Executive Summary

External Evaluation
National Plan
Against Drugs and Drug Addictions
2005-2012 (PNCDT)

Technical Sheet

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1. Introduction

This is an executive summary of the external evaluation report to the "National Plan Against Drugs and Drug Addictions 2005-2012" (PNCDT). This study was adjudicated to Gesaworld SA, in March 2012, by Restricted Procedure through Prior Qualification Nº 01/2011/SC-IDT, I.P.

The array of policies to combat drugs and drug addictions is based on two Mission Areas, Demand Reduction and Supply Reduction. The vectors related to Demand Reduction axis are Prevention, Dissuasion, Risk and Harm Reduction, Treatment and Reintegration. The second axis, Supply Reduction, is based on efforts to limit the supply, use and access to illicit drugs.

Various documents produced by bodies and institutions responsible for implementing the National Strategy helped to guide this work. On one hand, internal instruments, such as the "National Action Plan for Combating Drugs and Drug Addiction – Horizon 2004" and the "National Plan Against Drugs and Drug Addictions". On the other hand, the first external evaluation procedure to the National Strategy for the Fight Against Drugs (ENLCD), that was carried out by the National Institute for Public Administration (INA) in 2004 (INA: 2004).

The actual study is intended to evaluate the PNCDT 2005-2012, which was delivered in two Action Plans: one was completed, until 2008, with the adoption of a National Strategic Plan for 2005-2012, followed by an internal evaluation impact assessment and afterward, by a new Action Plan for the period 2009-2012.

The study of this evaluation aims to critically assess the 2005-2012 cycle of the PNCDT, with the purpose of obtaining references and directions to plan the next strategic cycle. The specific objectives, duly explained in the technical specifications document, unfold in four assessment components, namely: i) analysis of the fulfilment of the PNCDT goals and the supposed deviations, including in particular aspects of the strategic options of focus on the citizen, territoriality, integrated approaches and responses, quality and accreditation improvement mechanisms, and prevention of drug-related crime; ii) impact assessment based on analysis of epidemiological data and responses in Portugal, compared with the same figures in Spain and Norway; iii) economic evaluation of cost-benefit of implementing integrated responses in relation to a previous structure of pulverized and dispersed responses. This assessment component is intended to estimate, in economic terms, the benefits generated by this strategic reorientation; iv) study of efficiency, effectiveness and quality of specific interventions in the field of strategic vectors in Demand Reduction and Supply Reduction axes.

2. Framework

In Portugal, the National Coordinating Committee for Drugs, Drug Addictions and Harmful Use of Alcohol ensures the coordination and articulation among the various government departments involved in these issues. Through the Decree-Law No. 17/2012 of January 26th, the general manager for Intervention on Addictive Behaviors and Dependencies (SICAD) is created, extinguishing the Institute for Drugs and Drug Addictions, Public Institute (IDT, I.P.) and introducing a major innovation based on strengthening the planning and monitoring component in programs for the reduction of consumption of psychoactive

substances, for the prevention of addictive behaviors and for the decrease of dependencies.

The extinct IDT, I.P., was concerned with the tasks of coordination and implementation of the national drug strategy which is committed by the Health Minister. This Institute was developing an integrated strategy to combat drugs and drug addictions based on prevention, treatment, risk and harm reduction and social reintegration, ensuring in a cross-cutting manner the functioning of the national system of information about drugs and its addictions (SNIDT); promoting and stimulating research into the phenomenon, supporting the training of professionals involved in this field, ensuring the function of the Drug Addiction Dissuasion Commissions (CDT), ensuring cooperation with external entities and proposing legislative and administrative measures in the area, together with their application.

PNCDT Starting Point

The following table presents the starting point summary, in the development of the 2005-2012 PNCDT, by different subjects:

PNCDT Starting Point Summary

Drug Consumptions:

- cannabis had the highest consumption prevalence among the Portuguese population from 15-64 years old, the school population and the prison population (national epidemiological studies). At school population level was noted an increase of consumption in various substances;
- the prevalence of cannabis consumption among students is higher than in other psychoactive substances, either in Health Behavior in School-Aged Children/World Health Organization study in 2002 or in the ESPAD study (*European School Survey Project on Alcohol and other Drugs*) results in 2003 (9.2% and 15%, respectively in the first and second study). The consumption prevalence among Portuguese students continues to be lower than European averages;
- heroin consumption was the predominant drug in problematic specific groups (often associated with cocaine).

Treatment:

- **Primary Drug:** in 2004, heroin was the primary drug for most of the users in the various treatments structures and units: 85% of ambulatory uses on the public network (from which 63% were only from heroin and 22% from heroin and cocaine) and 75% of users in early appointments;
- **Via of consumption**: intravenous consumption of main drug stands between 25% to 52%;
- Reduction of intravenous consumption practice among users in early appointments on the public network drug treatment units (from 45% in 1999 to 25% in 2004 of users reported intravenous consumption in the last 30 days before appointment).

Infectious Diseases:

- **Reporting of Human Immunodeficiency Virus (HIV) Infections**: 39% of the cumulative total of HIV infection notifications in 2004 were cases associated with drug dependence, having however been decreasing compared to 1998, to 62%;

- **HIV-positive**: 12 to 28% of users of the drug treatment structures;
- **Anti-retrovirus therapy**: the percentage of HIV-positive drug addicts who were with anti-retrovirus therapy in 2004 varied between 19% and 68%;
- **Hepatitis B**: 3% in 2004 among the drug addict population;
- **Hepatitis C**: 44% in 2004 among the drug addict population;
- **Tuberculosis**: in 2004 between 1% (users of public and licensed Detoxification Units (UD)) and 4% (users of treatment public network – outpatient clinic);

Deaths: 156 cases in 2004 (positive in the toxicological drug testing exams made by the National Institute for Forensic Medicine, Public Institute (INML, I.P.).

Drug Consumption Offences: 5.370 occurrences that led to the opening of criminal processes in 2004, of which 68 were related to cannabis.

Sources: Instituto da Droga e da Toxicodependência, Relatório de atividades 2004; Lisboa, IDT; Instituto da Droga e da Toxicodependência, (2005). A situação do país em matéria de drogas e toxicodependências 2004, Lisboa, IDT.

Based on this summary, recommendations were made for the future evaluation of the National Strategy for the Fight against Drugs (INA, 2004), namely: i) reorganize and enhance the reach of the SNIDT; ii) supply reduction by increasing drug trafficking seizures; iii) develop a new generation of initiatives and prevention programs with the community and businesses; iv) improving risk and harm reduction responses through the development of lines of action already pursued; v) enrich the services offered by networks of day treatment centers and Therapeutic Communities (CT), improving the monitoring and evaluation systems; vi) launch of a new range of initiatives to reduce the social stigma of drug use among employers and promote employment and social reinsertion; vii) reorganization of IDT, I.P. and establishment of new interministerial cooperation model and; viii) clarify priorities for training and research efforts to enhance their results.

THE PNCDT 2005-2012

The PNCDT structure was based on cross-cutting areas (Coordination; International Cooperation; Information, Research, Training and Evaluation and Legal Framework Review) and related Mission Areas: Demand Reduction and Supply Reduction.

The strategic principles defined in the PNCDT are designed to ensure the consistency and coherence of coordinated and optimized results, meaning:

- Focus on the individual: interventions for substance abuse are not an end in themselves, so they shouldn't focus solely on the substances but rather on the individual and his/her objective and subjective needs;

- Territoriality: for a better understanding, intervention and evaluation of the situations, the focus must be on local and territorial management and planning;

- Integrated approaches and responses – integrated intervention at internal and external level: approaches and responses should be constructed in an integrated manner, without dissociating individual reality from social reality. Services should organize their operational intervention by setting up comprehensive response mechanisms that form a consistent active network, while being capable of dealing with the complexity and cross-cutting nature of the drugs problem and related issues;

- Quality improvement and certification tools: through a process that starts with a diagnosis, in which is set the final outcome as well as indicators and instruments to be used. The assessment must therefore be an integral part of the institutional culture.

3. Methodology

This evaluation combines the use of quantitative and qualitative techniques (e.g. nominal group techniques[1] and interviews[2]) in order to achieve a global perspective on the process of the PNCDT implementation. It became essential not only to describe the results and check whether there were deviations from what was planned (efficacy) but also important to know what was their effect (impact), in which way they were obtained (efficiency and quality) and in what context; framing-up the axis and the activities foreseen in the PNCDT on the set of circumstances that influenced their implementation, whether they were from political decisions, from the market, from resources or others.

In this study we identified the tools for collecting the information[3] and presented a proposal for a set of indicators to be used for assessment of the areas under analysis. This set of indicators was agreed upon with the team that supervised the project (Steering Committee). The calculation of indicators was done through quantitative and qualitative information gathered.

[1] Seven sessions in which supervisors who were at the base in the elaboration of the PNCDT, representatives of partner entities of the IDT, I.P., Regional Delegates and representatives of the Territory Support Nucleus in the Regional Delegations, professionals of the Integrated Responses Centers, professionals of the Integrated Responses Programs, representatives of different police authorities and from the Drug Addiction Dissuasion Commission and Street Teams professionals.

[2] Five interviews took place: National Coordinator for drug problems, drug addiction and the harmful use of alcohol; a member of the Board of Directors of the IDT, I.P.; a representative of the EMCDDA and two users of the day center of Detoxification Unit – Centro das Talpas.

[3] Collecting information available through the following sources: IDT, I.P. (Activity Reports); IDT,IP ("*Situação do país em matéria de drogas e Toxicodependências*") and European Monitoring Centre for Drugs and Drug Addiction (statistical data). It was necessary to develop meetings and request for information with the coordinators of each vector in the mission area concerned; the IDT, I.P. financial department, and two specific requests to Regional Delegations and Drug Addiction Dissuasion Commissions. Concerning supply demand reduction, contact was established with different security forces (Judicial Police, Public Security Police and National Republican Guards).

4. Results

By analyzing each of the vectors related to the demand reduction mission area, the current assessment of the PNCDT implementation concluded that the interventions for the 2005-2012 period within Prevention, Dissuasion, Risk and Harm Reduction, Treatment and Reintegration have been extensively achieved and configured a network of integral and integrated intervention, based on response of proximity, which places the individual at the center of assistance regardless of their situation in relation to drug consumption and therefore allowing to establish the basis for a comprehensive system of quality management.

4.1 Prevention

The conceptualization of the intervention is based on the health-based prevention model that includes Universal, Selective and Indicated prevention types.

The implementation of programs focused on developing social skills constituted a reconfiguration of the strategy within the framework of universal prevention, which allowed to meet scientific recommendations more effectively in strengthening the protection factors opposing to drug experimentation and/or consumption increase. More contextualized interventions were favoured, at the expense of massive campaigns. Among the projects that depict this stake are the following programs "Eu e os Outros" (EEOO), “Trilhos”, “Copos, quem decide és tu” (Copos), “E agora Ruca”, “Atlante”, among others.

At the same time, a number of programs addressed at specific populations identified within uniform criteria on the national territory (Program of Focused Intervention (PIF) and Operational Plan of Integrated Responses (PORI)). These programs made it possible to respond to gaps in preventive intervention areas, by working with populations with specific and appropriate interventions that need to address the social and economic conditions presented (selective and indicated prevention).

Additionally, intensive work was carried out to assess the effectiveness of these interventions, projects and programs, this way increasing the know-how about interventions with better results.

In the external assessment, it was verified that different projects and programs evaluated constitute an innovative and experimental approach consistent with the principles set out in the PNCDT. It allowed to: identify key dimensions to the definition and implementation of the programs not only in terms of universal prevention, but also as selective prevention of drug addiction; test new methodologies and practices; evaluate and reflect on the results in order to gain advantage as guiding contributions to future preventive interventions.

It also established the foundations to develop future preventive interventions in the working environment, in cooperation with employers (*European Research and Intervention on Dependency and Diversity in Companies and Employment* (EURIDICE)).

Under the vector of prevention, the efficiency, effectiveness and quality of interventions was assessed specifically via *the increase in the number of prevention programs promoting strategies and actions based on scientific evidence and exchanges of experiences and improving the selection process, follow-up and monitoring of the projects implemented*. The prevention projects that have been developed and which have complied with the requirements as promoters of strategies and action based on scientific evidence were identified in conjunction with the IDT, I.P., in particular: PIF; Prevention project of drug consumption developed in a partnership between *Casa Pia de Lisboa* and the IDT, I.P.; *Copos; EEOO* and *Trilhos*. Concerning efficacy, it was examined the coverage of prevention programs and the number of prevention actions performed. As regards to the coverage of prevention programs, the average annual number of individuals covered between 2005 and 2012 (all programs included) is 91,015 (*ad-hoc* information provided by the IDT, I.P.), and the average annual number of preventive actions carried out per program between 2005 and 2012 was 658.5 actions (*ad-hoc* information provided by the IDT, I.P.). The average annual cost per program and by individual is 3.5 Euros (all programs under analysis). It is important to note that PIF is the program with the higher average annual cost (13.4 Euros) and the EEOO program is the lowest, with an average cost of 0.2 Euros (*ad-hoc* information provided by the IDT, I.P.). Despite the complexity of the programs under analysis, we can conclude an efficient intervention and should be praised the merit for the ability of integrating resources from other sectors in the implementation of these programs.

Regarding quality, a panoply of actions in different areas was developed which allows to conclude that the interventions are guided mainly by their ability to integrate in the conceptualization and implementation of programs. Both the technical-scientific and methodological quality were strengthened through professional training, continuous monitoring of programs and projects, the production of good practices manuals and procedures and focused on collaborative work in with the local actors (local authorities, schools, etc.) to promote coherence and complementarity.

Overall, the intervention strategy in prevention availed of a boost with the implementation of the PNCDT. Substantially, the 3 general objectives defined in the prevention mission area of the PNCDT were fulfilled.

4.2 Dissuasion

At the time of drawing up the plan now under evaluation, Portugal had very recently adopted an innovative policy that called for the decriminalization of the consumption, purchase and possession of illicit psychoactive substances, not exceeding the amount for individual consumption during 10 days and whose effects were yet unknown. The Plan had therefore the role to ensure the organization and functioning of Dissuasion responses and create evidence on its results and effects. It should be noted that, until now, there have already been made 4 international studies (Domoslawski: 2011; Greenwald: 2009; Hughes and Stevens: 2010; EMCDDA: 2011) on the consumption decriminalization policy adopted by Portugal, demonstrating the international recognition and interest raised by this model.

Under the vector of dissuasion, the efficiency, effectiveness, and quality of interventions was assessed

specifically by the *promotion of interministerial coordination with the guardianship whose mission encompasses responses in the context of drug abuse as well as promoting and ensuring internal coordination (within the IDT, I.P.) and intraministerial (with other structures of the Ministry of Health – MS) between departments with responsibilities or implications of the Law 30/2000, from November 29th*, as referred in the Terms of Reference. The agencies involved in law enforcement are diverse and include the Courts, Security Forces, Health Services, Prisons, among others. It can be observed from this report that the implementation of the PNCDT allowed the procedure to operate more efficiently, while at the same time ensuring enforcement of the law. The increase accessibility to resources with which the CDTs articulate was accomplished through an increase in the number of cases decided between 2005 and 2011. The dissuasion effect of consumption has had the desired effects to the extent that the CDTs have received an increasing number of offenders classified as non-addicts who otherwise would not have access to specific responses to their needs. Moreover, there is a significant volume of consumers who are referred for the first time to treatment and other structures through the expertise of CDTs.

The number of processes in the CDTs remained stable during the period under evaluation. In 2005, the CDTs had a total of 7.368 processes and in 2011 that number was 7.388 (IDT, I.P.: 2005, 2011).

In terms of articulation, it is important to point out the development of new mechanisms for the duration of the PNCDT, with different entities, being that these partnerships serve to meet the needs of specific responses to non-addicted offenders, with problematic life trajectories or at risk and also able to support the drug-addicted offenders in their processes of referral to treatment or to another type of responses (offering transport and/or decentralizing the hearings to locations closer to the indictees, such as on the premises of Municipal City Halls).

The average cost per case in CDTs remained stable over the 2005-2011 period, ranging from the minimum amount of 346 Euros for 2007 and a maximum of 388 Euros in 2006, but the appearances of offenders and resolved cases tended to increase, which shows the functioning optimization of the CDTs (IDT, I.P.: 2005-2011). We must bear in mind that according to the Directorate-General of Justice Administration, the expenditure per case per 100.000 inhabitants was 525.25 Euros (*in* 2007). The costs per process in each CDTs are less than the costs presented in Judicial Courts (Ministry of Justice: 2007).

Improvements were also observed in the framework of the monitoring and feedback process concerning the results of the procedures. A system of follow-up monitoring the work regarding the technical teams was implemented, integrating partners in the strategy for demand and supply reduction. It is important to recognize the work that has been done between the CDTs and the Courts.

The implementation of the Integrated System for Performance Assessment in Public Administration (SIADAP) in the CDTs occurred in 2011 and provides the evaluation of members and staff having there also been an order (n.º 12132/2011, from September 15th) of delegation of powers to the IDT, I.P.. The scope of supervision and follow-up meetings to every CDTs has resulted in a best practices manual, being drafted (on the basis of contributions and exchange of experiences between experts and members of CDTs, at national level) upon the end of the current report.

The CDTs have their own system of complaints that requires registration and the subsequent submission of the content to the headquarters of the IDT, I.P. For a number of 52,820 processes that have entered into the eighteen CDTs between 2005 and 2011, only two complaints were reported (*ad-hoc* information provided by the CDTs).

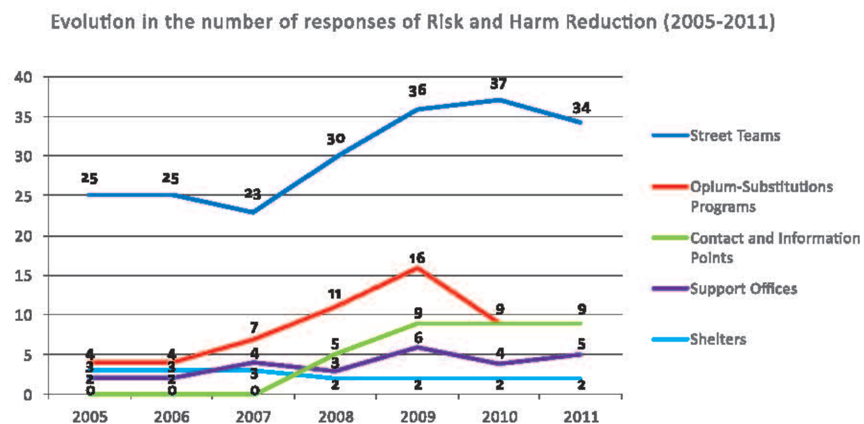
Overall, the strategy regarding the dissuasion intervention obtained an important stimulus with the implementation of the PNCDT.

Most of the goals defined in the PNCDT for this area of dissuasion have been complied.

4.3 Risk and Harm Reduction

Regarding the intervention in the risk and harm reduction area, the PNCDT implementation has resulted in the expansion of the responses network between 2005 and 2011, except for shelter. The number of low-threshold opium-substitutions programs (PSO-BLE) increased until 2009 and decreased between 2010 and 2011. In this period was implemented the Contact and Information Points (PCI) response, advancing on intervention in recreational spaces. It is important to highlight the progress done in prison establishments through the creation of intervention proposals in these environments (information and awareness programs about the risks of overdose and evaluation of the Syringe Exchange Experimental Program – PETS).

The increase in the number of risk and harm reduction responses allowed to reach in 2011 a total of 12,550 users (IDT, I.P.: 2011), increasing accessibility to individuals who were not usually contacted through the conventional structures, fulfilling the objective established in the PNCDT for this vector. In the total of users contacted, 72% benefited from psychosocial support, 18% from health care and 13% were referred to other services (IDT, I.P.: 2011). It was testified an increase of 41% in terms of psychosocial support provided between 2009 and 2011 (IDT, I.P.: 2009-2011), which shows that investment in this area has significant results.



Own Elaboration.
Sources: Instituto da Droga e da Toxicodependência, I.P., *Relatórios de Actividades 2005-2011*, IDT, I.P.

The annual average fund allocated per individual to cover in Street Teams is 336.50 Euros (information provided by the IDT, I.P.), which, given the services provided, seems a relatively low financial forecast,

if we take into account the resources involved in the strategy of risk and harm reduction. Nevertheless, there is a great variation among Street Teams in the annual amount assigned per individual (where the minimum value is 16.35 Euros and the maximum value is 1,095.36 Euros (information provided by the IDT, I.P.)), a situation which is essentially due to the services included in each Street Team and the subsequent variation of individuals covered.

The expansion of the responses of PSO-BLE and Street Teams, with an intervention in Syringe Exchange Program (PTS) framework and the prison-based activities raise accessibility to specific groups with apparent results in terms of health outcomes. These responses ran for the results obtained from reduction of the prevalence of infectious diseases among injecting users, in accordance with the objectives of the Plan.

To strengthen the intervention and the know-how in the risk and harm reduction area, it was essential the work done within the framework of continuous improvement of quality in the responses, throughout professional training; drawing up guidelines for intervention and boosting the culture of registration, monitoring and evaluation of interventions. In 2006, the elaboration of a methodological guide was distinguished for the PTS. In 2007, a study was made to assess the results of the Street Teams intervention, as well as define technically and normatively their expertise and activities. Both the elaboration of the manual of procedures KLOTHO and the document of quality control program, in collaboration with the National Coordination for HIV/AIDS Infection, have provided a security of imposing regulations and conditions in the services in this area. The creation of a risk and harm reduction projects portfolio with the support of the IDT, I.P. (IDT, I.P.: 2011) provided a detailed knowledge of all existing initiatives. After the great effort made in this area in previous years, in 2011 the focus turned to joint initiatives with other intervention vectors and to proposals for quality certification.

The evaluation of the construction of a global network of integrated responses with both public and private partners receives positive note, in particular due to the percentage of referrals to a variety of health services and psychosocial support ensuring responses appropriate to the needs of network users. On the other side, a wide network of partnerships was implemented, essentially with Private Charity Institution(s) (IPSS), which allowed reaching wider fringes of the population and providing an extensive network of services to users, something virtually non-existent before the PNCDT 2005-2012. Additionally, it was ensured complementarity in interventions among services provided in risk and harms reduction, via the integration of this area in the Integrated Responses Centers (CRI) and the creation of an interlocutor person in risk and harm reduction for these centers. The work developed in Prison Establishments, with the PETS and the awareness action carried out in that environment, also confirms the extent of the intended intervention.

The 3 objectives defined in the PNCDT for the risk and harm reduction area were broadly met.

4.4 Treatment

The existing network of treatment responses during elaboration of the PNCDT was ample and offered a wide portfolio of services. Therefore the work done in the PNCDT focused on the internal reorganization of the Teams via the CRI conception; in the elaboration of guidelines and in the implementation and consolidation of a Multidisciplinary Information System (SIM). The integration of alcoholism services had particular impact on this vector as it may have eventually conditioned the implementation of some goals defined under the PNCDT.

The territorial reconfiguration of public ambulatory responses and the reinforcement of links between internal and external responses provided a greater accessibility of the population to responses: from a total of 30,226 users in treatment in 2004 to 38,292 in 2011. Concerning the level of treatment in outpatient regimen, provided by the CRI, the increase in number of patients attended in 2007 is related to the integration of users with problems related to alcohol consumption, from the second half of the year, which shows the impact of integrating these individuals in annual activity. In 2008 existed approximately more than 19% of users in treatment and more 32% of users in early appointments compared to 2006, year in which the activity referred exclusively to consumers of illegal substances (IDT, I.P.: 2006-2007).

The almost doubling of the number of early appointments, comparing the 2005 data with 2011, indicates that the treatment structures have increased its capacity to attract and serve new users. Since 2010, with the functioning of the SIM, it has been possible to obtain information broken down according to the type of clients attended in early appointments. It turns out that in 2011 the users with problems related to alcohol consumption nearly equals the percentage proportion of illicit psychoactive substances consumers. However, it should be noted the extension of the intervention directed at specific groups and other licit substances than alcohol, such as tobacco.

Specialized appointments were decentralized into other establishments (Health Centers, Youth Centers) and have reinforced the opioid agonist treatment, programs in health centers, hospitals, pharmacies, prisons establishments and other structures.

During the implementation of the PNCDT, there was a consolidation of the work which provided the responses network with a supply of programs and care covering a wide range of psychosocial and pharmacological approaches, guided by ethical principles and scientific evidence.

Regarding services available for outpatient treatment, it includes the CRI, Day Centers (CD) and with regard to inpatients, it integrates the CT and UD.

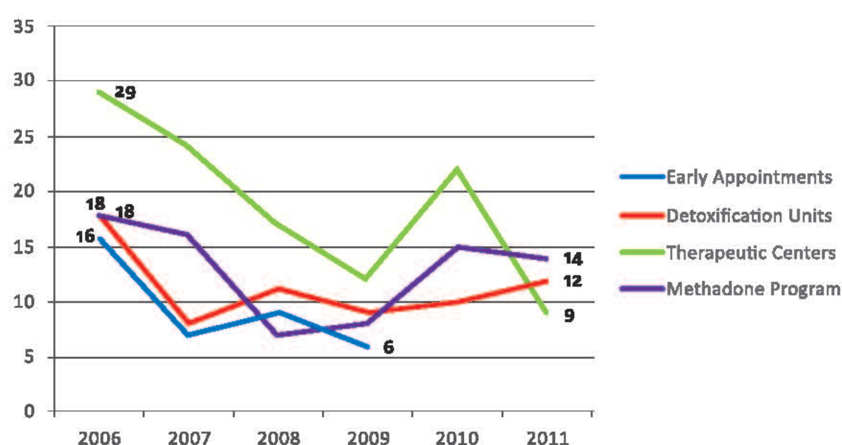
Outpatient treatment services available include appointments for individual psychotherapy and family therapy, social care and sociotherapeutic services, nursing appointments, group and family appointments and medical consultations from other different levels. Also included in the portfolio of services is the treatment with opioids agonists; treatment with opioids antagonists; Drug-Free Treatment / Relapse Prevention; and referral to other treatment responses.

Concerning the level of responses to groups with specific needs, all the CRI have specific appointments

for pregnant addicts and there is cooperation between regional public services and the maternities. In the treatment structures was conducted identification of users with infectious diseases, from the implementation of the KLOTHO program and adoption of the methodology "Advice, Diagnosis and Referral" (ADR). In relation to conventions, the CTs proceeded to the differentiation of the treatments by consumer types (children, pregnant and drug addicts with concomitant mental illness).

The calculation of costs per user attended in CRI was conducted from a sample of these centers[4]. The average annual cost per user attended in CRI decreased from 633.40 Euros to 303.90 Euros between 2009 and 2011 (ad-hoc data provided by the Regional Delegations – DR). The 2009 figures show a large dispersion with maximum values around 1,400 Euros per user attended/per year.

Evolution of waiting time for treatment (in days), 2006-2011



Own Elaboration.
Sources: Instituto da Droga e da Toxicodependência, I.P., *Relatórios de Actividades 2005-2011,* IDT, I.P.

The decrease observed in waiting times for admission in the responses and programs of this vector was essential to allow adequate access in compliance with the objective foreseen in the PNCDT "to assure the population that wishes to access timely answers". Waiting times for early appointments were significantly reduced from 2006 to 2009 (IDT, I.P.: 2006-2009) as it reduced to half. It should be noted that the average waiting time is considered acceptable for 10 days and, therefore, in 2009, the goal was not only met but surpassed. In the case of the UD, the acceptable waiting time is 13 days and the actual time in 2006 was 18 days, down to just 8 days in 2007. Regarding CT, since 2008 it has not exceeded the average waiting time deemed as reasonable (22 days). From 2006 to 2008, waiting times for methadone programs have decreased considerably, having situated in 18 days for the first year and in 7 days for 2008. Since then there has been a noticeable upward trend concerning this variable. The average time deemed acceptable is 10 days, and since 2010 it has been over this limit.

In order to speed up access to treatment programs, the administration of methadone partnerships has been strengthened with various agencies, resulting in a gradual increase of clients within the program. The intervention capacity increased to 16% (Information *ad-hoc* provided by the IDT, I.P.) in the national

[4] From the Regional Delegation (DR) of the Central and North regions.

network units, which includes public and contracted units like UD, CT and CD.

The SIM development was a fundamental element for the systematization on the public network of the multidimensional approach of the individual (physical, psychological and social) by creating a single intervention and interdisciplinary process for each individual and brought efficiency in the management and monitoring of the activity and production. The elaboration of guidelines and referral channels constituted important instruments for the promotion of good practices of intervention. It were also defined the criteria for admission to the UD and Customer Service Units (UA).

The objectives outlined for the treatment vector were mostly completed in the context that the integration of alcoholism services implied an increased effort vis-à-vis to the goals established in the Plan.

4.5 Reintegration

Regarding the reintegration vector, the creation and implementation of a particular model itself – Reintegration Intervention Model (MIR)[5] - constituted without a doubt key elements in homogenization and systematization of the intervention, boosting its role in the global process of work with each individual.

The MIR took on the character of technical guidance in 2009 and as regards its implementation the evaluation is positive, even though 93% of local services in 2010 had the model, this percentage rose to 95% in 2011 (only 4 local services in a total of 72 had not implemented the MIR) (IDT, I.P.: 2010-2011). It should be noted that the application of the model surpassed the CRI scope and extended to CT and UA. The implementation of the model in the CRI was 100% in 2011 (IDT, I.P.: 2010).

Alongside the development of this Model, instruments and mechanisms were created in 2009 that enable the management of each user case in its multidimensional aspects, comprising the approach directed towards social reintegration, as is the case of the Insertion Individual Plan (PII) (in 2011, 44% of the users had the PII elaborated (IDT, I.P.: 2011)). The MIR includes an integrated approach of the user from the supervisors, who facilitate their access to services and answer whatever they need, and also accompany and evaluate the PII process.

In addition, the establishment or strengthening of partnerships has been prioritized in order to provide the most extensive resource rehabilitation and formal ties with its partners. The internalization within the competence of the Reintegration Teams of the CRI with the role "for mediation training and employment" in the framework of the Program "*Vida Emprego*" (Life/Employment) (PVE) by equating the social and professional reinsertion as an integral part of the treatment process of the individual was a fundamental aspect in the reintegration responses. In 2011, the result was a total of 77,112 annual appointments

[5] This model aims at underpinning the social diagnosis and intervention in the interest of the individual as well as concerted proposals with other partners of the social and work environments. Also permitted the definition of the competences of the reintegration teams.

carried out by reintegration teams under the CRI, which supposed an increase of 11% comparing to 2008 (IDT, I.P.: 2008-2011). In 2011, 431 responses have been developed for housing, 872 responses for education, 608 responses for vocational training and 1.883 responses for employment (IDT, I.P.: 2011). It should be noted the growth between 2008 and 2011 in integration of users with identified needs, although such growth has not been accompanied in the specific case of housing responses (IDT, I.P.: 2008-2011).

The average annual value per user supervised in 2011 by reintegration teams is 120.46 Euros (*ad-hoc* information provided by the Regional Delegations), being that most of the CRI has a value well below this mark, which means that there are seemingly high costs relative to the mean in some of the CRI under evaluation.

At the level of employment responses, a general increase in insertion capacity was noted between 2008 and 2011. It is important to mention the success obtained with the Exchange of Employers initiative created in 2009, which managed to embrace already 177 entities that same year, reaching 928 entities in 2011 (IDT, I.P.: 2009-2011). Given the current economic situation, with negative implications in terms of ease of access to the labor market, these positive discrimination measures for specific groups are crucial and must be kept, allowing the intervention process to be global and inclusive of profession reintegration.

The innovations introduced in the reintegration approach made it possible to influence the larger intensity in the work which was also complemented by a set of instruments and manuals that facilitated the good practices, monitoring and evaluation of the intervention, in compliance with the objectives defined in the PNCDT. In 2009 the guidelines have been drawn up for the PVE (with the goal to promote the creation and consolidation of channels of communication and coordination between regional and local services from the IDT, I.P. and the Employment and Professional Training Institute (IEFP, I.P.) in a logic of integrated response). The MIR evaluation assessment is approved and it is created the model for evaluation of inpatient units active in the addiction field. It was also defined and developed a set of indicators and the corresponding information system, promoting the standardization of needs and knowledge of the intervention results.

It seems clear that the intended objectives have been achieved since the conceptual bases of this model include multidimensional responses to users, involving him (or her) in the reintegration process.

4.6 Supply Reduction

In the supply reduction mission area, the action of the Portuguese Criminal Police Organisms (OPC) in the fight against drugs is consolidated and allows for rationality in allocation of resources to each security force and authority with competence in the matter.

The articulation and coordination at **national level** between the security forces and other organizations with responsibilities in the development of activities to prevent and combat drug-related crime can be noted in the assessment through several elements, namely: i) joint collaboration developed among security forces or between organisms with responsibilities in this context; ii) implementation of reporting mechanisms between supervisory, administrative, trade and industry authorities and the Judicial Police (PJ); iii) implementation and development of mechanisms and operational support to financially investigate criminal organizations and its economic structures; iv) strengthening of mechanisms for streamlining and coordinating the activities of all entities with intervention in the fight against drug trafficking. In relation to the mechanisms of coordination between security forces and agencies involved in national supply reduction, these were strengthened through instruments that allowed optimizing the work, highlighting the consolidation of the common information system.

At **International level**, there is a permanent and regular cooperation between security forces and similar organizations in other countries with a responsibility to prevent and combat drug-related crimes. Information-sharing structures between countries have been strengthened through liaison officers who work with similar organizations and training actions were also carried out with counterparts in other countries. Important to mention that Portugal, through the PJ was founder of the Maritime Analysis and Operations Center – Narcotics project (MAOC-N) in 2007 and currently holds the presidency. In terms of international cooperation, the work carried out by the OPC was marked by the change in cocaine transit routes by sea, through the decrease in the use of national territory as a transit platform.

However, evaluating the articulation and coordination mechanisms established for the fight against drug-related crime was a difficult task given the lack of a common conceptual framework on drug-related crimes, due to the sensitive nature and confidentiality of this kind of information.

In terms of quality, we highlighted the formalization in 2008 of a protocol concerning the competences of criminal investigation of drug trafficking within the framework of Common Intervention Coordination Units (UCIC) and the developed training activities involving the intersection of various security forces / organisms with responsibilities in this field. During the strategic cycle being evaluated, training actions were performed by the PJ to other OPC elements and security forces from other countries (Cape Verde and Brazil).

In terms of increasing the security of the population by reducing the small drug-related crime, it was identified some relevant measures. An example is the outreach work to the population obtained through programs such as Escola Segura. As part of this, in the 2010/2011 school year awareness-raising actions were performed in 43% of public and private educational establishments nationwide through action taken by the National Republican Guard (GNR) and 22% by the Public Security Police (PSP) (ad-hoc information provided by the GNR and PSP). In school year 2010/2011 both entities have intensified awareness

actions in relation to the school year 2005/2006. These actions focus on, among others, the issue of alcohol and drugs. It is worth noting that this program focused on young people, with greater exposure to the adoption of marginal behaviors.

For the prevention of small crimes there is also the availability of alternatives to replace opiate dependence treatment or risk and harm reduction services (IDT,I.P.: 2005-2011)). Several studies elaborated in Europe (Killias, Ribeaud, Aebi: 2006 y Uchtenhagen, Dobler Mikola, Steffen, Gutzwiller, Blater y Pfeifer: 1999 *in* Lobbman, R. y Verhein, U: 2008) have focused on the relationship between the reduction of crimes and the inclusion of consumers in PSO-BLE. Although empirically there is a realization on the part of experts, security forces and the community in general that the inclusion of problematic users in Opium-Substitution Programs (PSO), and fundamentally in PSO-BLE in the case of the most excluded ones, can have an effect on crime prevention, it is however not possible to assert the existence of a linear causality between them and a drug-related crime reduction.

In relation to seizures and arrests due to drug trafficking, it cannot be established any linear relationship between the volume of drug seized, number of seizures or number of detainees and the intensity and resources allocated to operations / investigations every year. Between 2005 and 2011 there has been a constant number of seizures and of the amount of drugs seized, with the exception of 2005 when was seized the largest quantity in grams and in units of all drugs under assessment, which according to the information obtained with the PJ supervisors in this field, made 2005 a particular year in terms of seizures.

4.7 Strategic Reorientations

The PNCDT contemplated the strategic reorientation of the Focus on the Individual, Territoriality and Integrated Approaches and Responses. The elements presented above show the results in terms of orientation responses for the citizen and not for the substance. In doing so, it was important to create proximity (territoriality) and integrated responses, relying on two dimensions of work:

Internal Strategic Reorientations, by incorporating all vectors of demand reduction in the proper response devices of the IDT, I.P. (CRI) and the creation or review of programs or integrated response plans at the expense of previously existing partial or sectorial response. The constitution of CRI allowed:

- **Local Availability in public integrated responses between different mission areas**, with the aim of improving articulation, defining roles and responsibilities of various professionals that constitute the creation of mechanisms and indicators for monitoring the activity. The number of CRIs formed, and at present is of 22;

- **Providing diversified services to integrate the four vectors in the area of demand reduction**: appointments (General Practice, Psychiatry, Psychotherapy), Treatment Programs for Opioid Agonist, Risk and Harm Reduction Programs, Programs for Social Reintegration, Training Actions

Results 4.7 Strategic Reorientations

and Research Projects. It was given importance to the development of actions in order to implement and / or improve specific programs in a vertical record (referral network) and horizontal record (joints of different vectors) for groups with special needs: pregnant women and newborns, children, prisoners and ex-offenders; groups suffering from physical (infectious), psychological or social (exclusion) comorbility;

- **Ensure the integration of activities developed by CRI with other structures in its area of influence**, at the level of diagnosis and response planning coordination and monitoring of projects, plans and programs, while promoting their complementarity.

In the opinion of the Regional Delegates and representatives from Territory Support Nucleus (NAT), the integrated approach enabled an improvement of the results in terms of health by allowing an intervention that meets the needs of each individual and to ensure continuity of interventions in terms of reducing risks, treatment, harm minimization and integration into society.

External Strategic Reorientations, which consisted of: the creation and consolidation of partnerships, the creation of protocols with other services, by defining guidelines for articulation; promotion of mechanisms for coordination and management of partnerships at local, regional and national level and in redesigning and setting pivot areas that have not been or are specifically not under the responsibility of the IDT, I.P. One of the key measures on this level was the development and implementation of PORI, which generated a great consensus among respondents and members of the technical group performed relative to its pertinence, relevance and quality.

Under the PORI, diagnoses were made in 92 territories (IDT, I.P.: 2007) intending to fill up lacunars areas (125 in 2008 and more 45 areas in 2009 (IDT, I.P.: 2008 and 2009)) identified in four areas of intervention: Prevention (52 in 2008 and 24 in 2009), Risk and Harm Reduction (32 in 2008 and 7 in 2009), Treatment (3 in 2008) and Reintegration (38 in 2008 and 14 in 2009). The PORI settled on four strategic principles: Partnership; Territoriality; Integration and Participation. The amount budgeted for PORI (2008-2012) was 17,118,469.45 €, an average annual cost of 23 Euros per person in the Prevention vector, 52 Euros in Risk and Harm Reduction, 238 Euros in Treatment and 275 Euros in Rehabilitation (*ad-hoc* information provided by IDT, I.P.). Based on the identification of priority areas, and in the definition of the existing lacunars areas, applications were launched for the PRI (Program of Integrated Responses) and 146 projects have been approved (IDT, I.P.: 2009) in the four areas of intervention: Prevention (68); Risk and Harm Reduction (34); Treatment (3) and Reintegration (41) (IDT, I.P.: 2010). The average number of PRI in operation during the years of the PORI implementation was 81 (IDT, I.P.: 2008-2011). It should be noted that in some of the territories identified as priorities, it was found that there was no need for additional funding but just a reorganization of existing interventions in order to maximise the resources available. Therefore some PRI did not resulted in new tender proceedings and allocated direct funding, but in the reorganization of existing interventions and defining an action plan made by the IDT, I.P. in conjunction with entities of those territories.

In all territories with PRI, a Territorial Nucleus (NT) was constituted as a key structure in the integration

of approaches between local actors as they develop their action in other areas. The operation provides coherence to the intervention and enables the analysis, monitoring and evaluation of the nature and evolution of local intervention in the area of the use / abuse of psychoactive substances.

The PORI introduces, by the PRI, a reorientation of the paradigm of intervention operability by creating comprehensive response devices, representing a network of coherent action to deal with the complexity and transversality of drug problems and related issues. The evaluation results corroborate that the integrated strategy is more cost-effective than the pulverized response. From the analysis of the interventions included in the PRI under PORI, the cost-benefit of the plan is positive, because of the avoided social costs, such as in education, health, labor productivity or the national judicial system. Therefore:

- **Prevention**: The savings generated during the period 2009-2011 for the prevention responses within the PRI amounts to EUR 88,829,011.92 (Information *ad-hoc* provided by the IDT, I.P.), which reflects the benefits resulting from the implementation of responses in this vector under the PRI;

- **Risk and Harm Reduction**: the benefit-cost ratio was obtained through the intervention of street teams within the PTS and PSO-BLE, by comparing the performance of street teams under the PRI (2009 to 2011) with those prior to the intervention (2004-2007). According to estimates following the model of Laufer (2001), infections prevented by the action of street teams under the PRI were 71, while in the period before the number was 45 people (estimates with data from the IDT, I.P.). So there was a higher savings in the first (difference of 2,541 million Euros) (estimates with data from the IDT, IP). The benefit-cost ratio corroborated the best result of the interventions of street teams within the PRI since it is lower than the ratio found for the intervention prior to the PRI (1.52 to 3.41, respectively (estimates with data from the IDT , I.P.));

- **Treatment**: among the responses of individuals in treatment covered under the PRI are heroin users, many of whom had intravenous consumption. According to the literature, although the relationship between drug abuse and crime is not causal, it appears that there is a high probability of committing a crime during life. The result shows that between 2009 and 2011, responses under the PRI are cost-effective and cost-beneficial, since the avoided costs as a result of the responses (measurement of costs saved by the crimes avoided) are much higher than those incurred (37,393,293.5 Euros compared to 385,606.55 Euros, respectively), with a cost-benefit ratio of 96.97 (estimates with data from the IDT, I.P.);

- **Reintegration**: this vector considered the number of people reinserted, understood as the incorporation or reintegration into the labor market, as well as the economic value that is imposed upon society. Results showed that the responses of reintegration within the PRI are cost-effective, since the cost per person reinserted (cost-effectiveness) is lower than the productivity gain per person reinserted. Regarding cost-effectiveness, this is more than 1 throughout the study period (2009 to 2011) and those benefits outweigh the costs of interventions (6,202,200.43 Euros to 2,233,663.57 Euros, respectively (estimates based on data from IDT, I.P.)).

Results 4.7 Strategic Reorientations

Strategic reorientations of the focus on the individual, integrated approaches and territoriality provided a clear improvement on: accessibility of individuals to interventions, by improving the ability to track an individual throughout their life course; coverage of the population in need of intervention and effectiveness of the interventions for achieving the desired results.

The implementation of PNCDT also allowed the achieving of objectives related to strategic reorientation – quality improvement and certification mechanisms, namely:

- **Diagnosis, Monitoring and Evaluation**: the implementation of PNCDT is based on performing diagnostics prior to the implementation of responses and solutions (e.g. PORI) and intervention (e.g., multidimensional diagnosis of individual needs). As part of monitoring, systems report have been optimized or created (e.g. SIM, etc.) and, concerning evaluation, professional satisfaction is inferred through satisfaction surveys used in training activities. The claims made by users of the Services Specialized Units (IDT, I.P.: 2008) under the yellow book, are currently handled through a database created for this purpose;

- **Technical Guidelines prepared for the Definition and Standardization of Good Practices**: under PNCDT was created a vast work of drafting technical guidelines and manuals of procedures based on best practices, which aim to create a conceptual and practical framework allowing the harmonization of the intervention;

- **Licensing and Inspection of Structures, Programs and Projects**: during the strategic cycle of PNCDT, the performance of IDT, I.P. was intensified, in relation to the licensing and inspection of units, including the overcoming of the goals set for the cycle and increased supervision of private institutions along with the development of new instruments of work (updated scripts of inspections and / or surveys);

- **Certification / Accreditation**: In 2009, it is of note the effort for the development of a certification model for projects of Risk and Harm Reduction and in the Treatment vector stands out the achieving of Quality Management System certification according to NP EN ISO 9001:2008 of two CTs (IDT, I.P.: 2009) which were the target of UKAS and IPAC, I.P. (Portuguese Institute for Accreditation, Public Institute) accreditation entities in 2010. It was also obtained in 2010 the certification of Quality Management System in two other units - by Lloyd's Register Quality Assurance (LRQA), according to NP EN ISO 9001:2008 (IDT, I.P.: 2010). Four units were also accredited by IPAC, I.P., that previously had been subject to certification by ISO 9001:2008 (IDT, I.P.: 2010);

- **Audits**: The IDT I.P. performs audits of various projects and co-financed interventions. In 2009, an audit plan was drafted and 14 technical and financial audits were carried out, 4 to PIF and 10 to projects in different mission areas that integrate the PRI of the different mission areas developed under the PORI (IDT, I.P.: 2009), and having overcome the goals defined in the Framework for Assessment and Accountability (QUAR). In 2010, 8 audits were conducted of projects under the PRI.

The 9th scheduled audit was conducted in early 2011;

- **Training**: The IDT, I.P. receives the status of training entity of Public Health Services accredited to conduct training. In this sense, every project developing official training is certified and becomes the target of a process of evaluation and monitoring. In 2005, about 60% of professionals had participated in training activities and in 2011 there were 35% (Information ad-hoc provided by IDT, I.P.). Furthermore, of the 100% of actions undertaken there were selection criteria of participants through the development of needs training diagnosis and of the annual training plan. From 2009 onward, under the training field, manuals were elaborated describing the formal procedures for dealing with incidents, complaints and suggestions;

- **Research**: between 2005 and 2011 the area of research played an important role in the collection, analysis and consolidation of national data contributing to the quality and coordination of interventions and technical rigor. This effort was performed at the level of national and European projects. Between 2005 and 2010, three numbers of the Drug Addiction Journal (*Revista Toxicodependências*), were annually published. About 60 authors and co-authors participated in articles focused on drug addiction.

4.8 Coordination

Coordination is listed in the PNCDT as a cross-sectional area and addresses four major areas: on a **interministerial level**, it highlights the functioning of the National Coordination for Drug Problems, Drug Addiction and the Harmful Use of Alcohol that is assumed as the coordination structure and articulation between various government departments involved in these problems; at the level of **external coordination**, interviewed members of partner organizations stressed the creation of partnerships as the second strong point obtained with the implementation of PNCDT; the level of **internal coordination** has complied with the procedure regarding the reorganization of functions of their professional skills and their Departments (at the level of central services), of DR (regional) and Specialized Units (locally, through the creation of CRI) and, in relation to **coordination with other structures** of the MS, were formalized referral networks in order to assure citizens to address their multidimensional needs (e.g. ADR methodology).

4.9 Impact Evaluation

The impact evaluation was based on the comparison of the epidemiological and response indicators in Portugal with two other countries to choose from a set of countries mention in technical specifications document[6]. We opted to select Spain and Norway, and included in the analysis of the following dimensions: i) developments relating to drug consumption and consequences related to that consumption, and ii) the supply of services available that help reducing the consequences.

In the area of drug policy, national objectives are in line with European objectives, but there is one specific characteristic: the decriminalization of the consumption, purchase and possession for personal consumption of plants, substances or preparations, not exceeding the amount for individual consumption during 10 days. This decriminalization of consumption represents a paradigm shift, which "replaces" the repressive actions by others such as right to health and social reintegration. We can thus recognize that a humanistic approach, pragmatic and focused on protecting public health is what distinguishes the Portuguese drug policy.

Services Supply:

The comparison between the object of study from the three countries highlighted the following issues:

- The three countries have strategies and action plans which outline the development of responses and services under the drugs and drug addiction scope. All include services in the area of prevention, risk and harm reduction, treatment and reintegration;

- The three countries make interventions in the context of universal prevention, through partnership with the school system, and selective prevention, targeting vulnerable groups or with risk factors;

- The three countries implement comprehensive programs of treatment, including pharmacological, psychological and social approaches, for outpatient and inpatient cases. Portugal and Norway distinguish themselves by the presence of a high coverage of psychosocial services in outpatient, inpatient and detoxification. In Portugal, as in Spain, care for addicts is organized mainly through the public network of treatment services for substance dependence. In all three countries, in addition to public services, there are services contracted with private and Non-Governmental Organizations (NGOs) and protocols between NGOs and other treatment services that ensure wide access to various treatment modalities. The services provided in the public system in all three countries, are free or subsidized and accessible to all users seeking treatment;

[6] Spain, France or Italy and Norway or Switzerland.

- The interventions related to Risk and Harm Reduction are driven by a supply of equivalent services in all three countries. It is important to highlight the values obtained in Portugal, such as the PTS, with one of the most relevant ratios of needles exchanged by users through injected drug worldwide, along with Norway: an average of 199 needles exchanged per user / year in Portugal (variation between 149-298 needles per user / year) and 434 distributed in Norway, varying between 168-1048 (Mathers *et al*: 2010);

- The three countries compared have PSO. The PSO coverage in Portugal in relation to the number of users in treatment whose primary drug is heroin is very high (96% in 2009) compared with Spain (78% in 2008) and Norway 55% (in 2009) (EMCDDA: 2012). Methadone is the replacement drug most often prescribed in Europe, eventually being administered to three-quarters of users. In Portugal, the percentage of users in substitution treatment with methadone is 70% and 56% in Norway. Most PSO users in Spain are under methadone treatment;

- Relatively to the percentage of users in opioid agonist treatment programs in correctional services, this number is lower in Norway (5.09% of the total prison population) than in Portugal and Spain, with coverage rates of 6.14% and 11.72%[7] (EMCDDA: 2012) of the prison population, respectively. The coverage rate of prisoners consuming opiates in Portugal is estimated from the data of Torres, A. (2008) and the IDT, I.P. (2010), at 46%;

- Finally, with regard to the relationship between services, Portugal is among the six European countries that have structured protocols for interagency coordination (EMCDDA: 2011). In other countries, partnerships are mainly based on informal networks.

Characterization of users: in 2010 users that initiated treatment in Portugal had an average age of 38 years, positioning Portugal among the countries with the oldest users, jointly with Netherlands, Italy and Spain, where the average age is 34 years, according to 2008 data (IDT, I.P.: 2010; EMCDDA: 2011). The percentage of female users was less than 1/4. Both in Portugal and in Spain 40 to 45% of users were unemployed (*idem*), information that corroborates the importance of working within the vector reinsertion. Special attention should be given to the existence of a percentage of 12% in Portugal (and 14% in Spain) of treatment users who live alone (*ibidem*), and may have special social features needs.

Consumption pattern: In Portugal, the proportion of new users in treatment with intravenous intakes conducted within 30 days prior to the first consultation decreased considerably between 2000 and 2009 (de 36% in 2000 to 10% in 2009), stabilizing from 2010 with a share of 8% (IDT, I.P.: 2011).

Estimates: The estimates of users in treatment indicate a total of 5 users per 1,000 inhabitants aged between 15 and 64 years old in Portugal, in 2011 (38,292 users in total), in Spain (year 2008) 6 users per 1,000 inhabitants (173,092 users) and in Norway, 2 per 1,000 inhabitants in 2009 (5,383 users) (IDT, I.P.: 2011; EMCDDA: 2012).

[7] The percentage is over the total number of the population in prisons.

In Norway, the number of CDI increased until 2001, experiencing a decline until 2003, year when there was stabilization. A 2008 estimate indicates a total of approximately 6,600 to 12,300 problematic users, including those drug injection users and smoking (2.1 to 3.9 problem drug users per 1,000 inhabitants aged 15-64 years) (EMCDDA: 2011). Regarding CDI in Portugal, the number per 1,000 inhabitants aged between 15-64 years is estimated at 1.8 and 2.2 (using a treatment multiplier) and 1.5 and 3.0 (using a mortality multiplier) (EMCDDA: 2012).

In Spain, the number of problematic users in 2008 was estimated (based on the multiplier method) at 1.3 per 1,000 inhabitants aged between 15-64 years, which denotes a decline in the number of new heroin users and problematic cocaine consumers. Portugal held four estimates to calculate the number of problematic consumers using multiplier methods, based on 2005 data. The gap stood at least on 4.3 consumers per 1,000 inhabitants aged 15-64 years (30,833 individuals[8]) and, at most, 7.4 cases[9] per 1,000 inhabitants aged 15-64 years (*idem*).

In terms of population coverage in problematic consumers in Portugal there has been an increase operated by PNCDT in the enlargement of risk and harm reduction responses. Thus, when we added up to the values of 38,292 (IDT, I.P.: 2011) treatment users in 2011 in CRI the users contacted in the context of risk and harm reduction responses (12,550) (idem) and also users in units (from public or contracted) seen at CT, UD and CD (ibidem), we noticed that more than 55,000 users contacted in 2011 with some of the structures. While this result may be inflated, this is a calculation that estimated roughly the level of coverage of problematic users of psychoactive substances reached by existing services, which points to a high degree of coverage.

Consumption Evolution

Regarding the evolution of drug consumption, it should be noted first that, in European terms, we are witnessing the consolidation of some contrasts. Indeed, as stated in the Annual Report 2011 of the EMCDDA "on the one hand, the drug consumption seems relatively stable in Europe. The prevalence levels remain generally high compared to the past, but are not increasing (...), the polydrug use, including the combination of alcohol and illicit drugs, sometimes not controlled drugs and substances, is now the predominant pattern of drug use in Europe "(EMCDDA: 2011).

With regard to the consumption in the Portuguese population (15 to 64 years), it is observed a low prevalence compared to populations from other European countries. During this coming year, the National Survey on Psychoactive Substances Consumption in the General Population will be concluded, which will present the developments that have taken place in recent years in Portugal.

In relation to the young adult population from 15 to 24 years old, Portugal is the country, among the 27 European Union countries compared in the Eurobarometer (2011), where the population shows ease

[8] Multiplier of proximity teams.

[9] With a broader definition and not limited to a population of regular or long term users, estimated with the help of a treatment multiplier.

access to all the illicit psychoactive substances, with the exception of heroin and cocaine, and cannabis being the substance with greater accessibility. Regarding the consumption in the school-age population (15 to 16 years old) the results obtained, just for Portugal, in the ESPAD 2007 and 2011 show an increase in the prevalence of consumption of illicit psychoactive substances over life and over last year, contrary to what happened in Spain and Norway, countries in which the consumption decreased and stabilized, respectively. However, it should be noted that the values obtained in 2011 in Portugal with regard to the consumption of psychoactive substances throughout life (19%) are lower than those of the neighbouring country (27%) and equivalent to the average value found in all the countries included in this survey (18%). On the other hand, in Portugal and in Spain, there is a high prevalence, in 2011, of tranquillizers without prescription in this same population (8% and 7% respectively) compared to the European average (4%).

Regarding the **risk of consumption of illegal psychoactive drugs** (Eurobarometer: 2011) perceived by the population aged between 15-24 years surveyed, the results indicate:

- **Regular consumption:** about 90% of respondents across the EU-27 consider that regular consumption of cocaine and ecstasy is highly risky. However, this percentage decreases compared to regular cannabis use (67% and 64% in EU-27 and Portugal, respectively);

- **Occasional Consumption**: the perceptions of respondents in Portugal of risk related to consumption of cocaine, ecstasy and cannabis are similar to those obtained in the average EU-27 countries. Spain stands out for a higher percentage of respondents who perceive the occasional use as less risky than its European counterparts.

Regarding the sources of information to which young people use to obtain information about illicit substances, most respondents stated that the first search option for information is the Internet (73% in Portugal and 64% in Spain) (idem). In Portugal, the demand from peers (41% of responses) and family (33%) would be choice number 2 and 3, respectively (*ibidem*).

With respect to prison:

- the prevalence of consumption in the prison population indicates that 63.6% of prisoners surveyed in 2007 report having used drugs at least once in their lives (Torres et al: 2008);

- the **prevalence of consumption in prisons declared by prisoners**, indicates that there are higher percentages of consumption in Portuguese prisons than in Spanish ones in relation to all illegal drugs, particularly in the case of cocaine (9.9% and 3% respectively (EMCDDA: 2012)) and heroin (13.4% and 5% respectively (idem)). However, between 2001 and 2007 in Portugal there was a strong decrease in the prevalence of consumption of all these substances (Torres *et al*: 2008).

Health Consequences

The main indicators observed in the study show that:

- **Number of HIV diagnoses among CDI**: Portugal has submitted, along with Spain, a continuous decrease. In 2010 the value in Portugal was between 1-3 cases per 100,000 HIV attributable to CDI (Wiessing *et al.*: 2011), a higher percentage than that observed in Spain and Norway (0.2 to 1 cases per 100,000 population) (*idem*);

- **HIV Prevalence**: In Portugal the ratio of CDI receiving antiretroviral treatment stands at 10 per 100 CDI with HIV (*ibidem*), Spain and Norway in 63 and 32, respectively (*ibidem*). The prevalence of HIV in CDI in public UD in Portugal decreased between 2004 and 2011 (from 19.1% to 17.5%, respectively) (Information ad-hoc provided by the IDT, I.P.);

- **Prevalence of Hepatitis C in CDIs**: it appears that the infection caused by the Hepatitis C virus (VHC) has a high prevalence throughout Europe. In Portugal there was stagnation in prevalence in CDI seen at public UD during this strategic cycle: 85.1% in 2004 to 84.3% in 2011 (*ad-hoc* information provided by the IDT, I.P.). In Norway, 85.4% of reported cases of infection by Hepatitis C in CDI were caused by needle exchange (EMCDDA: 2012);

- **Prevalence of Hepatitis B in CDI attended in public UD**, in Portugal, there was a marked decrease in this strategic cycle: 4.9% in 2004 to 1.9% in 2011 (ad-hoc information provided by the IDT, I.P.). The prevalence of Hepatitis B in Norway in CDI was 2.9% in 2002, 0.8% in 2005 and 0% in 2009 (EMCDDA: 2012);

- As for **Tuberculosis**, Portugal has a rate of 28.7 cases per 100,000 inhabitants (EMCDDA: 2011). In Europe, Portugal is one of the countries where there are higher rates of active tuberculosis among drug users in treatment (1% -2%) (idem).

The PSO and PTS are the most effective measures in preventing the spread of infectious diseases among CDIs. In Europe, it is estimated that one in every two opium consumers is in PSO. These programs, together with antiretroviral treatment and the application of measures such as addiction treatment and distribution of condoms to reduce the risk of infection through sexual activity are interventions that, when performed simultaneously, can maximize the impact of the decrease in contagion and damage reduction. We observed that Portugal stands out for its high degree of coverage of PTS between the consumer population and also of PSO (in Portugal the number of people included in these programs is between 81-162 per 100 CDI, with an average of 108, compared to 85 in Spain and 36 in Norway (Mathers et al.: 2010)), a factor that may explain the trend observed in our country, of a large decrease in the number of cases of HIV infection in drug users.

Regarding **deaths related to drug use** in the countries under review, there are several sources of information. In Portugal these sources come from the General Registers of Deaths in the National Statistics Institute (INE) and the INML, I.P. Data from the Special Registration INML, I.P. is since 2008 in accordance with the definition proposed by the EMCDDA. In 2011 there were 19 deaths by overdose

and 138 deaths with positive toxicology results (Information ad-hoc provided by the IDT, I.P.).

From the results presented and in relation with Portugal, the following elements can be highlighted:
i) Portugal has a distinctive feature in its drug policy, based on the decriminalization of drug possession for consumption, until recently unparalleled in Europe, embedded on the decriminalization of the consumption, purchase and possession for personal consumption of plants, substances or preparations defined in the law n.°30/2000 from November 29th, not exceeding the amount for individual consumption during 10 days and the constitution of a network of resources within the deterrence; ii) the effectiveness and the benefits, achieved through an integrated approach to intervention between the various vectors and coverage obtained from the addicts linked to specialized structures within the addiction, by expanding the risk and harm responses; iii) high coverage provided by Portugal in the PTS and PSO and decreasing, in recent years, the incidence of infectious diseases (HIV) among consumers. However, despite the decline seen in the last decade, Portugal still has a high incidence of HIV / AIDS among consumers when compared with other countries in Europe.

5. General Conclusions

The PNCDT defined a policy against drugs nationwide between 2005 and 2012, providing continuity of the political structuring principles previously embodied by ENLCD.

The assessment presented allows to conclude that the objectives in terms of reducing the demand and supply have been achieved as a whole, highlighting the results achieved in terms of creating a global network of integrated and proximity responses, which offers a diverse range of interventions to meet the diagnosed needs of individuals and based on scientific evidence. We also highlight the enhancement of coordination at the political and technical levels in the country, with results in terms of improved coordination and cooperation between actors and the inclusion of new partners that operate coherently. Finally, it is noted the strengthening of a culture of registration, monitoring and evaluation of interventions and the introduction of best practice guidelines.

The development of interventions under PNCDT allowed obtaining in 2012 a network of responses and actors that make up a system:

- **Which places the individual at the Center of assistance;**
- **Which is comprehensive and integrated** between different sectors and levels of intervention, ensuring a continuous and consistent intervention;
- **Which is founded on respect for human rights**, not stigmatizing and marginalizing consumers but supporting them and encouraging their participation in interrupting the escalation to problematic consumption of illegal drugs and the reduction of risk practices;
- **Which prioritizes health gains**, both individual and public. Although Portugal has implemented strategies of risk and harm reduction 10 to 15 years after the phenomenon of heroin emerged, the intense work has allowed achieving very positive results in terms of reducing the spread of infectious diseases;
- Which initiated interventions to **increase the safety of individuals and the population** by preventing and combating small-scale crimes and organized crimes;
- Which places relevant importance in the **planning** and allocation of resources based on identified needs and resources in areas with insufficient intervention;
- Which diversified **models and areas of intervention** (e.g., intervention in the workplace, specific groups);
- Which places **relevant emphasis on strengthening coordination and cooperation at the intra and interinstitutional** levels and promoted the networking of local actors, encouraging the pooling of efforts from the macro to the micro level in order to obtain the targeted results defined by the PNCDT;

- Which places efforts focused on implementing a **culture of registration, monitoring and evaluation of results**;
- Which constitutes the basis for a global management system based on **quality**;
- Which promotes continuous **training and research**.

The PNCDT intends, in the spirit of ENLCD, to focus their priorities, by keeping their guiding principles. It places important relevance on a strategic reorientation in mission areas (Demand Reduction and Supply Reduction) in order to optimize the results in terms of health gains. The evaluation results showed that the implementation of the PNCDT addressed the main recommendations of the external evaluation of ENLCD.

6. General Recommendations

The next strategic cycle should consolidate the work done over the past few years, which, as noted throughout this review, was consolidated in the improvement of key indicators related to reducing demand and supply of psychoactive substances.

Among the biggest challenges of the future strategic cycle, due to the current economic circumstances and given the organic changes observed in the current year, is the ability to ensure the results obtained are sustainable in the future. Therefore, the next strategic cycle should strengthen the effectiveness, efficiency and quality achieved in terms of planning, development and evaluation of interventions preventing backlash in relation to overall situation reached and described in this assessment.

Extending the range of intervention to the area of addictive behaviors and dependencies is a relevant strategic option that should be reflected in the adequacy of responses to address the issue. In this sense, it is very important to enhance the role of national strategy and coordination in the planning and operation of assistance and know-how acquired by professionals and institutions in these matters.

The recommendations, listed below, are based on the results obtained in this review which concluded that the design of the PNCDT was adequate to face the existing problem and that its implementation responded to most of the goals set. So, the next strategic cycle should enable in a global way, the continuation and deepening of the work developed.

General Recommendations

The main general recommendations are based on strategies that ensure:

1) Maintaining coordination at national level, within the politics of psychoactive substances and alcohol and respective developments for coordination of addictive behaviors and dependencies;

2) The proper planning of interventions based on the periodic update of the diagnostic needs in a harmonized and shared manner at regional and local levels, taking into account the expansion of the object for intervention in addictive behaviors and dependencies;

3) The existence of a supply and diversified portfolio of services, adapted to the introduction of other addictive behaviors and dependencies, ensuring the consistency of interventions and equity in the access to answers in the national territory;

4) The consolidation of the monitoring system, monitoring and evaluation of interventions, stabilizing indicators and optimizing systems for recording and reporting;

5) The momentum of a comprehensive model of quality management of the interventions, programs and projects;

6) The maintenance strategies of cooperation and coordination at national and international levels;

7) The promotion of actions for research, training and information / awareness of professionals, with special focus on professionals not specialized in dealing with addictive behaviors and dependencies;

8) The development of a communication area at national and international levels on Portuguese policy and experience in addictions and addictive behaviors, enhancing the dissemination of good practices and results;

9) Adequate funding.

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8. List of Abbreviations

ADR	- Advice, Diagnosis and Referral
CD	- Day Center(s)
CDI	- Injected Drug Users
CDT	- Drug Addiction Dissuasion Commission
Copos	- Copos, quem decide és tu
CRI	- Integrated Reponses Centers
CT	- Therapeutic Community
DR	- Regional Delegation(s)
EEOO	- Eu e os outros
EMCDDA	- European Monitoring Centre for Drugs and Drug Addiction
ENLCD	- National Strategy for the Fight Against Drugs
ESPAD	- The European School survey Project on Alcohol and other Drugs
EURIDICE	- European Research and Intervention on Dependency and Diversity in Companies and Employment
GNR	- National Republican Guards
HIV	- Human Immunodeficiency Virus
IDT, I.P.	- Institute for Drugs and Drug Addiction, Public Institute
IEFP, I.P.	- Employment and Professional Training Institute , Public Institute
INA	- National Institute for Public Administration
INE	- National Statistics Institute
INML,I.P.	- National Institute for Forensic Medicine, Public Institute
IPAC, I.P.	- Portuguese Institute for Accreditation, Public Institute
IPSS	- Private Charity Institution(s)
MAOC-N	- Maritime Analysis and Operations Center - Narcotics
MIR	- Reintegration Intervention Model
MS	- Ministry of Health

List of Abbreviations

NAT	- Territory Support Nucleus
NGO	- Non-Governmental Organization(s)
NT	- Territorial Nucleus
OPC	- Criminal Police Organisms
PCI	- Contact and Information Points
PETS	- Syringe Exchange Experimental Program
PIF	- Program of Focused Intervention
PII	- Insertion Individual Plan
PJ	- Judicial Police
PNCDT	- National Plan Against Drugs and Drug Addictions 2005-2012
PORI	- Operational Plan of Integrated Responses
PRI	- Program(s) of Integrated Responses
PSO	- Opium Substitutions Programs
PSO-BLE	- Low-Threshold Opium-Substitutions Programs
PSP	- Public Security Police
PTS	- Syringe Exchange Program
PVE	- Program “Vida-Emprego” (Life/Employment)
QUAR	- Framework for Assessment and Accountability
SIADAP	- Integrated System for Performance Assessment in Public Administration
SICAD	- General-Directorate for Intervention on Addictive Behaviors and Dependencies
SIM	- Multidisciplinary Information System
SNIDT	- National Information System on Drugs and Drug Addictions
UA	- Customer Service Units
UCIC	- Common Intervention Coordination Units
UD	- Detoxification Unit(s)
WHO	- World Health Organization

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