A Path to Peace in the U.S. Drug War: Why California Should Implement the Portuguese Model for Drug Decriminalization

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A Path to Peace in the U.S. Drug War: Why California Should Implement the Portuguese Model for Drug Decriminalization

MALLORY WHITELAW*

Scientific evidence and our concern for health and human rights must shape drug policy. This means making sure that fewer people die from drug overdoses and that small-time offenders do not end up in jail where their drug problems get worse. It is time for a smarter, health-based approach to drug policy.

Kofi Annan1

I. INTRODUCTION

The U.S. is losing its very public war on drugs. Both at home and abroad, reformers balk at punitive drug policies that primarily employ the criminal justice system to control drug use, thereby incurring heavy economic and social costs.2 Accordingly, unprecedented public support for easing the U.S. drug war has catalyzed state-level drug law reform across the country.3 Over twenty U.S. states have legalized medical marijuana.4

2. Christopher Ingraham, Global drug policy isn’t working. These 100+ organizations want that to change, WASH. POST (May 5, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/05/05/global-drug-policy-isnt-working-these-100-organizations-want-that-to-change/.
Furthermore, several U.S. states now allow the recreational use of mari-juana. Clearly, there is great public and legislative willingness to reform drug laws.

My note will focus on this opportunity for states, California in par-ticular, to continue along the path of liberalization by decriminalizing possession for all drugs. Furthermore, because U.S. states can be fertile testing ground for changes to federal law, drug decriminalization in Cali-fornia will be a worthy experiment that may pave the way for further de-escalation of the U.S. drug war. To implement this change, I will argue that California should look to Portugal’s decriminalization of drug pos-session as a proven model for liberalized drug policies. Following the Portuguese approach in California will have a positive effect on the state’s budget by alleviating the social and economic costs associated with drug criminalization. I will include specific predictions for how the state’s budget would be bolstered through refocusing the state’s resources from criminalization to public health, as Portugal has done since 2001.

Section II discusses the failings of U.S. criminalization of drug pos-session. It will address how the government is trapped in a “no-win” pat-tern of costly over-incarceration, which actually exacerbates the drug ep-idemic, both in addiction rates and in social ramifications, especially for vulnerable populations. Specifically, the section will discuss the eco-nomic and structural burdens that criminalization places upon U.S. law enforcement, the penal system and the healthcare system.

Section III will outline how the country is on the cusp of a new age of drug reform. The section will briefly discuss the growing recognition of the failing drug war, a few of the liberalized approaches to drug laws at the state level. In this spirit of reform, the U.S. should look to interna-tional models, specifically Portugal’s decriminalization approach, for re-form frameworks.

Section IV will document how Portugal has decriminalized personal possession of all drugs. Portugal has implemented a system of regional panels that process most drug offenders, diverting users away from the courts and the penal system. The section will further outline how Portu-gal’s system has had a positive impact on drug addiction, and reduced risky user behaviors and drug related illnesses. These results have allievated both the human and monetary costs of drug abuse.

Section V will argue that California is well poised to implement highly progressive drug law reform. The state is faced with a drug-in-duced public health crisis and heavily impacted prisons. Yet currently,
California perpetuates the costly and ineffective U.S. approach of criminalizing drug possession. The section will argue that despite the state’s recent reforms and its use of drug courts, California’s impacted prisons and strained budgets call for more drastic reform measures by rethinking the state’s drug laws.

Section VI will argue that California should pave the way for progressive U.S. drug reform by implementing the Portuguese decriminalization model. The section will outline the expected economic and social benefits of this model, working with the assumption that results would roughly mirror those seen in Portugal. Section VII will outline potential legal and social obstacles to decriminalization in California. The note will conclude that California should be cautiously optimistic that Portuguese-style decriminalization will offer substantial benefits and help pave the way for further nationwide liberalization of drug laws.

II. STATISTICS SHOW THAT THE U.S.’S DRUG EPIDEMIC IS NOT A WAR THAT CAN BE WON USING A LAW ENFORCEMENT APPROACH

Failed drug war policies have cost the U.S. dearly.6 Historically, U.S. and state governments have sunk their resources into reactive tactics to combat drug use, such as incarceration, to “stanch the flow” of drugs, instead of investing in preventative measures.7 In fact, for every dollar spent by federal and state governments to prevent addiction, fifty-nine dollars is spent “shovel[ing] up its wreckage.”8 This policy of only “treat[ing] the symptoms” of the drug epidemic creates a costly cycle for our healthcare system and for law enforcement, yet leaves us with no greater ability to understand or prevent the underlying causes of addiction.9

Tactically, the U.S. chooses to address its drug problem primarily through its “love affair with lock and key.”10 This tactic has led to a heavily incarcerated population.11 With over two million people in prisons and jails, the U.S. incarcerates more people per capita than any other country.12 About a quarter of these two million inmates are serving time for

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7. See id.
8. Id.
9. See id. at ii–iii.
12. Too many laws, too many prisoners, supra note 10.
drug offenses.\textsuperscript{13} As a result, our penal system is currently stretched beyond capacity. Prison overcrowding leads to unconstitutional conditions, which in turn leads to costly lawsuits.\textsuperscript{14} Equally troubling are the stark disparities in incarcerated populations; in 2014, 2.7\% of the U.S. black male population and 1.1\% of the U.S. Hispanic male population were serving sentences of at least one year, compared to less than 0.5\% of the U.S. white male population.\textsuperscript{15} This means black males were over five times as likely as white males to serve a long sentence, with Hispanic males twice as likely as whites.\textsuperscript{16}

Despite the U.S. government’s exorbitant expenditures and overcrowded prisons, these efforts to fight the drug war have not paid off.\textsuperscript{17} Stateside illegal drug use persists, and in some areas, looms larger than it does overseas.\textsuperscript{18} For example, the prevalence of cocaine users in the U.S. is tied for first place with Spain. For amphetamines and opioids, U.S. users maintain a solid lead over all European counterparts in terms of usage.\textsuperscript{19} Indeed, a World Health Organization study of seventeen countries found that the U.S. had the highest rates of illegal drug use.\textsuperscript{20} The National Center on Addiction and Substance Abuse (CASA) found that forty million Americans age twelve and over “meet the clinical criteria for addiction.”\textsuperscript{21} CASA estimates that another eighty million are “risky substance users,” which means they use substances in ways that “threaten public health and safety.”\textsuperscript{22} Addiction and risky drug use also contribute to a variety of expensive health and social problems, including crime, child neglect and lost productivity.\textsuperscript{23} Accordingly, CASA estimates the U.S.’s failure to prevent problematic drug use may cost the government over $468 billion each year.\textsuperscript{24}

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\item \textsuperscript{13} Natarajan et al., supra note 11, at 1.
\item \textsuperscript{14} See Amanda Petteruti et al., Pruning Prisons: How Cutting Corrections Can Save Money and Protect Public Safety 7–8 (Justice Policy Institute ed., 2009).
\item \textsuperscript{15} E. Ann Carson, Ph.D., The Bureau of Justice, Prisoners in 2014 15 (Lynne McConnell & Jill Thomas eds., 2009).
\item \textsuperscript{16} Id.
\item \textsuperscript{17} Id.
\item \textsuperscript{18} Drug Use in America vs. Europe, Recovery Brands (July 22, 2010), http://recoverybrands.com/drugs-in-america-vs-europe/.
\item \textsuperscript{19} Id.
\item \textsuperscript{20} Alex Kreit, The Decriminalization Option: Should States Consider Moving from a Criminal to a Civil Drug Court Model?, 2010 U. Chi. L. Rev. 299, 303 (2010) [hereinafter The Decriminalization Option].
\item \textsuperscript{21} National Center on Addiction and Substance Abuse, Addiction Medicine: Closing the Gap Between Science and Practice 39 (CASA ed., 2012).
\item \textsuperscript{22} Id.
\item \textsuperscript{23} Id. at 39–40.
\item \textsuperscript{24} Id. at 2.
\end{itemize}
A recent national epidemic of overdose deaths from opioids, including heroin, provides further evidence of our failing drug policies. In 2013, about 700,000 Americans took heroin, which is twice the number from a decade ago. This increase in the popularity of heroin may be due to a crackdown on liberal prescription of pain medications and increased smuggling operations from Mexico. Seizures of heroin at the U.S.-Mexico border increased “from 560 [kilograms] in 2008 (1,230 [pounds]) to about 2,100 [kilograms]” in 2013. To exacerbate matters, a gram of pure heroin now sells for half of its 1980s price tag, enhancing its mass appeal. This resurgence has proven deadly: the National Institute on Drug Abuse reports that between 2001 and 2015, there was a six-fold increase in the number of overdose deaths from heroin.

Despite these failures to stem the tide of illegal drug use, federal and state governments continue to combat this epidemic using law enforcement and the penal system, even against low-level drug offenders. This approach places enormous burdens on public budgets and has strained our communities in the following ways.

A. Criminalization places burdens upon law enforcement and the penal system

In 2014, 1.5 million prisoners were held in the nation’s penal system, with 50% of federal inmates and 15% of all male state prisoners convicted for drug offenses. A Harvard economist estimated that annual net state and local expenditures for enforcing drug prohibition are about $30 billion, with federal expenditures at about $15 billion. When the collateral costs of arrest and incarceration are factored in, such as removing convicted users from the job market, family hardship and opportunity

26. Id.
28. Id.
costs, the U.S.’s law enforcement approach to drug use looks even more outlandishly expensive.\textsuperscript{33}

The high costs of this penal approach are felt most acutely in communities of color. Although whites outnumber African-Americans by five to one in the U.S. population,\textsuperscript{34} and both groups use and sell drugs at similar rates,\textsuperscript{35} African-Americans are significantly more likely to be arrested and jailed for a drug offense.\textsuperscript{36} Even after release from prison, existing policies continue to complicate the lives of ex-inmates. A prison record can lead to denial of child custody, voting rights, employment, business loans, student aid, and public housing.\textsuperscript{37} To make matters worse, the prison environment may exacerbate addiction or even create new addicts.\textsuperscript{38} This is partially due to widespread availability of drugs in prisons, but also to prisons’ ineffective drug treatment policies.\textsuperscript{39} All these collateral factors combine to perpetuate addictions and create a second-class status that poses tremendous barriers to employment, housing, and stability for individuals and communities.\textsuperscript{40}

Diverting substance-abusing prisoners to community drug treatment programs rather than prison could reduce crime rates and save our criminal justice system billions of dollars.\textsuperscript{41} These savings would result from immediate reductions in the cost of incarceration, and from reducing the crime level among successfully treated offenders.\textsuperscript{42} In fact, a study by

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\item[33.] The Decriminalization Option, supra note 20, at 302.
\item[37.] AM. PUB. HEALTH ASS’N, DEFINING AND IMPLEMENTING A PUBLIC HEALTH RESPONSE TO DRUG USE AND MISUSE 2 (2013).
\item[39.] Id.
\item[41.] Diverting Individuals With Substance Use Disorders From Incarceration to Community Treatment Saves Billions, Prevents Crime, 1 CENTER FOR HEALTH & JUST. (2013), http://www.centerforhealthandjustice.org/FOJ%202003-13.pdf.
\item[42.] Id.
\end{itemize}
Portuguese Model for Drug Decriminalization

Crime and Delinquency estimates that if just ten percent of eligible offenders were diverted into drug treatment programs, the criminal justice system would save $4.8 billion per year.\textsuperscript{43}

B. Criminalization places burdens upon the healthcare system

The criminalization of drugs also exacerbates the dangers of illicit drugs, leading to greater difficulties for the healthcare system.\textsuperscript{44} For example, the fear of being caught makes users less likely to engage with the healthcare system to obtain preventative care, which leads to more emergency room visits.\textsuperscript{45} The threat of arrest also encourages riskier drug-using behavior, such as bingeing and poor sanitation in drug-using environments.\textsuperscript{46} Criminalization has also led to more overdose deaths because illicit drug markets encourage the sale of more potent forms of drugs. In addition, people are afraid to call 911 when they witness an overdose.\textsuperscript{47}

The CDC and the National Institute for Health have both recommended wider access to medication-assisted treatments, including methadone and buprenorphine. Yet only 9% of U.S. drug treatment facilities offer these treatments, and publicly funded treatment programs are even less likely to offer them.\textsuperscript{48} This lack of access to drug treatment not only results in untreated addiction, but also encourages behavior that puts drug users at an increased risk of HIV infection and heightens vulnerability to fatal overdoses.\textsuperscript{49}

In this system, it is unsurprising that only one in ten users seeks drug treatment.\textsuperscript{50} According to CASA, this leaves a treatment gap of 20.7 million individuals, whose only “treatment” will occur in an emergency room.\textsuperscript{51} The vast majority of treatment referrals come from the criminal justice system, showing that addiction is typically addressed “only at the point at which it results in profound social consequences.”\textsuperscript{52} This creates

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\item[44.] AM. PUB. HEALTH ASS’N, \textit{supra} note 37, at 1.
\item[45.] \textit{Id.} at 2.
\item[46.] \textit{Id.}
\item[47.] \textit{Id.}
\item[48.] \textit{Id.} at 5.
\item[49.] \textit{Id.}
\item[51.] ADDICTION MEDICINE, \textit{supra} note 21, at 10.
\item[52.] \textit{Id.} at 11.
\end{itemize}
a substantial burden on our healthcare system, including hospitals, which attribute almost a third of their inpatient costs to substance abuse and addiction.\textsuperscript{53} The Department of Justice estimates that treatment for addiction and for drug-induced illnesses costs our healthcare system over $9 billion per year.\textsuperscript{54} In addition, CASA estimates that the U.S. government spends more than thirty times as much mitigating the health effects from substance abuse as it spends on “prevention, treatment and research.”\textsuperscript{55} With recent data showing that prevention programs create a $10 return for every $1 spent,\textsuperscript{56} it is clear that our government’s reliance on the criminal justice system to alleviate drug abuse is misguided, and prevention should instead focus on drug treatment and recovery.

III. LOOKING AHEAD

Thankfully, the public is beginning to take an increasingly honest look at failing U.S. drug policies. Recent measures show that a considerable groundswell exists for exploring alternative models.\textsuperscript{57} For example, the U.S. Sentencing Commission voted in 2014 to reduce sentencing guidelines for some drug offenses.\textsuperscript{58} This commission “prioritized controlling federal prison costs” and recognized that the overcrowded penal system “makes prisons less safe for guards and inmates and makes successful reentry programming more difficult.”\textsuperscript{59} The more notable liberalization of drug laws seems to be happening at the state level, often through ballot measures.\textsuperscript{60} In 1996, California Proposition 215 was approved by 56% of the state’s voters.\textsuperscript{61} The measure allows patients and

\textsuperscript{53} Id.


\textsuperscript{55} ADDICTION MEDICINE, supra note 21, at 5.


\textsuperscript{59} Id. at 2.


\textsuperscript{61} California Proposition 215, the Medical Marijuana Initiative, BALLOTPEDIA (1996), https://ballotpedia.org/California_Proposition_215_the_Medical_Marijuana_Initiative_%281996%29.
defined caregivers to possess and cultivate marijuana for medical purposes. California is now one of over twenty states that have legalized and regulated medical marijuana. Recently, several states went a step further, legalizing the possession of marijuana for recreational use. Despite the tension between these new state laws and federal laws, the state laws remain valid and prevent state-level prosecution.

Sentencing for drug crimes has been another target for recent state reforms. California voters passed Proposition 47 in 2014, which reduced penalties for many drug offenses. Minnesota took similar measures in 2015, with a commission voting to reduce prison sentences for some drug offenders, and Utah passed laws that favor treatment over incarceration for many drug offenses.

These state-level reforms show strong public willingness to rethink our system of drug criminalization and incarceration. However, partially reduced sentences and some legalization of select substances will not sufficiently alleviate the impact of drug criminalization on government budgets, public health, and communities. More drastic steps must be taken to end the drug war. This is because, even with reduced sentences, many apprehensions for drug use will still burden the criminal

62. Id.
63. Hauser, supra note 4.
64. Smith, supra note 60.
65. See id.
69. See State Medical Marijuana Laws, supra note 57.
70. A study by the ACLU, which reviewed records from all 58 California counties, found variations in how Prop. 47 has affected law enforcement. See generally ACLU, CHANGING GEARS: CALIFORNIA’S SHIFT TO SMART JUSTICE (2015), https://www.aclu.org/wp-content/uploads/2015/11/Prop47_report_final11.pdf. Some counties have prioritized low-level arrests, while others deprioritized them. Id. at 7. “For example, the Fresno Sheriff’s Department reported that their arrests for low-level offenses went up by 77%” in the first six months of 2014 compared to the first six months of 2015, “while their Los Angeles counterpart reported an increase in low-level arrests of just 10%. In contrast, the Sacramento Sheriff’s Department reported that arrests for the same offenses were actually down by 43%.” Id. at 9. Additionally, the study found that jail populations fell after Prop. 47, but are rising again. Id. at 7; see also DRUG POLICY ALLIANCE, WHY IS MARIJUANA DECRIMINALIZATION NOT ENOUGH? (2016), http://www.drugpolicy.org/sites/default/files/DPA_Fact%20sheet_Marijuana%20Decriminalization%20and%20Legalization_%28February%202016%29.pdf.
justice system, even for low-level offenses. Instead of “flying blind” in reforming our drug policies, the U.S. should look to international efforts, where proven models for reform already exist for guidance. Furthermore, the federal government should allow states to act as “laboratories” for testing new legislative models. Such state-level innovations allow for “novel...experiments without risk to the rest of the country.”

Several European and South American countries have experimented with liberalized drug laws. Some have legalized selected narcotics, others have decriminalized them, while some have decided not to enforce their drug laws in certain circumstances. Portugal decriminalized the use, possession and acquisition of all narcotics in 2001. This change included a two-fold approach: (1) the end of penal sanctions for drug possession and the re-routing of drug offenses to regional panels, and (2) a health-oriented approach to addressing problematic drug use. This national strategy has led to an increase in treatment, decreased use of several dangerous drugs and a decrease in drug-related death and illness in Portugal. States should implement this successful model for decriminalization, thereby proving to the rest of the country that the framework will produce better results at a lower cost than our criminal justice approach.

76. Id. at 2.
77. Id. at 3.
IV. PORTUGAL’S PUBLIC HEALTH APPROACH TO DRUG ABUSE IS MORE EFFECTIVE AND LESS COSTLY THAN CRIMINALIZATION

Portugal decriminalized drugs over fifteen years ago. Although differing opinions exist about the new framework’s success, many feel the reformed laws have decreased the stigma attached to drug addiction and alleviated drug problems within the country. Drug use has declined for certain groups, public willingness to seek treatment has improved and prison populations have decreased. Overall, Portuguese decriminalization has emerged as a promising alternative to the drug war.

A. History of Portuguese Decriminalization

Throughout the 1980s and 1990s, Portugal struggled with a serious drug problem. This was partially attributed to the country’s location in the southwestern corner of Europe, which makes it a handy gateway for drug traffickers from Brazil, Mexico, Spain, and Morocco. Although many of the drugs funneled through Portugal are destined for the external market, the country began to have serious problems with intravenous heroin users. This problem was most visible in Lisbon’s Casal Ventoso neighborhood, where intravenous heroin users obtained their drugs through open-air drug markets.

Like the U.S., Portugal first focused on a law enforcement approach to its soaring rates of addiction and other drug-related casualties. This approach did not pay off; by 1999 the country saw record numbers of addicts and had the highest rate of HIV infection among injecting drug users.

78. Id. at 3.
79. See George Murkin, Drug Decriminalisation in Portugal: Setting the Record Straight, TRANSFORM 1 (2014) [hereinafter Setting the Record Straight].
80. GLENN GREENWALD, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES 6 (2009).
81. See generally id.
82. See id. at 27–28.
83. See Kellen Russoniello, Note, The Devil (and Drugs) in the Details: Portugal’s Focus on Public Health as a Model for Decriminalization of Drugs in Mexico, 12 YALE J. HEALTH POL’Y L. & ETHICS 370, 380–83 (2013) [hereinafter The Devil (and Drugs) in the Details].
84. Caitlin Elizabeth Hughes & Alex Stevens, What Can We Learn From The Portuguese Decriminalization Of Illicit Drugs?, 50 BRIT. J. CRIMINOLOGY 999, 1001 (2010) [hereinafter What Can We Learn].
85. Id.
86. The Devil (and Drugs) in the Details, supra note 83, at 373.
87. Id. at 380–83.
88. Susan Ferreira, Portugal’s Drug Law Draws New Scrutiny, WALL ST. J. (2010), http://www.wsj.com/articles/SB10001424052702303411604575168231982388308 (reporting that 1% of Portugal’s population was addicted to illegal drugs). This number is comparable to current U.S. statistics. For example, in 2013, U.S. Department of Health and Human Services estimates 2.6
users in the European Union.\textsuperscript{89} Throughout this period, Portugal slowly recognized the need for a new approach to its drug problem.\textsuperscript{90} The country’s criminal justice approach stigmatized users and only seemed to exacerbate problematic drug use.\textsuperscript{91} Researchers and policy makers began to challenge the dominant “zero tolerance” dogma, and health professionals advocated a paradigm-shift to a more functional, humanitarian approach to addressing illicit drug use.\textsuperscript{92} In 2001, this new pragmatism finally led to the passage of Law 30/2000.\textsuperscript{93}

Law 30/2000 made Portugal the first country to fully decriminalize possession of drugs for personal use.\textsuperscript{94} The country’s shift to a public health approach signaled an acceptance that, for many users, expectations of absolute sobriety was neither realistic nor possible. A more realistic approach was harm reduction: reduce the risk individuals posed to themselves and to the public by helping them manage their addiction, instead of by applying a zero tolerance policy across the board.\textsuperscript{95}

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\item percent of persons aged 12 or older were addicted to illicit drugs in 2013. \textit{SUMMARY OF NATIONAL FINDINGS, supra} note 35, at 82.
\item \textit{Jordan Blair Woods, A Decade After Drug Decriminalization: What Can The United States Learn From The Portuguese Model?}, 15 UDC/DCSL L. REV. 1, 20 (2011) [hereinafter \textit{A Decade After Drug Decriminalization}].
\item \textit{The Devil (and Drugs) in the Details, supra} note 83, at 383–85.
\item \textit{Id} at 222.
\item \textit{See Lei n.° 30/2000 de 29 de Novembro [Law 30/2000 of the 29th of November]. Article 2 reclassifies consumption, acquisition and possession as an administrative offense, within established quantities; Article 3 establishes confidentiality for those requesting drug treatment and for medical providers; Article 4 allows for seizure and identification; Article 5 establishes civil drug dissuasion panels, operating under the Portuguese Institute on Drug and Drug Addiction; Article 6 establishes a central register; Article 7 lays out the structure and appointment of commissions; Article 8 outlines the jurisdictions of the commissions; Article 9 calls for the commissions’ cooperation with other health services, welfare services and police; Article 10 enumerates the factors the commissions will use to evaluate the drug use in question, including requests for medical examination; Article 11 specifies circumstances where proceedings will be suspended; Article 12 and 13 specify ways to submit to treatment and the duration of suspension; Articles 14–20 outline penalties, suspension of penalties and warnings; Articles 21–24 specify periodic attendance at health programs, notification of failure to comply, effects of suspension, duration of penalties and compliance. \textit{Id}.
\item \textit{Maia Szalavitz, Drugs in Portugal: Did Decriminalization Work?}, \textit{TIME MAG.} (Apr. 2, 2009), http://content.time.com/time/health/article/0,8599,1893946,00.html.
\item \textit{What Can We Learn, supra} note 84, at 1005.
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B. Drug Possession is Now An Administrative Offense in Portugal

Portugal’s new approach is defined by decriminalization, not legalization. This means that purchase, possession and consumption of drugs for personal use are still illegal and subject to police intervention. But violations are now exclusively administrative offenses and no longer burden the criminal justice system. Drug trafficking endures as a criminal offense and remains in the realm of the courts and the penal system.

For those caught with a ten-day supply or less of any drug, including hard drugs like heroin and crystal methamphetamine, there are no arrests, prosecutions or prison sentences. Instead, the Portuguese law established “Comissões para a Dissuasão da Toxicodependência” (Commissions for the Dissuasion of Drug Addiction), or “CDTs.” To adjudicate drug offenses, CDTs impose sanctions when appropriate, or let users off with a warning.

96. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 2; Lei n.º 30/2000 de 29 de Novembro, supra note 93, art 2 (“The consumption, acquisition, and possession for own consumption of plants, substances, or preparations listed in the table referred to in preceding article constitute an administrative offense.”).

97. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 4 (“Even in the decriminalization framework, police officers who observe drug use or possession are required to issue citations to the offender, but they are not permitted to make an arrest. The citation is sent to the commission, and the administrative process will then commence. The cited offender appears before the commission within 72 hours of the citation’s issuance. If the commission finds compelling evidence of drug trafficking, it will refer the case to criminal court.”).

98. Id. at 2 (“one’s own consumption” is defined as a quantity “not exceeding the quantity required for an average individual consumption during a period of 10 days”). The quantities delineated are one gram of heroin, one gram of ecstasy, one gram of amphetamines, two grams of cocaine, or twenty-five grams of cannabis. Wiebke Hollersen, ‘This Is Working’: Portugal, 12 Years after Decriminalizing Drugs, DER SPIEGEL (Mar. 27, 2013), http://www.spiegel.de/international/europe/evaluating-drug-decriminalization-in-portugal-12-years-later-a-891060.html. See also Decreto-Lei n.º 15/93, de 22 de Janeiro [Decree-Law no. 15/93 of 22 January].

99. Id. at 3.

100. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 3.

101. Id. at 3.

102. Id; Lei n.º 30/2000 de 29 de Novembro, supra note 93, arts. 10–15 (“The commission shall hear the consumer and gather the information needed in order to reach a judgment as to whether he or she is an addict or not, what substances were consumed, the circumstances in which he was consuming drugs when summoned, the place of consumption and his economic situation . . . . The commission shall provisionally suspend proceedings whenever a consumer with no prior record of offences under this law is deemed to be a non-addicted consumer. . . . The commission shall provisionally suspend proceedings whenever an addicted consumer with no prior record of previous proceedings for offences under this law agrees to undergo treatment. . . . The commission may provisionally suspend proceedings if an addicted consumer with a prior record of previous proceedings for offences under this law agrees to undergo treatment. . . . In applying penalties, the commission shall take into account the consumer’s circumstances and the nature and circumstances of consumption”).
There is one CDT for each of Portugal’s eighteen districts, and per Article 7 of Law 30/2000, each panel is comprised of three members.\textsuperscript{103} Each member has a background in social service, medicine, or law.\textsuperscript{104} CDTs cannot mandate treatment. Their primary aim is to dissuade drug use and to encourage dependent drug users to seek treatment for their addictions.\textsuperscript{105} Accordingly, a CDT can suspend a fine in exchange for a user’s agreement to seek treatment.\textsuperscript{106} For a user with an addiction or a prior record, stricter sanctions may apply, such as the suspension of a professional license.\textsuperscript{107} However, a CDT’s “sanction” may be as minor as a warning if the drug use is not deemed problematic and if the user will abstain from future use.\textsuperscript{108}

Because the overriding goal of decriminalization was to de-stigmatize drug users, a user’s visit to the CDT will focus on health instead of guilt.\textsuperscript{109} The commission’s members strive to avoid any trappings of a courtroom, sitting at a table with the offender instead of elevated on a bench or podium and dressing casually.\textsuperscript{110}

The positive outcomes from Portugal’s new approach cannot be attributed to decriminalization alone. The other “critical link” has been the reclassification of drug addiction as a medical problem.\textsuperscript{111} This new approach has alleviated the stigma and “red tape” surrounding drug treatment and emphasized social solidarity between drug users and the rest of society.\textsuperscript{112} Portugal’s implementation of this national strategy has increased the resources available for prevention, harm reduction, treatment, and social reintegration.\textsuperscript{113} Public health workers have played a critical role by building relationships with communities of at-risk users and

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\textsuperscript{103} DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 4; Lei n.º 30/2000 de 29 de Novembro, supra note 93, art. 7.
\textsuperscript{104} DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 4.
\textsuperscript{105} Id.
\textsuperscript{106} Lei n.º 30/2000 de 29 de Novembro, supra note 93, art. 11 (“2. The commission shall provisionally suspend proceedings whenever an addicted consumer with no prior record of previous proceedings for offences under this law agrees to undergo treatment. 3. The commission may provisionally suspend proceedings if an addicted consumer with a prior record of previous proceedings for offences under this law agrees to undergo treatment”).
\textsuperscript{107} DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 3; Lei n.º 30/2000 de 29 de Novembro, supra note 93, art. 17.
\textsuperscript{108} The Devil (and Drugs) in the Details, supra note 83, at 388; Lei n.º 30/2000 de 29 de Novembro, supra note 93, art. 18.
\textsuperscript{109} DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 6.
\textsuperscript{110} Id.
\textsuperscript{111} The Devil (and Drugs) in the Details, supra note 83, at 384–87.
\textsuperscript{113} What Can We Learn, supra note 84, at 1002.
\end{flushleft}
providing health services such as syringe-exchange programs, medication-assisted treatments, and supervised injection facilities. In some areas, teams of health workers in vans hand out fresh foil, offer needle exchanges, and supply methadone. These mobile teams comport with the bedrock principles of harm reduction: meeting people “where they’re at,” offering choices, and not coercing people into treatment.

Portugal’s accessible, health-oriented approach lies in sharp contrast to U.S. drug treatment, where methadone is more tightly controlled and monitored than all other prescription medications. Retrieving a methadone prescription from a neighborhood pharmacy is unheard of, let alone from a convenient mobile unit. In the U.S., methadone is only available in special clinics licensed by the DEA and can only be prescribed by designated doctors. The clinics are restrictive and humiliating; armed security guards patrol clinic halls and patients are separated from workers by bulletproof glass.

Meanwhile, Portugal’s increased resources for drug treatment have provided wider access to health services and lessened the impact of drug control on public budgets. Most data since decriminalization shows the Portuguese framework has been successful, both financially and from a health-oriented perspective. The country’s reforms even received the blessing of the International Narcotics Control Board, who is responsible for overseeing UN drug conventions. In 2004, the INCB conceded that Portugal’s two-pronged framework for decriminalization was in keeping with the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances because drug possession was still prohibited, even if sanctions were administrative rather than criminal.
C. Outcomes from Portugal’s decriminalization approach

Since Portugal enacted decriminalization and harm reduction in 2001, the country’s rates of drug use have declined in many categories, and “drug-related social ills” have been partially alleviated. Furthermore, while drug addiction and drug-associated problems continue to increase across the EU, those problems have mostly declined in Portugal. Funding for treatment programs—and addicts’ willingness to seek them—has improved substantially. The success of this public health approach has provided benefits for Portugal’s law enforcement, penal system, addiction rates, and public health.

1. Decriminalization Benefits Law Enforcement and the Penal System

By turning low-level drug possession into an administrative offense rather than a criminal offense, decriminalization has led to a dramatic decline in Portuguese drug arrests, “from over 14,000 in the year 2000, to around 5,500-6,000 per year once the policy came into effect.” A dramatic decrease in “crimes strongly linked to drugs” also ensued, decreasing by as much as 60% for assaults, 30% for robberies, and 10% for theft.

The percentage of inmates convicted for drug-related offenses in Portuguese prisons also decreased—from 44% in 1999 to about 21% in 2012. Prison density—the number of prisoners per 100 prison places—likewise fell from 119 in 2001 to about 101 in 2005. Another bright spot for Portuguese prisons has been the falling rates of drug use within the prison system: between 2001 and 2007, prisoners’ heroin use declined by 14%. Overall, Portuguese decriminalization has resulted in considerable efficiency for the court and prison systems.

2. Decriminalization Helps to Alleviate Problematic Drug Use

By many accounts, Portugal’s shift in drug policy has resulted in reduced addiction rates, and some of the lowest overall drug use in the

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125. See DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 11–15.
126. See id.
127. See id.
128. See id.
129. SETTING THE RECORD STRAIGHT, supra note 79, at 6.
130. What Can We Learn, supra note 84, at 1009–10. Certain crimes, such as robbery, are strongly linked to drug use because they are sometimes committed to obtain money to support drug use, Drug-Related Crime, NCJ-149286 (Dep’t of Justice Sep. 1994) (fact sheet).
131. SETTING THE RECORD STRAIGHT, supra note 79, at 6.
132. What Can We Learn, supra note 84, at 1010.
133. Id. at 1010–11.
Since decriminalization, lifetime prevalence rates, which measure lifetime drug use, have decreased for several age groups. For citizens between thirteen to fifteen years old, the rate decreased from 14.1% to 10.6% in the first six years after decriminalization. For individuals aged sixteen to eighteen, that number decreased from 27.6% to 21.6%. “For some older age groups,” including nineteen to twenty-four year olds, “there has been a slight to mild increase in drug usage, generally from 2001 to 2006.” Experts view a mild increase in lifetime drug use for the general population as virtually inevitable in all nations, regardless of their drug policies and regardless of whether there was an actual increase in drug use, due to the cohort effect; with the passage of time, older people who have never tried drugs are replaced by a new generation, “among whom a significant percentage” have already tried drugs.

In observing the long-term effects of Portuguese drug policy, experts view drug use among adolescent and post-adolescent age groups, especially the age fifteen to twenty-four group, as the most significant. The use of drugs at this young age is considered one of the “harbingers for long-term behavioral changes.” While prevalence rates for this fifteen to twenty-four age group have increased slightly, “the rates for the critical [fifteen to nineteen] age group—critical because such a substantial number of young citizens begin drug usage during these years—have actually decreased,” suggesting the prevalence of drug use in Portugal will continue to ebb.

Comparative usage rates across the European Union further highlight the success of Portugal’s drug policies. For example, only five countries had a lower prevalence rate for cocaine usage than Portugal. For the fifteen to sixty-four age group, Portugal has the lowest lifetime prevalence rate for cannabis use, which is the most widely used drug in the EU. In fact, Portuguese cannabis prevalence is less than half of that of the majority of EU states. Statistics for amphetamines, ecstasy and heroin are similarly encouraging. Overall, the trend is clear: decriminalization seems to have partially alleviated problematic drug use in Portugal.

134. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 12.
135. Id. at 11.
136. Id. at 11–12.
137. Id. at 12.
138. Id.
139. Id. at 13.
140. Id. at 14.
141. Id. at 22.
142. Id.
143. See id.
144. Id.
3. Decriminalization Benefits the Healthcare System

Portuguese decriminalization is likewise linked to a decrease in diseases associated with intravenous drug use. For example, newly reported cases of HIV and AIDS among addicts have declined. Between 2001 and 2012, the number of HIV cases among injection drug users decreased from 1,016 to 56, and the number of AIDS cases among injection drug users decreased from 568 to 38. Before decriminalization, more than 50% of those infected with HIV in Portugal were drug addicts. Now, addicts make up only 20% of new HIV cases. Portugal has also seen a small decrease in new hepatitis B and C infections nationwide since decriminalization. Analysts have attributed these improvements to the enhanced treatment programs that accompanied the legislative reforms. Additionally, by some accounts, drug-related deaths have decreased since decriminalization. According to clinical data, deaths due to drug use have dropped from approximately 80 in 2001, to 16 in 2012.

Overall, these successes indicate that Portugal’s two-pronged approach for drug decriminalization, now in place for over fifteen years, has improved the country’s drug situation on several fronts. By reducing the social stigma against addicts, the country’s policies help to encourage problematic drug users to seek treatment. In addition, removing most drug possession from the realm of criminal justice helped to free up resources for providing treatment programs. Although the Portuguese approach to drug law reform may not achieve these exact results if implemented outside of Portugal, it can provide U.S. states with a proven model for cautious experiments with drug war de-escalation.

145. Id. at 16–17.
146. Id. at 16.
147. SETTING THE RECORD STRAIGHT, supra note 79, at 4.
149. Id.
150. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 16.
151. Id.
153. SETTING THE RECORD STRAIGHT, supra note 79, at 5.
154. See DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 11–15.
155. Id. at 6.
156. What Can We Learn, supra note 84, at 1002.
V. CALIFORNIA SHOULD LEAD THE WAY FOR U.S. DRUG REFORM

States have historically served as laboratories for new policies and for assessing political support for new ideas. Through state “experiments,” the federal government can learn from legislative successes and failures without risking broad national consequences. In particular, California’s large population, liberal leanings, and diversity make the state fertile testing ground for new laws. It was the first state to legalize medical marijuana with the passage of the Compassionate Use Act of 1996, which inspired similar state laws nationwide. This laid the groundwork for over twenty other states to legalize medical marijuana. With such a track record, the state is well positioned to blaze a trail away from the failed U.S. drug war, and toward an economically and socially rational drug policy.

Besides providing a learning opportunity for the rest of the nation, California has strong state-level reasons to reform its drug policies. Like Portugal before enacting decriminalization in 2000, the U.S. is currently gripped by a heroin epidemic. The Center for Disease Control reports that nationwide, heroin use has increased 63% since 2002, and heroin overdose death rates have nearly quadrupled. California has not been spared from this public health crisis. In 2014, opioids were involved in 28,647 deaths, or 61% of all drug overdose deaths nationwide. Exacerbating this crisis, a synthetic opioid called fentanyl has made this epidemic even more dangerous; the growing ubiquity of fentanyl-tainted heroin, which is thirty to fifty times stronger than traditional heroin, is causing users, even “experienced” ones, to overdose.

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158. See generally id.
160. CAL. HEALTH & SAFETY CODE § 11362.5.
161. State Medical Marijuana Laws, supra note 57.
163. Id.
Methamphetamine use is likewise on the rise. In 2014, San Diego regained its “Meth Capital of America” title as countywide methamphetamine deaths increased by 55% from 2008 to 2012.\footnote{José A. Álvarez, Meth Deaths up Dramatically in County, SAN DIEGO COUNTY NEWS CENTER (Feb. 4, 2014), http://www.countynewscenter.com/news/meth-deaths-dramatically-county.} San Diego’s Meth Strike Force reported the second highest number of meth deaths in 2012 since they began keeping records in 1995.\footnote{Id.} The San Bernardino police report that a pound of “good meth” now costs half what users paid in the 1990s.\footnote{Id.}

Like Portugal, California’s geography and cultural ties make it an ideal port of entry for international drug traffickers.\footnote{See Sandra Dibble, Record Border Meth Seizures, SAN DIEGO UNION-TRIBUNE (Jan. 3, 2015), http://www.sandiegouniontribune.com/news/2015/jan/03/record-border-meth-seizures-california/.} In 2014, meth seizures reached “unprecedented levels” at California-Mexico borders.\footnote{Id.} Mexican drug cartels supplied 70% of the U.S. meth supply through the San Ysidro border crossing alone, making California the primary source for methamphetamine nationwide.\footnote{Id.} These cartels have formed alliances with California prison and street gangs to control trafficking routes and distribution rings.\footnote{Id.} Cartels continue to battle over smuggling routes, and with the recent rise of Cartel Jalisco Nueva Generación in Tijuana and their rivalry with the Sinaloa Cartel, a surge in homicides has gripped the California-Mexico border.\footnote{See Kamala D. Harris, California Attorney General, Gangs Beyond Borders: California and the Fight Against Transnational Organized Crime 1–3 (2014).}

California continues to take a criminal justice approach to the possession of drugs for personal use. While the passage of Proposition 47 in 2014 reduced most drug possession crimes to misdemeanors, this was not decriminalization.\footnote{Sandra Dibble, A New Force in Drug Trafficking Reaches Tijuana, Los Angeles Times (Feb. 21, 2106), http://www.latimes.com/world/mexico-americas/la-fg-mexico-tijuana-cartel-20160221-story.html.} These offenses may still result in arrests, and may
still burden our court and penal system with prison sentences up to one year. In addition, drug possession for sale remains a felony, and because California’s laws don’t define a bright line between possession for personal use and possession for sale, there remains ample room for discriminatory sentencing. For example, courts may consider two grams of heroin as mere personal use for one case, but possession for sale for the next. While Proposition 47 was a commendable effort to decrease the prison population, it is a far cry from Portugal’s strategy of de-stigmatizing drug crime and emphasizing harm reduction techniques over penalties. Under the revised laws, instead of being prosecuted by the D.A., some California users whose drug offenses qualify as “personal use” will receive a misdemeanor and will be diverted to drug courts where they may seek drug treatment as an alternative to a jail sentence or probation. However, apprehension will still at least result in an arrest record and users will still face the stigma imparted from contact with the criminal justice system.

With substantial criminal justice resources still dedicated to the apprehension of illegal drug use, the overall drug war has cost the golden state dearly. By one estimate, the state’s “expenditures attributable to drug prohibition” totaled $5,378,683,000 in one year. Despite recent reforms, the state’s prison population stood at 112,300, or 135.8% of

175. See Gazzar, supra note 71; ACLU, supra note 70, at 9 (reporting that low-level arrests rose after Proposition 47 passed).
179. Adam Hudson, California’s Prop. 47 Reduces Prison Sentences but Won’t End Mass Incarceration, TRUTHOUT (2015), http://www.truth-out.org/news/item/31419-california-s-prop-47-reduces-prison-sentences-but-won-t-end-mass-incarceration; CAL. PENAL CODE § 851.87 (permits the court to order sealing of arrest record, but applicant must wait two years after successful completion of a diversion program. However, even after a successful petition, the Department of Justice can still disseminate the record in response to requests by police officers and authorized officials).
180. JEFFREY A. MIRON & KATHERINE WALDOCK, CATO INSTITUTE, THE BUDGETARY IMPACT OF ENDING DRUG PROHIBITION 5 (2010) (most recent year for which data is available). However, the passage of Proposition 47 may have reduced this number. For example, the Legislative Analyst’s office predicted a reduction of 1,900 inmates and an increase of 900 paroles in 2015–16, with $18 million in savings due to Proposition 47. TAYLOR, supra note 174, at 10. California’s passage of Proposition 47 has likely had some corrective effect on this number because under the new law, more offenders will be diverted away from prison. Id.
capacity as of March 2015. Outside of prison, 60% of California’s adult male population is nonwhite or Latino, but these groups comprise 75% of the male prison population: Latinos comprise 42% of the state prison population, African Americans are 29%, and other races are 6% of the state prison population. Among adult men in 2013, African Americans were incarcerated at a rate of 4,367 per 100,000, compared to 922 for Latinos, 488 for non-Latino whites, and 34 for Asians. The imprisonment of marijuana offenders alone cost the state $60 million in 2011.

In addition to the burdens upon California’s legal system, significant healthcare expenditures are currently devoted to treatment for addiction-related conditions or emergencies. In 2013, California hospitals treated more than 11,500 patients suffering an opioid or heroin overdose. That was a 50% increase from 2006. In 2014, there were more than 28,000 deaths from opioid overdose. Overall, the state’s yearly healthcare expenditure for illicit drug use may total $220 million.

California’s drug problems are similar to those seen in Portugal shortly before decriminalization. Like Portugal, the state’s geography makes it ideal for drug trafficking. Another similarity can be seen in drug-induced deaths: Portugal’s overdose death rate peaked right before decriminalization. Indeed, one percent of the Portuguese population was addicted to heroin. Because of these similarities between California’s current drug situation and that of Portugal right before decriminalization, it is reasonable to believe that the state will reap similar benefits and restricts the re-imprisonment of parole violators. Proposition 47, passed in November 2014, reclassifies some drug possession as a misdemeanor instead of a felony. 

182. Id.
183. Id.
184. Id.
185. MIKE MALES, PH.D., CENTER ON JUVENILE AND CRIMINAL JUSTICE, MISDEMEANOR MARIJUANA ARRESTS ARE SKYROCKETING 5 (2011) (most recent year for which data available).
187. Id.
189. DRUG ENFORCEMENT ADMINISTRATION, 2011 NATIONAL DRUG THREAT ASSESSMENT SUMMARY 4–5 (2011). Author’s $220 million estimate is based on the Department of Justice’s (DOJ) $11 billion estimate concerning annual nationwide “drug-related healthcare costs . . . including both direct and indirect costs related to medical intervention.” Id. Because the DOJ’s estimate was across fifty states, the author’s amount is one fiftieth of the DOJ’s total.
190. What Can We Learn, supra note 84, at 1001.
191. Id. at 1014.
from a two-pronged model for drug law reform that is derived from Portugal’s approach.

VI. APPLYING PORTUGAL’S APPROACH TO THE CALIFORNIA DRUG PROBLEM WILL LEAD TO SIGNIFICANT BENEFIT AND SAVINGS

While the full legalization of marijuana is a worthy experiment, various states are already testing the legalization waters. In light of this recent public willingness to innovate new drug policies, California has an opportunity to undergo an even more radical experiment with decriminalization of illicit drugs. With a solid model already developed by Portugal, the state should implement a similar model. This experiment will likely prove to other states and the federal government that decriminalization holds vast potential for substantial harm reduction and financial savings.

A. Crunching the Numbers for California

If California enacts Portuguese-style drug policies—which would include decriminalization coupled with healthcare and social programs—the following is an optimistic hypothetical outcome that assumes California’s results would roughly track those of Portugal.

1. Decriminalization Will Benefit California’s Law Enforcement and Penal System

Decriminalization would provide the most immediate and dramatic benefits to the state’s law enforcement and penal systems. The new policies would mean that apprehension for drug possession would be addressed by a panel similar to Portugal’s CDTs instead of by arrest or incarceration. If Californian decriminalization led to the same dramatic decline in arrests seen in Portugal, the state’s drug arrests would drop

194. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 2.
from approximately 229,523 per year to 91,809 within a few years of decriminalization.\textsuperscript{195} At approximately $750 per arrest, this decrease would save the state over $103 million per year.\textsuperscript{196}

Portuguese-style drug policies would also provide relief for California’s overcrowded prison system. Inmates convicted for drug-related offenses would decrease from 24,546\textsuperscript{197} to 19,146 within the first year.\textsuperscript{198} This decrease would save the California prison system approximately $253,800,000 per year.\textsuperscript{199} This measure would also help alleviate the state’s prison density, which would improve from 135.8% to 132% of capacity.\textsuperscript{200}

2. Decriminalization Will Cause Drug Use to Decline

A decrease in California drug use would be less dramatic than the shifts in numbers for law enforcement and prisons, but still significant. If the state’s results are substantially similar to Portuguese numbers, decriminalization will cause addiction rates to drop.\textsuperscript{201} For two critical groups—thirteen-to-fifteen and sixteen-to-eighteen year-olds—prevalence rates will decline for virtually every substance, with reduction in

\textsuperscript{195}. Author’s calculation based on Portuguese results. Misdemeanor arrests for 2014 drug offenses in California totaled 92,469, whereas felony arrests for drug offenses in 2014 totaled 137,054. \textbf{CALIFORNIA DEPARTMENT OF JUSTICE, CRIME IN CALIFORNIA 2014} 28, 34 (2015). That totals 229,523 drug offense related arrests. Portuguese criminal arrests for drug offenses were reduced from over 14,000 offenders in 2000 to an average of 5,000–5,500 offenders per year in 2008, which is a reduction of approximately 60%. \textit{What Can We Learn, supra} note 84, at 1008–09.


\textsuperscript{197}. \textbf{CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, CALIFORNIA PRISONERS AND PAROLEES} 16 (2011). \textsuperscript{198}. Author’s calculation based on Portuguese results. Between 2000 and 2010, Portugal’s convicted prisoners serving time for a drug related offense decreased from 43% to 21%—a 22% decrease. Hannah Laqueur, \textit{Uses and Abuses of Drug Decriminalization in Portugal}, \textbf{40 LAW & SOC. INQUIRY} 746, 757 (2015). Author’s estimated figure of 19,146 prisoners is a 22% decrease from the Department of Corrections figure of 24,546 prisoners. \textit{CALIFORNIA PRISONERS AND PAROLEES, supra} note 197, at 16.

\textsuperscript{199}. In 2008, it cost an average of about $47,000 per year to incarcerate an inmate in prison in California. Chris Nichols, \textit{Did California Spend $5 Billion to Execute 13 People?}, POLITIFACT CALIFORNIA (Sept. 21, 2016), http://www.politifact.com/california/statements/2016/sep/21/tom-steyer/did-california-spend-5-billion-execute-13-people/. Author’s estimate is therefore based on a reduction of 5,400 prisoners, at $47,000 per person.

\textsuperscript{200}. As of March 2015, California’s prison population stood at 112,300, or 135.8% of capacity. \textit{California’s Changing Prison Population, supra} note 181. Author estimates that if inmates convicted for drug-related offenses decreased from 24,546 to 19,146, total state prison density would decrease to 132%.

\textsuperscript{201}. \textbf{DRUG DECRIMINALIZATION IN PORTUGAL, supra} note 80, at 11–12.
some substances as dramatic as 50%. For the critical fifteen-to-nineteen year age group, prevalence rates will decrease in absolute terms. For some older age groups, there may be a slight increase in drug usage. However, such an increase in lifetime prevalence rates for the larger population is expected in every nation, regardless of drug policies, due to the cohort effect.

3. Decriminalization Will Benefit the Healthcare System

If California’s reduction in diseases and deaths due to drug use were to mirror Portuguese results, the state’s healthcare system would benefit significantly. For example, newly reported cases of HIV among injection drug users would decrease from 278 per year to 64 per year, with a savings of over $5.5 million to California’s Medicaid costs alone. The decrease in new AIDS cases among injection drug users would likewise lead to Medicaid savings of over $4.5 million. Deaths due to drug use

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202. Id.
203. Id. at 12.
204. Id.
205. Id. ("[O]lder people that never try drugs are replaced for a new generation among whom a significant percentage already had that experience.").
206. These figures are based on Author’s estimate. In six years, Portugal’s newly reported cases of HIV among drug users decreased from approximately 1,380 cases per year to approximately 310 cases per year. Id. at 16 (fig. 8). This was a decrease of approximately 77%. See id. In 2013, there were 4,636 newly diagnosed HIV cases in California. HIV Surveillance Report, 2013, CTR. FOR DISEASE CONTROL & PREVENTION 66 (table 18), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2013-vol-25.pdf. In 2015, 6% of the 39,513 new HIV cases in the U.S. were attributed to injection drug use (IDU). HIV and Injection Drug Use in the United States, CTR. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/hiv/risk/idu.html. Assuming the percentage of new HIV cases in California attributed to IDU is consistent with the national percentage, Author calculates that 278 of the 4,636 newly diagnosed HIV cases in California were attributed to IDU. Decreasing this number by 77%—the decrease seen in Portugal—the number of newly diagnosed HIV cases attributed to IDU in California would become just 64. See DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 16 (fig. 8). In 2011, California’s annual Medicaid spending per enrollee with HIV/AIDS was $25,823. Medicaid Enrollment and Spending on HIV/AIDS, KAISER FAMILY FOUNDATION, http://kff.org/hivaid/stats/state-indicator/enrollment-spending-on-hiv/. At $25,823 per 214 fewer HIV cases, the state would save an estimated $5,526,122.
207. This figure is based on Author’s estimate. In six years, Portugal’s newly reported cases of AIDS among drug users decreased from approximately 550 cases per year to approximately 180 cases per year. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 16 (fig. 8). This marks a decrease of approximately 67%. See id. In 2011, there were 2,655 newly diagnosed AIDS cases in California. 2012 Annual HIV Surveillance Report, COUNTY OF LOS ANGELES PUB. HEALTH 4, http://publichealth.lacounty.gov/www/files/phlai/hiv/2012AnnualHIVSurveillanceReport.pdf. In 2015, 10% of the 18,303 new AIDS cases in the U.S. were attributed to IDU. HIV and Injection Drug Use in the United States, supra note 209. Assuming the percentage of new AIDS cases in California attributed to IDU is consistent with the national percentage, Author calculates that 265 of the total 2,655 new AIDS diagnosed cases were attributed to IDU. Decreasing this number by 67%—the decrease seen in Portugal—the number of newly diagnosed AIDS cases attributed to
would decrease from approximately 4,500 per year to 3,510, saving the state over $16 million.\textsuperscript{208}

4. Decriminalization Will Reduce Collateral Consequences

Beyond the benefits to the penal and healthcare systems, decriminalization will offer further benefits to California’s budget. Portuguese-style CDTs are likely to be less expensive than criminal courts, or even our current drug courts, because they would not require the same amount of resources to process a case through its early stages: there would be no need for arrests, charging decisions, setting bail or public defenders.\textsuperscript{209} Removing arrests from the picture would have the added benefit of eliminating the economic and human consequences of removing a user from public and family life.\textsuperscript{210} Also, CDTs often impose fines, which would help offset their costs.\textsuperscript{211}

*Health Services Research* found that on average, California substance abuse treatment costs the state $1,583 per patient.\textsuperscript{212} However, when this treatment replaces incarceration, it produces a monetary benefit of $11,487 per patient, representing a ratio greater than 7:1 of benefits to costs.\textsuperscript{213} These benefits are primarily due to reduced costs associated with crime and increased employment earnings.\textsuperscript{214} If California provided sub-

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IDU in California would become just 88. See *Drug Decriminalization in Portugal*, supra note 80, at 16 (fig. 8). In 2011, California’s annual Medicaid spending per enrollee with HIV/AIDS was $25,823. *Medicaid Enrollment and Spending on HIV/AIDS*, supra note 206, at $25,823. At $25,823 per 177 fewer AIDS cases, the state would save an estimated $4,570,671.

208. This figure is based on Author’s estimate. About 4,500 Californians died following drug poisoning in 2014. Phillip Reese, *Two maps that illustrate California’s growing opioid epidemic*, SACRAMENTO BEE (Jan. 27, 2013), http://www.sacbee.com/site-services/databases/article56168810.html. Portuguese drug overdoses decreased from 280 in 2001 to 216 in 2006—a 22% decrease. *Drug Decriminalization in Portugal*, supra note 80, at 17. If California drug deaths decreased at this rate, it follows that the number of deaths would fall to approximately 3,510. Considering California hospital costs in 2011 for “illicit drug-induced illnesses” were $16,588 per event, the state would save roughly $16,422,120. *Economic Impact of Illicit Drug Use*, supra note 54, at 24.


211. Id.

212. Ettner et al., supra note 209, at 205.

213. Id.

214. Id.
stance abuse treatment instead of incarceration for the people apprehended and incarcerated for drug possession, the state would save almost $97 million per year.215

VII. OBSTACLES

Decriminalizing the possession of all illicit drugs in California will be met with social, cultural, and legal obstacles. First, due to recent liberalization of the state’s drug laws, the public may not perceive an urgent need for reform.216 Even if advocates can convince the public that further liberalization is necessary despite the state’s recent reforms, cultural differences between California and Portugal may raise doubt that the state will see similar successes from decriminalization.217 Lastly, there may be legal questions as to whether decriminalization conflicts with federal drug laws, and whether the state and federal governments can reach a tenable solution.218 However, these are not insurmountable obstacles and decriminalization can ultimately prevail.

A. Decreased Public Perceptions that California’s Drug Laws Need Reform May Hinder Decriminalization

First, California voters’ passage of Proposition 47 in 2014 may have created a public perception of de facto decriminalization of drug possession that will alleviate problems associated with the state’s drug war.219 After all, the measure transformed drug possession into a misdemeanor and reduced maximum sentences to one year in jail.220 While a positive step, the measure does not go far enough and may even create new problems. For example, experts tout California drug courts as an effective alternative to prison for treating addicts, partially because these drug courts

215. This figure is based on Author’s estimate. Inmates convicted for drug-related offenses in 2010 totaled 8,445. CALIFORNIA PRISONERS AND PAROLEES, supra note 197, at 16. Treatment in place of incarceration can provide a monetary benefit of $11,478 per individual. See Ettner et al., supra note 209, at 205. With $11,478 in monetary benefits for each of 8,445 treated offenders, the state would save $96,931,710.
217. A Decade After Drug Decriminalization, supra note 89, at 26–27.
refer offenders to drug treatment programs. However, Proposition 47 has “changed the calculus of drug courts,” since some users would not agree to a treatment program without a “felony hanging over [their] head[s].”

In addition to Proposition 47, the existence of drug courts may be another reason for the public to feel that drug possession has already been per se decriminalized in California. After all, these courts often redirect users into treatment instead of prison. However, drug courts are still part of the criminal system, and this marriage leads to inefficiencies. For example, some users who do not have a drug abuse problem will still have an incentive to obtain treatment just to avoid criminal penalties. On the flip side, serious drug addicts may be counseled by their attorneys to avoid a mandated treatment program because the light prison sentence they would face does not justify the burdens of a drug court. In these ways, drug courts may waste resources on casual users, while allowing problem users to escape treatment.

In contrast, Portuguese CDTs are civil, not criminal. The panel therefore may address each user’s treatment needs instead of approaching each case in the context of a punishment. CDTs have great discretion in determining each case’s outcome. They have the flexibility to decide the cost of sanctions, and are prohibited from imposing sanctions on non-problematic users. In these ways, CDTs can address drug use more efficiently and effectively than the court system.

B. Geographic and Cultural Differences May Hinder Decriminalization

Portugal and California are geographically and culturally distinct from each other, which raises the question of whether Portuguese policies would result in the same outcomes for California. For example, California has three times Portugal’s population and the state’s population

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221. Id.
222. Id. Nevertheless, some argue “the initiative will ensure that treatment beds are available for addicts who want them, not those trying to avoid incarceration.” Id.
223. The Decriminalization Option, supra note 20, at 311.
224. Id.
225. Id. at 312.
226. Id.
227. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 2.
228. The Decriminalization Option, supra note 20, at 327.
229. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 2.
density is more than twice that of Portugal. And at over four times Portugal’s geographical size, Californians would face the formidable task of establishing a system of panels that is accessible to all. Economically, this comparatively wider network may not be an insurmountable barrier. After all, the International Monetary Fund estimates that California’s GDP is over nine times that of Portugal.

However, Portuguese CDTs are provided by the country’s Ministry of Health using a single payer healthcare system. With most Californians covered by a wide variety of privately insured healthcare plans, the state will be challenged with organizing CDT-style panels that are accessible to all residents. But California’s successful implementation of a state healthcare exchange in 2013, under the Affordable Care Act, may signal a legislative proficiency for retooling the state’s healthcare system. Furthermore, in late 2015, the legislature reached an agreement to create a new state office that, along with cities, will issue medical marijuana licenses. This may prove the legislature’s willingness to invest in the type of statewide resources that are required to innovate drug laws.

California may not have the same groundswell of support for liberalized drug laws that existed in Portugal shortly before passage of law 30/2000, which may pose another obstacle for state drug decriminalization. After all, a widespread recognition in Portugal that addiction should be approached as a public health problem led to the formation of the Commission for a National Drug Strategy, which made recommendations that led to the country’s two-pronged approach for fighting the growing drug epidemic. Additionally, experts attribute the program’s success to the Portuguese public’s recognition that addicts should be treated, not stigmatized as social outcasts. For the Portuguese model to be effective in California, the change may require a concerted campaign to change public attitudes towards addiction.

231. Id.
237. A Decade After Drug Decriminalization, supra note 89, at 26–27.
238. Id.
C. Conflicts Between State Decriminalization and Federal Prohibition May Hinder Decriminalization

If California decriminalized drug possession, this new measure could conflict with Federal law. This would not, however, be an insurmountable obstacle, as demonstrated by recent state laws legalizing marijuana for medical purposes or for recreation, and the recent trend of federal toleration of these experimental laws. However, beyond simply hoping for the federal government’s toleration of reformed state laws, arguments against federal preemption may provide further protections for state-level drug decriminalization. Furthermore, cooperative federalism may provide a sustainable solution to the conflict.

California legalized medical marijuana in 1996, despite the federal Controlled Substance Act’s categorization of marijuana as a Schedule I drug. After a rocky start with federal authorities, Attorney General Eric Holder in 2009 announced that the Department of Justice would not prosecute medical marijuana dispensaries conforming to state law, and instructed federal prosecutors to cease targeting marijuana dealers who were in compliance with their respective state law. Showing further promise of federal cooperation with state-level drug law reform, when several states recently legalized marijuana for recreational use, President Obama remarked that, “it would not make sense for us to see a top priority as going after recreational users in states that have determined that it’s legal . . . We’ve got bigger fish to fry.”

Despite these promising remarks, a regulatory conflict between California’s decriminalization and federal drug laws would still exist, and the federal government may still decide to crack down on state decriminalization measures that conflict with federal drug law. However, various legal precedents exist for arguing the federal government should not interfere with state-level experiments with drug regulations.

240. Drug liberalization, supra note 74.
241. California Proposition 215, the Medical Marijuana Initiative, supra note 61.
242. Steven W. Bender, Joint Reform?: The Interplay Of State, Federal, And Hemispheric Regulation Of Recreational Marijuana And The Failed War On Drugs, 6 ALB. GOVT’L REV. 358, 376–77 (2013) [hereinafter Joint Reform?].
243. Id. at 378. Despite this policy, DEA raids of medical dispensaries still occur, targeting “illegitimate fronts for recreational drug dealing that rely on the cover of medical marijuana dispensaries.” Id. at 378–79
246. Id. at 380.
1. Federal Preemption and Anti-commandeering

The Department of Justice could seek a Supreme Court ruling that state laws decriminalizing drug possession are preempted by Federal law, and therefore void under the Constitution’s Supremacy Clause, which states that federal laws take precedence over state laws. However, decriminalization advocates may undermine the federal government’s preemption argument by questioning whether these liberalized state laws truly create a conflict with state law; that is, whether the laws authorize or advocate violations of federal law. After all, implementation of the Portuguese decriminalization model, which requires users to come before a CDT-style dissuasion panel, still comports with the spirit of education and deterrence behind federal drug prohibition. Additionally, advocates may argue that the anti-commandeering principle allows states to constitutionally decide against criminalizing conduct under state law, even if such conduct violates federal law. In other words, while California could not stop the federal government from enforcing federal drug laws within the state, federal authorities may not command California to criminalize drug possession under state law. State decisions to decriminalize drugs should be beyond the control of the federal government.

However, even if California prevails in the anti-commandeering battle, the federal government could still decide to enforce federal drug laws within the state or attempt to force state compliance. For these reasons, simply prohibiting the federal government from commandeering state law may be ineffective, and cooperative federalism may be a more sustainable solution.

2. Cooperative Federalism

Instead of a battle over preemption and anti-commandeering, the California legislature and the federal government could proactively hash out a collaborative plan for evolving drug regulations at the state level. A

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249. Part of the DEA’s stated mission is to “to discourage drug use among the U.S. population by sharing information about the risks of drug use and the effects of drugs on society.” Cynthia S. Duncan, Note, The Need For Change: An Economic Analysis Of Marijuana Policy, 41 CONN. L. REV. 1701, 1713 (2009).
251. Id.
252. For example, the federal government may withhold disbursement of highway funds. See South Dakota v. Dole, 483 U.S. 203 (1987).
cooperative federalism approach would allow states meeting broad federal criteria to opt out of parts of federal law that criminalize drug use and to exert control over drug possession within their own borders. This framework would serve the interests of problem solving and efficiency, allowing these lawmaking bodies to work in harmony, instead of conflict. Under this model, drug possession would not only be decriminalized under California’s laws, but also would not violate federal law within the state. Various federal statutes already provide precedents for this model of cooperative federalism. Notably, The Clean Air and Clean Water Acts are structured around the idea of cooperative federalism. The underlying purposes of the CAA and CWA emphasize cooperation between federal and state governments to prevent pollution. Accordingly, the CAA grants each state primary responsibility for the air quality within its borders, but if states fail to act, then federal regulations apply. This model could easily apply to state drug laws by allowing states to promulgate their own standards, as long as those standards fall within certain federal guidelines.

Cooperative federalism would allow the federal government to influence the direction of legislative reform without commandeering the state legislature. The plan’s flexibility would also allow for experimental variation in state laws, which would enable diverse experiments among states to tease out the most effective drug laws. These results would help inform other states, and ultimately the federal government, regarding the best practices for de-escalation of the U.S. drug war.

VIII. CONCLUSION

The U.S. Drug War is an outdated and costly response to the drug epidemic. Public funds are frequently devoted to a criminal justice approach for handling low-level drug offenders, and relatively scant resources are spent on harm reduction techniques such as drug treatment and outreach. This war has resulted in heavy burdens for U.S. courts, penal systems and healthcare systems. Furthermore, drug war policies
have exacerbated social marginalization and aggravate high-risk behaviors among users. It is time for a more effective and less expensive approach to handling drug use.

Recent U.S. attempts, especially those at the state level, to liberalize drug laws show public and legislative willingness to liberalize drug laws, and have paved the way for further legislative innovation. Portuguese drug decriminalization can provide a proven model for moving forward with progressive reform. With the country’s two-pronged approach—drug dissuasion panels coupled with harm reduction through public health measures—Portugal has shown this reformed model can alleviate both the economic and public health problems associated with drug use.

California, with its history of trailblazing marijuana laws, is well poised to provide the laboratory to implement such a model. By following Portugal’s lead by decriminalizing possession for all illicit substances, the state may reap significant rewards. To name a few, the state may see 40% fewer drug arrests, a drop in prevalence rates for drug use, and over $2 million in Medicaid savings. Overall, calculating the total savings estimated in Section IV, supra, California’s budget may see rewards of over $480 million in the first few years after decriminalization.

If California decriminalizes drug possession, this change could collide with federal law. However, governments may use the cooperative federalism model provided by the federal Clean Air Act and Clean Water Act to avoid conflicts between state-level drug decriminalization and federal drug laws. After all, encouraging experimental drug law reform at the state level will help the remaining U.S. states, and ultimately the federal government, to implement smarter, more effective laws that will alleviate drug war casualties. California can and should lead the nation away from its destructive criminal justice approach towards drug possession.

262. McLemore, supra note 38.
263. State Medical Marijuana Laws, supra note 57.
264. See DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80.
265. What Can We Learn, supra note 84, at 1008.
266. DRUG DECRIMINALIZATION IN PORTUGAL, supra note 80, at 11.
267. Id.