THE PORTUGUESE MODEL FOR DECRIMINALIZING DRUG USE

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In 2001, Portugal decriminalized drug use and possession of small quantities of drugs for personal use. Instead of facing criminal charges, people are referred to a Commission for the Dissuasion of Drug Addiction, an administrative body composed of health, social, and legal experts which helps participants to address issues related to their drug use. This policy has not only kept people out of prison, it has also significantly reduced stigma, discrimination, and health harms.

Context and Description

In response to the increasing harms caused by the heroin epidemic in Portugal, the government approved Law 30/2000[2] that removed criminal sanctions for drug use and the illicit possession of small amounts of all drugs for personal use. Under the decriminalization regime which entered into force in 2001, drug use and possession remain illicit, but are now dealt with through an administrative process. A person stopped with less than 10 days' worth of drugs is referred to a Commission for the Dissuasion of Drug Addiction (*Comissão para a Dissuasão da Toxicodependência*) – an administrative body established in each of Portugal's regions and composed of three professionals including a legal expert, a social worker, and a doctor. Each Commission is supported by a technical team of health and social experts.

The decriminalization of drug use in Portugal was accompanied by significant investments in health and social programs, including drug dependence treatment and harm reduction services. The legal basis for this harm reduction approach was crystalized in Decree-Law 183/2001.[3]

People are usually referred to the Commissions when they are stopped by the police in possession of less than 10 doses of drugs. Individuals can also be sent to the Commissions by the courts when they are caught with more than the maximum amount of drugs allowed if the prosecutor or the judge decide that these drugs were destined for personal use and not for intent to supply.

Each person referred to the Dissuasion Commissions undergoes an interview during which the Commission asks the participant a series of questions to understand his/her circumstances (drug use, family situation, employment, any history of psychological or health problems, etc.), establish a relationship of trust, and try to identify the best possible response to help the person. In many cases, a Commission

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hearing may be the first time a person is discussing his/her drug use or receives information on the various services available in their city or region.[4] As such, the Dissuasion Commissions are considered as a critical mechanism to inform people about drug use, drug dependence, and the possible harms users may face, but also to refer them to the health and social services they may need. Although the Commissions can impose administrative penalties, the overall objective is to help people to overcome and address their health and social problems–not to punish them.[5]

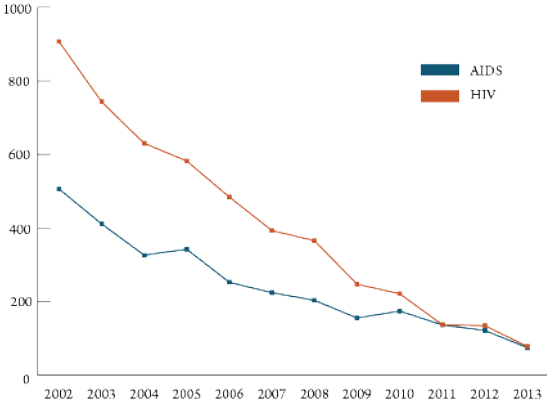
The approach adopted by the Commissions is incremental. If a person appears before the Commission for the first time and they are not dependent on drugs,[6] the work of the Commission is mostly informative and preventive. The Commission will offer information about the health effects of drug use, the law, etc. and advise the person on available services to prevent harm and help ensure that the person's consumption does not become problematic. If the person is dependent on drugs, the main objective is to encourage him/her to enter treatment or to resume a treatment program that has been interrupted – and as such regain control over their drug use, access opioid substitution therapy (OST), or stop using drugs altogether. Treatment is never coercive and is generally free of charge for the patient.[7] A person who fails to enter or remain in treatment will not receive any criminal sanction or citation.

The rate of people appearing before the Commissions more than once is very low, at a rate of 4-6%. In case an individual does appear more than once, the Commissions have the obligation to impose an administrative sanction. This can include periodic attendance requirements to health centers or hospitals for check-ups, social services, job centres or the police station, or community work (if the person does not have a job). More rarely, the Commissions can also impose bans on leaving the country without authorization, on undertaking certain jobs where health and safety would be at risk, from frequenting certain locations, and revocation of licenses. Fines are rare, and if applied, the Commissions usually impose the minimum amount of 25 Euros. The objective is to ensure that sanctions do not end up being counterproductive and create more harm to the person's life.[8] Most cases referred to the court do not involve any sanction at all (Figure 2).[9]

Results and Impact

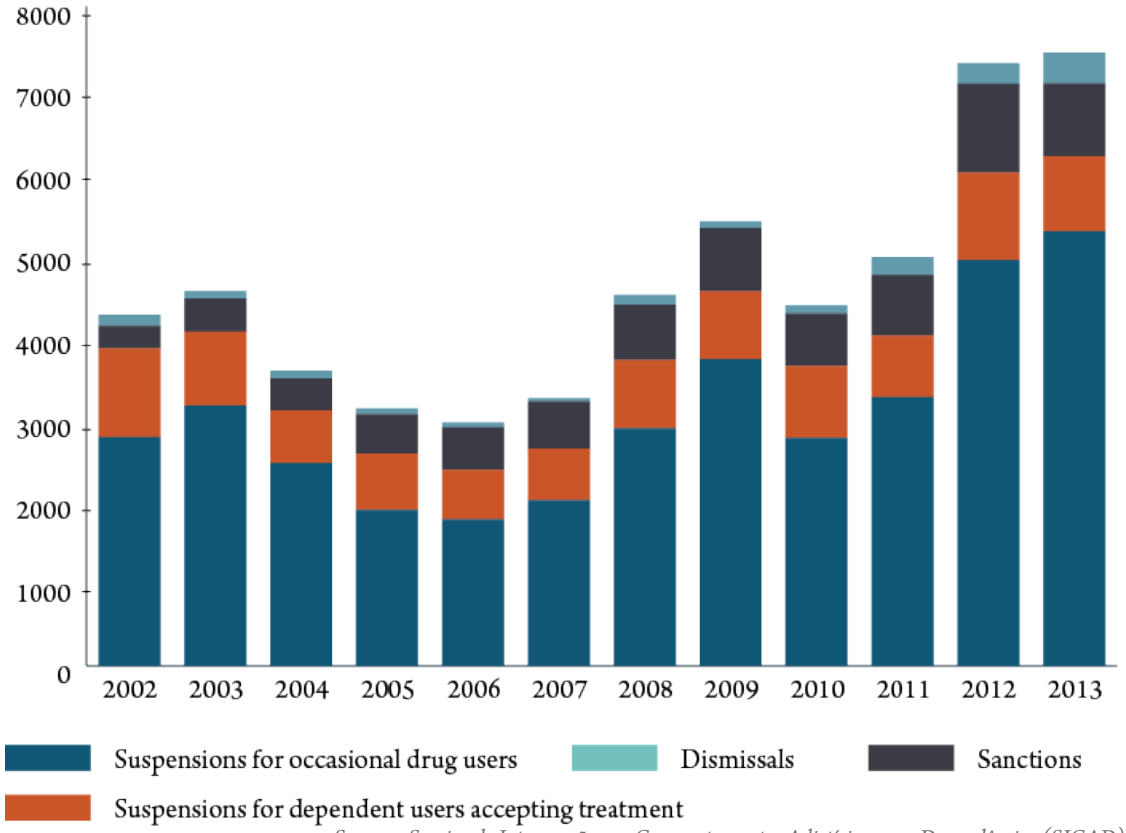
Portugal's decriminalization model did not result in overall increases in levels of drug use. Following decriminalization, the number of people who use drugs diagnosed with HIV significantly decreased from 907 new cases in 2000 to only 79 in 2012[10, 11] (Figure 1). Similar trends were observed for new cases of Hepatitis B and C,[12,13] and Portugal has one of the lowest prevalence of overdose deaths in the European Union.[14] Finally, the number of people receiving voluntary drug treatment increased by 60% between 1998 and 2008.[15]

Figure 1. HIV/AIDS Diagnoses in Portugal Among People Who Use Drugs, 2002-2013



Source: *Serviço de Intervenção nos Comportamentos Aditícios e nas Dependências (SICAD)*

Figure 2. Commission Decision Outcomes, 2002-2013



Source: *Serviço de Intervenção nos Comportamentos Adictícios e nas Dependências (SICAD)*

As for criminal justice, decriminalization led to a reduction in prison overcrowding – with the proportion of drug offenders in prison dropping from 44% in 1999 to 19.6% in 2013.[16] The policy also enabled law enforcement authorities to target violent, high-level traffickers and organized crime groups, instead of focusing on users and low-level dealers.[17]

The gender component of the approach, however, has been disappointing. Although most people who use drugs in Portugal are men, women who use drugs face very high levels of violence, stigma, and discrimination in accessing services, and available services are generally unable to address their needs. The rare gender-tailored services that currently exist mostly focus on pregnant women (for example, the treatment program "PIAM" – *Projecto Integrado de Atendimento Materno*). Available data suggests that the number of women sent to the Dissuasion Commissions has been increasing every year since the decriminalisation model was established. In Porto, for example, the number of women increased from 3% to 8% between 2014 and 2015 alone. The lack of available gender-sensitive services means that women continue to be oriented by the Commissions towards services that are not tailored to their needs.[18] Women who use drugs and who also engage in sex work are particularly vulnerable. When they come to harm reduction centers, they usually come face to face with a majority of men, some of whom are clients of their sex work – this can result in unpleasant, uncomfortable, and unsafe situations, exacerbating conditions of invisibility and violence.

Some efforts have been made to recruit

female peer workers in order to encourage women to access harm reduction and treatment services.[19] Nevertheless, much more remains to be done to ensure that the services available for people who use drugs are tailored to women and are provided in a non-judgemental, non-discriminatory manner.[20] For instance, specific harm reduction and treatment services should exclusively target women, or those already available should have opening hours for women only, and should include childcare for women with children, incorporate sexual and reproductive health interventions, and provide social support for women and mothers.[21]

Outreach testing: "European HIV Testing Week" in Mouraria Harm Reduction Centre, Lisbon, Portugal. Source: Pedro A. Pina

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Endnotes

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5. *Ibid.*
6. According to the United Nations Office on Drugs and Crime, only about 1 in 10 people who use drugs may experience drug dependence or problems associated with their use.
7. Treatment often consists of appointments with a psychologist or social worker in a public treatment center, where costs are covered by the Regional Health Authorities within the Ministry of Health. People

undergoing OST in a public clinic or an NGO can also access treatment free of charge. Low-threshold OST services can also be provided by NGOs supported by health authorities. Treatment with buprenorphine, however, is not entirely covered by the state and the patient will therefore need to cover part of the costs associated with the treatment. More rarely, patients can undergo treatment in private clinics, or private therapeutic communities; in that case, the Regional Health Authorities can cover up to 80% of the costs, the rest being covered by the patient, their family or social services. Finally, the patient may choose to enter an inpatient treatment by his or her own means in a center that has not been pre-agreed by the Dissuasion Commission; in that case, the patient or their family will cover the full costs of treatment.

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19. Pompidou Group & Council of Europe, *Seminar on Women, Drugs and Violence in Europe and the Mediterranean Region*, Rome, December 10-11, 2015.

20. Transgender people who use drugs face additional significant barriers in accessing harm reduction and treatment programs.

21. See: Ferreira, M. (2015), *Violence, Gender & Harm Reduction: Perspectives from a Peer Worker*, presentation at Seminar on Women, Drugs and Violence in Europe and the Mediterranean Region, Rome, December 10-11, 2015.

This series aims to share examples of innovative approaches that incorporate a gender perspective and the principles of public health and human rights into drug policy. Such innovations will have the best possible outcomes only when they are accompanied by more fundamental drug law and policy reform. However, in the absence of broader reforms, or carried out in conjunction with such reforms, these innovations can help break the vicious cycles of poverty, social exclusion, drug use, involvement in the drug trade, and incarceration that plague so many poor communities across the Americas today. Global Innovative Approaches is a tool that accompanies the publication Women, Drug Policies and Incarceration: A Guide for Policy Reform in Latin America and the Caribbean.