CRESCER has been working with hard-to-reach populations since 2001. This article, written by Américo Nave, Andreia Alves, Maria Carmona and Rita Lopes, reviews the organisation's evolution in parallel to policy developments in Portugal affecting outreach work.

FROM THE OFFICE TO THE STREET:

THE IMPORTANCE OF OUTREACH IN THE LIVES OF THE MOST VULNERABLE GROUPS




By **Américo Nave**, Psychologist/Executive Director, **Andreia Alves** Social worker, **Maria Carmona**, Psychologist and **Rita Lopes**, Psychologist at CRESCER

DRUG POLICY IN PORTUGAL: A NATIONAL PERSPECTIVE

Portugal lived under a dictatorship for about 4 decades, until 1974, with a political and socio-cultural context closed to any changes. In the 1970s, 1980s, and early 1990s, Portugal had to deal with a social problem associated with the consumption of psychoactive substances (PS). The significant increase in the number of heroin users (an estimated 100,000 heroin users - 1% of the population), many of them injecting, consuming in public spaces, without any hygiene conditions, sharing material, living in a homeless situation, in a context of severe social exclusion, led to the reflection on the creation of Harm Reduction (HR) responses (SICAD, 2016). This context has fostered the formation of a committee of experts, which listened directly to people who used drugs, intending to outline a set of recommendations for policymakers.

The first National Strategy for the Fight Against Drugs was then designed. In the 1990s, the transition from prevention, treatment and reintegration responses to health care took place, a measure that had a significant impact on the country's progress in this field and on its international recognition. However, the most emblematic measure of this Strategy was the decriminalisation of the consumption of psychoactive substances, with the Decree-Law nº 183/2001.

A humanistic and pragmatic approach to consumption was put in place with this law. Outreach teams were created, as well as the national needle exchange program, opiate substitution programs, drop-in centres and treatment teams specialised in providing care to people who use drugs (PWUD) – responses that aimed at improving their living conditions and promoting access to health facilities.

It was in this context that CRESCER was created in 2001 and began its outreach work with teams composed of professionals, with HR as the basic methodology of intervention, initially focused on PWUD. It was from this point that we reached people who were homeless, for whom the responses up until then had mostly been volunteer-based, with no technical know-how in terms of intervention.

The progressive shift in the mind-set of policymakers and civil society allowed the development of other measures, such as the National Strategy for the Integration of People Experiencing Homelessness, created in 2009. As of 2011, due to the change of government, the strategy was kept on standby until 2018. In 2019, it was updated and had greater exposure since the theme was defined by the Presidency of the Republic as one of the priority topics on the political agenda. Government and private entities that operate in the field, like CRESCER, were consulted about the strategy and its responses. Since 2015, the Municipality of Lisbon has made the largest ever investment in the area of homelessness – it has invested in innovative programs that provide an effective response to people experiencing homelessness, transitioning from an assistentialist model to a technical model.

CRESCER AND THE OUTREACH WORK

CRESCER has been working with vulnerable and hard-to-reach populations since 2001. When we refer to the “hard-to-reach public”, it is important to have in mind that we are describing extremely vulnerable groups, who are isolated and marginalised from traditional social and health services. They are underrepresented and traditional approaches do not meet their needs. Given this reality, it is necessary to put technical teams on the ground and to meet people in the places where they are every day. This is where the outreach team plays a key role in establishing a rapport and trustful relationships. We are in the same places at the same time every day due to the importance of regularity in establishing a relationship of trust. We provide on-site social and psychological support, medical and nursing care, and the exchange and supply of aseptic material. All the intervention carried out in the field is adapted to the needs of the people we support, respecting individual objectives.

Within health-oriented interventions, we highlight general medical observation and evaluation, psychiatry and sexual health, screening for infectious diseases, support in taking prescribed medication and referrals to health and treatment facilities.

Our teams register a significant prevalence of infectious diseases, namely HIV and HCV, among others. Since 2018 it has been possible to perform the diagnosis and treatment of the disease within our team, through specific protocols, without the user having to go to traditional services, such as hospitals.

Also in the field, and as an HR strategy, we promote access to appropriate information, through the development, with the beneficiaries themselves, of informative materials about sun exposure and high temperatures, harm reduction in the consumption of the various PS, how to prevent and act in the occurrence of an overdose, and information about infectious diseases, among other things.

> “We are in the same places at the same time every day due to the importance of regularity in establishing a relationship of trust.”

The understanding we developed about the issues of substance abuse allows us to adopt harm reduction strategies, often not condoned by stakeholders and policy makers, such as buying alcoholic beverages for a person with alcohol addiction as a strategy to buy time while waiting for a response from health and social services, or in cases of alcohol withdrawal, which can cause severe symptoms or even death.

On the social aspect, intervention mainly involves referral to social structures, housing, food, employability, and training opportunities, as well as access to social benefits and financial support. Whenever necessary, we provide transportation and accompaniment, and articulation and follow-up for each of the activated responses. This model of intervention promotes a close relationship that allows us to build bridges between people and services.

The bureaucratic process to access the social and financial support to which people are entitled, not only fails to provide an effective response to people, as would be expected, but also the beneficiaries themselves end up establishing a bad relationship with these services, often giving up the process.

As opposed to what happens in most traditional responses, which end up keeping people in a cycle that does not allow them to overcome their fragile condition, our intervention is person-centred and focused on their needs. It has been this perspective that has led us, from being a simple street team, to implementing projects such as Housing First, a restaurant where only people who have experienced homelessness work, a Drop-In centre, an HCV diagnosis and treatment project in the field and to integrating a significant number of peers in our team, whose importance and added value we have recognised and experienced over the years, as well as the potential of their intervention.

People do want to and can improve their living conditions, but we must adapt the responses to answer their needs and not expect the opposite. When supported, we see that people achieve their goals, improving their quality of life. We emphasise the importance of valuing all the steps, achievements, and goals attained. Even when small, they are extremely important in improving each person's self-esteem.

PEOPLE WHO EXPERIENCE HOMELESSNESS: THE VULNERABLE SIDE

In the last 5 years, our outreach teams have supported 4,864 PWUD, 4,067 men and 801 women, with an average age of 46 years. 1,468 people were in a homeless situation, sleeping on the streets, staying in shelters, hostels, abandoned houses, or other precarious housing.

Through the intervention of the technical team with this group, what we have observed is a clear gap between the group and the support networks and services that can respond to their problems. We have observed physical and psychological fragilities in a significant number of cases, which often result in the internalisation of negative stereotypes about themselves and a process of marginalisation and exclusion. Health problems, whether physical or psychological, are the result of each person's background and living conditions. From our perspective, it is not consumption or mental illness that leads a person to homelessness. In our view, it is the years on the street, and the vulnerable situation to which the person is exposed, that harms their mental health and potentially increases their substance use.

It is important to mention that one of the reasons why people who are in a homeless situation remain or often return to that condition, is because they do not have a permanent home. We consider this the main cause of homelessness. The technicians of entities that must respond to the needs of people who are experiencing homelessness, often believe that they need to solve other problems first – substance abuse, mental illness, or unemployment – and only then, by proving that they deserve it or are fulfilling certain criteria, can they have access to a house. The main problem of a person experiencing homelessness is, to be precise, not having a home, a basic human right, and once this issue is solved, it becomes easier to solve any other issues, respecting the rhythm of the person. Thus, more individualised housing responses are needed, with technical support, such as Housing First, so that people leave the cycle they are in and do not return to a homeless situation.

DOING SOME ADVOCACY – WHAT WE STAND FOR

Despite the innovative and pioneering law, effective in the intervention with PWUD, Portugal experienced several years of stagnation regarding HR responses, and there was strong pressure from organisations working in the field, including CRESCER, to implement new responses.

As an integrated part of our work, we also promote that PWUD and people who experience homelessness themselves fight for their rights and that they are heard in the processes of defining new strategies and intervention policies in these areas.

“More individualised housing responses are needed, with technical support, such as Housing First, so that people leave the cycle they are in and do not return to a homeless situation.”

Bibliography:

Estratégia Nacional de Luta contra a Droga, 20 anos de ENLCD (2019). SICAD http://www.sicad.pt/PT/20anosENLCD/Paginas/default.aspx

SICAD (s/d) Políticas da droga em Portugal. http://www.sicad.pt/PT/PoliticaPortuguesa/SitePages/detalhe.aspx