The Truth on Portugal

Countering false claims by activists concerning Portugal's decriminalisation using its own official statistics

DRUG FREE AUSTRALIA

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The Truth on Portugal

Portugal decriminalised all illicit drug use as of July 2001 and since that time drug decriminalisation/legalisation activists have inundated politicians and the media with glowing reports of Portugal's touted 'success', selectively using data with no context rather than giving the full picture.

But here is the reality, using Portugal's own official data sent to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the same statistics used for the yearly United Nations World Drug Report drug use tables.

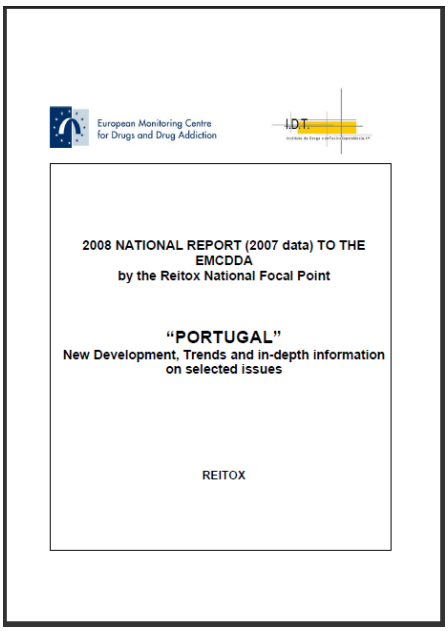

European Monitoring Centre for Drugs and Drug Addiction

SICAD

2014 NATIONAL REPORT (2013 data) TO THE EMCDDA
by the Reitox National Focal Point

"PORTUGAL"
New Developments, Trends

REITOX


European Monitoring Centre for Drugs and Drug Addiction

IDT

2008 NATIONAL REPORT (2007 data) TO THE EMCDDA
by the Reitox National Focal Point

"PORTUGAL"
New Development, Trends and in-depth information on selected issues

REITOX

http://www.emcdda.europa.eu/publications/national-reports/portugal-2014_en
http://www.emcdda.europa.eu/html.cfm/index86763EN.html

First, Australia's superior Tough on Drugs results

Compare the results of Australia's 'Tough on Drugs' strategy between 1998 and 2007 to those of Portugal in this document (Tough on Drugs was scrapped by the new Federal government of late-2007). The Tough on Drugs approach worked within an environment of States and Territories maintaining criminal penalties for use of all illicit drugs other than cannabis.

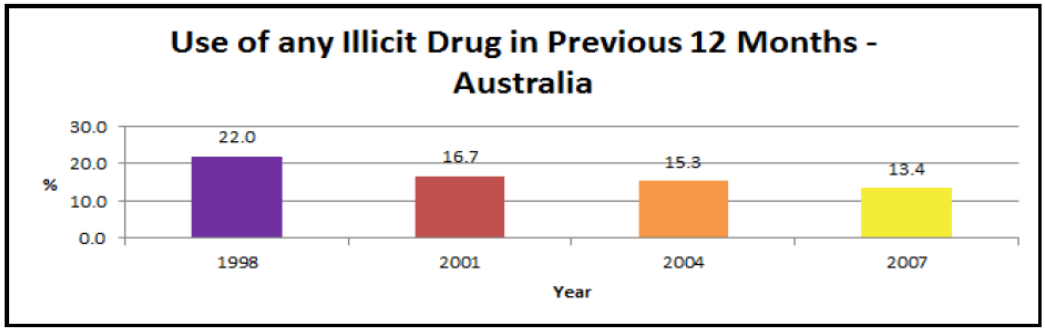
USE OF ALL ILLICIT DRUGS DECLINED BY 39% BETWEEN 1998 AND 2007.

View the actual drug use statistics for Portugal, then return here to compare them to the superior success of our Tough on Drugs approach.

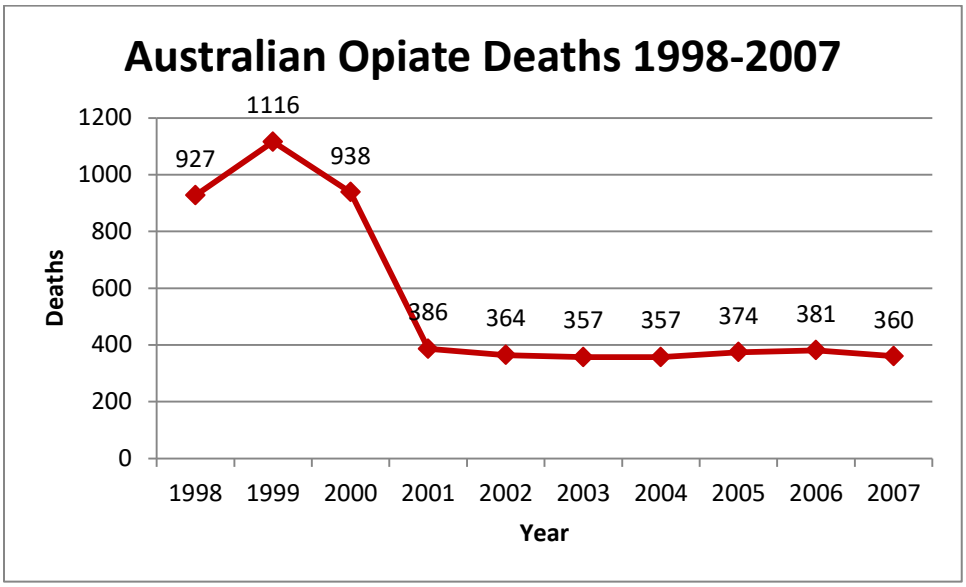
Table 2.1: Summary of recent[a] drug use, people aged 14 years or older, 1993 to 2010 (per cent)

Drug/behaviour	1993	1995	1998	2001	2004	2007	2010
Illicit drugs (excluding pharmaceuticals)							
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3
Ecstasy[b]	1.2	0.9	2.4	2.9	3.4	3.5	3.0
Meth/amphetamines[c]	2.0	2.1	3.7	3.4	3.2	2.3	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1
Injectable drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4
Any illicit[d][g]	**14.0**	**16.7**	**22.0**	**16.7**	**15.3**	**13.4**	**14.7**

https://www.aihw.gov.au/getmedia/85831350-afb6-4524-8d8d-764fa5d2d1f8/12668-20120123.pdf.aspx p 8



During Tough on Drugs Australian opiate deaths plummeted.

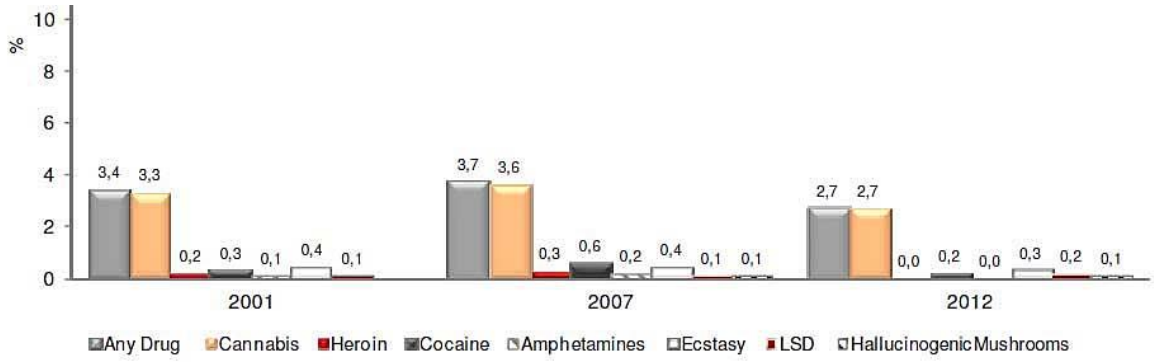


Portugal – overall drug use ROSE after decriminalisation

Since the implementation of decriminalisation in 2001 drug use for all age-groups in Portugal rose through to 2007 - compare the grey bars in Portugal's official REITOX 2014 annual report (page 26) to the European Monitoring Centre graphed below. While cannabis use increased marginally for all aged groups, cocaine use doubled as did use of speed and ice.

AGED 15-64

Any drug	**Up** 9%
Cannabis	**Up** 9%
Heroin	**Up** 50%
Cocaine	**Doubled**
Speed/Ice	**Doubled**
Ecstasy	No change
LSD	No change
Magic Mushrooms	**Up** from negligible to 0.1%

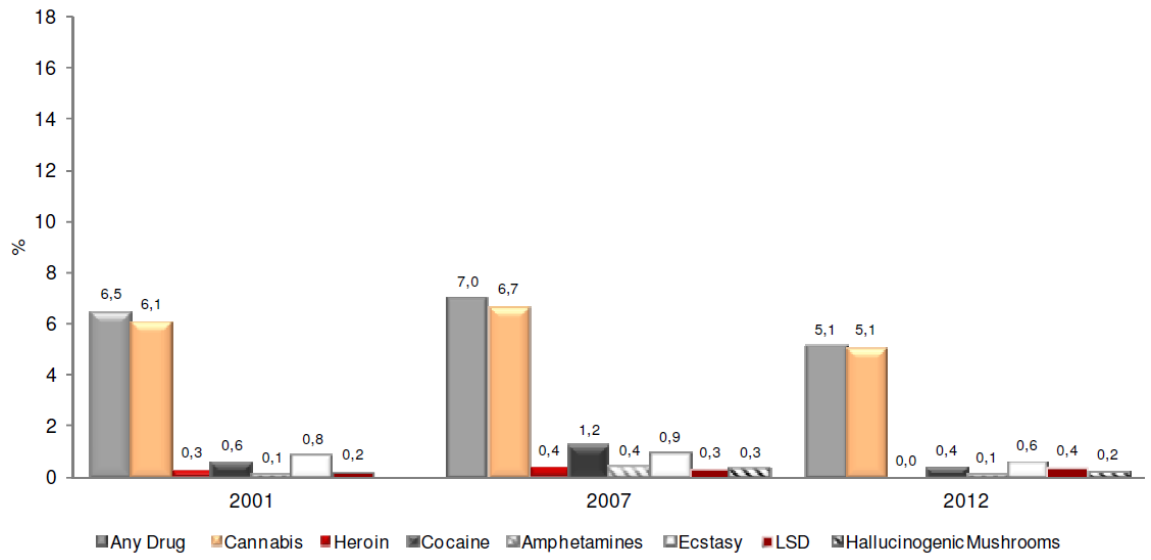


Graph 3 – General Population, Portugal – Total (15-64), last 12 months prevalence, by type of drug (%) (SICAD2013)

Drug use by young people aged 15-34, as graphed by the REITOX report (below), saw greater increases.

AGED 15-34

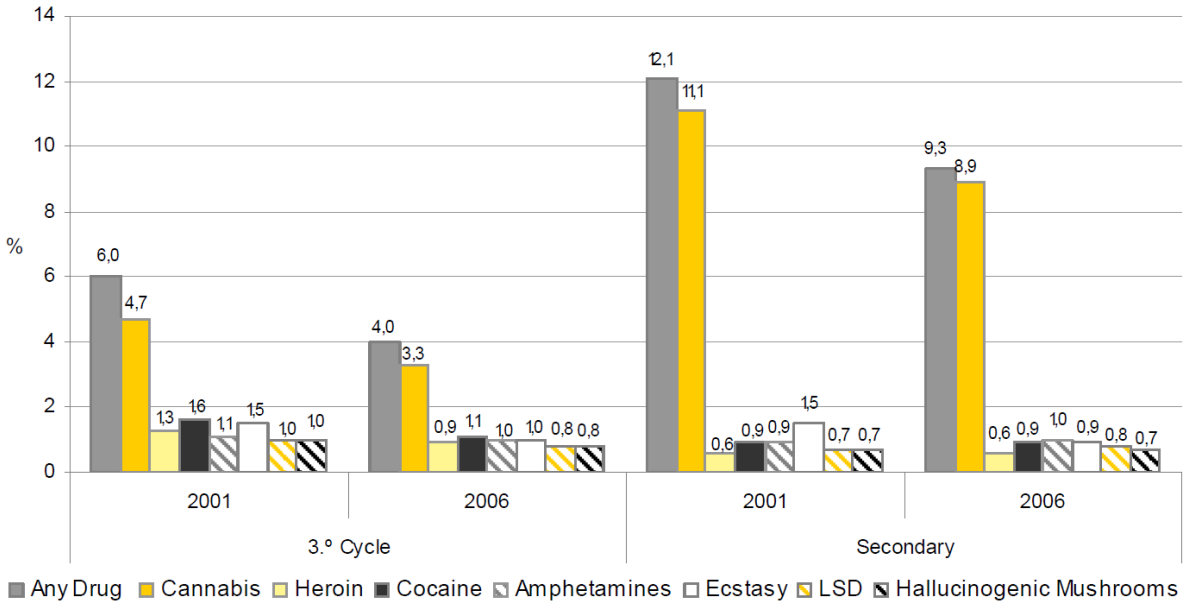
Any drug	**Up** 8%
Cannabis	**Up** 10%
Heroin	**Up** 33%
Cocaine	**Doubled**
Speed/Ice	**Quadrupled**
Ecstasy	**Up** 13%
LSD	**Up** 50%
Magic Mushrooms	**Up** from negligible to 0.3%



Graph 4 – General Population, Portugal – Young Adult Population (15-34 years), last 12 months prevalence, by type of drug (%) (SICAD2013)

Although high-school student use fell from 2001 to 2007

The dominant message given by activists about Portugal is that decriminalisation did not cause increases in drug use. Only high-school student use did fall - by 33% for 3rd Cycle students (typically aged 13-15) and by 23% for secondary students (aged 16-18) as per graphs copied from the 2008 REITOX National Report for Portugal (page 23). A Cato Institute report promoting the "success" of decriminalisation made much of these decreases while downplaying the increases for the greater part of the population already seen in the graphs above.



Graph 7 - School Population – 3rd Cycle and Secondary: Last Month Prevalence, by type of Drug

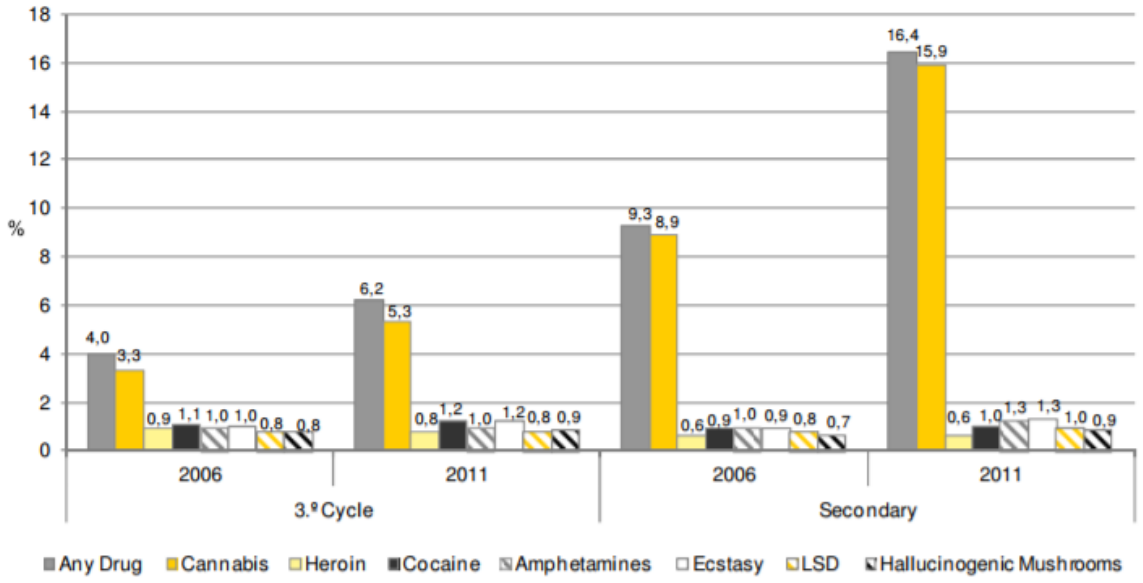
Overall drug use fell from 2007 to 2012

Between 2007 and 2012 drug use in Portugal for all age groups declined in line with general decreases across various European countries.

Italy - Opiates	0.8% (2005)	0.48% (2011)
Spain - Opiates	0.6% (2000)	0.29% (2012)
Switzerland - Opiates	0.61% (2000)	0.1% (2011)
Italy - Cocaine	1.1% (2001)	0.6% (2012)
Italy - Speed/Ice	0.4% (2005)	0.09% (2012)
Austria - Speed/Ice	0.8% (2004)	0.5% (2012)

Yet high school use rose steeply from 2006 to 2011

Use of any illicit drug by high-school students rose markedly between 2006 and 2011. The graph below is again copied directly from page 37 of the 2014 REITOX report to the EMCDDA. From 2001, when decriminalisation commenced, Secondary School drug use in 2011 was 36% higher than 2001 and 76% higher than in 2006.



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

Overall drug use has increased again from 2012 to 2017

Between 2012 and 2017 Lifetime Prevalence statistics for the general population (aged 15-64) have risen by 23% http://www.theportugalnews.com/news/alcohol-tobacco-and-drug-consumption-all-report-increases/43238. It is important to note that all other statistics cited thus far in this paper have been statistics for use in the last 30 days before survey, or alternatively the last 12 months. Lifetime Prevalence asks survey respondents if they have ever used a particular drug at any time in their lifetime. However a comparison of Portugal's Lifetime Prevalence graphs for 2001, 2007 and 2012 shows only a slightly attenuated difference for Lifetime Prevalence as compared to last 12 month figures indicating that Portugal is again seeing significant increases in illicit drug use. The Portugal News articles states,

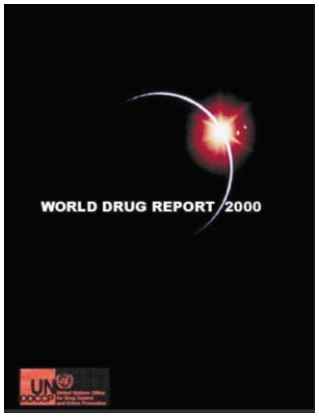
According to the 4th National Survey on the Use of Psychoactive Substances in the General Population, Portugal 2016/17, there has been a rise in the prevalence of alcohol and tobacco consumption and of every illicit psychoactive substance (essentially affected by the weight of cannabis use in the population aged 15-74) between 2012 and 2016/17.
The study focused on the use of legal psychoactive substance (alcohol, tobacco, sedatives, tranquilisers and/or hypnotics, and anabolic steroids), and illegal drugs (cannabis, ecstasy, amphetamines, cocaine, heroin, LSD, magic mushrooms and of new psychoactive substances), as well as gambling practices.

According to the study, alcohol consumption shows increases in lifetime prevalence, both among the total population (15-74 years) and among the young adult population (15-34 years), and among both men and women. Tobacco consumption shows a slight rise in lifetime prevalence, which, according to the report, "is mainly due to increased consumption among women."

The study also saw an increase from 8.3% in 2012, to 10.2% in 2016/17, in the prevalence of illegal psychoactive substance use.

Opiate use was already falling before decriminalisation

Much has been made of the decreases in heroin use in Portugal after decriminalisation. But Portugal's opiate use, which had topped OECD countries in 1998 at a staggering 0.9% according to the United Nation's World Drug Report for 2000, halved to 0.46% by 2005.



ANNEX 2 | ANNUAL PREVALENCE OF ABUSE OF ILLICIT DRUGS

EUROPE	Cannabis		Opiates		Cocaine*		Amphetamines		Ecstasy	
	%	Year	%	Year	%	Year	%	Year	%	Year
Western Europe										
Austria	3.0	1996*	0.2	1998	0.5	1996*	0.2	1996*	0.8	*
Belgium (18-65)	5.0	*	0.2	**	0.5	**	0.5	**	0.7	1998*
Denmark (18-69)	4.0	1995*	0.3	1995	0.3	1995	0.9	1995*	0.7	*
Finland	2.5	1998*	0.05	1997*	0.2	1998	0.1	1998*	0.2	1998*
France (18-69)	4.7	1995	0.3	1997*	0.2	1995	0.3	1995*	0.3	*
Germany (18-59)	4.1	1997	0.2	1998	0.6	1997	0.4	**	0.8	1997**
Greece (12-64)	4.4	1998*	0.4	*	0.5	**	0.06	1998*	0.01	1998*
Ireland	7.9	1995*	0.3	1997*	0.6	**	0.6	**	1.0	**
Italy	4.6	**	0.5	1997*	0.6	1996*	0.5	**	0.5	*
Liechtanstein	0.8	1996	0.1	1998	0.4	1998	0.02	1997	0.2	1998
Luxembourg	4.0	1998*	0.5	1997*	0.4	**	0.3	1998	0.2	*
Malta	2.2	**	0.2	1998	0.1	1996	0.01	1997	0.2	*
Monaco	0.4	1996	0.1	1995	0.01	1994	0.01	1993	0.4	*
Netherlands (12 and above)	5.2	1998	0.2	1998	0.7	1998*	0.4	1997*	0.8	1998*
Norway	3.8	1998*	0.2	1994	0.3	1997*	0.5	1997*	0.1	**
Portugal	3.7	**	0.9	1998	0.5	1998*	0.2	**	0.1	*
San Marino	4.0	1997*	0.02	1997	0.04	1994	0.3	1994	0.3	*
Spain	7.6	1997*	0.6	1999	1.7	1997	0.8	*	1.0	1997*
Sweden (15-75)	0.1	1998	0.1	1997	0.2	1998*	0.2	1997	0.1	1998*
Switzerland (18-45)	8.5	1998*	0.5	1998	0.5	1998*	0.7	**		
Turkey			0.01	1998						
United Kingdom	9.0	1998*	0.5	**	1.0	1998*	1.3	**	1.0	1998*

OCEANIA	Cannabis		Opiates		Cocaine*		ATS (1)	
	%	Year	%	Year	%	Year	%	Year
Australia (14 and above)	17.9	1998	0.7	1 998	1.4	1998	3.6(2.4)	1998
Fiji	0.2	1996						
Micronesia Fed.State.	29.1	1995						
New Caledonia	1.9	**						
New Zealand	15.0	1998	0.6	1998	0.04	1998	2.0	1998
Papua New Guinea (6-45)	29.5	1995			0.01	1995		
Vanuatu	0.1	1997						

* UNDCP estimate
** Tentative estimate for the late 1990s
* Includes *bazuco*
(1) Where available Ecstasy prevalence in brackets
Source: Global Illicit Drug Trends 2000

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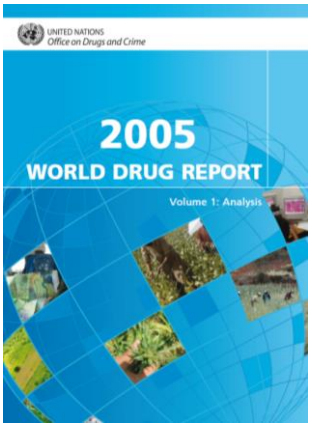
However roughly half of that decreased use predated decriminalisation, with 0.7% recorded in the UN World Drug Report for the year 2000. It is not clear what dynamic was in play for the 22% decrease in heroin use by 2000, the year prior to decriminalisation. However it may well have continued to be the dynamic at play without decriminalisation being a factor – we simply do not know.



World Drug Report 2005 Volume 2. Statistics

OPIATES
Annual prevalence of abuse as percentage of the population aged 15-64 (unless otherwise indicated)

EUROPE	
East Europe	
Russian Federation,2001	2.1
Ukraine*, 2002	0.8
Belarus*, 2003	0.4
Moldova, Rep., 2000	0.07
Southeast Europe	
Croatia,1999	0.7
Bulgaria, 2001	0.5
Albania*,2000	0.5
FYR of Macedonia,1998	0.4
Romania*, 2002	0.3
Turkey, 2003	0.05
Western and Central Europe	
Latvia,2001	1.7
Estonia, 2001	1.2
United Kingdom, 2001	0.9
Luxembourg,2000	0.9
Italy,2002	0.8
Denmark, 2001	[illegible]
Portugal, 2000	0.7
Spain,2000	0.6
Switzerland,2000	0.6
Ireland,2001	0.6
Lithuania,2002	0.6
Slovenia,2001	0.5

It appears that heroin use is simply not recorded for 2012 in the REITOX report graphs above and it is not at all clear why. Other data on page 71 of the same 2014 REITOX report (facsimile below) show that presentations for heroin use scored higher for outpatients and for detox units than any other type of illicit drug. Heroin also made up 42% of residential rehab admissions.

> Regarding the characterization of users' consumption that went in 2013 to the different structures of drug treatment[30] can be seen that, in outpatient, heroin remains the main substance more reported by patients in treatment in the year (82%). At the level of those who started treatment in 2013, this also occurred in the case of users readmitted (77%), but not in the case of new users, where cannabis has emerged as the main substance most referred (49%).
>
> Also among patients of DU's, heroin was the main drug most often reported (66% public and 69% in the licensed), but in TC´s this occurred at licensed (42%) level but not at the public, where main drug most reported was cocaine (61%).

Portugal's drug use was initially below European averages

Activist claims that Portugal's drug use is below European averages ignores the fact that Portugal, before decriminalisation, initially had drug use below European averages **other than for heroin**, as can be seen in the Annex 2 Table copied onto page 11 of this document. With the current increases in drug use between 2012 and 2017, it is not yet clear whether Portugal will be below or above – we await more data.

From 2001 to 2017 decriminalisation, despite being coupled with coerced rehabilitation and treatment, has failed to decrease the burden of drug use in Portugal, despite concerted efforts to target problem drug users with what they title "dissuasion". The diversion of funding from law enforcement to dissuasion and treatment has not ultimately succeeded.

Rising drug deaths in Portugal

Claims that there were significant decreases in drug-related deaths in Portugal immediately following decriminalisation are based on two errors.

First, claims that there were more than 75 drug-related deaths in 2001 which more than halved to 34 deaths in 2002 use a figure for 2001 for which there is no substantiation. Official drug-related deaths for Portugal, taken from the latest 2018 EMCDDA Statistical Bulletin are copied below. Notice that there is no such figure recorded for 2001.

Overdose deaths > Trends > EMCDDA 'Selection B'

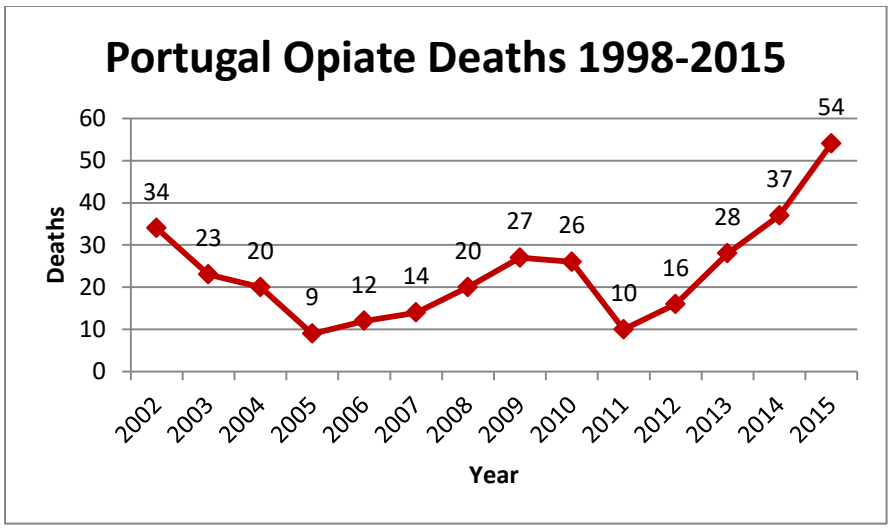
Download as Excel file (.xlsx)

Search:

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000
Poland	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Portugal	:	54	37	28	16	10	26	27	20	14	12	9	20	23	34	:	:
Romania *	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

http://www.emcdda.europa.eu/data/stats2018/drd_en

Second, there is no way of knowing what the real number of drug related deaths before 2002 were. Up until 2009 Portugal counted all deaths where any illicit drug was detected, whether the death was caused by that illicit drug or not. Portugal later changed its definition for Selection B drug-induced deaths to only those that were caused by overdose or poisoning, (see Appendix for definitions) and in 2009 reanalysed their data back to 2002. This leaves no comparison to the years before decriminalisation. The official figures yield the following graph.



Early decreases between 2002 and 2005 are part of the same decreasing trend in opiate use, as noted on page 12, which **predated** decriminalisation with reductions from 0.9% in 1998, to 0.7% in 2000. These decreases were not due to deciminalisation because they were not a part of it. Decriminalisation was introduced July 2001 and appears to be the beneficiary of whatever dynamic was driving opiate use and deaths down. However these early decreases in deaths are matched by an increasing trend between 2005 and 2010, which is followed by sharper rises in drug deaths from 2011 to 2015, the latest year for which data is currently available.

Portugal's graph should be compared with Australia's Tough on Drugs results on page 6. While Australia maintained criminal penalties for use of most drugs, it saw sharply decreased drug deaths that were then maintained at those lower levels throughout the tenure of Tough on Drugs.

Portugal's increasing trend in deaths since 2011 undoubtedly reflects rising drug use, in light of drug overdose deaths usually closely correlated to levels of rising opiate use. This is because there is a reasonably inelastic relationship between opiate use and opiate deaths, where typically 1% of opiate users fatally overdose each year. Portugal's increasing trend in overdose deaths should be indicate similar increases in opiate use.

One of the claims for Portugal that is in fact correct is that they have lower overdose deaths per million population than Australia. Below are the statistics for both countries to 2007 when Australia's Tough on Drugs ceased.

	PORTUGAL		AUSTRALIA	
Year	**Deaths**	**Per Million**	**Deaths**	**Per Million**
2002	34	3.3	364	18.5
2003	23	2.2	357	18.1
2004	20	1.9	357	17.9
2005	9	0.9	374	18.4
2006	12	1.1	381	18.5
2007	14	1.3	360	17.2

The most obvious factor for the much lower rate of overdose deaths per million population is that only 18% of heroin users inject heroin (*see circled datum on the EMCDDA Table copied on the next page*) whereas most heroin users in Australia inject. Users who smoke or snort their opiates do not run the same risks of overdose as injectors.

	High-risk opioid use estimate		Entrants into treatment during the year						Clients in substitution treatment
			Opioids clients as % of treatment entrants			% opioids clients injecting (main route of administration)			
			All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants	
Country	Year of estimate	cases per 1 000	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	count
Latvia	2014	3.4–7.5	46.2 (382)	24.7 (102)	67.8 (280)	91 (343)	87.1 (88)	92.4 (255)	518
Lithuania	2007	2.3–2.4	88.2 (1 905)	66.6 (227)	92.6 (1 665)	84.4 (1 607)	84.6 (192)	84.3 (1 402)	585
Luxembourg	2007	5–7.6	53.9 (146)	46.4 (13)	51 (100)	50.3 (72)	15.4 (2)	52 (51)	1 121
Hungary	2010–11	0.4–0.5	4.2 (196)	1.6 (51)	9.5 (118)	60.2 (109)	55.1 (27)	63.5 (73)	745
Malta	2014	5.3–6.2	72.8 (1 277)	27.5 (58)	79 (1 219)	63.4 (786)	47.3 (26)	64.1 (760)	1 013
Netherlands	2012	1.1–1.5	10.5 (1 113)	5.7 (346)	16.9 (767)	6.5 (44)	9.3 (18)	5.4 (26)	7 569
Austria	2013	4.9–5.1	50.8 (1 737)	29.2 (435)	67.3 (1 302)	35.9 (479)	23.1 (79)	40.3 (400)	17 272
Poland	2009	0.4–0.7	14.8 (1 061)	4.7 (162)	25 (877)	61.5 (639)	39.1 (61)	65.1 (555)	2 586
Portugal	2012	4.2–5.5	53.8 (1 538)	26.3 (357)	78.8 (1 180)	18.3 (255)	12.5 (39)	19.9 (216)	16 587
Romania	–	–	41.8 (1 064)	15.1 (211)	74 (852)	92.4 (1 007)	85.7 (180)	94 (799)	593

http://www.emcdda.europa.eu/edr2016_en p 71

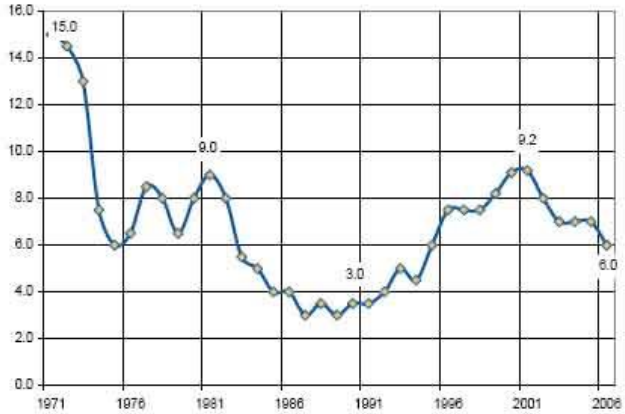
If Australia wants to replicate the low death rates from opiates, health authorities will have to convince Australians of the switch from injecting to smoking or snorting. It is unlikely that Australians will change.

However, smoked heroin is a harm reduction measure that is manifestly not the logical birth-child of decriminalisation. Netherlands has long promoted smoked heroin while drug use in that country is still technically criminalised.

Portugal uses coerced rehab and treatment

Portugal's policy coerces treatment and rehab, as does Sweden's which reduced its drug use from the late 1970s from the highest levels in Europe to the lowest in the developed world by the early 1990s with coerced rehabilitation central to its drug policy. In the graph on the next page from the United Nation's https://css.unodc.org/pdf/research/Swedish_drug_control.pdf decreases align with Swedish spending on rehab, which decreased between 1990 and 2001 due to Sweden's economic recession, but which was reinstated after 2001.

Figure 5: Life-time prevalence of drug use among 15-16 year old students in Sweden, 1971-2006



Source: CAN

Coerced rehabilitation has successfully reduced drug use in Sweden, and is not cited as an impingement on users' rights in Portugal by those who claim that everything Portugal is good. There is therefore no excuse for politicians to be discouraged from using the success of Sweden's coerced rehab policies within Australia, given its acceptability in Portugal.

HIV decreases not due to decriminalisation

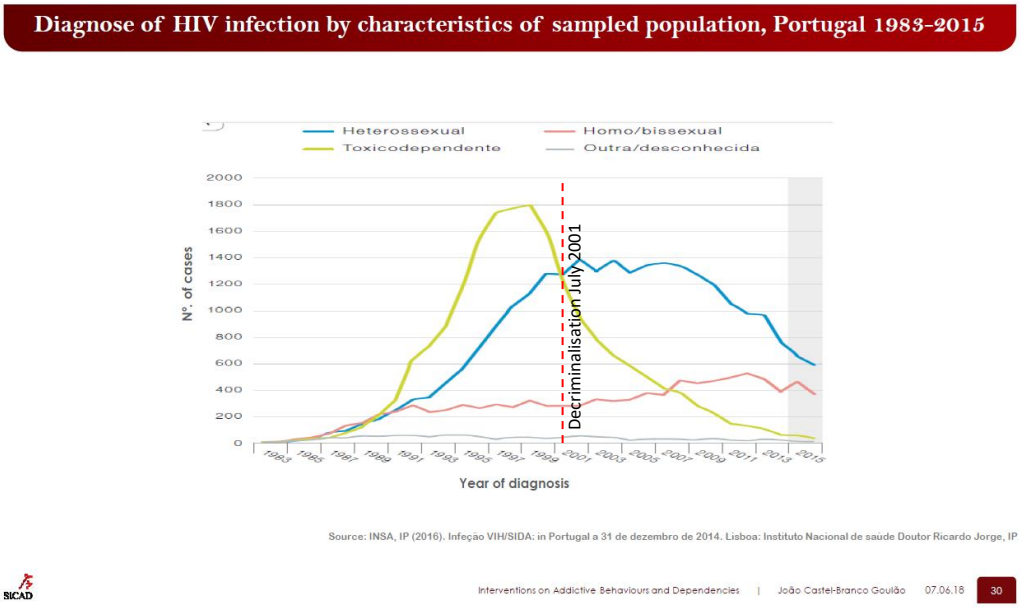
Drug legalisation/decriminalisation activists falsely claim that sharp decreases in Portugal's HIV incidence year on year are the result of decriminalisation.

Both HIV and Hepatitis C (HCV) are transmitted by sharing used needles. While Australia has some of the lowest HIV rates despite a sizeable injecting user population it has an HCV prevalence of 65% (https://catalogue.nla.gov.au/Record/3301382 p25) which is no different to any other drug-using country (ie typically 60-70% http://www.ifngo.org/main/pmwiki.php?n=Policy.DrugAbuse). While Australia's Needle & Syringe Programs (NSPs), the envy of every other country worldwide, took credit for our low HIV rates, our high HCV prevalence makes it clear that a majority of our injectors still often share needles despite provision of clean needles by our state-of-the-art NSPs. The failure of NSPs to control HCV has been confirmed by the world's most authoritative review of NSPs (https://www.nap.edu/catalog/11731/preventing-hiv-infection-among-injecting-drug-users-in-high-risk-countries p 145). If so many users are sharing needles as witnessed by high HCV rates, then Australia's low HIV rates are logically due to something other than NSPs.

The founder of Australian NSPs, Dr Alex Wodak, expressed alarm in a 1997 Medical Journal of Australia article (https://www.ncbi.nlm.nih.gov/pubmed/9087180) titled "Hepatitis C: Waiting for the Grim Reaper" where the apparent ineffectiveness of NSPs in preventing HCV led him to propose a new Grim Reaper campaign to target its spread. This of course suggests that Australia's Grim Reaper television advertising campaign targeting HIV was the likely reason for low HIV levels in Australia, not NSPs. Australia's higher levels of HIV testing than other countries also contributes.

While Australia's HIV interventions effectively stopped any growth in contracted HIV from an initially low base of infected persons, Portugal has had to initially contend with the highest HIV levels in Europe with 45% of Portugal's intravenous users having contracted HIV in the late 1990s. However, the identified interventions which have reduced HIV notifications in 2016 to less than 1 in 10 of their intravenous users (see http://www.emcdda.europa.eu/countries/drug-reports/2018/portugal/drug-harms_en) are not at all unique to decriminalisation.

First, from the graph below it is clear that the greatest reductions in HIV transmissions were already being achieved BEFORE the introduction of decriminalisation in mid-2001 (decreases from January to June 2001 can reasonably be expected to match the proportional magnitude of those in the year 2000). The significant decreases in opiate use, also before 2001 as discussed on page 11 & 12, would be a contributor.



https://www.qmhc.qld.gov.au/sites/default/files/downloads/the_portuguese_experience_0.pdf

Second, the success in decreasing heterosexual HIV transmissions evident from 2007 onwards also demonstrates that factors other than the decriminalisation of drug use were causal for decreases in HIV.

Third, while the move by Portuguese opiate users from intravenous drug use to smoked or snorted opiate use will have been somewhat responsible for the decreased transmissions of HIV, these changes are not the result of decriminalisation because they are not unique to decriminalisation. Smoked and snorted opiate use also happens within drug policy regimes that still maintain criminal penalties for drug use.

Fourth, one important factor has been the provision of free and readily available HIV screening, the very same factor that has led to low HIV transmissions in Sweden and Norway https://www.ncbi.nlm.nih.gov/pubmed/14533729. Yet freely available HIV testing and counseling in Sweden and Norway succeeds in a CRIMINALISED context, therefore free HIV testing is not synonymous with decriminalisation, given that it works successfully in either context.

While Portugal's success with HIV must be applauded, there is nothing to suggest that decriminalisation has in any way been causal.

Overblown activist claims about HIV reductions need to be publicly corrected.

Almost all Australians do not approve of illicit drug use

The Australian Government's Australian Institute of Health and Welfare (AIHW) conducts the National Drug Strategy Household Survey every 3 years, surveying close to 25,000 Australians each time. The very large sample gives this survey a great deal of validity.

The last survey was in 2016, and Table 9.17 from its statistical data https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data indicates Australian approval or disapproval of the regular use of various illicit drugs.

97-99% of all Australians do not give their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 86% do not give their approval to the regular use of cannabis.

Table 9.7: Personal approval of the regular use by an adult of selected drugs, people aged 14 years or older, 2007 to 2016 (per cent)

	Males				Females				Persons			
Drug	**2007**	**2010**	**2013**	**2016**	**2007**	**2010**	**2013**	**2016**	**2007**	**2010**	**2013**	**2016**
Tobacco	15.8	17.4	17.3	18.1	12.9	13.3	12.2	13.2	14.4	15.3	14.7	15.7#
Alcohol	51.7	51.5	51.7	52.4	39.0	38.9	38.6	39.8	45.3	45.1	45.1	46.0
Cannabis	8.7	11.0	12.6	17.8#	4.6	5.3	7.0	11.2#	6.7	8.1	9.8	14.5#
Ecstasy	2.6	3.0	3.3	3.9	1.5	1.7	1.6	1.8	2.0	2.3	2.4	2.9#
Meth/amphetamine[(a)]	1.5	1.5	1.6	1.6	0.9	0.9	1.1	0.8	1.2	1.2	1.4	1.2
Cocaine/crack	1.8	2.2	1.9	2.0	1.0	1.2	1.3	1.4	1.4	1.7	1.6	1.7
Hallucinogens	2.1	3.2	4.5	5.1	1.2	1.6	1.7	2.4#	1.7	2.4	3.1	3.7#
Inhalants	1.0	1.3	0.9	0.9	0.7	0.8	1.0	1.0	0.8	1.0	0.9	1.0
Heroin	1.3	1.5	1.3	1.3	0.7	1.0	1.1	1.0	1.0	1.2	1.2	1.1
Pharmaceuticals[(a)]	15.6	23.3	24.5	28.7#	11.9	21.4	21.9	26.9#	13.7	22.4	23.2	27.8#
Prescription pain-killers/analgesics[(a)]	n.a.	13.4	13.0	13.2	n.a.	12.6	12.2	12.1	n.a.	13.0	12.6	12.7
Over-the-counter pain-killers/analgesics[(a)]	n.a.	14.4	14.8	19.5#	n.a.	14.3	14.2	18.7#	n.a.	14.3	14.5	19.1#
Tranquilisers, sleeping pills[(a)]	4.8	7.2	9.5	10.1	3.4	5.7	6.8	8.5#	4.1	6.4	8.2	9.3#
Steroids[(a)]	2.5	3.0	3.0	3.0	1.0	1.4	1.5	1.8	1.7	2.2	2.2	2.4
Methadone or buprenorphine[(a)]	1.1	1.5	1.3	1.6	1.0	1.0	1.2	1.1	1.0	1.2	1.3	1.3

Statistically significant change between 2013 and 2016.
(a) For non-medical purposes.
Note: The list of response options changed across survey waves. Comparisons should be interpreted with caution.
Source: NDSHS 2016

Australians want less drugs, not more

With 97-99% of all Australians not giving their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 86% not giving their approval to the regular use of cannabis, it is clear that Australians do not want these drugs being used in their society. Decriminalisation of drugs has been associated worldwide with increased drug use. (see https://drugfree.org.au/images/13Books-FP/pdf/Decriminalisation.pdf) Australians need to be educated about the real results of decriminalisation, and the misleading portrayals of Portugal's drug policy need public correction.

Conclusions

Most of the claims being made for the 'success of Portugal's decriminalisation of all types of drug use are false claims.

- Decriminalisation has increased drug use for all age-groups
- Decriminalisation has seen sharp increases amongst high-school students
- Portugal's drug use, other than for heroin, was initially lower than European averages
- It is not clear what caused major decreases in opiate use before decriminalisation
- While drug deaths in Portugal are much lower in Portugal due to heroin being smoked or snorted rather than injected, drug overdose mortality is currently increasing
- HIV decreases are mostly not due to decriminalisation
- Australia's Tough on Drugs shows a far superior success

Recommendations

Australian politicians and media need to acquaint themselves with the real statistical picture for Portugal rather than accepting the claims of activists at face-value

Australian politicians and media need to be aware that Portugal coerces treatment and rehab and therefore should reject the notion that coerced treatment could never be accepted by drug users

Australian politicians and media need to seek every opportunity to advance the truth and not the false claims made about Portugal

Australian politicians need to recognise that Australians want less drugs, not more, and legislate those strategies which reduce drug use - Tough on Drugs was one such strategy

APPENDIX – drug death definitions

In 2012, the journal Drug and Alcohol Review reproduced an attempt by Caitlin Hughes and Alex Stevens to reconcile conflicting views of Portugal's drug statistics.

Drug and Alcohol REVIEW APSAD

Drug and Alcohol Review (January 2012), 31, 101–113
DOI: 10.1111/j.1465-3362.2011.00383.x

HARM REDUCTION DIGEST—44

A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs

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In this Harm Reduction Digest two observers and scholars of the 2001 Portuguese drug policy reform consider divergent accounts of the reform which viewed it as a 'resounding success' or a 'disastrous failure'. Acknowledging from their own experience the inherent difficulties in studying drug law reform, Caitlin Hughes and Alex Stevens take the central competing claims of the protagonists and consider them against the available data. They remind us of the way all sides of the drug policy debates call upon and alternatively use or misuse 'evidence' to feed into discussions of the worth, efficacy and desirability of different illicit drug policies. In doing so they provide pause for thought for those of us who operate as drug policy researchers and drug policy advocates.

SIMON LENTON
Co-editor, Harm Reduction Digest

Introduction

In July 2001 as part of a comprehensive new policy Portugal decriminalised use, acquisition and possession of all illicit drugs when conducted for personal use. Sales of all illicit drugs remained as criminal offences. Ten years on, the reform has attracted considerable about drug use and related harms, is often implied to be *the* tested, trustworthy tool for generating policies 'devoid of dogma' [7], this case study provides a much needed opportunity to examine the way *all* sides of the drug policy debate can call upon and alternatively use or misuse evidence to feed into discussions of the worth, efficacy and desirability of different illicit drug

This document has already described Portugal's definition of drug-related deaths through to 2009 when this data was reanalysed, creating new statistics for drug-induced deaths (EMCDDA's Selection B for Portugal) versus other drug-related deaths. On the following pages we have reproduced the discussion by Hughes and Stevens which confirms that only Appendix B deaths are comparable to Australian overdose data. We note that some activists make comparisons between Australia's and Portugal's mortality data, making conclusions about the lower mortality per million population in Portugal, while illegitimately using Selection D deaths to affirm decreasing deaths up to 2016. This of course is not legitimate.

if not more importantly, the accounts had differential appreciations of the weaknesses of the adopted indicator for reporting on deaths attributable to illicit drug use.

Unlike much of the Western world, Portugal has not historically collected or reported information on deaths that are directly attributable to drug intoxication. Indeed, information on 'overdose' only became available in November 2010 (following calls by the EMCDDA and Instituto da Droga e da Toxicodependência (IDT) for harmonisation and improvement of indicators of drug-related deaths) [12]. Until recently the primary indicator 'drug-related deaths' has been produced by the INML and defined as the number of deaths that involve a positive post-mortem toxicological test for the presence of illicit substances [12]. It is the only data available before and after the reform, but it has two major limitations. First, as noted by Greenwald, it is responsive to changes in recording practices, such as the number of toxicological autopsies. Second, it is only an indirect indicator of attributable death; many people are found to have traces of a drug in their body when they die, but this does not mean that the drug caused the death. This is why the standard international classification of drug-related death relies on reports by physicians on their assessment of the cause of death, *not* positive toxicological tests [41].

The data weaknesses and a substantial rise in toxicological autopsies from 2005 to 2009 give merit for suggesting that as argued by both Greenwald and our own account [8], the rise in 'positive post-mortem toxicological tests' may have been largely spurious. Yet neither the possibility of a spurious change nor substantial changes in recording practices were mentioned in the Pinto accounts.

Data from the National Statistics Institute (INE) has recently been made available and backdated from 2001 onwards. This provides a more accurate indicator of drug-attributable death as it refers to the number of people that have been determined by doctors according to International Classification of Diseases protocols

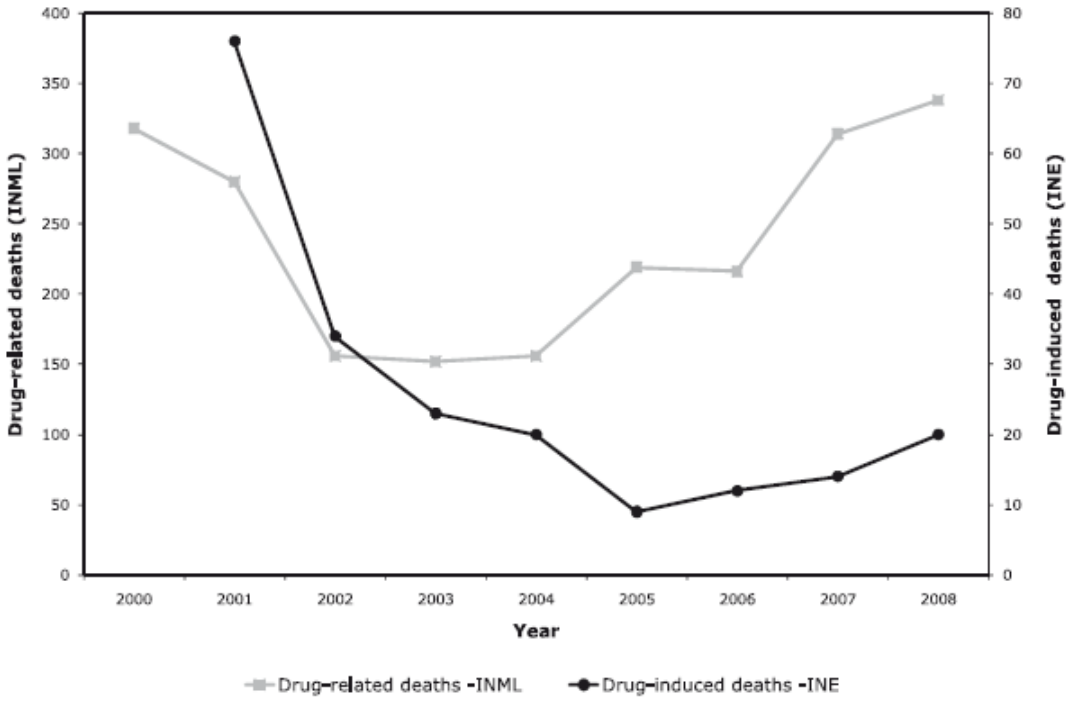

Figure 4. *Drug-related deaths in Portugal between 2000 and 2008 using National Institute of Forensic Medicine (INML) definition (positive post-mortem toxicological test for drugs) and National Statistics Institute (INE) definition (determination by physician according to International Classification of Diseases criteria that death was attributable to drugs). Source: Instituto da Droga e da Toxicodependência (2009, 2010) [12,42].*

to have died due to drugs [12]. INE data support the hypothesis that the reported rise in the INML data was spurious as the number of people determined by physicians to have died due to drug use decreased from 2001, with a slight increase from 2005 to 2008/9 (to levels that remain much lower than at the time of decriminalisation) [12,42] (see Figure 4). This is not to say that decreases are attributable solely to the reform, with the expanded services a more plausible explanation, but a key goal of the reform had been to reduce social stigma and thereby facilitate access to Portuguese drug treatment and harm reduction services. As shown in Hughes and Stevens [8] drug treatment access in Portugal expanded considerably post-reform. This provides partial evidence that the reform may have contributed to the observed declines.

Examining the other assertion by Pinto of a 40% rise in 'drug-related homicides' in post-reform Portugal, it is clear that this was based on a false attribution to the World Drug Report. The data referred to all homicides, that is, any intentional killing of a person, including murder, manslaughter, euthanasia and infanticide [43]. The 2009 World Drug Report [44] merely speculated that the rise 'might be related' to drug trafficking activity:

> While cocaine seizures in a number of European countries increased sharply during that period, in 2006, Portugal suddenly had the sixth-highest cocaine seizure total in the world. The number of murders increased 40% during this same period of time, a fact that might be related to the trafficking activity. Although the rate remains low and Lisbon is one of Europe's safest cities, Portugal was the only European country to show a significant increase in murder during this period.

There is no way of grounding or assessing whether the rise in homicides was drug-related or, if they were, whether they were attributable *to* the reform. Indeed, a striking omission from the Pinto assertions has been attention to the proposed causal mechanism (and its validity or lack thereof). For example, is it reasonable to assume that decriminalisation of penalties for minor drug use offences, in the absence of any legislative change for traffickers, would have a detectable effect on drug-related homicide? A much more plausible hypothesis is that this association is an artefact of increased European demand for cocaine and geography: namely that Portugal is one of two main gateways through which cocaine flows into Europe [40]. This leads us to conclude that assertions of a rise in drug-related homicide have questionable validity. They also run counter to our earlier reported trend that drug-related crime reduced, rather than increased post-reform [8].

Overdose deaths > Trends > EMCDDA 'Selection B'

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995
Austria *	122	150	139	194	221	237	207	223	221	186	202	196	185	192	84	153	167	135	119			
Belgium			61	74	72	94	106	155	146	118	86	105	74	97				113	48	123	137	132
Bulgaria *	22	17	15	21	24	25	41	38	74	52	29	40	26	15	13	24	41	28	21	16	11	19
Croatia	56	54	59	48	48	59	73	61	87	115	72	84	88	57	52	64	51	48	34	36	33	47
Cyprus																						
Czech Republic	41	53	35	39	32	22	29	33	24	19	19	19	14	18	13	31	23	24				
Denmark		201	250	247	249	301	254	277	267	246	227	207				258	247	239	243	256	242	214
Estonia	114	88	98	111	170	123	101	133	67	81	68	57	98	36	86	45	31	22	7	4		
Finland	194	166	176	201	213	197	156	175	169	143	138	126	135	101	97	110	134	119	84	98	107	
France			370	349	264	340	392	365	374	333	305	301	267	231	242	272	247	118	143	228	393	465
Germany		1306	1195	1179	1079	1076	1205	1276	1326	1284	1169	1223	1104	1161	1139	1239	1487	1337	1280	1088	1305	1227
Greece																						
Hungary	32	56	42	39	44	17	20	33	30	38	36	19	23									
Ireland													112	96	90	93	113	122	82	78	44	36
Italy			263	244	288	254	270	358	391	473	443			415	530	698	851	950	1068	1097	1369	1231
Latvia	18	18	15	11	17	11	7	19	24	20	17	14	14	12	35	36	42	32	3	5	1	
Lithuania	109	115	87	54	70	45	51	68	61	76	62	32	38	40	33	35	45	37	32	34	23	9
Luxembourg	5	12	8	11	8	6	12	14	10	27	19	8	13	10	12	16	21	14	22			
Malta	5	8	2	3	7	5	5	8	8	11	7	8	6	5	8	7	6	5	5	5	2	1
Netherlands	235	197	123	144	118	103	94	139	129	99	112	122	127	104	103	144	131	115	110	108	108	70
Norway *		289	266	234	246	262	248	285	263	275	251	234	303	255	307	405	374	256	282	194	204	
Poland																						
Portugal		54	37	28	16	10	26	27	20	14	12	9	20	23	34							
Romania *																						
Slovakia																						
Slovenia	40		28	28	26	24	25	28	36	42	26	36	25	22	26	21	19	23	19	13		
Spain *		105	117	114	144	150	163	160	165	217	204	316	480	579	536		604	609				
Sweden *	590	661	628	476	427	371	369	350	320	310	235	245	225	258	203	204	194	157	138	133	122	70
Turkey																						
United Kingdom		3070	2717	2529	2178	2197	2058	2432	2382	2397	2139	2122	2103									

(1) National definitions usually refer to acute deaths directly related to drug consumption ("overdoses", "poisonings" or "drug-induced"). Note that, in a few countries, the figures might include also a limited number of cases of deat
(2) Comparisons between countries must be made with caution, because mortality rates and trends are influenced by factors such as practices of reporting, recording information and coding overdose cases that may vary across coun
(3) General notes about interpreting the data are shown first, followed by notes which are specific to data in the table (these latter notes are indicated within the table with an asterisk (*)).
(4) Austria: Since 2008, the official number of drug related deaths includes cases were no autopsy was performed
(5) Bulgaria: From 2013 onwards data refers to EMCDDA "Selection B"
(6) Spain: data refers to selection B with no X44 ICD10 code.
(7) Norway: Until 2002 the national definition did not include "intentional poisoning" (ICD codes: X61,X62). From 2003 "Selection B" has become the national definition.
(8) Sweden: In 2016 Sweden updated data since 2001 in order to include T40.4 cases.
(9) United Kingdom: The UK has made several changes for 2015 reporting for Selection B: Reporting for England & Wales changed to report by the year deaths occurred rather than the year of registration. This is to give internal consist
(10) United Kingdom: From 2013 onwards data refers to EMCDDA "Selection B" whereas before data based on the Drug Strategy Definition (DSD) was used.
(11) Romania: sub-national coverage.

Overdose deaths > Trends > EMCDDA 'Selection D'

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995
Austria *	165	153	122	138	161	201	187	206	201	175	197	191	185	163	139	139	167	128	109	136	191	170
Belgium																						
Bulgaria *			32	25	32	25	21	33	32	47	18	36	36	56	33	79						
Croatia																						
Cyprus	6	9	6	3	5	8	9	12	11	12	7	9	14									
Czech Republic	32	44			38	28	55	49	44	40	42	62	57	55	44	84	80	79	61			
Denmark	207	167	191	164	166	218	204	206	195	205	221	206	214	198	198	201				216		
Estonia																						
Finland		141	137	162	155	165	130	105	112	92	88	72	74	67	66	60	96	87	51	42	31	30
France															82	101	98	85	113	184	351	
Germany																						
Greece *	73	78	64	68	73	107	151	229	208	242	253	325	255	217	259	321	304	265	245	232	222	176
Hungary	29	25	23	31	24	14	17	31	27	25	25	28	34	32		40	38	42	31	47	52	
Ireland		224	223	225	185	227	174	214	215	208	187	164	127	105	127	109	113	115	104			
Italy	266	308	313	349	393	365	374	484	517	606	551	653	653	517	520	825	1016	1002	1080	1160	1566	1195
Latvia	41	25	23	20	36	26	29	43	46	53	47	25	39	45	54	51	52	115				
Lithuania														31	19	23	23	23				
Luxembourg													13	14	11	18	26	17	16	9	17	22
Malta								7			5	7	7	5	5	8	5	4	6	5	3	2
Netherlands																						
Norway *								184	179	200	195	184	223	172	210	338	327	220	270	177	184	132
Poland																						
Portugal	27	40	33	22	29	19	52	56	94													
Romania *	19	21	33	30	28	15	34	32	33	32	21	6	7	7	3	12	0					
Slovakia	20	27	13	27	26	16	20	22	25	17	20	17	23									
Slovenia																						
Spain *		171	172	196	195	181	182	181	139	188	218	237	212	274	204	240	254	258	271	321	381	371
Sweden																						
Turkey	920	590	497	232	162	105	126	153	147	136	51	26										
United Kingdom																						

(1) National definitions usually refer to acute deaths directly related to drug consumption ("overdoses", "poisonings" or "drug-induced"). Note that, in a few countries, the figures might include also a limited number of cases of deat
(2) Comparisons between countries must be made with caution, because mortality rates and trends are influenced by factors such as practices of reporting, recording information and coding overdose cases that may vary across coun
(3) General notes about interpreting the data are shown first, followed by notes which are specific to data in the table (these latter notes are indicated within the table with an asterisk (*)).
(4) Austria: Since 2008, the official number of drug related deaths includes cases were no autopsy was performed
(5) Bulgaria: From 2013 onwards data refers to EMCDDA "Selection B"
(6) Spain: data refers to Madrid, Barcelona, Valencia, Zaragoza, Seville and Bilbao.
(7) Greece: From 2014 onwards the numbers used refer to the reported number of deaths (confirmed and pending cases).
(8) Norway: Until 2002 the national definition did not include "intentional poisoning" (ICD codes: X61,X62). From 2003 "Selection B" has become the national definition.
(9) United Kingdom: The UK has made several changes for 2015 reporting for Selection B: Reporting for England & Wales changed to report by the year deaths occurred rather than the year of registration. This is to give internal consist
(10) United Kingdom: From 2013 onwards data refers to EMCDDA "Selection B" whereas before data based on the Drug Strategy Definition (DSD) was used.
(11) Romania: sub-national coverage.