

EVOLUTION OF THE PORTUGUESE ADDICTION TREATMENT SYSTEM

1958 — 2014

With the support of



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Preface

Problems related to drug addiction in Portugal increase after 25 April 1974 due to easier access to substances, the challenge of living a free life full of new experiences and unawareness of the effects of drug habituation and addiction. Drug addiction has been considered the major concern or biggest problem in Portugal since the late 80s and throughout the 90s due to people's total lack of ability and knowledge of how to deal with the use of any illegal substance. In fact, in the early 90s, although the most popular drug was cannabis, it was estimated that 1% of Portuguese people were addicted to heroin. The majority administered it intravenously and shared syringes and needles, which led to the rapid development of HIV registered in subsequent years that has not yet been completely eliminated.

In terms of health and social issues raised by the problem, we could say that the Portuguese Government responded in 3 phases, with a fourth underway, now that drug addiction is no longer a major concern in Portugal.

Therefore, between 1975 and 1987, we could initially say that Portugal's response, through the Ministry of Justice, was focused on repression. However, the fight against drug trafficking and use for which the Ministry of Justice was still responsible is accompanied by initial responses from the addiction treatment forum: Drug Addiction Prevention Research Centers (Lisbon, Porto and Coimbra) and two Therapeutic Communities (Restelo and Coimbra).

The increasing number of drug addicts and the spreading of this "epidemic" to all social statuses, along with the common concern that drug addicts require help from healthcare institutions, give rise to initial responses specifically focused on treating these patients.

A new phase started with the establishment of the *Taipas Center* in 1987. In this phase, the addiction treatment program developed by the *SPTT* (Drug Prevention and Treatment Services) is under the supervision of the Ministry of Health. The *GCCD* (Office Coordinating the Fight against Drugs) and *Projecto Vida* (Life Project), respectively, under the supervision of the Presidency of the Council of Ministers, is responsible for the fight against drug trafficking and preventive and social responses.

In 1999, following the approval and publication of the National Drugs Strategy, we enter the third and decisive phase where there is a paradigm shift in the intervention process and in the appearance of results in terms of health benefits, which reverted all increases in drug use and addicts or HIV infection.

The National Strategy supported by two basic principles, humanism and pragmatism, among others, enabled the implementation of structural measures that made a marked difference in the response capacity of Public and Private Entities.

It is important to mention the major changes occurring through the implementation of this Strategy. Firstly the decriminalization of use and possession for use and the establishment of CDTs (Commissions for the Dissuasion of Drug Addiction).

Secondly, the possibility of implementing structures for reducing risks and minimizing damage (RRMD) to complement treatment structures that had been transformed into a real national network in the meantime.

The third measure involves integration of all responses (Prevention, Dissuasion, RRMD, Treatment and Reinsertion) in a single structure, the IDT (Drug and Substance Abuse Institute), under the supervision of the Ministry of Health.

It is also important to mention that prior supervision by the Presidency of the Council of Ministers, along with clear definitions of the National Strategy, promoted efficient and effective coordination and development between areas reducing the supply of drugs, within the Ministry of Justice and Ministry of Internal Affairs, and those reducing demand under the supervision of the Ministry of Health.

Another important point in this National Strategy is the assumption that drug addiction is a national problem involving all areas of governance and local power institutions that work together in this joint endeavor. A National Coordination Committee is therefore established based on 3 pillars (Inter-ministerial Council, National Coordinator and National Council), which was successful in its scheme for approval and implementation of the National Plan for the Fight Against Drugs and Drug Addiction (2005-2012), four years after the Action Plan for the implementation of the National Strategy had been adopted, and obtained a very positive external assessment.

The fourth phase involves the recognition of work performed on drugs and of the fact that problems related to alcohol abuse reach a magnitude that warrants a joint and integrated approach.

We could divide this phase into two periods: the first being integration of the response to alcohol-related problems by the IDT and the second, the period where this vertical structure is eliminated to give rise to a Management Board with technical and regulatory guidelines for addictive behaviors and dependencies and integration of local intervention units in Primary Healthcare Services.

In his book entitled "*Evolution of the Portuguese Addiction Treatment System-1958-2014*", the author, João Pedro Augusto, deals with aspects from this entire period and all the aforementioned phases of drug abuse treatment in Portugal, in a pragmatic, rigorous and in-depth analysis of protagonists, actions and results.

This document will be used as a future reference for all those who wish to write, investigate or provide opinions on the Portuguese drug policy and we would very much like to congratulate its author for its publication.

Manuel Cardoso
(Deputy General-Director from **SICAD**
*General-Directorate for Intervention on
Addictive Behaviors and Dependencies*)

Executive Summary

The aim of this document is to provide an orderly and systematic approach towards the history of addiction treatment in Portugal over the past five decades (1958-2014). It contains a rigorous and detailed compilation of events relating to the sector's emergence and development based on data from different sources and a substantial amount of scattered information that is not easy to understand even for specialists although laymen are also able to express their critical views, based on published facts.

It provides a description of the construction and improvement of this system, which includes a wide variety of responses through the structuring and disposition of public, social and private sectors in different intervention areas, helping Portugal to become an example for many other countries. This research entailed cross-referencing different data, reading and reviewing a wide variety of documents, laws considered fundamental for constructing all system structures, information provided by organizations, conference presentations, official entity activity reports and direct cooperation through personal and telephone interviews or e-mail questionnaires with people considered pioneers in the whole process described here.

A longer, in-depth analysis will always make it easier to obtain an integrated global view of the sector by interpreting and assessing it in such a way as to facilitate a transparent analytical framework. It is important to mention that the numbers shown contain no data on other addiction-related and problematic pathologies such as excess use of medicines, depression or compulsive gambling, shopping or internet.

The idea is to simplify an extremely complex reality that is full of details and nuances of a sector whose development was mostly organic and unplanned, through data divided into five major areas or Chapters:

- ▶ Drugs
- ▶ Alcohol
- ▶ Therapeutic Communities
- ▶ Dissuasion
- ▶ Conventions/Protocols (registered beds)

New paths should also be indicated for the sector to simultaneously provide governance structures and treatment providers with more in-depth and widespread knowledge of their intervention areas. The aim is to take the first step to encounter new paradigms that lead to more specialized and professional management and which help to support macro (political) and micro (more rational intervention planning) decision-making processes.

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CHAPTER I – Drugs

I.1 – Framework

The choice of the first Chapter to deal with treatment for drug-related problems is closely linked to an awareness of the increasing relevance of these issues over the past decades in the Western world in general and in Portugal in particular.

People are aware that addiction treatment was often viewed as less important in Healthcare or Social Services, where its development was mainly organic and fragmented due to lack of planning and where reactive responses always seemed to be found for emerging problems. Its origin, development and consensus were based on the social and political situation in Western Europe after World War II, which resulted in an initial response that was more focused on fighting drug trafficking than its treatment, considering the 3 UN Conventions on drugs:

- 1 – Single Convention of 1961 (*amended by the 1972 Protocol*)
- 2 – Convention on Psychotropic Substances of 1971
- 3 – Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988

In Portugal, more emphasis was given in the late 50s and throughout the 60s to creating a law and initial responses to mental health problems on the mainland, as drug-related problems only affected the health system in Macau, which was under Portuguese administration at the time. The Government drafted laws in the 60s for the creation of official treatment facilities, which led to the establishment, in 1961, of the Social Rehabilitation Centre on Taipa island for drug addicts, the homeless, juvenile offenders and the mentally ill.¹

During the 70s, a combination of factors led to a significant increase in the use of illicit substances by Portuguese youngsters. Consolidated student protests are influenced by May of 1968 in France, shaking the regime that grows stronger during the years of so-called "*Marcelist Spring*" between 1970 and 74, after the death of Salazar in 1970. Student unrest spreads to the rest of society; "*Political conflicts spread further afield to cultural ground*"², leading to 25 April 1974 and freedom from a totalitarian regime that lasted 48 year. This resulted in a whirl of social, cultural and economic changes that were to have a strong impact on society at the time.

The independence movement of former Portuguese colonies in Africa that led to the Colonial War (1961-74) caused one of the fastest decolonization's ever, relocating 600 thousand Portuguese citizens in mainland Portugal. These so-called "*retornados*" introduce new habits and customs as they had more freedom and access to external influences, which also made them more open-minded towards other ideas such as the use of cannabis. The use of LSD and illicit abuse of pharmaceuticals also prevails at this stage, especially Socegon, Lipoperdur, Dimintel or Romilar.³

¹ Revés, Sigismundo e Cotta Guerra, Alberto (1962) "*O Centro de Recuperação social da Ilha de Taipa em Macau*", Agência Geral do Ultramar, Lisbon.

² Cardina, Miguel (2008) "*Movimentos estudantis na crise do Estado Novo: mitos e realidades*", e-cadernos ces, 1, pp 57-76. Accessed on 12/07/2014, <http://www.ces.uc.pt/e-cadernos>.

³ GPCCD, Ministry of Justice (1992), "*Apoio a Instituições Privadas: para uma avaliação da acção desenvolvida pelo GPCCD entre 1987 e 1991*", pp 6.

In the early 70s, there is an obvious lack of response and an embryo of the future addiction treatment system in Portugal is created. The first reference to a more specialized response is associated with an appointment in the psychiatry department at the Santa Maria Hospital (Lisbon, 1973).⁴ This appointment for adolescents and drug addicts, started by José Carlos Dias Cordeiro with the subsequent collaboration (1975) of Nuno Silva Miguel, also a psychiatrist and other professionals, were a kind of "informal" or "occult" appointment, or rather, they did not officially exist, but patients, families and even other healthcare professionals became aware of them and started to forward situations detected to this service. Later on, between 1978 and 1980, a drug addiction service was also launched at São João Hospital in Porto being coordinated by the psychiatrist, António José Pacheco Palha, along the same lines as Santa Maria.

Facilities established to supervise and organize the sector are rather incipient in many ways and are often no more than a series of good intentions. Thus, in 1975, the CEJ (Youth Study Centre) and the CIJD (Judicial Investigation Centre on Drugs) were created. The CEJ was more focused on preventive medicine and treatment and social action, whereas the CIJD was responsible for suppressing and monitoring illicit drug trafficking. The CEJ was restructured in 1976 to be replaced by the CEPD (Drug Addiction Prevention Research Centre), whose purpose was to address the prevention, treatment and social reintegration of drug addicts and the CIJD was also replaced by the CICD (Drug Control and Research Centre), which was still responsible for suppressing illicit drug trafficking. These two bodies were then placed under the administration of a third, the GCCD (Coordination Office for the Fight against Drugs), which became the first centralized body created by the Government to take control of this problem.

The CEPD was responsible for central and regional services and three Regional Boards were created in 1977 in Porto, Coimbra and Lisbon, being considered "*executive bodies providing direct assistance to drug addicts, relatives, anyone involved and youngsters at risk.*"⁵ Different drug addiction, prevention and treatment models were tested at these three regional centers without any common guidelines being established,⁶ which confirms the huge lack of knowledge, from a political, legal or even technical point-of-view, of how the problem can be tackled by all those affected by drug use and related health, family, social and political issues.

All this creates an emptiness that is filled in different ways and at different times, taking advantage of the lack of health responses, the more repressive stance and the difficulty in obtaining training in the area. Gradually, heroin and medicines⁷, replace cannabis and weed leading to the creation of the experimental program using methadone in Porto in 1977, coordinated by the psychiatrist, Eduíno Lopes⁸ who had worked directly with this substance in the United States⁹.

⁴ González-Alcaide, Gregorio & All (2009) "*A investigação sobre Toxicodependências em Portugal: produtividade, colaboração científica, grupos de trabalho e âmbitos de investigação abordados*", Revista Toxicodependências, Edition IDT, Volume 15, Number 2, pp 13-34 quoting Sampaio, Daniel & All (1978) "*Droga, Pais e Filhos*", Lisbon, Bertrand.

⁵ National CEPD, Documentation Division & Social Information (1981) "*Relatório Actividades do Ano de 1980*", Introduction, pp 1.

⁶ GCCD, Presidency of the Council of Ministers (1979), "*1º Relatório de Actividades 1978*", pp 9.

⁷ GCCD, Presidency of the Council of Ministers (1979), "*1º Relatório de Actividades 1978*", pp 24.

⁸ Collection of Texts, Volume VI, Taipas Center, Lisbon (1994), "*Terapia Familiar com Suporte Clínico de Programas Por Agonista (cloridrato de metadona) e Por Antagonista (cloridrato de naltrexone)*" Sousa, Albina da Silva, VI Taipas Encounter, Lisbon, March 1993, pp 25.

⁹ Collection of Texts, Volume VIII, Taipas Center, Lisbon (1996), "*Agonistas – Metadona, da Rua para o CAT*" Malta, António, VIII Taipas Encounter, Lisbon, May 1995, pp 39.

This meant that all responses emerging were initially focused on opiate addicts so, in 1983, at Santa Maria Hospital's Psychiatric Department, Team 4c led by Nuno Silva Miguel, experimented with clonidine (agonist) in the heroin abstinence syndrome and, in 1986, at the Coimbra CEPD, the psychiatrist, Carlos Amaral Dias, started treatment with Naltrexone in Portugal¹⁰ to prevent relapses. However, this process was only to start being implemented at the Porto CEPD in 1989¹¹.

The second half of the 80s is full of relevant events that influence the system being constructed. The first group of Narcotics Anonymous (NA) was created in 1986 in Lisbon¹², as a result of the intervention of several people who had been treated abroad at centers using the Minnesota 12-step model. In subsequent years, many affluent Portuguese patients were still to go to England for treatment at similar units and also played a predominant role, in the 90s and 2000, in the launching of many therapeutic communities that were to operate under this American model. It is also important to mention that the Families Anonymous (FA) first group was created in 1984 in Lisbon, becoming more prominent from 1989 onwards and in 1992.¹³

In 1987, the Ministry of Health (MH) focuses on the creation of direct specialized treatment facilities with the opening of the *Taipas Center* (Lisbon), whose aim is to be a different and innovative project led by the psychiatrist, Luis Patrício.

This year is also marked by the creation of the *Projeto Vida* aimed at mobilizing different stakeholders, which operates as an additional inter-ministerial and civil society resource.

Other MH units will also be created, like the *Algarve SPAT* (Drug Addiction Prevention and Treatment Service), opening in 1988 in Faro (April) and a second unit¹⁴ in Olhão (June/July) led by the physician, João Goulão, along with the *CAT* (Rehabilitation and Treatment Center) in *Cedofeita* in Porto that opened one year later in July 1989¹⁵, led by the psychiatrist Júlio Machado Vaz.

It is important to mention the *Taipas Encounters*, I in 1988 and II in 1989, that are looked upon as a real avant-garde movement and which include the publication of texts and studies (*Collection of Texts*) and could have helped to influence the launching of the EMCDDA in Lisbon in 1993. We should remember that Europe's aim had been to establish a European information network on this problem since 1989 and Portugal would become President of the former EEC in 1992.

¹⁰ Collection of Texts, Volume III, Taipas Center, Lisbon (1991) "*Terapias Medicamentosas O Naltrexone no Tratamento de Dependentes de Opiáceos*" I CAT Porto Workshops, Porto, October 1990, pp 149.

¹¹ Collection of Texts, Volume VI, Taipas Center, Lisbon (1994), "*Terapia Familiar com Suporte Clínico de Programas Por Agonista (cloridrato de metadona) e Por Antagonista (cloridrato de naltrexone)*" Sousa, Albina da Silva, VI Taipas Encounter, Lisbon, March 1993, pp 27.

¹² Narcotics Anonymous Portugal, website, www.na-pt.org, accessed on 12/07/2014.

¹³ Families Anonymous Portugal, Interview to the magazine, "Saúde & Lar", Nº 642, April, 2001.

¹⁴ Collection of Texts, Volume I, Taipas Center, Lisbon (1989), "*Um Esclarecimento... Um sonho*" III Encontro – A Droga Hoje em Portugal. *Que Repostas?* – Montechoro (Albufeira), June 1988, pp 205.

¹⁵ Collection of Texts, Volume VIII, Taipas Center, Lisbon (1996) "*Vantagens e Desvantagens de Conviver com um Dilatado Programa de Substituição*" Gonzalez, José, VIII Taipas Encounter, Lisbon, May 1995, pp 36.

In the 90s, hashish and heroin were still on the market and there was a significant increase in cocaine.¹⁶ Major government investments were made at this time through the MH to increase and diversify government-owned facilities and install them all over the country.

The best example of this occurs in 1990 through the creation of the SPTT (*DL No. 83/90, of 14 March*), a central, autonomous body of the MH that will work together with other profit or not-profit government or non-government entities.

This increased attention and investment surges in response to heroin addiction and to its connection to AIDS, particularly in the injectable form, due to the rapid increase in the number of HIV-infected people in this specific group¹⁷, in addition to the increase in hepatitis.¹⁸ Thus, in October 1993, the Portuguese national syringe exchange program called “*Say No to a Second-Hand Syringe*” is launched in the country, promoted by the National Association of Pharmacies.¹⁹

In 1993/94, a Support and Treatment Plan is created and implemented for prisoners using drugs or drug addicts, estimated at the time to be around 13.500 inmates, 60% of whom were directly or indirectly connected to drug-related issues.²⁰ In May 1994, the *Taipas Center* started to use LAAM and was the first European facility to do so give its good relationship with the V.A. Hospital in Philadelphia to date and considering that the FDA (*Food & Drug Administration*) only approved this drug for treatment in July 1993.²¹ This solution was to be implemented on a national basis in 1997, only to be banned in 2000 by INFARMED.

It was evident that facilities created did not meet the needs of the Portuguese population and that inpatient and outpatient treatments with reasonable response times were not considered sufficient.²² This was when *Law No. 7/97* came into force, clearly and specifically defining Government objectives in this matter, with a view to increasing the network of public services for drug addict treatment and reintegration.

In this year, construction of the first round of facilities including one CAT per District with Bragança, Vila Real and Portalegre²³ CATs, had almost been completed. In 1998, the law on disability pensions was approved for HIV-infected people benefitting from the general regime (*DL n° 216/98 of 16 July*) and the *Life-Employment Program* was created to provide specific support for professional integration of chemical dependents.

¹⁶ Collection of Texts, Volume VIII, Taipas Center, Lisbon (1996), “*A Educação Para a Sexualidade dos Jovens para a Prevenção Primária da Toxicod dependência e da Sida*” Rosado, Marinela – Education for Young People - Lisbon, 1995, pp 18.

¹⁷ Collection of Texts, Volume V, Taipas Center, Lisbon (1993), “*Declaração de Lisboa*”, pp 12.

¹⁸ Collection of Texts, Volume VI, Taipas Center, Lisbon (1994), “*Dois Dias de Consulta de Toxicod dependências em Portugal Resultados do Inquérito de 1993*” Da Costa, Nuno Félix, pp 153.

¹⁹ National Association of Pharmacies, “*Programa de Troca de Seringas nas Farmácias*”, AIDS Prevention 1993-2008.

²⁰ Collection of Texts, Volume X, Taipas Center, Lisbon (1997), “*Experiência de Apoio e Tratamento a Toxicod dependentes Reclusos em Prisões Portuguesas*” Keating, Maria Livramento, Lisbon, April, 1997, pp 247.

²¹ Collection of Texts, Volume VIII, Taipas Center, Lisbon (1996), “*L.A.A.M.- Levo Alpha Acethyl Methadol The Experience at Centro das Taipas*” Patrício, et All, 3rd European Symposium on Drug Addiction and AIDS, Istambul, October, 1995, pp 48.

²² Collection of Texts, Volume X, Taipas Center, Lisbon (1997), “*Discurso de Abertura de Sua Excelência o Presidente da República Dr. Jorge Sampaio*”, Lisbon, April, 1997, pp 29.

²³ Collection of Texts, Volume X, Taipas Center, Lisbon (1997), “*Sessão de Encerramento*”, Goulão, João, SPTT Chairman, Lisbon, April, 1997, pp 282.

1999 is indelibly marked for the first time by the adoption of a genuine National Drugs Strategy (*CM Resolution No. 46/99 of 22 April*). This document will be fundamental for the orientation of different sectorial policies, guiding the activities of different organizations and used as a reference for society in these matters.

During this year, the regulatory licensing and supervision framework for service providers is launched, which will also clarify and state the objectives of the subsidy funding system. Also towards the end of this decade, it is evident that certain people are not using the services so investment is made in new treatment facilities with a view to Reducing Risks and Minimizing Damage (RRMD) and focus on substitution programs is significantly increased. As from July 1998, pharmacies are allowed to administer methadone through a protocol signed between the National Association of Pharmacies and the Pharmacists' Association.²⁴

The aim is to continue to increase the service network, more specifically, to make changes and promote the adjustment and refinements of the system implemented to date and stabilize relationships with other institutions from different sectors. The general idea is that new units were created during the first 10 years of the SPTT covering all parts of the country and that now, a new era had begun that was more focused on achieving higher quality levels.

The year two thousand starts with continued focus by the Government on the use of RRMD policy national network tools (*DL No. 183/2001, of 21 June*). This year sees the start of treatment with Buprenorphine (2000), for example, and classification and division into high/medium/low thresholds substitution programs.²⁵ This period is also marked by the publication of the so-called law on decriminalization and creation of Commissions for the Dissuasion of Drug Addiction (CDTs). (*this subject will be dealt with in more detail in Chapter IV - Dissuasion*)

2002 is marked by the creation of the **IDT** as a kind of natural epilogue through the merging of different ministerial bodies that had been dealing with matters relating to drug addiction for the past decades. For the first time ever, a global mandate is attributed to a single body, guaranteeing unity, planning, design, management, supervision and assessment of the system as a whole.

Focus on abstinence from the use of drugs is emphasized as the cornerstone of therapy although people are aware that this therapy should not be reduced solely to this perspective.²⁶ In 2004, a clearer definition is made of IDT Mission Areas, or rather, its priority assistance areas: Prevention / (Treatment + RRMD + Reintegration) / Dissuasion.

Still in this year, professionals were reminded of the fact that programs in which opiate agonists were used are included in a global treatment program and are "only" one of its dimensions. This enables patients to be chosen and therapy for medical and psychological support established for designing a social reintegration project.²⁷

²⁴ SPTT 1998 Activities Report, Lisbon, March, 1999, pp 8.

²⁵ SPTT 2000 Activities Report, Lisbon, March, 2001, pp 22.

²⁶ IDT 2003 Activities Report, Lisbon, 2003, pp 84.

²⁷ IDT 2004 Activities Report, Lisbon, 2004, pp 46.

In 2004/05, a policy is followed for supporting Shelters, which are temporary residences where people are steered away from their addictions and transferred to more organized therapy facilities. In 2006/07, the central body makes an obvious attempt to assert a new strategy, focusing on improving the quality of services provided and results showing overall health benefits.

The Integrated Operational Response Plan (PORI) is a valuable tool that starts to be used as a national structural measure to promote local synergies by implementing Integrated Response Programs (PRI) as a result of territorial assessments, identifying priority areas up to 2013. The PORI intervention model proposed believes that the response to problems must be based on a more general principle of major choices and approaches for specific proposals to guarantee that actions implemented are not random solutions but based on an overall view. Therefore, the PORI will be based on both a theoretical and operational reference to clearer and more reflective Operational Objectives of a whole practice to be introduced.

In this phase, emphasis is placed on the PORI as a great unifier of the 5 Mission Areas that currently exist: *Prevention / Dissuasion / RRMD / Treatment / Reintegration*²⁸.

It is important to mention two existing Operational Objectives of the PORI that are noted for their capacity to create and eventually design the whole system and that are still entirely up-to-date at present.

► Operational Objective nº 40

"To increase programs/projects approved by the IDT that promote strategies and actions based on scientific evidence."

► Operational Objective nº 61

*"Promote the resizing and reorientation of the healthcare network based on an analysis of global and local contexts, formed by a network of integrated units."*²⁹

As from 1 August 2007, former Regional Alcoholology Centers (CRAs) are integrated in the IDT network within the framework of new alcohol policies, starting with the definition of new circuits for patients and professionals, (*this subject will be dealt with in detail in Chapter II - Alcohol*).

In 2008/09, people appear to be focusing on the quality of services supplied as a priority for intervention by the central body, based on the certificate obtained in 2009 by the Ponte da Pedra governmental TC³⁰, in accordance with standards SGQ-ISO 9001:2008. The truth is that this tendency that appeared to have been put into practice, did not produce the expected results in the end and only very few units from the social and private sector followed its example.

²⁸ IDT 2007 Activities Report, Lisbon, 2008, pp 17.

²⁹ IDT 2006 Activities Report, Lisbon, 2007, pp 23 – Op. Obj. nº 40 and pp 19 – Op. Obj. nº 61.

³⁰ IDT 2008 Activities Report, Lisbon, 2009, pp 12.

The 2010-12 period starts with explicit references to constraints and difficulties due to the economic and subsequent social crisis experienced in the country, which required a great capacity to adapt to financial restrictions limiting the expansion of new competences, such as alcohol.³¹

On a more positive note the SIM³² is implemented for data collection and processing in outpatient CRIs services, combining different data bases in a single information system and allowing for more uniform registration and collection of data on a national level, which facilitates the process for analyzing results and makes it more consistent.³³ Other units whose data has not been migrated to the SIM will continue to use the MH *SIU* (Patient Information System) or *SONHO* (Integrated Hospital Information System) programs.³⁴

2011 and 2012 are particularly difficult years in terms of achieving goals due to the severe economic crisis in Portugal, resulting in fewer human and financial resources and the huge sense of instability created by the announcement to terminate the IDT and create the SICAD.³⁵

For a long time, politicians remain silent as to how to tackle this problem. It had always warranted a deep understanding and coherence for almost 40 years, irrespective of party political positions, which therefore leads us to question respect for the essence of an organizational and practice model developed and implemented for decades.

The sector has obviously ceased to be a priority in the MH's more generalized view of the problems involved and an atypical period follows on with an undefined organizational model and insufficient clarification and assumption of competencies, as well as lack of information and orientation with regard to activities to be performed in this new body.³⁶

A profound change in the organics of public services such as ARS's that starts to intervene directly in these areas and is also responsible for planning policies and extending the competencies of the SICAD to new psychoactive substances, medicines and anabolic substances and to addictions without drugs, requiring cooperative learning and interaction for national coordination and "onsite" intervention.

Basically, the creation of the SICAD was based on the obvious choice to alter the structure of the existing building, transferring direct administration by a highly specialized and centralized body to the ARS's, opening up a new strategic political position that should take into account all risks and challenges posed for such an "apparently" disruptive purpose.

³¹ IDT 2010 Activities Report, Lisbon, 2011, pp 71.

³² Note: *SIM-Multidisciplinary Information System*: now managed by the SICAD, existing since 1976/77, although only data collected from 2000 onwards have a more comprehensive national coverage, consistency (standardization of collection concepts and instruments) extension (socio demographic and clinical data on each patient as well as registration of interventions performed and their evolution):


DGS 2013, <http://dis.dgs.pt/2013/05/29/sistema-de-informacao-multidisciplinar/>

³³ IDT 2010 Activities Report, Lisbon, 2011, pp 71.

³⁴ IDT 2010 Activities Report, Lisbon, 2011, pp 176.

³⁵ IDT 2011 Activities Report, Lisbon, 2012, pp 3.

³⁶ SICAD 2012 Activities Report, Lisbon, 2013, pp 2.



In this Chapter, it is important to understand whether the whole set of changes made in this area with a new organic structure will, in fact, lead to better management, so data on the following points will be presented to help with this analysis:

- ▶ History of Central government bodies
- ▶ History of Regional government bodies (*treatment area*)
- ▶ History of clinical production capacity developed since 1990
- ▶ Budget history of the central government bodies
- ▶ History of the number of workers at central government bodies

I.2 – Central Government Bodies

Structures created by the Portuguese Government between 1975 and 2012 that have played a key role in drug addiction, indicating their organic dependence on the ministry and period the body is in force, its senior management, respective professions and seniority.

Table I – Evolution of the Central Government Bodies (Drugs)

N	Body + Organic Dependency	Validity	Head of Department	Profession	Period
1	▶ Centro Estudos Juventude (CEJ) ▶ Centro de Investigação Judiciária da Droga (CIJD) – P.C.M.	31.12.1975 05.11.1976	- Ant ^o . Aug Gomes Silva	lieut. navy cap.	14.04.76 / 05.11.76
2	▶ Gabinete Coordenador do Combate à Droga (GCCD) – P.C.M.	(1 st Phase) 05.11.1976 08.09.1982	- Ant ^o . Aug Gomes Silva - Armando E.M. Rocha - Fr. José Fouto Pólvora	lieut. navy cap. insp.min. educ. psychiatrist	05.11.76 / 06.01.78 28.03.78 / 13.11.80 06.08.81 / 08.09.82
	▶ Gabinete Planeamento e Coordenação do Combate à Droga (GPCCD) – Ministry Justice	(2 nd Phase) 08.09.1982 05.02.1999	- Fr. José Fouto Pólvora - Joaquim Seabra Lopes - Fernando Duarte - Joaquim Aug. Rodrigues	psychiatrist lawyer lawyer psychologist	08.09.82 / 16.09.83 06.12.83 / 30.11.85 30.11.85 / 20.02.86 30.03.87 / 05.02.99
3	▶ Projecto Vida - Programa Nacional de Combate à Droga – P.C.M.	21.04.1987 18.05.2000	- Ana M ^a . Lowndes Vicente - Armando Leandro - Vítor Feytor Pinto - Alexandre Rosa - Elza Pais	National Coord. NC - judge High Com. - priest NC - sociologist NC - sociologist	12.05.88 / 06.06.90 / 11.11.92 12.11.92 / 19.12.97 15.09.98 / 28.10.99 27.11.99 / 18.05.00
4	▶ Serviço Prevenção e Tratamento Toxicodependência (SPTT) – M.Health	14.03.1990 29.11.2002	- Nuno Pereira Miguel - José Luís Castanheira - João Goulão	Inst.Com. – psych. physician physician	19.03.90 / 31.12.93 15.03.94 / 25.02.97 05.03.97 / 30.11.02
5	▶ Instituto Português da Droga e Toxicodependência (IPDT) – MADPM	05.02.1999 29.11.2002	- Joaquim Aug. Rodrigues - Elza Pais	psychologist sociologist	29.03.99 / 18.05.00 23.05.00 / 30.11.02
6	▶ Instituto da Droga e da Toxicodependência (IDT) – M. Health	29.11.2002 29.12.2011	- Fernando Negrão - Nuno Freitas - João Goulão	judge physician physician	05.12.02 / 17.07.04 08.09.04 / 01.05.05 02.05.05 / 31.12.11
7	▶ Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD) – M. Health	29.12.2011	- João Goulão	physician	01.02.12 /

Note 1: all bibliographical references of Table I can be found in the Portuguese version of this document.

Note 2: Ministries references: P.C.M. (Presidency of the Council of Ministries) / MADPM (Deputy Minister of the Prime Minister)

I.3 – Regional Government Bodies

Presentation of the evolution of the first decentralized government structures that will influence different areas in subsequent years and creation of local responses, between 1976 and 1990/93, when all these responses are integrated in the new MH service, SPTT.

Table II – Evolution of the Regional Government Bodies (*Drugs*)

N	Body + Organic Dependency	Validity	Head of Department	Profession	Period
1	▶ Centro Investigação e Controlo da Droga (CICD) – P.C.M.	05.11.1976 08.09.1982	- <u>António Maria Claro</u> - <u>Fernando Passos</u>	lawyer inspect. m. justice	12.01.77 / 06.01.82 06.01.82 / 08.09.82
2	▶ Centro Estudos Profilaxia da Droga (CEPD) – Central Services - P.C.M.	(1 st Phase) 05.11.1976 08.09.1982	- <u>Alberto Cotta Guerra</u> - <u>António Redondo</u> - <u>Luísa Vasconcelos Raposo</u> - <u>Fr. José Fouto Pólvora</u>	psychiatrist licensed social worker psychiatrist	17.02.77 / 31.08.78 01.03.79 / 18.02.80 14.03.80 / 31.10.80 31.10.80 / 15.07.81
	▶ Centro Estudos Profilaxia da Droga (CEPD) – Central Services – M. Justice	(2 nd Phase) 08.09.1982 14.03.1990	- <u>Joaquim Aug. Rodrigues</u>	psychologist	22.02.86 / 30.03.87
	▶ Centro Estudos Prof. Droga (CEPD) – Northern Regional Structure, Porto – P.C.M. + M. Justice + M. Health	28.04.1977 14.03.1990 31.12.1993	- <u>Eduíno Lopes</u> - <u>Carlos Vasconcelos</u>	psychiatrist psychiatrist	10.05.77 / 29.02.92 29.02.92 / 31.12.93
	▶ Centro Estudos Prof. Droga (CEPD) – Center Regional Structure, Coimbra – P.C.M. + M. Justice + M. Health	28.04.1977 14.03.1990 31.12.1993	- <u>Carlos Amaral Dias</u> - <u>Maria Livramento Keating</u> - <u>Teresa Nunes Vicente</u>	psychiatrist psychiatrist psychiatrist	28.04.77 / 17.02.89 17.02.89 / 27.04.90 27.04.90 / 31.12.93
	▶ Centro Estudos Prof. Droga (CEPD) – Southern Regional Structure, Lisbon – P.C.M. + M. Justice + M. Health	28.04.1977 14.03.1990 31.12.1993	- <u>Nuno Afonso Ribeiro</u> - <u>Maria Conceição Lacerda</u> - <u>Fr. José Fouto Pólvora</u> - <u>António Maria Pereira</u> - <u>Artur Marinha Campos</u> - <u>António Maria Pereira</u> - <u>Domingos Neto</u> - <u>Artur Marinha Campos</u>	psychiatrist licens. - interim psychiatrist physician - subs. physician physician - subs. psychiatrist physician	06.09.77 / 01.06.78 14.11.78 / 23.03.79 22.01.80 / 15.07.81 08.04.82 / 26.06.82 26.06.82 / 07.07.82 07.07.82 / 28.06.85 28.06.85 / 02.05.90 02.05.90 / 31.12.93

Note: all bibliographical references of Table II can be found in the Portuguese version of this document.

I.4 – Production (Clinical Movement – Central Facilities)

I.4.1 – Appointments between 1990 and 2012

Data presented refers to production capacity in relation to outpatient accompaniment calculated by the number of appointments: total, first and follow-up. The number of facilities is also shown.

Table III – Appointments SPTT (1990-2002) & IDT 2003-2012 (Drugs)

Year	Nr. Total of Appointments	First Appointments	Follow-up Appointments	Nº Facilities (CAT's + Ext.)
1990	56.438	4.236	52.202	16
1991	65.828	4.644	61.184	19
1992	68.485	5.065	63.420	22
1993	72.502	4.895	67.607	23
1994	93.850	5.750	88.100	26
1995	133.009	7.460	125.549	32
1996	171.952	9.889	162.063	35
1997	207.405	9.183	198.222	39
1998	238.037	8.935	229.102	43
1999	288.038	9.991	278.047	50
2000	310.044	9.559	300.485	50
2001	352.281	8.743	343.538	53
2002	367.367	6.241	361.126	54
2003	366.280	5.212	361.068	54
2004	379.172	5.023	374.149	56
2005	411.254	4.844	406.410	56
2006	433.600	4.745	428.855	55
2007	472.913	5.124	467.789	25
2008	667.149	9.244	657.905	53 ET
2009	667.216	10.130	657.086	-
2010	511.880	8.390	501.279	-
2011	519.229	7.841	508.856	45 ET
2012	562.617	10.611	552.006	-

Note 1: all bibliographical references of Table III can be found in the PT version of this document.

Note 2: SPTT closed and integrated in IDT in 2002.

Note 3: in 2007, CRAs are integrated in the IDT showing those figures in 2008.

Note 4: ET- Treatment Teams since 2008 correspond assignments of former CAT's.

1.4.2 – Total number of active patients between 1998 and 2012

Data shown refers to the number of patients assisted at outpatient centers at least once during the year. As from 2008, numbers from former Regional Alcoholism Centers (CRAs) are included.

Table IV – Number of active patients 1998-2012 (Drugs)

Year	Nº Total of Patients with appointments	CAT's /CRI's	Alcoholism Units
1998	24.164	-	-
1999	27.750	-	-
2000	29.204	-	-
2001	32.064	-	-
2002	31.835	-	-
2003	29.596	-	-
2004	30.266	-	-
2005	31.822	-	-
2006	32.460	-	-
2007	34.266	-	-
2008	47.245	38.532	8.713
2009	47.893	38.970	8.923
2010	46.301	37.983	8.318
2011	45.863	38.292	7.571
2012	45.724	38.894	6.830

Note: all bibliographical references of Table IV can be found in the PT version of this document

1.4.3 – Total number of patients in substitution programs between 1997 and 2011

Data shown refers to the number of patients attended before 31 December of the respective year and who have started a substitution program using methadone, LAAM (up to 2000) or buprenorphine.

Table V – Number of active patients in substitution programs 1997-2012 (Drugs)

Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Nº Pat.	2.115	4.000	6.040	10.614	12.863	15.768	16.877	19.260	21.054	22.922	24.312	25.808	27.031	27.392	26.351

Note 1: all bibliographical references of Table V can be found in the PT version of this document

Note 2: data not provided for 2012 (AR_SICAD_2012, pp. 98)

1.5 – Budgets (Central Structures)

1.5.1 – SPTT - Drug Prevention and Treatment Services between 1994 and 2001

Table VI – SPTT Operating Budgets 1994-2001 (Drugs)

INCOME EXPENSES	SPTT 1994	SPTT 1995	SPTT 1996	SPTT 1997	SPTT 1998	SPTT 1999	SPTT 2000	SPTT 2001
INCOME								
Sb. Exp S.B.	1.623.545	1.909.627	1.967.693	3.095.741	4.554.369	5.997.718	4.711.822	6.792.522
Ref. S.B.	-	-	-	-	-	-	2.352.353	-
Sub. Joker	511.367	627.884	972.378	539.873	(325.550)	(410.000)	410.000	500.000
Own. Inc.	-	156.475	154.542	127.816	459.049	535.251	408.317	426.181
Prev. Yea. Bal	27.655	511.367	249.711	671.176	519.125	381.197	170.242	-
Ot Inc. (Pr)	-	-	-	-	-	162.703	-	364.906
Res. (C+DL)	-	62.475	-	474.521	172.470	445.338	236.099	800.000
TOTAL (escudos)	2.162.567 \$	3.268.328 \$	3.344.324 \$	4.909.127 \$	5.705.013 \$	7.521.307 \$	8.288.833 \$	8.883.609 \$
EXPENSES								
Staff (H.R.)	1.244.686	1.452.319	1.797.962	2.204.547	2.804.640	3.827.910	4.571.616	5.417.906
Acq. G. & Ser	316.796	429.288	508.660	924.544	913.420	1.244.963	1.402.305	1.368.582
Conventions	-	-	-	462.739	905.298	1.571.661	1.633.069	1.837.852
Diverse Sub.	-	127.933	275.500	702.662	325.619	98.999	243.826	351.067
Cir./Ot/Pro	26.744	77.758	91.027	95.509	250.066	494.117	438.017	128.705
TOTAL (escudos)	1.588.226 \$	2.087.298 \$	2.673.149 \$	4.390.001 \$	5.199.043 \$	7.237.650 \$	8.288.833 \$	9.104.112 \$
Trend		▲ (+ 33,8 %)	▲ (+ 2,3 %)	▲ (+ 31,9 %)	▲ (+ 14,0 %)	▲ (+ 24,2 %)	▲ (+ 9,3 %)	▲ (+ 6,7 %)
Difference		+ 1.105.761 \$	+ 75.996 \$	+ 1.564.803 \$	+ 795.886 \$	+ 1.816.294 \$	+ 767.526 \$	+ 594.776 \$

Note 1: all bibliographical references of Table VI can be found in the PT version of this document

Note 2: only after 1993 there are budgets without being from SPTT Installation Committee that worked from 1990 to 1993.

1.5.2 – IDT - Drug and Drug Addiction Institute between 2002 and 2011

Table VII – IDT Operating Budgets 2002-2011 (*Drugs*)

INCOME EXPENSES	SPTT-IDT 2002	IDT 2003	IDT 2004	IDT 2005	IDT 2006	IDT 2007	IDT 2008	IDT 2009	IDT 2010	IDT 2011
INCOME										
Sb. Exp S.B.	57.552.449	52.457.354	57.443.664	55.472.337	53.657.650	50.709.978	46.602.513	46.122.944	45.777.895	43.979.132
Ref. S.B.	-	-	-	-	4.730.000	-	-	-	-	-
Sub. Joker	4.925.034	-	-	9.452.808	4.625.000	16.489.062	21.155.310	26.465.000	26.465.000	25.837.500
Own Income	1.948.726	11.550.228	9.614.174	-	1.233.686	-	1.298.048	2.187.157	2.159.857	2.159.857
Prev. Year Bal.	-	-	-	586.565	1.157.241	-	2.438.972	1.609.530	77.273	-
Ot Inc (Pr)	559.410	-	912.687	-	1.155.496	6.270.287	550.365	828.918	210.044	166.219
Res. (C+DL)	-	-	-	989.428	-	-	1.633.068	2.441.010	-	1.909.881
PIDDAC/Inv	2.431.522	1.198.384	766.781	-	-	-	-	-	-	-
TOTAL (Euros)	€ 67.417.141	€ 65.205.966	€ 68.737.306	€ 66.501.138	€ 66.558.878	€ 73.469.327	€ 73.678.276	€ 79.654.559	€ 74.690.069	€ 74.052.589
EXPENSES										
Staff (H.R.)	35.155.027	36.223.394	37.332.920	37.023.310	39.550.283	40.379.758	41.491.218	44.967.611	42.827.375	41.941.661
Acq. G & Serv.	12.118.674	9.448.866	10.820.364	10.187.723	11.742.774	10.721.546	10.149.833	13.461.221	13.288.516	10.830.935
Conventions	9.110.721	9.043.853	8.695.737	9.038.050	9.143.498	10.543.434	9.365.789	11.651.313	11.583.113	11.500.000
Diverse Sub.	6.640.148	7.663.116	7.412.019	4.904.023	6.122.323	11.824.589	10.680.642	6.683.402	6.485.704	7.870.112
Cir./Ot/Pro	-	(727.682)	-	-	-	-	1.840.794	2.441.012	-	1.909.881
PIDDAC	1.337.360	-	192.524	989.428	-	-	-	-	-	-
TOTAL (Euros)	€ 64.361.930	€ 63.106.943	€ 64.453.564	€ 62.142.534	€ 66.558.878	€ 73.469.327	€ 73.678.276	€ 79.654.559	€ 74.689.408	€ 74.052.589
Trend		▼ (- 3,3 %)	▲ (+ 5,2 %)	▼ (- 3,3 %)	▲ (+ 0,1 %)	▲ (+ 10,3 %)	▲ (+ 0,3 %)	▲ (+ 7,5 %)	▼ (- 6,2 %)	▼ (- 0,9 %)
Difference		€ 2.211.175	€ 3.531.340	€ 2.236.168	€ 57.740	€ 6.910.449	€ 208.949	€ 5.976.283	€ 4.965.151	€ 636.819

Note 1: all bibliographical references of Table VII can be found in the PT version of this document.

Note 2: in 2002, budgets include SPTT and IDT.

I.5.3 – SICAD – General-Directorate for Intervention on Addictive Behaviors and Dependencies between 2012 and 2013

Table VIII – SICAD Operating Budgets 2012 and 2013 (Drugs)

INCOME EXPENSES	SICAD 2012	SICAD 2013
INCOME		
Sub. Exploration S.B.	15.973.917	9.228.399
Reinforce of S.B.		-
Joker Subsidy	Note: includes: Sub. Exploration SB, Santa Casa, own income or others.	6.500.000
Own Income		300.000
Previous Year Balance		-
Other Income (Projects)		-
Resolutions (Circ + DL)		35.000
TOTAL (Euros)	15.973.589 €	16.063.399 €
EXPENSES		
Staff (H.R.)	5.818.035	5.400.000
Acquisition Goods & Ser.	3.871.216	3.125.606
Conventions	-	-
Diverse Subsidies	-	1.037.793
Circulares/Others/Proj.	6.284.666	6.500.000
TOTAL (Euros)	15.973.917 €	16.063.399 €
Trend		▲ (+ 0,55 %)
Difference	-	89.482 €

Note: all bibliographical references of Table VIII can be found in the PT version of this document.

I.6 – Accrued Amounts (*Long-Term Analysis*)

I.6.1 – Budgets between 1994 and 2013 (*Central Structures*)

Table IX – Long-Term Analysis – Budgets 1994-2013 (*Drugs*)

Year	Budgets <i>Escudos/ Euros</i>	Trend (▲ ▼)	(%) Percentage Variation
1994	2.162.567 \$	-	-
1995	3.268.328 \$	▲	+ 33,8 %
1996	3.344.324 \$	▲	+ 2,3 %
1997	4.909.127 \$	▲	+ 31,9 %
1998	5.705.013 \$	▲	+ 14,0 %
1999	7.521.307 \$	▲	+ 24,2 %
2000	8.288.833 \$	▲	+ 9,3 %
2001	8.883.609 \$	▲	+ 6,7 %
Total SPTT	44.083.108 \$ (220 million €)	▲	<u>(+ 17,45 %)</u>
2002	67.417.141 €	-	-
2003	65.205.966 €	▼	- 3,3 %
2004	68.737.306 €	▲	+ 5,2 %
2005	66.501.138 €	▼	- 3,3 %
2006	66.558.878 €	▲	+ 0,1 %
2007	73.469.327 €	▲	+ 10,3 %
2008	73.678.276 €	▲	+ 0,3 %
2009	79.654.559 €	▲	+ 7,5 %
2010	74.690.069 €	▼	- 6,2 %
2011	74.052.589 €	▼	- 0,9 %
Total IDT	709.965.249 €	▲	<u>(+ 1,08 %)</u>
2012	15.973.917 €	-	-
2013	16.063.399 €	▲	+ 0,55 %
Total SICAD	32.037.316 €	▲	<u>(+ 0,55 %)</u>
Accrued Amount 1994-2013	962.002.565 €	▲	<u>(+ 1,12 %)</u>

Note 1: SPTT global percentage variation, weighted average calculated over 7 years.

Note 2: IDT global percentage variation, weighted average calculated over 9 years.

Note 3: accrued weighted average calculated over 17 years.

I.6.2 – Number of workers between 1994 and 2013 (Central Structures)

Table X – Long-Term Analysis – No. Workers 1994-2013 (Drugs)

Year	Total No. Workers Contracts/Agreements	Trend (▲ ▼)	(%) Percentage Variation
1994	527	-	-
1995	662	▲	+ 20,4 %
1996	804	▲	+ 17,7 %
1997	872	▲	+ 7,8 %
1998	1.098	▲	+ 20,6 %
1999	1.297	▲	+ 15,3 %
2000	1.478	▲	+ 12,3 %
2001	1.564	▲	+ 5,5 %
			▲ + 14,3 %
2002	1.553	-	-
2003	1.830	▲	+ 15,1 %
2004	1.841	▲	+ 0,6 %
2005	1.791	▼	- 2,8 %
2006	1.771	▼	- 1,1 %
2007	1.868	▲	+ 5,2 %
2008	1.810	▼	- 3,2 %
2009	1.821	▲	+ 0,6 %
2010	1.760	▼	- 3,5 %
2011	1.583	▼	- 11,2 %
			▼ - 0,03 %
2012	1540	-	-
2013	181	-	-
Average Workers 1994-2013	-	▲	(+ 8,91 %)

Note 1: all bibliographical references of Table X can be found in the PT version of this document.

Note 2: SPTT global percentage variation, weighted average calculated over 7 years.

Note 3: IDT global percentage variation, weighted average calculated over 9 years.

Note 4: accrued weighted average calculated over 16 years.

Note 5: in 2003 are included the workers from IPDT and SPTT.



CHAPTER II – Alcohol

II.1 – Framework

Health services start to become directly involved in these problems, through the publication of *DL No. 41759 of 25 July 1958*, when the Psychiatric Care Institute (IAP) was created as a national coordination body, which was responsible for including high-ranking official establishments and services for preventive, therapeutic and pedagogical treatment in the field of mental health.

1958 will be mainly marked by the foundation of the Ministry of Health and Assistance (*DL No. 41825 of 13 August*) to which public healthcare services under the administration of the Ministry of Internal Affairs are transferred.

As this is considered a special healthcare scheme, the IAP is under the direct administration of the Medical Care Department although supervised by the Welfare Department but will become technically and administratively autonomous. It will also have the power to create and maintain establishments and services required for observation, surveillance and treatment.

The IAP divides the country into 3 areas (*North/Center/South*), with the possibility of sub delegations being created for each district, given that a minimum amount of psychiatric care institutions considered fundamental is indicated for each area: *Central Dispensary / Regional Dispensaries / Mobile brigades / Psychiatric hospitals and clinics / Mental health asylums*.

In subsection V of this decree, when reference is made to "Mental health asylums", paragraph e) of Article 18 explains that these can also include "*Colonies and rehabilitation centers for alcoholics, drug addicts and individuals suffering from other complaints.*"

This is the first explicit reference to alcoholism and drug addiction in Portugal, which is only seen again in 1963, with the publication of the Mental Health Law that once again mentions the problem as well as the need to treat it and create structures within the new ministry for this purpose.

The first stone for creating the first direct structure of the "building" for treating alcoholism is already laid before the end of 1963 establishing the *António Flores Center* integrated in the Júlio de Matos Psychiatric Hospital in Lisbon. The *António Flores Center* is the result of a donation from the Calouste Gulbenkian Foundation for the construction of a rehabilitation center for alcoholics occupying two pavilions, one for "*treatment and rehabilitation of alcoholics and other drug addicts*" and the second for the "*supply of psychiatric services, night and day, to outpatients.*"

This first facility starts operating in Lisbon in 1964 and is accompanied by the first Treatment Services for Alcoholics at the Sobral Cid Psychiatric Hospital in Coimbra and the Magalhães Lemos Psychiatric Hospital in Porto, which is technically but not administratively or financially autonomous. These spaces ended up by being basically used for some do-gooders to improvise responses.

In 1971, there is increasing evidence of formalization of the political desire to fight alcoholism and other drug addictions, despite these specialized services continuing to operate in psychiatric hospitals, being an example of this the Sobral Cid Hospital in Coimbra, which created a Rehabilitation Center for Alcoholics. The aim is to start up a service that is especially designed for prevention, inpatient and outpatient treatment and social rehabilitation of alcoholics and other drug addicts, even with technical autonomy alone.

In an attempt to continue divulging the problem, the "*Commission for Fighting Alcoholism*" is created in 1977, depending on the General Department of Health, which is focused mainly on prevention care.

One of the turning points in the history of the treatment of alcoholism occurs in the mid 80s, with the "*Community Response to Alcohol-Related Problems in Portugal*" project under the management and control of the World Health Organization³⁷. It is due to this project, which is highly appreciated and distinguished by Portuguese specialists, that the name "*Alcohol-Related Problems*" (ARP)³⁸ starts to be used in Portugal and still is to date.

This trajectory started in 1984 with adhesion to "*European Technical Cooperation Programs for Prevention of ARP*", which will enable the more classical medical/social alcoholism model to be seen in a broader perspective, leading to the multiplication and multidisciplinary approach of intervention strategies.³⁹

The Portuguese Alcoholology Society (SPA) is created on 12 June 1986 with the objective of promoting research, divulging knowledge in this field, participating in training activities and seeking to cooperate with organizations and specialists working on prevention, study and research of ARP. The idea was to follow the Alcoholology concept originating in France in 1966 with Fouquet as the "*sacred subject for everything related to the world of ethyl alcohol, production, preservation, distribution normal and pathological use with the implications of this phenomenon, causes and consequences, be they on a collective, national or international level.*"⁴⁰

Also in June 1987, in the editorial of the 1st SPA bulletin, the psychiatrist, Maria Lucília Mercês de Mello, summarized with the authority where she had worked for 20 years until that year: "*The Alcoholology movement in Portugal has long been evident in the search for a fairer and more adequate approach to the dimensions and type of problems caused by alcohol, mainly through personal initiatives, goodwill and improvisation.*"

³⁷ "*Community response to alcohol-related problems*" was an international study started in 1977 by the WHO in countries from different continents in response to global concern over problems related to alcoholism raised in 1975 in the 28th WHO World Conference and included methods for investigating and testing solutions to improve formal and informal responses, especially in developing countries.

³⁸ "*Alcohol-Related problems - ARP*" a more official name adopted by the WHO in 1982, is much too vague but has been used in recent years to designate the harmful consequences of the use of alcohol.

³⁹ Mercês de Mello, M.L. & All (2001) "*Álcool e Problemas Ligados ao Álcool em Portugal*", DGS, pp 9-15, Lisbon.

⁴⁰ Sociedade Portuguesa de Alcoologia, "*Opening Speech of the VI Congress of SPA*", The SPA Chairman, Augusto Franco Pinheiro Pinto, Coimbra, 23 October 2014.

And she continued:

"However, psychiatrists working in this area deeply sensed the transformation of the unsatisfactory and lame concept of «alcoholism» in the 60s; this concept was increasingly shattered by its «moralizing/punitive» approach, pursuing new medical and social models and focusing more and more on modern knowledge of Public Health, its diagnosis and intervention techniques."

There is a growing awareness of the severity of the problem and of its complex and transverse nature, with related risks and pressure placed on public health. This warrants the development of primary healthcare services to ensure intra and inter-sectorial collaboration and cooperation and to reduce the prevalence of ARPs.

It is in this context, through emphasis by all those living through these times on the importance of recommendations made by the aforementioned WHO study and the expert consultant for Portugal given, that, in 1988, one of the most relevant steps in this whole process was taken, which was to create **Regional Alcoholology Centers (CRAs)** in **Porto, Coimbra and Lisbon**.

CRAs are regional facilities for the prevention of ARPs, coordination of alcoholology-related activities and treatment in respective geographical areas, working along with different services and healthcare facilities. CRAs will be technically and administratively autonomous but are still dependent on the Primary Healthcare Department.

All tasks and duties performed by the Alcoholology Department at the Magalhães Lemos Hospital in Porto, Rehabilitation Center for Alcoholics at the Sobral Cid Hospital in Coimbra and the Rehabilitation Center for Alcoholics António Flores at the Júlio de Matos Hospital in Lisbon will be transferred to new regional alcoholology centers (*CRAP / CRAC/ CRAL*).

Work performed by pioneers organizing these new services is worthy of mention. They are all recognized professionals with direct experience in alcoholology who are led in Porto by the psychiatrist, José António Barrias, in Coimbra by the psychiatrist, Maria Lucília Mercês de Mello and in Lisbon by the psychiatrist, Maria Odília Castelões.

A nuance that should be noted in order to understand some of the difficulties occurring almost two decades later on is based on the understanding that the organizational model for alcoholology defined by the central government was admittedly different to that used for drugs.

In the case of alcohol, the major issue is directly linked to the decision not to create any specialized and centralized body to directly control its regional facilities that operate with a high degree of technical autonomy in terms of intervention. In view of the above, it is also evident that these facilities for treating alcoholism are based on a more "medical" or "traditional" healthcare environment with a strong psychiatric influence.

The first half of the 90s saw an attempt at consolidation of different views of the organizational model chosen, through contracting personnel to work in these specialized regional units, thus stabilizing the sector and creating conditions for obtaining an eventually attractive medical career in "alcoholology" in Portugal.

In 1995, a reduction in ARPs is confirmed, which is directly related to the significant increase in measures to fight alcoholism. It is therefore important to clarify all competencies of CRAs and how they operate in the healthcare environment and provide them with an indispensable organic structure for normal development of their activities.

CRAs maintain their technical and administrative autonomy and are responsible for prevention and treatment, rehabilitation and coordination of activities related to the fight against alcoholism, and teaching and research in the area of alcoholology. From a financial point-of-view, this is financed by National Health Service (NHS) funds.

In 1999, there is a sharp increase in ARPs, which is particularly evident in younger generations where alcohol consumption rose and an estimated 1,800,000 excess drinkers was registered, 800,000 of whom will be addicts.⁴¹ This concern is in line with the fact that, in 1998, for the first time in Portugal in terms of alcoholism, goals and objectives had been defined in a strategy for the turn of the century, integrated in the Department of Health (DGS) Action Plan (1998-2002).

Also in 1999, the central government finalizes the review of the law on CRAs but there is also a pressing need to respond to the amplitude and severity of the problem in terms of public health. Immediate more comprehensive legal and supervisory measures are required for education and promotion of healthcare to reduce ARPs. It is in this context that the Inter-ministerial Commission for the fight against alcohol is created to analyze and integrate the wide variety of aspects associated with this problem.

The aforementioned decree-law is published in late 2000, aimed at restructuring CRAs, and focuses on the urgent need to create alcoholology intervention units in local mental health services. This need stems from an ever-growing concern over the serious repercussions and consequences this problem will have on the physical and mental health of individuals and families, as well as other direct and indirect personal and social costs, especially due to violent behavior in which road and work-related accidents play a major role.

It is clearly assumed in the introduction of the aforementioned *DL No. 318/2000, of 14 December*, that alcohol addiction is the largest national addiction, albeit in legal terms. Reference is also made to the 1st Alcohol Action Plan drafted by the WHO in Europe, approved in 1994 and in force until the year 2000, explaining that countries following the recommendations established therein and with similar consumer indexes as Portugal have registered a negative increase.

⁴¹ Introduction to *Council of Ministries Resolution nº40/99*, DR I Series-B nº 107 of 08.05.1999, pp. 2398.

As Portugal failed to follow these regulations that were also contained in the "European Alcohol Charter", regarding which a consensus was reached in 1995, its consumer indexes rose, especially in some more vulnerable population groups like young people and women. It is this context, associated with the new mental health law and approval of the 2nd Alcohol Action Plan drafted by the WHO in Europe (2000/05) that the adequacy of the legislation is justified.

New legal guidelines defined in the late 90s establish that healthcare services specializing in mental health must be integrated on a regional and local level to guarantee unity and the continued supply of these same services. CRAs continue to be considered specialized mental health services and classified as regional services that are responsible for providing support and operating alongside local mental health services, according to national plans for the sector. It is maintained that this reorganization and restructuring of CRAs will bring them into line with their mission and insertion in the National Health Service (NHS), where they are complemented by functional units in local mental health services to form an alcoholology network.


The Porto/Coimbra/Lisbon CRAs become known as North/Centre/South CRAs and their technical and administrative autonomy is finally extended to the area of finance, although they remain under the supervision of the Ministry of Health, which still has the power to delegate some tasks to other bodies involved like the ARS and DGS (*Ministry of Health structures*).

This means that the ARSs will be responsible for certain aspects like coordination, orientation and assessment and the DGS for management of the technical and scientific area, which will also be the case, in functional terms, in several local mental health services. Powers attributed to CRAs become much clearer and, in terms of financial aid, funds will come from the NHS budget based on Fee-For-Service/Block contract programs.

The MH will have a new organic structure in the final quarter of 2006 aimed at distinguishing management of this ministry's central and regional resources, from the management of NHS internal resources and, in particular, the creation of the ACSS (*Central Healthcare System Administration*) that will take over the competencies of many important bodies that become extinct.

Guidelines issued by *DL No. 212/2006 of 27 October* are very clear, stating that, in order to simplify the existing organic structure, some bodies reinforce their powers, like the IDT, which takes over the competencies of CRAs. They will be integrated in the IDT during 2007, maintaining that drugs and addiction surpassed the use of illicit narcotics and psychotropic substances and also extended to the consumption of licit substances like alcohol.

It must be acknowledged and understood that after pursuing a certain path for 18 years with a view to the affirmation of a decentralized model, rehabilitation facilities for alcoholics are integrated in a central body operating nationwide. Another point that is worth mentioning is the fact that, to define technical guidelines for intervention in the field of alcohol, the IDT must explicitly work together with central services responsible for promoting health in general and mental health in particular.



Former CRAs will be transformed into Alcoholology Units (UAs) in the new IDT structure and it is understandable that some of their professionals may have sensed a certain "demotion" and/or devaluation because of the historical past of these bodies.

This is why the transfer of competencies from the IDT to the SICAD is used to call people's attention to the fact that integration of responses to alcohol problems in new organizational models must respect the identity and experience of teams treating alcoholic patient. Coordinator positions in this area should be given to people with recognized competence and experience in alcoholology and another set of recommendations that effectively help to launch the aforementioned alcoholology network.⁴²

A decision was made to stop the comments on this period of integration of CRAs in the IDT (2006 to 2007) in this Chapter, providing a detailed description of the most significant episodes and situations occurring in the past, in particular the following:

- ▶ History of the most relevant legislation between 1958 and 2007
- ▶ History of the CRAs management staff between 1988 and 2006
- ▶ History of clinical production developed between 2002 and 2006 and 2008 and 2010/12
- ▶ History of CRAs budgets between 2002 and 2006

⁴² Sociedade Portuguesa de Alcoologia, "SPA Memorandum", The SPA Chairman, Augusto Franco Pinheiro Pinto, March 2014.

II.2 – Relevant legislation between 1958 and 2007

The most relevant laws since 1958, which mentions alcoholics and addicts for the first time, and 2007, when units specializing in alcoholism are integrated in the IDT.

Table XI (part 1) – Summary of the relevant law on ARPs (*Alcohol*)

N	Year	Legislation	Synthesis / Key events
1	1958	► Decreto-lei nº 41759 of 25 July, Ministry of Internal Affairs	<ul style="list-style-type: none"> - <u>Creates (IAP) Psychiatric Care Institute</u> • Subsection V, Article 18, for the first time refers to “recovery house for alcoholics and drug addicts”
2	1963	► Lei nº 2118 of 3 April, Presidency of the Republic	<ul style="list-style-type: none"> - <u>Approves the Mental Health Act</u> • Cap. I, Base I, Pts. 3 e 4 + B. II Par. a) “Treatment of addictions” • C. II, B. IV, Pa. c) “Cooperation with organizations work addictions.” • C. II, B. VI, Pt. 1 “Commission for studying and information about alcoholism and other addictions” • C. II, B. XIV, Pa. d) “Facilities to treat and recover alcoholics and other addicts”
3	1963	► Decreto-lei nº 45465 of 26 December, Ministry of Finances	<ul style="list-style-type: none"> - <u>Regime setting for the António Flores Center (Lisbon)</u> • Will be part of Júlio Matos Hospital, a Gulbenkian donation for the “construction of a recovery center for alcoholics and other addicts”
4	1964	► Decreto-lei nº 46102 of 23 December, Ministry of Health and Assistance	<ul style="list-style-type: none"> - <u>Allow create Mental Health Centers planned on the Lei nº 2118</u> • The Mental Health Institute (ISM) substitutes the IAP • Mental Health centers are integrated in the existing hospitals, Porto, Coimbra and Lisbon, starting to have technical autonomy
5	1971	► Portaria 192/71 of 14 April, Ministry of Health and Assistance	<ul style="list-style-type: none"> - <u>Creates in Sobral Cid Hospital (Coimbra) – Recov. Cent Alcoholics</u> • Reinforce the idea of fight against alcoholism and other addictions throughout specialized services
6	1971	► Decreto-lei nº 413/71 of 27 September, Ministry of Health and Assistance	<ul style="list-style-type: none"> - <u>Approves the organic of the Ministry of Health and Assistance</u> • Article 78 refers the possibility of creating services or facilities by minister decree
7	1977	► Despacho Normativo 176/77 of 30 August, Ministry of Social Affairs	<ul style="list-style-type: none"> - <u>Creates the “Commission For Fighting Alcoholism”</u> • Sets its powers and goals
8	1984	► Decreto-lei nº 74-C/84 of 2 March, PCM + M. Finances & Plan + M. Health	<ul style="list-style-type: none"> - <u>Creates at the M. Health, General-Directorate Primary Care (DGCSP)</u> • Operational services of the DGCSP goes to DSSM • Artº 11, Pa. f) says “prevent alcoholism” in collaboration with services of direct provision • Artº 14, Pa.c) is the DSSM the responsible to assess results and prepare technical norms for the services intervention
9	1988	► Decreto-Regulamentar nº 41/88 of 21 November, Ministry of Health	<ul style="list-style-type: none"> - <u>Creates CENTROS REGIONAIS DE ALCOOLOGIA Lisbon, Porto, Coimbra</u> • Sets decentralization of the services to treat and prevent alcoholism • They work together with ARS, Health Ct., Psych. Hosp. & MH Centers • Receive duties of the specialized Alchoology Services that are extinct: - Serviço de Alcoologia do Hospital Magalhães Lemos (Porto) - Centro de Recuperação de Alcoólicos do H. Sobral Cid (Coimbra) - Serviço Recup. Alc. do Cent. Ant. Flores do H. Júlio Matos (Lisbon) • Become dependents on DGCSP and start a installation period regime
10	1991	► Portaria nº 338/91 of 13 April, M. Finances + M. Health	<ul style="list-style-type: none"> - <u>Approval of the human resources map from CRA Coimbra</u> • Still with the CRA Coimbra in installation regime

Table XI (part 2) – Summary of the relevant law on ARPs (*Alcohol*)

N	Year	Legislation	Synthesis / Key events
11	1991	► Portaria nº 142/91 (2ª série) of 2 May, Ministry of Health	- <u>Renews the installation regime of the 3 CRAs</u>
12	1992	► Decreto-lei nº 127/92 of 3 July, Ministry of Health	- <u>Restructures Mental Health Center (from Lei nº 2118 & DL nº 46102)</u> • Creates the Mental Health Centers from North/Center/South • End of M.H.C., integrated in general/central/district Hospitals
13	1992	► Portaria nº 715/92 of 13 July, M. Finances + M. Health	- <u>End of the installation regime CRA Coimbra</u> • Approves the CRAC permanent workforce
14	1993	► Portaria nº 282/93 of 12 March, M. Finances + M. Health	- <u>End of the installation regime CRA Porto</u> • Approves the CRAP permanent workforce
15	1993	► Portaria nº 490/93 of 8 May, M. Finances + M. Health	- <u>End of the installation regime CRA Lisbon</u> • Approves the CRAL permanent workforce
16	1995	► Decreto-lei nº 269/95 of 19 October, Ministry of Health	- <u>Restructures CRAs Porto/Coimbra/Lisbon</u> • Approves CRAs organic (structure, competencies, functions, bodies). • Sets competencies Tech. Serv. (in & out patient) & support services • Clarifies competencies and framing the functioning
17	1998	► Lei nº 36/98 of 24 July, Assembly of the Republic	- <u>Approves Mental Health Act (reforms Lei nº 2118 of 1963)</u> • Article 47º refers that the organization of the mental health services will be regulated by a Decree of Law
18	1998	► Despacho nº 16184/98 (2ª série) of 25 August, Ministry of Health	- <u>Changes the name of the CRAC (Coimbra)</u> • Becomes to be called “Maria Lucília Mercês de Mello” in recognition for the services rendered by its first director
19	1999	► Decreto-lei nº 35/99 of 5 February, Ministry of Health	- <u>Organizes the provision of psychiatric and mental health care</u> • Guidelines to organize, manage and evaluate the psychiatric and mental health services • Emphasizes attempt to treat in the community and not in institutions
20	1999	► Resolução Conselho Ministros nº 40/99 of 22 April, PCM	- <u>Creates an inter-ministerial commission to fight alcoholism</u> • Try to analyze and integrate the several aspects of this problem
21	2000	► Decreto-lei nº 318/00 of 14 December, Ministry of Health	- <u>Restructures CRAs and creates alcohol units in local services</u> • Change the name to CRA North/Center/South • The local mental health services are supported by the CRAs
22	2006	► Decreto-lei nº 212/06 of 27 October, Ministry of Health	- <u>Approves the Organic Law of the Ministry of Health</u> • Predict the end of CRAs with the IDT receiving the competencies and duties in 2007 according Article 26º
23	2007	► Decreto-lei nº 221/07 of 29 May, Ministry of Health	- <u>Approves the organic of the IDT</u> • IDT assumes the control of the CRAs

Note: all bibliographical references of Table XI (part 1 and part 2) can be found in the PT version of this document.

II.3 – Managerial Staff at Regional Alchoology Centers (CRAs) between 1988 and 2006

Presentation of the list of heads of the three Regional Alcoholology Centers and respective leadership times between 1988 (creation) and 31.12.2006 (absorption).

Table XII – Management Staff CRAs 1988-2006 (*Alcohol*)

N	Body	Head of Department + Profession	Period
1	▶ Centro Regional Alcoologia do Porto (CRAP - 1988-2000)	- <u>José António Alves Carvalho Barrias</u> (psychiatrist)	01.02.89 / 00.08.99
		- <u>Júlio Figueiredo Amaral</u> (hospital manager – substitute director)	00.08.99 / 03.04.01
	▶ Centro Regional Alcoologia do Norte (CRAN - 2000-2006)	- <u>Rosa Idalina Tavares da Encarnação</u> (psychiatrist)	03.04.01 / 21.10.04
		- <u>Rui Augusto Moreira</u> (psychiatrist)	21.10.04 / 31.12.06
2	▶ Centro Regional Alcoologia de Coimbra (CRAC - 1988-2000))	- <u>Maria Lucília Mercês de Mello</u> (psychiatrist)	01.02.89 / 07.07.94
	▶ Centro Regional Alcoologia do Centro (CRAC - 2000-2006)	- <u>Augusto Franco Pinheiro Pinto</u> (psychiatrist)	07.07.94 / 31.12.06
3	▶ Centro Regional Alcoologia de Lisboa (CRAL - 1988-2000))	- <u>Maria Odília Castelão</u> (psychiatrist)	02.03.89 / 02.04.96
	▶ Centro Regional Alcoologia do Sul (CRAS - 2000-2006)	- <u>Domingos Alfredo Alves Neto</u> (psychiatrist)	02.04.96 / 31.12.06

Note 1: all bibliographical references of Table XII can be found in the PT version of this document.

Note 2: 31.12.06 does not correspond to the final manager mandate date but was established by choice as explained before.

II.4 – Production (*Clinical Movement*)

II.4.1 – Appointments between 2002 and 2006 and 2008 and 2012

Table XIII – Appointments CRA (2002-06) & (2008-12) (*Alcohol*)

Year	Nº Total Appointments	Trend (▲ ▼)	(%) Percentage Variation
2002	32.099	-	-
2003	33.813	▲	+ 5,1 %
2004	32.494	▼	- 2,9 %
2005	34.051	▲	+ 4,6 %
2006	37.684	▲	+ 9,6 %
2008	43.472	-	-
2009	45.360	▲	+ 4,1 %
2010	44.449	▼	- 2,0 %
2011	41.059	▼	- 7,6 %
2012	44.365	▲	+ 7,5 %

Note 1: all bibliographical references of Table XIII can be found in the PT version of this document

Note 2: 2007 data are not shown because is the merger year of CRAs in IDT.

II.4.2 – Number of patients treated in CRAs between 2002 and 2006 and UAs 2008 and 2011

Table XIV – No. Patients treated CRAs (2002-06) & UAs (2008-11) (*Alcohol*)

Year	Nº Patients Treated	Trend (▲ ▼)	(%) Percentage Variation
2002	1.212	-	-
2003	1.250	▲	+ 3,1 %
2004	1.243	▼	- 0,6 %
2005	1.292	▲	+ 2,1 %
2006	1.265	▼	- 2,1 %
2008	1.229	-	-
2009	1.137	▼	- 7,5 %
2010	1.074	▼	- 5,5 %
2011	811	▼	- 24,5 %

Note 1: all bibliographical references of Table XIV can be found in the PT version of this document

Note 2: 2007 data are not shown because is the merger year of CRAs in IDT.

II.4.3 – Number of inpatient days in CRAs between 2002 and 2005 and UAs 2008 and 2010

Table XV – No. Days In-patient in CRAs (2002-05) & UAs (2008-10) (*Alcohol*)

Year	Nº Days In-patient	Trend (▲ ▼)	(%) Percentage Variation
2002	22.744	-	-
2003	23.805	▲	+ 4,5 %
2004	24.446	▲	+ 2,6 %
2005	25.432	▲	+ 2,1 %
2006	-	-	-
2008	24.907	-	-
2009	22.371	▼	- 10,2 %
2010	22.281	▼	- 0,4 %
2011	-	-	-

Note 1: all bibliographical references of Table XV can be found in the PT version of this document

Note 2: 2006 data were not obtained for CRAC.

Note 3: 2007 data are not shown because is the merger year of CRAs in IDT.

Note 4: in 2011 CRAP closed In-patient UA at 29.10.2010 and integrated it in the UD North of IDT.

II.5 – Budgets

II.5.1 – Centros Regionais Alcoologia North/Center/South between 2002 and 2006

Table XVI – Operating Budgets CRAs 2002-2006 (Alcohol)

Year	CRA North	CRA Center	CRA South	GLOBAL
2002	1.278.837 €	1.379.787 €	1.050.925 €	3.709.549 €
2003	1.250.628 €	1.281.236 €	988.591 €	3.520.455 €
2004	1.248.993 €	1.258.736 €	1.314.593 €	3.822.322 €
2005	1.632.360 €	1.293.555 €	1.666.662 €	4.592.577 €
2006	1.380.406 €	1.319.928 €	1.085.625 €	3.785.959 €

Note: all bibliographical references of Table XVI can be found in the PT version of this document.



CHAPTER III – Therapeutic Communities (*TCs*)

III.1 – Framework

The need to create addiction treatment facilities arose in the Western world between 1940 and 50, when three important treatment trends emerged that influenced decisions made at any given time in Europe and Portugal through modifications and evolutions:

Global Trend + Phases	Main Features
► PSYCHIATRY or SOCIAL PSYCH. (1938/40 to 1950 / present day)	- <u>Social Movement</u> / <u>Environmental Movement</u> / <u>Democratic Model</u> - Hospital environment (<i>innovation / original / alternative</i>)
► PHARMACOTHERAPY (1949 to 1964 / present day)	- <u>Administration of legally prescribed medication</u> - Medical environment (<i>evolution</i>)
► THERAPEUTIC COMMUNITIES FOR DRUGS (1958/67 to 1968 / present day)	- <u>In-Out Patient for Drugs and Alcohol</u> / <u>Hierarchical Model</u> - Non-hospital environment (<i>disruption / counter reaction / Synanon 1958</i>)

In the case of Portugal, as mentioned in previous Chapters, after 1974 a growing number of increasingly complex cases appear in outpatient appointments, some of which require more intensive treatment and internment. This specific need determines and justifies the creation of TCs in Portugal, with European influences from the second half of the 70s so it will be useful to define the type of TC to be created in the country.

“TCs for Drugs» are substance-free environments in which addicts live together in an organized and structured manner to promote a change in direction for rehabilitation and reintegration into society.”⁴³

“Treatment at a TC can be looked upon as an educational process where support is given to each for rehabilitation and a lifestyle without drugs so that they can once again gain control over their own lives.”⁴⁴

The first TC for drug addicts in Portugal was founded on 21 June 1978 in Coimbra under the name of Arco-Iris^{45 46}, and operated under the supervision of the Regional CEPD in Coimbra. Between 1978 and 1980, it operated on the first floor and attic of the "Casa do Sal" and was then transferred to its current location in Vale de Canas (outskirts of Coimbra) in 1980, to a building provided by the Bissaya-Barreto Foundation with capacity for 12 over 18-year-old patients of both sexes.

⁴³ Vanderplasschen, W. & All (2012) *“Therapeutic Communities for Addictions: A Review of Their Effectiveness from a Recovery-Oriented Perspective”*, the Scientific World Journal, Volume 2013, pp 1.

⁴⁴ De Leon, George (1996) *“Integrative recovery: a stage paradigm”*, Substance Abuse, Volume 17, nº 1, pp 51-63.

⁴⁵ Henriques, Tatiana (2013) *“Toxicodependência: O caso da Comunidade Terapêutica Arco-íris”*, Report from traineeship for a Master's Degree in Sociology presented at Coimbra University Faculty of Economics, pp 30, 43, 50 e 51.

⁴⁶ Vieira, Carlos (2007) *“A CT: da integração à reinserção”*, Toxicodependências, IDT, Volume 13, Number 3, pp 15.

In 1978, treatment lasted one month, extending to between 3 and 6 months in 1979 and between 6 and 8 months in 1980. Treatment methods are divided into psychotherapeutic, occupational, cultural and recreational activities and others to support social reintegration. One of the founders of the Arco-Íris TC project is the psychiatrist, Carlos Amaral Dias, who was its supervisor, along with the psychologists, Joaquim Augusto Rodrigues and Carlos Vieira, the social worker, Ana Maria Ribeiro and psychiatrists, Teresa Nunes Vicente and Maria Livramento Keating.

In the same year, the Praça de Diu/Restelo TC opens in Lisbon under the supervision of the CEPD, which will be marked by two different situations.⁴⁷ The first, between 1978 and 1984, and the second, between its reopening, in 1986, up to the present. In the first phase, senior management, the psychiatrist, Nuno Afonso Ribeiro, was to be responsible for the project but it experienced some serious problems that led to its closure. From 1986 onwards, its director, the psychiatrist, Domingos Neto and psychologist, Graça Poças, seek to establish a new philosophy and take advantage of experience gained from their previous year's trip to the "Le Centre du Levante"⁴⁸ (Lausanne, Switzerland, open since 1971), to obtain more references on how to intervene in this TC.

In objective terms, TCs were seen at the time as a solution to situations considered more problematic, which required internment for more prolonged and extensive treatment. As indicated above, the first two TCs facilities that opened in Portugal are a direct result of the initiative taken by healthcare professionals. In other words, a marked presence of these professionals and their leadership is sensed, more specifically psychiatrists who are to be the founders of almost all similar facilities created in Portugal, be they public, private or social, and will influence their positioning and development.

From this point-of-view, the situation in Portugal is similar to that experienced in other European countries and called "European Identity"⁴⁹, where professionals are the driving force behind all responses given when treatment systems are launched. This fact is relevant if we remember that these pioneers often had to depend on their own learning to discover alternatives for emerging situations for which they had not received any specific training and the great difficulty found in obtaining scientific information on the subject at that time (second half of the 70s)

The truth is that problems, especially due to the increased use of heroin, continue to grow and units created to treat these patients were manifestly insufficient. Therefore, following the creation of these facilities planned and managed by professionals, there is a second moment in the first half of the 80s when the combination of the scarcity of supply and the Government's delay in dealing with it, leads to the appearance of another two units with very different features in Portugal.

⁴⁷ Healthcare & Addictions Guide (2011) "Revista Dependências" pp. 98.

⁴⁸ CEPD South (1986) "Relatório de Actividades de 1985 e Perspectivas Para 1986" pp. 7.

⁴⁹ Broekaert, Eric et All, (2006) "The Third Generation of Therapeutic Communities: The Early Development of the TC for Addictions in Europe", European Addiction Research, pp 7.

The Fanhões TC opened in Loures in 1981, under strong religious influence, which was natural due to the organization running it, more specifically Teen Challenge, led by the priest, Lucas da Silva.⁵⁰ During 1985, facing the need felt by Portuguese patients to seek treatment in France or Spain, the first Le Patriarche Association unit called Casa Azul TC opened in São João da Madeira.

This organization, founded in 1972 in Toulouse, first as La Boére and then, after 1974, as Le Patriarche, the name under which it became known for offering treatments in isolated rural environments, did not include healthcare professionals or others and based its services essentially on self-help. It also followed a hierarchical model and supported a drug-free but not necessarily alcohol-free environment, strongly believing in occupational therapy and rehabilitation for life (with no set time for therapeutic intervention) and that physical detoxification should be performed without any kind of medication. In the late 80s, the increase was so sharp that, following an analysis of 1986 conducted in seven European countries in which it operated (France, Belgium, Spain, Italy, Ireland, Portugal and Switzerland), over 80 treatment facilities (TCs and others) offering over 4500 beds had opened!⁵¹

From the above, it is obvious that in both Portugal and Europe, no national or global treatment strategy was established by the Government, meaning that organic and experimental growth was to continue for years to come.

Therapeutic models not backed by scientific evidence are used, some of them with profound religious influences and others highly customized or even posing a risk of indoctrination, like Synanon and Patriarche.

This causes a confluence of conservative views on TCs associated first of all with the scandal surrounding Synanon (1977/78-1991) and then Patriarche (1995-99), influencing situations of antagonism and dissonance amongst professionals and non-professionals that led to the appearance of features that are still a part of the TC "environment" such as: fragmentation and atomization, use of different therapeutic intervention models that are too different and heterogeneous from each other and have a strong oral tradition of transmitting knowledge, methods and practices.

This situation brought about the opening of the Aldeia de Eiras TC, which belonged to the Ares do Pinhal Association, with the aid of the psychiatrists, Nuno Miguel and Luis Patrício.⁵² This project was idealized by these two professionals in 1983 but it only materialized in 1986⁵³, its primary reference being the psychiatrist, Claude Olievensteins (1933-2008) who specialized in treating drug addicts mainly at the Marmottan Hospital in Paris.⁵⁴

⁵⁰ Teen Challenge Portugal, website, www.desafiojovem.pt, accessed on 12/06/2014.

⁵¹ Engelmaier, Lucien (1986) *"Para os toxicómanos: a esperança"*, Le Patriarche, 3rd Edition, Casa Azul, SJ Madeira pp 316 to 326.

⁵² Collection of Texts, Volume I, Taipas Center, Lisbon (1989), *"O Toxicodependente e a Comunidade Terapêutica"* VII National Pastoral Social Week, Fátima, September 1988, pp 162 and 163.

⁵³ Collection of Texts, Volume V, Taipas Center, Lisbon (1993), *"Políticas Gerais em Toxicomania"* Armando Leandro, Projecto Vida National Coordinator, pp 4 e 5.

⁵⁴ Collection of Texts, Volume X, Taipas Center, Lisbon (1997), *"Dez Anos. Formas, modelos, respostas. Que futuro?"* Miguel, Nuno, X Taipas Encounter, Lisbon, April, 1997, pp 42

Also in 1986, as mentioned above, the Restelo TC, under the supervision of the Southern CEPD, is reopened with an initial capacity for 12 patients, increasing to 20 in 1987, and a minimum internment of 13 months, divided into 4 different phases.⁵⁵ 1987 is also marked by other events already mentioned like the opening of the *Taipas Center* and launching of the *Projecto Vida* and represented a turning point for this sector in terms of visibility.

In 1988, the Ares do Pinhal Association opens a second unit, the Chão de Lopes TC and then the Jovem Tejo Association opens the Casa do Alcaide TC on the south bank of the River Tagus, whilst in the north, in Penafiel, the Remar Association opens a shelter. 1990 is marked by the appearance of the ERA TC, the first private profit-making unit in this sector and also the first one to implement the 12-step model in Portugal. It now operates in the Algarve but had opened in Lisbon at the time.

In this phase, civil society manages to react more quickly than the Government, making it possible to identify the type of organizations that will establish and implement TCs in Portugal based on their legal, social and, in some cases, religious classification. These are all factors that condition the type of therapeutic intervention selected, all the more so in a period in which requirements for opening this kind of organizations were practically non-existent.

The following classifications will emerge for TCs:

- ▶ Government units (*influence from healthcare professionals*);
- ▶ Private non-profit units (*civil society - NGOs, social sector - IPSSs*);
- ▶ Private non-profit units (*religious motivation*);
- ▶ Private for profit units (*healthcare companies*);

Reformulation of the *Projecto Vida* will be decisive in terms of incentive and support for treatment in general and for TCs in particular. It is important to mention the *Despacho-Conjunto of 19 May 1991*, which will provide a clearer and more objective idea of the support to be given through "Cooperation Agreements". The Government provides financial support for operation of already-existing units and foresees the provision of funds for investment in the creation of facilities by these institutions.⁵⁶

(this matter will be described in more detail in Chapter V – Conventions – registered beds)

People are very strongly focused on diversifying Government facilities, increasing their number nationwide and providing more continuous support to other institutions with a view to maintaining and opening facilities. As mentioned above with regard to differences amongst professionals and obvious exploitation of situations, the so-called *Lisbon Declaration* (April 1992, at the V Taipas Meeting) reminds us that some therapeutic, medical or alternative institutions have benefitted from treatment difficulties and family anguish, using false advertising for patients and relatives.

⁵⁵ Collection of Texts, Volume V, Taipas Center, Lisbon (1993), "*Comunidade Terapêutica do Restelo – Quatro Anos Depois...*" Isabel Prata, Psicóloga, CEPD Lisbon, pp 112.

⁵⁶ Collection of Texts, Volume V, Taipas Center, Lisbon (1993), "*Discurso de Abertura, Ministro da Saúde – Dr. Arlindo de Carvalho*", pp 19, 20.

After collecting and studying all elements comprising the addiction treatment system, it is evident that the 90s is an era of significant Government investments through the broadening of the system's foundations and pillars. In terms of TCs, this decade was also to register the highest growth rates in the number of units opened, distinguishing three large future groups:

- ▶ Group 1 – Government (*bodies dependent on the MH*);
- ▶ Group 2 – Non-profit (*NGO, IPSS, Religious – different therapeutic models*);
- ▶ Group 3 – For-profit (*healthcare companies – 12 Steps therapeutic model*);

Attention must be paid to this matter and, given that it is a distinguishing feature of the Portuguese addiction treatment system in general and TCs in particular, conditions are created for them to emerge from different fronts and contexts (public, social, religious and private), thus enriching the therapeutic services offered, which only occurs in very few European countries. This is a matter that began to be a major concern on the political agenda as a result of the emergence of several groups that felt the need to intervene for different reasons.

TCs from Group 1 only include units created and maintained exclusively by the Government. They are sustained by healthcare professionals, mainly psychiatrists, and there are only 3 units in these conditions: *Arco-Íris TC* - Coimbra, *Restelo TC* - Lisbon, both founded in 1978, and *Ponte da Pedra TC* - Matosinhos, founded in 2006. Therapeutic models implemented evolved over the years, but used in particular the Democratic Model.

TCs from Group 2 are organizations or associations created and sustained by relatives of addicts (e.g. *ATT - O Farol, São Fiel*, etc.), groups of professionals (e.g. *Outeiro Clinic, Lugar da Manhã*, etc), religious groups (e.g. *Cáritas, Teen Challenge, CVP*, etc.) and external projects imported for implementation in Portugal at the time (e.g. *Le Patriarche, Projecto Homem*). Despite Portugal's focus on the clinical psycho-social model⁵⁷, there are several very different therapeutic models in this second group of TCs (12-Step, Bio-Psycho-Social, Hierarchical, Cognitive-Behavioral, Democratic, Humanistic, Portage, Systemic and others), which are often unclear and unsubstantiated, focusing more on promoting occupational therapy and medium/long-term therapeutic interventions.

The majority of TCs in Group 3 stem from the intervention of different people receiving treatment in England at centers using the 12-Step Minnesota Model, more specifically in the second half of the 80s. Many of these wealthy Portuguese ex-patients who had been in the United Kingdom in similar units (e.g. *Broadway Lodge, Western Counseling*) will take precedence in the 90s and in the year 2000, when many TCs open and start operating under this American-based model (e.g. *ERA, CRETA, CRATO, RAN, R12, SAE*, etc.) in which intervention periods are normally shorter and preference is given to individual and group therapies.

⁵⁷ Nunes Dias, Lúcia (2007) "*As drogas em Portugal – o Fenómeno e os Factos Jurídico-Políticos de 1970 a 2004*", ed 500 First volume Coimbra, Pé de Página, pp 16.

It is once again important to mention that this is unique to the Portuguese system in general and to TCs in particular as alternatives may be added in terms of the diversity and quality of therapeutic services, which have no parallel in Europe even in terms of the number of units. It must also be underlined that this process did not only have a positive side to it as some private, profit-making facilities raised many questions regarding technical training, which benefitted from already-existing legal vacancies⁵⁸, and generated the aforementioned disputes and controversies.

Treatment responses are created to comply with the Basic Health Law (*Law No. 48/90, of 24 August*) that establishes and defends a mixed healthcare model, upholding the complementary nature and competitiveness of the private and social economic sector and integrating in the national network private entities and professionals that entered into an agreement with the Government to provide all or some activities relating to health promotion, prevention and treatment. In legal terms, it is important to mention the *Despacho do Ministro da Saúde No. 21/95, of 30 August*, which establishes the requirements that must be met by private units in the field of secondary prevention.

Law No. 27/97, of 8 March, will establish public service network objectives to be implemented, where TCs are expected to provide 1000 beds for treatment under financial agreements signed with the Government. Also in 1997, facilities created were considered insufficient to meet people's needs in terms of inpatient and outpatient treatment in reasonable time.⁵⁹ The idea was to establish agreements with private units with a view to establishing a national network, ensuring equal access to treatment and creating a clearer, more transparent picture of the essence of a TC and its purpose.

1999 is also noted for the appearance of *DL No. 16/99, of 25 January* and *DL No. 72/99, of 15 March*, resulting in greater rigor in the establishment of rules and maturity of the treatment system itself. In the 21st century, new units continued to be opened, although at a slower rate, and the Portuguese system was consolidated, focusing more on healthcare quality. A move towards innovation is also evident, based on initiatives like the Decriminalization Law and the creation of Drug Addiction Dissuasion Commissions. (*this subject will be dealt with in more detail in Chapter IV - Dissuasion*)

CRAAs will be integrated in the IDT during 2007, maintaining that drugs and addiction surpassed the use of illicit narcotics and psychotropic substances and also extended to the consumption of licit substances like alcohol. This affects TCs through the increase in the number of patients treated who only had problems with alcohol and through the creation of legal conditions for financing TCs in terms of extending the registered bed program to alcoholic patients.

⁵⁸ Collection of Texts, Volume VI, Taipas Center, Lisbon (1994), "*O Que se passa em Portugal Face à Droga*" Patrício, Luis Duarte, Conference "Droga, Liberalizar ou Reprimir – para uma política Europeia face à Toxicodependência", Lisbon, November 1993, pp 227.

⁵⁹ Collection of Texts, Volume X, Taipas Center, Lisbon (1997), "*Discurso de Abertura de Sua Excelência o Presidente da República Dr. Jorge Sampaio*", Lisbon, April, 1997, pp 29.

In 2008/09, the central body seems to give priority to service quality, which is achieved through the certificate obtained in early 2009 by the Ponte da Pedra TC⁶⁰, in accordance with the standards of the Quality Management System ISO 9001:2008. The truth is that this provision did not produce the expected results and, in the end, only a few units from the social and private sector followed this trend that had been influenced by experiences in Spain, instead of it spreading to all units in general.

Nevertheless, the basis of general TC operation is stabilized and organizations adapt to reality, discovering how to operate in the existing system with regard to the rules established, bureaucratic and administrative procedures and their communication channels and adapting resources to be allocated to therapeutic and non-therapeutic activities according to intervention timeframes established and funds determined by the Government for each patient. There is only a minority of private TCs that receive no Government support so they are not directly affected by these measures.

Between 2010 and 2012, reference to constraints and difficulties due to the economic and social crisis increases, requiring adaptation to a context of financial restrictions and scarce resources, and comes to a peak between 2011 and 2012. These are particularly difficult years, not only in terms of activities and the reduction in human and financial resources but also instability created by the announcement of the termination of the IDT and creation of the SICAD.

For quite a long time, a huge political silence prevails with regard to the path to follow in this problematic context after almost 40 years of great alliance and understanding in all political parties. As mentioned above, despite the limitations, vicissitudes and difficulties imposed on the relationship with TCs, the model created had allowed organizations to adapt to a type of reality that guaranteed them some form of predictability.

During 2012 and 2013, it is obvious that the sector ceases to be a priority in the more general view of the MH, which led to an atypical period with an undefined organizational model along with insufficient clarification and assumption of its responsibilities. There was also lack of information and orientation in terms of dynamic approaches to be implemented in the new central body and respective responsibilities in relation to TCs under the supervision of the IDT to be transferred to ARSs.⁶¹

This period is also marked by the extension of the SICAD's responsibilities to new psychoactive substances, medicines and anabolic substances as well as to addictions with no substances, forcing it to deal with a new type of patient profile. All these changes require TCs to have the agility and capacity to adapt to new rules, bureaucracies and communication model in an attempt to find another way of carefully selecting resources to allocate to therapeutic and non-therapeutic activities. However, no change has been made to the amount payable by each patient determined by the Government.

⁶⁰ IDT 2008, Activities Report, Lisbon, 2009, pp 12.

⁶¹ SICAD 2012, Activities Report, Lisbon, 2013, pp 2.

We face a scenario in which the Government lacks the lucidity and capacity to present a strategic opinion, even to solve short-term problems for the sector let alone medium and long-term ones. There is a possibility that this difficult and "agonizing" situation might become really disruptive and follow a path that may be beneficial for the entire service supply chain, where Portugal once again comes into the limelight in this specialized health niche in which Portuguese know-how is already recognized.

There is an opportunity to focus on creating a specific health cluster on several levels (therapeutic innovation, management, training, technology) with the capacity to attract patients from all corners of the world, especially Europe, using the *European Cross-Border Healthcare Directive*.⁶²

The main objective entails highlighting the quality of healthcare supplied without neglecting the significant role played by tourism in terms of health, which has already been in operation for some years through the *Health Cluster Portugal*. This means implementation of a new cycle in which assessment and quality of these same services along with transparent and reliable cost/benefit analyses become the centre of concern for those participating, whose aim is to actually achieve a level of professionalism and reliability in the sector that is lacking nowadays.

After witnessing the organic growth of this type of units, we must now move on to strategic planning to improve the efficacy of existing resources by questioning interests installed through the natural and understandable fear of losing the support from agreements or protocols needed for their survival. This debate should start with 3 essential points regarding continuity of TCs as a whole:

- 1- Installed capacity (available beds);
- 2- Quality and variety of therapeutic programs used;
- 3- Amounts spent by the Government on conventions (rethink the matrix)

There are too many units operating without using the tools and methods provided for assessing the impact of results obtained and it is not customary to create national and international partnerships (fragmentation, atomization), which causes a wide-scale lack of critical mass in different fields. There is no continued investment in good therapeutic practices or new non-therapeutic management models to help release TCs from their current dependence and immobility.

If nothing is done, they may become irrelevant in the medium/long-term, disappearing or undergoing such a traumatic change that the reasons for their foundation will be irremediably affected.

Due to all this, after understanding that time has been wasted but that there is still an opportunity today to remedy this, it will also be worth mentioning the unfortunate current situation already referred to by the investigator, Richard Bale, in 1979!

⁶² European Parliament and Council Directive, 2011/24/EU of 9 March 2011, regarding the exercise of patient's rights in terms of cross-border healthcare.

"The majority of studies on the effectiveness of treatment (Drug TC) are lacking in scientific rigor and show a wide variety of methodological limitations, namely: inadequate sampling procedures, lack of comparison control groups, unclear definition of outcome variables, low follow-up completion rates, absence of descriptive data on patients or treatment processes and absence of data to validate self-reports."


*"It is still necessary to standardize treatment methods and research at TCs and other units in order to establish comparisons between comparable items and reach valid conclusions."*⁶³

This outlook can be summarized through a list of the main points of a proposal for a new path for the TCs:

STAGNATION vs INNOVATION

Limitations of Current Models	TCs Challenges
<p>► Low Innovation Processes (Low Added Value)</p> <ul style="list-style-type: none"> - Response for homogeneous groups: (mainly men, specific age groups, marginalized groups) - No response for a wide variety of dependent profiles - Very long or short treatment programs - Belief in the use of substitution drugs in the same terms - Belief in the use of occupational therapies as the essence of the therapeutic intervention - Location of facilities (remote and isolated) - Reactive unplanned responses - Therapeutic teams without adequate training - Under financing - Too personalized management models (non-scalable) - Self-centered opinion (little sense of collective identity) 	<p>► Modernization of Therapeutic Services (Discovering New Answers)</p> <ul style="list-style-type: none"> - New chemical dependent profile (urban, professional /social/family-integrated, multi-substance-users and adolescents) - New emotional and behavioral dependents profiles - More demanding & critical patients (educated & integrated) - More demanding & critical families (decrease in stigma) - Balanced location of facilities (less isolation) - Balanced offer of therapeutic programs (differentiation) - Offer of therapeutic programs in search of excellence - Reduce/balance the use of substitution drugs - Reduce/balance the use of occupational therapies - Awareness/definition of market position - Balanced dimension of facilities (according with position) <p>► More Professionalized Approach (Adding Value)</p> <ul style="list-style-type: none"> - Evidence-based practice (proven results) - Highly trained teams (balanced combination of academic backgrounds and practical experience) - Presentation of cost/benefit analyses - Use of reasoned / objective / consensual indicators - Use of metric indicators - Comparison & replication of results (benchmarking) - Use of Quality standard procedures and manuals - Use of customized global management software programs - Use of EHR and develop THR (Therapeutic Health Records) - Use of coding procedures (ICD9-ICD10 and DSM V) - Billing of all activities performed - Alignment with DRG practices - Explore possibilities of collecting data and applying Big Data / Internet Industrial / Business Intelligence in the sector

⁶³ Bale, Richard N. (1979) "Outcome Research in T.C. for Drug Abusers: A Critical Review 1963-1975", International Journal of Addictions, Volume 14, Number 8, pp 1053-1074.



Data on the following points will be presented to complete and complement several affirmations in this Chapter:

- ▶ Detailed list of all TCs opened in Portugal between the 70s and 2014;
- ▶ History of the installed capacity (*No. of TCs and No. Of Beds - licensed vs. registered*);
- ▶ History of clinical production developed between 1996 and 2011

III.2 – List of TCs since the 70s

Table XVII (*part 1*) – Appearance of TCs in Portugal (*Therapeutic Communities*)

N	Name TC + Organization Name	Area	Type of Organ.	Year open	Year close	Mentors	Capacity	
							L	R
1	TC Arco-íris / CEPD Center	Coimbra	Govern.	1978	-	Carlos A. Dias	12	12
2	TC Restelo / CEPD South	Lisboa	Govern.	1978 1986	1984 -	Nuno A. Ribeiro Domingos Neto	20	20
3	TC Fanhões / <i>Desafio Jovem (Teen Challenge)</i>	Fanhões/Loures	Assoc.	1981	-	Pastor Lucas Silva	31	31
4	TC Casa Azul / <i>Assoc. Le Patriache Sec. Port.</i>	S.J. Madeira	Assoc.	1985	2004	-	50	-
5	TC Qta. Lapas / <i>Le Patriache-Dianova (1999)</i>	Torres Vedras	IPSS	1986	-	-	100	40
6	TC Aldeia de Eiras / <i>Ares Pinhal Ass. Rec. Tox.</i>	Mação/Sant.	IPSS	1986	-	Nuno Miguel	18	18
7	TC Chão Lopes / <i>Ares Pinhal Ass. Rec. Tox.</i>	Mação/Sant.	IPSS	1988	-	Nuno Miguel	14	14
8	TC Casa Alcaide / <i>Ass. J. Tejo (hj CT Luis Barros)</i>	Qt. Conde/Palm.	IPSS	1989	-	-	21	21
9	Ctr. Acolh. Penafiel / <i>Associação Remar</i>	Penafiel	Assoc.	1989	-	-	-	-
10	TC ERA / <i>Emp. Rec. e Apoio (1ª priv. c/ fins luc.)</i>	Lisboa/Silves	Company	1990	-	-	29	0
11	TC Azinheiro / <i>GATO – Grupo Ajuda Toxic.</i>	Estói/Faro	IPSS	1990	-	-	30	24
12	TC Encontro / <i>Cáritas Diocesana Coimbra</i>	Maiorca/F.Foz	IPSS	1991	-	-	25	25
13	TC Quinta Bianchi / <i>Clínica do Outeiro</i>	Bagunte/V.Con.	IPSS	1991	-	Freitas Gomes	43	0
14	TC Parede CRETA / <i>Cl. Trat. Toxic. Alcool. Adição</i>	Parede/Oeiras	Company	1991	-	-	20	0
15	TC Cup. Miranda / <i>Ct.. Sol. Braga - Proj. Homem</i>	Braga	IPSS	1991	-	-	60	60
16	TC Murtal / <i>FPEPTT Fund. Prev. Est. Trat. Toxic.</i>	Murtal/Parede	IPSS	1991	2001	-	12	12
	TC Casa da Barragem / <i>FPEPTT</i>	Alcabideche		(2001)	-	-	46	37
17	TC Ant. Lopez Aragón Hom. / <i>C. Dioces. Évora</i>	Évora	IPSS	1992	-	-	20	20
18	TC Ant. Lopez Aragón Mulheres /	Évora					15	15
19	TC CRATO / <i>Centro Rec. Alcool. e da Toxicod.</i>	Grijó/Gaia	Company	1992	2010	-	23	0
20	TC São Fiel / <i>Fund. Frei Manuel Pinto Fons.</i>	C. Branco	IPSS	1992	2004	-	34	6
21	TC O Farol / <i>Ass. P/O Tratam. das Toxicod.</i>	Sintra	IPSS	1992	-	-	24	0
22	TC Rinchoa / <i>Ares Pinhal Ass. Rec. Tox.</i>	Rinchoa/Sintra	IPSS	1993	-	Nuno Miguel	23	0
23	TC Picapau / <i>Ass. Pic. Ctr. Form. e Rec Toxicod.</i>	Almoster/Sant.	IPSS	1993	-	-	20	20
24	TC CVP Qta. Tornada / <i>Com. Vida e Paz</i>	V. Pinheiro/Lrs.	IPSS	1993	-	-	65	52
25	TC Modo Viver / <i>Modo Viver, Ass. Reab. Tox.</i>	Serpa/Beja	IPSS	1993	1999	-	8	8
26	TC UTITA / <i>Un. Trat. Int. Toxic. Alcool. - Marinha</i>	Lisboa	Govern.	1993	-	-	14	14
27	TC Quinta do Anjo / <i>Erguer - Ass. Reab. Tox.</i>	Palmela	IPSS	1994	-	-	24	24
28	TC Stª Marinha / <i>Ctr. Soc. Ap. Tox.- Conv. Frat. II</i>	Avanca/Aveiro	IPSS	1994	-	Carlos Fugas	25	25
29	TC Stª Luzia /			1994	-		17	10
30	TC Lugar Manhã Grelhal / <i>Ass. Pr. Am. Cri. V. Fig.</i>	Setúbal	IPSS	1994	-	Carlos Fugas	9	9
31	TC Lugar Manhã Vale da Rasca /	V. Rasca/Setúb.		1994	-		18	18
32	TC Vale de Acór / <i>Ass. Vale Acór - Proj. Homem</i>	Almada	IPSS	1994	-	-	15	0
33	TC Casa Grande / <i>PPVSCV, Ass. Desenv. Social</i>	Mozelos/Aveiro	IPSS	1994	-	-	20	15
34	TC Reencontro / <i>Sta. Casa Miseric. Campo Maior</i>	Campo Maior	IPSS	1994	2007	-	17	17
35	TC Casarão /						20	20
36	TC da Carvalha / <i>Ass. Prev. Cons. Tóxicos</i>	Arruda Vinhos	IPSS	1994	2012	-	10	10
37	TC Qta. Golfinho / <i>Nv. Front. – Ass. Reab. Tox.</i>	Carregueira/Ch.	IPSS	1994	2013	-	41	24
38	TC Qta. Pai Poldro /	Ulme/Chamusc					35	??
39	TC de Azeitão / <i>Entender - Ass. Reab. Tox.</i>	Brejo Azeitão	IPSS	1994	??	-	??	??
40	TC RAN / <i>RAN, Lda – Rec. Alc. e Narcóticos</i>	Vila Real	Company	1995	-	-	14	0

Table XVII (part 2) – Appearance of TCs in Portugal (Therapeutic Communities)

N	Name TC + Organization Name	Area	Type of Organ.	Year open	Year close	Mentors	Capacity	
							L	R
41	TC Padre Cruz / Ass. Invest. Trat. Adição	Fátima/Ourém	IPSS	1995	1999	-	30	30
42	TC Qta. Sol Magrelos / Associação SER (TC later transferred to ART management)	Magrelos/M. Canaveses	IPSS	1995	Transf. ART	-	30	20
43	TC Minha Casa / Assoc. Minha Casa	O. Marinho/Ób.	IPSS	1996	-	-	22	8
44	TC da Montanha / Ass. Cristã Mocid. Beira Int.	Covilhã	IPSS	1996	2006	-	14	14
45	TC Ponte dos Rios / Provilei – Ass. Solid. Soc.	Leiria	IPSS	1996	2011	-	10	10
46	TC R12 / R12 – Ctr. Rec.Doenças Adição Lda	Ovar/Aveiro	Company	1996	2011	-	14	-
47	TC Sol Nascente / Ass. Sol Nasc. Rec. Toxic.	1º - Azambuja Pinhal Nv./Set.	IPSS	1996	-	-	14	14
48	TC Servir / Servir - Ass. Ap. à Toxicodependência	Benavente/Set.	IPSS	1996	-	-	??	??
49	TC Fonte da Prata / Centro da Fonte da Prata	Alhos Vedros	IPSS	1996	-	-	??	??
50	TC do Fárrio / ARADO – Ass. Ap.Reins. Des. Op.	Ourém	IPSS	1996	-	-	31	24
51	DC/TC J. Guilh. P. Hom. Abrantes / C.S.I. Ab.	Abrantes	IPSS	1996	-	-	40	40
52	TC D. Maria Amélia P. Hom. Abrantes /	Abrantes		1996	Ap.Rei.	-	26	26
53	TC Freiria / Ass. Rec. Reins. Soc. Toxic.	Sob. Mt. Agraço	IPSS	1996	??	-	7	7
54	TC Adictum / Adictum Acons. em Toxicod.	Cascais	Company	1996	2006	-	16	0
55	TC A Ponte / Associação A Ponte	Grândola	IPSS	1997	-	-	18	18
56	TC CVP Fátima / Com. Vida e Paz	Fátima/Ourém	IPSS	1997	-	-	70	70
57	TC Clínica Adaúfe / Semp. Crescer Coop.Sol.Soc.	Adaúfe/Braga	IPSS	1997	-	Júlio M. Vaz	40	0
58	TC Plátano / Plátano - Ctr. Apoio Adictos, Lda	Cascais	Company	1998	??	-	??	??
59	TC da Tapada – P. Homem / C. Dioces. Vila Real	Vila Real	IPSS	1998	-	-	35	25
60	DC SAE / Serviços Aconselhamento Espinho	Espinho	Company	1998	-	-	-	-
61	TC Horta Nova / Cáritas Diocesana Beja	Beja	IPSS	1998	-	-	32	30
62	TC Lua Nova / ANA Jovem – Ass. Nac. Apoio Jov.	Coimbra	IPSS	1998	-	-	14	14
63	TC Alter / Desafio Jovem (Teen Challenge)	Alter Chão	IPSS	1999	-	-	34	27
64	TC do Meilão / Associação Norte Vida	Ág. Santos/Maia	IPSS	1999	??	-	20	20
65	TC Rumo Certo / Ap. T. Dep. Quim.Outrs. Adi.	Palmela	Company	1999	2014	-	20	12
66	TC Qta. Horta da Nora / ART- Ass. Resp. Terap.	Castro Verde	IPSS	1999	-	-	80	30
67	TC Dr. Nuno R. Santiago / Clín. Dr. N. Sant. Lda	Fafe	Company	1999	-	Nuno R. Santiago	55	38
68	TC Viagem de Volta / Ass. Viagem de Volta	Bombarral	IPSS	2000	-	-	26	20
69	TC Viver Mais / Terap. Alc. e Toxic. Unip.	Braga	Company	2001	-	-	12	9
70	TC Cucujães / Desafio Jovem (Teen Challenge)	Cucuj./O. Azem.	IPSS	2001	-	-	25	20
71	TC Villa Ramadas / Ramadas, Sv. Ac. Dep. Lda	Alcobaça	Company	2002	-	Eduardo Silva	25	0
72	TC Clínica Beco com Saída / Ct. Trat. D. Ad. Lda	Chaves	Company	2002	-	-	16	3
73	TC S F. Assis / Domus Fraternitas - Fd. Sol. Soc.	Braga	IPSS	2002	-	-	21	17
74	TC Sol Por Hoje / A Clin. Sol P/ Hj.Clin. Psicot. Lda	Grijó/Gaia	Company	2002	2012	-	20	12
75	TC CRTT / CRTT – Clin. Rec. Trat. Toxic. Lda	Carregal Sal	Company	2003	-	-	25	20
76	TC C. Rainha-Nadadouro / Ass. Foz – Rec. Tox.	Caldas Rainha	IPSS	2003	-	-	15	12
77	TC Casas Santiago / Entre Pontes, C.T. Rei. Ad.	Belmonte	Company	2005	-	-	20	8
78	TC Monte da Lua / Moonheal – Couns. Serv. Lda	Sintra	Company	2005	2013	-	10	0
79	TC Ponte da Pedra / IDT	Matosinhos	Govern.	2006	-	-	32	32

Table XVII (part 3) – Appearance of TCs in Portugal (*Therapeutic Communities*)

N	Name TC + Organization Name	Area	Type of Organ.	Year open	Year close	Mentors	Capacity	
							L	R
80	TC Dorial-Qta. Tapada / Dorial Saúde Ment. Lda	Luso/Mealhada	Company	2006	-	José Dória	18	0
81	TC Crescer em Loures / Ass. Luis Per. Mota	Loures	IPSS	2006	2013	-	27	??
82	TC Odessa / Tratam. Depend. Lda	Bombarral	Company	2007	2013	-	14	4
83	TC Cleanic / Programa Portage Lda	VN Gaia	Company	2010	-	-	28	0
84	TC Villa Ramadas Feteira / Ram, Sv. Ac. Dep. Lda	Alcobaça	Company	2010	-	Eduardo Silva	18	0
85	TC Liberdade XXI / Liberdade XXI Lda	Ovar	Company	2012	2014	-	14	0
86	TC Heritage / Counselling Services Lda	Sintra	Company	2013	-	-	??	??
87	TC Clínica Linha de Água / Ct.Rec. Alc. Toxic. Lda (ex-Odessa)	Bombarral	Company	2013	-	-	14	??
88	TC Aceitar / Aceitar, Cdentro Tratam. Lda (ex-Liberdade XXI)	Ovar	Company	2014	-	-	14	??

Note 1: all bibliographical references of Table XVII can be found in the PT version of this document.

Note 2: in the part "Capacity" L corresponds to "Licensed beds" and R to "Registered beds".

Note 3: the yellow color corresponds to TCs closed and the no. of beds for Capacity, when in *italics* are between 1995 and 1998.

Note 4: the most accurate reconstitution possible to the opening dates, requesting the contribution of stakeholders for further rectification.

III.3 – Installed Capacity

III.3.1 – Total number of licensed as opposed to registered TCs between 1997 and 2011

Table XVIII – Total No. TCs: Licensed Vs Registered (1997-2011) (TCs)

Year	Total No. TCs Licensed	Total No. TCs Registered	% TCs Registered in the total Licensed
1997	66	33	50,0 %
1998	65	54	83,1 %
1999	68	56	82,4 %
2000	66	54	81,8 %
2001	74	62	83,8 %
2002	74	62	83,8 %
2003	-	63	-
2004	-	61	-
2005	-	62	-
2006	70	64	91,4 %
2007	73	60	82,2 %
2008	67	62	92,5 %
2009	67	62	92,5 %
2010	65	62	95,4 %
2011	65	61	93,8 %

Note 1: all bibliographical references of Table XVIII can be found in the PT version of this document.

Note 2: in 2003/04/05, it was impossible to obtain the total number of licensed TCs.

III.3.2 – Total number of licensed as opposed to registered beds between 1996 and 2011

Table XIX – Total No. Licensed Vs Registered Beds (1996-2011) (TCs)

Year	Total No. Beds Licensed	Total No. Beds Registered	% of registered beds in the total Licensed
1996	-	454	-
1997	1.692	650	38,4 %
1998	1.694	800	47,2 %
1999	1.744	1.050	60,2 %
2000	1.751	1.055	60,3 %
2001	-	1.226	-
2002	-	1.226	-
2003	-	1.206	-
2004	-	1.220	-
2005	-	1.298	-
2006	-	1.339	-
2007	-	1.288	-
2008	2.154	1.516	70,4 %
2009	2.098	1.516	72,3 %
2010	2.062	1.516	73,5 %
2011	2.112	1.530	72,4 %

Note 1: all bibliographical references of Table XIX can be found in the PT version of this document.

Note 2: for 1996 and from 2001 to 2007, it was impossible obtain the total number of licensed beds.

III.4 – Production (*Clinical Movement*)

III.4.1 – Total number of patients admitted to licensed units between 2003 and 2011

Table XX – Patients admitted in licensed TCs (2003-11) (TCs)

Year	Total No. Patients Admitted in TCs (Licensed)	Trend (▲ ▼)	(%) Percentage Variation
2003	4.081	-	-
2004	4.179	▲	+ 2,3 %
2005	4.161	▼	- 0,4 %
2006	4.118	▼	- 1,0 %
2007	4.423	▲	+ 6,9 %
2008	4.567	▲	+ 3,2 %
2009	4.451	▼	- 2,5 %
2010	4.375	▼	- 1,7 %
2011	3.996	▼	- 8,7 %

Note 1: all bibliographical references of Table XX can be found in the PT version of this document.

III.4.2 – Number of patients admitted to public and registered units between 1996 and 2011

Table XXI – No. patients admitted TCs public & registered (1996-2011) (TCs)

Year	Total No. Patients Admitted TCs (Public + Registered)	Trend (▲ ▼)	(%) Percent. Variation
1996	333	-	-
1997	858	▲	+ 61,2 %
1998	1.195	▲	+ 28,2 %
1999	2.357	▲	+ 49,3 %
2000	2.586	▲	+ 8,9 %
2001	2.897	▲	+ 10,7 %
2002	2.943	▲	+ 1,6 %
2003	2.948	▲	+ 0,2 %
2004	2.975	▲	+ 0,9 %
2005	3.012	▲	+ 1,2 %
2006	3.036	▲	+ 0,8 %
2007	3.167	▲	+ 4,1 %
2008	3.385	▲	+ 6,4 %
2009	3.601	▲	+ 6,0 %
2010	3.626	▲	+ 0,7 %
2011	3.142	▼	- 13,3 %

Note 1: all bibliographical references of Table XXI can be found in the PT version of this document.

III.4.3 – Number of patients admitted to private units between 2003 and 2011

Table XXII – No. patients admitted in private TCs (2003-11) (TCs)

Year	Total No. Patients Admitted TCs (Private)	Trend (▲ ▼)	(%) Percentage Variation
2003	1.133	-	-
2004	1.204	▲	+ 5,9 %
2005	1.149	▼	- 4,6 %
2006	1.082	▼	- 5,8 %
2007	1.256	▲	+ 13,9 %
2008	1.182	▼	- 5,9 %
2009	850	▼	- 28,1 %
2010	749	▼	- 11,9 %
2011	854	▲	+ 12,3 %

Note 1: all bibliographical references of Table XXII can be found in the PT version of this document.

III.4.4 – Overall Comparison: patients admitted to all units (TCs and CRA-UAs - 1996-2011)

Table XXIII – Patients admitted TCs and CRA-UAs Overall Comparison (1996-2011) (TCs)

Year	Total No. Patients Admitted TCs (Licensed)	Total No. Patients Admitted TCs (Public + Registered)	Total No. Patients Admitted TCs (Private)	Total No. Patients Admitted CRA-UAs
1996	-	333	-	-
1997	-	858	-	-
1998	-	1.195	-	-
1999	-	2.357	-	-
2000	-	2.586	-	-
2001	-	2.897	-	-
2002	-	2.943	-	1.212
2003	4.081	2.948	1.133	1.250
2004	4.179	2.975	1.204	1.243
2005	4.161	3.012	1.149	1.292
2006	4.118	3.036	1.082	1.265
2007	4.423	3.167	1.256	-
2008	4.567	3.385	1.182	1.229
2009	4.451	3.601	850	1.137
2010	4.375	3.626	749	1.074
2011	3.996	3.142	854	811

III.4.5 – Number of days staying in public TCs between 2001 and 2011

Table XXIV – No. of staying days Public TCs (2001-11) (TCs)

Year	No. Staying Days	Trend (▲ ▼)	(%) Percentage Variation
2001	9.733	-	-
2002	10.256	▲	+ 5,1 %
2003	10.089	▼	- 1,6 %
2004	8.410	▼	- 16,6 %
2005	9.943	▲	+ 15,4 %
2006	15.882	▲	+ 37,4 %
2008	17.027	▲	+ 6,7 %
2009	16.405	▼	- 3,7 %
2010	17.127	▲	+ 4,2 %
2011	15.929	▼	- 7,0 %

Note 1: all bibliographical references of Table XXIV can be found in the PT version of this document.

Note 2: data from 2006 reflect the opening of the Ponte da Pedra TC.

Note 3: CRAP closed UA at 29.10.2010 and integrated it in the Northern U. Detox of IDT.

III.4.6 – Number of days staying in registered TCs between 2002 and 2011

Table XXV – No. of days registered TCs (2001-11) (TCs)

Year	No. Staying Days	Trend (▲ ▼)	(%) Percentage Variation
2002	360.956	-	-
2003	366.206	▲	+ 1,4 %
2004	354.061	▼	- 3,3 %
2005	379.832	▲	+ 6,8 %
2006	385.928	▲	+ 1,6 %
2007	366.334	▼	- 5,1 %
2008	416.191	▲	+ 12,0 %
2009	453.102	▲	+ 8,1 %
2010	448.864	▼	- 0,9 %
2011	421.368	▼	- 6,1 %

Note: all bibliographical references of Table XXV can be found in the PT version of this document.

CHAPTER IV – Dissuasion

IV.1 – Framework

Dissuasion emerges as a complementary strategy for a drug using population with its own idiosyncrasies, who had not been supplied with any existing response nor were they seeking specialized support for their problem.

The so-called decriminalization law (*Law No. 30/2000, of 29 November*) established a new system applicable to the use of illicit psychoactive substances whose initial aim was to be of added value in terms of primary prevention for those dependent on chemicals by introducing illicit substance users to healthcare services.

The aim is to remove behavior considered a crime from criminal courts, turning it into an administrative infraction in terms of reducing demand and another way of indicating and sending individuals using illicit substances to specialized support services, removing users from courts and steering them away from the stigma of a criminal record.

Decriminalization of use and possession for use, within the established limits, will grant jurisdiction to process infractions and apply respective sanctions to commissions called Addiction Dissuasion Commissions (CDTs) especially created for this purpose, located in district capitals (*DL No. 130-A/2001, of 23 April*), 18 of which start operating in 2001.

It must be noted that there is no difference between the types of illicit psychoactive substance used, frequency of use and usage practices and processes and that CDTs are intended for use as mediating platforms in the local response network for the identification and early detection of those accused as being high-risk users and addicts. This model included a set of humanistic principles with CDTs attempting to offer an alternative response to the user's situation as oppose to the repressive and criminalizing paradigm of more traditional approaches.

Their aim is to assess the accused and the latter's situation with regard to the use of the substance, considering existing facilities and responses and facilitating referral and monitoring of the sanctions applied. Besides placing health facilities in contact with people not seeking help, there is also a possibility of referring to these facilities those in whom the Government invested technically and financially and who abandoned therapeutic projects and suffered relapses or who were undergoing treatment but continued to purchase and use drugs.

This Law was believed to have great potential from the very start, especially for cannabis users, so a constant attempt was made to show how different interveners always sought to censor such conduct, which is still unlawful and punishable in Portugal, by continuing to convey a message of social reprimand.

Between 2002 and 2007, there are repeated complaints about a divestment tendency in the area, which had effective repercussions on the application of the law, legitimating of the legislative framework in force and credibility and respect of entities involved. For several reasons, it is very difficult for the IDT to establish and standardize practices and procedures, implement and optimize follow-up of CDTs in order to obtain a different understanding of the enforcement of the Law and the theoretical model itself.

Only from 2008 onwards is this situation inverted through the resolution of some points constantly mentioned as impeditive of better performance of CDTs. 2009 will be noted for international recognition and visibility of the Portuguese drug and alcohol policy, with special emphasis on the CATO Institute report issued by Glenn Greenwald, *"Drug Decriminalization in Portugal: lessons for creating fair and successful drug policies"*.

This interest and recognition of the operation of the Portuguese model had a very positive internal impact and improved people's knowledge of it and the work performed by CDTs in the prevention and referral of addicts to health facilities. This included work carried out on a network with police and court authorities, as well as civil government authorities at the time.

This whole consolidation process ends up by being undermined in 2012 by the huge transformations made to the sector with the abolition of the IDT and creation of the SICAD. CDTs are the only operational wing remaining under the supervision of the new central body. This new layout obliges a new strategy to be formed in which the technical outlook for the sector is often confronted, in organizational terms, with political pressure from the Secretary of State for Health, but which is still very unclear and unstable.

Basically, Dissuasion was considered a new and different area of intervention in the Portuguese system from the very start (and later on it was internationally recognized) although it did not back the potential of the operational approach and measures (CDTs) as anticipated, which was possibly due to the different changes listed above.

IV.2 – Total number of processes opened by Dissuasion Commissions - 2001-2013

Table XXVI – No. processes opened CDTs (2001-2013) (*Dissuasion*)

Year	Total No. Processes Opened in CDTs	Trend (▲ ▼)	(%) Percent. Variation
2001	2.248	-	-
2002	6.025	▲	+ 62,7 %
2003	6.785	▲	+ 11,2 %
2004	5.899	▼	- 13,1 %
2005	7.365	▲	+ 19,9 %
2006	6.975	▼	- 5,3 %
2007	7.453	▲	+ 6,4 %
2008	7.364	▼	- 1,2 %
2009	8.441	▲	+ 12,8 %
2010	7.870	▼	- 6,8 %
2011	7.388	▼	- 6,1 %
2012	9.046	▲	+ 18,3 %
2013	9.316	▲	+ 2,9 %
-	92.175	▲	(+ 8, 5 %)

Note: all bibliographical references of Table XXVI can be found in the PT version of this document.

CHAPTER V – Conventions (*registered beds*)

V.1 – Evolution and framework

This chapter is aimed at providing an understanding of the role and importance of *Conventions* in the area of addictions through a broad description of changes and modifications made to it between the late 80s and 2013. The Government always needs a particular legal framework to enable it to provide support to institutions developing primary, secondary and tertiary prevention activities in this specific field.

In the late 80s, drug-related problems concern modern societies, causing situations whose complexity and horizontal nature required joint intervention by the Government, families, private institutions and Portuguese citizens. In an initial phase, non-governmental organizations (NGOs) occupy the empty space and seek solutions for a new and complex problem. When they address the Government, they request and stress the need to receive two types of support: technical and financial.

It is in this environment that, in 1988, a legal document is published that will advocate and establish the first procedures to be followed by NGOs performing or wishing to perform activities in this area. Its aim is to prioritize treatment and reintegration solutions, through allocating facilities and equipment or technical and financial support to non-profit-making NGOs.

The *Projecto Vida* will be a new public administration structure aimed at improving flexibility and speed, adapting its intervention with the many other participants involved in the process at this stage such as ARSs, CRSSs, IEPF job centers and district branches of the Support Fund for Youth Organizations.

The *Projecto Vida-Coordination Group* (PV-CG) will be responsible for performing a technical and scientific analysis of requests for technical or financial support for subsequent approval. This will entail the monitoring, assessment and inspection of activities by ministerial bodies involved and coordination and supervision by the PV-CG.

In 1991, a new legal document is published to amend, improve and complete the definition of support to be granted. It will contain the name of these instruments established as "*Cooperation Agreements*" and underline the need to introduce clauses reflecting the obligation to treat patients, regardless of their own or their family's economic status.

Other relevant progress includes presentation of the first indication and definition of establishments to receive financial aid: **DC** - Day Centre; **CREP** - Long Stay Residential Community
RF - Reintegration Flat; **EASD** - Direct Social Support Teams

Each government department involved in implementing *Projecto Vida* measures should take responsibility for distributing financial charges established as percentages. This situation is not at all functional for NGOs as it obliges interaction with many representatives to obtain the money.

An average monthly amount is also established per patient, which could be updated every year. The first amounts established (DC - \$15,000; CREP and RF - \$90,000) are known to have been obtained through negotiations between the PV-CG and institutions in an attempt to assimilate them with the real and effective average cost of each activity performed at the time.

Introductions of different legal instruments regulating these matters reflect a sharp awareness of the need to create quick and effective responses in secondary and tertiary prevention areas in terms of treatment and reintegration. The truth is that despite the more objective approach taken of the whole support process, there is clearly still a large margin of discretion with regard to its assessment but this Government option is understandable in a temporal, social and political context.

A change in cycle is evident when the first socialist government comes into power (1995-99) and the importance of this problem is stressed by the participation of an increasing number of Government services and bodies, which calls for greater involvement of society as a whole, especially NGOs.

Experience gained warrants the need to facilitate the understanding of different intervention areas and tools in order to optimize resources created in the meantime and clarify eventual grey areas or those with overlapping powers. It is concluded that more effective intervention is required through modernizing the current system by reviewing subjects covered, determining percentages of subsidies provided by official bodies and NGOs and clarifying the responsibility for supplying financial aid and respective access criteria.

It is in this context, in 1996, that concepts used are redefined to match current technical advances. This affects more initiatives through different forms of financial aid for their *installation and cooperation agreements to maintain their activities*. It also includes establishing a relationship between the amount of financial aid provided, the total cost and maximum duration of activities and treatments performed, limiting the total amount granted to 80%.

This requires a *consent form* to be issued by the SPTT for admission of patients receiving financial aid and the amount of subsidies granted are based on lists of names to be supplied on a monthly basis. Another important change is the speed at which financial aid is supplied to institutions for maintaining activities, in which only the SPTT is involved (for CREP and DC) instead of three or four interveners.

In 1998, regulations for entering into agreements are established, in compliance with the *Basic Law on Health* published in 1990, which already defended a mixed health system model, paying particular attention to the complementarity and competitive nature of the private sector and social economy and integrating a broad concept of a national healthcare network. One of the mainstays of this view is the patient's free choice of duly certified healthcare providers that guarantees access by everyone to all areas of healthcare, regardless of their economic status.

These assumptions show us that, in the health sector in general, this situation conditions the terms and content of future agreements without abdicating from gradual improvement in Government intervention, accompanied by the profitability of installed capacity. It is the first document to make such clear reference to division into a profitable private sector based on social solidarity. This guarantees secure investment and stability through separation of private and public sectors and also facilitates people's choice of the medical profession outside the NHS as well.

This required that the sector be given credibility based on its connection to the NHS, triggering conflicting aspects that ensure its competitiveness. The definition of the *Convention* will be clarified and more well-founded and standardized rules established through presentation of more accurate and concise criteria of services to be contracted and the need for central bodies to create monitoring and control mechanisms for conventions signed.

1999 sees a review of the legal framework where support is granted for private addiction institutions in operation, which will henceforth be guided by 3 structural principles:

- ▶ It ceases to finance institutions themselves and starts to contribute towards costs payable by patients for treatment provided at private units;
- ▶ Priority of public investment in treatment given to the promotion of access conditions and profitability of existing resources, that is, after expanding the infrastructures network, is focused on the equity and effectiveness of the system's response capacity;
- ▶ Financial support can be granted to any private institutions, even though they are for-profit, with a view to increasing the system's response capacity.

The new support system is implemented with a view to achieving the goal of 1.000 registered beds provided for treatment of drug addicts under financial agreements signed with the Government. A new service is created, the *physical detox clinic*, as well as an alternative to a prison sentence applicable by courts. This point becomes obligatory for private units wishing to enter into conventions.

This renewed legal framework also included a new classification of support instruments, which are divided into 3 different items:

- ▶ Conventions: contracting of healthcare services for drug addicts;
- ▶ Cooperation Agreements: promotion of social reintegration activities;
- ▶ Installations Protocols: equipment for treatment or reintegration of drug addicts;

These specific support instruments do not interfere with other existing social aid and protection mechanisms but we should specify the difference recognized by law that these forms of Government support are only intended for contributing to costs payable by patients for treatments provided by private units and **not for paying the real costs of same**.

TCs maintain financial support of up to a maximum of 80% of the average monthly price established by law and a maximum support of only 80% of all beds through the signing of conventions. Treatment duration times are also increased and there is a possibility that the family be charged up to an extra 15% of the maximum price established for the patient's personal expenses.


Basically, in the late 90s, the PV loses its influence and it is clear that the Ministry of Health should be the sole administrator of the system, through the SPTT, and will be responsible for the monitoring, inspection, control and payment of conventions. The obvious intention is to create a national treatment unit network (TCs, DCs and Detox Clinics) and standard clauses will be inserted into Conventions to reinforce its uniformity.

The IDT will assume the responsibilities of the three Regional Alcoholism Centers following their closure, which will be part of a broader reform of the Ministry of Health that entails redefinition of organizational models of services offered. This central body operates all over the country and has five regional branches whose main responsibilities are: to support policy development, plan, coordinate and develop treatment programs for reducing risks and minimizing damages, social reintegration, dissuasion from use, licensing of social and private sector units and definition of technical and therapeutic requirements and entering into agreements or conventions.

The central scheme of the 1999 convention system required compliance with financing requisites, procedures, mechanisms and criteria for services supplied and no decision had been pronounced since that time, whereby rules and amounts in force had to be updated.

The legal support framework is revised in 2008, offering alcoholics the chance to benefit from treatments formerly offered only to illicit substance addicts, although substantially different treatment times were established for the former in this initial phase. Conventions signed continue to comply with standard clauses, paragraph k), which mentions new *Specific Programs* for TCs: *Minors & Adolescents, Pregnant Women, Comorbidity*, with prevention of acceptance of the same patient in a TC or DC also imposed after two unscheduled or one scheduled release in the following six months.

2011 sees a change in the political cycle due to economic difficulties that lead to the arrival of the Troika, forcing the country to reduce public expenditure, whereby a new organic Law issued by the MH and its direct and indirect administrative bodies is approved. The SICAD is created and the IDT closed and prevention of addictive behavior and other addictions is increased, opting for the closure of a central specialized building that started to be built in 1975/76 in the area of drugs and, later on, alcohol. The ARSs then became responsible for the direct operation of this type of healthcare policies and licensing, and IGAS for inspection.



Basically, a central government body in the field of addiction is no longer responsible for the regulation, planning, financing, orientation, monitoring, assessment, auditing and inspection of public and private healthcare services. Before 2013, *Conventions* meant the establishment of a special Government contracting model with private operators supplying healthcare services based on adhesion contracts, which were only available for individuals or private companies complying with the requirements contained in the standard clauses, approved by a Minister of Health Dispatch.

Therefore, at the end of the year, a new convention model is defined that is more flexible in terms of procedures, enabling conventions to have a regional or national scope and to be signed according to one of the following procedures: contract adhering to standard clauses previously published or following a specific contracting procedure. Conventions covering an integrated or wide range of services (bundled) may also be signed, as an exception to the rule.

The choice of the type of contracting procedure must consider the area in which the services are to be supplied and the nature and characteristics of the market to which the convention is addressed. Therefore, in highly competitive markets, the specific contracting procedure is more adequate as oppose to the adhesion contract, which will be preferable for low-competition markets. It must be remembered that convention contracts must comply with the principles of equity, complementarity and freedom of choice and guarantee quality standards.

The choice of the type of contracting procedure is determined by the Minister of Health, based on a proposal from the ARS or ACSS, depending on whether it is regional or national. It also depends on a non-binding prior opinion of the ERS, in accordance with the characteristics of the market to which the convention is addressed (competition, service supply area and nature).

Convention contracts must also pursue the following objectives:

- Readiness, continuity, proximity and quality;
- Efficient distribution and allocation of NHS resources (flexible management and competitive mechanisms;
- Quality promotion (required license and indexation of quality standards for access to financing)

The procedure program and specification must indicate the content of conventions signed based on specific procedures and their competitive aspects. The procedure to follow for adhesion to standard clauses must be defined by the ACSS in conjunction with ARSs.

Prices established for conventions relating to addiction are subject to a dispatch containing minimum prices required for supposedly guaranteeing the quality of healthcare services supplied under normal competitive conditions. The ARS is responsible for payment of convention charges, be they regional or national, and ULS (Local Health Units) for payment of registered entities, with regard to patients from their area of influence.

The duties of registered entities are rather general and contract provisions are remitted to conventions. Monitoring, control, quality, accessibility and full compliance with conventions must also be guaranteed by ARSs that, under the coordination of the ACSS and in conjunction with IGAS, must confirm the supply of healthcare services invoiced and the corresponding cash flow. The law also establishes that ARSs are responsible for monitoring and controlling registered acts and respective expenses.

At the end of 2013, requirements are established that must be complied with for conventions between the Government (SICAD) and private health units, through a dispatch that revises and updates that published in 2008, with regard to financing procedures, mechanisms and criteria for services supplied under a convention. These are considered national conventions signed between the former IDT or preceding bodies and private health units.

The signing of conventions requires compliance with standard clauses that will be increasingly comprehensive and demanding but is not accompanied by the same type of review as the financial component. Many limitations previously imposed (financing limit of 80% of the maximum price established or total beds) will be maintained and no substantial changes will be made to public or private operator rules. The difference between Government financing and maximum prices established, as appropriate, is still also payable by the patient or the family in addition to 15% of the maximum price still payable as pocket money.

Maximum prices are established annually, based on the inflation rate, according to a joint Dispatch issued by the Minister of Health and Finance and Government subsidies will continue to be processed according to lists of names to be supplied every month to the ARS-DICAD of the patient's area of residence by the institution. This means that each institution must have seven instead of only one representative (former IDT) to collect the amount owed for the convention that is 5 ARSs from the Mainland and 2 from the Autonomous Regions (Azores and Madeira Islands).

This Chapter is particularly important as it focuses on one of the system's central components and as we know that it would be imperative to start very serious discussions, without taboos, on this instrument that has a permanent effect on this sector despite it having caused great discord or disputes. The current model has many limitations that do not allow new attractive methods to be established in different fields and may reinvent it.

The following points will be focused on for further reflection on the subject:

- ▶ History of the most relevant legislation between 1988 and 2013;
- ▶ Identification, definition and evolution of types of services supported between 1991 and 2013;
- ▶ Identification and evolution of specific programs between 2008 and 2013;
- ▶ Evolution of maximum values established and reimbursed per service between 1991 and 2013;
- ▶ Evolution of maximum times established and reimbursed per service between 1996 and 2013;
- ▶ Global amount payable to direct service providers for conventions between 1997 and 2011.

V.2 – Relevant legislation timeline between 1988 and 2013

Table XXVII (part 1) – Timeline of relevant law on Conventions (*Conventions*)

N	Year	Legislation	Synthesis / Relevant facts
1	1988	► Despacho Conjunto of 20 April, PCM/Defense/Justice/Education/Employ. & Soc. Security	<ul style="list-style-type: none"> - <u>Appointment of the Group to Coordinating the “Proyecto Vida (PV)”</u> • Also with the specific prerogatives in terms of treatment
2	1988	► Despacho Conjunto of 19 May, PCM/Health/Employment & Social Security	<ul style="list-style-type: none"> - <u>Definition of technical and financial support from the PV-CG</u> • Technically & financially support non-profit NGOs for primary, secondary & tertiary prevention for drug addiction • Determines 7 criteria for attributing technical & financial supp.
3	1991	► Despacho Conjunto of 18 Dec. 1990, PCM/Health/Employment & Social Security	<ul style="list-style-type: none"> - <u>First clearer and more objective definition of support to be granted</u> • It determines through 12 specific points • For the first time IPSS and other particular institutions are mentioned but always non-profit making • Instrument “<i>Cooperation Agreements</i>” containing specific clauses • First definition of establishments to fund: <u>Day Center - DC</u> / <u>Long Stay Resi. Com.</u> - CREP / <u>Reintegration Flat - RF</u> / <u>Direct Social Support Teams - EASD</u> • First definition of distribution of financial charges: <u>DC</u> (Fam 20%/CRSS 35%/ARS 20%/IJ 25 %) / <u>CREP</u> (Fam 20%/CRSS 60%/ARS 20%) / <u>RF</u> (Fam 20%/IEFP 80%) / <u>EASD</u> (ONG 10%/CRSS 50%/IJ 40%) • Establishes average monthly cost per patient: <u>DC</u> (15.000\$) / <u>CREP</u> (90.000\$) / <u>RF</u> (90.000\$) • It mentions the possibility of the amounts being updated annually
4	1991	► Despacho Conjunto of 1 de April, PCM/Health/Employment & Social Security	<ul style="list-style-type: none"> - <u>It introduces improvements to the previous Joint-Dispatch</u> • It mentions the urgent need to create responses • It continues to mention only private non-profit organizations • Alters definition of <u>RF</u> and Professional Training sessions • Subsidies to <u>EASD</u> will have their own global & indiv. budget
5	1996	► Resolução Conselho Ministros nº 3/96 of 21 December 1995	<ul style="list-style-type: none"> - <u>It determine the unification of “PV” into a single document</u> • It proposes that a general review be made of the PV in an attempt to clarify its role
6	1996	► Despachos Conjuntos (2) of 9 October, PCM/Health/Qualif. Emp. Solid. Soc. Securi.	<ul style="list-style-type: none"> - <u>Dispatch 1</u> • It approves the financing regulation of NGOs/IPSSs operating in the field of drug addiction • Review of services to be covered; it defines percentages; subsidies from official bodies; it clarifies financing responsibility and respective access criteria • It redefines concepts used in response to technical development • Different funding for “Facilities” and “Activities” • It establishes a relationship between the amount financed, total cost and maximum duration of activities and treatments performed • It defines max. supp. at 80 % of total cost of max. amounts estab. • It obliges registered organizations to have a license or permit • Max. <u>DC</u> & <u>CREP-TC</u>: treatments to 6 months extendable to 1 year & <u>RF</u> 6 months with no extension • Difference between “Cooperation Agreements” for maintaining activities and investment - <u>Dispatch 2</u> • It establishes the average monthly cost per patient: <u>DC</u> (15.000\$) / <u>TC-CREP</u> (150.000\$) / <u>RF</u> (90.000\$) • EASD subsidies individual budget approved for each case

Table XXVII (part 2) – Timeline of relevant law on Conventions (*Conventions*)

N	Year	Legislation	Synthesis / Relevant facts
7	1997	► Lei nº 7/97 of 8 March, Assembly of the Republic	<ul style="list-style-type: none"> - Expands public service network for addiction treat. & reintegration • It defines public services network in Art 2º: 1 CAT per district; Detox Unit 1 bed p/ 100.000 inhab. / TCs 1 bed p/ 10.000 inhab.
8	1997	► Despacho Conjunto of 28 January, PCM/Health/Qualif. Emp. Solid. Soc. Secur.	<ul style="list-style-type: none"> - Clarifies Regulations for Funding NGOs treating addictions • New Cooperation Agreement for Social Solid. signed in meantime • Changes to Art 5º transfers charges to SPTT: DC (Fam 20%/SPTT 80%) / TC-CREP (Fam 20%/SPTT 80%) RF (Fam 20%/CRSS 80%) / EASD (Other 20%/CRSS 80%) • It conditions DC and TC funding to the issue of SPTT consent form with organizations signing a cooperation agreement for maintenance of activities • It maintains DC & TC max. treatment until 6 m extendable to 1 year
9	1997	► Despacho Conjunto of 31 January, PCM/Health/Qualif. Emp. Solid. Soc. Secur.	<ul style="list-style-type: none"> - Setting maximums prices for 1997 • Average monthly cost per patient: DC (25.000\$) / TC-CREP (150.000\$) / RF (90.000\$) • EASD subsidies individual budget approved for each case
10	1998	► Decreto-Lei nº 97/98 of 18 April, Ministry of Health	<ul style="list-style-type: none"> - It regulates the signing of conventions mentioned in the Law no. 40/90 (Basic Health Law) • First reference to division into private for-profit sector and with social solidarity purposes in the registered sector and its connection with the NHS to clearly distinguish between private and public sectors • Clearer definition of "Convention" (Art 3) and other points for greater consistency • Enforcement defined for Conventions is 5 years with automatic renewals for the same period • Present more accurate and concise criteria for the signing of Conventions in 15 articles
11	1998	► Lei nº 17/98 of 21 April, Assembly of the Republic	<ul style="list-style-type: none"> - It regulates public funding for investment projects in secondary prev. • Drug addiction is only for non-profit organizations • Present more accurate and concise criteria in 10 articles
12	1999	► Decreto-Lei nº 72/99 of 15 March, Presidency of Council of Ministries	<ul style="list-style-type: none"> - It reg. system for supp. treatment & social reintegration of addicts • It mentions financial support to private organizations and attempts to follow 3 structural principles: <ul style="list-style-type: none"> 1- Families and patients at the center with financial support, ceases to finance the organization and starts to subsidize the costs to be paid by the patients in private units 2- After an extension period of the service network, it attempts to focus on guaranteeing equity and effectiveness of the response given by the general treatment system (resource profitability) 3- Funding becomes available for any private organization, even with for-profit aim • It seeks to establish a goal of 1000 registered beds nationwide • It includes the new service physical detox clinics • It establishes mechanisms that only permit conventions to be signed with org. accepting treatments as an alternative to prison sentences • It typifies 3 support tools: Conventions / Cooperation Agreements / Facilities Protocols
13	1999	► Despacho Conjunto nº 261-A/99 of 22 March, PCM/Ministry of Health	<ul style="list-style-type: none"> - Sets conventions requirements SPTT/private org. & max. prices 1999 • It mentions the goal to create a national treatment units network (TC/DC/PDC – Physical Detox Clinic) • It maintains max. supp. to 80 % total cost for DC & TC & 100 % PDC • Sets max. prices chargeable in 1999: Average monthly cost per patient: DC (27.000\$-m) / TC-CREP (165.000\$-m) / PDC (13.700\$-day) • It increases max. treatm. periods DC and TC until 1 year extendable for + 6 months / PDC (6 to 10 days)

Table XXVII (part 3) – Timeline of relevant law on Conventions (*Conventions*)

N	Year	Legislation	Synthesis / Relevant facts
14	2007	► Decreto-Lei nº 221/2007 of 29 May, Ministry of Health	<ul style="list-style-type: none"> - <u>It approves IDT organics</u> • Agreements and conventions may only be signed with private licensed organizations • IDT is the successor in assignments to Reg. Alcology Centers (CRAs)
15	2008	► Despacho Conjunto 18683/2008 of 16 June, M. Finances/M. Health	<ul style="list-style-type: none"> - <u>Set conv. requirements IDT/private organiz. & max. prices 2008</u> • Recognizes since 1999 no decision was reached on the matter • <u>Extends conventions to alcoholics</u> (except physical detox) • It creates <u>Specific Programs</u> (Minors & Adolescents / Pregnant / Double Diagnosis) • Requirements set forth in clauses becomes increasingly demanding • It maintains max.supp. at 80 % total cost/ DC & TC & 100 % PDC • Set maximum prices chargeable in 2008: Average monthly cost per patient: <u>DC (150 €-m) / TC-CREP (900 €-m) / PDC (75 €-day) / Spec. Prog.-TC (1000 €-m)</u> • It maintains max. treatm. period DC & TC until 1 year extends + 6 months / PDC (10/14/21 days) & for <u>alcoholics only 3 months</u>, extendable for only more 3 months
16	2011	► Decreto-Lei nº 124/2011 of 29 Nov., Ministry of Health	<ul style="list-style-type: none"> - <u>It approves the new organic Law of the Ministry of Health</u> • Preamble refers closure IDT & new SICAD (<i>Art 13º defines new serv.</i>) • Art. 23 confirms <u>licensing to ARSs & inspection by IGAS</u>
17	2012	► Decreto-Lei nº 17/2012 of 26 January, Ministry of Health	<ul style="list-style-type: none"> - <u>Approves SICAD organics</u> • It maintains duties: planning, monitoring, assessment, prevention • Interventions are henceforth performed by ARSs
18	2012	► Decreto-Lei nº 22/2012 of 30 January, Ministry of Health	<ul style="list-style-type: none"> - <u>Approves new ARSs organics</u> • To “accommodate” duties for which IDT was previously responsible • Former oper. “wing” of the IDT (CRIs) transferred DICAD in ARSs
19	2013	► Decreto-Lei nº 139/2013 of 9 October, Ministry of Health	<ul style="list-style-type: none"> - <u>Legal system for NHS conventions in national healthcare network</u> • It updates DL nº 97/98 (<i>see Art 6 regarding convention content</i>)
20	2013	► Despacho Conjunto 16938/2013 of 02 September, M. Finances/M. Health	<ul style="list-style-type: none"> - <u>Sets conv. requirements SICAD/private org. & max. prices 2013</u> • Updates proced., mechanisms & financ. criteria in conventions • Agreements made with SICAD but payments made by ARSs • Introduces assessments from the DICAD residential area (<i>con. forms</i>) • It remains impossible to enter into conventions with physical detox clinics for alcoholics • Creates new spe. prog. (<u>Long-term Programs-LTP</u>) besides P. Gen. • Maintain mx.supp. at 80 % total cost/ DC & TC & 100 % PDC + TC-LTP • Average monthly cost per patient: <u>DC (150€-m) / TC-PG (900€-m) / PDC (75€-day) / SP-TC (1000€-m) / LTP-TC (800€-m)</u> • Max. treat. period: <u>TC-GP SP</u> until 1y ext. + 6m / <u>GP-Alcohol</u> until 6m ext. + 6m / <u>DC</u> until 6m ext. + 3m / <u>LTP-TC</u> until 3y ext. + 1y /PDC (10/14/21 days)

Note: all bibliographical references of Table XXVII can be found in the PT version of this document.

V.3 – Identification, definition and evolution of types of services supported

Table XXVIII – Type of services/establishments supported (1991-2013) (*Conventions*)

Year	Name + Abbreviation	Definition
1991	<ul style="list-style-type: none"> ▶ Day Center (<i>DC</i>) ▶ Resid. Comum. Long Stay (<i>CREP</i>) ▶ Reintegration Flat (<i>RF</i>) ▶ Direct Social Supp. Teams (<i>EASD</i>) 	<ul style="list-style-type: none"> • <u>DC</u>: out-patient treatment response • <u>CREP</u>: in-patient medium-long term response • <u>RF</u>: in-patient response (<i>post CREP</i>) • <u>EASD</u>: resource for crisis situations
1999	<ul style="list-style-type: none"> ▶ Day Center (<i>DC</i>) ▶ Therapeutic Community (<i>TC</i>) ▶ Physical Detox Clinic (<i>PDC</i>) 	<ul style="list-style-type: none"> • <u>DC</u>: out-patient treatment response • <u>TC</u>: in-patient medium-long term response • <u>PDC</u>: in-patient short term response
2008	<ul style="list-style-type: none"> ▶ Day Center (<i>DC</i>) ▶ Therapeutic Community (<i>TC</i>) ▶ Physical Detox Clinic (<i>PDC</i>) 	<ul style="list-style-type: none"> • <u>DC</u>: out-patient treatment response • <u>TC</u>: in-patient medium-long term response • <u>PDC</u>: in-patient short term response
2013	<ul style="list-style-type: none"> ▶ Day Center (<i>DC</i>) ▶ Therapeutic Community (<i>TC</i>) ▶ Physical Detox Clinic (<i>PDC</i>) 	<ul style="list-style-type: none"> • <u>DC</u>: out-patient treatment response • <u>TC</u>: in-patient medium-long term response • <u>PDC</u>: in-patient short term response

Note: all bibliographical references of Table XXVIII can be found in the PT version of this document.

V.4 – Identification and evolution: Specific Programs

Table XXIX – Specific Programs (2008-2013) (*Conventions*)

Year	General Program + Specific Programs + Abbreviations	Applicable in Typology
2008	<ul style="list-style-type: none"> ▶ General Program Drugs (<i>GP-Dr</i>) ▶ General Program Alcoholics (<i>GP-AI</i>) ▶ <i>Specific Program Minors & Adolescents</i> (<i>SP-M&A</i>) ▶ <i>Specific Program Pregnant</i> (<i>SP-Pr</i>) ▶ <i>Specific Program Double Diagnostic</i> (<i>SP-DD</i>) 	<ul style="list-style-type: none"> • <u>DC / TC / PDC</u> • <u>DC / TC</u> • <u>TC</u> • <u>TC</u> • <u>TC / PDC</u>
2013	<ul style="list-style-type: none"> ▶ General Program Drugs (<i>GP-Dr</i>) ▶ General Program Alcoholics (<i>GP-AI</i>) ▶ <i>Specific Program Minors & Adolescents</i> (<i>SP-M&A</i>) ▶ <i>Specific Program Pregnant</i> (<i>SP-Pr</i>) ▶ <i>Specific Program Double Diagnostic</i> (<i>SP-DD</i>) ▶ <i>Specific Program Long-Term</i> (<i>SP-LT</i>) 	<ul style="list-style-type: none"> • <u>DC / TC / PDC</u> • <u>DC / TC</u> • <u>TC</u> • <u>TC</u> • <u>TC / PDC</u> • <u>TC</u>

Note: all bibliographical references of Table XXIX can be found in the PT version of this document.

V.5 – Evolution of maximum values established and reimbursed per service 1991-2013

Table XXX – Maximum amounts established & reimbursed per service (1991-2013) (*Conventions*)

Type of Service	Fixed Cost per Patient (maximum amount + reimbursed amount)					
	1991	1996	1997	1999	2008	2013
► Day Center (DC)	• <u>15.000 \$</u> (12.000 \$)	• <u>15.000 \$</u> (12.000 \$)	• <u>25.000 \$</u> (20.000 \$)	• <u>27.000 \$</u> (21.600 \$)	• <u>150 €</u> (120 €)	• <u>150 €</u> (120 €)
► Therapeutic Community (CREP-TC) –Gen. Prog.	• <u>90.000 \$</u> (72.000 \$)	• <u>150.000 \$</u> (120.000 \$)	• <u>150.000 \$</u> (120.000 \$)	• <u>165.000 \$</u> (132.000 \$)	• <u>900 €</u> (720 €)	• <u>900 €</u> (720 €)
• TC – Specific Programs (Min.&Adol./Preg./D.Diag.)	-	-	-	-	• <u>1.000 €</u> (800 €)	• <u>1.000 €</u> (800 €)
• TC – Specific Program (Long Term)	-	-	-	-	-	• <u>800 €</u> (800 €)
► Physical Detox Clinic (PDC)	-	-	-	• <u>13.700 \$/d</u> (13.700 \$/d)	• <u>75 €/d</u> (75 €/d)	• <u>75 €/d</u> (75 €/d)
► Reintegration Flat (RF)	• <u>90.000 \$</u> (72.000 \$)	• <u>90.000 \$</u> (72.000 \$)	• <u>90.000 \$</u> (72.000 \$)	-	-	-

Note: all bibliographical references of Table XXX can be found in the PT version of this document.

V.6 – Evolution of maximum periods and extensions established per service 1996-2013

Table XXXI – Maximum periods & extensions established per service (1996-2013) (*Conventions*)

Type of Service	Period of time established per patient (maximum time + extensions)			
	1996	1999	2008	2013
<ul style="list-style-type: none"> ▶ Day Center (DC) • DC – General Program (Alcoholics) 	<ul style="list-style-type: none"> • <u>6 m + 6 m = 12 m</u> - 	<ul style="list-style-type: none"> • <u>12 m + 6 m = 18 m</u> - 	<ul style="list-style-type: none"> • <u>12 m + 6 m = 18 m</u> • <u>3 m + 3 m = 6 m</u> 	<ul style="list-style-type: none"> • <u>6 m + 3 m = 9 m</u> • <u>6 m + 3 m = 9 m</u>
<ul style="list-style-type: none"> ▶ Therapeutic Community (CREP-TC) – GP Drugs • TC – General Program (Alcoholics) • TC – Specific Programs (Min.&Adol./Preg./D.Diag.) • TC – Specific Program (Long Term) 	<ul style="list-style-type: none"> • <u>6 m + 6 m = 12 m</u> 	<ul style="list-style-type: none"> • <u>12 m + 6 m = 18 m</u> 	<ul style="list-style-type: none"> • <u>12 m + 6 m = 18 m</u> • <u>3 m + 3 m = 6 m</u> 	<ul style="list-style-type: none"> • <u>12 m + 6 m = 18 m</u> • <u>6 m + 6 m = 12 m</u> • <u>12 m + 6 m = 18 m</u> • <u>36m + 12m = 48 m</u>
<ul style="list-style-type: none"> ▶ Physical Detox Clinic (PDC) • PDC – Specific Program (Double Diagnostic) 	<ul style="list-style-type: none"> - - 	<ul style="list-style-type: none"> • <u>6 d + 4 d = 10 days</u> - 	<ul style="list-style-type: none"> • <u>6 d + 4 d = 10 days</u> • <u>6 d + 4+11 = 21 d</u> 	<ul style="list-style-type: none"> • <u>6 d + 4 d = 10 days</u> • <u>6 d + 4+11 = 21 d</u>
<ul style="list-style-type: none"> ▶ Reintegration Flat (RF) 	<ul style="list-style-type: none"> • <u>6 m = 6 m</u> 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> - 	<ul style="list-style-type: none"> -

Note: all bibliographical references of Table XXXI can be found in the PT version of this document.

V.7 – Global amount payable for conventions to direct providers 1997 to 2011

Table XXXII – Annual convention costs 1997-2011 (*Conventions*)

Year	Conventions Costs <i>Escudos/ Euros</i>	Trend (▲ ▼)	(%) Percentage Variation
1997	462.739 \$	-	-
1998	905.298 \$	▲	+ 48,9 %
1999	1.571.661 \$	▲	+ 42,4 %
2000	1.633.069 \$	▲	+ 3,8 %
2001	1.837.852 \$	▲	+ 11,1 %
Total SPTT	6.410.619 \$ (31,9 millions €)	▲	(+ 26,55 %)
2002	9.110.721 €	▼	- 0,5 %
2003	9.043.853 €	▼	- 0,7 %
2004	8.695.737 €	▼	- 3,8 %
2005	9.038.050 €	▲	+ 3,8 %
2006	9.143.498 €	▲	+ 1,2 %
2007	10.543.434 €	▲	+ 13,3 %
2008	9.365.789 €	▼	- 11,2 %
2009	11.651.313 €	▲	+ 19,6 %
2010	11.583.113 €	▼	- 0,6 %
2011	11.500.000 €	▼	- 0,7 %
Total IDT	99.675.508 € (99,6 millions €)	▲	(+ 2,00 %)
Accrued 1997-2011	131.675.508 € (131,6 millions €)	▲	(+ 2,04 %)

Note 1: SPTT global percentage weighted average, calculated over 4 years.

Note 2: IDT global percentage weighted average, calculated over 10 years.

Note 3: Accrued weighted average, calculated over 14 years.

ABBREVIATIONS

- Abbreviations used

Abbreviation	Meaning
UN	▶ United Nations
CEJ	▶ Youth Study Center
CIJD	▶ Drug Criminal Investigation Center
CEPD	▶ Drug Addiction Prevention Research Center
CICD	▶ Drug Control and Research Center
GCCD	▶ Drug Fighting Coordination Office
GPCCD	▶ Drug Fighting Planning and Coordination Office
NA	▶ Narcotics Anonymous
FA	▶ Families Anonymous
MH	▶ Ministry of Health
SPAT	▶ Prevention and Support Center for Addicts
CAT	▶ Drug Addiction Treatment Center
EMCDDA	▶ European Monitoring Center for Drugs and Drug Addiction
EEC	▶ European Economic Community
LAAM	▶ Levo Alpha Acetyl Methadol
INFARMED	▶ National Institute for Pharmacy and Medicine
RRMD	▶ Reduction of Risks and Minimizing Damages
ANF	▶ National Association of Pharmacies
SPTT	▶ Drug Addiction Prevention and Treatment Service
CDT	▶ Commission for the Dissuasion of Drug Addiction
IDT	▶ Institute for Drugs and Drug Addiction
PORI	▶ Operational Integrated Responses Plan
PRI	▶ Integrated Response Program
CRA	▶ Regional Alcoholology Center
TC	▶ Therapeutic Community
SIM	▶ Multidisciplinary Integrated System
SICAD	▶ Gen.-Directorate Intervention on Addictive Behaviors & Dependencies
IAP	▶ Institute of Psychiatric Care
NHS	▶ National Health Service
ARP	▶ Alcohol-related Problems
SPA	▶ Portuguese Alcoholology Society
DGCSP	▶ General-directorate of Primary Healthcare
DGS	▶ General-directorate of Health
WHO	▶ World Health Organization
ARS	▶ Regional Health Department
CRAP	▶ Regional Porto Alcoholology Center
CRAN	▶ Regional North Alcoholology Center
CRAC	▶ Regional Coimbra/Center Alcoholology Center
CRAL	▶ Regional Lisbon Alcoholology Center
CRAS	▶ Regional South Alcoholology Center
CRSS	▶ Regional Social Security Center
IEFP	▶ Employment & Professional Training Institute
ERS	▶ Health Regulation Authority
IGAS	▶ Inspectorate-general of Health Activities

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