2010 NATIONAL REPORT (2009 data) TO THE EMCDDA
by the Reitox National Focal Point

“PORTUGAL”
New Development, Trends and in-depth information on selected issues

REITOX
As the Focal Point to the EMCDDA, one of the core tasks of the Institute on Drugs and Drug Addiction (IDT, I.P.) is the elaboration of this Annual Report, which structure and contents are mandatorily defined by the EMCDDA (to allow comparability of data among National Focal Points).

This year report describes the national situation in 2009 as well as new developments and trends regarding 2010. The report is divided in three main parts: summary, new developments and trends and selected issues.

In addition to this Annual Report, the core tasks of the Portuguese Focal Point are the following:
- including data in several standard tables and structured questionnaires;
- implementation of the 5 key epidemiological indicators;
- implementation of the Council Decision on New Psychoactive Substances through the National Early Warning System;
- monitoring good practices projects under the Exchange on Drug Demand Reduction Area;
- updating national legal framework information to the European Legal Data Base on Drugs.

The National Focal Point works closely with several other Governmental Departments, namely, Ministérios da Saúde (Health Ministry), Ministério da Educação (Education Ministry), Polícia Judiciária (Criminal Police), Direcção Geral das Alfândegas e Impostos Especiais sobre o Consumo (Customs), Instituto Nacional de Estatísticas (Portugal Statistics), Instituto Nacional Medicina Legal (National Forensics Institute).

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Summary

Part A: New development and trends

Drug Policy: legislation, strategies and economic analysis

The year 2009, saw the completion and submission to the Health Secretary of State the evaluation of the “Action Plan Against Drugs and Drug Addiction – Horizon 2008”, the drafting of the “Action Plan Against Drugs and Drug Addiction 2009-2012” and the drafting of the “National Action Plan for Alcohol related Problems”. All these documents were approved by the Inter-Ministerial Council for the Fight Against Drugs and Drug Addiction, in the 26th of May 2009.


In April 2010, entered in force a Decree-Law that reorganize the coordination structures for the fight against drugs and drug addiction, extending their competences to the definition and implementation of policies related to harmful use of alcohol.

The year in analysis, was also of recognition and international visibility of drug policy, conferred by the CATO Institute report, “Drug decriminalization in Portugal: lessons for creating fair and successful drug policies”, which stimulate enormous interest in the international press and national authorities of other countries, that visited Portugal to see in-loco the results of the national policy and the implementation of the Decriminalization Law.

Drug use in the general population and specific targeted-groups

Results from the II National Population Survey on Psychoactive Substances in the Portuguese Population (15-64 years old) indicate that alcohol and tobacco are the licit substances preferred used by the Portuguese population and cannabis, cocaine and ecstasy the illicit substances with lifetime prevalence’s respectively of 11,7%, 1,9% and 1,3%.

Considering the use of illicit psychoactive substances in the last year and in the last month, a stabilisation was verified, with the exception of cocaine, heroin and LSD, whose prevalence of use increased a little.

Results from the Survey on Alcohol, Tobacco and Drug Use indicate that not only drug use did not increase among young people, but instead the trend seems to be in the direction of a decrease, either in the number of users (prevalence) or in the intensity of use (lower level of intensive use-more than 20 times in last 12 months) among the users.

Cannabis continues to be the most used drug in Portugal and its visibility in several indicators continues to increase, alone or in combination with other substances. Nevertheless, heroin remains the main drug involved in health drug use related consequences and in some of the legal drug use related consequences. The presence of cocaine is increasingly being mentioned in several indicators, namely concerning the recreational, treatment and market settings.

Illicit drug use is increasingly used by “conventional” citizens, as a form of diversion and to get pleasure. Studies suggest that various drug users are conscious about drugs’ potential harms but, taking into account their risks and benefits, decide to use them. However, they do it with some care, using some drug use management strategies, in order to minimize
potential harms. The existence of drug users whose global adjustment is not significantly damaged by this practice is nowadays recognized. In this study we call them «non problematic» illicit drug users, and we intend to explain the processes by which some subjects manage their drug use in order to keep them as so. The main results indicate that «non problematic» illicit drug users resort to several strategies to manage their habit, namely, the control over the regularity, locations and types of drugs they use. Understanding these kinds of strategies may be an important contribution to reduce drug use potential harms and to enhance harm reduction efforts.

Prevention
The operational objectives of the National Plan Against Drugs and Drug Addictions 2005/2012 are:

- Increase the quality of the intervention through adequate strategies, mainly selected and indicated prevention, with monitoring and evaluation of the results of the interventions;
- Contribute for an integrated intervention of IDT, I.P. investing in seeking answers adapted to the problems and needs, sharing resources in a articulate way, both internally and with civil society.

The first objective was achieved through a program and several projects. The Program of Focused Intervention (PIF), that intends to identify a set of best practices in gap areas, properly assessed.

In 2009 continuity was given to the evaluation of PIF, and the implementation and monitoring process was concluded. During 2009, the 23 projects targeted to risk groups (vulnerable families (8), vulnerable children and youth (8) and individuals with drug use patterns in recreational contexts (7) where finished. In some areas small but important steps were given to improve the intervention, particularly in the development of intervention guidelines with regard to the care of young users of psychoactive substances, including alcohol, and in the intervention on recreational settings.

For the second objective, investment was made in quality within the PORI. Forty-seven projects managed by the Regional Delegations and the Centre of Integrated Responses (CRI) are in the field.

The implementation of universal prevention strategies has been achieved through a set of responses that are meant to prevent use and abuse of illicit psychoactive substances among large ranges of the Portuguese population. The universal prevention strategies are being developed at school, community and family level. We will mention several projects of universal prevention that are being implemented in different settings.

Problem Drug use
Results from national estimations on problematic drug use in Portugal indicate that there are between 6.2 and 7.4 problematic drug users for each 1 000 inhabitants aged 15-64 years, and between 1.5 and 3.0 for the definition of problematic drug users (injecting drug users).

Between 2000 and 2005, the estimate number of problematic drug users in Portugal has shown a clear decline, with special relevance for injecting drug users.

Drug-related treatment: treatment demand and treatment availability
In 2009, special focus was given to the articulation with other health care resources and socio-sanitary conditions of public and private sectors, in order to improve the answers to the
multiple needs of users with problems associated with the consumption of psychoactive substances. It is also to highlight the orientation for the quality of services provided.

The number of active clients in the outpatient public treatment network increased (+1%) as well as first treatment demands (new clients). Concerning first treatment demands for the third year was inverted the downward trend initiated in 2000, probably due to an upper and better articulation of responses in the field, registering an increase (+9%) in relation to 2008, increasing the number of clients with alcohol related problems that went to the Treatment Teams (ET).

Heroin remains the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures but references to cocaine, cannabis and alcohol in this setting are increasing.

The availability of substitution programmes continues to increase and the number of clients continues to increase steadily; increases were registered in the number of clients in methadone and buprenorphine programmes.

The clients in treatment were mainly from the male gender (84% to 86%), aged 25-24 (28% to 35%) and 35-44 (31% to 44%), varying the mean age between 33 and 38 years old depending on the structure. It remains the gradual ageing of these populations, namely the clients of first treatment demands of the public network.

Health Correlates and Consequences

Concerning infectious diseases, between populations in drug addiction treatment in 2009, the positivity values for HIV (7%-19%), Hepatitis B (2%-3%), Hepatitis C (29%-50%) and Tuberculosis (1%-2%), reinforce the downward trend verified in previous years, namely at HIV level and Hepatitis C.

In the ambit of HIV/AIDS infection diagnosis (identified by notifications) maintains the proportional downward trend of the cases associated to drug addiction in the different stadiums of the infection, as well as the continuous decrease through the years of new cases diagnosed with HIV associated to drug addiction. Considering the improvements implemented in last years at the coverage level of HIV screening in these populations, seems to be towards an effective decrease of recent infections in the drug addiction population, reflecting the decrease in intravenous drug use practices and share of material, and also as a result of harm and risk reduction policies.

In 2009, were registered 27 cases of drug-related deaths, representing an increase in comparison to 2008 (20 in 2008) in the General Mortality Register (GMR - Selection B of the DRD Protocol). The values registered in 2009, were the highest since 2003, but inferior to the ones registered in 2002 (year when ICD-10 was implemented in Portugal).

Following a strategic recommendation of the Action Plan on Drugs 2009-2012, as well as the implementation of procedures to improve the quality of the national mortality statistics, from 2008 start to be presented data from the national mortality statistics of INE, I.P., simultaneously we intensified the work on optimizing the information coming from the INML, I.P. As result of the excellent articulation between IDT, I.P. and INML, I.P., for the first time it is possible to provide information from the INML, I.P. on overdose cases.

Responses to Health Correlates and Consequences

The Harm and Risk Reduction model implemented in Portugal, aims to propose, through integrated work, to users who are unable or unwilling to renounce drug use, help to reduce harm they cause themselves trough alternatives paths that lead to treatment facilities and therefore a gradual process of stabilization and organization, which may allow the recovery process. Thus the focus is the National Network of Harm and Risk Reduction (RRMD) as an integrated intervention
model, recommended by the Operational Program of Integrated Responses (PORI), via the implementation of projects under the Program of Integrated Responses (PIRs).

Prevention of drug-related infectious diseases amongst problematic drug users is mainly ensured through the national syringe exchange programme “Say no to a second hand syringe”, established by the National Commission for the Fight Against AIDS (CNLCS) in collaboration with the National Association of Pharmacies (ANF). This programme was externally evaluated in 2002 and it was concluded that it had avoided 7 000 new HIV infections per each 10 000 IDU at that time of existence of this programme.

Programme Klotho (Project of Early Identification and Prevention of HIV/AIDS directed to Drug Users), already described in last year’s National Report, is an initiative of the IDT, I.P. and the National Coordination for HIV/AIDS Infection which aims at early detection of the infection amongst drug users and their early referral to treatment, thus increasing their quality of life and life expectation.

In Portugal, treatment for HIV, AIDS and Hepatitis B and C is included in the National Health Service and therefore available and free for those who need it.

Social Correlates and Social Reintegration

The National Plan on Drugs and Drug Addiction 2005-2012, includes objectives and actions based on integrated approaches that simultaneously put the focus on the user and family and on the social systems. While the user approach aims to enable his integration, with the social systems the objective is to reverse the subjective factors, which are a significant obstacle to the emergence of opportunities and possibilities of integration, developing integrated strategies for the systematic monitoring of the relationship between the parties.

The National Strategy for the Integration of Homeless is a priority area, as given the effective economic disadvantage and social exclusion of a significant group of drug users, the IDT, I.P. implication and the services provided are an important added value.

Among the responses in the area of socio-professional integration, Programme Vida-Emprego, continues to be of vital importance as a resource in the area of employment, which in 2009 benefited 1 115 individuals.

Drug related Crime

Concerning the administrative sanctions for drug use, in 2009, the 18 Commissions for the Dissuasion of Drug Use (CDT) instated 7 549 processes, representing a 15% increase in comparison to last year, representing the highest value ever of processes. Most of which were again referred by the Public Security Police. These cases are mainly related to cannabis use.

From the 5 508 rulings made, 85% suspended the process temporarily, 1% found the presumed offender innocent and 14% were punitive rulings (14% in 2008, 17% in 2007 and 2006 and 15% in 2005).

In 2009, the number of presumed offenders increased in comparison last year (+17%), registering the highest value since 2002. This increase resulted from the increase of presumed traffickers (+14%) and traffickers-users (+19%) that registered the highest value of the decade.

Court data indicates that in the past years, decreases were reported in terms of the number of convictions for traffic and for traffic-use. The majority of these individuals possessed only one drug, mainly cannabis, for the seventh time, followed by cocaine. The trend initiated in 1998 of the decreasing importance of heroin related convictions continues.
Prison data indicates that, on the 31st of December 2009, 2,026 (+10% than in 2008 with 1,849) individuals were in prison for crimes against the Drug Law, representing an increase of 10% in relation to 2008 and inverting the continuous downward trend registered over the decade. In this date, prisoners represented 23% in the universe of the convicted prisoner population at national level, proportion that increased for the first time this decade. The majority of these individuals where convicted for traffic (89%), 9% for minor traffic and 2% for traffic-use, values similar to last years patterns.

Responses in the criminal justice system continue to be developed to ensure treatment availability to drug users in prison, specific training for prison staff and the prevention of infectious diseases.

Results from the II National Prison Survey on Psychoactive Substances, indicate that cannabis, cocaine and heroin are the substances with higher prevalence’s of use in this population, as in the context prior to prison as in prison. Between 2001 and 2007, a generalised decrease on drugs use prevalence was verified in both contexts. An important reduction was noted in intravenous drug use in comparison to 2001.

**Drug Markets**

In 2009, increases were verified at the level of several indicators in the drug markets context, many of them registered the highest figures of the decade.

Once again was confirmed the trend through the decade of cannabis predominance and the increased visibility of cocaine in these contexts. Moreover, in 2009 there was a greater visibility of heroin, after the stability trend manifested in the second half of the decade and contrary to the continuous decrease verified in the first half.

For the eight consecutive year, hashish was the substance involved in a higher number of seizures (3,144) and for the first time in the last five years the number of heroin seizures (1,475) was superior to cocaine (1,421). The number of herbal cannabis (liamba) (568) and ecstasy (63) seizures continue to be much lower.

In general, the number of seizures of the several substances was the highest of the decade, noting in the last five years an increasing trend for almost all drugs, comparing to the first half of the decade.

Concerning the quantities seized, liamba registered in 2009 the highest value ever (around 5,045 kg) and cocaine registered the lowest value of the decade (around 2,697 kg).

Concerning countries of origin of the seized drugs in 2009, heroin came from Netherlands and Spain, cocaine from Brazil, Venezuela and Colombia, liamba from South Africa and once more hashish from Morocco. Despite the fact that vast majority of the seized quantities of several substances with information on the routes was destined to the internal market, an important large number of seizures had as final destination other countries, especially European – with particular emphasis to Spain – and Africans, maintaining the trend of Portugal to work as a transit point on international trafficking, particularly in the case of cocaine.

Regarding the prices of drugs, at trafficker and trafficker-user level, they were higher than in 2008 (with the exception of cannabis), being those of cocaine and liamba the highest since 2002. Despite the annual variations, since 2002 there has been a downward trend in the average prices of heroin and ecstasy, and an upward trend of liamba and cocaine, and stability in the average price of hashish.
**Part B Selected Issue**

**History, methods and implementation of national treatment guidelines**

In Portugal, the problem of drug abuse was always recognised in its medical aspects. Even before the treatment centres were integrated in the Ministry of Health, the psycho-social and prevention aspects always played a significant part in the approach of the problem.

The role of guidelines in assisting practitioners about the most adequate intervention in a specific situation was always recognised. Several guidelines were developed with a view to ensure treatment appropriateness and homogeneity of interventions, some of them are described in the selected issue.

**Cost of drug-related treatment in Europe**

The Portuguese policy concerning drug related treatment is based on an integrated approach and resources are used in different combinations with inpatient and outpatient services targeting both illegal and legal psychoactive substances.

The Institute on Drugs and Drug Addiction (IDT, I.P.), a public institute under the patronage of the Minister of Health, is the public provider for the treatment of drug addiction in mainland Portugal. Its public treatment network coexists with a private treatment network, run by organizations and medical clinics operating either for profit or non profit.

In view of the fact that IDT, I.P. mission covers not only the treatment of drug addiction but also alcohol, the estimated drug related treatment expenditures is difficult since analytical accounting is not pursued in a systematic way. As a consequence it is not possible for most items to individualize treatment related costs, neither the part that is only committed to drug treatment (since alcohol treatment is also provided by IDT, I.P).

The difficulty of calculating public expenditures, at macro level or at more detailed level of drug related treatment is jeopardize by data assessment and accounting systems. In view of that, organizational and comparable data are just a minor aspect of the complexity to determine and understand the cost of resources used in drug related treatment.
Part A

New Developments and Trends
1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

The Institute on Drugs and Drug Addiction (IDT, I.P.) is the national governmental structure responsible for the policy coordination in the field of illicit substances and alcohol. The main responsibility of the IDT, I.P. is to promote the reduction of the use of licit and illicit substances and the decrease of addictions. The Institute assures the planning, conception, management, monitoring and evaluation of the different steps of prevention, treatment and reintegration in the field of illicit substances and alcohol, in the perspective of a better fulfilment in the coordination and implementation of the policies and strategies established.

The main areas of intervention of the Institute are:

- Prevention
- Treatment
- Harm reduction
- Reintegration
- Dissuasion
- Research and Monitoring
- Training
- International Relations

In May 1999, the National Strategy on the Fight Against Drugs\textsuperscript{1} (ENLCD), was published a landmark in the political intervention. It is a structuring document whose principles and fundamentals remain generally current face to the characteristics of the problem.

Therefore, the definition of the National Plan on Drugs and Drug Addiction 2005-2012\textsuperscript{2} gave continuity to the aforementioned Strategy, meanwhile adapted to the existing reality and framing it in terms of the several national documents already published. Similarly, to the European option, Portugal adopted a 2005-2012 National Plan, operated by an Action Plan until 2008, followed by an evaluation, after which an Action Plan for the period 2009-2012 was prepared.

The year 2009, saw the completion and submission to the Health Secretary of State the evaluation of the “Action Plan Against Drugs and Drug Addiction – Horizon 2008”, the drafting of the “Action Plan Against Drugs and Drug Addiction 2009-2012” and the drafting of the “National Action Plan for Alcohol related Problems”. All these documents were approved by the Inter-Ministerial Council for the Fight Against Drugs and Drug Addiction, in the 26\textsuperscript{th} of May 2009.

The main drug law in Portugal is Decree Law 15/93 of 22 of January, which defines the legal regime applicable to trafficking and consumption of narcotic drugs and psychoactive substances.

The Portuguese legal framework on drugs changed on November 2000 with the adoption of Law 30/2000. The decriminalisation of consumption and possession for own use of substances is no longer a crime, but constitutes an administrative offence, sentenced with

\textsuperscript{1} Estratégia Nacional de Luta Contra a Droga (1999), Presidência do Conselho de Ministros, Imprensa Nacional – Casa da Moeda, Lisboa.

penalties whose main purpose is the dissuasion of the consumption. According to the Decriminalisation Law, the offences are no more judged in court; they are submitted to the Commissions for the Dissuasion of Drug Use (CDT), especially created for this purpose. There are Commissions all over the country and in the Autonomous Regions of Madeira and Azores. These Commissions, which main objective is the dissuasion of consumption, hear all the users, found in possession or using drugs, whether in a public place, in prison, or being judged by other crimes. However, a person caught in possession of a small quantity of drugs for personal use (established by law, this shall not exceed the quantity required for an average individual consumption during a period of 10 days), without any suspicion of being involved in drug trafficking, will be evaluated by the Commission, composed of a lawyer, a doctor and a social worker (see chapter 9.2 for data on administrative offences).

This law reinforces the resources in the context of demand reduction by sending to treatment drug addicts and pointing out those that are not addicted but need a specialized intervention. With this Law, we expect to contribute to the resolution of the problem in an integrated and constructive way, looking at the drug addict as a sick person, who nevertheless must be responsible for a behaviour that is still considered an offence in Portugal.

The year in analysis, was also of recognition and international visibility of drug policy, conferred by the CATO Institute report, "Drug decriminalization in Portugal: lessons for creating fair and successful drug policies", which stimulate enormous interest in the international press and national authorities of other countries, that visited Portugal to see in loco the results of the national policy and the implementation of the Decriminalization Law.

To mention that the United Nations (UN), initially apprehensive with the adoption of this policy, recognized in the World Drug Report 2009, presented in June 2009 by the United Nations Office on Drugs and Crime (UNODC) that decriminalization of drug use in Portugal fits into the UN Convention of 1961, since the possession and consumption of drugs continue to be forbidden, although subject to administrative penalties and not criminal.

1.2 Legal Framework

Decree-Law 8/2010 of 28 January 2010 – Creates a set of units and teams for integrated continuous care in mental health for persons with severe mental illness, ending in psychosocial disability and for those in dependency situation.

Mental health is a priority of the social and health policies of the XVIII Constitutional Government, whose program provides for the creation of new responses of integrated continuous care in mental health, in conjunction with social security and taking into consideration the different levels of autonomy in mental health patients.

This Decree-Law defines concrete measures for the organization and coordination of multidisciplinary units and teams for the provision of psychosocial support and medical care, the strengthening of skills, rehabilitation, recovery and social integration of persons with disability and the promotion of families dealing with these situations.

Thus, are created multidisciplinary structures of continuous care in mental health, adapted to the characteristic age groups, in conjunction with the national network of integrated continuous care and with the local services of mental health care.

These multidisciplinary structures providing integrated continuous care are of three types: home support teams, socio-occupational units and residential units.

Decree-Law 40/2010 of 28 April 2010 – Reorganizes the coordination structures for the fight against drugs and drug addiction, extending their competences to the definition and implementation of policies related to harmful use of alcohol and defines the first amendment to Decree-Law 1/2003 of 6th January.
Through the Decree Law 212/2006 of 27 October (Organic Law of the Health Ministry) and the Decree Law 221/2007 of 29 May, which adopted the restructuration of the Institute on Drugs and Drug Addiction, were committed to this Institute competences in the use of licit substances, namely alcohol. As these are issues that cut across several bodies, it was important to establish an institutional frame in which participate public and private authorities.

Given the new mandate in the harmful use of alcohol related problems, the Decree-Law 40/2000, reviewed the coordination structures, namely the Interministerial Council for the Fight Against Drugs and Drug Addiction now renamed Interministerial Council for Drugs Problems, Drug Addictions and the Harmful Use of Alcohol, whose composition was enlarged integrating currently the Government members responsible for:

a) Foreign Affairs;
b) Finances;
c) National Defence;
d) Home Office;
e) Justice;
f) Economy;
g) Agriculture;
h) Environment;
i) Labour;
j) Social Security
l) Health;
m) Education;
n) Science and Higher Education.

The Interministerial Council on Drugs, Drug Addiction and the Harmful Use of Alcohol has now a mandate to evaluate and approve the National Plan to Reduce the Alcohol Related Problems and the respective Action Plan.

The other coordination bodies saw also its mandate enlarged to alcohol issues and its designation amended accordingly and are now designated as follows: National Coordinator for Drugs Problems, Drug Addictions and the Harmful Use of Alcohol and National Council for Drugs Problems, Drug Addictions and the Harmful Use of Alcohol.

The National Council will also include representatives from the National Federation of the Local Youth Associations and Representatives of the industry and trade beverages.


1.3. National action plan, strategy, evaluation and coordination

The National Plan on Drugs and Drug Addiction (2005-2012) foresees that its evaluation should be organised as a monitoring and feedback constant process in order to guarantee, apart from its implementation, a real adaptation to field realities as well as to human and financial resources availability.

The National Plan determines that to ensure a timely and qualified evaluation (processes, results, and impacts) it shall be evaluated internally and externally, which terms are to be
defined by the Technical Committee of the Interministerial Council for the Fight against Drugs and Drug Addiction. The Interministerial Council for the Fight Against Drugs and Drug Addiction is headed by the Prime Minister and composed of the following Ministers: Finances, National Defence, Foreign Affairs, Home Office, Justice, Deputy Prime Minister, Education, Science and Higher Education, Health, Social Security and Labour, Cities, Planning and Environment as well as the National Coordinator.

The President of the Executive Board of the Institute on Drugs and Drug Addiction is the National Coordinator for the Fight Against Drugs and Drug Addiction and as such is the Head of the Interministerial Council’s Technical Commission.

The Technical Commission is composed by Ministers’ representatives, closely associated to the Ministers’ Cabinets. Its core mandate is to conduct the design, monitoring and evaluation of the National Plan on Drugs and Drug Addiction (2005-2012) and the Action Plans 2005-2008 and 2009-2012. Furthermore, the Technical Commission has decentralized its mandate over eleven Subcommittees composed of top representatives of the General Directorates and Institutes competent on drugs related issues, as well as key representatives from the National Council for the Fight Against Drugs and Drug Addiction, mainly the General Public Attorney and the Civil Governments and representatives from the Social and Economic Council.


The internal evaluation methodology prepared by the National Coordinator and approved by the Technical Commission is presented in the table below:

<table>
<thead>
<tr>
<th>Work Methodology</th>
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<tbody>
<tr>
<td>1. Evaluation period: 1st October 2006 to 30th June 2008*</td>
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<tr>
<td>2. Filling Action Plan – Horizon 2008 tables Double criteria for each Subcommittee contributions Common Structure; Filling up the new column “Present situation”</td>
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<tr>
<td>4. Results evaluation, based on the results fulfilment (achievement) analysis in each Cross-cutting and Mission Areas</td>
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<tr>
<td>5. Impact Evaluation</td>
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<td>6. SWOT Analysis</td>
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<td>7. Overall General Questionnaire</td>
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<tr>
<td>8. Foreseen Financial Expenses and executed by the responsible services as stated at the Action Plan – Horizon 2008</td>
</tr>
<tr>
<td>9. Conclusions and Strategic Recommendations</td>
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</tbody>
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Table 1 - Evaluation methodology (IDT, I.P. 2010)

For the internal evaluation, the Technical Committee created an Evaluation and Follow-Up Subcommittee - with the aim to follow-up the implementation of the Action Plan - and created

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3 Decree Law 1/2003 of 6 January – Reorganizes the coordination structures for the fight against drug and drug addiction and creates the Interministerial Council for the Fight Against Drugs and Drug Addiction. Creates the Interministerial Council for the Fight Against Drugs and Drug Addiction, responsible for the approval of the National Drugs Strategy (this Decree-Law was amended in April 2010 as mentioned in Chapter 1.2).

4 In some cases it was possible to gather data that was available until 30th of September.
10 other specialized Subcommittees covering each of the missions and cross cutting areas of the Action Plan.

The ten specialized Subcommittees, reporting to the Evaluation and Follow-Up Subcommittee met regularly to monitor the 2008 Action Plan and design the new Action Plan. These ten Subcommittees comprised 88 representatives from 36 different Central Administration and Civil Society bodies.

By the end of 2009 these Subcommittees had carried a dual mandate: the 2008 Action Plan internal evaluation and the design of the 2009-2012 Action Plan.

This ongoing evaluation process was set by the National Plan that also determined a feedback process. Graphically it can be represented thus:

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Graph 1– Internal Evaluation of the 2008 Action Plan (IDT, I.P. 2010)

Filling in 2008 Action Plan tables and grids and discussing them within the Subcommittees allowed for objectives and actions that were lingering behind to be given an extra push forward. The coordination structure was an added value in the sense that gave impetus to combining efforts as well as redefining objectives for the 2009-2012 Action Plan.

Process evaluation was accessed on a qualitative basis according with the achievement of objectives set by the 2008 Action Plan.

Evaluation results were accessed on a quantitative basis, since most of the transversal and mission areas established results that could be monitored in that way.

Impact evaluation was by far the most difficult task to achieve. The Evaluation and Follow-Up Subcommittee agreed to compare the situation in 2005 (coinciding with 1999 National Strategy external evaluation) and 2008 for selected indicators, as a replacement of a genuine impact evaluation.

The SWOT analysis was conducted, as all other pieces of the evaluation methodology, by extracting the more relevant conclusions from each Subcommittee. The Overall General Questionnaire was inspired from the EU Action Plan Steering Committee that conducted in

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5 These Subcommissions cover the Transversal and Mission Areas of the National Plan: International Relations, Law Framework, Information, Research, Training and Evaluation, Demand Reduction – Prevention, Dissuasion, Treatment, Harm Reduction and Risk Minimization, Reintegration, Supply Reduction, Workplace Intervention.
2007 the evaluation of the European Union Action Plan, adapted of course to the Portuguese reality.

The Evaluation and Follow-Up Subcommittee conducted an exercise based on budget expenditures, comparing data submitted in the financial record that accompanied the National Plan and the 2008 Action Plan bill’s approval (see chapter 1.4).

From the 246 actions in the 2008 Action Plan, the process evaluation concluded that 210 actions were achieved, 18 were partially achieved and 14 were not achieved. The remaining 4 were set apart, either because the rationale behind its inscription in the Action Plan was no longer valid or because they had grown useless. Among these was the implementation of “safe drug rooms”, which the integrated approach carried from 2006 showed was no longer needed.

![Graph 2 – 2008 Action Plan Execution (IDT, I.P. 2010)](image)

The evaluation results showed extensively the actions developed for each of the 19 objectives established. Most actions not achieved were linked with Dissuasion Law and Framework.

The main conclusions refer:

The success of the coordination model on leveraging the monitoring and evaluation process;

1. The results attained on the international cooperation level, projecting and reinforcing Portugal’s leadership in some areas;

2. The optimization of the National Information System on Drugs and the launch of Multidisciplinary Information System (SIM);

3. Drug use reduction attested by last year quantified reduction of drug use for any drug in age group 15-24, which decreased from 8.3% in 2001 to 7.0% in 2007 (Balsa et al, 2008), on continuity rate drug use reduction for any drug on general population and age groups 15-34 and 15-24, that decreased, respectively, from 44.2%, 51.7% and 67.1% in 2001 to 31%, 40% and 45.3% (Balsa et al, 2008). From 2001 and 2006 drug use prevalence’s of any drug also decreased among school age students; data was 14.2% (3rd level basic school, grades 7th to 9th) and 27.9% (secondary school (grades 10th to 12th)) in 2001 and decreased to 8.4% (3rd level basic school, grades 7th to 9th) and 19.9% (secondary school (grades 10th to 12th)) in 2006 (Feijão, 2008). Also among inmates, studies showed a decrease of drug use prevalence’s before and during imprisonment; in 2001 drug use prevalence’s for any drug was 60.6% before imprisonment and 47.4% during imprisonment, and in 2007 those figures decreased to 55% and 35.7%, respectively (Torres et al, 2008).

4. Within the Demand Reduction Mission area activities were pursued under the umbrella of the four axis defined by the National Plan: citizen oriented, territorially, integrated approaches and responses, quality improvement and certification
mechanisms. Prevention, Dissuasion, Harm Reduction, Treatment and Reintegration objectives and actions were pursued under an integrated approach:

a. Prevention activities were impaired by legal constraints imposed to financial support to non profit entities.

b. In 2008 the Drug Addiction Dissuasion Commissions (CDT's) decision making was restored, from 2004 to 2007 several CDT's had less than the mandatory three members, what enable them to decide on drug users presented to them.

c. Also on the Harm Reduction vector there was an increase of Outreach Structures and the allocation of a Prize on Health Partnership Best Practices assigned by “Hospital do Futuro” that awarded the monitoring and evaluation model pursued by IDT. This award followed criteria as innovative work pursued clinical or sanitary relevance, social or economical relevance, and dynamization of public and civil society partnership.

d. Treatment results’ aimed at providing anyone wishing to access varied and customized therapy based on ethical principles and scientific evidence. Due to the changing aspects of the target population, especially vulnerable and at risk, the results were not fully achieved.

e. On the side of Reintegration, endogenous resources, institutional synergies and networking enabled to leveraging reintegration as a global process trough participated management involving all partners.

5. There is a strong exogenous factor within the Supply Reduction Mission area. Due to the illegal character of the activities pursued it is impossible to access which part of the illicit actions planned have been avoided. Notwithstanding, from 2006 to 2008 Portugal has seen a reinforcement of the illicit trafficking detection capability and was endowed with drug fighting information, monitoring and screening systems. Portugal geographic situation is one of the main drug entries to the European continent. Special ties with African countries fostered the establishment of cooperation to fight the changing patterns of drug routes through Western Africa.

Impact Evaluation was based in a quantitative assessment of the situation in 2004 (coinciding with 1999 National Strategy external evaluation) and 2007 for selected indicators. The Impact Evaluation was partially coincident with the Results Evaluation and it showed a decrease of drug use in certain age groups amongst the general population, students and inmates and also a decrease on negative health effects on drug users. Furthermore it showed the need to introduce further improvements on the research of drug-related deaths, since most of data does not correspond to the standard definition.

The SWOT evaluation showed the areas that remained to be addressed in the next Action Plan and enhanced areas on which the design, monitoring and evaluation process had achieved strong satisfaction. Namely the 2008 Action Plan had far too many objectives and actions and that the institutions compromise within the Action Plan progress was sometimes unsatisfactory, while IDT, I.P. reorganization and the incorporation of alcohol related policies and competences in IDT, I.P. increased the scope and the purpose of the integrated approaches dealing with psychoactive substances.

The Overall General Questionnaire supported findings from the SWOT analysis, just as the Impact evaluation was supported by the Results evaluation, a cross over process that enhanced the validity of the internal evaluation.

Based on the report analysis, the Technical Commission and the National Council issued strategic recommendations thus summarized:
• Restructuring of the Technical Commission’s Subcommittees and creation of a Subcommittee on Public Expenditures;

• Launching of studies on the impact of public policies promoting the decrease of drug use and drug addicts in order to enable evidence based knowledge, especially in view of the decrease of prevalence’s drug use in general population and school;

• Regarding the indicator “Drug-related deaths” IDT, I.P. should promote research on positive toxicological examinations, cross studies on positive matching registered on death certificates should be pursued as well as cohort studies on mortality in drug addicts and drug-related deaths within communities total weight estimate;

• In order to clarify the decrease on HIV infection among drug addicts within mandatory notification, studies should be pursued also in view to deepen understanding on intervention strategies;

• Municipalities intervention should be deepened and reinforced on 2009-2012 Action Plan actions;

• Madeira and Azores Autonomous Regions interventions should complement and incorporate mainland intervention;

• Finally, in view of the newly mission and competences assigned to IDT, I.P. within the Ministry of Health framework, competent coordinating bodies and organs on the National Plan on Drugs and Drug Addiction and on the National Plan to Reduce the Harmful Use of Alcohol should coordinate interventions to maximize their resources and impact.

By the time the Action Plan Horizon 2008 internal evaluation was being completed, the Subcommittees worked simultaneously on the proposal of the 2009-2012 Action Plan. This Action Plan follows the structure of the previous one and covers the areas of coordination, international cooperation, information/research/training/evaluation, legal framework, demand reduction and supply reduction. It identifies for each action the party or parties responsible, a timetable and the indicators/assessment instruments to monitor the Plan’s implementation.

Despite efforts to turn the 2009-2012 Action Plan less extensive than the previous one, it still contemplates 69 objectives and 214 actions. The internal evaluation enabled to highlight actions that needed to be addressed again and others whose implementation needed be further pursued.

Amongst its innovative aspects it’s worth to point the following:

• The social-urban integration of territories having critical vulnerability by means of specific intervention planning;

• The implementation or improvement of specific programs, both vertically and horizontally, oriented towards special vulnerable groups, including co-morbidity symptoms;

• Improvement of networking and articulation with other public health providers, namely on basic primary care;

• Development of an intervention model on working environment compatible with social reintegration and poverty prevention;

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6 Decree-Law N.º 221/2007, of 29 May, assigns to IDT, I.P. the mission to promote and reduce licit and illicit drugs consumption and the task, among others, to support to the member of Government in charge of health, on the definition of the national strategy and public policies on drugs, drug addiction and alcohol and their evaluation.
• Improvement of exogenous and endogenous institutional and resources’ maximization on the implementation of the National Action Plan for Alcohol Related Problems.

1.4. Economic analysis

Unlike what is envisioned for the 2005-2012 National Plan external evaluation, the 2006-2008 Action Plan internal evaluation did not carry a cost-benefit analysis.


The assessment of the 2008 Action Plan budget expenditures was based on data provided by the public institutions competent to implement the 2008 Action Plan, though for some Ministries an estimate had to be calculated based on 2006 estimate.

This exercise highlighted the need to devote further work into the way public institutions carry on their accounting, especially when their core activity is not limited to the field of drugs.

<table>
<thead>
<tr>
<th>2006</th>
<th>2007</th>
<th>2008 1st Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>92,725.9</td>
<td>91,109.7</td>
<td>39,714.3</td>
</tr>
</tbody>
</table>

Unity: Thousand Euros

Table 2 – 2008 Action Plan budget expenditure estimate (IDT, I.P. 2010)

In view of the fact that most institutions were not able to furnish labelled and unlabelled expenditures for actions achieved, the new 2009-2012 Action Plan coordination area foresees the creation of a Subcommittee on Public Expenditures. This Subcommittee will work with representatives from all Ministries involved to provide a common framework to calculate public expenditures for the 2009-2012 cycle.
Drug use in the general population and specific targeted-groups

2. Drug use in the general population and specific targeted-groups

2.1. Introduction

In 2009 there were no new studies on drug use in the general population neither in the school or youth population, so we continue to report here the last studies realized. We report a new study on specific targeted-groups on «non problematic» illicit drug users.

Drug use in the population is mainly monitored through surveys repeated every 5 or 6 years (general population and prison surveys), every 2 years (school population surveys) and by ad-hoc basis for specific groups such as university students or young people in recreational settings. In 2006 and 2007 several surveys took place to allow time trends in these different settings: 2 school surveys, 1 general population survey, 1 prison survey, 1 problem drug use survey.

Results from the II National Population Survey on Psychoactive Substances in the Portuguese Population (15-64 years old) indicate that alcohol and tobacco are the licit substances preferably used by the Portuguese population and cannabis, cocaine and ecstasy, the illicit substances with lifetime prevalence respectively of 11.7%, 1.9% and 1.3%.

Results from the Study on Alcohol, Tobacco and Drug Use (ECTAD) indicate that not only drug use did not increase among young people, but instead the trend seems to be in the direction of the decrease, either in the number of users (prevalence) or in the intensity of use (lower level of intensive use-more than 20 times in last 12 months) among the users.

Illicit drug use is increasingly used by “conventional” citizens, as a form of diversion and to get pleasure. Studies suggest that various drug users are conscious about drugs’ potential harms but, taking into account their risks and benefits, decide to use them. However, they do it with some care, using some drug use management strategies, in order to minimize potential harms. The existence of drug users whose global adjustment is not significantly damaged by this practice is nowadays recognized. In this study we call them «non problematic» illicit drug users, and we intend to explain the processes by which some subjects manage their drug uses in order to keep them as so. The main results indicate that «non problematic» illicit drug users resort to several strategies to manage their habit, namely, the control over the regularity, locations and type of drugs they use. Understanding these kinds of strategies may be an important contribution to reduce drug use potential harms and to enhance harm reduction efforts.

2.2. Drug use in the general population

In 2007, the II National Population Survey on Psychoactive Substances in the Portuguese Population (INPP – Inquérito Nacional ao Consumo de Substâncias Psicoactivas na População Portuguesa) was implemented for the second time (first study was in 2001). See Standard Table 1.

The objective of this epidemiologic study is to describe the dimension and the characteristics of the phenomenon of illicit and licit use of psychoactive substances, in the Portuguese population between the 15-64 years old.

The questionnaire was used on a sample of 15 000 individuals, representative of the Portuguese population aged 15-64 years old living in family household, at national and regional levels.

The questionnaire was administered via a face-to-face interview (CAPI). A multi-stage sampling was used, stratified according to congregations, with previous selection of primary units (councils) and secondary units (sectors) following a proportional random method and
the selection of the final units (individuals) by means, first, of a systematic selection of the homes and, them, selecting individuals by an aleatory numbers table.

In 2007, alcohol and tobacco were the most widespread psychoactive substances used by the Portuguese population aged from 15 to 64. The most widespread illicit trade drugs were cannabis, cocaine and ecstasy (the prevalence’s of use at least once in lifetime were 11.7% for cannabis, 1.9% for cocaine and 1.3% for ecstasy). Use of other illicit drugs was less common, apart from heroin, which prevalence of use at least once in lifetime was 1.1%.

Considering the use of illicit psychoactive substances in the last year and in the last month, a stabilisation was verified, with the exception of cocaine, heroin and LSD, whose prevalence of use increased a little.

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevalence of use at least once in lifetime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>75.6</td>
<td>79.1</td>
</tr>
<tr>
<td>Tobacco</td>
<td>40.2</td>
<td>48.9</td>
</tr>
<tr>
<td>Tranquilizers or sedatives</td>
<td>22.5</td>
<td>19.1</td>
</tr>
<tr>
<td>Any illicit drug</td>
<td>7.8</td>
<td>12.0</td>
</tr>
<tr>
<td>Cannabis</td>
<td>7.6</td>
<td>11.7</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.7</td>
<td>1.1</td>
</tr>
<tr>
<td>LSD</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Hallucinogenic Mushrooms</td>
<td>--</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Prevalence of use in the last 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>65.9</td>
<td>70.6</td>
</tr>
<tr>
<td>Tobacco</td>
<td>28.8</td>
<td>30.9</td>
</tr>
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<td>12.0</td>
</tr>
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<td>Any illicit drug</td>
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<td>3.7</td>
</tr>
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<td>3.6</td>
</tr>
<tr>
<td>Cocaine</td>
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<td>0.6</td>
</tr>
<tr>
<td>Amphetamines</td>
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<td>0.2</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>LSD</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Hallucinogenic Mushrooms</td>
<td>--</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Prevalence of use in the last 30 days</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>59.1</td>
<td>59.6</td>
</tr>
<tr>
<td>Tobacco</td>
<td>28.6</td>
<td>29.4</td>
</tr>
<tr>
<td>Tranquilizers or sedatives</td>
<td>11.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Any illicit drug</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>2.4</td>
<td>2.4</td>
</tr>
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<td>Cocaine</td>
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<td>0.3</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>LSD</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Hallucinogenic Mushrooms</td>
<td>--</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 3 – Portuguese Population (15-64 years old): Lifetime Prevalence by type of drug 2001-2007 (IDT, I.P. 2009)

In 2007, the average age of initiation in drug use varied substantially depending on the type of drug. In general terms, use of licit drugs began at a younger age: as was the case for tobacco and alcoholic drinks (17 years). Cannabis (18) was the illicit drug for which initiation of use at an earlier age was observed.
Drug use in the general population and specific targeted-groups

The reverse was true for sedatives, for which use began later in life (34). In general terms use of other drugs was initiated between the ages of 20 and 22.

Comparing with the results of 2001, the average age of initiation is the same for alcohol, tobacco, cannabis and heroin, and increased a year or two for the remaining substances.

Except for the case of tranquilizers or sedatives, the extent of drug use in the Portuguese population was significantly higher amongst males than females. This was especially so in the case of illicit drugs, for which prevalence amongst males was several times higher than for females. In reference to use over the last 12 months, differences in cannabis use (18.4% for males, and 5.2% amongst females) and cocaine use (0.9% for males and 0.3% for females) are significant.

There are no significant differences between 2001 and 2007 results; there was a slight increase of cocaine and heroin use at least once in lifetime by females and a decrease in all the other substances.

<table>
<thead>
<tr>
<th>Prevalences</th>
<th>Lifetime 2001</th>
<th>Last 12 Months 2001</th>
<th>Last 30 Days 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Drug</td>
<td>7.8</td>
<td>3.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>7.6</td>
<td>3.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.7</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.9</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.5</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.7</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>LSD</td>
<td>0.4</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Hallucinogenic Mushrooms</td>
<td>0.8</td>
<td>0.1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 4 – Portuguese Population (15-64 years old), Lifetime, Last 12 Months and Last 30 days Prevalence by type of drug (IDT, I.P. 2009)

As in 2001, drug use is higher amongst younger age groups, except in the case of licit drugs, mainly tranquilizers or sedatives. The use of psychoactive substances was made by young people, aged 25-34 years. This was particularly true for licit drugs, with a prevalence of use over the last 12 months in almost all cases much higher for this group of age. Heroin has a higher prevalence in the age group 35-44.

Most drug users only consume one illicit drug (75.5%). Around 11% use two substances and 6% three substances. Cannabis is the most used drug. The most frequent combinations of substances are cannabis and cocaine (3.8%) and cannabis, cocaine and heroin (3%).

Comparing with the results from the prior study, the percentage of polydrug use has increased. In 2001, 81% of drug users consumed one illicit drug, 8% combined two substances, and 4% used the combination of three drugs. The most frequent combinations in 2001 were cannabis and ecstasy, and cannabis and cocaine.

The types of conduct considered most dangerous by respondents were frequent use of cannabis, and occasional use of ecstasy and cocaine. On the other hand, types of behaviour subject to lower perceived risk were five or more drinks on the weekend and to smoke one or more packs of cigarettes per day.

Regional analyses show that Algarve and Lisbon are the regions that present higher (above the national average) prevalence’s of lifetime and last month use of any illicit substance for the total population and for young adult population.
Drug use in the general population and specific targeted-groups

Despite the prevalence’s of use of any illicit substance, that reflects mostly the prevalence of use of cannabis, in a general way, either in total population either in young adults, these regions were the ones registering the higher lifetime and last month prevalence of use for almost all the considered illicit substances. Among the exceptions, special emphasis to the case of amphetamines use in Azores (one of the regions with higher amphetamines lifetime prevalence of use in total and young populations) and to the case of heroin in Alentejo (one of the regions with higher prevalence of heroin use in the total and young populations).

In general, all regions maintained the preferential pattern of use in the country – in first place the use of cannabis, followed by cocaine and ecstasy, with the exception of Alentejo (heroin is the second most used drug after cannabis), Algarve (heroin emerge between the three substances with higher prevalence of use) and Azores (amphetamines have similar position to the one ecstasy occupies at country level.

Also the general pattern of evolution of lifetime prevalence use between 2001 and 2007 was maintained on the whole, at regional level, both in the total population and amongst young adults, to state between the exceptions, the decrease of heroin use in the North, in Lisbon and in Azores (in these two last regions only in terms of the young adult population), and the decrease of lifetime prevalence use of all the illicit substances in Madeira (except the increase of cocaine use in the young adult population).

Between 2001 and 2007, the use of any illicit substance increased from 7,8% to 12%. It means that 12 % of respondents, aged 15 to 64, had used an illicit drug at least once in their lives (lifetime prevalence).

The most-reported substance in this context was cannabis (11,7 % lifetime prevalence). The use of other illicit drugs was less frequently reported. Lifetime prevalence was almost 2% for cocaine (1,9%), near 1% for ecstasy (1,2%) and heroin (1,1%), and less than 1% for amphetamines (0,9%), hallucinogenic mushrooms (0,8%) and LSD (0,6%).

Gender differences concerning illegal drugs experimentation were found for all substances. A higher proportion of males than females had used these substances at least once (18.4 % vs 5.2 % for cannabis, 1.8 % vs 0.4 % for heroin and 3.2 % vs 0.7 % for cocaine).

The use of illicit drugs is more frequent among the youngest (15-34 years old), especially in the age group 25-34 years.

A significant proportion of the population perceives a relatively low risk attached to these types of behaviour: take five or more drinks on the weekend; smoke one or more pack of cigarettes per day; and smoke hashish/marijuana regularly.

In 2001, the Portuguese population perceived the access to substances in a 24-hour period as more difficult than in 2007.

Finally and comparatively with studies results from other European countries, we can state that, even being the national results the most recent European results, Portugal remains among the countries with the lowest prevalence of use for most of the substances, with the exception of heroin, where Portugal shows higher prevalence’s.

2.3. Drug use in the school and youth population

Portugal developed school surveys on probabilistic samples representative, at national level, of students from basic school since 1989. Portugal is also among the countries developing the ESPAD since the first survey in 1995. Furthermore, since 2003, the ESPAD is being developed in samples representative not only of the 16 years old cohort, but also among those between 13 and 18 years old.
In 2007, was conducted the ECATD – Estudo sobre o Consumo de Álcool, Tabaco e Drogas (Study on Alcohol, Tobacco and Drug Use), which questionnaire include the core questions of ESPAD and additional questions about specific attitudes, information about the effects of drug use and beliefs on the difficulty of quitting drug use. All the methodology, either for data collection or for data analysis, is the same of ESPAD. Results from the 16 years old age group are sent to the ESPAD Coordination to be included in the European Report. The sample was designed in order to have about 2 800 students in each age group (globally about 18 000 students).

Below we will present the 2007 (Feijão, F. 2009a) results and their comparability with those from 2003 (Feijão, F & Lavado, E., 2006).

Prevalence and frequency of drug use by age cohort and gender

Considering either the global indicator about the use of any drug or cannabis use, at least once in lifetime, results point to a general decrease from 2003 to 2007, in all age groups globally (T) and for both males (M) and females (F). See Standard table 02.

Drug use of other substances, with the exception of cannabis, is present in less than 5% of the students of all the age groups.

In 2007, lifetime prevalence of ecstasy use remains at a low level presenting some decrease when comparing with 2003, particularly among girls in all the age groups. Lifetime prevalence of amphetamine use remains stable for all age groups except for the two older ones (17 and 18 years old) that show some small increase, for boys and girls.

Cocaine use lifetime prevalence pattern is very similar to amphetamines: stable since 2003 and with a small increase in 2007 for the 17 and 18 years old students, either male or female. Relating GHB, among the younger age groups there was stability or some decrease and again a small increase for older age groups (17-18).

Lifetime prevalence of hallucinogenic substance use, from 2003 to 2007, also show stability (LSD) or decrease (magic mushrooms) among the younger age groups and among the older ones (17-18 years old) there was some increase for boys, both for LSD and magic mushrooms and stability (LSD) or decrease (magic mushrooms) for girls.

The same pattern of lifetime prevalence, by age group, is found for heroin and injected drug use: lower level among the younger ones and, from 2003 to 2007, stability among these age groups and small increase among the 17 or 18 years old students, boys and girls.

Considering again cannabis use, last 12 months and last 30 days prevalence repeat the pattern found for lifetime: general decrease for boys and girls in almost all age groups since 2003.

Going into depth in the characterisation of the pattern of cannabis use, the frequency of use show that the decrease is more relevant in all age groups for the higher level of use: 20 times or more in the last 12 months.

Perceptions and beliefs

The analysis of risk perceptions shows that from 2003 to 2007, in general, there was an increase of those considering that there is a “high” risk in the drug use, either among “non users” or among “users”. Here, “non users” are those that never try any drug.

In the case of cannabis, among non-users this increase is due mainly to the decrease in the percentage of those that didn’t know how to evaluate the risk; and among drug users that increase is due mainly to the decrease in the perception of “low” or “moderate” risk of use.
Drug use in the general population and specific targeted-groups

Considering the perceptions of risk about cocaine use, the increase in the percentage of those considering “high” risk is due to the decrease of those saying they don’t know how to evaluate, either among “non users” or “users”.

In both cases cannabis and cocaine (but also this was the case for the other drugs whose results are not presented here), there was a bigger increase in the risk perception as “high”, among drug “users” than among “non users”.

The perceptions about the market, namely concerning the facility to the access to drugs, show that there was a decrease in the percentage of those saying that it is “very difficult” and a correspondent decrease among those saying that it is “very easy”.

The beliefs about how difficult it would be to quit using cannabis after a regular use, among the older ones (16 to 18 age groups), change was found: in 2007 more students refer that it would be “very difficult” and less refer that it would be “easy”.

Conclusion

Considering the legal status of drug use in Portugal – decriminalization of drug use was implemented in 2001 – it is interesting to realize that drug use did not increase among young people, but instead the trend seems to be in the direction of the decrease either in the number of users (prevalence) or in the intensity of use (lower level of intensive use-more than 20 times in last 12 months) among the users.

On the other side, the perceptions of the risk of using drugs show a generalised increase of those considering that drug use presents a “high risk” despite the fact that the perception of access to the cannabis (and other substances) had increased.

The beliefs about being very difficult to quit the regular use also increased among the older students, perhaps translating a deeper knowledge about the effects and risks of cannabis use and being one of the possible explanations to the decrease in the prevalence of cannabis use.

2.4. Drug use among targeted groups/settings at national and local level

Nowadays, it is recognized that there are some drug users whose global adjustment is not significantly damaged by this practice. In the study (Cruz2009) carried out they are called «non problematic» illicit drug users, and the main purpose is to develop a grounded theory to explain how are they able to manage their consumption in order to keep it «non problematic». The nine participants, subjected to an in-depth interview, were selected through theoretic sampling and reached by a snowball sampling strategy. For participants selection it was established external and internal criteria. The first ones included: (i) absence of medical, social or legal problems related to drug use; (ii) subject’s characterization as a «non problematic» illicit drug user by significant others; and (iii) maintenance of «non problematic» illicit drug use for, at least, 5 years. Internal criteria concerned subjects self-characterization as «non problematic» drug users. The first phase of this study was conducted with 6 Portuguese males and 3 Portuguese females, between 23 and 32 years old and with various occupations (e.g., college students, industrial employee, and farmer). They were asked to collaborate in a study about different patterns of illicit drug use and about consumption management strategies. The interviews, analysed through grounded analysis principles, occurred in a single moment, although with variable duration (from 1 to 3 hours). For theory validation, in a second contact, they were showed to participants. It was consensual that the theory represented subject’s experiences and perspectives. For grounded theory enrichment, the next step, actually ongoing, is the collection and analysis of data from two contrasting groups: «problematic» and «ex-problematic» drug users (subjects that have had «problematic» drug use in the past but that currently have «non problematic» ones).
Main results: Curiosity about the drug emerged as the central reason to illicit drug use initiation (n=7). Cannabis was, consensually, the first illicit drug used (around 15 years, in average), and the use of all other illicit drugs began only when subjects were older (around 19 years, in average). Ecstasy was, for most, the second illicit drug used after cannabis (n=6). Furthermore, all participants recognized that they have passed through an experimentation period, more or less longer, of multiple illicit substances, such as powder cocaine (n=7), hallucinogenic mushrooms (n=7) and LSD (n=6). All participants considered positively their illegal drug use, mainly for the pleasure obtained (n=9). However, all subjects identified some negative dimensions of drug use, as laziness related to cannabis consumption (n=6). Three subjects also reported negative experiences with the use of some illicit drugs, such as heroin and crack. The relevance of experiences with other illicit drug users was consensually emphasized as a source of learning about drugs. Currently, only four participants used just cannabis, most of them being polydrug users (n=5). In these polydrug use cannabis was the main substance, although accompanied by occasional use of other illicit drugs, mainly stimulants, and particularly cocaine (n=5). These polydrug users maintained a continued use of substances rather than cannabis for average of 9 years. Furthermore, the nine subjects reported a regular and daily use of cannabis, for average of 10 years.

Participants discussed several illicit drug use management strategies, related to: substances type (n=9); drug use regularity (n=9); consumption contexts and circumstances (n=9); drug use occultation (n=9); drug acquisition management (n=9); experiences with other drug users (n=9); and drugs quantity (n=7). Concerning substances type, drugs were consensually differentiated, mostly in: cannabis vs. all other illicit drugs (n=8). This distinction was based on the different effects attributed to drugs, and considered less prejudicial only in respect to cannabis (n=8). Participants also established additional differentiations in respect to illicit drugs rather than cannabis (n=7), mainly contrasting heroin and powder cocaine (n=7). The idea of the majority of participants was that all drugs rather than cannabis were harmful, but some of them – namely stimulants and hallucinogens – are more controllable than others mainly opiates (n=7). Therefore, in order to maintain non-problematic drug use, most subjects emphasized the importance of not using heroine (n=6) and 3 referred the same in relation to crack. Furthermore, the majority of participants were conscious about drugs harms (n=6).

Concerning regular consumptions, the necessity to conciliate drug use with conventional activities was consensual, being stressed the importance of reducing consumption regularity, mainly due to occupational constraints (n=9). However, most interviewees reported working or studying under cannabis effects (n=6). This practice is comprehensible if we consider subject’s consensual perception about cannabis use as compatible with the accomplishment of conventional activities. The same was not argued in relation to other illicit drugs that, according to participants, have to be used only occasionally (n=9).

As to consumptions contexts and circumstances, the importance of using drugs in proper contexts was consensual, in order to better appreciate them (n=7) and to avoid bad experiences (n=6). So, cannabis was consensually characterized as the only illicit drug that can be used in almost every context and circumstance, alone or with others. All participants said that illicit substances rather than cannabis have to be used in special, and recreational contexts and circumstances, and always in the presence of trustful persons. Recreational or partying contexts (n=9) and private residences (n=8) emerged as relevant drug use locations. To preserve social image the necessity of consumption occultation was consensual, in order to avoid negative judgements (n=9) and legal problems (n=6).

The importance of drugs acquisition management was also consensual, with all participants preferentially buying drugs from known persons and in safety places (n=7), in order to guarantee transactions occultation (n=5) and drugs quality, since this was a concern reported by the most of them (n=7). To obtain positive effects and to avoid unpleasant experiences,
most subjects referred strategies related to drugs quantity (n=7), stressing the importance of not using drugs in big amounts (n=6). Furthermore, all participants emphasized that illicit drug use management is idiosyncratic and influenced by subject’s personal characteristics, such as their self-control ability (n=7). Finally, it is important to stress that all participants characterized themselves as «non problematic» illicit drug users, mainly because they saw themselves as able to maintain their adjustment in different life domains (n=9), as work, family and social integration.

Results lead to consider «non problematic» illicit drug use as a constant process of consumption self-regulation. This use begins mainly by the curiosity about the drug and is facilitated by experiences with other illicit drug users, especially because they promote substances access and acquisition. These two factors contribute to consumption desire and its concretization is facilitated by some subject’s perceptions that legitimize illicit drug use (e.g., actual consumption diffusion, cannabis social acceptance). In this way, conditions are gathered for consumption initiation, which typically occurs with cannabis, being followed by a period of experimentation of many other drugs. Meanwhile, subjects pass through a lot of drug experiences, more or less positive, which, in association with experiences with other drug users, lead to the development of some illicit drug use management strategies. In fact, the quality of drug experiences contribute to drug use self-adaptation: positive experiences, which promote pleasure and are the most frequent, lead to drug use maintenance; negative dimensions experienced with certain drugs, although insufficient to generate consumption desistance, promote changes in the pattern of drug use in order to avoid those negative experiences; and, finally, some really negative experiences with certain substances, although more rare, lead to the abstinence of those drugs.

In this way, «non problematic» illicit drug use bases upon the quality of personal consumption experiences and by experiences among other illicit drug users, insofar as they work as an important source of learning about substances and as models, including to the decision of using a drug, or not. In function of these two factors, subjects develop some drug use management strategies, in order to maximize pleasure and to minimize potential negative outcomes. Drug use self-regulation process involves persistent analysis (although sometimes not explicitly articulated) of the relation between costs (e.g., medical problems, drug’s cost) and benefits (e.g., pleasure). This process implies consumption continuous management, through strategies often not deliberately applied. The most important ones refer to substances types and to the regularity and frequency of consumption, because it is around them that actual pattern of drug use tend to be defined. Indeed, after an initial phase of different drugs experimentation, consumptions tend to develop and stabilize in a pattern of cannabis regular use and all other illicit drugs occasional use only. This pattern is frequently held for a long time (almost 10 years, sometimes more). As time goes by, subjects develop more management strategies intended to maintain functionality in various life dimensions, which involves several aims: illicit drug use control; social image preservation and stigmatization avoidance; positive effects promotion and unpleasant experiences avoidance.

To keep control over illicit drug use the key management strategies concern drugs type, consumption regularity and frequency, and its contexts and circumstances. To preserve social image and to avoid stigmatization vital strategies are consumption occultation, drug acquisition management, and, again, the control over contexts and circumstances of use. Finally, to obtain positive effects and to avoid unpleasant experiences, crucial management strategies respect to drugs quantity, substances type, consumption contexts and circumstances, and also experiences with other illicit drug users (insofar as they are valued as important sources of drugs knowledge).

Discussion: the study shows that there are illicit drug users that do not fit in the common notion of «problematic» drug users. This seems recognized by Portuguese drug laws, since they distinguish between «addict» and «non addict» users. Although the participants use
illicit drugs for almost a decade, they define themselves as well adjusted in different life areas. Furthermore, they were characterized by significant others as «non problematic» illicit drug users, and they have never experienced social or medical drug related problems.

In fact, other investigations report some illegal drug users social integration and valorisation, being able to conciliate consumption with a conventional lifestyle (Galhardo, Cardoso, & Marques, 2006; Parker, Williams, & Aldridge, 2002; Smith & Smith, 2005). This ability seems to result from a risk management process, as described by other authors (Kelly, 2005; Silva, 2005), in which apprenticeships with other illicit drug users are vital (Becker, 1973; San Julián & Valenzuela, 2009).

Drug user’s self-control is also frequently emphasized (Ehrenberg & Mignon, 1992, cit. Quintas, 2006). In the sample, the maintenance of a non-problematic drug use pattern involves three kinds of strategies intended to preserve subject’s global functionality (although often not deliberately used). Strategies concerning drugs type and consumption regularity are vital because it strongly influence actual consumption pattern. This pattern usually involves cannabis’ regular use and other illicit drugs occasional use only, as documented in previous studies (Levy, O’Grady, Wish, & Arria, 2005; Silva, 2005). The participants also stress that drugs must be used in proper contexts, to improve their effects and to hide their consumption. This necessity of drug use occultation lead us to consider that prohibition related problems faced by drug users change their patterns of use, as reported by other authors (Fernandes, 2009; Smith & Smith, 2005).

Official discourses tend to focus on illicit drug use problematic dimensions and to ignore positive ones, such as pleasure (O’Malley & Valverde, 2004). In that way, they risk to misunderstand, at least, some drug user’s motivations and experiences and also to be unable to reach them. Furthermore, illicit drug use seems considerably independent from its juridical or medical readings, and drugs tend to be appreciated for recreation and seem increasingly integrated in many otherwise conventional subjects’ lifestyles (Quintas, 2006).

So, instead of working for abstinence, it seems more pragmatic and useful to reduce drug use potential harms. In this sense, it is crucial to promote an honest dialogue, in which both drugs’ harms and benefits are discussed. It is also important to intervene in significant consumption contexts, as partying-clubbing ones, working with its clients (e.g., information strategies, pill testing), and also with their workforce (e.g., information strategies about drugs and context safety, formative actions concerning how to react in drug emergency situations) (Calafat, Fernández, Juan, & Becoña, 2005).

Finally, it is important to note that data cannot be generalized, because it was not used a representative sample of Portuguese drug users. However, the sample used represents a frequently ignored picture of illicit drug use and it promotes a more complex debate about this phenomenon.

At the military setting (MDN2009), in 2009, the Armed Forces collected 11,836 (11,282 in 2008, more 554 than in 2008) urine samples from contracted (RC), volunteer (RV) and permanent (QP) staff. The samples are mostly collected on a random basis but follow-up tests (after one positive test) and tests following drug use suspicious reports are also included in these figures, (age group was 18-39).

47,344 toxicological tests were performed on the collected samples for illicit drug use (cannabis, opiates, amphetamines and cocaine). 0.8% of these samples tested positive, which represents the same value of 2008 and 2007 and a decrease in comparison to 2006 (1.3%), 2005 (1.5%), 2004 (2.3%) and 2003 (2.2%).

When considering results per professional category, volunteer staff (3.1%) registered a higher percentage of positive tests followed by contracted personnel (1.2%) and permanent staff ranked quite lower (0.15%). The main illicit substance found was cannabis (89% of all
Drug use in the general population and specific targeted-groups

Positive tests, 88% in 2008, 85% in 2007, 93% in 2006 and 86% in 2005) followed by opiates (1%) and cocaine (2%), positive tests for amphetamines (1%) and polydrug (7%).

In relation to previous years, it was verified the evolution synthesized in the next graph. It is important to recall that in the last four years under consideration is no longer considered the provision of SEN Service (normal effective service), due to the extinction of the service, which was the compulsory military service, usually with relatively higher positivity.

Graph 3 – Positive results (%) in the toxicological screening, between 2003 and 2009, by regime of service (MDN2010)
3. Prevention

3.1. Introduction

The main strategic goals of the prevention area are: prevent the beginning of psychoactive substance use, the continued use and abuse and prevent the transition from use to abuse or misuse and dependence.

The operational objectives of the National Plan Against Drugs and Drug Addictions 2005/2012 are:

1. Increase the quality of the intervention through adequate strategies, mainly selected and indicated prevention, with monitoring and evaluation of the results of the interventions;
2. Contribute for an integrated intervention of IDT, I.P. investing in seeking answers adapted to the problems and needs, sharing resources in a articulate way, both internally and with civil society.

The first objective was achieved through a program and several projects. The Program of Focused Intervention (PIF), that intends to identify a set of best practices in gap areas, properly assessed:

- The intervention in Casa Pia de Lisboa, addressing youth in situation of institutionalization;
- In professional schools with a selective intervention;
- In the University setting to reinforce the intervention, in the promotion of support structures and referral to young people in a logic of early diagnoses and intervention, where from the existing experiences a coherent way will be seek, from the selective prevention to the indicated prevention;
- Cooperation with other entities in the Educational System where the articulation with other health structures and Ministry of Education will surely be the answer to the shared responsibilities of IDT, I.P.;
- In the work and sports setting, trying to create and consolidate knowledge to define the intervention.

In 2009 continuity was given to the evaluation of PIF, and the implementation and monitoring process was concluded. During 2009, the 23 projects targeted to risk groups (vulnerable families (8), vulnerable children and youth (8) and individuals with drug use patterns in recreational contexts (7) were finished. In some areas small but important steps were given to improve the intervention, particularly in the development of intervention guidelines with regard to the care of young users of psychoactive substances, including alcohol, and in the intervention on recreational settings.

For the second objective, investment was made in quality within the Operational Program of Integrated Responses (PORI). 47 projects managed by the Regional Delegations and the Centres of Integrated Responses (CRI) are in the field.

During the year 2009, the preventive approaches privileged the vulnerable groups, contexts, drug use patterns and associated behaviours, without forgetting the specificities of each of the psychoactive substances and its effects on the individuals. Not neglecting the brief or punctual interventions targeted to larger groups, namely students or the community, but trying to focus on those who most needed the contribute of a specialised agency in addressing the issue of consumption and drug addiction.

That strategic option involved an important investment in diagnostic tools for identifying problems, setting priorities, monitoring and evaluation of interventions promoted by the IDT, I.P. itself or supported or financed by it.
3.2. Universal prevention

The implementation of universal prevention strategies has been achieved through a set of responses that are meant to prevent use and abuse of illicit psychoactive substances and alcohol among large ranges of the Portuguese population. The universal prevention strategies are being developed at school, community and family level.

We will mention several projects of universal prevention that are being implemented in different settings.

School

The preventive intervention in schools is a major universal prevention, aimed at giving some awareness to school population on the use and the risks associated to it.

In Portugal, prevention of drug use is part of the school curricula and dealt within the framework of health promotion and education (please see SQ22/25 for description of framework and availability of responses), approached in several school subjects mainly in Sciences, Biology and Civic Education.

In 2009, school-based prevention in Portugal continued to be mainly implemented through programs developed by 3 different actors: the Ministry of Education, which is responsible for the inclusion of health promotion and substance use prevention in the school curricula; IDT, I.P. (Ministry of Health) through the prevention component of PORI framework described below and the Ministry of Home Affairs (Public Security Police - PSP and National Republican Guard - GNR).

During the school year 2009/2010, several prevention activities and projects were developed in the school settings, in a more global perspective of health promotion and in a more specific scope of thematic approach to the use of psychoactive substances.

These awareness actions and/or projects have been developed in the schools curricula dynamics, in the disciplinary curricula areas and in the non-disciplinary as well, or through specific programs for the prevention of psychoactive substances.

The school activities were developed by teachers with the participation of students, several times in articulation with partners working in this area: health centres, autarchies, IDT, I.P., NGOs, among others.

The articulation with the five the Regional Directorate of Education (DRE), in particular with their health promotion interlocutors, is an important element for the monitoring and follow-up of interventions at the level of Promotion and Education for Health (PES) and prevention in the school setting.

Also in this school year, continuity was given to the implementation of several prevention programs, in a structured and continued way; examples are: Projecto Atlante (for the second and third cycle of Basic School); o Programa Crescer a Brincar (for the first cycle); o Programa PRÉ – competências for the preschool (see SQ 22/25) and the Projecto “Eu e os Outros”.

Projecto de Redução de Riscos em Meio Universitário (Project of Risk Reduction in the University context)

In 2009, giving continuity to the work initiated in 2008, this project involved 138 technicians of 22 CRI’s of IDT, I.P., which trained 465 university mediators, who intervened in 92 nights of the academic weeks, totalling 400 hours, in a average of 5 hours per night. More than 50 000 interactions with the visitors were registered during these interventions. Over 125 000
informational and promotional materials (leaflets, condoms, among other things) were distributed and 4,934 alcohol tests conducted. Despite the volume of data collected, the heterogeneity of procedures and instruments used does not allow the presentation of results and reliable conclusions. The definition of common testing procedures was seen as a priority objective for the year 2010. The evaluation of this project offered data based on the perspective of the technicians involved, the university mediators and the visitors of the event. It is transversal the attribution of a high degree of relevance to the intervention, reaching an appropriate level of visibility (61% of 2,500 respondents were aware of intervention). The mediators’ intervention was generally considered of good quality both in the contact established and the information provided (note 5 on a Likert scale of 6 points). The assessment was made in a sample of 168 responses to the subsequent use of electronic mail. It was also valued the intervention strategy through peers (5.3 on a Likert scale of 6 points).

**Projecto Eu e os Outros** (Project Me and the Other’s - see SQ 25 Mustap Questionnaire)

Project Me and the Other’s was created in 2006 by a team from the IDT, I.P. This Project was aimed at promoting a better knowledge and utilization of resources linked with drugs and drugs misuse, like the official website (www.idt.pt and www.tu-alinhas.pt), the help-line (Linha1414), email, chat, etc.

It is a program of universal prevention based on the exploration of interactive narratives covering different topics related to adolescence, addressing the use of psychoactive substances in an integrated manner with other day-to-day problematic of young people, such as sexuality, violence, eating habits, exercise and health, school dropout, etc. This program is targeted to young people between 10 to 18 years old.

The school year 2008/09 finished with the coverage of 65 institutions (schools, professional schools, social security institutions, Private Social Solidarity Institutions (IPSS), etc.), involving and training 262 professionals from different areas (teachers, psychologists, social workers, socio cultural animators, etc.) for the stimulation of 3,493 young people (between 12 and 18) covering all the country. The new school year 2009/2010 began with the enlargement of regional coverage, which resulted in the involvement of two more Centres of Integrated Response of IDT, I.P. (20 CRI comprised) and in the response to 166 institutions, increasing the number of professionals trained for 630 game masters and 10,629 young people reached.

It is noted that although most young people involved is part of a universal prevention perspective, some interventions use the program as a selective prevention strategy particularly in the work developed in some homes/shelters, as well as near the classes of Integrated Plan of Education and Training, at risk of interrupt the school career.

Two missing stories were finalized, fixing in eight the number of interactive narratives available to the professionals involved. The illustration of the stories was initiated and the revision of the materials to its edition. Also started a process of creating a network of partner structures, with responsibility in the areas covered by the program that commented on it, validated the contents and suggested improvements. This process began with the Ministry of Education (DGIDC - Program of Promotion and Health Education), the Ministry of Internal Affairs (PSP / GNR - Safe School), the Ministry of Health (Platform Against Obesity) and the Presidency of the Council of Ministers (Commission for Gender Equality). It is foreseen for 2010 the enlargement of this network to the Ministry of Labour and Social Security (Programme for Inclusion and Citizenship) and the involvement of Portuguese Youth Institute I.P. (IPJ, I.P.) and Institute of Preventive Cardiology.

Finally, in 2009 started an experimental process of integration of the training of Project Me and the Other’s in the university curriculum of Social Education at the University of Algarve. Students explored the theory and basic methodology of the project in a discipline of the 2nd year of the course and its implementation is foreseen during the 3rd year. This experimental
process will serve as basis for enlarging the training process of the Project Me and the Others to the academic context.

**Copos – Quem decide és tu (See SQ 25 Mustap Questionnaire)**

Another example of universal prevention is the Project “Copos quem decide és tu” – a partnership project between the Portuguese Red Cross (CVP – Cruz Vermelha Portuguesa) and IDT, I.P. with the support of General Directorate for Health (DGS – Direcção-Geral da Saúde). The main goal of the project is to raise awareness between secondary school population, aged between 15 and 20 years, to the problems of harmful use and early drinking.

This project aimed at preventing the use, with special emphasis on prevention of alcohol abuse, providing information about alcohol and promoting reflexion on this type of consumption.

The Project “Copos – Quem decide és tu”, takes place across the country as a school-based intervention endorsed by Portuguese Red Cross and technically supported by the IDT. I, P. Key target areas for the initiative were the issues related to the risks associated to the harmful use of alcohol by young people.

In several districts, the project is implemented in cooperation with autarchies and other local partners aiming to create a more consistent intervention.

The main goal of this intervention is to enhance personal responsibility towards alcohol use. The conceptual frame fits in the field of universal prevention, throughout three sorts of actions: peers involvement, school-based activities and geographical flexibility.

The intervention has two main purposes: provide accurate information about harmful use of alcoholic beverages and promote healthy lifestyles and behaviours among young people.

Scientific evidence was collected: the project has been evaluated, in order to gain insights in the most effective instruments and helpful implementation strategies.

In 2008/2009, 39 schools were involved, 12 districts and 6 480 students covered.

**Grupo de Intervenção no Ensino Superior (Group of Intervention in Higher Education)**

The Group of Intervention in Higher Education (GIES – Grupo de Intervenção no Ensino Superior) was created in 2006 and aims to increase the involvement of the Universities in the community intervention (prevention, risk reduction, rehabilitation and research) and to give answers to the academic community (prevention, risk reduction and treatment) in the scope of the use of psychoactive substances.

In this sense, a raising of IDT, I.P. /Higher Education interfaces was done, through questionnaires sent to the higher education establishments. The report of this raising stated:

- At the level of research, from the 76 received answers (representing 36% of return) referred the existence of 191 research works in the drug addiction area (masters, doctorates, research lines), concluded or initiated in the last five years.

- At the level of existing training in this area in higher education structures, from the 55 received answers (representing 48% return) were the inclusion of contents related to drug addiction and alcohol area in the curricula of 54% of the inquiries/respondents, the vast majority at degree level, including 35% of traineeships. The areas with more needs identified by teachers in the trained given, were the prevention and harm and risk reduction for which the need of training stood at an average of 3.8 on a Likert scale of 1-5. The participation of IDT, I.P. structures in training teachers was considered important, the majority of respondents referred (58%) the relevance of additional training provided to teachers to ensure a better approach to the issue during the training processes.
- Concerning the involvement of Students Support Cabinets, from the 30 answers received (42% return rate) the main needs identified concern technical support for the development of preventive interventions (73%), training in the drug addiction area (60%) and the creation of channels for referral of clinical cases followed by them (57%).

- At the level of Students Associations, from the 26 answers received (20% return rate) was identified a low involvement of these structures in interventions in the drug addiction area. Concerns are identified by several academic associations concerning the use and abuse of alcohol and the use of so called “soft” drugs (as designated by the students). The needs reported are located at the level of information, awareness and training.

- Finally, at the articulation level of the social network with the higher education from the 45 answers received (26% return rate) it was noted a scarce articulation, often limited to curricula traineeships. The report included suggestions of action lines, corresponding to each of the raising areas.

**PASITForm**

This project, implemented in the context of professional vocational training, assumes an approach of integrated responses and a perspective of intervention in network, promoting the articulation between the IDT, I.P. and the Institute for Labour and Professional Training (IEFP, IP), in context of professional training. This is an intervention in a context considered a priority due to the existence of an increasing number of individuals at risk or in situation of exclusion, namely young people in professional training actions promoted by IEFP, IP. The relevance of the intervention is based on the assumption that professional training and access to employment may be an important protective factor in relation to the use of psychoactive substances. Thus, the Project focused on three intervention axes in order to: improve the articulation between the services of the two Institutes, defining a methodology for referral and monitoring of users (Articulation); aware the technicians and trainers for the problematic of consumption of psychoactive substances (Training) and aware students to the problematic of consumption.

**Professional Schools**

A pilot project was designed in 2006 for 5 professional schools in two districts, based on a study of social representations of the trainees about psychoactive substance use. The aim was to elaborate training referential on the use of psychoactive substances to be implemented in professional schools.

At this stage of the project, emphasis is put in the collaboration of a monitoring model with territorial specifications, aimed at early intervention in situations of problematic use and case referral.

**EURIDICE**

This European program (EURIDICE: European Research and Intervention on Dependency and Diversity in Companies and Employment), initiated in 2004, aims to promote health in work environment, enhancing protective factors and minimising the risk factors associated with the consumption of psychoactive substances. The program objectives are:

- Prevent and intervene in problems related with the alcohol and other psychoactive substances use;
- Promote healthy lifestyles;
- Changing attitudes, behaviours and risk factors;
- Change the work conditions that favour and/or potentiate the use of psychoactive substances;
- Increase the knowledge on psychoactive substance use;
- Promote the creation of a social and healthy work environment.

The National Confederation of Portuguese Workers - National Trades Union and the IDT, I.P. ensured continuity and development of the project.

Following the results obtained in 2008 in the questionnaires used in the needs diagnosis, addressed to the personal perceptions that workers have on the phenomenon of dependence on psychoactive substances, awareness and training actions were promoted and informational materials produced and edited. In this work, the intervention focused primarily on two entities: the Council Camera of Seixal – District of Setúbal, Council Camera of Loures - District of Lisbon. Two awareness actions were conducted; one training, a public presentation of the Project and twelve work meetings.

Regarding the execution of the project it is considered that a significant effort was made and the problematic of dependences in work environment is considered a health problem, where it is important to intervene in a comprehensive manner (preventing, treating and reintegrating).

A relevant work was developed since it is an area where intervention is intended to bring changes in the organizational culture of employers’ entities and promote a policy of social responsibility, aiming the health promotion and welfare of the workers.

In addition, constitute an example of a project institutionally comprehensive, including within its scope the intervention of local autarchies and other regional and local structures of the IDT, I.P.

The next step will be the creation of a methodology to assess the impact of intervention in order to clarify the usefulness and quality of the results.

Programa Escola Segura (Safe School Program)

The Ministry of Home Affairs continues to develop a proximity policing programme, Escola Segura (Safe School) to improve safety in the neighbourhood of schools through the PSP (Public Security Police) and the GNR (National Republican Guard).

The commitment in the work to be carried out near schools and educational communities is one of the fundamental pillars of the institutional strategy, which is reflected in the "Safe School Program". The main objectives of this programme are: raising awareness and acting near students, parents, teachers and responsible school staff on the problematic of security; advising good practices and recommending the adoption of adequate preventive measures with the aim of ensuring that schools will be a safe place and free of drugs, collect information and statistical data and conduct studies to provide the competent entities an objective knowledge about violence, insecurity feelings and victimization in the educative community.

In the school year 2009/2010, PSP promoted more than 6 873 awareness, training, and demonstration sessions in schools. From the 3 023 schools covered, 1 079 568 students and 153 045 teachers were involved.

Many of these actions were about prevention, criminal prevention and road safety prevention; actions for education for citizenship were also undertaken and several other events.

GNR data indicates that in 2009, 228 agents (211 in 2008, 198 in 2007, 196 in 2006 and 208 in 2005), were allocated to Safe School Programme. Apart from the proximity policing and
offence dissuasion, these law enforcement agents were also involved in training and awareness raising initiatives in schools. The initiative targeted 8 016 schools covering a universe of 810 125 students and 7 588 awareness raising sessions were developed.

**Family**

In some of the projects developed under PORI and PIF (please see subchapter 3.3), interventions of universal prevention occurred in the communities where those target populations are included.

**Community**

In some of the projects developed under PORI and PIF (please see subchapter 3.3) interventions of universal prevention occurred in the community, mainly complementing selective and indicated approach on target groups.

The IDT, I.P. keeps the national telephone helpline, *Linha Vida – SOS Drogas*, an anonymous and confidential service that gives priority to counselling, information and referral in the drug abuse area and associated themes (adolescence, sexuality, AIDS, amongst others). In 2009, *Linha Vida* was available from 10 am to 8 pm every working day. The staff includes doctors, psychologists, pharmacists and social workers with specific training in drug abuse.

From the 1st January to 31st December 2009, the helpline received a total of 13 307 calls (15 860 in 2008, 23 412 in 2007) from which only 2 681 (2 787 in 2008, 3 169 in 2007) were real calls, the rest being silent calls (2 407 in 2009, 3 000 in 2008 and 5 069 in 2007), pranks (8 123 in 2009, 9 854 in 2008 and 14 881 in 2007) and 96 (219 in 2008, 293 in 2007) insults. Corresponding in percentual values respectively to 20% of real calls, 18% silent calls, 61% pranks and 1% insults.

It is verified that a large percentage of calls are Pranks, following the trend observed in previous years with a slight decrease, followed by Silent, appearing after the Real, that contrary have been increasing.
Concerning the client profile, most calls continue to be made by those who had a problem or needed information 68% in 2009, (57.86% in 2008, 56.48% in 2007, 58.40% in 2006) followed by calls made by mothers 15% in 2009, (16.87% in 2008, 16.66% in 2007, 14.63% in 2006) with doubts about drug use and relationship problems with their children. In 2009, most callers were aged 36-50 (19%) and 26-35 (6%) and were mainly female (51%).

Concerning the contents of the Real calls, it was verified that 77% of calls fall into the Drugs category and deal with the presentation of a problem or a request for information related to drugs, while 23% refer to other issues.

As expected, most calls answered in the service are drug-related problem, since this is the area of operation of the Helpline. These calls are related either to information requests and clarification of doubts or requests for support or referral.

1,968 calls in 2009 (1,922 in 2008 and 1,992 in 2007, 2,551 in 2006) concerned information requests about substances mainly cannabis (31%) and opiates (32%) followed by cocaine (18%) and alcohol (11%).

In calls related to problems drug use, from a total of 435 calls in which was possible to obtain information about the current situation face to drug use, 359 are current situations of active use and 29 refers to individuals in treatment. 16 clients refer situations of stop using.

In relation to referrals made by the services, those are from different types according to specific problem situations: 47% are related to indications of outpatient treatment services, 21% to therapeutic communities, 10% of psychological support and 7% to self-help groups.

Linha Vida also continued to respond to emails (e-mail counselling). In 2009, 263 emails were received (707 in 2008, 689 in 2007, 781 in 2006), 159 came from Linha Vida and 104 from Tu-alinhas. 153 of the emails were requests for information and 33 were related to requests for support/counselling and 7 are requests for referral to treatment.

Concerning the themes approached, 50 emails were related with substances, 16 with requests for analysis to detect specific drugs. Only one prank mail was received, and one request for statistical information.

Concerning the substances, it was noted a higher number of questions related to drug addiction/drugs in general (64 emails), followed by questions concerning cannabis (45 emails), cocaine appears as the second most common referred with 12 emails.

Concerning the client profile, most emails are sent by those who had a problem or needed the information (140 emails), followed by technicians (21), parents and companion (13). In 2009 like in 2008, most of the questions came from female gender (133) and 55 from male gender.

In particular situations and under specific criteria, Linha Vida makes face-to-face counselling available to some of the callers, mainly for psycho-social assessment and referral. The purpose of this counselling is the follow-up on a continuous basis of patients and families, functioning as an impulse for seeking help, stimulating family mediation and allowing access to referral.

Face to face counselling is targeted to patients who go directly to IDT, I.P. by their own initiative, advice of other services or by suggestion of the Helpline technicians.

From the years 2005 to 2008, 111 clients were followed-up in the different responses provided by IDT, I.P. and 42 new clients were followed in 2009. Most of these clients are from the male gender.
<table>
<thead>
<tr>
<th>Nº of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Follow-up 2005-2008</td>
</tr>
<tr>
<td>Total of new cases in 2009</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Table 5 – Face to face counselling (NAI /IDT, I.P.2010)

Other community intervention project using new technologies is [www.tu-alinhas.pt](http://www.tu-alinhas.pt), a website that promotes healthy behaviours and prevention of drug use in a teenager-youth public (12-21 years old). This project is running since 22\textsuperscript{nd} of February 2007, has both entertaining and pedagogical approaches with the main goal of informing and promoting healthy behaviours and drug addiction prevention.

During 2009 were registered 37 635 unique visitors\textsuperscript{7}, 44 372 page visits and 223 1396 hits to the juvenile website “Tu Alinhas”.

“Tu Alinhas” was in the course of 2009 considered one of the most useful website page in Portugal, in the category Youth and Academic Life, which includes other websites such as Youth Portal of the IPJ, I.P. ([http://www.sitesmaisuteis.pt/](http://www.sitesmaisuteis.pt/)).

### 3.3. Selective prevention in at-risks groups and settings

PORI is a structural measure that highlights accurate diagnosis, fundamental for putting in practice a field intervention and obeys to sequential phases, achieved through the creation of PRI in the identified territories. It promotes an integrated intervention, which means the coordination between all the axes of the intervention (prevention, harm reduction, treatment and reintegration) and not an isolated approach.

PRI is a specific intervention program that integrates interdisciplinary and multi-sectorial answers, according to some or all areas of IDT, I.P. mission (prevention, treatment, harm and risk reduction and reintegration) and it is dependent from the results diagnosed in a territory identified as priority.

As can be observed in the operational scheme, the activities developed in 2009 are located on phases 6, 7 and 8 – Constitution of PRI, Territorial Nucleus (NT) and Technical and Financial Coordination of PRI.

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\(\text{\textsuperscript{7}}\) Hits – It’s everytime a archive (e.g a photo) or a website page is accessed. Can also be referenced as “requests”. Pages – It is everytime a page is seen. Also referred as "views" (visualizations). Visits – Counts one visit by computer for a few minutes. If the person access the page again after half an hour will be counted one more visit. Unique Visitors – Counts un visitor per day no matter how often and at what time accessed. Leaves a cookie by computer, that expires next day. If the browser doesn’t accept cookies, he counts the number of IP.
In 2009 the priority was the stabilization and normalisation of the procedures of follow-up, monitoring and evaluation of the interventions developed within PRI.

Considering the three levels of achievement and therefore assessment of PORI, several tools were constructed and applied, namely:

1) At the level of projects by mission area;
   • Interim Report for the projects co-financed;
   • Model opinion of the CRI;
   • Model for Evaluate Regional Delegations;
   • Evaluation Model Point Status of projects;

2) At the level of PRI as an integrated response to each territory;
   • Monitoring and evaluation form of PRI;

3) At the level of PORI as measure at national level;
   • Database in Access that allows analyzing the information at national level.

It was completed a Circuit of Procedures with the aim of clarifying the role of each intervenient in the process (CRI, Regional Delegations and Central Services of IDT, I.P.) as well as to standardize the associated procedures.

In 2009, 71 PRI were functioning\textsuperscript{8}, driven by the respective Territorial Nucleus (NT), which include 108 projects\textsuperscript{9} co-financed by the IDT, I.P. Was also implemented the system for monitoring and evaluation planned, both at projects level as well as at PRI level.

\textsuperscript{8} 57 PRI initiated in 2008, being the respective NT constituted in that year.
With a view to extend the network of responses, was initiated the process towards the creation of 29 new PRI co-funded by IDT, I.P. and 4 PRI without the need of additional financing, 33 in total.

In the call for tenders held in 2008, there were five gap areas without response to the needs identified (i.e., no applications submitted or projects not approved) that were also put to tender in 2009. Thus, tenders were opened for PRI in 29 territories, with the distribution, by region as shown in the Graph below.

Graph 5 – PRI Call for tenders, by Region (N=29), (IDT, I.P. 2010)

With the opening of these tenders was intended to give answer to 45 gap areas, with the following distribution by axe of intervention: prevention (24), Harm and risk reduction (7) and Reintegration (14).
Graph 6 – Areas with gaps by Region and axe of intervention (N=45), (IDT, I.P. 2010)

In response to the 45 gap areas placed for tender, 60 applications were received and 38 were approved. The approved projects will be developed by 24\(^{10}\) new PRI with the distribution, by region, which is presented in the Graph below.

Graph 7 – Projects Approved by Axe of Intervention (N=38), (IDT, I.P. 2010)

DRN – North Regional Delegation; DRC – Center Regional Delegation, DRLVT – Lisbon and Tagus Valley Regional Delegation, DRA – Alentejo Regional Delegation

Graph 8 – New PRI, by Region (N=24) (IDT, I.P. 2010)

\(^{10}\) From the 38 projects approved, four were integrated in PRI already previously constituted.
In sum, in 2009 were in execution 108 co-financed projects by IDT, I.P., from which 105 were contracted in 2008.

Graph 9 – Projects in execution by Area of Mission (N=108) (IDT, I.P. 2010)

In 2009, was initiated the monthly collection of process indicators of the co-financed projects in the ambit of PRI.

The execution indicators collected monthly relate only to actions undertaken in the projects near the beneficiaries, i.e. not intended to reflect all the work the implementation of a project implies, but report some important data.

The next graph shows the total number of individuals covered by all the projects in execution during the year 2009, by axe of intervention. Although this present report has the aim at reporting 2009 data, we chose to include the number of people still covered in 2008, since the consolidation of this information has only been possible in 2009.

Graph 10 – Total number of individuals covered, by axe of intervention (N=69 515), (IDT, I.P. 2010)
Note: In the case of Harm and risk reduction (RRMD) the 5 550 individuals covered relate to people contacted by Harm Reduction structures, which does not mean that users are followed in continuity in the ambit of the projects.

Specification by Axe of Intervention - Prevention

The 47 ongoing projects in the area of prevention covered 61 230 individuals.

The regions that covered the greatest number of people (North and Center) are those with more projects underway and more actions being developed.

47 projects in execution were carried out: most projects (42) carried out actions of training competences, 36 developed awareness/information actions, 32 educational-cultural/ludic-pedagogical and 28 actions of psychosocial follow-up. It is noteworthy the fact that the vast majority of projects develop actions targeted at specific groups with particular emphasis on Training Competences, taking into account the importance that such type of action has in the context of prevention.

The graph below shows the number of individuals covered by target group category in the different types of actions. It is important to refer that the same person can fall into several types of action.
Axe of Harm and Risk Reduction

With respect to the axe of Harm and Risk Reduction, 29 projects were implemented in 2009 under the PRI, covering 5 500 people.

Based on the diagnoses of the territories, emerged the need to implement projects to develop several responses to the same territory, particularly among drug addicts in recreational settings. Thus, the responses developed by the projects, according to the established by Decree-Law N.º 183/2001 of 21 June, are presented in the following graph.

Projects co-financed by the IDT, I.P. under Administrative Rule N.º 131/2008 of 13 February are an integral part of the National RRMD network, in that way the option was to give a general overview of several activities developed in the ambit of PRI.

Reintegration Axe

With respect to the Reintegration axe, the intervention is being developed in the North, Center and Lisbon and Tagus Valley regions, in a total of 29 projects and covering 2 479 individuals.

Much of the covered population is located in the northern region (65%), since it is in this region that 18 of the 29 reintegration projects in implementation in 2009 are being developed.
In the following graph is presented a typology of the actions developed which represent the several strategies used to achieve the expected results near the target groups.

The psychosocial follow-up is the base of intervention strategies in reintegration, which is verified by the large number of projects that develop this type of action (28). Also noteworthy the actions of awareness/information, developed in 21 projects, training competences, developed in 20 projects, educational/cultural/ludic/pedagogical and the vocational guidance presented in 19 projects and the social mediation, developed in 18 projects.

With regard to the number of people covered in each action, worth mentioning the existence of different target groups, situated in two dimensions of intervention, distinct and complementary: the individual dimension, which fits the intervention near psychoactive substances users in reintegration process and the dimension of social systems, which includes the remaining target groups presented in the following graph:
Most of the actions were aimed at users in reintegration process, especially the actions of psychosocial follow-up. Awareness/Information actions covered the largest number of people, including users in reintegration process and several elements of social systems, in a total of 1,346 people. It was also stressed the importance of the presence of family elements in several actions developed, taking into account the fundamental role they can play in the reintegration process.

**Treatment Axe**

With respect to the Treatment axe, the intervention was developed in the Northern Region with two projects and in Lisbon and Tagus Valley with one project, being the number of clients covered similar in both regions.

It was observed that the outpatient appointment and Methadone and Buprenorphine programs became the base of the intervention in treatment.

There is a close articulation among the 44 existing treatment teams across the country and the several responses taking place in the ambit of PRI in order to promote the resizing and
reorientation of the network of integrated care in function of the diagnosis of global and local contexts.

**Implementation of PRI**

In what concerns the constitution of Territorial Nucleus (NT) of 68 PRI, from the 71 in implementation during 2009, it was verified that are several entities participating in this dynamic and on average each Nucleus is constituted by 7 entities.

From the 409 entities that were part of the NT, 156 were NGOs that include Mercies, Private Institutions of Social Solidarity, Associations, Foundations, among others. It was noted that from the 156 NGOs present in the NT, 69 are co-financed by the IDT, I.P. in the ambit of PRI.

**Graph 19 - Typology of the entities that constitute the NT (N=409), (IDT, I.P. 2010)**

With intervention in the area of Education 96 entities were present, from the Elementary Schools and Secondary Education and Universities. There is also an important weight of Municipalities in the NT, with 66 representations, including Council Cameras and Parish Councils.

Also noteworthy were the entities in the Social Security area (31), which included the District Centres of the Institute of Social Security, the Commissions for Protection of Children and Young People and Social Networking. In the health area 31 entities were present, including local health units. In the ambit of Employment, IEFP, I.P. was represented by 12 entities, including Centres of Professional Training and Employment Centres. Security forces were also present (7), which included the PSP and GNR. In the area of justice, entities present were the General Directorate for Prisons and the General Directorate of Social Reintegration.

**Monitoring the 1st year of PRI execution**

From the 71 PRI in execution in 2009, it was possible to analyse data on the first execution year of 15 PRI, based on the available monitoring data sheets, according to the following geographical distribution: 13 PRI in the North, one in Lisbon and Tagus Valley and one in Algarve. Of the 15, two were PRI projects without co-finance by the IDT, I.P., however, it is not yet possible to draw general conclusions, at national level.

In relation to the target groups of intervention in these 15 PRI, they are expected to cover 17 699 people in total and in the first year of implementation 15 078 were reached.

It was verified that, in the PRI which presented information on the percentage of people covered in the 1st year of execution, 12 covered more than 50% of the foreseen population
and 4 PRI covered more than 100% of the number of people foreseen for two years of intervention.

In the diagnoses of the territories were presented qualitative characteristics of the target groups to be covered. In the case of co-financed projects, the opening of tenders’ notices also contained some qualitative information on the characteristics of the groups to cover in each gap area by intervention axis.

Concerning the implemented actions, it was verified that, generally and in the 15 PRI, there was a high degree of execution, comparing to what was foreseen initially, as can be observed:

<table>
<thead>
<tr>
<th>Number of PRI (n=15)</th>
<th>1 – Minimum Level</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 – Maximum Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6 – Execution degree of the actions foreseen (IDT, I.P. 2010)

On the adequacy of the actions developed to problems and needs of the target groups, it can be considered that in an overall reading, were considered very appropriate, since almost all the scores are in the grade 4 and grade 5.

<table>
<thead>
<tr>
<th>Number of PRI (n=15)</th>
<th>1 – Minimum Level</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 – Maximum Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 7 – Adequacy of the actions to the target groups and to their problems (IDT, I.P. 2010)

It is verified that the NT of the 15 PRI in analysis have the perception that the goals outlined are being achieved, as shown in the table below, where “1” represents the minimum level of achievement and “5” the maximum level:

<table>
<thead>
<tr>
<th>Number of PRI (n=15)</th>
<th>1 – Minimum Level</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 – Maximum Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 8 – Level of achievement of the planned objectives (IDT, I.P. 2010)

Taking into account the guiding principles of PORI (Partnership, Integration, Territoriality and Participation) are shown below the perception of these NT about the implementation of PRI in relation to some of these aspects.

It can be seen in the table presented below, that the vast majority of the NT considered that actions are being developed in partnership.

<table>
<thead>
<tr>
<th>Number of PRI (n=15)</th>
<th>1 – Minimum Level</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 – Maximum Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 9 – Level of development of actions in partnership (IDT, I.P. 2010)

Generally, the perception of these NT is also positive in relation to the complementariness of the actions of PRI.
Table 10 – Level of complementariness of the actions (IDT, I.P. 2010)

One of the key aspects in the principle of participation is related to the direct involvement of target groups in the planning and implementation of interventions, as elements fully active in all phases of development of the actions and not just as "receivers" of external responses. As can be seen in the table presented below, the perception of these NT was also quite positive in this respect, so generally we can say that the target groups of PRI have played an important role in actions developed.

Table 11 – Level of participation of the target groups in the planning and implementation of the actions (IDT, I.P. 2010)

As shown by the information submitted in 2009 several stages of PORI were simultaneously in execution, since the elaboration of new diagnoses, opening of tenders, constitution of new PRI till the follow-up and monitoring of a large number of projects co-financed and PRI, highlighting the increased effort that involved the application of new monitoring tools. Overall, there was a high level of implementation of planned activities. All the work developed was the result of the involvement of all intervenient, from entities promoters, to the entities that constitute the NT and provided services and specific responses, as well as IDT, I.P. services.

Another program of selective prevention is the Program of Focused Intervention (PIF) which envisages developing selective preventive interventions in the drug addiction area, based in scientific evidence, dealing with problematic specific groups, namely families, vulnerable children and youngsters and individuals with patterns of use in recreational settings. These interventions aim developing specific individual and family competences to deal with illicit substances use and inherent problems and risks. The main objective of this program is the creation of guidelines for prevention interventions practice-based as well as selection, monitoring and evaluation criteria’s for upcoming IDT, I.P. projects and programs.

In the ambit of PIF in 2009, it was concluded the process of implementation and monitoring and continuity was given to its evaluation process. The overall reading of the results, allows to consider that most of the planned activities, implemented the principles of PIF and consolidated the proposals set.

Since the procedures for the evaluation of results are in development, it was not possible in 2009, to come up with concrete statements regarding guidelines about practices validated on the development of new projects with vulnerable groups. However, the evaluation conducted until the moment confirmed that the principles and assumptions of PIF were implemented and its validity confirmed.

During 2009 were developed and concluded, the 23 projects target at risk groups (vulnerable families (8) vulnerable children and youth (8) and individuals with patterns of use in recreational settings. During the twenty-four months of PIF execution a total of 210 017 participants were covered, distributed by the different target groups, as presented in the table below.
164 actions were developed, through which were addressed the components shown in the next graph. Of all the defined components stand out as having been addressed by more projects the following: personal competences, knowledge about psychoactive substances and their effects, health related issues, perception of risk associated with consumption, parental competences, competences to deal with use and abuse and competences of interrelation parent/sons.

Table 12 – Number of participants by target group (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teenagers going to recreational contexts</td>
<td>69527</td>
</tr>
<tr>
<td>Youth going to recreational contexts</td>
<td>65318</td>
</tr>
<tr>
<td>Young adults going to recreational contexts</td>
<td>56845</td>
</tr>
<tr>
<td>Adults going to recreational contexts</td>
<td>10833</td>
</tr>
<tr>
<td>Preadolescents (10-14 years)</td>
<td>1985</td>
</tr>
<tr>
<td>Adolescents (15-19 years)</td>
<td>1525</td>
</tr>
<tr>
<td>Families (sons, father, mother, other figure with parental functions, other element of the family)</td>
<td>1022</td>
</tr>
<tr>
<td>Children (5-9 years)</td>
<td>888</td>
</tr>
<tr>
<td>Fathers and Mothers (parental figures)</td>
<td>521</td>
</tr>
<tr>
<td>Mother</td>
<td>443</td>
</tr>
<tr>
<td>Professors</td>
<td>287</td>
</tr>
<tr>
<td>Staff elements of the recreational contexts (promoters, security, barman, etc)</td>
<td>191</td>
</tr>
<tr>
<td>Young (20 - 29 years)</td>
<td>190</td>
</tr>
<tr>
<td>Babies (0-4 years)</td>
<td>157</td>
</tr>
<tr>
<td>Grandfather/Grandmother</td>
<td>112</td>
</tr>
<tr>
<td>Technicians of social and health area (psychologists, social assistants, sociologists, etc)</td>
<td>102</td>
</tr>
<tr>
<td>Other educational agents in school (educators, auxiliaries, etc)</td>
<td>70</td>
</tr>
<tr>
<td>Pré-adolescents going to recreational contexts</td>
<td>42</td>
</tr>
<tr>
<td>Father</td>
<td>32</td>
</tr>
<tr>
<td>Young Adults (25-34 years)</td>
<td>17</td>
</tr>
<tr>
<td>Other family members with parental functions</td>
<td>10</td>
</tr>
</tbody>
</table>
Concerning the type of strategies, it was noted that information/awareness sessions, competences training, training and counselling were the ones used in more projects.

Given the global data, it was noted that several target groups were covered through various components and different strategies, which may be an indicator that the program implementation, in general, followed the principles of comprehensiveness and multi-component approach, contributing to the effectiveness of preventive intervention.

Next we present the data for each of the categories that constitute the PIF.

**At risk families**

In the category of vulnerable families was covered through 44 actions, a total of 2,558 participants, distributed across the different types of target group, as presented in the graph below. The families were the type of group with more participants, which represents an adequacy with what was expected for this category.

![Graph 21 – Number of participants covered by type of target group (N=2558), (IDT, I.P. 2010)](image)

All projects in this category covered in its intervention fathers and mothers. In addition, it was noted that half of the projects also covered children, preadolescent, adolescent and others with parental function, which is an indicator that the intervention focused on family as a whole, meeting the principles of effective preventive intervention in families.

![Graph 22 – Number of projects covering each one of the target groups (N=8), (IDT, I.P. 2010)](image)
With regard to components, we highlight that the majority of the projects covered more than one component and focused its intervention in developing parental competences, personal and social competences of inter-relation parent/sons and knowledge about other topics related to health. These results indicated that intervention targeted to families covered by the projects was guided by a multi-component approach, which meets the assumptions defined for the PIF.

Regarding the type of strategies used, the majority of the projects covered more than one strategy, primarily using sessions, training competences, information/awareness, training and psychosocial follow-up. These results seem to indicate that most of the projects sought to use different strategies in order to tailor the intervention to the characteristics and needs of target groups.

**Graph 23 – Number of projects by type of strategies (IDT, I.P. 2010)**

**At-risk groups**

In the category of vulnerable children’s and youth, a total of 4,363 participants were covered, through 86 actions, distributed by the different target groups, as presented in the Graph below. The type of target groups with more participants, were the preadolescent and the adolescents.

**Graph 24 – Number of participants covered by type of target group (N=4 363), (IDT, I.P. 2010)**
As can be seen in the graph below, most projects in this category, as expected, focused his intervention in adolescents. In addition, it was noted that most of the projects covered, as well teachers, preadolescents and fathers and mothers, which is an indicator that the intervention in this category had a comprehensive character, i.e., focused on more that one domain of the life of the individual.

Graph 25 – Number of projects that covered each one of the target groups (N=8), (IDT, I.P. 2010)

With respect to the components used, it is emphasized that all projects covered more than one component and focused its intervention in the development of personal and social competences and knowledge about other topics related to health. In addition, most projects also addressed in his intervention the dimensions related to school, the perceived risk associated with use, knowledge about psychoactive substances, among others. These results indicated that intervention target to children and vulnerable young people covered by the projects, was marked by a multi-component approach, which meets the assumptions defined for the PIF.

In relation to the type of strategies used, stands out that the majority of the projects covered more than one strategy using essentially the cultural and pedagogical activities, competences training sessions, recreational activities, information/awareness sessions and training and counselling. These results seem to indicate that most of the projects sought to use different strategies, thus contributing to the adequacy of intervention to the characteristics and needs of target groups.
Recreational settings

In the category of individuals with patterns of use frequenting recreational settings 203,196 participants were covered, distributed by different types of target group, as shown in the Graphs below through 34 actions. The type of groups with more participants were adolescents, youth and young adults going to recreational contexts, reflecting an adjustment to what was expected for this category.
The majority of the projects of this category conducted their intervention to young people going to these recreational contexts. In addition, it was noted that half of the projects covered as well staff elements of those recreational context, what is an indicator that the intervention in this category had a comprehensive character.

Concerning the components used, it was emphasized that, most of the projects covered more than one component and focused their intervention in the work on the risk perception associated with consumption and knowledge about psychoactive substances and risks associated with consumption. These results indicated that the intervention targeted at individuals with consumption patterns of recreational contexts covered by the projects, was marked by a multi-component approach, which meets the assumptions defined by the PIF.

In relation to the type of strategies used it was emphasized that the majority of the projects used more than a strategy using mainly the distribution of informative material and information/awareness sessions. These results seem to indicate that most of the projects sought to use different strategies, thus contributing to the adequacy of intervention to the characteristics and needs of target groups.

In addition to the actions undertaken directly with the target groups, in most projects were implemented activities that guided the intervention to achieve its objectives. Thus, and as regards the training of the elements that constitute the technical staff, it was found that more than half had internal training (13 projects) and/or external training (12 projects).

Through the analysis of data collected on these types of activities, it can be seen that most of the projects had team meetings on a weekly basis and that the degree of participation of the constituent elements of the technical team was high.

In the ambit of PORI, 12 projects included assistance in recreational settings, some of them associated with harm reduction interventions in populations identified, others by complementing interventions in school populations.

### 3.4. Indicated Prevention

Within the Integrated Project of Community Support with IDT, I.P. resources or in articulation with external entities, functioned near 30 appointments to youth and adolescents, in a
perspective of indicated prevention, located preferably in institutions with no image associated with drug addiction.

Some of the results of the activities realized in 2009 are presented below:

- 975 clients registered (children, youth and families or relatives) subject of screening;
- 921 follow-up appointments in psychiatry to relatives of children or youth at risk;
- 8 225 appointments of psychotherapy or individual psychological counseling to children, youth or relatives (1 400 appointments to teenagers consuming hashish);
- 892 appointments of family therapy;
- 4 appointments to families;
- 3 follow-up appointments;
- 116 young people covered by interventions of psychotherapeutic groups;
- 45 teenagers covered by 3 psycho pedagogic group actions.

Interventions on Health Promotion were performed in 56 schools, comprising 350 students, training actions for 75 teachers and 4 interventions of selective prevention in education to health with problematic groups.

The IDT, I.P. in partnership with Casa Pia de Lisboa (CPL) developed a project on prevention of psychoactive substance use. This Project, focused at young school and institutional settings intervention was a preventive response to psychoactive substance consumption and healthy development promotion for students at CPL.

Following the work developed since 2006 in partnership with Casa Pia de Lisboa, and the diagnosis made, the action of the project for the prevention of substance use has resulted in operationalisation of the identified needs. In this sense the intervention focused on two complementary aspects: strengthening the qualification of the preventive intervention by conducting training activities and in the conclusion of leaflets on the procedures to be used in situations of suspicion/consumption/trafficking of psychoactive substances addressed to students, families and social educative agents.

3.5. National and local media campaigns

In 2009 and 2010 media and public debate was focused mainly on the following drug-related issues:

- The launch in September 2009 of the awareness campaign against the use of alcohol and illicit substances in workplaces, in conjunction with the Portuguese Association of the Companies of the Employment Private Sector.
- With the aim to promote healthy lifestyles, the IDT, I.P., in partnership with Sportis, held several editions of the Bike Tour in São Paulo (January 2009, January 2010), Lisbon (May 2009, June 2010), Madrid (November 2009, October 2010), Porto (July 2010), which counted with the participation of thousand of participants and large coverage by TV channels and press.
- Decriminalisation of drug use, with several articles in the most important international magazines and with a big number of interviews and visits from national and international journalists, as well as institutional delegations.
• Launch of the 7th edition of the campaign “Brigadas 100% Cool”, a partnership of GNR and the National Association of Alcohol Drinks which took place in 9 cities, from June to December 2009, with the aim of raising awareness in nightlife settings on the harmful use of alcohol.
4. Problem Drug Use

4.1. Introduction

In 2009 there were no new studies on problematic drug use, so we continue to report here the last study realized.

During 2006-2007, a study was conducted to estimate the national prevalence of problem drug use (PDU) and intravenous drug use (IDU) in Portugal (Negreiros2009). The study adopted EMCDDA definitions of PDU (i.e., injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines) and IDU (i.e., injecting for non-medical purposes). Besides, the prevalence estimates included the age group of the 15-64 year olds and were referred to the year of 2005. The study was carried out in the framework of the contract celebrated between the IDT, I.P. and the Faculty of Psychology and Educational Sciences (FPCE/UP).

PDU and IDU estimates were calculated based on the multiplier method using the treatment data; IDU estimates were also calculated based in the deaths multiplier method. The number of identified problem drug users (benchmark) was provided by the public treatment agencies (i.e., number of problem drug users who underwent treatment in the “Centros de Atendimento a Toxicodependentes” in 2005). The National Forensic Institute provided the information (i.e., number of registered drug-related deaths) for IDU estimates for the deaths multiplier method.

Respondent-driven sampling (RDS) was implemented to recruit problem drug users (n=237) in a large metropolitan area (Oporto) and in a medium size city (Viseu; n=50). RDS is a network-based method for sampling hidden populations that has been shown to produce unbiased populations estimates. To implement RDS, ethnographic research was conducted to develop familiarity with local sites and populations. An incentive system (financial reward) was also used. In order to estimate the multiplier value, a direct question and nomination techniques were used.

Elsewhere, both samples were described in terms of social and demographic variables as well as drug use patterns (Negreiros2009).

4.2. Prevalence and incidence estimates of PDU

a. National estimate of overall PDU for Portugal

Multiplier method using treatment data

The number of problem drug users registered in the public treatment agencies served as benchmark. According to IDT, I.P. the number of problematic drug users registered in these treatment centres, in 2005, was 27 685. The in-treatment rate of problematic drug users was estimated by applying respondent-driven sampling (RDS) and nomination techniques described above.

The estimation of the multiplier was based on research in Oporto, a large metropolitan area, and Viseu, a medium size Portuguese city. Respondents were questioned using a direct question and a nomination procedure. The nomination technique evolved into two phases. First, respondents could nominate five friends of their network of acquaintances that were using drugs regularly in the past year. Second, respondents had to indicate the proportion of these drug-using acquaintances that have been for treatment in the past year in a public treatment agency (Centro de Apoio a Toxicodependentes – CAT - Specialised Outpatient Drug Abuse Treatment Centre).
In Oporto, the in-treatment rate was 0.59, for the direct question (i.e., in 2005, have you ever attended a CAT?) and 0.52 for the nomination procedure. In Viseu, a medium size Portuguese city, the in-treatment rates were 0.62 and 0.56 for the direct question and the nomination question, respectively.

Due to lack of information about in-treatment rates outside Oporto and Viseu, a range of 0.52-0.62 was used to estimate the number of problem drug users. As so, given that the public treatment centres reached on average 52% of the total number of problem drug users nationally, there are 27 685/0.52 = 53 240 estimated problem drug users; if 62% is taken has an average percentage nationally, there are 27 685/0.62 = 44 653 estimated problem drug users in Portugal.

**Limitations**
Not all treatment facilities are covered. The public treatment centers couldn’t provide data of problem drug users seeking treatment categorized by type of drug. The estimation of the in-treatment rate was based in the samples selected in only two Portuguese cities.

**b. National estimates of IDU’s in Portugal**

**Multiplier method using treatment data**

The national estimation of IDU method was based in the number of problem drug users that have reported injecting drug use in the last 30 days. In the sample from Oporto, the only place where was possible to collect information on this issue, 30% of problem drug users admitted injecting drug use in the last 30 days. Applying this proportion to the total number of problem drug users, the total of IDU cases is estimated at 13 395 - 15 972.

**Limitations**
This multiplier method was calculated based only on the data from the sample of Oporto.

**Multiplier method using mortality data**

This estimation method is based on the total of drug-related deaths and the mortality rate of problem drug users. In 2005, the number of drug related deaths (the definition of “drug related deaths” included deaths due to an overdose) were 219 cases. If a mortality rate of 1% is used the estimated number of IDU's is 10 950; with a mortality rate of 2%, the estimated number of IDU's is 21 900.

**Limitations**
Mortality rates are not constant. The existing mortality rates are almost exclusively based on studies on drug users in treatment.
### Table 13 – Prevalence Estimations of Problematic Drug Users in Portugal (IDT, I.P. 2009)

<table>
<thead>
<tr>
<th>Definition of Case</th>
<th>Year</th>
<th>2000</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users of opiates, cocaine and/or amphetamines</td>
<td></td>
<td>Treatment Multiplier</td>
<td>Treatment Multiplier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>48 673 - 73 010</td>
<td>44 653 - 53 240</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.4 - 10.7</td>
<td>6.2 - 7.4</td>
</tr>
<tr>
<td>Long term users/regular use of opiates, cocaine, and/or amphetamines</td>
<td></td>
<td>&quot;Back-calculation&quot;</td>
<td>Outreach teams Multiplier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 620 - 43 966</td>
<td>30 833 - 35 576</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.3 - 6.4</td>
<td>4.3 - 5.0</td>
</tr>
<tr>
<td>Users (actual or recent) of drug by intravenous route</td>
<td></td>
<td>Mortality Multiplier</td>
<td>Mortality Multiplier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 900 - 31 800</td>
<td>10 950 - 21 900</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.3 - 4.7</td>
<td>1.5 - 3.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment Multiplier</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 183 - 16 285</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.8 - 2.2</td>
<td></td>
</tr>
</tbody>
</table>

### Conclusion

Results from national estimations on problematic drug use in Portugal indicate that there are between 6.2 and 7.4 problematic drug users for each 1 000 inhabitants aged 15-64 years, and between 1.5 and 3.0 for injecting drug users.

Between 2000 and 2005, the estimate number of problematic drug users in Portugal has shown a clear decline, with special relevance for injecting drug users.

### 4.3 Data on PDUs from non-treatment sources

Please see subchapter 4.2.

### 4.4. Intensive, frequent, long-term and other problematic forms of use

No new information available.
5. Drug-related treatment: treatment demand and treatment availability

5.1. Introduction

Treatment demand data in Portugal is collected through the outpatient public network. In 2009, the network received treatment demand data from all 79 treatment centres across Portugal. Data were available only on clients who entered treatment for the first time in their life (new clients) and not on the total of those who entered treatment in 2009.

In 2009 a special focus was given to the articulation with other health care resources and socio-sanitary conditions of public and private sectors, in order to improve the answers to the multiple needs of users with problems associated with the consumption of psychoactive substances. It is also to highlight the orientation for the quality of services provided.

The number of active clients in the outpatient public treatment network increased (+1%) as well as first treatment demands (new clients). Concerning first treatment demands for the third year was inverted the downward trend initiated in 2000, probably due to an upper and better articulation of responses in the field, registering an increase (+9%) in relation to 2008, increasing the number of clients with alcohol related problems that went to the Treatment Teams (ET).

Heroin remains the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures but references to cocaine, cannabis and alcohol in this setting are increasing.

The availability of substitution Programs continues to increase and the number of clients continues to increase steadily, increases were registered in the number of clients in methadone and buprenorphine Programs.

5.2. Strategy/policy

Healthcare for drug users is organized in Portugal mainly through the public network services of treatment for illicit substance dependence, under the IDT, I.P. within the Ministry of Health. In addition to public services, certification and protocols between NGOs and other public or private treatment services ensure a wide access to quality-controlled services encompassing several treatment modalities. The public services provided are free of charge and accessible to all drug users who seek treatment.

The main priorities established by the National Plan for the 2005-2012 period in the area of treatment are:

- To ensure just-in-time access to integrated therapeutic responses to all those who request treatment (target to all citizens);
- To make different treatment and care Programs available, encompassing a wide range of psycho-social and pharmacological possibilities, based on ethical guidelines and science based practices (target to problematic drug users and vulnerable population);
- To implement a continuous process for improving quality for all therapeutic programs and interventions (target to professionals in the treatment area).

In addition to the National Plan, three legal diplomas define the legal framework in the treatment area:
Drug-related treatment: treatment demand and treatment availability

Decree-Law 183/2001 – the objective is to create programs and social and health structures designed to raise awareness amongst drug users and to guide them towards treatment, as well as to prevent and reduce risk attitudes and to minimise the damage caused to individuals and society by drug addiction.

Administrative Rule 748/2007 - established the criteria for the IDT to authorise the setting up of harm reduction programs and facilities listed in Decree-Law 183/2001.

Administrative Rule 749/2007 - established the criteria for the IDT to fund harm reduction Programs and structures listed in Decree-Law 183/2001.

During 2009, the activity in the treatment area of the IDT, I.P. has been marked by investing in different dominiums, as a result of the integration of alcohol in the IDT, I.P. mandate:

- a proposal of referral network according to the different severity levels and needs of users with alcohol related problems (PLA);
- Integration of health care to drug users and to clients with PLA, at regional and territorial level, namely through the articulation with the health centres, hospitals and community structures that provide health care;
- Strengthening of care systems, information, referral and support in the area of alcohol related problems in pregnant women;
- Increase the number of clients and consultations to clients with PLA;
- Implementation in all CRI of attending services, evaluation and screening of children from families with drug addiction or PLA and youngers at risk or young people abusing alcohol and drugs;
- Implementation of training programs for technicians of IDT, I.P. and for family doctors and general practitioners, currently existing 616 technicians from CRI with competences to implement specific programs and projects on drugs and alcohol, tobacco or medicines abuse.

It is also to note the focus on improving communication and organization through the collection of indicators that allow to reflect the quality of results achieved with the activity developed, operationalized through the implementation of SIM.

The investment in the articulation with the entities of health service providers, was well translated in the 399 protocols in force and in 724 informal articulations established with the same in 2009.

The systematization of best practices was achieved through the contributions of guidelines:

- For early treatment of youth at-risk and young consumers with a focus on early symptoms, physical and psychological;
- For the follow-up of children, daughters or relatives of drug addicts;
- For the reception in ET;
- For the transference of clients between ET;
- For the definition of admission criteria in the Therapeutic Communities (CT);

To improve the quality of responses offered were created six new treatment programs and implemented in new territories two existing programs.

The waiting times for first consultations and Therapeutic Community were reduced and kept within the limits previously defined as acceptable, the entries for detoxification and methadone program within the limits previously defined as acceptable.
5.3. Treatment systems

Treatment Teams (ETs), mainly outpatient units, are usually the door for the treatment system, where the client’s situation is assessed and a therapeutic project is designed. From there, if necessary, referrals can be made to other available programs, mainly inpatient ones (public and private detoxification units or therapeutic communities). In ETs, clients have access to individual and group therapy, substitution programs (usually high threshold) and a variety of support services for the drug user and his/her family, depending on the ET resources (infectious diseases testing and treatment or referral, family therapy, general health care, amongst others).

In 2009, 47 outpatient treatment centres were working in mainland Portugal as well as 32 decentralised consultation units. These centres provide both drug free and medically assisted treatment.

Inpatient units are usually a second step of the process, as most clients of detoxification units and therapeutic communities are referred to those units by their therapists. In detoxification units, medically assisted withdrawal treatment is available, whereas in therapeutic communities most, though all, available programs are drug free (in some cases patients can enter with agonist medication and stop it in the therapeutic community). Inpatient drug free treatment is mainly available in public and private therapeutic communities.

In 2009 there were 70 therapeutic communities (3 public and 67 private units) in mainland Portugal. The number of clients in therapeutic communities increase 6% in comparison to last year (3 601 in 2009, 3 385 in 2008 and 3 167 in 2007), consolidating the grown of last years.

In 2009 there were 13 Detoxification Units (4 public and 9 private units). The number of clients in detoxification units decrease 14% in comparison to last year (2 597 in 2009, 3 009 in 2008, 2 977 in 2007 and 2 671 in 2006).

Substitution treatment is widely available in Portugal, through public services such as specialized treatment centres, health centres, hospitals and pharmacies as well as NGOs and non-profit organizations. Methadone has been made available since 1977, buprenorphine since 1999 and recently also the buprenorphine/naloxone combination.

Methadone treatment can be initiated by treatment centres whereas buprenorphine treatment can be initiated by any medical doctor, specialized medical doctors and treatment centres. Moreover, the provision of buprenorphine in pharmacies started in 2004 (for more information on treatment availability and diversification, please see Structured Questionnaire 27, part I).

Referral to different treatment response is encouraged across the prison system, that, in addition, ensure to all new inmates, the continuity of pharmacological treatments initiated in freedom (for more info see chapter 9.6).

Similar to last years, it was repeated at national level by the treatment teams of CRI, a raising of the average waiting time for entry into detoxification inpatient, first treatment, for therapeutic programs with methadone and therapeutic community.

The data obtained is compared with the maximum waiting time in days, considered reasonable for each of the programs already mentioned, being inferior in all the cases, as you can see in the following table.
Drug-related treatment: treatment demand and treatment availability

<table>
<thead>
<tr>
<th></th>
<th>Average waiting time at National level (in days)</th>
<th>Reasonable waiting time (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006</td>
<td>2007</td>
</tr>
<tr>
<td>1st treatment demand</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>Methadone Program</td>
<td>18</td>
<td>16.5</td>
</tr>
<tr>
<td>Detoxification</td>
<td>18</td>
<td>8.5</td>
</tr>
<tr>
<td>Public Therapeutic Community</td>
<td>29</td>
<td>24.5</td>
</tr>
</tbody>
</table>

Table 14 – Average waitsing time (IDT, I.P. 2010)

The increasing of effectiveness of the treatment network is evidenced by several indicators related to the clinic movement of the outpatient and inpatient structures of the public and private networks.

Contributing to the monitoring and evaluation of treatment programs, indicators for monitoring and evaluation of these programs were defined. The implementation of the Multidisciplinary Information System (SIM) started in 2009 (as reposted last year) and it is close to conclusion. 1 200 professionals will use daily this tool. This System promotes a strict control of repeating user and the data production and analysis.

5.4. Characteristics of treated clients

The clients in treatment were mainly from the male gender (84% to 86%), aged 25-24 (28% to 35%) and 35-44 (31% to 44%), varying the mean age between 33 and 38 years old depending on the structure. It remains the gradual ageing of these populations, namely the clients of first treatment demands of the public network.

Continue to be predominantly Portuguese (90% to 97%) and single (54% to 67%). Most living with family, predominantly cohabitation with the family of origin (36% to 45%) or with the family based (13% to 26%). In general, these populations remain with low qualifications (37% to 61% did not complete the third Cycle of Basic School) and precarious labour situations (46% to 63% were unemployed).

2009 national first treatment demand data concerned 7 643 individuals from the outpatient public network centres (79) (see also Standard Table 34). These individuals were mainly:

- Male gender (84.5%);
- Mean Age 33, 28.8% were aged 25-34, 30.6% were aged 35-44, 20.6% were aged under 25. In 2009, continued the ageing trend of this population, already visible in previous years, especially in clients in first treatment demand.
Drug-related treatment: treatment demand and treatment availability

- Using heroin as the main substance (47.5% - 51.1% in 2008, 59.5% in 2007, 64% in 2006), followed by cannabis (11.7% - 10.5% in 2008, 10.9% in 2007, 10.8% in 2006), cocaine (8.7% - 10.8% in 2008, 11.6% in 2007, 8.5% in 2006), heroin and cocaine (8.1% - 11.7% in 2008, 10.3% in 2007, 12% in 2006);
- Data concerning the administration route of the main substance indicate that 64.3% (63.1% in 2008, 74.3% in 2007, 74.4% in 2006) of these clients refer smoking/inhaling and 12.5% referred injecting (21.5% in 2008, 19.0% in 2007, 21.9% in 2006);
- 94.8% (94.4% in 2008, 94.6% in 2007, 94% in 2006) were Portuguese, 54.7% (58.9% in 2008) were single and 59.7% (53.5% in 2008) had not completed compulsory school;
- 30.4% (34.5% in 2008, 37% in 2007 and 2006) were employed when the treatment program started but 47.2% (46.5% in 2008, 47.9% in 2007, 50.7% in 2006) were unemployed;
- 35.8% lived with their parents and siblings (39.6% in 2008, 40.3% in 2007, and 42.7% in 2006).

In 2009, active clients in treatment (38 875, 38 532 clients in 2008, 34 266 in 2007, 32 460 in 2006) in CRIIs were:
- Male gender (84.3% - 83.9% in 2008, 83.9% in 2007, 83.5% in 2006);
- Mean Age 37 (36 in 2008 and 2007, 35 in 2006) – 72.1% were aged 25-44 (27.9% were 25-34, 44.2% were 35-44);
- Using heroin as the main substance (67.7% - 69.2% in 2008, 72.2% in 2007, 72.8% in 2006), followed by heroin and cocaine (10.8% - 11.8% in 2008, 11.7% in 2007, 10.9% in 2006), cocaine (5.9% - 6.1% in 2008, 5.7% in 2007, 5% in 2006) and cannabis (5.5% - 5%, as in 2008, 2007, 2006);
- Data concerning the administration route of the main drug indicate that 66.9% (64.1% in 2008, 68.4% in 2007, 69% in 2006) of these clients referred smoking/inhaling and 25% (30.8% in 2008, 29% in 2007 and 2006) referred injecting;
- They were mostly Portuguese 95.2% (95.8% in 2008, 96% in 2007, 2006, 2005 and 2004), single 60.3% (62% in 2007 and 2006) and had not completed compulsory education (60.4% in 2008, 60.5% in 2007 and 60.8% in 2006);
Drug-related treatment: treatment demand and treatment availability

- 41.8% (43.9% in 2008, 45.6% in 2007, 45.7% in 2006, 48% in 2005 and 2004) were employed and 46.3% (45.6% in 2008, 45.1% in 2007 and 45.7% in 2006) unemployed;
- 44.8% (46.3% in 2008, 47.9% in 2007, and 48.5% in 2006) were living with their parents and siblings.

In public and private detoxification units\(^{11}\), the 2 597 clients registered in 2009 were:
- Mainly male gender 85.6%;
- Aged 25-34 (34.4%);
- Most of these clients continued to refer heroin as the main substance for which they were seeking treatment (71.3%) followed by cocaine (8.6%), heroin and cocaine (2.6%);
- Concerning the administration route for the main drug, 60.1% of the clients reported smoking/inhaling while 20.1% reported injecting;
- As for risk behaviours concerning paraphernalia sharing ever in life, 30.3% shared any IDU paraphernalia and 45.1% shared non-IDU paraphernalia;
- These clients were mainly unemployed (61.6%) as in previous years;
- And continued to report a low educational level as 44.1% had not finished the 9 years of compulsory basic school.

In public and private therapeutic communities, the 3 601 clients registered in 2009 were:
- Mainly from male gender (84.1%), as in previous years;
- The mean age was 36;
- They continue to request treatment mainly for heroin (52%), cocaine (19.1%), heroin and cocaine (4.1%);
- Concerning the administration route for the main drug, 53.3% of the clients reported smoking/inhaling, while 26.2% reported injecting;
  - As for risk behaviours concerning paraphernalia sharing ever in life, 36.7% shared other IDU paraphernalia and 55.4% shared non-IDU paraphernalia;
  - And continued to report a low educational level as 37.3% had not finished compulsory basic school.

A 1% increase (in comparison to 2008) was verified in the number of active clients in the outpatient public treatment network. The 38 875 active clients in 2009 were regionally distributed in the following way: 38.9% in the North, 32.7% Lisbon and the Tagus Valley, 14.5% in the Centre, 8.9% in Algarve and 5% in Alentejo.

At district level, Oporto, Lisbon, Setúbal, and Faro registered in 2009 the highest number of outpatient clients in the public treatment network, as well as the highest number of new clients. With the exception of the districts of Beja, Coimbra, Lisbon, Portalegre and Viseu, all the other Portuguese continental districts registered in relation to 2008 an increase in the number of new clients. The higher increases in absolute values were verified in the districts of Oporto and Braga and in percentual values in the districts of Braga (+48%), Vila Real (+47%) and Viana do Castelo (+43%).

The higher taxes per habitants of (15-64 years old) of new clients were registered in the districts of Oporto, Faro, Leiria and Beja.

In 2009, 614 213 follow-up treatment episodes were reported, value close to the one verified last year (-0.4%), when was registered the highest value ever, consolidating the upward trend verified in previous years.

Contrarily to what has been registered since 2000 (7 019 in 2008, 5 124 in 2007, 4 745 in 2006) the number of first treatment episodes in the outpatient public network for the third consecutive year, in 2009 (7 643) increased in comparison to 2008 (+9%), probably due to a higher and better articulation of the responses in the field, but also, to the increase in the number of clients that went to the Treatment Teams (ET) of IDT, I.P. for alcohol related problems.

In the context of the public network, the higher increases of the total number of outpatient clients as well as new clients were registered in the North and Alentejo Regional Delegations.

The higher taxes of outpatient new clients by habitants (15-64 years old) were registered in the districts of Oporto, Faro, Leiria and Beja.

Concerning the source of referral for the clients who demanded treatment for the first time see ST 34.
In 2009, 274 inmates were integrated in the abstinence-oriented treatment programs in the prison setting, 261 in drug-free units and 13 in the halfway house. For the third consecutive year a decrease was registered in the number of inmates in these programs (-8% in relation to 2008), despite the slight increase in their capacity (more 5 beds in drug-free units in relation to 2008).

Withdrawal treatment is mainly available in public and private\textsuperscript{12} detoxification units\textsuperscript{13}. In 2009 there were 13 detoxification units (4 public and 9 private units) in mainland Portugal. In 2009, a decrease (-14%) in the number of clients in detoxification units was registered representing the lowest value of the decade (2 597 in 2009, 3 161 in 2008, 3 196 in 2007, 3 059 in 2006 and 3 237 in 2005).

In 2009, the number of clients in substitution and maintenance programs represented 70% of the total active clients in the outpatient public treatment network, a +5% increase in comparison to 2008 and reinforcing the tendency of increase of previous years.

<table>
<thead>
<tr>
<th>Regional Delegation</th>
<th>2009</th>
<th>%</th>
<th>∆ 08-09</th>
<th>∆ 06-09</th>
<th>∆ 03-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>27 031</td>
<td>100,0</td>
<td>4,7</td>
<td>17,9</td>
<td>60,2</td>
</tr>
<tr>
<td>North</td>
<td>9 217</td>
<td>34,1</td>
<td>5,8</td>
<td>23,7</td>
<td>58,0</td>
</tr>
<tr>
<td>Center</td>
<td>3 555</td>
<td>13,2</td>
<td>0,3</td>
<td>-12,7</td>
<td>49,8</td>
</tr>
<tr>
<td>Lisbon and Tagus Valley</td>
<td>10 061</td>
<td>37,2</td>
<td>3,1</td>
<td>24,2</td>
<td>83,3</td>
</tr>
<tr>
<td>Alentejo</td>
<td>1 265</td>
<td>4,7</td>
<td>2,7</td>
<td>34,6</td>
<td>40,6</td>
</tr>
<tr>
<td>Algarve</td>
<td>2 933</td>
<td>10,8</td>
<td>14,4</td>
<td>24,4</td>
<td>28,5</td>
</tr>
</tbody>
</table>

\textsuperscript{12} Data from private units cover only the units accredited by the IDT, I.P.
\textsuperscript{13} For more detailed information, please see ST 09 and the Report on Public Detoxification Units 2004-2008 in the following link: http://www.idt.pt/PT/Estatistica/Documents/ReducaoProcuraConsumos/RelatorioGrupoTrabUD12008.pdf
27 031 clients were registered in these programs in 2009 (25 808 in 2008 and 24 312 in 2007). 5 029 cases were new admissions (5 022 in 2008 and 4 953 in 2007), 3 187 readmissions (3 004 in 2008 and 2 524 in 2007) and 6 302 (6 993 in 2008 and 6 530 in 2007), left the program during the year, 14% of whom with medical release (14% in 2008 and 15% in 2007) and 42% left the program or were expelled\textsuperscript{14}.

Regional data show that:

- Increases in the number of clients in substitution and maintenance programs were registered in all Regions;
- The North registered the higher increase in absolute values and the Algarve Region in percentual values;
- Like in previous years the percentages in relation to the total number of active clients in each region continued to be higher in Algarve (85% in 2009, 79% in 2008, 82% in 2007, 81% in 2006 and 83% in 2005);
- The districts of Faro, Setúbal, Beja and Bragança, registered the highest taxes of clients in substitution and maintenance programs by habitants of 15-64 years.

A survey made each year on the 31\textsuperscript{st} of December 2009 allows differentiation in terms of substances involved in this type of treatment.

On that date, 20 729 clients were registered in the outpatient public treatment network substitution programs, representing an increase of 5% in comparison to 2008 (18 815).

- 76% (75% in 2008, 74% in 2007, 73% in 2006 and 71% in 2005) were registered in methadone programs;
- 24% (25% in 2008, 26% in 2007, 27% in 2006 and 29% in 2005) in buprenorphine programs.

In comparison with the situation on the 31\textsuperscript{st} of December 2008, methadone clients increased more (+12%) than buprenorphine (+4%) consolidating the inversion occurred in 2006 of the upward trend of clients in buprenorphine verified in previous years.

Concerning the place of administration for the clients registered in methadone programs, on the 31\textsuperscript{st} of December 2009:

- 69% (69% in 2008, 70% in 2007, 69% in 2006 and 2005, 68% in 2004) of these clients took their methadone in the ET;
- 17%\textsuperscript{15} (17% in 2008, 18% in 2007, 19% in 2006, 2005 and 2004) in health centres;
- 4% (as in 2008, 5% in 2007, 4% in 2006, 2005 and 2004) in the prison setting;
- 2% in Hospitals (as in 2008, 2007 and 2006);
- 5% (as in 2008 and 2007, 3% in 2006, 2005 and 2004) in other settings\textsuperscript{16}.

In all Regions, ETs were the main place of administration, followed by the health centres (primary health care centres).

\textsuperscript{14} In 2009, left the Methadone programmes 4 362 clients, 16% of which with medical release and 45% abandon or were expelled and left the Buprenorphine programmes 1 940 clients, 8% with medical release and 33% abandon or were expelled.

\textsuperscript{15} There are partnerships between IDT, I.P. and several agencies – Health Centres, Hospitals, Pharmacies, prison establishments and others – with the aim to facilitate access to this type of program and promote a higher autonomy and social rehabilitation of users. In case of hospitalisation or detention of users, the treatment teams of IDT, I.P. articulate with those institutions to ensure the continuity of the medicinal administration.

\textsuperscript{16} At home, in Pulmonary Diagnostic Centres and other local organisations.
The methadone therapeutic programs through pharmacies are the result of a protocol between IDT, I.P., National Association of Pharmacies (ANF), National Institute of Pharmacy and Medicines (INFARMED) and Pharmaceutical Order.

Since the beginning of the program (July 1998) until 31 December 2009, integrated this project 498 pharmacies, 749 pharmaceutics and 2,433 clients. From the 498 pharmacies, 226 follow 848 clients in 2009 at the date of 31 December 2009, were in methadone program through pharmacies, 714 patients (more 135 individuals that in the same data in 2008). 24 months is the average period of permanence in the program by active clients.

Since the beginning of the program till 31st of December 2009, 202 clients had medical release, after completing the therapeutic scheme for reducing doses. During 2009, three training sessions were made, covering pharmaceutics of 39 pharmacies.

Buprenorphine and Naltrexone are personally administrated to clients in Pharmacies.
In the particular case of the prison setting, in 31/12/2009 were integrated 472 inmates in pharmacological programs in prison (407 in opioid agonists’ programs and 65 in antagonists opioids), representing the highest value of the decade and a 24% increase in relation to last year.

### 5.5 Trends of clients in treatment

For the patients that in 2009 went to the different drug treatment structures, heroin remains the substance most referred as main drug (between 47% and 71% depending on the type of structure). Followed by cocaine (between 6% and 19%), and heroin associated to cocaine (between 1% and 11%), cocaine continues to assume greater relevance in the inpatient structures than outpatient, despite the increase verified in the last years on the proportion of clients in first treatment that refers cocaine as main drug (passing from 5% in 2003 to 9% in 2009). Also references to cannabis (between 1% and 12%) and alcohol (between 4% and 16%) as main substance of clients, begin to appear more significantly in the different drug treatment structures, assuming cannabis higher relevance at outpatient level, particularly in the case of first treatments. The route of administration of the main drug remains smoked/inhaled.

Concerning intravenous drug use of any substance, lifetime prevalence in these populations ranged from 25% to 55% and last month prevalence preceding the appointment, inpatient or entry into the program, between 10% and 24%. It is noted a gradual reduction of this practice of use during the years, especially among new clients in the public drug treatment network where between 2003 and 2009 there was a continue decrease of 28% to 10% of clients that used the intravenous administration in the last month preceding the appointment. Concerning the sharing of drug use material, between 30% and 46% of the population that seeks access to the different treatment structures in 2009 have already shared syringes at least once in their lifetime and between 5% and 12% in the last month preceding the appointment.

In 2009, 38 875 clients were active (had at least one treatment episode during the year) in the 79 Centres of Integrated Responses, which represents an increase (+ 1%) comparing to 2008 and reinforces the increase already registered in previous years.

In first treatment demands, for the third consecutive year and contrarily to the decrease trend verified since 2000, an increase of +9% was registered in relation to last year, due to an upper and better articulation of responses in the field, increasing the number of clients that pass to appeal to the ETs of the IDT, I.P. by alcohol related problems

The following table summarises the information presented above:

---

17 Outpatient structures of the public network (where the distinction of the total of clients in treatment during the year and the subgroup of clients in first treatment demands are made), Detoxification Units, Therapeutic Communities.

18 Although the percentage for 2009 could be somewhat higher if we consider only drug users, it is indisputably the downward trend over the decade of this practice of consumption among drug users population who have appeal to different drug treatment structures and particularly in this population of new clients in the public treatment network.
### Table 17 – Drug use profile of clients in treatment, by type of structure (IDT, I.P. 2010)

#### Use

<table>
<thead>
<tr>
<th>Structure / Network</th>
<th>Outpatient Clients in the Public Network</th>
<th>Clients Detoxification Units (Public and Accredited)</th>
<th>Clients Therapeutic Communities (Public and Accredited)</th>
<th>Clients Day Centres (Public and Accredited)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>1st Consults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Drug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>67.7%</td>
<td>47.5%</td>
<td>71.3%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Heroin and Cocaine</td>
<td>10.8%</td>
<td>8.1%</td>
<td>2.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5.9%</td>
<td>8.7%</td>
<td>8.6%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>5.5%</td>
<td>11.7%</td>
<td>0.8%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>3.6% b)</td>
<td>10.8% b)</td>
<td>13.4%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Smoking / Inhaling</td>
<td>66.9%</td>
<td>64.3%</td>
<td>60.1%</td>
<td>53.3%</td>
</tr>
<tr>
<td>Injecting</td>
<td>25.0%</td>
<td>12.5%</td>
<td>20.1%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Lifespan Prevalence</td>
<td>39.2% c)</td>
<td>25.4% c)</td>
<td>54.5%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Last 30 Days</td>
<td>23.9%</td>
<td>10.2%</td>
<td>23.6%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Any Intravenous Material</td>
<td>_</td>
<td>_</td>
<td>30.3%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Non-Intravenous Material</td>
<td>_</td>
<td>_</td>
<td>45.1%</td>
<td>55.4%</td>
</tr>
<tr>
<td>Last 30 Days</td>
<td>_</td>
<td>_</td>
<td>4.9%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Any Intravenous Material</td>
<td>_</td>
<td>_</td>
<td>18.6%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Non-Intravenous Material</td>
<td>_</td>
<td>_</td>
<td>18.6%</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

a) In the variables considered, only are mentioned the categories with higher percentage relevance.

b) In the case of clients in public outpatient treatment, alcohol values as main drug are sub-evaluated, due to the registering procedures of the previous information system that was implemented in many IDT, I.P. units in 2009.

c) No data available for the RD of Lisbon and Tagus valley and RD of Alentejo.
6. Health Correlates and Consequences

6.1. Introduction

Concerning infectious diseases, between populations in drug addiction treatment in 2009, the positivity values for HIV (7%-19%), Hepatitis B (2%-3%), Hepatitis C (29%-50%) and Tuberculosis (1%-2%), reinforce the downward trend verified in previous years, namely at HIV level and Hepatitis C.

In the ambit of HIV/AIDS infection diagnosis (identified by notifications) maintains the proportional downward trend of the cases associated to drug addiction in the different stadiums of the infection, as well as the continuous decrease through the years of new cases diagnosed with HIV associated to drug addiction. Considering the improvements implemented in last years at the coverage level of HIV screening in these populations, seems to be towards an effective decrease of recent infections in the drug addiction population, reflecting the decrease in intravenous drug use practices and share of material, and also as a result of harm and risk reduction policies.

In 2009, were registered 27 cases of drug-related deaths, representing an increase in comparison to 2008 (20 in 2008) in the General Mortality Register (GMR - Selection B of the DRD Protocol). The values registered in 2009, were the highest since 2003, but inferior to the ones registered in 2002 (year when ICD-10 was implemented in Portugal).

Following a strategic recommendation of the Action Plan on Drugs 2009-2012, as well as the implementation of procedures to improve the quality of the national mortality statistics, from 2008 start to be presented data from the national mortality statistics of INE, I.P., simultaneously we intensified the work on optimizing the information coming from the INML, I.P. As result of the excellent articulation work undertaken between IDT, I.P. and INML, I.P., for the first time it is possible to provide information from the INML, I.P. on overdose cases.

6.2. Drug-related infectious diseases

According to 31/12/2009 notification data (analytical tests) from the National Health Institute Doutor Ricardo Jorge (INSA, I.P.), the decreasing trend concerning the percentage of drug users in the total number of notified HIV positive cases since 1993 continues to be reported. From the 37 201 notifications ever received, near 42% (42% in 2008, 44% in 2007 and 45% in 2006) were drug use related. Considering the different stages covered by these notifications, 47% of the AIDS cases, 35% of Symptomatic Non-AIDS cases and 39% of the asymptomatic carriers cases were drug use associated, confirming the proportional downward trend in this group in the different stadiums of the infection.

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20 The National Health Plan 2004-2010 envisaged a project to improve the mortality statistics "(...) with the aim till 2005, the mortality due to symptoms, signs and undefined affection decrease from 13% to 5%. To this end, was introduced a new medical certificate of death to each will be apply new circuits for data transmission and will made the transition to ICD-10 from January 1, 2002". There will be at short and medium term a number of other measures to improve these statistics, including the on line medical certificate.
21 All data reported in this chapter is collected from analytical tests.
a) The posterior update of the cases diagnosed in previous years, requires the reading of these data as provisional.

Table 18 – HIV notifications: Total number of cases and cases associated to drug use (AIDS, Asymptomatic Non-AIDS and Asymptomatic Carrier), (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th>Year Diagnostic</th>
<th>AIDS Cases</th>
<th></th>
<th>Asymptomatic Non-AIDS</th>
<th></th>
<th>Asymptomatic Carrier Cases</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Drug Users</td>
<td>Total</td>
<td>Drug Users</td>
<td>Total</td>
<td>Drug Users</td>
</tr>
<tr>
<td>Total</td>
<td>15 685</td>
<td>7 339</td>
<td>3 677</td>
<td>1 297</td>
<td>17 839</td>
<td>6 891</td>
</tr>
<tr>
<td>2009 a)</td>
<td>297</td>
<td>70</td>
<td>141</td>
<td>9</td>
<td>669</td>
<td>85</td>
</tr>
</tbody>
</table>

Figure 3 – HIV Notifications associated or not to drug addiction in the different stadiums of the infection (%), (IDT, I.P. 2010)
Taking only 2009, from the notified cases of HIV diagnosed at 31/12/2009, the cases associated to drug addiction represented 15% of the total diagnosed cases in the different stadiums of the infection: 24% of the AIDS cases, 6% Symptomatic Non-AIDS and 13% of the asymptomatic carriers cases.

There has been a downward trend in last years on the weight of drug addicts, in the total number of cases diagnosed each year with HIV infection (15%, 20%, 21%, and 27% of the cases diagnosed in 2009, 2008, 2007 and 2006), as in the cases diagnosed each year with AIDS (24%, 27%, 30% and 38% of the cases diagnosed in 2009, 2008, 2007 and 2006). In addition to the decreasing trend of these proportions, it is worth of notice the continuous decrease over the past few years in the number of new cases diagnosed with HIV associated with drug addiction, safeguarding the future update of data (164 cases diagnosed in 2009, 385 in 2007, 602 in 2005 and 751 in 2003).

Graph 33 – HIV/AIDS notifications – drug users and non-drug users by diagnosis year, absolute numbers (IDT, I.P. 2010)

Graph 34 – HIV/AIDS notifications drug users and non-drug users by diagnosis year and % (IDT, I.P. 2010)
Concerning HIV infection associated to drug addiction diagnosed in 2009 and for which is known the probable year of infection (26%), it is noted that for about a third of the cases (30%) the probable date of infection took place more than 5 years ago (23% between 2000 and 2004 and 7% before 2000) and for the remaining 70%, the probable date of infection occurred during the last 5 years. In the other cases not associated with drug addiction (29%) the probable dates of infection are more recent (for 86% of the cases the probable date of infection occurred in the last 5 years)\textsuperscript{22}.

![Cases Non-Associated to Drug Addiction](image1)

![Cases Associated to Drug Addiction](image2)

\textbf{Figure 4 – Cases of HIV infection diagnosed in 2009, Associated or not to Drug Addiction, by probable year of infection (%) (IDT, I.P. 2010)}

It is worth to note the improvement in the screening coverage of HIV infection in the drug use population – namely with the emergence of harm and risk reduction policies in 2001\textsuperscript{23} and more recently with the implementation of Klotho Program\textsuperscript{24} since 2007. All this combined with the continuous decrease over the last years in the number of new HIV diagnosed cases associated with drug addiction seems to indicate that we are facing a real decline of recent infections in the drug user population\textsuperscript{25}.

For AIDS cases associated with drug addiction notified until 31/12/2009, the pathologies predominantly observed at the diagnosis date belonged to the group of opportunistic

\textsuperscript{22} In both groups, there was, in the last years, an increased trend of the percentages of cases with information on the probable date of infection and in 2009 a decrease was registered of this percentage in the group of cases associated with drug addiction (37% in 2008 and 26% in 2009) and a stability of that percentage (29% in 2008 and 2009) in the group of cases non associated to drug addiction.

\textsuperscript{23} The measures of risk and harm reduction allowed a closer approximation to drug addiction populations not covered by conventional services, including health, which may explain the weight of diagnosed cases of "old infections".

\textsuperscript{24} Since 2007 has been developed, in collaboration with the National Coordination for the Infection of HIV/AIDS, targeted to drug users – Program KLOTHO – implemented at the level of outpatient clients in the public network and clients from the outreach teams. In 2009 continued to be applied the methodology ADR - Counseling, Detection and Reference – in these clients.

\textsuperscript{25} The risk and harm reduction policies allowed a change in the user behaviour, with objective results in terms of decreasing the intravenous drug use and sharing of consumption material, what could explain the decrease of "recent infections".
infections (95%), with emphasis on tuberculosis and *P. jiroveci* (respectively 58% and 11%, and, more 6% with both diagnoses). In the other cases not associated with drug use, was verified a lower weight of opportunistic infections between the pathologies at diagnosis date (87%), namely tuberculosis (30%).

2009 notified drug use-related AIDS cases are:

- Mainly of the male gender 83% (83% in 2008, 85% in 2007, 2006, 2005 and 2004);
- Most of them (94%) aged 20-44.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Number of Cases</th>
<th>Drug Users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>M</td>
</tr>
<tr>
<td>Total</td>
<td>15685</td>
<td>12762</td>
</tr>
<tr>
<td>≤ 14 years</td>
<td>131</td>
<td>71</td>
</tr>
<tr>
<td>15-19 years</td>
<td>170</td>
<td>107</td>
</tr>
<tr>
<td>20-24 years</td>
<td>1223</td>
<td>906</td>
</tr>
<tr>
<td>25-29 years</td>
<td>2874</td>
<td>2289</td>
</tr>
<tr>
<td>30-34 years</td>
<td>2333</td>
<td>2714</td>
</tr>
<tr>
<td>35-39 years</td>
<td>2710</td>
<td>2271</td>
</tr>
<tr>
<td>40-44 years</td>
<td>1855</td>
<td>1569</td>
</tr>
<tr>
<td>45-49 years</td>
<td>182</td>
<td>974</td>
</tr>
<tr>
<td>50-54 years</td>
<td>851</td>
<td>698</td>
</tr>
<tr>
<td>55-59 years</td>
<td>519</td>
<td>415</td>
</tr>
<tr>
<td>60-64 years</td>
<td>409</td>
<td>312</td>
</tr>
<tr>
<td>≥ 65 years</td>
<td>458</td>
<td>375</td>
</tr>
<tr>
<td>Unknown</td>
<td>70</td>
<td>61</td>
</tr>
</tbody>
</table>

Table 19 – AIDS notifications (total and drug use related), by gender and age group 01/01/1983 - 31/12/2009 (IDT, I.P. 2010)

The male gender is also predominant in the other AIDS cases not drug use-related but these individuals are older.

In general, the districts of Lisbon, Oporto and Setúbal registered the highest rates of HIV cases (33%, 30% and 14% of all notifications) and of cases of infection by HIV non-drug addiction associated (respectively 42%, 15% and 12%). These districts, together with Faro, are the ones with higher rates of drug users with HIV per inhabitant in the age group 15-64.

Concerning HIV infection between the clients that went to the different drug addiction treatment structures, the percentages of HIV positive cases (prevalence’s) varied between 7% and 19%, confirming the last years tendency for decrease of these percentages.

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26Public Outpatient structures (distinction between total clients in treatment in the year and the sub-group of clients in first appointments or new clients): Detoxification Units, Therapeutic Communities of the public and accredited networks.

27The percentual base include all the cases with information on screening results, including the ones made in previous years. It is to refer that for the clients in outpatient, the screening coverage rates were calculated from the total of clients in question, despite some of them are not considered eligible to do this screenings. In 2009, there was information on the screening results of HIV for 44% of clients in treatment during the year, 33% of clients in first treatment demand, 89% of clients in Detoxification Units (95% public and 78% Accredited), 83% of clients in Therapeutic Communities (82% publics and 83 Accredited).
Such situation, is seen in several groups of clients, namely among new clients in the public network (7% in 2009, 9% in 2008 and 2007 and 11% in 2006).

It is to refer that in the ambit of Program Klotho and Counselling Detection and Reference (ADR) methodology the results of the quick test donned to new clients and follow-up clients in outpatient public treatment network, shows incidence rates of HIV of 1.5% and 0.8% in 2009 and 1.5% and 1.1% in 2008. The positive results of ADR tests lack of laboratorial confirmation and they are only applied when the serological state of the client is unknown.

As to the **active clients of the public treatment network** (clients with at least one consultation episode during the year, which also includes first treatment demands) 11% of these clients tested positive for HIV (these clients are tested at the moment of their admission), 12% in 2008, 2007 and 2006. 40% of them were following antiretroviral therapy, (36% in 2008, 39% in 2007, 43% in 2006).

11% of clients from **inpatient public and private detoxification units** tested positive for HIV, 12% in 2008, 13% in 2007 and 2006. 50% of these individuals were on antiretroviral therapy, (50% in 2008, 37% in 2007 and 33% in 2006). Specific data on infectious diseases amongst IDUs in this setting can be consulted in Standard Table 9.

Concerning **public and private therapeutic communities**, the percentage of clients tested HIV positive was 12% (14% in 2008, 16% in 2007 and 2006). 68% of those were in antiretroviral therapy, 66% in 2007 and 60% in 2006.

In 2009, the percentage of clients who tested positive for HIV and were in antiretroviral therapy, ranged from 23% and 69% (16% - 74% in 2008, 35% - 69% in 2007, 27% - 76% in 2006), corresponding once more the minimum percentage to the group of first treatment. It should be noted that there are significant annual fluctuations in the percentages of HIV positive in antiretroviral therapeutic at these drug addicted groups, with special emphasis for the patients in first treatment demand, so it is difficult to establish trends in this context.

<table>
<thead>
<tr>
<th>Structure/Network</th>
<th>HIV Positive clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td>Public Outpatient</td>
<td></td>
</tr>
<tr>
<td>Active clients during the year</td>
<td>–</td>
</tr>
<tr>
<td>First treatment demand clients</td>
<td>2 883</td>
</tr>
<tr>
<td>Detoxification Units</td>
<td>2 694</td>
</tr>
<tr>
<td>Public Network</td>
<td>1 802</td>
</tr>
<tr>
<td>Accredited Network</td>
<td>892</td>
</tr>
<tr>
<td>Therapeutic Communities</td>
<td>3 863</td>
</tr>
<tr>
<td>Public Network</td>
<td>59</td>
</tr>
<tr>
<td>Accredited Network</td>
<td>3 804</td>
</tr>
</tbody>
</table>

As referred in previous note, in 2007 and 2008 was developed in collaboration with the National Coordination for the HIV/AIDS Infection a program of Early Identification and Prevention of HIV/AIDS directed to drug users – program Klotho. In 2009, the ETs of IDT, I.P. continue to apply the Counselling Detection and Reference (ADR) methodology.
Concerning **Hepatitis B and C** data available, as reported in Standard Table 9, refer to the analytical tests made in drug user’s subpopulations that demand treatment in the public and accredited treatment structures.

In 2009, data on Hepatitis B (prevalence’s AgHBs)\(^{29}\) varied in 2009 between 2% and 3%, values inferiors to the ones registered in previous years.

In the case of Hepatitis C (HCV+)\(^{30}\) the percentages of positivity varied between 29% and 50%, reinforcing the downward trend verified in the last five years.

In detoxification units the global\(^{31}\) percentages for public and accredited units were 3% for Hepatitis B and 50% for Hepatitis C. 2009 specific data on infectious diseases amongst IDUs in this setting can be consulted in Standard Table 9.

In public and accredited therapeutic communities 3% of the clients test positive for Hepatitis B and 40% for Hepatitis C.

The percentages of positivity for **Tuberculosis (prevalence’s)**\(^{32}\), in these populations varied between 1% and 2%, following the patterns of last years.

2% of the new outpatient clients who presented results for their tests were positive and all were following treatment.

In detoxification units the global percentage of positive cases was 1% for Tuberculosis (1% in 2008, 0.4% in 2007, 1% in 2006 and 2005, 2004, 2003 and 2002).

In therapeutic communities the percentage of positive cases was 1% for Tuberculosis (1% in 2008, 3% in 2007, 2% in 2006, 2004 and 2003 and 1% in 2005, 2002, 2001 and 2000).

<table>
<thead>
<tr>
<th>Structure / Network</th>
<th>HIV</th>
<th>Hepatitis B</th>
<th>Hepatitis C</th>
<th>Tuberculosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient/Public Network</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients in Treat. During the year</td>
<td>11%</td>
<td>3%</td>
<td>46%</td>
<td>2%</td>
</tr>
<tr>
<td>Clients First Treat. Demand</td>
<td>7%</td>
<td>2%</td>
<td>29%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Detoxification Units</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Public and Accredited)</td>
<td>11%</td>
<td>3%</td>
<td>50%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Therapeutic Communities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Public and Accredited)</td>
<td>12%</td>
<td>3%</td>
<td>40%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Table 21 – Percentages of clients who tested positive for HIV, Hepatitis B, Hepatitis C and Tuberculosis by type of service in 2009 (IDT, I.P. 2010)**

In the drug addiction population, the percentages of positivity for Hepatitis B ranged in 2009 between 2% and 3%, smaller values than the ones registered in previous years. In the case of Hepatitis C, the percentages of positivity ranged between 29% and 50%, reinforcing the downward trend verified in the last five years.

\(^{29}\) In 2009, results for Hepatitis B were presented by 34% of all active clients in outpatient treatment, 20% of the clients in outpatient first treatment episodes, 90% of the clients of detoxification units (92% of the clients in public DUs and 86% of the clients in accredited DUs) and 82% of the clients in Therapeutic Communities (76% of the clients in public TCs and 82% of the clients in accredited TCs).

\(^{30}\) Results for Hepatitis C were presented by 36% of all active clients in outpatient treatment, 20% of the clients in outpatient first treatment episodes, 92% of the clients of detoxification units (95% of the clients in public DUs and 88% of the clients in accredited DUs) and 82% of the clients in Therapeutic Communities (82% of the clients of public TCs and 82% of the clients in accredited TCs).

\(^{31}\) Considering results per type of service but not differentiating between public and accredited units.

\(^{32}\) Concerning Tuberculosis, in 2009, tests results were presented by 17% of all active clients in outpatient treatment, 12% of clients in outpatient first treatment episodes, 83% of the clients of detoxification units (98% of the clients of public DUs and 58% of the clients in accredited DUs) and 81% of the clients in Therapeutic Communities (88% of the clients of public TCs and and 81% of the clients in accredited TCs).
The percentages of positivity for Tuberculosis in these populations ranged in 2009, between 1% and 2%, similar to last year’s patterns.

### 6.3. Other drug-related health correlates and consequences

No new information available.

### 6.4. Drug related deaths and mortality of drug users

#### Drug-induced deaths

In Portugal, data on drug-related deaths are collected from two different sources: the General Mortality Register - GMR (at the National Statistics Institute, coded by the General Directorate of Health) and the Special Mortality Register - SMR (at the National Institute of Forensic Medicine), both have national coverage.

Until 2007, due to the limitations of general mortality registries of the National Statistics Institute, Portugal privileged in the context of this key indicator data records of the National Institute of Forensic Medicine (INML). These data referred to positive post-mortem toxicological results from the INML, which in the absence of information on the cause of death did not allow an accurate assessment of the number of overdoses, yet possessing rich and quality toxicological data allowing trend analysis.

Following a strategic recommendation of the Action Plan on Drugs 2009-2012, as well as the implementation of procedures to improve the quality of the national mortality statistics, from 2008 start to be presented data from the national mortality statistics of INE, I.P., simultaneously we intensified the work on optimizing the information coming from the INML, I.P. As result of the excellent articulation between IDT, I.P. and INML, I.P., for the first time it is possible to provide information from the INML, I.P. on overdose cases. In a near future this information will contribute to improve the national mortality statistics in this area, and will now overcome some constraints related to statistical secrecy in the provision of toxicological information and social demographic in the context of national mortality registries of INE, I.P. However, it should be noted that these methodological improvements in the general and specific mortality registries, require additional caution in the analysis of trends.

With regard to drug-related deaths in the context of general registries, although the numbers remain low, since 2006 there has been an increase in the number of these deaths, contrary to the downward trend observed in previous years, which may be a result of the increase in the number of deaths and of the methodological improvements on the general mortality registries.

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33Portugal has data on positive post-mortem toxicological results from the INML more than 25 years.
35 The National Health Plan 2004-2010 envisaged a project to improve the mortality statistics "(...) with the aim till 2005, the mortality due to symptoms, signs and undefined affection decrease from 13% to 5%. To this end, was introduced a new medical certificate of death to each will be apply new circuits for data transmission and will made the transition to ICD-10 from January 1, 2002". There will be at short and medium term a number of other measures to improve these statistics, including the on-line medical certificate.
36 It is foreseen in a second phase of this work to optimize the flow of information circuits between INML, I.P. and DGS.
According to the EMCDDA criteria in 2009 were registered 27 cases of drug-related deaths, representing an increase in comparison to 2008 (20 cases). The values registered in 2009, were the highest since 2003, but inferior to the ones registered in 2002 (year when ICD-10 was implemented in Portugal).

In 2009\textsuperscript{38}, the predominant cause of these deaths were disorders (63%): multiple dependence or other (above 84%) were male in the age group of 25-44 years (81%).

In 2009, the number of autopsies performed by INML, I.P. (6 814) as well as the number of requests for post-mortem toxicological exams (illicit substances) (2 948) showed the highest values of the decade, representing increases of respectively 15% and 5% in relation to previous year and 21% and 117% in relation to 2003. Despite the upward trend of these two indicators, the number of cases with positive toxicological results (269) decreased 16% compared to 2008 and consequently also decreased the percentage of positivity in the set of the exams made (9%, 11%, 12% and 9% respectively in 2009, 2008, 2007, and 2006).

\textsuperscript{38} For “statistic secrecy” reasons (Law of the National Statistic System – SEN, Law n.º 22/2008 of 13 May), there are some constraints in the provision of disaggregated data on the causes of death and socio-demographic of these deaths.
As previously referred, for the first time in 2009 it was possible to obtain information on causes of death in cases with positive toxicological results (for 2008 and 2009), and thus distinguish in this set of positive results the cases of overdose.

Since these deaths require forensic investigation and difficulties in collecting this information remain,(whether due to the delay in completing the final report or to access it), it was decided to make the update two years after, to optimize the proportion of cases with positive toxicological results and cause of death known. The 2009 data will be updated next year, which limit the comparative analyses with previous year.

In 2008, from the 262 deaths with information on the cause of death (82% of the cases with positive toxicological results), approximately 36% were considered overdoses. In 2009, from the 194 deaths with information on the cause of death (72% of the cases with positive toxicological results), approximately 28% were considered overdoses.

![Graph 37 – Causes of death* of the cases with positive Toxicological results, by year (IDT, I.P. 2010)](image)

Despite the comparative limitations referred, it is very likely to be registered a decrease in the number of overdoses, considering the decrease between 2008 and 2009 in the number of positive toxicological results (320 to 269 cases -16%) and the current proportion of overdoses in the set of deaths with information on the cause of death in 2008 (36%) and 2009 (28%).

Concerning the substances detected in these cases of overdose, predominantly opiates in 82% and 89% of the cases in 2008 and 2009), followed by cocaine (in 54% and 43% of the cases in 2008 and 2009).

Was detected the presence of methadone in near 9% and 4% of the overdoses in 2008 and 2009, and methamphetamine in 1% of the overdoses in 2008.

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39 includes heroin, morphine and codeine.
Like occurred in the context of the general mortality registries of the INE, I.P., in the majority of these cases of overdose was detected more than one substance (87% and 85% of the overdoses of 2008 and 2009), considering the associations with illicit and/or licit substances. In this context, it was noted that the overdoses of opioid with cocaine (10% of the overdoses in 2008 and 11% in 2009) or with other substances (29% of the overdoses in 2008 and 22% in 2009). In combination with illicit substances, it is to highlight the cases of overdose with the presence of alcohol (47% of overdoses in 2008 and 57% in 2009) as well as in the presence of benzodiazepines (39% of overdoses in 2008 and 37% in 2009).

The vast majority of these overdoses are from the male gender (92% in 2008 and 96% in 2009). Near 65% of the cases in 2008, aged between 25-39, 30% more than 39 years and 5% less than 25, being the mean age 36. In 2009, near 62% aged between 25-39, 36% more than 39 years and 2% less than 25, being the mean age 38 years.
Both in 2008 and 2009, prevailed in all age groups the cases of overdose with the presence of opioids. In 2008, the age groups 30-34 and 35-39 presented respectively the higher absolute values of cases with the presence of opiates and cases with the presence of cocaine. In 2009, the age group 35-39 had the highest number of overdoses either with the presence of opioids either with cocaine (in the last situation with the same value to the age group with 45 or more years). Both in 2008 and 2009, the cases of overdose with the presence of methadone appeared exclusively in age groups 35-39 and 45 or more years, and in 2008, the only case with the presence of methamphetamine has emerged in the group of 45 or more years.

**Specific causes of mortality indirectly related to drug use**

Among all the AIDS cases, 7 475 deaths\(^{40}\) have been notified until 31/12/2009, 51% were associated with drug addiction and 49% of the cases were non-drug addiction associated. Mortality observed among AIDS cases associated with drug addiction was 52% (survival 48%) and in the cases not associated with drug addiction of 43% (survival 57%). In 2009, were notified 145 deaths occurred in the year, among the AIDS cases, 55% of which were AIDS cases associated with drug addiction.

<table>
<thead>
<tr>
<th>Geographical area of Residence</th>
<th>Total</th>
<th>Geographical area of Residence</th>
<th>Total</th>
<th>Gender</th>
<th>AIDS Notifications: Total Number of Cases</th>
<th>AIDS Notifications: Total Cases Assoc. to Drug Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total 1) N.º of Deaths</td>
<td>Total 1) N.º of Deaths</td>
</tr>
<tr>
<td>Total</td>
<td>15 665</td>
<td>Portugal</td>
<td>15 274</td>
<td></td>
<td>Total M F Unkn.</td>
<td>Total M F Unkn.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Portugal</td>
<td>12 435</td>
<td></td>
<td>1 2 822 1 922 1 747 5 629 1 176 7 339 6 256 1 083 3 648 3 325 523</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td></td>
<td>Other Countries</td>
<td>24</td>
<td></td>
<td>1 1 1176 1 083 523 11 63 52 11 11 10 1 11 7 6 1</td>
<td></td>
</tr>
<tr>
<td>Other Countries</td>
<td></td>
<td>Unknown</td>
<td>294</td>
<td></td>
<td>60 234 60 88 74 14 100 78 22 33 24 9</td>
<td></td>
</tr>
</tbody>
</table>

Table 23 – Notifications of AIDS Related Deaths - Total number of cases and cases associated to drug use, by gender, 01/01/1983 - 31/12/2009 (IDT, I.P. 2010)

\(^{40}\) Due to sub notification of deaths, information related to mortality does not reflect the cases of the ones that survive.
7. Responses to Health Correlates and Consequences

7.1. Introduction
The Harm and Risk Reduction model implemented in Portugal, aims to propose, through integrated work, to users who are unable or unwilling to renounce drug use, help to reduce harm they cause themselves through alternatives paths that lead to treatment facilities and therefore a gradual process of stabilization and organization, which may allow the recovery process. Thus the focus is the National Network of Harm and Risk Reduction (RRMD) as an integrated intervention model, recommended by the Operational Program of Integrated Responses (PORI), via the implementation of projects under the Program of Integrated Response (PRIs).

The main priorities established by the National Plan 2005-2012 in the area of Harm and risk reduction are:

- To set up a global network of integrated and complementary responses in this area with public and private partners;
- To target specific groups for risk reduction and harm minimisation programs.

Considering the enlargement of the harm reduction national network and the specific programs towards target groups, the work undertaken in 2009 aimed at:

- To reinforce the Harm and Risk Reduction National Network;
- To consolidate, adapt and improve the Model of Follow up, Monitoring and Evaluation of the structures implemented;
- To continue the development and evaluation of the intervention targeted at specific groups;
- To increase the knowledge and information production for an improvement of the interventions quality.

In the framework of the Administrative Rule N.º 748/2007 and N.º 749/2007, it was possible to open procedures for funding new projects to be implemented among the various units of the IDT, I.P. Also through the Administrative Rule N.º 131/2008 were opened procedures to finance RRMD structures in the framework of PORI. In this process, the identification of the necessary responses was based primarily on the diagnosis of territorial basis held under PORI.

7.2. Prevention of drug related emergencies and reduction of drug-related deaths
In the area of Harm Reduction, two levels of action on prevention of emergencies related to drug use should be consider: the strategic level of planning, training, setting guidelines, the monitoring/evaluation and the level of direct intervention with drug users.

Strategically, IDT, I.P. has invested in the enlargement of the Harm Reduction National Network, considering that one of the components of the specialized agencies must be prevention. In this sense, 14 procedures for funding new projects were open. The enlargement of the network’s scope is reflected on the availability of responses in other areas, as prevention and treatment of infectious diseases and other consequences on health and social level41. In this area we must refer the increase of availability of substitution
programs of low threshold, associated to a decrease or elimination of injected opioid use. In 2009, an average of 1 677 dug users per month have benefited from this program.

In parallel, IDT, I.P. designed guidelines on harm and risk reduction (Suppor Guide for the Intervention in Harm and Risk Reduction), conceived in conjunction with specialized agencies, in which include the issue of drug use related emergencies and the technical monitoring of specialized agencies and fosters counselling in lower risk practices with regard to overdoses. This task is followed by monthly monitoring the number of drug injectors, the number of emergency interventions, the availability of information materials and the launching of information /training campaigns. The materials and training courses are previously analysed by IDT, I.P.

In 2009, an average of 1 671 drug injectors benefited from these services and 134 emergencies interventions were realized. The profile of each drug user is analised, taking into consideration his clinical history and pattern of risk behaviour, in accordance with a Caracterisation File elaborated by IDT, I.P. which is comum to all specialised agencies.

As for the direct intervention, the NGO’s ensure the tasks of information, counselling and awareness concerning high risk behaviors leading to overdoses and emergency interventions. In 2009, around 25 240 information materials were made available to drug users and 3 219 awareness activities were realized, in areas which cover also prevention and treatment of infectious diseases and other health problems.

In addition to this work, an experimental intervention (in the Northern region) is taking place, providing Naloxone administrated by technicians trained for this purpose by the outreach work teams.

7.3. Prevention and treatment of drug-related infectious diseases

Prevention of drug-related infectious diseases amongst problematic drug users is mainly ensured through the national syringe exchange program “Say no to a second hand syringe”, established by the National Commission for the Fight Against AIDS (CNLCS) in collaboration with the National Association of Pharmacies (ANF). Since it was set up, in October 1993, it has been using the national network of pharmacies and has enlarged its partner network through protocols with mobile units, NGOs and other organisations in order to reach a wider population (49 partners in 2009 and 36 in 2008). This program was externally evaluated in 2002 (as reported in previous National Reports) and it was concluded that it had avoided 7 000 new HIV infections per each 10 000 IDU at that time of existence of this program.

45.413.034 syringes have been exchanged through this program since October 1993 and until December of 2009 (ANF2010). In 2009, 2 365 821 syringes were exchanged (2 449 351 in 2008). These syringes are included in a kit with 2 syringes, 2 disinfecting towels with 70º alcohol, 1 condom, 1 ampoule of bi-distilled water, 1 filter and 1 informative leaflet, top bottles and citric acid. (For more information see Standard Table 10 - syringe availability).
Responses to Health Correlates and Consequences

Graph 39 – Syringes exchanged / Totals of the Country from 1993 to 2009 (Program “Say no to a second hand syringe” 1993-2009), (ANF2010)

In 2009, 1 360 pharmacies (1 384 in 2008, 1 314 in 2007, 1 341 in 2006) were active in this program (48% of the existing pharmacies in the country, 50% in 2008, 48% in 2007 and 2006).

Graph 40 – Number of pharmacies in the national exchange syringe program 1993 to 2009 (ANF2010)

The mobile units of Cova da Moura (set up in July 2002, in the sequence of a Protocol with the Municipality of Amadora) and Odivelas (set up in October 2003, in the sequence of Protocol with the Municipality of Odivelas), exchanged 19 177 syringes in 2009 (6 120 in 2008, 15 986 in 2007, and 18 112 in 2006).

These mobile units since they were set up exchanged 139 407 (99 933 the mobile unit of Cova da Moura and 39 474 the mobile unit of Odivelas).

In the act of exchanging syringes, complementary information is given to the users.

Districts of Lisbon, Oporto and Setúbal, continued to be the ones that registered the highest number of syringes exchanged since the beginning of the program.
As regards the available material, in addition to syringes, were distributed to the participants of the National Syringe Exchange program, around 274 541 ampoules of distilled water, 396 820 wipes, 246 053 containers, 296 493 acid citric packages and 409 984 condoms and also lubricants.

Program Klotho (Project of Early Identification and Prevention of HIV/AIDS directed to Drug Users), already described in last year’s National Report, is an initiative of the IDT, I.P. and the National Coordination for HIV/AIDS Infection which aims at early detection of the infection amongst drug users and their early referral to treatment, thus increasing their quality of life and life expectation.

Program KLOTHO came from the recognition by the National Coordination for HIV/AIDS Infection and IDT, I.P. of the central role of injecting of drugs in the transmission of HIV/AIDS in Portugal and, consequently, the priority need for intervention in the drug use population in the country.

The program was designed as a pilot intervention in public health, targeted to a population of approximately 30 000 drug users, from the public drug addiction treatment, and aimed to develop a network of early identification of HIV / AIDS through the local integration of health care providers. The program was focused on drug users and adapted to the specificities of their relation with health structures, using rapid tests for detection of HIV infection and promotion of mechanisms for referral between providers of health care.

Program KLOTHO continue to be developed by the ETs, applying the methodology Counselling, Detection and Referral – ADR and a drop blood quick test for the detection of HIV.
Table 24 – Rapid tests to New Clients (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th></th>
<th>Screenings</th>
<th>% drugs users tested /eligible drug users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>North</td>
<td>770</td>
<td>1,157</td>
</tr>
<tr>
<td>Center</td>
<td>523</td>
<td>630</td>
</tr>
<tr>
<td>Lisbon</td>
<td>287</td>
<td>583</td>
</tr>
<tr>
<td>Alentejo</td>
<td>179</td>
<td>283</td>
</tr>
<tr>
<td>Algarve</td>
<td>219</td>
<td>272</td>
</tr>
<tr>
<td>Total</td>
<td>1,978</td>
<td>2,925</td>
</tr>
</tbody>
</table>

Table 25 – New Clients reactive to HIV (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th></th>
<th>HIV reactive cases</th>
<th>% HIV reactive cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>North</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>Center</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Lisbon</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Alentejo</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Algarve</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>45</td>
</tr>
</tbody>
</table>

Table 26 – Rapid tests performed in Clients under monitoring (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th></th>
<th>Screenings</th>
<th>% drug users tested/eligible drug users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>North</td>
<td>2,839</td>
<td>3,409</td>
</tr>
<tr>
<td>Center</td>
<td>2,206</td>
<td>2,542</td>
</tr>
<tr>
<td>Lisbon</td>
<td>968</td>
<td>1,750</td>
</tr>
<tr>
<td>Alentejo</td>
<td>779</td>
<td>824</td>
</tr>
<tr>
<td>Algarve</td>
<td>1,097</td>
<td>1,155</td>
</tr>
<tr>
<td>Total</td>
<td>7,889</td>
<td>9,680</td>
</tr>
</tbody>
</table>

Table 27 – Clients reactive to HIV under monitoring (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th></th>
<th>HIV reactive cases</th>
<th>% HIV reactive cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>North</td>
<td>116</td>
<td>51</td>
</tr>
<tr>
<td>Center</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Lisbon</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Alentejo</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Algarve</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>191</td>
<td>106</td>
</tr>
</tbody>
</table>

327 new clients were involved in ADR without quick test application for being positive or having negative result in very recent analysis. 62% of the new clients know now their serologic state. In fact, among new clients, 154 already knew they were HIV positive, being the global prevalence of HIV in the new clients (reactives + already positives) of 5.7%.
804 clients in follow-up were involved in ADR but without application of the quick test for already being positive or having negative result in very recent analysis. 9 551 drug users under monitoring had information of their HIV status, under ADR methodology.

During the year, 11 919 screenings by quick test for the detection of HIV were made; in relation to 2007 a 20% increase was verified. The percentage of HIV reactive cases in new clients maintained 1.5% and in follow-up clients that did quick test decreases from 1.1% to 0.8%.

Being RRMD a mission area, crosscutting all the intervention in the ambit of the use of psychoactive substances, in 2009 sought to enhance all the dynamic of intervention already existing in the field, complementing the national network of harm reduction and incorporating it into a broader and complementary logic.

Thus, the considerable increase of the number of structures implemented in the field (20 new projects), reflected in the diversity and increase in the range of responses. This increase in the number of structures was reflected in its diversity and in the increase in the range of responses.

In the year of reference, the National Network of RRMD included 47 projects. As each project can provide more than one response, those projects correspond to 36 street teams, 9 contact and information points, 16 substitution treatment of low threshold (PSO-BLE), 6 drop in centres for drug users without family framework and 2 residential centre.

In 2009, IDT, I.P. continued the gradual process of harmonizing information gathered from the projects funded, which is a major challenge as these correspond to different structures and different responses and because they are funded under different legal framework (Administrative Rule No.131/2008 of 13th February (PRI) or Administrative Rules No. 748 and 749 of 25th June 2007) and their Implementation period covers different time schedules.

Therefore it is possible to present the information gathered from the analysis of the RRMD projects funded in 2009 in what concerns the street teams, drop in centres and activities undertaken under PSO-BLE.

Considering the 10 241 people contacted by these structures, the use of their RRMD services varies significantly over the months, which can be explained by three main reasons: around 643 drug users failed to benefit from the projects in a specific month as they started a more structured process of reintegration (6.3% of the total population monitored), 96 clients were arrested and 66 people died. We should also refer that from those 643 users starting a new reintegration process, 64% were integrated in PSO-BLE.

In Portugal, treatment for HIV, AIDS and Hepatitis B and C is included in the National Health Service and therefore available and free for those who need it.

In ETs efforts to promote free antiretroviral treatment and Hepatitis B vaccination, as reported in previous National Reports, continue to be implemented. However, as reported in Chapter 6.2. of this Report, the percentage of clients in antiretroviral treatment in several public and certified units (outpatient, detoxification and CTs) ranges between (16% - 74% in 2008, 35% - 69% in 2007, 27% - 76% in 2006) in these populations, the lowest percentage corresponding to the group of clients in first treatment demands.

In the prison setting, inmates and staff are routinely vaccinated against Hepatitis B.

Integrated in the National Action Plan Against Spread of Infectious Diseases in Prisons, several actions of information / awareness were developed among the prison population, with the aim of promoting the acquisition of healthy lifestyles and increase knowledge on the use of psychoactive substances and the harm related.

These activities aimed at preventing first use and promoting the motivation to treatment. 205 actions were realized, involving 4 355 inmates, on the areas of healthy behaviors, use of psychoactive substances/ polydrug use, new substances, associated risks to use and abuse of psychoactive substances, among others.
With the entry into force of the Manual of Procedures for the Provision of Health Care in Prisons (July 2009), certain practices have been strengthened, in particular the importance of inmates referral at the end of sentence to appropriate health facilities, so that no interruption of treatment occurs after release.

In order to standardize the procedures adopted by all prisons on interventions in health promotion, which inevitably includes drug addiction issues, it was foreseen in the Manual, the design and implementation of programs to promote health and disease prevention, bearing in mind the population that arrives each day to the Portuguese prisons.

Although many of the actions of information/awareness on health promotion and addiction issues developed in the prison context also include the area of harm and risk reduction, and the permeability of the areas, 13 specific actions on harm reduction, comprising 272 inmates were developed in 2009.

These initiatives cover several thematic areas as: harm and risk reduction, morbidity and co-morbidity related to risk behaviors, risks related with piercings and tattoos, risk behaviors and protective factors, healthy life habits, etc.

In July 2009, the report of the National Plan Against Spread Of Infectious Diseases in Prisons was prepared by IDT, I.P. in collaboration with the National Coordination for HIV/AIDS Infection and transmitted to the Minister of Justice Cabinet.

The report focused on two main aspects, firstly the Plan in its various areas of national scope, and, secondly, the Pilot Project 42 that is ongoing in two prisons (Lisbon and Paços Ferreira) integrating the Syringe Exchange Program.

Concerning the Plan qualitative data, evaluation items and proposals for the development for intervention, were included.

Regarding the Syringe Exchange Program, the evaluation synthesis was undertaken, as well as the presentation of proposals for development.

### 7.4. Responses to other health correlates among drug users

No new information available.

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42 The Law 3/2007, of 16 January, add article 5 to the Law 170/99 of 18 September, which adopts measures of combat to the spread of Infectious diseases in Prison settings, creating therefore the Specific programme on Needle exchange (PETS). the regulation of the Specific Programme on needle exchange was adopted in 14th May 2007 by the Council of ministers, published by the Order 22 144/2007, in the DR II 183, of 21 September 2007 and was destined to prison settings previously selected. In accordance with number 1 of article 9 of the PETS Regulation, the norms for the internal functioning of the two prisons were defined and approved by the Director General of Prisons.
8. Social Correlates and Social Reintegration

8.1. Introduction

The National Plan on Drugs and Drug Addiction 2005-2012, includes objectives and actions (see Structured Questionnaire 28) based on integrated approaches that simultaneously put the focus on the user and family and on the social systems. While the user approach aims to enable his integration, with the social systems the objective is to reverse the subjective factors, which are a significant obstacle to the emergence of opportunities and possibilities of integration, developing integrated strategies for the systematic monitoring of the relationship between the parties.

The integration paths of those with use and abuse of psychocative substances are usually slow and tortuous, requiring global and systemic interventions which contribute to their sustainability.

The integration paths of users seeking support of specialised services, public or private, starts with the first request for help and continues until the person acquires stability and participates as full rights citizen.

Due to the important social stigma towards users of psychoactive substances, IDT, I.P. continued to focus its action on the involvement of different partners on integrated responses, which meet the users needs.

In 2009, IDT, I.P. strengthened the agreements and protocols already signed, to adapt and improve the quality of the existing resources and responses, so they can serve effectively the real users needs.

In 2009, we reinforced the importance to stabilize and standardize the procedures of follow-up, monitoring and evaluation of the activities and interventions in the area of reintegration, as well as the Exchange of Employers.

The National Strategy for the Integration of Homeless is a priority area, as given the effective economic disadvantage and social exclusion of a significant group of drug users, the IDT, I.P. Implication and the services provided are an important added value.

8.2. Social Exclusion and drug use

In 2009, the elaboration of the National Strategy for the Integration of Homeless – Prevention, Intervention and Follow-Up 2009-2015, under the coordination of the Social Security Institute, involved a set of representatives of public/private sectors, namely IDT, I.P.

The absence of legal rules that frame the implementation of policies towards homeless and the diversity of problems associated to this phenomenon, contributing to its multidimensionality and complexity, have determined the need to define a joint strategy for the development of integrated measures of intervention that will allow to prevent and to solve the homeless situation (in which drug users are included).

The Strategy focus on 3 specific areas: Prevention, Intervention and Monitoring and it is based on several guiding principles, amongst:

1. Promotion of the Citizenship rights;
2. Promotion of equal opportunities and gender;
3. Updated knowledge of the dimension and characteristics of the phenomenon to sustain the strategies development;
4. Recognition of the phenomenon’s multidimensionality and complexity and consequent need to adapt and sustain the implementation of measures;

5. Definition and implementation of measures of prevention, intervention and monitoring;

6. Empowerment and mobilization of all public and private entities for an integrated and consistent intervention;

7. Acknowledgement and adjustment to local specificities;

8. Ensuring a quality intervention person-centered throughout the process of support and monitoring;

9. Proactive participation and empowerment promotion of the homeless in all moments of the insertion process;

10. Education and community mobilization;

11. Monitoring of the process and evaluation of the strategy implementation.

The Strategy was based on the analysis of elements that may be considered risk factors, enhancers of homelessness, related to intervention and monitoring of the homeless situation and the follow up of access to housing and insertion, in a way to identify a set of measures aimed at:

- Risk groups prevention
- Intervention in street and temporary housing
- Monitoring intervention

The development of the Strategy involved a process and shared responsibility among various private and public institutions, which participated in the Interinstitutional Group as their competences were considered indispensable to ensure the implementation of the Strategy, considering the heterogeneity of issues and the potential events related to homeless situation.

So, in this Group participated in addition to Social Security, the public sector like Housing, Health, Justice, Home Office, Employment, the High Commissioner for Immigration and Intercultural Dialogue, the Commission for Citizenship and Gender Equality and the National Association of Portuguese Municipalities, and private sector representatives.

The Strategy set out guidelines for intervention – an Intervention and Monitoring model, in line with the IDT, I.P. guidelines for social intervention. The model Intervention and Monitoring to be used in the Strategy implementation contemplates the need to make profit of human and financial resources, as well as the need to avoid duplication of responses, focusing on the individual, family and the community.

This model implies a multidimensional approach in diagnosis and monitoring the situations, with the design of a life project for the integration and empowerment in relation of support services. The diagnosis is built on the relationship user and case manager, with whom he maintains a special relationship.

As the setting up of the Strategy is done through the local social networking, several Planning and Intervention Units for Homeless (NIPSA) were created, involving all agencies working in this area.

IDT, I.P. is a core part of all NIPSA created in 2009, sharing responsibilities in the promotion and achievement of the objectives and actions inscribed in the Strategy. It was in Oporto that this process has progressed more rapidly, with the IDT, I.P. experts as case managers of homeless users of psychoactive substances.

In cases in which a NIPSA is not needed, a local interlocutor for the Homeless Strategy from the social network should be found.
The Intervention and Monitoring model defined in the Strategy applies to all homeless cases, requiring a specialised intervention and throughout the period needed for finding and consolidating a solution.

The model includes two phases: the emergency intervention and the monitoring after emergency.

A – Emergency intervention

The emergency is the period elapsing the signalling of an homeless situation and its identification to the NPISA for monitoring and assignment of a case manager. The cases can be signalled by outreach teams, law enforcement agents, local emergency units, health services and other social care services.

Each entity aware of an homeless situation, by direct or indirect contact, must signal it and send to the emergency center or to street teams specialised (psychoactive substances users or mental disease). These teams, in addition to the signalling, also make the first attendance and consequently give the information to the NPISA to be assigned a case manager and to proceed the referral to accommodation.

The case managers are experts from the different institutions of the network, which will follow and be responsible for case management, in accordance with their specific competences.

The diagnosis/screening can be done by the emergency centers, the specialized street teams or the local interlocutor and has to be submitted to the NPISA, within one month from the first contact, so the assignment of a case manager and the referral for a follow up response be immediate. The diagnosis should be undertaken by a multidisciplinary team, taking into account the multidimensionality of the associated problems, identifying when possible the main problem.

The exit of the emergency centre must correspond to another response, which should be made available according to the specific situation, taking into account the diagnosis (in the case of psychoactive substances users to shelters or therapeutic communities).

B - Monitoring after emergency

Following the assignment of the case manager, the necessary resources to the individual plan of integration must be presented to the NPISA, since the case manager is responsible for the full follow-up of the user, with whom concrete measures for its integration (Insertion Individual Plan) are negotiated. The case manager is also responsible to assess the resources to be mobilized by the community, keeping the NPISA informed on the evolution of the case.

The actions leading to integration are translated into the Insertion Individual Plan, which is not a close document, being constantly adapted to the changing circumstances over the monitoring process. Thus, the duration of this plan should be variable and adapted to the different types of actions involved.

Throughout the monitoring process, the case manager acts as mediator and facilitator in the process of articulating and communicating with different entities/responses with which the homeless has to relate in his integration path.

Also, in cases needing an intervention in the health area, namely for users of psychoactive substances, the case manager articulates with his counterpart on the health services to guaranty adequate care.

The monitoring of individual path is ensured by the case managers, who must submit a monthly report of their activities to NPISA or to the social network interlocutor and update the information system with clients registrations. The report must include information on the
progress and evaluation of the activities pursued, identifying needs and obstacles and proposals for overcoming them.

Monitoring should continue until the situation of the homeless is considered stable and autonomous. The situations still needing support in their contacts with social care services are forwarded to local services, and the case manager should be informed of the progress situation for 3 years, in a regular and agreed way, thus ensuring the monitoring to prevent relapse.

The implementation of the Strategy requires the continuous activity of the Interinstitutional/Interagency Group, which will be renamed as “Group for the Implementation, Monitoring and Evaluation Strategy” and will assure the implementation, mobilizing and promoting the participation of all stakeholders, as well as the monitoring and evaluation of the entire process.

Three evaluation periods are considered:

- Initial evaluation (ex-ante) - corresponds to the initial diagnosis of the national situation and will be accomplished through questionnaires filled in by interlocutors chosen;
- Process evaluation (ongoing) – relates to the monitoring of the achievement of the different goals set for each of the objectives;
- Evaluation impact (ex-post) – is the assessment of the Strategy to be undertaken by external entities.

The evaluation report will include proposals for the recast of the Strategy by 2015.

The IDT, I.P. reintegration teams identified 628 homeless people, within a total of 1443 with housing needs.

<table>
<thead>
<tr>
<th>Needs identified in housing and shelter (A)</th>
<th>Users of Illicit substances</th>
<th>Users with alcohol related problems</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Clients</td>
<td>1,208</td>
<td>235</td>
<td>1,443</td>
</tr>
<tr>
<td>Needs fulfilled (B)</td>
<td>535</td>
<td>93</td>
<td>628</td>
</tr>
<tr>
<td>Response Rate (B/A)</td>
<td>490</td>
<td>102</td>
<td>592</td>
</tr>
<tr>
<td></td>
<td>41%</td>
<td>43%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Table 28 – Users with needs in the habitation ambit by type of substance use/Homeless Clients (IDT, I.P. 2010)

The ability to respond to users needs in housing was 41% (592), the majority of responses via temporary accommodation.

8.3 Social Reintegration

Any rehabilitation intervention, regardless the exclusion level of the user, involves the joint development of social diagnosis, with the identification of needs in order to define with the user the integration pathway (Insertion Individual Plan).

On this basis, there are initiatives for the operationalization of the strategies agreed with the user, coordinating with other institutions and mobilizing the community resources, in a logic of integrated responses, to meet the identified needs and to create conditions for the development of a sustained insertion pathway.
In 2009, we continued to implement the monitoring process of the interventions and activities undertaken by IDT, I.P. on the rehabilitation area and adapted the collecting data instruments on the priorities set for 2009.

We have built an informatics application for online registration of drug users that will be available in 2010. The collection of indicators related to rehabilitation interventions, allow to assess the users’ needs along their path and simultaneously to evaluate the level of implementation of the strategies and the IDT, I.P. and partners ability to respond to the identified needs.

As foreseen in the Action plan – Horizon 2012, the guidelines for social intervention – an intervention model in reintegration were adopted, being essential to harmonize the team practices and to the continuous improvement of services provided to users of psychoactive substances and alcohol. These guidelines were accepted by 87% of the IDT, I.P. local structures with social intervention, meaning 66 units:

Implementing the intervention Model in Reintegration implies: 1) joint development of social diagnosis and identification of users needs; 2) negotiation and contracting the Insertion Individual Plan – the commitment of the parties across the whole integration process; 3) development of systemic strategies for follow-up and social mediation; 4) evaluation and reformulation or social release.

Throughout 2009, around 74 766 reintegration consultations took place (therapeutic and social service) in a universe of 47 798 persons who contacted IDT, I.P. and as a result 1 160 individual plans where contracted. The geographic distribution is in the chart below:

**Figure 6 – Implementation of the Intervention Model in Reintegration (IDT, I.P.2010)**

Housing

Housing is a fundamental component for a sustained and durable integration, as it is a central part in people’s lives.

The housing issues are conceived through a strategy involving partnership and flexibility, associating all the local entities, including Local Government, Private Institutions of Social Solidarity, Social Security Institute (ISS), Institute of Housing and Urban Renovation, among others. During 2009, 592 users have been integrated in a housing response.
The interventions accounted for 41% of the 1,443 users, at national level, similar value at 42% (1,662 cases) observed in 2008, when the users with alcohol problems were not included. It appears that the housing responses are few and clearly insufficient for the existing situations and that part of the responses available are only temporary accommodation.

Social Reintegration Apartments are a social response fundamental for those lacking social/family and housing support, that have completed the treatment process via outpatient services, therapeutic communities or prisons and are now searching a job.

In 2009, IDT, I.P. and the Social Security Institute developed guidelines to standardize the response at national level, ensuring quality standards and enabling the evaluation and comparability, in the sense of continuous improvement and quality. Users with alcohol problems also benefit from this response.

In 2009, 29 apartments were operational serving 227 users. If we consider an average 6 months period at the accommodation, it is estimated that 454 used this response.

To ensure adequate access to social protection measures, the interinstitutional protocol involving IDT, I.P, ISS, I.P and Santa Casa da Misericórdia de Lisboa was maintained.

The protocol, which also seeks to promote integrated support and to facilitate users access to network resources and social protection measures, widened this year its scope to users with alcohol problems.

The implementation of this Protocol facilitated access to an estimate of 1,310 individuals, namely 137 with alcohol problems.

1,125 insertion agreements were concluded and monitored by teams from the different services, 133 of those for users with alcohol problems.

The Institute for Housing and Urban Renovation, a strategic partner in this area, whose action is directed towards disadvantaged families, do not develop specific policies for drug users. However, several actions namely on the urban requalification, insertion of marginalized populations and cities dynamization may relate to problems posed by addictions as the rehabilitation of neighborhood, in conjunction with the support to population in risk of social exclusion.

**Education, training**

Education is one of the aspects of individual lives that can and should be encouraged in the context of the intervention in rehabilitation. The acquisition of a degree of higher education may be crucial to the success of other interventions and the route of the user.

From 2008 users, (1,956 illicit substances and 194 alcohol) with specific needs for improve qualification, around 30% (661 persons) returned to school (32% in 2008), proving that the existing responses are not enough.
As for the kind of response, the Revalidation and Certification of Competencies Centres (RVCC) continue to be the most used option, representing 77% of the cases (513 users). It is the most adequate response for users, as it is very flexible.

Providing vocational training for users who have a low employability profile is a step for the development of more sustained paths: 501 users in a total of 2,150 with specific needs participated in training activities (23% in 2008 and 2009). Nevertheless, the majority of users (77%) with an Insertion Individual Plan, including the acquisition of professional skills, do not find available responses.

To overcome users difficulties in accessing training courses, a better articulation with Employment Centres was implemented and new guidelines were created to improve the communication channels and articulation of the local/regional structures of IDT, I.P. and Institute for Labour and Professional Training (IEFP, I.P.) and to enhance the Life-Employment Program – Programa Vida Emprego (PVE) with procedures and recommendations for both services.

The PASITForm is a joint action program involving IEFP, I.P. and IDT, I.P. that emphasises the articulation of the two institutes and maximizes the specific competences of each one, contributing to the improvement of the quality of responses available to the population at risk or exclusion in the field of social and professional integration.

The aim of this program is to promote awareness and prevent use of psychoactive substances, in particular among youngsters of the Training Centers directly managed by IEFP, I.P. In 2009, 869 trainees and 37 training activities were undertaken.
During 2009, two sessions of On-going pedagogical training for trainers specifically oriented to raise awareness on the different Interventions on addiction’s problems were realized, involving 26 participants.

The following table shows the activities undertaken by the IDT, I.P and IEFP, I.P structures:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local or regional team meetings</td>
<td>Meetings 39</td>
</tr>
<tr>
<td>Experts 151</td>
<td></td>
</tr>
<tr>
<td>Application of questionnaires to the trainees of the Learning and Education and Training of Young People</td>
<td>Questionnaires 49</td>
</tr>
<tr>
<td>Celebration of the International Day Against Drug Abuse and Illicit Drug Trafficking</td>
<td>Participants 1 523</td>
</tr>
</tbody>
</table>

Table 33 - activities undertaken by the IDT, I.P and IEFP, I.P structures (IDT, I.P. 2010)

**Employment**

Obtaining and keeping an employment is a crucial step in the reintegration process. Having a job means not only being able to maintain himself and family but it is also important for the self estime, social skills, knowledge and life experience which contribute to the self stability, as an active and useful member of society.

In comparison to 2008, more users expressed needs in the context of employment but even with different responses available; only 37% of the requests were satisfied against 38% in 2008.

<table>
<thead>
<tr>
<th>Years</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified needs (A)</td>
<td>4 338</td>
<td>4 626</td>
</tr>
<tr>
<td>Positive responses (B)</td>
<td>1 654</td>
<td>1 700</td>
</tr>
<tr>
<td>Response rate (B/A)</td>
<td>38%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Table 34 – Users with specific needs / users integrated in employment answers (IDT, I.P. 2010)

The satisfaction of these employment needs was obtained through the mobilization of different measures, as we can see in the chart below:
The regular labour market, without protected employment programs, continues to be the most frequent response with 50% of cases. This option proposes an employment contract, with full rights and duties, which represents an effective integration. 24% of cases appealed to Life-Employment Program, 13% to other IEFP, I.P. measures and 13% to other professionalization measures. These responses correspond to mechanisms of protected or semi-protected employment, which allows contact experiences in work context.

Program Vida-Emprego\(^\text{(43)}\) (Life-Employment Program - PVE) continues to be of vital importance as a resource in the area of employment for users with weak conditions for employability. During 2009 the Regional Delegations of IDT, I.P., in conjunction with IEFP, I.P, continued to organise training activities for reintegration teams which, will replace the IEFP, I.P, mediators on the monitoring of the integrated users and on new cases.

During 2009, 1,115 individuals were accompanied by the Reintegration teams and other licensed treatment facilities, with the following distribution:

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stages of Socio-professional Integration</td>
<td>688</td>
<td>646</td>
<td>623</td>
<td>559</td>
<td>596</td>
</tr>
<tr>
<td>Socio-professional Integration Awards</td>
<td>40</td>
<td>53</td>
<td>57</td>
<td>54</td>
<td>479</td>
</tr>
<tr>
<td>Support for Employment</td>
<td>535</td>
<td>624</td>
<td>603</td>
<td>554</td>
<td>35</td>
</tr>
<tr>
<td>Support for Self-Employment</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>1,264</td>
<td>1,324</td>
<td>1,283</td>
<td>1,168</td>
<td>1,115</td>
</tr>
</tbody>
</table>

Table 35 – Specific measures of PVE, national total (IDT, I.P. 2010)

Also in area of employment, and to facilitate the users’ access to labour market, it is worth highlighting the implementation of the computerized database at national level – Exchange of Employers, a support tool for experts which aims to organize and share information on employers partners of IDT, I.P. By the end of 2009 the Exchange of Employers included 177 employers (which employed users in 2009 or had done it in previous years).

Through the analysis of data of the Exchange of Employers, partner entities are mainly private companies (40%), Local Administration entities represent 25% of the total and the Private Institutions of Social Solidarity - IPSS represent 23%. Regarding the size of entities,
micro-enterprises (businesses with less than 10 employees) represent 40% of companies participating in the Exchange of Employers and small enterprises (10-50 employees), are 37% of the total.

The micro and small companies are the most collaborative in this area, maybe due to the close knowledge of the community, or due to the hierarchical structure, both factors may have facilitated the approach and monitoring of the reintegration teams. Medium-sized enterprises (50 to 250 employees) represent 10% of the total and large companies (more than 250 employees) 5% of entities included in the Employment Exchange.

Graph 43 – Legal status of the entities in the Exchange of Employers (N=177), (IDT, I.P. 2010)

The intervention of IDT, I.P. in workplace setting didn’t had the relevance of other contexts, for example, the school setting. Face to the growing request by public and private entities in this theme and in accordance with Action Plan Against Drugs and Drug Addiction 2009-2012, the National Plan for the Reduction of Alcohol Related Problems and the National Strategy for Security and Health at work 2008-2012, the IDT, I.P. in the ambit of the protocol established with the Authority for Working Conditions has been planning in articulation with public and private entities a enlarge intervention in work setting.

This intervention, is part of a strategy of health promotion and prevention of psychoactive substances use.

In a first phase a conceptual document was elaborated “Security and Health Work and Prevention of psychoactive substances use: Guidelines for Workplace Intervention”, that
count with contributions from the public and civil society and is in the final approval phase by the Ministries of Health and Work and Solidarity. The pretension is the document became a reference for the interventions in this theme to be developed in enterprises and institutions. From the objectives and goals to achieve we highlight:

- Elect the work places as privileged contexts for the prevention of problematic use of psychoactive substances;
- Center strategies in responsibility and ethic organizacional, supporting the organizations and workers;
- Contribute for the prevention of work risk accidents and for the promotion of security level, minimising the use of psychoactive substances;
- Give support to the creation and development of health and security policies in the organisations.

It should be noted that the workplace intervention, launched by IDP, I.P. and General Confederation of Portuguese Workers (CGTP IN), in two municipalities and two private companies was maintained in 2009 and training sessions were developed for professionals of these entities, including experts and health teams of the municipalities involved.
9. Drug-related crime, prevention of drug related crime and prison

9.1. Introduction

In 2009, concerning the administrative sanctions for drug use\textsuperscript{44}, the Commissions for the Dissuasion of Drug Use instated more 15\% processes\textsuperscript{45} than in 2008 most of which were, again, referred by the Public Security Police (PSP).

From the 5 508 rulings made, 85\% suspended the process temporarily, 14\% were punitive rulings and 1\% found the presumed offender innocent.

The number of presumed offenders increase in relation to last year (+17\%), registering the highest value since 2002. This increase resulted from the increase of presumed traffickers (+14\%) and trafficker-users (+19\%), that registered the highest value of the decade.

Again, the visibility of cocaine increased in this setting, particularly amongst traffickers than trafficker-users, the opposite is verified in the situations related with cannabis.

In the context of judicial decisions under the Drug Law, in 2009 1 360 processes were finalised involving 2000 individuals\textsuperscript{46}, 1 684 were convicted, 82\% for traffic, 17\% for use and 1\% for traffic-use. As occurred in 2004, and contrarily to previous years, once more prevailed in the convictions under Drug Law the application of the suspended prison (50\%) instead of effective prison (29\%).

Court data indicates that in the past years, decreases were reported in terms of the number of convictions for traffic and for traffic-use. The majority of these individuals possessed only one drug, mainly cannabis, for the seventh time, followed by cocaine. The trend initiated in 1998 of the decreasing importance of heroin related convictions continues.

Prison data indicates that, on the 31\textsuperscript{st} of December 2009, 2 026 (+10\% than in 2008 with 1 849) individuals were in prison for crimes against the Drug Law, representing an increase of 10\% in relation to 2008 and inverting the continuous downward trend registered over the decade. In this date, prisoners represented 23\% in the universe of the convicted prisoner population at national level, proportion that increased for the first time this decade. The majority of these individuals where convicted for traffic (89\%), 9\% for minor traffic and 2\% for traffic-use, values similar to last years patterns.

9.2. Drug related Crime

Drug Law offences

Concerning the administrative sanctions for drug use\textsuperscript{47}, in 2009, the 18 Commissions for the Dissuasion of Drug Use (CDT) instated 7 549 processes\textsuperscript{48}, representing a 15\% increase in comparison to last year, representing the highest value ever of processes.

Similarly, to preceding years, most of these processes were instated in the districts of Oporto and Lisbon, followed by Braga, Setúbal, Aveiro and Faro. However, when taken into account the number of residents in each district, Portalegre, Faro, Beja and Oporto presented the higher occurrences rates per inhabitant aged 15-64.

\textsuperscript{44} Law n.º 30/2000, of the 29\textsuperscript{th} November.

\textsuperscript{45} Each process corresponds to one occurrence and to one person. Information collected on 31 March 2009.

\textsuperscript{46} In line with the methodological criteria used in previous years, the judicial decisions dated of 2008 and 2009 and registered at IDT, I.P. until 31st of March 2010. 2009 data will be updated next year and 2009 decisions registered between 31\textsuperscript{st} March 2010 and 31\textsuperscript{st} March 2011 will be taken into account.

\textsuperscript{47} Law n.º 30/2000, of the 29\textsuperscript{th} November.

\textsuperscript{48} Each process corresponds to one occurrence and to one person. Information collected on 31 March 2009.
In comparison to last year, the highest increase in absolute values occurred in the district of Lisbon and in percentual values in the district of Leiria, the highest decrease in absolute value occurred in the district of Aveiro and in percentual value in Beja.

Rates per 100 000 inhabitants in the age group 15-64 years

Figure 7 – Distribution of the Administrative sanctions for drug use by District (IDT, I.P. 2010)

Similarly to previous years, most cases (49%) were referred by the Public Security Police (PSP), followed by the National Republican Guard (GNR) with (37%) and the Courts with 14% of the cases, it is worth noting the increasing trend of occurrences sent by GNR (+29% in relation to 2008) and by PSP (+22% in relation to 2008), for the second consecutive year a decrease was registered in the number of processes referred by the Courts\(^\text{19}\) (-20% in relation to 2008).

On the 31\(^\text{st}\) of March 2009, near 73% of the processes instated in 2009 had been decided: 31% were suspended (35% in 2008, 27% in 2007, 26% in 2006 and 2005 and 32% in 2004) and 42% were filed (35% in 2008, 23% in 2007, 22% in 2006, 49% in 2005 and 36% in 2004), representing for the second consecutive year an increase of decision-making capacity in relation to previous years, which reflects the replacement of quorum in CDTs during the year 2008.

\(^{19}\)The decrease in the number of processes by the Courts can be related, among others, with the Judicial precedent of the Supreme Court of Justice n.º 8/2008, of 5 August (Acórdão do Supremo Tribunal de Justiça n.8/2008, de 5 de Agosto), which remains in force n.º 2 of the article 40 of the Decree-Law n.º 15/93, of 22 January, “... not only “the cultivation” and on the acquisition or possession, for personal consumption, plants, substances or preparations listed in Tables I to IV, this shall not exceed the quantity required for an average individual consumption during a period of 10 days”.
From the 7,549 instated in 2009, the Commissions had ruled on 72.96% (5,508 processes). This percentage is higher than the one verified last years, but lower than the ones verified in previous years – 70.3% in 2008, 49.5% in 2007, 48.5% in 2006, 51% in 2005, 68% in 2004, 76% in 2003, 78% in 2002 and 75% in 2001:

- 85% were suspensive rulings;
- 14% were punitive rulings and
- 1% found the presumed offender innocent.

As in previous years, the provisional suspension of the process in the case of users who were not considered addicted were the majority of the total percentage of rulings (68%), (63% in 2008, 60% in 2007, 59% in 2006 and 2005). Followed by suspensive rulings in the case of drug users who accepted to undergo treatment (15%), (18% in 2008, 19% in 2007, 20% in 2006 and 21% in 2005).

The punitive ruling in this setting was identical to last year. The non-pecuniary sanctions represented 10% of the punitive rulings (10%, 10%, 11% and 59% in, 2008, 2007, 2006 and 2005 respectively) and were mainly related with the periodical presence in a place selected by the CDT.

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50 When interpreting the data related to the decision taken, should be take in account that some CDTs were between 2003 and 2008 functioning without a quorum, that conditioned the diligences in some CDTs, namely the decision making in the application of Law 30/2000: since 2003 the CDT of Viseu and Guarda; since last semester of 2004 Faro and Bragança; since 2005 the CDT of Lisbon; since the end of June 2007 the CDT of Coimbra and June 2008 the CDT of Vila Real. The reposiition of quorum in these CDTs was accomplished during the first semester of 2008, with the exception of the CDT of Vila Real which reposition occurred in February 2009.

51 Year when occured the fact sanctioned as an administrative offence Information collected on 31 March of the year after the one when occured the fact sanctioned as an administrative offence.

52 In 2001 data refers to 6 month only as the Law was implemented from the 1st of July on. It is also important to mention that, during the reporting period the Lisbon and Faro CDTs had no possibility of ruling due to lack of quorum.
Concerning the substances involved:

- In relation to 2008, decreases were verified in the number of processes on several drugs: -27% involving several drugs, -20% involving only ecstasy, -5% involving only heroin and -5% involving only cocaine, with the exception of the processes involving only cannabis (+30%).

- As in previous years, most cases involved only one drug (96%):
  - Mainly cannabis (76%) - 68% in 2008, 64% in 2007, 70% in 2006 and 68% in 2005;
  - 11% of these processes involved only heroin (14% in 2008, 17% in 2007, 14% in 2006 and 15% in 2005). 8% involved only cocaine (6%, 8%, 7% and 6%, respectively in 2008, 2007, 2006, 2005);
  - The predominance of occurrences involving only cannabis was found in all CDTs.

- For the 6% processes involving more than one drug (10% in 2008 and 2007, 9% in 2006, 11% in 2005), the association heroin-cocaine was again predominant, and like in the last five years, the association cocaine-cannabis surpassed the association heroin-cannabis.
Concerning the individuals involved:

- In 2009, 7,122 individuals\(^{54}\) were involved (6,044 in 2008, 6,268 in 2007, 5,815 in 2006, 5,824 in 2005) in the instated processes and without acquittal of the Commissions for the Dissuasion of Drug Abuse;

- 4% of those were recidivists in 2009 to a Commission (6% in 2008 and 2007, 5% in 2006 and 6% in 2005). The majority of the recidivists (90%) registered only one criminal relapse in the year.

- In relation to previous years, no relevant changes were verified concerning the socio-demographic profile of these individuals:
  - They were mostly from the male gender (93.4%);
  - 50.6% were aged 16-24;
  - 31% were aged 25-34;
  - Mean age 27;
  - They were mainly Portuguese (94.2%), single (86%) and living with their parents/siblings (65%);
  - 39.3% had frequented the 3\(^{rd}\) level of compulsory school (7\(^{th}\) - 9\(^{th}\) grade) and 29.4% reported an educational status above that;
  - 30% were unemployed and the 41% were employed and 21% students.

Like in previous years, between foreigners (6%) Africans were predominant (2%), with particular relevance to Cape Verdean. It is noted that the number of Brazilians has increased in recent years, and in 2009 already exceeded the number of Cape Verdeans.

\(^{53}\) Year when occurred the fact sanctioned as an administrative offence. Information collected on 31 March of the year after the one when occurred the fact sanctioned as an administrative offence.

\(^{54}\) Individuals who were sent twice to a Commission in any year (and thus originated the instatement of more than one process) were counted only once.

<table>
<thead>
<tr>
<th>Year</th>
<th>Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>393</td>
</tr>
<tr>
<td>2004</td>
<td>277</td>
</tr>
<tr>
<td>2005</td>
<td>362</td>
</tr>
<tr>
<td>2006</td>
<td>395</td>
</tr>
<tr>
<td>2007</td>
<td>4043</td>
</tr>
<tr>
<td>2008</td>
<td>4104</td>
</tr>
<tr>
<td>2009</td>
<td>5429</td>
</tr>
</tbody>
</table>

Graph 47 – Type of drug involved in administrative offences by year\(^{53}\) (IDT, I.P. 2010)
Drug-related crime, prevention of drug related crime and prison

Other Drug related crime

Concerning criminal offences, in 2009, data from the Criminal Police identified 6,348 presumed offenders: 41% were presumed traffickers and 59% presumed trafficker-users.

The number of presumed offenders increase in relation to last year (+17%), registering the highest value since 2002. This increase resulted from the increase of presumed traffickers (+14%) and trafficker-users (+19%), that registered the highest value of the decade.

![Graph 48 – Presumed offenders by year and category of criminal offence (IDT, I.P. 2010)](image)

Similarly to previous years, the districts of Lisbon and Oporto presented the higher percentages of these presumed offenders (respectively 34% and 22%), followed by Setúbal (6%) and Faro (6%). The higher rates of presumed offenders per inhabitant from the age group 15-64 were registered in the districts of Portalegre, Lisbon and the Autonomous Region of Azores, Faro and Oporto.

Concerning the substances identified in the moment of the occurrence:

- 74% of these individuals possessed only one drug (70% in 2008, 68% in 2007, 71% in 2006 and 64% in 2005);
- Among these cases, and like in previous years, cannabis was predominant in comparison to other substances (51%);
- 12% of the cases concerned heroin only (11% in 2008 and 12% in 2007);
- 10% of the cases concerned cocaine (11% in 2008 and 12% in 2007);
- 1% of the cases concerned several other drugs;
- In the situations where more than one drug was involved (26%), the combination “heroin and cocaine” continues to be predominant, followed by the combination of heroin, cocaine and cannabis.
- In comparison to 2008, we can point out an increase in the number of presumed offenders in the possession of cannabis only (+30%), as well as in the possession of heroin only (+30%). Cannabis represented the highest value of the decade, reinforcing the increasing trend verified through the decade, despite the two consecutive years of decrease in 2006 and 2007. Heroin represented the highest value since 2003, coming this increase after the stability occurred in the last three years, contrary to the clear downward trend in the first half of the decade. The number of presumed offenders in the...
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possession of only cocaine represented the highest value of the decade, and a increase in comparison to 2008 (+9%), confirming the increasing trend through the decade, after the stability between 2006 and 2008.

In the last four years, it was verified a stability in the number of presumed offenders in the possession of several drugs, registering in the second half of the decade values lower than in the first half.

Like in previous years, situations related with possession of cocaine alone continue to have a higher relative importance in the group of presumed traffickers than in the group of trafficker-users; the opposite was verified in the situations related with cannabis.

Concerning the individuals involved:

- 90% of the presumed offenders were of the male gender;
- 74% were aged between 16-34, mainly 16-24 (38%) and 25-34 (34%), being the mean age 30;
- 83.1% were Portuguese, among those who were not Portuguese (17%), the Africans were predominant (11%), mainly from Cape Verde. 84% were single, 55% frequented the 3rd level of compulsory school and 58% were unemployed, 31% were employed and 9.9% were students at the time of their arrest.

Once more the presumed trafficker-users when comparing the presumed traffickers, present a higher percentage of male gender individuals, Portuguese nationality, single, more academic skills, a higher percentage of employed individuals and students, and are also younger.

Concerning Court data:

In the context of judicial decisions under the Drug Law\textsuperscript{55}, in 2009 1 360 processes were finalised involving 2 000 individuals\textsuperscript{56}, the vast majority were accused of traffic (92%). Near 84% were convicted and 15% were acquitted.

\textsuperscript{55} With the enter in force on the 1 July 2001, the Law 30/2000 of 29 November, the use of illicit substances foi descriminalized being an administrative offence. The cultivation situation foreseen in the article 40 of the Decree Law 15/93, of the 22 January is still considered a crime independently of the entering in force of the Law 30/2000. Later one with the Judicial precedent of the Supreme Court of Justice n.º 8/2008, of 5 August (Acórdão do Supremo Tribunal de Justiça n.º 8/2008, de 5 de Agosto), which

\textsuperscript{56}
Despite the annual variations in the number of processes, of individuals accused and convicted under the Drug Law, there is a decline in the first half of the decade and a relatively stability despite the peak in the second half of 2007. There is expectations that the updating of 2009 data next year, reflects an increase of processes, individuals charged and convicted for 2008, taking into account the increased number of cases related with consumption occurred after the fixation of case law on situations for own consumption, in superior amount than the required for the average consumption for 10 days.57

Of the 1,684 convicted individuals (1,392 in 2008, 1,420 in 2007, 1,474 in 2006 and 1,281 in 2005), 82% were convicted for traffic, 17% for use and 1% for traffic-use, the focus goes to the increase in the proportion of individuals convicted by consumption, related with the fixation of case law mentioned above.

Graph 50 – Processes, Individuals Accused and Convicted under Drug Law, by Year (IDT, I.P. 2010)

56 In line with the methodological criteria used in previous years, the judicial decisions dated of 2008 and 2009, and registered at IDT, I.P. until 31st of March 2010. 2009 data will be updated next year and 2009 decisions registered between 31st of March 2010 and 31st of March 2011 will be counted.

57 Supreme Court of Justice n.º 8/2008, of 5 August.
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From the 1,373 individuals convicted for traffic, 1,372 were initially accused for that crime and 1 for traffic-use. From the 288 individuals convicted for use, 47% were accused for that crime and 53% accused of traffic. Around 39% of the 23 individuals convicted by traffic-use were accused for that and 61% were accused of traffic.

The districts of Lisbon (39%) and Oporto (17%), followed by Setúbal (9%), and Faro (6%). Lisbon, the Autonomous Region of Azores and the districts of Faro, Portalegre and Beja registered the higher rates per resident (15-64 years old);

Concerning the sanctions applied in these convictions, mostly related with trafficking crimes, occurring 2004 and contrary to previous years, these convictions involved mainly suspended prison (50%) and effective prison (29%). To refer an increase of convicted only sentenced with an effective fine, predominantly applied to convictions related with consumption.

As for the substances involved:

- In 2009 the majority of these convictions involved, once again, the possession of only one drug (65% in 2009, 66% in 2008, 69% in 2007, 67% in 2006 and 2005, 69% in 2004). Hashish was the main substance involved (37% in 2009, 36% in 2008 and 2007, 32% in 2006 and 30% in 2005), followed by cocaine (16% in 2009 and 2008, 17% in 2007, 18% in 2006 and 15% in 2005), heroin (12% in 2009 and 2008, 14% in 2007, 16% in 2006 and 18% in 2005) and less than 1% several other drugs;

- When polydrugs are considered (in 35% of the processes), the association heroin-cocaine was predominant.

\[58\] Sanctions concern the final conviction and may involve more than one crime.
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### Table 36 – Individuals Convicted, by situation towards drug and type of drug (IDT, I.P. 2010)

- Similar to previous years the cases related with the possession of cocaine only continue to have greater relative importance in the group of traffickers than in the group of traffickers-users. In the group of convicted by crimes related with consumption, once more the vast majority of the cases were cannabis related;
- In comparison to previous years and despite 2009 data is going to suffer changes in next year, it was noted in the convictions related to only one drug, the preponderance of hashish for the seventh consecutive year instead of heroin, and the preponderance for the fourth consecutive year of the convictions by possession of cocaine only in relation to the cases involving only heroin, strengthen the trend verified in last years of higher visibility of cocaine in these circuits.

In line with the methodological criteria used in previous years, the judicial decisions dated of 2008 and 2009, and registered at IDT, I.P. until 31st of March 2010. 2009 data will be updated in the next year and will be counted the decisions related to 2009 registered in the IDT between 31st of March 2010 and 31st of March 2011, will not be presented the variations related to previous years.

**Graph 52 – Individuals convicted, by Year, by Type of Drug (IDT, I.P. 2010)**

In line with the methodological criteria used in previous years, the judicial decisions dated of 2008 and 2009, and registered at IDT, I.P. until 31st of March 2010. 2009 data will be updated in the next year and will be counted the decisions related to 2009 registered in the IDT between 31st of March 2010 and 31st of March 2011, will not be presented the variations related to previous years.

**IDT, I.P. 114**
Concerning the individuals involved:

- Most of these convicted individuals were of the male gender (87%);
- Aged mainly 16-24 (36%) and 25-34 (34%), 30 being the mean age.

- They were mostly Portuguese (84.5%), single (56%) and living with their parents/siblings (32%). Among those who were not Portuguese (16%), the Africans (8%) were predominant with special relevance to Cape Verdeans;
- Near 50% had habilitations equal to or above 3rd cycle and 40% were employed and 48% unemployed at the date of their conviction;
- Concerning the professional status, 40% were employed at the time of their conviction, and 47.6% were unemployed.

Convicted by consumption represent a socio demographic profile more differentiated comparatively to traffickers and traffickers-users, with more individuals from the male gender, young, single, living with their family of origin, with higher level of education and a higher percentage of employed and students.

**Prison data** indicates that, on the 31st of December 2009, 2,026 (+10% than in 2008 with 1,849) individuals were in prison for crimes against the Drug Law, representing an increase of 10% in relation to 2008 (when was registered the lowest value since 1995) and inverting the continuous downward trend registered over the decade.

Was also broke the trend initiated in 2000, of the decrease weight of these prisoners in the universe of the convicted prisoner population, representing on the 31st of December 2009 near 23% of these population.

Most of these individuals were convicted for traffic (89%) but also for minor traffic (9%) and for traffic-use (2%), these percentages are in line with previous year’s patterns.
The increase of prisoners convicted verified in 2009 under the Drug Law is due to the increase of conviction for traffic (+10%) and less serious traffic (+9%), persisting the decrease trend in the number of convictions of traffic-use (-6%).

Most of these convicted individuals were male gender (88%); aged 30-39 (37%), 40-49 (28%) and 21% with less than 30 years; mean age 38.

They were mostly Portuguese (67%), but once more was reinforced the increasing tendency of foreigners weight verified in previous years.

### 9.3. Prevention of drug related crime

The Ministry of Home Affairs continues to develop a proximity policing program, *Escola Segura* (Safe School) to improve safety in the neighbourhood of schools through the PSP (Public Security Police) and the GNR (National Republican Guard).

The commitment in the work to be carried out near schools and educational communities is one of the fundamental pillars of the institutional strategy, which is reflected in the "Safe School Program". The main objectives of this program are: raising awareness and acting near students, parents, teachers and responsible school staff for the problematic of security; advising good practices and recommending the adoption of adequate preventive measures with the aim of ensuring that schools will be a safe place and free of drugs, collect information, statistical data and conduct studies to provide the competent entities an objective knowledge about violence, insecurity feelings and the victimisation in the educational community.

PSP promoted more than 6,873 awareness, training, and demonstration sessions in schools, with the participation of near 1,079,568 pupils and 153,045 teachers.

Many of these actions were about prevention, criminal prevention and road safety prevention; actions for education for citizenship were also undertaken and several other events.

GNR data indicated that in 2009, 228 agents (211 in 2008, 198 in 2007, 196 in 2006 and 208 in 2005), were allocated to Safe School Program. Apart from the proximity policing and offence dissuasion, these law enforcement agents are also involved in training and awareness raising initiatives in schools. The initiative targeted 8,016 schools covering a universe of 810,125 students and 7,588 awareness raising sessions were developed.

### 9.4. Interventions in the criminal justice system

As an alternative to prison, Courts may send drug abusers to treatment instead of sending them to prison when the crime in question was committed with the intent to finance personal drug abuse, clinical evidence suggests the individual could profit from treatment and the judges find no aggravating circumstances that might raise objections to treatment outside prison. Other Services from the Criminal Justice System also refer clients to treatment services, while they are on probation, just being follow-up or upon release from prison (see also chapter 5.2. on this Report).

**Alternatives to prison**

The decriminalisation of possession and use of drugs, Law 30/2000 of 29 of November, is an operational instrument of objectives and policies to combat the use and abuse of drugs, and the promotion of public health, complementary to the strategies of other areas of intervention.
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of IDT, I.P. in the field of demand reduction, representing as well a measure against social exclusion.

The purpose of this legal change was the reduction of drug use and safeguard of the needs of individuals at preventive, health and therapeutic level. For this objective, Commissions for the Dissuasion of Drug Use (CDT) were created in each capital of district to develop a proximity work in the mediation between situations of use and the application of administrative sanctions (see chapter 9.2 for further developments).

The CDTs have organised several actions related with the follow up of the individuals, towards preventive answers, treatment or, in some cases, to the choice of sanction measures.

To achieve these referrals is necessary to assess and evaluate the connexion that the individual has with the illicit substance consumed. This means trying to meet the actual needs of each individual, allowing for early detection of problem drug use and identification of dysfunctional behaviours, which involve greater risks, including escalation of consumption.

The following tables characterize the situation of consumption of the individuals in process filed in 2009 and the type of forwarding /reply made within the scope of a provisory suspension of proceedings.

<table>
<thead>
<tr>
<th>Individuals</th>
<th>N.º</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Addict</td>
<td>778</td>
</tr>
<tr>
<td>Non- Drug Addict</td>
<td>3563</td>
</tr>
<tr>
<td>Pending cases</td>
<td>2076</td>
</tr>
<tr>
<td>Total</td>
<td>6417</td>
</tr>
</tbody>
</table>

Table 37 – Situation towards the use of the primary individuals without previous record (IDT, I.P. 2010)

Approximately 76% of the cases opened in 2009 are related to the primary individuals, in a figure very close to the previous year. On 2,076 cases, it was not possible to define the individuals position with regard to consumption due to non-appearance in the CDT or because they were waiting for procedural issues.

<table>
<thead>
<tr>
<th>Type of referral</th>
<th>N.º of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treatment Teams</td>
</tr>
<tr>
<td>Referral</td>
<td>179</td>
</tr>
<tr>
<td>Second Referral a)</td>
<td>90</td>
</tr>
<tr>
<td>Follow-up treatment</td>
<td>376</td>
</tr>
<tr>
<td>Total</td>
<td>645</td>
</tr>
</tbody>
</table>

a) When an individual goes to a CDT for the second time and has already a process open, he is referred for the second time

Table 38 - Provisional Suspension of the processes from Drug Addicts – voluntary treatment (IDT, I.P. 2010)

Of the 778 drug addicts presented to the CDTs, 747 (96%) voluntarily agreed to go to treatment, under a suspension of the process. From those, 215 (28.8%) had never
established contact with treatment facilities, 94 (12.6%) reinitiate the treatment once had left and 438 (58.6%) were under treatment at the time when the offence occurred.

<table>
<thead>
<tr>
<th>Type of answers</th>
<th>N.º</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without motivation diligence</td>
<td>1.312</td>
</tr>
<tr>
<td>Only motivation diligence</td>
<td>771</td>
</tr>
<tr>
<td>Motivation diligences and referral for support structures</td>
<td>522</td>
</tr>
<tr>
<td>Direct referral to support structures</td>
<td>958</td>
</tr>
<tr>
<td>Total</td>
<td>3.563</td>
</tr>
</tbody>
</table>

Table 39 – Provisional Suspension of the process for primary Non-drug addicts (IDT, I.P. 2010)

From the total number of individuals non-drug addicts (3 563), 771 (21.6%) were subject only to diligence of motivation, 522 (14.6%) were subject to measures of motivation and referred for support and 958 (26.8%) were directly referred for support without motivation diligence.

Therefore, it should be noted that 57.6% (3 563) of the non-drug addicts were considered consumers in a problematic situation which could indicate major risk towards an addiction, needing expert support and differential approach. For the remaining 1 312 (36.8%), mostly were consumption situations, that after psychosocial evaluation, the technical staff considered not worthy of any intervention as they were not risk situations.

The number of non-drug addicts defendants that were subject to motivation diligence and/or referred to support structures in 2009, registered an increase in relation to 2008 (+ 132%) and to 2007 (+ 148%).

Also in the context of referrals, some were made through the application of non-pecuniary sanctions. Almost all penalties consisted on regular presentations at a designated local, usually the CDT, the Health Services or Police Authorities.

### 9.5. Drug use and problem drug use in prisons

In 2009 there were no new studies on drug use in prisons, so we continue to report here the last study realized. In 2007, the II National Prison Survey on Psychoactive Substances (Torres2007) was implemented (first study was in 2001). As for the 2001 project, the survey used a random sample of 20% of the individuals in prison. Directors and staff were also interviewed on perceptions. The sample was representative at national level and comparability with the EMCDDA’s Standard Table 12 was ensured.

The IDT commissioned for the second time a prison survey. The survey was conducted on a random sample of 2 394 (2 601 in 2001) imprisoned individuals (20% of all imprisoned individuals in Portugal - Continent and Isles) from whom 1986 (2 057 in 2001) valid, anonymous and self-completed questionnaires were collected in 44 prisons (47 in 2001).

See also chapters 5.4 and 7.3.

Results from national study implemented in 2007 in the prison population show that cannabis, cocaine and heroin are the substances with higher prevalence of use in these population, as in the prior imprisonment context (respectively 48,4%, 35,3% and 29,9%) as in prison (respectively 29,8%, 9,9% and 13,5%). Between 2001 and 2007, a generalised decrease was verified in the prevalence’s of drug consumption in both contexts, but more accentuated in the prison context. To note the important reduction of intravenous drug use in
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related to 2001, in prior imprisonment context (27% in 2001 and 18% in 2007) and prison context (11% in 2001 and 3% in 2007).

In 2007, as in 2001 cannabis was the illicit substance that registered the highest prevalence of use in the context prior to imprisonment and in prison. Contrarily to 2001, in 2007, in prior to imprisonment context, the prevalence’s of cocaine use was superior to heroin; the inverse situation was verified in prison context, similar to what happened in 2001.

Graph 54 – National Prisoner Population: Lifetime Prevalence, by type of Drug (IDT, I.P. 2009)

Between 2001 and 2007, a generalised decrease of the prevalence’s of use between the prisoners population was evidenced. Such was verified at the level of several contexts and illicit substances, being the only exception the slight increase in the prevalence of use of ecstasy (experienced at least once) before imprisonment. In both contexts - prior to

imprisonment and in prison - special accent to the decrease of prevalence’s use of heroin and cocaine.

The evolution pattern of lifetime prevalence of any illicit substance decrease between 2001 and 2007 was not maintained, at the female level and older age groups (more than 35 years), where increases were verified.

Both in 2001 and in 2007, was noted that prison has a containment role in consumption, being the decrease of consumption with entrance in prison more accentuated in 2007. However, in prison, the regular consumption – everyday in the last month – of several illicit substances with the exception of heroin and cocaine was superior in 2007.

In 2007 an important reduction of intravenous drug use in relation to 2001 was verified, in the context prior to imprisonment (18% in 2007 and 27% in 2001) and in prison (3% in 2007 and 11% in 2001).

Concerning lifetime prevalence’s of 2001 to 2007, the results indicate:

- slight decrease in the percentage of prisoners that consumed drugs, being superior to the values of general population;
- Decrease of the percentage of prisoners that consumed heroin, cocaine, medicines of the type tranquilisers, amphetamines and other substances.

9.6. Responses to drug-related health issues in prisons

Drug treatment

The referral to treatment is encouraged in the prison setting, as is ensured to all new inmates the continuity of pharmacological treatments initiated in freedom.

Concerning treatment, the General Directorate for Prisons (DGSP) coordinates programs aimed at abstinence (Drug Free Wings and Exit Units) and pharmacological programs (with opioids agonists and antagonists), being important to refer that the number of inmates participating in treatment programs in prisons settings was in December 2009 the highest of
the decade: 1300. From those, 1015 were in substitution treatment, 120 in detoxification, 85 in substitution treatment with Suboxone and finally, 80 in opioid agonist programs.

In the context of the National Action Plan Against Spread of Infectious Diseases in Prison (PANCPDI), were organized several actions to raise information/awareness among the prison population, to promote the acquisition of healthy lifestyles and increase knowledge on the psychoactive substances use and their associated risks. These activities focused the prevention of use and the motivation to treatment. 205 actions were developed on healthy behaviours, the use of psychoactive substances/polydrug use, new drugs, harm and risks associated to use, etc. 4355 inmates participated in those actions.

With the entry into force of the Guide of Procedures for Health Care in Prison Settings in 2009, certain practices were strengthened, namely the importance of identification and referral of inmates that are close to release to the adequate health structures, so they won’t interrupt treatment.

In order to standardize the procedures adopted in all prisons concerning the interventions of health promotion, which inevitably include drug addiction, the Guide foresees the drafting and the implementation of programs to promote health and disease prevention, bearing in mind the persons which enter daily in the Portuguese prisons.

**Prevention and reduction of drug-related harm**

In 2009, although many of the actions of information/awareness on health promotion and drug addiction developed in prison settings also addressed the Harm and risk reduction issues, 13 specific actions on risk reduction were promoted, comprising 272 inmates.

Such initiatives covered various topics, including: programs to reduce harm and risk; morbidity and co-morbidity associated with risk behaviours, risks associated with piercings and tattoos, risk behaviour and protective behaviour; the acquisition of healthy lifestyles, among others.

In July 2009, the Report of the National Action Plan Against the Spread of Infectious Diseases in Prison (PANCPDI) was prepared in collaboration with IDT, I.P. and National coordination for HIV/AIDS Infection (CNIVS), which focused on two main areas: the Plan itself, in its different areas with national coverage and the pilot project developed in two prisons (Paços Ferreira and Lisbon) that integrates the Needle Exchange Program.

Concerning the Plan, quantitative data, evaluation criteria and proposals for the development of specific actions, in its different aspects were presented. In the case of the Needle Exchange Program, there was an assessment synthesis and the presentation of proposals for development.

**Prevention, Treatment and care of infectious diseases**

The implementation of the National action plan against spread of infectious diseases in prison settings (PANCPDI) followed the schedule. The prisons organised during 2009, 205 interventions, involving 4 355 inmates, in the areas of: healthy behaviours; use of psychoactive substances, polydrug use, new psychoactive substances, use related risks, harm and risks related to the use and abuse of psychoactive substances, etc.

See also information on Prevention and reduction of drug-related harm.

**Prevention of overdose-risk upon prison release**

See chapter 7.3.
9.7. Reintegration of drug users after release from prison

In the area of education and training several activities were continued, promoted by partners, always with the aim of creating conditions for increasing skills and educational qualifications in the inmates.

In the academic year of 2009, 2 264 inmates were attending classes, distributed in the following levels:

<table>
<thead>
<tr>
<th>Education levels</th>
<th>Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} cycle and Educational and Vocational Training for Adults</td>
<td>612</td>
</tr>
<tr>
<td>2\textsuperscript{nd} cycle and Educational and Vocational Training for Adults</td>
<td>544</td>
</tr>
<tr>
<td>3\textsuperscript{rd} cycle and Educational and Vocational Training for Adults</td>
<td>729</td>
</tr>
<tr>
<td>Secondary</td>
<td>332</td>
</tr>
<tr>
<td>University</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>2.264</td>
</tr>
</tbody>
</table>

Table 40 – Inmates attending school (IDT, I.P. 2010)

The training in prison setting aims at providing to inmates tools to a better social and professional reintegration, through the acquisition of technical and social skills, for a qualified professional performance and personal/social development. The actions conceived were more flexible and shorter.

The training modalities used in 2009 were the following: education and training courses of double certification for adults; certified training modules and training for inclusion.

The training strategy of DGSP involved also the reinforcement of training activities in partnership with new organizations and the strengthening of others in the development and implementation of the training interventions. In 2009, 2 000 inmates participated in professional training activities.

In the area of work/professional activity, DGSP tried to reinforce the network cooperation with organizations outside prisons, seeking to increase the employment rate among inmates, to create conditions for an improved professional training and future social/professional reintegration. Their occupation in the prison setting was as described above:
Concerning Protocols, it should be referred the Commitment of Collaboration involving the organizations that constitute the Territorial Nucleus of the Program of Integrated Responses (PRI) in Leiria Prison, signed in February 2009 and the Protocol DGSP/IDT, I.P. signed in August 2009.

The first Protocol was targeted to the inmates drug users and the employees (experts and prison guards), which will participate in awareness/training activities, for future collaboration and integration in the work teams. The general objectives were the prevention, dissuasion, harm and risk reduction, treatment and reintegration, through an integrated intervention. The second was aimed at providing health and psychosocial care, in the areas of treatment and reintegration, by the Treatment and Reintegration Teams, which gave therapeutic support, medical and psychosocial support to drug addicts inmates in the prisons of Algarve.

The reintegration of drug users after release from prison is undertaken in the framework of the national reintegration policy referred in chapter 8.
10. Drug Markets

10.1. Introduction

In 2009, increases were verified at the level of several indicators in the drug markets context, many of them registered the highest figures of the decade.

Once again was confirmed the trend through the decade of cannabis predominance and the increased visibility of cocaine in these contexts. Moreover, in 2009 there was a greater visibility of heroin, after the stability trend manifested in the second half of the decade and contrary to the continuous decrease verified in the first half.

For the eight consecutive year, hashish\textsuperscript{59} was the substance involved in a higher number of seizures (3 144) and for the first time in the last five years the number of heroin seizures (1 475) was superior to cocaine (1 421). The number of herbal cannabis (liamba) (568) and ecstasy (63) seizures continue to be much lower.

In general, the number of seizures of the several substances was the highest of the decade, noting in the last five years an increasing trend for almost all drugs, comparing to the first half of the decade.

Concerning the quantities seized, liamba registered in 2009 the highest value ever (around 5 045 kg) and cocaine registered the lowest value of the decade (around 2 697 kg).

Concerning countries of origin of the seized drugs in 2009, heroin came from Netherlands and Spain, cocaine from Brazil, Venezuela and Colombia, liamba from South Africa and once more hashish from Morocco. Despite the fact that vast majority of the seized quantities of several substances with information on the routes was destined to the internal market, an important large number of seizures had as final destination other countries, especially European – with particular emphasis to Spain – and Africans, maintaining the trend of Portugal to work as a transit point on international trafficking, particularly in the case of cocaine.

Regarding the prices\textsuperscript{60} of drugs, at trafficker and trafficker-user level, they were higher than in 2008 (with the exception of cannabis), being those of cocaine and liamba the highest since 2002. Despite the annual variations, since 2002 there has been a downward trend in the average prices of heroin and ecstasy, and an upward trend of liamba and cocaine, and stability in the average price of hashish.

10.2. Availability and supply

Regarding the main origin of the seized drugs in Portugal:

- Netherlands and Spain are the main origin of the heroin seized in 2009 (respectively - 36% and 21%) the origin of 32% of the seized heroin remains unknown;
- Brazil, Venezuela and Colombia are the main origin of cocaine seized in 2009 (respectively 45%, 13% and 6%) the origin of 25% of the seized cocaine remains unknown;
- Similarly to previous years, Morocco (51%) was the main origin country of the seized hashish but 48% of the seized hashish was from unknown origin;

\textsuperscript{59} Data relative to hashish include resin, and cannabis pollen.
\textsuperscript{60} Since 2002 that prices refers only to traffic and traffic-use market. Prices are reported by traffickers and traffickers-users (there is no information at retail/street level).
• Concerning herbal cannabis (liamba), South Africa (99%) was the main origin;
• Most of the seized ecstasy was from unknown origin.

Despite the fact that the vast majority of the seized quantities of several substances with information on the routes was destined to the internal market, a large number of seizures had as final destination other countries, especially European – with particular emphasis to Spain – and Africans, maintaining the trend of Portugal to work as a transit point on international trafficking, particularly in the case of cocaine.

According to 2007 General Population Survey (see Chapter 2), the Portuguese population perceived the access to substances in a 24-hour period more easy than in 2001.

According to the 2007 ECTAD survey (see Chapter 2), there was a decrease in the percentage of youngsters (13 to 18 years old) saying that is “very difficult” to have access to drugs and also of those saying that is “very easy”.

10.3. Seizures

Quantities and number of drug seizures (for more information see ST 13)

In terms of number of drug seizures and by the eighth consecutive year hashish was the main substance involved in seizures (1 444). Contrary to the trend verified in the four previous years, the number of cocaine seizures (1 421) was lower than heroin (1 475).

As usual, herbal cannabis (liamba) and ecstasy registered lower numbers of seizures (respectively 568 and 63). In relation to 2008, liamba registered an increase (+48%) and ecstasy a decrease (-28%) in the number of seizures in comparison to 2008.

In comparison to 2008, there were increases in the number of seizures of liamba (+48%), hashish (+20%) and heroin (+10%), in the case of cocaine a stability was verified (-1% in relation to 2008, year where it was registered the highest value since 2000) and once more a decrease in the number of ecstasy seizures (-28%). The number of heroin seizures was the highest since 2002, hashish and cannabis the highest of the decade and cocaine the second highest of the decade. Despite the annual fluctuations, in the last five years an increasing
trend in the number of seizures of almost all drugs is verified with the exception of ecstasy with a decreasing trend.

In addition to these seizures, in 2009 were confiscated several other substances and other forms of presentation of the substances mentioned above, but there is no record of any new substance.

Concerning the **quantity of seized drugs** in 2009, liamba registered the highest value of the last decade with 5 044 kg seized\(^{61}\), value far above of the ones registered in previous years, justified not by the increased number of seizures but mainly by the seizures involving very significant quantities in the international trafficking context. For the second consecutive year, the quantities of heroin seized increased in comparison to last year (+88%). In contrast, and despite the increased number of seizures, a decrease was verified in the quantities of hashish seized in comparison to 2008 (-63% than in 2008, year where was registered the highest value of the decade), in the quantity of cocaine seized (-45% than in 2008, registering the lowest value of the decade) and ecstasy (-87% than in 2008, presenting the lowest value of the decade).

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>Grammes</td>
<td>72 365</td>
<td>99 047</td>
<td>182 266</td>
<td>144 295</td>
<td>61 669</td>
<td>68 090</td>
<td>128 073</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3 016 881</td>
<td>7 422 752</td>
<td>18 083 231</td>
<td>34 477 476</td>
<td>7 362 975</td>
<td>4 877 905</td>
<td>2 697 083</td>
<td></td>
</tr>
<tr>
<td>Hashish a)</td>
<td>31 559 269</td>
<td>28 995 141</td>
<td>28 395 514</td>
<td>8 503 664</td>
<td>44 623 450</td>
<td>61 262 140</td>
<td>22 965 577</td>
<td></td>
</tr>
<tr>
<td>Liamba</td>
<td>264 821</td>
<td>118 929</td>
<td>121 394</td>
<td>151 915</td>
<td>133 300</td>
<td>36 634</td>
<td>5 044 569</td>
<td></td>
</tr>
<tr>
<td>Pills</td>
<td>165 539</td>
<td>111 833</td>
<td>213 788</td>
<td>133 290</td>
<td>70 591</td>
<td>70 309</td>
<td>8 987</td>
<td></td>
</tr>
<tr>
<td>Ecstasy b)</td>
<td>165 539</td>
<td>111 833</td>
<td>213 788</td>
<td>133 290</td>
<td>70 591</td>
<td>70 309</td>
<td>8 987</td>
<td></td>
</tr>
</tbody>
</table>

\(\text{a) Hashish quantities include resin and cannabis pollen.}\)

\(\text{b) Ground and dust Ecstasy seized quantities were converted in pills, according to the Administrative Rule 94/96 of 26 of March}\)

Table 42 – Drug seized, by year and by type of drug 2003-2009 (IDT, I.P. 2010)

Seizures involving **significant quantities**\(^{62}\) in 2009 represented 5% of the total number of heroin seizures, 3% of hashish, 3% of liamba, 3% of ecstasy and 18% of cocaine seizures. However, in terms of quantities seized, those seizures involving significant amounts accounted for almost all of the liamba, hashish and cocaine seized (99% or more) and most of the heroin and ecstasy seized in the country in 2009 (91% of heroin and 78% of ecstasy).

At regional level, the highest number of heroin, cocaine and hashish seizures was registered in the districts of Lisbon and Oporto, liamba in the Autonomous Region of Azores and in the districts of Braga, Oporto and Lisbon, the highest number of ecstasy seizures was registered in the districts of Portalegre and Lisbon. In terms of quantities seized, stood out the district of Lisbon at the various substances, with the exception of hashish that was seized in Faro, and it is also to note, the districts of Guarda and Oporto in the case of heroin, Azores and Oporto at cocaine level, Setúbal in the case of hashish and Portalegre at ecstasy level.

\(\text{\(^{61}\) In this chapter data related to hashish include resin and cannabis pollen.}\)

\(\text{\(^{62}\) For heroin and cocaine, quantities equal or above 100g are considered and in the case of cannabis quantities equal or above 1000g are considered in the case of ecstasy equal or above 250 pills, according to the criteria used by the UN. The percentages presented here were calculated on the seizures expressed in grammes, or in the case of ecstasy in pills (quantities seized of ground ecstasy or in dust were converted in pills, according to the Administrative Rule 94/96 of 26 March).}\)
10.4. Price/Purity

The average price of drugs in 2009 was superior to the one registered in 2008, with the exception of hashish. However, the average price of heroin remained inferior to the one registered between 2002 and 2007, while cocaine and liamba registered the highest values since 2002. For the fifth consecutive year, the average prices of heroin registered a lower value than cocaine.

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Year 2003</th>
<th>Year 2004</th>
<th>Year 2005</th>
<th>Year 2006</th>
<th>Year 2007</th>
<th>Year 2008</th>
<th>Year 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>46.80 €</td>
<td>46.54 €</td>
<td>41.01 €</td>
<td>42.17 €</td>
<td>37.57 €</td>
<td>33.25 €</td>
<td>36.62 €</td>
</tr>
<tr>
<td>Cocaine</td>
<td>41.40 €</td>
<td>42.23 €</td>
<td>45.11 €</td>
<td>45.73 €</td>
<td>44.65 €</td>
<td>45.56 €</td>
<td>47.44 €</td>
</tr>
<tr>
<td>Hashish</td>
<td>2.49 €</td>
<td>2.31 €</td>
<td>2.13 €</td>
<td>2.18 €</td>
<td>3.45 €</td>
<td>3.28 €</td>
<td>2.99 €</td>
</tr>
<tr>
<td>Herbal cannabis</td>
<td>4.00 €</td>
<td>2.66 €</td>
<td>3.67 €</td>
<td>2.15 €</td>
<td>4.70 €</td>
<td>5.09 €</td>
<td>6.22 €</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>5.27 €</td>
<td>4.50 €</td>
<td>3.56 €</td>
<td>3.18 €</td>
<td>3.20 €</td>
<td>2.80 €</td>
<td></td>
</tr>
</tbody>
</table>

*Prices posterior to 2001 refers only to trafficking and trafficking-use market

a) No sufficient data to proceed with the calculation of average price

Table 43 – Average* price of drugs 2003-2009 (IDT, I.P. 2010)

Despite annual variations, since 2002 a decrease trend is verified in the average prices of heroin and ecstasy, an increase trend in the average price of liamba and cocaine and stability in the average price of hashish.

In 2009, concerning purity, and according to the data reported in Standard Table 14, there were no significant changes comparing to 2008. Despite the increase in the number of toxicological analysis, there were no significant changes in the purity of substances.

The composition of pills sold at street level, as reported in Standard Table 15, indicated a considerable increase of tablets containing mCPP and BZP.

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83Since 2001 prices refer only to traffic and traffic-use market. Prices are reported by traffickers and traffickers-users (there is no information at retail/street level).
Part B

Selected Issues
11. History, methods and implementation of national treatment guidelines

11.1. History and overall framework

Until 1987 there was no inter-departmental drug abuse prevention plan in Portugal. In 1976 the Cabinet for Coordinating the Fight Against Drugs (GCCD) was created, under the Presidency Council of Ministers. This Cabinet coordinated and gathered information from other two Centres for the Study and Profilaxy of Drugs (CEPD). These three structures were responsible for demand reduction issues and the Centre for Drug Research and Control (CICD) was responsible for supply reduction. By that time, some hospitals, as for instance Santa Maria in Lisbon, also provided drug treatment services.

The National Program Projecto VIDA was created in 1987, under the name Integrated Drugs Fight Plan. Aware of the complexity of the drug problem, the government proposed 30 measures, including prevention, treatment, reintegration and supply reduction, to be implemented by 6 different Ministries. At the same time, Portugal was facing an important drug problem of heroin and cannabis and the Taipas Centre was created in Lisbon by the Ministry of Health. It was conceived as an integrated unit, comprising an outpatient clinic, an inpatient detoxification unit, a 24 hour emergency unit (to handle psychological emergencies rather than life-threatening intoxications) and a day care unit with a strong reintegration purpose. The team was young and very motivated and included psychiatrists, psychologists, nurses and social workers. During the first year, there were 3000 new patients in treatment.

In 1989 two other specialised centres were opened in Oporto and Faro and, in 1990, the Ministry of Health created the Service for the Prevention and Treatment of Drug Abuse (SPTT), a department to which was given the responsibility of implementing and managing the specialised treatment centres, including the CEPDs, which were integrated in this Service.

In 1990, some of Projecto VIDA’s 30 measures were restructured and the Interministerial Commission and the National Council were created to increase the political commitment in the fight against drugs, as well as to mobilise the civil society awareness to the problem.

The main Drug Law was issued in 1993, as well as directives related to money laundering, certification of NGO’s working in the field of drug treatment and Projecto VIDA’s access to lottery revenues for funding demand reduction projects.

The problem of drug abuse was always recognised in its medical aspects. Even before the treatment centres were integrated in the Ministry of Health, the psycho-social and prevention aspects always played a significant part in the approach of the problem. At that time, however, there was some concern about the close institutional relationship between the treatment and the legal systems. By giving the Ministry of Health the responsibility of drug treatment in 1987, the Government recognises the need to formally separate supply and demand issues and to face the drug user as a person with a health problem independent from the legal/criminal consequences of the act. The same philosophy is reflected in the Drug Law which states that offenders who committed drug related crimes and have a drug problem may, in certain circumstances, be given a suspended sentence if they entry in a drug treatment program.

Separation of supply reduction and demand reduction areas is also reflected in Projecto VIDA’s philosophy. The relevant legislation started by including into the national program measures related to both supply and demand issues and lead to the redefinition of Projecto VIDA as the National Drug Abuse Prevention Program, which maintains a close contact with the public authorities in the area of supply reduction, but has only legal competencies in prevention issues.

During the nineties, many outpatient clinics were created, one in each city and several in the suburban areas of Lisbon and Oporto, comprising 45 teams working in 78 outpatient clinics.
Often, through a process of meiosis, each pioneer team would divide itself into two or three new autonomous centres.

During this fast growing period, a large number of professionals with different background, including several general practitioners, felt motivated to work in the Institute, either full or part-time, while there was a shortage of psychiatrists in the country.

Each new team leader always had a training period of up to three months in one of the pioneer comprehensive centres, learning with senior colleagues the daily clinical practice of outpatient and inpatient units. Other members of the new team, psychologists, social workers and nurses, also received their own training. When someone had a difficult clinical situation there was always a senior colleague, or the national clinical director, one could contact and ask for advice. The professionals of the different teams had regular clinical supervision, a practice which has given consistency to the professional intervention.

After the general elections in March 2002, the new government’s program in this area stated “drug abuse as a health problem and the need for the government to act in order to minimise this social problem”.

The same document maintains the Portuguese Institute for Drugs and Drug Addiction (IPDT) as the coordinating agency in the field but relocates it from the Presidency of the Council of Ministers to the Ministry of Health, now responsible for drug issues coordination. General national priorities include: for prevention - the promotion of healthy lifestyles; for treatment - further coordination and quality control, as well as more support to drug users in prison; and, for rehabilitation - redefinition of the rehabilitation programs after their current evaluation. Special emphasis is placed upon the setting up of outreach work programs, and of all initiatives, which may prevent drug, related infectious diseases, namely AIDS/HIV.

In November 2002 the Institute on Drugs and Drug Addiction (IDT) was set up, resulting from the merger between the Service for the Prevention and Treatment of Drug Abuse (Serviço de Prevenção e Tratamento da Toxicodependência – SPTT) and the Portuguese Institute for Drugs and Drug Addiction (IPDT).

Between 1997 and 2002, the Institute promoted eight comprehensive courses of post-graduate level to professionals working or intending to work in drug addiction, summing 200 participants. Each course was composed of a theoretical part of 80 hours and a practical instruction of 200 hours.

Since 1988, and for more than 20 consecutive years, the ‘Taipas’ Centre has promoted an annual 2-day national scientific meeting. Everybody attended the meeting which contributed to the maintenance of a social network. Invited foreign scientists and clinical doctors, mainly from France, Spain and the USA, bring new scientific discoveries and new methodologies. In the last 8 years, likewise, the Institute has also promoted an annual national congress.

As a rule, each team organizes regular events (conferences or workshops), way of sharing knowledge and clinical practice and discussing with other professionals their latest experiences and results.

11.2. Existing guidelines: narrative description of existing guidelines

11.3. Implementation process

In Portugal, the role of guidelines in assisting practitioners about the most adequate intervention in a specific situation was always recognised. Several guidelines were developed with a view to ensure treatment appropriateness and homogeneity of interventions. Below, some of those guidelines are described.
1. Manual of concepts and procedures of the Multidisciplinary Information System

Since the creation in Portugal of a national body coordinating the drug-related treatment that the gathering and data analysis of the population treated has become a priority.

In this context, we tried to build (between 1990 and 1995) a chart of data collection allowing to define users profile and evolution. At that moment, it wasn’t possible to go further than the number of new patients and the number of consultations. Also, each year was promoted an analysis based on the different socio-demographic and clinical data collected in a representative sample of the users.

In 1995-2002 period, a new impulse was giving to the National Information System, with the identification of the information needed, the creation of tools for gathering and recording data and implementation of the System in the local units. In 2003, due to a reorganisation of services, the System was stoped, jeopardizing its national coverage.

In 2005, the strategy concerning the National Information System was revised and the key elements for the Multidisciplinary Information System defined, using part of the previous requirements and therefore developing an online clinical file.

This substantial evolution facilitated access of different experts to their colleague’s registrations, promoting the cohesion and the articulation of the multiple somatic, psychological and social interventions. Also, the dissemination of information was increased, allowing for the patient to be followed in his therapeutic way by the clinical file.

The Multidisciplinary Information System created standardized registers for each professional domain (Medecine, Psychology, Nursing, Social intervention, Occupational Therapy, Physiotherapy and Nutrition (ICD 10\textsuperscript{64}, ICPC\textsuperscript{65}, ICNP\textsuperscript{66}, etc.).

This achievement was reached by developing an informatic application centralized, accessible via browser from any IDT, I.P. network spot, which gathers more then 70 local databases and promotes a strict control of the repeating users and the data analysis and information production.

In conjuntion with the importance of developing record data tools, it was defined that, due to the number and diversity of professionals responsible for collecting and recording data, as well as the size of the records, guidelines to promote more reliable information based on the Multidisciplinary Information System should be drafted.

A Manual of Procedures and Concepts was developed, integrating EMCDDA’s and other international and national sources, which aims to harmonize the interpretation of concepts and the data collection procedures and defines the various tasks with specific instructions to perform them. Thus it attempts to answer the question: “Who collects? Which data? When? How?”

This Manual was built as a dynamic tool that, will evolve with the contributions, questions and requests for clarification of the local IDT, I.P. units. At the same time, procedures for periodical monitoring of data reliability are being implemented near the points of gathering and recording information.

In terms of data processing, an application called “Business Intelligence” is being created, which, allowing for standardized reporting, will answer to most of the information needs for supporting clinical or management decisions or to respond to EMCDDA and WHO requests.

The implementation of this System started in 2009 and is close to conclusion. It involved approximately 1 200 professionals (who will use daily this tool), the migration of 70

\textsuperscript{64} International Classification of Diseases.  
\textsuperscript{65} International Classification of Primary Care.  
\textsuperscript{66} International Classification of Nursing Practice.
Cost of drug-related treatment in Europe: a comparative analysis

databases of 3 different systems and the setting up of an helpdesk particularly active in this initial period.

Naturally, such a project involved an adjustment period of several tools, from tuning of IT infrastructure (network communications equipment, servers, tuning the database, etc...), to functional evolution of the application (by improving their integration into the daily work of different professionals and correcting errors identified), through the organizational adaptation to a model that is intended to be more demanding and rigorous on the information production.

2. Regulations for inpatient treatment in private institutions and their governmental financial support

Health care for drug users is organised in Portugal mainly through the public network services of treatment for illicit substance dependence, under the Institute on Drugs and Drug Addiction and the Ministry of Health. In addition to public services, certification and protocols between NGOs and other public or private treatment services ensure a wide access to quality-controlled services encompassing several treatment modalities.

Portugal considered necessary to regulate the functioning of these private units, with profit or not, and adopted in 1999 the legal framework to support the families of drug users in the area of treatment (Decree Law n° 72/99, of March 15th).

This Decree defined the reimbursement to be granted by the state, the costs incurred by patients in treatment in private health units and the requirements, procedures, mechanisms and criteria for funding of services. Their functioning is regulated in different aspects such as: overall capacity of the unit (number of beds in therapeutic communities and detoxification clinics, number of users for day care centers), duration of specific treatments and amount to be paid by State for each user, etc.

With the new competences of IDT, I.P. in alcohol issues, the Government extended to alcoholics the treatment instruments available for drug users (Order n° 18683 of July 14th). The fact that these rules are inscribed in a legal text allowed for a better implementation, as they are mandatory for private health units, being IDP, I.P. responsible for their supervision.

3. Manual of Standards Guiding Therapeutic Program with Opioid Agonist

The therapeutic programs with opioid agonist aimed at replacing the illicit use of an opioid by the administration of an opioid drug prescription, full or partial agonist (Methadone or Buprenorphine), procedure which should facilitate stopping or reducing the illicit use and to reduce the risks and arms related to a risky behavior. This is a substitution treatment, usually temporary, in a user already addicted to opioids.

Opioid agonists are important resources in providing health care for some patients dependent on opioids. The use of these substances allow:

- To be integrated in a therapeutic program and to facilitate the treatment of other diseases, psychic or somatic, that may coexist in the drug users.
- To reduce the use of illicit substances and limit the use of injection, source of viral transmission and infections;
- To counter exclusion and improve the social and professional insertion;
- To improve interpersonal and family relationships;
- To promote the ability to live without using any psychoactive substances, including methadone or other opioids.
In Portugal the use of methadone was initiated in Oporto in 1978 and currently remains the drug most used in opioid substitution treatment.

The Levoalfacetilmetadol - LAAM - was introduced in Portugal in 1995, but suspended in 2000 after a recommendation of the European Medicines Agency (EMEA), following reports of serious cardiac disorders in patients undergoing therapy with LAAM.

Buprenorphine, marketed in Portugal as Subutex and used for the first time in 1999, is currently the 2nd most commonly used in therapeutic programs with opioid agonist.

Substitution treatment is widely available in Portugal, through public services such as specialised treatment centres, health centres, hospitals and pharmacies as well as NGOs and non-profit organizations.

In the beginning, each treatment team prepared their own set of guidelines and afterwards, in 2006, the IDP, I.P. developed an instrument for clarifying and guiding the intervention: a Manual of Standards Guiding Therapeutic Program with Opioid Agonist, with the purpose of standardizing procedures, methodologies and terminology and thus promoting greater consistency in the intervention. This manual is waiting formal approval, but is already used in daily work practices of the professionals involved in substitution treatment processes.

4. National guidelines for the social intervention in reintegration

In 2009, the Guidelines for Social Intervention - An Intervention Model in Reintegration (MIR) were adopted, constituting a set of principles and assumptions which configure strategic pillars of intervention with drug users.

The guidelines, developed by a working group with experts on illicit substances and alcohol coming from different regions, was a process widely participated with debates on reintegration, concepts and of deepening knowledge on the practices and services provided, gathering and systematizing several years of experience of IDT, I.P. experts.

Based on the models of integrated intervention and case management preconised by IDT, I.P., the objective of these guidelines for social intervention are: 1) to promote the sistematization and harmonization of interventions in reintegration; 2) to promote the efficiency and effectiveness of social intervention trough a common methodology for planning, assessment, intervention, monitoring and evaluation used by all professionals and available to all users; 3) to ensure the quality of the intervention, considering the assessment and the comparability in the sense of continuous improvement and full quality.

This model of intervention, underlying a set of assumptions that frame the professional and ethics practices of the reintegration teams, should be adapted to the specific characteristics of intervention contexts and to users.

The following elements should be emphasized:

a) Putting users at the center of the action, guaranteeing and ensuring full accomplishment of their citizenship rights and duties, in the respect of the dignity and freedom of choice of users as an ethic pattern to guide all activity.

b) Assess the multidimensional needs of users, through the development of a social diagnosis and inventory of the multidimensional needs and different implications for the integration path.

c) Create a meaningful relationship with the patient, based on mutual trust. The involvement and committement of the expert in users acquisitions , contributing to the establishment of a relationship of trust and complicity, encouraging users to continue their reintegration process with determination and trust.

d) Negotiate and contractualize an Insertion Individual Plan, reflected in the drafting of the whole integration path, defining objectives, strategies to be taken, responsabilities and goals,
priority actions at medium and long term, which meet the personal and social needs of the patient, as they are defined at each step of the evaluation process.

e) Intervene in a logic of integrated response, at team level and on interinstitutional and intrainstitutional articulation. The connexion of the different IDT, I.P. areas involved in the process of users reabilitination, as well as the close collaboration with external partners, appears to be an inalienable factor in integrated interventions, only way of satisfying needs for individual development, maximizing available resources and adapting them to the the interventions needed.

f) Ensure the continuous and systematic monitoring of users in the process of empowerment and integration in a case management logic. The continuous and systematic monitoring starts when the social diagnosis and the Insertion Individual Plan are concluded and should continue untill the user needs are fulfilled and the Insertion Individual Plan accomplished and evaluated. Tracking the insertion path is also accompanied by the support to the acquisition and development of tools of personal, social and professionals competences, which can reduce the insecurity feeling and promote a behaviour and progressive trust in himself and others.

g) Ensure the development of practices of social mediation, aimed at creating conditions for the social systems to guaranty the effectiveness and sustainability of interventions undertaken at individual level, the reorganization of routines and reference frames in the acquisition and/or repurchase of personal, social, professional and citizenship skills.

This Model of Intervention applies to all IDT, I.P. users, which problematic use of psychoactive substances require a specialized social intervention.

The phases of MIR are: 1) the initial assessment of the situation with the drafting of a social diagnosis, which allows negotiation and contractualization; 2) planning and Insertion Individual Plan; 3) an intermediate evaluation of the Insertion Individual Plan for a period set by the expert; 4) final evaluation of the Insertion Individual Plan; 5) social release; 6) follow-up.

Tools for social assessment and for the development and evaluation of the Insertion Individual Plan were created as instruments to support the Model’s implementation.

In October 2009, the guidelines were distributed to the regional and local IDT, I.P. structures as Technical Guidelines with the assumption that their implementation had to be in accordance with the specific characteristics of each service and team, context of intervention and target users. They were adopted by 87% of the services and a year later, their implementation is under evaluation, to identify constraints and introduce improvements. The results of this evaluation will be available in 2011.

5. Building an ICNP1.0® Catalogue on Alcohol and Other Drug Addictions

By 2009, the different informatic documentation systems on heath care in the IDT, I. P. did not cover nursing interventions. In the absence of previous standartization, the record of these interventions were in paper format, with important discrepancies (as there are 56 care units in the country) and various denominations for similar interventions or the same denomination with different meanings. This situation made impossible to count nursing interventions in addictions and impossible to ensure the continuity of this kind of care for addicts, a typology of clients with important geographical mobility.

The National Multidisciplinary Information System, implemented in 2009 in all outpatient services, included an initial standard nursing information system, which already establishes the more usual nursing diagnosis and interventions for patients with alcohol and/or drug addiction related problems. This catalogue adopts the terminology of International Classification for the Nursing Practice (ICNP®), supports nurses in the definition of nursing
diagnosis and guide their decisions within their respective clinical interventions. The catalogue is not standardized, but has been used at national level (only mainland) by all nurses in outpatient services.

The International Classification for Nursing Practice (ICNP®) Program of International Council of Nurses (ICN) was contacted in an attempt to develop and improve the registration system and to obtain information on other ongoing projects in the field of nursing addiction. As ICN was not aware of this or any other catalogue or project in this area, IDT, I.P. decided to give continuity to our project.

So, since June 2009, a team of eight nurses working with addicts in the five regional delegations of IDT, I.P. (five of them working in outpatient units and the others three working in inpatients units), is developing the first ICNP® Nursing Minimum Data Set (NMDS) in the addiction area known around the world. This Catalogue on Addictions Nursing will include diagnosis, interventions and outcomes sensitive to nursing care and their intensity. The project includes the participation of a nurse from the Portuguese Nursing Order and can be found at http://www.icn.ch/ID182.htm.

In a near future, the group also intends to ask for the cooperation of Members of the National Association of Users of Psychoactive Substances (CASO-Association), which is being created and will contribute to the validation of the contents of the ICNP® Catalogue.

The ICNP1.0® catalogue used in the inpatient services of IDT, I.P., should be concluded by December 2010, followed by the preparation of the future ICNP1.0® catalogue for the outpatient services. The produced catalogues will be sent to the Nursing Order.

6. **Support Guide for the Intervention in Harm and Risk reduction**

The Support Guide on Intervention in Harm and Risk Reduction (the “Support Guide”) was developed in a context where the National Network for Harm and risk reduction expanded in number and diversity of specialized agencies implemented and when the existing guidelines were exclusively focused on a specific type of agency, the street teams. By that time, other structures more expressive than the street teams were implemented, of low threshold, such as the Support Units for drug users without social/familiar integration, the Substitution Treatment in low-threshold and Contact Points (structures defined by the Decree-Law No 183/2001 of 21 June).

Two other factors, added to this scenario, contributed to the need of establishing intervention guidelines in Harm and Risk Reduction (RRMD): the fact that this being a relative new area of intervention meant that few publications existed in Portugal and that the main model of implementation for specialized agencies in RRMD was the private/public paternship, which requires a greater effort to promote quality standards.

Thus, the definition of the Support Guide was based on the definition of a scientific and technical framework for RRMD intervention, as developed by several non-governmental agencies.

The Support Guide was therefore targeted to non-governmental agencies that implement RRMD projects, but also to IDT, I.P. experts in charge of monitoring these projects.

In the drafting of this Guide, were involved several experts and governmental agencies working in this field, in a way to reflect the state of play of the scientific literature and debate and the Portuguese experience. The Support Guide covers also several aspects as the integration of RRMD in the strategy against addictions, the concept definition, the RRMD paradigm, the scope of this type of behaviour, its guiding principles and objectives. On the other hand, it also seeks to define the essential elements of each type of specialized structures inscribed in the legislation, finally addressing the issue of expert’s teams.
Once published, the Support Guide was launched at the IDT, I.P. National Conference in May 2010 and distributed to the Institute decentralized bodies, especially among those responsible for the coordination of the RRMD mission at regional and local level and to all specialized agencies partners of IDT, I.P., being used as background material for training programs in RRMD.

Currently, it is foreseen to make an assessment by the second semester of 2011 on the knowledge and appreciation of the Guide among the target audiences.

### 7. Technical Guidelines for the Implementation of Programs of Opioid Substitution of Low Threshold

The relevance of the definition of the Technical Guidelines for the Implementation of Programs of Opioid Substitution of Low Threshold (the "Technical Guidelines for the PSO-BLE) is determined by the nature of this type of program, which involves the handling of a medicinal product. By their nature, complexity and level of adjustment to a specific population, the implementation of these programs requires clear guidelines that constitute a support for the professionals who execute them locally, while ensuring that users have access to a program with high level of quality.

Based on the principles of pragmatism and humanism, the programs and measures of harm and risk reduction were inscribed in the National Strategy on the Fight Against Drugs (1999-2004), adopted by the Council of Ministers - Resolution No. 46/99 of April 22th (Presidency of the Council of Ministers, 1999).

Following the Strategy and the subsequent recognition of the legitimacy of these measures by international agencies, a first diploma defining the structures of harm reduction was adopted. This legislation (Decree-Law No. 183/2001, 21st June) defines the legal framework of the Prevention, Harm and Risk Reduction Policies. As stated in Article No. 42 of the Decree-Law the PSO-BLE pursue the following objectives:

A) The decrease of heroin use, its replacement by methadone to be distributed through programs of high accessibility, without requiring immediate withdrawal and in adequate facilities;

B) The increase and the regularity of contacts drug users/ health team, which can contribute, particularly to future withdrawal."

Also, in the National Plan Against Drugs and Drug Addiction 2005-2012, the need to provide, in comprehensive and coordinated programs, opioid substitution of low-threshold is reinforced. The implementation of these responses is guided by the logic of proximity and focus on the individual, emphasizing values such as citizenship, participation and accessibility.

However this measure was only regulated on 2007, June 25th, by the Administrative Rule No. 748 and 749 of 25 June 2007 (Annex II), which set the requirements and procedure for the establishment and functioning of programs and structures of Harm and Risk Reduction and the rules for allocating public funding.

For developing the "Technical Guidelines for the PSO-BLE", IDT, I.P. conducted a study which characterized the PSO-BLE implemented in the treatment facilities, noting that there was a wide variety of rules, procedures and objectives. Moreover, the fact that the IDP, I.P. also finances non-governmental organizations, which implement this type of program would also carry greater diversity of practices. Thus, notwithstanding the necessary adjustments to local and individual realities, it was considered important to set guidelines.

Thus, the "Technical Guidelines for the PSO-BLE" target all professionals in public and private organizations that intervene in these programs. Its definition involved the analysis of existing guidelines at international level and practices in various treatment facilities. The first
draft was done by IDT, I.P. involving also the Clinical Management and on a second phase, it was sent to the decentralized IDT, I.P. units for discussion.

This document is still under discussion, but its approval is expected shortly. Despite this, in 2009 IDT, I.P. organized, at regional level, several training sessions and meetings to explain the guidelines.

11.4. Comparison with WHO guidelines

<table>
<thead>
<tr>
<th>Name of Assessors: Dr. José Pádua – Director of Treatment and Rehabilitation Department, IDT, I.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Choice of treatment</td>
</tr>
<tr>
<td>1.2 For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>1.3 For opioid-dependent patients not commencing opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>2 Opioid agonist maintenance treatment</td>
</tr>
<tr>
<td>2.1 For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>2.2 During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30 mg. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>2.3 On average, methadone maintenance doses should be in the range of 60–120 mg per day. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>2.4 Average buprenorphine maintenance doses should be at least 8 mg per day. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>□</td>
</tr>
<tr>
<td>2.5 Methadone and buprenorphine doses should be directly supervised in the early phase of treatment. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>2.6 Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
</tr>
<tr>
<td>2.7 Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence. Do the present guidelines include this recommendation?</td>
</tr>
<tr>
<td>X</td>
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</tbody>
</table>
### Management of opioid withdrawal

<p>| | | | |</p>
<table>
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</thead>
<tbody>
<tr>
<td>3</td>
<td><strong>Management of opioid withdrawal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used. Do the present guidelines include this recommendation?</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>3.2</td>
<td>Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>3.4</td>
<td>Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal. Do the present guidelines include this recommendation?</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### Pregnancy

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Pregnancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy. Do the present guidelines include this recommendation?</td>
<td>X</td>
<td>☐</td>
</tr>
<tr>
<td>4.2</td>
<td>Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered. Do the present guidelines include this recommendation?</td>
<td>X</td>
<td>☐</td>
</tr>
</tbody>
</table>
12 Cost of drug-related treatment in Europe: a comparative analysis

Introduction


The Institute on Drugs and Drug Addiction (IDT, I.P.), a public institute under the patronage of the Minister of Health, is the public provider for the treatment of drug addiction in mainland Portugal. Its public treatment network coexists with a private treatment network, run by organizations and medical clinics operating either for profit or non profit.

IDT, I.P. establishes protocols with the private treatment network in order to complement the drug addiction public treatment network according to needs assessed on a yearly basis. These protocols are designated “conventions”. IDT, I.P is also the licensing agency for the drug addiction private treatment network units.

Inmates have a dual public provider, the Ministry of Justice’s General Directorate of Prison Services (DGPS) and IDT, I.P units. Inmates may attend IDT, I.P public outpatient network under proper security rules or drug related treatment on prison wards, supplied either by DGPS’s Health Services or by IDT, I.P medical personnel. DGPS provides Drug Free Wings in some prisons, agonistics and methadone substitution treatment and Half Way Houses. The purpose of DGPS and IDT, I.P partnership is to ensure that patients’ treatment is not interrupted due to entering or leaving prison, as well as providing drug related treatment to inmates who wish to start or renew it.

Following a major reform of the State’s Central Administration in 2006, the IDT, I.P. mandate was enlarged to include the harmful use of alcohol and the 3 existing Alcohol Centres were incorporated into IDT, I.P structure. IDT, I.P competences cover transversal areas - Coordination, International Cooperation, Information, Training, Research and Evaluation - and the Demand Reduction mission area, which includes Prevention, Dissuasion, Harm and Risk Reduction, Treatment and Reintegration.

The Portuguese policy concerning drug related treatment is based on an integrated approach and resources are used in different combinations with inpatient and outpatient services targeting both illegal and legal psychoactive substances.

Drug Related Treatment Expenditures

IDT, I.P.’s mission is funded by three sources, the State General Budget, PIIDAC and a part of the revenue of lottery and social games. PIIDAC is the acronym for Programa de Investimentos e Despesas de Desenvolvimento da Administração Central (Central Administration Development Expenditures and Investment Program), which include investment support expenditures from institutional sources other than the State’s Central Budget. These expenditures are transferred through subsidies, incentive systems and collaborative schemes from sources external to the Central Administration. Most sourcing comes from European Union’s structural and cohesion funds. PIIDAC funding is committed only to infrastructures and thus it cannot be used for human resources, operating and maintenance costs, medical appliances and clinical tests and medicines.

In 2009 the public network managed by IDT, I.P comprehended 23 Integrated Responses Centres that comprise outpatient units dispensing several specialized consultations such as psychiatric and other medical specialties, including general practice and public health, psychological and group therapy – family and parental, nursing consultations, screening for infectious diseases and dispensing medicines under surveillance. These 23 Integrated Responses Centres encompass 44 Treatment Teams which provide outpatient treatment for
drug addiction and alcohol related pathologies, 3 Therapeutic Communities and 4 Drug Withdrawal Units which provide inpatient drug related treatment solely, 3 Day Centre Units and 3 Alcohol Treatment facilities.

In view of the fact that IDT, I.P. mission covers not only the treatment of drug addiction but also alcohol, the estimated drug related treatment expenditures is difficult since analytical accounting is not pursued in a systematic way. As a consequence it is not possible for most items to individualize treatment related costs, neither the part that is only committed to drug treatment (since alcohol treatment is also provided by IDT, I.P). With the exception of “conventions”, that is, payments to private network units which complement the public drug addiction treatment network offer on an accredited basis.

Graph 58 shows the number and allocation rate of IDT, I.P professionals to treatment and to the other areas that encompass its mission. The number of professionals fully dedicated to treatment (illicit drugs and alcohol) in 2009 was 1109, representing 60.9% of the total. That percentage was used to extrapolate unlabelled costs and estimate the treatment’s part of IDT, I.P. year end report.

Graph 58 – IDT, I.P. Allocation % of Human Resources in 2009 (IDT, I.P. 2010)

Next Table presents expenditures with the public treatment network and the drug related accredited private network, along with the available number of drug related treatment beds and places, number of patients assisted, 1st time consultations and total consultations in 2009. As it has been referred above the public treatment network expenditures was calculated based on an extrapolation and includes both drug and alcohol related treatment. In 2009 the public network expenditures amounted to 41,088,230.61 € and the drug related expenditures regarding the covenanted private network amounted to 11,645,361 €, with a total of 52,733,591.61 €. This amount does not cover drug related treatment in the Madeira and Azores Autonomous Regions, with the exception of methadone dispensed in Madeira.
### Table 44 – Treatment expenditures - public and accredited private network 2009 (IDT, I.P. 2010)

<table>
<thead>
<tr>
<th>Drug Related Treatment</th>
<th>Public Network</th>
<th>Covenanted Private Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detoxification Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Beds (1)</td>
<td>51 bed, 1644 patients</td>
<td>70 beds, 953 patients</td>
</tr>
<tr>
<td>Therapeutic Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Beds (2)</td>
<td>65 beds, 127 patients</td>
<td>1516 beds, 3474 patients</td>
</tr>
<tr>
<td>Day Centers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Places (3)</td>
<td>39 places, 70 patients</td>
<td>187 places, 232 patients</td>
</tr>
<tr>
<td>New Patients</td>
<td>7.722</td>
<td></td>
</tr>
<tr>
<td>Total Patients assisted</td>
<td>38.875</td>
<td></td>
</tr>
<tr>
<td>1st Time Consultations</td>
<td>7.643</td>
<td></td>
</tr>
<tr>
<td>Number of Consultations</td>
<td>621.856</td>
<td></td>
</tr>
</tbody>
</table>

(1) The number of patients assisted in 2009 is indicated.
(2) The number of patients assisted in 2009 is indicated.
(3) This figure is reported to December 31st. The number of patients attended in 2009 is indicated.

Whereas the (public) National Health Service tends to be free but is co-participated by users through a fee (moderator tax) to avoid that patients overdraw on its resources, drug addiction treatment is provided on a free basis as is treatment provided at the 3 alcohol treatment facilities that are part of IDT, I.P network.

Next Table singles out the methadone program expenditures and it covers exclusively methadone’s acquisition and handling. Only IDT, I.P. may acquire and hand out methadone in Portugal, though it may be dispensed on places other than IDT, I.P.’s treatment facilities. In 2009 the methadone program was attended by 15,823 patients. In view of promoting the patients’ autonomy and their social and professional reintegration, and to facilitate their displacement, methadone may be dispensed at hospitals, health centres, pharmacies and prisons. In 2009 the methadone program costs were 490,279.83 €, an expenditure that excludes operating and human resources associated costs.
### Cost of drug-related treatment in Europe: a comparative analysis

<table>
<thead>
<tr>
<th>MATERIALS</th>
<th>Quantities</th>
<th>Value with TVA €</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powdered Methadone</td>
<td>340 KG</td>
<td>113.883,00</td>
</tr>
<tr>
<td>Methadone 40 mg pills</td>
<td>362800 Units</td>
<td>38.094,00</td>
</tr>
<tr>
<td>Methadone 10 mg pills</td>
<td>380000 Units</td>
<td>31.919,60</td>
</tr>
<tr>
<td>Methadone Processing (Flasks) - Mainland and Madeira</td>
<td></td>
<td>74.869,48</td>
</tr>
<tr>
<td>Methadone Transportation - Mainland and Madeira</td>
<td></td>
<td>18.472,63</td>
</tr>
<tr>
<td>Acquisition of Tests, Flasks and Pipettes</td>
<td></td>
<td>152.803,12</td>
</tr>
</tbody>
</table>

| PHARMACIES PROTOCOL                               |                |                   |
| Administrative Support                           | 43.200,00      |
| Materials (flasks, pouches and printed material) | 14.392,09      |
| Methadone Processing (Flasks)                    | 2.645,91       |

**Table 45 – Methadone expenditures 2009 (IDT, I.P.2010)**

In 2009 the Syringe Exchange Program exchanged 2,365,821 syringes with a cost of € 169,149.62. Though this is a Risk Reduction program, syringes are also dispensed at drug related treatment units and its purpose is to prevent HIV/AIDS and other infectious diseases propagation. This syringe exchange national program was launched in 1989 by the Ministry of Health in partnership with the Pharmacies National Association (ANF). While the Program is funded by public resources and paid by the Ministry of Health’s General Secretary, the operating cost of the program is supported by the ANF and its amount is not recorded. Managing the program comprises the acquisition of the Kit components, syringes, swabs, condoms, distilled water vials, filters, bottle caps and citric acid, stock control and delivers to NGO partners and pharmacies, as well as preparing kits exchanged at pharmacies. NGO partners receive the kit components and prepare the final boxes.

The labelled expenditures of DGSP staff related with drug programs were, in 2009, 228,936 €. A Specific Syringe Exchange Program is also run in prison, though it is not possible to determine its cost. In December 31st, 2009 drug related treatment was attended by 1300 inmates, of which 1015 on opioid substitution program, 120 on abstinent treatment program, 85 on suboxone program and 80 on antagonist program, the cost of which is not possible to calculate.

**Conclusion**

An exercise to calculate the cost of public expenditures has already been conducted by EMCDDA and its Focal Points and was the theme of an Annual Report Special Issue in 2008. Once again the difficulty of calculating public expenditures, at macro level or at more detailed level of drug related treatment is jeopardize by data assessment and accounting systems. In view of that, organizational and comparable data are just a minor aspect of the complexity to determine and understand the cost of resources used in drug related treatment.
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List of Abbreviations used in the text

ACT – Authority for Working Conditions / Autoridade para as Condições do Trabalho
ADR - Counselling Detection and Reference / Aconselhamento Detecção e Referenciação
ANF – National Association of Pharmacies / Associação Nacional de Farmácias
BZP – 1 – benzylpiperazine / benzilpiperazina
CDT – Commissions for the Dissuasion of Drug Use / Comissão para a Dissuasão da Toxicodependência
CGTP IN - General Confederation of Portuguese Workers / Confederação Geral dos Trabalhadores Portugueses
CNIVS – National Coordination for HIV/AIDS Infection / Coordenação Nacional para a Infecção VIH/sida
CNLCS – National Commission for the Fight against AIDS / Comissão Nacional de Luta Contra a SIDA
CPL – Lisbon Casa Pia / Casa Pia de Lisboa
CRI - Centre of Integrated Responses/ Centros de Respostas Integradas
CT – Therapeutic Community / Comunidade Terapêutica
CVP – Portuguese Red Cross / Cruz Vermelha Portuguesa
DGIDC – General Directorate for Innovation and Curricular Development / Direcção-Geral de Inovação e de Desenvolvimento Curricular
DGS – General Directorate for Health / Direcção-Geral da Saúde
DGSP – General Directorate for Prisons / Direcção-Geral dos Serviços Prisionais
DR – Regional Directorate / Delegação Regional
DRD – Drug-related deaths / Mortes relacionadas com droga
DRE – Regional Directorate of Education / Direcção Regional de Educação
ECATD – Estudo sobre o Consumo de Álcool, Tabaco e Droga / Study on Alcohol, Tobacco and Drug use
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction / Observatório Europeu da Droga e das Toxicodependências
ENLCD – Estratégia Nacional de Luta contra a Droga / National Strategy on the Fight Against Drugs
ESPAD – European School Survey Project on Alcohol and other Drugs / Inquérito Europeu sobre o Consumo de Álcool e outras Drogas
ETs - Treatment Teams / Equipas de Tratamento
EURIDICE - European Research and Intervention on Dependency and Diversity in Companies and Employment
FPCE – Faculty of Psychology and Educational Sciences / Faculdade de Psicologia e de Ciências da Educação
GIES - Group of Intervention in Higher Education / Grupo de intervenção no Ensino Superior
GMR – General Mortality Register / Registo Geral de Mortalidade
GNR – National Republican Guard / Guarda Nacional Republicana
IDT, I.P. – Institute on Drugs and Drug Addiction, Public Institute / Instituto da Droga e da Toxicodependência, Instituto Público

IDUs – Intravenous Drug Users / Consumidores de drogas injectáveis

IEFP – Institute for Labour and Professional Training / Instituto de Emprego e Formação Profissional

INE – National Statistics Institute / Instituto Nacional de Estatística

INFARMED – National Institute of Pharmacy and Medicines/Instituto Nacional da Farmácia e do Medicamento

INML – National Institute of Forensic Medicine / Instituto Nacional de Medicina Legal


INSA, I.P. - National Health Institute Doutor Ricardo Jorge / Instituto Nacional de Saúde Doutor Ricardo Jorge

IPJ – Portuguese Youth Institute / Instituto Português da Juventude

IPSS – Instituições Particulares de Solidariedade Social / Private Social Solidarity Institutions

ISS – Social Security Institute / Instituto da Segurança Social

ISSS – Institute of Solidarity and Social Security / Instituto de Solidariedade e Segurança Social

KLOTHO – Project of Early Identification and Prevention of HIV/AIDS directed to Drug Users / Projecto de Identificação Precoce e Prevenção da Infecção VIH/Sida e Direccionado a Utilizadores de Drogas

mCPP – meta-Chlonophenylpiperazine / piperazina

MDN – Ministry of National Defence / Ministério de Defesa Nacional

NGOs – Non-Governmental Organisations / Organizações Não Governamentais

NPISA - Planning and Intervention Units for Homeless / Núcleos de Planeamento e Intervenção Sem-Abrigo

NT – Territorial Nucleus / Núcleos Territoriais

PANCPDI – National Action Plan for the Fight Against the Spread of Infection Diseases in Prison Setting / Plano de Acção Nacional de Combate à Propagação de Doenças Infecciosas em Meio Prisional

PASITForm – Action Programme for Awareness and Intervention in Drug Abuse / Programa de Acção para a Sensibilização e Intervenção nas Toxicodependências

PDU – Problem drug use

PES - Promotion and Education for Health / Promoção e Educação para a Saúde

PETS – Specific Programme on Needle Exchange / Programa Específico de Troca de Seringas

PIIDAC - Central Administration Development Expenditures and Investment Program /Programa de Investimentos e Despesas de Desenvolvimento da Administração Central

PIF – Program of Focused Intervention / Programa de Intervenção Focalizada

PJ – Criminal Police/ Polícia Judiciária

PLA – Alcohol Related Problems / Problemas Ligados ao Álcool
PORI – Operational Program of Integrated Responses / Programa Operacional de Resposta Integradas

PRI – Programs of Integrated Responses / Programas de Respostas Integradas

PSP – Public Security Police / Policia de Segurança Pública

PVE – Life-Employment Program / Programa Vida Emprego

QP – Permanent staff of Armed Forces of Portugal / Quadro Permanente das Forças Armadas de Portugal

RC – Contracted staff of Armed Forces of Portugal / Regime de Contrato das Forças Armadas de Portugal

RDS – Respondent Driven Sampling

RRMD – Harm and risk reduction / Redução de Riscos e de Minimização de Danos

RV – Volunteers of Armed Forces of Portugal / Regime de Voluntariado das Forças Armadas de Portugal

RVCC – Revalidation and Certification of Competencies Centres

SIM – Multidisciplinary Information System/Sistema de Informação Multidisciplinar

SMR – Special Mortality Register / Registo Especial de Mortalidade

UD – Detoxification Units / Unidades de Desabituação

UN – United Nations / Nações Unidas

UNODC – United Nations Office on Drugs and Crime / Escritório das Nações Unidas sobre Drogas e Crime)
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Chapter 1:

- Resolução do Conselho de Ministros nº 115/2006 de 18 de Setembro (Diário da República, 1ª série, nº 180 de 18 de Setembro) – Aprova o Plano Nacional contra a Droga e as Toxicodependências e o Plano de Acção Contra a Droga e as Toxicodependências Horizonte 2008

- Decreto-Lei nº 15/93 de 22 de Janeiro (Diário da República, 1ª série – Nº 18 de 22 de Janeiro) – Regime Jurídico do tráfico e Consumo de Estupefacientes e Psicotrópicos
  http://dre.pt/pdf1sdip/1993/01/018A00/02340252.pdf

- Lei nº 30/2000 de 29 Novembro (Diário da República, 1ª série A – Nº 276 de 29 de Novembro) – Define o regime jurídico aplicável ao consumo de estupefacientes, bem como a protecção sanitária e social das pessoas que consomem sem prescrição médica

- Decreto-Lei 8/2010 de 28 de Janeiro (Diário da República, 1.ª série — N.º 19 de 28 de Janeiro) Cria um conjunto de unidades e equipas de cuidados continuados integrados de saúde mental, destinado às pessoas com doença mental grave de que resulte incapacidade psicossocial e que se encontrem em situação de dependência.

- Decreto-Lei 40/2010 de 28 de Abril (Diário da República, 1.ª série — N.º 82 de 28 de Abril) Reorganiza as estruturas de coordenação do combate à droga e à toxicodependência, alargando as respectivas competências à definição e à execução de políticas relacionadas com o uso nocivo do álcool, e procede à primeira alteração ao Decreto-Lei n.º 1/2003, de 6 de Janeiro.

- Decreto Regulamentar nº 28/2009 de 12 de Outubro (Diário da República, 1.ª série — N.º 197 de 12 de Outubro de 2009) que contém as medidas adequadas à aplicação dos Regulamentos Comunitários em matéria de precursores (Regulamento (CE) nº 273/2004 do PE e do Conselho relativo aos precursores de drogas e do regulamento (CE) nº 111/2005 do Conselho que estabelece regras de controlo do comércio de precursores de drogas entre a Comunidade e países terceiros).

- Decreto-Lei 1/2003 de 6 de Janeiro (Diário da República, 1ª série, nº 4, 6 de Janeiro) – Reorganiza as estruturas de coordenação do combate à droga e à toxicodependência.
  http://www.utl.pt/admin/docs/26_lei12003.pdf

Chapter 3:

- Portaria nº 131/2008 de 13 de Fevereiro (Diário da República, 1ª série, nº 31, 13 de Fevereiro) – Aprova o Regulamento que estabelece as condições de financiamento público dos projectos que constituem programas de respostas integradas (PRI)
  http://dre.pt/pdf1sdip/2008/02/0310/0099100995.pdf

- Decreto-Lei nº 183/2001 de 21 de Junho (Diário da República, 1ª série, nº142, de 21 de Junho) – Aprova o regime geral de prevenção e redução de riscos e minimização de danos
  http://dre.pt/pdf1sdip/2001/06/142A00/35943601.pdf

Chapter 5:

- Decreto-Lei nº 183/2001 de 21 de Junho (See chapter 3)

- Portaria nº 748/2007 de 25 de Junho (Diário da República, 1ª série, nº 120 de 25 de Junho) – Aprova o Regulamento Que Estabelece as Condições e o Procedimento de Criação e


Chapter 6:
- Lei nº 22/2008 de 13 de Maio (Diário da República, 1ª série, nº 92, de 13 de Maio) – Lei do Sistema Estatístico Nacional http://dre.pt/pdf1sdip/2008/05/09200/0261702622.pdf

Chapter 7:
- Portaria nº 748/2007 (See chapter 5)
- Portaria nº 749/2007 (See chapter 5)
- Portaria nº 131/2008 (See chapter 3)

Chapter 9:
- Lei nº 30/2000 (See chapter 1)
- Lei nº 3/2007 (See chapter 7)
- Decreto-Lei nº 15/93 (see chapter 1)
- Acordão do Supremo Tribunal de Justiça nº 8/2008, de 5 de Agosto (Diário da República, 1ª série N.º 150 — 5 de Agosto de 2008) - Não obstante a derrogação operada pelo artigo 28.º da Lei n.º 30/2000, de 29 de Novembro, o artigo 40.º, n.º 2, do Decreto-Lei n.º 15/93, de 22 de Janeiro, manteve-se em vigor não só «quanto ao cultivo» como relativamente à aquisição ou detenção, para consumo próprio, de plantas, substâncias ou preparações compreendidas nas tabelas I a IV, em quantidade superior à necessária para o consumo médio individual durante o período de 10 dias. http://www.dre.pt/pdf1sdip/2008/08/15000/0523505254.PDF

Chapter 10:
- Portaria nº 94/96 de 26 de Março (Diário da República, 1ª série B – Nº 73 de 26 de Março) – Procedimentos de diagnóstico e dos exames periciais necessários à caracterização do estado de toxicodependência http://dre.pt/pdfgratis/1996/03/073B00.pdf