PERMANENT MISSION OF PORTUGAL
GENEVA

DH -434/2023

The Permanent Mission of Portugal to the United Nations Office and other International Organizations in Geneva presents its compliments to the Office of the United Nations High Commissioner for Human Rights and, with reference to its request dated 11th of October, has the honour to enclose herewith the input of the Portuguese authorities to the report on "Drug policies and responses: a right to health framework and harm reduction" of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The Permanent Mission of Portugal avails itself of this opportunity to renew to the Office of the United Nations High Commissioner for Human Rights the assurances of its highest consideration.

Geneva, 20 November 2023

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S. R.

MINISTÉRIO DOS NEGÓCIOS ESTRANGEIROS
Direção-Geral de Política Externa

Call for input – Special Rapporteur on the right to health – Drug policies and responses: a right to health framework on harm reduction

Input from Portugal

Contact Details

	☒ Member State ☐ Observer State ☐ Other (please specify)
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Key Questions

1. **While the concept of harm reduction has traditionally been applied to drug use, the Special Rapporteur is taking a broadened approach to harm reduction. What types of harm reduction policies, programmes, and practices are in place in your community, and what is their purpose or aim? How successful have they been at achieving that aim? Please provide data, as possible.**

   Within the framework of no. Decree Law 183/2001, the following types of services/socio-sanitary structures are available in Portugal:

   - **Drop-in Centres**

   Cabinets running 24 hours per day, 7 days per week. They can operate in fixed or mobile facilities and are proximity structures, where the provision of basic health and hygiene care takes place, as well as basic needs are supplied, nursing care, psychiatric and medical support, needle and syringe exchange programme, screening for infectious diseases and psychosocial support, allowing for an effective approach to treatment structures that can provide access to substitution programmes.

   - **Shelters**

   Overnight facilities that work during the night period, 7 days a week, and are intended to provide basic health and hygiene care, responses to basic needs (nourishment), as well as screening for and treatment of infectious diseases, psychological and social support, nursing care, access to condoms, low threshold substitution treatment and needle and syringe exchange programmes.

- **Contact and Information Points**

Services sited close to the locations associated with consumption, in places where young persons hang around, especially night settings. They can be fixed or mobile and are intended to avoid or attenuate the consumption of drugs and respective risks and to inform about the effects and risks related to drug use. These structures may also be furnished with instruments intended to test the composition of substances (drug checking).

- **Outreach / Street Teams**

Outreach/street teams aim to promote risk reduction in the community, by providing information, needle exchange programmes and other interventions within the premises where the consumption of psychoactive substances is experienced.

- **Supervised drug consumption facilities**

Since 2019, supervised drug consumption facilities are available, providing supervised consumption spaces, basic healthcare, rapid testing, psychosocial support, peer support, distribution of prevention and risk reduction materials, referral to health structures, community mediation.

These socio-sanitary structures may develop one or more of the following socio-sanitary programmes, also foreseen in the same Decree-Law:

- **Low threshold substitution programmes**

Programmes aimed at reducing the use of heroin by replacing it by methadone, which is distributed through widely accessible programmes.

- **Needle and Syringe exchange programme:**

Programmes aimed at preventing the transmission of infectious diseases through the promotion of asepsis in intravenous drug use, and are designed, therefore, to foster accessibility to clean syringes and needles, as well as filters, wipes, distilled water, citric acid and other paraphernalia.

Since 2001, the year in which this harm reduction policy was implemented, the results obtained have demonstrated the high effectiveness of these measures:

- Reduction in the number of HIV infections (in 1998, 56% of all infections were among drug users, nowadays it is 3%);
- Preventing overdose deaths (in 1998 there were 350 overdose deaths, nowadays there are 74);
- Reducing the number of problematic users (in 1998, we had 100.000 problematic users, nowadays we have 33.200);
- Reducing the number of persons that use the IV route (in 1998, 48% were IV users, nowadays it is 2%);
- Improving the health status of drug users in general, as well as diminishing the criminality associated with drug use (fewer offences and convictions).

2. **How do legal frameworks affect the harm reduction policies, programmes, and practices (whether related to drug use or otherwise) that are available in your community, country, or region? Are there laws or policies that either facilitate or serve as a barrier to adopting or implementing certain harm reduction policies, programmes, and practices? Aside from legal and**

regulatory barriers, are there other obstacles in place? Please provide specific examples.

Portuguese drug policy is based on the principles of humanism and pragmatism, following a balanced approach between supply and demand reduction measures, including a prevention programme in partnership with municipalities and NGOs, a treatment network covering the whole country, the development of a harm reduction network and reintegration programmes aimed at the recovery of persons who use drugs. Human rights are at the centre of our policy design and interventions are based on the premise that it is fundamental to respond to the needs of individuals, as early as possible, and therefore harm reduction is a key priority.

Considering that Portugal has decriminalised drug use in 2000 and created a legal framework for harm reduction structures and programmes in 2001, we can say that the law in Portugal does not stand as a barrier.

However, the harm reduction projects have a complex funding system that requires many administrative procedures to obtain funding. This process is managed by the SICAD (Directorate-General for Interventions on Addictive Behaviours and Dependencies), which is part of the Ministry of Health, and which issues calls for tenders for the implementation of harm reduction interventions, with a view to funding of NGOs. The funds available for these projects have proved to be insufficient and the teams are undersized, given the current situation in terms of costs, but also because we are witnessing an increase in the most problematic drug use.

On the other hand, another obstacle we can identify is the stigma associated with drug consumption and persons who use drugs. We can still witness prejudice and discrimination against persons who use drugs in Portuguese society, which can be an obstacle to respect and fulfil human rights. For example, when the implementation of supervised consumption rooms was decided in Lisbon (2019), in one of the locations, the residents of the neighbourhood and the local authority expressed strong opposition to the installation of the facility, and it was not possible to proceed with the supervised drug consumption room in that location. A facility was set up in the western part of the city and a mobile unit covers the eastern side. This is an example of how stigma can be a barrier to the implementation of harm reduction policies, even though they are a very important part of the Portuguese model. Further research into stigma and its origins, as well as action to reduce prejudice, is one of the priorities of the Action Plan to Reduce Addictive Behaviours and Dependencies – Horizon 2024.

3. **How does the jurisdiction in place in your region/country/state approach the criminalisation (or decriminalisation) of drug use? Please provide disaggregated data, including but not limited to gender, age, race/ethnicity, status of poverty, sexual orientation and the number of persons deprived of liberty for drug possession or consumption.**

As mentioned above, in 2001 Portugal has decriminalised the possession for personal consumption of all drugs, in an attempt to reduce the problems associated with the use of illicit drugs and to shift the focus from crime to health issues. The Portuguese approach to drugs has been considered a model of best practice, since we recognize drug use as a health issue and drug dependence as a multifactorial health disorder that needs to be treated rather than punished.

The decriminalisation of drug use, as an alternative measure to coercive sanctions for drug-related offences has brought about significant changes in our country's political strategy, especially in the way we approach the problem of drug use. This measure is not only innovative, which is why Portugal is being watched by many countries, but above all it is a humanist option that restores the dignity of drug users.

The prevention of social exclusion stems from the neutralisation of the social stigma to which the drug addict has been subject: decriminalising consumption means removing users from the reality of the courts and bringing them closer to health services, if necessary. From this perspective, the drug addict is no longer perceived as a criminal and the drug user is not necessarily seen as a sick person.

The decriminalisation of consumption and the whole approach that this measure entails has made it possible to focus on the individual characteristics and needs of the user, in most cases going beyond the mere application of the law. For this reason, it is considered a surgical approach, enabling the detection of problematic situations that, although not of drug addiction, require a specific response and support.

The approach developed focuses on assessing users' motivation to cage behaviour, promoting health and adherence to available specialised support, whether indicated for prevention, treatment, or reintegration.

Offenders go through a three-phase intervention, which includes: (1) assessment of the individual and their situation; (2) targeted motivational intervention and focus on identified needs; (3) monitoring of the situation and the change.

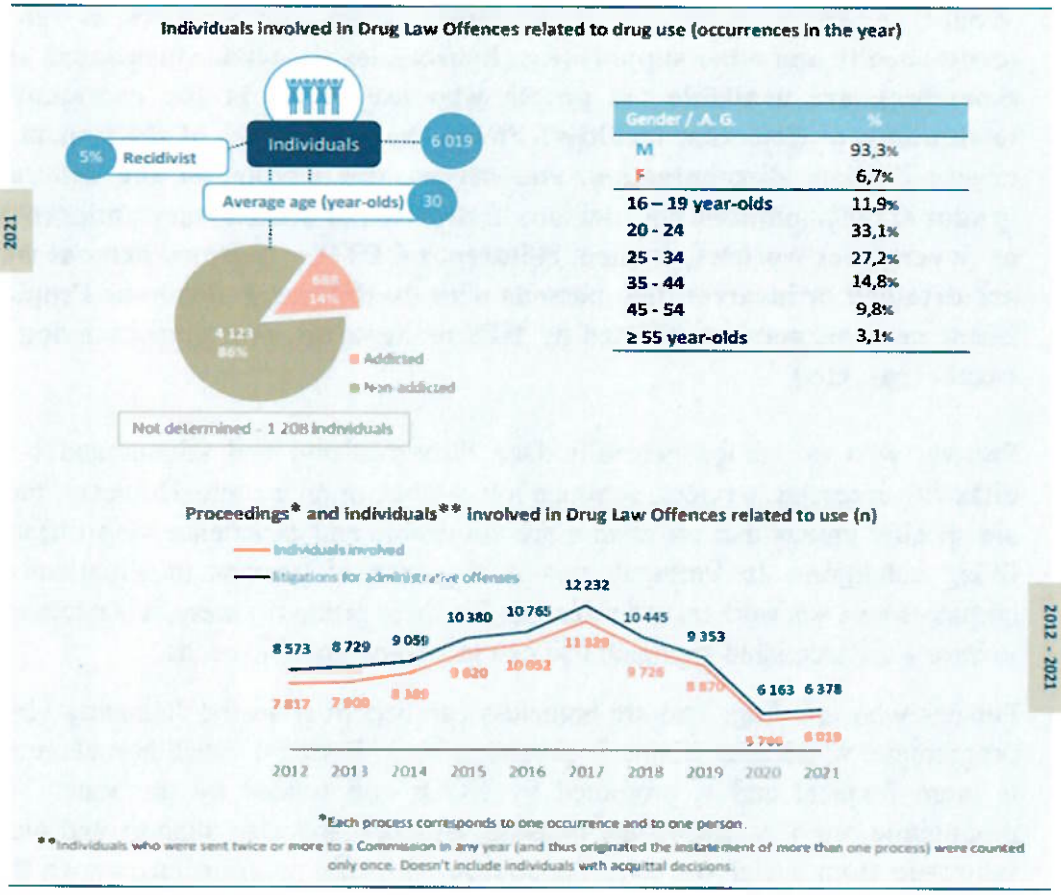
The Commissions for the Dissuasion of Drug Addiction – CDTs, created to implement the Decriminalisation Law (Law no. 30/2000, of 29 November) are public services, under the Ministry of Health, with the main task of deterring the consumption of psychoactive substances among the population they address, following notification by the police authorities or courts.

These services, composed of multidisciplinary teams with training in addictive behaviours and dependencies are specialized in the assessment of people who use illicit substances and develop an approach that also includes prevention, reduction, and suppression of potential factors of social exclusion. This holistic approach provides a unique opportunity for many persons who would not spontaneously seek help.

Below is presented some disaggregated data related to the activity of the CDTs and the implementation of the Law no. 30/2000. For more information, please consult SICAD website:

https://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/189/SinopseEstatistica21_substanciasIlicitas_EN.pdf

Litigations for Administrative Offenses Related with Drugs (Law 30/2000) [9] [10]



4. **Beyond reducing the adverse health, social, and legal consequences of drug use, what other areas can benefit from harm reduction policies, programmes, and practices in furtherance of the right to health and related human rights? Examples may include, but are not limited to, the decriminalisation of sex work, the decriminalization of abortion, and safe sex programmes.**

Harm reduction interventions are very important in ensuring the right to health for persons who use drugs. For those in a very vulnerable situation and living in marginalised conditions, outreach programmes are essential to link persons to health services or to bring health responses directly to users. Mobile vans that provide medical and nursing consultations, provide screening for infectious diseases, accompanying medication, treatments for HIV, HEP-C, are examples of good practice in this area. These interventions significantly improve the quality of life of persons who use drugs and increase their life expectancy. On the other hand, these interventions provide relevant public health benefits and contribute to important savings in the National Health Service budget.

In the Portuguese context, where decriminalisation is in place, we can say that this broader drug policy also has an impact on crime and on the safety of citizens. Since the implementation of decriminalisation and harm reduction measures, we have witnessed a very significant reduction in minor drug-related crime and in the number of court convictions.

5. **What type of harm reduction policies, programmes, and practices, as well as mental health and other support (e.g., housing, legal, social, educational, and economic), are available for people who use drugs in the community, institutions, or detention facilities? Please share examples of the impact of criminalisation, discrimination, stereotypes and stigma on the different groups of the population e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

Persons who use drugs generally face discrimination and stigma and have difficulty accessing services, getting a job, a home or an income. However, there are specific groups that are even more vulnerable and experience very difficult living conditions. In Portugal, this is the case of persons in situations of homelessness, sex workers and migrants. For these groups of users, it is necessary to have a differentiated approach that can meet their specific needs.

Persons who use drugs and are homeless can benefit from the "Housing First" programme, which is available in several cities in Portugal where homelessness is more frequent and is promoted by NGOs and funded by the state. This programme provides immediate housing solutions and also support and close follow-up from social workers. Experience with this program has shown that when persons have access to better living conditions, drug consumption decreases, and all other aspects of the person's life can improve.

There are also programmes designed for migrants and ethnic minorities, also promoted by NGOs, as migration is an emerging reality in some of Portugal's major cities, such as Lisboa, Porto and Faro, but also in smaller and more rural cities in the Alentejo region.

Women who are engaged in sexual work and use drugs are highly stigmatized and live in very vulnerable conditions, often being exploited by male partners and without a support network. They experience greater severity of the consequences of consumption and further deterioration due to their very precarious social situation. There are outreach teams and self-support groups that address the specific problems and social needs of women who use drugs.

It is also worth mentioning that persons who use drugs and are imprisoned have full access to health care, under similar conditions as those who are not in prison. It is possible for inmates to have access to substitution programmes during the period of incarceration. They can also have access to medical and psychological consultations, so that their treatment process is not interrupted.

6. **Are there alternative measures to institutionalisation or detention? For example, are there outpatient or inpatient facilities available in your country for people using drugs? Please provide additional details (are they compulsory, voluntary; number available in urban and rural areas; entity in charge; type of support provided and type of staff working in these facilities/centres)?**

In Portugal, all persons have equal access to the public health care network, from primary care to differentiated care in hospital units and there is also a specific care network for persons with addictive behaviours and dependencies, which encompasses public specialized services under the Ministry of Health, NGOs and other public or private treatment services based on the treatment needs presented by clients by clinical evaluation. The network ensures access to quality-controlled services provided through several treatment modalities and in integration with other, non-health, services, to this vulnerable population.

The public services are free of charge for drug users who seek or accept treatment and include primary healthcare services, specialised care, mainly in outpatient settings and differentiated care, mainly in inpatient settings such as detoxification units, alcohol units, therapeutic communities and day centres and/or specialised psychiatric or hospital care.

According to the Portuguese law, the treatment of citizens with addictive behaviours and dependencies is voluntary, except in cases in accordance with the Mental Health Law, Law no. 35/2023, when the users have severe psychiatric comorbidities. In these few cases the court may order involuntary/coercive admission to psychiatric hospitals.

In the case of problematic alcohol consumption comorbidities, hospitalisation in alcohol units may also be proposed, but on a voluntary acceptance basis.

Portugal also provides for another alternative measure to detention or institutionalisation, specifically designed for persons who use illicit psychoactive substances. Portugal has decriminalised the consumption of all illicit psychoactive substances in order to reduce the problems associated with the use of illicit substances, distinguishing situations of trafficking (crime) from situations of consumption (administrative offence).

Law no. 30/2000 establishes that consumption, acquisition, and possession for personal consumption, provided that the amount involved does not exceed that necessary for average individual consumption for ten days. If this amount is exceeded, criminal proceedings are initiated – the individual commits a crime, which is punished and foreseen (investigation, prosecution and trial) by the criminal justice system. Below this limit, it is no longer a crime and has become an administrative offense. It applies to the use/possession of all illicit drugs. Using drugs is still an illegal act.

The decriminalisation law is implemented by the Commissions for the Dissuasion of Drug Addiction – CDT, services within the Ministry of Health, which ensure compliance with the law through the prosecution of administrative offences and

the application of the measures and other sanctions provided for. Their main mission is to discourage the use of psychoactive substances.

The law is designed to protect the consumer and offers several options: to stop using illicit psychoactive substances; to start a treatment process; and, in situations of sporadic and occasional use, to benefit from preventive and health education interventions, raising awareness of the risks and negative consequences of consumption.

(http://www.sicad.pt/BK/Institucional/Legislacao/Lists/SICAD_LEGISLACAO/Attachments/525/Decriminalisation_law_EN.pdf).

The main objective of the law, from a health perspective, is to bring the consumers closer to support/treatment structures (in case of need and with the consent of the user), and to keep them away from courts/prisons (criminal proceedings).

The work carried out by CDTs since 2001 has shown that there are undoubtedly benefits for public health and the justice system, as they avoid overburdening the judicial system and act preventively, thus allowing for health benefits.

7. **Please provide examples of harm reduction policies, programmes, and practices adopted or implemented with international cooperation or through foreign assistance in your country, as well as their impact on different groups within the population. What types of challenges can arise from reliance on foreign assistance? Please also provide examples focusing on the need for, and impact of, harm reduction policies, programmes, and practices on different groups of the population (e.g., persons in situation of homelessness, migration, or poverty, sex workers, women, children, LGBTIQ+ persons, persons who are detained or incarcerated, persons with disabilities, Indigenous Peoples, Black persons, persons affected by HIV or hepatitis, and persons living in rural areas, etc.).**

In 2022, the National Tuberculosis Program, as part of the consultancy project "Country support for TB elimination in Europe" promoted by the European Center for Disease Prevention and Control (ECDC), developed the "Tuberculosis health care guide for vulnerable people" through a working group, created for this purpose, with the participation of several public entities, including SICAD and other private entities such as NGOs, with intervention among the most vulnerable populations.

This guide intended to encourage a coordinated response by providing guidance between the National Tuberculosis Program and its partners to reduce the incidence of TB in the most vulnerable populations, namely people living with HIV, migrants, persons living in homeless situations and persons with alcohol and/or drug dependence.

8. **Are there programmes of research and innovation related to harm reduction from a right to health perspective (e.g., needle and syringe programmes, supervised injection and drug use facilities, opioid substitution therapy, and others beyond the area of drug use), including outreach and education**

programmes, in your community, country, or region? Please provide good practices and examples.

In Portugal, the Syringe Exchange Program emerged in 1993, with the aim of preventing HIV infections caused by the hepatitis B and C viruses via sexual, intravenous and parenteral routes among persons who use injectable drugs, preceded the subsequent development of structures in 2001, and has been adapted over the years, in what concerns the partnerships involved and the materials available according to the evolution of the needs of drug user. Currently, there is an emerging need to include pipes for smoked consumption, an update that is already in resolution by SICAD through a partnership with other entities from the Ministry of Health (National Authority of Medicines and Health Products, General Directorate of Health, Shared Services of the Ministry of Health).

A new development was the approval of the intranasal naloxone in the services, following the pilot study in 2019, which included training of service staff and peers, on all key aspects related to the use of this medicament.

New developments are expected with the Buprenorphine Long-Action Programs, currently under development.

In addition to the public network of specialised care for addictive behaviours and dependencies, in order to finance specific interventions at regional level, SICAD has created the PORI programme (Integrated Responses Operational Plan) for private entities and NGOs that develop interventions in the field of prevention, harm reduction, treatment and social reintegration. Managed by SICAD, PORI aims to reinforce the integrated intervention in this field, which is considered an effective strategy to reduce the demand for the consumption of psychoactive substances, seeking to improve synergies available in the territory. This programme has also been developed in accordance with the strategic orientation defined by the ILO, in the context of the fight against poverty and social exclusion, and all interventions are co-financed up to 80% by the State, through funds from the revenue stemming from the game: lotteries, mutual betting and gambling tax. One of these co-financed entities, Associação Ares do Pinhal, was distinguished with two awards: in 2018 with "Good practices in health sector response to HIV in the WHO European Region" and in 2020 with "Good practices in health sector response to viral hepatitis in the WHO European Region".

Associação Ares do Pinhal which provides a shelter, outreach, needle and syringe exchange program and low threshold substitution programmes, was also responsible for developing the first supervised drug consumption facility in Portugal: Integrated Support Service that aims to respond to people who consume in public spaces or in the street. This facility, located in Lisbon, has a space for intravenous consumption and a space for smoked consumption, connected through an intermediate space for the technical team, a medical office, a nursing office, a reception space/information and awareness actions/ social space (comfort café room), a psychosocial support office, laundry, bathrooms and changing rooms.