HR4Homelessness

Integrating Harm Reduction in Homeless Services

COUNTRY REPORT PORTUGAL

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Abstract

According to the latest national homeless count, 7,107 people were in situation of homelessness, of whom 2,767 were rough sleeping. Drug use is strongly associated with homelessness in Portugal. Heroin, cocaine, and alcohol have been the most used substances in the drugs 20 years.

Despite the innovative intervention model for addictive behaviors and addictions, which has been implemented in Portugal, and despite the significant correlation between homelessness and drug use, many of the services who support people in homelessness, do not provide specific services for People Who Use Drugs (PWUD). The National Strategy on Homelessness has increased awareness of the interrelatedness between drug use and homelessness and shows greater commitment to improve service policies for people in situation of homelessness.

Harm Reduction (HR) approach has been widely adopted in Portugal. Support provision for PWUD in homelessness could substantially be improved by the establishment of the 'Help Desks for PWUD' ('Gabinetes de Apoio a Utilizadores de Drogas') which provide low-threshold methadone programs drug use related and social support. However, some homeless service providers do not provide proper HR support to users. Some continue to follow an abstinence-based approach, in particular in temporary and emergency accommodation services, which is an important access barrier.

The homeless continues to strongly rely on temporary and emergency accommodation while the tourism boom, which led to a strong increase of rents and property prices, jeopardises the development of long-term housing solutions for people in homelessness. An important positive development to solve homelessness in the long-term is the Second National Strategy for the Integration of the Homelessness People (2017- 2023). The Strategy prioritises permanent housing solutions based on the Housing First approach. So far, almost half of the housing unit made available through Housing First programmes and projects have been destinated at people in situation of homelessness who use drugs.

Chapter I

Homelessness and the use of Drugs – trends and developments

This report intends to analyze and create evidence of the need to provide specific answers in the scope of reducing risks and minimization of damages associated to the use of high-risk drugs, from here on in referred to as Drugs, amongst people in situation of homelessness and solutions which address high-risk drug use and homelessness.

The analysis will focus on the relationship between the phenomena of homelessness and drugs usage and the way the installed support systems are prepared to deal with this complexity.

Statistical data collection of a phenomena such as homelessness implies a very high level of complexity due to the obscurity and social periphery that this situation holds in itself and, as such, the statistical data is always quite far from reality.

The phenomena represent a residual number in face of the population´s total number, although it has become a more visible and public reality in recent years, with a relevant statistical increase.

In 2008, prior to the implementation of the first strategy for people in homelessness, a survey was conducted in order to understand how many people were in situation of homelessness and what their characteristics were. This action counted people that were sleeping on the streets, people sleeping in cars and abandoned houses, as well as in homeless shelters. The total count was of 2133 people.

In 2011, date of the last national census, 700 people were counted as homeless, nationwide, which was a cautious number due to the methodology that was used. The methodology of sociodemographic characterization on the census is more adapted in the domiciled population, being therefore less sensitive to the quantification and characterization of persons in situation of homelessness. According to the OECD policy brief '*Better Data and Policies to Fight Homelessness in the OECD'* from 2020, homelessness has increased by 157% since 2008 with a total of 3,396 people reported to be homeless in 2018.

Out of this total of almost 3500 people, which represents 0.035% of the total population, around 74% of the amount is registered in the areas of Oporto and Lisbon´s urban center.

Also, in 2020, the data shared by national strategy for homelessness points to a number of 6,044 people in situation of homelessness.

This data was collected through a survey conducted in 2019 with all the institutions that are part of the 'National Strategy for Integration of the Homeless' (ENIPSSA) and that provide services for people in situation of homelessness. This methodology may not include the total number of actual people in homelessness since only the cases that have already entered the formal homeless service support system were taken into consideration, leaving out everyone that has not contacted a support service. In areas that are particularly excluded, such as contexts of drug trafficking or use of drugs, most times drug users do not contact the formal support system due to their lifestyle centered in the substance.

The Portuguese strategy adopts the ETHOS typology in its definition and typification of the person in situation of homelessness. As such, there has been a very significant increase of persons in situation of rooflessness (ETHOS Categories 1 & 2).

The growth of this particular profile is due to a scarcity in the number of accommodations (collective or individual) destined to people in homelessness and not due as much to an actual increase of the number of people in homelessness in general. A lot of low price and low-quality guest houses were used as monthly room rentals, supported by public social work to house people in homelessness. Due to growing gentrification, in most cases in result of touristic pressure, the rooms that were once destined to people in homelessness are now used to accommodate tourists, which leads the more people in situation of rooflessness.

So, in terms of profile, the socio-demographic data of the current strategy show a predominance of people between 45 and 64 years of age (48%), mainly male (83%), single (58%), Portuguese nationality (75%) and the majority remain in situation of homelessness in its birth municipality (43%). This study shows that the most people, who become homeless, stay in a situation of

homelessness between 1 and 5 years (27%), another 17% between 5 and 10 years, 10% will experience homelessness for over 10 years.

As a source of income, 65% of this population subsists with social insertion income, pensions or other social incomes. Around 10% lives with their salary although 6% only indicates occasional salary as an income source. As main causes for their homelessness, not exclusively though, addictive behaviors and dependence are described by 41% of people in homelessness.

Around 26% refer to a lack of family support as the cause of their situation of homelessness, 21% name unemployment or work precariousness as cause and 20% consider mental health problems the reason for becoming homeless. A similar number, 19%, refer lack of social support as the main reason of the situation of homelessness. The rest of the motives that were given are related to loss of a job, losing their accommodation or illegal immigration.

As we break up the data, according to ETHOS typology, we see that in terms of the percentage weight, both categories “roofless” and the “houseless” are in agreement with the statistical weights presented earlier. There is no relevant information regarding the prevalence rate of infectious diseases amongst people in situation of homelessness.

People who engage in high-risk drug use are usually poly-consumers who mostly use cocaine, heroin, cannabis, alcohol and non-prescribed benzodiazepines. This users’ profile is in severe social rupture and in a homeless situation, having changed his main substance of use from heroin to cocaine maybe because access to the low requirement opiate substitution programs has contributed to a decrease in the need to consume heroin. Cocaine has been gaining drugsce as the main drug of choice for the high risk PWUD.

People taking drugs use, on a daily basis, the accommodation, food, hygiene, counseling, treatment services and street units that are supporting people in a homeless situation, as they are also in this same condition.

The way to use drugs has also been changing, from intravenous to crack or coke base, smoked through a pipe, This means of use, almost as satisfying as the intravenous use, along with constant awareness to safe usage, made most of the users change from intravenous to smoked drug use.

The high risk use of drugs and homelessness have always walked hand in hand in Portugal. Homelessness was a concept legally recognized in the year 1211 (year of the first national legislation of what used to be known as wandering and begging) and has become, for the last 30 years, an important corporate matter due to the massive change of this phenomena’s collective representations.

The literature published in Portugal states that the percentage of people that use drugs and are in a homeless situation is almost always higher than 50%, while mental illness is the second cause of homelessness in Portugal. It is not always possible to establish a causality and consequence relationship between homelessness and drugs and this will not be analyzed in the current report, but it is important to state this phenomenon´s complexity.

Usually a high-risk user will have 20 or more years of DRUGS consumption.

Data from 2018 confirms that cannabis is still the most used drugs used in Portugal, in general, in the housed population as well as among persons in situation of homelessness. In the general population the use of cannabis is estimated at 6%, while evidence suggests that more than 70% of people in homelessness use cannabis. People in homelessness, who engage in high-risk drug use, are most often poly-consumers.

The most traditional usage in Portugal was heroin, but currently we have seen a decrease in the use of heroin as it is substituted by cocaine and cannabis. According to the specialized treatment units, since 2016 cannabis is the main substance used by the people who request their first treatment consultation (848 people).

Heroin is the second substance that leads more people to request first consultations for treatment (348 people). Cocaine use was responsible for 341 new first requests for treatment. Contrary to heroin, which maintains a decreasing number of users, since 2009 that cocaine has been increasing its presence amongst the high-risk consumers that are already in treatment such that in 2018 a total of 16,888 people were following opiate substitution programs, including low-threshold programs which are the type of service most frequently used by people in homelessness.

The coverage rate of programs with low threshold, with methadone hydrochloride, is quite reasonable amongst people in homelessness who use drugs. Regarding alcohol, it is estimated that around 20% of people in situation of homelessness, who use drugs**,** consume alcohol as their main substance.

Furthermore, the way it is used as well as the use pattern amongst the high-risk users has been changing. The use through smoking became more dominant than through intravenous but still, the number of syringes exchanged in Portugal in 2018 was 1,421,666 units. Cocaine is mostly smoked through a pipe with a coke base (69% of the users), the rest accounts for intravenous use. Heroin use has a similar share: 67% of users smoke heroin.

The existing data base on the prevalence of infectious diseases among people in homelessness is insufficient. According to EMCDDA data from 2017, the HIV infection rate amongst high-risk users is 13.4% (compared to 0.6% among the general population), the HCV infection rate is estimated at 81.5% (EMCDDA Statistical Bulletin). In this same year, the number of new HIV infections due to injecting drug use is less than 2%. The number of overdoses in 2017, was less than 40 deaths but this indicator has been increasing since 2011, the year when the number of overdoses was less than 10 people.

As a result of this report, we aim to understand what the solutions from the organizations are, for the people in a homeless situation, how they are organized and whether they offer specific measures for people in homelessness with addictive behaviors and dependences. Our goal is to clarify strategies which help to improve support provided by homeless services in Portugal. Several organizations that manage the temporary home shelters, street units, integration communities and canteens were queried.

In what concerns home equipment that offer collective shelter to people in situation of homelessness, there are two different fostering channels that were analyzed.

- First line channel: people in situation of homelessness may be admitted with less requirements, that is, may transition directly from the street to the shelter even if they are still using drugs.

Usually, the accessibility criteria is bed availability and the result of the tuberculosis test on entry date or subsequent days. Most of these shelters are, theoretically, used for short term stays and their goal is to tend to basic human necessities and preparing for social reintegration in an average period of 6 months. These shelters usually only offer overnight stay and do not have specific solutions for drugs users namely, a syringe exchange program, low-threshold opioid replacement program, condom distribution, health promotion actions, observed and combined treatments, etc. From the 9 centers contacted in the scope of this questionnaire, only 2 confirmed having HR strategies available at their shelters.

Although they accept people that have daily or regular substance use practices, any use of drugs is prohibited at all temporary shelters. If it is true that substance use is forbidden, most of the technical teams in the organizations are aware of regular use inside the institutions, and still don't provide any protection mechanisms for users and staff, for example containers to deposit contaminated material.

- Second line channel: the mission of these long-term shelters is to work towards the socio-professional reintegration in an average time frame of 6 months. This type of shelter makes it more difficult to gain access. They require abstinence from abusing any drugs, including non-problematic substance use, tuberculosis testing, a vacancy available and motivation to be employed. These shelters offer overnight housing, expecting residents to spend their day looking for a job. These institutions do not have any HR strategies nor do they deal with healthcare, focusing their activity, exclusively, in social promotion and protection.

The 'Housing First' approach is not yet very well implemented in Portugal, although we observed that almost half of the housing unit made available through Housing First programmes / projects are destinated at people in situation of homelessness with problematic psychoactive substance use, while the other half is destinated for people in homelessness with severe mental health issues.

Regarding the provision of screening services for infectious diseases, only two centers currently provide screening in Portugal, three services provide treatment for people with infectious diseases.

In social canteens, which is the most robust and universal social measure for people in a situation of homelessness, most of them do not have an organized response for promoting the health of the PWUD, they only give out the meal without providing any HR support.

In the street units we can see more of a promoting attitude of HR, as most of them provide different HR support services to users.

The choices in the street units vary according to the origin of their financing source, that is, it depends on whether they are financed by the Health Ministry or the Social Security Ministry. The units that are financed by the Health Ministry usually provide syringe exchange programs, opiate replacement programs, screening for infectious diseases, combination therapy with psychology and psychiatry sessions, as well as social assistance.

On the other hand, the units that are financed by the Social Security Ministry provide a smaller variety of HR services which offers no more than a syringe exchange programs and condom

distribution, as well as psychological support and social assistance. These units base their work on signaling and referral to specialized shelters and social support structures.

The 'Help Desks for PWUD' ('Gabinetes de Apoio a Utilizadores de Drogas') offer the widest range of support services, providing medical, psychological, and social support, and the full range of HR support throughout Portugal. The Help Desks provide specialized drug use related support with basic social support. Here the access is free and although substance use is not allowed, abstinence is not required and the activities are organized to promote health and social protection of people who use drugs and are in situations of social vulnerability. There is no time limit to stay and there is rarely a waiting list.

None of the respondents reported providing a naloxone program, despite the fact that national law has allowed non-medical dispensation since 2017.

Regarding the intervention philosophy, all the contacted NGOs refer to act according to the humanistic, collaborative, participatory and inclusive principles reflected in ENIPSSA (National Strategy). All organizations assume that the person, their needs and desires are at the center of their intervention. They state that all intervention processes are outlined along with the individual, being that the person´s priorities always prevail.

Although all NGOs work according to ENIPSSA's technical guidelines, only those specialized in drugs dependencies do so in accordance with the technical standards of the anti-drug strategy. All organizations offer an interdisciplinary approach (social and human sciences), more or less diversified, according to their institutional profile. NGOs working on addictive behaviors and addictions usually offer a broader range of disciplines (social and life sciences). The diagnoses, which are bio-psychosocially based, are carried out by specialists, as are the interventions.

The participation of the users of the provided services is encouraged by the majority of the surveyed NGOs, although it is not always as intense as desired. In addition to the characteristics of the population itself, one of the possibilities for the lack of participation may be due to the feedback system and the consequent lack of adaptation of the service, according to users´ participation. The evaluation systems made available are more focused on the needs, interests and frequency of activities and not as much on the way the response is organized, and the influence that the user has on the way it is organized.

As for territoriality, most NGOs working on the phenomena are local, even because the funding structures increasingly value agents that are strongly implemented in the communities and that are capable of activating and working the different local networks. Most organizations admit involving stakeholders and the community in their organizations' structural decisions, especially in what relates to planning. A lot of the organizations that provide support for people in homelessness and form part of ENIPSSA at national level and NPISA at local level, are able to influence existing local activity. Many organizations that work with drug users are part of ENIPSSA and NPISA (local networks of the national strategy), as well as different referral networks for mental health and infectious diseases.

Only four organizations engage in advocacy work and define advocacy as part of their permanent efforts to influence technical and political positions.

All the NGOs that were surveyed reported that they do not have diversified activities according to gender, and with regard to accommodation, most of them only provide it for males. In fact,

about 80% of the available accommodation are for men. With regard to *trans* people, few, if any, are integrated into the home shelters, and no positive discrimination measure is in place.

As for the employability of peers, we start to observe an increase of peers working in organizations who support people in homelessness and PWUD. Often their functions are not peer mediation, but auxiliary tasks. Even so, in the last three years we have seen an increasing number of job opportunities occupied by peers.

As for technical teams, although highly specialized, for the most part, they do not have access to training provided by their employers in order to update their skills and knowledge. This is one of the biggest gaps in the sector, although legally, all employees are entitled to 30 hours of training per year.

There is, therefore, a big difference in access to HR programs in the different structures. It is our opinion that that is due to the funding structure provided, where each funding Ministry values its specificities by financing the activities that are closer to their general mission.

On this subject we realized that organizations who have their activity directed to the PWUD are more inclusive and have better ability to respond to the population in a situation of social exclusion and criminality. Naturally, these structures are also better prepared to support people in situation of homelessness, including PWUD, when compared to other solutions that are traditionally addressing people in homelessness.

HR services are available to the general population and not only to high-risk consumers. An example of this is the accessibility to screening for infectious diseases. These services are, especially in the large urban centers of Lisbon and Porto that are undersized, which causes an intensive use and consequent decrease in quality for the risk drugs users. Despite the high accessibility, the over use of the services means that not all the population with CAD use the services, as it stigmatizes them for consumers with a higher risk profile.

Chapter II

Laws and Politics

Portugal is a country where there is ample and robust legislation on social policies for people in situations of poverty and social exclusion. The regulation is extensive, complete and provides relief and / or resolution measures for each identifiable situation. The base of the legislation is almost always humanistic and comprehensive, alluding to a strong and effective action.

However, the legislation applicable to homelessness is not extensive, and the existing is mainly of regulatory nature in relation to the regulation of social facilities for homeless people. Despite this, there are some official publications orientation profile, such as action plans, strategies and reports. All existing guidelines follow a comprehensive and integrative humanist profile.

In terms of drugs, Portugal has a legal and conceptual model for fighting drugs dependence that is an international reference, presenting a wide range of national legislation for control of both, supply and demand.

Regarding the legislation applicable to the phenomena of homelessness, we can find the technical norms for social responses such as for street units, accommodation centers, insertion communities, social canteens, and transition apartments.

With regard to specific legislation to deal with the situation of homelessness and the right to a home we can find references in the following documents:

- Constitution of the Portuguese Republic (CPR) approved in 1976 - Article 65 of the CRP states that *"everyone has the right, for themselves and for their family, to a house of adequate size in conditions of hygiene and comfort that preserves personal intimacy and family privacy",* stating that it will be up to the state to ensure this right.
- National strategy for Homelessness (2009-2015) - refers that *"it is aimed at creating conditions so that no one has to remain on the street for lack of alternatives and, above all, ensuring the existence of conditions that would guarantee the promotion of autonomy through mobilization of all available resources according to diagnosis and individual needs".*
- Ministers Council Resolution No. 107/2017 - validates the evaluation report of the first ENIPSA and states *"although there was an operational deficit, the assumptions that were at its basis were, however, considered adequate by all entities that are part of the GIMAI (inter-ministerial group)… "*and authorizes the creation of ENIPSSA, the second national strategy with a 2017-2023 time frame.
- The Second National Strategy for the Integration of Homeless People (2018-2023), takes a qualitative leap in the design of social services aimed at people in situations of homelessness, conceiving as a priority response in housing in deterioration of temporary accommodation in shelters. In addition to this premise of accommodation, it also intends to increase the knowledge of the phenomenon through the collection of systematic data and to improve social support for people in homelessness. This strategy aims at rehousing as many people in situation of homelessness as possible. .
- Council of Ministers Resolution No. 50ª / 2018 - approves the New Generation of Housing Policies - which "*articulates with instruments that respond to the needs of the most vulnerable groups, such as the strategy for the integration of gypsy communities, the national strategy for integration of homeless people and support measures for the protection and empowerment of victims of domestic violence."*

  This new generation of housing policies focuses on some housing policy instruments such as: 1- **First Right** *"… guarantees access to adequate housing for people living in unworthy housing conditions…"… "It is based on the granting of financing to public and assistance local intervenients (municipalities, municipal companies, NGOs, residents' associations and housing cooperatives… to provide affordable housing to the universe of recipients "*; 2- **"Porta de Entrada" program** -" *urgent housing support program to respond to families that become deprived of housing arrangements… ".* Temporary lease measures are also referred to as: 3-**Affordable tenancy program** - which as the name implies, focuses on "*promoting affordable tenancy that is compatible with household income, in terms of their effort rate* "; 4 **– Lease security instruments,** aiming at **"***different taxation according to the type of lease contract in place";* **5 - informative price and housing accessibility programs**; 6 - **National building rehabilitation fund – "Porta 65 Jovem" Program**, - promotes the lease, to young people, for their permanent housing; "Rehabilitation to rent" program, amongst others.

What we were able to understand in this new generation of housing policies is that they are aimed at people in an economic disadvantage situation, but with income, which leaves people in a situation of homelessness out of this scope. This resolution refers ENIPSSA only for situations where there is a risk of deinstitutionalization.

- Dispatch nº 11199/219 - creates measures to grant financial support to employers who make homeless people eligible for integration, therefore creating positive discrimination for homeless people.

As for the legislation in force for addictive behaviors and dependencies, we verified the existence of a great diversity of legislation regarding, both, the supply side as well as the demand side. We refer to the following legislation as the most relevant to the subject in hand:

- National Drug Control Strategy RCM No. 46/99 - which *"recognizes the importance of developing measures and programs that contribute to risk´s reduction and minimizing damage"*. For the first time in Portugal, the HR approach is introduced, making it so that treatment is not the only option available to drug users. The objective was not to abandon the option of treatment, but to provide complementary health services´ options. It introduces the concept of humanism and pragmatism in intervention with people who use drugs.
- Decree nº 183/2001 - this diploma *"creates socio-sanitary programs and structures for preventing and reducing attitudes or behaviors with increased risk and minimizing individual and social damages caused by drug addiction".* This diploma specifies all the structures and activities that must be implemented and developed for the population using drugs. Among several socio-sanitary ambulatory and accommodation equipment, the document foresees the installation of assisted drugs users´ rooms, which are not fully implemented yet.
- Law no. 30/2000 - this diploma changed the paradigm of intervention with people who use drugs, as it redefined the interaction with the person who uses drugs. Until then, the drugs user incurred a crime that could lead to detention in prison. This law decriminalizes the consumer! Consuming illicit drugs continues to be a crime, as well as it still carries legal consequences such as mandatory outpatient monitoring in a specialized unit, for a period of up to three years.
  The possession of a forbidden substance gives the right to seizure in favor of the State and the person will be identified and pointed to the Drug Addiction Dissuasion Commission. If the PUD (person who uses drugs) does not comply with the process, he may be demanded to attend psychology and social work consultations. If the person persists on not complying with the court´s orders, he may serve a prison sentence, although this consequence rarely happens.
- Action plan for addictive behaviors and addictions 2014 - 2020: this strategy reinforces the humanist principles and pragmatic intervention of the first strategy for addictive behaviors. It reinforces the centrality of the citizen in the intervention as well as the integrated intervention in terms of territory, quality and innovation of the interventions. In what refers to demand, it considers some particularly vulnerable groups as priorities (pregnant women, sex workers, people infected with HIV, hepatitis and tuberculosis, people with suicidal and ordeal behaviors, the elderly (especially due to alcohol use),

children of PWUD and people with migrant background. The HR activities are mainly address alcohol use and drug us in recreational contexts.

- Decree-Law No. 124/2011 – Reorganizations made by the Government decreased efficiency in the actions of the competent institution (SICAD). It maintains its responsibility in matters of public health promotion, in individual health, particularly in terms of infectious diseases, associated with substance use.

  As for the relationship between drugs use and infectious diseases, this strategy clearly defines the articulation between the units that work in the streets and the central reference hospitals, so that the process may formally be constituted thus trying to eliminate access barriers that currently exists.

  All projects which provide HR services are developed by NGOs working on the streets and, according to the document, followed up through the Operational Program for Integrated Responses (PORI). This program brings together all the agents in the streets working the different mission areas (prevention, treatment, reintegration, dissuasion, and HR) in order to plan integrated interventions. With the reorganization of SICAD, PORI also suffered with divestment and saw its articulated work impoverished.

- Recommendation Council of Ministers N. 19/2018, which aims to finance projects by a 100% (instead of the current 80%) and to increase the financing period for situations exceeding 24 months (the current maximum period). This recommendation also encourages a greater consultation of NGOs in the definition of intervention policies, allowing for a *bottom-up* methodology.
- Dispatch 283/2018 - establishes which hospitals must respond to the signaling of new infections by HIV and hepatitis, confirmation of screening, medical follow-up and therapeutic prescription.

We realized that in this legislation much remains to be explored regarding the issues of people with dual diagnoses. The dichotomy between mental illness and substance use takes us down two different roads. On one side we have psychiatric hospitals, on the other we have the specialized units in ABD (Addictive Behaviors and Dependencies). Both focus on the intervention that they believe is their competence; that is, mental health rejects ABD interventions, while the specialized ABD network rejects intervening in mental illness situations.

Chapter III

Barriers to accessing HR Units

The survey we conducted in more than 20 homeless service providers, especially those who provide basic support and emergency accommodation, such as night shelters, most are not prepared and do not have specific measures in place for people in a situation of homelessness who use drugs. The main barriers to access are:

- In addition to the lack of responses and HR strategies, there is an inadequacy of the responses made available in cases of recurrent homelessness.

- Paraphernalia are made available through a pre-made kit for intravenous use only. The kit is quite incomplete as it does not include the tourniquet and a disinfectant substance for intravenous consumption post-use. As for smoking consumption, the kit has no element for this kind of use, being completely out of date in view of the current greater number of smoked consumption.
- The criteria for accessing the services are also an obstacle to their use. The abstinence from DRUGS use criteria (licit or illicit) prevents the integration of a large number of people who need support but are unable to be abstinent in order to get them.
- The opening hours of social support services often do not fit the needs of PWUD in situation of homelessness but follow a being the traditional working hours.
- The policy for managing non-compliance with internal regulations by the users of the services is also paradoxical. We realize that the information we collected in the questionnaire carried out with service providers refer that, often times, the suspensions and expulsions due to the non-compliance(s) leave the person in the condition he was in before entering the accommodation, that is, in a homeless situation. Few are the organizations that do not suspend or expel PWUD in situation of homelessness who use drugs inside the facilities, especially if they do so repeatedly. About 50% of the services say that, despite the suspension or expulsion of the individual, they continue to provide him social support and monitoring.
- Hospital discharges need improvement. The Portuguese guidelines in relation to hospital discharges establish that these, in order to take place, have to meet criteria of clinical discharge (health) as well as social discharge, that is, that it is verified that the person that is to be discharged will not be in a situation of social vulnerability that may compromise his health. If these two criteria are not met (clinical and social discharge), in theory, there should be no discharge. Nevertheless, and as a result of some kind of discrimination, difficulties in the management of services or economic issues, many people in situation of homelessness are discharged without having met the criteria for social discharge and, sometimes, not even meeting the criteria for clinical discharge.
- Difficulty in accessing primary health care due to bureaucratic requirements, namely the need for an address for the allocation of the health unit that covers the person´s place of residence. However, the absence of a home address often makes the assignment of a health unit and of a family doctor, impossible.
- The existing conduct / disciplinary rules in place for the users lead to disruption of the intervention processes, since when a service´s user has a disruptive behavior they, either, are suspended and are no longer able to use the service for a defined time, or are expelled and stop using the service on a permanent basis. This cases often are not forwarded to another institution due to the lack of process managers to assume the lead of the intervention.
- Prison establishments have poorly planned prisoner's´ release practices and often release people onto the street without ensuring they have access to housing or accommodation.
- Few accommodation centers or pension rooms accept people with animals, which limits the admission of people living with animals.

- The entire accommodation system is practically based on collective and temporary accommodation. The fact that long-term residential opportunities, collective and individual responses, are not created causes a crystallization of users in temporary accommodation centers which are not prepared nor able to provide proper HR support to ensure users can use drugs safely during overnight stays.
- Structurally, what we would like to point out is the low economic investment from social support, granted to people in situation of homelessness. The economic support given is not sufficient to cover expenses, and usually does not even cover rental costs. Especially before 2008, social policies in Portugal did not aim to interrupt the cycles of poverty and homelessness, but rather tried to enable minimum conditions for survival.
- The intervention model for addictive behaviors and addictions has always paid special attention to the situation of high-risk consumers who are in a situation of social vulnerability and / or homelessness. As such, they implemented a set of responses directed to basic needs, with a philosophy of interdisciplinary and humanist intervention. The administrative organization of the public entity that oversees the subject of addictive behaviors and dependencies has been changing and losing strength in the decision-making process and in its ability to provide resources. This results in a less robust and adequate intervention.
- Another reason for lack of focus on a good intervention has to do with the shared responsibility of the different ministries, especially the Ministry of Social Security and Employment and the Ministry of Health. Despite the new strategy sitting them at the same table in order to work together as an inter-ministerial commission, the distance between the decision center and the terrain is considerable and sometimes the decisions reflect that same distance. The coordination of the new strategy made an advance in this matter as NPISAs - centers (places) for planning and making interventions together with people in homelessness, started to be coordinated by the respective City Halls, bringing local power closer to the decision center.
- The lack of financial resources in the first strategy and the divestment in the current one (2017-2023) are also a focus of resistance to a good intervention. The current strategy was presented with a financial package of 131 million euros, but as of the date of this report, no funds were reserved for new and different approaches to homelessness. The only exception is some Housing First units created in 2019.
- The number of vacancies available, in community or individual accommodation, across the country is clearly insufficient, and since the first strategy was implemented, few responses have been created.
- Underfunding of projects, whether for people in homelessness or for PWUD, is a chronic problem, where some the overall amount of funding is usually insufficient for the good development of projects. These projects are seldom rarely 100% financed and some of them are only financed at 80%, which leaves service providers with severe budget constraints.
- In terms of access to health care, one also feels the added difficulty for people in a situation of homelessness and that are, simultaneously, DRUGS consumers. Stigma and discrimination often means that this people's pathologies and complaints are not taken as seriously when compared to the general population. This situation is frequent in access to hospital emergencies, as well as in access to higher value therapies, such as HCV treatment. If to homelessness and drugs consumption we add mental illness, then

this last condition is highly devalued and neglected, especially due to DRUGS consumption.

- The social protection system also has an internal organization that is constantly challenged by the needs of people in homelessness since it was designed as an inflexible tool and for the general population. It is highly bureaucratic and time consuming, being incompetent in preventing homelessness. The level of bureaucracy to access social support is quite high, as is the time of allocation, which often leaves people in homelessness in an even more vulnerable state. The same level of bureaucracy is imposed on service providers, which so often becomes an obstacle to new social responses.
- Institutions have little capacity to adapt to their users and often demand that they comply with the service´s internal regulations. These are not simple rules for those who come from the street and present such severe levels of biopsychosocial disorganization.

As for the dimension and organization of DRUGS trafficking in the cities of Oporto and Lisbon, it is organized mainly in big trafficking areas, causing high public annoyance. These areas of trafficking and substance use are installed in areas of multi-problem social neighborhoods where there are high poverty rates. The relationship that traffickers establish with the communities is increasingly one of domination and submission rather than integration in the communities. This relationship is marked by intimidation and violent behaviors towards communities in general, but also DRUGS users, organizing the territory according to the trafficking activity.

Population in general is also hostile, not so much towards the consumer, since several opinion studies carried out confirm the understanding of the need for consumption by the problematic DRUGS user, but because of this consumption being made openly, for everyone to see, therefore conflicting with the rest of the more normative population. Usually, the general population does not show hostile or violent behavior towards consumers and has even mobilized itself to pressure public agencies to open spaces dedicated to safer drug use.

Portugal has a strong consensus regarding the need to provide adequate responses to people who use drugs as well as to people in situation of homelessness. In general, there is no behavior of violence and authority in relation to people in homelessness.

Even with regard to the Security Forces, there has been a notable change in attitude towards people in situation of homelessness, with officers usually having more of an informative role, referring the people in homelessness to NGOs.

Chapter IV

Implications for service providers

Funds available at national level have a rather narrow scope, close to the respective Ministries' mission and agenda., with clearly different areas of response. According to the origin of funding, funds need to be used in a very specific way which hinders the establishment of a cross-sector, integrated service response, based on HR standards. With a high prevalence of people who use drugs in situation of homelessness, there is a clear need to universalize programs to reduce risks and minimize damage associated with risky use, in the structures which support people in homelessness.

The accommodation that is provided is scarce and too typified, based on a logic of collective accommodation. There is the need to provide more housing, especially in large urban centers, as well as diversify the available housing measures, focusing more on *housing led* models in order to provide a more comprehensive and inclusive housing system. Notwithstanding, it will also be necessary to rethink the offer of collective accommodation by thinking more about long-term collective accommodation measures for people who have high biopsychosocial[1] support needs due to disease or old age. This measure requires, in addition to changing the type of solutions available for this specific issue, a change in the logic behind the interpreting of the phenomena assuming it may be, in many cases, a permanent state and not exclusively transitory.

There is a progressive awareness of the need to adapt support structures for people in homelessness, through molding their responses to people´s real needs. *Housing First* models should also start standardizing their response throughout the territory, as well as the need to train and qualify the intervening organizations (and staff) in the process. Although there is a high level of qualification among professionals who provide support to people in a situation of homelessness, there are weaknesses when it comes to supporting people who use drugs and service users with mental health support needs.

Improving the quality of the information collected shall also be an important aspect to be taken into account, as the improvement of information will influence the change in the support responses to be developed for people in situation of rough sleepers. This will allow for the homeless people to be referred to the correct solutions according to their real needs, based on the most dominant evidence and profiles of homeless people.

The accommodation system available, as mentioned, is based on collective overnight accommodation models with a philosophy of transience assuming, theoretically, the person's reintegration and autonomy. This perspective is based on a philosophy transferred from the treatment models, a biomedical model, which presupposes a “cure”. In fact, what is observed is that this model generates entropies, stifling the “upward movement” of homeless people and, consequently, turning a short-term transitory accommodation into a long-term accommodation, but without being able to provide adequate care in terms of health, protection and social promotion, as it is not prepared to do so in the first place.

Finally, it is important to highlight the lack of financial investment in the various strategies implemented. The announced budgets were not allocated to the implementation of the strategy, as well as ensuring the functioning of the existing social support structures available in the support network. As such, not all the solutions that could qualify the intervention are going to see the light of day due to lack of budget assigned for their effect.

[1] The term ‘biopsychosocial’ refers to biophysical, psychlogical, and social support needs.