European Monitoring Centre for Drugs and Drug Addiction

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

Portugal

Country Drug Report 2017

THE DRUG PROBLEM IN PORTUGAL AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

5.1 %

2.7 % 7.5 %

Other drugs

MDMA	0.6 %
Cocaine	0.4 %
Amphetamines	0.1 %

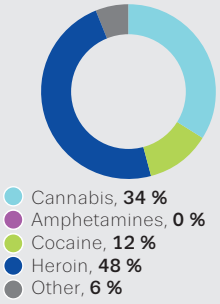
High-risk opioid users

31 858

(27 434 - 36 282)

Treatment entrants

by primary drug



Opioid substitution treatment clients

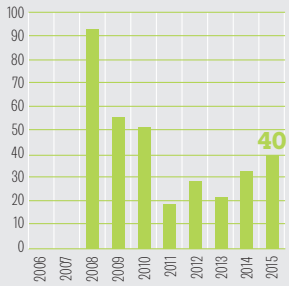
17 011

Syringes distributed

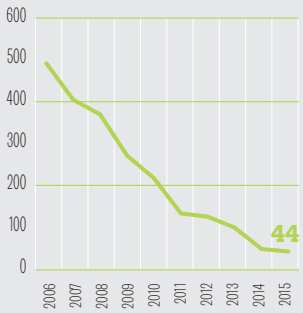
through specialised programmes

1 004 706

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

16 102

Top 5 drugs seized

ranked according to quantities measured in kilograms

1. Cocaine
2. Cannabis resin
3. Herbal cannabis
4. Heroin
5. Amphetamine

Population

(15-64 years)

6 779 414

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

About this report

This report presents the top-level overview of the drug phenomenon in Portugal, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

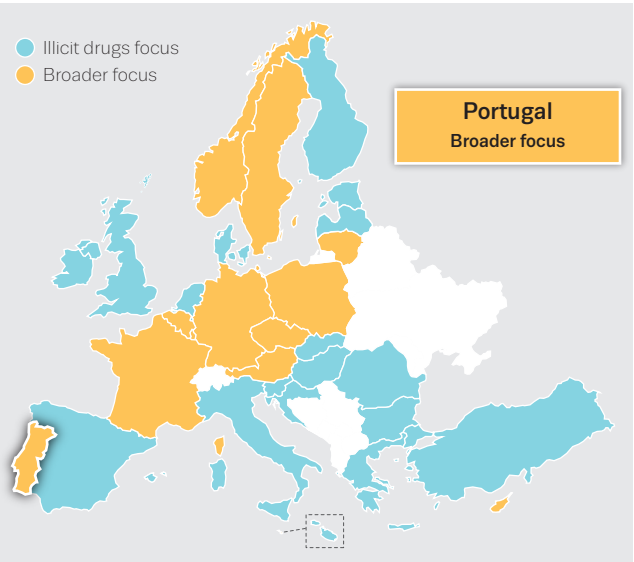
National drug strategy and coordination

National drug strategy

Portuguese drug policy is detailed in three strategic documents (National Strategy for the Fight Against Drugs 1999, National Plan Against Drugs and Drug Addiction 2005-12 and National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20). Launched in 1999 and envisaged as a long-term policy document, the National Strategy for the Fight Against Drugs defines the general objectives in the drug field. The strategy is built around eight principles, six objectives and 13 actions. The National Plan for the Reduction of Addictive Behaviours and Dependences (2013-20) builds on the 1999 strategy and takes a broad and integrated view of drug and addiction problems, including illicit drug use, new psychoactive substances (NPS), alcohol, prescription medications, doping and gambling (Figure 1). It is guided by five overarching objectives and is built around the two pillars of drug demand and drug supply reduction. It consists of two structural measures (the Operational Plan of Integrated Responses (PORI) and the referral network) and four transversal themes (information and research; training and communication; international relations and cooperation; and quality). The National Plan has defined a set of indicators and targets that are to be achieved during its timeframe (2013-20). Three management areas — coordination, budget and evaluation — support the plan's implementation alongside two action plans covering the periods 2013-16 and 2017-20.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

Like other European countries, Portugal evaluates its drug policy and strategy using routine indicator monitoring and specific research projects. In 2012, an external final evaluation was undertaken of the country's National Plan Against Drugs and Drug Addictions (2005-12). An internal evaluation of the last action plan (2009-12) was also completed. Both evaluations contributed to the development of the National Plan for the Reduction of Addictive Behaviours and Dependencies (2013-20), which expanded the scope of drug policy at the strategic planning level into the wider area of drugs and addiction strategies.

National coordination mechanisms

The National Coordination Structure for Drugs, Drug Addiction and Alcohol-Related Problems comprises several entities. The interministerial Council for Drugs, Drug Addiction and Alcohol-related Problems has the overall responsibility for the endorsement, coordination and evaluation of drug policy. It is chaired by the prime minister and consists of ministers from all relevant areas (currently 13) and the national drug coordinator. It is supported by the Interministerial Technical Commission, chaired by the national coordinator and composed of representatives designated by the different ministers. Its main function is to design, monitor and evaluate the National Plan and support action plans on illicit drugs, as well as evaluate the National Plan for Alcohol. The Directorate General for Intervention on Addictive Behaviours and Dependencies (SICAD), attached to the Ministry of Health, supports the National Strategy's implementation, through planning and evaluating demand reduction interventions. It is the national focal point to the EMCDDA and provides technical and administrative support to the Commissions for Dissuasion of Drug Addiction. The SICAD General-Director is the National Coordinator for Drugs, Drug Addiction and Alcohol-Related Problems.

The National Plan for the Reduction of Addictive Behaviours and Dependences (2013-20) addresses illicit drug use, new psychoactive substances, alcohol, prescription medications, doping and gambling

Public expenditure

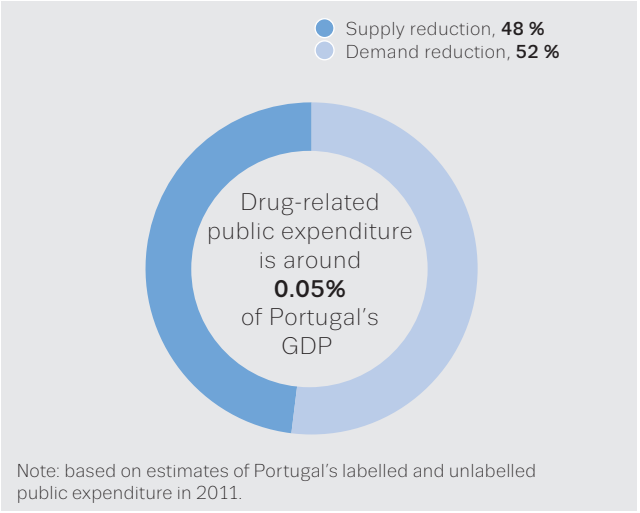
Understanding of the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments to expenditure on tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the bulk of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

One of the aspects of the evaluation of the Portuguese Action Plan 2009-12 focused on labelled drug-related expenditure. Some types of expenditure were missing from the estimates (e.g. spending on prisons, social security, etc.) and, for some areas, spending on alcohol initiatives was included. Taking these limitations into account, drug-related public expenditure was estimated to represent between 0.06 % and 0.05 % of gross domestic product (GDP) over the period 2009-11 (0.06 % of GDP in 2009 and 2010, and 0.05 % in 2011) (Figure 2).

The previous action plan for 2006-08 had a comprehensive associated budget. This budget forecast that labelled drug-related expenditure would represent 0.05 % of GDP with a 3 % annual nominal growth rate. The implementation of that budget was never fully assessed. Currently, there are no specific budgets financing drug policy, and public entities are provided with funds within their global budget on an annual basis, notwithstanding the creation of a sub-commission on public expenditures within the Technical Commission for Drugs, Drug Addictions and the Harmful Use of Alcohol.

FIGURE 2

Public expenditure related to illicit drugs in Portugal



Note: based on estimates of Portugal's labelled and unlabelled public expenditure in 2011.

Drug laws and drug law offences

National drug laws

The main drug law in Portugal is Decree Law 15/93 of 22 January 1993, which defines the legal regime applicable to the trafficking and consumption of narcotic drugs and psychoactive substances.

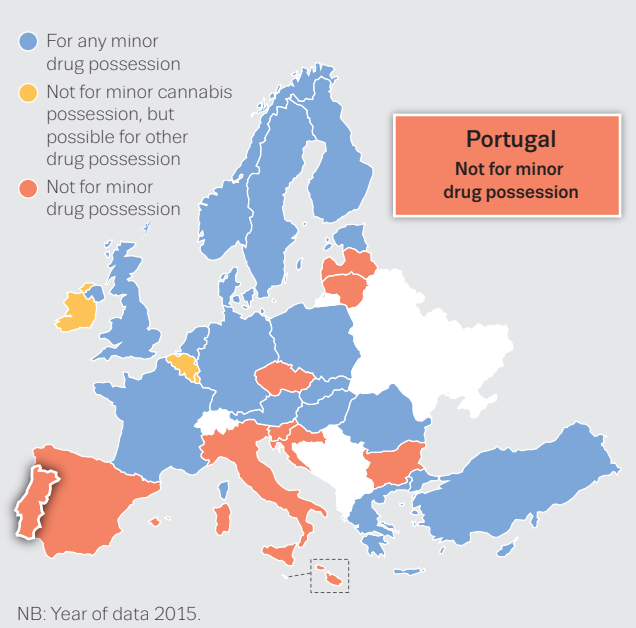
The Portuguese legal framework on drugs changed in November 2000 with the adoption of Law 30/2000, which has been in place since July 2001, which decriminalised illicit drug use and related acts. However, a person caught using or possessing a small quantity of drugs for personal use (established by law, this should not exceed the quantity required or average individual consumption over a period of 10 days), where there is no suspicion of involvement in drug trafficking, will be evaluated by a local Commission for the Dissuasion of Drug Addiction, composed of a lawyer, a doctor and a social worker. Punitive sanctions can be applied, but the main objective is to explore the need for treatment and to promote healthy recovery (Figure 3).

Drug trafficking may incur a sentence of 1-5 or 4-12 years' imprisonment, depending on specific criteria, one of these being the nature of the substance supplied. The penalty is reduced for users who sell drugs to finance their own consumption.

Decree Law 54/2013 was adopted in April 2013. It prohibits the production, export, advertisement, distribution, sale or simple dispensing of NPS named in the list accompanying the Decree Law and sets up a control mechanism for NPS. Administrative sanctions including fines of up to EUR 45 000 can be imposed for offences under this law, while a person caught using NPS, but who is not suspected of having committed another offence, is referred to a local Commission for the Dissuasion of Drug Addiction.

FIGURE 3

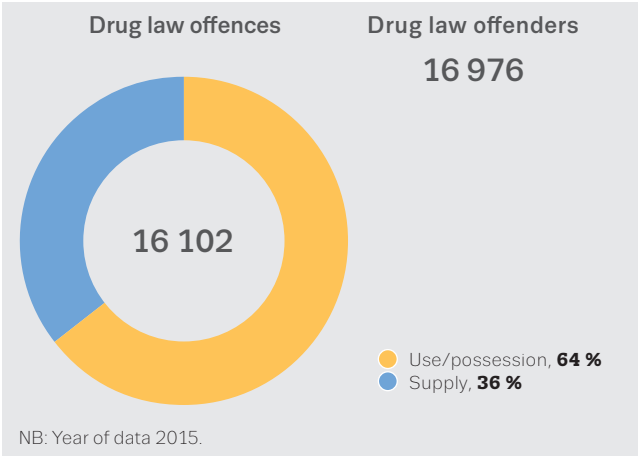
Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 4

Reported drug law offences and offenders in Portugal



NB: Year of data 2015.

Drug law offences

Drug law offences (DLO) data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

In 2015, around two thirds of drug law offences in Portugal were related to possession (Figure 4). The majority of drug law offences were linked to cannabis, followed by heroin- and cocaine-related offences.

Drug use

Prevalence and trends

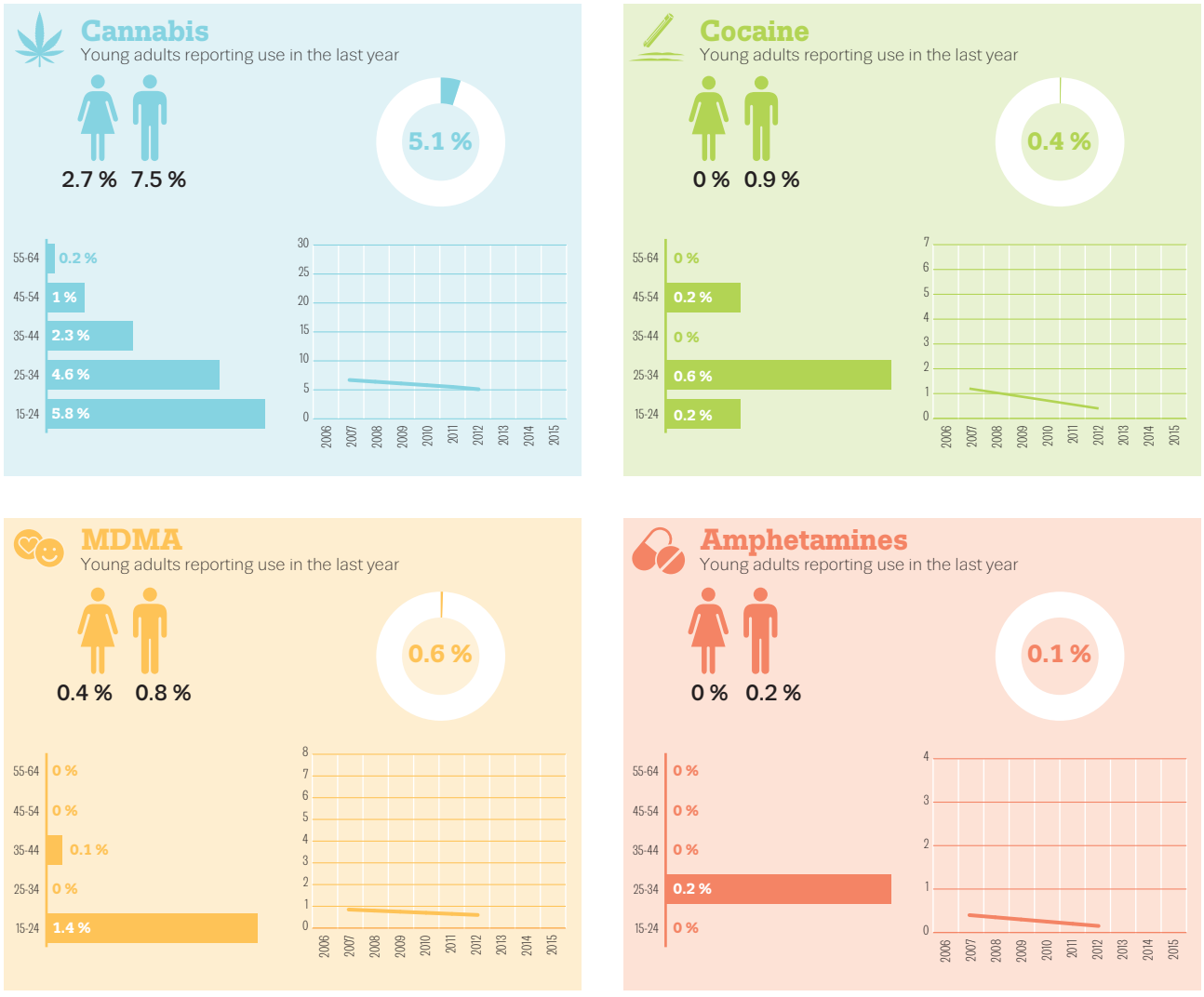
In Portugal, use of illicit substances among the adult general population seems to have been on the decline over the past decade. Cannabis remains the most frequently used illicit drug, followed by MDMA/ecstasy and cocaine. Use of illicit substances is more common among young adults (aged 15-34 years) (Figure 5).

However, last-year use of drugs other than cannabis remains low even in this age group. In general, males are more likely to report drug use than females. In 2012, approximately 0.4 % of all respondents and 0.9 % of young adults reported having used a NPS at least once in their lifetime.

Lisbon, Almada and Oporto participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on illicit drug use at a community level, based on the levels of different illicit drugs and their metabolites in wastewater. The results indicate an increase in cocaine and MDMA use in Lisbon between 2013 and 2016, and the use of these substances seems to be more common in Lisbon than in Porto and Almada (in 2015 and 2016). Moreover, in all locations the presence of these substances was higher at weekends than on weekdays. In 2016, amphetamine and methamphetamine levels detected in the three cities were low, indicating very limited use of these substances in these cities.

FIGURE 5

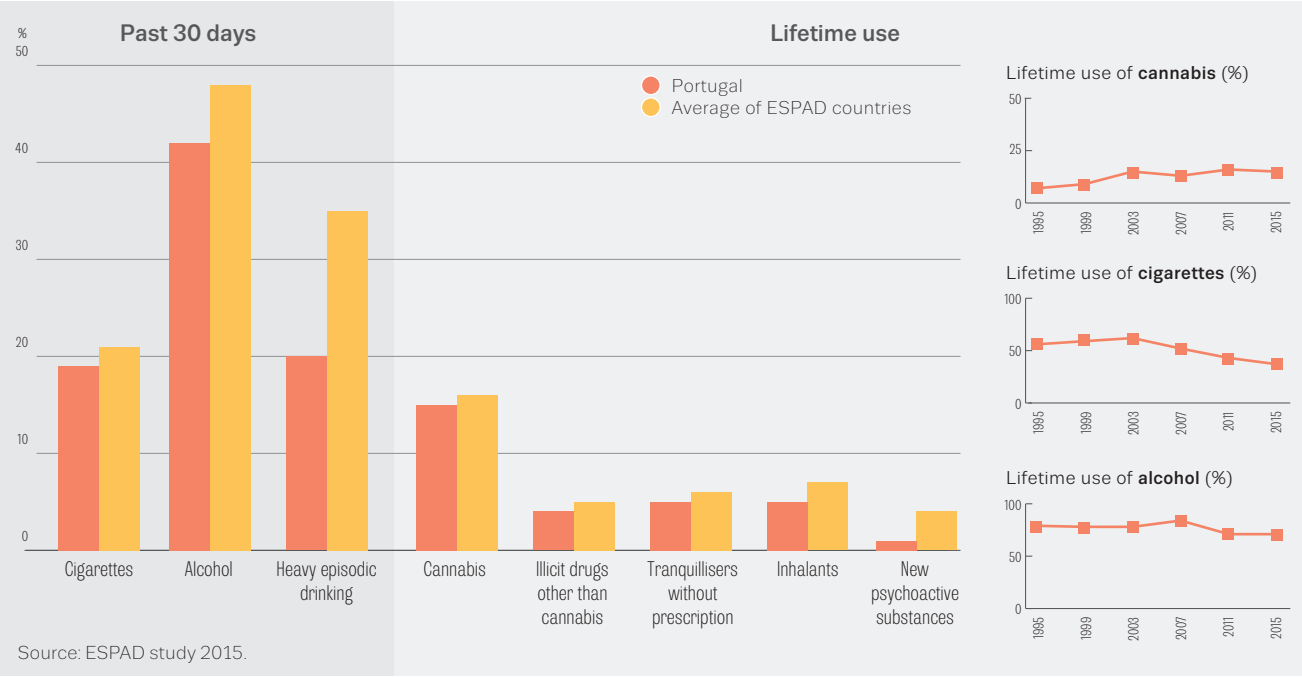
Estimates of last-year drug use among young adults (15-34 years) in Portugal



NB: Estimated last-year prevalence of drug use in 2012.

FIGURE 6

Substance use among 15- to 16-year-old school students in Portugal



Source: ESPAD study 2015.

The most recent data on drug use among students were reported in the 2015 European School Survey Project on Alcohol and Other Drug (ESPAD). Lifetime use of cannabis and other illicit drugs among Portuguese students was slightly lower than the European average (based on data from 35 countries), with lifetime use of NPS much lower than the average. Similarly, use of cigarettes in the last 30 days was just below the European average and alcohol use and binge drinking in the last 30 days were much lower than the average. Lifetime use of cannabis showed an increase in the 2003 survey, but it has remained relatively stable since, as indicated in the subsequent three surveys (Figure 6).

High-risk drug use and trends

Studies reporting estimates of high-risk use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 8).

The latest studies in Portugal indicate that, in 2012, the prevalence of high-risk cocaine use was 6.2 per 1 000 and the estimated prevalence of high-risk opioid use was 4.9 per 1 000 (Figure 7).

The Severity of Dependence Scales included in the 2012 survey suggested that about 0.7 % of 15- to 64-year-olds could be considered high-risk cannabis users.

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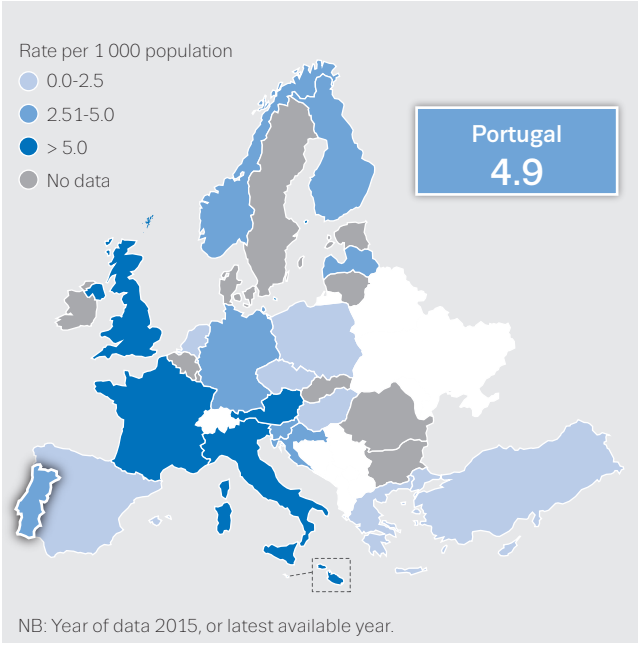
Data from specialised treatment centres show that the first-time treatment demands attributable to heroin use have declined in the past five years. In contrast, new treatment entries resulting from the primary use of cannabis have almost doubled in recent years. In the past decade, a decline in cocaine-related new treatment demands was noted with a stabilisation in the most recent years. In general, males accounted for the majority of treatment entrants (Figure 8).

FIGURE 7

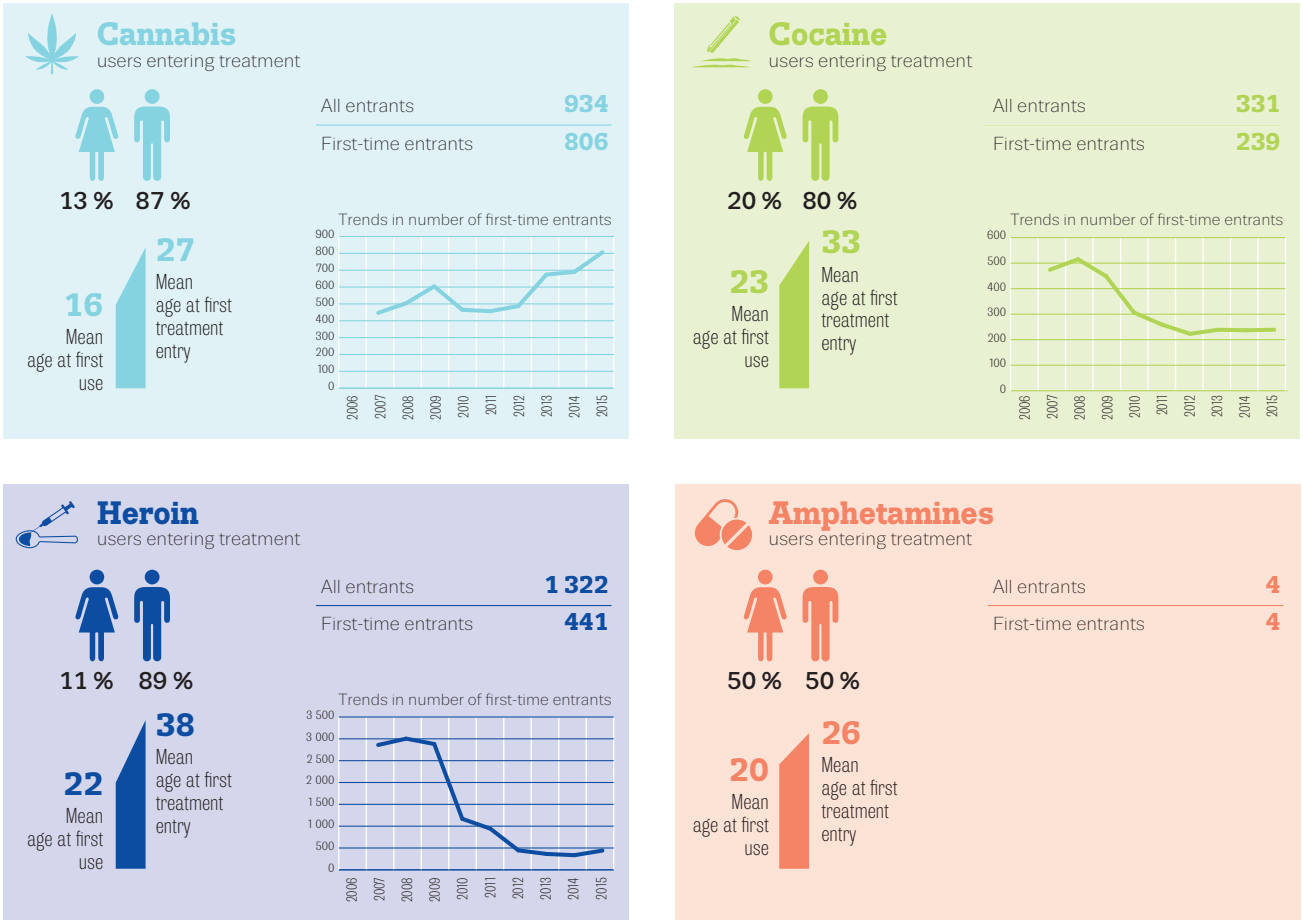
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 8

Characteristics and trends of drug users entering specialised drug treatment in Portugal



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

Drug-related infectious diseases

In Portugal, global estimates of the prevalence of infectious diseases among drug users are not available. However, data based on clients of some treatment facilities are available, and these can provide information on rates among some sub-groups of drug users: (i) those demanding treatment for the first time at the public network of outpatient treatment facilities; (ii) those admitted to public detoxification treatment units or certified private detoxification units; or (iii) those in treatment in public or certified private therapeutic communities.

In general, a decreasing trend in the total number of notifications of human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) cases has continued to be registered since the early 2000s in Portugal. In 2015, a total of 990 new HIV-positive and 238 new AIDS-infected individuals were reported for all risk groups together.Approximately 5 % (44 cases) of HIV and 14 % (33 cases) of AIDS were associated with injecting drug use. Similarly, there has been a large decline in the incidence of HIV and AIDS associated with injecting drugs in this risk group since 1999-2000 (Figure 9).

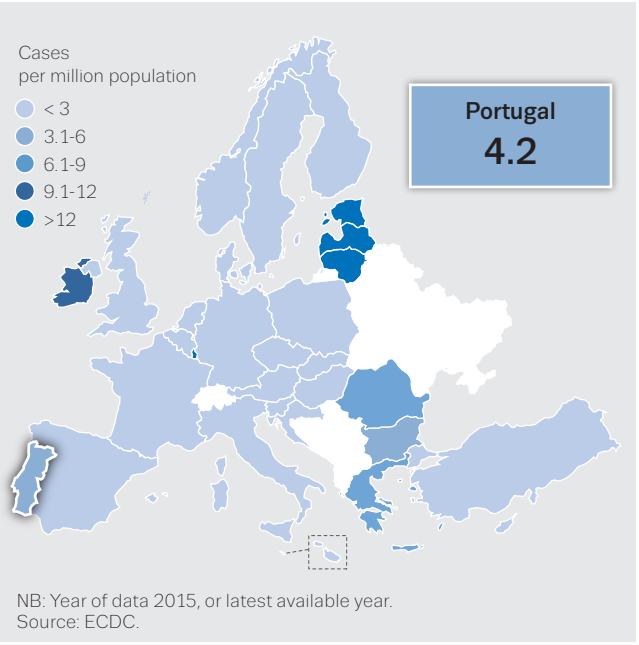
In 2015, 12 % of drug users who had ever injected drugs and who were tested at outpatient treatment services were HIV positive. This downward trend has continued since 2012, following a period of stability. The prevalence was higher in sub-groups of ever-injectors than in those who had never injected, ranging between 5 % and 27 % in different treatment settings; the maximum value was registered among licensed therapeutic communities and detoxification units.

This decreasing trend of new cases of HIV infection associated with injecting drug use, despite the improvements in the screening coverage, suggests a decrease in 'recent infections' in this risk group.

Among injecting drug users admitted to treatment, the rate of chronic hepatitis B virus (HBV) infection varies across studies in different settings, from 1 % to 11 %. In the case of hepatitis C virus (HCV), the prevalence of antibodies was 83.5 % among patients in drug treatment, and varied between 66 % and over 80 % in studies conducted among different populations (Figure 10).

FIGURE 9

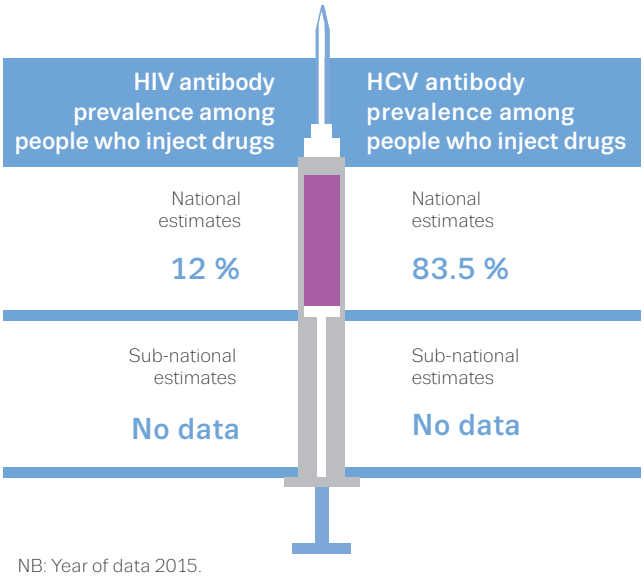
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 10

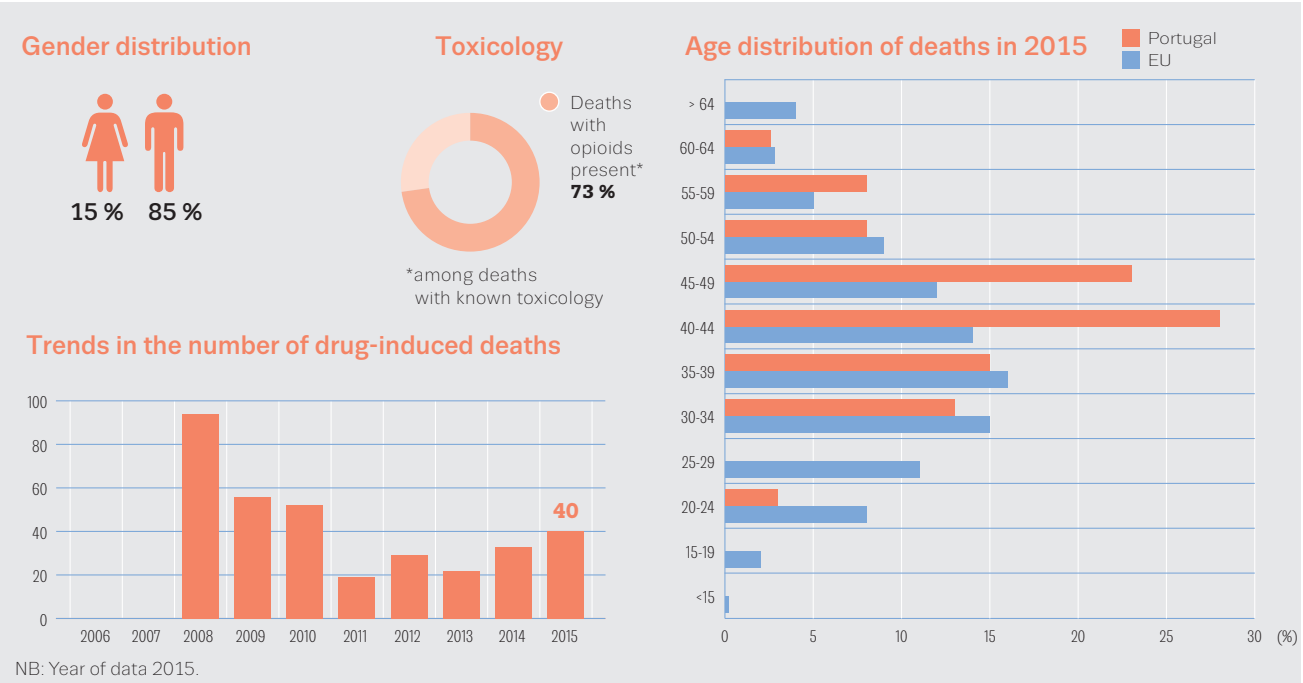
Prevalence of HIV and HCV antibodies among people who inject drugs in Portugal



NB: Year of data 2015.

FIGURE 11

Characteristics of and trends in drug-induced deaths in Portugal



NB: Year of data 2015.

Drug-induced deaths and mortality

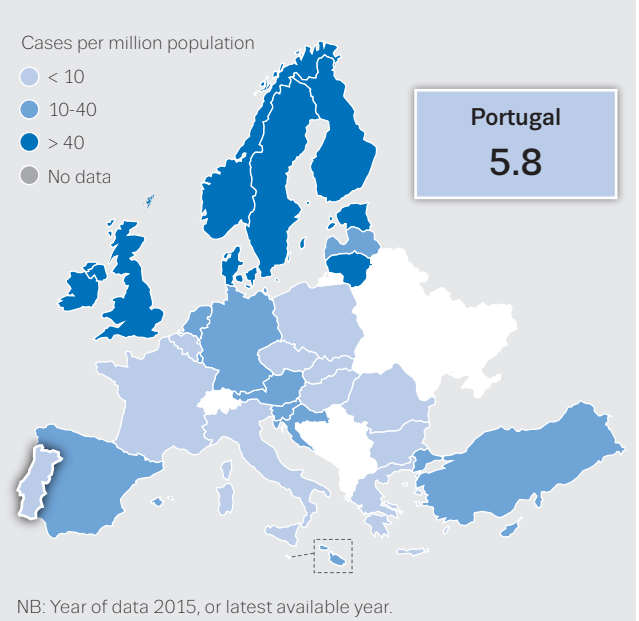
Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

According to data from the special registry of the National Institute of Forensic Medicine, there have been consecutive increases in reported drug-induced deaths in the last two years, although the number of deaths has remained below those reported for the period 2008-10. In 2015, the majority of deaths occurred among males. The mean age of victims in Portugal was 43, which is older than the European average. Opioids were detected in the majority of drug-related deaths, with heroin mentioned in 18 cases; however, in the majority of cases more than one substance was detected, and many cases recorded the presence of alcohol and benzodiazepines (Figure 11).

The drug-induced mortality rate among adults (aged 15-64 years) was 5.8 deaths per million in 2015 (Figure 12), which is lower than the most recent European average of 20.3 deaths per million.

FIGURE 12

Drug-induced mortality rates among adults (aged 15-64 years)



NB: Year of data 2015, or latest available year.

Prevention

The Portuguese National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20 recognises a need for age-specific prevention in the context of family, school, recreational and sports settings, community, workplaces, road safety and prisons. At the national level, prevention is a task of the Division of Prevention and Community Intervention of SICAD, while the Regional Health Administrations have a further role in the operational health policies.

In the framework of the National Plan, the Operational Plan of Integrated Responses (PORI) is an intervention framework targeted at drug demand reduction and is organised at the local/regional level. In each specific geographical area, an intervention may address specific local needs by bringing together relevant partners working in different settings. Within PORI, the most vulnerable geographical areas have been mapped in order to prioritise them for resource and intervention allocation. In continental Portugal, 163 geographical areas were identified for the development of integrated intervention responses at various levels (prevention, treatment, harm and risk reduction, and reintegration). In 2015, 18 integrated response projects were implemented in the framework of the Operational Plan with an estimated coverage of 21 143 people; 16 projects from 2014 were continued and two were new.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

In terms of environmental prevention, in 2015, the main initiative was the adoption of a new legal instrument that changed the legal framework for tobacco and alcohol, regulating their sale to and consumption by minors.

Universal drug prevention is part of the Portuguese school curriculum and is mainly implemented in sciences, biology and civic education classes. Throughout 2015, several prevention actions and projects were developed nationally in the school setting, either from an overall perspective of health promotion or focusing on specific aspects of addictive behaviours and dependences. Activities were developed by teachers, with the involvement of students, and often of other stakeholders in this area: public health care centres, municipalities, SICAD and civil society organisations (Figure 13).

Universal prevention strategies such as Me and the Others have been preferred to less structured approaches. The Me and Others programme has been implemented across various educational settings since 2006 and focuses on promoting children's healthy development. The programme is evaluated annually using a pre-post design only, and the evaluations suggest an increase in self-efficacy among the participants, which might be a result of the programme. Other standardised school-based prevention programmes are available at regional and local levels. Drug prevention activities in the workplaces, the military, communities and with families have also taken place.

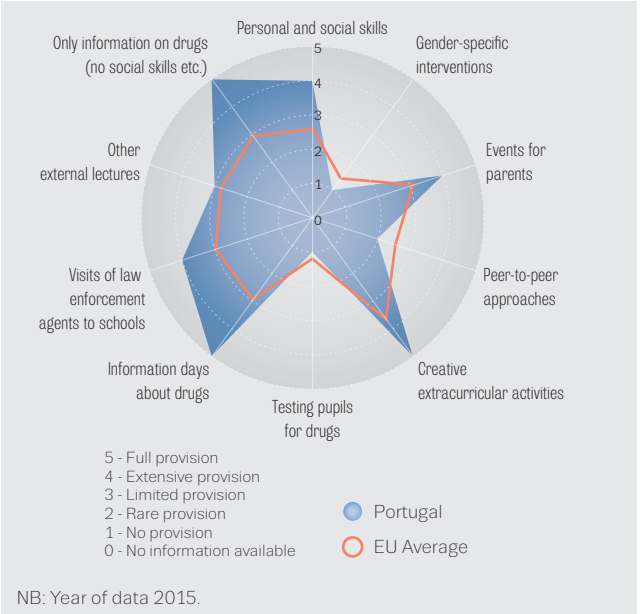
Different types of selective prevention interventions including community-based interventions for vulnerable groups, family-based interventions for vulnerable families and interventions for vulnerable neighbourhoods have been carried out. Kosmicare, an intervention to tackle crisis events related to the use of psychoactive substances at music festivals, was continued in 2016.

Indicated prevention consultations are carried out in integrated response centres by multidisciplinary teams, mainly targeting teenagers and young people who have already started using psychoactive substances. This indicated prevention service provides psychosocial support and referral to other services.

Several large media campaigns have been implemented in recent years to complement awareness-raising and information activities targeting young people. There has been a growing interest in the application of new technologies to support preventative interventions and health promotion, particularly in the recreational context.

FIGURE 13

Provision of interventions in schools in Portugal (expert ratings)



NB: Year of data 2015.

Harm reduction

The main priority established by the current national plan in the area of risk and harm reduction is to promote and develop the existing risk and harm reduction intervention model and to adapt it to the evolving drug use phenomenon by promoting effective and integrated responses. The governance and implementation of harm reduction services and interventions occur within the framework of the Operational Plan of Integrated Responses (PORI). This plan, managed by SICAD, relies on the diagnosis made by the regional authorities of health, after which intervention needs are identified in specific territories. While non-governmental organisations (NGOs) were instrumental during the creation of an infrastructure of health- and social service providers under Decree Law 183/2001, harm reduction has also become an integrated part of the services provided by the national network of health service providers.

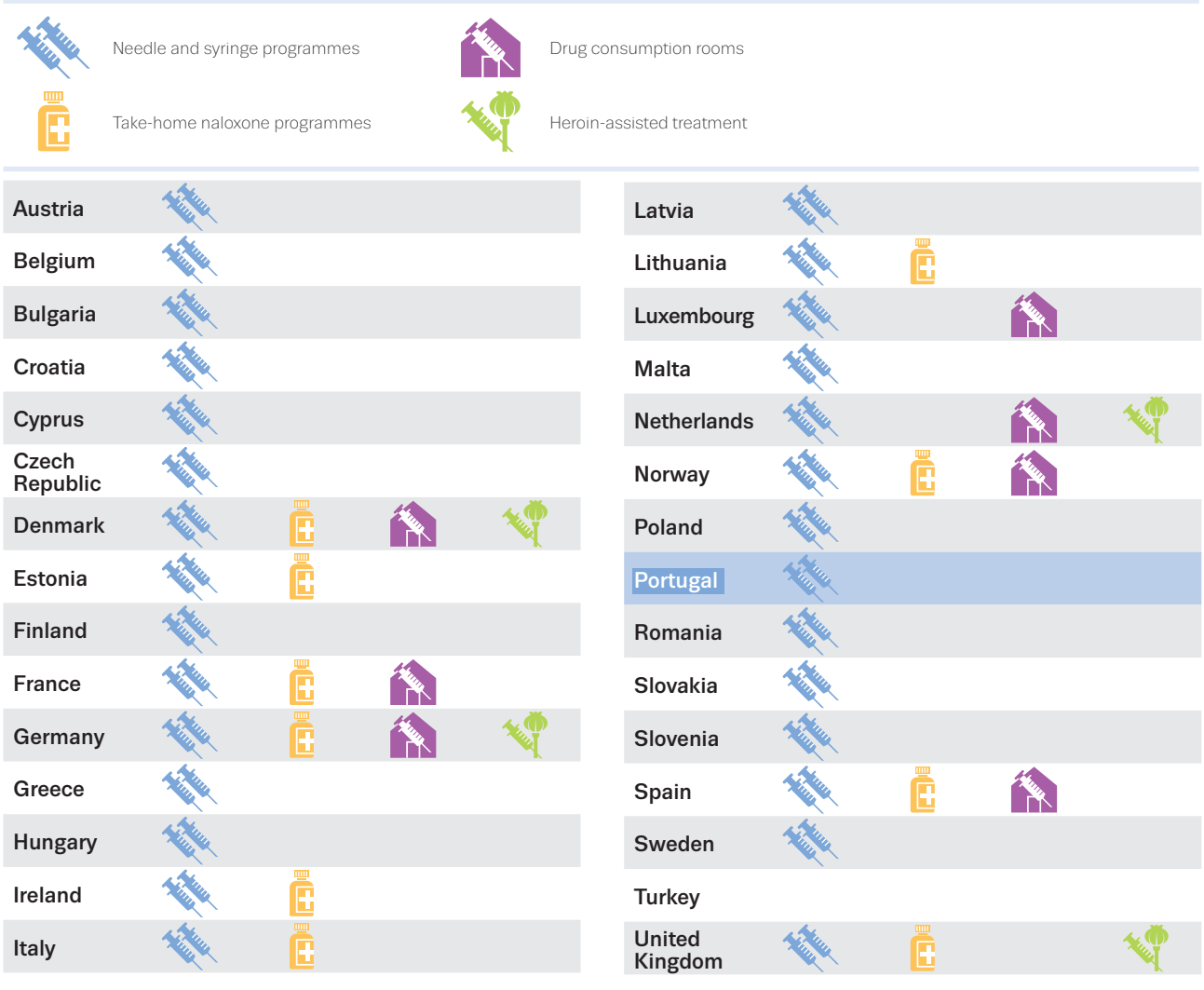
Harm reduction interventions

A nationwide network of harm reduction programmes and structures, including needle and syringe exchange programmes, low-threshold substitution programmes, drop-in centres/shelters, refuges, contact units and outreach teams, has been consolidated in areas of intensive drug use with the aim of preventing drug-related risks such as infectious diseases, social exclusion and crime (Figure 14).

The National Commission for the Fight Against AIDS (Comissão Nacional de Luta Contra a SIDA), in cooperation with the National Association of Pharmacies (Associação Nacional de Farmácias), implements the national needle and syringe programme, Say No to a Used Syringe, which was set up more than 20 years ago to prevent HIV among people who inject drugs. The programme involves pharmacies, primary care health centres and NGOs, and includes several mobile units.

FIGURE 14

Availability of selected harm reduction responses



NB: Year of data 2016.

Approximately 54 million syringes were distributed under this needle and syringe programme, in cooperation with pharmacies, between its launch in October 1993 and December 2015. Overall trends in syringe exchange show an increase in syringe numbers dispensed until 2001, followed by stabilisation at a lower level until 2005, and a decline thereafter. In 2015, around one million syringes were distributed by the programme. In 2014, SICAD initiated a two-year project to develop guidelines focusing on the competencies of harm reduction teams.

Treatment for HIV, AIDS, HBV and HCV is included in the range of services provided by the National Health Service of Portugal and is available free of charge.

Approximately 54 million syringes were distributed under this needle and syringe programme, in cooperation with pharmacies, between its launch in 1993 and December 2015

Treatment

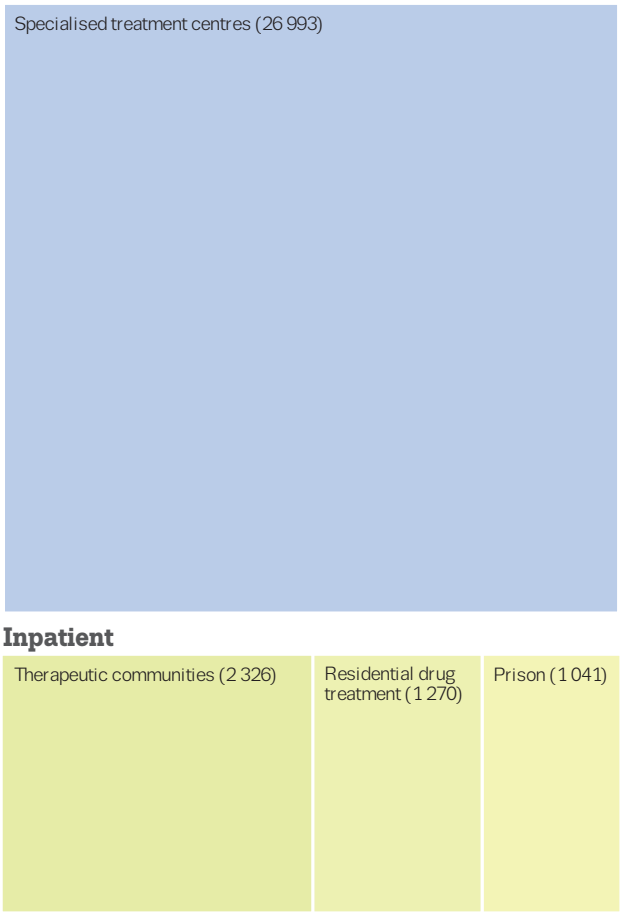
The treatment system

The National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20 states that treatment interventions should be based on a comprehensive diagnosis of each citizen's full biopsychosocial needs, be accessible and adaptable, be based on scientific evidence in terms of effectiveness, efficiency and quality, and be underpinned by guidelines.

Healthcare for drug users was reorganised in Portugal in 2013-14, and it is now provided by the Referral Network for Addictive Behaviours and Dependencies. The network encompasses public specialised services of treatment for illicit substance dependence, under the authority of Regional Health Administrations of the Ministry of Health, NGOs and other public or private treatment services interested and competent in provision of care. The network ensures wide access to quality-controlled services provided through several treatment modalities and in integration with other, non-health, services to this vulnerable population. The public services are provided free of charge and are accessible to all drug users who seek treatment. The network envisages three levels of care: (i) primary

FIGURE 15

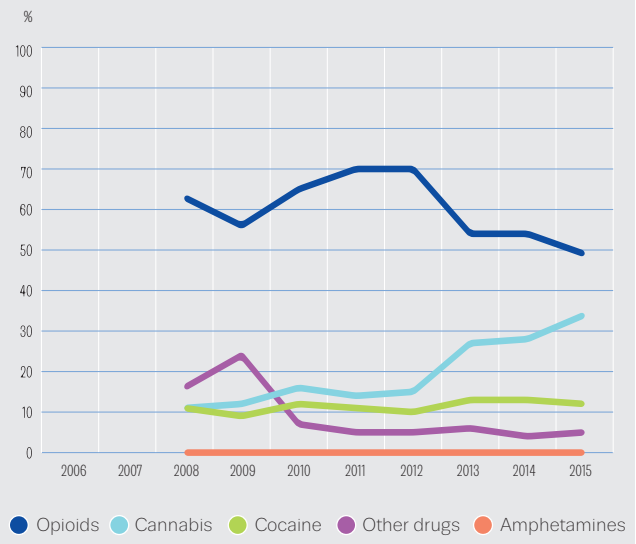
Drug treatment in Portugal: settings and number treated



NB: Year of data 2015.

FIGURE 16

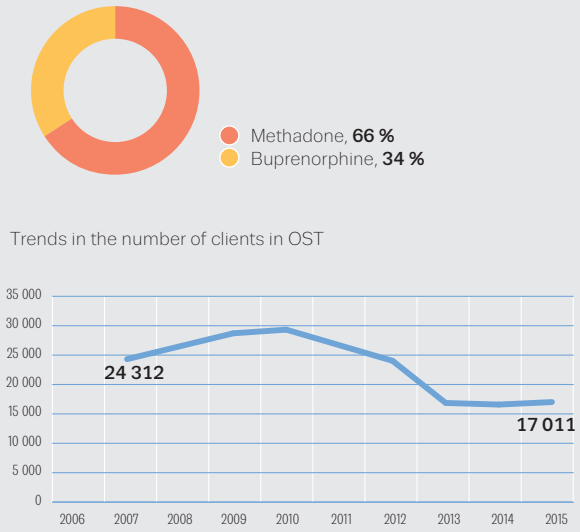
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Portugal



NB: Year of data 2015.

FIGURE 17

Opioid substitution treatment in Portugal: proportions of clients in OST by medication and trends of the total number of clients



NB: Year of data 2015.

healthcare services; (ii) specialised care, mainly in outpatient settings; and (iii) differentiated care, mainly in inpatient settings (detoxification units, therapeutic communities, day centres and/or specialised mental or somatic healthcare).

Although the model accepts that clients can enter treatment at any of these levels, in the long term it is expected that clients will enter treatment through first-level services, that is, primary healthcare.

Outpatient treatment is available at all three levels of care; however, the main providers of outpatient treatment are second-level services and include 72 specialised treatment teams from the integrated response centres. These treatment teams are usually the first point of contact for the clients. From there, referrals are made to public or private detoxification units or therapeutic communities. All centres provide both psychosocial care and opioid substitution treatment (OST). Activities that are primarily aimed at early intervention and the provision of counselling take place in general healthcare centres, while mental health services provide care to drug users with mental comorbidities.

Inpatient treatment is mainly provided through third-level care services. This includes short-term withdrawal treatment (7-10 days usually), which is available in eight public and private detoxification units. There are also 59 therapeutic communities, which usually provide 3- to 12-month residential treatment programmes. Therapeutic communities are mainly privately owned and publicly funded. Recently, a new programme of extended duration (up to three years) has been designed to meet the needs of clients who require longer term support services. Although treatment of opioid use remains a focus of the drug treatment system, special programmes for cannabis and cocaine users have also been created. In Portugal, OST is widely available through public services such as specialised treatment centres, health centres, hospitals, pharmacies, NGOs and non-profit organisations. Methadone has been available since 1977 and buprenorphine since 1999; the buprenorphine/naloxone combination was approved for use in 2007. Methadone maintenance treatment (MMT) can be initiated in treatment centres, and buprenorphine treatment can be initiated by any medical doctor, specialised medical doctors and treatment centres. MMT is free of charge to the client, while buprenorphine-based medications are available in pharmacies, with the National Health System covering 40 % of the market price of the medication.

Treatment provision

In 2015, approximately 27 000 clients — the majority of those in treatment — were treated in outpatient services, while about 3 500 clients were treated in inpatient services (Figure 15). This number has been decreasing since 2010. Of the 3 389 clients entering treatment in 2015, three out of every five were first-time clients. The number of previously treated treatment entrants has been decreasing since 2012, while the number of first-time entrants has been stable over this period. Since 2012, there has been an increase in the proportion of entrants reporting primary cannabis use and a decrease in the proportion reporting primary opioid use (Figure 16). Among first-time entrants, cannabis has been the most commonly reported primary drug since 2014.

In 2015, 17 011 clients received OST in Portugal. About 66 % of clients in OST receive MMT, while the remaining clients receive buprenorphine-based treatment. The number of OST clients decreased between 2010 and 2013 and has been relatively stable since (Figure 17).

Drug use and responses in prison

Drug use in prisons has always been a major concern in Portugal.

According to a survey on drug use among the adult prison population (older than 16 years) carried out in 2014, 69 % of adult prisoners report lifetime drug use. Cannabis was the most common illicit drug, with 56 % reporting having used it at some point during their lifetime and 28 % reporting having used it during imprisonment, followed by cocaine (39 % lifetime use and 8 % during imprisonment) and heroin (26 % lifetime use and 8 % during imprisonment).

Having ever injected an illicit drug was reported by 14 % of prisoners, with 4 % reporting injecting drugs during their current period of imprisonment. In addition, a survey of young offenders (aged 12-16 years) in custody conducted in 2015 found that almost 89 % of those who responded had lifetime drug use experience.

The prevalence of HIV infection among those receiving treatment for drug dependence in prison is reported to be 17 %; the majority of HIV-infected prisoners receive antiretroviral therapy. All prisoners are screened for infectious diseases on entry to prison and tests are repeated at least once a year.

Prisoner healthcare is managed by health services under the responsibility of the Ministry of Justice in partnership with the National Health System.

All prisons make detailed yearly plans for health promotion and disease prevention, which include initiatives (awareness and training actions) to tackle infectious diseases, drug dependency and addictive behaviours focusing on the relationship between these two phenomena.

The detection of addictive behaviours and dependences is part of the evaluation protocol when the prisoner enters prison. Referral to treatment is encouraged in the prison setting and ensures the continuity for new prisoners of OST and other treatments initiated before imprisonment and allows them to access the different interventions available in prisons.

Interventions in this area are divided into two types of responses: programmes oriented towards abstinence (Drug Free Wings and Exit Units) and medication-assisted treatment programmes (with opioid agonists and antagonists). The General-Directorate of Reintegration and Prison Services (DGRSP), with 49 prison establishments, coordinates these treatment programmes. Medication-assisted treatment programmes can be provided in each prison by internal clinical staff, or by the appropriate regional health administrations.

69 % of prisoners report lifetime drug use

Quality assurance

Ensuring the quality of services provided to citizens is a general objective in the National Plan for the Reduction of Addictive Behaviours and Dependencies (2013-20). Quality is a cross-cutting principle in the implementation of all measures aimed at tackling drugs and drug-related issues, to be achieved by the building of knowledge, training of professionals and international cooperation. Within this framework, SICAD assumes an important role in quality promotion by supporting the national coordinator (who is in charge of putting into practice the National Plan and corresponding action plans) and by developing an all-encompassing orientation towards quality improvement at different levels. In terms of interventions with communities and/or citizens with addictive behaviours and dependences (in prevention, dissuasion, treatment, social rehabilitation and harm reduction areas), the following activities are undertaken: defining evidence-based best practices, technical and normative guidelines to support interventions, as well as requirements in order to ensure quality of interventions; developing, planning and coordinating methodologies aimed at establishing orientations of activities undertaken by organisations in charge of implementing interventions; and providing detailed diagnostic criteria in order to identify intervention needs nationwide.

In 2015, SICAD developed several instruments for monitoring, at the service level, the implementation of some guidelines (Physiotherapy intervention in addictive behaviours and dependencies; Technical Standards and guidelines for detoxification units; and Harmonisation of judicial Procedures for the Commissions for the dissuasion of drug addiction).

Within the Ministry of Health, the Directorate General of Health (DGS) is the body responsible for quality accreditation of health programmes and interventions in terms of content and responses. In addition, within the framework of quality systems, the Portuguese Institute of Quality is in charge of the Portuguese Quality System, in accordance with international quality norms, and is mainly concerned with standardisation of procedures. The complementarity of actions between SICAD (quality

promotion), DGS (quality accreditation of the basis of health programme contents) and the Institute of Quality (quality accreditation based on standardisation of processes) is therefore of major importance in all matters regarding quality in addictive behaviours and dependencies programmes and interventions.

Training and continued education forms one of the objectives of the national plan. Psychoactive drugs, addictive behaviours and dependencies are part of the academic training of doctors, psychologists, nurses and psychosocial workers. SICAD also provides training in the domain of addictive behaviours and dependences.

The Directorate General of Health (DGS) is the body responsible for quality accreditation of health programmes and interventions in terms of content and responses

Drug-related research

Both the National Plan for the Reduction of Addictive Behaviours and Dependences 2013-20 and SICAD´s Strategic Plan for 2013-16 include the topics of monitoring, research and evaluation of results at the national and international levels, to contribute to a better understanding of the phenomenon of addictive behaviours and dependences, and to assess the impact of the measures adopted at national, regional and local levels. This is done on the basis of a global and integrated information system (the National Information System on Psychoactive Substances, Addictive Behaviours and Dependencies). The National Plan also defines research priorities for the same period, which address the harmonisation of data, monitoring and evaluation of interventions, further promotion of knowledge transfer and emerging trends.

Academic research has been carried out across all topic areas, but recent drug-related studies implemented or funded by SICAD mainly focus on population-based studies.

The Portuguese national focal point, SICAD, uses its website and reports, national scientific journals and scientific meetings and seminars as the main dissemination channels for drug-related research findings. A list of scientific production (scientific papers, reports and academic theses) in the areas of illicit drugs, alcohol and addictive behaviours is available on SICAD's website.

Recent drug-related studies implemented or funded by SICAD mainly focus on aspects related to the prevalence, incidence and patterns of drug use and epidemiology.

The National Plan defines research priorities for the period, which address the harmonisation of data, monitoring and evaluation of interventions, further promotion of knowledge transfer and emerging trends

Drug markets

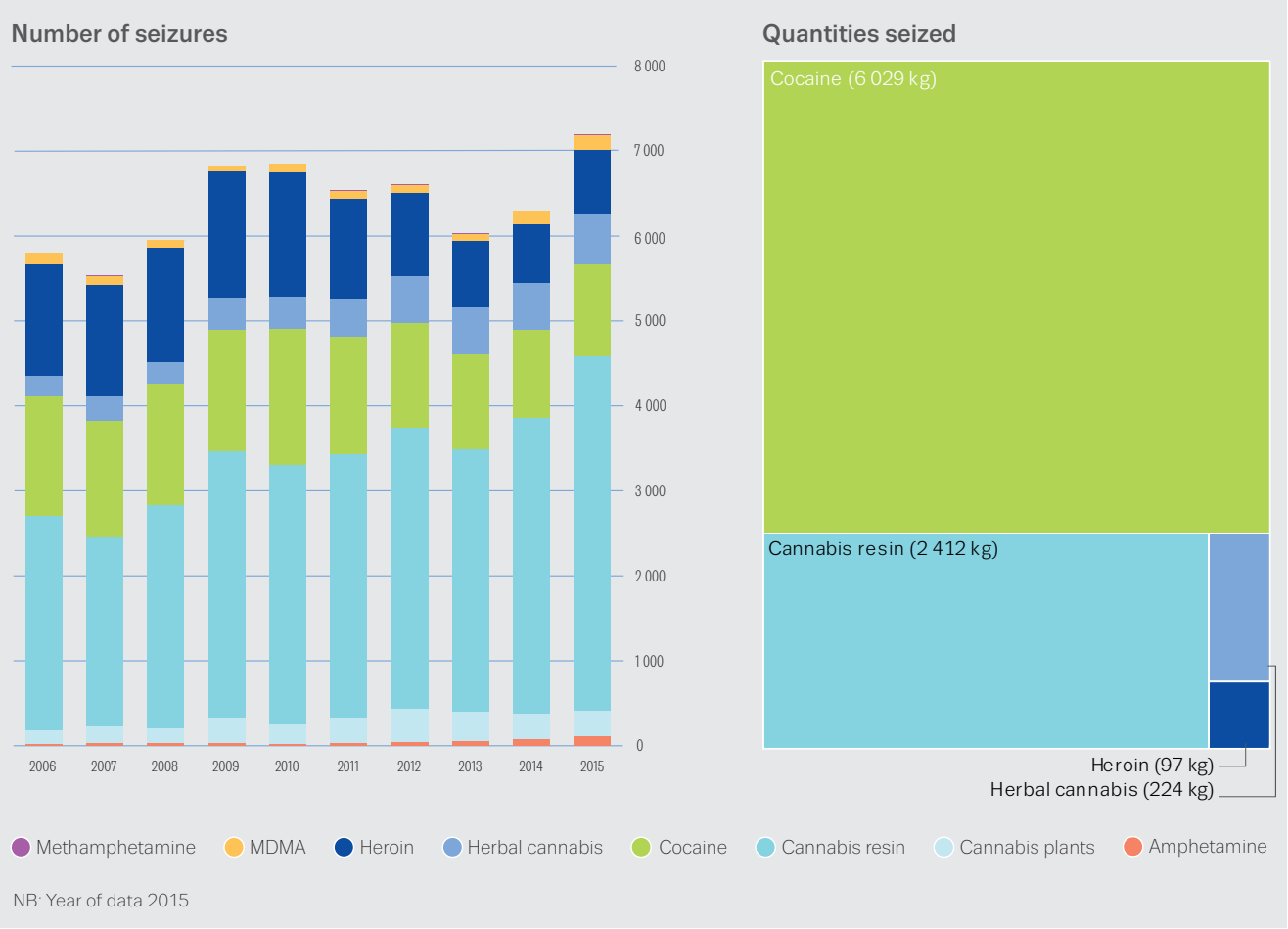
Portugal is the final destination for various types of illicit drugs to supply the home market. It is also a transit country for important quantities of cannabis resin and cocaine from Morocco and Latin America, respectively, destined for other European countries. This results from the country's geographical position, but is also linked to the existence of special relations with some Latin American countries, such as Brazil, where a large amount of cocaine originates. The majority of illicit drugs enter Portugal via sea routes, while land (from Spain) and air routes are used to a lesser extent. An increase in the use of recreational and fishing vessels has recently been noted. MDMA, predominantly from the Netherlands, is transported by air or overland in light vehicles. Heroin seized in Portugal comes mainly from the Netherlands and Spain.

In 2015, the highest number of seizures involved cannabis resin, followed by cocaine and heroin (Figure 18). The number of cocaine seizures, which had been decreasing since 2010, stabilised in 2015. After reductions in the number of heroin seizures since 2010, the number increased in 2015, although it remains just over half of the number in 2010. MDMA and amphetamines continue to be seized in Portugal less frequently than other illicit drugs; however, the number of seizures for these drugs increased in both 2014 and 2015.

Retail price and purity data of the main illicit substances seized are shown in Figure 19.

FIGURE 18

Drug seizures in Portugal: trends in number of seizures (left) and quantities seized (right)



NB: Year of data 2015.

FIGURE 19

Price and potency/purity ranges of illicit drugs reported in Portugal

NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum.
Year of data 2015.

KEY DRUG STATISTICS FOR PORTUGAL

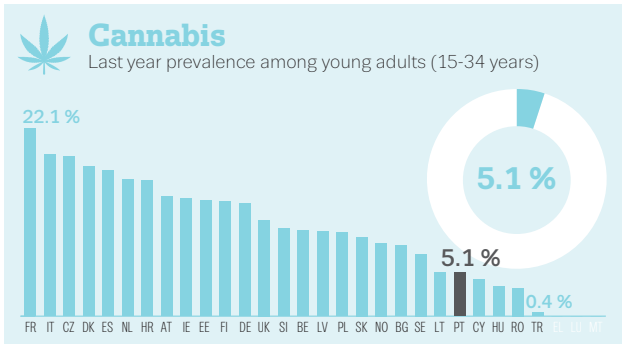
Most recent estimates and data reported

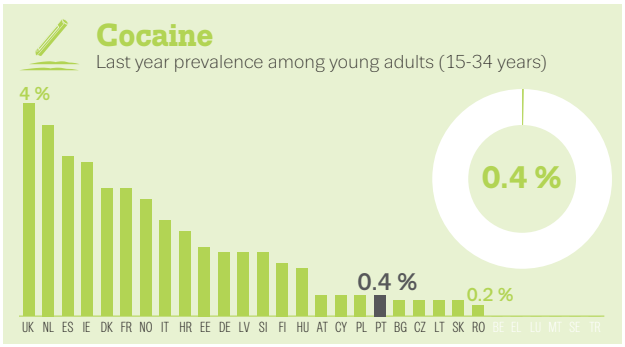
	Year	Country data	EU range	
			Minimum	Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	15.3	6.5	36.8
Last year prevalence of use — young adults (%)	2012	5.1	0.4	22.1
Last year prevalence of drug use — all adults (%)	2012	2.7	0.3	11.1
All treatment entrants (%)	2015	34	3	71
First-time treatment entrants (%)	2015	51	8	79
Quantity of herbal cannabis seized (kg)	2015	223.7	4	45 816
Number of herbal cannabis seizures	2015	582	106	156 984
Quantity of cannabis resin seized (kg)	2015	2 412	1	380 361
Number of cannabis resin seizures	2015	4 180	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0.2-42.8	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	1.1-55.6	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	No data	No data	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	No data	No data	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.7	0.9	4.9
Last year prevalence of use — young adults (%)	2012	0.4	0.2	4
Last year prevalence of drug use — all adults (%)	2012	0.2	0.1	2.3
All treatment entrants (%)	2015	12	0	37
First-time treatment entrants (%)	2015	15	0	40
Quantity of cocaine seized (kg)	2015	6 028.7	2	21 621
Number of cocaine seizures	2015	1 079	16	38 273
Purity (%) (minimum and maximum values registered)	2015	4.9-92.8	0	100
Price per gram (EUR) (minimum and maximum values registered)	No data	No data	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.1	0.8	6.5
Last year prevalence of use — young adults (%)	2012	0.1	0.1	3.1
Last year prevalence of drug use — all adults (%)	2012	0	0	1.6
All treatment entrants (%)	2015	0	0	70
First-time treatment entrants (%)	2015	0	0	75
Quantity of amphetamine seized (kg)	2015	2	0	3 796
Number of amphetamine seizures	2015	109	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	5-98.9	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	No data	No data	1	139.8

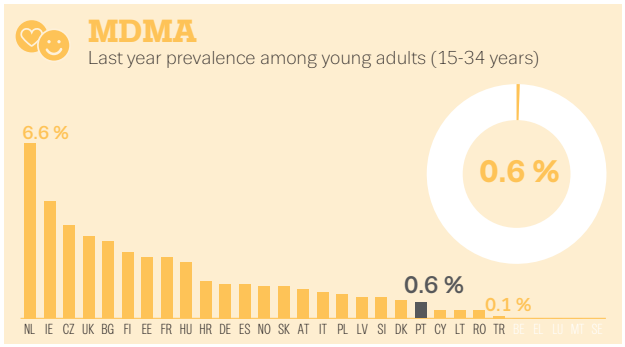
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.9	0.5	5.2
Last year prevalence of use — young adults (%)	2012	0.6	0.1	6.6
Last year prevalence of drug use — all adults (%)	2012	0.3	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	0	0	2
Quantity of MDMA seized (tablets)	2015	35 484	54	5 673 901
Number of MDMA seizures	2015	180	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	4.5-136.4	0	293
Price per tablet (EUR) (minimum and maximum values registered)	No data	No data	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2012	4.9	0.3	8.1
All treatment entrants (%)	2015	49	4	93
First-time treatment entrants (%)	2015	29	2	87
Quantity of heroin seized (kg)	2015	97	0	8 294
Number of heroin seizures	2015	763	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	2.7-75.4	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	No data	No data	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	4.2	0	44
HIV prevalence among PWID* (%)	2015	12	0	30.9
HCV prevalence among PWID* (%)	2015	83.5	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2012	2.2	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	5.8	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2015	1 004 706	164	12 314 781
Clients in substitution treatment	2015	17 011	252	168 840
Treatment demand				
All clients	2015	3 389	282	124 234
First-time clients	2015	2 024	24	40 390
Drug law offences				
Number of reports of offences	2015	16 102	472	411 157
Offences for use/possession	2015	10 380	359	390 843

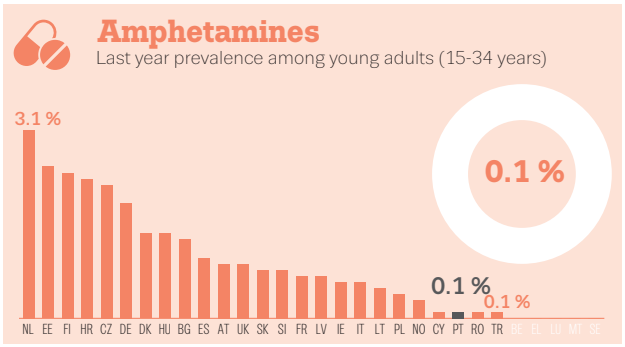
* PWID — People who inject drugs.

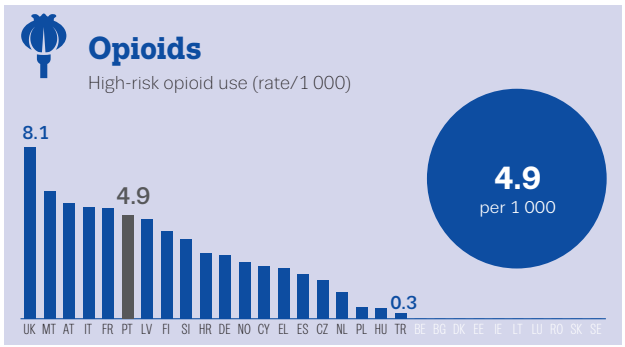
EU Dashboard

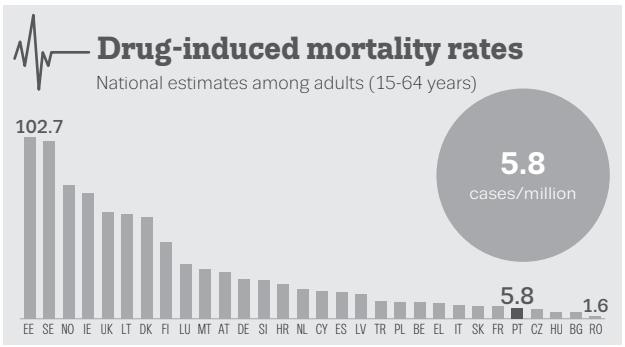


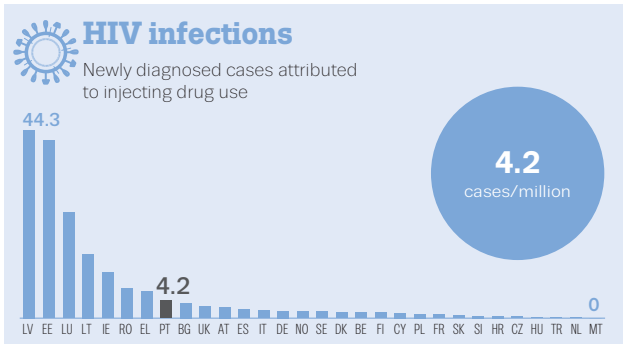


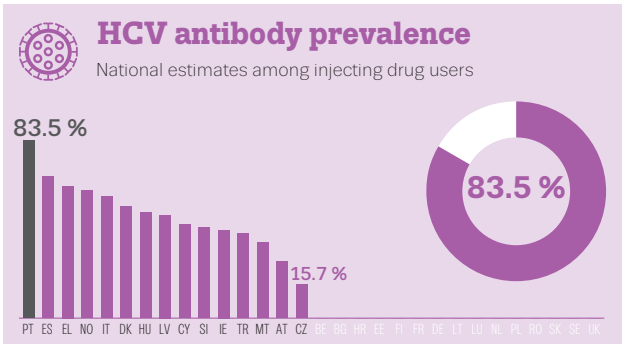












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

SICAD Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

About our partner in Portugal

The Portuguese national focal point is located within the General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD). Attached to the Ministry of Health, SICAD's mission is to promote a reduction in the use of psychoactive substances, the prevention of addictive behaviours and a decrease in dependences. SICAD is the national focal point and is directly responsible for the implementation of the National Plan. It plans, implements and coordinates drug demand reduction interventions, and collects, analyses and disseminates information on drug use and responses to it. The Director General of SICAD is also the National Coordinator for Drugs, Drug Addiction and Alcohol-Related Problems.

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