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

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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. Harm reduction responsiveness was informed by the priorities defined at the local level, 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 (SI) 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 Harm Reduction (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 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 SI PWUD. While the approach in Porto was described as restrictive and zero-tolerance towards drug use, Lisbon´s strategy was harm reduction-focused and inclusive. The study participants revealed better results in Lisbon regarding the harm reduction responsiveness to the pandemic health crisis and the accessibility and adherence of SI PWUD to services.

Conclusion The pandemic constraints and adaptations must be contextualized in the ongoing city-level debates regarding drug policies and harm reduction in Portugal. Moreover, city-level drug policies and local support are crucial to map the opportunities and challenges of implementing the Portuguese Drug Decriminalization Model in different contexts.

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

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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, increased flexibility in take-home opiate agonist treatment (OAT) policies, 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 difficulties in the context of decreased in-person care [2, 13, 18], revealing that besides responding to basic and essential needs, harm reduction services are pivotal in providing physical and emotional safe spaces. This fact 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 unveils post-COVID-19 burnout among professionals working with PWUD, uncovering the costs of 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 and were not applied uniformly in different regions, and, consequently, access of PWUD to services needed to be more consistent in many countries [8, 15], making visible previous asymmetries in implementing responses at the local level.

Like in other countries [58], harm reduction professionals in Portugal tried to adapt their responses to the COVID-19-related risk and changes in illicit drug markets and drug use trends. In the first confinement period, there were reports of the injection of benzodiazepines and the increase in crack cocaine use among SI PWUD [40, 58]. 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 prevalence in Portugal [29]. Instead, this integrated drug policy contributed to decreasing imprisonment for trafficking [30], reduced problematic drug use and drug-related harms [29, 31], increased 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 criminalization of PWUD when the number 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 threatened the stability of this drug policy model. At that time, structural changes in the Portuguese authority on the drug field brought uncertainty and the risk of disinvestment in harm reduction [32, 35].

Despite the overall discussion regarding the beneficial impacts of the Portuguese Decriminalization mode, the city-level drug policies and the consequent impact on local harm reduction practices remained overlooked. This study aims to bridge this gap by comparing the city-level harm reduction responsiveness to the COVID-19 pandemic in Porto and Lisbon. However, it should be noted that in recent years, the Porto and Lisbon city councils expressed different perspectives and concerns regarding the national drug policies and differed in their support for harm reduction.

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 local strategy 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].

In Lisbon, the teams have institutional and financial support from the City Council. A protocol established between the Lisbon City Council and the General Directorate for Intervention on Addictive Behaviors and Dependencies (SICAD) formalized the attribution of 20% of funding to harm reduction teams intervening with PWUD in the city (to complement the 80% of funding provided by SICAD). To our knowledge, Lisbon is the

only city in the country providing this financial 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, community-based, 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 drug 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 public administration domains, including health and social support [42].

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). The study was implemented in Porto and Lisbon, and we applied a gender-balanced approach in the participants´ recruitment to guarantee gender-representative data collection and analysis. This paper presents a comparative analysis regarding the impact of COVID-19 on harm reduction and outreach practices in Porto and Lisbon. We explored and categorized transversal experiences and differences in adapting the outreach practices and harm reduction responsiveness during the pandemic crisis.

Moreover, by using the responsiveness to the COVID-19 pandemic as an analyzer, we were interested in identifying and describing facilitators, opportunities, obstacles, and constraints in implementing and adapting harm reduction intervention targeting SI PWUD in crisis contexts. This analysis expands the discussion by bringing insights into city-level implementation and support for harm reduction in two cities. It 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 two focus groups involving 12 h professionals (1 focus group in Porto with 6 participants and 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 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 min, 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 ten living in Lisbon, with ages between 21 and 56 years old; 8 ciswomen, three transwomen, and 11 cismen; 20 Portuguese, and two migrants.

The focus groups with professionals in Porto and Lisbon were implemented online using Zoom in May 2021. We purposefully selected the profile of participants to have a sample of professionals involved in delivering harm reduction responses targeting SI PWUD during the COVID-10 confinement periods. Signed informed consent was collected before the focus groups, which were then recorded. The focus groups explored the experiences of professionals in implementing harm reduction responses in the 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 min.

A total of 12 professionals participated in the focus groups (6 participants in Porto and 6 in Lisbon). As described in Table 2, most of them collaborated in harm reduction outreach teams and drop-in centers ($n = 9$); 2 participants worked in an Alcohology unit, and 1 participant in a peer-led organization. In terms of roles,

[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].

Table 1 SI PWUD participant demographics

	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 2 Professional participants by City, gender, and locus of work

	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

the sample included psychologists ($n = 7$), social workers ($n = 3$), a peer representative, and a psychiatrist.

Considering that we were interested in participants' perspectives on 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 = first 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 fluctuating readings and familiarization with the raw data, we used NVivo software to aid the analysis process. We adopted a deductive 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. We performed a vertical thematic analysis to see the city-level intra and intergroup experiences and compare the experiences and perceptions of professionals in Porto and Lisbon. 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. We coded the data to ease the comparative approach, organizing the themes and subthemes per city. The research findings and analysis section will present the adaptations of harm reduction responses to the pandemic contexts in the two cities. We will describe similar adaptation experiences but highlight differences due to the perspectives and priorities of the two city councils.

Research findings and analysis

The interviews and focus groups captured a solid perspective of the harm reduction responsiveness in Porto and Lisbon during the pandemic. Considering the topic of this paper, we present the main findings organized in two major themes: (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 the harm reduction teams faced uncertainty during the first lockdown, trying to define potential risks and strategies to guarantee a safer continuation of their services.

HR professionals working in Porto highlighted the need for more guidelines to inform the development of contingency plans. While some teams remained open but struggled to understand the best ways to deliver their services, others were closed for the first 2 weeks of the first lockdown, 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. Moreover, we began to feel that we could not 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 did not come here for a long time… Furthermore, even when it opened they would not 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 excellent. 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, supporting 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 shared the specific strategies and contingency plans they adopted to guarantee the continuity of their services (e.g., offering takeaway meals, working in "mirrors teams"[2], 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 and 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 [harm reduction] material, they were there doing screenings… They did not close themselves in a shell; now we will leave us on the sidelines. No, with COVID-19, they continued to help and I think*

[2] Planned rotations between telework and outreach work.

even more effectively than before during COVID-19. (P5_Lx)

However, some participants, particularly those from Porto, shared that social isolation measures increased the segregation between professionals and SI PWUD, increasing the emotional distancing between them and constraining their access to essential 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… It felt pure because they love what they do and 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 is like I am saying right now, they should help more, but they are doing the opposite; they are 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 also good things, and the teams made a huge effort. It is a fact. I can say that I have been working for over a year without vacations, but as I say, 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 developing and implementing innovative responses. 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 of outreach 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.

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 and these were described by most of the SI PWUD participating in this study.

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 flexible take-home methadone policies could also have 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 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, does not represent a long-term and persisting trend.

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. Furthermore, they started selling it, and when they needed it, they no longer had it. Moreover, they had to go to [slang for heroin]. (P1_Lx)

Moreover, some participants (3 participants in Porto and 2 participants in Lisbon) 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 enter an opioid substitution treatment.

As I have not been making as much money, I consume less; I think this is better… That is why I was more encouraged to take treatment, too, now that I am consuming so little that I almost do not even have a hangover; on the one hand, it was good… (P2_Porto).
Also, it was lockdown, and it was impossible to make money. I think it is better to take methadone, so I stopped. (P5_Lx)

A social innovation specific to Lisbon was the design and implementation of a low-threshold harm reduction intervention targeting SI with alcohol-related problems [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.

> *In our view, this response is essentially a bridge to treatment. In other words, users felt they should now independently manage their consumption. Therefore, this helped people a lot to manage their consumption and feel confident, for example, to transition to treatment, which was an added value. (…) Therefore, it has become a bridging response for health care rather than for prevention… given its usefulness, we consider maintaining it. This response was possible due to the collaboration between the Lisbon City Council, the entities managing the emergency centers, and the hospital pharmacy that created a distribution circuit like the methadone one (…). (PROF6_Lx)*

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

● Governmental support to harm reduction teams during the COVID-19

According to the HR professionals participating in this study, SICAD took some time to provide guidelines to inform the adaptation of the national outreach teams to confinement. Nevertheless, they reported that the dialogue and collaboration between SICAD and the Portuguese Harm Reduction Network (R3) was reinforced during the pandemic. 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. At this level, the participants did not describe any difference regarding the support of SICAD to harm reduction teams in Lisbon, Porto, or other cities. However, this was a one-time support. Even though an increasing number of SI PWUD are smoking crack cocaine, the provision of this drug paraphernalia was not continued.

> *I want to say that there were positive things in political terms, but we still do not 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 harm reduction and SICAD than in the last 10 years altogether. (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 to distribute, but when these are finished… I do not know if there are still more to come, but it is not a… post-covid; we have already been told that this support will not be continued. Therefore, each team must 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 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 focused on harm reduction.

Zero-tolerance responses in Porto

The Temporary Shelter Center, which targeted people experiencing homelessness, was expanded during COVID-19. Several SI PWUD participating in this study reported using this service to access accommodation, meals, and other goods and services. However, both professionals and most of the SI PWUD participating in this study 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 most significant issue… the big negative issue. Many people wanted to be housed and did not have that possibility because the rules or restrictions imposed by the shelters did not allow it, didn't they? These were incompatible 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 does not 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 center]. I quarantined for three months, from Easter until… I went through the whole process. I explained to you to join the shelter, I took the exams, and all that. What happened… well, happened [she was evicted after breaking the rules concerning the time allowed to be outside the shelter], which is 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 could not go out anymore, you know? (P2_Porto)

Professionals also reported difficulties in collaborating with this response, highlighting 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 invoke their rights and ask them to explain to 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 am talking, for example, in Porto. When meals were centralized at [the temporary shelter center]… I met people who were living [in the center of the city] and who had not eaten for I do not 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… So they were not eating for I do not know how many days, even being 500 m 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 does not 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 approach in the Temporary Shelter Center is integrated into the overall strategy that includes the dismantling of drug trafficking territories and the re-criminalization 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. 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 very noticeably in the Pasteleira area, Pinheiro Torres, etc. In the meantime, we saw a significant fluctuation in people running away to other consumption areas. However, a concerted action throughout the city involves patrols and going to places regularly, with a constant police presence. (PROF3_Porto).

Harm reduction-focused responses in Lisbon

Harm reduction principles informed the sheltered responses implemented by the Lisbon City Council. 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 designing and implementing 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, increasing 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 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. They created a safer space for PWUD to make 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]. The first time I did methadone. I knew that methadone was a medicine for drugs, but I had not taken 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 tiny dose. I took advantage, 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. Furthermore, I had wanted to do that for a while, but the conditions had not yet been 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 evidence of other studies that highlight the positive

benefits of low-threshold and harm reduction-focused approaches in shelters [51, 52].

> *(…) 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. Thus, 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 did not exist and… In other words, nowadays, it is easier to find a response 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 prescriptions of medicines (for people with problematic alcohol use) [40, 41]. Additionally, professionals and SI PWUD from the two cities reported flexible regulations in access to methadone as a pandemic novelty, even though the take-home approaches varied (some participants revealed a prescription for one week while others referred one month). Our data shows evidence of drug diversion of these substances during the first confinement, revealing the self-regulation and management strategies implemented by SI PWUD [57] to adapt to an abruptly changed context.

Nevertheless, these changes should be comprehended as initial self-regulation strategies in the management of drug use in the context of abrupt economic deprivation. Similarly to other studies, both SI PWUD and professionals revealed that more permissive and flexible medicine prescriptions have benefits in promoting 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 take-home methadone experiences of PWUD to guarantee person-centered approaches instead of one-size-fits-all models [16].

Despite the recommendations to maintain evidence-based and integrated practices during the COVID-19 outbreak (48), it is uncertain if the innovative approaches implemented in Portugal will continue and become permanent practices.

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 on SI PWUD in Porto and Lisbon. Different drug policies informed these responses. While the responses led by the Lisbon City Council followed harm reduction principles, the Porto City Council applied more restrictive and zero-tolerance approaches in the services promoted to support 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 realized 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." At the same time, "when individuals are given autonomy over their recovery, it may foster a sense of agency, self-reliance, and empowerment." Evidence demonstrates that over-policing and punitive approaches in healthcare and law enforcement harassment increase the stigma and the health and social risks of PWUD [49, 50]. In contrast, harm reduction approaches promote a culture of care and compassion that is 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 aftermath of the pandemic is revealing some challenges, uncertainty, and additional constraints for harm reduction teams and professionals in Portugal. Our data revealed that the responses to the pandemic were based on 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 the professional experience may trigger resilience and activate the process of overcoming challenges [54], the post-pandemic context

reveals the overload and burnout among professionals working with PWUD in Portugal [27].

In addition, the current inflation rates are imposing severe constraints on harm reduction teams in Portugal. The funding of harm reduction teams has remained the same for more than 10 years, and as a result, 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), publicly stated 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 a new conservative government and an expressive representation of the 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 essential 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 our data to be gender-inclusive and representative. The participation of HR professionals and people with lived experiences is another strength since it allows a comprehensive analysis and the detection of thematic patterns representative of their experiences.

The study has some limitations. Firstly, since we are harm reduction professionals and were actively involved in adapting 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 based on the scope of the harm reduction responses implemented by the authors. In Porto, harm reduction and peer-led organizations supported the team in recruiting participants. Thirdly, the non-random convenience sampling strategy via harm reduction organizations could lead to the involvement of participants already well-acquainted with services and ideologies aligned with the ham reduction philosophy. Therefore, SI PWUD, less well-connected with existing responses, may need to have their views represented in the results.

Abbreviations

PWUD	People who use drugs
HR	Harm Reduction
SI	Street–involved

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Author contributions

Writing– Original draft: CVP. Data acquisition: CVP, AC, MCC, RF. 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.

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Data availability

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.

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 before they participated in the study.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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