

General-Directorate for Intervention
on Addictive Behaviours and Dependencies
Ministry of Health - Portugal

NACIONAL PLAN FOR REDUCING ADDICTIVE BEHAVIOURS AND DEPENDENCIES 2013-2020

Executive Summary



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Executive Summary

June 2014

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Technical Sheet

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INTRODUCTION

The National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020, hereinafter referred to as PNRCAD, comes at the conclusion of the National Plan on Drugs and Drug Addiction 2005 – 2012 (PNCDT), National Plan for Reducing Alcohol Related Problems 2010-2012 (PNRPLA) and the redefinition of policies and health services.

Taking into account the new challenges identified in recent years, it has been decided to extend the approach and responses to other Addictive Behaviours and Dependencies (CAD), beyond psychoactive substances. Among the diverse behaviours identified as potentially addictive, the focus has been primarily centred on gambling, later in time other themes and behaviours could be developed.

The PNRCAD is an important development in the field of health policies, recognising that problems associated with CAD include risks and costs which are important to address due to the consequences and impact they have on the lives' of individuals, families and society. It will invest in two major areas, demand and supply. This allows for a balance approach to the issue.

In the **demand field**, the citizen is at the centre of the conceptualisation of policies and interventions in CAD, having as basic assumption that is fundamental to answer to the individuals needs, foreseen dynamically along is life cycle. It is intended to develop a global and comprehensive intervention that ranges from health promotion, prevention, dissuasion, risk and harm reduction (RRMD), to treatment and social reintegration. Such interventions will be developed in accordance with the legal framework in force on the use and abuse of licit and illicit psychoactive substances and gambling, and will promote health and access to care and services to the individuals' in need, to increase health and social welfare outcomes.

On the **supply field**, the focus of policies and interventions based on national and international cooperation is the reduction of the availability and access to traditional illicit substances and new psychoactive substances, the regulation of the market of licit substances and respective supervision and harmonisation of legal provisions already existing or to be developed, in particular in the area of online gambling.

In the **field of Cross-cutting themes** continuity is given to last year strategy and **Information and Research, Training and Communication**, and **International Cooperation** still cross-cutting areas of supply and demand, while ensuring the production of knowledge through the training of all agents involved: decision-makers, professionals and citizens.

The strategic options of this Plan reflect a broad, global and integrated perspective

of the problems and responses in the field of CAD. Based on a set of assumptions, principles, types of intervention and structural measures, within the new institutional architecture created, intended to respond effectively and sustainably to the current needs in this area, in a balanced approach perspective. To that extent, it is important to maintain an integrated system that includes the areas of supply and demand, based on specialised services, which regulate the relationships and the technical support between the different entities already involved and those to be involved in the implementation of the Plan.

To this end, we sought to align it with other Plans and Strategies already existing or under elaboration, at national level namely the National Health Plan 2012-2016, at international level, in particular the European Union Drugs Strategy 2013-2020, the EU Strategy to support Member States in reducing the problems associated with alcohol and the Global Strategy to reduce the harmful use of alcohol of the World Health Organization.

The PNRCAD provides the overall policy framework and establishes the priorities of the Portuguese State in the field of CAD for the next eight years, and it will be operated by two Action Plans of 4 years, in the periods of 2013-2016 and 2017-2020.

Finally, it should be noted that this Plan of approach and interministerial response was built and will be monitored and evaluated by a national coordination structure.

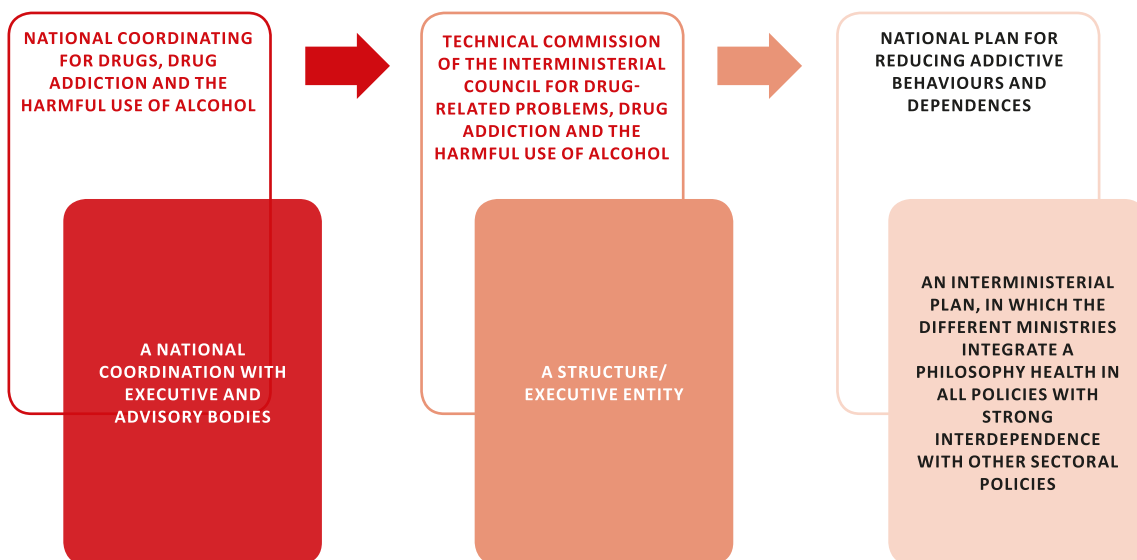


Figure 1. From the Coordination to the Plan

PART I

I.A. FRAMEWORK

The international interest in knowing and assessing the Portuguese model for illicit psychoactive substances has been maintained over time and it is a reinforcement and recognition of the fact that Portugal has passed through an innovative, effective and appropriate path to deal with this issue, to which it is important to give continuity and improve.

Among the conclusions of the internal evaluation of the PNCDT 2005-2012, and the PNRPLA 2010-2012, done in the context of the Subcommittees of the Technical Commission of the Interministerial Council for Drug Problems, Drug Addiction and the Harmful Use of alcohol, there was an emphasis on the recommendation to extend the structure of coordination to other addictive behaviours and dependencies, in addition to drugs, drug addiction and the harmful use of alcohol, and the elaboration of a unique National Plan in the field of addictive behaviours and dependencies, in a perspective of health and health promotion, with a view to ensure and enhance the efficiency, effectiveness and quality of the intervention to reduce these behaviours.

It was also recommended that the Action Plans cover a smaller number of objectives and actions in relation to those of the previous strategic cycle.

The external evaluation of PNCDT 2005-2012 concluded that there was an improvement in core indicators in the areas of supply and demand of licit and illicit psychoactive substances. Among the recommendations made are the maintenance, continuity and consolidation of the policies that are already developed, alongside the “proper planning of interventions, based on periodic update of the diagnosis of needs, the development in the communication area, with a focus on Portuguese model and dissemination of good practices, and adequate funding “ (Gesaworld, SA., 2012, 31).

Overall, the external evaluation carried out and the general recommendations pointed the need to ensure the sustainability of the results achieved and the extension of the scope of the Interministerial Coordination Structure, through the reorientation of the problems relating to psychoactive substances, which already includes the harmful use of alcohol, with the inclusion of other CAD.

The knowledge acquired in the context of the various approaches concerning psychoactive substances should be leveraged and extended to other behaviours generating dependencies. The production of knowledge, through the development of studies, appears as a cross-cutting priority as well as the training of the professionals in the services to better meet the needs of intervention and the implementation of models of effective intervention extended to other CAD.

The certification and accreditation of units, departments, teams and programs must also be addressed and consideration should be given to the most appropriate strategy to respond to the needs and priorities. Hence the absolute need to base strategic and operational decisions in the identification of needs sustained in national diagnostics, with prior analysis of regional components and Local Intervention Units (UIL).

The interministerial coordination and the inter-sector articulation, in which the Portuguese model is based, represent important pillars in the definition and implementation of public policies, through the convergence of objectives, resources and strategies among the different partners with direct responsibilities in the implementation of policies and interventions in the area of CAD.

In the current political and economic context of strong restrictions, it is fundamental to maximize existing resources, as well as to prioritize needs and define clear lines of intervention. It is now a priority to meet the network of responses already existing in a balanced way, so it is necessary to strive for further improvement of its quality and in the creation of new responses adapted to the dynamics of emerging problems in CAD. Thus, the PNRCAD is done in a strategic and operational alignment with other Plans and National Strategies, Action Plans and Programs, either from the Ministry of Health¹, either from other public entities, following the respective objectives and goals, correlated with CAD or contributing to its prosecution.

International Framework

This National Plan is based in the firm belief that it is needed an adequate and effective response from the international community in regard to the issue of addictive behaviours and addictions. This Plan seeks, therefore to articulate with the strategies and policies developed in the framework of the United Nations, the European Union and other international fora that deal with this issue, and that Portugal has followed, recognizing that our main concern is the protection of public health and the effects of the substances subject to international control, the new psychoactive substances, alcohol and behaviours likely to lead to dependence have on individuals and society.

It should be noted that the approach of the international community to the problem of addictive behaviours is, still, very unequal, to the extent that the responsible bodies/institutions and the strategies formulated differ, when directed to the intervention in the area of illicit substances, on harmful use of alcohol and other addictive behaviours generating dependencies, that gambling is an example.

Illicit Substances

The development of international strategy in the fight against drugs is legally based on three United Nations Conventions: the Single Convention on Narcotic Drugs of 1961², modified by the Protocol of 1972³; the Convention on Psychotropic Substances of 1971⁴; and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988⁵.

Of greater importance to the current strategy of the international community are the Political Declaration and Plan of Action adopted in 2009 under the aegis of the

¹ In particular in the framework of the National Plan for Health 2012-2016, at the level of some ongoing Programs, priority or not.

² Approved for ratification by the Decree-law no. 435/70, of 12 September.

³ Approved for adhesion by the Decree-law no. 161/78, of 21 December.

⁴ Approved for adhesion by the Decree-law no.10/79, of 31 January.

⁵ Approved for ratification, by Resolution of the Assembly of the Republic no. 29/91, of 20 June and by the Decree of the President of the Republic no. 45/91, of 6 September.

United Nations Commission on Narcotic Drugs (CND), and which represent the reaffirmation of the formal commitment of the Member States in order to address the global problem of drugs, on the basis of an integrated and balanced strategy.

Within the framework of the European Union is the role of the Horizontal Drugs Group – cross-pillar group of the Council of the European Union responsible for the definition and coordination of EU policy in this area, which deserves special mention the EU Drugs Strategy (2013 - 2020) and the Action Plans (2013-2016) and the future Plan (2017- 2020).

Also in the context of the EU it is important to point out the role of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), a specialized agency of the European Union that aims to provide reliable and comparable information on the phenomenon of drugs and addictions, within which operates the Reitox Network, composed by the national Focal Points of each of the EU Member States (and extended even to Norway and Turkey).

Alcohol

One of the most important tools of recent action of WHO, the *Global Strategy to reduce harmful use of alcohol*, was adopted in the Sixty-third Session of the World Health Assembly, which took place in 2010.

As a response to the implementation of the Global Strategy, the Regional Office of the World Health Organization for Europe has prepared in close coordination with the Member States, the Action Plan on Alcohol for the period 2012-2020.

In the field of alcohol policy, within the framework of the EU, the European Commission adopted in October 2006, an *EU strategy to support Member States in reducing alcohol related harm*.

Within the framework of the European Union the Committee on National Alcohol Policy and Action (CNAPA), aims to coordinate the policies designed to reduce the harmful effects of alcohol at national and local level, on the basis of the good practices identified in the EU Strategy to support Member States in reducing alcohol related harm.

Still at EU level, it is important to mention the decision of the European Commission to submit a proposal of Joint Action – a Joint Action to support Member States in reducing alcohol related harm (Joint Action on RARHA - Reducing Alcohol Related Harm), within the framework of the Second Multiannual Program of Action of the EU in the field of Health, to support Member States in the implementation of the EU Strategy on alcohol, assuming Portugal, through SICAD, the role of main partner. This project for three years (2014-2016), oriented towards the reduction of alcohol related problems, mobilizes 32 EU entities that will participate as associate partners, and 28 other with the status of collaborative partners, being represented 27 Member States and also Iceland, Norway and Switzerland.

Medicines and Anabolic Steroids

Both the International Narcotics Control (INCB) as the United Nations Office on Drugs and Crime (UNODC) has been addressing this problem. At international level there is, in addition to the illegal sale via the Internet, the existence of problems with the illicit diversion of medicines containing this type of substances as active principles.

Gambling

With regard to the problem of online gambling, this has been addressed by various institutions of the European Union (European Commission, Council and European Parliament), it should be noted that the European Commission approved in October 2012 an Action Plan for online gambling, which includes a series of initiatives to develop over the next two years, with the objective of producing recommendations to Member States on this issue and encourage the administrative cooperation between them.

I.B. VISION AND PRINCIPLES

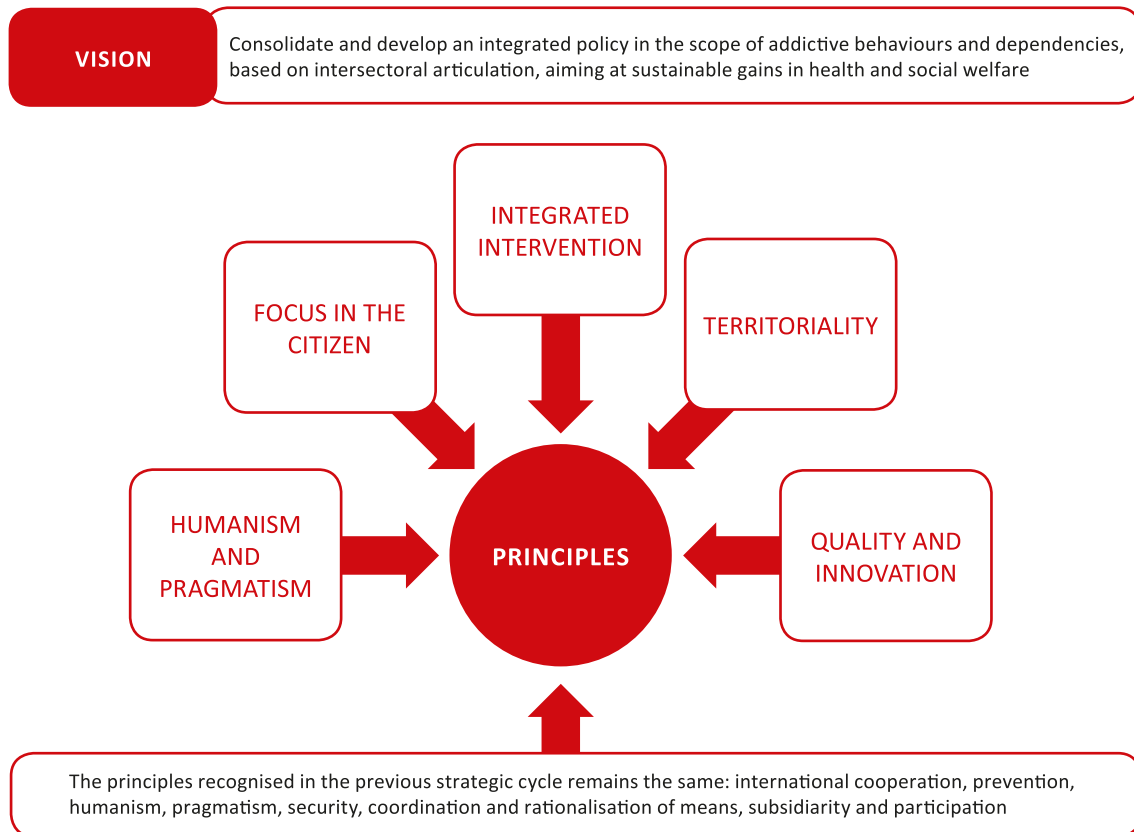


Figure 2. Vision and principles

Humanism and pragmatism

The humanistic principle means the recognition of the full human dignity of the people involved in the phenomenon of drugs and has as corollaries the understanding of the complexity and importance of individual history, family and social of these people, as well as the consideration of drug addiction as a disease, and the consequential responsibility of the State in the implementation of the constitutional right to health care by drug addicts citizens and in combating social exclusion, without prejudice to the individual responsibility. (...)

The principle of pragmatism complements the humanistic principle and determines an attitude of openness to innovation, through the account, without dogmas or pre-understandings, the results scientifically proven experiences tested in various areas of the fight against drugs and drug addiction the consequent adoption of solutions appropriate to the situation and that can provide positive practical results. (PCM, 1999).

Centrality in the citizen

The citizen is perceived dynamically throughout the different stages of the life cycle as co-responsible individual and ensures/manages his choices and behaviours in relation to his health, quality of life and well-being, as a citizen and user of services, as well

as an active promoter element of the exercise of citizenship in contexts that he attends, along the different stages of his live.

Integrated Intervention

The processes leading to CAD are diverse and often cumulative. They can be structural in nature and its manifestations may be economic, social, political and even cultural. Integration should be understood as a global, concerted and comprehensive response, which includes the various dimensions of the phenomena, allowing strategically articulating the actions to be developed.

A model of integrated responses assumes an interdependent continuum of responses, namely prevention, dissuasion, harm and risk reduction, treatment and reintegration. Is based on a multidimensional reading of the reality of addictive behaviours and dependencies and a proximity intervention, multi and cross-sector, which allows you to maximize results and achieve social and health gains. This design dissociates itself from the partiality of the vision from the mere sum and juxtaposition of interventions, making it essential to have a strong investment in inter institutional articulation and in the formulation of strategic goals cross-sectional to interventions, thus avoiding the dispersion, taking advantage of the entire set of the available resources and potential synergies.

Territoriality

Adopting the principle of territoriality to action within CAD means locating and defining a space to draw or foresee the intervention. It is assumed the territory as part of the intervention, the centre of the definition of a common and mobilising project with its own dynamics.

The focus of the intervention is on the subject/target groups that you want to assist, taking into account the stages of development in which they are and the spaces they attend. Any effective and appropriate intervention should be based on the knowledge of reality, through the implementation of a robust diagnostic. This should include a global approach, articulated and theoretically substantiated that, in addition to the identification of the problems, recognizes the potential for change that exist in the social environment of intervention, as well as the available resources, with the participation of all the actors that have an important role in the community.

Quality and Innovation

It is important to ensure approaches, models, requirements and practices based on logic of innovation and sustainability, based on evidence and to ensure the training and the continuous education of professionals and other stakeholders.

A strong investment in quality can contribute to the sustainability of policies and responses, which can still be enhanced if there is an appeal to strategic alliances, channels of communication and cooperation with the strategic stakeholders.

I.C. GENERAL OBJECTIVES AND GOALS

The overall results obtained up to now with the policies and measures implemented indicate that the strategy followed and the models used are the basis of a suitable public policy, but it requires improvement and more investment.

The integration of issues related to the new CAD, in particular gambling, requires special attention in this Plan.

The overall strategy of action in the context of this Plan is based on a coordinated action, thereby maximising the synergies between the strategic frameworks and the budgetary resources of services and organizations with intervention in these fields.

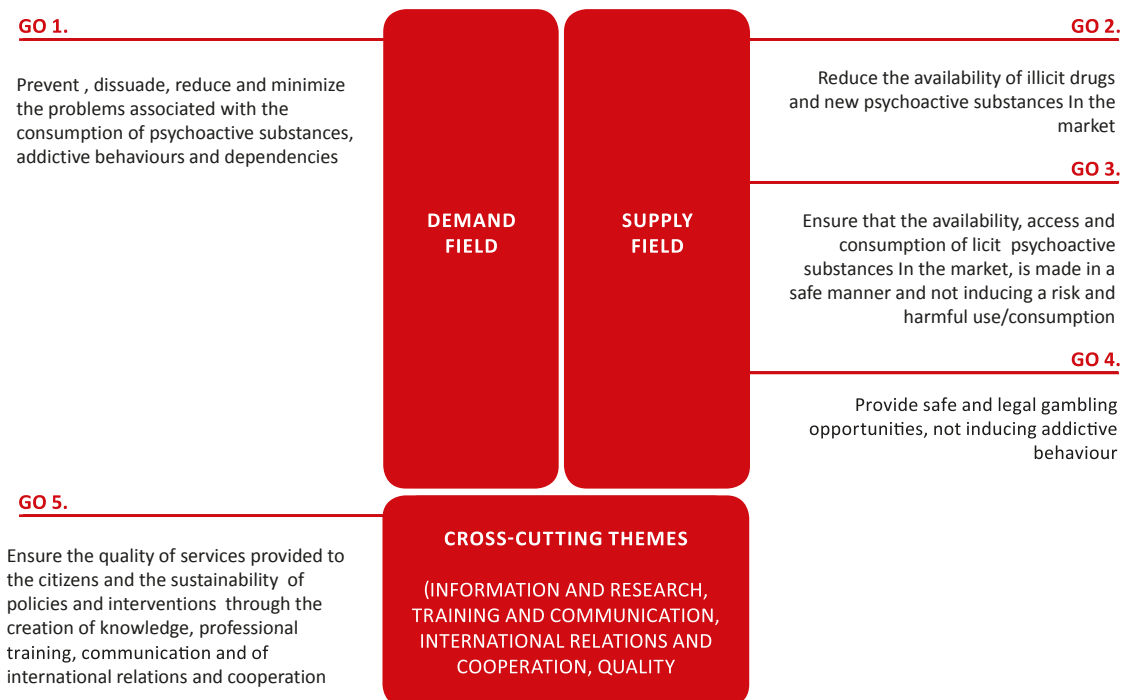


Figure 3. General objectives

The PNRCAD defines five general objectives, as well as indicators for seven global goals (table 1), divided and quantified in 42 specific aims (table 2), to achieve at the end of the two cycles of reference, 2016 and 2020, in accordance with the following tables.

GENERAL OBJECTIVES	GOALS	INDICATORS
GO 1.	G2. Increase the perceived risk of consumption of psychoactive substances	Place Portugal above the current EU average in 2 percentage points in 2016 and 5 percentage points in 2020: <i>Perception of high risk to health;</i> <i>Perception of high risk of getting hurt (physically or in other ways)</i>
	G3. Delay the age of onset of psychoactive substance use	Reduce the beginning of consumption with 13 years or less in 15% by 2016 and 30% by 2020 and the beginning of harmful consumption patterns with 13 years or less in 25% by 2016 and 50% by 2020 Increase 1 year by 2016 and 2 years by 2020 - <i>Mean age</i>
	G4. Reduce the prevalence of recent use (last 12 months), risk consumption patterns and dependence on psychoactive substances	Reduce in 10% until 2016 and in 20% until 2020
	G6. Decrease the morbidity related with CAD	Reduce in 25% until 2016 and in 50% until 2020: <i>Hospitalisations HDG 202 (cirrhosis and alcoholic hepatitis)</i> Reduce 3 percentage points until 2016 and 6 percentage points until 2020: <i>Notifications of cases diagnosed in the last 3 years with HIV/AIDS associated with drug addiction</i>
	G7. Reduce the mortality related with CAD	Follow the goals of PNS Follow the goals of ENSR Reduce 10% until 2016 and 20% until 2020: <i>Fatal overdoses due to the consumption of illicit drugs</i> Reduce in 15% until 2016 and 30% until 2020: <i>Notifications of deaths occurred in the last 3 years of AIDS cases associated to drug addiction</i>
	G1. Reduce the perceived ease of access (if desired) to markets	Place Portugal below the current EU average 2 percentage points in 2016 and 5 percentage points in 2020: <i>Ease (relatively/very easy) perceived access (if desired)</i>
	G3. Reduce the perceived ease of access (if desired) to markets	Reduce in 15% until 2016 and 30% until 2020: <i>Ease (easy/very easy) perceived access (if desired)</i>
GO 4.	G5. Decrease the prevalence of risk and gambling dependence	Reduce in 10% until 2016 and 20% until 2020: <i>Gambling prevalence (money) of risk and pathological (12M) (SOGS)</i>
GO 5.		<i>The Action Plan will list the performance indicators of the respective actions</i>

Table 1. Relationship between objectives, goals and indicators

PART II

II.A. CONTEXTUALIZING THE PHENOMENON OF ADDICTIVE BEHAVIOURS AND DEPENDENCIES IN PORTUGAL

The PNRCAD presents a wide review of the phenomenon of CAD in Portugal, whereby the Executive Summary opted to present in the following tables the base values referenced in the last studies available on which were built the specific goals to be achieved by the end of the two cycles of reference.

REFERENCE	INDICATOR	BASE VALUE	2016	2020
A 1. <i>Ease (relatively/very easy) perceived access (if desired)</i>				
ESPAD*: 16 years old students	Cannabis	PT: 30% European average: 29%	27%	24%
	Ecstasy	PT: 15% European average: 13%	11%	8%
	Amphetamines	PT: 14% EU27: 12%	10%	7%
Eurobarometer*: 15-24 years	Cocaine	PT: 23% EU27: 22%	20%	17%
	Heroin	PT: 18% EU27: 13%	11%	8%
<i>Ease (relatively/very easy) perceived access (if desired)</i>				
ECATD*: Students 13-15 years	Beer	49%	42%	34%
	Wine	48%	41%	34%
ECATD*: Students 13-15 years 16-17 years	Spirit drinks	33%	28%	23%
		70%	59%	49%
A 2. Perception of high risk to health				
Eurobarometer*: 15-24 years	Occasional use (once or twice of cannabis)	PT: 24% EU27: 23%	25%	28%
	Occasional use (once or twice of cocaine)	PT: 65% EU27: 66%	68%	71%
	Occasional use (once or twice of ecstasy)	PT: 51% EU27: 59%	61%	64%
	Regular use of cannabis	PT: 64% EU27: 67%	69%	72%
Perception of high risk of getting hurt (physically or in other ways)				
ESPAD*: 16 years old Students	Consumption of 1-2 alcoholic drinks almost everyday	PT: 25% European average: 30%	32%	35%

Table 2. Indicators: current⁶ situation and desired evolution for 2016 and 2020

⁶ * 2011.

REFERENCE	INDICATOR	BASE VALUE	2016	2020	
A 3. <i>Beginning of consumption with 13 years or less</i>					
ESPAD*: 16 years old students	<i>Cannabis</i>	PT: 4% European average: 3%	3,4%	2,8%	
	Alcohol	PT: 51% European average: 57%	43%	36%	
	Tranquillisers or sedatives Without medical prescription	PT: 2% European average: 2%	< 1,5%	<1%	
	Drunkenness	PT: 8% European average: 12%	6%	4%	
<i>Mean age of onset of consumption</i>					
INPG**: Portuguese population 15-74 years (sub group 15-24 years)	Illicit Drugs	17 years	18 years	19 years	
	Alcohol	16 years	17 years	18 years	
	Medicines (sedatives, tranquilisers or hypnotics) w/ or w/o prescription	17 years	18 years	19 years	
A 4. <i>Prevalence of use (last 12 months)</i>					
ESPAD*: 16 years old students	<i>Cannabis</i>	16%	14%	13%	
	Drunkness	29%	26%	23%	
	Any illicit drug	2,3%	2,1%	1,8%	
INPG**: Portuguese population 15-74 years	Alcohol <i>binge</i> (at least 1)	7,4%	6,7%	5,9%	
	Alcohol <i>binge</i> (1 + times per moth)	3,4%	3,1%	2,7%	
	Drunkenness (stagger, with difficulty speaking, vomit, and/or do not remember after what happened)	5,1%	4,6%	4,1%	
	Medicines (sedatives, tranquillisers or hypnotics)	13,7%	12,3%	11%	
<i>Prevalence of risk consumption and dependence (last 12 months)</i>					
INPG**: Portuguese population 15-74 years	<i>Cannabis</i> (CAST)	<i>High risk</i> Moderate risk	(0,3%) - 3‰ (0,3%) - 3‰	2,7‰ 2,7‰	2,4‰ 2,4‰
	Alcohol (AUDIT)	<i>Risk and harmful dependence</i>	(2,7%) - 27‰ (0,3%) - 3‰	24‰ 2,7‰	22‰ 2,4‰
	Alcohol (CAGE)	<i>Abuse or depend- ence</i>	(0,8%) - 8‰	7‰	6‰

Table 2. - Indicators: current⁷ situation and desired evolution for 2016 and 2020 (continuation)

⁷ * 2011; ** 2012

REFERENCE	INDICATOR	BASE VALUE	2016	2020
A 5. <i>Gambling prevalence (money) of risk and pathological (12M) (SOGS)</i>				
INPG**: Portuguese population 15-74 years	Risk (some problems)	(0,3%) - 3‰	2,7‰	2,4‰
	Pathological	(0,3%) - 3‰	2,7‰	2,4‰
A 6. <i>Hospital admissions GDH 202 (cirrhosis and alcoholic hepatitis)</i>				
DGS/ACSS, I.P.*: Portuguese Population/ Portugal Continental	Exit of patients	3163	2372	1581
<i>Notifications of cases diagnosed in the last 3 years with HIV/AIDS associated to drug addiction</i>				
INSA***: Portuguese Population	Total proportion of HIV cases	12%	9%	6%
	Total proportion of AIDS cases	21%	18%	15%
A 7. <i>Standardized mortality from diseases attributable to alcohol</i>				
DGS/ACSS, I.P.****: Portuguese Population/ Portugal Continental	Rate per 100 000 habitants, less than 65 years	PNS, 2009: 12,9‰ INE: 12,7‰	12,5‰	To be defined in the next PNS
<i>Mortality in road accidents related to the consumption of alcohol</i>				
ANSR/INMLCF, I.P.**: Portuguese Population	Number of drivers killed in road accidents with a TAS \geq 0,5 g/l	105		To be defined in the next ENSR
<i>Fatal overdoses due to the use of illicit drugs</i>				
INMLCF, I.P.*: Portuguese Population	Number of deaths by overdose in the last 3 years	127	114	101
<i>Notifications of deaths occurred in the last 3 years of AIDS cases associated to drug addiction</i>				
INSA*: Portuguese Population	Proportion of the total cases of deaths with AIDS	44,9%	42%	39%

Table 2. Indicators: current^a situation and desired evolution for 2016 and 2020

^a * 2011; ** 2012; *** 31.12.2012; **** 2009/2011.

II.B. STRATEGIC OPTIONS

Resulting from the various assessments made and already mentioned, overall the current Plan keeps the same structure, which was readjusted in function of the new challenges that arise. It is, therefore, an Interministerial Plan that deals with the theme of CAD in a balanced perspective between the demand field, in which are highlighted the structural measures, and the supply field. It also includes cross-cutting themes related to the importance of continuous updating of information and knowledge, with the training of professionals through training and communication, with international co-operation and with quality. In terms of construction and implementation, the Plan is sustained in areas such as coordination, budget and evaluation.

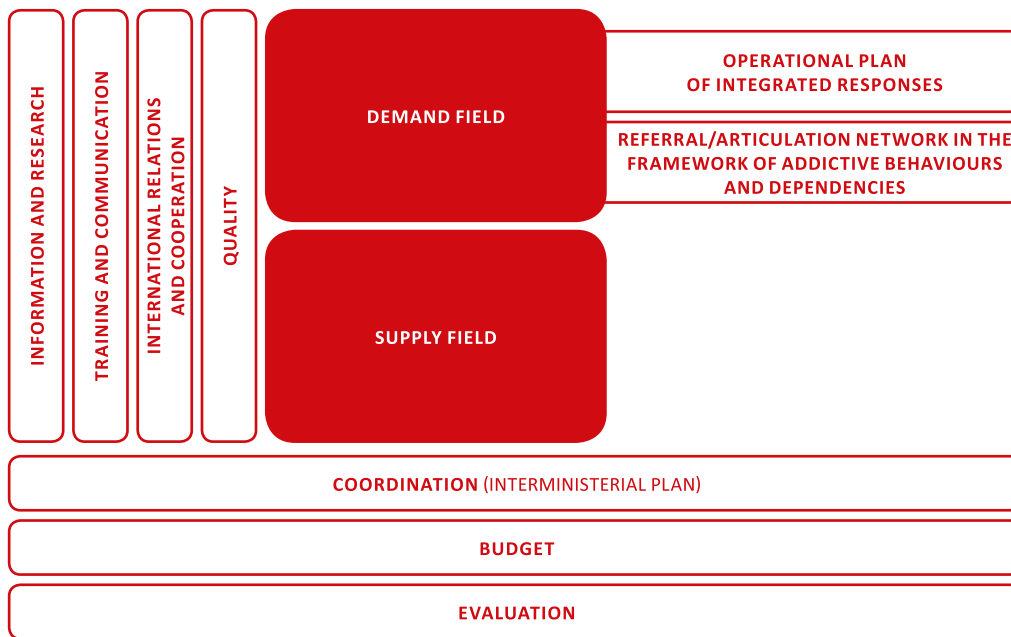


Figure 4. PNRCAD Structure

Similar to the previous PNCDT 2005 - 2012, invest in two major areas: the demand and the supply, with specific approaches.

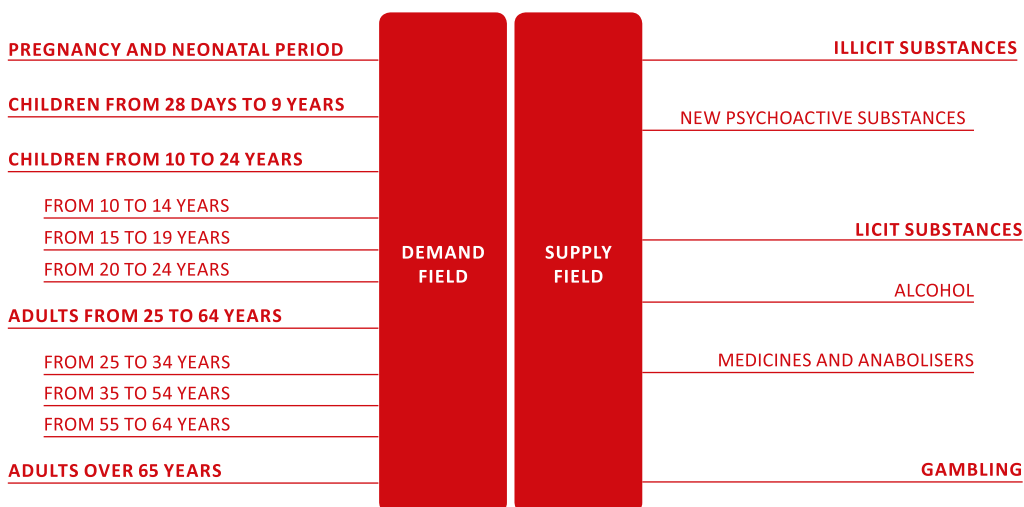


Figure 5. Specificities of the Fields

In the **demand field**, the citizen is at the centre of the conceptualisation of the framework of policies and intervention options, designed and oriented according to the life cycle stages and the contexts of belonging.

The **approach by life cycle** is founded on a dynamic and bio psychosocial perspective of the development process of the Human Being, that addresses and identifies critical periods and focuses more adequately the strategies and interventions to develop according to the needs/competences of individuals expressed in this process. They are considered the steps of the life cycle presented in Figure 5.

Thus, in the definition of the intervention per life cycle of the citizen, it is important to identify specific needs of each stage, taking into account the risk and protective factors, in a perspective of prevention of risk behaviours and worsening of the determinants of health and still in a perspective of gains in health and in social welfare.

Often, the identification of groups is directly related with the social contexts where they are inserted. In this context, the social context is understood as a shared space by individuals that may be associated with a certain risky behaviours or health problems.

In this sense, the **approach by contexts** and, within these, the focus in terms of levels of risk and of the life cycle, add improvements to the planning and monitoring of results leading to the containment of behaviours inductors/enhancers of dependencies. In this Plan, the focus of the intervention will be on the Family, School, Community, Recreational, Employment, Road, Prison and Sports contexts, considered as those where the intervention is more relevant and necessary.

The prevention, dissuasion, the risk and harm reduction, the treatment and reintegration will be the **types of interventions** to develop for the pursuit of the objectives and targets set. Giving continuity to the strategy developed in recent years, in the present Plan the strategic option is geared toward the implementation of global and comprehensive interventions, developed in an integrated way.

Thus, it becomes important to develop, within the framework of CAD, strategies that take into account a whole range of factors and circumstances that interact in the development of protective factors or risk enhancers behaviours, leading to a deterioration of individual and social problems associated with addictive behaviours and addictions.

The present Plan suggests that the mobilisation of resources to promote the healthy development of young people is essential whilst also responding early and effectively to the needs of those who already have mental, emotional and behavioural disorders, in particular those related to CAD. (NRC and IOM, 2009).

In the current situation of the country, there is a need to ensure equal access for individuals with CAD to health, social and solidarity systems. On the other hand, some vulnerabilities that characterize different groups might require a more differentiated level of intervention, it is also crucial that the focus and prioritization of actions take into account the **risk levels (no consumption, low risk, risk, harmful and dependence)** in these different population groups. Priority lines of action may be established, leading to a better management and monitoring of risk and protective factors, particularly for some groups that are in a situation of greater vulnerability and/or social exclusion, and associated with CAD, such as young people and problem drug users of psychoactive substances, pregnant, sex workers, people infected with HIV/AIDS, Hepatitis and Tuberculosis, people with suicidal and ordeal behaviours, elderly (note-if problems related to alcohol abuse and behaviours indicative of gambling dependence), children of drug addicts and migrant populations.

On the other hand, and cannot be separated from the **demand field**, in the **supply field** it is important to reduce the availability and access to illicit substances and NPS, regulate and supervise the market of licit substances and in this strategic cycle, trying to harmonize the legal devices already existing or to be developed in respect to the gambling area and the internet.

II.B.1. DEMAND FIELD

As already mentioned, in the demand field the citizen is the centre of conceptualisation of the framework of policies and interventions options, designed and oriented in the present strategic period of the intervention in CAD by life cycle stages and belonging contexts.

II.B.1.1. TYPES OF INTERVENTION

The Portuguese model, created and implemented in the context of the reduction of the consumption of psychoactive substances and dependencies, encloses a broad, global and integrated vision of the phenomenon of psychoactive substances use and drug addiction, having been implemented through mechanisms of Prevention, Dissuasion, Treatment, Risk and Harm Reduction and Reintegration, which proved to be as a whole, capable to respond effectively to the growing challenges and the complexity that this problematic ends⁹.

In this way, it is important to continue and deepen this model and adapting it to the evolution of the phenomenon of CAD and the new organizational architecture created in the framework of the current legislature, so that, in an integrated and articulated way with the strategic partners, to promote mechanisms for effective and efficient responses on CAD approach and the problems associated with them.



Figure 6. Types of Intervention

The present Plan advocates also the need to boost interventions based on scientific evidence, taking into account the best practices, by softening the intervention areas developed until now. This understanding can lead to the recombination of its modalities,

⁹ Part of national policies for reducing the consumption of psychoactive substances and dependencies, drawn over time, had as original frame of reference the model proposed in the 1990s by the Institute of Medicine - IOM. This model envision intervention in public health, in particular in mental health context, namely in mental, emotional and behavioural disorders, (in which is included the consumption of psychoactive substances and other addictive behaviours and dependencies), as a continuous health care that includes the promotion, prevention, treatment and reintegration.

in order to enhance its specific scope, such as the extension of the field of prevention to reduce the risks associated with the consumption, the interaction between practices, in particular treatment and harm reduction, changes for which the most recent data of scientific knowledge already point (Faggiano, F. et al, 2008; EMCCDA, *European Drug Prevention quality Standards*, 2011).

Prevention

The focus of **preventive¹⁰ intervention** is centred on the assessment of the risk of occurrence of a disease, to operate according with the following levels¹¹:

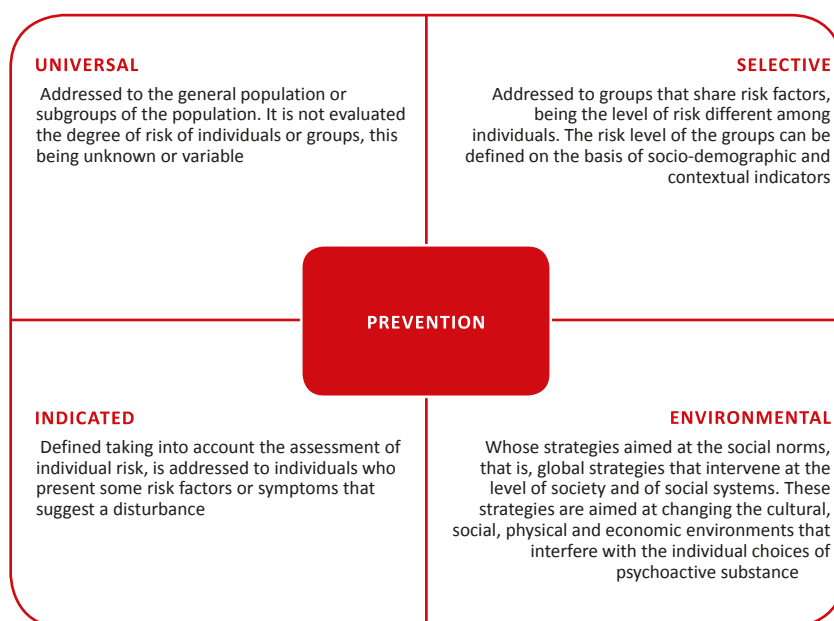


Figure 7. Types of Intervention in Prevention

Recently, more comprehensive models have been developed, which encompass the wide range of variables related with addiction, an example of which is the Model COM-B, which calls for the understanding of the behaviour in terms of interaction between the motivations, abilities and opportunities of individuals. (EMCCDDA, 2013).

It is essential that the preventive strategies to be developed continue to be based on scientific knowledge and accurate diagnosis and that in the context of preventive approach, is placed the focus on detection and early intervention.

Dissuasion

Dissuasion is a global and integrated intervention strategy, going beyond the mere application of the Law. It establishes a strong potential in terms of reducing the consumption of psychoactive substances and dependencies with most people who experience dissuasion engaging with the services and available responses for the first time. Dissuasion is implemented and mobilized through a set of partners for a complementary approach that involves security and public order and with the early detection of risk

¹⁰ According to this model, preventive intervention occurs before the beginning of a disease diagnosed and aims to reduce the risk of this disease from occurring in the future.

¹¹ The classification of universal, selective and indicated prevention strategies (Mrazek and Haggerty, 1994), replaced the medical paradigm previously used for primary, secondary and tertiary prevention, and proved to be more appropriate in this context (EMCCDDA, 2011).

situations, in which a timely intervention can make a difference. It also incorporates a widespread intervention in the field of prevention, the promotion of local responses and Community intervention, thus contributing to gains in health and safety.

Inseparable from other types of intervention that are part of the recognized Portuguese model, the dissuasion operates in a network of articulated responses, working for the reduction in the consumption of psychoactive substances and dependencies, the health protection of users and populations and for the prevention of social exclusion.

The cooperation is distinguished as a core value in the intervention recommended by the Commissions for the Dissuasion of Drug Use (CDT). These services, which operate under the decriminalisation law, have a national scope, being the coordination in conjunction with the other internal or external services outside the SICAD, in the area of dissuasion, performed by the Ministry of Health.

The CDT welcome the indicted (users of illicit psychoactive substances) sent by the security forces, and carries out an exhaustive assessment of their situation with regard to consumption and the administrative offence proceedings against the individual, always valuing their psychosocial needs, without ever neglecting the reason why they were created: the urgency to bring consumers of illicit substances to the health area facilities.

Risk and Harm Reduction

The socio health structures developed in Portugal, in which NGOs and IPSS have an important role, are part of a national network of intervention of **risk and harm reduction**, with a legal regulatory framework since 2001 expressed in the Decree-Law no. 183/2001, of 21 June¹², *and are intended to raise awareness and referral of drug addicts as well as the prevention and reduction of attitudes or behaviours of increased risk and harm reduction of individual and social caused by drug addiction.*

Also in Portugal, and as mentioned by Patricia Erickson (1999), the RRMD approach has evolved in three phases: in a first phase, this contemplated public health actions in relation to illicit substances and availability of methadone to heroin addicts. In a second phase, focused mainly on the intravenous consumer population and preventing HIV/AIDS transmission. The third phase covers the activities in the field of public health in an integrated manner, both in terms of the level of consumption of illicit substances and consumption of licit substances.

The expansion of so-called *consumption in recreational contexts*, characterized by a positive social representation of this type of behaviour, combined with a low perception of their own risks and a great diversity and supply of substances, lead the relevance of action in this reality according to an RRMD approach.

The RRMD model applies to and is, therefore, necessary for an heterogeneous population, whether in terms of age groups, styles and life histories, and contexts that provide the framework for the consumption, (in particular the recreational context); also applies to different psychoactive substances and forms of consumption.

In this sense, whenever possible, should give priority to risk reduction, without losing, however, by virtue of a pragmatic attitude, the harm reduction.

Treatment

In the context of **treatment**, the intervention should focus on approaches requiring an individualized diagnostic and a response based on the supply of a network that ensures appropriate and continuous care, on the basis of the pathology and possible co morbidities presented. With regards to gambling, the strategic option should be directed to the implementation of a support and treatment network for addiction.

The Integrated Model of Treatment *is the main axis of multidisciplinary approach in CAD, with the use of various therapeutic resources, including specific treatment programs, of risk and harm reduction, programs of rehabilitation/reintegration, in articulation, in simultaneous or successive moments, having into consideration the diagnosis, the needs and capabilities of the patient and the family or immersive and his prognosis.* (SICAD, 2013).

The answers available should be standardized, based on scientific evidence and embedded in guiding documents, diversified according to the multiplicity and interaction of factors that are at the origin of the development and maintenance of addictive behaviours and their possible evolution for dependency.

Historically, the responsibility for the provision of care in the treatment context has been shared by public institutions and non-governmental organizations. The action of the latter has focused mainly in the provision of inpatient care in therapeutic community, option of intervention to attend situations of greater complexity.

The evolution towards a more comprehensive view of CAD reality, their expression in different stages of the life cycle and in diversified contexts determines that care for the citizens with this problem should mobilize the entire spectrum of health responses. In this sense, a Referral/Articulation Network was developed in the context of Addictive Behaviours and Dependencies, which brings together not only entities of the Ministry of Health, as well as other entities of other ministries and non-governmental organizations with intervention in the area.

Reintegration

Integration pathways of individuals with problems of use and abuse of psychoactive substances are characteristically, slow and tortuous, requiring global and systemic interventions that contribute to its sustainability. In this perspective, the approach in the context of **social integration** goes beyond the correction of the behaviours and attitudes of individuals, focusing also on the change, no less profound, of institutions, of social and economic agents. The monitoring of integration processes represent, in itself, a strategy that ensures the ongoing assessment of the course, the correction of options and back-up support to the individual, in a proactive logic of relapse prevention.

Over the past few years it has been recommended integrated intervention models, centred on the needs of the individual who is or is at risk of disintegration, regardless of the degree of dependence on psychoactive substances.

In this way, matter adequate strategies to the situation in which the individual is, what is reflected in the integration of various types of intervention, seeking always to ensure an approach based on a logic of satisfaction of individual needs, adapting the available responses to interventions diagnosed as necessary.

From a technical point of view, the possibility of reversing these dysfunctional boards of disintegration goes through intervention at two levels: recalibrate the daily routines of

¹² Where are clarified "the terms and the bases on which the agents can develop its activity, subject to evaluation and systematic monitoring." General-Directorate for Intervention on Addictive Behaviours and Dependencies

consumers and, concomitantly, in social systems, in order to fit, to give consistency and sequence to changes operated in individuals.

II.B.1.2. CONTEXTS OF INTERVENTION

An approach taking into account the specificities of the different contexts ensures the adequacy of interventions to be developed, because it takes into consideration the dynamics and the different interdependencies that occur in these contexts, between individuals and the formal and informal networks that operate within. This leads to the ability to adapt and focus the interventions, ensuring the consistency of messages and objectives that lead to the changes that are intending to operate.

In this sense, the interventions to advocate shall serve primarily to the following contexts:

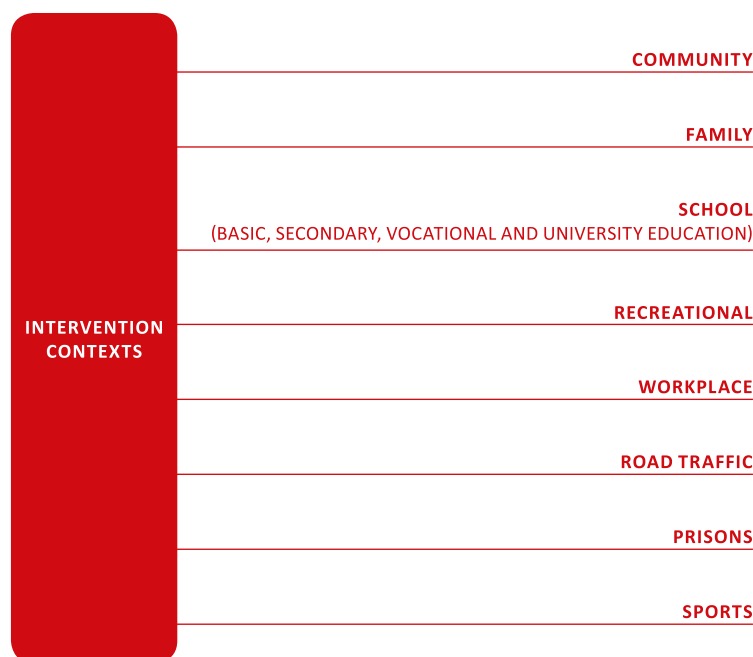


Figure 8. Intervention Contexts

Community Setting

The intervention in the community implies an integrated and global vision, as well as an ecological perspective, that contemplates the existence of different systems - micro, meso and macro, which interact and are generators of complexity.

It also implies that a planning takes into account the absolute need to ensure an articulation of strategies to optimize the best assessment of needs and use of existing resources in the different systems, and the development of macro environmental strategies will be of particular relevance, in terms of the impact it has on the others.

Here it assumes particular relevance the role of autarchies, public local services and non-governmental entities, such as the IPSS and NGOs that, while privileged experts of local or regional reality, are more able to contribute to the diagnosis that sustains the adequacy of responses to be developed¹³.

¹³ In this context, presents itself as an example, the development of Programs of Integrated Responses (PRI) and the Referral/Articulation Network in the context of Addictive Behaviours and Dependencies.

Family Setting

It is essential to foster and promote family interventions, particularly in those presenting risk factors associated with CAD.

The intervention with families must also focus on the different subsystems of the family and as a whole (parents, children and siblings), as well as favouring an early approach with regards to the problem situation, the life cycle phase of the family and age of the children.

There are a growing number of effective preventive programs and therapeutic interventions directed to the family, restricted or extended, some of them already developed in our country. These programs have helped to obtain positive results in the target groups, and these good practices that are identified must be extended, when the conditions for its implementation are appropriate.

It is also from this assumption that we must consider the intervention with children and young people, either within the framework of the protection system, or in the context of educational guardianship system.

School Setting – Basic, Secondary, Vocational and University Education

The intervention in the school environment should focus on a global approach, through the involvement of different actors of the educational community and the surrounding community. The intervention should act within the different aspects of school dynamic. The key dimensions in preventive approach in the school context are the following: school climate and positive relationships, binding and academic success of students, focus on the needs and specificities of each school context on the basis of socio demographic variables and the level of education, effective pedagogy and regulatory measures (normative with respect to CAD).

The definition of priorities and options for intervention are essential, taking into account other existing plans relating to health promotion, namely the National School Health Program, among others.

Finally, the university context has established itself as the last stage in the school process, the requirements which it contains and the specificities of its dynamics, in particular the festive and recreational occasions - which are strongly associated with the consumption of licit and illicit psychoactive substances are of particular relevance as a context of preventive intervention and of RRMD of CAD. In this context there are reported situations of greater severity in terms of occurrence of risk behaviours, particularly related to binge drinking and risk situations aggravated violence, unprotected sexual behaviour and driving under the influence of drugs and alcohol.

In terms of school context it is important to mention the national scope intervention, which is carried out through the Safe School Program, a joint initiative between the Ministry of the Interior and the Ministry of Education and Science, whose origin dates back to 1992. In this area, the GNR and PSP are continuing their assignments in order to guarantee the safety of the surrounding areas of educational establishments and to promote awareness and prevention near schools, in partnership with the executive councils and the local community.

Recreational Context

The patterns of consumption of psychoactive substances has undergone changes that are associated among other factors, to the multiplication of nightlife scenarios and the increasing supply of events, such as parties and music festivals. Currently recreational experience has a great social acceptance; there is not a unique consumer profile.

In this sense, the intervention should focus on actual patterns of consumption as regards to the type/group of goer (privileging the life cycle stages of pre-adolescence and adolescence), the motivation for the consumption, the type of substances used, and the form and context of its consumption.

It is worthy to point out that the recreational context environment is not confined to young people, with all stages of the life cycle generally participating in recreational and festive contexts. In these leisure and socialising spaces, there is a higher prevailing atmosphere of tolerance and permissiveness towards the consumption of psychoactive substances.

Workplace Context

Although in our country there is no representative business data base, it is known that the CAD in workplace context constitutes a problem of significant magnitude with reflections on the health of workers, in their safety and enterprises, in absenteeism and productivity.

The consumption and dependencies in the working environment are not only enhanced by unemployment and precarious employment. The workplace environment can also affect the consumption, and there are other factors, such as intense work rhythms and unregulated schedules, which can cause health problems, namely mental, such as stress and depression, which in turn induce the consumption of drugs, alcohol and other substances. These circumstances may contribute to the emergence of CAD, interfering, both in working life of the employee, with repercussions for enterprises, both in their personal and family life.

The strategic objectives of the intervention in workplace environment consist of support workers and companies in reducing this problem, either through awareness to put in the "agenda" of security policies and health of companies this theme, either in helping the development and implementation of effective measures to reduce and control the problem.

Road Traffic Context

It is widely recognized that the consumption of alcohol and other psychoactive substances are associated with a higher probability of occurrence of road accidents, and the consumption of alcohol pointed out as one of the main causes of this type of accident.

In addition to the inspection actions, it is important to continue to invest in information and awareness of the various stakeholders in the road traffic context on the importance of not driving under the influence of any substance, licit (such as alcohol or psychoactive medicines) or illicit, that influences the necessary capabilities to a proper prevention of road traffic accidents.

Prison Context

The inmates with substance use problems have specific health needs that require a multidisciplinary approach, it is important to ensure these citizens are provided with the necessary means for treatment and reintegration, either by verifying a relationship between drug use and criminal recidivism, either by the number of persons convicted for drug-related crimes and gambling related problems.

The screening of health problems linked to CAD should be integral in prison management. This context lacks an intervention strategy based on a better knowledge of the situation in terms of substances consumption and practices that exacerbate or configure CAD, namely money gambling, with a view to improve the available responses. It is intended to facilitate and make possible the design of programs and projects targeted at the population that presents risk behaviours and in respect of which it is necessary to act in a dynamic and focused way, in close coordination with the responsible services and other public and social entities available for an intervention in a harmonized way.

Sports Context

The sports context, although regularly referenced in national and international strategies of CAD prevention, is currently poorly defined, requiring greater investment and objectification. It should, therefore, be the target of a closer look and of continuous nature investment, paying attention not only to the general population or school context, but analyzing concretely the reality of those that regular go to gyms and fitness centres.

Studies are needed to better clarify the reality, production of specific information aimed at clarifying the impact of the substances used for the increase of physical performance and muscle moulding near the school population, as well as the training of professionals (teachers, coaches, personal trainers, etc.), in the areas of physical activity and health and sport and physical education, in order to qualify them to raise awareness of the risks associated with psychoactive substances among young people in at charge.

Another area traditionally linked to this context concerns the association of alcohol consumption at sporting events, there is an intense debate around its sponsorship by operators of alcoholic beverages, on the application of the law and on the capacity of self-regulation measures to prevent this practice occurs in competitions outside the timetables established for the advertising of alcoholic beverages and in particular in competitions of under-age athletes.

The awareness of sport governing bodies can ensure the adoption of risk reduction measures in the management of sports events or in moments of gatherings associated with them, with a special focus in the younger age groups, allowing a more effective application of the measures of self-regulation of commercial communications in relation to the advertising of alcoholic drinks at sporting events involving minors.

II.B.1.3.OBJECTIVES BY LIFE CYCLE STAGES

Generically, the different stages of the life cycle tend to match different tables of physical characteristics, psychological and socio-cultural, with influence on the manifestation of CAD and associated problems.

The CAD share common substrates that are translated into different manifestations, which are achieved in different ways throughout the life cycle, according to specific contexts.

This multiplicity of intersections requires a planning of interventions that will be translated into objectives that accompany the adjusted development of the person, through measures of preventive intervention, or in the natural history of disturbance, fashioning in each moment of intervention the responses that more adequately can deal with the consequences and the impact of these problematic and associated with these.

On the other hand, the contexts, understood as the physical or emotional spaces in which the intervention takes place, have their own specificities. These are integrated or extremely connected to other more engaging and with whom they strongly interact, generating interdependencies that we need to know and understand. It is necessary to create mechanisms and strategies that facilitate the strengthening of what each one can do to bring improvements to the life quality of individuals and groups that constitute them.

As referenced in the "Strategic Options", the focus and approach by life cycle stages allows matching the response needs and the interventions according to the developmental stage of the citizen. Thus, the approach by life cycle becomes crucial to potentiate the type of intervention and the actions that will be identified as a priority, taking into account the contexts in which they will develop the interventions.

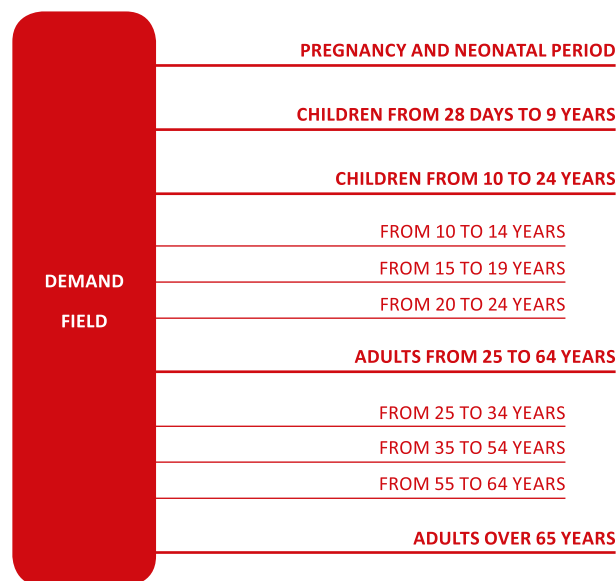


Figure 9. Specificities of the demand field – life cycle stages

In this sequence, it is presented the delineation of the objectives defined by life cycle stages, as well as the main perspectives that should guide the interventions.

It should be noted that some goals and some perspectives are accepted and appropriate along the life cycle stages, in the sense or to enhance skills already acquired or adjust them according to the age.

Pregnancy and Neonatal period

This stage focuses on women's health and development of their pregnancy, postpartum and the newborn up to 28 days of life.

The data relating to the life cycle stage point to the need to privilege prevention policies of consumption occurrence during pregnancy, early identification of the same, support to pregnant women in which these consumptions are identified and monitoring of newborns in this clinical picture. In this context, considering the environmental determinants of consumption, the linkage of intersectoral policies is essential, both at health level (with policies to promote maternal and newborn health, for example), or other areas.

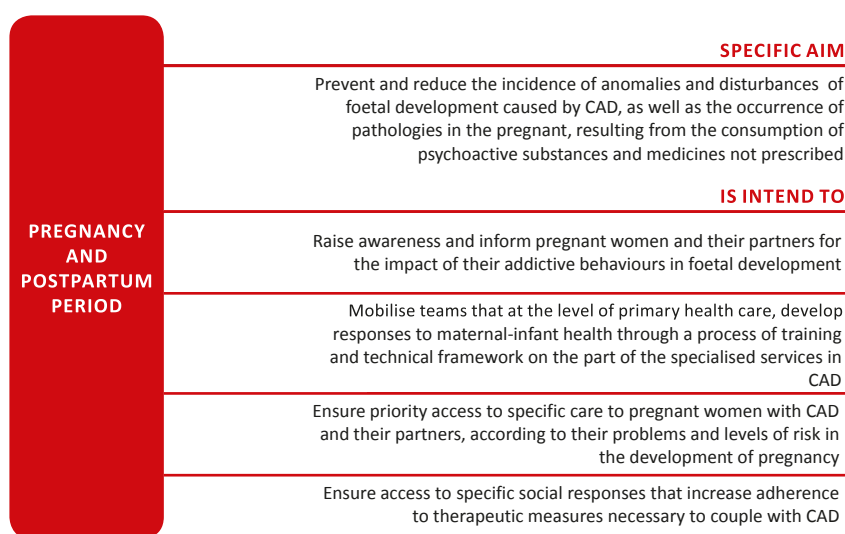


Figure 10. Specific Aims to the stage – pregnancy and neonatal period

The intervention should focus, in the first place, on a preventive perspective, in the processes of awareness and information to improve the preparation of pregnant women and the family for the birth of the child, to breastfeeding and to parenthood and secondly, to provide answers to specific and continued monitoring to all situations identified of CAD cases in pregnant women, referring to the activation of the Referral/Articulation Network.

Children from 28 days to 9 years

Although the consumption of substances tends to start in the next life cycle stage, the studies carried out in the school context show that a portion of this population begins its consumption at an earlier age.

In this sense, it is important to develop policies with a view to delay the age of onset of consumption, taking as a reference the determinants of this process for the identification of target groups at greatest risk.

At this stage of the life cycle, we should also consider a subgroup of particular risk, which consists of the children who had been exposed to environments, namely family, where the harmful use of psychoactive substances is present.

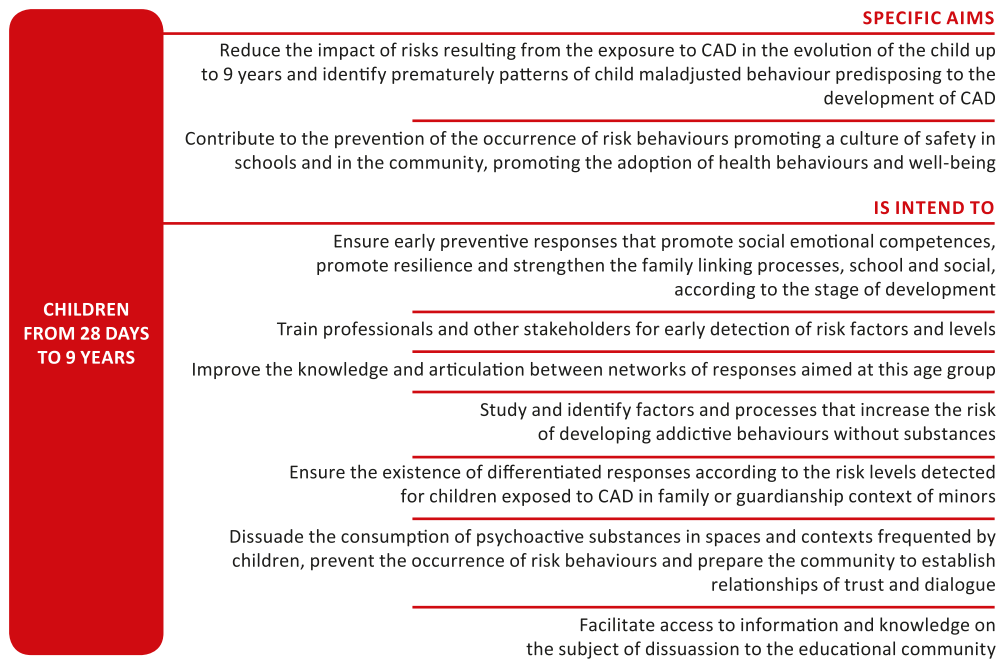


Figure 11. Specific aims to the stage – children from 28 days to 9 years

The intervention should be of preventive nature, focusing on processes and families' dynamics and health promotion. Its fundamental the development of socio emotional skills of the subjects, focused on the child and their direct or indirect surroundings, that is, at this stage, a crucial influence on health education of children and the adoption of healthy behaviours on their part, thus fostering resiliency. For this purpose it is vital to raise awareness and training to professionals and family members.

Young People from 10 to 24 years

Adolescence is characterized by behavioural and neurobiological changes, making this stage a unique period in human development. This is a time in which there is a demand for sensations, with a decrease of perceiving the risks, an increase in the importance of social interaction and the pairs, and the construction of identity. During adolescence there are multiple changes in the organism, including rapid hormonal changes and the formation of new synapses in the brain, which are crucial for the development (McAnarney, 2008; McQueeney et al., 2009).

The consumption of alcohol and other psychoactive substances during adolescence can compromise the development, both at biological level, interrupting or hindering its maturation, as at psychosocial level, involving adolescents in relational and behavioural situations with unforeseeable consequences (Barroso, 2012).

The psychoactive substances inhibit the perception of risk and deteriorate the capacities of adolescents to consider the consequences of their actions, encouraging involvement in risk behaviours (Spear, 2002; OMS, 2004; NIAAA, 2005; McQueeney et al., 2009).

Due to the complexity of the phenomena development that makes the adolescence a critical phase for the emergence of this problem, it was divided the analysis and interventions to be developed in three distinct periods in what refers to CAD related problems: 10-14 years, 15-19 years and 20-24 years old.

From 10 to 14 years

In relation to 10-14 years, the studies carried out in the school context show that a portion of the school population starts the consumption of psychoactive substances in this age group, noticing already some worrying consumption patterns.

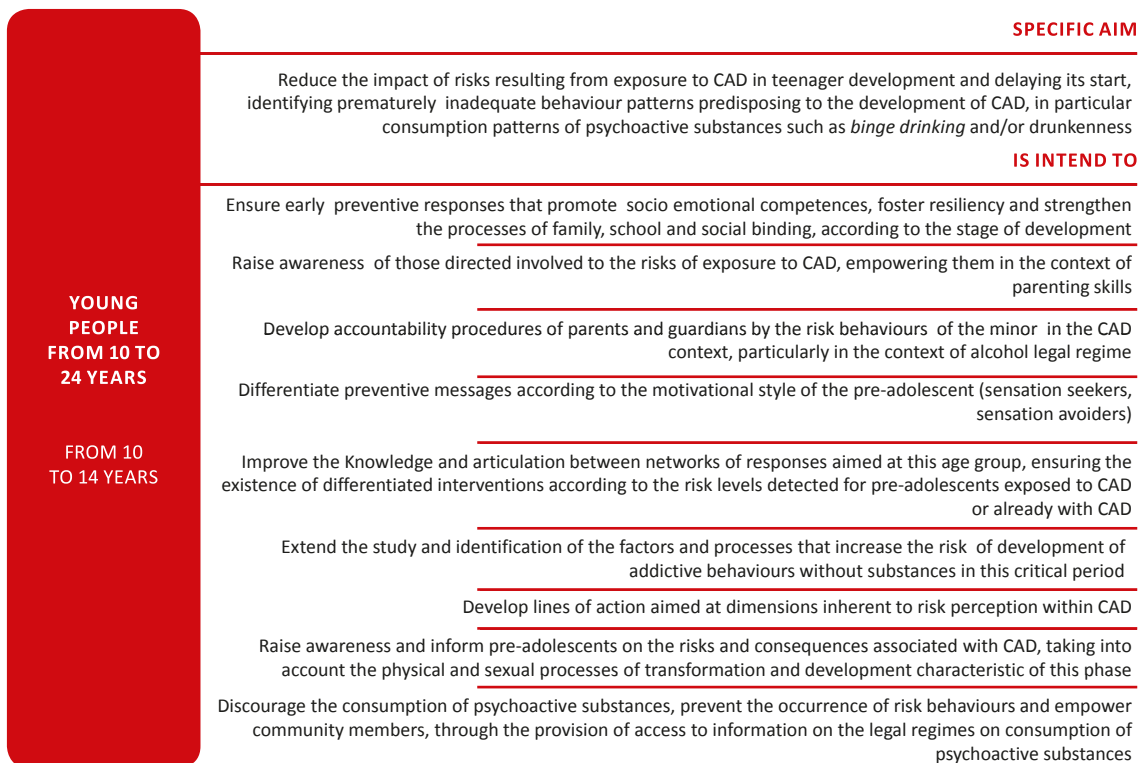


Figure 12 . Specific Objectives for the stage - young people from 10 to 14 years

The focus of the intervention should have a preventive character, focusing on the development of socio emotional competences in the individuals, developed within the framework of programs and projects on a continuing basis, with special emphasis to family and school context. The identification of risk groups with greater vulnerability should guide the interventions - selective and indicated prevention, in accordance with the diagnoses performed. For this purpose it is vital to raise awareness and training of professionals and family members.

From 15 to 19 years

As for 15-19 years, this is the age group where mostly begin the consumption of psychoactive substances and harmful and abusive patterns of use can start to emerge.

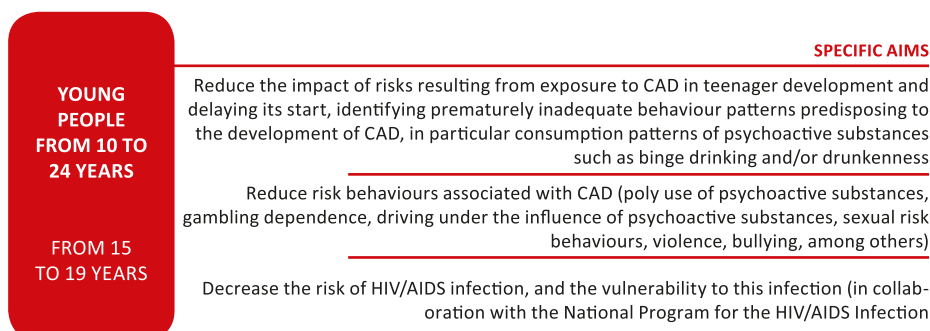




Figure 13 . Specific Objectives for the stage - young people from 15 to 19 years

The intervention should have a preventive character, focusing on the development processes of socio emotional competences in young people, developed within the framework of programs and projects in a continuous basis, with special emphasis to the school/university and recreational context. The identification of risk groups with greater vulnerability should guide the interventions - selective and indicated prevention, in accordance with the diagnoses performed. For this purpose it is vital to raise awareness and training of professionals and peers.

From 20 to 24 years

In the period from 20-24 years some consumption of psychoactive substances, started in the 15-19 years age group, often persist and may evolve to situations of more problematic addictive behaviours and dependence.

YOUNG PEOPLE FROM 10 TO 24 YEARS

FROM 20 TO 24 YEARS

SPECIFIC AIMS

Reduce CAD in young people and the impact of risks resulting from the exposure to CAD, identifying patterns of maladjusted behaviour, in particular consumption patterns of psychoactive substances such as binge drinking and/or drunkenness

Reduce risk behaviours associated with CAD (poly use of psychoactive substances, driving under the influence of psychoactive substances, sexual risk behaviours, violence, and gambling)

Decrease the risk of HIV/AIDS infection, and the vulnerability to this infection (in collaboration with the National Program for the HIV/AIDS Infection)

Reduce the risk of development of comorbidity associated with CAD

Develop specific approaches adapted to the needs and characteristics of citizens/indicted

IS INTEND TO

Ensure preventive responses which (i) explore perception of risk associated with CAD, and beliefs and attitudes facilitators of CAD, (ii) mutual aid processes (iii) promote the development of life projects, according to the stage of development

Capacitate the direct stakeholders to identify signs of change behaviour, cognitive deficits and mental illness associated with CAD, as well as behavioural patterns associated with dependencies without substance

Enable health professionals for the identification of CAD and indicators of comorbidity, intervene in a perspective of motivation for change (brief interventions and motivational interview) as well as reference for answers in accordance with the level of risk identified

Differentiate preventive message according to the motivational style of the young person (*sensation seekers, sensation avoiders*)

Improve the Knowledge and articulation between networks of responses aimed at this age group, ensuring the existence of differentiated responses according to the risk levels detected

Extend the study and identification of the factors and processes that increase the risk of development of addictive behaviours without substances in this critical period

Raise awareness and inform for the risks and consequences associated with CAD, in particular the NPS, anabolic steroids and dependencies without substance taking into consideration the experience of sexuality and the adaptive processes of changing contexts

Promote responsibility and the involvement of peers in the preventive process, technically framed

Promote the reduction of risks and harm reduction associated with CAD

Detect and contribute to the reduction of poverty and social exclusion situations related with CAD, as well as emerging deviant behaviours related to these phenomena

Develop intervention strategies aimed at the reintegration/rehabilitation in cases of psychoactive substance dependence with deterioration of insertion in the support networks

Make available to indicted in CDT presenting diagnosis of risk and/or dependence, related comorbidity and/or another type of weaknesses of social character, family, professional, integrated responses qualified and recognised that meet the needs they present, contributing to an effective stop of the consumption and social integration

Figure 14. Specific Objectives for the stage - young people from 20 to 24 years old

The focus of intervention should have a preventive character and of RRMD, focusing on processes of promotion of socio emotional competences and perceiving the risk associated with CAD in the subjects, and be developed in the context of programs and projects with continuity and proximity character, with special emphasis on recreational, university and community contexts. The identification of risk groups with greater vulnerability should guide the interventions - selective and indicated prevention, and RRMD, according to the diagnoses performed. For this purpose it is vital to raise awareness and training of professionals, peers and other stakeholders.

Adults from 25 to 64 years

It is considered that this stage in the life cycle includes at least three distinct periods in which relate to CAD related problems: 25-34 years¹⁴, 35-54 years and 55-64 years.

In this respect, it should be noted that it is in the age group of 25 to 34 years that the consumption of illicit substances and of new psychoactive substances is higher.

In the patterns of consumption of illicit substances, it is in the age group of 35 to 54 years that is more common dropped out consumption or not recent consumption. (Balsa et al., 2008).

Regarding more harmful consumption patterns of alcoholic beverages, it is noted in relation to the age group of 25 to 34 years, a decrease in the prevalence of drunkenness (Balsa, Vital & Urbano, 2013).

It is also at this stage that occurs more often the development of gambling related problems.



Figure 15. Specific Objectives for the stage – adults from 25 to 64 years

¹⁴ Part of the young adult population, which covers the period of 15 to 34 years old.

Intervention should focus on different perspectives of approach, in particular in the areas of prevention, dissuasion, RRMD, treatment and rehabilitation, favouring the proximity and accessibility of responses to individuals who need it. The identification of risk groups with greater vulnerability, resulting from the individual determinants and macro environmental, should guide the interventions - selective and indicated prevention and treatment. In this extensive stage in the life cycle, which corresponds to the active life period, special attention must be paid to the intervention in work context. For this purpose it is vital to raise awareness and training of professionals and other stakeholders.

Adults over 65 years

This stage in the life cycle has been little invested in relation to CAD, requires greater attention. Some data suggest a likely emergency or increase of CAD in these ages, associated with other health and social problems.

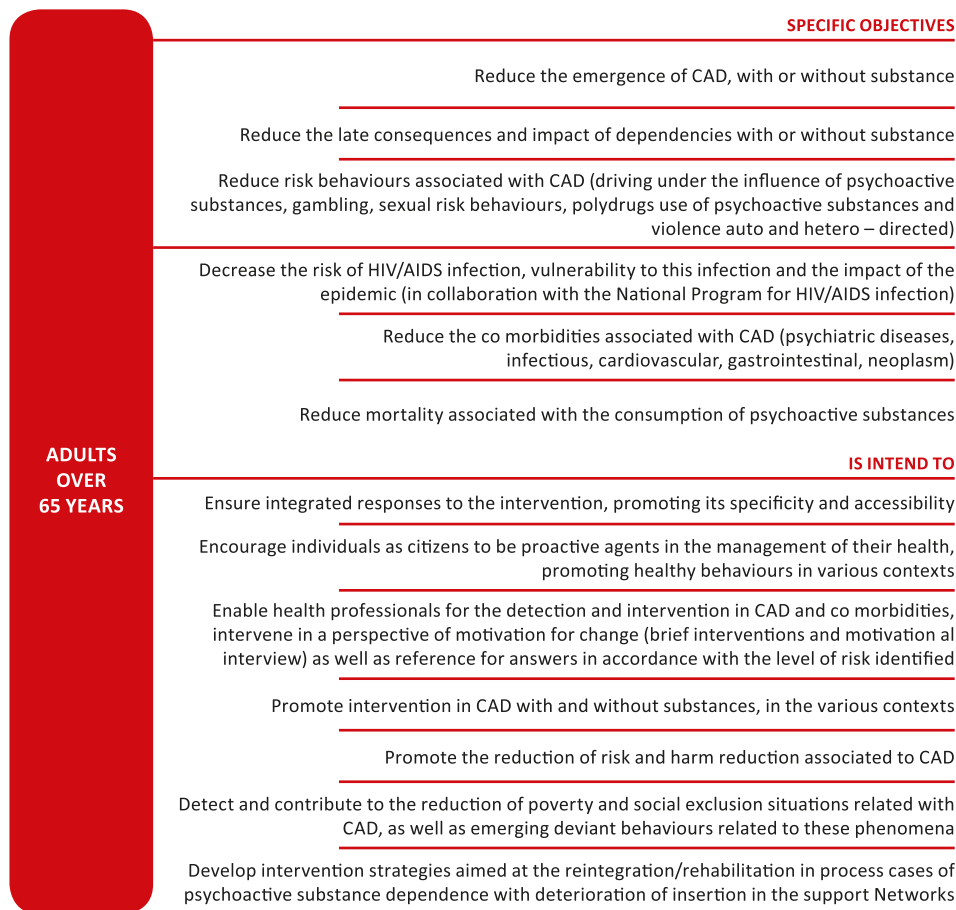


Figure 16. Specific Objectives for the stage – Adults over 65 years

The intervention should focus on different perspectives of approach, in particular in the areas of prevention, RRMD, treatment, rehabilitation, favouring the proximity and accessibility of responses to individuals who need it. For this purpose it is vital to raise awareness and training of professionals and other 'mentors' and the creation of conditions for the development of a joint and cross-sector intervention, necessary to ensure that the services of specialized response, in particular provision of primary health care and the social network, providing an appropriate follow-up to this issue in the final stage of the life cycle.

II.B.1.4. STRUCTURAL MEASURES

The Operational Plan of Integrated Responses and the Referral/Articulation Network in the context of Addictive Behaviours and Dependencies are two structural measures that pass through the previous strategic cycle, with updates and adjustments however introduced, and given the changes in the reorganization of services.

Considered an add value and a support to address the needs identified at regional and local level, operating the set of PNRCAD principles.

Operational Plan for Integrated Responses (PORI)

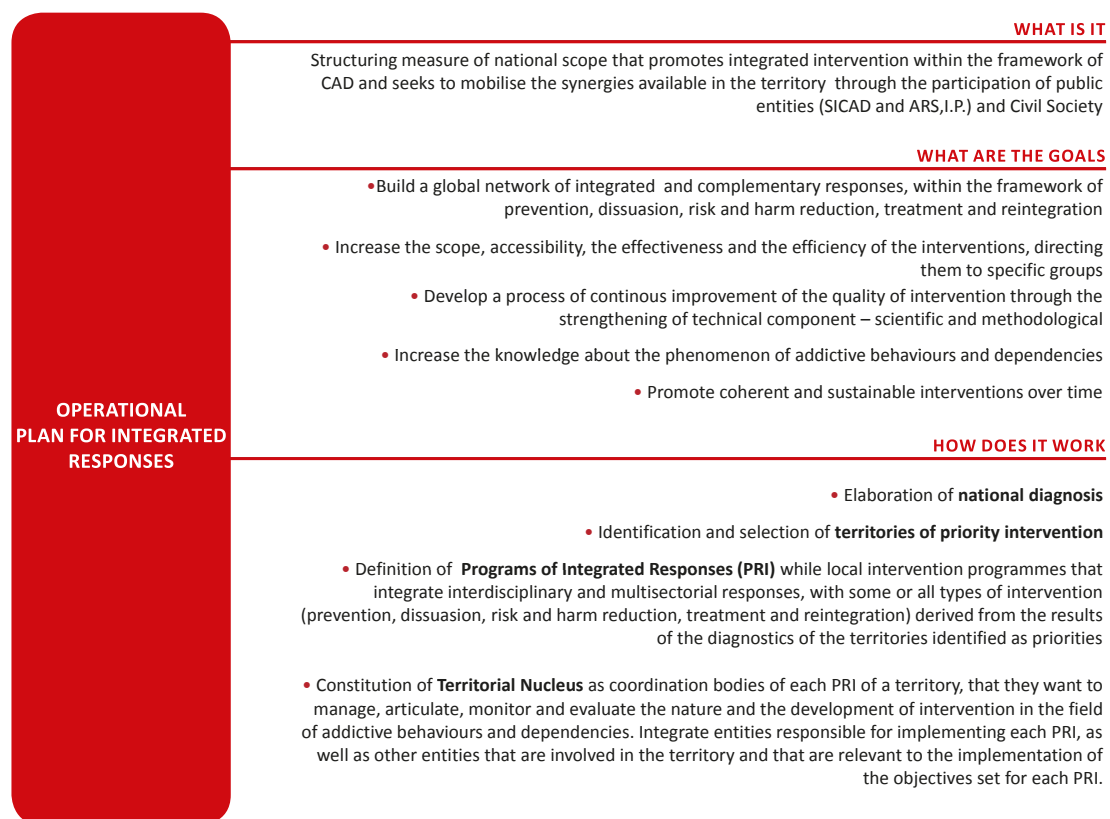
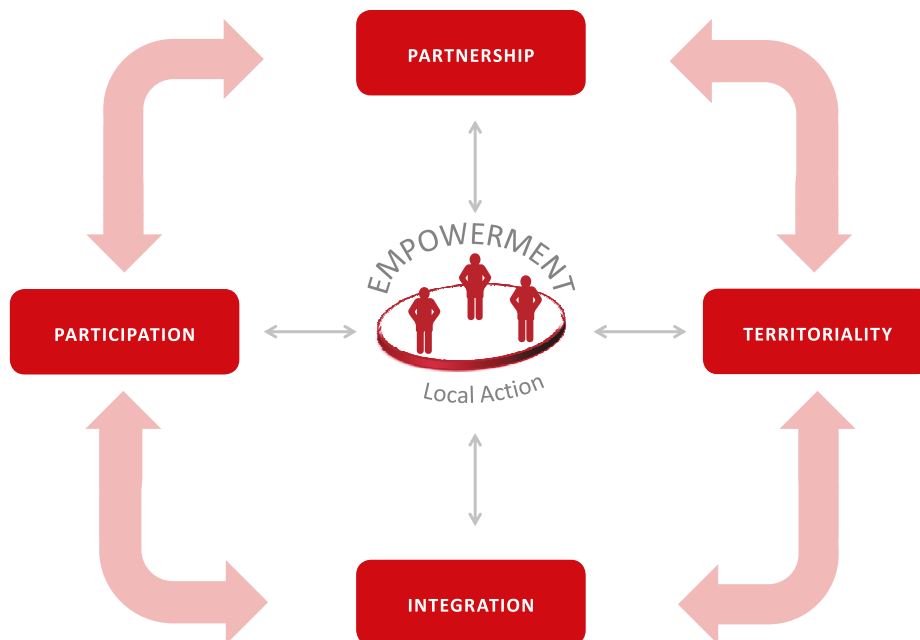


Figure 17. PORI

The **Operational Plan of Integrated Responses** is, since 2006, a structural measure of national scope in terms of integrated intervention in the area of addictive behaviours and dependencies, which seeks to potentiate synergies available in the territories, either through the development and implementation of methodologies for performing diagnostics to justify the intervention, either through the implementation of Programs of Integrated Responses (PRI).

The integrated intervention should be develop to contribute to the improvement of its quality in theoretical and operational terms, taking into account a common conceptual basis to guide the various types of intervention in the scope of addictive behaviours and dependencies. However, PRI implementation process can have several formulas or paths, which will vary depending on local intervention experiences, namely from existing local social networks, autarchies, the decentralised services of the Public Administration and the civil society organisations in this field of intervention.

PORI is based on the principles of territoriality, integration, partnership and participation that constitute the strategic orientation framework defined by the International Labour Organization, for the fight against poverty and social exclusion context, as represented in the following figure.



adapted from the strategic approach of Fight Against Poverty and Social Exclusion of the International Labour Organization, 2004

Figure 18. PORI strategic framework

In addition to these principles, empowerment is considered a fundamental concept of the intervention model in the scope of psychoactive substances use. This is understood as a desire changing process in order to reinforce the autonomy of the “territories” for problems resolution, helping to promote the implementation of coherent and sustainable interventions over time.

Referral/Articulation Network in the scope of Addictive Behaviours and Dependencies

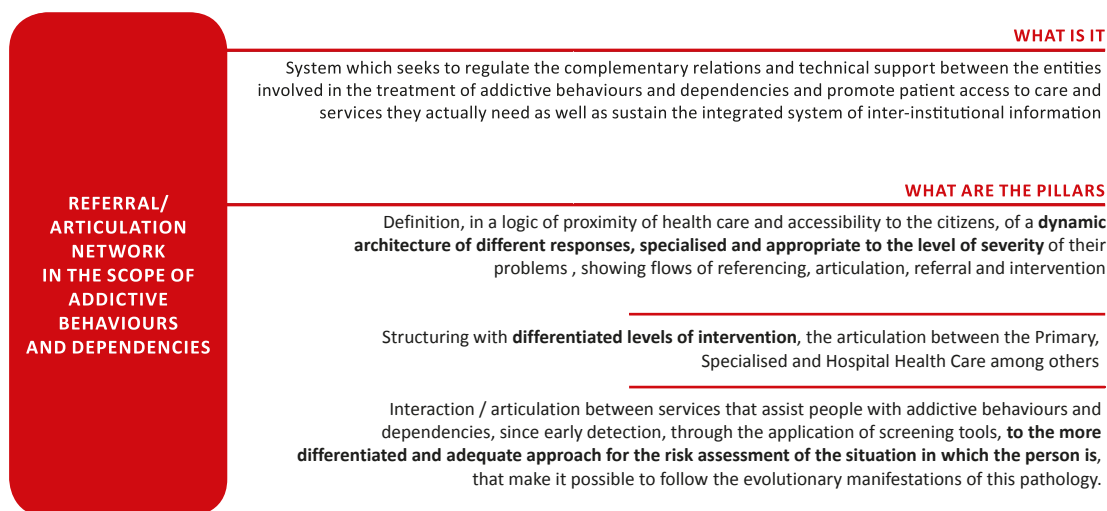
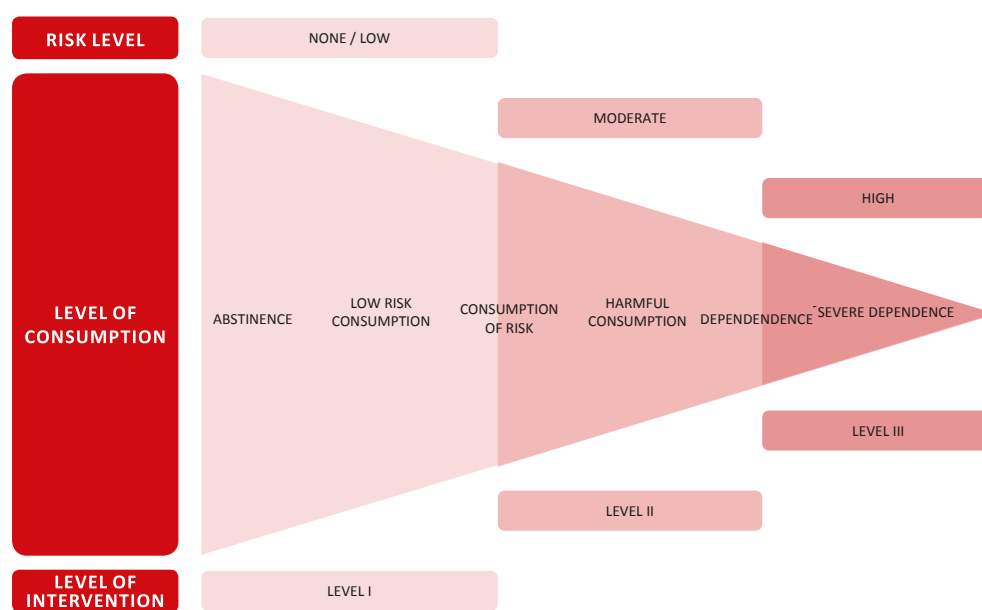


Figure 19. Referral/Articulation Network

From the recent reorganisation and assumption of attributions of intervention in the context of CAD, exist the need of implement a **Referral/Articulation Network** that meets the local-regional specificities and constrains. It is thus intended, to the redefinition of the relations of complementary and technical support in the light of a new attribution of competences between public institutions, as well as the enlargement and integration of care, according to the real needs of the populations in terms of CAD.

Contemplate the progress that scientific evidence has been devoting in relation to these phenomena, which may occur in any phase of an individual life cycle, evidence that defines a holistic vision of the concept of addictive conduct and addiction and calls for the mobilisation of this Network of other interventions, Units and Plans that until now operated in a less interconnected way.



Adapted from Springer, IOM - J.F. & Phillips, J. (n.d.), *The Institute of Medicine Framework and its implication for the advancement of prevention policy, programs and practice*. Washington: CARs e de Ferreira-Borges, C. e Cunha Filho, H. (2007), *Intervenções Breves: Alcool e Outras Drogas – Manual Técnico e Cd-Rom*, Lisboa: CLIMEPS!

Figure 20. Relation of consumption, risk and intervention levels in the scope of CAD

In this sense, the Referral/Articulation Network in the context of Addictive Behaviours and Dependencies gathers the public health services, the different systems potentially involved in the monitoring course of these populations (Social Security, Education, Labour, Public Security, Justice), as well as the devices target to the problematic of domestic violence/family, children and young people at risk and young people with adjustment and social inclusion problems, and also private entities that over time have played an important role in the treatment of CAD.

Integrating these guiding elements, the implementation of the Referral/Articulation Network will consolidate the focus on the citizen and their real needs, articulated according to logical and rationale criteria's. It is intended to mobilise selectively structures with the differentiation and the technical and human resources appropriate to the implementation of interventions that effectively respond to their health problems, in terms of specificity, complexity and degree of severity.

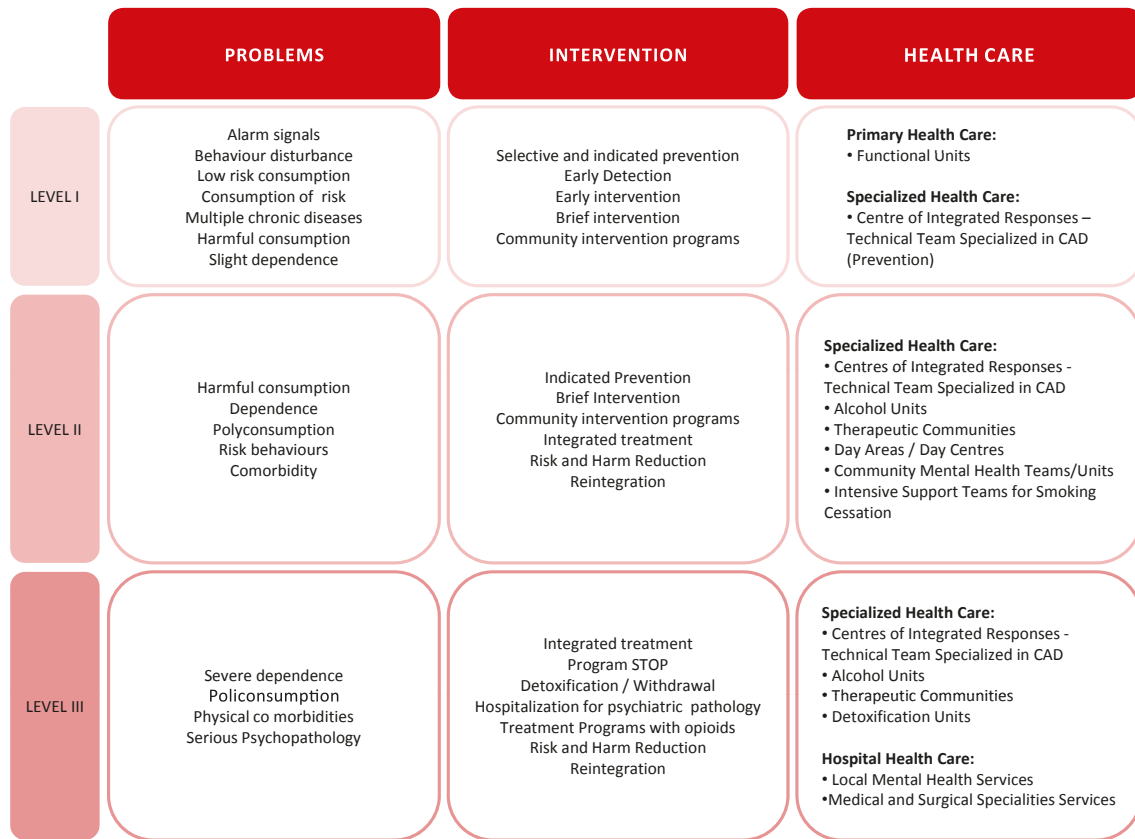


Figure 21. Algorithm of the Referral/Articulation Network

II.B.2. SUPPLY FIELD

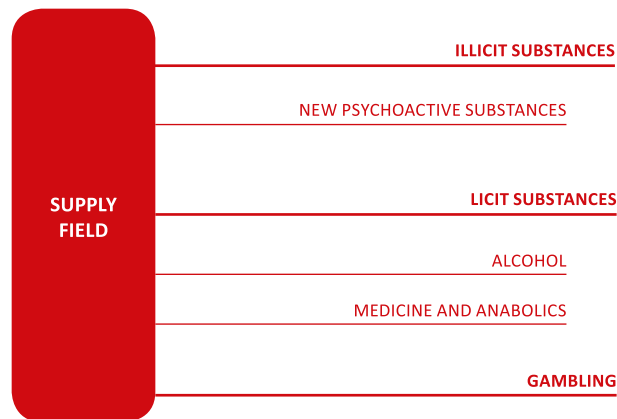


Figure 22. Specificities of the Supply field

In the **supply field** it is important to reduce the availability and access to illicit substances and new psychoactive substances (NPS), regulate and supervise the market of licit substances and during this strategic cycle, trying to harmonise the legal devices already existing or to be developed in respect of gambling, medicines and anabolic areas in the context of CAD, always from the perspective of reducing risk behaviours and enhancers of dependence.

II.B.2.1. ILLICIT SUBSTANCES

The main legal instruments of the international community strategy for illicit psychoactive substances are the three specific international conventions for drugs problems: Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol; Convention on Psychotropic Substances of 1971 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

The transposition into national law of the United Nations Conventions was revised in 1993 by the Decree-Law no. 15/93, of 22 January, following the ratification by Portugal in 1991, of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. This Decree-law also contemplates the implementation of multilateral treaties and provisions of the EU in the field of money laundering. Subsequently, the Regulatory Decree no. 61/94, of 12 October, established the rules for the licit market of narcotic drugs, psychotropic substances, precursors and other chemicals products susceptible of being used in the manufacture of the substances listed in tables I to VI of the Decree-Law no. 15/93, of 22 January, safeguarding the legitimate uses, in particular for the manufacture of medicinal products and scientific research.

The regulatory framework and national sanctioning is completed by the Administrative Rule no. 94/96, of 26 March, which establishes the maximum quantitative limits for each average daily individual dose of plants, substances or preparations consumed more often, listed in tables I to IV annexed to Decree-law no. 15/93, of 22 January, which is an important element for the applicability of some of the provisions of that law.

Based on the exchange of information between EU Member States and the risk assessment of substances, exercise that culminates placing in control and criminal sanctions across the EU of substances which present risks¹⁵, other substances can be added to the control lists. On the other hand, based on a risk assessment performed by the WHO, new substances may be considered and subject to control at the United Nations level, which obliges the addition on the lists of the Decree-Law no. 15/93, of 22 January.

The supervision by the criminal police bodies ensures the application of the law.

Law no. 30/2000, of 29 November, defined the legal framework applicable to the consumption of narcotics and psychotropic substances, turning the consumption, acquisition and possession for own consumption of plants, substances or preparations listed in the tables referred in Decree-Law no. 15/93, of 22 January, constitute an administrative offence. The consumption and possession of these substances, in quantities not exceeding an average individual consumption during a period of 10 days (defined in the Administrative Rule no. 94/96, of 26 March) are no longer considered as a crime and become an administrative offence. The possession of drugs in a quantity greater than an average of 10 days consumption, even for individual consumption, remains criminalised, as provided in the Supreme Court of Justice no. 8/2008, of 25 June.

New Psychoactive Substances (NPS)

In the last few years in Portugal it was observed an escalation in the emergence of psychoactive substances whose prohibition is not under the international control system of the United Nations. These are substances that, in pure form or in a preparation, can

¹⁵ Council Decision 2005/387/JHA has established a system at EU level to combat the new psychoactive substances (natural and synthetic) that are of concern at EU level. The abovementioned decision establishes standards for the exchange of information on these substances between the Member States, coordinated by the EMCDDA and Europol, on the assessment of their risks and placing under control and criminal sanctions throughout the EU the substances which present risks.

be a threat to public health comparable to the substances included in the lists annexed to Decree-Law no. 15/93, of 22 January, with danger to life or health and physical integrity and for which are not known licit uses. Its control, through its own legislation, was misleading through the modification of molecules, thus changing the chemical composition of controlled substances. The opening of sites dedicated to the sale of psychoactive substances represented a threat to public health, created social alarm and led to the regulation of these substances.

Due to existence of consensus formed around the danger of new psychoactive substances already known and the susceptibility and thus predict new administrative offences, it was considered essential to establish health measures of immediate effect against the production, distribution, sell, dispensation, import, export and advertising of other new substances that may arise in the market, given the serious threat and unpredictability that these substances contain, which was implemented through the provisions of Decree-law no. 54/2013, of 17 April, that defines the legal framework for the prevention and protection against advertising and commerce of new psychoactive substances already known and others that may arise in the market. The control list was approved by the Administrative Rule no. 154/2013, of 17 April.



Figura 23. Specific goals in the context of illicit substances and NPS

II.B.2.2. LICIT SUBSTANCES

The regulation and supervision of the licit substances market aims to ensure that consumers' access is done safely, ensuring their protection through legislative, regulatory, self regulation of economic operators and law enforcement measures.

States have at their disposal a wide range of measures, including fiscal nature and prohibition or limitation of production, placing in the market, advertising and use, focused in public and individual health defence of consumers.

Democratic societies subject the imposition of these measures to public discussion and consultation through economic operators, civil society, consumers and their representatives, including the politic representatives in their respective legislative assemblies.

In Portugal it is important to point out the experience resulting from the establishment of the National Alcohol and Health Forum, a platform at national level, which is representative of all the concerned stakeholders in civil society that engaged to strengthen the necessary actions to reduce the harm caused by harmful use of alcohol.

It is intended to ensure, not only a collaboration of proximity with all the actors, but also to provide a space for sharing, discussion and reflection on relevant content within the proposed thematic (Relatório FNAS 210-2012, SICAD, 2012).

Alcohol

The harmful use of alcohol is a serious health problem which is reflected in both acute and chronic conditions. Alcohol consumption is associated with many serious issues of development and social, including violence, neglect, child abuse, absenteeism at work, work and road accidents.

There is not a world framework convention for the harmful use of alcohol, contrary to psychoactive substances subject to control measures within the framework of the United Nations Conventions or tobacco, subject to the provisions of the World Health Organization Framework Convention on Tobacco Control, 2003, transposed into national legislation by Decree-Law no. 25-A/2005 of 8 November.

In 2006 the EU adopted a strategy to support Member States in reducing alcohol related harm. This Strategy focused on the prevention and reduction of the harmful alcohol use patterns by minors, as well as in some of their most harmful consequences, such as traffic accidents caused by alcohol and foetal alcohol syndrome. To mention the structure created to promote the exchange of best practices and to monitor the implementation of the Strategy, in particular the Committee on National Alcohol Policy and Action (CNAPA) and the European Alcohol and Health Forum.

In 2010, the World Health Organization approved the Global Strategy to reduce the harmful use of alcohol and in 2011 WHO Europe approved the European Action Plan to reduce the harmful use of alcohol 2012-2020. This Action Plan includes a range of evidence-based policy options to reduce the harmful use of alcohol and is closely linked to the 10 action areas and the 4 priority areas of the Global Strategy.

In the previous strategic cycle, the National Plan for Reducing Alcohol Related Problems 2010-2012, implemented wide measures for the reduction of harmful use of alcohol in a health perspective, with a multisectorial focus approach, including in its Operational Plan, actions in the areas of intervention with young people, children and pregnant women, road accidents, adults and working environment, prevention, training, com-

munication and education, information systems and data collection, treatment and reinsertion. The PNRPLA incorporated the state-of-the-art in terms of interventions based on scientific evidence that contribute to the reduction of the harmful use of alcohol, the European Strategy and on the experience of the European Alcohol and Health Forum.

Among the most significant, results of PNRPLA come out the internal coordination (IDT.I.P.), intra-ministerial, interministerial and external, the implementation and development of the National Information System on Alcohol (SNIA), the production of knowledge, the creation of a Referral/Articulation Network, the enlargement of responses to the problem to the entire network of Centres of Integrated Responses, public and accredited therapeutic communities, the creation of the National Alcohol and Health Forum and the publication of the Decree-Law nº 50/2013 of 16 April – that establish a new regime of provision, sale and consumption of alcoholic beverages in public places and in places open to the public. Its application will be the subject of a study to be developed by January 1, 2015 by SICAD.

Among the most significant changes stand out the prohibition to provide regardless of business objectives, sell or for business purposes, make available in public places and in places open to the public, spirits, or equivalent, to those under 18 years of age and all alcoholic beverages, spirits and not spirits, who have not completed 16 years of age, the prohibition to sell alcoholic beverages between 00:00 and 08:00 hours in any commercial establishment, except in restaurants and bars, as well as in service stations located on highways or outside towns¹⁶ and the changes to the Highway Code, Law nº 72/2013, of 3 September, related to the reduction of blood alcohol concentration for drivers on probation, emergency vehicles or urgent service and drivers of collective transport of children and young people up to 16 years, taxis, heavy car passengers or goods or transport of dangerous goods.

Under PNRCAD it is intended to deepen and pursue the establishment of partnerships and dialogue with the alcohol industry partners to reduce the problems resulting from the harmful use of alcohol.

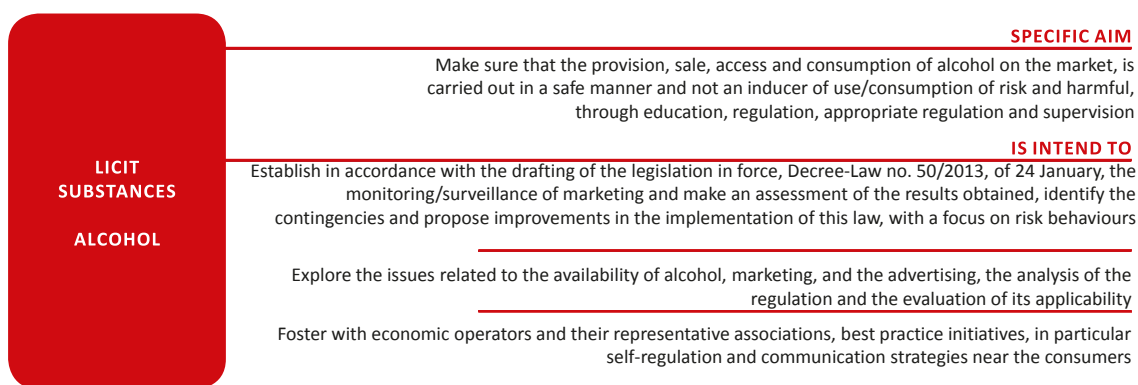


Figure 24. Specific objectives in the context of licit substances - alcohol

Medicines and anabolic steroids

The use of non-prescribed medicines is a distinct category for different points of view, and requires attention according to several perspectives. (UNODC, 2011).

The use of medicines subject to prescription without medical supervision or exceeding the quantity and/or limitation of prescription period has harmful consequences

¹⁶ With the exception of commercial establishments or drinks and establishments in ports and airports in place of access reserved for passengers and nightlife establishments.

for health. Some types of medications (analgesics, medicines for opioids substitution, sedatives and hypnotics) are used to induce psychoactive effects, or used in association with others, change the effect of other medicines, and their use and abuse may result in dependence.

Some of the reasons for the use of medicines outside the therapeutic framework are related with the easy availability compared to illicit psychoactive substances, without the need to go to the illegal market and dealers, the greater social acceptance of its use, and also to the dosage known and no adulteration of drugs, which reduces the impact on users' health. Stimulants and anabolic steroids trigger an increase in aggressiveness that can have very serious consequences.

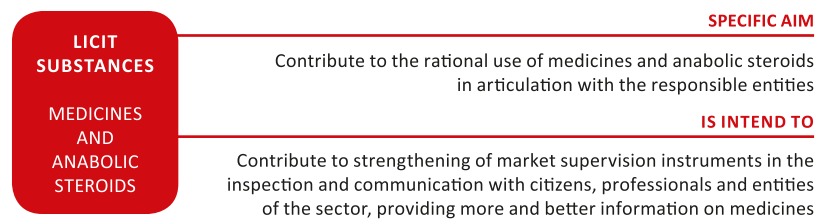


Figure 25. Specific objectives in the context of licit substances – medicines and anabolic steroids

II.B.2.3. GAMBLING

In relation to CAD without psychoactive substances, it is considered to be relevant to highlight the gambling phenomenon. Gambling is a problem with a recent history in terms of health policy definition at European level, the evidence about its various aspects is sparse and somewhat inconsistent, fruit of the use of distinct conceptual boundaries.

There is a lack of knowledge in Portugal regarding the phenomena of money gambling addiction, particularly among the new focus of concern, such as the young people of 14-18 years (or 12-18 years) and patient groups (Lopes, 2009).

The gambling addiction prevalence in Portugal is identical to the majority of European countries, and the incidence is also predictably similar (Lopes, 2009).

It should also be noted that, between gambling dependents, there is an important comorbidity with other dependencies, namely alcoholic beverages, as well as other mental health problems such as depression and suicide (Lopes, 2009).

Gambling has a leisure and learning side and is a behaviour rooted in the progress and learning of human cultures. The traditional society games potentiate the acquisition of social and sociability competences.

With technological development there have emerged new forms of gambling, allocated in interactive platforms, which allow the purchase of games programmed to insert in consoles and games online, accessible 24 hours per day.

As for games of chance, the first distinction is between legal and illegal games. And within the legal games we must also take into account the different types of games and regimes.

Gambling is an activity of significant importance in the national economic space, in its social effect has been historically recognized. Its exploration and practice within a framework of legality is a generator of resources that the State mobilizes in favour of

¹⁷ <http://www.turismodeportugal.pt/Portugu%C3%AAs/AreasAtividade/atividadedejogo/combatejogollicito/Pages/CombateJogollicito.aspx>

social welfare. This exercise becomes impossible when the same takes place outside the law, a situation in which only a few will benefit but certainly enough will be penalized¹⁷.

The legal regime has, therefore, means and regulatory instruments for the prevention of gambling addiction or pathological gambling; however, there is not a public network of support and treatment, main lacking area identified with regard to gambling addiction. Its creation should be especially reinforced in the geographical areas in which are located casinos and bingo game rooms, in such a way that there is a greater proximity to the player.

The intervention in this area, in a health perspective, should focus on the development of knowledge and in the areas of training, advertising, accessibility and monitoring.

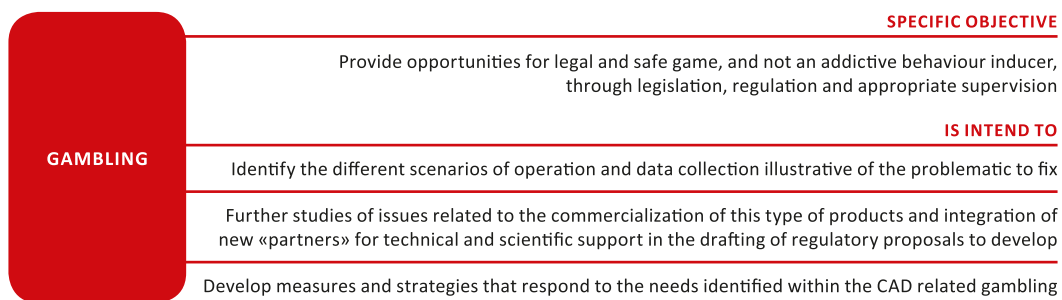


Figure 26. Specific objectives in the gambling context

II.C. CROSS-CUTTING THEMES

The quality, sustainability and innovation policies and interventions is only possible through a continuous knowledge process.

Giving continuity to the strategy advocated in the past few years, the **Information and Research, Training and Communication** and the **international Cooperation** remain cross-cutting themes to demand and supply fields, while ensuring the production of knowledge, the training of all staff involved: decision-makers, professionals and citizens, and international coordination.

The area of **Information and Research** comprises the production of scientific knowledge, which allows the qualitative evolution and the adequacy of effective interventions, as well as support for the decision.

Training and Communication, indispensable tools for the training of multiple agents, are fundamental in democracy, it is a duty of the State permit and ensure access to information, promoting the exercise of an educated citizenship and the development of competences that prepare individuals to act, from the perspective of health promotion.

International Relations and Cooperation continues to assume special relevance in the problem of CAD, due to its configuration as a complex and multifaceted phenomenon, which cannot be subject of a strictly national approach. It is a global phenomenon, which also requires a global and concerted response by the international community.

In the context of **Quality**, it is important to invest in a flexible and progressive strategy that facilitates the development and implementation of tools, resources, regulatory and legal provisions to regulate the existence of systems of crediting and accreditation of programs in the context of CAD.

II.C.1. INFORMATION AND RESEARCH

The evaluation of the previous strategic cycle and the European strategic guidelines in the context of this subject indicate the need for harmonisation of methodologies, for strengthening synergies, with recourse to networking and encouraging intersectoral cooperation, and the appropriately and sustainable allocation of resources. The strategy must also pass by an improvement in the transmission of the monitoring, research and evaluation results at national and international level.

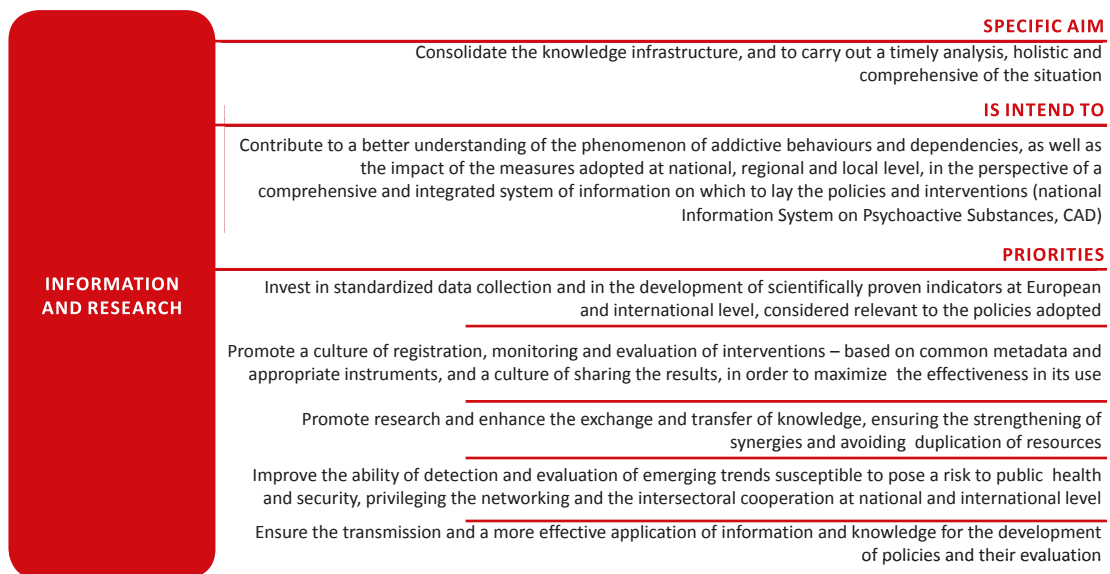


Figure 27. Specific objectives in the context of information and research

II.C.2. TRAINING AND COMMUNICATION

Training and Communication are essential to ensure the success of any strategy, to give visibility and support and to strengthen the development of the actions included in the Plan.

The extension of the intervention range in the area of CAD should be reflected in the adequacy of the responses, as well as in the development of knowledge about the new assignments and training services.

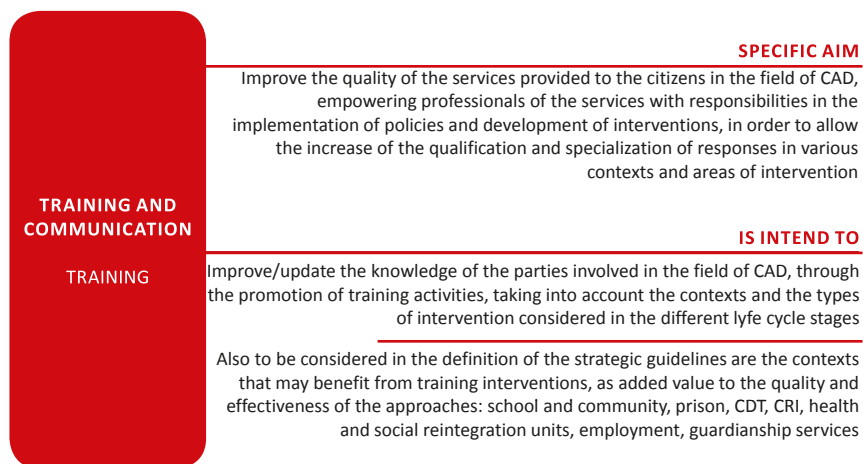


Figure 28. Specific objectives in the training context

On the other hand, the management and dissemination of information through several formats and the promotion and dissemination of technical scientific materials, using new technologies, are determining factors for the visibility of actions undertaken and fundamental to the consolidation of knowledge.

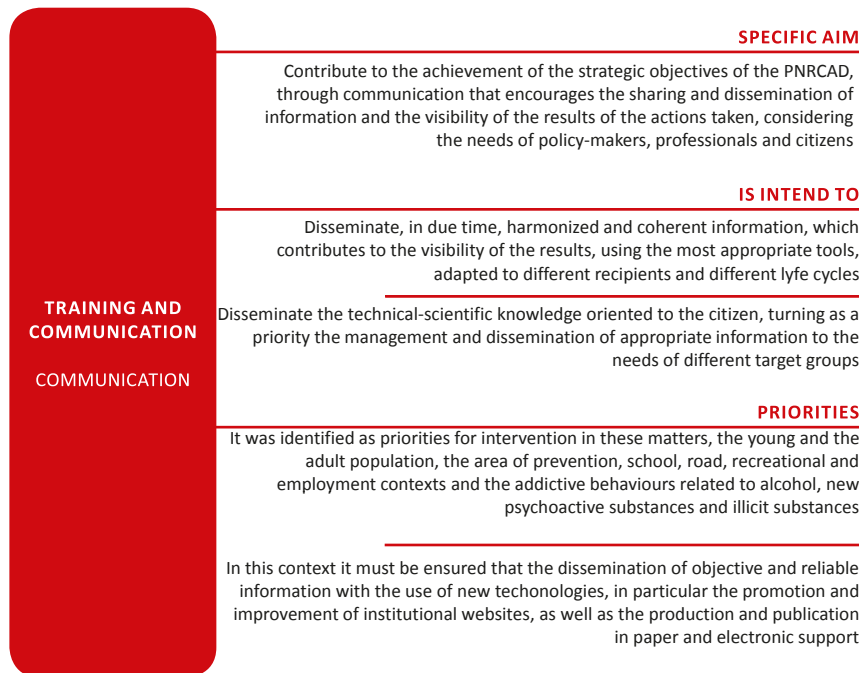


Figure 29. Specific objectives in the context of communication

II.C.3. INTERNATIONAL RELATIONS AND COOPERATION

In the international context, the PNRCAD 2013-2020 aims to consolidate all international efforts carried out up to the present, and to respond to new needs and challenges that may arise, such as the emergence of new substances, new forms of consumption or new routes of trafficking illicit substances.

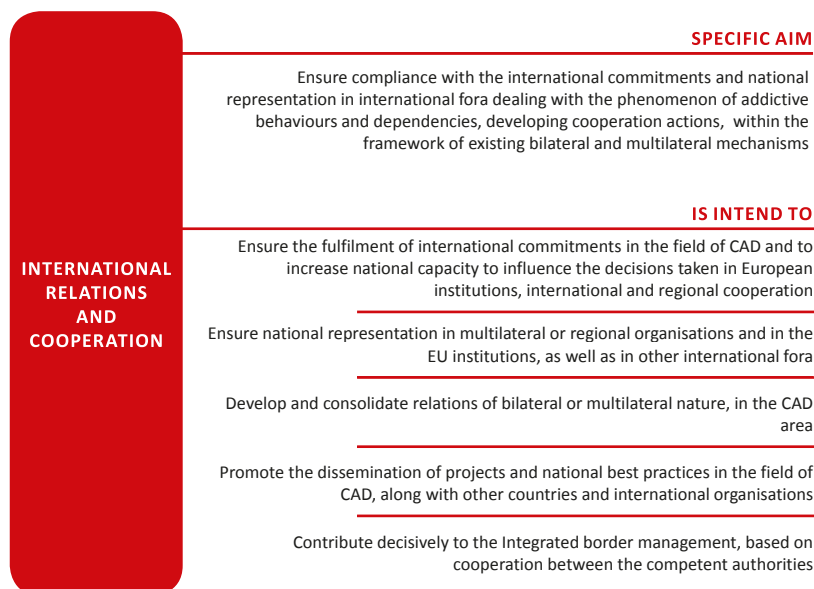


Figure 30. Specific objectives in the context of International Relations and cooperation

II.C.4. QUALITY

The quality culture in services provided to citizens by public and private institutions in the context of CAD should be based on the gradual improvement of validated programs, imposing itself as an essential requirement between institutions, professionals

responsible for the development of programs and their beneficiaries. This process is reflected on the recognition of the right of citizens to receive, on the part of the institutions, a portfolio of services with quality criteria, and the progressive requirement of these for the financial or institutional support be given to programs and services that have shown their effectiveness and efficiency.

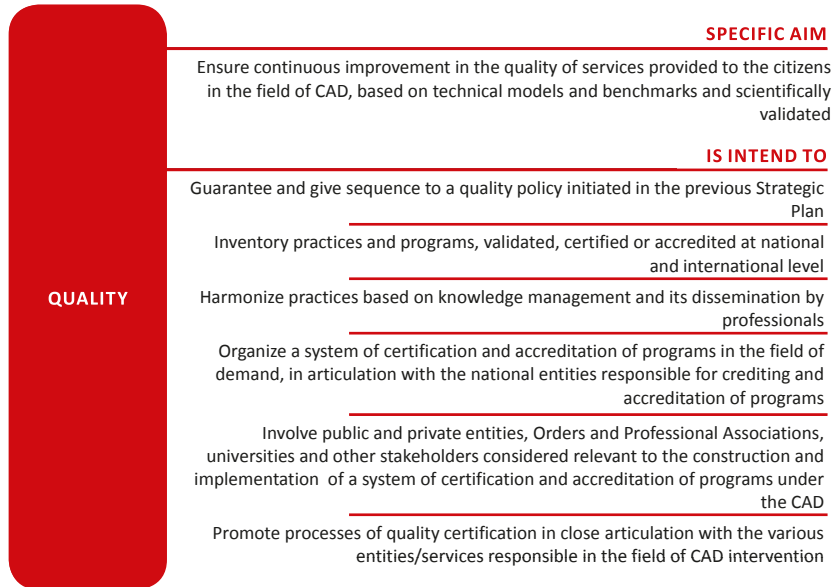


Figure 31. Specific objectives in the context of quality

PART III

III.A.COORDINATION

The coordination structure¹⁸ was considered by internal and external evaluation as a crucial element for the implementation of the previous cycle plans.

The **National Coordination for Drug Problems, Drug Addiction and the Harmful Use of Alcohol** has the purpose to guarantee an effective coordination and articulation between the several governmental departments involved in drug-related problems, drug addiction and harmful use of alcohol.

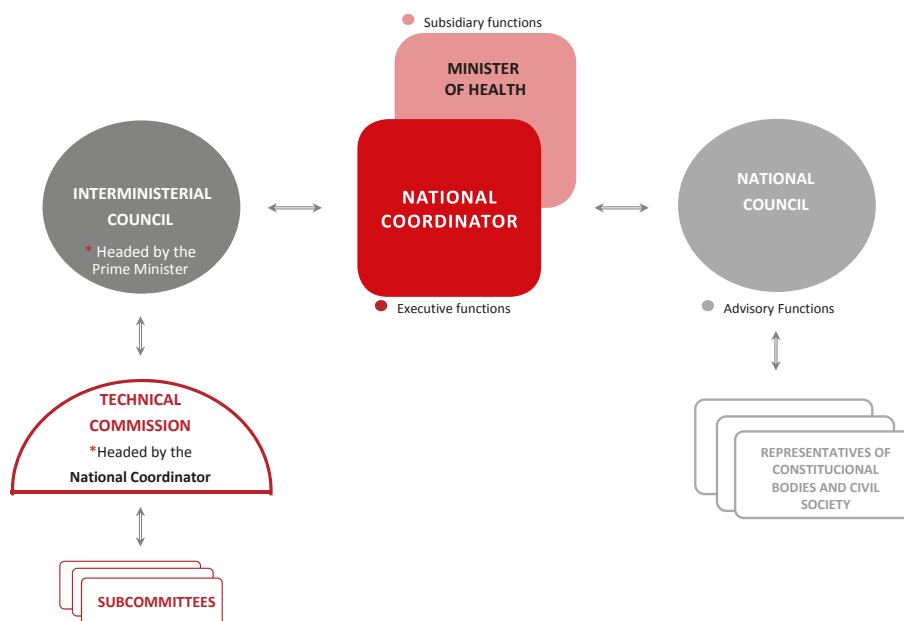


Figure 32. Coordination Structure

The particular institutional configuration of this structure takes into account the cross-cutting nature of the problem. It includes:

- The political and governmental level, represented in the **Interministerial Council** in the figure of the government member responsible for drug policy and alcohol problems;
- The level of executive coordination, ensured by the **National Coordinator**;

¹⁸ Renewed by Decree-Law n° 40/2010, of 28 April.

- The technical level, through a **Technical Commission of the Interministerial Council** composed of representatives of the Ministers participating in the Interministerial Council;
- Civil society, represented in the **National Council**.

The **Minister of Health** is the government member responsible by drug-related policies, drug addiction and the harmful use of alcohol and has subsidiary functions.

The **Technical Commission of the Interministerial Council** composed by representatives of the Ministers who are members of the Interministerial Council, is represented in figure 33.

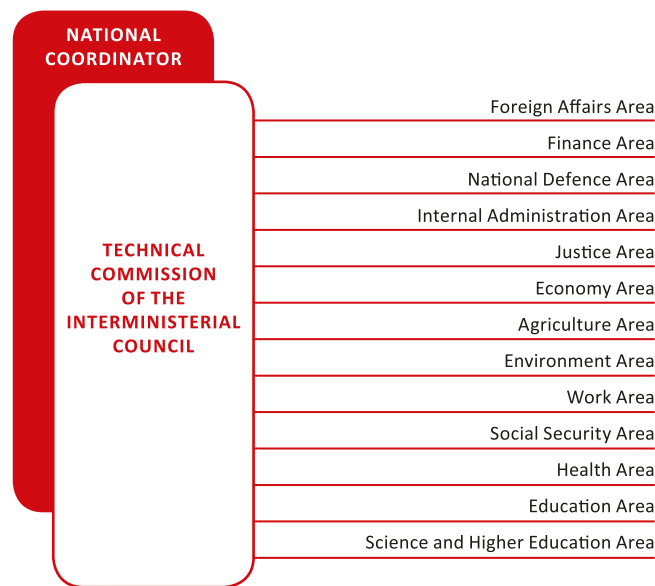


Figure 33. Constitution of the Technical Commission

This Technical Commission created several Subcommittees, which are represented by Public Administration bodies with expertise in these areas, who implement the Action Plans in terms of planning, monitoring and evaluation.

The various bodies of the Structure of Coordination for Drugs Problems, Drug Addiction and the Harmful Use of Alcohol provide the systemic environment for articulation of the competences of Public Administration entities, institutional partners and civil society, ensuring the forums for discussion, consensus and harmonisation of positions.

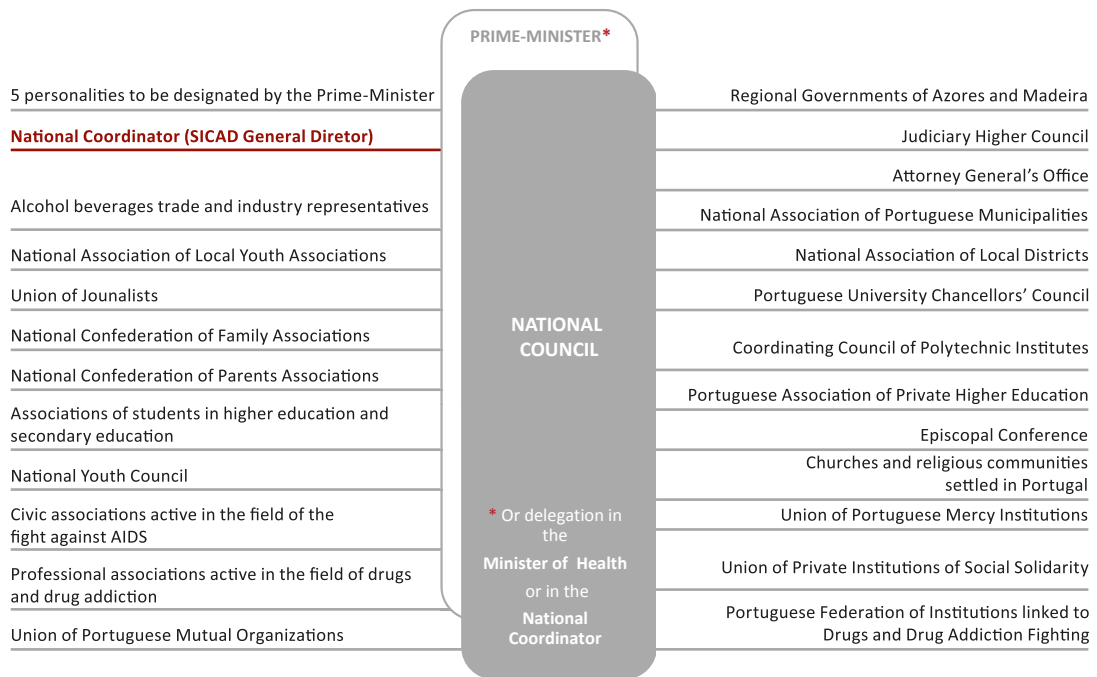


Figure 34. National Council Constitution

The enlargement of the strategic planning to other addictive behaviours and dependencies not previously covered by strategies or national plans requires a symmetrical enlargement of coordination at various levels.

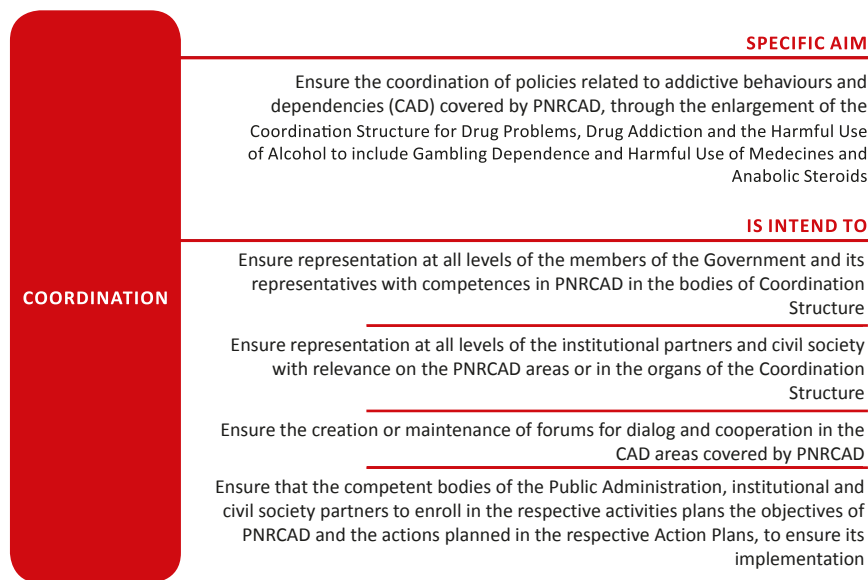


Figure 35. Specific objectives in the coordination context

III.B. BUDGET

The resources for the implementation of actions arising from the PNRCAD are from the budgets of the competent entities, not including the budgeting of PNRCAD as stand-alone instrument. In a macroeconomic scenario characterized by a high degree of uncertainty, and face to a predictable contraction of public expenditure, it is necessary to ensure that these entities have the necessary and sufficient resources.

The objectives were defined by taking as a reference the assumptions exposed and the budget implementation of the competent bodies in previous years, and taking into account the economies of scale arising from the introduction of other CAD on an intervention model already operated in other areas.

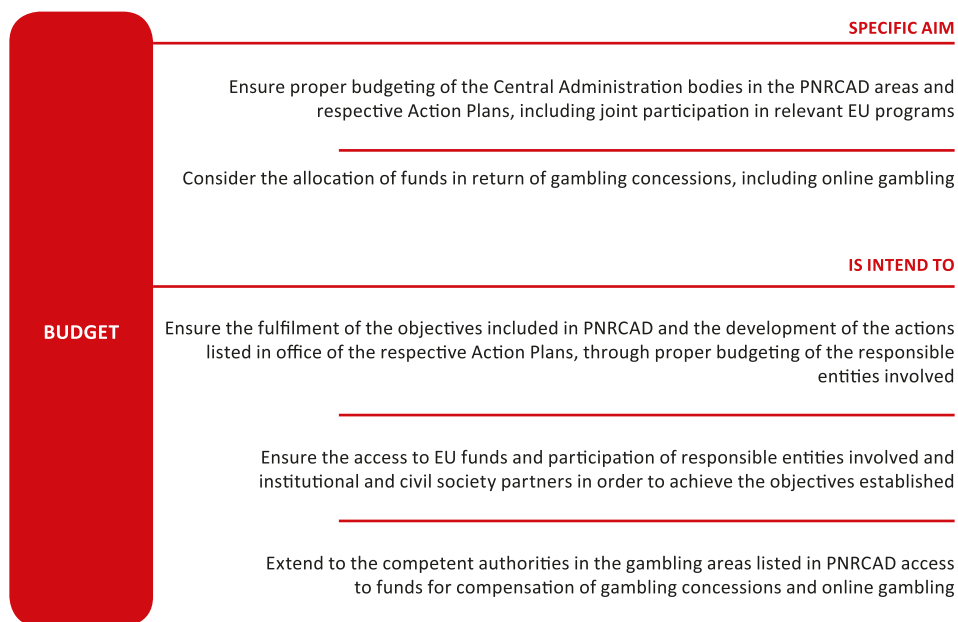


Figure 36. Specific objectives in the budget context

III.C. EVALUATION

The decision-making process of the policies and programs at the level of CAD is complex, particularly in a context of deterioration of living conditions of citizens (reflecting the upsurge of CAD) and strong contraction of public expenditure. This circumstance makes it essential, not only the evaluation of health gains and social goods produced and the results achieved, through the monitoring and continuous evaluation, but also the allocation of adequate resources due to the developments of the situation in the field of CAD.

Evaluation is considered one of the components of the Public Policies cycle. The legitimacy of public policies is reinforced by an external evaluation, performed by independent experts of competent organizations.

The evaluation of the PNRCAD 2013-2020 should be seen as part of the decision-making process, and should benefit from a strong political commitment and the support of all the partners, with the involvement of all actors involved in its implementation, including the civil society.

Taking into account the extended period of the strategic cycle 2013-2020, it is necessary to provide a mid-term internal assessment, drawn up by the Subcommittees of the Technical Commission, coinciding with the end of the first Action Plan of this National Plan. This mid-term evaluation should allow adequate time to achieve the goals and objectives established for the first part of the strategic cycle, 2013-2016, the second part of the cycle, 2017-2020, by fine tuning the interventions and responses in accordance with the developments of CAD and benefiting from the acquired knowledge.

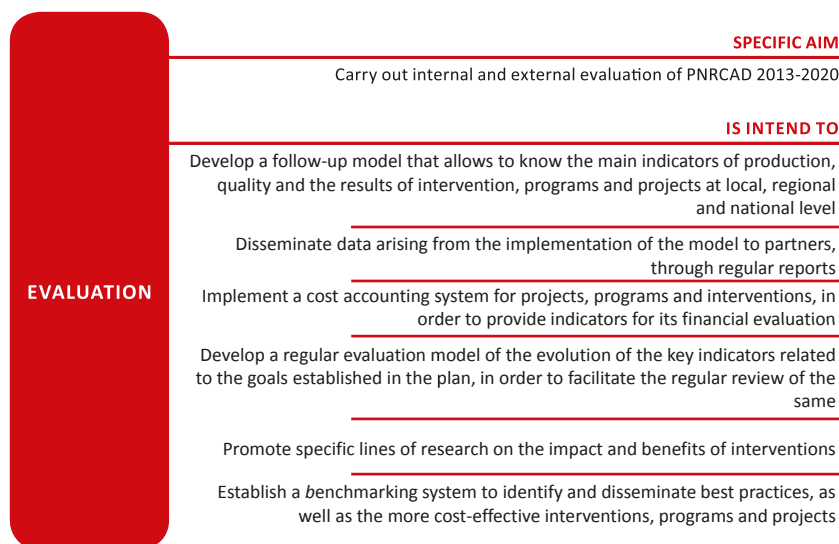


Figure 37. Specific objectives within the evaluation framework

III.D. METHODOLOGY FOR THE DEVELOPMENT OF THE PLAN

The Plan was drawn up on a proposal of the National Coordinator for the problems of Drugs, Drug Addiction and the Harmful Use of alcohol in the framework of bodies of the structure of Coordination for the problems of Drugs, Drug Addiction and the Harmful Use of alcohol, heard the National Forum Alcohol and Health, and also involving the partners of new areas in the design and draft of the document.

During the construction process of the Plan, the various contributions made were integrated into a bottom-up perspective. Subsequently, the initial proposal was submitted to public consultation.

In total, spoke out about 150 public and private entities, from the social and market economy.

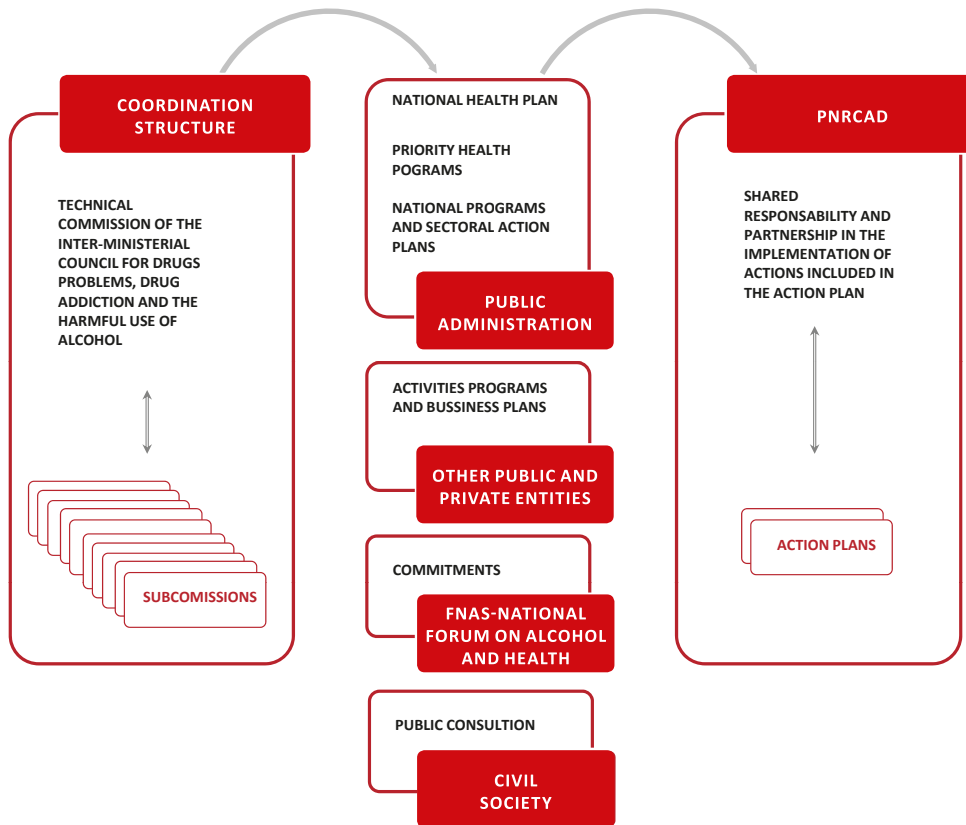


Figure 38. PNRCAD and Action Plan Methodology

PART IV

IV.A. ACTION PLAN 2013-2016

The PNRCAD will be operated by two Action Plans of four years each for the periods 2013-2016 and 2017-2020, to monitor and evaluate under the Coordination Structure.

The Action Plan for the first four years has enabled the planning of a large number of objectives and actions undertaken by multiple entities.

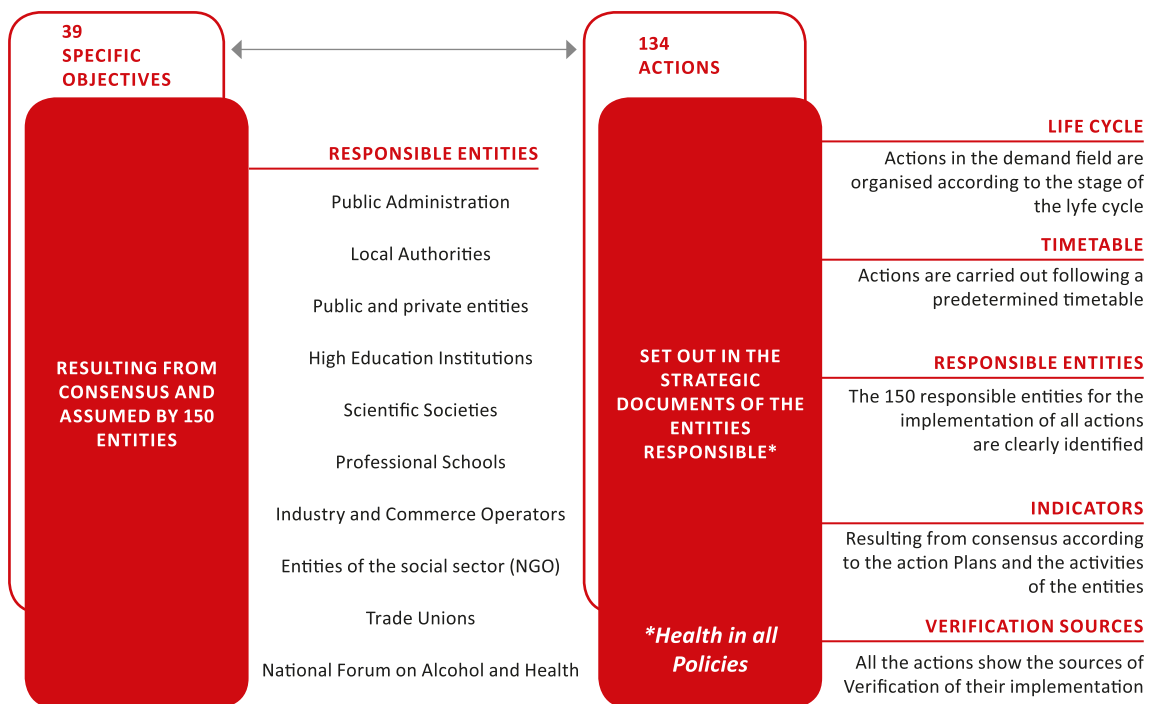


Figure 39. Action Plan 2013-2016

LIST OF ABBREVIATIONS AND ACRONYMS

ACSS, I.P.	• Central Administration of the Health System, I.P.
AUDIT	• Alcohol Use Disorders Identification Test
CAD	• Addictive Behaviours and Dependencies
CAST	• Cannabis Abuse Screening Test
CDT	• Commissions for the Dissuasion of Drug Addiction
CNAPA	• Committee on National Alcohol Policy and Action
CND	• Commission on Narcotics Drugs
DGS	• General Directorate for Health
ECATD	• Study on Alcohol, Tobacco and Drug use
EMCDDA	• European Monitoring Centre for Drugs and Drug Addiction
ENSR	• National Road Safety Strategy
ESPAD	• European School Project on Alcohol and other Drugs
EUROJUST	• European Union's Judicial Cooperation Unit
EUROPOL	• European Law Enforcement Organisation
FNAS	• National Alcohol and Health Forum
GDH	• Homogeneous Diagnostic Groups
INE, I.P.	• National Statistics Institute
INMLCF, I.P.	• National Institute of Forensic Medicine, Public Institute
INPG	• National Population Survey on Psychoactive Substances in the Portuguese Population
INSA	• National Health Institute Doutor Ricardo Jorge
IPSS	• Private Social Solidarity Institutions
NPS	• New Psychoactive Substances
OCDE	• Organisation for Economic Co-operation and Development
INCB	• International Narcotics Control Board
OMS	• World Health Organization
ONG	• Non-Governmental Organization

ONU
PNCDT
PNRCAD

PNRPLA
PNS
PORI
PRI
RRMD
SICAD

AIDS
SOGS
TAS
EU
UIL
UNODC
HIV

- United Nations Organization
- National Plan on Drugs and Drug Addiction
- National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020
- National Plan for Reducing Alcohol related Problems 2010-2012
- National Health Plan 2011-2016
- Operational Plan of Integrated Responses
- Programs of Integrated Responses
- Harm and risk reduction
- General-Directorate for Intervention on Addictive Behaviours and Dependencies
- Acquired Immune Deficiency Syndrome
- South Oaks Gambling Screen
- Blood Alcohol Rate
- European Union
- Local Intervention Unit
- United Nations Office on Drugs and Crime
- Human Immunodeficiency Virus



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