Portugal's Post-Criminalization Policy Success

Portugal's move to decriminalize all low-level drug possession in 2001 was not simply a legal change but a comprehensive paradigm shift toward expanded access to prevention, treatment, harm reduction and social reintegration services.[169] The explicit aim of the policy shift was to adopt an approach to drugs based not on dogmatic moralism and prejudice but on science and evidence. The criminalization of drug use was deemed a barrier to more effective, health-centered responses and at odds with the principle that people who use drugs deserve to be treated with dignity and respect.[170]

Portugal's legal and policy changes altered the role of police officers, who now issue citations – but do not arrest – people found in possession of small amounts of illicit substances. Cited persons are ordered to appear at a "dissuasion commission," an administrative panel that operates outside of the criminal justice system. The panel, with two health practitioners and one legal practitioner, examines the individual's needs and circumstances, and determines whether to make referrals to treatment or other services, and/or to impose fines or other non-criminal penalties.

By decreasing the stigma around drug use, decriminalization allowed for the discussion of previously taboo issues and optimum policy responses, including whether to create supervised injection facilities and to introduce sterile syringe exchange programs in prisons.[171] Further, the administrative, community-based "dissuasion commissions" have provided earlier intervention for drug users, a broader range of responses, an increased emphasis on prevention for occasional users, and increased provision of treatment and harm reduction services.[172]

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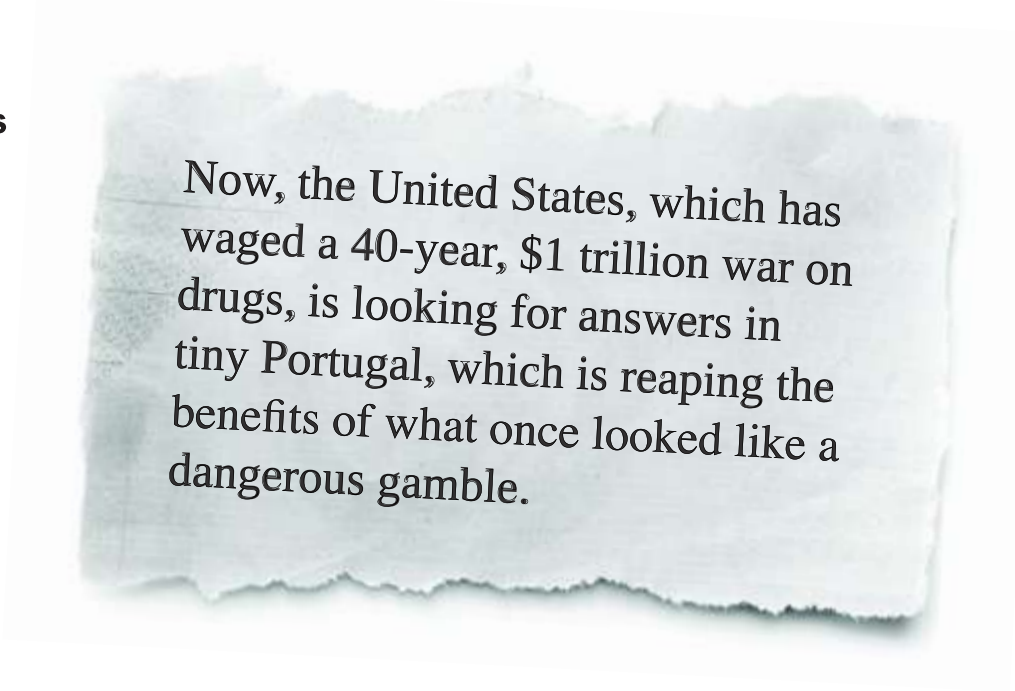
Portugal's drug policy pays off; US eyes lessons



A decade later, Portugal's paradigm change from a punitive approach to a health-centered one has proved enormously popular. It has not created a haven for "drug tourists" nor has it led to increased drug use rates, which continue to be among the lowest in the European Union.[173] Rather, fatal overdose from opiates has been cut nearly in half,[174] new HIV/AIDS infections in people who inject drugs fell by two-thirds,[175] the number of people in treatment increased[176] and the number of people on opioid maintenance treatments more than doubled.[177] Portugal's paradigm shift has facilitated better uptake of prevention, treatment, harm reduction and social reintegration services and, ultimately, a more realistic approach to drug use driven by experience and evidence.[178]

The failure of U.S. stopgap measures and the success of the Portuguese model challenge advocates and policymakers in the U.S. to focus on building the political will to work toward removing criminal penalties for drug use and implement instead a comprehensive and effective health-centered approach.

Recommendation: Invest in Public Health, Including Harm Reduction and Treatment

Public health interventions are wise, necessary long-term investments. They reduce the harms associated with drug use, prevent crimes against people and property, and cut associated costs. These approaches must not begin and end with abstinence-only programs. While treatments aimed at supporting people who desire to cease drug use must be made much more widely available, strategies to prevent overdose deaths and reduce the spread of communicable disease are also critical and must be expanded.

A 2006 analysis found that every dollar invested in drug treatment saves $7 due to increased employment earnings and reduced medical care, mental health services, social service supports, and crime.[179] A 1994 RAND study commissioned by the U.S. Army and the White House Office of National Drug Control Policy found treatment to be seven times more effective at reducing cocaine consumption than domestic law enforcement, ten times more effective than drug interdiction, and 23 times more effective than trying to eradicate drugs at their source.[180] A 1997 SAMHSA study found that treatment reduces drug selling by 78 percent, shoplifting by almost 82 percent, and assaults by 78 percent.[181]

Despite the health and fiscal benefits of drug treatment, too many people lack access to it. Federal health care legislation, signed by President Obama in 2010, takes a promising step forward by expanding eligibility for private and public insurance and by requiring all insurers to provide coverage for substance use and mental health service benefits on par with coverage for other chronic conditions. This parity requirement will help to reduce two significant barriers to treatment – cost and stigma – by promising to make treatment accessible through public and private health insurance and through more doctors' offices.

Significantly, under the new health care legislation, all nonelderly adults with income up to 133 percent of the federal poverty level will become eligible for Medicaid in 2014.[182] This will capture many currently uninsured people, including many in the criminal justice system. Medicaid eligibility will not translate into real access to treatment, however, unless states work to preserve, and then expand, their addiction treatment systems. As adults become able to access drug treatment through Medicaid, it will make even less sense to invest in resource-intensive drug courts that focus on people whose illegal activity is largely limited to drug use. These new dollars, too, must not be devoted solely to abstinence-only approaches, such as those mandated by drug courts, but to a wide range of services that focus on improving people's health.

Bringing drug treatment into the primary care setting is essential, but it is not enough. Programs designed for people who do not routinely access the mainstream health care system are also needed. For example, syringe exchange programs and safe injection facilities – which focus on empowering individuals to make healthier choices – have proven to be safe, effective opportunities for more marginalized people to engage help and services.[183]

Just as public health principles support the use of condoms, contraceptives, cigarette filters and seat belts to reduce health risks, drug policies must seek to reduce the harms and risks associated with drug use. As Portuguese policymakers learned, an overemphasis on abstinence can obstruct efforts to

Public health interventions are wise, necessary long-term investments. They reduce the harms associated with drug use, prevent crimes against people and property, and cut associated costs.

successfully mitigate drug-related harms.[184] Programs that focus on reducing drug-related harms and risks result in better individual and public health than criminal justice interventions – including drug courts – and, by any measure, deliver more bang for the buck. Failing to invest in such programs is expensive in terms of both lives and dollars.

Drug overdose is now the second leading cause of accidental death, trailing only motor vehicle fatalities.[185] According to the National Institute on Drug Abuse, injection drug use is responsible for one-third of adult and adolescent HIV/AIDS cases, while more than one-half of HIV/AIDS cases at birth are the result of a parent contracting HIV through injection drug use. Hepatitis B and C are prevalent in 65 percent and 75 percent, respectively, of people who have injected drugs for six years or less. People who use drugs, either intravenously or otherwise, are two to six times more likely than others to contract tuberculosis. The geographic distribution of syphilis and gonorrhea infections reflects the distribution of crack cocaine use.[186]

Overdose deaths and the spread of HIV/AIDS, hepatitis, tuberculosis, syphilis and gonorrhea are *largely preventable.* Good Samaritan policies, which encourage people to call for help in the case of a suspected drug overdose, may help reduce fatalities. Proven public health measures, such as syringe exchange programs, have consistently been shown to substantially reduce the rate of HIV/AIDS transmission among people who inject drugs without increasing injection drug use.[187] Facilities that allow supervised, on-site injection of drugs reduce vein damage, disease transmission[188] and fatal overdose[189] as well as public disorder, improper syringe disposal and public drug use.[190] Additionally, the provision of naloxone (an FDA-approved overdose antidote) to people who use opioids – either as prescription analgesics for pain (such as phentanyl, oxycodone, hydromorphone and methadone) or as a result of opioid dependence – can greatly reduce fatal overdose.[191]

Moreover, non-judgmental services such as syringe exchanges reach people turned off by or excluded from abstinence-only programs. In 2005, more than 85 percent of roughly 160 syringe exchange programs in the U.S. regularly made treatment referrals.[192] Many referrals were for people who do not inject drugs, illustrating that such programs deliver important health services for a larger community beyond their primary syringe-exchanging clients.[193] In 2009, the federal government removed a significant hurdle when it ended the ban on federal dollars going to life-saving syringe exchange programs. Much more is needed in the way of direct investment – and these costs could easily be covered by reduced investment in arrests and incarceration for drug law violations.

Similarly, many people struggling with drugs may benefit from a variety of support services before – or in lieu of – formal treatment services. It is well-documented that stable social and financial circumstances help prevent relapse both during and after treatment, regardless of whether a person is mandated to treatment by the courts.[194] Efforts to aid people with drug problems might therefore involve addressing other needs entirely, such as access to physical and mental health services, housing, employment or education.

Conclusion

There are several reasons why now is the time to rethink our drug policies, including drug courts. The hysteria of the 1980s drug war is now a distant memory, and states and the federal government are seeking cost-effective ways to achieve better results. The Obama Administration's commitment to a greater public health approach than its predecessors has already resulted in significant policy reform, with the inclusion of drug treatment in the 2010 health care laws. At the same time, the federal crack cocaine sentencing reform of 2010 illustrates that bipartisan consensus is possible on drug policy. Moreover, the evidence from abroad regarding the health and fiscal benefits of harm reduction strategies and non-punitive approaches has grown dramatically. And here at home, harm reduction programs once regarded as inconceivable in some parts of the U.S. are now standard. Finally, the criminalization-focused approach to drug policy, including drug courts, continues to fail to demonstrate its efficacy or cost-efficacy.

Let's be clear: drug court programs have saved lives. People correctly perceive them as having benefits. Drug court proponents deserve to take pride in their accomplishments. However, we all, including drug court supporters, have an obligation to step outside the drug court paradigm to consider other approaches that might work better and whether the particular modalities of the drug court are best directed at people other than those whose only offense is drug use or drug possession. This will not be easy. People have a vested interest in defending and promoting that which they have given so many years of their lives. Drug courts have developed substantial political rapport, which risks providing them immunity from honest, critical analyses.

Looking forward, however, we should strive toward a world where drug courts focus primarily on more serious offenses and where drug use absent harm to others is no longer regarded as a criminal justice matter.

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About the Drug Policy Alliance

The Drug Policy Alliance (DPA) is the nation's leading organization promoting alternatives to the drug war that are grounded in science, compassion, health and human rights. DPA serves as a national watchdog and global advocate for sane and responsible drug policies. It is headquartered in New York and has offices in California, Colorado, New Jersey, New Mexico and Washington, D.C.

DPA has built broad coalitions to reduce the role of criminalization in drug policy at the state and federal levels. DPA spearheaded the passage and implementation of Proposition 36, California's landmark treatment-not-incarceration law, approved by 61 percent of California voters in November 2000. Prop. 36 allows people convicted of a first and second low-level drug law violation the opportunity to receive drug treatment instead of incarceration. Since the law's passage, more than 300,000 people have been diverted from conventional sentencing to drug treatment, saving taxpayers more than $2.5 billion. For all the reasons outlined in this report, DPA remains committed not just to alternatives to incarceration but to ultimately removing criminal penalties for drug use absent harm to others and to expanding health-centered approaches to drug use.

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