

# RAND *Europe*

## **Guidelines for Implementing and Evaluating the Portuguese Drug Strategy**

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## Preface

Drug addiction is a problem of increasing incidence and seriousness all over the world. Governments increasingly realize that treating the drug consumer as a criminal will help neither society nor the consumer, and that new approaches to the drug problem are needed. Portugal is one of the countries that recently introduced a new drug policy, as first described in the Portuguese Drug Strategy (Government of Portugal, 2000). The present report describes the characteristics of the Portuguese Drug Strategy and discusses the possibilities and pitfalls of its implementation and evaluation.

This study was initiated by the Luso-American Foundation (abbreviated FLA for its name in Portuguese) and the Association for Innovative Cooperation in Europe (AICE) who commissioned RAND Europe and Prof.dr. Alexandre Quintanilha, former president of the Committee on National Drug Strategy, to conduct a study about the Portuguese Drug Strategy. Professor Quintanilha assembled a panel of Portuguese experts on drug use, which met with the RAND Europe team four times during the course of the project. The members of this Project Panel completed and discussed qualitative and quantitative questionnaires, discussed the findings of the interviews as RAND Europe presented them, and commented extensively on interim and final project efforts. The following persons were members of the Project Panel<sup>1</sup>:

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<sup>1</sup> Members of the Project Panel participated as private persons; affiliations are mentioned for identification purposes only.

This report may be of interest to anybody who is involved in or concerned with drug policy. The report is first and foremost meant to support Portuguese policy makers in taking well-considered decisions with respect to the Portuguese drug policy. However, the report might also be of interest to drug policy makers outside Portugal as it will increase their understanding of the Portuguese Drug Strategy and the drug policy in their own country. Finally, people with an interest in drug policy will find that this report enhances their understanding of the way the drug problem is approached in Portugal and other European countries.

Rui Chancerelle de Machete,  
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*Guidelines for Implementing and Evaluating the Portuguese Drug Strategy* discusses the characteristics of the Portuguese Drug Strategy focusing on the possibilities and pitfalls of its implementation and evaluation. The purpose of this study is to discuss (a) how to implement the Portuguese Drug Strategy in such a way that it serves the Strategy's overall goals, and (b) how to evaluate the effects of implementation of the Strategy.

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The authors also thank all interviewees for sharing their time and experience. Without their support and expertise, we would not have been able to complete this project successfully. The names of the interviewees can be found in Annex A. We also thank RAND colleague Elizabeth Rolph for a helpful and constructive critique of an earlier draft of this report.

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## Executive summary

### Background

Portugal recently changed its drug policy by adopting a strategy based upon a series of principles to contain and reduce the negative effects of substance abuse. The flagship of this strategy is the decriminalization of consumption of all types of drugs and possession of these drugs for personal use. The strategy has begun to be implemented through a series of laws and administrative decisions, of which the decriminalization law took effect on 1 July 2001. Other laws address harm reduction and risk reduction; ones on prevention and rehabilitation are in process as of this writing (February 2002). All are being implemented under a National Action Plan (*Plano de acção nacional de luta contra a droga e a toxicodependência – Horizonte 2004*).

The objective of the current study is to analyze the new Portuguese Drug Strategy and to develop recommendations for its implementation and evaluation. To do this, we examined the history of Portuguese society and its drug problem over the past 75 years, looked in detail at the strategy, proposed laws and action plans, and examined it in light of the existing literature on drugs and drug abuse. In addition, we obtained opinions from leaders in all areas of the Portuguese approach to drugs and drug abuse.

RAND Europe worked closely with a Project Panel of experts, many of whom have been central to the development of the new strategy.

The main question addressed in this project is: **Which parts of the National Drug Strategy deserve priority in its implementation and how should the effects of implementation of the Strategy be evaluated?** This was divided into three subquestions:

- **What are the objectives of the National Drug Strategy?** The precise aims of the National Drug Strategy have to be defined very clearly in order to determine how to implement and evaluate the Strategy.
- **What are the most appropriate ways of prioritizing the individual components of the National Drug Strategy?** The term components refers to the thirteen strategic options formulated in the Portuguese Drug Strategy. If these options are to serve the overall goals of the Drug Strategy, it needs to be determined how the options ought to be brought into practice in the short and medium term. In practice, we concentrated on the seven of these

components that the Project Panel believed to be most important, namely: international cooperation, decriminalization of drug consumption, primary prevention, a health care network for drug addicts, harm reduction, reintegration initiatives and harm reduction policies in prisons.

- **How can the real effects of the National Drug Strategy be assessed?**

The project addressed how the effects of the National Drug Strategy could be assessed and what data would be needed to make these assessments.

### **Structure of the drug policy environment**

Over the past 75 years, Portugal has moved back and forth in its approach to drugs, starting with legal drug use in the 1920s, shifting to prohibition of drugs use in the 1960s, and followed by a gradual shift towards the legalization end of the continuum, resulting in the current situation of decriminalization of drug consumption. The first law regarding drug use dates from 1926 and was fully prohibitionist. This law continued in force throughout the totalitarian regime that ruled Portugal for over forty years in the middle of the twentieth century. After 1974, as freedom came, the drug phenomenon became more visible: use of cannabis among youth was reported, and prescription drugs were more freely available at pharmacies and frequently abused. In 1976, the first governmental organization dealing with drugs was established, the *Gabinete de Coordenação do Combate à Droga* (Drug Fighting Coordination Office). This office was responsible for data collection and coordination regarding demand reduction and treatment as well as supply reduction. In 1983, a new law suspended punishment for some drug related offences if the offender accepted integration in a treatment program. This was a large change in Portuguese policy regarding drug consumption. Major steps occurred in 1987, with the establishment of *Projecto Vida* (Project Life), a national program against drugs that coordinated prevention, treatment, reinsertion, and supply reduction across six different ministries, and the creation of Portugal's first specialized treatment center for drug addicts.

At the end of the 1980s and in the early 1990s, the negative consequences of drug use became more visible, including increasing criminality, health problems of heroin addicts, and feelings of insecurity among the general population. Although Portugal's drug problem almost certainly worsened during this time, real data on the extent of the problem have remained scarce. Opinions range from 50,000 to 100,000 drug addicts out of a total population of approximately 10 million people. Arrests for drug offenses, the extent of drug treatment, and data on drug seizures suggest an increasing use of heroin. Portugal compares unfavorably with

other harm-reductionist countries in terms of drug-related deaths per capita. By 2000, Portugal was spending over 100 million Euro per year on drugs and drug abuse.

In this period, new institutions aimed at centralizing and coordinating drug policy came. The *Instituto Português da Droga e da Toxicodependência* (IPDT, Portuguese Institute for Drugs and Addiction) was created to replace Projecto Vida. A Coordination Board of the National Strategy and the National Board for Drugs and Drug Addiction were set up to coordinate all policies in the areas of drugs and drug addiction and to advise the Prime Minister, respectively. IPDT is responsible for the coordination of prevention, harm reduction, research, rehabilitation and other activities, and works closely with the agency responsible for treatment. In particular, it coordinates the government implementation of decriminalization.

After a number of measures believed to be largely ineffective were attempted, the government created an elite committee to recommend a new strategy; the result was a report that formed the basis for the National Drug Strategy of the Portuguese government. Within the boundaries set by international conventions on drug policy, Portugal created a set of policy measures based upon the philosophy of harm reduction, referring to activities that reduce harm to the individual drug consumer and society as a whole.

**The new strategy.** The Portuguese Drug Strategy is built on eight "structuring principles," of which two are key--the "humanistic" and "pragmatic" principles that declare that drug users should not be regarded as criminals, but as full members of society, and that the Strategy will not attempt to strive towards an unachievable perfection such as "zero drug use," but will instead try to "make things better" for all segments of society.

The structuring principles were translated into a set of thirteen "strategic options" that form the heart of Portuguese Drug Strategy. These are:

1. international cooperation,
2. decriminalization of the use of drugs,
3. primary prevention,
4. a health care network for drug addicts,
5. harm reduction policies,
6. social and professional reintegration of drug addicts,
7. extension of treatment and harm reduction to prisons,

8. establishment of implementation mechanisms for law enforcement through alternatives of imprisonment,
9. increasing scientific research and training,
10. establishing evaluation methodologies and procedures,
11. simplifying interdepartmental coordination,
12. combating drug trafficking and money laundering, and
13. doubling the public investment in drugs and drug abuse over the next five years.

**Decriminalization.** The law on decriminalization represents a significant deviation from previous law, and is different from efforts in other countries such as Spain and the Netherlands, in that it explicitly separates the drug user from the criminal justice system, stating as basic principle that a drug addict should be considered a patient, not a criminal. Under this law, the use and possession for use of drugs is no longer a criminal offense, but instead is prohibited as an administrative offense. There is no distinction made among different types of drugs, nor whether drug use is in private or in a public place. Decriminalization only refers to possession of drugs for personal use and not to drug trafficking. To deal with administrative offenses, the eighteen administrative districts in Portugal will establish administrative committees that deal with drug users in that district. The administrative committees will generally consist of three people, two people from the medical sector (physicians, psychologists, psychiatrists or social workers) and one person with a legal background. Committee members are not supposed to be involved in drug treatment but should be sufficiently knowledgeable to judge what is best for the user.

In deciding what to do with drug users, administrative committees should consider several criteria, including the severity of the offense, the type of drug used, whether use is in public or private places; if the person is not an addict, whether use is occasional or habitual; the personal and economic/financial circumstances of the user. If the user is an addict, the administrative committee will try to convince him to go into treatment. In this case, the sanction will be postponed and might even be remitted. The administrative committees have a broad range of sanctions available to them, including fines and cessation of public subsidies or allowances, suspension of professional and other licenses, banning visiting certain places or meeting certain people, and confiscation of personal possessions. The administrative committee can demand periodic reporting. However, the administrative committee may not send a user to jail or mandate compulsory treatment; moreover, the consequences of disobedience of committee rulings is unclear.

IPDT is charged with appointing and overseeing the administrative committees, and has organized a training program for administrative committee members, a set of regulations for procedural matters and guidelines on how the administrative committees should deal with specific cases. In addition to the administrative district committees, it has created a central committee that serves as a center of information and advice to the districts. IPDT has also begun designing a database in which information about the individuals brought before the administrative committees, the decisions of the administrative committees, and - to a more limited extent - the consequences of administrative committee actions.

**Other promulgations of the strategy.** In addition to the law on decriminalization, the government has established rules for harm reduction and risk reduction measures. The implementation of prevention, harm reduction, risk reduction and rehabilitation is discussed in a so-called "action plan", which focuses on the period 2001 - 2004. Both the laws and the action plans set frameworks for implementation, rather than obliging anybody to implement them. That is, they are so-called 'enabling laws', because they provide a structure for anybody who wishes to implement the law.

The harm reduction action plan aims to 'create programs and social-sanitary structures to lower the threshold to treatment for drug addicts, as well as structures for prevention, reduction of harms to the individual and to society and reduction of risk behavior by the individual.' The law calls for support and reception centers and shelters for addicts, points of contact, mobile centers, syringe exchange programs and programs of supervised consumption. All programs should be accessible to any drug addict who wishes to use them and ought to be organized by the municipality or the regional authorities.

Rehabilitation is dealt with in the *Plano de ação nacional de luta contra a droga e a toxicodependência - Horizonte 2004*, the national action plan of the fight against drugs and drug addiction - Horizon 2004. In this plan, the government explains what activities should be undertaken in the coming four years and which social actors should be involved. The action plan sets forth concepts for primary prevention in the community, schools, leisure environments, and with youth who dropped out of school. For secondary prevention, the government has a number of measures to stimulate safer consumption and to prevent harms to the individual and his surroundings.

The National Drug Strategy also discusses the fight against illicit drug trafficking and money laundering. Here the responsibility lies with the central government to decrease the supply of illicit drugs by 50% in 2004, to reduce drug-related criminality by 25% in 2004 and to gain access to bank information to reinforce the fight against money laundering. Furthermore, the government will focus on the fight against new synthetic drugs, which are believed to become increasingly important in the near future.

Finally, the government plans to give education and training to all parties involved in implementation of the national action plan, and intends to collect information and conduct evaluations to assess the consequences of the new policy. However, the discussion on evaluation is quite sketchy, with little elaboration of what kind, when and how evaluations should take place, nor who should do them.

**Implementation of the Portuguese Drug Strategy.** The members of the Project Panel and the interviewees were asked for their expectations of the effect of the Portuguese Drug Strategy, especially on the consequences of decriminalization. Although almost everybody favored decriminalization in principle, some cast doubts about the way the law would be implemented, how the administrative committees would behave, and whether drug users would perceive the changes in terms of an improvement in their own lives. The wide range of potential ways of implementing the law and the great need for coordination among agencies was viewed as problematic. Decriminalization was not expected to increase the amount of drugs available or the use of new types of drugs, but it would increase the need for prevention. Some believed that there might be an increase in the number of people experimenting with drugs. One likely positive effect of the new policy was that there would be less stigmatization of drug consumers, which would eventually make it easier for recovered addicts to reintegrate into society.

It was expected that there would be an increase in the number of people in treatment, but also that the type of patients would change. Some interviewees were also concerned about the question whether the modes of treatment currently used in Portugal were the right ones to meet the anticipated need for treatment. It was expected that at least part of the addicts referred to treatment by the administrative committees would not be as motivated for treatment as those who enter voluntarily.

**Prioritizing implementation activities and budgets.** We asked the panel members to indicate for the different fields of the Drug Strategy what specific policy measures would be needed to make the policy a success. Their answers are summarized in Table S-1.

**Table S-1: Implementation priorities**

<b>Prevention:</b>	<ul style="list-style-type: none"> <li>- training of technicians for primary prevention</li> <li>- training of professionals for direct intervention in primary prevention</li> <li>- prevention in schools and in the workplace</li> <li>- better support of the administrative committees in the municipalities</li> <li>- evaluation</li> </ul>
<b>Treatment:</b>	<ul style="list-style-type: none"> <li>- low-threshold treatment facilities</li> <li>- completing the national coverage with CATs</li> <li>- reinforcement of the CATs in Porto, Setubal and Lisboa</li> <li>- substitution programs</li> <li>- training of health professionals</li> <li>- programs of integrated treatment (for example, addiction and HIV or Tuberculosis)</li> <li>- evaluation</li> </ul>
<b>Rehabilitation:</b>	<ul style="list-style-type: none"> <li>- creation of so-called "halfway houses"</li> <li>- professional development programs</li> <li>- evaluation</li> </ul>
<b>Harm reduction:</b>	<ul style="list-style-type: none"> <li>- general reinforcement of harm reduction activities</li> <li>- increase of the number of drug-free units in prisons</li> <li>- reinforcement of low-threshold programs, including health vigilance and substitution programs</li> <li>- expansion of syringe exchange programs</li> <li>- shelters</li> <li>- support centers</li> <li>- evaluation</li> </ul>
<b>Prisons:</b>	<ul style="list-style-type: none"> <li>- treatment of addicted prisoners, specifically detoxification</li> <li>- drug-free wings</li> <li>- treatment with antagonists</li> <li>- co-operation with therapeutic communities</li> <li>- harm reduction activities, including syringe exchange</li> </ul>
<b>Justice and police:</b>	<ul style="list-style-type: none"> <li>- the war on the traffic of drugs</li> <li>- coordination between the Justice and Health departments</li> <li>- coordination between police and health professionals</li> </ul>
<b>Research:</b>	<ul style="list-style-type: none"> <li>- epidemiological studies</li> <li>- prevention studies</li> <li>- treatment effectiveness studies</li> </ul>

We also asked if there was anything that is currently done that has become redundant. The panel members stated that proportionally less money should be spent on prevention campaigns since their efficacy is controversial. Furthermore, they said that treatment centers that deliver poor quality care should be closed.

The government has announced that it will increase its budget for drug policy by 10% annually between 2000 and 2005. We asked the Project Panel how they would allocate the budget available for drug policy in 2005. Each of the panel members initially allocated the budget as he or she believed advisable. Then the results of the individual work were discussed in the panel. The panel proposed the following changes to the budget as compared to the budget for the year 2000 (Table S-2):

**Table S-2: Budgetary priorities**

(numbers are averages of the amounts given by the panel members)

<b>Subject</b>	<b>Budget 2000 (MEuro)</b>	<b>Budget 2005 (MEuro)</b>	<b>Net increase (SD)</b>	<b>Percentage change</b>
Prevention	24.2	33.33	9.1 (4.1)	+37.7%
Treatment	29.3	35.33	6.0 (4.9)	+20.6%
Rehabilitation	15.2	25.83	10.6 (4.9)	+70.0%
Harm reduction	4.6	16.00	11.4 (6.3)	+247.8%
Prisons	3.4	10.33	6.9 (2.6)	+203.9%
Law enforcement	24	21.17	-2.8 (6.4)	-11.8%
Research	2.1	6.83	4.7 (2.5)	+225.4%
International cooperation	0.9	1.83	0.9 (1.6)	+103.7%
<b>Total</b>	<b>103.7</b>	<b>150.67</b>	<b>47</b>	<b>+45.3%</b>

**How to implement the strategy.** A short-term increase of treatment capacity was considered crucial. Fast responses are needed to make decriminalization work and to maintain public support for the new policy. Treatment and harm reduction measures in prisons, such as a syringe exchange, are considered high priority. Training of the members of the administrative committees that deal with users is crucial to ensure comparability of sanctions among different regions. Furthermore, better cooperation between the involved parties – police, treatment centers, prevention institutions, justice department, medical sector, municipalities – is necessary to make a comprehensive approach to the drug problem possible. This comprehensiveness includes an international fight against drug trafficking.

In the field of prevention and harm reduction, several accompanying measures were mentioned, including information campaigns for the general public, prevention programs targeted at very young people, additional harm reduction programs such as methadone maintenance and shooting rooms, and improvements in primary prevention in general. These were all thought of as reinforcing the overall strategy, in part to prevent decriminalization from dominating the entire policy arena.

**Evaluation of the Portuguese Drug Strategy.** Evaluation is explicitly included as part of the guidelines for implementing the Portuguese strategy, but details of that implementation are lacking. Therefore, the project constructed an evaluation design tailored to the particular features of the Portuguese situation, and consistent with measures used throughout Europe by, for example, the European Monitoring Centre for Drugs and Drug Abuse. In that design, the structure, process, and outcome of programs were taken into consideration, quantitative and qualitative methods were employed as needed, and ex-ante and ex-post measures were also recommended. The key questions addressed were:

- What do we want to evaluate? The object of evaluation determines the method of evaluation and the type of data needed.
- When do we want to evaluate? An implementation process could and probably should be evaluated within the first year or two of implementation, in order to enable policy makers to adjust the policy. But the effects of a policy are felt later.
- How do we want to evaluate? The object of evaluation determines the methodology needed to usefully assess its effectiveness.
- Who should conduct the evaluation?
- How much money do we want to spend on it?

The responses of the Project Panel and interviewees to these questions led directly to the details of the design and the overall findings of the project.

## **Findings and recommendations**

**1. The Drug Strategy's objectives are rather abstract and subject to diverse interpretations.** As the objectives of the Portuguese Drug Strategy are stated in a vague and abstract way, it becomes very difficult to determine whether the efforts to combat the drug problem are worthwhile. We believe that the objectives of the Strategy should be specified in order to measure whether specific policy measures, such as changing the law or spending additional budget on prevention, have indeed led to the intended results. Instead of reducing the use of drugs, the objective should, for example, be a reduction in the number of drug users by 20% over five years. By stating specific objectives, it becomes easier to measure whether intended effects are reached.

**2. The actual coherence of the Strategy depends on its implementation.** In theory, the Drug Strategy seems coherent. The eight structuring principles, the six general objectives, and the thirteen strategic options seem to form a coherent

approach of the problem of drugs and drug addiction. However, its actual coherence depends on the practical implementation of the Strategy. Although the components of the Drug Strategy (i.e. the thirteen strategic options as formulated in the Portuguese Drug Strategy) do not contradict each other in theory, they might have opposite effects in practice. For example, the reinforced combat against drug trafficking might make it more difficult to traffic drugs, whereas decriminalizing the possession of drugs might make this easier, since it will become more difficult to distinguish drug traffickers from drug users (especially when people traffic small amounts of drugs). This means that a careful and coordinated implementation of the Strategy is important to make sure that the Strategy will in the end attain the intended effects.

**3. Successful implementation requires a focused effort.** Successful implementation is not straightforward. Among the pieces of the strategy requiring particular attention are the following:

- **Informing the public.** In order to implement the Drug Strategy, it is important that the general public understands the rationale behind that Strategy. It should be clear to them what decriminalization means, and how that is different from depenalization, legalization or liberalization.
- **Providing sufficient treatment capacity.** An increase in treatment capacity, both in terms of physical capacity and in terms of quantity and quality of caregivers, is crucial to make decriminalization possible and maintain public support.
- **Training the administrative committees.** Training the members of the administrative committees is essential to make sure that appropriate decisions on individual drug users are taken and to make sure that similar sanctions are given in similar cases.
- **Improving coordination.** Better cooperation between the stakeholders involved in the field of drugs and drug addiction - i.e. between the medical system, the criminal justice system, the education system, etc., is needed to make a comprehensive approach of the drug problem possible.
- **Refocusing allocation of the budget.** To enable successful implementation of the Drug Strategy, the budget available for combating the problem of drugs and drug addiction should be both increased and better allocated. The Drug Strategy already provides in an increase in the budget to 150% of the 2000 budget. The allocation of the budget should shift in favor of harm reduction, imprisoned drug addicts and research on drugs and drug addiction.

- **Informing the policy makers.** Policy makers involved in the implementation of the Drug Strategy should have sufficient information to take decisions that are consistent with the overall objectives of the Strategy. In order to generate this information, evaluation of the Drug Strategy and research on drugs and drug addiction are of great importance.

**4. Standardization and fine-tuning must be delicately balanced.** Looking at the recommendations of the Project Panel and the interviewees for implementation, it emerges that a balance needs to be found between standardization and fine-tuning. On the one hand, drug users all over the country should be 'treated' similarly and equally. This means, for example, that they should have equal treatment opportunities and that administrative committees in different regions should take similar decisions in similar cases. On the other hand, an individualized approach of drug users is considered important. This means that characteristics of the drug users, such as their treatment history and the region they come from, should be taken into account. There is no easy way to solve the tension between standardization and fine-tuning, but it is important to recognize the existence of this tension and take it into account when important decisions on the implementation of the Drug Strategy have to be taken.

**5. There is an immediate need for data collection.** Measuring the effects of Portugal's Drug Strategy is only possible if accurate information on the starting point is available, i.e. the situation before implementation of the Strategy has begun. This means that it is important to start designing the evaluation as soon as possible, and to determine which data are needed for the evaluation. As soon as it is clear which indicators will be used for the evaluation, information on these indicators for the current situation should be collected. The longer one waits before collecting these data, the more problematic interpreting the evaluation results will be.

**6. Further work should explore the bases of success.** To measure the success of the Drug Strategy, it is essential to evaluate both the process and the outcome of the implementation of the Strategy. Evaluating the outcome of the Strategy, i.e. the effects on drug supply and demand, is essential to assess whether the Drug Strategy has led to its intended results. Evaluating the process is essential to monitor and, if necessary, change the implementation of the Strategy. And more importantly, evaluating the process is essential to explain which elements of the Drug Strategy have contributed to its success or failure. Just measuring the outcomes is thus not sufficient; it is important to know the reasoning behind successes or failures so that

Portugal and other countries can benefit from the knowledge resulting from the radical change in Portugal's Drug Strategy.

**Conclusion.** Portugal has deliberately set forth on a novel approach to deal with the problems of drug use, that is consistent with a set of general humanistic and pragmatic principles, as well as with international laws and treaties. However, it is not clear how these changes will work out in practice. Careful specification of the objectives of the approach, a thorough evaluation, and an ongoing willingness to learn offer the potential of major breakthroughs in society's efforts to deal with drug problems.

## Chapter 1 Studying the Portuguese Drug Strategy

### 1.1 Background

Portugal took a large step on 1 July 2001 when it radically changed its drug policy towards completely separating the demand side of the drug problem from the criminal justice system. Although Portugal has always been more to the side of the "harm reduction" view of drug policy than the "use reduction" side (MacCoun and Reuter, 2001), the change was considered radical because it included decriminalization of consumption of all types of drugs and possession of these drugs for personal use. This includes not just marijuana but also heroin and cocaine. As a consequence of this change, use and possession for use are subject to administrative sanctions instead of criminal proceedings. The decriminalization policy is the flagship of the Portuguese Drug Strategy<sup>2</sup>, in which it is one of the measures taken to contain and reduce the negative effects of substance abuse, both on individual users and Portuguese society as a whole.

The revision of the Portuguese Drug Strategy began with the formation of an elite expert commission to consider what was widely regarded as an increasing drug use problem. This commission, named the *Comissão para a Estratégia Nacional de Combate à Droga* (Commission for a National Drug Strategy, CNDS), produced a report (CNDS, 1998) recommending a major shift in Portuguese drug policy in the direction of containing and reducing the negative effects of substance abuse, including decriminalization. This shift was the logical consequence of an explicit set of policy principles developed by the Commission.

To the surprise of some of the members of the CNDS, the Council of Ministers approved the report almost in its entirety (Government of Portugal, 1999) and produced a National Drug Strategy consistent with that report (Government of Portugal, 2000). The *Assembleia da República* (parliament) and the Council of Ministers, with the approval of the President of the Republic, passed legislation to specify parts of the National Drug Strategy.

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<sup>2</sup> In this report, the terms Portuguese Drug Strategy, National Drug Strategy, Drug Strategy and Strategy are used as synonyms and refer to the new Portuguese drug policy as laid down in Government of Portugal (2000).

In July 2001 a law on decriminalization took effect, followed by a law on harm reduction and risk reduction as well as a law that specifies the responsibilities of local administrative drug committees which form part of the implementation of the decriminalization law. Laws on prevention and rehabilitation are being prepared: a National Action Plan describing the elements of these laws has been issued and is under public discussion (*Plano de acção nacional de luta contra a droga e a toxicoddependência – Horizonte 2004*).

The objective of the current study is to analyze the new Portuguese Drug Strategy and to develop recommendations for its implementation and evaluation. This can, however, not be done without knowledge about the context in which the Strategy is to be implemented, i.e. Portuguese society in general and the Portuguese drug problem in particular.

This chapter states the research questions and discusses the research methodology that was applied to answer them. Chapter 2 provides background information on the history of Portuguese drug policy and shows how this culminated into the Portuguese Drug Strategy. Also, the laws and action plans resulting from the Strategy are described. Chapter 3 focuses on implementation of the Strategy. A panel of Portuguese experts on drug use, further referred to as Project Panel<sup>3</sup>, discussed the practical consequences of the law and indicated for the different fields of the Drug Strategy what specific policy measures would be needed to make the Strategy a success. Chapters 4 focuses on the possibilities and pitfalls of evaluation of drug policies. It starts out with a typology of evaluation methodologies and then goes into the specifics of evaluation of the Portuguese Drug Strategy. The final chapter describes the conclusions and recommendations for implementation and evaluation of the Portuguese Drug Strategy that resulted from this study.

## **1.2 The research question**

The original objective of the project was to provide the government with a basis for legislation on decriminalization. However, when the project team arrived in Portugal for the first time, in November 2000, the government had just published a draft law on decriminalization, which came into force on 1 July 2001.

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<sup>3</sup> The members of the Project Panel are named in the preface.

Together with the Project Panel, RAND Europe revised the research question at issue. The Project Panel indicated that it believed that decriminalization was an important element, but not the only important element of the National Drug Strategy. They therefore proposed widening the focus of the study to include all policy measures included in the Strategy.

Consequently, the project team and the Project Panel jointly rephrased the research question so that it better reflects in their belief the issues the Portuguese are facing with respect to their Drug Strategy. The research question reads as follows: **Which parts of the National Drug Strategy deserve priority in its implementation and how should the effects of implementation of the Strategy be evaluated?**

In order to answer this complex question, the project focused on the following subquestions:

**A) What are the objectives of the National Drug Strategy?** The precise aims of the National Drug Strategy have to be defined very clearly in order to determine how implement and evaluate the Strategy.

**B) What are the most appropriate ways of prioritizing the individual components of the National Drug Strategy?** The term components refers to the thirteen strategic options as formulated in the Portuguese Drug Strategy. If these options are to serve the overall goals of the Drug Strategy, it needs to be determined how the options ought to be brought into practice in the short and medium term. For example, the government agreed to increase the budget for drug policy by 10% annually in the coming five years. However, it was not specified how this money should be spent. Therefore, it was important to determine what the most appropriate allocation of this money would be.

**C) How can the real effects of the National Drug Strategy be assessed?**

Since the Portuguese Drug Strategy is unique in the way it deals with decriminalization of possession of heroin and cocaine for personal use, it is very important to evaluate the consequences of this approach. However, only few data on drugs are currently being collected. The project therefore addressed how the effects of the National Drug Strategy could be assessed and what data would be needed to make these assessments.

### **1.3 Research methodology**

The method of this study is qualitative, combining existing literature with experiences of professionals working in the field of drugs and drug addiction. As the project entails both the implementation and evaluation of policy measures, and considering the versatile policy environment, a diversity of methodologies was applied to address each issue appropriately.

Firstly, a literature review was conducted to understand Portuguese drug policy in its historical and international context. However, because of the rapid developments in and the specific characteristics of the Portuguese Drug Strategy, the literature review could only form a theoretical information source. Therefore, other research methods needed to be applied to understand the consequences of the National Drug Strategy.

Secondly, the project team conducted open-ended interviews with a variety of professionals in the drug field. The interviews were conducted to gain an insight in the range of stakeholder perspectives on the National Drug Strategy. The information from the interviews was analyzed by the project team and subsequently served as input for meetings with the Project Panel. The interviewees offered insights into how their agency might be positively and negatively effected by various implementation plans and what their needs were in this context. Strikingly, virtually everybody active in the field of drug abuse in Portugal subscribes to the proposed strategy. Although we sought views opposing the new Strategy, one of the remarkable aspects of this change is the strong consensus it has.

The project team visited Portugal three times for cycles of interviews and meetings with the Project Panel. The first cycle focused on decriminalization policy and its context. Both the National Drug Strategy and the law on decriminalization were discussed. Policy makers were interviewed about the background of the National Drug Strategy in general and the law on decriminalization in particular. Practitioners from the drug treatment field were asked about their view on the Drug Strategy and its possible effects on their work. They were also asked how the Drug Strategy would affect current and future drug use in Portugal. The first meeting of the Project Panel focused on the decriminalization law. The experts discussed the contents and consequences of the law, and explored how the law should be implemented. This discussion was based on a priority rating that all members of the Project Panel did before the meeting. In the rating exercise, the members of the Project Panel were

asked to determine to what extent they believed the different components of the National Drug Strategy were consistent with decriminalization. The agenda for the meeting and the rating forms can be found in Annex D.

The second cycle focused on seven out of the thirteen components of the National Drug Strategy, which the members of the Project Panel believed to be the most important, namely:

- international cooperation;
- decriminalization of drug consumption;
- primary prevention;
- a health care network for drug addicts;
- harm reduction;
- reintegration initiatives; and
- harm reduction policies in prisons.

The project team interviewed various people with expertise in these fields. The second meeting of the Project Panel took two days. During the first day, the members of the Panel considered the different options for evaluation of the National Drug Strategy and had a preliminary discussion on possible outcome measures for such an evaluation. During the second day, the Project Panel was asked to prioritize the budget for implementation of these so-called strategic options using a rating form. This ratings form can be found in Annex E.

The third cycle focused on evaluation. The project team conducted a study of the literature on evaluation, which was sent to the Project Panel as preparation for the next meeting. During the third cycle, different actors were asked when they would consider the National Drug Strategy a success and how this could be measured. The Project Panel meeting was an evaluation exercise: the panel members conducted a structure (*ex ante*) evaluation of the National Drug Strategy and set criteria for process evaluation and outcome (*ex post*) evaluation (see Chapter 4).

After these three visits, the project team wrote a draft report based on information gathered during the previous visits to Portugal. The draft report was sent to the members of the Project Panel and discussed during a fourth, final meeting in Portugal.

## **Chapter 2 Structure of the drug policy environment**

### **2.1 Introduction**

A government can choose from a large set of options for its drug policy. The options can be seen as points on a continuum, with total prohibition of all drugs on one end, and full legal freedom to sell and consume drugs on the other end; in between, distinctions between legalization and different forms of decriminalization (moving prohibition away from the criminal justice system) can be made, along with differentiation between providers and users, as well as “hard” and “soft” drugs.

Portugal moved back and forth on this scale, starting with legal drug use in the 1920s, shifting to prohibition of drugs use in the 1960s, followed by a gradual shift towards the legalization end of the continuum, resulting in the current situation of decriminalization of drug consumption.

After a brief discussion of the history of Portuguese drug policy, we discuss the turning point in policy-making and the resulting drug policy. We describe the Portuguese Drug Strategy, the principles underlying the Drug Strategy, and the current laws that relate to the Strategy. Finally, we relate the characteristics of the Portuguese Drug Strategy to the characteristics of drug policies of other European countries. Countries are compared using a number of key elements of drug policy.

### **2.2 Historic developments in the drug policy environment**

**1926-1979** Portugal's first law regarding drug use dates from 1926 (Decree Law No. 12210) and was fully prohibitionist. Until this law, trafficking was a penal offence, but use of drugs was not against the law. This law continued in force throughout the totalitarian regime that ruled Portugal for over forty years in the middle of the twentieth century. During the 1960s, when the use of drugs increased in the majority of developed countries, Portugal suppressed drug usage compared to its incidence elsewhere in Europe. Although the use of narcotics and psychotropic drugs was very limited at that time, the Portuguese government organized its first anti-drug campaign in 1973. The slogan for that campaign was 'drugs-madness-death'. In this period, use became a penal offence (Decree Law No. 420/70). After 1974, with freedom from totalitarianism, the drug phenomenon became more visible: use of cannabis among youth was reported, and prescription drugs were more freely available at pharmacies and frequently abused. In 1976, the Portuguese

government ran its second anti-drug campaign. In this year also, the first governmental organization dealing with drugs was established, the *Gabinete de Coordenação do Combate à Droga* (Drug Fighting Coordination Office). This office was integrated in the Presidency of Ministers Council and was responsible for data collection and coordination of two other organizations: (1) the *Centro de Estudo e Profilaxia da Droga* (Drug Prophylaxis Studies Center) which was responsible for demand reduction and treatment and formed the basis for treatment centers in Lisboa, Porto and Coimbra, and (2) the *Centro de Investigação e Controle da Droga* (Drug Control and Research Center) which was responsible for supply reduction.

**1980 – 1989** During the first half of the 1980s, the use of cannabis grew moderately. The extent to which heroin and cocaine use penetrated all segments of society is subject to discussion. Some state that heroin and cocaine were used only in restricted groups ([www.drugtext.org](http://www.drugtext.org)), but others say that they were already used extensively and that the growth of use was not a consequence of growing prosperity (members of the Project Panel, November 2001). In 1982, the *Gabinete de Coordenação do Combate à Droga* was replaced by the *Gabinete de Planeamento e de Coordenação do Combate à Droga* (Drugs Planning and Coordination Office). In 1983, a new law (Decree Law No. 430/83) came into effect. This law provided the suspension of punishment for some drug related offences if the offender accepted integration in a treatment program. This was a large change in Portuguese policy regarding drug consumption. In 1987, the government established *Projecto Vida* (Project Life), a national program against drugs. In this program the government took thirty measures focused on prevention, treatment, reinsertion, and supply reduction. These measures had to be implemented by six different ministries. In the same year, the Ministry of Health created its first specialized treatment center for drug addicts named *Centro das Taipas*. Following this center, more *Centros de Atendimento à Toxicodependentes* (Addict Consultation Center, CAT) were formed.

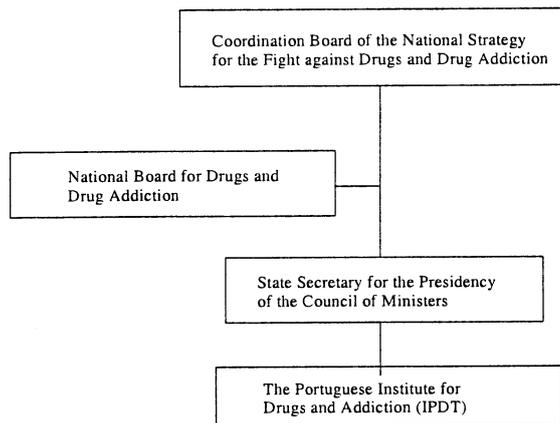
**1990 – 1999** At the end of the 1980s and in the early 1990s, a substantial introduction of heroin in Portugal occurred. At that time, the negative consequences of drug use became visible: heroin abuse started a social and human degradation process, involving increasing criminality, health problems of heroin addicts, and feelings of insecurity among the general population. A few years later, cocaine also found its way to the Portuguese market. However, the cocaine market appears to be smaller and less visible than the heroin market ([www.drugtext.org](http://www.drugtext.org)).

In 1990, a special department within the Ministry of Health was created to deal with prevention of drug addiction and treatment of drug addicts, named the *Serviço de Prevenção e Tratamento da Toxicodependência* (Drug Addiction Treatment and Prevention Service, SPTT). Also in 1990, interdepartmental commissions were created, expressing a strong political commitment to the fight against drugs. In the following years, a large number of laws regarding several elements of the fight against drugs were put into place ([www.drugtext.org](http://www.drugtext.org)). In 1993, a law on control, use and traffic of narcotic drugs, psychotropic substances and precursors came into effect (Decree Law No. 15/93) which was slightly altered in 1996 (Law No. 45/96). The law regulated penalties, medical prescriptions, authorizations, certification and control activities, as well as responsibilities concerning treatment, prevention, criminal investigation and money laundering. These laws provided of detail regarding types of consumption, traffic, types of drugs, etc. The changes in 1993 formed a continuation of the 1983 law; they were meant to bring the law in line with the convention of Vienna of 1988 (<http://eldd.emcdda.org>).

**1999 – 2001** The year 1999 was a turning point in Portuguese drug policy. With Decree Law 31/99, the *Instituto Português da Droga e da Toxicodependência* (IPDT, Portuguese Institute for Drugs and Addiction) was created to replace *Projecto Vida* and the government approved the National Strategy for the Fight Against Drugs covering the period until 2008. As a consequence, a series of legislative modifications took place during the year 2000 (<http://eldd.emcdda.org>). This led to a new institutional framework of dealing with drugs and drug addiction.

In May 2000, the Coordination Board of the National Strategy and the National Board for Drugs and Drug Addiction were set up. The Coordination Board is presided over by the Prime Minister and coordinates all policies in the areas of drugs and drug addiction. The national Board is a consultation body for the Prime Minister, who may delegate responsibilities to the State Secretary for the Council of Ministers. All political decisions in the area of drugs are thus centralized at the highest level (IPDT, 2000). The reasoning behind this is that centralization at a high level will ensure full cooperation from government bodies that have responsibilities in the implementation of the National Drug Strategy.

**Figure 1: Position of IPDT**



At a more operational level, the emphasis, in 2000, was to reorient the national agencies' work plans towards the political commitments of the National Drug Strategy and to uphold international commitments (IPDT, 2000). The newly created IPDT is responsible for the coordination of prevention, harm reduction, research, rehabilitation and other activities. SPTT is responsible for treatment and undertakes some prevention activities as well. At the local level it has district delegations, which allow closer proximity to the problems and the individuals. IPDT works in cooperation with ministerial services, such as SPTT and the prevention programs in schools set up by the Ministry of Education (EMCDDA, 2001).

### **2.3 The size of the problem**

Although Portugal's drug problem seems to have worsened during the 1990s, real data on the extent of the problem have remained scarce. Some recent data suggest a population as high as 100,000 drug addicts. However, more usual and conservative estimates put the number of Portuguese drug users between 50,000 and 60,000 out of a total population of approximately 10 million people ([www.drugtext.org](http://www.drugtext.org)). What data are collected are reported to the European Monitoring Center on Drugs and Drug Addiction (EMCDDA), which was set up to provide the European Commission and its Member States with objective, reliable and comparable information concerning drugs and drug addiction. The bullet points below reflect the main conclusions that can be drawn from the available data ([www.emcdda.org](http://www.emcdda.org); EMCDDA, 2001). The related data can be found in Annex B.

- The data on drug-related deaths place Portugal unfavorably with respect to other harm-reductionist countries, with 34 drug related acute deaths per

million citizens, compared to 4 per million in the Netherlands, 8 per million in Spain and 19 per million in Italy. Although these data cannot be compared directly since all countries use different definitions, they do suggest that Portugal has a high ratio of drug-related deaths.

- The data on arrests for drug offences suggest an increasing use of heroin. In 1991, 4667 people were arrested for drug offences, mostly related to heroin. By 1995, this number was up to 6380, and by 1998, the figure was 11395, or 235 percent of the 1990 figure. It is, however, not clear whether this increase in arrests for drug offences is related to a more strict enforcement policy, ease of detection, record keeping or incidence of criminality.
- The data on seizures of drugs also indicate that the heroin problem increased in the 1990s (for more information: see Table B.2 in Annex B). Comparing Portugal to its neighboring countries, the number of heroin seizures per million inhabitants is quite low: whereas the Portuguese police seize heroin 37 times per 1 million inhabitants, this number is 52 for the Netherlands, 337 for Spain and 112 for Italy. It is, however, inadvisable to draw any conclusions about the heroin market in a country on the basis of these numbers, because the number of seizures depends on a variety of factors, of which the effectiveness of the police is one. Seizures of other drugs do not reflect the pattern of heroin. The quantities for ecstasy and LSD are so small that they cannot be used to form reliable indicators of the extent of usage of these drugs.
- The number of treatment episodes in Portugal has increased fivefold in the last nine years, from 56,438 in 1990 to 288,038 in 1999 (SPTT, 1999). The 1999 episodes were for 27,750 individual drug users, for an average of about 10.4 annual visits to a treatment center per user. Of all drug addicts undergoing treatment in 1997, 95.4% were heroin users. Methadone or LAAM is not extensively used, being prescribed for 28.5% of individuals in treatment (IPDT 2001: p.34). Drug treatment centers in Portugal have a limited number of available places. In urban centers, waiting lists for substitution programs exist (EMCDDA, 2000a: p. 213).
- In 2000, the Portuguese government spent slightly over 100 million Euro on drug policy. As Table 1 shows, the four largest cost categories were treatment, prevention, law enforcement and rehabilitation.

**Table 1: Government Budget on Drugs and Drugs Abuse by Intervention Areas**

<b>Intervention area</b>	<b>Year 2000 (Euro)</b>	<b>Percent</b>
Prevention	24,150,976	23.3
Treatment	29,288,115	28.2
Rehabilitation	15,234,195	14.7
Harm reduction	4,589,728	4.4
Prisons	3,427,404	3.3
Law enforcement	24,007,142	23.2
Research	2,097,445	2.0
International cooperation	887,860	0.9
<b>Total</b>	<b>103,682,864</b>	<b>100.0</b>

Source: IPDT, 2000

## **2.4 The Portuguese Drug Strategy**

In 1998, the CNDS was formed in response to a perceived rapid increase of the drug problem in the 1990s, principally but not exclusively involving heroin use. It produced a report that formed the basis for the National Drug Strategy of the Portuguese government (CNDS, 1998). Within the boundaries set by international conventions on drug policy<sup>4</sup>, Portugal created a set of policy measures based upon the philosophy of harm reduction, referring to activities that reduce harm to the individual drug consumer and society as a whole.

The Portuguese Drug Strategy is built on eight "structuring principles". These principles begin with acknowledgment of the international arena and stress the importance of prevention, but then go immediately to the heart of the matter - the "humanistic" and "pragmatic" principles. These two principles declare that drug users should not be regarded as criminals, but as full members of society, and that the Strategy will not attempt to strive towards an unachievable perfection such as "zero drug use," but will instead try to "make things better" for all segments of society. The fifth principle, the principle of security, refers not only to the general public as potential victims of drug-induced crime, but also to the drug users themselves. The

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<sup>4</sup> Such as the 1961 Single convention on narcotic drugs; the 1971 Convention on psychotropic substances; and the 1988 United Nations convention against illicit traffic in narcotic drugs and psychotropic substances.

remaining three principles reflect Portuguese political philosophy, with efficiency of resources needed to maintain economic development, subsidiarity as part of an effort to push policymaking to as local a level as possible, and participation as a legacy of the revolution of 1974 (Government of Portugal, 2000, p. 39).

The structuring principles are translated into a set of thirteen "strategic options" (Government of Portugal, 2000, pp. 43-44) that form the heart of Portuguese Drug Strategy. These are:

1. To reinforce international cooperation and to promote active participation of Portugal in the definition and evaluation of the strategies and policies of the international community and the European Union.
2. To decriminalize the use of drugs, prohibiting them as a breach of administrative regulations.
3. To redirect the focus to primary prevention.
4. To extend and improve the quality and response capacity of the health care network for drug addicts, so as to ensure access to treatment for all drug addicts who seek treatment.
5. To extend harm reduction policies, namely through syringe and needle exchange programs and the low-threshold administration of substitution drugs as well as the establishment of special information and motivation centers.
6. To promote and encourage the implementation of initiatives to support social and professional reintegration of drug addicts.
7. To guarantee conditions for access to treatment for imprisoned drug addicts and to extend harm reduction policies to prison establishments.
8. To guarantee the necessary mechanisms to allow the enforcement by the competent bodies of measures such as voluntary treatment of drug addicts as an alternative to prison sentences.
9. To increase scientific research and the training of human resources in the field of drugs and drug addiction.
10. To establish methodologies and procedures for evaluation of public and private initiatives in the field of drugs and drug addiction.
11. To adopt a simplified model of interdepartmental political coordination for the development of the National Drug Strategy (IPDT replaces Projecto Vida).
12. To reinforce the combat against drug trafficking and money laundering and to improve the articulation between the different national and international authorities.
13. To double public investment to 160 million EURO (at the rhythm of 10% per year) over the next five years, so as to finance the implementation of the National Drug Strategy.

The first strategic option again acknowledges the international context, but the second moves immediately to decriminalization of drug consumption and possession of drugs for personal use. Decriminalization, as is made clear, is not legalization, but

replacement of criminal sanctions for drug use by administrative regulations. The remainder of the strategic options are also clearly within the structuring principles and very much in the philosophy of reducing harms to individual drug users and to society as a whole.

The thirteen strategic options formed the basis for legislation and an action plan that set the legal framework for the Strategy and its implementation in a first stage between 2001 and 2004. In 2000 and 2001, laws and an action plan were issued for prevention, decriminalization, harm reduction and reintegration and for the combat against drug trafficking and money laundering. Furthermore, treatment capacity was added in order to be able to respond to the expected increase of demand for treatment as a result of the decriminalization law.<sup>5</sup> The government has also made money available to build new treatment centers as part of the implementation of the National Drug Strategy, but it has not made money available to staff these centers.

## **2.5 Law on decriminalization**

Decriminalization represents a significant deviation from the previous law, and is different from efforts in other countries such as Spain and the Netherlands, in that it explicitly separates the drug user from the criminal justice system. The CNDS recognized, and the government explicitly concurred, that imprisonment or fines have so far not provided an adequate response to the problem of drug use, and that it has not been demonstrated that subjecting a user to criminal proceedings constitutes the most appropriate and effective means of intervention. The decriminalization law includes as basic principle that a drug addict should be considered a patient, not a criminal.

The international arena is explicitly addressed in the decision to adopt decriminalization. The Portuguese Drug Strategy report declares that after a study of the 1988 United Nations Convention against illicit trafficking in narcotic drugs and psychotropic substances, it was consistent with that convention to adopt the strategic option of decriminalizing drug use, as well as the possession and purchase for this use. In the Portuguese view, replacement of a criminal process with one that views use as a mere breach of administrative regulations maintained the international obligation to establish in domestic law a prohibition of those activities and behaviors. Moreover, decriminalization as defined by the Drug Strategy was

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<sup>5</sup> The members of the Project Panel believe that this increased treatment capacity is not the consequence of the National Drug Strategy, but a general response to an increased need.

believed by the CNDS to be the maximum degree of liberalization possible within the international conventions currently in effect (Government of Portugal, 1999, p.61).

**How decriminalization will work:** Under the law that took effect on 1 July 2001, the use and possession for use of drugs is no longer a criminal offense, but instead is prohibited as an administrative offense. This distinguishes Portugal from Spain, where the policy is de facto decriminalization, but where a drug consumer will still be judged by a court, although he will never be sent to prison for drug consumption alone (MacCoun and Reuter, 2001). The same holds for the American system of drug courts, which send a drug consumer to treatment only after he has been convicted by a criminal court (Sechrest and Shicor, 2001). In the U.S. drug court system, the consumer has a criminal record and it is this stigmatization that the Portuguese policy explicitly aims to prevent. There is no distinction made among different types of drugs ("hard" vs. "soft" drugs), nor whether drug use is in private or in a public place. Decriminalization only refers to possession of drugs for personal use and not to drug trafficking. "Trafficking" for purposes of the law is possession of a larger quantity of drugs than the average dose for ten days of use (however, these levels are not specified per type of drugs).

To deal with these administrative offenses, each of the eighteen administrative districts in Portugal will establish at least one administrative committee that deals with drug users in that district (larger districts such as the ones containing Lisboa and Porto will probably have more than one administrative committee). The administrative committees will generally consist of three people, two people from the medical sector (physicians, psychologists, psychiatrists or social workers) and one person with a legal background. Committee members are not supposed to be involved in drug treatment but should be sufficiently knowledgeable to judge what is best for the user.

Drug users will be brought to the attention of the administrative committees when police officers observe them using drugs. Police officers may ask drug users for their name and address and send this information to the administrative committee; they cannot arrest users. If the administrative committee determines on the basis of the evidence brought before it that the person is a drug trafficker, then the administrative committee will refer that person to the courts. Although the law states that any doctor who detects a drug problem in a patient may bring this to the attention of the administrative committee or any other health service in his or her district, interviewees and the Project Panel regarded this as highly unlikely. Not only

do doctors feel repugnance towards such reporting, but it might also violate the doctor's oath of confidentiality. In any event, the law does not allow this information to be used in criminal proceedings.

The law states that the administrative committee should consider several criteria when it takes a decision on an individual drug user. These criteria include the severity of the offense, the type of drug used, whether use is in public or private places, whether the person is not an addict, whether use is occasional or habitual, and the personal and economic/financial circumstances of the user. How these criteria are to be used is not stated. Some are of the opinion that the administrative committee may choose not to take any action, others believe that some form of action, even if suspended, is required.

The administrative committees have a broad range of sanctions available to them. These include:

- fines, ranging from 25 to 150 EURO. These figures are based on the Portuguese minimum wage of about 330 EURO per month (Banco de Portugal, 2001) and translate into hours of work lost;
- suspension of the right to practice if the user has a licensed profession (e.g. medical doctor, taxi driver) and may endanger another person or someone's possessions;
- ban on visiting certain places (e.g. specific discotheques);
- ban on meeting with specific other persons;
- interdiction on travel abroad;
- requirement to report periodically to the administrative committee;
- withdrawal of the right to carry a gun;
- confiscation of personal possessions;
- cessation of subsidies or allowances that a person receives from a public agency.

The administrative committee cannot mandate compulsory treatment, although its orientation is to encourage addicts to enter and remain in treatment. The administrative committee has the explicit power to suspend sanctions conditional upon voluntary entry into treatment, but because disobedience of committee rulings is not defined as a criminal offense, it is not clear what the further sanctions are if users do not follow either the treatment recommendations or the orders of the administrative committee. Some experts believe that the administrative committees will see users repeatedly and can "build up a relationship of trust with the addict."

Other experts believe that this is not possible, because the administrative committee is acting as a judge and jury.

**Preparations for decriminalization.** IPDT is charged with overseeing the administrative committees. One of the major tasks involved is appointing committee members; IPDT has organized a competition to select the members of the administrative committees and their technical staff and the administrative committees were all in place on 1 July 2001. It has also operationalized a number of articles of the decriminalization law. Furthermore, IPDT has organized a training program for administrative committee members, as well as a set of regulations for procedural matters and guidelines on how the administrative committees should deal with specific cases. In addition to the administrative district committees, it will create a central committee that will serve as a center of information and advice to the districts.

IPDT has also begun designing a database in which information about the individuals brought before the administrative committees, the decisions of the administrative committees, and - to a more limited extent - the consequences of committee actions are recorded. They hope that this database can be employed to assist in standardizing the approaches of the administrative committees and may, eventually, assist in evaluating the performance of the administrative committees. Ultimately the database, plus the documented experience of the administrative committees may contribute to evaluating the effect of decriminalization.

## **2.6 Other laws concerning the National Drug Strategy**

In addition to the law on decriminalization, the government has issued law No. 183/2001 to establish rules for harm reduction and risk reduction measures. The implementation of prevention, harm reduction, risk reduction and rehabilitation is discussed in three separate "action plans", which focus on the period 2001 - 2004. Both the laws and the action plans set frameworks for implementation, rather than obliging anybody to implement them. That is, they are so-called "enabling laws", because they provide a structure for anybody who wishes to implement the law.

In the past, local initiatives have led to innovative programs for prevention, rehabilitation and harm and risk reduction. For example, one experiment that has been in progress for a number of years now is the Casal Ventoso project. Casal Ventoso is a neighborhood of Lisboa where drug traffickers and drug users used to

gather, to the detriment of themselves and the inhabitants of that area. The municipality of Lisboa started a project where addicts are offered a place to wash, eat and sleep, where clean needles are handed out and where people get informed about treatment possibilities. This approach has proven successful, because fewer people sleep in the streets and more addicts are induced to enter treatment or at least to inject hygienically. The current law tries to enhance and coordinate these initiatives at a national level.

**Decree Law No. 183/2001:** The law starts with the statement that it is based on the principle of pragmatism, as cited in the Portuguese Drug Strategy. The law aims to 'create programs and social-sanitary structures to lower the threshold to treatment for drug addicts, as well as structures for prevention, reduction of harms to the individual and to society and reduction of risk behavior by the individual.' In fact, the law mainly focuses on harm reduction measures, since a separate law will be issued for prevention.

The law is quite specific in the programs and structures it calls for, including:

- Support centers for addicts who do not have a social environment to take care of themselves;
- Reception centers for addicts, where they can get something to eat and where social workers are available to be of help and, possibly, stimulate addicts to seek treatment. Addicts cannot stay overnight here;
- Shelters for addicts; these are overnight centers which help to keep addicts off the street at night and provide them with a safe place to stay and to wash in the morning;
- Points of contact and information;
- Mobile centers that have the aim of preventing infectious diseases;
- Syringe exchange programs;
- Teams of social workers in the streets;
- Programs of supervised consumption, which aim to stimulate safe and hygienic use of drugs;

All programs should be accessible to any drug addict who wishes to use them and ought to be organized by the municipality or the regional authorities. The principle of subsidiarity presides. This way, the law will enable those who were already thinking about harm reduction activities to take the opportunity given by the law to bring their ideas into practice. However, effective implementation is less likely for those who had never thought about harm reduction, say it is not their responsibility, or are

at a loss because they have no clue how to bring the law into practice. The enabling nature of the law includes a risk that a large diversity of drug policies will develop in different parts of the country, because every actor may choose which parts of the policy it wishes to implement. However, diversity of drug policies is not necessarily problematic; it might also mean that local characteristics are better taken into account.

## **2.7 The National Action Plan**

The law does not mention any rehabilitation activities. These are mentioned in the *Plano de acção nacional de luta contra a droga e a toxicodependência – Horizonte 2004*, the national action plan of the fight against drugs and drug addiction – Horizon 2004 (Conselho de Ministros, 2000). In this plan, the government explains what activities should be undertaken in the coming four years and which social actors should be involved. The action plan forms the basis for legislation that is still in the making at the time of writing of this report.

For example, the chapter on prevention explains how primary prevention should work in the community, in schools, in leisure environments, with youth who dropped out of school, and so on. The focus on prevention is heavy, because the government wants to stress that the decriminalization law does not imply that drug consumption is not bad for a person's health. For those who have started using drugs, the government has a number of measures to stimulate safer consumption and to prevent harms to the individual and his surroundings. If the addict decides to seek treatment, there should be treatment available to him. Therefore, the government plans to enhance the network of CATs, to reinforce detoxification services and to reinforce substitution treatment centers. The chapter on treatment in the national action plan is surprisingly short. This is perhaps because the network for treatment is already more extensive than networks in the fields of prevention, harm reduction, and the other new measures. Therefore, the government can limit itself to enhancing and reinforcing existing treatment measures. One aspect is new, however, and that is the inclusion of the whole prison system in the national treatment network. The *Programa Vida Emprego* ("Life and Work Program") and the individual CATs are responsible for implementation of rehabilitation activities; the government aims to reinforce these activities, among others by doubling the number of apartments for drug addicts (Conselho de Ministros, 2000: p.21).

The National Drug Strategy also discusses the fight against illicit drug trafficking and money laundering. Here the responsibility lies with the central government to decrease the supply of illicit drugs by 50% in 2004, to reduce drug-related criminality by 25% in 2004 and to gain access to bank information to reinforce the fight against money laundering. Furthermore, the government will focus on the fight against new synthetic drugs, which are believed to become increasingly important in the near future.

Finally, the government plans to give education and training to all parties involved in implementation of the national action plan. Furthermore, the government will collect information – this chapter is very long and detailed - and will hold evaluations to assess the consequences of the new policy – this chapter is the shortest in the action plan. The government does not specify:

- which kind of evaluation it has in mind;
- what should be evaluated;
- when the evaluation should take place;
- and who should do the evaluation.

Personal communications with officials make clear that this lack of clarity results from the fact that the government does not know how to conduct such an evaluation. In chapter 4 of this report, we will address evaluation in more detail in order to provide information about the above issues.

## **2.8 The Portuguese Drug Strategy in an international perspective**

The new Portuguese Drug Strategy means an important change in policy for the country. When designing the Drug Strategy, its writers made sure that the Strategy did not conflict with international regulations or conventions, but they did not explicitly examine the drug policies in surrounding countries to see to what extent the Portuguese Drug Strategy is in accordance with those policies<sup>6</sup>. To understand the Portuguese Drug Strategy, it is interesting to compare it with drug policies in other countries.

In recent years, the national drug policies of many European countries have shifted considerably (MacCoun and Reuter, 2001, EMCDDA, 2000c). Generally, priorities have shifted from repressive policies towards prevention, care and harm reduction. Many countries now recognize that drug consumers should be treated as patients or malfunctioning citizens rather than criminals, and have formal or

informal policies to prevent drug consumers, especially occasional users, from ending up in prison. However, because of the international treaties, especially the Single Convention of 1961, and because of the economic and political sanctions that bind nations to the treaties, at the present time it would be very difficult for any country to formally end its national prohibition regime (<http://www.hereinstead.com>). A closer look at the national drug policies of selected European countries makes clear that important differences between the policies exist and helps to determine to what degree the Portuguese Drug Strategy has unique characteristics that cannot be found in other countries.

We have chosen to compare the main characteristics of the Portuguese Drug Strategy to the drug policies of Spain, Italy, the United Kingdom, the Netherlands, Sweden, and Switzerland. These countries were chosen either because of their vicinity to Portugal, or because they have a drug policy that is known to be either very tolerant or restrictive regarding drug possession. The seven selected countries have been compared on important characteristics of their drug policies. These dimensions were chosen because they were the only dimensions for which comparable data were available.

- Enforcement
  - minor drug related offences (e.g. possession of small amounts of drugs)
  - major drug related offences (e.g. drug trafficking and money laundering)
- Treatment
  - availability of substitution treatment
  - treatment for 'regular' drug addicts
  - treatment for criminals addicted to drugs
- Harm reduction
  - syringe exchange programs
  - access to syringes in pharmacies
  - availability/distribution of condoms
  - HIV counseling and testing
  - HIV treatment
  - Hepatitis B vaccination
  - Hepatitis C related activities
  - Measures available to prisoners

The table in Annex C gives an overview of the main characteristics of the drug policy of the selected countries.

It should be noted that most countries differentiate drug traffickers and consumers and that they might differentiate between types of drug within these groups. Below,

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<sup>6</sup> Personal communications with members of the CNDS, 2001.

we discuss some of the noticeable similarities and differences among the drug policies of the selected seven countries. This discussion will center on the three dimensions for which comparable data were recorded in Annex C. In addition, a few remarks on prevention are made, as the role of prevention in a country's drug policy is considered important.

**Enforcement.** In their enforcement policies, most countries make a difference between minor offences (e.g. drug consumption and possession of drugs for personal use) and major offences (e.g. drug trafficking and money laundering). Within the category of minor offences, most but not all countries make a distinction between soft and hard drugs. In many countries, consumption and possession of soft drugs is decriminalized to a certain extent, and elsewhere it is low on the list of priorities for the Public Prosecutor. In Sweden and the United Kingdom, for example, the formal policy is very strict, but even in those countries drug consumers are not sent to jail without recourse to alternatives such as treatment or a fine. In fewer countries, including Portugal, the consumption and possession of (small amounts of) hard drugs are also decriminalized. All countries have a hard approach to trafficking of drugs and drug-related money laundering.

**Treatment.** The treatment of drug consumers has high priority in all seven selected countries. In all of these countries, substitution treatment for drug addicts is to some degree available. Treatment is often offered as an alternative to imprisonment. There are, however, differences between countries in the way they treat imprisoned drug addicts. In the United Kingdom, the Netherlands, and Sweden, for example, imprisoned drug addicts are strongly encouraged to enter treatment. In Portugal, however, treatment for imprisoned drug addicts is to date poorly developed but is a priority for implementing the new Strategy.

One way of helping addicts reduce the unhealthy aspects of their addiction is substitution treatment, i.e. by prescribing a substitute drug for the illicit opiate. Prescribing a drug helps addicts regain control over their lives, because substitution drugs are administered on a less frequent and more systematic basis. The most common drug for substitution treatment is methadone, but LAAM, buprenorphine, and to a lesser extent heroin and morphine, are also used as substitution drugs. In all EU countries except France, methadone is the preferred substitution drug. In France, all medical doctors may prescribe buprenorphine, but methadone may only be prescribed in specialized treatment centers (Van Beusekom and Iguchi, 2001). Although substitution treatment is widely accepted as a useful treatment and harm

reduction tool, some Portuguese doctors show reluctance to include it in their addiction treatment practice. Furthermore, only a limited number of treatment centers include substitution treatment in their treatment options. The number of treatment centers and doctors who do prescribe methadone is slowly increasing (João Goulão, president of SPTT, interview 10 July 2001).

**Harm reduction.** In all seven selected countries, increasing importance is attached to harm reduction. The harm reduction measures that all countries take indicate that these countries recognize that drug use creates a physical dependency and inflicts harms on the user and his environment. Consequently, most countries develop a number of different initiatives to reduce harms. The Netherlands and Switzerland are very advanced in this respect, whereas Sweden retains a repressive orientation. Portugal is catching up with the harm reductionist countries: it has initiated a wide variety of harm reduction programs, but experiences difficulties with the accessibility of those programs (e.g. the availability of syringes). The changes in Portuguese policy will move it to the forefront.

**Prevention.** Although prevention was not included in the comparison (because comparable information for the selected countries was lacking), a brief comment on prevention can be made. In some countries, prevention is considered as part of drug policy, whereas other countries see prevention as a separate health promotion policy. The Portuguese government explicitly includes prevention in its drug policy.

## **2.9 Conclusion**

In this chapter we have provided an overview of the Portuguese drug environment from early in the twentieth century until the present day. During the mid-twentieth century, Portugal introduced – concomitant with the totalitarian regime – a policy of severe repression. Since the establishment of democratic rule, policy has become slowly relaxed. The recent efforts as laid down in the National Drug Strategy form a logical consequence of this trend.

## **Chapter 3 Implementation of the Portuguese Drug Strategy**

### **3.1 Introduction**

RAND Europe asked the interviewees and the Project Panel to express their views on possible consequences of the Portuguese Drug Strategy. In the course of time, these opinions underwent change as more information about the Strategy became available.

In the beginning of the project, just after publication of the draft decriminalization law, decriminalization was one of the most heavily discussed issues, because it was the most revolutionary part of the Portuguese drug policy, and it was the first law to enter into force.

In the course of the project, it became more clear that decriminalization was part of a broader policy aimed at “harm reduction” in the broadest possible sense. Consequently, the interviewees and the Project Panel focused more on the consequences of the Portuguese Drug Strategy for the whole drug policy field, including prevention, treatment, and social rehabilitation (“reinsertion”).

This chapter gives an overview of the perspectives of the interviewees and the Project Panel on the National Drug Strategy. It first describes the vision of the involved stakeholders on the possible positive and negative consequences of the introduction of the Strategy. The next section discusses the priorities of the members of the Project Panel with respect to both budget allocation and implementation of the Portuguese Drug Strategy. The chapter ends with recommendations and conclusions with respect to implementation of the Portuguese Drug Strategy.

### **3.2 Implementation of the National Drug Strategy**

The members of the RAND Europe project team asked the interviewees and the Project Panel for their expectations with respect to the effect of the Portuguese Drug Strategy and grouped their opinions into the categories below.

**Expected effects of the National Drug Strategy.** Although the interviewees and the Project Panel favored decriminalization in principle, some cast doubts about the way the law would be implemented and what its effects would be. The new law seems to leave a lot unsaid; it sums up possibilities for implementation rather than

imposing specific measures to be taken. This led to a considerable lack of clarity among the people who were to be in charge of implementing the law and those people who would be affected by the law. The administrative committees would have to coordinate with each other and with people from other organizations, such as prevention workers and police. This was viewed as problematic, as there is no culture of coordination in Portugal, especially with regard to drug treatment (Van het Loo, et al., 2000).

**Drug market effects.** Decriminalization was not expected to increase the amount of drugs available or the use of new types of drugs. However, there was a general belief that decriminalization would increase the need for prevention, e.g. to communicate to the public that decriminalization does not condone drug use. The Project Panel did not believe that decriminalization would result in an increase in the total number of drug users. However, there could be some increase in people experimenting with drugs among people who previously to the new law did not use drugs because they feared criminal sanctions.

**Image of drug users.** An expected positive effect of the new policy was that there would be less stigmatization of drug consumers because drug consumption would be dealt with administratively and would be separated from the justice system. They would be now considered patients, not criminals. This change in thinking would need some time and adequate information provision. The burden on the shoulders of addicts would be less, because they would not have a stigma anymore and because there would be no more trouble with the police. There would be a possibility for addicts to be close to treatment facilities without fear of the police. Finally, it was expected that it would be easier for people who had been addicted to drugs to reintegrate into society, because they were no longer seen as criminals and would not get a criminal record. Some members of the Project Panel wondered whether addicts would actually feel destigmatized.

**Role of the administrative committees.** The administrative committees that deal with identified drug users were the subject of a lot of discussion, both due to lack of clarity about their role and due to distrust of their usefulness. The administrative committees are supposed to build up a relationship of trust with the addict. The expected difficulty for the administrative committees was that they will need to judge whether somebody is a casual user or an addict and that they have to decide upon the most appropriate sanction for this person.

There is a risk, sometimes explicitly expressed in Portugal, that the administrative committees will not be clearly differentiable from the current court procedures by users or the police. A particularly pessimistic view expressed by some of the interviewees was that the administrative committees were doomed to fail because of bad coordination, and that the committees in fact mean that one police system was replaced by another repressive system.

There was also a lot of confusion about the types of sanctions that could be given. Most people were aware of the range of possibilities mentioned in the law, but did not see what criteria would be used by the administrative committees to determine what sanctions should be given. In principle, possession of all types of drugs is decriminalized. However, as explicitly mentioned in the law, the type of sanctions prescribed by the administrative committees may differ per type of drug used.

**Type of people in treatment.** It was expected that there would be an increase in the number of people in treatment, but also that the type of patients would change. It remains to be seen whether the people who are sent to treatment have been in treatment before. If they have, they have dropped out in the past and caregivers will have to prevent them from dropping out this time. If they have not, they may or may not be motivated for treatment. Care providers did count on a number of patients who would be coming to treatment just to avoid other sanctions. Generally, they saw such unmotivated patients as a challenge and considered it positive that they would get into contact with treatment in any case.

Some interviewees were also concerned about the question whether the modes of treatment currently used in Portugal were the right ones to meet the anticipated need for treatment. More low-threshold methadone maintenance treatment would perhaps be needed to appropriately treat the anticipated new population of drug consumers entering treatment.

**Prevention and harm reduction.** The prevention and harm reduction laws are enabling laws. The law does not force any community to take action; it instead sets the possibilities and constraints for those who wish to undertake any harm reduction activities. The Panel members believed that the law would enable those who were already thinking about harm reduction activities to take the opportunity given by the law to bring their ideas into practice. However, those who had never thought about harm reduction were not expected to receive much guidance from the law or they would deny that harm reduction is their responsibility. Furthermore, those who were

to start implementing the law would inevitably encounter problems of finding money and people, and if they find people, these need training. IPDT was trying to stimulate municipalities to implement the law, but it did not provide guidance. One could discuss whether the enabling nature of the laws answers sufficiently to the task of the government, as formulated in article 2 of Decree Law No. 183/2001, to make treatment accessible to all Portuguese citizens who need it.

Finally, there was a political problem: if a CAT had a president of one political party and the mayor was of another party, they would not be willing to cooperate in the implementation of the law. The risk of such an enabling law was thus that large differences in implementation may occur, because everybody could choose what elements he wished to implement.

**Prioritizing implementation activities and budgets.** Here we discuss what relative importance the members of the Project Panel gave to the different components of the policy – their priority for budget allocations – and which aspects of the policy merit more or less importance. Overall, the panel members stated that evaluation of any policy measure is critical to improve its implementation over time and to assess whether a policy achieves its goals and is worth its money.

We asked the panel members to indicate for the different fields of the Drug Strategy what specific policy measures would be needed to make the policy a success. Their answers are summarized in Table 2.

**Table 2: Implementation priorities**

<b>Prevention:</b>	<ul style="list-style-type: none"> <li>- training of technicians for primary prevention</li> <li>- training of professionals for direct intervention in primary prevention</li> <li>- prevention in schools and in the workplace</li> <li>- better support of the administrative committees in the municipalities</li> <li>- evaluation</li> </ul>
<b>Treatment:</b>	<ul style="list-style-type: none"> <li>- low-threshold treatment facilities</li> <li>- completing the national coverage with CATs</li> <li>- reinforcement of the CATs in Porto, Setubal and Lisboa</li> <li>- substitution programs</li> <li>- training of health professionals</li> <li>- programs of integrated treatment (for example, addiction and HIV or Tuberculosis)</li> <li>- evaluation</li> </ul>
<b>Rehabilitation:</b>	<ul style="list-style-type: none"> <li>- creation of so-called "halfway houses"</li> <li>- professional development programs</li> <li>- evaluation</li> </ul>
<b>Harm reduction:</b>	<ul style="list-style-type: none"> <li>- general reinforcement of harm reduction activities</li> <li>- increase of the number of drug-free units in prisons</li> <li>- reinforcement of low-threshold programs, including health vigilance and substitution programs</li> <li>- expansion of syringe exchange programs</li> <li>- shelters</li> <li>- support centers</li> <li>- evaluation</li> </ul>
<b>Prisons:</b>	<ul style="list-style-type: none"> <li>- treatment of addicted prisoners, specifically detoxification</li> <li>- drug-free wings</li> <li>- treatment with antagonists</li> <li>- co-operation with therapeutic communities</li> <li>- harm reduction activities, including syringe exchange</li> </ul>
<b>Justice and police:</b>	<ul style="list-style-type: none"> <li>- the war on the traffic of drugs</li> <li>- coordination between the Justice and Health departments</li> <li>- coordination between police and health professionals</li> </ul>
<b>Research:</b>	<ul style="list-style-type: none"> <li>- epidemiological studies</li> <li>- prevention studies</li> <li>- treatment effectiveness studies</li> </ul>

We also asked if there was anything that is currently done that has become redundant. The panel members stated that proportionally less money should be spent on prevention campaigns since their efficacy is controversial. Furthermore, they said that treatment centers that deliver poor quality care should be closed. Except for these two points, no decrease in budget was suggested. This is because the government has announced a budget increase for the coming years, so the panel members did not have to decrease any budget to be able to increase another.

The government has announced that it will increase its budget for drug policy by 10% annually between 2000 and 2005. We asked the panel members how they

would allocate the budget available for drug policy in 2005. Each of the panel members initially allocated the budget as he or she believed advisable. Then the results of the individual work were discussed in the panel. The panel proposed the following changes to the budget as compared to the budget for the year 2000 (Table 3):

**Table 3: Budgetary priorities**

(numbers are averages of the amounts given by the panel members)

<b>Subject<sup>7</sup></b>	<b>Budget 2000 (million Euro)</b>	<b>Budget 2005 (million Euro)</b>	<b>Net increase (SD)</b>	<b>Percent age change</b>
Prevention	24.2	33.33	9.1 (4.1)	+37.7%
Treatment	29.3	35.33	6.0 (4.9)	+20.6%
Rehabilitation	15.2	25.83	10.6 (4.9)	+70.0%
Harm reduction	4.6	16.00	11.4 (6.3)	+247.8%
Prisons	3.4	10.33	6.9 (2.6)	+203.9%
Law enforcement	24.0	21.17	-2.8 (6.4)	-11.8%
Research	2.1	6.83	4.7 (2.5)	+225.4%
International cooperation	0.9	1.83	0.9 (1.6)	+103.7%
<b>Total</b>	<b>103.7</b>	<b>150.67</b>	<b>47</b>	<b>+45.3%</b>

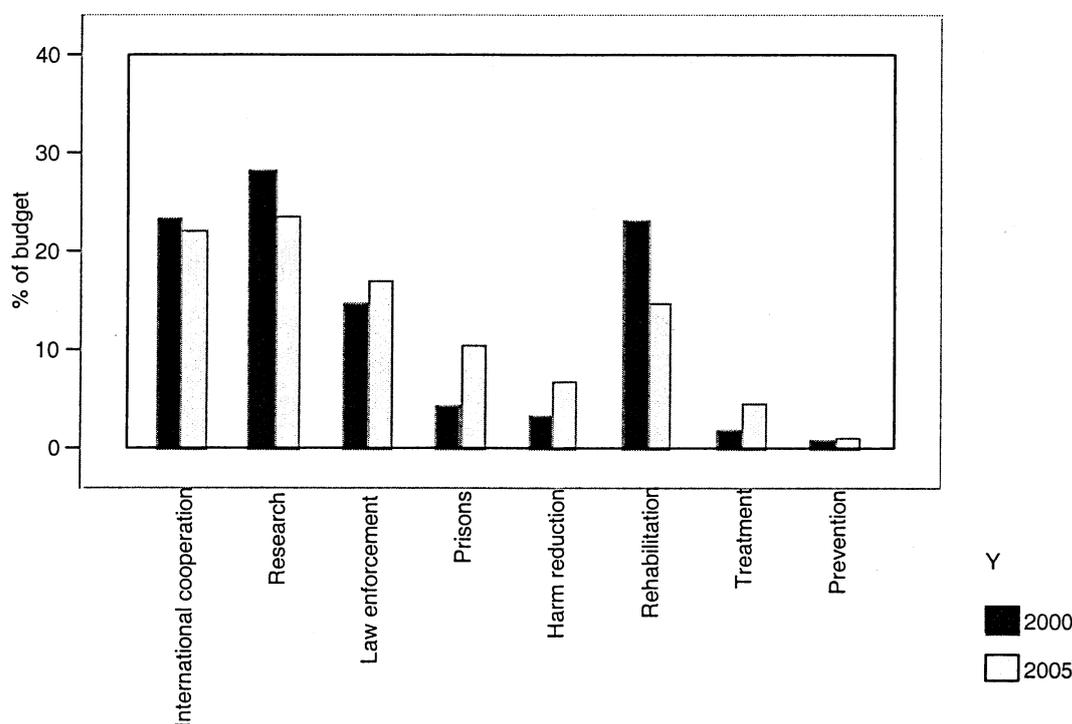
A uniform across-the-board increase would have given 45.3% to each subject. Instead the range was from a 12% decrease to a 248% increase. Figure 2 presents how these changes affect the overall distribution. The panel members suggested a relative shift of the allocation of the budget in favor of harm reduction, prisons, and research. This would mainly be at the cost of enforcement. The other categories, prevention, treatment, rehabilitation, and international cooperation are stable in terms of the relative percentage of the budget that should be spent on those activities according to the members of the Project Panel. As the standard deviations show, the Project Panel could sometime disagree amongst themselves. This was especially true for treatment, law enforcement and international cooperation. Not all of these disagreements were resolved through discussion, but the Panel did accept the average figures in Table 3 as representative of a general opinion.

One of the members of the Project Panel remarked that any increase in budget should be done on the basis of an analysis and evaluation of data regarding the effectiveness of a policy. The resulting information may show whether a budget

<sup>7</sup> These subjects were used because the Portuguese government splits up its budget in these categories.

increase is justified. In the following paragraphs we describe the comments the members of the Project Panel gave on the individual policy options.

**Figure 2: Budget reallocation  
as proposed by the Project Panel**



**Harm reduction.** There is agreement among the panel members that a larger percentage of the budget for drug policy should be spent on harm reduction. Harm reduction programs that are currently implemented on a small scale should be reinforced and expanded. The main focus should be on reinforcement of harm reduction activities, reinforcement of low-threshold programs (including health vigilance and substitution programs), programs focusing on syringe exchange, and on shelters and support centers.

**Prisons.** The Strategy makes explicit reference to drug addicts in prison. Many interviewees did so as well. They noted that a number of initiatives to introduce harm reduction measures in prisons have failed, because the prison directors would not allow them. It is said that they do not want to admit that there are drugs in their prisons and therefore say that there is no drug problem in their prison. The cooperation with prison directors is of foremost importance to address this problem.

The number of addicted people in prisons might decrease, because addicts are no longer considered as criminals. This would mean that only the people who are addicted drug traffickers would be in prison. They might need a different type of treatment than 'average' drug addicts.

The budget for prisons includes all activities focusing on drug addicts and prevention of drug addiction in prisons. According to the panel members, the efforts undertaken in prison should mainly focus on harm reduction (including syringe exchange programs) and treatment (including detoxification programs, and cooperation with therapeutic communities to ease transfers from prison to therapeutic communities). Finally, attention should also be paid to efforts focusing on prevention (including drug-free wings) of drug addiction.

**Research.** The suggested research budget was tripled on average. This can partly be explained by the great importance that some of the panel members attach to research and partly by the low initial budget for research. Two of the panel members suggested very large increases in the amount of money available for research. One did so because he believes there should be more research on prevention, the other because he believed there should be research about the biological background of drug addiction: why do some people become addicted and others not? Hardly any research has been done on this topic. Spending more money on research could also help Portugal to get a foot in the door in this field of research. The other five panel members kept research at a relatively even spending level, but did not object to the increase when presented with the summary table.

**Prevention.** Many people were afraid that the number of people starting to use drugs would increase, because decriminalization might be perceived as depenalization or liberalization. Everybody stressed the importance of an information campaign and of prevention activities to clarify that drug consumption is still full of risks. Some people thought that the number of people starting to use drugs would not change, because people were not sent to prison for drug use only anyway. On the other hand, some said that more young people will start to use drugs because it is not prohibited. One person expects that the number of drug users in rural areas will increase, because these people have less understanding of the meaning of decriminalization and because drug consumption is only just starting to become known outside the cities.

All stakeholders agreed that more prevention activities are needed to keep people from starting to consume drugs and to reduce the harms for those using drugs. The laws provide an opportunity for health centers to be involved in prevention activities. Institutions in the field of prevention expected increased activity in their sector. The panel members suggest that the money available for prevention should increase in absolute, but not in relative terms. The increased budget should be mainly spent on training professionals to improve primary prevention.

**Treatment.** Treatment was discussed regularly. Many people expected that, as a consequence of the decriminalization policy, more people would go into treatment because the administrative committee dealing with drug consumers (*Comissão para a Dissuasão da Toxicodependência*), would recommend this. On the longer term, harm reduction programs were also expected to get more clients. Some people said that there would be a large increase of the number of people in treatment in the short term. The two main reasons for this were:

- 1) Since the draft law of decriminalization became public, judges have not sent people to prison, because they think it is not fair to send people to prison at this moment, knowing that a new policy is forthcoming. They therefore leave these cases pending and will send people to the administrative committee as soon as the law has entered into force;
- 2) Police officers will be more inclined to send drug users to the administrative committees than they were to arrest drug users and send them to court. Many police officers consider imprisonment to be a bad sanction for drug use, and with the new policy, they can send addicts to the administrative committee, and in that way help reduce the harms to the individual drug consumer and to society.

Furthermore, the opinions focused on the effectiveness of treatment and the needed treatment capacity. Some people believed that if people were sent to treatment by an administrative committee, they would not be as motivated for treatment as are the drug consumers who enter treatment voluntarily. People who are sent to treatment would need a different treatment approach, because the current treatment system might be less effective if people are less motivated. People were afraid that there would be a lack of capacity to respond to an increased demand for treatment. SPTT did not share this fear; it had received funding for additional treatment capacity and was busy creating this additional capacity. One interviewee mentioned the necessity of increasing the capacity for low-threshold methadone maintenance treatment, because this could be useful for a less motivated group of addicts.

According to the panel members, relatively less money should be spent on treatment. In absolute terms, the budget should increase slightly. Most members of the Project Panel argue for a small increase in budget because a large amount of money is already being spent on treatment. One of the members of the Panel thinks there should be a decrease in the budget for treatment, because its effectiveness has not been proven sufficiently. Moreover, this member of the Panel said there are many other diseases in Portugal that do not get any treatment and these deserve attention as well. According to another panel member, treatment will need an increase on the short term, right after the law comes into effect, but if the law is implemented well, harm reduction and prevention will improve and therefore less money will be needed for treatment on the longer term (by 2005).

**Law enforcement.** The police will focus more on traffickers, that way addressing the supply side of the drug market. An important issue in this respect is of course how a consumer can be distinguished from a trafficker. The law defines a person as a consumer when he possesses a quantity of drugs that equals less than ten days of average drug use. The policemen in the street will need to be able to decide upon that rather vague decision. The courts will also have less work, because they will not see drug consumers any more.

Two Panel members suggested increasing the budget available for law enforcement, while all the others decreased it. This led to an overall decrease of the budget spent on law enforcement in both absolute and relative terms.

### **3.3 Recommended policy choices**

Both interviewees and members of the Project Panel shared their thoughts about the needed efforts for a successful implementation of the policy.

A short-term increase of treatment capacity was considered crucial. Fast responses are needed to make decriminalization work and to maintain public support for the new policy. Assuming that the number of people who seek treatment will go up, the number of technicians treating these people will also need to go up. Treatment and harm reduction measures, such as a syringe exchange, in prisons are considered high priority. One way of relieving the burden on treatment centers is to stimulate treatment by general practitioners to prevent a large influx in treatment centers. This might lead to an increased need for training of general practitioners in this field.

The Panel members noted that training of the members of the administrative committees is crucial to ensure comparability of sanctions between different regions. Also, the members have to learn how to take the specific characteristics of regions into account when this is considered to be appropriate. This is especially important, since some people noted that the laws were made from the perspective of the big Portuguese cities, which is not necessarily applicable to rural areas.

Furthermore, better cooperation between the involved parties – police, treatment centers, prevention institutions, justice department, medical sector, municipalities – is necessary to make a comprehensive approach to the drug problem possible. This comprehensiveness includes an international fight against drug trafficking. A political will is needed to target this fight against the drugs market.

In the field of prevention and harm reduction, several accompanying measures were mentioned:

- Information campaigns:
  - to inform the general public about the implications of the laws, and to explain them the differences between decriminalization and depenalization;
  - to explain young people that using drugs is not okay; and
  - to change the way in which the public thinks about drug users in order to make social reintegration of drug users easier.
- Introduce and intensify programs aimed at the development of young people in general, one of the effects of these programs should be prevention of drug use;
- Additional harm reduction measures should be taken, e.g. increase the number of methadone programs and shooting rooms;
- Increase and improve efforts in the field of primary prevention.

Many interviewees stressed the need to improve information gathering and provision. This means that information technology is needed to keep the data, but also that standardization is needed to enable comparison of data.

One could imagine that a final potential problem is that decriminalization may come to dominate the entire drug policy arena, with a corresponding diminution of important efforts in prevention, rehabilitation, and other programs consistent with the principles of humanism and pragmatism. On the other hand, one could also

believe that decriminalization can act as a flagship for implementation of policies consistent with the structural principles, and can ease the way for improved harm reduction strategies such as the introduction of new needle exchange programs, social housing for drug addicts, shooting rooms, more frequent supply of methadone, and consideration of heroin as a substitution drug.

### **3.4 Conclusion**

The expectations about the Portuguese Drug Strategy were generally positive, but tempered by a 'wait and see' attitude. The final opinion will depend on the way the policy will be brought into practice. In this chapter, we identified a number of expected positive effects of the policies, as well as negative effects that are expected or feared. A number of barriers and facilitators to successful completion of the implementation plans were mentioned, and recommendations were given to increase the chances of success of the policies.

The members of the Project Panel listed a number of implementation priorities and gave their opinion on the way the budget should be drawn up if the government is to spend its money as effectively and efficiently as possible.

The interviewees expected that more drug consumers would apply for treatment, since that is an escape from administrative sanctions. Most interviewed policy makers (SPTT) and care givers (CATs) believe that the current financial and human resources for treatment may not be adequate to accommodate this influx of new patients, and worry that waiting lists from the administrative committee referrals could become a major problem.

The action plans regarding prevention, harm reduction and reinsertion exhibit a different implementation problem. The legislation regarding these activities does not oblige communities to implement the law. The law rather sets a framework for those communities that wish to undertake such activities – it is an enabling law.

During the interviews and panel meetings, the use of evaluation was mentioned regularly. The only way to know if the new Drug Strategy works is by conducting an evaluation. It is however hard to set the criteria for such an evaluation. What should be evaluated, and when and how should evaluation be done in order to get credible information? The next part of this report focuses on different ways to conduct evaluations. It also sets the framework for an evaluation of the Portuguese Drug Strategy.

## Chapter 4 Evaluation of the Portuguese Drug Strategy

### 4.1 Introduction

The Portuguese Council of Ministers recently published a resolution that is intended as a guideline on drug policy in the coming years, both for the administration and for its social partners (Conselho de Ministros, 2000). One section in this resolution that marks a departure from previous policies is a short section on evaluation of the Strategy and the related laws. By including this section, the council recognizes the need for evaluation as a means of assessing the consequences of its drug policy. This is especially important, because the policy is different both from Portugal's previous drug laws and from the policies in any other EU country. The discussions following the publication of the resolution revealed that the Council was still considering how, when and with what precise goal evaluation should take place.

This chapter provides background information for this discussion. We start with a description of different types of evaluation, each leading to different recommendations concerning (among other subjects) the moment of evaluation, the precise object of evaluation, the type of data needed and the appropriate body for conducting the evaluation. After this general introduction to types of evaluation, we discuss the specific elements of drug policy evaluation, and evaluation of the Portuguese Drug Strategy in particular. This formed the basis for discussions of the Project Panel about the criteria that should be assessed in evaluation, which led us to aspects of the drug policy that require assessment when they are being implemented.

### 4.2 Typology of evaluation methodologies

This section gives a typology of evaluation methodologies. It first discusses different types of evaluations, namely structure, process and outcome evaluations. Then it discusses the pros and cons of internal and external evaluations. Finally, it goes into the key questions that should be asked in the conduct of an evaluation.

**Types of evaluation.** All three types of evaluation<sup>8</sup>, concerned respectively with the outcomes, structure and process of policy, are important. When thinking about evaluation, the first type of evaluation that comes to mind is that which tries to answer whether the goals of a policy have been achieved. This type of evaluation is

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<sup>8</sup> This discussion is based on Hoogerwerf, A. (ed.), 1989, p.170-175 and EMCDDA, 2000c, p.29 +53-59.

known as ex-post effectiveness evaluation, and concerns the outcomes of policy. In order to conduct this type of evaluation it is necessary to define goals in measurable terms. In the case of drug policy, effectiveness could be defined as an increase in the number of persons who stop using illicit opiates. The government might decide, however, that a program is effective if the number of persons who enter treatment or remain in treatment increases. On the other hand, the government might also be interested in the social and mental situation of the drug users. In all three cases, different types of data are needed: quantitative and qualitative, categorical and numerical. In most cases, data on the situation before the start of the policy are needed in order to assess the changes that occur after the policy has been implemented.

A second type of evaluation considers the content of a policy before it is implemented. This is called ex-ante or structure evaluation. Such an analysis assesses whether the policy is legally feasible, internally consistent, whether it will serve the goals it aims at, and so on. This analysis is also known as formative analysis, because it helps to form (and reform) policy. Structure evaluation can be done before and during implementation. Before implementation, the first question one should ask is whether a structure exists that will make implementation of the policy possible, thus studying the feasibility of the plans. Furthermore, internal or external experts assess the quality of the policy or the implementation program before its implementation.

Finally, evaluation can focus on the implementation of a policy. This process evaluation can be done either during or after implementation. Process evaluation studies the way in which a policy is implemented. During implementation, process evaluation can be a part of formative evaluation in the sense that it helps improve the implementation of the policy. Process evaluation can also be done alongside ex-post evaluation. Then it helps to distinguish whether the effects of a policy are a result of the content of the policy, or of the way it was implemented.

**Internal and external evaluations.** Internal and external evaluations each have their advantages. The advantage of an internal evaluator is that this person knows the program very well, and is in a good position to carry out long-term or continuous evaluation. The disadvantage is that he might not have a good overview, and that his independence and objectivity are not sufficiently credible. The external evaluator, on the contrary, can have greater objectivity and a more independent status. Besides, he is probably hired because he has experience in doing evaluations. An

external evaluator will, however, have to learn about the program before he can start evaluating. An external evaluator is probably more expensive as well (Nadeau, 1981). Some state that internal evaluation should always be done throughout the planning and implementation phases of a program (EMCDDA, 2000b: p.163).

**Key questions for evaluations.** When planning an evaluation, the following questions should be taken into account:

- **What do we want to evaluate?** The object of evaluation determines the method of evaluation and the type of data needed. For example, evaluation of the clinical effectiveness of a medical treatment does not need to look at the cost of treatment, although this is a pivotal element in a cost-effectiveness analysis.
- **When do we want to evaluate?** This second question is closely related to the first. An implementation process could and probably should be evaluated within the first year or two of implementation, in order to enable policy makers to adjust the policy. The effects of a policy - especially when a policy marks a significant departure from the existing one - cannot be assessed after such a short period, however, since new policies tend to have starting problems, which might blur the view of their effectiveness.
- **How do we want to evaluate?** The answer to this question should also flow from the first question, since the object of evaluation determines the methodology needed to usefully assess its effectiveness.
- **Who should conduct the evaluation?** In its resolution, the Council already discussed two types of evaluators: internal and external. The choice as we stated above, is not simple, and many factors must be considered.
- **How much money do we want to spend on it?** The volume of the budget largely determines the boundaries of the evaluation.

### **4.3 Evaluation in the Portuguese policy context**

The EMCDDA has published a manual for evaluations of prevention programs (EMCDDA, 1998). This could be a useful tool to start an evaluation of the current Drug Strategy. A good plan for a program would include all three types of evaluation:

- Structure evaluation now to see if the right structures are in place to start implementing the law that came into effect on 1 July 2001;
- Process evaluation during the whole implementation process in order to track whether the plans are being met and to learn from starting problems. Clearly

there are a host of uncertainties surrounding the implementation phase of the new policy initiative. Process evaluations can help with short term fine tuning;

- Outcome evaluation - based on the terms of measurement as defined during ex-ante evaluation – so that the rate of success of the Drug Strategy can be empirically tested and the soundness of the approach can be determined.

The Portuguese Drug Strategy encompasses a large diversity of programs, each of which has its own focus, but all of which aim to reduce the harms associated with the use of drugs in Portugal. Since each of the programs has a different focus, it would be impossible to conduct an analysis of the Strategy as a whole. The only way to assess whether the Strategy serves and achieves its objectives is to evaluate the separate parts of the Strategy and to study the coordination among different programs.

Structure and process evaluation both look at the Strategy as a whole, while outcome evaluation looks at separate programs.

#### **4.4 Expert views on evaluation of the Portuguese Drug Strategy**

The interviewees and the members of the Project Panel were asked how the drug policy could be evaluated. Key questions asked were:

- When would you consider the Drug Strategy to be a success?; and
- What data are needed to measure the success of the Drug Strategy?

Almost all observers agreed that it would be useful to evaluate the effectiveness of the policy, but there was concern that the results of this evaluation would be subject to politically colored interpretations. Most respondents said that they considered this Strategy to be a success if the number of people who enter treatment would increase. However, some indicated that the drug policy could only become a success if other things happened, such as a decrease in money laundering and drug trafficking. Others said they considered the Strategy a step towards an even better Strategy of liberalization or legalization of drug consumption. In this report, we studied ways to make the National Drug Strategy as is a success.

In the last few decades, the effects of Portuguese drug policies have sporadically been evaluated. Some of those results of evaluations have been used in decision-making, but others have not. Moreover, it would be almost impossible to do a good evaluation in the absence of valid data. At the moment of writing, steps were being taken to improve the process of data collection and analysis. IPDT had the primary responsibility for this. However, some people believed that it was not a good idea for

the organization that is responsible for implementation of the drug policy to be also responsible for its evaluation.

Most interviewees and members of the Project Panel agreed that it is important but difficult to measure the effects of drug policies, especially the effects of policies focused on prevention.

Evaluations are often politically burdened. The interviewees and members of the Project Panel mentioned that evaluations are only useful if:

- All actors act similarly, i.e. when policies are implemented in similar ways, e.g. by the people responsible for prevention or by the administrative committees;
- Numbers are collected and interpreted in a neutral way (by an independent organization).

The interviewees and members of the Project Panel all considered a rise in the percentage of drug users seeking and receiving treatment a good indicator for success of the National Drug Strategy. In addition, several other measures of success were mentioned, including: a decrease of the number of people consuming drugs, a decrease of the number of drug addicts sent to prison, full incorporation of prevention in school curricula and dissemination of prevention over all school youth, a decrease in the number of children in schools who start consuming drugs, expanded contact between public services and drug consumers. Some of the above outcome measures relate to decriminalization alone, but some seem to relate to the broader objectives of the Strategy. The respondents mentioned them when asked about decriminalization alone. Perhaps they mentioned the other measures because they see decriminalization as an integral part of the National Drug Strategy.

In addition to the data currently collected, new data should be collected to measure the effects of the new Portuguese Drug Strategy:

- Number of people who are referred to treatment by an administrative committee;
- Number of people in treatment and number of people in harm reduction programs;
- Prevalence of drug use in different societal groups/layers;
- Effectiveness of treatment, with special attention for the effects on people who did not seem to be motivated for treatment;
- Characteristics of people that stay in treatment and those dropping out;

- Harm reduction actions;
- Length of waiting lists for treatment;
- Prevalence of HIV, hepatitis, and tuberculosis
- Indicators for drug-related crime;
- It would be helpful if a way to follow people who have left treatment (completed or dropped out) would be invented.

Information should be collected through different channels to get a better impression of the effects of policies:

- Quantitative patient information;
- Interviews with staff of organizations involved in implementation of the Drug Strategy;
- Interviews with other social organizations;
- Client satisfaction surveys.

#### **4.5 Type and timing of the evaluation of the Portuguese Drug Strategy**

Evaluation of a policy program is usually more complicated than evaluating a single policy, because a program usually consists of several policy measures and aims at reaching several objectives at the same time. It is therefore more difficult to single out the effect of a single policy on a single outcome measure. This makes evaluation of the National Drug Strategy a difficult task, which should be handled with care, because interaction between the different policy measures might occur. For example, the decision to decriminalize drug use might lead to an increase in the number of drug users, whereas redirecting focus to primary prevention might lead to a decrease in drug use, the overall effect being zero. This means that an evaluation of the National Drug Strategy should be carefully designed.

Here, we provide an overview of issues that should be considered when thinking seriously about evaluation of the Portuguese Drug Strategy. Based on both scientific literature and information from the interviews with experts in the field of drug policy, we have come up with concrete suggestions for doing such an evaluation. We will discuss what type of evaluation should be done and when it should be done, what the evaluation should focus on and what data are needed, and who should do the evaluation.

As discussed earlier in this chapter, a good evaluation plan would include all three types of evaluation, i.e. (a) structure evaluation to assess whether the right

structures are in place to implement a policy (*ex ante*); (b) process evaluation to track whether the implementation process proceeds as planned; and (c) outcome evaluation to assess the effectiveness of the policy in reaching the defined objectives (*ex post*).

As the implementation of the law has already begun, it is now too late to do a serious *ex ante* structure evaluation. However, important elements of a structure evaluation can also be included in the process evaluation. The question then is not whether the right structures are in place to start implementing a policy, but whether an effective and efficient implementation process is possible with the organizational structure that is in place at the moment that the process evaluation is being conducted. The members of the Project Panel did conduct an informal *ex ante* evaluation, which led to a set of recommendations for implementation of the Strategy (see chapter 3). The recommended evaluation of the Portuguese Drug Strategy thus focuses on the process of implementation and on the outcomes of the Strategy.

Process and outcome evaluation can take place in different phases of policy implementation. Whereas process evaluation could start almost immediately after implementation of the policy has been initiated, outcome evaluation should not take place until the policy has had the chance to have an effect. In the case of evaluating the implementation of the Drug Strategy, we believe it would be recommendable to do process evaluations immediately and three years after the law on decriminalization became effective, i.e. in 2002 and 2004. In addition, we believe an outcome evaluation should be done approximately five years after the law became effective.

The first process evaluation (2002) would be mainly focused on identifying 'growing pains' in the implementation of the Strategy and on suggesting modifications in the way the Strategy is implemented. At the time of the second process evaluation (2004), all parties will have extensive experience working with the Strategy, and the evaluation would be more focused on identifying and solving structural problems.

An outcome evaluation should be done as soon as the full effects of a new set of policy measures might be visible. It is difficult to determine when this moment has come. However, there seemed to be agreement among interviewees and panel members that this would be (at least) five years after implementation of the Drug Strategy has started. We therefore believe that it would be a good idea to do an

outcome evaluation of the Drug Strategy in the year 2006. Even as the full effects of the Drug Strategy might not be visible at that time, this evaluation should at least provide an insight in the direction in which developments have been going.

The above makes clear that it is not useful at this moment to conduct an outcome evaluation. However, in order to make future evaluations possible, it is important to start collecting data now. Without information on the initial situation, it will be impossible to determine the consequences of the Drug Strategy at a later stage.

**Process evaluation.** A process evaluation of the implementation of the Portuguese Drug Strategy should focus on the degree to which the Portuguese Drug Strategy is implemented in such a way that the overall objectives of the Strategy could be reached, and, if not, what suggestions can be made for future implementation of the Strategy. This evaluation could also enable a study focusing on the structures that are in place, to see whether the structures enable a good implementation process. In order to evaluate implementation of the Strategy, the following data need to be collected. Many of these data should be collected separately for each of the Portuguese districts, and some of the data should be split into data on the general population and data on imprisoned drug addicts. Furthermore, the specific characteristics of each district should be taken into account. This list is not comprehensive, but should rather be seen as a starting point for the evaluation agencies.

#### *General*

- Number and type of information campaigns providing information in the National Drug Strategy aimed at the general public

#### *Prevention*

- Number and type of new prevention programs initiated
- Number and type of people reached by prevention programs (e.g. socio-demographic characteristics of the target groups)

#### *Treatment*

- Accessibility of treatment centers for drug users
- Capacity of treatment centers
  - physical capacity (number of treatment slots)
  - human resources (number of care givers + number of care givers in training)

- types of treatment offered

#### *Harm reduction*

- Number and type of new harm reduction programs initiated

#### *Social reintegration*

- Number and types of initiatives focused on social reintegration of drug addicts

#### *Administrative sanctions*

- Number of administrative committees per district
- Composition of the administrative committees
- Number of people referred to the administrative committees
- Characteristics of drug users related to decisions taken by the administrative committee
- Number of appeals against administrative committee decisions
- Percentage of people who do not show up at the administrative committee upon invitation
- Actions taken by the administrative committee if people do not show up
- Type of information provided to the administrative committees both actively (e.g. brochures) and passively (e.g. number and types of questions asked by the administrative committees at the central helpdesk for committees at IPDT)

#### *Criminal sanctions*

- Number of people involved in the combat against drug trafficking and money laundering

#### *Information collection*

- Type of data on drugs and drug addiction that are being collected
- Type of scientific research conducted in the field of drugs and drug addiction and the amount of money spent on this research
- Quality of data collection
- Quality of research
- Comparability of data

### *Coordination between involved parties*

- Division of responsibilities between different actors
- Type and frequency of coordination between national authorities in the field of drugs and drug addiction
- Type and frequency of coordination between national and international authorities in the field of drug trafficking and money laundering
- Effectiveness and efficiency of coordination between national organizations working in the field of drugs and drug addiction
- Effectiveness and efficiency of coordination between national and international organizations in the field of drug trafficking and money laundering

Evaluation of the proposed policy measures, except for decriminalization, is difficult because they are not compulsory by law (it is an enabling law). The evaluation should therefore try to assess why certain communities have chosen to implement the law and others have not. This might reveal thresholds to implementation that can be solved.

**Outcome evaluation.** An outcome evaluation of the Portuguese Drug Strategy should focus on the degree to which the Strategy has contributed to reaching the intended goal. A major problem in this respect is that the Strategy does not clearly specify what the intended goals are. The interviewees and the members of the Project Panel have, however, discussed when they consider the Portuguese Drug Strategy to be a success. This information can be used to define indicators for the outcome evaluation:

- A decrease in the number of drug users;
- A (relative) increase in the number of drug users in treatment;
- An increase in the number of drug users in harm reduction programs.

The objectives of the Drug Strategy are abstract. This makes it very difficult to determine whether the efforts to combat the drug problem have sufficient effect. The objectives of the Strategy would need to be specified in measurable goals in order to enable evaluation. Instead of the abstract objective of "reduction of the number of drug users" the policy goal could state that "a reduction of the number of drug users by 20% in 2005" would have to be achieved. This way, the effects of the implementation could be compared to the goals that have been set and will be less subject to political discussion. There is one important condition for this to work: the starting point would have to be known. A reduction in the number of

drug users can only be seen if the number of drug users now and in the future can be measured.

Measuring these indicators implies a need for collecting the data listed below. Many of these data should be collected separately for each of the Portuguese districts, and some of the data should be split into data on the general population and data on imprisoned drug addicts. Here also, the consequences of the law on prevention and harm reduction, being an enabling law, poses restrictions on the way evaluation is conducted.

#### *Prevention*

- Number of drug users
- Perceptions of young people on drug use
- Number of drug-related deaths

#### *Treatment*

- Number of people in treatment
- Average length of waiting lists for treatment
- Capacity of treatment centers
  - physical capacity (number of treatment slots)
  - human resources (number of care givers + number of care givers in training)
- Effectiveness of treatment; does increased diversity in treatment options lead to improved care?

#### *Harm reduction*

- Number of people in different types of harm reduction programs (e.g. number of people benefiting from needle exchange programs, number of people entering substitution treatment, etc.)

#### *Social reintegration*

- Perceptions of drug addicts on how they are 'treated' by society

#### *Administrative sanctions*

- Work loads of administrative committees
- Date of first and last contact with the administrative committee and number of contacts
- Number and type of sanctions

- Percentage of addicts who go to treatment
- Percentage of drug users referred for treatment by the administrative committee who have been in treatment before
- Characteristics of drug users related to decisions taken by the administrative committee (e.g. rate habitual users vs. addicted users)
- Work loads of courts

#### *Criminal sanctions*

- Number of drug traffickers convicted

#### *Information collection*

- Quality of data collection
- Quality of research
- Comparability of data

#### *Coordination among involved parties*

- Effectiveness and efficiency of coordination between national organizations working in the field of drugs and drug addiction
- Effectiveness and efficiency of coordination between national and international organizations in the field of drug trafficking and money laundering

## **4.6 Division of responsibilities for evaluation**

In an evaluation process several responsibilities can be distinguished:

- Initiation of the evaluation;
- Conduct of the evaluation;
- Data collection; and
- Communication of the results.

These responsibilities do not necessarily have to be performed by one organization. Moreover, it is even advisable to split these tasks over more than one organization.

**Initiation of the evaluation:** Generally, we believe it would be best if the evaluation of the Portuguese Drug Strategy is initiated by the organization that is responsible for that Strategy, in this case the Coordination Board of the National Strategy. This shows the organization's commitment to its program or policy, and the initiator is the first one to take action upon the results of the evaluation. However, other parties that have questions about the effectiveness of the Strategy,

such as parliament, political parties, media, universities, etc, could also initiate the evaluation. It would be good if one organization were to coordinate all evaluation efforts or if all evaluation efforts were to be conducted by one and the same organization, so that all efforts continue to be seen as part of the National Drug Strategy as a whole.

**Conduct of the evaluation.** As explained in the above, either an internal or an external evaluator could conduct an evaluation of the Portuguese Drug Strategy. We believe it would be preferable if the evaluation of the Drug Strategy is conducted by another organization than the organization that is responsible for the actual coordination and implementation of the Drug Strategy. We prefer an external evaluation because the evaluators have no stake in the outcome of the study and can therefore be more objective in evaluating the Strategy. The independence of the evaluator will be important if the results are to be accepted by all stakeholders. In addition, external evaluators generally have more experience in doing evaluations than internal evaluators which results in a more thorough, higher quality evaluation, assuming that the evaluator has sufficient knowledge about drugs and drug addiction. This means that the external evaluator should be selected carefully. The organization initiating the evaluation might consider putting out a tender to recruit organizations which are willing - perhaps in consortium - to carry out an evaluation of the Portuguese Drug Strategy.

**Data collection.** The collection of data should be coordinated by the organization that is responsible for conducting the evaluation. However, the actual collection of data could also be performed by other organizations. We believe data on specific aspects of the Drug Strategy, such as data on prevention, treatment, and social reintegration, should be collected by the organizations working in those fields. It is important that all actors use the same definitions to ensure comparability of the data.

**Interpretation and communication of the results.** Conducting an evaluation does not end with collecting and analyzing data. The results can be interpreted in many ways. The evaluator should be careful to conduct such an evaluation and to explain the interpretation of the results clearly. Statement of raw data might lead to misunderstandings that do more harm than good to the policy. The results of the evaluation should be communicated by the organization that conducted the evaluation to the organization that initiated the evaluation, in this case preferably the Coordination Board of the National Strategy. This organization is on its turn

responsible for communicating the results to the other relevant organizations in the field of drug and drug addiction. The organization conducting the evaluation and interpreting and communicating the results should be a respected organization whose communications are considered unbiased. Clear and unambiguous communication of the results will stimulate improvement of process and outcomes of the policy and can help avoid political discussions about the meaning of the results.

#### **4.7 Conclusion**

The Portuguese Drug Strategy is a very recent document and its implementation is still in the planning phase. This is a good moment to do a formal or informal ex-ante evaluation to make explicit what exactly a program needs to achieve; in other words, how the objectives should be split up into specific goals. These goals then form desirable end points for action plans that implement the law. This way, criteria for evaluation can help shape the implementation: a true structure evaluation.

In the case of the Portuguese Drug Strategy different types of evaluation are useful at different moments in time. For example, the government could decide to do a structure evaluation of the process after one year, and then study the effects of the policy on drug use and treatment entry after four or five years.

Doing an evaluation piecemeal is the only way to do it. On the other hand, evaluation of the different parts of the National Drug Strategy is only useful if the results of the different evaluations are seen in relation to one another and in relation to the overall goals of the Strategy. This implies that one organization should coordinate the evaluations and put them in perspective.

Evaluation is only useful if it is done very thoroughly and on the basis of good definitions and data. Data collection is of foremost importance to any evaluation. A lot of data are already being collected, but many more need to be collected. This data collection needs to start as soon as possible if the evaluator is to be able to compare the effects of the Drug Strategy to the current situation. In this chapter we summarized what data are minimally needed and what actions ought to be taken to conduct a good evaluation of the Portuguese Drug Strategy. The evaluating organization will need to operationalize this framework into concrete data collection variables.

## Chapter 5 Findings and recommendations

### 5.1 Introduction

This final chapter gives an overview of the main findings of the project, followed by recommendations formulated by the authors of this study regarding implementation and evaluation of the Portuguese drug policy. This focus on implementation and evaluation results from the often-stated remark by the Project Panel and the interviewees that they agree with the principles of the Drug Strategy, but that the eventual success of the Strategy will depend on the way the Strategy is brought into practice.

### 5.2 Specifying the objectives

**The Drug Strategy's objectives are rather abstract.** In the Drug Strategy, the objectives are only vaguely defined. The stated objectives are: (1) to contribute to an appropriate and efficient international approach of the world drug problem; (2) to provide Portuguese society with better information about the phenomenon of drugs and drug addiction; (3) to reduce the use of drugs; (4) to guarantee the necessary resources for treatment and social reintegration of drug addicts; (5) to protect public health and the security of people and property; and (6) to repress illicit traffic of drugs and money laundering. These objectives leave plenty of space for the stakeholders to interpret them according to their own interests.

**From policy plan to policy responsibility.** As the objectives of the Portuguese Drug Strategy are stated in a vague and abstract way, it becomes very difficult to determine whether the efforts to combat the drug problem are worthwhile. We believe that the objectives of the Strategy should be specified in order to measure whether specific policy measures, such as changing the law or spending additional budget on prevention, have indeed led to the intended results. Instead of reducing the use of drugs, the objective should, for example, be a reduction in the number of drug users by 20% over five years. By stating specific objectives, it becomes easier to measure whether intended effects are reached.

### 5.3 Coherence of the drug strategy

**The actual coherence of the Strategy depends on its implementation.** In theory, the Drug Strategy seems coherent. The eight structuring principles, the six

general objectives, and the thirteen strategic options seem to form a coherent approach of the problem of drugs and drug addiction. However, its actual coherence depends on the practical implementation of the Strategy. Although the components of the Drug Strategy (i.e. the thirteen strategic options as formulated in the Portuguese Drug Strategy) do not contradict each other in theory, they might have opposite effects in practice. For example, the reinforced combat against drug trafficking might make it more difficult to traffic drugs, whereas decriminalizing the possession of drugs might make this easier, since it will become more difficult to distinguish drug traffickers from drug users (especially when people traffic small amounts of drugs). This means that a careful and coordinated implementation of the Strategy is important to make sure that the Strategy will in the end attain the intended effects.

#### **5.4 Attention for implementation**

**Successful implementation requires a focused effort.** The Project Panel and the interviews made clear that successful implementation is not straightforward. The panelists and interviewees have defined actions that deserve priority attention in implementing the Drug Strategy. Here, these actions will be briefly discussed.

- **Informing the public.** In order to implement the Drug Strategy, it is important that the general public understands the rationale behind that Strategy. It should be clear to them what decriminalization means, and how that is different from depenalization, legalization or liberalization.
- **Providing sufficient treatment capacity.** An increase in treatment capacity, both in terms of physical capacity and in terms of quantity and quality of caregivers, is crucial to make decriminalization possible and maintain public support.
- **Training the administrative committees.** Training the members of the administrative committees is essential to make sure that appropriate decisions on individual drug users are taken and to make sure that similar sanctions are given in similar cases.
- **Improving coordination.** Better cooperation between the stakeholders involved in the field of drugs and drug addiction - i.e. between the medical system, the criminal justice system, the education system, etc., is needed to make a comprehensive approach of the drug problem possible.
- **Refocusing allocation of the budget.** To enable successful implementation of the Drug Strategy, the budget available for combating the problem of drugs and drug addiction should be both increased and

better allocated. The Drug Strategy already provides in an increase in the budget to 150% of the 2000 budget. The allocation of the budget should shift in favor of harm reduction, imprisoned drug addicts and research on drugs and drug addiction.

- **Informing the policy makers.** Policy makers involved in the implementation of the Drug Strategy should have sufficient information to take decisions that are consistent with the overall objectives of the Strategy. In order to generate this information, evaluation of the Drug Strategy and research on drugs and drug addiction are of great importance.

The members of the Project Panel noted a number of times that developments in the area of drug policy have followed each other in a too short period. The government has imposed a large number of new laws and strategies, but the communities lack the money, time, training and personnel to implement them.

**Balancing standardization and fine-tuning.** Looking at the recommendations of the Project Panel and the interviewees for implementation, it emerges that a balance needs to be found between standardization and fine-tuning. On the one hand, drug users all over the country should be 'treated' similarly and equally. This means, for example, that they should have equal treatment opportunities and that administrative committees in different regions should take similar decisions in similar cases. On the other hand, an individualized approach of drug users is considered important. This means that characteristics of the drug users, such as their treatment history and the region they come from, should be taken into account. There is no easy way to solve the tension between standardization and fine-tuning, but it is important to recognize the existence of this tension and take it into account when important decisions on the implementation of the Drug Strategy have to be taken.

## **5.5 Measuring the success of the drug strategy**

**Need for immediate data collection.** Measuring the effects of Portugal's Drug Strategy is only possible if accurate information on the starting point is available, i.e. the situation before implementation of the Strategy has begun. This means that it is important to start designing the evaluation as soon as possible, and to determine which data are needed for the evaluation. As soon as it is clear which indicators will be used for the evaluation, information on these indicators for the current situation

should be collected. The longer one waits before collecting these data, the more problematic interpreting the evaluation results will be.

**Explore the bases of success.** To measure the success of the Drug Strategy, it is essential to evaluate both the process and the outcome of the implementation of the Strategy. Evaluating the outcome of the Strategy, i.e. the effects on drug supply and demand, is essential to assess whether the Drug Strategy has led to its intended results. Evaluating the process is essential to monitor and, if necessary, change the implementation of the Strategy. And more importantly, evaluating the process is essential to explain which elements of the Drug Strategy have contributed to its success or failure. Just measuring the outcomes is thus not sufficient; it is important to know the reasoning behind successes or failures so that Portugal and other countries can benefit from the knowledge resulting from the radical change in Portugal's Drug Strategy.

## **5.6 Conclusion**

In conclusion, Portugal has deliberately set forth on a novel approach to deal with the problems of drug use that is consistent with a set of general humanistic and pragmatic principles, as well as with international laws and treaties. However, it is not clear how these changes will work out in practice. Careful specification of the objectives of the approach, a thorough evaluation, and an ongoing willingness to learn offer the potential of major breakthroughs in society's efforts to deal with drug problems.

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[www.drugtext.org](http://www.drugtext.org)

[www.emcdda.org](http://www.emcdda.org)

[www.hereinstead.com](http://www.hereinstead.com)

## **Annex A: Interviewees**

Dr. Vitalino Canas, Secretário de Estado, Presidência\_de Conselho de Ministros, Lisboa

Dra. Maria Teresa da Costa Macedo, president, Confederação Nacional das Associações de Família, Lisboa

Dr. Rodrigo Coutinho, Serviço de Prevenção e Tratamento da Toxicodependência, Lisboa

Dr. João Augusto Castel-Branco Goulão, president, Serviço de Prevenção e Tratamento da Toxicodependência, Lisboa

Dr. Domingos Duran, Associação Nacional de Intervenientes em Toxicodependencia (ANIT), Centro de Atendimento a Toxicodependentes das Taipas, Lisboa

Dr. Luis Evangelista, advisor to Vitalino Canas (see above)

Dr. Carlos Fernandez, Instituto Português da Droga e da Toxicodependência, Lisboa

Dr. Antonio Cardoso Ferreira, Centro de Atendimento a Toxicodependentes, Guarda

Dr. Armando Leandro, Supremo Tribunal de Justiça, Lisboa

Dr. Emilio Leitão, Serviço de Prevenção e Tratamento da Toxicodependência, Lisboa

Dra. Filomena Marques, Gabinete de Toxicodependência, Câmara Municipal de Lisboa, Lisboa

Dr. Fernando Mendes, Instituto Português da Droga e da Toxicodependência, Lisboa

Dra. Maria Moreira, Instituto Português da Droga e da Toxicodependência, Lisboa

Dra. Elza Pais, president, Instituto Português da Droga e da Toxicodependência, Lisboa

Dr. Luis Duarte Baptista Patricio, Centro de Atendimento a Toxicodependentes das Taipas, Lisboa

Dra. Margarida Prata, Conselho Nacional de Juventude, Lisboa

Dr. Almeida Santos, President of the Portuguese Assembly, Lisboa

Dra. Ana Sofia Santos, Instituto Português da Droga e da Toxicodependência, Lisboa

Dr. João Manuel da Silva Miguel, Procurador-Geral Adjunto, Conselho Consultivo da Procuradoria-Geral da República, Lisboa

Dr. João Soares, mayor of Lisboa

Dr. Angelou da Souza, Responsible for drug prevention in the Comissão de Coordenação de Promoção e Educação para a Saúde (CCPES), Ministry of Education, Lisboa

Dr. Julio Machado Vaz, psychiatrist, director of a private clinic and of a therapeutic community, Porto

## **Annex B: Data on drug usage and treatment in Portugal**

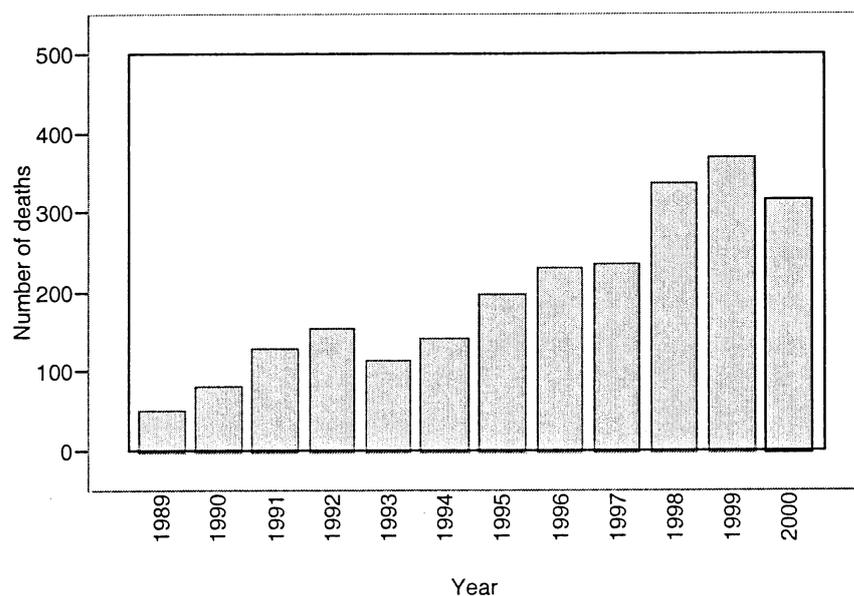
Although Portugal's drug problem seems to have worsened during the 1990s, real data on the extent of the problem have remained scarce. Some recent data suggest a population as high as 100,000 drug addicts. However, more usual and conservative estimates put the number of Portuguese drug users between 50,000 and 60,000 out of a total population of approximately 10 million people ([www.drugtext.org](http://www.drugtext.org)). One third of both the general population and population of drug users are concentrated in the Lisboa area.

Portuguese data on drug usage are scant and not always reliable. There is no equivalent to the national surveys on drug use that take place in some North American and European countries; no data exist on the lifetime or last 12 months prevalence of drug use among the general population in Portugal. What data are collected are reported to the European Monitoring Center on Drugs and Drug Addiction (EMCDDA), which was set up (coincidentally, in Lisboa) to provide the European Commission and its Member States with objective, reliable and comparable information concerning drugs and drug addiction. It collects information on drug use in each of the Member States of the European Union ([www.emcdda.org](http://www.emcdda.org); EMCDDA, 2001). Although some of these data (e.g. prevalence of HIV infection among drug users in Lisboa) stretch credulity, according to the experts, these data indicate that drug and drug-related problems increased significantly during the 1990s.

**Table B.1: Statistical description of drug use in Portugal**

<i>Lifetime prevalence of use of different illegal drugs among 15- to 16 year-old students (from a sample of 4767 students; year 1995)</i>	
All illegal drugs	4.7%
Cannabis	3.8%
LSD	0.2%
Cocaine	1.0%
Heroin	0.9%
<i>Characteristics of the persons treated for drug problems</i>	
Mean age	28.6 yrs
Gender = male	84%
Heroin as main drug	>90%
Injection as main route of administration	42%
<i>Incidence of drug-related AIDS cases (annual incidence rates per million population)</i>	
1985	0.1
1990	4.3
1995	39.5
1998	54.7
<i>Prevalence of hepatitis C among drug injectors</i>	
Lisboa, 252 people tested 1998-1999	74%
<i>Prevalence of HIV infection among drug injectors</i>	
Nationwide, 632 people tested 1998-1999	14%
Lisboa sample	48%

**Figure B.1 : Number of acute drug-related deaths 1987 - 1998<sup>9</sup>**



<sup>9</sup> The large increase in 1998 compared to 1997 is due to a change of definition of the number of acute drug-related deaths. On the other hand, some estimate that the actual number is higher, because the question whether someone's death is drug-related is only studied if the drug user died in a problem area.

The data from Table B.1 and Figure B.1 place Portugal unfavorably with respect to other harm-reductionist countries, with 34 drug related acute deaths per million citizens, compared to 4 per million in the Netherlands, 8 per million in Spain and 19 per million in Italy. These data cannot be compared directly, since all countries use different definitions, but this does show that Portugal has a high ratio of drug-related deaths.

### **Data on criminal justice system activity with regard to drugs**

Arrests for drug offenses reflect the increasing use of heroin. In 1991, 4667 people were arrested for drug offenses. By 1995, this number was up to 6380, and by 1998, the figure was 11395, or 235 percent of the 1990 figure. It is, however, not clear whether this increase in arrests for drug offenses is related to a more strict enforcement policy, ease of detection, record keeping or incidence of criminality. In 1998, 61% of the arrests were for use or possession for use (as opposed to sale or possession for sale), and 45% of the arrests were heroin-related. Given the overwhelming prominence of heroin in drug treatment, mention of heroin in arrests is relatively low.

Table B.2 provides information on seizures of drugs. This table is another indication that the heroin problem increased in the 1990s, but that seizures of other drugs did not reflect the pattern of heroin. The quantities for ecstasy and LSD are so small that they cannot be used to form reliable indicators of the extent of usage of these drugs.

**Table B.2: Numbers of Seizures and Quantities of Drugs Seized in Portugal, 1995, 1998, 1999 and 2000<sup>10</sup> (IPDT 2000 and 2001)**

	<b>Seizures per year</b>	<b>Total quantities per year</b>
<b>Cannabis</b>	1995: 914 1998: 2063 1999: 2726 2000: 2662	1995: 7493 kgs 1998: 5582 kgs 1999: 10701 kgs 2000: 30690 kgs
<b>Heroin</b>	1995: 2828 1998: 3750 1999: 4058 2000: 3209	1995: 66 kgs 1998: 97 kgs 1999: 76 kgs 2000: 567 kgs
<b>Cocaine</b>	1995: 872 1998: 1377 1999: 1691 2000: 1181	1995: 2116 kgs 1998: 625 kgs 1999: 10636 kgs 2000: 30467 kgs
<b>Amphetamines</b>	1995: not available 1998: 1 1999: not available 2000: not available	1995: not available 1998: not available 1999: not available 2000: not available
<b>Ecstasy</b>	1995: 5 1998: 35 1999: 73 2000: 81	1995: 77 tablets 1998: 1127 tablets 1999: 31319 tablets 2000: 25496 tablets
<b>LSD</b>	1995: not available 1998: 10 1999: not available 2000: not available	1995: 11 doses 1998: 261 doses 1999: not available 2000: not available

Comparing Portugal to its neighboring countries, the number of heroin seizures per million inhabitants is quite low: whereas the Portuguese police seize heroin 37 times per 1 million inhabitants, this number is 52 for the Netherlands, 337 for Spain and 112 for Italy. It is inadvisable, however, to draw any conclusions about the heroin market in a country on the basis of these numbers, because the number of seizures depends on a variety of factors, of which the effectiveness of the police is one. Still, one might expect Portuguese seizures to be higher, given that its coastal access and links to Brazil make it an attractive transshipment country.

#### **Data on treatment of drug addicts**

The number of treatment episodes in Portugal has increased fivefold in the last nine years, from 56,438 in 1990 to 288,038 in 1999 (SPTT, 1999). The 1999 episodes were for 27,750 individual drug users, for an average of about 10.4 annual visits to a treatment center per user. Of all drug addicts undergoing treatment in 1997, 95.4% were heroin users. Methadone or LAAM is not extensively used, being prescribed for

<sup>10</sup> These data do not necessarily reflect the relative size of different drugs on the drug market, because of differences in effectiveness of enforcement.

about 28.5% of individuals in treatment (IPDT 2001: p.34). Methadone and LAAM are not prescribed extensively, because they do not form the recommended treatment. Furthermore, low-threshold methadone prescription is not considered treatment, but is rather seen as a harm reduction measure. Medium and high threshold methadone provision is considered part of treatment. Unlike methadone centers in other countries, drug treatment centers in Portugal have a limited number of available places. In urban centers, waiting lists for substitution programs exist (EMCDDA, 2000a, p. 213).

**Table B.3: Treatment in Portugal in 1999/2000, by type of treatment center (IPDT 2000, IPDT 2001)**

<b>Type of treatment center</b>	<b>Number of centers</b>	<b>Number of patients</b>	<b>Number of consults/ days</b>
Addict consultation centers (CAT - <i>Centros de Atendimento a Toxicodependentes</i> )	40 (+ 10 annexes)	27750	288038 consults
Rehabilitation centers ( <i>Unidades de Desabituacão</i> )	5 UD - 46 beds	1945	11431 days
Public therapeutic communities ( <i>Comunidades Terapeuticas</i> )	2 CT - 34 beds	63	10578 days
Private therapeutic communities	120	2357	Not available
Day centers ( <i>Centros de Dia</i> )	4	106	Not available

Although the data are not always reliable, it is clear that the drug problem has increased. The government has decided to react to the changed reality by issuing the National Drug Strategy.

## Annex C: Comparison of the drug policies of seven selected European countries

<b>I.</b>	<b>SANCTIONS</b>	
<b>I.A)</b>	<b>Minor drug-related offences</b>	
	Portugal	Administrative sanctions: decriminalization of drug possession for personal use.
	Spain	Administrative sanctions for use of drugs and possession of drugs in public places.
	Italy	Administrative sanctions for activities related to personal use of drugs.
	United Kingdom	Proceedings can be dropped for possession of small quantities, occasional or personal use.
	Netherlands	Investigation and prosecutions of possession of <0.5g hard drugs and possession and sales of soft drugs (< 5g) has low priority. Possessing, selling, or producing up to 30g of soft drugs is sentenced with 1-month imprisonment and/or a fine (ca. 2250 Euro). Possessing hard drugs for personal use is sentenced with max. 1-year imprisonment and/or a fine (ca. 4500 Euro).
	Sweden	Use or possession of small amounts are usually sentenced with a fine, or on a voluntary basis, exchanged with counseling. In special cases, proceedings may be suspended.
	Switzerland	The Swiss Drug Strategy proposes depenalization of consumption of cannabis. Under certain conditions, consumers of other types of drugs are not prosecuted.

<b>I.B)</b>	<b>Illicit drug trafficking</b>	
	Portugal	Drug traffickers are punished by imprisonment according to the circumstances and the different lists. The offender is considered a dealer-user when the quantity exceeds 10 normal daily doses. Maximum penalty: 25 years.
	Spain	Spanish law distinguishes between the nature of drugs and the seriousness of the health hazard they present, and the special circumstances of trafficking. Maximum penalty: 23 years, 4 months and fine
	Italy	Police authorities and courts are responsible for deciding on the basis of the available evidence whether a user found in possession of drugs is involved in trafficking. For leading a group of >3 persons, minimum penalty is 20 years.
	United Kingdom	Penalties for trafficking are the same for users as for traffickers, taking into account 3 classes of drugs. Penalties: up to life time imprisonment (class A), up to 14 years (class B), and up to 5 years on indictment (class C).
	Netherlands	Dutch law distinguishes between trafficking of drugs with an unacceptable risk and other drugs, and between national and international drug trafficking. Repeated offences can be punished with severe penalties. Maximum 22 years and a fine of ca. 450,000 Euro.
	Sweden	Punishment according to the nature or quantity of drugs involved. An offence is serious when it was part of a large-scale and professional activity. Maximum penalty for multiple offences is 18 years.
	Switzerland	The federal government has introduced new legal instruments against money laundering and organized crime. A new law makes it mandatory for banks to report suspicious accounts to the federal authorities and to freeze the assets concerned.

<b>II.</b>	<b>TREATMENT</b>	
<b>II.A)</b>	<b>Availability of substitution treatment</b>	
	Portugal	Yes: methadone, LAAM
	Spain	Yes: methadone, LAAM, experiments with buprenorphine
	Italy	Yes: methadone, buprenorphine
	United Kingdom	Yes: methadone, buprenorphine (some heroin)
	Netherlands	Yes: methadone, heroin
	Sweden	Yes: methadone
	Switzerland	Yes: methadone, heroin
<b>II.B)</b>	<b>Treatment for 'regular' drug addicts</b>	
	Portugal	Drug addicts viewed as sick persons rather than criminals. Therapeutic alternatives to prison are available. Public prosecutor is substituted by a district commission that deals with non-violent drug use offenders in order to provide treatment and full rehabilitation.
	Spain	No information available.
	Italy	No information available.
	United Kingdom	The UK Drug Strategy contains a target to increase the participation of problem drug users in treatment programs by 100% by 2008.
	Netherlands	Focus on improving effectiveness of treatment for addicts causing nuisance: opportunities for clients to move from one facility to another, and follow-up facilities where the (new) treatment objectives are in line with the results of the previous treatment.
	Sweden	Narcotic medicines may only be supplied on prescription. For the methadone program, strict criteria are laid down which must be met before treatment is commenced. Compulsory treatment is available and applies especially to juvenile addicts.
	Switzerland	Drug dependents should be encouraged to enter therapy. In addition, specific means and individual support have to be made available in order to overcome addiction. The goal is abstinence and social reintegration/ rehabilitation.

<b>II.C)</b>	<b>Treatment for criminals addicted to drugs</b>	
	Portugal	No information available.
	Spain	No information available.
	Italy	For imprisoned drug users there exists the opportunity to start or restart treatment and subsequently apply for an alternative measure instead of the prison sentence to complete the treatment in a therapeutic environment. For drug using offenders, the focus is on treatment and rehabilitation measures that address both criminal behavior and drug-using behavior.
	United Kingdom	The UK Drug Strategy has a target to reduce repeat offending amongst drug misusing offenders by 50% by 2008. Arrest Referral Schemes employ drug workers to make contact with people in police cells and encourage those with drug problems to enter treatment. The courts have powers to impose new community sentences aimed at breaking the link between addiction and offending. Drug testing for offenders > 18 is allowed.
	Netherlands	Drug addicts who have committed a small offence are pressured to participate in treatment programs. Arrested drug addicts might opt for treatment by suspension of preventive custody, provided they enter clinical treatment and complete the program, they will be granted permission by a judge to leave the prison to be admitted to an addiction clinic as soon as they have served at least half their sentence. Also alternative sanctions and counseling are available. Drug addicts who repeatedly commit crimes and who failed voluntary treatment and coercion, are placed in a Penitentiary Treatment Institution.
	Sweden	Drug addicts who have committed a drug offence can access treatment signing a treatment contract. Addicts must need treatment, must be motivated to undergo treatment, must misuse drugs, and the drug habit must have contributed to the crime. The person is not sent to prison and a personalized treatment plan is established.
	Switzerland	No information available.

<b>III.</b>	<b>HARM REDUCTION MEASURES FOR INTRAVENOUS DRUG USE</b>	
<b>III.A)</b>	<b>Syringe exchange programs</b>	
	Portugal	One mobile unit, rest via pharmacies
	Spain	Yes, low-threshold services
	Italy	All regions, mostly from machines
	United Kingdom	Yes (>300 programs)
	Netherlands	Yes
	Sweden	2 programs
	Switzerland	Yes
<b>III.B)</b>	<b>Unrestricted access to syringes in pharmacies</b>	
	Portugal	Yes, but some problems
	Spain	Yes
	Italy	Yes
	United Kingdom	Yes (>2000 pharmacies)
	Netherlands	Yes
	Sweden	No
	Switzerland	Yes, there is a nation-wide program, incl. distribution through pharmacies and dispensing machines.
<b>III.C)</b>	<b>Availability/distribution of condoms</b>	
	Portugal	Yes
	Spain	Yes
	Italy	Yes
	United Kingdom	Yes
	Netherlands	Yes
	Sweden	Yes
	Switzerland	No information available.
<b>III.D)</b>	<b>HIV counseling and testing</b>	
	Portugal	Yes
	Spain	Yes
	Italy	Yes
	United Kingdom	Yes
	Netherlands	Yes
	Sweden	Yes
	Switzerland	Yes
<b>III.E)</b>	<b>HIV treatment</b>	
	Portugal	Yes, but very limited
	Spain	Yes
	Italy	Yes, free
	United Kingdom	Yes
	Netherlands	Yes
	Sweden	Yes
	Switzerland	Yes

<b>III.F)</b>	<b>Hepatitis B vaccination</b>	
	Portugal	Yes
	Spain	In prisons
	Italy	Yes (5-6% vaccinated)
	United Kingdom	Information and testing
	Netherlands	Pilot
	Sweden	Yes
	Switzerland	No information available.
<b>III.G)</b>	<b>Hepatitis C action</b>	
	Portugal	No information available
	Spain	Testing
	Italy	Screening (60% tested)
	United Kingdom	Information for pregnant women
	Netherlands	Experimental treatment
	Sweden	No information available.
	Switzerland	No information available.
<b>III.H)</b>	<b>Measures available to prisoners</b>	
	Portugal	Information and testing, condoms, methadone, vaccination
	Spain	Information and testing, vaccinations, methadone
	Italy	Information + testing, methadone, bleach for cleaning needles
	United Kingdom	Information not available.
	Netherlands	Information
	Sweden	Information and HIV testing
	Switzerland	Information, methadone.

Sources: EMCDDA (1999), EMCDDA (2000a),  
EMCDDA (2000c) Swiss Drug Policy (1999)

## **Annex D: Materials used in Project Panel Meetings**

### **Drug Decriminalization: Priorities for Portugal Meeting 2 November 2000**

#### **I. Decriminalization in context**

- A. Discuss the effects of decriminalization in Portugal on:
1. Drug treatment (access, effectiveness, mix of treatments, resources)
  2. Prevention (effectiveness, mix of primary/secondary/tertiary, targeted populations, resources)
  3. Re-integration (effectiveness, mix of strategies, resources)
  4. Harm reduction (mix of strategies, resources)
  5. Prisons (change in population, in-prison programs, resources)
  6. Street-level enforcement (mindset of police and other criminal justice agencies, strategies, resources)
  7. Wholesale dealer enforcement (strategies, resources)
- B. Rate the consistency of decriminalization with the other strategic options mentioned in the strategic plan document. See Rating Form 1.

**II. The New Legislation.** Last week, the Assembleia Republica passed a law on decriminalization. Our understanding is that it awaits the President's signature. We have copies of this law available here in case you haven't read it.

- A. Discuss the strengths, weaknesses, opportunities and threats posed by this law.
- B. What is missing in this law for effective implementation of decriminalization?

**III. Details of Decriminalization.** Discuss how the following should be decided. (This is more important than the actual decisions made.)

- A. Which drugs are subject to what strategies (i.e., hard vs. soft drugs)
- B. What levels of possession constitute presumed intention to traffic?
- C. Private vs. public use.
- D. Guidelines for administrative sanctions: which sanctions under what circumstances?

#### **IV. Evaluation and measurement.**

- A. Imagine some "scenarios" of the near-term future that would indicate the success of the decriminalization strategy (drug "utopias").
- B. Imagine some "scenarios" of the near-term future that would indicate the failure of the decriminalization strategy (drug "doomsdays").

C. What data are needed to know whether Portugal is headed towards one of the utopias or one of the doomsdays?

**V. The National Strategy as a Basis for Evaluation**

Take home and fill out Rating Forms 2, 3, 4, and 5 to provide your opinions of the relative importance of the 8 Principles and 6 General Strategies. Indication how well you believe the 13 Strategic Options serve each of the Principles and General Strategies.

## Princípios

1. Princípio da cooperação internacional
2. Princípio da prevenção
3. Princípio humanista
4. Princípio do pragmatismo
5. Princípio da segurança
6. Princípio da coordenação de meios
7. Princípio da subsidiariedade
8. Princípio da participação

## Objectivos gerais

1. Internacional
2. Informação
3. Reduzir o consumo
4. Tratamento e reinserção
5. Saúde pública e segurança
6. Reprimir o tráfico e branqueamento de capitais

## Opções estratégicas

1. Cooperação internacional
2. Descriminalizar o consumo
3. Reorientar o prevenção
4. Qualidade e capacidade de resposta
5. Redução de danos
6. Reinserção
7. Acesso ao tratamento de reclusos
8. Alternativas à pena de prisão
9. Investigação científica e formação
10. Metodologias e procedimentos de avaliação das iniciativas
11. Coordenação política interdepartamental
12. Combate ao tráfico e branqueamento de capitais
13. Duplicar o investimento público (10% ao ano)

**Public Administration Budget on Drugs and Drug Abuse (millions of EURO)**

Please indicate how you would divide the budget for 2005, assuming that the budget will be increased with ten percent (as the government indicated in the National Drug Strategy).

<b>Category</b>	<b>2000</b>	<b>2005</b>
Prevention	24,1	
Treatment	29,3	
Rehabilitation	15,2	
Harm reduction	4,6	
Prisons	3,4	
Law enforcement	24,0	
Research	2,1	
International cooperation	0,9	
<b>TOTAL</b>	<b>103,6</b>	<b>150,0</b>