City-level drug policies in Portugal: the COVID-19 pandemic as an analyser of harm reduction intervention responsiveness in Porto and Lisbon

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Research Article

Keywords: COVID-19, Harm Reduction, City-level drug policies, Comparative analysis

Posted Date: July 23rd, 2024

DOI: https://doi.org/10.21203/rs.3.rs-4656985/v1

Additional Declarations: No competing interests reported.

Version of Record: A version of this preprint was published at Harm Reduction Journal on March 12th, 2025. See the published version at https://doi.org/10.1186/s12954-025-01179-y.

Abstract

Background

The COVID-19 pandemic health crisis and its potential implications for people who use drugs (PWUD) created permissive conditions toward social innovation and experimentation. Still, it also exposed gaps in harm reduction approaches. The local level situations informed the harm reduction responsiveness, so it was not applied uniformly in different regions. This paper intends to contribute to the analysis of harm reduction responsiveness during the COVID-19 outbreak by comparing the adaptations and implementation of harm reduction and municipal services to support street-involved PWUD in two Portuguese cities – Porto and Lisbon. This study aims to shed light on the city-level implementation of drug policies in Portugal.

Methods

This study is based on a comparative qualitative analysis based on the experiences of PWUD and HR professionals regarding the implementation of harm reduction responses during the COVID-19 pandemic in Porto and Lisbon. The study is based

on interviews with street-involved (SI) PWUD (n=22, 12 in Porto and 10 in Lisbon) and online focus groups with harm reduction professionals (N=12, 6 in Porto and 6 in Lisbon).

Results

Harm reduction teams in Porto and Lisbon implemented contingency plans and proactive adaptations to respond to the pandemic-related emerging needs. However, the study revealed contrasting experiences in the city-level support to harm reduction and responsiveness to the impacts of COVID-19 among SI PWUD in Porto and Lisbon. There were relevant differences in the support they received from the City Council and the city-level responses implemented to support street-involved (SI) PWUD. While the approach in Porto was described as restrictive and zero-tolerance towards drug use, in Lisbon, the responses were harm reduction-focused. The harm reduction-focused approach implemented in Lisbon revealed better results regarding the harm reduction responsiveness to the pandemic health crisis and adherence of SI PWUD to services, mostly because of their inclusive approaches.

Conclusion

The pandemic constraints and adaptations must be contextualized in an overall process of disinvestment in harm reduction in Portugal. Moreover, beyond the Portuguese drug policy model, city-level drug policies are crucial in the design and implementation of local drug policies.

Background

The impacts of COVID-19 on people who use drugs (PWUD) (1–4) and the harm reduction strategies and adaptations implemented to respond to a very complex and demanding scenario have been widely documented in recent years (1, 5–12). The pandemic health crisis and its potential implications for PWUD created permissive conditions toward social innovation and experimentation in harm reduction approaches (1, 6). At this level, telehealth, naloxone distribution, take-home methadone flexibility, and other harm reduction-focused policies reported positive results in the adherence of PWUD to low-threshold responses (3, 13–19)). However, some PWUD expressed their higher difficulties in the context of decreased in-person care (2, 13, 18), revealing that despite responding to basic and urgent needs, harm reduction services are recognized for the physical and emotional safe spaces they provide. This highlights the buffering effect of social support to respond to stressful events (20), particularly among people disproportionately impacted by stigma, structural inequalities, and social exclusion (21–23). Notwithstanding, recent evidence is unveiling post-covid burnout among professionals working with PWUD, uncovering the costs of the personal and organizational efforts invested in buffering the impacts of the pandemic (24–27).

The pandemic context also exposed gaps in implementing harm reduction services. The harm reduction adaptations were heterogeneous, were not applied uniformly in different regions and, consequently, the access of PWUD to services was inconsistent (8, 15) making visible previous asymmetries in implementing responses at the local level.

This paper intends to contribute to the analysis of harm reduction responsiveness during the COVID-19 outbreak by comparing the adaptations and implementation of emergency services to support street-involved PWUD in two Portuguese cities – Porto and Lisbon.

Context of the study

The Portuguese drug policy, colloquially known as the Portuguese Decriminalization Model, is internationally recognized for its vanguardism and beneficial impacts (28). Law n. º 30/2000 (decriminalization of drug use) and the Decree-Law n. º 183/2001 (that regulated harm reduction in the country) did not affect drug use prevalences in Portugal (29). Instead, this integrated drug policy contributed to decreasing the imprisonment for trafficking (30), reduced problematic drug use and drug-related harms (29, 31), promoted treatment adherence (31, 32), and reduced the social costs of illicit drug use (33). However, the increase in the sanctions for drug use, imprisonment, and fines due to the 2008´s criminalization of PWUD when the amount of drugs in their possession exceeded the average use for 10 days (article 40°, Decree-Law n. 15/93), reveals a retake of punitive approaches targeting PWUD (34). In addition, the impact of the 2007–2008 financial crisis in Portugal and the bailout of the European Commission, European Central Bank, and International Monetary Fund in 2011–2014 (colloquially known as Troika) threatened the stability of this drug policy model due to structural changes in the Portuguese local authority on the drug field and the risk of disinvestment of harm reduction (32, 35).

The local experiences of implementing harm reduction responses and city-level drug policies remain overlooked. In this sense, it is relevant to contextualize the state of the city-level drug policies to compare the harm reduction responsiveness to the COVID-19 restrictions in Porto and Lisbon.

In April 2019, at the Harm Reduction Conference opening ceremony in Porto, the city's mayor informed the audience about the City Council's intention to finance the first drug consumption room (a mobile unit) in Porto. A few months later the mayor received international criticism after defending publicly the (re)criminalization of drug use in public spaces. The creation of drug consumption rooms (DCR) and the reinforcement of law enforcement in the city´s drug consumption sites were announced as being integrated into the overall strategy of the city to contain drug-related problems (36). In 2017, the City Council also created the Temporary Shelter Centre, a frontline and low-threshold response to support people living in homelessness. This shelter includes accommodation, a meal service, and psychosocial and health support. Later, in response to the COVID-19 pandemic, the City Council created extra vacancies for accommodation and centralized the distribution of solidary takeaway meals in the facilities of the Temporary Shelter Center (37).

The Lisbon City Council has a protocol with the General Directorate for Intervention on Addictive Behaviors and Dependencies (SICAD) that formalizes the attribution of (the uncovered) 20% of funding to harm reduction teams intervening with PWUD in the city. Lisbon is the only city in the country providing this type of support. Moreover, the City Council supported a participatory process and the funding that led to the implementation of the first DCRs in Portugal, a mobile DCR in 2019 (38, 39), a fixed DCR in 2021 (a third DCR was halted after the construction site was set up). In response to the onset of the COVID-19 pandemic, the Lisbon City Council created four emergency shelters following low-threshold, inclusive, participatory, and person-centered approaches. These centers were harm reduction-focused, integrating opioid agonist program, needle and syringe program and distribution of smoked consumption materials, training in overdose response, distribution of nasal naloxone, a low-threshold pharmacological program to prevent alcohol withdrawal syndrome, and a mobile supervised consumption program (outside of two centers) (40, 41).

The discussion about the role of City Councils in drug policies has gained added importance in the context of administrative reforms aimed at decentralizing competencies in various domains of public administration, including health and social support (42). In this context, by comparing the harm reduction responsiveness to COVID-19 impacts among PWUD in Porto and Lisbon, this study aims to shed light on the city-level implementation of drug policies in Portugal.

Methodology

This paper is based on the findings of a qualitative study aimed at exploring the experiences and perceptions of street-involved people[1] who use drugs (SI PWUD) and harm reduction professionals (HR professionals) in Lisbon and Porto regarding the impact of COVID-19 restrictions in their daily lives and harm reduction outreach work. This study was implemented to identify, describe, and document

emerging needs, changes in drug use patterns and profiles, changes in informal drug markets, and adaptations of the harm reduction care and outreach practices (social innovations and constraints). To perform a comparative analysis, the study was implemented in Porto and Lisbon, and we applied a gender-balanced approach in the recruitment of participants to guarantee gender-representative data and further analysis. The analysis presented in this paper is based on a comparative analysis regarding the impact of COVID-19 on harm reduction and outreach practices in Porto and Lisbon. We explored and categorized common experiences but also differences in the adaptation of the outreach practices and harm reduction responsiveness during the pandemic crisis. Moreover, by using the harm reduction responsiveness to the COVID-19 pandemic as an analyzer we were interested in identifying and describing facilitators, opportunities, obstacles, and constraints to the adaptation of harm reduction intervention targeting SI PWUD to crisis contexts. By bringing insights into the city-level implementation and support to harm reduction in two different cities, this analysis allows the expansion of the discussion and contributes to the current debate regarding the Portuguese drug policy model.

The study followed qualitative principles and methods (45, 46). Qualitative interviewing (for SI PWUD) and focus groups (for professionals) were the chosen methods due to their advantages in accessing the subjective discourse, meanings, and reality representation of the participants regarding the topic under analysis (46). We conducted 22 semi-structured interviews with SI PWUD (12 in Porto and 10 in Lisbon) and implemented 2 focus groups involving 12 HR professionals (1 focus group in Porto with 6 participants; 1 focus group in Lisbon with 6 participants).

The recruitment of SI PWUD was facilitated by outreach teams working in the two cities. In this sense, we used a non-random convenience sampling strategy, considering eligible adult SI PWUD who were willing to participate in the study. After consenting, the participants were invited to join the researcher in a more private area on the street or in the facilities of the outreach services, where they were asked about the impact of COVID-19 in their daily lives, drug use patterns, and contact with harm reduction and other health and social services. The data collection was implemented between May and November 2021. The interviews lasted approximately 35–60 minutes, and each participant received a 10€ incentive, compensating them for sharing their lived experiences and expertise. As described in Table 1, the sample of SI PWUD was composed of 22 participants, 12 living in Porto and 10 living in Lisbon, with ages between 21 and 56 years old; 8 ciswomen, 3 transwomen, and 11 cismen; 20 Portuguese, and 2 migrants.

	PARTICIPANT	AGE	GENDER	NATIONALITY
PORTO	P1_Porto	56	Ciswoman	Portuguese
	P2_Porto	27	Transwoman	Portuguese
	P3_Porto	43	Ciswoman	Migrant
	P4_Porto	43	Ciswoman	Portuguese
	P5_Porto	47	Cisman	Portuguese
	P6_Porto	36	Ciswoman	Portuguese
	P7_Porto	44	Ciswoman	Portuguese
	P8_Porto	56	Cisman	Portuguese
	P9_Porto	44	Cisman	Portuguese
	P10_Porto	47	Ciswoman	Portuguese
	P11_Porto	56	Cisman	Portuguese
	P12_Porto	53	Cisman	Portuguese
LISBON	P1_Lx	48	Ciswoman	Portuguese
	P2_Lx	40	Cisman	Portuguese
	P3_Lx	31	Cisman	Migrant
	P4_Lx	34	Ciswoman	Portuguese
	P5_Lx	27	Trans woman	Portuguese
	P6_Lx	42	Cisman	Portuguese
	P7_Lx	21	Cisman	Portuguese
	P8_Lx	46	Cisman	Portuguese
	P9_Lx	30	Trans woman	Portuguese
	P10_Lx	56	Cisman	Portuguese

Table 1 – SI PWUD participant demographics

The focus groups with professionals in Porto and Lisbon were implemented online, by using Zoom, in May 2021. We purposefully selected the profile of participants to have a sample of professionals who were involved in the delivery of harm reduction responses targeting SI PWUD during the COVID-10 confinement periods. Signed informed consents were collected before the focus groups, which were then recorded. The focus groups explored the experiences of professionals in implementing harm reduction responses in a context of COVID-19 restrictions, and the perceived impact of the pandemic among SI PWUD (daily lives, drug use patterns, health and social needs). Each focus group lasted approximately 75 minutes.

A total of 12 professionals participated in the focus groups (6 participants in Porto, 6 participants in Lisbon). Most of them were collaborating in harm reduction outreach teams and drop-in centers (n = 9), 2 participants were collaborating in an Alcohology unit and 1 participant in a peer-led organization. In terms of roles, the sample included psychologists (n = 7), social workers (n = 3), a peer representative and a psychiatrist.

	PARTICIPANT	GENDER	LOCUS OF WORK
PORTO	PROF1_Porto	Cisman	HR team working with PWUD
	PROF2_Porto	Ciswoman	HR team working with sex workers
	PROF3_Porto	Cisman	Drop-in center working with PWUD
	PROF5_Porto	Ciswoman	Drop-in center working with PWUD
	PROF5_Porto	Ciswoman	Drop-in center working with SI people
	PROF6_Porto	Cisman	Peer-led organization
LISBON	PROF1_LX	Ciswoman	Drug Consumption Room (DCR)
	PROF2_Lx	Cisman	Drop-in center working with PWUD
	PROF3_Lx	Ciswoman	HR team working with PWUD
	PROF4_Lx	Ciswoman	HR team working with PWUD
	PROF5_Lx	Ciswoman	Alcohology Unit
	PROF6_Lx	Ciswoman	Alcohology Unit

Table 2 – Professional participants by city, gender and locus of work

Considering that we were interested in participants' perspectives in the scope of their professional activities and not in the functioning of their organizations, we are not disclosing the names of their NGOs in the analysis.

The audio recordings of the interviews and focus group were transcribed *verbatim*. The transcriptions of the interviews were identified using the code “P” from the participant followed by the number of the interview and city (e.g., P1_Lx = 1st participant interviewed in Lisbon). To de-identify the participants of the focus group, we used the code “PROF” followed by their number (ordered from the first to the last one who talked during the focus group) and the city (e.g., PROF1_Porto = professional nº1 from the focus group implemented at Porto).

The study protocol was revised and received ethical approval from the Ethics Committee for Health (CES) of the Catholic University of Portugal (Ref. nº 122).

Data analysis

The data was analyzed using the thematic analysis framework (45, 46), particularly a reflexive thematic analysis approach (47) to interpret and identify patterns within data, major themes, and subthemes in the participant´s narratives. After a fluctuating reading and familiarization with the raw data, we used the NVivo software to aid the analysis process. We adopted an inductive approach to create the *a priori* codes (based on the topics explored during the interviews and focus groups) and synthesize and organize the textual data to identify thematic patterns. This process informed the later narrative writing of the data, describing the identified themes and illustrating them with data extracts. The analysis was sequential since we first analyzed the interviews, to categorize the data for SI PWUD. After this, we analyzed the focus group using the previously defined categories and created new ones related to professional experiences. To ease the comparative approach, we coded the data organizing the themes and subthemes per city.

Research findings and analysis

Through the interviews and focus groups, we captured a solid perspective of the harm reduction responsiveness in Porto and Lisbon during the pandemic period. Considering the topic of this paper, we present the main findings organized in two major teams: 1) Harm reduction responsiveness in Porto and Lisbon; 2) Governmental support and city-level responses targeting SI PWUD in Porto and Lisbon.

1) Harm reduction responsiveness in Porto and Lisbon

● Contingency plans and adaptation to the pandemic

HR professionals in both cities revealed that during the first confinement, the harm reduction teams faced uncertainty, trying to define potential risks and strategies to guarantee a safer continuation of their responses.

The lack of guidelines to inform the development of contingency plans was particularly highlighted by HR professionals working in Porto. While some teams remained open but struggled, trying to understand the best ways to deliver their services, others were closed for the first 2 weeks of the first confinement compromising the access of SI PWUD to their services,

We were closed for two weeks, more or less… [The drop-in center] *has two main targets, sex workers and drug users (…) Okay, we have a drop-in center here, in the center of Porto, which works…it ends up being very structuring for several users, for many years now. And therefore, we began to feel that we couldn't be closed, couldn't we? At a certain point, we began feeling that we, the professionals, were deeply confined and they, the users, were deeply unconfined…* (PROF5_Porto)

When the pandemic came, this [drop-in center] *had been closed for a long time. It was a really long time... I didn't come here for a long time... And even when it opened, they wouldn't let anyone eat there anymore.* (P11_Porto).

In Lisbon, the collaborative networking of civil society organizations led by the City Council allowed a quicker adaptation of outreach interventions.

I want to say that since the beginning of the pandemic, I think it [the response to SI PWUD] *was very good, the coordination between the different teams, with the Lisbon municipality, and all the work that was done, I think it was really good and very quick.* (PROF2_Lx)

These differences in the city-level support provided to harm reduction responses targeting SI PWUD in the two cities were particularly highlighted by HR professionals in Porto.

After declaring the state of emergency, we saw local authorities trying to mobilize resources to keep services guaranteeing the satisfaction of basic needs and the safety of their entire population. Therefore, as [PROF6_Porto] *said, the city of Porto delayed this response a lot. We saw Lisbon creating housing, food, and hygiene solutions for people living on the streets almost immediately, Porto needed a month.* (PROF1_Porto)

In terms of adaptation, all the professionals reported their strategies and contingency plans to continue implementing their responses (e.g., offering takeaway meals, teams working in mirrors, providing alcohol

wipes and masks, and limiting the number of people accessing the services). In general, most SI PWUD participating in this study reported that harm reduction teams were always present, available, and supportive during the COVID-19 outbreak period, adapting their responses to the different needs that emerged during the two confinements.

Everything was closed, everything was in lockdown and [the teams] *were on the front line. They were there with the van, they were there at* [the drop-in center] *giving material, they were there doing screenings... They didn't close themselves in a shell and now we're going to leave us at the sidelines. No, with Covid they continued to help, and I think even more effectively than before during Covid.* (P5_Lx)
However, some participants shared that social isolation measures increased the segregation between professionals and SI PWUD, increasing the emotional distancing between them and constrained their access to basic services (e.g., showers, point of distribution of meals).

Well, yes, I did notice a difference. Because that contact, you know, that contact that used to be… I felt like pure, because of course, they love what they do, and they know what they do, but we no longer felt that "touch", you know? (P6_Lx)

They are less available, the locations have changed, and so have the opening hours. It's like I'm saying, right now they should help more, but they're not doing the opposite, they're helping less. (P1_Porto)
Moreover, several HR professionals revealed their effort and personal investment in guaranteeing that the responses were always present in a very complex and demanding context.

There are bad things, but there are also good things, and the teams also made a huge effort, it's a fact. I can say that I've been working for over a year, without vacations, but as I say, I mean most of the workers in these teams. (PROF4_Lx)

● Social innovation in harm reduction

Despite the difficulties, all the HR professionals revealed that this was a fertile ground for the development and implementation of innovative approaches. In the context of the exponential digitalization of healthcare and social services, the risk of reproducing health inequities among SI was higher. In this sense, one of the innovations highlighted by the HR professionals in both cities was the creation, in their teams, of conditions and means for users to access online medical and social appointments. This was also seen as an opportunity to refer and create proximity between their users and the health services.

We continued to work daily on the administration of methadone, we were able to have remote appointments due to the excellent relationship with the doctor who prescribes methadone, we were able to have remote appointments and we managed to get the doctor to prescribe medication so he could reduce the impulse to consume cocaine… (PROF1_Porto)

The second thing was the possibility for street teams, on the street, to provide teleconsultations to patients who are not normally able to come [to treatment services]. *(…) So, a person thinks "Ah, but it's an*

easy idea, why didn't we think about this before?". In other words, the street team can go to the corner where he usually is, and we can do the teleconsultation there. I think this flexibility has also created new responses that I think might be useful to maintain in the future. (PROF6_Lx)
To decrease the social contact between the treatment teams and PWUD, there was an increased tolerance in the access and provision of (take-home) methadone in both cities.

Interviewer – Did you notice any changes to the methadone program?

Participant - There was. During confinement, I got a week's worth of methadone, and during these confinement times, I was not given urine tests. They have not been carried out because of Covid. (P5_Lx)
The take-home methadone approaches could also an impact on the survival strategies and self-organization of SI PWUD. Some studies pointed out the risk of drug diversion or misuse due to more permissive protocols in the prescription of opioid agonists (17, 19). However, in a context of economic deprivation and higher permissiveness in the access to methadone, it could be used as a substitute for other drugs or sold to raise money to buy the preferred drugs. This revealed the initial adaptations of SI PWUD to the perceived changes in their drug markets. It could be related to the lack of options for smokeable medicines (23) and, according to participants, doesn´t represent long-term and persisting trends.

And there was an issue here with methadone, right? With the teams that were giving methadone for a week, there was also an increase in the consumption of injectable methadone. (PROF3_Porto)

Interviewer: You said a while ago that some people sold their methadone…

Participant: Some?!? Lots of them. (...)… There was no money… (...) When people sold methadone, they probably needed it, right? They needed money for crack. And they started selling it and then when they needed it, they didn't have it anymore. And they had to go to [slang for heroin]. (P1_Lx)

Moreover, some participants also expressed that, due to the difficulties in raising money for drug use and the discomfort related to the craving and abstinence symptoms in the street, they saw the pandemic context as an opportunity to adhere to an opioid substitution treatment.

As I haven't been making as much money, I consume less, I think this is better... That's why I was more encouraged to take treatment too, now that I'm consuming so little that I almost don't even have a hangover, I think on the one hand it was good.... (P2_Porto)

Also it was lockdown, impossible to make money. I think it's better to take methadone, I stopped. (P5_Lx)

Another social innovation was the low-threshold harm reduction intervention targeting SI with alcohol-related problems implemented in Lisbon (41). This response was based on the prescription of

benzodiazepines to reduce the risk of abstinence symptoms and alcohol withdrawal symptoms. This innovative response was implemented in Lisbon and was led by the Alcohology unit in close collaboration with the harm reduction teams and emergency centers for SI people implemented by the Lisbon City Council.

The feeling we have is that this response essentially constitutes a bridge to treatment. In other words, users themselves felt that they should now independently manage their consumption. And, therefore, this helped people a lot to manage their consumption and, also, to feel confident, for example, to transition to treatment, and I think this was an added value. (...) Therefore, it has become a bridging response for health care and not so much for prevention... given its usefulness, we consider maintaining it. Therefore, this was also a response that was only possible because there was a partnership with the Lisbon City Council, with the entities, at the time, that were managing the emergency centers, and with the hospital pharmacy that created a distribution circuit, like the one of methadone and the proximity of, therefore, providing these drugs that were stored in the centers themselves. (PROF6_Lx)

2) Governmental support and city-level responses targeting SI PWUD in Porto and Lisbon

● Governmental support and responsiveness

According to the HR professionals participating in this study, SICAD took some time to provide guidelines to inform the adaptation of the outreach teams to confinement. Nevertheless, they highlight that during the pandemic the dialogue and collaboration between SICAD and the Portuguese harm reduction network (R3) was reinforced. In addition, additional support was provided by SICAD, including the provision of smoking pipes for the consumption of crack cocaine, to prevent the risks of COVID-19 infection among SI PWUD. However, this was a one-time support. Even though an increasing number of SI PWUD are smoking crack cocaine, the provision of this drug use paraphernalia was not continued.

I would like to say that there were positive things in political terms, but we still don't know what will happen in the future, in terms of impact, because in the last year and a half, I think there have been more meetings between risk reduction and SICAD than in the last 10 years all together. (PROF6_Porto)

It continues [the pipe distribution] *for now, but we have already had official information from SICAD that it will stop. In other words, we still have the pipes because we are giving, but when these are finished... I don't know if there are still anymore to come, but it is not a... post-covid, we have already been told that this support will not be continued public. Therefore, then each team will have to manage it, just like last year.* (PROF3_Lx)

● City-level responses targeting SI PWUD in Porto and Lisbon

The narratives of HR professionals and SI PWUD participating in this study revealed clear differences in the approaches and drug policies orienting the city-level low-threshold and sheltered responses targeting SI people in Porto and Lisbon. While the approach in Porto was described as restrictive and zero-tolerance towards drug use, in Lisbon the responses were harm reduction-focused.

● Zero tolerance responses in Porto

The Temporary Shelter Center targeting people living in homelessness was expanded during COVID-19. Several SI PWUD participating in this study reported that they resorted to this service to access accommodation, meals, and other goods and services. However, both professionals and SI PWUD revealed some criticism towards the strict rules and zero-tolerance drug policies that tend to be exclusionary.

*I think it took some time to have a housing response and then there was the question of shelters adapted to people with active drug use. I think that was the biggest issue... the big negative issue. Many people wanted to be housed and didn't have that possibility because the rules or restrictions imposed by the shelters didn't allow it, didn't they? These were compatible with people who wanted to maintain their drug use. (*PROF3_Porto).

In this respect, P2_Porto and P10_Porto revealed that they were evicted from the Temporary Shelter Center due to their use of alcohol and other drugs. P8_Porto also reported that he doesn't trust this sheltered response due to their authoritarianism and rigid confinement measures.

My case is very specific because I was approached by [harm reduction outreach team] *in March to join* [the temporary shelter centre]. *I quarantined for three months, from Easter until... I went through the whole process that I was explaining to you to join the shelter, I took the exams and all that. What happened, happened* [she was evicted after breaking the rules concerning the time allowed to be outside the shelter], *and that's why this relationship* [with the professionals] *is now a bit limited. (…) It was not allowed to go out. (...) And I found myself very limited by the confinement that was imposed on me. Then when I could... initially, two hours and then four hours a day* [to be outside the shelter]. *If we exceeded it, we didn't go out anymore, you know?* (P2_Porto)

Professionals also reported difficulties in articulating with this city-level response and highlighted that their zero-tolerance and punitive rules compromise harm reduction principles and the trust of PWUD.

I even had to go there myself with users to revoke their rights and ask them to explain my users the reason why they were being taken away from antiretroviral therapy, which is not a punishment, it is a response.... (PROF2_Porto)

For now, harm reduction is already the last frontier, isn't it? So, people are no longer used to going to any other service, and I'm talking for example in Porto. When there was the centralization of meals at [the temporary shelter center]. *I met people who were living* [in the center of the city] *and who hadn't eaten for I don't know how many days for fear of going to* [the temporary shelter center] *and being caught and*

arrested, and going there with that fear of being quarantined, this and that, so they were not eating for I don't know how many days, even being 500 meters away from the distribution point. (…) I think Porto [emergency responses to COVID-19] *intersects with other phenomena, doesn't it? Of a certain governance that doesn't understand harm reduction and invests more in cleaning up territories or something like that, which makes everything even more difficult.* (PROF6_Porto)

In this sense, the zero-tolerance approaches in the Temporary Shelter Center, is integrated in overall strategy that included the dismantling of drug trafficking territories and recriminalization of drug use in public spaces.

I highlight two distinct issues, the cleaning actions of the municipality, which are perceived by people who are homeless as bullying actions. Therefore, in essence, they are intended to disturb and make people feel uncomfortable in that place, so it is another way of exercising repression mechanisms. And these more recent issues of sieges on trafficking and consumption sites, right? It started in a very noticeable way in the Pasteleira area, Pinheiro Torres, etc., and in the meantime, we saw a large fluctuation of people, running away to other consumption areas. However, there is a concerted action throughout the city that involves patrols, going to places regularly, with a constant police presence. (PROF3_Porto).

● Harm reduction-focused responses in Lisbon

The sheltered responses implemented by the Lisbon City Council were informed by harm principles. As explained in the previous theme, the design of the emergency centers was based on a collaborative process, involving harm reduction services and treatment centers in the design and implementation of a holistic response to support SI PWUD during the COVID-19 confinement and social distancing period (40, 41). Their implementation followed a low-threshold and harm reduction-focused approach, and this increased the adherence of SI PWUD to the emergency centers.

Shelters began having a much more open attitude towards users and welcomed people even with [drug use] *paraphernalia, something that previously prevented people from entering the hostels. If you had forgotten a kit in your backpack when the security guard searched you… I think that homeless people who sleep in shelters cannot have any type of paraphernalia. And then that changed. They adapted a lot.* (P1_Lx)

The harm reduction-focused approach and the collaborative character of these emergency centers favored the accessibility to specific services and created a safer space for PWUD to take decisions regarding their drug use and treatment possibilities.

Interviewer: How long did it take to start methadone there in [emergency center]? *Immediately? Or not?*

Participant: Yes, immediately. One day after entering [emergency center]. First time I did methadone. I knew that methadone is a medicine for drugs, but I didn't take it before.

First time. They checked my urine, and they gave me methadone. (P3_Lx)

I took the opportunity to join the center. I even stopped using drugs. At the time, I was already taking methadone, but I was taking a very small dose. I took advantage and increased my dose of methadone and stopped using drugs completely. The fact that I was protected and that I was busy made it a lot easier for me. And the fact that I had been wanting to do that for a while, but the conditions hadn't yet met. Strange as it may seem, it took all that to meet the conditions. (P2_Lx)

Moreover, these emergency centers were also innovative due to their inclusive design, creating conditions to accommodate social groups traditionally excluded from conventional sheltered responses, specifically SI women and LGBTQIA + people. These results are aligned with the results of other studies that highlight the positive benefits of low-threshold and harm reduction-focused approaches in shelters (

(…) The responses that were implemented by the municipality… these shelter center responses in Lisbon, there was also this capacity of responding to the situation of women because previously it was, at times, very complicated to find a place for women because the shelter centers, most or most of them, are for men. And so, this was a very positive response because more places for women opened here in the various shelter centers. (PROF4_Lx)

Just to highlight what [PROF4_Lx] *was also saying, I completely agree, not only for women but also for LGBT people because one of the pavilions, one of the centers that the municipality opened targeted LGBT people, LGBT, and couples. This was something that didn't exist and... In other words, nowadays it is easier to find an answer for a woman and for an LGBT person than it was before because there are more specific responses…* (PROF1_Lx)

Discussion

The harm reduction teams in Porto and Lisbon revealed a proactive and ongoing adaptation of their responses to the immediate needs of SI PWUD. Their contingency plans and adaptations were consonant with the measures implemented by harm reduction services in other countries (1–3, 5, 6, 15). In Lisbon, there were relevant social innovations in implementing low-threshold harm reduction-focused sheltered responses, and more flexible prescription of medicines (for people with problematic alcohol use) (40, 41). Professionals and SI PWUD from the two cities referred also higher permissiveness in the access to methadone as pandemic novelty, even though the take-home approaches varied (some participants revealed a prescription for one week while others referred one month). Our data reveals evidence of drug diversion and misuse of these substances during the first confinement. Nevertheless, these changes should be comprehended as initial self-regulation strategies in the management of drug use in a context of abrupt economic deprivation. Overall, and similarly to other studies, both SI PWUD and professionals revealed that more permissive and flexible medicine prescription have benefits in promoting the autonomy and self-regulation of PWUD and their adherence to services (13, 16, 17). Considering the variability in flexible prescription approaches it would be relevant to create guidelines to

inform the implementation of these practices (14, 17), and assess the take-home methadone experiences of PWUD to guarantee person-centered approaches instead of one-size-fits-all models (16).

However, despite the recommendations to maintain the evidence-based and integrated practices during the COVID-19 outbreak (48), it is uncertain if the innovative approaches implemented in Portugal continued and were established permanently in different contexts.

Beyond the decriminalization model: City-level drug policies in Portugal

The study revealed contrasting experiences in city-level support to harm reduction and responsiveness to the impacts of COVID-19 among SI PWUD in Porto and Lisbon. These were informed by different drug policies. While the responses of the Lisbon City Council followed harm reduction principles, the Porto City Council applied more restrictive and zero-tolerance approaches in their support to PWUD. At this level, it is relevant to analyze the responsiveness to COVID-19 in an ongoing political positioning and local strategies to deal with drug-related harms. The different city-level drug policies were mainly felt by the institutional and financial support provided for harm reduction. The contrast between the two city-level drug policies was amplified considering all the harm reduction-focused innovations and integrated care models led by the Lisbon City Council (40).

Similarly to the findings of Holeksa (49), our results demonstrate that “an emphasis on punitive measures and mistrust may lead to a cycle of deceit and hiding” while “when individuals are given autonomy over their recovery, it may foster a sense of agency, self-reliance, and empowerment”. Evidence demonstrates that overpolicing and punitive approaches in healthcare and law enforcement harassment increase the stigma and the health and social risks of PWUD (49, 50). On the contrary, harm reduction approaches promote a culture of care and compassion beneficial for the empowerment and autonomy of PWUD while improving public health (22, 49, 51, 52).

The uncertain future of harm reduction in Portugal

The pandemic hangover is revealing some a challenges, uncertainty, and additional constraints for harm reduction teams and professionals in Portugal. Our data revealed that the responses to the pandemic were based in the political activism of HR professionals “as a praxis that promotes and is guided by a sense of (in)justice” that “demands a positioning in defense of the people with whom professionals work, leading to interventions oriented by/for a utopian ideal of transformation toward social justice” (53). Even though professional experience may trigger resilience and activate the process of overcoming challenges (54), the post-pandemic context is revealing the overload and burnout among professionals working with PWUD in Portugal (27).

In addition, the contemporary inflation is imposing serious constraints to harm reduction teams in Portugal. The funding of harm reduction teams remains the same for more than 10 years, and for this reason several organizations are rationing their resources, limiting their services and dismissing some of

their staff. Furthermore, in February 2024, João Goulão, the director of the recently created Institute for Addictive Behaviours and Addictions, IP (ICAD, a unified authority reuniting SICAD with the treatment responses), stated publicly that there was an overall disinvestment in the field of drugs, exposing the lack of resources for integrated community-based and treatment responses (55). The uncertainty regarding the future of harm reduction in Portugal is intensified by the recent political changes, with new conservative government in the country and an expressive representation of far-right in the parliament. These changes are happening at the same that the gentrification and housing crisis are increasing the number of people living in homelessness and when new social groups of PWUD are emerging with specific needs and intervention priorities, namely southern Asian migrants and people engaged in chemsex (56).

Finally, although the process of decentralizing competencies to municipalities in health and social support (42) is not yet fully implemented, it prompts important discussions about the ability of local administrations to effectively address the needs of stigmatized communities, while remaining immune to populist approaches and simplistic solutions."

Strengths and limitations

One of the main strengths of our study was the gender-balanced criteria applied in the recruitment of SI PWUD, which allowed the representation of cis and trans women. The gendered impacts of the COVID-19 pandemic will be analyzed and discussed in another paper, nevertheless, we consider that our data is gender-inclusive and representative. The participation of HR professionals and people with lived experiences is another strength since it allowed a comprehensive analysis and the detection of thematic patterns that were representative of their experiences.

The study has some limitations. Firstly, since we are harm reduction professionals, and were actively involved in the adaptation of harm reduction to the pandemic context, there is a possibility of social desirability bias in the interviews. Secondly, considering the different levels of involvement of the authors in harm reduction teams targeting SI PWUD, the recruitment strategy was different in the two cities. In Lisbon the participants were recruited in the scope of the harm reduction responses implemented by the authors, in Porto harm reduction and peer-led organizations supported the team in the recruitment of participants.

Abbreviations

PWUD – People who use drugs

HR – Harm Reduction

SI – Street-involved

Declarations

Ethics approval and consent to participate

The study protocol was revised and received ethical approval from the Ethics Committee for Health (CES) of the Catholic University of Portugal (Ref. nº 122). Informed consent was obtained from all participants prior to their participation in the study.

Consent for publication

Not applicable.

Availability of data and materials

Data is not publicly available to respect the confidentiality of participants in this study.

Data and materials are sensitive, and participants did not consent to the transcripts of their interviews and focus groups being publicly available.

Data extracts about which editors have questions or concerns may be provided upon request after de-identification of details that may compromise the confidentiality of the participants.

Competing interests

The authors declare no competing interests.

Funding

This research received a small grant from the CEDH – Research Centre for Human Development for the data collection. The authors are grateful to the Fundação para a Ciência e Tecnologia (FCT) for the support to CEDH – Research Centre for Human Development (Ref. UIDB/04872/2020).

Authors' contributions

Writing – Original draft: CVP, AC, RF, MCC, HV. Data acquisition: CVP, AC, MCC, RF, HV. Data analysis and interpretation: CVP. Conceptualization, study design, and methodology: CVP, MCC, AC, RF, HV. Funding acquisition: CVP, MCC. All authors have read, revised, and approved the final article.

Acknowledgments

We want to thank all the PWUD and HR professionals who participated in this study, sharing their lived and professional experiences, insights, and feedback on harm reduction responses during the COVID-19 pandemic.

We are also grateful for the generosity and support of CASO, Autoestima, Porto Solidário, GAT, and other civil society organizations in support of PWUD participant recruitment. A special thanks to Rui Salvador

for helping us with the recruitment of participants, and for his incredible work as a peer educator.

Finally, we want to thank Magda Ferreira, Filipa Gonçalves, and Sara Fernandes for supporting data collection and transcriptions.

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Footnotes

1. According to Bungay (43) “street-involvement” (SI) is used as a broad concept and umbrella term to define people who, due to structural disadvantages (e.g. poverty, precarious housing, migration, racism, and difficulties in accessing health and social services), have high degrees of “public visibility, problematic drug use, minimal connections to social support, and criminalization associated with survival strategies such as stealing, sex work, and drug dealing” (44).