Queensland Mental Health Commission

Portugal's response to drug-related harm

July 2018

qnada
Queensland Network of Alcohol and Other Drug Agencies Ltd

Queensland Government

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Introduction

The Queensland Mental Health Commission was established in 2013 to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, alcohol and other drug service system in Queensland.

Queensland, like the rest of Australia, has been experiencing an increase in methamphetamine use since around 2010. Problematic methamphetamine users have put significant pressure on general health, justice and child safety systems, particularly in rural and remote communities. Those seeking specialist treatment have difficulty accessing it.

The 2015 final report of the National Ice Taskforce noted: *Ice use is not a problem we can solve overnight, and not something we can simply arrest our way out of. Nevertheless, we believe we can do more to reduce the use of this drug and the harm it is causing, enhancing the already significant efforts being taken by governments, communities and individuals*.[1]

In June 2018, the Queensland Mental Health Commissioner visited Portugal to observe the country's response to illicit drug use, which is acknowledged by the International Narcotics Control Board as a best practice model. The Commissioner was accompanied by the CEO and Board President of the Queensland Network of Alcohol and other Drug Agencies and an Addiction Medicine Specialist from Metro North Hospital and Health Service.

This report outlines the group's reflections on what they observed of the Portuguese approach to illicit drug use.

[1] Commonwealth of Australia. "Final Report of the National Ice Taskforce." edited by Department of the Prime Minister and Cabinet. Canberra: Commonwealth of Australia, 2015.

The Portuguese model

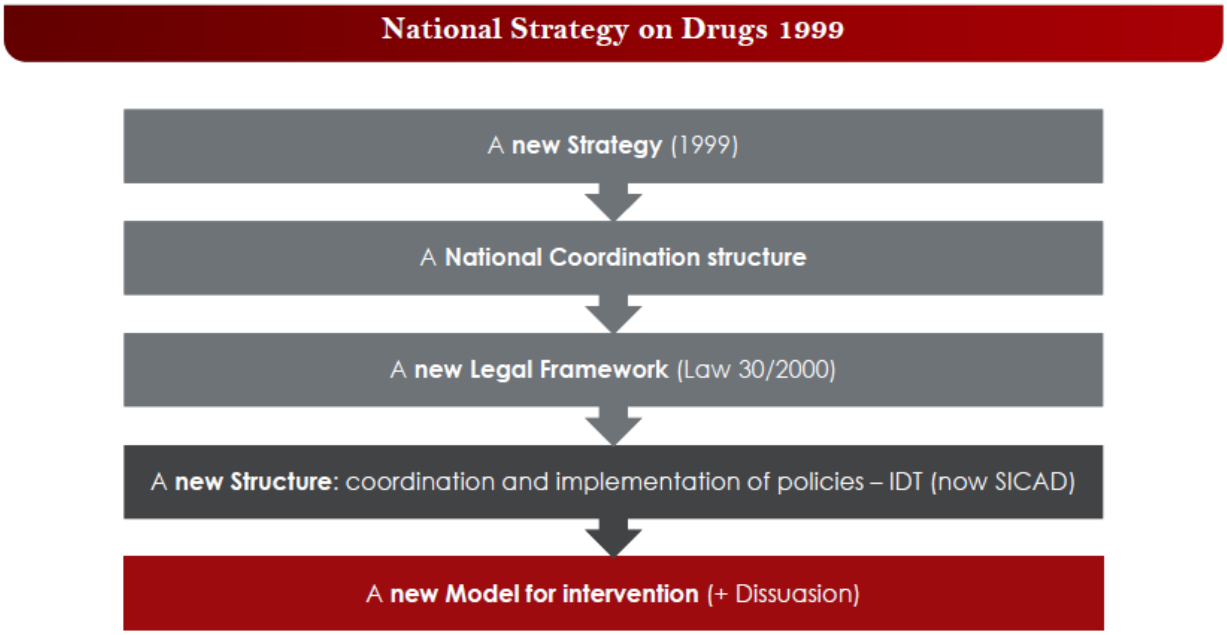
In the late 1990s Portugal had the highest prevalence of problematic drug use in Europe, affecting 1% of the population (100,000 people). The primary drug of choice was heroin, with high levels of injecting drug use and associated HIV and HCV infection rates.

Social issues associated with problematic drug use were obvious, as was community concern that their loved ones did not have ready access to treatment and that the primary response to drug use was through the criminal justice system.

An expert panel was established to examine more effective ways to respond. The nine-member panel included professionals from medicine, law, philosophy and police, as well as young people. Its final report made 84 recommendations and the parliament accepted all but one (related to establishing a supervised injecting facility).

In 1999, a new national strategy on drugs was released, which aimed to shift the response from criminal justice to public health.

Figure 1: Stages in the development of the Portuguese model



The strategy was based on the concepts of humanism and pragmatism, recognising the drug user as a citizen with dignity who should be understood within the framework of the complexity of his or her individual, family and social history. This reframed the policy response as favouring an openness to innovation, rejecting dogma and pre-conceived ideas and instead developing evidence-informed policy.

The strategy has two mission areas: demand reduction and supply reduction. The demand reduction area includes prevention, dissuasion, harm reduction, treatment, and reintegration. The two mission areas are supported by coordination, international cooperation, information, training and evaluation and a review of the legal framework.

Objective limits were set on the quantity of drugs that would be considered for personal consumption (constituting an administrative offence), representing up to 10 days' supply for a dependent user. It should be noted that the drug quantity thresholds were set very low and, as such, created little resistance from law enforcement teams.

Figure 2: Prescribed schedule for personal consumption

Law 30/2000

ILLICIT SUBSTANCE	GRAMS
Heroin	1
Methadone	1
Morphine	2
Opium	10
Cocaine (hydrochloride)	2
Cocaine (methyl ester benzoilecgonine)	0.3
Cannabis (leaves and flowers or fruited dons)	25
Cannabis (resin)	5
Cannabis (oil)	2.5
LSD	0.1
MDMA	1
Amphetamine	1

People in possession of more than the prescribed schedule are charged, though they may be referred to the Dissuasion Commission by the courts, depending on what other charges are laid.

As Nuno Capaz of the Dissuasion Commission noted: "The dissuasion intervention provides an opportunity for an early, specific and integrated interface with drug users, targeted at the drug user's characteristics and individual needs".

In practice, this means recreational drug users are diverted from both the justice and health systems with a caution, while dependent users are encouraged to access treatment services.

Policing efforts have shifted from regular contact with problematic users to focus instead on international cooperation targeted at trafficking syndicates, with the police regularly seizing tonnes rather than kilograms of illicit substances destined for European drug markets.

The policy shift did not lead to an increase in drug use. It has now been in place for 18 years and is supported by both sides of parliament.

Day 1

National Unit for Fighting Drug Trafficking (UNCTE)

The delegation met with Rosa Mota, Criminal Investigation Coordinator. Ms Mota's unit deals with serious organised crime related to drugs and coordinating efforts with the Policia Judiciara and GNR (national guard), who had some competency in dealing with lower level offences (lower level drug dealers, direct distribution, possession in excess of levels defined as personal consumption).

The UNCTE is a large organisation, consisting of four units:

1. Intelligence
2. Sea trafficking
3. Air trafficking
4. Land trafficking

Portugal is a transit port for illicit drugs smuggled from South America and Africa into Europe, with most large seizures not destined for the Portuguese market. Current trends include high purity cocaine (>90%) from Brazil and high quality hashish from Morocco (which is 3–4 hours away by boat). Heroin imports are primarily from Turkey overland via Holland (difficult to detect land trafficking operations).

Ms Mota reported that prior to decriminalisation, a lot of police time was spent pursuing cases that did not involve significant quantities of drugs. While decriminalisation initially was not popular among police, the success of the approach over the last 18 years has made the policy more widely accepted, as police can see the benefits of supporting people to access treatment, as well as the benefits of focusing policing efforts on trafficking and international smuggling.

Pictured: Inside the courtyard of the new Police Headquarters in Lisbon

Lisbon Drug Addiction Dissuasion Commission

The delegation met with Nuno Capaz, sociologist and member of the Dissuasion Commission. The Commission is an administrative body responsible for applying sanctions to people referred by either the police or the courts for drug possession or consumption. The Commission is part of the Health Ministry, which he believes is key to ensuring drug consumption is treated as a health issue. He contrasted this approach with that of Spain, where drug possession has also been decriminalised, but police issue fines without assessment or personalised response.

The Commission has three members, who are supported by four technical support staff and three administrative staff. The Commission receives around 3000 referrals per annum. Technical staff conduct the initial assessment using a modified ASSIST score (to differentiate between dependent and recreational use) and provide advice to the Commissioners about whether the person is likely a recreational user, potentially problematic user or a dependent user.

Recreational users who attend the Commission for the first time are not sanctioned, though their file is retained for five years. The second time a person is referred to the Commission a sanction must be applied. This could be a fine, community service or regular presentation (most often to a community centre). The Commission can also revoke access to state benefits or revoke a licence to work in particular industries.

Dependent users who attend the Commission are offered support to access treatment. Where treatment is accepted, the sanction is suspended. If treatment is refused, a sanction other than a fine is applied, as it is assumed that dependent drug users will not have the capacity to pay a fine.

Sanctions are generally agreed with the person (e.g. if a person is unemployed, community service is generally preferred to a fine, while employed people will generally prefer a fine or donation to charity).

Of the people who are referred to the Commission, approximately 90% are assessed as recreational users, with the remaining 10% assessed as dependent users. The success of the approach is not just decriminalisation (which only solves the problem of a person getting a criminal record), but also the structured and prioritised access to treatment and other support services (such as employment and housing).

Up to 85% of people referred attend the Commission. Where people do not attend, a reminder notice is sent and then police provide a third notification if necessary. A sanction (usually a fine) is applied and sent by post on the rare occasions where these strategies are unsuccessful.

Pictured: (above left) Case files from the Dissuasion Commission — each case involves about half the expenditure of a case going through the court; (above right) Mr Nuno Capaz discusses the role of the Dissuasion Commission.

Mr Capaz advised the key to the process was the way in which the Commission could tailor the response to suit the individual. Where a person is assessed as a recreational user, the commission can provide harm reduction advice and tolerate continued use (which the court system cannot do). The key for dependent users is ready access to a publicly funded treatment system, including free access to methadone and needle and syringe programs.

Mr Capaz also noted the shift in prevention campaigns since the policy change. Portugal has abandoned mass media campaigns with a 'just say no' message and instead developed smaller campaigns targeted at particular groups (e.g. unemployed, sex workers, school drop-outs) with messages such as shifting use from injecting to smoking heroin, or aiming to increase the age of first use, and information sessions not focused on fear tactics in schools. The switch from a justice to a health approach has led to significant savings, with the average 'cost per file' processed being about 50% of the cost when the courts were involved.

Mobile low-threshold methadone program (Aires do Pinhal)

The delegation attended an outreach site for a low-threshold mobile methadone program. The program visits three sites around Lisbon twice a day (morning and afternoon) on weekdays and once a day on weekends. The program provides doses of methadone to around 1200 patients daily and is accessed via self-referral.

Pictured: The low-threshold mobile methadone service with the health care team, serving free opioid treatment to 1200 patients each day

New patients undertake a urine drug screen and simple interview process to access the program and are generally started on a 30mg dose of methadone, which can be increased up to 50mg and then up to 120mg over time. There is no requirement for daily attendance or abstinence from heroin, although if two doses are missed, the protocol is to drop the dose by one-third.

The van also provides access to a general practitioner, as well as psychologists and social workers who can link patients with other services or refer them into more formal, clinic-based treatment. Other daily treatments can also be administered from the mobile service as required.

Day 2

Residential Therapeutic Community (Communidade Vida e Paz)

The delegation attended a faith-based non-government organisation that offers street outreach and two residential therapeutic communities. The organisation has 110 professionals, supported by around 500 volunteers. Its mission is to establish a relationship for change with their clients, with engagement primarily through connections made by street outreach teams and referrals from the Dissuasion Commission.

The street teams provide a meal to homeless people with a view to building a trusting relationship and supporting the person to access services to support change. They have an open dialogue space (or drop-in centre) that provides services to support people to address alcohol and other drug use, employment and/or housing issues. They operate two residential therapeutic communities and two reintegration centres. The therapeutic communities provide alcohol and other drug treatment and the reintegration centres support graduates of the therapeutic communities, as well as providing accommodation and support to homeless people who are not drug dependent.

Approximately 65% of the cost of delivering services is funded by government grants, with the remainder made up through social security benefits and donations.

The profile of residents has changed in recent years, with a larger proportion of clients aged 55 years and over, which presents a challenge in terms of connecting people with employment. Planning has commenced to adjust the program to provide longer term accommodation support to this cohort.

Pictured: Communidade Vida e Paz — a therapeutic community. On the left are the printing and graphic design centre and the woodwork shop where residents acquire skills to prepare for employment after completing their program. The bakery and vegetable patches are behind.

Community-based intervention service (Crescer)

The delegation attended a non-government organisation that provides community-based interventions, including outreach and harm reduction. The organisation has 50 staff and operates a drop-in centre as well as three outreach teams to different parts of Lisbon and operates on a housing first model. Funding is provided by the Portuguese government, Lisbon City Hall, the European Union, together with some philanthropic funding.

Outreach teams provide harm reduction information as well as sterile injecting equipment and sterile smoking equipment. They can refer people they come across to treatment services if they wish. They are also able to provide transport to medical and other appointments.

Their 'Housing First' program has no requirement for people to be in treatment or intending to go to treatment, with properties provided through the private rental market. The organisation provides a minimum of six visits per month to support people to maintain their tenancy.

Outreach teams visit the same sites at around the same time each day and can be contacted via mobile phone if people have specific needs. The teams estimated that around 90% of the local drug-using population would be aware of them and accept their presence. They come across the occasional overdose, but do not have access to naloxone (though they have been lobbying for access for the last 3–4 years).

They have established a partnership with a doctor at a local hospital who provides access to Fibroscan and Hepatitis C treatment (provided free by the government) and can support medication adherence during treatment.

Pictured: Meeting the team at Crescer. Also pictured is an 'unofficial' injection room on a patch of waste land, and the contents of sharps kit, though no sharps disposal bins were provided.

Day 3

Addictive Behaviours and Dependencies Intervention Division (DICAD)

The delegation visited a public treatment service that provides residential withdrawal management, opioid substitution therapy, counselling and a day program. The Taipas Centre opened in 1987 and was the first medical withdrawal service in Portugal. Previously, withdrawal management had been offered through the Ministry of Justice (though was still run by health professionals).

The service uses a biopsychosocial model and is staffed mainly by psychiatrists and psychologists. Initially the team consisted of 165 people, but with funding difficulties this number has reduced to 65. No identification is required to access the service, and a file can be opened with a date of birth.

The service noted an increase in the age of their clients over the last 20 years, with the mean age shifting from the 20s to the mid-40s. In the early days, 90% were experiencing problems related to heroin, though this has shifted now with a mix of substance-use issues, including heroin, cannabis and cocaine. Alcohol is the largest problem substance.

The service philosophy encompasses four pillars: harm reduction, prevention, treatment, and rehabilitation and reintegration. 90% of its clients are self-referred, with around 6% referred by the Dissuasion Commission.

The ward was rather grim, with only six in-patients due to financial constraints, and the door was locked by a security guard on leaving. In an adjacent wing of the building art therapy and other activities were available, with multiple art works decorating the walls.

Pictured: The Taipas withdrawal centre, one of a maze of 50 plus such buildings gradually transitioning from clinical to administrative spaces. In the flight path of Lisbon airport, planes roared just overhead every 2–3 minutes

General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD)

The delegation attended SICAD, which provides policy and practice support to the Government of Portugal on alcohol and other drug related issues. Dr Juao Gulao was one of the architects of Portugal's current approach and advised that a public health approach to drug use was made possible by the significant rates of heroin related harms experienced in Portugal during the 1980s and 1990s, where all levels of society were impacted. He advised that decriminalisation was only part of the policy and the availability of free treatment was crucial to the policy's success, as was abandoning mass media prevention campaigns in favour of targeted harm reduction campaigns.

The policy is now well entrenched, with both sides of politics comfortable with the disease model approach where people are entitled to the same dignity as other 'self-inflicted' diseases such as diabetes.

Decriminalisation helped to change the public mindset of drug use to a health issue (rather than a criminal issue), which reduced the stigmatisation of people experiencing problems related to their drug use. Over the nearly two decades the model has been in place, the directorate has been able to educate politicians on the importance of harm reduction as an intervention that keeps people alive, opening lines of communication which enable relationships to be built. This approach encourages people to access treatment while respecting their decisions.

Reintegration was a big part of the initial policy with positive discrimination to support employment. Small enterprises (micro business) received tax advantages and government paid the wages for the first six months while the person adjusted to the routine of work and the associated expectations of performance. The global financial crisis presented a problem, however, as many micro businesses collapsed and heroin returned as people lost employment and confidence in the system. For Dr Gulao, this highlighted the importance of engaging with employers across small to medium, as well as large enterprises, to ensure some protection during economic downturns. It also led to a change in focus, promoting safer use (i.e. smoking not injecting drugs and raising the idea of medically supervised injection rooms once more).

Pictured above: Final meeting on Day 3 at SICAD with Dr Juao Gulao, one of the architects of Portugal's drug policy.

Since 2001, the Portuguese approach to managing the use of alcohol and other drugs has resulted in:

- a small increase in illicit drug use amongst adults
- a decrease in illicit drug use amongst adolescents since 2013
- a reduced burden of drug offences on the criminal justice system
- a reduction in the prevalence of injecting drug use
- a dramatic reduction in opioid-related deaths and infectious diseases
- a reduction in stigmatisation of drug users
- an increase in the amount of drugs seized by authorities
- a reduction in the public burden caused by drugs.

A comprehensive presentation on the Portuguese experience (*A public health approach as a base for drugs policy: the Portuguese experience*) is included as an appendix to this report.

Observations and insights for the Queensland context

- The overarching take-home message for the delegation was that treating substance use as a health problem, and not a justice problem, has resulted in major benefits, including:
  - more police resources to tackle serious crime
  - reduced delays in the court system
  - reduced demand on the prison system
  - reduced stigma and marginalisation of substance users.
  - improved access to individualised treatment for substance user
- Freeing up police, courts and prisons, enabled additional investment in health and related systems.
- All strata of society were accessing the methadone program; the process was quick, and not degrading or complicated for people to access.
- The methadone program was seen as treatment and not substitution, by analogy with a person with diabetes receiving insulin treatment daily.
- Even though over the last 15-plus years there has been a small increase in illicit drug use among adults, there was a decrease in drug use by adolescents since 2003.

Learnings from Portugal for Queensland

The Queensland Mental Health Commission can progress the learnings from Portugal by:

- convening an expert group of key Queensland stakeholders to fully consider the learnings from Portugal and assess the potential benefits and challenges for Queensland in taking a health response
- promoting the evolution of police and court diversion programs into a system that has a greater health focus
- trialling a dissuasion component within a health context in Queensland that individualises the response to each person with a dependence and focuses on engaging people early into treatment and rehabilitation and away from the criminal justice system.

Appendix 1

A public health approach as a base for drugs policy. The Portuguese experience (more than just decimalisation)

Refer separate document at: https://www.qmhc.qld.gov.au/media-events/news/report-portugal.