



**2005 NATIONAL REPORT (2004 data) TO THE
EMCDDA
by the Reitox National Focal Point**

**PORTUGAL
New developments, Trends and in-
depth information on selected issues**

REITOX

The IDT's National Monitoring Centre for Drugs and Drug Addiction staff members wish to thank the motivation and active co-operation of our internal departments and all our national partners, which made this National Report possible.

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Summary

Concerning **National policies and context**, the most important development in 2005 was the drafting of the National Strategic Plan 2005-2012, which updates the 1999 National Strategy and sets priorities for the next implementation period. Information on money laundering activities also became available for the first time.

As for **situation and responses**, data presented in this report allow to conclude that:

Concerning drug use:

Regional data available confirm the geographical dissemination in use patterns already reported since 2001;

Cannabis continues to be the most used drug and its visibility in several indicators continues to increase, alone or in combination with other substances. Nevertheless, heroin remains as 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 increasing in several indicators, but the main substances of abuse referred in a study conducted in the workplace are alcohol, cannabis and prescribed drugs.

Responses to drug use continue to include several types of prevention interventions with special emphasis on community/municipal prevention. The monitoring system which is being put in place allowed for an evaluation of the work already developed and for an identification and systematisation of best practices in this area. Specific attention has been given to the drafting of new guidelines for both drug-free and medically assisted treatment programmes in order to improve quality and harmonisation of procedures.

Concerning drug related health consequences:

Indicators available continue to suggest effective responses at treatment level (increase in the number of clients involved in both drug free and substitution programmes) and at harm reduction level (increase in the number of syringes exchanged, levelling off of infectious diseases). The number of active clients in the outpatient public treatment network increased. Heroin is still the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures;

The availability of substitution programmes continues to increase and pharmacies have become involved in the provision of naltrexone and buprenorphine, as well as methadone. The number of clients in buprenorphine substitution treatment has been increasing steadily since this substance was introduced (in 1999).

In 2004, treatment clients were mainly from the male gender and from the age group 25-39, (mean age in all treatment settings ranged from 31 to 34) confirming the ageing trend of this population, already perceptible in previous years;

The decreasing trend in the percentage of drug users in the total number of notifications of AIDS cases continues to be registered. Concerning HIV infection in the treatment setting, data on HIV positive cases remained stable in comparison to previous years though data from therapeutic communities registered a slight increase in comparison to 2003. Concerning hepatitis, data collected since 2000 continues to register a decreasing trend for hepatitis B and stabilisation for hepatitis C;

The stabilisation of the global rates of positive HIV tests may be related, amongst other factors, to the implementation of harm reduction measures, which may be leading to a decrease in intravenous drug use (also visible in data concerning administration route in first treatment demands), or to intravenous drug use in better sanitary conditions, as

indicated by the number of exchanged syringes in the National Programme "Say no to a second hand syringe";

In 2004, contrary to the trend verified in recent years, an increase was registered on drug-related mortality in the Special Register (156 cases in 2004, 152 in 2003, 156 in 2002), but the General Mortality Register continues to register a decrease which may be pointing towards a stabilisation of this indicator. Although data from these two sources are not directly comparable, both have been registering a decreasing trend until 2003. 51% of the positive cases with information on the presumed aetiology in the Special Register were considered possible acute drug related deaths, a higher percentage than the one reported in 2003 (44%) but inferior to the one registered in 2002 (58%). Opiates continued to be the most referred substance associated with these cases;

The national outreach network continues to be implemented, targeting particularly problematic drug users. In 2004 and 2005, special attention was given to instruments and procedures for data collection and reporting.

Concerning drug related legal consequences:

In 2004, concerning the administrative sanctions for drug use, the Commissions for the Dissuasion of Drug Use instated -12% processes than in 2003 most of which were, again, referred by the Public Security Police (PSP). On the 31st March 2004, 32% had been suspended, 31% were pending and 36% had been filed. These cases are mainly related to hashish use but cocaine has been increasing in this setting.

From the 3 631 rulings made, 86% suspended the process temporarily, 3% found the presumed offender innocent and 11% were punitive rulings (this percentage continues to rise in comparison previous years).

In 2004, concerning criminal offences against the Drug Law, the number of presumed traffickers increased slightly in comparison to 2003 (2%), but the number of presumed trafficker-users decreased (-6%), contributing to an overall decrease of 3% in the number of presumed offenders in general.

Amongst the presumed offenders who possessed only one drug, for the fourth time since 2001, hashish (42%) was reported more often than heroin (10%), which until 2000 had always been the substance more often reported to be held by presumed offenders at the time of their identification. The percentage of cases related to cocaine increased (15%) in comparison to 2003.

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 hashish, for the first time, and not heroin, as in previous years. In comparison to 2003 there was a 3% increase in the number of individuals who possessed only cocaine. Of the convicted individuals, 95% were convicted for traffic, 1% for use (cultivation) and 4% for traffic-use, just as in 2003.

The percentage of individuals in prison for Drug Law offences, in 2004, continues to decrease to reach again the lowest value since 1997 (29%). Individuals were mainly imprisoned for traffic offences (89%).

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.

Markets

Following the trend, which has been verified since 2000, the number of heroin seizures decreased. The number of hashish and cocaine seizures increased in comparison to 2002 and 2003. The number of ecstasy seizures, after decreasing in 2003, increased

again in 2004 and the number of herbal cannabis (liamba) seizures also increased. For the third time since 1990, the number of hashish seizures again surpassed that of heroin, the substance that always registered the highest number of seizures in Portugal until 2002.

The seized quantities of hashish and heroin registered the third highest value of the decade, the seized quantities of herbal cannabis (liamba) and ecstasy were the lowest since 2000 and 2001, respectively, and the seized quantities of cocaine were the highest ever registered.

Concerning countries of origin of the seized drugs, heroin came mainly from Spain and The Netherlands, cocaine from Brazil, hashish from Morocco, herbal cannabis (liamba) from Angola and ecstasy from The Netherlands. The totality¹ of the seized heroin, herbal cannabis (liamba) and ecstasy were destined to the national market. 77% of the seized cocaine and 35% of the seized hashish² was directed towards the external market.

Regarding the prices of drugs at trafficker and trafficker-user level were very similar to 2003, except for herbal cannabis (liamba), which had registered an increase in 2003 and decreased in 2004 and ecstasy which continues to decrease. For the third consecutive year and contrarily to what was the case since 1997, the average price of cocaine was lower than that of heroin.

Key issues

Gender issues – In Portugal, individuals of the male gender represent the majority of people who experiment with drugs, use them occasionally or regularly and, in an even higher proportion become problematic drug users. The male gender is predominant in the drug related treatment, legal and criminal justice settings as well as in the drug-related indicators on infectious diseases and deaths. Individuals of the male gender with a problematic abuse of drugs usually report the use of heroin, although most of them currently do not use an intravenous administration route. In terms of responses, and apart from well established interventions in the area of treatment, specifically orientated towards pregnant women and women with children, the only systematic gender specific responses reported were interventions amongst young offenders in the framework of Programme Choices.

European drug policies - With the exception of psychotropic medicines and other small references to doping substances, to polydrug use and alcohol abuse, there is no specific mention in the National Drug Strategy (1999) to alcohol or tobacco, nor to comorbidity or “addictive-type” behaviours (such as gambling). Although all the national and international literature from 1998 on strongly supports a holistic approach to substance use, in Portugal different national organizations undergo separated efforts. This implies different economic, physical and human resources, different logistics, different legislation, different professional training, and different research funds.

New developments in drug use within recreational settings - There is a growing interest concerning this theme at different levels in our society, for the recognition of the phenomena dimension in itself and for the concern of its implication on the current society. Notwithstanding the work already developed in this area there is a need to monitor this phenomenon with more precision and care, as to create a set of sufficient and extensive responses. For these to be developed it is fundamental, first and foremost, to create a consensus involving professionals and researchers in this area. To surpass some barriers, attitudes and practices can facilitate common work as well as promote the involvement of the decision-makers in an investment which is urgent in this area.

¹ Seizures with information on the destination of the seized substances.

² Seizures with information on the destination of the seized substances.

Part A

New Developments and Trends

1. National Policies and Context

1.1 Legal framework

Previously unreported legislation from 2004 and new legislation in 2005 include:

2 diplomas which implemented EU and UN decisions:

Law n.º 11/2004, of the 27th of March – Changes the Drug Law (15/93) and the Penal Code, concerning the prevention and repression of money laundering and illicit sources by transposing Directive n.º 2001/97/CE, of the 4th of December.

Law n.º 14/2005, of the 26th of January 2004: adds 2C-I, 2C-T-2, 2C-T-7 and TMA-2 to the schedules annexed to the Decree-Law 15/93, of 22nd of January which defines the legal regime applicable to trafficking and use (only cultivation) of narcotic drugs and psychotropic substances. All substances were added to table II-A.

1 diploma concerning institutional changes:

Regulation nº 17/2004 of the 28th of April – sets up the General-Directorate of Innovation and Curricular Development in the Ministry of Education which, amongst its other responsibilities, will be responsible developing the area of substance abuse prevention in the school setting.

2 diplomas were issued concerning specific law implementation matters:

Regulation nº 103/2005, of the 25th of January – includes the infection by HIV in the list of diseases with mandatory notification.

Regulation nº 7/2005 of the 10th of August – Extinguishes the National Commission for the Fight Against AIDS and sets up, in the framework of the National Plan for Health, the High Commissioner for Health.

It is expected that the National Plan, which is currently being drafted, will also be published as a Resolution of the Council of Ministers, late in 2005.

1.2 Institutional framework, strategies and policies

Coordination arrangements and National Plan

In 2005, following the evaluation of the 1999-2004 National Strategy and its 2001-2004 Action Plan, as well as the appointment of a new National Coordinator (João Goulão), it was decided to extend the 1999-2004 National Strategy to Fight Against Drugs to the next strategic planning cycle of 2005-2012 and to prepare two Action Plans to implement it: 2005-2008 and 2009-2012.

The first of these Action Plans (2005-2008) is currently being drafted on the basis of a National Strategic Plan, which complemented the National Strategy and refocused its priorities for the 2005-2012 period. The National Strategic Plan took into account the results of the 2004 evaluation of the National Strategy and the recommendations from both external and internal evaluators which were merged and re-organised to provide a basis for this Plan:

- **Legal framework**

In the 1999-2004 period there was an intensive production of legal documents in this area. The contribution of this area was found to be globally positive but there are still areas where specific regulation is needed (e.g. in the harm reduction area).

- **International Cooperation**

The objectives established for the 1999-2004 period were met.

- **National Coordination, Follow-up and Evaluation**

Follow-up and evaluation were insufficient during this period and the national coordination did not meet the objectives.

- **Research, Statistics and Information**

The IDT is responsible for the National Information System on Drugs and Drug Abuse. The objectives concerning research were met but, given the complexity and diversity of this phenomenon, it is important to invest more in this area, strengthen the support and development of research projects, namely with universities and research centres, to ensure a wider and stronger decision support mechanism.

- **Training**

Between 2000 and 2004 a significant investment in this area was registered but in the earliest years of implementation a decrease in the training indicators (number of sessions, number of hours and number of professionals on training) were registered. In 2004 this tendency was changed through the significant increase of these indicators, particularly the strong increment in internal training.

It is important to define and implement new interventions to ensure specialised professional training in this area.

- **Prevention**

Taking into account the evolution of substance use amongst the Portuguese young students between 2000 and 2003, the efforts developed were not enough to meet the objectives of the National Strategy and the National Action Plan – to significantly reduce the number of new drug users aged under 18.

A significant number of local and regional intervention programmes and projects were implemented and developed which helped mobilise the local authorities and the local communities. A strong investment was made in professional training for actors who took responsibility for the preventive interventions at their own geographical level. This investment will facilitate the further development of the future National Plan 2005-2012 in terms of quality and type of the interventions.

- **Supply Reduction**

A considerable effort was registered in illicit substance control. A review of the legal diploma which defines the average personal doses for 10 days as the borderline between the offence of using and the crime of trafficking is called for in order to clarify aspects which may currently be affecting the effectiveness of interventions in the supply reduction area.

- **Treatment**

The public network of outpatient specialised treatment units was expanded, and the number of clients in substitution treatment increased significantly, both in low and high threshold, in this period. On the other hand less inpatient clients were registered and first treatment demands also dropped within this period. In the prison setting less inmates were registered in inpatient treatment but more in substitution treatment.

- **Risk reduction and harm minimisation**

Drug use related deaths decreased, particularly in what concerns opiate use related deaths, but the relative weight of deaths related to the use of other drugs increased. The notifications of drug-related AIDS cases decreased in global and in relative terms,

when compared to other non drug related cases. In the treatment setting the number of HIV and Hepatitis positive tests between 2000 and 2003 decreased and the number of positive tests for tuberculosis increased. The proportion of positive cases slightly increased for the HIV and tuberculosis positive cases and decreased for Hepatitis B and C.

- **Social Rehabilitation**

Although several initiatives, both from the governmental and the non-governmental sector, were implemented during that period it was not possible to quantify and assess them. The evolution seems to be positive and an encouraging effort was developed but the intervention in this area is still insufficient and the availability and coverage of these programmes is still reduced.

- **Dissuasion**

It was not possible to assess compliance of individuals in this system with the referrals made for treatment and/or sanctions imposed, since no information was available concerning their follow up and progress.

- **Financial resources**

It was not possible to ascertain objectively the public expenses in the area for the 1999-2003 periods.

Several working groups were set up to draft the National Strategic Plan 2005-2012, which will be presented in November 2005. This Plan will follow closely the areas and structure of the European Strategy and will be followed by more specific Action Plans.

At National Coordination level, the Technical Committee (representatives of the Ministers involved in the implementation of the National Strategy) met twice in 2005 to discuss and approve the guidelines for the drafting of the new National Strategic Plan.

Implementation of policies and strategies

- **Money laundering**

The Ministry of Justice has been working within the Financial Action Task Force on Money and Laundering (FATF) to prevent and fight the activities connected to money laundering. Main activities in 2004 include the participation in the Plenary Sessions and in the various working groups – Terrorism, Finance, International Financial Institutions and Typologies – and particularly in the discussion and approval of the new Anti-Money Laundering and Combating Finance for Terrorism methodology, which will serve as a basis for mutual evaluation, and in the discussion of the new Special Recommendation IX about the so-called cash couriers as well as the approval of Interpretative Notes and of documents of good practices for Special Recommendations.

The Ministry of Justice has also represented Portugal in GAFISUD – the Financial Action Task Force of South America Against Money, particularly on the drafting of a document concerning the use of special investigation techniques and in the elaboration of a judiciary cooperation guide concerning the fight against money laundering. At national level, these initiatives were coordinated with the Bank of Portugal.

Also at national level, the International Relations Unit at the Ministry of Justice, together with the Bank of Portugal, the National Insurance Institute, Portuguese Securities Market Commission (CMVM) and the Criminal Police Financial Information Unit (also at the Ministry of Justice), participated in a voluntary self-assessment exercise to diagnose the internal situation in legal and regulation terms, for preparing the FATF evaluation foreseen for early 2006, already using the new AML/CFT methodology.

Contacts with the World Bank and the International Monetary Fund (IMF), in the framework of the Technical Assistance Programme for Portuguese Speaking Countries, in the area of prevention and fight against money laundering and the financing of terrorism, also took place in Lisbon in the first semester of 2005.

1.3 Budget and public expenditure

Although budgets were generally available in the past concerning most of the Ministries involved in the National Coordination for the Fight against Drugs, data from 2003 and 2004 was not possible to collect mainly due to the change of Government in July 2004.

It is however possible to present the IDT's expenses in 2003 and 2004 which represent the main part of public expenditures in the areas of prevention, treatment, harm reduction, research, information, training and international cooperation and also include major areas of investment in the NGO sector:

Total budget available	€65 205 966
State budget	€ 52 457 354
Own funds	€ 11 550 229
Investment in treatment ³ :	
Enlargement of the public treatment network	
National funds	€ 81.047
EU funds	€ 590.983
Investments in non-governmental organisations	€ 526.353
Investment in prevention programmes ⁴	
Renewed Municipal Plans	€ 1 678 552,07
New Municipal Plans	€ 1 032 993,79
Framework for Prevention II	€ 207 274,13
<i>Ad-hoc</i> Projects	€ 402 205,14

Table 1- Budget and funding arrangements at the IDT – 2003 (IDT 2004)

³ PIDDAC

⁴ Please see Chapter 3 on this Report for more information on these programmes

Total budget available	€68.747.306
State budget	€57.443.664
Own funds	€10.536.861
Investment in treatment ⁵ :	
Enlargement of the public treatment network	
National funds	€192.524
EU funds	€103.588
Investments in non-governmental organisations	€470.669
Investment in prevention programmes ⁶	
Renewed Municipal Plans	€5 335 793,24
New Municipal Plans	€702 509,30
Framework for Prevention II	€1 211 735,00
<i>Ad-hoc</i> Projects	€415 220,46

Table 2- Budget and funding arrangements at the IDT – 2004 (IDT 2005)

Also available is the information that the Institute of Solidarity and Social Security (Ministry of Employment and Social Security) spent, in 2004, more than €1 532 227 in **reinsertion** projects, and €2 725 619,69 to support families and individuals in **treatment** programmes, as described in Chapters 8 and 9 of this Report. Also in the **reinsertion area**, the Institute for Employment and Professional Training (Ministry of Employment and Social Security) reported a €5 756 333,92 budget for the Programme *Vida-Emprego* (please see chapter 9 of this Report).

The IDT is funding research at the School of Economics (*Faculdade de Economia*) of Universidade Nova de Lisboa which has 2 main objectives: to develop a model to estimate costs of drug abuse and test it, and to estimate the size of the illicit markets of heroin, cocaine, cannabis and synthetic drugs. Preliminary results on the first objective include the identification of the areas positively or negatively affected in economic terms by drug abuse and suggest a cost-benefit analysis. The identification of specific data sources and an exercise with one of the selected areas will follow in 2006.

1.4 Social and cultural context

The main topics covered by the media in 2004 concerned the institutional changes after the new government took over and the National Coordinator was replaced. The possibility of creating assisted injecting rooms and syringe exchanges was also focused by the media as well as concern over the increasing use of cannabis amongst pupils.

Concerning the specific setting of the workplace, a research project (Pereira, O.G. et al. 2005) involving the European Union and the International Labour Office, looked into the situation in Portugal in 1993 and in 2003.

The study aims at evaluating the proneness to act of enterprises and employer's organisations against the abuse and dependence of alcohol and drugs in the workplace

⁵ PIDDAC

⁶ Please see Chapter 3 on this Report for more information on these programmes

in Portugal, in 2003, in comparison to Europe and Portugal, in 1993. Both, the present and the previous studies (promoted by the European Commission and executed by the International Labour Office) adopted a strategic research design in which representatives of the three above mentioned types of organizations were interviewed and answered similar questionnaires. A parallel legal study complemented the empirical studies. In Europe, in 1993, alcohol and prescription drugs were of primary concern and also more than 50% of drug addicts were currently employed. In the decade 1993-2003 this did not change in Portugal.

Social representations of alcoholism and drug addiction, in Portugal, in 2003, are close to each other. Common core words are disease, dependence and degradation. Categorization showed the central semantic role of degradation. The semantic network is, in all cases, more complex for alcohol than it is for drugs.

The need to respond to the problems and the advantage of written policies continued to be recognized and some new programs were set up. Testing to determine the presence of alcohol or drugs in body fluids is, now, more accepted, but is not a universal practice. More perplexing is the attitude towards costs of the problems. Everybody agrees they are crucial but, in Portugal, in 2003, only 5% of the organizations try to evaluate them.

Legal innovation, in Portugal, from 1993 to 2003, was not significant and the legislator tends to assume that the individuals concerned, the civil society and the organizations in the field, but not the government should deal, primarily, with the problems. It is felt that the EU legal framework is enough to support management correct measures.

In 1993 in Europe the substances that caused more concern to the participants were alcohol and prescription drugs. The frequency of drug problems reported was inferior and was verified that more than 50% of drug users was professionally stable.

Clinical evidence shows that substance abusers are capable to maintain their work post for some time without treatment, more so in the case of alcohol than for drugs, but there is a moment where the adaptation mechanisms fail and the evolution towards social exclusion is inevitable. This process, in case of alcohol abuse is less visible due to high cultural tolerance.

The six main problems referred in the interviews and questionnaires are: reduced production; lateness; absenteeism, reduce of motivation for work; interpersonal conflicts and disciplinary problems.

2003 – Total (n=52) %	
Absenteeism	50
Lateness	50
Reduce Motivation	48
Reduce Production	48
Disciplinary Problems	40
Conflicts manager – worker	38.8

Table 3 – Work problems related to the use of illegal drugs in organisations in the last 3 years

In 2003 more interviewees referred concerns over the use of each of the substances considered (in every case superior to 80%). The participants are mainly concerned with alcohol (96%), followed by cannabis (94%), cocaine and stimulants (92%), opiates (92%) and prescribed drugs (81%).

The majority refers that the alcohol abuse did not increase in the last years contrarily to what is verified for the use of prescription drugs. The number of workers identified with alcohol abuse problems was near five times higher than those identified with an illicit drug abuse problem.

Policies at national level for alcohol in the work place were inexistent in 1993; the control of psychotropic substances was consistent with the obligations established by treaties, the national health system was already available for workers with problems and, in general, the control of drugs of medical prescription was considered to be the doctor's responsibility and not a target of local policies at work.

In 2003, workers tend to perceive that managers, supervisors and directors do not have the necessary skills to identify and resolve substance abuse related problems in the workplace. The companies themselves recognise that measures should be taken in this area and particularly concerning prescription drugs. The issue of training is referred to by 89% of the respondents.

Near 46% of the organisations now have written policies, the majority (54%) combining alcohol and drugs. 54% of the policies related to alcohol, 78% of the combined policies and all the policies for illicit drug use were adapted in the last ten years. Amongst those which do not have a policy, 61% are considering having one or already working on one.

Almost all the organisations agree that to develop a policy is necessary a consensus between employees and employers and 59% refers that this is normally achieved. Both employers and employees believe that workers with a substance abuse problem can be helped in the work setting and be supported by it through the treatment period. Most (75%) also consider that those workers are capable to recover and work efficiently. 88% of the organisations are prepared to help and 46% consider that they should fund part of the treatment costs.

The use of toxicological tests to determine the presence or absence of alcohol and other drugs is necessary for clinical, forensic and selection procedures, as well as for preventing accidents. This was not current practice in 1993, especially for non-medical purposes. Most companies did not test their staff or their candidates. This was mainly due to unclear legal and ethical issues, controversy and not to affect the relationship between employers and employees. In 1993 guidelines were prepared for the use of drug and alcohol tests in the workplace.

In 2003 there is, on the one hand, a more favourable perception of the use of toxicological tests in the workplace but, on the other, more specific reserves, especially concerning discriminating practices, are being put forward. Around 71% of the companies are requesting this type of tests to staff and/or candidates, a significant higher figure than in the past. Although 94% of the respondents considered that these tests may be a useful measure, only 50% are totally in favour of its use, even though 71% of the companies are not worried about the associated costs.

This study concludes that employers accurately evaluate the nature, seriousness, gravity of the situation and the response needs, but do not, in general, act on that assessment.

2. Drug Use in the Population

2.1 Drug use in the general population

NO NEW INFORMATION AVAILABLE (the general population survey is scheduled to be repeated in 2005)

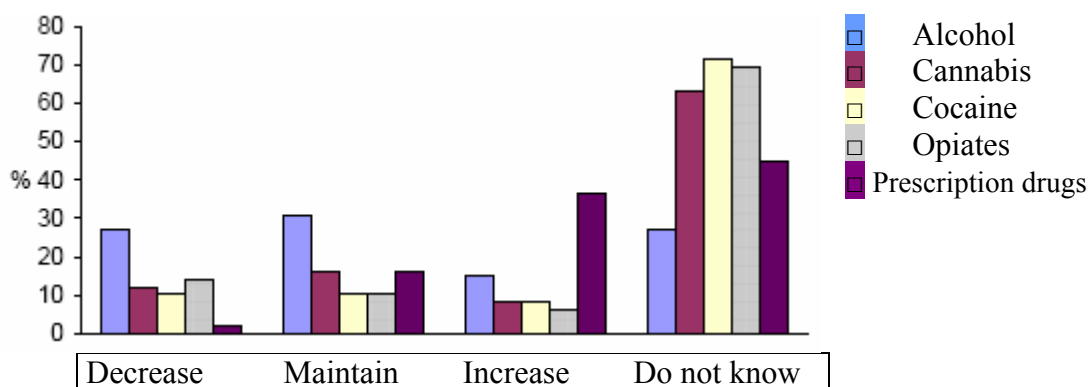
2.2 Drug use in the school and youth population

NO NEW INFORMATION AVAILABLE (the school population survey is scheduled to be repeated in 2005)

2.3 Drug use among specific groups

Amongst the specific population in the workplace, a research project (Pereira, et al. 2005) involving the European Union and the International Labour Office looked into the situation in Portugal in 1993 and in 2003.

In 1993 and then again in 2003, 52 private companies in Portugal were questioned on the use of alcohol and drugs in the workplace. Although most of the information is related to the social context and is therefore reported in chapter 1.4. of this Report, it is worth mentioning that alcohol was referred by the managers as the most used substance in the workplace (5 times more workers with an alcohol abuse problem were identified than workers with an illicit drug abuse problem), but its use was not perceived to have increased in the reporting period. As to illicit substances, the main substance referred was cannabis, followed by cocaine and the abuse of these substances was perceived to have stabilised or decreased in the reporting period. The issue of prescription drugs was not perceived to be a significant problem but concern over that rose from 1993 to 2003.



Graph 1 – Estimation of the number of workers affected in the last years

Clinical evidence shows that substance abusers are capable to maintain their work post for some time without treatment, more so in the case of alcohol than for drugs, but there is a moment where the adaptation mechanisms fail and the evolution towards social exclusion is inevitable. This process, in case of alcohol abuse is less visible due to higher cultural tolerance.

3. Prevention

As in previous years, intervention in the area of prevention in 2004 focused on the implementation of the guidelines of the National Strategy namely on what concerns its local implementation, based on an effort of proximity to local problems, resources and responses and also on developing a complementary approach between the regulating and stimulating role of the IDT and the commitment of municipalities and the civil society.

The approach allowed for a development in terms of continuity and sustainability of the national prevention network, based on the technical and financial support given to projects in the framework of the two programmes already described in previous reports:

- **The Primary Prevention Municipal Plans (PMP)** – intervention projects integrated in a municipal plan (or a plan which joins more than one municipality with similar problems) in a partnership between the IDT, the intervening municipalities and non-governmental organisations with a view to act in the school, sports, family and recreational settings and amongst young people who have left school at an early age;
- **Framework for Prevention II (PQPII)** – intervention projects which complement those of the Municipal Plans with a view to develop specific actions in the school, sports, family and recreational settings, amongst young people who have left school at an early age and also in the framework of *Programa Escolhas* (Programme “Choices”) for young offenders.

This network is being implemented for about 4 years and was complemented by a set of agreements signed between the IDT and non-profit non-governmental organisations which promoted the development of transversal initiatives considered to be good practice or innovative interventions in the area of prevention and also of itinerant initiatives. Due the continuity and sustainability of this network, it was possible to identify “good practices” in this area and to promote accountability.

In 2004, the main challenge for this area was how to contribute to the evaluation of the National Strategy for the Fight Against Drugs and its Action Plan – Horizonte 2004. The Prevention Department at the IDT planned and implemented a retrospective and prospective internal evaluation which collected data and information from the programmes in the field. For this exercise, the existing evaluation instruments were used (Table 2) but also new instruments were created (Table 3).

Programmes	PMP	PQPII	Ah-hoc projects	Telephone helpline
Existing instruments	Activity reports (3/year) Questionnaires for Municipalities, NGOs and Prevention Units	Execution Reports Technical and financial intermediate evaluation Execution data	Project data	Annual activities report

Table 4 – Prevention: Existing instruments for the evaluation of the National Strategy/Action Plan (IDT 2005)

Programmes	PMP	PQPII	Ah-hoc projects	Telephone helpline
New instruments	2004 Activity Report Questionnaires for counselling units Focus Groups in the IDT 5 Regional Delegations for Municipalities, NGOs and strategic target populations	2004 Summary Reports Questionnaires for the Prevention Units on the perception of PQPII; Questionnaires for counselling units Focus Groups in the IDT 5 Regional Delegations for, NGOs and professionals	2004 Activity Report Evaluation Reports Focus Groups for NGOs and professionals	2004 Activity Report Questionnaires for callers of the helpline and, through email, for other national telephone helplines

Table 5 – Prevention: New instruments for the evaluation of the National Strategy/Action Plan (IDT 2005)

The final report of the internal evaluation results is available at the IDT's website (<http://www.idt.pt>) but the main conclusions were the following:

- The National Strategy was considered to be extremely positive in terms of the definition of the drug abuse problem and the conceptualisation of multiple interventions;
- As for its implementation, the strong points were considered to be a higher consistency and structuring of the interventions and, consequently, higher quality standards. As for the weak points, some discontinuity of the intervention due to political changes at national and local level as well as difficulties in inter-institutional cooperation were reported;
- In terms of procedures, the strong points were considered to be the follow-up and technical support given by the IDT and the weak points the excessive centralisation in the Central Services of the IDT and the focus on quantity;
- In terms of future priorities, this evaluation pointed towards the need for continuity at intervention level, the qualification of professionals and the investment in training in the area of prevention.

In 2004, 21 new Municipal Plans were established increasing to 103 the total number of Municipal Prevention Programmes and to 439 the number of projects involved in those plans. 124 of these projects were finalised until December 2003 and 315 were still in execution during 2004. In 2004, 72% district capitals reported having a Municipal Plan, a strategic objective which had been set as a priority in 2001. These plans also covered 38% municipalities.

This achievement represents an important effort involving technical support in the different steps of the project methodology: conceptualisation, design, implementation and evaluation of the projects. It also implied a global investment of € 7 665 258,00 in 2004 (€ 3.321.025,13 in 2003) distributed in the following way:

Programme	Amount
Renewed Municipal Plan	€ 5 335 793,24
New Municipal Plans in 2004	€ 702 509,30
Framework for Prevention II (PQP II)	€ 1 211 735,00
<i>Ad-hoc</i> Projects	€ 415 220,46
Total	€ 7 665 258,00

Table 6 - IDT global investment in prevention programmes 2004 (IDT 2005)

It was again possible, as in 2003, to clearly identify best practices and organise the information in forms which include their identification, number of implementation years, intervention area, main problem targeted, general objectives, target population(s), selected strategies/methodologies, used materials, developed actions, geographical scope, infrastructures involved and main evaluation instruments/type of evaluation (forms available upon request). These projects were publicly disseminated as examples of best practice and are currently being prepared to be inserted in the EDDRA database.

3.1 Universal prevention

School

In 2004, school-based prevention in Portugal was mainly implemented through programmes developed by 3 different actors: the Ministry of Education; the IDT (Ministry of Health) through both the Framework for Prevention II and the Municipal Prevention Plans; and the Public Security Police (Ministry of Home Affairs).

At the Ministry of Education, the General-Directorate of Innovation and Curricular Development is responsible for conceptualising the educational and pedagogic component of the education system, including the definition of the curricular contents⁷. The Coordination Commission for Health Promotion and Education (CCPES), referred in previous National Reports, was merged into this General Directorate

The issue of substance abuse has been gradually inserted in school curricula. In 2004, the 9 year curricula for the Basic School levels included transversal areas which have to be explored in all academic subjects. Amongst them, the area "health and well-being education" included sex education and education for the prevention of personal risk situations, which include the area of substance abuse (both licit and illicit substances are covered). More specifically, the subject Physics and Natural Sciences explores, throughout the 9 years and in a suitable approach for each age group, the theme of health risks (alcohol, tobacco, drugs and physical activity) as well as the need for healthy life habits.

In terms of a non-mandatory but complementary approach, each school should assess the context at community level and decide to streamline the available resources in order to organise interventions in several areas, including the substance abuse one, if found to be a concern of the school community. A programme or project is them

⁷ Regulation n° 17/2004 of the 28th of April.

conceptualised and implemented to address those concerns. This should be done, as much as possible, with the active participation of all school staff, the pupils themselves, families and the community.

Concerning the IDT's Municipal Plans with projects in this area, it is possible to verify that the highest number of activities continues to take place between the 5th and 9th grade (ages 10-15, approximately), but in 2004, interventions in the primary school (ages 6-9, approximately) increased significantly and have registered practically the same number of interventions. These projects mainly approach issues such as individuals and social skills development, educational/cultural activities and training activities (please see Standard Questionnaire 22 on Universal School Based prevention for more information). Projects in the school setting are implemented in all 18 continental districts.

As far as intervention in the school setting in the Framework for Prevention II, the main objectives of the funded projects was to improve the quality of interpersonal relationships, minimise the risk factors linked to the use/abuse of licit and illicit substances.

A total of 80 activities were developed (104 in 2003) which reached a total of 4671 individuals (mainly in the primary school setting). The main type of activities implemented was again cultural/educational (26,9%), followed by training activities and acquisition of individual and social skills (approximately 21% and 15% for each).

It is also important to refer that, although intervention in early childhood (kindergarden and pre-school) accounts for only 10 projects in this Framework, this is a setting where the number of interventions has been increasing.

Amongst other activities, the Ministry of Home Affairs established a proximity policing programme, *Escola Segura* (Safe Schools) to improve security in the vicinity of schools through the PSP (Public Security Police) and the GNR (National Republican Guard).

PSP data for 2004/05 shows an increase in both the number of activities implemented and student population reached in comparison to 2002/03 and, for the first time indicates the number of teachers and school staff who also participated in the programme:

<i>Teaching Establishments</i>			<i>Number of Students</i>		<i>Number of Teachers and School Staff</i>	
	Public	Private	Public	Private	Public	Private
Basic (1 st Cycle)	1 250	287	180 319	43 624	14 588	2 541
Basic (2 nd Cycle)	283	108	124 036	15 090	18 405	1 751
Basic (3 rd Cycle)	281	89	124 708	19 268	16 195	1 807
Secondary	275	114	202 664	31 391	30 711	2 581
University	85	69	206 202	58 126	11 317	3 206
Sub-Total	2 174	667	837 929	167 499	91 216	11 886
Total	2 841		1 005 428		103 102	

Table 7 – PSP activities and target population for *Escola Segura* - 2004/05 (IDT 2005)

In the school year of 2004/05 the PSP had a total of 320 police officers (10 more than in previous years), 54 of which are female, and 253 vehicles (207 in previous years) specifically allocated to prevention actions in the school setting. The law enforcement agents ensure proximity policing and offence dissuasion, both during the day and the night, and are also involved in awareness and training activities in the teaching establishments, especially in the following areas:

- Drug abuse and alcoholism;
- Road safety;
- Self-protection;
- Risk prevention;
- Security of the school community.

Data on the interpellation of individuals in the schools or in the vicinity of schools for possession/use of illicit drugs continues to register decreases in comparison to previous years, a trend which is also verified in other indicators (see Chapter 8). The PSP attributes this to an increase of the control measures but also to the perception that young people prefer other types of settings (such as the recreational setting) for substance use. However, it has been detected that drug users sometimes use schools at night for shelter and privacy for substance use and leave behind paraphernalia which may pose a health threat to younger students. Surveillance near schools during the night will therefore be increased within this programme.

Possession/ Use of illicit drugs	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	TOTAL
	12	12	45	60	98	76	26	24	353

Table 8 - PSP offence interpellations in *Escola Segura* - 1997-2005 (IDT 2005)

GNR data indicate that a total of 279 agents (400 in 2003), working in teams of 3, and 227 vehicles (90 in 2003) are currently allocated to this programme. Apart from the proximity policing and offence dissuasion, these law enforcement agents are also involved in training and awareness raising initiatives in schools. In 2004 the number of interventions increased but there are no available data on the number of students reached.

Districts	Bragança, Vila Real, Braga, Viana do Castelo and Porto		Guarda, Castelo Branco, Viseu, Coimbra and Aveiro		Leiria, Santarém, Setúbal and Lisbon		Évora, Beja, Faro and Portalegre	
	2003	2004	2003	2004	2003	2004	2003	2004
Nº of teaching establishments	3 348	2 864	2 955	3 346	2 154	3 031	848	1 174
Nº of students	288 390	n.a.	194 233	n.a.	219 065	n.a.	73 207	n.a.
Nº of specifically committed agents	62	64	81	83	78	85	42	47
Nº of vehicles (not full time)	55	58	67	66	77	71	34	32
Nº of training actions	3 087	4 390	1 062	2 206	3 272	5 514	1 763	1 848

Table 9 - GNR activity data on *Escola Segura* intervention (2003/04)

Both law enforcement agencies stress the importance of having female agents allocated to this programme who are considered to play an important role in approaching female victims and presumed offenders.

More information on school prevention is reported through Structured Questionnaire 22 on Universal School Based Prevention. See also the next topic "Community".

Family

The development of projects in the area of family aims at increasing and promoting parental skills and to provide updated and useful information in the area of drug abuse. The main objective in 2004 was to promote the evaluation of the implemented projects to feed the information in the National Strategy evaluation process

In 2004, 131 projects of universal prevention in the family setting were promoted both through Municipal Plans and in the Framework for Prevention Programme. The activities implemented and the profile of the target groups was identical to what was referred in last year's National Report: an emphasis on training, counselling/follow-up, skills acquisition, workshops/debates and the implementation of self-help groups, mainly for individuals aged 26 or above but also worth mentioning is the involvement of the age group 16-25 (see also Structured Questionnaire 25 Universal Community Located Prevention for more information on universal prevention and the family setting).

Community

Community intervention at prevention level is mainly achieved through the Municipal Plans (which in 2004 reached 34% of the municipalities in Portugal) and projects funded under the Framework for Prevention.

Although projects within Municipal Plans include different types of settings, in 2004, most of them focused on the school setting (all grades although less represented at university and pre-school level) with 153 projects, followed by interventions in "leisure and sports settings" (102 projects), intervention in the family setting (68 projects) and interventions with young school drop-outs (21 projects).

The IDT was responsible for 47% of the funds for these projects, the rest having been financed by the municipalities, NGOs and private partners.

Concerning the type of activities, and similarly to 2003, most activities were of the type "educational-cultural", followed by "skills acquisition and training" and "counselling and follow-up interventions". The target population was very wide, from 6 year olds (2,7%) to over 40s (4,4%), but mostly from 6-9 to 16-18 (83,8%).

At a more general level, the IDT keeps the national telephone helpline, *Linha Vida – SOS Drogas* which, in 2004, as in 2003, was available from 10 am to midnight every working day and continued to respond to emails sent to a publicly advertised address in order to improve the availability of information and referral services. In 2004, 322 emails were received (103 in 2003) and, identically to 2003, 53,4% of those were information requests on substances.

From the 1st January to 31st December 2004, the helpline received a total of 40 022 calls from which only 5 072 were real calls, the rest being silent calls (9 350), hoaxes (24 915) and 685 insults. In the same period of 2003, it received a total of 50 266 calls from which only 7 341 were real calls, the rest being silent calls (13 939), hoaxes (27 810) and 1 176 insults.

Concerning the client profile, most calls continue to be made by those who had a problem or needed the information (71% in 2004 and 76% in 2003) followed by calls made by mothers (10% in 2004 and 7,7% in 2003) with doubts about drug use and

relationship problems with their children. In 2004, most callers were aged 11-15 (16-20 in 2003) and were mainly female (53,3%, 55,3% in 2003).

2 592 calls (4 093 in 2003) concerned information requests about substances mainly cannabis and opiates followed by cocaine, tobacco, alcohol and ecstasy. Calls which concerned substance use (638 calls for which it was possible to register information against 873 in 2003) include 509 calls related to active drug use (716 in 2003) and 101 (88 in 2003) from individuals in treatment. 31 of those callers (35 in 2003) referred being abstinent and 10 (21 in 2003) in reinsertion programmes at the time of their calls.

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.

In 2004, *Linha Vida* was also involved in developing materials, both for general information (leaflets on Drugs – Cannabis, Ecstasy, GHB, Opiates, LSD and Ketamine) and for prevention purposes (a leaflet on the ‘Parents and Cannabis’ and another on ‘Young people and Cannabis’).

In April of 2004 *Linha Vida* organized the II National Meeting of Helplines for all telephone healplines in Portugal to share experiences and information.

The EELDA project – Evidence Based Electronic Library on Drug and Drug Addiction- was another activity, funded by the EC, in which the *Linha Vida* team was involved together with the Trimbos Institute in the Netherlands and Drugscope in England.

3.2 Selective/indicated prevention

Recreational Settings

Both the Municipal Plans and the projects funded under the Framework for Prevention reported initiatives in this area, mainly for promoting healthy lifestyles through strategic interventions in recreational, leisure and sports settings normally used as leisure time settings. Under the Municipal Plans, 102 such interventions were reported (37 in 2003) in 70 Municipal Plans in all 18 districts of mainland Portugal. Under the Framework for Prevention 119 interventions (102 in 2003) were implemented in this area targeting 2 934 individuals. Most of these interventions, similarly to 2003, focused particularly on “educational and cultural activities”, “sports activities” and “training activities”.

The profile of the targeted populations was identical for both programmes: mainly children and youngsters from 6 to 15.

Please see also Structured Questionnaire 26 Selective and Indicated Prevention.

At-risk groups

Both the Municipal Plans and the projects funded under the Framework for Prevention reported sustainability of initiatives in this area: in the prison setting, with young school drop-outs and other at-risk groups and with young offenders through Programme “Choices” (Program Escolhas).

Prevention in the prison setting included, in 2004, the development of 20 interventions, mainly “training”, “educational and cultural” and “counselling/follow-up”. These interventions reached 1 196 individuals, mostly aged 25-40 (749 individuals), 18 to 25 (293 individuals) and over 40 (150 individuals).

Interventions with young school drop-outs reached 2 283 individuals, mostly aged 10-15. The main interventions implemented (47) focused on “educational and cultural” activities, “skills acquisition and training” and “counselling/follow up”.

Other projects (15) were implemented which promotes 122 interventions for 1 983 individuals (mostly children and youths) in different at-risk groups. Most of these interventions were focused on “educational and cultural” activities, “skills acquisition and training” and “leisure activities”.

On the other hand, the projects funded by Programme “Choices” target specifically young offenders aiming at the promotion of healthy lifestyles and specific activities for the development of social and individual skills. In 2003, 65 activities (46 in 2003), mostly education/cultural activities and sportive initiatives (similarly to 2003) were implemented. 292 individuals were reached, mostly aged 13 to18, similarly to 2003.

At risk families

“Prevenir pela Família” (Preventing through Family) is an NGO promoted project in cooperation with the local community of Barreiro (a municipality south of Lisbon) and funded by the IDT, which works directly with 40 families (Coelho, S. 2005). These families identified their own needs in terms of parental skills which were afterwards addressed by professionals in that area always in very close cooperation with the resources available in the community and the families themselves. The objective was to promote parental skills which might help families to deal with their own specific problems.

This project was initially intended as a selective prevention programme but was finally re-orientated towards a pilot project aiming at drafting of a good practise manual for professionals working in this specific area.

4. Problem Drug Use

4.1 Prevalence and incidence estimates

NO NEW INFORMATION AVAILABLE (the national estimate project is scheduled to be repeated in 2005)

4.2 Profile of clients in treatment

2004 national **first treatment demand data** concerned 5 023 individuals from the **outpatient** public network centres (CATs). These individuals were mainly:

- Of the male gender (84%);
- Aged 31 (mean age) - nearly half of them was aged 25-34 (22% were 25-29 and 25% were 30-34), 19% were aged under 25 (14% were 20-24) and 34% over 34 (18% were 35-39). In 2004, the ageing trend of this population, already visible in previous years, was again confirmed: in 2003, 31% of these clients were aged over 34 (30% in 2002, 28% in 2001, 26% in 2000 and 22% in 1999). The regions of North and Lisbon and the Tagus Valley registered an older population, the Centro and Alentejo Regions registered a younger population;
- Using mainly heroin as the main substance used (50%) – 55% in 2003 -, followed by heroin and cocaine (25%), cannabis (12%), cocaine (7%), benzodiazepines (2%) and ecstasy (0,5%);
- 69% of the clients referred daily use of their main substance while 16% stated they had not used it for the past month.
- Data concerning the administration route indicate that 72% of these clients refer smoking/inhaling and 25% referred injecting (respectively 68% and 30% in 2003).
- 25% of clients in first treatment demand referred injecting drug use in the last 30 days prior to the first treatment episode, (28% in 2003).
- 95% were Portuguese, 61% were single and 56% had not completed compulsory school;
- 37% were employed when the treatment programme started but 51% were unemployed;
- 44% lived with their parents and siblings.

In 2004, it was also possible, for the first time, to collect data on the profile of **all clients in treatment** (30 266 clients). These clients are:

- Of the male gender (83%);
- Aged 34 (mean age) - nearly half of them was aged 30-39 (28% were 30-34 and 23% were 35-39), 19% were aged 25-29 and 8% under 25 and 22% over 39;
- Using mainly heroin as the main substance used (63%), followed by heroin and cocaine (22%), cannabis (5%) and cocaine (3%);
- 80% of the clients referred daily use of their main substance when the treatment started while 11% stated they had not used it for the past month.

- Data concerning the administration route of the main drug indicate that 64% of these clients referred smoking/inhaling and 34% referred injecting at the time they started treatment;
- 25% of clients in first treatment demand referred injecting drug use in the last 30 days prior to the first treatment episode, (28% in 2003).
- They were mostly Portuguese (96%), single (63%) and had not completed mandatory education (62%).
- 48% were employed and 43% unemployed;
- 49% were living with their parents and siblings.

Data on characteristics of persons starting treatment on drugs in the **outpatient** public network centres (CATs) is also reported in Standard Tables 3 and 4.

In public and private⁸ **detoxification units**, clients are:

- Mainly for the male gender (87% in public units and 86% in private units)
- Aged 25-34, mean age 33 in public units, with a tendency towards aging in comparison to previous years' data although in the private units the age distribution within this age group indicated a younger profile.
- Most of these clients referred heroin as the main substance for which they were seeking treatment (67% in public units and 60% in private units), followed by cocaine (9% in public units and 23% in private units) and alcohol (8% in public units and 9% in private units).
- Concerning the administration route for the main drug: In the public units, 46% of the clients reported smoking/inhaling and 35% referred injecting; 71% referred ever had injected in their lifetime, 43% in the last 30 days and 36% admitted ever had shared syringes and/or other type of drug paraphernalia. In the private units 52% of the clients reported injecting while 33% referred smoking/inhaling; 56% referred ever had injected in their lifetime, 40% in the last 30 days and 30% admitted ever had shared syringes and/or other type of drug paraphernalia.
- These clients were mainly unemployed (64% in public units and 62% in private units).

53% of the clients in public and 50% in private **therapeutic communities** were admitted for the first time in 2004. These clients were:

- Mainly from the male gender (65% in public units and 84% in private units);
- The mean age in the public units was 31 and in the private units of 32. They were mainly aged 25-29 (33% in the public units) and 30-34 (28% in the private units).

In public and private **day centres** most clients were:

- Of the male gender (84% in public units and 86% in private units),
- Aged (mean age) was 34 in public units and 32 in private units,
- With low education status (59% in the public units and 68% in the private units had not completed the 9th grade);
- And single (69% in the public units and 67% in the private units);

⁸ Data concerning private units cover only the units accredited by the IDT.

- These clients reported heroin as the main substance (83% in the public units and 73% in the private units), followed by cocaine (18% in the public units and 9% in the private units), and most had used for more than 10 years (77% in the public units and 61% in the private units).

4.3 Main characteristics and patterns of use from non-treatment sources

Drug abuser individuals who are particularly excluded turn to the Institute for Solidarity and Social Security (ISSS) for psycho-social, referral and financial support. These individuals (3 470 in 2004) are:

- Mainly of the male gender (77%);
- Aged mainly 30-34;
- With a low educational status (51% finished basic school but 40% did not);
- 82% are unemployed.

Those who reported being in treatment are mainly integrated in public outpatient treatment units (53%).

A recent research project (Joaquim 2005) looked retrospectively to 278 male individuals in Lisbon – 71 drug abusers in prison, 48 individuals in prison with no drug abuse problems and 159 drug abusers outside prison. Although this is a local study which can not be extrapolated at national level, some results are worth referring to concerning drug abusers in that particular Lisbon prison:

- 75,7% referred using hard drugs in prison,
- 64,2% referred polydrug use;
- They also indicated, more often than the non-imprisoned drug abusers, solvents heroin or cocaine as their first substance of abuse;
- They reported having started using drugs at age 15,8 (14,9 for the non-imprisoned group) and starting using hard drugs at age 19 (17,7 for the non-imprisoned group);
- 55,3% have only finished 6th grade or less and among these 11,6% reported only having learnt how to read and write;
- 22,4% came from problematic neighbourhoods (2,7% for non-imprisoned drug abusers);
- 46,8% have been using drugs for more than 10 years (76,5% for non-imprisoned drug abusers);
- 60,7% use more than two grams a day (19,9% of non-imprisoned drug abusers);
- 56,5% were unemployed at the time of their arrest (65,9% of non-imprisoned drug abusers when they start treatment). Those who were employed reported very unspecialised and undifferentiated jobs. (See also chapter 8.2);
- 76,1% come from low income families (49,7% of the non-imprisoned drug abusers);
- 67% reported current injecting behaviour.

5. Drug-Related Treatment

5.1 Treatment systems

In 2005, the main priority in the treatment area has been promoting quality through the development of new guidelines for both drug-free and medically assisted treatment programmes. In particular, the IDT collected information on the procedures of substitution programmes with opiate agonists in the public network. An internal report characterising procedures and practices was already prepared in order to prepare the path for issuing guidelines in this area.

In order to continue improving the availability of all types of treatment programmes, pharmacies, which had been providing methadone (since 1998) and naltrexone (since 2001) in the framework of CAT high threshold programmes, are now involved in the provision of buprenorphine (January 2004). Suitable training was provided for professionals of the involved pharmacies.

For more information on treatment systems, please see Structured Questionnaire 27 on Treatment Programmes.

5.2 Drug free treatment

Inpatient drug free treatment is mainly available in public and private⁹ therapeutic communities. In 2005 there were 73 therapeutic communities (2 public and 71 private units) in mainland Portugal. In comparison to 2003 there were 2 less therapeutic communities (private ones). In 2004, the number of registered clients in both public (75 clients) and private units (4 179) increased in comparison to 2003 by more than 100 clients.

Data from the **public therapeutic communities** indicate that the majority of their clients (53%) were admitted for the first time in 2004 into a therapeutic community. 96% of the admissions resulted from a therapeutic project. Of those:

- 67% entered the TC after 2 months follow-up at an outpatient treatment centre;
- 27% after a detoxification programme in a detoxification unit;
- 3% after follow-up at a day centre.

Concerning the source of referrals:

- The majority of these clients (89%) were referred by a therapist (83% by a CAT therapist, 4% by a therapist from another health service and 3% by a private therapist);
- 7% stated they had registered due to their family pressure or initiative;
- 3% by their own initiative;
- 1% were referred by the Court as an alternative to prison (see also chapter 9.2.).

The situation of these clients on the 31/12/2004 was the following:

- 9% of the 2004 clients had been given programmed medical release (13% of all those who left the CT):
 - 86% of those who had medical release were referred to a CAT;
 - 14% were referred to other types of drug treatment centres.

⁹ Data from private units cover only the units accredited by the IDT.

- 61% had left without medical release (87% of those who left).
 - Those who had left without medical release did so at their own request (57%), were expelled (35%) or ran away (2%);
 - 52% of these situations occurred after the first 3 month period and 20% during the first month period;
 - Follow-up was possible for 76% of those who left without programmed medical release: 80% were referred to a CAT and 9% to other types of drug treatment centres.
- 29% were still following their programme in the CT.

On the same date, those who had left with programmed medical releases were mainly abstinent (86%) for their main drug. 14% stated they were using occasionally. For those who left without programmed medical release, and for whom information is available (52%), 54% were abstinent of their main drug, 17% stated occasional use and 29% stated they were using regularly but were following a treatment programme.

2004 data for **private therapeutic units** indicate that near 50% of the clients had been admitted for the first time in a therapeutic community in that year but only in 49% of the cases was there a therapeutic project:

- 22% of the clients were referred to the TC after 2 month follow-up at an outpatient treatment centre;
- 17% after a detoxification programme at a detoxification unit;
- 10% after follow-up at a day centre.

Of the 51% clients who had no therapeutic project, 18% had had no previous treatment.

Concerning the source of referrals:

- The majority of these clients (33%) stated they had registered in the TC by their own initiative;
- 32% were referred by a therapist (21% by a CAT therapist, 8% by a therapist from another treatment service and 3% by a private therapist);
- 28% stated they had registered due to their family pressure or initiative;
- 4% were referred by the Court as an alternative to prison.

The situation of these clients on the 31/12/2004 was the following:

- 28% of the 2004 clients had been given programmed medical release (39% of all those who left the CT):
 - 36% of those who had programmed medical release were referred to half-way apartments for rehabilitation projects;
 - 6% were referred to private therapist;
 - 5% were referred to a CAT;
 - 3% were referred to a day centre.
- 43% had left without medical release (61% of those who left).
 - Those who had left without medical release did so at their own request (72%), were expelled (14%) or ran away (12%);
 - 39% of these situations occurred during the first month period and 33% after the first 3 month period;

- 43% of those who left without programmed medical release were referred to a CAT, 8% to a private therapist, 4% to another treatment service and 4% to a day centre.
- 29% were still following their programme in the TC.

On the same date, those who had left with programmed medical releases were mainly abstinent (81%) for their main drug. 8% stated they were using regularly but were following a treatment programme, 6% were using regularly and were not following a treatment programme and 10% were using occasionally. For those who had left without programmed medical release, 35% were using regularly and were not following a treatment programme, 33% were abstinent of their main drug, 21% were using regularly and were following a treatment programme, 9 were using occasionally and 2% had died.

For information on the profiles of clients in these units please see Chapter 4 of this Report.

In 2004, as in 2003, 54 **Outpatient treatment centres** were active in mainland Portugal, and 16 decentralised consultation units (*locais de consulta*).

A slight 2% increase (in comparison to 2003) was verified in the number of **active clients in the outpatient public treatment network**, contrary to the decrease verified in 2002 and 2003. The number of active clients in all the Regional Delegations increased, except in the Regional Delegation of the Alentejo, particularly in the Algarve (+12%). The 30 266 active clients in 2004 (29 596 in 2003) were regionally distributed in the following way: 36% in Lisbon and the Tagus Valley, 32% in the North, 19% in the Centre, 9% in the Algarve and 4% in the Alentejo.

Once more the districts of Lisbon and Porto, followed by Setúbal, Faro, Braga and Aveiro registered, in 2004, the highest numbers of active clients. In comparison to last year, increases were registered in the districts of Faro and Aveiro. Decreases were registered mainly in the districts of Lisbon and Castelo Branco. Similarly to previous years Faro, Beja, Setúbal and Bragança were the districts with higher rates of active clients per total number of inhabitants.

Regional Delegation \ Year	2000	2001	2002	2003	2004
Total	29 204	32 064	31 835	29 596	30 266
Northern	9 573	9 881	10 464	9 685	9 786
Central	4 973	5 518	5 610	5 371	5 655
Lisbon and Tagus Valley	10 914	12 466	11 611	10 711	10 739
Alentejo	1 448	1 455	1 397	1 373	1 342
Algarve	2 296	2 744	2 753	2 456	2 744

Table 10 – Active clients, by Year and Regional Delegation (IDT 2005)

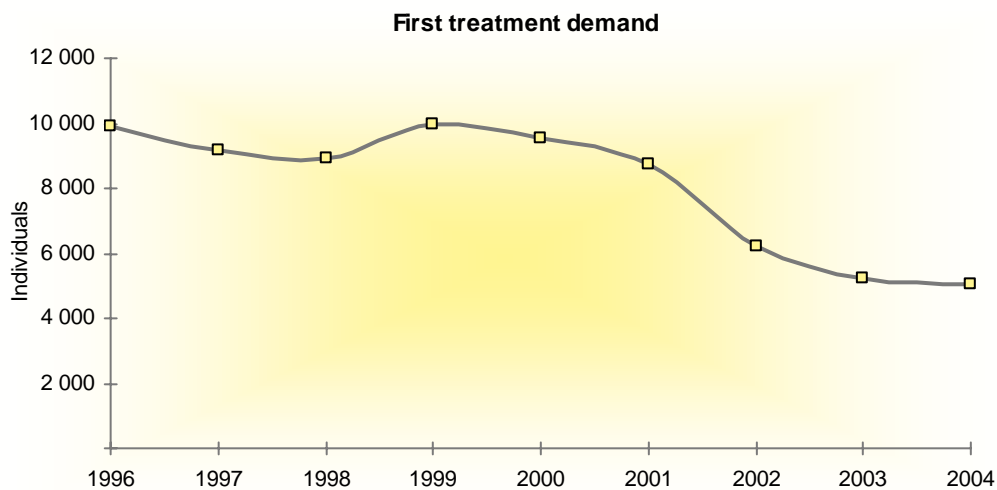
Concerning the source of referral for the active clients in treatment (30 266 in 2004)

- 31% of the clients registered in the CAT by their own initiative;
- 29% were referred by other health services;
- 11% were referred by their families or friends;
- 6% by the Criminal Justice Services;

- 5% by the Social Services.

In 2004, 374 149 **follow-up treatment episodes** were reported, a 4% increase in comparison to 2003 (355 018).

Similarly to what has been registered since 2000, the number of **first treatment episodes in the outpatient public network** in 2004 (5 023 clients) also decreased in comparison to 2003 (-4%), representing the lowest value registered since 1994. This was mainly related to decreases in the Regions of Lisbon and the Tagus Valley and Porto, as in the other regions the number of first treatment demands increased. Leiria and Braga were the districts with higher increases whereas Lisbon, Porto and Portalegre registered decreases. However, the districts of Faro, Beja, Bragança, and Lisbon were the districts, which registered the highest rates of first treatment demands per number of inhabitants aged 15-39.



Graph 2 – First Treatment demand (IDT 2005)

Concerning the source of referral for the clients who demanded treatment for the first time:

- 33% were referred by the Health services;
- 25% came by their own initiative;
- 12% were referred by their families or friends;
- 8% by the Criminal Justice Services;
- 5% by the Social Services.

Public and private¹⁰ **day centres** also provide outpatient care in Portugal. In 2004, 611 clients were registered in day centres, both public (83) and private (528), representing a slight decrease in comparison to 2003.

Day Centres	Year						
	1998	1999	2000	2001	2002	2003	2004
Day Centres	76	380	335	507	579	617	611
Public	76	106	83	80	89	73	83
Accredited	–	274	252	427	490	544	528
Funded by the IDT	–	274	252	318	340	338	317

Table 11 – Clients in Day Centres by Year (IDT 2005)

80% of the **public units'** clients had never registered in a **day centre**. The majority (98%) registered after 2 month follow-up at an outpatient centre, 1% after a detoxification programme at a detoxification unit and 1% after following a treatment programme in a TC.

Concerning the source of referral, all these clients were referred to the day centre by a CAT therapist.

On the 31/12/2004 the situation of the 2004 clients was the following:

- 40% of the 2003 clients had left with medical release (57% of all that left):
 - 64% of these clients remained for less than 6 months;
 - 82% were referred to a CAT;
 - 15% were referred to a TC.
- 30% left without medical release (43% of all that left):
 - 88% abandoned the programme at their own request;
 - 8% were expelled;
 - 52% of those who left without medical release did so during the first month of the programme and 32% after the first 3 months of the programme;
 - All these clients were referred to a CAT.
- The remaining 30% were still at the centre.

At the **private day centres**, 75% of the clients had never registered in a day centre. 34% of the individuals registered after 2 month follow-up at an outpatient centre, 6% after a detoxification programme at a detoxification unit and 1% after following a programme at a TC. For the remaining 59% of the clients, entering a day centre was not a result of a therapeutic project and 18% reported they had never followed a treatment programme before.

Concerning the source of referral:

- The majority of these clients (40%) stated they had registered in the centre due to their family pressure or initiative;

¹⁰ Data from private units cover only the units accredited by the IDT.

- 28% by their own initiative;
- 26% were referred by a therapist (17% by a CAT therapist, 8% by a therapist from another treatment service and 1% by a private therapist);
- 5% were referred by the Court as an alternative to prison.

On the 31/12/2004, the situation of these clients was the following:

- 33% of the 2003 clients had left with programmed medical release (45% of all that left);
 - 68% of these clients remained for less than 6 months;
 - 58% were referred to a TC.
 - 9% were referred to another treatment service;
 - 2% for half-way apartments.
- 40% left without programmed medical release (55% of all that left):
 - 93% abandoned the programme at their own request;
 - 4% were expelled;
 - 47% of those who left without medical release did so during the first month of the programme and 20% after the first 3 months of the programme;
 - 35% of these clients for which information is available (44%) were referred to a CAT, 5% to a TC and 4% to a private therapist.
- And the remaining 27% remained at the Day Centre.

In the specific area of abstinence-oriented treatment in the **prison setting**, in 2004, there were 5 drug-free units in five prisons with a total capacity for 172 individuals, a therapeutic community with a capacity for 45 individuals and one halfway house with capacity for 12 individuals.

216 inmates were integrated in the drug-free units and 67 in the therapeutic community which represented, respectively, a variation of -33% and +5% increases in comparison to 2003 and +3% and 37% increases in comparison to 2002. 14 clients were registered in the halfway house, representing a small decrease in comparison to 2003 (17 clients).

5.3 Medically assisted treatment

Withdrawal treatment is mainly available in public and private¹¹ detoxification units. In 2003 there were 14 detoxification units (5 public and 9 private units) in mainland Portugal. In comparison to 2003 there was 1 less detoxification unit (a private one). In 2004, slightly more clients were registered in detoxification units, in comparison to 2003 (+1%).

Both public and private **detoxification units** reported on the motive and main objective of the detoxification request. Clients (1 792 in public units and 1 579 in private units) referred as motives and main objectives the following:

¹¹ Data from private units cover only the units accredited by the IDT.

In public units:

- Motives:
 - 92% wanted to achieve detoxification from one or more illicit substances;
 - 8% stated other reasons including co-morbidity problems and substitution programmes.
- Objectives:
 - 61% wanted to start substitution treatment;
 - 16% wanted to enter a TC;
 - 12% wanted to stop their problematic drug use;
 - 9% wanted to achieve abstinence from illicit substances, agonists and antagonists.
- In private units:
 - 55% wanted start a substitution programme.
 - 31% wanted to enter a TC;
 - 8% wanted to achieve abstinence from illicit substances, agonists and antagonists.
 - 4% wanted to stop their problematic drug use;

On the 31/12/2004, the situation of these clients was the following:

In public units:

- 80% of the 2004 clients had left with programmed medical release;
- 20% left without programmed medical release:
 - 80% abandoned the programme at their own request;
 - 19% were expelled.

In Private units

- 76% of the 2004 clients had left with programmed medical release;
- 23% left without programmed medical release;
- 1% remained in the programme;

For information on the profiles of clients in these units please see Chapter 4 of this Report.

In 2004, the number of clients in **substitution and maintenance programmes** represented near 64% of the total active clients in the outpatient public treatment network, an increase in comparison to previous years (57% in 2003, 50% in 2002, 40% in 2001, 36% in 2000 and 22% in 1999).

19 260 clients were registered in these programmes in 2004, which represented a 14% increase in comparison to 2003 (16 877). 5 037 cases were new admissions and 4 679 left the programme during the year, 25% of whom with a medical release.

In terms of regional data:

- For the first time ever, it was the Region of Lisbon and the Tagus Valley, and not the Northern Region, which registered the highest number of clients;

- Nevertheless, the percentages in relation to the total number of active clients in each region continued to be higher in south area, the Algarve Region (80%) and the Alentejo Region (71%);
- Other regions registered a relative weight of these clients between 51% and 65%.

A survey made each year on the 31st of December 2004 allows to differentiate in terms of substances involved in this type of treatment.

On that date, there were 14 581 clients in the outpatient public treatment network substitution programmes, representing an increase of 17%, 20%, 42%, 75%, in comparison to the same date in 2003, 2002, 2001 and 2000, respectively.

- 72% were registered in methadone programmes;
- 28% in buprenorphine programmes.

In comparison with the situation on the 31st of December 2003, an increase of 7% was registered in the number of clients in methadone programmes and a significant increase (+51%) was registered in the number of clients registered in the buprenorphine treatment programmes.

In terms of regional data:

- All regions registered an increase in the number of clients in methadone programmes except the Algarve Region, which, for the third consecutive year, registered a decrease in the number of those clients;
- As for the number of clients registered in buprenorphine programmes, the increase was verified in all Regions;
- Contrary to what was verified in previous years, the Lisbon and the Tagus Valley Region, and not the Northern Region, registered the highest number of clients in substitution treatment programmes, in absolute and relative terms, both with methadone and buprenorphine.

Regional Delegation	Programme	Total	Substitution Programmes	
			With Methadone	With Buprenorphine
	On the 31/12/2003	12 508	9 765	2 743
Total	On the 31/12/2004	14 581	10 438	4 143
Northern		5 097	3 585	1 512
Central		2 239	1 481	758
Lisbon and Tagus Valley		5 202	3 649	1 553
Alentejo		648	567	81
Algarve		1 395	1 156	239

Table 12 – Clients in substitution programmes (IDT 2005)

Concerning the place of administration for the clients registered in methadone programmes, on the 31st of December 2004:

- 68% of these clients took their methadone in CATs;
- 19% in Health Centres;
- 4% in the prison setting;

- 3% in pharmacies;
- 3% in other settings¹².

In all Regions, CATs were the main place of administration, followed by the Health Centres. In the particular case of the prison setting, a 45% increase was verified in the number of clients using methadone prescribed by CATs (431 clients on the 31/12/04), though taken in the prison setting, and a decrease (-9%) in the number of clients using methadone prescribed by the health services of prisons (315 clients on the 31/12/04).

Regional Delegation	Structures Total	Treatment	Health	Prison Establishment	Hospitals	Pharmacies	Other Structures ^{a)}
		Centres for Drug Addicts	Centres Users				
Total	10 438	7 137	1 997	431	233	286	354
Northern	3 585	2 333	647	169	192	90	154
Central	1 481	874	475	59	26	41	6
Lisbon and Tagus Valley	3 649	2 959	253	134	10	140	153
Alentejo	567	389	141	28	9
Algarve	1 156	582	481	41	5	15	32

Table 13 – Clients of Methadone Administration Network and place of administration, by Regional Delegation (IDT 2005)

a) Home, BCG, Centres of Pneumonological Diagnosis and other local institutions

Substitution Treatment is also available in the prison setting, apart from the above mentioned programmes which are developed in partnership with CATs. The General Directorate of Prisons implements its own substitution treatment programme which, in 2004, included 410 individuals.

¹² Pulmonary Diagnostic Centres and other local organisations.

6. Health Correlates and Consequences

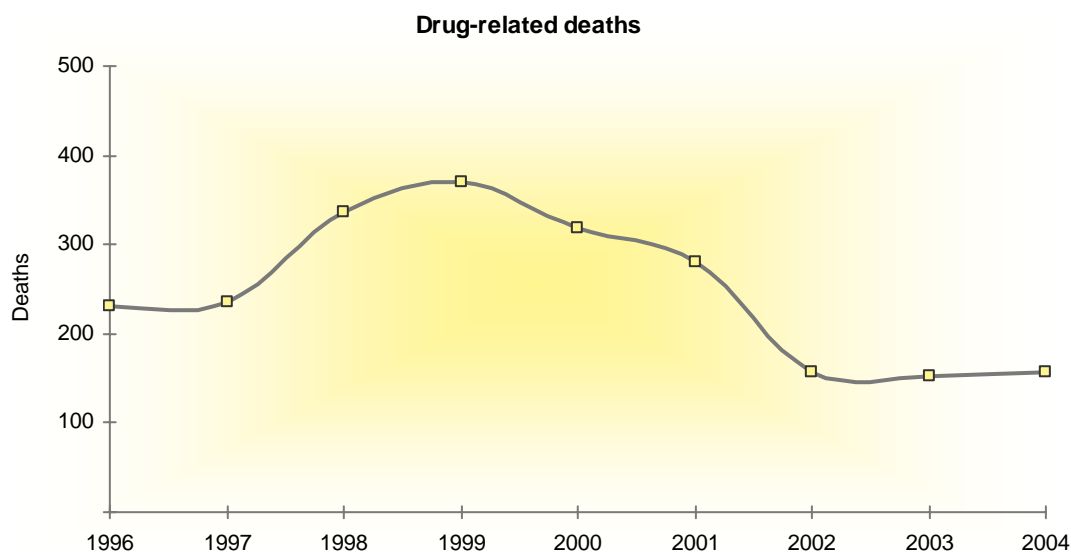
6.1 Drug related deaths and mortality of drug users

Direct overdoses and (differentiated) indirect drug related deaths

As reported in Standard Tables 4 and 5, the national definition of drug-related deaths is still based in data from the Special Mortality Register (SMR) due to the already reported limitations of the General Mortality Register (GMR) and for trend setting purposes.

Data from the GMR (Selection B of the DRD Protocol) indicate a decrease which started to take place from 1996 (114 cases) until 2004¹³ (18 cases). These cases occur mainly in individuals of the male gender aged 35-44, but there is no information available on toxicology.

Although acute drug-related deaths are not yet possible to identify amongst the cases reported by the SMR it has been possible to identify the percentage of suspected acute drug-related deaths. In 2004, 156 cases with positive *post mortem* toxicological tests were reported by the Special Register. The last 3 years indicate these figures are levelling off (152 cases in 2003 and 156 cases in 2002) after significant decreases in previous years since 1999. Near 51% of these deaths occurred in the forensic region of Lisbon, 29% in Coimbra and 20% in Porto.



Graph 3 – Drug-related deaths 1996 – 2004 (IDT 2005)

The number of requested tests has been increasing but, at the same time, there has been a decrease in the number of positive tests since 1998 in all the delegations of the INML. In 2004, the percentage registered for all delegations was 9% (11% in 2003, 13% in 2002, 22% in 2001, 25% in 2000, 35% in 1999 and 37% in 1998).

Most of these episodes occurred in individuals¹⁴ of the male gender (90%), mainly aged 25-39 (60%). Opiates are, in all age groups, the main substance involved in drug related deaths, except in the lowest age group (<20 years), where cannabis was predominant and in the age group 20-24 where cocaine was predominant.

¹³ Provisional data which may be updated.

¹⁴ Percentages calculated on the cases for which information exists on the considered variables.

Contrarily to previous years, the cases where more than one substance was detected were predominant (62%) if both licit and illicit substances are considered.

- Once again opiates¹⁵ were the main substance involved in drug related deaths (69% of the cases – 64%, 69%, 81%, 88% and 95%, in 2003, 2002, 2001, 2000 and 1999), followed by cocaine (49%) and cannabis (10%);
- In 50% of the cases, opiates were found together with other substances, particularly cocaine and/or alcohol (44%);
- The percentage of cases where cocaine was detected increased (37% in 2003, 44% in 2002 and 34% in both 2001 and 2000) and in most of them other substances were detected, particularly opiates and/or alcohol (36%);
- On the other hand, the percentage of cases where cannabis was detected decreased (22% in 2003, 13% in 2002, 11% both 2001 and 6% in 2000) and only in 5% of the cases was it detected isolated.
- Methadone and amphetamines were detected in 3% of the cases.
- More often than in 2003, was alcohol involved in combination with other illicit drugs, and in 6% of the cases medication was associated to other drugs, also a higher percentage than in 2003.

51% of the cases with positive toxicological tests and information on the presumed aetiology of death were suspected to be acute drug-related deaths. This percentage, which decreased between 2000 and 2003, increased in 2004, in comparison to 2003 (44% in 2003, 58% in 2002, 73% in 2001 and 72% in 2000).

Mortality and causes of deaths

The Surveillance Centre of Transmissible Diseases (CVEDT) received, from 1993 and until the 31/03/2005, 6 195 notifications of AIDS-related deaths, 51% of which were drug related. The percentage of deaths in drug-related and non drug-related AIDS cases were, respectively, 54% and 50%, with no significant difference between genders. Once again it was verified that the districts which presented higher percentages of drug-related AIDS cases (Lisbon, Porto and Setúbal) were the ones that also registered a higher number of deaths. Nevertheless, inland districts (such as Vila Real, Viseu and Braga) registered the highest mortality percentages of drug related AIDS cases.

In 2005, the infection by HIV was included in the national list of diseases which implies mandatory notification (please see Chapter 1.1). Although this had no implications for 2004 data, it will have implications for 2005 data, not only because it will help improve the efficacy and efficiency of the system but also because it will probably imply an increase in the number of notifications which may not automatically imply a higher incidence in the population.

6.2 Drug-related infectious diseases

HIV/AIDS, viral hepatitis, STD, tuberculosis, other infectious morbidity

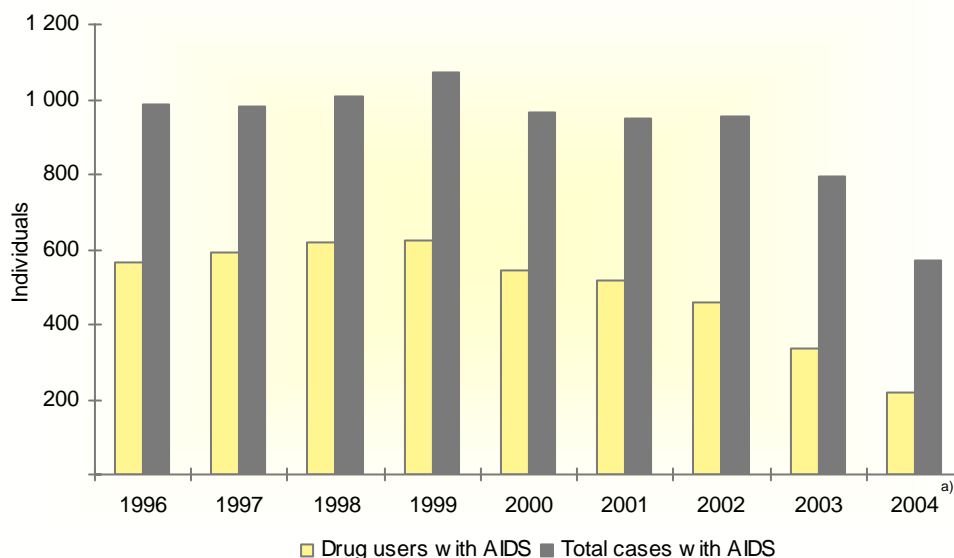
According to 31/03/2005 **notification data** from the Surveillance Centre of Transmissible Diseases (CVEDT), the decreasing trend concerning the percentage of drug users in the total number of notified HIV positive cases since 1993 continues to be reported. From the 26 445 notifications received, 48% were drug use related. Considering the different stages covered by these notifications, 50% of the AIDS

¹⁵ Includes heroin, morphine and codeine.

cases, 43% of the AIDS related complex cases and 48% of the asymptomatic carriers cases were drug use associated.

Taking only 2004 notified cases, 39% of the AIDS cases, 28% of the AIDS related complex cases and 23% of the asymptomatic carriers cases were drug use associated.

Total notification of AIDS cases and cases associated to drug use



Graph 4 – Total notification of AIDS cases and cases associated to drug use (IDT 2005)

Since 1998, the percentage of drug users in the overall number of diagnosed AIDS cases, has been decreasing: 62%, 59%, 56%, 55%, 48%, 42% and 39% of the diagnosed cases in, respectively, 1998, 1999, 2000, 2001, 2002, 2003 and 2004.

Notified drug use-related AIDS cases are:

- Mainly of the male gender (88%),
- Most of them aged 20-39 (90%), mainly 25-34 (59%).

The male gender is also predominant in the other AIDS cases not drug use-related (81%), but those individuals are older: only 47% were aged 20-39, and 51% were aged over 39. Drug users with AIDS related complex and asymptomatic carriers are mainly of the male gender and aged 20-39.

Once again the district of Porto registered the highest rates of drug users with AIDS over the total number of AIDS cases notifications (70%). The relativisation of notification data to the resident population in each district also shows the districts of Lisbon, Porto and Setúbal as the ones with higher rates of drug users with AIDS per inhabitant. Faro ranked fourth, despite registering only 3% of the total number of notification cases of AIDS and 2% of drug use related AIDS.

In 2005, the infection by HIV was included in the national list of diseases which implies mandatory notification (please see Chapter 1.1). Although this had no implications for 2004 data, it will have implications for 2005 data, not only because it will help improve the efficacy and efficiency of the system but also because it will probably imply an increase in the number of notifications which may not automatically imply a higher incidence in the population.

Also concerning this topic, it is important to consider data concerning HIV testing in the **drug user's sub-populations which requested treatment** in the public detoxification and treatment network and in the accredited private detoxification and treatment units¹⁶, as reported in Standard Table 9.

2004 outpatient **first treatment demand data** concerning HIV tests indicate 12% of HIV positive individuals amongst those individuals who presented the results of their tests. This percentage was lower than the one registered in 2003 (15%) and in 2001 (14%) and slightly higher than the one registered in 2002 (11%). Near 19% of these HIV positive individuals were following antiretroviral therapy, a lower percentage than the ones registered in 2003 (28%), 2002 (33%), 2001 (44%) and 2000 (22%).

For the first time it was possible to collect data on the **active clients of the public treatment network** (clients with at least one consultation episode during the year, which also includes first treatment demands). 16% of these clients tested positive for HIV (these clients are tested at the moment of their admission). 36% of them were following antiretroviral therapy, a higher percentage than the one registered in 2003 (34%).

13% of clients from **inpatient public and private detoxification units** tested positive for HIV. These percentages were 16%, 13%, 17% and 14%, respectively in 2003, 2002, 2001 and 2000. 36% of these individuals were in antiretroviral therapy, (40% in 2003, 38% in 2002, 28% in 2001 and 27% in 2000).

An information and data collection project was launched by the IDT's Monitoring Centre to collect data in all 5 public Detoxification Units in Portugal concerning, amongst other items, HIV, hepatitis B, hepatitis C and tuberculosis in **IDUs**. Data was not made available yet but will probably be submitted before the end of 2005.

Concerning **public and private therapeutic communities**, the percentage of clients tested HIV positive (17%) was slightly higher than in 2003 (16%), and slightly inferior or similar to the ones verified in the previous years (18% in 2001 and 17% in 2000). 68% of those were in antiretroviral therapy percentage similar to the ones verified in 2003 and 2002.

Figures are therefore stable in comparison to recent years, although outpatient first treatment demand data and detoxification units data registered a slight decrease and therapeutic community data registered a slight increase. In 2004, the percentage of clients who tested positive for HIV and were in antiretroviral therapy, ranged from 19% and 68%, globally lower percentages than in previous years.

Concerning **Hepatitis and Tuberculosis**, data available, and also as reported in Standard Table 9, refer to the tests made in drug user's subpopulations that demand treatment in the public and accredited treatment structures¹⁷.

¹⁶ In 2004, 23% of the clients in outpatient first treatment episodes, 22% of the active clients in treatment (data presented for the first time), 84% of the clients of detoxification units (92% of the clients of DUs and 75% of the clients in accredited DUs) and 95% of the clients in Therapeutic Communities (100% of the clients of public TCs and 96% of the clients in accredited TCs), presented valid tests for HIV status.

¹⁷ In 2003, results for Hepatitis B were presented by 20% of all active clients in outpatient treatment, 20% of the clients in outpatient first treatment episodes, 81% of the clients of detoxification units (87% of the clients in public DUs and 75% of the clients in accredited DUs) and 96% of the clients in Therapeutic Communities (100% of the clients in public CTs and 97% of the clients in accredited TCs).

Results for Hepatitis C were presented by 21% of all active clients in outpatient treatment, 21% of the clients in outpatient first treatment episodes, 82% of the clients of detoxification units (89% of the clients in public DUs and 75% of the clients in accredited DUs) and 96% of the clients in Therapeutic Communities (100% of the clients of public TCs and 96% of the clients in accredited TCs).

Concerning Tuberculosis, tests results were presented by 9% of all active clients in outpatient treatment, 11% of clients in outpatient first treatment episodes, 86% of the clients of detoxification units (96% of the clients of public DUs and 75% of the clients in accredited DUs) and 94% of the clients in Therapeutic Communities (100% of the clients of public TCs and 94% of the clients in accredited TCs).

In 2004, data on Hepatitis B and C show that 3% of the tested **active clients in outpatient treatment** were positive for Hepatitis B (AgHBS+) and 58% for Hepatitis C (HCV+). These percentages were very similar to the ones verified in 2003 (4% for Hepatitis B and 58% for Hepatitis C).

3% of the tested clients in their **first outpatient treatment episode** were positive for Hepatitis B (AgHBS+) and 44% for Hepatitis C (HCV+). These percentages were very similar to the ones verified in previous years, especially in the case of Hepatitis B (3% in 2003, 8% in 2002, 5% in 2001 and 10% in 2000), but also for Hepatitis C (45% in 2003, 64% in 2002, 45% in 2001 and 49% in 2000).

In **detoxification units** the global¹⁸ percentages for public and accredited units were 9% for Hepatitis B and 62% for Hepatitis C. The percentage of positive tested clients in these units was in 2003, 2002, 2001 and 2001, respectively 7%, 10%, 7% and 25% for Hepatitis B and 62% 59%, 58% and 69% for Hepatitis C

In public and accredited **therapeutic communities** 7% were positive for Hepatitis B and 50% for Hepatitis C. The percentage of positive tested clients in these units was in 2003, 2002, 2001 and 2000, respectively 8%, 10%, 95 and 14% for Hepatitis B, and 48%, 51%, 51% and 49% for Hepatitis C.

These data suggests, in the case of Hepatitis B, a slight tendency for decrease of the positive percentages and, in the case of Hepatitis C, a stability of positive cases.

Concerning **Tuberculosis**, 4% of the **active outpatient clients** who presented results for their tests were positive and all were following treatment. This figure is similar to the one registered in 2003 (3%).

4% of the **new outpatient clients** who presented results for their tests were positive and all were following treatment. This figure is similar to the ones registered in 2003 (3%), 2002 (4%) and in previous years (2% in 2001 and 2000).

In **detoxification units** the global percentage of positive cases was again 1% for Tuberculosis, identical to the ones registered in 2003 and 2002.

In **therapeutic communities** the percentage of positive cases was also again 2% for Tuberculosis (2% in 2003 and 1% in 2002, 2001 and 2000).

6.3 Psychiatric co-morbidity (dual diagnosis)

An information and data collection project was launched by the IDT's Monitoring Centre to harmonise definitions and procedures in all 5 public Detoxification Units in Portugal. The project included the redesign of the data collection instrument and experts meetings to comment on the statistical analysis. Disaggregated data was collected from all clients in these units in 2004 which includes information on psychiatric co-morbidity, however, due to difficulties in harmonising diagnostic and recording procedures, the information was not yet made available.

6.4 Other drug-related health correlates and consequences

NO NEW INFORMATION AVAILABLE

¹⁸ Considering results per type of service but not differentiating between public and accredited units.

7. Responses to Health Correlates and Consequences

7.1 Prevention of drug related deaths

Prevention of drug related deaths is one of the activities included in the National Harm Reduction Network, funded by the IDT, which included 26 projects throughout the country in 2004. Please see Structured Questionnaire 29.

7.2 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 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). Since it was set up, in October 1993, it has used 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. This programme was 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 during the eight years of existence of this programme.

32 846 581 syringes have been exchanged through this programme since October 1993 and until December of 2003. The number of exchanged syringes had increased between 1994 and 1997, reaching a maximum that was stable until 1999, increased again in 2000, decreased 23% in 2002 and slightly decreased in 2003 (-0,42%).

In 2004 2 744 901 syringes were exchanged, which represented a slight 3% increase in comparison to 2003. These syringes are included in a **kit** (684 520 kits were distributed in 2004) with 2 syringes, 2 disinfecting towels with 70° alcohol, 1 condom, 1 ampoule of bi-distilled water, 1 filter and 1 informative leaflet.

In 2004, 1 270 **pharmacies** (1 232 in 2003) were active in this programme (45,9% of the existing pharmacies in the country – 45,2% in 2003). Those pharmacies exchanged 1 434 234 syringes (1 580 720 in 2003), representing 52,3% of the total of syringes exchanged in 2004 in the framework of this programme (59% in 2003).

The **mobile units** of Curraleira¹⁹ (set up in November of 1998), Cova da Moura (set up in July 2002) and Odivelas (set up in October 2003), exchanged 27 193 syringes (47 487 in 2003) in 2004 (1% of the total syringes exchanged – 2% in 2003).

The remaining 1 283 474 syringes (1 034 681 in 2003) were exchanged by the **other 34 partners** of the programme (36 in 2003), representing 46,8% of the total number of exchanged syringes in 2004 (39% in 2003) in the context of the programme.

The districts of Lisbon, Porto and Setúbal, continued to be the ones that registered the highest number of syringes collected since the beginning of the program. However the global figure of these 3 districts in comparison with the rest of the country, mainly in the case of Lisbon, has been decreasing for the past years, which may indicate more regional dispersion.

In 2004, the National Commission for the Fight against AIDS (CNLCS) continued a series of initiatives to implement from 2003 to 2006 with a view to improve the efficiency of this programme, namely:

¹⁹ Deactivated in May 2004 due to the relocation of the population in that area.

- To develop research in cooperation with the National Association of Pharmacies (ANF) and the IDT to identify areas in need of this programme which are not currently covered and to suggest adequate solutions for those areas;
- To add two new elements to the kit which is currently being distributed: a recipient to prepare the substance and citric acid;
- To elaborate, in cooperation with the IDT, a needs assessment document for professional training to outreach workers in order to develop a national training programme for HIV/AIDS infection prevention;
- To elaborate, in cooperation with the National Association of Pharmacies, a needs assessment document for professional training to pharmacy staff in order to develop a national training programme for HIV/AIDS infection prevention;

It also started a new National Plan to Fight Against AIDS (“Diferentes, SIM! Indiferentes, NUNCA!”) which will be implemented from 2004 to 2006 and includes, amongst the 10 national objectives, the objective of structuring and implementing centres for combined therapy in the Hospital setting for drug users with infectious diseases.

Prevention of drug related infectious diseases is one of the activities included in the National Harm Reduction Network, funded by the IDT, which included 26 projects throughout the country in 2004. In comparison to 2003:

- The number of projects decreased by 7% (28 in 2003, 26 in 2004);
- The number of new contacts decreased by 31% (7 184 in 2004);
- The number of follow-up contacts increased by 79% (163 319 in 2003);
- The number of kits distributed in 2004 was 105 075 (in 2003, although kits were distributed only syringes were counted);
- The number of exchanged syringes increased again, this time by 84% (857 429 exchanged syringes in 2004);
- The number of distributed condoms increased by 89% (491 695 distributed condoms in 2004);
- The number of clients in low threshold substitution programmes increased significantly again, this time by 165%(1 836 clients in 2004);
- The number of referrals to CATs decreased (+96% with 1 092 referrals), to detoxification units increased (+21% with 115 referrals) and to therapeutic communities increased (+47% with 187 referrals).

In Portugal, treatment for HIV, AIDS and Hepatitis B and C are included in the National Health Service and therefore available and free for all who need it. However, clients complain about waiting lists in public hospitals and accessibility issues in general, including the price of medication.

In outpatient public treatment centres (CATs) 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 TCs) ranges between 19% and 68% but is generally lower than the figures registered in previous years.

In the prison setting, inmates and staff are routinely vaccinated against Hepatitis B. In 2004, 27 staff members (311 in 2003) and 2 034 inmates (3 196 in 2003) were vaccinated in several prison establishments.

An action-research protocol was established in November 2004, amongst the General-Direction of Prison Services, the IDT, the National Commission for the Fight Against AIDS and the Gulbenkian Foundation. This intervention will involve 2 prison establishments (1 for female inmates and 1 for male inmates), for a period of 3 years and will promote:

- The characterisation of the prison population and the identification of their knowledge, attitudes and behaviours (including risk behaviours) related to AIDS;
- Testing of the prison population for HIV 1 and 2, Hepatitis B and Hepatitis C, syphilis and Chlamydia;

Integration of HIV/AIDS affected individuals and of drug users with or without associated morbidity, in treatment programmes with anti-retrovirals, anti-tubercular and methadone, assisted by a multidisciplinary team and subject to therapeutic efficacy control and adverse effect monitoring, for a three year period;

- Promoting healthy lifestyles and the prevention of risk behaviour;
- Evaluating the programme and identifying intervention practices which may be disseminated throughout the prison system.

7.3 Interventions related to psychiatric co-morbidity

NO NEW INFORMATION AVAILABLE

7.4 Interventions related to other health correlates and consequences

NO NEW NATIONAL INFORMATION AVAILABLE.

8. Social Correlates and Consequences

8.1 Social Exclusion

Social exclusion indicators continue to be visible in the profiles of problem drug users in treatment settings and of offenders. The available information on the residential status of these individuals, educational and employment data usually refers a lower educational status and a higher unemployment rate than the national average for the same age groups and gender (see chapters 4. 2. and 8.2 of this Report). A local study (Joaquim 2005) established a statistical relation between some social variables and the adoption of criminal behaviours to finance illicit drug abuse (see chapter 8.2. of this Report).

Another social exclusion indicator is the number and type of requests (psycho-social, referrals and financial support) from users and their families, to the Institute of Solidarity and Social Security (ISSS). In 2004, this governmental agency, supported 5 884 (5 512 in 2003) financial requests with a total of € 2 725 619,69 (€ 3 153 786,71 in 2003), distributed in the following way:

	Number of requests in 2003	Number of requests in 2004	Amount spent in 2003	Amount spent in 2004
Medication	1 778	n.a.	€ 467 747,46	€ 389 963,43
Food and shelter	1 462	n.a.	€ 1 086 208,22	€ 1 195 496,89
Treatment programmes in private organisations	1 189	n.a.	€ 1 248 618,02	€ 733 364,43
Transportation	418	n.a.	€ 78 146,65	€ 92 645,69
Other types of support	665	n.a.	€ 273 066,36	€ 314 148,59

Table 14 – Types of support given by the ISSS and amount spent in 2003 and 2004 (IDT 2004) (IDT 2005)

Please see chapter 4.3. for more information on the profile of these clients.

8.2 Drug related Crime

Drug offences and drug related crime

Concerning the **administrative sanctions for drug use**²⁰, in 2004, the 18 Commissions for the Dissuasion of Drug Use (CDT) instated 5 370 processes²¹, representing a decrease of 12% in comparison to 2003 (6 100 processes) and of 8% in comparison to 2002 (5 580 processes).

²⁰ Law n. ° 30/2000, of the 29th November, regulated by the Decree-Law n. ° 130-A/2001, of 23rd of April, and by Regulation n. ° 604/2001, of the 12th of June.

²¹ Each process corresponds to one occurrence and to one individual

Similarly to preceding years, most of these processes were instated in the **districts** of Porto (20%), Lisbon (18%), Aveiro (9%), Faro (9%) and Braga (8%). However, when taken into account the number of residents in each district, Faro, Beja, Viseu and Portalegre presented the higher occurrences rates;

- The **monthly distribution** of the processes ranged between 338 in the month of December and 592 in the month of January, registering a monthly average of 508 processes (lower than the 508 registered in 2003);
- Similarly to previous years, most cases (49%) were **referred** by the Public Security Police (PSP), followed by the Republican Guard (GNR) with 27% of the cases and the Courts with 23%;
- On the 31st of March 2005, 36% of the instated processes in 2004 had been **filed**, 32% were **suspended** and 31% were **pending**. In comparison to 2003, decreases were verified in the number of processes filed (-20%) and suspended (-23%) and an increase was registered in the number of the pending processes (+18%).

Of the 5 360 processes instated in 2004, the Commissions had **ruled** on 68% (3 631 processes). This percentage is lower than the ones verified in previous years – 76% in 2003, 78% in 2002 and 75% in 2001²²:

- 86% were suspensive rulings,
- 3% found the presumed offender innocent and
- 11% were punitive rulings.

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%). In 2001, 2002 and 2003 this percentage was, respectively, 61%, 64% and 68%.

Also similarly to previous years, the percentage of **suspensive rulings** in the case of drug users who accepted to undergo treatment (18%) slightly decreased in comparison to previous years (19% in 2003, 25% in 2002, 32% in 2001).

On the other hand, **punitive rulings** in this setting continue to increase (9% in 2003, 6% in 2002 and 3% in 2001). Amongst the punitive rulings, the non-pecuniary sanctions were still predominant, despite of the increasing trend in the application of pecuniary sanctions (representing in 2004, 2003, 2002, 2001, respectively 49%, 38%, 23% and 11% of the punitive rulings). The most frequent non-pecuniary sanction was the mandatory periodical presentation in an institution chosen by the CDT, representing 87% of the non-pecuniary sanctions and 44% of all the punitive rulings.

Type of Ruling	Total	Type of Ruling (Law 30/2000, 29th of November)				
		Suspensive			Punitive	Absolution
		n.º 1, art.º 11.º	n.º 2 e 3, art.º 11.º	art.º 14.º e art.º 19.º		
	Temporary Suspension for non-addicts	Temporary Suspension with treatment for drug addicts	Suspension of the determination for sanction execution	art.º 16.º	n.º2, art.º 17.º	art.º 18.º
2003 Total	4 626	3 157	899	78	403	89
2004	3 631	2 461	638	47	389	96

Table 15 – CDTs rulings by type of ruling (IDT 2005)

²² In 2001 data refers to 6 month only as the Law was implemented from the 1st of July on.

Concerning the **substances** involved:

- in 2004 there was a general **decrease** of processes concerning only heroin, only hashish, only herbal cannabis (liamba) and only ecstasy but the number of processes involving only cocaine registered a 11% **increase**. The percentage of processes involving polydrugs registered a 3% decrease.
- as in previous years, most cases involved **only one drug** (91%), mainly **hashish** (66%) - (67% in 2003, 57% in 2002 and 47% in 2001).
 - As in 2003, 17% of these processes involved only **heroin** (24% and 33% in 2002 and 2001). 6% involved only **cocaine** (4%, 6% and 5%, respectively in 2003, 2002 and 2001).
 - the percentage of cases involving only the possession of **herbal cannabis** (liamba) decreased only slightly (2% in 2004, 3% in 2003 and 2002 and 5% in 2001), and the cases related only with **ecstasy** continue to be inferior to 1%.
- For processes involving **more than one drug** (9%), the association heroin-cocaine was again predominant (5% of the total of cases and 58% of those identified with polydrugs), followed by the association cocaine-cannabis and heroin-cannabis (in 2003 it was followed by the association heroin-cannabis e then cocaine-cannabis).

Concerning the **individuals** involved:

- In 2004, **4 998 individuals were involved** in the instated processes (absolution rulings excluded) at the Commissions for the Dissuasion of Drug Abuse;
- 5% of those **were referred twice in 2004** to a Commission. In 2003, the same was true for 6%. Although large urban centres such as Porto and Lisbon continue to register most of these cases, other less urban district capitals such as Faro, Aveiro, Braga and Viseu also started to be mentioned in association with this variable.
- In relation to previous years, no relevant changes were verified concerning **the socio-demographic profile** of these individuals²³:
 - They were mostly from the male gender (93%);
 - 83% were aged 16-34);
 - They were mainly Portuguese (95%), single (85%) and living with their parents/siblings (64%);
 - 39% had finished compulsory school (9th grade) and 26% reported an educational status above that;
 - 28% were unemployed and among the 47% who were employed most were in the extraction industries and civil construction, artisans and non-qualified labour in general.

Concerning **criminal offences**, in 2004, data from the Criminal Police identified 5 159 presumed offenders: 2 277 presumed traffickers (44%) and 2 882 presumed trafficker-users (56%).

The number of **presumed offenders** was very similar to 2003 (-3%) especially due to a decrease in the number of presumed trafficker-users.

²³ Individuals who were sent twice to a Commission in any given year (and thus originated the instatement of more than one process) were counted only once.

Similarly to previous years²⁴, the districts which reported a higher number of, presumed offenders were the more populated ones: Lisbon (40%), Porto (15%), Faro (7%), Setúbal (6%), Braga (5%) and Aveiro (4%). The rates of presumed offenders per inhabitant again highlights Lisbon, Faro, Madeira and Beja.

Concerning the **substances** identified in the moment of the occurrence:

- 65% of these individuals possessed only one drug (64% in 2003 and 62% in 2002);
- Among these cases, and for the fourth consecutive year, **hashish** was predominant in comparison to the other substances (42%), contrarily to what occurred in the years before 2001, when heroin was always predominant;
- Near 10% of the cases concerned **heroin** only, a percentage that has been decreasing in the past years (12%, 17%, 28%, 33% and 39% of the cases respectively in 2003, 2002, 2001, 2000 and 1999);
- 8% of the cases concerned **cocaine** only, a percentage similar to the one registered in 2003 (7%) and 2002 (8%) and higher than in previous years (4% in 2001 and 2000, and 5% in 1999). This is influenced by the current composition of this group: the absence of the users' group, which had, until July 2001, an important weight in the offenders' group and registered very small percentages of situations which involved cocaine only. But it also reflects the frequency of this situation in the traffickers' group;
- The offenders in the possession of **herbal cannabis** (liamba) alone (2%) or **ecstasy** alone (1%) continued to register low frequencies;
- In the situations where more than one drug was involved (35%), the main combination was the category "others" which groups less traditional combination of substances (this had been registered in 2003 but in Court setting). Cannabis was present in 69% of these combinations, cocaine in 51%, heroin in 45% and ecstasy in 25%. This category surpassed, for the first time, the most traditional **heroin and cocaine** combination (11% of the presumed offenders and 33% of those who possessed more than one drug). The combinations **heroin, cocaine and cannabis** and **heroin and cannabis** were registered, each, in 4 % of these situations (11% of the presumed offenders with polydrugs);

When comparing the traffickers and the trafficker-users, the latter present a higher percentage of the male gender individuals and are also younger. They registered, more often than traffickers, situations where only one drug was possessed and the possession of hashish, a profile closer to that of users referred to the Commissions for the Dissuasion of drug Abuse.

Concerning the individuals involved:

- 86% of the presumed offenders were of the male gender;
- 86% were aged between 15-39, mainly 20-24 (28%) and 25-29 (22%);
- 83% were Portuguese, a percentage that has been decreasing since 2000, also related to the increase in the relative weight of the traffickers among these presumed offenders. Among those who are not Portuguese nationals, most of them come from Portuguese speaking countries (10%), mainly from Cape Verde (7%), a situation already verified in previous years;
- 83% were single;
- 81% reported having frequented the 3rd Cycle (7th to 9th grades);

²⁴ The percentage data presented are calculated for the cases for which information exists on the considered variables and do not include neither individuals who relapsed nor those found innocent.

- 53% were unemployed, 34% were employed and 8% were students at the time of their questioning.

Concerning **Court** data:

- In 2004, 1 390 Court processes were closed which represents a decrease in comparison to 2003 (1 625) and 2002 (1 640);
- These processes involved 2 335 individuals (2 454 in 2003), 75% of whom were convicted and 24% found innocent;
- The vast majority of these individuals were accused of traffic (97%), 2% accused of traffic-use and 1% accused of use (growing any illicit substance remains a crime of use);
- Of the 1 669 convicted individuals²⁵ (1 828 in 2003), 95% were convicted for traffic, 4% for traffic-use and 1% for use²⁶;
- The districts of Lisbon (34%) and Porto (17%), followed by Faro (8%) and Setúbal (6%) registered the highest number of these convictions. The districts of Faro, Portalegre and Lisbon registered the highest rates of conviction per resident, followed by Setúbal and Bragança;
- These convictions involved mainly²⁷ effective prison (45%) and suspended prison (49%).

As for the **substances** involved:

- The majority of these convictions involved, once again, the possession of only one drug (69%), hashish was, for the first time, the main substance involved (28%), followed by heroin (24%), cocaine (11%) and herbal cannabis (liamba) (5%);
- When polydrugs are considered (in 31% of the processes), the association heroin-cocaine (17% of the total of convictions and 55% of those who possessed polydrugs) was predominant followed by the variable “others” (less traditional substance associations);
- By heroin-cannabis (4% of the convicted and 11% of those who possessed polydrugs). For the first time in this setting;
- The trend, initiated in 1998, of the decreasing importance of heroin related convictions, continued, (24% 28%, 40%, 44%, 45%, and 52% of the cases, respectively in 2004, 2003, 2002, 2001, 2000 and 1999).
- On the other hand, the situations where other drugs were involved, particularly in the case of hashish only and cocaine, continue to increase.

Concerning the **individuals** involved:

- Most of these convicted individuals were of the male gender (87%);
- They were younger than 35 (72%). The age structure was similar to those who were convicted in previous years, though slightly younger. Since 2001 a small increase has also been reported for the under 20 age group;
- They are mostly Portuguese (84%), an inferior percentage to the ones registered in 2003 (86%) and 2002 (90%), single (59%) and living with their parents/siblings (39%);

²⁵ Percentage data presented are calculated for the cases, which have information on the considered variables.

²⁶ Drug planting (article 40. ° of Decree-Law 15/93, of the 22nd of January) continues to be considered a crime.

²⁷ Sanctions may involve more than one crime.

- The gradual increase in terms of educational status already verified in previous years is reflected, for the first time, in a majority of individuals reporting having attended the 3rd Cycle (7th to 9th grades);
- Concerning the professional situation, 49% were employed at the time of their conviction, and 39% were unemployed, a slightly higher percentage to the one registered in 2003. Near 4% were students and 5% were in prison. Most of the employed individuals worked in the extraction industries and civil construction, with a high number of cases reporting non-qualified work in several activity sectors;

In comparison to traffickers-users, traffickers continued to report a lower percentage of situations involving the possession of heroin only but higher percentages of situations involving hashish, cocaine and polydrugs (the same happened in 2003 and 2002). Traffickers also reported more individuals under 20 and over 39, and a higher weight of foreign individuals.

Prison data indicate that, on the 31st of December 2004, 2 927 individuals were in prison for crimes against the Drug Law. This is the lowest number reported since 1997 and represents 29% of all individuals in prison. In comparison to 2003, -18% individuals were in prison for such crimes. These individuals continue to be mainly of the male gender (86%), aged 25-49 (82%) and Portuguese, although the percentage of foreign individuals continued to increase (23% in 2004).

Most of these individuals were condemned for traffic (89%) but there was also a -19% decrease in comparison to 2003 figures.

A recent research project (Joaquim 2005) looked retrospectively to 278 male individuals in Lisbon – 71 drug abusers in prison, 48 individuals in prison with no drug abuse problems and 159 drug abusers outside prison. Although this is a local study which can not be extrapolated at national level, some results are worth referring to as the author concluded that **delinquency** (reported by both those who were in prison and those who were not) **is significantly related to several variables** including:

- **Time of abuse of a hard drug:** though statistical significance was not found between the time of abuse, in general, and the adoption of criminal behaviour with 3 or more years of abuse history, it was found that abusers of hard drugs (heroin and cocaine) had 5 times more chances of adopting criminal behaviour in order to finance their drug use habits. A relation between the quantity of heroin or cocaine user per day and the adoption of criminal behaviour was not established but the relation between not using only hashish and the adoption of criminal behaviour was establish;
- **Poly drug abuse:** no significant relation was found between the use of “heroin+cocaine”, “cocaine+heroin” and “cocaine+heroin+hashish” and the adoption of criminal behaviour to finance drug abuse but the simultaneous use of any other combination of more than two illicit drugs was found to represent a 5 times higher risk of adopting criminal behaviours;
- **Route of administration:** a 3 times higher risk of adopting criminal behaviours to finance drug abuse was established for individuals using intravenous route of administration;
- **Not living with relatives:** living in a degraded neighbourhood or the influence of different types of education (authoritative, democratic or permissive) were not significant related to the adoption of criminal behaviour but living away from one’s family was found to represent a 3 times higher risk of adopting criminal behaviour;
- **Being unemployed:** Education level did not prove to be significant in this research but being unemployed showed a 3 times higher risk of adopting criminal behaviour than being employed.

Other variables which were tested and were not found to be related to the adoption of criminal behaviour include “not belonging to social support groups”, “not being religious” and “having a low income family”.

The article refers that the type of crime committed by drug abusers in prison was particularly related to acquisitive crime (52,1%) and drug law offences (45,1%) but rarely violent crimes which was more than 5 times lower in drug abusers in prison than in non drug abusers in prison.

The drug abusers in prison spend more money to acquire drugs than those who are not in prison (9,8% spend less than 25€ a day – 11,5% for non-imprisoned drug abusers – 82,9% spend more than 50€ day - 61,9% for non-imprisoned drug abusers – 14,6% spend more than 250€ a day – 10,4% for non-imprisoned drug abusers to finance their abuse.

See also chapter 4.3. for more information on this research project.

8.3 Drug Use in Prison

A recent research project (Joaquim 2005) looked retrospectively to 278 male individuals in Lisbon – 71 drug abusers in prison, 48 individuals in prison with no drug abuse problems and 159 drug abusers outside prison. Although this is a local study which can not be extrapolated at national level, some results are worth referring to concerning drug abusers in that particular Lisbon prison:

- 75,7% referred using hard drugs in prison;
- 64,2% referred polydrug use;
- They also indicated, more often than the non-imprisoned drug abusers, solvents heroin or cocaine as their first substance of abuse;
- They reported having started using drugs at age 15,8 (14,9 for the non-imprisoned group) and starting using hard drugs at age 19 (17,7 for the non-imprisoned group);
- 55,3% have only finished 6th grade or less and among these 11,6% reported only having learnt how to read and write;
- 22,4% came from problematic neighbourhoods (2,7% for non-imprisoned drug abusers);
- 46,8% have been using drugs for more than 10 years (76,5% for non-imprisoned drug abusers);
- 60,7% use more than two grammes a day (19,9% of non-imprisoned drug abusers);
- 56,5% were unemployed at the time of their arrest (65,9% of non-imprisoned drug abusers when they start treatment). Those who were employed reported very unspecialised and undifferentiated jobs. (See also chapter 8.2);
- 76,1% come from low income families (49,7% of the non-imprisoned drug abusers);
- 67% reported current injecting behaviour.

See also chapters 4.3., 7.2. and 8.3. for related information.

8.4 Social Costs

Please see data reported in Chapters 1, 8.1 and 9.1 of this Report.

The IDT is funding research at the School of Economics (*Faculdade de Economia*) of Universidade Nova de Lisboa which has 2 main objectives: to develop a model to estimate costs of drug abuse and test it, and to estimate the size of the illicit markets of heroin, cocaine, cannabis and synthetic drugs. Results are expected to be available in 2005.

9. Responses to Social Correlates and Consequences

Responses to social consequences of drug abuse in Portugal are mainly promoted by social reintegration programmes implemented by the IDT, the Institute for Employment and Professional Training (IEFP), the Institute of Solidarity and Social Security from the Ministry of Social Security and by public and private treatment centres which consider reinsertion to be part of the complete treatment process. In the criminal justice setting the Institute for Social Reinsertion and the General-Directorate of Prisons are the main actors in this area.

The IDT defined as main priorities for the reintegration area in 2004 the following:

- To improve and diversify housing programmes;
- To facilitate the improvement of the educational status;
- To capacitate individuals for integration in the work market;
- To foster active participation of the individuals as citizens;
- To promote the healthy management of leisure time;
- To help develop and consolidate the family and social network;
- To promote the availability of responses for each individual's reintegration project through coordination and referral to other Services.

These are implemented, at local level, through the IDT's local units.

Particular effort was focused, in 2004, in professional training and the selection of indicators for evaluating intervention in this area.

9.1 Social Reintegration

housing

Governmental welfare centres at district level are responsible for the certification process of reinsertion housing facilities. In 2004, 5 new contracts were made which provided a place for 39 individuals/month in the reintegration phase. 22 other reinsertion apartments (halfway houses for clients of treatment centres leaving with a programmed medical release or for individuals in prison after release) were active during the year for a total of 205 individuals/month that type of service. The annual costs incurred in € 420 438,50 (not comparable with the €1 015 695, 56 reported in 2003 as some organisations did not report on this item on time).

Other reinsertion promoting services accredited by the Institute of Solidarity and Social Security include innovative responses for promoting support to homeless users. The Institute spent € 244 962,84 (€ 674 271,99 in 2003) in 6 such projects in Porto, Viana do Castelo, Lisbon and Faro which provide support for more than 90 clients/month (280 in 2003 in 8 projects). One more new contract was made in Porto which will be able to house 50 clients/month.

Although not directly related to housing but as a means of identifying situations and promoting family support and referrals to other services, the Institute funded, with € 866 825,56 (€ 1 125 812,40 in 2003, for 23 projects), 20 outreach work projects throughout the country, which reach 988 individuals/month and contracted one more, in Lisbon, which will reach 50 individuals/month.

In order to ensure quality of service, the Institute regularly visits these projects onsite.

Education, training

Prevention programmes for **young school drop outs** and **young offenders** are implemented by the IDT mainly through the funding of specific projects under the Framework for Prevention II. In general they aim at developing preventive measures on the basis of the promotion of social integration, vocational counselling and pre-professional training. They may be implemented both in the school setting and outside of school. Please see information on chapter 3.2. of this Report.

Employment

The major actor in employment related reinsertion activities in Portugal is the IEFPP which main objective, concerning this area, is to promote the social and professional (re)integration of recovered drug users, or of drug users in treatment, through their participation in professional training and job promotion initiatives. The referrals, made by the IEFPP regional and local services, are usually combined with specific counselling and intervention in the clients' personal and social setting.

In 2004, the IEFPP acted mainly in two different areas:

- Regular programmes and interventions where no identification of drug users is made and thus no specific data exists for this area.
- Specific programmes and interventions (already described in the 2004 National Report) where information exists for the number of drug users who were involved since 2001:

	2000	2001	2002	2003	2004
Specific training	102	50	9	76	62
Reinsertion businesses	56	60	97	83	47
Insertion/Employment	n.a.	23	46	61	36
Occupational programmes	n.a.	n.a.	58	23	78
Other programmes	n.a.	48	18	132	134
Totals	158	181	228	375	357

Table 16 – Special interventions and number of drug users participating – 2000-2004 (IDT 2005)

Particularly targeted to ex-drug users who have finished or are finishing a treatment programme is **Programme Vida-Emprego** (Resolution of the Council of Ministers n.º 136/98, of the 4th of December), implemented through 5 regional agencies and already described in previous National Reports.

In 2004, this programme had a budget of € 5 756 333,92 (€ 5 994 835,82 in 2003. Data is also available since 1999 on request) which was not totally executed (€ 4 853 735) through the funding of 1 428 initiatives (1 445 in 2003) which represented an increase in comparison to 2003 (data on previous years available on request). 778 companies, non-profit organisation and local and central administration services were active partners in this programme. The Northern region implemented 36% of the initiatives, the region of Lisbon and the Tagus Valley 29%, the Central region 21%, the

Alentejo region 9% and the Algarve region 5% of the initiatives in the framework of this programme.

The IDT's Regional Delegation of the Algarve also promoted specific reinsertion programmes for recovering drug users. Through the Programme **Rede de Artesãos** (Artisans' Network), an EQUAL funded programme which aims at promoting pre-professional experiences to help integrate drug users, and Professional Training Programmes, the Regional Delegation reached 117 individuals (115 in 2003) and involved 75 private businesses, non-profit organisations and local and central public administration services (49 in 2003). This represented a 1,7% increase in the number of clients integrated in the Programme *Rede de Artesãos* and a 34,7% increase in the number of employers involved in comparison to 2003.

In the work setting, the IDT signed a protocol with the National Workers Union CGTP-IN to:

- Help prevent alcohol and drug abuse in the workplace;
- Promote healthy habits;
- Change attitudes, behaviours and risk factors;
- Change the working conditions which may be promoting drug use in the workplace;
- Increase the information and knowledge on the use of addictive substances;
- Promote a social and professional healthy atmosphere.

This programme will potentially reach 5 000 workers in the districts of Lisbon and Aveiro.

9.2 Prevention of Drug related Crime

As an **alternative to prison**, the 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)

In 2004,:

- 1% of the clients starting treatment in a public therapeutic community and 4% of those starting treatment in a private therapeutic community were referred by the Court as an alternative to prison;
- 5% of the new clients in private day centres were referred by the Court as an alternative to prison;
- 6% of all the active clients and 8% of first treatment demands in the public outpatient units were referred by Criminal Justice Services.

The General-Directorate of Prisons and the Institute for Social Rehabilitation, agencies of the Ministry of Justice, are the main actors in the criminal justice system. In the **prison setting**, interventions are implemented in the framework of the Special Drug Abuse Prevention Programme in Prisons (*Programa Especial de Prevenção da Toxicoddependência nos Estabelecimentos Prisionais-PEPTEP*) set up in 1999 and already described in previous National Reports. It includes interventions in treatment, social rehabilitation and harm reduction and is implemented by the General Directorate of Prisons in close co-operation with the IDT and the Institute for Social Rehabilitation.

In the framework of the Framework for Prevention (see chapter 3.2.), prevention in the prison setting main aims at health promotion, the promotion of a global development at personal, social and professional level and the development of personal, social and parental (among mothers in the prison setting) skills, all aiming at social inclusion.

In the specific area of abstinence-oriented treatment, in 2004, there were 5 drug-free units in five prisons with a total capacity for 172 individuals, a therapeutic community with a capacity for 45 individuals and one halfway house with capacity for 12 individuals. A situation identical to that one was registered in 2002 and 2003. For figures concerning the number of clients integrated in these responses, please see chapter 5.2.

Substitution treatment is also available in the prison setting. Please see chapter 5.3.

In the area of risk reduction and health promotion this programme implements infectious diseases testing (HIV and hepatitis B and C), hepatitis B vaccination, the provision of medical care for such conditions, condom and disinfecting substances distribution. These have also already been described in previous National Reports. The available figures concerning these responses are reported in chapter 7.2. of this Report.

10. Drug Markets

Concerning the **number of seizures**:

- In 2004, for the 3rd consecutive year, hashish was the substance involved in a higher number of seizures (2 439), followed by heroin (1 088) and cocaine (1 047). The number of herbal cannabis (liamba) and ecstasy seizures continue to be much lower;
- In comparison to 2003, there were, again, less seizures of heroin but more seizures of cocaine and hashish. The number of herbal cannabis (liamba) and ecstasy seizures also continued to increase.

Concerning the **seized quantities**:

- In comparison to 2003, less hashish, cannabis (liamba) and ecstasy were seized but more heroin and cocaine were seized;
- As for less traditional substances, LSD stamps, magic mushrooms, cannabis pollen and powder ecstasy, already referred in previous years, were seized and, for the first time, there was a reference to the seizure of buprenorphine pills and mescaline seeds.

Concerning **countries of origin** of the seized drugs, heroin came mainly from Spain and The Netherlands, cocaine from Brazil, hashish from Morocco, ecstasy from The Netherlands and Liamba from Angola. Most of the heroin and cocaine and a significant quantity of hashish and herbal cannabis (liamba) seized were of unknown origin. 77% of the seized cocaine and 35% of the seized hashish were destined to the external market. The totality of the seized heroin, herbal cannabis (liamba) and ecstasy with available information were destined to the internal market.

The prices of these substances at trafficker and trafficker-user level were very similar to the ones registered in 2003 except for herbal cannabis (liamba), which had increased in 2003 and decreased in 2004. The price of ecstasy continues to decrease since 2001 and the price of cocaine was also, for the 3rd consecutive year, lower than the price of heroin.

10.1 Availability and supply

Regarding the **main origin** of the seized drugs in Portugal:

- Spain and The Netherlands are the main origin of the **heroin** seized in 2004 (respectively 25% and 8%) both being traditional countries referred in these routes in previous years. The origin of 58% of the seized heroin remains unknown;
- In the case of cocaine, more than half of the **cocaine** seized in 2004 was from unknown origin, from Brazil (39%), Venezuela (5%) and Colombia (2%);
- Similarly to previous years, Morocco (53%) was the main origin countries of the seized **hashish** but around 35% was, for the first time, grown in Portugal. 10% of the seized hashish was of unknown origin;
- Concerning **herbal cannabis** (liamba), again Angola (58%) appeared as the main origin but with a much lower percentage as 46% reached Portugal coming from an unknown origin;
- The Netherlands was the main origin for almost all the seized **ecstasy** (90%).

In 2004, contrary to previous years, most of the seized drugs were destined to the external market. But the totality of the seized quantities of heroin, ecstasy and herbal cannabis (liamba), with information concerning its route, had Portugal as destination.

The IDT is funding research at the School of Economics (*Faculdade de Economia*) of Universidade Nova de Lisboa which aims at proposing a definition of an economic model to serve as a reference for the decision making process of illicit drug traffickers concerning the maximisation of their business value. It also aims at presenting an estimation of the drug trafficking business in Portugal. Preliminary results will be available in late 2005.

10.2 Seizures

Quantities and numbers of drug seizures

In terms of **numbers of drug seizures** and for the third consecutive year **hashish**, and not heroin, was the main substance involved in seizures²⁸ (2 439), contrarily of what had been happening since 1990. It was followed by heroin (1 088) and cocaine (1 047).

Since 2000 the number of **heroin** seizures has been decreasing, in comparison to 2003 a 6% decrease was registered in 2004.

In 2003, the number of **cocaine** and cannabis seizures registered increases, respectively +6% and +7%, contrarily to the decreasing trend which was being verified since 2000.

As usual, **herbal cannabis** (liamba) and **ecstasy** registered lower numbers of seizures (respectively 289 and 158). The numbers of **herbal cannabis** (liamba) seizures increased in comparison to 2003 (+38%), and, contrary to what happened in 2003, an increase of **ecstasy** seizures was registered (+6%).

Concerning the **quantity of seized drugs**, in comparison to 2003, in 2004 decreases were verified in the seized quantity of **hashish** (-8%), **herbal cannabis** (liamba) (-55%) and **ecstasy** (-31%).

Increases were verified in **heroin** (+37%) and **cocaine** (+146%).

Globally speaking, when considering the quantities seized during the last decade, in 2004 the highest values of cocaine were registered, hashish and heroin quantities ranked third in the decade, and the herbal cannabis (liamba) and ecstasy quantities were the lowest registered since 2000 and 2001, respectively.

Concerning other drugs availability in the national market, seizures of LSD stamps, hallucinogenic mushrooms, cannabis pollen and powder ecstasy were again referred in 2004 and there was a first time reference buprenorphine pills and powder ecstasy.

Seizures involving **significant quantities**²⁹ in 2004 recorded similar percentages to previous years: 8% of the total number of **heroin** seizures, 25% of **cocaine**, 4% of **hashish**, 2% of **herbal cannabis** (liamba), but a much lower values concerning **ecstasy** seizures (16% instead of the 30% registered in 2003).

These seizures involving significant quantities have been increasing their relative weight in the total number of seizures, which reflects, on the one hand the consequences of the decriminalisation of drug use, and, on the other, the reinforcement of supply control interventions and/or higher availability of drugs in the country, especially because, in some cases, the increasing trend became visible before decriminalisation was implemented.

²⁸ A seizure involving more than one drug is included in the number of seizures for each of the involved substances.

²⁹ For heroin and cocaine quantities above 100g are considered and for cannabis quantities above 1000g are considered, according to the criteria used by the UN. For ecstasy, according to the criteria used by the National Criminal Police, seizures above 50 pills were considered significant. Accordingly, for the purpose of data analysis, only the seizures expressed in that unit were considered.

At regional level:

- The district of Lisbon registered the highest quantity of seized **heroin** (45%), followed by the districts of Setúbal (17%), Porto (8%) and Faro (7%);
- Concerning **cocaine**, Faro registered the highest quantity of seized cocaine (40%), followed by the districts of Porto (31%), Lisbon (24%) and Setúbal (4%);
- As in previous years except for 2003, in 2004, Faro registered the highest quantity of seized **hashish** (83%), followed by the district Setubal (12%), Lisbon (2%) and Porto (1%);
- Similarly to previous years, Lisbon was the district with the highest quantity of seized **herbal cannabis** (liamba) (56%), followed by Aveiro (25%), Beja (8%) and Leiria (6%);
- Lisbon (61%) and Porto (20%) were the districts that registered the highest quantity of seized ecstasy in 2004.

In 2004, the district of Setúbal recorded the highest quantities of hallucinogenic mushroom seized, Santarém, Porto and Setúbal the highest quantities of LSD stamps, and Lisbon of powder ecstasy. Porto presented the highest quantities of cannabis pollen. Buprenorphine pills were seized mainly in Lisbon and Coimbra, while mescaline seeds were exclusively seized in Lisbon.

Type of Drug	Year				
	2000	2001 ^{a)}	2002	2003	2004
Grammes					
Heroin	567 533	316 039	96 315	72 365	99 047
Cocaine	3 026 374	5 573 994	3 140 103	3 016 881	7 422 752
Hashish	30 467 121	6 472 688	7 022 029	31 555 686	28 994 459
Liamba	223 212	234 533	361 026	264 821	118 929
Other	25 106 ^{f)}	14 265 ^{g)}	13 006 ^{h)}	19 353 ⁱ⁾	24 456 ^{j)}
Tablets					
Ecstasy	25 496	126 451	222 466	155 492	107 734,5

Table 17 – Seizures, by year and by Type of Drug (IDT 2005)

a) With the implementation, on 1st of July 2001, of the new legal framework on the decriminalisation of drug use, data in this area started to be collected in a central register kept by the IDT and kept apart from the Criminal Police's central register. f) to j) See Standard Table 13

10.3 Price/Purity

In comparison to 2003, with the exception of brown heroin and cocaine powder where changes were not relevant, a general **decrease in the price** of drugs at trafficker and trafficker-user level³⁰ was verified. The decrease was particularly relevant in the case of **herbal cannabis** (liamba) (€2,66/gramme in 2004 and €4/gramme in 2003) and LSD (€2,5/dose in 2004 and €6,58/dose in 2003). This decrease placed cannabis herb in the same price range verified in 2002, thus indicating that 2003 was an untypical year at this level, but clearly confirmed a decrease in the price of **LSD** which in 2002, at €6,87/dose, was even more expensive than in 2003.

³⁰ The Criminal Police does not collect data on price at street level since the 1st of July 2001, when the decriminalisation law came into force as users are no longer questioned by the police.

In 2004, for the third time since 1997³¹ the average price of **cocaine** (€42,23/gramme), though registering a small increase in comparison to 2003, presented a lower value than **heroin** (€46,54/gramme). The price of **ecstasy** suffered a small decrease (€4,5/tablet in 2004 and €5,27/tablet in 2003) maintaining the trend verified since 2002 and even smaller was the decrease in the price of **hashish** (€2,31/gramme in 2004 and €2,49/gramme in 2003).

Year	1997	1998	1999	2000	2001	2002	2003	2004
Type of Drug								
	Per gramme							
Heroin	38,50€	38,50€	31,33€	49,72€	50,27€	43,78€	46,80€	46,54€
Cocaine	45,63€	45,63€	40,37€	60,31€	53,31€	38,57€	41,40€	42,23€
Hashish	1,99€	1,78€	1,09€	4,13€	4,06€	2,45€	2,49€	2,31€
Liamba	2,25€	2,25€	1,40€	3,83€	3,26€	2,62€	4,00€	2,66€
	Per tablet							
Ecstasy	8,94€	11,70€	6,70€	5,98€	6,86€	5,90€	5,27€	4,50€

Table 18 – Average Price (IDT 2005)

Concerning **purity**, and according to the data reported in Standard Table 14, increases were verified in the average purity of cannabis herb and cocaine. The **composition of pills** sold at street level, as reported in Standard Table 15, also indicates a general decrease of the percentage of the tested illicit substance in pills, except for MDA (with similar values registered between 2003 and 2004) and the combination of MDMA+AMPH, for which registered values were higher than in 2003.

³¹ First time data on this indicator became available.

Part B
Selected Issues

11. Gender Differences

11.1 Situation

In Portugal, prevalence of **drug use in the general population** is generally associated to the male gender. In fact, the general population survey in 2001 (Balsa 2002) registered higher prevalence in the male groups of any age group, for all substances and periods in consideration:

- 11,7% of the male respondents reported lifetime prevalence of any illicit substance but only 4% of the female respondents;
- 5,6% of the male respondents reported last year prevalence of any illicit substance but only 1,4% of the female respondents;
- 4,2% of the male respondents reported last month prevalence of any illicit substance but only 0,7% of the female respondents;

Concerning the substances more often experimented by gender, the female group registered a higher “interest” in ecstasy and cocaine, whereas the male gender reported more use of cocaine. In the specific case of heroin (the most registered substance in treatment demand), the figure was very low in the female group but much more often reported in the male group where it was only surpassed by the use of cannabis and cocaine. The lower female/male ratio are nevertheless to be found in LSD lifetime prevalence, followed by lifetime prevalence of heroin and cocaine. On the other hand, the higher female/male ratio was found in lifetime prevalence of amphetamines, cannabis and ecstasy.

If we look at the more recent use (last 30 days prevalence), the female group reported no use of LSD or heroin and very little use of ecstasy and amphetamines, whereas the male group prevalence of cocaine and heroin use were almost identical and even higher was ecstasy use. In the last 30 days, the use of cocaine registered the highest female/male ratio.

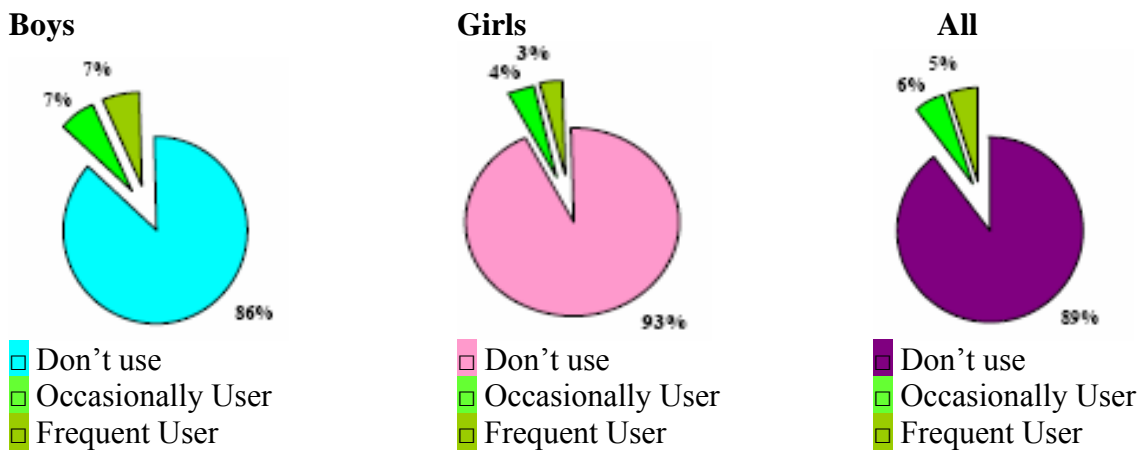
Considering age groups, the proportion of women who referred substance use tends to increase in the lower age groups, except in the case of cocaine and amphetamines where the proportion of women is higher in the 35-44 age group than in the 25-34 age group.

Regarding the geographical dimension, lifetime, last year and last month reported experience for any illicit substance and in all 5 national regions is always much higher in the male group. In the Algarve and Madeira, however, are exceptions in some very specific situations for the younger age group: in the Algarve, women aged 15-24 reported a higher lifetime experience of cannabis, amphetamines, ecstasy and LSD than men of the same age but no experience of cocaine or heroin; in Madeira, women also aged 15-24 reported a higher lifetime, last year and last month experience of ecstasy and also, though in a lower proportion, cocaine than men in the same age group. If these results are confirmed in further surveys, this might indicate a shift in terms of the regular pattern for young women, which should be addressed in terms of specific responses. On the other hand, concerning more recent heroin use (last year and last month prevalence) only women in the region of Lisbon have reported it.

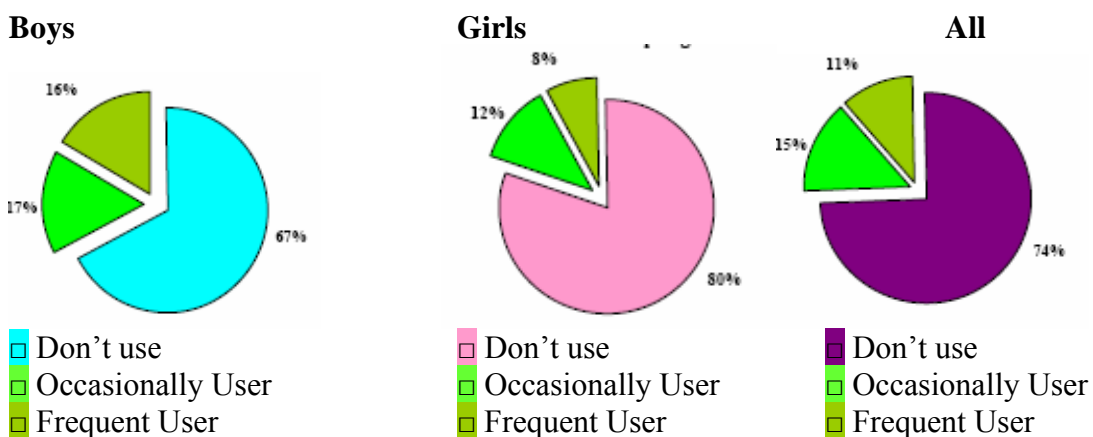
In recent **school surveys** (ESPAD 2004) and (Feijão 2002), differences between genders in terms of illicit drug use are also reported. Feijão (2002) reports higher

lifetime prevalence in the 7th-9th grades male group (aged in average 12-14) than in the female group both for any illicit drug (17% for boys and 10%) for girls) and for cannabis (13 for boys and 7% for girls). The same was verified in older pupils in the 10th-12th grades (aged in average 15-17) with 36% of the boys reporting lifetime experience of any illicit drug and 32% reporting lifetime experience of cannabis and 22% of the girls reporting lifetime experience of any illicit drug and lifetime experience of cannabis.

It is also interesting to look at other cannabis use patterns in the same grades which show that, in secondary school, and although boys continue to report higher use levels for occasional and frequent drug use, girls tend to get closer to boys in terms of the occasional illicit drug use:



Graph 5 – Patterns of cannabis use amongst 7th – 9th graders (Feijão 2002)



Graph 6 – Patterns of cannabis use amongst 10th – 12th graders (Feijão 2002)

ESPAD (2003) confirms the higher prevalence for all illicit substances in all types of prevalence (and all ages in Portugal ESPAD data covers pupils aged 13 to 18) in the male group, but also that girls reported higher prevalence in the use of tranquillisers or sedatives than boys. It also gives important information on the age at time of first use and on the first illicit substance used. It is reported that the percentage of boys who

reported having less than 13 years of age at time of first use was higher than the percentage of girls except for tranquillisers and sedatives and that boys experimented first with cannabis, while girls preferred tranquillisers or sedatives.

As for problematic drug users, (Fernandes 2003), using a snowball sampling technique, interviewed 2 groups of problematic drugs users in Porto, from the “up” and “down” drug abuse settings (the upper and lower social levels). Although there is no mention in the study of concerning the mirroring of the reality in terms of gender proportion, it is interesting to verify that he recruited 22 male and 6 female problematic drug users from the “up” setting and 28 male and 4 female problematic drug users from the “down” setting, similar proportions than the ones verified in the treatment setting referred below.

In all treatment settings from which data is available (IDT 2005) the percentage of clients of the male gender greatly surpasses those of the female gender. Both the gender and the substance information are inline with the data collected in both the general and the school population surveys.

Data from treatment sources (see Standard Table 03 and 04 as well as Chapter 4) indicate that, in 2004, 83% of the clients in treatment in the public **outpatient** treatment centres and 84% of those who requested treatment for the first time in the same centres were of the male gender. Identical figures were reported in previous years. The substances more often reported for all those who requested treatment for the first time was heroin and the combination heroin+cocaine.

Also from treatment sources but this time from **detoxification units** again, data show that the majority of clients in this setting in 2004, and similarly to previous years, were of the male gender (87% in the public units and 86% in private ones). Again, the main substances referred are heroin and cocaine.

In **day centres** the scenario is almost identical and, again, similar to previous years. In 2004, 84% of the clients in public Day Centres and 86% of those in private ones were of the male gender and reported mainly the use of heroin.

Therapeutic communities are the treatment setting were the percentage of female clients is higher. Nevertheless, in 2004, 65% of the clients of public therapeutic communities and 84% in the private therapeutic communities were of the male gender.

In general, and inline with the available data from previous years, individuals who requested treatment for drug abuse in 2004 were mostly of the male gender and reported mainly the use of opiates.

For individuals infected with **HIV, Hepatitis B and C and tuberculosis** in the treatment setting, there disaggregated data by gender is not available. However, national data on drug abuse related **AIDS**, concerning all notified cases until 31/03/2005, refer that 88% of these individuals are of the male gender, whereas in AIDS cases not related to drug abuse 81% of the individuals are of the male gender. Individuals of the male gender are also predominant in notified cases of asymptomatic carriers and AIDS related complex.

As for **drug-related deaths** (see Standard Tables 5 and 6 and Chapter 6 of this Report), the vast majority of the individuals involved (90%) were of the male gender and the substance more often reported in association with these cases was, again, heroin.

Legal offences, crime and the prison setting

Concerning the **presumed offenders** (trafficker-users and traffickers) who were questioned by the police in 2004, 86% were of the male gender and possessed mainly

hashish. 22% of the questioned traffickers were of the female gender, a much higher percentage than the 7% of the questioned trafficker-users who were of the female gender. In this setting, both for traffickers and trafficker-users, the main substance referred is hashish.

In the **Courts**, where the number of traffic cases which involved hashish was for the first time higher than those involving heroin, only 13% of the convicted individuals for traffic were of the female gender, a percentage which, though low, reflects the percentage of women presumably involved in the traffic of illicit substances. As for those convicted for traffic-use, situation in which heroin keeps the top position, 14% of those convicted were of the female gender.

Also for those individuals in **prison** for having committed a crime against the Drug Law, the male gender also continues to be predominant.

11.2 Responses

In terms of responses, very few gender specific interventions were reported. Most of those which exist are well established responses in the area of treatment, oriented towards the female gender, that include:

- Specific preparation and follow-up for pregnant drug users in outpatient centres as well as in maternity wards and paediatric hospital units which liaise with CATs locally;
- Specific follow-up of female drug users with children in CATs, including paediatric psychiatry services in some CATs and family therapy in most of them. One of the CATs (CAT do Conde) in Porto is totally dedicated to the treatment and follow-up of pregnant drug abusers and their families;
- Therapeutic communities that are oriented towards pregnant drug abusers and/or drug abusers with small children.

Although literature supports the idea that girls seem to have lower physiological tolerance concerning substance abuse, and present more often a personal history of psychological, physical or sexual abuse (see next chapter), and boys tend to experiment with drugs earlier than girls, gender specific responses in the prevention area for girls or boys were reported only in very specific settings of institutionalised young offenders due to the fact that boys and girls are placed in separate institutions (see references to Programme Choices in Chapter 3).

11.3 Conclusion:

In Portugal, individuals of the male gender represent the majority of people who experiments with drugs, uses them occasionally or regularly and, in an even higher proportion become problematic drug users. The male gender is predominant in the drug related treatment, legal and criminal justice settings as well as in the drug-related indicators on infectious diseases and deaths. Individuals of the male gender with a problematic abuse of drugs usually report the use of heroin, although most of them currently do not use an intravenous administration route. In terms of responses, and apart from well established interventions in the area of treatment, specifically orientated towards pregnant women and women with children, no systematic gender specific responses were reported except for some interventions amongst young offenders.

12. European Drug Policies: extended beyond illicit drugs?

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12.1 Summary

The Portuguese official National Strategy, dated 1999, is limited to “illicit drugs” with the exception of psychotropic medicines and other small references to doping substances, alcohol abuse or poly drug use. There is not yet a specific mention to the use of other substances such as alcohol and tobacco, neither to other kinds of “addictive-type” behaviours such as gambling, binge eating, compulsive sexual behaviour, compulsive work, compulsive exercising, compulsive video games playing, compulsive internet use, and so on. No explicit reference is made to co-morbidity either.

The National Drug Strategy invested considerable a amount of effort in children and young people, across several settings and either in primary prevention, treatment or rehabilitation, but mention is only made to illicit drugs and some psychotropic medicines.

Another more recent official document published in 2001 by the Government (PCM 2001a) with executive guidelines and a time frame, aiming at implementing the national drug strategy until 2004 (Action Plan- Horizonte 2004), claims for a broad scope substance use prevention (mentioning alcohol and psychotropic medicines), in the area of safe driving and within family and schools settings (PATO).

A reflexive document published by the government in 2001 - “Regime Geral da Política de Prevenção Primária de Toxicodependências (PCM 2001b) - strongly claims for preventive efforts, early intervention, community-based decentralised action, school-based and family-based interventions, stressing the importance of specific interventions for at-risk groups. This document presents primary prevention of drugs use and addiction conceptually, in a framework of individual empowering and providing supportive environments through actions in the family and school settings, and with the local authorities. This conceptual framework allows for a broad assumption which goes “beyond illicit drugs” in what primary prevention is concerned.

Considering treatment and rehabilitation, national legislation is, again, rather limited to drug use and addiction, but the conceptual framework, concerns, aims and strategies presented in the National Strategy (1999) suggests that a broad “general health and primary health care perspective “and a “quality of life and equality of opportunities perspective” is behind it, which means principles that may improve demand reduction and stability, for different substances.

Scientific production related to an “extended theory, intervention and policy beyond illicit drugs” appeared mostly after 1998, and were mostly unavailable by the time the national drug strategy was prepared. Some main theoretical changes occurred: (1) the focus on a large range of environmental risk factors, besides peers (family, school, availability); (2) the possible protective role of peers, that is, moving from considering peers mostly a “risk”; (3) the focus on protective factors; (4) the mediating role of personal characteristics and thus the importance of promoting individual competences; (5) a larger perspective of substance use including, besides drugs, other psychotropic medicines, tobacco, alcohol and doping substances in sports, poly drug use, co-morbidity, and some compulsive like behaviours such as gambling, compulsive sex, binge eating; (6) a shift from description of effects and associations towards an “in-depth” attempt to understand how associations happen in what concerns their way, extent and direction.

During the period 1999-2004, in Portugal, primary prevention interventions began to adopt a broader approach of substance use, either within of the school system, or in community settings, supported by local authorities (IPDT 2001 vol. II; IPDT 2002; INA 2004; IDT 2005), Conversely, in Portugal, in the area of treatment and rehabilitation, different national organizations underwent separated efforts considering different substances use and addiction. This implies different economic, physical and human resources, different logistics, different legislation, different professional training, and different funding.

The external evaluation (INA 2004) points out that treatment centres for drug addiction (CATs and NATs) and Therapeutic Communities (TC) are mostly used by heroin users a population which decreasing, and that it would be worthy to extend their use to other substance addictions and addictive behaviours. This issue is also addressed in a recent internal evaluation (IDT 2005) and is a proposal in the National Strategy guidelines for 2005-2012 (IDT 2005). However even if a common mix strategy is to be implemented in the area of treatment and rehabilitation, further research is needed to show evidence that this common mixed strategy is the best option. Cost-benefits/economical perspective should not be the only criteria. National and international literature from 1998 on, strongly supports a holistic expended approach to substance use and addiction, but most of the studies refer, indeed, to primary prevention/universal interventions and to demand reduction.

A last word to point out another strong recommendation from the Pompidou Group Conference (CE/Pompidou Group 2004) claiming that it is time to give up priority to unexpensive symbolic projects that are easily sold politically, and it is time to invest in quality research and interventions, independent, carried on by well trained and supervised professionals, based in theoretical models and in scientific evidences, integrated, sustained, evaluated and “at a long run”, although these are harder to “sell” to the general public and do not produce immediate effects.

12.2 Official endorsement by the National Drug Strategy

Portugal – The “state of the art”

An expert committee was nominated in February 1998 to elaborate the Portuguese Drug Strategy document. In October 1998, the committee presented a National Drug Strategy that was officially approved in May 1999 after a period of wide public discussion (Resolution of the Council of Ministers, 46/99, 1999/26/5). This official document was published and broadly disseminated and is still the official national document (PCM 1999).

In March 2001, the Government approved an “Action Plan” (PCM 2001a), defining specific targets and a time frame. Another official document called “Regime geral da política de prevenção primária de toxicodependências” (PCM 2001b), reported a couple of recommendations for primary prevention.

The Portuguese National Focal Point (NFP) is the IDT (Instituto da Droga e Toxicodependência), which resulted from the merger of IPDT (Instituto Português da Droga e Toxicodependência) and SPTT (Serviço de Prevenção e Tratamento das Toxicodependências), in 2002. A follow-up of the “drug situation in Portugal “ can be consulted in the IDT’s National Reports to the Portuguese Parliament (IDT 2001, 2002, 2003, 2005) and in the EMCDDA Annual Reports (EMCDDA, 2002, 2003, 2004).

The national drug strategy was evaluated by an external agency (INA 2004) and some guidelines for the new period 2005-2012 of a national drug strategy were already made available (IDT 2005b).

Coming back to the National Drug Strategy (1999), this document presents the IPDT, created by the Public Law 31/99, 5 February 1999, whose aims concerned “illicit

consumption of drugs” and a “national information system on drugs and drug addiction”. It describes the epidemiology of drug use among Portuguese youths referring the prevalence of cannabis/hashish, heroin, cocaine and ecstasy experimentation, use and addiction. There is no mention to the use of “legal substances” or other “addicted-type” behaviours.

When referring to drug phenomena in the world, this document makes a first allusion to psychotropic medicines and prescriptions (benzodiazepines (“bennies”), amphetamines (“speeds”) and other drugs aiming at the “improvement of physical appearance, athletic performance and sexual performance”.

The document refers to European politics, namely the Pompidou Group (European Cooperation group to fight drugs and psychotropic medicine abuse and illicit traffic) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and its information network, REITOX created by the CEE Council Regulation 302/93, and located in Lisbon.

Shortly, in the first part of the National Strategy, dated 1999, the “drug” situation is limited to the “illicit drugs” and psychotropic medicines and occasionally poly drug use or alcohol abuse, and doping substances, with no specific mention to the use of other substances use such as alcohol, tobacco, neither to co-morbidity or to other kinds of “addictive-type” behaviour such as gambling, binge eating, compulsive sexual behaviour, compulsive work, compulsive exercising, compulsive video games playing, compulsive internet use.

Primary Prevention

A few principles are stated in the National Strategy document, which include prevention (focusing on primary prevention, both within and out of school contexts, stressing the importance of targeting adolescents and youths). Despite stressing preventive strategies, no mention is made to “extended policies beyond illicit drugs” except for psychotropic medicines, and limiting the focus to “illicit traffic of psychotropic medicines”, as in previous sections.

Later in the document, a reference is made, for the first time, to “extended policy, beyond illicit drugs”. Allusions are made to “healthy lifestyles within healthy communities”, “alternative activities such as sports and dance”, “health promoting policies” and it is stated that preventive efforts must include, besides dissemination of information on drugs and health promotion, other methodologies that allow “promoting ability to problem solving and decision making, interpersonal communication skills, resisting peer pressure, alternatives to drug use and self-assertion and self esteem promotion”.

At this point, the document mentions the multi factorial model of associations with drug use, including as risk factors a wide spectrum of variables, either individual (such as school failure and drop out, violent behaviour, early onset of experimentation and use, poor skills to deal with peer pressure, poor self-esteem), or familiar (poverty, lack of secure economic or job status, single parent families or disruptive families with high conflict and/or poor communication, poor emotional and affective supporting families, non realistic expectations towards children), or related to the school setting (bad physical and environmental conditions, bad ethos with high conflicts, no rules and no pupils participation). Those statements situated prevention of drug use in a conceptual framework of “increasing individual resources and skills and decreasing individual vulnerability” and are strongly supported by well-established and long lasting research in this field.

Besides, as it is well know from the literature, this text refers explicitly to the risk for youths to be systematically included in a peer group involved in substance use. It also describes protective conditions such as individual skills, supportive families, supportive

schools calling for and allowing for pupils' participation, and finally active and supportive communities.

A developmental approach is pointed out in order to understand the role of substance use across life span, as well as an ecologic approach in order to understand contexts that are more "consumption promoters". An "in-depth" epidemiological study is asked for in order to define "profiles of drug users". It is strongly recommended for strategies to be tailored to target population in terms of intensity of impact.

Special recommendations are made concerning some age groups (end of childhood and beginning of adolescence), and specific conditions (school "drop outs", drug dependent parents, migrant and other minority groups). Special focus is made in the preventive "message" itself, that must include an increase of individual skills as well as a simultaneous changing action promoting the quality and the support of the environment and of social structures. An "integrated intervention" approaching different aspects of risk behaviours" is strongly recommended.

The importance of a "peer tutoring" methodology is stressed as well as the importance of continuing the joint action with the Portuguese Institute for Youth (Instituto Português da Juventude - IPJ).

At school level, the coordination is recommended between the IPDT, the Ministry of Education and the Ministry of Health to support the existing programs (Programa de Promoção e Educação para a Saúde - PPES and Rede Nacional de Escolas Promotoras de Saúde – RNEPS (included in the ENHPS). An intervention is recommended in the prison setting, in the armed forces and in the workplaces and, as far as preventive action is concerned, there is a strong recommendation to act at the level of local authorities through Municipal Plans.

A strong focus is placed on assessment and evaluation procedures. This is recommended at an "outcome" level, at a "process" level and at an "impact" level. Evaluation is recommended at a short, medium and long term. It is recommended for evaluation to be, when possible, external and carried on by, e.g., University experts in this field. The need for further research is also stressed.

As it was clearly described, although the text is again rather limited to drug use, the conceptual frame work, the concerns, the aims and the strategies presented, strongly support a wider "health promotion perspective" in order to improve the prevention of substance use and addiction.

Treatment / secondary prevention of drug use

The National Strategy document deals with treatment strongly claiming the need for an integrated approach that includes individual, psychosocial, economic and political issues. Again, a perspective of "reducing vulnerability / increasing individual skills and quality of life and promoting supportive environment" is defended. A wide scope of treatment procedures is recommended in order to fully tackle this complex and heavy subject, and a special focus is made on promoting the quality of professional training.

The resources in the area of treatment are mostly CATs (Centro de Atendimento a Toxicodependentes), which were local units of the SPTT and which aimed at ensuring treatment availability for all in need (the IPDT and the SPTT merged in 2002 and became the IDT).

To improve efficacy, it is strongly recommended at all the National Health Service should pay attention to the drug phenomena and treatment of dependent users, by means of family doctors and general practitioners, hospitals and local health centres. Here again a strong focus is placed on assessment and evaluation procedures. This is recommended at an "outcome" level, a "process" level and an "impact" level. Evaluation is essential at short, medium and long term. It is recommended for

evaluation to be, when possible, external and carried on by, e.g., University experts in this field. The need for further research is also stressed.

Although the chapter about treatment is again limited to drug use and dependence, the conceptual framework, concerns, aims and strategies presented imply that a broad “general health and primary health care perspective “ is behind, that can improve the prevention of other types of consumptions. Besides, when referring to the Army, the text refers explicitly the UTITA (unit for the intensive treatment of drug addiction and alcoholism).

Rehabilitation of drug users

The National Strategy document continues dealing with rehabilitation, claiming strongly, once again, the need of an integrated approach that includes individual, psychosocial economic and political issues. Again, a perspective of “reducing vulnerability/ increasing individual skills and quality of life and promoting supportive environment” is recommended. A wide scope of intervention procedures is recommended to tackle this complex and heavy subject, and a special focus is made on social exclusion and the snowball of social exclusion – marginalisation/social isolation - deviant behaviour- drug consumption.

To improve efficacy, it is strongly recommended that the Instituto de Emprego e Formação Profissional should participate both at a professional training level and at placement in the workplace, including protected employment, supported employment and benefits to employers. Also, for some, basic housing needs are to be provided. For all, settling down in a social supporting group is a priority, including social networks and self-help groups.

Although this chapter concerning rehabilitation is again limited to drug use and dependence, the conceptual framework, the concerns, aims and strategies presented imply that a broad “general health and quality of life perspective“ is behind, that can improve other the prevention of other consumptions.

Evaluation, Research and professional Training within the drug field

In a latter part of the document, a specific chapter refers to research and a strong focus is again placed on assessment and evaluation procedures. It is recommended for evaluation to be external and professional, carried out by University experts in this field, and not only a description of a set of personal or political opinions.

The need for further research is also stressed and a special reference is done to the changes in the nature of research in this area, which moved from a pure biological/ pharmacological/ toxicological pole towards a more psychological, behavioural, social and environmental pole. “It is not be an individual psychopathological phenomena, but a problem to be understood/ interpreted in the dramatic daily life existence, seen through the sight of a true eco social psychology”.

It is strongly recommended that the quality and scope of professional training should be improved to include knowledge, specific skills and evaluation procedures. This professional training is sought at a field work/community level, at a clinical level, at an academic/research level and at a team capacity building level. It is sought in areas such as medicine, psychology, sociology, biology, law, nursing, social work, education sciences, and “mass media” communication.

The document finishes by stressing the importance of civil society, education actors (namely parents and teachers) as well as opinion makers. In its last words it stresses (1) the importance of “mass media” in primary prevention, (2) the importance of resource coordination, (3) the importance of allocating economic means and (4) the need to review the present document no later that 2004.

Conclusion

With the exception of psychotropic medicines and other small references to doping substances, to polydrug use and alcohol abuse, there is no specific mention in the National Drug Strategy (1999) to alcohol or tobacco, nor to co-morbidity or “addictive-type” behaviours (such as gambling).

The National Drug Strategy invested considerable amount of efforts in children and young people, across several settings and either in primary prevention, treatment or rehabilitation, mentioning mostly illicit drugs and some psychotropic medicines.

Another more recent official document published in 2001 by the Government (PCM 2001a) with executive guidelines and a timeframe, aiming at implementing the National Drug Strategy until 2004 (Action Plan- Horizonte 2004), claims for a broad scope in substance prevention (mentioning alcohol and psychotropic medicines), in the area of safe driving and in family and schools settings (PATO).

A reflexive document published by the Government in 2001 “Regime geral da política de prevenção primária de toxicodependências (PCM 2001b) strongly claims for preventive efforts, recommends early interventions, community, school and family-based interventions, stressing the importance of specific interventions for at-risk groups and referring to both “licit and illicit substances”. This document conceptually presents primary prevention of drug use and addiction in a framework of individual empowerment and providing supportive environments through actions in the family, schools and local settings. This conceptual framework allows for a broad assumption “beyond illicit drugs” in what primary prevention is concerned.

12.3 Genesis and rationale of a policy extended beyond illicit drugs

From “illicit drugs” to substance use

There are chapters on “the drug situation in Portugal” in both the National (IDT 2001, 2002, 2003, 2005) and the EMCDDA Annual Reports (EMCDDA 2002, 2003, 2004) where a broad range of substances is already clearly considered, especially where primary prevention/ demand reduction is concerned.

The National Drug Strategy was evaluated by an external agency in 2004 (INA 2004), and “new addictions are mentioned, together with the need to address addictions as a whole, and as a related phenomena, or at least worsted, by a lack of psychological and social well being and sense of worth and belonging.

This strategy was not reviewed so far, however some guidelines for the new period 2005-2012 are already available (IDT 2005b), and included this new perspective with obvious implications in primary prevention, treatment, rehabilitation and research.

The IPDT National Report (IPDT 2001 vol. I) referred to polydrug use, but mostly within the “illegal” range, and in volume II (IPDT 2001, vol. II) a wide range of primary prevention, treatment and rehabilitation of drug is presented, within a wide range of institutional collaboration but mostly limited to “illicit drugs”.

In the IPDT Activities’ Reports for the period 2000-2002 (IPDT 2002) a long list of preventive efforts was presented including “Programa Quadro Prevenir”, “Planos Municipais de Prevenção” and “Planos Integrados”³² where there is no specific mention to working “beyond illicit drugs”. The exceptions were P.A.T.O (Prevention of alcohol, tobacco and other drugs, in school settings), the preventive campaign on alcohol and drug use when driving (“Se não vês o perigo, o perigo és tu”) and the publication of information brochures that included information on both drugs and alcohol. A publication from the Ministry of Education (IIE 2002) already included the reference to a

³² Please see chapter 3 on this Report.

great number of publications and other pedagogical resources following this broad approach to substance use, in school-based primary prevention.

An official document published by the Ministry of Health (MSaúde 1999) included tobacco, alcohol and drugs in a chapter called “quality of life and determinants of health”.

A brochure published by the SPTT (1999), included tobacco, alcohol and psychotropic medicines, in the chapter “substances”.

The ESPAD study (Hibell, B. et al. 2000), a study supported by the Pompidou Group where Portugal participates actively, soon began an integrated approach to alcohol and drug use. The ESPAD study in Portugal is ensured by the IDT as well as the national school survey (INME) (Feijão & Lavado 2002), which presents national data on tobacco, alcohol, drugs and psychotropic substances since 1987, assuming the relevance of this broad assumption of substance use.

Scientific literature review (published after 1998)

In this sub-chapter, a brief literature review will be undertaken, considering scientific production not earlier than 1998, related to an “extended theory, intervention and policy beyond illicit drugs” and then some reflections will be made on future national action plans.

Some main theoretical changes are pointed out and will be described shortly: (1) the focus on a large range of environmental risk factors, besides peers (family, school, availability); (2) the possible protective role of peers, that is, moving from considering peers mostly a “risk”; (3) the focus on protective factors; (4) the mediating role of personal characteristics and thus the importance of promoting individual skills; (5) a larger perspective of substance use including psychotropic medicines, doping substances, tobacco, alcohol and drugs, polydrug use, co-morbidity, and some compulsive like behaviours such as gambling, compulsive sex, binge eating; (6) a shift from describing effects and associations towards an “in-dept” attempt to understand the way, the extend and the direction of associations

All those changes have obvious implications on intervention strategies and were not yet available for the preparation of the 1999 Portuguese Drug Strategy.

From effects to determinants

Some initial studies used to consider “drug use” as an independent variable and tried to identify its consequences: personal physical consequences, personal psychological consequences, social/ familiar consequences, economic consequences. More studies in the late 80s started to consider “drug use” as the dependent variable and tried to identify predictors or associations either contextual (social, family and physical involvement factors), or personal (personality, life events, genetic/biological characteristics), or even related to drug characteristics or effects, or associations to other substance use (tobacco and alcohol) or specific behaviours (violence, crime). Studies of the first kind were useful to inform about effects, to try to decrease the appeal of drugs or drug addiction and to limit risks and harm. Studies of this second kind are useful to prevent or decrease risk factors and the effects of risk contexts and processes or, when possible, to promote protective factors and increase the effect of protective contexts and processes.

Considerable and comprehensive work has been carried on since 1998, concerning determinants of substance use, namely during adolescence (Gilvarry 2000; Kandel 1998). Some initial work stressed the importance of peers, peer culture, peer substance use, peer pressure and other social influences in drug abuse. Then, the role of other broader social factors was also highlighted: family ambience, school ethos,

community characteristics which can act as protective or risk factors providing social support, social norms and social learning.

Several factors have been repeatedly related to drug initiation and use in the beginning of adolescence such as gender, age, ethnicity, socio-economic status, parents substance use (tobacco, alcohol, drugs), relation to family and peers, communication with parents, low involvement in school, “stress”, low monitoring parents, anxiety and depression, low self-esteem, social support, personality characteristics (Wiesner & Ittel 2002; Mendes, Relvas, Lourenço et al. 1999).

The onset of substance use before the age of 15 is considered in itself a risk factor to a wide range of mental health problems and poor positive adaptation to adult world (Dishion, Capaldi & Yoerger 1999). Social and health problems related to substance use are more obvious and important if the initiation has an early onset, and one of the paths is becoming part of a group whose culture tends to present health harming styles or a low health commitment (DuRant, Smith, Kreiter & Krowchuk 1999).

All those factors seem relevant in explaining use, but they fail to explain why adolescents with similar social backgrounds start using substances while others do not.

More recently, some research in this area, as in others related to risk, stressed the importance of individual factors such as resilience, social competence, affiliation, agency, as mediators between social settings and social influence and individual choices and behaviours. Most of the more recent research focuses, though, on the cumulative and interactive effects of both personal and social factors related to substance use risk and substance use protection. Thus, drug use comes at the end of a complex process where several small effects interact in a synergic way, rather than being possible or even sensible to try to identify strong single effects. Personal and social protective factors, in the same way as risk factors, can be categorised in one or more of the following interactive settings: the individual, the family, the school, the neighbourhood and the peers (Matos et al, 2004; Ciairano 2004).

“Beyond” illicit drugs

Research available only after the publication of Portuguese National Drug Strategy (Braconnier, & Marcelli 2000; Prinstein, Boergers, & Spirito 2001; Matos, Simões, Carvalhosa, Canha & Reis 2000; Matos et al. 2003; Matos et al 2004) showed that alcohol, tobacco and drugs use are inter-related and are related to substance use by peers. “Substance use” was then considered a best formulation, including tobacco, alcohol, illicit drugs and psychotropic medicines.

Kandel (1998) and Weinberg (1998) claim that tobacco and alcohol developmentally precede the use of drugs in adolescence and that the sooner the initiation the worse the prognosis. Some authors claim that occasional and frequent users need different approaches (Steinberg 2001). The first are much more numerous although less problematic: Baer, MacLean, & Marlatt, (1998) claimed that occasional use of substances is so frequent in adolescence that can almost be seen as a “cultural norm”; especially for tobacco and alcohol use. However, a minority is really dependent and needs treatment: Gilvarry (2000) claimed that illicit drug consumption in youths from 12 to 17 doubled in 3 years, between 1992 and 1995, in the USA and in Europe and this phenomenon co-existed with an increase in tobacco and alcohol use.

A wider concept of “associated factors”

Currently substance use (drugs, tobacco and alcohol) is considered a public health problem responsible for high rates of morbidity and mortality. Determinants are, as referred, psychosocial, environmental and political in nature, may lead to an individual or social vulnerability, and are associated to each other (Michel, Ouakil, & Siméoni 2001).

In presence of several risk factors the probability increases to initiate and maintain substance use. Prevention urges to identify groups at risk and risk situations (Hartnoll 1998).

Baer et al (1998) refer that longitudinal studies revealed two different pattern of substance use: one that begins in adolescence and ends in adulthood, and another that does not end with adulthood. Those authors claimed that for prognostic purposes it is more relevant the general social and personal adaptation and the sense of social "belonging" than the amount of substances used during adolescence. Experimentation and use are more related to cultural norms, perception of tolerance, peer use and availability; conversely, substance abuse seems more frequent within a frame of biological and psychological vulnerability and distress, such as among special populations - homeless, those running away from home, school "drop outs", mental disorders, learning disabilities (Kandel 1998), as well as situations of physical or sexual abuse (Reiff, Simantov, Schlen, & Klein 2000). Substance abuse within this frame leads to heavier and long lasting problems (Gilvarry 2000).

Depression (Reiff, & al 2000; Gilvarry 2000; Gilvarry 2000), aggression and physical fights (Kodjo, Auinger & Ryan 2002; White, Loeber; Sege, Stringham, Short & Griffith 1999), hyperactivity (Gilvarry 2000; Pascual-Castroviejo 2002), behaviour problems and suicide (Gilvarry 2000; Weinberg 1998), seem to be more related to substance use. Wills, Sandy, Yaeger e Shinar, (2001) claimed that all those risk factors are mediated by individual characteristics. In a study trying to analyse the temporal sequence of this association, (White et al. 1999), claim that there is more an interactive association than a unidirectional prediction.

Roche (1999) referring to a study by Marsh (1996) identified a wide range of antecedents to substance use in adolescents, such as functional use (curiosity, boredom, search for good feelings, shyness in social relationships), peer associations, weak family bonds, parental attitudes and substance use, personality traits (rebelliousness, extroversion, stress on independence and non-conventionality). Roche (1999) points out that common causes of substance use are lack of knowledge about danger, lack of fear of use, personal problems, peer pressure and lack of social skills. Summarising correlates of substance use from the literature, Roche (1999) points out that users reported less interest in school matters, had poorer relationships with parents, were more oriented to peers, more involved in delinquent activities, had poorer health and psychological adjustment with frequent depression, and lived in an environment where a lot of people used drugs including their parents. Other factors included availability, cost and media influences (for instance, "glamorised" or "trendy" messages). Students who use substances performed worse in school and inside the family (Roche 1999). School interest was found to be an important indicator in early stages of use, while detachment from parents was found to be more important at later stages.

The influence of family structure, peer use and acceptance of substance use were also stressed (Jenkins & Zunguze 1998).

Substance users (specially substance abusers) report a low perceived quality of life (Zullig, Valois, Huebner, Oeltmann & Drane 2001). This fact is true for tobacco, alcohol, psychotropic medicines and drugs. A few authors report results from longitudinal studies evidencing long lasting effects concerning this lower perception of quality of life in adulthood (Sheldrick 1999). Substance users, namely alcohol and drug users, tend to present higher health risk related to HIV and other STD and non-planned pregnancy (Sen 2000).

Youth's attitudes towards substance use (tobacco, alcohol and drugs) are a determinant feature in experimentation, use and abuse of substances. Those attitudes concerned expectation of effects (over estimation of positive effects and minimization

of side negative effects), under evaluation of risk, over estimation of substance use in peer group and over estimation of drugs availability (Rodrigues, Mendes, & Antunes 1997; Ciairano 2004; Simões 1997).

Focus on “protective factors”

On the other hand, and concentrating on protective factors of substance use, intelligence (Weinberg 1998), self-regulation skills, self control skills, social and personal skills (Stice & Gonzales 1998; Weinberg 1998), absence of parental substance use habits (Wickrama 1999), absence of parental psychopathology (Weinberg, 1998) and parental positive monitoring, communication, emotional support and parental democratic style, interaction style and familiar culture regulation (Ciairano 2004; DiClemente 2001; Stanton et al. 2000; Fletcher & Jefferies 1999; Mendes et al. 1999; Stice & Gonzales 1998) seems to prevent substance use. Non user peers seem to be a strong protective factor to substance use in adolescence (Beauvais & Oetting 1999; Luthar & D'Avanzo 1999), as well as a strong school connection (Bonny 2000).

In-depth integrative studies

Another later shift in research leads to in-depth studies in order to study “processes”, (Prinstein, Boergers e Spirito 2001) verified that family disruption, low social acceptance, and depression increased the risk of substance use in adolescents, by means of making them more vulnerable to social learning process and compliance to peer pressure. These effects are more severe when peers themselves are substance users.

It is essential to consider the advantages and expectations of substance use, as those are perceived by individuals: relaxation, tension and stress reduction, easier sexual contact and social relationships, anti-depressive effect (Wills, Sandy, Yeager, Cleary & Shinar 2001) and an in-depth effort must be made in order to understand the phenomenology of adolescence and the meaning of daily life, challenges and resources (Ciairano 2004).

In-depth studies on substance use by means of quantitative and qualitative methods revealed gender differences related to the pattern, the role and the perceived consequences of substance use, in boys and girls (Matos, Gaspar, Vitoria & Clemente 2002).

Recent research evidenced different patterns of risk behaviours in both genders which called for the evaluation of specific interventions for girls: compared to boys, girls tend to use substances in order to improve appearance, promote their social-image and sense of maturity and independence, show toughness, reduce stress and keep a low weight. The use of drugs by family and boyfriend have a stronger weight in girls. Girls seem to have lower physiological tolerance, and present more often a personal history of psychological, physical or sexual abuse (Amaro, Blake, Schwartz, & Flinchbaugh 2001).

Another study using the HBSC survey (Currie et al. 2000, 2004), and carrying on an in-depth study of drug use using Portuguese data (Matos, Battistuta & Carvalhosa 2002) examined the way in which variables related to demographic factors, personal characteristics, peer relationships, parent relationships, and school involvement can predict the use of drugs in adolescents. The aim of this in-depth study was to evaluate potential associations between illicit drug use in the preceding month and demographic, personal, familial, school-related and peer-related variables, as well as other substance use. The sample was representative at national level of adolescents attending the 6th, 8th and 10th grade. The hypothesis that was confirmed is that those factors are associated and interactive, contributing to drug use in adolescents. Drug use was related to gender (higher for boys), age (higher with age) tobacco use, alcohol

use, violence (bullying at school and participation in fights), boredom at school and dislike of school, worst communication with parents, worst relationship with teachers, company of friends after school and poorer relationships with peers at school.

A set of variables was considered, inquiring about reasons for drug use. All students, irrespective of whether they had used illicit drugs in the preceding month, were asked their representation of reasons "for and against" drug use. The most commonly cited reasons for illicit drug use were 'new experiences' (64.2%), 'peer group culture' (53.5%), 'loneliness' (52.8%). The most commonly cited reasons against drug use were 'a personal decision' (74.3%), 'fear of disease' (43.5%) and 'lack of motivation' (42.8%). Four years after, a new HBSC survey was carried out (Matos et al. 2003), and similarly, the most commonly cited reasons for illicit drug use were 'new experiences' (67.1%), 'peer group culture' (64.4%), 'loneliness' (46.7%).

In this HBSC survey it was also inquired about where and with whom they thought that drug use takes place. The six most popular places were: poor neighbourhoods (79.1%), discotheques (62.1%), in the street (60.7%), at friend's (45.6%), at the dealer's house (41.7%) and in schools (36.3%). According to the answers, drug use happens "with a group of friends" (53.7%), "with one friend" (20.4%), "with boy/girl friend" (8.4%), "alone" (6.9%), "with relatives" (5%).

Initial work on drugs used to support the idea that drug use would be an escape door from lack of well being, however, more recent theories stressed the interactivity of personal and social factors. Lack of communication skills, lack of appropriate problem solving skills and lack of appropriate social skills can narrow adolescents' social repertoire and positive social interaction opportunities. Thus, both the existence of feelings of loneliness and unhappiness, and substance use can be associated to a narrower range of social behaviour repertoires and coping skills that adolescents can use. School interest and school achievement, as well as supporting families, have a protective effect on substance use (Ciarrano 2004; Roche 1999).

Occasional substance use is becoming more and more frequent and involves substances as tobacco, alcohol and drugs such as cannabis. This increased occasional use has a parallel with the increase of night leisure places. "Raves", discotheques, "house" music and "ecstasy" use, are all products of this recent culture. Besides, addiction and secondary effects of "ecstasy", tend to be under evaluated by consumers and the scientific community kept using, once again, the "only informing" pitfall (Calafat 2000).

Substance use (alcohol, tobacco and drugs) is, at a first glance, an empowering strategy that gives power, well being, reduces tension, shyness, anxiety and promotes social positive interactions. This is a dangerous feature on becoming dependent (Michel, Ouakil, & Siméoni 2001). Vulnerability factors and their interaction urge to be identified (Bühringer & Kunzel 1998). Special at risk individuals or groups need to be addressed the sooner the better (Michel, Ouakil, & Siméoni 2001).

When considering studies and reports available after 1988, it is very clear that authors generally give up speaking about "illicit drug use" or "drug use" and initiated the formulation "substance use". This fact stands for an association between the use of different substances, as well as the recognition that different substance use shared the same type of determinants and can be addressed by proposing the same kind of strategies. Most of adolescents that report use of substances (tobacco, alcohol, psychotropic medicines or illicit drugs) speak about the lack of alternatives. Some adolescents would argue "why not?" ("I've nothing to lose"). Some adolescents refer using substances to "have an experience", to cheer up, to increase connectedness and sense of belonging namely to the peer group (Matos, Gaspar, Vitoria & Clemente 2002).

Preventive Interventions

From the 70s on, heavy efforts have been carried out to improve prevention knowledge and efficacy in what substance use is concerned (Amaro, Blake, Schwartz, & Flinchbaugh 2001). Recent trends strongly recommend risk behaviours to be seen as an integrated phenomenon, in need to be addressed by a global promotional preventive strategy: no longer specific and different strategies to be taken for different substances or different compulsive-type behaviours. Efficacy is associated from one side with individual capacity building, from another side to the promotion of environmental support. In both cases, long lasting and sustained interventions and interventions aiming at the promotion of alternatives and quality of life/ sense of well being, are sought (Matos 2004; Bühringer & Künzel 1998).

Those strategies must include an early pre-adolescent intervention; include a broad range of substances, both legal and illegal, including tobacco and alcohol; (Shadili 2001) and must be long lasting and sustained. However, it is also pointed out, that “early” is not “as early as possible” because a too early intervention can be psychologically irrelevant for individuals and thus unable to produce change (Cairano 2004).

The scientific claim that different risk behaviours co-occur, do not mean that scientist should become paralysed with the assumption that “all bad things come together (and thus, there is nothing we can do)”. Conversely, primary prevention can target general populations but, at the same time, some action can occur with at risk selected situations or individuals, as recommended by the broad range of determinants already pointed out by recent studies (both related to risk and to protection). But what we are now able to understand is that, within each developing child or adolescent, some behaviours or situations precede other risk behaviours or situations in entirely different domains. An in-depth understanding of these phenomena allows preventive efforts to be more efficient if targeting behaviours or situations that are not “risk behaviours” themselves but are known to have a possible development towards substance use in the future. Examples could be personal traits such as aggression or shyness in early childhood; too strict or too permissive parental style; school failure.

Recent preventive interventions are mostly within school settings or community settings, mostly supported by (or through) local authorities. In the last couple of years a broad integrated perspective of substance prevention was in general used, and was based in the promotion of individual resources through the use of interactive methodologies, searching at the inclusion of families, as reported both in international literature (Cuijpers 2003; Botvin et al. 2003; Cairano 2004) and in national literature (see IIE 2002; IPDT 2001 vol II; IPDT 2002; Mendes et al. 1999; Matos 2004; Matos; Branco, Carvalhosa & Sousa 2005; Matos; Branco, Carvalhosa & Silva 2005).

12.4 Responsibility and competences (Coordination)

Since the publication of Portuguese Drug Strategy in 1999, meant to be revised in 2004, a lot of research and international policy seems to show a clear direction towards a broader conception of substance use and dependence, beyond illicit drugs and including psychotropic medicines, alcohol, tobacco and compulsive/dependent behaviours such as gambling, compulsive sex, shopping, binge eating, e.g. This claim becomes strong, firm and rooted in an extended research work even if it is clear that most of the studies are based on primary prevention (universal, selected and indicative preventive interventions, mostly in schools settings).

In a recent conference of Pompidou Group (Pompidou Group/CE 2004) it was stressed the urge to think laterally and to avoid reductionism, converging across substances but, it was also pointed out that converging across substances was much more clear concerning primary prevention than treatment and rehabilitation.

Primary prevention

The *Comissão de Coordenação da Promoção e Educação para a Saúde* (CCPES) whose field professionals (TPES) are in charge and responsible for health promotion in schools, was created by the public law *Despacho* 15 587/ 1999 dated August 12th. Another public law *Despacho conjunto* from Education and Health 271/1998 dated April 15th, created the *Centro de Apoio Nacional* (CAN) (National Support Centre) to the RNEPS (National Network of Health Promoting Schools). Both were extinguished in 2003.

The CCPES coordinated all preventive health actions in schools, nationally, from 1999 to 2003, adopting a wider perspective of substance use prevention (beyond “illicit drugs”), positive health and promoting quality of life and healthy life styles and building personal and social competences (Matos et ex-CCPES team 2004a).

TPES and CCPES professionals, were also involved in the implementation and supervision of school projects, namely in the 3 407 Portuguese schools included in the RNEPS.

The majority of the second and third cycle schools (86.3%) referred preventive projects in the area of health promotion, mostly (86.7%) within the classroom setting (Matos et ex-CCPES team 2004b). Both considering TPES work and other local school level projects, health primary promotion interventions in schools began to adopt a wider perspective of substance use (beyond “illicit drugs”), positive health and promotion of quality of life and healthy life styles and reinforcement of personal and social competences. The CCPES also coordinated with different specific organisations (IPDT/IDT for drug use, for instance).

Other interventions concerning national policy based primary prevention adopted this broad approach of substance use, out of the school system, based in community settings supported by local authorities, either intervening with youngsters or adult populations (IPDT 2001 vol. II; IPDT 2002; INA 2004; IDT 2005a)

Treatment and Rehabilitation

A different picture was foreseen considering treatment and rehabilitation.

Treatment and rehabilitation of tobacco, alcohol and drugs users is a duty and a responsibility of different organizations that hardly articulate: The Conselho Português do Tabagismo (National Tobacco Council) for tobacco; the Centros de Alcoologia (Alcohol Centres) for alcohol and the IPDT / IDT for drugs.

The IDT, coordinates with other Ministry of Health structures (primary care/health centres; school doctors and nurses, hospitals) professional institutions (IEFP), Ministry of Justice structures (prisons, residences for youth offenders), Ministry of Foreign Affairs (coordinating international policies and methods, fighting substance traffic and trade). Besides “demand reduction” and “supply reduction”, prevention of associated conditions such as HIV/AIDS, and related diseases such as tuberculosis and Hepatitis, are the priorities that motivate structures to co-ordinate. At a decentralised level, the IDT articulates with local authorities; local community centres, police and armed forces, NGOs and non profit organisations, in order to implement treatment and rehabilitation interventions (IPDT 2001, vol I, II; IPDT 2002; INA 2004; IDT 2005a).

Differently from some countries, where national organisations are responsible for prevention, intervention and rehabilitation in the area of tobacco, alcohol and drugs use and addiction (WHO, e.g. has taken this approach now for quite a while as reported by Harkin, Anderson & Goos 1997), in Portugal different national organizations undergo separated efforts. This implies different economic, physical and human resources, different logistics, different legislation, different professional training, and different research funds.

The external evaluation of the Portuguese strategy (INA 2004) points out that treatment centres for drug addiction (CATs and NATs) and Therapeutic Communities (TC) are mostly used by heroin users, a population which is decreasing, and that it would be worth to extend their use to other substance addictions, and addictive behaviours. This issue is also addressed in a recent internal evaluation (IDT 2005b). However if a common mix strategy is to be implemented in the area of treatment and rehabilitation, further research is needed to show evidence that this common mix strategy is the best option. A cost-benefits/ economical perspective should not be the only criteria.

All the national and international literature from 1998 on strongly supports a holistic approach to substance use, but most of the studies refer, indeed, to primary prevention/universal interventions.

In what treatment and rehabilitation are concerned, in Portugal as internationally (Hartnoll 2004), further evidences and conceptual discussions are necessary in order to understand demand reduction, considering conditions such as alcohol and tobacco addictions, polydrug use, doping substances use, or “addictive behaviours” like gambling, because not all treatment and rehabilitation strategies may be equally relevant. Hartnoll (2004) questioned the relevance of concepts as “supply reduction”, “replacement”, “decriminalisation”, “harm reduction”, “prevention of social exclusion” when, e.g., tobacco, alcohol and doping substances are also concerned substances.

It is strongly recommend that the “evaluation process” becomes a natural routine of every intervention, either aiming at reducing the demand or reducing the supply, either concerning universal, selective or indicative interventions, either concerning treatment or rehabilitation. However, this natural “quality routine” should not become a new “addiction” in itself (that someone called “evalopathy”) consisting of a mere “ritual of pseudo-evaluation”. When time arrives to evaluate intervention programs, all actors concerned are rather interested in “positive outcomes”, and this fact is enough to bias the all process. A continuous “quality evaluation routine” is strongly recommended (CE/Pompidou Group 2004), which should go beyond a descriptive level, and go in-depth through underneath processes, keeping in mind a pro-active orientation.

A last word to point out another strong recommendation from the Pompidou Group Conference (CE/Pompidou Group 2004): it is time to give up unexpensive symbolic projects that are easily sold politically, and it is time to invest in quality research and interventions, independent, carried on by well trained and supervised professionals, based in theoretical models and in scientific evidences, integrated, sustained, evaluated and “at a long run”, although these are harder to “sell” to the general public and do not produce immediate effects.

13. Developments in Drug Use within Recreational Settings

By Fernando Mendes
Psychologist and researcher

For centuries Human Beings used psychoactive substances with different purposes, basically involved in certain rituals and religious contexts and culturally well delimited.

The 60s clearly marked a turning point – the use of these substances in the context of different social cultural and political developments starts to integrate social reality in a constant and progressive way.

Regardless of what that use turned out to be, concerning the substances used and the groups that used them, we face a phenomenon that went unseen by many and which now has an important expression: *recreational drug use*.

In the 60s, particularly in the United States cannabis use and LSD was associated to the development of rock roll and pop music. Reggae is associated with cannabis use in a way which is clearly promoted and assumed by promoters and artists alike. In the end of the 80s a new and strong association between house and techno music and the use of ecstasy (MDMA) is observed.

This new phenomenon which, evolving side to side with new music styles, substances and users and centred in a new context (the recreational one), originated new patterns of use and new users groups, with social repercussions that make us rethink and update our preventive responses. According to the EMCDDA (2002b) and Eurobarometer (2002), the use of recreational drugs became a reality in the EU countries, making part of recreational night culture today.

Calafat, A et al. (2005) states that in many cultures drugs were historically used with different purposes, but any similarity with the actual recreational drug use, both by its dimension as for its cultural significance is anecdotic.

Nowadays, drug use can be a factor of inclusion and/or exclusion in the social network and is a component of the psycho-social identity of the individual.

Today we face a new fact – the globalization of the night life imply new challenges for our societies and for public health. This phenomenon is trans-national and involves a structure that promotes it and globalises it even more. The number of European youths that travels to other cities or countries during the weekend and holidays to participate in parties and other relevant events is increasing. Not to mention the holiday programmes specifically target to youths in summer places where the promotion is based in the number and quantity of parties that they can enjoy (Bellis, Hughes 2003).

Families, schools and some institutions traditionally associated to churches are socialising institutions by nature, but lately other institutions and entities have become socialising agents as well and with an increasing influence in the youth groups. We are for example referring to the media and to professionals in the recreational area that create styles, new fashions, define patterns, establish the recreational rules and all that it is related to it.

There is an increasing heterogeneity of the institutions linked to the recreational and leisure world. But the recreational industry, more than answering our needs, is creating them in a selective way, conditioning us in the choices and recreational options. Are we free to choose nowadays...?

To understand this phenomenon is to understand the life of our young people, their aspirations and ambitions, the framing in the adult's society, the expectations, the relationship with the family, the group life and the satisfaction /dissatisfaction levels and integration versus exclusion dynamics, amongst many others.

For our young people, the occupation of leisure times and the management of idleness is more and more associated to external spaces – coffees, streets, bars, together with their peers and mostly by night, especially in the weekends that became the elected period of time. This context is an essential part of the reality today and licit and illicit drugs are a part of it.

Attention has to be given to this recreational use because, contrarily to what many think, this type of use can not be seen as a result of problematic situations but as a part of this new current reality.

Answers are not easy to find and the challenge of prevention is huge and complex.

Preventive Approaches

In the 80s Amaral Dias already stated that prevention worked as an orthopaedic cane, correcting the incapacity of our society in facing substance use, reinforcing our self-regulation skills.

Grund (1993) referred that “drug prevention, as a professional activity, appears when our societies, values and traditional life styles are not capable to guarantee acceptable ways of substances use.

Is not possible to work in this area of recreational use without considering the strong social cultural influence of society in these behaviours, thus prevention is positioned as a partner which has to intervene in this dialectic. Prevention can not be seen as an instrument that is aseptically applicable upon a certain reality and which may work independently of the cultural logics”, (Calafat; Montse 2003).

Technicians and professionals alike agree that prevention intervention in this area has to go further than a simple and classic sanitary and individual approach of the problem. Integration is need in the logic and preventive practice, the economic thinking, cultural thought and marketing practices.

There exists today, in our societies, a higher diversity, availability and abundance of drugs than ever before. We deal with new groups of users, both in age groups and gender, with sufficient economic capacity for the acquisition of licit and illicit drugs and with a large tolerance of acceptance concerning their use, explained by the need of seeking pleasure at any price, but also in a *pure and simple* logic of consuming.

The recreational industry has been creating more diverse activities, targeted to different groups, taking in account their life philosophy, beliefs, fashions and substance use. It is important to understand that in relation to substance use, the recreational industry not only responds to the needs of users but creates new products, instigating new use needs.

This phenomenon caught by surprise the prevention experts who, not knowing it in its distinct forms, replied with interventions used in other contexts and often with *ad-hoc* interventions. We are referring the interventions based only in the information about substances and its effects, pill testing or alternatives to the recreational settings.

The debate is now how to *intervene* in this situation, and the consensus is not on the approach needed but on the need to structure those responses and to implement them for longer periods of time.

Understanding the motives to use or not to use psychoactive substances is fundamental in the conception of prevention programmes.

We know that drug use acts as an inclusion or exclusion factor in a social network, acting also as a psycho-social identity behaviour in the individual.

Taking into consideration the knowledge we have of the different risk and protective factors, we know that, if a professional consensus exist, it is on these factors that we should built prevention, including as target-groups the family, the community, the peer group and individual factors. If these factors do not, *per se*, justify the increase in recreational substance use we must redirect research in to other areas and variables.

We thus propose four fundamental concepts to increase knowledge and more efficiently answer to this phenomenon:

- a) **Recreational drugs:** recreational drugs are a series of psychoactive substances which shared characteristic is not the chemical structure nor the type of effect, but the fact that they are frequently used with in recreational contexts, especially during the weekend. (Calafat; Montse 2003).

We are thus referring a group of licit and illicit psychoactive substances (alcohol, tobacco, cannabis, ecstasy, LSD, amphetamines, ketamine and GHB) all used in recreational settings.

- b) **Recreational setting:** terminology that contextualizes a form of night life and weekend leisure, particularly associated to young people, in bars, discos, streets and other places where the main aspects are centred in a fundamental trilogy, music-dance – partying with friends, and to a growing association of licit and illicit drug use.

- c) **Risk perception:** the construction of risk perception for each individual is a complex process where different variables intervene such as, and amongst others: information available, use by family/friends, expectations, actual or past use experiences, context, substances availability and social tolerance (Calafat; Montse 2003).

Given the fact that the “invulnerability feeling” (Leigh 1999) and the risk perception associated to substance use is low and with no negative valorisation, research has to be reviewed concerning, what we will for now designate, as social factors based in intra and inter personal life styles and risk perception.

- d) **Management of the weekend recreational life:** the indicators the characterising the recreational life of each individual are the following:

- Motivation to go out on the weekend;
- Intensity of the weekend experiences;
- Selected places to go out to.

Is necessary to understand the rhythm of these outings: how many times during the weekend, for how long, how many and which locations, and why the choices are made.

The massive incorporation of youth in the social “normalisation” of recreational drug use was produced through cultural motivations, in a social construction process with a dynamic which favours substance use. The increase of this economic and social cultural logic leads to HRNM (Hegemonic Recreational Nightlife Model), proposed by the European Research Institute for the Research of Risk Factors in Children and Adolescents (IREFREA), through which the explanations and, possibly, the solution for recreational drug use should be found. Prevention programmes centred in the individual should be inevitability complemented through other type of actions that take

in consideration the social and environmental context and the social and cultural construction process, where the need to use drugs in recreational context is based.

It is important to review the dominant preventive models – universal prevention and risk reduction.

It is fundamental to insist in the need for more qualitative and quantitative research and for evaluation of the activities that already exist, considering the different groups in the current recreational setting. An permeability analysis of the changes proposed by the prevention programmes should be done, since substance use continues to increase. This involves a real effort so that prevention actions achieve the expected results, using more creative and efficient approaches.

Risk reduction in prevention

Risk reduction interventions, based in therapeutic approaches with heroin users and included by some professionals as a preventive approach became popular. Nevertheless, these preventive approaches, also contribute, by making information available about the substances, the consequences of their use and the best way to avoid problematic use, to the normalisation of the process, the logic of the *lesser evil* and may hinder a true preventive approach. Those activities do not question the model in which recreational activity is based and often imply an acceptance, without criticism, of substance use.

We emphasise that the training disco staff, making public transportation availability near the exit, the use of plastic cups or the creation of relaxing (chill out) areas, are important measures in the recreational context, and questioned, on the other hand, the range and effectiveness of measures such as pill testing or the availability of information on how to use substances “without problems”.

European Programmes

Reviews of European recreational programmes were made in the past years: (Calafat, A. et al. 1998); (Tossmann, R., Boldt, & Tensil 2001); (Burkhart; Lopez 2002); (Calafat, A. et al. 2003).

IREFREA reviewed, in 2003, 40 preventing programmes implemented in 10 countries (United Kingdom, Spain, Italy, Greece, France, Austria, Germany, Portugal and Finland). Although it is not a representative sample of what is going on in Europe, it allows for reflection and analysis of the preventive approaches implemented in those countries.

The effectiveness analysis of the prevention programmes implemented in the recreational settings in Europe allows to conclude that those programmes are still in an initial phase and do not present yet a clear theoretical framing. A proliferation of interventions which were not evidence based, without well defined prevention goals and which evaluation did not prove for the effectiveness in achieving the pretended goals was verified, both in the area of substance use reduction and in the area of reduction.

To enable an easier understanding of these distinct prevention interventions a matrix for analysing the programmes was applied on the following items:

1. Conceptualising the programmes

Although these programmes were directed to an apparently well defined target population, the result seems to point towards unselective interventions, more directed towards the general population.

2. Objectives

The majority of the objectives present in this revision are undoubtedly to “give information” and to “promote an intervention in the framework of risk reduction”.

3. Target-groups

The preventive programmes target to specific groups based in aspects such as gender, sexual orientations or juvenile cultural differences were a minority in recreational settings. However substance use situations and individuals are varied so prevention strategies should be so as well. The target group that needs special attention are non-users and women. Prevention should learn with them, especially with non-users, concerning the strategies they adopt, the risks they avoid and their point of view in relation to recreation and the use of drugs. It would also be very positive to discern how their influence could be used in juvenile sub cultures.

4. Execution / implementation

The execution of these programmes mostly ensured by peers, health professionals and NGO professionals for different approach reason: working with peers facilitates information transmission and the identification process whereas professionals have more technical credibility.

5. Timeframe

Interventions are in their vast majority limited to events themselves (festivals, raves – parties in discos). Sometimes the same information is used to cover different events and in a non selective way. Whereas research has shown that longer term interventions and the selectivity of the information, taking into account the context and the group, is extremely important.

6. Evaluation

This fundamental component of any programme which evaluate its efficiency and efficacy seems not be present in most of these interventions in recreational settings.

Only a careful evaluation, in the different moments of a certain prevention programme, will allow us to conclude for its feasibility. From then on it will be much easier to conceptualise and implement new programmes with different specificities.

Maybe the more innovating and realistic interventions are implemented by “Club Health” and “Safer Dance”, which promote the cooperation with the recreational industry, parties and events, with a high level of quality, taking in consideration the setting and the physic welfare of the users. This approach fits in the model proposed by IREFREA - the HRNM (Hegemonic Recreational Nightlife Model). Any intervention implemented in this area has necessarily to ensure cooperation with the industry.

The internet being one of the main sources of information that young people go for currently, three different types of sites are available:

Institutional sites – linked to public services or ministries (Health/Education/Justice) where the content is basically on information about substances and its consequences identifying treatment centres and legislation.

NGO sites – that do not promote the liberalisation of drugs and with a similar type of content on substances and its consequences.

NGO and other Organizations sites –defend and promote the use of psychoactive substances, giving indications and useful advices for the users, indicating, in some cases, how you can bypass the law.

The high increase of internet use by the youth justifies a quantitative and qualitative investment in this sector.

It is easy to find all types of information about illicit and licit substances, psychic and physical effects of use, norms and legislation, games, quizzes, public and private treatment or counselling centres or institutions. It is easy to find information about the best way to use, with the minimum of consequences, arguments for use liberalisation, best products and ways to bypass the law, amongst others.

It would thus be important to guarantee a serious investment in this area also, through a scientifically correct, updated well based approach.

In some sites is possible to create an interactive dynamic through an intelligent and attractive organisation of the pages. If these sites are to be effective, they should be directed to the target groups you want to reach, bearing in mind that some sites are more generalist (universal) and others more selective.

Internet can increasingly become a preventive setting / instrument.

Background for Prevention in Recreational Settings

IREFREA has been researching on the *state of art* in this area since 1976, and already pointed out several prevention priorities concerning recreational younger use (Calafat, A. et al. 1998); (Calafat, A. et al. 1999); (Calafat, A. et al. 2001); (Calafat, A. et al. 2003); Thus concrete reflections and interventions are proposed to be taken into account in the organisation of the different prevention activities in the context of nightlife and weekend recreational. These should influence the *form and content* of such responses and should be widely debated with a view to a consensus.

1. To establish consensus in the scientific and professional communities on the meaning and possible interventions in recreational settings

There is an urgent need to increase knowledge and research in this area to allow the conception of evidence-based prevention programmes or activities which are prepared to be evaluated. The majority of these actions are limited in time, without continuity, universal, based only on the information concerning substances.

Rigid ideological stances should be abandoned in order to create conditions for more scientific debate, the conceptualisation of a theoretical model and more knowledge on risk factors, integrating several types of responses.

Responses in this area are not limited to harm reduction, pill testing or in the availability of alternative activities.

2. To develop and disseminate evidence-based and updated information on licit and illicit psychoactive substances and their effects.

We know that information alone does not imply the change or adoption of healthy behaviours but it is a precious instrument in prevention strategy.

Calafat et al (2001) showed how astonishing lack of information about the effects and consequences of the use of licit and illicit drugs is, in particular the physical and psychic negative effects, as well as the ignorance on the legal framework. It is important to reinforce the information with preventive measures, taking into consideration the drugs which are more generally used (alcohol, tobacco, cannabis). It is also important to review the dominant preventive model (universal prevention and harm reduction) in a way that make it possible to adapt it better to the current recreational use amongst young people.

3. To develop strategies that increase the risk perception linked to the use of licit and illicit substances

Strategies that improve the critical capacity of young people should be adopted: strategies that help them find symbolic connections between ideals and substances and to face the current cultural dynamic, targeted to the direct or indirect promotion of

drug use, with more visible mechanisms in the case of licit drugs. It is important to increase the risk perception associated to drug use, or else achieving a decrease in drug use will be extremely difficult, and to increase the compliance to harm reduction strategies. The significant expansion of drug use lead to a decrease in the risk perception, particularly amongst the youth and the new groups that come out each year.

It is therefore necessary to act near the young users, increasing their knowledge concerning psychoactive substances and its consequences and giving them a higher critical capacity.

4. To postpone the age of onset in the participation of recreational activities which are more associated to drug use in adolescents

One of the risk factors with a higher predictive value on the use/abuse of drugs is substance use in premature ages. Several studies established a relation between the premature initiation in recreational nightlife and the use of drugs. This situation implies, on the one hand, that the family has to assume its responsibilities by establishing limits and, on the other hand that the State and the municipalities have to enforce the laws that control access to nightlife contexts and the use of licit and illicit substance use. Alternatives to the existing activities, appealing and attractive enough, should be provided by municipalities and NGOs in the field. It is paramount to avoid that the experimental drug use in the youth evolve to regular use or abuse.

5. To demystify the association of drug use and social success or as a part of the “normal” socialisation process.

We know that the use of licit and illicit drugs can “*facilitate*” some individuals to become more social, more expansive, more innovative and, in some cases more “*audacious*”, all this in logic of socialisation or rising to social success. It is important to fight the idea that success, prestige and good social image is just possible for some through drug use. In this context, we should also work on the information that passes in the media and is a potential for socialising models.

6. To pay more attention to gender as a use group

During the last few years there was a progressive increase of use amongst the female populations as well as access to traditionally “male spaces” and a higher social tolerance for the use of licit and illicit drugs. The role of women is rapidly changing particularly amongst the younger ones. There is a strong pressure that these changes should follow the “market logic” for the use of alcohol and tobacco under the auspice of independence and freedom. Prevention should expose those strategies and facilitate amongst girls a critical vision of their new role.

The main concept here should not be the passive adoption of feminine roles and stereotypes but an adaptative and interactive process, oriented towards the training of a female identity. Both non-users and women are a preventive potential by themselves. Their attitude towards moderation and their diversified interests represent a cultural and preventive option that should be considered. This implies not only to support their options but also to explore the preventive effectiveness that may come from the involvement of girls in prevention and in harm reduction activities, amongst their user friends.

7. To adequate preventive strategies to the different juvenile sub-cultures thus rendering them more effective

Knowing the importance that recreational culture has among the youth, preventive strategies should aim at the media, the advertisement industry, symbolic elements associated to use, music and, in particular, fashion, this last one being an element of huge relevance in the decision process as most recreational users assume that the use

of drugs is “fashionable” (Kemmensies 2000). It is important to have more knowledge of the different subcultures in each community and adjust prevention responses in a selective way.

8. To establish “non use/moderate use”, as a social and cultural accepted option in the recreational setting

“The logic that, for having fun, you need to use licit or illicit drugs has to be inverted” (Calafat, A. et al. 2003). The idea is to support a moderation culture reinforcing the models and practices of non use / moderate use.

9. To make adults more aware of the new recreational models and of their consequences, turning them into partners in the recreational settings

It is not easy today, for parents and educators to understand and comprehend the new patterns of juvenile entertainment – the opening hours of discos, each time later, the distinct night tours, the use of licit and illicit drugs, the abundance of resources, the parties and numerous promotions. Is important to refer that there are no spaces to be shared by young people and adults (family).

All actors should be involved, including clubs, schools, families and the industry, in alternative forms of entertainment and leisure for the young people.

Parents and educators have to understand that a permissive and tolerant attitude towards substance use favours use/abuse behaviours.

10. To pay more attention to the group of non users and moderate users

In preventive terms, it is important to understand the logic and behaviour of non-users or moderate users in their recreational activities, pondering the strategies used to avoid use pressure. More favourable conditions to young non-users or moderate users that frequent recreational environments should be created so that their options (non-use) are considered to be more reasonable and evaluated positively. These young people make efforts to have fun in a context where they are pressured towards substance use and where they are not understood in their conduct and values.

11. To involve the recreational industry in the creation of quality spaces for different recreational activities

It is important to create conditions for a responsible collaboration with the recreational industry as they do not offer only the service but also model an important part of the social and personal development of young people, contextualising new forms of juvenile entertainment and creating conditions and opportunities where the youth has fun.

Recreational quality settings should be promoted, with minimum conditions for entertainment: existence of emergency exits, control temperature in the room, control of the number of persons in a same room. Quality also means: available training for the staff in recreational settings, for the security agents and other actors in first aids, availability of non alcoholic drinks at cheap prices and cooperation of law enforcement with health and municipal services.

12. Monitoring the “non official” circuits of recreational activities

Organising parties and events in alternative spaces (abandoned warehouses, forests, and pavilions) is becoming more frequent and popular.

The realisation of these events is done mainly through the internet, sms or flyers. Those are situations not known to the law enforcement and health authorities and some times generate violence situations. Each community should denounce these situations and try to find the more adequate and integrate responses.

13. To give adolescents and young adults the possibility of having access to alternative recreational settings

The industry knows very well the potential of use of adolescents and young adults promoting more and more the creation of distinct, selective and restricted contexts to these groups.

To support other varied, creative and more participant forms of entertainment should be promoted. The Spanish experience in community prevention is relevant here – though the existent programmes are based in structured activities, without the specific objective of drug prevention, they are considered as a good health promoters and an alternative to juvenile leisure time.

14. To be aware of the reappearance of “afternoons in discos” target to pre-adolescents

It is important to be aware of this new reality that reappears everywhere and promotes the reproduction of young adults’ behaviour in pre-adolescents.

15. To integrate in Prevention Programmes (Family – School – Community), activities that address the issues such as the nightlife, the entertainment industry, group pressure, use and risk perception

If possible, it is desirable that preventive modules integrating themes related to recreational activities are development in existing programmes that.

Conclusion

There is a growing interest concerning this theme at different levels in our society, for the recognition of the phenomena dimension in itself and for the concern of its implication on the current society.

Notwithstanding the work already developed in this area there is a need to monitor this phenomenon with more precision and care, as to create a set of sufficient and extensive responses. For these to be developed it is fundamental, first and foremost, to create a consensus involving professionals and researchers in this area. To surpass some barriers, attitudes and practices can facilitate our common work as well as promote the development of the decision-makers in an investment which is urgent in this area.

In reviewing the scientific literature there is an heterogeneity of interventions of generalist character, a lack of a clear definition of the objectives and choices of target groups as well as a of evaluation to support the work developed.

This does not mean that we all have to work in the same way, with the same frameworks and objectives, but we should all recognise that our different evidence-based practices will allow for an important and diverse complement of interventions.

It is therefore important to:

- Recognize and base prevention in recreational setting as an important part of family, school and community training;
- Recognize that intervention in recreational setting can be transversal with other existing preventive programmes and may strengthen its action;
- Involve politicians in this consensus for a higher profile of attention to the phenomenon and provide technical and financial support for the development and implementation of preventive and research actions The results will allow later for a “political” evidence-based decision involving added value at social and cultural level.

Part C
Bibliography and Annexes

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15. Annexes

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List of Abbreviations used in the text

- ANF – Associação Nacional de Farmácias / National Association of Pharmacies
- CAN – Centro de Apoio Nacional / National Support Centre (Ministry of Health and Ministry of Education). Extinguished in 2003.
- CAT – Centro de Atendimento a Toxicodependentes / Specialised Outpatient Drug Abuse Treatment Centres (Ministry of Health/IDT)
- CCPES – Comissão de Coordenação da Promoção e Educação para a Saúde / Coordination Commission for the Promotion of Health Education (Ministry of Education)
- CDT – Comissão para a Dissuasão da Toxicodependência / Commission for the Dissuasion of Drug Use (Ministry of Health/IDT)
- CESOP/UCP – Centro de Estudos e Sondagens de Opinião da Universidade Católica Portuguesa / Centre for Research and Opinion Surveys from the Portuguese Catholic University
- CGTP-IN – Confederação Geral dos Trabalhadores Portugueses – Intersindical Nacional / National Workers Union
- CMVM – Portuguese Securities Market Commission / Comissão do Mercado de Valores Mobiliários
- CNLCS – Comissão Nacional de Luta Contra a SIDA / National Commission for the Fight Against AIDS
- CVEDT – Centro de Vigilância Epidemiológica das Doenças Transmissíveis / Epidemiological Surveillance Centre of Transmissible Diseases (Ministry of Health)
- DCITE – Direcção Central de Investigação do Tráfico de Estupefacientes / Central Narcotics Traffic Investigation Division
- DGS – Direcção-Geral da Saúde / General Directorate of Health (Ministry of Health)
- DGSP – Direcção-Geral dos Serviços Prisionais / General Directorate for Prisons (Ministry of Justice)
- DU – Detoxification units / Unidades de Desabitação
- EC – European Commission / Comissão Europeia
- EDDRA - Exchange on Drug Demand Reduction Action
- EELDA - Evidence Based Electronic Library on Drug and Drug Addiction
- EMCDDA - European Monitoring Centre for Drugs and Drug Addiction / Observatório Europeu da Droga e das Toxicodependências
- ENHPS – European Network of Health Promoting Schools / Rede Europeia de Escolas Promotoras de Saúde
- ESPAD - *European School Survey Project on Alcohol and other Drugs*
- FATF - Financial Action Task Force on Money and Laundering / Grupo de Acção Financeira sobre o Branqueamento de Capitais
- GAFISUD – Financial Action Task Force of South America Against Money / Grupo de Acção Financeira da América do Sul
- GMR - General Mortality Register (In Portugal the INE/DGS) / Registo Geral de Mortalidade (em Portugal o INE/DGS)

GNR – Guarda Nacional Republicana / National Republican Guard (Ministry of Home Affairs)

HRNM – Hegemonic Recreational Nightlife Model / Modelo Hegemónico Recreativo Nocturno

IAC – Instituto de Apoio à Criança / Institute for Child Support

IDT - Instituto da Droga e da Toxicodependência / Institute for Drug and Drug Addiction (Ministry of Health)

IDUs - Intravenous Drug Users / Consumidores de drogas injectáveis

IEFP - Instituto de Emprego e Formação Profissional / Portuguese Institute for Labour and Professional Training (Ministry of Labour and Social Welfare)

IMF - International Monetary Fund / Fundo Monetário Internacional

INA – Instituto Nacional de Administração / National Public Administration Institute (Ministry of Finances)

INE – Instituto Nacional de Estatística / National Institute of Statistics (Presidency of the Council of Ministers)

INML – Instituto Nacional de Medicina Legal / National Forensic Institute (Ministry of Justice)

IPDT – Instituto Português da Droga e da Toxicodependência / Portuguese Institute for Drugs and Drug Addiction (1999-2002. Replaced by the IDT)

IPSS – Instituições Particulares de Solidariedade Social / Private Non-profit Organisations

IREFREA – European Research Institute of Risk Factors on Adolescents / Instituto Europeu para o Estudo dos Factores de Risco e de Protecção em Crianças e em Adolescentes

IRS -Instituto para a Reinserção Social / nstitute for Social Rehabilitation (Ministry of Justice)

ISSS - Instituto de Solidariedade e Segurança Social / Institute of Solidarity and Social Security (Ministry of Labour and Welfare)

NAT – Núcleo de Atendimento a Toxicodependentes / Drug Abusers Counselling Units

NFP – Ponto Focal Nacional / National Focal Point

NGOs – Organizações Não Governamentais / Non-Governmental Organisations

ODT – Observatório de Droga e Toxicodependências / National Monitoring Centre for Drugs and Drug Addiciton (IDT/Ministry of Health)

PATO – Prevenção de Álcool, Tabaco e Outros / Prevention of Alcohol, Tobacco and Other Substances

PCM – Presidência do Conselho de Ministros / Presidency of the Council of Ministries

PEPTEP – Programa Especial de Prevenção da Toxicodependência nos Estabelecimentos Prisionais / Special Prevention Programme for the Prevention of Drug Abuse in Prisons (DGSP/Ministry of Justice)

PIDDAC – Plano Integrado de Desenvolvimento da Administração Central / Government Integrated Plan for the Development of the Central Administration

PPES – Programa de Promoção e Educação para a Saúde / Programme for Health Promotion and Education (Ministry of Education)

PSP – Polícia de Segurança Pública / Public Security Police (Ministry of Home Affairs)

RNEPS – Rede Nacional de Escolas Promotoras de Saúde / National Network of Health Promoting Schools (Ministries of Health and of Education). Extinguished in 2003.

SMR - Special Mortality Register (In Portugal the INML) / Registo Especial de Mortalidade (em Portugal o INML)

SPTT – Serviço de Prevenção e Tratamento da Toxicodependência (Ministério da Saúde até 2002 - fundido com o IPDT em 2002 para formar o IDT) / Service for Drug Abuse Prevention and Treatment (Ministry of Health until 2002 - merged with the IPDT in 2002 into the IDT)

TC – Therapeutic Community / Comunidade Terapêutica

TPES – Técnicos de Promoção e Educação para a Saúde (Ministérios da Saúde e Educação). Extintos em 2003 / Health Promotion and Education Professionals (Ministries of Health and of Education). Extinguished in 2003.

UTITA – Unidade de Tratamento Intensivo de Toxicodependência e Alcoolismo (Ministério da Defesa Nacional) / Unit for the Intense Treatment of Drug and Alcohol Abuse (Ministry of National Defence)