



# **Austerity and the Portuguese Drug Policy Model**

*An exploratory mixed method research*

2015

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in People we trust

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The image of the cover is a wordcloud generated with Nvivo software. It represents the frequency of the most used words by the interviewees. “People” is the most frequent word.

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# Abbreviations and Acronyms

<b>ACES</b>	Agrupamentos de Centros de Saúde [Health Centres' Clusters]
<b>ARS</b>	Administração Regional de Saúde [Regional Administration of Health]
<b>CAD</b>	Centros de Aconselhamento e Detecção Precoce [Counselling and Early Detection Centres]
<b>CAT</b>	Centros de Atendimento a Toxicodependentes [Care Centre for Drug Addicts]
<b>CDS-PP</b>	Partido do Centro Democrático e Social – Partido Popular [Christian Democratic – People's Party]
<b>CDT</b>	Comissões para a Dissuasão da Toxicodependência [Commissions for Dissuasion of Drug Addiction]
<b>CRI</b>	Centros de Respostas Integradas [Integrated Responses Centres]
<b>D</b>	Decision-makers
<b>DCR</b>	Drug Consumption Rooms
<b>DGS</b>	Direção-Geral da Saúde [Directorate-General of Health]
<b>DICAD</b>	Divisão de Intervenção nos Comportamentos Aditivos e Dependências [Intervention Division in Behaviours and Additives in Dependencies]
<b>E</b>	Experts
<b>ECDC</b>	European Centre for Disease Prevention and Control
<b>EMCDDA</b>	European Monitoring Centre for Drugs and Drug Addiction
<b>ER</b>	Emergency room
<b>ERS</b>	Entidade Reguladora da Saúde [Portuguese Health Regulation Authority]
<b>ET</b>	Estruturas de Tratamento [Treatment Facilities]
<b>FG</b>	Focus Group
<b>HR</b>	Harm Reduction
<b>IDT</b>	Instituto da Droga e da Toxicodependência [Institute on Drugs and Drug Addiction]
<b>IEFP</b>	Instituto do Emprego e Formação Profissional [Employment and Vocational Training Institute]
<b>IMF</b>	International Monetary Fund
<b>INE</b>	Instituto nacional de Estatística [Statistics Portugal]
<b>INSA</b>	Instituto Nacional de Saúde Dr. Ricardo Jorge [National Health Institute Doutor Ricardo Jorge]
<b>IP</b>	Instituto Público [Public Institute]
<b>IPDT</b>	Instituto Português da Droga e da Toxicodependência [Portuguese Institute of Drugs and Drug Addiction]
<b>IPSS</b>	Instituições Privadas de Solidariedade Social [Private Institutions of Social Solidarity]

<b>LVT</b>	Lisboa e Vale do Tejo [Lisbon and Vale do Tejo region]
<b>MoU</b>	Memorandum of Understanding
<b>MSESS</b>	Ministério da Solidariedade, Emprego e Segurança Social [Ministry of Solidarity, Employment and Social Security]
<b>NGO</b>	Non-Governmental Organisation
<b>NPS</b>	New Psychoactive Substances
<b>NSP</b>	Needle and Syringe Programme
<b>NUTS</b>	Nomenclature of Territorial Units for Statistics
<b>P</b>	Professionals
<b>PJ</b>	Polícia Judiciária [Judicial Police]
<b>PREMAC</b>	Plano de Redução e Melhoria da Administração Central [Plan for the Reduction and Improvement of the Central Administration]
<b>PRI</b>	Programa de Respostas Integradas [Programme of Integrative Responses]
<b>PORDATA</b>	Database of Contemporary Portugal
<b>PORI</b>	Plano Operacional de Respostas Integradas [Operational Plan of Integrative Responses]
<b>PSD</b>	Partido Social Democrata [Social Democratic Party]
<b>PVE</b>	Programa Vida-Emprego [Life Employment Programme]
<b>PWID</b>	People Who Inject Drugs
<b>PWUD</b>	People Who Use Drugs
<b>OECD</b>	Organisation for Economic Cooperation and Development
<b>OPSS</b>	Observatório Português dos Sistemas de Saúde [Portuguese Observatory of Healthcare Systems]
<b>RSES</b>	Rede de Serviços e Equipamentos Sociais [Social Services and Responses Network]
<b>RSI</b>	Rendimento Social de Inserção [Social benefit]
<b>SICAD</b>	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências [Intervention on Addictive Behaviours and Dependencies]
<b>EU</b>	European Union
<b>UNAIDS</b>	Joint United Nations Programme on HIV and AIDS
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>WHO</b>	World Health Organization

# Introduction

The idea to study the impact of austerity measures on drugs came first from professionals that work in the harm reduction field with excluded populations. The challenges reported by them have been more difficult to overcome in recent years. Solicitations for social support had been increasing and the answers from the Portuguese Central State services were getting harder to obtain. The professionals felt real changes, caused by some alarming signs: the bureaucratisation of services, the cuts on social protection budgets and the deterioration of the life conditions of their users. The idea of studying the phenomenon emerged from the outbursts of some professionals, but we needed more data to design the research. We started to analyse more carefully data that arrived from Greece: the alarming HIV outbreak (e.g., Malliori, Terzidou, Paraskevis & Hatzaki, 2011<sup>1</sup>, **Pharris et al., 2011**<sup>2</sup>); mandatory health examinations for groups considered at risk (Health Regulation No. GY/39A); worrying changes in social and health policies (e.g., Kentikelenis et al., 2011<sup>3</sup>); increasing harms and low coverage of harm reduction responses (e.g., Paraskevis et al., 2013<sup>4</sup>). Greece was not the mirror we wished to look at.

At the same time, in Portugal, there were narratives coming from official services on drug use that seemed to have gone back in time. The addictive nature of drug use seemed to overcome a more comprehensive and sociological perspective of drugs and its users (SICAD, 2013<sup>5</sup>). A lot of things were happening and drug services were also suffering the effects of structural changes and challenges (Cf: Coordination on matter of drugs).

When addressing the concrete changes that professionals felt on the field, it would not be honest to neglect other confounding dimensions. What do these narratives mean? If they do mean something, does their expression changes the way we think and respond to drug problems? Is this an impact of austerity measures or of ideological changes? Were any of them mediator variables of one another?

Before delineating the research questions and starting to study the phenomenon, we knew that addressing the effects of austerity or any other variable on the drug field would be a hard thing to do. First, the passionate debate that the Portuguese Drug Policy Model (PDPM) raises is misleading and responsible for exacerbating positions and arguments and by dragging the debate to the *faith* level. Both the supporters of its “resounding success” (Hughes and Stevens, 2012)<sup>6</sup> and of its “disastrous failure” (*ibidem*) contribute to the dogmatic thinking that surrounds the drug phenomenon. Perhaps it is still the reason why it is so difficult to make evidence-based studies or gather consensus around this subject, even when the same data are being considered (*ibidem*). This does not mean that researchers on the drug field should do *tabula rasa* of their political position or concern about

- 1 Malliori, M., Terzidou, M., Paraskevis, D., & Hatzaki, A. (2011). HIV/AIDS among IDUS in Greece: report of a recent Outbreak and initial response policies. Retrieved [www.emcdda.europa.eu/news/2011/update1/greek-report](http://www.emcdda.europa.eu/news/2011/update1/greek-report)
- 2 Pharris, A., Wiessing, L., Sfetcu, O., Hedrich, D., Botescu, A., Fotiou, A., Nikolopoulos, G.K., Malliori, M., Salminen, M., Suk, J. E., Griffiths, P., & van de Laar, M. J. (2011). Human immunodeficiency virus in injecting drug users in Europe following a reported increase of cases in Greece and Romania. *Euro Surveill* 16(48) Retrieved <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20032>
- 3 Kentikelenis A, Karanikolos M, Papanicolas I, Basu S, McKee M, & Stuckler, D. (2011). Health effects of financial crisis: omens of a Greek tragedy. *Lancet* 378(9801), 1457-1458.
- 4 Paraskevis, D., Nikolopoulos, G., Fotiou, A., Tsiara, C., Paraskeva, D., Sympa, V, Lazanas, M., Gargalianos, P., Psychogiou, M., Skoutelis, A., Wiessing, L., Friedman, S., Jarlais, D., Terzidou, M., Kremastinou, J., Malliori, M., Hatzakis, A. (2013). Economic Recession and Emergence of an HIV-1 Outbreak among Drug Injectors in Athens Metropolitan Area: A Longitudinal Study. Yang R, ed. *PLoS ONE*, 8(11). Retrieved <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3827120/>
- 5 SICAD (2013). Plano nacional para a redução dos comportamentos aditivos e das dependências - 2013-2020. [http://www.portaldasauade.pt/NR/rdonlyres/E920478E-66F7-4083-8D09-3BED11A012B1/0/PNRCAD\\_2013\\_2020.pdf](http://www.portaldasauade.pt/NR/rdonlyres/E920478E-66F7-4083-8D09-3BED11A012B1/0/PNRCAD_2013_2020.pdf)
- 6 Hughes, E.; Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. *Drug and Alcohol Review*, 31, 101 – 113. DOI: 10.1111/j.1465-3362.2011.00383.x



the subject. Becoming aware of the personal beliefs that surround the study implies not only a critical view on epistemological and methodological positions, but also on political and ideological positions. That effort was made by the authors and the design of the research was developed in order to seek for exemption.

The Portuguese Drug Policy Model is, according to its main inspirers (Estratégia Nacional de Luta contra Droga, 1999<sup>7</sup>), based on humanistic and pragmatic principles; these principles (that contributed to the worldwide acknowledged Portuguese model of decriminalisation) should influence the interventions and the studies developed. However, as we will see, this model means more than the sole decriminalisation of the use of all illicit drugs (Law 30/2000, November 29<sup>th</sup>). It involved a structural change in the way the country responded to drug use; for example, by recognising the crucial role of harm reduction services (Decree-Law 183/2001, June 21<sup>st</sup>). This model is a good example of how drug policies can be based on participative methodologies. In this case, the policy outlines are based on recommendations made by experts that genuinely combined science and the contributions of “real people” from the “real world”. Furthermore, and maybe the most important, this model also represents a clear message: problems associated with drug use aren’t an exclusive concern of people who use drugs, their families and friends. As we will see, drug use is a matter intrinsically connected with Social State that involves the community as a whole.

*“Defined the strategy, it is now the moment to act. And it is good to have no illusions: drug is not a problem of others, of others’ families, of the children of others. Drugs cannot be an exclusive concern of others - experts, professionals, authorities or politicians. We’ve built a strategy together; together we’ll fight”* (José Sócrates, Deputy Minister of the Prime Minister in 1999, in Estratégia Nacional de Luta contra Droga, 1999, p.8).

This message was disseminated during the development of specialised responses and programmes, scheduled to create and support governmental and non-governmental projects able to reach those who were “out-of-reach” until that time.

The main challenge of this research was to fulfil the wishes of professionals in this field and to understand how austerity was associated with the internationally praised PDPM. Therefore, the study was conceived in a particularly important moment of changes and uncertainty. Despite being a strategic time to explore those connections (if they even exist), it also posed a considerable challenge to our research, since the phenomenon we intended to study was changing while we were trying to “capture it with our lens”. Other issues were the difficulty to isolate economic restriction policies from other confounding variables and the obstacles to the collection of updated data.

Nevertheless, monitoring what is happening now, in this actual and unique moment, is an opportunity that cannot be lost; its explicative power will be useful to analyse, in a very near future, macro-indicators describing this period. Therefore, this study tries to understand how the current austerity measures can possibly change

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7 Estratégia Nacional de Luta contra Droga, 1999. Ministério da Saúde – Instituto da Droga e da Toxicodependência (4ª edição-2006). Imprensa Nacional-Casa da Moeda.

the lives of people who use drugs and the services they use. We also aimed to analyse if the implementation of the Portuguese Drug Policy Model had recently suffered any changes and to what extent those could be associated with the intrinsic properties of the model or with the context of the economic and financial crisis. In order to enhance the contextual dimensions of the study – and considering the opportunity to use the very concrete moment of instability as a living lab for the research – we took the time to make an exploratory and participatory research, by collecting points of view of key-actors: people who use drugs, professionals (including peer educators), decision-makers and researchers. Since the goal was to develop a comprehensive analysis that could contribute to a deeper questioning of the phenomenon, our methodological design was based on three major elements: (i) to listen to different actors, with different backgrounds: not only the drug field, but also the healthcare, justice and social sectors; (ii) to combine different data collection methods; (iii) and to combine the narratives of those who participated in the study with the results of the research or with other documented indicators/data.

For those reasons, a mixed research method was used, thus incorporating qualitative and quantitative methodologies, in order to achieve a more complete and holistic picture of the phenomenon. Both strategies were used in parallel: the different types of information were collected simultaneously and subsequently integrated in the interpretation of the global results. Beyond the literature review and data analyses on available indicators, the collection of the primary data involved the implementation of focus groups with outreach workers and peer educators; an online questionnaire to harm reduction professionals; and semi-structured interviews with those key-actors.

The specific contents of this study reflect the dialectic nature of the research process and the challenges previously stated. We start this document with a detailed description of the methodological options of the study. In chapter 2 (*Portuguese Drug Policy Model: Deadlocks and Breakthroughs*), the main challenges of the worldwide known Portuguese Model will be explored. The topic of drug use and risk behaviours will be addressed in chapter 3 (*Drug use: trends and uncertainties*). The intrinsic association between drug policies and the welfare system will be developed in chapter 4 (*Welfare State: changes and setbacks*). In chapter 5 (“Cushion effect”), we will try to present the changes underlying drug responses as an indicator of the system’s (in) adaptation to new challenges. In this chapter we will also explain why this research topic was the first to emerge among the professionals working in the field.

By looking at the chapters’ titles, you can anticipate more than conclusions, certainties or confirmatory self-made prophecies: the results of this study aim to contribute to the contextualisation of changes in the drug field and *be more than mere ammunition for the policy battlefield* (Hughes & Stevens, 2012, p. 111).

We are now certain that there is a great distance between developing pragmatic and humanistic policies and real people’s perception of these policies. We hope to have contributed in clarifying that distance.

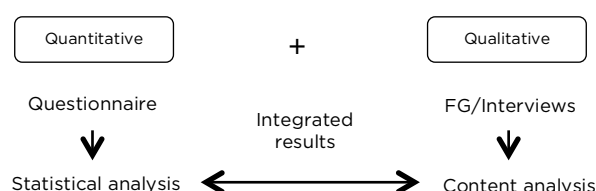
This report was written to all those interested in drugs and policies; people who use drugs; decision-makers; professionals; researchers and to activists from both sides of the fence!

# Chapter 1 | Methodology

In order to achieve a more complete and holistic profile of the phenomenon, we have integrated qualitative and quantitative methodologies in this research. As Morse suggests (1994), “because different ‘lenses’ or perspectives result from the use of different methods, often more than one method may be used within a project so the researcher can gain a more holistic view of the setting” (*Ibidem*, p. 224). Thus, a combined methodological approach favours pragmatic knowledge statements with a concern regarding the applicability (e.g. effectiveness), the consequences and the solutions to a problem (Creswell, 2007).

Regardless of this complementarity, this methodological model emphasises the qualitative methodologies. This relevance is primarily supported by the research’s investigative character: it is crucial to remember that this research aims to explore the relations between these two phenomena – the economic crisis of 2008 (Foundation Robert Schuman, 2011) and the drug issue – being the first one relatively new. As a consequence, especially in what concerns the social implications, there is still insufficient knowledge of this theme. While there are several studies on the impact of the economic crisis in broader areas of social welfare (such as healthcare and education), which have unveiled several of the variables associated with it, this does not happen in terms of the drug phenomenon. In fact, the interaction between the 2008 economic crisis and drugs has not received much attention by scientists and researchers, which explains why the variables involved are mainly unknown. Since the studied phenomena are characterised by a prominent complexity, there is an additional challenge in identifying the involved variables. In this sense, the qualitative methodologies provide a more satisfactory response.

During the implementation of this combined model, the data collection involved the compilation of quantitative information (in this case, through the use of a questionnaire) and texts (through interviews and focus groups).



Note: Adaptation of the Creswell model (2007).

In line with Flick (2009), both strategies were used in parallel: the collection of the 2 types of data was carried out simultaneously and the information was incorporated in the interpretation of the global results. Therefore, the strategy adopted was the concurrent procedure, which was also described by Creswell (2007) (see the diagram above).

## 1.1. Data collection techniques

### FOCUS GROUPS

The data was collected through focus groups and then organised and used during the first stage of the research. This was our starting point. When combined with the pre-existing research questions and the literature review, it led to the creation of data collection tools (i.e. interview guide and questionnaire).

### PARTICIPANTS

In September 2013, we conducted two focus groups consisting exclusively of technical staff involved in harm reduction projects in northern Portugal. Their composition was as follows:

Focus group 1: The 1<sup>st</sup> focus group was organised with a technical team working in a central urban area in the north of Portugal. The team had five members, one of which was a peer educator. Two of the participants were men and three were women. The average age was 34 (*range*= 32–38). Three had studied Social Sciences and one had studied Healthcare Sciences. They had an average of nine years of professional experience in HR (*range*= 5–11). It should be noted that, at the time of the invitation to join the focus group, the team had ‘frozen’ funding, but this problem was solved by the time we conducted the focus group. One of the participants was already working when the Portuguese decriminalisation model on drugs entered into force and all of them already worked in this area at the beginning of the 2008 economic crisis.

Focus group 2: The 2<sup>nd</sup> focus group involved a team working in a more peripheral area in northern Portugal – one of the main reasons why it was selected. Four professionals were involved, including one peer educator. The group was composed of three women and a man and the average age was 35 (*range*= 32–41). All of them studied Social Sciences, with an average of four years of professional experience in the HR field. None of the participants worked in this field when the Portuguese decriminalisation model on drugs entered into force and only two of them were employed when the economic crisis began.

### SEMI-STRUCTURED INTERVIEWS

For the primary data collection process, we used the technique of interview with a semi-structured setup, in order to capture the complexity that characterises the theme according to the participants’ frame of reference. As previously stated, we aimed at achieving a complementarity between the interview, as an intensive technique, and the questionnaire, an extensive technique, which also justifies the option for a semi-structured interview.

In addition, since one of the main purposes of this research was to collect the participants’ perception on the topic – which is moreover its added value –, and as it comprehends delicate ideological themes that are associated

with illegality, discrimination, identity and professional quality, the interview was confirmed as the adequate tool to give us access to all these dimensions.

During this process, the interviewer had to respect a set of key questions, but he/she was able to choose the order and the way in which the questions were presented, as well as to decide if he/she would present other questions that suited the purpose of the interview. The guide was developed in order to comprehend four main areas:

- The evolution of the Welfare State model in Portugal during the previous years and the possible relation between that same evolution and the 2008 economic crisis;
- The perception on the influence of the economic crisis and austerity measures over the services that work with drug users and over their life contexts;
- The evolution of the Portuguese Drug Policy Model and the possible relation of that same evolution with the economic crisis and austerity measures;
- The perceptions on the priority political measures of evaluation, monitoring and intervention that should be adapted in the drugs field on a medium/long-term.

In addition to each one of these domains, there was a set of guiding topics that could eventually be discussed by the interviewer, according to the spontaneous discourse of the participants. The original version of the guide was discussed with technical staff and peer educators, who made several suggestions regarding what should be changed. As a result, we were able to develop four versions of the guide, each one adapted (in terms of language and structure) to each type of key-actors involved in the research (Cf. Participants).

## **PARTICIPANTS**

Between September 2013 and December 2014, we interviewed 41 participants. Since this theme involves potentially sensitive issues, we chose to keep the participants anonymous, despite knowing that identifying them (especially those with a decision-making role or those who are experts on this theme) could be an important factor for the validation of the results of the study. To select the best to answer the research questions, we used the following parameters:

1. Type of actor: we have selected four different types of key-actors, who provided different and complementary perspectives on the phenomena being studied. They were: people who use drugs (1.1), professionals (1.2.), decision-makers (1.3.) and experts (1.4.).

**1.1.** Ten people who use drugs (PWUD) from HR services: with the exception of being involved in different projects, no particular criterion was used to select this group (it depended on the availability and motivation of the individuals). The majority were men (n=9), with ages ranging from 33 to 51 years old (mean=43) and qualifications were at the basic (n=7) and secondary (n=3) levels. The users' main sources

of income were: *Rendimento Social de Inserção*<sup>8</sup> (n=6); parallel activities (n=2); allowances (n=1) or wages (n=1). All the individuals had long consumption careers (mean=22; range= 13-30), so they continued to be in contact with drug associated contexts in the beginning of the Portuguese decriminalisation model on drugs, as well as during the economic crisis.

**1.2.** Thirteen professionals (P): the majority of them worked in HR projects (n=9), three of them were peer educators; followed by professionals from treatment facilities (n=2), reintegration (n=1) and dissuasion (n=1) services; it was not possible, however, to integrate the professionals working in prevention. Ten of them came from civil society organisations and three worked in state services. Eight participants were men and five were women and the age average was 34 (range= 27-50). In terms of education, the majority of the professionals had studied Social Sciences (n=9) and only one of them had studied Healthcare Sciences, with an average eight years of professional experience (range= 1-20) in the current field of work. Four of them were working in drug-related areas when the drugs decriminalisation law was established and eight of them were working in the beginning of the 2008 economic crisis.

**1.3.** Eight decision-makers (D): they were selected according to the compatibility of their work with the research themes and we divided them into two groups: political decision-makers from central government structures, responsible for national policies; and coordinating decision-makers – mediators who establish links between the state decision-making spheres. This group comprehended subjects who work in healthcare and drugs (n=3), social (n=1) and legal (n=2) areas, as well as two political decision-makers. Five men and three women participated in this process and the age average was 53 (range= 34-69). In what concerns the participants' academic profile, we can find the following fields of knowledge: Social Sciences (n=4), Law (n=2) and Healthcare Sciences (n=2); the average period of professional experience is 22 years (range= 10-44). Therefore, all the decision-makers (except one) were already working in this area when the drugs decriminalisation system was established.

**1.4.** Ten experts (E): they were selected due to their professional background in terms of research in drugs or related themes (e.g. public health). The pertinence, quality and quantity of the scientific work developed in their fields of expertise were the criteria used to select the participants. This group comprehended experts in drug policies (n=3); public health (n=3); employment and professional reintegration (n=3) and criminology (n=1). In terms of academic background, we were able to identify the following: Social Sciences (e.g. Economics, Sociology; n=6); Law (n=1) and Healthcare Sciences (n=3). There was an average of 26 years of professional experience (range= 14-44). All the experts were already working when the drug decriminalisation system was established. Six of them were men and four were women and the age average was 57 (range= 47-53).

**2. The Setting:** the distribution of the participants by NUTS II<sup>9</sup> was predominant in the North, being followed by Lisbon and the central region of Portugal (Figure 1). The decision-makers are distributed in Lisbon and the northern region, while the experts are predominantly located in Lisbon, followed by the

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<sup>8</sup> It is a pecuniary social benefit.

<sup>9</sup> NUTS II is a Nomenclature of Territorial Units for Statistics; it is composed by seven territorial units.

central region of Portugal and the North. Regarding the group of people who use drugs and the technical staff, they all come from the Northern region of Portugal and both groups were selected in more central and peripheral zones of that region; therefore, there's a considerable diversity of contexts the individuals belong to. On the other hand, the participants who were more relevant among professionals were the ones working in harm reduction projects, with greater numerical representation in the northern region of Portugal, in comparison to the remaining regions.

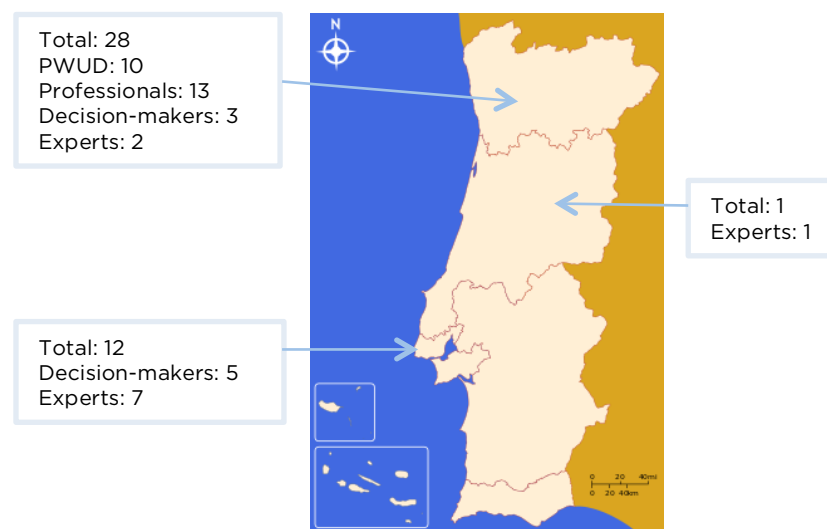


Figure 1: Distribution of the key-actor type by NUTS II.

The cluster analysis presented below (Figure 2) groups the interviewees according to the similarity of the themes discussed during the interviews. This reveals the existence of unique and distinct types of contribution among the different key-actors defined by this study. In fact, the cluster highlighted to the right comprehends the majority of PWUD, as well as the peer educators P2, P3 and P7. On the other hand, the group comprehending only two participants is thematically different from the rest, because its discourse is mainly dedicated to the legal aspects associated with drugs. The following cluster, displayed in blue, comprehends experts from the public health domain. The 4<sup>th</sup> group comprises most of professionals, who mainly come from the northern region of Portugal, with the exception of D41 and E27. Finally, the left cluster includes decision-makers and experts and it is important to emphasise that the individuals who are closer (E23, D38, P21, D20, P8 e D22) have a background training in Social Service. This analysis suggests the influence of the “group” variable, as well as other socio-demographic variables, such as the academic background, over the themes discussed by the individuals.





The questionnaire was adjusted to an electronic version, created with *Limesurvey 2.00+*. In spite of the lower control over the sample associated with this method, the online version was created as a way to increase the reach of the survey, to more participants and a wider geographical coverage. The questionnaires were collected between September 2013 and December 2014.

## **SAMPLE**

The questionnaire was designed to be applied to professionals and peer educators who intervene in the HR area in continental Portugal. Indeed, HR was selected as the main vector for the extensive data collection due its central role in the Portuguese Drug Policy Model. The invitations to participate were sent via social networks, by the institution in charge of the study and its partners/networks (e.g. R3 – *Rede de Redução de Riscos e Minimização de Danos* [HR network]), and also via e-mail and mailing lists. Those who received this information would be asked to advertise it in their own social networks pages.

A total of 100 individuals working in HR in the drugs domain participated in this questionnaire. According to the most recent statistics, there's an estimate of around 200 professionals who work in the HR field in Portugal (APDES, 2013). In what concerns the geographic distribution of the participants, 48% are from the northern region; 16% from the central region; 19% from Lisbon and 2% from Alentejo. There were no participants from Algarve or from the autonomous regions of Portugal (Azores and Madeira). Also, we were not expecting a balanced distribution of the participants of the sample, since the distribution of the universe of HR professionals in Portugal is centralised in the North and in Lisbon (IDT, 2011).

The sample consisted of 60 women and 22 men (18 participants didn't answer this question). In terms of training background, 43% studied Social Sciences, 14% Healthcare Sciences, 2% studied Law and 2% studied other subjects (39% of the participants did not answer this question). The participants' years of professional experience ranged from eight months to thirty years (mean= 10.35; *SD*= 6.85); 67% worked as technical staff, 7% as peer educators, 4% as volunteers and 5% as coordinators/directors. Finally, in terms of funding, 42% worked in teams with regularised funding; 17% were waiting for the results of the application while normally performing their work; 15% worked in teams with delayed funding; 9% didn't have any prediction about receiving funding; and finally 1% was waiting for public tender procedures, without developing any type of activity.

## 1.2. Narrative literature review

As mentioned above (Cf. Methodology), the existing scientific production associated with the theme under study is insufficient. For this reason, we have privileged the qualitative methods in this methodological design, since they allowed us to use the data to extract the variables that were relevant for this study. As a result, the literature is essentially used in an inductive way, but not only. On the one hand, the literature review (not systematic) turned out to be a vital stage to a better understanding of the 2008 financial and economic crisis processes; and to achieve a better knowledge of the evidence produced so far on the relation between the 2008 economic crisis and the peripheral domains that continue to be undoubtedly associated with the drug phenomenon (e.g. social care responses, drug-related diseases, criminality associated with drugs). On the other hand, the literature review was incorporated in the discussions of the study's results, in order to compare what was produced in the literature with the evidences that emerged during the analysis.

Among official documents, scientific publications and data analysis on available indicators, a total of 183 documents were collected. Literature review and public data systematisation were based on national and international published documents from the following sources: academic databases (e.g. Ebsco, Science Direct, Cochrane, EconLit, Medline, PsycArticles); grey databases (Google Scholar); scientific journals of interest (e.g. International Journal of Drug Policy); free access publications produced by national research groups (e.g. *Observatório Português sobre Crises e Alternativas* and *Observatório Português dos Sistemas de Saúde*); publications by international (WHO, UNODC, OECD, European Commission, World Bank, UNAIDS, ECDC, EMCDDA) and national coordination organisations (e.g. SICAD, *Polícia Judiciária*, DGS, INSA, Ministry of Health)<sup>10</sup>; as well as documents produced by national and international NGOs that work in the drugs field (e.g. OSF, Harm Reduction Coalition, Harm Reduction International).

The keywords used in this task included (in Portuguese and in English): economy, economic/financial crisis, austerity measures/policies, econometric studies and recession, combined with: illicit drugs, drug use/consumption, vulnerable populations, health/health policies, Welfare State, social policies, drug policies, harm reduction, unemployment, social determinants of health and drug related crime.

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10 *Observatório Português sobre Crises e Alternativas* [Portuguese Observatory of Crisis and Alternatives]; *Observatório Português dos Sistemas de Saúde* [Portuguese Observatory of Healthcare Systems]; *Polícia Judiciária* [Judicial Police].

## 1.3. Data analysis

### SECONDARY DATA ANALYSIS

We collected a set of statistical indicators as a secondary set of data to be used during the discussion of the results. This additional data allowed us to compare the trends found among the population with the results of this study. Thus, we looked at the data from these sources with a selective view. This data was collected from national coordination organisations in healthcare, namely those associated with illegal substances, law and social care: SICAD, EMCDDA, the Ministry of Health and the Ministry of Social Security.

### CONTENT ANALYSIS

When the focus groups and interview processes were completed, they were fully transcribed – except when the information could lead to the identification of the participants – and content analysis was made using *NVivo 10* software. The content analysis allowed us to move from description to interpretation, by highlighting the most relevant data. The analysis followed a horizontal scheme, i.e., with an inter-interview comparison and the collected data was grouped in units of analysis (categories), which were based on the issues that emerged from a first reading of the interviews. The final scheme was built as the new features emerged from an exhaustive classification of the features.

During the codification process, we selected the semantic units as registration units, more specifically the theme (Bardin, 2011). As we opted by semantic units, the implementation of a statistical inter-rater reliability became more difficult<sup>11</sup>. However, a less structured inter-rater agreement process was carried out in order to bring forth the categories and contents which were identified, in a clear, unambiguous and comparable way. This way (at an initial stage) the two classifiers in charge of the content analysis developed an independent classification system of those same contents. This was done with no communication between them, so that they could check whether there was an agreement between their two systems. This process was useful to evaluate if the categories were adequate and to improve them if necessary. After the codification process, there was a second process, to ensure its exactness: both researchers reviewed the codified excerpts and discussed the results of this stage. Whenever possible, we presented the more representative opinions, as well as the corresponding contradictions.

To present the results in the report, and whenever a certain type of key-actor is not prominent, we presented the number of respondents (n) who share similar opinions, regardless the type of actor.

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11 This happened because the content analysis was carried out with the *NVivo 10* software, a program in which the calculation of percentage agreement (*Kappa coefficient*) is volatile to small differences in the codification (e.g. spaces and commas). Since we didn't adopt a unit with more defined limits (like sentences or paragraphs), these changes became more evident.

## STATISTICAL ANALYSIS

To analyse quantitative data we used *SPSS Statistics 20.0* software. According to our objectives and characteristics of the sample, we selected descriptive statistics. *Valid Percent* was used to analyse trends and opinions. However, due to the high number of missing values observed in the analysis concerning the relation with austerity, we chose to use the *Percent*, in order to not overestimate the results.

# Chapter 2

## The Portuguese Drug Policy Model:

### deadlocks and breakthroughs in the wake of the economic crisis

The Portuguese model of decriminalisation of illicit drugs (in force since 2001) is, as we know, internationally recognised as one of the most relevant experiences regarding alternative drug policies to the prohibitionist paradigms.

According to what was introduced (Cf. Introduction) regarding the Portuguese Model, and considering the content of the participants' discourses in this study, the majority of those who focused on this topic (n=25) mentioned **the innovative character of the Portuguese decriminalisation model**, as well as its national and international acknowledgment (n=17). However, two participants stated that the model was a “conceptual mistake” (D19), since it did not manage to reduce the use of substances (P9). In line with these opinions, one of the interviewees found some limitations in the assessment of policies done so far, thus characterising this process “as strangely done and usually with a repetition of basic administrative data; in fact, it is not an assessment process of policies at all” (E39).

The Portuguese decriminalisation model has been a target of international vetting since its creation, so the **factors that determine its efficacy** are clearly interesting elements to be analysed. Among the participants who elected the most important elements for the model's efficacy (n=11): two decision-makers mentioned the legislation that led to the decriminalisation of drug use; four decision-makers and experts selected the solid and conceptually well designed Operational Plan of Integrated Responses [PORI]; other participants (one decision-maker and one expert) mentioned the fact that the Portuguese decriminalisation model was created according to a participative process that enabled the consensus among several key-actors; the fact that it had a strong social support basis – partially due to the transversal drug use among the country's social classes – was also commented by two decision-makers; and finally, the fact that the Portuguese decriminalisation model endorsed Humanist principles was highlighted by two professionals.

*“The decriminalisation was also made possible by the already existing framework, by the responses available at all levels and also the well implemented Harm Reduction policies. There were also several treatment services all over the country, there were..., there were... this allowed the development of the decriminalisation law.” (E12)*

*“I believe that, in spite of all the progressive policies developed in Portugal, the social support base was the main trigger of these policies. That same social support base is, in my opinion, associated with the transversal nature of these issues. In Portugal, these issues affected all social classes, something that did not occur in other countries, namely in European ones.” (D10)*

*“I think that the key to the success of the Portuguese decriminalisation model is the way it was created (...) all the social classes were called to reflect upon it and everybody was involved, including the police. It is better when these processes are bottom-up, instead of being imposed by the legislative bodies (...) sometimes, one can clearly see some initiatives that appear and that don't address a specific need. They're just some ideas of some theorists, which fail to be implemented later.” (D43)*

Aside from the positive opinions regarding the Portuguese decriminalisation model, **a set of obstacles to its implementation** was also identified. Some participants, mainly professionals, believed that there was a hiatus between the model's design and its implementation (n=6). The lack of financial investment, the reorganisation of technical and coordination services (Cf. Coordination on matter of drugs) and the gap between the actors who implemented it and the ones in charge of coordinating policies were some of the reasons pointed out for this hiatus.

*“The Portuguese decriminalisation model fulfils several intervention areas: prevention, treatment, dissuasion, harm reduction and reintegration. Currently, it can cover all these functions in theory, but the fact is that they are progressively ‘emptier’ in terms of fulfilment, achievement and efficacy, since there’s no investment. Between the reorganisation of services and the lack of financial investment, all these areas are disinvested.” (P6)*

In what concerns **the global evolution of the Portuguese Drug Policy Model and drug policies in more recent years** (n=13)<sup>12</sup>, some participants were able to identify a negative trend (n=6) associated with the changes implemented, motivated partially by financial goals. It is mentioned the existence of *“a retroceding policy during a period in which (...) the interventions should be reinforced” (E23)*; of *“reformulations that usually involve the loss of services to the population” (P15)* and the current absence of an actual drug model – *“at this time, there is no model, there is nothing.” (D22)*. One of the interviewees believed that the austerity measures mean a lack of investment in the Humanist principles that characterise the Portuguese decriminalisation model (P24); however, the same participant identified a positive evolution of that same model caused by the efforts of civil society actors. In fact, the increasingly important role of civil society as the main responsible for the implementation of drug policies is one of the aspects mentioned by two professionals, (Cf. Cushion effect). Other participants rejected the idea of evolution: before this same assumption, some attribute it a positive connotation talking about *“consolidation”* (n=3) and others emphasised the negative connotation of *“stagnation”* (n=3).

*“As soon as the crisis starts to ‘disappear’ (...) I hope we all know how to seize the moment, in order to preserve the drug policies. At this point, I believe that our drug policies are sort of a nest. It is a nest and we all worked to maintain things and don’t let them “fall”. But we still develop a differentiated intervention, although not doing everything we ‘sell’ out.” (P18)*

*“I believe that the austerity measures are a synonym of lack of investment in a humanised and Humanist society and the drug policies can’t/don’t have a place in a society like that. At least drug policies that are comprehensive, right? We can’t go back to drug policies supported by certain ideologies – like “zero tolerance”, “drug-free” or “maximum repression”. They’re still drug policies, but not very effective, in my opinion.” (P6)*

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<sup>12</sup> Here, not all the participants identified a trend or position themselves about this issue. Sometimes, they just made historical remarks.

In the quantitative component of this study, with a sample of Harm Reduction professionals and peer educators (N=100)<sup>13</sup>, the perceptions about the impact of austerity measures on the Portuguese Drug Policy Model were assessed through four main questions. In line with the results derived from the content analysis, the majority of the respondents (95.4%; n=82) considered that the austerity measures are compromising the Portuguese drug policies<sup>14</sup>. When questioned about the impact of austerity measures in the Portuguese Model *per se*, the majority (68.6%; n=59) agrees or strongly agrees that the model is being jeopardised by the current socioeconomic scenario<sup>15</sup>. **Thus, the participants are unanimous in agreeing with a negative impact of austerity in the political dimension of the Portuguese Drug Policy Model.**

In addition, the inclination (94.2%; n=81) is to consider that those measures are weakening the principles endorsed by the model, such as pragmatism and humanism (as also stated above by the interviewee P24)<sup>16</sup>. Finally, as professionals, the participants feared a change in the paradigm underlying the national policies regarding drugs (87.1%; n=74)<sup>17</sup>.

## 2.1. Evolution of the Paradigm and future prospects

The models of understanding psychoactive substances use and control have been mutating since the 19<sup>th</sup> century. By that time, some “traditional” discourses surrounding this issue emerged – the political-legal Model and the medical-psychological Model. Both of them aimed to achieve a drug-free world and they functioned as a social control vehicle (Cruz, Machado & Fernandes, 2012). In addition, these two models perceived the consumption as deviant from the legal and sanitary norms and also emphasised the subjects’ intrinsic factors in the explanation of substance use, rather than the environmental factors (*ibidem*). The political-legal discourses differ from the medical-psychological ones by representing the people who use drugs as criminals/delinquents who should be legally punished. By contrast, the medical-psychological model portrays drug users as patients suffering from addiction who need to be referred to proper abstinence-based therapies. Therefore, we find in the political-legal and the medical-psychological rhetoric contributions for the prohibitionist policies of intervention in the drugs domain.

Several alternative anthropological and sociological discourses started to emerge in mid-20<sup>th</sup> century, to question the traditional models and emphasise the fact that the use of substances should be analysed according to its context and its multiple meanings. To properly understand the phenomenon, these models established a substance-subject-context triad (Cruz et al., 2012). According to this line of thought, the existence of non-problematic drug use should be considered, as well as the concept of drug use as an anthropological constant and the hedonistic motivations to use drugs.

13 In an estimated universe of 200 HR professionals (APDES, 2013).

14 1.2% (n=1) disagree; 2.3% (n=2) neutral; 1.2% (n=1) don’t attribute any possible fluctuations to the austerity measures.

15 10.5% (n=9) disagree; 15.1% (n=13) neutral; 5.8% (n=5) don’t attribute any possible fluctuations to the austerity measures.

16 2.3% (n=2) disagree; 1.2% (n=1) neutral; 2.3% (n=2) don’t attribute any possible fluctuations to the austerity measures.

17 5.9% (n=5) disagree; 3.5% (n=3) neutral; 3.5% (n=3) don’t attribute any possible fluctuations to the austerity measures.

Moreover, Cruz and colleagues (2012) also mentioned the so called “critics” discourse, which conveyed several bold ideas, like the right to have pleasure without any significant damage – thus favouring the harm reduction policies –, as well as the decriminalisation or regulation approaches to drug use. On the other hand, when the models of understanding are associated with the more traditional perspectives, they end up validating the state, social and medical control (Ibd.), consequently supporting the prohibitionist intervention approaches.

In Portugal, there was a progressive integration of the more understanding discourses and the country was at the front line of that process at global level. This way, one could easily observe that the models of understanding about the drug use and drug users appeared to materialise in political approaches, which fluctuate in a spectrum ranging from prohibitionist approaches (dominant in the last century) to legal regulation approaches (as the ones recently experimented by Latin American countries and some states in U.S.A). In this spectrum, one can also find the decriminalisation approach, which became increasingly relevant during the last four decades and was the basis for the Portuguese Drug Policy Model.

The participants’ discourse (n=12) on the paradigm of intervention in drugs mirrored and fluctuated in this spectrum of approaches, also reflecting the current social, economic and political environment. Today, the discussion around this topic took place more intensely, mainly due to the most recent international experiences on drug policies.

When discussing the **international debate around a regulating paradigm and its potential reflection in the national policies** (n=6), one of the interviewees mentioned that Portugal still assumes a submissive position towards the international control system:

*“There are a lot of debates worldwide... Although we had decriminalised drug use, we’re still in a penalising paradigm, in line with the conventions; we have to respect the UN’s conventions, etc. However, some countries like the U.S.A. were bold enough to establish a different paradigm of legalisation, regulation, etc. They’ve ignored the UN’s conventions.” (D10)*

In what concerned the potential implementation of a regulating paradigm in Portugal, some participants adopted a more cautious or unsure position (n=3). Two of them were in completely opposite positions: one of them in favour of this paradigm (D37) and the other against it (PWUD30). Two interviewees emphasised the Portugal paradigm’s evolution in a more comprehensive direction (i.e. with the decriminalisation model) and stated that the gains obtained with this evolution could be seen even during the current period of economic instability (n=2).

*“It was mainly due to the efforts made by institutions similar to ours [NGOs] and, let’s say, due to a big struggle by a number of organisations and the emergence of new ideas and perspectives, that we were able to change the paradigm concerning this problem and establish a set of conditions that never existed before. And these were able to endure even during the period of crisis. And we are talking about bad, it was bad [referring*



to the conditions]. *But when we compare them to what used to exist before the economic crisis, it is a big difference. Sometimes, the difference between life and death.*” (P24)

On the contrary, other participants consider that the recent political options were a **setback to the paradigm** (T18), namely in what concerned the decisions made in the ambit of the New Psychoactive Substances. In 2013, five years after of the first *smartshop* opening in Portugal, a decree-law<sup>18</sup> designed to extinguish those shops was approved. 159 NPS were listed and prohibited in terms of production, importation, exportation, advertising, distribution and selling. Three participants (two policy-makers; one professional) recognised that Portugal adopted a prohibitionist approach, different from the driving rationale of the Portuguese decriminalisation model; however, they assumed it as a necessary approach.

*“I don’t know how to define the current drug policy model. I believe we used to have a clearly open, pragmatic and liberal drug policy model, which was walking towards the liberalisation of certain drugs, even if it was the so called soft drugs, doesn’t matter, we were walking towards these kinds of initiatives. (...) suddenly, everything stopped and there were several setbacks in some important things (...) like what happened to smartshops. We travelled 500 years back in terms of accepting a phenomenon, which even changed the legal framework.”* (P18)

Additionally, it was unanimous among the participants who discussed this question that the political-ideological and economic factors were the ones with the most influence **in the evolution of drugs’ paradigm**, regardless of the direction (n=5).

*“This model went through different governing political sectors [parties], which didn’t always agree with its basic design. For example, the current ruling parties do not support the idea of decriminalising drug use. The CDS-PP party rejected that idea several times, and when it was discussed, they were clearly against it... The PSD has a more ambiguous position... The PSD and the PS, well... it was approved in terms of the legal framework of drugs. Regarding the harm reduction component of the model, there’s still some ambiguity, despite the support this model kept receiving.”* (E39)

*“Then, there are ideological trends regarding PWUD, which clearly interfere in this lack of investment (...) there is a trend that we can’t ignore, stating that people continue to use drugs because they want to. Many say ‘I could also use drugs if I wanted to, but I didn’t’, right?’ Therefore, in addition to the lack of resources, we also have to deal with this issue and that’s not easy. The positive discrimination of drug users is not an easy thing to deal with.”* (D19)

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18 Number 54/2013, April 17<sup>th</sup>.

Following the opinions that emerged from the discussion of the previous topics and when questioned about their **expectations for the Portuguese decriminalisation model in the future** (on a short/long-term), the participants (n=17) tended to anticipate or fear eventual setbacks for the model's configuration (n=12). The main reason for their worries was the perceived lack of investment in the operational domain – the services designed to support PWUD – and its consequences (n=8).

*“The current social conditions are favourable to a recrudescence of the phenomenon. So, if we eliminate the existing services in the field, we will level the responses by the minimum, and probably have medium/long-term consequences which will cause again an increase, I don't know, in AIDS, the number of deaths, the number of people infected with hepatitis C, well, all these things... And then, social degradation will also increase: the ghettos and the neighbourhoods like Casal Ventoso<sup>1</sup>.” (D10)*

One of the reasons why the interviewees were expecting a negative scenario was the State's lack of actions in the substance dependence field (n= 4), which had been emphasised by the participants in several moments (regarding this and other social intervention fields) (Cf. 4. Welfare State: changes and setbacks in the age of austerity). Another major concern was the potential increase of private, profitable services in this area, which tend to promote the exclusion of those who don't have conditions to access that market (n=2).

*“My main concern is whether the next Government will make or not any changes or major investments in this area.” (E25)*

*“It is not surprising that, one of these days, private treatment clinics begin to proliferate, as already happened in the past. Since the State support is becoming scarce, it has created a void that is filled with private services. Therefore, I fear, indeed, they will begin to proliferate again. Those private treatment clinics that are very expensive. Many of them exploited the human suffering in order to get rich.” (D37)*

Moreover, two participants mentioned the current unstable social environment that threatens the social cohesion. They believed that this environment could lead to a change in the social conception of the PWUD and be the basis for new configurations of the drug policies (D10, E12). This analysis was similar to the one made by the Pompidou Group (2013) in the Athens Declaration: “Stigmatisation of people dependent on drugs has been increasing in countries implementing austerity measures (...) drug dependence may be seen as a moral failure and services dedicated to the treatment of dependent people as a first target for budget cuts (...) In such context, policy-makers are faced with increasing difficulties when advocating for humane drug treatment policies” (Ibd., p.11).

*“At the moment, I fear that this could lead to a Brazilian-kind approach, as a consequence of the exclusion of the more disorganised social groups (...) we face the fact that we’re helping the ‘bad and the ugly’, the ones who are already marginalised. And the common way to deal with this is marginalise them even more; incarcerate them or use compulsory treatments (...) the decriminalisation perspective, according to a more humanistic approach, appears to conflict with the Brazilians’ social representation of the topic. And I’m afraid Portugal will replicate this model.”(D10)*

*“I get pretty comfortable when the drug issue is not discussed or when it is discretely discussed, since the focus of the discussion ends up being the main concerns of the Portuguese people... the result could be pretty bad.”(D10)*

In addition, a group of participants (n=7) considered that the Portuguese decriminalisation model will be preserved, especially in terms of its legal dimension, in spite of the obstacles mentioned above (n=3).

*“I believe that, eventually, the decriminalisation model will continue. Nowadays, it would be difficult to go back in terms of criminalisation of drug use. I think it wouldn’t be possible. Maybe only with ideological influences...” (E12)*

*“I think that the austerity measures won’t lead to any changes in the model. I think that ten, thirteen or fourteen years after its implementation, it will be very difficult to reject the model.” (P15)*

With respect to these considerations, one of the interviewees (D10) emphasised that the main concern should be preserving what has been accomplished in terms of drug policies. He/she also considered that changes in this matter should be reserved for periods of higher social stability, since actions taking place during the current period could originate undesirable consequences.

*“I believe that the majority of European countries are not available to lead this debate, because in resemblance to what happens in Portugal, they are more concerned with maintaining what they were able to achieve during the last years than trying to move forward.” (D10)*

*“In Portugal, there are some campaigns to promote the debate regarding important topics on drug policies. For example, the Bloco de Esquerda’s initiative to regulate drug use, the consecration of cannabis clubs... discussing these kinds of questions at the Assembly of the Republic at the present could ‘open the Pandora’s box’. In the current social and political context, it could lead to serious setbacks.” (D10)*

We will now present the considerations on the more operational aspects of the model, particularly in what concerns the architecture of the drug policies’ coordination.

## 2.2. Coordination on matter of drugs

The quick expansion of psychoactive substance use in Portugal from the 1970's and the clear social concern surrounding the issue led to a growing need of developing coordination mechanisms that were more structured, specialised and autonomous. According to this principle, the *Instituto da Droga e da Toxicodependência* (IDT) [Drug and Drug Addiction Institute], created in 2002, was granted with the status of Public Institute (IP) in 2007. These bodies have their own legal status and are usually created whenever there is the need of a management that is not directly submitted with the Government – similarly to what happens in the cases of activities with technical specificities for the production of goods and services. This occurred in the ambit of the drugs interventions in Portugal, since the fulfilment of the goals defined did not match the diversified and scattered structures that functioned in an isolated and uncoordinated way.

After the approval of the IDT's status as PI<sup>19</sup>, more central (as well as decentralised) services became available, called regional delegations and local intervention units<sup>20</sup>. The strategic reorientation of this coordination body assumed as top priority the integrated intervention to the use/abuse of psychoactive substances. As a consequence, the PORI was established as a structuring measure at the integrative interventions' level.

However, four years after the approval of this strategy, some opposing changes were made. In 2011, with the approval of the new organic law of the Ministry of Health<sup>21</sup>, the Government decided to extinct the IDT I.P. and create the *Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências* (SICAD) [General Directorate for Intervention on Addictive Behaviours and Dependencies], thus leaving the Regional Administration of Health (ARS) in charge of operationalising the interventions in drug use/drug addiction. This decision was part of the Government's "efficiency" commitment and, as a result, the 19<sup>th</sup> Constitutional Government established the *Plano de Redução e Melhoria da Administração Central* [Plan for the Reduction and Improvement of the Central Administration]. In the decree-law, one can read that the plan is "an absolutely restructuring effort to initiate a new reform in the Public Administration, in order to make it more efficient and rational in the management of public resources. It should also be useful to achieve the reduction of the public expenditure, as the country had committed itself to do" (Decree-law number 124/2011, December 29<sup>th</sup>).

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19 Ministerial Order number 648/2007, May 30<sup>th</sup>.

20 *Centros de Respostas Integradas* (Integrated responses Centres), Detoxification Units, Therapeutic Communities and Alcohol Treatment Units.

21 Decree-law number 124/2011, December 29<sup>th</sup>.

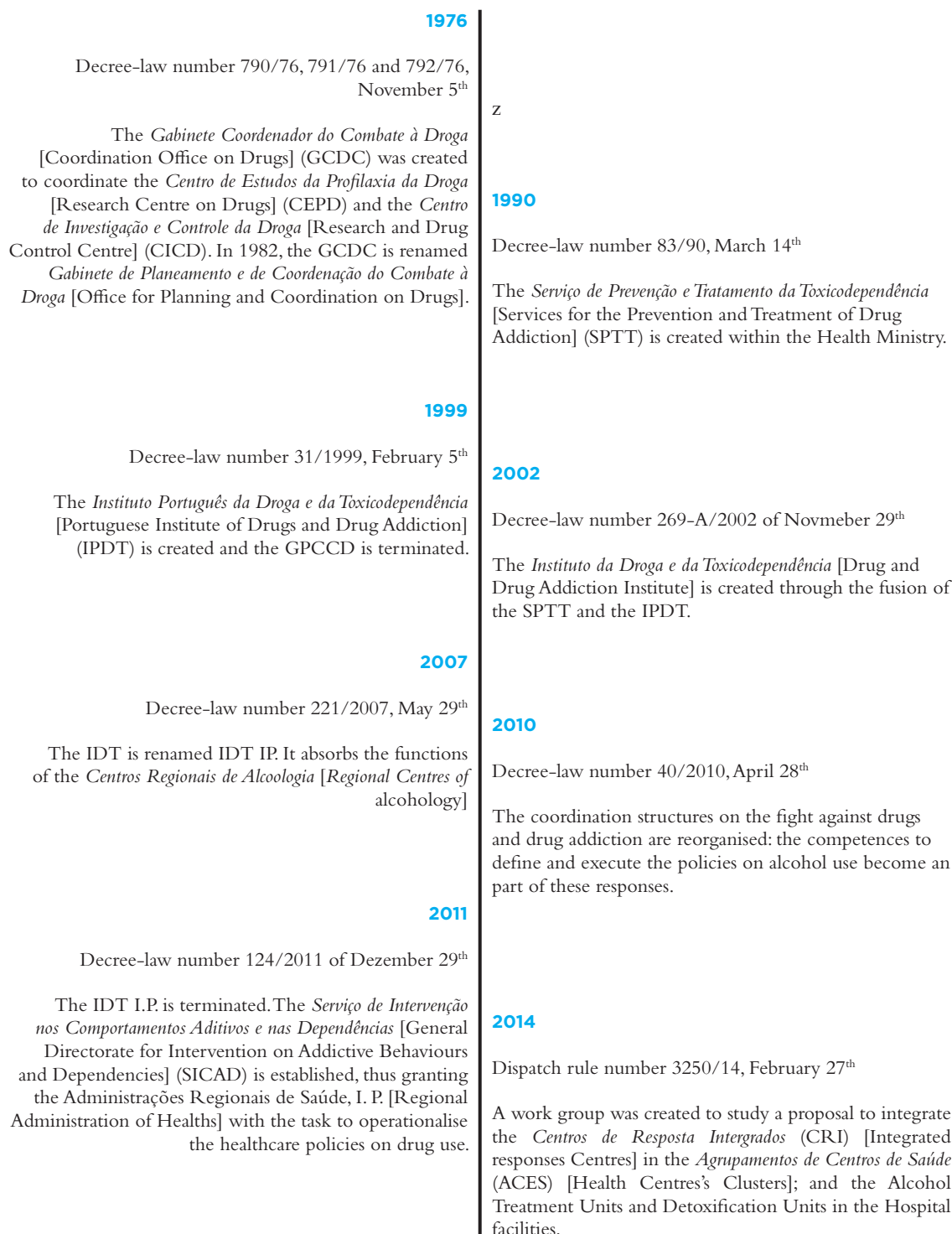


Figure 3: Chronogram of the main changes in the coordination mechanisms in matter of drugs, in Portugal, since the 1970's

In this document, it is stated that the motivation to restructure the coordinating bodies in the drugs field was a result from the commitments established by the Memorandum of Understanding (MoU) on the economic policies' constraints (2011, May 17<sup>th</sup>). According to this Memorandum, the Portuguese government agreed to reduce or extinguish the services that did not represent an effective use of public funds, in order to achieve 500 million euros of annual savings (subparagraph 1.7). This issue was also mentioned by SICAD in 2013, stating that its creation was a result "of the deep State's structural reform, via the elimination of indirect administration services, due to the national fragile economic situation and the pressure to reduce public expenditure" (SICAD, 2013, p. 2).

In agreement with the proposed amendment, the operationalisation of the interventions had to be established within the ARS's framework and the SICAD was in charge of the planning and follow-up processes of the programmes for the reduction of psychoactive substance use; the latter was also responsible for the prevention of addictive behaviours and the reduction of addiction (SICAD, 2014). The SICAD's organic law also established "the definition of technical and normative guidelines for the interventions in the area of addictive behaviours, as well as the general guidelines to orient the prevention interventions on addictive behaviours and dependence" as its mission and duties. "Considering the changes introduced, one of SICAD's main challenges is to contribute to the expansion of the intervention, by maximising and promoting the use of the available resources. This should be done without compromising the quality of the responses provided so far" (Decree-law number 17/2012, January 26<sup>th</sup>).

This decision was one of the themes discussed by the interviewees (n=19), when questioned about the evolution of the Portuguese decriminalisation model and the drug policies. The majority of the participants (n=11) had a negative opinion regarding the end of the IDT and the creation of the SICAD.

*"The IDT's organisational structure changed. Nowadays, it is no longer an institute; it lost its relevance, even in terms of the institutional hierarchy. We used to have an autonomous institute, dependent of the Ministry of Health. Now we have a service, the SICAD, also dependent on the Ministry of Health, but integrated in the ARS. It lacks autonomy and verticality. Personally, I preferred the previous model. This area of intervention became less relevant within the Ministry of Health's framework; this causes several difficulties, obviously"* (D37)

The main reasons for the participants' position regarding this issue were the ones associated with the interventions' area, i.e. those that identified the potential negative consequences of the organisational restructuration to the work developed with PWUD (n=4). The participants who identified this obstacle also emphasised the potential dilution/loss of relevance of the interventions in this field, within the priorities of the healthcare services. They were afraid that the interventions in this area would be one of the least important priorities, namely due to the stigma associated with drug use:

*“In terms of healthcare and drug addiction, the services provided should be more specific. They shouldn’t be ‘absorbed’ by the National Healthcare System. Otherwise, other diseases will be privileged, even due to the physicians’ prejudice towards this issue. It is vital to implement a specific drug addiction policy, developed by specific services, with the ability to manage their funds as they wish. Therefore, I think that it is hard to fulfil all the identified needs.” (D38)*

In addition, other participants considered that those organisational changes would lead to an approach to the drug issue which gives less emphasis to the social aspects (n=2):

*“The adoption of a new organisational structure, in which the support is provided by the ARS, leads to a model that favours the medical approach. Therefore, the professionals end up valuing the clinical aspects, rather than the social aspects.” (D37)*

One expert also highlighted the financial motivations behind this restructuring process, believing that these changes would not lead to an improved financial efficiency (E12); other interviewees believed that there was a hidden political/ideological agenda behind the organisational restructuring process (n=2). Finally, other participants considered that these changes would lead to the desegregation of the ‘critical mass’ dedicated to think about the drug phenomenon in Portugal (P18), as well to the impoverishment of the monitoring and assessment mechanisms (n=2).

*“The IDT used to do something very important and used to work very well; and that has to do with its information, monitoring and follow-up systems. In other words, it seemed as if we were all working to achieve the same, precise goals. We were able to see who was working more, better or worse, in order to implement some changes. Nowadays, we don’t have that opportunity. All the services are divided according to five independent ARS, in what concerns the way of functioning, managing and decision-making. The IDT is not capable of monitoring all the services, so they end up performing as they want and with not enough resources. The ARS are obsolete. At least the IDT had well defined systems and some of them continue to be updated and agile, thus providing us timely information.” (E12)*

However, a group of participants had a favourable opinion regarding the end of the IDT (n=3), since they considered that the access to healthcare services (D19) and the quality of those services (n=2) improved after the centralisation of the management in the drugs field.

*“There were several disadvantages associated with the fact that the IDT was not part of the national healthcare system. And some of them very relevant, associated with the communication with the users and the functioning of the services. Since it [IDT] was a smaller organisation, it was more agile, which was useful to its development. A body like the General Health Administration is far more complex, thus making the processes slower and more complicated. But it has some advantages, especially in terms of resources..” (D19)*

Without positioning themselves in none of the previous poles (favour or against), some interviewees demonstrated a feeling of uncertainty and expectation towards the future consequences of these measures (n=4); one of them even considered that this restructuring process would not lead to any changes (E39).

In 2014, following the end of the IDT and the creation of a service coordinated by the ARS, the Portuguese government published an order<sup>22</sup> which introduced two main changes: 1) the possible integration of the addictive behaviours in the conditions to be treated in the healthcare services for mental health; 2) the intention to invalidate the autonomous status of responses to drug use conveyed by the CRI [Centre of integrated responses], by transferring the services to drug users to the local Healthcare Centres – the services dedicated to primary healthcare. According to the document, this decision was motivated by the intention to equitably distribute human and financial resources.

Some participants also discussed this decree-law (n=4), since its publication occurred during the final period of data collection. In this case, there was a general negative opinion regarding this document (n=3), mainly because they believed that there would be a reduction in the human resources and services allocated to the drugs field (n=2), or the loss of the interventions’ specificities (D22).

*“It almost seemed like one of those Holocaust movies. We’re all happily moving towards the gas chambers, smiling, unaware of what is happening. When we finally understand what is truly going on, it is already too late. There won’t be anyone left to tell the story. It is somehow scary. I believe that the integration of CRI and local intervention units in the ARS is a bad decision. They will end up losing their autonomy by being integrated in the ACES [Health Centres’ Clusters]. This is completely diluting the responses. The users will have to go to the healthcare centres and we all know that things won’t work that way.” (E12)*

However, one of the participants believed that substance dependence is a behavioural disorder that should be dealt with by the mental health services – as long as this treatment is not done according to a psychiatric, pathologizing approach (E39). The decree-law also supported the notion that “psychoactive substance addiction is/leads to behaviour disorders, thus being classified as part of the mental health disturbances” (Dispatch number 3250/2014, February 27<sup>th</sup>). This notion seems to reflect the “traditional” psychopathological approaches on substance dependence, which perceived it as a mental disorder, thus opposing the “alternative” anthropological and sociological discourses. Therefore, understanding drug use as part of the mental health sphere is not a

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22 Number 3250/2014, February 27<sup>th</sup>.



consensual position among experts (APDES, 2014). Recent studies have been reconstructing the drug use phenomenon according to more holistic elements, hence considering the pharmacological, biological, psychological, socioeconomic and cultural facts, as well as those associated with the typology of consumption (Cruz et al., 2012). According to this notion, drug use is a complex combination of biopsychosocial factors, in which social aspects have an important role. Therefore, classifying drug use as “a mental health issue is a reductive and dangerous notion, which adds stigma and aggravates the individual’s condition” (APDES, 2014, p.2).

The participants also mentioned this issue during their interviews and the majority agreed with the specificity, multidimensionality and relevance of the social elements when thinking about drug use, thus contrasting with the psychopathological approach underlying the changes taking place.

## 2.3. Financial investment

As a consequence of the adjustments made in terms of coordination mechanisms in the drugs field, some changes occurred in terms of management of funds allocated to this area, as underlined by one of the participants in this study: “*we have six allocated budgets: one to the SICAD and five to the ARS*” (D10). Although it could be useful to analyse the evolution in terms of financial investment in this field over the years, the report of this data has been showing some inconsistencies and lack of clearness, thus placing strong barriers to such task. Between 2003 and 2013, the reports showed different formats in terms of presenting the indicators: they were either aggregated or disaggregated (e.g. the budget for each intervention axis); they were either clear or hidden, which hindered the processes of analysis and comparison. These obstacles have increased since 2012, due to the structural changes done to the coordination mechanisms (Cf. 2.2. Coordination on matter of drugs), as pointed out by one of the interviewees: “*The outreach teams changed completely. In other words, until 2012, there used to be an integrated institute; from 2013, we have a national coordinating body, with transversal areas*” (E11).

With respect to the financial investment in the drugs field, the participants mentioned the reduction in said investment (n=9). Some emphasised the insufficiency of the budget for the operationalisation of the Portuguese Drug Policy Model as it was designed (n=4), while others considered that this reduction was not relevant to the operationalisation of the policies (n=2).

*“In formal terms, there was a reduction in the public investment, but it is not dramatic (...) The IDT used to have a budget of around 75 million euros per year. Nowadays, there are six different budgets allocated to this area: one to the SICAD and five to the ARS... together, we’re talking about 68 million euros. We should be able to resist the budget cuts, but there are other factors that make this process more difficult, especially regarding support.” (D10)*

*“The budgets are constantly decreasing. Therefore, there will be fewer professionals and worse working conditions. A lot of good things will be left behind.” (PWUD31)*

*“The main question is: will the model be supported or not? Eventually, we’ll reach the most common outcome: only small operational teams will remain. Some of them will disappear, there won’t be enough money to support them all and, therefore, the model will be somehow ‘strangled’.” (E39)*

*“Between 2009 and 2011, there was a variation of 0.005%. In other words, the percentage of the costs to the implementation of the plan in the GDP was 0.056% in 2009; 0.055% in 2010 and 0.05% in 2011. As we can see, there has been a decrease, a little sharper between 2010 and 2011, but still relatively small. However, in terms of GDP, 0.005% is a huge amount.” (E11)*

One of the explanations for the lack of investment was the influence of the public opinion over the use of substances and its social consequences (n=3). Since the drugs-associated criminality is less visible, it softens the feeling of social insecurity linked to drugs. Therefore, the interventions in the drugs field eventually lost relevance among the population and decision-makers, since investments are highly dependent of “*being very afraid*” (E25).

The annual Eurobarometers showed that in 1997, the issues associated with drugs were some of the top concerns of the Portuguese population (European Commission, 1997) and that in 2009, they were in the 13<sup>th</sup> place (SICAD, 2014). The public concern regarding this topic has been surpassed by issues that affect the vast majority of the population, like unemployment and the nation’s economic situation (European Commission, 2014 cit. in SICAD, online). Some of the participants also made some remarks regarding this fact:

*“To this Government, the drug issue is not as important as it was to others, including to the ones from the same party. Is it because drugs are no longer the main concern to the Portuguese population? Previously, before decriminalisation, it was the main concern. Nowadays, it is the 13<sup>th</sup>. I can only imagine what the main concerns are: unemployment, starvation, social exclusion, immigration, etc. Drugs are no longer important. It’s because of this that we have less investment?” (E2)*

*“Today’s societies are not worried about this issue. They’re not investing in this area. Drugs are no longer a priority, nor the main concern to the population. The decriminalisation of drug use could have been the cause for this problem.” (D19)*

*“When the drugs were associated with crime, there was more investment to ensure people’s safety. However, other sectors also started to show disquieting signs – for example, many people are worried that they won’t be able to support their expenditure. This leads to a lack of investment in the drugs field. And we are fully aware of it. We can’t deny that this investment is not exclusive to the drugs field, right?” (D19)*

In addition to the question of funding *per se*, i.e. the budget allocated to this area, there were also some considerations regarding the **managerial dynamics**. More specifically, the participants talked about new mechanisms for the

allocation of the budget, which could block the use of that same budget and generate a gap between the formal budget and the available funds (D10). SICAD's last report (2014) showed that in 2013 there was an execution of around 60% of the budget line for projects (this execution used to be around 90%), namely due to the emergence of articulating mechanism with entities outside the SICAD (e.g. ARS).

*“Some entropies emerged from the constraints in the use of these funds: the commitments, the authorisations to assume multiannual commitments... All this is enough to delay the proposals' approval for several months; and this leads to significant savings for the State. Thus, there is an inability to spend the funding that is made available. (...) Then, we can't use the money that is formally and publicly announced.” (D10)*

Within the financial topic, some participants also identified problems in the sustainability of civil society organisations that implement the projects settled with the Ministry of Health. They reported the decreasing ability of these organisations to ensure its budget percentage (co-funding) in the projects (n=2).

*“And people ask me: ‘where does this come from? The 80% or 20%? I don't know. All I know is that the 80% are not exactly 80% of 300.000 or 150.000 or 75.000 euros. In some cases, the 20% are just symbolic partnerships that represent a sum, but they are not the sum.” (D20)* [the 80% represents the percentage co-funded by the State, while the 20% corresponds to the percentage co-funded by the civil society organisations that implement the projects]

## 2.4. Intervention on matter of drugs

In Portugal, the interventions implemented in the addictive behaviours and dependence area have been characterised by the applicability of a model that presents a “wide, global and integrated perspective of the consumption phenomenon” (SICAD, online). This model is operationalised through main five areas of intervention: Prevention, Dissuasion, Treatment, Harm Reduction (HR) and Reintegration – which should function as interrelated areas. Traditionally, its promotion has been done by the public bodies and by civil society organisations. It is important to emphasise that the State is the sole provider of dissuasion services and that the treatment services are mainly (but not exclusively) provided by the public entities; the other domains have been mainly operationalised by private entities, through co-funded projects or conventions.

In 2006, the PORI (Operational Plan of Integrated Responses) scheme was created as a structuring measure at the level of integrated interventions in the drugs field. It was based on principles of territoriality, integration, cooperation, partnership, participation and empowerment (SICAD, 2014). One of the results was the development of Programmes of Integrated Responses (PRI), in order to co-fund projects that would cover the needs identified

by territorial diagnosis<sup>23</sup>. These programmes were aimed at the integration of multidisciplinary and multi-sectoral responses according to the five intervention vectors mentioned before (Ibd.). The model proposed by the PORI implied an integrative notion of the drug use phenomenon and also of what needed to be done in this field. This way, it distanced itself from the intervention carried out through dispersed actions, aiming at the “*integrative logic*”, and having been “*designed to have four axes functioning simultaneously*” (FG5.1).

The implementation of the PORI was developed through a sequence of stages and implemented according to the identification and selection of territories where the PRI are needed. The PRI are then implemented via Núcleos Territoriais [territorial centres] composed of public and private entities who establish partnerships with the SICAD and the Divisão de Intervenção nos Comportamentos Aditivos e Dependências (DICAD) [Intervention Division in behaviours and additives in Dependencies] from the ARS I.P. to fulfil the initially designed goals. Therefore, it is under the regulation that established the conditions for the public funding of projects in the PRI scope that a significant part of the responses to drug addiction is implemented, mostly the ones delivered by civil society<sup>24</sup>.

We were able to identify a tendency to mention the lack of investment in the PRI (n=12) among the interviewees who discussed this theme (n=19; 2FG). According to the participants, this issue led to “*a reduction of the necessary responses*” (E13), thus originating “*situations that are not addressed and didn’t used to happen before*” (P15). The lack of investment was seen as an obstacle to the strategy of the PORI – “*The integrative strategy ended up losing relevance, losing a lot of relevance*” (D37). Also, some interviewees shared the idea that the programme was dismantled (FG5.1) and its integrative notion perverted (P17). The participants reported a lack of investment in the Prevention (n=8) and Reintegration (n=12; 2FG) vectors of the programme. On the other hand, the drug treatment domain was perceived as the one that absorbed the majority of the funds – “*they can’t spend 90% in treatment services and only 10% to the rest*” (P17). This statement is not surprising, since the treatment responses developed in Portugal are mainly implemented by the public services of the Ministry of Health (as well as licenced services), while the other vectors are in good part (but not exclusively) operationalised via the PRI.

In addition, some of the interviewees mentioned that **the operational programme is not being developed according to its conceptual design** (n=6) and that the “*effective practice of this model*” (E39) is at risk. One of the participants even considered that this programme was never implemented according to the way it was designed (P24). The identified decrease in terms of integrated responses was perceived as the result of the economic crisis combined with the “*organisational changes that happened simultaneously*” (E14). This statement is very similar to the one by SICAD (2012): “*We need to take into account the context, the macro-environmental situation in which the SICAD was created*” (Ibd., p.2)

*“The PORI was designed to comprehend four axes functioning simultaneously. It wasn’t designed to have, for example, only harm reduction responses functioning, while the drug treatment, prevention and reintegration stay*

23 The operational scheme of the PORI is initiated in 2006, with the identification of territories. The PRI is created in 2008, during the PORI’s 6<sup>th</sup> stage.

24 Ministerial Order number 27/2013, January 24<sup>th</sup>: regulation that establishes the public funding conditions of the PRI projects.

*in standby. And this was a result of the austerity measures: they decided that the prevention and reintegration responses were not a priority and they should be on standby. And that wasn't the PORI's strategy. The strategy was an integrated one. If we choose to ignore prevention in the ambit of drug addiction and the model that we want to use, we might as well say: 'there, I give up on future generations'.*" (FG5.1)

*"All of this is contradictory, since it wasn't done according to what was written and planned, well planned in the PORI. I believe that it is a remarkable programme that foresees the existence of integrated responses in each territory (...) regular diagnoses... but the majority of things that are planned to happen are not happening."* (P18)

*"We had an integrated policy. And it all went down the drain. Now we only have a treatment policy, we don't have an integrated policy."* (D37)

*"We've sold an operational programme that isn't actually working. It used to work when Portugal had more money."* (P18)

*"The PORI never existed. It should have been a solution for all the problems we're discussing, right? It would represent a change... The PORI was designed, implemented, but it doesn't exist. Everything remains the same."* (P24)

Although two participants considered that the economic crisis had nothing to do with the reduction of responses in the drugs field, the main tendency was to identify **a relation between the austerity measures and the reduction of responses in the drug dependence area** (n=9).

According to the participants, and concerning the public services (e.g. public services of treatment of the Ministry of Health), this reduction of responses was particularly materialised by the mechanisms that restricted the hiring of human resources. In fact, this issue was addressed in the 3.48 subparagraph of the MoU (2011, May 17<sup>th</sup>) – "Limit staff admissions in public administration to achieve annual decreases in 2012- 2014: 1% per year in the staff of central administration and 2% in local and regional administrations". Moreover, this goal was accomplished and exceeded, since the number of government employees decreased almost 8% between 2011 and 2013. The no-renovation of human resources, as well as the unavailability of specialised human resources in the drug services were also highlighted by the participants (n=5). One of them, however, mentioned that this issue was not exclusive to the drugs field (E11), but rather common within the public sector.

*"In countries where the economic crisis has resulted in a greater austerity - according to the reports produced by the OECD and European Commission - it was commonly observed that some key sectors that have an impact in the drugs field were severely affected."* (E27)

*"There has been a decrease in the number of new professional hired; and nothing new happened in relation to other kind of resources. This was a result of the austerity measures."* (E39)

*“Then, there are the difficulties associated with the personnel policies. The services aren’t able to replace the professionals who end up leaving the teams and the services. And many of those who leave have a very important role.” (D10)*

## PREVENTION

In the framework of the Portuguese decriminalisation model and concerning the demand-side actions, the interventions carried out in the ambit of drug prevention “perceive the citizens as the conceptual core of the framework of policies and interventions, designed and guided according to different life stages and contexts of belonging” (SICAD, online). One of the goals is to replicate the principles of global and integrative intervention mentioned before, through the coordination between public sectors (e.g. education), non-governmental organisations and civil society actors. This way, the SICAD’s responses in terms of prevention are largely provided by the PORI, but also by other programmes or projects developed through partnerships.<sup>25</sup>

The majority of the participants who discussed the question of prevention (n=12; 1FG) considered that currently the interventions in this domain is clearly insufficient or inexistent (n=8). When compared to other vectors, the one related to prevention was perceived as one with the lowest rate of investment during the last years. Some participants even mentioned that the investment made in this vector is close to **zero** (n=2) or even inexistent (D37; FG5). One of them pointed out the years of 2012 and 2013 as the period when this lack of investment was clearer (P18). Three interviewees also mentioned the existence of regional disparities in the implementation of prevention projects: *“Some regions don’t even have any prevention project”* (D37); *“The region with the highest percentage of investment is Porto”* (D19).

The quantitative data gathered on this topic is coherent with the above mentioned statements, since the majority of the HR professionals and peer educators (59.5%; n=53) considered that the access to preventive responses on drugs highly decreased/decreased in the six years preceding the data collection<sup>26</sup>. Among those, 56.6% (n=30) pointed to a high association with austerity<sup>27</sup>. On a contrasting position, 20.2% (n=18) considered that preventive responses increased/highly increased in the same period, with a tendency to attribute no relation with austerity. Therefore, it was observed that the association with austerity is more evident among those who report negative trends, while more positive ones are less associated with austerity.

Concerning this topic, the official data (IDT/SICAD, 2009-2013) indicated that there was an increase in the number of prevention projects co-funded in the ambit of the PRI between 2009 (n=47) and 2010 (n=68); however, between 2011 and 2013, there was a progressive and clear reduction in the number of prevention projects (2011=62; 2012=34; 2013=8). Regardless of these differences, this evolution cannot be understood in a linear and reducing way, since the main goal of many of the projects implemented in the past was to empower a

<sup>25</sup> During the period prior to the PRI implementation, the operationalisation of prevention was done in accordance with a program of focalised interventions (PIF) (2006-2009). This program was based on a funding model that foresaw the co-funding of the IDT I.P. up to 100%. It enabled the execution of 23 projects and worked as a boost to the interventions in terms of prevention in Portugal (Carvalho & Frango, 2011).

<sup>26</sup> 20.2% (n=18) considered that the access to preventive responses continued the same.

<sup>27</sup> 11.3% considered it is somehow associated, while no participants among these considered that there’s no relation with austerity; 32.1% (n=17) are missing values.

set of key-actors, like those who compose the school/educational context. This was favourable for the continuity of several prevention projects that were not funded nor included in the percentages presented above. With respect to the regional disparities pointed by the interviewees, it is a fact that the northern region of Portugal has been one of the regions with the highest number of projects (e.g. 2013 – North and Centre of Portugal with 3 projects each, from a total of 8), a reality already foreseen by the majority of the interviewees.

*“In Portugal, the work developed to prevent drug addiction is almost inexistent. This is a vector that we advertise in the PORI as being implemented, but it isn’t. We haven’t been able to do a complete prevention work probably since 2013.” (P18)*

Considerations about the concept of prevention were made by the participants (n=3). It was emphasised that *“it is normal to mistake prevention for the television campaigns or small information sessions. The scientific literature says that prevention is not that, initiatives like those are useless...”* (E39). Thus, the majority of the interviewees seemed to agree that *“nowadays, prevention needs to be global, at a larger scale”* (E25). In fact, there is a clear difference between the distinct operational levels of prevention – universal, selective and indicated prevention (those defined by risk assessment) and environmental (Institute of Medicine, 2009) –; and between the specific and nonspecific (an approach that goes beyond the exclusive focus on drug use) character of the intervention. These interviewees seemed to share the same notion of prevention, a broader one, which is closer to the indicated and selective modalities, in detriment of the universal one.

This is also coincident with the ideas presented in the last EMCDDA manual about prevention (2011): in addition to provide information on psychoactive substances, it is necessary to develop and train basic competences, namely social and emotional ones. However, contrary to these participants’ opinion, the majority of the European prevention projects traditionally favour the universal level, usually applied in educational contexts. In fact, according to EMCDDA (2011) all European countries report to develop this type of approach, while only 6–10 report to develop programmes of indicated prevention – that have higher levels of efficiency<sup>28</sup>.

According to these different approaches on prevention, and referring to one of the *“traditional”* prevention contexts, it was stated that *“saying that schools carry out prevention work is not true”* (P18) and that the intervention work developed in this axis is essentially dependent on *occasional sessions* requested by the teachers and provided by different Private Institutions of Social Solidarity (P18). Thus, the degree of systematisation in the implementation of interventions is also discussed here.

Taking into account the above mentioned concept of prevention, one of the participants stated that, in Portugal, prevention *“never existed in the past and it sure doesn’t exist now”* (E39). This is not the opinion of other participants, who mentioned that in the past, there were several pioneering projects in the universal, selective and indicated areas of prevention, including some municipal projects (n=3)<sup>29</sup>.

28 It is important to mention that in universal prevention there are some aspects that could lead to effective actions (beliefs and competences; peer education). At the same time, the components of universal intervention that are less supported by scientific evidence (experts visits, sharing of information, International Drug Day) seem to be the ones used by the majority of countries (EMCDDA, 2011).

29 In this case, the participant is mentioning the *Planos Municipais de Prevenção de Toxicodependências* [Municipal plans for preventing drug addiction], which



In short, one idea that is important to highlight about prevention is also present in the ‘general guidelines to preventive intervention in drug addiction’: “it is necessary to develop policies and interventions based on scientific knowledge that can contribute consistently to the increasing quality and efficacy” (SICAD, 2013, p.5).

## COMMISSIONS FOR DISSUASION OF DRUG ADDICTION

The Law number 30/2000 (November 29<sup>th</sup>) defined “the legal regime applicable to the use of psychoactive substances, as well as the sanitary and social protection of those who use those substances without medical prescription”. More specifically, this law established the maximum legal amount of drugs one can possess for own consumption; it created and defined the procedures of the Commission for the Dissuasion of Drug Addiction –CDT (administratively, technically and financially supported by the former IPDT) and set which were the sanctions and procedures to be applied in drug possession cases<sup>30</sup>. These commissions were developed to function as bodies/mechanisms of decriminalisation with hybrid characteristics: granted with legal power while reinforcing the perspective of health promotion (in accordance with priorities established in the law number 30/2000).

The dissuasion is also perceived as an integrating part of the other intervention areas that compose the Portuguese model and they should operate according to a notion of sanitary protection of the users and the promotion of the users’ adhesion to the available specialised responses. In other words, they follow the notion of “rather treat than punish” (Trigueiros, Vitória & Dias, 2010) and accommodate the premise presented by Beccaria (1964) that only the behaviours that can be effectively managed by this route should be the target of criminalisation – which is not the case of substances use, as the science has been proving. As Poiars (2007) stated “in the decriminalisation bodies (CDTs) the clinical and psychological approach prevails, rather than the legal and punishing one. The criminal law was “invited” to abandon a space that didn’t belong to” (*Ibidem*, p. 14).

In practical terms, the PWUD who were referred to the CDT by the police forces and the courts had to be evaluated in terms of consumption situation and psychosocial needs; then, they are ‘categorised’ according to the level of risk (low, moderate or high). This process orients the intervention and allows approximating the users to the services whenever it is necessary.

The participants who discussed this intervention axis (n=7) emphasised the need to invest and reinforce the role of CDTs (n=2), specially against “*the disappearance of everything that’s surrounding us*” (E12); and grant them with “*a more active role in terms of indicated prevention*” (E12) or a more active role in “*motivating people to enlist themselves in treatment programmes*” (E25). The interviewees also mentioned the improved competences and functioning of these teams when compared to the past (E29). At the same time, there were some questions regarding the ratio of commissions/number of users (too many commissions for the quantity of users in certain regions), as well as the practice of adequate psychosocial assessment (E25).

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were developed according to protocols between the IDT and the city halls. Between 2001 and 2005, these protocols led to the implementation of 440 intervention projects.

30 The organisation, processes and functioning of CDT were determined by the Decree-law number 130-A/2001, April 23<sup>rd</sup>.



In the present, Portugal has one CDT per district capital city, in a total of 18 Commissions (SICAD, 2014). Regarding some of the indicators of their activity, in 2013, 9316 cases were opened, the highest value since 2001, as well as a small increase (2%) compared with 2012. Similarly to what happened in previous years, the number of cases opened varied according to the regions: the urban centres of Porto (2666) and Lisbon (1381) registered the highest number of cases, which is not surprising. In districts like Bragança, Castelo Branco and Évora, the number did not even reach 100 cases, thus being coincident with the appreciations made above.

Finally, some experts mentioned the need to assess these commissions (n=3), which coincided with the goals declared by the coordination bodies that designed a research project that should end in 2015 on the Impact of the Dissuasion Interventions – assessed through the CDT's activity (SICAD, 2014).

*“The dissuasion commissions are currently stabilised... But it wasn't always like this. Some commissions weren't functioning correctly due to the absence of a quorum in certain districts (...) Thus, the law wasn't even enforced in some regions, because there were no commission teams. Nowadays, this doesn't happen. The teams are already established and functioning correctly. The question is if they're effective or not, but that's a long and complex story (...) However, I believe that they comply with their function to legally appreciate the cases.” (E29)*

In short, the importance of this mechanism to the Portuguese decriminalisation model was acknowledged by the participants, who supported its reinforcement despite the identification of some *inadequacies* (D10) in the dissuasion scheme.

It is noteworthy that among the five intervention axes, this was the less mentioned by the interviewees, which could be justified by the participation of only one professional from dissuasion services. However, other areas like the prevention (without any representative among the participants) were still largely discussed. Thus, it was interesting to observe how the participants occasionally mentioned the axis that should have been the “right-hand” of the decriminalisation law. In fact, the dissuasion approach was designed to promote “the reduction of illicit drugs use in a fair and equal way, according to the individuals' needs, whether they are preventive, sanitary, therapeutic or sanctioning” (IDT, 2005, p. 40). In other words, it foresees the fulfilment of the users' needs. The question is that, in some cases, the satisfaction of the individual's needs implies continuous substance use. If it is true that the dissuasion commissions also refer users to HR services – in which the main goal is not the drug treatment and abstinence –, it is also not incorrect to state that the total acceptance of drug use is not the decriminalisation model's goal, as would be in a legalisation approach. This subtle contradiction seems to reflect the contrast between the vital role of these services to the decriminalisation model in the 'formal' sphere and the degree of relevance attributed in the 'informal' one of daily interventions with PWUD.

## HARM REDUCTION

The implementation of HR programmes in Portugal has been characterised by several advances and setbacks (Fernandes et al., 2002). However, and according to Barbosa (2009), it has been evolving from clandestinity<sup>31</sup>, until the moment it achieved the political legitimisation by the Decree-law number 183/2001 (June 21<sup>st</sup>). Amid all these starting and finishing points, there was an experimental phase (1993–1998) in which several programmes were developed (e.g. support offices, outreach teams and shelters) “more due to the efforts by healthcare professionals than by political will” (Barbosa, 2009, p.35). By this time, and before the implementation of the decriminalisation law, the State and the civil society promoted an intense debate on the alternative responses to minimise the risks associated with the use of psychoactive substances. Therefore, there was an energetic involvement of civil society actors in the experimental phase, which eventually continued and expanded to the present day (Cf. 5. Cushion effect).

With respect to the target population, the HR approach was initially designed to aid psychoactive substance users, who were “underground” and to whom the more “orthodox” treatment services were not appropriate (i.e. users who did not want to/were not able to stop using drugs). Traditionally, the main target groups have been the marginalised cocaine and heroin “career” users, particularly fragile in social and health terms, with no access to the formal network of support (e.g. traditional healthcare services; Carapinha, 2009). In more recent years, the HR’s projects scope of action has been increasing, due to the identification and expansion of different consumption dynamics that are mainly associated with party scenes. This way, these teams are now designing their interventions for other populations who didn’t used to be their primary target. Nowadays, “the HR model is seen as a necessity to the heterogeneous population (in terms of age range, life style and history, contexts that provide the framework for the use of different substances)” (Carapinha, 2009, p.10).

This approach, aimed at the change of the users’ behaviours in order to reduce the risks associated with drug use, has been oriented by several fundamental principles: holistic and outreach approach; gradualism; respect and promotion of autonomy and individual freedom; integration on the community; promotion of citizenship and acknowledgement of the users’ dignity and humanity; promotion of communication; privileged role of social relations based upon trust and mutual respect; creation of negotiation models fundamental for all the stakeholders; education for health as an inseparable part of the interventions; promotion of the motivation to change, according to the users’ goals; and finally promotion of the proximity between the users and the social and healthcare services (Carapinha, 2009). The network of HR interventions is currently typified into nine programmes<sup>32</sup> – Low Threshold Opioid Substitution Programmes; Needle and Syringe Exchange programme (NSP); Drug Consumption Rooms, – and socio-sanitary structures –; Outreach Teams; Office for the Support to Drug Users without social and family support; Information and Outreach Stands; Housing Centres; Shelters and Mobile Units for the Prevention of Infectious Diseases.

However, and despite the fact that there has been a legal framework for these responses since 2001, not all of them were operationalised. Two participants mentioned the Drug Consumption Rooms as an example (n=2):

31 The first HR initiatives appeared in 1997. They had a pioneer, yet fragmentary character. In 1992, the first programmes of opioid substitution were implemented all over the country by one single organisation: the *Centro de Estudos e Profilaxia da Droga do Norte*.

32 For a more complete description of each response, please check: <http://www.sicad.pt/PT/Intervencao/RRMDMais/SitePages/Programas.aspx>

*“The PORI system would only be effective if there were several support services implemented. Some of them, like the drug consumption rooms, weren’t even operationalised, despite being described in law” (P18)*

Nonetheless, some of these social-sanitary services do exist, despite not being properly operationalised in the fieldwork context. Some examples are the Offices for the Support to Drug Users and the Shelter/Housing responses, which, in 2013, only had 4 facilities distributed between the central region of Portugal and the Lisbon/ *Vale do Tejo* region (SICAD, 2014).

On the other hand, the Outreach Teams<sup>33</sup> have been one of the most important vehicles of the HR policies, with a broader model of services provided (Carapinha, 2009). Namely, these teams function as central structures for the implementation of the NSP and Low Threshold Opioid Substitution Treatment. The outreach teams have been increasingly promoted by the municipal authorities, the Private Institutions of Social Solidarity (IPSS) and the NGOs, thus demonstrating the civil society’s role in this field intervention, in accordance with the law that advocates for “the cooperation with other public or private entities, which could be invited to promote these initiatives” (Decree-law number 183/2001, June 21<sup>st</sup>).

*“The NGOs have been playing an extremely important role in implementing the policies of Low Threshold Opioid Substitution Treatment.” (D41)*

These partnerships are made official according to PRI tenders (Cf. 2.4. Intervention on matter of drugs) and the Law number<sup>34</sup> 748/2007, July 25<sup>th</sup>; they are then established after the signing of public co-funding contracts for the implementation of projects, with the maximum duration of 24 months. After this period, the projects can be renewed for the same period “as long as there’s a positive assessment of the results achieved and the Regional Administration of Health decides to approve them (...) in accordance with the SICAD’s budget<sup>35</sup> (Ministerial Order number 27/2013, January 24<sup>th</sup>).

In its 2013 annual report, SICAD emphasised “the non-compliance with the budget allocated to Projects. The charged value was 5.164.839,54€ and the value under execution was 3.094.09,25€ [60%] (SICAD, 2013, p.218). According to the same document, this gap was caused by: a) the delay in the publication of the Ministerial Order (Law number 27/2013, January 24<sup>th</sup>) which approved the regulation that established the conditions for the public funding of PRI projects; b) the slowness in obtaining the legal authorisations to assume the presented commitment, according to the Law number 8/2012 (February 21<sup>st</sup>)<sup>36</sup>; c) the “proceedings established that determined the creation of an articulation mechanism, comprehending entities outside the SICAD, namely the

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33 Regulated by the Ministerial Order 1114/2001, 20<sup>th</sup> September.

34 Establishes the Regulation on the Conditions and Procedures for the Creation and Functioning of Programmes and Social/Sanitary Services of HR.

35 Ministerial Order number 27/2013, January 24<sup>th</sup>.

36 Establishes the regulation on the agreements and delayed payment in public entities, in accordance with the changes introduced by the Law number 20/2012, May 14<sup>th</sup>; the Law number 64/2012, December 20<sup>th</sup> and the Law number 66-B/2012, December 31<sup>st</sup>. In these laws, the Government presented the amending budget for 2012. According to the Executive, these changes are vital to the compliance with the requirements established in the Memorandum of Understanding between Portugal, the European Union, the European Central Bank and the International Monetary Fund. These measures aimed to promote the conditions necessary to the improvement of the Portuguese economy.

DICAD by the ARS, I.P.” (SICAD, 2013, p. 128). In fact, for each tender done<sup>37</sup>, it was necessary to establish commissions composed of SICAD and ARS members.

Although the consequences of the non-execution of the budget destined to projects were not explored by SICAD, it was exactly in the middle of this scenario that the participants were interviewed. Thus, it is not surprising that the questions associated with funds were central elements in the discourses of the participants (n=14) who reflected upon the HR situation in Portugal (n=29+2FG). In particular, the majority of the outreach teams’ members emphasised the **reduction in the grants provided by the Portuguese Government** to implement HR projects, in the ambit of the co-funding contracts explained above (n=6; FG4.2; FG4.4).

*“In 2013, there were many teams affected by budget cuts.” (P18)*

*“Since there weren’t enough funds to support this strategy of intervention, many policies in force are decelerating...” (D37)*

*“I believe that the State has been retreating in terms of harm reduction responses.” (D38)*

The participants perceived the end of HR projects and outreach teams, or the imminent risk of this happening, as a consequence of the loss of the funds provided by the Portuguese Government, through the non-renewal of contracts (n=6; FG4.3; FG5).

A similar perception is presented by the questionnaire’s participants, since the majority (83%; n=68) pointed out a “high decrease”/ “decrease” in the Government **funding of HR projects in order to ensure their continuity**, in the six years preceding data collection<sup>38</sup>. The participants who position themselves this way associated this scenario to austerity (69.1%; n=47)<sup>39</sup>.

Additionally, the fact that the Government **funding for new HR projects** highly decreased/decreased in the same time period (91.1%; n=72)<sup>40</sup> is also unanimous between the participants. Among the participants that identified this trend, 66.7% (n=48) associated it with austerity<sup>41</sup>.

It is also noteworthy that concerning the **territorial coverage of HR responses**, the questionnaire’s participants mentioned a “high decrease”/ “decrease” (68.3%; n=56)<sup>42</sup>. Among these, 60.7% (n=34) associated this trend with the austerity measures, while 10.7% (n=6) “somehow associated it”<sup>43</sup>.

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37 The tenders in all intervention axis are included, not just the ones associated with HR.

38 In addition, 14.6% (n=12) perceived a continuity in terms of funding, while 2.4% (n=2) identified an increase.

39 5.9% (n=4) “somehow associated it” with austerity, while no participants pointed out a possible inexistent association with austerity. 25% (n=17) are missing values.

40 Only 7.6% (n=6) reported a continuous funding for new HR projects, while 1.3% (n=1) perceived an increase.

41 5.6% (n=4) “somehow associated it” with austerity, while 1.4% (n=1) did not attribute it to austerity. 26.4% (n=19) are missing values.

42 28% (n=23) indicated a progression and half of those hailed from the country’s Central region. 3.7% (n=3) pointed out an “increase”/ “high increase” of coverage in the six years preceding the data collection.

43 The remaining percentage corresponds to missing values. No one established a null relation with austerity.

*“They’ve ceased their operations... at least three teams in the northern region. But I think that there are more. Viana do Castelo, Guimarães, one of Porto’s team has been shut down.” (FG4.3)*

*“The outreach teams are almost extinct (...) those who develop fieldwork are disappearing and everything is done according to people’s good will. Until when? I don’t know. There are no resources: vans, material, support, screening projects... Nothing, every day we have less.” (PWUD35)*

*“The outreach teams I know are still developing their work. But they’re on the verge of ceasing their operations (...) for a simple reason: there are no funds” (P3)*

In what concerns the number of active HR projects in Portugal, data published by the SICAD (2009–2013) did not show a linear reduction trend between those years. However, in 2013, there were less five projects implemented (n=31) than in 2012 (n=36; *ibidem*). Centre and Lisbon and *Vale do Tejo* (LVT) were the regions where this occurred.

On the other hand, with respect to outreach teams operating in the field, there was a reduction between 2009 and 2012 (2009=36; 2010=26; 2011=23; 2012=18), a trend that did not continue in 2013 (n=26, SICAD, 2009–2013). Even though the data collection process of this research was essentially carried out between 2013 and 2014, the information presented above sustains the participants’ point of view regarding the functioning of these services.

In addition to the previous considerations, other participants, mainly professionals, identified a period of hiatus in the funding of HR projects (n=6; FG5.2).

Also the results derived from the quantitative data highlight a “high decrease”/ “decrease” in the material resources possessed by the HR teams, in the six years preceding data collection (74.7%; n=62)<sup>44</sup>. Among the participants who pointed to these trends, 54.8% (n=34) highly associated it with austerity.<sup>45</sup>

*“The funds take a lot of time to arrive, the money transfers are never done... The institutions are living like their own users.” (P8)*

*“Last year, twelve or thirteen HR teams had to wait to know if they would continue to function. Luckily, they were renewed for another period of time (...) these tenders are slow, very slow...” (P18)*

*“Two months without funding and other two months in a very peculiar context (...) a sort of hiatus, due to a delay in the tenders.” (FG5.2)*

44 25.3% of the participants mentioned the same value in terms of materials allocated to the teams in the same time period, while none of the participants reported an “increase”/ “high increase”.

45 16.1% (n=10) “somehow associated it” with austerity, while 3.2% (n=2) did not associate it with austerity. 25.8% (n=16) are missing values.

*“In addition to the periods of hiatus in terms of funding (...) last year, we didn’t receive any funds for eight months (...) and we still continued to do our job.” (P17)*

*“I believe that some of the delays were caused by the Troika timings. They wanted to hold the money. But here and there was some investment made.” (D19)*

According to the participants, this situation was not only associated with the budget limitations described by SICAD, which ultimately led to obstacles in terms of administrative management. The interviewees also identified issues regarding the current model and conditions for the public funding of projects (n=3).

One of the main obstacles mentioned was the need to submit projects (to tender) every 24 months for their renewal and the barriers that this process poses to intervention (e.g. planning a medium/long-term intervention and establishing a relationship of trust with the users):

*“The project was going to end. Now, it will only end in a couple of months. So, in those last months, the professionals won’t be as committed as they wanted to, since they’re already aware that the project is going to end. Two more months and a final breath before dying (...) Then the project was approved again and we had to start from scratch (...) The PWUD used to resort to the outreach teams, to exchange their material and find some support. But they broke that habit. And they don’t trust the teams anymore.” (FG5.2)*

*“Weak solutions like the sporadic funding of the outreach teams and the lack stable investment in harm reduction and prevention projects. These programmes require more stable solutions, because they are very important. They should be as important as the teams who work in state services.” (P6)*

*“These shouldn’t be projects. They’re services.” (D24)*

*“Renewing the teams’ contracts is not a stable solution. It is a way to throw dust in our eyes.” (P18)*

The participants (n=11), especially professionals, also discussed a set of consequences associated with the aforementioned context:

**a)** the existence of outreach teams that cancelled some of the services provided to PWUD, with an inclination to penalise the psychosocial support services;

*“The psychosocial support services, the follow-up services, the case management in social security cases, the meetings to request the RSI, the food services... all of them were on standby. The services continued to function, but with the minimum amount of resources, and providing the minimum services” (P9)*

*“There are more and more users trying to contact us and expressing their desire to be part of our project. And it is not easy to work with these users, especially if the team is not being financially supported and is providing the minimum services.” (P1)*

**b)** a reduction in the number of working hours in the field and with the users;

Although it is not possible to reach the main reasons (e.g. reduction in the contact hours), more than a half (54.8%; n= 51) of the questionnaire respondents indicated a “high decrease”/ “decrease” on the PWUD access to HR services, in the six years preceding the data collection<sup>46</sup>. Among the participants that identified these trends, 58.8% (n=30) highly associated it with austerity measures, while 15.7% (n=8) “somehow associated it”.<sup>47</sup> It is significant that the majority of participants who position themselves in the “highly decreased” option are inserted in HR teams currently waiting for the opening/results of the call for proposals (42.9%).

*“In terms of fieldwork, we’ve noticed a reduction in the number of times we’ve contacted the users. This leads to a decreasing intensity of our work with the person.” (P18)*

*“The teams are not doing enough fieldwork. It is more difficult for them.” (P15)*

**c)** a reduction in the number of professionals in HR teams; regular delays and breaches in the payment of the workers’ wages; or, in alternative, professionals who once had contracts started working as volunteers;

This is also coherent with the results derived from the quantitative data, with the majority of the participants declaring a “high decrease”/ “decrease” in the human resources allocated to the HR teams (79%; n=64), in the six years preceding data collection<sup>48</sup>. Among these participants, 57.8% (n=37) attributed it to austerity<sup>49</sup>.

In resemblance, the majority of the participants also reported a “high decrease”/ “decrease” in the job stability of HR professionals (86.5%; n=71), in the same time period<sup>50</sup>. Among the ones that mentioned this trend, 60.6% (n=43) decidedly associated it with austerity.<sup>51</sup>

*“The employees are not getting paid; their wages are on standby or delayed. This has an impact in their performance and in the service provided.” (P15)*

46 29.9% (n= 27) of the participants mentioned that those services continued to work as before, while 16.1% indicated an “increase”/ “high increase”.

47 The remaining percentage (25.5%; n= 13) corresponds to missing values. None of those participants indicated an absence of relation with the austerity measures.

48 21% (n=17) considers that there is a stability in terms of human resources in HR teams, while none of the participants pointed out a “increase”/ “high increase”.

49 10.9% (n=7) “somehow associated it” to austerity, while 1.6% (n=1) did not relate this issue with austerity. 29.7% (n=19) are missing values.

50 12.2% (n=10) did not identify significant changes in the jobs’ stability, while 1.2% (n=1) reported a high increase.

51 8.5% (n=6) “somehow associated it” with austerity, while 1.4% (n=1) did not associate it with the austerity measures. 29.6% (n=21) are missing values.



*“It’s pretty unfair. The outreach teams are doing their best to assure the access to constitutional rights and the Government is completely nonchalant, as if the teams were obligated to assure these rights. We’re now going through a very active stage in terms of volunteer work (...) these tasks should be done by professionals with a superior academic qualification, in order to develop a serious and professional work.” (P1)*

*“At the beginning of the project, the coordinator had a full-time schedule. Nowadays, she has a part-time schedule (50%); the psychosocial professional also used to have a full-time schedule, but nowadays his attendance is around 80%. The project used to have a full-time anthropologist; now, he has a part-time schedule too (50%). There were two psychologists working on a full-time basis. Nowadays, there’s only one left (50%) (...) the team was reinforced in terms of nursing professionals, by resorting to the institution’s own budget. The State didn’t provide the necessary funds. (...) when compared to the team’s situation ten years ago, the staff is almost reduced in half.” (P17)*

*“The budget cuts led to the reduction of the teams. In some cases, the work developed by two full-time professionals ended up being carried out by only one full-time worker. In other words, we ended up with two part-time workers; they took turns, because the field activities shouldn’t be done by only one professional.” (P18)*

As a result of this professional context, some professionals (n=10), PWUD (n=2) and decision-makers (n=2) used expressions like “lack of motivation”, “frustration”, “helplessness”, “fatigue”, “powerless” and “insecurity”. They also mentioned a diminished **“solidarity” (P17)** of the technical staff towards the users: *“The motivation is affected by the late salaries, by the uncertainty regarding our future. We cannot make any life plans. It’s ironic how we are working to improve the users’ lives while ours are quite unstable” (P18).*

In line with those statements, the tendency of the questionnaire’s participants is for identifying a “high decrease”/ “decrease” in the motivation of the HR professionals regarding their daily work, within the six year period preceding data collection (74.7%; n=62).<sup>52</sup> Among the participants who positioned themselves this way, 16.1% (n=10) “somehow associated it” with the austerity, while 56.5 % (n=35) associated it with austerity<sup>53</sup>.

*“The reduction in terms of wages is unacceptable. The lack of funding for the projects leads to this situation. It is terrible, isn’t it? It affects the teams’ motivation and there’s always a certain uncertainty regarding the work being developed.” (P6)*

*“Nowadays, working as a social worker is quite stressful. We can easily observe the huge dissatisfaction among our population. And we feel powerless.” (P21)*

*“They should feel unmotivated. How can you feel motivated when there are so many situations happening at the same time? When things are going from bad to worse? When the resources are scarcer than before? Of course*

<sup>52</sup> In addition, 21.7% (n=18) reported a stable level of motivation, while 3.6% (n=3) reported an increase.

<sup>53</sup> The remaining percentage corresponds to missing values (27.4%; n=17). Thus, none of the participants pointed out the absence of relation between the austerity and the decreased motivation of HR professionals.



*they're unmotivated. They are tired. And this has an impact on the work being developed. Worse: it has an impact on the users' lives, people who are in extreme difficulties.” (P16)*

**d)** Finally, by the same reasons presented above, the interviewees also mentioned the difficulty in coordinating with the public and private entities (partners) that facilitated the execution of a comprehensive work with PWUD.

*“It is harder to communicate and coordinate with some partners, especially those who suffer from the impact of the crisis. And some of them are even supported by the state: the ARS, the CRIs and the ETs.” (P18)*

Among the professionals and peer educators that responded to the questionnaire there is no consensus about the topic above, with half of those (50.6%; n= 42) mentioning the continuous of liaison with other services/ partners; 27.7% (n=23) reporting a “high decrease”/“decrease” in this articulation; and oppositely 21.7% (n=18) identifying an “increase”/ “high increase”. It was possible to find some differences in the participants’ perspective on this topic according to two socioeconomic variables: NUTS and financial situation of the team. The participants from the north were more able to identify a decrease in the connection with other services (34%) when compared with the participants from the centre (14.3%) and south (16.7%). Also, the professionals from HR teams waiting for the opening of the public tender (at the time of the data collection) seemed to identify a decrease in the liaison with other services (37.5%), contrary to the ones with regularised funding (23.2%).

Among the participants that identified a “high decrease”/ “decrease” in this matter, 34.8% (n=8) “somehow associated it” with austerity, while 39.1% (n=9) associate it with the austerity. Among those who mentioned the “increase”/ “high increase” in the liaison with other services: 33.3% (n=6) did not associate it with austerity; 27.8% (n=5) highly associated it with austerity and 16.7% “somehow associated it” with austerity. Thus, it is possible to observe that the communication between services is somehow related with austerity. In fact, it is not surprising to observe that the financial constraints had an impact in this matter (e.g. less resources to invest in). On the other hand, several attempts to increase this collaboration, in order to bridge gaps in the provision of services, were also observed.

In short, one could say that *“in terms of services and outreach teams, they’re in a more precarious situation. Why? I’ll tell you why: because many of them are supported by Governmental or community funds. Or by IPSS, or other organisations, which are also dependent on those funds. Without having received those funds, the teams’ work was also affected” (P15).*

According to the Directorate-General of Health (DGS, 2013b), in 2013, the NGOs were the main entities responsible for the largest amount of distributed/exchanged needles in the country (n=899.662), when compared with the mobile units (n=22.296) and the Primary Healthcare Services (n=28.694). In fact, the NGOs were especially important during the implementation of the needle exchange programmes in healthcare centres. This scenario was also mentioned by the participants (n=7). For 19 years, this programme was operationalised through pharmacies and the cooperation between several entities. However, it ended in 2012, “due to the lack of availability by the National Association of Pharmacies to continue managing this programme” (DGS, 2013b, p.3).

As an alternative, a partnership with the Health Centres' Clusters (ACES) was established; however, the participants pointed out several obstacles to this initiative, not only placed by the professionals of these services, but also by the PWUD. These issues were reported by the shared services of the Ministry of Health (2013, September 21<sup>st</sup>), which also identified other barriers like the inadequacy of the Primary Healthcare Services' schedule to the PWUD reality and the PWUD's difficult access to some facilities where this programme was being developed.

*"I have to escort them to their medical appointments. Otherwise, they won't go by themselves. There are several problems and obstacles. Many of them are quite simple, like not feeling comfortable to talk about their own life or experiences."* (P18)

*"They [PWUD] don't want to go to the healthcare centres; these services are not prepared for receiving them... they don't want to exchange needles in the healthcare centres."* (P17)

*"I have to escort them to their medical appointments. Otherwise, they won't go by themselves. There are several problems and obstacles. Many of them are quite simple, like not feeling comfortable to talk about their own life or experiences."* (P18)

In addition to the lack of specialisation of those services, the participants also pointed out the stigma and the discrimination (n=2) as reasons for the malfunction of NSP developed in healthcare centres (n=6). One of the participants mentioned that *"the needle exchange programme should be perceived as a healthcare service. It is not carried out in the pharmacies anymore and it should be implemented in the healthcare centres, but it isn't. It is implemented in a 10% basis; instead of a 100% basis (...) the representatives of Gaia's city hall had several meetings with the pharmacies, in order to maintain this programme. Four or five of them agreed to do it. In practice, there isn't any type of needle exchange programme in the healthcare centres, and I believe it will never happen"* (P17).

*"I believe that there are spare needles in some healthcare centres. However, PWUD don't go there, especially in small towns like Freamunde or Paços de Ferreira. There's still a lot of prejudice towards PWUD."* (P15)

*"The commission of patients of the healthcare centre said that the mobile unit [of the outreach team], parked right next to the facilities, gives a bad image."* (P17)

The official data by the DGS (2013) showed that there was a reduction in the number of exchanged needles in 2013 (n=950.652), in comparison with 2012 (1.086.400). One of the causes of this reduction was the change in the functioning of the *"Say no to a used needle"* programme and the increasingly active role of the Primary Healthcare Services. In this document, the DGS also stated that *"the number of needles exchanged should not be overvalued, since it will likely increase in 2014. On the other hand, there was an increase in the number of needles exchanged via non-governmental services (outreach teams and mobile units); the volume of exchanged needles was already 87.5% of the value reached last year. In 2014, this value will probably increase."* (Ibd., p.43)

As a consequence, some of the interviewees suggested that there has been *“a clear and dramatic reduction in the needle exchange programmes”* (P24). The HR professionals and peer educators who completed the questionnaire identified a “high decrease”/ “decrease” in the PWUD access to needle exchange programmes, in the six years preceding quantitative data collection (68.8%; n=66)<sup>54</sup>. Among those who identified this trend, 62.1% (n=41) highly associated it with austerity<sup>55</sup>. As a consequence, some participants mentioned the increase of risk behaviours (n=3), since *“at the moment, it is not easy to find sterilised material as it was before”* (P15):

*“In the past, I used to go the pharmacy to exchange my needles. Nowadays, we have to wait for the mobile units. Sometimes, we just can’t make it on time and we end up injecting drugs with used needles.”* (PWUD30)

*“Many of them saw PWUD washing used needles, because the pharmacies didn’t exchange them anymore.”* (FG4.4)

*“Many PWUD began to buy and sell needles. Others gathered as many as they could. This was one of the main consequences I’ve noticed.”* (P9)

However, official data from treatment services and HR teams (Carapinha, 2012; SICAD, 2014) do not coincide with these statements (cf. Risk behaviours).

Subsequently, the Assistant Secretary of State for Health Minister, Fernando Leal da Costa, stated that pharmacies “are a vital partner for the needle exchange processes” (Leal da Costa in *Lusa/Sol*, 2014, April 16<sup>th</sup>); as a result, in July 2014, the Ministry of Health and the National Association of Pharmacies concluded an agreement for the implementation of public health programmes (including NSP) “for an experimental period of 12 months, without any kind of charges for the State (Infarmed, 2014, p.2).

In other words *“the needle exchange programmes changed after being included in the services provided by the healthcare centres. This was a result of the decision by the National Association of Pharmacies to charge this type of service. The pharmacies were not a part of this programme, but now they will be. There has been some controversy regarding the first decision, but despite all obstacles, we were able to maintain the programmes, since there has been a continuous financial investment”* (D41).

54 24% (n=23) mentioned the continuity of those programmes, while 7,3% (n=9) reported an “increase”/ “high increase” in the same time period.

55 6,1% “somehow associated it” with austerity; 4,5% (n=3) did not associate it with austerity; 27,3% (n=18) are missing values.

## DRUG TREATMENT

According to SICAD, the treatment process “begins when an individual with an addiction/dependence contacts a professional or a healthcare service, thus initiating the treatment programme. This process is done according to the integration of specific interventions (occurring singularly or concomitantly) and will only end when the individual achieves the highest health and well-being potential” (SICAD, online). In fact, treatment in the ambit of dependence could be done in accordance with different types of frameworks, services (e.g. outpatient, inpatient) or interventions/combination of different interventions (e.g. psychopharmacology, social rehabilitation, and psychology). One of the most relevant aspects in terms of treatment is its accessibility, especially in what concerns the adjustment of therapy services to the specific needs and goals of each person.

In Portugal, the treatment services are implemented by the State and by private or privately conventionalised tutelage organisations. The organisation of these responses is done according to a referral/coordination network. The treatment model implemented by the public services of the Ministry of Health has an integrative character supported by a biopsychosocial approach, in which different therapeutic resources are integrated and coordinated. The new organic law enforced by the Ministry of Health (Cf. 2.2. Coordination on matter of Drugs) aimed to extend the provision of responses in drug addiction to the primary healthcare services, thus integrating this type of interventions in healthcare services provided to the general population.

According to it, this type of services should become the main access to the healthcare network, rather than the direct admission in specialised treatment units. This way, the treatment process can begin: 1) in the primary healthcare services and then move on to the specialised services, via the family doctors; 2) in the specialised services on matter of drugs (the CRI or ET), via referral or the individuals’ own initiative<sup>56</sup>. The access to treatment services can be done: 1) according to the individuals’ own initiative, by resorting to one of these services; 2) via referral by different social entities. At a national level, this referral process is done: 2.1) via medical appointments, hospital emergency services or HR services; 2.2) via Commission for the Dissuasion of Drug Addiction; 2.3) via entities from the security forces, the educational system and the social security system; 2.4) via court orders, since the Portuguese legal framework perceives as alternative to imprisonment the willing to begin a treatment programme (among several options of treatment programme and not only detoxification).

Dissuasion is a key-element of the decriminalisation law; in addition, treatment also has a vital role, since the CDT’s decisions tend to privilege the referral of addicted individuals to these services (12% in 2013; SICAD, 2014).

During the discussion of the treatment axis and the users’ access to these services (i.e. to what extent can the users begin a treatment process, if they are willing to do so; n=27), the majority of the participants considered that this opportunity continued to be granted (n=14). Therefore, they believed that the access to treatment services was

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56 After the beginning of the treatment, the individuals can benefit from different therapeutic resources – Psychology and Psychotherapy Appointments; Nursing Appointments; Appointments for Children and Youngsters; Appointments for Pregnant Women; Therapeutic Support Groups; Treatment with opioid antagonist/agonist; Day care centres (service for treatment and reintegration). When the PWUD require a more specific therapy, they can be referred to other structures: Detoxification Units; Therapeutic Communities; Mental Health Services and Specialised Services – Medical and Surgical Hospital Services.

not confined; in fact, some even considered that the access became easier during the period of implementation of the Portuguese decriminalisation model (n=3). A participant also highlighted that: *“The treatment services are now working as the single support strategy to PWUD, which I think is very restrictive”* (D37)

*“I’ve started to work in 1998. When comparing the last 15 years, I believe that we are now closer to the users (...) I think we were able to cover the majority of problems that existed.”* (P15)

*“People made a huge effort to establish several facilities and enough treatment centres to help those who wanted to initiate treatment programmes and develop some kind of therapeutic processes”* (E39)

Among the HR professionals and peer educators that answered to the questionnaire, there is a divided positioning about the evolution of the PWUD’s access to drug treatment services. In fact, 49.5% (n=48) of the participants considered that the access to drug treatment “highly decreased”/ “decreased”, while 35.1% (n=34) stated that it remained stable. 15.5% (n=15) mentioned an “increase”/ “high increase” in the access to this service. Among those who perceived a “high decrease”/ “decrease” in the access to drug treatment services, 54.2% (n=26) associated it with austerity<sup>57</sup>. On the other hand, the participants who indicated an “increase”/ “high increase” did not attribute it to austerity. It is interesting to see that the association with austerity was more evident among those who reported negative trends, while more positive considerations are less associated with austerity.

Some interviewees (n=4; FG5.2) mentioned some constraints regarding treatment access, namely the temporary closing down of treatment units. As a consequence, they spoke of the overcrowding in the services still open (PWUD36) and the obstacles to the access to these services due to geographical reasons (n=2; FG5.2). The following situation clearly demonstrates this context: in order to have access to treatment services, the users from a region in the north of Portugal had to cover a distance of 30km to the nearest treatment centre, a process not always easy due to financial constraints. So, this trip was done many times *“by foot”* (FG5.1.).

*“In ★, there was a decentralised treatment unit similar to an ET. But it has been shut down eight months ago. Therefore, those who want to apply to a treatment process have to travel 30km. The users who were already monitored by professionals of these facilities, namely the ones who were in methadone programmes, are not being assessed at the moment.”* (FG5.2)

★ (the name of the parish was not mentioned, in order to protect the identity of the participants)

The official data by the public and licensed specialised treatment services showed that between 2011 and 2013, the number of treatment facilities did not change (46 facilities); in terms of other medical appointment services

57 18.8% (n=9) indicated that this is somehow associated with austerity; no participants on this group mentioned the absent relation with austerity; 27.1% (n=13) are missing values.

(*Outros Locais de Consulta*), the number decreased in some regions (Lisbon and *Vale do Tejo* region) between 2012 and 2013 (least 3 facilities); the number of therapeutic communities and detoxification units decreased in terms of licensed network, but not in the public network; there were no changes concerning day care centres (SICAD, 2011–2013). Regardless of the changes identified in these data, the participants in this study seemed to emphasise a specific situation, rather than a more generalised situation, contrary to what was anticipated by the political discourses conveyed in mass media (*Público*, 2010).

The interviewees, mainly PWUD (n=6; 1FG) also identified other obstacles in the access to treatment services. One of those obstacles was **the bureaucratisation of the entire process to access drug treatment** (n=2), attributed by one of the interviewees to the integration of these services in the Regional Administration of Health: “*Now that the treatment services are part of the Ministry of Health and the ARS, the decision-making system has become much more bureaucratic*” (P17).

The participants also pointed out the excessive **waiting time** before initiating the substitution therapy (n=3), associating it with the lack of availability of the physicians who prescribe them. Similar considerations were observed regarding the therapeutic communities (n=2). However, one individual mentioned a positive evolution in terms of waiting time, stating that “*the access is now easier. Six or seven years ago, we had to wait six or more months to have access to CAT [Care Centre for Drug Addicts]*” (PWUD29). Official data regarding the average waiting time for initiating a methadone programme showed a reduction between 2011 and 2012, from 14 to 4 days (SICAD, 2011–2012; no available data for 2013). As established, the average waiting time for this programme is 10 days.

*“The number of users resorting to the CATs is increasing, since some of the facilities closed or had to reduce expenses. This is the Government’s fault. In the past, there were much more support to the CATs (...) They are still functioning, but with limited resources.”* (PWUD36)

*“It is hard to coordinate our lives with the CAT. I try to schedule a medical appointment, but the only one available is next week. I’m already experiencing the withdrawal symptoms, how can I wait an entire week? I will not wait! And after the appointment, I’m not sure when or if I will be prescribed with methadone.”* (P2)

Another topic that didn’t emerge from the content analysis, but which is assessed through the questionnaire administered in this study, concerns the perception about fluctuations in the number of PWUD abandoning drug treatment<sup>58</sup> in the six years preceding data collection. In terms of the amount of PWUD abandoning drug treatment, some participants did not report significant changes (42.5%; n=37), while others mentioned an “increase”/ “high increase” of people in this situation (47.1%; 41)<sup>59</sup>. Among the first group, the majority was from the region of Lisbon and *Vale do Tejo* (57.1%). Among the participants who identified an “increase”/ “high increase”, 31.7% (n=13) “somehow associated it” with austerity, while 24.4 (n=10) strongly associated it with austerity<sup>60</sup>.

58 Abandoning drug treatment can be defined as the process in which the PWUD interrupt the treatment programme without medical release.

59 10.3% (n=9) believed that the number of PWUD abandoning treatment decreased/highly decreased in the indicated time period.

60 12.2% (n=5) did not establish a relation with austerity; 31.7% are missing values (n=13).

The official data concerning this indicator (IDT, 2008–2011) shows a stable percentage of PWUD abandoning or being excluded of drug treatment programmes with opioid agonists (methadone or buprenorphine) within the public services (2008=42%; 2009= 42%; 2010=43%; 2011= 43%). The merged presentation of two qualitatively different indicators – treatment exclusion and treatment abandon – is an obstacle to a comprehensive analysis of the situation. Moreover, since 2012, the above-mentioned data are not presented in those annual reports.

Additionally, with respect to the opioid substitution treatment programmes, the professionals identified some obstacles in the access to the different pharmacological substances used in those programmes, due to the fact that the users needed to co-fund some of them (n=3). This was particularly observed in programmes that used buprenorphine as the substitute substance, since the therapy programmes involving methadone are 100% supported by the Portuguese Government.

*“Some patients stopped taking buprenorphine and started to use methadone, because they didn’t have enough money... in the past, the buprenorphine’s costs were covered by the Government, but now, the users need to pay for this medicine. Although the price isn’t that high, they eventually started to prefer methadone because they can’t pay the buprenorphine” (P15)*

Among the professionals, peer educators and PWUD, some discussed issues regarding the **accessibility to drug treatment** (n=8), namely the difficulties to cover the transportation costs. They mentioned that these issues compromised the beginning or continuity of follow-up processes in drug treatment (e.g. absenteeism to medical appointments).

*“There are several patients who can’t come to the medical appointments because they can’t afford the transportation costs.” (P15)*

*“You have to follow my example: I have 8 subway tickets and 2 bus tickets. I couldn’t miss my daily dose of methadone! (...) I’m from Batalha and I had to go to Matosinhos [two Porto regions about 20 kilometres away from each other].” (P2)*

The interviewees also mentioned some organisational aspects of the public drug treatment services. More specifically, the PWUD pointed out the reduction in the available human resources (n=3), namely in what concerned the physician-patient ratio (n=2), the physicians’ working hours (PWUD31) and the professionals ageing (E39; non-renovation of the staff working in drug treatment facilities). On the other hand, a participant emphasised the inefficient management of human resources in specialised drug treatment services: *“the majority of physicians in those services are general practitioners. They deal with individuals who have AIDS and hepatitis. They prescribe substitution opioids. This could be done by the primary healthcare services and by the mental healthcare services, in those cases where the individuals have some sort of mental disorder” (D19).*



*“Nowadays, there’s only one or two nurses in the CAT (...) there are few physicians. In the past, they used to work from Monday to Friday. Nowadays, they only work twice a week.” (PWUD31)*

*“It’s the same group of people who has been working in treatment and prevention services. A group that is growing old and it is not being renewed.” (D39)*

In short, the provision of treatment to PWUD appeared to be relatively assured by these services, in spite of the mentioned obstacles that can influence the therapeutic process in a medium/long-term basis. Those shouldn’t be ignored.

## REINTEGRATION

Luís Capucha (1998) proposed the following definition of reintegration process: “it is not the isolated access to an allowance (...) it is also a process of having the necessary conditions to establish a life project; create a status and social identity; promote a positive self-image; increase the social networks; maintain a positive relation with the services; acquire healthcare and social protection rights; control your own destiny, as well as your family’s destiny” (Ibd., p.61). Therefore, the processes of reintegration of psychoactive substance users that traced a path “on the side-lines” need global and systematic interventions that take into account not only the user himself/herself, but also the social and economic agents. In accordance with this idea, the reintegration projects are also co-funded by the PRI, similarly to what happens with HR and prevention projects.

Similarly to the prevention field, the reintegration was perceived as one of the vectors that faced several barriers. The majority of the participants (n=24; 2FG) mentioned **the absence or insufficiency of reintegration responses in the ambit of employment and education/professional training** (n=12; 2FG). This was also the perception of the questionnaire’s respondents, since the majority of those (74.7%; n=68) reported a “high decrease”/ “decrease” of the PWUD’s access to reintegration responses in the six year period preceding data collection<sup>61</sup>. Among those participants, 54.4% (n=37) attributed it to austerity, while 11.8% (n=8) somehow attributed it to austerity<sup>62</sup>.

Although some of the interviewees believed that this vector suffered from a lack of investment since always due *“to the fact that the reintegration is (...) a mainly social process and therefore, an extremely difficult one, thus requiring a large financial investment”* (D19), others mentioned that this disinvestment was somehow recent, due to the end of some programmes and projects or the conditioned functioning of these initiatives (E13; FG4.3). In what concerned the number of reintegration projects co-funded by the PRI, there was a reduction between 2011 (n=34) and 2013 (n=5); the same happened to the number of people covered by these responses: 2136 in 2011 and 1134 in 2012 (SICAD, 2012-2014).

61 15.5% (n= 14) considered that the access to reintegration responses remained stable; and 9.9% (n= 9) considered that those responses increased in the same time period.

62 2.9% (n=2) did not establish a relation with austerity. 30.9% (n=21) are missing values.



*“In the beginning of these reforms, there was a broad programme directed to the entire population, similar to the Vida Emprego programme. And all the unemployed individuals were eligible. This was perceived as a breath of fresh air, since many believed that this programme would function as an extension of the previous one. But that didn’t happen and this shows a loss of interest in this matter.” (E12)*

*“I believe that the drugs strategy includes a policy of social reintegration, but it would be important to establish tangible policies.” (D38)*

*“I’m not sure if the training sessions are being created or have been shut down... it is a confusing situation.” (P6)*

With respect to the education area, SICAD’s official data (between 2012 and 2013) on the users being monitored by reintegration teams within the CRIs, showed that the response to the needs identified had a success rate of 49% in 2011, 36% in 2012 and 24% in 2013. In terms of professional training, SICAD (2012) data showed that “the fulfilment of needs is pretty low, thus hindering the acquisition of professional competencies that are many times vital during the reintegration processes” (SICAD, 2012, p. 267). The success rate in terms of needs identified was 36% in 2011, 32% in 2012 and 46% in 2013.

Regarding employment, if it is certain that, as stated by Capucha (1998), the reintegration measures are still focused on the increase of income via financial support and professional integration, it is also true that the acquisition and keeping of a job is a structuring and vital element for the sustainability of the reintegration processes. According to SICAD (2012), among the users followed by the reintegration teams, the job market “absorbed” the majority of those integrated in employment programmes (55%); the state’s programme *Vida-Emprego* had the second highest success rate (21%; *ibidem*).

In fact, in terms of employment questions, the programme *Vida-Emprego* was one of the key themes discussed by the participants. This programme is promoted by the Portuguese Government and it is inserted in the global context of active measures to promote employment and professional training. Its main goals are to provide information, guidance, professional training and social-professional integration of PWUD “who are currently in treatment programmes or just ended treatment programmes, either via therapeutic communities or outpatient processes. Inmates involved in programmes developed in prisons are also considered” (Council of Ministers Resolution number 136/1998, December 4<sup>th</sup>). This programme was primarily promoted by the coordination mechanisms, at national and regional level, among the IDT and the Institute of Employment and Professional Training (IEFP). The latter was responsible for the planning and implementation of said programme, namely in terms of cooperation with the treatment centres and employment offices. In addition, some mediators funded by the State (associated to those institutions) were in charge of providing the continuous support to PWUD who benefited from the programme, especially in terms of vocational and professional training and integration in work places.

The programme was created in 1998 as a result of the Resolution number 136 of the Council of Ministers and it was operationalised according to four main elements: a) Social and Professional Reintegration Internships; b) Support to Employment; c) Social and Professional Reintegration Award (prize for the entities who employed

PWUD by signing permanent contracts); d) Supports to Self-Employment. Each year, approximately 1000 PWUD benefited from one of these responses, while the micro and small companies represented 70% of the entities who decided to participate in the programme (EMCDDA, 2012). In 2013, the programme comprehended 840 users monitored by reintegration teams from CRI and 173 monitored by other licenced and conventionalised organisations. SICAD characterised this programme as “a good practice that should be supported” (2015, online).

Among the participants who believed that this programme was a concrete measure for the promotion of reintegration (n=11), the majority seemed to be unaware of the current status of the programme (n=6; FG5.1), i.e. the regions where it was still active, the number of reintegrated individuals, the slowness of the reintegration process. Other participants mentioned that the programme had already ended (n=3; FG4.4) in 2011 – “*in 2011, the programme ended (...) many individuals who were working under the regulation of this programme lost their jobs*” (FG4.4). A group of interviewees also mentioned regional inequalities during the implementation of the programme, identifying its total or partial functioning in Lisbon and the central region of Portugal, opposed to its inactivity or partial functioning in the northern region of the country (n=2; FG5.1).

*“I’m not aware of the current situation of the Vida-Emprego, but I believe it is slowly fading away...”* (E12)

*“The programme is over. There are no training or reintegration services...”* (P6)

In fact, the apparently dissimilar narratives of the interviewees focused on a broader period of negotiations in which the Government proposed the revocation of a set of active employment responses that “are not being executed for a long period of time or have become obsolete in terms of the identified needs and the job market context” (Decree-law number 13/2015, January 26<sup>th</sup>). In April 2013, a document that aimed at the revocation of the *Vida-Emprego* programme and other employment measures was presented to the social partners, in the sequence of the *Programa de Relançamento do Serviço Público de Emprego* [Programme for the Relaunch of the Public Service of Employment]<sup>63</sup>. This first proposal was not successful; a year later, the Government presented a new proposal to revoke these programmes. During this hiatus, which coincided with the interviews<sup>64</sup>, there were several changes in the programme’s functioning.

In 2013, there was a reduction in the support provided by the programme (less 23% than the previous year), as well as several obstacles “to renew the process of institutional coordination” between the IEFP and the SICAD, especially after the organisational restructuring of the latter (SICAD, 2013). The IEFP hasn’t been publishing the annual reports of the physical and financial implementation of the programmes and the employment/professional training measures summary report since 2004, but it would be important to analyse the more recent monthly reports (2013 and 2014), in order to better understand the participants’ considerations. Although the public tenders are permanently open, in January 2013, by regions, the number of individuals covered by the programme was zero in the northern region, LVT, *Alentejo* and *Algarve*. The sole beneficiaries were part of the central region of Portugal (IEFP, 2013). This scenario changed in March, when several beneficiaries from

<sup>63</sup> Programme in accordance with the MoU point 4.9.

<sup>64</sup> September 2013 to December 2014

different regions started to be covered by this programme. Until the end of that year, the number increased in a more or less regular way, except in the northern region, with only 55 beneficiaries for the entire year. In 2014<sup>65</sup> there weren't any beneficiaries from the northern region, although the pattern of functioning had remained similar to 2013 in the other regions.

These data seem to be similar to the participants' perception of the regional functioning of the programme: *"there are no open tenders in the northern region"* (P18). In terms of beneficiaries covered (n=55 in 2013; n=5 in 2014), despite the fact that the IEF's goal has been achieved in 2013 and was not far from being achieved in 2014, many participants believed that some of the needs identified were not fulfilled: *"A couple of months ago, maybe five, I went to a job interview. But they haven't said anything yet (...) my neighbour went as well and she is still waiting for an answer"* (P3, Peer Educator). This issue had an impact in users' lives: *"many of those who found a job after the programme were fired. Some of them were living in boarding-houses and they needed the money to pay for the room"* (FG4.4).

Finally, in January 2015, the Decree-law number 13/2015 (January 26<sup>th</sup>) officially revoked the *Vida-Emprego* programme, approving a new framework in terms of employment policies. In general terms, this framework put under the same umbrella "the groups who are excluded from the job market, namely those affected by poverty and social exclusion", not making any type of distinction between specific target-groups, except those with disabilities. This decree-law promoted "a set of goals that will increase prosperity and social well-being. It is guided by principles respecting universal aspects of economic and social cohesion: freedom and equal opportunities in the selection of jobs; equality and non-discrimination in the access to employment and professional training; the ability to adapt to different local and regional social and economic realities". This should be done "without hindering the positive measures that benefit underprivileged groups with specific difficulties in accessing the job market". However, this decree-law did not identify the positive measures that would be designed with this purpose.

This document and the language used there aimed to establish a parallel with the Europe 2020 and present a response that aimed to cover the increase of vulnerable groups, a clear result of the economic crisis (Amnesty International & SOCIUS/ISEG- UTL, 2010). In fact, in 2010, the groups that gathered the broader consensus among the public opinion on their situation of vulnerability were new vulnerable groups and groups associated with the employment/unemployment/precarious job situations – for example, the youngsters who were trying to find a new job were on top of the concerns of the Portuguese people. The authors of the aforementioned research (Amnesty International & SOCIUS/ISEG, 2010) stated that "it is curious – and worrisome – to observe how the 'new poor' from 10 years ago (Immigrants, Minority Groups, Single-parent Families, Disabled people...) are now a 'heritage' of the 'old poor'. This is very alarming, since it can lead to something we were already suspicious about: the 'old poor' are now less visible and less of a priority. If we interrupt the specific attention given to those groups, their situation can become worse. The crisis did not only generate 'new poor', but also aggravated the situation of those who were already poor" (Ibd., p.12).

Perhaps this is an important reflection to make concerning social exclusion and the specific case of those who use drugs: did the transformation of specific programmes of social and professional reintegration designed for PWUD into general programmes (for all the population) promote inclusion or stigma? Although the decree-law

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65 Data available only until November.

was not yet approved during the data collection process, some interviewees (n=5) gave their opinion on this theme and reflected upon this question. The following excerpts present the notion that, when facing similar problems (like unemployment), the “common citizen” (D37) is usually privileged in terms of political decision-making when compared with the PWUD.

*“The reintegration processes are not being carried out anymore. They’re not being implemented for the common citizens; even less for the PWUD.” (D37)*

*“When the Vida-Emprego programme was created, the chances to find a job were very high (...) nowadays, the situation is totally different. The first ones being left out are those who are addicted to drugs.” (E23)*

*“The unemployment rate is now close to 17%. In political terms, as well as in terms of intervention, it is hard to advocate publicly for the increase of the budget, since the general population does not seem to share this opinion” (D10).*

However, identifying the potential relevance of the *Vida-Emprego*, as well as the positive principles of its creation in 1998, does not invalidate the identification of the programme’s limitations in terms of its design and outputs. In fact, some participants considered that the programme was not properly adapted to the beneficiaries’ needs (P24) and did not follow comprehensive rules (n=3). They also mentioned that the training programmes were poorly paid (P3; FG5.1) and did not match the job market reality (n=2; FG5.1).

*“This perspective about the drug use had a negative impact on the Vida-Emprego programme. In more specific terms, those who were being covered by this programme didn’t even have the personal conditions to benefit from it. The programme wasn’t flexible. The individual would stop using drugs: Vida-Emprego, magic solution.” (P24)*

*“They are extremely inflexible. A simple problem could lead to your exclusion or elimination. It is normal for the users who are simultaneously involved in treatment programmes and training courses to use drugs occasionally. But if they submit to drug tests and the tests are positive they could be immediately eliminated.” (PWUD28)*

*“In my opinion, the training programmes available didn’t meet the job market requirements” (FG5.1).*

*“One of the training programmes was divided into several sessions (four or five hours a day). I was paid 4.30€. I used to make more money parking cars.” (P3)*

Some of these statements were similar to the conclusions by Marques, Mora and Santos (2012) in terms of the psychosocial characteristics of the eligible individuals: “The *PVE* is the only measure specifically destined to people with a psychoactive substance use record. However, it excludes the specific profile of PWUD in harm reduction programmes (...) since it implies a strict criterion of abstinence that marginalises the groups of people

who still use drugs” (Ibd., p.21). Also, in terms of training programmes, the authors stated: “there’s always the PWUD lack of interest towards training courses: they don’t provide monetary compensation or other types of short-term compensations (...) There’s also a lack of adequacy between the PWUD profile and the characteristics foreseen for the majority of training courses (schedules, payment, methods of payment, etc.), frequently dictating their exclusion in the access to these programmes” (Ibd., p.23).

During the implementation of social and professional reintegration measures, some researches in the social field (Capucha, 1998; Caleiras, 2008; Hespanha, 2008; Pedroso, 2005) have been identifying their typical malfunctioning, namely: the insufficient projects and services aimed at the reintegration of more vulnerable groups; the constant mutations of the available employment measures; the inadequacy of the social policies to the profile of some vulnerable groups; the interruption of projects due to the lack of funds and also the assistentialist character of some responses, thus leading to the ineffective resolution of the professional reintegration problems.

This way, and according to Hespanha (2008) “unveiling the biases and helping to rethink the policies in order to make them achieve nobler goals, is a challenge for us all and to the social scientists in particular” (Ibd., p.6). The content analysis made in this study regarding the intervention areas in the drugs field (Prevention, Dissuasion, Harm Reduction, Treatment and Reintegration) suggested that both prevention and reintegration are the vectors perceived as revealing the most negative trends. Accordingly, the participants answering to the questionnaire seemed to have a similar position. When indicating the trend in terms of PWUD’s access to those different intervention areas<sup>66</sup>, the results show that Reintegration was the area identified as having the most negative evolution ( $M= 2.00$ ;  $SD= .955$ ; range: 1-4); followed by Prevention ( $M=2.43$ ; range: 1-5;  $SD= 1.075$ ); Harm Reduction ( $M= 2.52$ ;  $SD=.985$ ; range: 1-5) and finally Drug Treatment ( $M=2.58$ ;  $SD= .956$ ; range: 1-5).

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66 In a Likert scale from 1 (highly decreased) to 5 (highly increased).

## Chapter 3 | Drug use: trends and uncertainties

The study on the relation between socioeconomic conditions and the use of psychoactive substances has been associated with the apprehension surrounding the increase of consumption in contexts of crisis. This investigative effort has also been the basis for many researches. Although “there is no clear theoretical answer, when assessing the impact of the current economic recession on drug use” (Storti, Grauwe & Reuter, 2011, p. 322), the economic crisis did have an impact in many protective factors, thus increasing other risk factors (Ibd.).

In addition, international studies indicate that the use of illicit drugs tends to increase during adverse economic periods (New Zealand Drug Foundation, 2009) or is, at least, associated with economic or socioeconomic conditions (Arkes, 2011; 2006; Shaw, Egan & Gillespie, 2007; Room, 2004); also, unemployment has a negative effect over the number of drug users who initiate therapy processes (Storti, Grauwe, Sabadash, & Montanari, 2011). Once again, the Greek case is frequently mentioned, since one of the indicators of the crisis impact was the increase in the prevalence of heroin use in 2009 (Kentikelenis et al., 2011).

In Portugal, SICAD’s President João Goulão released a public warning in October 2011, stating that there were signs showing the increase of problematic consumption during the crisis (Guedes, October 18<sup>th</sup>, 2011); and the research by Balsa and his colleagues (2014, p. 266) mentioned that not performing any tasks or being unemployed are the most common circumstances for the use of illegal psychoactive substances, especially in what concerns heroin.

In the meantime – and after a slight increase between 2001 and 2007 (7.8% to 12%) in lifetime prevalence of almost all substances – the results from the most recent study on drug use in Portugal indicated a reduction in the lifetime prevalence (12% to 9.5%), as well as last year and month prevalence of almost all substances between 2007 and 2012<sup>67</sup>. This research also showed a reduction in the rate of continuous use during the same period (Balsa, Vital & Urbana, 2014).

The participants were also questioned about their perception on what is happening in the field, since the studies carried out with the general population do not provide any data regarding the socio-spatial characteristics of its respondents. In other words, there are no data that allow us to understand the variations between territories; however, we know that the more problematic use patterns are frequently associated to vulnerable socioeconomic contexts and are well defined in terms of the territories, where many of the interviewees and questionnaire respondents develop their interventions. In broad terms, for some interviewees, it appears to exist a relation between what has been happening in the country over the last years in the economy and social areas and the changes in consumption patterns (n=9).

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67 The authors associated this “unexpected” result with a change in the sociological composition of the population, which is related with an emigration process of many Portuguese (Balsa, Vital & Urbano, p. 89).

*“We find more and more needles in the streets. I see it as a kind of rebellion.” (P1)*

*“This is the ideal moment for it to happen. People will return to their addictions. And I’m not exclusively talking about substance use, right? Gambling, internet addiction... As a form of alienation, of not wanting to think and not being able to fight for something they never achieve.” (D20)*

*“The truth is that we’re noticing some addiction peaks; and the numbers we’ll see in the future will scare us.” (E25)*

*“Due to the lack of follow-up services or structuring programmes, members of this population are returning to their old habits.” (PWUD35)*

## **EPIDEMIOLOGY**

In addition to the trends identified above, the majority of the participants who addressed this issue identified a set of negative variations. They mentioned the fact that there are new (n=2) and even more individuals using drugs (n=4) and also the geographical expansion to other consumption areas (PWUD31).

*“Some ‘new faces’ keep appearing; I don’t know them.” (D20)*

*“The drug territories are expanding. The Aleixo neighbourhood used to be one of the main drug routes, but now there’s also Pinheiro Torres, Pasteleira, etc. That’s because there’s a lot of demand, right?” (PWUD31)*

*“In my opinion, there are more and more people using drugs. I believe that this issue is also mentioned in the SICAD’s reports.” (P6)*

More considerably, the aggravation of the dependence (n=3) and the relapses (n=8) are perceived as a step back by the interviewees. In fact, most of questionnaire respondents reported that there was an increase/high increase in the number of PWUD who relapsed into drug use (73.4%; n=69) in the six years preceding data collection.

*“The situations of dependence are getting worse and increasingly regular.” (E13)*

*“We have been registering new admissions; the individuals are mainly former drug users, but also people who stopped using drugs, but eventually started to use again. This is one of the most mentioned issues.” (P16)*



However, these tendencies do not seem to be consensual: three of the interviewees (including two peer educators) believed that they were witnessing a reduction in terms of consumption; and 23.4% (n=22) of questionnaire respondents report that tendencies remain the same. Anyway, what is more consensual between different sources is that reports that could point to a positive outlook on what has been happening in the last years are a minority among interviewees or even residual among questionnaire respondents<sup>68</sup>.

*“Our team has been noticing a reduction in intravenous drug use, as well as in drug use in general.” (P17)*

Regarding the context of economic crisis Portugal was going through, some interviewees established a relation between these issues and the context of crisis and its consequences (n=7), as well as the majority of questionnaire respondents – who identified an increase in the number of relapses, somehow/highly associated with austerity (63.4%; n=44)<sup>69</sup>.

*“I’m aware of some issues; especially the fact that this level of austerity has been hindering the referral processes and people are now going back to the old habits in what concerns drug use.” (PWUD35)*

*“Apparently, there have been some setbacks in what concerns heroin use, mainly due to unemployment.” (D38)*

*“There are still people using drugs, there are still people having relapses. This issues are directly associated with the economic crisis.” (P9)*

However, the relation between these two phenomena did not appear to gather a consensus among interviewees as well. In addition to one of them who did not associate both factors (P18) and two PWUD who could not even see how they could influence each other, there were some interviewees who believed that the data to truly assess this relation was not enough (n=6+1FG).

*“In the drugs’ field there’s always drug; there’s no such thing as a crisis” (PWUD30)*

*“The drug users don’t care about the crisis, they are not aware of it. All they have to do is get some money to support their consumption.” (PWUD31)*

*“I have heard that there has been an increase in consumption, but in my opinion, and from what I have seen on the ground, this trend has been divided; in others words until the end of 2011 and the beginning of 2012, there were much more exchanges of paraphernalia. I usually exchange around a dozen needles and one or two tin foils per week. I don’t know, maybe that’s a sign that people just can’t afford drugs or don’t use drugs anymore.” (P7)*

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68 3.2% (n=3) considered that there had been a decrease.

69 Remaining percentages: 1.4% (n=1) considered that there had been a decrease; 34.8% (n=24) are missing values.



*“At this point, I don’t believe that there are sufficient data on this matter. We do have access to some of the data, but we don’t have a sustained reading, in order to understand if there has been a reduction or increase” (E11)*

In this report, we tried to understand this lack of consensus, but the type of actor or the geographic area of intervention did not seem to have any type of influence, since there were several opinions among decision-makers, experts, technical staff and users; these opinions also varied according to the cities and areas of intervention. Due to these realities differently interpreted by the participants, we raised the hypothesis that they were being influenced by different perspectives on consumption patterns. The participants’ position regarding this issue is presented below.

## DRUG USE PATTERNS

After retrieving the data on consumption patterns of illicit psychoactive substances from the results of the study carried out with the general population (between 2007 and 2012) and from the results of the research developed with HR teams’ beneficiaries (between 2004 and 2011), we observed a reduction in lifetime and last month **prevalence** for almost all substances.

However, it is important to mention several specificities. In what concerns the general population, between 2007 and 2012, there was a reduction in lifetime and last month prevalence in the following: cannabis, cocaine, amphetamines, heroin and mushrooms; the percentages regarding ecstasy and LSD consumption remained similar. However, when compared to 2001, data from 2007 showed a significant increase in lifetime prevalence, and for the last month the results were similar or somewhat higher (Balsa et al., 2014, p. 103), thus demonstrating the existence of a mid-decade consumption peak.

With respect to consumption patterns by HR teams’ beneficiaries (Carapinha, 2012), there was a slight reduction in the percentage of lifetime consumption between 2004 and 2011 in almost all substances (except with non-prescribed methadone and buprenorphine). However, in 2010, this percentage increased in almost all substances, when compared to 2009 and, in some cases, compared to 2004. Regarding more recent substance use, there was slight increase in heroin use in 2010, contrary to the usual reduction trend (Ibd.).

On the other hand, there were significant differences between the two target-groups in what concerns the **main substance**: the general population’s most used substance was cannabis (Balsa et al., 2014); and among the HR teams’ beneficiaries and the users admitted in treatment services (SICAD, 2014) heroin occupies the first place, followed by cocaine and cannabis<sup>70</sup>.

Therefore, this set of specificities associated with different time frames and target populations seems suitable

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<sup>70</sup> Despite the fact that the use of cannabis (in relation to other drugs) among new users involved in therapy programmes is growing since 2011, thus becoming the main substance used in 2013 (SICAD, 2014).

to understand why the interviewees had different opinions regarding consumption, as seen above. This also happened in terms of the most used substances, since some interviewees mentioned the predominance of cocaine (n=4), while others stated cannabis (n=3) or other synthetic substances (n=2).

*“We don’t see many people using heroin. Nowadays, they use cocaine and hashish.” (PWUD30)*

*“Cannabis is the main drug, but cocaine is the most used drugs in party scenes, since it is more available to the public.” (P6)*

*“Drug users are now going for synthetic substances, rather than heroin and cocaine.” (P9)*

In what concerns the **frequency of consumption**, the general population’s results showed the less regular consumption of all substances between 2007 and 2012, despite the number of times cannabis, cocaine, ecstasy and LSD were used during the last month had been more regular in 2007 than in 2001 (Balsa et al., 2014). In what concerns HR teams’ beneficiaries, they were questioned about daily consumption prevalence during the last 30 days of use, but the results were similar. Therefore, it was concluded that the daily use of heroin decreased drastically (91.3% to 29.3%) between 2004 and 2011, much like the daily use of cocaine/crack cocaine and cannabis. Nonetheless, the daily use of heroin mixed with cocaine increased significantly (46% to 73.7%) between 2009 and 2011 (Carapinha, 2012).

The HR professionals who answered the questionnaire reported, in the six years preceding data collection, an increase/high increase in drug use frequency (54.8%; n=51), but also an important percentage of questionnaire respondents mentioned that there were no changes in drug use frequency (41.9%; n=39)<sup>71</sup>. The same applies to the daily amount of drug use, where the respondents were mainly divided between the ones who considered that the daily amount of drug use remained the same (47.3%; n=43) and the ones who considered that there had been an increase (36.3%; n=33)<sup>72</sup>.

Thus, variations occur primarily among the most conservative positions – from those who considered that the trends remained – and the ones who reported increases in daily amounts and frequencies of drug use. Some small differences were found in terms of frequency, namely according to years of experience, as well as regional and financial issues of outreach workers<sup>73</sup>.

Moreover, those who identified the increasing frequency and daily amount of drug use associated it with austerity. This trend in drug use frequency was somehow/highly associated with austerity for 52.9% (n=27) of respondents<sup>74</sup>; and 48.5% (n=16) of them somehow/highly associated the growth in terms of daily amount with

71 Remaining percentages: 3.2% (n=3) identified a decrease.

72 Remaining percentages: 16.5% (n=15) mentioned a decrease.

73 For example, with respect to the frequency of use, the respondents of North of Portugal mentioned a stable drug use frequency (51.1%); while respondents from the Center and Lisbon reported an increase (66.7% and 55.6%, respectively). Moreover, respondents with 11 or more years of professional experience identified an increase in the frequency of drug use.

74 Remaining percentages: 3.9% (n=2) did not associate; 43.1% (n=22) are missing values.

austerity<sup>75</sup>. Also three PWUD who were interviewed mentioned a reduction in the frequency of consumption, associating it with lack of money.

*“When I use drugs, I usually take one or two doses, instead of four or five. And that’s when I have money for two doses.” (PWUD28)*

Nevertheless, the participants’ discourses in terms of drug use patterns were mainly dominated by their concerns on **drug administration routes**, namely injection. At an international level, “there is evidence in favour of the hypothesis that in times of economic recession, when the economic resources of drug users can decrease, they may prefer injection to other modes of administration in order to maximize the effect of what they have purchased (Lakhdar & Bastianic, 2011).

In Portugal, although there are no data on the evolution of this practice for the general population, cocaine and amphetamines consumption via injection was the least often method used and the second chosen method in what concerns heroin (2012). Smoking and sniffing cocaine appeared to be the predominant methods and the amphetamines were usually ingested (Balsa et al., 2014).

In what concerns the last month of substance use among HR teams’ beneficiaries “the prevalence of injection practices (except the cases of non-prescribed methadone and buprenorphine) in the 2010 and 2011 samples, is lower than the ones from 2004 and 2009” (Carapinha, 2012, p. 79). With respect to the users involved in treatment programmes, the analysis of the evolution over the past years showed there was also “a reduction of the prevalence of recent injected drug use; this affected not only the new users, but also former users who were reintegrated in the public services’ network” (SICAD, 2014, p. 47).

Although the results from the different researches appeared to be similar in terms of administration route, the interviewees (especially professionals and drug users) had different points of view. While some of them mentioned the reduction of this practice (n=7+1FG), others supported its increase (n=6+1FG). The second group associated it with the users’ lack of money, which eventually made them to return to old habits.

*“We didn’t notice that sensational thing “they will inject more”. We simply didn’t notice it.” (P18)*

*“We don’t see many people injecting drugs.” (PWUD30)*

*“Contrary to what my colleagues say, I have the perception that the users are now injecting more drugs. In my opinion, which is very personal and without deep analysis, the budget cuts are one of the main reasons. Now that they don’t have enough money, they start injecting more. However, my colleagues don’t feel the same way.” (P8)*

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<sup>75</sup> Remaining percentages: 9.1% (n=3) did not associate; 42.4% (n=14) are missing values.

*“They started to use drugs differently: instead of smoking, they started to inject drugs; that’s because they don’t have many chances to use drugs, nor the financial stability needed.” (PWUD32)*

The quantitative data is not consensual as well. While 22.4% (n=21) of HR professionals identified a decrease/high decrease of injected drug use; 45.7% (n=43) believed that the trends remained the same; and 32% (n=30) mentioned an increase/high increase. Moreover, respondents divided themselves between those who identified an increase of smoked drug use (56.4%, n=53) and those who did not report any changes (38.3%, n=36) <sup>76</sup>.

In the first case – those who noticed a decrease/high decrease of injection practices –, the majority did not associate it with the austerity (61.9%, n=13)<sup>77</sup>. In contrast, 63.3% (n=19) of those who reported an increase somehow/highly associated it with austerity<sup>78</sup>. On the other hand, in what concerned smoked administration way, the opinions of those who mentioned an increase of this practice are less marked: respondents were divided between those who somehow/highly associated it with austerity (35.8%, n=19) and those who did not establish this relation (24.5%, n=13)<sup>79</sup>.

*“I do not know if it is associated with crisis; I think it is not. It is associated with our intervention.” (FG4.5)*

Again, the dispersion of responses did not allow assertive conclusions and after comparing years of experience, regional and financial issues of outreach workers, the differences were not considerable relevant. However, these different perspectives should not be seen as inconsistencies, but as signs of what could be happening, even if very locally.

## **RISK BEHAVIOURS**

We conclude this point by addressing the perceptions on risk behaviours and the evolution of those practices over the last years. In general terms, questionnaire respondents positioned themselves towards the “increase”/“high increase” of risk behaviours (50.5%, n=48), but an interesting percentage of them also believed these behaviours remained the same (32.6%, n=31) and still 16.9% (n=16) reported a decrease of this kind of practices in the six years preceding data collection.

In addition to the themes that could be expected the interviewees would discuss – like polydrug use or consumption contexts –, the issues associated with the exchange of paraphernalia were the ones that dominated

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<sup>76</sup> Remaining percentages: 5.3% (n=5) mentioned a decrease.

<sup>77</sup> Remaining percentages: 4.8% (n=1) somehow associated with austerity; 33.3% (n=7) are missing values.

<sup>78</sup> Remaining percentages: 3.3% (n=1) did not associate; 33.3% (n=10) are missing values.

<sup>79</sup> Remaining percentages: 39.6% (n=21) are missing values.

the interviewees' discourses. Similarly to what happened with other questions, the participants had different opinions in this regard.

The available data on this theme were mainly developed HR teams' beneficiaries, as well as drug users who were in therapy programmes. In what concerns the first group, although it was difficult to establish a long-term comparison, the percentage of users who shared paraphernalia was similar among the studied samples<sup>80</sup>. However, this practice was less noticeable in the 2011 sample (Carapinha, 2014). Among the users admitted in therapy programmes "there was also a reduction of recent exchange practices among users (in 2014, it ranged from 0% to 34% among injectable drugs users from different types of structures)", but there are still some users "who still carry out these practices" (SICAD, 2014, p. 15-16).

These trends, difficult to be generalised, suggested a reduction of the risk practices, which was also observed by the majority of the interviewees. They mentioned the reduction of the general risk behaviours (n=10+1FG) and, some of them, associated it with the growing systems of paraphernalia exchange and the HR teams' intervention; or with the change in the more used drug administration routes, namely the reduction of injecting practices.

*"I think people are more careful nowadays (...) they don't share needles with other people and they try to be more cautious when exchanging the paraphernalia in the mobile units..." (P3)*

*"In the past, the PWUD would smoke and inject drugs with shared needles. They used to get infected and so on. Nowadays, things are quite different." (PWUD32)*

*"They tend to inject less, which is already a big step to solve some problems, like harm related issues." (E39)*

However, some participants made a reference to the potential risk of the increase of risk practices as a consequence of the economic crisis (n=5+1FG); one of the interviewees associated it with the difficult access to healthcare services and the fact that the pharmacies ceased to exchange needles (P15); another participant associated it with the lack of availability of HR teams in the field (P7). In this regard, in the ambit of the needle exchange programme, we emphasised the reduction to less than a half in the number of syringes distributed since 2011 (Cf. *Harm Reduction*).

*"We are witnessing not only the increase of risk behaviours associated with drugs and alcohol, but also a shifting pattern in what concerns resorting to the services to stabilise or cure diseases." (E13)*

*"The main questions here are if the pharmacies are open or closed and if the individuals have enough money to buy a new needle. In my opinion, there were several setbacks in this field. Maybe this issue is not very noticeable in the big cities, but you sure can see this happening in other places. Therefore, the individuals are now adopting riskier practices." (P15)*

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<sup>80</sup> In 2004, 35.7% of drug users shared some kind of material during the "last semester"; in 2009, 2010 and 2011, respectively, 31.7%, 34.2% and 28.7% of users shared paraphernalia during the last month of consumption.

*“They may not be able to exchange their needles because the teams aren’t always working in the field. So, they end up injecting themselves with infected needles.” (P7)*

In line with these results – and as it happened regarding drug administration routes –, we observed that the association with austerity is more evident among those who reported negative trends, while more positive considerations are less associated with austerity. In particular, 58.4% (n=28) of those who noticed an increase/high increase of risk behaviours somehow/highly associated it with austerity<sup>81</sup>; and 81.3% (n=13) of who reported a decrease did not associate it with austerity<sup>82</sup>. Together, results from quantitative and qualitative data suggest that more negative perceptions on injected drug use and risk behaviours are linked with the economic crisis and more positive perceptions are related with HR work.

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81 Remaining percentages: 39.6% (n=19) are missing values; 2.1% (n=1) did not associate it with austerity.

82 Remaining percentages: 18.8% (n=3) are missing values.

## Chapter 4 | Welfare State: changes and setbacks in the age of austerity

*“The balance of the experience of the austerity measures in Portugal emphasise the inefficiency in the containment of deficit and public debt, contrary to what is expected in the reversal of the external deficit. Both results are determined by the receding impact of the programme, higher than expected. (...) The social consequences of the adjustment programme in the employment/unemployment, social protection, in the increasing inequality and emigration are devastating”*

*Observatório sobre Crises e Alternativas, 2013, p. 106*

The work developed by authors like Bingham Dai (1970[1937]) since the 1930's has contributed to advances in the research on dependence, beyond the more pathological notion and comprehending the social dimension – associated with the lifestyle, living conditions and social relations. However, this field would become increasingly important due to the work developed by Becker (1985 [1963]) in the ambit of the Chicago School, which also helped to perceive dependence as a not necessarily negative condition.

In Portugal, the work of Cândido Agra was extremely important on the biopsychosocial perceptions on drug use. However, as the author stated “there is not only one, but several types of bio-Psychosociology: metaphorically speaking, some are inspired by the rhapsody model (simple juxtaposition of specialisations or notions coming from different subjects), others by the symphony model, the one here associated with drugs (harmonious integration of different concepts according to a strict mastery)” (1997, no page).

Although societies and policies didn't always manage to follow the evolution of scientific knowledge, the current notion that drug use is a behaviour that can't be understood without its context appears to be consensual. In this sense, when we tried to understand the effects of the (economic) crisis in the drugs field and we asked the participants to select a time frame in which the changes were more noticeable; the majority (12+1FG) of the participants (19+1FG) selected the time frame from 2009/2010, especially during 2011. 2011 was the year *Troika* “entered” Portugal and a set of budget cut measures started to be applied more forcefully in all areas (OPSS, 2013, p. 9), but also influencing the *automatic stabilisers*<sup>83</sup>.

*“We actually started to be aware of it the moment “troika” entered our country” (E12)*

Four outreach workers mentioned in particular the 2012/2013 period and two of them associated it with the IDT restructuring process and the interregnum in HR projects funding, which is relevant to show how a “simple” management measure had an impact in the work developed in this area (Cf. 2.2. Coordination on matter of drugs).

According to these results, the professionals were the ones who better defined these effects in terms of time

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<sup>83</sup> Automatic stabilisers are mechanisms (allowances, pensions and other social responses of the State) that tend to dampen the impact of the economic and fiscal measures.

frame, thus revealing their role as *stabilisers* of the impact in the users' lives, attenuating the way the impacts are perceived by the decision-makers or the experts (Cf. 5. Cushion effect).

Although a significant number of interviewees were able to mention the effects of the current state of affairs over the drugs field, some of them – namely the decision-makers and experts – had some difficulties figuring out if they're a direct consequence of the "crisis", mentioning that the phenomenon was not being assessed or monitored (n=7) and identifying the existence of problems in the indicators produced (n=2); therefore, they were able to perceive the changes, but they did not establish an immediate relation between them and the phenomenon.

"Since we understand that this type of programme affects well-being, it would be reasonable to think that we should foresee the consequences of the problem in people's well-being, in order to monitor it and try to ease its effects. But since we have ignored it from the beginning, we can only refuse to accept that this is actually happening." (E13)

"It is hard to define this crisis as an independent variable, but at least we should be able to measure the impacts temporarily coincident with the crisis." (D10)

The complexity and multidimensionality of the approach to this issue soon began to emerge in the participants' discourse, which eventually hampered the analysis. As a consequence – and since this is an exploratory study – we've selected the more representative dimensions and responses.

With more or less direct contact with reality, the questions on the welfare state in Portugal were the more consensual ones among the interviewees. In general, they expressed a negative vision about the development of the welfare state model or believed that we're witnessing a volte-face in the direction followed in recent years (n=22). Considerations like: "*it does not exist*" (P1), "*it does not work*" (P9), "*it's decaying*" (P7), "*destroyed*" (E12), "*vulnerable*" (E13), "*compromised*" (D20; D37), "*insufficient*" (P21) and "*under pressure*" (E26); and expressions like "*involution*" (P17), "*setback*" (D19; E26), "*disruption*" (E40), "*emptying*" (P6) and "*deep changes*" (D37) were some of the examples.

*"We still enjoy fighting against exclusion and assistentialist, which is wrong. (...) we are unable to understand that we are creating a terrible social exclusion gap which includes drugs."* (E25)

To better understand these positions, it is important to explain that the Portuguese welfare model (framed by the Southern Europe model) is characterised by "social protection schemes that generate overprotection of the labour force central sectors and the rudimentary levels of protection for the majority of the population; by their unique combination between Bismarck traditions in Social Security and Beveridge elements in Healthcare; as well as the impact of the political practices and organisational structures in the distributive outputs" (Silva, 2002,



according to Ferrera, 1996). In addition, it's important to mention the vital role of the family in the well-being, as well as the relevance of other traditional types of solidarity (Silva, 2002), also defined as “welfare society” (Santos, 1994). The latter specificity, as will be discussed ahead, is also very important to understand the drugs domain.

## 4.1. Social Protection System

The “moral obligation of protection in situations of necessity at the individual and family levels” exists almost since the foundation of Portugal (Segurança Social, 2012). However, since the establishment of the first *Misericórdia* in the late 15<sup>th</sup> century, this obligation was carried out in several different ways. Nowadays, the right to social protection is present in the Portuguese Constitution and it is achieved through the Social Security System, which is divided into three main pillars:

“the Welfare System, designed to cover the loss of income due to certain events; the Citizenship Social Protection System that comprises all the Portuguese citizens; and the Complementary System, which aims to share the responsibility of social protection by encouraging complementary regimes with a voluntary character” (Goulart & Camacho, 2014, p. 1).

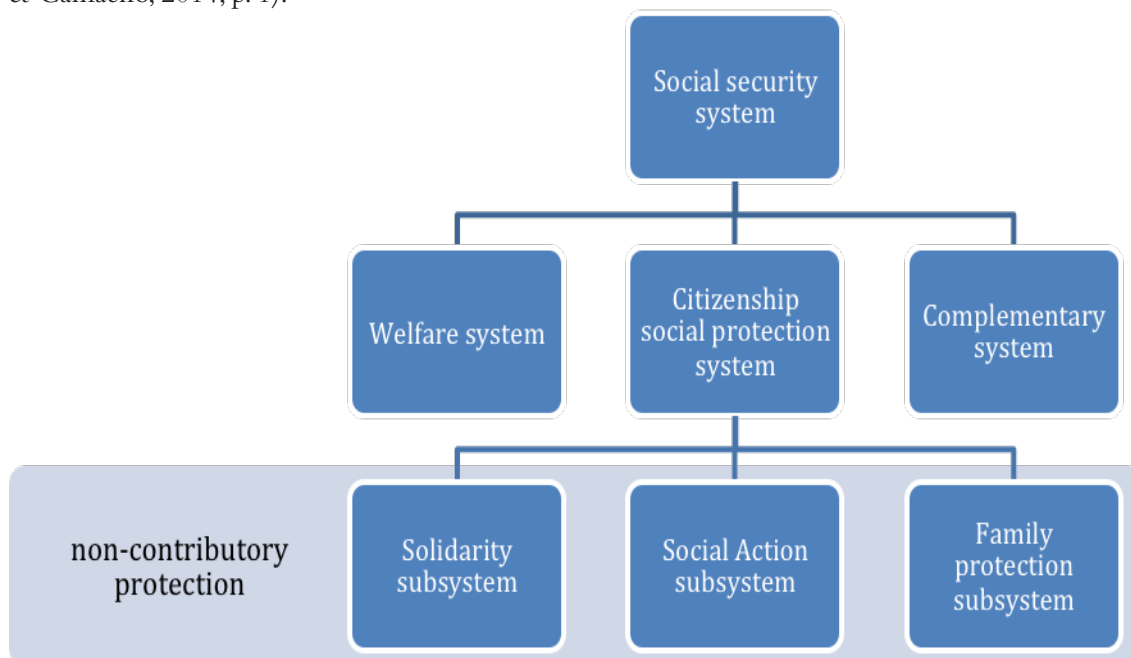


Figure 4: Social security system organisation

While addressing our subject – and according to what was mentioned above regarding budget cuts in the *automatic stabilisers* – the issues associated with the social protection of citizenship System, which ensures the universal and non-contributory protection, was one of the main themes in the subjects' discourse. This issue becomes even more urgent if we consider that, on the one hand, Portugal is one of the EU countries with a higher level of inequality (regardless of the indicator used) (Rodrigues, Figueiras & Junqueira, 2012) and, on the other hand, – contrary to the countries in which the more balanced income distribution seems to lead to high social protection expenses – there's a large amount of expenses and relatively high levels of income inequality<sup>84</sup> (OECD, 2011). According to The International Monetary Fund (IMF) this is partially explained “by the reliance on contributory social insurance programmes (including pensions and unemployment benefits) which generally go to the relatively well-off households instead of targeted social assistance programmes which generally go to the most needy” (Goretti et al., 2012, p. 84). In this context, the interviewees demonstrated their natural concern regarding:

- Issues associated with the budget cuts in the field (n=13);  
 “A few years ago, people lived in better conditions, in spite of their drug addiction problems.” (PWUD32)
- The lack of transparency regarding the budget cuts (n=2);  
 “The Ministry is not willing to clarify these measures and this discourse publicly. Technically, one can't even understand the advantages of these changes.” (P1)
- Consequently, the inability or insufficient number of responses by this system (n=4) ;  
 “They are excluded and I am not able to provide them tools to empower them” (P8)
- The increasingly complicated access to this system due to the increasing criteria (n=2);  
 “The Social Security performance has nothing to do with the way it functioned four or five years ago.” (PWUD28)
- And, finally, the illegal practices carried out by the users (n=1) or the fact that they started using drugs again (n=2), due to the breakdown of these stabilisers.  
 “Some protective elements (like social cohesion) aimed at the reduction of situations of increased consumption and drug use started to decrease.” (E27)

In terms of Welfare state, many of the interviewees stated that social protection was “at stake” (P16) or “deeply compromised” (D41). Since we tried to understand the narrowing of the state's social responses, the interviewees' testimonies (by questioning solidarity and social action subsystems) were quite important.

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<sup>84</sup> The income inequality (Gini coefficient) increased between 2010 and 2012, thus reversing the cycle that was decreasing since 2005 (*Observatório sobre Crises e Alternativas*, 2013, p. 104).

## SOLIDARITY SUBSYSTEM

The subsystem of Solidarity is part of the Citizenship Social Protection System and it is related to the responses that aim to ensure the minimum levels of income, to fight against poverty and social/professional exclusion. The *Rendimento Social de Inserção* (RSI) was, among others, one of the main benefits highlighted in the individuals' discourse, since it is a response that covers many drug users. It is a pecuniary transitory benefit that includes the signing and the compliance with a reintegration contract.

In Portugal, the data to show how many of these users are effectively covered by the RSI are clearly insufficient, but several surveying processes (ARSNorte, 2014; Carapinha, 2012; DRN/IDT, no date) showed the predominance of this benefit among this population, largely associated with a situation of unemployment or inactivity.

In order to deeply understand the centrality of the changes of this measure in the users' lives, it is important to understand that since its creation in 2003 (Law number 133/2003, May 21<sup>st</sup>) it was subjected to three main adjustments<sup>85</sup>. The last one (Decree-law number 133/2012, June 27<sup>th</sup>) – under the argument that “the economic and financial situation of the country requires a reassessment of the legal systems of the benefits of the Social security (...) in order to guarantee that social protection is effectively ensured the most needy citizens without putting into question the financial sustainability of the Social security system” – established the RSI monetary value according to the social support index, which led to a reduction of the pension's monetary value in January 2013 (Decree-law number 13/2013, January 25<sup>th</sup>) from 189,52€ to 178,15€. Due to the “minimalistic” nature of this benefit, whose attribution occurs in cases of severe economic deprivation, it's natural that its decreasing importance was the focus of many individuals' discourse (n=12+2FG), particularly associated with its inability to provide resources to the more basic needs (n=4).

*“And I wonder: what does he eat? How can he get new clothes, how can he move within the society? It is not enough.” (P1)*

Despite the monetary question, according to 67.2% (n=43) of HR professionals, requirement criteria for social benefits remained constant during the six years preceding data collection and 23.4% (n=15) of them believe that there was an increase<sup>86</sup>. More than the requirements, some issues regarding the bureaucracy in accessing social benefits (such as RSI) raised some concerns. Also, according to the questionnaire data, during the same period, 82.2% (n=69) of respondents considered that bureaucracy increased/highly increased<sup>87</sup>. Among them, some had no doubts that it was associated with austerity measures (60.9% (n=42) “highly associated with austerity”; 14.5% (n=10) “somehow associated with austerity”)<sup>88</sup>.

85 Law number 45/2005, August 29<sup>th</sup>; Decree-law number 70/2010, June 16<sup>th</sup>; Decree-law number 133/2012, June 27<sup>th</sup>.

86 Remaining percentages: 9.4% (n=6) mentioned a “high decrease”/ “decrease”.

87 Remaining percentages: 9.5% (n=8) identified a “high decrease”/ “decrease”; 8.3% (n=7) considered that there were no changes.

88 Remaining percentages: 1.4% (n=1) did not associate with austerity; 23.2% (n=16) are missing values.

The interviewees illustrated this issue with several examples: the end of the automatic annual renewal and the consequent accountability of the user in the presentation of a renewal proposal (n=5), as well as the mandatory character of the reintegration contract signing (in addition to the commitment to subscribe it as a condition to grant an allowance in a context of fewer technical staff (n=3).

*“Sometimes, some of my colleagues sign forty Social Security reintegration plans... That is impossible. How can you do that?” (P8)*

*“In my opinion, these are all measures to hinder the access to these benefits.” (P17)*

On the other hand – and despite the insufficiency of this benefit – when the second change to the law occurred in 2010, the penalty to false declarations that could lead to irregular allowances was aggravated. One of the examples were the “casual works” (i.e. undeclared activities), one of the main solutions the beneficiaries found to suppress the lack of the social benefits (n=2).

*“A person who lives with a 189€ pension and does other tasks to get some extra 20€ can be penalised and cease to receive that pension for 2 years.” (P17)*

In addition to these changes, there’s still the extension of the causes for the cessation of the allowance due to the groundless nonappearance to convocations (P9) and the new considerations regarding the household’s income (n=3) (Decree-law number 133/2012, June 27<sup>th</sup>).

*“The monetary value is reduced and a new concept of household is attributed, which leads to the loss of this benefit by half of the beneficiaries. In ★, this issue is aggravated due to the fact that the majority of people still live with their families.” (FG5.1)*

*“Since last year, the State began to impose more specific requirements to those who have access to this benefit. There are more medical appointments and less flexibility for faults, with consequences in income cuts.” (P9)*

★ Portuguese city of North region with around 20 000 inhabitants.

Regarding the submission of the request, the complexity of the forms (n=5+2FG) or the need to present a residence certificate (P17) were obstacles to a particularly vulnerable population (n=9), namely for reasons that relate to low levels of education (P17), the fact that many beneficiaries were homeless (P1; P17), marginalised (P21; D38) or lived on the margins of labour market (P8).

*“We are talking about people who do not read. And even those who know how to read look at it and don’t understand.” (P17)*

*“In the past, all you had to do was fill in a Social Security form. Now, in order to apply to the guaranteed minimum income [RSI], they demand a lot of things. There are a lot of documents needed and they make the process much more difficult. They are constantly reducing people’s income, saying that there are incorrect elements. I believe that they’re managing the money the way they want and these cuts are convenient to them. Eventually, they can approve another type of income, but nothing covers the months they didn’t pay.” (PWUD28)*

*“There are several obstacles, especially to people who haven’t lived in that parish for a period of 1 or 2 years. If you don’t take at least two people who can testify on your behalf, the services won’t provide a residence certificate. And my question is: where can a homeless person get a residence certificate?” (P17)*

Other issues identified were the delay in the attribution of the pension (n=4) [without any retroactive sum during that period (PWUD32)] and also the fact that if the individual found a job, he/she would not receive that pension and would be compelled to make a new request and wait for an answer, thus contributing to “increase the subjects’ vulnerability. In fact, the need and right to this benefit are not compatible with the bureaucratic delays that tend to perpetuate and reinforce the problem, supported by the supposed assumption of fraud” (Rodrigues, 2010, p. 217).

*“In this case, as well as in other cases I manage, the individual must wait more or less 3 months; sometimes even more than that. (...) But this should not happen. The individual has chosen to work and he learned a lesson that should not have learned. He now tells me: “if I have an opportunity to work next time, I will not take it”. I am giving an example, but I have more cases like this... (...) it is the complete opposite to any reinsercion in the labour market” (P15)*

There’s, therefore, a set of circumstances useful to understand the 37% reduction in the RSI coverage rate between March 2010 and October 2013 (*Observatório sobre Crises e Alternativas*, 2013); and, in particular – according to 64.6% (n=62) of HR professionals who answered the questionnaire – the decreased/highly decreased number of PWUD receiving social benefits in the six years preceding data collection<sup>89</sup>. Of these respondents, 58.1% (n=36) highly associated it with austerity; and 11.3% (n=7) somehow associated it with austerity<sup>90</sup>.

A result that can be explained by the inherent vulnerabilities of this population, which, in turn, helps to understand why HR professionals identified an increase/high increase in the easiness of exclusion of PWUD from social benefits over the same period (68.3%, n=56)<sup>91</sup>. Among professionals who positioned themselves this way, almost all of them somehow (10.7%, n=6) or highly associated (62.5%, n=35) it with austerity<sup>92</sup>. This headed to another

<sup>89</sup> Remaining percentages: 29.2% (n=28) considered that there had been an “increase”/ “high increase”; 6.3% (n=6) did not mention any changes.

<sup>90</sup> Remaining percentages: 30.6% (n=19) are missing values.

<sup>91</sup> Remaining percentages: 11% (n=9) identified a “high decrease”/ “decrease”; 20.7% did not point out any changes.

<sup>92</sup> Remaining percentages: 1.8% (n=1) did not associate; 25% (n=14) are missing values.

issue among the interviewees: this response was not fulfilling the goals it was designed for (n=4), i.e. granting allowances in cases of severe economic deprivation.

*“Regarding the RSI, I believe that it needs to be an integrative measure, since that is its main purpose. If not, then it should be inserted in other responses.” (P18)*

This means that we are dealing with individuals who are in a fragile situation and in need of an urgent response to their basic needs. That is why two of our interviewees believed that the fact that we are witnessing a decreasing number of beneficiaries (especially since 2010, according to Social Security online data) did not mean that there were less people needing it.

*“There are less people granted with RSI and there are a lot of people who need it. It is not true when someone mentions that people don’t need it. They do! In fact, there are some individuals with zero income.” (D22)*

*“We know that social services were instructed to try to reduce the number of RSI applications, as well as other type of social benefits.” (P18)*

On the other hand, if by 2010 the beneficiaries were entitled to a complementary support for the user and the other members of the family – among others, in terms of healthcare, education, housing and transportation – that right has been abolished since then<sup>93</sup> (P1).

*“If it was justified: clothing, some supports to buy transportation tickets and find a job, etc. We had that lifeline and now we’ve lost it. Without it, it becomes complicated to get Social Security’s support to get, for example, dental prosthetics. And we all know how important it is to those who are looking for a job.” (P1)*

Still according to a 2010 adjustment, in-kind supports such as regular public housing benefits had to be part of the formula to determine the RSI monetary value, in order to introduce “a higher effectiveness in the determination of the total value of income” (Decree-law number 70/2010, June 16<sup>th</sup>). The relevance of the housing issue to the interviewees requires a deep understanding of this matter.

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93 Decree-law number 70/2010, June 16<sup>th</sup>

## HOUSING

The right to housing is recognised by the Universal Declaration of Human Rights, as well as the Portuguese Constitution. However, the Portuguese state does not act the same way in all the situations regarding this right. According to the national strategy for the reintegration of homeless people, people who use psychoactive substances are covered by the following:

- Social reintegration apartments<sup>94</sup>
- Therapeutic Communities
- Shelter Centre
- Homeless Shelter

Whenever these specific resources are not available, the individuals can resort to temporary shelter centres, emergency centres, shared flats and medium-term shelter centres. However, none of the above is permanent and their goal is to refer those individuals to adequate responses. Ultimately, the main objective is to eliminate the individuals' need to these responses.

A tendency to mention a reduction/high reduction in terms of housing support services during the six years preceding data collection was observed by 82.1% (n=64) of HR professionals who answered the questionnaire<sup>95</sup>. A trend that many of these respondents highly associated with austerity (56.3%, n=36) or somehow associated with austerity (14.1%, n=9)<sup>96</sup>, which is a motive of concern when the needs appear to be obvious at this level.

A long-term research (2004, 2009, 2010 and 2011) carried out with HR<sup>97</sup> teams' users showed how the number of homeless beneficiaries increased in 2011 (33.5%), after the decrease in the absolute number and percentage between 2004 and 2010 (38.3% to 29.6%) (Carapinha, 2012, p. 73). On the other hand, the housing and shelter responses seemed to be insufficient to cover these needs. In 2013, in the ambit of the monitoring process developed in the reintegration area, the teams of the *Centros de Respostas Integradas* (CRI) [Integrated Responses centres] identified the following:

*“1559 needs identified (995 illegal substances users and 604 users with alcohol-related issues). 565 were covered by housing measures, corresponding to a 35% response rate (44% in 2012). From the total of people in need, 562 were homeless (371 illegal substances users and 191 with alcohol-related issues), a slight decrease (-3%) when compared to the previous year”* (SICAD, 2014, p. 72).

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94 Law number 17/1998, April 21<sup>st</sup>; Decree-law number 72/1999, March 15<sup>th</sup>; Joint dispatch rule number 363/1999, April 29<sup>th</sup>

95 Remaining percentages: 1.3% (n=1) identified an increase; 14.1% (n=11) did not identify any changes.

96 Remaining percentages: 29.7% (n=19) are missing values.

97 The results of this research cannot be generalised, since we are not dealing with a representative sample. One can only compare with samples from previous years.

Despite this “slight decrease”, these data show that the responses fall short of the identified needs, a problem that some of the interviewees (n=15+1FG) also mentioned and that can be even more noticeable in some regions (FG4). In this regard, for example, in terms of social reintegration apartments, the available data reported the insufficient responses at a national level and the fact that they have decreased since 2005 (MSESS, 2013).

*“Nowadays, in order to get a room, one must wait 2, 3 or even 5 years. It was easier a couple of years ago.”*  
(PWUD33)

*“I have witnessed the lack of shelters and social cafeterias here. We have to go to Porto...”* (FG4.4)

Related to these issues, the shelters – especially the ones aimed at a more immediate response, in which the technical teams have to place the individuals due to the absence of more structured responses – have a transitory character, thus hindering the empowerment of the individuals in other dimensions, a result of the short period of time available for the professionals to work with them (n=2).

*“We have a shelter and a hotel and they have to remain there for 3 months. Then, they’re continuously assessed, since a 3 months period is not enough to empower them.”* (P8)

As a consequence of this deficit – and since the formal housing benefits started to be considered to determine to RSI monetary value – was the fact that the beneficiaries who were transferred to other type of accommodation had to cover the generally increased costs of these alternative responses. As a result, the technical staffs ended up having a small margin and not enough tools to manage the cases.

*“Since there isn’t a proper response in terms of housing (except the shelters), the individual only has access to a room. The room’s cost is approximately 200€ and the income is 172€. He doesn’t have enough money.”* (P1)

*“The professionals should have access to an allowance, in order to help people. They’re not supposed to pay for the rooms with the beneficiaries’ income.”* (P2)

There was still another set of issues in terms of the available responses, namely the fact that these accommodations are often shared with other people with the same or other problems, which can lead to some tension between the subjects (PWUD28) and a feeling of social isolation (P21).

*“I’m currently living in a room and I have a lot of problems. There are a lot of people living in that inn and I asked Mrs C. if I could move to another room, because I wasn’t handling the pressure. It was too much for me.”* (PWUD28)



*“They live with other peers, but end up being alone. They don’t live by themselves, but they’re socially isolated, which is bad.” (P21)*

Due to all these issues, two of the interviewees indicated the absence of strategies in these responses, emphasising the lack of integrated work. For example, the cases when the individuals had to be admitted in unspecified accommodations without an integrated follow-up plan.

*“There are many case-based and isolated interventions between the Social Security and our services.” (D20)*

After establishing this relation between the *RSI* and housing, it is also important to mention that in those cases where the benefit’s monetary value is not enough to cover all the costs, the social workers who manage the case have to make an economic assessment and consider the monthly income and expenses of the beneficiary. This way, when this allowance is indeed granted to the individual and it does not cover all the costs, the percentage of the money used in the housing process can be assured by the subsystem of *Social Action*.

However, since 2010 (Decree-law number 70/2010, June 16<sup>th</sup>), the accommodation costs are covered by the *RSI* and the individual has to apply to other Social Action benefits to cover the remaining expenses. This process was perceived as a setback (n=3), since the accommodation costs used to be totally covered by the Social Action system in the past and the beneficiary could use the *RSI* to cover other expenses.

*“They used to pay for my room. In some situations, they’d provide the RSI so people could survive. Now, I need to pay 150€ for my room and they only give me 30€ per month to eat.” (PWUD29)*

Notwithstanding, there is a set of measures that can also be covered by this subsystem, as we will explain below.

## **SOCIAL ACTION SUBSYSTEM**

Social Action is a subsystem that is also part of the Social Protection system, essentially supported by the cooperation agreement between the State and the entities that are part of the solidarity network, by the user’s and/or family contribution and by the institutions’ revenue. It comprehends a set of a) social services and responses; b) programmes against poverty, social dysfunction, marginalisation and exclusion; c) occasional and exceptional pecuniary benefits and d) benefits-in-kind. The functioning of this subsystem is operationalised according to the *Rede de Serviços e Equipamentos Sociais* (RSES) [Social Services and Responses Network] and it is mainly developed by non-profit organisations (MSESS, 2013), namely Private Institutions of Social Solidarity (IPSS), whereby any change to the responses provided by them has a direct impact in the beneficiaries’ lives.

*“The social cafeterias are closing and there’s an absence of social housing responses or social instruments to help us work with our homeless users... (...) This absence makes the professionals’ work much more difficult.” (P1)*

According to data from the questionnaire, 86.9% (n=73) of respondents reported a decrease or heightened decrease in the availability of social action responses during the six years preceding data collection<sup>98</sup>. Of these respondents, 64.4% (n=47) highly associated it with austerity and 8.2% (n=6) somehow associated with it austerity<sup>99</sup>.

Regarding the types of social responses to “drug addicts” (MSESS, 2013), in addition to the social reintegration apartments, there are still other supports to this population, namely the direct intervention teams. The responsiveness of both measures has increased significantly since 2000, mainly due to the significant growth of the direct intervention teams’ support and not because of the number of apartments (a total of 40 in Portugal) (MSESS, 2013). In general, the social responses at this level have been registering a “period of stability during the last years” (MSESS, 2013, p. 45), despite the 56% growth between 2000 and 2013.

Since the users of psychoactive substances present a set of physical, psychosocial and economic vulnerabilities, they can apply to other social benefits, like the ones in the ambit of “Family and Community”, “People with HIV/AIDS”, “People with a mental or psychiatric condition” and “People in a situation of addiction”. To better understand the extension of these benefits in the total of social supports, in 2013 they made a total of 6.1% (MSESS, 2013), thus maintaining a not very significant tendency in comparison to other areas, like childhood, youth and old-age. This can also be seen through the analysis of the costs associated with these populations (especially “Family and Community”), which were more or less stabilised since 2000 (5% of the total costs of the RSES) (MSESS, 2013).

In addition to the housing issues mentioned above, the pecuniary benefits and the budget cuts in several areas, like transportation (n=8), medicines (n=4), dental prosthetics and glasses (n=2) were some of the issues mentioned by the participants, since they also have a significant impact:

*“The public transportation is getting increasingly expensive and the access to benefits is much more difficult. Some people aren’t able to attend medical appointments, thus ruining everything.” (D10)*

*“The first thing I have noticed was (...) we used to have some support to cover the cost of the users’ medicines. Nowadays, there are no supports.” (P15)*

*“I need to fix my teeth and I just can’t afford it. Social Security... I find it hard to look to that painting over there. Everything is blurred. Social Security doesn’t cover these issues.” (PWUD28)*

On the other hand, one of the participants also mentioned the issue of budget availability associated with pecuniary benefits:

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98 Remaining percentages: 7.2% (n=6) identified an increase; 6% (n=5) did not mention any changes.

99 Remaining percentages: 1.4% (n=1) did not associate; 26% (n=19) are missing values.

*“In the social action system, the Social Security budget is divided into different access areas and they have been decreasing. They eventually end mid-year or in August-September, there is not enough money to cover the remaining months. The following instalments will only become available in February or March, since they are on standby for the first three months. In other words, you only have a budget for half a year. And it became worse.” (P17)*

In what concerns the in-kind benefits, the interviewees mentioned the fact that these social responses are restricted to basic needs (n=4), like food. Between 2000 and 2010, the data showed a clear lack of investment in cafeterias, a trend that would only change in 2011, with a clear increase in the investment in these facilities (MSESS, 2013). This was also pointed out by one of the participants as a positive result (D41).

*“They give me 30€ per month to eat. Then, they refer me to other social services if I want eat. That’s the kind of support they provide me.” (PWUD29)*

*“Another important programme is the social cafeterias programme, which increased all over Portugal and it is increasingly sought after. This shows how these responses were needed and what kind of social issues we are currently experiencing.” (D41)*

Another issue mentioned by the participants is the difficulty in accessing these social benefits, due to the complex character of the system (n=5).

*“It’s not hard to apply, but very difficult to obtain an answer.” (P21)*

*“We keep applying, but it is very difficult to get an approval, that’s for sure.” (P8)*

Regarding the organisations that develop these services, the interviewees highlighted periodicity issue (n=2) and the fact that they were unable to cover all the existing needs (n=4) and reach all the territories (FG4.5). Many participants believed that this is an issue that became clear over the last years (n=5).

*“The Food Bank still exists and it provides some food. It is not a continuous support (weekly or daily). We distribute food baskets once a month, as long as the Food Bank can provide us some food.” (P1)*

*“AMI provides several services, but only to those who live in the town. Those who live in the outskirts don’t have access to the cafeteria and can’t have their daily meals.” (FG4.4)*

“They say they don’t have enough food for so many people. They were already struggling with the previous number of people and now they’re helping even more families.” (PWUD28)

Finally, it is important to mention that all of this is happened while the poverty rate was consecutively increasing since 2009, reaching its highest levels since 1994 in 2013 (28% in 1994; 30.3% in 2013 – provisory data by PORDATA). The ratio of population at risk of poverty and social exclusion also increased during the last years – associated with the fact that, in 2012, “the impact of the social changes (excluding pensions) in poverty was slightly reduced” (INE, 2014, p. 3).

## 4.2. Universal Healthcare Services

Similarly to the Portuguese social Protection system, “the right to health protection and the duty to defend and promote health”, implemented “by means of a national health service that shall be universal and general and, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge” was established by the Constitution of the Portuguese Republic (article 64), after the restoration of democracy in 1974.

Although it remains irrefutable, this “universal and general” right has been jeopardised, due to the social obstacles to the multiple mechanisms that interfere directly in the people’s and populations’ health. There are many international entities that document and advise against the impact of the economic and financial crisis in healthcare, especially among the more vulnerable populations and the more regular users (WHO, 2013; 2009; ECDC, 2013; Suhrcke & Stuckler, 2012; Mladovsky et al., 2012; Gottret et al., 2009). The “Europe 2020” framework of political strategies also mentioned how the results in terms of healthcare cover up huge inequalities: “poorer and disadvantaged people die younger and suffer more often from disability and disease” (European Commission, 2013, p. 2).

In Portugal, in spite of “an on-going government programme to monitor health impacts of the economic crisis” (Rechel et al., 2001, p. 170)<sup>100</sup>, the Portuguese Minister of Health publicly stated in 2013 the need to carry out “a broader research, regardless of other sectorial studies” (Lusa, 2013, June 13<sup>th</sup>). The *Observatório Português dos Sistemas de Saúde* (OPSS) [Portuguese Observatory of Healthcare Systems] has been dealing with this issue through the *Relatórios de Primavera* and, also in its last work, it emphasised the “absence of evidence on the impact of the crisis in people’s health” (OPSS, 2014, p. 13). This gap was also mentioned by two interviewees, one of them stating, however, that **“the resources available are enough to make something different from what we are doing”** (E13). It was associated with the coexistence of “two worlds”, as it is also mentioned in OPSS report:

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<sup>100</sup> In the ambit of an online survey to experts from the different countries involved in the research: experts from national agencies for communicable disease control from European Union (EU) and European Free Trade Association (EFTA) countries.

“The official dimension, where – according to the formal readings – things are more or less fine and will presumably improve in the short-term, after the budget cuts established by *Troika* and the absence of strategies to respond to the consequences of the crisis for people’s health. Then, there is the people’s real experience dimension, characterised by impoverishment, increasing unemployment, decreasing social cohesion factors and a significant disbelief regarding the present and future situation and all the foreseen consequences for people’s health.” (OPSS, 2013, p. 14).

This distinction is useful to understand the organisation of the participants’ discourse. The consequences of budget cuts in terms of human resources and medical equipment were the main worries (n=10). Although the analysis of the budget cuts in this field is limited<sup>101</sup> and “more detailed information on the way money is spent is needed to provide an accurate picture of policy intervention in this area” (European Commission, 2014, p. 345), “health spending in Portugal increased in real terms by 2.3% per year between 2000 and 2009, before slowing down to 1.8% in 2010” (OECD, 2013, p. 2). In 2011 and 2012, the reduction in health spending reached more than 5% per year in real terms” (OECD, 2014).

“We are aware that the national healthcare service can somehow support us and that the countries without national services are not protected. But it does not cover everything, so... it simply does not cover... it cannot cope with budget cuts or the reduction of human resources.” (E13)

“In my opinion, these cuts are administrative decisions. I used to pay 30€, now I only pay 25€. There are no researches supporting these measures. This also means that I may be jeopardising the quality of my work, since I didn’t assess the costs in a systematic basis.” (E14)

The consequences for the “people’s real experience” dimension (OPSS, 2014) are already being identified, in spite of the lack of evidence on the impact of the crisis in people’s health, at least in what concerns the more formal reading of the phenomenon. The primary consequence is the difficulty in having access to healthcare services, associated with the short number of physicians (n=2), the difficulty in covering the travelling/transportation costs (n=2) or even the lack of specialised services to deal with people who are dependent on substances (n=4).

“I am not entitled to a family doctor, because I didn’t show up at the last medical appointment. I “needed” to be sick.” (PWUD31)

“Nowadays, the patients who come to the ER are in worse conditions, much sicker than before. In our first approach, we talk to them and realise that they only show up pretty late. Why? Many times, they don’t have enough money to pay for public transportation.” (E14)

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<sup>101</sup> For example, Stuckler, Basu & McKee (2010) stated that the expenditure in social well-being are as important, if not more important, for the population’s health as healthcare costs.

*“I know what it feels like to try to have access to the national healthcare service, namely to the local healthcare centres. It is hard to provide responses for the drug users, due to practical difficulties.” (D10)*

However, a group of participants did not believe that there was a negative evolution of the access to healthcare services (n=4+1FG) and one of them even mentioned a positive evolution (P24).

*“I usually go to the local healthcare centre for my daily methadone dose. Every time I have a problem, they are always there for me.” (PWUD30)*

*“They are able to provide the minimum services, in terms of medical appointments and costumer care.” (P21)*

*“Getting closer to the primary healthcare services and others... The evolution is positive.” (P24)*

Notwithstanding the new regulation on the conditions of access to the national healthcare system benefits<sup>102</sup> – leading to the increase of the value of the patients’ contributions for the majority of the population – many psychoactive substances users who presented a series of physical, economic and social vulnerabilities are exempt from those same contributions (n=3). In this regard, Barros (2012) mentioned that the new regulation led to the increase in the number of accepted cases, although the MoU between *Tioika* and the Portuguese Government may have had the implicit aim to cut unjustified exemptions.

*“An excessive increase in the monetary value of the patients’ contributions. However, the majority, if not all drug users, are exempt.” (PWUD29)*

*“The national healthcare services are no longer free. There is a minimum fee, but we’re able to be exempt from it. All the RSI beneficiaries are exempt. Since our users are usually homeless or don’t have any type of income, they are also exempt.” (P1)*

*“I think that it is easier for drug users to have access to different types of medical specialties, rather than for the common citizen. A drug user can be seen by a psychiatrist, a psychologist or even a social worker, since they are available to him/her in drug treatment facilities.” (FG5.2)*

Among other situations, this exemption usually covers users in situations of economic insufficiency, as well as users with a degree of disability equal to or greater than 60% and with diseases associated with the consumption of psychoactive users – HIV/AIDS, chronic hepatitis, tuberculosis and severe hepatic cirrhosis (ERS, 2013). Users involved in “alcoholic and drug users’ treatment programmes” are also exempt from this fee (Ibd., p. 122).

However, certain health conditions are no longer covered by this exemption (for example, users who do not

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<sup>102</sup> Decree-law number 113/2011, November 29<sup>th</sup>

reach the 60% degree of disability) and nowadays users only have exception in the ambit of healthcare services related to the disease. In other words, there is no longer a “*tout court*” exemption, in which it “covered the entire provision of healthcare services, regardless its direct or indirect connection with the disease/clinical situation” (Ibd., p. 23).

*“Nowadays, the patients suffer from chronic diseases, not just AIDS. Not all of them are covered in terms of support in the access to services or medicines.” (E14)*

## MEDICATION

During the global financial crisis, some of the more common changes applied in 27 countries of the UE, as well as in Croatia, Iceland, Norway, Switzerland and Turkey (Vogler, Zimmermann, Leopold & Joncheere, 2011) were: the reduction in prices; the changes in out-of-pocket costs, the VAT tax over medication and the distribution margins. The countries that implemented the highest number of measures were Portugal, Iceland, Greece, Spain and the Baltic nations, all of them affected by the crisis in different times (Ibd.).

The containment of the Portuguese state costs with medication was largely carried out through the reduction in the medicines prices (OPSS, 2014), but other relevant changes included the centralised acquisition of medicines and diagnostic tests, as well as the increased availability of generic drugs and prescription by active substance (Mladovsky et al., 2012). This trend continued during the following years and between 2010 and 2013, the national healthcare system costs with medicines decreased “approximately 571 million Euros; 90.7% of this value is a result of the decreasing ambulatory expenditure” (i.e. pharmacies) (OPSS, 2014, p. 68).

As a consequence, there was a reduction in the medicines’ prices – perceived as a positive change by two experts –, as well as in the maximum margins of distribution (OPSS, 2014), which led to the reduction in the drugs’ level of distribution (n=2+1FG) and the closing down of several pharmacies (n=1):

*“Nowadays, they have limited resources (money). Sometimes there are no medicines, because there’s no money to buy them.” (PWUD28)*

*“We are not familiarised with any studies that have mentioned or predicted this situation. ‘We’re going to do this, 20% of all pharmacies will be closed...’ In some cases, the pharmacies were the only outreach services people had, right? These issues need to be foreseen, especially during periods of crisis. The effects of the policies need to be studied.” (E14)*

At the users' level, in addition to the difficulties in access to medication related with the decreasing patients' purchasing power (n=9+1FG), there was a reduction in the State's support to several medicines (OPSS, 2013; 2014), thus leading to the increase in the expenditure percentage paid by the users in healthcare services (n=3), which increased 4.5% between 2007 and 2012 (OECD, 2014, p. 129).

*"Nowadays, I've been noticing that they do something they didn't do before: they go to the medical appointments because they don't pay, but then they don't buy the drugs." (P15)*

*"A new medicine for hepatitis C just came out. It should have come out a year and a half ago. This drug will not be available for everybody, since many people can't afford it." (P7)*

Therefore, it is not surprising that, according to the questionnaire data, 77.4% (n=72) of HR professionals considered that, during the six years preceding data collection, there was a "high decrease"/ "decrease" in the PWUD's access to co-funded medication<sup>103</sup>. A trend that these professionals somehow associated (16.7%, n=12) or highly associated (52.8%, n=38) with austerity<sup>104</sup>.

*"The neuroleptic medication used to be 100% covered. Now, in some cases, this support decreased to 95%." (P15)*

*"Many of them are not taking their medicines every other day. I'm talking about people with chronic diseases." (E14)*

## MENTAL HEALTH

In a context and environment of economic crisis, the considerations on risk factors for mental health [poverty, deprivation, high debt, unemployment, job insecurity and stress (WHO, 2011)] were some of the main worries of the interviews in what concerned the health domain. The services response in this area was not a motive of concern, contrary to the decaying mental health of the general population (n=9). This relation finds evidence in international literature, namely between adverse economic conditions and the increasing cases of depression, suicide, anxiety (Modrek, Stuckler, McKee, Cullen & Basu, 2013; Reeves et al., 2012; WHO, 2011) and substance use (Goldman-Mellor, Saxton & Catalano, 2010).

*"We have the duty to report that in a country where all budgets are being reduced, people should not expect a proper mental health." (E25)*

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<sup>103</sup> Remaining percentages: 12.9% did not identify any change; 9.7% considered that there had been an "increase"/ "high increase".

<sup>104</sup> Remaining percentages: 30.6% (n=22) are missing values.



*“The level of anxiolytics consumption in our country is very high, when compared to other European countries. In today’s society, people find multiple ways to cope with things.” (PWUD35)*

*“I believe that the current national situation is totally compatible, if I may use that word, with the high levels of depression affecting people. This happens not only among those who use drugs, but among everybody, among every family.” (PWUD36)*

“Not sealed” to all these effects is the area of drugs” (E11). According to the quantitative data – and although there is still a significant percentage of HR professionals (31.4%, n=27) who believed the number of PWUD with mental disorders remained the same –, the majority of respondents mentioned that this number increased in the six years preceding data collection (63.9%, n=55)<sup>105</sup>. Of these, around half associated it or highly associated it with austerity (50.9% n=28)<sup>106</sup>.

These results are in line with Wilkinson and Pickett’s conclusions (2011), who observed that Portugal suffers of “high rates of most of the health and social problems” (Ibd., p. 174); as well as with the Directorate-General of Health, which mentioned the “probable relation of the relative positions of Portugal with the levels of social inequality”, thus attributing some responsibility to the sectors outside the healthcare sphere (DGS, 2013a, p. 60).

Finally, with respect to the responses in this area, two experts questioned the reorganisation of mental health services, which had consequences in the capacity to address people’s needs:

*“The programme for mental health had a negative effect in people’s mental health; at the moment, there are no responses at this level. And despite being more aware of this issue, there are no proper services, right? A person may try to schedule a psychology session, but there are no psychology services! And why’s that? Because they decided that those who had problems should be integrated, that all services needed to be shut down. In the end, they didn’t develop the existing services, so they shut them down.” (E12)*

*“In terms of mental health services, there were several attempts to end some projects.” (E14)*

## **DRUG-RELATED DISEASES**

We will now discuss the domain of drug-related diseases, namely infectious diseases like HIV/aids and tuberculosis, particularly associated with high risk populations (Semenza and Giesecke, 2008). An international systematic review of studies that assessed changes in terms of infectious diseases after periods of crisis<sup>107</sup> “found evidence of worse infectious disease outcomes during recession, often a result of higher rates of infectious contact under poorer living circumstances, worsened access to therapy, or poorer retention in treatment” (Suhrccke et al., 2011, p. 1).

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<sup>105</sup> Remaining percentages: only 4.7% identified a decrease.

<sup>106</sup> Remaining percentages: 7.3% (n=4) did not associate; 41.8% (n=23) are missing values.

<sup>107</sup> The review identified 230 studies of which 37 met the author’s inclusion criteria.

In what concerns HIV's evolution throughout history, "Big Events" like political and economic transitions and wars were accompanied by HIV epidemics in different countries (Friedman, Rossi & Braine, 2009). In recent years, also the Greek and Romanian cases became very well-known and controversial, since there was an outbreak of HIV infection among injectable drugs users, "associated with low or reduced levels of preventive intervention funding" (ECDC, 2012, p. 9).

In regards to tuberculosis, the participation of several countries in IMF programmes was associated with the increasing rates of mortality due to tuberculosis, as well as its incidence and prevalence (Stuckler, King & Basu, 2008), namely among injectable drugs users between 2008 and 2012 – in comparison with the 2002–2006 period, showing a fast increase of risky behaviours in the beginning of the economic crisis (Paraskevis, 2013). In other words, there was enough international evidence to support the interviewees' worries regarding the Portuguese reality in this area.

From an epidemiologic point of view, data have shown that since 2000 there have been a reduction in the tuberculosis incidence rate in Portugal, as well as a reduction in the number of HIV infection cases<sup>108</sup>; this is particularly observable among injectable drug users, who represent 6.9% of new identified cases in 2013 (DGS, 2014).

*"This situation was much more usual before, now one can hardly observe it."* (PWUD30)

However, the highest rates of tuberculosis incidence can be found in the urban centres of Lisbon and Porto (Ibd.), precisely the two places where the majority of the interviewees came from. Hence, not seeming to contradict the trends described above, some participants mentioned the increasing number of tuberculosis cases in certain regions and under certain circumstances<sup>109</sup> (n=6).

*"In what concerns tuberculosis, there was an increase in the disease's rate. In the northern region there are better defined focuses associated with drug use."* (P9)

*"The tuberculosis rate of infection increased in 7 districts. The national average keeps decreasing, but at a slower pace (...) We should analyse the other districts with high concentration of vulnerable groups and try to figure out why this is happening. In Porto, the incidence rate was 35% and rose to 38%, but in Portugal, the rate is only 21% per 100.000 inhabitants."* (E13)

This way, and despite the reduction in tuberculosis cases, its persistence and the fact that it is associated with more vulnerable groups – 30% of people with tuberculosis show social risks factors (DGS, 2014) – seem to justify some of the concerns, especially when "there is a reduction in the assessment of the serological status regarding HIV

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<sup>108</sup> Despite the reduction in infection cases, the numbers are still significantly high when compared to the ones from other West European countries (DGS, 2014).

<sup>109</sup> For example, in Porto, the cases of tuberculosis infection are particularly associated with risk factors like alcohol and drugs use. In Lisbon, they are more associated with immigration and HIV infection (DGS, 2014, p. 62)

among people who suffer from tuberculosis” (Ibd., p. 57).

With respect to HIV, the interviewees did not notice any changes (n=2+1FG), in spite of some worries that could be associated with the progressive reduction of HIV diagnostic tests in the Centros de Aconselhamento e Detecção Precoce (CAD) [Counseling and Early Detection Centres] between 2008 and 2013. This could be a consequence of “the widespread promotion of the HIV tests in several contexts, namely in community initiatives” (DGS, 2014, p. 45).

*“With respect to HIV testing, we don’t have any kind of problem, since we still collect blood in our mobile units and we still have the CAD’s support in case we need a quicker testing process. Therefore, we don’t have many issues at this level.” (P1)*

Perhaps this generalisation of diagnostic tests for several contexts help to understand the different and divided opinions of HR professionals regarding the implementation of diagnostic tests for drug-related diseases in the six years preceding data collection. I.e., while 44.6% (n=41) of respondents did not identify any changes, fewer considered that there was a decrease/highly decrease (37%, n=34) and 13.4% (n=13) mentioned an increase/high increase.

To understand these differences, other explanatory factors were taken into account. Namely, it was thought that regional or financial issues of outreach workers could be a factor to understand those differences, but it was not observed. Indeed, one verified possible explicative factor is related with years of experience in the field of drugs. In other words, it was noticed that the ones who worked for 10 or less years did not identify any changes (55.8%, n=24)<sup>110</sup>; and the majority of those who worked for 11 or more years positioned themselves towards the decrease/high decrease of the implementation of diagnostic tests (53.7%, n=22)<sup>111</sup>. On the other hand, among the ones who believed that there was a decrease/high decrease in the implementation of diagnostic tests, the majority (58.8%, n=20) somehow/highly associated it with austerity<sup>112</sup>.

Also, in what concerns the treatments and follow-up processes to drug-related diseases, the opinions of the interviewees seemed to vary. If on the one hand, the participants mentioned that the services continued to develop their work (n=3):

*“For now, the main services like the CDP [Centro de Diagnóstico Pulmonar – Pulmonary Diagnostic Center] are working... just like the infectiology and HIV departments. I’m not familiar with the majority of the controversies associated with the lack of HIV medicines distribution and I don’t know any user who doesn’t have access to the drugs.” (PWUD36)*

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110 Remaining percentages: 18.7% (n=8) identified a “high decrease”/ “decrease”; 20.9% (9) mentioned an “increase”/ “high increase”; 4.7% (n=2) are missing values.

111 Remaining percentages: 26.8% (n=11) did not mention any changes; 9.7% (n=4) thought there had been an increase/high increase; 9.8% (n=4) are missing values.

112 Remaining percentages: 41.2% (n=14) are missing values.

On the other hand, they also identified problems in the access to treatment (n=3+2FG). Indeed – despite a considerable 32% (n=31) of respondents who reported there were no changes regarding the access to drug-related treatment –, the majority of questionnaire respondents (54.6%, n=53) considered to be decreasing/highly decreasing this access during the six years preceding data collection<sup>113</sup>. The interviewees also mentioned the HIV/aids follow-up processes provided by general hospitals, which had accessibility issues (E14); the increasing number of criteria in the access to treatment (n=2+2FG); and the fact that the patients needed to be referred by the Primary Healthcare Services before being sent to the hospitals (P8), unlike what previously happened.

*“The HIV monitoring services are gradually moving to the hospitals. In some cases, the patients end up having a lot of difficulties. They don’t go there for obvious reasons, like having a lot of difficulty to move.” (E14)*

*“The changes are more visible in the new cases, when the users have access to medication for the first time. Previously, there was a set of symptoms a person had to present in order to have access to the medicines. Nowadays, this same set is reduced and people have to wait a little longer to start taking the medicines they need.” (P9)*

*“We also know that the criteria are getting stricter and that there isn’t much flexibility to reintegrate those who have already abandoned treatment.” (FG5.2)*

On the relation between these trends and austerity, according to quantitative data, 77.4% (n=41) of those who mentioned that there had been a decrease/high decrease in the access to drug-related treatment, somehow/highly associated it with austerity<sup>114</sup>. Besides, two interviewees mentioned the fact that the numbers may not be totally intelligible yet (n=2) and **“even perverse” (E40)**. For example, international evidence regarding alcohol consumption is mixed, i.e., while the evidence for alcohol use during recessions seems to indicate that overall use decreases during an economic downturn, harmful drinking tends to increase (New Zealand Drug Foundation, 2009).

*“There’s no such thing as a ‘good’ crisis or misery. That’s not what I’m saying. But we need to consider certain facts, right? If I can’t afford buying alcoholic beverages, the chances of dying from hepatitis or aggravating a previous condition are very small.” (E40)*

This can be perceived as a red flag, especially because Portugal presents values that are significantly higher than the ones reported by the majority of western Europe countries in what concerns HIV.

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113 Remaining percentages: 13.4% (n=13) identified an increase/high increase.

114 Remaining percentages: 22.6% (n=12) are missing values.

## Chapter 5 | The “Cushion effect”

*“We do not have that ability to keep the answers by ourselves. The partners have been an important factor and have helped and endured the crisis.” (D19)*

In general, the results indicate the existence of a very concrete effect of certain policies and budget changes in the lives of PWUD and in the functioning of the services they resort to, especially during periods of economic and financial crisis. This way, and although the participants did not always establish a direct association between the identified changes and the context of crisis – which demonstrates some caution to avoid linear conclusions –, they pointed out that the majority of changes occurred during the implementation of the Memorandum of Understanding (MoU) between the *Troika* and the Portuguese Government (May 2011 to May 2014). However, this does not preclude other arguments, such as the hypothesis of political and ideological options, which can be inherent to the partisan political change of government in June 2011: *“For this Government, the drug use issue is much less important than for other governments, including for the ones established by the same parties”* (E25).

In concrete terms, we were able to observe a set of considerations about changes in the Social security system and universal health care. However, the perception on the types and patterns of drug use were less consensual. Regarding the Portuguese Model of Drug Policy, the participants highlighted the gap between the model design and its operationalisation, due to contextual constraints. In addition, negative expectations have been raised about the future of the model, with obvious fears of a setback.

The role played by civil society appears to be emphasised in the different domains of analysis, namely in what concerns the current situation in terms of PWUD’ lives and the services they use and often depend on, as well as in the Portuguese Drug Policy Model. The idea is not new and the role of civil society in Portugal is even patent in the definition of the features of the welfare model of Southern Europe (Cf. 3. Drug use: trends and uncertainties), where the relevance and the importance of traditional forms of solidarity are very pronounced, when compared to other European realities (Silva, 2002). As it is described by Santos (1995), in a society in which the welfare state never reached its full development, there were many factors that, over the years, provided the necessary conditions for the existence of patterns of sociability, in which typical social relations of welfare-society could flourish. As the author points out (Santos, 2009), the modernity project forgot and depreciated the community principle (which, along with the State and Market, constitutes the regulation pillar), as well as the aesthetical-expressive rationality (which, along with the cognitive-instrumental and ethical-moral rationalities, constitutes the social emancipation).

While one could argue about the civil society institutions’ dependence on the Portuguese State, either on its social configuration or its functioning (Hespanha et al., 2000), the fact is that the role these institutions play in the suppression of social responsibilities of the State has been eliminating some of the existing gaps (Estanque, 2012; Silva, 2002). In this regard, it is important to mention that the Social Action subsystem is developed mostly by non-profit institutions, particularly Private Institutions of Social Solidarity (IPSS) (Cf. Social Action subsystem), but also other private partners cover several different needs (n=4):

*“Families organise themselves; institutions that come out of nowhere; associations that come out of nowhere, only to help ...” (P1)*

*“The local authorities have been promoting some programmes that are supporting it [access to medication] and some social movements that have been providing assistance.” (E14)*

*“For example, I believe that there are a lot of people working as volunteers in the street, in mobile kitchen vans (...) they escort people to medical appointments and try to get them off the streets. There are much more backings to this type of work than before.” (PWUD28)*

*“Sometimes, there are some people who want to help us and they give us some money, so we can take these individuals to treatment services and medical appointments.” (P9)*

With respect to the drugs domain, the development of the HR axis in Portugal has not only been widely implemented by civil society organizations (Cf. Harm Reduction), as it seems to have been thought with this purpose (D20; E12):

*“In spite of everything, we have to be fair, and I think that there has been an evolution, also due to the effort of civil society. They’re the ones who started developing these projects, demonstrating awareness on what were the issues related to fieldwork, to the real context. This perception didn’t exist before.” (P24)*

*“In terms of HR policies, I believe that they are now part of the IPSS’s and community spectrum (...) I think that this was the main goal, the real reason behind such a strong State intervention in HR policies. The fact that civil society had to integrate these policies was always the most up-to-date discourse.” (D20)*

Therefore, and although this situation could help explaining the greater frailty of the HR axis compared to the others (E39), it could also demonstrate its great effectiveness (P16):

*“I think harm reduction projects are at stake, because all others are institutionalised and functioning. With more or less people working, they are part of the system.” (E39)*

*“If we had to comply with a formal network or a more formal social security system, I believe we would not be able to support even half the people who are currently living in the streets and whose lives are characterised by drug use.” (P16)*

The importance of this work goes, however, beyond their nature and the role they play in fulfilling the needs that the State cannot cover. It is associated with the role played by private organisations – especially from outreach work – and their professionals in reducing the effects of the context of crisis. This is what we call “cushion effect”

- associated with the idea of professionals as *automatic stabilisers*, i.e., who contribute to smooth the impacts of changes among people who use drugs. However, some of PWUD frequently perceived it (n=4):

*“I think professionals try to cover this crisis a lot, and they are the ones who give more of them so that people do not feel that so much” (PWUD28)*

*“The teams are working a lot and they’re demotivated, no doubt about it. However, they are always playing and their good-will and love are reflected in what they do. They cover many, many needs.” (PWUD35)*

This becomes even more relevant when we realise the effort some teams did, even during periods in which they did not have any funds (Cf. Harm Reduction); they continued to carry out their work, trying not to let the users suffer from the internal obstacles hindering the projects. This is why this effect is considered to be important to understand the sometimes different perceptions on the existence and direction of impact.

*“We have more and more users seeking us, expressing interest in joining our project and I cannot say it is easy for a team to work with these users, especially when they can only perform minimum service due to a lack of funding. We have to multiply our efforts, in order to ensure the fulfilment of the basic needs of the users.” (P1)*

On the other hand, the fulfilment of responsibilities by the professionals frequently exceeds their own functions. This is the case of Social protection, particularly in terms of access to social benefits, such as *Rendimento Social de Inserção* (RSI). Some of the participants discussed the moment of the application and the renewal of this financial benefit (n=2):

*“What has been happening is that the team has handled... For example, the processes of renewal are handled by the team. The users know that; when they receive the letter, they have to come here and give it to us, so we can support them, help them and try to solve their situation. Therefore, many of them have been able to carry out processes of renewal because we take care of them.” (P17)*

*“Many of the users were able to maintain the RSI, because we used to take a computer with us to fill the online forms with them” (FG4.1)*

Still, professionals have to work together with the social security services towards the deconstruction of some myths, such as the idea that drug users are unable to perform an insertion plan and, therefore, are not eligible to receive a monetary benefit:

*“It was very important to deconstruct some myths among those who establish the RSI agreements. A user shouldn’t be excluded just because he/she continues to use drugs. On the contrary, the RSI*

*could lead to many other things, like dealing with their health situation, for example (...) We also know that the social services were encouraged to reduce the number of applications to the RSI and other social benefits. Therefore, if there wasn't a proper partnership, our users wouldn't stand a change (...) we were able to support the majority of users, especially when they were caught using drugs.” (P18)*

Other examples brought by the same professional are associated with the access to medication, namely the organisation of handcraft sales to raise money to buy medication for users; and also with the access to treatment, where it is described how the State treatment facilities (ET) need to coordinate their efforts with the outreach teams to overcome logistical and materials constraints:

*“We keep finding ways to raise funds. We usually sell some things in small markets, in order to get some money. Sometimes, the users can't afford their medicines and we believe they shouldn't spend a single day without taking their medication.” (P18)*

*“Some state services, social security, ET, ACES... they usually call the outreach teams and ask for their support in the technical follow-up processes, since they can't do it, they just can't provide transportation... social security supports the medication costs, but we're the ones who have to go to the pharmacy and ask for the budget.” (P18)*

Consequently, while there may be cuts, reductions and gaps in funds allocated by the Portuguese State to the implementation of HR projects (Cf. Harm Reduction), a setback in the implementation of projects of the HR axis did not seem to be in question for some participants (n=4). Among some of the reasons, they suggested the proven effectiveness of these measures compared to the involved costs (P15), as well as its international visibility (n=2):

*“Nevertheless, it [harm reduction] is the only option that they [decision-makers] have, because everything else was falling apart. It was a stroke of luck.” (P18)*

*“Harm reduction is something much more visible and creates a great social uproar; therefore, one we cannot cease to invest in it.” (D19)*

In this sense, the Portuguese Drug Policy Model can be seen as a “cushion effect” itself. This means that, as a key pillar of the Portuguese model, based on pragmatism, humanism, non-imposition of abstinence and proximity (Carapinha, 2009), the HR axis contributes to the positive international evaluation and evidenced benefits of the model, as well as its continuity. Summarily, beyond the legal framework that distinguishes drug use from drug trafficking, the Portuguese Drug Policy Model works as a protective system, by adopting an innovative and comprehensive approach to which the HR measures contributed. Therefore, despite all the fears in relation to disinvestments in the operationalisation of the model, it seems that the Portuguese Drug Policy Model is not at risk and, in a certain way, is itself responsible for this protective effect towards the drug phenomenon.



# Chapter 6 | Final considerations

## Particularities of the study

This research was designed with extreme caution, in order respect exemption in gathering participants' opinions. The researchers were particularly careful to avoid conditioning answers in any possible way. In fact, this was praised and explicitly recognised by some of the interviewees. Since scientific production around the Portuguese Drug Policy Model (PDPM) has not always been transparent, rigorous or impartial (Hughes and Stevens, 2012) and since this is a somehow controversial matter, we intended to do an irrefutable approach from that point of view.

The design of the scripts of the interviews and of the focus groups clearly reflects that concern, by the broad and open character of questions posed. Nevertheless, that option has had a price: participants were free to approach the subjects presented as they wished, resulting in a considerable dispersion of contents. If those scripts were more direct, specific and conditioned the answering behaviour, the number of persons discussing a particular subject would be more pronounced and the consensus/disagreements found would be more intense. Nevertheless, this was an exploratory study and, also from that point of view, it was developed to capture participants' perspectives about several matters, with the goal of finding tendencies to explore in future researches.

Also, the study was made in a very particular historical moment, which brought powerful elements to understand what was happening in the country in this troubled years; at the same time, and for the same reasons, there are scarce macro indicators to combine with what was captured in the field. These types of indicators need time to be reliable and to reveal tendencies. It means we have to wait a bit more to combine quantitative and macro indicators to data gathered qualitatively in the micro analysis. However, whenever this kind of information was available, it was used to produce a more comprehensive reading of data.

## Is the Portuguese Drug Policy Model in danger?

One relevant finding of the study is that participants were very consensual in recognising the value of the Portuguese Drug Policy Model (PDPM), describing it as innovative and exemplar. Yet, three of them affirmed that it has stagnated in time. Besides that, six of them feared a setback in services provided and in governmental investment in its implementation, even if legislation is preserved in the future. This is a sharp perspective of what is one of the main conclusions of the study, as we will see. The PDPM is far from being a simple reflection of the Decree-law 183/2001 (harm reduction measures) or even the Law 30/2000 (decriminalisation of drug use). It is structurally based on a considerably efficient network of multidisciplinary socio-sanitary services, linked with each other to provide comprehensive responses to people who use drugs.

One can be approached by harm reduction proximal teams in his/her natural life contexts and get psycho-social support; vaccination; food; sterilised material for drug use; harm reduction capacity building<sup>115</sup>; education for

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<sup>115</sup> Outreach teams are deeply involved in what happens in very open-drug scenes. Sometimes, they promote the adoption of less risky rituals of drug use while their beneficiaries are using drugs, making their work more effective. Harm reduction professionals can, in these cases, witness the act of drug

citizenship; low-threshold methadone programmes; screening and medication for HIV, tuberculosis and other diseases; referral to various community responses. Besides that, whenever necessary and justified, outreach teams will escort clients to services, picking them up before and taking them back after. Those projects exist in several cities of the country and are provided by NGOs deeply integrated in the local communities where, with and to whom they work for. This is crucial to ensure that penetrating in social and spatial margins is viable and to facilitate the liaison with other institutions and members of the community.

Besides that, people who use drugs (when prepared and willing for treatment) have a considerable easy access to several free treatment modalities in a wide territorially spread network of centres. There, access to specialised psychiatrists, nurses, psychologists and social workers is largely guaranteed. When infectious diseases are present, protocols established with specialised hospitals are put in place, in order to offer an integrated response (for example by complementing treatment with methadone, decisively contributing to raise adhesion). Simultaneously, all social support needed to assure compliance with these treatments is put in place. There are multiple measures of this kind being applied, in order to empower health and social care services to deal effectively with the phenomenon. A person experiencing drug addiction would eventually get support for eating, housing, medication, transportation and other dimensions (dentist consultations and/or dental prostheses to facilitate social inclusion). Besides that, drug issues are frequently discussed in meetings that gather a considerable number of institutions working in a given territory, which helps developing synergies to adequately address to challenges posed.

Also, regarding social reintegration, Portugal has made important efforts to stimulate professional inclusion. The “Life-Employment Programme” is a good example of that. It created links between treatment services and potential employers and offered a financial compensation for the inclusion of people in treatment, assuring the follow-up of the integration process by a social worker, in order to make it successful.

This very superficial and generic description aims to underline the idea that the PDPM is rooted in a comprehensive framework; on the one hand, drug use should be seen as a reality to be addressed in a rational, humanistic and pragmatic way. On the other hand, it perceives people who use drugs as individuals whose rights need to be protected and, in some cases, with pathologies to be addressed. This spirit is reflected in the complex, dynamic and integrated network of services aiming to support people who use drugs. The legal changes introduced in 2000 and 2001 resulted in positive changes and the participants of the study believe that some of them might be at risk:

- Concrete material consequences caused by the kind of approach voted for people who use drugs: putting away the incarceration scenario and contributing decisively to reinforce and recognise this comprehensive approach, by referring drug use to the health sector and take it from the justice system. According to this notion, governmental and non-governmental organisations felt compelled to continue to develop and deepen their comprehensive kind of interventions.
- Important symbolic improvements, by stimulating a public debate that may have contributed to decrease stigma and prejudice against people who use drugs and against the demonised psychoactive substances themselves.

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use, diagnose risky behaviours, help clients to assume safer practices and also evaluate *in loco* the impact of this kind of intervention.

The simple act of assuming this legal framework helped to spread the notion that those who consume drugs are not criminals, but people who should have access to care and professional attention. This is a very important contribution. The phenomenon of drug use, as it emerged within the modern industrial societies, was socially constructed, namely through a “demonization” process of certain substances and of those who used them. That is one of the negative effects of the War on Drugs: it fuels stigma and marginalisation, turning those symbolic and social processes a fundamental part of the problem. For example: the majority of the issues addressed by harm reduction services are, mainly products of prejudice and ostracism (infectious diseases like HIV, viral hepatitis and tuberculosis are deeply connected with life conditions which are directly linked with social exclusion).

## Collateral damages of austerity

According to the narratives of participants – and although the majority believed in the stability of the legal framework in the future – some of the beneficial effects of the model are at risk: one of the interviewees explicitly affirmed that the humanistic element of the policy is in decadence; by the other hand, the participants described the frail material conditions for its implementation. Even if the majority of participants did not fear a legal overturn, they described a very concerning decay scenario of the intricate system of services and, therefore, of the critical factors of success of the PDPM. Examples of these (mentioned by participants and to some extent certified by previously existing data presented) are:

- Clear divestment in harm reduction and treatment services and severe issues of sustainability – with direct impact in the interventions provided;
- The end of the governmental organism specialised in drug use issues (IDT) and the integration of its services in the national health system (this process was generally criticised by interviewees);
- Considerable cuts in social support were made, not only in pecuniary attributions (which are described as increasingly inaccessible and reduced), but also in several dimensions like transportation, medication, dental prostheses or glasses. This has a negative impact in the quality of life, the treatment’s success, the adhesion to infectious diseases services and the skills necessary to get a job;
- Lack of responses to homeless people, despite the fact that the number of clients of harm reduction teams in this situation has raised in 2014 – after a continuous decrease since 2004 (Carapinha, 2012);
- The change-over verified in the pioneer National Programme for Syringes Exchange, (implemented in 1993) (Cruz, 2005) supported by a network of pharmacies all over the national territory and classified by experts as “one of the most important harm reduction strategies in Portugal” (Estratégia Nacional de Luta Contra a Droga, 1999). The implementation of the programme was threatened by some issues during the negotiation process between the Government and the National Association of Pharmacies. This turn-over is reported as an obstacle to syringes’ accessibility and three of the interviewees explicitly mentioned the risk behaviours associated to it;

- Three persons who use drugs mentioned a reduction in: human resources available for their care; ratio professionals–clients; time for medical attention;
- Lack of responses dedicated to professional and educational reinsertion and the end of the “Life–Employment Programme”.

In brief, paradoxically, in an historical moment characterised by the vulnerability of Portuguese citizens, the participants identified a clear and generalised disinvestment in operative responses dedicated to people who use drugs, as well as the State’s disrespect towards its responsibilities – to care and protect those in most unfavourable situations. In fact, one of the more consensual assumptions was the recognition of a decadent welfare state.

We can affirm, based in the explicit assumptions of participants, that there is a growing distance between what is established by the PDPM in its core definitions and what is really happening in a day-to-day basis. It seems that the PDPM is at risk of becoming a mere statement of principles and intentions without a true correspondence in practice. What will be the consequences in a near future? We suggest the development of more studies, in order to gather enough data to explain possible variations in fundamental indicators, like rates for infectious diseases’ incidence; criminality among people who use drugs; adhesion to treatment; etc.

## **The role of civil society and harm reduction in particular**

As austerity measures were being applied – and the State was decreasing its protective role among those who use drugs – it seemed that civil society intensified its compromise with the interventions in the field. Data brought to light a considerable neutralising action of NGOs regarding the possible impact of austerity measures. This finding has two main sources: the key study described in this document, but also a research included in the broader project that comprises this one. This other study – the basis for a Master’s degree thesis developed in the University of Porto – consisted in interviewing people who use drugs to understand their point of view about the effects of austerity in their lives and in drug phenomenon (Almeida, 2014). Curiously, although participants clearly described the same constraints found in the present study, they felt greatly protected of its effects because of the intensified and adapted activity of harm reduction teams. This is what we called “cushion effect”, as described in the last section. It seems that the responses typically under the scope of the State are increasingly being transferred to the civil society domain. This has a price for NGOs, which are described in both studies as “working in the limits of their capacities, with tremendous negative effects on professionals and material resources and facing interruptions and cuts in funding”.

This is the critical element where the PDPM exposes its potential and value: this model has a protective role towards civil society, since the implementation of proximal, humanistic and pragmatic responses by NGOs working in the field is one of its core elements.

The most important lesson to be learned with this research is that a decriminalising legal framework is an important tool, but not a sufficient resource to achieve the desired results. Analysis of the PDPM potential must be concentrated in the micro-dynamics of its implementation, with particular emphasis in the work developed by civil society.

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#### (Footnotes)

- 1 The *Casal Ventoso* was a residential area in Lisbon. It was associated with poverty and social exclusion, as well as drug trafficking. Some of the buildings were demolished, according to an initiative promoted by the city hall. The difficult process of relocating the population of the neighbourhood started in 1999. In Portugal, this neighbourhood is many times used as an example of social marginalisation, namely in terms of drugs.

