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What's Not Working? The Criminalization of Addiction in the United States Compared to the Decriminalization of Addiction in Portugal

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ABSTRACT

Addiction is a growing problem in the United States, which is worsened by the unsuccessful policy of criminalization where drug use is treated as a crime to be punished. Portugal may offer a solution, as it has been successful in mitigating addiction through the decriminalization of all drugs. Drugs are illegal in the country, but they are treated as an administrative offense instead of a criminal one. This paper analyzes the applicability of Portugal's model to the United States which is dealing with increasing numbers of fatal overdoses.

This paper first will provide a brief introduction on addiction, including its brain chemistry, the factors that contribute to it, and the difference between the drugs. Then, it will move on to the history of drug criminalization and its impact on current American policy. This includes the early history of drugs, drug laws, and addiction research. It also shares information on the racially motivated War on Drugs, and the differing public health response to the Opioid Epidemic which predominately affected white communities. It briefly traces the evolving status of marijuana legalization.

Next, the paper will analyze Portugal's pioneering drug decriminalization model, introduced in 2000, within its historical, social and legal context. The paper then moves into the functions of decriminalization, and the judicial backlash that recriminalized possession of more than a ten-day personal use supply in 2012. Finally, it finds Portugal's public health-oriented model as more successful in every measure of addressing addiction. At the end, a case study of Oregon's brief experiment of decriminalization from 2022-2024 reveals the important qualities necessary for the success of decriminalization.

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Introduction

Drug use is pervasive in our world. In 2021, there were 296 million global drug users, representing one out of every 17 people- a 23% increase from 2011.[1] This behavior can turn deadly, as in 2019, 600,000 global deaths were attributed to drug use.[2]

The United States is an example of, not an exception to, the problem. In 2021, more than 46 million Americans aged 12 or older had at least one substance use disorder.[3] Drug overdose is the leading cause of injury-related deaths in the United States, and over 1 million Americans died from it between 1991 and 2020.[4][5] It is also getting worse- 70,630 Americans died from an overdose in 2019, and 111,029 died in 2022.[6] This costs Americans more than $700 billion per year due to increased healthcare costs, lost productivity, and crime.[7]

Addiction is worsened by the unsuccessful policy of criminalization in the United States, where drug use is treated as a crime to be punished. Portugal may offer a solution, as it has been successful in mitigating addiction through the decriminalization of all drugs. Drugs are illegal in

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[1] United Nations Office on Drugs and Crime (UNODC), World Drug Report 2023 (United Nations publication, 2023), https://www.unodc.org.
[2] World Health Organization (WHO), "Opioid Overdose," World Health Organization, last modified July 6, 2023, https://www.who.int/news-room/fact-sheets/detail/opioid-overdose.
[3] National Institute on Drug Abuse (NIDA), "New NIH Study Reveals Shared Genetic Markers Underlying Substance Use Disorders," National Institute on Drug Abuse, March 2023, https://nida.nih.gov/news-events/news-releases/2023/03/new-nih-study-reveals-shared-genetic-markers-underlying-substance-use-disorders.
[4] Centers for Disease Control and Prevention (CDC), "Drug Overdose Deaths."
[5] National Public Radio (NPR), "More Than a Million Americans Have Died from Overdoses During the Opioid Epidemic," National Public Radio, December 30, 2021, https://www.npr.org/2021/12/30/1069062738/more-than-a-million-americans-have-died-from-overdoses-during-the-opioid-epidemi.
[6] Centers for Disease Control and Prevention (CDC), "Drug Overdose Deaths," *National Center for Health Statistics*, last reviewed January 19, 2023, https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm#featured-charts; Centers for Disease Control and Prevention (CDC), "Press Release: CDC Reports on Drug Overdose Mortality," *Centers for Disease Control and Prevention*, May 15, 2024,
[7] National Institute on Drug Abuse (NIDA), *Substance Use in the United States: The National Institute on Drug Abuse Annual Report 2014* (National Institute on Drug Abuse, 2014), https://nida.nih.gov/sites/default/files/soa_2014.pdf

the country, but they are treated as an administrative offense instead of a criminal one. This paper analyzes the applicability of Portugal's model to the United States.

This paper first will provide a brief introduction on addiction, including its brain chemistry, the factors that contribute to it, and the difference between the drugs. Then, it will move on to the history of drug criminalization and its impact on current American policy. This includes the early history of drugs, drug laws, and addiction research. It also shares information on the racially motivated War on Drugs, and the differing public health response to the Opioid Epidemic which predominately affected white communities. It briefly traces the evolving status of marijuana legalization.

Next, the paper will analyze Portugal's pioneering drug decriminalization model, introduced in 2000, within its historical, social and legal context. The paper then moves into the functions of decriminalization, and the judicial backlash that recriminalized possession of more than a ten-day personal use supply in 2012. Finally, it finds Portugal's public health-oriented model as more successful in every measure of addressing addiction. At the end, a case study of Oregon's brief experiment of decriminalization from 2022-2024 reveals the important qualities necessary for the success of decriminalization.

1: The Basics of Addiction

Addiction alters the brain to perpetuate the cycle of drug use for those who struggle with it. Thus, it is a disease. The chapter will explore the brain science behind addiction and the people it affects. Additionally, the chapter will explore the various substances people can become addicted to, with a spotlight on opioids and cocaine as the two most commonly used.

Brain Chemistry

According to George Koob at Harvard Medical School, "addiction is about the complex struggle between acting on impulse and resisting that impulse."[8] Addiction can form around any object or activity, including shopping, gambling, and sex. If untreated, these urges can have negative effects on the individual affected as well as their community.[9]

Substance use disorder is a chronic, relapsing brain disease characterized by the compulsive nature to seek drugs despite their harmful consequences. It physically reduces the structure of the brain in important areas regarding judgement, decision making, learning, memory, and behavior control.[10]

Most drugs work by flooding the brain with dopamine via the mesolimbic dopamine system. This system is a neural circuit that facilitates reward, reinforcement, and motivation. The drugs cause euphoria, also known as a "high," by rewarding the brain with dopamine. Then, the brain reinforces this pleasurable experience, which causes people to repeat the behavior.[11]

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[8]George Koob, "What Is Addiction?" *Harvard Health Blog*, June 19, 2017, https://www.health.harvard.edu/blog/what-is-addiction-2-2017061914490.
[9] Ibid.
[10] National Institute on Drug Abuse (NIDA), Substance Use in the United States: The NIDA Annual Report 2014 (2014), https://nida.nih.gov/sites/default/files/soa_2014.pdf.
[11] Ibid.

Over time, the brain also reduces the ability of cells in the reward circuit to respond to the dopamine surges, known as tolerance. This may cause individuals to consume more of the drug to get the same high. By manipulating the brain into producing less dopamine, drugs lead people to lose pleasure in other things they enjoyed before like recreational activities, food, or sex.[12] Some drugs can release 2 to 10 times the amount of dopamine in natural rewards.[13]

Factors Contributing to Addiction

There is not a single factor that determines if someone will develop a substance use disorder. However, there are risk factors that may increase someone's propensity regarding their environment, development, and biological factors. This includes aggressive behavior in childhood, lack of parental supervision, poor social skills, the abuse of drugs or alcohol by parents or older siblings, the age drug experimentation first occurs, the availability of drugs at school, and community poverty.[14]

Genetic factors are estimated to account for between 40-60% of an individual's susceptibility to addiction.[15] They increase susceptibility when combined with environmental triggers. This can be seen in genome-wide association that suggests genetic variation in dopamine signaling regulation, rather than signaling itself, may be central to substance misuse risk. The same genome pattern for addiction was associated with higher risk of mental and physical illnesses such as suicidal behavior and chronic pain. For children ages 9 or 10 that had not used substances, it was correlated with externalizing behaviors and parental substance abuse.

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[12] National Institute on Drug Abuse (NIDA), "Understanding Drug Use and Addiction," *National Institute on Drug Abuse*, accessed November 11, 2024, https://nida.nih.gov/publications/drugfacts/understanding-drug-use-addiction.
[13] National Institute on Drug Abuse (NIDA), Substance Use in the United States: The NIDA Annual Report 2014 (2014), https://nida.nih.gov/sites/default/files/soa_2014.pdf.
[14] Ibid.
[15] Ibid.

Thus, a crucial finding is that there are shared genetic mechanisms between substance use and mental instability, so treatment should focus on solving both issues concurrently.[16]

Background on the Various Types of Drugs

The most used drug globally and in the United States is cannabis. In 2021, an estimated 4.3% of the global adult population used it, which is around 219 million people.[17] In the United States, about 55 million American adults currently use marijuana.[18] It is important to note that one cannot fatally overdose on marijuana.[19]

Opioids are the next most globally used drug at 60 million nonmedical users. They are followed by amphetamines at 36 million, cocaine at 22 million, and "ecstasy"-type substances at 20 million.[20] This trend continues in the United States, as in 2022, 81.8% of American overdose deaths included at least one opioid, and 57.1% involved at least one stimulant like cocaine or amphetamines.[21]

Opioids, primarily painkillers and euphoria inducing, come in legal and illegal forms.[22] They have the highest contribution to severe drug related harm, as close to 80% of the worldwide 600,000 deaths in 2019 were related to their use. They are also involved in largest percentage of

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[16] National Institute on Drug Abuse (NIDA), "New NIH Study Reveals Shared Genetic Markers Underlying Substance Use Disorders," National Institute on Drug Abuse, March 2023, https://nida.nih.gov/news-events/news-releases/2023/03/new-nih-study-reveals-shared-genetic-markers-underlying-substance-use-disorders.
[17] UNODC, *World Drug Report 2023*, https://www.unodc.org.
[18] Drug Abuse Statistics, "Marijuana Addiction," *Drug Abuse Statistics*, accessed November 11, 2024, https://drugabusestatistics.org/marijuana-addiction/.
[19] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Health Effects of Marijuana: An Evidence Review and Research Agenda, The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research (Washington, DC: National Academies Press, 2017), 9, Injury and Death, https://www.ncbi.nlm.nih.gov/books/NBK425742/.
[20] UNODC, *World Drug Report 2023*, https://www.unodc.org.
[21] Centers for Disease Control and Prevention (CDC), "SUDORS Dashboard: Fatal Overdose Data," Overdose Prevention, last reviewed April 26, 2023, https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html.
[22] WHO, "Opioid Overdose."

overdose deaths, as 25% of those deaths were caused by opioid overdose. They are made from compounds from the poppy plant and semisynthetic and synthetic compounds that interact with the opioid receptors in the brain.[23] Once in the body, they activate nerve cells called opioid receptors that block pain signals.[24] Thus, they are often prescribed for their pain-relieving and sedative effects.[25]

Opioid use often starts off legal, as about 75% of Americans who became addicted to street opioids in the early 2000s reported that they began taking prescription opioid drugs for legitimate pain relief.[26] Prominent examples of this are oxycodone, brand name Oxycontin, and hydrocodone, brand name Vicodin.[27]

Other opioids that can be prescribed are oxymorphone, hydromorphone, fentanyl, morphine, codeine, methadone, tramadol, and buprenorphine. Heroin is an illegal street drug that falls under the classification of opioid as well.[28]

Fentanyl is often to blame for overdoses, as it is 50-100 times more potent than morphine. It is mixed into street drugs by drug dealers because it is cheaper than other drugs and can increase the strength of their products. Those who use it are often unaware, as it is frequently disguised as other drugs like heroin.[29]

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[23] Ibid.
[24] Johns Hopkins Medicine, "Opioids," Johns Hopkins Medicine, accessed November 15, 2024, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/opioids.
[25] WHO, "Opioid Overdose."
[26] Johns Hopkins Medicine, "Opioids."
[27] National Institute on Drug Abuse (NIDA), "Opioids," *National Institute on Drug Abuse*, accessed November 15, 2024, https://nida.nih.gov/research-topics/opioids.
[28] Ibid.
[29] WHO, "Opioid Overdose."

Those who misuse opioids are said to have Opioid Use Disorder (OUD), and they are at risk for death during an overdose because opioids can inhibit the part of the brain that regulates breathing.[30]

Stimulants, such as amphetamines and cocaine, also highly contribute to drug related harm. They cause neuroadaptations in neurons to release the excitatory neurotransmitter glutamate in the reward centers of the brain. Essentially, they speed up the central nervous system.[31] This leads to increased feelings of exhilaration, energy, and mental alertness. But it also creates paranoia, panic, and psychosis.[32] Other stimulants include methylphenidates, methamphetamine, methcathinone, diet aids, and bath salts. Adderall is one of the most well-known prescribed stimulants, but there are also illegal forms of them like cocaine.[33]

Stimulants unsettle the orbitofrontal cortex and hinder decision-making, adaptability, and self-insight. Their overdoses lead to high fever, convulsions, destabilizing temperature changes, and cardiovascular collapse. They are often mixed with fentanyl without the consumer knowing, as it is a more expensive drug that sellers want to use less of.[34]

Drug policy in the United States has historically focused on opioids and stimulants, which is what this paper will explore. It is essential to understand that substance use disorder is not a choice, but a problem exacerbated by environmental and biologic factors. The following chapters will examine how addiction's scientific underpinnings and the unique characteristics of

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[30] Ibid.
[31] Centers for Disease Control and Prevention. "About Stimulant Overdose." Last reviewed February 13, 2023. https://www.cdc.gov/overdose-prevention/about/stimulant-overdose.html.
[32] National Institute on Drug Abuse. *Commonly Abused Drugs Chart.* National Institutes of Health, U.S. Department of Health and Human Services. https://nida.nih.gov/sites/default/files/cadchart.pdf.
[33] Drug Enforcement Administration. *2020 National Drug Threat Assessment: Stimulants.* Washington, D.C.: U.S. Department of Justice, 2020. https://www.dea.gov/sites/default/files/2020-06/Stimulants-2020.pdf.
[34] National Institute on Drug Abuse (NIDA), Substance Use in the United States: The NIDA Annual Report 2014 (2014), https://nida.nih.gov/sites/default/files/soa_2014.pdf.

opioids and stimulants have shaped drug policy. The history of marijuana is also offered as a contrast in policy.

Chapter 2: The Criminalization of Drugs in the United States

This chapter introduces the history of drug use and criminalization in the United States. It starts from the beginning, and dates prominent drug use back to the 19th century except for fentanyl, which was created in 1959. Then it shows how racial stereotypes dictated early drug laws which became more restrictive as the addictive effects of narcotics were revealed. Additionally, it finds that addiction research started off optimistic for a cure, but incorrect theories and government influence pointed it in a direction of legal instead of health interpretations.

It presents the War on Drugs as a systemic campaign against communities of color. In contrast, the Opioid Epidemic, which began due to intentional misleading about the addictiveness of Oxycontin by Purdue Pharma, is treated as a shift towards a public health problem because it affected white America. While illicit substance use is still a crime, the government has adopted a stance more aligned with treatment due to the epidemic.

Early History of Drugs

Drug use in the United States became prominent in the 19th century. In 1806, German pharmacist F.W.A Serturner isolated morphine from crude opium and it became a common pain medication. The commercial production of morphine began in 1827, but its widespread use in the United States did not occur until the 1870s.[35]

[35] DEA Museum. "History of Drug Use in the United States." Accessed November 13, 2024. https://museum.dea.gov/history-drug-use-america.

Opium use also surged during this time. In 1840, American customs created a duty fee for it because New Englanders brought 24,000 pounds of it into the country. By the time of the Civil War, doctors on both sides prescribed opium and morphine to treat casualties. However, it led to addiction for the veterans.[36]

In 1860, German chemist Albert Niemann isolated cocaine, which quickly gained popularity. From 1890 to 1902 the supply of cocaine increased 700% due to improved processing. One company even sold it in 15 varieties, which included wine, cigarettes, injectable solutions, and soft drinks.[37]

In 1874, heroin was synthesized from morphine by C. R. Wright. By 1898, Bayer Pharmaceutical Company was producing it commercially as a pain reliever and cough suppressant.[38]

Fentanyl was a much later invention, as Belgian scientist Paul Janssen first synthesized it in 1959. He was looking for a stronger pain medication with fewer side effects. Deemed a "designer drug," it is derived from synthetics instead of plant products which makes it easier to mass produce, create variations in potency, and disguise supply chains.[39]

Early History of Drug Laws and Addiction Research

In 1875, the first anti-drug law passed in San Francisco to ban opium dens. By 1890, Congress criminalized the manufacturing or importing of smoking opium by non-citizens. This occurred because tabloids owned by William Randolph Hearst ran a public information

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[36] Ibid.
[37] Ibid.
[38] Ibid.
[39] Paul J. Jannetto, Anders Helander, Uttam Garg, Gregory C. Janis, Bruce Goldberger, and Hemamalini Ketha, "The Fentanyl Epidemic and Evolution of Fentanyl Analogs in the United States and the European Union," *Clinical Chemistry* 65, no. 2 (2019): 242-253.

campaign that painted opium dens as centers for white women to be drugged and placed in sexual slavery by Chinese men.[40] This evoked anti-immigrant sentiment and fears of the 'Yellow Peril.'[41] Thus, the opium use that had gone virtually unnoticed became a way to perpetuate xenophobia.[42] This is an early example of the manipulation of drug use as a political tool, as the 'Yellow Peril' blended, "western anxieties about sex, racist fears of the alien other, and the Spenglerian belief that the West will become outnumbered and enslaved by the East."[43] Drug association was a way to criminalize marginalized communities while white use was overlooked.

At the same time, addiction research began to scratch the surface of disease. For example, in 1875, Edward Levinstein identified key elements of addiction, like withdrawal and drug prioritization. However, by the end of the century, the research attempted to incorporate antitoxins as a cure due to their success for diphtheria and tetanus. Thus, the concept of "autointoxication," or the bodily creation of antibodies or toxins to morphine, developed. While clinically incorrect, this was a time of high optimism for addiction treatment research. Estimates for a cure were as high as 75-99%.[44]

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[40] Ibid.
[41] "A History of the Heroin Epidemic," *PBS Frontline*, accessed November 13, 2024, https://www.pbs.org/wgbh/pages/frontline/shows/heroin/etc/history.html.
[42] K. B. Nunn, "Race, Crime and the Pool of Surplus Criminality: Or Why the War on Drugs Was War on Blacks," *Journal of Gender, Race and Justice* 6, no. 2 (2002): 381-446.
[43] Leung Wing-Fai, "Perceptions of the East: Yellow Peril – An Archive of Anti-Asian Fear," The Irish Times, September 29, 2014, https://www.irishtimes.com/culture/books/perceptions-of-the-east-yellow-peril-an-archive-of-anti-asian-fear-1.1895696.
[44] Institute of Medicine (US) Committee on Opportunities in Drug Abuse Research, *Pathways of Addiction: Opportunities in Drug Abuse Research* (Washington, DC: National Academies Press, 1996), chap. B, "Drug Abuse Research in Historical Perspective," https://www.ncbi.nlm.nih.gov/books/NBK232965/.

In 1909, Congress passed the first federal ban on any drug through the Smoking Opium Exclusion Act. It prohibited opium imports unless they were for medical purposes. Given that smoking opium was not used in a medical capacity, it almost completely banned the drug.[45]

In 1914, Congress passed the Harrison Act which required manufacturers, sellers, and distributors of narcotics to register with the Bureau of Internal Revenue. It also required doctors to register to prescribe narcotics and give them out "in good faith."[46]

At this point, the federal government ruled that providing nonmedical narcotics to avoid withdrawal was illegitimate, which the Supreme Court corroborated in 1919. This stirred debate, as it seemed to interfere with medical decision making and went against the proposition of some scientists that the lasting physical changes associated with opiates indicated that addiction was a medical problem. However, since this belief was not held by government policy, the field of addiction research became controversial.[47]

This tide of drug use rejection continued in 1920, when the American Medical Association recommended ending all medical use of heroin, and all branches of the US military followed this advice. By 1924, the Anti-Heroin Act criminalized the import of opium to be used for production into heroin.[48] This fear of drug abuse curtailed practices like maintenance treatments and emphasized a shift toward viewing addiction through a legal rather than a purely medical lens.[49]

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[45] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[46] Ibid.
[47] Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research*, B, *Drug Abuse Research in Historical Perspective* (Washington, DC: National Academies Press, 1996)
[48] Ibid.
[49] Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research*, B, *Drug Abuse Research in Historical Perspective* (Washington, DC: National Academies Press, 1996)

This criminalization continued with cocaine, as the Jones-Miller Act of 1922 banned the importation of cocaine or coca leaves outside of medical use. It also set up the Federal Narcotics Control Board to create narcotic import quotas.[50]

By 1930, heroin became the most popular drug to abuse, and smoking opium virtually disappeared. This was an evolution of the overprescription of morphine. In a dramatic shift, new heroin users found the drug on the street instead of from doctors like previous generations. Thus, the demographics of opiate addicts turned from female users who had become medically addicted to poor, young males who bought it illegally.[51]

Around the same time, the National Research Council created the Committee on Drug Addiction and chose to look for morphine substitutes that were not habit forming. This led to the establishment of a few special prisons for people who were addicted to drugs. They were called "narcotic farms," and were an early attempt to treat addiction as a health problem instead of a criminal issue. They provided major pharmacological research regarding opiate dependence as a physical or physiological problem and methadone as a possible way to limit withdrawal.[52] However, 90% of the people incarcerated went back to drug use.[53] Thus, they were shut down and turned into regular prisons.[54]

Between World War I and 1960, pessimism prevailed in the field of addiction research as a cure seemed out of reach. For example, Alexander Lambert, a leading advocate for addiction treatment, abandoned his idea of a "cure" in 1920 after working in the field for 11 years. The

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[50] Ibid.
[51] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[52] Institute of Medicine, Pathways of Addiction: Opportunities in Drug Abuse Research, B, Drug Abuse Research in Historical Perspective (Washington, DC: National Academies Press, 1996)
[53] Carrie Johnson, "America's First Drug Treatment Prison Revisited," *NPR*, November 1, 2008, https://www.npr.org/2008/11/01/96437766/americas-first-drug-treatment-prison-revisited.
[54] Ibid.

government reflected this trend and emphasized narcotics control through law enforcement instead of prevention and treatment.[55]

In 1937, Congress passed the Marijuana Tax Act which imposed a heavy tax and required the same registrations with the Bureau of Internal Revenue like the Harrison Act. While presenting in front of Congress, Harry Anslinger, Federal Bureau of Narcotics Commissioner, called marijuana "dangerous" and linked the drug to numerous "violent murders.'[56] The Department claimed it made smokers, especially Mexicans, "violent, lazy, and crime ridden."[57] One observer at the time noted that, "Public concern about marijuana grew because Americans wanted to drive the Mexicans back over the border, for reasons that had nothing to do with the nature of the drug or its physiological effects."[58] Thus, it is impossible to separate the criminalization of drugs in the US from racial bias.

The beginning of World War II closed the traditional smuggling routes of both Allied and Axis powers. This dropped heroin use in the United States to an all-time low. In 1948, authorities quarantined drug markets into poor segregated communities of color. This made the drug easily accessible to young, Black individuals in urban areas. In contrast, white users often had to go out of their way to hear about or use heroin.[59]

It is also important to note the negative stereotypes perpetuated between African Americans and cocaine that started in the 1890s. Stories of the "coke-crazed Black man"

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[55] Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research*, B, *Drug Abuse Research in Historical Perspective* (Washington, DC: National Academies Press, 1996)
[56] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[57] K. B. Nunn, "Race, Crime and the Pool of Surplus Criminality," *Journal of Gender, Race and Justice* 6, no. 2 (2002): 381-446.
[58] Ibid.
[59] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.

perpetuated the media, and some Southern sheriffs even claimed that caused them to switch from a .32 to a .38 caliber pistol. The racial justification for this characterization was to protect "innocent white women," which continued the trend of making addiction a crime and then associating it with a marginalized group. White people bought in to these stereotypes, as common beliefs were that cocaine made Black people more likely to commit crime and harder to catch.[60]

Mandatory minimums were introduced for all drug-related offenses through the 1951 Boggs Act. For the first offense, one received imprisonment for up to five years and a $2,000 fine. These penalties were increased through the Narcotic Control Act of 1956, so the punishment for simple possession offense increased to 20 years in prison and a $20,000 fine. Additionally, someone who dealt heroin to a minor could be punished to death. This set an example of harsh laws that many states went beyond, including making addiction itself a crime. This led to some convictions of people without drugs or paraphernalia present.[61]

The trends of heroin use changed in 1965 as more white youths moved into the urban communities of color. The drug began to spread from the cities into the suburbs. This was during a moment of drug experimentation in the country, as many youths had experience with LSD and marijuana as well. Heroin operated as fentanyl does now, acting as a cutting agent for more expensive drugs like cocaine.[62]

The rising use of marijuana clashed with the punitive policies of the time. In 1970, the White House created the National Commission on Marijuana and Drug Abuse to investigate if

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[60] K. B. Nunn, "Race, Crime and the Pool of Surplus Criminality," *Journal of Gender, Race and Justice* 6, no. 2 (2002): 381-446.
[61] Drug Enforcement Administration Museum, History of Drug Use in the United States, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[62] Ibid.

marijuana should remain a Schedule I drug. Its report, given in 1972, advocated for the decriminalization of marijuana because the current laws were "too harsh." It also noted that alcohol was more dangerous than marijuana.[63] However, President Nixon disagreed with the findings, and it stayed as a Schedule I drug.[64]

The War on Drugs

The War on Drugs began in the 1970s to deal with growing problems of addiction. In 1971, President Nixon declared drug abuse "public enemy number one."[65] His initial policies focused on prevention and treatment more than criminalization. In fact, treatment, education, and prevention received more funding than law enforcement and interdiction during his administration. This included medication-assisted treatments such as methadone clinics, public dissuasion campaigns, and academic research. He even told Congress in 1971 that, "Enforcement must be coupled with a rational approach to the reclamation of the drug user himself."[66] His action was influenced by a personal disgust of drugs, as well as the growing heroin addiction of soldiers in Vietnam.[67] It is estimated that 42% of those young men had used opioids at least once, and half of them had become physically dependent on them at some point.[68]

However, over time, Nixon shifted to the penal interpretation of addiction. He increased federal funding for drug-control agencies and created the Drug Enforcement Administration

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[63] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[64] Institute of Medicine, *Pathways of Addiction: Opportunities in Drug Abuse Research*, B, *Drug Abuse Research in Historical Perspective* (Washington, DC: National Academies Press, 1996)
[65] Encyclopaedia Britannica, "War on Drugs," by The Editors of Encyclopaedia Britannica, 2024, https://www.britannica.com/topic/war-on-drugs.
[66] German Lopez, "Nixon's 'War on Drugs,' Explained," *Vox*, March 29, 2016, https://www.vox.com/2016/3/29/11325750/nixon-war-on-drugs.
[67] Ibid.
[68] U.S. Department of Defense, Military Drug Program Historical Timeline, July 22, 2008, https://prhome.defense.gov/Portals/52/Documents/RFM/Readiness/DDRP/docs/72208/DoD%20Drug%20Policy%20History.pdf

(DEA) by combining the Office for Drug Abuse Law Enforcement, the Bureau of Narcotics and Dangerous Drugs, and the Office of Narcotics Intelligence. This consolidated federal efforts to curb drug abuse.[69] He proposed harsh mandatory minimums for drugs, which never materialized due to the Watergate Scandal.[70]

However, Nixon's concern had political motives as well. In 1994, John Ehrlichman, one of Nixon's top aides, contextualized the War on Drugs as:

> You want to know what this was really all about. The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying. We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[71]

Through criminalizing addiction, the Nixon Administration systemized the racial biases in the country under the guise of a health threat. It was a larger, centrally sourced, country-wide iteration of the criminalization that had been seen in the rhetoric surrounding opium dens and the stereotypes of innocent white women. What a country designates as a crime, designates who they deem a criminal. Once someone is deemed a criminal, they lose their political power and entrenched institutional structures remain in place. American addiction history must be understood with regard to the intentions of those who made and enforced the laws.

President Ronald Reagan first coined the phrase 'War on Drugs,' which is the systemic criminalization of illicit drug use, distribution, and trade by the United States. He significantly expanded its reach, and incarcerations for nonviolent drug offenses increased from 50,000 in

[69] Encyclopaedia Britannica, "War on Drugs."
[70] Lopez, "Nixon's 'War on Drugs,' Explained."
[71] Lopez, "Nixon's 'War on Drugs,' Explained."

1980 to 400,000 in 1997 due to it.[72] This facilitated the trend of racialized mass incarceration that continues today, as 1 out of every 3 Black men in the United States have felony convictions.[73]

The crack cocaine epidemic of the 1980s accelerated the War on Drugs. This was partially due to the skyrocketing price of heroin after Turkey ended opium poppy production, which decreased the supply. This action was supported by the government of the United States and significantly decreased the purity of the dug.[74] Increased and sensationalized media coverage of the health crisis called for punishment over rehabilitation. It depicted inner city Black and Latinx heroin users as 'junkies' and 'pushers' in the 1960s and 1970s and crack cocaine addicted 'super predators' and 'crack whores' in the 1980s and 1990s.[75]

Additionally, the death of Boston Celtics draft pick Len Bias due to cocaine use placed the issue front and center in American hearts and television sets[76]. Even though the use of recreational drugs decreased in 1982, both Republicans and Democrats took "hard on crime" stances against addiction in 1982.[77] By 1986, Congress passed the Anti-Drug Abuse Act and allocated $1.7 billion to create "mandatory minimum" prison sentences and enforce the "War on Drugs."[78]

Mandatory minimums are a set amount of time one must spend incarcerated due to the nature of their crime. While some praise the measures as a deterrent, they also create unfavorable

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[72] Encyclopaedia Britannica, "War on Drugs."
[73] Shannon, Sarah K.S., Christopher Uggen, Jason Schnittker, Melissa Thompson, Sara Wakefield, and Michael Massoglia. "The Growth, Scope, and Spatial Distribution of People with Felony Records in the United States, 1948–2010." *Demography* 54, no. 5 (2017): 1795–1818. https://doi.org/10.1007/s13524-017-0611-1.
[74] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[75] C. M. Parker and H. Hansen, "How Opioids Became 'Safe': Pharmaceutical Splitting and the Racial Politics of Opioid Safety," *BioSocieties* 17, no. 4 (2022): 583, https://doi.org/10.1057/s41292-021-00230-y.
[76] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[77] K. B. Nunn, "Race, Crime and the Pool of Surplus Criminality," *Journal of Gender, Race and Justice* 6, no. 2 (2002): 381-446.
[78] Ibid.

outcomes for first time offenders and those who could be swayed away from a life of crime if given the chance. When given for drugs, they reflect the racial legacy of the criminalization.

Crack cocaine and powder cocaine are the same substance, but powder cocaine is ingested, snorted or put on the gums while crack cocaine is smoked after being processed into a crystal. [79] Yet, during the War on Drugs, the possession of five grams of crack cocaine received the same five year sentence as 500 grams of powder cocaine.[80] The social difference between the drug types displays the policy's racial overtones- around 80% of crack users were African American.[81] This led to an unequal increase of incarceration rates for nonviolent Black drug offenders built on stereotypes dating back to the 1890s.

As a contrast, the movement to decriminalize and normalize marijuana gained traction. It was led by white advocates, often in response to their children's use. It was successful in changing the harsh Rockefeller Drugs Laws to decriminalize low-level possession due to the "racial dynamics and the portrayal of white youth as sympathetic victims of the organized narcotics trade."[82] There was also a public movement regarding the arrest of activist John Sinclair, who was arrested and sentenced to ten years in prison for giving undercover cops a couple of joints. Advocates railed against it as a disproportionate punishment, and in 1971, the "John Sinclair Freedom Rally" hosted celebrities like John Lennon and Stevie Wonder in Ann

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[79] M. Hodgman-Korth, "Crack vs Cocaine: What's the Difference between Crack & Cocaine?" *American Addiction Centers*, 2023, https://americanaddictioncenters.org/cocaine-treatment/differences-with-crack.; U.S. Department of Health and Human Services, "Cocaine DrugFacts," *National Institutes of Health*, 2022, https://nida.nih.gov/publications/drugfacts/cocaine.

[80] Encyclopaedia Britannica, "War on Drugs."

[81] K. B. Nunn, "Race, Crime and the Pool of Surplus Criminality," *Journal of Gender, Race and Justice* 6, no. 2 (2002): 381-446.

[82] J. Netherland and H. Hansen, "White Opioids: Pharmaceutical Race and the War on Drugs That Wasn't," *BioSocieties* 12, no. 2 (2017): 219, https://doi.org/10.1057/biosoc.2015.46.

Arbor, Michigan. He was released from shortly after. In 1973, Oregon decriminalized marijuana possession of up to 1 ounce. By 1980, eleven other states had done the same.[83]

At the same time, parent campaigns of all races began to promote abstinence and active resistance to drug use. In 1976, Marsha "Keith" Schuchard began organizing white parents to fight their children's drug exposure and use in their Atlanta suburb. African American activist Joan Brann founded the first club for families that were not white or middle class with Oakland Parents in Action. Nancy Reagan picked up the slogan, "Just Say No" from her office, and a grassroots effort to criminalize drugs was combined with the national one. This reflects the widespread support for criminalization as a response to addiction instead of rehabilitation during the period.[84]

The Opioid Epidemic

The first wave of the opioid epidemic began in the 1990s. Like morphine in the 19th century, prescription opioids were overprescribed and overmarketed. Between 1991 and 2011, opioid prescriptions for oxycodone based products increased from 76 million to 211 million.[85] The biggest culprit was Oxycontin, which Purdue Pharma lobbied as less addictive and longer lasting than other opioids.[86] They argued that there was an endemic of untreated pain, and their drug could fill that void. It was later revealed that Purdue Pharma knew their claims were false regarding its efficacy.[87] The drug had more oxycodone than other prescription drugs and was easy to crush into a powder to snort, smoke, or liquify for injections. This made all the active

[83] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[84] Ibid.
[85] Evans, William N., Ethan M. J. Lieber, and Patrick Power. "How the Reformulation of OxyContin Ignited the Heroin Epidemic." *The Review of Economics and Statistics* 101, no. 1 (2019): 1-15.
[86] H. Wiland, *Do No Harm: The Opioid Epidemic* (Turner Publishing Company, 2020).
[87] H. Wiland, *Do No Harm: The Opioid Epidemic* (Turner Publishing Company, 2020).

ingredients easier to access and created a bigger high for drug users.[88] Given its Food and Drug Administration approval and packaging as a pill, many viewed Oxycontin as safe and became addicted for the first time. It spread legally and illegally, which led to a surge in overdoses.[89]

The distinct characteristic of this addiction crisis is that it targeted white suburbia. In fact, branded advertisements were created to show white grandparents and injured veterans as the legitimate consumers of the drug. Purdue even presented prescribers with photos of elderly white Medicare patients as their target demographic.[90] When discussed in the media and academia, those struggling with opioid addiction were now painted as having a "chronic, treatable brain disease" affected by "genetics, trauma, and exposure in the neurobiology of the illness" through decades of scientific research.[91] While this is true, communities of color did not receive the same empathy and science during the War on Drugs.

The second wave of the opioid epidemic began in 2010 when Purdue Pharma reformulated OxyContin to incorporate abuse deterrent features. Customers switched to heroin as a less expensive alternative, and the wave became characterized by overdoses with heroin. The reformulation was ultimately a failure, as each prevented death from oxycodone was replaced by an overdose death with heroin. According to the DEA, the typical heroin user in the 1980s was an urban resident. However, since the 1990s and 2000s, its ‘‘spread to users in suburban and rural areas, more affluent users, younger users, and users of a wider range of ages. There is no

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[88] Evans, William N., Ethan M. J. Lieber, and Patrick Power. "How the Reformulation of OxyContin Ignited the Heroin Epidemic." *The Review of Economics and Statistics* 101, no. 1 (2019): 1-15.
[89] Drug Enforcement Administration Museum, *History of Drug Use in the United States*, accessed November 12, 2024, https://museum.dea.gov/history-drug-use-america.
[90] Claire M. Parker and Helena Hansen, "How Opioids Became 'Safe': Pharmaceutical Splitting and the Racial Politics of Opioid Safety," *BioSocieties* 17, no. 4 (2022): 577–600, https://doi.org/10.1057/s41292-021-00230-y.
[91] A. Sharman, "Opioid Epidemic: How Language Stigmatizes Addiction" (PhD diss., 2019), 2385345109, ProQuest Dissertations & Theses Global.

longer a typical heroin user.''[92] This was exacerbated by the fact that heroin could be consumed by smoking or inhalation due to increased purity, whereas bin the 1970s it was predominately through injections.[93] The trend of a public health designation continued, as President Obama called it a "national healthy emergency" and a "public health problem" instead of using a militaristic metaphor like a "war."[94]

The third wave of the epidemic began in 2013 with overdose deaths involving synthetic opioids, specifically fentanyl.[95] The DEA's National Forensic Laboratory information system reported an increase over 3000% in fentanyl encounters from 2014 to 2015.[96] Fentanyl is 50 times more potent than heroin, and thus easier to overdose on.[97]

Opioid overdoses disproportionately affect whites, men, and middle-aged individuals in Mountain, Rust Belt, and New England and Southern states. However, it is spreading to everyone as opioid overdose death rates shifted to be higher in urban areas compared to rural ones in 2017.[98]

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[92] William N. Evans, Ethan M. J. Lieber, and Patrick Power, "How the Reformulation of OxyContin Ignited the Heroin Epidemic," *Review of Economics and Statistics* 101, no. 1 (2019): 3.
[93] Ibid.
[94] Minhee, C., and S. Calandrillo. "The Cure for America's Opioid Crisis: End the War on Drugs." *Harvard Journal of Law & Public Policy* 42, no. 2 (2019): 547-624.
[95] Centers for Disease Control and Prevention. "Opioid Data Analysis and Resources." *Opioids*. Last modified 2023. https://www.cdc.gov/opioids/data/analysis-resources.html.
[96] Jannetto, Paul J., Anders Helander, Uttam Garg, Gregory C. Janis, Bruce Goldberger, and Hemamalini Ketha. "The Fentanyl Epidemic and Evolution of Fentanyl Analogs in the United States and the European Union." *Clinical Chemistry (Baltimore, Md.)* 65, no. 2 (2019): 242-253.
[97] Drug Enforcement Administration. "Fentanyl." *DEA.gov*. Last modified August 16, 2023. https://www.dea.gov/factsheets/fentanyl.
[98] Altekruse, Sean F., Candace M. Cosgrove, William C. Altekruse, Richard A. Jenkins, and Carlos Blanco. "Socioeconomic Risk Factors for Fatal Opioid Overdoses in the United States: Findings from the Mortality Disparities in American Communities Study (MDAC)." PLOS ONE 15, no. 1 (January 17, 2020). https://doi.org/10.1371/journal.pone.0227966.

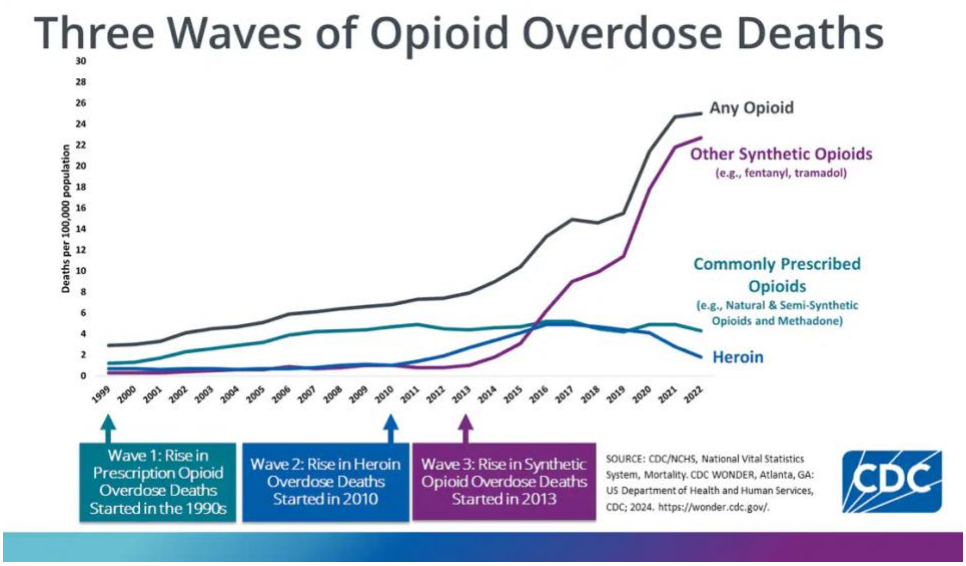

Figure 1. The Three Waves of Opioid Overdose Deaths. Centers for Disease Control and Prevention. "Understanding the Opioid Overdose Epidemic." Last reviewed August 9, 2023. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.

Current Policies

Addiction is still treated as a crime in the United States. The Controlled Substances Act of 1970 continues to dictate current federal law surrounding the prosecution of addiction. All substances regulated under existing federal law are grouped into five schedules based on their acceptable medical use, the drug's abuse, and its dependency potential. The drugs with the highest potential for abuse and severe psychological and/or physical dependence are in Schedule I. The abuse potential decreases as the schedule numbers increase, so Schedule V has the least potential for abuse.[99]

Schedule I drugs do not have a currently accepted medical use and a high potential for abuse. Some examples include heroin, lysergic acid diethylamide (LSD), marijuana, methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote.[100]

Schedule II drugs have a high potential for abuse and a high potential for dependency. They can be used medically but are considered dangerous. Some examples are combination products with less than

[99] Drug Enforcement Administration. "Drug Scheduling." Accessed November 14, 2024. https://www.dea.gov/drug-information/drug-scheduling.
[100] Ibid.

15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin.[101]

Schedule III drugs have a moderate to low potential for dependence and are used medically. They include products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, and testosterone.[102]

Schedule IV drugs have a low potential for abuse and low risk of dependence. Some examples are Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol.[103]

Schedule V drugs have an even lower potential for abuse than Schedule IV and have preparations with limited quantities of certain narcotics. Some examples are cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, and Parepectolin[104].

If federally convicted of possessing any controlled substance, a first time offender faces penalties of up to a year in prison, a $1000 fine, or both. If they are convicted a second time this becomes a minimum of 15 days and a maximum of two years in prison and a minimum fine of $2500. After that, the minimum time served is 90 days and the maximum is three years. This accompanied by a minimum fine of $5000. Possession of Flunitrazepam, also known as “roofies,” have special sentencing provisions that include a prison term of up to 3 years, a fine, or both. Individuals convicted of possession may also lose federal benefits, including school loans, grants, contracts, and licenses for up to a year for a first conviction and up to five for following ones. Sentences may also vary depending on the schedule of the drugs, the amount in possession, and the intent for its use.[105]

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[101] Ibid.
[102] Ibid.
[103] Ibid.
[104] Ibid.
[105] Seattle Pacific University. *Summary of Federal and State Drug Laws*. Seattle: Seattle Pacific University, May 6, 2016. https://spu.edu/-/media/university-leadership/student-life/Summary-of-Federal-and-State-Drug-Laws-as-of-5-6-16.ashx.

However, there have also been some policy changes that support a public health approach to addiction. The Fair Sentencing Act of 2010 decreased the crack-to-powder possession thresholds for mandatory minimums from 100-to-1 to 18-to-1. Other prison reforms have built on it, such as those in 2018 that further reduced the sentences for some crack cocaine–related convictions.[106] The Office of National Drug Control Policy has a $41 billion budget and is dedicated to addressing addiction and the overdose epidemic. There has been increased funding for treatment, expanded access to medications that reverse overdoses like naloxone, and a promotion of harm reduction strategies like safe needle disposal sites.[107] Every state but Kansas and Wyoming have Good Samaritan fatal overdose prevention laws, which protect someone who may have been using drugs from prosecution if they call the authorities to save someone they are with from an overdose.[108]

Marijuana continues to play a unique role in the drug conversation, as it is still criminalized federally but legal in many states. This began for medicinal purposes in 1996 by California. Mary Jane Rathbun helped champion this movement by giving pot brownies to local AIDS patients in San Francisco. The brownies increased patients' quality of life through providing much needed calories, stimulating appetites, and elevating energy and mood. When she was arrested in 1992, California galvanized behind her to legalize it through Proposition 215. As of February 2024, 47 states, the District of Columbia, and three territories have followed suit.[109] In 2012, marijuana was legalized recreationally in Colorado and Washington. As of May 2024, 22 other states had followed suit.[110]

In the United States, drug use is a crime, especially when it affects communities of color. This has dictated the treatment, or lack thereof, throughout history. As the United States tries to switch to a public

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[106] Encyclopaedia Britannica, "War on Drugs," by The Editors of Encyclopaedia Britannica, 2024, https://www.britannica.com/topic/war-on-drugs.
[107] Office of National Drug Control Policy. "The Office of National Drug Control Policy." The White House. Accessed November 14, 2024. https://www.whitehouse.gov/ondcp/.
[108] Legislative Analysis and Public Policy Association. *Good Samaritan Fatal Overdose Prevention: Summary of State Laws*. Published May 2024. https://legislativeanalysis.org/wp-content/uploads/2024/05/Good-Samaritan-Fatal-Overdose-Prevention-Summary-of-State-Laws.pdf.
[109] Centers for Disease Control and Prevention. "State Medical Cannabis Laws." Last modified May 16, 2023. https://www.cdc.gov/cannabis/about/state-medical-cannabis-laws.html.
[110] Ibid.

health framing of the problem, it is still struggling with assertions of criminality that facilitate the carceral system.

Chapter 3: The Decriminalization of Drugs in Portugal

Portugal was relatively isolated until 1974 due to authoritarian rule. Thus, the emergence of drug addiction was unforeseen and surged in a condensed time frame. This was exacerbated by the country's geographic location as a gateway to Europe. The Portuguese government decided to study the problem and created a public health model to solve it.

While the policies trended towards public health in the 1980s, the government's crowning achievement is the decriminalization of all illicit drugs that began in 2000. It has a comprehensive support system behind it, as those who are caught with an amount of drugs for personal use face a Commission for the Dissuasion of Drug Addiction for a free public health screening or pay a small fine. At the same time, the government passed a law to establish harm reduction measures. The entire Portuguese policy is focused on centering the dignity of the individual and humanistic principles.

Early History and Drug Laws

Before 1974, Portugal was led by the dictatorial regime called Estado Novo (New State). This was established in 1933 by António de Oliveira Salazar as an evolution of from the Ditadura Nacional (National Dictatorship) set up in 1926. During this time period, there was strict censorship, limited political freedoms, a commitment to traditional Catholic values, little economic

modernization, and isolation from much of Europe.[111] By 1974, the Portuguese people and the military were sick of the costly and violent Portuguese Colonial War in Mozambique, Angola, and Portuguese Guinea, so they staged a 'bloodless' coup and gained power within a day.[112] Nicknamed the Carnation Revolution, it led to a period of political instability for about two years called the Processo Revolucionario Em Curso (Ongoing Revolutionary Process). Interestingly, the process mirrored a nonviolent version of the French Revolution, as it started off in a moderate-conservative phase, was followed by a middle radical-leftist phase, and ended up with a final moderate reaction.[113]

Before 1970, drug consumption in Portugal was restricted to the social and economic elite. Drug laws were passed in 1924 and 1927, but they intended to regulate drug trading to prevent tax fraud.[114] This was especially important regarding Portugal's geographic location- it a gateway for trafficking drugs into Europe. Cocaine comes from Brazil and Mexico, heroin comes from Spain, hashish comes from Morocco, and herbal cannabis comes from southern Africa.[115] This trend continues into the 21st century, as the United Nations Office on Drugs and Crime found Portugal responsible for 35% of all European cocaine seizures in 2006, second only to Spain.[116]

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[111] Gulbenkian Museum Library. "Books Censored and Banned by the Estado Novo." *Gulbenkian Museum*, accessed November 14, 2024. https://gulbenkian.pt/biblioteca-arte/en/read-watch-listen/books-censored-and-banned-by-the-estado-novo/; Gallagher, Tom. "Controlled Repression in Salazar's Portugal." *Journal of Contemporary History* 14, no. 3 (1979): 385–402. http://www.jstor.org/stable/260013.

[112] "Portuguese Colonial War," *New World Encyclopedia*, accessed November 14, 2024, https://www.newworldencyclopedia.org/entry/Portuguese_Colonial_War

[113] C. Delano Smith, José Shercliff, Ilídio Melo Peres do Amaral, Douglas Lanphier Wheeler, Walter C. Opello, Marion Kaplan, and Harold V. Livermore, "Portugal," *Encyclopedia Britannica*, November 14, 2024. https://www.britannica.com/place/Portugal.

[114] Gonçalves, Ricardo, Ana Lourenço, and Sofia Nogueira da Silva. "A Social Cost Perspective in the Wake of the Portuguese Strategy for the Fight Against Drugs." *International Journal of Drug Policy* 26, no. 2 (2015): 199–209. https://doi.org/10.1016/j.drugpo.2014.08.017

[115] Hughes, Caitlin Elizabeth, and Alex Stevens. "What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?" *The British Journal of Criminology* 50, no. 6 (November 2010): 999–1022. https://doi.org/10.1093/bjc/azq038

[116] Ibid.

In 1970, the Estado Novo instituted Decree-Law no. 420/70 which made illicit drug use a crime for the first time in Portugal. This was influenced by international pressure, including the United Nation's Single Convention on Narcotic Drugs (1961). This convention coordinated the international fight against drug proliferation. By many this was seen as an overreaction, as Portugal had minimal illicit drug consumption at this time.[117] Those who struggled with addiction did not seek help for it due to a fear of police persecution [118]

When soldiers returned from ex-colonies after the 1974 revolution, they brought back with them a variety of drugs. The newly open borders allowed other sources to bring drugs into the country as well. For example, heroin was smuggled from India and Pakistan through Mozambique to Portugal beginning in the late 1970s.[119] Drug use became more prominent and visible, so the government studied the problem. They started the shift to a public health approach instead of a carceral one by passing a 1983 decree that allowed punishment for some drug-related offenses to be suspended if the offender agreed to enter a treatment program. Even 1993 legislation that increased penalties for drug trafficking and diversion made penalties for personal consumption more lenient.[120]

Yet, by the 1990s, the newly liberated country was entrapped by heroin. Out of a population of 10 million, an estimated 50,000-100,000 struggled with addiction.[121] It affected all classes in

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[117] Gonçalves, Lourenço, and da Silva, "A Social Cost Perspective," 199–209.
[118] Hawkes, Nigel. "Highs and Lows of Drug Decriminalisation." *BMJ* 343 (2011): d6881. https://doi.org/10.1136/bmj.d6881.
[119] Bajekal, Naina. "Want to Win the War on Drugs? Portugal Might Have the Answer." *Time*, August 1, 2018. https://time.com/longform/portugal-drug-use-decriminalization/.
[120] Russoniello, Kellen. "The Devil (and Drugs) in the Details: Portugal's Focus on Public Health as a Model for Decriminalization of Drugs in Mexico." *Yale Journal of Health Policy, Law, and Ethics* 12, no. 2 (Summer 2012): 371–432.
[121] Van Het Loo, Mirjam, Ineke Van Beusekom, and James P. Kahan. "Decriminalization of Drug Use in Portugal: The Development of a Policy." *The ANNALS of the American Academy of Political and Social Science* 582, no. 1 (2002): 49–63. https://doi.org/10.1177/0002716202582001005.

the small country, from lawyers to construction workers. By 1999, Portugal had the second highest prevalence of HIV among injecting drug users and highest rate of drug-related AIDS in the European Union.[122] The number of people arrested for drug offenses increased from 4,667 in 1991 to 11,395 in 1998. By that time, 61% of the arrests were for drug use or drug possession for use and 45% were heroin related.[123] In 2000, it had the second highest problematic heroin use in the European Union.[124]

Decriminalization of All Drugs

In 1998, The Commission for a National Drug Strategy produced an extensive analysis of potential solutions to drug use in Portugal. They proposed a policy based on harm reduction, prevention, and reintegration of the person who uses into society. Harm reduction prioritizes limiting the negative consequences of drug use.[125]

As one commentator shared, "decriminalization was driven not by the perception that drug abuse was an insignificant problem, but rather by the consensus view that it was a highly significant problem, that criminalization was exacerbating the problem, and that only decriminalization could enable an effective government response."[126]

The Commission's recommendation was adopted by the newly elected Portuguese Parliament and Council of Ministers in 1999, with the approval of the President. It was guided by the view that people who use drugs should be regarded as full members of society instead of being

[122] Hughes, Caitlin Elizabeth, and Alex Stevens. "What Can We Learn From The Portuguese Decriminalization of Illicit Drugs?" *The British Journal of Criminology* 50, no. 6 (November 2010): 999. https://doi.org/10.1093/bjc/azq038.
[123] Russoniello, "The Devil (and Drugs) in the Details," 371–432.
[124] Rêgo, X., M. J. Oliveira, C. Lameira, et al. "20 Years of Portuguese Drug Policy - Developments, Challenges and the Quest for Human Rights." *Substance Abuse Treatment, Prevention, and Policy* 16 (2021): 59. https://doi.org/10.1186/s13011-021-00394-7.
[125] Russoniello, "The Devil (and Drugs) in the Details," 371–432.
[126] Russoniello, "The Devil (and Drugs) in the Details," 384.

cast out. Its goal was not zero drug use, but betterment for all society.[127] It was guided by eight structuring principles:

1. the principle of international cooperation,
2. the principle of prevention,
3. the humanistic principle,
4. the principle of pragmatism,
5. the principle of security,
6. the principle of coordination and rationalization of resources,
7. the principle of subsidiarity, and
8. the principle of participation.[128]

It is interesting to note the health-centered nature of these principles. While advocating for "pragmatism" and "rationalization of resources," there is also a push for "the humanistic principle." This indicates that the new Portuguese direction was not just a policy shift, but a mindset shift. These principles were then translated into thirteen 'strategic' options:

1. to reinforce international cooperation and to promote active participation of Portugal in the definition and evaluation of the strategies and policies of the international community and the EU;
2. to decriminalize the use of drugs, prohibiting them as a breach of administrative regulations;
3. to redirect the focus to primary prevention;
4. to extend and improve the quality and response capacity of the health care network for drug addicts,so as to ensure access to treatment for all drug addicts who seek treatment;
5. to extend harm reduction policies, namely, through syringe and needle exchange programs and the low-threshold administration of substitution drugs as well as the establishment of special information and motivation centers;
6. to promote and encourage the implementation of initiatives to support social and professional reintegration of drug addicts;
7. to guarantee conditions for access to treatment for imprisoned drug addicts and to extend harm reduction policies to prison establishment ;
8. to guarantee the necessary mechanisms to allow the enforcement by competent bodies of mea-
sures such as voluntary treatment of drug addicts as an alternative to prison sentences;
9. to increase scientific research and the training of human resources
in the field of drugs and drug addiction;
10. to establish methodologies and procedures for evaluation of public and private initiatives in the field of drugs and drug addiction;

[127] Ibid.
[128] Van Het Loo, Van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," 55.

> 11. to adopt a simplified model of interdepartmental political coordination for the development of the national drug strategy;
> 12. to reinforce the combat against drug trafficking and money laundering and to improve the articulation between the different national and international authorities;
> And
> 13. to double public investment to 160 million euros (at the rhythm of 10 percent a year) during the next five years, so as to finance the implementation of the national drug strategy.[129]

The strategic options guided Decree Law 30/2000, which is most well-known for decriminalizing the use and possession of drugs. It made their prosecution an administrative offense. This was as long as the amount possessed or consumed was the quantity needed for an average ten day supply. The government calculated this as one gram for heroin, ecstasy, and amphetamines, two grams for cocaine, and twenty five grams for marijuana. The law does not distinguish drugs between categories of "hard" and "soft." It was enacted in October 2000 and took effect on July 1, 2000.[130]

To put the law into practice, there are special committees, known as Comissbes para a Dissuasdo da Toxicodependencia (CDTs), or Commissions for the Dissuasion of Drug Addiction, to impose fines and other penalties. They are composed of government-appointed civilians, including one legal expert appointed by the Ministry of Justice and two other experts in health chosen by the Ministry of Health. They can be from the fields of medicine, sociology, social services, psychology, and any other field where expertise in drug addiction exists. They listen to the person who has been accused and assess their economic status, if they are addicted, the circumstances surrounding the drug consumption, the nature of the substances consumed, and the place of use. They are designed to emphasize respect and encourage participation for the person

[129] Van Het Loo, Van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," 56.
[130]Van Het Loo, Van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," 56. Russoniello, "The Devil (and Drugs) in the Details," 387.

in front of them, so the commissioners dress informally, allow a therapist to take part in the proceedings if requested, and sit on the same level as the alleged offender. The police must refer people to a CDT within 72 hours of the offense, and they are not allowed to make arrests.[131]

If the person in front of the CDT has no prior offenses and is not addicted, the proceedings must be suspended provisionally. If they are deemed as addicted but they have not committed a prior offense, then the proceedings are provisionally suspended if the individual agrees to undergo treatment voluntarily. The CDT can also suspend proceedings if the individual is found to be addicted with prior offenses but agreed to undergo treatment. If someone is not addicted and does not repeat the offense, or they complete treatment if they are addicted, then the proceedings cannot be reopened. And, if penalties are imposed against someone who is addicted, they may be suspended if the individual agrees to undergo treatment voluntarily.[132]

Penalties can include fines that range from 25 to 150 euros, suspension of the right to practice if the individual is in a licensed profession and they could endanger another person or their possessions, a ban on visiting certain places, a ban on associating with certain individuals, a ban on traveling abroad, a requirement to report periodically to the committee, a loss of the right to carry a gun, the confiscation of personal possessions, a loss of subsidies or allowances from a public agency, a mandatory donation to a charitable organization, or community service.[133]

Portugal also implemented Decree Law 183/2001 to establish harm reduction measures alongside drug decriminalization. They include the establishment of drug substitution programs, syringe exchange programs, mobile centers for the prevention of infectious disease, and more.[134]

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[131] Ibid.
[132] Ibid.
[133] Van Het Loo, Van Beusekom, and Kahan, "Decriminalization of Drug Use in Portugal," 59; Russoniello, "The Devil (and Drugs) in the Details," 371–432.
[134] Ibid.

Reestablishment of Drug Use as a Crime

In 2008, The Supreme Court of Justice reestablished drug use as a crime if someone had an amount exceeding those established for a ten-day supply of personal use through article 40°, Decree-Law n. 15/93 by judgement n. 8/2008. This had not been defined explicitly by earlier laws, and sentences for drug use were almost non-existent. If they existed, they exclusively related to cultivation. This decision was validated by the Constitutional Court in 2014, and it is currently used as a standardizing instrument for judicial decisions. The Court's argument is that the law was intended to decriminalize less severe consumption of drugs, not legalize all drug use. This opinion has faced controversy as those opposed say it goes against the spirit of decriminalization.[135]

So, despite the decriminalization of all illegal drugs, there are people being incarcerated for drug use. For the 1883 convictions under the Drug Law in 2019, 42% were for people who only used drugs. No one was sanctioned for using and selling, and 58% of people were incarcerated for selling. Punishments can include fines (suspended or effective), jail time, (suspended or effective), or a combination of both. This is a paradox in the representation of decriminalization, as criminality still exists for some people who use drugs.[136] The division of punishments can be seen in Figure 2 below.

[135] Rêgo et al., "20 Years of Portuguese Drug Policy," 59.
[136] Ibid.

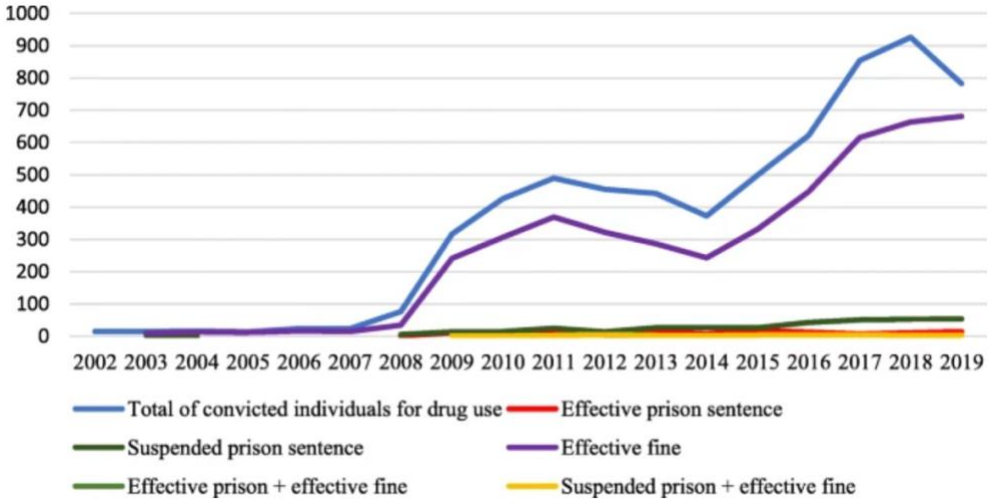

Figure 2. Convicted individuals for drug use by type of penalty in Portugal. Rêgo, X., M. J. Oliveira, C. Lameira, et al. "20 Years of Portuguese Drug Policy - Developments, Challenges and the Quest for Human Rights." Substance Abuse Treatment, Prevention, and Policy 16 (2021): 59. https://doi.org/10.1186/s13011-021-00394-7.

By addiction affecting all classes of Portuguese society as well as emerging as a big problem in a short time period, the Portuguese government felt compelled to take drastic steps and ditch the expectation of criminalization that international society promoted. However, the country still faces domestic controversy on the true application of the principles of decriminalization and public health.

Chapter 4: Comparative Analysis of Both Policies

While the United States has a mindset of addiction centered in criminalization, Portugal has a mindset centered in public health. This can be seen through the lack of legal classification of “hard” and “soft” drugs in Portugal and their more extensive handouts of harm reduction materials. Portugal has been more successful than the United States in every metric of fighting addiction, although some of its success may have been sensationalized.

Governmental Mindset

The most prominent difference between American and Portuguese drug policy is through the assertion of criminality. In Portugal, addiction is a disease to be treated and those who struggle with it are to be incorporated into society. Thus, they decriminalized all illegal drugs. During the War on Drugs in the United States, addiction was viewed purely as a crime. Now it is shifting more towards a public health issue, yet it still leads to stigmatization and incarceration. Drugs are still criminalized, following over a hundred years of similar policy.

One example of this is through Portugal not differentiating between types of drugs in its policies and the United States doing so. By dividing drugs into five schedules, the United States creates a spectrum of criminality despite every user suffering from the same disease. Not only does this reinforce stigma over support, but it can also perpetuate racial biases as seen through crack and powder cocaine sentencing. On the other hand, in Portugal there is no distinction between “hard” or “soft” drugs. This dissolves stigma, as all drug users are treated for the same problem even if their drug of choice has negative connotations.

This is also reflected in the harm reduction methods the two governments advocate for. On March 13th, 2024, the Biden-Harris administration launched a “White House Challenge to Save Lives from Overdose.” It was a call to action for stakeholders across all sectors to save lives by committing to increasing training and access for opioid overdose reversal medications like naloxone. It is commonly known by its brand name, Narcan. The Chicago Department of Aviation, seventeen airlines, Insomnia Events, Ohio Hotel & Lodging Association, The Alliance for Naloxone Safety in the Workplace, Fishing Partnership Support Services, Massachusetts Building Trades Unions, and many other companies took up the call. This reflects the growing trend of companies handing out Naloxone or retaining it to use in the United States, which the

Biden Administration even made available over the counter.[137] However, this drug only works on opioid overdoses. So, those who use other drugs like stimulants, do no have the same harm reduction support available. In contrast, in Portugal, opioid reversal medicine is available from the government along with kits that have two syringes, drug paraphernalia like tin foil, a condom, citric acid, distilled water and sanitation wipes.[138] Portugal has committed to harm reduction for everyone, while the United States has committed for harm reduction for the drug and drug users they find appropriate.

This ties into the racial legacy of the American model which does not translate in the Portuguese one. When addiction predominately affected communities of color, it was treated as a crime in the United States. However, once it affected white communities through the opioid epidemic, public perception shifted to it as a health problem. It has always been a health problem, but the United States only recognized that when it affected "appropriate" users.

In Portugal, the rapid influx of drugs into the country in a short window led to addiction visibly affecting all members of society at the same time, while American policy occurred over a longer period which allowed stereotypes to develop.

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[137] The White House, "FACT SHEET: Biden-Harris Administration Launches the White House Challenge to Save Lives from Overdose," March 13, 2024, https://www.whitehouse.gov/briefing-room/statements-releases/2024/03/13/fact-sheet-biden-harris-administration-launches-the-white-house-challenge-to-save-lives-from-overdose/.

[138] Bajekal, Naina. "Want to Win the War on Drugs? Portugal Might Have the Answer." *Time*, August 1, 2018. https://time.com/longform/portugal-drug-use-decriminalization/.

Success

While the true proportion of Portugal's success may be up for debate, it is significantly more successful than the United States in managing addiction. Portugal has approximately a million more people than the state of New Jersey. Yet, New Jersey alone averages almost 3000 overdose deaths a year, while the entire country of Portugal averages around 80.[139] In fact, people in Portugal are 45 times less likely to die from an overdose compared to people in the United States.[140]

Portugal now accounts for 1.7% of yearly HIV diagnoses linked to injecting drug use in the EU, compared to over 50% in 2001 before it decriminalized drugs.[141] In 2001, the country's death rates were very similar to the EU average and now there is a considerable gap shown in Figure 3. For example, in 2017, Portugal had an average of 6 deaths per million among people aged 15-64, while the EU average was 21.3 per million and the American average was 185 per million. This is shown in Figure 4. Additionally, the social cost of drugs in Portugal decreased 12% five years after decriminalization and 18% eleven years after.[142]

[139] National Public Radio (NPR), "More Than a Million Americans Have Died from Overdoses During the Opioid Epidemic," National Public Radio, December 30, 2021, https://www.npr.org/2021/12/30/1069062738/more-than-a-million-americans-have-died-from-overdoses-during-the-opioid-epidemi.
[140] Ibid.
[141] Transform Drug Policy Foundation. "Drug Decriminalisation in Portugal: Setting the Record Straight." *Transform Drug Policy Foundation*. Accessed November 14, 2024. https://transformdrugs.org/assets/files/PDFs/Drug-decriminalisation-in-Portugal-setting-the-record-straight.pdf.
[142] Gonçalves, Lourenço, and da Silva, "A Social Cost Perspective," 199–209.

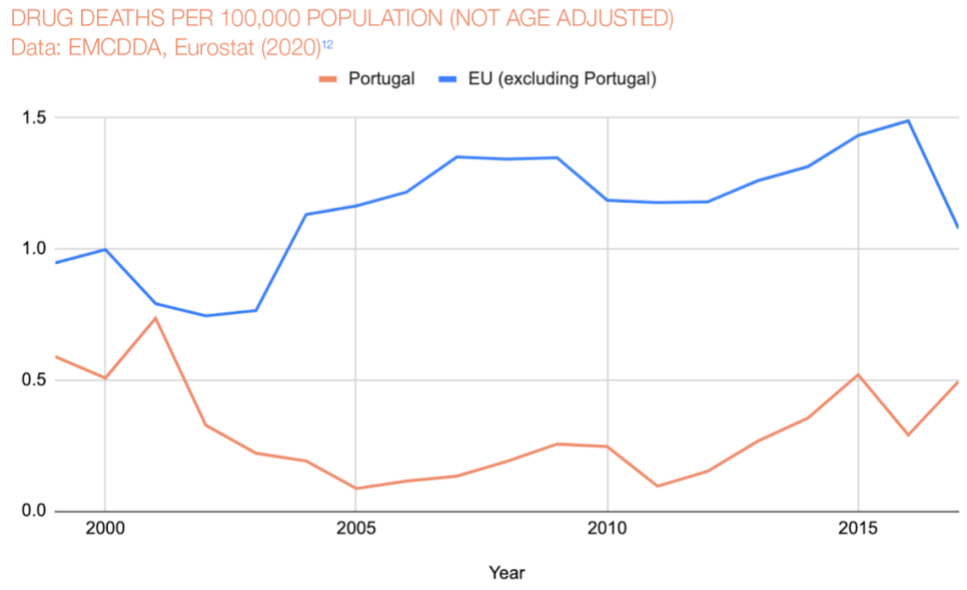

Figure 3. Drug Deaths Per 100,000 Population in Portugal and the EU. Transform Drug Policy Foundation. "Drug Decriminalisation in Portugal: Setting the Record Straight." Transform Drug Policy Foundation. Accessed November 14, 2024. https://transformdrugs.org/assets/files/PDFs/Drug-decriminalisation-in-Portugal-setting-the-record-straight.pdf.

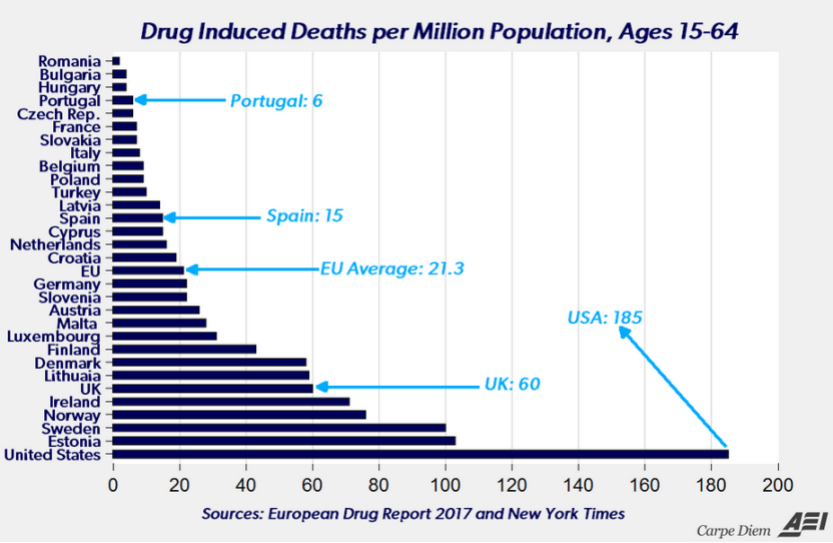

Figure 4. Drug Induced Deaths per Million Population in 2017, Ages 15-64. Mark J. Perry, “Chart of the Day: Drug Overdose Deaths per Million Persons. Can the US Learn Something from Portugal?” American Enterprise Institute, October 26, 2012, https://www.aei.org/carpe-diem/chart-of-the-day-5/.

On the other hand, overdoses in the United States are increasing. Figure 5 shows that during the same 20 years Portugal decriminalized drugs, the continuation of US policies led to increasing

overdoses. It also reflects the research previously shared, as overdoses are decreasing with prescription opioids of the first wave and heroin of the second wave, but sharply increasing with the synthetic opioids of the third wave.

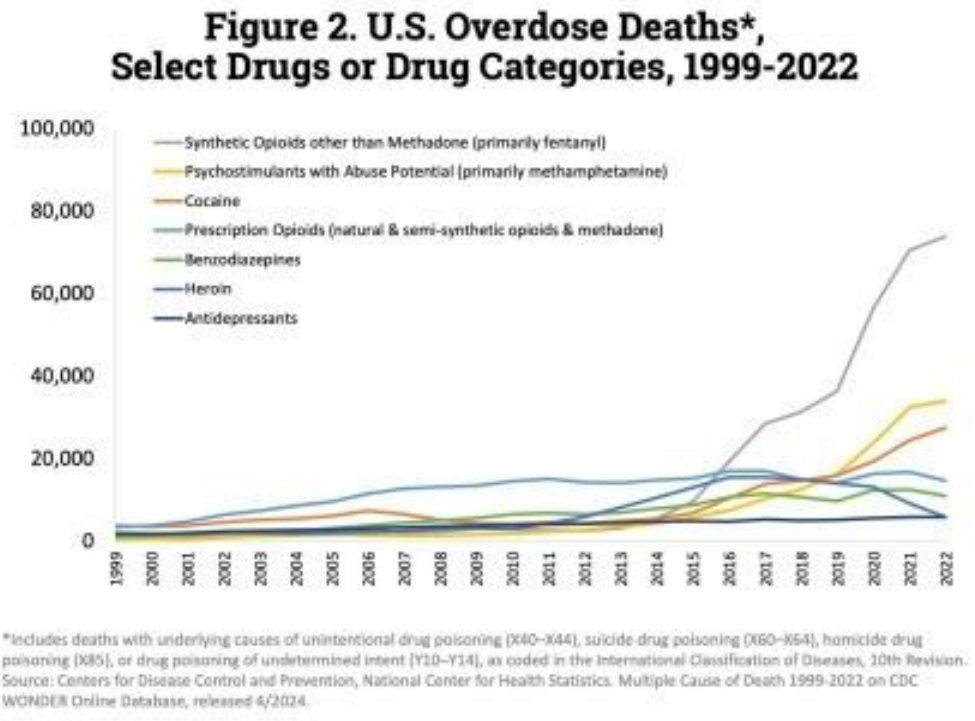

Figure 5. U.S. Overdose Deaths, Select Drugs or Drug categories, 1999-2022. National Institute on Drug Abuse, "Overdose Death Rates," National Institutes of Health, January 20, 2023, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig2.

There are valid criticisms of the exaggeration of Portugal's success. In 2014, Hannah Laqueur found that the reforms made by Portugal were more modest than projected because many of them were already in practice even if they were not codified.[143] Additionally, Portugal started at a place of lower use than most European countries, so its stark difference is not indicative of

[143] Hannah Laqueur, "Uses and Abuses of Drug Decriminalization in Portugal," Law & Society Inquiry 40, no. 3 (2015): 746–781, https://doi.org/10.1111/lsi.12104.

solely decriminalization policies. On top of that, Portuguese reform was not an immediate success as it was followed by slight increases in prevalence of overall drug use.[144]

Most startingly, the numbers of deadly overdoses are slightly increasing in Portugal, although they are still considerably lower than the European Union and the United States. However, one must consider that funding for the main decriminalization institute in Portugal dropped from 76 million euros to 16 million euros in 2012, which has forced it to outsource some of its programming. [145]

Yet, even if there are some exaggerations, the Portuguese numbers are better than they were before decriminalization. Significantly less people are dying in Portugal than in the United States, even if one accounts for the differences in size of population. Portuguese society does not accept the death of its citizens in the way the United States does. Portugal embraced change when disaster struck. The United States waited longer to do so, and still is not investing in a culture shift.

Oregon Case Study

In 2020, the state of Oregon decriminalized all drugs through Ballot Measure 110. This included substances such as heroin and fentanyl, as marijuana was legalized recreationally in 2014. It aimed to use money from the sale of recreational marijuana to fund treatment and infrastructure for the health screenings and support systems. It passed with more than 58% of the vote, and leaders often cited the success of Portugal in their reasoning. It was portrayed as a

[144] Faiola, Anthony, and Fernandes Martins, Catarina. "Once Hailed for Decriminalizing Drugs, Portugal Is Now Having Doubts." *The Washington Post*, July 7, 2023. https://www.washingtonpost.com/world/2023/07/07/portugal-drugs-decriminalization-heroin-crack/.

[145] Faiola, Anthony, and Fernandes Martins, Catarina. "Once Hailed for Decriminalizing Drugs, Portugal Is Now Having Doubts." The Washington Post, July 7, 2023. https://www.washingtonpost.com/world/2023/07/07/portugal-drugs-decriminalization-heroin-crack/.

correction for the War on Drugs, as it prioritized Black, Native, and other "historically underserved" communities in the historically white state.[146]

In Oregon, those who used drugs were served with a $100 ticket when caught with it in their possession. It was easily avoided if the person who received the ticket underwent a needs assessment over the phone.[147]

However, in September 2024, the state recriminalized personal drug possession. To many, Ballot Measure 110 was a failure. They blame it for increased overdoses, higher drug use rates, more public visibility for drug use, and a threat to the safety of their communities.[148]

While the sentiment behind Ballot Measure 110 was right, it did not have the support systems in place to mimic the Portuguese one. One of the hallmarks of the Portuguese Drug Policy is its referral and access to resources for those who choose treatment. This is boosted by country-wide universal healthcare which has existed since 1979.[149] Oregon's welfare system has historically ranked towards the bottom in supplying services for behavioral and mental health services. In some rankings, it is even placed at 49th. So, although the state invested $300 million to the initiative, they had too much ground to make up.[150]

Additionally, the treatment infrastructure the state built to support the program took about a year and a half to get going, yet decriminalization occurred right away. The lines for detox, inpatient rehabilitation and transitional housing kept getting longer, and the government only had safe use supplies to placate those who needed help. This caused community unrest, as it made

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[146] Kim, E. Tammy. "A Drug-Decriminalization Fight Erupts in Oregon." *The New Yorker*, January 15, 2024. https://www.newyorker.com/magazine/2024/01/22/a-new-drug-war-in-oregon.
[147] Ibid.
[148] Ibid.
[149] Russoniello, "The Devil (and Drugs) in the Details," 371-432
[150] Dave Davies, interview with E. Tammy Kim, NPR Fresh Air, podcast audio, March 27, 2024, https://www.npr.org/transcripts/1240892448

drug use more visible without showing the traditional forms treatment the electorate was expecting.[151] Addiction requires a multifaceted approach, and the beginning of Ballot Measure 110 only provided guiderails for a problem that requires institutional cooperation.

Another flaw is that the Oregon process was not centralized enough. In Portugal, the government founded a new agency called Instituto da Droga e da Toxicodepdndencia (Institute for Drugs and Drug Addiction, "IDT") two years before the law was announced. All parts of the project ran through them, and it had branches in every region of Portugal. In 2012, to consolidate resources, the Portuguese government transferred almost all of IDT's duties to regional government authorities and a new organization called Servigo de Intervenglo nos Comportamentos Aditivos e nas Dependncias (Service of Intervention in Addictive Behaviors and Addictions, "SICAD").[152] As previously stated, this may correlate with the country's recent struggles to continue the success of their program today.

In Oregon, decriminalization ran though the Oregon Health Authority which was already overwhelmed by COVID-19. Each county was forced to form a behavioral-health resource network to coordinate efforts by them. This created a convoluted sense of delegation between organizations who had competing goals.[153]

Critics also claim that there was no incentive for individuals to seek help in the Oregon system. While Portuguese CDTs can assign penalties, such as barring individuals from certain places or suspending their professional licenses, the Oregon system could not. In the first fifteen months, only 119 people called their hotline. This is because the people ticketed were not held accountable for the fine, so there was no reason to use the hotline. Additionally, critics claim that

[151] Kim, "A Drug-Decriminalization Fight," *The New Yorker*.
[152] Russoniello, "The Devil (and Drugs) in the Details," 371-432
[153] Kim, "A Drug-Decriminalization Fight," *The New Yorker*.

the reduced role of law enforcement in the Oregon model prevented the nudge necessary for people to get clean.[154]

The Ballot Measure also entered the state at an unsuitable time. Fentanyl was recently introduced to the state, which has an increased lethality that the population had not experienced. Yet, the Ballot Measure was blamed for the increase in overdose deaths from 737 in 2021 to 955 in 2022. According to a study by N.Y.U., there was "no evidence of an association" between the state's decriminalization and the fatal-overdose rates, so the policy received unwarranted criticism.[155]

There was also a rise of homelessness due to the economic effects of the COVID-19 pandemic and wildfire displacement at the time. Tent cities were already popping up around the state when it was passed, but the timelines were close enough that homelessness became indistinguishable from the Ballot Measure for the public.[156]

Proponents of Ballot Measure 110 claim that the quick return to criminalization in 2024 enforces the racialization of the War on Drugs and lacks patience. Larry Turner, the founder of a nonprofit that aids Black people with criminal records, argues that "It took us time to get here, it's going to take us time to get out."[157]

While personal drug use of hard substances was recriminalized, the corrective law continued some spirit of a public health future. It pledged an additional $211 million to treatment services and a new optional deflection program for counties. Now, when an individual is arrested for personal drug use, they can go to jail for six months or go into a recovery regimen. If they

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[154] Lopez, German. "From Portugal to Portland." *The New York Times*, January 12, 2024. https://www.nytimes.com/2023/08/04/briefing/portugal-portland-decriminalization-overdoses.html.
[155] Kim, "A Drug-Decriminalization Fight," The New Yorker.
[156] Ibid.
[157] Ibid.

complete the regimen, they will not do jail time, and their record will be wiped. However, counties, many of them scarred from Ballot Measure 110, must opt in.[158] As of September 21st, 2024, 28 of the state's 36 counties had applied for grants to support a deflection program.[159]

Some may say Ballot Measure 110 had to overextend to create the positive change it eventually ended up with. However, the failure of a policy should not be due to a failure to plan. In the foreseeable future, the United States will use Oregon for an example of what policy to not implement. However, they should look at it as what planning pitfalls to avoid instead.

Conclusion

One of the gifts of a globalized world is the opportunity for countries to learn from each other. Each nation has a distinct history and culture, yet many of the problems they struggle with are shared by everyone. This is true for addiction, as drugs have infiltrated every race, class, gender, ethnicity, and country in the world. Its effects are as detrimental to the doctor as they are to the farmer. Yet, their outcomes are determined by if they receive treatment and the quality of it.

In Portugal, the number of people seeking treatment for drug addiction increased from 23, 654 in 1998 to 38,532 in 2008.[160] There was an increase from 6,040 people receiving methadone replacement treatment in 1999 to 17,280 people receiving it in 2007. This growth in treatment highlights the success of the Portuguese model meeting people where they are at by eliminating stigma and keeping people alive long enough to want treatment. Even the most

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[158] Ibid.
[159] Rush, Claire. "Oregon Law Rolling Back Drug Decriminalization Takes Effect, Making Possession a Crime Again." PBS, September 1, 2024. https://www.pbs.org/newshour/politics/oregon-law-rolling-back-drug-decriminalization-takes-effect-making-possession-a-crime-again.
[160] Russoniello, "The Devil (and Drugs) in the Details," 392.

powerful government cannot decide that someone will get clean, the person must do so for themselves.

This paper explored the sociocultural contexts of drug use and policy in the United States and Portugal. It found one based on criminality in the United States and one based on public health in Portugal.

The United States must recognize that its journey towards progress has included systemic racism, which spills into mass incarceration and generational poverty. Drastic crises require drastic action, and it must change its mindset to embrace community health. This can include expanding treatment access through inpatient, outpatient, harm reduction and mental health services, increasing its harm reduction through expediting universal access to naloxone and investing in safe consumption sites, and shifting drug crimes from criminal penalties to civil infractions.

Portugal must recognize that its recent shortcomings reflect its decreased investment in the program they once proudly promoted. It must recommit to adequate funding and use it to restructure their outreach to meet even the most underserved populations.

While both countries cannot force their citizens to choose life, they have the power to create environments that facilitate the survival and recovery necessary for it.