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Portugal - 2002

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Summary

Concerning the **institutional and legal frameworks**, the most important development was the endorsement of the National Strategy and Action Plan by the new Government and the displacement of drug coordination issues from the Presidency of the Council of Ministers to the Ministry of Health. Legal diplomas issued mainly focus on the regulation of the approved harm reduction policy, the fight against money laundering and coordination aspects.

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

Concerning drug use:

An increase and geographical dissemination of drug use, as well as changes in drug use patterns, is visible in surveys and legal and health drug related consequences;

Cannabis is still the most used drug amongst users in general but other substances' visibility in this circuit is increasing, namely cocaine, ecstasy, amphetamines and hallucinogens;

Amongst problematic drug users (IDUs or not), heroin is still the main drug involved;

Heroin is also the main drug involved in health and legal drug related consequences, though hashish has been gaining relative weight and, in some cases, even surpassed heroin;

Concerning polydrug use, apart from the "traditional " association of heroin and cocaine, other associations gain visibility, such as cannabis and ecstasy and also licit and illicit substances;

Responses to drug use continue to include several types of prevention interventions with special emphasis in the school setting and in municipal/community plans tailored to each municipality's needs in this area.

Concerning drug related health consequences:

Indicators available suggest more effective responses are being implemented at treatment level (decrease in waiting lists, higher retention of clients in treatment) and at the level of harm reduction interventions (levelling off of the dissemination of infectious diseases and decrease in drug related deaths). Heroin is still the main substance in these settings;

There was an increase in the number of treatment facilities available at national level and a stronger cooperation between private and public services, which lead to more clients in treatment in the public services and less clients in waiting lists;

The decrease verified in first treatment demands (-9% than in 2000) and the increase in the follow up episodes (+14% than in 2000) also suggest more effective responses at this level, including higher availability and client uptake of opiate substitution treatments;

Heroin remains the primary drug for those who seek treatment;

In 2001, the decreasing trend, already verified in previous years, in the percentage of drug users amongst the AIDS infected population was again registered;

Levelling off of the number of drug users in treatment who tested positive for HIV and hepatitis B and C was also verified, but an increase was registered amongst those who tested positive for tuberculosis;

These data on infectious diseases may be the result of the implementation of harm reduction interventions, which may have lead to a decrease in intravenous drug use, and/or to the uptake of injecting drug use in higher sanitary conditions through the availability of the national syringe exchange programme;

Drug related deaths continue to decrease (-12% than in 2000) as well as the percentage of positive toxicological tests for illicit drugs in the total number of tests conducted in the reporting year;

Drug related deaths continue to be mainly associated to opiates but other substances (including cannabis) start to gain more visibility;

Harm reduction interventions placed a special emphasis on outreach work, through the setting up of a national outreach work network targeted both to recreational settings and problematic drug users.

Concerning drug related legal consequences:

Indicators point towards a reinforcement of the interventions at supply reduction and also to a larger number of drug users in this circuit. Hashish is the main drug involved in drug users cases and heroin in traffic cases;

The reinforcement of law enforcement agencies intervention and the new legal framework which decriminalises drug use had an impact in 2001 data: the number of presumed offenders of the Drug Law decreased, mainly of drug users (-57% than in 2000); the percentage of traffickers was the highest in the last 5 years;

The majority of these individuals possessed only one drug, mainly hashish, followed by heroin. Traffickers were the category with a higher percentage of polydrugs;

The Commissions for the Dissuasion of Drug Use instated 2 366 processes to drug users in the second semester of 2001 and decided on 1 783 of them: 93% were suspended (mainly in the case of non-addict drug users), 4% were absolutions and 3% were punitive. The majority of the individuals involved possessed only one drug, mainly hashish, followed by heroin;

Court data indicates that, in 2001, the number of finalised processes concerning infractions to the Drug Law increased in comparison to the 2 previous years, although the number of individuals involved in these processes has been decreasing since 1999. The number of convicted individuals decreased (-12% in comparison to 2000) mainly in cases of traffic and traffick-use. Of the convicted individuals 58% were convicted for traffic, 37% for use and 5% for traffic-use. Rulings were, in general, lighter than in previous years for all categories. Most of these individuals possessed only one drug, mainly heroin, followed by hashish. Polydrugs were found mainly in traffic processes;

The percentage of individuals in prison for Drug Law offences, in 2001, decreased in comparison to 2000. Nevertheless, the absolute number was higher for almost all Drug Law related crimes. Individuals were mainly imprisoned for traffic offences (87%) though, in the last years, the number of imprisoned individuals for criminal association and precursor crimes has been increasing;

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

Individuals involved in both health and legal systems for drug related problems are still mainly of the male gender and aged 25-39, with a tendency towards older age groups in comparison to previous years. They still report low education status and precarious labour situations.

Markets

The number of seizures continues to decrease and the quantities seized continue to increase. Heroin and hashish are the substances involved in a higher number of seizures, and cocaine, liamba and ecstasy the most seized substances (in quantities). This may indicate a higher effectiveness of supply reduction interventions probably related to the new legal framework in terms of criminal investigation and drug use;

Average prices of seized drugs suffered no significant changes though the price of cocaine went down and is now very close to heroin price;

There is more perceived availability of cocaine and ecstasy and the combination of drugs seized in cases of presumed offenders may indicate diversification in the supply and in the demand with the emergence of new types of drugs in the national market.

Key issues

Data on public expenses are not easily available for all demand reduction areas and data from private services which are not funded by public funds are not available. This leads to an underestimation of public expenses in this area and a global estimation is impossible to obtain at this stage;

Concerning drug use among young people, and despite limitations in the possible comparisons, there seems to be an increase in drug use prevalence, especially for other drugs than cannabis. Patterns point towards the diversification and specialization in the drugs used, as well as geographic widespread;

Social exclusion in this area is a growing concern. Although a series of responses are available to develop drug users rehabilitation, there is a lack of research which may allow for a more in-depht understanding of the problem and its impact.

Part I

National Strategies: Institutional and Legal Frameworks

1. Developments in Drug Policy and Responses

1.1. Political framework in the drug field

After the general elections in March 2002, the new government's programme [Assembleia da República2002] in this area stated "drug abuse as a health problem and the need for the government to act in order to minimise this social problem". The government further recognised the need to give continuity to both the National Strategy and the National Action Plan - Horizonte 2004, prepared under the previous government.

The same document maintains the IPDT as the coordinating agency in the field but relocates it from the Presidency of the Council of Ministers to the Ministry of Health, now responsible for drug issues coordination. This implies a redefinition of the national coordination policy and of the Institute itself, which is under preparation, and should be implemented until the end of the year. Rationalising budget and human resources is one of the priorities of this government and it is expected to have some impact on the area.

General national priorities include: for prevention - the promotion of healthy life styles; for treatment - further coordination and quality control, as well as more support to drug users in prison; and, for rehabilitation - redefinition of the rehabilitation programmes after their current evaluation. Special emphasis is placed upon the setting up of outreach work programmes, and of all initiatives, which may prevent drug, related infectious diseases, namely AIDS/HIV.

1.2. Legal framework

The new main legal diplomas in this area are listed in chronological order:

To create the necessary conditions for the implementation of the **Decree-Law n. º 183/2001, of the 21st of July 2001** which approves the general framework of harm reduction policies (cf. 2001 National Report), a series of regulations were issued to establish the conditions and criteria for the different facilities foreseen in the above referred document, namely:

Regulation n. º 1112/2001, of the 20th of September 2001 - approves the criteria for setting up and certifying Contact and Information Units (*Pontos de Contacto e Informação*).

Regulation n. º 1113/2001, of the 20th of September 2001 - approves the criteria to financially support Contact and Information Units (*Pontos de Contacto e Informação*).

Regulation n. º 1114/2001, of the 20th of September 2001 - approves the criteria for setting up and certifying outreach work projects.

Regulation n. º 1115/2001, of the 20th of September 2001 - approves the criteria to financially support outreach work projects.

Decree-Law n. º 265-A/2001 of the 28th of September 2001 - substitutes **Decree-Law n. º 162/2001 of the 22nd of May 2001** which was reported last year and regulates testing and related procedures on individuals suspected of driving under the influence of illicit substances, as well as on all involved individuals in case of a road accident. Concerning illicit substances there were no changes to the previously reported diploma.

Law 109-A/2001 of the 27th of December 2001 - indicates the major guidelines for 2002 in all governmental areas, including the drug area where the midterm objectives of the Action Plan Horizonte 2004 are stated.

Law n. º 5/2002 of the 11th of January 2002 - establishes special measures to fight against economic and financial organised crime concerning evidence collection, information confidentiality and confiscation of assets in crimes of drug trafficking, terrorism and terrorist organisation, weapons traffic, passive corruption, money laundering and criminal association, amongst others.

Decree-Law n.º 43/2002 of the 2nd of March 2002 - creates the national maritime authority with responsibilities at the level of the fight against drug trafficking.

Decree-Law n.º 120/2002 of the 3rd of May 2002 - places the coordination of drug demand issues under the Ministry of Health, including the tutelage of the IPDT.

Law 16-A/2002 of the 31st of May 2002 - states that, according to the new government programme, and Decree-Law 120/2002, the IPDT and the SPTT will be merged into a new agency.

1.3. Laws implementation

The main guidelines of the National Strategy continue to be implemented through the objectives of the National Action Plan - Horizonte 2004 which mid-term performance evaluation is expected by the end of 2002.

In the priority area of harm reduction and under the legal framework of **Decree-Law n. º 183/2001, of the 21st of July 2001**, the IPDT launched, in October 2001, a national tender directed to non-profit NGOs, for financing and ensuring technical assistance to the setting up and maintenance of outreach work projects. 22 projects were approved (see details in the Demand Reduction section).

The 18 Commissions for the Dissuasion of Drug Use (CDTs) set up on the 2nd of July 2001 have been implementing last year's legal diplomas concerning the decriminalisation of drug use, namely:

Law n. º 30/2000 of the 29th of November 2000 - defines the new legal framework for personal use of illicit substances.

Decree-Law n. º 130-A/2001 of the 23rd of April - regulates the functioning of the Commissions for the Dissuasion of Drug Use (CDTs).

Regulation n. º 604/2001, of the 12th of June 2001 - regulates the Central Drug Users' Registry of the CDTs.

For more detail on the activity of these Commissions, please see the Epidemiological Situation and the Demand Reduction sections.

1.4. Developments in public attitudes and debates

Although no formal research was recently conducted in this area, the press focused mainly on the following issues:

- Concern over the spread of drug use to rural areas according to data from the National School Survey (cf. chapter 2.2.);

- Concern over infectious diseases in general and, namely, over HIV and tuberculosis amongst drug users;

- Public concern over the displacement of drug trafficking and use and related feelings of insecurity to previously less affected areas in Lisbon, after major requalification interventions in problematic neighbourhoods such as Casal Ventoso and Curraleira;

- The need to ensure the necessary means for police investigation and further prosecution of drug related money-laundering offences (cf. new Law in chapter 1.2.);

- Social problems related to problematic drug use, namely the *arrumadores* (drug users who indicate parking spaces to drivers in exchange for money);

- The work developed by the CDTs during the first year of the Decriminalisation Law implementation.

1.5. Budget and funding arrangements

According to the National Action Plan, public investment in this field is expected to increase 10% per year until it reaches 159.615.327 € in 2004.

The figures presented in the next two tables show the distribution per Ministry and the distribution per areas in both 2000 and 2001. 2000 figures were updated since their reporting in our 2000 National Report and 2001 figures may still be updated until the end of the year. They do not include a special amount of 17.500 € used for setting up the CDTs and to support treatment facilities to receive drug users referred by the CDTs.

Most of the fluctuation between the 2000 and the 2001 budgets are due to small increases and decreases in PIDDAC, the Government Integrated Plan for the Development of the Central Administration, which is attributed each year to different infrastructures development programmes.

IPDT figures for 2000 still includes some residual budget from Projecto VIDA and figures for the Ministry of Justice and the Law Enforcement area does not include the Criminal Police Budget.

There is also a special 2.394.230 € budget (not included in the table) for research which was made available, through the Ministry of Science, for a 3 year period.

For specific framework programmes in the area of demand reduction, the IPDT budget includes 1.708.319,72€ for municipal (prevention) plans, 78.833,65€ for outreach work interventions and 4.987.978,82€ for funding of NGOs working in the field of prevention (cf. Demand Reduction section for more detailed information).

Table 1 – Public Administration budget on drugs and drug abuse (€)

2000-2001

Ministries	2000	2001
Presidency of the Council of Ministers		
IPDT	15.335.598	15.443.795
Youth State Secretary	7.132.810	7.681.488
Ministry of Health	36.366.057	37.180.180
Ministry of Education	3.396.814	3.484.293
Ministry of Justice	4.205.530	2.979.450
Ministry of Employment and Social Affairs	13.592.243	14.440.199
Ministry of Internal Affairs	24.007.143	23.768.319
Ministry of National Defence	1.666.758	972.307[1]
Total	**105.722.937**	**105.950.031**

Table 2 – Public Administration budget on drugs and drug abuse by intervention areas (€)

2000-2001

Area	2000	2001
Prevention	24.150.976	27.154.009
Treatment	31.333.187	32.192.202
Rehabilitation	15.229.195	15.661.162
Harm Reduction	4.589.728	4.073.782
Prisons	3.427.404	2.231.253
Law Enforcement	24.007.142	23.768.318
Research	2.097.445	732.036
International Co-operation	887.860	137.269
Total	**105.722.937**	**105.950.031**

[1] Prevention only

Part II

Epidemiological Situation

2. Prevalence, Patterns and Developments in Drug Use

2.1. Main developments and emerging trends

The recently held national surveys (general population, prison setting and school setting), as well as recent estimations on problematic drug use, allow us to conclude that illicit drug use has a small magnitude in the general population but is problematic in terms of the number of estimated problematic drug users and respective health and legal consequences.

For the only setting where previous data existed, the school setting, it is possible to conclude that substance and patterns are changing and that drug use has higher prevalence in rural and inland areas than in larger urban areas.

It is important to state that the above mentioned surveys were designed not only to assess the situation but also to be able to give a significant contribution in terms on the necessary inputs to the conceptualisation and implementation of demand reduction strategies.

2.2. Drug use in the population[2]

The IPDT funded the first national **general population survey** on the use of psychoactive substances [Balsa2002]. The questionnaire was used on a sample of 15 000 individuals, representative of the Portuguese population aged 15-64, at national and regional level (for more details on the methodology see Standard Table 1, [Balsa2002] and [CIDT2002]).

Table 3 - Drug use prevalence by type of drug (%)

2001

Prevalence / Drug	Lifetime	Last 12 Months	Last 30 Days
Any Drug	7,8	3,4	2,5
Cannabis	7,6	3,3	2,4
Heroin	0,7	0,2	0,1
Cocaine	0,9	0,3	0,1
Amphetamine	0,5	0,1	0,1
Ecstasy	0,7	0,4	0,2
LSD	0,4	0,1	0,0

Source: [CIDT2002]

Results indicate that 7.8% individuals aged 15-64 had at least one experience (lifetime prevalence) of illicit substance use. The most referred substance in this context was undoubtedly cannabis (7.6%). For other drugs, lifetime prevalence was inferior to 1% (cocaine 0.9%; heroin 0.7%; ecstasy 0.7%; amphetamines 0.5% and LSD 0.4%).

Last year and last month prevalence were, as expected, inferior to lifetime prevalence. Respectively 3.4% and 2.5% of the respondents reported any type of substance use during last year and during the last month. Again, cannabis use was predominant, but ecstasy, and not cocaine, followed as second most used substance in these periods.

[2] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

Variations were also verified at gender and age group level. Use prevalence was generally higher in the male gender of all age groups, all substances and all considered periods. Lifetime prevalence of the preferred substance shows, for the female gender, identical values for ecstasy and cocaine, whereas in the male gender group, the preferred drug is cocaine. On the other hand, while in the female gender group heroin use was one of the least reported drugs, in the male gender group it was one of the most reported and only surpassed by cannabis and cocaine. In fact, with the exception of LSD, lifetime prevalence for heroin and cocaine were those which presented highest differences between the female and male gender groups. On the contrary, amphetamines, cannabis and ecstasy lifetime prevalence presented more similar values between the female and the male gender groups.

Concerning more recent use prevalence (last month), the differences between the male and female gender groups were even higher, except for cocaine where the opposite happens. LSD and heroin use are not present in the last month prevalence of the female gender group and ecstasy and amphetamine use are also inexpressive. On the contrary, in the male gender group, use prevalence for heroin and cocaine in this period were identical and surpassed by ecstasy. For this period, cocaine use presented the lowest differences between use prevalence in the male and female gender group.

Use prevalence was clearly higher in the lowest age groups for the majority of substances and considered periods. Males aged 25-34 reported the highest figure for lifetime prevalence of cannabis but males aged 15-24 reported the highest last month prevalence for cannabis. The age groups 15-24 and 25-34 reported the highest prevalence for ecstasy and LSD. For heroin, the highest prevalence was found in the age groups 25-34 and 35-44. For cocaine and amphetamines the highest lifetime prevalence was reported for the 25-34 and 35-44 age groups, but last month prevalence showed more cocaine use in younger individuals (15-24 and 25-34 age groups) and more amphetamine use in the age groups 15-24 and 35-44.

In short, despite the use of cannabis being the highest one reported in all age and gender groups, some differences were found in these sub-groups use patterns. Special emphasis goes to the preference of younger individuals for ecstasy and cocaine use and a higher prevalence of heroin use in males aged 25-34 and 35-44.

Finally it should be referred that the comparison of these results with other available results from other European countries shows that illicit substance use in the Portuguese general population are the lowest in Europe, especially when lifetime prevalence of any drug is considered.

In the framework of the National Research Programme for School Surveys, the IPDT (with the co-operation of the Ministry of Education) conducted a **national school survey** in 2001, which included the 7th-9th graders and the secondary school students (10th-12th grades) [Feijão2002]. (See also Standard Table 2 and [CIDT2002]).

The stratified randomised sample is representative at national, regional and district level (district capital and other district areas), and at municipal level in municipalities with more than 4 000 students. A total of 25 000 students from 1 000 classes self completed an anonymous questionnaire during a regular class. Collected indicators approach several dimensions such as recreational culture and settings, the use of psychoactive substances (including alcohol and tobacco), individual characteristics, family, the school setting and the community, in an effort to contribute to the conceptualisation of prevention programmes.

Preliminary results from the survey (only data from 7th-9th graders are available at this time) indicate that:

- In comparison to ESPAD/99 results, drug use increased, especially for cocaine;
- Reported lifetime prevalence of any substance is 14%, last 12 months prevalence is 8% and last 30 days prevalence is 6%;
- Cannabis remains the most used illicit substance (lifetime prevalence 10%, last 12 months prevalence 8% and last 30 days prevalence is 5%);

- Cocaine and ecstasy present a lifetime prevalence of 4%, last 12 months prevalence of 3% for ecstasy and 2% for cocaine and last 30 days prevalence of 2% for both substances; Heroin presents a lifetime prevalence of 3%, last 12 months prevalence of 2% and last 30 days prevalence of 1%;

- It is clear that drug use is no longer taking place mainly in the major urban centres, but widespread especially in the inner districts like Castelo Branco, Vila Real and Santarem).

Results from the 2001 **prison survey** were presented in last year's report (key issue "Drug users in prison"). Updated values for this survey were sent in Standard Table 12.

2.3. Problem drug use[3]

The IPDT funded a series of national and local problematic drug use estimations which were conducted in 2001 [Negreiros2002] (see also [CIDT2002] and Standard Tables 7 and 8) according to the EMCDDA guidelines on this indicator.

Research was conducted in two different stages: the estimations themselves and research on the patterns of illicit drug use. The **estimations** were based on 2000 data and used the following methodologies:

- Three multipliers based on: law enforcement data, drug related treatment data and drug related deaths data;

- Back-calculation based on HIV/AIDS data;

- Capture-recapture for local estimations.

National results range from 2.3 and 8.6 problematic drug users per 1 000 inhabitants aged 15-64, while local estimations range from 8 to 24 problematic drug users per 1 000 inhabitants. Estimations of IDUs based on the back calculation method indicate figures from 29 620 and 43 966, which correspond to 4.3 to 6.4 IDUs per 1 000 inhabitants aged 15-64.

Disparities resulted from multiple factors such as: 1) the specificities of the different methodologies, namely the hypothesis, error margins and type of sub-populations concerned; 2) little information on national databases concerning problematic drug users; 3) the fact that to estimate hidden behaviour prevalence different methodologies have to be taken together. On the other hand, we may also conclude that methods aiming at establishing national estimates lead, generally, to lower values than those aiming at establishing local estimates. In fact, the heterogeneity found in local estimates may reflect, according to [Negreiros2002], the specificities of the municipalities were the research was conducted as well as the above referred database limitations. Even if we consider only the national estimates, it is important to differentiate from results aiming at prevalence rates of a specific problematic drug users sub-population (eg. IDUs in back calculation) and results aiming at prevalence rates in the drug users' population (eg. Multipliers). Nevertheless, the multiplier based on drug related deaths reported values which represented an underestimated number of problematic drug users and the target population was mainly comprised of IDUs which was one of the reasons for the low value reported.

Thus, if we disregard results from the drug related deaths multiplier and the back calculation, the estimate range varies between 41 720 and 58 980 problematic drug users, which corresponds to a national prevalence rate between 6.1 and 8.6 problematic drug users per 1 000 inhabitants aged 15-64.

As for the second stage, it was focused on the profile of the **patterns and nature of illicit drug use** in a sample of 176 problematic drug users selected in two districts (Porto and Aveiro) in four different settings:

[3] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

33% from an SPTT specialised outpatient treatment centre; 23% from a prison, 22% from inpatient therapeutic communities and 22% in social neighbourhoods. Data collection for this stage of the research was made through a guided interview conducted by psychologists working in the drug field. Data were subjected to quantitative analysis and content analysis techniques (inductive category analysis). Main results were the following:

1) Identification and socio-demographic data:

- 95% of the respondents were of the male gender and mean age was 31;
- 61.8% had completed primary school (31.8%) or left the 6th grade incomplete (30%). Only 28.7% had finished or gone further than 9th grade (compulsory schooling);
- 47% were unemployed at the time of the interview;

2) Use patterns:

- Respondents were almost exclusively opiate users and polydrug users (mainly heroin and cocaine but frequently associated more than two substances);
- The majority had their first experience with illicit drug use between 13 and 16 years of age, and mainly referred cannabis as their initiation substance;
- Smoking was the predominant administration route referred although injecting was still frequent (40%);

3) Behaviours and perceptions of health risks and treatment:

- 19% reported occasional sharing of syringes and 20% of other paraphernalia;
- 47% stated they had changed administration route but most of them changed from smoking to injecting;
- 20% referred having exchanged syringes in pharmacies in the last year and 36% stated they used condoms in sexual intercourse;
- 26% were HIV positive, but in the prison sub-sample 50% were HIV positive;
- 50% had a positive perception of the risk reduction measures which are being implemented;
- Among the respondents there were those who had never undergone treatment, those in outpatient treatment, those who were in methadone programmes and those who were in inpatient treatment;
- For 40% of the respondents, methadone programmes was the preferred choice for several reasons, one of which was the difficulty in accessing other treatment modalities;

4) Criminal justice system:

- Respondents reported several illicit activities with a criminal pattern which indicates that those activities are mainly of acquisitive nature in order to maintain use patterns, that is to say, a drug use related criminal activity.

According to [Negreiros2002] the results from this research reinforce the need to implement different risk and harm reduction strategies specifically targeted to problematic drug users and which should take into account their motivations, perceptions and strategies to adapt themselves to opiate substitution treatment programmes.

3. Health Consequences

3.1. Drug treatment demand[4]

SPTT data indicates that first treatment demands decreased 9% in 2001 (8 743 in 2001 and 9 559 in 2000) and follow-up episodes increased 14% (343 538 in 2001 and 300 485 in 2000) suggesting that more effective responses are being implemented at treatment level (more information in chapter 11.1.).

Outpatient first treatment demand data concerning 71% clients of the outpatient public network of the SPTT (CATs) indicate that heroin remains the main substance used[5] (78%), followed by cannabis (27%) and cocaine (27%). Alcohol and benzodiazepines use in the last 30 days were reported respectively by 11% and 10% of the clients. Ecstasy use was referred by 2% of the individuals and amphetamine use by 1%. These figures are similar to last year's figures except for cocaine which registered a lower value in 2001 (33% in 2000). Data concerning administration route for 70% of those clients also show a lower value of injecting drug use in the last 30 days, in comparison to 2001 and 1999 (32% in 2001, 36% in 2000 and 45% in 1999). In 2001, similarly to previous years, clients were mainly of the male gender (83%) and aged 25-34 (51%). 21% were younger than 25 (16% in the age group 20-24) and 28% older than 34 (17% in the age group 35-39). These figures confirm the ageing trend of this population already visible in previous years. Similarly to 2000, the regions of North, Lisbon and the Tagus Valley had an older population than the Central region. The Alentejo and Algarve regions, which last year also had younger populations, in 2001 presented a predominance of older clients, closer to the North and Lisbon and the Tagus Valley regions.

Regarding detoxification units of the public network of the SPTT, data concerning 1 852 inpatients in 2001 also report heroin as the main substance indicated as having motivated inpatient treatment demand (87%), followed by cocaine (20%) and methadone (11%). The use of psychoactive pills was referred by 253 inpatients as the main reason for seeking inpatient care. 1 743 clients indicated heroin as main drug and, of those, 44% used it intravenously. The most referred administration route was smoking/inhaling (54%). This population was mainly of the male gender (84%), but women had more programmed medical releases. Main age groups were 25-29 (28%) and 30-34 (27%). 61% were unemployed, 31% had a stable job and 7% temporary jobs. The main therapeutic project at admission was the use of an opiate antagonist (naltrexone reinforcement), followed by admission in a therapeutic community.

Data from 2 773 inpatients in certified private detoxification units point towards 88% of male clients, mainly aged 25-29 (31%). Around 94% of these clients left after programmed medical releases.

As far as therapeutic communities are concerned, data concerning 68 public and private units and 4 196 clients, indicate that the majority are of the male gender (84%), aged 25-29 (30%) and 30-34 (24%). Around half of them were admitted for the first time in a therapeutic community and 17% were admitted after medical release from a detoxification unit. 31% requested admission due to family pressure, 27% on their own initiative and 24% were referred by their CAT therapist. Of the clients admitted in 2001, 72% left, 44% having completed treatment. Around half of those who left after having completed treatment, and 14% of those who left without having completed treatment, were abstinent of the drug(s) for which they had seek treatment.

Information concerning 35 clients of the Day Centres of public network of the SPTT in the northern region also indicates heroin as the main drug (96%). These clients have been using heroin for more than 3 years

[4] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

[5] In the last 30 days prior to the first treatment episode.

and, for 35% of them, for more than 15 years. They were mainly of the male gender (92%), aged 35-39 (31%), single (62%) and with 6 years of compulsory school (35%). Data from private certified Day Centres indicate that 89% of their clients were of the male gender, aged 25-29 (31%) and 30-34 (30%), single (66%) and 6 years of compulsory school (49%). Around 35% left with programmed medical release and 36% with unprogrammed medical release.

As for the 717 clients in high threshold methadone substitution programmes who take their medication in pharmacies since the second semester of 1998, the available data indicates that they are mainly of the male gender (75%), aged 31-35 (29%) and 36-40 (26%). 59% have a regular job and 32% were unemployed. 6% are involved in the programme since its implementation and 62% for more than one year. In 31/12/2001, for around half of these clients there was follow-up information: 31% had been transferred to other treatment units, 6% had terminated the programme with a therapeutic scheme for doses reduction, 5% had been suspended, 3% had left the programme and 3% had been admitted in therapeutic communities.

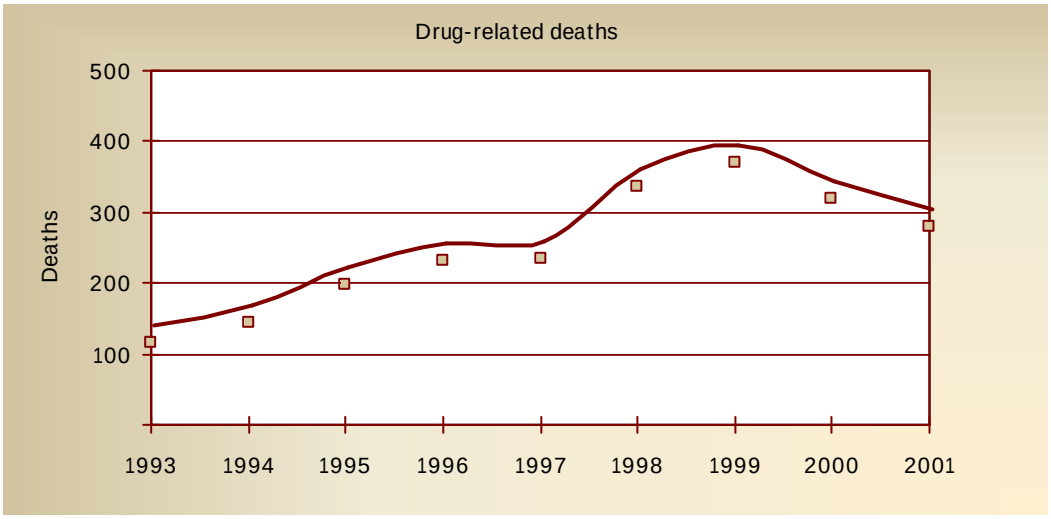
Data concerning other subpopulations in treatment (pregnant and recent mothers drug users) are also available [SPTT2002].

3.2. Drug-related mortality[6]

According to 2001 data from the Special Register (the National Institute of Forensic Medicine, Ministry of Justice), 280 drug related deaths (cases with positive toxicological tests) were reported, a 12% decrease which seems to confirm the trend already verified in previous years (14% decrease between 1999 and 2000). 47% of these episodes were registered in the forensic region of Lisbon (South), 39% in the forensic region of Porto (North) and 14% in the forensic region of Coimbra (Centre) The number of requested tests is similar to previous years but there has been a decrease of the positive tests: 22% in 2001, de 25% in 2000, 35% in 1999, and 37% in 1998. Similarly to last year, in 73% of the cases where there was a suspicion of acute drug related death (positive toxicological test and information on the presumed cause of death).

Graph 1 - Drug-related deaths

1993-2001



Source: [CIDT2002]

[6] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

In 2001, 90% of these episodes occurred in individuals of the male gender, a stable trend from previous years. Similarly to 2000, 84% of these individuals were aged 20-39, and mainly in the age group 25-39 (74%). In comparison to 2000 there was a higher relative weight of the age group 25-39 mainly because of a lower percentage of individuals aged less than 25. Some differences between the age groups of the male and female group are perceptible, namely concerning the aging of the male population in this indicator.

Although opiates[7] have been decreasing in comparison to other involved substances, they are still the main drug detected in these episodes (81%), isolated (24%) or associated to other substances (57%), mainly cocaine and/or alcohol (51%). With a similar value in comparison to 2000, cocaine was detected in 34% of the episodes, usually associated to other substances (31%), mainly opiates and/or alcohol (30%). Around 11% of these episodes involved cannabis products, mostly in association with other substances (9%). Amphetamines were detected in 9% of the cases, isolated (3%) or associated to other substances (6%). In 1% of the cases MDMA was detected, always associated to alcohol and sometimes with other substances. Methadone was detected in 5% of the cases, mostly associated to alcohol and/or opiates. In 41% cases, alcohol was involved in association with other drugs and, in 8% of the cases medication was associated to other drugs.

Although opiates are, in all age groups, the main substance involved, they are more significant in the 25-29 age group and in those over 45. Cocaine appears as the second most involved drug in this indicator for all age groups but, more expressively, in the 35-44 and 20-24 age groups. In individuals less than 20, the percentage of cases which involve cocaine is identical to the percentage of cases which involve cannabis, amphetamines and MDMA. Cannabis was the third most involved substance in all age groups with the exception of the age group 25-29, where the percentage was slightly inferior to the percentage of cases which involved amphetamines. The percentage of cases involving cannabis was identical to the percentage of cases involving amphetamines in the age groups under 25 and 35-39. Cannabis was less expressive in those under 25 and over 44. The younger age groups (under 25) reported higher percentages of cases involving amphetamines and MDMA, and the older age groups higher percentages of cases involving methadone. In all age groups, the percentage of cases involving more than one substance was higher than the percentages of cases involving one substance only, especially for those under 30 and in the age group 40-44. However, if we consider only the cases where more than one substance was involved, also excluding the association with alcohol and/or medication, the higher percentages of illicit polydrug use cases appear in the age group 20-29 and, mainly, 20-24. Nevertheless, in absolute figures, the age group 25-39 was the most affected age group by drug related deaths and the one where more cases involving any type of drug occurred with the exception of MDMA, where individuals under 25 predominated.

Concerning differences in the patterns of substances involved in the male and female group, opiates and amphetamines had a higher weight in the male individuals and methadone and MDMA in the female individuals, who also presented a higher pattern of association of illicit drugs with medication and/or alcohol.

Until the end of March 2002 [CIDT2002], there was a total of 4 965 notified AIDS related deaths, 50% of which were cases associated to drug use. Respectively 54% of the AIDS cases associated to drug use and 56% of the AIDS cases not associated to drug use had died, mortality being higher in both groups for the male gender. Districts were there are more notifications of drug related AIDS cases (Lisboa, Porto, Setubal and Faro) are also those which registered a higher number of drug related AIDS deaths.

For drug users mortality please see Standard Table 18. Analysis and more in-depth information will be available next year.

[7] Includes heroin, morphine and codeine.

3.3. Drug-related infectious diseases[8]

According to notification data for HIV/AIDS, on the 31/03/2002, 19 779 cases of HIV infection were notified (9 006 AIDS cases, 1 829 with AIDS related complex and 8 944 asymptomatic carriers). 1 566 of those notifications concerned diagnosed cases in 2001 (738 AIDS cases, 127 with AIDS related complex and 701 asymptomatic carriers). Notifications of drug use related cases diagnosed in 2001 represented respectively 55%, 38% and 41% of the AIDS, AIDS related complex and asymptomatic carriers notified cases.

These figures confirm the trend of the decrease of the percentage of drug users in the total number of notifications of AIDS cases (respectively 63%, 59%, 57% and 55% of the diagnosed cases in 1998, 1999, 2000 and 2001). Concerning the accumulated AIDS cases until 31/03/2002, drug users represent around 51% of the total of these notifications.

Notified drug users with AIDS are mainly of the male gender (85%) aged 20-39 (92%), mainly in the age group 25-34 (60%). Notified drug users with AIDS diagnosed in 2001 were also mainly of the male gender (91%), a percentage which increased in comparison to cases diagnosed in previous years. Although with lesser significance, the male gender is also predominant in the other AIDS cases which are not drug use related (82%), but those individuals are older (only 48% are aged 20-39 with a predominance of ages between 25-54 (79%). Drug users with AIDS related complex and asymptomatic carriers are also mainly of the male gender and aged 20-39.

The districts of Lisbon, Porto and Setubal remain the districts with higher percentages of the total AIDS cases notified (respectively 44%, 22% and 14%), as well as of the drug related AIDS cases (43%, 31% and 13% respectively). The relativisation of these notifications to the resident population in each district also show these districts as the ones with higher rates of drug users with AIDS per inhabitant.

2001 outpatient first demand treatment data from the SPTT concerning HIV tests indicate 13.6% of HIV positive individuals amongst those individuals who presented results of their tests. This percentage is close to last year's percentage (14.6%) and lower than the one registered in 1999 (18%). 44% of these HIV positive individuals were following antiretroviral therapy, a figure that doubled in comparison to 2000 (22% HIV positive individuals in antiretroviral therapy).

17% clients from inpatient public and private detoxification units tested positive for HIV, a percentage slightly higher than in 2000 (14%). 28% of these individuals were in antiretroviral therapy. Concerning public and private therapeutic communities, 18% of the tested clients were HIV positive (18% in 1999 and 17% in 2000) and 76% of those were in antiretroviral therapy (55% in 1999 and 69% in 2000).

The levelling off of the global rates of positive HIV tests could be related, amongst other factors, to the implementation of harm reduction measures which may be leading to a decrease in intravenous drug use (cf. also chapter 3.1.) or to intravenous drug use in better sanitary conditions, as indicated by the number of exchanged syringes in the National Syringe Exchange Programme "Say no to a second hand syringe" (cf. Standard Table 10).

[8] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

Table 4 - Clients tested for HIV by treatment service

2001

Testing Services	HIV		
	Tested clients	HIV+ clients	Clients in antiretroviral treatment
Outpatient/Public Network			
First treatment episodes	**2 683**	**365**	**159**
Detoxification Units	**2 694**	**452**	**125**
Public	1 802	302	81
Certified	892	150	44
Therapeutic Communities	**3 863**	**688**	**520**
Public	59	6	5
Certified	3 804	682	515

Source: [CIDT2002]

SPTT 2001 data on hepatitis B and C show that 5% of the tested clients in their first outpatient treatment episode were positive for Hepatitis B (AgHBS+) and 45% for Hepatitis C (HCV+). These percentages are lower than in 2000 (respectively 10% and 49%). In detoxification units, global percentages for public and private units are 7% for Hepatitis B and 58% for Hepatitis C. In public and private therapeutic communities 9% were positive for Hepatitis B and 51% for Hepatitis C. These percentages are generally lower than in 2000, both in detoxification units (25% for Hepatitis B and 69% for Hepatite C), and therapeutic communities (14% and 49%, respectively for Hepatitis B and C).

Concerning tuberculosis, 2% of the new outpatient clients of the SPTT who presented results for their tests were positive and all were following treatment. In detoxification units the global percentage of positive cases was 13%, and, in therapeutic communities 1%. The range of positive results in these different sub-populations may be explained, amongst other factors, by the admission criteria in detoxification units which prioritise individuals in very precarious health situations.

3.4. Other drug-related morbidity

No new information available.

4. Social and Legal Correlates and Consequences

4.1. Social problems

Main drug related social problems reported continue to be low educational status, unstable labour situation and legal consequences as reported in chapters 2.3., 3.1. and 4.2. In fact, specifically on unemployment, the highest national rate for the general population in 2001 was 4.2%, a much lower figure than the lowest figure reported for unemployed individuals with drug problems (25% for convicted individuals, see next chapter).

A survey made among drug users in a very problematic drug setting in Lisbon (Casal Ventoso) in 2001 [Lages2001], which involved 167 problematic drug users, shows that 57.4% did not complete 9th grade and 24% were unemployed. 70% lived in shelters and 9% were homeless. 18.4% have not seen their family in 2 years and 12.4% in 3 years, 30% reported having been victims of aggression by the population of the neighbourhood.

The main problems felt by respondents were: lack of income (43.1%), housing (31.3%) recovery, health and family (20-15%). In general respondents feel their situation has improved with the specific harm reduction policy implemented in this area but still feel isolated, rejected and socially excluded.

4.2. Drug offences and drug-related crime[9]

2001 data concerning presumed offenders concerns two different legal frameworks: from January to June 2001, prior to the implementation of the drug use decriminalisation Law[10], data was collected by the Criminal Police from all law enforcement agencies and sent to the IPDT for analysis; and from July to December 2001, after the implementation of the drug use decriminalisation Law, data on users was collected by and analysed at the IPDT, data on traffickers and users-traffickers was collected by the Criminal Police.

In 2001, data from the Criminal Police identified 8 736 presumed offenders: 2 041 presumed traffickers, 3 117 trafficker-users and 3 302 presumed users (first semester only for users). As expected, the number of presumed offenders identified by this source decreased in comparison to 2000 mainly because of the decrease (-57%) in the identification of users. Nevertheless, there was also a decrease (around 18%), both in the category of traffickers and in the category of traffickers-users in comparison to 2000.

There was an increase in the percentage of identified traffickers within the total group of presumed offenders, which did not happen since 1996. Together with seizure data that might indicate a higher effectiveness of law enforcement agencies interventions in this field, probably related to new legal diplomas in the area of criminal investigation (mainly on undercover agents) and in the area of drug use decriminalisation. Nevertheless, and despite the fact that this source only covered the first semester concerning drug use, offenders for drug use are still the largest group amongst presumed drug Law offenders in general (39%), followed by trafficker-users (37%) and traffickers (24%). As in previous years, the districts of Faro, Lisbon, Porto and Setubal had the higher rates per inhabitant.

The majority of these individuals possessed only one drug (cannabis, in the majority of cases, followed by heroin, but ecstasy continues to gain weight amongst the other substances), mainly in the category of users and similarly to previous years. Where polydrugs are present, there is variety of combinations which suggests diversification of demand and supply in the national market. Traffickers remain the category which possessed more polydrugs, mainly heroin and cocaine and trafficker-users is the category where more diversification of combinations was found. Most presumed offenders are of the male gender, mainly aged

[9] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt.
[10] Law 30/2000, of the 29th of November, Decree-Law 130-A/2001, of the 23rd of April and Regulation 604/2001, of the 12th of June.

20-39 and were of Portuguese nationality. Presumed trafficker-users offenders presented a profile closer to the users' category than to traffickers.

From July to December 2001, with the implementation of the drug use decriminalisation Law and the setting up of the Commissions for the Dissuasion of Drug Use (CDTs), drug users identified by law enforcement agents ceased to be prosecuted and were instead referred to these Commissions for assessment of the situation and decision on the measures to take. During that period, 2 366 processes were instated with particular relevance in the districts of Lisbon, Porto, Faro, Braga, Setubal and Aveiro. However, the districts where higher rates of processes per inhabitant were reported were Beja, Faro and Bragança. These rates were, in general, similar or higher to the rates verified in the first semester, which indicates a positive intervention of all actors in this process (mainly the CDTs and the local law enforcement authorities).

On the 31st of March 2002, and concerning the above referred processes instated, 60% had been suspended, 25% were pending and 15% had been filed. 1 783 rulings had been made: 93% were rulings to suspend the process temporarily, 4% had found the presumed offender innocent and 3% were punitive rulings. Most rulings to suspend the process temporarily (61%) were related no occasional or experimenting drug users.

Table 5 – CDTs rulings by type of ruling

01-07-2001 to 31-12-2001

Type of Ruling	Total	Type of Ruling (Law 30/2000, 29th of November)				
		Suspensive				
		Temporary Suspension for non-addicts	Temporary Suspension with treatment for drug addicts	Suspention of the determination for sanction execution	Punitive	Absolution
Number of Rulings	1 783	1 080	565	5	53	80

Source: [CIDT2002]

Most of these processes included only one drug (91%), mainly cannabis (47%) and heroin (33%). In the polydrug category most processes included heroin and cocaine. Different patterns were identified in different geographical regions: centre coast districts (Leiria, Coimbra e Santarem) and northern districts (Vila Real, Bragança, Braga and Guarda) reported mainly heroin only related processes, a situation which also happened in Beja (Alentejo). In all other districts cannabis predominated. Individuals involved in these processes were mainly of the male gender and aged 16-34, thus younger than those previously prosecuted and convicted for drug use. This may reflect a positive concern on the part of law enforcement authorities to contribute to early prevention of drug use and to minimise the health and legal consequences of problematic drug use. The individuals were mainly Portuguese, single and with a low educational status (only ¼ had gone further than the 9 years of compulsory school). There was a high percentage of unemployed individuals and most of those who worked had low qualifications and worked in the extraction industries or construction. 4% of these individuals relapsed during the same semester. The ones who did so were older, more often married or with a partner, had lower educational level and were more often unemployed than the individuals who did not relapse.

Data concerning individuals taken to Court for infractions to the Drug Law are collected at Courts and analysed by the IPDT. Similarly to previous years, the following concerns court decisions in 2001 sent to the IPDT until the 31st of March 2002.

The number of processes in 2001 was higher than in previous years, though the number of involved individuals is still decreasing since 1999. Similarly to previous years, the majority of these individuals faced traffic charges. The number of convicted individuals decreased in comparison to 2000, mainly due to fewer

cases of traffic and traffic-use. This may indicate a higher quantity of users in this setting, probably due to the implementation of the decriminalisation Law in the second semester of 2001 which was to cause the mandatory filing of a significant quantity of drug use related processes for lack of legal framework.

In 2001, 58% individuals were convicted for traffic, 37% for use and 5% for traffic-use. Southern districts registered the highest rates of convictions per inhabitant (Setubal, Lisbon, Faro and Beja). Similarly to previous years, the convictions were: effective imprisonment, fine and suspended imprisonment. As in 2000, the majority of convictions was related to possession of only one drug - mainly heroin, but the trend since 1998 indicates less weight of this substance in favour of cannabis and polydrugs). The majority of the convicted individuals were of the male gender, aged 20-34, thus indicating an ageing trend in the previous two years which may be related to the relative higher number of traffickers convicted. They are mainly Portuguese, mostly single with no children, with low educational status, although a small evolution in the educational status has been verified over the years. Around ¼ were unemployed at the time of their conviction and those who worked did so mainly in extraction metallurgic and mechanics industries and construction, but also in protection and security agencies. Traffickers registered more cases of polydrugs, were older, more often of the female gender and more often of other nationalities than the other categories. They were also less often single, more had children under their care, lower educational status and worked more often in security and protection services. They were more often convicted to effective imprisonment and also registered more cases of additional criminal charges.

According to data from the General Directorate of Prisons, on the 31st of December 2001, there were 3 930 individuals in prison convicted in the framework of the Drug Law (around 42% of all prison population). Although the absolute number of these individuals increased in comparison to 2000, there was a slight decrease in its percentage in relation to the total universe of convicted imprisoned individuals (43% in 2000).

Table 6 - Individuals in prison by year

1993-2001 (on the 31st of December each year)

Year / Individuals in prison	1993	1994[a)]	1995	1996	1997	1998	1999[a)]	2000	2001
Total number of individuals in prison	7 150	6 403	7 400	8 897	10 333	10 348	8 756	8 917	9 422
Individuals in prison for Drug Law offenses	1 526	1 688	1 940	2 566	3 653	3 902	3 863	3 829	3 930

Source: [CIDT2002] a) years with amnesties in this area

Crimes of trafficking remain the main cause of convictions although, in the past years, crimes related to criminal association and precursors have been gaining relative importance. Inmates convicted for Drug Law offences are mainly of the male gender, aged 25-49 (with particular emphasis for the 30-39 age group) and of Portuguese nationality.

4.3. Social and economic costs of drug consumption

No information available. Public expenses in this area for 1999 are reported in chapter 14.

5. Drug Markets[11]

5.1. Availability and supply

Based on previously presented indicators there seems to be an increase diversity in terms of supply and demand of illicit drugs which is reflected in occurrences with polydrugs with diverse combinations.

Main origin countries of the seized drugs are: Turkey for heroin, Ecuador for cocaine, Morocco for hashish, Angola for liamba and The Netherlands for ecstasy. Most of the seized drugs were destined to the national market with the exception of cocaine.

5.2. Seizures

In 2001, as in previous years, heroin was the substance involved in more seizures, followed by hashish. The district of Lisbon registered the highest quantity of seized drugs, with the exception of hashish which was mainly seized in the district of Faro. Fluctuations in relation to 2000 in seized quantities and prices seem to suggest more availability of cocaine and ecstasy in the internal market. The increase in the number of seizures and of quantities seized seems to suggest (together with other legal consequence indicators as already pointed out) more effectiveness on supply reduction interventions probably due to new legal framework for criminal investigations. For more information, please see Standard Table 13.

5.3. Price, purity

Average prices of seized drugs at street level did not suffer relevant variations in comparison to 2000, except for the decrease in the price of cocaine. Although still the most expensive drug in the market, the price of cocaine has been lowering to heroin street prices. Taken the price as a function of market supply and demand, and although the quantity of seized drugs is only a raw indicator of market availability, this seems to suggest (in association with previously reported prevalence, health and legal consequences of drug use) more availability of cocaine and ecstasy in the internal market (cf. Standard Table 16).

Concerning purity, an increase was verified in cannabis and cocaine and a decrease in heroin values (cf. Standard Table 14). A main concern for public health is the increase in amphetamine and methamphetamine contents in tablets sold as illicit drugs mainly as recent criminal police findings suggest that some of them are mixed with MDMA and other substances and sold as “ecstasy” (cf. Standard Table 14).

[11] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

6. Trends per Drug[12]

Cannabis

Cannabis remains the main drug used amongst drug users in general and it is starting to emerge in the drug related legal consequences settings almost always associated to the use of other drugs. It still circulates with visibility in the internal market with no significant changes in terms of sources of supply and prices.

Amphetamines, ecstasy and LSD

Ecstasy is gaining visibility in the reported indicators. It has been referred associated to experimental drug use, sometimes even more than heroin and cocaine. It has also gained weight in the settings of health and legal consequences, although still in a secondary role. Its circulation in the national market is becoming more visible but with no changes in terms of sources and price.

Amphetamines have also been referred in prevalence surveys but still with a low visibility in terms of other indicators, except in drug related deaths where it appears alone and in combination with other drugs. Less visible still is LSD which present similar prevalence to amphetamines in some surveys but has no expression in other indicators.

Heroin / opiates

Although still indisputably the main drug involved in problematic drug use, heroin tends to lose relative importance in comparison to other drugs in several indicators. It is still important in terms of internal market circulation with no changes in terms of source or price. Regarding other opiates, a large increase in the number of methadone substitution programme clients was verified but methadone related deaths also presented the highest value in recent years (5% of drug related deaths, mainly associated to alcohol and/or other opiates).

Cocaine / crack

Cocaine use, traditionally less expressive and visible in the reported settings, is beginning, in comparison to heroin, to be more referred in terms of drug use. It still has, though, a secondary role in terms of drug related health and legal consequences, mainly when not associated with other substances.

Other drug use / Multiple use

Hallucinogenic mushrooms have been seized for the first time in 2001, although in small quantities and have reported similar prevalence to LDS in the school population. As far as multiple drug use is concerned, and in parallel with traditional associations such as heroin and cocaine na increase in the importance of the association of other types of drugs, namely cannabis with ecstasy amongst others. Alcohol and medication still bear a significant weight in drug related deaths: in 2001, 41% and 8% of drug related deaths included the association of illicit substances and, respectively alcohol (25% in 2000) and medication (10% in 2000). According to 2nd semester data on drug users referred to the CDTs, the districts were more polydrug processes were instated were Porto, Coimbra, Leiria and Lisbon.

[12] Complete text, tables and graphs on this indicator are available in print [CIDT2002] and at http://www.ipdt.pt

7. Discussion

7.1. Consistency between indicators

The majority of the indicators point towards consistent results at the level of the characterisation of the Portuguese situation in 2001 as well as at the level of the **main trends** and are coherent with the previous year data.

The emergency of a more diversified drug use, expressed, amongst other indicators, in a higher visibility of cannabis, cocaine and ecstasy use, as well as, with less visibility, amphetamine and hallucinogenic use and new associations of drugs with a significant variety of substances involved, is visible namely in:

- Epidemiological survey data (general population, school setting and prison setting);
- Market indicators (seizures, quantities and prices);
- Legal consequences indicators, namely the substances possessed by presumed offenders for drug use;
- Health consequences indicators, namely the substances detected in drug related deaths.

The fact that heroin is still the main drug involved in problematic drug use is visible in:

- Prevalence estimate data and use patterns of problematic use in Portugal;
- Health consequences indicators, namely treatment demand and drug related deaths.

The increase and geographical dissemination of drug use in Portugal is visible in:

- Epidemiological school survey data which indicate an increase in drug use for students in grades 7 to 9, as well as a geographic dispersion of drug use;
- Legal consequences indicators, which indicate a higher circulation of users in these circuits.

Intravenous drug use is still frequent, at least in some sub-populations of users, as pointed out by some indicators, namely:

- Prevalence estimate data and use patterns of problematic use in Portugal;
- Data on the use of drugs in prison
- Treatment demand indicators.

Nevertheless, some indicators suggest possible changes in risk behaviours associated to drug use, namely:

- The decrease of the percentage of drug users with AIDS in the total of AIDS diagnosed cases in the past years;
- The levelling off, and in some cases decrease, of the percentage of positive cases in several infectious diseases among drug users in treatment;
- The decrease of drug related deaths.

7.2. Methodological limitations and data quality

Although significant progress has been made on the harmonisation of indicators in general and on the EMCDDA's key indicators in particular, some methodological limitations remain concerning treatment demand, drug related deaths and infectious diseases. As a result from the delay in the implementation of the National Treatment Information System at national level, treatment and infectious diseases data still has limitations at the level of data breakdown per type of substance, administration route and age group. General analysis on the situation and trend is possible and given in the respective chapter but the filling in of the TDI and other Standard Tables is still very limited to national aggregated data. Other sources of information, specifically for infectious diseases are under consideration and/or development but were not possible to use for the reporting period. On drug related deaths, a national agreement on the concept of drug related deaths and rearrangement of data collection procedures and information flows was finalised in 2001. Implementation was due to occur in 2002 but the new political framework and budget restriction rules have been impairing the process. Cases reported are thus still including all drug related deaths (acute and indirect).

With the implementation, on the 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 IPDT and kept apart from the Criminal Police's central register. The necessary procedures to ensure harmonisation of collected data within this new circuit were ensured to allow data comparability. In general, a strong consistency was verified concerning drug users' data between both registers. Differences, however, were verified at the level of users' age groups, which are probably related to the spirit of the new Law (to reach younger individuals in a prevention perspective), and some geographical differences in the distribution of drug use processes, related to different definitions of the concept "place" (in the Criminal Police's register "place" is the place were the infraction occurred and in the IPDT's register "place" is the place of residence of the individual). These different definitions respond to specific needs of the criminal circuit, in the first case, and of the CDTs' circuit, in the second case. Since these differences have been identified and their impact assessed for the analysis of 2001 data (the period of time where possible methodological limitations would have a higher impact due to the changes in the middle of the year), the other eventual methodological limitations that persists concern the concept of trafficker-user, which, from now on will be recorded in the Criminal Police register as trafficker and in the IPDT register as user, thus giving the perception of individual double counting and the collection of information on street level drugs price, which may be more difficult to assess.

Despite the above referred limitation, data quality and consistency has been improving over the years due to a major effort of the National Information System on Drugs and Drug Addiction and all its national partners in developing standardised protocols for data collection.

Part III

Demand Reduction Interventions

8. Strategies in Demand Reduction at National Level

8.1. Major strategies and activities

As described in Part I, the new Government's Programme, issued in April 2002, stated the adherence to the previous National Strategy and Action Plan and, within those, considered as priorities the following:

In terms of **prevention**, priority is given to promoting healthy life styles in order to prevent deviant behaviours especially in the school setting. Special attention will be given to the work of educators, trainees and prevention experts and the resources to prevent initiation of illicit and licit drugs, as well as adequate counselling to those who already use, will be reinforced.

Concerning **treatment**, the State should complement, co-ordinate and regulate private/social sector initiatives. A global value for the monthly funding for each treatment methodology will be determined, support to drug users in prison will be maintained and reinforced and more outreach and low threshold programmes will be created to ensure proximity to problematic populations. The current national social **rehabilitation** programmes and undergoing evaluation and will be redefined according to its results.

Special support will be given to initiatives, which aim at the prevention of AIDS, and other drug related infectious diseases.

As far as activities are concerned, following the National Framework for Prevention I, tenders opened for the National Framework for Prevention II (global financing 4.987.978,82€), the network of municipal plans (see Community Programmes in chapter 9.4.) was enlarged and tenders were launched for outreach work at National Level (global financing of 78.833,65€, see Reduction of Drug Related Harm in chapter 10). General objectives continue to be the development of the National Prevention and harm reduction networks, monitored and financed by the Central Government in co-operation with local authorities.

Prevention in the school setting remains one of the main priorities of drug demand reduction. The Ministry of Education through the CCPES, set as priorities for 2001 the further development of school curricula concerning this area, the training of school setting actors, the cooperation in research projects (cf. chapter 2.2. on school surveys), the production of educational materials and the cooperation with other actors in the field to improve the response capacity at local level.

In the area of treatment, major activities included the setting up of new units and decentralisation of some units external to the SPTT, with the objective of enlarging the responses and treatment modalities, assuming a proximity strategy towards the users and ensuring free and quality treatment within the National Health Care System. Special attention was also given by the SPTT to harm reduction initiatives with the identification and referral of clients in need of harm reduction programmes, criteria, objectives and priority definition, coordination with other national and local partners, counselling and support units for drug users with no family setting, information and counselling units, mobile units for the prevention of infectious diseases, low threshold programmes, syringe exchange and outreach work.

8.2. Approaches and New Developments

One year after the setting up of the **Commissions for the Dissuasion of Drug Use** (see last year's report for details concerning criteria, delivery of services and staff involved) it is already possible to have a first overview of this innovative systematic approach towards decriminalised drug use and drug users (please see chapter 4.2. for characterisation of processes and individuals). These Commissions cover an important target groups in terms of age and use patterns which, in general, are not covered by other services or institutions

and may be instrumental in preventing early abuse and diminishing the time lapse between problematic drug use and the contact with treatment institutions. The collected data allow the profiling of drug users in different stages and may be an important input for the conceptualisation of demand reduction services and interventions as well as a source of information concerning the use of new substances or the development of new trends.

Another two important new developments include the national tender for **outreach work** under the framework of the harm reduction diploma (see Part I) which approved 23 new projects in almost every district in Portugal, the setting up of **HIV/AIDS anonymous testing and counselling centres** in most district capitals (cf. Standard Table 10) and the implementation of **pill testing** programmes in recreational settings in Lisbon (cf. Standard Table 21). These initiatives mirror the current socio cultural developments and public concern expressed concerning drug related infectious diseases and the perceived growing use of synthetic drugs in recreational settings.

New research findings indicate that the national syringe exchange programme "Say no to a second hand syringe" is both efficient in preventing drug related HIV infection and cost effective. It was estimated that the programme prevented around 6 300 new HIV cases since its implementation and thus may have saved up to 400 million € in public health related expenses (cf. Standard Table 10).

Concerning the prison setting, results from last year's survey (cf. Standard Tables 12 and 20) are influencing the production of informative leaflets which are being prepared by the Ministry of Justice to be distributed in prisons nationwide and other preventive and harm reduction measures.

The general population survey and national school survey were designed to contribute to the conceptualisation of prevention initiatives and the SPTT promoted two case studies on pregnant women and recent mothers in outpatient treatment.

9. Prevention

In the context of Horizonte 2004's objectives (listed in last year's report), according to the priorities of the Government's Programme and in the follow up of the framework for prevention I (1997-1998), between November 2001 and January 2002, a national tender process was launched for the framework for prevention II to ensure financial and technical support to public and private non-profit organisations. Other objectives are to ensure and increase the quality of interventions at this level. The major target groups are children, teenagers, young adults, families, teachers and other social and community intervention professionals.

PQP II projects will run for 2 years along the following priority areas:

1. **Prevention for families** (especially targeting more vulnerable or at risk families) - through parenting skills' improvement, training professionals in this area, developing working instruments, and give access to useful and up to date information. (1.767.241,06 € available)

2. **Prevention for young school drop outs** - through social integration, vocational orientation, alternative school curricula and early professional training (441.436,17 € available)

3. **School prevention** (see correspondent item and Standard Table 19) - complementing the projects implemented by the Ministry of Education and in-line with its approach, the models include the promotion of healthy life styles, improvement of social skills to minimize the contact with harmful substances. Approaches include, training, awareness, information dissemination, the promotion of issues concerning substance abuse in school curricula and the development of educative material. (810.546,17 € available)

4. **Early response prevention for specific target groups** - to promote healthy life styles through the improvement of individual and social skills. Approaches include, training, awareness and information dissemination. These specific groups include children of drug and alcohol users, drug user pregnant women, excluded young people, amongst other vulnerable groups. (441.436,17 € available)

5. **Prevention in recreational, leisure and sportive settings** - to promote healthy life styles through strategic interventions in recreational, leisure and sportive settings, mainly through the organisation of recreational activities, information and awareness campaigns, training for prevention agents and the development of preventive and target group specific materials. (589.080,36 € available)

6. **Prevention in the prison setting** - complementing the projects implemented by the Ministry of Justice and in-line with its approach, the models include the promotion of healthy life styles, and the improvement of social, parenting and individual skills to support individual, social and professional inclusion. Intervention areas include: information, awareness and training sessions, recreational, cultural and leisure initiatives, the development of specific preventive materials and the setting up of services for counselling and referral. (589.080,36 € available)

7. **Prevention for young people in the criminal justice system** - (349.158,53 € available)

An external jury selected the projects according to the following criteria:

- The project's definition;
- The project's adequacy and internal consistency;
- The project's quality and pertinence;

- The experience and credibility of the promoting organisation;
- The co-operation with other interventions in the field, namely with the Municipal Plans;
- The intervention's adequacy regarding target groups;
- The intervention's adequacy regarding local problems/needs;
- The intervention's feasibility in each specific context;
- The possibility of project replication in other contexts;
- The project's capacity to generate autonomy and sustainability conditions which will allow its continuation beyond the financial support given in this framework;
- The existence of adequate partnerships;
- The results of evaluation concerning previous projects;
- The professional curricula of project managers and other involved professionals;
- Innovative aspects of the project.

Table 4 indicates the total number of applications for each priority area and the number of selected projects.

Table 7 – National Framework for Prevention II

2001-2002

	I	II	III	IV	V	VI	VII	Total
Number of candidate projects	58	16	96	51	63	17	10	**311**
Number of approved projects	44	8	21	16	16	8	7	**120**

Source: IPDT/Department of Community Intervention

Main institutional partners with specific responsibilities in the area of prevention are the CCPES (Ministry of Education) and the SPTT (Ministry of Health) as reported in the following chapters.

9.1. School programmes

Prevention in the school setting, including the inclusion of prevention issues in the formal curricula, is a responsibility of the Ministry of Education. Nevertheless, under PQPII and Municipal/Community Plans, the IPDT also funds NGOs with an intervention in this area. Both context and detailed information is provided in Standard Table 19.

For preliminary results of the National School Survey, please see chapter 2.2.

9.2. Youth programmes outside school

PQP II projects were funded under priority area 2. Data from those programmes is not yet available.

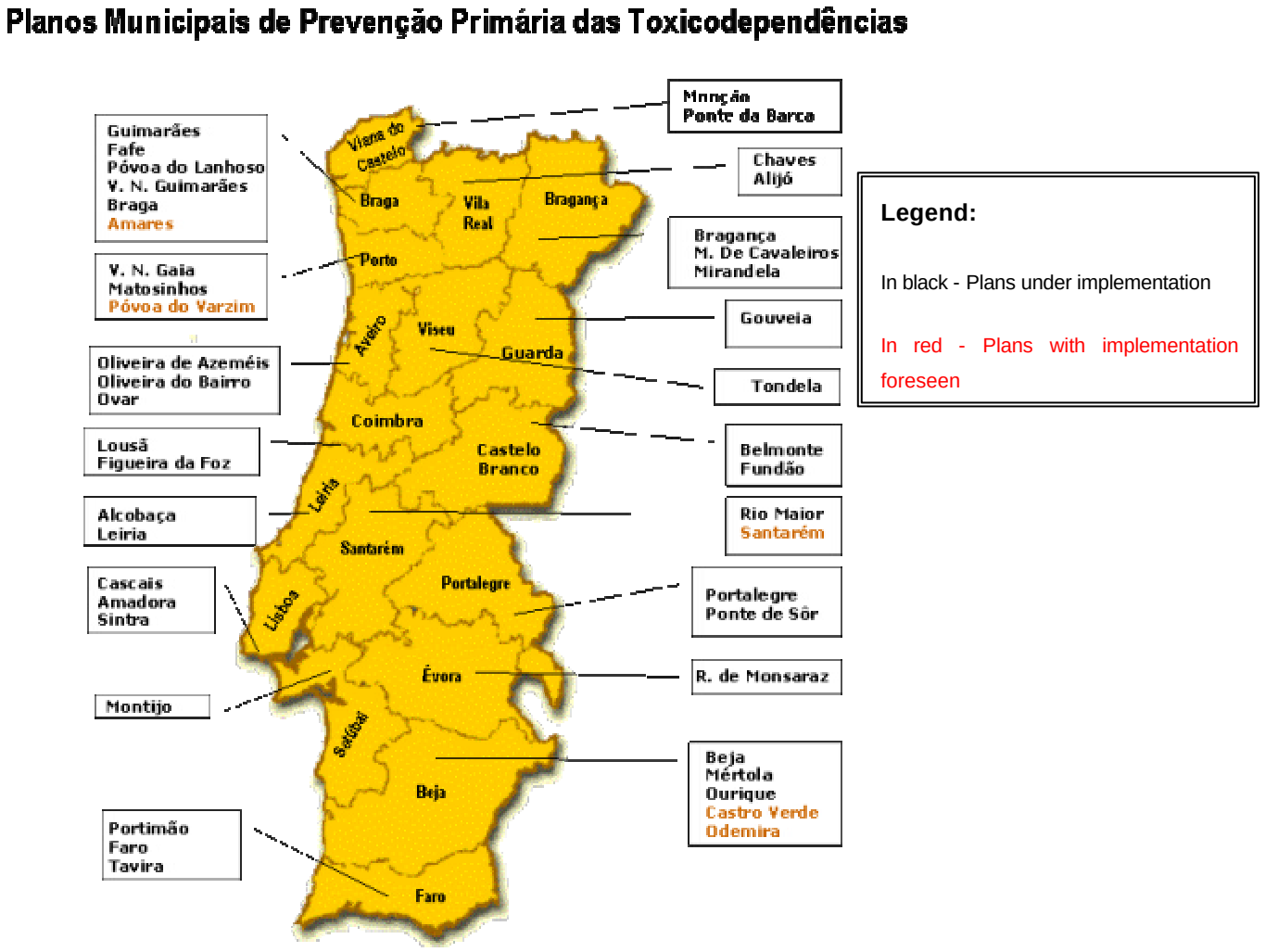
9.3. Family and childhood

Context and detailed information available on this topic regarding first childhood programmes funded by the IPDT are reported in Standard Table 19. PQP II projects in this area were funded under priority area 1. Data from those programmes is not yet available.

9.4. Other programmes

Since June 2001, 39 **municipal plans** were set up in the 18 national districts in the framework of the national prevention network (see last year's report for description and objectives of these programmes which aim at implementing responses closer to communities and local populations and complementing the government initiatives with the Civil Society). These plans comprise 68 projects which involve 65 organisations representing a total investment of 1.708.319,72 €. The network currently covers all country and involves several governmental and non-governmental organisations in all districts. Projects are expected to be finalised until 2004.

Map 1 – Municipal Plans



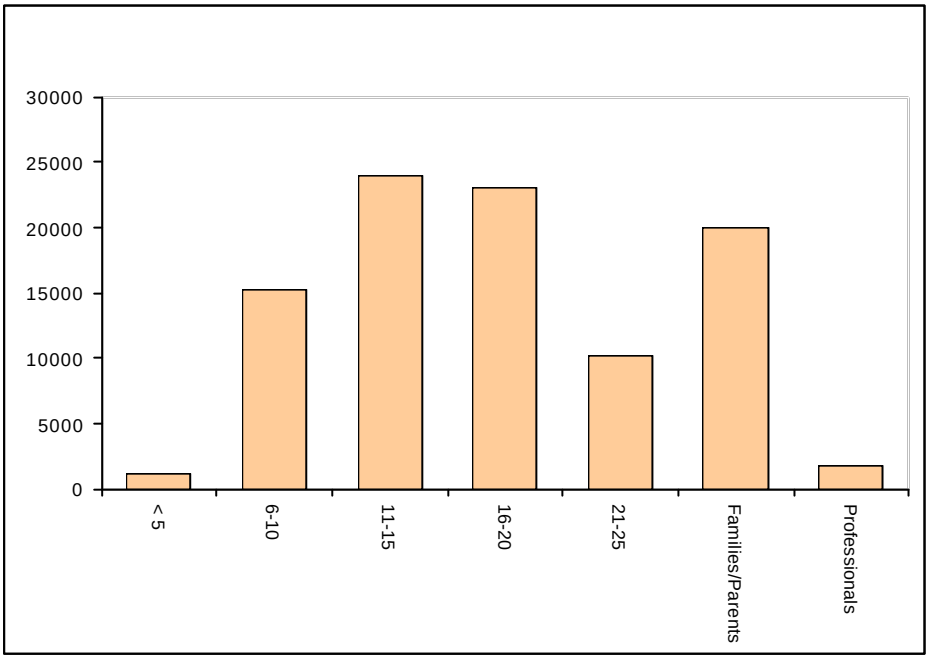
Source: IPDT/Department of Community Intervention

Preliminary data from 2001, indicate that school intervention (developed in 17 districts) and intervention in the recreational and sportive settings (also developed in 17 districts) are the priority areas of these community programmes. These are immediately followed by family interventions (in 16 districts). On the other hand, intervention for young people outside school (only developed in 5 districts) is the least represented area in these projects.

Graph 1 shows the target population of these interventions distributed by age group/category. The main targeted age group is 11-15 but the age group 16-20 and parents and/or families oriented interventions are also significant.

Graph 2 - Municipal Plans – targeted individuals by age group/category

2001

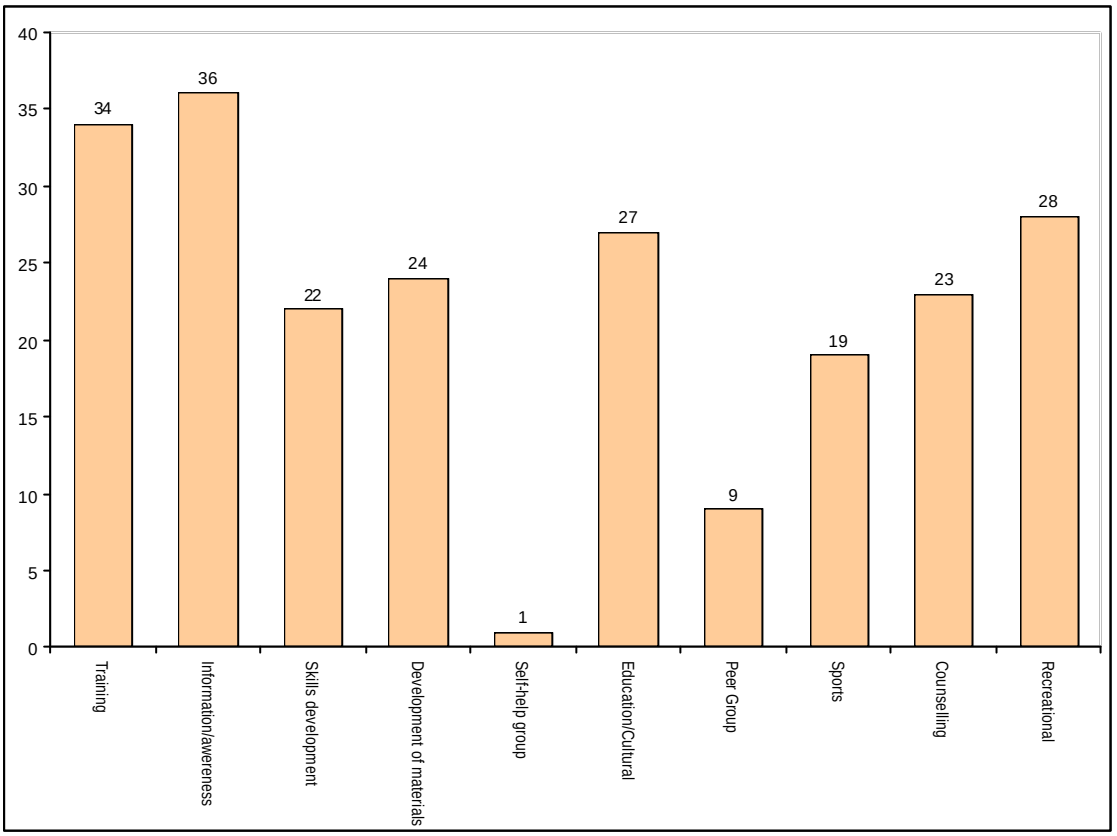


Source: IPDT/Department of Community Intervention

Considering the type and number of developed activities, Graph 2 shows that the main option, in terms of type of activity is information/awareness sessions, training, leisure activities and cultural activities, in this order.

Graph 3 - Municipal Plans – type of activity

2001



Source: IPDT/Department of Community Intervention

National Telephone helpline - Linha Vida - SOS DROGAS

This national telephone helpline (already described in previous reports) was available, in 2001, from 10 a.m. to midnight every working day. The delegations of Lisbon and Porto received a total of 73 860 calls (51 152 in 2000) from which only 11 045 were real calls (8 630 in 2000), the rest being silent calls (35 078) or hoaxes. All figures increased in comparison to 2000, a trend that has been verified in previous years. In 2001, to complement the helpline service, some of the callers were given the opportunity, according to specific criteria mainly concerning problematic drug use situations, of a personal interview and follow up with welfare professionals working with Linha VIDA. These individuals were referred to other institutions and followed-up by Linha VIDA.

This service, which has joined the National Network for the Early Warning System on Synthetic Drugs, has been instrumental in collecting data on questions clients have concerning new drugs and in disseminating preventive information on new drugs and drug use trends.

Campaigns

Main campaigns promoted by the IPDT in 2000/2001 were:

- Agarra a Noite sem Perder a Vida (*Seize the night without loosing your life*) - nationwide. Targeted to the recreational setting. Information provision, dissemination of the telephone helpline, leaflet, alcohol measurement kits, condoms and other preventive material distribution.

- Agarra a Vida (*Seize life*) - Lisbon. Targeted 20 schools. Information provision and dissemination of the telephone helpline.

- Se não vês o perigo, o perigo és Tu (*If you can't see the danger, you are dangerous*) - nationwide in co-operation with the General Direction of Traffic to prevent road accidents related to drug and alcohol use.

- Militar setting - Information provision, dissemination of the telephone helpline, leaflet, and other preventive material (a total of 37 050 items) were distributed to 5 700 young conscripts during their first medical inspection.

- Drogas.sem Desporto.com - nationwide. With the objective of drawing the attention to the importance of healthy practice of sports. Protocols were signed with the National Federations of football, handball and basketball.

Internet

The IPDT is a core member of PREVNET where it participates in the joint development of prevention strategies using the new information technologies. The management of the current IPDT website and of the national programmes inserted in EDDRA continues to be ensured and the development of new sites more targeted to information/prevention for the general public is under consideration. The CCPES also maintains its website www.ccpes.min-edu.pt which makes available prevention contents, discussion foræ, a newsletter and other general information on health promotion in general and drug issues in particular.

Training

The SPTT continues to ensure training for professionals on drug abuse prevention. In 2001, and considering the increase on the number of applications, the course took place in both Porto and Lisbon for 60 professionals and 20 observers. The trainees were mainly women under 30, psychologists from the SPTT itself, although a large number 15 also came from NGOs. The course runs for 130 hours plus 200 hours practical/in the field.

The SPTT also used a new format to deliver 2 courses of 100 hours each to social workers and mass media professionals in Madeira - a CDROM was distributed and an interactive course was available to 49 trainees between October and December 2001.

The Centres for Information and Counselling at the SPTT continue to develop training sessions for professionals of public and private institutions which develop their work in co-operation with the SPTT. In 2001, both the number of sessions (350 in 2000 and 2 328 in 2001) and the number of trainees (2 438 in 2000 and 27 291 in 2001) registered a significant increase mainly due to a closer contact and co-operation with students associations.

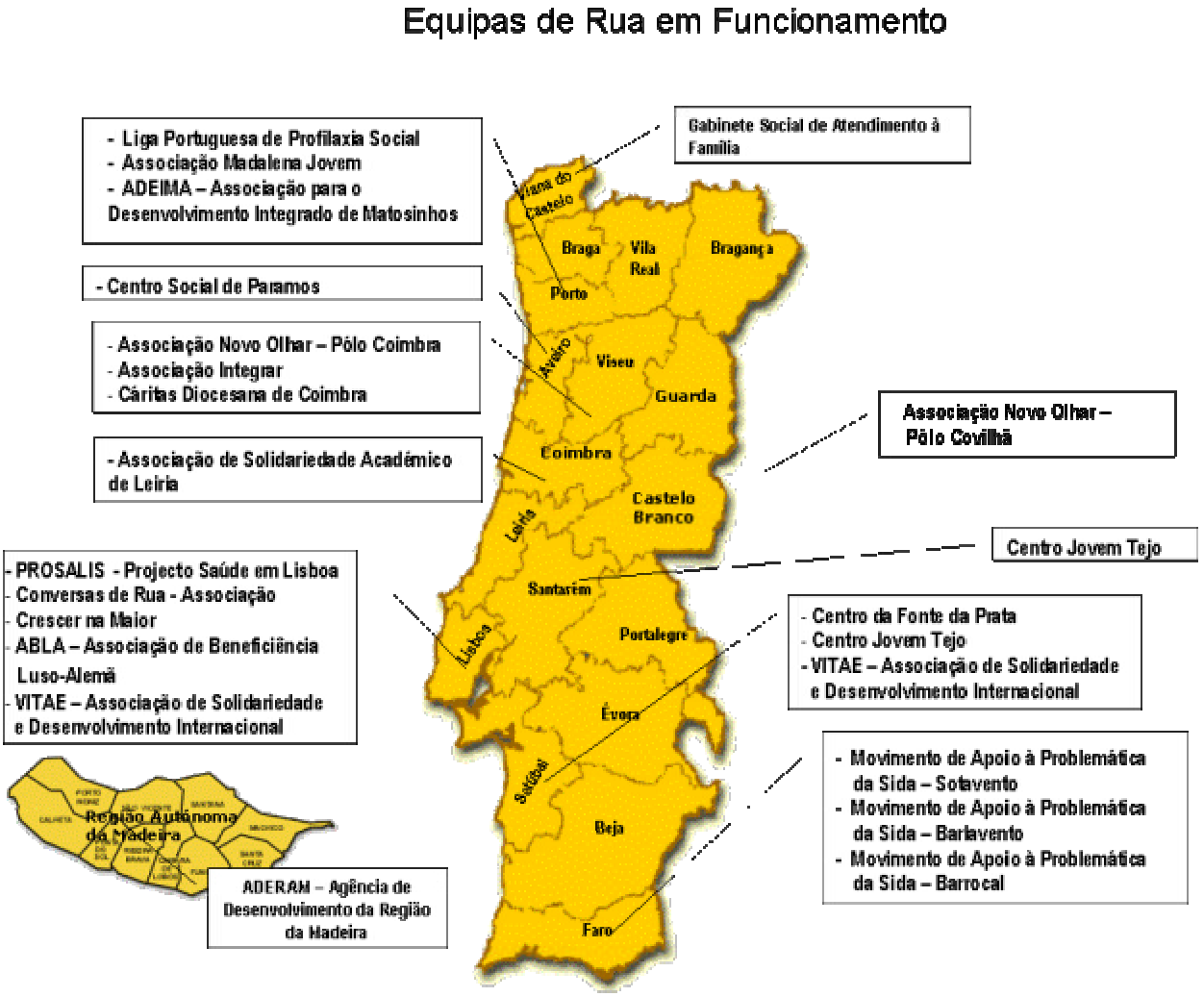
In the school setting, the CCPES ensures specific training for education professionals as a strategy in the promotion of global health in the school population. For more information on training in this setting, please see Standard Table 19.

10. Reduction of drug related harm

The National Strategy and Action Plan state specific objectives for the priorities concerning drug related harm which were already reported in last year's report. In 2001, to implement those objectives and the correspondent legal diplomas (see Part I) the IPDT promoted a national tender for outreach work projects to ensure financial (a total of 78.833,65€) and technical support to NGOs with projects in this field.

The candidate projects were reviewed and selected by an independent jury and 23 projects were selected in the following districts:

Map 2 – Outreach work projects



Source: IPDT/Department of Community Intervention

Projects target specific sub-populations of drug users of "old" (heroin, cocaine, polydrug use, etc.) and "new" (synthetic) drugs, and promote harm and risk reduction interventions which range from pill testing, syringe exchange, low threshold methadone dispensing, information provision, overdose prevention, infectious diseases testing and prevention to referral to other institutions. The trend has been to increase the mobility of outreach workers as the drug use populations themselves tend to spread to different geographical areas. (cf. Standard Tables 10 and 21 as well as information sent on overdose prevention).

10.1. Description of interventions

Concerning outreach in recreational settings, both context and available detailed information is reported in Standard Table 21.

Other outreach work projects are more targeted to problematic drug users and disseminate information and education material, including information to prevent overdoses, safe user training, distribute syringes, promote safe sex through information, awareness and the free distribution of condoms, ensure referrals to other social and health care services and provide basic health a social care to problem drug users.

Another important development in the area of the prevention and treatment of infectious diseases are the recently set up Testing and Counselling Centres, free and anonymous, where individuals also receive pre and post testing counselling (cf. Standard Table 10).

As far as specific projects in specially problematic areas are concerned, in Curraleira, a problematic neighbourhood in Lisbon, a new pilot project for harm reduction service delivery was set up in July 2001, in the framework of the harm reduction national policy, to reach out to drug users in the transition period caused by the demolition of slums and resettlement of the population. The "contact point", as it was called, delivered syringe exchange services and counselling to drug users with the objective to respond to basic health needs and referral to health and social agencies. Since September 2001 it also started a low threshold methadone substitution programme. There is a mobile unit in a van and a bus which is permanently stationed in the neighbourhood.

After the resettlement period was over and the problematic drug users tended to spread to other areas of Lisbon, this "contact point" moved to Sta. Apolonia e Alcantara. The provided services were also enlarged to the prevention and testing of drug related infectious diseases and support to the families of drug users, through a close cooperation with social and health structures in these different areas.

In Casal Ventoso, the responses already described in previous reports were kept in place despite the resettlement project for the neigbourhood. A positive evaluation of those responses was made both by drug users (see chapter 4.1.) and the involved agencies concerning the delivered services, decrease in positive tests for infectious diseases and risk behaviour in general. However, there is also the perception that problematic drug users now tend to spread to other areas of Lisbon, creating feeling of insecurity in previously less affected neighbourhoods.

For information on the national syringe exchange programme[13], and its cost-effectiveness evaluation, please see Standard Table 10.

10.2. Standards and evaluation

Professional standards on harm reduction interventions are ensured by the national legal diplomas, by the criteria set up by the IPDT to fund harm reduction projects and the selection and follow-up procedures.

Few evaluation studies have been held on harm reduction measures apart from the one mentioned in chapter 4.1. and the ones concerning the intervention at Casal Ventoso, as most of the systematic interventions only started in January 2002. The IPDT developed databases to monitor the funded projects under the framework of the national network for harm reduction. The national syringe exchange programme "Say no to a second hand syringe" was evaluated in terms of its cost-benefit performance (cf. Standard Table 10).

[13] Developed by the National Commission for the Fight Against AIDS and the National Association of Pharmacies.

11. Treatment

Inline with the National Action Plan, in 2001, the effort concerning treatment was to ensure availability of different modalities of treatment to all drug users. This was possible through the enlargement of the national SPTT health care system and of decentralised treatment units, protocols with NGOs and closer cooperation with other governmental agencies to ensure, for instance, higher treatment availability to drug users in prison (see chapter 12 and Standard Table 20).

11.1. "Drug-free" treatment and health care at national level

The national treatment network, anonymous, universal and free of charge, is oriented towards the response of the needs expressed by the clients who seek it having as main objective to treat problematic drug use. In this context, and bearing in mind both the dimension of polydrug use, common to a high number of users, and double diagnosis, it is understandable that, both in outpatient and inpatient care, abstinence for all used substances (including medication) is not always possible or even desirable and that issues concerning personality and behaviour disorders imply specific medication for the treatment of drug use related pathologies. This type of intervention, which uses medically prescribed medications, must not be confused with the substances used for substitution and maintenance treatment. Thus, and with the exception of some therapeutic communities which treatment model follows a philosophy of total deprivation of the use of any psychoactive substance, the concept of "drug free" treatment necessarily becomes a vague and subjective concept, both in terms of the concomitant illicit substance use and in terms of the medication which is sometimes necessary to ensure the client's bio-physic balance, and its use is avoided.

Concerning health care at national level, the SPTT, from the Ministry of Health, is the national authority on specialised drug use treatment. It is organised in Central Services, Regional Offices and Local Centres. The services provided are entirely free and accessible to all drug users who seek access to treatment. In 2001, similarly to previous years, the number of treatment units increased in the public SPTT health care network. The treatment programme is tailored to each client's specific problem and characteristics and the facilities/services include:

Table 8 - Public SPTT specialised treatment units

2001

	Northen Region	Central Region	Lisbon / Tagus Valley Region	Alentejo Region	Algarve Region	Portugal (excluding the Isles)
Specialised Treatment Centres	13	11	15	4	2	**45**
Consultation Units	2	2	10	1	1	**16**
Detoxification Units	1 (10 beds /428 clients)	1 (7 beds /342 clients)	2 (21 beds /794 clients)	-	1 (8 beds /288 clients)	**5**
Therapeutic Communities	-	1 (14 beds /29 clients)	1 (22 beds /43 clients)	-	-	**2**
Decentralised Consultation Units	-	-	3	-	-	**3**
Day Centres	2 (35 clients)	-	2 (45 clients)	-	-	**4**

Source: Serviço de Prevenção e Tratamento da Toxicodependência.

This capacity increase was visible in the majority of districts though some (namely Viana do Castelo, Bragança, Viseu and Guarda) still lack inpatient care units. The districts of Lisbon, Porto and Setubal remain those with a higher number of specialised treatment units.

Certification of NGOs and protocols between certified NGOs and the SPTT ensure a wide access to quality-controlled services encompassing several treatment methodologies, to better respond to the specific needs and profiles of clients.

Table 9 - NGO units with protocols with the SPTT

2001

Portugal (excluding the Isles)	Organisations	Units	Capacity	Clients
Detoxification Units	**18**	**18**	**186**	**5 900**
Certified	11	11	109 beds/places	3 127
With Protocols	7	7	77 beds/places	2 773
Terapeutic Communities	**94**	**136**	**3 290**	**7 280**
Certified	48	73	2 064 beds/places	4 455
With Protocols	46	63	1 226 beds/places	2 825
Day Centres	**11**	**12**	**530**	**745**
Certified	6	7	295 beds/places	427
With Protocols	5	5	235 beds/places	318

Source: Serviço de Prevenção e Tratamento da Toxicodependência.

On the 31st of December 2001, there were 514 individuals in waiting lists in the SPTT network, which represented a decrease in comparison to previous years. There was also an increase in the number of active clients[14] in SPTT units: 32 064 - 10% more than in 2000 and 16% more than in 1999. 39% of those active clients were in treatment in the Region of Lisbon and the Tagus Valley and 31% in the Northern Region. In comparison to previous years, the higher increases in active clients were registered in the Algarve Region (+20%) and in the Region of Lisbon and the Tagus Valley (+14%). At district level, and considering the residents aged 15-39, the districts of Faro, Beja, Setubal and Bragança reported the higher rates of active clients per residents in that age group.

The quantity of inpatients in public and private detoxification units and therapeutic communities also increased. In 2001, 4 625 inpatients were registered in public and protocoled[15] detoxification units (4 368 in 2000), and 3 127 in non-protocoled detoxification units. 2 897 inpatients were registered in public and protocoled therapeutic communities (+12% than in 2000). 4 455 inpatients were registered in non-protocoled therapeutic communities. 398 clients were registered in public and private Day Centres - interface units between treatment and rehabilitation) which represented a 19% increase in comparison to 2000.

Concerning first treatment episodes in the public SPTT network, a 9% decrease was registered (8 743 in 2000 and 9 559 in 1999). The fluctuation spanned between -2% in the Central Region and -28% in the Alentejo Region. In 2001, similarly to 2000, 74% of the clients demanding first treatment were from the Region of Lisbon and the Tagus Valley and the Northern Region. Again, Lisboa, Porto and Setubal were the

[14] Clients who kept treatment appointments at least once during the reporting year.

[15] In protocoled units (NGOs), the State funds part of the treatment programmes.

districts with a higher number of clients in first treatment episodes in 2001 and, as in 2000, the higher rates per residents in the age group 15-39 were registered in the districts of Faro, Setubal, Lisboa and Bragança.

Concerning follow-up treatment episodes, a 14% increase was verified (300 485 in 2000 and 343 538 in 2001), which points towards more quality and adequacy in the deliverance of services.

11.2. Substitution and maintenance programmes

Substitution and maintenance programmes in Portugal are divided in high/medium threshold and low threshold. Both aim at minimising drug use related risk and harm in order to contribute to the quality of life of drug users and to minimise the impact of their behaviour in terms of public health. High threshold substitution programmes are traditionally included in a perspective of global treatment, supporting psycho and social therapy and aiming at a progressive detoxification and abstinence. Low threshold programmes target mainly street problematic drug users who are not involved in treatment programmes and aim at reducing drug use consequences and motivating drug users to more global and comprehensive social and health care interventions.

High threshold programmes are developed by clinical staff according to inclusion and exclusion criteria. They include psycho and social therapy, tailored to each client needs, and are monitored by the clinical staff. Substances used include methadone - always prescribed at CATs but also available in other services to ensure mobility; buprenorphine - which may also be prescribed by private therapists and usually involves a third party (parents or others) close to the users to ensure uptake but aiming at a progressive autonomy of users; LAAM is prescribed and available only in CATs and its use is being discontinued due to previous evaluations and guidelines from the National Medication Agency.

In 2001, the enlargement of the substitution programmes was continued. 12 863 clients were registered in the SPTT network, which represented a 21% increase in comparison to 2000 (10 614 clients), but not as high as the one verified between 1999 and 2000 (+76%). Clients increased in all Regions, mainly in Lisbon and the Tagus Valley (+32%) and in the Northern Region (+29%). Clients in substitution programmes represented 40% of the total active clients in 2001. Similarly to last year, it was the Northern Region which registered a higher number of those clients, although the relative weight of these clients remains higher in the Regions of Algarve (80%) and Alentejo (64%). Other regions registered a relative weight of these clients between 29% and 43% of all active clients. From the 12 863 clients in substitution programmes in 2001, 3 576 were new admission and 2 630 left the programmes, 20% with programmed medical release.

On the 31st of December 2001, there were 10 233 clients in the SPTT network's substitution programmes. Although the majority of those on methadone still took it in CATs, 41% (39% in 2000) were taking it in health centres, pharmacies and other governmental and non-governmental services, always in co-ordination with the CATs.

Table 10 - SPTT clients in substitution programmes

Programmes / Direcção Regional	Total	Substitution Programmes		
		with Methadone	with LAAM	with Buprenorphine a)
Total on the 31-12-2000	8 324	7 598	719	7
Total on the 31-12-2001	10 233	9 664	42	527

Source: [CIDT2002]. a) Figures are underestimated because the substance may be taken at home (see text above on buprenorphine).

11.3. After-care and re-integration

For this area, the National Action Plan, inline with the National Strategy, states the following objectives until 2004:

- To reinforce Programme Vida-Emprego as the main programme for social reintegration for drug addicts and reclusive drug addicts in order to increase its capacity by 50% and to include new values which specifically work towards preventing the exclusion of working drug addicts or ex-addicts.

- To expand the network of reintegration apartments destined for drug addicts in rehabilitation, increasing the current capacity by 100%.

Main target populations for these objectives are drug users and ex-drug users, users in treatment, users who finalised treatment and individuals in prison with drug abuse problems or in treatment programmes in prisons.

Similarly to what happened concerning harm reduction and prevention, and to ensure the implementation of the recommendations from the National Strategy, harmonised criteria and approaches, the IPDT is working with other national partners, including worker's unions, to prepare a legal diploma on after care and re-integration.

Currently, the initiatives in this area are organised around 3 major programmes (cf. Table 11) which cover training, employment and housing and specific responses for specific settings, such as the Day Centre's programmes which follow some of the treatment methodologies available at the SPTT, re-insertion programmes made available by non-governmental therapeutic communities, specific re-insertion programmes for after prison. However, no evaluation results or studies are available on those.

Table 11 – Reintegration Programmes

2001

Identification of the Programme	Service delivered	Budget	Number of projects	Obs
Programa Quadro Reinserir (IPDT)	Socio-professional rehabilitation project funding	2.094.194,76 € + 227.246,37 €	24 projects nationwide since 1998	Will be concluded in 2002 and evaluated
PIDDAC/2001-2002 (IPDT)	Funding for halfway houses and motivation centres for drug users in rehabilitation process	399.038,32 €	4 halfway houses, and 10 motivation centres in Lisbon and the Tagus Valley area	
Programa Vida-Emprego (IPDT/IEFP)	Information, counselling, professional training, socio-professional reintegration	5.976.656€ in 2001	3 396 initiatives supported since 1999. 1 693 in 2001	External evaluation will start before the end of 2002
Specific measures of the Institute for Employment and Professional Training	Professional training and professional insertion	n.a.	172 individuals involved in 2001	

The promoting agencies identified as main problems of these populations:

- Lack of social and individual skills; unemployment and inexistent or inadequate professional training;
- Low receptivity of the employers;
- Treatment programmes without continuity at the level of reintegration;
- Low socio-economic conditions and difficulty in the management and occupation of leisure time.

The main services available in the above-referred projects include:

- Juridical support;
- Training and professional reinsertion of unemployed former drug users, promoting self-employment, training within potential employing companies and the promotion of awareness sessions in the labour setting;
- Social skills acquisition training;
- Preparation for living outside prison for those who have been released;
- Psychosocial counselling and setting up of self-help groups for individuals and their families;
- Development of a reinsertion "contract" made by the individual and social work professionals to and give guidelines and follow-up progress within these programmes.

Services are available through the district or regional services of the IPDT or the IEFP, ensuring full national coverage and availability. In Programa Vida-Emprego, permanent co-operation between the therapist/health professional and the labour setting is guaranteed by mediators of Vida-Emprego (currently 137 individuals) to ensure better transition processes.

Data reported in previous National Reports suggest that demand for support in this area has been increasing since 1999, suggesting both a dissemination of the programme and a higher demand level from ex-drug users finalising their treatment programmes.

For more information, please see key issue chapter 16.

12. Interventions in the Criminal Justice System

Intervention in the criminal justice system is mainly developed by the General-Directorate of Prisons and by the Institute for Social Rehabilitation, both agencies of the Ministry of Justice. The specific target of the Action Plan Horizonte 2004 concerning this area is included in the harm reduction chapter and points towards the availability of harm reduction programmes for all drug users in prison.

In the prison setting, interventions are implemented in the framework of the Special Drug Abuse Prevention Programme in Prisons (*Programa Especial de Prevenção da Toxicodependência nos Estabelecimentos Prisionais-PEPTEP*) set up in 1999 and 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 SPTT and the Institute for Social Rehabilitation.

For a profile of Drug Law offenders in prison, please see chapter 4.2.

12.1. Assistance to drug users in prisons

In the prison setting there are 5 units oriented to abstinence with capacity for 192 drug users, a therapeutic community with capacity for 45 drug users and a halfway house with a capacity of 12. In 2001, 381 drug users in prison (41 of which were women) were assisted by these services. 326 were involved in treatment programmes, which represents a 39% decrease in comparison to 2000. Substitution programmes are also available , either set up by the prisons themselves (3 prisons, 381 patients - 30 women - in 2001, a increase in comparison to 2000 - 341 patients) or in co-operation with CATs (33 prisons and, 69 patients in 2001).

For other information on available services for drug users in prisons, including harm reduction measures and release preparation programmes in co-operation with community services, please see Standard Table 20.

12.2. Alternatives to prison for drug dependent offenders

It is possible for drug dependents in preventive prison (prior to Court ruling) to enter a therapeutic community outside prison while waiting for trial. 53 prisons are currently offering that service which is envisaged to be enlarged.

12.3. Evaluation and training

Training sessions for prison staff on drug issues and public health are regularly held, usually in co-operation with prevention services from the SPTT.

For information on evaluation, please see last year's report on the survey in the prison setting for epidemiological situation and perceptions of individuals in prison and prison directors.

13. Quality Assurance

Quality assurance in the demand reduction area in general continues to be developed according to the procedures reported last year. Specific research, training, standards and quality criteria are described together with the correspondent initiatives in the respective chapters.

Part IV

Key Issues

14. Demand reduction expenditures on Drugs

The National Strategy defines a set of interventions to be promoted in order to minimise the social costs of drugs and drug addiction.

These interventions can have two goals: drug demand reduction and drug supply reduction.

This special chapter will focus on both the amount and allocation of the 1999's expenditures directly related with drug demand reduction. The importance of understanding them derives from the need to ensure, in the sight of the scarcity of resources, an intervention with minimum waste and maximum efficiency.

14.1. Concepts and definitions

Drug demand reduction activities are aimed at preventing drug abuse, assisting and treating drug users, reducing the negative consequences of such use and promoting positive health. It comprises four general action plan areas:

- Prevention can be defined as the set of strategies aimed at the reduction of the demand for drug by the creation and maintenance of healthy lifestyles (cf. chapter 9 for more information on the concept of prevention and main actors). In 1999, the IPDT (and the Projecto Vida during the first semester), the Ministries of Health and Education and the SPTT (through the CIACs - Centres of Information and Counselling) were the Public Organisations with higher financial and organisational responsibilities in the Prevention action area. Several prevention initiatives were promoted in 1999 namely: educational projects (Programme for Health Promotion and Education), information/sensitisation mass media campaigns, training activities, prevention interventions in the armed forces, activities developed by street teams and information points, prevention actions in sports associations and the free, confidential and anonymous advice service provided by the Helpline Linha Vida - SOS Drugs;

- Harm reduction activities are directed at minimisation of the harm and risks caused by drug addiction, even if the addiction does not cess (cf. chapter 10 for more information on the concept of harm reduction and main actors). In 1999, several harm reduction policies were pursued, namely, the expansion of the primary network of harm reduction (which includes street teams and contact and information points), the provision of social and medical services, the promotion of needle exchange programmes and low threshold methadone substitution schemes, the creation of metropolitan networks of refuges, shelters and occupational day centres and the creation of early, anonymous and voluntary HIV detection centres;

- Guaranteeing free access to treatment for all drug addicts has been one of the top priorities of the national interventions in this area. In fact, treatment is a constitutional right and may be thought as a prevention measure as it contributes to the reduction of use and the protection public health. The SPTT plays a very important role in the treatment area (cf. chapter 11 for more information on the concept of treatment and main actors). Besides financially supporting and controlling the performance of private units, it comprehends a network of specialised treatment centres, maintains partnerships with hospitals, autarchies and prisons and is involved in several substitution programmes (methadone and LAAM). Numerous treatment initiatives were continued in 1999 such as: consultations and confinements in specialised treatment centres with different treatment methods, substitution treatment programmes namely through protocols with the National Association of Pharmacies and partnerships with both public and private promoters of treatment projects. The SPTT, the Ministry of Health and the IPDT are the main pursuers of harm reduction activities;

- Social reintegration can be thought of as tertiary prevention as it contributes to the prevention of "relapses" and can minimise the social conditions favourable to drug consumption (cf. chapter 11.3 for more information on the concept of re-integration and main actors). Treatment is not completed nor successful if not associated with rehabilitation policies promoted both in familiar and professional environments. Social rehabilitation initiatives include: supervised residential support via "reintegration apartments", financial and psychological support to drug addicts' families, vocational training and work experience (provided by the IEFP -Institute of Employment and Vocational Training), counselling and assistance in the reorganisation of social relations of recovering drug addicts (through Narcotics Anonymous) and initiatives aimed at ex-inmates and members of the armed forces under treatment promoted respectively by the IRS (Institute of Social Reintegration) and the Armed Forces. The Vida-Emprego Programme plays an essential role in social reintegration.

Drug demand reduction activities can be of public or private nature. Public activities are obviously funded by the State Budget. As to private initiatives, they can be financed either by the State or entirely supported by private entities.

The expenditures directly related with drug demand reduction can be of two types:

- **Operational expenditures -** financial resources directly related with drugs, distributed by the State Budget to finance specific projects or authorities (central, regional or local) directly involved in drug demand reduction initiatives.

- **Institutional expenditures -** resources (salaries, rents and other expenditures) used by public or private organisations directly involved in drug demand reduction activities.

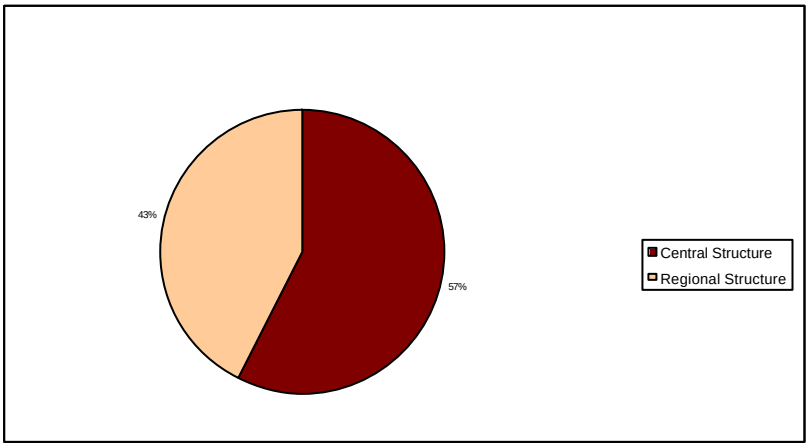
In the present chapter, the lack of detail of the available statistical data rendered impossible the classification of the public expenditures according to this typology (cf. conclusions and methodological issues).

14.2. Financial mechanisms, responsibilities and accountability

The budget concerning demand reduction was approximately of 74.119.177,78€ and was mainly allocated to the Central Structure (42.536.666,63€). The funds attributed to the Regional Structure were distributed by the SPTT to its five Regional Directorates (31.582.511,15 €) and referred to the treatment area.

Graph 4 - Demand reduction expenditures

1999

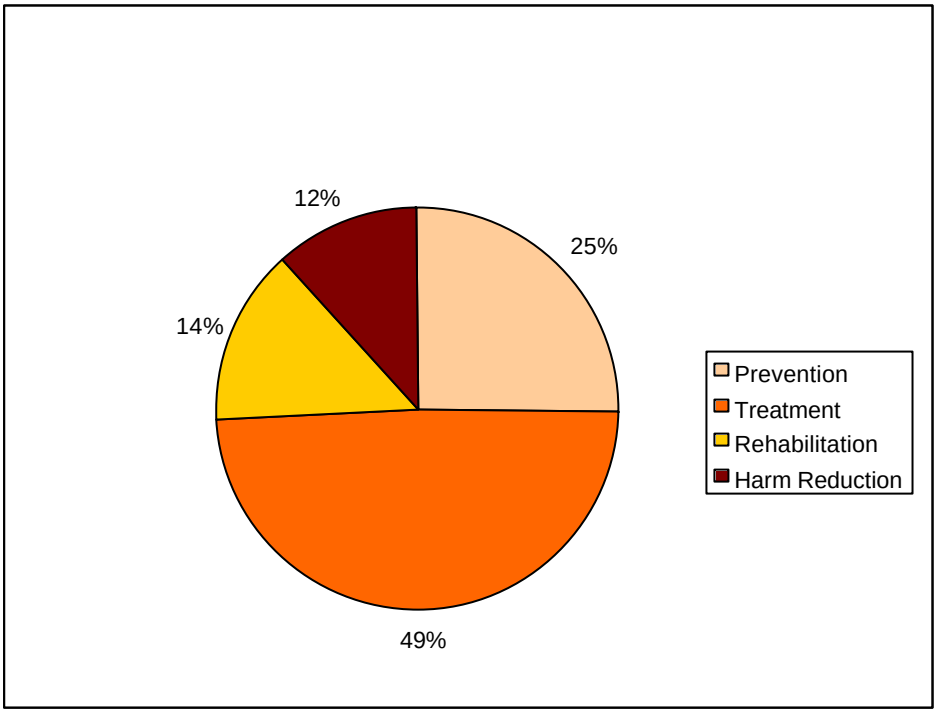


Sources: IPDT and SPTT.

The distribution of the demand reduction budget by the above referred intervention areas was the following:

Graph 5 - Public Administration budget on demand reduction by intervention areas

1999



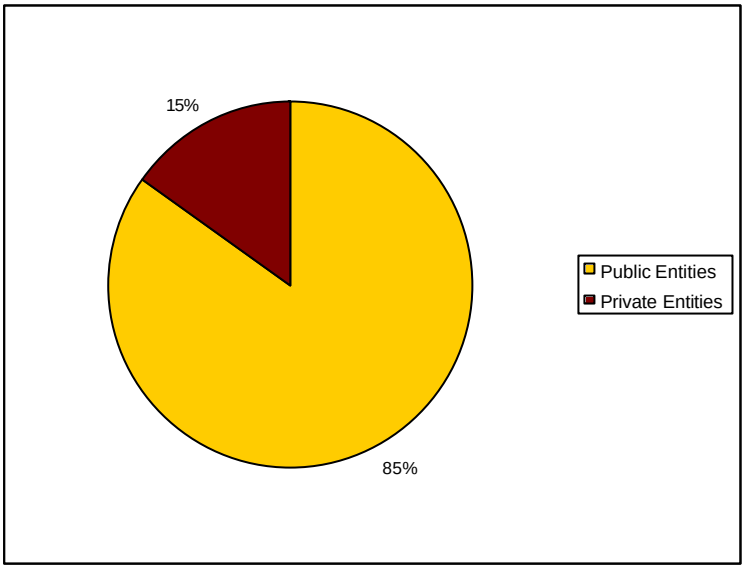
Source: IPDT.

In order to ensure the implementation of the National Strategy for the Fight Against Drugs, both the IPDT and the SPTT delegate funds to Private Entities. Only 15% of the 1999's demand reduction budget was allocated to Private Entities. The latter focused mainly in treatment although they also participated in prevention and harm reduction. In 1999, the IPDT transferred funds to 519 projects in the prevention area, which had applied for financing in 1997 and 1998 (Programa Quadro Prevenir) and 24 harm reduction projects (Programa Quadro Reinserir) in a total of 2.296.331€. All these funds were transferred to non-governmental, non-profit organisations. The mechanism of delegation of SPTT to private treatment institutions will be broadly described later on. Nevertheless, in 1999, it transferred to private entities 7.839.412 €.

Apart from the public financing, Private Entities incur in expenses while developing drug demand reduction activities. It would be of all interest to estimate the size of such expenses. However, it was not available neither data concerning the total private expenditure nor information about the importance of public funding of private institutions. Therefore it is only possible to emphasize the contribution of private institutions to the fight against drug and drug abuse namely in the treatment area, suppressing some of the gaps of the public system.

Graph 6 - Allocation of funds between public and private entities

1999



Sources: IPDT and SPTT.

The General State Budget establishes the annual amount of Euros to be allocated to the fight against drug and drug addiction. It also indicates to whom that amount will be given and what should it be used in. Normally, the drug budget is divided between the Public Entities with responsibilities in the drug abuse area: Ministry of Health, Ministry of Education, Ministry of Defence, Ministry of Justice, Ministry of Internal Affairs, Ministry of Employment and Social Affairs and Presidency of Council of Ministers.

Each of these institutions allocate the funds received in the manner they consider the most adequate to meet the priorities of the Portuguese State in general and their own goals in particular. Specifically, each Ministry distributes its own budget to the numerous public and private projects in the area of drug demand and supply reduction that are financially supported by it. As all publicly financed entities, the Ministries are legally responsible for the strategy concerning the allocation of the granted funds followed by them.

As to the responsibilities of the public and private entities financed by the Public Administration, they are described in several Decrees of Law, which have been regularly reported to the Centre in previous reports and which are available at the IPDT legal database at www.ipdt.pt.

14.3. Expenditures at national level

In 1999, all funds for the area of drugs and drug abuse are originated at a central level. Their main sources are the General Sate Budget, the JOKER subsidy granted by Santa Casa da Misericórdia and the PIDDAC subsidy for investment expenditures.

The total budget for the area against drugs and drug abuse was in 1999 of approximately 90.424.881€. The aforesaid budget was distributed in the following way:

Table 12 - Total budget by Ministry (€)

1999

Ministries	1999
Presidency of the Council of Ministers	16.245.848
Ministry of Health	41.603.006
Ministry of Education	3.162.379
Ministry of Justice	2.393.277
Ministry of Employment and Social Affairs	9.513.852
Ministry of Internal Affairs	16.305.703
Ministry of National Defence	1.200.816
Total	**90.424.881**

Source: IPDT.

The **Ministry of Health** was responsible for the allocation of 46% of the Public Administration Budget. The funds were mainly attributed to the SPTT (Drug Addiction Prevention and Treatment Service), which works chiefly in the treatment area. Nevertheless, the Ministry also undertook actions in the risk reduction area namely in what regards the National Commission for Combating Drugs' syringe exchange programme.

The **Presidency of Council Ministers** received 18% of the Public Administration Budget. It comprises both the IPDT (Portuguese Institute for Drugs and Drug Addiction) and the Portuguese Youth Institute. In 1999, it also comprised the Projecto Vida (National Drug Abuse Prevention Programme), which was extinguished in the meantime.

The Presidency of Council Ministers intervenes mainly in the Prevention area by launching promotional campaigns, organizing training activities, addressing risk groups and funding research initiatives among others.

The **Ministry of Education** (3%) through the Coordination Commission for Health Promotion and Education also operates in the Prevention area. The referred Commission attempts to minimise risk factors by promoting information, sensitisation and training initiatives.

The **Ministry of Justice** (3%) intervenes in the Prevention, Treatment and Social Rehabilitation areas through the Centre of Judicial Studies (CEJ), the Directorate-General of Prison Services (DGSP) and the Social Rehabilitation Service. It is important to state that the budget from the Criminal Police was not available.

The **Ministry of Employment and Social Affairs** (11%) participates specially in the Social Rehabilitation area. The department of Social Action and the programmes "Vida / Emprego" and "Integrar" have objectives of reintegration and provision of financial support to drug users.

Finally, the **Ministry of Defence** (1%) operates in the Prevention area by discouraging drug addiction and permanently controlling drug prevalence in the armed forces.

While the prior Ministries implement drug demand reduction strategies (with the exception of the Criminal Police in the Ministry of Justice which budget, as stated, was not available), the **Ministry of Internal**

Affairs (18%) seeks drug supply reduction. The National Republican Guard, the Public Security Police, the Security Information Service and the Emigration Services pursued the supply reduction goal. The Ministry also promoted the "Escola Segura" Project in an attempt to combat drug trafficking in the neighbourhood of schools.

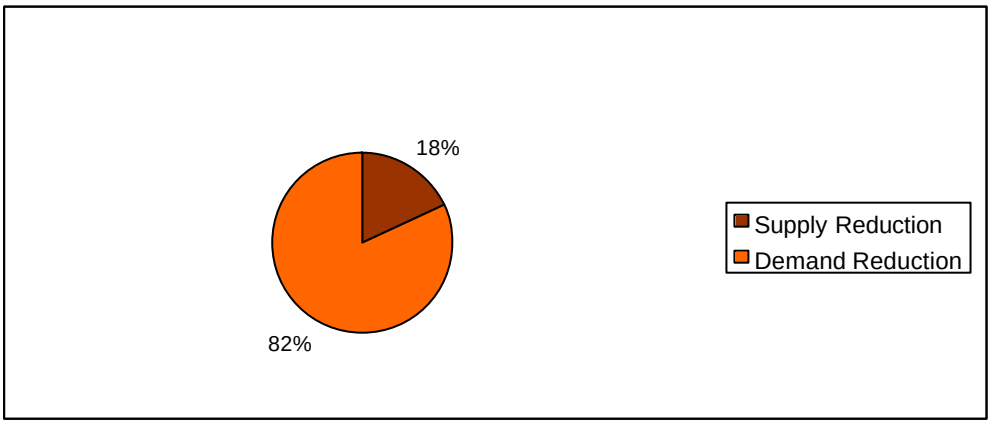
Concerning the **Funding of Private Initiatives,** only Projecto Vida (National Drug Abuse Prevention Programme), IPDT and SPTT were involved in the funding of Private Institutions: NGOs and Private Charity Institutions (IPSS).

Projecto Vida and IPDT (after the extinction of Projecto Vida) financially supported projects in the fields of Prevention (Programa Quadro Prevenir) and Social Rehabilitation (Programa Quadro Reinserir), while the SPTT established protocols and conventions in the Treatment intervention area.

Between demand reduction and supply reduction (but without the budget from the Criminal Police) the majority of the 1999's Portuguese Public Administration expenditures were aimed at drug demand reduction (74.119.177,78 €) in comparison to drug supply reduction (16.305.703,26 €).

Graph 7 - Demand vs Supply reduction budget

1999



Source: IPDT.

14.4. Expenditures of specialised drug centres

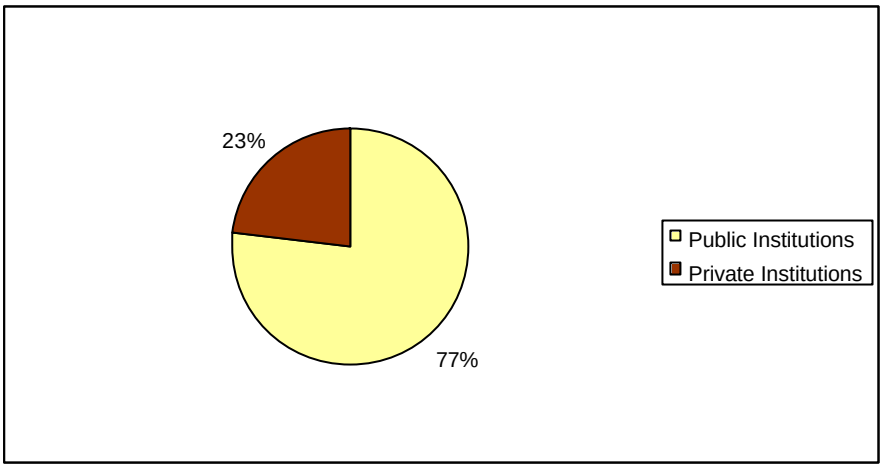
The guarantee of access to treatment for all drug addicts who look for it is an absolute priority of the national drug strategy. This is justified by the need to comply with the humanistic principle.

In order to achieve the aforesaid goal, the SPTT has improved and created innovative public therapy circuits and schemes. Moreover, the SPTT has increased the number and capacity of private units, operating either on contract or other basis and providing services to drug addicts undergoing detoxification and treatment. As a result SPTT was able to respond to the needs of 97.6% of the drug addicts seeking treatment.

The distribution of the 1999's treatment budget between public and private units was a total of 34.042.417,78€ distributed in the following way:

Graph 8 - Distribution of the treatment budget

1999

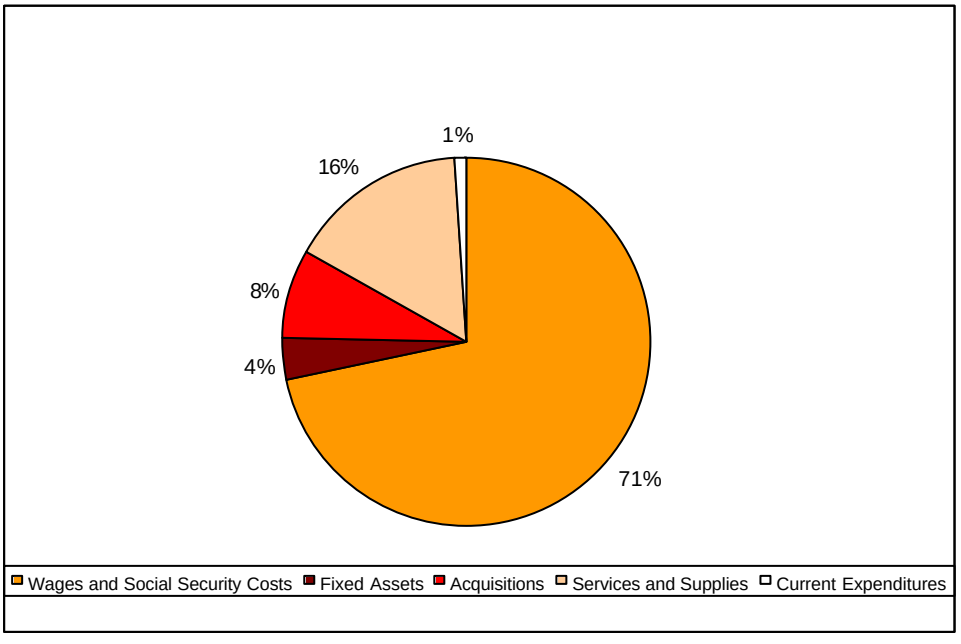


Source: SPTT.

The 1999 Public network of treatment institutions included: 40 CATs (Treatment Centres for Drug Addicts), 10 Extensions, 6 Consultation Places, 5 Detoxification Units, 2 Therapeutic Communities and 4 Daily Centres. There were held in the CATs treatment episodes that comprised 27 750 drug users. As to in-patients units, 1 945 drug users underwent treatment in Detoxification Units and 63 did it in Therapeutic Communities. Finally, 106 drug addicts attended treatment in Daily Centres.

Graph 9 - Public Institution's expenditures

1999



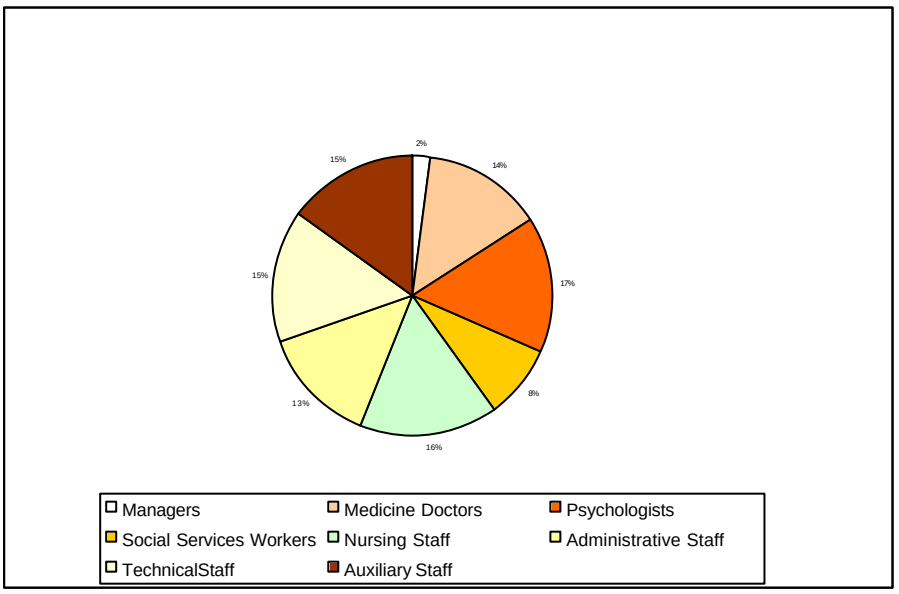
Source: SPTT.

The Wage and Social Security Costs represent 71% of the public treatment institutions' total cost 26.203.005,76 €. As there was no information concerning the extent of each professional category costs, it seems convenient to characterize these institutions' work force.

It can be seen in the subsequent table and graph that Medicine Doctors, Psychologists and Nurses constitute 46% of the total Staff (1 297).

Graph 10 - Workforce allocated to public treatment institutions

1999

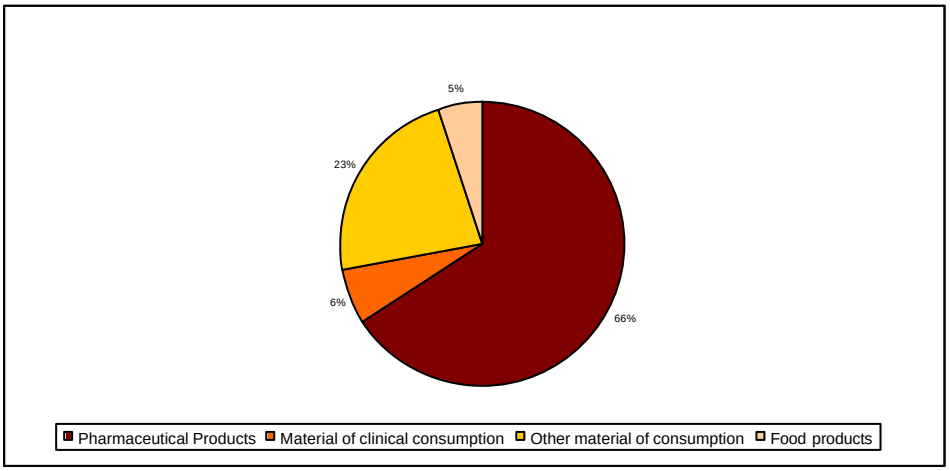


Source: SPTT.

As to Public Treatment Acquisitions, which were approximately 979.960,96€, the majority consisted of Pharmaceutical Products. In fact, in 1999, the SPTT focused on the expansion of the network of institutions involved in substitution therapies with methadone and LAAM. Around 6 040 drug addicts took part in programmes of treatment with substitution schemes.

Graph 11 - Acquisitions

1999

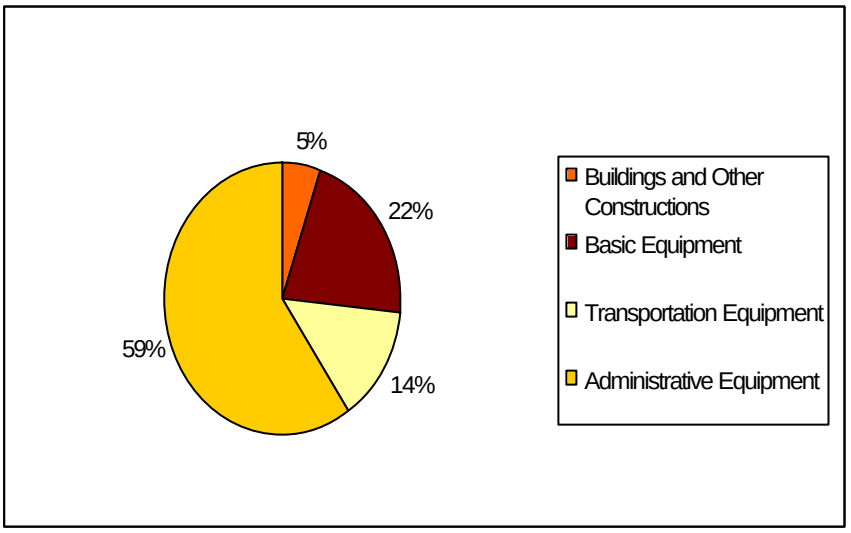


Source: SPTT.

Although the SPTT pursued the enlargement and reorganization of its network of services, the cost associated with the investment in Fixed Assets was almost negligible: € 4.114.356,75. This is due to the fact that the majority of the services operate in infrastructures ceded by the Santa Casa da Misericórdia, the General Direction of State Property, health services and town halls. On the other hand, there are not high needs for basic equipment (22% of the investment in fixed assets) as the treatment depends essentially on consumable goods. It can be seen that the investment expenditures were especially related with Administrative Equipment.

Graph 12 - Investment in fixed assets

1999



Source: SPTT.

It would be of all interest to compare the strategies of fund allocation followed by Public and Private Units. Nevertheless, it wasn't available descriptive data related to Private Unit's employment of granted funds.

It is only possible to describe both the size of the private treatment network and the number of patients receiving treatment in Private Units. Thus, in 1999, 41 Therapeutic Communities and 6 Detoxification Units provided services in the treatment intervention area on a contract basis to 2 357 and 2 304 drug addicts respectively. The private treatment area also included 3 Daily Centres.

14.5. Conclusions

The analysis of drug demand reduction expenditures on different policies and projects is crucial to the determination of its success and effectiveness. In fact, such analysis contributes to the establishment of a relationship between actual spending and outcomes.

Global drug demand reduction expenditure is the sum of public and private spending. Public spending is the sum of public entities' expenditures plus the amount of public funding of private entities. Nevertheless, the identification of drug demand reduction expenditures poses two problems: the strict definition of drug policies boundaries and drawing the line between drug demand and drug supply reduction activities. In some cases, it was not possible to estimate the proportion of drug demand reduction activities in the activities of some of the involved Ministries.

As to the public funding of private drug demand reduction projects, it is reasonably documented but in what concerns private spending, the incompleteness of financial data is much more serious. The estimation of the expenditures of publicly financed entities privately funded can be based on information about the importance (in percent terms) of the public funding. However, such estimation is not sufficient to solve the lack of information about the spending of non-subsidized private institutions.

The absence of crucial financial data renders impossible the estimation of the global drug demand reduction expenditure. The available data permits only an underestimation of the public spending on the area.

Efforts have to be made to ensure the periodical production of adequate, warrantable and comparable (in national and international terms) statistical information. The available financial data must allow the determination of the size of the expenditure of each entity and its allocation. If necessary, changes in information systems must be implemented in order to ensure more efficiency in operational terms and to support the decision making process at several levels and to allow a clear measurement of the national efforts to fight against drug (assessed as a function of the national GDP).

In the future, public and private entities publicly financed should be persuaded to present their financial indicators in such a way to facilitate this classification. It seems also important to establish a standard so as to guarantee the harmonisation and comparability of the data of different entities and the availability of indicators requested by national and international organisations.

Moreover, it is also important to gather all information about the part of each private or public institution that corresponds to the drug activity and the proportion of drug demand reduction activities publicly financed so as to estimate drug demand reduction expenditures. In what concerns non-subsidized private entities, it seems a much more hard task since this entities have no incentive to produce financial detailed data.

Finally, the analysis of the financial gathered data should be associated to the analysis of the evolution of the drug phenomena so as to evaluate the success of the drug policy, the progress made and the accomplishment of pre-defined measurable objectives.

14.6. Methodological information

In the collection of data, the difficulties concerned the dispersion of the data and the lack of detail of the public allocation of drug financial resources. The dispersion of data was due to the multiplicity of public entities with responsibilities in the drug demand reduction action plan. The lack of detail derived from confidentiality issues and from the fact that Ministries with wide responsibilities conducted the majority of public initiatives. In fact, the IPDT and the SPTT, which were created specially to deal with drug matters, had much more detailed information. In what concerns public initiatives, there were some problems both in the collection and in the analysis of the gathered information. Recently, efforts have been made to improve the Portuguese system of statistical information concerning the drug phenomena and its evolution: the IPDT's National Information System on Drugs and Drug Abuse. Likewise, the improvement of the system of collection, analysis and assessment of statistical information related with the allocation of financial resources directly related with drugs is urgent.

On the other hand, private initiatives, even when publicly financed, did not make available financial data related with the size and allocation of their expenditures. Only the amount of public financial support was documented. Information was neither available on the percentage that was financed by the Portuguese State nor the use of public funds.

Expenditure of private initiatives not funded through the public budget was not taken into account for this chapter.

15. Drug and alcohol use among young people aged 12-18

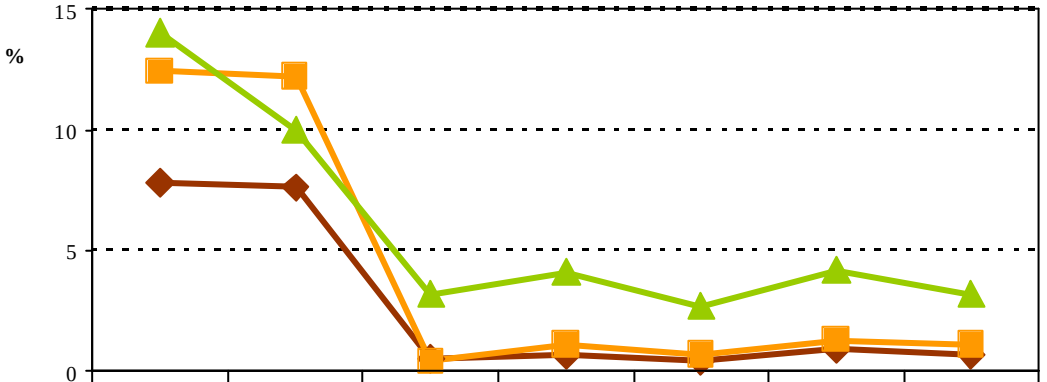
Drug use among young Portuguese populations has been regularly surveyed in recent years. Data from 2001 general population survey and national school surveys (3rd level of basic school and secondary school) are partially available, together with additional information from the national prison survey and the survey on minors under tutelage (due to delinquent behaviour). Qualitative research is also being developed but not yet available.

In order to follow recent trends it will be possible, at national level, to compare - in a rough way[16] - data from 2001 national school survey and the 1999 ESPAD, and - in a more precise way[17] - data from students born in 1983, in 1999 (when they were 16 years old) and in 2001 (when they were 18 years old). At local level, it will be possible to compare - again, in the same precise way[18] - 3rd level students data (grades 7th to 9th of basic school) from Greater Lisbon region (and municipalities) in 1998 and 2001.

15.1. Prevalence, trends and patterns of use

Both from the 2001 national population survey and from the 2001 national school survey, only preliminary data are available. This means that it will only be possible to compare global data (15-64 age group) with the 15-24 age group, within this the first survey, and with data from the 3rd level students, mostly (90%) from the 12-15 age group.

Graph 13 - Illicit drug use in Portugal 2001 - lifetime prevalence for the general and school population



	Any I. Drug	Cannabis	Amphet.	Ecstasy	LSD	Cocaine	Heroin
PS-(15-64)	7,8	7,6	0,5	0,7	0,4	0,9	0,7
PS-(15-24)	12,4	12,2	0,4	1,1	0,7	1,3	1,1
SS-(12-15)	14	10	3,2	4,1	2,7	4,2	3,2

Source: [Feijão2002] and [Balsa2002] Note: PS – general population survey; SS – national school survey

As graph 13 shows, lifetime prevalence of illicit drug use among young students is higher than in the general population in the specific 15-24 age group, for all substances but cannabis. *Differences between patterns of drug use related to the substances are quite evident*: either for the general population or for the specific

[16] Data come from different surveys using different data collection instruments, and relate to different target groups.

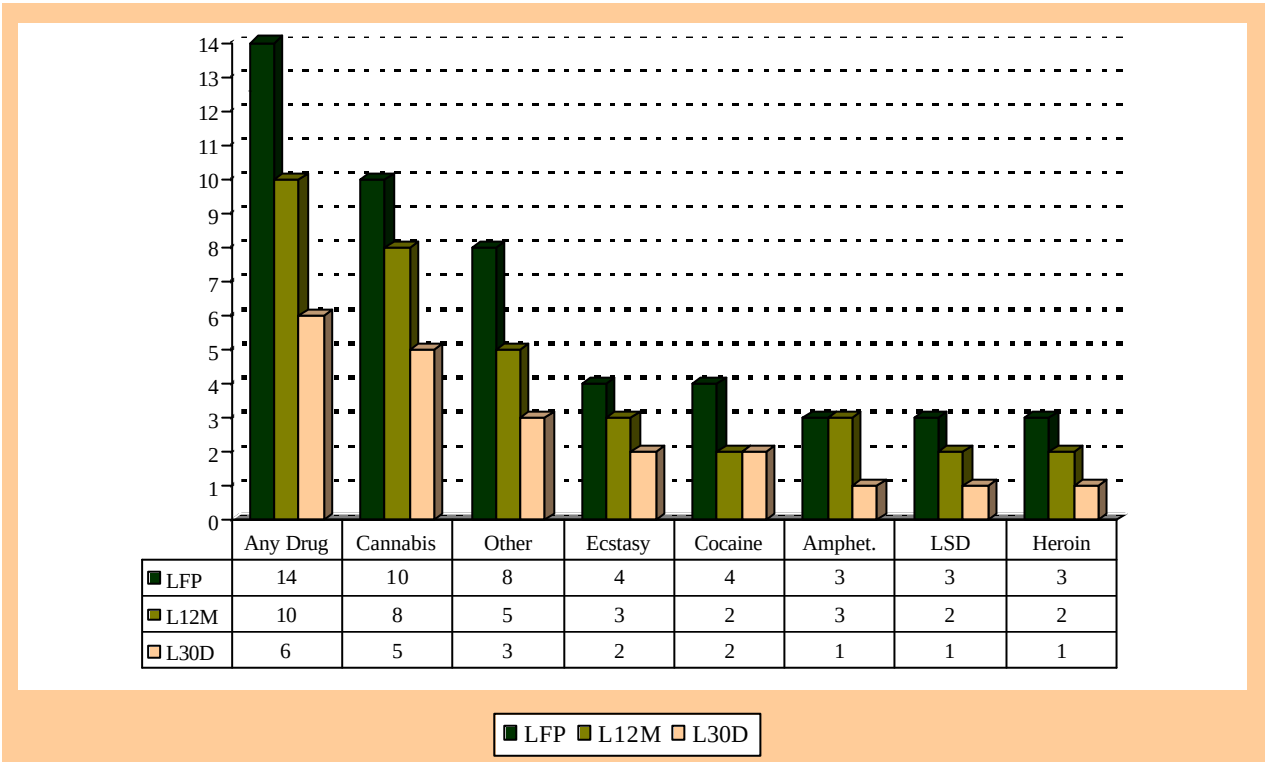
[17] Data come from different surveys using different data collection instruments, but refers to the same target group.

[18] Data come from different surveys using different data collection instruments, but refers to the same target group.

15-24 age group of the Portuguese population, cannabis is the only significant experience of drug use (8% of lifetime experience both for any drug and for cannabis); on the contrary, among young students, despite the fact that cannabis is the more experienced substance (10%), other drugs than cannabis were experienced by 8% of the students, meaning that 14% of all of them had some experience of drug use.

Similarly quite relevant, are the differences among recent and current use of the different illicit substances. Data from last-12-months and last-30-days prevalence (graph 14) show that differences between the different prevalence measures are smaller than they used to be in recent years, *probably suggesting that drug use is increasingly becoming part of daily life in this age group.*

Graph 14 – Illicit drug use in Portugal 2001 – lifetime, last 12 months and last 30 days prevalence (12-15 age group)



	Any Drug	Cannabis	Other	Ecstasy	Cocaine	Amphet.	LSD	Heroin
LFP	14	10	8	4	4	3	3	3
L12M	10	8	5	3	2	3	2	2
L30D	6	5	3	2	2	1	1	1

Source: [Feijão2002]

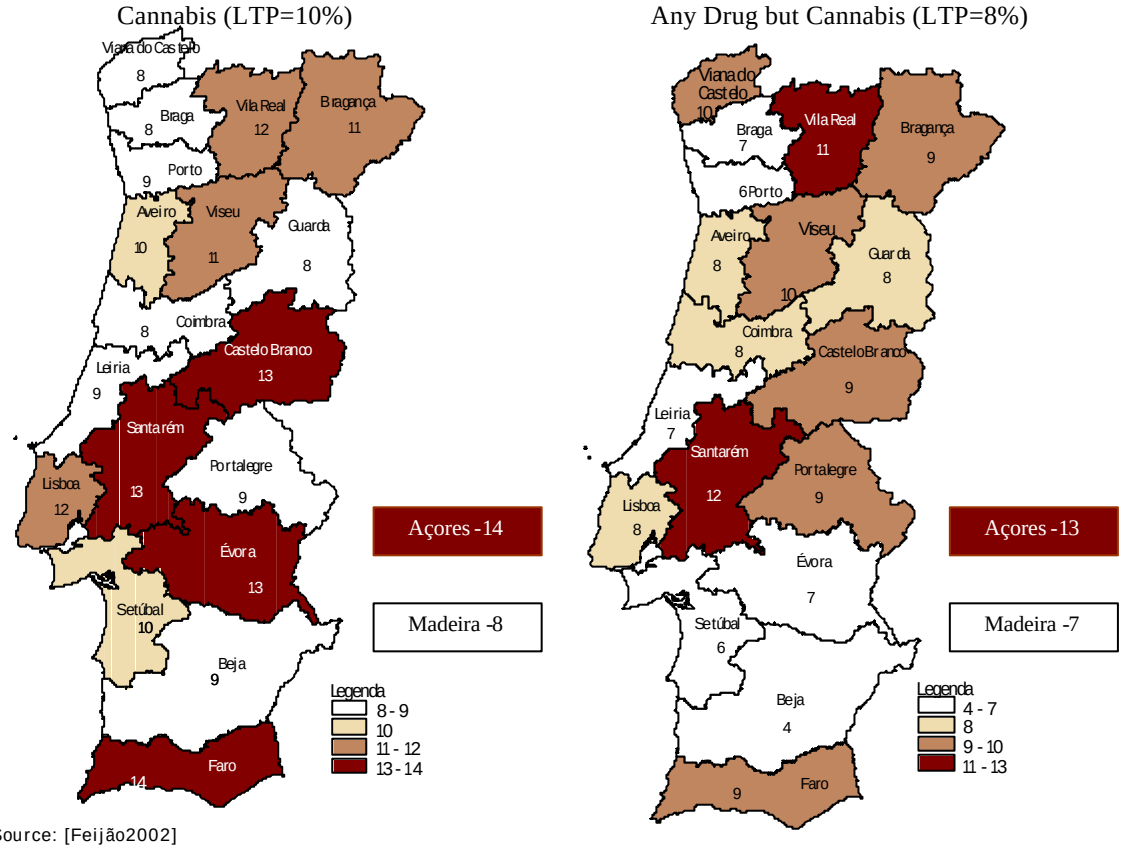
Comparing these results with those from the 15-24 age group of the general population, and despite the fact that 8% of them had recent use of drugs, this value was due to cannabis only (L12MP = 8%) as any of the other drugs had been used only by 1% or less of the adolescents or young adults. Among young students 10% tried some drug during last-12-months, 8% having used cannabis and 5% having used other drugs except cannabis.

The same conclusion can be drawn on recent use. The 6% of last-30-days prevalence in the 15-24 age group of national population was due to the 6% of young people using cannabis. Only about 0.5% of them used ecstasy or cocaine in that period.

These data seem to show that, despite the same figures for current and recent use of drugs in the two age groups, important differences surface when analysing prevalence for other drugs either than cannabis. This is quite evident when drug use is analysed at regional and local level.

This situation is very well documented in the Map 3, showing lifetime prevalence of cannabis and "other illicit drugs but cannabis" in all the districts of the country.

Map 3 – Illicit drug use in Portugal 2001 – Lifetime prevalence by district for cannabis and any drug but cannabis (12-15 age group)



Source: [Feijão2002]

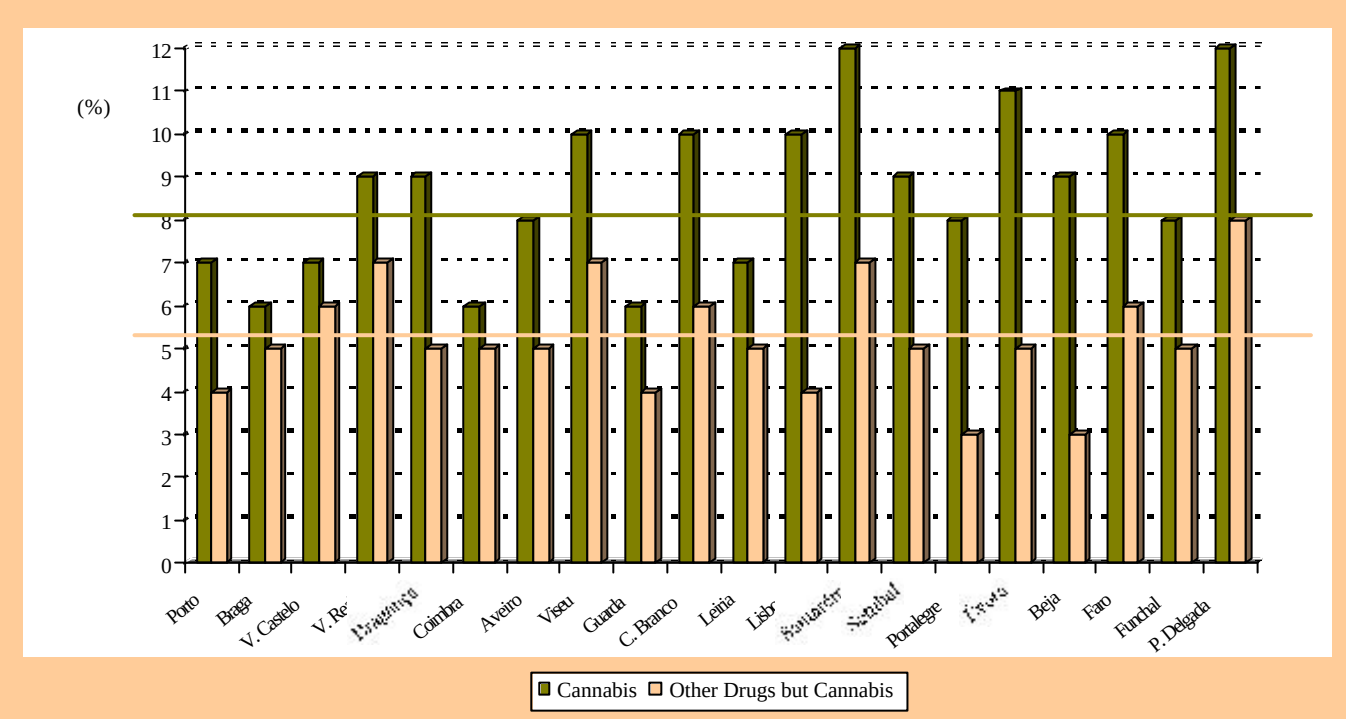
Differences between lifetime experience of cannabis and other drugs use in many districts are almost inexistent. Also quite evident are asymmetries at geographical level. *Regions where the prevalence is higher are no longer those of the most important urban areas* but those located inside the country near the North and North-East border of Spain, or in the South Atlantic border. *These are two of the most important conclusions of this survey*.

A new trend in drug use in Portugal might be surfacing: differentiation on the use of the substances, normalization of that use in recent and current use, and differentiation also at geographical level. In fact, not only in terms of more and less density of population (more urban areas vs. less urban areas) but also at regional level, there is no rule about which local area has more drug users: sometimes it is in the district capital, sometimes out of the district capital and sometimes both report similar values.

Analysing data within each distric, last-12-month prevalence range from 7% to 18%, the mean being 10%. It seems clear that, from the 4 districts where asymmetries are more relevant, two of them are in the Atlantic border (Porto, Aveiro) and the other two (Castelo Branco and Beja) are near the Spanish border.

In graph 15, recent use of cannabis and "other drugs but cannabis" is reported by district.

Graph 15 – Illicit drug use in Portugal 2001 – last 12-month prevalence: cannabis and any drug by district (12-15 age group)



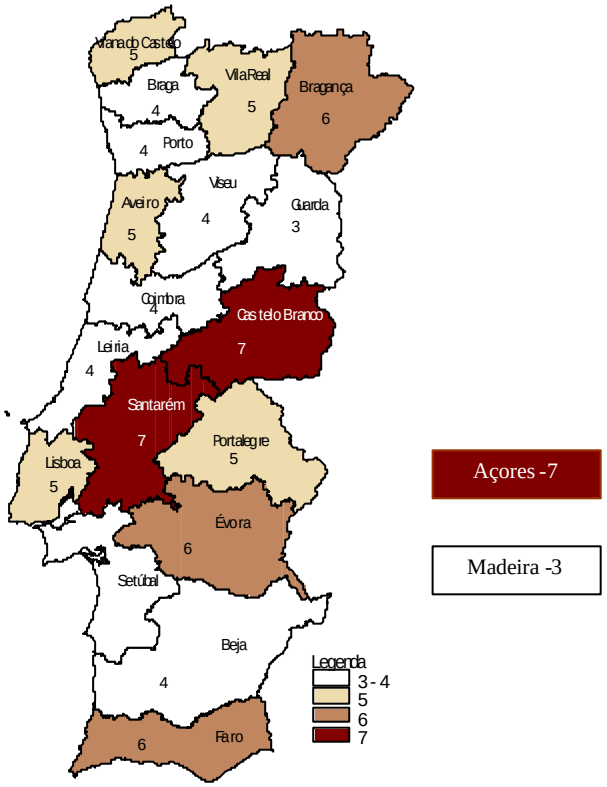
Source: [Feijão2002]

The relevance of the recent and current use of other drugs is clear all over the country, as also shown in Map 4.

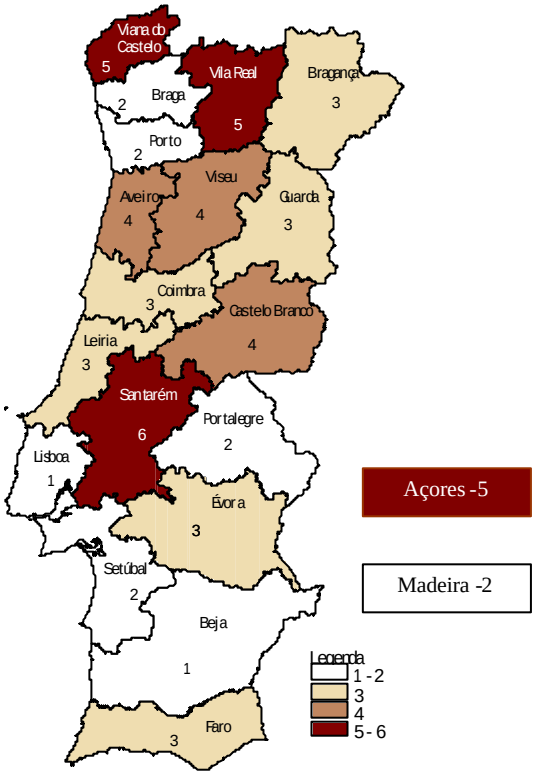
It is surprising to have, in some districts, 5 or 6% of young students with current use of other drug but cannabis as in 1999 ESPAD Survey, 6% was the average value of lifetime prevalence for this type of use. It seems, however, that where the values are higher, they are due to a specialization of drug use, meaning by it, that different users are trying different substances. For example, in Santarem, among the 6% of students using “other drugs”, 3% used cocaine, 3% used heroin, 2% used ecstasy, 2% used amphetamines, 2% used LSD, and 2% used magic mushrooms.

Map 4 – Illicit drug use in Portugal 2001 - last 30 days prevalence by district (12-15 age group)

Cannabis (L30DP=5%)



Any Drug but Cannabis (3%)

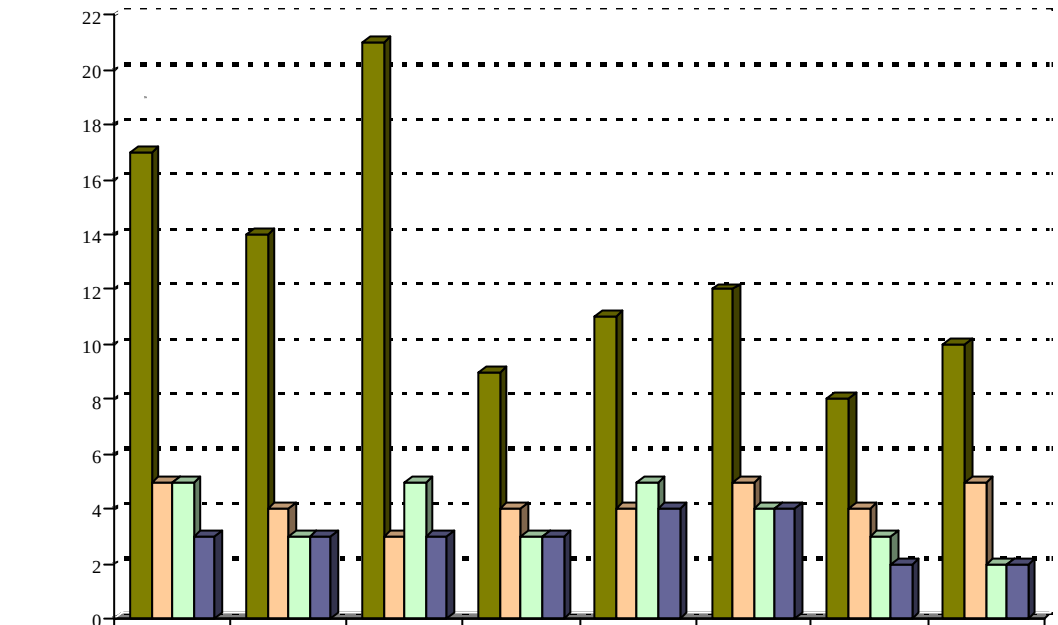


Source: [Feijão2002]

Despite the inexistence of a cutting pattern between urban and rural areas, it seems however that in Greater Lisbon (graph 16) it is possible to identify a more compatible pattern with what was expected to exist. In fact, high prevalence rates of lifetime drug use (20%, the national average being 14%) are mainly due to cannabis use (17%), and the 9% of other drugs use is also due to the specialisation of drug users as lifetime prevalence of the different substances is less than 5%, in the great majority of the cases.

The explanation for the highest figures found in some places in the countryside is not easy to find and may have different reasons. The spread of universities to almost all the cities that are district capitals, the development of an industry of night entertainment promoting the proliferation of dance clubs and pubs even in small cities, the existence of several rock festivals, rave parties, and boom and trance festivals (particularly in Spring and Summer), the recent increase of highways and good lanes that allow easy travel within the country and to Spain, the spread of cable TV and the Internet, placing Portuguese teenagers automatically in contact with last fashion lifestyles from Europe and USA, together with the freedom they are allowed and the fact that it is, now, much more easy to talk about drug use (mainly after the drug use decriminalisation law, which allow problematic drug users to be treated as patients and not, as in the past, as criminals) and, at last but not less relevant, the known existence of drug traffic in some specific regions could, all together, explain at least some of the extent of drug use.

Graph 16 – Illicit drug use in Portugal 2001 – lifetime prevalence in the municipalities of the Lisbon area (12-15 age group)



	Lisboa	Oeiras	Cascais	Sintra	Amadora	Odivelas	Loures	VFXira
Cannabis	17	14	21	9	11	12	8	10
Ecstasy	5	4	3	4	4	5	4	5
Cocaine	5	3	5	3	5	4	3	2
Heroin	3	3	3	3	4	4	2	2

Source: [Feijão2002]

A table with the prevalence for the age group 12-14 follows. This age group represents 76% of the sample of the 3rd level of basic school (grades 7th to 9th) in the national school survey. Data for the other requested age group (15-17) are not referred as they relate only to 14% of this sample. Only when results from the survey on secondary school students, is available (before the end of 2002) will it be possible to present reliable data for this age group.

Table 13 - Illicit drug use in Portugal 2001 - Prevalence in age group 12-14 (3rd level of Basic School)

Substances	Prevalences (12-14 age group)		
	Lifetime (%)	Last-12-months (%)	Last-30-days (%)
Any illicit drug	10	7	4
Any illicit drug but cannabis	6	4	2
Cannabis	7	5	3
Ecstasy	3	2	1
Amphetamines	2	2	1
LSD	3	1	1
Magic mushrooms	2	2	1
Cocaine	2	2	1
Heroin	3	1	1

Source: [Feijão2002]

From this table it is clear that the dimension of drug use in 12-14 age group is similar to the global one.

Information on patterns of use, set and settings, types of combinations and route of administration is available, not from qualitative research but also from school surveys. In fact, another point of particular interest from the national school survey is information about polydrug use assessed by the question about which substances students had used together in one same occasion, ***during last year***.

Among all students with some experience of drug use:

- *alcohol was associated* by 80% of them with tobacco, by 25% with cannabis, by 8% with ecstasy, by 7% with cocaine, or with inhalants or with tranquillisers or sedatives, by 6% with amphetamines or with magic mushrooms, and by 5% with LSD or with heroin;
- *cannabis was associated* by 37% of drug users with tobacco, by 25% with alcohol, by 7% with ecstasy, by 5% with tranquillisers/sedatives, or with amphetamines, or with ecstasy, or with LSD, or with magic mushrooms;
- *ecstasy was associated* by 12% of them with alcohol, by 8% with alcohol, by 7% with cannabis, by 5% with LSD, by 4% with amphetamines, or with inhalants, or with cocaine and by 3% of them with magic mushrooms , or with heroin;
- *amphetamines were associated* by 7% of drug users with tobacco, by 6% of them with alcohol, by 5% with cannabis, or with tranquillisers/sedatives, or with ecstasy, or with LSD, or with heroin, by 4% with magic mushrooms or with cocaine;
- *cocaine was associated* by 7% of drug users with alcohol, by 5% with heroin, by 4% with tobacco, or with cannabis, or with amphetamines, or with ecstasy; or with magic mushrooms, by 3% of them with tranquillisers/sedatives, or with LSD;
- *heroin was associated* by 10% of all drug users with tobacco, by 5% with alcohol, or amphetamines, or with cocaine, by 4% with magic mushrooms, and by 3% with cannabis, or with tranquillisers/sedatives, or with ecstasy or with LSD.

Considering that these are young students at an age of experimenting, it is not surprising to found such a diversity of situations. In fact, comparing the answers about the ***frequency of use*** among ***drug users*** during ***last-30-days***:

- *on cannabis* 7% of them declared to use it every day, 8% declared to use several times a week, 9% declared at least once a week, 13% less than once a week and 63% declared no use in last-30-days;
- *on amphetamines* 2% of them declared the use in each of the situations - everyday, several times a week, once a week, 4% less than once a week and 88% declared no use in last-30-days;
- *on ecstasy* 2% of them declared use either daily or several times a week, 3% declared once a week, 4% less than once a week, and 92% declared no use in last-30-days;
- *on cocaine:*
  - daily use: sniffed by 3%, inhaled by 3%, smoked by 4%, injected by 3%;
  - several times a week: sniffed 2%, inhaled 2%, smoked 2%, injected 2%;
  - once a week: sniffed 2%, inhaled 1%, smoked 2%, injected 1%;
  - less than once a week: sniffed 2%, inhaled 1%, smoked 3%, injected 1%;
- *on heroin:*
  - daily use: inhaled by 3%, smoked by 4%, injected by 3%;
  - several times a week: inhaled 2%, smoked 2%, injected 2%;
  - once a week inhaled 2%, smoked 2%, injected 1%;
  - less than once a week: inhaled 1%, smoked 2%, injected 1%;

Considering that only 14% of all students reported some experience of drug use, these use patterns are not problematic, in the sense that they concern only a small number of students.

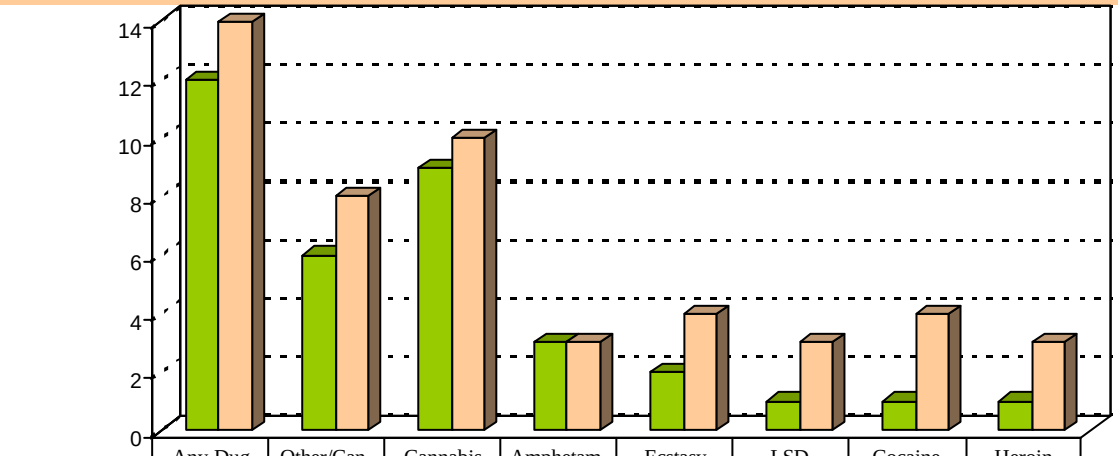
Looking at the ***places*** where drugs were used, in the ***last-12-months***, a question was addressed including 12 different places: at home, school, near school, street/gardens, bar/pub, discos, after-hours, concerts, raves, boom festivals, trance parties and rock festivals. Data show that, amongst those who answered to each item:

- *among those who used cannabis*:
  - 22% used it at home;
  - 70% used it at school, near the school or in street/gardens
  - 60% used it in some of the other places;
- *among those who used ecstasy*:
  - 30% used at home or near the school;
  - 30% used it at school, near the school or in street/gardens
  - 66% used it in some of the other places;
- *among those who used cocaine*:
  - 48% used it at home or near the school;
  - 51% used it at school, near the school or in street/gardens
  - 39% used it in some of the other places;

On the ***drug availability*** question from the **1999 ESPAD** survey, the percentage of 15-16 year old students who answer that it was "very easy" or "fairly easy" to get the different drugs was: 26% for cannabis, 21% for ecstasy, 19% for amphetamines, 14% for cocaine and heroin, 13% for LSD and 10% for magic mushrooms. Also in this survey, the most referred ***reasons for the first use*** were curiosity, the need top feel "high" and to forget problems.

As above referred it is only possible, at this moment, to compare data from the national school survey-2001, with ESPAD-1999, which is necessarily, a rough comparison as the target groups and the instruments of measure (questionnaires) are different, even if both surveys use national representative samples and the same methodological procedures at all the other aspects.

Graph 17 – Lifetime prevalence of illicit drug use (%) - 1999 - 2001



	Any Dug	Other/Can.	Cannabis	Amphetam.	Ecstasy	LSD	Cocaine	Heroin
ESPAD-1999	12	6	9	3	2	1	1	1
INME-2001	14	8	10	3	4	3	4	3

Source: [Feijão2002] Note: ESPAD99 Mainland Portugal (students born in 1983, in grades 8th to 10th); INME (National School Survey) Portugal, all students grades 7th to 9th

It seems clear that, despite all the cautions in comparing these two results, there is an increase in drug use prevalence, especially for other drugs than cannabis. Students from the national school survey are younger (76% age group 12-14) than those from ESPAD (aged 16 in the year of the survey).

It will be necessary to see if drug use patterns found in 3rd grade students will be similar among students from the secondary school and, in years to come, if the diversification and specialization in the drugs used, as well as the geographic diversity found in the national school survey-2001 are to be confirmed.

15.2. Health and social consequences

Among the health consequences of drug use, those related to ***acute deaths*** in young drug users concern the age group ***less than 20 years old***. During last 5 years there were 4 deaths in 1997, 8 in 1998, 6 in 1999, 4 in 2000 and 6 in 2001, in this age group, corresponding to about 2% of all the acute deaths related to drug use in each year.

On hospital emergencies or driving accidents, data are not available.

Concerning infectious diseases only data related to ***drug users infected by HIV*** virus are available. Among these, and in the age group "***less than 20***" since the beginning of the epidemic: 83 cases with AIDS (1.8% of all diagnosed cases), 29 with "complex related to AIDS (3.4% of all diagnosed cases) and 216 assymptomatic patients (4.4% of all diagnosed cases) were reported.

On ***social consequences at legal level***, during the last 5 years, 9 to 11% of all the individuals convicted for crimes related to the Drug Law were in the **age group 16-19**.

On young people with delinquent behaviour in State tutelage boarding schools, a recent research on 685 students (aged 9 to 18) [Lourenço2002], indicates that 39% of these individuals reported having used drugs, mainly cannabis (36%), followed by smoked or injected heroin (7%). In comparison to prevalence in the general population [Balsa2002] these problematic young individuals presents twice the lifetime prevalence of the general population for drug use in general (17% for general population) and for cannabis (16% for general population) and seven times higher for heroin (1% general population).

15.3. Demand and harm reduction responses

Please see Part II.

15.4. Methodological information

As stated above, when data from the representative sample of secondary school students is available (before the end of the current year) it will be possible to have global information on the complete age group of students.

Apart from these two samples (7-9th grades/3rd level of basic school and 10-12th /secondary), other representative samples will be built for each age group from 12 to 18 years old, in order to start having reliable data by age group and to enable trend follow-up by age group, over the years to come.

16. Social exclusion and re-integration

Social reinsertion of citizens with drug abuse problems is a relevant concern both in the National Strategy and in the National Action Plan and are founded in the following basic principles:

- The humanist principle which recognises "total dignity to individuals involved in drug problems" and states that availability to treatment and rehabilitation has to be ensured as well as "minimum quality" standards for the institution which implement those services;
- The pragmatism principle which aims at the incentive of harm reduction policies to optimise socio-professional rehabilitation of problematic drug users;
- The principle of coordination and rationalisation of human and financial resources;
- The participation principle which promotes the development of a network of private institutions offering services in the areas of treatment and social rehabilitation.

These principles which mark the new focus in the characterisation of individuals with drug use problems – a person in need of medical care, point towards a decisive objective which is to guarantee the indispensable means for treatment and socially (re)insertion and materialises the "State responsibility in the constitutional right to health" of these citizens.

Two other fundamental notions in this setting are the fact that reintegration in a part of treatment and that treatment is not completed unless reintegration is achieved, and that interventions should be centred simultaneously in the individuals and in the social setting which facilitates problematic behaviours.

The acquisition of social, individuals and professional skills is an indispensable means to the reinsertion of recovered individuals at family and labour level which will ultimately allow them to fully draw on their citizenship rights and duties.

16.1. Definitions and concepts

? **Reinsertion Apartments** - temporary residential units aiming at supporting drug users who are leaving inpatient treatment units or prisons with family, social, school or professional reinsertion problems. They are an intermediate means between inpatient care and complete autonomy.

? **"Drug Free" Units** - independent and protected prison areas where strongly psycho-social therapy oriented treatment is available.

? **Halfway Houses** - intervention units for individuals in prison who have been involved in treatment programmes in prison and comply with the legal criteria to spend the day outside of prison and report back at the end of the day.

? **Shelter (Atypical Response)** - specifically targeted at social exclusion situation such as drug abuse, alcoholism, infectious diseases, unemployment, homeless individuals, to create alternatives tailored to each individual and aiming at facilitating his/her social reinsertion. It usually offers services of day centres with occupational activities, night centres, meals, distribution of food and clothes, laundry and others;

? **Drop In Centres** - intervention units in areas with a higher number of problematic drug users to promote risk reduction behaviours, namely through information and counselling provision, referral to other services or programmes, including low threshold substitution programmes.

? **Motivation Centres** - transition units between the exclusion setting and/or shelters and a more structured therapeutic project. Preferably located far from more problematic use/traffic areas.

? **Outreach Work Units** - direct intervention units close to problematic drug users and their families and, in general, in problematic areas strongly affected by drug use. They aim at developing drug users integration in processes of recovery, treatment and social rehabilitation through counselling, awareness and referral.

? **Employment Units** - units to support long duration unemployed individuals with prior drug use problems to support their professional reintegration with the involvement of the civil society in employment promotion activities.

? **Insertion Community (Atypical Response)** - social response developed in residential setting comprising a set of integrated actions to promote social insertion of several excluded target groups, including drug users.

? Insertion Enterprise - positive discrimination employment policy to promote the socio-professional reinsertion of long duration unemployed individuals or individuals not prepared for the employment market through the creation of job opportunities, acquisition and development of social, professional and individuals skills, in labour areas with a demand market.

? **Special Professional Training** - Information and training sessions to promote socio-economic integration of target groups with specific needs through professional orientation, training, prevention/compensation of exclusion and social risk factors and specialised training for professionals who follow the processes.

? Drop In Unit (Atypical Response) - unit which guarantees temporary shelter to drug users in outpatient treatment programmes with no family support until his/her complete integration; special emphasis is placed on the follow-up and development of the clients' skills and autonomy accompanied by family counselling; These units also deliver basic hygiene, clothing and food services as well as counselling and referral to other services which may respond to specific clients' needs.

? Occupational Programme for the Underprivileged - provides temporary occupation to unemployed and underprivileged clients while a stable job or professional training alternatives and not available. Contact with other individuals in the same situation is encouraged thus avoiding isolation, lack of motivation and exclusion.

? Programme Vida Emprego (cf chapter 11.3.) - Specific measures which aim at developing social and professional reinsertion of ex-drug users as a fundamental and integrated part of drug abuse treatment. The programme develops awareness, professional training and socio-professional integration through 5 specific measures: mediation for training and employment, socio-professional training, socio-professional and financial incentives, employment support and self-employment support.

? **UNIVA** - Insertion in Active Life Unit. Set up in educational, professional training and other organisations. Aim at promoting the insertion/reinsertion of young people in co-operation with the employment centres, through guidance, placement, professional periods of training and professional training as well as other contact points with the labour market.

16.2. Drug use patterns and consequences observed among socially excluded population

In a recent research on 685 young people (aged 9 to 18) with tutelage processes (victims of abuse, deviant or criminal behaviour) [Lourenço2002], 39% of these individuals reported having used drugs, mainly cannabis (36%) followed by smoked or injected heroin (7%).

In comparison to prevalence in the general population [Balsa2002] these problematic young individuals presents twice the lifetime prevalence of the general population for drug use in general (17% for general population) and for cannabis (16% for general population) and seven times higher for heroin (1% general population).

16.3. Relationship between social exclusion and drug use

No data is available on this issue.

16.4. Political issues and reintegration programmes

The governmental agencies working in this area are the Portuguese Institute for Drugs and Drug Abuse (IPDT), the Institute for Employment and Professional Training (IEFP), the Institute for Solidarity and Social Security (ISSS) and the Institute for Social Rehabilitation (IRS).

The **IPDT** developed the National Framework for Rehabilitation (Programa Quadro Reinserir) since 1998 with the objective of supporting projects to develop socio-professional reinsertion activities for those who had been involved in drug abuse problems (cf. also chapter 11.3.). In conceptual terms, reinsertion within this framework is understood as a process which is initiated at the moment the drug user seeks treatment and is developed at the time his/her autonomy is rebuilt and his/her communication skills are consolidated is a process which will allow him/her to live in society, without open conflicts, with an integrated and adequate relational and professional life. Both needs assessment for the programmes and interventions and services are described in chapter 11.3. This Programme is developed in partnership with the **IEFP,** specialised treatment centres (CATs), municipalities, the **IRS** and NGOs. The number of promoting partners which co-operated in the several stages and activities of the programme – needs assessment, methodology development for candidate recruitment and selection, interchange of experiences/knowledge and professional staff, joint use of facilities and equipments, dissemination of activities and interventions, work division at the moment of implementation – was significant. The most commonly used methodologies for needs assessment were: experiences from previous projects, follow-up/evaluation of the target population, experience interchange with organisations working in the field, information collection from local organisations and the application of tests and questionnaires.

Drug users and ex-drug users in treatment and the two main groups vulnerable to risk behaviours/situations, followed by unemployed individuals, individuals in prison and young individuals who finish a treatment programme.

Another initiative at the **IPDT** in this area is the PIDDAC 2001 Programme (cf. also chapter 11.3.). The general objective is to promote and support reinsertion projects and programmes for individuals who have finished or are finishing drug abuse treatment programmes. The Programme funded adaptation or remodelling works in reinsertion units and the acquisition of equipments and transportation to reinforce the reinsertion units' capacity in the Lisbon and Tagus Valley area.

As above-mentioned, the **IEFP** is a partner of the **IPDT** in Programa Vida-Emprego since its implementation in 1998 (cf. also chapter 11.3.). The IEFP is responsible for the financial control of the programme and for the human and physical resources for its development. The general aim of the programme is to promote active and positive measures regarding the employment and training of drug users in order to develop their social and professional reinsertion and integrant and fundamental part of drug abuse treatment. The target group is drug users in professional active age who have finished or are finishing drug abuse treatment programmes, either in inpatient, outpatient or prison programmes as long as they have a positive referral from those programmes. This programme relies strongly in the role of mediators who mainly:

- Co-ordinate between the treatment units and the employers, the Employment Centres, the Training Centres and the public and private organisations which develop programmes and active measures for the training, insertion and employment of drug users;
- Ensure individual follow-up of each individual case;
- Participate in the motivation process for professional reinsertion, namely through the identification of main obstacles and the definition and support of each individual's personal training and reinsertion programme;
- Co-operates in awareness sessions for the general public, families, training organisations and employers;

Each mediator is responsible for the follow up of at least 15 and a maximum of 20 cases. The promoting organisations may be specialised treatment centres (public or private as long as certified by the SPTT), prisons, public health services and municipalities.

The **ISSS** conceptualises, supports, funds and evaluate outreach work programmes and reinsertion apartments, insertion communities, shelters and drop-in units as described in 16.1.

The **IRS** supports and follows-up insertion measures for presumed offenders and convicted individuals if not in prison as well as processes which pose alternatives to prison for drug users (cf. chapter 12.2.).

16.5. Methodological information

The main methodological limitation felt in this area is the lack of research and information on it. The inexistence of in-depth research on the problematic of social rehabilitation of individuals with problematic licit and illicit drug use is a major gap in the field of demand reduction responses at national level.

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Data base: software used, Internet addresses

SPSS, SQL Server 2000, Access, ArcoView and Excel software used for databases, GIS and data analysis.

http://www.ipdt.pt

http://www. parlamento.pt/legis/governo/progr_XV_gov.html

EDDRA: http://www.reitox.emcdda.org:8008/eddra/

http://www.ccpes.min-edu.pt

Annex

Drug monitoring systems and sources of information

No changes in the reporting period. In 2001, the National Information System for Drugs and Drug Abuse at the IPDT and its partners (see last year's National Report for full description) focused on the quality of data collection and analysis.

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List of Abbreviations used in the text

CAT - Centro(s) de Atendimento de Toxicodependentes/Specialised Treatment Centres (Ministry of Health/SPTT)

CCPES - Comissão de Coordenação da Promoção e Educação para a Saúde/Co-ordination Commission for the Promotion of Health Education (Ministry of Education)

CDT - Comissão para a Dissuasão da Toxicodependência/Commission for the Dissuasion of Drug Use

CEJ - Centro de Estudos Judiciais/Centre of Judicial Studies

CIAC - Centros de Informação e Acolhimento/Centres of Information and Counselling (Ministry of Health/SPTT)

CVEDT - Centro de Vigilância Epidemiológica das Doenças Transmissíveis/Epidemiological Surveillance Centre of Transmissible Diseases (Ministry of Health)

DGSP - Direcção-Geral dos Serviços Prisionais/General Directorate for Prisons (Ministry of Justice)

EDDRA - *Exchange on Drug Demand Reduction Action*

EMCDDA - European Monitoring Centre for Drugs and Drug Addiction

ESPAD - European School Survey Project on Alcohol and other Drugs

GDP - Gross Domestic Product

IDUs - Intravenous Drug Users

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

IPDT - Instituto Português da Droga e da Toxicodependência/Portuguese Institute for Drugs and Drug Addiction (Presidency of the Council of Ministers in the reporting period)

IPSS - Private Charity Institutions

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

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

NGOs – Non-Governmental Organisations

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

SPTT - Serviço de Prevenção e de Tratamento da Toxicodependência/Service for the Prevention and Treatment of Drug Abuse (Ministry of Health)