any illicit drug in Portugal among individuals aged 15–64 in 2001 and 2007. Source: Balsa et al. (2004, 2007)

Returning to Greenwald's paper, the "overly optimistic" assertions not only continue but are once again coloured with language more suited to describing weather fluctuations than objective statistical data.

"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.*"

As mentioned earlier, Hughes and Stevens and Hannah Laqueur clarify such findings with much of Greenwald's terminology is highly subjective and understates increases while amplifying decreases.

This was the conclusion reached from the *White House* in 2010 when examining the *Cato* report.[36]

For example:

The report emphasises a **decline in**:

- illicit drug usage among 15-19-year old from 2001 to 2007,
- lifetime prevalence rates for the 13-18 age group from 2001 to 2006
- heroin use in the 16-18 group from 1999 to 2005

Downplays **increases in**:

- 15-24 age group for psychoactive and illicit drugs
- greater increase in the 20-24 group
- lifetime prevalence rates for the 15-24 age group between 2001 and 2006
- lifetime prevalence in 16-18 age group between 1999 and 2005

One suggestion for the decline in early usage rates is that younger age groups are merely putting off more frequent drug use till later years—late teens or early adulthood; a trend suggestive in later reports. As this most recent article highlights. "Compared to 2012, there seems to be a trend toward *later average onset* age of consumption for alcohol, tobacco, drugs, amphetamines, heroin, LSD and hallucinogenic mushrooms."[37]

Greenwald begins to unpack the figures first referring to the decreases in lifetime prevalence rates of younger age groups 13-15-year old and 16- 18-year-old, noting they are "critical groups". This follows with a reference to older groups of 19-24-year old experiencing *slight to mild increases* and the 15-24-year old with a *small rise* in psychoactive substances but *substantial increases* for illicit substances.

The acknowledged increases in the latter age groups give the first indication as to why Greenwald emphasises the younger group as "critical". But there are two problems. Firstly, the *White House* report explains that decreases in lifetime prevalence for younger age groups spanning over a five

to six-year period is too short a timeframe for any meaningful inference. Particularly since scant data collection prior to 2001 would mean starting from a low base.

Secondly, Greenwald subsequently follows on his discussion by continually interchanging between different age groups that are considered *critical* and/or *significant*. Page thirteen of the report goes on to mention the age group *most significant* to policy specialists is now the 15-24 group NOT the initially stated 13-15 and 16-18 age groups. However, this shifts once again. The following page also states the 15-19 age group as *critical*.

Yet despite this obfuscation, Greenwald seems determined to 'prove' the success of decriminalization through decreased drug usage rates. The increases in "other age groups of older citizens" are explained away using comments from Dr. João Goulão: "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)."

The assumption that many "older people never try drugs", is too broad. What constitutes an older group? Over 24 years old? The growth of heroin use that began in the 70s and peaked in the 90s, included a generation of returning younger soldiers. If the often-reported estimate of 100,000 heroin users before 2001 is accurate, then these problem drug users would almost certainly still form part of the older cohort of drug users (40 to 60-year old), who have used and continue to use drugs. This is supported from MacCoun and Reuter discussing the US experience of rising and declining rates of heroin usage where addicts "turned out to be a very long-lived condition: the addicts recruited between 1967 and 1973 where still most addicted in 1990, as revealed in a remarkable 24-year follow-up of a California sample."[38]

Having given every reason why increases in any age group are not really that concerning, Greenwald now abandons any serious discussion on the *critical* 15-24 age group drug increases in "psychoactive usage" or "substantial increase of illicit substances generally" and now moves the readers focus to the decreases in *heroin* prevalence rates for 16-18 age group (its significance discussed more below); an age group that is also noted for an *increased somewhat* in cannabis and drugs generally. In fact, the increases were more than *somewhat*, ranging from 9.4 to 15.1 per cent and 12.3 to 17.7 per cent respectively between 1995 and 2005.

HEROIN USE AND PROBLEM DRUG USERS

Problematic drug use (PDU) particularly that of injecting heroin users is the specific category that is seen to determine the effectiveness of Portugal's drug policy model.[39] And this seems to give the strongest indication for the reason Greenwald's analysis often minimises the impact of other drug use increases but amplifies the decreases in heroin use specifically in the 16-18-year old age group.

The *Cato* paper summarises a key goal for decriminalisation:

> *"The substance Portuguese drug officials believed was far and away the most socially destructive..this was due to high levels of* ***problematic drug use and drug related problems...primarily with use of heroin****, with a* ***particular problem of injecting drug use and the related risk of HIV/AIDS and viral hepatitis.****"* (Cato, page 13)

This is the central premise to understanding Greenwald's conclusions of Portugal's drug policy particularly in the specificity of the language used, in this case success is stated in "absolute terms in the decriminalisation framework". This particular phrasing is deliberate, because it means the real measure of decriminalisation is based on achieving the main policy objectives which primarily focus on *decreasing problematic drug use*, mainly *heroin*, and its related harms. If these goals are achieved, then the program is deemed successful.

Greenwald includes a graph with figures derived from the EMCDDA (2007), *Prevalence of Problem Opioid Use* 15-64, 2001-2005 which curiously do not include Portugal.

However, the closest data approximations prior to decriminalisation are found from the UN, which estimated Portugal heroin use exceeded OECD countries in 1998 at 0.9%, dropped to 0.7% in 2000 and halved to 0.46% by 2005. In effect, half the decrease in heroin use began prior to decriminalisation and therefore any subsequent shifts cannot be directly attributed to decriminalisation.

Yet, heroin use remains widespread.

> *"Finally, and comparatively with studies results from other European countries, we can state that, even being the national results the most recent European results, Portugal remains among the countries with the lowest prevalence of use for most of the substances, with the exception of heroin, where Portugal shows higher prevalence's."*[40]

But what of the numbers for *Problematic Drug Users*, which are the leading concern for policy framers and Greenwald?

Once again, the numbers are inconsistent. The *EMCDDA* (2006) could not quantify its figures,

> *"Problem drug use is monitored mainly through estimates repeated every 5 years. In early 2007 the national estimate of 2001 (2000 data) will be repeated to allow for both a comparison and a baseline for the current National Action Plan."*[41]

While the *EMCDDA* (2007) report states,

> "Results from national estimations on problematic drug use in Portugal indicate that there are between 6.2 and 7.4 problematic drug users for each 1 000 inhabitants aged 15-64 years, and between 1.5 and 3.0 for the definition of problematic drug users (injecting drug users). Between 2000 and 2005, the estimate number of problematic drug users in Portugal has shown a clear decline, with special relevance for injecting drug users."

Of course, the same limitations surround PDU data collection that were mentioned earlier in this paper, but they also include the following qualifications:

- Limitations of data collection. "Not all treatment facilities are covered. The public treatment centers couldn't provide data of problem drug users seeking treatment categorized by type of drug. The estimation of the in-treatment rate was based in the samples selected in only two Portuguese cities."

- Also noted here, "Due to lack of information about in-treatment rates outside Porto and Viseu, a range of 0.52- 0.62 was used to estimate the number of problem drug users. As so, given that the public treatment centres reached on average 52% of the total number of problem drug users nationally, there are 27 685/0.52 = 53 240 estimated problem drug users; if 62% is taken has an average percentage nationally, there are 27 685/0.62 = 44 653 estimated problem drug users in Portugal."[42]

- The IDT reports that from 2010 due to methodological changes accompanying the new system, researchers cannot compare data from or after that year. (Hannah Laqueur, page 23)

- The issue of meaningful definitions. For example, how is "prolonged use" measured? As seen from the Queensland report there is a tendency to dismiss regular drug users. "Mr Capaz advised the key to the process was the way in which the Commission could tailor the response to suit the individual. Where a person is assessed as a recreational user, the commission can provide harm reduction advice and *tolerate continued use* (which the court system cannot do). The key for dependent users is ready access to a publicly funded treatment system, including free access to methadone and needle and syringe programs."

- How would the PDU definition (which does not include cannabis or other psychotropic drugs) affect PDU numbers if included? (The latest 2018 EMCDDA notes that since 2012, there has been an increase in the proportion of entrants reporting primary cannabis use and a decrease in the proportion reporting primary opioid use.)

- Data collection from IDT managed treatment centres only began in 2001 but what of the thousands receiving government services outside treatment centres such as from community-based intervention teams? "Outreach teams provide harm reduction information as well as sterile injecting equipment and sterile smoking equipment. They can refer people they come across to treatment services if they wish. They are also able to provide transport to medical and other appointments. Their 'Housing First' program *has no requirement for people to be in treatment or intending to go to treatment*, with properties provided through the private rental market. The organisation provides a minimum of six visits per month to support people to maintain their tenancy. [43]

- How does the clear decrease in the number of *injecting* heroin users (either switching to smoking heroin or taking opioid substitutions such as methadone) affect PDU numbers? [44] For example, is a smoking heroin user without HIV/AIDS or other viruses or methadone patient classified as problematic or merely a patient under state health care?

While the EMCDDA states methadone or other substance-substitution programs are generally viewed as successful it was noted that some Portuguese are beginning to question long-term methadone therapy.

> *"Now that the epidemic is under control for the most part, people start asking questions," says Dagmar Hedrich, a senior scientific analyst with the EMCDDA. "The question now is what is going to happen next? There is a part of the population who do not have the possibility of leaving the treatment. From 2000 to 2008, the number of people receiving substitution treatment increased from 6040 to 25 808 (24 312 in 2007), 75% of whom were in methadone maintenance treatment. The remaining patients received high dosage buprenorphine treatment."*

This *New Yorker* article sums up the growing concerns of government 'solving' one problem at the risk of exacerbating others, "Yet there is much to debate about the Portuguese approach to drug addiction. Does it help people to quit, or does it transform them into more docile drug addicts, wards of an indulgent state, with little genuine incentive to alter their behaviour? By removing the fear of prosecution, does the government actually encourage addicts to seek treatment?"[45]

The following story from that same article gives some indication, "For Miranda, however, and for thousands of others who find themselves participating in civil life rather than disrupting it, such questions don't matter. He has a wife and a sixteen-year-old son and adores them both. "My wife would never let me use heroin at home," he said. "I am not even allowed to smoke cigarettes in the house." With a stable family, a regular dealer, and his spot in the parking lot, Miranda's life has become orderly, almost routine. "This is because of the law," he said. "We are not hunted or scared or looked upon as criminals," he added, referring to the country's addicts. "And that has made it possible to live and to breathe." I asked if he had ever tried to overcome his addiction. He shrugged. "I guess I should," he said. "I know I should. But I'm not sure I can, and it isn't really necessary. I am lucky to live in a society that has accepted the fact that drugs and addiction are part of life."

A *Huffington Post* piece also presents a similar story, "'Will you pay us if we talk to you?' ask two thin men with dreadlocks, rolling down the window to their parked car and peering out. On their laps are tin foil sheets, on which they are spreading a brown sticky paste. Soon, they will heat up the foil from beneath with a cigarette lighter and take in a "hit" of heroin. 'We don't care that others quit,' they add, almost apologetic, cutting rather lonely figures on a street in which a baby carriage or two is pushed by, a hip cafe has opened, and many former addicts are working towards cleaning up their lives."[46]

And in the event such statements are seen as purely anecdotal, the latest EU reports, "People who are dependent on drugs are encouraged to seek treatment but are rarely sanctioned if they choose not to – the commissions' aim is for people to enter treatment voluntarily; they do not attempt to force them to do so."[47]

As this account from the Queensland report confirms, methadone is administered without hassle or major screening requirements. "The delegation attended an outreach site for a low-threshold mobile methadone program. The program visits three sites around Lisbon twice a day (morning and afternoon) on weekdays and once a day on weekends. The program provides doses of methadone to around 1200 patients daily and is accessed *via self-referral*. New patients undertake a urine drug screen and simple interview process to access the program and are generally started on a 30mg dose of methadone, which can be increased up to 50mg and then up to 120mg over time. There is *no requirement for daily attendance or abstinence from heroin*, although if two doses are missed, the protocol is to drop the dose by one-third."[48]

This also brings to focus the perverse financial incentivisation of big pharmaceuticals to keep patients on government controlled opiate substitution and other drug treatment programs. It is reminiscent of an earlier era during the 18th and 19th century when heroin was beginning to be viewed as addictive, prompting the rise of patent medicines to promote safer cocaine 'medicines' thought to cure heroin and alcohol addiction.[49]

SHIFTING THE DRUG USER PROFILE

DRUG USER TREATMENT

Greenwald praises both the increase in treatment services and the corresponding number of drug users opting for care, concluding that this outcome was both "predictable" and "desired".[50] Undeniably, this is the key policy achievement indicator for what Portugal sought out to achieve since decriminalisation, that is, increasing drug treatment facilities/programs and drug user access rates with a particular focus on decreasing the number of heroin injecting episodes, all possible due to a much-boosted health budget.

But Greenwald uses this result to press another unrelated point, namely, that the increased numbers of drug users in treatment centres should not be construed as suggesting *increasing rates of drug use*. Remembering that Greenwald considers *decreasing drug use* essential to pushing drug reforms no matter how tenuous the conclusions. In this instance even going as far to state "empirical evidence suggests the opposite". However, no credible source is offered for this empirical evidence.

Instead, the report goes onto to describe the excessive discrimination practiced pre-2001 where "addicts are afraid to seek treatment due to fear of criminal penalties," this being the "most substantial barrier to offering treatment".

This type of historical revisionism amounts to mythmaking and was discussed earlier, but it needs repeating because it continues as the dominant picture that frames the Portuguese drug policy narrative put forward by drug lobbyists and is uncritically accepted by the vast majority as factual.

Consider these latest accounts, beginning with the Queensland government's report, *Portugal's response to drug-related harm July 2018* (page 7),

> *"Mr Capaz also noted the shift in prevention campaigns since the policy change. Portugal has abandoned mass media campaigns with a '**just say no**' message and instead developed smaller campaigns targeted at particular groups (e.g. unemployed, sex workers, school drop-outs) with messages such as shifting use from injecting to smoking heroin, or aiming to increase the age of first use, and information sessions not focused on fear tactics in schools."*

This no doubt conjures up in the reader's mind scenes from Nancy Reagan's, often scorned, *Just Say No* campaign of the 90s. As *The Guardian* newspaper also depicts in yet another lauding article on Portugal drug policy pointing to, among other things, the purported failure of the *Just Say No* and *Drugs are Satan* Portuguese version of the tough of drugs campaign, which the reader can explore further within an embedded link. But when the hyperlink is clicked, it references the US experience *not* Portugal's.[51]

Of course, the no spin and less populist version is that the Portuguese campaign was in fact titled, *Just Say No to a Used Syringe*. A 1993 government drive as part of the harm reduction needle exchange program aimed at ages 17-18, to reduce infectious diseases spread through syringe sharing. Set up by the Ministry of Health and the National Association of Pharmacies, a "gentleman's agreement" between the user and pharmacist allowed the exchange of two syringes for one free kit containing two sterile syringes, a condom, two small disinfectant towels, an ampoule containing distilled water, a filter and an information leaflet.[52]

The Portuguese campaign was clearly not advocating abstentionism but reducing injecting drug harms. Similarly, the reference to *Drugs are Satan* is also widely circulated ad nauseam but cannot be found in any official Portuguese drug campaign documents.

Therefore, far from fears of impending prison, addicts were being treated without prejudice in an environment of minimal drug user screening and as has been frequently stated, without disproportionate coercion.

DRUG POSSESSION IMPRISONMENT AND THE DISSUASION COMMISSION

Supposed high incarceration rates for drug possession have always formed a major talking point for those pushing the relaxation of drug laws. It leaves the impression that drug users incarcerated for mere possession are routinely locked up.

Portugal's case is no different. For example, this sensationalised article claimed, "previously, the Portuguese police threw users into the cell without mercy."[53] And at first glance the statement seems supported from other assertions such as, "the arrest rate for heroin possession increased 250% between 1991 and 1998 (Loo, 52)."[54]

Pro-drug advocacy groups have been incessant in constructing a draconian representation of law enforcement toward drug users prior to 2001 claiming, "The percentage of people in Portugal's prison system for drug law violations also decreased dramatically, from 44 percent in 1999 to 24 percent in 2013."[55]

However, Greenwald's report acknowledges that in practice Portugal's addicts were hardly ever incarcerated prior to 2001, "Even before decriminalization, prosecution —and certainly imprisonment—for mere possession or use were rare, but not unheard of." But immediately goes on to cite figures from an IDT report (2005) claiming "at times, the use of the criminal process against those accused solely of usage approached the levels of those accused of trafficking."

It is here that Greenwald appears to blur vastly different issues. Accusation/suspicion, prosecution and imprisonment are all different procedures that the Cato report seems to conflate within the "criminal process". Yet the distinctions are significant. Briefly, accusations/suspicions do not necessarily lead to actual arrests, and arrests do not automatically lead to charges/convictions and of these there is no certainty of imprisonment.

Hannah Laqueur's paper also examined the criminal system surrounding drug use in the eight years leading up to Portugal's decriminalization and found the average number of inmates for simple drug possession was around 25 – not 25 per cent, but 25 people out of nearly 10 million or 0.00025%. Another 121 individuals, roughly three per cent, of the incarcerated drug offender population carried convictions for drug trafficking.[56] This data is a better fit with the first-hand accounts of lax policing and open drug use described at the beginning of this research.

In fact, de facto decriminalisation is the default practise for most Western nations with respect to personal drug use, including Australia. So, while classing many drugs as illegal, prosecution for small amounts of personal possession are rarely, if ever, prosecuted, particularly for marijuana. This is in line with the EU approach generally as cited by Greenwald. "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.'"

A recent submission from the *Dalgarno Institute* contending against the legalisation of recreational marijuana in Australia explains at length the national imprisonment rates showing the majority are for *drug related offences* such as trafficking where drug use may also be a feature.[57]

Similarly, in the US these assertions were debunked by Jonathan Caulkins, finding that more than 85 per cent of all drug-law violations were involved drug distribution, the remaining inmates had some suggestion of distribution involvement and approximately 0.5 per cent of the total prison population involved marijuana possession.

This finding disputes the conclusions of the *Marijuana Policy Project*, which Caulkins explains, "naively ... assumes that all inmates convicted of possession were not involved in trafficking." He determined that "an implication of the new figure is that marijuana decriminalisation would have almost *no impact* on prison populations."

Returning to Portugal, Laqueur goes on to explain that while police continue to formally issue citations to drug users, arrest rates remain largely unaffected, "The police were and still are responsible for detecting both drug consumers and drug traffickers. Decriminalization has not changed the number of formal drug-related contacts between citizens and the police... The number and composition of drug arrests and administrative citations in 2010 were almost

As was the generally the situation prior to decriminalisation, most drug users appearing before the *Dissuasion Commission* are summarily dismissed. "In 2012 concerning the administrative sanctions for drug use[40], the 18 *Commissions for the Dissuasion of Drug Addiction* (CDT) based in every capital district of Continental Portugal instated 8,573 processes[41], representing the highest value since 2001 and an increase of 24% in comparison to 2011, most of which were, again, referred by the Public Security Police (PSP), National Republican Guard (GNR) and Courts. From the 7,394 rulings made, 82% suspended the process temporarily, 15% were punitive rulings and 3% found the presumed offender innocent."

And similarly, of those found trafficking many do not face imprisonment, "Concerning the sanctions applied in these convictions, mostly related with trafficking crimes, such as occurred in 2004 and contrary to previous years, these convictions involved mainly suspended prison (48%) instead of effective prison (31%)."[58]

So, if the current practice of issuing citations is viewed as the equivalent to the previous custom of what Greenwald labels "accusations", then nothing of any consequence has changed since decriminalisation. In fact, post 2001 there are less monetary penalties. (HL page 9). Practically however, the status quo with respect to drug arrests, offences and use of police time remains fairly constant. Authorities continue to treat drug users leniently despite concerns that other underlying social phenomena may indicate otherwise. As this officer explains, "Pedro do Carmo, deputy national director of Portugal's judiciary police, says he doesn't see link the rise in violent crime with decriminalization. Instead, he praises the program for reducing the fear and stigma attached with drug use. "Now, when we pick up an addict, we're not picking up a criminal," he says. "They are more like victims."[59]

Of course, in a decriminalised setting, connections between the drug user and any related crimes are harder to delineate and prosecute. For example, how is law enforcement to treat a thieving drug *addicted* user when the law explicitly states they are foremost patients in need of treatment? And how does legal permission for users to carry ten days of supply and in the case of cannabis, grow their own plants, affect policing when the trafficker is also found to be a drug user *(trafficker-consumer)*? "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."

As Laqueur notes, "By increasing the quantity of a drug considered for personal use, decriminalization likely made distinguishing consumers from trafficker-consumers more ambiguous. Dealers may have altered their distribution strategies in accord with provisions of Sub article 2 of Act 30/2000 by carrying no more than the ten-day supply."

In summary, although a steady number of citations continue, there are less drug trafficking convictions and drug trafficking imprisonment rates.

A situation not altogether surprising if viewed through the lens of the decriminalisation policy makers. Particularly given the majority of the those appearing before the *Dissuasion Commission*

are considered non-addicted marijuana users. As the focus of decriminalisation was problematic drug use in mainly heroin injecting users, marijuana is seen as not problematic from both a legal and health perspective.

But despite decreasing trafficking imprisonment rates there is enough street level drug running to concern ordinary citizens. This news heading captures the public mood: *Portuguese most concerned about drug trafficking.*[60]

This would correspond with the increasing number of drug seizures since decriminalisation. And this is somewhat expected as personal drug use is decriminalised but users must still access their supply through illegal channels which since 2001 has remained readily accessible to drug users.

DRUG SEIZURES

As Portugal is part of the EU family, membership brings greater migration and trade whether legal or illegal. This is consistent with the rise of cannabis and cocaine trafficking in neighbouring countries that undoubtedly find their way into Portugal. As this EU report explains, "Trafficking of cocaine into Europe appears to mainly take place through western and southern countries, with Spain and Portugal in the south and ports in the Netherlands and Belgium in the north being the most important entry points for South American cocaine reaching the European market."[61]

Consistent with the number of marijuana users appearing before the *Dissuasion Commission*, Laqueur's paper notes that cannabis seizures have also increased. "The number of heroin seizures recorded by the police increased significantly in the 1990s, dropped at the turn of the twenty-first century, and has been essentially stable since 2002. In contrast, except for a small dip in the first couple of years following decriminalization, the annual number of hashish and cocaine seizures grew over the two decades...the quantities of drugs seized have varied considerably from year to year and across drug type. There was, for example, a large increase in hashish seizures between 2003 and 2005, then a decline followed by an even larger increase in 2007 and 2008. The quantity of cocaine seized also increased substantially in 2005 and in 2006, the year in which the UNODC estimated Portugal was responsible for 35 percent of all cocaine seizures in Europe (UNODC 2011)."

However, in a recent interview João Goulão restates the official government position that the of majority of drug seizures are not intended for Portuguese consumers, "As international drug traffickers discovered a new market in Lisbon, they also realized that the Iberian Peninsula was an ideal gateway to Europe. Portugal became a transit point for the distribution of cocaine from South America, heroin from Spain, and hashish and marijuana from Morocco and other African countries. (That has not changed. Goulão's institute estimates that seventy-seven per cent of the drugs seized in Portugal are destined for other countries.)"[62]

And Goulão continues with the same reasoning this *Huffington Post* article, "Goulao also has a ready explanation for why the amount of drugs seized has increased enormously too. An indication of more drugs out there? No, he argues. It's a sign that police officers, freed up from focusing on small-time possession, have been able to target big-time traffickers."[63]

However, another explanation for the increased drug seizures and trafficking is simply more drug use. Why increase supply to a market where there is low demand? Or as one user puts it, "The Portuguese say jokingly: 'It is forbidden, but it is allowed",64 and this health worker's matter-of-fact explanation, "Of course, you can come here and still buy heroin. The dealers know where we are and when we are here. People exchange syringes and then go buy drugs."[65]

Contrary to Goulão's assessment, research suggests an entrenched association between patterns of drug use, seizures and trafficking. "Irrespective of demand and supply market forces, generally the more demand, the more trafficking and seizures or the more supply the more drug consumption and trafficking. For example, the world's largest marijuana market (the USA, also characterized by low levels of transit trade), cannabis herb seizures and cannabis use among high-school students, were found to correlate strongly."[66]

Given that not much in practical terms with respect to the drug scene has changed in Portugal or to use Greenwald's oft used phrase "in absolute terms", what cost savings benefits has decriminalisation bought the nation?

Since, the shift of drug users from criminal courts to the commission there has been a rise of marijuana users appearing before the administrative body and researchers Hughes and Stevens observed delayed processing.[67]

UNSUSTAINABLE HEALTHCARE COSTS

Despite problems of congestion confronting the *Dissuasion Commission*, the Queensland report claims that the "switch from a justice to a health approach has led to significant savings, with the average 'cost per file' processed being about 50% of the cost when the courts were involved."[68]

But Portugal's decision to move further towards EU's stated aims of drug policy "healthification", required the expansion of law enforcement to monitor drug trafficking and distribution in parallel with the increases in drug prevention, treatment, harm reduction and social reintegration of drug users. In effect, legally defining a drug addict as a 'sick person' means free access to every level of the healthcare system including treatment centres, public and private housing initiatives, work reintegration programs, health care specialists, opioid substitution programs, needle exchange and drug injecting rooms.[69]

And these services needed a massive boost to the nation's public treasuries. Initially, the target was set for the "doubling public investment to PTE 32 billion (at the rhythm of 10% a year) over the next five years, so as to finance the implementation of the national drug strategy." (EMCDDA 2007) That is, 150 million Euros or 218 US dollars by 2004.

So, while some cost savings surrounding the criminal justice system in particular may have decreased, overall spending has increased and spread across the various government departments created since decriminalisation. As noted here, "However, while judicial costs have fallen, other costs associated with treatment and prevention have increased. The new health-

based approach basically changed the allocation of public expenditure to drug issues, which were directed to the creation of the system of referral to the "Commissions for Dissuasion of Drug Addiction", to the construction of new treatment facilities, and to prevention campaigns, among other target expenditures."[70]

Yet unlike the certainty of earlier claims (average 'cost per file' processed being about 50% of the cost when the courts were involved), locating reliable figures directly associated with the implementation of the 2001 drug policy changes remains elusive.

For 2005, 2012 and 2018 the total budget allocated for each organisations drug related expenditures were not available.

> *"Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, most drug-related expenditure is not identified ('unlabelled') and must be* ***estimated using modelling approaches****... However, the estimates have limitations, as data on some types of expenditure (e.g. on prisons or for social security) were missing or may also include spending related to alcohol. Currently, public entities implementing drug policy in Portugal are funded within their global budget on an annual basis and* ***there are no specific budgets that finance drug policy as such****. Public expenditure on drug-related initiatives was also estimated as part of the evaluation of the Portuguese Action Plan 2013-16; however,* ***the results are not yet available****."* [71]

And other strategic problems have surfaced.

First, Portugal's strong focus on one demographic of society (drug user as a patient) is disproportionate to the rest of the population (particularly the ageing population), putting a strain on its universal public healthcare system particularly for the average non-drug using Portuguese citizen that must shoulder the burden of inferior healthcare facilities and higher out of pocket costs.[72]

Furthermore, the long-term sustainability of Portugal's decriminalisation programs is severely tested in an economic crisis.

This was the harsh reality faced after the 2008 Global Financial Crisis. While some critics blame austerity, measures implemented after this period, others attribute it to the nations overly ambitious public programs implemented since 2001, an ageing population declining birth rates made worse by generation of drug addicts continuing their all-consuming, costly habit for decades.[73]

"The answer lies in Portugal's budgetary policy. During its cycle of expansion, Spain adjusted its public accounts and cut its taxes, spending and indebtedness. Portugal expanded its public spending but did not reduce its deficit. In 2001, Portugal broke with the European Pact of Stability and Growth by recording a budget deficit of 4.1%, above the 3% limit stipulated by the Pact. Last year, Portugal engaged in a major belt-tightening effort and managed to reduce its deficit to 2.8%.

According to Das Neves, the current setback in public finances "was not created by a revolution or cyclical crisis or external shock, as in earlier cases. It was the result of feudal interests, who forced their priorities on the public good. Pressure groups satisfied themselves at the cost of [higher] public spending, and they created a budgetary hole. A significant portion of the elite appears to have stopped producing; it dedicated itself to dividing what already existed. That's why there was a slowdown.

Now Portugal faces a crisis of indebtedness – in an international context that is not stable. "Raising taxes or selling public property are emergency measures that can be justified in public terms, but they contribute little to the solution of the problem. The problem is not a shortage of revenues; it is excessive spending. In a country where taxes amount to 38% of the GDP, something is wrong when public spending amounts to 48%."[74]

PORTUGAL – POST GREENWALD REPORT

THE SIGNIFICANCE OF CHANGE IN POLICY APPROACH - IDT REPLACED WITH SICAD

The 2008 GFC shock waves eventually reached Portugal in 2009/10.[75]

Among other factors, high unemployment meant less taxation for public programs especially those related to harm reduction that were now being strained even further as drug use increases particularly among the young triggered a policy priority rethink.

"In the context of school populations, the results of national studies have shown that the use of drugs that had been increasing since the 90s declined for the first time in 2006 and 2007, noting up in 2010 and 2011 again an increase of drug use in these populations, *alerting to the need for investment in prevention.*"[76]

The former IDT (*Instituto da Droga e da Toxicodependência or Institute for Drugs and Drug Addictions*) was wound up and the newly formed SICAD (*General-Directorate for Intervention on sAddictive Behaviours and Dependencies or Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências*)[77] now emphasised drug reduction and prevention. As outlined here: "Promote the reduction of licit and illicit psychoactive substances use, the prevention of addictive behaviours and the decreasing of addictions."[78]

But over a decade on from 2001 the harm reduction priorities that emphasised services for addicted heroin injecting users were now realising that short term drug use ("non-addicted" or occasional users) was also presenting different health challenges. "In general, for those experts whose work is related to mental health, the focus is on the mid long-term health effects, such as liver and kidneys problems (most related with synthetic cannabinoids), paranoia, and other psychiatric consequences. For those who are working in the field of harm reduction, the main challenge is to understand how to avoid short-term consequences associated with NPS use such

as bad trips, police or dealer conflicts. It is easy to notice differences between each expert and their work field. However, violent behaviour is often associated and identified as an NPS effect."[79]

And deteriorating mental health for older Portuguese was of particular concern. "Nevertheless, the latest official figures are concerning and call for further research on this sensitive issue. "The Portuguese National Institute of Health noted an increase in the incidence of depression reported by sentinel general practitioners in Portugal between 2004 and 2012. A substantial increase has occurred in new cases of depression in men aged 55–64 years, women aged 45–54 years, and those older than 75 years. The rise in unemployment (from 10·8% of the population in 2010 to 16·3% in 2013), salary and pension cuts, and loss of purchasing power could explain these figures."[80]

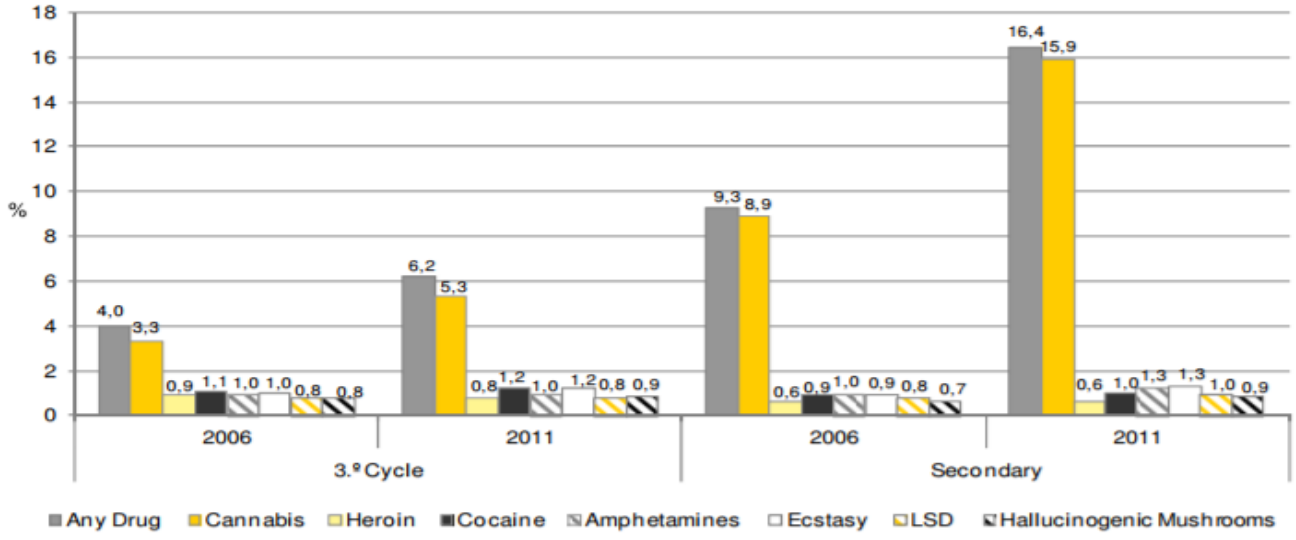
DRUG USE DATA SINCE 2007

Drug use patterns are never static. This holds true since Greenwald's report that mainly concentrated on the years 2001-2007.

"The data (2005-2007 surveys) confirms the increasing trend during the last year in France, Ireland, Spain, The United Kingdom, Italy, Denmark and Portugal" (EMCDDA 2008). While *rates of use of cocaine and amphetamine doubled in Portugal.* [81]

The same report continues: "Portugal did experience an increase in drug use after [decriminalisation] was implemented, but so did many European countries during this period. Cannabis use increased only moderately, *but cocaine and amphetamine use rates apparently doubled off a low base."*[82]

Most importantly however, as highlighted earlier, SICAD reports on the young drug use prompted its policy emphasis on prevention: "The *young adult population (15-34 years)* presented lifetime prevalence, recent rates and continuity rates of use higher than the general prevalence. Near of 0.7% the 15-64 years population and 1.2% of the young adult population resident in Portugal present symptoms of cannabis dependence, corresponding to about a quarter of cannabis users in the last 12 months."[83]



Graph 15 – School Population – INME (3º Cycle and Secondary): Last 30 Days Prevalence of use, by type of drug (IDT, I.P. 2012)

And the *National Survey on the Use of Psychoactive Substances in the General Population, Portugal* 2016/17, reports: "We have seen a rise in the prevalence of alcohol and tobacco consumption and of every illicit psychoactive substance (affected by the weight of cannabis use in those aged 15-74) between 2012-2016/17."

This is supported on page eleven of the Queensland report: "The service [Intervention Division] noted an increase in the age of their clients over the last 20 years, with the mean age shifting from the 20s to the mid-40s. In the early days, 90% were experiencing problems related to heroin, though this has shifted now with a mix of substance-use issues, including heroin, cannabis and cocaine. Alcohol is the largest problem substance."

As an aside, it should also be noted that alcohol (a socially acceptable and decriminalised substance) often gets missed in the Portugal analysis. An IDT report highlights that in 2005 there were an "estimated 1.8 million excessive drinkers and chronically ill alcoholics in Portugal. According to a report that year from the *World Drink Trends* organisation, 60 per cent of the country's 12-16-year-olds and more than 70 percent of over-16s said they drank regularly. That year alcohol was estimated as the fourth highest cause of death in Portugal, responsible for 33 percent of vehicle-related fatalities. This scenario is remarkably different to the previous decade, when IDT figures between 1988 and 1998 showed that only 1.2 percent of individuals turned to the IDT for alcohol-related issues, and heroin was responsible for 94 percent of the institute's patients."[84]

Could this be the reason governments keep sounding the same "alcohol is more harmful than drugs" message? In the 90s it was heroin which prompted the 2001 decriminalisation and massively increased drug related programs. Now with a shift to other illicit drugs such as cannabis, the focus changes towards alcohol (a substance civil liberties groups fought hard to ensure its wide spread use). Will governments now commit to exponential funding of alcohol and cannabis rehabilitation? ("Portuguese experts agree 'alcohol is more harmful than drugs' in wake of controversial UK study - The Portugal News.pdf"). Is this the future of drug policy? A reactive

response to decriminalising a substance and once it proves to be a widespread national disaster then greatly increase taxpayer funded treatment?

If decimalisation is believed to decrease substance use and abuse, then alcohol should serve as real life example of the contradiction in this argument.

Paraphrasing the words of Keith Humphreys, a professor of psychiatry at Stanford University, the changes in Portugal have had a somewhat expected outcome: More people are trying drugs.

CANNABIS USE

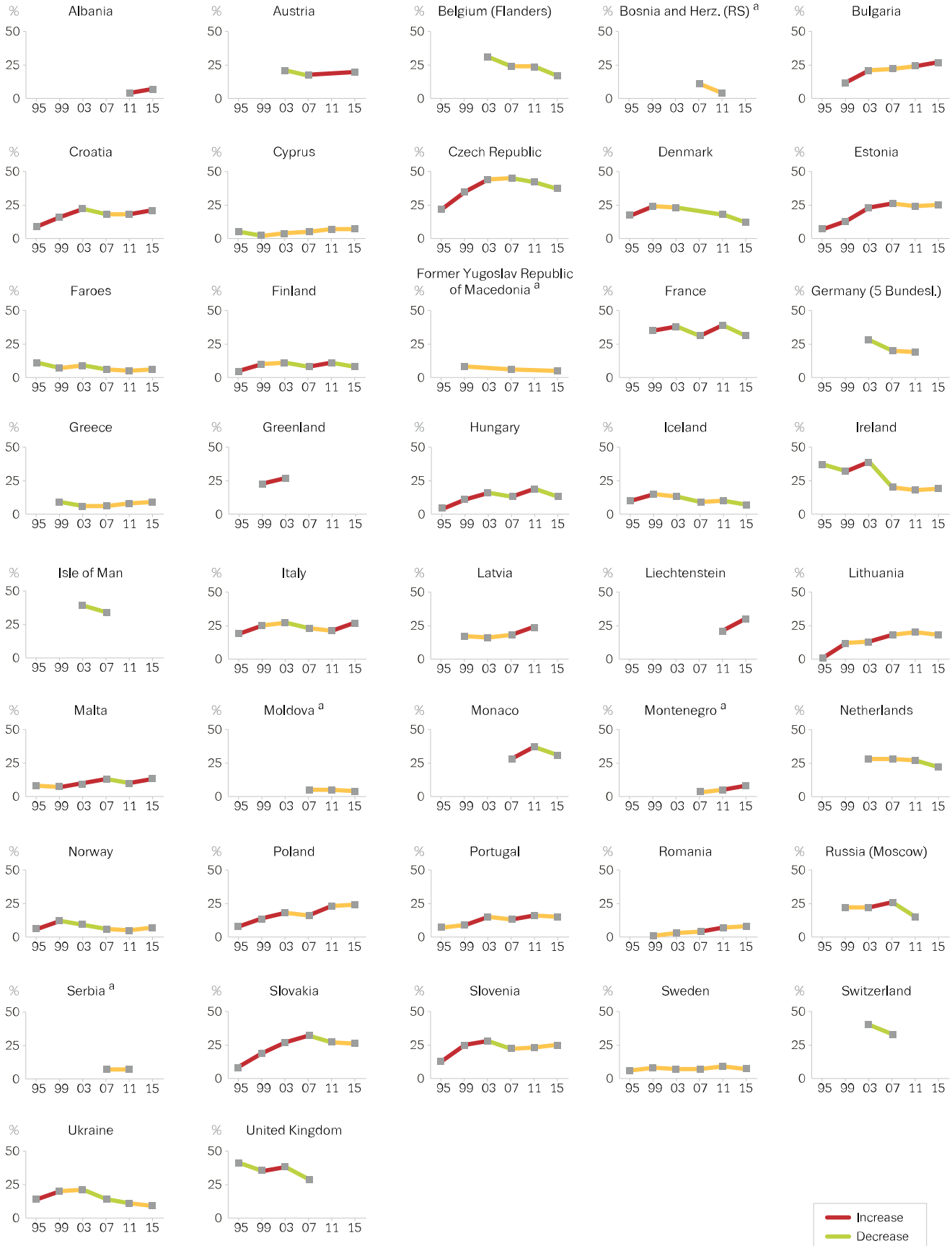
Greenwald's paper details a declining trend for cannabis use. "For the period 2001–2005, Portugal—for the 15–64 age group—has the absolute lowest lifetime prevalence rate for cannabis, the most used drug in the EU. Indeed, the majority of EU states have rates that are double and triple the rate for post decriminalization Portugal. 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."

However, since then the scene has shifted once again, "Cannabis remains the most frequently used illicit substance in Portugal, followed by MDMA/ecstasy and cocaine. Use of illicit substances is more common among young adults (aged 15-34 years). The available data indicate an increase in last year and last month cannabis use during the period 2012-16, mainly among those aged between 25 and 44 years.", and from the same report, "Analysis of data from the first three rounds of the ESPAD (European schools project on alcohol and other drugs) survey (1996–2003) showed marked geographical differences in trends in lifetime prevalence of cannabis use among school students aged 15–16 years...In the eastern and central European Member States, together with Denmark, Spain, France, Italy and Portugal, lifetime prevalence of cannabis use increased substantially between 1995 and 2003."

A few years later according to an EMDCCA (2011), "prevalence of daily or almost daily cannabis use among young adults (aged 15–34) [included] Spain, France, Portugal, Belgium, Netherlands, Italy, Czech Republic, Ireland, Austria, Germany, Denmark, Slovakia."

The European School Survey Project on Alcohol and Other Drugs (ESPAD) survey of 15- and 16-year-olds supports these finding and shows an initial dip in drug use but an overall increase in the prevalence of marijuana use between 1999 and 2011. Past-month prevalence for marijuana in that age group went from 5% in 1999, 3% in 2003, 6% in 2007 and finally up 9% in 2011 and continues at that rate at 2015.[85]

Lifetime use of cannabis by country: 1995-2015 (percentage)



a Collected data from 2008 instead of 2007.

And of course, the increasing trend is borne out in cases bought before the *Dissuasion Commission*, most involving either hashish or cannabis.

While the EU and Portugal once viewed marijuana as a relatively benign substance of little, if any, serious concern to drug related policy, the latest SICAD report seems to indicate this outlook is changing.[86]

IDEOLOGICAL CONTRADICTIONS OF THE CATO REPORT BY GLEN GREENWALD

The greatest inconsistency with Greenwald's analysis is that it advocates policy measures that are entirely at odds with the Libertarian principles of the *Cato Institute*.

The think tank's core principles include, "Individual liberty, limited government, and free markets." Freedom from coercive government control and self-determination are paramount and this includes the use of illicit drugs; likening their use to the freedom of choosing what high-risk sport to undertake or the type of medical procedure and drinking alcohol or caffeine.

Senior Fellow at *Cato Institute*, Doug Bandow, argues in the article, *From Fighting the Drug War to Protecting the Right to Use Drugs Recognizing a Forgotten Liberty*, "The use of drugs should be seen as a freedom, just like most human actions. Choosing to go hang-gliding is a freedom (of recreation). Choosing to have surgery is a freedom (of medical treatment). Choosing to use drugs is a freedom, usually of recreation or medical treatment, depending on the substance and intention...Few personal acts more closely implicate the life and dignity of the human person than deciding what to put into one's own body. Choices of food and medicine are largely left to individuals, not government. Similarly, most decisions to alter one's mental and physical states are vested in individuals, not politicians, hence the almost universal use of caffeine and alcohol. Despite laws imposing some limits on the use of these substances, as well as tobacco, people still are widely believed to possess a basic moral right to consume what they want."

But equally, free people must bear a large part of the consequences for their *informed choices*.

Cato Institute's views on government welfare and specifically healthcare give a clearer view of its inconsistency with Portuguese policy objectives, "Government involvement in the health care sector is harmful to patients and is a large and growing encroachment on individual liberty. The solution is to restore individual liberty by expanding the number of health care decisions made by individuals and reducing the number of decisions made by government."

In contrast, Portugal's drug decriminalisation policy was based on centralised and extensive government involvement, underpinned by paternalistic socialist principles that include a universal health system.

As Hannah Laqueur notes, "The Portuguese approach...still creates what may be unnecessary administrative costs and state oversight. Despite *Cato's* celebration of Portugal's drug reforms, the reforms were not a move toward liberty, but a shift from one arena of government

involvement to another...[and] is *not* based on a principle of an individual's right to consume drugs free from state intrusion."

In Australia, Senator Leyonhjelm (LDP) advocates libertarian principles and Portugal's *decriminalization* policy as a positive case toward the *legalisation* of recreational marijuana, despite the fact that his proposal violates the party's principles of lower taxation and regulation. In 2014, the Senator thanked Australia's three million smoking coughers for their contributions to the Treasury coffers while also bemoaning the heinous taxes being paid by mainly low-income smokers, stating that any *new taxes* raised from legalising marijuana could be redistributed toward the healthcare costs associated with tobacco and alcohol disease.

Unsurprisingly, this type of political double speak means politicians from every persuasion can continually push broad ranging individual freedoms, particularly with respect to illicit drug use, while the freedoms of others are traded off and diminished, as families most usually bear the huge weight and often break apart when dealing with a drug addicted family member. But so too taxpayers must shoulder the burden. Primary health care (hospitals, ambulance) and secondary welfare costs (Centrelink and disability) make up half of this government's expenditure. In effect, high welfare dependant nations such as Australia, run the risk of continually buffering the impact of adult choices.

Furthermore, it is worth recalling that the 1988 UN Convention (Article 3(6)) requires that the possession and use of illicit drug use remain a criminal offence in order to help and protect the young. It is not framed as a civil liberties issue.

Alcohol and tobacco harms serve as tangible, quantifiable examples of the misleading arguments centred around adult rights and entitlement while dismissing the wide-ranging consequences to the majority of society when these 'free' choices eventually turn out to be harmful and unmanageable.

Most often policy makers are presented with the extremes of drug strategies philosophy: Unfettered personal choice with some taxing and regulation or overly paternalistic healthcare that unintentionally supports all drug addiction without incentivisation for exiting drug use, as this health worker put it: "Francisco Chaves, who runs a Lisbon treatment center, also recognizes that addicts might exploit goodwill. 'We know that (when there is) a lack of pressure, none of us change or are willing to change.'"[87]

But these are not the only options to Australia's government. A sensible drug policy recognises all the three pillars of drug policy: supply reduction, demand reduction and harm reduction.

If Australia is to realise the aims of its *National Drug Strategy*, then it needs to adopt all the supports that underpin it. This requires a shift from perceiving the main objectives of drug policy as harm reduction *only* to also reducing drug demand and supply and prevention programs. There needs to be a recognition that illegal drug consumption is a threat to the entire society rather than exacerbate the problems by implicitly or explicitly accommodating existing users and creating an environment that increases drug use.

Finally, while Portugal's decriminalisation may offer some valuable insights there is a risk of misunderstanding its widescale policy changes that did not have any substantial effect on its legal system but put enormous strain on its healthcare system and unintentionally perpetuated another cycle of drug use particularly among its young.

CAN AUSTRALIA AFFORD TO MAKE THE SAME MISTAKES?

UNLIKE PORTUGAL, WE HAVE A UNIQUE OPPORTUNITY TO PAUSE, REFLECT AND RESTORE THE BALANCE AND COMMON SENSE TO DRUG POLICY.

Eleni Arapoglou – Dalgarno Institute Freelance Researcher

Online Edition can be located at
https://dalgarnoinstitute.org.au/images/resources/pdf/researchreports/2018/DRR-PortugalPolicyAnalysis2018.pdf

REFERENCES

1. http://www.globalcommissionondrugs.org/reports/the-war-on-drugs/
2. https://www.theatlantic.com/politics/archive/2016/04/richard-branson-drugs/477930/
3. http://catallaxyfiles.com/2017/03/06/david-leyonhjelm-on-drugs/; https://www.miragenews.com/legalising-marijuana-makes-sense/
4. https://fionapatten.com.au/news/greens-cannabis-policy-u-turn/; https://www.smh.com.au/politics/federal/australian-sex-party-to-become-the-reason-party-20170822-gy185f.html; "The full legalisation of the possession, cultivation, manufacture and sale to adults of all drugs which cause less harm than alcohol or tobacco." (source: https://www.ldp.org.au/drug_reform)
5. https://www.qmhc.qld.gov.au/sites/default/files/portugals_response_to_drug-related_harm.pdf
6. https://quadrant.org.au/opinion/qed/2014/07/legalise-drugs/
7. https://fee.org/articles/portugal-won-the-war-on-drugs-by-giving-it-up/
8. http://news.bbc.co.uk/onthisday/hi/dates/stories/april/25/newsid_4754000/4754581.stm
9. https://www.aljazeera.com/indepth/features/2016/10/portugal-fifteen-years-decriminalised-drug-policy-161015091127668.html
10. https://www.pbs.org/wgbh/pages/frontline/shows/drugs/archive/gunsdrugscia.html ; https://www.newyorker.com/magazine/2011/10/17/getting-a-fix
11.
12. https://www.huffingtonpost.com/danna-harman/when-heroin-was-king-ten-_b_897474.html; https://www.mirror.co.uk/news/world-news/how-former-junkie-capital-europe-6477320
13. https://www.medicaldaily.com/portugal-drug-experiment-heroin-decriminalizing-drugs-382598
14. Agnew, Jeremy, *Alcohol and Opium in the Old West: Use, Abuse and Influence*, McFarland.
15. http://www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf
16. The 2012 annual report of the Cato Institute (page 19) continues to show financial support from the Soros-funded Open Society Foundations, as well as the Marijuana Policy Project, BB&T, Facebook, Google and Whole Foods.
17. https://www.youtube.com/watch?v=RkB8c8l7-Dk; https://www.econlib.org/archives/2017/12/is_portugals_dr.html
18. https://www.tripadvisor.com.au/ShowTopic-g189158-i203-k8518903-Drug_pushers-Lisbon_Lisbon_District_Central_Portugal.html
19. https://wonderfulwanderings.com/lisbon-walking-city-day/
20. https://repositorio.iscte-iul.pt/bitstream/10071/15377/1/WP%20CIES%20Henriques%20et%20al_2018.pdf
21. http://reformdrugpolicy.com/beckley-main-content/new-approaches/future-directions-for-drug-policy-reform/portugal/
22. http://www.standaard.be/cnt/dmf20161231_02652658
23. https://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf (page 3 reads: "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."
24. https://www.sciencedirect.com/science/article/pii/S0376871699000484
25. https://content.time.com/time/health/article/0,8599,1893946,00.html
26. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf
27. http://theportugalnews.com/news/smartshop-drugs-to-be-illegalised/27524
28. Hannah Laquer's paper cites examples of earlier EU decriminalisation. "Italy decriminalized possession of all psychoactive drugs in 1975, recriminalized possession between 1990–1993, and then reinstated the laws decriminalizing possession. In 1983, Spain adopted, and main- tained, a decriminalization policy regarding the possession of these drugs (MacCoun and Reuter 2001) "
29. http://www.espad.org/sites/espad.org/files/TD0116477ENN_002.pdf (page 6)
30. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf (page 4)
31. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf (page 29)
32. https://core.ac.uk/download/pdf/91904.pdf (page 5)
33. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf (page 5)
34. https://kar.kent.ac.uk/29910/1/Hughes%20%20Stevens%202010.pdf (pages 105-106)
35. http://undrugcontrol.info/images/stories/documents/A_resounding_success_or_a_disastrous_failure.pdf (page 5)
36. https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/portugal_fact_sheet_8-25-10.pdf
37. http://theportugalnews.com/news/alcohol-tobacco-and-drug-consumption-rise-over-last-five-years/43214
38. MacCoun & Reuter, Drug War Heresies, page 18
39. The EMCDDA 2007 report defines PDU as, "injecting or prolonged use of heroin, cocaine, and/or amphetamines."
40. http://www.emcdda.europa.eu/system/files/publications/605/PT-NR2009_311194.pdf (page 20)
41. http://www.emcdda.europa.eu/attachements.cfm/att_44976_EN_NR2006pt.pdf (page 24)
42. http://www.emcdda.europa.eu/system/files/publications/605/PT-NR2009_311194.pdf (page 5)
43. https://www.qmhc.qld.gov.au/sites/default/files/portugals_response_to_drug-related_harm.pdf (page 12) & http://www.theportugalnews.com/news/lisbon-buses-to-distribute-methadone/10623

44. https://www.qmhc.qld.gov.au/sites/default/files/portugals_response_to_drug-related_harm.pdf (page 10)
45. https://www.newyorker.com/magazine/2011/10/17/getting-a-fix
46. https://www.huffingtonpost.com/danna-harman/when-heroin-was-king-ten-_b_897474.html
47. http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf (page 3)
48. https://www.qmhc.qld.gov.au/sites/default/files/portugals_response_to_drug-related_harm.pdf (page 8)
49. https://www.washingtonpost.com/news/wonk/wp/2017/04/11/doctors-once-treated-alcoholism-with-heroin-now-they-want-to-treat-heroin-addiction-with-marijuana/?noredirect=on&utm_term=.b13151db61c1
50. In 2005 31 822 clients were active (had at least one treatment episode during the year) in the 77 public specialised treatment centres (CATs), which represents a 5% increase in comparison to 2004. http://www.emcdda.europa.eu/attachements.cfm/att_44976_EN_NR2006pt.pdf (page 24)
51. https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it
52. http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=368&tab=overview
53. https://www.standaard.be/cnt/dmf20161231_02652658
54. https://www.eiu.edu/polisci/pdf/EIU%20Political%20Science%20Review%20Vol%201%20issue%201%20article%202.pdf
55. https://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Portugal_Decriminalization_Feb2015.pdf
56. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf (page 3)
57.
58. http://www.drugwarfacts.org/node/1666
59. https://www.wsj.com/articles/SB10001424052702303411604575168231982388308
60. http://theportugalnews.com/news/portuguese-most-concerned-about-drug-trafficking/2739
61. http://www.emcdda.europa.eu/cocaine-trafficking-europe_en
62. https://www.newyorker.com/magazine/2011/10/17/getting-a-fix
63. https://www.huffingtonpost.com/danna-harman/when-heroin-was-king-ten-_b_897474.html
64. https://www.standaard.be/cnt/dmf20161231_02652658
65. https://www.newyorker.com/magazine/2011/10/17/getting-a-fix
66. UNODC Drug Report 2000
67. https://www.law.berkeley.edu/files/Laqueur_%282014%29_-_Uses_and_Abuses_of_Drug_Decriminalization_in_Portugal_-_LSI.pdf (page 11)
68. https://www.qmhc.qld.gov.au/sites/default/files/portugals_response_to_drug-related_harm.pdf (page 7)
69. Some indication of the cost of methadone programs is seen in this Canadian example https://vancouversun.com/news/local-news/ian-mulgrew-cost-of-b-c-opioid-treatment-tops-90-million-a-year
70. http://ftp.iza.org/dp10895.pdf
71. http://www.emcdda.europa.eu/system/files/publications/8890/portugal-cdr-2018.pdf (page 3)
72. https://www.oecd.org/els/health-systems/Health-Policy-in-Portugal-July-2016.pdf
73. https://www.mercatornet.com/demography/view/12396 ; https://www.mercatornet.com/articles/view/what_happens_to_kids_who_do_drugs_when_they_re_old_codgers/
74. http://knowledge.wharton.upenn.edu/article/euro-2004-and-electricity-despite-budget-crisis-portugal-spends-heavily-to-compete-in-expanded-europe/
75. https://www.economicshelp.org/blog/6423/economics/portugal-economic-crisis/
76. http://www.sicad.pt/PT/RelacoesInternacionais/Documents/2013_NATIONAL_REPORT.pdf
77. "Also, on the second semester of 2011, the activity of IDT, I.P. was defined by the instability caused by the announcement of the governmental decision to extinguish the IDT, I.P. on the context of the PREMAC (Plano de Redução e Melhoria da Administração Central) and the creation of a new structure within the Ministry of Health, SICAD – Directorate General for Intervention on Addictive Behaviours and Dependencies."
78. https://www.eranid.eu/about/sicad-portugal/
79. https://npstransnational.org/onewebmedia/Expert%20report%20-%20Portugal.pdf (page 10)
80. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70251-2/fulltext
81. https://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf
82. https://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf (page 168)
83. http://www.sicad.pt/PT/RelacoesInternacionais/Documents/2013_NATIONAL_REPORT.pdf
84. http://www.theportugalnews.com/news/view/1016-17
85. http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/125/HighRisCannabisUse_PT2017_Summary_EN.pdf
86. http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/125/HighRisCannabisUse_PT2017_Summary_EN.pdf
87. http://www.foxnews.com/world/2010/12/26/portugals-drug-policy-pays-eyes-lessons.html

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