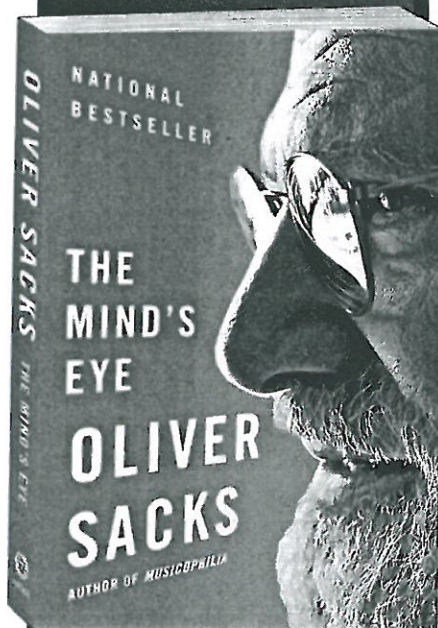


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GETTING A FIX

Portugal decriminalized drugs a decade ago. What have we learned?

BY MICHAEL SPECTER

Nuno Miranda has been parking cars for thirteen years, most of them in a lot just below Belém National Palace, the eighteenth-century estate that serves as the official residence of the President of Portugal. Miranda, who is thirty-seven, is a lanky, amiable man, dressed in the style of hipsters the world over: a few layers of untucked shirts and skinny black jeans tucked into well-worn work boots. His dishevelled hair falls just below his collar, and by 11 A.M. one day recently the sun was bouncing off the thin gold chain around his neck.

Miranda's "job," like that of the now-banished squeegee men of New York, falls into the poorly defined space between labor and harassment. Nobody is required to pay Miranda, but he rarely earns less than fifty euros a day—a passable sum in one of Europe's poorest countries. There is no fighting for turf, nor have the police ever tried to shoo him away. "I serve a purpose," Miranda told me, waving a metallic-blue Volkswagen Passat into an open slot. "But I know I am lucky. I could have died long ago."

Miranda is a heroin addict. Fifteen years ago, overwhelmed by depression and anxiety about the future, he turned to drugs. "Everyone did it then," he said. "It was something I had to try. It made my life bearable—it still does. Though it can ruin people, too. I have seen that. When we started, we had no idea of the consequences."

By the nineteen-eighties, drug abuse had become a serious problem in Portugal. The Lisbon government responded in the usual way—increasing sentences for convictions and spending more money on investigations and prosecutions. Matters only grew worse. In 1999, nearly one per cent of the population—a hundred thousand people—were heroin addicts, and Portugal reported the highest rate of drug-related AIDS deaths in the European Union.

In 2001, Portuguese leaders, flailing

about and desperate for change, took an unlikely gamble: they passed a law that made Portugal the first country to fully decriminalize personal drug use. (Other nations, such as Italy and the Netherlands, rarely prosecute minor drug offenses, but none have laws that so explicitly declare drugs to be "decriminalized.") "We were out of options," João Goulão told me. Goulão is the president of the Institute on Drugs and Drug Addiction, a department of the Ministry of Health that oversees Portuguese drug laws and policy. "We were spending millions and getting nowhere." For people caught with no more than a ten-day supply of marijuana, heroin, ecstasy, cocaine, or crystal methamphetamine—anything, really—there would be no arrests, no prosecutions, no prison sentences. Dealers are still sent to prison, or fined, or both, but, for the past decade, Portugal has treated drug abuse solely as a public-health issue.

That doesn't mean drugs are legal in Portugal. When caught, people are summoned before an administrative body called the Commission for the Dissuasion of Drug Addiction. Each panel consists of three members—usually a lawyer or a judge, a doctor, and a psychologist or a social worker. The commissioners have three options: recommend treatment, levy a small fine, or do nothing. Counseling is the most common approach, and that is what Nuno Miranda received when he appeared, in 2002, before the commission in Lisbon. "I was using drugs for five or seven years before that law passed," he said. "Since then, everything has changed. Everything."

In most respects, the law seems to have worked: serious drug use is down significantly, particularly among young people; the burden on the criminal-justice system has eased; the number of people seeking treatment has grown; and the rates of drug-related deaths and cases of infectious diseases have fallen. Initial

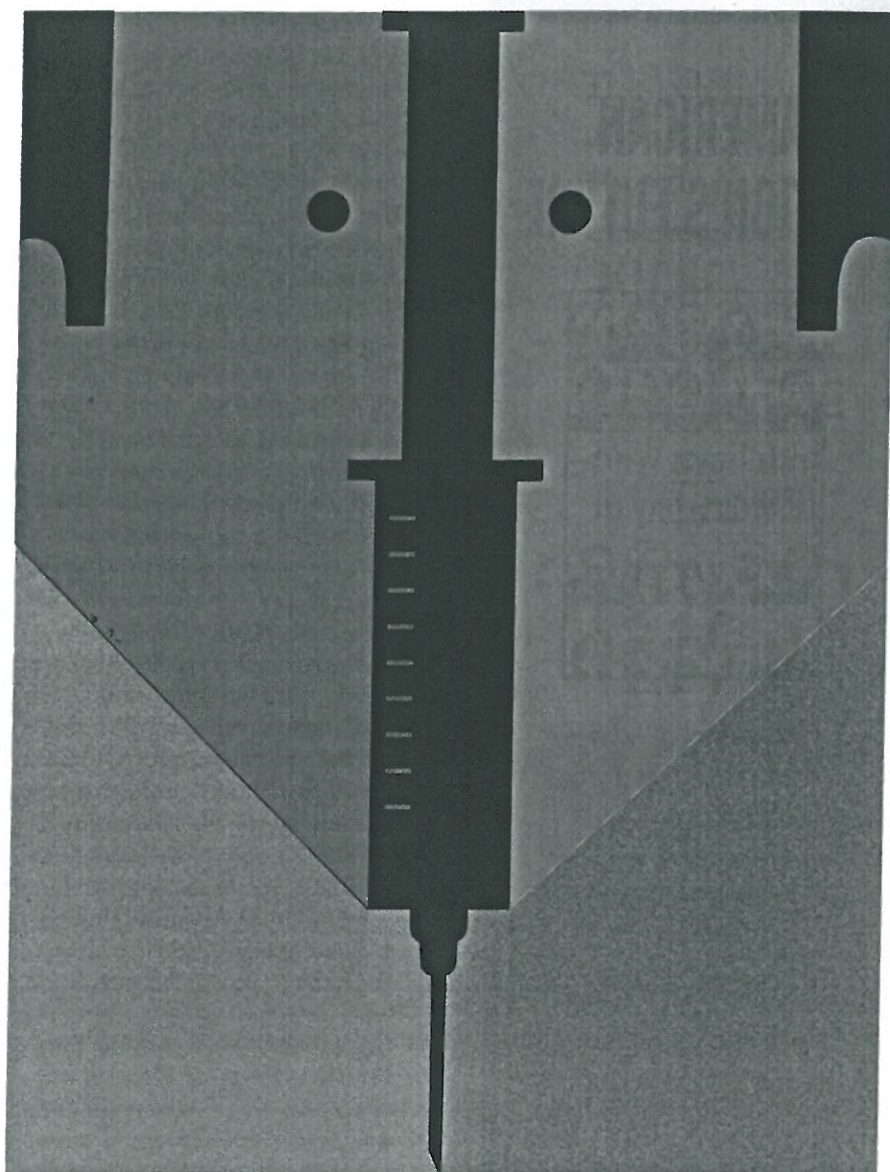
fears that Portugal would become a haven for "drug tourism" have proved groundless. Surprisingly, political opposition has been tepid and there has never been a concerted repeal effort.

Yet there is much to debate about the Portuguese approach to drug addiction. Does it help people to quit, or does it transform them into more docile drug addicts, wards of an indulgent state, with little genuine incentive to alter their behavior? By removing the fear of prosecution, does the government actually encourage addicts to seek treatment? Unfortunately, nothing about substance abuse is simple. For instance, although many people maintain that addiction would decline if drugs were legal in the United States, the misuse of legally sold prescription medications has become a bigger health problem than the sale of narcotics or cocaine. There are questions not only about the best way to address addiction but also about how far any society should go, morally, philosophically, and economically, to placate drug addicts.

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

In 1974, after decades of authoritarian rule, a left-leaning faction of the Portuguese military led a coup that subsequently became known as the Carnation Revolution. Suddenly, a closed society became a boisterous democracy, and Portugal began to face enormous social, economic, and political challenges. As

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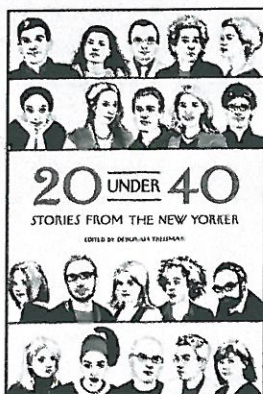
one of its first acts, the new government granted independence to Angola, Mozambique, and other colonies. Hundreds of thousands of Portuguese citizens returned from abroad, adding to the social tumult. "We had a tough regime for forty-eight years and we were a closed society, and this was particularly true for young people," Goulão said as we sat in his airy Lisbon office. Pictures of foreign dignitaries lined the walls. "We were completely isolated from other parts of the world—the hippies in San Francisco, the students in France in the sixties. Faint echoes reached our shores, but nothing really sunk in."

In the United States, as in many European countries, the acceptability of drug use—and its consequences—had been debated extensively. But in Portu-

gal, Goulão said, "the issue was never discussed." As international drug traffickers discovered a new market in Lisbon, they also realized that the Iberian Peninsula was an ideal gateway to Europe. Portugal became a transit point for the distribution of cocaine from South America, heroin from Spain, and hashish and marijuana from Morocco and other African countries. (That has not changed. Goulão's institute estimates that seventy-seven per cent of the drugs seized in Portugal are destined for other countries.)

"It spread very fast," Goulão said. "We had an extremely low prevalence of drug use compared with other countries, but then all at once the gap between occasional users and people with a problem began to disappear." By the nineteen-eighties, after the initial years of openness

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and experimentation, the government panicked and began running extremely harsh advertisements on television equating drug use with madness, evil, and crime.

In those days, Goulão ran a clinic in the Algarve. "It was a disaster," he said. "Such widespread heroin abuse fuelled the AIDS epidemic. It was difficult to find a single family without a drug problem."

Every effort to increase drug penalties, to add police officers, or to build neighborhood consensus seemed to end in failure. Prohibition and its enforcement appeared to intensify the harm they were trying to address. (That was most obviously true with the H.I.V. epidemic; H.I.V. spreads rapidly among people who share dirty needles.) In addition, banning some addictive substances while permitting and taxing others has proved difficult to defend, particularly considering the relative impact of the substances involved. There is no country where illegal drugs kill as many people as legal addictive substances. The World Bank estimates that tobacco will kill five hundred million of the present global population.

It has been exactly fifty years since the United Nations adopted the Single Convention on Narcotic Drugs, the first truly international effort to prohibit the growth, production, and sale of narcotics, cannabis, and other illegal substances. Since 1961, however, Western nations have struggled with rising rates of drug abuse. Law-enforcement officials, politicians, and public-health leaders have debated their alternatives frequently—and frequently disagreed about what to do. That debate has never ended, and there are still essentially two approaches to substance abuse: rehabilitation and incarceration. In Portugal, though, a consensus quickly formed, even among law-enforcement officials, that devoting ever-increasing resources to drug interdiction had little or no effect. And neither did relying on the criminal-justice system to address the problem.

Eventually, the Portuguese government moved responsibility for drug-control issues from the Justice Department to the Ministry of Health. It was a striking decision; in other countries, drug abuse has remained primarily a matter

for law-enforcement agencies. In the past forty years, American police officers have arrested millions of nonviolent drug offenders, and hundreds of thousands have been prosecuted. Rather than try to eliminate drug abuse, Portugal's approach, commonly known as "harm reduction," attempts to minimize the negative consequences for society. In recent years, those consequences have become both more obvious and more significant.

"The prevailing approach in the rest of the world ignores scientific reality and squanders resources on things that have been shown again and again to fail," said Miguel Vasconcelos, the chief psychiatrist at the Taipas treatment center, the largest in Lisbon, with eighteen hundred patients. When Vasconcelos began working at the clinic,

more than twenty years ago, there was no attempt at harm reduction. "The goal was to get people off drugs," he said. "And for many patients that is still the goal. But there are people for whom it is hard and some for whom it is not possible. This is an alternative that does get people off the streets, reduces the rates of H.I.V. infection, and lowers crime. It is humanistic but also pragmatic."

The relationship between crime and addiction has long been clear. In the United States, more than seventy per cent of inmates test positive for illicit drugs when they are arrested; substance abuse is by far the most common reason for parole violations. The attempt to support a habit frequently leads to criminal behavior—drug sales, theft, prostitution. Vasconcelos pointed out that punishment is not a deterrent: "The prisons are full, but that has not helped lower the rate of drug abuse. Our law does not permit drug use; that is important. Harm reduction is like a lure in fishing. It is the thing we can do to talk to people and tell them there is a way to stop."

Statistics associated with drug abuse are not easy to parse. Laws, approaches, and customs vary widely among countries, and they change over the years. In the nineteen-eighties, the prevailing trend in most of the world was toward harsher treatment of even casual users. Today, policy officials in many countries are trying to change that pattern, but



there are many goals in the war on drugs, and it is hard to choose the most meaningful among them. Is drug use increasing? Has it become socially and economically ruinous? What drugs are being used and by whom? How much violence is associated with drug addiction? How old are those with the biggest problem and why do they have that problem? Poverty is often the answer to the last question, and in 1999, before Portugal introduced the new regimen, the country had a high level of poverty compared with other European nations, many heroin addicts, and a serious problem with H.I.V. Thirty-seven per cent of injecting drug users were receiving methadone to manage their addiction; ten years later, that figure was sixty-seven per cent. The number of people convicted of drug offenses fell from forty-four per cent of the prison population, in 2000, to twenty-one per cent, in 2005; the percentage of people using heroin in prison also fell sharply.

"I used to be the biggest believer in locking up the bad guys," João Figueira, the chief inspector of the Judicial Police crime squad and its drug division in Lisbon, said. He told me that he was unhappy when the law was introduced, and he struggled with it morally. Within a year, he had changed his mind. "In the last years before the law, consumers were arrested by police," he continued. "They were fingerprinted and made statements and took mug photos and were presented to court. And always, always, always released. It was a waste of everyone's time. It didn't stop drug use or slow down the dealers. So the idea that somehow people are getting away with what they did not get away with before is silly."

Elisabete Moutinho, a clinical psychologist, who works for one of the drug outreach programs funded by the Ministry of Health, stood on a cobblestone plateau above the slope that leads to what was once the center of Lisbon's Casal Ventoso neighborhood. She looked across a nearby highway at a housing development of the type that often seems to rise along the ring roads that circle the world's capitals. It was utilitarian, and utterly lacking in charm. "That must be a dull place to live," I said. She smiled and replied, "There are worse things than dull. In this area, dull is an improvement."

Twenty-five years ago, Casal Ventoso was essentially a giant shooting gallery, and, every day, thousands of people would line up to buy heroin, then they would fade into the dense warren of homes and kiosks that covered a series of connected hills. Walking through the squalid neighborhood meant weaving around piles of used, often bloody needles and, on occasion, stepping over a dead body. Casal Ventoso was a daily catalogue of human misery. In 1998, the government brought in a fleet of bulldozers and razed the neighborhood.

Moutinho, who is thirty, is a charismatic and idealistic woman with a demeanor that invites people to tell her their problems. "We are not here to judge or scold," she said. "This is purely a public-health initiative. We want these people in the system, unafraid, able to come to us if they are in need. And in turn we test them for diseases, treat them when they are sick. This is a better outcome for them than taking them to the hospital or the morgue. And it is a better outcome for the people of this country."

She and her team had arrived in a station wagon filled with drug paraphernalia: tinfoil, for people who smoke heroin rather than shoot it (which is often the only way for longtime addicts to get their fix, since years of injections have ruined their veins), and stacks of clean syringes, sterile wipes, and other accessories required to inject heroin safely. The exchange policy is simple: bring in a used needle and get a new one. "There is no limit," Moutinho said, as a man approached clutching nine syringes in his fist. She chatted with him as he deposited the needles, one by one, into a container she had placed in the center of the platform. "How is your arm?" she asked, noticing what appeared to be significant ulcerations along the inner part of his left arm. He shrugged and told her that he had been at the doctor's office two days earlier; in order to receive methadone, people must agree to periodic checkups and blood tests. When the man had deposited the last of his refuse, Moutinho counted out nine new pouches for fixing heroin, along with nine syringes, and handed them over. He nodded and moved on.

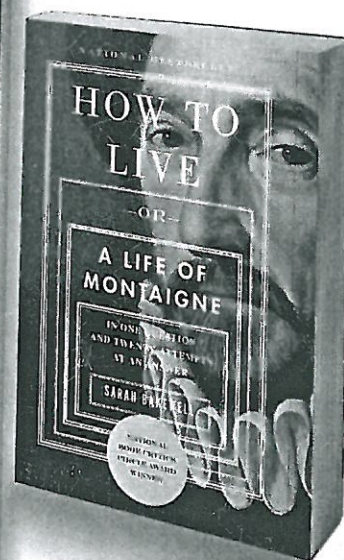
As people straggled up to the team, Moutinho explained, "We are here the same time every day, and people can

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count on that." I asked if she had any qualms about aiding people in their quest to satisfy addictions. "That is the wrong way to think about what we do," she said. "Of course, you can come here and still buy heroin. The dealers know where we are and when we are here. People exchange syringes and then go buy drugs.

"I know that is not easy for everyone to accept," she continued. "But they don't get AIDS from a dirty needle, or hepatitis. They are not beaten by gangs or arrested or put in jail. There is no police corruption, because there is nothing to get rich from. It is a program that reduces harm, and I don't see a better approach."

Later that afternoon, in the Alcântara section of Lisbon, I visited the Centro de Acolhimento, a short-term residency for drug addicts who need a place to begin new lives. The building, near the docks, is on both the seedy side of town and the cool side, and could easily have been the headquarters of an adventurous industrial designer. The floors—unbroken ex-

panses of concrete—and the soaring windows made the room feel accessible and spacious. A few dozen people sat quietly eating at picnic-style tables arranged in the middle of the room. Francisco Chaves, the psychologist who has run the center since it opened, in 2009, admitted that he had mixed feelings about Portugal's approach to drug addiction. He is a religious activist who believes in rehabilitation and moral tenacity. To him, "harm reduction" offers little of that. "This law takes away all pressure to stop using drugs," he said. "Nobody stops without pressure. That's not the way humans are built. When you promise methadone to anyone who wants it, you are going to get people who say there is no reason to stop. This idea that everybody has a right to take drugs is wrong. Morally, I don't agree. I worry because are we not simply creating a society that is completely socially dependent?"

That view is echoed by Manuel Pinto Coelho, a physician who has treated addicts for many years, and is the president

of the Association for a Drug Free Portugal. He has emerged as perhaps the most vigorous Portuguese critic of decriminalization, and when we met, in Lisbon, Pinto Coelho had just returned from Vienna, where, before the United Nations Office on Drugs and Crime, he had spoken passionately against easing drug penalties. "Medicalization of this deviant behavior has provided powerful support to the idea of expanding the concept of addiction as a disease," he told me. "That convinces most addicts that they have to remain dependent on methadone rather than struggle to become independent. It is a service neither to them nor to society." He is particularly offended by the notion that supporting human rights implies supporting greater investment in harm reduction: "Is it really a human right to remain in chemical chains?" Pinto Coelho argues that the system has been tilted in favor of those who don't even try to quit. "I have treated many addicts in my life," he said. "It is very hard to quit, and some people fail.

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But many succeed, and society should reward their success, not make a statement that the effort is unnecessary. We shouldn't be making life easier for people who decide to use drugs—we should make it more difficult."

Richard Nixon declared a "war on drugs" in 1971. For the next fifteen years, though, instead of battles there were mostly minor skirmishes. Then, in 1986, Ronald Reagan signed National Security Directive 221, which turned the war into a national-security priority. The reasons were clear: cocaine from South America, where drug cartels fought openly, had displaced Southeast Asian heroin as the major drug threat to the United States, and violence associated with drug sales escalated rapidly. Federal spending on drug control rose just as sharply, from \$1.5 billion, in 1980, to \$6.7 billion, in 1990. The number of arrests for drug offenses nearly quadrupled, to more than four hundred thousand per year.

According to the United Nations

Office on Drugs and Crime, by the mid-nineteen-nineties trafficking and sales of illegal drugs had become a four-hundred-billion-dollar-a-year industry—ranking it with the oil companies and the worldwide (and legal) arms trade. In the United States, tough words on drugs became a required part of any politician's rhetoric. In 1996, President Bill Clinton named Army General Barry McCaffrey as director of the Office of National Drug Control Policy and increased its staff significantly. Later that year, Clinton announced a new National Drug Control Strategy. The first priority, according to the President, was "to get young people to reject drugs." The problem had become acute, and many policymakers wanted to solve it no matter the cost.

By June, 1998, the sense of urgency had reached the United Nations. That month, delegates gathered in New York for a special session devoted to the world's growing drug problem. The session even had a slogan, "A Drug-Free World: We

Can Do It." The purpose was to produce a plan that the international community could use to fight, and win, the global war on drugs. The United States took the lead in writing early drafts of the proposal, which called for a complete end to illicit drug use by 2008. Later, after lobbying from Latin-American delegates, who were more realistic, the wording was amended to include the phrase "eliminating or significantly reducing."

Nobody questioned the severity of the crisis, but many politicians, scientists, and criminal-justice officials doubted that relying so heavily on law enforcement—and abolition—would work. There was already strong evidence that drug addiction was a biologically and psychologically complex illness—one far more amenable to preventive efforts and medical care than to punishment. On the first day of the special session, hundreds of the world's leading statesmen and political officials published an open letter to Secretary-General Kofi Annan in the *New York Times*. The signatories included former

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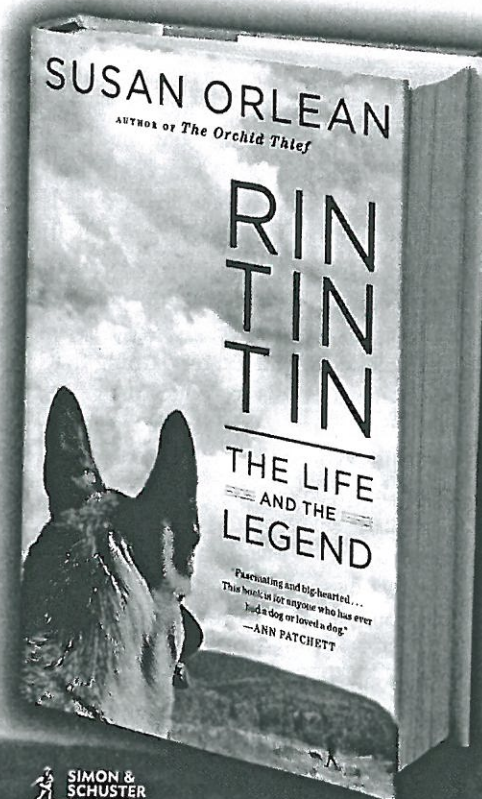
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U.N. Secretary-General Javier Pérez de Cuéllar, former Secretary of State George Shultz, Walter Cronkite, former Attorney General Nicholas Katzenbach, many Nobel Prize winners, and elected officials from around the world. "We believe that the global war on drugs is now causing more harm than drug abuse itself," the letter began, and pointed out that U.N. conventions, focussed largely on crime and punishment, made it difficult for countries to devise effective local solutions. Despite increasingly harsh sanctions, the drug industry "has empowered organized criminals, corrupted governments at all levels, eroded internal security, stimulated violence, and distorted both economic markets and moral values."

The letter concluded by warning that "realistic proposals to reduce drug-related crime, disease and death are abandoned in favor of rhetorical proposals to create drug-free societies."

The leadership at the United Nations ignored the message completely. But conservatives, who objected to any shift from punishment to rehabilitation, responded sharply. In the *Times*, A. M. Rosenthal, the paper's former executive editor, praised the U.N. meeting and described harm reduction as nothing more than the first step on the slippery slope to

legalization. Bill Clinton seemed to agree. In 1993, his Surgeon General, Joycelyn Elders, had been quoted on the subject of prosecuting drug users. "I do feel we would markedly reduce our crime rate if drugs were legalized," she said. "But I don't know all the ramifications of this. I do feel that we need to do some studies." Elders never advocated legalization or even the removal of criminal sanctions; she wanted more research. The White House had other ideas. "The President is firmly against legalizing drugs," Clinton's press secretary said at the time. "And he is not inclined in this case to even study the issue." Attitudes under George W. Bush were no different.

"This is an extremely complex issue involving producers, suppliers, distributors, local salespeople, and consumers, and we are into absolute simplicity," said Alan Leshner, the chief executive officer of the American Association for the Advancement of Science and a former director of the National Institute on Drug Abuse. He added that Americans tend to see these issues in stark terms; people are either for legalization or against it. "Those kinds of positions help no one," he said. "We need to use law enforcement. But, if there is one thing about this issue I can promise you, it is that we are

not going to arrest ourselves out of this problem.

"Yet we live in an ideologically fraught society," he continued, "a society that can pretend that drug use will go away if we just fight hard enough, if we 'just say no.' What politician will vote to reduce funds dedicated to the war on drugs?"

In the United States, the penalty for using a particular drug has rarely had any relationship to its inherent danger. As Arthur Benavie pointed out in "Drugs, America's Holy War," in 2009, the American approach to illegal substances has as much to do with who takes the drugs as it does with the drugs' putative effects on people or society. In the late nineteenth century, doctors often prescribed opiates with abandon—"The typical opiate addict was a chronically ailing middle- or upper-class woman who had been addicted by her doctor," Benavie wrote. Mary Tyrone, a character in Eugene O'Neill's "Long Day's Journey Into Night," believed to be modelled on his mother, was that kind of addict. Most cocaine addicts were doctors. Nobody talked about sending them to prison.

By 1915, however, the demographics of addiction had changed and so had American attitudes toward drug users. Cocaine had come to be seen as a drug taken by lower-class, urban men, who were often looked upon with fear and disdain. Opium had been tolerated in the United States for more than a century—until Chinese laborers began to compete with Americans for jobs. Since then, the more directly a drug has been perceived to be associated with minorities and the poor, the graver the danger it is seen as posing to society. Until last year, when President Obama signed the Fair Sentencing Act, penalties for possessing or selling crack cocaine, used heavily by minorities, were a hundred times more severe than those for powder cocaine, a form of the drug often consumed by prosperous white people.

"There has been, since the dawn of man, the desire to get high," Thomas McLellan, a longtime expert on addiction, told me not long ago. "Some of the first crops raised by humans were not meant to eat or to feed livestock. They were for fermentation. To drink." McLellan recently returned to academia after serving for two years as the deputy

director of the Office of National Drug Control Policy. He has taught at the University of Pennsylvania Medical School for thirty years and runs the Center for Substance Abuse Solutions, in Philadelphia, which promotes science-driven reform of substance-abuse policy. He had never served in the government until he was appointed the Administration's leading spokesman on prevention and treatment options. McLellan said that he wasn't eager to accept the job, but did so for personal reasons.

In 2008, a few months before he assumed his position, McLellan's youngest son, who was thirty, died of an overdose of anti-anxiety medication mixed with alcohol. McLellan's wife is a former cocaine addict. "My entire family is in recovery," he said. "I thought, Maybe there's a way where what I know plus what I feel could make a difference." Together with Gil Kerlikowske, the U.S. drug czar, who is a former Seattle police chief, the Office of National Drug Control Policy has attempted to shift the focus in the war on drugs from combat to treatment.

Under Kerlikowske and McLellan, the Obama Administration has placed a new emphasis on medical solutions to drug abuse. The Affordable Care Act, passed last year, requires for the first time that substance abuse be considered a chronic disease, like diabetes or hypertension. Beginning in 2014, insurers may no longer deny coverage based on known substance-abuse problems. "For approximately twenty-three million Americans, substance use progresses to the point that they require treatment," McLellan told Congress last year. "This is roughly the same number of American adults who suffer from diabetes. In the U.S., the only disease that affects more people is heart disease." Yet currently available medicine is rarely relied upon in drug programs. The Obama Administration has pushed for wider adoption of treatments that help manage withdrawal symptoms as well as those which reduce cravings for drugs. The drug-control office has also initiated programs that help health-care workers spot problems early.

"I think for some folks radical change will be their only measure of success," Kerlikowske has said. "I don't think we'll see that. I think we'll make a lot of progress, we'll slow the freighter down and

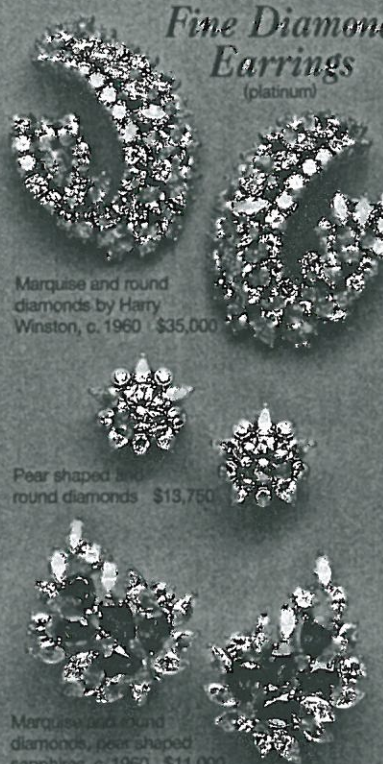
start turning it in the direction of the more balanced view." Federal health officials have estimated that every dollar spent on substance-abuse treatment saves the United States seven dollars that would be spent on prison, police, and courts. "I understand the desire to wring somebody's neck when you find out they are using drugs," McLellan told me. "If you imagine that addiction is the willful act of an antisocial person who needs to learn his lesson, you ought to lock him up. But we have tried that and I don't see many people learning their lesson."

Nonetheless, McLellan does not favor a Portuguese approach for the United States. "It's not an ideology with me," he said. "If you make any attractive commodity available at lower cost, you will have more users. Anything like legalizing drugs is preposterous—no less ridiculous than trying to lock up every offender." As evidence, he points to the epidemic of prescription-drug abuse. "These drugs are created, controlled, and distributed in the most careful possible way," he said. "It doesn't prevent abuse."

Many people argue that because nobody is forced to take drugs the burden of addiction should not be borne by society. "It is true that you don't have to start," McLellan said. "But once you do, and once you become an addict, then a certain series of biological changes take place and you are no longer able to simply stop." Nearly all addicts believe they can overcome their dependence without help. The overwhelming majority do not succeed. Research has shown that long-term drug abuse results in changes in the brain that persist after a person stops taking drugs. Often, the first time somebody abuses drugs, he experiences particularly intense feelings of pleasure. The brain has activated circuits that make him feel good, and that message is carried by the neurotransmitter dopamine. As the brain starts to become used to those pleasures and demand them, neurons, sensing a surplus, begin to make less dopamine. The chemical begins to lose its ability to activate the pleasure circuits. As that happens, people start to need drugs just to bring dopamine levels back to normal. To feel good, or to get high, requires more and more dopamine—which requires more and more drugs.

"Addiction is a disease you have for which there is no cure, and which fits the

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
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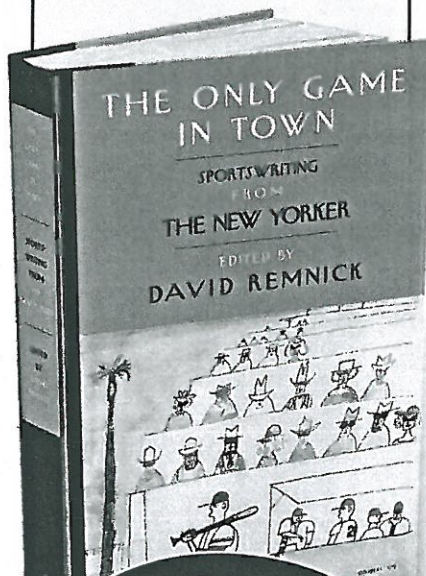
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model of chronic illness," McLellan said. "It will be a problem for the rest of your life. So you don't want a thirty-day program. It won't help. There are no thirty-day diabetes programs or twelve-visit hypertension clinics. The name for that is malpractice."

"Imagine we had an insurance program for diabetics along the lines of the programs we have had for substance abuse," he went on, noting the American inclination to treat chronic diseases after they have already caused irreparable harm. "Do you want to tell people who ate too many doughnuts that the American health-care system can't accommodate their illnesses? It is nobody's idea of the best use of a forty-two-thousand-dollar cell to house a person who has committed a minor crime or a parole violation associated with drug abuse. We all know that. And we are a better country than that."

Nobody can say with certainty whether Portugal's decriminalization program is helping persuade people to seek treatment, since those facilities became far more accessible just as the new law was passed. There are also questions about whether the benefits that Portugal has seen since 2001 reflect evolving patterns in European life and not the success of its program. Between 1998 and 2008, even though the number of addicts in Portugal enrolled in treatment jumped by sixty-three per cent—from twenty-three thousand to more than thirty-eight thousand—that could have potentially happened, critics say, without decriminalization or the expansion of clinics. "We know Portugal decriminalized drugs," said John Carnevale, a former director of planning, budget, and research at the Office of National Drug Control Policy under Presidents Reagan, Bush, and Clinton. "But we don't know the effects of that decriminalization."

People who favor policy reform say that Portugal's experiment shows, if nothing else, that decriminalization has permitted the Portuguese criminal-justice system to focus on more significant criminals and more dangerous crimes. But what works in a small seaside nation in Southern Europe is not necessarily

likely to work in a place that is larger, richer, and more heavily plagued by drug abuse. And, though about half of American adults believe that marijuana use should be legalized, there has been no serious discussion of making all drugs legal in the U.S.—or in any other country. Still, if prison were no longer a common penalty, there would clearly be more money available for treatment programs. And, if the Portuguese pattern held true, there would be fewer crimes to punish.

"It is never easy to draw a lesson from complex experience," Brendan Hughes, of the European Monitoring Centre for Drugs and Drug Addiction, in Lisbon, said. "But here we are in Lisbon thirteen years after the U.N. vowed to abolish illicit drugs in a decade. Has anybody here seen a drug-free world?" he said, noting that the annual United Nations World Drug Report usually runs to about three hundred pages. During the ten years following the 1998 declaration, when eradication was supposed to have been accomplished, the number of people using opiates throughout the world grew by thirty-five per cent; the number of cocaine users grew by nearly thirty per cent.

Expenditures, particularly those associated with the criminal prosecution of drug abusers, have also risen dramatically, as has the size of the correctional system in the United States. Since the late nineteen-eighties, most of that



growth can be attributed directly to drug abuse. The cost of running the state-prison systems has grown by four hundred per cent, and it is expected to grow even more rapidly in the next decade. According to the National Center on Addiction and Substance Abuse, those costs represent at least ten times the amount of money spent on treatment, prevention, and research. In Portugal, where drug control is funded in part by lottery receipts and money seized from traffickers, the ratio is the opposite: more than ninety per cent of costs are now devoted to treatment, not punishment.

Before I left his office, Hughes suggested that I take a close look at the 2009 World Drug Report, in part because it was issued by the same agency that, little more than a decade before, had called for

the worldwide elimination of drugs. It, too, expressed the need for a radical reassessment of the war on drugs.

Perhaps the strongest case against the current system of drug control has less to do with its costs, or even its effectiveness in reducing the availability of drugs, than with the violence and corruption associated with the black market. The prevailing approach has had the perverse effect of enriching criminals who kill and bribe their way from the countries where drugs are produced to the countries where drugs are consumed.

It is common in the U.S. to judge drug addiction morally rather than medically, and most policy flows from that approach. By now, however, the data showing that the war on drugs has failed are not in dispute; Obama Administration officials do not even use the phrase. Yet one has only to look at the American health-care system to be reminded that neither science nor evidence necessarily drives public-policy decisions. More money, per capita, and a greater percentage of income, is spent on health care in the United States than in any other nation. Nevertheless, the U.S. lags behind most of the rest of the Western world in health outcomes. If anything, the war on drugs is more complex; while it is clear that a purely punitive approach cannot succeed, it is far less obvious what might. While it would make no sense to base American policy on a decade-long Portuguese experiment, it seems even more foolish to ignore results that call so clearly for an increased focus on treatment, not jail time.

"You started by asking if I thought Portugal was on the right track," Hughes said. "That's not really a question I feel competent to answer. But if you look at enough of these reports, and study the data behind them, you can't help but feel that the country can't be on more of a wrong track than the rest of the world."

Night had begun to fall at the underpass near Lisbon's Praça de Espanha metro station. Two methadone vans, which cruise the city with the eerie regularity of ice-cream trucks, pulled into a cul-de-sac under the motorway. People were starting to gather for their daily doses. An outreach team arrives every day at 6 P.M. and stays for an hour and a

half, and often another van appears, carrying a doctor who is available to conduct checkups. "This is a strategic location," one of the physicians told me. "People need to take their methadone every day, and this place is near the metro and just off the roadway. If you are in a car, you can stop off without being conspicuous. If you need to get here on the metro, we are easy to find."

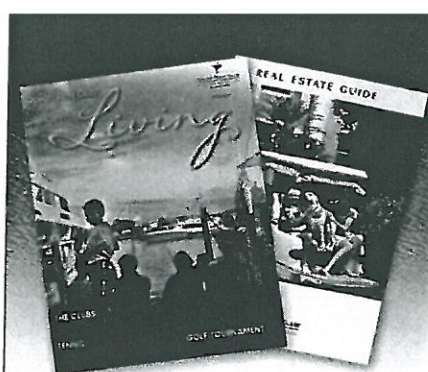
This van serves about six hundred people a day, and the economic status of the clients is not always easy to determine. Several people drove up in Fiats, but a couple of Mercedes sedans were also parked at the side of the road. A nurse sat with a laptop, a bottle of methadone, and a few hundred Dixie cups. Each person presented an I.D., and the nurse checked his or her dosage on a database, then gave the person a cup and a bottle of spring water to wash it down. Several cops walked by and smiled. The vans make five stops a day between 8:30 A.M. and 7:30 P.M. Everyone does his business briskly and walks away. There are no chats or knots of people who hang around at the methadone truck after work. It was a ghostly assembly, an effect no doubt enhanced by the failing light. You don't see a lot of smiles or laughter in lines like these. You don't sense a lot of promise, either. I told the doctor I was with that the entire program seemed strangely methodical.

He laughed and replied, "Thank you. We like methodical. It is better than frantic, or desperate, or dangerous. I admire these people exactly because they are methodical. They are trying. Every day, they get up and try. The main complaint about our approach, as far as I can tell, is that they ought to try for something harder. They all ought to stop using drugs."

"I think what's hard is to acknowledge reality," he continued. "These people are living in the real world. If they are boring, or live with narrowed vision or limited ambition, I am happy. I am proud. Because I know what the other side looks like. It is ugly. Perhaps it is a national failing, but I prefer moderate hope and some likelihood of success to the dream of perfection and the promise of failure." ♦

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Michael Specter talks about drug policy.



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