

# **GATEWAYS FROM CRIME TO HEALTH: THE PORTUGUESE DRUG COMMISSIONS**

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The logo for the Prison Reform Trust, featuring the text "PRISON REFORM TRUST" in white, stacked vertically, on a dark red rectangular background.

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## Executive summary

In Portugal, people who are found by the police with a defined amount of illicit substances are referred to the 'Commissions for the Dissuasion from Drug Abuse' (CDTs), civil bodies which operate under the Ministry of Health. These unique institutions provide information and advice and effectively function as gateways into a complex network of social, physical and psychological support.

My study has looked in detail at how such Commissions operate in practice, in the context of the Portuguese national strategy for dealing with substance mis-use in accordance with a public health model, rather than a criminal justice one. The Commissions are part of a web of integrated, locally based responses, working to achieve the strategy's key aims of dissuasion, prevention, treatment, harm reduction and reintegration. They work to provide:

- Information, advice and support to those who are not drug dependent, so as to prevent them from developing an addictive behaviour
- timely referrals to organisations that can offer appropriate interventions and ongoing support to those who are drug dependent (whether or not they are able to stay off drugs permanently).

It is important to bear in mind that although drug use, consumption and buying is decriminalised up to a certain daily amount in Portugal, it is NOT depenalised, i.e. it still incurs penalties, albeit of an administrative nature. The CDTs have the legal power to administer such penalties, but do so within the broader aim of dissuading from use and from behaviour that is harmful to health and social well being.

The report illustrates the findings of:

- in-depth interviews with CDTs staff and clients, practitioners and policy makers, medical experts and policy analysts
- process observation
- data mining and analysis.

These confirm that neither recorded substance use nor drug related offences have spiralled upwards since the introduction of the new system in 2001. Instead, having redirected resources from the criminal justice into preventative, treatment and reintegration work, Portugal has experienced positive outcomes, including:

- health improvements (e.g. steep declines in HIV incidence among injecting drug users)
- freeing up of police and court time
- fewer users in prison.

The stigma of having a criminal record for the possession of illicit substances is also avoided, as are its related problems (e.g. access to employment or housing).

Although direct correlations are difficult to demonstrate, the Portuguese experience shows that a number of areas provide reasonable expectations of good returns, in terms of both financial and social gains:

- public health
- recidivism
- public expenditure.

Such measurable indicators would constitute a sound base for engendering a measured public debate on 'drugs' use in other countries, including the UK.

The report therefore recommends that policy efforts be directed towards an integrated, health centred, long-term approach that takes ongoing stock of the scientific and social evidence available. To achieve this, policy makers should seriously consider working together to achieve a cross party consensus, from which to engage with the media and with the public.

## 1. INTRODUCTION

In 2014 I was lucky enough to be made a Fellow of the Winston Churchill Memorial Trust (WCMT). I had long been interested in ways to deal with social problems in a way that does not lead to the criminal justice system and to imprisonment. Thanks to the generous support of WCMT, in partnership with the Prison Reform Trust and the International Centre for Prison Studies, I was able to travel to Portugal to explore ways in which health policies can be used to reduce harm and social exclusion, prevent criminalisation and aid social integration.

### **Why this study – and why Portugal**

There has long been interest in the UK about alternative ways of dealing with illicit substances. Debates abound as to the effectiveness of the ‘war on drugs’ and punitive attitudes towards consumption. For instance the 2014 report by LSE’s Expert Group on the Economics of Drug Policy concluded, *inter alia*, that resources should be ‘drastically reallocated’ away from punitive enforcement and towards ‘proven public health’ approaches (p.14).

The aim of my study was to further understanding of ways in which drug related problems can be responded to in an effective and humane way, avoiding stigmatisation and marginalisation. Hence my interest in Portugal’s non-criminalising policies and in particular the country’s ‘dissuasion commissions’, a public health-based system of civil interventions which is unique not only in Europe but worldwide.

In 2001 Portugal de-penalised (it did *not* legalise) the personal use of all drugs, up to a stipulated limit. This approach eventually gained cross party and police support. As Brendan Hughes, senior scientific analyst at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) outlined to me, this sets Portugal apart from other countries (seven in Europe) where (at least some) drug use is treated as a non-criminal offence. There, if stopped by the police, users will still be dealt with representatives from the Ministry of Justice or the Interior: the consumption of illicit substances is still considered a security issue. ‘What makes the Portuguese drug policies unique’ is that use is treated as a health issue, addiction as a disease and addicts as people in need of care, in an integrated system of support under the aegis of the Ministry of Health’.

The EMCDDA (2011) has assessed the country’s drug policy as ‘internally consistent’ and ‘coherent’. As Hughes put it to me, Portugal ‘*changed the whole response system to reflect*’ its health based approach: it ‘put its money where its mouth is’.

### **What this study is (and is not) about**

The policies around drug use in Portugal have been the subject of much observation and comment, but they have concentrated on the decriminalisation of drug use introduced by the Law 30/2000 that was enacted in 2001. This change, however remarkable, is but one element in the national strategy for tackling substance abuses.

The strategy works as a whole, in a complex web of inter-related interventions, grouped in five strands:

- Prevention
- Dissuasion
- Treatment
- Harm reduction
- Reintegration.

The 'Commissions for the Dissuasion from Drug Abuse' (herein referred to as CDTs, the Portuguese acronym for *Comissões para a Dissuasão da Toxicodependência*) are the pivotal element in the Dissuasion strand of the national strategy. CDTs are the (symbolic and actual) **gateways from criminal justice into the health and civil administration systems**.

My study has sought to establish how such commissions operate, what kind of interventions they use and how they impact on the people who receive them.

Although I will inevitably touch upon decriminalisation, I shall not concentrate on arguments around it: these have already been well explored elsewhere, not least by WCMT Fellow Jessica Magson (2014). My report does not deal with supply issues.

## **Methodology**

During the time I spent in Portugal I visited two distinct areas, the metropolitan area of Lisbon and the more rural district of Aveiro, and undertook the following.

- a. Process observation of Lisbon and Aveiro CDTs and of some of the services that are part of their network of referral and support: Centres of Integrated Responses, Street Teams and mobile medical units. In particular, I conducted in-depth observation of the workings of the CDT of Aveiro: subject to ethical consents, I attended hearings and decision-making meetings.
- b. Extensive interviews with CDT staff, commission presidents and other panel members; with people attending CDT hearings on their experience and perceptions of the process and outcomes; with practitioners working for support services teams; with evaluators and with national policy makers.
- c. Examination and assessment of documentary evidence relating to the network of services and support of drug users (including policy documents, reports, evaluations) and collation and analysis of quantitative data (including CDTs outputs, imprisonment and drug use prevalence statistics and surveys).

The people I met with and the organisations I visited are listed in Appendix A.

## **A note of caution**

The terminology used in the area of illicit substances cannot be taken at face value: as commentators have pointed out, it is socially, politically and culturally contingent (see e.g.

Fraser and Moore, 2011). What/which are 'drugs'? What is 'problematic' drug use? Terms are contested and hide important differences: e.g. in common (policy) parlance there is often a conflation of recreational and problematic use. As shorthand in this report I refer to 'drugs' as to mean illicit substances; to 'problematic' drug use as to mean use connected with addiction and related behaviour (mostly, but by no means exclusively, associated with heroin use). This does not imply an acceptance of these definitions as given, but arguments about their social and ideological constructions are beyond the remit of this report.



## 2. BACKGROUND

### **Beyond punishment: the international context**

Although United Nations conventions commit governments to treat unauthorised supply and possession as criminal offences, personal use is subject to each country's 'constitutional principles and the basic concepts of its legal system' and has been differently interpreted and applied (EMCDDA, 2014). However, the need to move beyond a focus on punishment has long been stressed: the 1961 UN Single Convention encouraged 'alternatives to conviction or punishment' and for 'abusers of drugs' to be identified early and to 'undergo measures of treatment, education, after-care, rehabilitation and social reintegration' (Articles 36.1(b) and 38).

European Union drugs policy also prompts member states to provide 'alternatives to coercive sanctions' (EU Action Plan 2013-2016, Action 21). Although member states are not bound to EU directions in this field, they are expected to follow some key principles: drugs policies should be 'comprehensive (that is, cover not just law enforcement but economic, criminological and social aspects), balanced (demand and supply reduction should go hand in hand and receive similar amounts of political and financial resources) and evidence-based' (Danilo Ballotta, principal policy analyst, EMCDDA).

Other tenets are that drug addicts should not go to prison; treatment should reach all demand; public health should be increasingly incorporated into drugs policy (*ibid.*). In fact, the latest (2013-2020) EU strategy specifies the 'reduction of the health and social risks and harms caused by drugs' as a policy objective (EMCDDA, 2015). Likewise the UN has set 2019 as the target date for countries to reduce 'significantly and measurably' such risks (United Nations, 2009).

The EU drugs strategy also promotes the involvement of civil society and young people and service users in developing drug-related policy (EMCDDA, 2015).

### **The Portuguese context**

In line with UN convention rules, drug possession in Portugal is prohibited. However, since changes in the law in effect from 2001, sanctions fall under the country's administrative, not criminal law. This has gained the 'cautious' approval of the UN Office of Drugs and Crime (UNODC, 2009).

Although the fundamental tenet of the Portuguese approach is that 'it is better to treat than to punish', *use, buying and possession* of illegal substances are all still *illegal* in the country. However, the law differentiates on the basis of *purposes* and *quantities*. Use, buying and possession, up to a maximum daily limit<sup>1</sup> and for personal purposes only, are non criminal activities and fall within the remit of the CDTs. Anything other than that is still a criminal offence, including the selling or passing of any amount of illegal substances. 'If I give some to my friend, I have committed a crime' (Sergio Ferreira de Loureiro, Aveiro Police (PSP) District Command).

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<sup>1</sup> Set out for each substance in Tables I-IV, Annex to Decree Law 15-93 of 22/1

The founding principles of Portugal's new approach, as introduced in 2001, were established in the 1999 *National Strategy for the Fight Against Drugs*. Interventions were to be based on scientific knowledge but at the same time guided by 'humanist' values, which acknowledged the inherent dignity of drug users as citizens and involved them, as well as local communities, in development and implementation. The country's public policy would 'focus on primary prevention; assure access to treatment; extend harm reduction interventions; promote social reintegration; develop treatment and harm reduction in prisons; develop treatment as an alternative to prison; increase research and training; develop evaluation methodologies; double public investment in the drugs field' (EMCDDA, 2011a:15).

As Hughes among others points out, the policy makers' main objectives were to reduce the stigma suffered by drug users (hence the effort to change their public image from criminals to citizens in need of help, not punishment) and to respond to them in proportionate and effective ways. 'The lifting of the "criminal" label was promoted as a means of increasing the access to harm reduction, education, treatment and reintegration' (Hughes, 2006: 129).

The overall responsibility for policy coordination lies with the Inter-ministerial Council for Drug-related Problems, Drug Abuse and the Harmful Use of Alcohol. The body is chaired by the Prime Minister and comprises the National Drug Coordinator and the ministers for Justice, Health, Education, Science and Higher Education, Labour, Home Affairs, Foreign Affairs, National Defence, Finance, Environment, Social Security, Agriculture and Economy (the last two were included with the addition of alcohol to the remit of national drug policy in 2006).

Each one of those ministries appoints a representative to a Technical Committee, which is overseen by the National Drug Co-ordinator and devises strategic and action plans and supports practice nationwide. Sub-committees deal with different subject areas and can propose (changes to the) legislation: what is approved by the Technical Committee goes before the Inter-ministerial Committee.

The National Drug Coordinator is also the head of the General-Directorate for Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD)), the body directly responsible for the implementation of the national drug strategy. SICAD plans and coordinates demand reduction interventions and collects, analyses and disseminates information on drug use and responses to it. SICAD's remit also encompasses alcohol-related issues and addictive behaviour generally, e.g. as related to gambling and internet dependency.

### 3. THE COMMISSIONS FOR DISSUASION FROM DRUG ABUSE (CDTs)

The Commissions for the Dissuasions from Drug Abuse (CDTs) are civil institutions which deal with people caught when buying, in possession or using up to ten daily doses of any illicit substance. They were created by Law n.30/2000 (enacted in July 2001) and were conceived 'as essential to achieve positive outcomes from decriminalisation' through the 'dissuasion of occasional drug users and treatment of dependent drug users' (Hughes, 2005:131). They operate in each of the 18 districts of continental Portugal and in the independent regions of Madeira and the Azores.

They are unique entities: as Danilo Ballotta of EMCDDA confirmed to me, there is nothing comparable to them in the field of drugs worldwide. The law, via the CDTs, offers users the possibility to opt for a healthier lifestyle. Sanctions are a last rather than first resort. Rather than following a court model, they have a therapeutic approach; they operate a kind of 'psycho-juridical intervention' (Poiares, 2000).

'The key to the CDTs is their focus on helping users: they are *non judgmental*. This is a fundamental difference from the criminal justice system, including the drugs courts: it is not a "me v. you" attitude, but one of commonality: we are here to see if we can give help and, at the same time, help is *not imposed*.'

This attitude '*runs counter one hundred years of policy*' that regards use as deserving of moral and social sanctions. The Portuguese approach is that 'use is wrong legally and it *might have* some medical effects'. (D. Ballotta, Principal Policy Analyst, EMCDDA)

#### CDTs' staff and approach

The law stipulates that the Commissions be composed of three members (quorum is two), who are responsible for deciding on each case, promoting health and dissuading from use.

The members are appointed by the Ministries of Justice and Health: the member appointed by the Ministry of Justice has to be a legal expert, the other two usually are a health professional and a social worker. A multidisciplinary 'technical team' supports the Commission members: this can be composed of clinical psychologists, social workers, lawyers and administrators, which organise the casework and offer the diagnostic tools to enable the Commissioners' decision making.

The CDTs have a holistic and multi-disciplinary approach, based on a 'transtheoretical' model that sees change as occurring in progressive stages, each with its own characteristics. Interventions have to be appropriate to each individual's specific circumstances at that moment in time (DiClemente, 2005).

As Sofia Almeida, President of Aveiro CDT, put it, the Commissions look at drug use in

the overall context of a person's life - their work, school, family, relationships, hobbies, activities and sports, plans, goals and aspirations. This allows them to offer targeted advice and interventions, in conjunction with a network of wide-ranging (e.g. employment, psychological, medical, housing) local support.

### **Tailor-suited interventions**

'No two cases are ever the same' (Paula Paiva, Aveiro CDT Senior Technical Officer). Advice and information are delivered in a manner and at a level that is most likely to have an effect. Who CDTs refer to and the type of (psychological, pharmacological, social) interventions they recommend depend on each individual's circumstances.

CDTs focus on what is at the roots of (potential or established) problematic use. Paula Paiva pointed out that use can be a warning that something in the person's life is not right; it is the CDT's job to find out and refer appropriately so that the person can be enabled with tools to deal with the underlying issues in their lives – sometimes these have to do with loss (bereavement, divorce, death), family problems etc.

*'... what really matters is the relationship one establishes with the substance, not the substance itself.'* (J. Goulão, National Co-ordinator and SICAD Director General)

This approach runs counter the notion of a 'hierarchy' of drugs dangerousness (e.g. a heavy, sustained use of a 'light' substance may be more harmful than the occasional use of a 'heavy' substance). What matters is 'the motivation; the environment; the amount of use; the knowledge of the substance' (N. Portugal, Lisbon CDT Vice-President).

### **Information and dissuasion**

Even when there are no discernible problems at psychological level, it is still important to alert the person to the health repercussions of prolonged/continued use. As Raquel Lopes, psychologist at Lisbon CDT put it: 'Our aim is to inform people ... so they leave the CDT more able to make informed choices; so that if they choose to continue, it's a conscious decision: it's their responsibility. They know the law, they know the consequences. We cannot oblige them not to take drugs but we can explain what drugs do.'

*'CDTs use their processes as educational and empowering tools, to help each individual take responsibility and make informed choices.'* (S. Almeida, Aveiro CDT President)

CDTs carry out wider education and awareness work not only for the benefit of (potential) users (e.g. in schools and with parents), but also to sensitise social and health service providers, both in preventative and harm reduction terms (e.g. preparing GPs to support addicts and their children, liaising with specialists).

## Flexibility and localism

The law intentionally set CDTs broad national principles and parameters. This gives them a degree of latitude that allows them to be bureaucracy-light and sensitive to local specificities and individual needs.

As Nuno Portugal, Vice President of the Lisbon CDT, explained, this flexibility distinguishes the CDTs from the courts: while the latter apply the law equally to everybody, the CDTs apply the same law differently to each person who comes before them. 'We determine the problems and motivations and we aim to apply and adapt the law so as to eventually bring positive results'.

CDTs operate as 'referral platforms', as Raquel Lopes defined them, to a web of health and social support that includes: treatment centres, health centres and hospitals, job centres, day centres, shelters, local authorities, charities, schools, community groups. The CDTs I visited told me of their efforts to build partnerships and agreements at very local level, so as to be able to reach out to users as near as possible to where they live. Aveiro was the first CDT to offer decentralised services in order to address access problems, e.g. because of lack of (public) transport and/or affordability of attending hearings at the Commission's premises.

## Non-compulsory nature

As participation in the process and treatment is not enforced through the criminal law, CDTs cannot compel individuals to attend or abide by their advice. Despite this, the attendance rate is high (on average around 70-75% in Lisbon and 80% or over<sup>2</sup> in Aveiro), as is compliance with CDTs' requirements<sup>3</sup>.

*'We are not like a court. We help if help is wanted. Why bother if they don't want it? What good would it do?'* (N. Portugal, Vice-President, Lisbon CDT)

As Vasco Gomes, President of Lisbon CDT, put it, compulsion engenders resistance. The person has to feel that they need and want the care; the CDT aims to help motivate them.

However, as N. Portugal pointed out, even when someone refuses treatment, the CDT will always try alternative approaches in order to safeguard the person's wellbeing. For example, they can require attendance to a health centre: while the person is not compelled to have treatment there, the requirement will bring him/her into regular contact with the health system, which s/he may have never had before – this may lead to testing, getting prescriptions etc.

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<sup>2</sup> E.g. in 2014, the non-attendance rate for recreational users at Aveiro CDT was 7.7% (Aveiro CDT, 2014).

<sup>3</sup> In the experience of Aveiro CDT, follow-ups show 'significant changes in addictive behaviours' and in other aspects of the participants' lives (Sofia Almeida).

### **Commissions visited: a brief outline**

I visited CDTs in two distinct areas of Portugal. The CDT of the Lisbon district covers an urban, metropolitan area of approximately 800,000 people. The CDT of Aveiro covers a mainly rural district on the Atlantic side of the central region of Portugal, which counts around 79,000 inhabitants (of which about 50,000 live in the city of Aveiro).

The Lisbon CDT has three members and four technical support officers. It deals on average with about 1,500 cases each year. Aveiro CDT deals with about 600-700 cases a year. At the time of my visits it had three members (one about to retire) and one (senior) technical officer.

The overwhelming majority of both CDTs' cases relate to first-time appearances by recreational users of cannabis (hashish mainly). These tend to be young people, predominantly male, under 30 years old (mostly in the 16-24 age bracket). Most commonly they are employed, although the unemployed and students also constitute significant groups among the people who come before them (see Paiva, 2014). Heroin use is mostly associated with an ageing drug user population, cocaine is on the increase in some areas while only a very small minority of the CDTs' procedures relate to synthetic drugs like MDMA, amphetamines or LSD.

All of these aspects are in line with national trends (see Figures 1 and 2).

## 4. HOW DO THE CDTs WORK?

### Referrals

When a person is found using, buying or in possession of no more than 10 daily doses of illicit substances (the amount differs according to substance), and the police have no suspicions or evidence that supply offences are involved, the substance is seized. The police ask to see identification, record the circumstances of apprehension, weigh and identify the substance(s) and produce a report. This includes the date on which the person is required to present themselves to the local CDT (or, in the case of non-residents, to the one closest to the site of apprehension), within 72 hours. (The law provides that referrals are made to the person's local CDT, not where they are caught, because of the work that the person may have to do following attendance.) The police notify the CDT, but it is the individual's responsibility to contact the CDT and re-schedule if s/he cannot make that date.

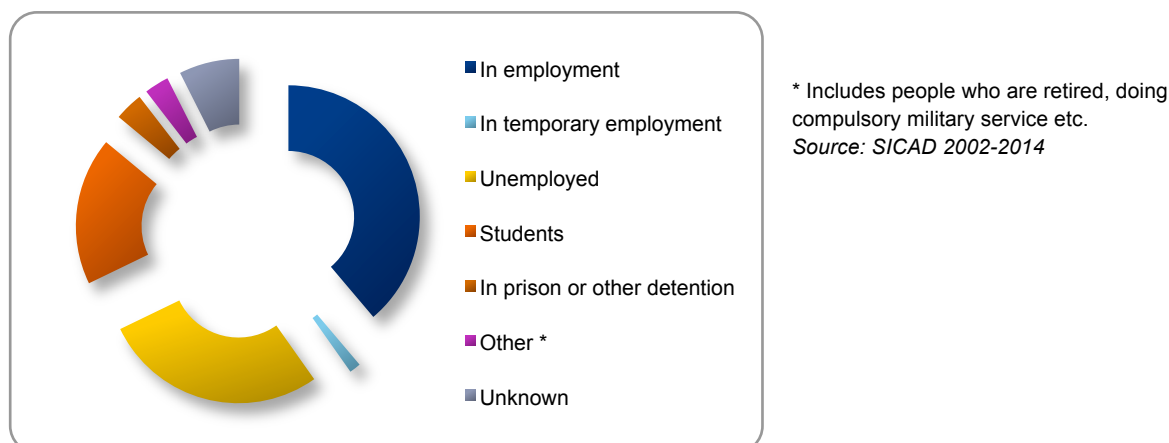
Although the majority of cases get referred to the CDTs by the two main police forces (PSP and GNR), a significant proportion (ranging from 14% to 30% in the period 2002-2013) comes from the courts (SICAD, 2002-2014). Courts can send people to the CDTs if (a) the person has been found over the limit of drugs but the court's view is that s/he is a user, not a dealer; (b) s/he can be dealing but to support her/his habit; (c) the person is only a witness in a court case but the judge assesses that s/he could benefit from attending a CDT.

If a person is stopped with an amount over the maximum daily limit, the case is not usually diverted to the CDTs but goes through the criminal justice system of prosecution and court hearing. However, the public prosecutor can also dismiss a case and refer to the CDT if they assess the amount to be only for personal use. As my interviewees pointed out, flexibility is inbuilt in the system.

### Who appears before the CDTs?

Data for the period 2001-2013 show that most (93-94%) of those who appear before the CDTs are males. The average age of someone attending a CDT is 27. Of those attending in this twelve-year period 40% were in work, 28% were unemployed, 18% students and 4% were in prison or some other form of detention (*ibid.*). See Figure 1.

**Figure 1: Status of people attending CDTs, 2001-2013**

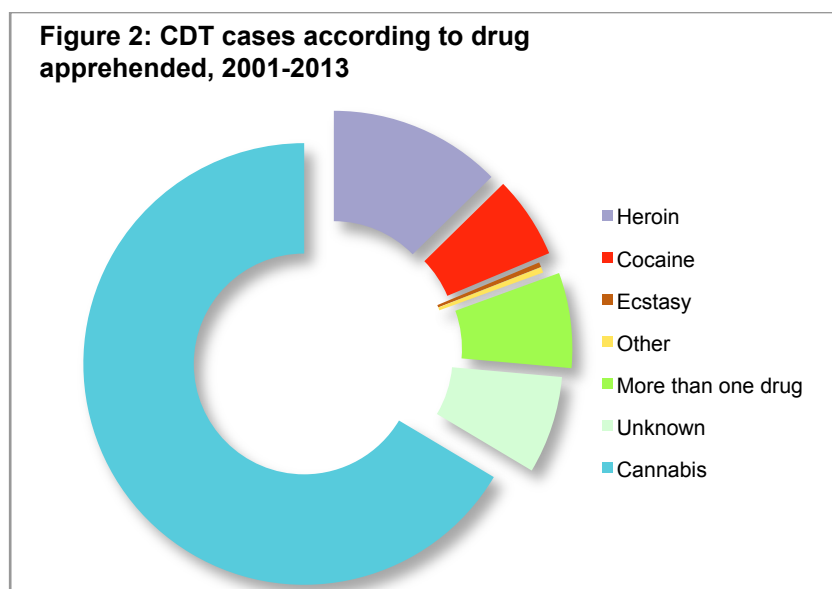


Class, income, status, gender, the type of substance, police perceptions and practices all play a part in who gets caught up in the authorities' net. As I was told by the staff of the CDTs I visited, the police tend to be present in what are perceived to be problematic neighbourhoods, hence more people get referred to the CDTs from those than from more affluent areas. Moreover, young people living at home and on lower incomes (such as students or unemployed people) are more likely to be using in public places where they can come to the police attention. However, this selectivity/targeting, which stigmatises and has profound negative consequences when related to the criminal justice system, can actually be beneficial in terms of approximating disadvantaged groups to health and social support that may be lacking in their lives (see p.29).

### Which substances?

CDTs started operating in Portugal from 1 July 2001. The number of cases the Commissions have been dealing with has steadily increased, from 5580 in 2002 to 8729 in 2013 (SICAD, 2002-2014).

Of all the cases that are dealt with by the CDTs, the overwhelming majority (66%) of all substances in the period 2001-2013) relate to people caught with cannabis. The second most common substance is heroin (13%), followed by cocaine (6%). Poly-drug use relates to 7% of the cases seen by the CDTs, while ecstasy and substances like amphetamines and other hallucinogens or 'club drugs' count for less than 1% of the illegal drugs that people appearing before the CDTs are caught with. See Figure 2.



Source: SICAD 2002-2014

### What happens on attending a CDT?

The CDTs aim to inform, dissuade from use or motivate people to undergo treatment. When a person attends a CDT after referral, s/he will spend about one to two hours talking to the CDT panel members and to a 'technical' officer. This process is referred to



as a 'hearing'. In this time, and in the absence of any compulsion, the CDT has to try and establish an appropriate course of action to ensure or improve the health and wellbeing of that particular person. They have to try and reach out to someone who may never have received health, social or any other support – and who may slip under the radar again. This involves assessing her/his specific circumstances and, most importantly, establishing a *relationship* of trust powerful enough to encourage the person to follow the CDT's advice. Such process takes place mainly through an in-depth interview by a member of the technical team (usually a psychologist, sociologist or social worker).

At the hearings I observed, the balance that the CDT members managed to strike between being approachable, friendly and authoritative impressed me. They had to carry out psychological assessments based on the circumstances they were able to glean of the person's life, including non-verbal clues from the interview. Based on this assessment, they imparted a substantial amount of medical and other information simply and effectively, whilst also working towards dissuading the person from any further harmful behaviour.

### **Hearings structure**

The formal structure of the 'hearings' is composed of some basic elements:

1. The CDT panel members explain the process to the person, check her/his identity and give her/him the opportunity to ask questions or provide factual corrections to the information the CDT already holds (via the police or other reports) about the circumstances of their apprehension.
2. A 'technical officer' carries out an evaluation interview, which looks into the individual's personal, family, social and economic circumstances. The officer also gathers information about the individual's use (history, current frequency and context) and her/his medical history.

The person is asked a wide range of questions, including her/his relationship with significant others (e.g. if a young person living at home, how does s/he get on with her/his parents? Do they know about her/his use?), schooling and education; future plans (e.g. training? Further education?); any job experience; sports, hobbies, other free time activities; any changes or significant events in her/his life. Questions about use include: age when s/he first experimented with drugs; in what context; why; circumstances around her/his use generally; what other drugs does or did s/he use?

The WHO-recommended ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) has been used since mid-2013 to help ascertain consumption habits and risk levels (see Figure 3 and Appendix C).

3. The technical officer briefs the panel members (two is quorate), who consider the case and decide on the outcomes.
4. The person is given the CDT panel's assessment of her/his use (recreational or problematic) and has the opportunity to comment and ask for amendments to the records. The CDT also outlines any recommendations, guidance and referrals (and/or sanctions where appropriate). Dates for follow-ups may also be arranged.

**Figure 3: CDTs: Dissuasion intervention model**

<b>First phase: Evaluation</b>	1. Interview	Gathering of information about the individual, his/her personal, family and social situation and her/his substance use (history, current frequency and context)	
	2. Evaluation of motivation	Evaluation of the risk of use and of the individual's motivation to change behaviour and undergo treatment if applicable	
	3. Evaluation of substance use	Evaluation of the problems related to the substance use	
		Application of ASSIST to evaluate the level of dependence	
	4. Evaluation of problems related to substance use	Clinical (physical and mental) problems	
		Social functioning and available social support	
How the individual relates to the substance and problems associated with use			
5. Identification of risk levels	Low Moderate High		
<b>Second phase: Individualised intervention</b>	Establishing an intervention strategy based on the risk level	Low risk <sup>4</sup>	Prevention and education
		Moderate risk	Brief motivational intervention Referrals
		High risk	Brief motivational intervention Health referrals

Source: Aveiro CDT (2013)

### **Users' perceptions**

At the time of writing no study had been published about how CDTs' 'clients' receive or perceive their interventions. I carried out interviews with about a dozen people who had attended a CDT hearing. There are of course significant methodological impediments to this being a representative sample (see Appendix B). However, my interviewees matched the national data in terms of age, gender, substance and type of use and nationality (they were all Portuguese young males, mostly first time recreational users of cannabis).

There were revealing non-verbal cues that I observed both before and during the hearings and during my interviews. Whilst before the hearing the young men were visibly nervous and worried, their demeanour changed considerably once they had been made aware of the purpose of the process: they were there to be helped, not punished. They relaxed visibly shortly into the hearing and were remarkably frank and open during it and during the interviews. Their opinions of the CDTs were, by the time I talked to them, overwhelmingly positive; even if not all of them thought that things would fundamentally

<sup>4</sup> An individual may be assessed as being at low risk (of dependency/danger to health) if s/he has at least some of these elements in her/his life: strong family links, established relationships, friends, work, study, economic and/or emotional, psychological, social stability. This is in line with risk and protective factors literature: see e.g. Silvestri et al. (2009).

change in their lives as a consequence, they understood and viewed favourably what the Commissions were there to do.<sup>5</sup>

For Raquel Lopes (Lisbon CDT) the assessment interview provides a safe opportunity for emotions to come out, including anger and upset: *'We need to have a space to create some empathy'*.

*'Acknowledging their realities is important.'*

(P. Paiva, Aveiro CDT)

As it was explained to me, being at the CDT may be the first occasion that some people have ever had to talk about their substance use. At times this brings an acceptance of the actual extent of their consumption and of whether it is problematic, or on the verge of becoming so.

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<sup>5</sup> Anonymised summaries of the interviews with those who gave consent to being recorded are available on request from the researcher.

## PEOPLE AND SPACES

*'This is a non-confrontational process – it's about convincing, talking, motivating.'*

(S. Almeida, Aveiro CDT President)

The CDTs' approach is reflected in the layout and visual elements of their physical spaces, and of the rooms where the hearings take place in particular: everyone sits around a table and the atmosphere is informal.

The trappings of institutional settings are dispensed with. The intent is to avoid resembling a court and its signifiers. The sitting arrangements are non-hierarchical and put only a minimal amount of distance between the two sides. As the photo below shows, the hearings take place in very normal looking meeting rooms.



The hearings room at Aveiro CDT

Staff do not wear uniforms or formal wear, so that their appearance does not distinguish them in status from the people who attend. This is symbolically meaningful and, psychologically, it helps the CDT members create a relationship with the people in front of them.

However, 'some formality is maintained' in the way the hearing process is conducted, as Sofia Almeida pointed out. 'It is important to maintain some distance, but not to alienate'. The technical officers have an 'empathetic' role; they conduct interviews (which Raquel Lopes, psychologist at Lisbon CDT, described as 'a conversation') aimed to inform (and calm and reassure if necessary) the person, at establishing facts about their personal and social situation and offer guidance or help if needed. The CDT members have a more 'authoritative' role, conducting the hearing and communicating decisions according to protocol.

## 5. CDTs' DECISION MAKING

*'I'm not here to judge, but to evaluate risk and to help'*

(P. Paiva)

In assessing each case CDTs need to consider:

- a) does the person have a substance dependency/addiction?
- b) is it the first time the person appears in front of a Commission? (All attendances are recorded on a national 'Central Register' held by SICAD.)

Which intervention the Commissions take depends on these two factors.

### **On first appearance**

- If the person is assessed as *not* being a problematic user, the CDT does not impose sanctions or obligations. However, first time recreational users are the bulk of CDTs' preventive and dissuasive work. First encounters provide precious opportunities to inform (e.g. about the health effects of drugs; about the law and the possible consequences of being caught in possession again) and to advice. The aim is, at the very least, to help the individual approach substances 'in a more responsible way, in a more conscious way about the risks and downsides. (...) We ... try at least to prevent them from developing a misusing situation' (N. Portugal).
- If the person is assessed as being a problematic user/having a dependency, the main aim (and this also applies to people appearing more than once) is treatment, or encouraging resumption if treatment has been interrupted.

Judging whether a person is a recreational user is not, of course, always easy; there is 'a huge grey area', as Nuno Portugal put it. Moreover, circumstances are not static. For example, if a person has emotional, social or other difficulties, s/he may develop a riskier relationship with drugs than s/he has at the time s/he meets with the CDT. In these instances CDTs' work as 'prevention units' is particularly important.

### **On second (or further) appearance**

The rate of people appearing in front of the CDTs more than once is between 4% and 6% (SICAD, 2002-2014). This rate may be attributable to a range of factors, including police stop and search decisions. We know, however, that most people do not appear in front of their local CDT more than once.

In cases of re-appearance, CDTs are obliged by law to administer a 'sanction'. The type of sanction depends on consumption levels and on the person's situation (e.g. income, family circumstances) – there is 'no wish to create further problems' (S. Almeida). A problematic user will not get fined and will be always referred for treatment.

## Non attendance

Legally a person is required to attend<sup>6</sup> a CDT upon notice, but no coercion can be used to ensure compliance (although a sanction can be administered). CDTs try repeatedly to get someone to attend. Aveiro CDT told me that they contact the person first informally, then write to them giving other hearing dates, up to three times, and as a last resort ask the police to serve the person with a notice to attend. If the person cannot be traced, the CDT will check with e.g. health or social services as to whether the person is in hospital, prison etc.

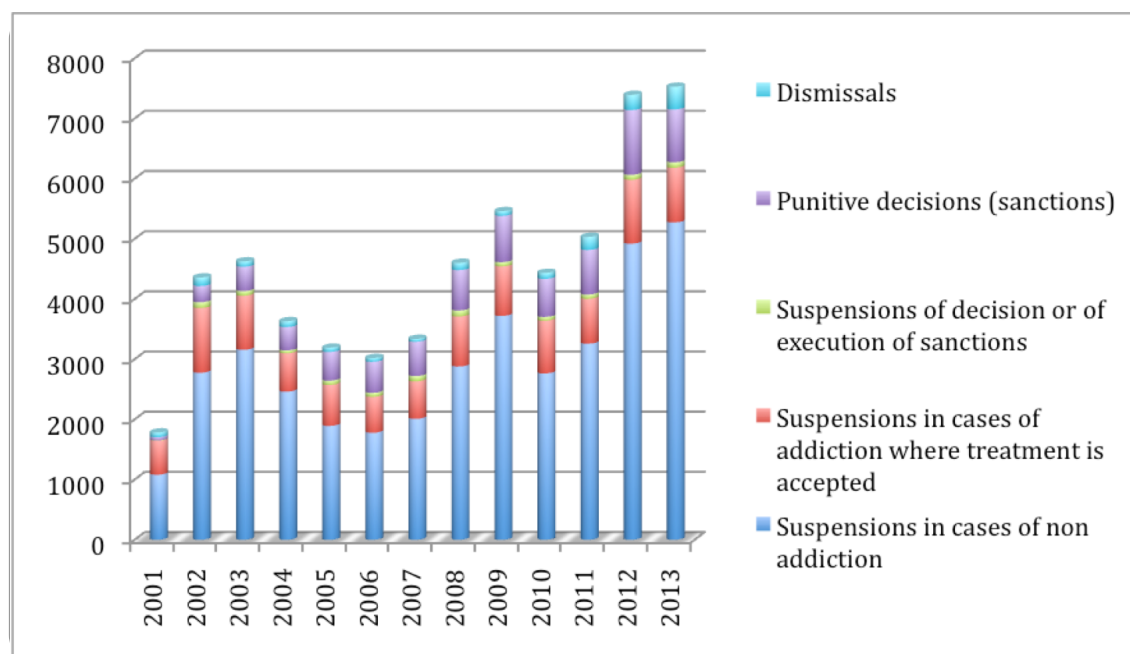
Ultimately all cases have a decision made, irrespective of attendance or not. In cases of non attendance, the law prescribes an assumption that a 'first timer' is a non-problematic user, and the process is suspended.

In the case of a second-attendance problematic user, Aveiro CDT straight away issue a request of attendance to the hearing. Most of the remaining 20% of those people who do not show up then attend (S. Almeida).

## Suspensions

Data for the period 2001-2013 shows that the majority (averaging 80%) of cases result in suspensions. The use of punitive means (sanctions) remains a distinctively minor outcome of the CDTs' decision making processes.

**Figure 4: Outcomes of CDT decisions, by number and year**



Statistics for 2001 are from 1st July, the date from which the new framework created by Law n.30/2000 was implemented. 2001 data is therefore for six months and covers continental Portugal only. (SICAD, 2002-2014)

A suspension means that the process is paused for a period of time that depends on the

<sup>6</sup> Art. 11 of Decree Law 130-A/2001

risk the individual is assessed to be at:

- low risk: 3 months
- medium risk: 4 months and upwards
- high risk and addicted people: varies, but longer than the above.

If the person is assessed as having an addiction, the process is suspended on condition that s/he attend treatment. If s/he refuses, the CDT will try and motivate her/him into doing so. If s/he still refuses, ultimately a sanction is applied (but never a fine, as this is considered counter-productive for people in these situations). Usually this will be a requirement to (periodically) attend a health centre, e.g. for tests like TB – the main purpose being to bring the person into contact with the health system.

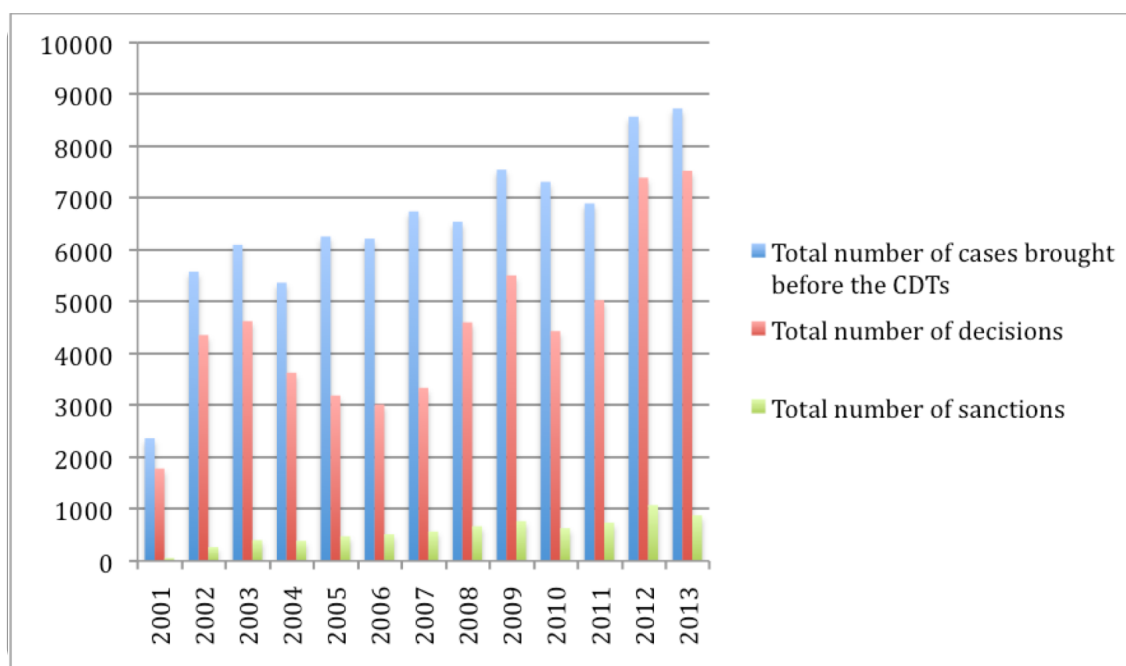
*‘Because we do not apply sanctions on the first occasion, the person is much more receptive to advice or recommendations’.*  
(N. Portugal)

During the time of suspension the individual is regularly monitored in terms of her/his progress and health. At the end of the suspension the case may be closed or continue, depending on the circumstances.

### Interventions and sanctions<sup>7</sup>

In line with the CDTs’ *‘tratar, não punir’* (‘treatment, not punishment’) principle, sanctions are used in the last resort and are not the main focus of the Commissions’ work (see Figures 4 and 5).

**Figure 5: Cases, decisions and sanctions, CDTs Portugal 2001-2013**



Source: SICAD 2002-2014

<sup>7</sup> Although ‘sanctions’ is the direct translation for what the CDTs have at their disposal, these are in effect measures that are meant to guide and help rather than punish. Fines are ‘sanctions’ in the more literal sense.

By law, sanctions can be applied to:

- problematic users if they refuse treatment (bar fines, as they are deemed to put addicts at further risk of harm)
- recreational users on their second (or further) appearance.

In such circumstances, CDTs have a range of measures<sup>8</sup> at their disposal. The most commonly used are:

- Periodic attendance requirements to health centres or hospitals for check ups or treatment (including mental health treatment), to social services, employment centres, (vocational) training centres, the CDT itself, the police station etc. (Cumulatively, attendance requirements constitute the most applied measure: see Figure 6.)
- Community work (e.g. if the person is not working and has time available).

More rarely applied are the following bans:

- leaving the country without authorisation
- undertaking certain jobs or tasks (where health and safety would be at risk, e.g. using machinery)
- frequenting defined places, areas or people
- revocation of licences (e.g. hunting licence).

In a minority of cases the management of welfare benefits can be taken over (this measure may be considered for people who are vulnerable and/or with dependants).

The only pecuniary sanction, the fine<sup>9</sup>, is a civil measure ('coima') which breach does not incur criminal charges (unlike the 'multa'). Its use by CDTs has been increasing over the years, from 62 instances in 2002 to 277 in 2013 (see Figure 6). CDTs often apply the minimum amount (25 euros at the time of my visits).

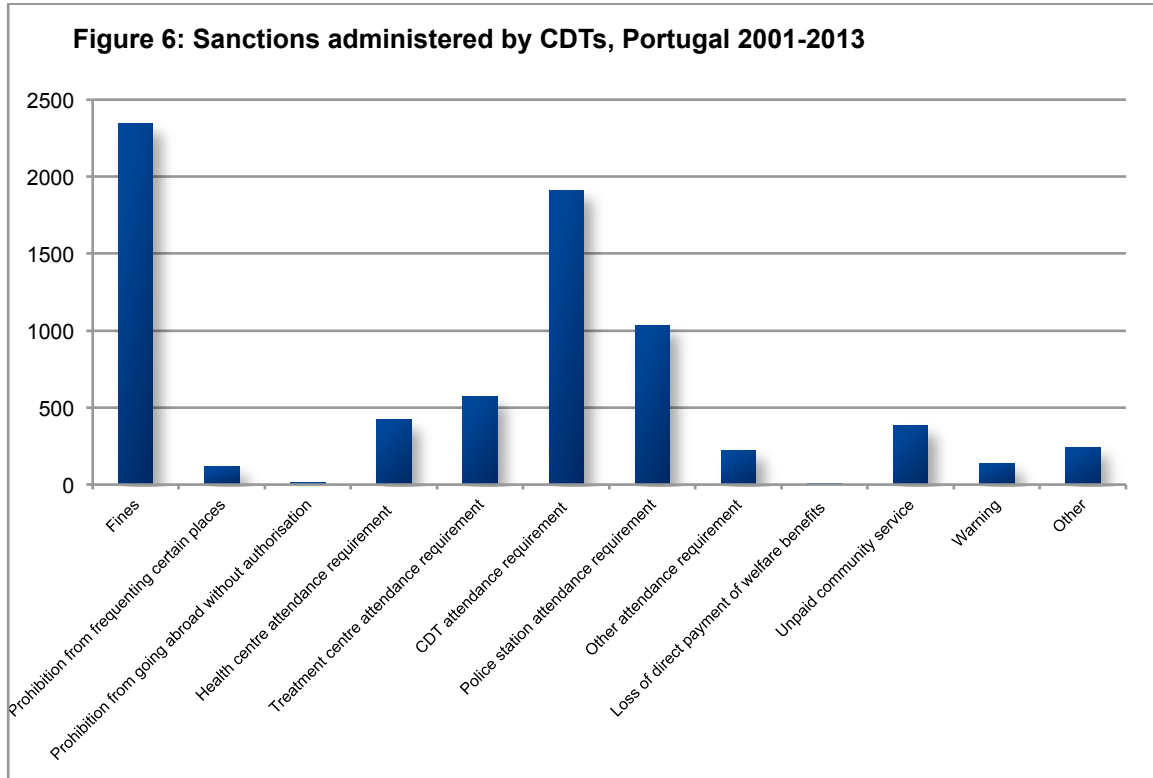
*'Sanctions are meant to be constructive, not punitive'.*  
(António Cavacas, CDT panel member, Aveiro)

When applying sanctions CDTs are mindful of the consequences on the individuals' lives and of whether they can be in fact counterproductive. The person is allowed a say in what sanctions s/he is to receive and the CDT will take account of her/his specific circumstances; e.g. if s/he lives in a small community s/he may risk stigmatisation if s/he is seen attending the police station. CDTs need always to be mindful of not compromising the person's right to privacy and confidentiality.

<sup>8</sup> Although 'sanctions' is the direct translation for what the CDTs have at their disposal, these are in effect measures that are meant to guide and help rather than punish. Fines are 'sanctions' in the more literal sense.

<sup>9</sup> Lisbon has adopted an alternative system of donations. People are given the choice to donate to an NGO/charity that operates where s/he lives. Donations 'work exceedingly well', with most attendees ('99.9%') opting for them over fines (N. Portugal).





Source: SICAD 2002-2014

## Follow-ups

A large part of the CDTs' work involves following the progress of each person who attends, checking with the relevant centres to which s/he has been referred that s/he is attending treatment (if the person has an addiction) or complying with other requirements.

'Everyone we have referred to somewhere, we follow' (R. Lopes).

In cases of non-compliance, the CDT will contact the person (follow-ups are either by personal attendance, phone or email) to establish the reasons, try to convince her/him to comply and/or consider alternative forms of action. In the last instance a sanction can be applied.

## **CDTs in prison**

CDTs go into prisons in two sets of circumstances:

1. Someone was due for a CDT hearing but ends up in prison (for any reason).
2. A prisoner is caught with an illegal substance; the prison authorities notify the police; the police refers the case to the public prosecutor. The public prosecutor can decide to pass the case to the CDT rather than charge and prosecute.

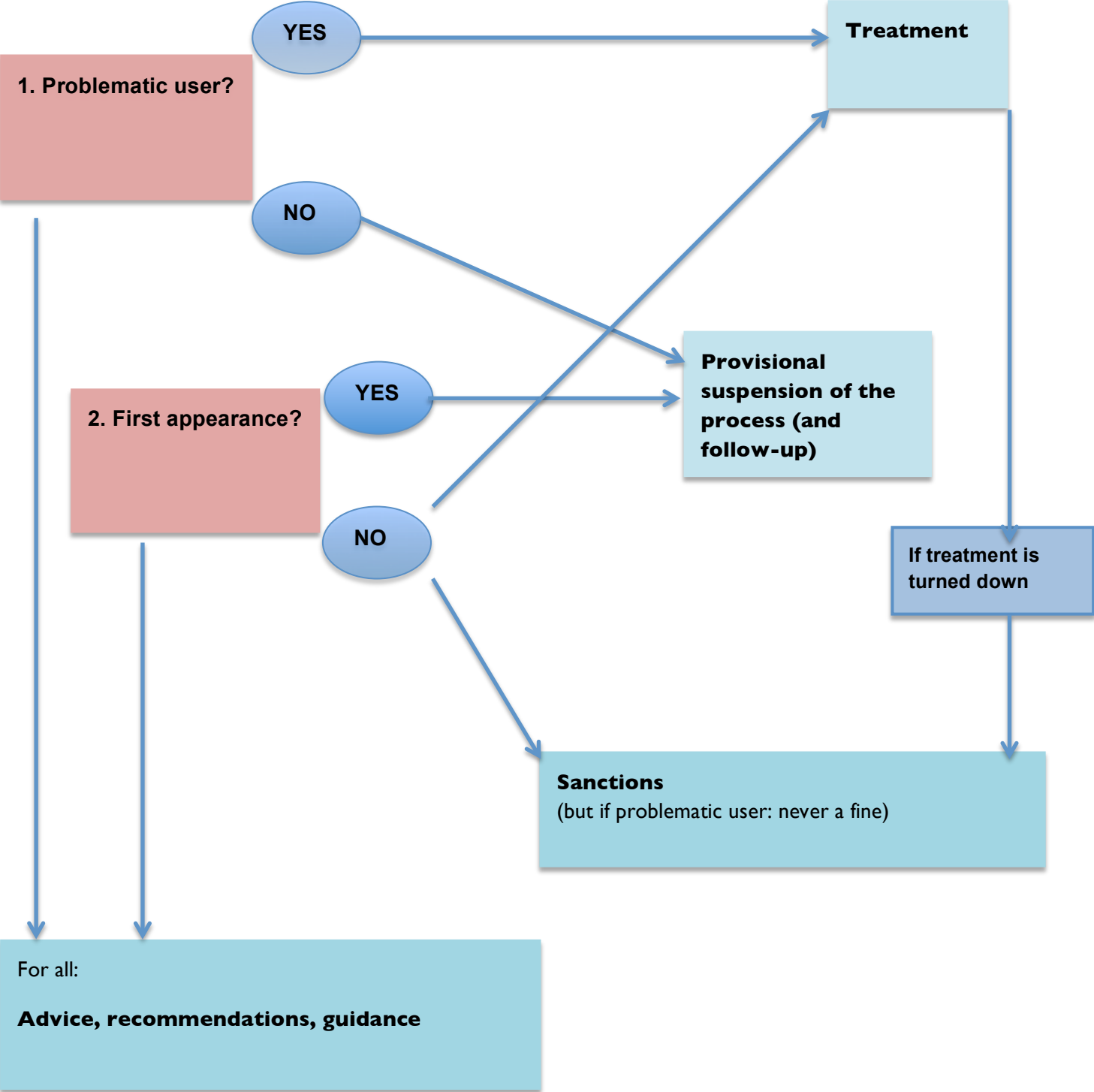
CDTs refer prisoners with dependencies to treatment (which can be pharmacological and/or psychological) inside the prison. They carry out follow-ups usually by phone or in writing.

The CDTs' approach is that sanctioning prisoners is not helpful. They are already being punished by virtue of being in prison, and may also have been subjected to restrictions (in relation to the drug use) by the prison authorities. Aveiro CDT Sofia Almeida and Paula Paiva did not recall ever applying a sanction to a prisoner in their eleven years of practice, apart from warnings. (According to Paula Paiva, most prisoners comply with CDT recommendations anyway.) However, she thought that the only constructive sanction that could be applied to a problematic user in prison (and most of the people who come before the CDT there are addicted) who refused treatment would be the periodic reporting to a treatment programme: the aim is to get an addicted person into treatment, not to punish her or him further.

Lisbon CDT, which oversees the six prisons in the district, in fact only applies regular attendance requirements to the health or treatment centres in the prisons (N. Portugal).

An important function of CDTs, as P. Paiva pointed out, as well as checking addicted prisoners either start or continue treatment while inside, is keeping track of people once they come out of prison and ensure they get the support they need. N. Portugal confirmed that they pay close attention to those who are to be released soon. 'When people come out of prison they need doors to knock on; and we are available for them'.

Figure 7: Decision making process, CDTs



## 6. AN INTEGRATED SYSTEM

CDTs operate in the public national health system and refer people to sources of free assistance (either provided directly by central or local government or outsourced), including:

- treatment teams (where CDTs refer cases of dependency)
- prevention teams
- GPs and health centres (for medical and psychological support)
- programmes run by community centres or charities
- schools (e.g. to in-house psychologists)
- educational centres, technical colleges etc. (for training and qualifications)
- social centres
- homeless shelters
- employment centres
- legal assistance organisations.

Treatment services available to CDT clients include individual, group and family psychotherapy; social care and social therapeutic services; medical and nursing consultations; treatment with opioid antagonists and agonists; drug free treatment; relapse prevention (Gesaworld, 2013).

For N. Portugal 'the key part' of any drug policy is the accessibility to treatment: 'without it nothing else will work'. This means *free, immediate, local access*. (The person can be seen by a specialist often the same day as her/his CDT attendance.) CDTs 'would not make sense' without this complex, integrated, capillary system (Gabriela Cierco, Aveiro CDT Vice-President).

'I think that the reasons for the good results we've had is because back in 2001 we decided to *change everything*. We didn't just deal with the treatment part, or the decriminalizing part, or the prevention part: we dealt with everything more or less at the same time.' (N. Portugal)

All the practitioners and experts I talked to agree that the Portuguese system can only work as a whole, all the elements converging into a dynamic and flexible support programme. The entry point for someone who shows signs of needing help can be any member of this support network: not just CDTs or the courts, but GPs, (school) counsellors, local authority officers etc.

According to the latest (external) evaluation, this integrated system ensures 'continuous and consistent' interventions and has led to 'a clear improvement' of accessibility to services, to the system's ability to follow individuals through their life course and to improved coverage and effectiveness of the interventions (Gesaworld, 2013: 20 and 28).

## The right to health, prevention, harm and risk reduction

*'The guarantee of access to treatment for all drug addicts who seek treatment is an absolute priority' of the Portuguese drug strategy. 'The humanistic principle on which the national strategy is based, the awareness that drug addiction is an illness and respect for the State's responsibility to satisfy all citizens' constitutional right to health, justify this fundamental strategic option and the consequent mobilisation of resources to comply with this right.'*  
(Ministerio da Saude 2006:153; my emphases)

As V. Gomes, President of Lisbon CDT put it, their main aim is to assess and convince each person to look after their health. The priority, especially with regards to problematic users, is that they are being looked after/cared for 'by someone or some agency, on a regular basis'.

The main architect of the national strategy, Dr. João Goulão, explained that 'it was a lot of work to convince people that this is a *chronic relapsing disease*. This changes everything. If you compare this disease to diabetes, for instance, why should we consider that drug addiction is self-inflicted and diabetes type 2 is not? Also, if I am a GP and I am following a diabetic, I know there are some moments of crisis during the year; for example before Christmas I'll talk to that [diabetic] patient and advise him on what to do re. the festive foods etc. If I am working with a chronically ill drug addict and I know, say, that his mother has died, I will call him, I will need to work very closely with him during that period, because he is going to have a crisis and probably a relapse.'

What I witnessed in Portugal is a system set up to reach people in need, going further and further out to the margins of society (see Figure 8). The system is both accessible and *unconditional*. As Dr. Goulão pointed out, it is geared towards providing:

- dissuasion for those who are not drug dependent, doing the outmost to prevent them from developing an addiction (hence ascertaining risks and taking appropriate steps)
- ongoing support for those who are drug dependent, whether they relapse or not. The strategy is underscored by a commitment to help users, even if they are not able to overcome their dependence, and improve the quality of their lives - 'instead of abandoning or marginalizing' them (Domaslawski, 2011).

'This does not mean viewing addicts as "incurable"', nor 'underestimating the effects of drugs'. It means creating 'a new type of intervention...that complements strategies of prevention with strategies of treatment and reintegration' (Ministerio da Saude 2006:167-168).

*'...even if a citizen is not in a condition to stop using drugs s/he still deserves the investment of the state in order to have a better and longer life.'*

*'We don't give up on people.'*

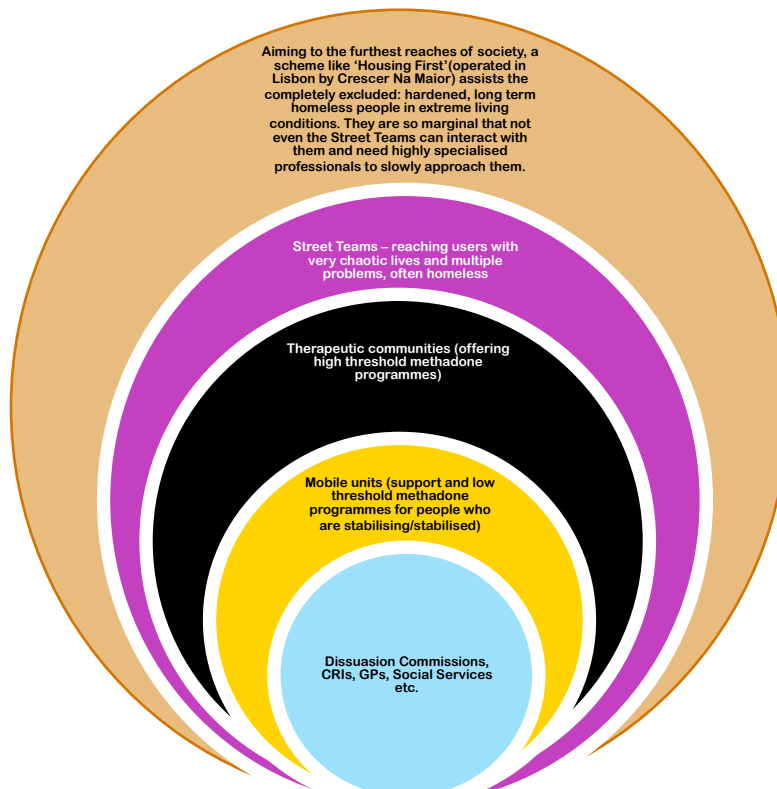
*'Even if you are still using drugs, we can screen you for infections/illnesses and address your treatment needs and gain your confidence to approach health support - and maybe later on you will decide to change your way of life.'* (J. Goulão)

Harm and risk reduction services in Portugal include:

- controlled administration of substitution substances (methadone in particular)
- links with maternity wards and obstetrician services for pregnant addicts
- integrated programmes of substitution treatment and antiviral or TB medications
- free screening for HIV, Aids and hepatitis
- programmes to facilitate substance misusers' access to family planning and contraceptives
- syringe exchange service in all pharmacies nationwide.

A range of bodies or programmes reach out to people at different levels of social integration or marginalisation, with the aim of getting them close(r) to support structures (see Figure 8). Among those assisting problematic users who have chaotic lives are also 'gabinetes de apoio', which offer food, washing and laundry facilities and 'centros de abrigos', which provide sleeping quarters (Ministerio de Saude, 2006).

**Figure 8: Bringing support to people: expanding circles of approximation**



### **Within the support network: Centres for Integrated Responses (CRIs)**

CRIs operate nationally and are one of the organisations that CDTs refer problematic users to. I spent time in the CRI of South Aveiro.

People with high levels of dependency (mainly on heroin) are assessed by treatment teams made up of doctors, nurses, psychologists, psychiatrists and social workers. A specific therapeutic programme is devised for each client and the team can support her/him *for life* (if s/he wants that). The programme is adapted as time goes on and as the person's situation changes.

CRIs use two types of substitution treatment (methadone or buprenorphine), depending on users and how chaotic their lives are. These programmes, Fátima Peixote (Senior Technical Officer – social work) told me, bring '*immense social gains*'. Users look after themselves better, do not need to commit crimes to feed their habits and are healthier (e.g. fewer instances of Hepatitis C and abscesses).

Not everyone is on substitution drugs. For example, some CRI clients are on anti-depressants or anti-anxiety medications, some are on no medications at all.

Once someone is stabilised, social reintegration teams offer support and signposting in relation to issues like employment, housing, finances, benefits and any legal problems.

The Aveiro CRI told me that more than 30% of their clients become employed after starting treatment. Once the person has found a job, the teams support them and help them stay in work.

CRIs also carry out prevention activities (e.g. awareness raising among young people; work with families; mediation work) and have links with a variety of other local bodies, e.g. health and social services, reintegration centres, probation, prisons, electronic tagging services, children's protection centres, hospitals and charities working in the field.

### **Outreach: Mobile support units ('methadone vans') and Street Teams**

Mobile support units and Street teams work at the 'frontline' of intervention, providing regular support to people with chaotic lives and multiple problems, e.g. homelessness, unemployment, reliance on petty crime, infections and mental health issues. These are mostly problematic heroin users (often in conjunction with other psychoactive substances), exhibiting risky behaviours and suffering from high rates of transmitted diseases (Aids, hepatitis, TB and syphilis). For many, 'this is the only routine they have', as a member of staff told me.

During my stay in Lisbon I visited the harm reduction and low threshold methadone programme operating from one of the two mobile units (sometimes referred to as 'methadone vans') run by the Associação Ares do Pinhal. I went on rounds with one of the Street Teams run by Crescer Na Maior.

Both organisations are locally based charities. Their objective is safe(r) consumption, stabilising addiction, reducing deviant activities and improving health through screenings and referrals.

The vans attend specific sites in the city twice a day.

Each van is staffed by one or two nurses and two monitors, who check the person's general state and keep track of their health appointments, provide referrals and advice, keep records, take emergency decisions, e.g. bringing a user in need to hospital.

Their main interventions are:

- medical check ups and screening
- psychosocial assessments
- regular blood sample collection for HIV, HBV, HCV and syphilis control
- daily medication distribution: methadone and, if needed antibiotics, anti-TB, antiretroviral, psychiatric, contraceptive medications etc.
- syringe exchange and condoms distribution.



Clients (in cars and on foot) attending the mobile unit (white van in the background, right) in East Lisbon

The vans are at times accompanied by x-ray units for TB monitoring.

Observations are checked against the personal records held at the charity's central offices. A computer in the van automatically calculates each client's medication dosage, based on her/his details, including attendance rates (e.g. if a person misses her/his doses three times the methadone dose is automatically reduced as a precaution).

Elsa Belo, the project co-ordinator and the van staff told me that at first they mostly attended to homeless users, but now their clients come from all walks of life and circumstances (e.g. some are settled with families, in work, some are professionals like lawyers and GPs). Most attend because they are not able to look after their own health systematically; professionals value the anonymity the service provides (each person can be identified using their registration number, so no names need to be used at the van).



Whilst users come to the methadone vans, the 'Equipas da Rua' (Street Teams) go to users, in sites of open consumption and other public areas where they congregate. Street Teams do not operate substitution programmes, but they can refer or take people to them. They hand out kits made up of clean syringes and needles and other items like distilled water, gauze, condoms. When getting a new kit, users are generally expected to give back used syringes and needles.

Two Street Teams operate in Lisbon. Each team is made up of two or three people, one of whom has to have a professional background in psychology. They work up to midnight each day, including weekends.



With Rui and Raquel, Street Team, in Casal Ventoso Lisbon

*During my visits and my rounds with the teams I was struck by how upbeat and harmonious the teams' operations and their interactions with their clients were: friendly, informal, chatty, respectful (shaking hands, smiles, jokes). I was also struck by the mix of ages, gender, ethnicity of the people reached by the teams and by the range of people (from different walks of life and at different stages of stabilisation) attending the 'methadone vans'.*

As Américo Nave, Director of Crescer Na Maior put it: 'The most important tool we have is the relationship [we establish with users]; all our work is about developing and improving it'. That relationship is one of respect: 'we don't tell them

what to do; they know better than us what they are ready to do'. 'We think with them, not for them' (A. Nave).

Both organisations take a staged approach. For example, if a person injects they try to get them to smoke the heroin instead. Instead of smoking heroin, they try to convince to start using methadone. The staff told me this method works well; 'as they feel better they get more disposed to change their ways of doing things' (Rui Coelho, Street Team monitor).

Each person on the low threshold programme has a dedicated case worker (social worker or psychologist) who follows her/him on a one-to-one basis, even after they stop using (as many still need psychological support). Likewise, the Street Teams stick with their clients. If a person they care for ends up in prison or in hospital, the team visits them regularly, for the length of their sentence or stay. 'We support them as long as long as they feel that they need it' (R. Coelho).

The support is motivational to the users. 'If we believe in them, they see that. It helps them to believe in themselves'. 'I always believe that they can change' (Raquel Glória, Street Team psychologist). The impact of the intervention can happen very quickly, sometimes 'immediately': e.g. from day to day the person can start to look after themselves, wash etc.

The staff have witnessed a 'substantial improvement' in the health of their clients, which appears in line with national data (see p.36): a decline in HIV and Hepatitis C infections; substantially fewer instances of abscesses, gangrene and amputations. Lower consumption has been accompanied by fewer illegal activities to fund it. Elsa Belo told me that TB treatment has been '100% successful' among their clients. And, in her experience, 'in the vast majority of cases it is possible, in the long run, to stop consuming heroin'.

## Reintegration

Social and professional reintegration is 'an integral part of the treatment process' (Gesaworld 2014:14). Every organisation operating the Portuguese strategy, irrespective of the specific strategic strand they fall under, plays a reintegrative role: all the bodies I examined do, for example, try to (re)connect users to their families or other support networks.

There are also specific Reintegration Teams (embedded in the CRIs) that deal with housing, education, training and employment issues. Examples of initiatives include day centres where problematic users learn to organise their life and develop social and work related skills; 'reintegrative housing' (an intermediate stage between therapeutic communities and complete autonomy)<sup>10</sup>; tailor suited vocational courses and (re)employment programmes (Ministerio da Saude, 2006).

The Vida Emprego (Life Employment) programme offers employers subsidies if they take on stabilised or ex users. Every person employed in this way has a dedicated mentor and personalised work plan (Ministerio da Saude, 2006). In one version of the scheme the employer receives tax deductions during six months of apprenticeship, and the employee is paid the minimum wage by the state. Dr. Goulão stated that 'in more than 90% of the cases, the employee is retained after the first six months and the state subsidy (pay) and tax relief have gone'. With the financial crisis, however, the social support for this kind of intervention has been diminishing.

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<sup>10</sup> Crescer Na Major operates a Housing First scheme (see Fig.8) for the most marginal homeless people, a programme partly funded by Lisbon Council. See [www.crescernamaior.com](http://www.crescernamaior.com)

## 7. IMPACT

What does the data from my research show about the impact of the national drugs and addiction strategy in Portugal, fourteen years on? The main points are summarised below.

### **More prevention, treatment and dissuasion, reduced criminalisation**

*‘This law has taken away the fear of stigma and has brought people closer to the health services.’ (S. Almeida)*

Underlining the Portuguese reforms is the awareness that treating drug consumption under criminal law hindered dependent users from seeking help. ‘Before decriminalisation, there were people that refused to go to treatment centres because they were afraid of being caught by the police’ (N. Portugal).

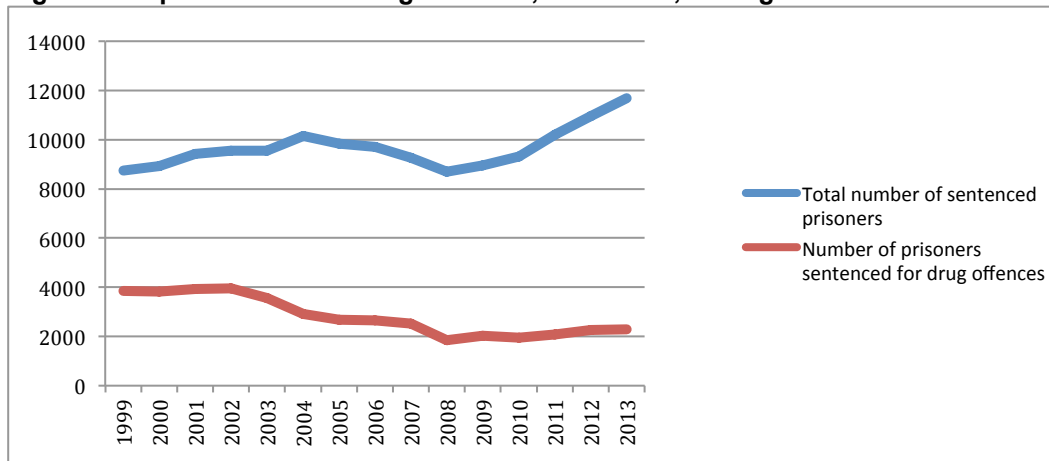
‘Without this law, many people would have *never* contacted the health services’ (R. Lopes). A 2006 study found that a greater number of people appear before the CDTs than went before the courts prior to 2001. These people are also younger: mainly 16-25 year old recreational users, caught with very small amount of cannabis. These people would have not, in the old system, been reached by preventative and dissuasion measures (Quintas, 2006).

N. Portugal also pointed out that CDTs work fast. For problematic users, early referrals are essential: referring someone to a treatment appointment two hours after his/her appearance at the CDT is much more effective than the person having to wait for an appointment, as it does not allow time to get into the ‘fix today, treatment tomorrow’ mindset that is typical of an addictive frame of mind.

The shift to a health based approach has also meant that fewer people caught with illegal substances have been criminalised in Portugal since 2001. This is obviously important because of the negative effect that a criminal record can have on people’s social and economic life (e.g. there is stigma and social shame attached to having a record, certain jobs are out of bounds, access to loans can be difficult).

While numbers of prisoners have been increasing in Portugal overall, the number of those in prison for drug offences (offences under the influence of drugs and/or to fund drug consumption) has been declining, from 44.1% of the sentenced prison population in 1999 to 19.6% in 2013: see Figure 8.

**Figure 8: Imprisonment for drug offences, 1999-2103, Portugal**



Number of sentenced adults in prison as at 31 December of each year.  
Source: DSPG (1999-2014)

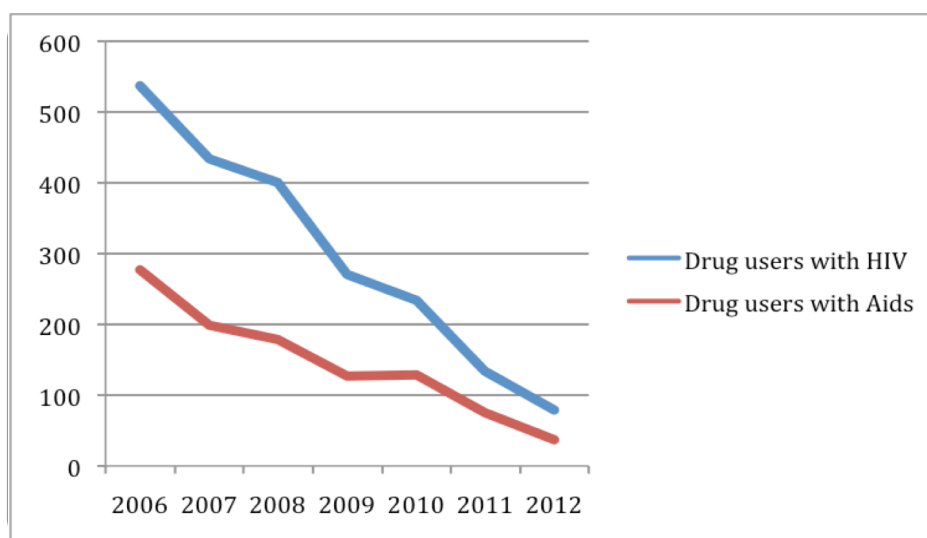
### Health gains

‘One of the clearest changes in Portugal since 2001 has been a considerable improvement in the indicators of health outcomes for drug users... These outcomes cannot be attributed to decriminalisation alone, and are likely to have been influenced by increases in the use of treatment and harm reduction’ (Home Office 2014, p.48).

The Home Office acknowledges ‘significant reductions’ (*ibid.*) in the number of new diagnoses of HIV and AIDS among drug users in Portugal. Between 2006 and 2012 the country has in fact witnessed an 85% and 86% decline in the number of HIV and AIDS cases respectively that have come to the attention of the authorities (see Figure 9).

Trend data also shows a decline in overdose deaths, from 34 in 2002 to 16 in 2012 (EMCDDA, 2015b).

**Figure 9: Number of HIV and Aids notifications in Portugal associated to drug addiction, 2006-2012**



Source: SICAD (2013a)

### **‘No lasting’<sup>11</sup> increase in use**

It is by now widely accepted (see e.g. Global Commission on Drug Policy 2011, Gonçalves et al, 2014 or the Home Office own research, 2014) that the new drugs strategy did not result in significant increases in drug use or dependencies in Portugal. All the experts and practitioners I interviewed agree that the feared ‘explosion in drug consumption’ did not materialise. Portugal did not become a ‘drug paradise’. Usage has stayed ‘pretty much in line with the other European countries’ (N. Portugal).

*‘There wasn’t [an increase in use], because it’s still illegal, it’s still difficult to buy, the substances are still apprehended from you, you are not allowed to do it openly outside, freely.’* (N. Portugal)

Although between 2001 and 2007 there was an increase in the percentage of the population which had used drugs at least once in the previous year (recent use), this rise was driven by those aged over 24: the rate of use among 15-24 years old actually decreased (Gonçalves et al, 2014). The rate of current use (within the last 30 days) showed no change overall and again a decline in the 15-24 age bracket (Hughes and Stevens, 2012). After 2007, recent use started declining overall and ‘use of most drugs has since fallen to below-2001 levels’ (Home Office 2014:47). ‘By 2012... Despite drug users no longer being punished, fewer people were taking drugs – and this was especially true among the young’ (Chivers, 2014).

### **Less burden on the criminal justice system, likely decline in acquisitive drug-related offending**

Many of the experts I interviewed agree that the new Portuguese system has (despite initial concerns from sections of the political spectrum and from the police) freed up not only prison spaces but also police and court time. According to the Home Office research, ‘Portugal appeared to apply similar police resourcing to drugs after decriminalisation as before’ (2014:51). However, those resources are applied in different ways. The police can, at least in theory, now concentrate on big time suppliers and dealers, on intelligence work and international co-operation. The results are, for example, ‘fewer apprehensions in Portugal since decriminalisation, but larger quantities of drugs apprehended’ (N. Portugal).

This was not, as Sergio Ferreira de Loureiro (Aveiro PSP) explained to me, an easy transition. The police lost the ‘bargaining powers’ by which they could persuade users to inform on dealers. Now they use and seek to develop new ‘technological solutions’ to assist their investigations, but it was ‘easier’ to rely on informers’ testimony.

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<sup>11</sup> Home Office, 2014:47

The practitioners I met told me that, from their perspective ‘on the ground’, they have been observing a decline in criminality (especially offences against property) motivated by substance addiction. ‘Steady methadone use has decreased criminality a lot’, told me Raquel Glória, a senior psychologist who works in one of the Lisbon Street Teams. ‘Usually when they [users] start a methadone programme they stop stealing because they don’t have the abstinence [cravings]’.

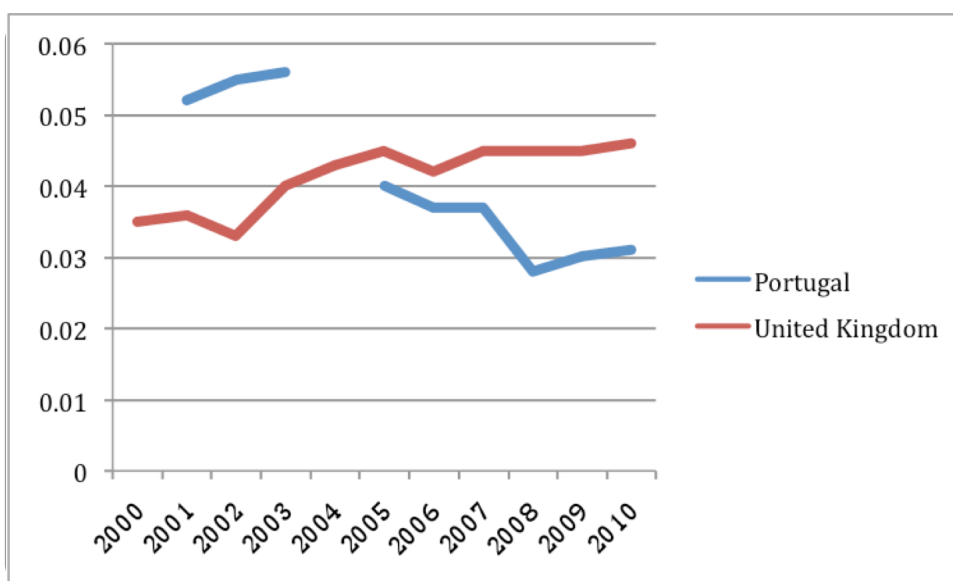
We need to bear in mind that the relationship between ‘crime’ and drug use is complex and not directly causal, and the elusiveness of the ‘dark figure’ of ‘crime’ (Reiner, 2007). However, ‘the effect that the availability of methadone treatment has on crime rates is well-documented by many other countries and consistent with the Portuguese experience’ (Domoslawski, 2011:39).

### Lowering costs

The experts and practitioners I met emphasized that the new system constitutes a less expensive process, in financial and social terms, than getting an individual through the criminal justice system. The process is much quicker (e.g. at Aveiro CDT a case takes between one day and a week on average to process, as compared to six months to a year in the criminal courts for charges of consumption/possession), therefore cheaper in terms of labour time and resources.

The latest (at the time of writing) estimates of public expenditure on sentenced drugs law offenders (EMCDDA, 2014) show a decrease in Portugal from 0.052% of GDP in 2001 to 0.031% in 2010. In the UK, expenditure is estimated to have increased from 0.035% in 2000 to 0.046% of GDP in 2010. See Figure 10.

**Figure 10: Estimated public expenditure on sentenced drug-law offenders in prison (as a percentage of GDP)**



No data available for Portugal for the years 2003 and 2004  
Source: EMCDDA (2014)

The Home Office research acknowledged the reduction of drug related offenders in

Portuguese prisons and in the number of cases going through the courts. 'There are indications that decriminalisation can reduce the burden on criminal justice systems (...) but it is not clear if the impact of this is balanced by the administrative burden of the dissuasion commission process' (2014:51). However, the processual costs of the CDTs have been found to be cheaper than the criminal courts. The 2013 external evaluation of the National Plan against Drugs and Drugs Addiction found that 'the average cost per case' in CDTs (2005-2011) was between 346 euros and 388 euros, while the expenditure per case in the courts was 525.25 euros (Gesaworld 2013:9).

The evaluation, looking at the period 2005-12, found the integrated responses strategy to be 'cost effective' and to have 'avoided social costs' in health (e.g. due to the reduction of infectious diseases), education, labour productivity and the criminal justice system. The costs of reintegrating users (2.2m euros) were also outweighed by the productivity gains of such reintegration (6.2m euros) (*ibid.*, p.19).

Another recent analysis examined the period between 1999 and 2010. Although the authors refrained from drawing direct causal links, they observed 'significant' decreases in the social costs of drugs since the approval of the new strategy. The study found that the social cost of drugs had decreased by a 'significant' 12% in the five years following the national strategy being approved. Taking the decade 2000-2010 into consideration shows a 'more significant' reduction in social costs: 18% on average, due to a decrease in:

- direct legal system costs related to criminal proceedings for drug law offences
- indirect costs to do with the lost income and production value of those imprisoned for such offences
- indirect health costs, mainly due to fewer drug-related deaths.

Although there had been an increase in (direct) health-related costs for drug addiction, this increase was small compared to the reduction in indirect health costs (Gonçalves et al, 2015).

## 8. LESSONS

It is, of course, the case that ‘what works in one country may not be appropriate in another’ (Home Office 2014:2); there are many variants, from social and cultural factors affecting the types and modalities of consumption, to the quality of the support infrastructure. However, useful lessons can be learnt from other countries’ experiences and policy choices. I therefore asked Portuguese policy makers, experts and practitioners for their reflections on this subject.

### Health first

The main architect of the Portuguese drug strategy, João Goulão, is clear that it is essential to develop the health responses *first*, in a *capillary system* of multi-faceted, integrated, quick on its feet assistance. ‘Without these it makes no sense to move the issue from the Ministry of Justice’.

In J. Goulão’s view, decriminalisation is not a silver bullet. ‘To decriminalise and not develop a network of responses in the several areas would be a disaster’.

A different mindset needs to be developed. ‘Seeing addiction as a sin, a vice, is a very different matter than seeing it as a disease.’

The first step is to convey/work on the idea that addiction is a **health issue**.

The second step is to acknowledge addiction as the very serious disease it is: to work on the concept that it is a **chronic relapsing disease**.

The idea of a chronic relapsing disease originally came from the UK, Dr. Goulão pointed out, but is at odds with the current focus on recovery. The latter implies a moral choice, strength of will etc., which are value judgments. (Yet we are funding medical interventions for conditions that can be also attributed to lifestyle choices, for example gastric bands.)

### Prevention work

In the ‘medium term’, it is essential to carry out ‘serious prevention work’, in the words of Vasco Gomes: e.g. comprehensive information provision for children from the age of 10 on how to handle drugs when they become available to them and to help them consume responsibly, if they choose to use them. J. Goulão concurred on the importance of informing about risks and precautions rather than just alarming. This empowers people to make informed choices. Deterrence is not the only strategy and can be counterproductive, as ‘people will still use if they want to’.

It is also important to consider how to introduce preventative measures at every stage of people’s lives: e.g. ‘what happens if you are pregnant and take drugs; how do you address risk with a young child; a teenager; at university; at work etc.’ (J. Goulão).

### Focus on problematic use

A small proportion of those who use drugs consumes the vast bulk: those who have a dependence. For example, out of an estimated 140-250 million adults (around 5% of the



world population) who used some illicit drug in 2008, 'only about 18-38 million could be classified as "problem drug users"' (UN World Drug Report 2009, p.175).

*'My business is the suffering that drugs can cause people, not the use itself.'*

(Jorge Sampaio, former Portuguese President of the Republic, quoting J. Goulão)

The Portuguese strategy is based on the notion that 'drugs', drug use and drug addiction are 'three separate issues and involve different problems'.

*'Not everybody is a problematic user. For instance, a lot of people drink wine: not all of them are problematic drinkers - not even most of them. Lots of people use substances knowing exactly the kind of effect they can expect. They use or drink responsibly'* (J. Goulão).

### **Embedding change**

Another priority that came out of the interviews I undertook was that policy makers need to be 'patient': changing attitudes takes time (much longer than an election cycle), as does the ability to properly monitor the impact of a policy and to develop an evidence base.

*'If you are changing your drug policy you have to wait for it [to bed in]. If you are dealing with mindsets and public opinion you have to wait for it.'* (N. Portugal)

*'Learning to look at people in a different way takes a long time. In Portugal it took 20-30 years.'* (V. Gomes)

### **Media and public perceptions**

*'Most of the users of hashish/cannabis [that attend CDTs] do not have health issues or problems with drugs. The problem is that in terms of public opinion, when you say the words 'drug users' nobody thinks about the 90%; everybody thinks about that 10% that are causing problems and that are very visible, normally heroin usage with some sort of small time dealing or petty criminality involved, health issues involved. So when you put a microphone or a camera in front of a politician, and someone says 'drug users' or 'drug policy', he will start thinking of that 5 or 10%.'*

*'That's what works in terms of public opinion'; in terms of policy, that's based on the 5-10% of the population of users, not the 90%.'* (N. Portugal)

The atypical reform of drug policy in Portugal took place because of the confluence of various factors, including: the country was facing a heroin and HIV-Aids crisis during the 1990s, which had originated in the mid-1970s and affected it across classes and social status; a treatment network (like the CRIs) was already in place; there was a(n eventual) willingness by politicians to listen to scientific evidence and practitioners; the ability of

'policy actors' like J. Goulão to capitalise on human rights discourses (to which the influential Portuguese Catholic church could subscribe) to win public, media and political support.

This meant that a 'zero tolerance' political attitude could be changed into a response which involved 'seeing the user not just as a criminal or a sick person, but as a citizen and deserving of dignity' (Hughes, 2006: 260). Hughes sees the media live footage of Casal Ventoso, an area of Lisbon where open, problematic use, infections and deprivation were rife, in the late 1990s and early 2000s as the catalyst for engendering public support and changing perceptions about drug users. The people I spoke to confirmed this. The 'emotive' and 'visceral' images that were being broadcast 'could have been framed as an example of undeserving criminals who were a threat to society'; instead, the messages being drawn attention to had to do with 'the plight of drug users' (*ibid*:243).

J. Goulão also explained: 'we invested a lot' in working with the media. [We initially] invited a group of journalists (about 30) and spent some weeks discussing these issues with them. [We provide ongoing] training specific to the media; it is important that they know the basics of the issues. So the background work has been done and links are now established with informed contacts....The news that come out now about drugs are usually well informed'.

### **'The creation of an alliance between experts and politicians',<sup>12</sup>**

The 'concerted actions' of lead practitioners, scientific experts and politicians, including the President himself (see quote on p.41) were instrumental: 'they used their multiple positions of power to mobilise societal support for reform' (Hughes, 2006:243). To achieve such concerted actions, one must not underestimate the ability of 'policy actors' to build arguments persuasive enough to enhance political receptivity, which allowed evidence to be input into policy formulation (*ibid.*).

The end result in today's Portugal is that the 'heat' seems to have been veritably taken off drugs issues in public discourse. Remarkably, the policies now go mostly unnoticed by the Portuguese public at large. Long standing concerns appear to have been abated while a 'broad consensus' (J. Goulão) exists at political level. Both the public and the politicians are in effect leaving the matter 'to the experts'.

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<sup>12</sup> Hughes, 2006:273

## 9. CONCLUSION

It is a well rehearsed argument that the criminal justice system is an expensive and not particularly effective way to deal with people who misuse substances. The Portuguese experience of focusing on problematic use while reducing criminal justice input appears to have borne fruit. Fewer people are imprisoned for drug related offences. Diseases and infections have vastly declined. The feared explosion in use has not materialised. External evaluations show the Dissuasion Commissions to be cheaper than the courts.

My study confirms the importance of a *long term, integrated* approach to tackling substance mis-use, improving health, achieving dissuasion and reintegration. The Dissuasion Commissions can only be understood within, nor would they be effective outside of a complex whole: they provide a gateway not only away from the criminal justice system but into a network of health and social support. The specialised Commission members and staff connect to each user as an individual, establishing a powerful relationship, which is intrinsically connected to the *non-punishing* nature of the process.

As Mr Ballotta at the EMCDDA points out, the Portuguese experience draws attention to areas that provide reasonable expectations of ‘good returns’:

- public health improvements
- effect on recidivism
- public expenditure savings.

Such measurable indicators can offer a sound evidence base from which to engage the public and policy makers in other countries, including the UK. They are conducive to reasoned debates and can contribute to ‘taking the heat off’ what is a politically thorny subject.

The Home Office leadership on drugs policy in England and Wales is ‘unique in Europe’ (House of Commons Home Affairs Committee, 2012). Some commentators argue (see e.g. UKDPC, 2012b) that, although this frames the issue as a criminal rather than a health one, at least it delivers resources for treatment. The NHS is seen as so overburdened as to be unable or unwilling to take on drugs as a priority. However, Portugal shows that redistribution of resources from the criminal to health systems can bring substantial benefits, in social and financial terms.

### **The UK: some figures**

- Comparative data suggests that historically the UK has had 'relatively high levels of drug use'. Since the early 2000s there has been an overall decline, but 'levels of heroin and crack cocaine use remain relatively high' (Home Office, 2014:9).
- The latest available Crime Survey data shows 'statistically significant increases' in the use of several substances in England and Wales in 2013/14 compared to the previous year. Overall use that year was 8.8% in England and Wales and 6.2% in Scotland (UK Focal Point, 2014:9). In England, the proportion of school children (aged 11-15) that reported having used drugs in the last year was 11% in 2013 and 10% in 2014 (Fuller, 2015).
- The estimated number of high risk drug users<sup>13</sup> in the UK (excluding Northern Ireland) for 2014 was 371,279, equivalent to 9.16 per 1,000 population aged 15 to 64 (UK Focal Point 2014:15).
- 1,957 drug misuse deaths were registered in 2013, up 20% on the figure for 2012 (1,636) and deaths related to heroin/morphine, the substances most commonly involved in drug poisoning deaths, rose by 32% compared to the previous year (Office for National Statistics, 2014).
- 'Public order and safety' gets the lion share of drug-related public expenditure in the UK. In 2010 it constituted 64% of the total drug-related public expenditure; 22.5% was spent on 'social protection' and 11.7% on health (EMCDDA, 2015c).
- The cost of drug-related offending was estimated in 2003 to be £13.9bn a year, £4bn of which incurred by the criminal justice system (House of Commons Home Affairs Committee, 2012:83).
- The total recorded drug offences in England and Wales and Northern Ireland was 4% lower in 2013/14 than the previous year, 'mainly due to a fall in the number of possession offences. There were fewer arrests in England and Wales in 2012/13 than in any year since 2007/08' (UK Focal point 2014:18).
- The UK has a high percentage of prisoners who have ever used illicit drugs prior to imprisonment (e.g. 79% in 2005/06) (EMCDDA 2012b:9).
- 'Almost half' of the prison population have an addiction to drugs (House of Commons Home Affairs Committee, 2012).
- Most people are not imprisoned for use and personal possession of illicit drugs, but receive fines, community work and other disposals like warnings, cautions or penalty notices for disorders (see e.g. EMCDDA 2009).
- In 2013, 1,141 people in England and Wales received immediate custody for possession offences: this constituted 3% of those sentenced by a court for such offences that year. 679 received a suspended sentence (1.8%), while 15% of those sentenced received a community sentence (5,761) and 51.2% (19,562) were fined. 28.9% received another disposal at court (Ministry of Justice (2014)).
- Research shows that 'many employers will not knowingly consider employing an applicant with a conviction, and nearly 50% of employers would not employ an individual with a drug related conviction.' (House of Commons Home Affairs Committee, 2012:71)

<sup>13</sup> High risk drug use is defined as the "problematic use of opioids (including illicit and prescribed methadone use) and/or the illicit use of benzodiazepines and implies routine and prolonged use as opposed to recreational and occasional drug use' (UK Focal Point 2014:15).

## **A public conversation and the importance of information**

The provision of factual information is fundamental to engage in a measured public conversation. As an important instance, it should be made clear that de-criminalisation is not the same as legalisation/de-penalisation: as we see in Portugal, drugs are still illegal, but the consequences of possession, use and purchase (of limited amounts) are civil, not criminal.

It is not clear that public opinion in the UK is overwhelmingly behind a punitive approach to drug use. Various polls suggest the picture is more complex and rather leaning in the opposite direction (see e.g. Observer, 2014; BMA, 2013). A. Ames, Ipsos Mori Research Director, concluded in 2013 that: 'What is apparent is that the majority of people are open to persuasion and debate, with two-thirds favouring a drugs policy review, comparing Britain's current system of criminalisation with alternatives' (Ipsos Mori, 2013). Deliberative approaches could help better understand public attitudes (UKDPC, 2012b).

## **Deterrence, education and prevention**

The logic of 'sending a message', i.e. 'detering use by enforcing the illegality of drugs' (HM Government, 2013) is not backed by evidence. No causal association has been observed between drug use and increasing or reducing penalties (see e.g. EMCDDA, 2011b; Reuter and Stevens, 2007; Hughes and Stevens, 2010). The Home Office's own research confirms this: '...we did not in our fact-finding observe any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country' (2014: 47).

On the other hand, criminalisation has a range of well documented negative effects. For example, a study by the University of Essex in relation to cannabis regulation considered the economic impact of 'criminal justice scarring'. 'Based on assumptions about employability and income, the study estimated that the result of a criminal record was a 19% reduction in average earnings.' (Home Office 2014: 48)

There is also no clear evidence that use is influenced by drug-specific education. What can influence behaviour, however, is what the CDTs in Portugal do: provide young people with accurate information about licit and illicit substances and their risks (UKDPC, 2012a). Imbuing the CDTs' work, and the whole Portuguese strategy, is the acknowledgment that people use substances for a variety of reasons and in different ways; recreational and problematic use are not the same, and conflating them is not helpful (J. Goulão).

The Portuguese Ministry of Health guides practitioners to provide information that avoids 'the danger of over-simplification and demonisation'. While 'it's important not to minimize the risks of using', the credibility of preventative messages 'depends in good measure on their suitability to the target population'. That credibility also rests on being open about the different degrees of dangerousness of the various substances (Ministerio da Saude, 2006:135).

## **Engaging with the experts, bipartisanship and inter-ministerial co-ordination**

The Portuguese strategy is committed to embedding evidence and knowledge development into the drug policy process. It is externally evaluated, has action plans and provides for nationwide data collection.

In Portugal the involvement of experts was an important element in solidifying the relationship between evidence and policy formation. A 'limited technocratisation' in the UK could help counter political concerns around voter and media reactions (UKDPC 2012b). Actively taking on board practitioners, police, users and ex-users would provide experiential evidence. Moreover, that Public Health England<sup>14</sup> is now charged with building an evidence base might facilitate such a bridge building with policy and practice.

A (at least relative) de-politicisation of the issues is needed to have an informed, rational, on-going public debate on how, as a society, we want to deal with drugs and drug use. As other commentators have suggested (e.g. UKDPC, 2012b; Magson, 2014), cross-party support for such a debate would help counter the pressure for the parties to out-bid each other on acting 'tough'.

In Portugal, even though the Health Ministry has the lead input, the National Coordinating Committee for Drugs, Drug Addictions and Harmful Use of Alcohol allows an overarching, strategic overlook involving different functions of government: health concerns are regularly considered in the context of other interests. Such inter-ministerial co-ordination should be encouraged; for example in England and Wales by building on and expanding the remit of the existing Inter-Ministerial Group on Drugs.

## **Early diversion, local reach and dedicated teams**

As we have seen, the CDTs are the primary route by which drug users are diverted away from the criminal justice system: as soon as someone is stopped by the police s/he is immediately referred to her/his local Dissuasion Commission.

CDTs (and the whole service delivery network) put the Portuguese national strategy of dissuasion into operation at a local, as far as possible capillary level. This is done in order to facilitate access to support and help deliver effective interventions. For the same reasons, dedicated teams work to find tailor-suited solutions for each user.

There are social and policy trends and initiatives in the UK that could be built on and might facilitate this kind of health based, non criminalising approach. Below are some examples.

In England, 'Liaison and Diversion' schemes operate at police stations in conjunction with the Department of Health and the NHS. These services identify and assess people with mental health or substance misuse issues as they 'first come into contact with the criminal justice system...so that they can either be supported through the criminal system

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<sup>14</sup> As health is a devolved matter I am concentrating here on England, purely as a matter of (personal and professional) familiarity.

pathway or diverted into a treatment, social care service or other relevant intervention or support service' (NHS England, 2015).

Drug and alcohol courts, although firmly set in the criminal justice system, also adopt a 'therapeutic', 'problem solving' approach. They garner dedicated teams of social workers, drugs counsellors, mental health and domestic violence specialists. Funding from the Department in Education in early 2015 has allowed this type of courts to be rolled out across England (see e.g. Lustig, 2015).

The 2010 Drug Strategy called for greater local control over service delivery (HM Government, 2010). The *Health and Social Care Act 2012* has entrenched public health concerns at local authority level.

In Scotland, Alcohol and Drug Partnerships bring together health boards, local authorities, police, voluntary agencies and others to develop locally based strategies.

These developments, together with wider devolution and localism trends, provide 'new opportunities for natural experiments in drug policy' (HM Government, 2013:8).

### **Evidence and values**

Looking back on my time in Portugal, the people I met, the processes I observed, I cannot but agree with Caitlin Hughes that 'effective reform' has to be both 'evidence-based and value-based' (2006:268). The CDTs, as well as the all the other organisations that work together to deliver drugs services, profoundly espouse empathetic, non-judgmental approaches. As experienced international policy analyst Danilo Ballotta put it, 'what is remarkable about the Portuguese system is not the decriminalisation per se', but this whole network that was created to deal with people as individuals'.

*'The whole point', in Sofia Almeida's words, 'is to bring the marginalised into the system'.*

*The Portuguese approach is 'the truest, most sincere application of the alternative to prison'. 'I would go further: this is alternative to coercive action. It is the full and most honest interpretation of the [harm reduction, humanistic] principle' (D. Ballotta, EMCDDA).*

If we are looking for more humane but also more pragmatic ways to deal with substance use and misuse, the Portuguese health model deserves our full attention.

## **SUMMARY OF RECOMMENDATIONS**

The following recommendations are inter-connected and mutually reinforcing. They can only be realistically achieved if policy makers are willing to make a concerted effort and commitment to work together to:

- achieve at least some measure of cross-party consensus and open up to a public conversation about drugs and drug consumption which is reasoned, measured and as far as possible de-politicised;
- take up a long view of the issue, which goes beyond electoral cycles;
- embed evidence and knowledge development in the policy process;
- submit strategies to robust evaluations, actions plans and data collection;
- meaningfully engage experts, practitioners and (ex)users in policy development.

For the short term (but ongoing):

- work on media and public engagement based on a two-way provision and exchange of factual, evidence-based information;
- open up the debate to acknowledging that 'drugs', use and mis-use are distinct issues, involving different policy measures;
- encourage a public conversation about humanistic and pragmatic approaches to substance mis-use;
- focus therapeutic attention on addictive behaviour, which covers the use of licit and illicit substances.

For the medium term:

- carry out comprehensive and measured preventative and educational work which is credible to its target audiences;
- focus on early diversion as a way to avoid the personally and socially damaging criminalisation of users (diversionary practices can be facilitated by drawing on existing experiences and structures, for example, the Liaison and Diversion schemes);
- encourage a strategic overlook that involves different functions of government and develop inter-ministerial co-ordination, for example through setting up national committees for addictions and harmful use of substances and/or expanding the functions and relevance of existing bodies like the Inter-Ministerial Group on Drugs.

For the long term:

- work to achieve public and political sensitisation to problematic drug use as a matter of public health, and to addiction as a very serious, chronic relapsing disease that benefits from support rather than punishment;
- develop a capillary, locally delivered and integrated system of support for people who abuse substances, whether legal or illegal;
- strategically consider the moving of resources from the criminal justice to health and social support budgets, taking into account potential and actual financial and social costs and benefits, in terms of public health, criminal justice processing and the impact of criminal records.



## **About the author**

Arianna Silvestri is a researcher and policy analyst, who has worked in the criminal justice field since 2006. Previously she had been working in housing and homelessness, human rights and immigration. She holds a first degree in Sociology and Criminology and a Master of Science in Social Policy and Planning from the London School of Economics. She is a member of the Editorial Collective of Critical Social Policy, a highly ranked, peer reviewed journal that provides an international forum for advocacy, analysis and debate on social policy issues.

## **Appendix A: PEOPLE AND ORGANISATIONS I ENGAGED WITH**

### Aveiro Dissuasion Commission (CDT):

Sofia Almeida, President

Gabriela Cierco, Vice President and Panel Member

Paula Paiva, Senior Technical Officer

António Cavacas, Panel Member (Lawyer)

### Centre for Integrated Responses (CRI), Aveiro South:

Fernanda Simões (Clinical Psychologist)

Fátima Peixote (Senior Technical Officer – social work)

### PSP Police Force:

Sergio Ferreiro Loureiro, Chief Superintendent, Operational Area, Aveiro District Police Command

### GNR Police Force:

Chief A. F. Roldão, GNR Police Force Headquarters in Aveiro

### Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD) (General-Directorate for Intervention on Addictive Behaviours and Dependencies), Ministry of Health

Dr João Goulão, Director General and National Co-ordinator of Portuguese Strategy to combat addiction and addictive behaviours

Alcina Ló, SICAD and EMPECO Co-ordinator

Sofia Santos, Head of International Relations, SICAD

Ana Rita de Castro, SICAD Lisbon

### Lisbon Dissuasion Commission (CDT):

Vasco Gomes, President

Nuno Portugal, Vice President and Panel Member

Raquel Lopes, Technical Team Officer (Psychologist)

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon:

Danilo Ballotta, Principal Policy Analyst and Institutional Relations Coordinator, Scientific division

Brendan Hughes, Senior Scientific Analyst for national legislation and the European legal database on drugs, Supply reduction and new trends unit

Vaughan Birbeck, Information management support officer, EMCDDA documentation centre

Monika Blum, Senior policy officer to the Management Board, Directorate

Low Threshold Methadone Programme Mobile Units

Elsa Belo, Senior Social Worker, Programme Co-ordinator, Ares do Pinhal

Mobile Unit Team: Hugo Faria, Psychologist

João Matos, Nurse

Crescer Na Maior

Américo Nave, Director and Co-ordinator, Lisbon Equipas da Rua (Street Teams)

Maria Carmona, Psychologist, Street Teams, Lisbon

Raquel Glória, Psychologist, Street Teams, Lisbon

Rui Coelho, Street Team Monitor

The attendees at Aveiro and Lisbon CDTs, who shall remain anonymous but to whom I am grateful for agreeing to talk to me and for their openness.

The University of Lisbon, ISCTE Institute

## **Appendix B: METHODOLOGICAL NOTES**

This study uses a mixed methodology: a predominantly qualitative approach involving the use of interviews to provide rich description, supplemented with quantitative data to increase the generalisability of the research.

The first logistical challenge for my research was language. I gained familiarity in reading Portuguese texts, including legislation, government documents, research and newspaper articles. Spoken skills proved a challenge and necessitated the use of an interpreter during most of the interviews, which were carried out in Portuguese, audio recorded, transcribed and translated. Some of the interviews were carried out in English and in these cases the recordings were transcribed by myself.

The second logistical challenge was obtaining access to policy makers in Portugal. My contacts at Lisbon University proved vital in facilitating this. Unsurprisingly, not everyone responded to my requests for access, and my research plans adapted and changed accordingly.

By necessity as well as by design snowball sampling was adopted, a method that is particularly useful for locating interviewees who are information-rich.

Key informants were approached by letter and/or email, outlining the nature of the research and interview process. A consent form was completed prior to undertaking each interview and interviewees were given the choice of the degree of anonymity they would be afforded.

The presence of an interpreter impacts upon the interview and reduces the involvement between the researcher and the interviewee. However, particularly when the interpreter is of the same culture as the interviewee, their presence can provide a rich(er) insight. As my interpreter was knowledgeable in the area of my research he was able to engage the interviewees with a degree of discretion and latitude, from which I benefited. The fact that I understand spoken Portuguese meant I still had control over the interview process.

During the observation phases of the project the presence of an interpreter was also required, as the Commission hearings were, obviously, conducted in Portuguese. The presence of myself and the interpreter potentially affected the behaviour and answers of the people attending (and for this reason Lisbon CDT limited our presence to certain parts of the hearing only). The fact that very personal issues were being discussed could make our presence particularly difficult for the participant. That is why permission was required beforehand and no pressure was put on the person to give consent to our presence. We tried to minimise the risk of our 'adulterating' the process by explaining clearly our reasons for being there and our role as impartial observers and by guaranteeing total anonymity; physically we positioned ourselves away from the participants' field of vision and we did not take notes during the hearing.

Both with regards to our presence to the hearings and our ability to interview CDT attendees I faced the risks inherent in self selection – people who were asked and consented may have been the most amenable, the 'easiest' cases. What was reassuring was that the sample of my interviewees in fact matched national trend data in terms of

age, substance apprehended with, gender, nationality, type of use and CDT attendance records.

My interviewees' responses could have been influenced by a variety of factors, including their assumptions about my relationship with the Commission. However, my overall impression as a researcher was that their replies were genuine. Their attitude towards me (and the interpreter) was likely influenced by their experience at the CDT hearing that had preceded my interviews. Almost all of the interviewees appeared to be feeling relieved and relaxed at the end of the hearing process, whereas they had been nervous, uptight and mistrustful on arrival at the CDT.

## Appendix C: DISSUASION INTERVENTION MODEL: GUIDANCE

(Source: SICAD 2013b)

### Stage 1: Individual assessment

A semi-structured interview aims to establish the person's risk level (see figure below) and motivations for changing behaviour (and undergoing treatment if relevant). This enables the identification of the most adequate and effective intervention(s) for each individual.

The information gathering about the individual must include:

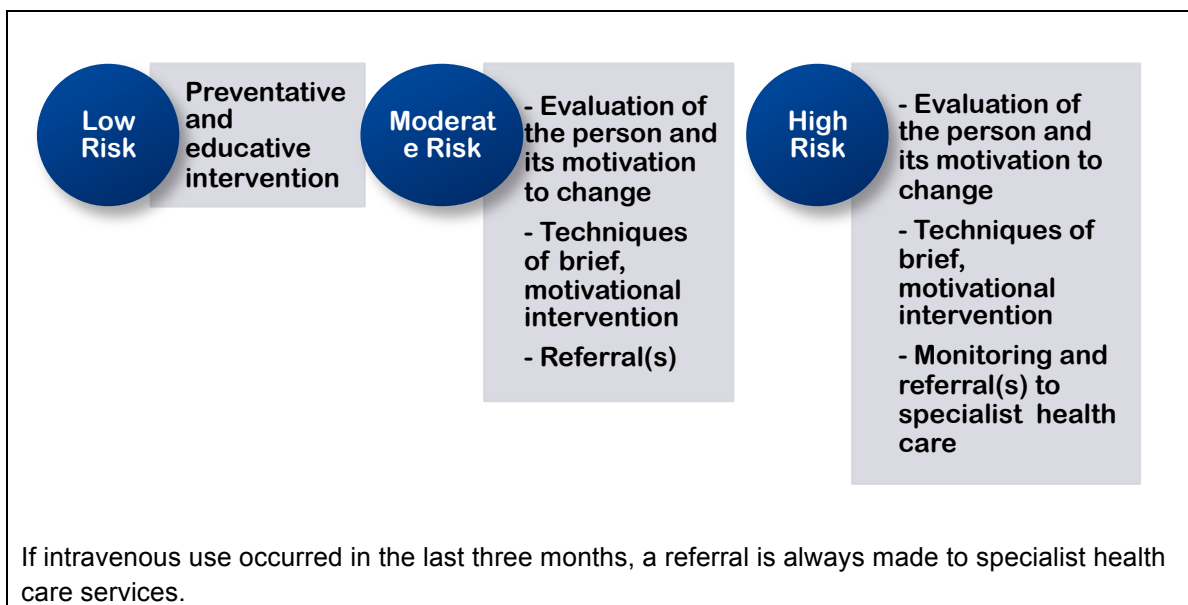
- demographics
- details of use (history, current frequency and context)
- personal, family and social circumstances
- medical history.

The ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) tool is applied to help with assessing the degree, if any, of substance dependence. ASSIST (Henry-Edwards et al., 2003) is a questionnaire that can be applied quickly (about 10 minutes). It has eight questions about 10 main substances (tobacco, alcohol, cannabis, cocaine, amphetamines, ecstasy, sedatives, hallucinogens, opiates, other substances).

*It is important in this phase to observe the mental and physical state of the person, looking out for signals and symptoms that may indicate situations of dual diagnosis.*

### Stage 2: Motivational Intervention, suited to individual needs

Each level of risk is associated with certain forms of intervention:



Motivational interviews are used to stimulate change and to help people accept and start treatment 'by exploring and resolving their ambivalence towards it' (SICAD, 2013b).

### Stage 3: Evaluation and follow up

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