

Decriminalisation of Drugs

What can we learn from Portugal?

Pierre Andersson

NARKOTIKA
POLITISKT
CENTER



This report was written by Pierre Andersson, a freelance writer with many years' experience in monitoring alcohol and drug issues. He currently works full-time as a policy advisor to the IOGT-NTO Movement.

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The NPC is a network of several Swedish and Nordic, non-profit-making organisations who lobby for a restrictive and humane drugs policy.

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Preface

A topic of much debate in Sweden and the rest of the world right now is the question of how we can reduce the consumption of drugs and drug-related deaths. The Swedish Government has presented a number of measures and additional proposals for action have been put forward by debaters, civil society, researchers and decision-makers. **Reference is often made to Portugal as an example of a country with a successful drugs policy, and, in the debate, the good results are attributed to the decriminalisation policy it carried out in 2001.**

Countries have a lot to learn from each other, although our different circumstances and starting points sometimes require different measures. But what do we actually know about the efforts made in the drugs field - and what results have they produced?

We have produced this report precisely because we want to learn more from the Portuguese example; the actions they took and which of them produced good results. In the Swedish debate, comparisons are often made between Portugal and Sweden, and we have therefore chosen to look more closely at the development of the two countries in terms of consumption, mortality and action.

We have also given a brief overview of another ten countries in Europe which have decriminalised drugs. You can read this at narkotikapolitisktcenter.se ("Decriminalization in Europe"). When we compare the developments following decriminalisation in these eleven countries, it becomes clear that drug-related deaths increased in some of them and decreased in others.

It therefore does not seem to be decriminalisation in itself that is the decisive factor in the developments.

The author of the report, Pierre Andersson, has conducted a series of interviews on the ground in Lisbon as well as studied most of the reports on Portugal's drugs policy published in scientific journals in recent years. The idea was to give the best possible picture of the huge efforts undertaken in Portugal at the beginning of the 21st century and the way in which the situation has developed since.

The report makes it clear that Portugal's reforms in 2001 were more far-reaching than the abolition of penalties for using and possessing small quantities of drugs. Above all, they included major efforts regarding for rapid and effective treatment, and good coordination between various health-care interventions. This is likely to have contributed to fewer people becoming dependent and, as a result, to a reduction in the number of deaths.

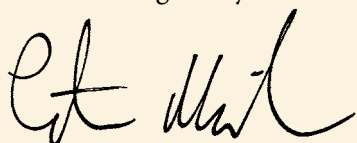
The report also shows that the drug-related death rate fell after the reform, when major efforts were made to expand healthcare, only to then increase again to almost the same level as before decriminalisation.

The Swedish debate often compares the figures for drug-related deaths between Portugal and Sweden. These comparisons are shaky, since the measurement methods differ from one country to another. **For example, over 75% of all deaths in Sweden that screened positive for drugs are ultimately classified as drug-related according to the definition laid down by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The corresponding figure in Portugal is below 5%.** The report also shows that Sweden undertakes twice as many post-mortem examinations and three times as many forensic analyses as Portugal. Comparisons between the figures make little sense when the methods differ as much as they do.

As far as the development of consumption in Portugal is concerned, the report shows that cannabis use has increased among schoolchildren and is now at a higher level than that of the corresponding age group in Sweden. What impact decriminalisation has had on the development of consumption is difficult to say, but we know that legislation has a regulating effect and thus acts in a preventive way.

Sweden – and certainly other countries – still has a lot to learn from Portugal, especially with regard to the short waiting time for treatment and the coordination between the various healthcare services. It is interesting to see how Portugal's Commissions for the Dissuasion of Drug Abuse (CDT), which people charged with possession or use have to appear before, are quick to make referrals to addiction specialists. The quick response and follow-up increase with all probability people's chances of overcoming - or avoiding - addiction.

The report points out the risk of overlooking some really good lessons from both Portugal and other countries, overshadowed by the hope that decriminalisation in itself is the solution to all problems. We hope instead that we can focus on initiatives that can seriously lead to an improved development both in Sweden and globally.



Stockholm, February 2020
Peter Moilanen
Head of The Swedish Drug Policy Centre, NPC

Why a report on Portugal?

The drug policy debate is becoming increasingly intense, both in Sweden and the rest of the world. Some countries have legalised cannabis, others have decriminalised minor possession and personal use of drugs.

A country often used as an example – almost always in a positive sense – is Portugal. The country decriminalised possession for personal use and use itself in 2001. At the time, there were huge problems caused by widespread heroin abuse. The head of the country’s drug agency estimates that, at the end of the 1990s, there were around 100,000 injecting heroin users in Portugal.¹ By way of comparison, Sweden (with approximately the same population as Portugal), estimated in 1998 a number of 26,000 “heavy users”, of which close to half had used heroin in the last year.²

The results shown by Portugal in the first few years after decriminalisation were impressive. In a matter of only a couple of years, drug-related mortality fell to a third of what it was before. The number of drug-related HIV cases fell to lower levels than for a long time and of drug use did not appear to be increasing.

When journalist Glenn Greenwald, on behalf of the American libertarian think tank Cato Institute, wrote a report on the country’s success in 2009, the example of Portugal was given serious consideration in the international

“The reporting on what Portugal has actually done and what the results were have often been marked by misunderstanding, misinterpreted data and politicisation.”

debate.³ Greenwald said that “judged by every metric, the Portuguese decriminalization framework has been a resounding success”. Since then, Portugal has been cited as an example on countless occasions in reports, op-ed pieces and commentary. It may be expedient to point out that the Cato Institute has

a clear agenda: The basic philosophy of the think tank is that the state should have a very limited role in people’s lives and have previously published texts arguing that drugs should be legalised and that use of drugs is a fundamental human right.⁴

The reporting on what Portugal has actually done and what the results were have often been marked by misunderstanding, misinterpreted data and politicisation. “The case of Portugal shows how political interpretation of a piece of legislation can take on its own life, regardless of the actual content of the policy,” summarises researcher Hannah Laqueur in the journal “Law and Social Enquiry”. “It has been misrepresented as a precedent that can speak to questions of legalization and misconstrued as a more radical policy change

than it in fact was. The Portugal case illustrates the way in which political interpretation of legislation can take on a life of its own, independent of policy content.”⁵

In other words, there are many reasons for looking more closely at Portugal. Mainly to see what we can learn, but also to untangle some of the many misconceptions apparent in the debate.

There is also cause to analyse the results more closely now that it has been almost 20 years since the reforms were implemented. The latest figures on drug-related mortality show, for example, that Portugal is now back at almost the same level as before decriminalisation. There are also signs that use of cannabis, especially among young people, has increased more rapidly than in Sweden.

Finally, there are good reasons to look at what Portugal did in parallel with changing the law. The ambitions regarding drug treatment greatly increased (for some types of treatment, the number of care places doubled in just a couple of years) and additional resources were provided for both care and prevention work. This is also something that the head of the Portuguese General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), João Goulão, touches on when he talks about policy change: “Decriminalisation is not a miracle cure. If that’s all you do, things will get worse.”⁶

Hopefully this report will show clearly what Portugal has done and what results it achieved in terms of drug mortality, drug use and other relevant indicators. What resulted from the actual change in the law and what can be explained by other actions or events? And what can we learn for future drugs policy in Sweden and in other countries?

However, it is almost impossible to draw any definite conclusions. The articles published in scientific journals on Portugal’s decriminalisation are largely descriptive. Trying to untangle which results are due to the change in law and which can be attributed to, for example, better care initiatives is almost impossible.



Gasal Ventoso, east of Lisbon city centre, once called "Europe's largest supermarket for drugs". Today, the shantytowns are demolished, but the area is still socially challenged. Photo by Gonçalo Fonseca.

Portugal's drugs problem came late – but fast

For much of the 20th century, Portugal was a police state under the dictator António de Oliveira Salazar. Repressed politically, the country was, in principle, cut off from the outside world until the so-called Carnation Revolution in 1974. Culturally, the country was dominated by the conservative Catholic Church. The drugs problem, compared to the rest of Europe, was fairly small.

In the final years of the dictatorship, the country became involved in bitter fights to keep its African colonies (now Angola, Guinea-Bissau and Mozambique). Nearly a million young men were sent off to war, many of them started using cannabis during this time. When the wars ended at the time of the Carnation Revolution, not only did the soldiers come home, they were followed also by hundreds of thousands of Portuguese settlers from the colonies.

João Goulão, head of the Portuguese drugs agency, SICAD, relates what happened: "They brought tonnes of cannabis with them and shared it with their friends. We saw an explosion in experimenting with drugs in all social groups during this time."¹.

Heroin came in the 1980s

When the country opened up to the outside world, it opened up to heroin as well, mainly from Pakistan initially via former colony Mozambique. Portugal's geographical situation meant that it was also used as a transit country, which further added to the influx. In the 1980s, heroin took hold in the country and its use spread rapidly among the population.

“Criminal organisations quickly arrived and started building a market,” relates João Goulão. “As a society we were naive, we had not had problems with this before. The effects began to be evident in the 80s, especially when people started falling ill with AIDS.”

Even though the discussion addressing the need for better care for drug addiction started back in the 1970s, preparedness for the rapid increase in heroin use in the 1980s was low, as became apparent in the 1990s.

“In the mid-1990s we had about 100,000 injecting drug users,” reports João Goulão. “Many of them started using drugs at the time of the liberation, it is largely the same group of people. The problem was now very visible, people used drugs openly wherever possible and virtually everyone knew someone caught up in addiction. This meant that society’s response was, from the outset, based on health and the social aspect, people did not see it primarily as a criminality problem. But we did not have a clear strategy.”

The expert group’s broad plan

In 1998, the government set up a group of experts to review society’s response to the crisis and to put forward proposals for change. João Goulão, who at the time worked with addiction treatment, was one of those who joined the group.

“There were nine of us from all areas of society, from addiction treatment to the voluntary sector and the church,” João Goulão explains. “The government asked us for strategic proposals. We had a very loose framework to limit what we could do, and the opportunity to travel around Europe to learn from others. The only restriction the government put on us was that our proposals should remain within the framework of the international drug control conventions. Our proposals included measures to cut supply, but the focus was

on reducing demand and working on treatment and damage mitigation measures.”

“Of the 30 proposals put forward by the group of experts, most concerned more and better treatment and more resources for prevention.”

Of the 30 proposals put forward by the group of experts, most concerned more and better treatment and more

resources for prevention. The group wanted to see tougher measures against the sale of drugs. They also proposed decriminalisation. Technically, this was a rather small change – the 1993 drugs law would remain in place, an amendment to the clause which regulated personal use and possession for personal use. All drug dealing, including personal use, would remain prohibited, but the penalty was changed from criminal to administrative.

Decriminalisation – a concept with many meanings?

Anyone who follows the debate on decriminalising drugs will notice that the participants in the discussion often do not even agree on what decriminalisation actually means. At times, the term is also used in discussions on legalisation – although these are two completely different policy measures.

There is no clear definition of the concept of decriminalisation to which everyone can subscribe. In a Swedish context, the discussion circles mainly around personal use of drugs, which in Sweden became a criminal offence in 1988. The reasoning among Swedish legislators was that the ban would have a preventive effect, particularly among young people. Five years later, imprisonment became part of the scale of punishments. This toughening up was carried out to allow the police to take coercive measures (physical examinations in the form of urine or blood tests) to determine drug use. The normal penalty is a fine, no one is actually sentenced to prison for personal use of drugs.

Possession for personal use also often crops up in the decriminalisation debate. Where the line is drawn varies. Even though personal use was not banned in Sweden before 1988, all possession of drugs was still punishable (and still is), even in small quantities.

Decriminalisation can entail either removing a ban or choosing to keep the ban in place, but removing the penalty. (There are examples of such solutions in Swedish law: Jaywalking is against the law, but there are no penalties for the offence.) In other cases, decriminalising means shifting society's reaction from the legal system to another authority.

The confusion is particularly acute when countries which retain fines for personal drug use (see Table 1 on the next page) are highlighted as examples of decriminalisation⁸, while Sweden (which in practice use fines only) is portrayed as one of the countries with the most stringent legislation of all.

As can be seen from the table, it is common in countries which themselves claim to have decriminalised to still be able to hand out fines, in some cases even prison sentences. How this is applied in practice varies, often it is up to individual prosecutors to decide.

Legalisation as a topic is outside the parameters of this report, but as the two concepts are sometimes mixed up, it may be appropriate to also clarify what this means. Legalising cannabis, for example, means that production and sale also become legal. A legal market for drugs is created, which can then be regulated in different ways. In the few places where cannabis has been legalised, the regulation varies from an almost entirely free market with only minor restrictions (certain US states) to a state monopoly.

Country	Decrim. since	Sanctions	Limit personal use of cannabis	Only cannabis?
Belgium	2003	If prosecutor so choose: 1 st time: fine 15-25 euro 2 nd : 26-50 euro 3 rd : 50-100 euro + prison	3 gram / 1 plant	Yes
Czech Rep	2013	Warning or fine up to 600 euro	10 gram / 5 plants	
Croatia	2010	Fine 650-2600 euro or prison 90 days. If addicted: treatment 3-12 m. If experimental: compulsory psych treatment 1-24 m. First time: No fine/prison.		
Estonia	2002	Fine, detention or drug treatment		
Georgia	2018	In public places: fine 250-400 €	70 gram / no plants allowed	Yes
Italy	2006	1-3 m or 2-24 m of one or more of suspension driving license, firearms, passport or tourist permit.	5 gram	
Luxembourg	2001	Prison is no longer a possible sanction. Cannabis criminal fine up to 2500 €.		
Slovenia	1978	Fine 20-200 €		
Spain	1982	Fine 600 € or more. If under 18 years old: Educational programme		
Switzerland	2012	Use: Fine 90 €	10 gram	Yes

Table 1. Countries often presented as examples of decriminalisation. Source: "Decriminalization in Europe – 10 voices beyond Portugal and the Netherlands", Narkotikapolitiskt Center (2020).

Using drugs still prohibited

So, what did Portugal do in 2001? In short, the system looks like this: Both use and possession for personal use are still prohibited, but the penalty has been moved from the legal system to an administrative one. It is still possible to impose fines and other sanctions. The limit for possession for personal use has been set at a level estimated as sufficient for 10 days (see Table 2).

Type of drug	Limit for possession for personal use
Heroin	1 gram
Ecstasy	1 gram
Amphetamine	1 gram
Cocaine	2 grams
Cannabis	25 grams

Table 2: Limits for possession for personal use.⁴

As before decriminalization, it is the task of the police to report people who are in possession of or are using drugs, also when the amount of drugs is less than that in Table 2. All drugs found are seized and, if the person cannot be identified there and then, he or she may be arrested. A report is drawn up, but instead of being sent to the prosecutor, it goes to a special authority created for this purpose under the Ministry of Health.

Commission for the Dissuasion of Drug Abuse within three days

Anyone caught for minor possession or personal use of drugs is expected to appear before the nearest Commission for the Dissuasion of Drug Abuse (Comissões para a Dissuasão da Toxicoindependência, CDT) the following day. Formally, the offender has three days to show up, mainly because the commissions close at weekends. The commission's staff carry out a quick diagnosis (usually by means of an interview, which takes place immediately) to determine whether or not the person is dependent on drugs and which risk group the person belongs to: Low, medium or high.

The visit concludes with a meeting with the commission itself: a group of three people comprising a social worker, a psychologist and a lawyer. The commission decides what happens next. People considered to be dependent are automatically put in the highest risk class and are referred for treatment. If treatment is accepted, the case is suspended indefinitely, although all information will be kept in a special register for five years. If the person does not accept treatment, the commission may choose to use sanctions.

Access to healthcare and treatment is normally quick, often an initial meeting with an addiction specialist takes place within a few days. Some types of treatment have waiting times of up to a few weeks, but often treatment already starts within a week after action by the police.¹

Those who fall into the middle group in terms of risk are not considered to

be addicted, but other factors (such as family relationships, unemployment, etc.) mean that there is an ever-present risk of becoming addicted. In this context, the commission may suggest refer the person to a psychologist or advisor with the employment services. The meeting is usually booked by the commission's staff.

“The most common sanction is for the commission to issue a warning. If the same person returns within five years, other sanctions, usually fines, may be imposed.”

People who are not addicted and who are considered to be at low risk of becoming so always receive information from members of the commission on the risks of drug use, what the law says and what sanctions could be imposed. The most

common sanction is for the commission to issue a warning. If the same person returns within five years, other sanctions, usually fines, may be imposed. Around 90% of those appearing before the CDTs are there for the first time.

Fines and other sanctions

Fines are only applicable to those who are not considered addicted. The size of the fines vary depending on the type of drugs involved. In the case of heroin, cocaine, ecstasy or amphetamines, the amount is minimum EUR 25 and maximum EUR 600. For cannabis, the amount is minimum EUR 25 and maximum EUR 150. In practice, it is usually a fine of between EUR 30 and EUR 40 for those brought before the commission for the second time within five years. In the event of repeat offences, the amount will increase.

The commission can also apply a number of other sanctions, such as:

- Work ban. Applies to occupations requiring special identification (e.g. doctors or taxi drivers) or to other occupations that may endanger others or the user themselves.
- Ban on staying at certain places.
- Ban on socialising with specific people.
- Ban on leaving the country without special permission.
- Duty to report at a specific place and time, decided by the commission.
- Loss of firearm licence.
- Seizure of certain items. Items that may pose a risk to the user or their environment may be seized. This also applies to items that may be used for future crimes.
- Seizure of funds. Money the user receives from public bodies (various types of benefit) can be placed under the control of the CDT. The money will still be used on behalf of the user and with their consent.

The duration of the various sanctions may vary: at least one month, not more than three years.

The 1993 drugs law is still in force

Basically, the 1993 drugs law still applies. The amendments made in 2001 relate only to the type of sanction that applies in the case of personal use or possession for personal use.

Before the law was amended, the penalty was a fine or a prison sentence of up to three months for buying, using or minor possession of drugs. If the quantity of drugs was considered to be more than three days' use, a prison sentence of up to one year could be handed down. However, the preparatory work for the law (implemented in 1993) states that it should be seen as “symbolic rather than punitive” and that the primary objective is to get people into treatment.

The 1993 law also contains provisions stating that occasional users of drugs may get away with a conditional sentence/warning and that those who are dependent and agree to treatment may have the charge dropped. Some researchers believe that the law as it was applied before 2001 was in practice close to decriminalisation and that the step taken was therefore not so dramatic.⁵

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Doubling of cases since 2011

In 2001, the CDTs handled around 2,400 cases, but then they were only active in the second half of the year. Up until 2011, the number of cases increased slowly, at around 6,000 to 7,000 cases per year. Since then, the increase in cases has grown more rapidly and, in 2017, more than 12,200 were recorded.¹⁰ (See Figure 1)

A growing proportion of those called before the commissions are not considered to be drug-dependent. (See Figure 2). Most of them are young with the 16–24-year-old bracket accounting for just over half of the cases.¹¹ This may reflect the fact that use is greater in this age group, but it may also indicate that the police prioritise young people since they are seen as more vulnerable.

The gender split is very uneven: In 2017, 92.6% attending a CDT were men and 7.4% women. This may be due in part to the fact that drug use differs between genders, although the differences are no way near as big: Statistics from the EMCDDA for 2016 show that 5% of women and 11% of men aged between 15 and 34 used cannabis in the last year. Other possible explanations for the uneven distribution are that the police prioritise men or that men as a group are more “visible” in their use of drugs.

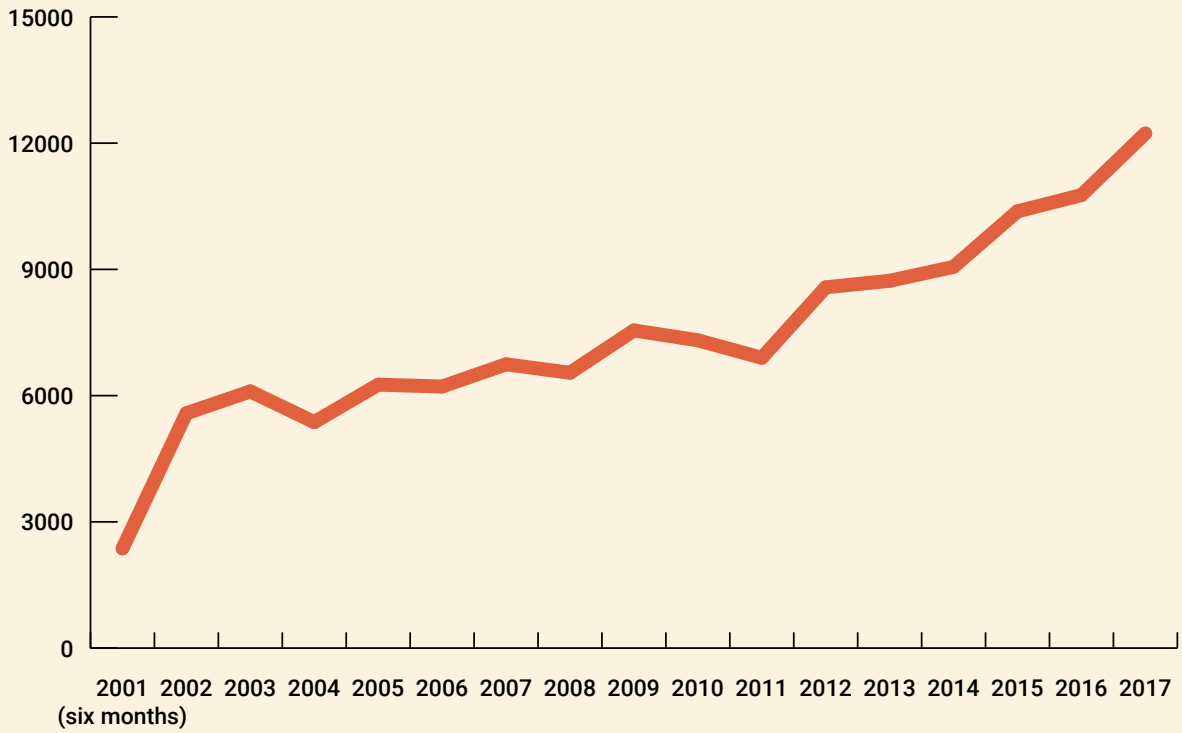


Figure 1. Number of cases handled by the Commissions for the Dissuasion of Drug Abuse 2001-2017

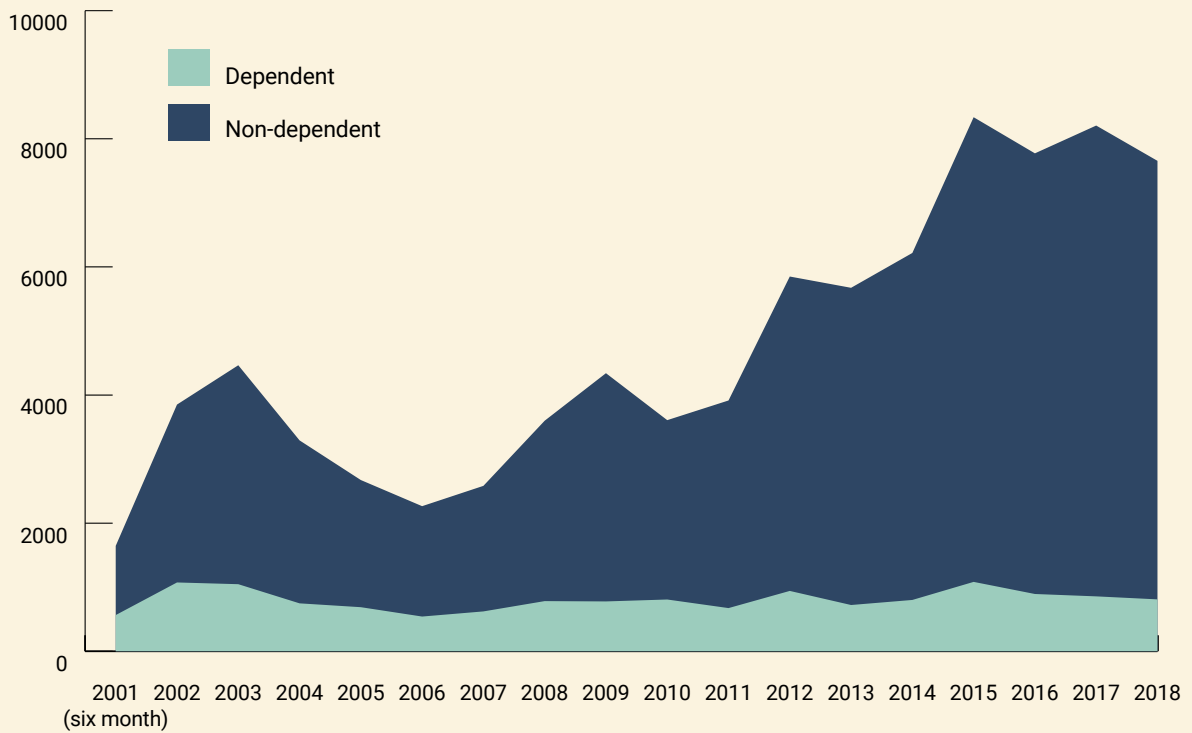


Figure 2. Number of dependent/non-dependent persons who appeared before the Commissions for the Dissuasion of Drug Abuse 2001-2018

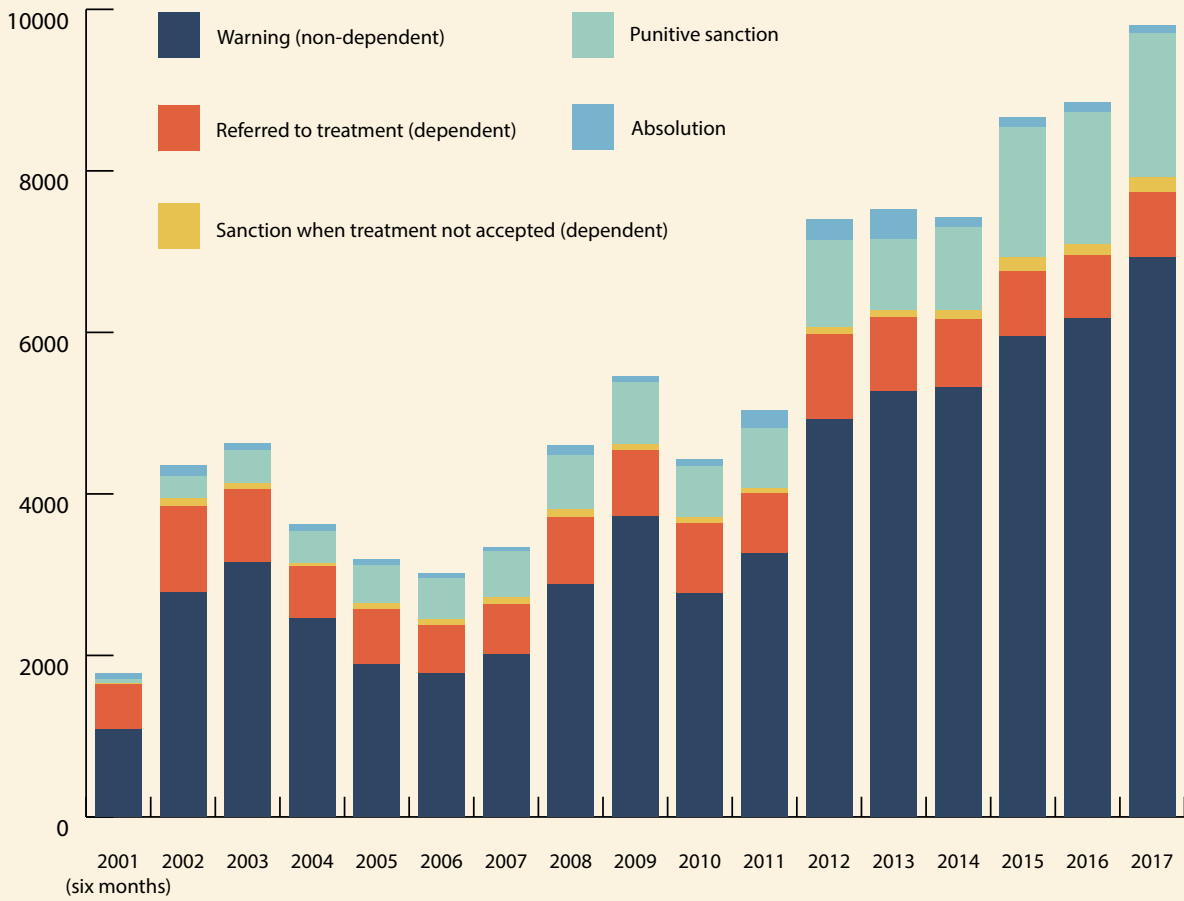


Figure 3. Type of measure 2001-2017

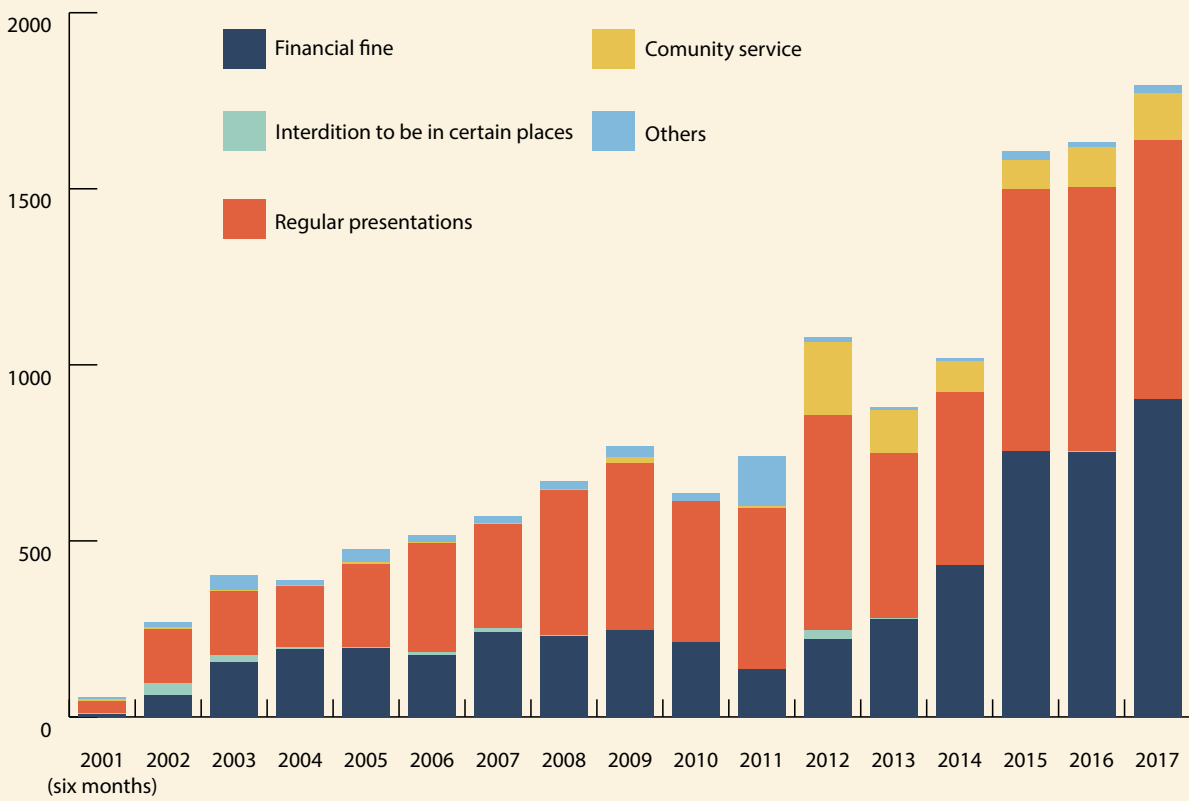


Figure 4. Type of sanction 2001-2017

Warning or fines most common

Looking at the type of measures the commissions use (Figure 3), the most common is a warning in the form of a provisional suspension of the procedure. As mentioned earlier, this is the normal procedure when someone appears before the commission for the first time and is not considered drug-dependent. In 2017, this type of warning was issued in 71% of cases.

Other types of sanctions were imposed in 18% of cases in 2017. In 8%, the outcome was provisional with referral for treatment – the measure by far the most common in the case of people classified as dependent. In about 1% of the cases, the offender was acquitted and the matter left without action.

Figure 4 shows the various sanctions in detail. The most common sanction is a fine, but a duty to appear (regular visits to the CDT, healthcare centre, etc.) and community service are also common.

Portugal's decriminalisation in short

- Since 2001, the use of drugs in Portugal is no longer legally punishable. This also applies to possession for personal use. Anyone arrested by the police for use or minor possession must instead appear before a CDT. Anyone considered to be dependent are referred in the first instance to care.
- The commissions have at their disposal a number of sanctions, such as fines, bans on visiting certain places or socialising with certain people, a duty to report or work bans. For anyone appearing before the CDT for the first time (and who is not dependent), the most common decision is a type of warning.
- The change in legislation was part of a broad reform, which also included major efforts in healthcare and treatment. Altogether, the budget for operations with respect to drugs was doubled.

More than just decriminalisation

What makes the example of Portugal both interesting and difficult to evaluate is the fact that, in the context of decriminalisation, the country also implemented other major and fundamental reforms in the same time period. A broad plan was drawn up with 30 ambitious targets, ranging from prevention through to treatment. Resources for primary prevention were boosted 150% and funding for civil society projects was doubled. The target was for 100% coverage in needle exchange schemes within four years and low-threshold programmes for substitution therapy.

The list goes on: The expansion of night shelters in towns and cities, twice the availability of social housing, 50% increase in rehabilitation capacity in two years and the doubling of resources for substitution therapy. Resources for research in this area were increased 200%.

Budget doubled in five years

Overall, the planned reforms meant that the budget for drug-related measures would double in five years.⁵ How this exactly turned out is difficult to say for sure, since the data available is uncertain. What is clear is that the policy changes the Portuguese government adopted in connection with decriminalisation, constitutes a very ambitious package of measures, to say the least. The evaluation carried out in 2004 shows also that most of the objectives were achieved, in whole or in part.¹⁵

João Goulão, head of the Portuguese drugs agency, SICAD, and one of the members of the group of experts behind the proposals is careful to point out that these measures were

key, without which the results would have been different.

Decriminalisation by itself would probably have made the

situation worse. He also believes that the amendment of the law became a platform for effective treatment efforts. “Attitudes are changing at all levels. I think that people addicted to drugs are treated with greater dignity these days and I know that many doctors are more comfortable now with distributing clean needles, for example.”¹

“Overall, the planned reforms meant that the budget for drug-related measures would double in five years.”

However, the 2004 evaluation report showed that some targets had not been met. One example is the failure to reduce drug-related crime. In addition to further improvements in care and prevention, the report’s authors recommended, among other things, arresting more drug dealers so as to reduce availability.

To summarise, a number of things were put into action alongside decriminalisation, which makes it difficult to determine what actually produced

the results we see. What have decriminalisation in itself led to? Is it perhaps the massive increase in care initiatives that led to the biggest change? It is clear that those responsible for the reform do not believe that decriminalisation alone would have produced the desired results; on the contrary, other reforms were crucial.

Developments in Portugal after 2001

Following decriminalisation in 2001, drug-related mortality in Portugal fell sharply. However, developments have not been so easy to follow; the authorities have changed their measuring methods over the years, which means that reports from the start in 2000 cannot be compared with the figures being published today. After recalculations based on today's methodology there still appears to have been a fall in the first ten years. After 2008-2009, the trend moved upwards again and, today, drug-related mortality are at levels similar to those before the reforms. More on this below.

Drug-related HIV transmission, a huge problem in the 1990s, has been steadily declining and has been down at the same level as in Sweden since 2017.

Use of cannabis, especially among young people, has increased since decriminalisation. The percentage of 15-16-year-olds who have used cannabis in the last 30 days is four times higher in Portugal than in Sweden. The number of

“Drug-related HIV transmission, a huge problem in the 1990s, has been steadily declining and has been down at the same level as in Sweden.”

hospital admissions for cannabis-related psychosis increased almost 30 times between 2000 and 2015.

The following is a more detailed account of how drug-related HIV transmission and drug-related mortality

have developed since 2001. One chapter is specifically devoted to trying to establish the differences between the way in which mortality is measured in Sweden and Portugal and whether it is relevant to compare the figures between the two countries. We also look at how drug use has developed.

In Sweden, gang crime and violence are sometimes presented as an argument for decriminalisation. However, researchers have found no fall in drug-related violence since the decriminalisation in Portugal in 2001. The number of murders in the country rose by 76% between 2001 and 2007, but it cannot be said whether or not this increase is related to drugs.⁵

Spread of drug-related HIV

At the end of the 1990s, Portugal had the highest rate of HIV infection among injecting drug users throughout the EU. In 1999, 18% of those treated for drug problems were HIV-positive. The trend had already started to fall

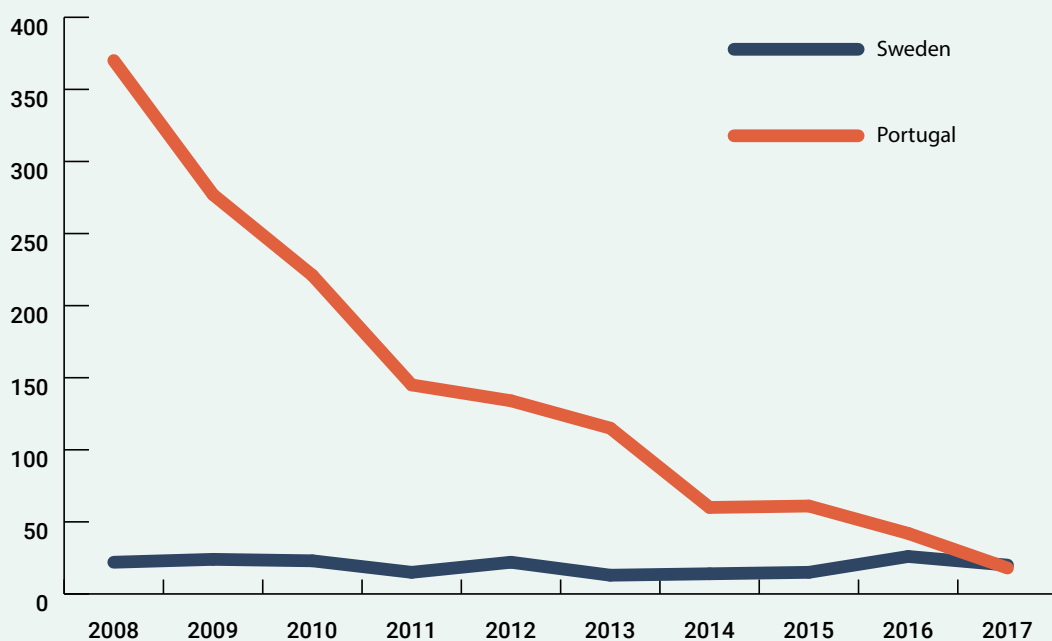


Figure 5. Number of new drug-related HIV cases 2008-2017.
 Source: EMCDDA Statistical Bulletin 2019

before decriminalisation and just one year after it was down at 14%.¹⁴ Since the turn of the century, the number of new cases has continued to decline steadily, but for a long time has remained at higher levels than many other European countries. As recently as 2015, Portugal’s figure was three times higher than that of Sweden, it wasn’t until 2017 that Sweden and Portugal reported similar figures.

A report to the EMCDDA points out that the reversal in trend coincides with the stabilisation of new HIV cases worldwide, which may have affected the results in Portugal. It is also believed that more needle exchange programmes are probably a contributing factor in the lower incidence of HIV among injecting drug users.¹⁵

Drug-related mortality

Studying drug-related mortality in Portugal is a complex task. Various ways of measuring are found in literature, and they are sometimes compared incorrectly. For a long time, data on drug-related mortality was based on toxicology reports only, whereby anyone who died and screened positive for drugs (and subject to a post-mortem) was included in the statistics. This is likely to result in a certain amount of overreporting. Work to improve the methodology started in 2007, but it has still not been possible to produce relevant statistics for the EMCDDA every year.¹⁶

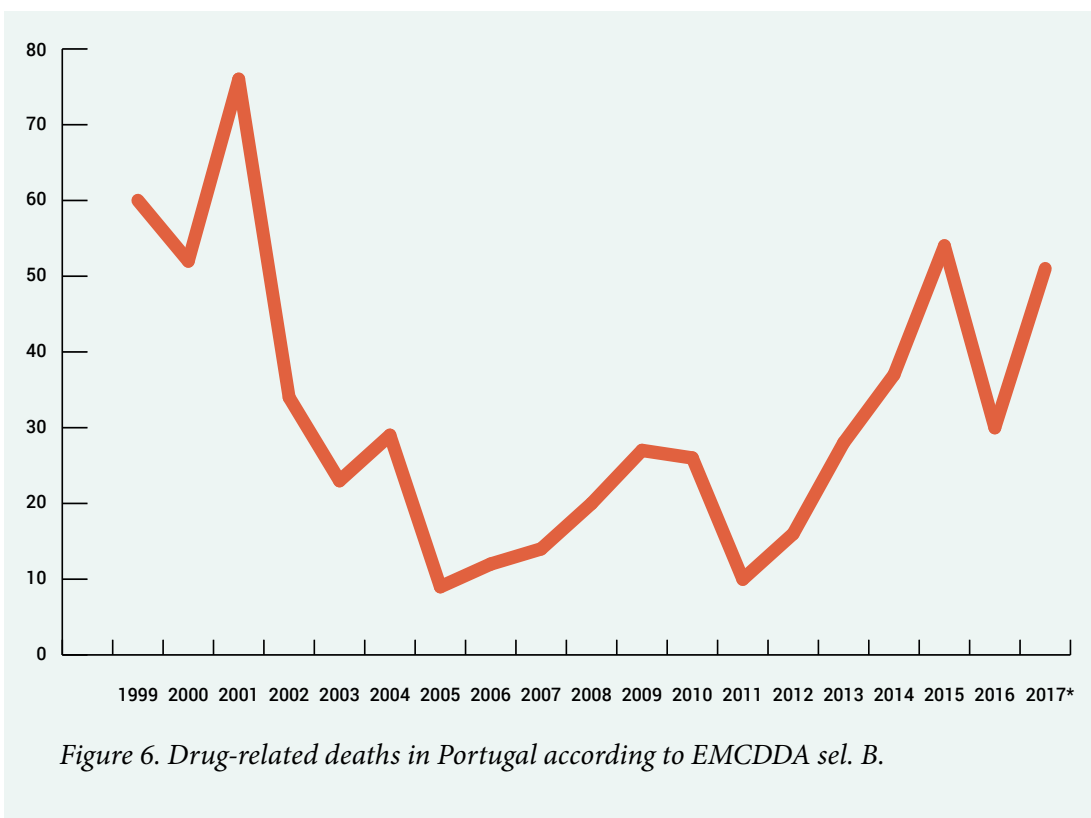
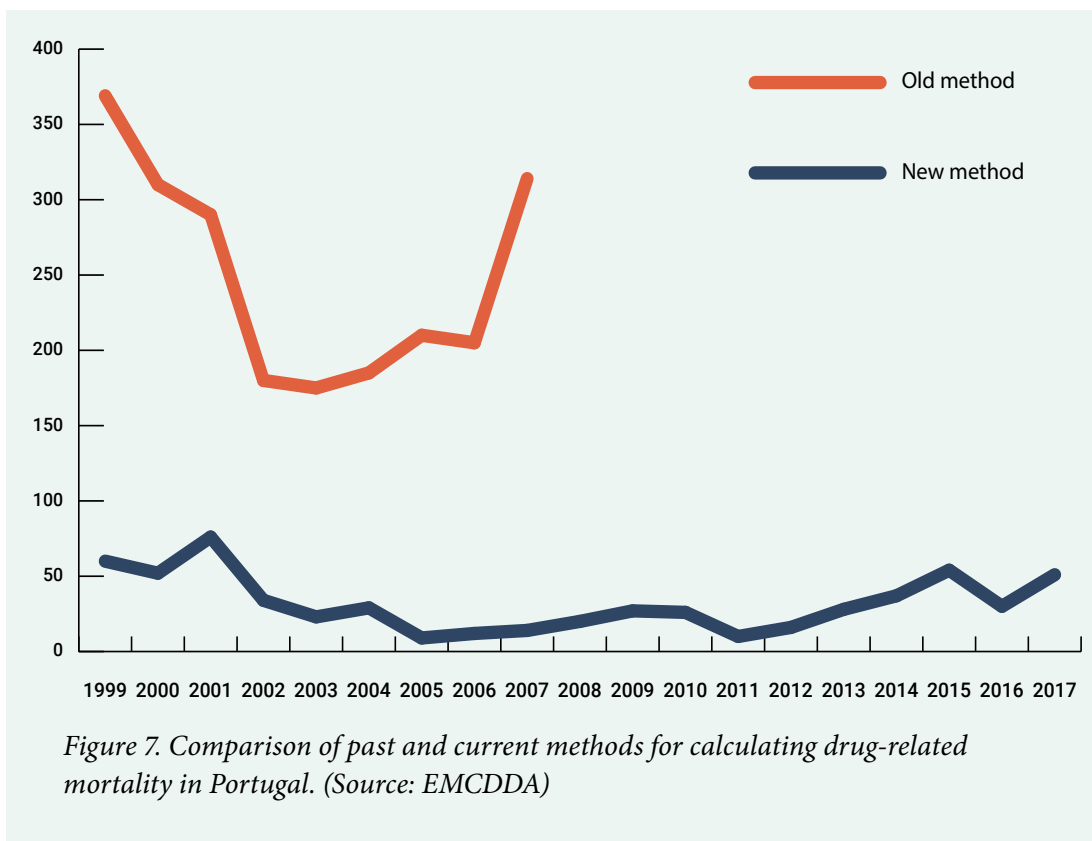


Figure 6. Drug-related deaths in Portugal according to EMCDDA sel. B.

Only in 2008 did data emerge based on a doctors medical assessment (and not just toxicology tests) and which, according to the Portuguese authorities, comply with the EMCDDA’s definition (called “selection B”) of drug-related mortality. When such data became available, a time series was also calculated back to 1999, making data comparable over time.¹⁷ (See Figure 6).

The fact that Portugal changed its method of calculating drug deaths during this period leads to some confusion. Significantly higher figures than today were reported up until 2008. For the year 2000, more than 300 deaths were reported according to the old method, while in subsequent reports, 52 deaths were recorded for the same year. Sometimes, the two methods of counting are mixed up, as in an op-ed piece in the Swedish daily newspaper, *Sydsvenska Dagbladet*, on 10 January 2020: “The country that has achieved the most well-documented successes is Portugal ...The death rate was at its highest in 1999. At that time, the number of deaths was 369 ...Today, Portugal has the lowest drug mortality rate throughout Europe. In 2015, the number of drug-related deaths in Portugal was only 60 ...”¹⁸

The mistake is easy to make. Anyone looking for statistics at the EMCDDA website can easily find the older reports with the higher numbers. Comparing these with subsequent reports, using the new method of reporting, is like comparing apples and pears. (The figures given in the op-ed piece



above – according to the new and comparable data – are 60 deaths in 1999 and 54 deaths in 2015. In other words, no substantial improvement.)

Whether you look at the new or old data (see Figure 7), there is a sharp decrease in mortality in the first years after decriminalisation. Around 2008-2009, however, there is a reversal in the trend and the curve starts to rise again. The numbers for 2015 and 2017 are at the same levels of 1999-2000, before the reforms entered into force.

What the rise in recent years is due to is hard to say. It may in part be related to the global economic crisis of around 2008, which hit Portugal hard and forced savings to be made in both healthcare and other measures. However, in Sweden and other countries, the trend in the statistics swings up around 2005, which is often linked to increased access to opioids. This may be part of the explanation also in Portugal.

In an article looking at the rise in recent years, SICAD itself points to other possible causes: Access to drugs is increasing, both through increased online trade and the country’s increasingly central role as a transit country in international drug trafficking.⁴⁸

Is it possible to compare death rates between Portugal and Sweden?

Many opinion pieces on decriminalising drugs published in Sweden compare the drug-related mortality rates between Portugal and Sweden. The comparison is rewarding: According to the tables compiled by the EU's drug agency, EMCDDA, Portugal is among the lowest and Sweden is second highest. The two countries have roughly the same population size, which makes comparisons even more enticing.

The differences in the data are striking. The drug-related mortality rate was at its highest in Portugal in 2001, when 76 deaths were reported to the EMCDDA (according to selection criteria "Selection B"). In the same year, Sweden reported 204 deaths. After that, the differences in the reported figures have only

"In the first few years Portugal saw a downward trend, but the death rate has since risen again."

increased. In 2016, Portugal reported 30 deaths and Sweden 590.¹⁹

In the first few years Portugal saw a downward trend, but the death rate has since risen again. The official figure for

2017 is not yet been published by the EMCDDA, but according to a SICAD report it was estimated at 51 deaths, an increase of 30% compared to the previous year.²⁰ This is significantly more than in 2002 and almost as many as in 2000, the year before decriminalisation.

New procedures and better machines produced higher numbers

In Sweden, the situation was fairly stable until 2006, when a sharp increase began. The reason for this increase is not entirely clear, but in a 2016 report, researcher, Håkan Leifman, believes that around half the increase over the last decade is due to changes in methodology.²¹

"More people are screened, new drugs are included, since 2011 fentanyl has been tested for in the same way as other drugs, and instruments have become more refined - and therefore more drug deaths are detected," says Håkan Leifman.²²

The real increase in Sweden from 2006 to 2016, if Håkan Leifman is right, is 40-50%, not the sharp doubling seen in the official statistics. The increase appears to be linked to higher availability and use of opioids. Heroin has remained stable during the period, while mortality associated with methadone and buprenorphine (medicines used in substitution therapy) has increased. Whether these drugs leak mainly from treatment or are smuggled in is not known. It is clear however, that the increase in drug-related deaths coincides with the expansion of substitution therapy in Sweden.

Comparison between countries is problematic

Comparing death rates between different countries is more problematic and

more complex than usually comes out in discussions on the subject. The EMCDDA itself says that any comparison between countries must be made with caution “since it is underreported in some countries”. In a technical report, EMCDDA has also identified significant differences between countries in a number of areas:²³

- The number and quality of post-mortem examinations and forensic analyses carried out. Procedures vary for when a post-mortem and forensic analysis is to be carried out.
- Availability of information to the medical doctor determining the cause of death.
- Different classification systems are used, and the quality of the classifications is considered to vary.
- The standard of available laboratory equipment varies

Since 2008, Portugal has reported death rates based on the general cause of death register, which is based on a doctor’s overall assessment. Sweden does the same, but there are several factors that indicate that the methods differ so much that in practice the statistics cannot be compared between the two countries.

This is apparent when looking at toxicological data, in other words the number of deaths that screened positive for drugs and comparing it with the number that were ultimately classified as drug-related deaths. This is data from 2007, the last year for which we have comparable numbers:

	Number of deaths screened positive for drugs	Drug mortality (EMCDDA sel. B)	Proportion
Portugal	314	14	4.5%
Sweden	396	310	78.3%

Table 3: Comparison between the number of people who died from drugs in the body and the number of deaths reported as drug-related in Sweden and Portugal in 2007. (Source: EMCDDA and Fugelstad 49)

In 2007 in Sweden, more than 75% of the number of deaths that screened positive for drugs were classified as overdoses according to the criteria set by the EMCDDA. In Portugal, the corresponding figure was below 5%. This suggests that there are major differences in methodology, availability of information and in the way medical doctors classify deaths in the two countries.

Large difference in the number of post-mortem examinations

A study by researchers Waal and Gossop points to further differences between countries, which make it difficult to interpret statistics and do not always provide a relevant basis for comparisons. In some countries, a post-mortem is standard procedure for all unexpected deaths, in others it is more unsystematic and irregular.²⁴

If you look at Portugal and Sweden in terms of number of post-mortem examinations, the latest comparable year in WHO's statistics is 2004: In that year, post-mortems were carried out on 6.9% of all deaths in Portugal, whereas the corresponding figure in Sweden was 13.9%.²⁵ In Sweden, in the same year, 4,961 forensic analyses were carried out in connection with a post-mortem.²⁶ The corresponding figure in Portugal was 1,656.²⁷ Overall, these differences will most likely affect how many drug-related deaths are actually included in the statistics.

	Percentage of deaths resulting in post-mortem examinations	Number of forensic analyses
Portugal	6.9%	1,656
Sweden	13.9%	4,961

Table 4: Post-mortem examinations and number of forensic chemical analyses in Portugal and Sweden in 2004.

When studying the reliability of the statistics in France – a country with low drug mortality rates in the EMCDDA's statistics – it was concluded that the country underreports the number of deaths by at least 30%, perhaps by as much as 60%.²⁸ There is no corresponding study for Portugal.

A general problem is that the procedures for which causes of death are recorded on the death certificate are not standardised and that the causes of death given are often rather vague. This often result in deaths being classified as “unknown cause”, a code used much more frequently in some countries – especially in connection with the death of someone with a drug addiction.²⁴ This is a convenient and simple coding for the doctor. It does not require follow-up and is often used in the absence of information, such as forensic analysis results.

Competing diagnoses

In some countries, there is a pattern showing relatively low figures for drug-related mortality, but high figures for other causes of death which are often linked to just drug use. In their study, Waal and Gossop cited Spain, Italy and Portugal as examples where the mortality rate from AIDS among drug users is high. Austria, Italy, Spain and France have high rates where death is due to hepatitis, also a disease closely linked to injecting drug use. According to the researchers, “competing causes of death” result in deaths directly related to drug abuse being coded in such a way that they do not appear as drug related.

To illustrate this, Waal and Gossop combined statistics on drug-related mortality with other diagnoses related to intravenous drug use. On the basis of data for 2007, Portugal was ranked second in Europe with only Estonia above.²⁹

Let's do the same kind of calculation with more recent data. According to Eurostat, 331 people died from HIV/AIDS in Portugal in 2016. In Sweden, the corresponding figure was 12. According to the EMCDDA's estimate³⁰, 12% of all deaths from HIV/AIDS in Sweden are attributable to injecting drug use. The corresponding figure for Portugal is 49.9%. Adding these deaths to those reported to the EMCDDA, the countries end up somewhat closer (see Table 5).

	EMCDDA sel B	Number of deaths due to HIV/AIDS	Percent related to drugs	Drug-related deaths from HIV/AIDS	Total
Portugal	30	331	49.9%	165	195
Sweden	590	12	12%	1	591

Table 5: Drug-related deaths when drug-related cases of HIV are taken into account.

If we also include a proportion of all deaths coded as hepatitis or "unknown cause" (R96-R99 in ICD10), the result is then as shown in Table 6. Unknown cause codes are used more than twice as often in Portugal than in Sweden. Hepatitis – which is often associated with injecting drug use – is also significantly higher.

	EMCDDA sel B	HIV/AIDS (see above)	Hepatitis (Eurostat, 30%)	Unknown (Eurostat, 30%)	Total
Portugal	30	246	40	809	1,125
Sweden	590	1	15	305	911

Table 6: Calculation example. Summation of drug-related deaths, 30% of deaths from hepatitis and of deaths coded "unknown cause".

In Table 6 we have used an estimation, counting 30% of all deaths from hepatitis and of deaths coded with unknown cause. These calculations are to be seen as an example only – there is no way of knowing how many of these deaths are actually drug-related. The example shows, however, that drug mortality is a complex subject and that the differences between Portugal and Sweden may not be as great as the EMCDDA's statistics suggest.

It is very difficult to compare statistics on drug-related mortality between different countries. To do this in a meaningful way, a more detailed analysis must be carried out than simply comparing the EMCDDA data.

In the case of Portugal and Sweden, the differences in the way in which deaths are collated and reported appear to be so vast that comparisons between the countries become meaningless in practice. Most people argue that the differences in method vary widely across Europe in general. Is Sweden really at the top in the EU when it comes to drug mortality? Nobody knows for sure.

Drug use after 2001

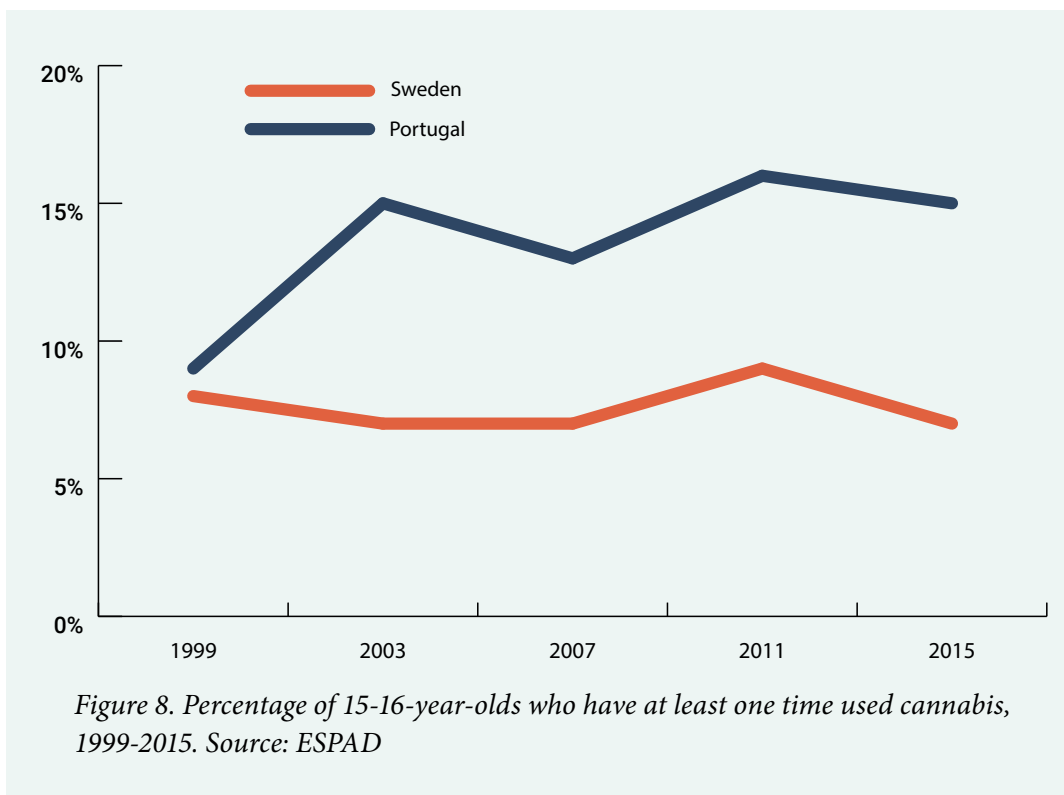
Portugal's first ever population study on drug use was carried out in 2001, the same year decriminalisation entered into force. Only a few studies focusing on young people was carried out (under the EU ESPAD project) before this time.

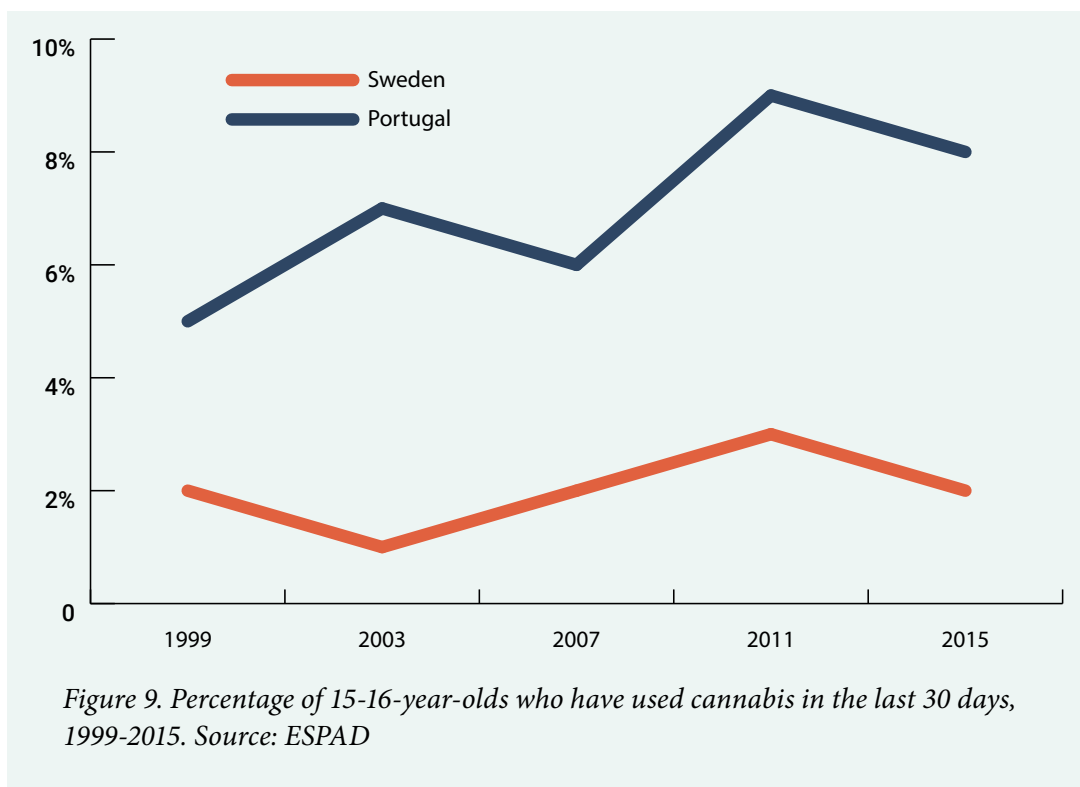
The lack of data does, of course, make it difficult to assess the changes implemented by Portugal. The data for 2001 can to some extent be seen as reflecting what the situation was like before the reforms, although policy and healthcare initiatives were already undergoing reform at this time. Comparable figures from the 1990s would have made it easier to get a true picture of how things developed.

Rise in cannabis use among 15–16-year-olds

The data available shows that cannabis use among 15–16-year-olds has increased in Portugal over the last 20 years. If we look at lifetime prevalence among this group, it rose from 9% in 1999 to 15% in 2015. The proportion using cannabis in the last 30 days rose from 5% to 8% over the same period. The biggest increase occurred between 1999 and 2003.³¹

If we look at the same source (ESPAD 2015) for Sweden, the figures have in principle remained at the same level for the period. Lifetime prevalence was slightly lower in 2015 compared to 1999, the proportion using cannabis in





the last 30 days both at the beginning and end of the period was 2%. (See Figures 8 and 9.) ESPAD school surveys are carried out every four years. The figures for 2019 were not available at the time this report was published.

In terms of the trend among the entire population (15–64 years) in Portugal, SICAD, the body responsible for drug matters, has been conducting regular measurements since 2001. The most recent was published in 2018 and covers the development up to 2017.³² Lifetime prevalence for cannabis among 15–64-year-olds has risen from 7.6% to 11% in 2017. The proportion who used cannabis in the last 12 months has risen from 3.3% to 5.4%. Here the biggest increase took place between 2012 and 2017. (See Figures 10 and 11)

In Sweden, in 2018, the proportion of the entire population (16–84 years) who used cannabis in the last 12 months was 3%.³³ The figures are not directly comparable with the Portuguese figures because of different study years and the different age selection, but nevertheless it does give an indication of the difference.

Fall in heroin and cocaine in the last 10 years

The use of heroin in Portugal increased in the first years after decriminalisation, but has decreased in recent years according to SICAD data. The figure was at its highest in 2007, when 0.3% of 15–64-year-olds said they had used heroin in the last 12 months. Lifetime prevalence at that time was 1.1%. In

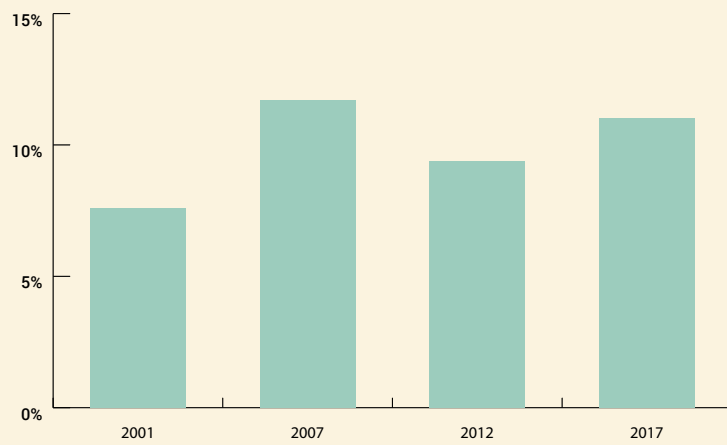


Figure 10. Percentage of 15-64-year-olds who have at least one time used cannabis. Source: SICAD

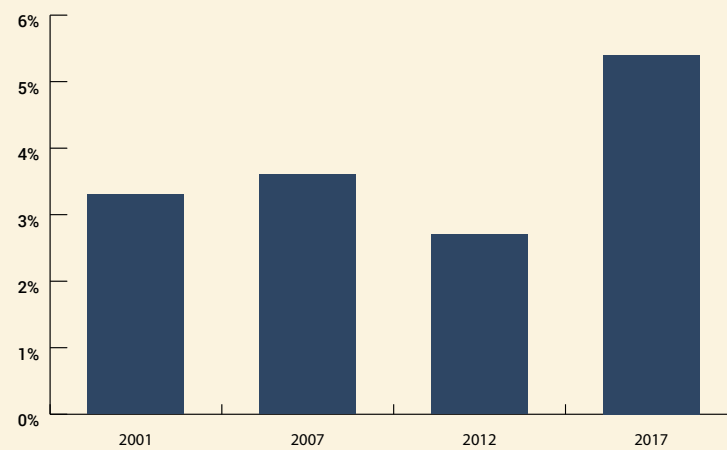


Figure 11. Percentage of 15-64-year-olds who have used cannabis in the last 12 months. Source: SICAD

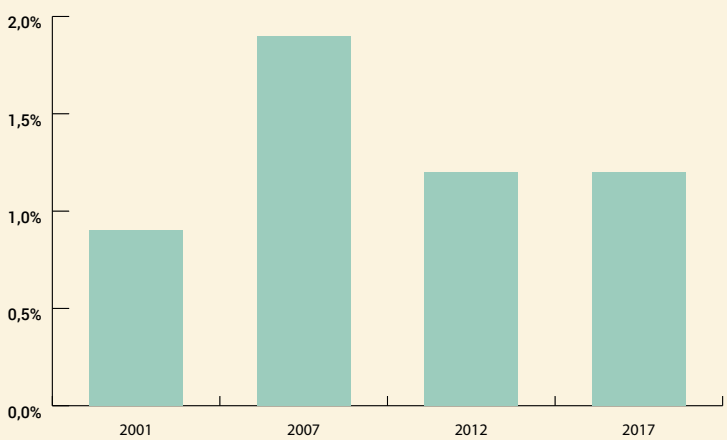


Figure 12. Percentage of 15-64-year-olds who have at least one time used cocaine. Source: SICAD

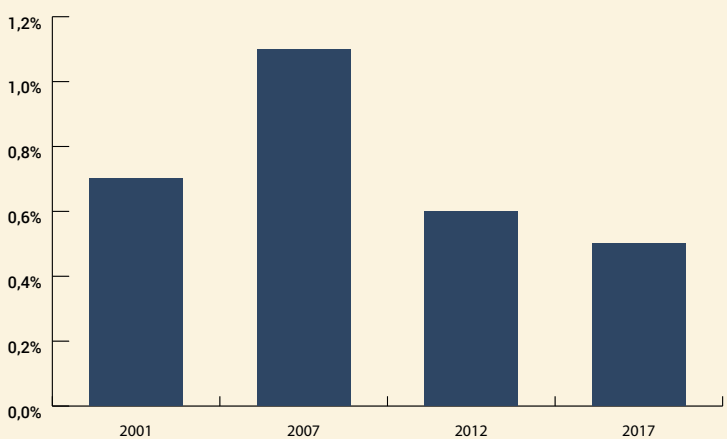


Figure 13. Percentage of 15-64-year-olds who have at least one time used heroin. Source: SICAD

2017, the corresponding figures were 0.1% and 0.5% respectively. A similar development can be seen for cocaine.³²

Overall, it's a mixed picture. The increase among the school age bracket is the most striking development – figures for Swedish and Portuguese pupils were fairly much the same at the end of the 1990s, while the ESPAD report shows that cannabis use today among 15–16-year-olds in the last 30 days is four times greater in Portugal than in Sweden.

Among the population in general, the trend in Portugal has been less clear. Cannabis use appears to have risen, however with a marked decline in 2012. (The number of participants in the study was significantly lower in this year than in other years, so the result should be interpreted with caution.) In the case of cocaine and heroin, there are clear signs of a decline, despite an increase between 2001 and 2007. (See Figures 12 and 13).

Cannabis-related psychotic disorders

At the end of 2019, a study published in the *International Journal of Methods in Psychiatric Research* showed that the number of hospital admissions for cannabis-related psychosis increased 29.4-fold between 2000 and 2015.³⁴ The trend rose from 20 cases a year to almost 600 in just 15 years.

The fact that cannabis can cause acute psychosis has been known for a long time. Whether cannabis also increases the risk of chronic psychosis, such as schizophrenia, has been the subject of discussion for a long time. Research has been able to show clear links – the incidence of psychosis is higher among cannabis users – but what is the chicken and what is the egg is still a matter of debate: Does the disorder depend on the cannabis user themselves, or do people with psychosis and precursors to psychosis tend to use more cannabis?

Back in 1987, a group of Swedish researchers already showed that young people with a high cannabis consumption had more than twice the risk of schizophrenia.³⁶ Since then, a number of studies have been published with similar results. Studies have also later shown that stronger types of cannabis produce a higher risk of psychosis – in other words, a clear dose-response curve.³⁶ A further study that compared various cities within Europe shows that in places where stronger cannabis is common (Amsterdam, London and Paris) psychosis is also more common.³⁷ In short, there is much to suggest that cannabis can also cause chronic psychosis.

The sharp increase in cannabis-related psychosis in Portugal (see figure 14) is spectacular to say the least. It should be noted that the increase starts from low levels and part of the increase might be explained by the fact that doctors more frequently catch the cannabis component of the disease. The researchers behind the study, however, point out that an increase in cannabis consumption during

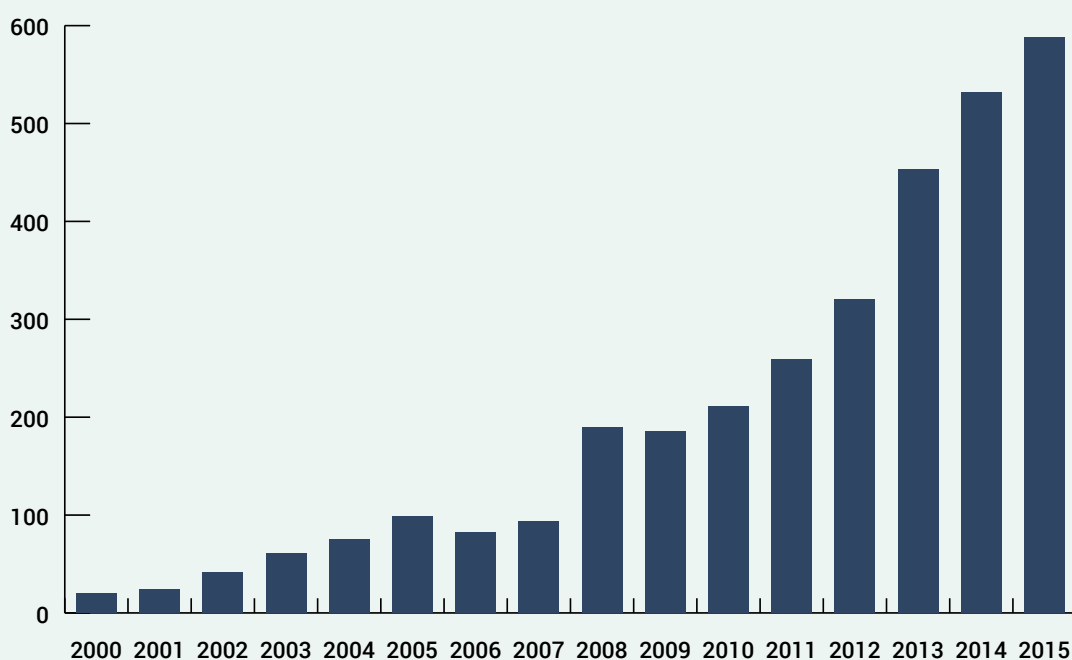


Figure 14. Number of hospital admissions with cannabis-related psychosis as a primary diagnosis. Source: Gonçalves-Pinho et al.³⁴

the same period is likely to play a role, especially as it is thought that the number of heavy users has increased.

Selling and availability

Decriminalisation in Portugal focuses only on drug use. Selling is still prohibited, and the police's job remains the same: Disrupt the drug market as much as possible in order to reduce supply.⁴⁶

In the case of heroin – the drug that causes by far the most deaths in Portugal – seizures increased in the 1990s. After 2001, seizures fell, first sharply, then at a slower rate (see Figure 15). In 2001, 316 kg of heroin were seized in Portugal, whereas in 2017 it was down to 29.5 kg. Statistics on drug seizures are difficult to interpret as they can vary considerably from year to year – particularly in Portugal, which is a transit country for drugs – but the trend has clearly been downwards.³⁸ Seizures of cannabis increased during the same period, so the overall trend is not clear.

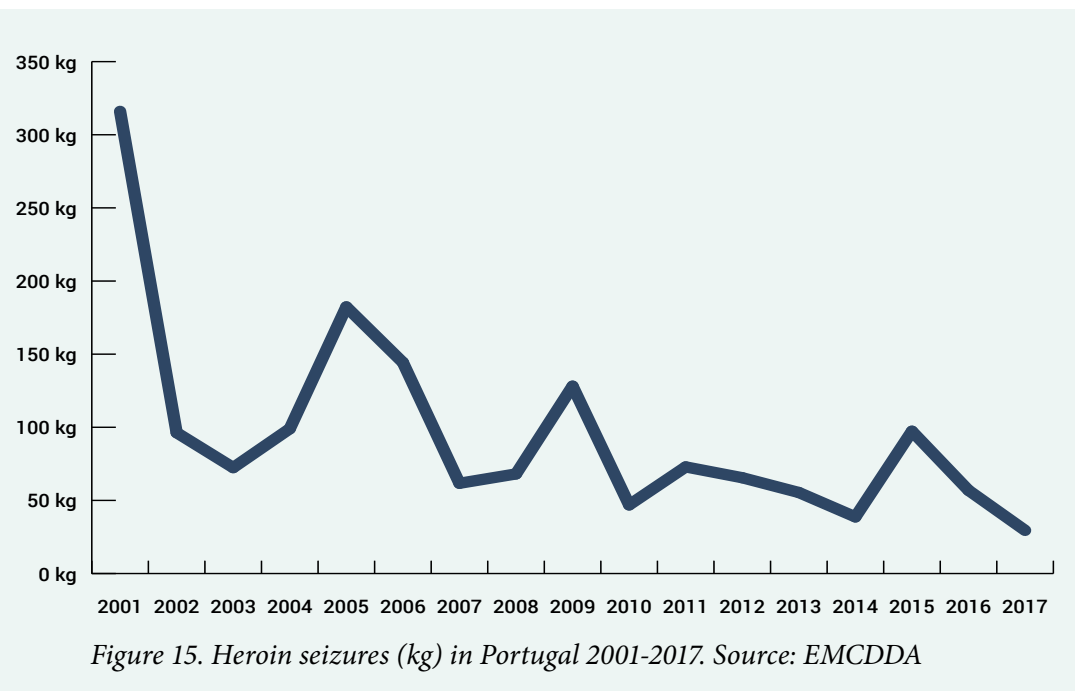
The number of convictions for selling drugs fell by 40% between 2001 and 2010. The number of individuals in prison sentenced for selling, distributing or producing drugs fell by 50% during the same period.⁵ It is worth pointing out that

the decrease was from high levels, as, in 2000, Portugal had the highest percentage of prisoners convicted of drug offences in Europe.³⁹

This development probably had little to do with the decriminalisation of drug use in 2001: Selling, distributing and producing drugs are still punishable offences. One possible partial explanation, however, is that, since 2001, it has become more difficult for the police to enforce drug law on the streets, since decriminalisation permits drug possession for personal use. The limit has been set relatively high, based on an estimate of the amount of drugs needed for 10 days' use. For heroin, it means that a person can carry around up to one gram without risk of prosecution, for cannabis it is 25 grams. Anyone selling drugs can easily avoid carrying more than the limit, which means that the police have to witness and/or document the sale itself in order to be able to prosecute.

Another possible explanation for the reduction in the number of convicted drug offences is that the courts might have changed their judgement on offences involving the passing on of drugs, as a result of a change of norms around drug use. Hanna Laqueur explains this by “reciprocal feedback processes between application of the law and a country's cultural and social norms”.⁵

Studies show that, since 2001, it has become easier to obtain drugs, both among schoolchildren and in the general population. When it comes to the percentage of schoolchildren who say that it is easy or very easy to get hold of cannabis, there has also been an increase in Sweden, although not as high as in Portugal.





Picture, top: Low threshold programme methadone treatment. Twice a day, the minibus parks under a motorway bridge in Casal Ventoso. Picture, bottom: Outreach programme on the outskirts of Lisbon. Photos by Gonçalo Fonseca

Could the positive results be due to anything other than decriminalisation?

As mentioned in previous chapters, Portugal's reforms of its drugs policy in 2001 were broader than just the decriminalisation of use and minor possession of drugs for personal use. What stands out, above all, is a very ambitious commitment to care and treatment, with significant additional resources.

What role did a greater focus on treatment play in the decline in drug-related mortality and other positive results in the first years after decriminalisation? And are there any other factors that may have played a role? Could the good results even have been achieved without decriminalisation itself?

There are no definitive answers to these questions. The changes in legislation coincided with other efforts and developments and it is very difficult to establish what led to what results. In practice, of course, it is most likely a combination.

“Could the good results even have been achieved without decriminalisation itself?”

The aim of this chapter is to expand on the developments in Portugal since 2001 and to try and separate cause and effect. All we can say with certainty, however, is that other efforts besides decriminalisation itself have played a major role in the development of the drugs issue in Portugal.

Accessible and coordinated care

Under a motorway bridge in the Casal Ventoso area in east Lisbon, you will find a grey van parked there twice a day. When it arrives, a small queue has already formed – this is one of the places where an NGO called *Ares do Pinhal* distributes methadone every day. The van comes at set times, both in the morning and in the evening.

The van also contains a miniature health clinic. A nurse is always present, and often a doctor, and visitors can get help with a range of health related issues. Sometimes vaccinations are provided in the vans.⁴⁷

Ares do Pinhal runs a low-threshold methadone distribution programme funded by the state. The only eligibility requirements are that you can identify yourself and that you can demonstrate, through a blood or urine test, that you are an established heroin user when you start treatment. The vans stop at six different places in the city, the idea being that anyone who needs it should find it easy to get their dose both morning and evening, perhaps on their way to and from work.

“Drug treatment in Portugal appears to be accesible and well-coordinated between the various health services.”

The methadone is taken in liquid form at the time of distribution. No one is permitted take the methadone away, so there is no risk of leakage onto the illegal market. When users approach the hatch, they identify themselves. Everyone has a unique number, which is entered in the record system. Here, the staff in the van can see, for example, treatments booked with other health facilities and can remind users of doctor’s appointments and the like.

Drug treatment in Portugal appears to be accesible and well-coordinated between the various health services, especially in comparison with Sweden, where there are many reports of individuals being bandied about between municipality and county council and often falling between gaps. As has already been explained, the Commissions for the Dissuasion of Drug Abuse can enroll people who they deem dependent directly with an addiction specialist – with the first visit often taking place within a week of the arrest. The various health services are part of the same network, whether they are run by the state, by the regions or by non-profit organisations. Within the network, information on patients is shared and the risk of falling between the gaps appears small.

In previous chapters it is described how, in connection with decriminalisation, the funding allocated to healthcare was doubled. The data on the actual outcome is poor, but it is clear that the resources and the number of care places for both out- and in-patient care increased significantly.

Other social measures

In the same year that decriminalisation entered into force, one of Lisbon’s residential areas, Casal Ventoso, was described as Europe’s “biggest and worst drugs ghetto”.⁴² Almost 5,000 heroin users lived in the area, which in parts was no more than a shanty town. The centre of Lisbon is only 20

minutes away, and many wandered daily down what was called the 'steps of death' to buy drugs.

Heroin, cocaine and other drugs were sold openly and used needles piled up in ditches and gutters. At the end of the 1990s, while preparing for decriminalisation, the authorities decided that something had to be done. Step by step, the shanty towns were torn down and sections of the Casal Ventoso population were compulsorily moved to other areas in Lisbon.⁴³

Today, Casal Ventoso is still a socially vulnerable area and in no way free from drug peddling or people living with addiction, but it is a long way from the "supermarket for drugs" it was back then.

During the same period, other similar initiatives were carried out in Portugal. Drug selling moved to other places, although it is not as visible today as it was at the end of the 90s.

An ageing population of heroin users?

Unlike in the rest of Europe, Portugal's drugs problem only started in the second half of the 1970s. (See the chapter on background.) Initially, it was mainly cannabis that came back with soldiers returning from the colonial wars, but in the 1980s, heroin use also began to spread.

The problems culminated in the 1990s when Portugal probably had almost 100,000 heroin users. At the end of the decade, this was also reflected in the death rate, which rocketed.

After 2001, the curve changed direction. The large group that started with heroin in the 1980s were now probably around 35-40 years old and it is conceivable that many of them actually stopped using by themselves, irrespective of legislation and care initiatives. There are numerous studies showing that the majority of heroin users actually stop without treatment and that this often happens within the 30-40 age bracket.^{44,45}

Conclusions

The decriminalisation in Portugal has received a great deal of international attention and is increasingly quoted both in the Swedish debate and elsewhere. Often, the conclusions drawn are simplified, making it sometimes sound like abolishing the ban on drug use in Sweden would lead to drastic reductions in both drug mortality and gang violence. The experience in Portugal and other countries who have decriminalised drugs shows that it is not that simple.

From the content of this report, the following conclusions can be drawn:

- The reforms in Portugal in 2001 were far broader than the abolition of penalties for use and minor possession of drugs. Alongside decriminalisation, ambitious initiatives were taken in healthcare. The head of the Portuguese drug agency, SICAD, João Goulão, himself believes that this was crucial: “Decriminalisation is not a miracle cure. If that’s all you do, things will get worse.”
- The care efforts in Portugal draw on prompt action and good coordination between the various health services. Someone dependent on drugs and arrested by the police will appear before a CDT (Commission for the Dissuasion of Drug Abuse) within three days and will often have an initial appointment with an addiction specialist within a week.
- Decriminalisation has likely contributed to a better response to people who use drugs, including in the care sector.
- Drug-related mortality decreased sharply immediately after the reforms, but has gradually increased again after 2008-2009. Portugal is now back at levels similar to those before decriminalisation.
- Comparing drug-related mortality between different countries is difficult. This report shows that comparisons in this respect between Portugal and Sweden are hardly meaningful. There are significant methodological differences between the countries – and Sweden carries out twice as many post-mortems and three times as many forensic analyses as Portugal.
- Heroin was only established as a major problem in Portugal in the 1980s and many of today’s users started during the same period. A cohort effect could be a partial explanation for the reduction in drug-related mortality at the beginning of the 2000s – a large group of heroin users were 35-40 years old then and may have stopped using drugs entirely irrespective of legislation or other measures.

- Drug-related HIV infection has reduced significantly in Portugal. However, it took until 2017 to be down to the same low level as in Sweden (where levels remained stable throughout the period).
- Cannabis use has increased, especially among schoolchildren, in Portugal. It is difficult to assess what has happened in other areas of drug use since, the first survey on drug use among the population was not carried out until 2001. There is no data for the time before the reforms to use as a comparison. Studies carried out later suggest that cannabis use has increased also among the adult population, while heroin use increased in the first years but has subsequently decreased since 2007.
- Researchers have seen neither a reduction nor increase in drug-related violence following the reform. The number of murders in Portugal increased sharply between 2001 and 2007, but it is not possible to establish any link to decriminalisation.
- Laws have a normative effect. Sweden is well placed in international comparisons with regard to drug use, both among young people and the population in general, and Swedish drug laws are likely to play a part in this. Decriminalisation risks sending signals that promote increased use.

It is likely that Sweden, as well as other countries, can learn from Portugal – not least in terms of organising drug treatment. A unified responsibility for treatment in Sweden, or at least radically improved coordination and information sharing between the main players in Sweden today, could make a big difference. Speed – being able to offer care when the motivation to receive it is at its highest – is probably also very important for the end result. Here, Sweden has a long way to go.



Pierre Andersson

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Portugal decriminalised all drugs in 2001 and is often mentioned in debate as an example of a successful reform that more should follow. As this report shows, the discussion is marked by misunderstandings and sometimes pure inaccuracies. Decriminalisation is at times confused with legalisation, and it is often difficult to see the full picture of what Portugal has done and what results the reforms has produced.

This report is an attempt to give clarification and thus contribute to a more informed debate on future drugs policy. What is the nature of decriminalisation? What results have the reforms in Portugal produced in terms of mortality, crime and drug use? And: Comparisons are often made between Portugal and Sweden – but does it even make sense to compare drug related mortality between the two countries?

The reforms carried out in Portugal were much broader than simply abolishing penalties for using drugs and minor possession. Considerable investment in care and treatment were likely essential to the positive results seen, as confirmed by the head of the Portuguese drug agency: “If decriminalisation had been the only step, the situation would probably have become worse”.

The report was written by Swedish freelance writer and policy expert Pierre Andersson on behalf of the Swedish Drug Policy Centre, NPC. Pierre Andersson has a background as a journalist and has long monitored drugs policy issues.