PANACEA OR PIPE DREAM: DOES PORTUGAL'S DRUG DECRIMINALIZATION POLICY TRANSLATE FOR HAWAII?

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FOREWORD

This report was prepared in response to House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016), which requested the Legislative Reference Bureau to analyze the potential impact on state government of decriminalizing certain offenses regarding the illegal possession of drugs.

The Bureau requested information from federal, state, county, and private entities and individuals to complete this study. The Bureau extends its appreciation to all those that generously provided information and assistance in the preparation of this report.

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January 2017

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EXECUTIVE SUMMARY

Introduction

The Legislative Reference Bureau (Bureau) prepared this report in response to House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127), which requested the Bureau to conduct a study on the potential impact on state government of decriminalizing the illegal possession of drugs for personal use in Hawaii. More specifically, HCR No. 127 requested that the study include:

(1) A survey of all existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes;

(2) A review of the current national drug policy of Portugal pertaining to the illegal possession of drugs for personal use, with a focus on the use of the policy as a potential model for the decriminalization of certain or all of the offenses identified under paragraph (1); and

(3) The potential impact on administrative and judicial systems of state government of decriminalizing certain or all of the offenses identified under paragraph (1), such that the conduct constituting an offense would constitute an administrative or civil violation rather than a criminal offense.

Decriminalization, Depenalization, Legalization, and the Focus of this Report

In preparing this report, our purpose was to address the Legislature's request that we focus on drug decriminalization's potential impact on state government in Hawaii, not the broader topic of drug policy, law, or enforcement. Accordingly, we did not explore other topics, such as arrest and incarceration levels for drug offenses in other states, racial disparities in enforcement, the ability of convicted persons to find employment, or drug legalization.

We note that decriminalizing illegal possession of drugs for personal use would entail the removal of all criminal penalties for such possession. However, administrative or civil penalties against offenders would remain in place, and the distribution of illicit drugs would still be a criminal offense. In contrast, legalization of the possession of drugs for personal use would involve the removal of all penalties for such possession, and would likely entail regulation of the legal production, sale, and use of drugs. Further, decriminalization is distinguishable from depenalization. While depenalization of the illegal possession of drugs for personal use would remove incarceration as a possible penalty for such possession, depenalization would still treat such offenses as criminal offenses, which would be reflected on an offender's criminal record.

The Portugal Experience

In our review of the current national drug policy of Portugal pertaining to the illegal possession of drugs for personal use, we must first note the historical impetus for that decriminalization. In 1999, authorities in Portugal approved a National Drug Strategy to fight against illicit drug use, largely in response to a rise in the use of heroin. The new national strategy proposed the decriminalization of the use and possession for use of drugs. Although statistical data suggest that few in Portugal were imprisoned at the time for illicit drug use or possession, the committee behind the new national strategy believed that drug users' contact with the judicial system and prison establishments, the creation of criminal records, and the social stigma attached to criminal offenses impeded the desired recovery and social reintegration of drug addicts.

However, it is important to emphasize that decriminalization was only part of the new national strategy, which included other components, such as prevention efforts, improvement in health care, the treatment of addicts, and additional funding for such efforts. The public health-focused strategy was consistent with the country's constitution, which guarantees all citizens the right to preventive, curative, and rehabilitative medical care. The strategy was also consistent with a 1979 law that established the National Health Service to provide free health care.

In 2000, Portugal passed its decriminalization law, Law No. 30/2000, which repealed existing criminal penalties against consuming, purchasing for consumption purposes, and possession for consumption purposes a ten-day supply of any drug among an exhaustive list of illicit drugs. The law did not specify what quantities of drugs would be considered ten-day supplies, but the application of a separate law establishes specific ten-day quantities for some, but not all, of these drugs. Those specific drugs and quantities include one gram of heroin; one gram of ecstasy; two grams of cocaine; twenty-five grams of marijuana; fifty grams of hashish; one-half gram of Delta-9-THC; and one gram of amphetamines.

Law No. 30/2000 referred to individuals who possess drugs in small quantities as "consumers," and not "offenders." The law also established new administrative tribunals called "dissuasion commissions" to take the place of courts in presiding over cases against alleged consumers. Each commission is composed of one expert in law and two other experts in medicine, psychology, social service work, or other allied professions.

When a consumer commits a drug offense, generally speaking, Portugal's law does not require the consumer to appear before a commission. In some cases, police may detain a consumer who cannot be identified until the commission disposes of the consumer's case. However, Portugal's law does not specifically authorize law enforcement or the commissions to order any consumer to appear before the commissions.

Commissions do not always impose penalties. Commissions are required to suspend proceedings against addicted consumers for first-time violations if they agree to undergo treatment. Commissions also have broad discretion to suspend proceedings against other addicted consumers

who agree to treatment. When penalties are appropriate, such penalties may include verbal warnings, suspensions of professional licenses, prohibitions on offenders from meeting with certain persons, restrictions on travel, and other non-criminal sanctions. However, addicted consumers may not be fined. In contrast, depending on the drug possessed, non-addicted consumers face possible fines from the equivalent of about $35 to a maximum equivalent to Portugal's national minimum monthly wage.

Evaluating the Portugal Experience

HCR No. 127 relied, in large part, on the findings of a 2009 report, which was published by the Cato Institute (hereafter "the Cato report"), that drug decriminalization in Portugal resulted in:

(1) No adverse effect on drug usage rates, which are among the lowest in the European Union, and particularly when compared with states with stringent criminalization regimes;

(2) A decrease in lifetime prevalence rates for drug use among various age groups, particularly for youths in the critical age groups of thirteen to fifteen year olds and sixteen to eighteen year olds;

(3) A dramatic decrease in drug-related deaths, including from sexually transmitted diseases; and

(4) Steady declines in drug trafficking convictions.

Our research and analysis led us to conclude that the situation in Portugal is not so straightforward.

While the level of illicit drug use in Portugal is generally lower than in other nations in Europe, *problem* drug use – that is, injecting drug use or long duration of use or regular use of opioids, cocaine, or amphetamines – is worse than or at least as bad as in other European nations. Available data do not conclusively prove, or disprove, that there has been no adverse effect on drug usage rates following the decriminalization of drug possession and use in Portugal. Notably, national prevalence statistics regarding drug use in Portugal before the enactment of Law No. 30/2000 are not available. Further, one source we reviewed questioned any attempt to attribute changes in patterns of drug use in Portugal solely or primarily to the country's decriminalization scheme, and asserted that there is no way to directly link national drug policies to prevalence of drug use. Factors other than laws that could affect drug use rates include the economy, religion, and culture. Notably, the Cato report does not appear to clearly recognize that Portugal's decriminalization of illicit drugs was only one component in Portugal's larger National Drug Strategy, which included prevention, treatment, and related funding. It is unclear what impact Portugal's Law No. 30/2000 would have had if the country had not attempted to implement the broader drug strategy.

It also appears that the Cato report may have been unduly selective in the use of data. The report focused on decreases in drug use among some age groups, while ignoring increases in other age groups. Its use of lifetime prevalence rates (which measure whether individuals have ever used an illicit drug at any point in their lifetimes) may be less reliable in examining drug trends than statistics that examine individuals' use of drugs within shorter amounts of time. Available data do not clearly establish that Law No. 30/2000 led to a dramatic decrease in drug-related deaths. Statistics that purportedly show drug-related deaths may be based on incorrect assumptions that the presence of illicit drugs in a deceased person's body indicate that drug use actually caused that person's death. While drug trafficking convictions have declined in Portugal, such a decline may not have been the result of a decrease in actual drug trafficking, since arrests for trafficking have not declined. One source we reviewed suggested that, because few people were incarcerated for mere drug use or possession before Law No. 30/2000, courts simply extended similar leniency to drug users whose behavior remained criminal even after the passage of that law. The source also suggested that drug traffickers may have adjusted the transportation of their supplies so that quantities of drugs in their possession at any given time would not exceed a ten-day supply.

HCR No. 127 also noted the Cato report's assertion that money saved on drug enforcement allowed for increased resources for drug treatment programs. However, the Cato report does not provide any information that demonstrates that resources were redirected for such treatment, nor does it specify the costs of implementing Portugal's National Drug Strategy (such as the costs of administering dissuasion commissions).

Portugal's Policy v. Hawaii's Legal Framework

Portugal's national government can implement laws that apply throughout its jurisdiction. In contrast, Hawaii is one state among many in the United States of America. Both federal law and Hawaii law prohibit the possession of illicit drugs for personal use. Even if Hawaii were to repeal its laws regarding such possession, residents who possess illicit drugs might still face prosecution under federal law. While the use of marijuana is legal for medical purposes under Hawaii state law (as well as under the laws of twenty-seven other states and the District of Columbia), such use remains illegal under federal law. The current lack of federal prosecution of medical marijuana users in Hawaii is solely the result of the discretion exercised by the United States Department of Justice to prioritize its caseload. Following the installation of the new presidential administration in 2017, it is possible that the Department of Justice will adjust its priorities.

Portugal's law decriminalized the possession of all illicit drugs for personal consumption. In contrast, the Legislature's request to the Bureau in HCR No. 127, did not include exploring the possibility of decriminalizing "dangerous drugs," which include "hard drugs" such as heroin, cocaine, and methamphetamine. Instead, the request was limited to surveying the existing criminal drug offenses in Hawaii that are class C felony or lower offenses and pertain to the illegal

possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes. These relevant drug offenses are:

- Section 712-1246, Hawaii Revised Statutes (HRS), Promoting a harmful drug in the third degree, a class C felony that carries a maximum prison term of five years and a maximum fine of $10,000;
- Section 712-1246.5, HRS, Promoting a harmful drug in the third degree, a misdemeanor that carries a maximum jail term of one year and a maximum fine of $2,000;
- Section 712-1247, HRS, Promoting a detrimental drug in the first degree, a class C felony that carries a maximum prison term of five years and a maximum fine of $10,000;
- Section 712-1248, HRS, Promoting a detrimental drug in the second degree, a misdemeanor that carries a maximum jail term of one year and a maximum fine of $2,000; and
- Section 712-1249, HRS, Promoting a detrimental drug in the third degree, a petty misdemeanor that carries a maximum jail term of one year and a maximum fine of $1,000.

Notably, while Portugal's constitution guarantees citizens the right to medical care, the constitutions of the United States and Hawaii do not provide a similar guarantee. Thus, legally speaking, treatment for drug use is a relatively lower priority in Hawaii than it is in Portugal where it was a significant component of the country's overall strategy. Nevertheless, treatment for drug use is already a possible alternative to incarceration in Hawaii for some offenders, including offenders whose crime is the possession of illicit drugs. Under certain circumstances, offenders may be placed on conditional discharge or probation, which requires the offender to comply with conditions, including conditions to receive drug treatment, in order to avoid incarceration. In some cases, an offender may even have his or her record expunged. Another alternative is provided in drug court programs, which involve intensive drug treatment and regular monitoring through the judicial system. However, due to the costly nature of treatment efforts employed in drug court programs, those programs only admit a limited number of offenders at a time. Further, individuals who have committed certain felonies in the past are precluded by law from participating in drug court programs.

Current Baseline Information is Insufficient to Estimate the Potential Impacts of Decriminalization

In our attempt to estimate the potential impact on administrative and judicial systems of state government of decriminalizing relevant drug offenses, we faced a barrier in the form of a lack of baseline information. While we reviewed multiple published reports from several governmental agencies and corresponded extensively with those agencies, we were not able to

obtain a complete picture of the effects that drug use and drug laws currently have on administrative and judicial systems of state government. This limitation affects our ability to analyze how changes in those drug laws might affect those systems of state government in the future.

We also sought information on drug use trends, treatment, and treatment expenditures. However, we faced challenges in collecting and comparing data regarding drug use in Portugal, the United States, and Hawaii. Challenges included the different age groups researched and surveyed in each jurisdiction, a lack of annual reporting on drug use in Portugal, and incongruent reporting on use estimates of specific drugs. According to the Hawaii High Intensity Drug Trafficking Area Investigative Support Center, the drugs that pose the greatest threat to Hawaii are methamphetamine and marijuana. Generally speaking, it appears that Hawaii and the United States have higher instances of any illicit drug use and marijuana use than does Portugal, although Portugal does have a significant number of people who have used marijuana. However, we were unable to accurately compare or quantify the drug use of the two drugs that pose the greatest threat in each respective jurisdiction, heroin (in Portugal) and methamphetamine (in Hawaii), as we could not locate annual, Hawaii-specific use prevalence estimates for those drugs.

In Hawaii, various state and county agencies spend funds on drug treatment. The primary source of public funds is the Alcohol and Drug Abuse Division (ADAD) of the Department of Health. That agency's statistics show that admissions for treatment for methamphetamine use comprised more than half of all ADAD-funded admissions in fiscal year 2015-2016. The average per-person expenditure for ADAD-funded treatment for all substances was about $4,000 per year, with some variation, from 2011-2012 to 2015-2016. However, treatment expenditures vary based on factors such as drugs for which treatment is provided and the needs of the individuals treated. For example, we calculated, based on available data, that during fiscal year 2014-2015, the Judiciary was prepared to spend $1,306.26 on each person that it referred to treatment to a Judiciary-contracted substance-use treatment provider. Based on our calculations, treatment expenditures for Medicaid clients of the Department of Human Services (DHS) have varied from $63 to $494 per person, depending on the year in which the individual was treated as well as the substance for which the individual was treated. On the other hand, treatment expenditures for Social Services Division clients of DHS appear to have been as high as $29,912 per person in some years. It also appears that the Corrections Division, Department of Public Safety expended an average of $3,959 per inmate to treat 994 inmates in 2015-2016.

The Bureau cannot conclusively determine whether the amount of available funding is adequate for current treatment needs. Further, given the variation in treatment expenditures, we cannot determine how demand for treatment might increase after decriminalization, and we cannot predict whether the Legislature would need to increase funding for treatment or by how much, given the shortage of qualified treatment personnel. We also lack sufficient information to predict what specific impact decriminalization might have on the need to fund drug prevention efforts.

We sought information on the efforts to enforce the relevant drug offenses, and expenditures for those efforts. Available statistics from police departments and the Hawaii Criminal Justice Data Center (HCJDC) suggest that few individuals are arrested and face charges

in court *solely* for the commission of a relevant offense within the scope of HCR No. 127. For example, according to HCJDC data, only three hundred seventy-nine arrests were made *solely* for a relevant offense in 2015. Court cases were only filed against two hundred nine individuals, and only one hundred eight of those individuals were convicted. Of those convicted, only sixty-nine were incarcerated. However, we found a significant problem with this data: arrest statistics from HCJDC showed consistently different numbers than arrest statistics from county police, and we were unable to determine from those agencies the reason for the discrepancies.

Further, it is difficult to determine what are the current expenditures relating to enforcement of the relevant offenses within the scope of HCR No. 127. Police departments and the Judiciary could not isolate expenditures related to drug offenses from expenditures related to other offenses. We also received no statistical information from county prosecutors about their enforcement efforts. One county prosecutor's office did not respond at all to our requests for information. Another prosecutor's office responded that it did not have the resources to provide information, given the limitations of its case management system. The Office of the Public Defender, which defends most accused indigent criminal offenders, provided a similar response to our request for information about its defense efforts in drug possession cases.

As to incarceration expenditures, the Corrections Division, Department of Public Safety estimated that the State expended $140 per day to house each incarcerated inmate during fiscal year 2015-2016. However, since it was unclear exactly how the Division arrived at this estimate, the estimate may not be reliable in helping to determine how much incarceration expenditures would be reduced as a result of any decriminalization scheme.

The Uncertainty Regarding the Legislature's Preferred Decriminalization Scheme Makes it Difficult to Estimate the Potential Impacts of Decriminalization

Even if we had sufficient statistical data regarding the use and treatment of illicit drugs and the enforcement of drug possession offenses, our ability to estimate the potential impact on administrative and judicial systems of state government of decriminalizing relevant drug offenses is hindered by the lack of specificity regarding the scope of any decriminalization scheme to be implemented in Hawaii.

There are many factors to consider in designing a decriminalization scheme. One factor is the determination of what drugs to decriminalize and in what quantities. It is not clear whether the State would decriminalize the possession of broad range of illicit drugs for personal use, or just marijuana. As noted previously, current federal law prohibits possession of the illicit drugs to which the relevant drug offenses apply, and the removal of criminal penalties under state law would not change federal law. Some states have decriminalized the possession of small quantities of marijuana. However, if Hawaii were to follow suit, it is not clear whether the Legislature would want to incur the expense of establishing Portugal-style dissuasion commissions just for the purpose of processing cases involving a single drug. It is also unclear what civil penalties should be imposed on violators, and whether violators should still be subject to arrest and detention to

ensure that they appear before the tribunals presiding over their cases. Further, the need for a broader health-based drug strategy may vary depending upon the type of drugs the State decriminalizes. If the State decides not to decriminalize methamphetamine, currently Hawaii's greatest drug threat, because it is a dangerous drug, then the need for treatment might not be as urgent in the eyes of some policymakers.

Other Decriminalization Approaches

In 2009, Mexico enacted a law to decriminalize the possession of small quantities of a wide range of illicit drugs. Unlike Portugal's decriminalization law, Mexico's law kept proceedings of decriminalized offenses within the court system. Mexico's law also allows alleged third-time offenders to be detained until released by the courts. Most notably, due to a lack of treatment efforts and treatment facilities, drug users are not receiving the medical help they need.

In the United States, laws have been enacted to decriminalize marijuana possession to some degree in nine states (Delaware, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Ohio, Rhode Island, and Vermont), as well as depenalize such possession in four states (Connecticut, Missouri, New York, and North Carolina). Missouri's law took effect on January 1, 2017. The foregoing list does not include the eight states (Alaska, California, Colorado, Maine, Massachusetts, Nevada, Oregon, and Washington) that, along with the District of Columbia, have enacted laws to legalize the possession of marijuana to some degree. Among the states that have decriminalized or depenalized such possession, the maximum quantity of the drug that is decriminalized varies, as does the maximum fine for such possession. The most common maximum quantity is one ounce, while the most common maximum penalty is a $100 fine.

While it does not appear that the decriminalization of small amounts of marijuana has led to significant increases of drug use in the United States, it is not clear if the same results would occur in the wake of the decriminalization of other illicit drugs, such as methamphetamine. To date, no other state has decriminalized other illicit drugs.

Our Recommendation

In light of the limitations we faced in obtaining relevant statistical information from governmental agencies regarding drug use and the enforcement of drug laws, funding for improvements in the information systems of governmental agencies may be necessary for policymakers to obtain the data required to make informed decisions on decriminalization. Such improvements may assist in obtaining drug use and treatment data from the Alcohol and Drug Abuse Division of the Department of Health; the Department of Human Services; the Judiciary; and the various counties. Improvements may also be necessary to obtain more consistent and reliable information on enforcement efforts from the Hawaii Criminal Justice Data Center; the county police departments; county prosecutors; the Office of the Public Defender; the Judiciary; and the Department of Public Safety.

Factors to Consider for the Legislature's Preferred Decriminalization Scheme

As noted above, the uncertainty regarding the Legislature's preferred decriminalization scheme makes it difficult to estimate the potential impacts of decriminalization. Therefore, in designing a decriminalization scheme, policymakers may wish to consider:

(1) Whether there is a need to implement a broader health-based strategy to reduce drug use;

(2) Which of the illicit drugs, and what quantities of those drugs, should be decriminalized;

(3) Whether, and what, civil penalties should be established;

(4) Whether administrative or judicial tribunals are better suited for proceedings to enforce decriminalized drug offenses; and

(5) Whether violators would remain subject to arrest and detention.

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Chapter 1

INTRODUCTION

The Legislative Reference Bureau (Bureau) prepared this report as requested by the Legislature in House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127).[1]

GENESIS OF THIS REPORT

The Legislature's request to the Bureau rests on a number of assertions made in HCR No. 127 regarding the scope, nature, and severity of the drug problem in the United States; the perceived trend by government agencies, including the courts, toward addressing the illicit use of drugs as a public health problem, rather than a law enforcement one; a change by federal, state, and local governments in the legal approach to marijuana, including decriminalization, legalization, medical use, and related enforcement priorities; and the decision by Portugal in 2000 to address its drug problem by decriminalizing the use and possession for use of illicit drugs in favor of an administrative scheme that relies on assessment, treatment, and non-criminal sanctions to deter users from violating the prohibition on drugs.

In particular, the HCR No. 127 relies on a white paper published in 2009 by the Cato Institute, which championed Portugal's drug decriminalization scheme as a "resounding success."[2] According to HCR No. 127, the Cato Institute's white paper found that drug decriminalization in Portugal resulted in:

- No adverse effect on drug usage rates;
- A decrease in lifetime prevalence rates for drug use among various age groups;
- A dramatic decrease in drug-related deaths;
- Steady declines in drug trafficking convictions; and
- Monetary savings on drug enforcement efforts, which in turn allowed for increased resources for drug treatment programs.

Based on the foregoing assertions, HCR No. 127 presented a hypothesis that Portugal's drug decriminalization system provides a potential model for more effectively managing drug-related problems in the United States. Pursuant to the Legislature's request, the Bureau sought to test this hypothesis with factual and legal research and analysis of the information generated by that research.

THE SCOPE OF THIS REPORT

By its adoption of HCR No. 127, the Legislature formally requested the Bureau to conduct a study on the potential impact on state government of decriminalizing the illegal possession of drugs for personal use in Hawaii. More specifically, HCR No. 127 requested the study to include:

(1) A survey of all existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes;

(2) A review of the current national drug policy of Portugal pertaining to the illegal possession of drugs for personal use, with a focus on the use of the policy as a potential model for the decriminalization of certain or all of the offenses identified under paragraph (1); and

(3) The potential impact on administrative and judicial systems of state government of decriminalizing certain or all of the offenses identified under paragraph (1), such that the conduct constituting an offense would constitute an administrative or civil violation rather than a criminal offense.

HCR No. 127 also requested the Bureau to submit a written report of its findings and recommendations, including any proposed legislation, to the Legislature.

OUR APPROACH TO THIS REPORT

Following the Legislature's adoption of HCR No. 127, the Bureau began its study by determining the specific scope of the Legislature's request. We then read and considered the written testimony submitted to the standing committees that heard HCR No. 127, and the sources cited both by HCR No. 127 and the testimony, especially the Cato Institute's 2009 white paper. We did not automatically assume the truth of the assertions made by the HCR No. 127, the testimony, or the source materials. Instead, we conducted independent research for purpose of conducting an impartial study.

Our research examined the Hawaii Revised Statutes and information from books, peer-reviewed articles, government publications (including those from Portugal, when available in English) and other publicly available resources. Our goal was to obtain information about the legal frameworks of Portugal and Hawaii, especially as it related to drug possession offenses; drug use and treatment statistics in Portugal and Hawaii; the enforcement of drug laws in Portugal and Hawaii; and decriminalization efforts in other jurisdictions. We also submitted written requests to multiple state, county, and federal agencies to obtain factual information regarding such matters as drug arrests, prosecutions, court dispositions, treatment, and incarcerations.[3] Not all of the agencies responded to our requests, and some agencies that did respond could not provide information, or could not provide everything we requested. The Bureau was still receiving

information even as 2016 drew to a close. While we did our best to capture that information in this report, the six-month time frame in which we were required to prepare the report did not allow for the depth of analysis we would have preferred.

ORGANIZATION OF THE REPORT

The remaining chapters of this report provide the following:

(1) Chapter 2 defines decriminalization and articulates the scope of the report;

(2) Chapter 3 explores the historical impetus behind Portugal's decriminalization effort; Portugal's broader health-based strategy to fight drug use; the empirical limitations on declaring Portugal's drug decriminalization effort a "resounding success;" and why drug decriminalization *in the absence of a broader health-based strategy* might not necessarily succeed in the terms described in HCR No. 127;

(3) Chapter 4 describes the legal framework within which decriminalization might be undertaken in Hawaii, and how that framework may limit Hawaii's options regarding decriminalization; a survey of the drug offenses in Hawaii that fall within the scope of HCR No. 127; and existing alternatives to incarceration that may presently be imposed in Hawaii;

(4) Chapter 5 explains how limitations on the collection and extraction of data and uncertainty regarding what specific decriminalization scheme might ultimately be considered prevented us from providing an empirically-based estimate of the potential impact that decriminalizing the illegal possession of drugs for personal use might have on the administrative and judicial systems of state government in Hawaii;

(5) Chapter 6 explores how some countries impose non-criminal penalties for an array of illicit drugs, as well as how other states in the United States have removed criminal penalties for the possession of marijuana; and

(6) Chapter 7 discusses salient points regarding factual information that we found; analyses based on that information; one recommendation regarding data collection; and factors that policymakers in Hawaii may wish to consider in constructing a drug decriminalization scheme.

ENDNOTES

1. House Concurrent Resolution No. 127 attached as Appendix A.

2. GLENN GREENWALD, CATO INSTITUTE, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES 1 (2009), http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf.

3. A list of agencies from which the Bureau sought information is attached as Appendix F.

Chapter 2

DECRIMINALIZATION, DEPENALIZATION, LEGALIZATION, AND THE FOCUS OF THIS REPORT

Drug laws and their enforcement have been the subject of much discussion, debate, and activism in the United States and around the world. In Hawaii, House Concurrent Resolution No. 127 H.D. 1 S.D. 1 (2016) (hereinafter HCR No. 127) requested, in part, that the Legislative Reference Bureau analyze "the potential impact on administrative and judicial systems of state government of decriminalizing" certain offenses involving possession of drugs for personal use in Hawaii. This request not only defines the scope of what is *included* in this report, but also what is *excluded* from it. While policymaking regarding drug possession and use often encompasses issues such as arrest and incarceration levels for drug offenses in other jurisdictions, racial disparities in enforcement, the ability of convicted persons to find employment, and even drug legalization, these issues are excluded from the focus of this report.

DECRIMINALIZATION, DEPENALIZATION, AND LEGALIZATION DEFINED

Clarity of terms is also necessary to understand the focus of this report. "Decriminalization" is not the same as "legalization," and the two terms should not be confused or used interchangeably. As one observer has commented:

> Portugal's 2001 decriminalization law did not legalize drugs as is often loosely suggested. The law did not alter the criminal penalty prohibiting the production, distribution, and sale of drugs, nor did it permit and regulate use. Rather, Portugal *decriminalized* drug use, which, as defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), entailed the removal of all criminal penalties' [sic] from acts relating to drug demand: acts of acquisition, possession, and consumption. Portugal's reform thus changed the nature of the sanctions imposed for personal possession and consumption of drugs from criminal to administrative. To obtain drugs, however, the user must still depend on illicit markets. Legalization, in contrast to decriminalization, involves the enactment of laws that allow and provide for the state regulation of the production, sale, and use of drugs.[1]

Further, "decriminalization" of illicit drug possession or use is not necessarily synonymous with "depenalization." A report published by EMCDDA proposed "tentative definitions" of these terms:

> According to our convention ["decriminalization"] comprises removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within the framework of the criminal law (elimination of the notion of a criminal offence). This may be reflected either by the imposition of sanctions of a different kind (administrative sanctions without the establishment of a police record – even if certain administrative measures are included in

> the police record in some countries, such as France), or the abolition of all sanctions. Other (non-criminal) laws can then regulate the conduct or activity that has been [decriminalized.]
>
> According to our convention ["depenalization"] means relaxation of the penal sanction provided for by law. In the case of drugs, and cannabis [also known as marijuana] in particular, ["denpenalization"] generally signifies the elimination of custodial penalties. Prohibition remains the rule, but imprisonment is no longer provided for, even if other penal sanctions may be retained (fines, establishment of a police record, or other penal sanctions).[2]

THE BROADER DEBATE ON DRUG LAWS V. THE NARROWER FOCUS OF THIS REPORT

Some of the debate surrounding drug laws has revolved around the question of drug legalization. For example, the Cato Institute[3] has asserted[4] (based on various estimates[5]) that if all states and the federal government were to *simultaneously* legalize all illicit drugs[6] – including trafficking in those drugs – and if those drugs were taxed at rates comparable to those imposed on alcohol, then governmental expenditures would decrease and tax revenues would increase, each by billions of dollars in the aggregate.[7] The Global Commission on Drug Policy, asserting that millions of people around the world use drugs without causing harm to others and that criminalizing people who use drugs has been ineffective and harmful,[8] has advocated the legalization of *some* drug offenses and called for the worldwide abolition of "all civil and criminal penalties" for the possession of drugs for personal use.[9] Some states in the United States, such as Colorado, have partially responded to calls for drug legalization by taking the narrower step of legalizing, to some extent, the possession and sale of marijuana, although the long-term effects of legalization are unclear.[10]

Human Rights Watch and the American Civil Liberties Union have raised awareness about related topics. These organizations have asserted that on a nationwide level, drug prohibitions: have led to mass arrests and incarcerations; are enforced in a racially disparate manner; cause financial hardship to defendants; harm defendants' employment prospects; and make some convicted individuals ineligible for public assistance.[11] All of these issues may be valid subjects of discussion in the broader debate regarding drug laws. However, HCR No. 127 requested that the Bureau analyze "the potential impact on administrative and judicial systems of state government of decriminalizing" certain offenses involving possession of certain drugs for personal use in Hawaii, which is the focus of this report.

Therefore, this report does not explore the *legalization* of personal use of illicit drugs, much less the trafficking of them. Further, the report also does not attempt to evaluate how decriminalization would impact the operations of the State as a whole, or of the counties, nor can it properly explore the complex topic of what impact decriminalization would have on the lives of accused and convicted drug offenders.

ENDNOTES

1. Hannah Laqueur, Comment, *Uses and Abuses of Drug Decriminalization in Portugal*, 40 LAW & SOC. INQUIRY 746, 747 (2015) (citations omitted).
2. EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION, ILLICIT DRUG USE IN THE EU: LEGISLATIVE APPROACHES 12 (2005), http://www.emcdda.europa.eu/system/files/publications/367/TP_IllicitEN_64393.pdf.
3. The Cato Institute regularly releases white papers that are intended to influence policy decisions, and generally espouses a libertarian political philosophy. *See infra* Chapter 3, note 77 and accompanying text.
4. JEFFREY A. MIRON & KATHERINE WALDOCK, CATO INSTITUTE, THE BUDGETARY IMPACT OF ENDING DRUG PROHIBITION 2 (2010), https://object.cato.org/sites/cato.org/files/pubs/pdf/DrugProhibitionWP.pdf (updating Jeffrey A. Miron, The Budgetary Implications of Drug Prohibition (Feb. 2010) (unpublished paper, Harvard University) (on file with author), http://scholar.harvard.edu/files/miron/files/budget_2010_final_0.pdf). This publication should not be confused with the Cato Institute's 2009 publication referenced in HCR No. 127, which is GLENN GREENWALD, CATO INSTITUTE, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES (2009), http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf. For a discussion of the 2009 publication, see Chapter 3 of this report.
5. For example, Miron and Waldock state that their paper "estimates the percentage of state and local arrests for drug violations and multiplies this percentage by the state and local budget for police" and likewise "estimates the percentage of state and local incarcerations for drug violations and multiplies this percentage by the state and local budget for prisons." MIRON & WALDOCK, *supra* note 4, at 2.
6. Miron and Waldock concede that such simultaneous legalization is "not currently on the table, nor is it likely to occur in the near future." *Id*.
7. *Id*. at 1.
8. GLOBAL COMMISSION ON DRUG POLICY, ADVANCING DRUG POLICY REFORM: A NEW APPROACH TO DECRIMINALIZATION 29 (2016). http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf.
9. *Id*. at 11.
10. 4 ROCKY MOUNTAIN HIGH INTENSITY DRUG TRAFFICKING AREA, THE LEGALIZATION OF MARIJUANA IN COLORADO: THE IMPACT 11 (2016), http://www.rmhidta.org/html/2016%20FINAL%20Legalization%20of%20Marijuana%20in%20Colorado%20The%20Impact.pdf.
11. HUMAN RIGHTS WATCH AND AMERICAN CIVIL LIBERTIES UNION, EVERY 25 SECONDS: THE HUMAN TOLL OF CRIMINALIZING DRUG USE IN THE UNITED STATES 2-12 (2016), https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web.pdf.

Chapter 3

THE PORTUGAL EXPERIENCE

House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127), contemplates using Portugal's Law No. 30/2000, which decriminalized the use or possession of small amounts of illicit drugs for personal use, as a potential model for Hawaii. Portugal's law, which has been the focus of much national and international attention, eliminated imprisonment as a penalty for such use and possession and replaced it with administrative fines and other penalties. An oft-cited look at Portugal's law is a white paper from the Cato Institute "Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies."[1] The white paper recommended the decriminalization of illicit drugs elsewhere, based on its findings that decriminalization in Portugal (1) saved resources that would have otherwise been used to prosecute drug users and (2) either decreased or had a neutral impact on drug usage rates.[2]

However, we conducted our own review of Portugal's law, the context in which it was adopted, and the strategy of which it was a part. We also reviewed the Cato report and the analysis of it by agencies and scholars. As will be explained in this chapter, it is abundantly clear that decriminalization in Portugal did not take place in a vacuum. Rather, decriminalization was implemented in Portugal as a part of a broader strategy, which included prevention and treatment, among other elements, in that nation's effort to reduce illicit drug use. While there is disagreement as to whether and to what extent Portugal's strategy has been effective in this regard, the example of Portugal *cannot* support the assertions that decriminalization *alone* (1) has a neutral or positive impact on drug usage rates, (2) automatically reduces enforcement costs, and (3) automatically frees up funding for the treatment of drug users.

PORTUGAL PRE-DECRIMINALIZATION

Portugal's geographic location on the southwestern border of Europe has made it a "gateway" of sorts for the trafficking of illicit drugs, such as cocaine from Brazil, heroin from Spain, and marijuana from Angola.[3] While the level of illicit drug use in Portugal is generally lower than in other European nations, *problem* drug use and drug-related harms are as bad as or worse than in other European nations.[4]

In 1926, Portugal enacted a law that prohibited drug trafficking, but did not address illicit drug consumption.[5] The possession and use of illicit drugs did not become a criminal offense in Portugal until 1970.[6] In 1974, the totalitarian regime that had ruled Portugal since 1926 fell[7] and, with liberation, came a new constitution in 1976.[8] Under its constitution, Portugal is a unitary national state,[9] unlike Hawaii, which is only one state within a federal system. Further, Portugal's constitution charges the government with "[g]uaranteeing access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care."[10] While Portugal's new government retained the criminal prohibition against drug use and possession, a 1983 decree[11] authorized the suspension of punishment for some drug offenses if

the convicted person agreed to participate in treatment for drug use.[12] In 1993, Decree Law No. 15/93 also retained criminal sanctions for the use or possession for personal use of certain illicit drugs, but allowed for the suspension of punishment, including the suspension of imprisonment, for drug-dependent individuals who voluntarily agreed to "treatment or admission to an appropriate establishment."[13]

Statistical information on illicit drug use in Portugal before 2001 is somewhat limited. For example, the national prevalence estimates for problem drug use in Portugal, unlike for other European countries, were noticeably absent from the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA[14]) 2000 Annual Report on the State of the Drugs Problem in the European Union.[15] However, available data show that Portugal has had its share of illicit drug issues. For example, between 1985 and 2000, the number of police reports for all drug law offenses rose nearly ten-fold from 1,471 to 14,276.[16] From 1995 to 1999, the number of arrests for the mere *use* of illicit drugs more than doubled from about 3,000 to about 8,000.[17] It has been estimated that one percent of the Portuguese people were addicted to heroin.[18] By 1998, forty to sixty percent of drug-related arrests in Portugal involved heroin.[19] In the 1990s, injection drug users in Portugal increasingly developed AIDS, and at a higher rate than in most European nations.[20] Based on data collected from 1996 to 1999, over twenty-five percent of drug injectors in Portugal were infected with HIV, the virus that causes AIDS.[21] By 1999, drug-related AIDS cases in Portugal numbered approximately sixty per million.[22] Rates of Hepatitis B and C also soared.[23]

Notably, however, individuals punished with incarceration for *possession or use of* illicit drugs did not comprise a significant portion of Portugal's prison population at the end of each year from 1993 to 2000, as shown in Table 3-1 in Appendix B.[24] The table separates individuals who were incarcerated as consumers of illicit drugs, those who were incarcerated for all drug offenses (including trafficking), and the prison population as a whole. These years and numbers do not represent the total number of people incarcerated over the course of a year, nor do they represent the population on any given day of the year. However, the data suggest that drug consumers were rarely punished with lengthy terms of incarceration for the mere use or possession of small quantities of illicit drugs.

In October of 1993, Portugal responded to increasing injected drug use, and the associated spread of HIV through such drug use, by starting a national syringe exchange program.[25] Between 1997 and 1999, several laws were also enacted to improve treatment for drug addicts and help them reintegrate into society.[26]

NATIONAL DRUG STRATEGY

Seeking a new course of action to address the growing national drug problem, Portugal's Council of Ministers in 1999 adopted a resolution approving a "National Drug Strategy." The strategy was set forth in a report produced by the National Drug Strategy Committee[27] and recognized that use of illicit drugs had increased in Portugal.[28] It noted that heroin was the drug

that had "the most damaging social and health effects," and that hashish was "the most used illicit drug . . . despite the substantial reduction in the quantity of this drug seized in 1998."[29]

The National Drug Strategy was based on thirteen strategic components, which emphasized:

- International cooperation;
- Decriminalization of the use of drugs;
- Prevention efforts, particularly among young people;
- Improvement of the health care network for drug addicts;
- Harm reduction policies, including syringe and needle exchange programs, and substitution drugs;
- Reintegration of drug addicts;
- Access to treatment and harm reduction for imprisoned drug addicts;
- The voluntary treatment of addicts as an alternative to prison or other penalties;
- Scientific research;
- The establishment of methodologies and procedures for evaluation of public and private initiatives in the field of drugs and drug addiction;
- Simplifying interdepartmental coordination;
- Reinforcing attempts against trafficking and money laundering; and
- Doubling the public investment over a five-year period to finance the National Drug Strategy, especially in the areas of prevention, research, and training.[30]

With regard to decriminalization, the Committee noted that it recommended decriminalizing only the private use of illicit drugs, and not the sale of such drugs.[31] With regard to treatment, the report stated: "The guarantee of access to treatment for all drug addicts who seek treatment is an *absolute priority* of this national drug strategy."[32] This recommendation was consistent with previously-established law. In 1979, Portugal had enacted a law that established the National Health Service to provide health care free of charge.[33] (The National Health Service is primarily funded through general taxation.[34])

Thus, while the decriminalization of the use and possession for personal use of certain drugs was an important component of Portugal's strategy, it was not the only component and not necessarily even the most important one.

DECRIMINALIZATION

Given the fact that few drug consumers were actually incarcerated for mere drug consumption before the enactment of Law No. 30/2000, decriminalization arguably could be described as symbolic.[35] However, the National Drug Strategy report stated in part:

> [I]n many cases, contact with the judicial system and, sometimes, with prison establishments themselves, together with the corresponding social stigma and, in certain cases, the subsequent criminal record, produce harmful effects on the desired recovery and, above all, the reintegration of drug addicts.[36]

As part of the National Drug Strategy, Portugal's Law No. 30/2000 repealed[37] existing criminal penalties imposed by Decree-Law No. 15/93 against consuming, purchasing for consumption purposes, and possession for consumption purposes certain drugs listed in Decree-Law No. 15/93.[38] The "decriminalization . . . enter[ed] into force throughout Portuguese territory on July 1, 2001."[39] However, Law No. 30/2000 retained Decree-Law No. 15/93's existing criminal penalties for cultivation of illicit drugs for personal consumption.[40] Furthermore, Law No. 30/2000 did not repeal existing criminal penalties against drug trafficking.[41]

Law No. 30/2000 "defines the legal framework applicable to the consumption of narcotics and psychotropic substances, together with the medical and social welfare of the consumers of such substances without medical prescription."[42] The law itself repeatedly refers to individuals who violate the law as "consumers," rather than "violators" or "offenders." In place of the repealed criminal offenses, Law No. 30/2000 states that "[t]he consumption, acquisition and possession for own [sic] consumption of plants, substances or preparations listed in [tables I to IV attached to Decree-Law No. 15/93] constitute an administrative offence."[43] However, there is a quantitative limit on such consumption, since "[f]or the purposes of this law, the acquisition and possession for own [sic] use of the substances referred to in the preceding paragraph shall not exceed the quantity required for an average individual consumption during a period of 10 days."[44] Law No. 30/2000 does not specify this quantity for any illicit drug. Instead, a separate law, Portaria No. 94/96,[45] specifies a daily quantity for certain illicit substances: Heroin, 0.1 grams; Ecstasy, 0.1 grams; Cocaine, 0.2 grams; Marijuana, 2.5 grams; Hashish, 0.5 grams; Delta-9-THC, 0.05 grams; and Amphetamines, 0.1 grams.

DISSUASION COMMISSION PROCESS

Drug consumption offenses are processed and penalties are applied by a commission referred to as a "commission for the dissuasion of drug addiction."[46] There are many of these commissions across Portugal, and each is composed of three persons,[47] as follows:

> One of the members of the commission shall be a legal expert appointed by the Ministry of Justice, and the Minister of Health and the member of the Government responsible for

> the coordination of the drugs and drug addiction policies shall appoint the other two, who shall be chosen from doctors, psychologists, sociologists, social services workers or others with appropriate professional expertise in the field of drug addiction . . . .[48]

Fines and other penalties imposed by these commissions are non-criminal in nature. Law No. 30/2000 requires commissions to set penalties with the goal of preventing the consumption of narcotics and psychotropic substances. Possible penalties that may be imposed upon any consumer include:

(1) Verbal warnings;

(2) Suspension of professional licenses;

(3) Prohibitions on visiting certain places;

(4) Prohibitions on meeting with certain persons;

(5) Restrictions on the possession of firearms;

(6) Restrictions on travel; and

(7) Seizures of any property belonging to the consumer that represents a risk to the consumer or to the community or that encourages commission of a crime or other offense.

Commissions may not impose fines upon addicted consumers, but the law authorizes a range of fines against nonaddicted consumers. Generally, consumers who possess drugs like heroin and methamphetamine are subject to higher fines.[49] Depending on the type of drug possessed, fines may range from a minimum of about $35 to a maximum of an amount equal to the national minimum monthly wage.[50]

Law No. 30/2000 requires the provisional suspension of proceedings against an addicted consumer if the consumer has no prior record of previous offenses under Law No. 30/2000 and agrees to undergo treatment. It also grants each commission the discretion to provisionally suspend proceedings against an addicted consumer with a prior record if the consumer agrees to undergo treatment.[51] Further, even if a commission decides to penalize an addicted consumer, the commission may choose to suspend a penalty for up to three years if the consumer agrees to "voluntarily" undergo treatment. Proceedings may be closed if, after the suspension period, no reason has been found that could lead to revoking the suspension. Grounds for revocation include a consumer's failure to start or continue treatment as necessary.[52] Moreover, even if a consumer cannot be treated or refuses to be treated, penalties may be suspended if the applicable commission requires the user to present himself or herself periodically to receive medical services or undergo other follow-up actions.[53]

Law No. 30/2000 requires proceedings against a consumer to be brought before the commission that has jurisdiction over the area in which the consumer resides. (If the address is

unknown, the proceedings shall be brought before the commission for the area in which the consumer was found.)[54] The commission "shall hear the consumer and gather the information needed in order to reach a judgement as to whether he or she is an addict or not," as well as consider other facts.[55] Notably, if it is "not possible to identify the consumer at the place and the moment of the occurrence, the police authorities may, if necessary, detain the consumer in order to ensure that he or she appears before the commission, in accordance with the legal rules on detention for the purpose of identification."[56] But technically, there is no language in Law No. 30/2000 that specifically authorizes the police or the commission to "order" a consumer to appear before the commission.

EFFECTIVENESS OF DISSUASION COMMISSIONS

The use and effectiveness of the dissuasion commissions has been called into question. Some skeptics in Portugal believe that the dissuasion commissions served only a symbolic purpose, that is, to show that Law No. 30/2000 was not intended to condone drug use.[57] The commissions faced difficulty in establishing standards and procedures and implementing their operations until about 2008.[58]

While the apparent impetus for decriminalization was to address and provide treatment for addicted users, and primarily those addicted to heroin, one observer noted:

> [I]n practice, most of the individuals who appeared before the Commissions have not been *problem* drug users. Instead, the majority of the issued citations for drug use have been to increasingly younger, nonaddicted, cannabis users. The proportion of cases involving cannabis [also known as marijuana] has steadily grown, from approximately 50 percent of the cases during the Commission's [sic] first eighteen months of operation to 76 percent of the cases in 2009.[59]

This trend has continued. In 2013, the dissuasion commissions processed 8,729 cases.[60] Of the year 2013 cases in which only one substance was involved, eighty-two percent involved marijuana, and only six percent involved heroin.[61] While it should be noted that this may reflect an actual shift in drug use patterns – with more users using marijuana, and fewer using heroin,[62] the latter drug, in the words of the National Drug Strategy Committee, has "the most damaging social and health effects."[63] Thus, while heroin users face the greatest risks to their health, the statistics suggest that a disproportionately low number of them benefit from the discipline and paths to treatment that the commissions were intended to provide.

There is also a lack of clarity regarding what impact the dissuasion commission process has had on treatment efforts. As one observer noted:

> Treatment attendance [the number of people receiving treatment] increased from 27,750 in 1999 to a peak of 32,064 people receiving treatment. This subsided to 30,266 in 2004. However, as noted earlier it is not known how many clients sent through the CDTs [dissuasion commissions] continued to receive treatment, if they were successfully treated, nor whether there were long term impacts upon drug-related problems.[64]

ADMINISTRATIVE MANAGEMENT OF TREATMENT

In 2002, the Instituto de Droga e da Toxicodependência (the Institute for Drugs and Drug Addiction, abbreviated as "IDT"), was established to consolidate drug program resources, oversee dissuasion commissions, appoint commission members, and gather drug use and addiction statistics.[65] It also provided drug treatment services.[66] The IDT was essentially a merger of different ministerial bodies that handled those tasks and, in the view of one observer, guaranteed "unity, planning, design, management, supervision and assessment of the [drug treatment] system as a whole."[67]

In 2012, most of the duties of the IDT were transferred to a new agency entitled the Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (General Directorate for Intervention on Addictive Behaviours and Dependencies,[68] abbreviated as "SICAD").[69] This change was met with some concern about instability in the availability of treatment, since services under SICAD are not as comprehensive and centralized as services under the IDT.[70] Notably, unlike the IDT, the SICAD is not responsible for treatment services. Instead, that responsibility is delegated to regional government authorities.[71] The elimination of IDT-based treatment means that drug users need to seek treatment from regular regional government health clinics and hospitals. Concerns have been raised that drug users who might otherwise be willing to receive specialized IDT-based treatment will find the prospect of accessing treatment from regular hospitals and clinics to be too intimidating and thus will avoid treatment altogether.[72] This change may have an impact on the success of the treatment component of Portugal's National Drug Strategy going forward.

HCR NO. 127'S RELIANCE ON THE CATO REPORT

As noted previously, HCR No. 127 specifically referenced a report issued in 2009 by the Cato Institute entitled "Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies" (hereinafter, "the Cato report").[73] The resolution stated that the Cato report determined that drug decriminalization in Portugal produced four key results:

> (1) No adverse effect on drug usage rates, which are among the lowest in the European Union, and particularly when compared with states with stringent criminalization regimes;
>
> (2) A decrease in lifetime prevalence rates for drug use among various age groups, particularly for youths in the critical age groups of thirteen to fifteen year olds and sixteen to eighteen year olds;
>
> (3) A dramatic decrease in drug-related deaths, including from sexually transmitted diseases; and
>
> (4) Steady declines in drug trafficking convictions[.][74]

Based on these assertions about the Cato report, the resolution posits that Portugal's decriminalization scheme could serve as a model for the decriminalization of possession for personal use of certain drugs in Hawaii. These assertions will be addressed in detail[75] following: the Bureau's general analysis of the Cato report; a discussion of findings by the United States Office of National Drug Control Policy regarding the Cato report; and a review of certain scholarly articles that comment on the Cato report.

GENERAL ANALYSIS OF THE CATO REPORT

The Cato report provides valuable information and insight, has been enthusiastically embraced by some authors of scholarly articles, and has attracted significant media attention.[76] However, it should be noted from the outset that the Cato Institute does not conduct "nonpartisan public policy research," as asserted by HCR No. 127. Instead, it espouses a libertarian political philosophy and advocates for limited government encroachment into personal and economic activities.[77] Accordingly, it should also be noted that the Cato report was presented as a "white paper" intended to influence policy discussions by advocating a decriminalization approach to drug policy, rather than presenting an objective analysis of data. For example, the report's executive summary proclaims Portugal's decriminalization "a resounding success" and concludes that "[w]ithin this success lie *self-evident* lessons that should guide drug policy debates around the world."[78] Moreover, certain methodologies on which the Cato report was based, as well as some of the report's findings and conclusions, have been challenged by the Office of National Drug Control Policy and authors of some scholarly articles. In addition, data that became available subsequent to the release of the Cato report support alternative conclusions, as will be discussed.[79]

The Cato report does not appear to clearly recognize, and at any rate does not clearly reflect, that decriminalization of drugs was *only one component* of a much larger drug control strategy in Portugal that also called for significant investments in public health-oriented programs prior to, and in conjunction with, decriminalization. While the Cato report does reference Portugal's increased emphasis on drug abuse prevention, treatment, and harm reduction programs as important components in the country's shift to a public health approach to drug abuse, the report clearly focuses on the decriminalization of drug possession and use, in particular, and tends to create the distorted impression that *decriminalization in and of itself* – rather than such factors as the *increased focus on a public health approach to addressing drug use* that began before, and continued in conjunction with, decriminalization – is primarily responsible for outcomes cited by the study. As an example, the report's executive summary recounts Portugal's shift to decriminalization of drug possession and use and asserts that "[t]he data show that, judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success."[80] However, the executive summary does not even mention Portugal's larger public health-oriented drug abuse control strategy, but attributes solely to decriminalization an enhanced ability of the Portuguese government to offer drug abuse treatment programs.

The Cato report also asserts that the decriminalization of drugs in Portugal has allowed financial resources to be redirected from criminal enforcement to public health-oriented programs such as drug abuse prevention, treatment, and harm reduction services.[81] However, the Cato report does not identify or quantify these resources or explain specifically either how the resources were freed up or how they were redirected. Paradoxically, the Cato report does note that criminal sanctions solely for drug possession or use were very uncommon in Portugal prior to decriminalization.[82] Therefore, it is unclear how any significant financial resources could have been saved or redirected from criminal enforcement of prohibitions against drug possession and use in order to finance public health programs as a result of decriminalization. Nor did the Cato report examine the financial costs of establishing administrative structures to implement Portugal's decriminalization scheme, such as the Commissions for Dissuasions of Drug Addiction – the bodies responsible for adjudicating administrative drug offenses and considering whether to refer drug users to treatment programs or impose sanctions for noncompliance with the decriminalization scheme – which could reasonably be expected to consume at least part of any savings redirected from criminal enforcement.

This is not to suggest that decriminalization of use and possession for personal use of drugs in Portugal has produced no positive results, or has not contributed significantly to an environment in which drug abuse is more effectively prevented and addressed. But any decrease in drug abuse or other changes to drug abuse indicators in Portugal following decriminalization may not necessarily or conclusively be attributed to decriminalization *per se*, and almost certainly not to decriminalization *alone*. Rather, it appears that Portugal's overall approach to treating drug abuse as a public health problem, and to investing in that approach in a decriminalized context, may be responsible for at least some positive outcomes, although economic and cultural factors unrelated to decriminalization may have also contributed and cannot be ruled out.[83]

For example, variations in the type, quantity, and price of available drugs, and the ability of consumers to access them, may reasonably be expected to affect drug use patterns and indicators. Nevertheless, it should also be said that the available data do not necessarily indicate that the decriminalization of drug possession and use in Portugal caused any dramatic general *increase* in drug abuse, as opponents of decriminalization had feared, although some data do indicate that use of certain drugs has increased among some segments of the population in the years following decriminalization, as will be explained.[84]

OFFICE OF NATIONAL DRUG CONTROL POLICY CRITICISMS OF CATO REPORT

In response to the Cato report, the Office of National Drug Control Policy, a branch of the Executive Office of the President of the United States, released a brief "fact sheet" criticizing and disputing certain aspects of the Cato report and its findings.[85] Under the heading, "Limitations in Current Research," the fact sheet stated these specific points:

- Supporting Analysis Not Definitive: The Cato Institute report does not discuss the statistical significance of the data shifts it highlights, sometimes focusing on prevalence rate changes as small as 0.8 percent.

- Fails to Recognize Other Factors: The report attributes favorable trends as a direct result of decriminalization without acknowledging, for example, the decline in drug-related deaths that began prior to decriminalization.

- Adverse Data Trends Not Reported: Evidence that may reflect [the Portuguese decriminalization law's] adverse social effects – such as the increase in drug-related deaths in Portugal between 2004 and 2006 – is sometimes ignored, downplayed, or not given equal recognition.

- Core Drug-Use Reduction Claims Not Conclusive:

  > As "proof" of drug legalization's[86] success, the report trumpets a decline in the rate of illicit drug usage among 15- to 19-year-olds from 2001 to 2007, while ignoring increased rates in the 15-24 age group and an even greater increase in the 20-24 population over the same period. In a similar vein, the report emphasizes decreases in lifetime prevalence rates for the 13-18 age group from 2001 to 2006 and for heroin use in the 16-18 age group from 1999 to 2005. But, once again, it downplays increases in the lifetime prevalence rates for the 15-24 age group between 2001 and 2006, and for the 16-18 age group between 1999 and 2005.

- Methodologically Limited: Cato's analysis relies heavily on lifetime prevalence data, which can be problematic when analyzing the impact of policy changes over time periods as short as the 5-6 years captured in most of the studies cited in the report.[87]

Under the heading "Additional Studies Offer More Contradictory Evidence," the fact sheet made the following additional points:

- Statistics compiled by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicate that between 2001 and 2007, lifetime prevalence rates for cannabis, cocaine, amphetamines, ecstasy, and LSD have risen for the Portuguese general population (ages 15-64) and for the 15-34 age group.

- Past-month prevalence figures show increases from 2001 to 2007 in cocaine and LSD use in the Portuguese general population as well as increases in cannabis, cocaine, and amphetamine use in the 15-34 age group.

- Drug-induced deaths, which decreased in Portugal from 369 in 1999 to 152 in 2003, climbed to 314 in 2007 – a number significantly higher than the 280 deaths recorded when decriminalization started in 2001.

- Despite Cato's assertion that increases in lifetime prevalence levels among the general population are "virtually inevitable in every nation," EMCDDA data indicate that other countries, including Spain, have been able to achieve decreases in lifetime prevalence rates for cannabis and ecstasy use between 2003 and 2008.[88]

And under the heading, "Claims of Benefits from Drug Legalization[89] Exceed Supporting Science," the fact sheet declared the following:

> The Cato Institute report does not present sufficient evidence to support claims regarding causal effects of Portugal's drug policy on usage rates. More data are required before drawing any firm conclusions, and ultimately these conclusions may only apply to Portugal and its unique circumstances, such as its history of disproportionately high rates of heroin use. However, it is safe to say that claims by drug legalization advocates regarding the impact of Portugal's drug policy exceed the existing scientific basis.[90]

While the points made in the fact sheet appear to be valid ones, those points do not necessarily disprove the thesis that decriminalization of use and possession for personal use of drugs can produce significant positive effects, especially when coupled with investments in public health, such as drug abuse prevention, treatment, and harm-reduction programs.

OTHER STUDIES DISPUTE OR CONTRADICT FINDINGS IN THE CATO REPORT

Scholarly articles have analyzed the Cato report and competing interpretations of data pertaining to the decriminalization of use and possession for personal use of drugs in Portugal and have criticized a perceived lack of objectivity and selective use of data, both by Cato and by critics of drug decriminalization, to reinforce beliefs that are largely based on ideology, rather than on objective analyses of data.

For example, Caitlin Elizabeth Hughes and Alex Stevens, writing in Drug and Alcohol Review, found what they determined was "clear proof of misuse" of data presentations in the Cato report and in another report[91] that disputed the Cato report's findings:

> Both showed selective use of evidence (focusing on different indicators, choice of years or datasets) and omission or a lack of acknowledgement of other pieces of the puzzle. Both also showed differential appreciations of data strengths and weaknesses: with weaknesses highlighted mainly by [the Cato report] to account for apparent failings. In so doing, both provided a version of events that offered certitude and support for opposing "core beliefs."[92]

Hughes and Stevens found that four datasets have evolved for collecting information on drug use among school students in Portugal, each of which provide a partial, but incomplete, picture.[93] Hughes and Stevens found that the Cato report relied on one set of data indicating that Portugal saw a 27-30 percent decrease in lifetime cannabis use after decriminalizing drug possession and use, but that other datasets suggested that there was actually a 16 percent reduction.[94] Hughes and Stevens also found that the Cato report inaccurately claimed that Portugal had the absolute lowest lifetime prevalence rates for cannabis use, when Bulgaria, Malta, and Romania all had lower lifetime prevalence rates than Portugal.[95]

Furthermore, Hughes and Stevens questioned the extent to which lifetime prevalence provides a meaningful indicator of changing drug use patterns in Portugal following decriminalization. They point out that, although lifetime prevalence is generally deemed useful for examining drug use trends among youth, examining trends among adults and the general population for recent (last 12 months) or current (last 30 days) drug use is generally believed to provide much better indicators.[96] Simply put, if a person has used an illegal drug at least once in her lifetime, that person's indicator of lifetime use will not change in the future whether she later uses an illegal drug again or not; thus it is of limited value for gauging any *change of drug use* among groups of people, especially among adults who may have first used a drug many years before.

Hughes and Stevens caution that any assumptions that changes to patterns of drug use in Portugal may be attributed solely or primarily to the country's decriminalization scheme are problematic, because "there is no direct, cross-sectional link between national drug policies and prevalence of use."[97]

> Apart from the decriminalization, there are many other factors that might explain national patterns of use (including disposable income, leisure time, religiosity and other cultural norms) and trends in drug-related harms (including changes in the availability of treatment and harm reduction services and the level of health-care and welfare support). More broadly[,] the overemphasis by both [the Cato report and a report questioning its findings] on the reform, and not the concurrent drug strategy which expanded services for drug users in Portugal, has fostered overconfident assertions about the effects of the reform and a lack of appreciation of the Portuguese model and the causal mechanisms by which outputs and outcomes could be expected to occur.[98]

Another author, Hannah Laqueur, writing in Law and Social Inquiry, observed that "[t]he story of decriminalization in Portugal has become a kind of screen onto which drug policy agendas are projected. It has been misapplied as a precedent that can speak to questions of legalization and misconstrued as a more radical policy change than it in fact was."[99] Laqueur noted, for example, that fines had long been the primary sanction imposed on persons convicted of drug use in Portugal prior to decriminalization, and that less than one percent of those imprisoned for a drug offense in Portugal in the year prior to decriminalization were serving time for drug possession.[100] Thus, rather than represent a dramatic shift away from criminal prosecution, decriminalization of drug use in Portugal primarily codified what had already been the existing de facto practice.[101] "The statute did not encompass a major change in legal sanctions. But it reflected and supported Portugal's evolving shift from a penal to a therapeutic approach to drug abuse and this, in turn, appears to have had a much broader impact on court practices."[102]

Laqueur contended that, in general, there has been a tendency to focus too much on Portugal's decriminalization of drug use rather than the larger shift in drug policy that included decriminalization as but one component.

> Most accounts of the Portugal experiment have focused on the 2001 change in the criminal law regarding drug use, less on the other prongs of Portugal's drug reforms – the

> expansion of programs providing treatment, prevention, and reintegration. Yet, such programs are clearly central to any analyses of drug-related harms and health outcomes. We cannot evaluate decriminalization in isolation, nor was it designed to function alone. The administrative commissions were established to support broader public health efforts by providing a more integrated and efficient method for detection and referral to treatment. The removal of criminal penalties for drug use was intended to de-stigmatize addicted users and encourage treatment. According to Portuguese drug policy officials, the new system has effectively done just that.[103]

Laqueur found that the most dramatic change in Portugal following decriminalization was not necessarily related to drug *use*, but rather to *criminal adjudication* of drug *trafficking* offenses. While the number of *arrests* for trafficking changed little in the ten years following enactment of the decriminalization statute and Portugal's drug trafficking laws did not change during that time, the number of drug trafficking *convictions* decreased by 40 percent during that same period, and the number of defendants *incarcerated* for criminal acts involving the sale, distribution, or production of drugs dropped by nearly half.[104]

Laqueur found that a decrease in Portuguese prison sentence lengths could account at least in part for the decrease in the number of incarcerated defendants, but that data regarding sentence lengths were unavailable.[105] The reduction in incarceration for drug trafficking "suggests that after formally acknowledging and codifying the de facto practice of not convicting and incarcerating drug users, the criminal courts embraced de facto practices of greater leniency for at least some drug users and purveyors whose behavior remained criminally sanctioned," Laqueur wrote, noting that some drug users are also traffickers.[106] Laqueur noted that some drug dealers may also have begun carrying no more than the ten-day supply of drugs that Portugal's revised drug laws consider indicative of personal use, rather than trafficking,[107] thus making it harder for authorities to distinguish between drug users and users who are also traffickers.[108]

"KEY RESULTS" OF DRUG DECRIMINALIZATION IN PORTUGAL

The four "key results" of drug decriminalization in Portugal cited in HCR No. 127[109] are discussed below:

(1) Available data do not support the statement made in HCR No. 127 that, following decriminalization, Portugal experienced "[n]o adverse effect on drug usage rates, which are among the lowest in the European Union, and particularly when compared with states with stringent criminalization regimes[.]"[110] Available data do indicate that reported cannabis usage rates in Portugal were substantially lower than the European average even prior to decriminalization, and remained so following decriminalization, and are also low when compared to states with stringent criminalization regimes.[111] However, Portugal's rate of *problem* drug use, which the European Monitoring Centre for Drugs and Drug Addiction defines as injecting or prolonged use of heroin, cocaine, or amphetamines, has approximated or exceeded the European average before and after Portugal implemented its decriminalization scheme, and was in fact a key motivator for decriminalization.[112]

Furthermore, data from other sources indicate that usage rates for certain drugs actually increased among certain age groups in Portugal following decriminalization, but do not necessarily suggest any increases were *caused* by decriminalization or by decriminalization *alone*. For example, as will be discussed below, some data suggest a significant increase between 2007 and 2011 in the percentage of Portuguese students who reported using illicit drugs at some point in their lifetime. And, as discussed previously, the Office of National Drug Control Policy fact sheet noted that data made available after the Cato report was issued indicate that use of some drugs increased among certain age groups between 2001 and 2007.[113] However, it should be noted that reported increases in some categories were less than 1 percent or as small as 0.1 percent.[114] The fact sheet noted that lifetime prevalence rates for use of cannabis, cocaine, amphetamines, ecstasy, and LSD increased in Portugal between 2001 and 2007 among the general population aged 15 to 64 and the population aged 15 to 34.[115] The fact sheet also noted that data indicate the prevalence rates for use of cannabis, cocaine, and amphetamines during the last 30 days increased between those same years among the 15-34 age group, and that use of cocaine and LSD during the last 30 days increased during that same period among the 15-64 age group.[116]

Also, data self-reported by Portuguese high school students and collected by the European School Survey Project on Alcohol and Other Drugs (hereinafter "the ESPAD report") indicate that lifetime use of illicit drugs among students increased from 12 percent in 1999 (approximately two years prior to implementation of Portugal's drug decriminalization statute in 2001) to 19 percent in 2011.[117] The ESPAD report also found that use of marijuana or hashish during the last 30 days nearly doubled, from 5 percent in 1999 to 9 percent in 2011,[118] and that lifetime use of marijuana or hashish increased from 9 percent in 1999 to 16 percent in 2011.[119] The ESPAD report found that lifetime use of illicit drugs other than marijuana or hashish increased from 6 percent to 8 percent during that same period.[120]

The ESPAD report indicates that lifetime use of marijuana or hashish by students in Portugal was slightly below the European average in 2011,[121] and that lifetime use of other illicit drugs was slightly higher than the average.[122] The report also characterized the change from 2007 to 2011 in the percentage of Portuguese students who indicated they had used illicit drugs during their lifetime as a "significant increase."[123] The report similarly found a "significant increase" in both the percentage of Portuguese students who had used marijuana or hashish during the past thirty days of the reporting periods in 2007 and 2011,[124] and the percentage who had used other illicit drugs during their lifetime.[125]

Thus, available data do not conclusively establish that there has been no adverse effect on drug usage rates following the decriminalization of use and possession for personal use of drugs in Portugal.

(2) Some available data do support the assertion that, during certain time periods, Portugal experienced "[a] decrease in lifetime prevalence rates for drug use among various age groups, particularly for youths in the critical age groups of thirteen to fifteen year olds and sixteen to eighteen year olds[.]"[126] However, data for slightly different age groupings indicate increases in drug use between different periods.[127] Data also indicate that lifetime prevalence

rates for use of any illicit drug increased between 2007 and 2011 among each specific age from 13 to 18.[128]

It should be noted that none of this data conclusively establish that any increases or decreases in drug use among young people in Portugal are causally related to decriminalization *per se*, or result *solely* from decriminalization. It is also possible, and perhaps more likely, that an increased emphasis on drug abuse education and prevention directed toward youth and young adults as part of Portugal's national drug abuse control strategy have had more of an impact on drug usage rates, along with any changes in the economy, societal acceptance of drug use, evolving preferences for specific drugs, accessibility of drugs by young people, and other related variables.

(3) The assertion in HCR No. 127 that Portugal has recorded "[a] dramatic decrease in drug-related deaths, including from sexually transmitted diseases" is problematic and misleading. While it is true that Portugal recorded, for two years immediately following the implementation of decriminalization in 2001, significant decreases in the number of deaths in which post-mortem toxicological tests *detected the presence* of illicit substances,[129] those tests did not necessarily find that drugs were the *cause* of death. As Hughes and Stevens have explained:

> Unlike much of the Western world, Portugal has not historically collected or reported information on deaths that are directly attributable to drug intoxication . . . [Data regarding the presence of illicit substances] is responsive to changes in recording practices, such as the number of toxicological autopsies. [Also], it is only an indirect indicator of attributable death; many people are found to have traces of a drug in their body when they die, but this does not mean that the drug caused the death. This is why the standard international classification of drug-related death relies on reports by physicians on their assessment of the cause of death, *not* positive toxicological tests.[130]

Moreover, the number of deaths in which post-mortem toxicological tests detected the presence of illicit substances had begun decreasing substantially two years *prior* to decriminalization in 2001, then *increased* substantially from 2003 to 2007, years *subsequent to* decriminalization.[131] It should be understood, however, that the Cato report, Laqueur, and the EMCDDA have all noted that the *number* of autopsies and toxicological tests conducted in Portugal have increased since decriminalization, and that an increased number of tests could reasonably be expected to produce an increase in test results that detected illicit substances.

Furthermore, the Cato report did not reference a decrease in "drug-related deaths, including from sexually transmitted diseases," as described in HCR No. 127.[132] Rather, the Cato report referenced a *stabilization of general infection rates* for HIV in Portugal since 2004, and a *decline in newly reported cases* of HIV and AIDS among drug users.[133] Although scientists have determined that HIV, and thus AIDS, may be spread through sexual contact as well as through shared needles used to inject drugs, the Cato report did not specifically address sexual transmission. Quoting from a 2007 report by Hughes and Stevens, the Cato report noted that injection drug use has been a major mode of transmission for HIV, and that Portugal recorded

decreases of new drug-related HIV infections and of tracked cases of Hepatitis C and B in drug treatment centers after 2000:

> With its relatively high rates of heroin use by injection, Portugal has had a serious problem with the transmission of HIV and other blood-borne viruses. For example, in 1999 Portugal had the highest rate of HIV amongst injecting drug users in the European Union . . . . This is a major target of a public health approach to drug use, with opiate substitution treatment and needle exchange being an important element of the Portuguese response. *Between 1999 and 2003, there was a 17% reduction in the notifications of new, drug-related cases of HIV . . . . There were also reductions in the numbers of tracked cases of Hepatitis C and B in treatment centres*, despite the increasing numbers of people in treatment.[134]

It should be noted that Hughes and Stevens also observed in the same 2007 report that "it is difficult to attribute any changes in drug use indicators in Portugal solely to the 2001 [decriminalization] law. It should also be recognized that it is notoriously difficult to measure drug use and related problems accurately."[135] The authors noted that drug use has generally been a hidden and stigmatized activity, and that the causal link between drugs, death, and disease is "not direct, but is mediated by culture, socio-economics and policy responses."[136] Hughes and Stevens further noted that Portuguese authorities have recorded a reduction in heroin users who are entering treatment for the first time, but an increase in cannabis users, which suggests a decline in new heroin users but an increase in new cannabis users in Portugal in the years following decriminalization.[137] "It seems that initiation into heroin use is falling, while cannabis use may be rising toward the levels experienced in some other European countries."[138]

Thus, the data do not support the assertion that the decriminalization of drugs in Portugal produced "a dramatic decrease in drug-related deaths, including from sexually transmitted diseases," although the available data indicate a decrease in new HIV cases among injection drug users referred for treatment.

(4) The assertion in HCR No. 127 that Portugal has experienced "[s]teady declines in drug trafficking convictions"[139] appears to be an accurate one. However, the relevance of a decrease in convictions is not clear, and a decrease in convictions does not necessarily indicate a decrease in drug trafficking *per se*, or of drug use. As noted previously, Laqueur found that although the number of drug trafficking *convictions* decreased by 40 percent in the decade following decriminalization, the number of *arrests* for trafficking changed little during that period.[140] The decrease in convictions may suggest, among other things, that courts have become more inclined to steer small-scale drug dealers who are also drug users toward drug abuse treatment rather than prison, and that street-level dealers have begun carrying no more than the ten-day supply of drugs that Portugal's revised drug laws consider indicative of personal use rather than trafficking, thus making it harder for authorities to distinguish between drug users and traffickers.[141]

ENDNOTES

1. GLENN GREENWALD, CATO INSTITUTE, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES (2009), http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf [hereinafter THE CATO REPORT].

2 *Id*. at 28-29.

3. Caitlin Elizabeth Hughes, Overcoming Obstacles to Reform?: Making and Shaping Drug Policy in Contemporary Portugal and Australia 50 (Oct. 2010) (unpublished Ph.D. thesis, The University of Melbourne) (on file with The University Library, The University of Melbourne), https://minerva-access.unimelb.edu.au/bitstream/handle/11343/39229/67255_00003215_01_Caitlin_Hughes_Thesis.pdf?sequence=1 [hereinafter Hughes thesis].

4. EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION, DRUG POLICY PROFILES 20 (2011), http://www.emcdda.europa.eu/attachements.cfm/att_137215_EN_PolicyProfile_Portugal_WEB_Final.pdf. "'Problem drug use'" is defined as "injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines." *Methods and Definitions*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats07/PDU/methods (last updated Mar. 20, 2012).

5. Hughes thesis, *supra* note 3, at 51.

6. *Id*. (citing Decreto-Lei 420/70, DIÁRIO DA REPÚBLICA de 3.9.1970 (Port.)).

7. Kellen Russoniello, Note, *The Devil (and Drugs) in the Details: Portugal's Focus on Public Health as a Model for Decriminalization of Drugs in Mexico*, 12 YALE J. HEALTH POL'Y, L. & ETHICS 371, 376 (2012), http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple.

8. MARGARIDA BENTES ET AL., HEALTH CARE SYSTEMS IN TRANSITION: PORTUGAL 2004 12 (2000), http://www.euro.who.int/__data/assets/pdf_file/0005/107843/e82937.pdf.

9. CONSTITUTION OF THE REPUBLIC, SEVENTH REVISION, 2005, art. 6(1) (Port.), http://www.en.parlamento.pt/Legislation/CRP/Constitution7th.pdf. The Azores and Madeira archipelagos are "autonomous regions with their own political and administrative statutes and self-government institutions." *Id.* art. 6(2). However, this autonomy "does not affect the integrity of the sovereignty of the state and shall be exercised within the overall framework of the Constitution." *Id.* art. 225(3).

10. *Id.* art. 64(3)(a).

11. Russoniello, *supra* note 7, at 377 (citing Decreto-Lei 430/83, DIÁRIO DA REPÚBLICA de 13.12.1983 (Port.)).

12. INEKE VAN BEUSEKOM ET AL., GUIDELINES FOR IMPLEMENTING AND EVALUATING THE PORTUGUESE DRUG STRATEGY 8 (2000), http://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1508.pdf.

13. Decreto-Lei 15/93, art. 44(1), DIÁRIO DA REPÚBLICA de 22.1.1993 (Port.), *translated in Decree-Law No. 15/93*, EUROPEAN MONITORING CTR FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/topics/law/drug-law-

texts?pluginMethod=eldd.showlegaltextdetail&id=729&lang=en&T=2 (last modified July 7, 2015) [hereinafter Law No. 15/93].

14. The EMCDDA, established in 1993 and located in Lisbon, Portugal, is an agency of the European Union. It has published reports on drug-related statistics since 1995. Hughes thesis, *supra* note 3, at 89.

15. EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION, 2000 ANNUAL REPORT ON THE STATE OF THE DRUGS PROBLEM IN THE EUROPEAN UNION 14-15 (2000), http://www.emcdda.europa.eu/system/files/publications/151/ar00_en_69639.pdf [hereinafter EMCDDA 2000 ANNUAL REPORT].

16. *Table DRCrime-1. Number of reports for drug law offences, 1985-2002. Part (ii) 1985 onwards*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://stats04.emcdda.europa.eu/html.cfm/index5308EN.html (last updated Nov. 23, 2004).

17. Hannah Laqueur, Comment, *Uses and Abuses of Drug Decriminalization in Portugal*, 40 LAW & SOC. INQUIRY 746, 754, fig.1 (2015) (citing INSTITUTO PORTUGUÊS DA DROGA E DA TOXICODEPÊNDENCIA, DROGA-SUMARIOS DE INFORMACAO ESTATISTICA-2000 (2000)).

18. JOÃO PEDRO SEQUEIRA RODRIGUES AUGUSTO, EVOLUTION OF THE PORTUGUESE ADDICTION TREATMENT SYSTEM 1958-2014 3 (2016), http://www.sicad.pt/BK/Publicacoes/Documents/EPATS_1958-2014_ENG_vweb.pdf.

19. EMCDDA 2000 ANNUAL REPORT, *supra* note 15, at 21.

20. *Id*. at 19.

21. *Id*.

22. *Id*.

23. Hughes thesis, *supra* note 3, at 85.

24. This table is adapted from a statistical table in Laqueur, *supra* note 17, at 755 tbl.2 (citing INSTITUTO PORTUGUÊS DA DROGA E DA TOXICODEPÊNDENCIA, DROGA-SUMARIOS DE INFORMACAO ESTATISTICA-2000 (2000)).

25. RODRIGUES AUGUSTO, *supra* note 18, at 12.

26. *Id*. at 12, 46 (citing Lei 7/97, DIÁRIO DA REPÚBLICA de 8.3.1997 (Port.); Decreto-Lei 72/99, DIÁRIO DA REPÚBLICA de 15.3.1999 (Port.); Dr. Jorge Sompajo, Presidente do Republica, Discurso de Abertura de Sua Excelencia o Presidente do Republica Dr. Jorge Sompajo (Apr. 1997), *in* 10 COLLECTION OF TEXTS 29 (1997)).

27. RESOLUÇÃO DO CONSELHO DE MINISTROS 46/99, DIÁRIO DA REPÚBLICA de 22.4.1999 (Port.), *translated in* PORTUGUESE NATIONAL DRUG STRATEGY COMMITTEE, NATIONAL DRUG STRATEGY (1999) http://www.emcdda.europa.eu/system/files/att_119431_EN_Portugal%20Drug%20strategy%201999.pdf [hereinafter NATIONAL DRUG STRATEGY].

28. *Id*. ch. I(2).

29. *Id*.

30. *Id*. ch. II(10).

31. *Id*. ch. IV(22).

32. *Id*. ch. VI(54) (emphasis added).
33. BENTES ET AL., *supra* note 8, at 12-13.
34. *Id*. at 33.
35. Laqueur, *supra* note 17, at 759.
36. NATIONAL DRUG STRATEGY, *supra* note 27, ch. IV(26).
37. Decreto-Lei 30/2000, art. 28, DIÁRIO DA REPÚBLICA de 29.11.2000 (Port.), *translated in* GENERAL-DIRECTORATE FOR INTERVENTION ON ADDICTIVE BEHAVIOURS AND DEPENDENCIES, DECRIMINALISATION: PORTUGUESE LEGAL FRAMEWORK APPLICABLE TO THE CONSUMPTION OF NARCOTICS AND PSYCHOTROPIC SUBSTANCES (n.d.), http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/96/Decriminalisation_law.EN.pdf [hereinafter Law No. 30/2000]. A copy of this law is attached to this report as Appendix D.
38. Law No. 15/93, *supra* note 13. A copy of the tables that list the drugs is attached to this report as Appendix E.
39. Law No. 30/2000, *supra* note 37, art. 29.
40. *Id*. art. 28.
41. *Id*. art. 21.
42. *Id*. art. 1(1).
43. *Id*. art. 2(1).
44. *Id*. art. 2(2).
45. Portaria 94/96, art. IV(9), mapa, DIÁRIO DA REPÚBLICA de 26.3.1996 (Port.); Laqueur, *supra* note 17, at 752; EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, EUROPEAN LEGAL DATABASE ON DRUGS COMPARATIVE STUDY: THE ROLE OF THE QUANTITY IN THE PROSECUTION OF DRUG OFFENCES 13 (2003) http://www.emcdda.europa.eu/attachements.cfm/att_5738_EN_Quantities.pdf [hereinafter EMCDDA QUANTITY].
46. Law No. 30/2000, *supra* note 37, art. 5(1).
47. *Id*. art. 7(1).
48. *Id*. art. 7(2).
49. *Id*. arts. 15-18.
50. Russoniello, *supra* note 7, at 387-388; Law No. 30/2000, *supra* note 37, art. 15.
51. Law No. 30/2000, *supra* note 37, art. 11.
52. *Id*. art. 14.
53. *Id*. art. 19.
54. *Id*. art. 8(1).
55. *Id*. art. 10(1).
56. *Id*. art. 4(2).

57. Hughes thesis, *supra* note 3, at 131-132.

58. RODRIGUES AUGUSTO, *supra* note 18, at 61.

59. Laqueur, *supra* note 17, at 756 (emphasis in original) (citing PORTUGAL INSTITUTE FOR DRUGS AND DRUG ADDICTION, REITOX NATIONAL FOCAL POINT, 2000 NATIONAL REPORT TO THE EMCDDA, TRENDS AND IN-DEPTH INFORMATION ON SELECTED ISSUES (2002); ANA SOFIA SANTOS ET AL., PORTUGAL INSTITUTE FOR DRUGS AND DRUG ADDICTION, REITOX NATIONAL FOCAL POINT, 2010 NATIONAL REPORT (2009 DATA) TO THE EMCDDA: "PORTUGAL" NEW DEVELOPMENTS, TRENDS AND IN-DEPTH INFORMATION ON SELECTED ISSUES (2010), http://www.emcdda.europa.eu/system/files/publications/664/PT-NR2010_399489.pdf [hereinafter 2010 REPORT TO EMCDDA]).

60. ANA SOFIA SANTOS & ÓSCAR DUARTE, PORTUGAL INSTITUTE FOR DRUGS AND DRUG ADDICTION, REITOX NATIONAL FOCAL POINT, 2014 NATIONAL REPORT (2013 DATA) TO THE EMCDDA: "PORTUGAL" NEW DEVELOPMENTS, TRENDS 11 (2015), http://www.emcdda.europa.eu/system/files/publications/996/2014_NATIONAL_REPORT.pdf.

61. *Id*. at 106.

62. The prevalence of the use of marijuana among students aged 16 to 18 increased from 9.4 percent in 1999 to 15.1 percent in 2003. The corresponding statistics for heroin are 2.5 percent and 1.8 percent, respectively. CAITLIN HUGHES & ALEX STEVENS, THE EFFECTS OF DECRIMINALIZATION OF DRUG USE IN PORTUGAL 3, 5 (2007), http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_14.pdf [hereinafter HUGHES & STEVENS 2007].

63. NATIONAL DRUG STRATEGY, *supra* note 27, ch. I(2).

64. Hughes thesis, *supra* note 3, at 191 (citing INSTITUTO DA DROGA E DA TOXICODEPENDÊNCIA, RELATÓRIO ANUAL 2004 - A SITUAÇÃO DO PAÍS EM MATÉRIA DE DROGAS E TOXICODEPENDÊNCIAS, VOLUME I - INFORMAÇÃO ESTATÍSTICA (2004)).

65. Russoniello, *supra* note 7, at 390 (citing Decreto-Lei 269-A/2002, DIÁRIO DA REPÚBLICA de 29.11.2002 (Port.)).

66. *Id*. at 395 (citing Decreto-Lei 17/2012, DIÁRIO DA REPÚBLICA de 26.1.2012 (Port.)).

67. RODRIGUES AUGUSTO, *supra* note 18, at 13.

68. SERVIÇO DE INTERVENÇÃO NOS COMPORTAMENTOS ADITIVOS E NAS DEPENDÊNCIAS, http://www.sicad.pt/en/Paginas/default.aspx (last visited Dec. 20, 2016).

69. Russoniello, *supra* note 7, at 395 (citing Decreto-Lei 17/2012, DIÁRIO DA REPÚBLICA de 26.1.2012 (Port.)).

70. RODRIGUES AUGUSTO, *supra* note 18, at 47, 61, 67-68.

71. Russoniello, *supra* note 7, at 395 (citing Decreto-Lei 17/2012, DIÁRIO DA REPÚBLICA de 26.1.2012 (Port.)).

72. Alexandra Kirby-Lepesh, *In Times of Austerity, a Threat to Portugal's Drug Policies*, OPEN SOCIETY FOUNDATIONS (Feb. 10, 2012), https://www.opensocietyfoundations.org/voices/in-times-of-austerity-a-threat-to-portugals-drug-policies.

73. THE CATO REPORT, *supra* note 1.

74. HCR No. 127.

75. The four "key results" asserted in HCR No. 127 are addressed later in this chapter.

76. *See, e.g.*, Alex Kreit, *The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?*, 2010 U. CHI. LEGAL F. 299, 300 n.1 (2010), http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1463&context=uclf (characterizing the Cato report as "excellent"); *Treating, not punishing*, ECONOMIST (Aug. 27, 2009), http://www.economist.com/node/14309861 (noting that the Cato report found that "nightmare scenarios" of increased drug abuse feared by opponents of drug decriminalization in Portugal did not materialize after decriminalization was enacted).

77. The Cato report includes the following description of the Cato Institute:

> Founded in 1977, the Cato Institute is a public policy research foundation dedicated to broadening the parameters of policy debate to allow consideration of more options that are consistent with the traditional American principles of limited government, individual liberty, and peace. To that end, the Institute strives to achieve greater involvement of the intelligent, concerned lay public in questions of policy and the proper role of government.
>
> The Institute is named for Cato's Letters, libertarian pamphlets that were widely read in the American Colonies in the early 18th century and played a major role in laying the philosophical foundation for the American Revolution.
>
> Despite the achievement of the nation's Founders, today virtually no aspect of life is free from government encroachment. A pervasive intolerance for individual rights is shown by government's arbitrary intrusions into private economic transactions and its disregard for civil liberties.
>
> To counter that trend, the Cato Institute undertakes an extensive publications program that addresses the complete spectrum of policy issues. Books, monographs, and shorter studies are commissioned to examine the federal budget, Social Security, regulation, military spending, international trade, and myriad other issues. Major policy conferences are held throughout the year, from which papers are published thrice yearly in the Cato Journal. The Institute also publishes the quarterly magazine Regulation.
>
> In order to maintain its independence, the Cato Institute accepts no government funding. Contributions are received from foundations, corporations, and individuals, and other revenue is generated from the sale of publications. The Institute is a nonprofit, tax-exempt, educational foundation under Section 501(c)3 of the Internal Revenue Code.
>
> THE CATO REPORT, *supra* note 1, at 34.

78. *Id*. at 1 (emphasis added).

79. *See, e.g.*, OFFICE OF NATIONAL DRUG CONTROL POLICY, FACT SHEET: DRUG DECRIMINALIZATION IN PORTUGAL: CHALLENGES AND LIMITATIONS 1 (2010), https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/portugal_fact_sheet_8-25-10.pdf (finding that "[i]t is difficult … to draw any clear, reliable conclusions from the [Cato] report regarding the impact of Portugal's drug policy changes" and disputing certain assertions made in the report); Caitlin Elizabeth Hughes & Alex Stevens, *A Resounding Success or a Disastrous Failure: Re-examining the Interpretation of Evidence on the Portuguese Decriminalization of Illicit Drugs*, 31 DRUG & ALCOHOL REV. 101, 108 (2012) http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.645.1699&rep=rep1&type=pdf [hereinafter Hughes & Stevens 2012] (finding that the Cato report contained errors, noting for example, that the Cato report "asserted Portugal had the 'absolute lowest lifetime prevalence rates for cannabis . . .' (when Bulgaria, Malta and Romania all had lower lifetime prevalence than Portugal).") See also the remainder of this chapter for further discussion.

80. THE CATO REPORT, *supra* note 1, at 1.

81. *Id*. at 9 (asserting that "decriminalization freed up resources that could be channeled into treatment and other harm-reduction policies") and 28 (asserting that "[t]he resources that were previously devoted to prosecuting and imprisoning drug addicts are now available to provide treatment programs to addicts").

82. *Id*. at 9 (asserting that "[e]ven before decriminalization, prosecution – and certainly imprisonment – for mere possession or use were rare, but not unheard of").

83. *See, e.g.*, Hughes & Stevens 2012, *supra* note 79, at 100-111. See also the remainder of this chapter for further discussion.

84. See the reminder of this chapter for further discussion.

85. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79.

86. Although the fact sheet uses the term "legalization," Portugal's decriminalization scheme did not legalize drug possession or use. Rather, the scheme treats drug possession as an administrative violation rather than as a criminal offense. For further discussion on the differences between legalization and decriminalization, see Chapter 2.

87. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79, at 1-2 (citations omitted).

88. *Id*. at 2 (citations omitted). It should be noted that although the source cited by the Office of National Drug Control Policy, a 2009 statistical table from the European Monitoring Centre for Drugs and Drug Addiction, characterizes the deaths reported by Portugal as "drug induced deaths" in a table that similarly lists twenty-nine other European Union states, the table also notes that, for Portugal specifically, these data include all cases in which a post mortem analysis tests positive for the *presence* of any illicit drug, which is likely to produce an overestimate compared to other reporting formats that include only deaths specifically *caused* by drug use. *Statistical bulletin 2009 Table DRD-2. Number of drug-induced deaths recorded in EU Member States according to national definitions, Part (i) Total drug-induced deaths, 1995 to 2007*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats09/drdtab2a (last updated July 21, 2009) [hereinafter EMCDDA *Table DRD-2*].

89. Portugal's decriminalization scheme did not legalize drug possession or use. *See supra* note 86 and accompanying text.

90. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79, at 2.

91. The report disputed the Cato report's findings and characterized the decriminalization of drugs in Portugal as "disastrous." MANUEL PINTO COELHO, ASSOCIAÇÃO PARA UM PORTUGAL LIVRE DE DROGAS [ASSOCIATION FOR A DRUG FREE PORTUGAL, OR APLD], THE "RESOUNDING SUCCESS" OF PORTUGUESE DRUG POLICY: THE POWER OF AN ATTRACTIVE FALLACY 14 (2010), http://www.wfad.se/images/articles/portugal%20the%20resounding%20success.pdf. Dr. Coelho has served as a Portuguese abstinence-based drug treatment provider and chair of the Association for a Drug Free Portugal. Hughes & Stevens 2012, *supra* note 79, at 102.

92. Hughes & Stevens 2012, *supra* note 79, at 109.

93. *Id*. at 103.

94. *Id*.

95. *Id*. at 108.

96. *Id*. at 105.

97. *Id*. at 110.

98. *Id*. at 110-111 (citations omitted).

99. Laqueur, *supra* note 17, at 747 (citation omitted).

100. *Id*. at 748.

101. *Id*.

102. *Id*. at 749.

103. *Id*. at 767-768.

104. *Id*. at 749, 756-757.

105. *Id*. at 758.

106. *Id*.

107. Quantities for a ten-day supply for personal consumption include one gram of heroin, one gram of ecstasy, one gram of amphetamines, two grams of cocaine, twenty-five grams of marijuana, five grams of hashish, and one half of one gram of Delta-9-THC. *Id*. at 752; Portaria 94/96, art. IV(9), mapa, DIÁRIO DA REPÚBLICA de 26.3.1996 (Port.); EMCDDA QUANTITY, *supra* note 45, at 13.

108. Laqueur, *supra* note 17, at 752.

109. *See supra* note 74 and accompanying text.

110. HCR No. 127.

111. According to data from the EMCDDA, lifetime prevalence for cannabis use among Portuguese adults was 7.6 percent in 2001 (the year decriminalization took effect) and 11.7 percent in 2007. Although data are not available for all other European countries for those same years, available data indicate that rates of cannabis use ranged from a low of 1.7 percent for Romania in 2004 to 38.6 percent in Denmark in 2008. *Statistical bulletin 2009 Table GPS-1. Lifetime prevalence of drug use among all adults (aged 15 to 64 years) in nationwide surveys among the general population*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats09/gpstab1a (last updated June 30, 2009) [hereinafter EMCDDA *Table GPS-1*].

112. *See, e.g.*, Laqueur, *supra* note 17, at 767. It should be noted, however, that some data suggest that heroin use in Portugal decreased in years following decriminalization, while other data suggest a slight increase. *See infra* note 137 and accompanying text.

113. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79. *See infra* notes 115-116 and accompanying text.

114. *See infra* notes 115-116 and accompanying text.

115. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79. The data indicate that lifetime use rates increased in Portugal between 2001 and 2007 among the general population aged 15 to 64 for cannabis from 7.6 percent to 11.7 percent; for cocaine from 0.9 percent to 1.9 percent; for amphetamines from 0.5 percent to 0.9 percent; for ecstasy from 0.7 percent to 1.3 percent; and for LSD from 0.4 percent to 0.6 percent. The data further indicate that lifetime use prevalence rates

among young adults aged 15 to 34 increased between those same years for cannabis from 12.4 percent to 17.0 percent; for cocaine from 1.3 percent to 2.8 percent; for amphetamines from 0.6 percent to 1.3 percent; for ecstasy from 1.4 percent to 2.6 percent; and for LSD from 0.6 percent to 0.9 percent. EMCDDA *Table GPS-1*, *supra* note 111; *Statistical bulletin 2009 Table GPS-2. Lifetime prevalence of drug use among young adults (aged 15 to 34 years) in nationwide surveys among the general population*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats09/gpstab2 (last updated June 30, 2009).

116. OFFICE OF NATIONAL DRUG CONTROL POLICY, *supra* note 79. The data indicate that use during the last 30 days increased in Portugal between 2001 and 2007 among ages 15 to 64 for cocaine from 0.1 percent to 0.3 percent; and for LSD from 0.0 percent to 0.1 percent. The data further indicate that use during the last 30 days increased in Portugal between those same years among the 15-34 age group for cannabis from 4.4 percent to 4.5 percent; for cocaine from 0.3 percent to 0.6 percent; and for amphetamines from 0.1 percent to 0.2 percent. *Statistical bulletin 2009 Table GPS-5. Last month prevalence of drug use among all adults (aged 15 to 64 years) in nationwide surveys among the general population*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats09/gpstab5 (last updated June 30, 2009); *Statistical bulletin 2009 Table GPS-6. Last month prevalence of drug use among young adults (aged 15 to 34 years) in nationwide surveys among the general population*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats09/gpstab6 (last updated June 30, 2009).

117. EUROPEAN SCHOOL SURVEY PROJECT ON ALCOHOL AND OTHER DRUGS, THE 2011 ESPAD REPORT: SUBSTANCE USE AMONG STUDENTS IN 36 EUROPEAN COUNTRIES 357 tbl.59 (2011), http://www.espad.org/Uploads/ESPAD_reports/2011/The_2011_ESPAD_Report_FULL_2012_10_29.pdf [https://web-beta.archive.org/web/20160801055713/http://www.espad.org:80/Uploads/ESPAD_reports/2011/The_2011_ESPAD_Report_FULL_2012_10_29.pdf].

118. *Id*. at 360 tbl.62.

119. *Id*. at 358 tbl.60.

120. *Id*. at 362 tbl.64.

121. The data indicate that 16 percent of Portuguese high school students surveyed had used marijuana or hashish during their lifetime. The European average was 17 percent. *Id*. at 358 tbl.60.

122. The data indicate that 8 percent of Portuguese high school students surveyed had used illicit drugs other than marijuana or hashish during their lifetime. The European average was 6 percent. *Id*. at 362 tbl.64.

123. The ESPAD report characterized changes in one of three ways: Significant increase, no change, or significant decrease. In 2007, 14 percent of Portuguese highs school students surveyed reported using illicit drugs during their lifetime; in 2011, 19 percent so reported. Id. at 134, fig. 25a; 377, table 59. *Id*. at 134 fig.25a, 377 tbl.59.

124. In 2007, 6 percent of Portuguese high school students surveyed reported using marijuana or hashish during the last 30 days; in 2011, 9 percent so reported. *Id*. at 140 fig.27a, 360 tbl.62.

125. *Id*. at 142 fig.28a, 362 tbl.64.

126. HCR No. 127. Although the resolution passed by the Hawaii Legislature does not specify a time frame in which these decreases are reported to have occurred, the Cato report specifies that:

> For students in the 7th-9th grades (13-15 years old), the rate [of lifetime drug use] decreased from 14.1 percent in 2001 to 10.6 percent in 2006. For those in the 10th-12th grades (16-18 years old), the lifetime prevalence rate, which increased from 14.1 percent in 1995 to 27.6 percent in 2001, the year of decriminalization, has decreased subsequent to decriminalization, to 21.6 percent in 2006. For the same groups, prevalence rates for psychoactive substances have also decreased subsequent to decriminalization.

THE CATO REPORT, *supra* note 1, at 11-12.

127. The most recent data currently available from the European Monitoring Centre for Drugs and Drug Addiction were collected in 2012 and are grouped to reflect lifetime prevalence of drug use in Portugal among persons aged 15-64, 15-24, 25-34, 35-44, 45-54, and 55-64. *Statistical Bulletin 2016*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/data/stats2016 (last visited Dec. 21, 2016). Data available in 2007 indicate that drug use among students in Portugal aged 15 to 16 increased between 1999 and 2003 for cannabis from 8 percent to 15 percent; for ecstasy from 2 percent to 4 percent; for LSD and other hallucinogens from 1 percent to 2 percent; and for cocaine from 1 percent to 3 percent. *Statistical bulletin 2007 Table EYE-3. School surveys: percentage lifetime prevalence of psychoactive substance use among students aged 15-16 years*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/stats07/eyetab03 (last updated Nov. 8, 2007).

128. ANA SOFIA SANTOS ET AL., PORTUGAL INSTITUTE FOR DRUGS AND DRUG ADDICTION, REITOX NATIONAL FOCAL POINT, 2012 NATIONAL REPORT (2011 DATA) TO THE EMCDDA: "PORTUGAL" NEW DEVELOPMENTS, TRENDS AND IN-DEPTH INFORMATION ON SELECTED ISSUES 29 graph 3 (2012), http://www.emcdda.europa.eu/system/files/publications/766/Portugal_NR2012_443595.pdf.

129. Hughes & Stevens 2012, *supra* note 79, at 107 fig.4.

130. *Id*. at 107 (emphasis in original).

131. The numbers of deaths in Portugal in which post-mortem toxicological tests detected the presence of illicit substances were 369 in 1999, 318 in 2000, 280 in 2001, 156 in 2002, 152 in 2003, 156 in 2004, 219 in 2005, 216 in 2006, and 314 in 2007. Laqueur, *supra* note 17, at 769 fig.2; EMCDDA *Table DRD-2*, *supra* note 88.

132. HCR No. 127.

133. THE CATO REPORT, *supra* note 1, at 16.

134. *Id*. at 16-17 (emphasis in original) (citing HUGHES & STEVENS 2007, *supra* note 62, at 3).

135. HUGHES & STEVENS 2007, *supra* note 62, at 2.

136. *Id*.

137. Portuguese authorities recorded that the percentage of persons referred to Commissions for the Dissuasion of Drug Addiction for heroin decreased from 33 percent in 2001 to 15 percent in 2005, while the referrals from cannabis increased from 47 percent to 65 percent in those same years. *Id*. at 3 tbl.2. However, a 2010 report found that the percentage of Portugal's population that self-reported using heroin slightly increased between 2001 and 2007 among people aged 15-64 in each of three surveyed categories. The report found that reported heroin use increased from 0.7 percent to 1.1 percent for "lifetime use" (heroin used at least once during a person's lifetime);

from 0.2 percent to 0.3 percent for use during the previous 12 months; and from 0.1 percent to 0.2 percent during the previous 30 days. 2010 REPORT TO EMCDDA, *supra* note 59, at 23 tbl.3.

138. HUGHES & STEVENS 2007, *supra* note 62, at 3.

139. HCR No. 127.

140. Laqueur, *supra* note 17, at 749, 756-757.

141. *Id*. at 758. The Bureau notes that collection of the data that would be necessary to determine the causes and relevance of the decrease in drug trafficking convictions in Portugal, in relation to patterns of drug use and in the context of decriminalization of drug possession and use, exceed the scope of this study.

Chapter 4

PORTUGAL'S POLICY v. HAWAII'S LEGAL FRAMEWORK

In chapter 3, we addressed the Legislature's request, expressed in House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127) that we review "the current national drug policy of Portugal pertaining to the illegal possession of drugs for personal use." This chapter addresses the Legislature's request that our review focus "on the use of [Portugal's drug] policy as a potential model for the decriminalization of certain or all" of the "existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes."[1] Any attempt to determine whether Portugal's national drug strategy can serve as a model for Hawaii must first explore existing Hawaii drug law and the framework in which it operates. As this chapter will show, the potential for emulation of Portugal's model is limited.

CONFLICTING LEGAL AUTHORITY IN A FEDERAL SYSTEM OF GOVERNMENT

As noted previously, drug control policy and law in Portugal are established by the national government and apply, as relevant here, uniformly throughout that nation.[2] However, in the United States, statutes regulating or prohibiting the possession and use of drugs have been established both by the federal government and by individual states, including Hawaii. Because federal law supersedes state law,[3] the federal government may enforce in any state a federal law prohibiting the same conduct that has been legalized or decriminalized under a state law. The United States Supreme Court has specifically ruled that the federal government may enforce federal drug prohibitions regarding activities that are explicitly authorized under state law, even when those activities do not cross state lines or involve federal property.[4]

The federal government regulates and prohibits certain drugs under the Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II of which is the Controlled Substances Act (CSA).[5] Although the cultivation and use of marijuana for medical purposes is legal under certain conditions in other United States jurisdictions including Hawaii, twenty-seven other states,[6] the District of Columbia, and the United States territories of Guam and Puerto Rico, the federal government has classified marijuana as a Schedule I controlled substance, meaning that the federal government considers marijuana to have a high potential for abuse and no currently accepted medical use in treatment in the United States.[7] This Schedule I classification renders the manufacture, distribution, or possession of marijuana a federal criminal offense. In 2005, the Supreme Court rejected a challenge to the CSA regarding the medical use of marijuana in California as authorized under California law and, by doing so, upheld the supremacy of federal law over state law regarding the regulation and prohibition of drugs.[8] The Court ruled in *Gonzales v. Raich* that the power vested in Congress under Article I, Section 8, of the federal

Constitution "[t]o make all Laws which shall be necessary and proper for carrying into Execution" its authority to "regulate Commerce with foreign Nations, and among the several States" includes the power to prohibit the local cultivation and use of marijuana even when conducted in compliance with California law.[9]

The *Raich* court held that "we have no difficulty concluding that Congress had a rational basis for believing that failure to regulate the intrastate manufacture and possession of marijuana would leave a gaping hole in the CSA[,]"[10] and that "the mere fact that marijuana – like virtually every other controlled substance regulated by the CSA – is used for medicinal purposes cannot possibly serve to distinguish it from the core activities regulated by the CSA."[11] The Court further held that the Supremacy Clause in Article VI of the Constitution "unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail."[12]

The Court recently reiterated in *Taylor v. United States*[13] that the Commerce Clause in Article I, Section 8 of the federal Constitution gives Congress the authority to regulate the national market for marijuana, including the authority to proscribe the purely intrastate production, possession, and sale of marijuana, and further held that federal authority also extends to activities that affect the illegal drug trade.[14] The Court held in *Taylor* that the Commerce Clause authorizes Congress to criminalize the theft or attempted theft of drugs that are regulated or prohibited under federal law, and of proceeds derived from the sale of those drugs, because "[u]nder [*Raich*], the market for marijuana, including its intrastate aspects, is [']commerce over which the United States has jurisdiction[.']"[15] Thus, the federal government may regulate or prohibit drugs and enforce prohibitions against drug-related activities within a state that has explicitly authorized those activities under state law, even where those activities take place entirely within the boundary of a single state. Federal authority also extends to activities that affect the drug trade, such as the robbery or attempted robbery of illegal drug dealers.

It should be noted that the United States Department of Justice has previously indicated that it is unlikely to enforce the CSA with regard to medical marijuana in states that have legalized the use of marijuana for medical purposes and which implement strong and effective regulatory and enforcement systems.[16] However, contrary to the assertion in HCR No. 127, the Department of Justice has not "deferred" its right to challenge state marijuana laws. Indeed, the Department's policies and priorities provide no legal defense to a violation of federal law[17] and are subject to change under future presidential administrations. The fact remains that the possession of any amount of marijuana remains illegal under federal law except under very limited circumstances.[18] Therefore, a state decriminalization scheme modeled after Portugal's drug policy may face legal uncertainty in our federal system of government. Even if the State were to adopt laws that emulate the Portuguese model by decriminalizing the use and possession of personal use quantities of certain illicit drugs, federal law would control if the federal government chose to enforce a federal law that prohibits the use and possession of those same drugs or that otherwise conflicted with state law.

A SURVEY OF HAWAII DRUG OFFENSES UNDER THE SCOPE OF THE RESOLUTION

HCR No. 127 also requested the Bureau to survey "existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes."[19] Accordingly, by definition, HCR No. 127 excluded those offenses relating to "dangerous drugs," which include "hard" drugs such as heroin, cocaine, and methamphetamine,[20] from consideration for possible decriminalization.

Portugal's law decriminalized the possession of *all* illicit drugs in quantities that the possessing individual could reasonably be expected to consume in 10 days, although it is not always clear what amounts of illicit drugs fall within that limit.[21] Similarly, while HCR No. 127 asked the Bureau to analyze "the potential impact on administrative and judicial systems of state government of decriminalizing" the "illegal possession of [certain] drugs for personal use in Hawaii," the resolution did not define or quantify what "possession of drugs for personal use" means. Hawaii laws that apply to the possession of illegal drugs do not generally distinguish between "possession for personal use" and "possession with intent to distribute,"[22] although higher penalties are authorized based on the amount of drugs in an offender's possession.

Further, the scope expressed in HCR No. 127 excludes the possible decriminalization of certain drug offenses based on the maximum level of punishment that may be imposed upon the commission of those offenses under current law. Under the Hawaii Revised Statutes (HRS), crimes are of three grades: felonies, misdemeanors, and petty misdemeanors.[23] Felonies include the following classes: class A, class B, and class C.[24] As previously noted, HCR No. 127 applies to drug offenses that are class C felonies or lower offenses. Class A and class B felonies are "higher offenses," punishable by terms of imprisonment and fines higher than the penalties for class C felony offenses,[25] and are thus excluded from the scope of the resolution. Class C felonies, misdemeanors, and petty misdemeanors are punishable by terms of imprisonment of up to five years, one year, and thirty days, respectively, as well as fines of up to $10,000, $2,000, and $1,000, respectively.[26]

Table 4-1 found in Appendix B lists the relevant drug offenses identified by the survey we undertook pursuant to HCR No. 127. We note that section 712-1247, HRS, and section 712-1248, HRS, are not solely "drug possession laws." This is because these sections not only prohibit drug possession, but also prohibit other illegal activity, such as drug distribution or sales.

THE LEGAL PRIORITY OF HEALTH CARE

As noted in Chapter 3, Portugal's constitution guarantees "access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care."[27] In contrast, while the United States Constitution grants Congress the power to "provide for the . . . general Welfare of the United States," it does not explicitly require the federal government to

provide health care.[28] The Hawaii State Constitution provides that the State "shall provide for the protection and promotion of the public health," but does not require the State to directly provide every person with health care.[29] One observer has noted that "[t]he emphasis on health as a common good (i.e., population health concerns) [e.g., in Portugal] distinguishes public health from individually oriented health care [e.g., in Hawaii]."[30]

Hawaii law does promote health care in some respects, such as by requiring employers to provide their full-time employees health insurance coverage in group health plans.[31] Employees may engage in collective bargaining to negotiate for the terms of their health insurance.[32] Nevertheless, since access to health care is not *guaranteed* by the federal or state constitution, access to individual health care may be viewed as less of a *legal* priority for policymakers in Hawaii than it is in Portugal. As a practical matter, this may impact the availability of treatment for drug use in the State, which would be an essential component of any decriminalization scheme modeled on Portugal's national drug strategy.[33]

EXISTING ALTERNATIVES TO INCARCERATION AVAILABLE UNDER HAWAII LAW

HCR No. 127 contemplates decriminalization as a way to possibly treat, instead of incarcerate, individuals who commit certain drug possession offenses. However, decriminalization is not the only path to treatment. As we will see in the next chapter from court statistics,[34] not everyone who commits a relevant drug offense in Hawaii is incarcerated under present law. As discussed below, a criminal defendant facing prosecution for a jailable offense may be able to avoid imprisonment under certain circumstances, such as when the defendant agrees to plead guilty or no contest to the alleged offense and to undergo substance abuse treatment. Thus, alternatives to imprisonment are already available under Hawaii's criminal justice system, and not only for those accused or convicted of committing drug offenses. As also discussed below, the use of those alternatives can lead to positive results for some individuals, although there is still room from improvement.

Deferred Acceptance of Defendant's No Contest or Guilty Plea

Typically, when a criminal defendant pleads guilty or no contest to an offense, the court accepts the plea, convicts the defendant, and imposes a sentence. However, the court, upon a proper motion by the defendant, may defer the acceptance of the defendant's plea and delay judicial proceedings[35] for an amount of time that varies based on the severity of the alleged offense.[36] The court has the discretion to require the offender to comply with certain conditions in exchange for the deferred acceptance of the plea. One of the conditions may include a requirement that the defendant undergo substance abuse assessment and treatment.[37] If the defendant meets all applicable conditions imposed by the court, the charge is dismissed after the corresponding passage of time,[38] and the defendant may eventually apply for the expungement of records of the arrest.[39]

Conditional Discharge

When a criminal defendant pleads guilty or is found guilty of certain drug offenses, including some offenses involving dangerous, harmful, or detrimental drugs,[40] the court, without entering a judgment of guilt and with the consent of the defendant, may defer further proceedings and place the accused on probation upon terms and conditions established by the court.[41] Upon violation of a term or condition, the court may enter an adjudication of guilt.[42] However, if the defendant fulfills all terms and conditions, the court is required to discharge the defendant and dismiss the proceedings against the defendant.[43] Further, if the defendant against whom proceedings were dismissed was not over the age of twenty-one at the time of arrest, the court, after application from the defendant, is required to enter an order to expunge from all official records any recordation relating to the person's arrest, indictment, or information, trial, finding of guilt, dismissal, and discharge.[44]

Probation and Expungement of Record of Conviction for Certain Drug Possession Offenses

An offender convicted of violating certain laws that apply to the possession of illegal drugs, even if previously convicted once before for a specified drug-related offense, may be eligible for probation and the expungement of the applicable criminal record if the offender:

- Is nonviolent, as demonstrated in the defendant's criminal history;
- Has been assessed by a certified substance abuse counselor to be in need of substance abuse treatment due to dependency or abuse; and
- Enters substance abuse treatment.[45]

After successful compliance with all the terms of probation and the completion of substance abuse treatment, an offender who has never been previously sentenced under section 706-622.5, HRS, relating to sentencing for drug offenders, is eligible to have his or her record of conviction for the drug possession or use offense expunged.[46]

Probation

When a court sentences a convicted defendant to probation, the court, at its discretion, may require the offender to undergo, as a condition of probation, "available . . . assessment and treatment for substance abuse dependency, and remain in a specified facility if required for that purpose."[47] Such a condition may be imposed even if the offense for which the defendant was convicted was not an offense relating to drug or other substance abuse.

While courts have the *discretion* to impose treatment, treatment is not imposed in every case. One version of probation in this State is Hawaii's Opportunity Probation with Enforcement

(HOPE), which has been in place since now-retired circuit court Judge Steven S. Alm initiated its use in 2004.[48] HOPE is targeted toward offenders – including drug offenders – who are at risk of becoming repeat offenders.[49] HOPE probationers undergo frequent and random drug testing as a condition of their probation. A positive drug test or an offender's failure to appear for a drug test may result in a jail sanction that lasts between two and fifteen days.[50] HOPE recognizes that not all drug abusers are addicts.[51] Under HOPE, substance abuse assessment, treatment, and drug court interventions are typically reserved for offenders who request treatment or who demonstrate through multiple violations of conditions of probation that they need treatment or drug court.[52] An offender who fails to complete treatment faces a jail sanction.[53]

Drug Court

A drug court program is considered an "alternative program" in lieu of imprisonment.[54] There are approximately 2,734 drug court programs in the country,[55] including in Hawaii, that are conducted "in lieu of traditional justice case processing."[56] For at least one year, offenders who participate in drug court programs are:

- Provided with intensive treatment and other services they require to get and stay clean and sober;
- Held accountable by a drug court judge for meeting their obligations to the court, society, themselves, and their families;
- Regularly and randomly tested for drug use;
- Required to appear in court frequently so that the judge may review their progress; and
- Rewarded for doing well or sanctioned when they do not live up to their obligations.[57]

Drug court programs have been in place in Hawaii since 1995.[58] Judge Alm describes the program in Honolulu as follows:

> [A] client sees the judge once a week, every week, to start. They are assigned a counselor and a case manager and given substance abuse treatment. Drug court clients typically live in an Oxford Clean and Sober House (or at the YMCA if they are truly indigent and have no family support on their release from jail).[59]

Notably, under Hawaii law, a person may not be considered for drug court if he or she has been convicted of a class A felony for which a sentence of imprisonment is mandatory.[60] Drug court programs in Hawaii are intended for high-risk offenders who have failed under community supervision or HOPE probation.[61] The drug court programs are usually the last resort before an offender faces prison.[62] Due to the costly and intensive nature of the drug court programs, Hawaii's programs can only admit a limited number of offenders at a time. For example, in September of 2014, there were only one hundred ninety-seven clients in the drug

court program in Honolulu.[63] Estimated annual drug court program expenditures statewide have remained fairly constant since fiscal year 2010-2011, as shown in Table 4-2 in Appendix B.[64] Any effort to increase the number of eligible offenders enrolled in the program would conceivably need additional funding.

Treatment or Imprisonment: Potential Limitations

There may be some drawbacks that accompany any program that allows defendants or offenders to choose drug treatment over imprisonment. For example, American drug court programs have been criticized as "overinclusive" because they may "cause individuals who do not have drug abuse or addiction problems and thus are not in need of drug treatment to use precious treatment resources in order to avoid the consequences of a conviction."[65] Further, persons with history of violent offenses are often prevented from entering drug court, even if they could significantly benefit from the program.[66]

Judge Alm, aware of some of the criticisms of drug court, initiated some adjustments to Oahu's version of the drug court program in 2011, by attempting to admit into the program the individuals who most need it, including some individuals who may have committed violent offenses.[67] Nevertheless, the statutory prohibition on placing class A felony offenders in drug court remains.[68] Notably, while all class A felonies are serious offenses, not all such felonies are acts of violence.[69]

Thus, while drug treatment programs are available to some defendants through Hawaii's judicial system, not all offenders can receive treatment due to limited resources. Moreover, other offenders who conceivably could benefit more from treatment than others might not be eligible to participate in treatment programs.

ENDNOTES

1. House Concurrent Resolution No. 127.
2. *See supra* Chapter 3 notes 9, 11-12, 37, and accompanying text.
3. The Supremacy Clause in Article VI of the Constitution of the United States of America provides that federal law shall prevail in the event of any conflict between federal and state law.
4. Gonzales v. Raich, 545 U.S. 1 (2005).
5. Controlled Substances Act, 21 U.S.C. § 812 et seq.
6. In addition to Hawaii, states that have legalized the use of marijuana for medical purposes under certain conditions include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington. *See* Table 1 in *State Medical Marijuana Laws*, NAT. COUNCIL ST. LEGISLATURES (Nov. 9, 2016), http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx#3. Alaska, California,

Colorado, Maine, Massachusetts, Nevada, Oregon, Washington, and the District of Columbia have also legalized adult recreational use of marijuana under certain conditions. *Marijuana Overview*, NAT. COUNCIL ST. LEGISLATURES (Nov. 10, 2016), http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx. See also "United States: Decriminalization of Marijuana for Non-medical Use" in Chapter 6 of this report for further discussion.

7. The Controlled Substances Act establishes five categories, or "schedules," into which controlled substances are placed. These schedules are updated on an annual basis and are found at 21 C.F.R. § 1308.11 et seq., as amended by subsequent revisions published in the Federal Register. The federal position is that marijuana has not met the rigorous safety and efficacy standards of the United States Food and Drug Administration's approval process and that smoking marijuana is a particularly unsafe delivery system that produces harmful effects. 21 U.S.C. §§ 812(b), (c); *Office of National Drug Control Policy Answers to Frequently Asked Questions about Marijuana*, WHITEHOUSE.GOV http://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana.
8. *Raich*, 545 U.S. at 29.
9. *Id.* at 2.
10. *Id.* at 19.
11. *Id*. at 25.
12. *Id*. at 26.
13. Taylor v. United States, No. 14-6166, 2016 WL (U.S. June 20, 2016).
14. *Id*.
15. *Id*. at 6.
16. In a memorandum issued on August 29, 2013, the Department of Justice enumerated the following specific nationwide enforcement priorities regarding marijuana:
    - Preventing the distribution of marijuana to minors;
    - Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs, and cartels;
    - Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
    - Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
    - Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
    - Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
    - Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
    - Preventing marijuana possession or use on federal property.

The memorandum noted that the Department of Justice "has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of marijuana for personal use on private property[,]" but has generally left enforcement to state and local authorities unless the marijuana-related activities implicated the priorities enumerated above.

The Department of Justice indicated that it is inclined to defer to state and local enforcement in states that authorize the production, distribution, and possession of medical marijuana only if the affected states "implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests."

The memorandum emphasized the need for effective implementation of state regulatory schemes: "Jurisdictions that have implemented systems that provide for regulation of marijuana activity must provide the necessary resources and demonstrate the willingness to enforce their laws and regulations in a manner that ensures they do not undermine federal enforcement priorities." The memorandum warned that states that enact marijuana legalization schemes but fail to implement them effectively could be subject to federal intervention: "If state enforcement efforts are not sufficiently robust to protect against [the harms that are the bases of the enforcement priorities enumerated above], the federal government may seek to challenge the regulatory structure itself in addition to continuing to bring individual enforcement actions, including criminal prosecutions, focused on those harms. . . ." Memorandum from Deputy Attorney General James M. Cole to all United States Attorneys (Aug. 29, 2013), http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.

17. The 2013 United States Department of Justice memorandum explicitly stated that it is intended "solely as a guide to the exercise of investigative and prosecutorial discretion[,]" but "does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law." The memorandum further cautioned that "[n]either the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the [Controlled Substances Act,]" and that investigation and prosecution that serve an important federal interest may continue regardless of a state's strong and effective regulatory system for marijuana. *Id*.

18. The federal government has designated the National Institute on Drug Abuse (NIDA) within the National Institutes of Health as the agency responsible for overseeing the cultivation of marijuana for medicinal research. NIDA contracts with the University of Mississippi to grow marijuana for use in research studies. *See, e.g.*, Marijuana Research with Human Subjects, U.S. FOOD & DRUG ADMIN. http://www.fda.gov/NewsEvents/PublicHealthFocus/ucm421173.htm (last updated Sept. 14, 2015).

19. HCR No. 127. A harmful drug is "any substance or immediate precursor defined or specified as a 'Schedule III substance' or a 'Schedule IV substance' by chapter 329 [Hawaii Revised Statutes], or any marijuana concentrate except marijuana and a substance specified in section 329-18(c)(14) [Hawaii Revised Statutes]." A detrimental drug is "any substance or immediate precursor defined or specified as a "Schedule V substance" by chapter 329, or any marijuana." Section 712-1240, Hawaii Revised Statutes (HRS).

20. A dangerous drug is "any substance or immediate precursor defined or specified as a 'Schedule I substance' or a 'Schedule II substance' by chapter 329 [HRS], or a substance specified in section 329-18(c)(14) [HRS], except marijuana or marijuana concentrate." Section 712-1240, HRS. See

Chapter 5 of this report for further discussion on dangerous drugs, harmful drugs, and detrimental drugs.

21. Except for seven substances, Portugal's law does not specify what constitutes a "10-day" supply. *See supra* Chapter 3, notes 45-46 and accompanying text.

22. One exception is found in section 712-1249.6, HRS, which prohibits, among other activities, possession with intent to distribute an illicit drug in or near a school. Since Portugal's law does not appear to be designed to eliminate criminal penalties for distribution of illicit drugs to others, we assume that the Legislature does not intend to decriminalize the offense of promoting a controlled substance in, on, or near schools, school vehicles, public parks, or public housing projects or complexes under section 712-1249.6, HRS, because that offense prohibits possession *with intent to distribute*. We note that one type of drug possession prohibited under federal law is the possession "with intent . . . to distribute" illicit drugs, and that law is unrelated to where the offense took place. 21 U.S.C. § 841.

23. Section 701-107, HRS.

24. Section 701-107, HRS. Murder offenses are not listed among class A, class B, or class C, but fall under their own separate categories.

25. The commission of class A and class B felonies are punishable by terms of imprisonment of up to twenty years and ten years, respectively, as well as fines of up to $50,000 and $25,000, respectively. Sections 706-640, 706-759, and 706-660, HRS.

26. Sections 706-640, 706-660, and 706-663, HRS.

27. CONSTITUTION OF THE REPUBLIC, SEVENTH REVISION, 2005, art. 64(3)(a) (Port.), http://www.en.parlamento.pt/Legislation/CRP/Constitution7th.pdf.

28. U.S. CONST. art. I, § 8, cl. 1.

29. HAW. CONST. art. IX, § 1.

30. Nancy M. Baum et al., *Looking Ahead: Addressing Ethical Challenges in Public Health Practice*, 35 J. L. MED. & ETHICS 657, 658 (2007).

31. Section 393-11, HRS.

32. Sections 89-9(e) and 377-4, HRS.

33. See "National Drug Strategy" in Chapter 3 of this report for a discussion of Portugal's national drug strategy.

34. *See infra* Chapter 5 note 231 and accompanying text.

35. Section 853-1(a), HRS.

36. Section 853-1(b), HRS.

37. Section 706-624(2)(j), HRS.

38. Section 853-1(c), HRS.

39. Section 853-1(e), HRS.

40. The "relevant" offenses applicable to this discussion on conditional discharge are those listed under section 712-1246, HRS (Promoting a harmful drug in the third degree; section 712-1248,

HRS (Promoting a detrimental drug in the second degree); and section 712-1249, HRS (Promoting a detrimental drug in the third degree).

41. Section 712-1255(1), HRS.

42. *Id*.

43. Section 712-1255(2), HRS.

44. Section 712-1256, HRS.

45. Section 706-622.5(1), HRS. This section provides in pertinent part that a person "convicted for the first or second time for any offense under section 329-43.5 involving the possession or use of drug paraphernalia or any felony offense under part IV of chapter 712 involving the possession or use of any dangerous drug, detrimental drug, harmful drug, intoxicating compound, marijuana, or marijuana concentrate, as defined in section 712-1240, but not including any offense under part IV of chapter 712 involving the distribution or manufacture of any such drugs or substances and not including any methamphetamine offenses under sections 712-1240.7, 712-1240.8 as that section was in effect prior to July 1, 2016, 712-1241, and 712-1242, is eligible to be sentenced to probation" if the person meets the specified eligibility criteria.

46. Section 706-622.5(4), HRS.

47. Section 706-624(2)(j), HRS.

48. Judge Alm determined that HOPE could be instituted without changing existing law. Judge Steven S. Alm, *HOPE Probation and the New Drug Court: A Powerful Combination*, 99 MINN. L. REV. 1665, 1672 (2015), http://www.minnesotalawreview.org/wp-content/uploads/2015/09/Alm_5fmt_final.pdf.

49. ROBERT L. DUPONT ET AL., INSTITUTE FOR BEHAVIOR AND HEALTH, INC., STATE OF THE ART OF HOPE PROBATION 2 (2015), http://www.courts.state.hi.us/docs/news_and_reports_docs/State_of_%20the_Art_of_HOPE_Probation.pdf.

50. *Id.* at 4.

51. ANGELA HAWKEN & MARK KLEIMAN, MANAGING DRUG INVOLVED PROBATIONERS WITH SWIFT AND CERTAIN SANCTIONS: EVALUATING HAWAII'S HOPE 32-33 (2009), https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf.

52. DUPONT ET AL, *supra* note 49 at 5-6, 23, 24.

53. *Id*. at 50, 64.

54. Section 706-605.1, HRS.

55. *Types of Drug Courts*, NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS , http://www.nadcp.org/learn/what-are-drug-courts/models (last visited Dec. 21, 2016).

56. *What are Drug Courts?*, NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS , http://www.nadcp.org/node/13 (last visited Dec. 21, 2016).

57. *Id*.

58. DUPONT ET AL, *supra* note 49 at 62.

59. Alm, *supra* note 48 at 1687.

60. Section 706-605.1(2), HRS.

61. DUPONT ET AL, *supra* note 49 at 51, 62.

62. *Id.* at 51, 63.

63. *Id*.

64. This table is adapted from E-mail correspondence from Judiciary staff on Aug. 26, 2016 (on file with the Bureau).

65. Alex Kreit, *The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?*, 2010 U. CHI. LEGAL F. 299, 311-312 (2010), http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1463&context=uclf.

66. *Id*. at 321 (citing Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1362 (2000); AVINASH SINGH BHATI ET AL., THE URBAN INSTITUTE, TO TREAT OR NOT TO TREAT: EVIDENCE ON THE PROSPECT OF EXPANDING TREATMENT TO DRUG-INVOLVED OFFENDERS 60-62 (2008)).

67. Alm, *supra* note 48 at 1685-1686, 1689-1690.

68. Section 706-605.1(2), HRS.

69. Nonviolent, non-drug-related class A felonies include those listed under section 708-891, HRS (Computer fraud in the first degree) and section 708-895.5, HRS (Unauthorized computer access in the first degree).

Chapter 5

THE CHALLENGES OF ESTIMATING THE POTENTIAL IMPACT OF DECRIMINALIZATION IN HAWAII

In House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127), the Legislature requested the Bureau to study "[t]he potential impact on administrative and judicial systems of state government of decriminalizing certain or all" of the "existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes."[1] Unfortunately, as explained below, our ability to estimate that impact is affected by the limits of the information available regarding drug use trends, treatment needs and capacity, prevention effects, and criminal enforcement. In addition, it is presently uncertain what specific scheme of decriminalization, if any, policymakers may find appropriate for Hawaii. While these challenges ultimately prevented us from estimating the impact of decriminalization, the discussion below seeks to shed light on some of the issues the Legislature may wish to consider in the context of devising and evaluating a potential decriminalization scheme.

CURRENT BASELINE INFORMATION IS INSUFFICIENT TO ESTIMATE THE POTENTIAL IMPACTS OF DECRIMINALIZATION

Any attempt to estimate the potential impact on state administrative and judicial systems of decriminalizing relevant drug possession offenses requires the collection of accurate information on the impact that current drug laws and use presently have on those systems. During the course of conducting research for this part of the study, we located several published reports with relevant information,[2] and we also wrote to numerous agencies to obtain more detailed data. Some agencies responded and provided some or all of the information that we requested. Other agencies responded, but could not provide any information, due to their limited ability to compile relevant data. Some agencies acknowledged our request, but did not follow up by providing the information we requested. Some agencies did not respond to our requests at all. A table indicating whether and how agencies responded to our requests for information is attached in Appendix F. While we were able to obtain some information, we did not obtain all of the information we sought, and some of the information was limited with regard to relevance, specificity, and reliability. Overall, the information obtained helped paint a very broad picture, but that picture is incomplete.

INFORMATION REGARDING HAWAII'S DRUG PROBLEM: TRENDS, TREATMENT, AND PREVENTION

To understand the extent of the current impact that drug use has on administrative and judicial systems, we sought relevant information about Hawaii's drug problem. Various illicit drugs are known to be in use in Hawaii, but we wanted to know which drugs are more pervasive than others, in terms of supply and demand, and which pose a greater threat than others, since more funding and resources may be necessary to provide treatment to individuals who use those drugs.

Drug Use Trends

Understanding and comparing the drug use trends in Hawaii and Portugal is necessary to grasp the potential impact that decriminalization modeled on Portugal would have on the State's administrative and judicial systems. The drugs specified for review by the Bureau, pursuant to HCR No. 127, include marijuana, marijuana concentrates, harmful drugs, and detrimental drugs. Notable omissions from this list include most opioid prescription pain relievers, heroin, and methamphetamine.[3] Along with information regarding the use of marijuana, marijuana concentrates, harmful drugs, and detrimental drugs, the following discussion provides selected information relating to the use of drugs not mentioned in HCR No. 127 as a means of presenting a more complete understanding of the nature and scope of drug use in Hawaii, and how it differs from drug use in Portugal.

Preliminarily, we note that comparing drug use in Hawaii and Portugal, whether in terms of the trends that led to the adoption of Portugal's drug strategy or the current trends in each jurisdiction, is an imperfect process for multiple reasons. First, the inaugural general population drug use survey of Portugal was conducted in 2001, after Portugal had modified its drug laws.[4] The lack of information regarding Portugal's drug use trends prior to the modification of Portugal's laws makes it difficult to present a comprehensive picture both of the specific circumstances that led to the change in Portugal's drug laws and of how Hawaii's drug issues today compare to Portugal's issues prior to 2001. Further complicating the presentation and assessment of drug trends in Hawaii and Portugal is the fact that surveys and studies conducted in each jurisdiction cover different age groups,[5] ask about different drugs,[6] and do not routinely ask the same questions regarding the prevalence of drug use.[7] Finally, it is difficult to accurately compare turn of the millennium drug use trends in Hawaii to current drug use trends because the United States Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that the results of surveys taken before 2002 not be compared to the results of surveys taken since then.[8]

An additional challenge to understanding Hawaii's drug use trends is the lack of statistics regarding usage trends for the specific drugs enumerated in HCR No. 127.[9] There is not enough information available to accurately quantify which types of harmful or detrimental drugs are used in Hawaii, or how often, largely because the harmful and detrimental terminology reflects statutory classifications pertaining to drug regulations and prohibitions, rather than public health classifications used to track the use of specifics drugs. Among other things, the statutory classifications of harmful and detrimental drugs include various prescription opioids, stimulants,

tranquilizers, sedatives, and steroids. While SAMHSA surveys the nonmedical use of pain relievers, which includes certain prescription opioids and sedatives, it does not survey the comprehensive list of harmful or detrimental drugs defined by Hawaii criminal statutes.[10] Additionally, SAMHSA's survey of nonmedical pain reliever use also includes various drugs that are classified under Hawaii law as dangerous, making these numbers unreliable in the assessment of harmful and detrimental drug use trends.

Regardless of the challenges in comparing drug use trends in Hawaii and Portugal, especially as it relates to trends in the use of harmful and detrimental drugs, enough information is available to paint a broad picture of certain drug use trends in each jurisdiction. Using estimated prevalence use rates, together with treatment admission rates, some of Hawaii's relevant drug use trends can be identified.

Illicit Drug Use, Generally

In 2014, approximately one in ten Americans aged twelve or older were estimated to be past-month users of an illicit drug,[11] which is the highest number of estimated past-month users of an illicit drug since 2002 when the current estimation survey methods were first used.[12] Hawaii has followed the national trend with an estimated 9.67 percent of the population of Hawaii aged twelve or older being past-month illicit drug users in 2013-2014.[13] This estimate is similar to recent estimates; 9.71 percent in 2011-2012 and 10.30 percent in 2012-2013, of illicit drug use of the population of Hawaii aged twelve or older.[14]

Unlike Hawaii and the United States, available data indicates that Portugal has not experienced a consistent increase in illicit drug use in recent years.[15] While illicit drug use rates in Portugal appear to have peaked in 2007, data indicate that there was an overall decline in past-month and past-year use rates from 2001 to 2012.[16] Use of any illicit drug in the past-year by those aged between fifteen and sixty-four in Portugal was estimated to be 3.4 percent in 2001, 3.7 percent in 2007, and 2.7 percent in 2012.[17] Use of any illicit drug in the past-month by those aged between fifteen and sixty-four in Portugal was estimated to be 2.5 percent in 2001 and 2007, and 1.7 percent in 2012.[18] The 2012 lifetime drug use rates for those aged between fifteen and sixty-four in Portugal have risen from 2001 estimates (7.8 percent in 2001 and 9.5 percent in 2012), although the 2012 estimate is less than the 12 percent estimate in 2007.[19]

When comparing estimates of past-month illicit drug use in Portugal, Hawaii, and the United States as a whole, it is clear that illicit drug use is more prevalent in the United States, generally, and in Hawaii separately (approximately ten percent of the population ages twelve and older), than it is in Portugal (between 1.7 and 2.5 percent of the population aged between fifteen and sixty-four).

Marijuana Use

> Marijuana, or Cannabis, refers to the dried leaves, flowers, stems, and seeds from the hemp plant Cannabis sativa, which contains the psychoactive (mind-altering) chemical delta-9-tetrahydrocannabinol (THC), as well as other related compounds. This plant material can also be concentrated in a resin called hashish or a sticky black liquid called hash oil. THC is believed to be the main chemical ingredient that produces the psychoactive effect. Marijuana is often smoked in hand-rolled cigarettes (joints), pipes, or water pipes (bongs). People also smoke it in blunts, which are partly or completely emptied cigars filled with marijuana. Marijuana is also mixed in food (edibles) or brewed as tea.[20]

Marijuana[21] is the most frequently used drug in Portugal,[22] not including licit drugs.[23] In 2001, an estimated 7.6 percent of Portugal's population aged fifteen to sixty-four had used marijuana at least once in their life, 3.3 percent had used marijuana once in the past-year, and 2.4 percent had used marijuana during the preceding thirty-day time period.[24] Portugal's lifetime and past-year marijuana use rates rose in 2007 to 11.7 percent and 3.6 percent, respectively, while the last month use rate remained 2.4 percent.[25] In 2012, Portugal's marijuana use rate in all three categories, 9.4 percent lifetime use, 2.7 past-year use, and 1.7 percent past-month use, were lower than the 2007 rates, and the past-year and past-month use rates were lower than the 2001 rates.[26]

In the United States, marijuana is also the most commonly used drug, not including alcohol and tobacco, with approximately 22.2 million Americans aged twelve and older, or 8.4 percent, estimated to be past-month users of marijuana in 2014.[27] Estimated marijuana use rates in the United States were steady between 2002 and 2008 with use rates at highs in 2002-2003 (the estimated national average of past-month marijuana use was 6.18 percent and the estimated past-year use was 10.78 percent) and lows in 2006-2007 (the estimated national average of past-month marijuana use was 5.94 percent and the estimated past-year use was 10.24 percent).[28] The marijuana usage rates rose sharply in 2009-2010 with an estimated past-month rate of 6.77 percent and past-year rate of 11.47 percent.[29]

In Hawaii in 2002-2003, an estimated 6.95 percent of the population aged twelve and older were past-month users of marijuana, and an estimated 11.56 percent were past-year users of marijuana, placing Hawaii slightly above the national average in past-month and past-year marijuana use.[30] Hawaii's percentages were an estimated 6.7 percent for past-month marijuana use and an estimated 10.43 past-year marijuana use in 2007-2008.[31] These estimates are in line with the national estimates of marijuana use mentioned in the previous paragraph, and remain well-above the 2007 peak in marijuana and illicit drug use in Portugal. As shown in Figure 5-3 in Appendix C, Hawaii's recent past-month and past-year marijuana use rate has remained consistent with the national average.

Thus, while marijuana use is common in Portugal, use of the drug is not nearly as widespread there as it is in the United States as a whole and in Hawaii separately. As previously mentioned, approximately 22.2 million Americans, or approximately 8.4 per cent of the population over the age of twelve are estimated to have been past-month users of marijuana in 2014, while Portugal, with a total population of approximately only ten million, estimates only 1.7 percent of its population between the ages of fifteen and sixty-four were past-month users of marijuana in

2012. The gross number of past-month marijuana users in Portugal and Hawaii is similar, even though Hawaii's total population is roughly one-tenth that of Portugal. Hawaii is estimated to have had 98,000 past-month marijuana users aged twelve and older in 2012-2013, while Portugal had approximately 120,000 past-month marijuana users between the ages of fifteen and sixty-four in 2012.[32]

Read in conjunction with use estimates, the number of admissions for treatment of drug use can present a more complete understanding of a jurisdiction's drug problem. SAMHSA data show that, excluding alcohol, marijuana has been one of the top two substances for which people in Hawaii aged twelve and older were admitted for treatment in each year between 2001 and 2015.[33] However, since 2011, there have been fewer admissions for treatment of marijuana use than there have been for treatment of methamphetamine or other amphetamine use.[34] The number of admissions for treatment in which marijuana was the primarily used substance was 2,032 (30.1 percent of all admissions) in 2013,[35] 1,785 (28.1 percent of all admissions) in 2014,[36] and 1,720 (27 percent of all admissions) in 2015.[37] The percentage of admissions for the treatment of marijuana use funded by the Alcohol and Drug Abuse Division of the State Department of Health (ADAD) varies by age. Marijuana use treatment for adults comprises 14.1 percent of the ADAD sponsored treatment funding, which is greater than the percentage of treatment funding for heroin use, cocaine use, and other drug use, and less than the funding for treatment of methamphetamine use and alcohol use. Marijuana use treatment for youths comprises 63.5 percent of ADAD sponsored treatment funding, with alcohol use treatment receiving 24.7 percent, other drug use treatment receiving 10.9 percent, and methamphetamine, cocaine, and heroin use treatment all receiving less than one percent.

Nonmedical Stimulant, Depressant, and Pain Reliever Use

HCR No. 127 requested a study on the decriminalization of possession of personal use quantities of harmful and detrimental drugs, among others. Under Hawaii law, harmful and detrimental drugs consist largely of prescription drugs.[38] There are more than one hundred individual harmful or detrimental drugs, including various opioids, stimulants, depressants, sedatives, and steroids.[39] Certain harmful or detrimental drugs are often used by persons for whom the drugs were not prescribed, or are used for purposes other than the intended medical uses, both of which are referred to as nonmedical or recreational use. While we located no surveys or studies that attempt to estimate the nonmedical or recreational use of any particular harmful or detrimental drug in Hawaii, the following information regarding the nonmedical use of stimulant, depressant, and pain relieving drugs serves to present a limited picture of drug use trends in Portugal and Hawaii.

Stimulants and Depressants. The terms "stimulant" and "depressant" are used broadly to describe certain drugs. Stimulants:

> [I]ncrease alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. Stimulants historically were used to treat asthma and other respiratory problems, obesity, neurological disorders, and a variety of other ailments. But as their

> potential for abuse and addiction became apparent, the medical use of stimulants began to wane. Now, stimulants are prescribed to treat only a few health conditions, including ADHD, narcolepsy, and occasionally depression – in those who have not responded to other treatments.[40]

Stimulants can include dangerous drugs like cocaine, amphetamines, or methylphenidate, or harmful drugs like benzphetamine. The Bureau could not locate any data that estimate the prevalence of nonmedical prescription stimulant use in Hawaii. Admissions for the treatment of nonmedical prescription stimulant [41] use in Hawaii are minimal and have been stable over the past three years, with five admissions in 2013,[42] seven admissions in 2014,[43] and seven admissions in 2015.[44] Admissions in each of these years totaled 0.1 percent of the total admissions for treatment.[45]

> When measured by national surveys, "depressants":
>
> [A]re often categorized as sedatives or tranquilizers. Sedatives primarily include barbiturates (e.g., phenobarbitol) but also include sleep medications such as Ambien and Lunesta. Tranquilizers primarily include benzodiazepines such as Valium and Xanax, but also include muscle relaxants and other anti-anxiety medications.[46]

Many commonly used depressants are categorized under Hawaii law as harmful drugs. Portugal surveys the prevalence of licit tranquilizer and sedative use. It is unclear whether the "licit" use rates provided by Portugal refers to medical use, nonmedical use, or both. Tranquilizers and sedative use was found to be common and stable in Portugal, with last month prevalence use rates estimated to be eleven percent in 2001, 9.9 percent in 2007, and ten percent in 2012.[47] Past year prevalence use was estimated to be 14.4 percent in 2001, twelve percent in 2007, and 12.2 percent in 2012.[48] Estimated lifetime use was 22.5 percent in 2001, 19.1 percent in 2007, and 20.4 percent in 2012.[49]

It appears that no agency in the United States gathers state-specific prevalence estimates for the nonmedical use of depressants, sedatives, or tranquilizers. Similar to stimulants, the number of admissions for treatment of depressants in Hawaii has been minimal. The number of admissions for treatment in Hawaii in which tranquilizers[50] were the primarily abused substance were thirteen (0.2 percent of total admissions) in 2013,[51] five (0.1 percent of total admissions) in 2014,[52] and eighteen (0.3 percent of total admissions) in 2015.[53] The number of admissions for treatment in Hawaii in which sedatives[54] were the primarily abused substance were even lower, with no admissions in 2013 and 2014, and one admission in 2015.[55]

Pain Relievers. Many different drugs may be prescribed for pain relief. While medical professionals have various pain relief options to offer clients,[56] opioids are the most common form of pain relief prescribed in the United States. Prescription opioids are natural, semi-synthetic, and synthetic drugs, including hydrocodone (Vicodin), oxycodone (OxyContin), morphine, and codeine.[57] In Hawaii, particular opioids have been classified as dangerous, harmful, or detrimental drugs.[58] It should be noted that more people in the United States die from opioid pain reliever overdoses than from heroin and cocaine overdoses combined.[59] A recent increase of opioid abuse

in the United States resulted in the enactment of the federal Comprehensive Addiction and Recovery Act of 2016,[60] which, among other things, authorized the United States Attorney General and Secretary of Health and Human Services to awards grants to address prescription opioid and heroin abuse.[61]

There does not appear to be any reliable data regarding nonmedical opioid or pain reliever use in Portugal for comparison purposes. However, in the United States, the estimated prevalence of nonmedical pain reliever use in the past-year was 4.79 percent of total pain reliever use in 2002-2003,[62] 4.57 percent in 2010-2011[63] and 2011-2012,[64] 4.51 percent in 2012-2013,[65] and 4.06 percent in 2013-2014.[66] The estimated prevalence of nonmedical pain reliever use in the past-year in Hawaii was similar to the national rates, with 3.90 percent of total pain reliever use in 2002-2003[67] and 2010-2011,[68] 4.36 percent in 2011-2012,[69] 4.54 percent in 2012-2013,[70] and 4.24 percent in 2013-2014.[71] See Figure 5-4 in Appendix B.

In Hawaii, admissions for treatment of opioids other than heroin[72] are the third most frequent admission for an illicit substance, after marijuana and amphetamines (which includes methamphetamine). However, this frequency is a distant third. There were three hundred three admissions (4.5 percent of total admissions) in 2013,[73] two hundred eighty-eight admissions (4.5 percent of total admissions) in 2014,[74] and two hundred seventy-eight admissions (4.4 percent of total admissions) in 2015.[75]

It should be noted that the estimated prevalence use rates reported by SAMHSA do not identify the specific pain relievers for which use is estimated and that the treatment admission numbers include those for dangerous, harmful, and detrimental drugs.

Heroin Use

As reviewed in Chapter 3, an increase in the use of and addiction to heroin in the general population of Portugal has been cited as a leading factor in that country's decision to adopt its revised drug control strategy, which took effect in 2001.[76] Heroin was a concern in Portugal in the 1990s not only because of the effects of use and addiction, but also because the sharing of needles used to inject heroin led to an increase in the transmission of disease.[77] Portugal's reported heroin usage rates in all three surveyed categories (lifetime, past-year, and past-month) increased between 2001 and 2007,[78] while a 2012 survey found that rates had by then dropped to 0.6 percent for lifetime use and, most interestingly, zero percent use in both the past-year and past-month categories.[79] In comparison to other drug use surveyed in Portugal, heroin use has consistently been ranked as either less common or equal to marijuana, tranquilizers and sedatives, and cocaine use.[80] See Figure 5-5 in Appendix C.

The use of, and the threat posed by, heroin in the United States has increased since 2007, particularly in the northeast, mid-Atlantic, and Midwest states.[81] Although limited information is available on heroin use in Hawaii, it is unclear how much of a problem heroin use currently poses in Hawaii because, as noted above, SAMHSA does not release estimated usage percentages for heroin, per state.[82] The National Drug Intelligence Center of the United States Department of

Justice released a Drug Threat Assessment for Hawaii in 2002 that provided some insight into heroin use in Hawaii shortly after Portugal modified its drug laws in 2001. While the Assessment found that "the availability, distribution, and abuse of heroin continue to present a threat to Hawaii," the threat was not as severe as the threats posed by methamphetamine and marijuana.[83] The Assessment reported that Hawaii had a 0.9 percent lifetime heroin use rate and four hundred thirty-four admissions for treatment of heroin use in 1998.[84] However, after falling for a decade, the number of admissions for treatment of heroin use in Hawaii rose in 2015. More specifically, until last year, 2002 was the most recent year in which there were over two hundred admissions for treatment of heroin use in Hawaii (two hundred twenty-one admissions); in 2015, the number of admissions climbed to two hundred two admissions.[85]

Methamphetamine Use

> Methamphetamine (meth) is a stimulant that has a similar chemical structure to amphetamine. Regular methamphetamine is a pill or powder, while crystal methamphetamine takes the form of glass fragments or shiny blue-white "rocks" of different sizes. Meth is taken orally, smoked, injected, or snorted. To increase its effect, users smoke or inject it, or take higher doses of the drug more frequently.[86]

Methamphetamine is categorized as a dangerous drug.[87] It is difficult to *quantify* Hawaii's methamphetamine problem because annual studies or surveys that estimate its use rates or trends are not conducted, but one way to understand the severity of methamphetamine use is to consider the number of admissions for substance use treatment in which amphetamine or methamphetamine is the primary substance for which treatment was sought. However, calculating the specific number of treatment admissions in which methamphetamine is the primarily used substance is problematic because, when reported by SAMHSA, admissions for methamphetamine use are reported under the broader category of amphetamines, rather than being reported alone. Amphetamine include substances other than methamphetamine, and when admission numbers are reported, the amphetamine category includes admissions both for methamphetamine and other amphetamines.[88] Between 2013 and 2015, SAMHSA reported that amphetamine was the primary drug for which there were the most adult admissions for drug use treatment in Hawaii. In 2013, there were 2,063 (30.6 percent of all admissions) treatment admissions in Hawaii in which amphetamines were identified as the primarily treated substance.[89] Admissions rose in both 2014 (2,166 admissions, representing 34.1 percent of total admissions)[90] and 2015 (2,260 admissions, representing 35.5 percent of total admissions).[91]

While we are unable to quantify the number of admissions for treatment of methamphetamine use, rather than amphetamine use, with SAMHSA-reported admissions, we note that ADAD reports on adult admissions for treatment of methamphetamine use. The SAMHSA and ADAD data are different because: (a) ADAD only reports admission data that is funded by ADAD, and SAMHSA reports ADAD- and non-ADAD-funded admission data; and (b) the reporting criteria may be different. However, the considerable number of ADAD reported admissions for methamphetamine treatment (1,428 in fiscal year 2015-2016, which was 50.5 percent of all ADAD-funded admissions for treatment) suggests that methamphetamine likely represents a majority of SAMHSA-reported admissions for amphetamine treatment.[92]

The general population survey of drug use in Portugal reports on the estimated prevalence of amphetamine use, but not on methamphetamine in particular,[93] and the Bureau was unable to verify whether the data collected on amphetamines also include methamphetamine. Still, use of amphetamine in general (lifetime, past-year, and past-month) in Portugal was minimal in 2001, 2007, and 2012. Past-month use of amphetamines by fifteen to sixty-four year olds in Portugal was 0.1 percent in 2001 and 2007, and zero percent in 2012.[94] If methamphetamine use is included in the reported amphetamine use, it may be inferred that the amount of methamphetamine use in Portugal is negligible, at most.

While the scope of the Legislature's request in HCR No. 127 was limited to marijuana, marijuana concentrates, harmful drugs, and detrimental drugs, the vast difference between methamphetamine use in Portugal and Hawaii highlights a key point regarding decriminalization. When adopting its drug strategy, Portugal did not have to account for a need to dedicate significant resources to combat methamphetamine use and addiction, as methamphetamine use appears to have been minimal there. In Hawaii, by contrast, treatment for methamphetamine use consumes a major portion of the resources used to combat the overall drug use problem.[95] Thus, if marijuana, marijuana concentrates, or harmful or detrimental drugs are decriminalized in Hawaii, an increase in resources dedicated to treatment for use of those substances could have the effect of reducing the resources necessary for treatment of methamphetamine use unless overall treatment resources are increased.

The Limits on Evaluating Drug Use Trends

As previously noted,[96] the various obstacles to evaluating drug use trends in both Portugal and Hawaii make comparing those trends difficult. One similarity that can be drawn is the wide prevalence of marijuana use in both Portugal and Hawaii. However, the only clear similarity in that prevalence is that marijuana use is common in both places, although Portugal's marijuana use has decreased over time while Hawaii's has grown, and the percentage of marijuana users in Portugal is much smaller than the percentage in Hawaii. Other differences in the drug trends between the two jurisdictions include: secondarily popular drugs -- heroin and cocaine in Portugal versus methamphetamine in Hawaii; and an overall increase in Hawaii's drug use. In view of the limited information available regarding drug use trends, any further comparison between trends in Portugal and Hawaii should be avoided.

The Current Drug Threat

In conjunction with our review of drug use trends, we asked the federal Drug Enforcement Administration (DEA); the Hawaii High Intensity Drug Trafficking Area (HIDTA) Investigative Support Center; and the Narcotics Enforcement Division of the Hawaii Department of Public Safety for their assessments of which drugs pose the greatest threats.[97] The DEA did not respond. The Hawaii HIDTA Investigative Support Center responded,[98] and included a copy of its published annual report, which determined that methamphetamine currently poses the greatest drug threat to

Hawaii "due to its widespread availability and association with addiction, crime, overdose deaths, treatment, law enforcement efforts and prosecutions."[99] In 2015, law enforcement agencies seized 126.646 kilograms of the drug.[100] The agency also stated that marijuana poses the second greatest threat, "based on its consistent high demand, criminal association, drug seizures, and encumbered medical resources to drug treatment admissions,"[101] and noted that the abuse of prescription drugs is a "noteworthy emerging threat."[102] While heroin, ecstasy, and cocaine are present in the State, the Support Center considers those substances "a comparatively lower threat to the user population in Hawaii."[103] The Narcotics Enforcement Division's response reiterated the threats posed by methamphetamine and marijuana, and also noted the threat posed by opioid pain relievers, which reportedly contributed to 35 percent of drug overdose deaths in Hawaii from 2010 to 2014.[104]

Substance Use Treatment

If Hawaii were to attempt to follow the portion of Portugal's drug strategy regarding decriminalization, an important issue facing policymakers is whether to also follow the critical component of that country's strategy regarding treatment. In contrast to the cultural and legal backdrop in Portugal that encourages a public health approach to drug use, people in the United States with substance use disorders [105] have traditionally and historically been considered morally flawed, which has resulted in these individuals being treated in a punitive manner, rather than in a mental health-oriented or preventative manner.[106] The current White House National Drug Control Strategy suggests a reversal in this tradition and highlights the importance of recognizing substance use disorders as diseases that require a public health approach.[107] Additionally, the National Drug Control Strategy incorporates multiple strategies to reframe and address substance use disorders as health issues rather than criminal issues, including integrating substance use disorder treatment into mainstream health care and developing infrastructure to promote alternatives to incarceration.[108] A 2016 Surgeon General's report also emphasized the need to treat substance use, substance misuse,[109] and substance use disorders as public health matters.[110]

The Need for and Availability of Treatment in Hawaii

While individuals may be admitted for treatment of substance use, substance misuse, and substance use disorders, it is not possible to differentiate between these three when reviewing treatment admission data.[111] Accordingly, for consistency and clarity, "substance use treatment" when used this part, refers to treatment for substance use, substance misuse, and substance use disorder. Treatment for substance use can consist of counseling, inpatient and residential treatment, outpatient treatment, in-hospital care, medication, twelve-step programs, and support groups,[112] but the ability to obtain effective treatment can vary based on a number of factors, including:

(1) The drug for which treatment is sought;[113]

(2) Frequency of drug use;[114]

(3) Financial resources of the user;[115]

(4) What sort of post-treatment support the user needs;[116] and

(5) Whether the user seeks out treatment or is referred by the criminal justice system.[117]

In SAMHSA surveys taken between 2007 and 2014, an estimated average of 85.6 percent of individuals aged twelve and older in Hawaii who reported illicit drug use did not receive treatment for their drug use within the year prior to being surveyed.[118] However, simply because an individual uses an illicit drug does not mean that the individual is in need of treatment. In its 2013-2014 National Survey on Drug Use and Health, SAMHSA estimated that only 2.22 percent of those aged twelve or older in Hawaii need, but do not receive treatment[119] for, illicit drug [120] use.[121]

The 2014 National Survey of Substance Abuse Treatment Services conducted by SAMHSA found that one hundred seventy-seven facilities in Hawaii provide mental health treatment, which is the highest number of facilities since 2004.[122] Of these facilities: [123]

- One hundred fifty-one provided substance use treatment services, two provided other mental health treatment services, twenty-one provided a mix of mental health and substance use treatment services, and three provided other services;[124]

- One hundred fifty-one are private non-profit operated, nineteen are private for-profit operated, three are state operated, and four are federally operated;[125]

- One hundred seventy offer some outpatient services, and fifteen offer non-hospital[126] residential treatment;[127] and

- Fifty-five accept cash or self-payment, fifty-one accept private health insurance, twenty-nine accept Medicare, forty-two accept Medicaid, forty-three accept State-financed health insurance, twenty-eight accept federal military insurance, eighty-three do not accept payment, thirteen accept Access to Recovery vouchers,[128] four accept IHS/638 contract care funds, thirty-three accept other funds, seventeen have a sliding fee scale, and one hundred nineteen provide treatment at no charge for clients who cannot pay.[129]

Treatment Information from the Alcohol and Drug Abuse Division

In Hawaii, the Alcohol and Drug Abuse Division of the Department of Health (ADAD) is the primary and often sole source of public funds for substance use treatment.[130] Pregnant women and injection drug users have priority in admission for ADAD funded treatment services.[131] In fiscal year 2015-2016, 50.5 percent of the ADAD-funded adult admissions for treatment were for

methamphetamine use, 13.8 percent were for marijuana use, 2.6 percent were for cocaine/crack use, 5.3 percent were for heroin use, and 5.6 percent were for other drug use.[132]

When calculating the amounts of funding allocated for substance use treatment, ADAD categorizes treatment as:

- Residential treatment - long-term;[133]
- Therapeutic living - long-term;[134]
- Intensive outpatient treatment;
- Outpatient treatment;
- Methadone maintenance;
- Residential social detoxification;
- Residential pregnant women with dependent child treatment - long-term;[135] and
- Therapeutic living pregnant women with dependent child - long-term.[136]

As noted by Figures 5-6 and 5-7 in Appendix C,[137] nearly half of all admissions for substance use treatment in Hawaii are self-admitted, and nearly one-fourth are referrals from the criminal justice system.

Between fiscal years 2011-2012 and 2015-2016, the per person average expended by ADAD for treatment was as low as $3,873 and as high as $4,670.[138] Between fiscal years 2011 and 2016, overall ADAD funding for illicit drug treatment has remained relatively steady, between the low of $12,129,862.50 in fiscal year 2011 to a high of $13,554,573 in fiscal year 2015. Additionally, as shown by the Table 5-1 in Appendix B, the funding of specific types of treatment has remained steady between those years.

Individuals performing clinical supervision of drug use treatment are required to be certified as counselors by the Department of Health or hold an advanced degree in behavioral health sciences.[139] Currently, the Department of Health certifies fourteen categories of counselors.[140] As shown in Table 5-2 in Appendix B, the number of certified substance abuse counselors [141] has steadily risen over this decade, with 1,229 certified substance abuse counselors in fiscal year 2015-2016.[142] Nonetheless, Hawaii ranks low among the states with regard to the number of specialists available to treat those with substance use disorders.[143]

Treatment Information from the Judiciary

According to a Judiciary report to the 2016 Legislature entitled "A Report on Statewide Substance Abuse Treatment Monitoring Program" ("2016 SATMP Report"), during fiscal year 2014-2015, the Judiciary referred 4,310 adults and 211 children (a total of 4,521 individuals) to twenty-six service providers for substance use treatment.[144] All of the referred individuals were admitted to treatment.[145] Expenditures for treating these individuals were not specified in the report, which noted that "[s]ervices rendered to Judiciary referred clients may not have been paid for by the Judiciary."[146] To help determine how many of these individuals received treatment paid for by the Judiciary, we consulted another publicly-available document. According to the Judiciary's written testimony submitted to the 2015 Legislature, as of December 1, 2014, the Judiciary had contracts with only thirteen service providers for substance use treatment services. The lengths of the contacts varied but generally ran from July 1, 2013, to June 30, 2015. The aggregate maximum value of these contracts was $7,917,231.20.[147]

Based on data from the 2016 SATMP Report, it appears that 3,121 adults and 201 children (a total of 3,322 individuals) were admitted to these thirteen Judiciary-contracted substance use treatment providers during fiscal year 2014-2015.[148] Based on the Judiciary's corresponding report to the 2015 Legislature, it appears that a total of 2,739 individuals were admitted to the Judiciary-contracted substance use treatment service providers during fiscal year 2013-2014.[149] Based on the known maximum value of the contracts ($7,917,231.20), and the number of individuals admitted into treatment during those two fiscal years (6,061), it can be estimated that the Judiciary was prepared to spend an average (statistical mean) of $1,306.26 per person admitted into treatment. However, we caution that this amount does not necessarily reflect actual treatment expenditures.

Treatment Information from Other Agencies

We asked the Hawaii Department of Human Services (DHS) to provide information regarding how many members of the public received treatment services through that agency for illicit drug use, and the associated expenditures for treatment.[150] We made similar inquiries to the Department of Community Services, City and County of Honolulu; the Department of Finance, County of Hawaii; the Department of Finance, County of Kauai; and the Department of Housing and Human Concerns, County of Maui about what, if any, efforts the counties currently make toward providing drug use treatment.[151] We asked the Hawaii Department of Public Safety (PSD) how much it spent to treat correctional system inmates for illicit drug use during fiscal year 2015-2016.[152] In response to these inquiries, we received statistical information only from the state DHS and PSD, and the Department of Housing and Human Concerns, County of Maui, and some of that information had limitations.

Treatment Information from the Department of Human Services

Based on data from DHS,[153] and as illustrated in Tables 5-3 and 5-4 in Appendix B, the number of Medicaid program clients who received alcohol and drug use treatment has increased significantly over the years. For example, the number of drug-dependent clients treated rose from 2,658 in fiscal year 2006-2007 to 8,002 in fiscal year 2014-2015. However, per-person expenditures for treatment appear to have decreased over time for individuals in the Medicaid program. For example, we calculated the average (statistical mean) expenditure for each drug-dependent client to be approximately $178 in fiscal year 2006-2007 and approximately $88 in fiscal year 2014-2015.

Among those Medicaid Program clients who were receiving treatment for what the department deemed "dependence" upon illicit drugs (which, for our purposes, do not include alcohol and tobacco), treatment for opioid dependence and amphetamine dependence were most frequent among specified categories of dependencies. The number of individuals treated for opioid dependence increased by more than 300 percent from fiscal years 2006-2007 to 2014-2015. The number of individuals treated for amphetamine dependence increased by more than 100 percent during the same period. Per-person expenditures for treatment for each respective dependence peaked near the end of the last decade but have declined since then. See Tables 5-5 and 5-6 in Appendix B.

Among those Medicaid Program clients who were receiving treatment for what the department deemed "abuse" of illicit drugs (excluding alcohol and tobacco) but who were not necessarily dependent upon those drugs, treatment for amphetamine abuse was the most frequently specified category of abuse. The number of individuals treated for that category of abuse increased by more than 400 percent from fiscal years 2006-2007 to 2014-2015. The second-most frequently specified category listed was "other drug abuse." The third-most frequently specified category was marijuana. The number of individuals treated for that category of abuse increased by more than 300 percent from fiscal years 2006-2007 to 2014-2015. Per-person expenditures for amphetamine abuse peaked near the beginning of this decade but have declined since then, while average expenditures for marijuana have declined steadily since fiscal year 2006-2007. See Tables 5-7 and 5-8 in Appendix B.

Some clients in the DHS Division of Vocational Rehabilitation had a diagnosis relating to drug use in fiscal years 2014-2015 and 2015-2016. These individuals received mental restoration services,[154] and the expenditures of services for those individuals increased from fiscal years 2014-2015 to 2015-2016. See Table 5-9 in Appendix B.

Among clients of the DHS Social Services Division, considerably more funds were expended for treatment: up to nearly $29,912 per person. See Table 5-10 in Appendix B.

We caution that it is very difficult to determine the causes in changes in the numbers of people treated. Increases in treatment for certain drugs may reflect the increased use of those drugs; increases in the availability of treatment; or other unknown factors. We also caution that the per-person expenditure calculations in Table 5-10 are only very general "per person"

expenditures, especially since we do not know how long individuals were treated and whether expenditures were driven by the availability of funding, or lack thereof.

DHS noted that General Assistance recipients and First-to-Work participants have also received drug treatment over the years. However, expenditure information regarding these individuals was not available.[155]

Treatment Information from County Agencies

Based on the data provided by the Department of Housing and Human Concerns, County of Maui,[156] we created Table 5-11 in Appendix B, which includes our calculation of the average expenditure (statistical mean) of treatment, which reached up to nearly $1,365 per person.

We again caution that the averages in Table 5-11 are only very general "per person" expenditures, since we lack data regarding how long individuals were treated and the substances for which they were treated. These calculations are provided only as a very broad estimate of the expenditures of treatment for some individuals in Maui County-funded treatment programs.

The Department of Finance, County of Kauai forwarded our inquiry to the Life's Choices Kauai Program at the Office of the Mayor, which informed us that one of its duties is to refer substance abusers to treatment. The agency did not have data available on the number of users it referred to treatment.[157]

Treatment Information from the Department of Public Safety

The Corrections Division, Department of Public Safety (PSD) noted that 994 inmates in state correctional facilities received treatment for illicit drug use in fiscal year 2015-2016, for which expenditures were an estimated $3,935,376.[158] Based on our calculations, the average expenditure (statistical mean) for the treatment of each inmate during that time was approximately $3,959.13.

Adequacy of Treatment Funding and Capacity

The Patient Protection and Affordable Care Act,[159] for the first time under federal law,[160] required all insurers, including Medicaid, to cover the treatment of drug and alcohol addiction as an "essential benefit."[161] Previously, Medicaid covered only certain people, and private insurance either did not pay for treatments or paid so little that most people could not afford to make up the difference.[162] For those with private insurance coverage, the Mental Health Parity and Addiction Equity Act[163] now ensures that the duration and dollar amount of coverage for substance use disorders is comparable to coverage for medical and surgical care.[164] Together, the two federal laws are expected to make billions of dollars available to the behavioral health care market.[165]

The United States spent $24,000,000,000 on the treatment of drug and alcohol disorders in 2009, the most recent year for which comprehensive data are available.[166] Spending from public sources such as state and local governments, Medicaid, Medicare, and federal grants accounted for 69 percent of the total; private sources, including commercial insurance and out-of-pocket spending, made up the balance.[167] However, despite that spending, treatment capacity has not kept pace with the demand for treatment or the funding available to support it.

While acknowledging the scarcity of treatment specialists, the federal government has failed to quantify and assess it.[168] A health care consulting firm developed a "provider availability index" – the number of psychiatrists, psychologists, counselors, and social workers available to treat every 1,000 people with substance use disorders.[169] The index ranges from a high of 70 in Vermont to a low of 11 in Nevada. The national average is 32 behavioral health specialists for every 1,000 people afflicted with the disorder, while Hawaii has 22, and is ranked forty-fourth out of fifty-one US jurisdictions.[170] The "growing workforce crisis in the addictions field" is due to a variety of factors, including stigma, an aging workforce, and inadequate compensation for treatment service providers, according to a 2013 report to Congress from SAMHSA.[171]

Reimbursement rates and consequently salaries for physicians, psychologists, social workers, and counselors in the addiction field historically have been well below salaries for comparable professionals in other health care specialties that require the same level of education and training.[172] For example, the average annual salary for social workers in the addiction field is $38,600, compared to $47,230 in the rest of the health care industry, according to the Bureau of Labor Statistics.[173] Moreover, only 55 percent of addiction practitioners accept Medicaid reimbursements, which tend to be lower than private insurance.[174]

The shortage of treatment specialists is particularly acute for Medicaid beneficiaries. They are prescribed highly addictive painkillers at twice the rate of non-Medicaid patients and are at three to six times the risk of prescription opioid overdose.[175] As a group, Medicaid enrollees suffer from opioid addiction and other substance abuse disorders at a higher rate than the general population.[176] Overall, less than half of the 2,200,000 people who need treatment for opioid addiction are receiving it, according to the United States Department of Health and Human Services.[177] It will be largely up to states to make the changes needed to develop an adequate addiction treatment workforce.[178]

States have responded by, among other steps, trying to encourage opioid addiction treatment centers to offer more counseling when patients need it, by reimbursing providers for as much counseling and related medical services as are needed for individual patients, rather than paying a flat rate per patient.[179] Others are turning to a nurse manager approach, in which registered nurses take over from doctors the labor-intensive office visits, behavioral health assessments, drug screenings, and paperwork, to make it easier for physicians to accept more patients and write prescriptions for the medication patients need.[180] Thirty-eight states, including Hawaii, now certify peer specialists, who are people who have personally struggled with mental health or substance abuse problems but are now in recovery and helping others in community behavioral health centers, psychiatric inpatient facilities, and other health-care settings.[181] Medicaid programs reimburse peer specialists in thirty-six states, including Hawaii.[182]

It is important to note that demand for substance use treatment may increase if the possession of personal use amounts of one or more drugs is decriminalized in Hawaii, as was the case in Portugal.[183] The Bureau is unable to conclusively determine whether available funding is adequate to meet Hawaii's current treatment needs, let alone any increased demand for treatment that may develop after enactment of a decriminalization scheme. Additionally, considering that funding for treatment may come from a variety of sources (i.e. from the State, federal, and county governments; grants; insurance providers; and individuals receiving treatment), it is unclear the extent to which the Legislature may need to appropriate additional treatment funds following decriminalization.

Furthermore, despite the information reviewed by the Bureau, it is difficult to accurately assess the adequacy of substance use treatment capacity in Hawaii, as information related to, among other things, the number of vacancies for residential treatment, the physical capacity of locations that provide treatment, or the number of drug users seeking but not receiving treatment is not readily available. Yet, considering that punitive measures have historically been chosen over treatment when addressing substance use in the United States, and the growing understanding that the nation's capacity to treat substance use is lacking, it seems reasonable to assume that decriminalization would increase the need for treatment resources and personnel.

DRUG PREVENTION EFFORTS BY THE DEPARTMENT OF HEALTH'S ALCOHOL AND DRUG ABUSE DIVISION

Drug use prevention efforts were and continue to be a crucial component of Portugal's drug strategy.[184] The scope of funding for and the results of Hawaii-based drug use prevention efforts are difficult to quantify or evaluate because there are local and national, private and public, drug use prevention efforts ongoing in Hawaii. One quantifiable measure is the amount of money allocated for drug use prevention efforts conducted by ADAD. The Prevention Branch within ADAD implements a broad array of prevention strategies directed at individuals who have not been identified as in need of treatment.[185] The primary prevention activities and services are provided in a variety of settings for the general population as well as targeted sub-groups that are at high risk for substance use.[186] Funding is provided to six categories of prevention strategies:

Alternative Activities;[187]

Community-based Processes;[188]

Education;[189]

Environmental;[190]

Information Dissemination;[191] and

Problem Identification and Referral.[192]

Table 5-12 in Appendix B breaks down the amount of money expended by the Prevention Branch for each program from fiscal years 2011-2012 to 2015-2016.[193]

INFORMATION REGARDING THE ENFORCEMENT OF RELEVANT HAWAII DRUG POSSESSION OFFENSES

Efforts to enforce any criminal law consumes time and resources. In theory, eliminating criminal penalties for some offenses could free up time and resources for the enforcement of other offenses. However, in order to determine whether the decriminalization of possession of amounts for personal use of certain illicit drugs would significantly reduce the need for enforcement efforts and the expenditures related to those efforts, it is necessary to review data regarding arrests, prosecutions, convictions, and incarcerations for relevant drug possession offenses, and associated expenditures. We sought such information, but faced several obstacles in obtaining accurate and complete data.

Arrests; Information from Police Departments

We attempted to find out how often individuals are arrested for relevant drug offenses, and the associated expenditures. By "relevant drug offenses," or simply "relevant offenses," we mean those offenses that, pursuant to the terms of HCR No. 127, include "class C felonies and lower offenses that can be committed by the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate."[194] Published reports from the Department of the Attorney General provide some relevant information regarding arrest statistics for criminal offenses. The statistics in these reports "were collected and compiled using the FBI's Hierarchy Rule that limits crime counts to only the most serious offense committed within an incident that is constrained by time and place, and limits arrest counts to only the most serious charge per booking."[195] As the Table 5-13 in Appendix B shows, between 2000 and 2014, drug possession offenses comprised the most serious offense for 3.46 to 5.19 percent of all non-traffic criminal offense arrests of adults.[196]

However, these reports do not state the *specific drug-related offenses* for which the individuals were arrested. This is significant because some drug possession offenses include large quantities of drugs and thus are more likely correlated with the distribution or sale of drugs than personal consumption. Further, these reports do not specify how often a relevant possession offense was the *sole* offense for which an arrested person was charged. This distinction is important because the impact of decriminalizing any given drug possession offense may be minimal or nonexistent for a person who would be arrested for another offense anyway, especially for an equally serious or more serious charge. Therefore, while the published reports from the Department of the Attorney General are helpful in understanding the overall scope of all arrests made in the State, the data provided in those reports have severe limitations for purposes of this study.

In an attempt to find more specific information, we asked the police departments of the several counties to provide statistical data on the number of arrests made for state drug possession offenses, the expenditures associated with making those arrests, and the sources of funding for those expenditures.[197] From the departments' responses,[198] we compiled the data found in Table 5-14 in Appendix B, which shows the number of arrests by county police for all offenses for which the simple possession of illicit drugs constitutes the offense. The table also summarizes the number of arrests for relevant drug offenses.

Generally speaking, it appears that arrests for the specified offense increased during the period from 2011 to 2014, with a slight decrease in 2015. Available statistics for 2016 are too incomplete to draw any conclusions as of this writing. We note, however, that the foregoing tables may overestimate the number of arrests that police made for drug possession offenses because several of the statutory sections under which drug possession offenses may be committed have multiple subsections, some of which also prohibit the distribution or sale of illicit drugs. [199] Thus, based on the data provided, it is impossible to determine whether a person arrested for one of these offenses was arrested for *possessing* an illicit drug, *distributing* an illicit drug, or *selling* an illicit drug.

Further, it is still not entirely clear how many of these arrests included a relevant offense within the scope of HCR No. 127 as the sole offense for which the suspect was arrested. Honolulu Police Department (HPD) and Kauai Police Department (KPD) did not specify those arrests in their responses. HPD explained that its database would need to be updated in order to provide that information.[200] KPD responded that it did not have the time to review its records to provide that information.[201] Based on available data from Hawaii (County) Police Department (HCPD) and Maui Police Department (MPD), it appears that during the vast majority of arrests in the counties of Hawaii and Maui for relevant drug charges, the suspects were arrested for other charges as well, as shown in Table 5-15 in Appendix B. In other words, relatively few arrests are based solely on a single relevant drug offense. For example, Table 5-15 in Appendix B shows that in 2015, a total of three hundred thirteen arrests were made in Hawaii County for violations of section 712-1249, Hawaii Revised Statutes (HRS), promoting a detrimental drug in the third degree. In only seventy of those arrests was that offense the only offense for which the suspect was arrested. As another example, the table shows that in fiscal year 2014-2015, a total of four hundred fifty arrests were made for violations of section 712-1249, HRS. In only two hundred twenty-four of those arrests was that offense the only offense for which the suspect was arrested. However, whether this general pattern also applies to the islands of Oahu and Kauai is unknown.

It is also difficult to determine exactly how much money county police departments spend to enforce laws regarding drug offenses that are relevant to the scope of HCR No. 127. HPD informed us that it would not be able to provide expenditure information for enforcement relating to the possession of illicit drugs, as it could not accurately separate what funds were spent specifically on the enforcement of relevant drug offenses, as opposed to laws relating to other offenses such as gambling or prostitution.[202] HCPD stated that it "does not keep statistical information relative to expenditures to enforce laws against illicit drugs, as this involves all sections of the department."[203] The department noted that its Vice Section "concentrates mainly on drug offenses,"[204] and estimated the expenditures for that section as noted in Table 5-16 in

Appendix B. The department cited its "budget" as the source of "funding,"[205] so it is presumed that Vice Section funds come from Hawaii County.

KPD and MPD provided more specific estimates regarding their expenditures for drug-related offenses.[206] However, we note that these estimates, which are replicated in Tables 5-17 and 5-18 in Appendix B, are related to the enforcement of drug laws in general, and not just the relevant drug offenses that are within the scope of HCR No. 127.

Court Cases: Information from the Judiciary

We attempted to learn how many individuals are prosecuted in state courts each year for drug possession offenses that are within the scope of HCR No. 127, and how much the Judiciary expends to adjudicate those cases. A published report from the Judiciary of the State of Hawaii provides some statistical data regarding the types of offenses processed through Hawaii's criminal justice system in fiscal year 2014-2015. Tables 5-19 and 5-19 in Appendix B summarize relevant information from that report. Notably, while the statistics provide information on how many narcotic drug offenses are processed in the courts, especially in proportion to other matters, the statistics do not identify which specific drug offenses were processed and do not distinguish between drug possession offenses and other drug offenses. As a result, those statistics, while helpful, do not allow us to fully evaluate what impact decriminalization of the drugs specified in HCR No. 127 could have on Hawaii's courts.

Because the Judiciary's report provided mostly aggregated information, we requested more specific information directly from the Judiciary regarding the number and outcomes of criminal court cases filed against individuals for drug possession offenses, associated expenditures, and sources of funding.[207] We were able to obtain some of this information.[208]

From fiscal years 1999-2000 to 2015-2016, a total of 299,098 criminal counts were filed for all charges in the State's circuit courts and family courts. Drug offenses comprised 49,968 of those counts, of which 28,305 were for offenses that can be committed by the simple possession of illicit drugs. Of those counts, 6,295 counts were filed against 5,711 parties for relevant offenses. From fiscal years 2012-2013 to 2015-2016,[209] a total of 111,025 criminal counts were filed for all charges in the State's district courts. Of those counts, 3,255 were for relevant misdemeanor drugs offenses.[210]

Tables 5-21, 5-22, 5-23, 5-24, and 5-25, found in Appendix B, were created based on the Judiciary's data. Once again, the tables may overestimate the number of filings made regarding drug possession offenses, because several of the statutory sections under which drug possession offenses may be committed have multiple provisions under which a person may be charged, some of which prohibit the distribution or sale of illicit drugs.

Based on the statistics we received, it is unknown how many of the defendants against whom a relevant drug offense was filed were charged for that offense only. It is also unclear how the courts disposed of each of the drug offenses.

The Judiciary stated that it was unable to provide information on expenditures imposed by the judicial branch of government for the enforcement of drug laws. The Judiciary also noted that its accounting systems "do not have the capability to capture the detail needed to isolate expenditures relating to criminal cases involving illicit drug offenses."[211] Further, appropriations to the Judiciary do not specifically apply to cases involving illicit drugs. The only relevant fiscal information that the Judiciary could provide related to federal grants for the treatment of substance abuse offenders.[212] That information is replicated in the Table 5-26 in Appendix B.

Court Cases: Lack of Information from Prosecutors and the Public Defender

Criminal cases impose costs not only on the courts, but also on the prosecutors who pursue these cases and the defense attorneys who represent defendants. In light of this, we attempted to obtain information from the prosecutors of the several counties[213] and the Criminal Justice Division of the Department of the Attorney General on the number of drug possession cases filed in each county and the outcomes of those cases and associated expenditures.[214] We also attempted to obtain corresponding information from the Office of the Public Defender,[215] which provides free legal representation to indigent criminal defendants.[216]

The Department of the Attorney General indicated that it prosecuted sixteen relevant drug offense counts during the entire period from 2000 to 2016. Expenditures for those enforcement efforts were unknown.[217] The number of cases prosecuted by Attorney General is not surprising, given that responsibility for the prosecution of the vast majority of state criminal offenses falls to county prosecutors. However, we did not receive any statistics from the county prosecutors. The Department of the Prosecuting Attorney, City and County of Honolulu, did not acknowledge receipt of our initial request letter or our follow-up letter. The prosecutors' offices for Kauai and Maui counties acknowledged our request,[218] but did not subsequently provide any information. The Office of the Prosecuting Attorney, County of Hawaii, informed us that it did not have the resources to research individual dispositions of relevant drug cases and create timely reports given the limitations of its case management system.[219] The Office of the Public Defender provided a similar response.[220]

Arrests and Court Cases: Information from the Hawaii Criminal Justice Data Center

In light of the limitations of much of the arrest and court data that we received from the police departments and the Judiciary, we also inquired with the Hawaii Criminal Justice Data Center (HCJDC), Department of the Attorney General, for data regarding the number of arrests, and the number and outcomes of criminal court cases, for relevant drug possession offenses.[221]

Two sets of data tables, Tables 5-27 and 5-28 found in Appendix B, are based on data provided by the HCJDC.[222] While the information that we received from the HCJDC was grouped

according to both fiscal years and calendar years, for the sake of simplicity, our tables include data for only calendar years. The first set of tables (Table 5-27 found in Appendix B) shows, from calendar years 2000 to 2015:

- The number of arrests for each of the drug possession offenses, separated by arresting agency and county; and
- The number of criminal court cases filed, separated by county.

The second set of tables (Table 5-28 found in Appendix B) shows, from calendar years 2000 to 2015:

- The number of arrests, for each of the drug possession offenses, in which the specified offense was the sole offense for which the suspect was arrested;
- The number of criminal court cases filed, by county, for each of the drug possession offenses, in which the specified offense was the sole offense for which the defendant was charged; and
- Among criminal court cases in which the specified offense was the sole offense for which the defendant was charged, the number of cases:
    - In which the court deferred its acceptance of the defendant's "guilty" or "no contest" plea to the offense charged;
    - In which the court referred the defendant to a drug court program;
    - In which the defendant was convicted; and
    - In which the defendant was sentenced to incarceration.[223]

We also note that there was some discrepancy between arrest data obtained from the HCJDC and data obtained directly from police. HCJDC indicated that it was difficult to determine what was causing the differences, because it was unknown how the police departments were counting arrests in their own data systems. Staff commented that a single incident could generate zero arrests or multiple arrests and suggested that police may be counting arrests according to incidents that occur or according to charges filed. Staff also suggested that some arrests could have been expunged from the HCJDC database.[224]

We also asked the various police departments for a possible explanation of the difference between their own data and HCJDC's data. HPD suggested that its data appears to be based on report numbers. If a person is arrested on multiple charges, the department generates a different report for each charge. So, if a person is arrested for three drug charges, the data that HPD provided us will indicate three separate arrests.[225] KPD informed us that data may reflect criminal cases, and cases may be initiated even when an arrest has not yet occurred. Further, when more than one suspect is arrested in the same incident for the same charge, KPD treats each separately, and not

as a single arrest. KPD noted that while the statistics it provided to the Bureau reflected arrests made by the department as a whole, it is possible that some statistics from other sources only reflect arrests from a particular division of a police department.[226] Our contact person at HCPD informed us that he did not have an explanation for the discrepancies.

Therefore, even though we received data from the police departments, the Judiciary, and the HCJDC, the inconsistency in the data leaves some uncertainty as to exactly how many arrests were made against individuals whose *sole alleged offense* in any given case was the commission of a relevant drug possession offense.

We note that differences in data from the Judiciary and the HCJDC regarding the number of court filings for each offense can be explained by the fact that the Judiciary clearly reported its statistics by the number of *parties* against whom cases were filed,[227] while the HCJDC reported its statistics by the number of *cases* filed.[228] Therefore, since the data are measuring different statistics, we did not raise the same concerns regarding consistency that we raised regarding arrest data.

PATTERN IN ARRESTS, PROSECUTIONS, AND INCARCERATIONS FOR SINGLE DRUG POSSESSION OFFENSES

Figures 5-8 through 5-17 found in Appendix C[229] demonstrate the differences in some of the arrest data received from the police departments and from the HCJDC. However, in spite of the inconsistencies, the data provided by MPD, KPD and HCJDC all consistently suggest one point with regard to cases in which a relevant drug offense is the only offense for which a suspect is arrested: relatively few arrests by MPD and KPD are based solely on a single relevant drug offense.[230] Not only do HCJDC data suggest a similar conclusion, the data also suggest that few individuals are *prosecuted* and *incarcerated* solely for a single relevant drug offense.

As seen in Table 5-28 in Appendix B, according to statewide data from the HCJDC, in 2015 a relevant drug offense[231] was the sole offense in only:

- Three hundred seventy-nine arrests;
- Two hundred nine court filings;
- One hundred eight convictions; and
- Sixty-nine incarcerations.

Of those offenders, sixty-six were incarcerated pursuant to section 712-1249, HRS, for promoting a detrimental drug in the third degree, a petty misdemeanor (for which a convicted person may be imprisoned for up to thirty days).[232] One offender was incarcerated pursuant to section 712-1246.5, HRS, for promoting a harmful drug in the fourth degree, a misdemeanor (for which a convicted person may be imprisoned for up to one year).[233] The remaining two offenders were

incarcerated pursuant to section 712-1248, HRS, for promoting a detrimental drug in the third degree, which is also a misdemeanor.

INFORMATION REGARDING INCARCERATION EXPENDITURES

We attempted to calculate the extent to which expenditures related to incarceration might decrease if the relevant drug possession offenses were decriminalized. We therefore inquired with the Corrections Division, Department of Public Safety about daily expenditures for incarcerating inmates.[234]

The Division estimated that the State expended $140 per day to house each incarcerated inmate during fiscal year 2014-2015.[235] The Division noted that the estimate took into account wrap-around services for the inmate, including meals, rehabilitation programs, medical and dental care, mental health treatment, laundry services, as well as general facility operations. The Division was unable to break down this estimate by facility;[236] therefore, it is unknown, for example, what amount the State expends per day to incarcerate an inmate in the Oahu Community Correctional Center. Further, it was not clear exactly how the Division calculated its estimate.

By making very broad assumptions (as we discuss in more detail below), it may be estimated that if the foregoing offenses had been decriminalized in 2015, then the State may have saved up to $430,500 in incarceration expenditures, as shown in Table 5-29 in Appendix B.

However, we acknowledge that these calculations may overestimate incarceration expenditures, as the broad assumptions on which they are based may not be accurate:

- **Assumption 1:** *Sentenced offenders were incarcerated for the maximum term of imprisonment.* However, offenders sentenced to incarceration do not necessarily serve the maximum terms of imprisonment that may be imposed by law. When a person is incarcerated for the commission of a class C felony, the court normally establishes the maximum term of imprisonment, which may range from one year to five years, depending upon the offense involved.[237] However, the Hawaii Paroling Authority establishes a minimum length of imprisonment, which may be up to the maximum term of imprisonment established by the court, but may also be shorter.[238] When a person is incarcerated for the commission of a misdemeanor or a petty misdemeanor, the court may impose a maximum jail term of one year or thirty days, respectively, but also has the discretion to impose a shorter period of incarceration.[239]

- **Assumption 2:** *The offenders incarcerated for violating Section 712-1248, HRS, were guilty of possessing an illicit drug, not distributing an illicit drug.* Since a person may violate this section either by possessing or distributing a detrimental drug in certain quantities, it is possible that the incarcerated offenders reflected in this table engaged in distribution. If that is the case, then a law that decriminalized the *possession* of detrimental drugs would not have decreased the cost of incarcerating the two offenders.

- **Assumption 3:** *The estimated incarceration expenditure of $140 per day applies to all inmates.* As noted above, it is unclear how the Corrections Division arrived at this estimate. Therefore, it is unclear exactly how much the State could save in incarceration expenditures if relevant offenses were decriminalized.

THE UNCERTAINTY REGARDING THE LEGISLATURE'S PREFERRED DECRIMINALIZATION SCHEME MAKES IT DIFFICULT TO ESTIMATE THE POTENTIAL IMPACTS OF DECRIMINALIZATION

The information set forth in this chapter demonstrates that there are limitations regarding data on current drug use trends, the need for and availability of treatment, and the enforcement of statutes pertaining to drug possession offenses in Hawaii. But even if sufficient data were available, our ability to estimate the potential future impact on administrative and judicial systems of the decriminalization of relevant drug possession offenses faces another obstacle. That is, any attempt at such an estimation is hindered by the lack of specificity regarding the scope of any decriminalization scheme to be implemented in Hawaii. Specifically, based in part on the issues discussed in Chapter 4, the Legislature's preferences in this regard are unknown and the method by which laws would be enforced through the scheme are also unknown. In particular, uncertainty with respect to the following issues impedes our analysis.

UNCERTAINTY AS TO WHICH DRUGS SHOULD BE DECRIMINALIZED, AND IN WHAT QUANTITIES

As discussed in Chapter 4, Hawaii's legal framework presents challenges to the duplication of Portugal's model in this State. The most significant challenge is the fact that Hawaii law may be superseded by conflicting federal law.[240] Whether Hawaii decriminalizes possession of all illicit drugs for personal use, a smaller scope of illicit drugs as specified in HCR No. 127, or just marijuana, the possession of illicit drugs would remain illegal under federal law unless federal law were also changed.[241]

In light of the fact that the United States Department of Justice does not currently regard the possession of marijuana for personal use as an enforcement priority, some states have eliminated incarceration as a penalty for the possession of small quantities of marijuana, yet still impose civil penalties for the possession of the drug in those small quantities.[242] The maximum quantity that constitutes a decriminalized quantity varies from state to state, although the most common quantity is one ounce.[243] However, even if we assume that Hawaii would follow suit and decriminalize only marijuana, that assumption presents another problem, as discussed below.

UNCERTAINTY AS TO WHETHER ADMINISTRATIVE OR JUDICIAL TRIBUNALS WOULD PRESIDE OVER PROCEEDINGS IN A DECRIMINALIZED SYSTEM

As discussed in Chapter 3, under its decriminalization scheme, Portugal employs administrative dissuasion commissions, not courts, to preside over proceedings for alleged violations of decriminalized drug offenses. Policymakers in Hawaii would need to determine whether the State should utilize similar commissions here, or adapt to new uses the judicial structures that already exist. Portugal's commissions include experts in medicine, psychology, and social service who understand drug users. Such expertise, in theory, can arguably lead to better judgment in determining penalties and potential treatment for users of illicit drugs, especially in light of the fact that Portugal decriminalized the possession of small amounts of *all* illicit drugs. However, if Hawaii were to decriminalize only the possession of small amounts of marijuana, it is unknown whether the decriminalization scheme would also include a new tribunal system similar to Portugal's dissuasion commission system solely to handle cases involving only one substance.

The establishment of such tribunals, which are unprecedented in Hawaii, could require considerable funding, resources, and time to implement, including that needed to locate and employ qualified staff. Further, enforcement and oversight would require the creation of appropriate structures to track offenses and compliance with penalties, and to assign and monitor any additional sanctions imposed for noncompliance. In contrast, criminal courts are already established in Hawaii and include programs aimed at reducing drug use and recidivism (e.g. drug courts and HOPE probation). However, since judges are generally not health or social service experts, utilizing health professionals to help address the needs of drug users under a decriminalization scheme could require additional financial resources.

UNCERTAINTY AS TO WHAT PENALTIES SHOULD BE IMPOSED ON VIOLATORS

If Hawaii were to implement a decriminalization scheme for marijuana only, other states could provide models regarding what civil penalties should be imposed. Among the states that have eliminated incarceration as a penalty for the possession of small quantities of marijuana yet still impose civil penalties for such possession, the civil penalty varies. The most common penalty for the first violation is a civil fine of $100.[244] It is unclear if Hawaii would follow this model. Under state law, the current maximum fine in Hawaii for possession of less than one ounce of marijuana is $1,000.[245]

It is also unclear what the penalty would be if Hawaii were to implement a decriminalization scheme for other detrimental drugs and harmful drugs. Current criminal fines for the possession of such drugs under the offenses specified by HCR No. 127 range from $2,000 to $10,000.

UNCERTAINTY AS TO WHETHER VIOLATORS WOULD REMAIN SUBJECT TO ARREST AND DETENTION

In Portugal, drug users are only held in custody if their identification is unknown, and only until they appear before the appropriate dissuasion commissions.[246] In theory, eliminating arrests could remove a source of stigma that may deter users from seeking treatment and may affect employment and other opportunities. Since county police departments currently conduct most enforcement actions in Hawaii with regard to drug possession offenses, they might reasonably be expected to perform similar duties with regard to drugs that are decriminalized but not legalized, issuing administrative citations rather than making arrests. However, it may be argued that arrests may help ensure that users appear before the appropriate presiding authority, which may ultimately have a more positive impact on a user than the mere payment of a fine without any appearance.[247]

UNCERTAINTY AS TO WHETHER DECRIMINALIZATION WOULD BE PART OF A BROADER-BASED HEALTH STRATEGY

As noted previously, Portugal's strategy also included important components such as drug use education and prevention, health care for drug users, harm reduction programs for drug users (e.g., needle exchange), treatment of drug users in lieu of incarceration, treatment for incarcerated drug users, managed reintegration of formerly incarcerated drug users, research on drug use and treatment, and commitment of necessary financial resources.[248] However, the main impetus for Portugal's national decriminalization strategy regarding illicit drugs was a serious increase in the use of heroin, which is classified as a dangerous drug in Hawaii.[249] If the State were to decriminalize the possession all illicit drugs, especially methamphetamine, heroin, and other dangerous drugs, then it seems that the State would need to fund and implement a similar broader-based health-oriented strategy. If, on the other hand, the State were to decriminalize only the possession of marijuana, or even if the decriminalization scheme involved only marijuana and detrimental and harmful drugs, the need to implement and fund a broad-based health-oriented strategy may arguably be relatively less urgent, since these drugs may be perceived by some as "softer" than "hard" drugs like methamphetamine and heroin.

ENDNOTES

1. House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127).
2. These are primarily annual and periodic reports from governmental agencies, including the United States Department of Health and Human Services; and the State of Hawaii Judiciary, the Department of the Attorney General, and the Department of Health. The reports are cited in endnotes throughout this chapter.
3. The omission of these drugs is notable because of their prevalence in Hawaii, the United States, or Portugal, as noted throughout this chapter.

4. *Portugal country overview, Drug use among the general population and young people*, EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, http://www.emcdda.europa.eu/countries/portugal (last updated May 20, 2016).

5. As discussed in this chapter, the age range of Portugal's general population drug use survey is fifteen through sixty-four, while Hawaii and United States statistics survey those twelve and older.

6. The general population drug use surveys of Portugal reports on the use of any illicit drug; licit alcohol; licit tobacco; cannabis; heroin; amphetamines; cocaine; ecstasy; LSD; hallucinogenic mushrooms; and licit tranquilizers and sedatives. It is unclear which specific substances the Portugal survey includes when referring to "any illicit drugs," "amphetamines," and "tranquilizers and sedatives." Casimiro Balsa et al., III General Population Survey on Drugs Use, Portugal 2012: First Results (June 18, 2013) (slideshow presentation), http://www.emcdda.europa.eu/attachements.cfm/att_225966_EN_1.C.Urbano-GeneralPopulationSurveyonDrugsUse.pdf. The National Survey on Drug Use and Health (NSDUH) conducted annually by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) reports national estimated prevalence rates for a variety of drugs, but the only state-specific use data on which it reports is regarding the use of: any illicit drug; alcohol; tobacco; marijuana; cocaine; and nonmedical use of pain relievers. *See* UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2013-2014 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbl.1 (2015), http://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf [hereinafter SAMHSA 2013-2014 PREVALENCE ESTIMATES]. Illicit drugs are defined by SAMHSA as "marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically." *Id.* tbl.1.

7. The prevalence of drug use is categorized in three ways by the general population survey of Portugal as: (1) lifetime use, someone who has used a specific substance at least once in their lifetime; (2) someone who has used a specific substance at least once over the past year; or (3) current use, someone who has used a specific substance over the past month. SAMHSA and other surveys and studies use the same intervals to determine the prevalence of drug use, but not every survey or study collects or reports detailed information for each category. Balsa et al., *supra* note 6.

8. A report regarding the 2002 NSDUH states that "because of improvements to the survey in 2002, estimates from the 2002 NSDUH should not be compared with estimates from the 2001 and earlier [National Household Surveys on Drug Abuse] to assess change over time in substance use. Therefore, the 2002 data will constitute a new baseline for tracking trends in substance use and other measures." UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, RESULTS FROM THE 2002 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 1 (2003), https://ia801601.us.archive.org/12/items/resultsfrom2002n00offi/resultsfrom2002n00offi.pdf.

9. HCR No. 127 called for a review of the potential effects of decriminalizing marijuana, marijuana concentrates, and detrimental and harmful drugs. Section 712-1240, Hawaii Revised Statutes (HRS), defines and classifies drugs in multiple categories. "Dangerous drugs" are defined as "any substance or immediate precursor defined or specified as a 'Schedule I substance' or a 'Schedule II substance' by chapter 329 [HRS], or a substance specified in section 329-18(c)(14) [HRS], except marijuana or marijuana concentrate." "Harmful drugs" are defined as "any substance or immediate precursor defined or specified as a 'Schedule III substance' or a

'Schedule IV substance' by chapter 329 [HRS], or any marijuana concentrate except marijuana and a substance specified in section 329-18(c)(14) [HRS]." "Detrimental drugs" are defined as "any substance or immediate precursor defined or specified as a 'Schedule V substance' by chapter 329 [HRS], or any marijuana."

10. See note 6 of this chapter for SAMHSA's definition of illicit drugs

11. SARRA L HEDDEN, ET AL., UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH 1 (2015), http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

12. *Id.*

13. SAMHSA 2013-2014 PREVALENCE ESTIMATES, *supra* note 6, tbl.1.

14. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2011-2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbl.1 (2014), http://archive.samhsa.gov/data/NSDUH/2k12State/Tables/NSDUHsaeTables2012.pdf [hereinafter SAMHSA 2011-2012 PREVALENCE ESTIMATES]; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2012-2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbl.1 (2014), https://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/Tables/NSDUHsaePercents2013.pdf [hereinafter SAMHSA 2012-2013 PREVALENCE ESTIMATES].

15. Balsa et al., *supra* note 6 (unclear how the Portugal general population drug use survey defined "illicit drugs.")

16. *Id.*

17. *Id.*

18. *Id*.

19. *Id.*

20. *Marijuana (Cannabis)*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://www.samhsa.gov/atod/marijuana (last updated Nov. 21, 2016).

21. The General Population Drug Use Survey in Portugal reports on cannabis use rates. Balsa et al., *supra* note 6. For consistency within this report, we use the word "marijuana" in place of the word "cannabis."

22. *Id*.

23. Alcohol, tobacco, and tranquilizers or sedatives. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. HEDDEN, ET AL., *supra* note 11, at 5.

28. *Id.* at 6 fig.3 [hereinafter SAMHSA 2002-2003 PREVALENCE ESTIMATES]; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2006-2007 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE

DISTRICT OF COLUMBIA) tbls. 2 & 3 (2009), http://archive.samhsa.gov/data/NSDUH/2k07State/NSDUHsae2007/ExcelTabs/NSDUHsaeTabs2007.pdf.

29. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, COMPARISON OF THE 2002-2003 AND 2009-2010 MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbls. 2 & 3 (2012), http://archive.samhsa.gov/data/2k3State/2k3SAE.pdf; *Id.*

30. SAMHSA 2002-2003 PREVALENCE ESTIMATES, *supra* note 28.

31. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2007-2008 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbls. 2 & 3 (n.d.), http://archive.samhsa.gov/data/NSDUH/2k08State/NSDUHsae2008/ExcelTables/NSDUHsaeTabs2008.pdf.

32. The United States Central Intelligence Agency estimates Portugal's fifteen to sixty-four year old population to be 7,083,431, 1.7 percent of which is 120,418. *The World Factbook: Portugal*, CENT. INTELLIGENCE AGENCY, https://www.cia.gov/library/publications/the-world-factbook/geos/po.html (last visited Dec. 21, 2016).

33. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, TREATMENT EPISODE DATA SET (TEDS) 2001-2011: STATE ADMISSIONS TO SUBSTANCE ABUSE TREATMENT SERVICES 25 fig.19 (2013), https://www.samhsa.gov/data/sites/default/files/TEDS2011St_Web/TEDS2011St_Web/TEDS2011St_Web.pdf.

34. *Id.*

35. Center for Behavioral Health Statistics and Quality, *Treatment Episode Data Set, Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity, Year = 2013*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://wwwdasis.samhsa.gov/webt/quicklink/HI13.htm (last updated Nov. 1, 2016) [hereinafter *TEDS 2013*].

36. Center for Behavioral Health Statistics and Quality, *Treatment Episode Data Set, Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity, Year = 2014*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://wwwdasis.samhsa.gov/webt/quicklink/HI14.htm (last updated Nov. 1, 2016) [hereinafter *TEDS 2014*].

37. Center for Behavioral Health Statistics and Quality, *Treatment Episode Data Set, Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity, Year = 2015*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://wwwdasis.samhsa.gov/webt/quicklink/HI15.htm (last updated Nov. 1, 2016) [hereinafter *TEDS 2015*].

38. Some drugs formerly available with a prescription, such as methaqualone (quaalude) have been subsequently banned in their entirety. Victoria Bekiempis, *Do People Still Take Quaaludes?*, Newsweek (Aug. 2, 2015, 10:13 AM), http://www.newsweek.com/do-people-still-take-quaaludes-357914.

39. Section 712-1240, HRS, defines and classifies drugs in multiple categories. "Harmful drugs" are defined as "any substance or immediate precursor defined or specified as a 'Schedule III

substance' or a 'Schedule IV substance' by chapter 329 [HRS], or any marijuana concentrate except marijuana and a substance specified in section 329-18(c)(14) [HRS]." "Detrimental drugs" are defined as "any substance or immediate precursor defined or specified as a 'Schedule V substance' by chapter 329 [HRS], or any marijuana." Schedules III, IV, and V are listed in sections 329-18, 329-20, and 329-22, HRS.

40. *Misuse of Prescription Drugs: What are stimulants?*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/research-reports/prescription-drugs/stimulants/what-are-stimulants (last updated Aug. 2016).

41. This category includes admissions for all other stimulants that are not separately counted, such as cocaine or amphetamines. *Primary Substances*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://wwwdasis.samhsa.gov/webt/definitions.htm (last visited Dec. 21, 2016).

42. *TEDS 2013*, *supra* note 35.

43. *TEDS 2014*, *supra* note 36.

44. *TEDS 2015*, *supra* note 37.

45. *Id*.; *TEDS 2013*, *supra* note 35; *TEDS 2014*, *supra* note 36.

46. *Media Guide: Most Commonly Used Addictive Drugs*, NAT'L INST. ON DRUG ABUSE (last updated Oct. 2016), https://www.drugabuse.gov/publications/media-guide/most-commonly-used-addictive-drugs.

47. Balsa et al., *supra* note 6.

48. *Id.*

49. *Id.*

50. This category includes admissions for benzodiazepines, which include diazepam, flurazepam, chlordiazepoxide, clorazepate, lorazepam, alprazolam, oxazepam, temazepam, prazepam, triazolam, clonazepam, halazepam and other tranquilizers. *Primary Substances*, *supra* note 41.

51. *See TEDS 2013*, *supra* note 35.

52. *See TEDS 2014*, *supra* note 36.

53. *See TEDS 2015*, *supra* note 37.

54. This category includes admissions for barbiturates including phenobarbital, Seconal, Nembutal and other sedatives/hypnotics such as chloral hydrate, Placidyl, and Doriden. *Primary Substances*, *supra* note 41.

55. *See TEDS 2015*, *supra* note 37.

56. Such options include muscle relaxants. *Back Pain Health Center: Muscle Relaxants*, WebMD, http://www.webmd.com/back-pain/muscle-relaxants-for-low-back-pain (last updated May 22, 2015).

57. *Opioids*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids (last updated May 2016).

58. For example, oxycodone and codeine are dangerous drugs. Section 329-16, HRS. However, drugs with certain levels of codeine are harmful or detrimental drugs. Sections 329-18 and 329-20, HRS.

59. *Most Commonly Used Addictive Drugs*, *supra* note 46.

60. Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198.

61. The United States Department of Health and Human Services awarded $53 million to forty-four different states, four tribes, and the District of Columbia to improve access to treatment for opioid use disorders, reduce opioid related deaths, and strengthen drug misuse prevention efforts. Hawaii will split $6 million with twelve other states and the District of Columbia for "The Prescription Drug Overdose: Data-Driven Prevent Initiative" to advance and evaluate state level prevention activities to address opioid misuse and overdose. Press Release, HHS awards $53 million to help address opioid epidemic, Dep't Housing & Hum. Services Press Off. (August 31, 2016), https://www.hhs.gov/about/news/2016/08/31/hhs-awards-53-million-to-help-address-opioid-epidemic.html.

62. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, NATIONAL SURVEY ON DRUG USE AND HEALTH: COMPARISON OF 2002-2003 AND 2011-2012 MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbl. 8 (2014), https://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2011-2012/TrendTabs/Web/NSDUHsaeTrendTabs2012.pdf [hereinafter SAMHSA COMPARISON].

63. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, 2010-2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA) tbl.8 (2014), http://archive.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/ExcelTabs/NSDUHsaeTables2011.pdf [hereinafter SAMHSA 2010-2011 PREVALENCE ESTIMATES].

64. SAMHSA 2011-2012 PREVALENCE ESTIMATES, *supra* note 14, tbl.8.

65. SAMHSA 2012-2013 PREVALENCE ESTIMATES, *supra* note 14, tbl.8.

66. SAMHSA 2013-2014 PREVALENCE ESTIMATES, *supra* note 6, tbl.8.

67. SAMHSA COMPARISON, *supra* note 62.

68. SAMHSA 2010-2011 PREVALENCE ESTIMATES, *supra* note 63.

69. SAMHSA 2011-2012 PREVALENCE ESTIMATES, *supra* note 14, tbl.8.

70. SAMHSA 2012-2013 PREVALENCE ESTIMATES, *supra* note 14, tbl.8.

71. SAMHSA 2013-2014 PREVALENCE ESTIMATES, *supra* note 6, tbl.8.

72. This category includes admissions for non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects. *Primary Substances*, *supra* note 41.

73. *See TEDS 2013*, *supra* note 35.

74. *See TEDS 2014*, *supra* note 36.

75. *See TEDS 2015*, *supra* note 37.

76. See "National Drug Strategy" in Chapter 3 of this report for further discussion.

77. Portugal's national drug strategy included needle exchange programs. *See supra* Chapter 3 note 30.

78. Lifetime rates increased 0.7 percent to 1.1 percent, past year rates increased 0.2 percent to 0.3 percent, and past month rates increased 0.1 percent to 0.2 percent. Balsa et al., *supra* note 6.

79. *Id.*

80. *See, e.g., id.*

81. *See* note 6*;* UNITED STATES DEPARTMENT OF JUSTICE, DRUG ENFORCEMENT ADMINISTRATION, 2015 NATIONAL DRUG THREAT ASSESSMENT 27, 31 (2015), https://www.dea.gov/docs/2015%20NDTA%20Report.pdf.

82. See note 6 of this chapter for which drugs SAMHSA reports state-specific use estimates.

83. UNITED STATES DEPARTMENT OF JUSTICE, NATIONAL DRUG INTELLIGENCE CENTER, HAWAII DRUG THREAT ASSESSMENT iii-iv (2002), https://www.justice.gov/archive/ndic/pubs07/998/998p.pdf.

84. *Id.* at 12.

85. *See TEDS 2015*, *supra* note 37.

86. *Stimulants*, *Methamphetamine*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://www.samhsa.gov/atod/stimulants (last updated Mar. 2, 2016).

87. Section 329-16, HRS.

88. This category includes methamphetamine and other amphetamines including Benzedrine, Dexedrine, preludin, Ritalin and any other amines and related drugs. *Primary Substances*, *supra* note 41.

89. *See TEDS 2013*, *supra* note 35.

90. *See TEDS 2014*, *supra* note 36.

91. *See TEDS 2015*, *supra* note 37.

92. E-mail correspondence with ADAD staff on October 20, 2016 (on file with the Bureau).

93. *See* Balsa et al., *supra* note 6.

94. *Id.*

95. In fiscal year 2015-2016, over half of all ADAD-funded adult substance abuse treatment admissions were for methamphetamine treatment. E-mail correspondence with ADAD staff on October 20, 2016 (on file with the Bureau).

96. See "Drug Use Trends" in this chapter.

97. Letter to DEA staff on August 30, 2016; Letter to Hawaii HIDTA staff on August 24, 2016; Letter to Narcotics Enforcement Division staff on October 10, 2016. All letters are on file with the Bureau.

98. E-mail correspondence with Hawaii HIDTA staff on September 1, 2016 (on file with the Bureau).

99. HAWAII HIDTA INVESTIGATIVE SUPPORT CENTER, OFFICE OF NATIONAL DRUG CONTROL POLICY, STATE OF HAWAII, HAWAII HIDTA ANNUAL REPORT FOR CALENDAR YEAR 2015 11 (2016).

100. *Id.* at 52.

101. *Id.* at 11.

102. *Id.*

103. *Id.*

104. Letter from Narcotics Enforcement Division staff on October 19, 2016 (on file with the Bureau).

105. According to SAMHSA:

> The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.
>
> *Substance Use Disorders*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, https://www.samhsa.gov/disorders/substance-use (last updated Oct. 27, 2015).

106. EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES, NATIONAL DRUG CONTROL STRATEGY 2015 29 (2015), https://www.whitehouse.gov//sites/default/files/ondcp/policy-and-research/2015_national_drug_control_strategy_0.pdf.

107. *Id.* at 31.

108. *Id.* at 31, 43.

109. Substance misuse is the use of any drug in a manner, situation, amount or frequency that can cause harm to users of those around them. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE SURGEON GENERAL, FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 1-6 (2016), https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf.

110. *Id.* at 1-2.

111. *Id.* at iii.

112. *Treatments for Substance Use Disorders*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, http://www.samhsa.gov/treatment/substance-use-disorders (last updated Aug. 9, 2016).

113. For example, certain substance use treatment requires medication, and certain treatment is not benefitted by medication. *Id.*

114. For example, certain people may only need day treatment if the frequency of their substance use is minimal, whereas a more frequent user of a narcotic may require residential treatment. Additionally, treatment of opioid use often requires medication, while treatment for other drug use disorders does not use medication as a means of treatment. *Id.*

115. Persons with substance use who do not have private health insurance may have less options for treatment, as not all service providers accept publicly-funded health insurance. *See infra* notes 122-129 and accompanying text.

116. Certain substance use disorder treatment requires monitoring or assistance. Some treatment recipients may receive monitoring or assistance from family or friends, while others require state certified follow-up. SAMHSA, *Treatments for Substance Use Disorders, supra* note 112.

117. Courts often refer the highest risk offenders to treatment. See "Drug Court" in Chapter 4 of this report.

118. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, BEHAVIORAL HEALTH BAROMETER, HAWAII 2015 (2015), http://www.samhsa.gov/data/sites/default/files/2015_Hawaii_BHBarometer.pdf.

119. "Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but not receiving treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], or mental health centers)." SAMHSA 2013-2014 PREVALENCE ESTIMATES, *supra* note 6, tbl.33.

120. "Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006." *Id.*

121. *Id.* tbl.21

122. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SAMHSA, NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2014. DATA ON SUBSTANCE ABUSE TREATMENT FACILITIES 47 (2015), https://wwwdasis.samhsa.gov/dasis2/nssats/2014_nssats_rpt.pdf [hereinafter SAMSHA N-SSATS 2014].

123. The number of facilities that offer substance use treatment as reported by SAMHSA may differ from the number of facilities reported by the Alcohol and Drug Abuse Division (ADAD) because: (a) ADAD only reports admission data that is funded by ADAD, while SAMHSA reports ADAD- and non-ADAD-funded admission data; and (b) the reporting criteria may be different. E-mail correspondence with ADAD staff on Oct. 20, 2016 (on file with the Bureau).

124. SAMSHA N-SSATS 2014, *supra* note 122, at 53.

125. *Id.* at 49.

126. Unlike other states, none of the hospitals in Hawaii offer residential inpatient services for substance use disorder treatment. SAMSHA N-SSATS 2014, *supra* note 122, at 57.

127. *Id.*

128. Access to Recovery is a federal program that provides funding for substance abuse services for states, territories, tribes, and tribal organizations to carry-out voucher programs for substance abuse clinical treatment and recovery support services. *PPHF-2014-Access to Recovery (PPHF-2014)*, U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, https://www.samhsa.gov/grants/grant-announcements/ti-14-004 (last updated Sept. 11, 2015).

129. SAMSHA N-SSATS 2014, *supra* note 122, at 76.

130. *About the Alcohol and Drug Abuse Division*, ST. HAW., DEPT. HEALTH, ALCOHOL & DRUG ABUSE DIVISION, http://health.hawaii.gov/substance-abuse (last visited on Dec. 17, 2016).

131. *Id.*

132. E-mail correspondence with ADAD staff on October 20, 2016 (on file with the Bureau).

133. ADAD reports that there were five hundred ninety-six beds licensed and accredited in Special Treatment Facilities (both Residential Treatment Programs and residential Therapeutic Living

Programs) whose primary focus is substance use disorder treatment in fiscal years 2014-2015 and 2015-2016. The vacancy rates of these beds is not tracked. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. Figures provided by ADAD. *Id.*

138. Specifically, the average cost expended by ADAD for treatment per person were $4,670 (fiscal year 2011-2012), $3,902 (fiscal year 2012-2013), $3,873 (fiscal year 2013-2014), $4,316 (fiscal year 2014-2015), and $4,465 (fiscal year 2015-2016). *Id.*

139. *Id.*

140. Section 11-177.1-4, Hawaii Administrative Rules (HAR).

141. It should be noted that the number of *ADAD-certified* counselors may not represent the actual number of counselors actively working in the field of substance use treatment.

142. E-mail correspondence with ADAD staff on December 9, 2016 (on file with the Bureau).

143. See *infra* notes 168 to 171 and accompanying text.

144. THE JUDICIARY, STATE OF HAWAII, ANNUAL REPORT TO THE TWENTY-EIGHTH LEGISLATURE, 2016 REGULAR SESSION ON ACT 40, SESSION LAWS OF HAWAII 2004, HRS §601-21: A REPORT ON STATEWIDE SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM 5-6 (2015), http://www.courts.state.hi.us/docs/news_and_reports_docs/Proviso_Reports-final_12-15-15_1233PM.pdf [hereinafter JUDICIARY 2016 REPORT ON TREATMENT].

145. *Id*. at 7-9.

146. *Id*. at 7.

147. *Judiciary Informational Briefing: Hearing Before the S. Comm. on Ways & Means and the H. Comm. on Finance*, 28th Leg., tbl.20 (Haw. 2015) (written testimony of Judiciary), http://www.capitol.hawaii.gov/session2015/testimony/MASTER_TESTIMONY_WAM-FIN_1-6-15_JUD_20150106.pdf. The contracted entities were Aloha House, Inc.; Big Island Substance Abuse Council; Bobby Benson Center; CARE Hawaii; Hale Ho'okupa'a; Ho'omau Ke Ola; Maui Youth and Family Services, Inc.; Mental Health Kokua; The Queen's Medical Center; The Salvation Army; Waianae Coast Comprehensive Health Center; Women in Need; and Young Men's Christian Association of Honolulu.

148. JUDICIARY 2016 REPORT ON TREATMENT, *supra* note 144, at 5-6.

149. THE JUDICIARY, STATE OF HAWAII, ANNUAL REPORT TO THE TWENTY-EIGHTH LEGISLATURE ON ACT 40, SESSION LAWS OF HAWAII 2004, HRS §601-21: A REPORT ON STATEWIDE SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM 6 (2014), http://www.courts.state.hi.us/docs/news_and_reports_docs/2014_judiciary_proviso_report.pdf. The data in this report did not distinguish between children and adults admitted.

150. Letter to DHS staff on August 5, 2016 (on file with the Bureau).

151. Letters to Department of Community Services, City & County of Honolulu staff on August 5 and September 1, 2016; Letter to Department of Finance, County of Hawaii staff on August 5, 2016; letters to Department of Finance, County of Kauai staff on August 5 and September 1, 2016;

Letter to Department of Housing and Human Concerns, County of Maui staff on on August 5, 2016. All letters are on file with the Bureau.

152. Letter to Corrections Division, PSD staff on October 10, 2016 (on file with the Bureau).

153. Letter from DHS staff on August 26, 2016 (on file with the Bureau).

154. Mental restoration services can include treatment. Section 17-401.1-2, HAR.

155. DHS also provided statistics and expenditure data for treatment services for program recipients in the Office of Youth Services. Letter from DHS staff on August 26, 2016 (on file with the Bureau). However, since youth are not the focus of this study, we are excluding that data from this report.

156. E-mail correspondence with Department of Housing and Human Concerns, County of Maui staff on October 4, 2016 (on file with the Bureau).

157. Telephone Interview with Life Choices Kauai Program staff on September 6, 2016.

158. These numbers do not account for inmates at Saguaro Correctional Center in Arizona, which houses some Hawaii-based inmates. The Corrections Division informed us that while approximately 300 inmates at that facility received treatment for illicit drug use during fiscal year 2015-2016, such treatment is provided as part of the "all inclusive" services provided by the contractor. The contractor charges the State of Hawaii the same for housing the inmates whether treatment services are rendered to them or not. Letter from Corrections Division, PSD staff on October 31, 2016 (on file with the Bureau).

159. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat 119 (2010).

160. Christine Vestal, *Diverse Medicaid Rules Hurt in Fighting Addiction*, PEW CHARITABLE TRUSTS: STATELINE (Oct. 14, 2016), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/10/14/diverse-medicaid-rules-hurt-in-fighting-addiction; Christine Vestal, *How Severe is the Shortage of Substance Abuse Specialists?*, PEW CHARITABLE TRUSTS: STATELINE (Apr. 1, 2015), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists.

161. Patient Protection and Affordable Care Act § 1302(b), 124 Stat. at 163 (codified at 42 U.S.C. § 18022(b) (2012)).

162. Vestal, *Diverse Medicaid Rules Hurt in Fighting Addiction*, *supra* note 160; Vestal, *How Severe is the Shortage of Substance Abuse Specialists?*, *supra* note 160.

163. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343 tit. V, §§ 511–512, 122 Stat. 3765, 3881–3893.

164. Vestal, *How Severe is the Shortage of Substance Abuse Specialists?*, *supra* note 160.

165. *Id*.

166. *Id*.

167. *Id*.

168. *Id*.

169. *Id*.

170. *Id*.

171. *Id*.

172. *Id*.

173. *Id*.

174. *Id*.

175. Vestal, *Diverse Medicaid Rules Hurt in Fighting Addiction*, *supra* note 160.

176. *Id*.

177. Christine Vestal, *Nurses Step In to Boost Treatment for Opioid Addiction*, PEW CHARITABLE TRUSTS: STATELINE (Aug. 31, 2016), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/31/nurses-step-in-to-boost-treatment-for-opioid-addiction.

178. Vestal, *How Severe is the Shortage of Substance Abuse Specialists?*, *supra* note 160.

179. Christine Vestal, *States Move to Encourage More Addiction Counseling*, PEW CHARITABLE TRUSTS: STATELINE (Nov. 1, 2016), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/11/01/states-move-to-encourage-more-addiction-counseling.

180. Vestal, *Nurses Step In to Boost Treatment for Opioid Addiction*, *supra* note 177.

181. Mattie Quinn, *Your Peer Specialist Will See You Now*, GOVERNING (Aug. 2, 2016), http://www.governing.com/topics/health-human-services/gov-peer-specialists-mental-health.html; ADULT MENTAL HEALTH DIVISION, DEPARTMENT OF HEALTH, STATE OF HAWAII, HAWAII CERTIFIED PEER SPECIALIST PROGRAM: GUIDELINES, STANDARDS AND PROCEDURES 3 (2012), https://health.hawaii.gov/amhd/files/2013/06/HCPS-Handbook.pdf.

182. Quinn, *supra* note 181; ADULT MENTAL HEALTH DIVISION, *supra* note 181, at 12.

183. *See supra* Chapter 3, note 64, and accompanying text.

184. See "National Drug Strategy" in Chapter 3 of this report.

185. E-mail correspondence with ADAD staff on December 9, 2016 (on file with the Bureau).

186. *Id*.

187. The alternative activities strategy is to provide opportunities for participation in healthy, positive, and constructive activities that exclude substance use. These activities are assumed to offset the attraction to and/or meet the needs filled by alcohol and drugs, thereby reducing the likelihood of substance use. *Id.*

188. The community-based process strategy aims to enhance the ability of the community to more effectively provide prevention. Activities in this strategy include organizing, planning, enhancing the efficiency and effectiveness of service implementation, interagency collaborations, building coalitions and networking. *Id.*

189. The education strategy involves two-way communication between educator/facilitator and is distinguished from merely disseminating information by the fact that it is based on interaction between the educator and the participants. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, and critical analysis (e.g., of media messages). *Id.*

190. The environmental strategies seek to establish or change community standards, codes, and attitudes, thereby influencing the incidence and prevalence of alcohol and drug abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to service and action-oriented initiatives. *Id.*

191. The information dissemination strategy is to provide awareness and knowledge of the nature and extent of substance use, abuse and addiction, and their effects on individuals, families, and communities, as well as available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience with limited contact between the two. The information provided does not offer or promote a specific behavior change. *Id.*

192. The problem identification and referral strategy aims to identify those who have indulged in the illegal use of alcohol or drugs in order to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if an individual is in need of treatment. *Id.*

193. Amounts are from ADAD. *Id.*

194. These offenses are listed under section 712-1246, HRS (Promoting a harmful drug in the third degree); section 712-1246.5, HRS (Promoting a harmful drug in the 4th degree); section 712-1247, HRS (Promoting a detrimental drug in the first degree); section 712-1248 (Promoting a detrimental drug in the second degree); and section 712-1249, HRS (Promoting a detrimental drug in the third degree). See "A Survey of Hawaii Drug Offenses Under the Scope of the Resolution" in Chapter 4 for more information on these offenses.

195. DEPARTMENT OF THE ATTORNEY GENERAL, STATE OF HAWAII, CRIME IN HAWAII 2014: A REVIEW OF UNIFORM CRIME REPORTS i (2016), https://ag.hawaii.gov/cpja/files/2016/07/Crime-in-Hawaii-2014.pdf [hereinafter AG 2014 REPORTS]; DEPARTMENT OF THE ATTORNEY GENERAL, STATE OF HAWAII, CRIME IN HAWAII 2005: A REVIEW OF UNIFORM CRIME REPORTS 109 (2009), http://ag.hawaii.gov/cpja/files/2013/01/Crime_in_Hawaii_2005.pdf [hereinafter AG 2005 REPORTS].

196. This table is adapted from statistical tables in AG 2014 REPORTS, *supra* note 195, at 110; AG 2005 REPORTS, *supra* note 195, at 109.

197. Letter to Honolulu Police Department staff on August 5, 2016; Letters to Hawaii (County) Police Department staff on August 5 and September 1, 2016; Letters to Kauai Police Department staff on August 5 and September 1, 2016; Letters to Maui Police Department staff on August 5 and September 1, 2016. All letters are on file with the Bureau.

198. The data from the police departments analyzed in this report are drawn from correspondence made from August to December 2016. The primary sources of information were: E-mail correspondence with Honolulu Police Department staff on September 16, 2016; Letter from Hawaii (County) Police Department staff on September 8, 2016; Letter from Kauai Police Department staff on August 25, 2016; Letter from Maui Police Department staff on September 9, 2016. However, several follow-up communications were made in attempt to clarify information. All written correspondence is on file with the Bureau.

199. Sections 712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248, HRS.

200. Telephone Interview with Honolulu Police Department staff on September 23, 2016.

201. Telephone Interview with Kauai Police Department staff on September 21, 2016.

202. Telephone Interview with Honolulu Police Department staff on August 22, 2016.

203. Letter from Hawaii (County) Police Department staff on September 8, 2016 (on file with the Bureau).

204. *Id.*

205. *Id.*

206. Letter from Kauai Police Department staff on August 25, 2016; Letter from Maui Police Department staff on September 9, 2016. Both letters are on file with the Bureau.

207. Letter to Judiciary staff on August 5, 2016 (on file with the Bureau).

208. The data from the Judiciary analyzed in this report are drawn from correspondence made from August to October 2016. The primary source of information was e-mail correspondence with Judiciary staff on August 26, 2016. However, several follow-up communications were made in attempt to clarify information. All written correspondence is on file with the Bureau.

209. Judiciary staff informed us that some records were not available for earlier years. Telephone Interview with Judiciary staff on August 15, 2016.

210. Statistics we received from the Judiciary show that some felony drug cases were filed in the district courts of the State. However, while complaints may be filed in district courts in cases for which a preliminary hearing is held, that is only to initiate those cases, which are then sent to circuit courts. Rule 5(b), Hawaii Rules of Penal Procedure. Since district courts play only a small role in processing felony cases, we excluded those cases from district court statistics.

211. E-mail correspondence with Judiciary staff on August 26, 2016 (on file with the Bureau).

212. *Id.*

213. Letters to Department of the Prosecuting Attorney, City & County of Honolulu staff on August 5 and September 1, 2016; Letter to Office of the Prosecuting Attorney, County of Hawaii staff on August 5, 2016; Letter to Office of the Prosecuting Attorney, County of Kauai staff on August 5 and September 1, 2016; Letter to Department of the Prosecuting Attorney, County of Maui staff on August 5, 2016. All letters are on with the Bureau.

214. Letter to Criminal Justice Division staff on August 5, 2016 (on file with the Bureau).

215. Letters to Office of the Public Defender staff on August 5 and September 1, 2016 (on file with the Bureau).

216. Section 802-1, HRS.

217. Letter from Criminal Justice Division staff on August 25, 2016 (on file with the Bureau).

218. Telephone Interview with Office of the Prosecuting Attorney, County of Kauai staff on September 6, 2016; telephone interview with Department of the Prosecuting Attorney, County of Maui staff on August 23, 2016.

219. E-mail correspondence with Office of the Prosecuting Attorney, County of Hawaii staff on August 23, 2016 (on file with the Bureau).

220. Letter from Office of the Public Defender staff on October 12, 2016 (on file with the Bureau).

221. Letter to HCJDC staff on September 30, 2016 (on file with the Bureau).

222. The data from the HCJDC analyzed in this report are drawn from correspondence made from October to Novmber 2016. The primary source of information was e-mail correspondence with HCJDC staff on October 20, 2016. However, several follow-up communications were made in attempt to clarify information. All written correspondence is on file with the Bureau.

223. Our inquiry also asked the HCJDC to provide statistics on court cases in which the outcome was still pending at the end of each year. Letter to HCJDC staff on September 30, 2016 (on file with the Bureau). The HCJDC's data showed that none of the relevant court cases had such a status at

the end of any given year. *See* E-mail correspondence with HCJDC staff on October 20, 2016 (on file with the Bureau).

224. E-mail correspondence with HCJDC staff on November 3 and November 29, 2016 (on file with the Bureau).

225. Telephone Interview with Honolulu Police Department staff on November 4, 2016.

226. Telephone Interview with Kauai Police Department staff on November 28, 2016.

227. E-mail correspondence with Judiciary staff on August 26, 2016 (on file with the Bureau).

228. E-mail correspondence with HCJDC staff on October 20, 2016 (on file with the Bureau).

229. See notes 198, 208, and 222 for more information on the collection of the data utilized in these figures.

230. *See supra*, p. 64.

231. See note 194 for a listing of relevant drug offenses.

232. Section 706-663, HRS.

233. *Id*.

234. Letter to Corrections Division, Department of Public Safety (PSD) staff on October 10, 2016 (on file with the Bureau).

235. Letter from Corrections Division, PSD staff on October 31, 2016 (on file with the Bureau).

236. E-mail correspondence with ADAD staff on November 9, 2016 (on file with the Bureau).

237. Section 706-660, HRS.

238. Sections 706-660 and 706-669, HRS.

239. Sections 706-660, and 706-663, HRS.

240. See "Conflicting Legal Authority in a Federal System of Government" in Chapter 4 of this report.

241. *Id.*

242. Laws have been enacted to decriminalize marijuana possession to some degree in nine states (Delaware, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Ohio, Rhode Island, and Vermont) and depenalize such possession to some degree in four states (Connecticut, Missouri, New York, and North Carolina). *See infra* Chapter 6. Missouri's law took effect on January 1, 2017. The preceding list does not include states that, along with the District of Columbia, have enacted laws to legalize the possession of small amounts of marijuana by removing all criminal and civil penalties for such possession. For a discussion of the distinction between decriminalization, depenalization, and legalization, see Chapter 2 of this report.

243. The quantity is one ounce in Delaware, Nebraska, Rhode Island, and Vermont; any amount *less* than ten grams (0.35274 ounces) in Maryland; ten grams in Illinois and, effective January 1, 2017, in Missouri; 0.5 ounces in Connecticut and North Carolina; thirty grams (1.05822 ounces) in Mississippi; 42.5 grams (1.499143 ounces) in Minnesota; and one hundred grams (3.5274 ounces) in Ohio. In New York, the quantity is not defined in statutory law. See Chapter 6 of this report for further discussion.

244. The maximum fine for a first violation is $100 in Connecticut, Delaware, Maryland, and New York; $150 in Ohio and Rhode Island; $200 in Illinois, North Carolina, and Vermont; $250 in

Mississippi; $300 in Minnesota and Nebraska; and $500 in Missouri, effective January 1, 2017. *See infra* Chapter 6.

245. Section 712-1249, HRS. See also Table 4-1 in Appendix B.

246. See "Dissuasion Commission Process" in Chapter 3 for further discussion.

247. Some states that have decriminalized the possession of marijuana still provide for arrests in some circumstances. *See infra* Chapter 6.

248. See "National Drug Strategy" in Chapter 3 of this report.

249. *See supra* Chapter 4 note 20 and accompanying text. Sections 329-14(c) and 712-1240, HRS.

Chapter 6

OTHER DECRIMINALIZATION APPROACHES

Examining the experiences of other jurisdictions that have decriminalized certain aspects of drug possession and use may be instructive in relation to decriminalization approaches that may be contemplated for Hawaii. As will be reviewed in this chapter, Mexico has decriminalized the possession of small amounts of commonly used illicit drugs, including highly addictive drugs such as methamphetamine and heroin, but Mexico's approach and results have differed significantly from those in Portugal, which were discussed in chapters 3 and 4. In Europe, Spain and Italy had already taken steps to reduce penalties for possession of small amounts of illicit drugs by the time Portugal enacted its decriminalization law. A number of United States jurisdictions have also legalized, decriminalized, or designated as petty offenses the possession of small amounts of non-medical marijuana, but continue to criminalize possession and use of other illicit drugs.

MEXICO

Like Portugal, Mexico has decriminalized, through the legislative process, the possession of small amounts of drugs and devised strategies to direct drug users into treatment programs.[1] However, Mexico's approach has differed significantly from Portugal's and has not produced clear indications of success.[2] Rather, some analysts have viewed Mexico's shift to decriminalization in 2009 as a very problematic cautionary tale, underscoring the need to cast decriminalization as part of a larger shift toward treating drug abuse as a public health concern and to establish appropriate administrative structures and provide adequate resources for successful implementation.[3]

Over the past decade, Mexico has experienced a rapid increase in drug use and addiction[4] amid a horrific wave of violence related to drug trafficking and its suppression.[5] Mexico is a primary drug smuggling gateway to lucrative illegal markets in the United States for cocaine, heroin, marijuana, methamphetamine, and other drugs.[6] Competing criminal organizations have established drug production and distribution cartels with tightly controlled transportation networks within Mexico and the United States, in some areas challenging the Mexican government's control of territory or gaining de facto control of territory and government structures through widespread corruption and ineffective policing.[7] In 2006, the Mexican government began dispatching thousands of military troops and federal police officers across the country to assume duties normally carried out by state and local police officers.[8]

Nonetheless, the widespread availability of drugs has contributed to increased drug abuse, especially injected drug use, and the spread of HIV and other diseases associated with injected drug use. Heroin and methamphetamine injection and addiction are especially prevalent in some areas near the United States border that serve as major smuggling hubs. In the northwestern Mexican state of Baja California, 4.8 percent of the population in 2008 reported

injecting drugs, compared with 0.2 percent in Mexico as a whole.[9] Tijuana, the largest city in Baja California, may have the highest number of injected drug users per capita of any city in Mexico, along with one of the nation's most severe rates of HIV infection.[10]

In 2009, in response to the escalating drug-related violence and inability of authorities to prosecute and incarcerate the growing number of drug users and addicts, the Mexican Congress approved a drug decriminalization bill that has since been codified in Articles 478 and 479 of Mexico's General Law of Health.[11] The legislation generally provides that anyone apprehended by law enforcement officers with amounts of drugs below certain small limits may not be prosecuted, imprisoned, or fined.[12] A person caught possessing a decriminalized amount of drugs will be "encouraged" to seek treatment, if a first or second instance; drug abuse treatment is mandatory upon a third instance.[13] However, the sale of drugs, even in decriminalized amounts, remains a criminal offense, and the legislation increased penalties for possession of amounts of drugs that exceed the decriminalized limits.[14]

Mexico's approach to decriminalization and the circumstances in which it was undertaken differ from Portugal's in significant ways. For example, the amounts of drugs that may be possessed without criminal liability are much smaller in Mexico,[15] often below the amounts in which drugs are commonly sold on the street.[16] This may undermine the decriminalization scheme and expose drug users and addicts to criminal charges because most possession for personal use is still criminal.[17] Also, a person caught with drugs for a third time in Mexico may be taken into police custody and detained until released by a prosecutor or a judge,[18] rather than receive a citation and appear before a health-oriented civilian commission as in Portugal.[19] Cases in Mexico are routinely routed through the criminal justice system, and a prosecutor decides whether the amount of drugs possessed exceeded the decriminalized quantity.[20]

Widespread corruption is also a major concern, and the prospect of detention leaves drug users and addicts vulnerable to police extortion. Absent more sweeping reforms, corruption could remain a serious obstacle to decriminalization even if Mexico adopted Portuguese-style civilian dissuasion commissions but failed to properly fund their implementation and administration. As one analyst observed:

> The level of corruption that pervades the Mexican government is staggering and stands in the way of executing any real reform. An extensive reform of the justice system in Mexico is needed; Portuguese-style decriminalization will not be a panacea for the system – and may in fact suffer as a result. Should the members of [Portuguese-style dissuasion commissions] be as corrupt as their existing law enforcement analogs, they may extort users diverted to them, and fail entirely to impose sanctions or refer addicts and users to treatment.[21]

Decriminalization in Mexico has also been hampered by a severe shortage of drug abuse treatment opportunities and facilities as well as other barriers to treatment. For example, a 2011 survey found that only 18 percent of Mexicans who meet the criteria for drug dependence were in treatment.[22] Tijuana is home to an estimated 10,000 heroin addicts and other injection drug users.[23] However, as of 2012, only three methadone maintenance[24] clinics were in operation in

Tijuana, two of which were private, for-profit businesses and the third of which was a public facility that charged fees for services.[25] Furthermore, data indicate that people who receive treatment for heroin addiction in Tijuana may be at increased risk of extortion by police.[26] There is also the potential for increased extortion nationwide:

> There is a very real concern that this law will actually increase corruption and extortion by police forces. Jurisdiction to enforce criminal penalties for small-scale trafficking has been extended to state and local police, believed to be the most corrupt segments of Mexican law enforcement. These agencies will in turn experience new pressure to pursue drug offenders, requiring them to obtain more resources and skills. This will be a difficult task because they are already lacking in professional staff and sufficient capital. Extortion may also increase under this law because the low possession quantities that qualify as personal use under the amended laws could encourage state police forces to "shake down" addicts who possess an amount over the prescribed limit.[27]

Thus, although Mexico has decriminalized the possession of small quantities of drugs and partially begun a shift toward a public-health approach for the control and treatment of drug abuse, it has yet to implement a system that provides adequate access to treatment opportunities, nor does it adjudicate minor drug possession violations in a non-criminal context as does Portugal. Furthermore, the lucrative markets for illegal drugs in the United States continue to fuel violent conflict in Mexico over drug trafficking control and suppression and have contributed to the creation, growth, and maintenance of ancillary drug markets in Mexico.[28]

EUROPE

Portugal's Law No. 30/2000 has often been portrayed as somewhat revolutionary. For example, in his 2009 white paper for the Cato Institute, Glenn Greenwald states that "no [European Union] state other than Portugal has *explicitly* declared drugs to be 'decriminalized.'"[29] However, the significance of this declaration should be understood in a proper historical and legal context. While it is true that Portugal's Law No. 30/2000 was distinct in that, with regard to the possession of small amounts of illicit drugs, the law replaced the criminal court system entirely with an administrative process. Yet, at the time that Portugal enacted Law No. 30/2000, laws already in effect in Spain and Italy allowed offenders to avoid imprisonment as a possible sanction for the possession of small amounts of a broad range of illicit drugs, and that range was similar in scope to that of Portugal's new law.[30] For example, an offender under Spanish law could still be judged by a criminal court and acquire a criminal record, but the offender would not be sent to prison for mere consumption or possession.[31] Notably, Portugal's 1999 National Drug Strategy report praised Spain and Italy for their "bold" laws.[32] In light of the common geographic, cultural, political, legal, and economic factors that European countries face in addressing illicit drug use, it appears that Portugal's adoption of Law No. 30/2000 was not a significant departure from the laws of other countries on the continent. Rather, it would seem to have been an extension of an approach already undertaken elsewhere in Europe.[33]

UNITED STATES: DECRIMINALIZATION OF MARIJUANA FOR NON-MEDICAL USE

Decriminalization that may have been effective in Portugal, an independent and sovereign nation in Europe, may not necessarily work for Hawaii, one state within a nation bound together by a federal government. A more apt comparison for Hawaii policymakers considering the decriminalization of illicit drugs may be the decriminalization legislation enacted in other American states.

As noted in Chapter 4, even if a state of the United States decriminalizes, depenalizes, or legalizes an illicit drug under its state laws, the practical effect of such a change may be limited by the fact that state laws may be superseded by federal law. To date, marijuana is the only illicit drug that any state has decriminalized, depenalized, or legalized with regard to non-medical use.[34] Broadly speaking, the decriminalization of small amounts of marijuana does not appear to have led to major increases in the consumption of marijuana.[35] However, this does not necessarily mean that the decriminalization of harder drugs such as heroin or methamphetamine would have a similarly benign effect.[36] Perhaps for this reason, to our knowledge, there has been only one recent state legislative measure that has attempted to decriminalize illicit drugs other than marijuana.[37] That 2016 Maryland bill would have made possession of "de minimis" quantities of seven "controlled dangerous substances" a civil offense, but it did not receive favorable committee action.[38]

Below is a brief discussion of the states that have decriminalized, depenalized, or legalized the personal possession of marijuana to some degree.

Alaska

Alaska first moved toward legalization of marijuana use in 1975, when the Alaska Supreme Court ruled that, based on the state's constitutional guarantee of a right to privacy, adults have the right to possess marijuana in their homes for personal use.[39] The Alaska legislature responded that year by passing a law that replaced criminal penalties for the possession of (1) up to one ounce of marijuana in public and (2) any amount of marijuana in private with a civil fine of up to $100.[40] However, in 1982, in order to bring the state's criminal code into true compliance with the 1975 court decision, Alaska law was again amended to repeal any penalty (civil or criminal) for any adult possession of less than four ounces of marijuana for in-home personal use.[41]

From 1990 to 2006, personal possession of small amounts of marijuana in the home went through a series of recriminalizations and decriminalizations through legislative acts and court decisions,[42] leaving a period of legal confusion that lasted until 2014.[43] That year, voters approved "Measure 2," an initiative that legalized the recreational use and retail sale of marijuana,[44] and allowed adults twenty-one years or older to possess up to one ounce of marijuana and certain amounts of plants.[45]

California

In 1975, California enacted a law that made possession of up to one ounce of marijuana a nonjailable criminal "misdemeanor" that is only punishable by a fine of up to $100.[46] In 2011, California's governor, noting that possession of such an amount of marijuana was already "an infraction in everything but name,"[47] signed a bill that officially made the offense an infraction.[48] Notably, while a person who commits an infraction in California is not subject to a sentence of imprisonment for that infraction, the person is still subject to arrest.[49]

One article estimated that California saved at least $1 billion between 1976 and 1986 on enforcement expenditures as a result of making possession of an ounce or less of marijuana a citable and depenalized misdemeanor instead of a felony.[50] However, we cannot assume that Hawaii would save a significant amount of money if the State were to similarly depenalize or decriminalize the possession of up to one ounce of marijuana. As noted previously,[51] depending upon the amount in question, possession of less than one *pound* of non-medical marijuana is already a misdemeanor or petty misdemeanor in Hawaii, albeit an offense for which incarceration remains a possible penalty.[52] Further, as noted previously, Hawaii does not appear to routinely incarcerate large numbers of people solely for possession of less than one ounce of marijuana.[53]

During the 2016 general election, California's voters approved a marijuana legalization measure, Proposition 64.[54] Many of the provisions of the ballot measure became effective on November 9, 2016,[55] including provisions that allow adults 21 years of age and older to possess and distribute without compensation up to 28.5 grams of non-concentrated marijuana or 8 grams of marijuana concentrate, and cultivate up to six living marijuana plants.[56] The measure also provides for the sale of recreational marijuana starting January 1, 2018.[57]

Colorado

In 1975, Colorado enacted a law that deemed possession of one ounce or less of marijuana a "class 2 petty offense" punishable by a fine of up to $100.[58] In 2012, Colorado voters approved a ballot initiative that amended Colorado's constitution to legalize and regulate certain acts regarding marijuana.[59] For example, adults twenty-one years of age or older may possess, as well as transfer without compensation to other adults, up to one ounce of marijuana. They may also possess, grow, process, or transport up to six marijuana plants, including up to three mature plants.[60] The law also provides for the sale of marijuana in certain circumstances.[61]

Connecticut

In 2011, Connecticut depenalized the possession of up to one-half ounce of marijuana. First time offenders face a fine of up to $100, while repeat offenders face a fine up at least $200 and up to $500. Offenders who plead "no contest" or are found guilty of this offense upon the third time are referred to participate in a drug education program at their own expense.[62] While

offenders cannot be imprisoned for the offense of marijuana possession alone, an offender faces a separate jailable misdemeanor offense if he or she fails to (1) pay the fine, (2) fails to submit a timely plea of "not guilty," or (3) fails to appear for any scheduled court appearance.[63]

Delaware

In 2015, Delaware passed a law that imposed a civil penalty of up to $100 for the possession of a "personal use quantity" (up to an ounce[64]) of marijuana.[65]

District of Columbia

In 2014, the District of Columbia enacted a law that decriminalized the possession of up to one ounce of marijuana. Possessors would be required to pay a civil penalty of $25.[66] Later that same year, voters approved Initiative 71,[67] which allows adults over the age of twenty-one to possess up to two ounces of marijuana and consume it on private property.[68]

Illinois

In 2016, Illinois decriminalized the possession of up to ten grams of cannabis.[69] A person who knowingly possesses up to ten grams of cannabis is guilty of a civil law violation and may be fined up to $200.[70]

Maine

In 1975, Maine was one of the first states to decriminalize the possession of marijuana.[71] Currently, a person who possesses up to one and one-quarter ounces of marijuana commits a civil violation and may be fined between $350 and $600.[72] A person who possesses between one and one-quarter ounces to two and one-half ounces of marijuana commits a civil violation and may be fined between $700 and $1000.[73]

Marijuana legalization appeared on Maine's ballot during the 2016 general election. Among other reforms, the measure proposed to allow adults 21 years of age and older to use, possess, and transfer without compensation up to 2.5 ounces of prepared marijuana, as well as cultivate a limited number of marijuana plants. The measure also provided for the retail sale of marijuana.[74] Voters in Maine approved the measure by a margin of 4,073 votes out of more than 750,000 cast.[75] After a recount challenge, the margin was reduced to 3,995 votes, but the "yes" side still prevailed.[76] On December 31, 2016, the Governor issued a proclamation verifying the results of balloting on the measure, which took effect on January 30, 2017.[77]

Maryland

In 2014, Maryland enacted Chapter 158, which, among other things, made the use or possession of marijuana in a quantity of less than ten grams a civil offense.[78] Violation of this chapter is punishable by a fine of no more than $100 for a first violation, $250 for a second violation, and $500 for each subsequent violation.[79] In 2016, following the override of a gubernatorial veto, Maryland enacted Chapter 4, which, among other changes, made smoking marijuana in a public place a civil offense punishable by a fine of no more than $500, and decriminalized the use or possession of drug paraphernalia involving the use or possession of marijuana.[80]

Massachusetts

In 2008, the State deemed possession of up to one ounce of marijuana a civil offense. Offenders were subject to a civil penalty of up to $100 and forfeiture of the marijuana.[81]

During the 2016 general election, voters in Massachusetts approved Question 4.[82] Effective December 15, 2016, the ballot measure allows many activities in relation to marijuana.[83] For example, it allows persons 21 years of age and older to possess, use, purchase, process, or manufacture up to one ounce of non-concentrated marijuana or 5 grams of marijuana concentrate, as well as, within the person's own residence, to possess up to ten ounces of marijuana and cultivate up to twelve marijuana plants.[84]

Minnesota

Minnesota decriminalized the possession of a small amount of marijuana in 1976.[85] In Minnesota, a person who possesses a small amount of marijuana[86] is guilty of a petty misdemeanor and is required to participate in a drug education program unless a court enters a written finding that a drug education program is inappropriate.[87] Petty misdemeanors are not considered crimes and carry a maximum fine of $300.[88]

Mississippi

Mississippi was one of the states to decriminalize marijuana in the late 1970s.[89] Currently, a person that possesses thirty grams or less of marijuana will be fined between $100 and $250 for a first violation.[90] Subsequent violations within two years of the initial violation are misdemeanors that are punished with higher fines, jail time, and mandatory participation in drug education programs.[91] First and second convictions of those found to have thirty grams or less of marijuana are reported to the Mississippi Bureau of Narcotics, which maintains for up to two years a private, nonpublic noncriminal record of the convictions that is used to help determine judicial penalties.[92]

Missouri

In 2014, the Missouri Legislature passed Senate Bill No. 491, which comprehensively amended that state's criminal code, including depenalization of the possession of limited amounts of marijuana.[93] Many parts of the bill take effect on January 1, 2017.[94] Beginning on that date, a person with no prior drug-related convictions who possesses not more than ten grams of marijuana, or a synthetic cannabinoid, commits a class D misdemeanor.[95] Also beginning on January 1, 2017, a class D misdemeanor is punishable with a fine of no more than $500.[96]

Nebraska

In Nebraska, the first offense for possession of one ounce or less of marijuana is an infraction, which results in a citation, a fine of $300, and assignment to a course relating to the effects of the misuse of drugs, if the judge determines that attending such a course is in the best interest of the individual.[97] Subsequent offenses for possession of one ounce or less of marijuana are misdemeanors that may result in imprisonment, among other penalties.[98]

Nevada

Prior to January 1, 2017, in Nevada, the first and second offenses of possession of up to one ounce of marijuana were misdemeanors.[99] The penalty for a first offense was a fine of not more than $600 or mandatory substance abuse treatment.[100] The penalty for a second offense was a fine of not more than $1,000 or mandatory substance abuse treatment.[101] The penalty for subsequent violations included imprisonment.[102]

During the 2016 general election, Nevada's voters approved Question 2.[103] Effective January 1, 2017, the new law, among other matters, allows persons 21 years of age and older to possess, use, purchase, process or manufacture up to one ounce of non-concentrated marijuana or one-eighth of an ounce of marijuana concentrate, as well as cultivate and transport a limited number of marijuana plants.[104]

New York

In 1977, New York enacted a law that made possession of a small amount of marijuana a violation punishable by a fine of up to $100 for first-time offenders.[105] The statute does not define what constitutes a small amount, which leaves interpretation up to the courts.[106] While certain repeat offenders may face fines of up to $250 and imprisonment of up to fifteen days, no sentence of imprisonment of first-time offenders is possible.[107] A related law authorizes the arrest of first-time offenders, but when a defendant is arrested without a warrant, the defendant is not held in custody and is instead given a ticket to appear in court. A warrant of arrest is issued if the defendant fails to appear as required by the appearance ticket.[108]

North Carolina

North Carolina was another state that enacted a form of marijuana depenalization in the 1970s.[109] Currently, possession of up to one-half of an ounce of marijuana is a Class 3 misdemeanor[110] and carries a penalty of up to $200.[111] Any sentence of imprisonment imposed must be suspended, and at the time of sentencing, the judge may not require that the defendant serve a period of imprisonment as a special condition of probation.[112]

Ohio

In Ohio, the possession of less than one hundred grams of marijuana is a minor misdemeanor,[113] which carries a maximum fine of $150[114] and for which the offender does not incur a criminal record.

Oregon

In 1973, Oregon became the first state to remove imprisonment as a possible penalty for simple possession. The state enacted a law that made possession of less than one ounce of marijuana a violation punishable by a fine of up to $100.[115] In 2014, voters passed "Measure 91," which legalized adult possession of up to eight ounces of marijuana.[116]

Rhode Island

Rhode Island decriminalized marijuana possession in 2013.[117] For a first violation, or a second violation within eighteen months of the first, a person who possesses up to one ounce of marijuana commits a civil offense and subject to a $150 fine; provided that violators under eighteen years of age must complete an approved drug-awareness program and community service, as determined by the court.[118]

Vermont

Vermont decriminalized adult possession of up to one ounce of marijuana in 2013.[119] A person who is at least twenty-one years old and who possesses one ounce or less of marijuana, or five grams or less of hashish, commits a civil violation that does not result in the creation of a criminal record.[120] A person that violates this offense can be fined up to $200 for a first violation, up to $300 for a second violation, and up to $500 for a third or subsequent violation.[121]

Washington State

Instead of first decriminalizing marijuana, Washington went directly from criminalization to outright legalization. In 2014, voters approved Initiative 502.[122] As a result of that initiative and subsequent legislation, Washington allows adults of the age of twenty one and older to possess up to one ounce of useable marijuana, as well as other amounts of marijuana-based products, without any civil or criminal penalty.[123]

ENDNOTES

1. *See, e.g.*, Justin B. Shapiro, Note, *What Are They Smoking?! Mexico's Decriminalization of Small-Scale Drug Possession in the Wake of a Law Enforcement Failure,* 42 U. MIAMI INTER-AM L. REV. 115 (2010), http://repository.law.miami.edu/cgi/viewcontent.cgi?article=1004&context=umialr.

2. *See,* e.g., Kellen Russoniello, Note, *The Devil (and Drugs) in the Details: Portugal's Focus on Public Health as a Model for Decriminalization of Drugs in Mexico,* 12 YALE J. HEALTH POL'Y L. & ETHICS 371 (2012), http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple.

3. *Id*. at 429-430.

4. A national survey found that drug addiction doubled in Mexico between 2002 and 2008 to nearly half a million people. *Id.* at 402-403. Between 2002 and 2011, the use of illicit drugs increased 87 percent. Erick G. Guerrero et al., *Mexicans' Use of Illicit Drugs in an Era of Drug Reform: National Comparative Analysis by Migrant Status*, 25 INT. J. DRUG POL'Y 451, 451 (2014).

5. Between 2006 and 2012, an estimated 47,000 to 51,000 people were killed in drug-related violence in Mexico. *See, e.g.*, TED GALEN CARPENTER, CATO INSTITUTE, THE FIRE NEXT DOOR: MEXICO'S DRUG VIOLENCE AND THE DANGER TO AMERICA 45 (2012).

6. An estimated $25 billion to $30 billion worth of illegal drugs enter the United States via Mexico each year, including ninety percent of the cocaine consumed in the U.S. (transshipped from Central and South America) and many tons of Mexico-produced heroin, marijuana, and methamphetamine. *See, e.g.*, Shapiro, *supra* note 1, at 118-119.

7. *See, e.g.*, 1 UNITED STATES DEPARTMENT OF STATE, INTERNATIONAL NARCOTICS CONTROL STRATEGY REPORT: DRUG AND CHEMICAL CONTROL 432 (2010), http://www.state.gov/documents/organization/137411.pdf. The report noted:

   > The cross-border flow of money and guns into Mexico from the United States has enabled well-armed and well-funded cartels to engage in violent activities. They employ advanced military tactics and utilize sophisticated weaponry such as sniper rifles, grenades, rocket-propelled grenades and even mortars in attacks on security personnel. [Drug trafficking organizations] have openly challenged the [government of Mexico] through conflict and intimidation and have fought amongst themselves to control drug distribution routes. The results led to unprecedented violence and a general sense of insecurity in certain areas of the country, particularly near the U.S. border.
   >
   > *Id.*

See also, e.g., ANABEL HERNÁNDEZ, NARCOLAND: THE MEXICAN DRUG LORDS AND THEIR GODFATHERS 7 (2013).

> Currently, all the old rules governing relations between the drug barons and centers of economic and political power have broken down. The drug traffickers impose their own law. The businessmen who launder their money are their partners, while local and federal officials are viewed as employees to be paid off in advance, for example by financing their political campaigns. The culture of terror encouraged by the federal government itself, as well as by the criminal gangs through their grotesque violence, produces a paralyzing fear at all levels of society.
>
> *Id.*

8. *See, e.g.*, Shapiro, *supra* note 1, at 129.

9. Angela M. Robertson et al., *Evaluating the Impact of Mexico's Drug Policy Reforms on People Who Inject Drugs in Tijuana, B.C., Mexico, and San Diego, CA, United States: A Binational Mixed Methods Research Agenda*, Harm Reduction J. 2014 11:4, at 3.

10. In 2006, an estimated one in every 116 people aged 15 to 49 in Tijuana was infected with HIV. *Id.*

11. *See, e.g.*, Shapiro, *supra* note 1, at 132.

12. The decriminalized quantities are: five grams of marijuana, 500 milligrams of cocaine, 40 milligrams of methamphetamine or ecstasy/MDMA, and fifty milligrams of heroin. *See, e.g.*, Russoniello, *supra* note 2, at 406.

13. *See, e.g.*, Shapiro, *supra* note 1, at 134.

14. The sentence for possession of drugs exceeding the amounts designated for personal use but less than one thousand times the maximum amount for personal use is three to six years in prison upon a finding that the drugs were intended for distribution, or ten months to three years if not intended for distribution. The sentence for the sale of any drug in an amount exceeding the quantity for personal use but below one thousand times that amount is four to eight years. The sentence for possession of an amount equal to or greater than one thousand times the quantity for personal use, with intent to distribute, is five to fifteen years. *See, e.g.*, Russoniello, *supra* note 2, at 407.

15. *See supra* note 12. In contrast to Mexico, Portugal's decriminalization statute allows a person to possess an amount no greater than a ten-day supply of drugs for personal consumption, which has been determined to include up to one gram of heroin, one gram of ecstasy, one gram of amphetamines, two grams of cocaine, or twenty-five grams of cannabis. *See, e.g.*, Russoniello, *supra* note 2, at 385 n.58. Thus, Portugal decriminalized possession of 25 times the amount for methamphetamine or ecstasy, twenty times the amount for heroin, five times the amount of marijuana, and four times the amount of cocaine as did Mexico.

16. Russoniello, *supra* note 2, at 409.

17. *Id.*

18. *Id*. at 408.

19. Portugal's use of civilian "dissuasion commissions" to adjudicate administrative citations for drug possession is highly regarded by many advocates of public health-centered drug abuse policies.

> The [dissuasion commissions] are arguably the most unique feature of decriminalization in Portugal. These bodies represent a marked departure from traditional law enforcement in addressing drug use. Mexican decriminalization could much more effectively reduce drug use, drug-related disease, and burdens on the criminal justice system if it were to adopt commissions like the [dissuasion commissions] of Portugal for two reasons: First, a diverse panel would be able to make offender-specific determinations and impose a variety of sanctions aimed at achieving the most effective outcomes. Second, the commission would be removed from the criminal justice system. This separation is likely to encourage users to seek treatment voluntarily; reduce the burden of drug use cases on the courts; decrease corruption, extortion, and human rights abuses; and refocus law enforcement efforts on large-scale drug trafficking.
>
> An advantage of the Portuguese system in that experts in the field of drug addiction, and not judges with limited knowledge in this field, determine whether a drug possession offense has occurred and whether the offender is addicted. The creation of similar commissions in Mexico would allow for experts in the area of substance abuse to determine whether or not a user is addicted. This is preferable to having a judge perform this task, since the commission would likely be more familiar with the symptoms and presentation of addiction and would be able to more accurately decide whether a person is addicted. Additionally, removal of this decision-making power from the criminal justice system would help reduce the stigma associated with addiction, thus mitigating one barrier to treatment.
>
> *Id.* at 417.

20. *Id.* at 409.

21. *Id.* at 426-27.

22. Editorial, *Mexico's Drug Policy Reform: Cutting Edge Success or Crisis in the Making?* 25 INT. J. DRUG POL'Y 823, 823 (2014), http://www.ijdp.org/article/S0955-3959(14)00145-5/pdf.

23. *Id.*

24. Methadone maintenance is a form of opioid substitution treatment in which a person addicted to an opioid such as heroin receives regular doses of methadone to avoid debilitating withdrawal symptoms that typically result when an addict stops using the opioid. *Methadone,* U.S. DEP'T HEALTH HUM. SERVICES, SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone (last updated Sept. 28, 2016).

25. *Mexico's Drug Policy Reform*, *supra* note 22, at 823.

26. *See, e.g.*, D. Werb et al., *Police Bribery and Access to Methadone Maintenance Therapy Within the Context of Drug Policy Reform in Tijuana, Mexico*, DRUG & ALCOHOL DEPENDENCE 221 (2015).

27. Russoniello, *supra* note 2, at 410.

28. *See, e.g.*, CARPENTER, *supra* note 5.

29. GLENN GREENWALD, CATO INSTITUTE, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES 2 (2009) (emphasis added), http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf.

30. EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, DECRIMINALISATION IN EUROPE? RECENT DEVELOPMENTS IN LEGAL APPROACHES TO DRUG USE 3-4 (2001), http://www.emcdda.europa.eu/attachements.cfm/att_5741_EN_Decriminalisation_Legal_Approaches.pdf.

31. Mirjam Van Het Loo et. al, *Decriminalization of Drug Use in Portugal: The Development of a Policy*, ANNALS AM. ACAD. POL. & SOC. SCI. 49, 58 (2002).

32. RESOLUÇÃO DO CONSELHO DE MINISTROS 46/99 ch. IV(29), DIÁRIO DA REPÚBLICA de 22.4.1999 (Port.) *translated in* PORTUGUESE NATIONAL DRUG STRATEGY, NATIONAL DRUG STRATEGY (1999), http://www.emcdda.europa.eu/system/files/att_119431_EN_Portugal%20Drug%20strategy%201999.pdf.

33. EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, ILLICIT DRUG USE IN THE EU: LEGISLATIVE APPROACHES 22 (2005), http://www.emcdda.europa.eu/system/files/publications/367/TP_IllicitEN_64393.pdf.

34. Laws have been enacted to decriminalize marijuana possession to some degree in nine states (Delaware, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Ohio, Rhode Island, and Vermont) and depenalize such possession to some degree in four states (Connecticut, Missouri, New York, and North Carolina). Missouri's law took effect on January 1, 2017. The preceding list does not include eight states (Alaska, California, Colorado, Massachusetts, Maine, Nevada, Oregon, and Washington) that, along with the District of Columbia, have enacted laws to legalize the possession of small amounts of marijuana by removing all criminal and civil penalties for such possession. The states' laws will be discussed in more detail in this chapter.

35. JONATHAN P. CAULKINS ET AL., MARIJUANA LEGALIZATION: WHAT EVERYONE NEEDS TO KNOW 106, 171-172 (2016).

36. *Id.* at 106.

37. Lindsay LaSalle, *Md. Legislation Would Create Drug-Use Facilities, Decriminalize Possession of Small Amounts*, BALT. SUN (Feb. 4, 2016, 11:41 AM), http://www.baltimoresun.com/news/opinion/oped/bs-ed-morhaim-legislation-20160204-story.html.

38. *HB1119 History*, GEN. ASSEMBLY MD. http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=03&id=hb1119&tab=subject3&ys=2016RS (last updated Mar. 14, 2016).

39. Jason Brandeis, *The Continuing Vitality of* Ravin v. State*: Alaskans Still Have a Constitutional Right to Possess Marijuana in the Privacy of Their Homes*, 29 ALASKA L. REV. 175, 179 (2012) (citing Ravin v. State, 537 P.2d 494, 511 (Alaska 1975)), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1343&context=alr.

40. *Id*. at 181-182 (citing Noy v. State, 83 P.3d 538, 541 (Alaska Ct. App. 2003); Act of 1975 § 1, 1975 Alaska Sess. Laws ch. 110, 2).

41. *Id*. at 182 (citing *Noy*, 83 P.3d at 542).

42. *Id*. at 183-202 (citations omitted).

43. Jason Brandeis, Ravin *Revisited: Alaska's Historic Common Law Marijuana Rule at the Dawn of Legalization*, 32 ALASKA L. REV. 309, 310 (2015) (citation omitted), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1499&context=alr.

44. *Id*. (citing Alaska Ballot Measure 2: An Act to Tax and Regulate the Production, Sale and Use of Marijuana (2014); ALASKA STAT. §§ 17.38.010-17.38.900 (2014)), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1499&context=alr.

45. *Id*. at 321.

46. ROSALIE LICCARDO PACULA ET AL., MARIJUANA DECRIMINALIZATION: WHAT DOES IT MEAN IN THE UNITED STATES? 30 (2003) (citing 1975 Cal. Stat. ch. 248; CAL. HEALTH & SAFETY CODE § 11357 (b) and (c) (West 1975)), http://www.nber.org/papers/w9690.pdf.

47. Patrick McGreevy, *Schwarzenegger Signs Bill Reducing Offense for Marijuana Possession*, L.A. TIMES: POLITICAL (Oct. 1, 2010, 10:31 AM), http://latimesblogs.latimes.com/california-politics/2010/10/schwarzenegger-signs-bill-reducing-offense-for-marijuana-possession.html.

48. 2011 Cal. Legis. Serv. ch. 15 (A.B. 109) (West); CAL. HEALTH & SAFETY CODE § 11357 (b) (West 2011).

49. CAL. PENAL CODE § 840 (West 1976).

50. Michael R. Aldrich & Tod Mikuriya, *Savings in California Marijuana Law Enforcement Costs Attributable to the Moscone Act of 1976* J. PSYCHOACTIVE DRUGS 75, 79 (1988).

51. See table 4-1 in Appendix B.

52. Section 712-1249, Hawaii Revised Statutes (HRS), provides, in pertinent part, that possession of any marijuana *in any amount* is a petty misdemeanor. Section 712-1248, HRS, provides, in pertinent part, that possession of one or more preparations, compounds, mixtures, or substances, *of an aggregate weight of one ounce or more*, containing any marijuana, is a misdemeanor. Section 712-1247, HRS, provides, in pertinent part, that possession of one or more preparations, compounds, mixtures, or substances *of an aggregate weight of one pound or more*, containing any marijuana, is a class C felony.

53. *See supra* Chapter 5 notes 231-233 and accompanying text.

54. Thomas Fuller, *Californians Legalize Marijuana in Vote That Could Echo Nationally*, N.Y. TIMES (Nov. 9, 2016), http://www.nytimes.com/2016/11/09/us/politics/marijuana-legalization.html.

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61. *Id*. § 16(4).
62. 2011 Conn. Acts 11-71 (Reg. Sess.); CONN. GEN. STAT. ANN. § 21a-279a (West 2011).
63. CONN. GEN. STAT. ANN. § 51-164r (West 1993).
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72. 22 ME. REV. STAT. §2383 (2009).
73. *Id.*
74. Question 1 (Me. 2016), http://www.state.me.us/sos/cec/elec/upcoming/citizensguide2016.pdf.
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85. PACULA ET AL., *supra* note 46, at 30.
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87. *Id.* §152.027.
88. *Id.* §609.02.
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91. *Id.*
92. *Id.*
93. S.B. 491, 97th Gen. Assemb., Reg. Sess. (Mo. 2014).
94. *Id.*
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Chapter 7

IN CONCLUSION: FINDINGS, A RECOMMENDATION, AND FACTORS FOR POSSIBLE CONSIDERATION

House Concurrent Resolution No. 127, H.D. 1, S.D. 1 (2016) (hereinafter HCR No. 127) requested the Legislative Reference Bureau to conduct a study on the potential impact on administrative and judicial systems of state government of decriminalizing drug offenses in Hawaii that currently are graded as class C felonies or lower and pertain to the illegal possession for personal use of a harmful drug, a detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes (HRS). HCR No. 127 also requested the Bureau to review the national drug policy of Portugal pertaining to the illegal possession of drugs for personal use and to consider that policy as a potential model for the decriminalization in Hawaii of certain or all offenses referenced above. Further, HCR No. 127 requested the Bureau to report its findings and recommendations to the Legislature.

This chapter begins with a discussion of the salient points that emerged from the information we presented in the preceding chapters, and continues with findings based on our analysis of those facts and related information. This chapter also includes one recommendation, and concludes with a summary of some of the factors that policymakers may wish to consider regarding the potential decriminalization of possession of personal-use quantities of illicit drugs.

SALIENT POINTS

The following salient points are essential to an understanding of decriminalization as reviewed in this report.

Decriminalization is Not the Same as Legalization or Depenalization

HCR No. 127 contemplates the potential decriminalization of what this report has chosen to call "relevant drug offenses," or simply "relevant offenses." These are drug offenses in Hawaii that currently are graded as class C felonies or lower and pertain to the illegal possession for personal use of a harmful drug, a detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, HRS.[1] Decriminalization is not the same as legalization or depenalization:

- Decriminalization eliminates criminal penalties for engaging in a prohibited activity, but still prohibits that activity and may impose fines or other civil penalties for violations of the prohibition.[2]

- Decriminalization should not be confused with legalization, which involves the enactment of laws that authorize and may provide for state regulation of an activity, such as the production, sale, or use of drugs.[3]

- Further, decriminalization should not be confused with depenalization, which involves the elimination of custodial penalties for an offense that remains classified as a criminal activity and thus may subject an offender to criminal fines and the establishment of a police record.[4]

The Decriminalization of Personal Use Quantities of Illicit Drugs in Portugal was One Component of a Larger National Strategy Designed to Reduce Drug Use and Address Public Health and Other Concerns Associated with Drug Use

- Portugal's strategy also included important components such as drug use prevention, health care for drug users, harm reduction programs for drug users (e.g., needle exchange), treatment of drug users in lieu of incarceration, treatment for incarcerated drug users, managed reintegration of formerly incarcerated drug users, research on drug use and treatment, and commitment of necessary financial resources.[5]

A Drug Decriminalization Scheme in Hawaii that is Modeled After Portugal's Approach Would Need to Similarly Consider the Expansion of Public Health-Oriented Programs and Their Associated Costs

- Depending on the specific drugs that would be decriminalized in Hawaii, additional drug use prevention, harm-reduction, and treatment opportunities, facilities, and personnel may be necessary to help control or reduce instances of drug use and their associated effects on public health and society. A robust public health-oriented approach may entail significant expenses, and policymakers would accordingly need to consider appropriate sources of funding.

Access to Health Care is Addressed Differently in Portugal and Hawaii

- Health care is a constitutional right in Portugal, and treatment for drug use must be made available to all who seek or agree to accept it.[6]

- In contrast, comprehensive health care in Hawaii is generally mandated only pursuant to an individual's health insurance coverage, state law pertaining to health insurance, and collective bargaining agreements. Although Hawaii law mandates parity in medical and mental health care, including treatment for drug dependency, under health insurance policies,[7] treatment for drug use is not guaranteed for persons covered by

those policies,[8] and the capacity to provide treatment does not currently appear to be sufficient to meet the needs of those who have insurance coverage, whether privately or publicly funded, because of a shortage of drug treatment specialists.[9]

The Decriminalization of the Greatest Drug Threat to Hawaii is Beyond the Scope of This Study

- HCR No. 127 limited the Bureau's evaluation to the impact of decriminalizing certain illicit drugs ─ that is, those classified by state law as harmful or detrimental, marijuana, or marijuana concentrate ─ but excluded methamphetamine and other drugs classified as dangerous.

- Marijuana use is prevalent in both Portugal and Hawaii, but marijuana is not viewed by health and law enforcement authorities as posing the greatest threat to Hawaii.[10] The main impetus for Portugal's national decriminalization strategy regarding illicit drugs was a serious increase in the use of heroin.[11] However, heroin also does not currently appear to be as great a threat to Hawaii.[12] Moreover, heroin is classified as a dangerous drug under Hawaii law,[13] and is thus outside the scope of HCR No. 127. Based on our research, it appears that methamphetamine is seen as currently posing the greatest drug threat to Hawaii.[14] Similarly, methamphetamine is also classified as a dangerous drug and thus is also outside the scope of HCR No. 127.

Hawaii Law is Superseded by Federal Law in the Event of a Conflict Between the Two

- Portugal's decriminalization of the possession of personal-use quantities of *all* illicit drugs applies uniformly across that nation.[15]

- In contrast, Hawaii is but one of fifty states, all of which are subject to federal laws that supersede states' laws in the event of a conflict with state law.[16] If Hawaii were to decriminalize the possession of even a limited number of illicit drugs for personal use, the federal government could still enforce superseding federal law prohibiting that possession.[17]

- Even the relatively modest level of decriminalization contemplated by HCR No. 127 would be unprecedented in the United States. Although twenty-one states and the District of Columbia have removed incarceration as a penalty for the possession of small amounts of marijuana,[18] no state has done so regarding other illicit drugs.[19]

- The possession of any amount of marijuana remains illegal under federal law except under very limited circumstances.[20] While the criminal prohibitions against possession of marijuana are not currently a federal enforcement priority with regard to small amounts of marijuana for personal use, the U.S. Department of Justice has warned that

its priorities will be affected by the ability and willingness of state and local governments to establish and maintain strong and effective enforcement systems to prevent, among other activities, distribution of marijuana to minors, use of marijuana sales revenues to support criminal activities, acts of violence and the use of firearms in criminal activities, drugged driving, and other adverse consequences, including those pertaining to public health.[21] Moreover, there is no indication that the federal government would defer enforcement of federal laws pertaining to the possession of dangerous drugs like methamphetamine, or even "softer" harmful or detrimental drugs (other than marijuana), as contemplated by HCR No. 127.

- The Justice Department's enforcement policies and priorities are subject to change under future presidential administrations. Thus, it remains possible that the Department will more aggressively enforce federal law in the future with regard to marijuana.[22]

The Experiences of Other States Provide Limited Guidance Regarding Drug Decriminalization

- Decriminalization of marijuana in other states does not appear to have led to long-term significant increases in marijuana use in those states.[23] However, reliable data is very limited regarding any long-term public health impact attributable to marijuana decriminalization, any monetary savings resulting from an end to enforcement of criminal laws against marijuana use and possession for personal use, or whether and to what extent any monetary savings could be redirected to support a transition to a public health-oriented approach to marijuana use.[24]

Alternatives to Incarceration as Punishment for Drug Use Already Exist in Hawaii

- While decriminalization is one alternative to incarceration, other alternatives are currently available under certain circumstances.

- Certain criminal offenders may avoid incarceration by agreeing to participate in a drug treatment program as a condition of probation, or by participating in the Drug Court program.

FINDINGS BASED ON OUR ANALYSIS

Based on our review of known facts, data, and competing interpretations of those facts from diverse sources, as well as the absence of certain data, the Bureau finds as follows:

Decriminalization Should Not be Viewed as a Panacea

- Decriminalization of possession of small amounts of certain illicit drugs for personal use may produce some positive results, such as reducing the stigma that may deter some drug users from seeking treatment that could help end or decrease their drug use, or at least prevent increased drug use.

- However, decriminalization *alone* – that is, in the absence of a comprehensive public health strategy to address drug use – may not necessarily decrease overall drug use or its impact on administrative and judicial systems of state government.[25]

The Effectiveness of Portugal's Strategy to Address Drug Use is Not Empirically Clear

- Portugal's baseline drug use survey was conducted in 2001, *after decriminalization*, so comparisons to drug use surveys taken in later years may not reveal a causal connection between decriminalization and subsequent changes in drug use trends.[26]

- Any assumptions that changes to patterns of drug use in Portugal may be attributed solely or primarily to the country's decriminalization scheme are problematic because other important factors, such as Portugal's emphasis on drug education, prevention, and treatment, as well as changes to the drug market and the economic status of users, cannot be clearly quantified as contributing factors or clearly ruled out.[27]

Available Data is Presently Insufficient to Draw Clear Conclusions Regarding the Exact Nature and Extent of Drug Use in Hawaii

- Accurate data regarding drug use in Hawaii is necessary in order to draw comparisons between drug use in the State and Portugal, which in turn would help accurately estimate the potential impacts of drug decriminalization.[28]

- Excluding marijuana and cocaine, there is a lack of current and comprehensive data regarding drug use in Hawaii.[29]

- The lack of information can be attributed to the scarcity and infrequency of studies or surveys regarding drug use in Hawaii and the limited number of specific drugs surveyed annually.[30]

- The federal Substance Abuse and Mental Health Services Administration's (SAMHSA) annual state-based reports estimate the prevalence of any illicit drug, marijuana, cocaine, and nonmedical use of pain relievers, but not heroin, methamphetamine, hallucinogens, or nonmedical use of depressants or stimulants.

Additionally, nonmedical use of pain relievers is not surveyed in a manner to show which type of pain relievers are being nonmedically used.[31]

- There is very little drug-specific information regarding the general or individual use of harmful drugs or detrimental drugs (other than marijuana), which mostly consist of non-opioid-based prescription drugs.[32]

- While the extent of Hawaii's drug problem can be viewed through multiple frames, including arrest records, drug-related charges and convictions, and admissions for drug abuse treatment, these frames do not present the entirety of drug use trends, as arrests, charges, convictions, and admissions for treatment only account for a specific subset of the drug user population. All of this information combined is useful for a very broad understanding of drug use in Hawaii, but is insufficient with respect to a clear understanding of the prevalence of specific drug use.[33]

- Determining trends in drug use and their causes, for the purpose of focusing a public health approach to addressing drug use, is challenging. Beyond changes in laws, changes in drug use can be attributed to factors such as changes to the economy (more or less disposable income), cultural norms, and the availability of health care and drug use prevention, treatment, and harm reduction services.[34]

Available Data on the Enforcement of Current Drug Laws in Hawaii is Insufficient to Predict What Effects Decriminalization of Certain Drugs Could have Regarding the Cost of Law Enforcement

- The costs to enforce drug laws, from arrest to prosecution, adjudication, and corrections, are not clearly segregated by offense or substance, so it is difficult to assess the cost of enforcement with respect to use or possession for use of a particular drug.[35]

- Data regarding enforcement of specific drug offenses was difficult to obtain from state and county agencies. Several agencies were not able to provide statistics regarding the frequency with which specific drug offenses are enforced and prosecuted.[36] Data obtained from police departments regarding arrests was inconsistent with data maintained by the Hawaii Criminal Justice Data Center.[37]

- Most expenditures for drug enforcement in Hawaii are made at the county level, while most expenditures for drug use prevention, education, harm reduction, and treatment are made at the state level.[38] Thus, even if decriminalization of certain drugs resulted in a decrease to county police and prosecution enforcement expenses, it is not clear whether the State would realize monetary savings as a result.

- It is difficult to estimate how much it costs the State to incarcerate violators of relevant drug possession offenses. Although the Department of Public Safety estimates that it costs the State $140 per day to incarcerate an individual, it is not clear how the department reached its estimate.[39]

- The available data is not sufficient to allow us to estimate, with any certainty, either the nature and extent of Hawaii's drug problem or the true cost of providing treatment for different substance use disorders. Further, it is uncertain which drug or drugs the possession of which for personal use might be the focus of decriminalization efforts. Thus we are unable to estimate whether any savings realized by decriminalization would be sufficient to fund expanded public health-oriented drug control efforts such as prevention, treatment, and harm reduction programs, at the level provided in Portugal.[40]

Available Data Suggest that Few Individuals in Hawaii are Incarcerated Solely for Drug Possession Offenses that Fall Under the Scope of House Concurrent Resolution No. 127 (2016)

- 2014 data concerning the most serious offenses for which individuals were arrested reveal a total of 2,225 arrests for the possession of illicit drugs (including 247 for opium or cocaine, 792 for marijuana, 31 for synthetic narcotics, and 1,115 for non-narcotic drugs).[41]

- However, it does not appear that many drug offenders in Hawaii are either incarcerated or incarcerated for extended periods of time *solely* for the possession of small amounts of drugs that are classified as harmful or detrimental, or marijuana or marijuana concentrate, which are the relevant drugs specified in HCR No. 127. For example, according to data from the Hawaii Criminal Justice Data Center, only sixty-nine offenders were incarcerated in 2015 when their *sole offense* was the possession of a small amount of a relevant drug within the scope of HCR No. 127.[42]

- Thus, it appears unlikely that a decriminalization scheme would immediately produce a significant decrease in the cost of incarcerating persons convicted only of offenses involving possession of personal-use quantities of the illicit drugs addressed by HCR No. 127.

- However, given the limitations and inconsistencies regarding the data for arrests and prosecutions for relevant offenses, we note that we cannot reach these conclusions definitively.[43]

OUR RECOMMENDATION

The Collection and Analysis of Pertinent Data Should be Improved

As noted previously, we faced several limitations in our attempt to gather data and information for this report, including the lack of comprehensive information on specific drug use trends, as well as inconsistent or incomplete data regarding arrests and prosecutions.[44] Investing in timely and consistent collection and analysis of quality data regarding drug use, prevention,

treatment, enforcement, and incarceration would be necessary to achieve a clearer picture for policymakers and the public of the extent of Hawaii's drug problem, and the effectiveness of efforts undertaken to address it. Improved data collection and analysis would help gauge the effectiveness of any policy changes that are ultimately undertaken to address the drug problem. To improve the availability of relevant data, legislation may be necessary to fund structural improvements in the information systems of the:

- Hawaii Criminal Justice Data Center and the county police departments so that their data regarding arrests are consistent;
- County police departments in calculating the costs associated with enforcing specific drug prohibitions;
- County prosecutors in tracking how specific offenses are prosecuted, and associated costs;
- Office of the Public Defender in tracking the defense of specific offenses, and associated costs;
- Judiciary in tracking how specific offenses are processed through the court system and in tracking treatment statistics, and the respective associated costs;
- Department of Public Safety in tracking the costs of incarcerating offenders.
- Alcohol and Drug Abuse Division of the Department of Health and the Department of Human Services in tracking specific drug use trends and treatment expenditures; and
- Counties in tracking expenditures on their treatment efforts.[45]

FACTORS FOR POSSIBLE CONSIDERATION

Given the previously noted limitations with respect to the data and information we were able to gather for this report, the Legislative Reference Bureau takes no position on the issue of drug decriminalization as contemplated by HCR No. 127 or how any decriminalization scheme should be implemented. However, policymakers considering the issue may wish to address the following:

Whether There is a Need to Implement a Broader Health-Based Strategy to Reduce Drug Use

- As noted, Portugal decriminalized the possession of certain illicit drugs for personal use as part of a much broader comprehensive strategy that included enhanced efforts to provide drug use education, prevention, harm-reduction, treatment, and rehabilitation services.

- As also noted, it is not clear whether decriminalizing the use and possession for use of specified drugs would necessarily yield savings to the State, and whether any savings would be sufficient to significantly fund a more comprehensive public health-oriented illicit drug policy strategy. Consequently, legislators may need to consider how to fund the various aspects of a comprehensive public health-oriented strategy and, in particular, how to provide for additional treatment opportunities, facilities, and relevant personnel.

Which of the Illicit Drugs, and What Quantities of Those Drugs, Should be Decriminalized

- As previously noted, no other states have decriminalized illicit drugs other than marijuana. Most states that have decriminalized marijuana impose civil penalties for the possession of one ounce or less of the drug, although this quantity varies in some states.[46]

Whether Civil Penalties Should be Included

- States that have decriminalized or depenalized the possession of small amounts of marijuana have established monetary penalties for first violations.[47] In those states, the most common penalty for a first violation is a $100 fine. Fines for subsequent violations may be higher.[48] In addition, a violator may still face additional penalties, including incarceration under certain circumstances. For example, in Connecticut, failure to pay a fine for possessing marijuana is a jailable misdemeanor. In Nebraska and New York, subsequent violations after a first violation may result in imprisonment of up to one year or fifteen days, respectively.[49] In Rhode Island, in addition to a $150 fine, violators under the age of eighteen must complete an approved drug-awareness program and community service, as determined by the court.[50]

- Portugal authorizes a range of possible fines against nonaddicted violators. Depending on the type of drug possessed, fines may range from a minimum of about $35 to a maximum equivalent to the national minimum monthly wage. Generally, those who possess drugs like heroin and methamphetamine are subject to higher fines. Fines may not be imposed on addicted persons. Possible penalties that may be imposed on all violators include verbal warnings, suspensions of professional licenses, prohibitions on offenders meeting with certain persons, and restrictions on travel. Portugal also requires the provisional suspension of proceedings against an addicted person if the person has no prior record of previous drug possession violations and agrees to undergo treatment. Portugal also grants a tribunal the discretion to provisionally suspend proceedings against an addicted person with a prior record if the person agrees to undergo treatment.[51]

Whether Administrative or Judicial Tribunals are Better Suited for Enforcement of Decriminalized Drug Violations

- If Hawaii chooses to incorporate the use of administrative tribunals similar to the dissuasion commissions employed in Portugal, policymakers will need to decide whether to establish entirely new administrative systems or adapt to new uses the judicial structures that already exist.

- One advantage of using the dissuasion commission model seems to be that experts in medicine, psychology, and social service who are included on those commissions may better understand addiction and the health needs of the drug user.[52]

- However, the establishment of dissuasion-type commissions, which are unprecedented in Hawaii, and the appointment of qualified experts to those commissions, would likely require both funding and time to establish those commissions and to find and employ sufficient personnel to staff and lead them. Further, enforcement and oversight would require the creation of appropriate structures to track violations and compliance with penalties, and to assign and monitor implementation of any additional sanctions imposed for noncompliance.

- In contrast, criminal courts in Hawaii already include programs aimed at reducing drug use and recidivism that might be more easily and cost effectively adapted to a decriminalized scheme. However, since judges are generally not health or social service experts, policymakers may wish to consider including the assistance of health professionals to address the needs of drug users, which would likely require additional financial resources.

Whether Violators Would Remain Subject to Arrest and Detention

- In Portugal, a drug user is only held in custody if the user's identity is unknown, and only until the user appears before the appropriate dissuasion commission.[53]

- In contrast and for example, even though the state of New York has removed the possibility of imprisonment for first-time offenders apprehended with small amounts of marijuana, that state still authorizes the arrest of any offender who fails to appear in court for proceedings pertaining to an alleged violation.[54]

- On the one hand, discontinuing arrests of alleged violators may remove a source of stigma that may deter users from seeking treatment and may affect employment and other opportunities.

- On the other hand, arrests may help ensure that drug users appear before the appropriate presiding authority, which may ultimately have a more positive impact on a user than the mere payment of a fine without any appearance requirement.

- Finally, since county police departments currently conduct most enforcement actions in Hawaii with regard to drug possession offenses, they could potentially perform similar duties with regard to drugs that are decriminalized but not legalized, issuing administrative citations rather than making arrests, as is done in other jurisdictions that have decriminalized the possession of small amounts of marijuana.

ENDNOTES

1. These offenses are listed under section 712-1246, HRS (Promoting a harmful drug in the third degree); section 712-1246.5, HRS (Promoting a harmful drug in the 4th degree); section 712-1247, HRS (Promoting a detrimental drug in the first degree); section 712-1248 (Promoting a detrimental drug in the second degree); and section 712-1249 (Promoting a detrimental drug in the third degree). See "A Survey of Hawaii Drug Offenses Under the Scope of the Resolution" in Chapter 4 of this report for more information on these offenses.
2. *See supra* Chapter 2.
3 *Id.*
4. *Id.*
5. See "National Drug Strategy" in Chapter 3 of this report.
6. *See supra* Chapter 3 note 10 and accompanying text.
7. *See supra* Chapter 4 notes 31-33 and accompanying text.
8. *Id.*
9. See "Adequacy of Treatment Funding and Capacity" in Chapter 5 of this report.
10. *See supra* Chapter 5 notes 34-36, 97-104, and accompanying text.
11. *See supra* Chapter 3 note 29 and accompanying text.
12 *See supra* Chapter 5 notes 81-85, 103, and accompanying text.
13. *See supra* Chapter 4 note 20 and accompanying text.
14. *See supra* Chapter 5 notes 97-104, and accompanying text.
15. *See supra* Chapter 3 notes 9, 11-12, 37, and accompanying text.
16. See "Conflicting Legal Authority in a Federal System of Government" in Chapter 4 of this report.
17. *Id.*
18. Laws have been enacted to decriminalize marijuana possession to some degree in nine states (Delaware, Illinois, Maryland, Minnesota, Mississippi, Nebraska, Ohio, Rhode Island, and Vermont) and depenalize such possession to some degree in four states (Connecticut, Missouri, New York, and North Carolina). Missouri's law took effect on January 1, 2017. The preceding list does not include eight states (Alaska, California, Colorado, Massachusetts, Maine, Nevada, Oregon, and Washington) that, along with the District of Columbia, have enacted laws to legalize the possession of small amounts of marijuana by removing all criminal and civil penalties for such possession. See Chapter 6 of this report for further discussion of these states' laws.

19. *See supra* Chapter 6 note 34 and accompanying text.
20. The federal government has designated the National Institute on Drug Abuse (NIDA) within the National Institutes of Health as the agency responsible for overseeing the cultivation of marijuana for medicinal research. NIDA contracts with the University of Mississippi to grow marijuana for use in research studies. *See supra* Chapter 5 note 18 and accompanying text.
21. *See supra* Chapter 4 note 16 and accompanying text.
22. See "Conflicting Legal Authority in a Federal System of Government" in Chapter 4 of this report.
23. *See supra* note 35 and accompanying text.
24. *See supra* Chapter 5.
25. *See supra* Chapter 3 notes 83, 114, and accompanying text.
26. *See supra* Chapter 5 note 4 and accompanying text.
27. *See supra* Chapter 3 note 83 and accompanying text.
28. See "Drug Use Trends" in Chapter 5 of this report.
29. *Id.*
30. *Id.*
31. See "Nonmedical Stimulant, Depressant, and Pain Reliever Use" in Chapter 5 of this report.
32. *See supra* Chapter 5 notes 9 and 10 and accompanying text.
33. Not everyone who uses an illicit drug is arrested or treated for the use of that drug.
34. *See supra* Chapter 3 notes 97-98 and accompanying text.
35. *See supra* Chapter 5 notes 202-206 and accompanying text.
36. See "Court Cases: Lack of Information from Prosecutors and the Public Defender" in Chapter 5 of this report.
37. *See supra* Chapter 5 notes 224-229 and accompanying text.
38. *See supra* Chapter 5 notes 202-206 and accompanying text.
39. *See supra* Chapter 5 notes 235-236 and accompanying text.
40. See "Adequacy of Treatment Funding and Capacity" in Chapter 5 of this report.
41. See Table 5-13 in Appendix B.
42. *See supra* Chapter 5 note 231 and accompanying text.
43. *See supra* Chapter 5 notes 224-229 and accompanying text.
44. *See supra* Chapter 5.
45. *Id.* See "Treatment Information from County Agencies" in Chapter 5 of this report.
46. *See supra* Chapter 5 note 243 and accompanying text.
47. *See supra* Chapter 5 note 244 and accompanying text.
48. *Id.*
49. *See supra* Chapter 6 notes 62-63, 97-98, 105-108, and accompanying text.

50. *See supra* Chapter 6 notes 117-118 and accompanying text.
51. See "Dissuasion Commission Process" in Chapter 3 of this Report.
52. *See supra* Chapter 3 notes 46-48 and accompanying text.
53. *See supra* Chapter 3 note 56 and accompanying text.
54. *See supra* Chapter 6 notes 105-108 and accompanying text.

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HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.C.R. NO. 127 H.D. 1 S.D. 1

HOUSE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO CONDUCT A STUDY ON THE POTENTIAL IMPACT ON ADMINISTRATIVE AND JUDICIAL SYSTEMS OF STATE GOVERNMENT OF DECRIMINALIZING THE ILLEGAL POSSESSION OF DRUGS FOR PERSONAL USE IN HAWAII.

WHEREAS, despite a longstanding policy that enforces illicit drug prohibition and imposes some of the world's harshest penalties for drug possession and sales, illicit drug use in the United States has been increasing, according to the results from the 2013 National Survey on Drug Use and Health; and

WHEREAS, the survey, conducted annually by the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, found that an estimated 24,600,000 people aged twelve or older nationally--9.4 per cent of the population--had used an illicit drug in the past month, up from 8.3 per cent in 2002; and

WHEREAS, there is a growing heroin epidemic in the United States, particularly along the East Coast and in many cases beginning when patients are legally prescribed drugs containing opium; and

WHEREAS, acknowledging the need for a change in solutions to illicit drug use, the federal administration's 2014 National Drug Control Strategy presented a marked departure from previous approaches to national drug policy by focusing on both the public health and public safety aspects of drug use and substance use disorders, recognizing addiction as a disease, emphasizing the importance of preventing drug use, and promoting treatment to those who need it, including those who are involved in the criminal justice system; and

WHEREAS, the 2014 National Drug Control Strategy also recognized that many people charged with drug-related crimes are afflicted with an underlying substance abuse disorder that warrants the diversion of non-violent offenders to drug treatment instead of prison; and

WHEREAS, in Hawaii, drug court and related programs alleviate prison overcrowding and offer more effective rehabilitation options for qualified defendants by providing them with an opportunity to be granted community supervision to obtain substance abuse treatment in lieu of incarceration; and

WHEREAS, while the distribution of marijuana remains a federal offense, in 2013 the United States Department of Justice, in the wake of recent state ballot initiatives that legalized the possession of marijuana for personal use, announced an update to its marijuana enforcement policy that deferred the federal government's right to challenge state marijuana legalization laws under the expectation that each affected state would implement an appropriate regulatory system; and

WHEREAS, Hawaii is among twenty-three states that authorize and regulate medical uses of marijuana; and

WHEREAS, nineteen states and the District of Columbia have decriminalized the possession of small amounts of marijuana for personal use; and

WHEREAS, the foregoing examples at the national and state levels demonstrate a burgeoning trend towards addressing illegal drug use by focusing on treatment on a wider scale; and

WHEREAS, in 2001, Portugal became the first European country to officially abolish all criminal penalties for the possession of drugs for personal use, making these violations exclusively an administrative matter processed in noncriminal proceedings, while continuing to prosecute drug trafficking as a criminal offense; and

WHEREAS, the strategy behind Portugal's drug decriminalization framework was to maintain the prohibition against using or possessing an illicit drug for personal use without authorization but to replace penalties of imprisonment

with the offer of therapy, under the belief that the fear of jail time drives drug addicts underground and that incarceration is more expensive than treatment; and

WHEREAS, under Portugal's revamped drug control regime, a person found in illegal possession of small amounts of drugs is ordered to appear before a panel consisting of members with a legal, medical, or social services background who determine whether and to what extent the person is addicted to drugs; and

WHEREAS, depending upon the panel's final determination, the person found in illegal possession of small amounts of drugs may be referred to a voluntary treatment program, ordered to pay a fine, or subjected to administrative sanctions, such as community service, suspension of a professional license, or restrictions on where the person may visit or who the person may associate with; and

WHEREAS, the Cato Institute, which is a public policy research organization that conducts independent, nonpartisan research on a wide range of policy issues, commissioned a 2009 report that found the following results of drug decriminalization in Portugal:

(1) No adverse effect on drug usage rates, which are among the lowest in the European Union, and particularly when compared with states with stringent criminalization regimes;

(2) A decrease in lifetime prevalence rates for drug use among various age groups, particularly for youths in the critical age groups of thirteen to fifteen year olds and sixteen to eighteen year olds;

(3) A dramatic decrease in drug-related deaths, including from sexually transmitted diseases; and

(4) Steady declines in drug trafficking convictions; and

WHEREAS, the Cato Institute report also found that money saved on drug enforcement allowed for increased resources for drug treatment programs; and

WHEREAS, the positive results from Portugal's drug decriminalization system provide a potential model for more effectively managing drug-related problems in the United States; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-eighth Legislature of the State of Hawaii, Regular Session of 2016, the Senate concurring, that the Legislative Reference Bureau is requested to conduct a study on the potential impact on state government of decriminalizing the illegal possession of drugs for personal use in Hawaii; and

BE IT FURTHER RESOLVED that the study include:

(1) A survey of all existing criminal drug offenses in Hawaii that are class C felonies or lower offenses and pertain to the illegal possession of a harmful drug, detrimental drug, marijuana, or marijuana concentrate, as defined in section 712-1240, Hawaii Revised Statutes;

(2) A review of the current national drug policy of Portugal pertaining to the illegal possession of drugs for personal use, with a focus on the use of the policy as a potential model for the decriminalization of certain or all of the offenses identified under paragraph (1); and

(3) The potential impact on administrative and judicial systems of state government of decriminalizing certain or all of the offenses identified under paragraph (1), such that the conduct constituting an offense would constitute an administrative or civil violation rather than a criminal offense; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to submit a written report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2017; and

BE IT FURTHER RESOLVED that the Judiciary and the Department of Public Safety are each requested to provide

statistics and other information as may be requested by the Bureau to assist in the timely completion of the study; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of the Legislative Reference Bureau, Chief Justice, Administrative Director of the Courts, and Director of Public Safety.

Appendix B

CHAPTER 3 TABLE

Table 3-1. Year-End Count of Prison Population in Portugal								
	1993	1994	1995	1996	1997	1998	1999	2000
Total Drug Consumers (Users or Possessors)	36	12	10	14	42	4	23	25
Total Drug Inmates	1,507	1,683	1,934	2,557	3,649	3,882	3,862	3,793
Total Inmates Overall	7,150	6,403	7,400	8,897	10,333	10,348	8,756	8,917
Drug Consumers Among the Total Population (Percentage)	0.50%	0.19%	0.14%	0.16%	0.41%	0.04%	0.26%	0.28%

CHAPTER 4 TABLES

Table 4-1. Hawaii Relevant Drug Offenses Under the Scope of HCR No. 127

Name of Offense in Hawaii Revised Statutes (HRS)	A Person Commits the Offense When the Person Knowingly Possesses…	Level of Offense	Maximum Penalty for First Offense Under HRS
§712-1246: Promoting a harmful drug in the 3rd degree	…25 or more capsules or tablets or dosage units containing one or more of the harmful drugs or one or more of the marijuana concentrates, or any combination thereof.	Class C Felony	Imprisonment: Five years (§706-660); Fine: $10,000 (§706-640)
§712-1246.5: Promoting a harmful drug in the 4th degree	…any harmful drug in any amount. (This offense is usually charged when the amount possessed is less than the amount specified in §712-1246.)	Misdemeanor	Imprisonment: One year (§706-663); Fine: $2,000 (§706-640)
§712-1247:* Promoting a detrimental drug in the 1st degree	…(1) four hundred or more capsules or tablets containing one or more of the Schedule V substances; or (2) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one ounce or more, containing one or more of the Schedule V substances; or (3) one or more preparations, compounds, mixtures, or substances of an aggregate weight of one pound or more, containing any marijuana; or (4) twenty-five or more marijuana plants.	Class C Felony	Imprisonment: Five years (§706-660); Fine: $10,000 (§706-640)
§712-1248* Promoting a detrimental drug in the 2nd degree	...(1) fifty or more capsules or tablets containing one or more of the Schedule V substances; or (2) one or more preparations, compounds, mixtures, or substances, of an aggregate weight of one- eighth ounce or more, containing one or more of the Schedule V substances; or (3) one or more preparations, compounds, mixtures, or substances, of an aggregate weight of one ounce or more, containing any marijuana.	Misdemeanor	Imprisonment: One year (§706-663); Fine: $2,000 (§706-640)
§712-1249: Promoting a detrimental drug in the 3rd degree	...any marijuana or any Schedule V substance in any amount. (This offense is usually charged when the amount possessed is less than the amount specified in §712-1248.)	Petty Misdemeanor	Imprisonment: Thirty days (§706-663); Fine: $1,000 (§706-640)

* §§712-1247 and 712-1248 are not solely "drug possession offenses." Persons may also violate these statutory sections by distributing or selling drugs in certain amounts.

Table 4-2. Judiciary Drug Court Program Expenditures

FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
$4,040,391	$3,860,282	$3,740,085	$4,036,696	$4,012,214	$3,901,538	$4,051,483

CHAPTER 5 TABLES

Table 5-1.
ADAD Funds expended for Illicit Drug Treatment by Modality and Fiscal Year

Modality Type State Code	2011	2012	2013	2014	2015	2016
	Total Charge Amount	Total Charge Amount	Total Charge Amount	Total Charge Amount	Total Charge Amount	Total Charge Amount
Residential Treatment – Long-Term	$3,349,332	$3,671,052	$3,947,020	$4,064,746	$4,094,580	$3,348,870
Therapeutic Living – Long-Term	$634,286	$568,550	$642,088	$452,599	$465,298	$460,733
Intensive Outpatient Treatment	$1,115,151	$1,506,331	$1,464,526	$1,314,430	$1,555,327	$1,533,769
Outpatient Treatment	$4,912,758	$5,212,569	$5,047,986	$5,021,769	$4,909,959	$4,553,681
Methadone Maintenance	$498,246.50	$459,719	$463,368	$529,152	$566,714	$570,250
Residential Social Detoxification	$246,792	$232,596	$227,864	$224,224	$277,186	$294,112
Residential PPW Child Treatment – Long-Term	$865,503	$1,055,237	$878,883	$771,145	$1,042,508	$1,182,905
Therapeutic Living PPW Child – Long-Term	$507,794	$504,997	$402,965	$526,054	$643,001	$573,945
Total	$12,129,862.50	$13,211,051	$13,074,700	$12,904,119	$13,554,573	$12,518,265

ADAD reports that there were five hundred ninety-six beds licensed and accredited in Special Treatment Facilities (both Residential Treatment Programs and residential Therapeutic Living Programs) whose primary focus is substance use disorder treatment in fiscal years 2014-2015 and 2015-2016. The vacancy rates of these beds is not tracked.

Specifically, the average cost expended by ADAD for treatment per person were $4,670 (fiscal year 2011-2012), $3,902 (fiscal year 2012-2013), $3,873 (fiscal year 2013-2014), $4,316 (fiscal year 2014-2015), and $4,465 (fiscal year 2015-2016). Figures provided by ADAD.

Table 5-2. Number of ADAD Certified Counselors per Fiscal Year	
Fiscal Year	Number of ADAD Certified Counselors
2011-12	947
2012-13	1,015
2013-14	1,066
2014-15	1,185
2015-16	1,229

Table 5-3. Treatment Expenditures on DHS Medicaid Drug-Dependent Clients (Alcohol-Dependent Excluded)			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2007	2,658	$473,268.00	$178.05
2008	4,055	$934,791.00	$230.53
2009	4,256	$1,244,656.00	$292.45
2010	4,201	$1,379,152.00	$328.29
2011	4,267	$1,243,234.00	$291.36
2012	4,840	$1,155,686.00	$238.78
2013	5,757	$895,145.00	$155.49
2014	6,213	$72,200.00	$11.62
2015	8,002	$707,720.00	$88.44

Table 5-4. Treatment Expenditures on DHS Medicaid Non-Drug-Dependent Clients (Alcohol-Dependent Included)			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2007	1,539	$415,409.00	$269.92
2008	2,946	$827,319.00	$280.83
2009	3,051	$946,331.00	$310.17
2010	3,386	$904,596.00	$267.16
2011	3,748	$1,112,440.00	$296.81
2012	4,557	$1,092,872.00	$239.82
2013	6,860	$1,128,221.00	$164.46
2014	7,859	$1,266,992.00	$161.22
2015	7,671	$1,141,723.00	$148.84

Table 5-5. Treatment Expenditures on DHS Medicaid Opioid-Dependent Clients			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2007	713	$45,003.00	$63.12
2008	981	$108,717.00	$110.82
2009	1,033	$160,545.00	$155.42
2010	1,197	$173,035.00	$144.56
2011	1,434	$231,519.00	$161.45
2012	1,761	$225,222.00	$127.89
2013	2,048	$187,086.00	$91.35
2014	2,405	$159,623.00	$66.37
2015	2,986	$127,548.00	$42.72

Table 5-6. Treatment Expenditures on DHS Medicaid Amphetamine-Dependent Clients			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2007	943	$183,908.00	$195.02
2008	1,327	$309,011.00	$232.86
2009	1,395	$423,258.00	$303.41
2010	1,350	$496,387.00	$367.69
2011	1,356	$437,689.00	$322.78
2012	1,448	$395,437.00	$273.09
2013	1,658	$264,246.00	$159.38
2014	1,603	$255,096.00	$159.14
2015	2,006	$223,247.00	$111.29

Table 5-7. Treatment Expenditures on DHS Medicaid Amphetamine Non-Dependent Clients			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2007	222	$59,988.00	$270.22
2008	341	$98,497.00	$288.85
2009	405	$86,813.00	$214.35
2010	501	$165,940.00	$331.22
2011	525	$196,087.00	$373.50
2012	674	$230,301.00	$341.69
2013	979	$229,256.00	$234.17
2014	1,172	$247,360.00	$211.06
2015	1,125	$304,754.00	$270.89

Table 5-8. Treatment Expenditures on DHS Medicaid Marijuana Non-Dependent Clients			
Fiscal Year	**Number of Clients Treated**	**Expenditures**	**Expenditures Per person (Statistical Mean Calculated by LRB)**
2007	108	$53,355.00	$494.03
2008	231	$65,806.00	$284.87
2009	253	$79,959.00	$316.04
2010	335	$111,363.00	$332.43
2011	374	$113,624.00	$303.81
2012	375	$101,817.00	$271.51
2013	413	$67,156.00	$162.61
2014	439	$87,566.00	$199.47
2015	452	$63,925.00	$141.43

Table 5-9. Mental Restoration Expenditures on DHS Vocational Rehabilitation Clients			
Fiscal Year	**Number of Clients Who Received Mental Restoration Services**	**Expenditures**	**Expenditures Per person (Statistical Mean Calculated by LRB)**
2015	40	$66,481.83	$1,662.05
2016	38	$72,821.55	$1,916.36

Table 5-10. Treatment Expenditures on DHS Social Services Division Clients					
Fiscal Year	**Number of Clients Treated**	**State Funds**	**Federal Funds**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2011	N/A	$27,865	$109,333	$137,198.33	Unknown
2012	5	(Blank)	$149,559	$149,559	$29,911.80
2013	6	$70,668	$27,959	$98,627.00	$16,437.83
2014	22	$32,623	$64,962	$97,585.27	$4,435.69
2015	N/A	$96,830	$69,089	$165,919.00	Unknown
2016	7	$81,372	$58,059	$139,431.00	$19,918.71

Table 5-11. Treatment Expenditures on Department of Housing and Human Concerns, County of Maui Clients			
Fiscal Year	**Number of Individuals Treated**	**Expenditures**	**Expenditures Per Person (Statistical Mean Calculated by LRB)**
2011	536	Not Provided	Unknown
2012	639	$825,171.00	$1,291.35
2013	619	Not Provided	Unknown
2014	766	Not Provided	Unknown
2015	583	Not Provided	Unknown
2016	561	$765,707.00	$1,364.90

Table 5-12.
Amounts Expended by ADAD Prevention Branch for Prevention Strategies Per Fiscal Year

Fiscal Year	Alternative Activities	Community - Based Process	Education	Environmental	Information Dissemination	Problem ID & Referral	Total Amount
2011-2012	$900,764	$874,101	$4,684,419	$642,263	$556,379	$38,571	$7,696,497
2012-2013	$1,444,010	$756,304	$864,888	$430,747	$972,447	$13,600	$4,481,996
2013-2014	$1,468,681	$592,807	$855,512	$472,890	$949,386	$13,600	$4,352,876
2014-2015	$1,497,779	$625,312	$862,878	$215,221	$887,469	$13,600	$4,102,259
2015-2016	$1,812,000	$1,207,010	$1,089,980	$999,263	$856,650	$13,600	$6,068,413

Amounts are from ADAD. E-mail correspondence with ADAD staff on December 9, 2016 (on file with the Bureau).

Table 5-13.
Arrest Statistics (Adults) from the Department of the Attorney General, Based on Most Serious Offense

	Drug Possession				Drug Manufacturing or Sale					
	Opium or Cocaine	Marijuana	Synthetic Narcotic	Non-Narcotic	Opium or Cocaine	Marijuana	Synthetic Narcotic	Non-Narcotic	All Non-Traffic Criminal Offenses*	Drug Possession Arrests as a Percentage of All Non-Traffic Criminal Offense Arrests
2000	535	597	181	477	320	116	22	177	51,789	3.46%
2001	444	512	88	697	294	97	12	175	48,184	3.61%
2002	484	513	163	721	194	96	30	183	50,630	3.72%
2003	339	635	138	996	107	159	50	297	46,977	4.49%
2004	259	556	40	1,221	79	110	23	406	47,455	4.37%
2005	214	561	28	1,411	67	133	47	274	45,547	4.86%
2006	298	687	42	1,126	87	191	43	211	47,273	4.55%
2007	292	752	107	1,068	69	214	41	180	50,271	4.41%
2008	210	698	242	517	44	198	52	148	48,227	3.46%
2009	176	873	252	494	31	165	61	121	47,541	3.78%
2010	164	924	141	623	31	166	31	150	46,968	3.94%
2011	241	801	33	761	13	139	17	191	47,084	3.90%
2012	272	849	46	906	18	129	16	151	48,382	4.28%
2013	305	794	32	956	36	137	9	189	48,130	4.34%
2014	247	792	31	1,155	25	97	3	224	42,887	5.19%

This table is adapted from statistical tables in DEPARTMENT OF THE ATTORNEY GENERAL, STATE OF HAWAII, CRIME IN HAWAII 2014: A REVIEW OF UNIFORM CRIME REPORTS i (2016), https://ag.hawaii.gov/cpja/files/2016/07/Crime-in-Hawaii-2014.pdf [hereinafter AG 2014 REPORTS]; DEPARTMENT OF THE ATTORNEY GENERAL, STATE OF HAWAII, CRIME IN HAWAII 2005: A REVIEW OF UNIFORM CRIME REPORTS 109 (2009), http://ag.hawaii.gov/cpja/files/2013/01/Crime_in_Hawaii_2005.pdf [hereinafter AG 2005 REPORTS].

* This column lists (1) the number arrests for all non-traffic criminal offenses and (2) all arrests for negligent manslaughter, whether or not the alleged act of negligent manslaughter was traffic-related. AG 2014 REPORTS, *supra* note 169, at 2; AG 2005 REPORTS, *supra* note 169, at 2.

Table 5-14. Arrest Statistics from County Police for All Simple Drug Possession Offenses							
		2011	**2012**	**2013**	**2014**	**2015**	**2016#**
HRS §712-1241* Promoting a dangerous drug in the 1st degree	Honolulu	11	7	18	3	4	6
	Hawaii County	40	10	10	11	23	17
	Kauai	11	3	1	2	0	2
	Maui**, +	8	8	15	11	11	6
	ALL**	**70**	**28**	**44**	**27**	**38**	**31**
HRS §712-1242* Promoting a dangerous drug in the 2nd degree	Honolulu	52	85	72	73	39	23
	Hawaii County	80	84	75	93	74	56
	Kauai	37	42	20	15	17	20
	Maui**, +	9	22	19	32	19	19
	ALL**	**178**	**233**	**186**	**213**	**149**	**118**
HRS §712-1243 Promoting a dangerous drug in the 3rd degree	Honolulu	620	629	626	748	656	433
	Hawaii County	578	651	773	652	732	434
	Kauai	291	306	222	176	187	163
	Maui**, +	332	380	371	525	605	523
	ALL**	**1,821**	**1,966**	**1,992**	**2,101**	**2,180**	**1,553**
HRS §712-1244* Promoting a harmful drug in the 1st degree	Honolulu	12	8	0	4	9	4
	Hawaii County	8	14	13	7	15	6
	Kauai	5	6	0	0	1	3
	Maui**, +	0	0	2	0	2	1
	ALL**	**25**	**28**	**15**	**11**	**27**	**14**
HRS §712-1245* Promoting a harmful drug in the 2nd degree	Honolulu	7	2	3	6	11	3
	Hawaii County	17	19	8	19	12	3
	Kauai	6	2	3	2	1	1
	Maui**, +	2	1	0	2	1	3
	ALL**	**32**	**24**	**14**	**29**	**25**	**10**
HRS §712-1246 Promoting a harmful drug in the 3rd degree (A "Relevant Offense")	Honolulu	16	4	9	6	7	8
	Hawaii County	10	13	12	11	27	7
	Kauai	6	7	3	4	2	3
	Maui**, +	1	7	3	4	8	6
	ALL**	**33**	**31**	**27**	**25**	**44**	**24**

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Arrest statistics for these offenses may include individuals arrested for distribution or sale of dangerous, harmful, or detrimental drugs.

** Maui Police Department provided its statistics in fiscal years instead of calendar years. This means that the statewide total arrests by police for relevant drug-related offenses are estimated.

+ Statistics from Maui Police Department include juveniles, while statistics from other departments exclude them.

Data for 2016 includes arrests up to August 16, 2016, for Honolulu; up to June 30, 2016, for Hawaii County and Maui; and up to August 22, 2016, for Kauai.

Table 5-14.
Arrest Statistics from County Police for All Simple Drug Possession Offenses *(continued)*

		2011	2012	2013	2014	2015	2016#
HRS §712-1246.5 Promoting a harmful drug in the 4th degree (A "Relevant Offense")	Honolulu	48	60	24	51	25	13
	Hawaii County	56	60	68	58	66	23
	Kauai	22	34	20	17	8	8
	Maui**, +	15	10	14	19	11	10
	ALL**	**141**	**164**	**126**	**145**	**110**	**54**
HRS §712-1247* Promoting a detrimental drug in the 1st degree (A "Relevant Offense")	Honolulu	27	20	10	10	16	3
	Hawaii County	44	39	50	18	29	16
	Kauai	7	3	5	1	4	1
	Maui**, +	16	14	15	14	4	12
	ALL**	**94**	**76**	**80**	**43**	**53**	**32**
HRS §712-1248* Promoting a detrimental drug in the 2nd degree (A "Relevant Offense")	Honolulu	53	45	19	19	20	9
	Hawaii County	52	67	56	34	44	17
	Kauai	13	2	4	5	6	9
	Maui**, +	34	35	20	39	45	29
	ALL**	**152**	**149**	**99**	**97**	**115**	**64**
HRS §712-1249 Promoting a detrimental drug in the 3rd degree (A "Relevant Offense")	Honolulu	398	460	383	376	316	168
	Hawaii County	424	339	399	340	313	178
	Kauai	168	126	132	91	71	59
	Maui**, +	224	250	470	537	450	384
	ALL**	**1,214**	**1,175**	**1,384**	**1,344**	**1,150**	**789**
All Simple Drug Possession Offenses	**TOTAL****	**3,760**	**3,874**	**3,967**	**4,035**	**3,891**	**2,689**
All "Relevant Offenses"	**TOTAL****	**1,634**	**1,595**	**1,716**	**1,654**	**1,472**	**963**

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Arrest statistics for these offenses may include individuals arrested for distribution or sale of dangerous, harmful, or detrimental drugs.

** Maui Police Department provided its statistics in fiscal years instead of calendar years. This means that the statewide total arrests by police for relevant drug-related offenses are estimated.

+ Statistics from Maui Police Department include juveniles, while statistics from other departments exclude them.

Data for 2016 includes arrests up to August 16, 2016, for Honolulu; up to June 30, 2016, for Hawaii County and Maui; and up to August 22, 2016, for Kauai.

Table 5-15.
Arrest Statistics from Hawaii County and Maui County Police Departments for Relevant Offenses

		2011	2012	2013	2014	2015	2016#
HRS §712-1246 Promoting a harmful drug in the 3rd degree	Hawaii County	10	13	12	11	27	7
	Sole Offense	0	0	1	0	0	0
	Maui**	1	7	3	4	8	6
	Sole Offense	0	3	1	1	3	3
	Both**	**11**	**20**	**15**	**15**	**35**	**13**
	Sole Offense	**0**	**3**	**2**	**1**	**3**	**3**
HRS §712-1246.5 Promoting a harmful drug in the 4th degree	Hawaii County	56	60	68	58	66	23
	Sole Offense	0	3	2	8	3	1
	Maui**	15	10	14	19	11	10
	Sole Offense	11	7	7	10	11	7
	Both**	**71**	**70**	**82**	**77**	**77**	**33**
	Sole Offense	**11**	**10**	**9**	**18**	**14**	**8**
HRS §712-1247* Promoting a detrimental drug in the 1st degree	Hawaii County	44	39	50	18	29	16
	Sole Offense	1	1	5	2	1	1
	Maui**	16	14	15	14	4	12
	Sole Offense	0	3	8	8	7	2
	Both**	**60**	**53**	**65**	**32**	**33**	**28**
	Sole Offense	**1**	**4**	**13**	**10**	**8**	**3**
HRS §712-1248* Promoting a detrimental drug in the 2nd degree	Hawaii County	52	67	56	34	44	17
	Sole Offense	10	5	11	8	6	3
	Maui**	34	35	20	39	45	29
	Sole Offense	19	16	9	17	15	9
	Both**	**86**	**102**	**76**	**73**	**89**	**46**
	Sole Offense	**29**	**21**	**20**	**25**	**21**	**12**
HRS §712-1249 Promoting a detrimental drug in the 3rd degree	Hawaii County	424	339	399	340	313	178
	Sole Offense	117	90	79	75	70	42
	Maui**	224	250	470	537	450	384
	Sole Offense	149	152	310	321	224	214
	Both**	**648**	**589**	**869**	**877**	**763**	**562**
	Sole Offense	**266**	**242**	**389**	**396**	**294**	**256**
All Relevant Offenses	**TOTAL****	876	834	1,107	1,074	997	682
	Sole Offense	307	280	433	450	340	282

* HRS §§712-1247 and 712-1248 are not solely "drug possession offenses." Arrest statistics for these offenses may include individuals arrested for distribution or sale of detrimental drugs.

** Maui Police Department provided its statistics in fiscal years instead of calendar years. This means that the statewide total arrests by police for relevant drug-related offenses are estimated.

+ Statistics from Hawaii Police Department exclude juveniles. Statistics from Maui Police Department include juveniles.

Data for 2016 includes arrests up to June 30, 2016, for Hawaii County and Maui.

Table 5-16. Hawaii (County) Police Department - Estimated Vice Section Expenditures					
FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
$2,507,529	$2,620,560	$2,566,282	$2,692,230	$3,002,295	$3,122,832

Table 5-17. Kauai Police Department - Drug Enforcement Expenditures						
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
County Fund (for Salaries/ Benefits)	$1,156,891	$1,020,056	$1,039,590	$1,385,071	$1,441,118	$1,521,000
Federal Funds (for Overtime)	$14,351	$41,610	$35,173	$34,385	$113,026	Not Specified
Federal Funds (for Other Expenses)	$150,003	$231,811	$212,143	$353,005	$127,876	Not Specified
TOTAL	$1,321,245	$1,293,477	$1,286,906	$1,772,461	$1,682,020	

Table 5-18. Maui Police Department - Drug Enforcement Expenditures						
	FY 2012	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
County Fund	$2,370,115	$2,627,196	$2,759,989	$2,829,779	$2,412,485	$2,559,913
Grants (from all Sources)	$220,296	$204,054	$156,503	$316,897	$453,649	Not Specified
TOTAL	$2,590,411	$2,831,250	$29,164,921	$3,146,676	$2,866,134	

Table 5-19. Offenses Processed Through the District Courts During Fiscal Year 2014-2015					
Court	**Status**	**Narcotic Criminal Offenses**	**All Criminal Offenses (Except Traffic)**	**Criminal Traffic Offenses**	**Non-Criminal Traffic & Parking Matters**
District	Pending Cases at Start of Fiscal Year	1,974	66,665	63,860	213,589
	Cases Filed	959	29,291	38,309	328,367
	Total Caseload	2,933	95,956	N/A	N/A
	Case Discharged or Dismissed	509	6,812	N/A	N/A
	Prosecution Declined	70	819	N/A	N/A
	Other Terminations	2	1,004	N/A	N/A
	Sent to Circuit Court for Jury Trial	10	330	N/A	0
	Conviction/Entry of Judgment	299	14,719	32,736	339,557
	Pending Cases at the End of Fiscal Year	2,043	72,271	22,301	225,511

This table is adapted from statistical tables in THE JUDICIARY, STATE OF HAWAII, 2015 ANNUAL REPORT STATISTICAL SUPPLEMENT tbls.22, 27 (2015), http://www.courts.state.hi.us/docs/news_and_reports_docs/annual_reports/Jud_Statistical_Sup_2015.pdf.

Table 5-20. Offenses Processed Through the Circuit Courts During Fiscal Year 2014-2015 (footnote 183)				
Court	**Status**	**Narcotic Criminal Offenses**	**All Criminal Offenses (Except Traffic)**	**Criminal Traffic Offenses**
Circuit	Pending Cases at Start of Fiscal Year	2,421	11,866	213
	Cases Filed	939	4,298	127
	Total Caseload	3,360	16,164	340
	Termination Due to Lack of Service of Process	28	149	2
	Dismissed	203	865	14
	Terminated by Trial	14	76	0
	No Trial Held Yet	657	2,771	0
	Other Terminations	75	458	22
	Defendant Acquitted	6	49	0
	Convictions	707	3,151	50
	Defendant Fined	2	36	3
	Defendant Incarcerated	535	2,342	28
	Defendant Sentenced to Probation	120	433	1
	Defendant Sentenced to Community Service	0	4	0
	Other Disposition	49	264	4
	Remanded to Court after Appeal	1	72	14
	Pending Cases at the End of Fiscal Year	2,444	12,099	276

This table is adapted from statistical tables in THE JUDICIARY, STATE OF HAWAII, 2015 ANNUAL REPORT STATISTICAL SUPPLEMENT tbls.22, 27 (2015), http://www.courts.state.hi.us/docs/news_and_reports_docs/annual_reports/Jud_Statistical_Sup_2015.pdf. This table is adapted from statistical tables from the Judiciary. *Id.* tbls.7, 12.

Table 5-21.
Filings of Select Criminal Counts, Hawaii State Circuit and Family Courts, Fiscal Years 1999-2000 to 2015-2016 in the Aggregate

	Counts	No. of Cases	No. of Parties
All Counts Filed	299,098	132,016	136,310
All Drug-Related Counts Filed	49,968	17,752	19,256
Charged with Only Drug-Related Counts			11,279
HRS §712-1241* Promoting a dangerous drug 1	718	Not Specified	564
HRS §712-1242* Promoting a dangerous drug 2	2,848	Not Specified	2,335
HRS §712-1243 Promoting a dangerous drug 3	18,190	Not Specified	15,043
HRS §712-1244* Promoting a harmful drug 1	65	Not Specified	45
HRS §712-1245* Promoting a harmful drug 2	189	Not Specified	174
HRS §712-1246 Promoting a harmful drug 3 ("Relevant Offense")	134	Not Specified	128
HRS §712-1246.5 Promoting a harmful drug 4 ("Relevant Offense")	1,072	Not Specified	829
HRS §712-1247* Promoting a detrimental drug 1 ("Relevant Offense")	435	Not Specified	372
HRS §712-1248* Promoting a detrimental drug 2 ("Relevant Offense")	638	Not Specified	606
HRS §712-1249 Promoting a detrimental drug 3 ("Relevant Offense")	4,016	Not Specified	3,776
All Simple Possession Drug Offenses	28,305	Unknown	23,872
All Relevant Offenses	6,295	Unknown	5,711

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-22.
Filings Against Parties for Simple Drug Possession Offenses,
Hawaii State Circuit and Family Courts, Separated by Year

						← "Relevant Offenses" →				
	HRS §712-1241*	**HRS §712-1242***	**HRS §712-1243**	**HRS §712-1244***	**HRS §712-1245***	**HRS §712-1246**	**HRS §712-1246.5**	**HRS §712-1247***	**HRS §712-1248***	**HRS §712-1249**
2000	46	169	883	3	5	14	35	16	30	164
2001	33	146	736	2	3	5	25	10	37	151
2002	52	162	831	1	6	5	37	20	35	201
2003	66	197	926	2	3	3	36	10	25	179
2004	55	176	1,034	2	2	4	38	18	28	239
2005	71	173	1,210	0	6	6	32	13	32	260
2006	44	170	1,069	0	13	7	46	15	35	266
2007	38	156	1,036	0	7	4	40	24	36	219
2008	34	119	826	1	15	5	45	29	34	228
2009	14	93	707	7	12	10	43	39	32	207
2010	29	117	685	9	15	6	55	32	48	214
2011	26	104	676	3	17	12	63	24	43	254
2012	10	111	839	4	14	11	79	24	37	249
2013	11	113	788	4	9	13	56	23	32	205
2014	11	123	890	2	13	3	62	26	37	241
2015	11	99	921	3	16	10	76	26	37	252
2016	13	107	986	2	18	10	61	23	48	247

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-23. Results for Select Criminal Counts, Hawaii State Circuit and Family Courts, Fiscal Years 1999-2000 to 2015-2016 in the Aggregate			
	Counts	**No. of Cases**	**No. of Parties**
Drug Counts Not Adjudicated	3,810	Not Specified	Not Specified
Adjudications for All Drug Counts	46,160	Not Specified	Not Specified
Acquitted/Not Guilty	517	Not Specified	Not Specified
Convicted	24,561	Not Specified	Not Specified
Deferred	1,492	Not Specified	Not Specified
Dismissed	19,434	Not Specified	Not Specified
Other (includes cases transferred)	156	Not Specified	Not Specified

Table 5-24. Filings of Select Criminal Counts, Hawaii State District Courts, Fiscal Years 2012-2013 to 2015-2016 in the Aggregate			
	Counts	**No. of Cases**	**No. of Parties**
All Counts Filed	111,025	91,183	Not Specified
HRS §712-1246.5 Promoting a harmful drug 4	169	Not Specified	Not Specified
HRS §712-1248* Promoting a detrimental drug 2	189	Not Specified	Not Specified
HRS §712-1249 Promoting a detrimental drug 3	2,897	Not Specified	Not Specified
Relevant Misdemeanor Drug Counts Filed	3,255		

Table 5-25. Results for Select Criminal Counts, Hawaii State District Courts, Fiscal Years 2012-2013 to 2015-2016 in the Aggregate			
	Counts	**No. of Cases**	**No. of Parties**
Drug Counts Not Adjudicated	Not Specified		Not Specified
Adjudications for All Drug Counts	4,984	Not Specified	Not Specified
Acquitted/Not Guilty	4	Not Specified	Not Specified
Convicted	881	Not Specified	Not Specified
Deferred	206	Not Specified	Not Specified
Dismissed	2,117	Not Specified	Not Specified
Other (includes cases transferred)	1,776	Not Specified	Not Specified

Table 5-26. Federal Grants to the Judiciary for the Treatment of Drug Offenders	
Grant	**Amount/Period**
Big Island Adult Drug Court Enhancement Project	$199,950 for 3-year period (FY2012 - FY2014)
Mea Kokua Grant	$200,000 for 3-year period (FY2012 - FY 2014)
Maui/Molokai Drug Court Program (Edward Byrne) Grant	$105,960 for 4-year period (FY2013 - FY2016)

Table 5-27. HCJDC Data, Simple Drug Possession Offenses

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2000	**Arrests**	177	386	2,114	27	20	56	96	55	111	1,026
	Honolulu	80	190	1,229	18	11	21	44	13	21	338
	Police	62	138	1,010	3	7	13	30	11	20	292
	Sheriffs	18	52	219	15	4	8	14	2	1	46
	Hawaii County	51	120	370	6	7	23	31	35	61	337
	Police	51	120	369	6	7	23	31	35	61	337
	Sheriffs	0	0	1	0	0	0	0	0	0	0
	Kauai	11	38	151	1	0	2	0	3	8	73
	Police	11	38	151	1	0	2	0	3	8	73
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	35	38	364	2	2	10	21	4	21	278
	Police	35	38	364	2	2	10	21	4	21	278
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	47	149	834	4	8	14	32	12	50	491
	Oahu	20	82	541	2	4	5	9	1	17	211
	Hawaii Island	10	28	83	2	2	7	9	6	16	132
	Kauai	2	8	73	0	1	0	0	3	6	31
	Maui	15	31	137	0	1	2	14	2	11	117
2001	**Arrests**	137	364	2,137	12	11	30	75	50	100	944
	Honolulu	54	218	1,227	6	7	8	40	9	21	340
	Police	40	180	1,039	2	5	4	27	9	18	313
	Sheriffs	14	38	188	4	2	4	13	0	3	27
	Hawaii County	47	81	379	2	4	16	20	26	50	312
	Police	47	81	379	2	4	16	20	26	50	312
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	7	23	99	2	0	1	1	3	4	85
	Police	7	23	99	2	0	1	1	3	4	85
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	29	42	432	2	0	5	14	12	25	207
	Police	29	42	432	2	0	5	14	12	25	207
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	40	166	833	1	2	5	38	17	54	482
	Oahu	11	96	481	0	1	1	15	1	18	226
	Hawaii Island	14	35	113	1	1	2	15	11	23	129
	Kauai	6	10	68	0	0	1	1	2	3	57
	Maui	9	25	171	0	0	1	7	3	10	70

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2002	**Arrests**	201	360	2,114	6	18	26	94	43	93	1,013
	Honolulu	91	182	1,172	2	2	6	40	10	24	400
	Police	77	143	967	2	1	5	27	6	21	310
	Sheriffs	14	39	205	0	1	1	13	4	3	90
	Hawaii County	34	81	306	4	5	6	29	31	40	278
	Police	34	81	306	4	5	6	29	31	40	278
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	11	17	139	0	0	4	2	0	7	82
	Police	11	17	139	0	0	4	2	0	7	82
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	65	80	497	0	11	10	23	2	22	253
	Police	65	80	497	0	11	10	23	2	22	253
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	67	198	886	1	7	6	47	16	57	576
	Oahu	30	85	465	0	0	1	17	3	23	258
	Hawaii Island	11	49	148	1	3	0	10	13	17	157
	Kauai	4	11	77	0	0	1	4	0	5	47
	Maui	22	53	196	0	4	4	16	0	12	114
2003	**Arrests**	203	366	2,523	10	7	47	98	57	111	1,277
	Honolulu	66	182	1,293	5	2	8	37	5	19	461
	Police	55	153	1,042	0	1	4	30	4	14	310
	Sheriffs	11	29	251	5	1	4	7	1	5	151
	Hawaii County	47	97	520	1	4	26	32	19	52	406
	Police	47	97	520	1	4	26	32	19	52	406
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	7	29	148	1	0	0	7	2	7	105
	Police	7	29	148	1	0	0	7	2	7	105
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	83	58	562	3	1	13	22	31	33	305
	Police	83	58	562	3	1	13	22	31	33	305
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	53	215	1,087	4	1	27	39	29	52	718
	Oahu	20	102	580	2	1	1	14	1	13	288
	Hawaii Island	11	58	249	1	0	22	13	5	17	233
	Kauai	1	20	75	0	0	0	4	5	6	64
	Maui	21	35	183	1	0	4	8	18	16	133

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2004	**Arrests**	195	369	2,562	11	13	28	107	67	109	1,273
	Honolulu	65	218	1,219	4	5	0	33	5	30	473
	Police	52	192	1,002	3	3	0	31	5	29	388
	Sheriffs	13	26	217	1	2	0	2	0	1	85
	Hawaii County	45	61	637	2	2	16	52	29	43	437
	Police	45	61	637	2	2	16	52	29	43	437
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	20	32	173	2	0	5	1	8	9	112
	Police	20	32	173	2	0	5	1	8	9	112
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	65	58	533	3	6	7	21	25	27	251
	Police	65	58	533	3	6	7	21	25	27	251
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	64	202	1,249	1	7	10	40	25	73	767
	Oahu	27	123	635	1	3	0	10	2	25	345
	Hawaii Island	15	35	322	0	2	6	23	16	23	239
	Kauai	8	19	87	0	0	1	3	3	9	85
	Maui	14	25	205	0	2	3	4	4	16	98
2005	**Arrests**	147	310	2,539	8	14	36	139	53	82	1,293
	Honolulu	30	152	1,131	1	7	5	40	5	23	452
	Police	25	130	967	1	6	4	34	3	22	405
	Sheriffs	5	22	164	0	1	1	6	2	1	47
	Hawaii County	36	72	674	4	1	15	60	28	40	411
	Police	36	72	674	4	1	15	60	28	40	411
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	26	29	189	0	0	7	9	8	5	134
	Police	26	29	189	0	0	7	9	8	5	134
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	55	57	545	3	6	9	30	12	14	296
	Police	55	57	545	3	6	9	30	12	14	296
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	52	212	1,273	2	7	13	57	20	54	811
	Oahu	13	121	631	0	5	2	15	3	19	362
	Hawaii Island	14	43	321	2	1	3	19	11	17	232
	Kauai	13	18	116	0	0	7	7	5	4	83
	Maui	12	30	205	0	1	1	16	1	14	134

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2006	**Arrests**	112	271	2,102	19	35	20	116	65	133	1,241
	Honolulu	32	124	1,023	2	12	7	28	4	23	441
	Police	28	101	894	2	11	6	23	2	23	417
	Sheriffs	4	23	129	0	1	1	5	2	0	24
	Hawaii County	37	62	543	16	18	7	45	44	84	406
	Police	37	62	543	16	18	7	45	44	84	406
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	9	31	106	1	1	1	7	0	5	122
	Police	9	31	106	1	1	1	7	0	5	122
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	34	54	430	0	4	5	36	17	21	272
	Police	34	54	430	0	4	5	36	17	21	272
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	42	186	1,102	5	13	7	59	15	69	771
	Oahu	14	106	629	0	6	3	19	1	18	353
	Hawaii Island	19	45	287	5	7	4	21	13	38	239
	Kauai	4	11	59	0	0	0	2	0	3	73
	Maui	5	24	127	0	0	0	17	1	10	106
2007	**Arrests**	106	232	2,046	10	21	31	115	87	140	1,309
	Honolulu	32	116	910	3	8	2	38	14	18	449
	Police	23	100	772	2	5	0	29	12	17	406
	Sheriffs	9	16	138	1	3	2	9	2	1	43
	Hawaii County	35	61	498	5	10	20	41	51	95	457
	Police	35	61	498	5	10	20	41	51	95	457
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	4	20	99	2	0	3	4	2	0	107
	Police	4	20	99	2	0	3	4	2	0	107
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	35	35	539	0	3	6	32	20	27	296
	Police	35	35	539	0	3	6	32	20	27	296
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	35	161	1,055	2	8	7	68	29	73	888
	Oahu	14	92	507	0	3	0	22	5	17	374
	Hawaii Island	11	36	239	1	5	4	22	21	37	277
	Kauai	2	11	60	1	0	2	6	2	1	71
	Maui	8	22	249	0	0	1	18	1	18	166

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2008	**Arrests**	89	188	1,568	38	28	25	115	80	118	1,305
	Honolulu	32	82	638	15	6	6	31	12	19	414
	Police	19	62	504	14	4	2	27	9	18	376
	Sheriffs	13	20	134	1	2	4	4	3	1	38
	Hawaii County	15	47	366	13	13	9	36	44	64	426
	Police	15	47	366	13	13	9	36	44	64	426
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	3	10	118	1	1	1	6	1	7	90
	Police	3	10	118	1	1	1	6	1	7	90
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	39	49	446	9	8	9	42	23	28	375
	Police	39	49	446	9	8	9	42	23	28	375
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	27	149	876	13	18	5	79	50	65	918
	Oahu	13	69	357	2	3	0	15	3	9	342
	Hawaii Island	7	37	243	7	8	2	27	29	35	312
	Kauai	1	11	73	1	1	1	4	3	4	66
	Maui	6	32	203	3	6	2	33	15	17	198
2009	**Arrests**	110	220	1,576	18	25	39	118	90	173	1,443
	Honolulu	9	77	596	7	5	4	31	9	56	442
	Police	7	58	473	2	2	3	24	7	54	400
	Sheriffs	2	19	123	5	3	1	7	2	2	42
	Hawaii County	33	79	341	5	14	6	25	50	69	438
	Police	33	79	341	5	14	6	25	50	69	438
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	4	14	152	1	0	4	9	7	2	107
	Police	4	14	152	1	0	4	9	7	2	107
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	64	50	487	5	6	25	53	24	46	456
	Police	64	50	487	5	6	25	53	24	46	456
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	35	127	823	8	11	13	57	53	83	990
	Oahu	4	53	311	3	1	2	13	1	15	348
	Hawaii Island	23	41	195	3	10	0	13	35	40	321
	Kauai	3	9	84	0	0	1	5	5	0	71
	Maui	5	24	233	2	0	10	26	12	28	250

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2010	**Arrests**	76	199	1,496	29	41	32	168	86	200	1,508
	Honolulu	23	59	598	7	3	4	26	14	50	467
	Police	19	47	503	3	2	3	22	10	50	434
	Sheriffs	4	12	95	4	1	1	4	4	0	33
	Hawaii County	12	77	356	7	21	12	55	45	75	465
	Police	12	77	356	7	21	12	55	45	75	465
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	9	32	135	3	4	5	16	6	19	137
	Police	9	32	135	3	4	5	16	6	19	137
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	32	31	407	12	13	11	71	21	56	439
	Police	32	31	407	12	13	11	71	21	56	439
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Court Cases Filed	30	125	791	14	29	10	90	44	91	1,035
	Oahu	7	38	323	5	2	0	13	5	7	387
	Hawaii Island	13	55	239	4	18	5	31	26	57	322
	Kauai	6	13	74	1	2	1	10	5	9	79
	Maui	4	19	155	4	7	4	36	8	18	247
2011	**Arrests**	37	178	1,665	19	40	45	186	92	165	1,347
	Honolulu	17	55	628	7	14	14	46	22	57	448
	Police	11	50	536	6	13	11	38	19	53	408
	Sheriffs	6	5	92	1	1	3	8	3	4	40
	Hawaii County	4	72	395	7	16	10	46	35	49	397
	Police	4	72	395	7	16	10	46	35	49	397
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Kauai	8	25	210	5	6	5	19	7	12	172
	Police	8	25	210	5	6	5	19	7	12	172
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	8	26	432	0	4	16	75	28	47	330
	Police	8	26	414	0	4	14	74	28	46	325
	Sheriffs	0	0	18	0	0	2	1	0	1	5
	Court Cases Filed	14	105	830	8	20	22	95	38	81	875
	Oahu	8	35	350	5	5	7	25	8	19	343
	Hawaii Island	2	36	207	1	12	6	24	21	29	266
	Kauai	4	21	121	2	3	2	16	4	13	116
	Maui	0	13	152	0	0	7	30	5	20	150

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2012	**Arrests**	37	250	1,808	22	39	37	199	78	165	1,433
	Honolulu	5	95	690	8	4	5	46	19	47	525
	Police	5	79	585	6	4	3	43	17	41	474
	Sheriffs	0	16	105	2	0	2	3	2	6	51
	Hawaii County	10	79	418	7	19	13	50	37	65	362
	Police	10	79	418	7	19	13	47	37	65	326
	Sheriffs	0	0	0	0	0	0	3	0	0	36
	Kauai	2	29	151	3	2	6	28	3	3	123
	Police	2	29	151	3	2	6	28	3	3	123
	Sheriffs	0	0	0	0	0	0	0	0	0	0
	Maui	20	47	549	4	14	13	75	19	50	423
	Police	20	39	495	4	12	13	64	18	46	395
	Sheriffs	0	8	54	0	2	0	11	1	4	28
	Court Cases Filed	9	130	809	12	11	10	103	20	65	889
	Oahu	2	46	358	6	2	2	25	2	21	402
	Hawaii Island	3	40	216	4	6	7	31	13	30	229
	Kauai	1	20	78	1	0	1	12	2	3	75
	Maui	3	24	157	1	3	0	35	3	11	183
2013	**Arrests**	44	202	2,001	21	27	37	230	94	132	1,419
	Honolulu	19	65	633	1	3	7	28	12	20	414
	Police	12	58	555	0	3	7	14	9	17	388
	Sheriffs	7	7	78	1	0	0	14	3	3	26
	Hawaii County	6	72	493	8	8	10	59	49	54	390
	Police	6	72	493	8	8	10	59	49	54	369
	Sheriffs	0	0	0	0	0	0	0	0	0	21
	Kauai	2	20	160	0	2	3	14	4	6	118
	Police	2	20	156	0	2	3	14	4	6	117
	Sheriffs	0	0	4	0	0	0	0	0	0	1
	Maui	17	45	715	12	14	17	129	29	52	497
	Police	17	43	676	12	12	15	119	29	48	476
	Sheriffs	0	2	39	0	2	2	10	0	4	21
	Court Cases Filed	11	109	846	6	17	10	114	43	79	814
	Oahu	8	30	331	1	1	1	11	4	9	296
	Hawaii Island	2	42	244	4	9	4	24	30	42	226
	Kauai	1	15	99	0	2	1	11	3	6	73
	Maui	0	22	172	1	5	4	68	6	22	219

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-27. HCJDC Data, Simple Drug Possession Offenses (*continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2014	**Arrests**	36	238	2,189	12	23	32	198	44	125	1,344
	Honolulu	7	71	792	6	3	6	42	9	28	424
	Police	4	61	680	4	3	5	35	8	25	387
	Sheriffs	3	10	112	2	0	1	7	1	3	37
	Hawaii County	6	69	465	3	13	11	52	18	37	332
	Police	6	69	463	3	13	11	52	18	35	307
	Sheriffs	0	0	2	0	0	0	0	0	2	25
	Kauai	3	18	156	0	2	1	13	1	5	112
	Police	2	16	126	0	2	1	13	1	5	86
	Sheriffs	1	2	30	0	0	0	0	0	0	26
	Maui	20	80	776	3	5	14	91	16	55	476
	Police	19	72	723	2	4	14	86	15	53	454
	Sheriffs	1	8	53	1	1	0	5	1	2	22
	Court Cases Filed	11	124	938	7	13	3	98	17	51	768
	Oahu	5	33	427	4	2	1	21	1	10	291
	Hawaii Island	3	40	239	2	7	1	29	8	27	211
	Kauai	1	11	83	0	0	0	6	0	1	74
	Maui	2	40	189	1	4	1	42	8	13	192
2015	**Arrests**	40	195	2,305	17	43	45	186	62	127	1,248
	Honolulu	6	49	696	3	13	8	30	11	17	368
	Police	4	36	611	2	10	5	27	11	16	325
	Sheriffs	2	13	85	1	3	3	3	0	1	43
	Hawaii County	22	66	544	11	10	20	47	26	41	298
	Police	20	64	537	11	10	19	46	26	40	290
	Sheriffs	2	2	7	0	0	1	1	0	1	8
	Kauai	0	19	182	1	3	2	16	6	7	96
	Police	0	16	144	1	1	2	9	4	7	70
	Sheriffs	0	3	38	0	2	0	7	2	0	26
	Maui	12	61	883	2	17	15	93	19	62	486
	Police	12	52	801	2	17	12	83	17	61	452
	Sheriffs	0	9	82	0	0	3	10	2	1	34
	Court Cases Filed	13	115	978	5	20	17	105	27	68	672
	Oahu	2	30	355	1	6	5	7	0	5	257
	Hawaii Island	9	32	245	4	8	10	28	13	29	161
	Kauai	0	9	105	0	2	0	10	4	2	62

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28.
HCJDC "Sole Offense" Data, Simple Drug Possession Offenses

The following table represents:

- The number of arrests, for each of the drug possession offenses, in which the specified offense was the sole offense for which the suspect was arrested;
- The number of criminal court cases filed, by county, for each of the drug possession offenses, in which the specified offense was the sole offense for which the defendant was charged; and
- Among criminal court cases in which the specified offense was the sole offense for which the defendant was charged, the number of cases:
    - In which the court deferred its acceptance of the defendant's "guilty" or "no contest" plea to the offense charged;
    - In which the court referred the defendant to a drug court program;
    - In which the defendant was convicted; and
    - In which the defendant was sentenced to incarceration. Our inquiry also asked the HCJDC to provide statistics on court cases in which the outcome was still pending at the end of each year. Letter to HCJDC staff on September 30, 2016 (on file with the Bureau). The HCJDC's data showed that none of the relevant court cases had such a status at the end of any given year. *See* E-mail correspondence with HCJDC staff on October 20, 2016 (on file with the Bureau).

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2000	**Arrests**	52	100	222	11	5	1	5	7	27	306
	Court Cases Filed	16	27	105	0	3	4	8	1	25	333
	Oahu	4	16	68	0	2	0	1	0	12	161
	Hawaii Island	5	5	16	0	0	4	2	1	6	96
	Kauai	0	1	2	0	0	0	0	0	1	4
	Maui	7	5	19	0	1	0	5	0	6	72
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	1	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	1	0	0	0	0	0	0	0
	Convictions	4	15	32	0	1	0	0	0	9	109
	Incarcerations	4	12	25	0	0	0	0	0	2	33
2001	**Arrests**	37	107	247	3	4	1	5	8	20	294
	Court Cases Filed	9	37	120	0	1	2	11	3	25	329
	Oahu	2	30	46	0	1	0	2	0	14	191
	Hawaii Island	5	4	30	0	0	2	9	2	7	82
	Kauai	0	0	2	0	0	0	0	0	1	18
	Maui	2	3	42	0	0	0	0	1	3	38
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	4	20	30	0	0	0	1	0	12	93
	Incarcerations	4	18	21	0	0	0	0	0	5	29
2002	**Arrests**	40	76	226	2	1	2	5	7	32	314
	Court Cases Filed	16	31	150	0	2	4	7	0	32	376
	Oahu	8	16	67	0	0	0	4	0	20	199
	Hawaii Island	0	7	30	0	1	0	1	0	6	101
	Kauai	0	0	4	0	0	0	0	0	2	14
	Maui	8	8	49	0	1	4	2	0	4	62
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	2	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	2	0	0	0	0	0	0	0	0
	Convictions	3	4	38	0	0	0	0	0	13	106
	Incarcerations	3	2	24	0	0	0	0	0	10	36

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2003	**Arrests**	54	81	256	4	0	5	6	13	34	400
	Court Cases Filed	14	51	190	2	0	20	12	8	27	529
	Oahu	10	27	45	1	0	0	6	0	9	238
	Hawaii Island	0	18	85	0	0	19	4	1	5	177
	Kauai	0	0	4	0	0	0	0	0	3	29
	Maui	4	6	56	1	0	1	2	7	10	85
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	9	29	20	1	0	0	5	0	6	134
	Incarcerations	7	27	10	1	0	0	2	0	2	44
2004	**Arrests**	40	97	275	3	2	1	4	22	27	422
	Court Cases Filed	19	49	251	0	3	4	16	5	38	529
	Oahu	9	34	71	0	2	0	3	0	19	275
	Hawaii Island	6	9	93	0	1	2	12	3	13	146
	Kauai	0	0	0	0	0	0	0	0	2	45
	Maui	4	6	87	0	0	2	1	2	4	63
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	1
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	5	31	36	0	2	1	3	1	14	154
	Incarcerations	3	28	27	0	0	1	1	1	6	47
2005	**Arrests**	20	53	242	0	6	2	5	11	17	355
	Court Cases Filed	5	55	215	1	2	3	21	3	21	549
	Oahu	2	37	59	0	2	1	8	2	13	283
	Hawaii Island	3	12	78	1	0	2	8	1	3	128
	Kauai	0	0	3	0	0	0	0	0	0	36
	Maui	0	6	75	0	0	0	5	0	5	102
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	1	38	23	0	3	0	4	0	3	158
	Incarcerations	1	32	19	0	2	0	1	0	0	62

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2006	**Arrests**	27	65	172	1	3	0	5	9	40	403
	Court Cases Filed	13	32	97	1	5	0	13	3	37	542
	Oahu	8	27	58	0	2	0	6	1	15	285
	Hawaii Island	5	4	37	1	3	0	4	2	18	145
	Kauai	0	0	1	0	0	0	0	0	1	54
	Maui	0	1	1	0	0	0	3	0	3	58
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	3	25	23	0	2	0	8	0	10	175
	Incarcerations	3	19	18	0	1	0	0	0	8	67
2007	**Arrests**	24	58	178	1	1	3	7	20	33	504
	Court Cases Filed	8	24	76	0	0	0	16	0	24	648
	Oahu	7	18	35	0	0	0	10	0	10	315
	Hawaii Island	1	3	39	0	0	0	3	0	9	191
	Kauai	0	0	1	0	0	0	0	0	1	45
	Maui	0	3	1	0	0	0	3	0	4	97
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	1
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	7	18	13	0	0	0	8	0	9	255
	Incarcerations	4	5	10	0	0	0	5	0	6	75
2008	**Arrests**	27	33	143	13	4	1	8	13	40	521
	Court Cases Filed	4	16	90	3	5	0	17	7	32	636
	Oahu	2	10	33	0	1	0	8	0	9	287
	Hawaii Island	2	6	57	3	4	0	6	6	18	225
	Kauai	0	0	0	0	0	0	0	0	2	33
	Maui	0	0	0	0	0	0	3	1	3	91
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	2	7	15	0	0	0	5	1	18	273
	Incarcerations	0	3	13	0	0	0	2	1	8	101

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2009	**Arrests**	30	31	163	4	2	1	9	5	79	573
	Court Cases Filed	13	20	64	0	3	0	9	10	36	702
	Oahu	2	10	30	0	0	0	2	0	9	289
	Hawaii Island	11	10	32	0	3	0	5	10	22	237
	Kauai	0	0	2	0	0	0	0	0	0	40
	Maui	0	0	0	0	0	0	2	0	5	136
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	1	0	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	1	6	14	0	0	0	3	0	11	318
	Incarcerations	0	3	13	0	0	0	3	0	2	96
2010	**Arrests**	23	27	118	6	0	2	14	15	74	624
	Court Cases Filed	4	17	80	2	5	3	19	6	36	740
	Oahu	2	7	28	1	1	0	6	0	7	333
	Hawaii Island	2	10	51	1	4	3	11	6	23	232
	Kauai	0	0	1	0	0	0	0	0	0	42
	Maui	0	0	0	0	0	0	2	0	6	133
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	1	1	0	0	0	0	0	0	1
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	0	2	18	1	0	0	6	0	14	309
	Incarcerations	0	1	14	1	0	0	4	0	1	124
2011	**Arrests**	8	15	125	5	2	3	12	7	57	516
	Court Cases Filed	3	3	41	4	1	3	11	1	31	584
	Oahu	3	1	21	3	1	1	6	1	13	273
	Hawaii Island	0	2	20	1	0	1	3	0	15	181
	Kauai	0	0	0	0	0	0	0	0	0	52
	Maui	0	0	0	0	0	1	2	0	3	78
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	0	0	0	0	0	1	1	2
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	0	0	10	2	0	0	4	0	13	303
	Incarcerations	0	0	8	2	0	0	2	0	6	127

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2012	**Arrests**	15	32	141	1	2	2	25	7	42	594
	Court Cases Filed	2	8	41	3	1	0	20	0	28	565
	Oahu	1	3	14	3	1	0	6	0	12	308
	Hawaii Island	1	5	27	0	0	0	10	0	12	140
	Kauai	0	0	0	0	0	0	0	0	0	26
	Maui	0	0	0	0	0	0	4	0	4	91
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	3	0	0	0	0	0	1	0
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	0	2	6	0	0	0	10	0	18	279
	Incarcerations	0	2	5	0	0	0	7	0	7	132
2013	**Arrests**	6	20	163	0	0	2	21	12	36	475
	Court Cases Filed	2	2	17	0	0	1	7	2	20	316
	Oahu	2	1	14	0	0	0	2	0	5	154
	Hawaii Island	0	1	1	0	0	1	0	0	7	75
	Kauai	0	0	0	0	0	0	0	2	3	16
	Maui	0	0	2	0	0	0	5	0	5	71
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	3	3	0	0	0	0	0	0	0
	Drug Court Referrals	0	0	1	0	0	0	0	0	0	0
	Convictions	0	0	8	0	0	0	8	0	14	185
	Incarcerations	0	0	8	0	0	0	6	0	9	86
2014	**Arrests**	4	18	185	1	0	0	16	5	31	455
	Court Cases Filed	2	2	31	0	0	0	7	2	14	287
	Oahu	2	2	27	0	0	0	2	0	4	150
	Hawaii Island	0	0	3	0	0	0	4	2	7	71
	Kauai	0	0	1	0	0	0	0	0	1	10
	Maui	0	0	0	0	0	0	1	0	2	56
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	6	0	0	0	0	1	0	2
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	0	0	21	0	0	0	3	0	9	167
	Incarcerations	0	0	14	0	0	0	3	0	7	85

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

Table 5-28. HCJDC "Sole Offense" Data, Simple Drug Possession Offenses *(continued)*

		HRS §712-1241*	HRS §712-1242*	HRS §712-1243	HRS §712-1244*	HRS §712-1245*	HRS §712-1246	HRS §712-1246.5	HRS §712-1247*	HRS §712-1248*	HRS §712-1249
2015	**Arrests**	3	19	223	3	1	0	14	6	28	331
	Court Cases Filed	0	2	35	2	1	0	3	2	7	197
	Oahu	0	2	26	1	0	0	1	0	0	117
	Hawaii Island	0	0	6	1	1	0	1	0	4	37
	Kauai	0	0	0	0	0	0	0	0	0	10
	Maui	0	0	3	0	0	0	1	2	3	33
	Selected Court Statuses (Statewide)										
	Deferrals of Acceptance of Pleas	0	0	4	0	0	0	0	0	0	2
	Drug Court Referrals	0	0	0	0	0	0	0	0	0	0
	Convictions	0	2	16	0	0	0	1	0	5	102
	Incarcerations	0	1	16	0	0	0	1	0	2	66

* HRS §§712-1241, 712-1242, 712-1244, 712-1245, 712-1247, and 712-1248 are not solely "drug possession offenses." Statistics for these offenses may include charges filed against individuals accused of the distribution or sale of dangerous, harmful, or detrimental drugs.

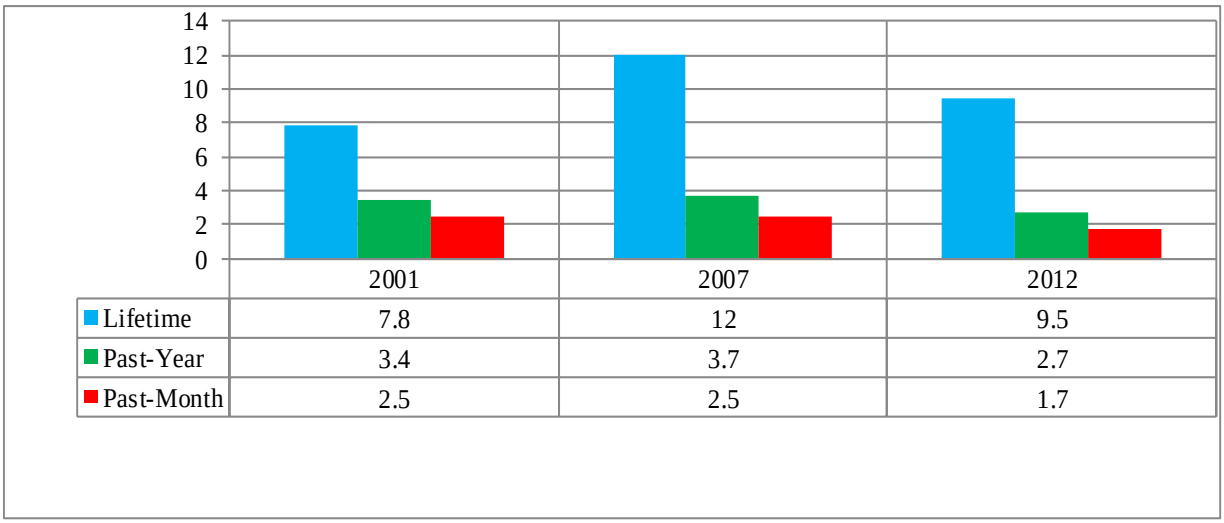
Table 5-29.
Estimate of Expenditures to Incarcerate Inmates, Sentenced in 2015, Whose Sole Offense was a Relevant Offense (Based on Multiple, Broad Assumptions)

	HRS §712-1246.5	HRS §712-1248*	HRS §712-1249
Inmates Incarcerated	1	2	66
Days of Imprisonment Per Inmate (Maximum)	365	365	30
Incarceration Expenditure Per Inmate Per Day	$140	$140	$140
Expenditures for Year for Offense	$51,100	$102,200	$277,200
TOTAL FOR YEAR			**$430,500**

Appendix C

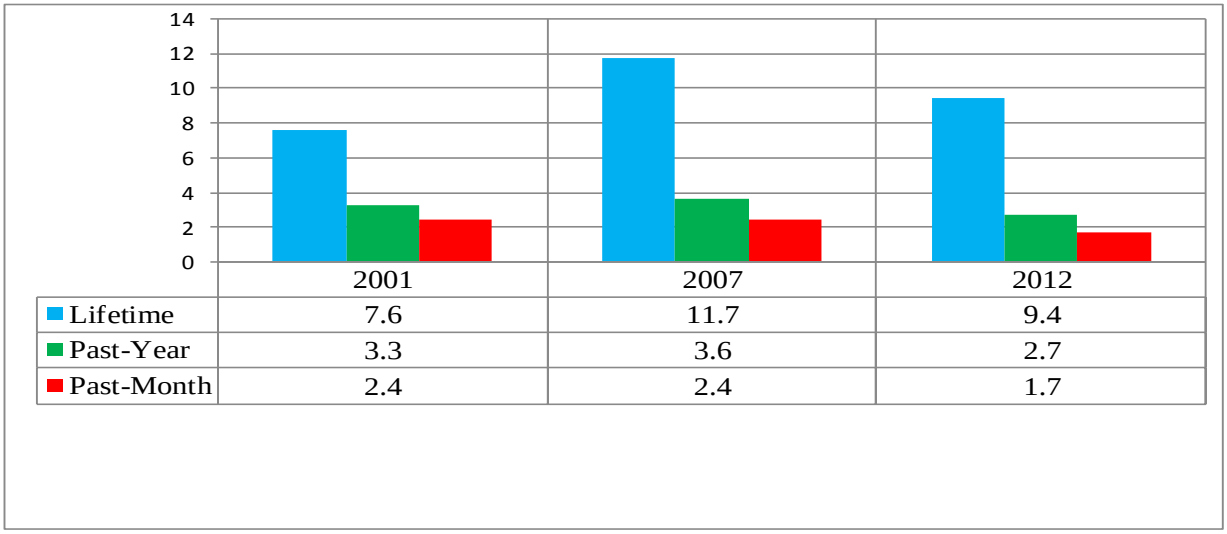
CHAPTER 5 FIGURES

Figure 5-1. Estimated Percentage of Lifetime, Past-Year, and Past-Month Illicit Drug Use in Portugal



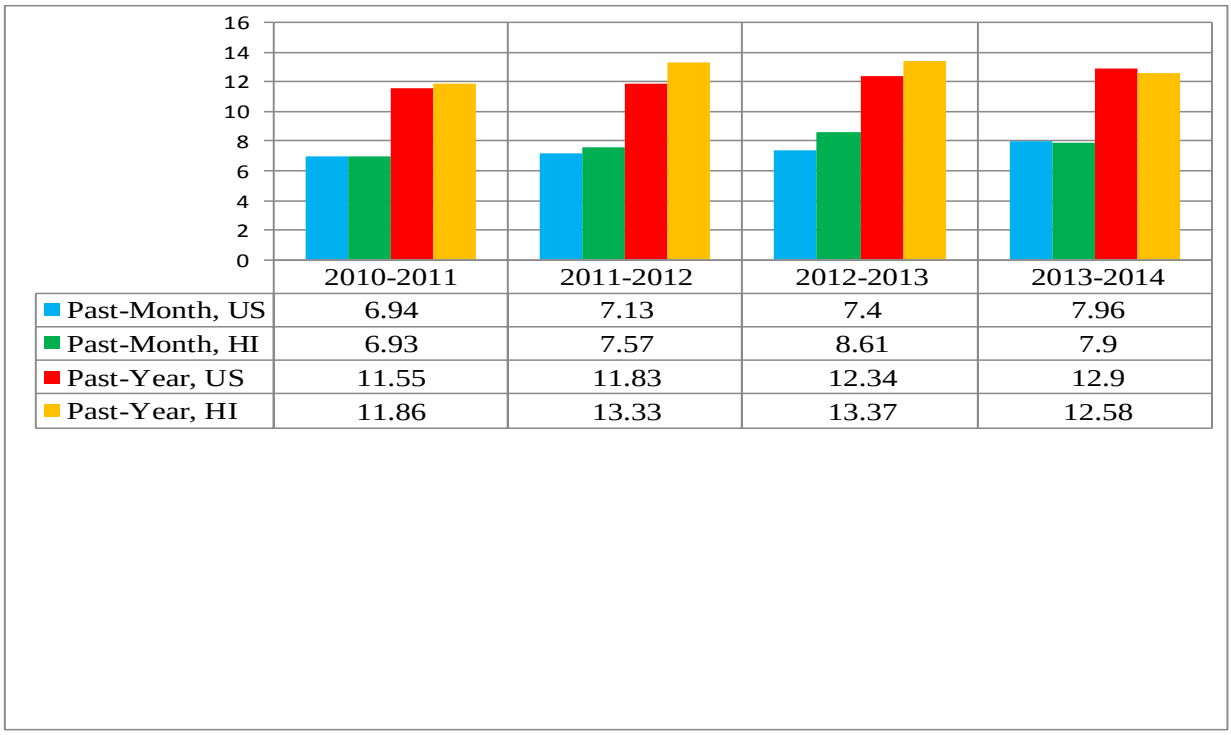
	2001	2007	2012
Lifetime	7.8	12	9.5
Past-Year	3.4	3.7	2.7
Past-Month	2.5	2.5	1.7

Figure 5-2. Estimated Percentage of Lifetime, Past-Year, and Past-Month Marijuana Use in Portugal



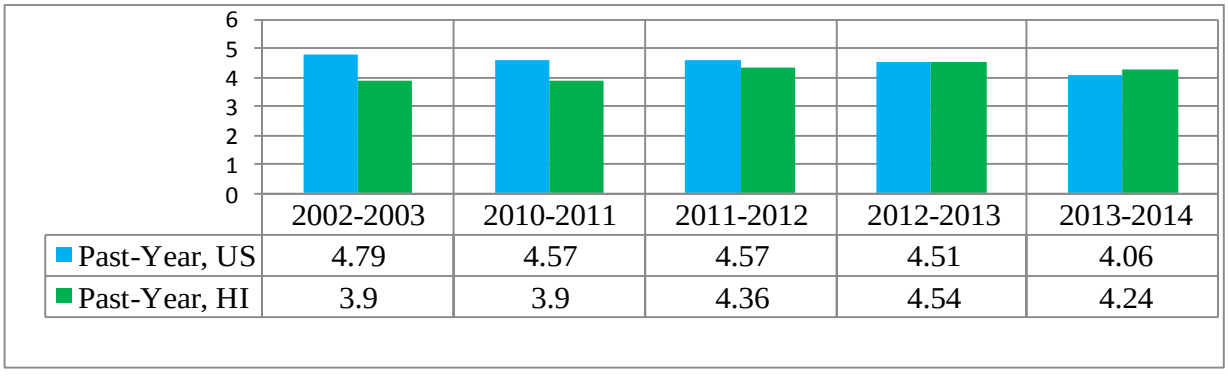
	2001	2007	2012
Lifetime	7.6	11.7	9.4
Past-Year	3.3	3.6	2.7
Past-Month	2.4	2.4	1.7

Figure 5-3. Estimated Percentage of Past-Year and Past-Month Marijuana Use in the United States (US) and Hawaii (HI)



	2010-2011	2011-2012	2012-2013	2013-2014
Past-Month, US	6.94	7.13	7.4	7.96
Past-Month, HI	6.93	7.57	8.61	7.9
Past-Year, US	11.55	11.83	12.34	12.9
Past-Year, HI	11.86	13.33	13.37	12.58

Figure 5-4. Estimated Percentage of Past-Year Nonmedical Pain Reliever Use in the United States (US) and Hawaii (HI)



	2002-2003	2010-2011	2011-2012	2012-2013	2013-2014
Past-Year, US	4.79	4.57	4.57	4.51	4.06
Past-Year, HI	3.9	3.9	4.36	4.54	4.24

Figure 5-5. Estimated Percentage of Lifetime, Past-Year, and Past-Month Heroin Use in Portugal

	2001	2007	2012
Lifetime	0.7	1.1	0.6
Past-Year	0.2	0.3	0
Past-Month	0.1	0.2	0

Figure 5-6. ADAD-Funded Admissions for Substance Use Treatment by Source of Referral, 2011 and 2015

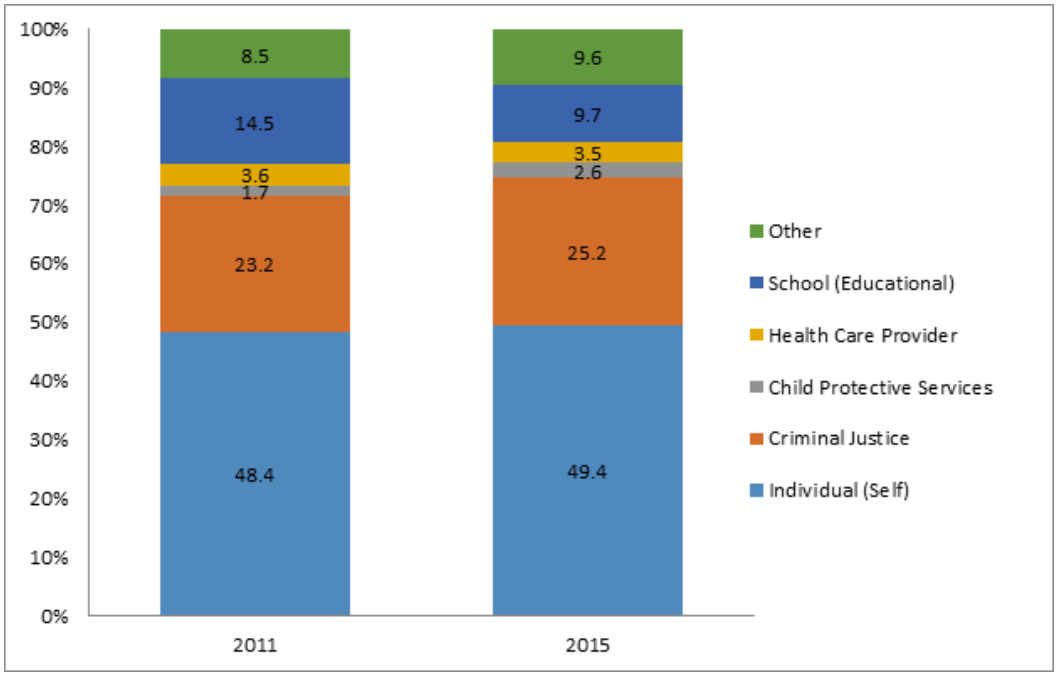


Figure 5-7. ADAD- Funded Admissions for Substance Use Treatment by Source of Referral, 2016

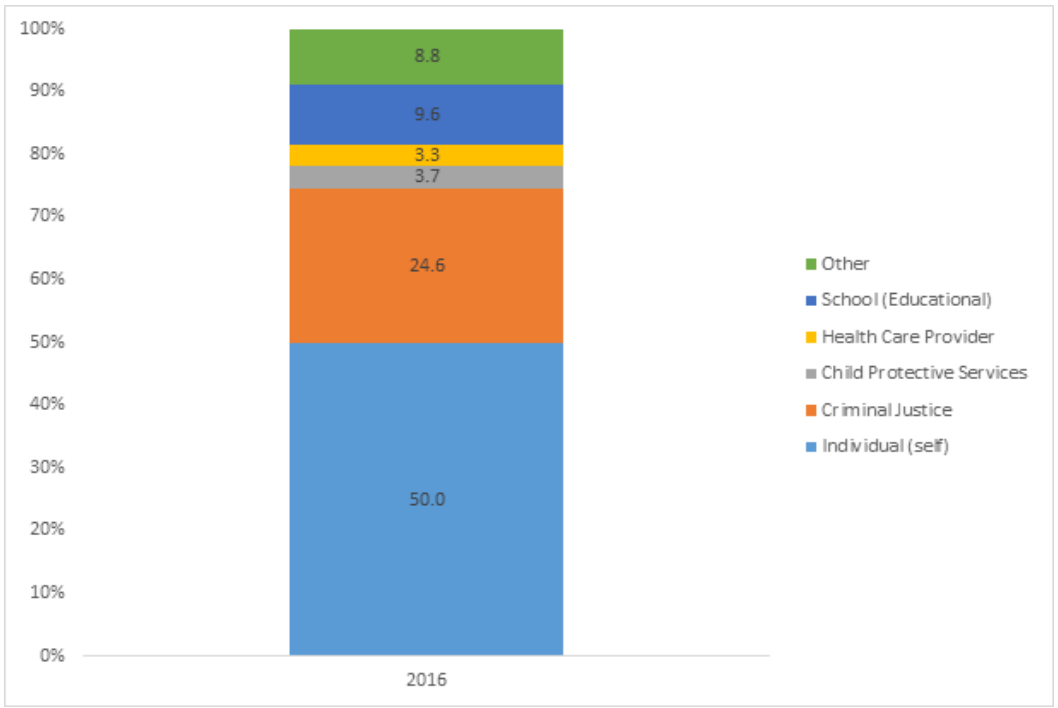


Figure 5-8. Arrests Made for Violations of Section 712-1241, HRS: Promoting a Dangerous Drug in the First Degree

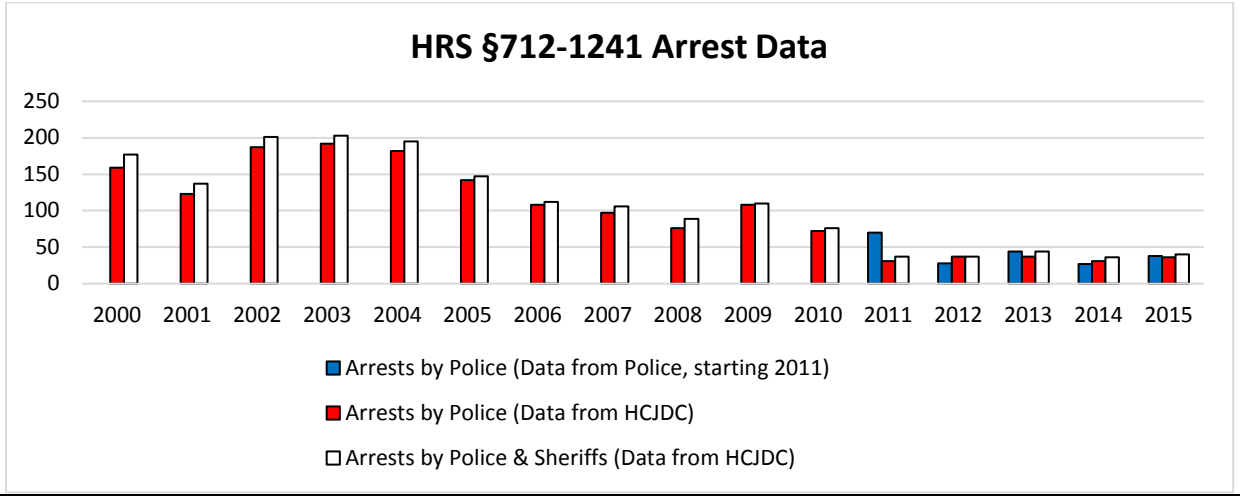


Figure 5-9. Arrests Made for Violations of Section 712-1242, HRS: Promoting a Dangerous Drug in the Second Degree

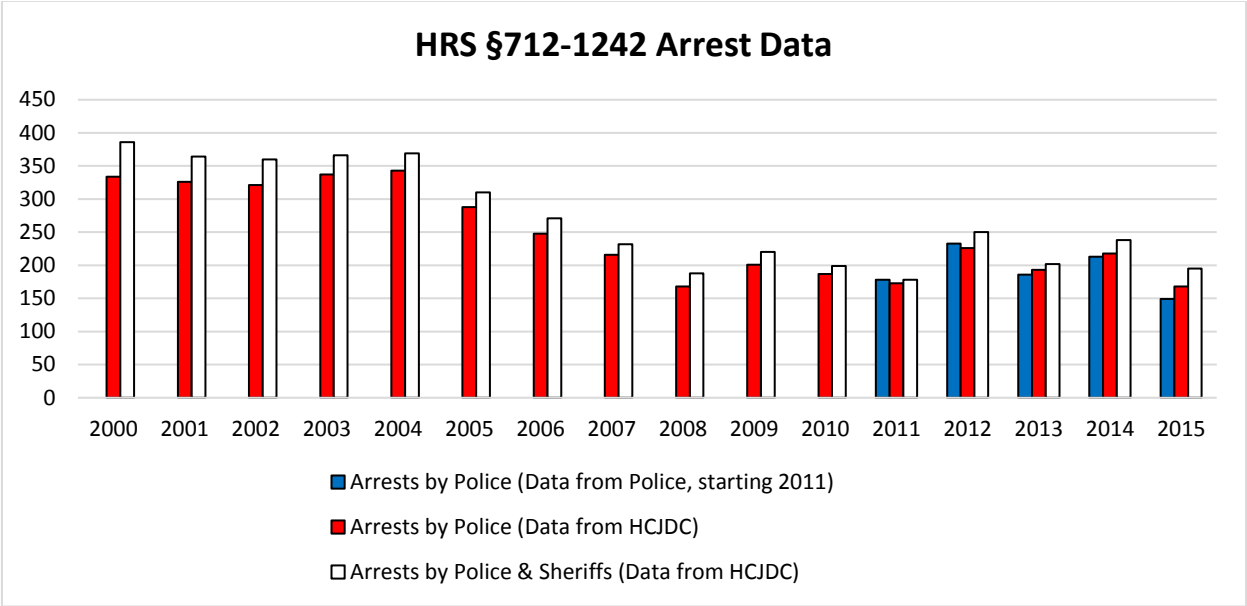


Figure 5-10. Arrests Made for Violations of Section 712-1243, HRS: Promoting a Dangerous Drug in the Third Degree

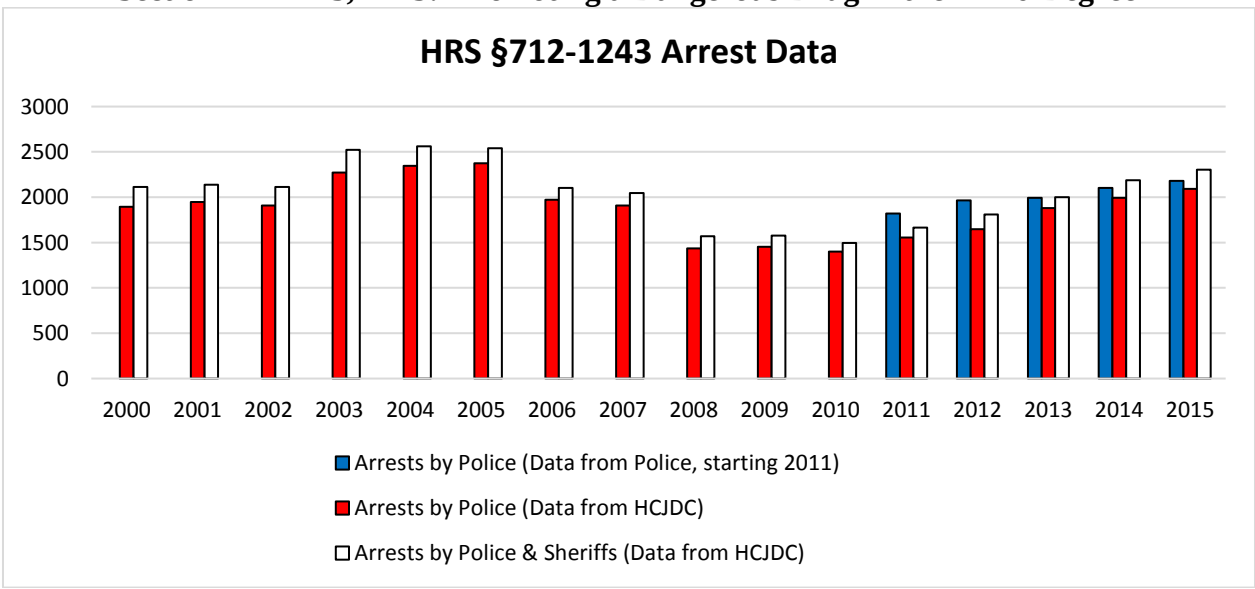


Figure 5-11. Arrests Made for Violations of Section 712-1244, HRS: Promoting a Harmful Drug in the First Degree

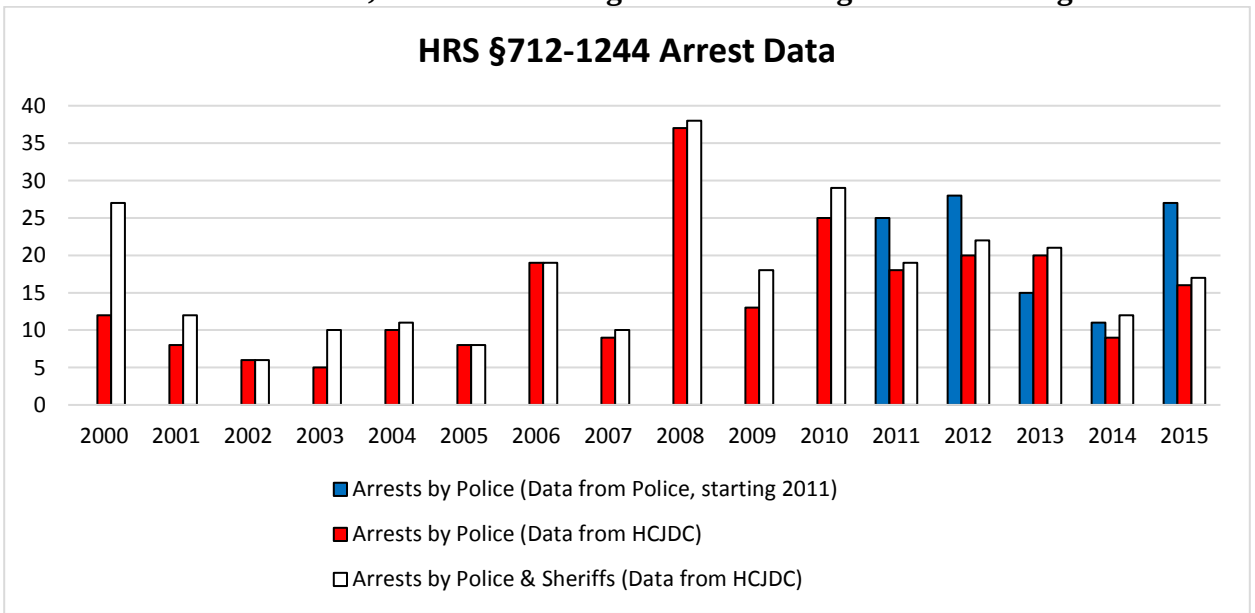


Figure 5-12. Arrests Made for Violations of Section 712-1245, HRS: Promoting a Harmful Drug in the Second Degree

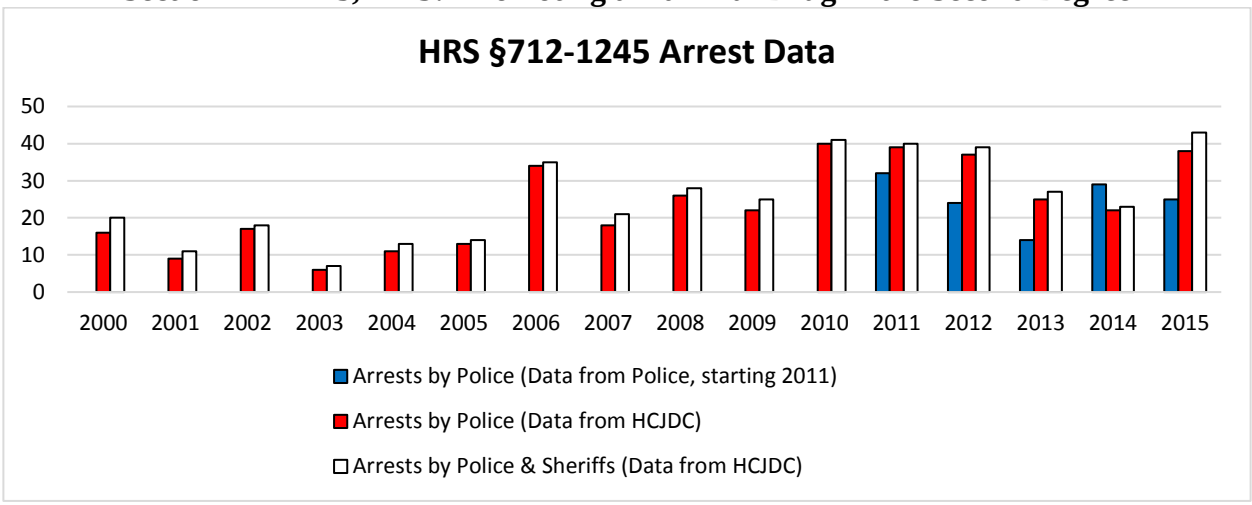


Figure 5-13. Arrests Made for Violations of Section 712-1246, HRS: Promoting a Harmful Drug in the Third Degree

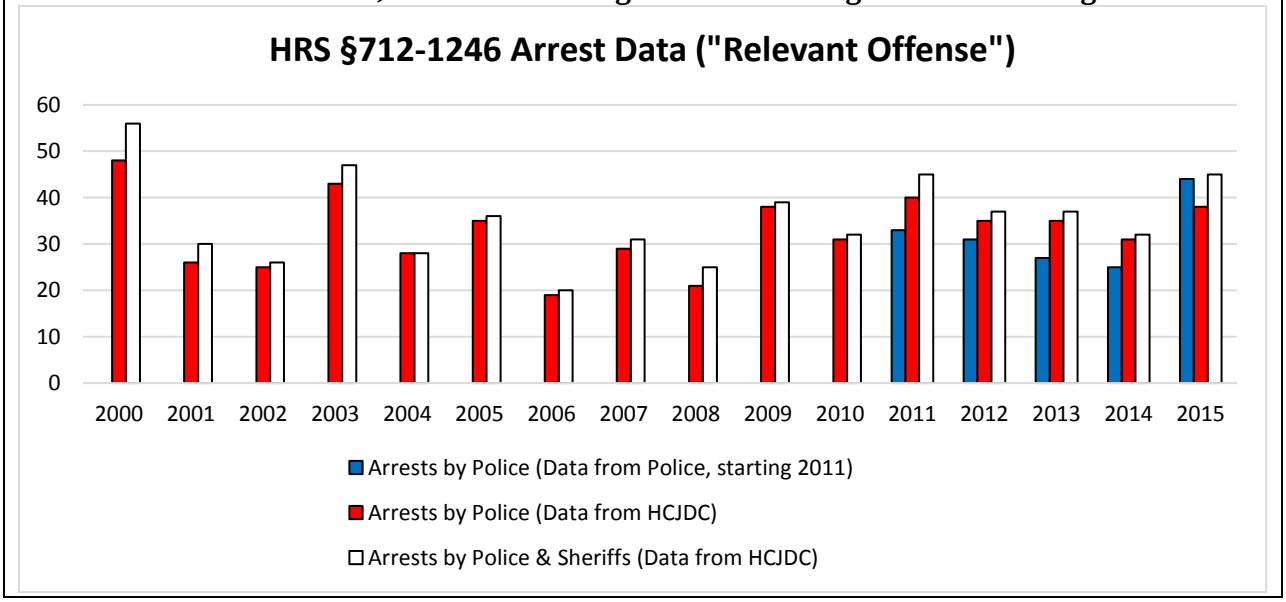


Figure 5-14. Arrests Made for Violations of Section 712-1246.5, HRS: Promoting a Harmful Drug in the Fourth Degree

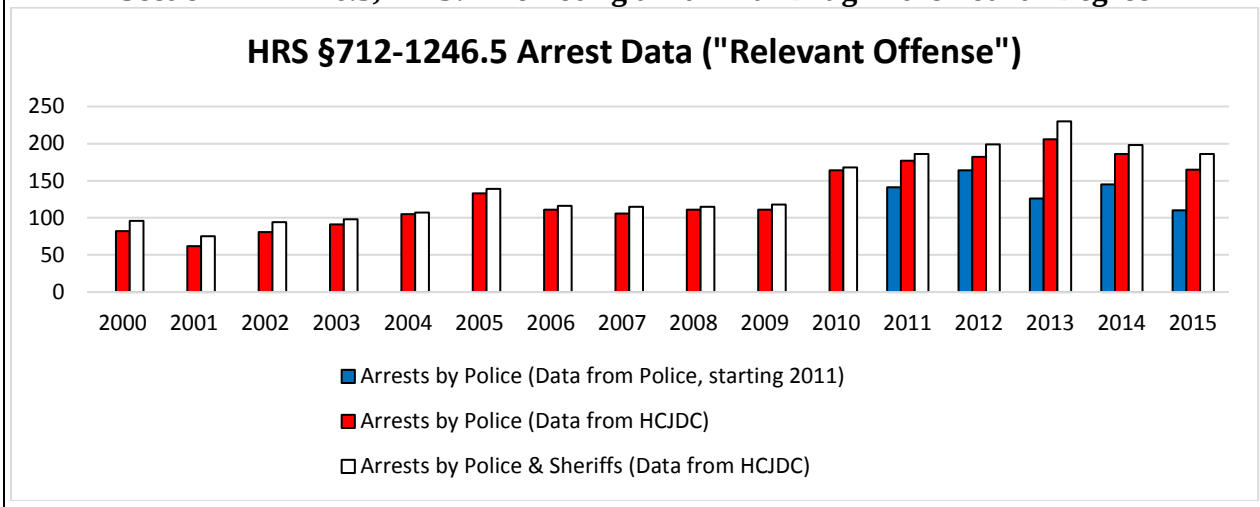


Figure 5-15. Arrests Made for Violations of Section 712-1247, HRS: Promoting a Detrimental Drug in the First Degree

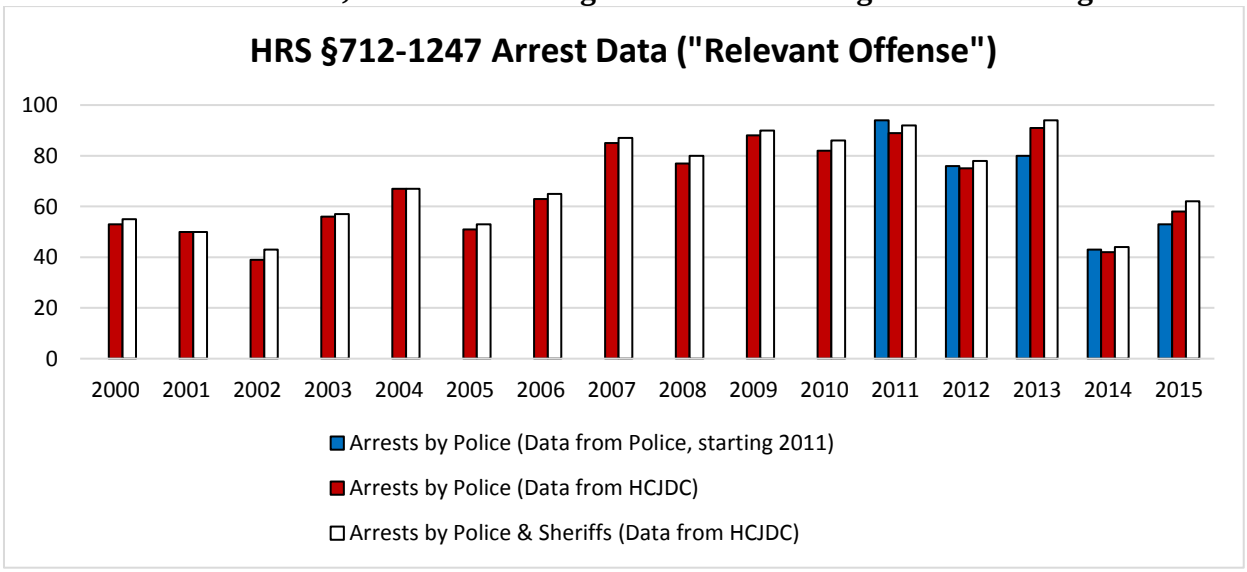


Figure 5-16. Arrests Made for Violations of Section 712-1248, HRS: Promoting a Detrimental Drug in the Second Degree

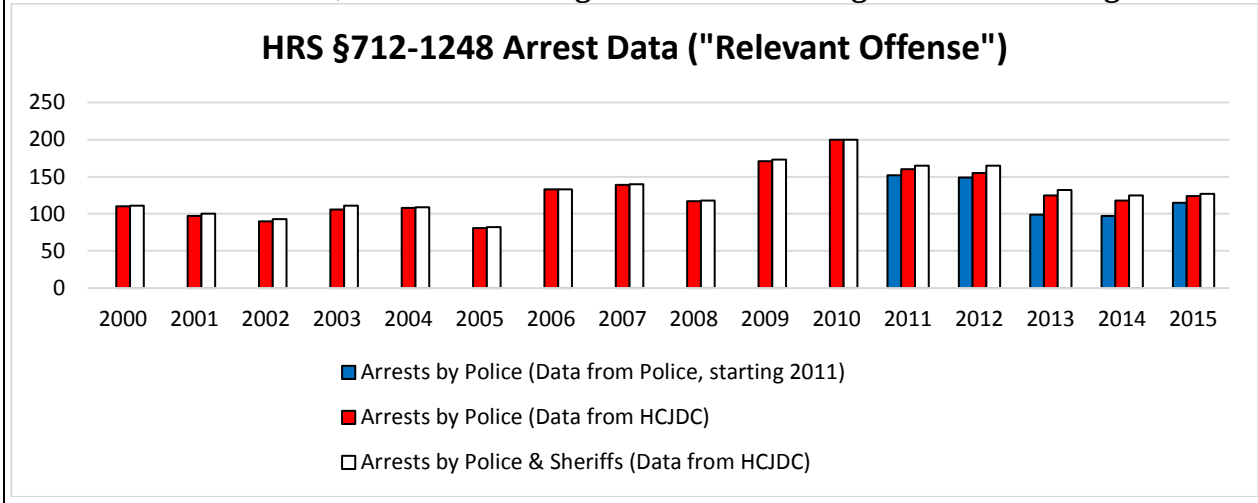
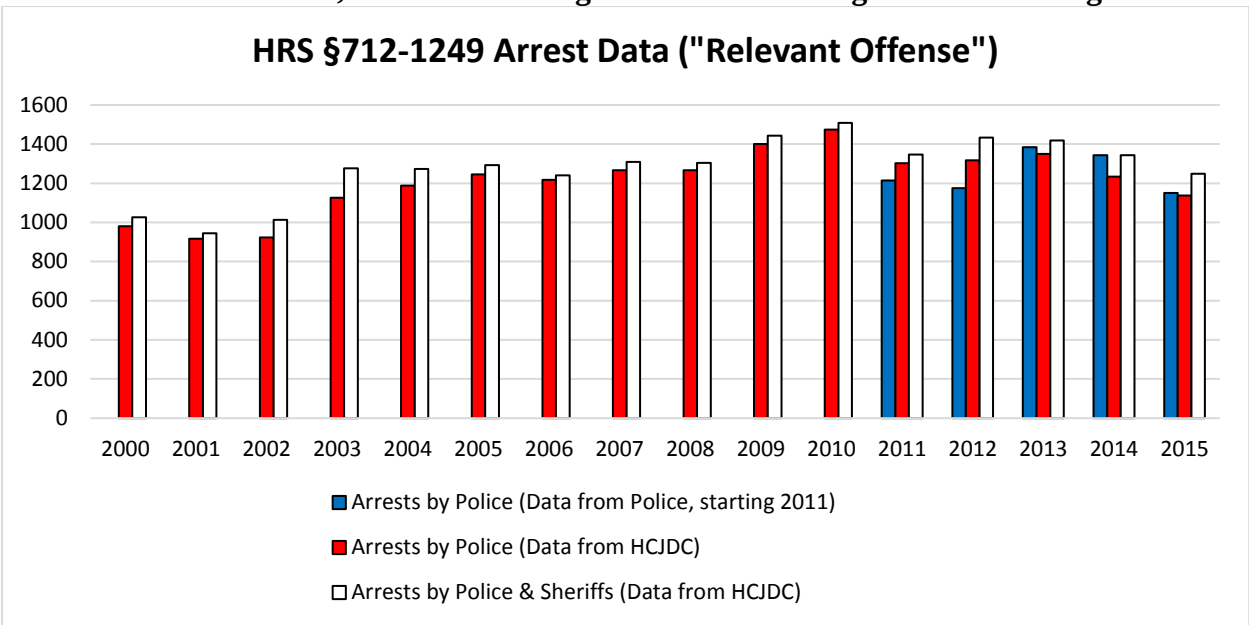


Figure 5-17. Arrests Made for Violations of Section 712-1249, HRS: Promoting a Detrimental Drug in the Third Degree



Appendix D

PORTUGAL'S DECRIMINIALIZATION LAW

General-Directorate for Intervention
on Addictive Behaviours and Dependencies
Ministry of Health - Portugal

DECRIMINALISATION

Portuguese legal framework applicable to the consumption of narcotics and psychotropic substances

General-Directorate for Intervention
on Addictive Behaviours and Dependencies
Ministry of Health - Portugal

DECRIMINALISATION

Law n.º 30/2000, of 29 November

Translated from Portuguese to English by SICAD

Law n.º30/2000, of 29 November

Defines the legal framework applicable to the consumption of narcotics and psychotropic substances, together with the medical and social welfare of the consumers of such substances without medical prescription.

The Assembly of the Republic hereby decrees the following, in accordance with paragraph c) of article 161 of the Constitution, as a general law of the Republic:

Article 1

Aim

1 – This law defines the legal framework applicable to the consumption of narcotics and psychotropic substances, together with the medical and social welfare of the consumers of such substances without medical prescription.

2 – The plants, substances and preparations subject to the framework established here are those listed in tables I to IV attached to Decree-Law no. 15/93 of 22 January.

Article 2

Consumption

1 – The consumption, acquisition and possession for own consumption of plants, substances or preparations listed in the tables referred to in the preceding article constitute an administrative offence.

2 – For the purposes of this law, the acquisition and possession for own use of the substances referred to in the preceding paragraph shall not exceed the quantity required for an average individual consumption during a period of 10 days.

Article 3

Spontaneous treatment

1 – The provisions of this law shall not apply when the consumer or, in the case of a minor, certified or disqualified person, his legal representatives, request the assistance of public or private health services.

2 – Any doctor may notify the State health services of the cases of the abuse of plants, narcotic or psychotropic substances which he encounters in the course of his professional duties, when he believes that treatment or healthcare measures are justified in the interest of the patient, the members of his family or the community, for which he or she lacks the resources.

3 – In the cases provided for in the preceding paragraphs there shall be a guarantee of confidentiality, the doctors, technical staff and other health workers who care for the consumer being subject to the duty of professional secrecy, and such persons shall not be obliged to testify in inquiries or judicial proceedings neither to provide information on the nature and evolution of the therapeutic process or on the identity of the consumer.

Article 4

Seizure and identification

1 – The police authorities shall identify the consumer and may also proceed to search him and seize the plants, substances or preparations referred to in article 1 which have been found in the possession of the consumer, which shall be forfeit to the State, drawing up the respective police report, which shall be forwarded to the relevant territorial commission.

2 - Whenever not possible to identify the consumer at the place and the moment of the occurrence, the police authorities may, if necessary, detain the consumer in order to ensure that he or she appears before the commission, in accordance with the legal rules on detention for the purpose of identification.

Article 5

Powers to process, apply and enforce

1 – Offences shall be processed and the respective penalties applied by a commission referred to as "commission for the dissuasion of drug addiction", especially created for this purpose, operating in the premises of the civil governments.

2 – The Governo Civil [1] shall have powers to enforce fines and alternative penalties.

3 – In districts with a greater concentration of proceedings, more than one commission may be created by order of the member of the Government responsible for coordinating drug and drug addiction policy.

4 – The Governo Civil and the IPDT (Portuguese Institute on Drug and Drug Addiction) shall provide the commissions with administrative support and technical support respectively.

5 – Expenses relating to the members of the commissions shall be borne by the IPDT.

Article 6

Central Register

The IPDT shall keep a central register of proceedings relating to the offences provided for in this law, which shall be kept in accordance with regulations issued by the Minister of Justice and the member of the Government responsible for the coordination of drugs and drug addiction policies.

Article 7

Composition and appointment of commissions

1 – The commissions provided for in paragraph 1 of article 5 shall comprise three persons, one of which shall serve as chairman, appointed by the member of the Government responsible for the coordination of drugs and drug addiction policies.

2 – One of the members of the commission shall be a legal expert appointed by the Ministry of Justice, and the Minister of Health and the member of the Government

1 The Governo Civil is the administrative structure that represents the government in the districts.

responsible for the coordination of the drugs and drug addiction policies shall appoint the other two, who shall be chosen from doctors, psychologists, sociologists, social services workers or others with appropriate professional expertise in the field of drug addiction, who in the course of their duties shall guard against any possible direct therapeutic interest or ethical conflict.

3 – The Minister of Justice and the member of the Government responsible for the coordination of drugs and drug addiction policies shall issue regulations on the organization of the commissions, on their proceedings and procedures, and the status of the members shall be established by joint order of the Minister of Finance, the Minister for the Reform of the State and Public Administration and the member of the Government responsible for the coordination of drugs and drug addiction policies.

4 – The members of the commission shall be subject to the duty of secrecy with regard to the personal data contained in proceedings, without prejudice of the legal rules on the protection of public health and the criminal proceedings, where applicable.

Article 8

Territorial jurisdiction

1 – Proceedings shall be brought before the commission of the residence area of the consumer, except in case of unknown address, in which case the proceedings shall be brought before the commission of the area in which the consumer was found.

2 – Appeals against penalties applied by the commissions shall be brought before the court with jurisdiction at the head office of the commission in question.

Article 9

Cooperation with other bodies

1 – In order to undergo treatment voluntarily accepted by the consumer, the latter may use the public health services or duly licensed private services.

2 – In order to comply with the provisions of this law, the commissions and the Governo Civil shall request the assistance, as the case may be, of the public health services, the social welfare services, the police authorities and the administrative authorities.

Article 10

Judgement as to the nature and circumstances of consumption

1 – The commission shall hear the consumer and gather the information needed in order to reach a judgement as to whether he or she is an addict or not, what substances were consumed, the circumstances in which he was consuming drugs when summoned, the place of consumption and his economic situation.

2 – The consumer may request that a therapist of his or her choice takes part in the proceedings, and the commission shall establish the rules for such participation.

3 – In order to formulate the judgement referred to in paragraph 1, the commission or the consumer may propose or request that appropriate medical examinations be conducted, including blood or urine tests or any other tests as may be deemed appropriate.

4 – If the commission does not base its definition of the nature of consumption on the findings of a medical examination with the characteristics set out in the preceding paragraph, the consumer may request such examination, and the findings shall be analysed with a view to a possible reconsideration of the initial judgement reached by the commission.

5 – The commission shall have the examination conducted by a duly licensed health service, the costs being borne by the consumer if he or she chooses a private service, and the tests shall be carried out within a period of no more than 30 days.

Article 11

Provisional suspension of proceedings

1 – The commission shall provisionally suspend proceedings whenever a consumer with no prior record of offences under this law is deemed to be a non-addicted consumer.

2 – The commission shall provisionally suspend proceedings whenever an addicted consumer with no prior record of previous proceedings for offences under this law agrees to undergo treatment.

3 – The commission may provisionally suspend proceedings if an addicted consumer with a prior record of previous proceedings for offences under this law agrees to undergo treatment.

4 – The decision to suspend proceedings may not be impugned.

Article 12

Submission to treatment

1 – If an addicted consumer agrees to undergo treatment, the commission shall notify the public or private health service chosen by the consumer, who shall be notified of the alternatives available.

2 – If the consumer opts for a private health service he or she shall bear the respective costs of treatment.

3 – The organization referred to in paragraph 1 shall notify the commission every three months of whether treatment is continuing or not.

Article 13

Duration and effects of suspension

1 – Proceedings may be suspended for up to two years, which may be extended by one additional year by means of a decision with due grounds by the commission.

2 – The commission shall file proceedings, which may not be reopened, if:

a) in the case of a non-addicted consumer, there is no repeated offence;

b) an addicted consumer undergoes treatment and does not interrupt it unduly.

3 – Other than as provided for in the preceding paragraph, the proceedings shall continue.

4 – The limit period for the expiry of proceedings shall not be counted whilst its suspension.

Article 14

Suspension of penalties applied in the event of voluntary treatment

1 – The commission may suspend a decision to apply a penalty if an addicted consumer agrees to undergo, voluntarily, treatment in a public or duly licensed private service.

2 – Penalties may be suspended for up to three years.

3 – If during the suspension period, for reasons attributable to him or her, the addict does not undergo or interrupts treatment, the suspension shall be revoked and the penalty corresponding to the offence applied.

4 – The commission shall declare proceedings closed if, on expiry of the suspension period, no reason has been found which could lead to revoking the suspension.

5 – Refusal to undergo treatment under the terms of article 11 and the continuation of proceeding under the terms of article 13 shall not prejudice the provisions of paragraph 1 of this article.

6 – The provisions of paragraph 2 of article 12 and of paragraph 4 of article 13 are correspondingly applicable.

Article 15

Penalties

1 – Non-addicted consumers may be sentenced to payment of a fine or, alternatively, to a non-pecuniary penalty.

2 – Non-pecuniary penalties shall be applied to addicted consumers.

3 – The commission shall set the penalty in accordance with the need to prevent the consumption of narcotics and psychotropic substances.

4 – In applying penalties, the commission shall take into account the consumer's circumstances and the nature and circumstances of consumption, weighing up namely:

a) The seriousness of the act;
b) The degree of fault;
c) The type of plants, substances or preparations consumed;
d) The public or private nature of consumption;
e) In the case of public consumption, the place of consumption;
f) In the case of a non-addicted consumer, the occasional or habitual nature of his drug use;
g) The personal circumstances, namely economic and financial, of the consumer.

Article 16

Fines

1 – In the case of plants, substances or preparations contained in tables I-A, I-B, II-A, II-B and II-C, the fine shall be fixed between a lower limit of PTE 5.000$00 and an upper limit equivalent to the national minimum monthly wage.

2 – In the case of substances or preparations contained in tables I-C, III and IV, the fine shall be fixed between PTE 5.000$00 and PTE 30.000$00.

3 – The proceeds of fines shall be distributed as follows:

a) 60% to the State;

b) 20% to the SPTT (Drug Addiction Treatment and Prevention Service);

c) 10% to the Governo Civil;

d) 10% to the IPDT.

Article 17

Other penalties

1 – Instead of a fine, the commission may issue a warning.

2 – Without prejudice to the provisions of paragraph 2 of article 15, the commission may apply the following penalties, as an alternative measure to a fine or as the main penalty:

a) Banning from the exercise of a profession or occupation, namely those subject to licensing requirements, when such exercise jeopardises the well being of the consumer or third parties;

b) Banning from certain places;

c) Prohibiting the consumer from accompanying, housing or receiving certain persons;

d) Forbidding the consumer to travel abroad without permission;

e) Presenting himself periodically at a place to be indicated by the commission;

f) Disenfranchisement, removing the right to be granted or to renew a fire arms license for defence, hunting, precision shooting or recreation;

g) Seizure of objects belonging to the consumer which represent a risk to him or her or to the community or which encourage the committing of a crime or other offence;

h) Privation from the right to manage the subsidy or benefit attributed on a personal basis by public bodies or services, which shall be managed by the organization

managing the proceedings or monitoring the treatment process, when agreed to by the consumer.

3 – As an alternative to the penalties provided for in the preceding paragraphs, the commission may, if the consumer so agrees, instruct the consumer to make a financial donation to a public or private charitable organization or to provide community service free of charge, in accordance with the rules established in paragraphs 3 and 4 of article 58 of the Criminal Code.

4 – The commission may suspend enforcement of any of the penalties

provided for in the preceding paragraphs, replacing them by performance of certain duties, under the terms of article 19.

Article 18

Warnings

1 – The commission may issue a warning if, in view of the personal circumstances of the consumer, the type of consumption and the type of plants, substances or preparations consumed, it considers that the consumer will abstain from future consumption.

2 – The warning shall consist of an oral reprimand, with the consumer being expressly warned of the consequences of his behaviour and urged to abstain from consumption.

3 – The commission shall deliver the warning when the decision to apply it becomes definitive.

4 – The commission shall deliver an immediate warning if the consumer declares that he waives the right to bring an appeal.

Article 19

Suspension of enforcement of penalty

1 – In the case of an addicted consumer for whom there is no feasible treatment, or who refuses to accept treatment, the commission may suspend enforcement of the penalty, requiring the consumer to present himself or herself periodically at medical services, with the frequency deemed necessary by such services, with a view to improving his

health conditions, and suspension of enforcement may also be made conditional on the acceptance by the consumer of the measures provided for in paragraph 3.

2 – In the case of a non-addicted consumer, the commission may opt to suspend the penalty if, in the light of the personal circumstances of the consumer, the type of consumption and the type of plants, substances or preparations consumed, it concludes that this is the most appropriate form of achieving the aim of preventing consumption should the consumer agree to the conditions proposed by the commission under the terms of the following paragraphs.

3 – The commission may propose other follow-up solutions which may be particularly advisable in view of the specific nature of each case, in such a way as to ensure respect for the dignity of the individual and with the acceptance of the latter, such measures being chosen from those provided for in subparagraphs a) to d) of paragraph 2 of article 17.

4 – The rules governing periodic attendance as provided for in paragraph 1 shall be issued by the Minister of Health.

Article 20

Duration of suspension of enforcement of penalty

1 – Suspension shall have a duration of between one and three years as from the date on which a decision becomes final, not counting the time for which the consumer may be deprived of liberty due to coercive procedural measures, prison sentence or security measure.

2 – The commission shall determine the duration of the measures provided for in paragraph 3 of the preceding article, never exceeding an upper limit of six months.

Article 21

Periodic attendance

1 – In the case of suspension of the enforcement of the sentence with periodic attendance at health services, the commission shall notify the health centre of the consumer's area of residence or any other health service which may be agreed with him.

2 – The services referred to in the preceding paragraph shall notify the commission of the consumer's regular attendance or, when applicable, of his failure to attend, indicating any reasons of which it may be aware.

Article 22

Notification of measures

1 – The services and authorities whose cooperation is requested for the purpose of monitoring compliance with measures shall be notified of the decision to suspend enforcement of penalties.

2 – The services and authorities referred to in the preceding paragraph shall notify the commission of any failure to comply with measures, for the purposes of the provisions of paragraphs 2 and 3 of the following article.

Article 23

Effects of suspension

1 – The commission shall declare a penalty to have been set aside if, on expiry of the suspension period, there exist no reasons which would lead to revoking such suspension.

2 – Suspension of enforcement of penalty shall be revoked whenever, whilst such suspension is in effect, the consumer repeatedly fails to comply with the measures imposed.

3 – If suspension is revoked, the penalty applied shall be enforced.

Article 24

Duration of penalties

The penalties provided for in paragraph 2 of article 17 and the follow-up measures provided for in article 19 shall have a minimum duration of one month and a maximum duration of three years.

Article 25

Compliance with penalties and follow-up measures

The Governo Civil shall be notified of the decision to apply penalties or follow-up measures, and shall notify the services and authorities whose cooperation is required for the enforcement of such measures.

Article 26

Subsidiary law

In the absence of specific provisions herein, the general rules on administrative offences shall apply.

Article 27

Application in the Autonomous Regions

In the Autonomous Regions, the geographical distribution and composition of the commission, the powers to appoint their members, the definition of the services taking part in proceedings and the distribution of the proceeds of fines shall be established by regional legislative decree.

Article 28

Repeal

Article 40, save with regard to cultivation, and article 41 of Decree-Law no. 15/93, of 22 January, are hereby repealed, together with any other provisions which prove incompatible with the framework established herein.

Article 29

Entry into force

The decriminalisation approved herein shall enter into force throughout Portuguese territory on July 1, 2001, and all the regulatory, organizational, technical and financial measures needed in order to apply the treatment and follow-up framework herein provided for shall be adopted within 180 days from publication.

Approved on 19 October 2000. - The President of the Assembly of the Republic, António de Almeida Santos. - Promulgated on 14 November 2000. Publish. - The President of the Republic, Jorge Sampaio. -Countersigned on 16 November 2000. The Prime-Minister, António Manuel de Oliveira Guterres.

GOVERNO DE PORTUGAL
MINISTÉRIO DA SAÚDE

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

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Appendix E

Tables of controlled plants, substances and preparations(Articles 2 and 3 of Decree-Law No. 15/93)

TABLE I- A

Acetorphine - 3 - *0*- acetyltetrahydro- 7- ı - (1 - hydroxy - 1 - methylbutyl)- 6,14- *endo*etheno- oripavine.

Acetyl- *alpha* - methylfentanyl - *N*- [1 - (ı- methylphenethyl) - 4- piperidyl] - acetanilide.

Acetyldihydrocodeine - 3- methoxy- 4,5- epoxy- 6 - acetoxy - 17- methylmorphinan.

Acetylmethadol - 3- acetoxy- 6- dimethylamino- 4,4- diphenylheptane.

Alfentanil - *N*- [1 - [2- (4- ethyl- 4,5 - dihydro- 5- oxo- 1 *H*- tetrazol- 1 - yl)ethyl] - 4- (methoxymethyl)-4- piperidinyl]- *N*- phenylpropanamide monohydrochloride.

Allylprodine - 3- allyl- 1 - methyl- 4- phenyl- 4- propionoxypiperidine.

Alphacetylmethadol - *alpha*-3-acetoxy-6-dimethylamino-4,4-diphenylheptane.

Alphameprodine - *alpha*- 3 - ethyl- 1 - methyl- 4- phenyl- 4- propionoxypiperidine.

Alphamethadol - *alpha*- 6- dimethylamino- 4,4- diphenyl- 3- heptanol.

Alpha- methylfentanyl - *N*- [l(ı- methylphenethyl)-4-piperidyl]-propionanilide.

Alpha- methylthiofentanyl - *N*- [1 - [1 - methyl- 2- (2- thienyl)- ethyl] - 4- piperidyl]- propionanilide.

Alphaprodine - *alpha*- 1,3- dimethyl- 4- phenyl- 4- propionoxypiperidine.

Anileridine - 1- *para*-aminophenethyl-4-phenylpiperidine-4-carboxylic acid ethyl ester.

Benzethidine - 1 - (2- benzyloxyethyl)- 4- phenylpiperidine -4- carboxylic acid ethyl ester.

Benzylmorphine - 3- benzyloxy- 4,5- epoxy- *N*- methyl- 7- morphinen- 6- ol; 3- benzylmorphine.

Betacetylmethadol - *beta*- 3- acetoxy- 6- dimethylamino- 4,4- diphenylheptane.

Beta- hydroxyfentanyl - *N*- [1 - (*beta*- hydroxyphenethyl)- 4- piperidyl]propionanilide.

Beta - hydroxy- 3 - methylfentanyl - *N*- [1 - (*beta* - hydroxyphenethyl)- 3- methyl- 4- piperidyl] propionanilide.

Betameprodine - *beta* - 3- ethyl- 1 - methyl- 4- phenyl- 4- propionoxypiperidine.

Betamethadol - *beta* - 6 - dimethylamino- 4,4- diphenyl- 3- heptanol.

Betaprodine - *beta*- 1,3- dimethyl- 4- phenyl- 4- propionoxypiperidine.

Bezitramide - 1 - (3 - cyano- 3,3- diphenylpropyl)-4- (2- oxo-3- propionyl- 1 - benzimidazolinyl)- piperidine.

Clonitazene - 2- *para*-chlorbenzyl-1-diethylaminoethyl-5-nitrobenzimidazole.

Codeine - 3- methoxy - 4,5- epoxy- 6- hydroxy- 17- methyl- 7- morphinene; 3- methylmorphine.

Codeine *N*-oxide - 3-methoxy-4,5-epoxy-6-hydroxy-17-methyl-7-morphinene-17-oxy-ol. Codoxime - dihydrocodeinone-6- carboxymethyloxime.

Concentrate of poppy straw - the material arising when poppy straw has entered into a process for the concentration of its alkaloids, when such material is made available in trade.

Desomorphine - 3- hydroxy-4,5- epoxy-17- methylmorphinan; dihydrodeoxymorphine.

Dextromoramide - (+)- 4- [2- methyl- 4- oxo- 3,3 - diphenyl- 4- (1 - pyrrolidinyl)butyl] - morpholine.

Dextropropoxyphene - ı - (+)- 4- dimethylamino- 1,2- diphenyl- 3- methyl- 2- butanolpropionate.

Diampromide - *N*-[2-(methylphenethylamino)-propyl]propionanilide.

Diethylthiambutene - 3- diethylamino- 1,1- di- (2'- thienyl)- 1- butene.

Difenoxin - I- (3- cyano- 3,3- diphenylpropyl)- 4- phenylisonipecotic acid.

Dihydrocodeine - 6- hydroxy- 3- methoxy- 17- methyl- 4,5- epoxymorphinan.

Dihydromorphine - 3,6- dihydroxy- 4,5 -epoxy- 17- methylmorphinan.

Dimenoxadol - 2- dimethylaminoethyl- 1- ethoxy- 1,1 - diphenylacetate.

Dimepheptanol - 6- dimethylamino- 4,4- diphenyl-3- heptanol.

Dimethylthiambutene - 3- dimethylamino- 1,I- di- (2'- thienyl)- I- butene.

Dioxaphetyl butyrate - ethyl-4-morpholino-2,2-diphenylbutyrate.

Diphenoxylate - I- (3- cyano- 3,3- diphenylpropyl)- 4- phenylpiperidine- 4- carboxylic acid ethyl ester.

Dipipanone - 4,4- diphenyl- 6- piperidine- 3- heptanone.

Drotebanol - 3,4- dimethoxy- 17- methylmorphinan-6- [_,14- diol.

Ethylmethylthiambutene - 3- ethylmethylamino- 1,1- di- (2'- thienyl)- 1- butene.

Ethylmorphine - 3 - ethoxy- 4,5- epoxy- 6- hydroxy- 17- methyl- 7- morphinene; 3- ethylmorphine.

Etonitazene- 1-diethylaminoethyl- 2- *para*-ethoxybenzyl- 5- nitrobenzimidazole.

Etorphine - tetrahydro-7-,ı-(1-hydroxy-1-methylbutyl)-6,14- *endo*etheno-oripavine.

Etoxeridine - 1 - [2 - (2- hydroxyethoxy)-ethyl] -4- phenylpiperidine - 4- carboxylic acid ethyl ester.

Fentanyl - I - phenethyl - 4 - *N*- propionylanilinopiperidine.

Furethidine - 1 - (2- tetrahydrofurfuryloxyethyl)- 4- phenylpiperidine- 4- carboxylic acid ethyl ester.

Heroin - 3,6 - diacetoxy -4,5 - epoxy - 17 - methyl- 7 - morphinene; diacetylmorphine.

Hydrocodone - 3 - methoxy - 4,5 - epoxy - 6 - oxo- 17 - methylmorphine; dihydrocodeinone.

Hydromorphinol - 3,6,14- trihydroxy- 4,5- epoxy- 17- methylmorphinan; 14- hydroxy-dihydromorphine.

Hydromorphone - 3 - hydroxy - 4,5 - epoxy- 6 - oxo- 17 - methylmorphinan; dihydromorphinone.

Hydroxypethidine - 4- *meta*- hydroxyphenyl - 1 - methylpiperidine- 4- carboxylic acid ethyl ester.

Isomethadone - 6- dimethylamino- 5- methyl- 4,4- diphenyl- 3- hexanone.

Ketobemidone - 4- *meta*- hydroxyphenyl- 1 - methyl- 4- propionylpiperidine.

Levomethorphan - (-) - 3- methoxy - *N* - methylmorphinan[*] .

Levomoramide - (-) - 4- [2- methyl- 4- oxo- 3,3 - diphenyl- 4- (1 - pyrrolidinyl)butyl] - morpholine.

Levophenacylmorphan - (-)- 3- hydroxy- *N* - phenacylmorphinan.

Levorphanol - (-)- 3- hydroxy- *N*- methylmorphinan[*] .

Metazocine - 2'- hydroxy- 2,5,9- trimethyl- 6,7- benzomorphan.

Methadone - 6- dimethylamino- 4,4- diphenyl- 3- heptanone.

Methadone intermediate - 4- cyano- 2- dimethylamino- 4,4- diphenylbutane.

Methyldesorphine - 6- methyl- *delta*- 6- deoxymorphine; 3- hydroxy- 4,5- epoxy- 6,17- dimethyl-6-morphinene.

Meth yldihydromorphine - 6 - methyidihydromorphine; 3,6 - dihydroxy- 4,5 - epoxy - 6,17-dimethylmorphinan.

3 - methylfentanyl - *N*- (3- methyl- 1 - phenethyl- 4- piperidyl)propionanilide (and its *cis* and *trans* isomers).

Metopon - 5-methyldihydromorphinone; 3-hydroxy-4,5-epoxy-6-oxo-5,17-dimethylmorphinan.

Moramide intermediate - 2- methyl- 3 - morpholino- 1,1 - diphenylpropane carboxylic acid.

Morpheridine - 1 - (2 - morpholinoethyl) -4- phenylpiperidine-4- carboxylic acid ethyl ester.

Morphine - 3,6- dihydroxy- 4,5 - epoxy- 17- methyl- 7- morphinene.

Morphine methylbromide and other pentavalent nitrogen morphine derivatives.

Morphine - *N*- oxide - 3,6 - dihydroxy - 4,5 - epoxy - 17 - methyl- 7 - morphinene - *N*- oxide.

MPPP - 1 - methyl - 4 - phenyl- 4 - piperidinol propionate.

Myrophine - myristylbenzylmorphine; 3- benzyloxy- 4,5- epoxy- 17- methyl- 7- morphinene - 6- yl tetradecanoate.

Nicocodine - 3-piridinocarboxylic acid codeine ester; 6-nicotinylcodeine.

Nicodicodine - 3- piridinocarboxylic acid dihydrocodeine ester; 6- nicotinyl- dihydrocodeine.

Nicomorphine - 3,6-dinicotinylmorphine.

Noracymethadol - (1)- *alpha*-3-acetoxy-6-methylamino-4,4-diphenylheptane.

Norcodeine - 3- methoxy- 4,5- epoxy- 6- hydroxy- 7- morphinene; *N*- demethylcodeine.

Norlevorphanol - (-) - 3 - hydroxymorphinan.

* Dextromethorphan ((+)- 3 - methoxy - *N*- methylmorphinan) and dextrorphan((+) - 3- hydroxy- *N*-methylmorphinan) are specifically excluded from this table.

Normethadone - 6- dimethylamino-4,4- diphenyl- 3- hexanone.

Normorphine - 3,6- dihydroxy- 4,5- epoxy- 7- morphinene; demethylmorphine.

Norpipanone - 4,4- diphenyl- 6 - piperidino- 3 - hexanone.

Opium - the coagulated juice spontaneously generated by the seed pod of *Papaver somniferum L*. which has undergone only the operations necessary for its packaging and transport, regardless of its morphine content.

Opium - mixture of alkaloids in the form of hydrochlorides and bromides.

Oxycodone - 3- methoxy- 4,5- epoxy- 6- oxo- 14- hydroxy- 17- methylmorphinan; 14- hydroxy-dihydrocodeinone.

Oxymorphone - 3,14- dihydroxy- 4,5- epoxy-6- oxo- 17- methylmorphinan; 14- hydroxy-dihydromorphinone.

Para - fluorofentanyl - 4'-fluoro-N-(1-phenethyl-4-piperidyl)propionanilide.

PEPAP - 1 - phenethyl- 4- phenyl- 4 - piperidinol acetate.

Pethidine - 1 - methyl- 4- phenylpiperidine- 4- carboxylic acid ethyl ester.

Pethidine intermediate A - 4- cyano- 1- methyl- 4- phenylpiperidine.

Pethidine intermediate B - 4- phenylpiperidine-4- carboxylic acid ethyl ester.

Pethidine intermediate C - 1 - methyl- 4- phenylpiperidine- 4- carboxylic acid.

Phenadoxone - 6-morpholino-4,4-diphenyl-3-heptanone.

Phenampromide - *N*- (1 - methyl - 2- piperidinoethyl) - propionanilide.

Phenazocine - 2'- hydroxy- 5,9 - dimethyl- 2- phenethyl- 6,7 - benzomorphan.

Phenomorphan - 3- hydroxy- *N*- phenethylmorphinan.

Phenoperidine - 1- (3- hydroxy- 3- phenylpropyl)- 4- phenylpiperidine- 4- carboxylic acid ethyl ester.

Pholcodine - 3 - (2- morpholino- ethoxy)- 6- hydroxy- 4,5 - epoxy- 17- methyl- 7- morphinene; morpholinylethylmorphine.

Piminodine - 4 - phenyl- 1 - (3 - phenylaminopropyl) - piperidine - 4- carboxylic acid ethyl ester.

Piritramide - 1 - (3- cyano- 3,3- diphenylpropyl)- 4- (1- piperidino)- piperidine- 4- carboxylic acid amide.

Proheptazine - 1,3-dimethyl-4-phenyl-4-propionoxyazacycloheptane.

Properidine - 1 - methyl- 4- phenylpiperidine- 4- carboxylic acid isopropyl ester.

Propiram - *N*- (1 - methyl- 2- piperidinoethyl)-N- 2- pyridylpropionamide.

Racemethorphan - (1)- 3 - methoxy- *N*- methylmorphinan.

Racemoramide - (1)- 4 - [2 - methyl- 4-oxo- 3,3 - diphenyl- 4- (1 - pyrrolidinyl)- butyl]- morpholine.

Racemorphan - (1)- 3 - hydroxy - *N*- methylmorphinan.

Sufentanil - *N*- [4 - (methoxymethyl)- l - [2- (2- thienyl)ethyl] - 4- piperidyl] - propionanilide.

Thebacon - 3 - methoxy - 4,5 - epoxy- 6 - acetoxy - 17 - methylmorphinan; acetyldihydrocodeinone.

Thebaine - 3,6- dimethoxy- 4,5 - epoxy- 17- methyl- 6,8 - morphinadiene.

Thiofentanyl - *N*- [1- [2- (2- thienyl)ethyl]- 4- piperidyl] propionanilide.

Tilidine - (1)- ethyl- *trans*- 2- (dimethylamino)- 1 - phenyl- 3 - cyclohexene - 1 - carboxylate.

Trimeperidine - 1,2,5- trimethyl-4- phenyl-4- propionoxypiperidine.

The isomers, unless specifically excepted, of the drugs in this table whenever the existence of such isomers is possible within the specific chemical designation.

The esters and ethers, unless appearing in another table, of the drugs in this table whenever the existence of such esters or ethers is possible.

The salts of the drugs listed in this table, including the salts of esters, ethers and isomers as provided above, whenever the existence of such salts is possible.

TABLE I-B
Coca leaf - the leaves of *Erythroxylon coca* (Lamark), *Erythroxylon nova granatense* (Morris) Hieronymus and varieties thereof, the Erythroxylaceae family and their leaves, other species of this genus, from which it is possible to extract cocaine directly or to obtain it by chemical conversions; the leaves of the coca bush, with the exception of those from which all the ecgonine, cocaine and any other alkaloid that may be derived from ecgonine have been extracted.

Cocaine - (-)- 8 - methyl - 3- benzoyioxy- 8- aza- bicyclo- (1,2,3)- octane - 2- carboxylic acid methyl ester; methyl ester of benzoylecgonine.

Cocaine-D - dextro-isomer of cocaine.

Ecgonine - (-)- 3- hydroxy- 8 - methyl- 8 -aza- bicyclo- (1,2,3)-octane- 2- carboxylic acid, and its esters and derivatives which are convertible to ecgonine and cocaine.

The salts of the compounds listed in this table are deemed to be included in this table, whenever the existence of such salts is possible.

TABLE I-C
Cannabis - the leaves and flowering or fruiting tops of the plant *Cannabis sativa L*. from which the resin has not been extracted, by whatever name they may be designated.

Cannabis resin - separated resin, whether crude or purified, obtained from the cannabis plant.

Cannabis oil - separated oil, whether crude or purified, obtained from the cannabis plant.

The salts of the compounds listed in this table are deemed to be included in this table, whenever the existence of such salts is possible.

TABLE II-A
Bufotenine - 5 - hydroxy - *N*- *N*-dimethyltryptamine.

Cathinone - (-)-ı- aminopropiophenone.

DET - *N*- *N*-diethyltryptamine.

DMA - (1) - 2,5- dimethoxy- ı - methylphenethylamine.

DMHP - 3- (1,2- dimethylheptyl)- 1- hydroxy- 7,8,9,10- tetrahydro- 6,6,9- trimethyl- *6H*- dibenzo[*b*, *d*]pyran.

DMT - *N*- *N*-dimethyltryptamine.

DOB - 2,5- dimethoxy- 4- bromoamphetamine.

DOET - (1)- 4- ethyl- 2,5- dimethoxy-a - methylphenethylamine.

DOM, STP - 2- amino- 1- (2,5- dimethoxy- 4- methyl)phenylpropane.

DPT - dipropyltryptamine.

Eticyclidine, PCE - *N*- ethyl- 1- phenylcyclohexylamine.

Lysergide, LSD, LSD-25 - (1)- *N*, *N*-diethyllysergamide; dextro-lysergic acid diethylamide.

MDMA - 3,4-methylenedioxyamphetamine.

Mescaline - 3,4,5-trimethoxyphenethylamine.

4- methylaminorex - (1) - *cis* - 2- amino- 4- methyl- 5- phenyl- 2- oxazoline.

MMDA - (1)- 5- methoxy- 3,4- methylenedioxy- ı - methylphenylethylamine.

Parahexyl - 3- hexyl- 1 - hydroxy - 7,8,9,10- tetrahydro- 6,6,9- trimethyl- 6 *H*- dibenzo[*b*, *d*]pyran.

Phencyclidine, PCP - 1- (1- phenylcyclohexyl)piperidine.

PMA - 4- methoxy- ı - methylphenylethylamine.

Psilocybine - 3- (2- dimethylaminoethyl)indol- 4- yl dihydrogen phosphate.

Psilocine - 3- (2- dimethylaminoethyl)-4- hydroxyindole.

Rolicyclidine, PHP, PCPY - 1- (1-phenylcyciobexyl)pyrrolidine.

Tenamphetamine, MDA - (1)-3,4 *N*-methylenedioxy, ı-dimethylphenethylamine.

Tenocyclidine, TCP - 1- [1- (2- thienyl)cyclohexyl]piperidine.

TMA - (1)- 3,4,5 - trimethoxy- ı - metbylphenylethylamine.

The salts of the substances listed in this table, whenever the existence of such salts is possible.

TABLE II-B
Amphetamine - (1) - 2 - amino- 1 - phenylpropane.

Cathine - *d*- *threo*- 2- amino- 1- hydroxy- 1 - phenyipropane.

Dexamphetamine - (+) - 2 - amino- 1 - phenylpropane.

Fenetylline - (1)-3,7-dihydro-1,3-dimethyl-7-[2-[(1-methyl-2-phenylethyl)- amino]ethyl]-1 *H* - purine - 2,6 - dione.

Levamphetamine - (-)-2- amino- 1-phenylpropane.

Levomethamphetamine - (-)- *N*- *alpha*-dimethylphenethylamine.

Methamphetamine - (+)- 2- methylamino- 1 - phenylpropane.

Methamphetamine racemate - (1)- 2- methylamino- 1 - phenyipropane.

Methylphenidate - 2-phenyl-2-(2-piperidyl) acetic acid methyl ester.

Phendimetrazine - (+)- 3,4- dimethyl- 2- phenylmorpholine.

Phenmetrazine - 3- methyl- 2- phenylmorpholine.

Phentermine - ı - ı- dimethylphenethylamine.

Tetrahydrocannabinol - the following isomers: Δ 6a (10a), Δ 6a (7), Δ 7, Δ 8, Δ 9, Δ 10, Δ (11).

The derivatives and salts of the substances listed in this table, whenever the existence of such derivatives and salts is possible, as well as all preparations in which these substances are associated with other compounds, regardless of their action.

TABLE II- C

Amobarbital - 5-ethyl-5- (3-methylbutyl) barbituric acid.

Buprenorphine - 21 - cyclopropyl- 7- *alpha*- [(*S*)- 1- hydroxy- 1,2,2- trimethylpropyl] - 6,14- *endo*- ethano- 6,7,8,14- tetrahydrooripavine.

Butalbital - 5 - allyl- 5 - isobutyibarbituric acid.

Cyclobarbital - 5- (1 - cyclohexen- 1- yl)- 5- ethylbarbituric acid.

Glutethimide - 2- ethyl- 2- phenylglutarimide.

Mecloqualone - 3-(*O*-chlorophenyl)-2-methyl-4(3 *H*)-quinazolinone.

Methaqualone - 2- methyl- 3- *O*- tolyl- 4(3 *H*)- quinazolinone.

Pentazocine - 1,2,3,4,5,6 - hexahydro- 6,11 - dimethyl-3- (3- methyl- 2- butenyl)- 2,6 - methano- 3- benzazocin-8- ol.

Pentobarbital - 5- ethyl- 5- (1 - methylbutyl) barbituric acid.

Secobarbital - 5 - allyl- 5 - (1 - methylbutyl) barbituric acid.

The salts of the substances listed in this table, whenever the existence of such salts is possible.

TABLE III

1. Preparations whose quantitative composition, notwithstanding the fact that they are derived from narcotic drugs, presents no serious risk of use or abuse.

2. Preparations of acetyldihydrocodeine, codeine, dihydrocodeine, ethylmorphine, pholcodine, nicocodine, nicodicodine and norcodeine, when compounded with one or more other ingredients and containing not more than 100 milligrams of the drug per dosage unit, with a concentration of not more than 2.5 per cent in undivided preparations.

3. Preparations of cocaine containing not more than 0.1 per cent of cocaine, calculated as cocaine base, and preparations of opium or morphine containing not more than 0.2 per cent of morphine, calculated as anhydrous morphine base, and compounded with one or more other ingredients, whether active or inert, and in such a way that the drug cannot be recovered by readily applicable means or in a yield which would constitute a risk to public health.

4. Preparations of difenoxin containing, per dosage unit, not more than 0.5 milligram of difenoxin, calculated as base, and a quantity of atropine sulphate equivalent to at least 5 per cent of the dose of difenoxin.

5. Preparations of diphenoxylate containing, per dosage unit, not more than 2.5 milligrams of diphenoxylate, calculated as base, and a quantity of atropine sulphate equivalent to at least 1 per cent of the diphenoxylate.

6. *Pulvis ipecacuanhae et opii compositus*: 10 per cent opium in powder; 10 per cent ipecacuanha root, in powder; 80 per cent of any other inert powdered ingredient containing no controlled drug.

7. Preparations of propiram containing not more than 100 milligrams of propiram per dosage unit and compounded with at least the same amount of methylcellulose.

8. Preparations for oral use containing not more than 135 milligrams of salts of dextropropoxyphene base per dosage unit, or with a concentration of not more than 2.5 per cent in undivided preparations, provided that such preparations contain no substance controlled under the 1971 Convention on Psychotropic Substances.

9. Preparations conforming to any of the formulations listed in this table and mixtures of the same preparations with any ingredient that is not a controlled drug.

TABLE IV

Allobarbital - 5,5- diallylbarbituric acid.

Alprazolam - 8- chloro- 1 - methyl- 6- phenyl- 4 *H*- *s*- triazolo[4,3- a] [1,4]benzodiazepine.

Amfepramone - 2-(diethylamino)propiophenone.

Barbital - 5,5- diethylbarbituric acid.

Benzphetamine - *N*- benzyl- *N*,ı - dimethylphenethylamine,

Bromazepam - 7 - bromo- 1,3 - dihydro- 5 - (2 - pyridyl) - 2 *H*- 1,4 - benzodiazepin - 2 -one.

Butobarbital - 5 - butyl- 5 - ethylbarbituric acid.

Camazepam - 7 - chloro- 1,3 - dihydro- 3- hydroxy- 1 - methyl- 5 - phenyl- 2 *H*- 1,4- benzodiazepin-2- one dimethylcarbamate (ester).

Chlordesmethyldiazepam - 7- chloro- 5 - (2- chlorophenyl) - 1,3 - dihydro- 2 *H*- 1,4- benzodiazepin-2- one.

Chlordiazepoxide - 7-chloro-2-(methylamino)-5-phenyl-3 *H*-1,4-benzodiazepin-4-oxide.

Clobazam - 7- chloro- 1 - methyl- 5- phenyl- 1 *H*- 1,5- benzodiazepine- 2,4(3 *H*,5 *H*)- dione.

Clobenzorex - (+)- *N*-(*o*-chlorobenzyl)- ı-methyiphenethylamine.

Clonazepam - 5 - (*o*- chlorophenyl)- 1,3 - dihydro- 7- nitro- 2 *H*- 1,4- benzodiazepin- 2- one.

Clorazepate - 7- chloro- 2,3 - dihydro- 2 - oxo- 5- phenyl- 1 *H*- 1,4- benzodiazepine - 3- carboxylic acid.

Clotiazepam - 5 - (*o*- chlorophenyl) - 7- ethyl- 1,3 - dihydro- 1 - methyl- 2 *H*- thieno- [2,3 - *e*] -1,4 - diazepin - 2 - one.

Cloxazolam - 10 - chloro-11b-(*o*-chlorophenyl)-2,3,7,11b-tetrahydrooxazolo-[3,2- *d*][1,4]-benzodiazepin-6(5 *H*)-one.

Delorazepam - 7- chloro- 5 - (2-chlorophenyl)- 1,3- dihydro- 2 *H*- 1,4- benzodiazepin- 2- one.

Diazepam - 7 - chloro- 1,3 - dihydro- 1 - methyl- 5 - phenyl- 2 *H*- 1,4- benzodiazepin- 2 - one.

Estazolam - 8-chloro-6-phenyl-4 *H*- *s*-triazolo[4,3-a][1,4]benzodiazepine.

Ethchlorvynol - ethyl- 2- chlorovinylethynylcarbinol.

Ethinamate - 1-ethynylcyclohexanol carbamate.

Ethylamphetamine - *dl* - *N*-ethyl- ı -methylphenylethylamine.

Ethyl loflazepate - ethyl7- chloro- 5- (*o*- fluorophenyl)- 2,3- dihydro- 2- oxo- 1 *H*- 1,4-benzodiazepine -3- carboxylate.

Fencanfamin - (1) - *N*- ethyl- 3- phenylbicycio(2,2,1)- heptan- 2- amine.

Fenproporex - (1)-3-[(ı-methylphenethyl)amino]propionitrile.

Fludiazepam - 7 - chloro- 5 - (*o*- fluorophenyl)- 1,3 - dihydro- 1 - methyl- 2 *H*- 1,4- benzodiazepin-2- one.

Flunitrazepam - 5 - (*o* - fluorophenyl)- 1,3- dihydro- 1 - methyl- 7- nitro- 2 *H*- 1,4- benzodiazepin-2- one.

Flurazepam - 7- chloro- 1 - [2- (diethylamino)ethyl] - 5- (*o*- fluorophenyl)- 1,3- dihydro- 2H-1,4 - benzodiazepin - 2 - one.

Halazepam - 7 - chloro- 1,3- dihydro- 5 - phenyl- 1 - (2,2,2- trifluoroethyl)- 2 *H*- 1,4- benzodiazepin-2- one.

Haloxazolam - 10- bromo- 11b- (*o*- fluorophenyl)- 2,3,7,11b - tetrahydrooxazolo- [3,2- d] [1,4]-benzodiazepin-6(5 *H*)-one.

Ketazolam - 11 - chloro- 8,12b- dihydro- 2,8- dimethyl- 12b- phenyl- 4 *H*- [1,3]- oxazino- 3,2- d] [1,4]bezodiazapine-4,7(6 *H*)- dione.

Loprazolam - 6- (*o*- chlorophenyl)- 2,4- dihydro- 2- [(4- methyl- 1 - piperazinyl)- methylene] - 8-nitro-1 *H*-imidazo[1,2- *a*][1,4]benzodiazepin- 1-one.

Lorazepam - 7 - chloro - 5 - (*o*- chlorophen yl)- 1,3 - dihydro- 3 - hydroxy- 2 *H*- 1,4- benzodiazepin - 2- one.

Chlordesmethyldiazepam - 7- chioro- 5 - (2- chlorophen yl)- 1,3- dihydro- 2 *H*- 1,4- benzodiazepin-2-one.

Chlordiazepoxide - 7 - chloro- 2- (methylamino) - 5 - phenyl- 3 *H*- 1,4- benzodiazepin - 4 - oxide.

Clobazam - 7- chloro- 1- methyl-5- phenyl- 1 *H*- 1,5- benzodiazepine- 2,4(3 *H*,5 *H*)- dione.

Clobenzorex - (+)- *N*-(*o*-chlorobenzyl)-ı-methylphenethylamine.

Clonazepam - 5 - (*o*- chlorophenyl)- 1,3- dihydro- 7- nitro- 2 *H*- 1,4- benzodiazepin- 2- one.

Clorazepate - 7- chloro- 2,3 - dihydro-2-oxo- 5-phenyl-1 *H*-1,4-benzodiazepine-3-carboxylic acid.

Clotiazepam - 5 - (*o* - chlorophenyl) - 7- ethyl- 1,3- dihydro- 1 - methyl- 2 *H*- thieno- [2,3 - *e*] -1,4-diazepin- 2- one.

Cloxazolam - 10 - chloro- 11b- (*o*- chlorophen yl)- 2,3,7,11b- tetrahydrooxazolo-[3,2 - *d*] [1,4] - benzodiazepin - 6(5 *H*) - one.

Delorazepam - 7- chloro- 5 - (2- chlorophenyl) - 1,3 - dihydro - 2 *H*- 1,4 - benzodiazepin - 2 - one.

Diazepam - 7 - chloro- 1,3- dihydro- 1 - methyl- 5 - phenyl- 2 *H* - 1,4- benzodiazepin - 2 - one.

Estazolam - 8-chloro-6-phenyl-4 *H*- *s*-triazolo[4,3-a][1,4]benzodiazepine.

Ethchlorvynol - ethyl-2-chlorovinylethynylcarbinol.

Ethinamate - 1-ethynylcyclohexanol carbamate.

Ethylamphetamine - *dl*- *N*-ethyl- ı -methylphenylethylamine.

Ethyl loflazepate - ethyl7- chloro- 5 - (*o*- fluorophenyl)- 2,3 - dihydro- 2- oxo- 1 *H*-1,4- benzodiazepine-3- carboxylate.

Fencanfamin - (1)- *N*- ethyl- 3- phenylbicyclo(2,2,1)- heptan- 2- amine.

Fenproporex - (1)-3-[(ı-methylphenethyl)amino]propionitrile.

Fludiazepam - 7 - chloro- 5 - (*o*- fluorophenyl)- 1,3- dihydro- 1 - methyl- 2 *H*- 1,4- benzodiazepin- 2- one.

Flunitrazepam - 5 - (*o*- fluorophenyl)- 1,3- dihydro- 1 - methyl- 7- nitro- 2 *H*- 1,4 - benzodiazepin - 2- one.

Flurazepam - 7-chloro-l-[2-(diethylamino)ethyl]-5-(*o*-fluorophenyl)-1,3-dihydro-2H- 1,4- benzodiazepin- 2-one.

Halazepam - 7- chloro- 1,3- dihydro- 5 - phenyl- 1 - (2,2,2 - trifluoroethyl) - 2 *H*- 1,4 - benzodiazepin - 2 - one.

Haloxazolam - 10-bromo-11b-(*o*-fluorophenyl)-2,3,7,11b-tetrahydrooxazolo-[3,2- *d*] [1,4]- benzodiazepin-6(5 *H*)-one.

Ketazolam - 11 - chloro- 8,12b- dihydro- 2,8 - dimethyl- 12b- phenyl-4 *H*- [1,3] -oxazino- 3,2- d] [1,4]bezodiazapine-4,7(6 *H*)-dione.

Loprazolam - 6-(*o*-chlorophenyl)-2,4-dihydro-2-[(4-methyl-l-piperazinyl)-methylene]-8-nitro-1 *H*-imidazo[1,2- *a*][1,4]benzodiazepin- 1-one.

Lorazepam - 7 - chloro- 5 - (*o*- chlorophenyl) - 1,3- dihydro - 3 - hydroxy - 2 *H*- 1,4 - benzodiazepin - 2 - one.

Lormetazepam - 7- chloro- 5- (*o*- chlorophenyl)- 1,3- dihydro- 3- hydroxy - 1 - methyl- 2 *H*- 1,4- benzodiazepin- 2- one.

Mazindol - 5 - (*p*- chlorophenyl)- 2,5 - dihydro- 3 *H*- imidazo[2,1 -ı]isoindol- 5- ol.

Medazepam - 7 - chloro- 2,3- dihydro- 1 - methyl- 5- phenyl- 1 *H*- 1,4- benzodiazepine.

Mefenorex - (1)- *N*-(3-chloropropyl)- ı -methylphenethylamine.

Meprobamate - 2- methyl- 2- propyl- 1,3- propanediol dicarbamate.

Methylphenobarbital - 5 - ethyl- 1 - methyl- 5 - phenylbarbituric acid.

Methyprylon - 3,3- diethyl- 5- methyl- 2,4-piperidine- dione.

Midazolam - 8- chloro- 6- (*o*- fluorophenyl)- 1 - methyl- 4 *H*- imidazo[1,5 - ı][1,4] - benzodiazepine.

Nimetazepam - 1,3 - dihydro- 1 - methyl- 7- nitro- 5 - phenyl- 2 *H*- 1,4- benzodiazepin- 2-one.

Nitrazepam - 1,3- dihydro- 7- nitro- 5 - phenyl- 2 *H*- 1,4- benzodiazepin- 2- one.

Nordazepam - 7 - chloro- 1,3 - dihydro- 5- phenyl- 2 *H*- 1,4- benzodiazepin- 2- one.

Oxazepam - 7 - chloro- 1,3 - dihydro-3- hydroxy- 5 - phen yl- 2 *H*- 1,4-benzodiazepin - 2 - one.

Oxazolam - 10- chloro- 2,3,7, 11b- tetrahydro-2- methyl- 11b- phenyloxazolo[3,2- *d*] - [1,4]benzodiazepin-6(5 *H*)-one.

Pemoline - 2- amino- 5- phenyl- 2- oxazolin- 4- one (= 2- imino- 5- phenyl- 4- oxazolidinone).

Phenobarbital - 5 - ethyl- 5 - phenylbarbituric acid.

Pinazepam - 7- chloro- 1 ,3- dihydro- 5- phenyl- 1- (2- propynyl)- 2 *H*- 1,4- benzodiazepin- 2- one.

Pipradrol - 1,1 - diphenyl- 1 - (2 - piperidyl)- methanol.

Prazepam - 7 - chloro - 1 - (cyclopropylmethyl) - 1,3 - dihydro- 5 - phenyl- 2 *H*- 1,4- benzodiazepin - 2- one.

Propylhexedrine - (1)-l-cyclohexyl-2-methylaminopropane.

Pyrovalerone - (1)-l-(4-methylphenyl)-2-(l-pyrrolidinyl)-l-pentanone.

Ouazepam - 7- chloro- 5 - (2- fluorophenyl)- 1,3- dihydro- 1 - (2,2,2- trifluoroethyl)- 2 *H*- 1,4- benzo-diazepine- 2- thione.

Secbutabarbital - 5 - *sec*- butyl- 5 - ethylbarbituric acid.

SPA, Lefetamine - (-)- 1 - dimethylamino- 1,2- diphenylethane.

Temazepam - 7 - chloro- 1,3- dihydro- 3- hydroxy - 1 - methyl- 5- phenyl- 2 *H*- 1,4- benzodiazepin - 2-one.

Tetrazepam - 7 - chloro- 5 - (cyclohexen - 1 - yl)- 1,3 - dihydro- 1 - methyl- 2 *H*- 1,4- benzodiazepin- 2 - one.

Triazolam - 8-chloro-6-(*o*-chlorophenyl)-1-methyl-4 *H*- *s*-triazolo[4,3- ı][1,4]-benzodiazepine.

Vinylbital - 5 - (1- methylbutyl)- 5- vinylbarbituric acid.

The salts of the substances listed in this table, whenever the existence of such salts is possible.

TABLE V

Ephedrine.

Ergometrine.

Ergotamine.

Isosafrole.

Lysergic acid.

3,4-methylenedioxyphenyl-2-propanone.

N- acetylanthranilic acid.

1 - phenyl- 2 - propanone.

Piperonal.

Pseudoephedrine.

Safrole.

The salts of the substances listed in this table, whenever the existence of such salts is possible.

TABLE VI

Acetic anhydride.

Acetone.

Anthranilic acid.

Ethyl ether.

Hydrochloric acid.

Methylethyl ketone.

Phenylacetic acid.

Piperidine.

Potassium permanganate.

Sulphuric acid.

Toluene.

The salts of the substances listed in this table, whenever the existence of such salts is possible.

Secretariat-General, Office of the Chairman of the Council of Ministers, 20 February 1993. - *Franga Martins*, Secretary-General.

* Dextromethorphan ((+)- 3 - methoxy - *N*- methylmorphinan) and dextrorphan((+) - 3- hydroxy- *N*- methylmorphinan) are specifically excluded from this table.

Appendix F
LIST OF AGENCIES FROM WHICH LRB REQUESTED INFORMATION

Agency	Responed with some or all of requested data	Responded, but agency unable to provide data	Responded, but no follow up on data	Did not respond at all
State of Hawaii				
Judiciary	X			
Department of the Attorney General, Criminal Justice Division	X			
Department of the Attorney General, Hawaii Criminal Justice Data Center	X			
Department of Budget and Finance, Office of the Public Defender	X			
Department of Health, Alcohol and Drug Abuse Division	X			
Department of Human Services	X			
Department of the Public Safety, Corrections Division	X			
Department of the Public Safety, Narcotics Enforcement Division	X			
	X			
City & County of Honolulu	X			
Honolulu Police Department	X			
Department of the Prosecuting Attorney	X			X
Department of Community Services	X			X
	X			
County of Hawaii	X			
Hawaii (County) Police Department	X			
Office of the Prosecuting Attorney	X	X		
Department of Finance	X		X	
	X			
County of Kauai	X			
Kauai Police Department	X			
Department of the Prosecuting Attorney	X		X	
Department of Finance	X	X		
	X			
County of Maui	X			
Maui Police Department	X			
Department of the Prosecuting Attorney	X		X	

Agency	Responed with some or all of requested data	Responded, but agency unable to provide data	Responded, but no follow up on data	Did not respond at all
Department of Housing and Human Concerns	X			
	X			
Federal				
Drug Enforcement Administration				X
Hawaii High Intensity Drug Trafficking Area Investigative Support Center	X			

Appendix G

LIST OF ACRONYMS

ADAD	Alcohol and Drug Abuse Division of the State Department of Health
DEA	Drug Enforcement Administration
DHS	Department of Human Services
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
HAR	Hawaii Administrative Rules
HCJDC	Hawaii Criminal Justice Data Center
HCPD	Hawaii (County) Police Department
HIDTA	Hawaii High Intensity Drug Trafficking Area
HOPE	Hawaii's Opportunity Probation with Enforcement
HPD	Honolulu Police Department
IDT	Instituto de Droga e da Toxicodependência (the Institute for Drugs and Drug Addiction)
KPD	Kauai Police Department
SATMP	Statewide Substance Abuse Treatment Monitoring Program
MPD	Maui Police Department
NSDUH	National Survey on Drug Use and Health
N-SSATS: 2014	National Survey of Substance Abuse Treatment Services: 2014
PSD	Hawaii Department of Public Safety
SAMHSA	United States Substance Abuse and Mental Health Services Administration
SICAD	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (General Directorate for Intervention on Addictive Behaviours and Dependencies)
TEDS	Treatment Episode Data Set
THC	Delta-9-tetrahydrocannabinol, the psychoactive (mind-altering) chemical

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