



European Monitoring Centre
for Drugs and Drug Addiction



**2012 NATIONAL REPORT (2011 data) TO THE
EMCDDA
by the Reitox National Focal Point**

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

REITOX

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

This year report describes the national situation in 2011 as well as new developments and trends regarding 2012. The report is divided in three main parts: summary, new developments and trends and selected issues.

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

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Summary

Part A: New development and trends

Drug Policy: legislation, strategies and economic analysis

The current economic crisis that Europe is experiencing, with direct implications in our country, led to the adoption of measures of rationalization and containment of public expenditure, which resulted in the reduction of human and financial resources compromising the performance of the mission of IDT, I.P.

Also, on the second semester of 2011, the activity of IDT, I.P. was defined by the instability caused by the announcement of the governmental decision to extinguish the IDT, I.P. on the context of the PREMAC (Plano de Redução e Melhoria da Administração Central) and the creation of a new structure within the Ministry of Health, SICAD – Directorate General for Intervention on Addictive Behaviours and Dependencies, in charge of planning and monitoring programs of reduction of use of psychoactive substances, prevention of addictive behaviours and reducing dependencies. The implementation of interventions will lie on the competence of the Regional Health Administrations (ARS).

The mission of SICAD is to promote the reduction of use of psychoactive substances, the prevention of addictive behaviours and the reduction of dependencies.

The external evaluation of the National Plan on Drugs and Drug Addiction 2005-2012 is taking place now and the final report will be presented in December 2012, which will include recommendations for the next policy cycle.

The final report of the internal evaluation of both Plans (Drugs and Alcohol) will be presented by the end of 2012 for approval of the Inter-ministerial Council.

Drug use in the general population and specific targeted-groups

In the Strategic cycle initiated in 2005, were carried out several national epidemiological studies that allowed trend analysis and comparability of the national situation at the European and international context, namely in the general population (2007 and 2012, results not yet available for 2012), in prison population (2007), in school populations (2006, 2007, 2010 and 2011) and in the driving population (2008-2009).

In the study conducted in 2007 in the Portuguese General Population (15-64), cannabis, cocaine and ecstasy were the illicit substances preferably used by the Portuguese with lifetime prevalence (at least one use experience) of 11,7% for cannabis, 1,9% for cocaine and 1,3% for ecstasy). Between 2001 and 2007, despite the increase in lifetime prevalence's (of any illicit drug from 8% to 12%) it was verified a stability in the prevalence of use of any drug in the last month (2,5% in 2001 and 2007) and a decrease in continuity rates of use (of any drug passed from 44% to 31%). In 2007, Portugal was among the European the countries the one with the lowest prevalence of drug use with the exception of heroin.

In the context of school populations, the results of national studies have shown that the use of drugs that had been increasing since the 90's declined for the first time in 2006 and 2007, noting up in 2010 and 2011 again an increase of drug use in these populations, alerting to the need for investment in prevention. In all studies carried out in 2010 and 2011, cannabis remains the drug preferentially used (prevalence of lifetime use ranged from 2.3% in students from 13 years old and 29.7% in 18 years old), with values close to the prevalence of use of any drug (between 4.4% in students of 13 years and 31.2% in 18 years). Followed by

prevalence of lifetime use far below, cocaine, ecstasy and amphetamines among younger students, and amphetamines, LSD and ecstasy among the older ones. Despite the increases registered in the prevalence of drug use between 2006/2007 and 2010/2011 especially cannabis but also other drugs such as LSD and amphetamines, the prevalence's of use of any drug among younger students (13-15 years) remain lower (short) than the ones registered in 2001/2003.

Despite the increase of drug use in this the end of strategic cycle, the perception of the risk of regular drug use among students increased, considering the Portuguese students more risky that use than the European average.

Prevention

During 2011, the intervention in the mission area of prevention followed the task to achieve the main strategic goals defined in previous years: prevent the beginning of psychoactive substance use, prevent the continue use and abuse and the transition from use to abuse or misuse and dependence. To achieve them, activities were planned in accordance with operational objectives of the Action Plan Against Drugs and Drug Addiction 2009-2012:

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

During 2011, it was verified a diversification of intervention contexts (family, school, professional schools and training centers, care institutions for children and youth, university setting, workplace, recreational settings, prison setting, community), at universal intervention level as well as selective and indicated, and in some cases this intervention was complementary and covered individuals in different spheres of their life.

In the education system, there was a strengthening in the articulation with the Ministry of Education, and other health structures, with the use of universal prevention strategies combined with more focused interventions.

The prevention structures gave technical support, throughout all its stages, to projects and programs developed in partnership between IDT, I.P. and other structures of local and regional community, particularly in programs of school and family context and interventions in recreational and university context (articulated with the Harm Reduction area).

There was throughout the country a strong investment in selective and indicated prevention interventions, focused in groups, individuals and contexts that presents an increase risk for the use/abuse of substances, particularly in the implementation of personal and social competence training programs in the vocational and alternative curricular education and the creation of selective and indicated prevention appointment spaces thus contributing to the strengthening of a Teenagers Appointment System in articulation with the Treatment Mission Area. Such has been developed through appointments with psychosocial support for teenagers and young people with consumption of psychoactive substances, particularly cannabis.

In 2011, Program of Focused Intervention Final Report was concluded, evaluating interventions and the implementation of the program, having published a document with the conclusions. These documents were widely disseminated by managers and professionals of IDT, I.P. It was also finalized a Catalogue of Best Practices in Prevention, which includes a set of projects selected from among those in PIF, complemented with projects with final evaluation developed under Operational Program of Integrated Responses (PORI) - they all have characteristics that confer quality at methodological level, evaluation process and results.

Support was provided to carry out research work with the Psychology University of Porto under the ambit of intervention held in 2010 at the Boom Festival, through information collected in Kosmicare (an emergency service developed at Boom Festival, whose purpose was to intervene in the crisis resulting from the use of psychedelic substances). This study was concluded and a joint document was prepared, Report of Process Evaluation of Kosmicare intervention, which will certainly be useful for future interventions in the same context and for the preparation of the intervention in other festive and recreational contexts.

Among the projects supported by NP professionals, we highlight the intervention in the Casa Pia de Lisboa, in addressing youth in institutionalization situation, looking for suitable management models of problematic situations and strengthening factors that promote resilience and the project Euridice within the working environment, promoting awareness about psychoactive substance consumption.

The year 2011 also included the final evaluation and possible continuation of projects developed under PORI, in addition to maintaining all the procedures involved in the process of follow-up, monitoring and evaluation of these projects. It was also enhanced the integration of responses to alcohol use in our teams, (elaboration of training modules, extending the intervention to festive contexts).

In the context of FESAT, IDT, I.P. participated in the elaboration of guidelines for the dissemination of best practice, which are available as an end product of the Leonardo da Vinci – Mobility Project.

Problem Drug use

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

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

Drug-related treatment: treatment demand and treatment availability

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

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

In 2011 continuity was given to the articulation with other health care resources and socio-sanitary conditions of public and private sectors, in order to improve the answers to the multiple needs of users with problems associated with the consumption of psychoactive substances. It is also to highlight the orientation for the quality of services provided.

It should be noted that in 2010 came into implementation at national level the Multidisciplinary Information System (SIM) of the IDT, I.P., implying methodological changes

particularly in the registration criteria and the potential in data results. These changes were reflected, among others, in the register of medical appointments and the possibility of exclude double counting at national level and individuals with alcohol related problems.

Heroin remains the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures but references to alcohol, cocaine and cannabis in this setting are increasing. In the administration of the main substance continues to be predominant the mode smoked/snorted.

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

Clients in Outpatient treatment were mainly from the male gender (83% to 84%), aged 25-34 (29% to 31%) and 35-44 (29% to 39%), varying the mean age between 33 and 35 years old.

This year for the second time it was possible to have TDI data fully in line with EMCDDA TDI Protocol. 2011 national **first treatment demand data** concerned 5 900 individuals from the **outpatient** public network centres (78) from these population only 2 265 are Drug Users.

Health Correlates and Consequences

The National Action Plan on Drugs and Drug Addiction 2005-2012 includes among its objectives a specific reference to the need of reducing the number of users of psychoactive substances, as well as health and social risks associated, being foreseen an action to promote the counselling, diagnosis and referral of infectious diseases within drug users population to be implemented until 2012.

Concerning infectious diseases among IDUs, ever injectors (lifetime) in outpatient treatment centres in 2011, the positivity values for HIV was 16.48%, (19.48% in 2010), Hepatitis B 4.26%, (5.80% in 2010), Hepatitis C 79.65% (90.73% in 2010)

In the ambit of HIV/AIDS infection diagnosis (identified by notifications) maintains the proportional downward trend of the cases associated to drug addiction in the different stadiums of the infection, as well as the continuous decrease through the years of new cases diagnosed with HIV associated to drug addiction.

In 2011, were registered 10 cases of drug-related deaths, representing the lowest value since 2006 and a decrease of 62% in relation to 2010 (27) in the General Mortality Register (GMR - Selection B of the DRD Protocol). The values registered in 2009, were the highest since 2003, but inferior to the ones registered in 2002 (year when ICD-10 was implemented in Portugal).

Following a strategic recommendation of the Action Plan on Drugs 2009-2012, as well as the implementation of procedures to improve the quality of the national mortality statistics, from 2008 start to be presented data from the national mortality statistics of National Statistics Institute, simultaneously was intensified the work on optimizing the information coming from the National Institute of Forensic Medicine (INML, I.P.) As result of the articulation between IDT, I.P. and INML, I.P., for the third year it is possible to provide information from the INML, I.P. on overdose cases.

Responses to Health Correlates and Consequences

The Harm and Risk Reduction model implemented in Portugal, aims to propose, through integrated work, to users who are unable or unwilling to renounce drug use, help to reduce harm they cause themselves through alternatives paths that lead to treatment facilities and therefore a gradual process of stabilization and organization, which may allow the recovery process.

In collaboration with organizers of summer festivals, IDT, I.P. intervened, nationally, in 26 summer festivals. This intervention is part of a strategy of information and awareness to participants in these events, for better management of risks potentially associated with use of licit and illicit substances.

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

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

Social Correlates and Social Reintegration

The National Plan on Drugs and Drug Addiction 2005-2012, includes objectives and actions (see Structured Questionnaire 28), based on integrated approaches centred on the users' needs, its characteristics and personal path, on the nature and level of dependencies of psychoactive substances, adapting the strategies of intervention to the psychosocial diagnosis of the person and to ensure his liaison with social systems network. While the user approach aims to enable his integration, with the social systems the objective is to reverse the subjective factors, which are a significant obstacle to the emergence of opportunities and possibilities of integration, developing integrated strategies for the systematic monitoring of the relationship between the parties.

In 2011, in the context of economic crisis and social exclusion and poverty growing, and when public and private funding is being cut for social interventions, the main priority of IDT, I.P. was to strengthen the agreements and protocols previously signed, reinforcing partnerships and guidelines to provide more focused integrated responses to the at risk population.

Therefore in 2011, IDT,I.P. strengthened the Agreements and protocols already signed with local bodies, trade unions, Private Institutions of Social Solidarity, the Social Security Institute (ISS), the Institute of Housing and Urban Renovation to adapt and improve the quality of the existing resources and responses, so they can serve effectively the real users needs in housing, education and employment. An example is the Protocol signed in 2007 by IDT,I.P., the ISS and Santa Casa da Misericórdia, an integrated response that includes care, counseling, referral and resource allocation, that allowed in 2011 for the referral of 1 031 drug users. As for the field of employment, Programa Vida Emprego (Life Employment Program – PVE) that aims to provide an employment to drug users in treatment process in therapeutic community, outpatient or in prison settings, involved in 2011 1243 persons in reintegration process.

Drug related Crime

In 2011, concerning the administrative sanctions for drug use, Commissions for the Dissuasion of Drug Use (CDT) instated 6 898 processes, representing a slight decrease (-6%) in comparison to last year, most of which were, again, referred by the Public Security Police (PSP), National Republican Guard (GNR) and Courts.

Concerning criminal offences, in 2011, the number of presumed offenders was very similar to last year and the last three years registered the highest values since 2002.

Court data indicates that despite the annual variations in the number of processes, of individuals accused and convicted under the Drug Law, there is a decreasing trend in the first half of the decade, on the other hand a slight increase in the second half, is expected that the

data update in 2011 next year, reflects an increase of processes of individuals accused and convicted relatively to 2010.

Prison data indicates a 6% increase in the number of individuals in prison for crimes against the Drug Law, representing an increase of 6% in relation to 2010. It is noted in the last four years a stability in the number of inmates convicted under the Drug law, although with lower values than those registered in previous years. Once more was reinforced the trend initiated in 2000, of the decrease weight of these prisoners in the universe of the convicted prisoner population, representing on the 31st of December 2011 near 20% of these population. The majority of these individuals where convicted for traffic (90%), 9% for minor traffic and 1% for traffic-use, percentages that falling within the partners of last years.

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

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

Drug Markets

The year 2011 consolidates the majority of the trends verified in previous years in terms of various indicators in the markets context.

Remains the trend expressed over the decade of cannabis predominance and the increased visibility of cocaine in these contexts. In the case of heroin after a clear downward trend at several (various) indicators observed during the first half of the decade, followed by a stability in the second half, in 2011 turn to reduce its visibility in some indicators. The indicators related with the possession of several drugs confirm the stability trend occurred in the second half of the decade and several indicators concerning (on) possession of other drugs registered increases in 2011 although continues with residual relative values.

For the tenth consecutive year, hashish was the substance involved in a higher number of seizures (3 093), reinforcing the trend initiated in 2005, and once more the number of cocaine seizures (1 386) was superior to heroin (1 169). However, it should be noted that, in general, the values recorded in the two previous years (last two years) were the highest since 2002.

In comparison to 2010, increases were registered in the seized quantities of liamba, heroin and cocaine but on the other hand (instead) decreased the quantities of ecstasy and hashish. Despite the annual fluctuations the trends expressed in the previous decade showed increases in the seized quantities of cocaine, hashish and liamba in the second half of the decade (2006-2010) compared to the first half (2001-2005), contrarily to the decreases observed in the case of heroin and ecstasy.

Concerning countries of origin of the seized drugs in 2011, stood out in the ambit of international trafficking: the Netherlands and Pakistan in the case of heroin, Brazil and Bolivia in the case of cocaine, South Africa in the case of liamba and once more Morocco in the case of hashish. Although the majority of drugs seized and with information on routes intended for the domestic market, remains a significant number of seizures that had as final destination other countries, especially European – with particular emphasis to Spain, maintaining the trend of Portugal to be a transit point on international trafficking, particularly for cocaine.

Regarding the prices of drugs, at trafficker and trafficker-user level, they didn't registered relevant changes in relation to 2010, with the exception of cocaine that registered an

increase. Despite the annual variations, since 2002 there has been a downward trend in the average prices of heroin and ecstasy, and a upward trend of liamba and cocaine, and stability in the average price of hashish (although with slightly higher values in the second half of the decade).

Part B Selected Issues

Drug Policies of large European cities

The municipality of Lisbon, city of 564.657 inhabitants, develops a regular activity in the drugs field. Since 1990, with the creation of the Municipal Plan of Drug Prevention, the City Council considered a priority to involve the 53 parishes, the private institutions of social solidarity, the local institutions and the Central Administration in the definition of an integrated intervention focusing mainly on the prevention of risk behaviours, the implementation of risk and harm reduction measures, aimed at risk populations as youngsters, elderly and homeless.

Fostering networking and inter-institutional collaboration, the City Council (CML) have trough out the years defined a strategy aimed at transforming Lisbon into a city designed for its inhabitants, open, intercultural and showing solidarity, where outreach work is available in the deprived neighborhood and specific programs/facilities are funded for the drug users population.

Residential treatment for drug users in Europe

Historically, in Portugal, TC's were always in the frontline in what concerns responding to drug abuse. Since the mid – 70's, when a first public response to emerging drug problems was implemented, two TC's were created (in Lisbon and Coimbra), as part of a set of treatment modalities to drug abusers. The next decade saw the appearance of private TC's, mainly inspired by "Le Patriarche" movement, who stood aside of the public treatment services. Later, with the development and integration of public responses to drug related problems in one single structure – IDT, IP, a new framework for TC's licensing and operation was devised, in which preservation and enhancement of ethical, legal, and scientific - based criteria were the main concern. Since then, a wide network of professional units covered the country' needs in what concerns residential treatment.

As a result of its history as specific modalities of intervention in drug addiction, exists several "models" or programs exists (hierarchical, democratic, religious inspiration – Catholic, Protestan or other, Minnesota, 12 steps, Portage and others), accepted as valid methods for treatment.

In what concerns models of intervention, only in the 90's, within the framework provided by public policies and institutions encompassing all the intervention on drug addiction, integrating private and state institutions, that professional TC's and scientific – based methods of treatment could flourish, and "take the ground". Binded to the respect of minimal standards and quality criteria depicted in the law, the spread of professional TC's occurring in the last two decades entailed a diversification of scientific – controlled intervention models and conceptual frameworks. Thus, from the initial two public TC's until nowadays, new forms of intervention on residential treatment were implemented.

Patients that undertake residential care are an older population with a significant number of years of addiction, presenting a severe psychiatric and physical co-morbidity and a long path in different help and care structures and services leading to an overall feeling of frustration and helplessness, creating a group of "veterans" with great difficulty on building up a healthy and adequate life style.

One challenge related with this is the need to adjust the therapeutic programs to these situations and at the same time fidelity to the program, in order to increase the program efficiency.



Part A

New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Introduction

The current economic crisis that Europe is experiencing, with direct implications on our country, led to the adoption of measures of rationalization and containment of public expenditure, which resulted in the reduction of human and financial resources compromising the performance of the mission of IDT, I.P.

Also, on the second semester of 2011, the activity of IDT, I.P. was defined by the instability caused by the announcement of the governmental decision to extinguish the IDT, I.P.¹, on the context of the PREMAC (Plano de Redução e Melhoria da Administração Central) and the creation of a new structure within the Ministry of Health, the SICAD – Directorate General for Intervention on Addictive Behaviours and Dependencies, in charge of planning and monitoring programs of reduction of use of psychoactive substances, prevention of addictive behaviours and reducing dependencies. The implementation of interventions will lie on the competence of the regional health administrations (ARS).

The mission of SICAD is to promote the reduction of use of psychoactive substances, the prevention of addictive behaviours and the reduction of dependencies.

SICAD has the following assignments:

- a) Support the member of Government responsible for the elaboration of the national strategy and of policies for reducing the use of psychoactive substances, prevention of addictive behaviours and reduction of dependencies and their evaluation;
- b) Plan and evaluate the programs of prevention, risk and harm reduction and treatment of psychoactive substances, addictive behaviours and dependencies, namely the definition of standards, methodologies and requirements to ensure quality;
- c) Plan the intervention on addictive behaviours and dependencies, through a network of primary care, centres of integrated responses and in patient or outpatient facilities, depending on the severity of the addiction or the use of psychoactive substances;
- d) Develop and promote the scientific research on psychoactive substances, addictive behaviours and dependencies, maintaining an information system on drugs and addictions phenomenon;
- e) Develop effective mechanisms for planning and coordinating the definition of policies for the interventions on addictive behaviours and dependencies;
- f) Perform diagnosis of the needs for interventions at national level, define priorities and the type of intervention to develop;
- g) Define the technical and normative guidelines for the intervention in addictive behaviours and dependencies;
- h) Promote training in psychoactive substances, addictive behaviours and dependencies;
- i) Ensure the collection, treatment and dissemination of data and information from public and private bodies with intervention in psychoactive substances, addictive behaviours and dependencies;

¹ See Decree Law 124/2011, December 29 – Adopts the Organic Law of the ministry of Health

- j) Ensure international representation in its field of expertise and specific assignments, without prejudice of the competences of the Ministry of Foreign Affairs, as well as ensuring the obligations as National Focal Point of the European Information Network on Drugs and Drug Addiction of European Monitoring Centre for Drug and Drug Addiction, coordinating with Directorate General of Health, as the body responsible for the international relations of the Ministry of Health;
- k) Provide technical and administrative support and ensure the necessary structures for the functioning of the Commissions for Dissuasion;
- l) Define the requirements for the licensing of private units providing health care in the field of dependencies and addictive behaviours.

The decision to extinguish IDT, I.P. coincided with the end of the cycle of the national policy on drugs and alcohol, initiated with the evaluation of the National Plan on Drugs and Drug Addiction 2005-2012 (PNCDT) and the National Plan for Reducing Alcohol Related Problems 2010-2012 (PNRPLA) – See chapter 1.3

1.2 Legal Framework

Law 13/2012 of 26 March 2012

Amends for the nineteenth time the Decree Law No. 15/93 of 22th January which approves the legal regime applicable to trafficking and consumption of narcotic drugs and psychotropic substances, adding tapentadol and mephedrone to the attached tables.

Law 11/2012 of 8 March 2012

Establishes the new rules for prescribing and dispensing medicines, proceeding to the sixth amendment to the legislation on medicinal products for human use, approved by Decree-Law 176/2006 of 30 August and the second amendment to Law 14/2000 of 8 August. This change establishes the mandatory inclusion of the International Common Denomination (ICD) in the medicines prescriptions and the authorization for pharmacists to recommend generic medicines.

Order n. ° 8816/2012 of 3 March 2012

Defines the Departments of the General Directorate on Addictions and Behaviours -Health Ministry.

Administrative Rule 46/2012 of 13 February 2012

First amendment to the Administrative Rule N. ° 198/2011 of 18 May, which establishes the legal framework that obeys the rules of electronic prescription of medicines.

Decree Law 17/2012 of 26 January 2012

Approves the structure of the General Directorate for Intervention on Addictive Behaviours and Dependencies

Decree Law 124/2011 of 29 December 2011

Approves the new structures within the Health Ministry and creates the General Directorate for Intervention on Addictive Behaviours and Dependencies, extinguishing the IDT, I.P.

1.3. National action plan, strategy, evaluation and coordination

The National Coordination Structure for Drugs, Drug Addiction and Alcohol Related Problems

Following the restructuring in 2010 of the National Coordination Structure for the Fight of Drugs and Drug Addiction, now the Inter-ministerial Council for Drugs, Drug Addiction and Alcohol Related Problems², 2011 was marked by the total re-nomination of the members of the Inter-ministerial Technical Commission³.

The Inter-ministerial Technical Commission is composed of representatives of the Ministers composing the Inter-ministerial Council for Drugs, Drug Addiction and Alcohol Related Problems and following elections in June 2011, after which a new government took place.

The National Coordinator asked for re-nomination of the technical commission members.

The newly created Licit Substances' Regulation and Supervision Subcommission was particularly active in the study of addressing objectives set on the National Plan for the Reduction of Alcohol Related Problems who demand for legislative bills as well as smart shops and legal highs which were a case of concern in 2011.

External Evaluation of the National Plan on Drugs 2009-2012

The National Plan on Drugs and Drug Addiction 2005-2012 sets for an external evaluation, to be carried by an independent institution. It determines that the external evaluation team must incorporate, if judged necessary, international experts.

The Action Plan 2009-2012 schedules that the terms of reference should be drafted in 2009-2010 and that the call-for-tender should take place by 2010, with the public presentation of the external evaluation report to take place in 2012.

Within the Inter-ministerial Technical Commission it was decided in 2009 that the terms of reference should be drafted by an external consultant, and thus a call-for-tender had to be called in 2009, resulting in that the external consultant started its work by mid-2010.

However, the terms of reference for the launching of the external evaluation call-for-tender were considered unsuitable, and thus, early 2011, at the demand of the Inter-ministerial Technical Commission, IDT, I.P. drafted new terms of reference and the call-for-tender programme. The terms of reference and the call-for-tender programme were approved by the Inter-ministerial Technical Commission at their meeting on October 2011 and on November 22nd it was published in *the* Official Journal "public contracts" section. Due to the new law on public spending, the launching of the call-for-tender was preceded by pre-budgeting the amount to spend.

Under the Portuguese law, public contracts are subject to strict rules, being mandatory that the procedure be submitted on an electronic platform.

It was considered that it would be impossible to evaluate and compare candidates based on their evaluation proposal, should quarrelling over decision making take place, but that it was possible to compare technical capacity, the inclusion on the scientific team of international experts, as well as team members experience and capability on selected areas.

² The Inter-ministerial Council is chaired by the Prime Minister and integrates the Ministers with intervention on drugs, drug addiction and alcohol related issues as well as the National Coordinator for Drugs, Drug Addiction and Alcohol Related Problems. It appreciates, approves and proposes to the Council of Ministers the National Strategy; the multiannual and annual Action Plans and the National Strategy evaluation report. It also ensures the inter-ministerial articulation of policies developed by the ministries with competence on drugs, drug addiction and harmful use of alcohol.

³ The Inter-ministerial Technical Commission supports technically the Inter-ministerial Council decisions and is chaired by the General-Director of SICAD, who is also the National Coordinator for Drugs, Drug Addiction and Alcohol Related Problems. It is composed by Ministers' representatives, closely associated with Ministers' Cabinets. Its core mandate is to design, monitor and evaluate the National Plan on Drugs and Drug Addiction (2005-2012), the Action Plan on Drugs and Drug Addiction (2009-2012) and the National Plan for the Reduction of Alcohol Related Problems.

Therefore, and due to the very short calendar set out on the Action Plan on Drugs and Drug Addiction 2009-2012, it was decided that the program of the call-for-tender should be two fold, with a pre-approval of candidates, which would only be admitted to the second phase should they get at least 65 points on a scale of 100.

Also, it was set that the team should encompass specialists from five key areas, health, quantitative methods, management, criminology and political science.

It was also set that the maximum price should be 150.000 € and that the maximum delay for presenting the final report was 250 calendar days, counted from the adjudication date.

Finally, it was determined that candidates should present an environmental certificate.

Punctuation was given to all items, based on which candidates would be ordered. Should two or more candidates get the same punctuation, the technical capacity of the proposed team should be assessed on a case by case to resolve situations where candidates have the same punctuation.

As for the terms of reference, they comprised the mandatory characteristics of the external evaluation, the nature of the relationship of the external consultant with the Technical Commission Subcommittee on Monitoring and Evaluation, as well as the deliverance of preliminary and final reports, executive summaries in three languages (Portuguese, English and Spanish) and the furnishing of data bases and data collection instruments.

A steering group to evaluate candidates and decide upon the winner proposal was set, comprising two members of the Inter-ministerial Technical Commission and three experts from IDT, IP.

The mandatory characteristics of the external evaluation are, no doubt, the most important piece of the terms of reference. They were drafted after an in-depth process of consulting with the members of the Inter-ministerial Technical Commission and IDT, I.P. managers and were subjected to the valuable expertise of European Monitoring Centre for Drug and Drug Addiction (EMCDDA). EMCDDA inputs were accepted in order that scope was narrowed.

The external evaluation will thus cover the mandatory following scope:

1. Evaluation of the objectives set on the National Plan on Drugs and Drug Addiction 2005-2012, focused on the strategic options of specific areas: citizen's centrality, territoriality, integrated approaches and quality improvement and certification mechanisms. Deviations occurred should be highlighted.
2. Impact evaluation, by comparing epidemiological indicators and responses in Portugal, with those of two other countries, chosen from two pre-determined groups, Spain, France or Italy, and Norway and Switzerland. This impact evaluation should consider the evolution of drug consumption as well as health consequences and services offered to diminish health consequences derived from drug consumption.
3. Cost-benefit analysis of the financing of integrated responses programs, with a pre-determined counterfactual, pulverized and disperses interventions.
4. Evaluation of the efficiency, efficacy and quality of interventions on key aspects of all vectors of demand reduction and supply reduction strategic axis.

The external evaluation of the National Plan on Drugs and Drug Addiction 2005-2012 is taking place now and the final report will be presented in December 2012, which will include recommendations for the next policy cycle.

Internal Evaluation of the Action Plan on Drugs and Drug Addiction 2009-2012 and National Plan for the Reduction of Alcohol Related Problems

The internal evaluation of the Action Plan on Drugs and Drug Addiction 2009-2012 and the National Plan for the Reduction of Alcohol Related Problems proceeded in 2011 based on the Inter-ministerial Technical Commission Subcommittees, which address the following areas:

- Monitoring and evaluation;
- international cooperation;
- public expenditures;
- communication, information and training;
- data and research;
- prevention, harm reduction, treatment and reintegration;
- drug addictions' dissuasion;
- intervention in school and university;
- labour, recreational and road settings;
- illicit substances supply reduction;
- Licit substances' regulation and supervision.

The whole process is subject to the supervision of the Technical Commission Subcommittee on Monitoring and Evaluation (chaired by the National Drugs Coordinator), which met in 2011 to review the terms of reference of the internal evaluation.

It was decided that the internal evaluation will cover a process and a results evaluation, as well as SWOT analysis.

The process and results evaluation will be based on the filling up of the Action Plan on Drugs and Drug Addiction 2009-2012 matrix.

Data collection will cover January 2009 to December 2011, and events and actions will cover January 2009 to June 2012.

Should the Subcommittees signal non planned events and actions, those should be marked as such (non-planned).

The final report of the internal evaluation of both Plans (Action Plan on Drugs and Drug Addiction 2009-2012 and National Plan for the Reduction of Alcohol Related Problems) will be presented by the end of the year 2012 for approval by the Inter-ministerial Council for Drugs, Drug Addiction and Alcohol Related Problems.

The National Council on Drugs, Drug Addiction and Alcohol Related Problems⁴

The National Council on Drugs, Drug Addiction and Alcohol Related Problems held no meetings in 2010.

The final report of the internal evaluation of both Plans (Drugs and Alcohol) will be presented by the end of 2012 for approval of the Inter-ministerial Council.

⁴ The National Council is an advisory body, chaired by the Prime Minister, who can delegate on the Member of Government responsible. It is composed of representatives from 23 constitutional organs and public and private institutions such as: Government of the Autonomous Regions of Madeira and Azores, Mayors Association, Judges Council, General Public Prosecutor, University Deans, Churches and Religious Communities, Caring and NGO's, Youth Council, Students, Parenting Associations, Family Federation, Journalists Union, and since 2010 representatives from Alcohol Industry and Commerce.

1.4. Economic analysis

The internal evaluation of the Action Plan on Drugs and Drug Addiction (2005-2009), incorporated a Public Expenditure analysis for the years 2006 to 2008. This exercise highlighted the need to devote further work into the way public institutions carry on their accounting, especially when their core activity is not limited to the field of drugs.

In view of the fact that most institutions were not able to furnish labelled and unlabelled expenditures for actions achieved, the 2009-2012 Action Plan coordination area created a Subcommittee on Public Expenditures.

It was expected that the work undertake at the Public Expenditures Subcommittee gathered aggregated information on the implementation of the Action Plan on Drugs and Drug Addiction 2009-2012, but due to the major reform promoted by the Government in the Central Administration it was not possible to get aggregated information on public expenditures.

Budget

There is no State budget rubric for drug and drug addiction policy. Each of the ministries that implement the National Plan on Drugs and Drug Addiction 2005-2012 are granted rubric for the development of their activities (on an annual basis).

The public administration body with the largest budget for drugs and drug addiction policy is the Ministry of Health's Institute on Drugs and Drug Addiction, but the Institute has, since 2006, an enlarged mandate that encompasses alcohol related problems. Therefore its budget is now allocated for drugs, drug addiction and alcohol related problems in the fields of national coordination, international cooperation, data and research, communication, information and training, prevention, harm reduction, treatment and reintegration.

The budget's amount approved in 2011 was 72.276,354 Euros, of these 43.590,403 were transferred from the Portuguese State budget.

The Ministry of Defence runs the Program for Drug and Alcohol Prevention and Fighting in the Armed Forces, which budget allocation amounted to 626,587 Euros. Please see sub-chapter 2.4. for more information on this Program.

The Ministry of Employment and Social Security also runs several programs aimed at supporting drug addicts under treatment, by supplying resources to buy medicines, for instance, as well as drug addicts recovery associated costs such as housing. In some cases funds are allocated through NGO's.

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

2.1. Introduction

In the Strategic cycle initiated in 2005, were carried out several national epidemiological studies that allowed trend analysis and comparability of the national situation at the European and international context, namely in the general population (2007 and 2012, results not yet available for 2012), in prison population (2007), in school populations (2006, 2007, 2010 and 2011) and in the driving population (2008-2009).

In the study conducted in 2007 in the Portuguese General Population (15-64), cannabis, cocaine and ecstasy were the illicit substances preferably used by the Portuguese with lifetime prevalence (at least one use experience) of 11,7% for cannabis, 1,9% for cocaine and 1,3% for ecstasy). Between 2001 and 2007, despite the increase in lifetime prevalence's (of any illicit drug from 8% to 12%) it was verified a stability in the prevalence of use of any drug in the last month (2,5% in 2001 and 2007) and a decrease in continuity rates of use (of any drug passed from 44% to 31%). In 2007, Portugal was among the European the countries the one with the lowest prevalence of drug use with the exception of heroin.

In the context of school populations, the results of national studies have shown that the use of drugs that had been increasing since the 90's declined for the first time in 2006 and 2007, noting up in 2010 and 2011 again an increase of drug use in these populations, alerting to the need for investment in prevention. In all studies carried out in 2010 and 2011, cannabis remains the drug preferentially used (prevalence of lifetime use ranged from 2.3% in students from 13 years old and 29.7% in 18 years old), with values close to the prevalence of use of any drug (between 4.4% in students of 13 years and 31.2% in 18 years). Followed by prevalence of lifetime use far below, cocaine, ecstasy and amphetamines among younger students, and amphetamines, LSD and ecstasy among the older ones. Despite the increases registered in the prevalence of drug use between 2006/2007 and 2010/2011 especially cannabis but also other drugs such as LSD and amphetamines, the prevalence's of use of any drug among younger students (13-15 years) remain lower (short) than the ones registered in 2001/2003.

Despite the increase of drug use in this the end of strategic cycle, the perception of the risk of regular drug use among students increased, considering the Portuguese students more risky that use than the European average.

Results from national study implemented in 2007 in the prison population showed that cannabis, cocaine and heroin are the substances with higher prevalence of use in these population, as in the prior imprisonment context (respectively 48,4%, 35,3% and 29,9%) as in prison (respectively 29,8%, 9,9% and 13,5%). Between 2001 and 2007, a generalised decrease was verified in the prevalence's of drug consumption in both contexts, but more accentuated in the prison context. To note the important reduction of intravenous drug use in relation to 2001, in prior imprisonment context (27% in 2001 and 18% in 2007) and prison context (11% in 2001 and 3% in 2007), it wasn't possible to repeat the study to assess the evolution in the end of this strategic cycle. For more information concerning this study please see chapter 9.5 of this Report.

In 2005 was also conducted a periodic study (not repeated in the end of this cycle) that allows to analyse the tendencies and the comparability in the European context about estimations on problematic drug use in Portugal, that indicate that there are between 6.2 and 7.4 problematic drug users for each 1 000 inhabitants aged 15-64 years, and between 1.5 and 3.0 for injecting drug users. Between 2000 and 2005, the estimate number of problematic drug users in Portugal has shown a clear decline, with special relevance for injecting drug users. For more information concerning this study please see chapter 4 of this Report.

For the first time in Portugal, was conducted in this strategic cycle an epidemiological study on the prevalence of alcohol, drugs and medicines in drivers in general and in wounded or death drivers in traffic accidents, inserted in a European project. In drivers in general the prevalence of use of any illicit drug was 1.57%, being the most prevalent drug cannabis (1.38%). The prevalence of opiates was 0.15% and of cocaine 0.03%. Portugal presented a prevalence of use of any illicit drug inferior to the European average (1.89%) despite the prevalence of cannabis being very identical and opiates higher than the European average. Portugal registered a prevalence of alcohol in association with other psychoactive substances (0.42) slightly above the European average, and association of psychoactive substances without alcohol (0.23%) below this average. In the drivers that died in traffic accidents, the more prevalent illicit drugs in Portugal were cannabis (4.3%) and cocaine (1.4%) with values higher values than the other three countries taking part in this study, with the exception of Norway that presented a higher prevalence of cannabis. In contrast the prevalence of amphetamines was zero, contrarily to the other countries where was the most prevalent illicit drug. Regarding the associations of these substances among the four countries in this study, Portugal registered the second lowest prevalence of associations' with alcohol (6%) and the lowest prevalence of associations without alcohol (0.4%).

2.2. Drug use in the general population

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

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

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

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

In 2007, alcohol and tobacco were the most widespread psychoactive substances used by the Portuguese population aged from 15 to 64. The most widespread illicit trade drugs were cannabis, cocaine and ecstasy (the prevalence's of use at least once in lifetime were 11,7% for cannabis, 1,9% for cocaine and 1,3% for ecstasy). Use of other illicit drugs was less common, apart from heroin, which prevalence of use at least once in lifetime was 1,1%.

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

	2001	2007
Prevalence of use at least once in lifetime		
Alcohol	75,6	79,1
Tobacco	40,2	48,9
Tranquilizers or sedatives	22,5	19,1
Any illicit drug	7,8	12,0
Cannabis	7,6	11,7

Cocaine	0,9	1,9
Amphetamines	0,5	0,9
Ecstasy	0,7	1,3
Heroin	0,7	1,1
LSD	0,4	0,6
Hallucinogenic Mushrooms	--	0,8
Prevalence of use in the last 12 months		
Alcohol	65,9	70,6
Tobacco	28,8	30,9
Tranquilizers or sedatives	14,4	12,0
Any illicit drug	3,4	3,7
Cannabis	3,3	3,6
Cocaine	0,3	0,6
Amphetamines	0,1	0,2
Ecstasy	0,4	0,4
Heroin	0,2	0,3
LSD	0,1	0,1
Hallucinogenic Mushrooms	--	0,1
Prevalence of use in the last 30 days		
Alcohol	59,1	59,6
Tobacco	28,6	29,4
Tranquilizers or sedatives	11,0	9,9
Any illicit drug	2,5	2,5
Cannabis	2,4	2,4
Cocaine	0,1	0,3
Amphetamines	0,1	0,1
Ecstasy	0,2	0,2
Heroin	0,1	0,2
LSD	0,0	0,1
Hallucinogenic Mushrooms	--	0,1

Table 1 – Portuguese Population (15-64 years old): Lifetime Prevalence by type of drug 2001-2007 (IDT, I.P. 2009)

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

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

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

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

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

Prevalences Type of Drug	Lifetime		Last 12 Months		Last 30 Days	
	2001	2007	2001	2007	2001	2007
Any Drug	7,8	12,0	3,4	3,7	2,5	2,5
Cannabis	7,6	11,7	3,3	3,6	2,4	2,4
Heroin	0,7	1,1	0,2	0,3	0,1	0,2
Cocaine	0,9	1,9	0,3	0,6	0,1	0,3
Amphetamines	0,5	0,9	0,1	0,2	0,1	0,1
Ecstasy	0,7	1,3	0,4	0,4	0,2	0,2
LSD	0,4	0,6	0,1	0,1	0,0	0,1
Hallucinogenic Mushrooms	–	0,8	–	0,1	–	0,1

Table 2 – Portuguese Population (15-64 years old), Lifetime, Last 12 Months and Last 30 days Prevalence by type of drug (IDT, I.P. 2009)

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

Most drug users only consume one illicit drug (75,5%). Around 11% use two substances and 6% three substances. Cannabis is the most used drug. The most frequent combinations of substances are cannabis and cocaine (3,8%) and cannabis, cocaine and heroin (3%).

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

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

Regional analyses show that Algarve and Lisbon are the regions that present higher (above the national average) prevalence's of lifetime and last month use of any illicit substance for the total population and for young adult population.

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

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

Also the general pattern of evolution of lifetime prevalence use between 2001 and 2007 was maintained on the whole, at regional level, both in the total population and amongst young adults, to state between the exceptions, the decrease of heroin use in the North, in Lisbon

and in Azores (in these two last regions only in terms of the young adult population), and the decrease of lifetime prevalence use of all the illicit substances in Madeira (except the increase of cocaine use in the young adult population).

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

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

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

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

Gender analysis shows lifetime prevalence and last month use higher in men for all drugs. The preferential pattern of use of the Portuguese population - first cannabis followed by cocaine and ecstasy maintained in both genders in general and young adult population. The pattern evolution between 2001 and 2007 remained in both genders, among the exceptions a decrease in the prevalence of heroin lifetime use in women in young adult population and the decrease of cannabis prevalence and stabilisation of cocaine use in last month in women of both populations.

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

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

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

2.3. Drug use in the school and youth population

In this strategic cycle several national studies in school populations were conducted, all inserted in projects started before 2005: in 2006 the Health Behaviour in School-aged Children (HBSC/OMS⁵) (6.^o/8.^o/10.^o grades) and INME⁶ (3^o Cycle and Secondary), in 2007 the European school survey project on alcohol and other drugs (ESPAD⁷) (16 years old students) and Estudo sobre o Consumo de Álcool, Tabaco e Drogas/Study on Alcohol, Tobacco and Drug Use (ECTAD) (students from 13 to 18 years old) and again in 2010 the HBSC/OMS and in 2011, the INME, ESPAD and ECTAD.

Studies carried out between 1995 and 2003 – ESPAD in 1995, 1999 and 2003, the HBSC/OMS in 1998 and 2002, the INME in 2001 and ECTAD in 2003 – showed in general a widespread increase of drug use during that period. All these studies presented much higher

⁵ Portugal integrates the HBSC/OMS - Health Behaviour in School-aged Children - since 1996 and is an associate member since 1998. National data of these studies are published (Matos et al., 2000; Matos et al., 2003; Matos et al., 2006; Matos et al. 2010).

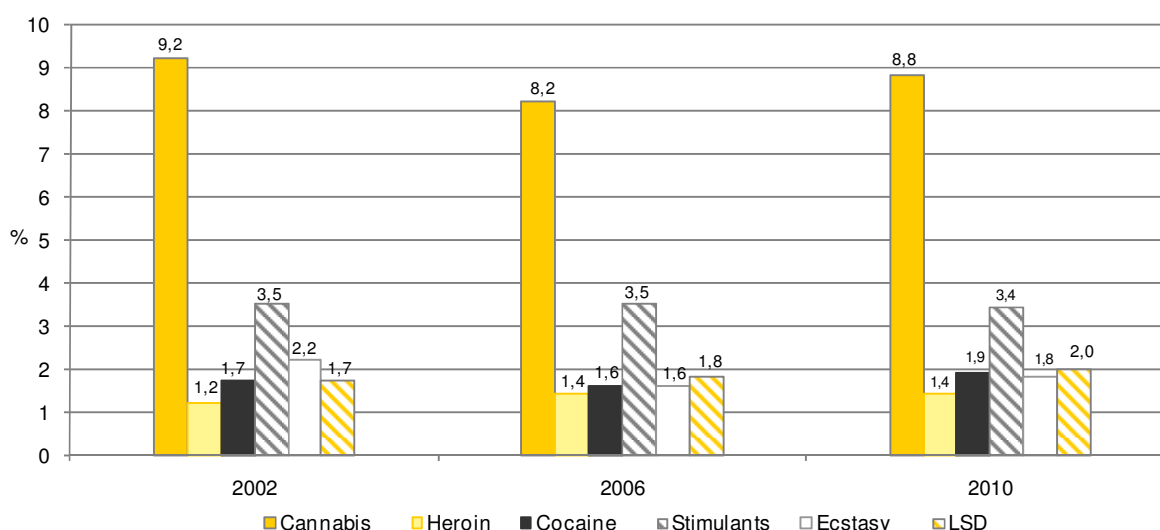
⁶ O INME - Inquérito Nacional em Meio Escolar – was conducted by the first time in 2001 by the IDT, I.P. and was repeated in 2006 and 2011.

⁷ Portugal is part of ESPAD – European School Survey Project on Alcohol and Other Drugs since 1995.

prevalence's of cannabis use than other drugs. After the generalized increase of drug use in the period between 1995 and 2003, 2006 and 2007 studies revealed consistently decreases in drug use prevalence's.

In 2006 results from HBSC/OMS and INME showed decreases in drug use respectively between 2002-2006 and 2001-2006, emerging once more cannabis as the drug with higher prevalence of use. In HBSC/WHO, cannabis, stimulants and LSD appeared with the higher lifetime prevalence's of use highlighting the prevalence decreases of cannabis and ecstasy in relation to 2002. However there were subgroups that didn't had this declining trend of cannabis use, particularly the younger ones and the ones with lower socioeconomic status. In the INME, cannabis, cocaine and ecstasy appeared with the the highest prevalence of lifetime use among students of the 3rd cycle, and cannabis, ecstasy and amphetamines, with the highest prevalence among Secondary students. It was noted between 2001 and 2006 a decrease in the prevalence of use of all drugs, in the students of 3º Cycle and Secondary. There was also a decrease in the last month prevalence in these two groups of students with some exceptions from Secondary students.

In 2007, ESPAD and ECTAD results reinforced the downward prevalence trend of drug use seen in 2006. In ESPAD once more cannabis appeared with higher lifetime prevalence of use and with a value very close to lifetime prevalence of any drug. Between 2003 and 2007 it should be noted the decrease of lifetime prevalence use in several illicit substances. In ECTAD once more cannabis stood out with higher lifetime prevalence's in all ages followed by cocaine (except in 18 years old where ecstasy prevalence was slightly higher than cocaine). In general, lifetime prevalence use of different drugs varied in direct ratio of the ages. Between 2003 and 2007, there has been a decrease in the prevalence of lifetime use of any drug at all ages. It is however noted that the prevalence of use of any drug mainly reflect the prevalence of cannabis use and at the level of other substances not always occurred this evolution pattern in all age groups, like in the increase of lifetime prevalence of cocaine, amphetamines and heroin between 17 and 18 years old students.

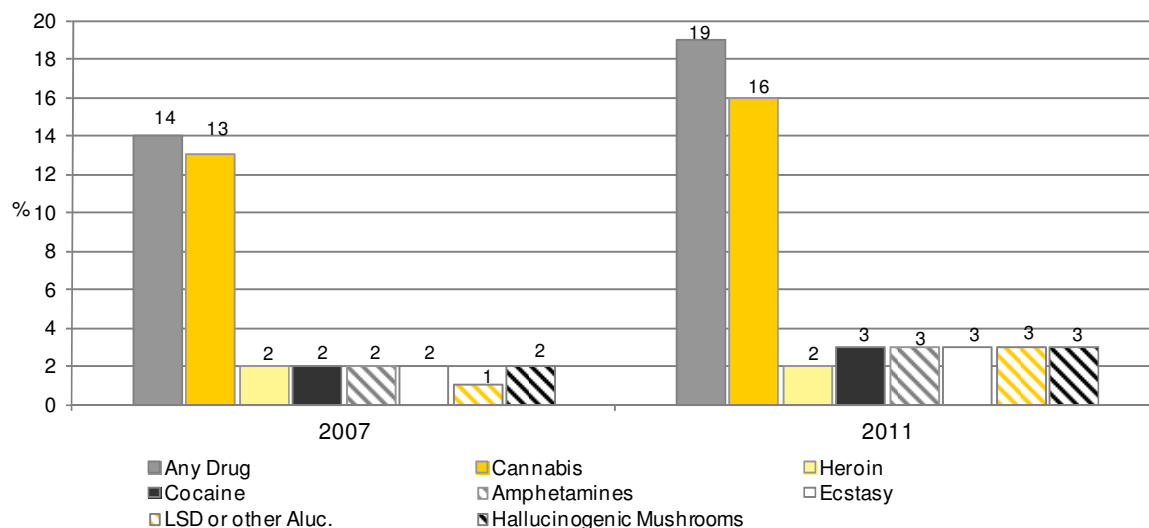


Graph 1 – School Population – HBSC/WHO (students of 6º/8º and 10º grades): Lifetime Prevalence's of use, by type of drug (IDT, IP. 2011)

In 2010, the results of the HBSC / WHO showed an increase in the prevalence of use (Graph 1) between 2006 and 2010, after the decrease occurred between 2002-2006. As in 2006, cannabis, stimulants and LSD had in 2010 the highest prevalence of lifetime use

(respectively 8.8%, 3.4% and 2%). Between 2006 and 2010 there were increases in the prevalence of lifetime use of various substances - particularly cannabis (from 8.2% to 8.8%) - as well as the prevalence of drug use in the last month (4.5% in 2006 and 6.1% in 2010).

In 2011, the ESPAD, ECTAD and INME results reinforced this increasing trend of prevalence use, between 2007 and 2011 in the first two and between 2006 and 2011 in the last one.



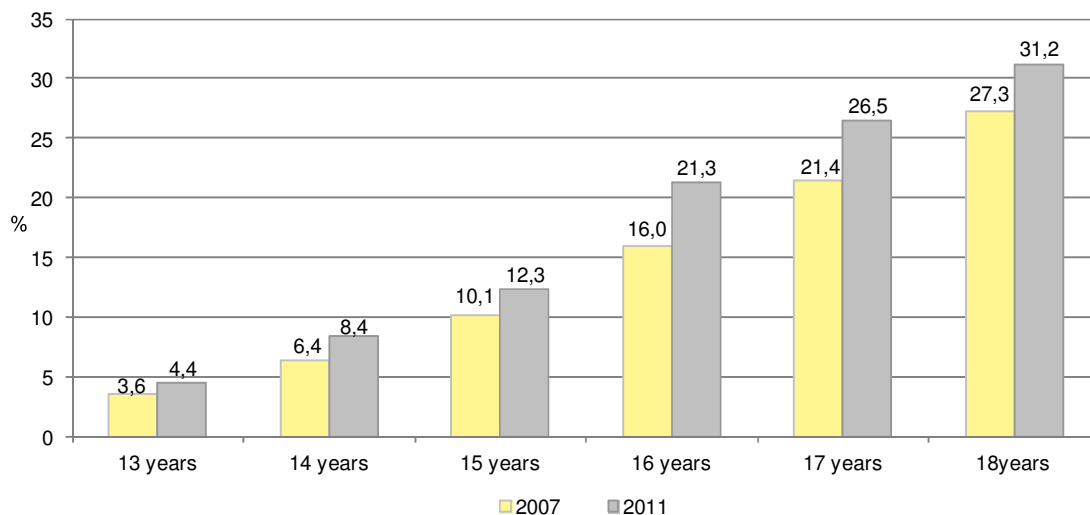
Graph 2 – School Population – ESPAD (16 years students): Lifetime Prevalence, by type of drug (IDT, I.P. 2012)

In ESPAD 2011 once more cannabis was the drug that presented the higher lifetime prevalence of use (16%) a value closer to lifetime prevalence of any drug (19%). Between 2007 and 2011 increased the lifetime prevalence of use of any drug (from 14% to 19%), decreases were verified in the prevalence of use of all drugs with the exception of heroin. The cannabis prevalence of use in last 30 days also increased between 2007 and 2011 (from 6% to 9%). In 2011, Portugal registered prevalence's of use very similar to the European average, being in some cases superior (namely the prevalence of use of cannabis in last 30 days – 7% European average and 9% in Portugal, and lifetime use of other drugs than cannabis – 6% European average and 8% in Portugal) contrarily to what occurred in 2007, where they were overall inferior (lower).

In ECTAD 2011, lifetime prevalence of use of any drug varied between 4,4% (13 years old) and 31,2% (18 years old). Once more cannabis stood out with higher lifetime prevalence in all ages (between 2,3% in 13 years old and 29,7% in 18 years old), followed by cocaine in the younger ones and amphetamines in the olders (from 16 years old inclusively). Lifetime prevalence of any drug and cannabis varied in direct ratio of the ages, the same didn't happen with the other drugs than cannabis due to the higher prevalences in 15 or 16 years depending on the drugs. The last 30 days prevalence of cannabis use ranged between 0,7% (13 years) and 15,7% (18 years). Between 2001 and 2007 after the downward between 2003 and 2007⁸, was registered an increase in lifetime prevalence of any drug at all ages. It is however noted that the prevalence of use of any drug mainly reflect the use of cannabis and that at the level of other substances not always occurred this evolution pattern in all ages,

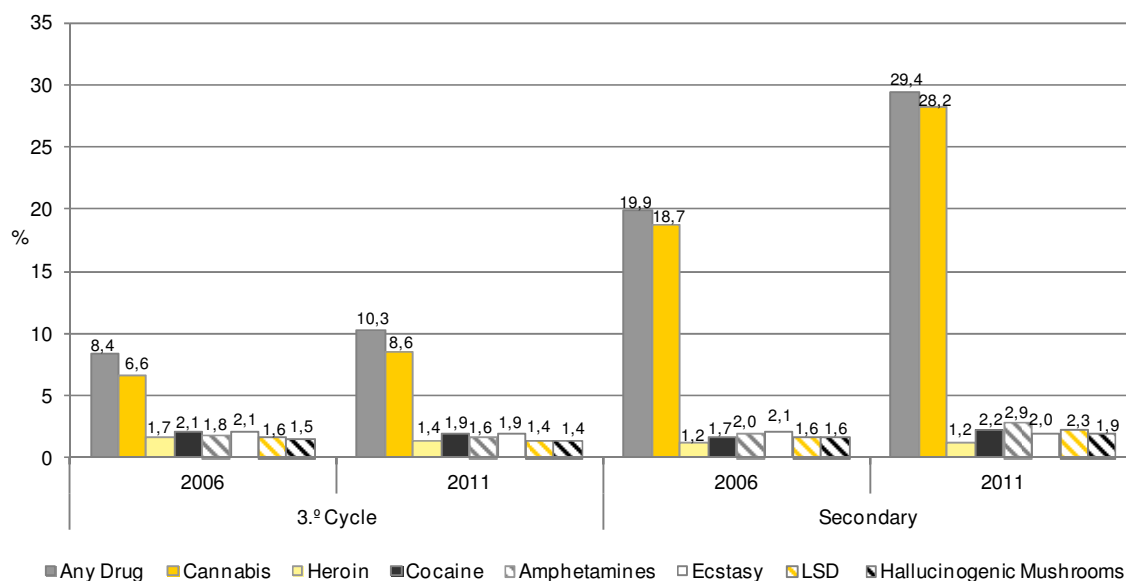
⁸ In ECTAD 2007 had shown that among the younger students (13 years old) there was no decrease in the use of cannabis as in the other ages

such as the lifetime prevalence decrease of heroin, cocaine and ecstasy among 17 and 18 years old students.

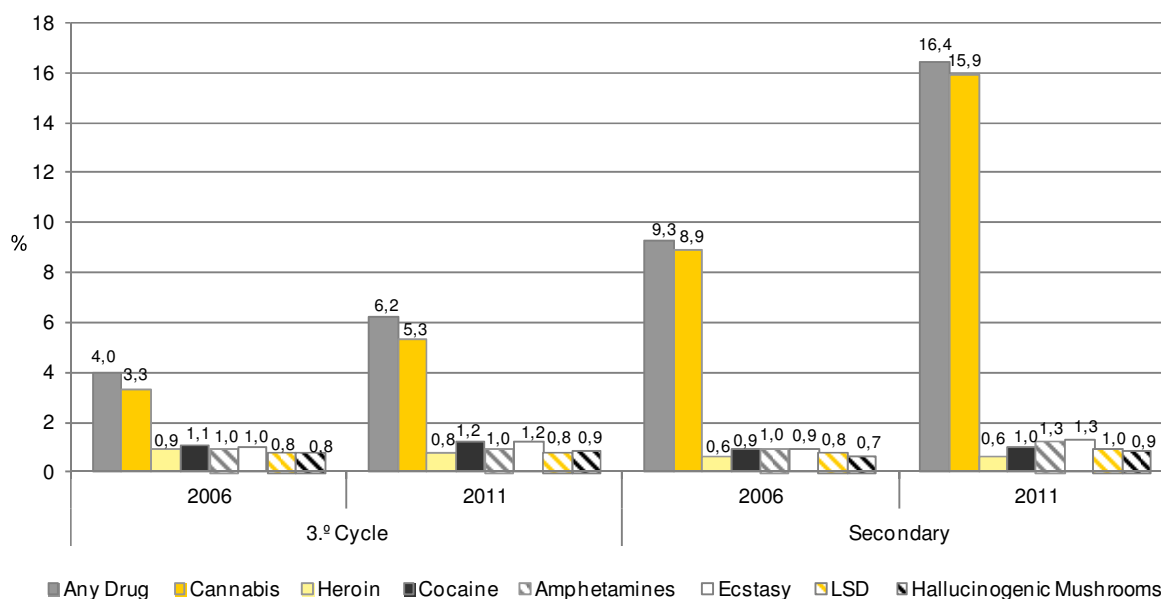


Graph 3 – School Population – ECTAD (students 13-18 years old): Lifetime Prevalence of use of Any Drug (IDT, I.P. 2012)

In INME 2011, lifetime prevalence of any drug was 10,3% in the 3rd Cycle and 29,4% in the Secondary. Cannabis once more stood out with the higher lifetime prevalences in the 3rd cycle (8,6%) and in the Secondary (28,2%). Followed by cocaine and ecstasy in the 3rd Cycle (1,9%) and amphetamines (2,9%) and LSD (2,3%) in Secondary. The lifetime prevalence of other drugs than cannabis were 3,9% in 3rd Cycle and 5,5% in the Secondary. In last year and last 30 days the prevalences of use of any drug were respectively of 8,7% and 6,2% in 3rd Cycle and 24,4% and 16,4% in Secondary, maintaining the pattern of use referred above (except in last 30 days prevalence in Secondary, where ecstasy was equal to amphetamines and higher than LSD). Between 2006 and 2011, in the 3rd cycle was found an increase in the prevalence of cannabis use and stability and even decreases in most drugs. In the Secondary an increasing trend in most drugs, apart from cannabis the increase of prevalence of use of amphetamines and LSD. Despite these increases in relation to 2006, the majority of prevalence use remained lower than the ones registered in 2001, in the 3rd cycle (with the exception of last 30 days prevalence of cannabis use) and in Secondary (with the exception of cannabis prevalence in any of the periods considered and the prevalence of use of most drugs in the last 30 days). The regional analysis by NUTS II showed that in the 3rd cycle and Secondary the regions of Algarve, Alentejo and Lisbon and Tagus Valley presented prevalence of any drug use superior to national average.



Graph 4 – School Population – INME (3º Cycle and secondary): Lifetime Prevalence, by type of drug (IDT, I.P. 2012)



Graph 5 – School Population – INME (3º Cycle and Secondary): Last 30 Days Prevalence of use, by type of drug (IDT, I.P. 2012)

ESPAD results of 2003, 2007 and 2011 related to perceptions of regular drugs use, showed an increase perception of risk of regular drug use in the current strategic cycle. With regard to cannabis, the drug with higher prevalence of use, respectively 79%, 82% and 71% of students in 2011, 2007 and 2003 referred to be of high risk its regular use. In the case of ecstasy these percentages were 78%, 74% and 72% and in the case of amphetamines of 78%, 74% and 64%, respectively in 2011, 2007 and 2003. Compared to the European

averages, Portuguese students perceived as higher risk the regular use of several drugs (in 2011, the European averages of attribution of higher risk to the regular use of cannabis, ecstasy and amphetamines, were respectively of 72%, 73% and 73%).

Generally speaking, the studies conducted in this strategic cycle presented consistent results between them, whether the level of amplitude of prevalence's, either in trends use. At the end of this cycle there are increases in prevalence use after the decrease occurred in the beginning of the cycle, alerting to the need to reinforce preventive measures in the future, where is predicted a probable aggravation of addiction and dependency related problems with the new challenges of new psychoactive substances in a conjuncture of profound economic and social crisis.

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

Social representation of the smart drugs – a brief description of the phenomenon (Silva2012)

This exploratory research aims at analyzing the perceptions and social representations that users have of the emerging phenomenon of smart drugs and smart shops. The study was conducted to contribute to a better characterization of the substances, the users profiles and motivations towards use, gathering data on the perceptions and representations that the youngsters have of the new psychoactive substances, creating useful information for health professionals in the area of prevention and harm reduction.

Based on 64 semi directed interview conducted in nightlife settings in Bairro Alto, Santos e Alfama, to individuals of 18 to 25 years that go out regularly and have contact with smart drugs and smart shops, the field research took place on Thursdays, Fridays in the beginning of night (22h-01h) in April and May.

After the transcription, the content of the interviews was analysed, statistical data as age and qualification were also considered in the matrix and the results crossed with the level of use and knowledge of the phenomenon of smart drugs and smart shops.

The results indicate that a vast majority of the participants in this study had certain knowledge of the phenomenon (75% of the sample, meaning 48 persons), of which 77% had already tried at least one new psychoactive substance. 98% have tried illicit substances.

The substances most referred by the interviewees were incense/synthetic Cannabinoids (20%), Salvia (11%), plant fertilizers (9%), LSA seeds (5%), poppers (3%) and others (1%).

The research also focus on the perceptions that users have towards the legality of substances they consume, with 60% considering that effects are similar to the illicit drugs. As for the risk perception, smart drugs are considered of higher risk for 16%, far from the 39% of the illicit and substances. Therefore participants reported an association between legal issues and the danger inherent to use, referring that the fact of certain substances being legal is a guarantee of the inexistence of health risks.

The last question was on the perception of the impact of the legality of smart drugs in the increase of the use: 56% considered that there is an impact, 40% said no and 4% had no opinion.

Analysis of amphetamine-type stimulants in biological matrices (Moreno et al 2012 a)

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Introduction

New synthetic drugs of abuse have recently appeared in the illicit market, particularly the so-called amphetamine-type stimulants (ATS), such as 2C-T-2, 2C-T-7, PMA, PMMA, ephedrine, norephedrine and methcathinone, which have been associated to deaths in Europe. In this sense, it's justified the need of development of an analytical methodology for the identification and quantification of these drugs in biological fluids.

Methods

A simple and fully validated procedure is described for the qualitative and quantitative analysis of ATS in whole blood samples, using mixed-mode solid-phase extraction and GC-MS. Additionally, an innovator procedure was also tested for the first time in this compounds, the bar adsorptive micro-extraction (BA μ E). The target analytes were extracted from urine samples by BA μ E and analyzed by LC-MS/MS.

Results

The SPE-GC-MS method was linear from 5 (limit of quantification) to 500 ng/mL, with determination coefficients (R^2) higher than 0.99 for all analytes, except for methcathinone (0.96). The limits of detection (LOD) were 1 ng/mL for all analytes and the method was considered selective and robust, presenting adequate precision and accuracy for all analytes, except methcathinone, fulfilling the criteria usually accepted for bioanalytical method validation. Extraction efficiency was higher than 80% for all analytes. Furthermore, the procedure showed to be sensitive and with appropriate selectivity to detect small amounts of the compounds and quantification of 2C-T-2, 2C-T-7, PMA, PMMA, ephedrine and norephedrine in blood samples. Considering that the BA μ E-LC-MS/MS methodology was applied in standard conditions the preliminary results were very satisfactory, presenting extraction efficiencies between 19% and 48% and LOD of 2 ng/mL. Conclusions. A simple and fully validated procedure is described for the qualitative and quantitative determination of amphetamine-type stimulants in human whole blood samples, using SPE-GC/MS. A new approach is presented as a possible alternative to traditional samples preparation techniques.

Method For The Quantification Of Several Piperazine-Type Stimulants In Human Urine (Moreno et al 2012b)

A method for the detection and quantitation of 1-benzylpiperazine (BZP), 1-(3-trifluoromethylphenyl) piperazine (TFMPP), 1-(3-chlorophenyl) piperazine (mCPP) and 1-(4-methoxyphenyl) piperazine (MeOPP) in urine samples was developed, for concentrations ranging from 0.1 to 5 μ g/mL. The limits of detection were 0.1 μ g/mL for BZP and TFMPP, while for MeOPP and mCPP 0.05 μ g/mL was obtained. Intra- and interday precision ranged from 1 to 14%, and accuracy was within a $\pm 15\%$ interval for all analytes, fulfilling the criteria normally accepted in bioanalytical method validation. Extraction efficiency was higher than 80% for all analytes, except for BZP (50%).

The analytes were rapidly extracted from the samples (< 2 min) by means of microextraction in packed sorbent (MEPS), allowing reducing the handling time and costs usually associated to this type of analysis. Furthermore, the fact that only 0.1 mL of sample is required make this method a valuable and powerful tool for drug monitoring in human urine in situations where the studied compounds are involved, for instance in forensic scenarios.

Briefly, the procedure is as follows:

0.1 mL of urine is diluted with 0.1 mL of deionised water in a glass tube, and the sample is agitated for 30 s. Then, it is manually drawn through the sorbent (packed inside a syringe) and ejected in the same vial 8 times (strokes) at a flow rate of 10 μ L/s. The sorbent is washed with 250 μ L of 1% acetic acid and 100 μ L of 10% methanol in water to remove matrix-borne interferences. The analytes are eluted with 50 μ L of 5% ammonia in methanol, and directly injected into the chromatographic system.

The piperazines were separated in a Zorbax 300 SB-C₁₈ (5 μ m, 4.6x150 mm) column at 25 °C with a mobile phase consisting of 5 mM ammonium formate (pH 6.4)-methanol (55:45, v/v), using the isocratic mode at a flow rate of 0.8 mL/min. The monitored wavelengths were 211 for BZP, 208 for mCPP, 236 for MeOPP, and 246 nm for TFMPP.

The method was fully validated according to internationally accepted guidelines (FDA and ICH), and the studied parameters were selectivity, linearity and calibration model, limits, intra- and interday precision and accuracy, recovery and stability.

The fact that low detection and quantitation limits were obtained in reduced sample volumes enables the detection of small amounts of the compounds, which makes this procedure useful for those laboratories performing routine urine analysis.

This method to detect piperazines, hallucinogenic pills sold in smart shops and internet, allows also for the detection of legal substances made of plants extracts and for the use of corps (and not only urine) as reference samples.

This method is a result of a joint research project developed by the Centro de Investigação em Ciências da Saúde, Universidade da Beira Interior (CICS-UBI) and the Serviço de Toxicologia Forense do Instituto de Medicina Legal – Delegação do Sul and has been awarded by the Criminal Police and the University of Coimbra.

Program for Prevention and Fight against Drugs and Alcoholism in the Armed Forces

The Program for Prevention and Fight against Drugs and Alcoholism in the Armed Forces (PPCDAFA) is coordinated by a Steering Group, chaired by the General Directorate of Personnel and Recruitment and composed by representatives from the Navy, Army and Air Force.

In the branches of the Armed Forces (Navy, Army and Air Force), the coordination of the PPCDAFA is assured by specific Groups of the different branches, operating in accordance with internal directives produced at the level of the respective superior hierarchy.

In primary prevention foreseen by PPCDAFA, plays an important role the toxicological screening of the military population for detection of illicit substances in the urine, primarily cannabis, opiates, amphetamines and cocaine. The laboratories of the Branches of the Armed Forces are equipped with technical means of reference internationally recognized as the most suitable for screening and confirmation of drugs of abuse in urine.

The big advantage of the toxicological screening lies in the early detection as a mean of demand reduction, not only for security reasons of the organization, but fundamentally it allows detecting and stopping addiction as close as possible of the first use.

To ensure the credibility of the whole process and at the same time, the individual rights of the military screened, the realization of analysis is associated with a chain of custody of samples and a control of analytical performance to ensure the security, the accuracy and confidentiality of all data since the collection till the result validation.

Officers, sergeants and soldiers are analysed based on a random nomination (drawing), extraordinary (on suspicion) and mandatory (as determined by the governing body of personal or follow-up of previous detection).

At the military setting (MDN2011), in 2011, the Armed Forces collected 16 289 (20 961 in 2010 and 11 836 in 2009) urine samples. Concerning previous years, were added to the

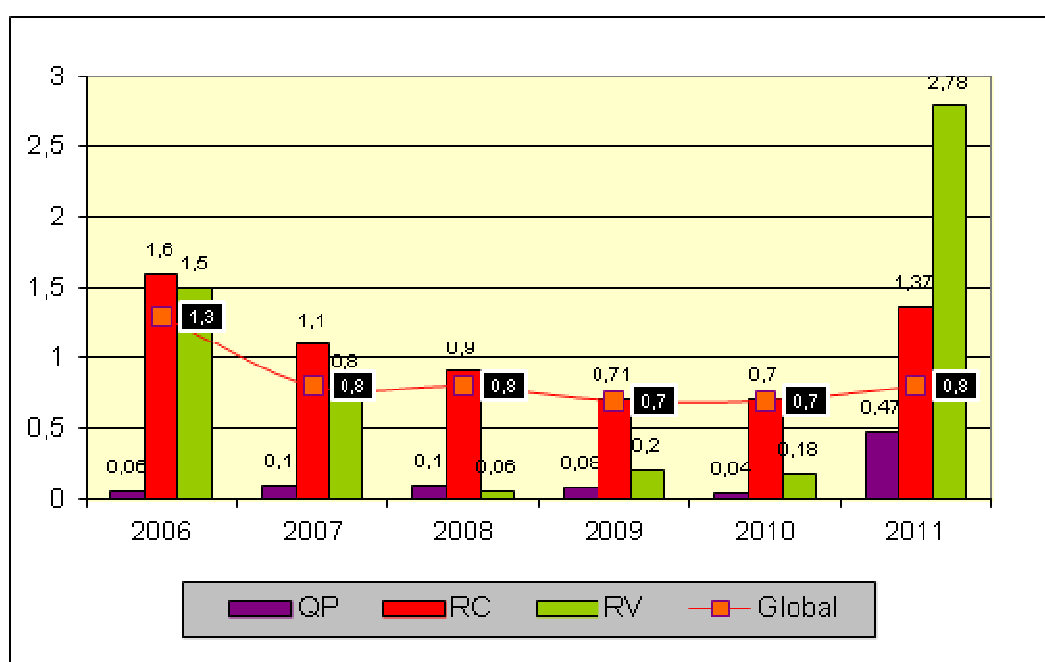
urine samples not only the active military population but also the candidates. The samples are mostly collected on a random basis but follow-up tests (after one positive test) and tests following drug use suspicious reports are also included in these figures, (age group was 18-39).

65 156 toxicological tests (83 844 in 2010 and 47 344 in 2009) were performed on the collected samples for illicit drug use (cannabis, opiates, amphetamines and cocaine). 0.8% of these samples tested positive, which represents an increase of +0.1% in comparison to 2010 and the same value of 2008.

In a global appreciation of the results of the three branches of the Armed Forces, it is verified a positivity of 0.8% (+ 0.1 than last year and the same of 2008).

When considering results per professional category, was observed a positivity of 0.47% in permanent staff, 1.37% to contracted personnel and 2.78% to volunteer staff.

In relation to previous years, it was verified the evolution synthesized in the next graph:



Graph 6 – Positive results (%) in the toxicological screening, between 2006 and 2011, by regime of service (MDN2012)

The main illicit substance found was cannabis (86% of all positive tests, 79% in 2010 and 89% in 2009), followed by cocaine (3%), opiates (0%), amphetamines (0%) and polydrug (0%).

3. Prevention

3.1. Introduction

During 2011, the intervention in the mission area of prevention followed the task to achieve the main strategic goals defined in previous years: prevent the beginning of psychoactive substance use, prevent the continue use and abuse and the transition from use to abuse or misuse and dependence. To achieve them, activities were planned in accordance with operational objectives of the Action Plan Against Drugs and Drug Addiction 2009-2012:

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

During 2011, it was verified a diversification of intervention contexts (family, school, professional schools and training centers, care institutions for children and youth, university setting, workplace, recreational settings, prison setting, community), at universal intervention level as well as selective and indicated, and in some cases this intervention was complementary and covered individuals in different spheres of their life.

In the education system, there was a strengthening in the articulation with the Ministry of Education, and other health structures, with the use of universal prevention strategies combined with more focused interventions.

The prevention structures gave technical support, throughout all its stages, to projects and programs developed in partnership between IDT, I.P. and other structures of local and regional community, particularly in programs of school and family context and interventions in recreational and university context (articulated with the Harm Reduction area).

There was throughout the country a strong investment in selective and indicated prevention interventions, focused in groups, individuals and contexts that presents an increase risk for the use/abuse of substances, particularly in the implementation of personal and social competence training programs in the vocational and alternative curricular education and the creation of selective and indicated prevention appointment spaces thus contributing to the strengthening of a Teenagers Appointment System in articulation with the Treatment Mission Area. Such has been developed through appointments with psychosocial support for teenagers and young people with consumption of psychoactive substances, particularly cannabis.

The use of interventions based on consolidated programs such as *Eu e os Outros* - Me and the Other's (See SQ 25 Mustap Questionnaire) and project *Trilhos* have been privileged in relation to less structured approaches. However, the response to brief or punctual interventions was not abandoned, as it was considered that this might allow future engagement in continuity interventions. Furthermore, there was an investment in the capacity of professional's partner institutions through training and support, implementation, monitoring and evaluation of prevention projects.

Within the ambit of the Prevention Nucleus (NP), a contribution to improving the quality of preventive intervention was carried out by the conclusion of several processes that began some years ago and followed a planning that previewed the production of some key documents to the prevention intervention. Thus, the NP produced, in 2011, the Guidelines for the design of Preventive Intervention in the Consumption of psychoactive substances,

essential tool for improving the quality of prevention intervention. This journey began with the implementation of the Program Focused Intervention (PIF), which allow identifying good practices in lacking areas or poorly developed in the prevention ambit, through the funding, selection, monitoring and evaluation of projects designed based on scientific evidence.

In 2011 PIF Final Report was concluded, evaluating interventions and the implementation of the program, having published a document with the conclusions. These documents were widely disseminated by managers and professionals of IDT, I.P. It was also finalized a Catalogue of Best Practices in Prevention⁹, which includes a set of projects selected from among those in PIF, complemented with projects with final evaluation developed under Operational Program of Integrated Responses (PORI) - they all have characteristics that confer quality at methodological level, evaluation process and results.

Activities and meetings were held in order to promote harmonization of instruments, registering and collecting information. The result of this work was then disseminated to all professionals of IDT, I.P. and it remains open the possibility of continuing the work.

It was widespread after approved by IDT, I.P. Executive Board, the document Definition of the competences of Prevention Teams crucial tool for intervention work in prevention and articulation with other mission areas.

Support was provided to carry out research work with the Psychology University of Porto under the ambit of intervention held in 2010 at the Boom Festival, through information collected in Kosmicare (an emergency service developed at Boom Festival, whose purpose was to intervene in the crisis resulting from the use of psychedelic substances). This study was concluded and a joint document was prepared, Report of Process Evaluation of Kosmicare intervention, which will certainly be useful for future interventions in the same context and for the preparation of the intervention in other festive and recreational contexts.

Among the projects supported by NP professionals, we highlight the intervention in the Casa Pia de Lisboa, in addressing youth in institutionalization situation, looking for suitable management models of problematic situations and strengthening factors that promote resilience and the project Euridice within the working environment, promoting awareness about SPA consumption.

The year 2011 also included the final evaluation and possible continuation of projects developed under PORI, in addition to maintaining all the procedures involved in the process of follow-up, monitoring and evaluation of these projects. It was also enhanced the integration of responses to alcohol use in our teams, (elaboration of training modules, extending the intervention to festive contexts).

The preferential incidence in interventions of selective and indicated prevention requires a closer follow-up by the professionals and those from the different structures of IDT, I.P. to assure harmonization and consistency of the intervention, as well as a reinforcement of the competences of their professionals.

The definition of prevention teams competences, circuits and procedures, as well as the training of professionals with the purpose to extend best practice in this mission area, to ensure the harmonization of procedures and quality of interventions was object of investment of IDT, I.P.

The attending and Information Unit in addition to all the activity concerning Linha Vida and the website Tu-Alinhas, was actively involved in Project Eu e os Outros establishing during 2011 the accreditation process of teachers intervening in the project.

Regarding Prevention in School setting and the Project Eu e os Outros, the perspective was, after the 'shielding' of the materials contents by the institutional partners and the

⁹

http://www.idt.pt/PT/Prevencao/Documents/Programas_Projectos/catalogo_de%20Boas_Praticas_Prevencao_das%20toxicodependencias_em_Grupos%20Vulneraveis.pdf

consolidation of the joint articulation with ME/DGIDC (Ministry of Education/General Directorate for Innovation and Curricular Development), investing in the training of teachers of Promotion and Health Education, as 1st line professionals in the implementation of the project in school setting.

In the context of FESAT, IDT, I.P. participated in the elaboration of guidelines for the dissemination of best practice, which are available as an end product of the Leonardo da Vinci – Mobility Project.

3.2. Universal prevention

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

Several projects of universal prevention are being implemented in different settings:

School

The preventive intervention in schools is a major area of universal prevention, aimed at giving some awareness to school population on use of drugs and the risks associated. In Portugal, prevention of drug use is part of the school curricula and dealt within the framework of health promotion and education (please see SQ22/25 for description of framework and availability of responses), approached in several school subjects mainly in Sciences, Biology and Civic Education.

In 2011, school-based prevention in Portugal continued to be mainly implemented through programs developed by 3 different actors: the Ministry of Education, which is responsible for the inclusion of health promotion and substance use prevention in the school curricula; IDT, I.P. (Ministry of Health) through the prevention component of PORI framework described below and the Ministry of Home Affairs (Public Security Police - PSP and National Republican Guard - GNR).

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

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

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

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

Throughout the year, several prevention actions and projects were developed in school setting, in a global perspective of health promotion or a more specific aspect of approach to the issue of psychoactive substances use, contributing to reinforce universal prevention activities, effective and evaluated, namely the analysis of the approach of content relating to SPA in the curricular disciplinary areas and not disciplinary.

Several activities were held in schools throughout the country, targeted at students, and teachers, a part developing universal prevention interventions (459 interventions covering about 11 500 students) and selective and indicated prevention (42 interventions covering 800 students) . The effort was made to strengthen the interventions more focus in schools, classes and most vulnerable students who presented associated risk factors and most pressing intervention needs. We emphasized the application of the universal prevention project *Eu e os Outros* in 244 schools covering 10 246 students and involving in its implementation 693 applicators teachers, plus a wide range of IDT, I.P. professionals, which supported the training, supervision and evaluation of the project.

Since the school year 2005/2006, Program *Atlante – Enfrentar o Desafio das Drogas* (Portuguese version of *ORDAGO – Afrontar el Desafio de Las Drogas*), is being implemented in the IDT, I.P. Regional Delegation of Algarve. In 2011 it was developed in 136 classes covering 2 807 students.

The implementation of the program to promote personal and social skills: “*E Agora Ruca*”, continues covering children and youth in school setting.

In 2011, the 4th edition of the health promotion and community engagement multi-annual campaign “**Mocktails**: memories of a funny night time” was promoted by Dianova in partnership with 36 Strategic Allies from the public, private and social sectors (Government, Local Authorities, Police, Schools, Media, Bars & Disco clubs, Sponsors). The campaign aims to increase awareness without prejudices of alcohol use, the risk behavior incurred and its negative effects on physical coordination and state of alert, school dropout, anxiety / depression, road accidents, and other consequences, among young and young-adults (15-25 years old), using a face-to-face and cooperative proximity methodology.

In these past 4 years, the campaign is being held in the city of Torres Vedras (40kms from Lisbon) during the Youth Week in May, promoted by the Torres Vedras Municipality, starting with drug prevention workshops in 10 Schools and University and ending in the weekend, Friday fever night, in 21 Restaurants, Bars and Disco clubs. More than 140 trained Volunteers as Health Ambassadors are at the core of the campaign, helped by 260 nightlife Staff and 33 Police officials from PSP and GNR working together to promote a more responsible alcohol consumption and driving attitude in order to decrease offenses and other risk behavior related consequences.

This partnership is an effective way to increase socially responsible attitudes and behaviors, as well as for peers to learn how to behave in a way to promote, maintain and /or restore health through education, information and mobilization of multiple stakeholders and the public opinion, enrolling the Community and the society at large in an active civic activity on behalf of others and the community/society itself.

The positive outtakes really show the social impact of this campaign: 13 460 People have been impacted in the 4 editions between 2009-2011; 36 Strategic (Institutional, Sponsors, Logistic and Media) Partners are involved; 149 Health Ambassadors with an open smile and a lot of attitude and preventive energy; 260 Nightlife Staff joining the “party”; 33 police agents and civil protection helped to promote a more secure environment; 9 754 cocktails without alcohol (mocktails) have been consumed; 408 people have been impacted on auto-stop police operations, winning the Civic 0% Alcohol Award; and 3 000 Students in 10 Schools (junior high schools, professional schools and university) were engaged in previous prevention activities promoted by Dianova professional Team.

The positive impact allows to scale the campaign to other cities, being Lisbon the next city in which it will be developed in 2013, and the 5th edition in Torres Vedras is already scheduled for next May 2013.

Project Eu e os outros - Me and the Other's (see SQ 25 Mustap Questionnaire)

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

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

The school year 2011 finished with the coverage of 247 institutions (schools, professional schools, social security institutions, Private Social Solidarity Institutions (IPSS), involving and training 543 professionals from different areas (teachers, psychologists, social workers, socio cultural animators) for the stimulation of 10 414 young people (between 10 and 24 years old) covering all the country.

	Professionals	Institutions	Applicators	Players
2010	39	145	544	9 459
2011	43	166	543	9 871

Table 3- Number of people involved on the project in 2010 and 2011 (IDT, I.P. 2012)

In relation to the implementation of the Project the following table summarized the CRI's involved, the number of support professionals of IDT, I.P. the Institutions and applicators receiving training and implementing the project as well as the number of students covered in 2011.

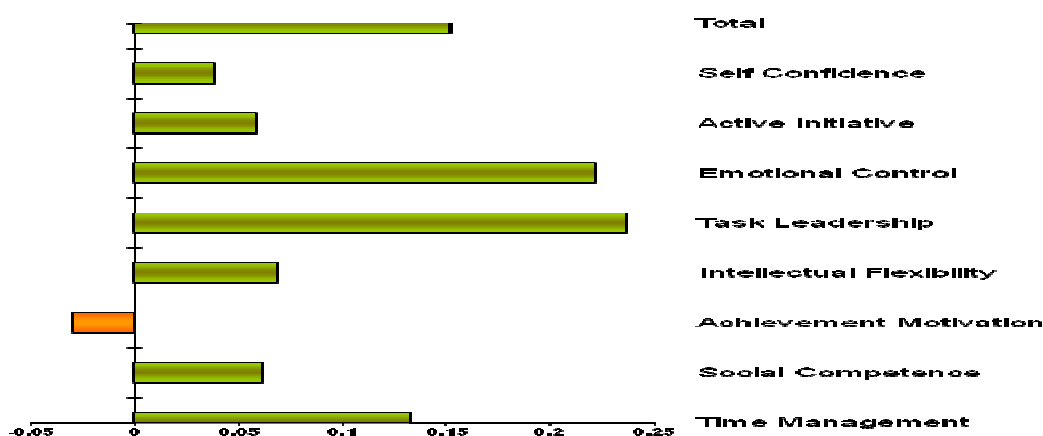
2010	Schools	Students		
DR North	100	2403		
DR Center	32	3019		
DRLVT	37	1220		
DR Alentejo	44	4467		
DR Algarve	5	3239		
Totals	218	14348		
2011	Professors	Schools	Students	
DR North	151	91	2723	
DR Cenetr	347	75	3779	
DRLVT	66	19	797	
DR Alentejo	151	48	2612	
DR Algarve	38	14	503	
Totals	753	247	10414	

Table 4 – Number of Schools and students involved in 2010, Professors, Schools and Students in 2011 (IDT, I.P. 2012)

Note: The data presented were provided by CRI's. Still shows the increase of collaborators, professionals and players participating in this project annually nationwide.

The impact evaluation of the Project was conducted during the school year 2010/11. The evaluation is based on a evaluation scale self-efficiency/effectiveness (LEQ - Richards, G. E , Ellis, L. A., Neill, J. T. 2002), which results were inserted in a database of Excel format online (online questionnaire of Google) completed by the applicators and technical support and checked in SPSS vs. 17.

In the school year 2010/11, the LEQ scale was applied to young people who were exposed to Eu e os Outros Project, with a sample of 1 680 subjects, 873 males and 736 females, belonging to the CRI's of Évora (40), BAAL (393), Aveiro (23), West Lisbon (55), Setúbal (274), Viana do Castelo (12), central Porto (312), Ribatejo (61), Bragança (68), Portalegre (404) and Guarda (38) – from 9 to 24 years old from the 5th to 12th of school.



Graph 7 – General Variation of Effectiveness Effect by factor 2010/2011 (IDT, I.P. 2012)

The green bar symbolizes the improved effects in our sample, i.e., it was evident in all factors except in motivation, the positive effect of auto efficiency in general. In comparison to last school year a remarkable increase was noted in all factors, although the motivation for goals is still the factor without positive effect, probably an aspect to be considered in the intervention.

Effects	2009/10	2010/11
Time Management	0,04**	**0,13
Social Competence	-0,06	**0,06
Achievement Motivation	-0,22	-0,03
Intellectual Flexibility	-0,02	**0,07
Task Leadership	0,10*	**0,24
Emotional Control	0,07*	**0,22
Active Initiative	-0,03	**0,06
Self Confidence	-0,01	*0,04
Total	0,01**	**0,15

Table 5 – General Variation of effectiveness by factor, comparing 2009/2010 and 2010/2011 (IDT, I.P. 2012)

Table nº 5 represents the effect variation by comparing 2009/10 with 2010/11, verifying significant improvements. Taking in consideration the parameter - Age – the factors where positive changes were found significant, were time management (11, 12, 13, 18 and 21 years old); social competence (12 years old); Intellectual flexibility (11 and 15 years old); Task leadership (11, 12, 13, 14 and 16 years old); Emotional Control (11, 12, 13, 14, 15, 18 and 19 years old) and Self-Confidence (13 years old).

In terms of total effects from 11 to 15 years old, only in Proactive and Achievement Motivation weren't found results of full difference.

Factors facing the school year, showed significant positive changes in relation to Time Management effect (6º, 7º, 9º, 11º and 12º Grades), Social Competence (6º and 9º Grades) Intellectual Flexibility (6º and 9º grades) Task Leadership (6º, 7º, 8º, 9º and 12º grades) and Emotional Control (6º, 7º, 8º, 9º, 12º, Integrated Program of Education and Training - IEF 2 and 3), Effect of Proactivity (6º, 9º and PIEF 2) and Self-Confidence (9º grade). Overall, in terms of total effects, there were positive changes in the following school years, 6º, 7º, 8º, 9º and 12º grades. Only in the Achievement Motivation are no results for the full difference. The positive differences observed in both sexes are found in all factors except in self-confidence (which was lower in males) and Achievement Motivation (which was lower in females). Overall, it was noticed a major positive change effect in females.

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

Another example of universal prevention is the Project “Copos quem decide és tu” – a partnership project between the Portuguese Red Cross (CVP – Cruz Vermelha Portuguesa) and IDT, I.P. with the support of General Directorate for Health (DGS – Direcção-Geral da Saúde). The main goal of the project is to raise awareness between secondary school population, aged between 14 and 20 years, to the problems of harmful use and early drinking.

Being a national project was applied by several Delegations of the CVP in various parts of the country and coordinated by the CVP Youth Office in close collaboration with the Prevention Nucleus of IDT, I.P. and the CRI involved in local actions.

Since the beginning the project counted with the collaboration of the General Directorate of Health, particularly in the scientific support to the production of materials. The Ministry of Education, through the NESASE (Center for Health Education and Welfare School) of the General Directorate for Innovation and Curricular Development (DGIDC), also monitored the implementation and expansion of the project.

In 2011 the Project was implemented in 16 localities through the respective CVP Delegations: Guimarães, Braga, Fafe, Penafiel, Évora, Almendra, Caldas da Rainha, Bragança, Ovar, Setúbal, Lisboa, Cadaval, Madeira, Leiria, Chaves e Portalegre.

The implementation was adapted to the local needs and resources having been executed as follows:

1) Actions:

- a) Sessions: approximately 230 around the country, covering 42
- b) “Espaço Copos”: 3 actions, in Madeira, Caldas da Rainha and Braga. Each action (except in Madeira that was made by volunteers) implied the capacitance of a class that dynamize the activity to the respective school community.
- c) “Desafio Copos”: Braga, Chaves, Caldas da Rainha in a total of 32 works.

2) Training:

- a) Local training actions: 6 actions in Setúbal, Guimarães, Almendra, Chaves, Penafiel, Cadaval covering a total of 68 CVP volunteers trained for the project.

In 2011 the total participation of students in the Copos Actions was 4 700.

Group of Intervention in Higher Education

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

The information/awareness interventions on psychoactive substances and associated harms continued to be asked by the entities namely schools and the prevention teams of CRI give answer seeking to continue the ad-hoc interventions. Prevention teams participated actively in the implementation of some activities in higher education, as training programs of personal and social competences, participation in the curriculum of Nursing Degrees, Science Education and Master Health Education, support in research on the topic of drugs and addictions, intervention in the academic festivities.

Professionals from the prevention and harm reduction teams were also involved in interventions in the academic weeks of universities and polytechnic institutes, constituted by professionals of prevention teams in collaboration with harm reduction teams through the training close to a group of students previously trained to intervene in these events, in a proximity logic through peers interventions, as well as in the direct intervention of Academic weeks space.

EURIDICE Project

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

- Prevent and intervene in problems related with alcohol and other psychoactive substances use;
- Promote healthy lifestyles;
- Changing attitudes, behaviours and risk factors;
- Change the work conditions that favour and/or potentiate the use of psychoactive substances;
- Increase knowledge on psychoactive substance use;
- Promote the creation of a healthy and social climate at workplace, through integrated actions that include a training and information dimension.

The General Confederation of Portuguese Workers - National Trades Union (CGTP-IN) and the IDT, I.P. ensured continuity and development of the project EURIDICE, developed in Portugal under the designation of Interaction Program, in the framework of the protocol celebrated in 2006.

The Interaction Program was established as a preventive intervention of drug addiction, universal character, in which IDT, I.P. gave technical and scientific support for the coordination and development of actions in workplace, by increasing the quality of the intervention with the groups identified as priorities, as well as a check the results obtained near them.

The target group of Universal Prevention will be the working population of organizations targeted by the Interaction Program, in which the goal of intervention is, globally, to prevent the harmful use of alcohol and other psychoactive substances. It is an intervention of

reduced intensity, requiring few professionals with training that doesn't need to be specialized, for a large number of beneficiaries. In this type of intervention, the costs are lower as well as the effectiveness of the intervention.

In place of application, the assumptions for intervention were: comprehensive attitude and support from the company and the work actors, target to situations of consumption, the reduction of psychoactive substance use can benefit socio labor relations, the absence of information about the risks of psychoactive substance use compromises the capacity of the individual's decision, the development of personal and social skills can enhance their ability to deal with the issue of problematic of psychoactive substance use; intervention aimed at key stakeholders of the company provides a multiplier effect of an integrated dynamic, a comprehensive intervention, focusing on the problems associated with the consumption of licit and illicit psychoactive substances, enhances its success.

During 2011 the intervention took place in four different organizational entities, namely: Loures Council Camera, Seixal, Águeda and Vendas Novas, reaching 193 actors of the working environment that included directors and workers. The diagnosis was made based on the questionnaire of the Eurydice Network, Cooperativa di Estúdio e Ricerca Sociale Marcella. Those actions were followed by, with the elaboration, reproduction and distribution of guidelines on alcohol and drugs problems to directors, the distribution of various materials with information about the harmful consequences of substances use and information sessions, target either to directors or to workers.

IDT, IP and the Authority for Working Conditions (ACT), prepared a document that aims to integrate the concerns and sensitivities of the working environment and also reflect a set of suggestions aimed at providing the organizations of a technical-legal framework that responds to the generality of the different situations in this problematic, mind, give continuity to this partnership in order to disseminate the work developed.

Safe School Program

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

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

In the school year 2011/2012, PSP teams allocated to the Program "Safe School" about 391 (369 in 2010/2011) police officers at national level.

In the school year 2011/2012, PSP promoted more than 6 704 (4 158 in 2010/2011) awareness/information actions at national level, focussing especially in issues such as prevention and road safety education (with 2 001 actions), bullying (with 841 actions) through the organisation of several events to demonstrate ways (means), ludic, sportive and cultural events. Of the total number of awareness actions referred, 183 were on Juvenile delinquency, 338 on internet use, 296 on criminal prevention, 137 on violence in schools, 674 on alcohol and drugs and 68 on self-protection.

In the school year 2011/2012 from the 3 453 schools covered were involved 1 033 921 studentes and 137 949 professors and auxiliary educators.

GNR data indicates that in 2011, 263 agents (237 in 2010, 228 in 2009, 211 in 2008), were allocated to Safe School Programme. Apart from the proximity policing and offence dissuasion, these law enforcement agents were also involved in training and awareness raising initiatives in schools. The initiative targeted 6 902 schools covering a universe of 79 0655 students and 10 843 awareness raising sessions were developed.

Family

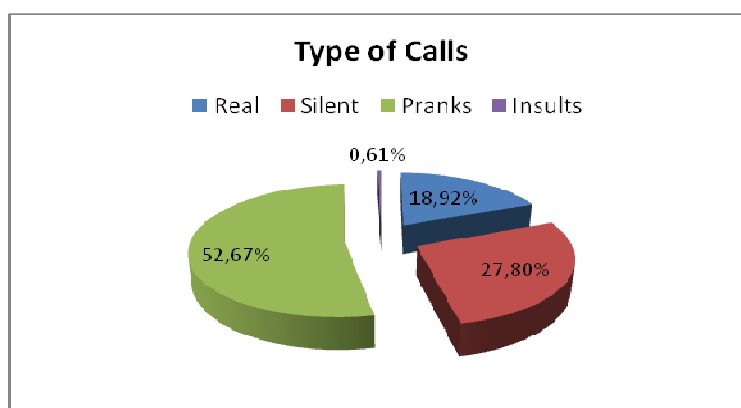
In some of the projects developed under PORI and PIF (please see subchapter 3.3), interventions of universal prevention occurred in the communities, where families are included.

Community

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

IDT, I.P. hosts the national telephone helpline, *Linha Vida – SOS Droga*, an anonymous and confidential service that gives priority to counselling, information and referral in the drug abuse area and associated themes (adolescence, sexuality, AIDS, amongst others). The helpline was available from 10 am to 8 pm every working day, and staff includes 5 psychologists and 1 social worker with specific training in counselling and drug abuse.

From the 1st January to 31st December 2011, the helpline received a total of 11 168 calls from which only 2 113 were real calls, the rest being silent calls 3 105, pranks 5 882 and 68 insults. Corresponding in percentual values respectively to 18,92% of real calls, 27,80% silent calls, 52,67% pranks and 0,61% insults.



Graph 8 - Type of Calls received by Linha Vida (NAI / IDT, I.P. 2011)

It was verified that a large percentage of calls are Prank calls, following the trend observed in previous years, although with a slight decrease, followed by Silent calls that contrary have been increasing appearing after the Real and Insults calls.

The high number of Pranks and Silent calls may reflect a form of "test" the quality of service, for individuals who actually have doubts and that they can return the call later with the aim of clarify.

Concerning the client profile, most calls continue to be made by those who had a problem or needed information – 1 372 clients, followed by calls made by mothers 292 with doubts about

drug use and relationship problems with their children. In 2011, most callers were aged 36-50 (17,08%), followed by >50 (3,41%) and 26-35 (2,74%) and were mainly female (58,02%).

Concerning the contents of the Real calls, it was verified that 86,10% of calls fall into the Drugs category and deal with the presentation of a problem or a request for information related to drugs, while 13,90% refer to other issues.

As expected, most calls are drugs related problem (86,10%), since this is the area of operation of the Helpline. These calls are related either to information requests and clarification of doubts or requests for support or referral.

As regards the data concerning the type of request we found a predominance of requests for support / counselling (52.20%) followed by requests for information (45.46%). (Percentages are calculated on the total actual calls, including those not related to the subject and drug addiction).

It was observed that cannabinoids (32,93%) opiates (30,49%) are the source of a greater number of calls on information on the substances, followed by cocaine (14,49%) and alcohol (10,98%) although in a slightly lower percentage.

Concerning calls related to problems drug use, in which was possible to obtain information about the current situation face to drug use, 82,93% are current situations of active use and 9,76% refers to individuals in treatment, and finally, with the same percentage (3,66%), are calls in which users referred situations of relapse.

Lastly, with regard to referrals made in accordance with situations/problems presented, the majority of users were referred to outpatient treatment responses (45,20%), mainly for the IDT Treatment Teams, followed by referrals to therapeutic communities (12,93%) and the remaining was referred for other type of answers/structures.

Linha Vida also continued to respond to emails (e-mail counselling). In 2011, 137 emails were received. 37 of the emails were requests for information and 22 were related to requests for support/counselling, 26 were requests for both (information and support/counselling), 44 were requests for referral to treatment and 9 to other situations.

Concerning the themes approached, emails were related with substances: it was noted a higher number of questions related to cannabis (31 emails), followed by questions concerning drug addiction/drugs in general (13 emails), cocaine and alcohol with the same number of emails (10 emails) and heroine (7 emails) as most common referred.

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

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



Other community intervention project using new technologies is www.tu-alinhas.pt, a website that promotes healthy behaviours and prevention of drug use in a teenager-youth public (12-21 years old). This project is running since 22nd of February 2007, has both entertaining and pedagogical approaches with the main goal of informing and promoting healthy behaviours and drug addiction prevention. The information available in the website is broader than the specific topic of drugs and drug addiction.

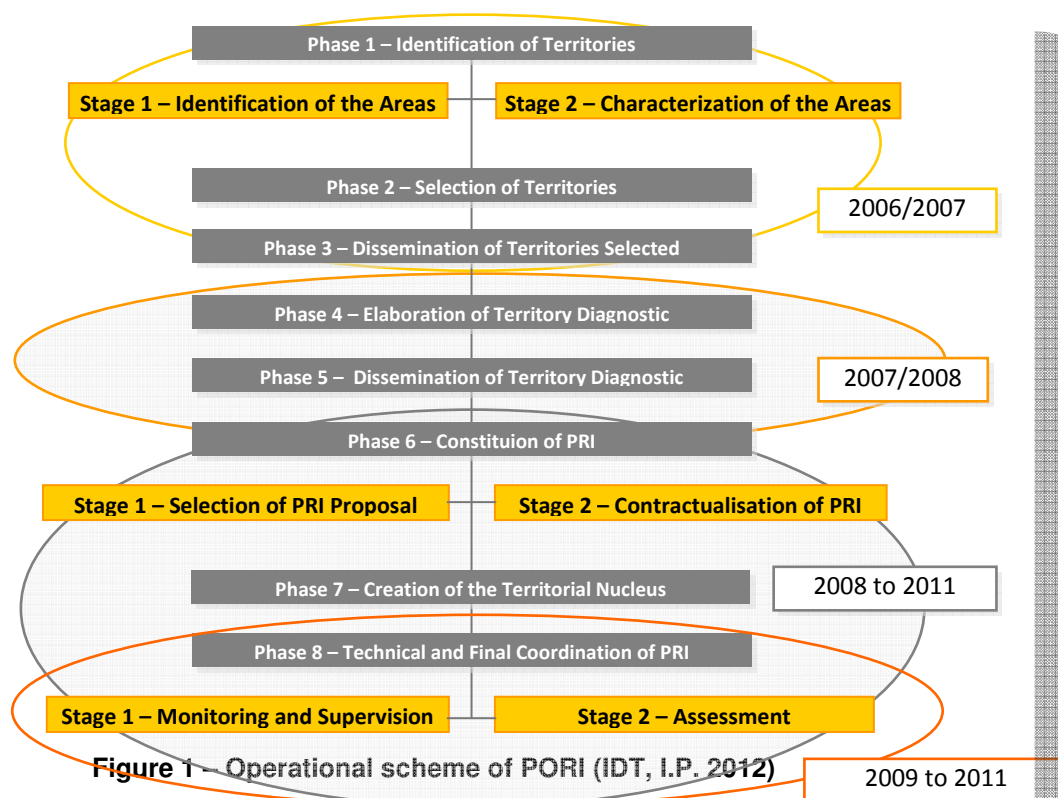
During 2011 were registered 65.531 unique visitors¹⁰, 255.381 visits¹¹, 162.242 page visits¹² and 3.032.155 hits¹³ to the juvenile website “Tu Alinhas”.

3.3. Selective prevention in at-risks groups and settings

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

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

As can be observed in the operational scheme, the PORI activities developed in 2011 are located on phases 7 and 8 – Creation of Territorial Nucleus (NT) and Technical and Financial Coordination of PRI in the sequence of the work developed in previous years.



Thus, in 2011 continuity was given to the implementation of the PRI contracted in 2008 and 2009, besides the accomplishment of new PRI without need of additional funding.

⁽¹⁰⁾ **Unique Visitors** – Counts un visitor per day no matter how often and at what time accessed. Leaves a *cookie by computer* that expires next day. If the browser doesn't accept *cookies*, he counts the number of IP.

⁽¹¹⁾ **Visits** – Counts one visit by computer for a few minutes. If the person access the page again after half an hour will be counted one more visit.

⁽¹²⁾ **Pages** – It is every time a page is seen. Also referred as "*views*".

⁽¹³⁾ **Hits** – It's every time a archive (e.g a photo) or a website page is accessed. Can also be referenced as "*requests*".

In 2011 the priorities were the continued normalisation of the procedures of follow – up, monitoring and evaluation of the interventions developed, the evaluation of the first period of implementation of the projects and PRI formalised in 2009 and consequently the updating of the initial diagnosis and the decision on maintaining co-financed projects according to the needs identified as well as the budget available.

Continuity was also given to the monitoring of interventions, through the collection of monthly indicators, and monitoring of PRI, by collecting the records of monitoring and evaluation.

In September of 2010 it was decided that face to the overcoming budget constraints, the projects that ended its execution of two or four years in 2011 would not be renewed. An exception is possible, based on quality criteria, in projects that reveal technical quality and which the priority territory continued to have need for intervention. Thus, the continuity of the projects would be dependent on the following assumptions:

- The territory covered after the diagnoses update still in need of intervention;
- The entity through the work developed reveals a quality intervention and have answered to the objectives and indicators proposed.

In 2011, 99 PRI were functioning driven by the respective Territorial Nucleus (NT), which include 130 projects co-financed by IDT, I.P.

Continuity was given to the implementation of the system for monitoring and evaluation, both at projects level as well as at PRI level.

In the map is presented the PRI distribution by district and the number of PRI followed by each Regional Delegation (DR) of IDT, I.P.

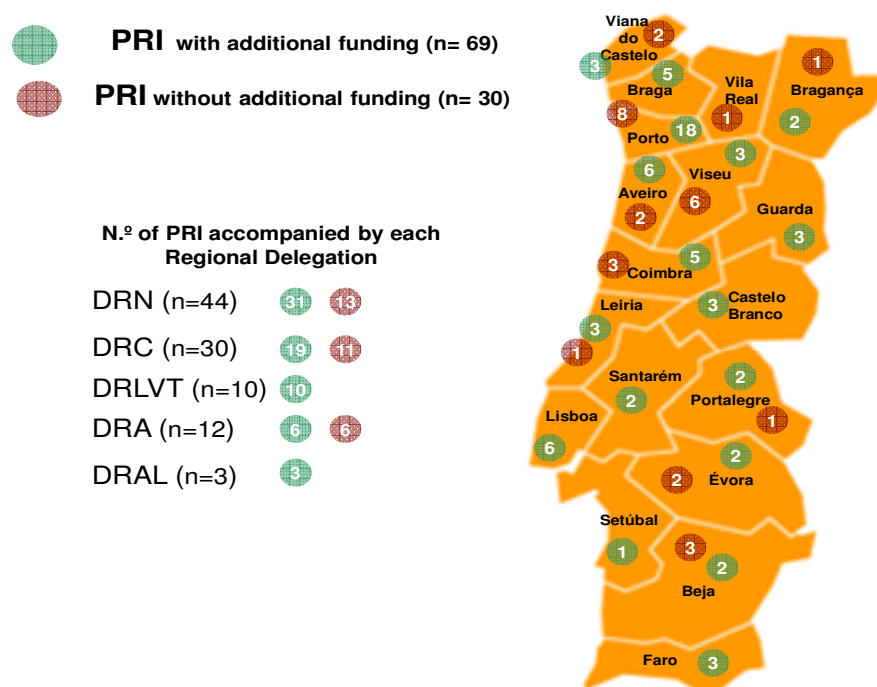
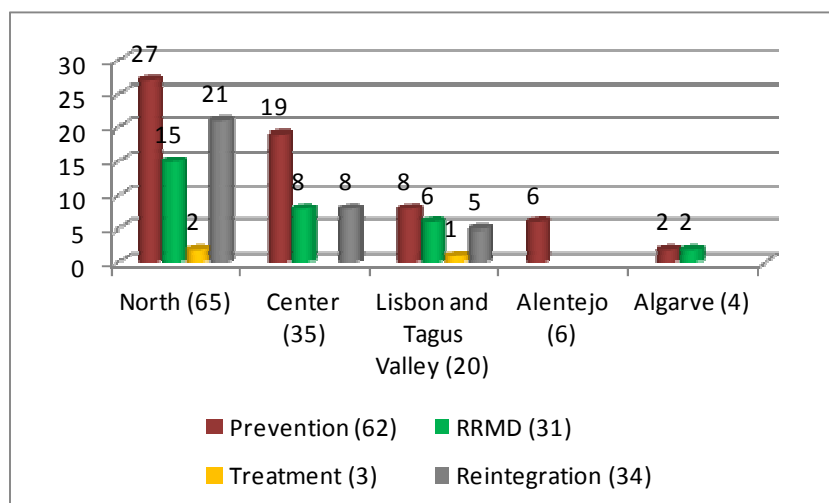


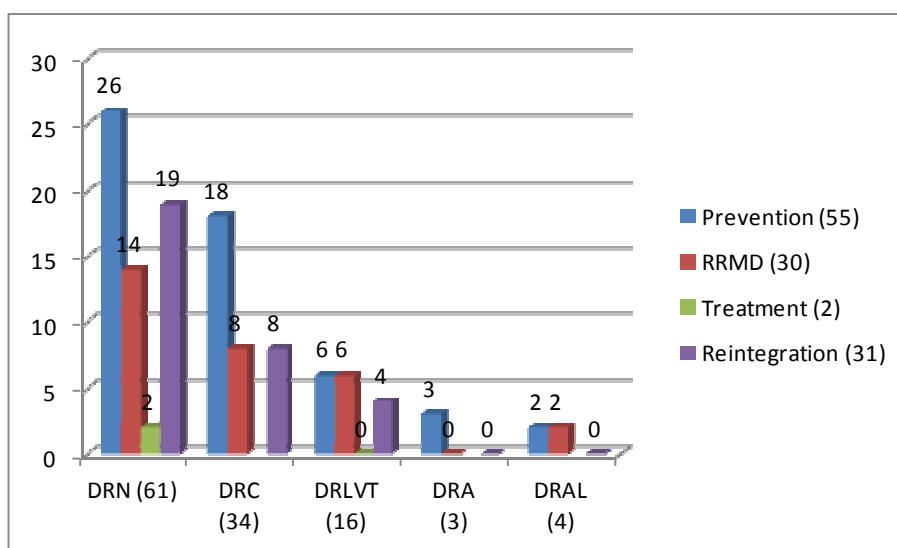
Figure 2 – Programs of Integrated Responses (PRI), by District and Region (IDT, I.P. 2012)

In 2011 were in execution 130 co-financed projects by IDT, I.P., with the following distribution by region and axe of intervention:



Graph 9 – Projects co-financed in execution in 2011 N=130 (IDT, I.P. 2012)

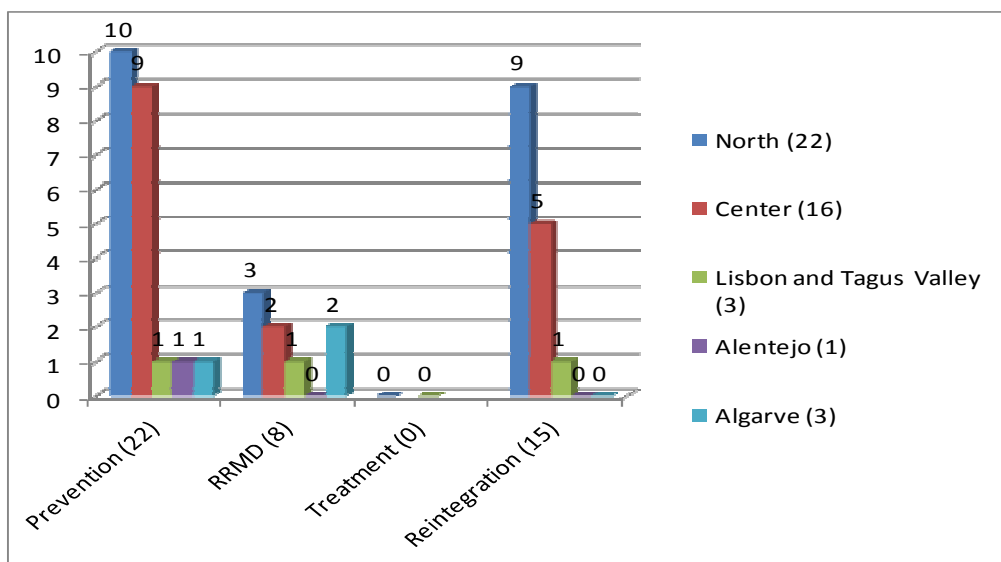
In 2011, continuity was given to the elaboration of situation points of the ongoing projects in the 11^o month and 23^o month of execution in order to decide on the relevance to renew the projects or continuity for the last year of implementation. 118 situation points were elaborated of the 128 projects that meet the conditions for its production, according to the following Graph.



DRN – Northern Regional Delegation; DRC – Center Regional Delegation, DRLVT – Lisbon and Tagus Valley Regional Delegation, DRA – Alentejo Regional Delegation, DRAL – Algarve Regional Delegation

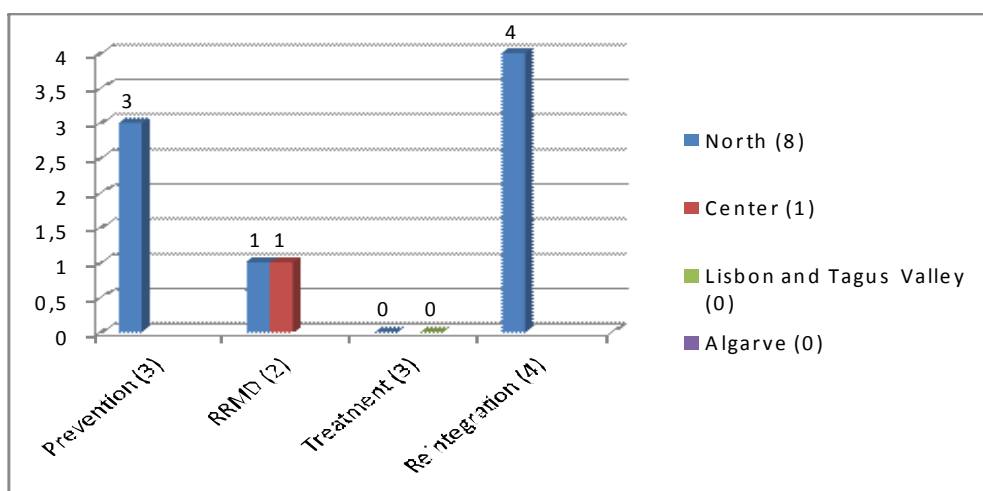
Graph 10 – Distribution of the projects by region and axe of intervention, (Point of Situation) N=118 (IDT, I.P. 2012)

The analysis of the projects that concluded the execution period (which correspond in most cases to 2 years) led to the renewal of some projects and the conclusion of others. The following graph presents the distribution of the number of projects concluded by region and by axe of intervention.



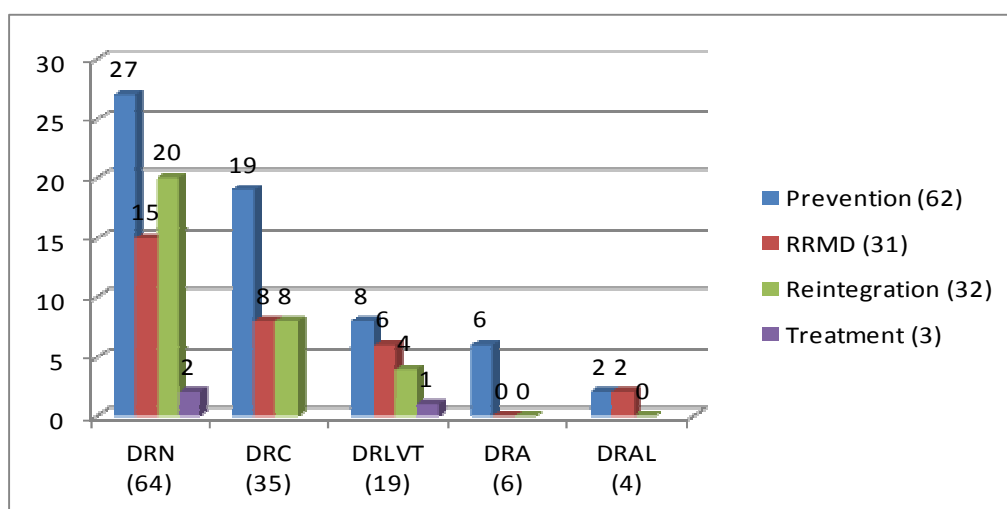
Graph 11 – Projects concluded in 2011, N=45 (IDT, I.P. 2012)

The following graph presents the distribution by region and by axe of intervention of the projects renewed. The reduced number of projects renewed is due to budget constraints and not to a lack of quality of the interventions developed.



Graph 12 – Projects renovated in 2011, N=64 (IDT, I.P. 2012)

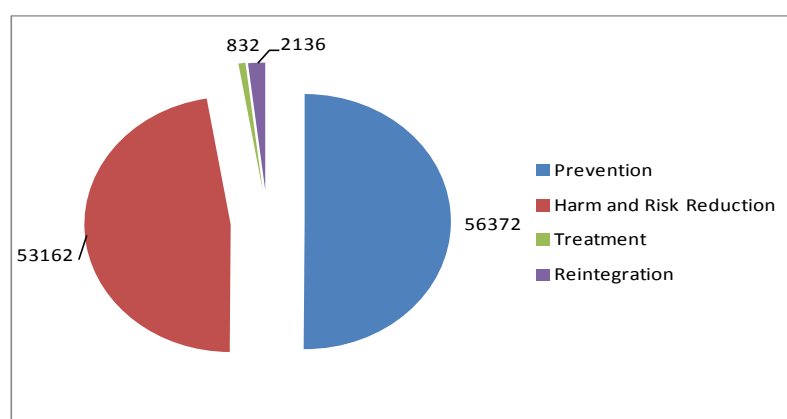
In 2011, continuity was given to the monthly collection of process indicators of the co-financed projects in the ambit of PRI. Monthly information was collected from the 128 of the 130 projects in progress, with the distribution by region and axe of intervention showed in the next graph.



Graph 13 – Distribution of the projects with information concluded and registered in the database, N=128 (IDT, I.P. 2012)

Below is presented the main data on the number of persons covered (by target-groups) and the type of activities they participated in 2011. It is important to note that the execution indicators monthly relate solely to the actions developed in the projects among the beneficiaries, i.e., are not intended to reflect all the work that the implementation of a project entails, but report some of the most important numbers.

The following Graph presents the total number of individuals covered by the projects in execution. It should be noted that the Harm and Risk Reduction (RRMD) axis includes also the intervention carried out in recreational context and/or festivities.



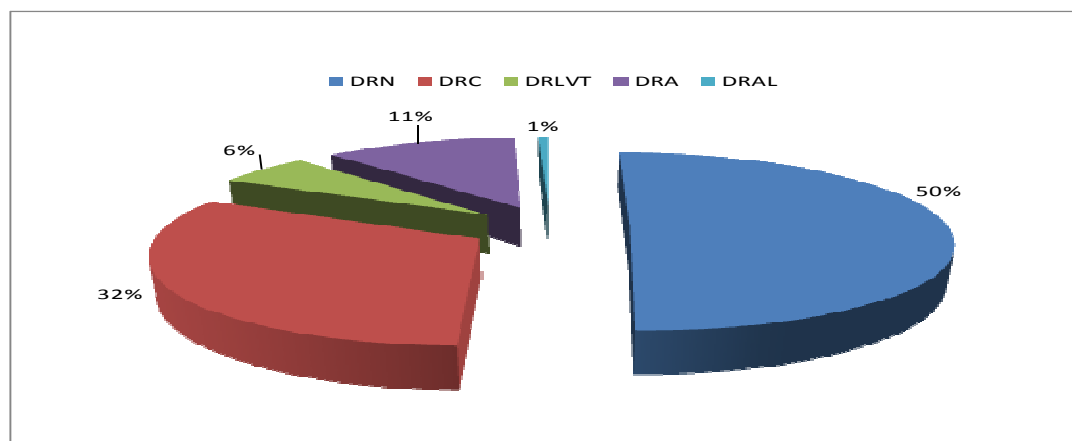
Graph 14 – Total individuals covered by axe of intervention N= 112 502 (IDT, I.P. 2012)

Specification by Axe of Intervention - Prevention

Concerning the prevention axe in the ambit of PRI co-financed by IDT, I.P., 62¹⁴⁾ projects were implemented covering a total of 56.372 individuals (93 636 individuals in 2010, 61 230 in 2009).

The majority of the population covered is situated in the North (50%) and Center (32%) since these are the regions with a higher number of projects and actions in execution.

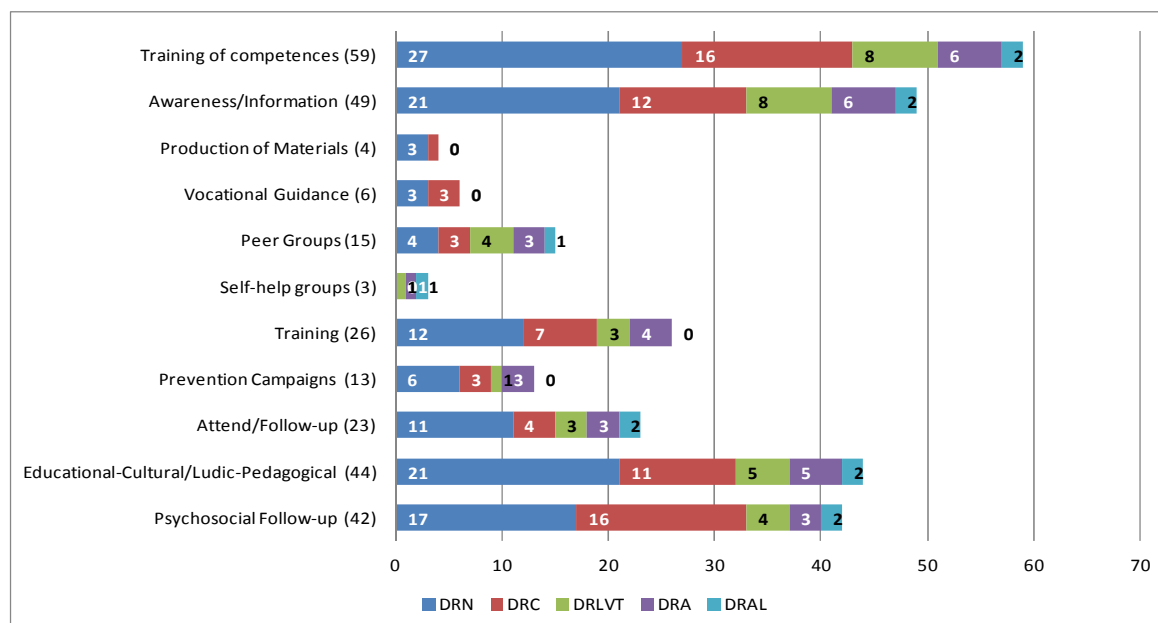
⁽¹⁴⁾ Of the 62 projects implemented, 2 had an execution period of 5 months and 10 a period inferior to 3 months.



DRN – Northern Regional Delegation; DRC – Center Regional Delegation, DRLVT – Lisbon and Tagus Valley Regional Delegation, DRA – Alentejo Regional Delegation, DRAL – Algarve Regional Delegation

Graph 15 – Total individuals covered, N= 56 372 (IDT, I.P. 2012)

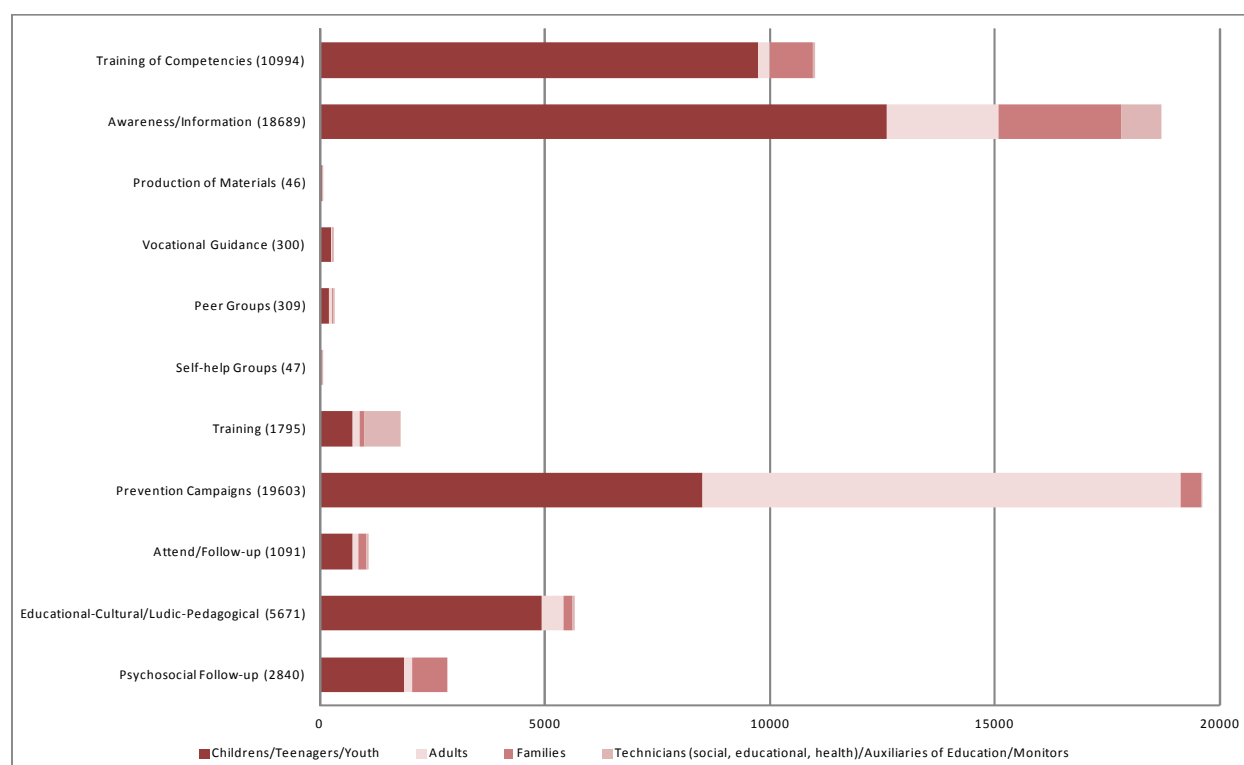
In the following graph is presented the type of actions developed in the 62 projects in execution:



Graph 16 – Type of actions developed in the projects by region, N=62 Projects (IDT, I.P. 2012)

The majority of the projects (59) carried out actions of training competences, 49 of awareness/information, 44 educational-cultural/ludic-pedagogical and 42 projects developed actions of psychosocial follow-up.

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



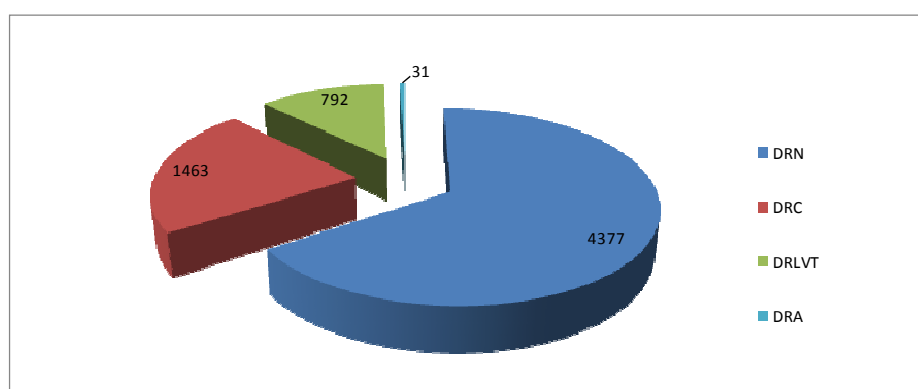
Graph 17 – Distribution of the individuals covered by type of action (N=56 372), (IDT, I.P. 2012)

The type of actions that covered more individuals were the awareness/information and prevention campaigns, usually targeted to larger groups, concerning more focused interventions prevail the type of actions of training competences, psychosocial follow-up.

Thus, in 2011 the intervention in the prevention area continues to promote the reinforcement of actions targeted to specific groups with particular emphasis to children, teenagers and young people, remaining the focus of intervention at the level of selective and indicated prevention.

Axe of Harm and Risk Reduction

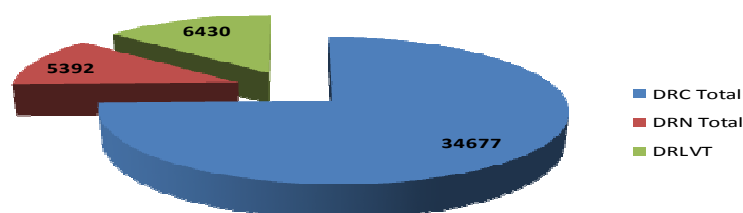
With respect to the axe of Harm and Risk Reduction, in 2011, 31 projects were in course under the PRI (31 in 2010, 29 in 2009). In the ambit of Outreach teams, Drop in Centre and PSO-BLE, 6 663 people were covered (7 685 in 2010, 5 500 in 2009).



Graph 18 – Target population, Drug addicted without social family environment (N=6 663), (IDT, I.P. 2012)

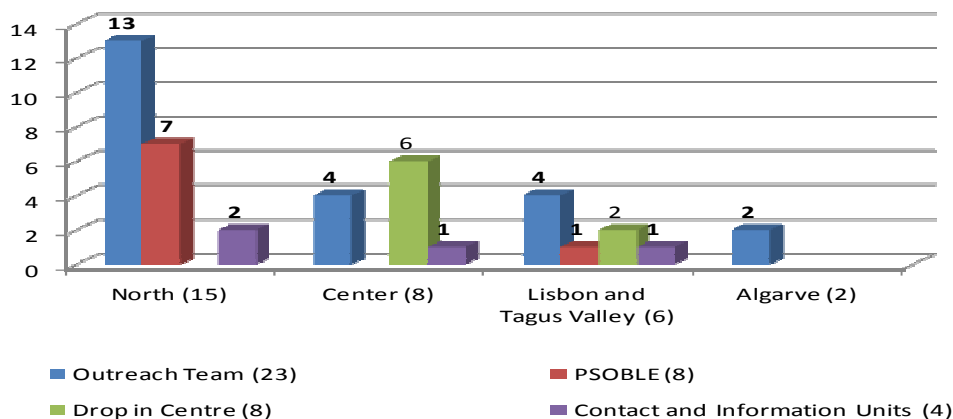
It is important to highlight that the ambit of intervention of these structures is centred near the addiction population without social-family environment with very specific characteristics, namely individuals with many years of dependence presenting psychal, psychological and social weakness. From the perspective of the context of the intervention, these responses are located in areas identified as problematic in terms of trafficking and consumption (mainly urban areas and peripheral housing estates).

In relation to intervention in recreational and/or festivities settings, the 9 projects under PRI covered near 46 499 individuals from whom 14 022 were contacted in the bar/disco setting and 32 477 in the party/festival context (for more info on these intervention, see chapter 7.2).



Graph 19 – target population of RRMD intervention in recreational setting (N=46 499), (IDT, I.P. 2012)

The responses developed by the projects, according to the established by Decree-Law N.º 183/2001 of 21 June, are presented in the following graph:



Graph 20 – Total number of responses developed by the projects, by region (N=43), (IDT, I.P. 2012)

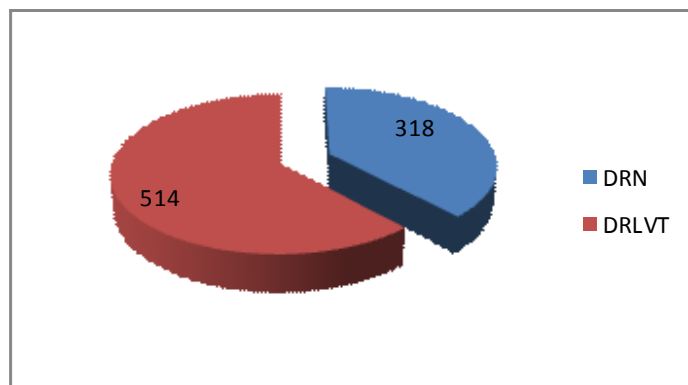
Treatment Axe

The IDT, I.P. network care provider develops a work supported by the treatment mission area through the 23 Centre of Integrated Responses (CRI) and 45 Treatment Teams (ET) and respective decentralised appointments, in a strict articulation with all PRI.

With respect to the Treatment axe, and the projects co-financed by IDT, I.P., the intervention was developed in the North Region, with two projects and in Lisbon and Tagus Valley, with one project. In 2011 these projects concluded the 3rd year of execution, their relevance and continuity was assessed.

Taking into consideration the importance of the work developed, the population covered and the geographical locations of implementation, its continuity was considered essential to intensify the work done.

It's worth to note that the population covered with these projects increase 28% in relation to 2010, passing from 650 to 832 individuals followed-up.

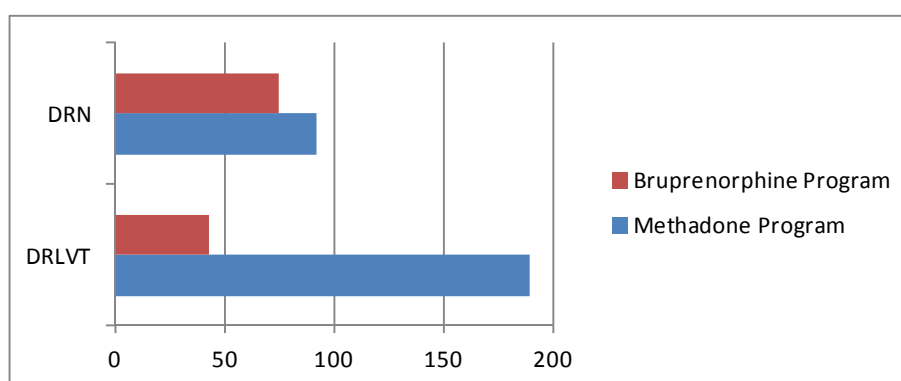


Graph 21 – Total number of individuals covered in the year 2011 by the 3 projects (N=832), (IDT, I.P. 2012)

Type of answers developed by the projects:

Throughout 2011, 8 178 appointments were realized to the 802 patients followed by 2 of the three projects that have the response “Appointments Centres” corresponding to an average of 10 appointments by patient, by year.

The treatment projects have also developed a program of opioids antagonist maintenance as we can observe in the following graph, with a total of 281 patients in methadone program and 118 in buprenorphine.



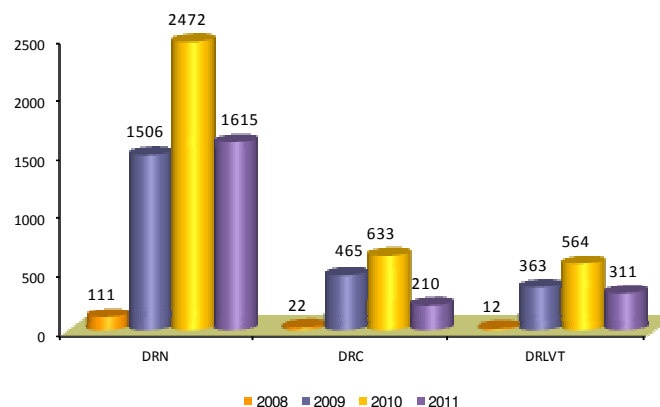
Graph 22 – Distribution of the individuals covered by the programs of opioids antagonist programs (N=399), (IDT, I.P. 2012)

Giving continuity to the work developed in previous years in the ambit of co morbidities screenings were made to the clients in follow-up in the 2 appointment centers; in the Northern region¹⁵ 95 individuals were screened for HIV, 59 for Hepatitis B and 59 for Hepatitis C.

⁽¹⁵⁾ No data available for Lisbon and Tagus Valey in relation to the screening donned in 2011.

Reintegration Axe

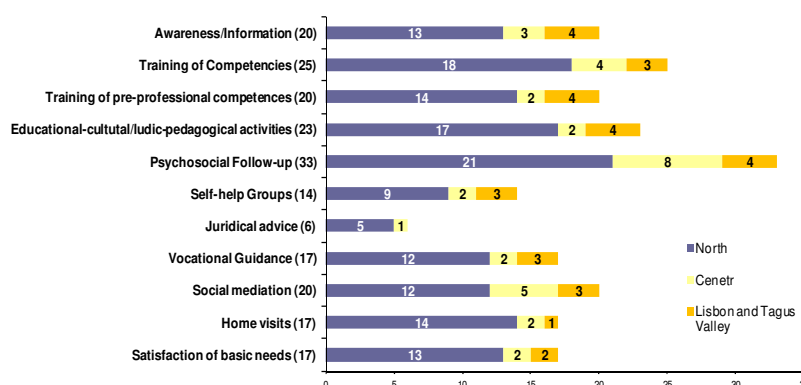
34¹⁶ co-financed projects were developed in the Reintegration Axe, distributed by the Northern, Center and Lisbon and Tagus Valley regions. These projects covered a total of 2 136 new patients who were targeted by interventions in the reintegration context. In addition to these new patients, projects continue to follow-up a high number of clients that passed from previous years.



Graph 23 – Total number of individuals covered in 2011 (N=2 136), (IDT, I.P. 2012)

Most of the covered population is located in the northern region (76%), since it is in this region that 21 of the 34 reintegration projects in implementation in 2011 are being developed. There was a significant decrease of new patients covered by the projects in 2011 in comparison to previous year (42%), this is related with the high number of projects that ended in 2011 (15) projects.

In the following graph is presented a typology of the actions developed in the projects.



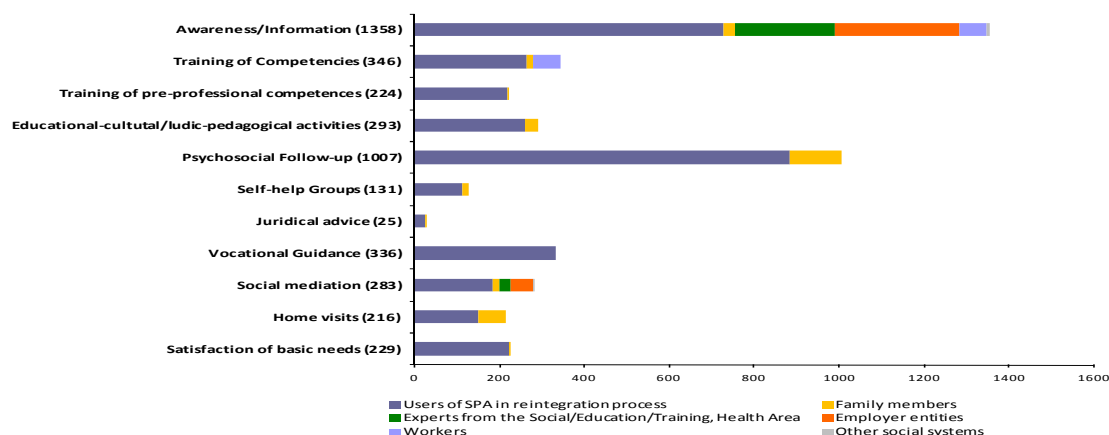
Graph 24 – Type of actions developed in the projects, by region (N=41 projects), (IDT, I.P. 2012)

The psychosocial follow-up is the base of intervention strategies in reintegration, which is verified by the large number of projects that develop this type of action (33). Also noteworthy the actions of training competences, presented in 25 projects, the educational/cultural/ludic-pedagogical activities developed in 23 projects, the awareness/information action, developed

¹⁶ Monthly indicators were not available for one of the projects, so the indicators presented concern 33 projects.

in 20 projects, as well as the actions of pre-professional training competences and social mediation. Social Actions Mediation assume a very important character in the process of reintegration, once aimed at the preparation of social systems, as facilitating elements of the processes of integration and, concomitantly, a systematic follow-up of patients on those systems.

These actions involved different target groups, users of psychoactive substances in reintegration process and their parents, and other social systems that play an important role in the concretisation of the reintegration paths of the users, such as experts from partner entities, employer entities, and others which are listed in the following graph:



Graph 25 – Distribution of the individuals covered by type of action (N= 2 136), (IDT, I.P. 2012)

Most of the actions developed were targeted to users in reintegration process, especially the actions of psychosocial follow-up (885 patients and 122 families). Awareness/Information actions covered the largest number of people, including users in reintegration process and several elements of social systems, in a total of 1 358 people. It was also stressed the importance of the work developed near the social systems, in special the developing of actions of awareness and social mediation that allows the establishment of linkage, between the individual and the context where is integrated which is fundamental for the achievement of integration individual plans and for the success of the intervention in reintegration.

Implementation of PRI

Monitoring and evaluation of PRI

In 2011, continued the collection of PRI Monitoring and Evaluation sheets. The purpose of this instrument is to assess how the execution is taking place at each PRI. This sheet is filled in the Territorial Nucleus with the participation of the elements that constitute it. The objective is a brief qualitative assessment of the main aspects of PRI development. Were registered 55 monitoring sheets of the 69 PRI co-financed who met conditions for its elaboration. In relation to the PRI without need to additional fund, were received 13 evaluations of 30 PRI in execution. Most evaluations have not followed the full model set. However, through the information available it is known that the participation of the constituent entities of the Territorial Nucleus was very active and it meetings took place with some regularity, which allowed a monitoring of the interventions developed by the different partners.

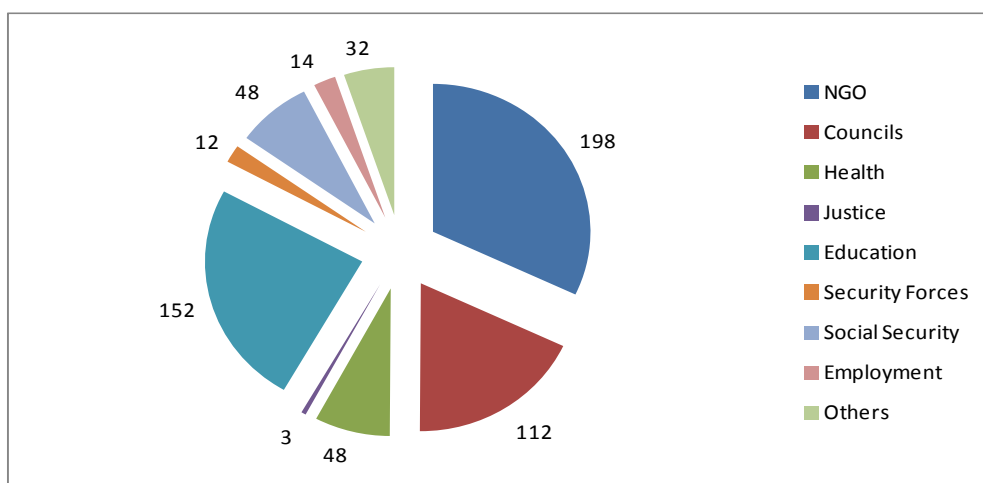
Constitution of Territorial Nucleus:

In what concerns the constitution of Territorial Nucleus of 91 PRI, from the 99 implemented in 2011, it was verified that several entities are participating in this dynamic and, on average, each Nucleus is constituted by 9 entities.

From the 619 entities that are part of the NT, 198 are NGOs, including Mercies, Private Institutions of Social Solidarity, Associations, Foundations, among others. It was noted that from the 198 NGOs present in the NT, 86 are co-financed by the IDT, I.P. in the ambit of PRI.

With intervention in the Education area there are 152 entities. There is also an important weight of Municipalities in the NT, with 112 representations, including Council Cameras and Parish Councils. Also noteworthy were the entities in the Social Security area (48), which included the District Centres of the Institute of Social Security, the Commissions for Protection of Children and Young People and Social Networking. In the health area 48 entities were present, including health centres, regional administration of health and local health units.

In the ambit of Employment, IEFP, I.P. was represented by 14 entities, including Centres of Professional Training and Employment Centres. Security forces were also present (12). In the area of justice, entities present were the General Directorate for Prisons and the General Directorate of Social Reintegration.



Graph 26 – Typology of the entities that constitute the Territorial Nucleus (N=619), (IDT, I.P. 2012)

Program of Focused Intervention (PIF) was a prevention program for vulnerable groups in the ambit of the mission area of prevention that was implemented between 2007 and 2009, evaluated in 2010 and concluded its final report in 2011.

PIF was designed to increase the number of preventive interventions scientific evidence based and to enhance preventive interventions of selective nature for families, children and vulnerable youth and individuals with patterns of psychoactive substance use in recreational settings, composed by 23 projects developed in national territory.

Considering the objectives and assumptions defined for PIF and the evaluation results, we concluded that the interventions developed contributed to the development of competences in the target groups to deal with the use of psychoactive substances and to improve the knowledge about their effects. On the other hand the intervention was multi-component, comprehensive, focused on a specific group of regular intensity, based on a conceptual and methodological framework developed by multidisciplinary teams of professionals with specific training and experience in the area, looking further evaluation as a structuring principle.

With FIP was possible to identify key dimensions to the definition and implementation of drug selective prevention programs, to test new methodologies and practices, evaluate them, but also reflect on their results and based on them define guidelines for future preventive intervention.

In 2011 was concluded the rigorous process of administrative financial management and continue the dissemination of the program results. In this sense, and concerning the dissemination of PIF results were developed the following activities¹⁷:

- Publication of a scientific article in the magazine *Toxicodependências* on the results of PIF, entitled "Prevention of drug addiction in vulnerable groups: The results of the Focused Intervention Program - PIF";
- Presentation of papers in a poster at the First Meeting of the Northern Regional Delegation of IDT, I.P., under the title "*Pensar as Dependências-Temas cruzados*" and the 2nd International Conference and Members Meeting European Society for Prevention Research, entitled "Synergy in prevention and health promotion: individual, community, and environmental approaches".
- Edition of the e-book "*Intervenção Preventiva com Grupos Vulneráveis*" – A Experiência do Programa de Intervenção Focalizada". The document was systematized from the Final Report of the PIF, and was released in November 2011 by IDT, I.P., available at IDT, I.P. and via CD -ROM.

The process of implementation and evaluation of PIF was concluded with the production of important documents: "Guidelines for Preventive Intervention Consumption of licit and illicit psychoactive substances" and also a document of good Practices - "Prevention of drug addiction Vulnerable Groups - Catalogue of Good Practices".

Intervention in the Boom Festival (see also chapter 7.2)



A cooperation agreement was signed between the producer of the Boom Festival, held in Idanha-a-Nova, and IDT, I.P., with the aim of carrying out cooperation actions in the research area, prevention, harm and risk reduction of the use of psychoactive substances, within the existing legal framework. The collaboration resulted in the implementation of Kosmicare, an emergency service developed at BOOM festival, whose purpose was to intervene in the crisis resulting from the use of psycadelic substances

The project developed, called Kosmicare (KC) it's a psychoactive substance (SPA) crisis intervention service. The service is carried out 24 hours during all the festival days in one particular area - the KC Dome. The project's mission is to transform potentially unpleasant crisis experiences in a constructive experience, what is obtained through offering a safe and protective environment where such processing and integration can unfold (Nielsen & Bettencourt, 2008). The main goals are to diminish the risk for development of mental illness associated with the use of SPA, mostly psychedelics. Guided by psychedelic psychotherapy principles (Grof, 2008a), crisis intervention in situations related to unsupervised use of psychedelics (Grof, 2008b), general crisis intervention models (Hoff & Adamovski, 1998; Roberts, 1990; Kanel, 2003) and harm reduction principles (Marlatt, 1998), a variety of services are offered with the intention expressed above, alongside with other project goals

¹⁷ The documents referred can be found on the official website of the IDT, IP. In the separator Documentation Centre – Publications - http://www.idt.pt/PT/Prevencao/Documents/PIF/relatório_final_PIF.pdf

such as to share vital information about SPA, their potential effects, benefits and risks; and reduce damage associated with the use of SPA (Kosmicare, 2010).

The protocol of cooperation established, formalized not only technical support and resources to intervention, but also a research project to evaluate with the purpose of developing research and project evaluation, thus contributing not only to specific process and outcome evaluation goals, but also to the formalization of a crisis intervention model in SPA use in recreational contexts.

During 2011 the IDT, I.P., allocated two professionals as external consultants to the research project to evaluate the intervention model Kosmicare 2010. This consultancy reviewed the relevant technical research and designed methodology. It was also provided support to the assessment of Project Kosmicare at the level of treatment and analyzing data; conception and revision of the final report; consolidation of an intervention model on crisis in similar contexts, preparation of the final research report.

Data and knowledge gathered on crisis intervention in the context of Boom Festival was collected and integrated from Visitor's who benefited from intervention and from Team Members' perceptions about KC and about the Festival as a whole. Below we stress some of the major conclusions and point out what we consider to be important implications in the design of future KC interventions.

Considering the project's mission was to transform potentially unpleasant PAS crisis situations in a constructive experience, and considering process evaluation results, we can conclude that KC intervention accomplished successfully its main objectives. It is also possible to conclude that we gained useful knowledge about the main aspects to consider for future interventions.

We conclude that Process Evaluation offers valuable data on population presenting SPA related crisis episodes, their drug use patterns, recreational setting's dynamics and a number of other aspects. However, it should be noted that all results concerning SPA use by Visitors refer specifically to the range of situations attended at KC that are potentially associated with a crisis experience. By no means can these be generalized to reflect SPA being globally used at the event or among its general participants.

Team member's perceptions present particularly relevant contributions for evaluation purposes. In fact, Team Members present multiple views on the intervention and global Festival experience since they act, simultaneously, as Festival participants, workers directly dealing with general Festival organization structure, and are also carers of other participants.

There is a considerable gap between Team Member's satisfaction and Visitor's satisfaction towards the project. This aspect should be interpreted, in our opinion, as revealing considerable professional standards, dedication and commitment of the staff towards the project's mission. In fact, and notwithstanding the fact of having to deal with considerable challenges in terms of work conditions and perceived negative structural aspects of the Festival, Team Members preserved high quality standards developing their tasks and responsibilities as proved by Visitor's satisfaction results.

Considering the positive and negative aspects deriving from the evaluation, we can conclude that it is very important to gather a team with previous experience on Boom and/or KC work. It is also clear that particular attention should be paid in the future to guarantee heterogeneity of academic skills (psychiatry, psychology, various types of therapies, nursing, etc.), and heterogeneity of personal skills, help skills, personal backgrounds and language knowledge. All together, these distinctive aspects ensure the holistic approach that makes the intervention unique.

Considering the diversity of languages spoken, we stress that Visitor's nationality consists of a major feature to attend regarding the project's design, since communication aspects need to be considered in order to guarantee that the most frequent languages are spoken by Team Members, allowing intervention to take place in Visitor's native idiom.

Evaluation showed us that the main source of motivation for Team Members was the opportunity of human interaction with Visitors and Co-Workers, along with the opportunity to perform a challenging task. These aspects might, however, become insufficient to guarantee quality volunteers in the future if we consider the obstacles encountered in terms of Team's logistic support and work conditions, what could represent a serious threat for the intervention. Future editions should guarantee basic work conditions such as food and safety for all workers involved in the project.

The fact that some of KC's job functions involve a payment (Pilot, Co-Pilots and Team Leaders) and others don't (Sitters, Health Staff and Consultants) is also an aspect to be considered in the future as potentially influencing team climate in a negative way.

The specific nature of KC's intervention associated with the unpredictability of many project implementation aspects makes Coordination Team efficacy particularly central to the project's success. Essential features for Coordination implementation are (i) a clear definition of coordination tasks, (ii) a reasonably hierarchic (yet flexible and democratic) structure, (iii) high competence in Team Management and conflict solving, (iv) the ability to present quick and effective responses to problem solving even in presence of unexpected circumstances, among other skills. These essential features have not always been met according to Team Member's perceptions.

It is also the Coordination Team's responsibility to guarantee acceptable field-work conditions for all workers, especially in crisis situations where physical and environmental risks are probable to occur. This level of effectiveness is, of course, dependent of successful articulation with Festival Organizers which, in accordance to Team Members perceptions, has not always been achieved.

Data have also stressed the main issues to be attended by Festival Organizers. The most central ones, according to Team's perceptions and Visitor's related data, had to do with ensuring safety, offering a location for the dome that increases Visitor's accessibility and promoting close articulation between all care services operating on site.

It is also Organizer's responsibility to ensure an effective divulgation of KC in order to guarantee every Festival participant in need is able to locate and use the service. According to data related to how visitors came to KC and Team Members perceptions on this topic, we conclude that divulgation was insufficient.

If we consider the type of situations attended and diversity of data regarding visitors and intervention it is possible to conclude that KC operates, in fact, far further than what would be expected from a SPA crisis related intervention project. Apparently no other context at the Festival seems to offer better conditions to deal with participants that have been robbed, that have been victims of violence, that have no documentation, that are in withdrawal from opiate agonist medications, or that present severe psychiatric symptoms (related or not to SPA use). All the situations attended by KC, that future evaluation data are expected to report more thoroughly, can present serious challenges to Organizers. This justifies, in our opinion, an increased attention to resources dedicated to the project. We stress that even if these situations represent only small numbers (which was the case in the present edition), they are time and resource consuming and pose challenges that other help services at the Festival are likely to be unprepared to deal with.

These situations also justify that future editions consider to include a social worker and/or a psychosocial response at the project. This new job function could be in charge of articulating with resources external and internal to the Festival. We believe this Team structure could offer an increased response to the challenging situations that are expected to appear at the service.

Data on visitor's affluence to KC, data on number of cases attended at KC per Festival day and peaks per intervention shift are important indicators that potentially help human resources management. If we consider that shift 2 (15h-23h) was signaled has the one registering higher affluence, also being the one where climate conditions are at their worst,

we suggest that future editions consider diminishing the number of hours per shift (from 8 to 6/5 hours) and that number of Sitters at expected high affluence shifts is increased.

KC intervention model has been defined as work-in-progress since its early beginnings back in 2006 (then presented as KosmiKiva). Up to the present edition in 2010, this initiative hadn't yet been submitted to a structured evaluation process. Investment in research and evaluation reinforce the relevance for this kind of intervention on a Festival with the characteristics Boom presents. This said, and given the data and experience collected, we present suggestions for future evaluation research planning.

We recommend the development of an effective intervention monitoring system. This should enable a simplified characterization of participants, simplified intervention description and effective management of Visitor affluence (how many, number of arrivals, number of departures, types of situations presented, etc.).

Evaluation would also benefit from further assessment of intervention efficacy. Even though efforts were made with this purpose¹⁸ we suggest that future evaluation considers including *intensive designs of research* such as *time-series designs*, or other forms of designs that allow measurement of specific efficacy indicators while adjusting to intervention's idiographic character (Powers, 1990).

Data collection should be developed by an increased number of team members dedicating exclusively to this task. These collaborators should be selected in accordance to their familiarity with the project and data collection instruments. These suggestions were reported at IDT consultant's report (Carvalho, Vasconcelos & Frango, 2010) following consideration of the challenging work conditions on site and the demanding nature of all research associated tasks.

Data collection instruments should be further improved, simplified, pre-tested and/or reviewed by experienced researchers and team members (Carvalho, Vasconcelos & Frango, 2010).

We also suggest that collected data are periodically gathered and briefly reviewed during intervention, what could be achieved through brief meetings coinciding with end of shifts (Carvalho, Vasconcelos & Frango, 2010).

A comparison with available data concerning the 2008 edition of KC is useful to discuss target group's coverage by intervention. On that previous occasion a total of 200 situations were attended¹⁹ (Nielsen & Bettencourt, 2008). This comparison could lead us to conclude for the decrease of crisis situations occurring at the festival at the 2010 edition, where in contrast only a total of 130 situations (related to 122 Visitors) were attended. These results must be discussed, however, in consideration with a number of other factors potentially interfering with KC affluence. Evaluation shows that a number of factors might have impeded intervention accessibility for all those in need. As stated above, these have to do with difficulties in the partnerships with other help structures operating on-site (mainly Paramedics), KC location and distance towards main structures at the festival, and difficulties with communications. In our opinion, the fact that KC has operated on a lower total of participants should not, therefore, mean that less PAS related crisis episodes are occurring at Boom Festival.

Another aspect to reflect upon has to do with the discussion concerning intervention conceptualization. We consider KC to fully integrate the current definition of health promotion, that recognizes that interventions addressing "behavioral health fall on a spectrum ranging from promotion and prevention to treatment and maintenance", the goal of promotion and prevention interventions being "to decrease exposure or impact of risk factors that increase individuals' likelihood of developing mental and emotional behavioral problems

¹⁸ We refer to data regarding Mental State assessment on arrival and on departure from the service, using an observational scale created for this purpose. Further results regarding this instrument will be presented during 2012.

¹⁹ 58% of which referring to males aged 20-24 Y.O.A. (50%), LSD being the most frequently used PAS (50%) (Nielsen & Bettencourt, 2008)

(...) and to reinforce protective factors within individuals, families and communities that increase health and well-being and lower the likelihood of problems.” (National Research Council and Institute of Medicine, 2009). Throughout this report we used the term *Kosmicare* (KC) to refer to the PAS crisis intervention service at the Festival, implemented at the KC Dome – this intervention is considered to potentially diminish the risk for development of mental illness associated with the use of PAS, mostly psychedelics.

Nevertheless, we consider that KC presents a clearly innovative nature, since HRRM fields of intervention have been mostly developed around problematic drug use patterns, with scarce to the specific nature of recreational contexts. We propose a conceptualization for KC at Boom Festival as a prevention targeting harm reduction and risk minimization (HRRM) project, integrating a number of more specific services and strategies, achieved through the collaboration with partners such as Check-In/APDES/Portugal and EROWID/USA, among others. These partnerships allow the project to offer a variety of services that range in a continuum from prevention through risk reduction/RR (outreach, information, STD prevention through condoms and information, paraphernalia distribution, safer use training) to minimization of drug use related harms/HR (crisis intervention, medication, nursing, etc.), in accordance to Hedrich’s (2005) proposal. We stress that both components of the program are closely related in many of the situations attended. These other services are only briefly mentioned by our results and should, in the future, be systematically analyzed by evaluation research.

Since crisis intervention in recreational settings is yet to be conceptualized as an HRRM strategy or as integrating any other known intervention strategy or model, we consider it is fundamental to further invest in its evaluation, as a way to turn KC into an evidence-based model of intervention to be replicated in other recreational settings around the world.

3.4. Indicated Prevention

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

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

In order to meet the needs expressed by collaborators regarding the availability of pedagogical materials for the intervention with students was elaborated the program “SPA - Know how to deal with psychoactive substances: Informing, Demystify, Prevent and Educate” and respective manual.

This manual is intended to complement the intervention model as part of the Social Integrated Competency (CSI) developed in Casa Pia. Once the CSI works a set of components (emotional regulation, decision making, problem solving, communication, among others), the SPA program is only focused on two components: information component and competences to deal with SPA; component to handle pressure and decision making in relation to SPA.

It is addressed mainly to students of the 2nd Cycle to Secondary School and students of the Initial Training of Double Certification educative responses and training of Casa Pia de

Lisboa, as well as students in residential care attending these levels of education and training.

It's constituted by four sections each year in a total of 32 sessions.

The application of the program should be made by technical teams and/or teachers and/or educators and for this it is necessary the participation in a training action with a duration of 10h30.

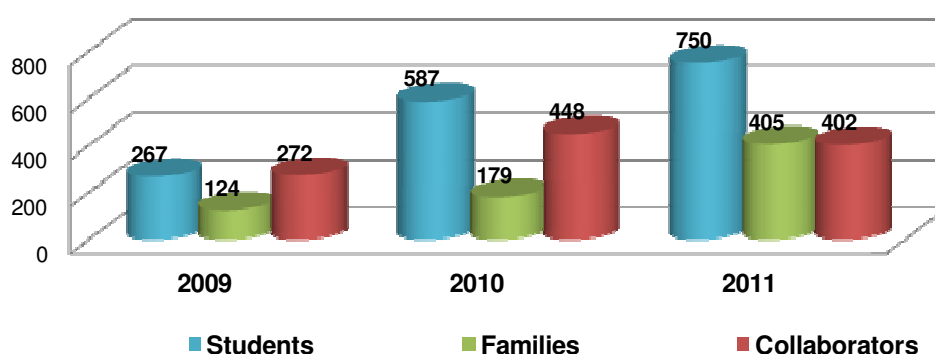
The reference groups should participate in training, to give support to the applicators in clarifying doubts that may arise in the preparation and execution of the sessions and be responsible for the implementation of program evaluation. The core nucleus of the SPA program will be responsible for the treatment; analyses and data collected, as well as provide support to the reference groups in order to ensure quality and fidelity in the implementation of this manual.

The decision to implement SPA thematic sessions in the CSI program should be taken in the planning phase of CSI and the application of the manual sessions implies the development of four sessions throughout the year. This program should be preferably implemented on an ongoing basis covering students of all levels of education, if it is not feasible to implement on an ongoing basis, the students should be preferentially targeted by the program during two years, or eight sessions.

Activities undertaken in 2011 operationalized the project objectives by continuing the work done in previous years, namely:

- Follow-up meetings to the Reference Groups by Education Center – 42 meetings took place;
- Meetings of the core group - 12 meetings took place;
- Awareness/Information actions in the ambit of prevention of psychoactive substance use for professionals and teachers – 24 hours

The preventive intervention developed in 2011 reached 750 students, 405 families and 402 collaborators of the CPL.



Graph 27 – SPA intervention by target group (IDT, I.P. 2012)

In comparison to the last two years we verified that the range of the actions target to students and families has been steadily increasing and actions target to collaborators are decreasing.

These data reveal the strategies outlined by CED, i.e., in a first phase there was a need to address a greater number of actions to collaborators in order to raise awareness and provide tools for prevention and in a second phase to focus the intervention on students.

3.5. National and local media campaigns

In 2011 and 2012 media and public debate was focused mainly on the following drug-related issues:

- Presentation, at the National Parliament, on the 21st December, of the Annual Report 2010 “A situação do País em Matéria de Drogas e da Toxicodependência”;
- With the aim to promote healthy lifestyles, the IDT, I.P., in partnership with Sportis, participated and supported several editions of the Bike Tour in Lisbon Porto, Sao Paulo e Rio de Janeiro. A kids bike tour, called Biklas, was organized in Lisbon with the participation of 200 kids from 4 to 11 years;
- International Conference: Drugs regulatory models

The School of Criminology, Faculty of Law, University of Porto, held on the 10th November 2011, an international conference called Drug Regulatory Models: the Portuguese experience in the European context. This event, attended by national and international researchers, served to mark the 10th anniversary of the entry into force of the Law of Decriminalization of Drug Use in Portugal Law No. 30/2000 of 29 November;

- Conference Global Addiction 2011 (5-7 December)
Lisbon received the bi-annual meeting of Global Addiction, which includes the 6th European Congress of the Addiction Therapy Association, in which participated experts of 43 countries;

- Joint press release on new psychoactive substances (9th November 2012)
Following several articles in the national press on licit substances sold in head/smart shops, which included mixed messages concerning the toxicity of substances, SICAD, DGS and Food and Economic Safety Authority (ASAE) issued a press statement recalling the definition of new psychoactive substances as referred in the Council Decision 2005/387/JHA.

4. Problem Drug Use

4.1. Introduction

In 2011 there were no new studies on problematic drug use, so we continue to report here the last study realized.

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

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

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

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

4.2. Prevalence and incidence estimates of PDU

a. National estimate of overall PDU for Portugal

Multiplier method using treatment data

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

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

In Porto, the in-treatment rate was 0.59, for the direct question (i.e., in 2005, have you ever attended a CAT?) and 0.52 for the nomination procedure. In Viseu, a medium size Portuguese city, the in-treatment rates were 0.62 and 0.56 for the direct question and the nomination question, respectively.

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

Limitations

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

b. National estimates of IDU's in Portugal

Multiplier method using treatment data

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

Limitations

This multiplier method was calculated based only on the data from the sample of Porto.

Multiplier method using mortality data

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

Limitations

Mortality rates are not constant. The existing mortality rates are almost exclusively based on studies on drug users in treatment.

Year		2000	2005
Definition of Case			
Users of opiates, cocaine and/or amphetamines	Method	Treatment Multiplier	Treatment Multiplier
	Prevalence Estimation	48 673 - 73 010	44 653 - 53 240
	Taxes by 1000 inhabitants 15-64 years	6,4 - 10,7	6,2 - 7,4
Long term users/regular use of opiates, cocaine, and/or amphetamines	Method	"Back-calculation"	Outreach teams Multiplier
	Prevalence Estimation	29 620 - 43 966	30 833 - 35 576
	Taxes by 1000 inhabitants 15-64 years	4,3 - 6,4	4,3 - 5,0
Users (actual or recents) of drug by intravenous route	Method	Mortality Multiplier	Mortality Multiplier
	Prevalence Estimation	15 900 - 31 800	10 950 - 21 900
	Taxes por 1000 habitantes 15-64 anos	2,3 - 4,7	1,5 - 3,0
			Treatment Multiplier
			13 183 - 16 285
			1,8 - 2,2

Table 6 – Prevalence Estimations of Problematic Drug Users in Portugal (IDT, I.P. 2009)

Conclusion

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

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

4.3 Data on PDUs from non-treatment sources

Please see subchapter 4.2.

5. Drug-related treatment: treatment demand and treatment availability

5.1. Introduction

Treatment demand data in Portugal is collected through the outpatient public network. In 2011, the network received treatment demand data from all 78 Treatment centres across Portugal.

In 2011 continuity was given to the articulation with other health care resources and socio-sanitary conditions of public and private sectors, in order to improve the answers to the multiple needs of users with problems associated with the consumption of psychoactive substances. It is also to highlight the orientation for the quality of services provided.

It should be noted that in 2010 came into implementation at national level the Multidisciplinary Information System (SIM) of the IDT, I.P., implying methodological changes particularly in the registration criteria and the potential in data results. These changes were reflected, among others, in the register of medical appointments and the possibility of exclude double counting at national level and individuals with alcohol related problems.

Heroin remains the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures but references to alcohol, cocaine and cannabis in this setting are increasing. In the administration of the main substance continues to be predominant the mode smoked/snorted.

5.2. Strategy/policy

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

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

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

In 2011 there were 32 treatment programs for users of specific substances (alcohol, tobacco, cannabis and cocaine) in function.

Concerning the improvement of technical guidelines or norms for the various types of intervention, took place in 2011 an updating and approval of some documents, such as the guidelines for Early Treatment of Youth at Risk and Teenage Users with focus on Early Symptoms, physical and Psychic (approved in May 2011) and the guidelines for Treatment and Rehabilitation in Therapeutic Community (adopted in December 2011).

5.3. Treatment systems

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

In 2011, 46 outpatient treatment centers were working in mainland Portugal as well as 28 decentralised consultation units. These centers provide both drug free and medically assisted treatment.

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

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

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

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

Similar to last years, it was repeated at national level by the treatment teams, an evaluation of the average waiting time for entry into treatment programs.

The data obtained is compared with the maximum waiting time in days, considered reasonable for each of the programs, being inferior in all the cases with the exception of methadone as you can see in the following table.

2011	Average waiting time at National level (in days)	Reasonable waiting time (in days)
Methadone Program	14	10
Detoxification Unit	12	13
Public Therapeutic Community	9	22

Table 7 – Average waiting time (IDT, I.P. 2012)

Data analysis indicates that therapeutic programs showed, globally, an average waiting time that falls in waiting times defined as reasonable (RA2007). Of the 4 Detoxification Units, 3 presented waiting times of less than 13 days. As for the therapeutic communities, they all presented values below the 22 days referred as acceptable. In terms of admission to methadone program, 32 of the existing 43 treatment structures responded to the

questionnaire, presenting a waiting time of less than 10 days. The above table shows the national average waiting times of the different programs.

5.4. Characteristics of treated clients

2011 national first treatment demand data concerned 5 960 individuals from the outpatient public network centres (78) from these population only 2 265 are Drug Users, this year for the second time it was possible to have TDI data fully in line with EMCDDA TDI Protocol (see also Standard Table 34).

	New Clients in IDT, I.P.
Alcohol related problems	2 142
Drug Users	2 265
Other clients	1 553
TOTAL	5 960

Table 8 – Number of clients by type of problem (IDT, I.P. 2012)

These individuals (2 265) in first treatment demand were mainly:

- Male gender (84%);
- Mean Age 33, 31.4% were aged 25-34, 29% were aged 35-44, 24.5% were aged under 25.
- Using heroin as the main substance (52.3%, 54% in 2010, 47.5% in 2009, 51.1% in 2008 and 59.5% in 2007), followed by cannabis (25.3%, 21% in 2010, 11.7% in 2009, 10.5% in 2008 and 10.9% in 2007);
- cocaine (12.5%, 12% in 2010, 8.7% in 2009, 10.8% in 2008 and 11,6% in 2007);
- Data concerning the administration route of the main substance indicate that (73.4%, 93% in 2010, 64.3% in 2009, 63.1% in 2008 and 74.3% in 2007) of these clients refer smoking/inhaling and 7.2% referred injecting (7% in 2010, 12.5% in 2009, 21.5% in 2008, 19.0% in 2007, 21.9% in 2006);

In 2011, were integrated in the drug addiction treatment public network 26 351 clients in **substitution and maintenance programs**, representing a decrease of 4% in relation to 2010 (27 392 in 2010, 27 031 in 2009, 25 808 in 2008 and 24 312 in 2007), after the continuous increase verified through the last decade.

From those, 5 241 were admitted in the programs (methadone and buprenorphine), being 2 308 readmissions (2 862 in 2010, 3 187 in 2009, 3 004 in 2008 and 2 524 in 2007) and 2 933 new admissions (3 801 in 2010, 5 029 in 2009, 5 022 in 2008 and 4 953 in 2007). Left the program during the year 5 115 (6 282 in 2010, 6 302 in 2009, 6 993 in 2008 and 6 530 in 2007), 18% of whom with medical release (13% in 2010, 14% in 2009 and 2008 and 15% in 2007) and 41% left the program or were expelled²⁰, being the percentage of medical release

²⁰ In 2010, left the Methadone programmes 4 847 clients, 14% of which with medical release and 45% abandon or were expelled and left the Buprenorphine programmes 1 435 clients, 11% with medical release and 30% abandon or were expelled.

the higher value of the strategic cycle initiated in 2005, and of patients leaving the programme the lower in the period (19%).

Regional Delegation	2011	%	Δ 10-11	Δ 08-11	Δ 05-11
Total	26 351	100,0	-3,8	2,1	25,2
North	9 560	36,3	0,4	9,8	36,0
Center	3 505	13,3	-6,4	-1,2	4,0
Lisbon and Tagus Valley	8 813	33,4	-8,0	-9,7	20,8
Alentejo	1 367	5,2	-2,5	11,0	37,9
Algarve	3 106	11,8	-1,4	21,1	31,0

Table 9 – Clients in Substitution and Maintenance Programs, by Regional Delegation (IDT, I.P. 2012)

Regional data show that:

- Decreases in the number of clients in substitution and maintenance programs were registered in all Regional Delegations with the exception of the North (stable);
- The higher decrease in absolute values and percentual was registered in Lisbon and Tagus Valley;
- Like in previous years the percentages in relation to the total number of active clients in each region continued to be higher in Algarve (89% in 2011, 94% in 2010, 85% in 2009, 79% in 2008 and 82% in 2007);
- The districts of Faro, Bragança, Setúbal and Beja registered the highest taxes of clients in substitution and maintenance programs by habitants of 15-64 years.

A survey made each year on the 31st of December 2011 allows differentiation in terms of substances involved in this type of treatment.

On that date, 21 236 clients were registered in the outpatient public treatment network substitution programs, representing a decrease in relation to 2010.

From those 78% (77% in 2010, 76% in 2009, 75% in 2008 and 74% in 2007) were registered in methadone programs and 22% (23% in 2010, 24% in 2009, 25% in 2008 and 26% in 2007) in buprenorphine programs.

In comparison with the situation on the 31st of December 2010, methadone clients increased (+2%) and buprenorphine decrease (-3%) consolidating the inversion occurred in 2006 of the upward trend of clients in buprenorphine verified in previous years.

Concerning the place of administration for the clients registered in methadone programs, on the 31st of December 2011:

- 66% (67% in 2010, 69% in 2009 and 2008 and 70% in 2007) of these clients took their methadone in the ET;
- 16%²¹ (16% in 2010, 17% in 2009 and 2008 and 18% in 2007) in health centres;
- 3% (4% in 2010, 3% in 2009, 2008 and 2007) in pharmacies;

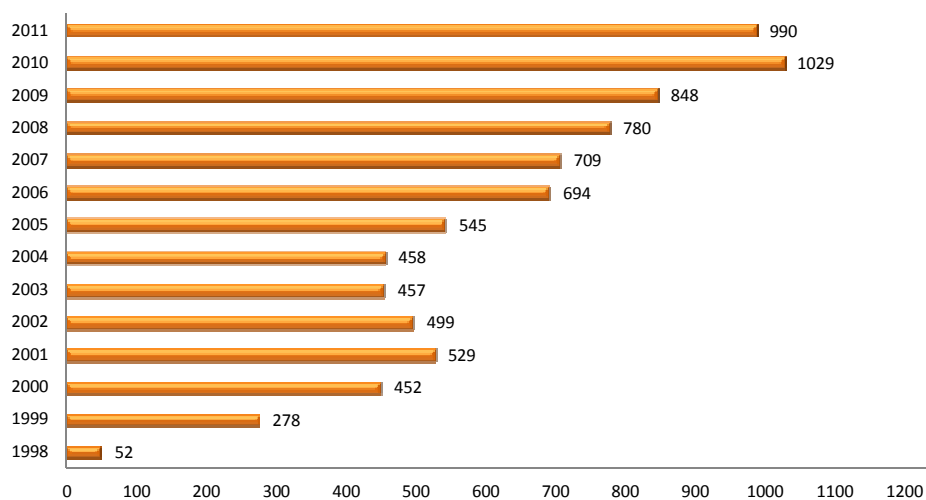
²¹ There are partnerships between IDT, I.P. and several agencies – Health Centres, Hospitals, Pharmacies, prison establishments and others – with the aim to facilitate access to this type of program and promote a higher autonomy and social rehabilitation of users. In case of hospitalisation or detention of users, the treatment teams of IDT, I.P. articulate with those institutions to ensure the continuity of the medicinal administration.

- 3% in Hospitals (2% as in 2010, 2009, 2008 and 2007);
- 7% (5% as in 2010, 2009, 2008 and 2007) in other settings²².

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

The methadone therapeutic programs through pharmacies are the result of a protocol between IDT, I.P., National Association of Pharmacies (ANF), National Institute of Pharmacy and Medicines (INFARMED) and Pharmaceutical Order.

Since the beginning of the program (July 1998) until 31 December 2011, integrated this project 506 pharmacies, 792 pharmaceuticals and 2 913 clients.



Graph 28 – Evolution of the number of clients in pharmacies (IDT, I.P. 2012)

Buprenorphine and Naltrexone are personally administrated to clients in Pharmacies.

In the particular case of the **prison setting**, in 31/12/2011 were integrated 503 inmates in pharmacological programs in prison (454 in opioids agonists' programs and 49 in antagonists opioids), representing a decrease in relation to 2010 (-11%) but with a superior value than the ones registered till 2009.

5.5 Trends of clients in treatment

Heroin remains the main substance associated to health consequences and specifically in the sub-population of drug users that seek access to different treatment structures but references to alcohol, cocaine and cannabis in this setting are increasing. In the administration of the main substance continues to be predominant the mode smoked/snorted.

²² At home, in Pulmonary Diagnostic Centres and other local organisations.

6. Health Correlates and Consequences

6.1. Introduction

The National Action Plan on Drugs and Drug Addiction 2005-2012 includes among its objectives a specific reference to the need of reducing the number of users of psychoactive substances, as well as health and social risks associated, being foreseen an action to promote the counselling, diagnosis and referral of infectious diseases within drug users population to be implemented until 2012.

Concerning infectious diseases among IDUs, ever injectors (lifetime) in outpatient treatment centres in 2011, the positivity values for HIV was 16.48%, (19.48% in 2010), Hepatitis B 4.26%, (5.80% in 2010), Hepatitis C 79.65% (90.73% in 2010)

In the ambit of HIV/AIDS infection diagnosis (identified by notifications) maintains the proportional downward trend of the cases associated to drug addiction in the different stadiums of the infection, as well as the continuous decrease through the years of new cases diagnosed with HIV associated to drug addiction.

In 2011, were registered 10 cases of drug-related deaths, representing the lowest value since 2006 and a decrease of 62% in relation to 2010 (27) in the General Mortality Register (GMR - Selection B of the DRD Protocol). The values registered in 2009, were the highest since 2003, but inferior to the ones registered in 2002 (year when ICD-10 was implemented in Portugal).

Following a strategic recommendation of the Action Plan on Drugs 2009-2012²³, as well as the implementation of procedures to improve the quality of the national mortality²⁴ statistics, from 2008 start to be presented data from the national mortality statistics of National Statistics Institute (INE, I.P.), simultaneously was intensified the work on optimizing the information coming from the National Institute of Forensic Medicine (INML, I.P.) As result of the articulation between IDT, I.P. and INML, I.P., for the third year it is possible to provide information from the INML, I.P. on overdose cases.

6.2. Drug-related infectious diseases²⁵

According to 31/12/2011, notification data (analytical tests) from the National Health Institute Doutor Ricardo Jorge (INSA, I.P.), the decreasing trend concerning the percentage of drug users in the total number of notified HIV positive cases continues to be reported. From the 41 035 notifications received since 1983, near 39% (41% in 2010, 42% in 2009 and 2008, 44% in 2007 and 45% in 2006) were drug use related. Considering the different stages covered by these notifications, 45% of the AIDS cases, 33% of Symptomatic Non-AIDS cases and 35% of the asymptomatic carriers cases were drug use associated, consolidating the proportional downward trend in this group in the different stadiums of the infection.

Year Diagnostic	Cases					
	AIDS Cases		Asymptomatic Non-AIDS		Asymptomatic Carrier Cases	
	Total	Drug Users	Total	Drug Users	Total	Drug Users
Total	16 880	7 679	4 160	1 366	19 995	7 098
2011 ^{a)}	303	53	131	11	552	31

²³ Recommendation made by the Technical Committee of the Inter-ministerial Council in the ambit of the internal evaluation of the Action Plan - Horizon 2008.

²⁴ The National Health Plan 2004-2010 envisaged a project to improve the mortality statistics "(...) with the aim till 2005, the mortality due to symptoms, signs and undefined affection decrease from 13% to 5%. To this end, was introduced a new medical certificate of death to each will be apply new circuits for data transmission and will made the transition to ICD-10 from January 1, 2002". There will be at short and medium term a number of other measures to improve these statistics, including the on line medical certificate.

²⁵ All data reported in this chapter is collected from analytical tests.

a) The posterior update of the cases diagnosed in previous years, requires the reading of these data as provisional.

Table 10 – HIV notifications: Total number of cases and cases associated to drug use (AIDS, Asymptomatic Non-AIDS and Asymptomatic Carrier), 01/01/1983 – 31/12/2011 (IDT, I.P. 2012)

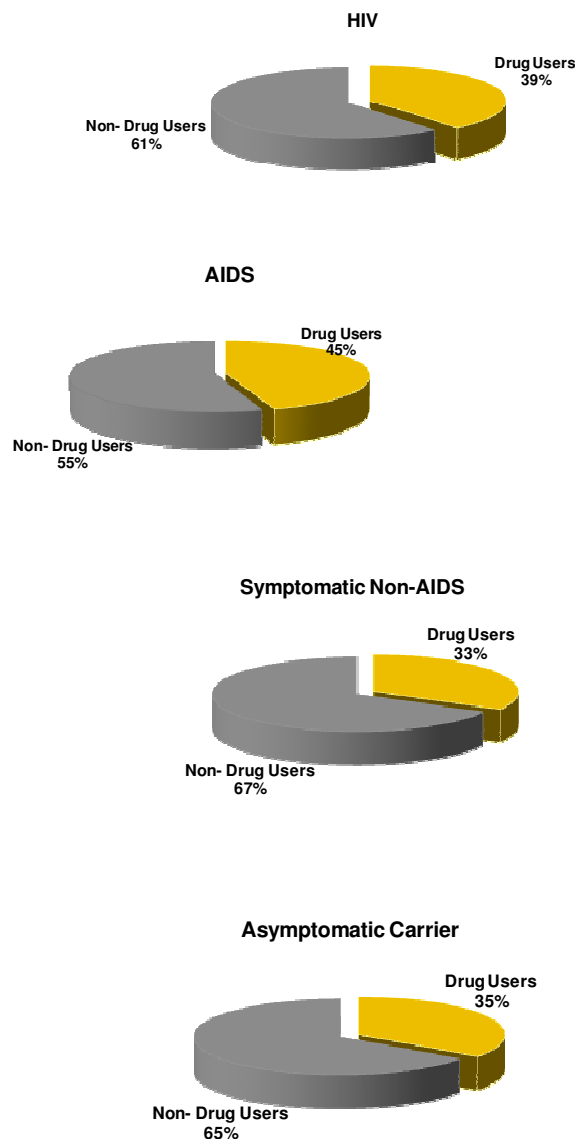
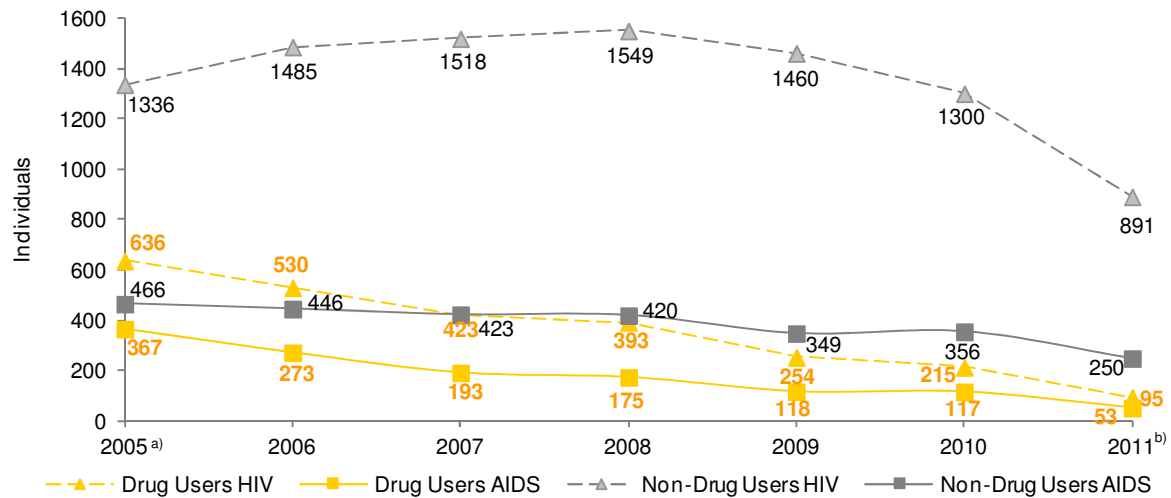


Figure 3 – HIV Notifications associated or not to drug addiction in the different stadiums of the infection (%), (IDT, I.P. 2012)

Taking only 2011, from the notified cases of HIV diagnosed at 31/12/2011, the cases associated to drug addiction represented 10% of the total diagnosed cases in the different stadiums of the infection: 17% of the AIDS cases, 8% Symptomatic Non-AIDS and 6% of the asymptomatic carriers cases.

There has been a downward trend in last years on the weight of drug addicts, in the total number of cases diagnosed each year with HIV infection (10%, 14%, 15%, 20% and 22%, of the cases diagnosed in 2011, 2010, 2009, 2008, 2007), as in the cases diagnosed each year with AIDS (17%, 25%, 25%, 28% and 31% of the cases diagnosed in 2011, 2010, 2009, 2008, 2007). In addition to the decreasing trend of these proportions, it is worth of notice the continuous decrease over the past few years in the number of new cases diagnosed with

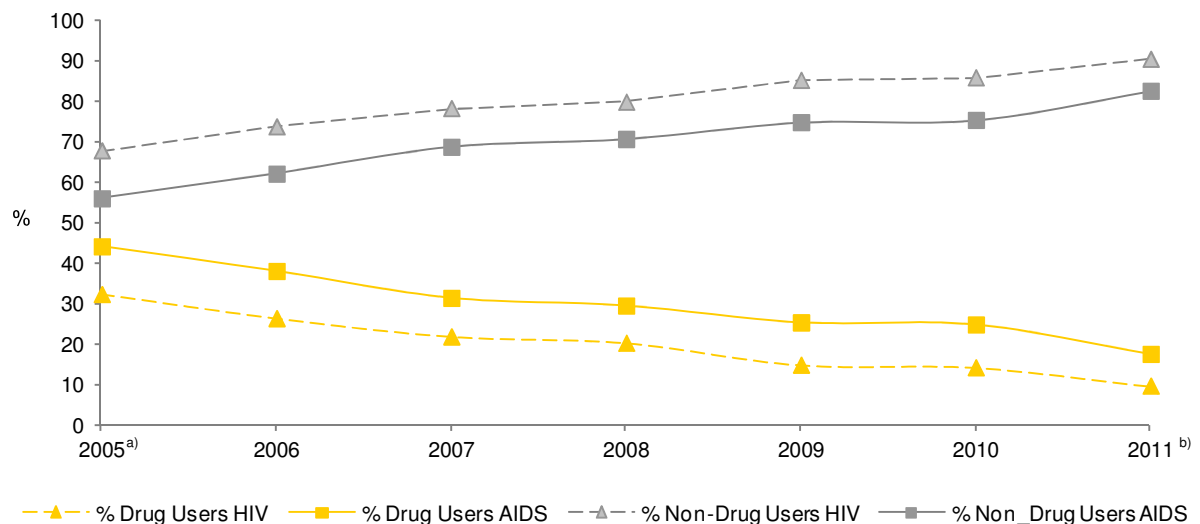
HIV associated with drug addiction, safeguarding the future update of data (95 cases diagnosed in 2011, 254 in 2009, 423 in 2007 and 636 in 2005).



a) In 2005, the infection by HIV was integrated in the mandatory list of infectious diseases.

b) The posterior update of the cases diagnosed in previous years, requires the reading of these data as provisional.

Graph 29 – HIV/AIDS Notifications: Drug Users and Non-Drug Users, by year of diagnosis (IDT, I.P. 2012)



a) In 2005, the infection by HIV was integrated in the mandatory list of infectious diseases.

b) The posterior update of the cases diagnosed in previous years, requires the reading of these data as provisional.

Graph 30 – HIV/AIDS Notifications: % Drug Users and Non-Drug Users by year of diagnosis (IDT, I.P. 2012)

Continues to be verified in the new cases diagnosed with HIV a higher weight of older infections in the addict population than in the general population. Indeed concerning HIV infection associated to drug addiction diagnosed in 2011 and for which is known the probable

year of infection (44%), it is noted that near 67% of the cases the probable date of infection took place more than 5 years ago (24% between 2002 and 2006 and 43% before 2002), in the other cases not associated with drug addiction and with information on this issue (35%), only in 13% of the cases the probable date of infection occurred more than 5 years (6% between 2002 and 2006 and 7% before 2002).

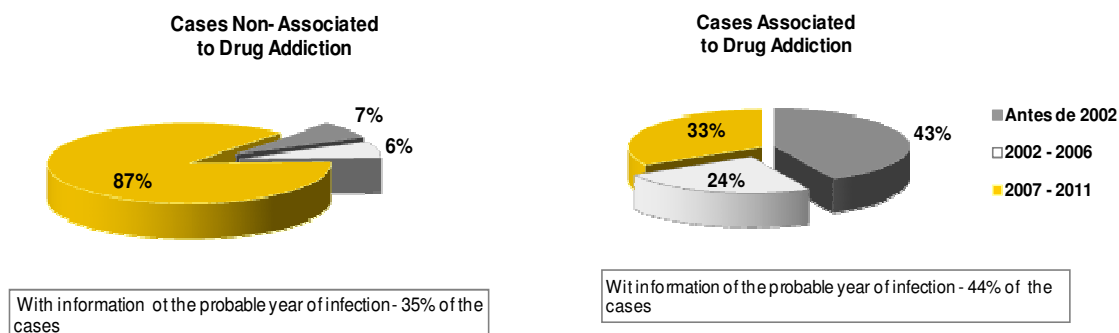


Figure 4 – Cases of HIV infection diagnosed in 2011, Associated or not to Drug Addiction, by probable year of infection (%) (IDT, I.P. 2012)

It is worth to note the improvement in the screening coverage of HIV infection in the drug use population – namely with the emergence of harm and risk reduction policies in 2001²⁶ and more recently with the implementation of Klotho Program²⁷ since 2007. All this combined with the continuous decrease over the last years in the number of new HIV diagnosed cases associated with drug addiction seems to indicate that we are facing a real decline of recent infections in the drug user population²⁸.

For AIDS cases associated with drug addiction notified until 31/12/2011, the pathologies predominantly observed at the diagnosis date belonged to the group of opportunistic infections (95%), with emphasis on tuberculosis and *P. jirovecii* (respectively 57% and 11% and more 6% with both diagnoses). In the other cases not associated with drug use, was verified a lower weight of opportunistic infections between the pathologies at diagnosis date (88%), namely tuberculosis (29%).

2011 notified drug use-related AIDS cases are:

- Mainly of the male gender 83% (83% in 2010, 2009 and 2008 and 85% in 2007,);
- Most of them (71%) aged 25-39.

²⁶ The policies of risk and harm reduction allowed a closer approximation to drug addiction populations not covered by conventional services, including health, which may explain the weight of diagnosed cases of “old infections” in this population.

²⁷ Between 2007 and 2008 has been developed, in collaboration with the National Coordination for the Infection of HIV/AIDS, targeted to drug users – Program KLOTHO – implemented at the level of outpatient clients in the public network and clients from the outreach teams. In 2009 continued to be applied the methodology ADR - Counselling, Detection and Reference – in these clients.

²⁸ The risk and harm reduction policies allowed a change in the user behaviour, with objective results in terms of decreasing the intravenous drug use and sharing of consumption material, what could explain the decrease of “recent infections”.

Cases/Gender Age Group	AIDS Cases						
	Total Number of Cases				Drug Users		
	Total	M	F	Unkn.	Total	M	F
Total	16 880	13 655	3 224	1	7 679	6 545	1 134
≤ 14 years	132	70	62	..	2	2	..
15-19 years	172	110	62	..	97	71	26
20-24 years	1 269	937	332	..	896	701	195
25-29 years	2 958	2 346	611	1	2 044	1 702	342
30-34 years	3 388	2 835	553	..	2 134	1 857	277
35-39 years	2 899	2 417	482	..	1 476	1 295	181
40-44 years	2 062	1 724	338	..	693	605	88
45-49 years	1 354	1 104	250	..	229	214	15
50-54 years	956	777	179	..	60	54	6
55-59 years	628	493	135	..	14	13	1
60-64 years	467	361	106	..	1	..	1
≥ 65 years	531	426	105	..	1	1	..
Unknown	64	55	9	..	32	30	2

Table 11 – AIDS notifications: total and drug use related, by gender and age group 01/01/1983 - 31/12/2010 (IDT, I.P. 2012)

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

Lisbon, Porto and Setúbal continues to be the districts with higher weight in the cumulative total of notifications of infection by HIV cases associated to drug addiction (34%, 30%, and 14% respectively) and of cases of infection by HIV non-drug addiction associated (respectively 44%, 15%, and 12%). These districts, together with Faro, are the ones with higher rates of drug users with HIV per inhabitant in the age group 15-64.

Concerning infectious diseases among IDUs, ever injectors that went to outpatient treatment centres in 2011, the percentages of HIV positive cases (prevalence's)²⁹ was 16.48%, (19.48% in 2010).

Such situation, is seen in several groups of clients, namely among new clients in the public network (3% in 2010, 7% in 2009, 9% in 2008 and 2007, 11% in 2006, 12% in 2005 and 2004 and 15% in 2003)³⁰.

It is to refer that in the ambit of Program Klotho and Counseling Detection and Reference (ADR)³¹ methodology the results of the quick test donned to new clients and follow-up clients in outpatient public treatment network, shows incidence rates of HIV³² of 0.7% and 0.8% in 2011 (1% and 0.6% in 2010, 1.5% and 0.8% in 2009 and 1.5% and 1.1% in 2008 and 2.5% and 2.4% in 2007).

Concerning **Hepatitis B and C** data available, as reported in Standard Table 9, refer to the analytical tests made in drug user's subpopulations that demand treatment in the outpatient

²⁹ The percentual includes all the cases with information on screening results, including the ones made in previous years.

³⁰ Despite the percentages related to the last two years maybe higher if we consider only the drug addiction clients it is undeniable the downward trend of HIV prevalence over the decade between the populations who have resorted (went) to the different drug addiction treatment structures and particularly in this population of new clients in the public treatment network.

³¹ As referred in previous note, in 2007 and 2008 was developed in collaboration with the National Coordination for the HIV/AIDS Infection a program of Early Identification and Prevention of HIV/AIDS directed to drug users – program Klotho. In 2009 and 2010, the ETs of IDT, I.P. continue to apply the Counseling Detection and Reference (ADR) methodology.

³² Not all HIV reactive cases had confirmation of the result.

treatment structures in 2011, the percentages of Hepatitis B 4.26%, (5.80% in 2010), Hepatitis C 79.65% (90.73% in 2010).

6.4. Drug related deaths and mortality of drug users

Drug-induced deaths

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

Until 2007, due to the limitations of general mortality registries of the National Statistics Institute (INE), Portugal privileged in the context of this key indicator data records of the National Institute of Forensic Medicine (INML). These data referred to positive post-mortem toxicological results from the INML, which in the absence of information on the cause of death did not allow an accurate assessment of the number of overdoses, yet possessing rich and quality toxicological data allowing trend analysis³³.

Following a strategic recommendation of the Action Plan on Drugs 2009-2012³⁴, as well as the implementation of procedures to improve the quality of the national mortality³⁵ statistics, from 2008 start to be presented data from the national mortality statistics of INE, I.P., simultaneously we intensified the work on optimizing the information coming from the INML, I.P. As result of the articulation between IDT, I.P. and INML, I.P., for the first time it was possible to provide information from the INML, I.P. on overdose cases. In a near future this information will contribute to improve the national mortality statistics in this area³⁶, and will now overcome some constraints related to statistical secrecy³⁷ in the provision of toxicological information and social demographic in the context of national mortality registries of INE, I.P.

With regard to drug-related deaths in the context of general registries of the INE, I.P., after the continuous increase registered between 2006 and 2009 that inverted the downward trend of previous years, again is verified decreases in 2010 and 2011 in the number of these deaths.

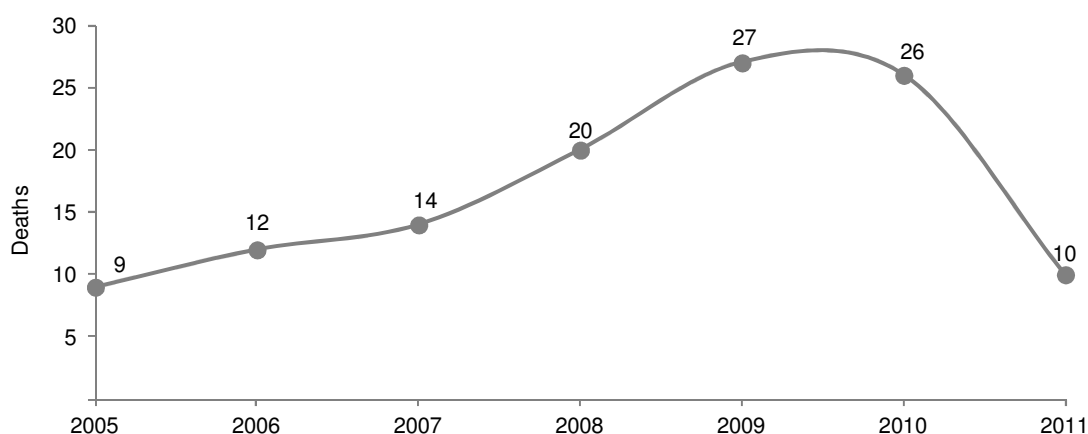
³³ Portugal has data on positive post-mortem toxicological results from the INML more than 25 years.

³⁴ Recommendation made by the Technical Committee of the Inter-ministerial Council in the ambit of the internal evaluation of the Action Plan - Horizon 2008.

³⁵ Among other, the introduction of a new medical certificate of death with new circuits of data transmission and the transition to ICD-10 (in 2002), and more recently measures to implement the on-line medical certificate.

³⁶ It is foreseen in a second phase of this work to optimize the flow of information circuits between INML, I.P. and DGS.

³⁷ Law of the National Statistic System – SEN, Law n.º 22/2008 of 13 May.



Graph 31 – Generally Mortality Register - Drug-related deaths (IDT, I.P. 2012)

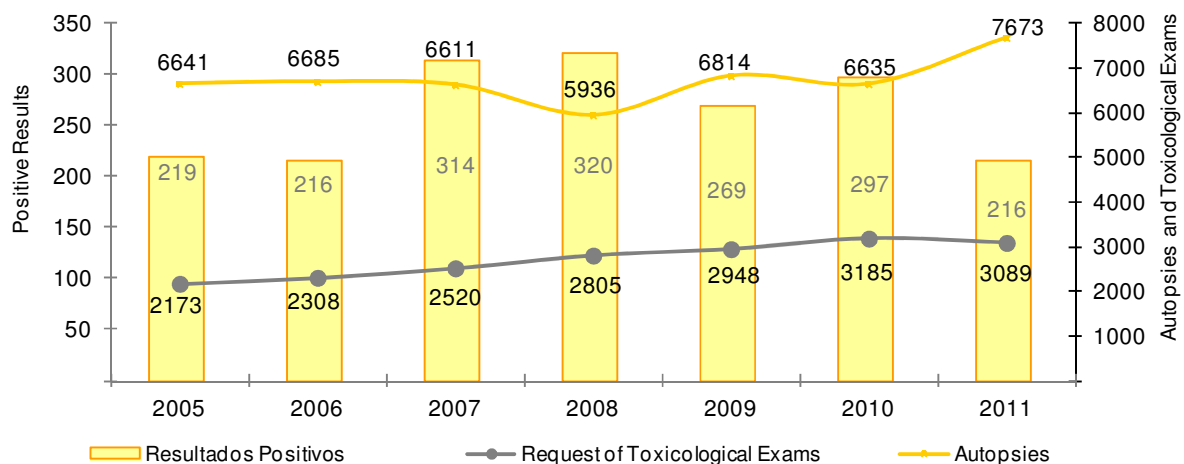
According to the EMCDDA protocol in 2011 were registered 10 cases of drug-related deaths, representing the lowest value since 2006 and a decrease of 62% in relation to 2010.

In 2011, there is no specific information³⁸, about the cause of death. However in 2009, last year with this information available - the predominant causes of these deaths were disorders (63%): multiple dependence or other (code F19.2 ICD10) cause that include polydrugs use. For the same reasons it's not possible to provide the information by gender (in 2010 all the cases were from the male gender and in 2009 male gender predominated with percentages above 84%) in relation to age the only information available is for the age group above 49 (ith 40% according the EMCDDA).

Concerning the information on specific mortality registries related with drug use from the INML, I.P., it is important to contextualize within some indicators related to the activity of this Institute.

In 2011, despite the number of autopsies performed by INML, I.P. (7 673) increased in relation to last year (+16%), the number of requests for post-mortem toxicological exams (illicit substances) (3 089), decrease slightly (-3%), however representing the second highest value of the decade and an increase of 42% in relation to 2005. The number of cases with positive toxicological results (216) decreased (-27) in relation to 2010, decreasing the percentage of positivity in the set of exams made (7%, 9%, 9%, 11%, 12%, 9% and 10% respectively in 2011, 2010, 2009, 2008, 2007, 2006 and 2005).

³⁸ For "statistic secrecy" reasons (Law of the National Statistic System – SEN, Law n. ° 22/2008 of 13 May), there are some constraints in the provision of disaggregated data on the causes of death and socio-demographic of these deaths.

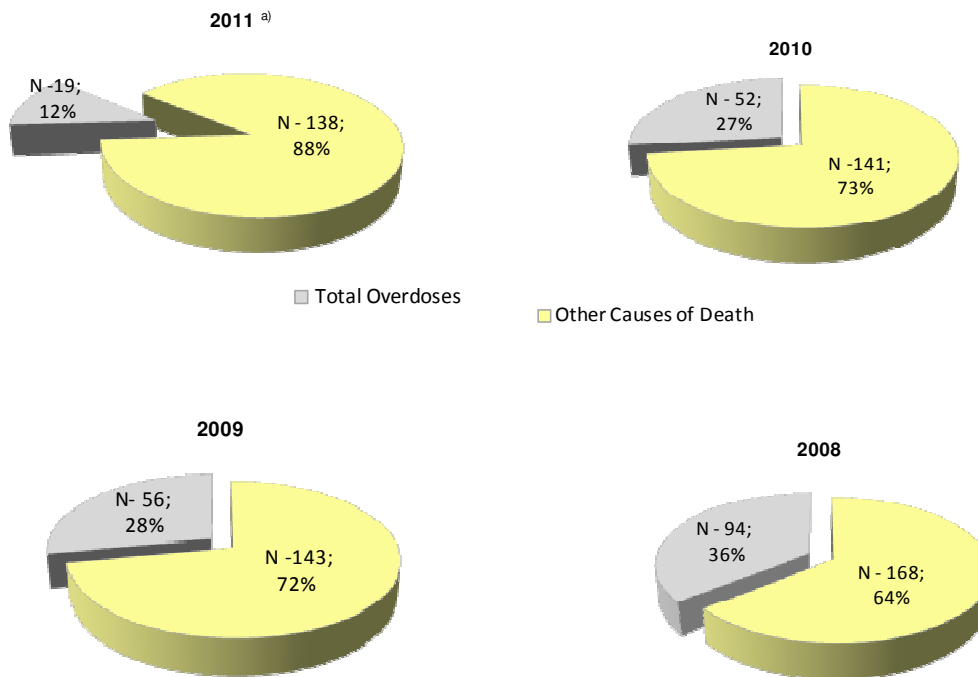


Graph 32 – Autopsies, Toxicological Exams and post-mortem positive results by year (IDT, I.P. 2012)

As previously referred, for the first time in 2009 it was possible to obtain information on causes of death in cases with positive toxicological results (for 2008 and 2009), and thus distinguish in this set of positive results the cases of overdose.

Since these deaths require forensic investigation and difficulties in collecting this information remain, (whether due to the delay in completing the final report or to access it), it was decided to make the update two years after, to optimize the proportion of cases with positive toxicological results and cause of death known. Thus 2011 data will be updated next year, which limit the comparative analyses with previous year.

In 2011, from the 157 deaths with information on the cause of death (73% of the cases with positive toxicological results), approximately 12% were considered overdoses. Despite the comparative limitations referred, is registered a decrease in the number of overdoses between 2010 and 2011, considering the proportion of overdoses in the set of deaths with information on the cause of death (12% in 2011 and 27% in 2010) and the percentage of deaths with information on the cause of death (73% in 2011 and 65% in 2010). It is also noted the decrease in the proportion of overdoses in comparison to 2009 (28%) and 2008 (36%). Concerning the substances detected in these cases of overdoses once more opiates were predominant (89%), registering an increase of cases with the presence of methadone. Cocaine was detected in 26% of the cases. As occurred in previous years the majority (79%) of these overdose cases was detected more than in one substance (87% in 2010, 84% in 2009 and 87% in 2008), considering the associations with illicit and/or licit substances. In 2011, the majority (84%) of overdose cases are from the male gender (88% in 2010, 89% in 2009 and 92% in 2008) being the mean age 38 years old (39 in 2010, 38 in 2009 and 36 in 2008).



a) 2011 data will suffer updates next year, requiring cautions in the interpretative interpretation of data
 *causes of death known at the date of information collection (July 2012)

Graph 33 – causes of death* of the cases with positive toxicological results, by year (IDT, I.P. 2012)

Concerning the substances detected in these cases of overdose, contrarily to previous years where opiates³⁹ were predominant, in 2011 methadone was predominant, present in 53% of the cases (15% in 2010, 4% in 2009 and 9% in 2008), followed by opiates, present in 42% of the cases (73%, 88% and 82%, respectively in 2010, 2009 and 2008) and cocaine detected in 26% of the cases (50%, 43% and 54% respectively in 2010, 2009 and 2008).

However the total number of cases with methadone was similar in the last three years (10 cases in 2011, 8 in 2010 and 2009) as you can see in the following table.

³⁹ Includes heroin, morphine and codeine.

Substance	2008	%	2009	%	2010	%	2011 ^{a)}	%
Total	94	100,0	56	100,0	52	100,0	19	100,0
Opioids ^{b)}	77	81,9	49	87,5	38	73,1	8	42,1
Alone	4	4,3	5	8,9	4	7,7	1	5,3
Associated with alcohol only	18	19,1	16	28,6	7	13,5	2	10,5
With other substances	55	58,5	28	50,0	27	51,9	5	26,3
Cocaine	51	54,3	24	42,9	26	50,0	5	26,3
Alone	8	8,5	4	7,1	3	5,8	2	10,5
Associated with alcohol only	1	1,1	..	..	2	3,8	..	..
Associated with opioids ^{b)}	9	9,6	6	10,7	5	9,6	1	5,3
With other substances non-opioids	6	6,4	2	3,6	3	5,8	..	..
With opioids ^{b)} and other substances	27	28,7	12	21,4	13	25,0	2	10,5
Methadone	8	8,5	2	3,6	8	15,4	10	52,6
Alone	..	..	..	..	..	..	1	5,3
Associated with alcohol only	..	..	..	..	..	..	1	5,3
Associated with opioids ^{b)}	..	..	..	..	..	..	..	..
With other substances non-opioids	3	3,2	1	1,8	8	15,4	7	36,8
With opioids ^{b)} and other substances	5	5,3	1	1,8	..	..	1	5,3
Amphetamines	1	1,1	..	..	..	..	1	5,3
With other substances non-opioids	1	1,1	..	..	..	..	1	5,3
Cannabis	..	..	..	..	..	..	3	15,8
With other substances non-opioids	..	..	..	..	..	..	3	15,8
Synthetic Drugs	..	..	..	..	..	..	1	5,3
With other substances non-opioids	..	..	..	..	..	..	1	5,3

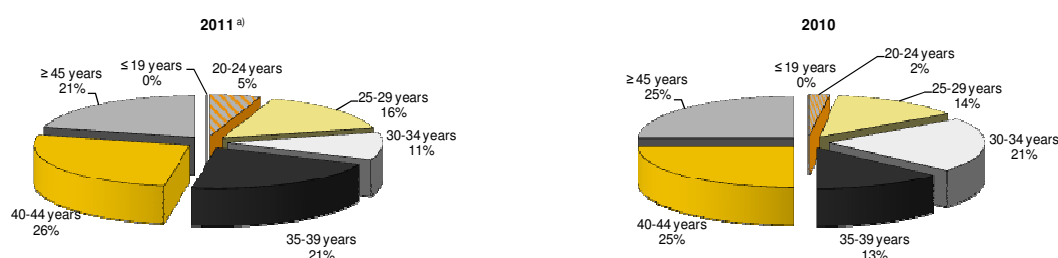
a) 2011 data will suffer updates next year, requiring cautions in the interpretative interpretation of data

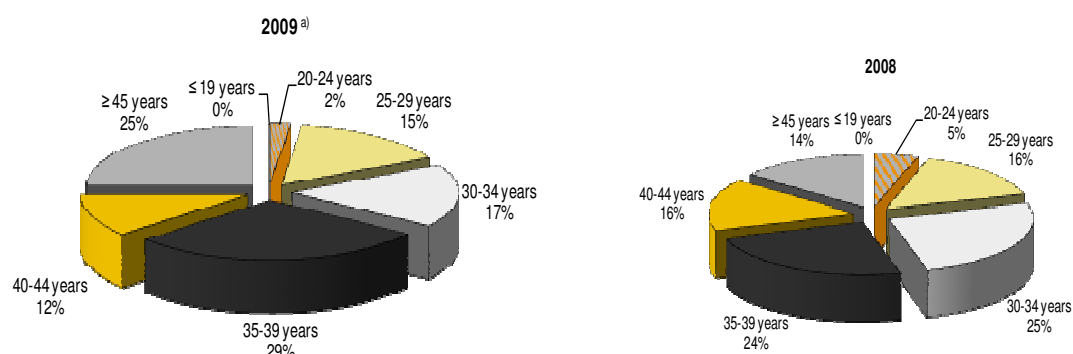
b) Include heroin, morphine and codeine.

Table 12 – deaths by Overdose, by year and Substance (IDT, I.P. 2012)

Like occurred in previous years, in the majority (79%) of these cases of overdose was detected more than one substance (87% in 2010, 84% in 2009 and 87% in 2008), considering the associations with illicit and/or licit substances. In this context, it was noted that in 2011 the overdoses with simultaneous presence of methadone and other non-opiates substances (37% of the total overdoses) with special emphasis to benzodiazepines (32%). It's also important to refer in combination with illicit substances the cases of overdose with the presence of alcohol (37%, 44%, 57% and 47% of the overdoses 2011, 2010, 2009 and 2008) as well as in the presence of benzodiazepines (37%, 35%, 38% and 39% of the overdoses of 2011, 2010, 2009 and 2008).

In 2011, the vast majority (84%) of these overdoses are from the male gender (88% in 2010, 89% in 2009 and 92% in 2008). Near 47%, were aged 40 or superior (26% between 40-44 years old and 21% with ages superior to 44) and 47% between 25-39 being the mean age 38 (39 in 2010, 38 in 2009 and 36 in 2008).





a) 2011 data will suffer updates next year requiring cautions in the interpretative interpretation of data

Graph 34 – Deaths by Overdose, by year and age group (IDT, I.P. 2012)

Specific causes of mortality indirectly related to drug use

Among all the AIDS cases, 7 856⁴⁰ have been notified until 31/12/2011, 51% were associated with drug addiction and 49% of the cases were non-drug addiction associated. Mortality observed among AIDS cases associated with drug addiction was 52% (survival 48%) and in the cases not associated with drug addiction of 42% (survival 58%). In 2011, were notified 135 deaths occurred in the year, among the AIDS cases, 60 (44%) of which were AIDS cases associated with drug addiction.

Cases/Gender Geographical area of Residence	AIDS Notifications: Total Number of Cases								AIDS Notifications: Total Cases Assoc. to Drug Use						
	Total ^{a)}				N.º of Deaths				Total ^{a)}			N.º of Deaths			
	Total	M	F	Desc.	Total	M	F		Total	M	F	Total	M	F	
Total	16 880	13 655	3 224	1	7 856	6 595	1 261		7 679	6 545	1 134	4 014	3 463	551	
Portugal	16 450	13 318	3 131	1	7 700	6 464	1 236		7 568	6 456	1 112	3 972	3 431	541	
Other Countries	121	95	26	..	64	53	11		11	10	1	7	6	1	
Unknown	309	242	67	..	92	78	14		100	79	21	35	26	9	

a) Alive and Deaths

Table 13 – Notifications of AIDS related deaths – total number of cases associated to drug use, by gender, 01/01/1983 – 31/12/2011 (IDT, I.P. 2012)

⁴⁰ Due to sub notification of deaths, information related to mortality does not reflect the cases of the ones that survive.

7. Responses to Health Correlates and Consequences

7.1. Introduction

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

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

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

In 2011 the main objectives for the area of Harm and Risk reduction were:

- Ensure the systematic collection of information through proximity structures with the view to a better knowledge of the phenomenon, specially for the group of users/consumers of psychoactive substances which don't seek the conventional treatment network;
- Consolidate the RRMD national Network through following and monitoring the work done and also invest in the training of the different intervenients;
- Integrate and complement the intervention in this area with the several responses available at the level of prevention, treatment and reintegration at intra and interinstitutional level.

7.2. Prevention of drug related emergencies and reduction of drug-related deaths

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

In 2011, IDT, I.P. proceeded its activity under the assumption that the national network of risk and harm reduction should be adjusted to the characteristics of the problematic, following as far as possible its evolution. To this end, it maintained the implementation of instruments and methodologies allowing so little time-deferred to know the developments achieved.

This update information based the decisions adopted on the reports for the continuity of projects and financing of interventions. RRMD technical teams maintained discussion and reflexion spaces with a view to:

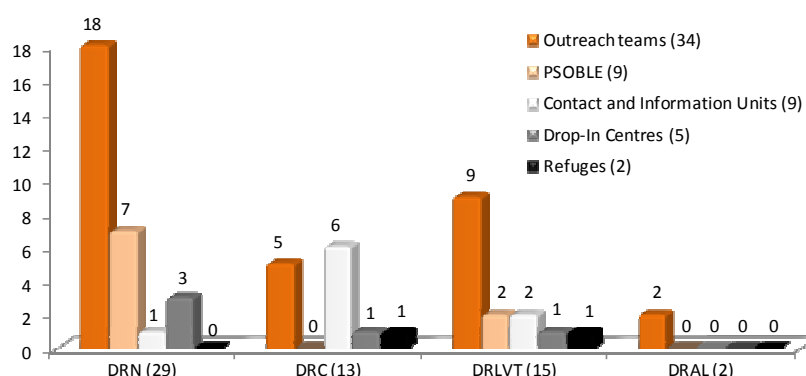
- Share of experiences and enrichment of knowledge and competences;
- Promote the articulation between the different interventions in the field of RRMD in the territory;
- Sharing institutional resources in common and border territories;
- Coordination in mapping border territories with the purpose to update diagnosis;

- Uniformisation of procedures in filling in the data collection instruments.

The characterisation process of the population monitored by RRMD projects in particular, outreach teams, drop in centres for drug addicts with socio family framework and Shelters, involves a close articulation between IDT, I.P. and the partner entites which implement these structures and are in direct contact with these population.

The characterization of the population followed by RRMD projects is based on one hand in a local logic definition of an intervention based on diagnoses of the needs and characteristics of the users and at national level, of update knowledge of the population followed to define priorities in relation to the programs and projects needed. The conclusion of this characterization in 2012 will enable the analysis of eventual changes occurred in the characteristics of this population that benefits from this type of interventions, through the comparison of studies previously carried out by IDT, I.P. in this field (see “Caracterização das Equipas de Rua – 2006).

In what concerns the direct intervention with drug users in 2011, 46 projects were ongoing at national level, co-funded under the Administrative rules 749/2007 of 25th June and 131/2008 of February 13th. The diagnosis done raised the need to implement several projects to develop responses in the same area, particularly among drug users and recreational settings. In 2011, 59 responses were implemented at national level, within the 46 projects co-funded by IDT, I.P. Considering the typology of responses foreseen, the distribution of responses (Outreach Teams, Drop-in Centres, Low Threshold Substitution Program, Shelters) implemented in each region is the one described in the graph above.



DRN – Northern Regional Delegation; DRC – Center Regional Delegation, DRLVT – Lisbon and Tagus Valley Regional Delegation, DRA – Alentejo Regional Delegation, DRAL – Algarve Regional Delegation

Graph 35 – Type and number of responses implemented in the framework of the National Harm and Risk reduction per region (59) (IDT, I.P. 2012)

Also in 2011, approximately 12 550 persons were contacted by the street teams, the drop in centres and on the context of Low Threshold Substitution Program (PSO-BLE). As the population reached by these structures is quite floating in terms of use of the different services, each month were contacted an average of 5 979 persons.

Of these, around 1 501 persons benefited each month of the PSO-BLE and an average of 1 650 from the Needle Exchange Program.

As an average of 1 692 drug injectors were followed each month, it appears that the number of users and the beneficiaries of the program are closely linked⁴¹

7 032 clients contacted by month (average)	
Beneficiaries of Syringe Exchange Program	Beneficiaries of PSO-BLE
1 650	1 501
28%	25%

Table 14 – Number of clients Beneficiaries of each program (IDT, I.P. 2012)

Among the 12 550 users reached by RRMD projects, most (9 081) benefit of a psychosocial support and support of basic needs (meaning 72% of the population considered), 2 210 benefit from health care (18% of the population considered) and 1 654 were referred to other services (13%), we can therefore conclude that the level of implementation regarding the provision of health care and referral to services has remained constant during the previous year.

12 550 clients contacted per year		
Beneficiaries of Psychosocial support	Beneficiaries of Health Care	Referrals to other services
9 081	2 210	1 654
72%	18%	13%

Table 15 – Number of users beneficiaries of psychosocial support, healthcare and referrals in 2011 (IDT, I.P. 2012)

The psychosocial monitoring done by these RRMD projects includes several activities among which, psychosocial attainment, psychological support, hygiene and food care.

5 979 clients contacted			
3 623 Beneficiaries of Psychosocial Support			
Psychosocial Attainment	Psychological Support	Hygiene Care	Food Care
2 058	244	298	2 218
57%	7%	8%	61%

Table 16 – Number of patient's beneficiaries of the several activities of Psychosocial Support (average/month) (IDT, I.P. 2012)

⁴¹ In geographical areas in which coexist RRMD projects with different components, drug injectors may be beneficiaries only of the Needle Exchange Program and not of the other program.

In 2011, from the 3 623 patients followed in average by these projects (monthly average) at the level of psychosocial support, a larger number of patients benefited from food support 2 218 (61%), psychosocial care 2 058 (57%). Benefited from a more structured psychologic support 244 patients (7%) and hygiene care 298 patients (8%).

It should be noted in that regard that in 2011, were made 81 718 psychosocial attendances and 7 950 sessions of psychological support

The following carried out at health care level includes activities as medical appointments, nursing care, screenings, medicines therapeutic and vaccination.

5.979 Patients contacted				
1.094 Health care Beneficiaries				
Medical Appointments	Nursery Care	Screenings	Medic Therapeutic	Vaccination
216	483	159	211	31
20%	44%	15%	19%	3%

Table 17 – Number of patients' beneficiaries of the several health care activities (average/month) (IDT, I.P. 2012)

In the year 2011, among the 1 094 patients followed by these projects (average/month) of health care, the vast majority had access to nursery care (44%) and near 20% had access to medical appointments. It's noticed the realisation of medicines therapeutic (19%) and screening (15%). Concerning the intensity of execution of the several activities, 3 259 medical appointments and 93 interventions in urgent situations were performed. It was verified a significant decrease in relation to last year.

5.979 patients contacted				
770 patients referred				
Hospital	Hospital: Infecilogia	Health Centre	CDP	CAD
94	56	89	194	1
Treatment Unit	Therapeutic Community	Detoxification Unit	Drop-In Centre	Refuges
122	15	9	67	17
Shelters	Day Center		Social Security	
8	9		184	

Table 18 – Number of patients for several services (average/month) (IDT, I.P. 2012)

In the referral component it's verified that approximately 770 clients were, on average per month, referred to other structures, and on average each patient was sent to more than one type of structure per month (on average were performed 1 052 referrals per month).

The two types of structures for which more patients were referred were the Social Security structures (in average 184 referred each month) and Treatment Units (in average 122 referred each month)

The information and awareness component includes in addition to counseling, the availability of pedagogical materials and the realisation of information and awareness initiatives. So in 2011 were available 2 215 harm reduction manuals and 13 628 other materials, having yet been

organized 4 433 information and awareness actions. To note that in relation to last year the number of information and awareness actions doubled.

The harm reduction intervention in recreational settings has gained particular expression. These actions, carried out near a population that do not experience their use as problematic and for this reason does not seek the conventional health services and the drug addiction treatment structures.

In collaboration with organizers of summer festivals, IDT, I.P. intervened, nationally, in 26 summer festivals in collaboration with other organisers, NGO's and voluntary mediators.

The intervention of IDT, I.P. in summer festivals is part of a strategy of information and awareness to participants in these events, for better management of risks potentially associated with use of licit and illicit substances.

The "Manual para uma diversão mais Segura"⁴² (manual for a safer fun), was elaborated, which aims to protect and improve social and individual welfare, protect public health and offer a safety high level for alcohol and drug users in nightlife settings and to general public.

The intervention in parties and academic festivals was dinamized locally, having involved a joint work with the organisers of the festivities; NGOs in addition to the mobilisation of volunteer mediators (were involved near 181 volunteers). IDT, I.P. role was at the level of organisation of the procedure, preparation (namely through the training of mediators) and in its implementation.

The information that we will be presenting bellow refers to interventions developed in recreational settings and/or festivals, 9 being Contact Points that have developed activities during last year and some data from 3 outreach teams with punctual interventions in recreational contexts and/or festive.

In 2011, these interventions took place in 250 parties/festivals, and near 21 bars and discos (average/month). An average of 52 683 individuals were reached by these interventions, 9 587 being clearly users of psychoactive substances. Most of the persons were contacted during parties or festivals (38 503), although the number of those reached in bars and discos is also important (14 180). Between the individuals contacted (reached), 18% are users of illicit substances.

In this type of intervention, an approach of information and awareness is used, trough personal contacts or the distribution of brochures (38 143 leaflets were distributed, 47% in bars/discos and 53% in parties/festivals). Teams also provided material for safer behaviours and/or with less risk, as condoms (69 918 were distributed, 65% parties/festivals and 35% in bars/discos), or a kit for those who snort drugs (1 384 kits were distributed, most in bars/discos (97%), but some in parties/festivals (3%).

38.143 Informative leaflets					
Bars/Discos			Parties/Festivals		
47%			53%		
Number of individuals covered by theme					
RRMD Prevention/Use		Prevention of infectious diseases		Community Support structures	
27.017		36.858		8.986	
Bars/Discos	Parties/Festivals	Bars/Discos	Parties/Festivals	Bars/Discos	Parties/Festivals
35%	65%	26%	74%	12%	88%

Table 19 – Information and Awareness (IDT, I.P. 2012)

⁴² Manual for a Safer Fun is an adaption of the Guide Saffer Clubbing - *Guidance for licensing authorities, club managers and promoters* (2002), published by Home Office and *London Drugs Policy Forum* in partnership with Release. The authorization was request and authorized by Home Office in 2005.

7.3. Prevention and treatment of drug-related infectious diseases

Prevention of drug-related infectious diseases amongst problematic drug users is mainly ensured through the national syringe exchange program "Say no to a second hand syringe", established by the National Commission for the Fight Against AIDS (CNLCS) in collaboration with the National Association of Pharmacies (ANF), with the aim to prevent HIV transmission between intravenous drug users through the distribution of sterilized material and the collection and destruction of the materials used by IDUs.

Over the years the program was adjusted according to the evolution needs of IDUs and harmonization of procedures among the various partners.

Since it was set up, in October 1993, it has been using the national network of pharmacies and has enlarged its partner network through protocols with mobile units, NGOs and other organisations in order to reach a wider population (49 partners in 2010 and 2009 and 36 in 2008). This program was externally evaluated (as reported in previous National Reports) and it was concluded that it had avoided 7 000 new HIV infections per each 10 000 IDU at that time of existence of this program, having estimate savings to the State between 400 to 1.700 million Euros, reinforcing the importance of this program in term of public health.

49.121.482 syringes have been exchanged through this program since October 1993 and until December of 2011 by all the entities involved in this program. In 2011, 1.650.951 syringes were exchanged representing a decrease of 20% in relation to previous year (2 057 497 syringes in 2010).

These syringes are included in a kit with 2 syringes, 2 ampoules of bi-distilled water, 2 acid citric packages, 2 condoms, 1 filter and 2 disinfecting towels and 1 informative leaflet. (For more information see Standard Table 10 - syringe availability).

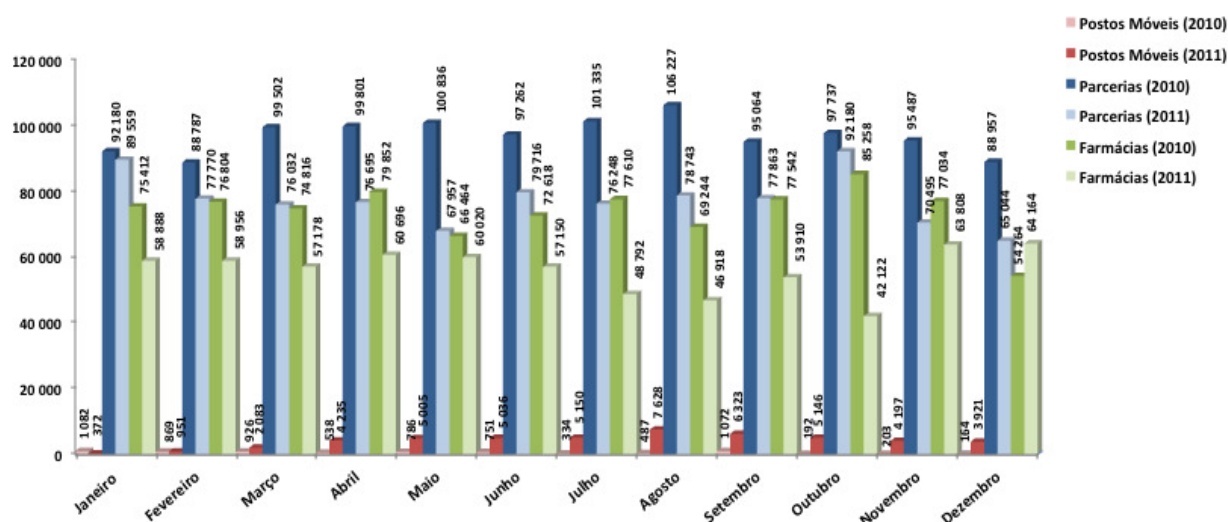
Between October 1993 and December 2011 were distributed 49 121 482 syringes by all the entities involved in the National Syringe Exchange program. The number of syringes exchanged increased progressively till 1997, with some fluctuations in the following years. From 2005 has been registered a downward trend in the number of syringes exchanged.

In the year 2011 and in comparison to last year it was verifies an increase in the percentage collected and a decrease in the number of syringes distributed (-55%).

The Partners in this program are all Governmental and nongovernmental organizations that signed the cooperation protocol with the National Coordination HIV/AIDS and ANF under the program "Say no to a 2nd hand syringe."

From the beginning of the program till know 3 817 192 syringes were exchanged by Mobile Units (in several places, such as Casal Ventoso, Curraleira, Cova da Moura, Bairro de Santa Filomena and Odivelas), 12.308.326 by partnerships and 32.995.964 by pharmacies.

In 2011, 1 267 pharmacies (1 336 in 2010, 1 360 in 2009, 1 384 in 2008 and 1 314 in 2007) were active in this program.



Graph 36 – Comparative between Mobile Units, Partnerships and Pharmacies in 2011 in comparison to 2010 (ANF2012)

Similar to last year the Districts of Lisbon and Porto continued to be the ones that registered the highest number of syringes exchanged, representing near 50% of the total. It was verified an increase in the number of exchanges in the districts of Coimbra and Leiria.

In 2011, were collected 50 047 syringes in Mobile Units, 928 302 by partnerships and 672 602 by pharmacies.

Under the Framework of the Syringe Exchange Program a pilot project on smoking use was conducted. Three thousand pipes were distributed for smoke use of psychotropic substances by several harm reduction structures, with the purpose to assess the need of this type of material among drug users with new/different patterns of use. Auto fill in forms to evaluate the material provided were distributed.

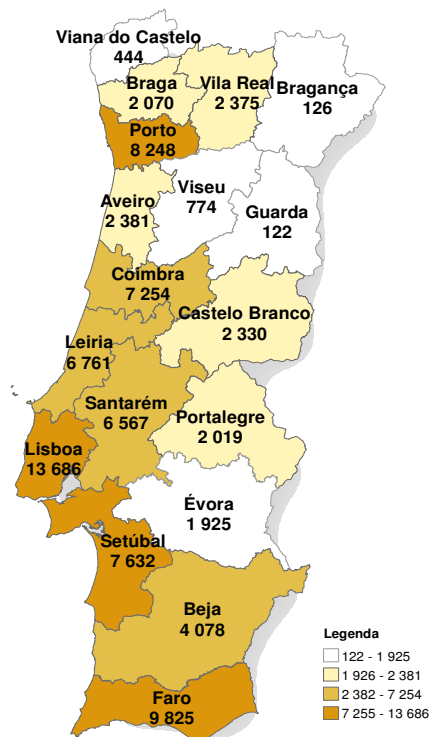


Figure 5 – Exchanged syringes in the in the framework of the National Syringe exchange program “Say no to a second hand syringe” 01/10/1993 to 31/12/2011

Despite the several information/awareness actions on health promotion and drug addiction problematic that are developed in prison context approach as well the harm and risk reduction vector, in 2011 were promoted 54 specific actions on risk reduction, covering a total of 900 frequencies.

Such initiatives contemplated several themes, namely, harm and risk reduction programs, morbidity and comorbidity associated to risk behavior, risks associated with the practice of piercings and tattoos, risk behaviours and protective behaviours, the acquisition of healthy lifestyles among others.

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

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

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

Program KLOTHO continue to be developed by IDT, I.P. Treatment Teams, applying the methodology Counselling, Detection and Referral – ADR and a drop blood quick test for the detection of HIV.

In 2011, the treatment teams continue the application of the methodology ADR – Counselling, Detection and Reference in the ambit of the Program of Early Identification and Prevention of Infection of HIV/AIDS among drug users, being covered 7 880 users.

The result of the application of this methodology to 2 452 new admissions in this year allowed to determine reactive results for AcHIV in 77 users (3.1%). As for those who were unaware, at the time of admission, their serological state, the application of the quick test resulted reactive to 15 users (0.7%), constituting probable HIV infections that were not previously screened.

From the 5 428 patients in follow-up submitted to ADR methodology, reactive results for AcHIV were verified in 270 cases (5%). Having justified the application of the quick test 4 937 of these users, results were reactive in 38 cases (0.8%), corresponding to the detection of probable infections with this virus and were at that time unknown.

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

8. Social Correlates and Social Reintegration

8.1. Introduction

The National Plan on Drugs and Drug Addiction 2005-2012, includes objectives and actions (see Structured Questionnaire 28), based on integrated approaches centred on the users' needs, its characteristics and personal path, on the nature and level of dependencies of psychoactive substances, adapting the strategies of intervention to the psychosocial diagnosis of the person and to ensure his liaison with social systems network. While the user approach aims to enable his integration, with the social systems the objective is to reverse the subjective factors, which are a significant obstacle to the emergence of opportunities and possibilities of integration, developing integrated strategies for the systematic monitoring of the relationship between the parties.

For this purpose, the processes of integration of clients seeking support in specialized services, public or private, start at the first contact with the request for help, and maintained until the person regains independence and stability by integrating as a citizen with rights and duties, the society in which he lives.

In 2011, in the context of economic crisis and social exclusion and poverty growing, and when public and private funding is being cut for social interventions, the main priority of IDT, I.P. was to strengthen the agreements and protocols previously signed, reinforcing partnerships and guidelines to provide more focused integrated responses to the population at risk.

8.2. Social Exclusion and drug use

The National Strategy for the Integration of Homeless entered in 2011 in its third year of implementation and focused on the creation of conditions to execute the measures foreseen.

In the Portuguese actual context of economical debility, with a direct effect on poverty and exclusion, IDT, I.P. considered that it was important to ensure the continuity of the Strategy and in 2011 the involvement of local structures of IDT, I.P. in partnership with municipalities and welfare institutions was strengthened, to guarantee the implementation of actions and monitoring of the three levels foreseen in the Strategy: prevention, emergency and intervention/follow up.

According to the last survey undertaken by the Social Security Institute (ISS) in 2009, there were 2 133 homeless people, mainly men (84%), aged between 30 and 49 (60%) and with basic education (54%).

The family breakdown is the most given reason (33.1%) to justify the situation of homeless, followed by unemployment (22.3%) and personal causes (20.8%).

Among the problems associated with the situation of homeless and the main cause of need for support are the use of illicit substances (31.3% for drugs and 19% for alcohol), mental health diseases (11.4%), physical diseases (11.3%) and the lack of occupation.

IDT, I.P. reintegration teams identified 315 homeless people, with illicit substances problems, that have enormous difficulty and resistance to search for institutional support, a strong distrust of institutions and on the possibility of changing their situation of marginalization and exclusion. This number corresponds to a 36% decrease in comparison to 2010 with 496 cases.

At national level, 13 Planning and Intervention Units for Homeless (NIPSA) were created, as local bodies responsible for implementing the measures and models of the Strategy, in areas where the diagnosis calls for an intervention. These bodies have the function of planning the intervention in the territory, according to the diagnosis made and the emerging issues

(mental illness, unemployment, drug addiction, alcoholism) and ensure the operationalization of the intervention model, with the case manager. IDT, I.P. is a core part of all NPISA created in 2009, sharing responsibilities in the promotion and achievement of the objectives and actions inscribed in the Strategy.

In the area of prevention of homeless situation inscribed in the Strategy, IDT, I.P. drafted in 2011 guidelines on the release of users of psychoactive substances in admissions of short and long term in therapeutic communities and detoxification units. These guidelines, disseminated to the licensed therapeutic communities and detoxification units, seek to guarantee the appropriate follow up in due time and to avoid the lack of suitable housing at the release.

In 2011, remained in force the inter-institutional agreement signed in 2007 by IDT, I.P., the I.S.S. and Santa Casa da Misericórdia, aimed at promoting greater efficiency in intervention with individuals with insufficient social-economic resources contacting IDT, I.P. services as well as promoting the integrated support and facilitate their access to network resources and social protection measures. The implementation of this integrated response, which include care, counseling, referral and resource allocation facilitated the referral of 1 031 drug users (1 067 in 2010).

The ISS integrated intervention towards social excluded groups allowed in 2011 to support 4 774 persons all over the country, mostly in the urban centers of Porto (1 261), Aveiro (622), Lisbon (608) and Setubal (563). 79.5% of the persons receiving support were men, mainly single (59.5%), with no kids (69.3%), living alone (45.6%) and unemployed (82.4%). As the beginning of an insertion process is often followed by the referral to health structures, in 2011, 2 684 were treated in outpatient facilities, of which 813 started treatment in a therapeutic community. Concerning resources, 63.4% of the persons reached received the Rendimento Social de Inserção - RSI (Social Insertion Income) and 25.8% had none social benefits.

8.3 Social Reintegration

In 2011, all IDT, I.P. Integrated Responses Centers have adopted the Intervention Model in Reintegration (MIR) as Guidelines for Social Intervention⁴³ (IDT, I.P.2009), launched in 2009. These guidelines point to an integrated intervention involving, concomitantly, the dimensions of individual and social systems, where the family plays a key role. The systematic monitoring strategies and social mediation are fundamental and embody in the definition, evaluation and follow up of the Insertion Individual Plan, negotiated and contracted with the person, based on the social diagnosis and the personal interests.

The main conclusions of the evaluation carried out in 2011 on the guidelines implementation, through a questionnaire applied by all reintegration professionals, were very positive, indicating that the majority is implementing the guidelines and they consider it to be an added value for the users. Some lacks and debilities were also identified on definitions/procedures and needs of training on the negotiation of the Individual Insertion Plans, which are being revised.

Throughout 2011, around 77 112 reintegration consultations (therapeutic and social service) took place, more 7% than in 2010 (71 735) in a universe of 15 064 persons who contacted IDT, I.P. (an increase of 6 % from 2010 – 14 162 cases). In 2011 (45 863), IDT, I.P. teams followed 33% individuals, value inferior of the 38% in 2010. 7 509 individual plans were contracted (3 457 in 2010).

⁴³ See the link <http://www.idt.pt/PT/Reinsercao/Documents/MIR.pdf>

Also in 2011, continued the process of consolidating the monitoring of the different activities and interventions implemented by IDT, I.P. proceeding to an evaluation that allowed to revise procedures and strategies to access the needs of homeless.

Housing

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

The housing intervention is sustained on a partnership with local entities, Private Institutions of Social Solidarity, Social Security Institute, Institute of Housing and Urban Renovation (IHRU), among others.

In 2011, were identified 1 359 housing needs and the responses capacity was of 32%. Comparing to previous years, the level of responses are decreasing as the housing or shelter responses are still insufficient for the needs and most of the responses are temporary. The 431 housing responses available were possible due to partnerships with municipalities, which provided accommodation.

	Years			
	2008	2009	2010	2011
Identified Needs (A)	1 662	1 443	1 323	1 359
Positive responses (B)	706	592	484	431
Response rate (B/A)	42%	41%	37%	32%

Table 20 – Clients with Needs/Integrated in housing or shelters responses (IDT, I.P. 2012)

Social Reintegration Apartments remain a social response fundamental for those lacking social/family and housing support, that have completed the treatment process via outpatient services, therapeutic communities or prisons and are now searching for a job. In 2011, 29 apartments were operational, serving 227 users.

To ensure adequate access of users to social protection measures, the stakeholders' dynamic of integrated responses created by the 2007 Inter-institutional protocol involving IDT, I.P., the Social Security Institute and the Santa Casa da Misericórdia was maintained. Under this Protocol, payment of rented bedrooms or small flats, temporary apartments or the referral of situation of homeless to social services was reinforced.

Education, training

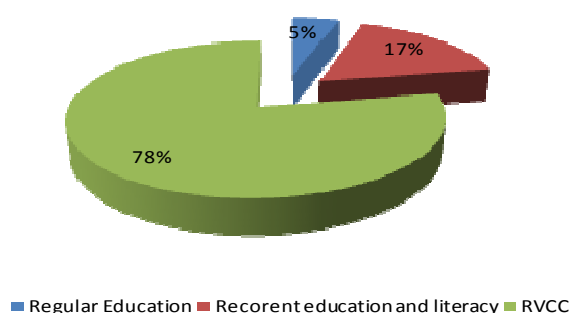
Education is one of the aspects of individual lives that can and should be encouraged in the context of the intervention in rehabilitation. The acquisition of a mandatory minimum level of education may be crucial to the success of other interventions and the route of the user.

In 2011, 1 766 needs for improving qualification were identified. And even if the capacity to meet the identified needs is far from desired, there was a more effective intervention in this area (49% versus 44% in 2010).

	Years			
	2008	2009	2010	2011
Identified needs (A)	1 867	2 208	1 965	1 766
Positive needs (B)	596	661	861	872
Response rate (B/A)	32%	30%	44%	49%

Table 21 – Users with specific needs integrated in educational responses (IDT, I.P. 2012)

Analyzing the type of response triggered by the Revalidation and Certification of Competences (RVCC), similarly to previous years; continued to be the option most chosen, representing 78% of the cases (679 users). According to the characteristics, criteria and flexible procedures, this option is best suited to the profile of users and access is easier, compared to other options available of regular and recurrent education.



Graph 37 – Type of Response provided in the area of education, national total (n=872) (IDT, I.P. 2012)

Training presented in last year's shows a very low level of efficiency in satisfying needs conditioning the acquisition of professional skills, essential to reintegration.

In 2011, 1 675 needs were identified with a response rate of 36%, representing an increase over the previous years, which could mean an improvement of coordination with Institute for Labor and Professional Training (IEFP) and other entities providing training, but also showing that once more an important part of users with an Individual Insertion Plan (64%) do not find appropriate responses.

	Years			
	2008	2009	2010	2011
Identified needs (A)	2 466	2 150	2 280	1 675
Positive responses (B)	575	501	601	608
Response rates (B/A)	23%	23%	26%	36%

Table 22 – Users with specific needs/users integrated in vocational training (IDT, I.P. 2012)

The guidelines created to improve the communication channels and articulation of IDT, I.P. and the IEPF, I.P. continued in 2011 to be implemented, aiming at better meeting the users' needs in the areas of training and employment via an integrated response.

Employment

The possibility of obtaining and keeping an employment is a priority for most users followed by IDT, I.P., as an important step in the integration process that allows maintaining him and family, getting self-esteem, social skills, knowledge and life experience which contribute to the self-stability, as an active member of the society. In 2011, 4 246 needs in the context of employment were identified, 44% of which were satisfied.

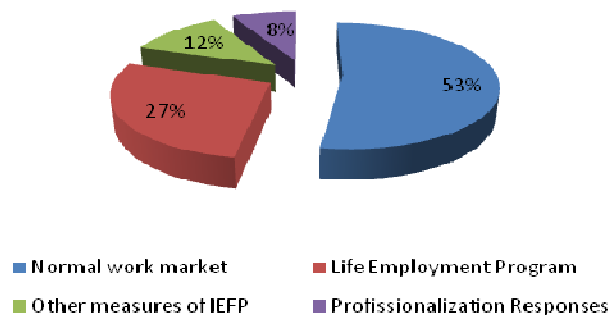
	Years			
	2008	2009	2010	2011
Identified needs(A)	4 338	4 626	4 719	4 246
Positive responses (B)	1 654	1 700	2 011	1 883
Response rate (B/A)	38%	37%	43%	44%

Table 23 – Users with specific needs/users integrated in employment programs (IDT, I.P. 2012)

The satisfaction of these employment needs was obtained through the mobilization of different measures, as we can see in the chart below:

The regular work market, without protected employment programs continues to be the most frequent response with 53% of cases. This option proposes an employment contract, with full rights and duties, which represents an effective integration.

These responses correspond to protected or semi-protected employment mechanism, which allows experiences in work context.



Graph 38 – Type of employment answer (n=1 883), (IDT, I.P. 2012)

In the field of employment, Programa Vida Emprego (Life-Employment Program- PVE) that aims to provide an employment to drug users in treatment process in therapeutic community, outpatient or in prison settings, involved, in 2011, 1 243 persons in reintegration process, accompanied by the Reintegration teams and by other structures licensed or funded by IDT, I.P. with specific measures:

	2005	2006	2007	2008	2009	2010	2011
Stages of Socio-professional	688	646	623	559	596	715	676
Support for Employment	535	624	603	554	479	501	489
Socio-Professional Integration	40	53	57	54	35	27	77
Support for Self-Employment -	1	1	-	1	5	1	1
Total	1 264	1 324	1 283	1 168	1 115	1 244	1 243

Table 24 – Specific measures of PVE, national total (IDT, I.P. 2012)

Among the different measures proposed, the stages of socio-professional integration is the one that gathered more users (53%), as it provides for a practical training in the labour market, useful tool for a future integration and the measures of support for employment corresponded to 40%. These numbers reflect the continuity of the processes of integration, since to pass from stage to employment the beneficiary must have a positive evaluation, condition *sine qua non* to the employer to propose a work contract.

To facilitate the users' access to labour market, the Reintegration Teams use a computerized database at national level – Exchange of Employers, support tool for experts created in 2009, which aim to organize and share information of employers' partners of IDT, I.P. This database allows the characterization of possible employers, mainly private companies, Local Administration and private Institutions of Social Solidarity, by location, sector, size and history of collaboration with IDT, I.P. In 2011, a significant adhesion of professionals to this tool was visible and 177 new entities were recruited, which constitute along with the existing 751 the IDT, I.P. partner's network. It is worth noting that most of the employers participating in the Exchange of Employers are private companies (52%), small enterprises (50%) with less than 10 employees and that 85% (792) employers received users included in the PVE.

Also in the field of employment, we should highlight the innovative project InPar, implemented between August 2009 and August 2011 in the region of Porto, aimed at the pre-professionalization and stabilization of drug users with no family support, integrated in Risk and Harm Reduction (RRMD) structures. The intervention developed among drug users reached by the street team GiroGaia was divided in 2 groups. The first group of 8 drug users was integrated as peer educators in street teams and the other 12 were followed individually to access and promote their social reinsertion in the local community.

The first component was experimental, as having drug users performing activities related with psychoactive substances is a way to make use of their competences and by the end of the project 50% of them continued in the street teams. As for the second component, the objective was to propose to drug user's job offers, issued from the local community. Having a task to accomplish, even simple, paid by hour, day or week, is a strong motivation for change and to acquire social skills, necessary for a successful social reintegration. As result of this experimental project, methodological guidelines for the reintegration of drug users were drafted and will be presented in 2012.

During 2011, the IDT, I.P. Reintegration Unit was particularly active in the dissemination of the guidelines for intervention in work setting – "Security and Health Work and Prevention of psychoactive substances use: Guidelines for Workplace Intervention", through IDT, I.P. and Authority for Labor Conditions (A.C.T.) websites and translated to English by the Pompidou Group. Also, specific training in workplace, conceived in collaboration with the trade union General Confederation of Portuguese Workers (CGTP-IN), was developed with the municipalities of Loures, Seixal, Águeda e Vendas Novas, involving 193 participants.

To note also the continuity given to the joint protocol, launched by IDT, I.P. and the CGTP-IN to the Interaction Program, European program (EURÍDICE – European Research and

Intervention on Dependency and Diversity in Companies and Employment) initiated in Portugal in 2004. This program aims to promote healthy lifestyles, changing attitudes, behavior and risk factors to psychoactive substances use. Also, IDT, I.P. developed 25 interventions in companies interested in implementing programs for health promotion and prevention of drug use, involving 896 workers.

IDT, I.P. also signed 2 protocols in 2011 with the Santa Casa da Misericórdia de Albufeira where 8 awareness actions took place involving 178 workers and with the Municipality of Albufeira, where 384 workers participated in 24 actions.

9. Drug-related crime, prevention of drug related crime and prison

9.1. Introduction

In 2011, concerning the administrative sanctions for drug use⁴⁴, Commissions for the Dissuasion of Drug Use (CDT) instated 6 898 processes⁴⁵, representing a slight decrease (-6%) in comparison to last year, most of which were, again, referred by the Public Security Police (PSP), National Republican Guard (GNR) and Courts.

From the 5 033 rulings made, 81% suspended the process temporarily, 15% were punitive rulings and 4% found the presumed offender innocent.

The number of presumed offenders was very similar to last year, registering these last three years the highest values since 2002. Continues the trend manifested through the decade of the predominance of presumed offenders in the possession of cannabis and the increased visibility of the number of presumed offenders in the possession of cocaine (the values registered in the last three years for cannabis and cocaine were the highest since 2002). In the case of heroin, after the downward trend verified in the first half of the decade, followed by a stability and a peak in 2009, it's verified again a decrease in the number of presumed offenders.

In the context of judicial decisions under the Drug Law, in 2011, 1 629 crime processes were finalised involving 2 318 individuals, 2 041 were convicted, 78% for traffic, 21% for use and less than 1% for traffic-use, being noted the increase in the proportion of individuals convicted by use since 2008, related with the fixation of case law on situations for own use in superior amount than the required for the average individual use during a period of 10 days.

Concerning the sanctions applied in these convictions, mostly related with trafficking crimes, such as occurred in 2004 and contrary to previous years, in 2011 these convictions involved mainly suspended prison (46%) instead of effective prison (32%). To refer specially in the last three years, the increase of convicted only sentenced with an effective fine, predominantly applied to convictions related with consumption. Similarly to previous years, the majority of these convictions were related to only one drug, maintaining the predominance of cannabis by the ninth consecutive year and a higher number of convictions by possession of cocaine in relation to heroin by the sixth consecutive year, consolidating the trend verified in previous years of the increase visibility of cocaine in these convictions.

Prison data indicates that, on the 31st of December 2011, 2 075 individuals (+6% than in 2010 with 1 950) were in prison for crimes against the Drug Law, representing an increase of 6% in relation to 2010. It is noted in the last four years a stability in the number of inmates convicted under the Drug Law, although with lower values than those registered in previous years. Once more was reinforced the trend initiated in 2000, of the decrease weight of these prisoners in the universe of the convicted prisoner population, representing on the 31st of December 2011 near 20% of these population. The majority of these individuals where convicted for traffic (90%), 9% for minor traffic and 1% for traffic-use, percentages that falling within the pattern of last years.

⁴⁴ Law n. º 30/2000, of the 29th November.

⁴⁵ Each process corresponds to one occurrence and to one person. Information collected on 31 March 2012.

9.2. Drug related Crime

Drug Law offences

Concerning the administrative sanctions for drug use⁴⁶, in 2011, the 18 CDT instated 6 898 processes⁴⁷, representing a slight decrease (-6%) in comparison to 2010. 2009 and 2010 were the years that registered the highest value ever of processes.

Like in previous years the districts of Porto and Lisbon followed by Braga, Setúbal, Faro and Aveiro registered the higher number of processes; the districts of Faro, Beja, Porto and Portalegre presented the higher occurrences rates per inhabitant aged 15-64.

In comparison to last year, the highest increase in absolute values occurred in the district of Porto and Santarem and in percentual values in the districts of Santarem and Bragança. The highest decrease in absolute value occurred in the district of Lisbon and in percentual value in the districts of Viana do Castelo, Guarda and Vila Real.

Similarly to previous years, most cases (46%) were referred by the PSP, followed by the GNR with (37%) and the Courts with 17% of the cases. In comparison to last year was registered a decrease in the number of occurrences sent by PSP (-9%) and by GNR (-4%) and an increase in the number of processes referred by the Courts (+6%). However, it is noted that in the last three years were registered the highest values of the decade of occurrences sent by the GNR and PSP and the lowest values of the decade of occurrences sent by the Courts⁴⁸.

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

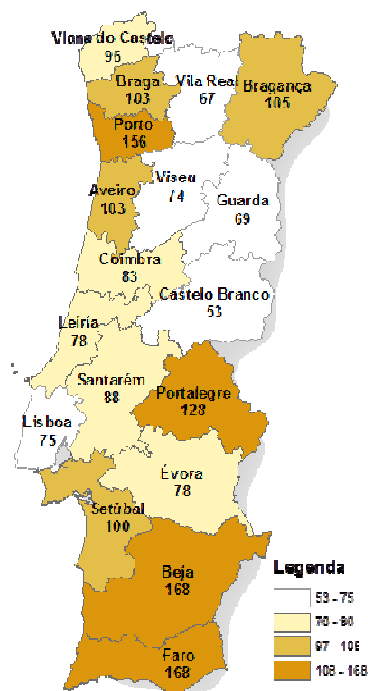


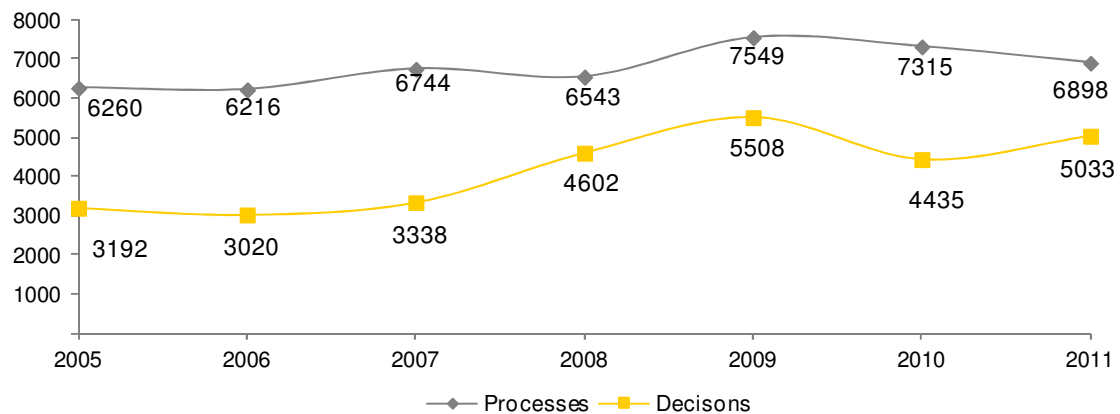
Figure 6 – Distribution of the Administrative sanctions for drug use by District (IDT, I.P. 2012)

⁴⁶ Law n.º 30/2000, of the 29th November, regulated by the Decree-Law n.º 130-A, 23 April and Administrative Rule n.º 604/2001, 12 of June.

⁴⁷ Each process corresponds to one occurrence and to one person. Information collected on 31 March 2011.

⁴⁸ The decrease in the number of processes by the Courts can be related, among others, with the Judicial precedent of the Supreme Court of Justice n.º 8/2008, of 5 August (Acórdão do Supremo Tribunal de Justiça n.º 8/2008, de 5 de Agosto), which remains in force n.º 2 of the article 40 of the Decree-Law n.º 15/93, of 22 January, "... not only "the cultivation" and on the acquisition or possession, for personal consumption, plants, substances or preparations listed in Tables I to IV, this shall not exceed the quantity required for an average individual consumption during a period of 10 days".

On the 31st of March 2011, near 73% of the processes instated in 2011 had been decided: 40% were suspended (26% in 2010, 31% in 2009, 35% in 2008 and 27% in 2007) and 33% were filed (35% in 2010, 2% in 2009, 35% in 2008 and 23% in 2007), indicating an increase in the decision-making capacity in relation to previous year.



*When interpreting the data related to the decision taken, should be take in account that some CDTs were in certain periods functioning without a quorum, that conditioned the diligences in some CDTs, namely the decision making in the application of Law 30/2000: since 2003 the CDT of Viseu and Guarda; since last semester of 2004 Faro and Bragança; since 2005 the CDT of Lisbon; since the end of June 2007 the CDT of Coimbra and June 2008 the CDT of Vila Real. The reposition of quorum in these CDTs was accomplished during the first semester of 2008, with the exception of the CDT of Vila Real which reposition occurred in February 2009. In 2010, the CDT of Porto and Faro stayed without quorum in September having been reinstated in August and November 2011 respectively. On other hand continued to persist gaps in some CDT technical teams, related to the insufficient number of professionals

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

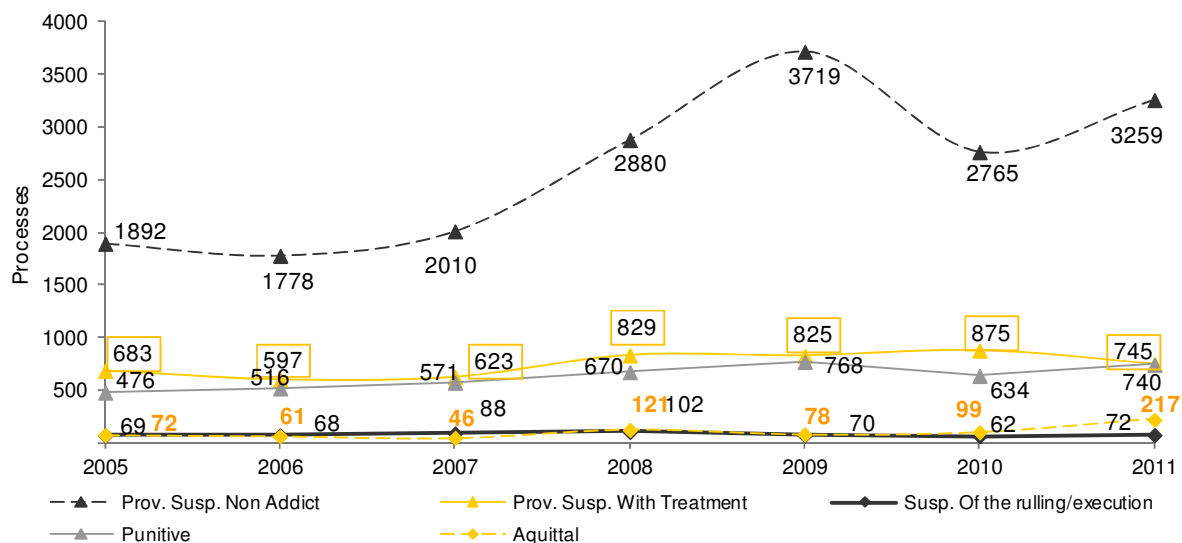
Graph 39 – Administrative sanctions processes and decisions*, by year (IDT, I.P. 2012)**

From the 6 898 processes instated in 2011, the Commissions had ruled on 5 033 decisions

- 81% were suspensive rulings;
- 15% were punitive rulings and
- 4% found the presumed offender innocent.

As in previous years, the provisional suspension of process in the case of users who were not considered addicted were the majority of the total percentage of rulings (65%), (62% in 2010, 68% in 2009, 63% in 2008 and 60% in 2007), followed by suspensive rulings in the case of drug users who accepted to undergo treatment (15% in 2011, 20% in 2010, 15% in 2009, 18% in 2008 and 19% in 2007).

In 2011, the weights of the punitive ruling in this setting was identical to last year (15%), continues to be predominant non-pecuniary sanctions (12% in 2011, 9% in 2010, 10%, 10%, 11% and 59% in, 2008 and 2007), mainly related with the periodical presence in a place selected by the CDT.



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

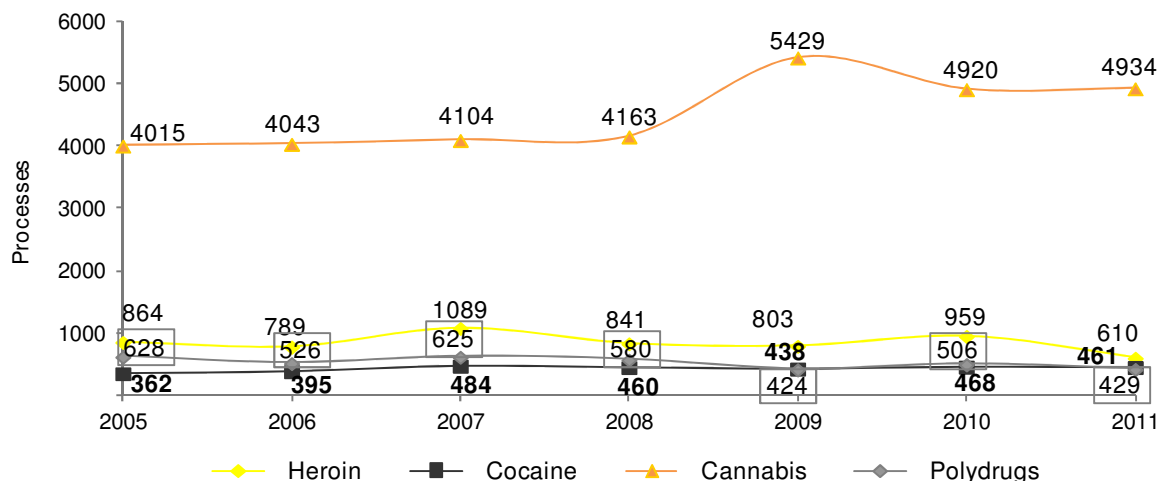
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Graph 40 – Type of ruling for administrative sanctions by year* and type of Decision (IDT, I.P. 2012)**

Concerning the substances involved:

- In relation to 2010, only the processes related with ecstasy registered an increase (+167%), although the number is still residual. The number of processes involving only cannabis and only cocaine remained stable and there were decreases in the number of heroin only (-36%) and with several drugs (-15%).
- As in previous years, most cases involved only one drug (93%):
- Mainly cannabis (76%) – 71% in 2010, 76% in 2009, 68% in 2008 and 64% in 2007
- 9% of these processes involved only heroin (14% in 2010, 11% in 2009, 14% in 2008 and 17% in 2007). 7% involved only cocaine (7%, 8%, 6% and 8%, respectively in 2010, 2009, 2008, 2007);
- The predominance of occurrences involving only cannabis was found in all CDTs,

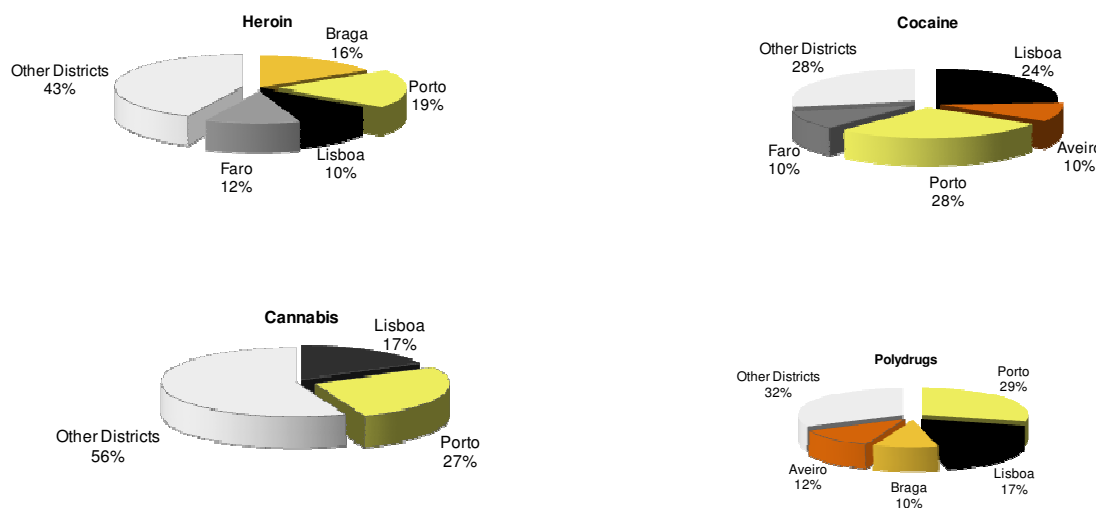
a) For the 7% processes involving more than one drug (7% in 2010, 6% in 2009, 10% in 2008 and 2007), the association heroin-cocaine was again predominant, and like in the last seven years, the association cocaine-cannabis surpassed the association heroin-cannabis.



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

Graph 41 – Type of drug involved in administrative offences by year* (IDT, I.P. 2012)

In general, the distribution of processes by district and type of drug involved shows that the districts with the highest total number of processes are - Porto (28%), Lisbon (16%), Braga (9%), Setúbal (8%), Aveiro (7%) and Faro (7%). Those districts concentrate also the largest number of processes of each of the drugs considered, although with a different distribution depending on the type of drug.



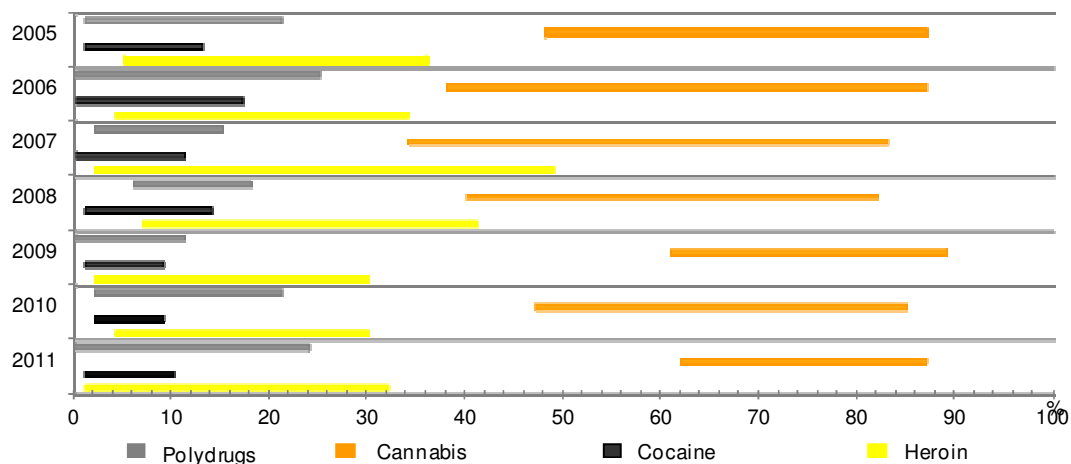
(Districts with more than 10% of the total number of processes of each type of drug)

Graph 42 – Distribution of the administrative sanctions by type of drug involved and by district (IDT, I.P. 2012)

The reading of the interdistrict percentages by type of drug⁴⁹ shows some heterogeneity: processes involving only cannabis varied at district level between 62%-87%, heroin only between 1%-32%, cocaine between 1%-10% and the processes involving several drugs between 0%-24%.

⁴⁹ Considering as percentual base the processes opened in each district.

In general, these variations between minimum and maximum values of the interdistrict percentages by type of drug involved in the processes follows the pattern registered in previous years.



Graph 43 – Administrative sanctions processes by type of drug, intervals of the interdistrict percentages, by year (IDT, I.P. 2012)

Concerning the individuals involved:

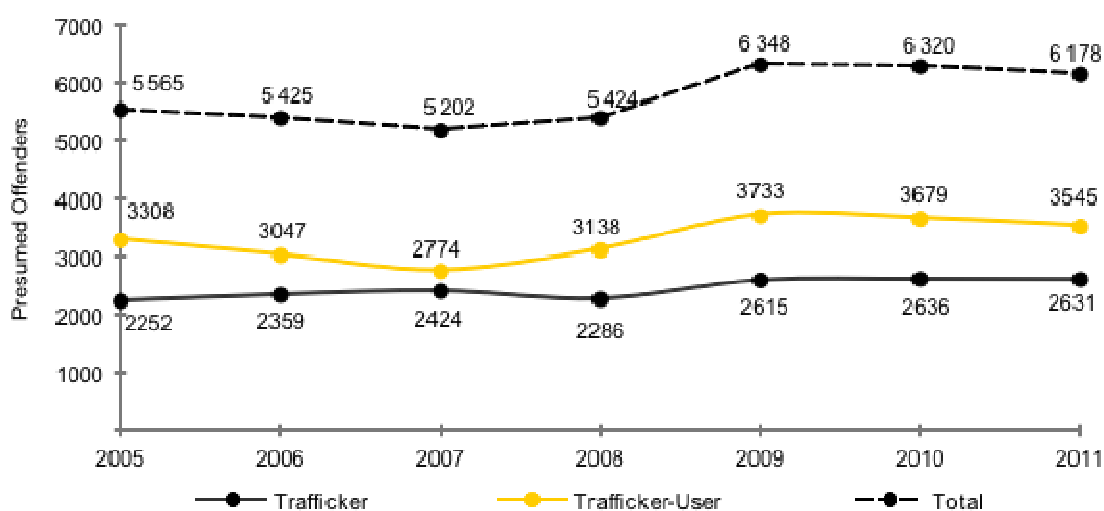
- In 2011, 6 507 individuals⁵⁰ were involved (6 826 in 2010, 7 122 in 2009, 6 044 in 2008 and 6 268 in 2007) in the instated processes and without acquittal of the CDT's;
- 5% of those were recidivists in 2011 to a Commission (5% in 2010, 4% in 2009, 6% in 2008 and 2007). The majority of the recidivists (90%) registered only one criminal relapse in the year.
- The district of Porto registered the higher number of recidivists in the year and the higher interdistrict percentages of recidivists in the year was in the districts of Bragança (13%), Aveiro (7%) and Porto (7%).
- In relation to previous years, no relevant changes were verified concerning the socio-demographic profile of these individuals:
 - They were mostly from the male gender (93%);
 - 87% single
 - i. 49% were aged 16-24;
 - ii. 29% were aged 25-34;
 - iii. Mean age 27;
 - iv. They were mainly Portuguese (94.6%), single (86.9%) and living with their parents/siblings (65%);
 - v. 40.2% had frequented the 3rd level of compulsory school (7th - 9th grade) and 26.4% reported an educational status above that;
 - vi. 29.8% were unemployed and the 39.8% were employed and 23.7% students

⁵⁰ Individuals who were sent twice to a Commission in any year (and thus originated the instatement of more than one process) were counted only once.

Like in previous years, between foreigners (5%) Africans were predominant (2%), with particular relevance to Cape Verdean.

Other Drug related crime

Concerning **criminal offences**, in 2011, data from the Criminal Police identified 6 178 presumed offenders: 43% were presumed traffickers and 57% presumed trafficker-users. The number of presumed offenders was very similar to last year (-2%) registering these last three years the highest values since 2002.



Graph 44 – Presumed Offenders by year and situation towards drug (IDT, I.P. 2012)

Similarly to previous years, the districts of Lisbon and Porto presented the higher percentages of these presumed offenders (respectively 35% and 24%), followed by Faro and Setúbal (both with 6%). The higher rates of presumed offenders per inhabitant from the age group 15-64 were registered in the districts of Portalegre, Lisbon, Faro, Porto and Autonomous Region of Azores.

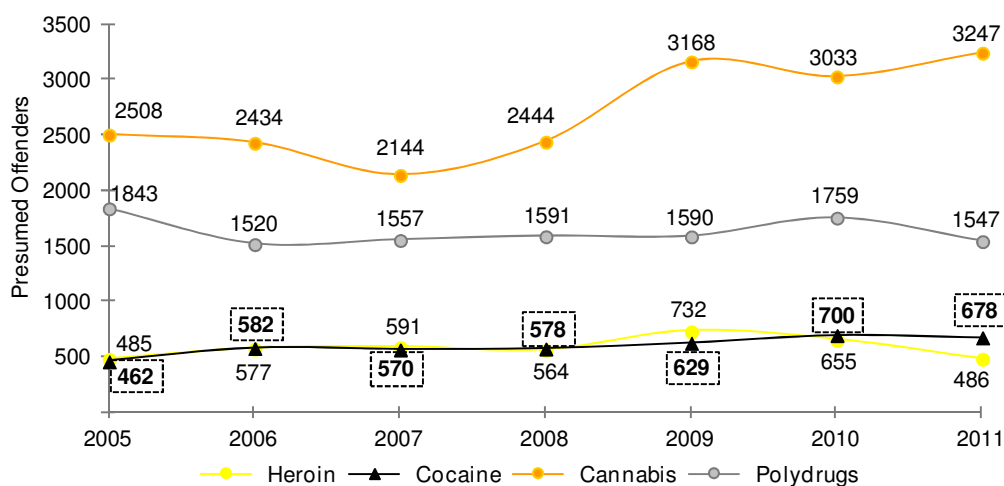
Concerning the substances identified in the moment of the occurrence:

- 74% of these individuals possessed only one drug (71% in 2010, 74% in 2009, 70% in 2008 and 68% in 2007);
- Among these cases, and like in previous years, cannabis was predominant in comparison to other substances (54%);
- 8% of the cases concerned heroin only (11% in 2010, 12% in 2009, 11% in 2008 and 12% in 2007);
- 11% of the cases concerned cocaine (11% in 2010, 10% in 2009, 11% in 2008 and 12% in 2007);
- Less than 1% of the cases concerned several other drugs;
- In the situations where more than one drug was involved (26%), the combination “heroin and cocaine” continues to be predominant, followed this year by the combination of heroin with cocaine and cannabis and the association cocaine with cannabis.
- In comparison to 2010, was registered a decrease in the number of presumed offenders in the possession of heroin only (-26%) and in the possession of polydrugs (-12%) and a

slight decrease in the number of presumed offenders in the possession of cocaine only (-3%). On the other hand, increased the number of presumed offenders in the possession of other drugs (+44%) and in the possession of cannabis only (+7%).

It's worth noting that the values registered in the last three years at the level of cannabis and cocaine was the highest since 2002. In the case of heroin, after the downward trend verified in the first half of the decade, followed by a stability and a peak in 2009, it's verified again a decrease in the number of presumed offenders. Concerning the number of presumed offenders in the possession of several drugs, the value registered in 2011 is very similar to the ones registered since 2006 (with the exception of 2010 that registered the highest value of this period) maintaining the stability trend occurred in the second half that registered lower values than those of the first half.

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



Graph 45 – Presumed Offenders by year and type of drug (IDT, I.P. 2012)

The district distribution of presumed offenders by type of drug involved, evidence like in previous years, a highly concentration of presumed offenders in the possession of cocaine alone in the district of Lisbon. There is a higher regional dispersion in the case of presumed offenders in possession of other drugs, namely in the possession of heroin alone.

The interdistrictal percentages by type of drug in the possession of presumed offenders present some heterogeneity: the percentages of those who were in possession of cannabis only ranged between 38%-80%, in the possession of only heroin between 1%-29%, in the possession of only cocaine between 0%-20% and the percentage of presumed offenders with several drugs ranged between 10%-37%.

Concerning the individuals involved:

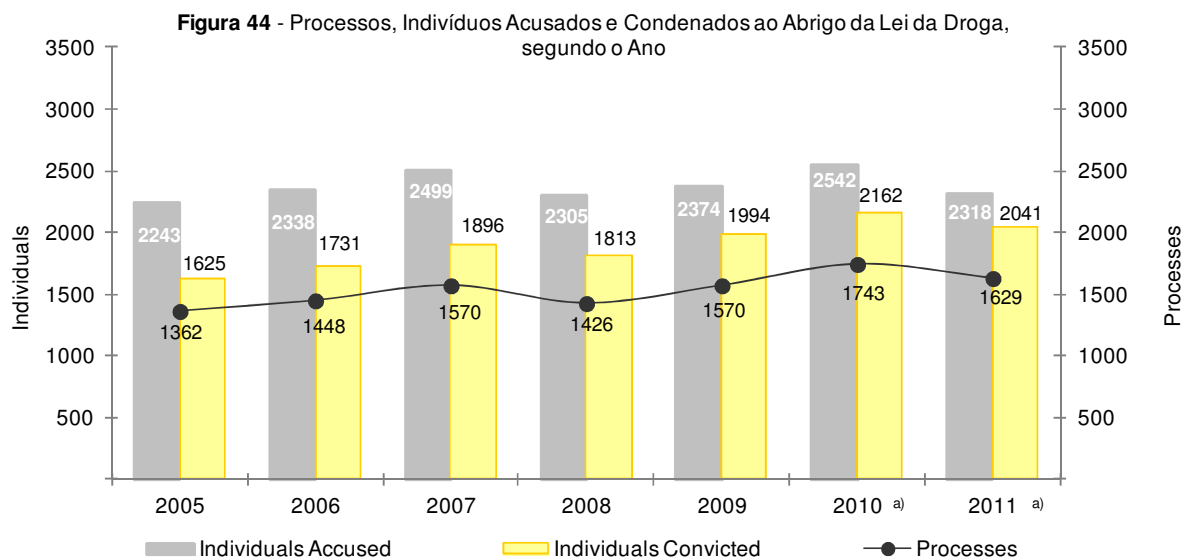
- 89% of the presumed offenders were of the male gender;
- 71% were aged between 16-34, mainly 16-24 (37%) and 25-34 (34%), being the mean age 30;
- 83.7% were Portuguese, among those who were not Portuguese (16%); the Africans were predominant (9%), mainly from Cape Verde. Most (85%) were single, near 59% frequented the 3rd level of compulsory school and more than half (59%) were unemployed when they were interplead by the police.

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

Concerning Court data:

In the context of judicial decisions under the Drug Law⁵¹, in 2011, 1 629 processes were finalised involving 2 318 individuals⁵², the vast majority were accused of traffic (86%). Near 88% were convicted and 12% were acquitted.

Despite the annual variations in the number of processes, of individuals accused and convicted under the Drug Law, there is a decreasing trend in the first half of the decade, on the other hand a slight increase in the second half, is expected that the data update in 2011 next year, reflects an increase of processes of individuals accused and convicted relatively to 2010.



a) In line with the methodological criteria used in previous years, the judicial decisions dated of 2010 and 2011, and registered at IDT, I.P. until 31st of March 2012. 2011 data will be updated next year and 2011 decisions registered between 31st of March 2012 and 31st of March 2013 will be counted.

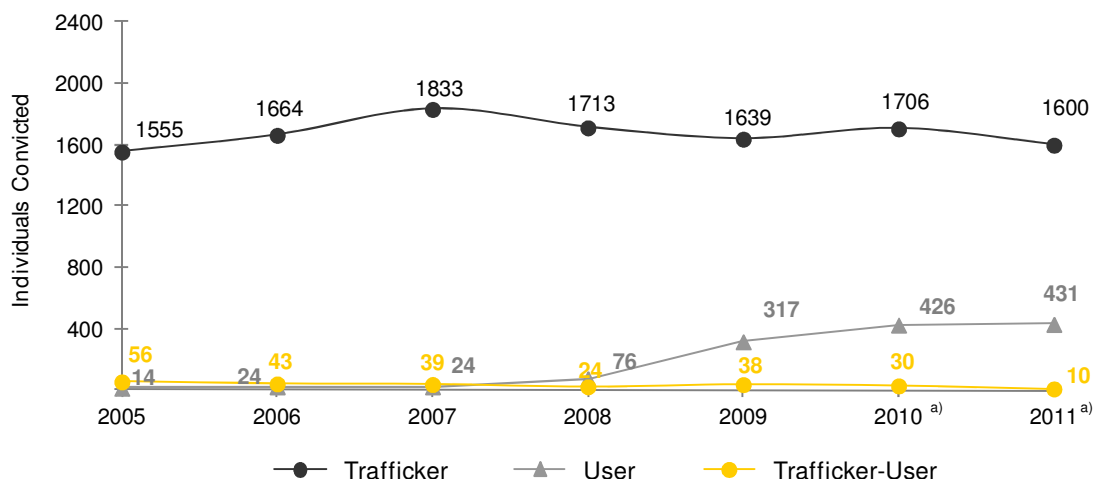
Graph 46 – Processes, individuals Accused and Convicted under Drug law, by Year (IDT, I.P. 2012)

Of the 2 041 convicted individuals (1 770 in 2010, 1 684 in 2009, 1 392 in 2008 and 1 420 in 2007), 78% were convicted for traffic, 21% for use and 1% for traffic-use, the focus goes to the increase in the proportion of individuals convicted by use since 2008, related with the fixation of case law on situations for own use in superior amount than the required for the average individual use during a period of 10 days⁵³.

⁵¹ With the enter in force on the 1 July 2001, the Law 30/2000 of 29 November, the use of illicit substances was decriminalized being an administrative offence. The cultivation situation foreseen in the article 40 of the Decree Law 15/93, of the 22 January is still considered a crime independently of the entering in force of the Law 30/2000. Later one with the Judicial precedent of the Supreme Court of Justice n.º 8/2008, of 5 August (Acórdão do Supremo Tribunal de Justiça n.º 8/2008, de 5 de Agosto), which remains in force n.º 2 of the article 40 of the Decree-Law n.º 15/93, of 22 January, "... not only "the cultivation" and on the acquisition or possession, for personal consumption, plants, substances or preparations listed in Tables I to IV, this shall not exceed the quantity required for an average individual consumption during a period of 10 days".

⁵² In line with the methodological criteria used in previous years, the judicial decisions dated of 2008 and 2009 and registered at IDT, I.P. until 31st of March 2010. 2009 data will be updated next year and 2009 decisions registered between 31st March 2010 and 31st March 2011 will be taken into account.

⁵³ Supreme Court of Justice n.º 8/2008, of 5 August.



a) In line with the methodological criteria used in previous years, the judicial decisions dated of 2010 and 2011, and registered at IDT, I.P. until 31st of March 2012. 2011 data will be updated next year and 2011 decisions registered between 31st of March 2012 and 31st of March 2013 will be counted.

Graph 47 – Individuals Convicted, by year and situation towards drug (IDT, I.P. 2012)

From the 1 600 individuals convicted for traffic, 1 594 were initially accused for that crime, 2 for use and 4 for traffic-use. From the 431 individuals convicted for use, 66% were accused for that crime, 34% for traffic and less than 1% for traffic-use. The vast majority (90%) of the convicted by traffic-use were accused for traffic and only 10% for traffic-use.

Once more Lisbon (39%) and Porto (21%) were the districts that registered the higher percentages of these convictions, followed by Setúbal (7%) and Faro (5%). The higher rates per habitant 15-64 years old; were registered in the district of Lisbon, Autonomous Region of Madeira and in the districts of Portalegre, Faro and Porto.

Concerning the sanctions⁵⁴ applied in these convictions, mostly related with trafficking crimes, such as occurred in 2004 and contrary to previous years, these convictions involved mainly suspended prison (46%) instead of effective prison (32%). To refer specially in the last three years, the increase of convicted only sentenced with an effective fine, predominantly applied to convictions related with consumption.

As for the substances involved:

- In 2011 the majority of these convictions involved, once again, the possession of only one drug (71% in 2011, 70% in 2010, 65% in 2009, 66% in 2008 and 69% in 2007). Hashish was the main substance involved (43% in 2011, 42% in 2010, 37% in 2009, 36% in 2008 and 2007), followed by cocaine (16% in 2011, 17% in 2010, 16% in 2009 and 2008 and 17% in 2007), heroin (11% in 2011 and 2010, 12% in 2009 and 2008 and 14% in 2007) and less than 1% several other drugs;
- When polydrugs are considered (in 29% of the processes), the association heroin-cocaine was predominant.

⁵⁴ Sanctions concern the final conviction and may involve more than one crime.

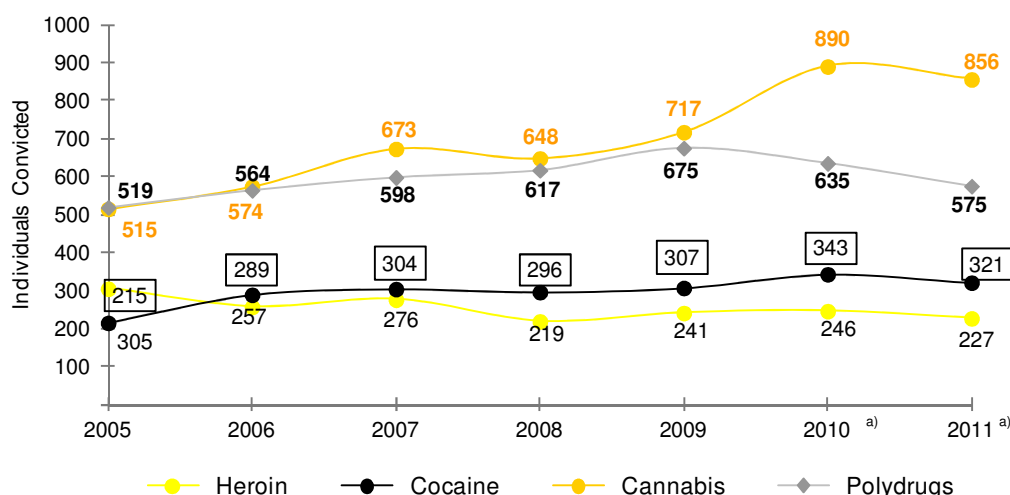
Type of Drug	Total		Trafficker		User		Traf.-User	
	%		%		%		%	
Total	2 041	100,0	1 600	100,0	431	100,0	10	100,0
Heroin	227	11,4	204	12,8	20	5,1	3	30,0
Cocaine	321	16,1	308	19,4	10	2,6	3	30,0
Cannabis	856	43,0	527	33,2	328	83,7	1	10,0
Ecstasy	3	0,2	1	0,1	2	0,5	..	..
Other	9	0,5	8	0,5	1	0,3	..	..
Polydrugs	575	28,9	541	34,0	31	7,9	3	30,0
Unknown	50	..	11	..	39	..	..	..

*In line with the methodological criteria used in previous years, the judicial decisions dated of 2010 and 2011, and registered at IDT, I.P. until 31st of March 2012. 2011 data will be updated in the next year and will be counted the decisions related to 2011 registered in the IDT between 31st of March 2012 and 31st of March 2013.

With the enter in force on the 1 July 2001, the Law 30/2000 of 29 November, the use of illicit substances was decriminalized being an administrative offence. The cultivation situation foreseen in the article 40 of the Decree Law 15/93, of the 22 January is still considered a crime independently of the entering in force of the Law 30/2000. Later one with the Judicial precedent of the Supreme Court of Justice n.º 8/2008, of 5 August (Acórdão do Supremo Tribunal de Justiça n.º 8/2008, de 5 de Agosto), which remains in force n.º 2 of the article 40 of the Decree-Law n.º 15/93, of 22 January, "... not only "the cultivation" and on the acquisition or possession, for personal consumption, plants, substances or preparations listed in Tables I to IV, this shall not exceed the quantity required for an average individual consumption during a period of 10 days".

Table 25 – Individuals Convicted* by situation towards drug and type of drug (IDT, I.P. 2012)

- Similar to previous years the cases related with the possession of cocaine only continue to have greater relative importance in the group of traffickers than in the group of traffickers-users. In the group of convicted by crimes related with consumption, once more the vast majority of the cases were cannabis related;
- In comparison to previous years and despite 2011 data is going to suffer changes in next year, it was noted in the convictions related to only one drug, the preponderance of hashish for the ninth consecutive year instead of heroin, and the preponderance for the sixth consecutive year of the convictions by possession of cocaine only in relation to the cases involving only heroin, strengthen the trend verified in last years of higher visibility of cocaine in these circuits.

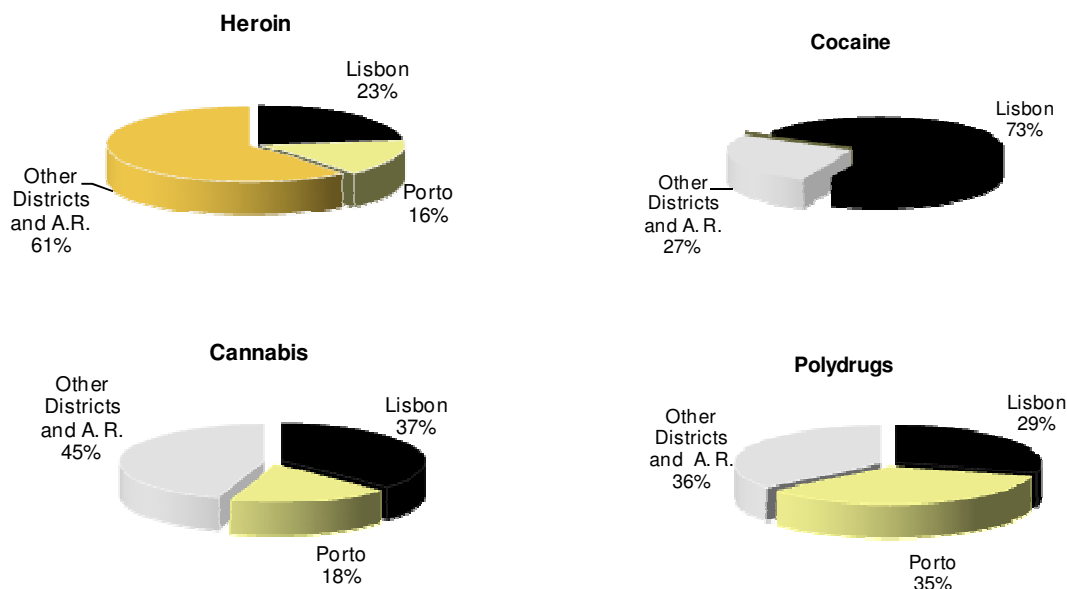


a) In line with the methodological criteria used in previous years, the judicial decisions dated of 2010 and 2011, and registered at IDT, I.P. until 31st of March 2012. 2011 data will be updated in the next year and

will be counted the decisions related to 2011 registered in the IDT between 31st of March 2012 and 31st of March 2013.

Graph 48 – individuals convicted by year and type of drug (IDT, I.P. 2012)

In relation to the district distribution of convicted by type of drug involved and as occurred with presumed offenders, it is to highlight the high concentration of convicted in the possession of only cocaine in the district of Lisbon.



Graph 49 – Distribution of convicted individuals by type of drug, by district and Autonomous Region (R.A.) % (IDT, I.P. 2012)

The interdistrict percentages by type of drug in the possession of individuals convicted shows some district heterogeneity: the percentages of convicted in the possession of cannabis only ranged from 22%-80%, in the possession of heroin only from 0%-32%, in the possession of cocaine from 0%-30% and the percentages of convicted with several drugs ranged from 5%-48%.

Concerning the individuals involved:

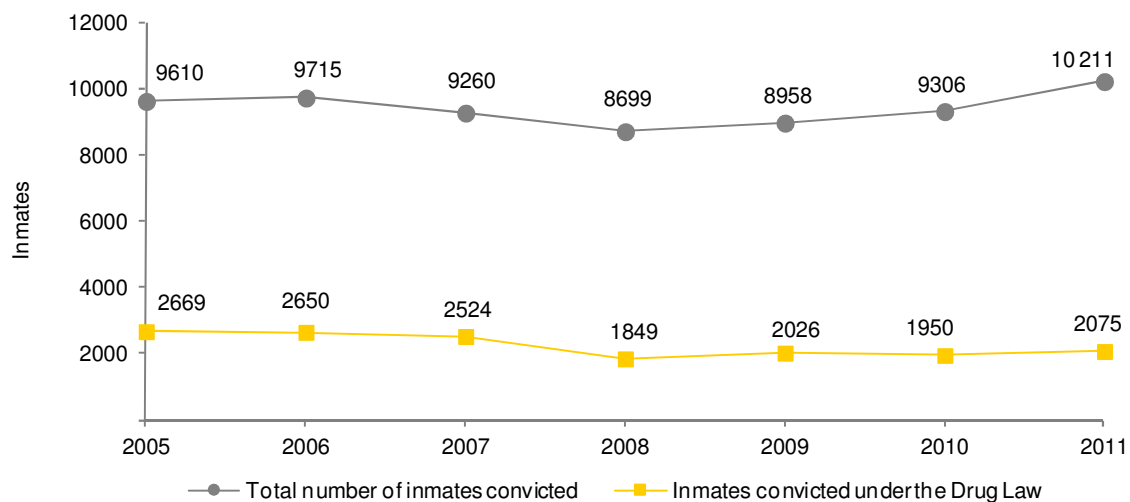
Most of these convicted individuals were of the male gender 90%

- Aged mainly 16-24 (34%) and 25-34 (34%), 30 being the mean age.
- They were mostly Portuguese (89%), single (58%) and living with their parents/siblings (31%). Among those who were not Portuguese (11%), the Africans (6%) were predominant with special relevance to Cape Verdeans;
- Near 54% had habilitations equal to or above 3rd cycle;
- Concerning the professional status, 40% were employed and 45% unemployed at the date of their conviction.

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

Prison data indicates that, on the 31st of December 2011, 2 075 (+6% than in 2010 with 1 950) individuals were in prison for crimes against the Drug Law, representing an increase of 6% in relation to 2010. It is noted in the last four years a stability in the number of inmates convicted under the Drug Law, although with lower values than those registered in previous years.

Once more was reinforced the trend initiated in 2000, of the decrease weight of these prisoners in the universe of the convicted prisoner population, representing on the 31st of December 2011 near 20% of these population.



Graph 50 – Total number of Inmates convicted and Inmates convicted under the drug Law (IDT, I.P. 2012)

Most of these individuals were convicted for traffic (90%) but also for minor traffic (9%) and for traffic-use (1%), these percentages are in line with previous year's patterns.

In comparison to last year decreases were registered in the number of inmates convicted by traffic-use (-57%) reinforcing the downward trend registered over the decade, and in opposition small increases in the number of inmates convicted for minor traffic (+7%) and traffic (+6%). It's important to refer the increase in relation to last years of the number of inmates convicted by other crimes related to the Drug law (although with a very residual weight – 1%), namely criminal association.

Most of these convicted individuals were male gender (88%); aged 30-39 (34%), 40-49 (29%) and 20% with less than 30 years; mean age 39.

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

9.3. Prevention of drug related crime

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

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

In the school year 2011/2012, PSP teams allocated to the Program "Safe School" around 391 (369 in 2010/2011) police officers at national level.

In the school year 2011/2012, PSP promoted more than 6 704 (4 158 in 2010/2011) awareness/information actions at national level, focussing especially in issues such as prevention and road safety education (with 2 001 actions), bullying (with 841 actions) through the organisation of several events (ludic, sportive and cultural). Of the total number of awareness actions referred, 183 were on Juvenile delinquency, 338 on internet use, 296 on criminal prevention, 137 on violence in schools, 674 on alcohol and drugs and 68 on self-protection.

In the school year 2011/2012 from the 3 453 schools covered were involved 1 033 921 studentes (1.289.786 students in 2009/2010) and 137 949 professors and auxiliary educators (130 103 professors and auxiliary educators in 2009/2010).

GNR data indicates that in 2011, 263 agents (237 in 2010, 228 in 2009, 211 in 2008), were allocated to Safe School Programme. Apart from the proximity policing and offence dissuasion, these law enforcement agents were also involved in training and awareness raising initiatives in schools. The initiative targeted 6 902 schools covering a universe of 79 0655 students and 10 843 awareness raising sessions were developed.

9.4. Interventions in the criminal justice system

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

Alternatives to prison

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

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

The CDT's continued to play in 2011 an important role in the articulation with the CRI's in the context of the preventive responses. There were a significant number of referrals to

structures with responses in risk reduction and harm reduction, as well as regular contacts and meetings with the treatment facilities in the various districts, in a relation of proximity and positive articulation.

In order to enhance the intra-ministerial articulation under the Health Ministry, regular referrals to structures within the Ministry, as health centers, hospitals and other integrated services were developed.

Regarding the promotion of inter-ministerial coordination and as in 2011 were extinguished the Civil Governments, it was necessary to find alternative solutions to the functioning of CDT's which wouldn't prejudice the defendant and patients

Under the same goal it should be noted the proximity work with the Public Ministry and Police Forces, maintaining also a regular joint working with partners in the field of social reintegration

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

The following tables characterize the situation of consumption of the individuals in process filed in 2011 and the type of forwarding /reply, within the scope of a provisory suspension of proceedings.

Individuals	N.º
Drug Addict	674
Non- Drug Addict	3 241
Pending cases	1 946
Total	5.861

Table 26 – Situation towards the use of the primary individuals without previous record (IDT, I.P. 2012)

Approximately 79% of the new cases in 2011 were related to primary individuals. On 1 946 cases, it was not possible to define the individuals position with regard to consumption due to non-appearance in the CDT or because they were waiting for procedural issues.

Type of referral	N.º of Individuals			
	Treatment Teams	Health Centre	Other responses	Total
Referral	95	13	21	129
Second Referral a)	107	1	9	117
Follow-up treatment	295	3	76	374
Total	497	17	106	620

Table 27 – Provisional Suspension of the processes from Drug Addicts – voluntary treatment (IDT, I.P. 2012)

Of the 674 drug addicts presented to CDTs, 620 (92%) voluntarily agreed to go to treatment, under a suspension of the process. From those, 129 (21%) had never established contact

with treatment facilities, 117 (19%) reinitiate the treatment once had left and 374 (60%) were under treatment at the time when the offence occurred.

It should be noted a decrease in the number of addicts who voluntarily agreed to go to treatment compared to 2010 (-12%) and 2009 (-17%).

Type of answers	N.º
Without motivation diligence	704
Only motivation diligence	1 815
Motivation diligences and referral for support structures	485
Direct referral to support structures	237
Total	3 241

Table 28 – Provisional Suspension of the process for primary Non-drug addicts (IDT, I.P. 2012)

From the total number of individuals non-drug addicts (3 241), 1 815 (56%) were subject only to diligence of motivation, 485 (15%) were subject to measures of motivation and referred for support and 237 (7%) were directly referred for support without motivation diligence.

Therefore, it should be noted that 2 537 (78%) of the universe of primary non-drug addicts were diagnosed as users in a problematic situation which could indicate major risk towards an addiction, needing expert support and specific approach. For the remaining 704 (22%), mostly were consumption situations, that after psychosocial evaluation, the technical staff considered not worthy of any intervention as they were not risk situations.

The number of primary non-drug addicts defendants that were subject to motivation diligence and/or referred to support structures in 2011, registered an increase in relation to 2010 and 2009, of 28% and 13% respectively.

9.5. Drug use and problem drug use in prisons

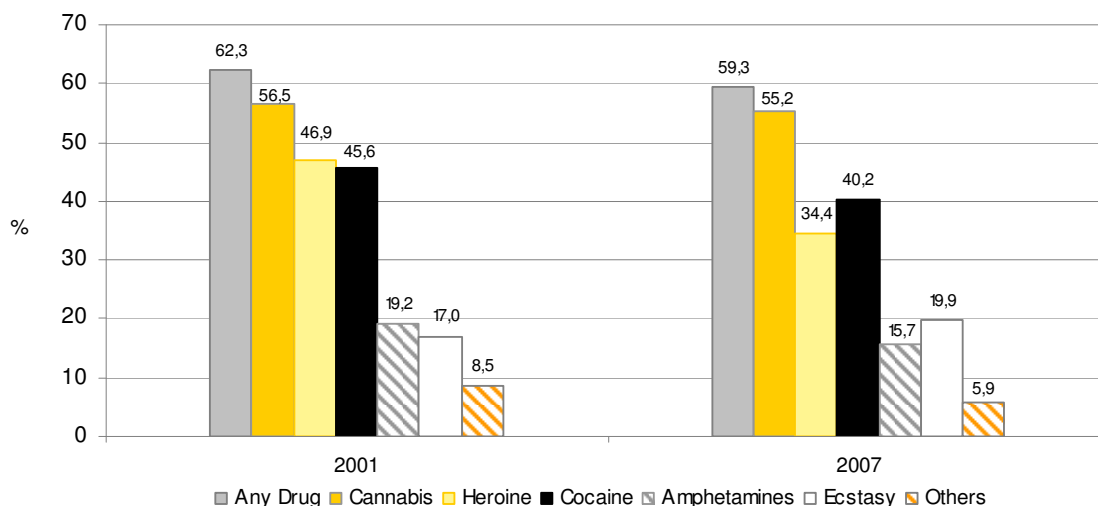
In 2011 there were no new studies on drug use in prisons, so we continue to report here the last study realized. In 2007, the II National Prison Survey on Psychoactive Substances (Torres 2007) was implemented (first study was in 2001). As for the 2001 project, the survey used a random sample of 20% of the individuals in prison. Directors and staff were also interviewed on perceptions. The sample was representative at national level and comparability with the EMCDDA's Standard Table 12 was ensured.

The IDT, I.P. commissioned for the second time a prison survey. The survey was conducted on a random sample of 2 394 (2 601 in 2001) imprisoned individuals (20% of all imprisoned individuals in Portugal - Continent and Isles) from whom 1 986 (2 057 in 2001) valid, anonymous and self-completed questionnaires were collected in 44 prisons (47 in 2001).

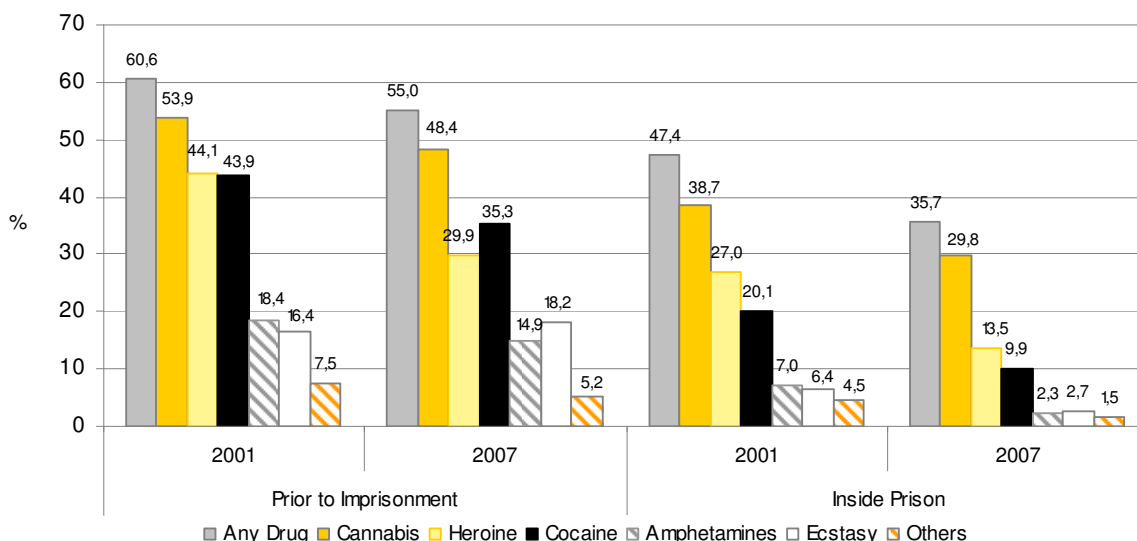
See also chapters 5.4 and 7.3.

Results from national study implemented in 2007 in the prison population show that cannabis, cocaine and heroin are the substances with higher prevalence of use in these population, as in the prior imprisonment context (respectively 48,4%, 35,3% and 29,9%) as in prison (respectively 29,8%, 9,9% and 13,5%). Between 2001 and 2007, a generalised decrease was verified in the prevalence's of drug consumption in both contexts, but more accentuated in the prison context. To note the important reduction of intravenous drug use in relation to 2001, in prior imprisonment context (27% in 2001 and 18% in 2007) and prison context (11% in 2001 and 3% in 2007).

In 2007, as in 2001 cannabis was the illicit substance that registered the highest prevalence of use in the context prior to imprisonment and in prison. Contrarily to 2001, in 2007, in prior to imprisonment context, the prevalence's of cocaine use was superior to heroin; the inverse situation was verified in prison context, similar to what happened in 2001.



Graph 51 – National Prisoner Population: Lifetime Prevalence, by type of Drug (IDT, I.P. 2009)

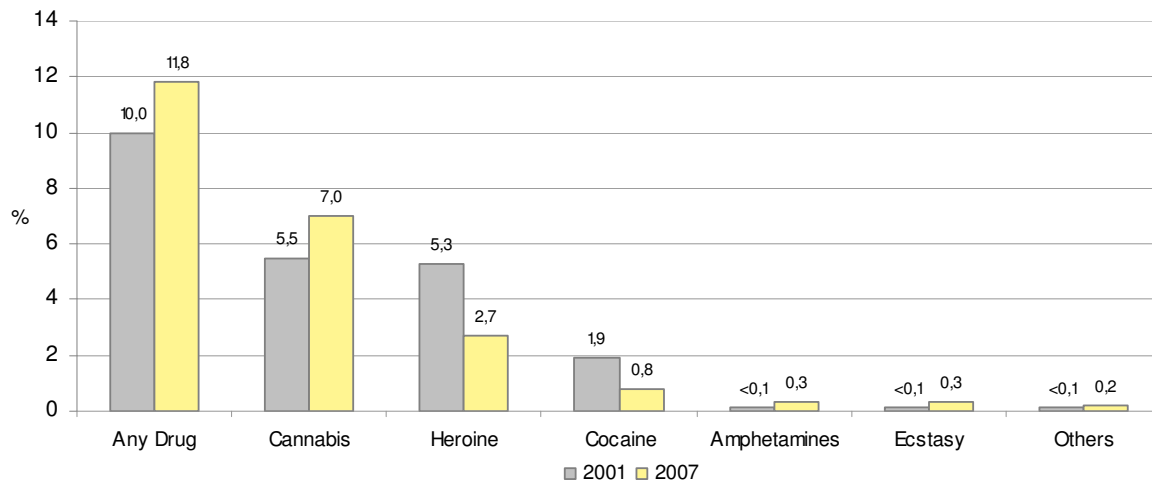


Graph 52 – National Prisoner Population: Prevalence of Use in Prison by type of Drug (IDT, I.P. 2009)

Between 2001 and 2007, a generalised decrease of the prevalence's of use between the prisoners population was evidenced. Such was verified at the level of several contexts and illicit substances, being the only exception the slight increase in the prevalence of use of ecstasy (experienced at least once) before imprisonment. In both contexts - prior to imprisonment and in prison - special accent to the decrease of prevalence's use of heroin and cocaine.

The evolution pattern of lifetime prevalence of any illicit substance decrease between 2001 and 2007 was not maintained, at the female level and older age groups (more than 35 years), where increases were verified.

Both in 2001 and in 2007, was noted that prison has a containment role in consumption, being the decrease of consumption with entrance in prison more accentuated in 2007. However, in prison, the regular consumption – everyday in the last month – of several illicit substances with the exception of heroin and cocaine was superior in 2007.



Graph 53 – National Prisoner Population: Regular Consumption in Prison, by year and type of Drug (IDT, I.P. 2009)

In 2007 an important reduction of intravenous drug use in relation to 2001 was verified, in the context prior to imprisonment (18% in 2007 and 27% in 2001) and in prison (3% in 2007 and 11% in 2001).

Concerning lifetime prevalence's of 2001 to 2007, the results indicate:

- slight decrease in the percentage of prisoners that consumed drugs, being superior to the values of general population;
- Decrease of the percentage of prisoners that consumed heroin, cocaine, medicines of the type tranquilisers, amphetamines and other substances.

9.6. Responses to drug-related health issues in prisons

Drug treatment

The referral to treatment is encouraged in the prison setting, as is ensured to all new inmates the continuity of pharmacological treatments initiated in freedom. Since the entry into force of the Guide of Procedures for Health Care in Prison Settings in 2009, certain practices were strengthened, namely the importance of identification and referral of inmates that are close to release to the adequate health structures, to guarantee they won't interrupt treatment.

The General Directorate for Prisons (DGSP) coordinates treatment programs aimed at abstinence (Drug Free Wings and Exit Units) and pharmacological programs (with opioids agonists and antagonists), being important to refer that the number of inmates participating in

treatment programs in prisons settings was in December 2011 the highest of the decade: 1 411 (1 385 in 2010). From those, 1 185 were in substitution treatment, 116 in detoxification, 6 in substitution treatment with Subutex, 46 in substitution treatment with Suboxone and finally, 58 in opioid agonist programs.

In December 2011, 5 prisons (Lisboa, Tires, Leiria, Porto and Santa Cruz do Bispo) had Drug Free Wings, with a capacity of 194 beds (205 in 2010). During 2011, the Drug Free Wings had 223 users (210 in 2010).

In the context of the National Action Plan against Spread of Infectious Diseases in Prison (PANCPDI), several actions were organized to raise information/awareness among the prison population, to promote the acquisition of healthy lifestyles and increase knowledge on the psychoactive substances use and their associated risks. These activities aim at preventing the first use and promoting the motivation toward treatment.

In 2011, 54 specific activities focused on health promotion and diseases prevention were promoted in a total of 900 participants.

Prevention and reduction of drug-related harm

In 2011, although many of the actions of information/awareness on health promotion and drug addiction developed in prison settings also addressed the harm and risk reduction issues, 54 specific actions were promoted, comprising 900 participants.

Such initiatives covered various topics, including: programs to reduce harm and risk; morbidity and co-morbidity associated with risk behaviours, risks associated with piercings and tattoos, risk behaviour and protective behaviour; the acquisition of healthy lifestyles, among others.

Prevention, Treatment and care of infectious diseases

The implementation of the National action plan against spread of infectious diseases in prison settings (PANCPDI) followed the schedule, undertaking activities on the 5 main areas defined: Health promotion and prevention disease, drug treatment, tuberculosis, infectious diseases, harm reduction. The prisons organised during 2011, 788 (202 in 2010) interventions, involving 15 432 (3.847 in 2010) inmates, in the areas of: healthy behaviours; use of psychoactive substances, polydrug use, new psychoactive substances, use related risks, harm and risks related to the use and abuse of psychoactive substances, etc.

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

Prevention of overdose-risk upon prison release

See chapter 7.3.

9.7. Reintegration of drug users after release from prison

In the area of education and training several activities were continued, promoted by partners, always with the aim of creating conditions for increasing skills and educational qualifications in the inmates.

In the academic year of 2011, 3 893 (2 170 in 2010) inmates were attending classes, distributed in the following levels:

	Students 2010/2011	Students 2011/2012	Total
Training in basic skills		188	188
Primary	1.411	1.582	
Secondary	174	455	629
Post-secondary (technical courses)	5	2	7
University	34	42	76
Total	1.624	2.269	3.893

Table 29 – Inmates attending school (IDT, I.P. 2012)

The training in prison setting aims at providing inmates tools to a better social and professional reintegration, through the acquisition of technical and social skills, for a qualified professional performance and personal/social development. The actions conceived were more flexible and shorter.

The training modalities used in 2011 were the following: education and training courses of double certification for adults; certified training modules and training for inclusion.

The training strategy of DGSP involved also the reinforcement of training activities in partnership with new organizations and the strengthening of others in the development and implementation of the training interventions. In 2011, 1 905 (2 086 in 2010) inmates participated in professional training activities.

In the area of work/professional activity, DGSP tried to reinforce the network cooperation with organizations outside prisons, seeking to increase the employment rate among inmates, to create conditions for an improved professional training and social/professional reintegration. Their occupation in the prison setting was as described above:

Prisons	1st Semester	2nd semester
Central	3 047	2 989
Specific	485	531
Regional	1 020	1 023
Total	4.552	4 543

Table 30 - Work activities in prison settings (IDT, I.P. 2012)

In April 2011 were signed several Commitments of Collaboration involving DGSP and IDT, I.P. which aims to provide health and psychosocial care in treatment and reintegration,

including therapeutic support, medical and psychosocial support to drug addicts in the prisons of Montijo, Alcoentre, Vale dos Judeus, Setubal and Torres Novas.

In June 2011, Commitments of Collaboration were also signed to extend the same activities to the prisons of Guimarães, Chaves, Lamego and Vila real.

10. Drug Markets

10.1. Introduction

The year 2011 consolidates the trends verified in previous years in terms of various indicators in the markets context.

Remains the trend expressed over the decade of cannabis predominance and the increased visibility of cocaine in these contexts. In the case of heroin after a clear downward trend in several indicators observed during the first half of the decade, followed by a stability in the second half, in 2011 cannabis reduced its visibility in some indicators. The indicators related with the possession of several drugs confirmed the stability trend occurred in the second half of the decade and several indicators concerning the possession of other drugs registered increases in 2011, although continues with residual relative values.

For the tenth consecutive year, hashish was the substance involved in a higher number of seizures (3 093), reinforcing the trend initiated in 2005, and once more the number of cocaine seizures (1 386) was superior to heroin (1 169). It is worth to highlight the increase, especially in the last three years, in the number of liamba seizures, representing in 2011 (660) the highest value since 2002. In relation to 2010, it was verified in 2011 a decrease in the number of heroin and cocaine seizures, remained stable the number of hashish seizures and increased the number of liamba and ecstasy seizures. However, it should be noted that, in general, the values recorded in the last two years were the highest since 2002. The trends revealed in the previous decade showed increases in the numbers of seizures of cocaine, hashish and liamba in the second half of the decade (2006-2010) compared to the first half (2001-2005), contrarily to the decline observed in the case of heroin and ecstasy.

In comparison to 2010, increases were registered in the seized quantities of liamba, heroin and cocaine, but on the other hand the quantities of ecstasy and hashish decreased. Despite the annual fluctuations, the trends expressed in the previous decade showed increases in the seized quantities of cocaine, hashish and liamba in the second half of the decade (2006-2010) compared to the first half (2001-2005), contrarily to the decrease observed in the case of heroin and ecstasy.

Concerning countries of origin of the seized drugs in 2011, stood out in the ambit of international trafficking: Netherlands and Pakistan in the case of heroin, Brazil and Bolivia in the case of cocaine, South Africa in the case of liamba and once more Morocco in the case of hashish. Although the majority of drugs seized and with information on routes intended the domestic market, remains a significant number of seizures that had as final destination other countries, especially European – with particular emphasis to Spain, maintaining the trend of Portugal being a transit point on international trafficking, particularly for cocaine.

Regarding the prices of drugs, at trafficker and trafficker-user level, they didn't registered relevant changes in relation to 2010, with the exception of cocaine that registered an increase. Despite the annual variations, since 2002 there has been a downward trend in the average prices of heroin and ecstasy; an upward trend of liamba and cocaine and stability in the average price of hashish (although with slightly higher values in the second half of the decade).

10.2. Availability and supply

Regarding the **main origin** of the seized drugs in Portugal in 2011, stood out in the ambit of international trafficking: Netherlands and Pakistan in the case of heroin, Brazil and Bolivia in the case of cocaine, South Africa in the case of liamba and once more Morocco in the case of hashish, not knowing the source of almost all the ecstasy seized in the country in 2011. The majority of the seized quantities of all drugs with information on the routes were destined to the domestic market. To be noted that a large number of seizures at the level of several substances seized had as final destination other countries, especially European – with particular emphasis to Spain, maintaining the trend of Portugal being a transit point on international trafficking, particularly in the case of cocaine.

In heroin, the main means of transport use remains land (passenger car) and air transport (airplane), for cocaine the shipping circles (maritime transport) remain the most widely used for transporting large quantities but air transport (airplane) is also important. Regarding hashish shipping is undoubtedly the most important, but land also has significant expression, by the number of cases associated. For ecstasy land transport is the most relevant with emphasis for the transport in passenger cars (for the quantities involved and by the number of associated cases) and for the transportation in light commercial vehicles (by the quantities involved).

According to 2007 General Population Survey (see Chapter 2), the Portuguese population perceived the access to substances in a 24-hour period more easy than in 2001.

According to the 2007 ECTAD survey (see Chapter 2), there was a decrease in the percentage of youngsters (13 to 18 years old) saying that is “very difficult” to have access to drugs and also of those saying that is “very easy”.

According to ESPAD 2011, the perceived ease access to cannabis is the same of Norway, Sweden, Baltic countries, Germany and Italy (among others) being lower than in Spain, France, UK and much lower than the US.

In 2011, drug trafficking in Portugal didn't registered significant changes in trends or prevalence's.

Aiming to strengthen the surveillance activities, control and inspection of the external border of the European Union in order to eliminate the possibilities of introducing drugs into the national territory and in Europe, in the ambit of the Criminal Police (PJ) participation in the Maritime Analysis and Operation Centre – Narcotics (MAOC-N), was proceeded in 2011, the treatment and monitoring of numerous vessels on suspicion of being used for transcontinental traffic. In 2011, were made several control operations, collection of information, monitoring and surveillance of passengers suspected of involvement in drug trafficking. It should be noted, the close collaboration between PJ, the Coastal Management Unit of the GNR, General Directorate of Customs and Special Taxes on Consultation (DGAIEC) and Emigration Services (SEF). Through the Coordination and Criminal Investigation Units (UCICs) and bilaterally have been developed actions aimed at prevention and repression of drug and psychotropic substances and their precursors trafficking phenomena. These efforts are permanently linked with MAOC-N.

In order to prevent and fight against money laundering generated by the production and trafficking of illicit drugs, psychotropic substances and precursors, the investigations trafficking of narcotic drugs and psychotropic substances and their precursors are in PJ, always complemented by a prior research and evaluation of any assets belonging to suspects. The Financial Information Unit (UIF) is the central national authority for the collection, analysis and dissemination of information on money laundering and terrorism⁵⁵ financing and it's also responsible for the processing of information relating to tax infractions,

⁵⁵ Law nº 25/2008, from 5th June - Establishes measures of preventive and repressive nature of fight against laundering benefits of illicit origin and terrorism financing, transposing into internal juridical law Directives Nº 2005/60/EC of the European Parliament and the Council of 26 October and 2006/70/EC of the Commission.

which is an atypical competence among counterparts and a very important tool for their purposes.

At the level of international cooperation on the exchange of information with counterparts, 104 requests were received and 59 were sent.

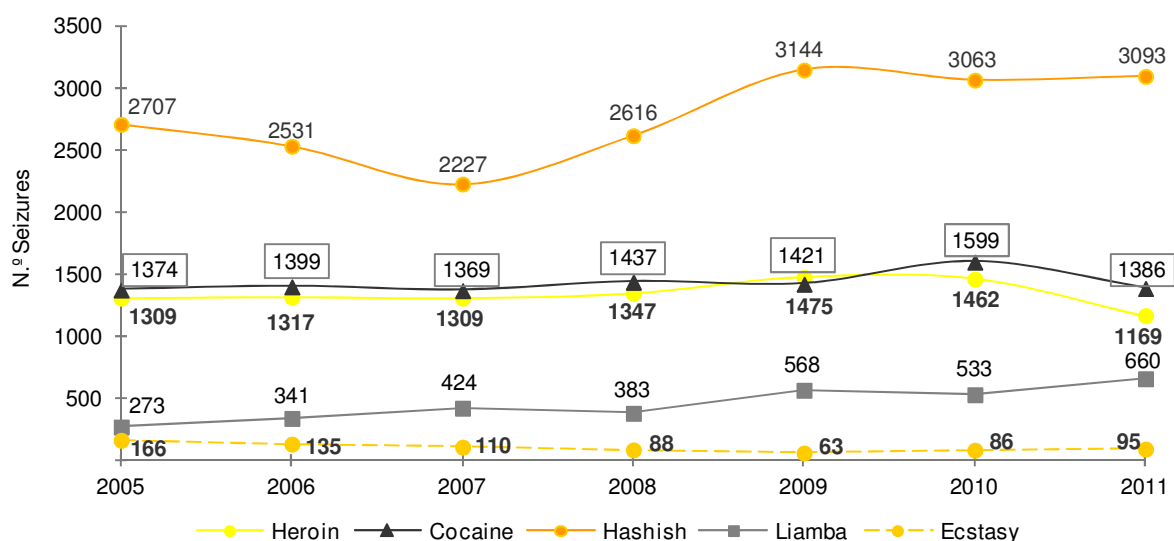
In 2011, similarly to what happen in previous years, PJ intervention had particular impact on drug trafficking at international level affecting important criminal structures, responsible for the introduction of hashish and cocaine in Europe and for supplying at national and regional level several types of drugs. Despite the resistance orchestrated by the authorities' repressive systems, these structures reveal themselves quite resilient, reformulating new strategies of action, which include innovative modi operandi, new routes for introduction of these substances in Europe and avoid and circumvent the procedures used by the control bodies. This is well reflected on the difficulty in achieving undercover actions in certain areas.

Following the cooperation with other counterparts, PJ actively contributed to the dismantling of criminal organizations in other countries.

10.3. Seizures

Quantities and number of drug seizures (for more information see ST 13)

In terms of **number of drug seizures** and by the tenth consecutive year hashish⁵⁶ was the main substance involved in seizures (3 093) and reinforcing the trend initiated in 2005, once more the number of cocaine seizures (1 386) was superior to heroin (1 169). Followed by liamba (660) and ecstasy (95) with a much lower number of seizures.



Graph 54 – Number of seizures, by Year and Type of Drug (IDT, I.P. 2012)

In comparison to 2010, there were increases in the number of seizures of liamba (+24%) and ecstasy (+10%), it was verified a decrease in the case of heroin (-20%), cocaine (-13%) and a stability in the number of hashish seizures (+1%). It's worth mention the increase, especially in the last three years, in the number of liamba seizures and the values registered in the last two years of heroin, cocaine and hashish seizures were the highest since 2002.

⁵⁶ Data relative to hashish include resin, and cannabis pollen.

In addition to these seizures, in 2011 were confiscated several other substances but there is no record of any new substance.

Concerning the **quantity of seized drugs** in 2011, there was an increase in comparison to last year at liamba, heroin and cocaine level, on the other hand, a decrease in the seized quantities of ecstasy and hashish. Despite the annual fluctuations it's worth mention the trend showed in the last decade that pointed to the increase in the seized quantities of cocaine, hashish and liamba in the second half of the decade (2006-2010) in comparison to the first half (2001-2005), contrarily to the decrease verified in the case of heroin and ecstasy.

Type of Drug	2003	2004	2005	2006	2007	2008	2009	2010	2011
Grammes									
Heroin	72 365	99 047	182 266	144 295	61 669	68 090	128 073	46 947	72 908
Cocaine	3 016 881	7 422 752	18 083 231	34 477 476	7 362 975	4 877 905	2 697 083	3 244 350	3 678 217
Hashish ^{a)}	31 559 269	28 995 141	28 395 514	8 503 664	44 623 450	61 262 140	22 965 577	34 773 666	14 632 884
Liamba	264 821	118 929	121 394	151 915	133 300	36 634	5 044 569	40 079	107 873
Pills									
Ecstasy ^{b)}	165 539	111 833	213 788	133 290	70 591	70 309	8 987	48 370	7 791

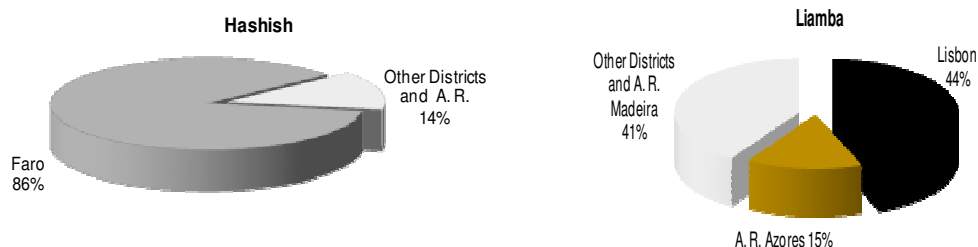
a) Hashish quantities include resin and cannabis pollen

b) Ground and dust Ecstasy seized quantities were converted in pills, according to the Administrative Rule 94/96 of 26 of March

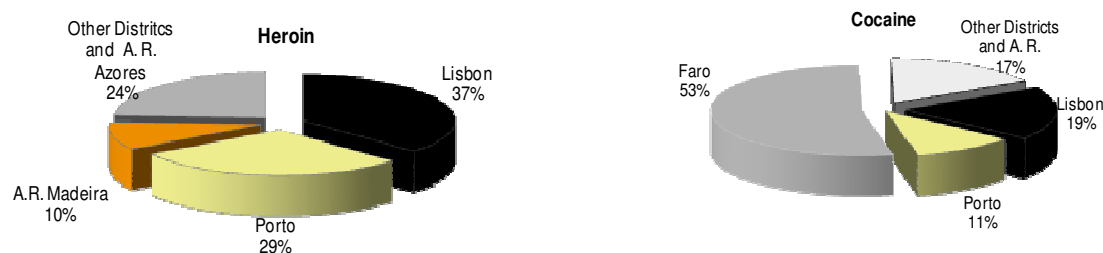
Table 31 – Drug seized, by year and type of drug 2003-2011 (IDT, I.P. 2012)

Seizures involving **significant quantities**⁵⁷ in 2011 represented 2% of the total number of liamba seizures, 4% of hashish, 5% of heroin, 6% of ecstasy and 21% of cocaine seizures. However, in terms of quantities seized, those seizures involving significant amounts represented the majority of ecstasy (55%), the great majority of liamba and heroin (80% and 88% respectively) and almost all hashish and cocaine (up to 99%) seized in the country in 2011.

At regional level, the districts of Lisbon and Porto were the ones with the higher number of seizures at the level of several substances, although the district of Lisbon stood out in the case of heroin and liamba and the district of Faro registered the largest quantities seized of hashish and cocaine.



⁵⁷ For heroin and cocaine, quantities equal or above 100g are considered and in the case of cannabis quantities equal or above 1000g are considered and in the case of ecstasy equal or above 250 pills, according to the criteria used by the UN. The percentages presented here were calculated on the seizures expressed in grammes, or in the case of ecstasy in pills (quantities seized of ground ecstasy or in dust were converted in pills, according to the Administrative Rule 94/96 of 26 March).



Graph 55 – Distribution of quantities seized, by District and Autonomous Region (%) (IDT, I.P. 2012)

10.4. Price/Purity

The average price⁵⁸ of drugs in 2011 didn't registered relevant changes in relation to 2010, with the exception of cocaine that registered an increase.

Type of Drug	Year						
	2005	2006	2007	2008	2009	2010	2011
Grammes							
Heroin	41,01 €	42,17 €	37,57 €	33,25 €	36,62 €	35,32 €	35,74 €
Cocaine	45,11 €	45,73 €	44,65 €	45,56 €	47,44 €	46,00 €	50,07 €
Hashish	2,13 €	2,18 €	3,45 €	3,28 €	2,99 €	3,59 €	3,12 €
Liamba	3,67 €	2,15 €	4,70 €	5,09 €	6,22 €	— ^{a)}	— ^{a)}
Pills							
Ecstasy	3,56 €	3,18 €	3,20 €	2,80 €	— ^{a)}	3,68 €	— ^{a)}

* Prices posterior to 2001 refers only to trafficking and trafficking-use market

a) No sufficient data to proceed with the calculation of average price

Table 32 – Average* price of drugs, by year and type of drug 2004-2010 (IDT, I.P. 2012)

Despite the annual variations, since 2002 there has been a downward trend in the average prices of heroin and ecstasy, and an upward trend of liamba and cocaine, and stability in the average price of hashish (although with slightly higher values in the second half of the decade).

In 2011, concerning **purity**, and according to the data reported in Standard Table 14 - the number of lots submitted to quantitative analysis has increased significantly. The "purity" of THC essentially in hashish samples is higher than in previous years. The purity of heroin samples is inferior to previous years. There has not been a significant fluctuation in relation to the "purity" of other drugs.

Concerning Standard Table 15 – the number of pills seized is not significant compared to previous years. There were no seizures of pills with amphetamines and/or methamphetamines. In the pills analysed in 2011 weren't detected mixtures of type: MDMA+Amphetamine; MDMA+MDA; MDMA+MDEA.

⁵⁸Since 2002 prices refer only to traffic and traffic-use market. This information is obtained through the individuals arrested in the context of this seizures, that mention the price they paid by the product seized.

Part B

Selected Issues

11. Drug Policies of large European cities

1. Large cities: Lisbon

Lisbon, capital of Portugal, is also its biggest city, counting 564 657 inhabitants and a population of 5 527.4, in accordance with 2010 National Statistics Institute (INE). On opposition to the population's concentration in the metropolitan areas of Lisbon and Porto, the municipality of Lisbon has been losing inhabitants in recent years, mainly due to high prices of housing and the inexistence of a rental policy, as well as the development of the new housing areas in neighbor municipalities (Cascais, Montijo e Sesimbra), with higher investment in living standards in the periphery and faster transports. Also, it is worth referring that the level of poverty in the city of Lisbon has increased 80% in the period 1989-2009, mainly due to the emergence of new forms of poverty related to urban areas and unemployment.

2. Case study: The city of Lisbon and its drug policy

The Municipality of Lisbon is composed of two bodies: the City Council with executive competences and the Municipal Assembly, with a deliberative role.

The Lisbon City Council (CML) is divided into 9 departments, overseen by the Mayor and 8 town Councilors, with delegated powers. In the specific case of drug policies, the competence lies on the Office of Housing and Social Development, which is organized into the Department of Social Development, Department of Housing Policy and Department of Municipal Housing Management.

The CML and specifically the Office of Housing and Social Development has undertaken a set of social policies aimed at transforming Lisbon in a city designed for people, open, intercultural and showing solidarity. To this end, the improvement of living conditions of the inhabitants, particularly the most disadvantaged or socially excluded, with a view of prevention/minimization of the poverty and social exclusion, promoting social cohesion and an integrated social development that strengthens citizenship.

The action of the city is oriented towards active policies for social inclusion, fostering coordination with public and social partners and mobilizing volunteers. It lies on the strengthening of social network by implementing measures to support and accompany families under social and economic constraints, under the framework of the Plan for Social Development of the City of Lisbon, which targets homeless people, elderly and children. In this framework, we should refer the city policy actions towards elderly, family and homeless, to promote citizenship, health promotion, promotion of social entrepreneurship, support for social institutions.

Under the responsibility of the Department of Social Development, a multidisciplinary team was created to act mainly on the prevention of risk behaviours field, intervening in the areas of risk and harm reduction, fostering networking and inter-institutional collaboration, covering the entire city with outreach work.

Concerning addictions, the City Council follows a strategy aimed at developing an integrated intervention in Lisbon, in a way to:

- Contribute to the prevention of risk behaviours among children, youngsters and families by supporting projects and programs at local level;
- Reduce risk and minimize harms associated with dependencies in persons without family environment, namely through partnerships with the Central Administration and private institutions of social solidarity, to ensure adequate care and follow up.

In 1990, with the creation of the Municipal Plan of Drug Prevention, drafted in cooperation with IDT, I.P, the City Council considered a priority to involve the parishes due its knowledge of local issues. Although parishes didn't have a very significant membership, rapidly conquered new players interested in developing locally preventive. This effort has allowed for, in the last 22 years, the creation of synergies and the strengthening of strategies to prevent drug addiction, involving local actors, covering most of the City of Lisbon.

The first project, "Contigo Vais Longe" (Going away with me) was developed in several parishes of the city, under the supervision of the Office of Drug Prevention (Gabinete de Prevenção da Toxicodependência - GPT) created in 1992 as the CML coordination body for the prevention of drug addiction.

Given the emergence of new preventive models, the original design of the project "Contigo Vais Longe ", focused primarily on universal prevention and on leisure activities for children and youth, giving rise to the need to allocate to project stronger preventive purposes. In this sense, arises in 2000 the Lisbon Programme "Pensa em Ti" (LISPETI), which includes the above mentioned project "Contigo Vais longe" and a new challenge, the project "Dar as Mãos " as a selective prevention action. Also, to give proper support and continue to target most vulnerable groups, the CML created the position of Local Prevention Agent – staff of the parishes trained and certified by the Drug Addiction Prevention and Treatment Centre (SPTT) of the Ministry of Health.

In parallel with the work done on prevention and due to the urgent need of controlling drug phenomenon and associated consequences in a specific neighborhood, where drug related problems caused an increase public health urgency, the CML created in 1996 the "Gabinete de Reconversão do Casal Ventoso", supervised by the CML and the Central Administration, gave the bases for the Comprehensive Plan for the Prevention of Drug Addiction (PIPT). During the period 1998-2002, IDT,I.P. developed in collaboration with CML and NGO's a set of activities aimed at drug users living in Casal Ventoso, as the creation of shelters, a day center providing food and accommodation and established a network of proximity through street teams an outreach work, activities that occurred in parallel with the destruction of the buildings of the neighborhood and the relocation of the inhabitants by the CML services. Also, the joint efforts of IDT, I.P, CML and law enforcement authorities in the elaboration of alternative strategies for this at risk population, combined with the creation of contact points and distribution of methadone programs, as well as referral to health structures of urgent cases, allowed for the non-dispersion of this population to other areas of the city and to the progressive reinsertion of many drug users.

In 2002, was created the Municipal Plan for the Inclusion of Drug Addicts and Homeless - LX Plan, based on three main axes of intervention: Primary Prevention, Secondary Prevention and Reintegration of the PIPT.

As for Primary Prevention, the Plan LX integrated a wide range of projects that met three dimensions considered strategically essential: the community, the family and the school environment. In this framework and continuing the program LISPETI, emerged the project "INTERVIR" (Municipal Program of Prevention of Risk Behaviors in Lisbon) that aims at promoting, with the support of the parishes, indicated prevention projects targeting children and young people, covering also other social stakeholders, including parents, educational assistants and teachers, as target groups of preventive actions at local level.

In 2003, as a result of the need for a concerted and monitored intervention of the outreach teams, was created the project "Perto Lisboa".

The CML evaluating its activity in the drugs field, concluded for the urgency of creating a Municipal Social Intervention Strategy for the city, that would include proposals for intervention based on the person, the proximity intervention and the counseling, using as reference the strategic lines of the EU and the National Plan Against Drugs and Drug Addiction and the National Action Plan for Social Inclusion. The Municipal social Intervention Strategy was developed in two levels:

The Municipal Plan of Intervention in Addiction, with four priority areas: Prevention, Risk and Harm Reduction; Treatment and Social Rehabilitation;

The Municipal Intervention Plan for Social Inclusion which deals with Contact and Referral, Housing, Reinsertion areas.

In November 2006, the CML decided the implementation of municipal strategies for social intervention in the field of addiction and social inclusion, to be developed through the Municipal Intervention Strategy for Addiction (EMID), which includes the Municipal Intervention Strategy for Social Inclusion (EMIIS).

Since 2010, the main CML intervention in the field of prevention is program “INTERVIR” –, aiming to support at technical and financial level, prevention projects of risk behaviors and the promotion of healthy lifestyles, targeting children, youngsters, parents, teachers, educational assistants and other educators. The parishes participate as partners in this program, which is currently running in 47 of the 53 parishes of Lisbon.

“INTERVIR” general objective is to promote projects which strengthen personal and social skills and implement activities with focusing specially on specific behaviors as: bullying; juvenile delinquency; risk behaviors in sexual and reproductive health; obesity; use of psychoactive substances and violence in relationships. The program is developed following specific objectives: to promote the strengthening of protective factors in target groups; to minimize risks and damage to the target groups; to promote parenting skills, promote personal and social skills in children and youth; to promote program evaluation that allows the adjustment to the level of intervention strategies through knowledge of its impact on the community and promote networking.

Also, this program aims to contribute to promote full development of children and youth by developing personal and social skills in order to enrich them with behaviors and socialization strategies as well as tools to enable them to deal with different situations every day. Fostering autonomy, accountability, active participation, decision making and willingness, are the concepts to be taken into account when talking about risk behaviors with youth and that are the ground for this project.

In 2011, this program covered 19,524 children and youth (target final group) and 10,231 parents/educators, teachers, assistants and other education staff (strategic target group).

The CML participates also as partner at the risk and harm reduction focused project “Perto LX”, which intends to track and monitor the phenomenon of drug addiction, by strengthening partnership of the organizations working in the field. This project is operationalized in meetings each two months, in which future strategies, intervention sites, and results of contacts made and referrals done by residents are discussed. It also enables a more accurate understanding of the development of the addiction phenomenon and spread in the city, as several NGO's with outreach work participate: “Crescer na Maior,” “Comunidade Vida e Paz”; AMI; “Médicos do Mundo” and “Novos Rostos Novos Desafios”.

The Project “Perto LX” has for guidelines: strengthening approaches and integrated responses in the territories of priority intervention, in line with the structures of the social network, optimizing capabilities and resources available; increasing knowledge of the phenomenon of use of psychoactive substances, namely among homeless population in Lisbon. Ensure the continuity of the network of integrated responses in risk and harm reduction, adjusting structures of proximity and easy access to existing territories considered priority.

Through partnership protocols, CML supports financially three institutions that provide answers to homeless drug users population, including AMI Foundation, Social Center of the Salvation Army and “Associação Vitae”.

This partnership is the funding of 3 Temporary Accommodation Centers which provide a social response, using facilities for accommodating for short period adults in distress, with a view to referral to more appropriate social response. Thus it is vital to respond to basic needs

such as housing, personal hygiene, nutrition, treatment and psychosocial counseling. This monitoring is carried out by a multidisciplinary team (social service experts, psychologists, among others), that elaborate an alternative individual project with the objective of the socio-professional reintegration of the homeless person.

The “Centro de Acolhimento do Beato”, managed by the Association Vitae, funded by a Protocol with the CML and the ISS, created in 1999 with the capacity of 271 beds (241 for males and 30 for females), is the only center that accepts homeless people with drug related problems.

In 2010, under the Operational Integrated Response Plan (PORI) developed by IDT, I.P, the CML met regularly different stakeholders and NGO's operating in priority areas, which signed a Commitment to Collaboration and become partners. The operationalization of PORI is done through the implementation of the Integrated Response Program (PRI), developed in each territory considered a priority. The zones correspond to various sites related by common problems signaled by tools identifying risk factors and defining priorities.

In the areas where with ongoing interventions and/or where the resources are not adequately used, PRI allows a reorganization of the available resources in accordance with the needs identified.

For better assessing the needs of each area and provide possible intervention strategies, the territorial unit meets regularly under 2 working groups: group 1 on "legislation in recreational areas" and group 2 on "promotion of youth health", both having established as priority the use and abuse of alcohol in recreational settings. CML participates in group 2, based on the idea of complementarity between the different actors in order to jointly find responses for the increasing phenomenon of alcohol abuse by younger population, namely in the parishes identified as priority areas and coordinating with Project “INTERVIR”.

Another important activity of the CML in the drugs field is the funding of institutions/NGO's dealing with drug addiction, using as tool the Municipal Regulation for the Assignment Support. Currently an NGO working in the field of risk and harm reduction is funded. Two street teams try on establishing close relationships with people who do not access specialized structures, having a role in mediating and facilitating the connection with health and social structures, with the objectives of: risk and harm reduction, promote the rehabilitation of addicts health's, decrease drug use, social and professional reintegration of drug addicts and the decrease of marginality.

On the bases of the legislation that regulates the Social Network (Decree-Law 115/2006), some parishes have decided to create Social Commissions of the Parish, which comprise several local stakeholders meeting regularly in plenary. A first session is held aimed at identifying the problems and the needs, forming working groups to elaborate proposals for methodologies, strategies and actions plans for the problems of the city, namely on drug addiction. The diagnosis will be the ground for outlined strategies to be included in the Budgetary Options, to be implemented later on y the Annual Work Program of the different structures of the CML.

In 2012, following the strategy of renovation of deprived neighborhood of Lisbon set by the “Gabinete de Apoio ao Bairro de Intervenção Prioritária”, CML adopted the “Plano de Desenvolvimento da Mouraria”, which involve 44 partners, as NGO's, welfare institutions and the parishes of Anjos, Socorro, St. Justa e São Cristovão and has a budget of 1 ME for 2012-2013. The objective is to strengthen the social and health conditions of the population of the neighborhood, targeting namely at risk population as sex workers (171), drug users (200) and homeless (23), actions that will go along with a progressive urban rehabilitation of the neighborhood, the creation of social equipments and a reinforcement of the law enforcement presence. During 2012 summer, several cultural activities were organized with the objective of drawing the attention to the renovation of the neighborhood, its multicultural specificity and characteristics.

a. Four areas of drug policy in Lisbon city

Local policing strategies against drug scenes/ drug trafficking

The “Escola Segura” Program

Aimed at improving safety in the neighborhood of schools, where drugs are frequently present, the Ministry of Home Affairs and the Ministry of Education created in 2006, a proximity policing programme with national coverage, *Escola Segura* (Safe School) in which participate the Public Security Police (PSP) and the National Republican Guard (GNR)

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

In the school year 2011/2012, PSP teams allocated to the program 391 police officers ensuring national coverage. In Lisbon, the main crimes reported by the PSP were petty crime, robberies and bullying, accounting for 910 committed inside the schools settings and 481 outside. Also resulting from the activity of the PSP agents 56 guns/illegal weapons were seized and 52 persons arrested for illegal activities, namely due to drug trafficking near the campus.

Apart from the proximity policing and offence dissuasion, these law enforcement agents were also involved in training and awareness raising initiatives in schools. The initiative targeted 120 000 students, 2585 awareness raising sessions were developed and 130 visits to the PSP facilities were organized.

Interventions in recreational nightlife settings

This intervention in recreational settings is considered a priority in Lisbon, as young people initiate nightlife around 12. IDT, I.P has adopted several with NGO's, clubs and disco owners to ensure regular awareness and intervention campaigns, as well as basic prevention and harm reduction measures are implemented in nightlife facilities and music festivals.

Also, on the context of the Integrated Response Program (PRI), several projects were recently funded by IDT, I.P on recreational settings interventions. We will report here 2 that refer to Lisbon.

Project CHECKIN LX, implemented by APDES – “Agência Piaget para o Desenvolvimento”, between January 2010 and January 2012 (currently under evaluation).

This project was an intervention targeting teenagers and young adults in recreational settings associated with the consumption of alcohol and / or other psychoactive substances. It was drafted with the objective to raise awareness of young people on the management of pleasure and risks involved with the nightlife settings. Thus, this project held its intervention with young clubbers and partygoers, users or not of psychoactive substances, carrying out educational work of the street, giving information on the substances, their effects and risks, on how to act in crisis situations with users of psychoactive substances in recreational settings, in a way to change perceptions on the toxicity of substances. Also, reducing early use, preventing recreational use to evolve to abuse/addiction cases, the monitoring and referral of individual situations to health structures are targeted in this project.

There was another project of Harm Reduction in Marvila, developed between January 2010 and January 2012. The project aimed at intervening with 20 young people (between 12 and 18 years) with an history of use of cannabis, alcohol and other psychoactive substances, living in the neighborhoods of Lóios, Flamengo e Amador, of the Marvila parish. Through the

involvement of a peer education program and proximity responses it involved the dissemination of information on substances and risk/healthy behaviours, with the objective to reduce/change the trends of psychoactive substances use, the risky sexual practices and foster the creation of competencies for social and professional integration.

Low threshold services for problem drug users

The interventions in the area of risk and harm reduction, developed in Lisbon are defined by the National Drugs Strategy and the Action Plan against Drugs and Drug Addiction 2009-2012. According to the National Strategy, treatment programs include psychotherapeutic interventions, or socio-therapeutic which constitute an important aid in the recovery process, while harm reduction programs, primarily include health and social intervention. It is therefore essential that treatment programs are made available and that whoever is included in harm reduction programs meet their objectives and be informed of the existence of treatment programs and have easier access. The idea is not to abandon treatment of drug users, but in certain situations, to change the immediate objective of abstinence in order to ensure an intervention that aims to reduce harm that users cause themselves and to others. This intervention should be complementary to strategies for prevention, treatment and reintegration, and conceived to provide a rapid and integrated response to drug users' population in deprived neighborhoods. Therefore the harm reduction responses implemented in Lisbon are various and include street teams, low threshold programs and shelters.

The street teams aim at promoting harm reduction, acting in public places spaces where drug use is perceived as a social problem, namely settings associated with drug trafficking. Through a street work based on the proximity with drug users, street teams provide tools and harm reduction programs, share information on substances and health strategies, trying to interact with users in risk situation, speeding referral to treatment facilities, intervening in first aid situations, replacing needles and syringes and providing clean kits.

For the period 2012-2013, two street teams projects were funded by IDT, I.P. The first one, implemented by NGO Associação Crescer na Maior will run from February 2012 until January 2013 and covers places of the parishes of Charneca, Ameixoeira, Lumiar, Carnide, Benfica, S. Francisco Xavier, Santa Maria de Belém, Ajuda, Alcântara, Prazeres, Santo Condestável, Campolide, S. Domingos de Benfica, Santos o Velho, Lapa, Santa Isabel, Campo grande, N.S. de Fátima, S. Sebastião da Pedreira, S. José, Coração de Jesus, S. Nicolau, Sta. Catarina, S. Mamede, Sacramento, Encarnação, Mercês e S. Paulo. The second team, also run by "Associação Crescer" na Maior will be from April 2012 to April 2013 in some places of the parishes of St. Maria dos Olivais, S. João de Brito, Marvila, Alvalade, S. João de Deus, S. Jorge de Arroios, St. Justa, Pena, Beato, Alto do Pina, S. João, Anjos, Penha de França, Socorro, S. Cristovão e São Lourenço, St. Engrácia, Graça, Madalena, S. Miguel, Santiago, St. Estevão, S. Vicente de Fora, Sé e Castelo.

The low threshold program implemented in the shelter of Xabregas, also a program funded by IDT, is run by "Associação de Solidariedade e Desenvolvimento Internacional – VITAE" will cover the period April 2012 to April 2014. It includes psychosocial monitoring of homeless drug users, providing psychological, social and medical support, in conjunction with the other activities of the Centre. This shelter receiving many of the Lisbon homeless, some with drug related problems, seeks to relate this at risk population to the social services and to ensure the referral to treatment and reinsertion facilities.

The shelter of Alcântara, Rua de Cascais, is a temporary residential facility that aims to provide to drug users, with medical condition, a space and a timeline to prepare their integration in a integrated therapeutic project, contributing to distance of usual settings of consumption and to the referral of socially excluded drug users to social and medical structures. The shelter provides also accommodation, food, basic health care, nursing and occupational activities.

The low threshold program of the city of Lisbon, implemented by the “Associação Aires do Pinhal” from February 2011 to January 2013, seeks to cover all parishes of Lisbon, developing an intervention of proximity with the target population, runs in 2 drop in centers in Quinta do Lavrado and Bairro do Charquinho at Benfica, and in 2 vehicles specially conceived for receiving drug users. The Mobile Units stops at Praça de Espanha, Santa Apolónia, Bela Vista, Av. de Ceuta, Ameixoeira/Lumiar/Charneca.

Responses to head/ smartshops

In Portugal, as the phenomenon of head/smart shops is quite recent there is no specific legislation, but the combination of several legislative and administrative measures are used to counteract their activity. Also, due to the increasing visibility of the phenomenon of new psychoactive substances that appear to the public to be of easy access and low toxicity and recent cases of accidents drug related, IDT, I.P created an Interministerial group evolving representatives of Ministry of Health, Ministry of Justice and the Autoridade de Segurança Alimentar e Económica (Food and Economic Safety Authority – ASAE) to draft a legislative proposal to regulate the activity of smartshops. A first action of this group was to disseminate a press statement recalling the definition of new psychoactive substances as referred in the Council Decision 2005/387/JHA and calling the attention for the need of media to use adequate terminology to counteract the idea referred in several articles of national press that licit substances sold in head/smart shops are not dangerous and can be used on a recreational bases.

At the present moment, the responsibility of controlling head/smart shops lies on the responsibility of the Municipalities in what refers to the licensing of the commercial space and the stocking of food products and on ASAE for the supervision of economic activities. These bodies regularly cooperate on the monitoring and investigation of new shops, carrying regularly control activities.

It is important to note that there is no precise number of the existing shops as the labeling differs and is changed frequently, as herbalists, stores of agricultural and farming products, selling pills, fertilizers, incense and other products, usually labeled as “not for human use”, denomination that do not discourage youngsters. Since December 2011, ASAE conducted 6 major inspection operations in 40 smartshops located all over the country, of which resulted 6 crime process, 57 administrative sanctions and the seizure of 62 000 units of products as incenses, fertilizers and fresheners. Just in the last operation, carried on in November 2012 by ASAE, 26 administrative sanctions, 1 crime process, 1 arrest were decided, as well as the seizure of 9790 units and 165 000 Euros.

Also on the demand side, the phenomenon is increasing visibility as 30 persons were attended in urgencies due to problems related with the use of licit products sold in smartshops, mainly incenses, 11 of them in Lisbon, during the months of November/December 2012.

2.2. Current issues in Lisbon city

Policy concerns

Budgetary constraints at national level and the reorganization of the public health structures, as the extinction of IDT and the dispersion of its competences to National Health System (NHS) may jeopardize in the future the allocation of funding for this policy area.

12. Residential treatment for drug users in Europe

History and policy frameworks

The Therapeutic Communities (TC's) here understood as units that provide care to patients drug addicts and patients with polydrug use requiring prolonged hospitalization with psychotherapeutic and socio-therapeutic support, under psychiatric supervision in order to a better rehabilitation and reintegration of the patient and to prevent relapses, to allow the development of responsible and accountable life projects. TC's are structures with specific programs open to internment and treatment of patients' dependent of psychoactive substances with different programs and models that vary among themselves in philosophy, therapeutic structure, with different concepts in the responsibility and self esteem of patients, valuing different methods and values.

TC's appeared before there was any coordinated and comprehensive public policy of intervention in the phenomenon. Therapeutic communities grew, multiplied and occupied spaces, once didn't exist at that time programs, projects and public legislation that offered alternatives to dependent people who wanted to treat themselves.

The history of residential treatment in Portugal reports to the 70s closely linked to other vectors of intervention such as prevention and reintegration and appeared as an answer to the abuse of substances nationally.

Due to the expansion and complexity of the problem, governments that followed the 25th of April 1974 sought to find answers to this phenomenon and contribute to all citizens have access to adequate responses to the needs expressed and identified.

Thus in 1975 were created in the Presidency of the Council of Ministers: - The Youth Study Center (Centro de Estudos da Juventude), with mandate to "study problems related to drug use, particularly the social medical treatment of the drug addict, anti-drug prevention, as well as, in general, the youth drug use related problems " and – The Judiciary Drug Research Centre (Centro de Investigação Judiciário da Droga), for "the prosecution of the research, fiscalisation, supervision and criminal prosecution activities in this area".

In the sequence of the work done by these Centers was created in 1976 the Coordinating Cabinet for the Fight Against Drugs and structured the Center Study and Prophylaxis of Drugs (CEPD).

CEPD organization assumed a national and regional ambit to facilitate the elaboration of policies and the speed up of responses to the target population, so in 1977, were created three Regional Delegations Porto, Coimbra and Lisbon.

It was in the framework of Regional Delegations that appear the first Therapeutic Community as a residential project intervention for drug addicts. Besides these aspects the hurry to train future experts, the individual and family care were contemplated in the assisting caring policy.

To the spread of drug addiction phenomena occurred in the 80s, the politic answer tried to find integrated responses at treatment level and others that allow dealing with the phenomena and with the sanitary and social problematic related with it. The history and evolution of this initiative since that age till present is reflected in different aspects: on one hand, there was a multiplication of responses regarding intervention on phenomenon (in terms of quantity and diversity of approaches), an effort that convoke public entities as well as social civil society forces and, on the other hand, it was possible to frame it in the scope of public policies coordinated by governmental institutions.

In 1982, CEPD moved to the Ministry of Justice maintaining the national and regional structures.

In 1987, within the Council of Ministries and interministerial dependence, was created "Projecto Vida", an integrated plan to fight drugs, contemplating actions in the fight against traffic and in the vectors of prevention, treatment and reintegration of drug addicts.

For treatment was intended:

- National coverage with adequate services and a articulate and efficient response;
- The creation of a hospital emergency unit for drug addicts encompassing a detoxification service;
- And in outpatient an attending center.

And so arises, in Lisbon, in the framework of the Ministry of Health, the Taipas Center in 1987 (made 25 years in October this year).

In 1990, was created the Drug Addiction Prevention and Treatment Service (SPTT) in the framework of the Ministry of Health and all the existing services were integrated into it.

In the '90s, with many TC, linked to Private Social Solidarity Institutions and Non-Governmental organizations (IPSS/NGO) and complexity of consumption of substances, occurred the developing of residential treatment, with the appearance of the CT, with the service opting by conventions instead of their own units.

Subsequently, the national network of outpatient of the SPTT has been renamed to Specialised Outpatient Drug Abuse Treatment Centres (CAT). Simultaneously, appears "Projecto Vida" service tutored by the Presidency of the Council of Ministers, which becomes par excellence, the dynamic body for interventions of preventive nature and with the publication of Decree-Law n.º 90/2001, 18th May, has established itself as the Portuguese Institute of Drugs and Drug Addiction (IPDT), service endowed with administrative, technical and financial autonomy.

The finding that the existence of two different organisms linked to the same problematic would not be sustainable in terms of rational management of public resources has led to the fusion of both, as stipulated in Law n.º 16-A/2002, 31st May, looking up, to achieve not only the services complementarities and the need for effective coordination of goals to proceed in the framework of the fight against drugs, how to use more efficiently the existing resources.

The fusion process is concluded with the publication of the Decree-Law n.º 269-A/2002, of 29th of November that creates the Institute on Drugs and Drug Addiction (IDT, I.P.) as the organism resulting from the merger of SPTT with IPDT. IDT was a service tutored by the Ministry of Health that only had administrative and technical autonomy, being the body responsible for all the intervention areas in the fight against drugs and drug addiction.

As body dependent of the Ministry of Health with the mission to be the entity of the public administration with specific responsibilities in the reduction of licit and illicit drug use and decrease of addictions, and with the vision to be the national reference entity with international recognition, to intervene in addiction behaviors, established the aegis under which the coordination, articulation and implementation of drug addiction policy would fall.

With regard to treatment, one of the consequences of this design and evolution of public policies related to drug addiction, focused primarily in the articulation of the different therapeutic modalities in a comprehensive and integrated care framework that allows finding specific and appropriate answers to the needs of each user.

In organizational terms, this initiative of articulation of responses involved not only the public treatment structures but also congregate the private institutions operating in this area. The vast majority of these structures were therapeutic communities. The needs determined by that articulation led to become indispensable the definition of forms and procedures to allow the clear passage of patients between treatment structures, offering differentiated and specific therapeutic answers, as also become evident the need to define criteria and

indicators that could ensure the minimum and necessary conditions for the therapeutic intervention.

Finally in 2007 with the publication of the Decree-Law n.º 221/2007, 29th May, appears the IDT, I.P., body that resulted from the merger between the extinct Regional Centers of Alcohol (North, Center and South) and the IDT, basing, based on this option on the understanding that the phenomenon of drugs and drug addiction, attentive to its transversal nature should pay particular care and attention not only to the consumption of narcotic and psychotropic substances, illegal by definition, as well as the consumption of licit substances such as alcohol and medicinal substances.

In the passage of the century, the growing offer of opiates substitution programs was diversified both in number and in exigency in a perspective to reach more clients with different levels of exigency that was translated into a less demand of responses, as the residential treatment.

In that sense, since the beginning of the 90s the public agencies to which was entrusted the responsibility of treating drug addiction seek, by law, imposition to implement a set of norms and criteria's related to the licensing, fiscalisation and functioning of these units. On the other hand were created units with competence for the prosecution of these actions. The evolution of the public administrative device for the area of drug addiction and which culminated in the creation of IDT, I.P. didn't do more than stabilize and reinforce the importance of this area. Within IDT, I.P. was created a Licensing and Fiscalisation Unit inserted in the Treatment and Reintegration Department, which oversees all the activities in this domain.

In 2012, for issues related to the financial crisis that crosses the country was extinguished by fusion IDT, I.P. A new body was created, SICAD (General-Directorate for Intervention on Addictive Behaviours and Dependencies), with attributions in planning and monitoring programs to reduce the consumption of psychoactive substances, in preventing addictive behavior and decrease of dependents, being the operacionalization of interventions concentrated in the framework of the Regional Administration of Health (ARS).

11.1. History of residential treatment

History of residential treatment for drug users (since 1980s if possible): origins, main actors, factors that have influenced development; - changes in use of residential and outpatient treatment over time

TC's appeared historically in response to the inefficiency of Psychiatric Institution to meet the needs of persons with mental health problems (Maxwell Jones model) and severe problems of drug abuse (Day Top model). TC revealed well structured and an efficient instrument for the reform of Mental Health – known by his deinstitutionalization – that WHO in the 50s didn't had doubts to suggest its adoption. However it has been under drug addiction treatment that it has developed its potential and show her efficiency.

It's known that in the area of intervention of drug addiction and alcoholism several organisations have emerged that do not require the action of experts such as Alcoholics Anonymous (AA). The evolution of this type of organizations that choose the US as their privileged area of development, influenced scientific practices in this area.

Europe was confronted later on with drug addiction problema. Of course the idea of TC wasn't strange in the old continent. Maxwell Jones was the founder of a democratic model. But the application of this model of TC was done to other populations, such as war wounded in hospital setting (Kooyman, 2001; Jones, 1969).

The first TC's free of drugs followed, between us, the principles of democratic models. The experience did not prove fruitful and demanded a reformulation. Since the beginning of the 70s, however, the practice used has been approaching certain principles of the American tradition.

In Portugal, the first TC for dependents was created in June 1978 in Coimbra. Over 28 years of functioning the TC Arco-íris suffered some changes, maintaining however the fundamentals inspired by Maxwell Jones, Daytop and Eric Erikson. Lately, this institutional triad saw the need to add the concept of fuzzy identity of Otto Kernberg.

In Portugal institutions such as PATRIARCHE, REMAR, RETO or BETEL are institutions close to the Synanon model approach, although doesn't have as many means or powers as that American organization has come to possess. However also here is seen the cult's founder, a certain institution's closing in on itself and a consequent disdain by the outside.

REMAR (Rehabilitation of marginals) owns farms that serve the first stages of monitoring. The idea of the residents being displaced from the geographical area where they inhabit, is other of the principles followed. Reinsertion is done within the institution: residents can participate in collections or work in the sales. However the dogmatism of its functioning is evident through the cultivation of a religious idea strongly anti-Catholic. Ideally, the reinsertion is done in the militancy of REMAR. The ideal evolution of the organisation would be exponential, since the criteria for success passes by a blind and permanent adhesion to daily values of institutional experience. Internally play an important role the religious ceremonies that occur in a special environment.

These practices are not confrontive as in Synanon or Daytop. However, the public confession of sins (similar to what happened in the first Christian communities) strengthens the feeling of belonging to the group, as well as can have auto-disciplinary effects.

In the early days the TC's were concentrated in the North of Europe. The Southern countries have not had this type of institutions. This is understandable: Portugal and Spain only knew the first waves of heroin addicts with the entry of the eighties (Romani, 1991).

In 1978, Don Mario Picchi in Rome is the empeller of Project Homem that later would internationalize. In Portugal, Project Homem has for example intervention centers in Braga, where it proposes a phased staggered intervention: day center, join TC in a full inpatient regime and finally reintegration programmes in protected apartments. TC it's integrated in a program which constitutes only one of its phases.

A modern TC must be able to coordinate the confrontation groups at the same time that applies other group technics. The technic team must incentivate the hierarchy and the observation of essential rules. The experts however are not above the residents and can be called to the confrontations. On other hand, the hierarchies can be reformulated, leaders replaced or there may be a specific leader for each task. A modern TC must establish a dynamic balance between the confrontation groups and the traditional psychoterapeutic groups must combine the teachings of the hierarchy model with the democratic model (although the hierarchy remains the matrix, from which you can perform these combinations).

These are the nets of an unstable balance that is a renewed challenge to the technical teams working in the area. Psychologists and other experts must be able to coordinate their knowledge and technical capacities with specific knowledge that emerged through long decades of tradition, of the several self-help movements.

Changes in use of residential and outpatient treatment over time

One of the consequences that have been verified in the patients' population and clinic realities was the need to fit one of the central aspects of therapeutic programs, namely the determination of time permanence in TC. The period of 6 to 12 months initially determined for treatment – Therapeutic Community type of illicit psychoactive substance-dependent user, also was passed to admit and consagrate average times of treatment of 3 months for patients with problems related to alcohol use. However, depending on the evolution of the patient, these deadlines initially determined may be extended.

As a result of the evolution of the phenomenon over the last few decades, TC's had to adapt to new realities. The target population – of these units (persons with problems of addiction to psychoactive substances) reflected this evolution, whether in relation to new patterns of abuse/dependence of substances, whether in the biopsychosocial problems associated with drug addiction. These amendments, which originated new subgroups of people with problems related to the abuse/dependence of psychoactive substances, added to the already known subpopulations, which due to the natural phenomenon of progression through the stages of the life cycle, began also to highlight new intervention needs.

As result, the interventions dispositives had to accommodate to new realities by changing and adapting its responses. TC's tried to give answers to the new specificities, adjusting the therapeutic programs to specific populations such as:

- Users and/or polyusers of illicit psychoactive substances /alcohol, medicines and tobacco);
- patients with comorbidity (ies) somatic and/or mental;
- Ageing of drug addiction population;
- Pregnants;
- Parents with small children⁵⁹;
- Couples;
- Teenagers with consumptions;
- Young/Adults with long and very serious judicial pathways and eventually with judicial measures restricting their own freedom.

Each TC should consider the capacity of response that efectively have, to answer to each one of these problems. In the definition of your profile answers must be taken into account, among others, the following.

- The therapeutic program implemented;
- Physical conditions;
- Technical team (number of technicians, time allocation);
- Geographical localisation (accesses and accessibilities);
- Interinstitutional colaborations established.

Of the various changes that the evolution of the phenomenon came to produce in terms of target populations – for treatment in a TC, deserve particular emphasis the issues related to minors. Thus, and in respect of its legislative framework-normative, according to the Joint Order No. 18683/08 admissions for specific programmes dedicated to young people and teenagers, in TC's beds with conventions lack of an appointment in treatment team of the Centre of integrated Responses in the area of residence of the patient. If it has not been possible to date of admission to the TC, this appointment can be provided by the treatment team of the geographical area where is located the TC. Must be justified by the treatment team technicians accompanying the minor the benefit of going to a TC for the family in general and for the minor in particular. Whenever possible, intervention near the family of origin, should take place in order to involve her as an active part in the process of change.

⁵⁹ All children and youth with less than 18 years old that goes to TC, either by its own need or accompanied by family members, since they are not sent by the Court, must be identified by the Commission of protection of Children and youth (CPCJ).

11.1.2. Strategy and policy frameworks for residential treatment

Current policy frameworks for provision of residential treatment

The legal diplomas that specifically regulate this activity, are Decree-Law 16/99, 25th January and Joint Order of the Ministry of Finances and Ministry of Public Administration and Health n.º 18683/2008, apart from others, that can embrace relevant juridical approaches as those regarding foreign residents in Portugal and legislation on minors.

Prior to their opening, all private TC's must obtain a license from IDT, I.P., and are subject to regular inspections. Therefore, these units must comply with the requirements expressed in the Decree – Law Nº 16/99, issued January 25th, 1999, in order to obtain the official approval of their license demand, which can be revoked in case of non compliance with legal requirements, also contains requirements concerning Clinical Direction and staff.

All patients that wishes to undertake treatment in a TC with convention (with financial benefits from the Government) should do it accordingly to the Joint Order n.º 18683/08 that states the mandatory requisites of the established conventions, through the IDT, and the private health units, with or without profit means, with the aim of treating drug addicts and alcoholics.

Foreign citizens, living in Portugal, can access medical internment, when caring the Portuguese National Card of the National Service Health. Without this Card, medical treatment is only accessible when presenting a more than 90 days proof of residence (stated by the local Parish Council) as stated in Decree-Law n. 135/99, 25th April, article 34.

Objectives regarding residential treatment listed in documents

In the Portuguese Strategy and National Action Plans there are no direct references to residential treatments or TCs. They are mentioned in the Treatment Axe and the Guidelines for the Treatment and Rehabilitation in Therapeutic Communities objectives are described.

The approval by the Government of the “National Drug Strategy 1999” was a clear sign of maturity in the political intervention regarding the complex problem of drugs and drug addiction.

The principles, objectives and strategic options that guided the action for those years were accurately defined. This document was a historic turning point in the structuring of a global policy faced with the problem of drugs and drug addiction on different fronts: from prevention to the fight against drugs and money laundering, from treatment to the social reintegration of drug addicts, from harm reduction to training and research.

For that purpose, we gathered together the best of our scientific knowledge, we listened to our most renowned specialists and practitioners in this field, we reread the experiences of the last twenty years, we promoted intense public debate and, finally, we made options, which are intended to be clear and coherent, on a par with the challenges that we face and Portugal's international responsibilities in this domain.

In the first Portuguese Drug Strategy (1999) several references are made to the objectives, role, criteria admission, quality requirements of Therapeutic Communities:

“54 – The strategic importance of the treatment of drug addicts

The guarantee of access to treatment for all drug addicts who seek treatment is an absolute priority of this national drug strategy.

The humanistic principle on which the national strategy is based, the awareness that drug addiction is an illness and respect for the State's responsibility to satisfy all citizens constitutional right to health, justify this fundamental strategic option and the consequent mobilisation of resources to comply with this right.

56 – The diversity of treatment methods and the principle of holding qualified Specialists responsible

Although progress has been noted in recent years, the treatment of drug addicts is difficult and does not permit sectarian orthodoxy or absolute certainties. There is a great diversity of models of intervention, especially in therapeutic communities, but also in other support structures. From physical withdrawal, as outpatients or inpatients, to psychotherapies of various types, whether for individuals or groups, to family therapy, to long-term confinement in therapeutic communities, as well as the use of antagonist medicines (naltrexone) or agonists (methadone and LAAM), many are the possible combinations.

The diversity of treatment methods is rewarding and, therefore, to be maintained, and it is necessary to encourage dialogue between the different models.

It should also be remembered that the establishment of admission criteria based on the ideological or religious positions of drug addicts can make their maturation and individualisation more difficult, when it does not, in certain cases, result in a outrageous exploitation of the particularly vulnerable state in which drug addicts are to be found.

Faced with the inevitable diversity of treatment models, what is important, in general terms, is to ensure that the services provided satisfy minimum requirements of quality, namely by holding the qualified specialists responsible.

This type of requirement has been reinforced in the new legal regulations for the licensing, operation and supervision of the activities of private units acting in the field of drug addiction (Decree-Law 16/99 of 25th January), which should now be controlled by the relevant licensing and supervisory authorities, in order to prevent the provision of services by entities that do not satisfy a series of basic quality requirements.

On the other hand, it also is important to promote the evaluation of the results of the different treatment programs.

58– Guaranteeing access to treatment

The guarantee of access to treatment for all drug addicts who seek treatment implies the development of a global policy, in a variety of areas.

The guarantee of treatment resources also includes, as we can see, an increase in provision through private units, especially for long-term internment in therapeutic communities. Naturally, it will only be possible to talk of true accessibility for drug addicts when this supply is covered by conventions, so as to ensure partial funding of the cost of the services provided by the State.

From this point of view, special significance can be attributed to the new system of support for the treatment and social reintegration of drug addicts, guided by the purpose of promoting conditions for accessibility, the attention that was previously focused on extending the infrastructure now turned towards the equity and response efficiency of the system (Decree-Law, 72/99 or 15th March).

The problem of the persistent waiting lists at some CATs is even more important today, especially in more densely populated regions and where the drug problem is felt more intensely. The elimination of waiting lists at CATs is an imperative for this national drug strategy. For this purpose, a more rational management of available resources must be ensured, more human and material resources must be made available to the SPTT, and obstacles in attracting practitioners to this field must be overcome.

It is also necessary to increase, through conventions, the number of places available in therapeutic communities, especially in the North and, in particular, for minors, pregnant women, mothers with young children and cases of double diagnosis.

It is also important to involve the whole health system – and not just the SPTT – in the treatment of drug addicts.

60 – Caring for high-risk groups

“One of the concerns that should guide improvements to the system of provision of health care to drug addicts is the guarantee of programmes especially designed for specific or high-risk groups.

Particular groups of patients also have extreme difficulty in finding appropriate responses for their cases. For example, there are very few specific treatment programmes for drug addicts with AIDS or for pregnant drug addicts, which only exist in Lisbon, Porto and Coimbra. The problem is even more serious when there is a need to use therapeutic communities. The need for more places in therapeutic communities for minors, pregnant women, mothers with young children and cases of double diagnosis, namely drug addicts with an associated mental pathology, have already been noted.

69 – Treatment of imprisoned drug addicts

“Available indicators on the judicial system and, in particular, on the prison system show the existence of a high number of imprisoned drug addicts, with the additional problems of high rates of contagious diseases, especially hepatitis, AIDS and tuberculosis.

In this respect, significant progress has been made over recent years in the area of health care provision in prison establishments, through both the installation, or rather improvement, in infrastructures and equipment, and recruitment of health staff.

It was also in response to this concern that the Ministry for Justice extended and diversified drug addiction treatment structures and programmes in prison establishments.

“G Wing” (a therapeutic community) at the Lisbon Prison, created in 1992, was doubled in size, as was the *Casa de Saúde das Caldas da Rainha* (Health House of Caldas da Rainha).

It is considered a priority to use prison terms to promote treatment, with the possibility of access to any therapeutic form that is considered appropriate. It is therefore important to guarantee the continuity and extension of prison programmes, namely withdrawal with psychopharmacological support, treatment with antagonists, substitution therapeutics and socio-therapeutic programmes.

But it is also important to implement mechanisms to enable inmates to have recourse to forms of treatment that do affect the prison regime, namely commitment to therapeutic communities and admission to residential reintegration units”.

In the Action Plan Horizon 2004, several references are made to the objectives or role of Therapeutic Communities

TREATMENT

Bearing in mind the strategic aim of ensuring access to treatment for all drug addicts seeking it, the National Plan for Combating Drugs – Horizon 2004 proposes that existing schemes be stepped up and innovative responses piloted in order to achieve the general objectives detailed below.

Overall aims and guidelines

1. By the end of 2002, complete the national CAT network, increase the number of drug addicts receiving treatment by 50% and substantially increase the number of drug addicts being treated successfully;
2. By 2002, increase the capacity of detoxification services by 50%, making this sufficient to meet demand;
3. Increase by 100% the public capacity for low threshold substitution treatment;
4. Increase by close to 100% the number of health centres working with the SPTT in providing substitution treatment and increase by 300% the number of health centres and hospital services joining addict screening and treatment schemes.

Areas of intervention and action:

a) create, by the end of 2002, intervention programmes for treatment (outpatient support and in-patient units), which should be providing operational services by the end of 2004, aimed at specific groups or populations with risk behaviour,

namely:

- under-age consumers or addicts;
- pregnant addicts or mothers with small children;
- addicts with related mental pathologies (double diagnosis cases);
- addicts with related organic pathologies (AIDS, hepatitis, tuberculosis), in order to extend screening and medical supervision;
- non-addicted user workers or addicts taking part in the Aid Programme for Employees at Work (specialist unit for intervention at work) run by the Ministry of Defence;

b) design therapy circuits which increase the involvement of the whole Health System in the treatment of drug addicts, through greater coordination between the relevant public and private services in this area, namely the Directorate-General of Health, the Mental Health Services, the Alcohol Abuse Centres and private health care organizations providing care on a contract basis;

c) promote access for drug addicts to new forms of treatment;

d) develop, adapt and implement therapeutic strategies to respond to the consumption of new drugs and new patterns of consumption;

e) extend psycho-therapeutic support programmes to the children of drug addicts;

f) extend intervention strategies for drug addicts not seeking the available treatment services;

g) develop and gauge methods of assessing the results achieved by different treatment programmes;

h) involve the whole Prison Health Service in the treatment of addicted inmates. By the end of 2002 the pluri-disciplinary health worker teams at all prisons should be structured or increased;

i) build and equip new drug-free units at prisons, by the end of 2004;

j) continue with treatment programmes when entering and leaving the prison system, extending and improving cooperation with the organizations providing services in this field.

k) use all the possibilities allowed by law and any new procedures, which may be created in order to guide addicts convicted of drug-related offences towards treatment.

l) Step up supervision of the private units, operating on a contract or other basis, providing services to drug addicts undergoing detoxification or treatment.

ACTION PLAN AGAINST DRUGS AND DRUG ADDICTIONS HORIZON 2008

The Action Plan Against Drugs and Drug Addictions - Horizon 2008 is structured according to Cross - Cutting Areas (Coordination, International Cooperation, Information, Research, Training and Evaluation, Legal Framework Review) and Mission Areas. Demand Reduction (Prevention, Dissuasion, Risk and Harm Reduction, Treatment and Reintegration) and Supply Reduction.

It has been designed not as a static list of objectives, but as a dynamic and adjustable policy instrument. Under each axis and each vector the results to be achieved are identified, the objectives and actions are time-scheduled, and the parties responsible for implementation, as well as their main partners, are indicated. Assessment tools and indicators for each action are also proposed, with a view to the structural qualification, constant improvement and regular evaluation of the different programmes and interventions.

It is also envisaged to strengthen the active involvement of civil society, namely private and social care institutions, viewed as fundamental to complement the public treatment network and to ensure responses in the areas of prevention, risk and harm reduction and reintegration.

Objective 63. “Improve the provision of treatment programmes to the drug-using population based on ethical criteria and scientific evidence.

Action 63.1. “Define guidelines for outpatient and inpatient (residential and short-stay) treatment programmes, as well as pharmacological (with opiate agonists, opiate antagonists and psychopharmacs), psychotherapeutic, social and public health/risk and harm reduction (vaccination, referral) treatment programmes

Objective 68. Ensure the adequate training of professionals in the treatment area, both internally (IDT) and externally.

Action 68.1. Training action addressed to professionals according to a biunivocal cascade model, including prison staff”.

ACTION PLAN AGAINST DRUGS AND DRUG ADDICTIONS 2009-2012

Objective 51. Promote measures to facilitate access to the different treatment programs, managing waiting times according to ethical and scientific criteria, local realities and international recommendations.

Action 51.1. Monitoring waiting times for first appointments and admissions to treatment programs.

Action 51.2. Definition of models for admission/transfer of users to services or programs (street teams, Therapeutic Communities, Day Centers, Detoxification Units, Alcohol Units and Therapeutic Program with Opiates Agonists).

Action 51.3. Definition of admission criteria for the different programs.

2. Availability and characteristics

Historically, in Portugal, TC's were always in the frontline in what concerns responding to drug abuse. Since the mid – 70's, when a first public response to emerging drug problems was implemented, two TC's were created (in Lisbon and Coimbra), as a part of a set of treatment modalities to drug abusers. The next decade saw the appearance of private TC's, mainly inspired by the “Le Patriarche” movement, who stood aside of the public treatment services. Later, with the development and integration of public responses to drug related problems in one single structure – IDT, IP, a new framework for TC's licensing and operation was devised, in which preservation and enhancement of ethical, legal, and scientific - based criteria were the main concern. Since then, a wide network of professional units covered the countries' needs in what concerns residential treatment.

2.1 National (overall) availability

In 2011, there were 68 therapeutic communities (3 public and 65 private units) operating in mainland Portugal.

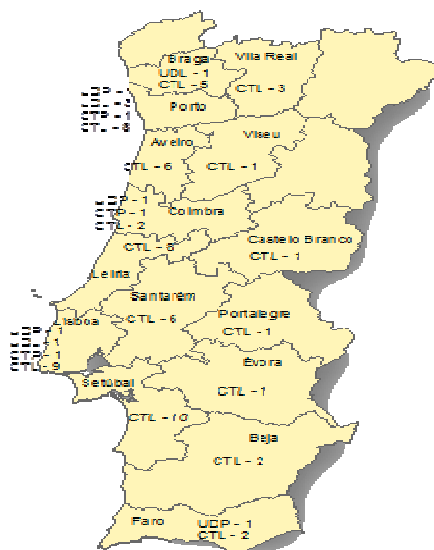


Figure 7 – Distribution of Therapeutic Communities within the Country (IDT, I.P. 2012)

Therapeutic Communities (TCs) are specialised units that provide care to drug users who require prolonged hospitalization and psychotherapeutic and socio-therapeutic support with the purpose to promote their rehabilitation and treatment.

A residential internment usually has duration of 3 to 12 months, usually without need for medication. IDT, I.P. has three units of this type: Porto, Coimbra, Lisbon, 65 private Therapeutic Communities are accredited by IDT, I.P.

Prior to their opening, all private units underwent a licensing process and are subject to regular inspections. 61 of these 65 private units also established a convention with IDT, I.P., by which some or all of their places can be occupied by patients coming from the public network of outpatient treatment services managed by IDT, I.P. This means that IDT, I.P. pays or supports a number of beds.

Of these 68 TC's, 3 are public, with a total of 55 beds, 134 patients were treated in 2011 in these units, a total of 15 929 days of hospitalization, which corresponds to an occupancy rate of 79,3%, -7% decrease in comparison to last year.

	N.º of clients					N.º of days of hospitalization					Occupancy rate (%)				
	2008	2009	2010	2011	TX.CR %	2008	2009	2010	2011	TX.CR %	2008	2009	2010	2011	TX.CR %
North	56	54	55	56	+1,8	6.683	6.818	6.975	6.326	-9,3	83,0	84,9	86,9	78,8	-9,3
Center	25	29	30	28	-6,7	3.775	3.981	4.217	4.272	+1,3	86,0	90,9	96,3	97,5	+1,2
Lisbon	50	44	39	50	+28,2	6.569	5.606	5.935	5.331	-10,2	85,5	73,1	77,4	69,5	-10,2
Total	131	127	124	134	+8,1	17.027	16.405	17.127	15.929	-7,0	84,6	81,7	85,3	79,3	-7,0

Table 33 – Public Therapeutic Communities (IDT, I.P. 2012)

The other 65 TC's are private, with a total of 2 112 places – in 2011, a total amount of 3 996 patients were treated in these services representing a decrease in relation to last year of 379 clients.

From the 65 private therapeutic communities, 61 have conventions with the IDT, I.P. in 2011 supported 1 530 beds, more 14 than last year in the same date.

	N.º of Units	N.º of Beds 31 December	N.º of Clients	N.º de días de Internamento	Occupancy Rate (%)
Licenciadas	65	2.112	3.996	-	-
Convencionadas	61	1.530	3.008	421.368	78,8%

Table 34 – Private accredited and convention Therapeutic Communities (IDT, I.P. 2012)

Concerning patients admitted to beds with convention, was registered a variation rate of 14.1% in comparison to last year; equally this variation was negative regarding the number of internment days, -6% than in 2010.

N.º of Convencionadas beds				N.º of clients					N.º de días de Internamento				
2008	2009	2010	2011	2008	2009	2010	2011	TX.CR	2008	2009	2010	2011	TX.CR
1.516	1.516	1.516	1.530	3.254	3.474	3.502	3.008	-14,1%	416.191	453.102	448.864	421.368	-6,1%

Table 35 – Private TC's and with Convention (IDT, I.P. 2012)

In 2011, the total number of places under convention with IDT, I.P. was 1 530. Under the terms of this convention, IDT, I.P. will pay for an important part of treatment of each individual patient (80% of the total cost), during the actual period of his/her stay in TC. Thus, no direct or automatic public funding is awarded to private TC's, on any other basis than "receiving for treatment services actually rendered".

Among the 65 private licensed TC's, 53 provide specific programs, in order to meet patient's special needs. Places available within the scope of specific programs add up to 400, being their distribution as follows:

- 29 TC's provide specific programs for patients with psychiatric co-morbidity, with a total capacity of 219 places;
- 17 TC's provide specific programs for adolescents, with a total capacity of 148 places;
- 7 TC's provide specific programs for adolescents, with a total capacity of 33 places.

In what concerns public TC's in 2011, of the total number of 134 patients treated, 37 had psychiatric co-morbidity. No records of pregnant women or adolescents admittances were obtained.

To be admitted in a TC, the patient prior therapist has to evaluate his knowledge and motivation to undertake this type of intervention as well as its individual adequacy to this therapeutical tool.

All patients that wish to undertake medical treatment in a TC with convention must do it according to the Joint Order n.º 18683/08. Admission criteria are several: voluntary internment; signing up of the Informed Consent Form (patient and family, if possible); Clinical history, Analysis and other recent medical exams; In case of disease or cronical infeccion, a specific medical report must be sent together.

The Expulsion criteria: (mandatory) are the following: risk behaviours for the patient and/or others; possession and/or use of abuse substances; serious failure on accepting TC rules of procedure.

2.2. Types and characteristics of residential treatment units

The health care system of IDT, I.P. is composed of various types of specialized units, in relation to residential treatment, have been created, streamlined or celebrated to the rhythm of the needs expressed by the target population and the budgetary possibilities, as well as the design of policies intervention that enable more integrated responses, citizen-centered and advocating a easy accessibility.

Thus we have:

- public units, those units within the network of the service.

Private units are all the units providing health care in the drug addiction area, which were assigned by IDT, I.P. operating licences allowing them to accept drug addicts in treatment, under Decree-Law n^o 16/99 of January 25th and Decree - Law 13/93 of 15th January.

Private units with conventions are those ones where the service reserves some beds in order to increase the number of beds available for the treatment of drug addicts who have clinically indicated to do so.

Each region has a number of conventioned beds which can be occupied through a internment proposal elaborated by the therapist of the patient with the collaboration of other intervenients and with favour order of the responsible regional clinical.

TC is an integrated resource and a specialised unit that provides care to drug addicts needing prolonged internment with psychotherapeutic and sociotherapeutic support with the aim to promote treatment and (re) socialization. A residential treatment usually has the duration of 3 to 12 months.

Aiming to create a space for reflection: promoting the change negative behavioral patterns; promote autonomy and responsibility; develop relational ability; (re) discover social competences and forseen social inclusion.

The most important approach element of the TC is the Community. The community is both the context and the method in the change process. It is the element of community that distinguishes TC from all other approaches to treatment and rehabilitation of substance abuse and related disorders, is the use of the community as a method that differs from other TC community modalities.

Each TC should choose the target population that want to reach taking into account among other questions the following:

- The therapeutic program implemented;
- Physical conditions;
- Thechnical team (number of technicians, time allocation);
- Geographical localisation (accesses and acessibilities);
- Interinstitutional colaborations established.

In the therapeutic program of the TC there are elements which structure the diary organization, daily work agenda, therapeutic groups, stahes, and recreational time while others as treatment goals, program structure flexibility, the intensity of interactions are adaptable. Works based on scientific evidence favoring the strength of TC as a method.

Thus, IDT, I.P. has at national level three public CT's, in a total of 55 beds.

The importance of its existence is being reference units with a key role in training technicians intervening in the area and because they provide different responses to the drug addict population.

TC Ponte da Pedra – Leça do Balio, Porto is the first certified TC according the norm ISSO 9001:2008 and the the intervention is based in a bio-psycho perspective – social understanding of drug addiction, has the duration of 9 to 12 months divided into different phases.

TC Arco-íris: the therapeutic program is based in planning individual treatment dimensions in medical/psychiatric, psychotherapeutic, sociotherapeutic, social, family and relapse prevention has duration of 6 to 12 months, divided into different phases.

TC do Restelo: the therapeutic program is based in a comunitary model hierarchical organized and offers a systemic treatment modality, whose general assumptions fit the perspective of De Leon, and are based on fundamental aspects that intertwine and guide the therapeutic process: drug addiction, the person, the healthy lifestyle and recovery, has a minimum duration of 12 months and is divided into 5 phases.

As a result of its history as specific modalities of intervention in drug addiction, exists several “models” or programs exists (hierarchical, democratic, religious inspiration – Catholic, Protestan or other, Minnesota, 12 steps, Portage and others), accepted as valid methods for treatment.

In what concerns models of intervention, only in the 90's, within the framework provided by public policies and institutions encompassing all the intervention on drug addiction, integrating private and state institutions, that professional TC's and scientific – based methods of treatment could flourish, and “take the ground”. Binded to the respect of minimal standards and quality criteria depicted in the law, the spread of professional TC's occurring in the last two decades entailed a diversification of scientific – controlled intervention models and conceptual frameworks. Thus, from the initial two public TC's until nowadays, new forms of intervention on residential treatment were implemented – an overall assessment of the scope of the conceptual and treatment frameworks put to practice by TC's in 2011 shows:

- Minnesota / 12 steps: 9
- Bio-psycho -social : 9
- “Projeto Homem” (Daytop Village inspired) : 7
- Hierarchic : 5
- Mix Model (Minnesota+Democratic) : 4
- Systemic : 2
- *Portage Programme for drugs* : 2
- Cognitive-behavioural: 2
- Intensive Psychotherapy: 2
- Client centered; Democratic ; Bonding Therapy : 1

Along with their increase in number, in the last two decades TC's had to adapt to new problems arisen by the ever-changing phenomenon of drug abuse and addiction, and its health and social consequences. This effort of constant adaptation led to a diversification of treatment and rehabilitation interventions provided by TC's, concerning these three areas: an enlargement of the scope of services provided to patients, admittance of OST – medicated patients, and a stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas. The following examples are clear in illustrating the results of these efforts:

- An overview of integration of services typically provided by Portuguese TC's include:
- For the most part of TC's: OST; case management; HIV/AIDS, HCV, and STI screening, testing/diagnosis, treatment, and monitoring; group therapy; institutional therapy; recreational therapy; educational; employment; peer-group support;
- For some TC's (in accumulation with mentioned above): Detoxification; housing; motivational and /or relapse prevention therapy; individual therapy; vocational training; life

skills; training; aftercare; professional training.

2.2.3. Integration of OST in residential treatment

From the enlargement of the scope of services provided to patients, , admitting OST patients was probably one of the most clear example of the effort put forth by TC's to adapt to new reality and needs of people suffering from addiction to opiates (TC's were classically seen as a non – medicalized form of treatment). Nevertheless, since the final of the 90's, progressively more TC's admitted patients under OST, with discontinuation during residential treatment being seldom envisaged as an initial objective for these patients, and later evolving to a more flexible approach to the complementarity of treatments required for dealing with such a complex problem as drug addiction. Actually, in Portugal, programme characteristics in what concerns patients under OST shows that from the 65 licensed TC's, 59 admit patients under OST; in most cases, patients are already on OST prior to admittance. Methadone and High Doses Buprenorphine can be used.

Programme characteristics:

From the 65 licensed TC's, 59 admit patients under OST; in most cases, patients are already on OST prior to admittance. Methadone and High Doses Buprenorphine can be used. OST discontinuation during residential treatment is seldom envisaged as an initial objective for these patients.

Portugal has two Guidelines in this area – “Normas Orientadoras dos Programas Terapêuticos com Agonistas Opiáceos em Portugal” and “Manual de orientações técnicas para a implementação de programas de substituição opiácea de baixo limiar de exigência”. The first, aims to establish itself as a support to harmonise procedures, methodologies and terminologies, but also a clarifying and oriented instrument for the intervention itself in Therapeutic Programs with Opiate Agonists, under treatment and risk and harm reduction and consequently, to promote greater consistency of intervention.

2.2.4 Typical levels of collaboration and networking

- **Systemic links of residential treatment to other units and services: descriptively, to what extent each level of networking is being used (please use the categories provided in the Appendix 1);**
- **If available, please give examples of established collaborations with external partners and organisations, indicating the particular area of collaboration (e.g. referral process; management of co-morbidity; programme exit, aftercare, management of drop out);**

A stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas was another consequence of the evolution of TC's in Portugal. The evolution of TC's in Portugal brought about a multidisciplinary approach to the problem, that fitted its complexity. As seen above, this movement entailed a diversification in the response on what concerned treatment modalities; subsequently, a parallel evolution was also observed in the field of networking. Thus, from its early stages where TC's were designed as closed environments without perspectives of real recovery from drug addiction, the evolution towards more scientific and humanistic approaches led to the recognition of the importance of establishing links to and from the community. Networking became one of the major building blocks for the intervention of TC's, which grants them the statute of treatment units.

An overall assessment of the typical levels of networking by TC's in Portugal can be put forth:

- Level 1: Employment Centers, Judicial matters;

- Level 2: Physical co morbidity, and general health issues;
- Level 3: Aftercare, halfway houses, transferral, social matters (family, children, protected employment), psychiatric co morbidity, severe/urgent physical co morbidity, OST, drop out management;
- Level 4: Treatment admittance, treatment discharge and continuation of treatment in outpatient services.

This is merely an example: levels of networking can differ from one TC to another; and also, accordingly with his / her evolution in treatment, patients can be proposed to play a greater role in managing relevant networking for his / her specific situation (more Level 1 networking).

3 Quality management

As previously mentioned, the integration and coordination of policies and interventions regarding drugs and drug related problems in one single public structure – first SPTT (created in 1990) which dealt mainly with treatment issues, evolving subsequently to IDT, (2002), which detained a broader scope of competencies in this field, opened ways to attend to important dimensions in what concerns TC treatment. Thus, the compliance with minimal criteria for licensing and functioning by these unites (covering all the main areas, from building features, accessibility, staff, clinical records, assessment and reporting, and so on...) could be determined and universally imposed by law (Decree – Law N° 16/99, issued January 25th, 1999). Furthermore, improvement of quality of care in both public and private units can be easily managed. The framework for TC's approval, functioning and accountability to IDT, IP thus created opened a way for a better and more fluid collaboration between the national authority on drugs and drug abuse, and private TC's. As a result, conventions between IDT, I.P. and private units could be established, by which patients coming from the public outpatient treatment services can be referred to these private units, with a substantial part of the costs of their treatment to be assumed by IDT, .IP. (80%).

Several therapeutic communities implemented a Quality Management System ISO 9001.2000, which is an international reference for the Certification of Quality Management Systems.

Certification according to ISO 9001 recognizes the effort of the organization to ensure compliance of its products/services, customer satisfaction and continuous improvement.

The use of this system corresponds to the following objectives:

- Develop your activity in accordance with the satisfaction of clients;
- Strengthen the effectiveness and efficiency of the process;
- Build trust based on a standardized and transparent management;
- Increase social legitimacy and promote continuous improvement of its services aimed at expanding its social intervention.

This Quality System Certificate allows for clear benefits for clients-users, the organization and the community:

- Systematic evaluation of the dynamics of global activity at the TC, stimulating continuous improvement trough an increase of transfer of know-how and motivation,
- Increased satisfaction of users.
- Increased social legitimacy, strengthening integration in local networks and welfare and the community, ultimately benefiting the families, the networks and the society.

In 2011, the public TC's having quality certification was: Ponte da Pedra 2009 and the private TC's having quality certification were Dianova and "Entre Pontes". It was the first private TC to obtain the certification ISO 9000:2008. Issued on 2010-09-30, validity date 2013-09-29.

3.1 Availability of guidelines and service standards for residential treatment

National and/or local guidelines

In Portugal national guidelines for treatment and rehabilitation in Therapeutic Communities are available – (Linhas Orientadoras para o Tratamento e Reabilitação em Comunidades Terapêuticas"2011). These guidelines has as objective to systematize and clarify the procedures and criteria that support the relationship between public institutions that regulate the activity in the field of drug treatment and the private TC's.

The guidelines are a working tool for all partners involved in this relationship, based on one hand a summary of the provisions scattered trough the different legal instruments that govern this activity and on the other hand, the results of the initiatives undertaken by IDT, I.P. concerning quality on these type of units. A practical reference guide was elaborated, that intends to be a support for experts and professionals working in this field and for those who intend to intervene in it.

Service standards: staffing levels, minimum requirements for staff qualification

It is the task of the State to ensure the guarantee of a minimum level of quality of health services provided, not only in what refers to requirements of infrastructure and operating standards, but specially on human resources, in order to ensure the necessary technical monitoring and necessary medical accountability on the supervision of the treatment provided.

The objective is not, and it wouldn't be possible, to guarantee from the start the success of treatment or even to restrict the diversity of treatment methods available in the market. But rather to set basic quality requirements, that private units must have in order to provide this type of services. The regulation of these mechanisms, respecting the singularity of the centres, follows closely the standard rule for licensing and supervising private health units, without prejudice to the specific reality that addiction requires.

Prior to their opening, all private TC's must obtain a license from IDT, I.P., and are subject to regular inspections. Therefore, these units must comply with the requirements expressed in the Decree – Law Nº 16/99, (issued January 25th, 1999), in order to obtain the official approval of their license demand, which can be revoked in case of non compliance with legal requirements. These legal requirements cover all the relevant areas:

- Definition of a TC unit;
- Physical requirements
- Facilities
- Construction characteristics
- Technical installations and equipment
- Clinical Direction
- Staff
- Rules and treatment programme
- Clinical records
- Insurance
- Price
- Complaints book.

The Decree – Law 16/99 also contains requirements concerning Clinical Direction and staff:

- Clinical Director should be a college graduate with adequate training in the area of addiction
- Supervision by psychiatrist is mandatory;
- Patient physical health follow up, treatment initiation/continuation and referral are to be guaranteed by a medical doctor;
- Staff with an adequate training in the field of addictions, and in what TC treatment is concerned, properly deployed in a work schedule that guarantees a permanent attention to patients.

Also, a detailed list of facility requirements is depicted in the Decree – Law 16/99, concerning:

- Construction;
- Accessibility;
- Building features: areas for rooms, common areas, service areas;
- Circulation of persons and goods;
- Electrical systems;
- Residues disposal;
- Food and nourishment;
- Laundry equipments;
- Refrigeration equipment;
- Water supply, and waste water disposal;
- Security systems: fire and intrusion.

For specific programmes:

As previously stated, the evolution of the phenomenon determined the need to create specific intervention programs, in order to fit subsets of users with problems that require adapted interventions - minors/teenagers, pregnant women, drug addicts with severe mental illness concomitant. In this sense, the licensing of TC's that in its therapeutic program explicitly address the inclusion of users carrying these specific characteristics, will be dependent on the mandatory following requisits:

a) Treatment of pregnant in TC's:

- Assure the conditions in the pregnant room taking into account the space occupied by the crib or bed and coordination with the kindergarden
 - Existence of therapeutic programme specifically developed for pregnant
 - Ensure follow-up of pregnant in obstetrics/gynecology as well as the need for pediatric monitoring of the newborn
- Communicate to CPCJ and Social Security child's birth, for evaluation and monitoring, namely in the search of nurseries, kindergarden and respective payment.

b) Treatment in TC of minors/teenagers

- Existence of treatment program specifically developed to minors/teenagers
- Provide differentiated pedagogical support, for mandatory school
- Promote carefully monitoring of the legal aspects related to minors/teenagers

c) Treatment in TC's for double diagnosis (Concomitant mental health)

- Therapeutic program specifically developed for drug addicts and alcoholics carriers of serious concomitant mental disease;
- Assure the monitoring whenever necessary of the medicine therapeutic administration;
- Assure that the number of drug addicts and alcoholics carriers of serious concomitant mental disease do not exceed 10 patients simultaneously;
- Include in the technical team a psychiatrist with weekly presence, a general practitioner with bi-weekly effective presence (both easy to contact in the remaining time); a

psychologist with daily presence and on-call on weekends and a qualified social educator/education social/monitor daily.

To guarantee the fulfillment of the norms fixed, it is organised a System of inspections and supervision in charge of IDT, I.P.

In 2011 there were 40 inspective actions and/or fiscalisation to private entities with intervention in the field of drug addiction. The actions were distributed, ones for licensing and others for the follow-up, which sought to contribute to the reduction of inadequacies, verifying almost complete correction of non-conformities detected.

These actions focused in parameters such as:

- quality of the care provided to drug addicts and the health gains;
- the technical conditions of the premises where the care is taking place
- the technical teams of the Institutions.

For each patient admitted, TC's under convention are liable to send to IDT, I.P.

- An Admittance questionnaire;
- A Discharge questionnaire;
- A Follow up questionnaire, after discharge;
- A Three – year follow up questionnaire, after discharge.

Some TC's also report their yearly activities to IDT, I.P.

Links between funding and reporting

In Portugal, TC's under convention with IDT, I.P. receive their funding on a “treatment service rendered” basis, i. e., per patient in treatment. Thus, they must report monthly the number of patients that were effectively treated during the previous month.

Through the Joint Order n. º 18683/2008, 14th of July 2008, the Ministries of Finances and Health fixed the values:

- TC – 900€ month/patient
- TC with specific program and expressly dedicated to minors/pregnants or drug addicts with serious concomitante mental disease – 1000€/month/patient.

4. Discussion and Outlook

The next decade saw the appearance of private TC's, mainly inspired by the “Le Patriarche” movement, who stood aside of the public treatment services. Later, with the development and integration of public responses to drug related problems in one single structure – IDT, IP, a new framework for TC's licensing and operation was devised, in which preservation and enhancement of ethical, legal, and scientific - based criteria were the main concern. Since then, a wide network of professional units covered the country' needs in what concerns residential treatment.

As a result of its history as specific modalities of intervention in drug addiction, exists several “models” or programs exists (hierarchical, democratic, religious inspiration – Catholic, Protestan or other, Minnesota, 12 steps, Portage and others), accepted as valid methods for treatment.

In what concerns models of intervention, only in the 90's, within the framework provided by public policies and institutions encompassing all the intervention on drug addiction, integrating private and state institutions, that professional TC's and scientific – based methods of treatment could flourish, and “take the ground”. Binded to the respect of minimal standards and quality criteria depicted in the law, the spread of professional TC's occurring in the last two decades entailed a diversification of scientific – controlled intervention models and conceptual frameworks. Thus, from the initial two public TC's until nowadays, new forms of intervention on residential treatment were implemented – an overall assessment of the scope of the conceptual and treatment frameworks put to practice by TC's in 2011 shows:

- Minnesota / 12 steps: 9
- Bio-psycho -social : 9
- “Projeto Homem” (Daytop Village inspired) : 7
- Hierarchic : 5
- Mix Model (Minnesota+Democratic) : 4
- Systemic : 2
- *Portage Programme for drugs* : 2
- Cognitive-behavioural: 2
- Intensive Psychotherapy: 2
- Client centered; Democratic ; Bonding Therapy : 1

A stronger effort put on building a network with other institutions working in the field of drug addiction, and/or related areas was another consequence of the evolution of TC's in Portugal. The evolution of TC's in Portugal brought a multidisciplinary approach to the problem, that fitted its complexity. As seen above, this movement entailed a diversification in the response on what concerns treatment modalities; subsequently, a parallel evolution was also observed in the field of networking. Thus, from its early stages where TC's were designed as closed environments without perspectives of real recovery from drug addiction, the evolution towards more scientific and humanistic approaches led to the recognition of the importance of establishing links to and from the community. Networking became one of the major building blocks for the intervention of TC's, which grants them the statute of treatment units.

In 2011, there were 68 therapeutic communities (3 public and 65 private units) in mainland Portugal. The number of clients in therapeutic communities increase 13% in comparison to last year (3 601 in 2009, 3 385 in 2008 and 3 167 in 2007), consolidating the grown of last years.

Concerning average waiting time for entry into treatment programs the public therapeutic communities present 9 days of waiting, all TC's presented values below the 22 days referred as acceptable

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Therapeutic Communities	67	75	79	75	73	72	73	76	70	70	69	68
Public Netw ork	2	2	2	2	2	2	3	3	3	3	3	3
Accredited Netw ork	65	73	77	73	71	70	70	73	67 ^{a)}	67	66	65
With Convention	54	63	64	63	61	62	64	60	62	62	62	62
Without Convention	11	10	13	10	10	8	6	13	5	5	4	3
Patients in Therapeutic Communities	4032	4527	4189	4138	4254	4161	4228	4557	4698	4578	4499	4130
Public Netw ork	67	72	66	57	75	68	110	134	131	127	124	134
Accredited Netw ork	3 965	4 455	4 123	4 081	4 179	4 093	4 118	4 423	4 567	4 451	4 375	3 996 ^{b)}
With Convention	2 519	2 825	2 877	2 891	2 900	2 944	3 036	3 033	3 254	3 474	3 502	3 008
Without Convention	1 446	1 630	1 246	1 190	1 279	1 149	1 082	1 390	1 313	977	873	988

Table 36 – Number of Therapeutic Communities and Patients from 2000 to 2011 (IDT, I.P. 2012)

a) The change in the number of structures in relation to last year is due to adjustments made in some Private Units, not reflecting a real reduction in supply in this context since was an increase in the number of beds available

b) Information received at IDT, P.P. until 31/12/2012, data will suffer update next year, with the inclusion of information received between 31/12/2012 to 31/12/2013.

Challenges

Patients that undertake residential care are an older population with a significant number of years of addiction, presenting a severe psychiatric and physical co-morbidity and a long path in different help and care structures and services leading to an overall feeling of frustration and helplessness, creating a group of “veterans” with great difficulty on building up a healthy and adequate life style.

One challenge related with this is the need to adjust the therapeutic programs to these situations and at the same time fidelity to the program, in order to increase the program efficiency.

Other challenges that TC's will have to face in the near future are the following:

- Financial issues (it should not decrease the minimum limit for treatment);
- New drugs, new addictions and new ways of use;
- Lack of professional skills, economical crisis and high unemployment rates endanger patients' professional reintegration;
- The search for a place to live, asylum or hostel instead of a therapeutic project;
- Work together with Universities to supply scientific-based studies that might support the increase of residential treatments efficiency.

Regarding the dependencies without substance, like gambling, internet, and shopping, it is urgent to validate the use of TC's. There are already some experiences in the United States and China, with inpatient programs in TC, which is a surprising answer, since common sense tends to consider these dependencies without substance, as a minor problem and a minor concern.

In time of crisis, it is not expected to reduce the number and urgency of cases we face. If this answer (TC's) significantly weaken or disappear, people untreated will return to society, frustrated and angry, with predictable consequences in terms of public and social order. Back to the past, to repression, prison incarceration, where costs per individual and to the State will be higher than the recovery in TC.

Specific added value of residential treatment

National Institute on Drugs Abuse (NIDA, 2005) investigations showed that patients in CT present better results in all physical and mental health indicators than any other treatment strategy.

Besides that, TCs have capacity to respond to the treatment of some substances that have been trivialized, such as hashish and marijuana. Some substances have increased their prevalence, has it is the case of cocaine, a product for which there is no substitute or antagonist, i.e. medicinal weapon's that are used for opioids. In the current situation the TC's are basic instruments that work in network with multiple society structures, authentic foundations in response to the referred increase in the prevelences reffered.

Studies also showed that after leaving a TC, 55% of the individuals had never relapse and 43% had relapse, from these last ones 31% after relapse stopped, being abstinent for several years. The percentage of relapses in subjects with medical release is four times less than the percentage of individuals without medical release. Therefore, stay in the program

until the end is a predictor of success. If the vast majority at the entry date to TC reported to have committed delinquent acts (theft, robbery, drug possession and trafficking, forgery, among many others) after leaving the TC the vast majority had not committed any of the offenses mentioned. Also in relation to employment, results are positive, since the vast majority of individuals who left TC were employed, and those who are unemployed are those who are consuming.

These are some facts that demonstrate the need and clear fundament for the existence of TC's. One can think in a logical of immediate savings, which can be expendable. But if this happens, you lose a key resource in order to give hope and efficiency in the help to problems that afflict and martyr Portuguese families. We also referenced the various models and the history of TC's in Portugal for the last 20 years, which ceased to be an experience to become a reality and gave a decisive contribution to the international recognition of the Portuguese approach to the drug problem.

Part C

Bibliography and Annexes

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PREVENTION

http://www.idt.pt/PT/Prevencao/Documents/Programas_Projectos/catalogo_de%20Boas_Praticas_Prevencao_das%20toxicodependencias_em_Grupos%20Vulneraveis.pdf

http://www.idt.pt/PT/CentroDocumentacao/Documents/IntervencaoPreventivaComGruposVulneraveis_ExpDoPIF.pdf

http://www.idt.pt/PT/PORI/Documents/Enquadramento/2008/12/PORI_Documento%20de%20Apoio.pdf

Centro de Atendimento a Jovens e Envoltentes (CAJE) - www.cm-pombal.pt

Ei! Clica aqui! - www.eiclicaqui.com

Tu-Alinhas - www.tu-alinhas.pt

Observatório Europeu da Droga e da Toxicodependência (OEDT) www.emcdda.europa.eu

Prevention Evaluation Resource Kit (PERK) - www.emcdda.europa.eu

Electronic Evaluation Instrument Bank (EIB) - www.eib.emcdda.europa.eu

Portal Boas Práticas - www.emcdda.europa.eu/themes/best-practice

Fundación de Ayuda contra la Drogadicción (FAD) - www.fad.es

Plan Nacional sobre Drogas (PNSD) - www.pnsd.msc.es

Sociedade científica Espanhola de Estudos sobre o Álcool, Alcoolismo e outras Toxicomanias - www.socidrogalcohol.org

Education para la Salud Y la Prevencion de las Drogodependencias - www.edex.es

Centre for Public Health - UK - www.cph.org.uk

The National Collaborating Centre for Drug Prevention (NCCDP) - UK - www.drugpreventionevidence.info/default.asp

Center for Substance Abuse Prevention (CSAP) - EUA - <http://nrepp.samhsa.gov>

SAMHSA - <http://modelprograms.samhsa.gov>

The Centers for Disease Control and Prevention (CDC) - EUA - www.cdc.gov/hiv/projects/rep/compend.htm

The National Institute of Drug Abuse (NIDA) - EUA - www.nida.nih.gov

Office of Juvenile Justice and Delinquency Prevention (OJJDP) - EUA - www.colorado.edu/cspv/blueprints/index.html

The Surgeon General's Office (SGO) - EUA - www.surgeongeneral.gov/library/youthviolence/report.html

Evidence-Based Electronic Library for Drugs and Addiction (EELDA) - <http://pt.eelda.org>

Instituto para el Estudio de las Adicciones - www.ieanet.com/drogas/

www.drogasycerebro.com / www.talktofrank.com

www.namethatdrug.com

Modelo Lógico - www.uwex.edu/ces/lmcourse
www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
www.edtechevaluation.com/logicmaphow2.htm

TREATMENT

Associação Portuguesa de Narcóticos Anónimos - <http://www.na-pt.org/>
Euro-Methwork - Amsterdam - www.euromethwork.org
 Entidade Reguladora da Saúde – ERS - www.ers.pt
 Direção Geral de Saúde – DGS - www.dgs.pt
 Inspeção-Geral das Atividades em Saúde – IGAS - www.igas.min-saude.pt
 Institute of Behavioral Research - IBR - www.ibr.tcu.edu
The Drug Abuse Treatment Outcome Studies – DATOS - www.datos.org

RISK AND HARM REDUCTION

Associação *AIDES* - www.aides.org
 Associação de Redução de Danos da Argentina - ARDA - <http://arda.iwarp.com>
Canadian Harm Reduction Network - www.canadianharmreduction.com
Dance Safe - www.dancesafe.org
 Fundação *Drugtext* - www.drugtext.org
Energy Control - www.energycontrol.org
Euro - MethWork - www.q4q.nl
Harm Reduction Coalition - HRC - www.harmreduction.org
Harm Reduction Journal - www.harmreductionjournal.com
 Ministério da Saúde Francês - www.sante.gouv.fr
 Associação *Prevtech* - www.prevtech.ch
 SIDA InfoService – SIS - www.sida-info-service.org

REINTEGRATION

http://www.idt.pt/PT/CentroDocumentacao/Documents/Manual_Reinsercao.pdf
http://www.idt.pt/PT/CentroDocumentacao/Documents/novaspersp_novoshoriz.pdf
<http://www.idt.pt/PT/Reinsercao/Documents/MIR.pdf>

Rede Europeia Anti Pobreza / Portugal www.reapn.org  www.flashrede.blogspot.com

Programa Operacional do Potencial Humano (POPH) www.poph.qren.pt

➤ Instituições nacionais com respostas na área da Reinserção Social

Fundação de Assistência Médica Internacional (AMI) www.ami.org.pt
 Comissão Nacional de Proteção das Crianças e Jovens em Risco www.cnpcjr.pt
 Direção Geral de Reinserção Social www.irsocial.mj.pt
 Instituto de Apoio à Criança www.iacrianca.pt
 Instituto da Segurança Social (ISS) www.seg-social.pt

Instituto do Emprego e Formação Profissional (IEFP) www.iefp.pt
 Instituto Português da Juventude (IPJ) www.juventude.gov.pt
 Ministério do Trabalho e da Solidariedade Social www.mtss.gov.pt
 Ministério dos Negócios Estrangeiros (MNE) www.mne.gov.pt
 Novas Oportunidades www.novasoportunidades.gov.pt
 Portal Tribunais www.tribunaisnet.mj.pt
 Santa Casa da Misericórdia (SCML) www.scml.pt
 União das Misericórdias Portuguesas (UMP) www.ump.pt

SELECTED ISSUES

DRUG POLICIES OF LARGE EUROPEAN CITIES

<http://www.cm-lisboa.pt/>

http://www.portaldocidadao.pt/PORTAL/entidades/ADL/CMLX/pt/ORG_camara+municipal+de+lisboa.htm

<http://www.sscml.pt/internet/>

RESIDENTIAL TREATMENT FOR DRUG USERS IN PRISON

<http://www.ibmcp.up.pt/e-drogas/ajuda.php>

www.idt.pt

http://www.apcer.pt/index.php?option=com_content&view=article&id=96%253Aiso-9001&catid=3&Itemid=10&lang=pt

<http://portaldastaipas.com/>

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List of Abbreviations used in the text

ACT – Authority for Labor Conditions

ADR - Counselling Detection and Reference / Aconselhamento Detecção e Referenciação

ANF – National Association of Pharmacies / Associação Nacional de Farmácias

Agência Piaget para o Desenvolvimento – APDES

ARS – Regional Health Administrations / Administrações Regionais de Saúde

ASAE - Food and Economic Safety Authority / Autoridade de Segurança Alimentar e Económica

CAPi - Computer Assisted Personal Interviewing

CAT – Specialised Outpatient Drug Abuse Treatment/

CDT – Commissions for the Dissuasion of Drug Use / Comissão para a Dissuasão da Toxicodependência

CED - Education Centers and Development

CEPD – Centro de Estudos e Profilaxia da Droga / Center Study and Prophylaxis of Drugs

CGTP-IN - General Confederation of Portuguese Workers / Confederação Geral dos Trabalhadores Portugueses

CML - Lisbon City Council

CNLCS – National Commission for the Fight against AIDS / Comissão Nacional de Luta Contra a SIDA

CNIVS – National Coordination for HIV/AIDS Infection

CPL – Lisbon Casa Pia / Casa Pia de Lisboa

CPCJ- Commission of protection of Children and youth/ Comissão de Protecção de Crianças e Jovens

CRI - Centre of Integrated Responses/ Centros de Respostas Integradas

CSI - Social Integrated Competency

TC – Therapeutic Communities/ Comunidades Terapêuticas

CVP – Portuguese Red Cross / Cruz Vermelha Portuguesa

DGAIEC - General Directorate of Customs and Special Taxes on Consultation

DGIDC – General Directorate for Innovation and Curricular Development / Direcção-Geral de Inovação e de Desenvolvimento Curricular

DGS – General Directorate for Health / Direcção-Geral da Saúde

DGSP – General Directorate for Prisons / Direcção-Geral dos Serviços Prisionais

DR – Regional Directorate / Delegação Regional

DRA – Alentejo Regional Delegation

DRAL – Algarve Regional Delegation

DRC – Center Regional Delegation

DRD – Drug-related deaths / Mortes relacionadas com droga

DRE – Regional Directorate of Education / Direcção Regional de Educação

DRLVT – Lisbon and Tagus Valley Regional Delegation

DRN – Northern Regional Delegation

ECATD – Estudo sobre o Consumo de Álcool, Tabaco e Droga / Study on Alcohol, Tobacco and Drug use

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction / Observatório Europeu da Droga e das Toxicodependências

EMID - Municipal Intervention Strategy for Addiction

EMIS - Municipal Intervention Strategy for Social Inclusion

ENLCD – Estratégia Nacional de Luta contra a Droga / National Strategy on the Fight Against Drugs

ESPAD – European School Survey Project on Alcohol and other Drugs / Inquérito Europeu sobre o Consumo de Álcool e outras Drogas

ETs - Treatment Teams / Equipas de Tratamento

EU – European Union

EURIDICE - European Research and Intervention on Dependency and Diversity in Companies and Employment

FPCE – Faculty of Psychology and Educational Sciences / Faculdade de Psicologia e de Ciências da Educação

GIES - Group of Intervention in Higher Education / Grupo de intervenção no Ensino Superior

GMR – General Mortality Register / Registo Geral de Mortalidade

GNR – National Republican Guard / Guarda Nacional Republicana

HBSC/OMS – Health Behaviour in School-aged Children

HIV/AIDS - Human immunodeficiency virus infection/Acquired immunodeficiency syndrome

ICD – Classificação Internacional das Doenças / International Classification of Diseases

IDT, I.P. – Institute on Drugs and Drug Addiction, Public Institute / Instituto da Droga e da Toxicodependência, Instituto Público

IDUs – Intravenous Drug Users / Consumidores de drogas injectáveis

IEFP – Institute for Labor and Professional Training / Instituto de Emprego e Formação Profissional

IHRU – Institute of Housing and Urban Renovation/

INE – National Statistics Institute / Instituto Nacional de Estatística

INFARMED – National Institute of Pharmacy and Medicines/Instituto Nacional da Farmácia e do Medicamento

INME – National Survey at School setting/Inquérito Nacional em Meio Escolar

INML – National Institute of Forensic Medicine / Instituto Nacional de Medicina Legal

INPP – National Population Survey on Psychoactive Substances in the Portuguese Population / Inquérito Nacional ao Consumo de Substâncias Psicoactivas na População Portuguesa

INSA, I.P. - National Health Institute Doutor Ricardo Jorge / Instituto Nacional de Saúde Doutor Ricardo Jorge

IPJ – Portuguese Youth Institute / Instituto Português da Juventude

IPSS - Private Social Solidarity Institutions / Instituições Particulares de Solidariedade Social

ISS – Social Security Institute / Instituto da Segurança Social

KLOTHO – Project of Early Identification and Prevention of HIV/AIDS directed to Drug Users
 Projecto de Identificação Precoce e Prevenção da Infecção VIH/Sida e Direccionado a Utilizadores de Drogas

MAOC-N - Maritime Analysis and Operation Centre – Narcotics

MDN – Ministry of National Defence / Ministério de Defesa Nacional

ME – Ministry of Education /Ministério da Educação

MEPS - microextraction in packed sorbent

MIR - Intervention Model in Reintegration

NAT – Núcleo de Apoio Técnico

NESASE – Center for Health Education and Welfare School

NFL – Fiscalisation and Licensing Nucleus / Núcleo de Fiscalização e Licenciamento

NGOs – Non-Governmental Organisations / Organizações Não Governamentais

NHS – National Health System

NP – Prevention Nucleus / Núcleo de Prevenção

NPISA - Planning and Intervention Units for Homeless / Núcleos de Planeamento e Intervenção Sem-Abrigo

NT – Territorial Nucleus / Núcleos Territoriais

PANCPDI – National Action Plan for the Fight Against the Spread of Infectious Diseases in Prison Setting / Plano de Acção Nacional de Combate à Propagação de Doenças Infecciosas em Meio Prisional

PDCM - Plano de Desenvolvimento da Mouraria

PDU – Problem drug use

PES - Promotion and Education for Health / Promoção e Educação para a Saúde

PETS – Syringe Exchange Programme

PIEF (Programa Integrado de Educação e Formação / Integrated Program of Education and Training)

PIF – Program of Focused Intervention / Programa de Intervenção Focalizada

PIPT - Comprehensive Plan for the prevention of Drug Addiction –

PJ – Criminal Police/ Polícia Judiciária

PNCDDT – National Plano n Drugs and Drug Addiction

PNRPLA – National Plan for reducing Alcohol related Problems

PPCDAFA – Programa de Prevenção e Combate à Droga e ao Alcoolismo nas Forças Armadas/ Prevention and Fight Against Drugs and Alcoholism in the Armed Forces

PORI – Operational Program of Integrated Responses / Programa Operacional de Resposta Integradas

PREMAC - Plano de Redução e Melhoria da Administração Central

PRI – Programs of Integrated Responses / Programas de Respostas Integradas

PSO-BLE - Low Threshold Substitution Program / Programa de Substituição de Baixo Limiar

PSP – Public Security Police / Polícia de Segurança Pública

PVE – Life-Employment Program / Programa Vida Emprego

QP – Permanent Staff of Armed Forces of Portugal / Quadro Permanente das Forças Armadas de Portugal

RA – Autonomous Regions

RC – Contracted Staff of Armed Forces of Portugal / Regime de Contrato das Forças Armadas de Portugal

RDS – Respondent Driven Sampling

RRMD – Harm and risk reduction / Redução de Riscos e de Minimização de Danos

RSI – Social Insertion Income/Rendimento Social de Inserção

RV – Volunteers of Armed Forces of Portugal / Regime de Voluntariado das Forças Armadas de Portugal

RVCC – Revalidation and Certification of Competencies

SEF – Emigration Services

SICAD - General-Directorate for Intervention on Addictive Behaviours and Dependencies

SIM – Multidisciplinary Information System/Sistema de Informação Multidisciplinar

SMR – Special Mortality Register / Registo Especial de Mortalidade

SPA – Psychoactive substances / Substâncias Psicoactivas

SPSS - Statistical Package for the Social Sciences

SPTT - Drug Addiction Prevention and Treatment Service/ Serviço de Prevenção e Tratamento da Toxicodependência

TDI - Treatment Demand Indicator

UCIC – Coordination and Criminal Investigation Units / Unidades de Coordenação de Investigação Criminal

UIF - Financial Information Unit

WHO – World Health Organization

List of Standard Tables and Structured Questionnaires sent to the EMCDDA

Standard table 01: basic results and methodology of population surveys on drug use

Standard table 02: methodology and results of school surveys on drug use

Standard table 05: acute/direct related deaths

Standard table 06: evolution of acute/direct related deaths

Standard table 07: National prevalence estimates on problem drug use

Standard table 09-1: prevalence of hepatitis B/C and HIV infection among injecting drug users: methods

Standard table 09-2: prevalence of hepatitis B/C and HIV infection among injecting drug users

Standard table 09-3: voluntary results for behavioural surveillance and protective factors

Standard table 09-4: notified cases of hepatitis C and B in injecting drug users

Standard table 10: syringe availability

Standard table 11: arrests/reports for drug law offences

Standard table 12: drug use among prisoners

Standard table 13: number and quantity of seizures of illicit drugs

Standard table 14: purity at street level of illicit drugs

Standard table 15: composition of tablets sold as illicit drugs

Standard table 16: price in Euros at street level of illicit drugs

Standard table 17: leading edge indicators for new developments in drug consumption

Standard table 18: overall mortality and causes of death among drug users

Standard table 24: access to treatment

Standard table 30: methods and results of youth surveys

Standard table 34: TDI data

Standard table: public expenditure

List of full references of laws in original language

Chapter 1:

- Decreto-Lei 124/2011 de 29 de Dezembro (Diário da República, 1.^a série — N.º 249 — 29 de Dezembro de 2011) - Aprova a Lei Orgânica do Ministério da Saúde. O IDT deixa de existir e a maior parte das suas funções passa para o novo Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD).

<http://dre.pt/pdf1s/2011/12/24900/0549105498.pdf>

- Lei n.º 13/2012 de 26 de Março (Diário da República 1.^a série — n.º 61 de 26 de Março de 2012) - Altera pela décima nona vez o Decreto-Lei n.º 15/93, de 22 de janeiro, que aprova o regime jurídico aplicável ao tráfico e consumo de estupefacientes e substâncias psicotrópicas, acrescentando a mefedrona e o tapentadol às tabelas que lhe são anexas.

<http://dre.pt/pdf1s/2012/03/06100/0141401419.pdf>

- Decreto-Lei n.º 17/2012 de 26 de Janeiro (Diário da República 1.^a série — n.º 19 de 26 de Janeiro de 2012) - Aprova a orgânica do Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências.

http://www.idt.pt/PT/Legislacao/Legislao%20Ficheiros/Servi%C3%A7o%20de%20Interven%C3%A7%C3%A3o%20nos%20Comportamentos%20Aditivos%20e%20nas%20Depend%C3%Aancias/Decreto-Lei_17_2012.pdf

- Lei n.º 11/2012 de 8 de Março (Diário da República, 1.^a série — N.º 49 — 8 de março de 2012) - Estabelece as novas regras de prescrição e dispensa de medicamentos, procedendo à sexta alteração ao regime jurídico dos medicamentos de uso humano

<http://dre.pt/pdf1s/2012/03/04900/0097800979.pdf>

- Despacho n.º 8816/2012 de 3 de Julho (Diário da República, 2.^a série — N.º 127 — 3 de julho de 2012) – Ministério da Saúde - Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências - Criação das unidades orgânicas flexíveis e da estrutura matricial.

http://www.idt.pt/PT/Legislacao/Legislao%20Ficheiros/Servi%C3%A7o%20de%20Interven%C3%A7%C3%A3o%20nos%20Comportamentos%20Aditivos%20e%20nas%20Depend%C3%Aancias/Despacho_8816_2012.pdf

- Portaria n.º 46/2012 de 13 de Fevereiro (Diário da República, 1.^a série — N.º 31 — 13 de fevereiro de 2012) – Primeira alteração à Portaria n.º 198/2011, de 18 de maio, que estabelece o regime jurídico a que obedecem as regras de prescrição eletrónica de medicamentos.

<http://www.dre.pt/pdf1s/2012/02/03100/0073500736.pdf>

Chapter 3:

- Lei n.º 30/2000 de 29 Novembro (Diário da República, 1.^a série A – N.º 276 de 29 de Novembro) – *Define o regime jurídico aplicável ao consumo de estupefacientes, bem como a proteção sanitária e social das pessoas que consomem sem prescrição médica.*
<http://dre.pt/pdf1sdip/2000/11/276A00/68296833.pdf>

Chapter 6:

- Lei n.º 22/2008 de 13 de Maio (Diário da República, 1.^a série, n.º 92, de 13 de Maio) – *Lei do Sistema Estatístico Nacional* <http://dre.pt/pdf1sdip/2008/05/09200/0261702622.pdf>

Chapter 9:

- Decreto-Lei nº 15/93 de 22 de Janeiro (Diário da República, 1ª série – Nº 18 de 22 de Janeiro) – *Regime Jurídico do tráfico e Consumo de Estupefacientes e Psicotrópicos*.
<http://dre.pt/pdf1sdip/1993/01/018A00/02340252.pdf>

- Lei nº 30/2000 (See chapter 1)

Decreto-Lei 130-A/2001 de 23 de Abril (Diário da República, 1ª série A – Nº95 de 23 de Abril) - Estabelece a organização, o processo e o regime de funcionamento da comissão para a dissuasão da toxicodependência, a que se refere o n.º 1 do artigo 5.º da Lei n.º 30/2000, de 29 de Novembro, e regula outras matérias complementares.

<http://dre.pt/pdf1sdip/2001/04/095A01/00020008.PDF>

- Portaria nº 604/2001 de 12 de Junho (Diário da República, 1ª série B – Nº136 de 12 de Junho) – *Procede à regulamentação do registo central dos processos de contra-ordenação previstos na Lei n.º 30/2000, de 29 de Novembro*.

http://www.idt.pt/PT/Legislacao/Legislao%20Ficheiros/Controle da Oferta e da Procura/portaria_604_2001.pdf

- Acórdão do Supremo Tribunal de Justiça nº 8/2008, de 5 de Agosto (Diário da República, 1ª série N.º 150 — 5 de Agosto de 2008) - Não obstante a derrogação operada pelo artigo 28.º da Lei n.º 30/2000, de 29 de Novembro, o artigo 40.º, n.º 2, do Decreto-Lei n.º 15/93, de 22 de Janeiro, manteve-se em vigor não só «quanto ao cultivo» como relativamente à aquisição ou detenção, para consumo próprio, de plantas, substâncias ou preparações compreendidas nas tabelas I a IV, em quantidade superior à necessária para o consumo médio individual durante o período de 10 dias.

<http://www.dre.pt/pdf1sdip/2008/08/15000/0523505254.PDF>

Chapter 10:

Lei nº 25/2008 de 5 de Junho (Diário da República, 1ª série N.º108 — 5 de Junho) - Estabelece medidas de natureza preventiva e repressiva de combate ao branqueamento de vantagens de proveniência ilícita e ao financiamento do terrorismo, transpondo para a ordem jurídica interna as Diretivas nºs 2005/60/CE, do Parlamento Europeu e do Conselho, de 26 de Outubro, e 2006/70/CE, da Comissão, de 1 de Agosto, relativas à prevenção da utilização do sistema financeiro e das atividades e profissões especialmente designadas para efeitos de branqueamento de capitais e de financiamento do terrorismo, procede à segunda alteração à Lei n.º 52/2003, de 22 de Agosto, e revoga a Lei n.º 11/2004, de 27 de Março.

http://www.incm.pt/site/resources/docs/L_25_2008.pdf

- Portaria nº 94/96 de 26 de Março (Diário da República, 1ª série B – Nº 73 de 26 de Março) – *Procedimentos de diagnóstico e dos exames periciais necessários à caracterização do estado de toxicodependência* <http://dre.pt/pdfgratis/1996/03/073B00.pdf>

Chapter 11:

- Decreto-Lei n.º 115/2006 de (DIÁRIO DA REPÚBLICA— I SÉRIE-A N.º 114 — 14 de Junho de 2006) - consagra os princípios, finalidades e objectivos da rede social, bem como a constituição, funcionamento e competência dos seus órgãos.

http://www.igualdade.gov.pt/images/stories/documentos/legislacao/legislacao/Violencia_Domestica/DL_115_2006.pdf

Chapter 12

- Decreto-Lei n.º 16/99 de 25 de Janeiro - Regula o licenciamento, o funcionamento e a fiscalização do exercício da atividade das unidades privadas que atuem na área da toxicodependência (revoga o Decreto Regulamentar n.º 42/93, de 27 de Novembro)

<http://www.dre.pt/pdf1s/1999/01/020A00/04210429.pdf>

- Decreto-Lei n.º 83/1990, de 14 de Março - Cria o Serviço de Prevenção e Tratamento da Toxicodependência no Ministério da Saúde

<http://dre.pt/pdf1sdip/1990/03/06100/12221225.pdf>

- Lei n.º 16-A/2002, de 31 de Maio - Primeira alteração à Lei n.º 109-B/2001, de 27 de Dezembro (aprova o Orçamento do Estado para 2002)

<http://dre.pt/pdf1sdip/2002/05/125A01/00020017.pdf>

- Decreto-Lei n.º 269-A/2002, de 29 de Novembro - Cria o Instituto da Droga e da Toxicodependência (IDT), resultante da fusão do Serviço de Prevenção e Tratamento da Toxicodependência (SPTT) e do Instituto Português da Droga e da Toxicodependência (IPDT)

<http://dre.pt/pdf1sdip/2002/11/276A01/00020011.pdf>

- Decreto-Lei n.º 221/2007 de 29 de Maio (Diário da República, 1.ª série— N.º 103 — 29 de Maio de 2007) - Aprova a orgânica do Instituto da Droga e da Toxicodependência, I. P.

<http://www.idt.pt/PT/Legislacao/Legislao%20Ficheiros/IDT - Instituto da Droga e da Toxicodepend%C3%Aancia/dl 221 2007.pdf>

- Despacho n.º 18683/2008 de 14 de Julho (Diário da República, 2.ª série — N.º 134 — 14 de Julho de 2008) - fixa os requisitos a observar no estabelecimento das convenções entre o Estado, através do IDT, I. P, e as unidades privadas de saúde, com ou sem fins lucrativos, tendo em vista o apoio ao tratamento de pessoas toxicodependentes e alcoólicas.

<http://www.cm-odivelas.pt/CamaraMunicipal/ServicosEquipamentos/CoesaoInovacaoSocial/Anexos/Despacho18683de14Jul2008.pdf>

- Decreto-Lei n.º 135/99 de 22 de Abril (DIÁRIO DA REPÚBLICA — I SÉRIE-A N.º 94 — 22-4-1999) - Define os princípios gerais de acção a que devem obedecer os serviços e organismos da Administração Pública na sua actuação face ao cidadão, bem como reúne de uma forma sistematizada as normas vigentes no contexto da modernização administrativa. Inclui as alterações introduzidas pelo Decreto-Lei n.º 29/2000, de 13 de Março.

http://www.algebrica.pt/i_ap/bo2/data/upimages/135_99.pdf

- Decreto-Lei n.º 72/99 de 15 de Março (DIÁRIO DA REPÚBLICA — I SÉRIE-A N.º 62 — 15-3-1999) - Revê o quadro jurídico de apoio às instituições privadas, na área do tratamento e da reinserção social de toxicodependentes

<http://www.dre.pt/pdf1s/1999/03/062A00/14181423.pdf>

- Decreto-Lei n.º 13/93 de 15 de Janeiro (DIÁRIO DA REPÚBLICA — I SÉRIE-A N.º 12 — 15/1/1993) - Criação e Fiscalização das Unidades Privadas de Saúde

<http://www.dre.pt/pdf1s/1999/03/062A00/14181423.pdf>