STUDY

HARM REDUCTION

IN THE 21ST CENTURY

PHASE II
DIAGNOSIS

New Harm Reduction Strategies

UNAD LA RED DE ATENCIÓN A LAS ADICCIONES

With the technical assistance of:

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POR SOLIDARIDAD OTROS FINES DE INTERÉS SOCIAL

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LETTER FROM THE PRESIDENT

I would like to share with you the significant achievements and progress that we have made in 2022, with a particular focus on our commitment to harm reduction as a fundamental pillar in the defence of the rights of people who use substances. The Harm Reduction in the 21st Century study has been key to this process, and we are pleased to present its second phase.

This new work is presented as a document with concrete strategies and valuable conclusions that address various aspects of harm reduction in Spain. Special consideration is given to the intersection of factors like gender, sexual orientation and homelessness.

I want to highlight the importance of integrating a gender perspective in the design of the accompaniment model from the initial stages. We recognise that the intersection of inequality axes is essential to understand and address the discomforts produced by the oppression systems present in the lives of PWUS, considering aspects such as male violence, employment barriers, social class, country of origin and administrative situation.

The need for greater sensitivity and services adaptation is crucial in the response to chemsex, making visible the need to develop specific harm reduction strategies for this community and pointing out the lack of safe places for LGTBIQ+ people in these services.

In relation to homeless PWUS, their vulnerability increases by factors such as age, place of origin and administrative situation. This situation urges us to seek more resources, especially in regions with structural and institutional constraints, and to provide culturally sensitive care.

Identifying patterns of substance use, consumption spaces and different routes of administration reflects a dynamic and complex reality. The connection between substance use, socio-economic context and social expectations highlights the continued need to adapt our harm reduction services to evolving needs.

It is our hope that this study becomes a useful tool to help us in moving forward and building a community where people with addictions have the opportunities they deserve.

Finally, I would like to thank the participation and commitment of all the people who in one way or another have participated and believed in this work

LUCIANO POYATO ROCA

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RESEARCH TEAM

COORDINATION

ESTER ARANDA RODRÍGUEZ

Senior Researcher of the Diagnostic Phase of this study and Coordinator and author of this paper. Graduate in Social Work. Master's Degree in Public Health. Eleven years of experience in HR services. She designed and managed the first inhalation paraphernalia exchange programme in Spain, the first housing support service with a DCR in Spain and co-founder of Kit-Safe, a peer developed project for the design and distribution of materials for the use of substances. She currently conducts research for UNAD, works as Deputy Director of the Drug Area at ABD Group and carries out international consultancy work in the field of HR. She is a member of the European Network of Drug Consumptions Rooms (ENDCR) and the Emerging Substances Methamphetamine research group. She conducts peer reviews for the EMCDDA as an expert on HR. Co-teaching lecturer on the Master's Degree in Drug Dependence (UB-IL3) and the Bachelor's Degree in Criminology (UOC).

GENDER EXPERT

GEMMA ALTELL

Social psychologist. Master's degree in drug addiction. Director of the Drugs, Gender and Families Area of the Fundació Salut i Comunitat (2000-2016). Specialist in gender and sexist violence. Founder and promoter of work on drugs and gender at Fundació Salut i Comunitat with the projects: Espai Ariadna, Noctambul@s and Malva. Lecturer at the University of Barcelona: Master's Degree in Drug Addiction, Master's Degree in Community Mental Health, Master's Degree in Family Violence (2010-present). Current co-director of the gender consultancy G360, she has developed different publications in the field of addictions and gender (prevention and care). Advisor on gender and sexual diversity at the Subdirección de drogas Generalitat de Cataluña. Supervisor and advisor of services and projects: CRI Galena (Public Health Agency-ABD), CAS Baluard (ASP- ABD), Gen-A private addiction care centre, TRANS-MET METODOLOGÍAS TRANSNACIONALES DE REDUCCIÓN DE DAÑOS y ABORDAJES COMUNITARIOS (Catalonia-Colombia) (2022), Estudio de Reducción de daños en el siglo XXI (UNAD). Provides accompaniment, together with FCD, on the incorporation of the gender perspective in member organisations. Specific professional training on substance use and gender since 2000. Article writer for the magazine: Drogas.Info. Own publications and various co-authorships. Member of the work team RED (substance use and gender). Member of UNAD's gender committee.

WORK AND RESEARCH TEAM

ANNA LAGO PORREDON

Senior Social Integration Technician trained in psychology. She has managed the first Supervised Inhalation consumption room in Spain for +10 years, and created the first drug-checking service implemented in a drug consumption room in Spain. She was part of the team that designed the first state programme for the distribution of hygienic paraphernalia for inhalation. Co-founder of Kit-Safe, a peer developed project for the design and distribution of materials for substance use. Member of the research group Emerging Substances Methamphetamine.

ELISABET GARCÍA FOLK

Degree in social work although she has spent her entire professional career as a social educator. In recent years she has focused her training on gender, conflict between Hutu and Tutsi ethnic groups and communicable diseases in Central Africa. Her professional experience starts with children at risk of social exclusion. In 2009 she started working in the field of harm reduction, mainly in 'Calor and Café' spaces in Barcelona. She currently combines management functions of the CRI Galena (Barcelona), Housing First social inclusion for people in a previous situation of homelessness and addictions, and member of the Red de Atención a Personas en situación de Sinhogarismo de Barcelona (XAPSLLB).

ELISABET MARÍN RECHE

Degree in Social Education from the University of Barcelona. Postgraduate in sexually transmitted infections and HIV (UOC). Postgraduate in Housing First (UOC). Multiple training in gender perspective and LGTBIQ+. 12 years of work experience in social intervention from the perspective of Risk and Harm Reduction. During these years she has been a referent in gender perspective in the HR drop-in centre Fundació Àmbit Prevenció and the CRI Galena (ABD) in Barcelona. Reference person in the programme 'Cuidarte' on HIV and stigma. Experience as a peer trainer. Member of the research group Emerging Substances Methamphetamine.

GARAZI RODRIGUEZ BRUÑA

Degree in Social Education. Master in Gender. +10 years experience in direct attention to HR services in Spain, Portugal and Canada. Currently working in public administration and collaborating in harm reduction activist groups.

JOSEP ROVIRA GUARDIOLA

Degree in Social Work and Social Mediation. With +30 years of experience in the field of substance use, he has been the director of the Drug Area of the ABD Group since 2006, which includes outpatient care services, outpatient harm reduction services, as well as housing support for homeless PWUS and preventive programmes at local, national and European level in the fields of education, nightlife and community. He is a member of the board of directors of the Catalan Federation of Drug Dependency (FCD) and coordinates the Working Group on Drug Dependency of the Municipal Council of Social Welfare of Barcelona. Senior Researcher in the Diagnostic Phase.

JOSEP LLUÍS SALVADÓ SÁNCHEZ

Graduated in Social Work in 2015, his entire professional career has been linked to harm reduction services. He has worked in CAS Baluard and CRI Galena for people in active consumption and sleeping rough, services that he has managed and coordinated. He is also trained in Housing First intervention and methodology (UOC) and gender perspective (chemsex, men and addictions, intervention with men who exercise sexist violence and accompaniment in sexual rights). He has led groups of professional men from the harm reduction network with a gender perspective.

MARINA SONADELLAS ARAGÜES

Degree in Social Education and Anthropology. Trained in accompaniment of young migrants and displaced persons. Master's degree in Promotion and defence of human rights, thesis on migrant children and youth in transit through Mexico. +10 years of experience in HR direct care services in Barcelona. Lecturer at the UOC.

MARTA ESCOLANO VEGA

Degree in Social Work with experience in accompanying homeless people in strict street situations and in housing support facilities, especially in addressing the area of substance use from a HR perspective. Academic training in community cooperation and development, and experience in activism in community and political movements.

PAULA SORIA CARRASCO

Degree in Social Education and master's degree in Community Mental Health. Experience in accompanying homeless PWUS from the perspective of harm reduction and with a community approach. At an academic level, I have received training in addressing gender violence, mediation and conflict resolution, substance use and gender perspective.

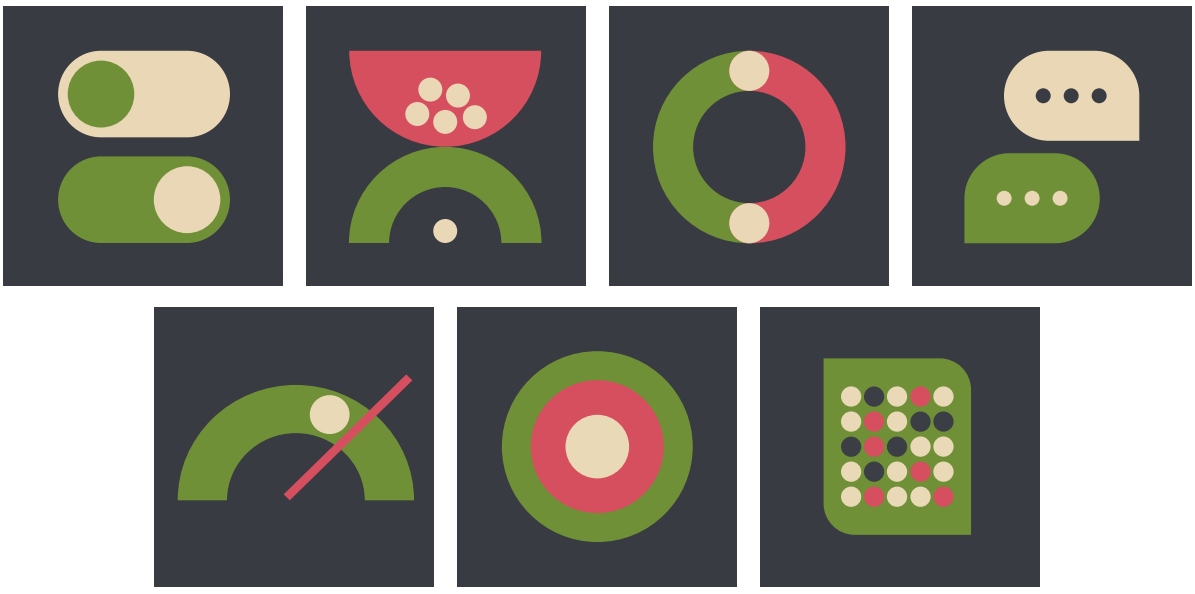
SONIA ORTIZ MORENO

Degree in Social Education. She has been trained in Systemic Family Therapy, Social Intervention from the Gestalt Perspective and Violence against Women. She was part of the team that opened the first consumption room in Spain (Barranquillas). Since then, 22 years of experience in HR direct care services in Madrid and Barcelona. Founding partner of a cooperative that operates in the context of the social economy movement in Madrid.

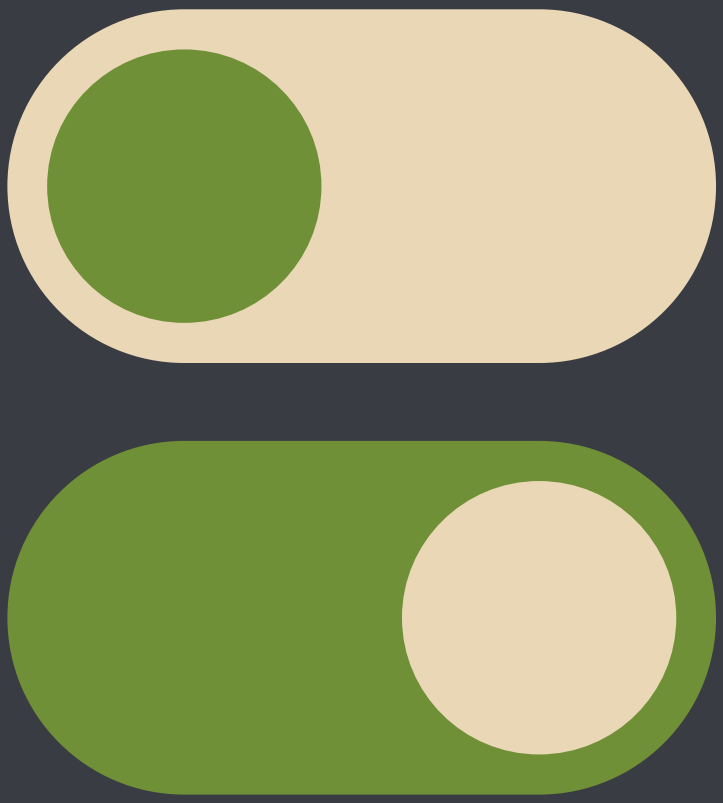
ZOE FERNÁNDEZ MOSQUEDA

General Health Psychologist with experience in mental health care, accompanying people with mental suffering in their homes and in hospitalisation facilities. In recent years, I have accompanied women and people of different genders, as well people who engage in chemsex from a harm reduction perspective. At the academic level, I have received training in substance use, chemsex, care from a transcultural perspective and trauma perspective.

ÍNDICE



1 INTRODUCTION



In 2021 UNAD committed to conduct an in-depth review of Harm Reduction in Spain, after more than 30 years of its implementation. In a first phase (2022), a diagnosis of the issues that needed to be given greater attention was made. This first review also made it possible to identify elements that had not been considered in the first designs of these strategies.

Based on these themes, a second stage of research was carried out in 2022 with the aim of exploring in depth, but also identifying new strategies that are already being applied and are showing good results. Despite the diversity of national territories, compiling good practices promoted and developed by community entities continues to be a strategy that can facilitate the implementation of harm reduction in Spain with a common philosophy and characteristics.

In contrast to the first phase, this document is structured around the qualitative results of the 12 research themes.

The first theme focuses on the review of the Harm Reduction (HR) model in Spain and the identification of new strategies successfully implemented that are fundamental to address contemporary challenges related to substance use and its impacts on society. Ongoing evaluation of the existing strategies effectiveness and the search for new successful practices are essential to make an efficient use of available resources. Revising the model and implementing new strategies fosters innovation and adaptability in the field of HR, allowing the incorporation of new and flexible approaches for long-term effectiveness.

In relation to the beneficiary communities of HR in Spain, during phase I it became evident that the model was offering adequate responses, and consequently favouring white, native, 40-50 year old, male, who use opiates by the injected route. The intersectionality made it possible to take into account different explanatory frameworks for understanding social inequality that not only had to do with the multiplicity of axes, but also with the diverse and changing ways in which they relate to each other and their variable configuration depending on the context. Accepting this situation allows the visibility of other community groups that are becoming unnoticed and that, within social exclusion, present greater vulnerability.

There are different positions in relation to gender conception, different feminist approaches and also the relationship between gender and other axes. The positioning of the present research avoids both the debate on the prioritisation of the different gender dimensions and the usual internal disregard between axes as shapers of inequality.

Thus, the starting point is a broad view of the gender spectrum, where, yes, there are cis women, but also cis gay men and trans-feminists, rejecting a view of masculinity as a single structure, and an approach where the concept of woman does not exhaust all the diversity of existing women. The aim is for HR to be a bidirectional strategy with regard to gender. Forcing the deconstruction of the social imaginary of gender, not only by questioning the masculine hegemony, but also by criticising the hegemony that operates within the category of woman. Thus promoting the visibility of multiple options, positions, forms... and in sequence opportunities.

Therefore, the focus was on women, but with equal determination on the LGTBIQ+ community, a group identified in the first phase as the most excluded. It was then decided that most of the participating users would not be heterosexual and that their gender expression would not be normative.

It is also important to position and situate the applied key perspective. We started from the results obtained in the first phase, which pointed to poverty as an axis of inequality that constantly mediated in the identification of inequality in PWUS. The priority was to focus on homelessness as the ultimate expression of poverty, trying to identify current responses and areas for improvement.

The conceptualisation of the community and the exploration of who shapes it and what place it has in the implementation and sustainability of services was another aspect to deepen, as per the diagnostic phase. Discrimination and social rejection were reported as key elements in reducing violence and opportunities for PWUS. In this second phase, priority was given to the identification of successful strategies in this regard, but the focus was also on facilitating a voice for the different community agents identified.

In relation to the programmes, it was pointed out that the distribution of paraphernalia, DCRs, and *Calor y Café* centres were the three main responses offered by HR in Spain. The increase in the use of stimulants and the growth in the use of inhalants required an immediate review in order to adapt to new communities and new forms of substance use.

Finally, the worrying burnout situation of the professional community working in HR that emerged in the diagnostic phase was explored, giving this element the relevant place it deserves, and promoting its visibility and importance in the complex interplay of responses' quality.

2 METHODOLOGY

STUDY DESIGN

This is a qualitative, descriptive and exploratory study. A feminist, intersectional and psychosocial perspective was applied.

STUDY TARGET POPULATION

Women, men and non-binary people using the services and/or programmes of the HR network in Spain.

RESEARCH TEAM

On the basis of the results of the study Harm Reduction in the 21st Century. Phase I: Diagnosis

the following themes were identified as requiring further study: 1) Harm Reduction application model in Spain; 2) Vulnerable community groups (women and gender-dissident, ageing communities, people who engage in chemsex, young migrants in a situation of homelessness); 3) Homelessness axis of vulnerability; 4) Pattern of substance use; 4) Harm Reduction associated with the use of Alcohol; 5) Harm Reduction and substance use paraphernalia; 5) Drop-in Services; 6) Harm Reduction and Outreach Services and Programmes; 7) Burnout in the Harm Reduction Network.

The only theme that was discarded was harm reduction in rural contexts, as it could be transversally integrated with the previously mentioned themes.

In order to carry out a specific in-depth study of each of the topics identified, the senior research group of the Diagnostic Phase decided to complement the team with junior researchers with expertise in each of the themes identified.

The criteria for inclusion in the research group were to have over 5 years of work experience in the state harm reduction network, to have worked in at least 2 different services and/or programmes that were directly related to the assigned research theme, and to have specific training in the topic and gender perspective. A selection of convenience was applied.

The research was coordinated by a person from the senior research team from the first phase and supervised by a person with expertise in gender and substance use.

DATA COLLECTION INSTRUMENT

The theoretical framework constructed during the first phase of this research was used as a starting point. All the thematic areas complemented the previous findings with the specific literature review.

The focus group technique was used to collect information from the population sample. A total of 14 focus groups were set up, one for each theme. They consisted mainly of professionals, representatives of the public administrations and members of the community. Two focus groups were made up exclusively of PWUS (*FG-First Person*) where the themes were explored transversally. Due to the nature of the subject matter, the focus group on chemsex used a mixed methodology, allowing professionals and PWUS (PWUS) to participate simultaneously.

Each focus group was led by a member of the research team with expertise in the specific theme, together with the UNAD representative and the study coordinator as facilitators.

The duration of all groups was 120 minutes. The groups made up of PWUS were conducted face-to-face in order to reduce access barriers related to technology. The rest of the groups were conducted online to guarantee the territorial diversity of participants. The participation of gender and racial diversity was promoted. Participation was not remunerated in any case.

INFORMED CONSENT AND DATA PROCESSING

The informed consent for the registration and transfer of data used in the study was provided by the Technical Department of UNAD. It was essential that each person agreed to participate. All the participants were informed about the stage of the research process and the possible implications of the results.

DESCRIPTION OF SAMPLING AND SUBJECTS

The sampling was theoretical, of convenience and across the entire research team. The inclusion, exclusion and specific selection criteria are specified in the results section of each theme explored.

The following table describes the characteristics of participants in this research phase. The request of 2 participants for anonymity was maintained.

DESCRIPTION OF PARTICIPANTS		
Participation Role		
HR User	23	19%
Public Administration	9	8%
Community Association	3	3%
Neighborhood Movement	1	1%
Private Sector	2	2%
Public Health Sector	9	8%
Third Sector	72	60%
University	1	1%
Gender		
Female	83	70%
Queer	3	2%
Male	34	28%
Territory		
Andalusia	8	7%
Aragon	1	1%
Asturias	1	1%
International	3	3%
Castila-La Mancha	1	1%
Catalonia	43	39%
Ceuta	1	1%
Community of Madrid	10	8%
Valencian Community	6	5%
Basque Country	12	10%
Galicia	1	1%
Balearic Islands	3	3%
Canary Islands	5	4%
Melilla	1	1%
Murcia	1	1%
National	19	16%

A total of 122 people participated. Of these, 23 identified themselves as users of HR services and/or programmes. A total of 53 collaborating organisations took part, made up of community entities, public bodies, government representatives, family associations, PWUS associations, political and neighbourhood associations and professionals.

The majority of participants were women (70%). A total of 14 Regional Autonomous Communities were represented, with Catalonia (39%) being the most represented, followed by the Basque Country (10%) and the Community of Madrid (8%). In addition, people working nationally (16%) and internationally (3%) participated.

DESCRIPTION DATA ANALYSIS AND PROCESSING

All audio recordings and speech transcriptions were coded to guarantee the anonymity of the data. In order to preserve the confidentiality of the participants, the unit of designation of the territory was defined as the Autonomous Community to which they belong. The individual interviews and focus groups were transcribed. The discourses were processed by the researchers using the software ATLAS.ti22, the segmentation of themes and the creation of categories were carried out in a constructive way based on the reference to the theoretical framework. The entire research team discussed the results of the analysis, participated in the interpretation of the results, and the gender expert witnessed all the sessions. The discussion and conclusions were carried out in a collaborative and participatory way in two telematic sessions lasting a total of 4 hours.

ETHICAL CONSIDERATIONS

The research team agreed to a declaration of free association with this research. There was no bidirectional profit motive. The do-no-harm approach was maintained in the conduct of the study.

3 RESULTS

3.1. HARM REDUCTION MODEL

AUTHOR: ESTER ARANDA RODRÍGUEZ

INTRODUCTION

This research dives into the current reality of the harm reduction model (HR) in Spain, exploring its implementation and evaluating its effectiveness in the context of contemporary substance use, health and social contexts. HR, in a broader health framework, seeks to mitigate the risks associated with substance use and risk behaviours, as well as to guarantee the rights of PWUS.

As a result of the findings of phase I of this research, there is a need for a review of the current HR model. It was observed that substance use policies in Spain have been shaped by the structural convergence of neoliberalism, the patriarchal system and prohibitionist policies on substance use. These policies were originally developed under a disease-centred biomedical approach, focusing on prevention, treatment and harm reduction. Likewise, the context in which they emerged was marked by injecting heroin use, high comorbidity and associated mortality. Furthermore, it became evident that treating Spain as a territorial unit made the diversity of realities in its territories invisible.

However, a stigmatising social imaginary persists towards PWUS, viewing them as lazy, criminal and responsible for their situation. And although HR has introduced an approach based on public health principles, the initial design of its services and programmes did not consider the different intersections and intensities of social inequality.

Regarding the HR model at the national level, the main proposal that emerged during the Diagnostic Phase was the incorporation of a transversal social justice approach to address existing disparities. The substance use status was identified to operate as an axis of social inequality, and most HR services tended to privilege certain groups, such as men, white, native and users of injecting heroin. This left out oppressed communities, making it difficult for minority groups to access and adhere to the HR network. In this sense, the need to reformulate the current model became imperative. Thus, to ensure that responses were inclusive, equitable and addressed the complexities of intersectionality in the field of substance use policy and support for PWUS.

The objectives of this research focused on describing the origin and current situation of the HR model, identifying and understanding possible differences between territories, and extracting elements for improvement that respond to the needs of the current state context.

METHOD

A qualitative experimental research methodology was applied using the focus group (FG) technique as a data collection instrument. The information was complemented with a semi-structured in-depth interview with two participants who were unable to attend the FG.

The selection of participants was of convenience. The topics of interest to be explored were identified as: activism, gender, homelessness, policies and mechanisms. On the basis of these categories of interest, a sample was designed, taking account of the representation of experts from local, regional, national and European public authorities; and the participation of professionals who also had direct care experience in the diversity of services and/or support programmes in the field of HR in Spain.

Out of the eleven people contacted, ten agreed to participate and only one person did not respond to the proposal. In total there were eight women, one man and one non-binary person. Eight of these individuals participated in the focus group. Another two were interviewed later due to the impossibility of scheduling.

The FG and the interviews were facilitated by the expert researcher and were observed by both the UNAD technical professional and a member of the research team. They were conducted telematically, with a total duration of 2 hours for the focus group and 45 minutes for the interviews.

All persons agreed to participate voluntarily, signed the informed consent for data transfer/participation, and did not receive any remuneration.

RESULTS

AND SUDDENLY MANY WERE DYING

The FG began by inviting participants to collaboratively describe the context prior to the implementation of HR in Spain. They dated the beginning to the 1970s, with the emergence of heroin on the illicit drug market and the increase in the prevalence of injecting substance use. They described this socio-political moment of dictatorial repression and depoliticisation of the general population, at least in the public sphere. They pointed out that the main substance used at that time was alcohol, being the only treatment option available to people with problematic use.

> "Heroin came to us by the end of the 70s, and you have to remember that we didn't have... this didn't exist... It was a non-existent issue, and there were just a few, and then suddenly there were hundreds. And we didn't have addiction services [...] And of course, in that context with intravenous heroin, people were dying from overdoses, and people were dying from AIDS, and people were dying from AIDS caused by tuberculosis."
>
> Medical Epidemiologist. State Government.

One of the participants, who was also directly involved in the whole process, recounted how in the late 1980s questions began to be raised about the prohibitionist legal framework in which the phenomenon of substance use was situated. The increase in the number of lethal overdoses due to heroin use, the increase in mortality associated with AIDS and the increase in mortality associated with tuberculosis were identified by all participants as the elements of greatest concern for professionals at that time. In addition, they found that treatment programmes had very little relevance for people who used heroin because they were designed as Drug-Free Programmes with an exclusive focus on abstinence.

The counterculture (meeting places, magazines, pamphlets...) and the informal mutual support networks derived from it were pointed out by one participant as the space where PWUS could find information and support as an alternative to abstinence. One participant disagreed with this statement, pointing out that even if such places and actions existed, this group of people were equally affected by the overdose and HIV/AIDS pandemics.

One participant related how she, together with a group of professionals from different disciplines, started to look for references of alternatives to the abstinence in other European countries such as England and the Netherlands. They discovered that strategies following a new paradigm called Harm Reduction were being applied.

WE DIDN'T KNOW WHAT WE WERE DOING, BUT WE ALSO HAD NO CHOICE

Beyond the mortality and morbidity associated with injecting heroin use and the rise of the first professional discourses calling for new support paradigms to PWUS, some participants pointed to the socio-political context prior to the 1992 Barcelona Olympics as an opportunistic element in the implementation of the first HR strategies in Spain. Although some participants were reluctant to validate this hypothesis, no one expressed any argument against it.

Under these circumstances and with the help of a group of very committed professionals, participants recounted that the first pilot of a needle exchange programme (NEP) in Spain was being implemented.

One FG participant pointed out that this initial impulse did not come from user pressure for health rights, noting that society in general was still very depoliticised due to the previous dictatorial context. Another participant added that it was probably more appropriate, in the eyes of public opinion, to present it as a new health strategy aimed at tackling the existing epidemiological crisis.

Despite the fact that the NEP strategy had scientific evidence and was internationally endorsed, all participants agreed that resistance from the professional community was extremely strong. One participant illustrated this by recalling voices that argued that access to the syringe market in pharmacies should be sufficient to promote individual syringe use.

> "When people talked about syringe exchanges, the response was "hey, but in Spain you can buy syringes in pharmacies", because there are countries where it is illegal to buy syringes without a prescription, but in Spain it never was."
>
> Medical Epidemiologist. State Government.

Another participant from Barcelona stressed the courage and commitment shown by professionals and organisations involved in implementing the NEPs at that time.

> "We felt the need to do it... sometimes we were giving answers to things that we didn't know how they worked... I remember setting up a syringe exchange programme in 1991, the first was "Surt del Rotllo", and we in Reus set up "Juguem net". And the next day 78% of syringes were returned."
>
> Psychiatrist. Catalonia.

The involvement of professionals, the emergence of health, regulatory changes and political consensus facilitated the implementation of the first Methadone Maintenance Programmes (MTDP) from 1992 onwards. Again, all participants in the FG agreed that there was increasing resistance from professionals providing direct care, as well as opposition from professionals in existing rehabilitation homes and therapeutic communities.

> "In 91-92 we started to have methadone programmes, which a large part of the professional spectrum was opposed to and they would say "methadone troughs, it's giving them opiates", but of course what mattered was that they were dying on us."
>
> Medical Epidemiologist. State Government.

Both the Madrid and Barcelona participants described these first programmes as transgressive, subject to extreme external control, and not free from controversy. One professional pointed out that the control stemmed both from the morality of supplying an opiate substance to heroin users and from the appearance in the press of cases of independent professionals arrested for selling methadone prescriptions.

A participant from Madrid reported that in her city, the MTDP was called the High Marginalisation Programme because it was initially aimed exclusively at hospitalised people with a very low CD4 cell count. It was not until 1997 that the participants reported that the MTDP was introduced at the outpatient level in this city. They reported that although the initial aim was to approximate care for PWUS, the requirements to which they were exposed were far beyond what was achievable.

> "To give a person methadone they had to test negative in several controls, they had to comply with a series of requirements, it was a restrictive methadone. It was a methadone very close to the drug-free programme. [...]
>
> Even the dosage of methadone was limited. I have the contracts that patients signed, and they were withdrawn from methadone for using, and they were withdrawn from methadone for entering certain services."
>
> MD. Public Administration. Community of Madrid.

Participants agreed that PWUS experienced fourfold discrimination: for using heroin, for using the injected route, for using methadone and for being considered 'contagiously' ill. This scenario of severe stigmatisation was pointed out by one participant as the driving force behind the emergence of the first associations of PWUS in Catalonia, which began to act as a pressure group in the face of the first social complaints and political threats to close HR programmes. The response of the public administration was to promote the first Municipal Plans against Addictions.

A participant, a specialist in substance analysis services, added to the chronology that in that same year, 1997, in Barcelona, the so-called Risk Reduction (RR) was born, launching the first project aimed at substance use in a recreational context: Energy Control. Its widely known objectives focused on direct attention to people in leisure contexts, and the first substance checking services.

THE PRIVILEGING OF RISK AND THE PROBLEMATISATION OF HARM

The use of Risk Reduction and Harm Reduction terminology, its opportunities and limitations were a point where the group participants paused to discuss. All participants agreed that risk was associated with prevention, leisure and youth; that it was a purely academic and administrative distinction unknown to policy makers, PWUS and the community.

Both participants who are experts in European drug policies agreed that this conceptualisation is a differential characteristic of Spain compared to most European countries. Participants from public administration positions in Catalonia added that, in practice, the two fields worked together. Professionals from Madrid indicated that, in their territory, the concept of risk was used in the accompaniment of young people, and the concept of harm in the accompaniment of homeless people who use the injected route.

Although no participant argued or defended the existence and maintenance of this terminology, it could be observed that some participants raised their voices in favour of the eradication of this categorisation. One participant indicated that it had been useful conceptually, but that nowadays the reality is indivisible in most spaces. Another participant added that using the term risk or harm forced a generalised, and possibly moralised, classification of substances and uses.

> "The issue we are facing is that these types of domains are strict categories, which have changed a lot historically, and now are sort of tensions towards different positions between what these substances provoke to us, and what we are the objective for their consumption."
>
> European HR Policy Expert.

This problematization of the terminology *harm* was an element on which all participants agreed. One participant contextualised this as the prohibitionist model of drugs legacy, which assumes that the use of substances inevitably causes harm, removes the possibility of validating certain lifestyles, makes the social and structural causes behind these lifestyles invisible, and consequently encourages discrimination against the particular group of PWUS.

> "Let's talk about HR, methamphetamine use and women living on the streets - which is more harmful? Staying awake with the help of methamphetamine?, or falling asleep knowing that anything can happen to you through the night?"
>
> Anthropologist. Expert in gender and HR policies. Catalonia.

SUPERVISED CONSUMPTION

The next event that the group highlighted chronologically was the implementation of the first Drug Consumption Rooms (DCRs) in Spain. The first one in Madrid in 2002, and then Barcelona in 2004. Participants from both cities considered this strategy a key element for the HR model at the national level, reporting the experience of similar political and community resistance at first instance.

> "The first room was established in Las Barranquillas, which was the centre that changed everything. Suffering a lot of resistance, but that allowed the model to start changing. Well it actually changed it all."
>
> MD. Public Administration. Community of Madrid.

> "We wanted to open the rooms against all odds, it was a priority. They were opened despite the community and political opposition, but they were opened. They were aimed at a certain community and had certain objectives that completely differ from what we have nowadays."
>
> MD. Public Administration. Catalonia.

DCRs were described as the driving force behind the expansion of HR programmes and services. They were the starting point for changes in the MTDP design, allowing more flexibility in their criteria and extending their coverage with the incorporation of mobile units, the first drop-in services (Catalonia) or psychosocial risk centres (Madrid), and consolidating community or proximity intervention teams.

In spite of this progress, participants identified 2011 as a point of difference between territories. While in Madrid the first DCR had to close, due to the dismantling of the settlement where it was located; in Catalonia the DCR network was extended to the city of Barcelona and other municipalities in need.

Nearly 20 years after their implementation, the group reflected on these programmes. They found that their design reproduces a modal hierarchy according to substance and route of administration. They agreed that in the majority of cases, people turned to these services when all other protection systems had failed. These services placed substance use at the centre of the accompaniment, making the other vulnerabilities that affect people invisible.

It was also noted that, for these reasons, people who attend do not want to be identified as users. The impact of this element was pointed out by one participant with concern about the depoliticisation of people that it implicitly entails. The opportunity to improve these mechanisms at present does not seem to be able to operate on the basis of a demand from the users themselves, given that they are ashamed to go to DCRs.

The group was directly questioned about the current territorial inequality in Spain regarding these services. This dialogue led to two different implementation logics. The first was based on the prevalence of the use of certain administrative channels in a specific territory, and the community's perception of the need.

> "All the proximity services we have are there because the community has wanted and needed them. This is very important, because otherwise these services would not exist.. But the story is that neighbours want socio-educational teams, they want a place of reference, they want to work in HR... but they don't see and they don't accept, and it's also their money. Because they decide that with their money they don't want people to be consuming within the premises."
>
> MD. Public Administration. Community of Madrid.

The second, opposing logic, considered PWUS as members of the community and placed their care and accompaniment as a main objective.

> "There are real neighbours and others that are not neighbours at all. So I attend to the needs of one neighbour, but ignore the needs of another. We have to look after the most vulnerable communities."
>
> Psychologist. Public Administration. Catalonia.

In recent years the cities of Madrid and Barcelona reported having implemented specific DCRs to monitor alcohol use. Both cities integrated these services in homeless shelters, reporting positive results from the programme and in terms of community acceptance.

Three different terminologies were used to refer to these services: 1) Supervised drug consumption rooms, used by participants from Catalonia when referring to services with a drug consumption room for the inhaled and/or injected route; 2) Consumption Accompaniment Room, used by a participant whose provision was integrated within a drop-in service for women victims of violence in Barcelona; 3) Risk Reduction Sites, used by participants from Madrid to refer to housing support services for homeless people where alcohol use was supervised.

THIRTY YEARS OF HR, THIRTY YEARS OF PUTTING CONSUMPTION AT THE HEART OF HR

Participants were asked about the HR model that has been implemented over the last few years.

The common characteristics described were that it is an approach based on the biomedical paradigm, with an institutionalising character, which places substance use at the heart of the problem, applying a care logic from a multidisciplinary perspective. Participants who work in third sector organisations, whose daily practice is direct care, warned that this support approach segments people by problems (substance use, gender violence, mental health, homelessness, migration), falling far short of holistic approaches.

> "The current approach, not only in substance use, is the segmentation of the person. Here for housing assistance, there for violence, here for drugs ... and here nobody looks at me as a whole, in all my complexity and putting me at the centre as the expert of my own reality."
>
> European HR Policy Expert.

This model of accompaniment was pointed out as a factor related to social exclusion chronification. Participants indicated that placing substance abuse at the centre focused on individual causes and made other structural problems invisible, thus favouring the stigmatisation of these people.

Some participants added with concern that another consequence of this welfare model was the depoliticisation of PWUS. They pointed out that these people currently identified themselves as users of public services, thus disarticulating any collectivisation for the fight of rights. This narrative was conveyed as a loss of the essence of HR itself, harking back to previous decades when activist groups had lobbied the public administration for the implementation of new programmes and/or improvements to existing ones. Both European policy experts added that, in countries where these groups have been maintained, not only a better and more solid support network was observed, but also a greater restoration of rights for PWUS.

The majority of FG participants agreed that disbanding organised groups of people who use substances could lead to the assumption that their basic rights are already guaranteed. This scenario was very far from the reality described by participants.

Regarding the management of HR services and/or programmes in Spain, participants described that the first NGOs, which had operated as community-based rights' organisations, had now become service-providing agencies. This transformation was described as both positive in terms of the strength it provides to the permanence of HR services and programmes, and negative as a contributing factor to the depoliticisation of HR. This risk has been exemplified in situations of change of government, where the lack of pressure from independent groups (users and community organisations) to fight for and demand the guarantee and continuity of services and/or programmes could lead to cuts in services and/or programmes, or even to the dismantling of the network itself.

> "That [NGO management of services] has led us to develop strategies in a solid and more effective way. But it also means that when HR is threatened, and suddenly the political consensus that existed is lost, these pragmatic strategies are put at risk, because we don't have a community that will defend them beyond professionals who come from the academy and who, eventually, become depoliticised."
>
> Anthropologist. Expert in gender and HR policies. Catalonia.

At the community level, the focus on substance use was another element of the debate. On one hand, the nightlife direct care professional pointed to the importance of community acceptance as central. She highlighted that in her experience, when the community accepts that there is substance use among its members, they perceive HR services and/or programmes as an element of improving their own quality of life. The group warned about the influence of social class on this acceptance, pointing out that nowadays the majority of nightlife-related PWUS belong to the middle class.

> "If you approach it like that... What do you find? It's all acceptance. It's a stigma issue after all. If at the end of the day you find yourself in a community that is consuming, and that understands what you are doing is providing more activities that are recognised, they will accept them."
>
> Pharmacologist. Expert in substance analysis programmes. State Level..

On the other hand, the other participants agreed that, despite the expansion of the HR network, in most of the areas where it was implemented, the community immediately associated the use of its services with poverty and marginalisation, and was immediately confronted with a rejection of identification and an increase in complaints about a response that they felt was far removed from their needs. One participant illustrated this reality by describing an existing conflict in an area where the community was demanding action from the administration in relation to drug trafficking and insecurity, and the implementation of HR services as a response that did not solve the problem, but rather exacerbated it.

> "A lot of people interpret that if you have a service like this, you're going to stop the drug trafficking and insecurity in the neighbourhood. So they are disappointed because they associate the HR with ending drug trafficking, with insecurity in the neighbourhood, and with ending muggings and so on. When they don't realise that the HR programmes are for people who are closely linked to the community, people who are part of the community and that you can work with them. And they're disappointed... they're disappointed that you don't stop all that. In the end, what do they want? To get rid of PWUS, to get rid of poverty... there's a lot of confusion."
>
> MD. Public Administration. Community of Madrid.

The invisibility of excluded PWUS in public spaces as the ultimate expression of poverty was also an aspect that participants reflected on. They pointed out that community dynamics had changed in recent years. On the one hand, they reported that the dismantling of settlements and their drug points of sale had led to a displacement of PWUS. On the other hand, the gentrification process and the housing crisis had favoured the location of these drug outlets in city centres and, consequently, the settlement of PWUS. Despite the fact that many inner-city neighbourhoods had historically been inhabited by poor and working-class people, recent unregulated processes of gentrification had resulted in people with greater purchasing power replacing the traditional neighbourhood fabric.

> "It's costing us a lot [the permanence of HR services] because apartments are worth millions right next to where the service is located. We are fighting tooth and nail, because neighbours don't come anymore, it's just their solicitors. Because they live in one million euro and two million euro apartments, so... This is a very different kind of community mediation."
>
> MD. Public Administration. Community of Madrid.

All participants agreed that the community work and mediation continued to be essential for the HR, although it had to adapt to the new dynamics. Participants from the public administration recognised that this task is best carried out by third sector organisations, praising their background and experience in dialogue between actors (politicians, neighbours, administrations, professionals and users) who at first sight can have very rigid and distant positions. Two professionals from Catalonia, when implementing a support service for women victims of violence using a HR approach, reported as good practice the strategy of moving consumption out of the centre through community mediation.

> "It's about focusing on the people rather than on the consumption. It doesn't mean that it doesn't exist because it does, but it implies its articulation in other ways that are more manageable. In this sense, you are pointing out the multiple situations of vulnerability and not the consumption. That also helps you to work with the community from another place."
>
> Psychologist. Public Administration. Catalonia.

HARM REDUCTION 2.0.

Finally, participants landed on the context in which they currently find themselves. The substance analysis expert reported that the illicit drug market and substance use patterns have changed significantly since the beginning of the HR implementation in Spain. Several participants noted the importance of changes in opium cultivation in Afghanistan in recent years, which have led to increased adulteration of the heroin available on the country's illicit market. One participant expressed concern about the need for systematic monitoring of these dynamics in order to anticipate shortages of this substance. Another participant added that the early warning system was seen as an effective response to identify and anticipate these possible changes.

> "Heroin is highly adulterated nowadays, we know what is happening in Afghanistan, we know that they have changed the opium cultivation. So we also know that if the heroin supply fails we are more likely to receive other options. But we have also been implementing HR for over 25 years and we have early warning systems in place."
>
> Pharmacologist. Expert in substance analysis programmes. State Level..

Also from this global perspective, several participants pointed to the epidemic of synthetic opioids and amphetamines in the USA as a scenario that should also be given special attention. Participants agreed that Spain had a greater HR response capacity than the US, and praised the extensive development of HR services and/or programmes over the last 30 years. Nevertheless, the group remained very cautious about the possibility of reproducing a situation with similar characteristics in our country. Despite the specific emphasis on the inclusion of heroin maintenance programmes as a response to this change, none of the public administration representatives expressed their opinions.

In terms of substances and use patterns, all participants agreed that there has been an increase in the use of stimulants, particularly methamphetamine. A participant from Catalonia added that they were also seeing a shift from inhaled crack cocaine to methamphe-

tamine. This increase in stimulant use was identified by the government representative as a challenge to existing HR services and/or programmes, which were initially designed to respond to opiates.

> "The increased presence of stimulants poses very new challenges, which are yet to be thought about and resolved. They threaten the viability of services, because it is not the same to inject an opiate and stay relaxed for a few hours as it is to get methamphetamine and go crazy, revolutionising the neighbourhood and come back after a couple of hours to recharge. These are very different contexts."
>
> Medical Epidemiologist. State Government.

The nightlife sector warned of both an increase in the diversity of substances and an increase in intoxication at large festivals attended by the emergency services. Administrations and professionals agreed on the importance of maintaining and extending drug checking services to the entire population that uses substances, regardless of the context in which they are used. This proposal, made by the group of participants, could be a first strategy to dissolve the boundary between HR and RR, as requested by the participants themselves.

The current situation of the HR network was described as a structure made up of third sector agencies and the public administration, with resistance from the community.

Some successful experiences of HR services and/or programmes had opted for a decentralised approach to substance use and had also incorporated components of oppression and violence caused by the intersectionality of the sex-gender axis in their accompaniment.

Harm reduction rooms for alcohol consumption in first reception centres in Madrid were reported as good practices for homelessness. Also, they highlighted the existence of similar facilities exclusively for women also in Madrid.

> "We started with these alcohol consumption rooms in 2012, initially within the homelessness care centres. They were seen as a good possibility to provide support to the homeless community. This makes them an important service in both shelters and the streets. These DCRs work well, we buy the boozes and keep them in the services."
>
> MD. Public Administration. Community of Madrid.

In the case of Catalonia, it was recognised that, although the model of care for homelessness had limitations in terms of HR, a pilot mixed shelter for homeless people had been implemented, designed with a gender mainstreaming perspective, with DCRs for both injecting and inhaling substances, and with an alcohol maintenance programme. This experience had shown very good results and was considered good practice to be replicated.

> "One of the things we should do is to replicate the Barcelona shelter, which is a model of good practice, but also to adapt the rest of the shelters."
>
> Psychologist. Public Administration. Catalonia.

The experience of integrating HR in the network for addressing male violence could also be drawn upon. Throughout the FG, reference was made on several occasions to a drop-in service in Barcelona for women and gender-diverse victims of substance-related violence, which had very good results in terms of activity and community acceptance.

> "This is not about consumption, this is about violence, this is about homelessness... and we have to incorporate consumption because it is a part of them, and of their coping mechanisms, of dealing with trauma..."
>
> Anthropologist. Expert in gender and HR policies. Catalonia.

All participants agreed that the HR model is undergoing a period of review and reform, where both the involvement of younger professionals and the community are essential to understand and provide appropriate responses.

> "Younger people are the ones who teach you how to adapt your project to the new needs. We are facing new substance use patterns, homelessness, gender, violence, migrant women, the entry of methamphetamine... how all of this creeps into recreational settings every now and then, all the new substances... There are a lot of stories that are happening and we need to understand the reasons why and how to address them."
>
> Pharmacologist. Expert in substance analysis programmes. State Level.

Reducing discrimination and restoring the fundamental rights of PWUS were two elements that were repeatedly mentioned by all participants. The positive involvement of the media was another aspect that came up at different points in the group as a key element in reducing stigma.

3.2. HARM REDUCTION AND GENDER

AUTHOR: GARAZI RODRÍGUEZ BRUÑA

INTRODUCTION

In recent decades, there has been an emergence of harm reduction (HR) studies that view the gender axis as a patriarchal artefact that produces inequalities which also affect substance use.

In this line, synchrony and parallelism between the spectra of HR and the continuum of gender identities are identified, since in the universe of HR, practices with different levels of risk are intertwined with uses related to different effects, ranging from benefit to harm.

This continuum fits perfectly with the range of possibilities and forms offered by gender identities, sex, gender expression and sexual orientation. But where is the approach to masculinity from a gender perspective in HR? Doesn't hegemonic masculinity also cause discomfort and harm to cis and trans men?

METHOD

A quantitative methodology was applied based on the development of two focus groups. Chronologically, the first focus group (*FG-Professionals*) was composed of people with a professional relationship in the field of gender and harm reduction (HR), while the second focus group (*FG-First Person*) was composed of people who presented first-person experiences as users of harm reduction services, programmes or projects and/or social accompaniment. Both focus groups formed the data collection instrument.

The criteria for the inclusion of the *FG-Professionals* were: to present a professional career in the field of specialisation and/or activism in harm reduction and in the intersectional gender perspective. The diversity of territories in Spain was guaranteed to be representative, as well as including international representation. The territory of Canada was selected because it is recognised for its investment and commitment to services centred on HR and gender; and Argentina, where, despite the fact that substance HR had limitations, the gender and homelessness community entities presented principles, values and strategies that are characteristic of HR.

Another element that was taken into account in the selection of *FG-Professionals* was that they had to embrace the concept of harm reduction as a broad strategy, in which substances and their problematic use do not necessarily occupy a central place in the accompaniment. This facilitated the inclusion of 2 professionals whose daily practice was not currently framed within the HR network, although they accompany women in a situation of active substance use and social vulnerability.

This FG was led by the expert on gender and HR. It counted on the observation of both the UNAD technical professional and the research coordinator. It was carried out telematically and lasted a total of 2 hours.

The *FG-First Person* was carried out face-to-face in the Basque Country and lasted 2 hours. Inclusion criteria included identifying oneself as a woman or gender-dissident, presenting experience and background in the use of substances and being in a situation of homelessness. The participation of both migrants and Spanish native people, as well as age diversity was guaranteed.

Access to the participants was facilitated by the '*Borobiltzen*' project of '*Bizitegi*', a space designed as a meeting place for women and people with different gender identities and sexual orientations in a situation of serious social exclusion. The organisation's professional team provided the space for the meeting and disseminated both the objectives and the characteristics of this FG. This FG was also facilitated by the researcher who is an expert on this subject. The total duration was 2 hours.

A total of 6 people participated, all of whom described a life history of different types of violence (mostly perpetrated by their male partners or ex-partners), deteriorating mental and physical health, and periods of homelessness and sleeping rough situations.

One woman refused to participate in this FG, claiming to be in conflict with another person present and not to feel that the space was a safe place. With this in mind, the participant was offered the opportunity to answer the questions electronically. In addition, three women of North African origin were unable to participate due to language barriers and the impossibility of providing simultaneous translation during the FG.

In both FGs, the participation of women and people with non-hegemonic identities was prioritised. As a result, this variable was established as a positive action in the selection criterion over and above voluntariness per se. Participation was voluntary and not remunerated.

RESULTS

INTERSECTIONALITY: HARM REDUCTION WITHOUT REDUCTIONISM

The first aspect that was addressed in the *FG-Professionals* was the identification of the different harms

that the HR network must reduce in terms of gender. Participants pointed out that the application of a gender perspective inevitably starts with the design of the accompaniment model itself. Only from there will it be possible to consider the degree of oppression of the different axes of inequality and their intersections in each of the lives of service users.

From this point of view, participants agreed that HR has the necessary characteristics to be an approach capable of liberating and alleviating the discomfort caused by systems of inequality. One of the participants clarified that in order to achieve a '*full spectrum*' of accompaniment, the social justice and human rights perspective should not be lost, thus avoiding the reductionism of considering only the health damage caused by the use of substances.

> "Substances are a part of HR, but I think the main harm to be treated is any symptom or discomfort from the discrimination or exclusion, murderous policies in patriarchal and marginalising states."
>
> MD. Experience in HR services. Catalonia.

FG-First Person participants pointed out the need to create and adapt HR strategies to the different oppressions axes that had run through their lives: male violence (sex-gender axis), lack of access to safe and permanent housing (social class, country of origin, administrative status, mother tongue, sex-gender axis), barriers in the labour market (social class, country of origin, administrative status, mother tongue, sex-gender axis), stigma due to substance use and/or mental suffering and mental pathologies.

GENDER AND HARM REDUCTION

Each participant of the *FG-Professionals* provided different definitions of the term harm reduction and gender. This allowed the identification of two concepts with no commonalities and differences.

> "In the face of "screw up" or "mistake", "harm", "violence", harm reduction is a space that can be used to think about how we can cushion this impact a bit."
>
> Women and LGTBIQA+ people in a street-based situation companion. Argentina.

When asked what the basic objective of HR is in relation to women and gender-dissident people, the participant from the Valencian community replied: '*For us, HR is that women don't die*.' The priority of reducing mortality was shared by the other participants. One of the professionals from Barcelona stated '*my goal in harm reduction is basically that someone goes from surviving to living*.'

It is also worth adding the concern expressed by one of the participants to try to reduce people's suffering as much as possible and to direct efforts towards the source of discomfort, '*because at the end of the day, in addiction, regardless of the person's gender, there is pain and alleviating it must be a priority*.' In this way, the usefulness of the harm reduction approach as a valid tool to address the root causes of people's suffering could be observed. The *FG-First Person* agreed with this perspective, identifying different relationships with substances depending on the time of life. Even so, the majority conceived substance use as a form of escape and relief from situations of discomfort.

All participants in both focus groups agreed that problematic substance use was directly related to the situation of vulnerability in which the person finds him/herself based on the oppression of different degrees of inequality.

> "I became homeless at the age of 58 and I was aware of how consuming only took away my money."
>
> Cis woman. Social care services participant. Basque Country.

Finally, it should be noted that user participants expressed a low level of knowledge about the HR network and services available in their area. They pointed out that these are mainly abstinence-based treatment programmes.

HARM REDUCTION AND INCLUSIVE SPACES

The overall aim of both focus groups was to explore and explain the conceptualisation of Harm Reduction from a gender and intersectional perspective.

Exploring the intersections and oppressions of different axes of gender inequality required that during the implementation of the FG, the dialogue between the experts was encouraged through reflective questions on the current situation of the HR model. The first concern emerged was who are the beneficiaries of HR services and/or programmes with a non-mixed design and who are excluded from them.

Participants agreed that all gender identity diversities should be included, with the exception of those who identify as cis men. Participants with professional experiences in non-mixed HR programmes reported that gender mainstreaming was initially designed by cis-women and aimed to provide responses to the needs of cis-women who use substances. Two participants added that some of these services and/or programmes have been adapting to changes in social reality, modifying their design and broadening the target group. This adaptation was highlighted as an element of

improvement in the gender-sensitive perspective of the harm reduction model, even though they indicated that it implied questioning the '*woman*' identity, its limitations and related problems.

> "Non-mixed HR services are scarce and mainly oriented towards women. Most of them are aimed at cis women. Then, new trends appeared and we started to think that the term "woman" goes beyond cis/trans. I think we should talk about Harm Reduction in non-mixed spaces for LGTBIQ+ people."
>
> MD. Experience in HR services. Catalonia.

Another participant specialised in single-sex spaces abroad recounted the experience in her organisation.

> "What happens to us is based on our own experience. When we started many years ago, we worked with women in vulnerable situations. They were all cis women with children. Then, because of the projects and the transformation we were going through, trans women, mainly trans and transvestites, started to come to our space."
>
> Women and LGTBIQA+ people in a street-based situation companion. Argentina.

All participants agreed on the need to incorporate a broader vision of women's identity. The current situation was defined as '*static*', '*archaic*', '*timeless*' or '*a product of patriarchy*', with designs needing to accommodate the full range of diverse and possible identities.

In relation to the exclusion of cis men in non-mixed HR spaces, participants agreed that a high percentage of people who use these spaces have been victims of violence perpetrated by this community group. One participant pointed out that placing this condition as a central criterion of exclusion allows for a collectivisation of the possible traumatic experience. The creation of spaces to which access is restricted has been identified as an element that guarantees both safety and a sense of being cared for and, as far as possible, helps to reduce exposure to certain types of violence.

The *FG-First Person* agreed that non-mixed spaces increased their sense of comfort, greatly reduced situations of abuse and harassment, and increased the sense of freedom mediated by the controlling gaze of the cis-male. Most of the participants also agreed that in mixed spaces, they are the main focus, whereas in non-mixed spaces, connecting with other people and creating affective networks based on peer support can happen.

However, both focus groups questioned whether simply introducing non-mixed spaces guarantees that they are safe places free from sexist attitudes.

> "Machismo is annoying, and it is done by both men and women, there are also macho women here."
>
> Cis woman. First-person experience. Basque Country.

A female participant *FG-First Person* on the other hand complemented this broader view of violence occurring in non-mixed spaces by pointing to machismo as the main structural cause, assuming that macho behaviours can be carried out by all people.

> "I don't come here just because there are women, it's a coincidence. I have nothing against men. I hate machismo and I prefer feminist men to chauvinist women."
>
> Cis woman. Social care services participant. Basque Country.

As a continuation of the violent dynamics observed in non-mixed spaces, a trans woman from *FG-First Person* mentioned the fear of transphobia.

> "Normally I do feel safer in women's spaces. Although with the whole issue of TERFs and transphobia... (...) I mean, what's going to happen? Am I going to suffer violence here now too?"
>
> Cis woman. First-person experience. Basque Country.

Participants of the *FG-Professionals* denounced the scarce availability and slow expansion of the network of non-mixed HR services and/or programmes. They felt that they were inadequate and did not prioritise the specific vulnerabilities of women and LGTBIQA+ people in active substance use. They also reported that most state territories currently did not have exclusive services for women and LGTBIQA+ people designed from a HR perspective.

> "Here the specific programmes that are being done for women and other identities are more dependent on different problems and not on consumption issues."
>
> Social worker. Experience in HR drop-in services. Valencian Community.

The professional from Argentina described a situation of regular violence that usually occurred at the entrance to the non-mixed space where she works. This experience was shared by the other participants.

> "In our case (cis-heterosexual) men are always waiting for the girls to come out of the premises. They can't go in, but they go around and this is often a cause for dispute between them (...) somehow, instead of being beyond gender and queering, we are in reality, strengthening the difference."

Women and LGTBIQA+ people in a street-based situation companion. Argentina.

Another participant reflected that when this type of situation is observed in non-mixed spaces exclusively for women, the binary gender division of male and female victims of violence is reproduced, which can create a '*rebound effect*' that reinforces hegemonic stereotypes of '*masculinity*' and '*femininity*'.

Another aspect that was questioned was the inclusion of cis-gay men in non-mixed spaces. All participants in the *FG-First Person* agreed that this group should have access to these spaces, focusing on violence and not so much on the situations of violence created by the expansion of the target groups of the services.

> "To me the problem is violence. I don't care about their gender identity and orientation."

Cis woman. Social care services participant. Basque Country.

This was echoed and nuanced by a professional with long experience working on various HR programmes, who commented as follows:

> "There are many spaces in which gay boys, (...), in vulnerabilities, traumatic processes and in violence, are totally excluded and I think that we should start including them.."

MD. Experience in HR services. Catalonia.

The reasons for disagreement about the inclusion of the gay community by other professionals stemmed from the potential for new violence that this could bring. They pointed to the violence that can occur between different axes of oppression.

According to the professionals, the answer to these questions lies in involving the reflexive participation of the users of these services and/or programmes, as well as in constant professional accompaniment in the individual and collective work of identifying and raising awareness of the experience and reproduction of violence.

THE CHASM: FROM WELFARISM TO ACTIVE PARTICIPATION

The feminist approach involves users at different levels of service structures playing an active role in services and programmes. Another element examined was the active participation and role of the people to whom services are directed in the different spaces.

Women with experience as service users mentioned being involved in the programming of the centre's cultural agenda and having meeting places to share their opinions and interests. Despite this, several participants shared the feeling of not being listened to when it came to higher-level decisions, such as those related to changes in housing or problems of cohabitation.

One woman, a former peer worker in a shelter, added that she did not feel that her opinions had the same value as those of her colleagues (non-peer workers). The following quote shows that there is still room for improvement in the involvement of peers in supporting these services.

> "The educators were my colleagues, they believed in me and gave me a lot of confidence, and I don't think I let them down. But then, when I stopped working as a peer, they wouldn't listen to me when I reported having conflicts with other people."

Cis woman. Social care services participant. Basque Country.

On the other hand, it was also interesting to analyse the degree of involvement of the target groups in the operating rules design. Most of them agreed that their involvement was very limited.

> "EIn these spaces we are never asked about the rules. Generally the rules are already there when we arrive."

Cis woman. Social care services participant. Basque Country.

These contributions were linked to the message expressed by one of the professionals in a non-mixed space, who pointed to the reproduction of systems of hierarchy, power and domination, despite the fact that both the professionals and the users of the space are women. She pointed out that it was common for female professionals to display patronising attitudes towards female project participants. In addition, the different accounts of the participants revealed situations in which women users had been deprived of their agency and capacity to act, thus promoting the role of passive recipients of services.

MASCULINITIES AND HARM REDUCTION

Patriarchal masculinity and its accompaniment with feminist masculinity was another aspect raised in both focus groups. Several *FG-Professionals* emphasised the importance of considering men as survivors of violence from an early age. They emphasised that implementing a gender perspective in HR should include working with men, which is essential if violence is to be reduced.

> "There is a need to work on the violence issues with its main perpetrators also, because otherwise the work is not bidirectional and will not serve any purpose."
>
> MD. Experience in HR services. Catalonia.

Another participant in the same group shared his experience of working in prisons, running workshops and setting up support groups for men, who reported partaking in chemsex practices. He pointed out that, when designing and making these spaces more dynamic, it is crucial to take into account the influence of gender mandates on some chemsex practices, especially those that are considered more risky. Another participant from Valencia reported on another initiative in this field, which consisted in the creation of practical guides on the violence experienced and reproduced by men who use substances, based on the experience of accompanying a group of this type in her organisation.

On the other hand, the lack of tools and resources to create spaces to address hegemonic and dissident masculinities with male service users was a concern shared by the Canary Islands participant.

> "Our colleagues were very anxious about what kind of men we are, how we work with the boys, what kind of authority we have with them (...)."
>
> Responsible for processing. Canary Islands.

Finally, one of the participants in the same FG contributed to the debate with the situation in Argentina, where she noted the accelerated production of legislation in the field of gender and the consequent assimilation of feminist thought. She observed that the radicalism of one's own ideas was diminishing. Other participants shared this concern about the assimilation of rights as a result of legislation. A parallel was drawn with Spain, where the '*Ley de Protección Integral contra la violencia de género*' came into force.

In the *FG-First Person*, participants related masculinity to violence, repeating the discourse that violence should be addressed with both men and women.

VISIBLE VIOLENCE; INVISIBLE VIOLENCE

From the analysis of all the stories, it is clear that the participants drew a triangle of intersection between harm reduction, gender and violence.

As mentioned above, most of the participants in the *FG-First Person* explicitly verbalised that they had survived different types of violence, mostly perpetrated by their parents. Despite this, several professionals participating in this FG pointed out and complained about the lack of existing protection services for women and dissidents who are victims of violence in a situation of active substance use. This lack of support was identified as an important element in not only triggering the person's subsequent serious lack of protection, but also in them becoming the victim of a new episode of violence, this time institutional.

The most invisible violence identified in both groups was intra-gender violence perpetrated by women service users against each other.

> "The invisible violence is our violence; what is most difficult for us to express is our own violence. Violence among our female peers (...). There we see very clearly all the gender stereotypes: the feminisation of our strength and the feminisation of our attitudes as women, like if violence could not be part of it."
>
> Women and LGTBIQA+ people in a street-based situation companion. Argentina..

This was followed by most of the participants nodding in agreement and expressing concern about the issue.

For the *FG-First Person* participants, the analysis was as follows: In the non-mixed spaces where they live and work, they noted the presence of episodes of violence on a daily basis. All of them stressed the disappointment of experiencing violence in spaces created to reduce hostile and stressful elements. Most of them agreed on the impossibility of creating violence-free spaces. One of them compared it to social movements.

> "You go to social movements and you see transphobia, you see machismo...from people who are supposed to be allies and who think the same way as you, and in the end that is more violent."
>
> Transgender woman. Social care services participant. Basque Country.

This element was in line with the opinion expressed by several professionals in the field, who referred to the consideration of violence as an instrument of power to which people have access, an instrument that is denied to bodies that are feminised or not interpreted as masculine.

In this sense, a large part of the participants in the study highlighted the management of high violence situations as one of the challenges in HR places for women and LGBTBIQA+ people. A professional from a housing support service shared her experience on managing the detection of violent behaviour between women.

> "Observing these dynamics meant accepting the violence inside the institution, because if we were to be like "the one who acts violently loses the bed" would mean everyone will be out".

With regard to the range of strategies for preventing, reducing and dealing with violence in the spaces, the following were mentioned. The '*No tan distintes*' collective created a therapeutic and intimate space where participants could talk about situations in which they had been violent without being judged. Another suggestion was to create a common language that moves away from complacency and makes it possible to take responsibility for the harm caused. In this context, a professional with experience on working with people deprived of their liberty stressed the general tendency to respond to violence with more violence and the urgent need to develop proposals that are far from punitive.

> "When violence has been exercised within groups, the reaction of the people who participate is a punitivist need to punish the people who have exercised this violence."
>
> Companion technician of LGTBIQA+ asylum seekers and LGTBIQA+ people in prisons.

Participants of the *FG-Professionals* agreed on the importance of approaching violence from the perspective of collectivisation and reparation of damages. From this point, it would be possible to eliminate condescending attitudes and reinforce victimisation with which institutions and/or professionals often treat the aforementioned community. Finally, users themselves pointed out the importance of providing people with educational strategies and giving visibility and a voice to people who may be being assaulted.

Framing stigma as a form of violence, participants of *FG-First Person* reported that they received less discriminatory treatment when going through different administrative procedures if they were accompanied by a care worker. One of the participants reported being treated in a prejudicial way because of her physical appearance in one of the drop-in services she attended. Another participant pointed to transphobia in different social care settings as a barrier to accessing night shelters.

> "I also don't go to housing services because I'm afraid of getting into trouble or being allocated with men."
>
> Trans woman, Social care services participant. Basque Country.

Faced with the emergence of situations of discrimination and the transformation of stigmatisation into self-stigmatisation, several professionals reported that they had opted for group support as a strategy to have a positive impact both on individuals and on the communities to which they belong.

Suicide was another of the invisible forms of violence on which opinions were exchanged. A professional from an HR centre in Valencia shared the following experience:

> "In almost every edition of our programme we lost someone and it is complex. There is little data. It is a taboo topic that nobody wants to deal with"

In response, participants suggested creating new spaces where professionals and users could share these issues and remove the socially acquired moral burden of suicides. The group also highlighted the importance of prevention, as suicides sometimes take the form of 'accidental overdoses' that could have been avoided.

DIVERSE

Finally, the *FG-Professionals* were asked about the characteristics of their working groups, while the service users were asked about the elements they considered essential among the professionals in the spaces where they work on a daily basis. In this sense, the participants of the *FG-Professionals* identified a diversity among their peers, but pointed out a certain homogeneity and quality at the highest level. There was a certain unanimity in reporting the imbalance of cis men in positions of power compared to women and LGTBIQA+ people, as well as the rigidity of the approaches of the HR models, the lack of connection with frontline work and the abuse at work exercised by senior managers of different entities.

On the other hand, users mentioned the following characteristics that professionals should have: '*Patience, empathy, resilience, tactfulness, class-consciousness, psychologically prepared and cold-bloodedness*.'

3.3. HARM REDUCTION AND AGEING

AUTHOR: ELISABET MARÍN RECHE

INTRODUCTION

Older people with substance use problems were a community described in the previous study as under-served in the Spanish health and social care service portfolios. The main challenges highlighted were: the need to reduce or eliminate the barrier to access to basic rights, particularly to adequate housing, and the requirement to adapt HR services to their specific needs.

In addition, multiple factors of oppression were described as intersecting with older people with SUD (substance use disorder), such as socio-economic class, gender, origin, race and other multiple intersections that outlined an unequal scenario in terms of the violence described, both individual and structural, accessibility to services and guarantee of rights.

METHODOLOGY

With the aim of finding out about the situation of older people actively using substances in Spain, the focus group (FG) was used as an information-gathering technique within the framework of qualitative methodology.

Therefore, the sources of information were the participants of two different focus groups, the first composed of people who used substances regularly or have been using for a long time, and the second composed of people who had professional experience in supporting this community group.

The inclusion criterion for the focus group of people actively using substances, hereafter referred to as *FG-First Person*, was age. It was also assessed whether the participants were, or had been, in close contact with older people in active substance use. In the selection process, participants with heterogeneous characteristics in terms of gender, race, origin and administrative situation were selected.

In the focus group composed of professionals, hereafter referred to as *FG-Professionals*, the inclusion criterion was that they had a long professional experience in accompanying PWUS. The diversity of professional disciplines and expertise was also taken into account. An attempt was made to ensure geographical diversity, with the aim of being able to count on intervention models and contexts that are more representative of the current Spanish scenario of drug dependency treatment.

In order to carry out the *FG-First Person*, the search method used consisted of contacting the main drug dependence care services operating in the city of Barcelona to request their collaboration in recruiting participants.

For the *FG-Professionals*, the search method consisted of selecting agencies that intervene with communities with problematic substance use. The search was carried out through the social and health services portfolios available on the websites of the different city councils and . The managers or coordinators of the services were contacted, and introduced to the research derived from the conclusions of the first phase of the diagnosis of Harm Reduction in the 21st Century Study (UNAD, December 2002), which identified the elderly community with substance use problems as a priority group due to their vulnerability.

Both groups were facilitated by the expert researcher in the field of harm reduction and ageing. The *FG-Professionals* were observed by both the UNAD expert and the research coordinator. Both focus groups lasted two hours. The *FG-First Person* was face-to-face and took place in the city of Barcelona. One of the main factors that led the researcher to conduct it in this city, and thus not to apply the criterion of geographical diversity, was the barriers in terms of economic resources and digital skills of this community. This element was a limitation because the telematic format of the meeting had to be rejected, as many people did not have a device with an autonomous connection and their travel to another territory did not comply with the principle of reality.

A total of 13 people took part in the focus groups. Regarding the characteristics of the *FG-First Person* sample, of the 7 participants, 5 were women and 2 were men. The *FG-Professionals* sample consisted of 6 people, 5 women and 1 man.

In the *FG-First Person* a total of 8 people refused to participate. The main reason for this was the difficulty that older people had in terms of mobility to travel to the place where the session took place. It should be noted that the main limitation in recruiting people from this group was the degree of physical and mental deterioration. This was a determining factor in the absence of some of the invited.

RESULTS

Participants from both groups agreed that people aged 45-50 belong to the elderly community in a situation of long-term substance use. They agreed on the description of a key characteristic of this group: premature ageing caused by factors related to physical health and factors

related to mental health. Participants pointed out that these elements are intersected by axes of inequality and oppression, such as homelessness, gender-based violence and irregular administrative status, which can intersect with multiple other axes of vulnerability, such as race, background, informal economic activities such as sex work, etc., and act as triggers or aggravators of illness, premature ageing and even death.

> "To me: the element is the street; and the age is 50. There is data that puts it (substance use people's ageing) in their 50s. English studies say that the life expectancy of people in the street drops 20 years. So, then, we make a parallel, I would say, that at the age of 50: elder and even death, which is much more complicated."
>
> Internist. Long professional career in hospitals and addiction treatment centres. Catalonia.

ORGAN AND PHYSICAL HEALTH DECLINE IN AGEING PEOPLE WITH ACTIVE SUBSTANCE USE

Deteriorating physical health was one of the main risk factors for premature ageing that emerged in both groups.

The *FG-Professionals* participants from Madrid, Catalonia and Asturias agreed on the serious impact of bone pathology on ageing. They pointed out that it is associated with a significant reduction in mobility and therefore, in many cases, a reduction in personal autonomy. Reference was also made to the serious deterioration of the feet in this community group, which often lives for long periods of time sleeping rough, leading to pathologies such as plantar heloma, fungus, spurs, etc. that may end up complicating and decreasing functionality.

Long-term, regular substance use and the organic progression of transmissible infections such as HIV or hepatitis C were two causes of ageing that generated debate and disagreement in both focus groups. On the one hand, some participants highlighted substance use as the main cause of physical decline and premature ageing. In both Catalonia and Madrid, alcohol was reported as the main substance used by people living on the streets, with the associated health damage, both physical and organ, highlighted as the most serious. It was also highlighted in both groups that the different risk factors for developing pathologies or physical problems are mostly related to the harm associated with the substance use pattern and not to the substance use itself. The variables of interest were poly-substance use, route of administration, quality of substance, frequency of use and context of use. One participant in the *FG-First Person* reported on her own experience:

> "Yes, it depends on how you use, the way of using, whether you abuse substances, the amount, the way you use, the substances, the quality, you know?"
>
> 35 years-old Italian woman. Linked to different HR services and/or programmes.

FG-Professionals participants, particularly those from Catalonia, argued that the impact of disease transmission associated with substance use was less important, emphasising instead structural and psychosocial factors such as social exclusion and gender-based violence.

> "I wouldn't give much importance to associated diseases, because in most cases you can live with them. For instance, we can nowadays live with Hepatitis C or HIV. And it's the same for substances. I think you will all agree that the important thing about substances is the context in which they are consumed, not the substance itself."
>
> Internist. Long professional career in hospitals and addiction treatment centres. Catalonia.

Most *FG-First Person* participants highlighted the impact that living in marginalised contexts and poverty have on physical ageing, over the substance use per se.

> "On the contrary, I've seen that those who consume stay young (laughs)... Beautiful skin... Maybe destroyed from the inside, who knows. I think that what E. means it's more a social context: the lack of money, the lack of resources destroys you, but not the substances. We are not talking about substance use, we are talking about active substance use by oneself, I don't think drugs make you old."
>
> 35 years-old Italian woman. Linked to different HR services and/or programmes.

In both focus groups, some participants pointed to gender-based violence, machismo and the daily abuse suffered by women and people who do not belong to the cis-gender as the main cause of physical deterioration and premature ageing in women who use substances.

> "(...) if I make a general analysis of my day-to-day work, which is mostly with women, I can say the age of 45, and the elements that trigger this early ageing are situations of violence."
>
> Social anthropologist; Palma de Mallorca. HR Intervention and political activism for human rights. Balearic Islands and Andalusia.

Only one *FG-First Person* participant and two *FG-Professionals* participants from Madrid and Catalonia directly mentioned substance use as the main risk factor for physical and organ deterioration. It should be noted that this user was in a situation of abstinence.

> "It's the over-consumption, the lifestyle and genetics that influence ageing. What you have to do is to get out of that situation, there are programmes and support to get a job, to feel fulfilment."
>
> 51 years-old Spanish man. Currently abstinent. Catalonia.

PSYCHOLOGICAL AND MENTAL HEALTH IMPAIRMENT IN OLDER PEOPLE WHO ARE IN ACTIVE SUBSTANCE USE

Several risk factors were identified by participants in relation to psychological and mental health decline. As in the previous section, long-term substance use, although relevant, was not identified by the majority of participants as the main risk factor for psychological decline and premature ageing.

The *FG-First Person* discourse analysis ranked methamphetamine, amphetamine and cocaine as the substances with the highest associated risk for mental health.

Nevertheless, negative effects were not identified as long-term physical or mental health consequences, but as occasional experiences of psychotic crises induced by stimulant use.

> "I mean people who use substances, have paranoia and so on. I've seen cases where after consuming they freak out, with rare movements and very accelerated."
>
> 42 years-old Slovakian woman. Linked to different HR services and/or programmes.

In this section, lack of economic resources and experienced violence were also identified as the main stressors and triggers of mental health problems. A differentiation of mental health problems could be observed according to the situation of the community. Participants in the FG working in a housing support service in Asturias, Catalonia and Madrid identified major depressive disorder as the main problem for older people in institutions. They pointed out that the difficulties of access to the labour market and to property for people with a long history of homelessness led to a lack of life expectancy aimed at social integration and autonomy. They described that this situation is exacerbated for people who have also gone through a migration process and have been in an irregular administrative situation for a long time. The discouragement of not achieving personal naturalisation goals and the consequent difficulties in obtaining economic resources had an impact on people's emotional health, leading to a general state of exhaustion and deterioration. In summary, it was reported that the possibilities of living a non-institutionalised life were scarce in this community, which was linked to a self-perception of failure and idleness that had a direct impact on people's mental health.

> "It's true that newcomers look old, and we also see them as old. And above all, it is due to the lack of illusion or expectations to face up their lives. Many people come with physical handicaps due to illnesses, but I think it's more emotional. And restarting it's sometimes very hard. It's like forgetting yourself, isn't it?"
>
> Social worker. Substance use care organisation. Asturias.

On the other hand, people from the *FG-First Person* who had lived for long periods on the street or without a suitable home, reported that the main mental health problems were stress and anxiety due to lack of basic resources. In the case of women or gender-dissident communities, gender-based violence, often in all its forms, and non-compliance with assigned gender roles, such as motherhood or caregiving, were reported by both groups as pervasive self-perceptions of self-stigma and self-rejection.

In the following quote, the situation of one of the participants can be analysed as an example of the intersection of different axes of oppression that significantly increase the chances of developing mental illness. In this case, the irregular administrative situation, which limited the possibilities of earning an income, together with gender as a factor of vulnerability.

> "In Barcelona you don't starve, if you prefer to get high. But you get old quicker, if that answers your question. Because you are stressed out, trying to make a living, with no ID, not knowing what will happen tomorrow, not knowing what to do now, not knowing or how to make money, not knowing anything at all, you get stressed. You are permanently feeling anxiety, so of course your mental health is screwed up, and your dignity might also go to hell. Because you are willing to do things that are going to harm your dignity, so you never know what is going to happen."
>
> 45 years-old Italian woman. Linked to different HR services.

HOMELESSNESS AND THE HOUSING ANALYSIS

From all the discourses reported in both focus groups, the following common characteristic was presented when referring to a person with premature ageing and substance use: homelessness or long history of living in the streets or in substandard housing.

For the participants, it was essential to focus on this social risk factor in order to understand the conditions under which this community reached an old age in a situation of alarming vulnerability. For this reason, some participants focused on this earlier stage, which generated the scenarios of precariousness, suffering, violence and general deterioration.

Public space, in particular in cities such as Barcelona, Palma de Mallorca or Madrid, was described as places where the uninhabitability of homeless people had been maintained or even increased. On the other hand, the lack of regulation of housing prices, according to some participants, left people with fewer resources out of the market. For example, the price of a room was described as affordable for people on minimum or non-contributory benefits less than a decade ago. Today, it is very difficult to afford the amounts required on the rental market. The same can be said of housing support services such as hostels and guesthouses. A few years ago, these were used by PWUS and the homeless for temporary breaks, to recover for a few days or simply to get away from the streets.

> "(...) So there is something to be said here. We have claimed that the tourist tax must be used to favour these people. Because if a person from Liechtenstein sleeps in a bed for 50 quids, it's because they are expelling locals from that bed. And this does not revert at all to these people, they are completely expelled (...) I only point this out because if we talk about flats, it is even more complicated. Many people were able to have a room for 200-300 euros, but now in Barcelona 450 euros is the minimum you pay and if you are lucky. Since there are no resources, what we have to recover are these suboptimal pensions. We need to penalise the excessive profiting from putting our people on the streets."
>
> Internist. Long professional career in hospitals and addiction treatment centres. Catalonia.

During the two sessions, different arguments emerged that could explain a scenario that hinders the integration of older PWUS into social and housing circuits: 1) the processes of gentrification in large cities that make it difficult to live on the streets and to access housing; 2) the spread of aporophobic and racist discourses that have political support and even power, and are therefore a determining factor in the management of the third sector and the municipal by-laws themselves. This last argument was exemplified by the installation of hostile urban architecture and social and police interventions to evict settlements of homeless people groups living and sleeping on the streets.

> "Perhaps it is a problem that I face in my day-to-day routine since I work very closely with political decisions and I do not think about this kind of service activation without the willingness to do it. To narrow the context a little, here in the Balearic Islands we are currently running the Department of Social Affairs with aporophobic discourses, moralistic discourses on consumption, discourses that are also against universal health care and leave migrants out of this system."
>
> Social anthropologist; Palma de Mallorca. HR Intervention and political activism for human rights. Balearic Islands and Andalusia.

PROPOSALS FOR A SUITABLE HOUSING MODEL FOR OLDER PEOPLE IN ACTIVE SUBSTANCE USE

While there was unanimous agreement on the essential need for a housing network for the long-term and ageing community that use substances, there were divergences in the description of appropriate intervention models based on abstinence or HR.

On the one hand, the housing support services in Asturias and Madrid were described, highlighting the insecurity generated in the ageing community by the fact that these residential facilities are limited in time. For this reason, an extension of the existing housing network was proposed, applying a model of indefinite temporality, centred and close to the person, which would accompany emotional and organic health and take into account fundamental aspects of the approach to substance use.

Participants from Asturias and Madrid showed a flexible position regarding the permissibility of substance use in the housing support services they managed, despite the fact that they generally described them as part of the substance-free circuit. In the case of Madrid, alcohol was identified as the main substance used by the people living in these centres, so that this substance in particular enjoyed a wider margin of tolerance compared to illicit substances.

> "You need a formal, specialised network, because the uncertainty of not knowing where you are going to sleep tomorrow affects your behaviour very much. It affects them a lot, we have noticed that here, establishing self-care habits (...) we can request an elderly service that is for life, so the user can feel relaxed: we have observed that they suddenly start taking care of themselves, they improve their self-care habits, and physical activation. Not feeling uncertain about tomorrow is very positive.
>
> Social worker. Experience in housing support services for homeless people and substance use. Community of Madrid.

On the other hand, professionals with experience in the territories of Catalonia, the Balearic Islands and Andalusia reported discourses that were deeply critical of the abstinence-based and demanding housing models in which practically the majority of services in the current state network are inscribed.

This discourse highlighted the need to implement the HR perspective throughout this general housing network. The aim was to expand the activation of HR in services and/or programmes serving such heterogeneous communities as older women survivors of gender-based violence, older people with mental health problems, in the HIV cycle or in homes for the elderly, among others, in order to guarantee access and coverage of the constitutional right to adequate housing.

> "In other words, I think that services in general are perverse, aren't they? In other words, they are not suitable for me, nor for my mother, nor for the homeless. In this framework, the HR model should be implemented in hospital and psychiatric centres, in women's services, in people with HIV, in the elderly, etc., to end up with the labels or stigma that normally goes with it. I mean the harm reduction model because we have been very very focused on homelessness, but alcohol and drugs are in our daily life. And we need to understand that when something happens to us, it becomes our baggage too. Because if we can't leave our baggage apart to get treatment, we need to carry, understand and readapt it."
>
> Social worker. Housing support service for homeless people coordinator. Catalonia.

In other interventions, the analysis of the current housing system for older people went beyond the implementation of the HR. The main barriers to access and adherence for the ageing and homeless community who use substances to housing services were explained through the paradigm of institutional care, crossed by the social stigma of people with substance use disorders in poverty. This premise was translated into concrete examples, referring to the infrastructures of housing support services, which were described as inadequate and consisting of overcrowded rooms. The need to review the model of care for homelessness, known as the housing ladder, was also highlighted, as it requires a series of targets that are unachievable for many people, placing them almost irrevocably outside the protection and welfare system.

The Housing First programme was cited as a good practice in the field of housing for older PWUS, by proposing a non-invasive model of independent living support and by proposing an alternative housing option in individual, self-sufficient spaces with no time limit.

The housing support services of the Arrels Fundació and Galena were also mentioned as pioneers in the implementation of harm reduction in Spain. Social workers from both centres agreed that the housing alternatives available for PWUS were not enough. They described how this deficit was a major limitation when it came to referring PWUS to other mainstream housing services or to the homelessness network itself. One of the main reasons that emerged was that a large number of the residents of both services did not meet the abstinence requirements to be referred to other centres, so that their stay in these centres became chronic, blocking the few places available in relation to the current demand in the city of Barcelona. In the few cases where a referral service had been found, they explained that the procedures had often resulted in the person returning to the street due to non-compliance with the rules in these services.

HR EVOLUTION AND ITS SERVICES ADAPTATION TO THE AGEING COMMUNITY

From the accounts of both groups it could be concluded that there is a portfolio of services available in terms of food, clothing, hygiene and showers and drop-in services for older homeless people who regularly use substances.

Concerning the provision of harm reduction rooms, the FG experts described an uneven scenario in Spain. In addition to the rooms in Catalonia and Bilbao, it was reported that the Community of Madrid has a syringe exchange programme and that there are harm reduction rooms for alcohol. However, none of the participants indicated that they were aware of any of these facilities that implement specific HR strategies for the ageing community.

The quality of the HR services and their adaptation to the ageing community led to discrepancies between the *FG-First Person* and the *FG-Professionals*. Therefore, no specific proposals for this community group were described. Some participants from Balearics, Andalusia and Catalonia pointed out the urgent need for the development of the HR model in general, since despite the emergence of some innovative services, there has been a certain stagnation since its origin in Spain.

According to some participants, both users and professionals of these services, there is aporophobia and social stigmatisation of PWUS, in this case in addition to ageism, which is also present in some institutional protocols and professional practices. It was therefore noted that in some cases traditional, authoritarian and/or paternalistic models of care can be reproduced, and the lack of plasticity of the HR network to adapt to new needs, such as the increase in the number of people over 45, was pointed out.

The specific needs of the ageing community described, apart from housing support already developed in the previous section, were related to the reduction of physical and mental deterioration. Thus, the following proposals were the most widely shared: 1) the provision of a physiotherapy and osteopathy service to reduce pain, prevent injuries and heal physical ailments; 2) the introduction of a podiatry service to provide specialised care for the feet of elderly HR users; and 3) the provision of appropriate cultural and sporting opportunities of interest to this community, such as aquatic activities that contribute to the development of basic physical skills.

Several participants with professional experience in Catalonia, the Balearic Islands and Andalusia described the existing portfolio of available services as inappropriate for older PWUS.

> "Physiotherapy seems very interesting to me and exercise is very important. I tried to find swimming facilities but, because they are old and there is no structure, it is impossible to find free services in sport centres. Neither in drop-in services, they are not even interested in their welfare, you know"

Social worker. Experience in long-term housing support services for homeless people in active substance use, and specialised in the elderly. Catalonia.

At present, in the absence of solutions such as those proposed in this paper, the physical and psychological pain of long-term substance users is described as being medicalised by psychotropic substances. This issue provoked a spontaneous debate among the *FG-Professionals* on the over-medicalisation of the elderly in general and the elderly PWUS in particular, which concluded that medication substitutes services that are not publicly available, either because they are expensive or because existing economic resources are not adapted to more appropriate services.

END-OF-LIFE CARE

The general discourse revealed the need for PWUS to be able to benefit from an adequate space at the end of their lives. This accompaniment process took place in some housing support services for homeless people where there is an elderly community, like the ones in Madrid and Barcelona. In the *FG-Professionals* as a whole, the support provided by home care teams specialising in palliative care for adequate end-of-life accompaniment and pain management was highlighted. However, no end-of-life care experiences or good practices in general housing support services for people in active substance use were described.

The obligation to carry out the dying person's last wishes was also supported by all participants in both groups. Nevertheless, limitations were noted in the implementation of these last wishes when they were based on the use of substances. The positions, according to the models of professional intervention of each of the participants, ranged between flexibility and permissibility in accompanying consumption in this final process.

The *FG-Professionals* with experience of intervention in public spaces denounced the institutional neglect of people who have died on the streets. According to them, this is a consequence of the lack of specialised services in the area and the barriers to access to housing for PWUS, due to substance use and other factors already described in previous sections. Mallorca, Barcelona and Andalusia were specifically mentioned.

> "I have experienced despicable, shameful, cruel situations. I know that, well, I have experienced them, especially because I used to work in Andalusia and I came across a centre where people were convalescent and in need of health and emotional support, because they are in their last phase, right? But it is an oversaturated service, where they can't do more. They have very limited seats and there is only one service for Andalusia. And well, I have had to face a lot of politicians demanding responsibility, demanding a hostel, demanding humanity, but I have also come across situations where people have died in a car park (...). It is a cruel system that blames these people, that does not pay enough attention to the problems they have and above all that is not articulated by humanity."

Social anthropologist; Palma de Mallorca. HR Intervention and political activism for human rights. Balearic Islands and Andalusia.

A minority of *FG-Professionals* suggested introducing heroin as an opioid substitution treatment for people at the end of life, either to treat pain or to improve adherence of people with heroin use disorder to palliative care.

> "And I don't know, I remember one situation that I think I will never forget, which was a girl who lived in a housing support service for PWUS and was constantly being abused. When the abuser was in the hostel, it was because he had extensive needs and so were his responses. We took her to a safer place where we offered her methadone and obviously it didn't work. That means that solutions need to convince the person and that is where we are, where heroin appears. (...) Heroin may not be a substance for the vast majority, but it is, for example, for particular cases and probably for people, let's not say at the end of life, but in specific processes, it can be the solution. (...) And also in those special moments, like at the end of life, where we need to consider comfort above all else."

Internist. Long professional career in hospitals and addiction treatment centres. Catalonia.

SOME LIMITATIONS TO THIS SECTION OF THE PHASE II STUDY: AGEING AND ADDICTIONS

The results may be biassed by the sample, as transgender or gender diverse people are not represented in the selection of the *FG-First Person*, and the present study lacks relevant information on ageing processes in gender-dissident communities who use substances.

Furthermore, despite the naming of different axes of inequality, analysis of the narratives of both focus groups did not elicit more detailed references to how racial and functional diversity oppression operates among prematurely ageing PWUS.

3.4. HARM REDUCTION AND CHEMSEX PRACTICES

AUTHOR: ZOE FERNÁNDEZ MOSQUEDA

INTRODUCTION

The diagnostic phase carried out in 2021 identified the chemsex community as a specific population group for which harm reduction strategies and/or the approach of specialised services should be explored in more detail. A vulnerability was identified in relation to: the sexual orientation axis, reinforced by substance use, gender expression and administrative status, among others.

There was also an increase in the number of people who engage in chemsex in situations of homelessness, often linked to the harm reduction network. There was also an increase in the use of injecting or slamming among this group. It was found that most harm reduction services were not safe spaces for the LGTBIQ+ community.

The following needs were identified 1) the incorporation of the LGTBIQ+ perspective and specific LGTBIQ+ competencies by professionals in the harm reduction network, 2) the implementation of strategies and models of support in the harm reduction network based on good practices already developed by the LGTBIQ+ sexual health network, 3) the design and implementation of specific LGTBIQ+ support services that incorporate benefits and strategies specific to the harm reduction network.

METHOD

The inclusion criteria of the *FG-Chemsex* were that the person should be a professional or peer support worker in services that provide direct care to the community practising chemsex. Following the results of the previous phase of research and the review of the bibliography[1], the inclusion of peers in this focus group was considered. This would validate the support methodology currently used in approaching and supporting people who engage in chemsex.

The diversity of genders, national territories, social and health professions and types of institutions was ensured to be representative. The variability of services was also prioritised, including those providing risk reduction approach, care services with a harm reduction approach, specialised chemsex services that provide comprehensive care, and other specialised sexual health services that also offer care to the chemsex community.

The sampling design took into account the participation of professionals and organisations further away from radical acceptance of substance use, but this was not possible either because they explicitly refused to participate or because they did not respond to the call. A total of 4 professionals refused to participate, with only one citing workload as the reason.

The FG Thematic Guide was developed on the basis of the diagnostic results from Phase I of this research. It was reviewed by both the researcher coordinating the study and the gender expert.

A total of 16 people participated, 14 of them in the FG, and 2 professionals were interviewed individually in a semi-structured online format.

The FG was moderated by the researcher and expert on chemsex. It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2 hours.

The discourse was supplemented by a semi-structured individual telephone interview with two participants who were unable to attend the focus group and who worked in a specific chemsex unit. This interview lasted 45 minutes.

RESULTS

PARTNERSHIP AND MIXED FORMAT

The FG was used as a validation tool for the choice of a mixed role sampling method (professionals and peers), applied by addressing possible reasons related to this differential element in relation to the rest of the community groups studied in this publication. All participants validated this methodological choice, indicating that the boundary between professionals and users in the field of chemsex was blurred. They did not report any limitations, either in terms of being able to play different roles depending on the context, or in terms of combining professional work with activism.

In addition, all participants highlighted the strong capacity of the LGTBIQ+ collective to form associations, which was not observed in other vulnerable groups studied in this research, such as homeless people or young migrants in an irregular administrative situation.

(1) Nagington, M., & King, S. (2022). Support, care and peer support for gay and bi men engaging in chemsex. Health & Social Care in the Community, 30(6), e6396-e6403.

In the case of the LGTBIQ+ group, they are recognised as a community on several levels, including the existence of specific laws that guarantee their rights, as well as a history of community building and fighting against stigma. There is a sense of pride and belonging that may be linked to this ability to associate.

One participant, a psychologist specialising in risk reduction, emphasised that chemsex should be separated from the general idea that it is a problematic issue (e.g. in the case of homeless PWUS, it is a social or consumer issue), but stressed that most people who engage in chemsex do not develop problematic use.

Participants agreed that this phenomenon is constantly evolving and allows for challenging generalisations and stereotypes around the issue.

DIVERSITY OF PERSPECTIVES ON SUBSTANCE USE IN SUPPORTING INDIVIDUALS

Another methodological aspect that participants were asked about was the refusal to participate in the FG of people whose approach and/or attitude to substance use was close to the prohibitionist or punitive model. Among the possible reasons, some participants highlighted that the LGTBIQ+ community has long carried and continues to carry the burden of stigma around substance use.

> "For a long time, excessive substance use has been associated with the collective, specifically with the gay and LGBT community, and it is possible that many associations haven't gotten over that."
>
> Psychologist. Experienced in online psychological accompaniment of homosexual men.

Participants agreed on the importance of a holistic approach to chemsex. They described it as a phenomenon involving a number of dimensions such as mental health, sexuality, mobile app usage and substance use. They therefore advocated for a comprehensive approach that understands the person without compartmentalising them, and that addresses their specific needs.

> "A lot of things come together and that mix, at least in my opinion, what brings to the table is the evidence that we can't work with a single theory or framework: or risk reduction, or harm reduction, or clinical, or pure disorder treatment... Alternatively, we need to focus on who we have in front of us. Let's not break them down into 800 parts... Let's shoot for the care of the person, assessing what they need according to the process."
>
> Psicóloga, especializada en salud y drogas. Comunidad de Madrid.

Participants were also critical of the abstinence-only approach as the only solution. They felt that this approach was not appropriate for all PWUS and that there was a need for care professionals to incorporate risk and harm reduction strategies, as well as supervision. The tendency of the biomedical model to establish a vertical relationship with the person was also highlighted, and the need to review this support was identified. It was suggested that an approach to care based on the logic of abstinence is not effective in most cases, as it distances users from feeling understood by professionals.

From the Canary Islands, participants also reported experiences of stigmatisation by specialised health services, with an androcentric approach and where substance use was not considered a 'disorder'.

> "There are many experiences of stigmatisation by specialised health services. Given that we live in a patriarchal society where programmes are designed under an androcentric approach where women have more limited access and where substance use is not yet understood as a disorder."
>
> Drug Dependency Care Unit Professionals. Canary Islands.

From the Canary Islands, they conclude that the approach they practise in their unit consists of a biopsychosocial intervention that addresses the detoxification and dishabituation phases.

Finally, it was pointed out that there was a clear lack of information about recreational substance use in this group. It was hypothesised that one of the possible reasons for this could be related to the fact that some agencies and/or professionals within the group had not previously considered this type of support, which could be due to the stigma associated with substance use. On the other hand, participants indicated that when someone or some institution offered programmes and strategies for safer substance use, the demand for information increased. Participants indicated that this shows that the goal of abstinence is not pragmatic or adapted to reality, and that it is essential to include this perspective.

HARM REDUCTION AS AN APPROACH

Participants were asked whether they used harm reduction strategies in their daily lives and were invited to reflect on this approach to counselling and its practical usefulness. This was based on the results of the diagnostic phase of this research, where it was reported that in some cases chemsex-community is accessing HR services for the first time when their basic needs were no longer met, when they were homeless, and when their substance use was no longer exclusively recreational, having moved to contexts of higher risk (public streets, hygiene conditions).

The impressions of the participants varied from one area to another. For example, a social worker from Barcelona with extensive experience in the field of harm reduction pointed out that people who practised chemsex and used HR DCR services were characterised by a situation of serious social deterioration that had occurred in a short period of time.

One participant, a social worker and project coordinator from Madrid, emphasised that her organisation's work focused on sexual health, with an emphasis on eroticism, people's identities and orientations and the possible trauma associated with these; it did not specifically include HR interventions linked specifically to substance use. She commented that they were dealing with people who were moving from a 'normalised' life project to 'marginalisation processes'. She added that one of the most vulnerable groups they identified were sex workers, who were often migrants with a history of trauma related to their prior situation in their country of origin and/or to their identity and/or orientation. It was also mentioned that there are no DCRs in Madrid, which severely limits HR practices.

One participant, who coordinates a specific chemsex service at a provincial level, agreed that since 2015 she had observed the social deterioration of the people she serves has been becoming more pronounced, particularly in terms of the social status of the people she supports, highlighting the case of male sex workers. He pointed out that in these cases they were applying HR approaches, but that this was within their possibilities and capabilities. This was assuming that the organisation specialised in other types of issues, such as sexual health within the LGTIBIQ+ community. He pointed out that in some cases the practice of slam could be associated with more significant deterioration.

> "Now there are more LBT women coming in, but at the beginning it was mainly gay men. And there was no coverage of those aspects that were related to their sexuality, their identity or other aspects not directly related to substance use. So if you don't take into account these cultural components, you don't understand the phenomenon and you don't understand the person in front of you, hence the invisibility of these types of cases."
>
> Social worker and chemsex service coordinator. State level.

In terms of HR practices, the Canary Islands participants pointed out that the chemsex phenomenon is starting to be recognised and addressed, and that there are only a limited number of tools available to deal with the problem. They also felt that HR should be seen as a tool to improve the quality of life of people who do not consider total abstinence.

RESISTANCE TO VISIBILITY

All participants stressed that the public administration treats the phenomenon of chemsex as if it were something new, when in fact it is a practice that has been developing for a long time. With regard to the characteristics of the people who engage in chemsex, it was pointed out that within the community itself, invisibilization processes of certain sectors with greater social problems have been generated, such as: male sex workers, migrant men. This became a form of discrimination against this part of the collective. They agreed that there is a social imaginary of a person who practises chemsex as a man, gay, 35-45 years-old, with a stable job and belonging to the upper middle class.

A social worker from Madrid reported that there has been and still is resistance within the LGTBIQ+ community to making more problematic issues around chemsex visible. Examples were given of situations where they had been asked not to make certain issues visible, citing the Pride campaign 2015-2016, where there was no interest from the administration to make issues around substances more visible in order not to associate them with the LGTBIQ+ group. It was reflected that both the administration and the organisations may be responsible for this lack of visibility and consequently the stigma associated with it.

Professionals from the Balearic Islands indicated that they work in a recently opened service, which currently has a low influx of users. They reported difficulties in attracting users to the resource.

MEDIA

All participants in the FG were concerned about the impact of the media on chemsex, its effect on the construction of the collective imagination and public opinion. Suggestions were made, such as taking a stance not to speak to certain media outlets, and the possibility of developing guidelines for recommendations and good practices in dealing with these issues in the media was also discussed.

VIOLENCE

The issue of violence within chemsex spaces was another aspect addressed in the FG. Both the studies on chemsex[2] and the findings of the diagnostic phase of this research highlighted the complexity of identifying and addressing violence in this context and the high number of intersections that operate.

Firstly, a social educator from a HR in Barcelona, a chemsex referent in such service, pointed out the difficulties for assaulted people to make a complaint after an incident.

All participants, regardless of the area, agreed that they often found it difficult to report situations of sexual abuse or violence. The impact of the prevailing culture of minimising or justifying abuse was mentioned, as well as the stigma that still exists in the legal system. Both of these elements were identified as barriers to recognising violence and taking legal action as a result. One participant pointed out that these factors make it difficult to obtain reliable data on the number of assaults in the context of chemsex. A psychologist from Barcelona who has worked with people who engage in chemsex explained that awareness-raising work within the community itself is essential.

> "We need to raise awareness in the community itself, work on the aggressors/perpetrators as well as the victims. But it is difficult to collect data on how much abuse and how much violence actually happens because of the stigma, because of the fear of being judged."
>
> Psychologist and coordinator of psychological care for people who engage in chemsex. State level.

It is worth noting that the intersecting axes that act as moderating variables in the impact of violence on the person, such as social class and homelessness, were never tabled. Also, the chemsex reference person from HR remained silent during the development of this point after his first contribution. This positioning could be related to the normalisation of violence that exists in HR circles. It was also noteworthy that although it was mentioned that there were some women who practised chemsex, they were not taken into account at this point.

> "When we are victims, it is difficult for us to see ourselves in that role. It doesn't seem logical because you're a man."
>
> Psychologist in a risk reduction service. Catalonia.

Participants compared this difficulty with the analogy between classic gender-based violence and cis-heterosexual relationships, where it is also very difficult for the victim to take legal action. From Andalusia, the parallel was drawn between the dynamics of domination and submission that are established in cis-heterosexual relationships in the context of gender-based violence and the dynamics of abuse that exist in the LGTBIQ+ community.

One of the themes that emerged throughout the blog was that of consent. It was reflected on what place consent has in '*chills*' or other sexual spaces.

> "I also believe that there are many users who, due to lack of knowledge or lack of information, do not even recognise when they are suffering abuse. So as they are not aware that they have suffered abuse until they talk about it and express it to someone else... And if there is no awareness or culture of consent: at what point am I giving permission for something to happen or not to happen? Until this is learnt, it will be difficult for them to recognise that they are suffering abuse and to be able to report it."
>
> Volunteer of an organisation working with people who engage in chemsex. Catalonia.

The experience of sexual consent in chemsex contexts in Catalonia was reported, where training is currently being provided to professionals and a protocol specifically addressing this issue is pending.

> "The administration is late, the public administration is late again and there is a situation that needs to be addressed, but the public administration is not there. Hopefully later on it will have the ability but we know that we currently lack resources to attend this community."
>
> Public policy maker. Canary Islands.

Another participant, a psychologist working in Andalusia, introduced the term '*Buen trato*' (good treatment) and stressed the importance and responsibility of promoting this culture.

> "It has a lot in common with gender-based violence. In the end, it is as if there is a dominated party and a dominant party as an object. And that person ends up normalising it and ends up falling into that relationship, forgetting that it started violently. So I think these are the mechanisms that allow this violence to reproduce itself and that we are not even aware of identifying."
>
> Specialised psychologist. Andalusia.

On the other hand, the concept of intersectionality in relation to violence reappeared. The added complexity in denouncing this violence by certain minorities with more vulnerable conditions was highlighted. A service in Barcelona reported on the accompaniment of a person

(2) Leyva-Moral, J., Aguayo-González, M., Mora, R., Villegas, L., Gómez-Ibáñez, R., Mestres-Soler, O., Maldonado-Alia, R., Lorente, N., & Folch, C. (2023). Chemsex in Barcelona: Qualitative study on factors associated with the practice, perception of the impact on health and prevention needs. Addictions, 0. doi:http://dx.doi.org/10.20882/adicciones.1790

who had suffered sexual aggression. Security forces prevented him from filing a complaint and he suffered police violence when they questioned his account, only because he had previously used substances. Another participant added that this invalidation of the account is common, not only by law enforcement but also within the community, and how this makes it difficult to build a support network for the victim. Stigma and internalised homophobia often lead to disbelief of the stories, re-victimisation and victim blaming.

A number of HR services reported that they had identified several cases where female PWUS, who usually live on the streets, encountered barriers to reporting. It was pointed out that very few women were able to complete the entire reporting process, and this fact was linked to the possibility of reproducing the same problem with chemsex practitioners. It was suggested that the HR network could be an example of good practice in terms of implementing action and support strategies for these cases, as they have been identifying them for years and working to provide quality support and care. However, most of the participants in the FG stressed that the main difficulty in this process was at the beginning, when the victim (and the perpetrator) identified the violence.

> "In a group therapy session a patient comments that men like sex more than women and more than heterosexual men... And I think this is a faithful representation of an idea that is very common, which is that men like sex. Because if you are at a "chill" unconscious, but you like sex, then logically why would they need to ask for consent?"
>
> Psychologist. Chemsex support. Catalonia.

It was discussed how the 'culture of abuse' is present within the community itself. Some participants reflected on the fact that many gay men and men who have sex with men learned about their sexuality in such spaces, and that this could be linked to a management of sexuality based on this culture of abuse. On the other hand, it was emphasised that these people are questioned when it comes to identifying situations of violence because they are men. This issue could be closely linked to the double or multiple stigmatisation that people who engage in chemsex experience for having sex with men and for using substances.

> "I think there are added factors that make the victim not feel like a victim of a violence situation. And if we sum up the fact that you are a man, you are already questioned for having suffered sexual violence in any administration, in any place you go, you are already questioned for the very fact that you are a man, and if you add consumption and you add the fact that you are gay..."
>
> Social worker and chemsex care service coordinator. State level.

All participants agreed that very few people reported violence in these cases. Finally, the importance of including strategies to prevent violence within the community itself, such as peer support and support networks, was highlighted.

Another aspect analysed in relation to violence was that the care and protection network at state level is currently very feminised, with scarce resources for care and coverage of identities other than cis-female. A social worker from Madrid reported difficulties in accompanying male victims of violence because, despite the existence of programmes for 'intragender violence', where these cases would fall, the responses offered were not effective.

The differences between the two types of violence were also discussed, but no general agreement was reached by all participants on the origin of violence and the possibility of distinguishing between intra-gender and gender-based violence. It was mentioned that gender-based violence focuses on women who have experienced violence at the hands of cis and heterosexual men. However, it was suggested that it is important to address the different expressions of violence in the LGTBIQ+ context, including multiple gender identities and orientations.

> "Gender violence, from my point of view, has been created by cis heterosexual men, and then they've put a bit of a twist on it at the time. There hasn't really been a perspective of "what it means to be a woman, what is understood with all women realities and diversities..." because a lot of times, at some point, bisexual lesbian women have been left out, or trans women have been left out, women of African descent have been left out."
>
> Social worker. LGTIBQ+ Expert. Community of Madrid.

With regard to intra-gender violence, the power of collectives and associations to put pressure on the public administration and to work together to ensure adequate and specific attention was highlighted.

> "Now is the time for organisations, associations, collectives... to start giving the public administration a hard time and to get involved from scratch. This hasn't happened with gender violence."
>
> Social Worker. Community of Madrid.

The importance of intersectionality was highlighted and the importance of looking at all the axes of oppression that might occur, such as age, sexual orientation, social class or being a racialized person, was mentioned. These were described as overlapping axes that increase complexity. In addition, the hegemonic model of masculinity, which is directly linked to violence

and access to bodies, was identified as a relevant factor in relation to violence, to the exclusion of other models of masculinity.

> "I think it has more to do with the concept of masculinity that we have. And that under that concept of masculinity and in a context where the substance consumed within chemsex practices disinhibits you and in a way expresses the most desirable model, thus a violent and aggressive model where the more sex you have the more masculine you are... The desired model within the community or the majority of the gay community is what is expressed in the chemsex sessions."

Social worker and chemsex service coordinator. State level.

Similarly, the model of masculinity was linked to childhood learning and gender socialisation as a man. Participants stressed the need for comprehensive sexuality education and more prevention. Participants commented that for most gay men, sex education is totally inadequate and learning about sexuality is ad hoc as they progress in their sexual experiences, which often take place in violent environments, resulting in the reproduction of certain forms of violence.

> "It is the sexual education that we have received, which is inexistent. So we have to learn as we go. This gap clearly generates inequality and violence."

Social worker and chemsex service coordinator. State level.

Participants from the Canary Islands agreed with the statements made by the other participants and stressed the difficulty of being served by the network of violence in terms of active consumption and the complexity of not falling within the gender spectrum. They highlighted the need to work together with the network of addiction services in order to provide an adequate and effective response to the routes taken by these people.

One participant, a psychologist and therapist who works with men who practice chemsex, reported that he often sees men in counselling who have experienced child sexual abuse (CSA). He explained that he saw a link between not being able to process these traumatic histories of CSA and then being re-traumatised by the exposure to similar situations. He also highlighted the fact that having been a victim and looking for a way to 'solve' it might lead to taking on the role of aggressor. He also suggested a possible tool to contribute towards the solution to this problem. This would be non-heteronormative sexual education from childhood in order to prevent these situations to some extent and to be able to provide children and adolescents with tools.

> "I also often hear stories of people who, when they were adolescents, in puberty, in their awakening of sexuality, tried to find their sexual place. And because there is little known and little talked about out of heteronormative sex, out of ignorance, and out of 'it's forbidden', they therefore try to search for information clandestinely, and by meeting people who have not cared for them or who have abused them. It is important to work with these people and help them release these traumatic stories. This has an impact onwards, since they will always look back and see themselves in situations where they weren't able to set limits and so they will probably act likewise in present situations. Or even worse, leading them to swing to the side of the aggressor in sexual encounters."

Psychologist and therapist for people who practice chemsex. State level.

On the other hand, another psychologist and therapist agreed on the prevalence of people who have experienced abusive situations in their childhood and how this affects the reproduction of the cycle of violence in later relationships. They agreed that the discovery of sexuality can be confusing and complex for many people in the community, especially when we consider these abusive experiences. The role of substances in the lives of some of these people was also highlighted, where it was observed that they acted as a regulating agent for certain traumatic histories.

> "And in many cases we find that they have more problematic use profiles and that has to do with the fact that the substance is helping them to process an experience that is still hurting them. We are talking about so many intersections, we have to put so many things on the table and then see how they affect each person individually... there are many, many factors."

Psychologist, psychotherapist and writer. State level.

Finally, the importance of addressing other types of violence that have so far gone unnoticed, such as rejection of other bodies or expressions, was highlighted.

> "We forget about other kinds of violence, like the rejection of certain bodies, certain expressions. At the end of the day, these are dynamics that are very normalised, especially in the mobile apps environment, but which also have their consequences for the people who are part of that community, so I think this is also an area that should be addressed in some way."

Collaborating psychologist and sexologist. Andalusia.

Throughout the block, the need to work with aggressors emerged. A preventive approach was identified as necessary, pointing out that traditionally hegemonic models and services have only supported victims.

NON-MIXED APPROACH IN HARM REDUCTION SPACES

Another aspect that was discussed with the participants of the FG was the possibility of including people who engage in chemsex in the non-mixed spaces that already exist in the services of the HR network. The majority were in favour of the creation of non-mixed spaces in order to guarantee comprehensive care for such a specific phenomenon. They considered it essential for these spaces to be staffed by professionals trained in skills and content. However, there were different positions regarding the implementation of non-mixed spaces for people who engage in chemsex within the existing HR spaces.

> "This is the constant complaint: I've gone to this or that service and they don't understand me, they don't know the particularities of my culture as a gay man, I feel judged in my practices, they don't know what cruising is, what a popper is... Things that are very basic to us. Of course, when you come to this service and you find yourself in this situation... It doesn't give you much confidence, you don't develop much of a therapeutic relationship. We understand that professionals have to be trained enough already, so they also have to be trained specifically in certain communities, groups... This is understandable, but if we put ourselves in the users' shoes, of course they will prefer to meet a person who understands them, who understands their subculture."
>
> Psychologist, psychotherapist and writer. State level.

> "I met professionals from other LGTBI community organisations who denied the specific phenomenon for fear of stigmatising the community... Well, it reminded me a bit of what happened with the HIV-AIDS pandemic in the 80s and 90s, which was more or less similar. And yes, it is still happening. Obviously we need specific spaces where professionals understand what the phenomenon is, understand these cultural components, in other words it is essential and it is still very difficult to understand."
>
> Social worker and chemsex service coordinator. State level.

There was no agreement on who would make up these spaces. The challenges of creating non-mixed spaces were discussed and concerns were raised about mixing (stereotypical) HR service users with (also stereotypical) people who engage in chemsex. Low adherence was anticipated in relation to the non-identification of the two groups as the same, even though they overlap as GBHS. It was discussed that one possible group that could work in a non-mixed format would be the GBMSM with cis and trans women. These differences in 'comfort' could be related to elements of aporophobia, rather than possibilities related to substance use patterns or components of the broad gender spectrum.

On the other hand, groups that included male sex workers and transgender women sex workers were shared as a good practice experience of the non-mixed format. One participant also noted the difficulties their organisation had in running groups with people who engage in chemsex when the design included slammers and non-slammers together. They found that there were difficulties in facilitating spaces for group emotion expression, and linked this to the potential stigma associated with injecting.

STRATEGIES IN NIGHTLIFE VENUES

Nightlife venues have been identified as a key player in the chemsex equation. While many of the encounters take place in a private context, some occur or are initiated in party spaces such as saunas, clubs, parties, hotels or specific venues. Participants therefore pointed out that it is essential to take into account how such spaces function and to reflect on how to integrate care strategies for people who engage in chemsex. A concern was expressed about the difficulty of working with leisure venues such as saunas, bars and clubs.

The refusal to allow substance use in these venues was reported as a common practice by businesses. It was suggested that this could be due to both the fear that such venues would be stigmatised in the community for not dealing with substance use, and the fact that consumption is illegal in Spain, which could jeopardise the stability of the business.

With regard to cooperation with the public administration, it was pointed out that there are precedents of cooperation with bodies to carry out interventions in recreational spaces, but that these interventions have not always received sufficient support, assistance or measures to be able to implement them.

Participants from the Canary Islands, on the other hand, reported that they found it easier to intervene in publicly subsidised festivals. This was not the case for hotel chains or small businesses. In Catalonia, it was noted that the previous year the administration had provided chemsex training for health workers and companies, and that the number of companies registered was around 19, while the number of health workers registered was very high. It was reflected that in this context, company employees may not be informed of such training or activities, as in many cases they would be interested, but employers do not spread the word.

3.5. HARM REDUCTION AND HOMELESS YOUNG MIGRANTS

AUTHOR: MARINA SONADELLAS ARAGÜES

INTRODUCTION

The focus group on young homeless migrants, developed as part of last year's UNAD study, produced a number of findings that are worth mentioning as a starting point for contextualising the present research.

On the one hand, the axis of age, place of origin and administrative situation was highlighted as a significant factor in the vulnerability of these young people, which is exacerbated by substance use, gender and language, among other factors. On the other hand, the HR network noted a predicted increase in this community group and, in this sense, expressed concern about the existing saturation of the drop-in services and, therefore, the need for more services to be able to provide good care. The child protection system, on the contrary, was identified as the first contact with the institutions for this group, highlighting the punitive logic of these services for substance use. Differences in this group's patterns of substance use were also noted, pointing out that many young people do not share the symbolic language with the community; in this sense, the lack of training and intercultural skills was highlighted.

METHOD

Young migrants experiencing homelessness were identified in the previous study as a priority community for HR services. This was due to the lack of existing support and the challenges and dilemmas posed by their particular characteristics and situations.

For all the topics covered by the FG, the specificities of each territory were taken into account, depending on whether it was an arrival (border points), transit or permanence territory, aiming to analyse the possible impact of these variables.

It is important to note that the focus group participants came from different backgrounds. Although the majority were European, mainly from Spain and Italy, we did have one person of Moroccan origin. Given that the majority of young people are of North African origin, it seemed important to us to have this representation in order to better understand the societies of origin of this community and the cultural practices and codes associated with them.

In a first contact, the objectives and methodology of the research were explained, last year's study was shared, and the FG's thematic guide was given to those who showed interest and agreed to participate; this enabled them to locate the previously designed content. On the other hand, in the areas where the research team and/or UNAD had fewer direct links, existing services were explored and formal contact was made with the same information.

Priority was given to people who work with young migrants experiencing homelessness in a variety of services and settings, such as harm reduction centres, drop-in services, street intervention teams and civil society organisations (particularly in areas where social services are virtually non-existent). The diversity of genders, professional disciplines and expertise was also taken into account. A direct link to harm reduction or a long professional career in the field was not a relevant factor for exclusion. Diversity in terms of geographical representation was also used as a selection criterion. This element made it possible to take into account the fluctuating movement of this community in different areas of Spain, taking into account the existence and specificity of arrival points, waiting-transit and permanence. Participation was voluntary, without any form of compensation.

Of the original list of 10 people, 3 were unable to participate and could not be interviewed for reasons beyond the control of this study.

A total of 7 people took part in the focus group, 6 women and 1 man. The areas represented were Barcelona, Donostia, Ceuta and Melilla. The following figure describes the characteristics of the participants in the *FG-Professionals*.

RESULTS

GENERAL CHARACTERISTICS

On this point, the participants agreed to describe the group as young people between 18 and 23 years of Maghreb origin, in a situation of homelessness and very often without documentation. In the case of the Basque Country, due to its border with France, the presence of more people coming specifically from Algeria was also highlighted.

> "There are also many people in transit, many Algerians, for example, who want to go to France. Others come from there and many others who want to stay here."
>
> Social educator. Social care work at a drop-in service for homeless people. Basque Country.

In the case of Ceuta and Melilla, the presence of a greater number of minors in street situations was mentioned, in contrast to the other areas of the peninsula, and it was pointed out that this could be due to the conditions in which the centres for minors in these cities are located and the fact that they are waiting. These are transit places where the intention to stay is relatively short.

> "In Ceuta, which is more of a transit city, the situation is a little different in the sense that there is no expectation of staying. And that's why everything revolves around doing 'risky' things and going to the peninsula."
>
> Social worker and volunteer.
> Referent of Intervention Project. Ceuta.

> "There are children who change a lot, they go in and out of the centres a thousand times... I go to the centre for a while to take a shower, change my clothes, get a haircut, and then I spend a week on the street, in the port, without leaving the port, consuming a lot and eating very little."
>
> Social worker and volunteer.
> Referent of Intervention Project. Ceuta.

Within the same general definition, reference has been made not to profiles but to the diverse, differentiated and individualised scenarios in which each young person finds themselves, traversed by a multitude of vulnerability factors that influence whether or not they engage with services and programmes.

> "These are children whom we have clearly defined as not being aware of their personal situation, therefore not wanting to change, not wanting to start a process of recovery and rejecting the intervention. Those who do not comply with the circuits and services."
>
> Service Director. Experience in care services for young migrants. Catalonia.

On the other hand, there was a consensus to understand the context of these young people as changing, unstable, fluctuating, not static; in other words, to describe them as people who live according to the logic of survival, where in many cases basic needs are not met and, in particular, the question of housing is not resolved. This fact pushes them into conditions of extreme precariousness and exclusion. It was also highlighted how this survival dynamic leads people to function on the basis of immediacy. This element is closely linked to consumption and the construction of more utilitarian social relations.

> "This means one day I shower and three days I don't, another day I eat and five days I don't."
>
> Project technician and member of the health commission.
> Experience in care services for youth on street situations. Catalonia.

Participants agreed that the lack of a social and family network is another defining element of this community and an important factor of vulnerability. The strong stigmatisation and criticism of the group, linked to crime and the religious dimension linked to Islamism, was also seen as relevant. In one case, a distinction was made between two large groups according to their history of substance use, a fact that goes hand in hand with time spent on the streets.

Another of the themes that was perhaps not explicitly expressed, but in which interest was detected during the development of the FG, was the approach to identity and adolescence when engaging with the collective.

The question of identity was approached from two angles. On the one hand, the approach of the so-called 'transnational identity' or 'bicultural identity', a concept that refers to people who live between two or more cultural models and therefore have to maintain a dialogue between the society of origin (there) and the society of destination or host (here). In the case of young migrants, this scenario is clearly reflected and influenced by the different experiences they have during the migration journey and once they arrive in the host society, as well as the meanings they attach to these experiences.

On the other hand, the influence of MDLR identity on the construction of these young people's personality and expectations, including the role and importance of substance use in their lives.

Moreover, a reflection on the stage of adolescence was opened up from two approaches. Firstly, the interest in knowing how this vital stage is experienced by young people according to their cultural origins and how this influences the construction of expectations, both their own and those of their families. It is well known that in certain societies in the Maghreb or sub-Saharan Africa, the transition from being a boy or a girl to being an adult is extremely short and that, from a Western point of view, people take on important responsibilities and commitments at a very early age, especially in the case of men, who are expected to provide for and help the family. This means that the expectations of both the young people themselves and their families regarding the migration journey and the future in the destination society can be ambitious and in some cases unrealistic, leading to frustration and unhappiness.

Secondly, these cultural differences must also be taken into account when the social care teams intervene with these young people. In this sense, some slogans and contradictions were highlighted when accompanying

this group, pointing to the 'danger' of infantilization and adultification in all their dimensions, both of which do not correspond to the reality of these young people.

Finally, knowledge and understanding of the religious sphere of these young people was also identified as a challenge and an area to be explored and as a tool that can help to improve the care and support of this group.

> "I think that to work with Maghrebi children, it is very important to know about their religion, because it is very important to them. You have to understand their religion more than their culture."
>
> Educational assistant. Experience in HR services. Catalonia.

MINOR FEMALES, YOUNG MIGRANTS AND LGTBI COMMUNITY

In relation to the issue of girls and the LGTBI community, it is important to highlight that all participants reported the lack or little presence of girls in their services and work organisations. Concern was expressed about the invisibility of minors, young people and the LGTBI community. Situations of greater risk and vulnerability for girls were also highlighted.

> "We have seen very few girls. In the last three years, I think I have seen five go through this service, all five referred by the streets intervention team."
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

> "I haven't seen any young girls, compared to young men."
>
> Educational assistant. Experience in HR services. Catalonia.

During the discussion, some positive cases were pointed out in relation to the low presence or low detection of minors and young migrants in street situations. Most participants argued that, on the one hand, many of these girls migrate through circuits linked to trafficking networks, sexual and/or domestic exploitation and, in the best cases, through family reunification processes. On the other hand, one of the services in Catalonia mentioned relevant concerns regarding the situation of young autonomous girls, formerly under guardianship, living on the streets, in active consumption and in some cases pregnant, who tend to have sexual affective relationships with young people of Maghreb origin in a situation of homelessness.

> "Then we have girls who come from the protection circuit, girls who come from the area, who have had a pretty bad journey in protection, who have been on the run for a long time... And they meet or hang out or have friendships with 'our' boys, boys of North African origin, and it all comes together on the street and creates a pretty big impact."
>
> Service Director. Experience in care services for young migrants. Catalonia

The existence of a wider network of social care services for girls (as part of a government strategy to tackle female homelessness) was also highlighted. It was pointed out that, due to the different risk situations and multiple forms of violence they face as women, they tend to spend much less time on the streets, both on the mainland and at arrival and transit territories.

> "Two girls recently arrived and immediately entered the Direct Provision Centre, while the boys who were in the same boat didn't, they were on the street.'
>
> Social educator. Crisis Intervention Team. Melilla.

Another element that emerged in the discussion was the close relationship that girls, adolescents and women in care have with violence, and how many of the social relationships they develop are permeated by this violence and by very accentuated logics of power. The enormous misinformation they have about sexuality and affective relationships was also pointed out by one of the participants, an opinion shared by the rest of the group.

> "As an anecdote, a few months ago we did some workshops with girls and the idea was to work on the subject of sexuality, affective relationships... and it was very clear that there is a clear taboo on this, right? The lack of knowledge and the fact that no one has ever talked to them about affectivity, no one has ever taught them this biological part, they have a very strong lack of knowledge about menstruation, they don't know, they don't understand, they have many cultural and mental barriers, everything."
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

On the other hand, and as a premise to be explored, reference was made to the situation of many young migrant women in sex work and how, in this context, consumption appears as a bargaining chip and/or a strategy for disinhibition and sustaining long working days. Throughout the focus group, this was the only reference to women and consumption.

In the case of Ceuta and Melilla, a certain opacity was noted in the women's shelters. This is due to the fact that many of them are located within programmes that work with victims of trafficking. In this sense, it was highlighted

that the logic of protection and security prevails, which is considered necessary in some cases, but at the same time makes it difficult to work with these girls in other areas.

> "It's not that there aren't any in Ceuta, but it's very complicated to work with them. It is true that in Ceuta there is a centre for girls, which is a bit 'hidden' and it is difficult to get there. We understand that there is a need for protection so they do not fall into trafficking, street situations, etc. In the two years that I have been working in Ceuta, I have only seen two girls.'"

Social worker and volunteer. R eference of Intervention Project. Ceuta.

Finally, it is important to note that beyond the existing concern about the invisibility of women and the LGTBIQ collective, there was no further reference to this issue in the development of the FG, nor any comments on specific strategies to address it.

CONSUMPTION: SUBSTANCES USED AND PATTERNS DETECTED

In terms of substance use, there was a consensus among participants that benzodiazepines (Rivotril) and gabapentin (Lyrica) were the main substances of concern among this community group.

The low cost of these medicines on the illicit market and their easy accessibility through medical prescriptions were mentioned. They pointed out that the young people who use these substances are reported to be in the emergency services and around DCRs, where they are provided by users.

> "It is medication prescribed by the psychiatrist, usually the prescription unlocks a couple of boxes. They go out with one box and lose it before they even release - stolen, sold... They are very easy to get, even easier than food, it's crazy!"

Social Educator. Social care work at a drop-in service for homeless people. Basque Country.

> "Consumption rooms are the point of sale of benzos, they can get prescriptions and we go to the consumption rooms to get them."

Education assistant. Experience in HR services. Catalonia.

In this sense, the need to work with inpatient and/or outpatient teams of mental health professionals to regulate and reduce the prescription of this type of medicines was requested and raised.

> "We even went as far as to ask a doctor to stop prescribing. It's like begging "please stop" because it's not doing any good."

Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

On the other hand, some participants pointed out that these medicines are often used in combination with other substances, especially cannabis, i.e. combined use with associated risks, one of which is misinformation and lack of knowledge.

> "I think for kids on the street, anything is acceptable. If it's cheap and gives you a big high, go for it. A lot of mixing and a lot of disorder and a lot of ignorance. Very abusive and disinhibiting, not recreational at all."

Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

> "And I see children who are on drugs 24/7, all the time, using all kinds of substances, mixed with alcohol, children who can hardly stand up or don't even know their names... It's very hard to handle."

Social educator. Experience in youth care services. Catalonia.

With regard to the point at which consumption begins, one of the participants, originally from Morocco and therefore familiar with the reality on the ground, mentioned the existence of Rivotril in Morocco, but as a non-prescription medicine, available only through smuggling. This makes it an expensive substance that is difficult to access. This explains the almost immediate transition to inhalants such as glue in some Moroccan towns, especially border towns such as Nador, and the more problematic use of benzodiazepines, which are easy to obtain once on Spanish territory.

In the case of alcohol, its use varied from one area to another, being practically non-existent in the cities of transit and more present as the young people progressed along their route. In some cases, especially in places of permanence and after passing through other Regional Autonomous Communities, the use of illicit substances was also reported (apparently quite residual).

> "We have seen an increase in relation to the fact that we used to see benzos and alcohol, and now we are also seeing cocaine and heroin, which has increased among young people, between 18 and 21 years old. (....) I don't know if it is because of the environment, where you go, because of course most of them go with older people and that takes them there."

Education assistant. Experience in HR services. Catalonia.

The use of crack cocaine was highlighted, especially in the case of large cities such as Barcelona, in the context of '*narcopisos*', spaces that some young people end up living in and visiting, both for consumption and for recreation purposes, due to their situation of homelessness.

On the other hand, the low prevalence of inhalant use in general was highlighted, with the exception of Melilla, where it was observed mainly during the winter period. As a substance, they highlighted its low position on the young people's own scale of evaluation, which is usually considered a substance of the poor and strongly linked to a lack of services. In contrast, they pointed out that the use of psychotropic substances and their mixed derivatives is usually understood and experienced as a more cosmopolitan and European use.

On the basis of the above, the question was raised in the FG as to whether use becomes more sophisticated as people move between territories, obviously excluding those who already had problematic use in their country of origin. There was no clear and unanimous position on this question, although in most cases the answer was yes, but not in a linear way. Problematic use was linked to the length of the waiting period and the level of psychological distress accumulated as a result of the breakdown of expectations, exposure to various forms of violence and social and material living conditions.

> "Most of the children, when they land in Barcelona, have already been to many places previously. It is even more complicated to work with these young people because they come more 'addicted', with more legal problems... It is very complex."
>
> Education assistant. Experience in HR services. Catalonia.

> "There are children who come with previous consumption problems, but newcomers who don't have such a high level of consumption, get really deteriorated on the streets. It's very hard for them to wait so long."
>
> Social Educator. Social care work at a drop-in service for homeless people. Basque Country.

For example, in transit cities such as Ceuta and Melilla, really problematic consumption was observed when people waited for a long time and were forced into a situation of homelessness.

> "In Ceuta, the longer you are 'trapped' there, the more you consume, in terms of the frustration of not being able to go to the mainland. And this is particularly evident when you have children who see other children who have arrived after them and who are leaving before them. The question then arises: when is my turn? Or, for example, your group of friends who are leaving, who manage to do 'risky' things together and you get stuck in Ceuta. It's something that makes you consume more."
>
> Social worker and volunteer.
> Referent of Intervention Project. Ceuta.

In the specific case of Ceuta, the existence of certain networks that facilitate and promote the well-being of young people was mentioned, although this is an observational element that should be explored in greater depth.

> "All the drugs come from El Príncipe and we have sometimes seen cars in the port distributing pills to young people. They arrive, park, give them away and leave. They do it in the middle of the night."
>
> Social worker and volunteer.
> Referent of Intervention Project. Ceuta.

In short, the group endorsed the idea of substance use as a symptom, linked to a condition of vulnerability made up of various intersections between using substances, being a non-white male, a migrant, from a low social class and with a language barrier, together with the experience of multiple forms of violence during the migratory journey, which in many cases led to traumatic experiences. In addition, consumption was understood to be framed within a particular stage of life, such as adolescence or early adulthood, when people are immersed in a highly complex process of identity and personality construction. It was thus defined as non-recreational consumption and as an avoidance strategy in the face of possible post-traumatic symptomatology and high levels of psychological and social suffering due to living conditions.

> "The harder the road gets for them, the more they tend to consume. Someone said that, didn't they? It's just that when I smoke, the problems go away."
>
> Social educator. Experience in youth care services. Catalonia.

On the other hand, substance use appeared as an element of concealment from the family, which is associated with a certain shame in relation to the expectations and projections of these families about their future. At the same time, as we will see later, it can be experienced as an impure act from a religious point of view. In parallel, and from a very exploratory point of view, it could be seen as an element of identity in more marginal contexts, in the logic of appropriating one's own stigma and integrating it into the aesthetics and image that reproduce the MDLR identity.

Finally, the incorporation of the transcultural perspective was mentioned as a challenge within the field. In this sense, it is worth highlighting the consensus

on the need to include the transcultural perspective in models of care and to give it more space when thinking about training programmes for professionals. The importance of knowing the culture of origin of these young people was stressed in order to better understand their vision of youth or adulthood, their life course and achievements, their experiences with substance use and the meanings and moral conflicts that may arise.

> "And we have a case of a person who inhales glue and hides it. He doesn't want to show his bag, he has never talked openly about the problem he has with it. He knows that he is frowned upon by his compatriots and that they will point it out to him. And that puts him on a very low scale. On the other hand, with other substances like hashish, which is very much from where they come from, he'd say: "I've got the best hashish in Barcelona". It's very prestigious. Everybody smokes it."
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

> "Alcohol, well it depends, if you are a very square Muslim it is a sin, it is haram and I will mark you for it. Maybe you can have a beer, but if I see you drunk, you will get a very bad image. Drinking alcohol is frowned upon."
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

MENTAL HEALTH: REASONS FOR AND IMPACTS OF PROBLEMATIC USE OF PSYCHOTROPIC SUBSTANCES

Another concern identified in the group was the issue of mental health in relation to substance use and homelessness and its impact on the psychological wellbeing of these people. The significant psychological distress of this group was widely noted, a statement observed by the teams and echoed by people themselves.

Participants highlighted the difficulties of establishing clear diagnoses and follow-up at this level in the street contexts where these people live.

Participants highlighted the difficulty of making diagnoses, which are often necessary to understand certain behaviours and levels of distress. However, they also pointed out that diagnosis places demands on them that they are not always able to meet.

> "The fact that the children are on a street situation does not allow for a good follow-up and the fact is that we have no diagnoses, they are not registered anywhere, we have no mental health references in the street and it is very difficult for us to do anything. The only thing we have is prescriptions at our discretion (...) We are treating a volcano with a watering can."
>
> Service Director. Experience in care services for young migrants. Catalonia.

The lack of a comprehensive intervention, both from more generalist and more specific services, including a more psychosocial approach, which addresses and takes into account the risk factors of these people, the traumatic experiences they have lived through, the various intersections that cross them and make them vulnerable, was also highlighted. In this sense, the need for better coordination between mental health services and the various services dealing with substance use (harm reduction, treatment, etc.) was highlighted. In short, a more global approach to dual pathology, recognising that these are two fields of intervention that have much in common and have not been well integrated:

> "I get the feeling that our kids are a bit like "spinning tops", aren't they? First they are told "go there because here we cannot help you anymore. Then go to this other service because you have a substance use problem". And so on, causing burnout. In the end they get tired of it and so do we."
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

On the other hand, the time and place of admission to the psychiatric unit was also highlighted as the only time when the person receives care in these two directions, when the social, personal and health situation is likely to have already deteriorated considerably and after having been treated several times in the emergency department. This highlighted the revolving door effect that occurs between these two types of intervention and the experience of many people in this regard, as well as the lack of follow-up when they return to the same environment that causes them discomfort.

> "And this is a trauma for the boy because in one place they treated him like a madman, in another place they treated him like a junkie and he ended up in a place where he came out very numb and he does not know what they did to him, right?"
>
> Project technician and member of the health commission. Experience in care services for youth on street situations. Catalonia.

Finally, participants reported a lack of specific courses on homelessness, mental health and substance use, describing most existing courses as generalist.

CARE OF THE COLLECTIVE BY HR SERVICES: DILEMMAS AND PROPOSALS

In general, all participants agreed that HR services could provide answers to the needs of this group.

However, opening up existing services could be counter-productive in some respects.

Firstly, the coexistence of young people with little experience of substance use with people with a long history of substance use, who are older and use routes of administration with greater associated risks, was described as problematic. There was an understanding that within this relationship framework, there could be synergies that could have a 'negative' impact on young people by encouraging the introduction of new substances and ways of use that had not previously been known.

> "Because there are risks for them too. Young men who smoke a pipe once a week come here and you put them in the lion's mouth. It's not good for them. They come with a pipe once a week and end up using it every day."
>
> Education assistant. Experience in HR services. Catalonia.

On the other hand, it also highlighted the discomfort that some older users reported when sharing spaces with younger people, either out of embarrassment, fear of worsening the situation of these younger people, or because they felt judged.

> "It's a mixture that nobody likes, neither the young nor the old. The old people see them as children and the young people see them as junkies."
>
> Education assistant. Experience in HR services. Catalonia.

> "You tell them to go to a hostel and they say "no, I don't want to go with those old junkies". Sometimes they don't want to socialise with them because they act as a mirror."
>
> Social educator. Experience in youth care services. Catalonia.

Faced with this scenario, there was agreement on the need to create new, specific care services for these people, with a comprehensive approach involving multi-disciplinary teams and designed from a harm reduction perspective. Harm reduction was understood from the prevention point of view, taking into account the enormous lack of information and knowledge about the use of substances, mixtures and effects identified in the group. These specific services were conceived as low-threshold places, with ample and flexible opening hours that would allow young people to access them without too many requirements. It was also envisaged that they should include social, psychological and health support, as well as safe and DCRs.

> "We have been saying for many years that we need low-threshold spaces, which we now call "high tolerance" spaces. (...) ... that they should be open for children to come, where nothing is asked in return. No connection, no continuity. Where they can have showers, washing machines, psychological care on the spot. And that doesn't exist."
>
> Service Director. Experience in care services for young migrants. Catalonia.

However, given the current situation, there was a shared sense of 'care limbo' for this community and the need for social and health care to be provided by the harm reduction network. The presence of these people as a group in the immediate vicinity of HR services was also highlighted, partly because of the buying and selling of benzodiazepines that takes place in these places, and the possibility of obtaining prescriptions from other users.

> "We started seeing kids around harm reduction spaces looking for benzos among users. And there they are."
>
> Education assistant. Experience in HR services. Catalonia.

The question of whether or not these people should be cared for in HR services until more specific services are in place was not unanimously agreed and there was a range of opinions. A majority felt that neglect could be more harmful, especially in street contexts, while in other cases certain risks were highlighted.

> "That it would be more harmful for them bumping into things that they haven't tried yet... But a perspective from people who work directly with substance use would help them more than what I am able to say."
>
> Social educator. Experience in youth care services. Catalonia.

Due to the lack of care and housing support services in the case of Ceuta and Melilla in particular, and to some extent also Donostia, the possibility of creating specific services for this group was considered unlikely. In this sense, priority was given to other issues related to the satisfaction of basic needs.

On the other hand, people working in these two cities described them as highly harmful and composed of a multiplicity of risks due to their nature of border areas, where several forms of violence are perpetrated against young migrants in a situation of homelessness for this very reason. The situation of geographical isolation was also highlighted as a factor that prevents this group from being assisted by more specialised care circuits.

> “For me, the harm is Ceuta, passing through there, the violence there, the violence at the border, the violence in the port. There is a lack of such basic services that you need a bit of everything. (...) The substance use problem goes hand in hand with many other issues and is not the main problem. I’m not saying it’s not important, but I see many things on the same level.”

Social worker and volunteer.
Referent of Intervention Project. Ceuta.

> “The main risk factor for these children is that they are in Melilla. There is no shelter, there is no soup kitchen, in other words, there is a lack of basic services in general. (...) And, for example, children who need treatment are referred to Cordoba, where there is a centre. And they say they had a good experience there, but afterwards, they are sent back to Melilla and they continue in the same situation.”

Social educator. Crisis Intervention Team. Melilla.

3.6. HARM REDUCTION AND SUBSTANCE USE PATTERN

AUTHOR: MARTA ESCOLANO VEGA

INTRODUCTION

Phase I of this study made a diagnosis of substance use patterns based on three categories that will be used in the subsequent analysis of this issue: substances, routes of administrations and contexts.

In terms of substances, the diagnosis showed that the most commonly used substances were those of the stimulant family. There was also a territorial generalisation of the decline in the use of injected heroin, which had led to the start of HR in Spain. In contrast to the increase in the use of stimulants, an increase in the use of psychotropic substances mixed with alcohol was noted, especially among women who were both linked to HR services and had a home.

In terms of contexts where substances are used, a total of five locations were identified in the diagnostic phase: drug consumption rooms, at home, '*narcopisos*', public space and saunas. In addition, '*narcopisos*' were described as squatted dwellings located in central areas. Particularly unsafe spaces, especially for women, where experiences ranged from extortion and verbal aggression to sexual assault, kidnapping and homicide happen. With regard to consumption rooms, a geographical inequality in their implementation was noted, leading to a greater use of drug dealing spaces in areas where this type of facility is not available.

Finally, diagnoses related to routes of administration showed an increase in the use of inhalation to the detriment of injection, with the exception of Barcelona, where the use of both routes was reported almost equal. Concerns have been expressed about the inadequacy of HR programmes and services to deal with this new reality. There is an imbalance in the attention paid to the injection and inhalation routes.

Having observed these elements highlighted in the previous diagnosis, this theme was developed based on different premises for the focus group approach. These premises took into account that the community targeted was predominantly homeless, living in an urban context.

Therefore, the hypothesis of their usefulness in maintaining wakefulness was used to approach the use of stimulants. Considering that it is a condition that helps to survive in the street, where various forms of violence are unleashed, ranging from robbery to sexual aggression. But also from their capacity to increase production within the urban dynamics of profiting and consuming.

According to these discourses, productive capacity seems to be the result of individual effort and not of segregated work, living or conditions, so that the use of stimulants fits in as a tool to facilitate this effort.

With regard to the contexts of consumption, particularly in '*narcopisos*', the groups focused on the hypothesis of common elements to the cities: the tertiarisation of the economy and the widening of the urban margins.

It has been hypothesised that the expansion of these margins has led to the dismantling of retail and comfort areas in the periphery and, in parallel, it seems that the tourist attraction to the central areas of the cities has led to a community replacement in neighbourhoods due to the increase in housing prices.

From this premise, both realities leave a liminal space in which the people expelled from the peripheral settlements are not welcomed in cities, which are aesthetically prepared for tourist attraction, while at the same time this community replacement has left empty houses.

It is worth noting that at this stage of the study, while differences in the choice of substances, contexts and pathways were identified according to gender, these contrasts were not elucidated according to country of origin or psychophysical ability. This could be explained by the preponderance of Westerners in the groups, who were able to absorb transcultural perspectives, and the barriers to participation for people with psychophysical difficulties, both in terms of mobility and technological accessibility.

METHOD

A focus group made up of users of HR services and/or programmes was set up and supplemented with elements of substance use patterns drawn from a second focus group made up of professionals.

The first focus group, hereafter referred to as *FG-First Person*, had the aim of exploring the topic and the inclusion criteria were: to be 35 years or older, to have a broad background in substance use or to have close contact with people in this age group.

The application of these criteria made it possible to identify changes in substance use patterns over recent years. In addition, a diversity of profiles according to administrative situation, place of origin and gender was ensured in order to analyse the possible influence of these variables on substance use patterns. In order to recruit participants for the *FG-First Person*, the research team provided professional contacts from the substance

use care services in the city of Barcelona, who gave access to their users.

The inclusion criteria for the second focus group, made up exclusively of professionals (*FG-Professionals*) was having a professional contact with PWUS. Thus, the participation of professionals was sought in the following areas: risk reduction services, substance analysis, contexts intersected by substance use in all its spectrum, and harm reduction programmes and/or services (HR).

The criteria for selecting participants were aimed at ensuring that information was obtained on the possible collective and structural dynamics that could influence substance use patterns identified in the diagnosis of this study. And also ensuring representativeness in terms of gender, national territories, professional profiles in the social and health sectors and types of services.

The *FG-Professionals* were led by the research expert on substance use patterns. It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2 hours.

A total of 14 people took part. The *FG-First Person group* consisted of 7 users and the *FG-Professionals* of 7: 5 women and 2 men. The maximum age was 51 years-old and the minimum 35 years-old, wth an average of 43 years-old. A total of 8 people refused to take part in the *FG-First Person* because of the difficulties that older people had in terms of travel mobility to the place where the session took place.

Regarding the *FG-Professionals*, 5 professionals did not agree to participate in the study. The reasons for refusal are unknown.

Finally, it should be noted that the *FG-First Person* was carried out in Barcelona. This was due to the difficulty in finding a group of users with these characteristics in the municipality where this part of the report was produced: Madrid. In this area, the preponderance of services aimed at abstinence or alcohol harm reduction meant that active users of other substances were not linked to services or that their patterns of use were not recognised by these services.

Both FGs included the same thematic areas of research: 1) characteristics of the current context, 2) changes in substance markets, 3) changes in the spatial contexts in which substances are consumed, and 4) characteristics of accompaniment by route of administration.

RESULTS

THE USE OF STIMULANTS AS A RESOURCE FOR SOCIALISATION ACROSS THE SPECTRUM OF SUBSTANCE USE

Both focus groups were in agreement that the Covid-19 pandemic had an impact on relationships patterns between the general community and PWUS. In the *FG-Professionals*, the terms 'anxiety' and 'social phobia' emerged as two opposing feelings in relation to each other, where spaces for interaction are both sources of discomfort and relief. In the *FG-First Person*, a reverence for stimulant substances such as methamphetamine was highlighted, the positive benefits of which were seen in increased productivity, mental activation and alertness.

Participants reported that these benefits spilled over into the relational sphere, as the positive experience associated with use was the ability to have group conversations, giving the substances a phatic function. This was reported as a motive for group cohesion, as evidenced by expressions of camaraderie such as 'smoking with colleagues' or 'surrounded by friends', placing more emphasis on using within the peer group than on the substance itself. This is interesting because this group was made up of homeless people, and achieving a satisfactory level of intimacy in personal relationships seemed to act as a healing element in a street context where relationships are mainly built around mistrust and survival.

This instrumentalisation of substances to disengage from relational contexts was mentioned by *FG-Professionals* as a consequence of the Covid-19 pandemic, which also affected other contexts impacted by substance use. A professional who intervenes in nightlife venues described the reality of substance use dynamics.

> "Years ago young people rented rooms (...) they put sofas, a TV, a PlayStation and basically it was a place to meet when it was cold (...) Well, that's all gone, people don't rent rooms anymore (...) they go out late at night to drink and party."
>
> Anthropologist. Experience in substance analysis services. Basque Country.

Although the expert did not make explicit reference to stimulants when explaining the disappearance of peer meeting places, she did refer to them later to mention the exponential increase in the presence of synthetic cathinones in the samples analysed by the HR services. Substances whose effects she described as '*more amphetamine-like*', while retaining the empathogenic effects reported in methamphetamine and stimulants.

In the same post-pandemic context, the Aragon HR units had also observed an upward trend in the acquisition of mephedrone by users, which they related as follows:

> "There is an entry in Aragon that didn't exist until two years ago, which is mephedrone, and people who have started using it have automatically made it their substance of choice."
>
> Social worker. Education and substance analysis experience. Aragon.

Participants in the FG Professionals working in LGTBIQ+ sexual health programmes attributed both methamphetamine and mephedrone use to overcoming barriers imposed by male socialisation and to greater difficulty in forming affective bonds at a collective level as a result of a long history of social disconnection. The same element was found in the *FG-First Person*, where the use of methamphetamine to 'open up' was identified as a benefit within the LGTBIQ+ group.

The peculiarity of the situations described here is the quantity of conversations, interrelated experiences and stimuli offered by these forms of social bonding. Their fragility seems to be compensated by an abundance that would be difficult to achieve without the specific effect of this type of substance.

Concerning HR programmes related to stimulants, the *FG-First Person* identified the need for spaces dedicated to methamphetamine use and after-use, separate from other supervised spaces for cocaine or heroin consumption, mainly because of the specific effects of this substance. From these demands it can be concluded that the dynamics of consumption determine the choice of the place where it is practised and, in turn, the space modulates them. In such a way, they are imbricated in the characteristics of the places and the people who inhabit them.

HIGH SOCIAL VALUATION OF PRODUCTIVITY

Another positive attribute of stimulants is that they increase productivity. This term, reappropriated from economic jargon, is particularly meaningful for street people in the current urban context. The premise of the semantics of productivity mentioned in the introduction was at work in the participants of the *FG-First Person*, who attributed to methamphetamine and cocaine the property of 'making them work'. One of the participants expressed this idea in the following way:

> "When I smoke meth (...) I walk, I recycle, I work, I activate my body, I have been able to walk a lot of kilometres, it makes me work."
>
> Female. Linked to HR services. Catalonia.

In the discourses of people who used this substance, a higher self-concept was detected, in that their personal value increased according to the number of activities they were able to do. On the other hand, when other substances were mentioned, such as heroin, elements of stigmatisation were observed on the part of stimulant users, who attributed a certain childishness to heroin use as the main substance, seeing it as a phase they had overcome. They also associated heroin use with inactivity, the moral burden of which was negative, as opposed to activation and productivity, especially in the male members of the group, where feelings of rejection of these states were underlying. One of the members, a former heroin user, made the following statement:

> "I used to smoke dope for a long time, almost 10 years, then I went to prison and inside I quit with methadone (...) I don't like it at all, I used to smoke as if I was dead. If I met her and she was smoking dope, I wouldn't like her, you know? Now I smoke meth (...) I like to mix it with a bit of alcohol to be talking, but when I smoked dope I wasn't even able to talk."
>
> Male. Linked to RDD services. Catalonia.

FG-Professionals justified these rejections in terms of the discourses that emerged in the 1980s and 1990s about heroin as a substance associated with delinquency and marginality. These narratives seemed to be divorced from any reflection on the centrifugal processes that led to the social exclusion of the people who embodied the heroin imaginary, and thus seemed to have been internalised by users. One of the participating professionals picked up on the symbolic charge of these discourses, along with the idea of productivity mentioned earlier.

> "There is a kind of hierarchy, and I say this as a recovered drug addict, so I am going to give myself permission, there is a hierarchy (...) that prevents you from realising at any given moment how much of a problem you have. There are views that have to do with the criminalisation of a reality that happened in this country as an epidemic in very specific years, and from there (...) there is this hierarchy, like looking over one's shoulder. I don't know who's fucked up. I'm not, I'm functional here because I work 18 hours, I've taken 5 grams, so I have no problem."
>
> Coordinator. Treatment and gender perspective expert. Catalonia.

In both quotations we can see how the concepts of 'being dead' or 'buggered' are used to refer to situations of unproductivity, giving value or assigning less danger to those substances that make the opposite possible.

THE BENEFITS OF VIGILANCE

The ability of stimulants to induce alertness was reported as a useful aspect in the street context. One user cited this as motivating or focusing use.

> "It helps me to stay awake, which is commonly known as sleeping with one eye open (...) I don't like to fall into a deep sleep (...) someone opens the sleeping bag or I hear a noise, whatsoever, and I jump up."
>
> Female. Linked to HR services. Catalonia.

In terms of the oppressive axes being a woman and homeless, the use of stimulants seems to be presented as a short-term advantage to maintain security.

ASYMMETRICAL LEVELS OF CONCERN AMONG PROFESSIONALS AND PWUS ON THE USE OF LEGAL SUBSTANCES

The term benzodiazepines appeared more than 10 times in the *FG-Professionals*, whereas it was mentioned only once in the *FG-First Person*. In relation to this question, it was noted that in the *FG-First Person*, when asked if they thought there was a difference in substance use according to gender, the general answer was no. However, when asked what substances they used to counteract the effects of stimulants, women referred to hypnotics, whereas men did not.

In contrast, professionals reported an increase in the use of these medicines in recent years as an element of concern.

> "We are concerned that benzodiazepines are not considered in the same way as other substances."
>
> Coordinator. Treatment and gender perspective expert. Catalonia.

The professional reflections showed that the rhythms required by the dynamics of production and consumption are exhausting, anxiogenic and require activation. One of the participants focused on the working environment:

> "Due to work-related demands in terms of waking hours, concentration, work and performance."
>
> Coordinator. HR Service. Catalonia.

However, in the professionals' accounts, it was perceived that these productive demands were not evenly distributed among the population, but added to the accumulation of reproductive demands, which were relegated due to the invisibility of those who suffer from them: women. One of the professionals described how consumption was problematised in these cases.

> "The increase in the use of alcohol and benzodiazepines is closely related to gender (...) What we are finding at the moment is that we have a very large group of women in their 30s and older, who have become ill with pathological patterns of use as a result of motherhood. And behind these hyper-motherhoods, these demands in terms of the gender role, to be able to handle everything and to feel extremely lonely (...) from there to such a collapsing stress that leads them to all this."
>
> Coordinator. Treatment and gender perspective expert. Catalonia.

Similarly, one of the *GF-Professionals* working in a low-threshold centre for homeless women stated that the element of greatest concern was the use of psychotropic substances by these women, who used them to '*relax*', '*be calm*' or '*self-harm*'. The asymmetry between professional concern and the importance given by users may be due to what was referred to in the professional group as the 'medicalisation of female discomfort'. One participant reported that this tool is offered to them by health centres in order to resolve discomfort related to the gender role, and is therefore validated by users as a means of resolving it. On the other hand, the *GF-Professionals* highlighted the low price of these medicines, so that the services needed to obtain them are lower and involve fewer additional concerns.

Suggestions in this regard focused on sharing and informing women about gender as a category of analysis for this discomfort as part of the HR. There were no reports of experience of HR in relation to benzodiazepines.

On the other hand, this asymmetry was reversed with regard to methadone. Professionals cited methadone as one of the reasons for the decline in heroin use among the community they worked with. This argument was also put forward by the MDs, as all those who reported heroin use as their main substance were in methadone programmes. However, the latter group emphasised the different dangers associated with heroin use. The following extract from a dialogue illustrates these concerns:

> "J: I think methadone is another drug, it's a drug to get you off another drug.
>
> A. Only that it's legal, and methadone causes withdrawal symptoms... methadone is a very difficult substance to control...
>
> E. That's why you come down little by little... I would also like another treatment, because I have heard that methadone is very bad and very harmful. Let's see if there is another way, because there is no other kind of treatment."

Users seemed to question the use of methadone as the only strategy for opiate treatment, implicitly calling for alternative treatments from a HR logic.

This view discriminated against people who use injected methadone as a psychoactive substance, and was explicitly rejected by the majority of the group with moral recommendations. However, there were no elements of concern about this substance among the FG professionals, although there were concerns about the route of administration. The only HR strategy reported in this regard was the adaptation of hygienic paraphernalia to include larger volume syringes, larger needles and hypodermic needles to facilitate the injection of this substance.

Relevant aspects relating to routes of administration.

One of the *FG-Professionals* noted that the adaptation of the paraphernalia for methadone use led to controversy within the professional team on the needle size. However, the advantage was that the wide range of HR regarding the injection route made it possible to adapt the equipment to this evolving need.

Conversely, a situation of vulnerability has been identified for inhalation users, which is more or less pronounced depending on the area concerned.

INEQUALITIES IN THE ADAPTATION OF HR PROGRAMMES TO THE INHALED ROUTE

FG-Professionals participants from Barcelona reported programmes to distribute paraphernalia and HR workshops for the inhalation route. One of the professionals listed the services and items available.

> "We have crack pipes and methamphetamine pipes and we also supply them with different mouthpieces (...) We didn't have access to this material before, so we contacted a supplier in the UK (...) and from there we started to include them (...). We also do some workshops on inhalation, hygienic consumption, for whose attendance they get remunerated."
>
> Coordinator. Expert in HR services. Catalonia.

In contrast, one of the professionals from Madrid explained that the people they looked after in their service were mainly inhalant users, but they only had equipment for parenteral use, so the HR intervention they could do in this respect was limited to one-to-one discussions about how to reduce the risks associated with this route.

Another of the services represented at the Valencia *FG-Professionals* reported that in 2004 they had to make pipes by buying curtain rods and bowls from DIY stores, recycling methadone canisters and using pieces of hose as mouthpieces because they could not afford the sterile material for inhalation. At present, they use household pipes made from these materials for distribution and buy glass pipes from tobacconists, which they give away as compensation for attending the workshops.

The element that stands out in these contrasts is that over the last 20 years, the processes of maturation and reflection that services need to adapt to this change in pathways are paralysed or absent in parallel with the increase in consumer needs, forcing them to cover this space from the professional initiative, as seen in the last example.

The group of users described this similarity by locating it in the spaces of supervised consumption for inhalation. They explained that in the city of Barcelona, people in street situations have only one alternative space to the public street (or '*narcopisos*') to consume through this route, which means saturation of people who want to use it and a worse consumption experience.

ADMINISTRATIVE CHANNELS AS AN ELEMENT OF TENSION BETWEEN USERS

The stigmatisation of injecting substance use was described by the *FG-Professionals* as an element operating in the community, closely linked to HIV and marginalisation. A transfer of these stereotypes to the imaginary of PWUS was noted, leading to a polarisation of the debate according to the route used.

While those who used both routes of administration remained neutral, those who used the inhalation route associated injection with disease transmission and the inability of individuals to take on the additional responsibilities of parenteral use, such as exchanging paraphernalia. These prejudices were reinforced if the route was also used for methamphetamine or methadone - especially the later, because it induces the previously reviled inactivity - and mitigated for the more common substances such as cocaine or heroin. In addition, the switch from injecting to inhaling was seen as an element of harm reduction.

Participants who used the parenteral route demonstrated agency in managing the responsibilities associated with using syringes. They referred to the other side's accusations as stereotypes they had picked up from the general population, and noted that they had more opportunities to use hygiene equipment than the inhaler. This was seen by the other side as unequal access to their rights.

Relevant aspects of the contexts.

The analysis identified several contextual elements in the routes of administration and substances. Space is a constitutive element, while the involvement of multiple variables shapes relationships with substances.

Below are some of those that stood out during the research.

DISMANTLING OF SETTLEMENTS IN THE CITIES AND THE USE OF NARCOPISOS AS A SHELTER RESOURCE.

Participants of the *FG-Professionals* agreed that in their different territories they had observed the dismantling of places traditionally reserved for socially excluded consumers, leaving them to wander in spaces they do not know and where they are rejected. One of the participating professionals described what had happened in her city..

> "Here there were a lot of outlets outside the city, in a very depressed environment, in the towns. Madrid has expanded and what I have seen, for example, in the last remaining large settlement, Cañada Real, there is a lot of police presence, many points of sale are being demolished (...) If it is not outside the city, it is settling in the city."
>
> Social educator. Linked to homelessness network. Community of Madrid.

This was linked to the rejection of the community in which the displaced people settled. It was reported that the urban management of conflict from a security perspective forces these people to choose private spaces for consumption. This led to the emergence of drug dealing as a context of consumption in the diagnostic phase of this study.

All the people in the *FG-First Person* said that they avoided these places as much as possible, especially women, who reported sexual aggression, higher consumption than desired due to the difficulty of leaving the room with any remaining substance and the lack of help in case of overdose. Instead, they identified DCRs as their first choice and linked this to the safety they offer. Similarly, one of the *FG-Professionals* who coordinated one of these consumption rooms agreed that it was the preferred space for users because of the elements of safety and lack of judgement that prevailed there.

ABSENCE OF ALTERNATIVES TO THE PUBLIC SPACES OR *NARCOPISOS* FOR NON-RESIDENT CONSUMERS IN BARCELONA

FG-Professionals highlighted that living in Barcelona meant being in a privileged position in terms of access to HR programmes and services compared to living in Valencia, Madrid or Zaragoza. Thus, urban spaces with identical or similar real estate dynamics and security approaches did not provide the same responses for this community.

This situation of disadvantage affects women in a different way, since they are not entities that are alien to their emotions and socialisation. There is an underlying learning that the public space does not correspond to them and that they will be looked down upon even more if they develop disruptive behaviour in it. In this way, the *FG-Professionals* found that, in the absence of regulated spaces to consume and provide training, violence in consumption rooms was a fair price to pay to avoid rejection by the community or police sanctions and substance withdrawal. Some of these ideas are identified in the following dialogue.

> "A: That violence against women is so widespread that in some way it doesn't happen in the context of a narcopiso, but that in some way the risk is there always, no matter where they go [...] or they even have to look for a protection partner.
>
> I: Of course, most of them have had problems in these places, but they put this need first. There they will be able to consume, and won't be fined or robbed."

In turn, both focus groups agreed that although '*narcopisos*' were settings in which violence occurred, it did not differ vastly from violence suffered in public or institutional settings. One of the participants in the *FG-First Person* thus equated '*narcopisos*' with other settings:

> "I don't go to drug houses anymore. In fact I don't go to houses nor other places... it doesn't change the fact that... it happens everywhere, in a bar or [...] in public spaces."
>
> Female. Linked to HR services. Catalonia.

EMERGING ISSUES IN THE FOCUS GROUPS

The causal attributions made to the elements revealed in both focus group discussions were so structurally located as to underlie a resignation to the proposed solutions. While the *FG-First Person* seemed to be more idealistic about the implementation of new services, the *FG-Professionals* did not show the same tribulations.

In this last group, there were elements highlighted as important: the classist view of substances, which made visible only one form of harm, that of sale and consumption, which prevented the real dynamics from being seen; a culture that materialised in prohibitionism; and an androcentric approach on the part of the majority. However, the difficulties in everyday professional life seemed to be caused by an element that was implicit but not verbalised: the refusal of the administrations to recognise the presence of substance use in the cities, which materialised in unequal attention to consumption, a failure to review the allocation of services and an approach based on the logic of emergency.

The difficulty, however, seemed to be that the assumption on the part of large cities administrations meant that they had to abstain from the cosmopolitan race to attract international investment and reserve space and efforts to design responses for this community. It remains to be seen whether this is really to the detriment of urban development or, on the contrary, to its advantage.

3.7. HARM REDUCTION AND COMMUNITY

AUTHOR: PAULA SORIA CARRASCO

INTRODUCTION

Community intervention or outreach work is based on the concept of health as '*a state of mental, physical and social well-being*'[3] and is therefore established as part of the harm reduction process. Historically, this has been based on the implementation of open interventions, including the needle exchange programme (NEP), the promotion of involvement and participation of PWUS at the community level, and contact with community actors and agents, with the aim of reducing or eliminating the impact of substance use in the community environment. In phase I of this study, a diagnosis of the harm reduction situation in Spain was carried out with the aim of describing the current needs of these services and programmes. The conclusions of this study identified some aspects in which the community approach is of great importance, including: the serious inequality in the distribution of services between urban and rural areas; communities in confrontation with Harm Reduction services, professionals and users; the need to reduce welfare and promote community care and support networks; and the professionalisation and medicalisation of services, which is a barrier to access for non-marginalised communities and for which community-based initiatives should be supported.

METHOD

With the aim of finding out about the situation of harm reduction at the community level in Spain, two techniques were used to collect information: the focus group and the semi-structured interview, both within the framework of qualitative methodology, given the need to use open, flexible and interactive techniques to gather information, with the aim of capturing reality from different perspectives and approaches. On the one hand, the inclusion criteria were: to demonstrate professional experience in the field of services for people who use or have used substances, to ensure a greater representation of female than male experts, to ensure representativeness of the different national territories, both large cities and smaller municipalities, to promote the diversity of professional categories of the participants and the diversity of types of equipment, and to include the participation of key community actors in HR. The exclusion criteria were: language barrier, gender and racial diversity among the participants. In order to recruit participants, a research was carried out to identify the institutions that deal with people who use psychoactive substances in Spain, by reading the Regional Plans of Addiction of each Autonomous Community. On the other hand, an analysis was made of the key actors that influence the community approach to HR, such as political, family and neighbourhood agents. Once this research and analysis had been carried out, we contacted those people who, according to the above inclusion criteria, could contribute different experiences, points of view and perspectives on the subject. It should be noted that all of them were contacted by email, where they were introduced to the research and its objectives, and were invited to participate. A total of 15 people were contacted, 5 of whom did not participate, more than half of them because of medical difficulties at the time and 2 of them because of time constraints. Among the people who refused to participate were: an anthropologist involved in a network that supports PWUS in Catalonia, a social educator from an association of volunteers who work with PWUS in Andalusia, and a doctor who heads the Health Promotion Department of a Catalan public institution. The focus group lasted two hours and was conducted telematically, while the semi-structured interview lasted half an hour and was also conducted telematically. All participants gave their informed consent and agreed to the audio and video recording. There was no remuneration for their participation. Finally, the reason for conducting a semi-structured interview was that one of the participants in the focus group had technical difficulties in connecting and participating fluently, and therefore it was decided that she should stop participating in the focus group and then conduct a semi-structured interview in order to better understand her opinions, reflections and experiences. With regard to the characteristics of the focus group sample, of the 9 participants, 5 were women and 4 were men, and the territories represented were Basque Country, Catalonia, Community of Madrid, Galicia, Valencia, Castilla La Mancha and the Canary Islands. The sample also included both urban and rural communities.

The services and/or programmes represented by the focus group participants were: Outreach Team, Mobile Methadone Dispensing Unit, HR Housing Support Service, Housing First, Mobile HR Unit, Home Care, Mobile Medical Screening Unit and HR Drop-in Service. It should be noted that some participants reported working in more than one state territory and in more than one HR service.

(3) RIOD. (2018). *La Reducción de daños en la intervención con drogas: concepto y buenas prácticas*. Retrieved from https://www.cuentocontigo-cuentaconmigo.riod.org/materiales/guia_rd_riod.pdf

Another characteristic of the focus group sample was the diversity of the professional categories of the participants. The only one that is exercised by more than one participant is social pedagogy, being the others represented by only one participant: social work, psychology, psychiatry and nursing. In addition, three of the participants have a coordinating role in the HR institutions where they work. On the other hand, there was also the participation of a non-professional woman who is part of an association of families affected by the substance use of a family member, and a social educator who is a member of a political party. She participated as an advisor to the city council on health and substance use, and also as a neighbour in a community association created to improve coexistence and well-being in the Raval district (Barcelona).

With regard to the semi-structured interview, the sample is a female anthropologist with experience in substance analysis courses in Andalusia. She currently works in an association that also carries out substance analysis in the Basque Country, where she is part of the gender and intersectionality unit.

RESULTS

MODEL AND FUNCTIONS OF THE COMMUNITY APPROACH

Regarding methodological issues of community work, most participants affirmed the need for an interdisciplinary team to address the needs of PWUS and the rest of the community from different disciplines and perspectives. Among the disciplines mentioned by participants were medicine, nursing, mediation, family counselling, occupational therapy, social work and social education.

Some professionals emphasised that the main function of the community approach in HR is to facilitate access to basic rights for PWUS on an equal basis with the general population, and to focus on promoting the creation of support networks among them in order to avoid the risk of professionalising care as the only option. On the other hand, a professional with a long career in the coordination of HR in the Valencian Community stressed the importance of establishing meaningful links between professionals and PWUS, given the lack of a network that characterises them and the need to be able to represent a real support for them.

> “To create communities of support, that is, to be in some way the community of support for those people who have less support. And that means going a step further, let's say, than providing a service, it also means a higher level of professional and personal commitment. In other words, having a community perspective means that in the end we are all part of a community and that this support takes place in different situations, not all of which were included in our service charter.”
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

Social inclusion was another of the functions highlighted by most participants as a priority in relation to the community approach. One professional highlighted the importance of the community itself as a facilitator of such inclusion, as this does not depend solely on PWUS, but it is the community that produces the processes of inclusion and exclusion. One participant described this as follows:

> “We cannot just put inclusion on the excluded, but must take collective responsibility for the social inclusion of all citizens.”
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

All the participants agreed that the HR programmes, and in particular the actions carried out at community level, are aimed at social and regulatory control imposed by the authorities. Likewise, one of the participants, who had been a member of the local government team and of the neighbourhood mobilisations in Catalonia, stressed that the reasons why the HR programmes had become social exclusion programmes were: the lack of updating and development of current programmes and public policies.

> “Thirty years ago, harm reduction services and programmes, as they are now designed, made sense. Today, if they stay in the same place, they become instruments of social exclusion and social control, constantly used to contain social outbursts. Frankly, having been in politics, I've seen perfectly how we don't put in the services we need to really deal with the problem, we just do it to contain social conflict.”
>
> Social Educator. Experience as a counsellor on substance use and health for the town council and in community associations. Catalonia.

On the other hand, some participants also pointed out that HR services end up perpetuating the social exclusion of people through purely welfare-based actions which, far from influencing the realities of PWUS and accompanying them, end up having a more focused function of hiding these realities, disguising them and trying to contain them so that they have the least impact on society. A

nurse in a mobile unit in a village in the Community of Madrid, put it this way:

> "Professionally and personally, this is a controversial issue for me because I end up working in a system that perpetuates the exclusion of PWUS, who are totally excluded and isolated from the city of Madrid, even though they are only a few kilometres from the city centre. So, in that sense, it's also a conflict, because at the end of the day we're not working towards the inclusion of these people, we're just focusing on the diseases that are of interest to public health, which are also of interest to the economy. So where is the social side of support? I think that it is the most important part of harm reduction."
>
> Nurse. Experience in HR services in Catalonia and the Community of Madrid.

With regard to the specific functions of the outreach teams, participants highlighted: mediation in conflicts and tensions that arise with the rest of the community, and reaching out to people who are not connected to HR services to provide information about them and encourage them to get involved.

On the other hand, one of the participants working with rural communities in Galicia in a mobile HR unit emphasised that they had identified difficulties in accessing women. Some of the barriers to access they identified were: the masculinisation of spaces, the lack of non-mixed spaces, the multiple situations of gender-based violence that women had experienced and were experiencing, and the gender-affective relationships of dependency with other men who came to the service. To address these limitations, they implemented positive discrimination measures, such as opening the service on a female-only day and creating non-mixed activities.

> "They are very masculinised spaces and the centre itself does not facilitate women's participation at all. So we have taken some measures to feminise the resource, which is to open a day for women only, carry out female only activities, because we also see that they often come accompanied by their partners, who do not allow them to participate. This is something that we also see a lot in street outings, women are always difficult to access. I usually mention a very important fact, which is that 100% of the women who come to harm reduction services are suffering or have suffered gender based violence at the hands of one or more of their partners."
>
> Coordinator and social educator. Experience in HR services. Galicia.

Another participant, an anthropologist with experience of substance analysis courses in Andalusia and the Basque Country, emphasised that, in order to work in an open environment, they had focused on adapting the language to the users they work with. At the same time, they had decided to use special clothing of a more festive nature, specifically a wig and a dressing gown, which made it easier for people to approach them and distinguish them from police officers.

COMMUNITY PARTICIPATION

All participants agreed that one of the foundations of the community approach to HR is to encourage the participation of PWUS in the community, although they also stressed the need to promote strategies that create meeting points, alliances and synergies with the various community actors in the area where the HR facilities are located.

Only one of the participants, a social educator in a community mediation service in Madrid, whose aim is to facilitate the link between HR services and the rest of the community, stressed the importance of disseminating the services developed by the organisation, so that both other organisations working in the sector and other community and administrations services are aware of the actions being carried out and can collaborate, coordinate or refer a person if necessary.

When the participants were asked whether they thought that the services in which they worked were able to promote a sense of belonging to the territory among PWUS, most of them emphasised the difficulties involved, and only one of the participants said that he thought they were able to do so. The following excerpt shows how a professional with a long experience in coordinating HR services in Valencia pointed out that the fact that the area is a large city and the long history of substance use were obstacles to the existence of a sense of belonging to the territory.

> "I think the sense of belonging is already complex, without consumption it is often, especially in big cities where there is a long history of consumption, more difficult to achieve a sense of belonging to the community."
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

All the participants highlighted the disadvantages of referring and/or linking PWUS to institutions, services or associations that only deal with this group, since, according to the analysis of all the discourses, this encourages the creation of ghettos and consequently prevents the creation of new links away from spaces where substance use and social exclusion prevails. One of the participants, a psychiatrist with experience in home care in the Canary Islands, put it this way:

> "There are certain barriers that perhaps we also put up, because often what is offered to the people we serve are services or entertainment that are always related to patients, to other people with mental illness. And often what we do, perhaps with good intentions, ends up encouraging the creation of ghettos."
>
> Psychiatrist. Experience in mental health and home care. Canary Islands.

Participants shared different experiences of linking PWUS with organisations or services that target the community in general. Firstly, one participant highlighted the importance of motivating people to explore their tastes and interests, seemingly simple aspects that can be difficult to identify due to the impact of long substance use histories, homelessness and the resulting experience of social exclusion. This element was emphasised as fundamental because, by knowing where the person's motivation lay, a range of entities could be considered.

Secondly, most FG participants emphasised the need to participate in activities that take place in community spaces, such as civic centres, and in outdoor activities in contact with nature. One of the participants who had been part of the district government team and neighbourhood mobilisation highlighted the complexity of this due to the stigmatisation of PWUS and the inadequacy of spaces, but also the need to do this as it would enable real partnerships to be forged with the community.

> "If we want to be able to establish links with the community, and also for a person to be able to participate in normal spaces of sociability that are not created on purpose, then we have to be able to work and invent formulas so that this can eventually happen."
>
> Social Educator. Experience as a counsellor on substance use and health for the town council and in community associations. Catalonia.

Some participants also highlighted that low self-esteem, linked to situations of discrimination, among other things, sometimes makes it difficult for PWUS to participate in community spaces. On the other hand, other participants pointed to the lack of training in caring for PWUS as a barrier to connecting them to community services.

> "We favour participation in all events of the area, but is the area ready? Well, it has to be prepared. When the person gets on the bus, we don't prepare the bus for them to hop on. But there are certain spaces that seem to have to be prepared so that people aren't stigmatised."
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

Another aspect on which the participants agreed was the need to influence public policies, and to this end they pointed out the importance of participating in the community roundtables that are held in the territories, with the aim of using these spaces as places of denunciation, where both the violations and the needs identified by the HR services that need to be covered are shared. One of the participants stressed the need for the HR mechanisms to act as a pressure group on the administrations.

> "It is important that we are present through our networks in which we participate, both in the institutions and in the administrations, because at the end of the day there is a problem that goes beyond our motivation, our technical ability, and that is social and health policies and investments. And when we talk about exclusion, it is a world that is very distant from those who make the decisions, so we have to bring it closer to them. And here it is essential that we participate in the networks of entities, of political advocacy, in order to be able to do this, because it is clear that the lobbying groups, those groups that have managed to become a pressure groups, are the ones that ultimately manage to ensure that social policies take them into account."
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

The current instrumentalisation and institutionalisation of social and associative movements by the administration and, at the same time, by the organisations was an issue raised by one of the participants, who considered that this fact makes it much more difficult for the community to play an active role in outreach work and perpetuates the fact that it is only a beneficiary of the HR mechanisms.

COMMUNITY ACTORS

The community actors most frequently mentioned by the participants were family and neighbours. On the other hand, only one participant mentioned friends, partners, the police and the administration. Therefore, none of the participants mentioned dealers, local businesses, other HR facilities, cultural and community centres, political agents and public institutions as important community actors.

With regard to neighbours, several professionals stressed the importance of involving them in community problem solving and the need to respond to their demands, when legitimate, in order to create synergies and supportive relationships. One of the participants stressed the complexity of this coordination with community organisations, but also the necessity of their existence.

> "It is impossible to develop community work without involving the neighbourhood organisations. [...] We have to think that the social institutions, as well as the neighbourhood organisations, have to see how to create spaces for dialogue and joint work. And this is sometimes complex because the timetables and schedules of a professional person are very different from those of a neighbour [...] The question is how to create community spaces where both parties can work together."

Social Educator. Experience as a counsellor on substance use and health for the town council and in community associations. Catalonia.

Regarding families, they were not mentioned as essential actors in community work in HR by some professionals, especially those from Catalonia, Valencia and Galicia. On the other hand, other professionals recognised the need to include a systemic perspective in the community approach and, therefore, to involve families in the processes, relieving them of their guilt, but at the same time making them responsible for their role in activating changes in PWUS, breaking taboos and stereotypes that end up affecting their self-esteem and self-perception. In addition, one of the professionals, a psychologist in the Basque Country, pointed out as a good practice the possibility of promoting meeting places between families and users in community spaces within the region, such as civic centres, in order to also have an impact on the social inclusion of people, as well as on the linkage and access to mainstream services.

Finally, one of the participants, who was part of an association of families affected by the substance use of a family member, gave her personal view on the issue and stressed the need to create spaces for mutual help between family members.

> "For every addict, there will always be three or four family members affected, and sometimes the family is relegated to being the sufferer in the shadows. In self-help groups, we regain our sense of dignity and worth, which frees us from a lot of negative feelings and is a great help to all those who are suffering from the substance addiction of a loved one."

Female. Linked to an association of families affected by the substance use of a relative. Castilla La Mancha.

STIGMA AND AWARENESS

All participants shared their discrimination and stigmatisation experiences due to their substance use, coupled with the confluence of other axes of oppression, which was of great concern to them, while at the same time creating a space to collectively develop tools and strategies for reporting and mobilisation.

HR facilities were highlighted by some participants as places where PWUS feel less discriminated against. Similarly, one of the participants, an anthropologist with experience in drug-checking services in Andalusia and the Basque Country, reported as a good practice the approach to PWUS by others who are also or have been substance users, supporting the inclusion of peers in the teams and thus promoting the creation of horizontal links.

> "We are an association of users and ex-users, and we make that clear, so that the prejudice that a person may feel for being a user is diluted with us and a bond is suddenly created, therefore differing from other actors or family members."

Anthropologist. Experience in substance analysis services, gender and intersectionality. Basque Country and Andalusia.

On the other hand, the places most frequently mentioned by participants where the rights of PWUS are judged, rejected, stigmatised and therefore most violated are the primary healthcare network. Some of the participants confirmed that these violations were reported by the users themselves, and others had witnessed them when accompanying people to the consultation.

With regard to the strategies adopted in the face of these violations, all the participants agreed on the need to report these acts, to file formal complaints and to collect all the information on the situation of discrimination experienced, with the aim of compiling, identifying and reporting on the places where they occur most frequently. One professional stressed the importance of not normalising this type of situation, as it is essential to demand dignified and equal attention. At the same time, she pointed out that poverty and social exclusion are structural axes of oppression that determine these discriminations.

> "We have to get used to the fact that we need to complain when our civil rights are violated, simply because we are substance users, because there are some very bloody things that I think we have become used to, that are tolerated. [...] It is very much taken for granted that someone can be kicked out of a service without a very good reason, and that they can be punished or sanctioned... Certainly in these centres and community spaces there will be many people who use substances. The problem, not just substance use, is substance use when there is a component of poverty or social exclusion."

Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

The discourse analysis shows that some participants thought that PWUS would identify these situations of discrimination and violation of rights. Others emphasised that their own self-stigma acted as a barrier to their identification. Thus, they considered it necessary to raise users' awareness of their rights on the one hand, and to inform them of the legal measures they could take when their rights are infringed. In addition, some participants stressed the need to guide users through the relevant steps to report violations in order to ensure that their rights are protected. One of the professionals, a social educator with previous experience in outreach teams in Barcelona, put it this way:

> "I have the feeling that users are aware of these violations. There are only a few who normalise more out of self-punishment and self-personality, saying things like: I don't deserve more than this".
>
> Social Educator. Experience in Outreach Teams and HR Drop-in Services. Catalonia.

The neighbourhood was identified as a community actor that plays a crucial role in facilitating or hindering coexistence in the areas where HR facilities are located. On the one hand, one of the participants who had been part of the district government team and neighbourhood mobilisations considered that there was often a large number of neighbours who understood the usefulness of HR services and did not stigmatise people who used substances; however, he noted that hate speech and discrimination were often fewer in number but ended up carrying more weight. On the other hand, most professionals, with the exception of those who intervened in the Basque Country, agreed that neighbours usually stigmatise PWUS and even, as one participant pointed out, are reluctant to accept the existence of HR facilities. They pointed out that this position was based on the traditional argument that the introduction of a HR service would make the area conflictual and dangerous, ignoring the usefulness and effectiveness of these services for both PWUS and the rest of the community.

> "For many neighbours, it's still a drama that we're here in the middle. It's a typical thing to think that because of the existence of the centreall the consumption, drug dealing, etc. exists. [...] For all the neighbours who are protesting against the hall, sometimes I wish I could really close the service for a whole week [...] to see what happens, to see if we are doing such a bad thing for the community, but well, there are some who don't see it, and they are still quite reluctant."
>
> Social Educator. Experience in Outreach Teams and HR Drop-in Services. Catalonia.

Only one of the participants, a non-professional woman who is part of an association of families affected by substance use in Castilla La Mancha, stated that families also suffer from the stigma associated with substance use. This causes them discomfort and generates feelings of guilt, shame, frustration, powerlessness and rejection. To address this, the participant stressed the importance of family support groups, which facilitate the release of these negative emotions and create spaces for non-professionalised care based on understanding and respect.

The strategy most frequently mentioned by all participants to tackle this discrimination and stigma was education and awareness raising. The areas identified by the participants as having the highest priority for implementing these actions were: education and training centres, health services, future health and social care professionals, cultural and community centres and families. In addition, most of the professionals stressed the need to start this awareness-raising work with the professionals working in the HR facilities themselves, who, according to them, also have discriminatory and stigmatising attitudes. One of the participants, a nurse from a mobile unit in the Community of Madrid, stressed the responsibility that falls to professionals and therefore the importance of them being able to accompany in a respectful and non-judgemental way.

> "In Madrid, it is well known that if we compare ourselves with a big city, we have been lagging behind in social policy since the 1990s, by whoever has been in power. So, in the end, I think that perhaps the most important strategy at the moment would be to raise awareness among professionals, because the responsibility lies with us rather than with the politicians, given the current situation."
>
> Nurse. Experience in HR services. Catalonia and the Community of Madrid.

One of the questions that arose spontaneously in the focus group was how the recent popularity of right-wing extremist discourse had affected the community's approach to HR. Participants working in the Basque Country reported that they had not noticed any changes. On the other hand, some participants, mainly from Catalonia and the Valencian Community, reported that they had noticed an increase in hate speech against PWUS, which they categorised as dangerous. Some participants also expressed that they had noticed changes at an institutional level, including increased police pressure around HR services.

> “Going from a progressive coalition government at local and regional level to a government in which Vox participates with councils and councillors, well, it has been noticeable. If we have always received a certain amount of inappropriate pressure from the police and we have had to put up a lot of barriers to prevent them from going beyond what the law allows them to do, we have had a bit more control over that in recent years and now there has been a change and we have noticed it.”
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

OBSTACLES AND PROPOSALS FOR IMPROVEMENT

All participants identified various aspects, involving multiple political, social and community processes, that symbolise obstacles to the development of their community functions in HR facilities. They also identified tools, actions or programmes that would be appropriate to address these issues.

The uneven territorial distribution of HR services was identified by professionals as a possible reason linked to the migration of PWUS from rural areas to cities with HR facilities. This migration could lead to an oversaturation of these services. Similarly, some participants pointed out that the lack of low-capacity HR facilities spread across different communities, and the presence of large facilities in the most marginalised areas of cities, has led to a greater number of people moving to these areas. Thus creating tensions with the rest of the community, especially neighbours, and greater difficulties in integrating these people into the community. One professional described this as follows:

> “When it comes to integration, numbers are important. It would be much better to have 15 small centres than not to have one big one. I think that in this sense it will be much more difficult to integrate 30 people at the same time than to integrate three.”
>
> Psychologist and Coordinator. Experience in HR drop-in services, treatment centres and prisons. Basque Country.

Most participants also recognised that another barrier to community integration for PWUS is their homelessness, given the high levels of housing exclusion they face simply because they are PWUS. As a result, participants emphasised that appropriate housing, particularly Housing First, significantly improves the quality of life of these people, while also facilitating a reduction in the number of people on the streets and therefore a reduction in the congregation of people around HR facilities. One of the participants recounted the advantages of Housing First programmes.

> “I’m not saying that the centres aren’t valuable, but it’s not the same to live in a centre with I don’t know how many people as it is to live with one or two people in an apartment. […] So I think it is a key to community inclusion to have small, normalised spaces within the city.”
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

The most frequent obstacle mentioned by the participants was the lack of financial independence of the centres and, consequently, their dependence on public administrations, which, according to the participants, implies the need to follow guidelines that are not usually based on the needs of the PWUS but on the political interests of the moment, as in the case of the social and regulatory control functions mentioned above. For this reason, the majority of professionals identified major structural difficulties caused by the lack of economic, professional and material resources, which hampered intervention and led professionals to carry out functions that were not theirs, long waiting lists for specialised services (as in the case of mental health), situations that became chronic due to difficulties in carrying out preventive actions, a failure to listen to the demands and needs expressed by professionals, and an increasing emphasis on welfare interventions rather than those aimed at medium/long term impact.

> “For funders, social inclusion is generally less important than the fact that there are no problems and that the citizens who vote are happy, so they see us as a mechanism of social control, which we are. From there, every centre and every professional can see how to use the system we have for the benefit of people who are in the most vulnerable situations. I think this is also a trump card that we have to learn to play, that it is a daily struggle. I think it’s interesting that we don’t fall into pessimism - we really have few resources, but the ones we have can be very powerful, so let’s aim for that, because that’s what we have.”
>
> Coordinator and Social Educator. Experience in HR Mobile Unit and HR Drop-in Services. Galicia.

One of the participants, an anthropologist with experience in drug-checking units in Andalusia and the Basque Country, noted that certain groups have a greater number of barriers to accessing these services due to the axes of oppression that affect them and the inadequacy of spaces, including: people with functional, physical and/or psychological diversity; racialized people; people belonging to the LGTBIQA+ group; and people over 50.

She also identified prohibitionist substance laws as another cause of these barriers.

> "And I think that people who don't feel interfered by consumption or think that they are not interfered, because licit substances are also drugs, find it very difficult to get out of that perspective. And in the end, the biggest persecution is the current policies that are based on drugs. So, as long as this doesn't change, it will be difficult to reach other sectors of the population."
>
> Anthropologist. Experience in substance analysis services, gender and intersectionality. Basque Country and Andalusia.

Several participants highlighted the high level of care provided in HR facilities as a result of a capitalist and individualistic system that prioritises individual and welfare-based interventions over community and group work, making it difficult for the impact of interventions to have medium and long-term effects on both users and the rest of the community. Similarly, one of the participants identified the large number of emergency interventions as a difficulty in implementing an appropriate community approach.

> "Counting how many sandwiches we give away has nothing to do with making an intervention that will have an impact in the medium term. But this part is also difficult to make people understand, and we have to introduce it into social policy, we have to keep working on it, because otherwise we get into a debacle of numbers that have nothing behind them but numbers. Moreover, I think that in the field in which we work, especially in harm reduction, we have often been very focused on direct work [...] and I think we have corrected this in recent years, but I think it is something that we must never forget because of the urgency. We have been very much in the urgency and it is very important to have a double track, to work with the social reality but to be present in the spaces of political incidence."
>
> Coordinator and Social Worker. Experience in HR drop-in services, Housing First and HR housing support services. Valencian Community.

The limitations and obstacles to the application of a gender perspective in HR services were only mentioned by one participant, who felt that it was essential to ask users themselves how gender influences the use of nouns, what stereotypes are associated with them and how they have or have not internalised them, in order to better understand how services need to take different measures to reduce androcentrism.

> "Our work on the gender perspective is still quite limited and we are in the process of including more of it, so that gender is more important to us, not only for the workers, because ultimately what goes on internally is projected outwards, but also in the work of the association itself. At the moment, when we meet a couple of women in the van who have come to analyse, we try to focus on other aspects to see what their vision of the world is, what their reasons for consumption are, and how they integrate or internalise it."
>
> Anthropologist. Experience in substance analysis services, gender and intersectionality. Basque Country and Andalusia.

Finally, there were some aspects that were commented on by the participants but were not discussed in depth, despite their importance. Firstly, although the participants agreed on the need for the community not to be the sole context of the intervention, but to take a leading role and be seen as the central actor in the intervention, none of them specified what actions could be taken to initiate this change of model, and furthermore most of them considered this model to be utopian due to structural limitations and pressures of care. Secondly, none of the participants mentioned how axes of oppression, such as social class, administrative status and mental health, influenced outreach work and the opportunities to adapt, integrate and/or be part of the community.

3.8. HARM REDUCTION AND HOMELESSNESS

AUTHOR: JOSEP LLUÍS SALVADÓ SÁNCHEZ

INTRODUCTION

Harm reduction is an approach that is nowadays directly related to a large proportion of the population who are homeless or sleeping rough. In the first study on Harm Reduction in the 21st Century Phase I, it became clear that the number of PWUS in a situation of homelessness has greatly increased, and that this reality is also a factor in the exclusion for these users from the network of homelessness and social assistance. It was also noted that active homeless female PWUS who are victims of gender-based violence are completely unprotected, as they are excluded from the services of the network for the protection of victims of gender-based violence.

As a result of the above factors, there was a need for more in-depth research into the profile of homeless people, the support offered and the identification of areas for improvement.

In order to gather as much information as possible, these issues that directly or indirectly affect homelessness were explored.

The participation of professionals from Regional Autonomous Communities that work with this population profile was fundamental, as well as other (few) Regional Autonomous Communities that lack this type of services. For those that do not have services, the research focused on how they manage their working day with homeless people with structural and institutional limitations.

METHOD

It is important to note that the study uses the term First Reception Centres to refer to those facilities that are popularly known as shelters.

The selection criteria for the participants in this focus group (FG) were that the person should be a professional in the field of HR and have more than 3 years of experience in the country in working with people who use legal and/or illegal substances in a situation of homelessness. Participants were also required to have expertise in other fields that intersect with this phenomenon, such as mental health, organic health and/or migration.

It ensured representativeness in terms of gender, national territories, professional profiles in the social and health sectors and the type of harm reduction mechanisms supporting people experiencing homelessness.

The FG Thematic Guide was developed on the basis of the diagnostic results of the first part of this research and the results of the individual questionnaire. It was reviewed by both the researcher coordinating the study and the gender expert.

The FG was facilitated by the researcher with expertise in homelessness. It was observed by both the UNAD technical professional and the research coordinator. It was telematic. The total duration was 2 hours.

A total of 9 professionals with experience in the field of homelessness and addiction, and specialisation in sectors such as mental health, organic pathologies, migration, etc., participated. From the initial list of 11 participants, one professional from the Basque Country refused to participate without giving reasons and one professional with a long career in a service for people in a situation of social exclusion in the city of Barcelona also refused to participate for professional reasons.

Professionals from different areas (Madrid, Balearic Islands, Basque Country (Vizcaya), Catalonia (Barcelona), Andalusia (Seville), Valencia) participated. During the recruitment process, it became clear that in some Regional Autonomous Communities there are no programmes aimed at the target community (homeless people with a harm reduction approach), making it difficult to guarantee territorial representation.

Of the 9 participants, it was important to include all kinds of perspectives, hence the great importance of achieving gender equity. The feminisation of this professional sector was made visible, with 3 men and 6 women taking part.

RESULTS

MODEL OF CARE FOR HOMELESSNESS AND PWUS

In the first initial question on whether there was good harm reduction care for homeless people in active substance use, all participants agreed that there was no real political will to address or alleviate homelessness of PWUS in their area. This was exemplified by the fact that the first reception or housing support services for people living on the streets did not accept PWUS. All participants reported that the main barrier to accessing these facilities was their own addiction status, which they considered a serious violation of fundamental rights and discrimination against homeless PWUS. One participant pointed out that the services available for homeless people were inadequate and noted that one of the screening criteria for access was to reject PWUS.

> "Existing policies talk about there being enough services for homeless people, but then you see people consuming on the streets and shelters are overcrowded."

Social Integration Technician.
Mental Health Organisation. Andalusia.

Professionals working in the city of Barcelona stated that people in street situations are specifically excluded from first-receptions or housing support services if they are active users of illicit substances. However, they agreed with other participants from different Regional Autonomous Communities (Catalonia, Andalusia, Basque Country, Madrid and the Balearic Islands) who noted that the degree of exclusion depended on the main substance used by the person, with alcohol being more acceptable than illicit substances. They pointed out that there was a logic of deservedness, where the use of illegal substances was the last step in homelessness. One participant illustrated this situation by pointing out that in the city of Bilbao there is a service that has a room on its premises for the use of alcohol, but not for the use of illegal substances.

> "There are no supportive policies, on the contrary, existing policies always hinder and promote stigma. Harm reduction is like something non-existent."

Social Integration Technician.
Mental Health Organisation. Andalusia.

The bureaucratisation of access to this type of basic service was another barrier reported by users of the homeless network. Irrespective of the area represented, all participants expressed their dissatisfaction and helplessness at the fact that people who are homeless and in need of a roof over their heads are obliged to have a social worker who will make the referral.

This condition was considered to be very demanding for the study population, indicating that it is really difficult for people living on the streets to get in touch with a social worker as a referral agent. They also added that this barrier was exacerbated by the saturation of the basic service network.

Another example of bureaucratisation reported by the participants was the introduction in some large cities (Barcelona, Seville, Madrid and Bilbao) of the so-called Homeless Commission, a body designed to screen applications and regulate the access of homeless people to first reception facilities. Its operation was described as a process that starts when the homeless person expresses to a social worker the need for a roof. After receiving this request, which in most cases must be explicit, the professional collects individual data (socio-demographics, health, family, duration of homelessness, links with other networks) and draws up a social report that is submitted to the relevant commission. On the basis of this vulnerability report, as if homelessness were not a sufficient reason for requesting access to a first reception centre, and without knowing the person referred directly, the committee meets and assigns a service that seems most appropriate for the homeless person. The meetings of this committee take place periodically and are mainly composed of professionals from the homelessness network, with no collaboration from the HR or addiction network professionals.

It is important to note that the vulnerability of PWUS and homeless people was addressed in this section, but no mention was made of the different risks faced by CIS and transgender women. The FG did not elaborate on the importance of women's priority access to first reception centres, which would have been interesting to analyse.

Participants pointed out that it is common for this process to result in the person being referred to services that are not adapted to their real needs and capabilities, leading to the failure of the process, implicitly blaming the person for their inability to adapt and optimise the service allocated, and inevitably leading to their return to the streets.

All participants noted with concern that this Commission also does not accept people who use illegal substances. One professional participant, who worked as a social worker in an HR centre in Barcelona, pointed out, in a tone of frustration and complaint, that on several occasions this Commission had ignored her reports and assessments, strongly emphasising that there is no coordination between the homeless network and the professionals who provide direct care to people living on the streets and those with addictions.

> "There are fewer and fewer services for these people, so they are getting stricter and stricter."

Social Worker. Experience in a HR centre. Catalonia.

Differences were observed in the support provided to homeless people living on the streets, depending on the national territory. Professionals in Barcelona reported that in this city there are specific multidisciplinary HR teams whose role is to identify and provide daily psychosocial support to street homeless people who use legal and/or illegal substances.

They also pointed out that this city has an outreach team that provides specific support for mental health and homelessness, consisting of a psychiatrist and a nurse. The participants who were not from Barcelona were very positive about this project. They pointed out that this community is the most vulnerable and justified their need for involvement.

Participants from Barcelona, who were familiar with this project, explained that this team had often accompanied people with severe mental disorders and that, thanks to their accompaniment, some of them had been referred and admitted to specific units. They reported this as a good practice to improve the person's health status and adherence to pharmacological treatment. They emphasised that even in situations where hospitals did not have sufficient resources for admission, they had diagnosed the person, an essential element in order to be able to continue the therapeutic plan on an outpatient basis from the HR centres.

Other cities, such as Menorca, Valencia, Seville, etc., reported that they did not have outreach teams, so the visibility of this community was greater. They agreed that it was common in their areas to have small shanty towns that were totally neglected by the administration. The participant from Madrid pointed out that this city had only two outreach teams dedicated to homelessness, which caught the attention of the rest of the participants, as it was a city with a large population and many services.

Participants from Barcelona and Bilbao reported the existence of DCRs, which they described as care services for street PWUS. Participants from the other areas (Seville, Madrid, Valencia, Balearic Islands) reported their non-existence and considered their implementation in their localities as an urgent need.

The participant from Madrid pointed out that the city currently has housing support services for the homeless community that include a harm reduction room, where alcohol consumption is allowed, but not the use of other illicit substances. The participant felt that since the introduction of this service, these centres had made a qualitative leap in the implementation of HR programmes in the city. The participant made an assessment in relation to the reduction of mortality in this community group and linked it to the use of these alcohol consumption spaces, as shown in the following quote:

> "I spoke to a worker in San Isidro and she told me that since the implementation of the harm reduction room, she has directly saved lives."

Head of the homeless care programme. Community of Madrid.

The majority of participants of the FG reported that the services they worked in allowed access to the person if they were under the influence of any kind of substance. All participants described examples of the ladder model as the hegemonic system of care for homelessness in their areas, where the person must deserve the basic right to shelter. Participants agreed that the situation of PWUS living on the streets is highly vulnerable, indicating that there are not only individuals but also structural difficulties. They expressed concern about the high demand for abstinence to access and stay in the services. Although participants were aware of the alternatives to the staircase model, they pointed out that it seemed to be an imposition of the system itself to continue to reproduce this model. They even pointed out the inclusion of more sophisticated elements, such as the commissions mentioned above or the requirement of commitment and compliance with a previous work plan. The professional from Madrid pointed out that these individual work plans are oriented towards abstinence while the person is still sleeping rough, not considering the use of substances as a coping strategy to their living condition and/or the possible traumatic experience(s) associated with it.

> "We will start working on your abstinence."

Head of the homeless care programme. Community of Madrid.

Some of the participants from other cities, such as Seville, Madrid, Valencia, Menorca, Barcelona and Bilbao, expressed concern about the lack of preventative measures for homelessness among PWUS and the resulting professional frustration with the logic of managing the problem once it has arisen.

> "Our programmes are designed to alleviate the existing problem, not to prevent it."

Head of the homeless care programme. Community of Madrid.

Another aspect that was highlighted as increasing the vulnerability of homeless PWUS was the lack of ID documents. This profile of people was pointed out as the most disadvantaged by the system of care for people in a situation of social exclusion, since to access it, they need an ID and then to have a registered address. This situation was described as a revolving door of refusals to access the homelessness network's services of greater autonomy. They explained that, in practice, these people were served only in hospital emergencies and with short-term work plans. Moreover, if the person did not have an ID, they would never be able to receive any kind of medium- or long-term support.

THE LOCATION OF SERVICES

Participants commented that, initially, all housing support services and/or first reception centres were located in deprived neighbourhoods, but they gradually moved to more affluent neighbourhoods. In the case of Barcelona, there is a first reception centre in an area with the highest purchasing power. On the other hand, harm-reduction drop-in services (with or without consumption rooms) tended to be located where the points of sale and consumption were.

Participants reported that first reception facilities and harm reduction drop-in services for the homeless community were not exempt from the NIMB phenomenon common to HR network services. For the most part, they were unacceptable in the community environment, as evidenced by the fact that on many occasions they had witnessed protests calling for their closure. In addition, they pointed out that, at the time of their opening, these services continued to provoke a great deal of rejection from the immediate neighbourhood community, as they were associated with elements of delinquency, criminality and insecurity. Participants agreed that young people were generally more inclusive in their behaviour and attitudes than older people.

As a strategy to mitigate these negative effects, the group suggested increasing community participation and involvement by: opening the doors of the centres and sharing spaces and activities with the community and neighbours. However, they pointed out that the activity that undoubtedly had the greatest impact on the relationship with the community was the consumption of people in the vicinity of the services.

HOMELESSNESS, GENDER AND HARM REDUCTION

All FG participants from the territories represented in Catalonia, Andalusia, the Basque Country, Valencia, Madrid and the Balearic Islands were concerned about the reality of women and/or LGTBIQ+ PWUS in street situations, because the vast majority of HR spaces are hyper-masculinised, creating a context in which women do not feel safe and reproducing the street atmosphere of insecurity and inequality.

> "The institutions are becoming more gender-sensitive, but the spaces are masculinised."
>
> Head of an association that accompanies people who are socially excluded. Basque Country.

At national level, participants reported the existence of only two housing support services for women in street situations and active substance use. One was located in the city of Madrid and the other in the city of Barcelona. Of these two centres, only the Catalan one reported specific experiences of care and support. As can be seen in the following quote, a professional participant from Madrid expressed concern about the absolute invisibility of the LGTBIQ+ group in a situation of homelessness.

> "Even the organisations that defend the rights of LGTBIQ+ people don't know that there are homeless people and that there are people who are on the streets because of this condition."
>
> Head of the homeless care programme. Community of Madrid.

Another serious issue that was highlighted with anger by all participants was the lack of services to provide emergency or medium-term protection for women who actively use substances and had recently been victims of serious physical or sexual assault. The condition for their safety was either prior abstinence or a commitment to enter and maintain an abstinence-based treatment programme. Participants reported that the justification they received from protection services for victims of gender-based violence was that these spaces were drug-free. In the absence of a specific line of care for this particular group of women, participants pointed out that in many cases it is in the HR and/or homelessness network where the purpose of protection falls on.

Participants from Seville and Catalonia commented that professionals in services for active substance users are increasingly being trained in the gender perspective, but in neither case did they talk about what kind of specific training they had on the subject, rather they lumped it together under this heading. It would have been interesting to know what training on gender they had received in the different services.

ORGANIC AND MENTAL HEALTH STATUS

The participation of an internist and a psychiatrist in the FG enabled a deeper understanding of the health status of homeless PWUS.

With regard to mental health, the specialist noted that this was a community with multiple intersections: substance use, traumatic experiences, loneliness, social isolation, exclusion... These conditions made it difficult to monitor their mental health status on a regular basis and led to clinical destabilisation. He pointed out that the characteristics presented by these people usually required admission to acute or medium stay units if the aim was to stabilise the clinical condition.

Unfortunately, participants reported that the reality they faced in their daily practice was that, when accessing hospital psychiatric emergency services, PWUS were usually treated at an early stage, classified as having substance-related symptoms and excluded from the possibility of admission. They reported that on the rare occasions when admission did occur, it was of short duration. For those users who were eventually assessed for long-term admission, a discharge plan was required, with the expectation of admission to detoxification or referral to a housing service.

Both conditions tended to be very demanding for this community, whose therapeutic objectives were aimed at reducing consumption. In some Regional Autonomous Communities, such as Catalonia, Andalusia, the Basque Country, the Community of Madrid, the Community of

Valencia and the Balearic Islands, undocumented status was even reported to be an exclusion factor for admission to long-term inpatient psychiatric services.

The FG did not explore the prevalence of certain diagnoses classically attributed to gender. This analysis would have been important to identify certain psychopathologies that are more often associated with masculinity and heteronormative beliefs, as this tendency may lead to false or mistaken diagnosis.

Regarding the organic health status of the community PWHS and are homeless, one doctor reported the following:

> "The health situation of people who are on the streets is already bad, and if you add substances and routes of consumption that have a negative effect, their organic situation is much worse."
>
> MD. Harm reduction centre. Catalonia.

This participant strongly emphasised the importance of putting the patient at the centre, constantly shifting the focus away from substance use, understanding that it is part of their life and that they may not want to give it up. She emphasised that the response should not be to get the person to move on to prescription therapies, although this is the most common scenario.

Both medical participants agreed with the psychiatrist's assessment of the need to stay in hospital as long as possible to stabilise and recover from possible mental and organic pathologies if a real improvement in health status is to be achieved. They themselves reported that these people are discriminated against and undertreated in hospitals because of the perceived difficulty of the professional teams in dealing with these patients. One suggestion for improvement was the need to develop community health care. The flexibility offered by this approach was seen as appropriate by participants. This was illustrated by the following quote:

> "This type of intervention takes place where the person feels safe and comfortable, smoking or even consuming substances. Something that is not even considered in the hospital."
>
> Internist. Catalonia.

One aspect highlighted by all participants was the difficulty in accessing pharmacological treatment for this group. In most cases, they did not have sufficient financial resources to cover the cost of these kinds of treatments. Participants from the city of Barcelona reported that public administration and some third sector services occasionally covered the cost of medication for people sleeping rough. Although services were insufficient and access was bureaucratic, they did not provide an effective response in emergency situations.

> "People's health is deteriorating not because they don't want to take their medication or because the street is not the best place to be treated, but because they don't have access to treatment."
>
> Head of an association that accompanies people who are socially excluded. Basque Country.

THE BASIC NETWORK OF SERVICES

During the FG, several situations of serious discrimination against homeless people with substance problems were reported when they came into contact with the basic service network. There were more examples and more violations in the primary health care and mental health care network. Participants agreed that this network often offered lower quality care to these people or directly excluded them from care, attributing inappropriate behaviour to the fact that they were PWUS and poor.

> "Professionals don't like these patients, they feel more comfortable with people who don't use substances."
>
> MD. Harm reduction centre. Catalonia.

The FG did not explore the situations of exclusion or stigmatisation that PWUS experience in their daily lives, nor were we able to distinguish them by gender. It would have been a more representative sample if gender had been taken into account, as well as providing us with more in-depth and detailed information.

In the case of emergency mental health services, participants emphasised that these people are directly linked to psychiatric symptoms related to substance use and do not receive in-depth assessment of their mental health status.

> "The homeless person who comes to the psychiatric emergency room without any kind of support... I don't know... it's more likely to get attributed everything to the toxic image."
>
> Psychiatrist. Community mental health team. Catalonia.

One of the professionals involved pointed out that this discrimination is exacerbated when homeless PWUS also have some form of functional diversity. In her account, she noted the requirement of abstinence in order to access a basic procedure such as the assessment of the disability degree.

> “In the case of people who have an obvious disability, some kind of cognitive impairment, etc., after many steps and many formalities, we arrived at the door of the Provincial Council to get them assessed. And they tell you that they cannot make an assessment of the disability because they are in active consumption. They can’t assess them until they have been in treatment for X period of time.”
>
> Head of an association that accompanies people who are socially excluded. Basque Country.

Most participants agreed that there is currently poor coordination between the mental health network and the addiction network, especially when dealing with homeless people. Participants reported that these were highly complex situations and that they observed that neither network was comfortable with this condition, resulting in a constant transfer of cases. It was noted as a common situation that this community received lower quality care or was directly neglected in the mental health network and therefore, the substance use network took on their care, despite the fact that they had serious mental health problems and perhaps substance use was only acting as a symptom. The end result was that the person received fragmented care rather than support that combined the expertise of both networks.

After analysing the participants’ accounts, it became clear that there was no good coordination between the two networks. Even in the specific case of people diagnosed with dual pathology, it was not possible to identify which of the two networks was actually responsible for their care and support. This situation led to the person wandering in a care limbo and receiving institutional violence corresponding to this fact. The participant from Seville reported that in the areas where they work with dual pathology, professionals providing direct care are not sufficiently prepared and there is a great lack of training among the homeless community.

Throughout the development of the FG, differences were observed in the characteristics of professionals working with homeless PWUS. Some participants reported that in their daily practice they worked with a large number of professionals who were part of the basic care network (including the homelessness network), who had expertise in specific areas (mental health, gender, etc.), but their training in harm reduction and addiction was insufficient to provide quality support to this group. In addition, some participants reported that in their daily work they had to deal with professionals who had difficulties in extending services or programmes to PWUS, repeating the attribute that these are complex, inadequate and uncomfortable people. These situations within the professional group itself illustrate again the high level of discrimination experienced by this group.

An issue that was not addressed in the FG, and which cuts across a large proportion of people with addictions who find themselves in a situation of homelessness, is coordination with the children’s network. Taking advantage of the fact that we had professionals with a degree in social work, it would have been very relevant to address this point and to discuss, based on their experience, on what kind of arrangements they make with the children’s network, as well as to explain how this coordination affects PWUS. The lack of focus on this point shows that the children’s network is still invisible in harm reduction.

3.9. HARM REDUCTION AND ALCOHOL

AUTHOR: JOSEP ROVIRA GUARDIOLA

INTRODUCTION

In the field of public health and social services, harm reduction has historically been associated with the prevention of infectious diseases and overdose associated with injecting substance use, mainly HIV and opiates. Only in recent years, and in some areas, has there been a greater focus on psychostimulant use and inhaling substance use. However, there is a growing awareness that harm reduction also needs to address: problem alcohol use, a substance with its own set of challenges and consequences.

Alcohol-related harm reduction must take into account the need for updates and improvements based on changes in community profiles and patterns of use. Important progress is recognised for heroin use and injecting substance users, but there is a perceived deficit in alcohol harm reduction efforts, particularly for specific and marginalised groups.

This paper, based on input from health professionals, is intended to contribute to the need for comprehensive harm reduction policies and interventions that prioritise people's well-being and choices.

METHODOLOGY

To understand the experiences and perspectives of health professionals in relation to alcohol harm reduction. A combination of qualitative methods, such as a literature review and a focus group with different profiles of health professionals, was used to provide a holistic and enriched understanding of the issues raised.

Bibliographic consultation was used as a starting point in this methodology to collect and analyse relevant information previously published in studies, articles and guidelines of interest, and to identify gaps in the development of harm reduction policies in Spain and the need to formulate relevant research questions.

The focus group of health professionals, as a qualitative technique, brought together participants with relevant knowledge and experience in the field of harm reduction. During the focus group session, participants were encouraged to engage in an open discussion and interaction among themselves, which allowed for a variety of perspectives, perceptions and expressions of proposals for greater implementation of harm reduction in alcohol prevention and care. Diversity was ensured in terms of gender, national territories, professional profiles in the social and health fields and types of services.

The FG Thematic Guide was developed on the basis of the diagnostic findings of the first part of this research. It was reviewed by both the researcher coordinating the study and the gender expert.

A total of 8 professionals participated. The FG was led by the expert researcher in the field of harm reduction in relation to alcohol use. It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2 hours.

RESULTS

UPDATED ALCOHOL HARM REDUCTION STRATEGIES: OVERCOMING BARRIERS AND BROADENING THE APPROACH

Throughout the focus group, there was a reluctance to incorporate harm reduction programmes in the context of alcohol use into health systems, particularly when compared with other substances such as injecting opiates. It was noted that the development of all Harm Reduction programmes has been driven by the need to reduce infectious and overdose morbidity and mortality and that there has been more emphasis on programme and service development than on thinking about what Harm Reduction is. This may not have been the case in other countries.

The difficulty lay in the all-or-nothing approach often taken with alcohol dependence, where abstinence is often required, rather than offering HR strategies according to the person's circumstances, capabilities and wishes. It was pointed out that HR should not be seen as a moral issue, but rather as a flexible approach that focuses on individual needs.

Participants emphasised that social tolerance of alcohol use is considerably higher than for other substances, which may be related to the difficulties in effectively implementing harm reduction strategies in this area. It was suggested that social acceptance of alcohol use in public places, even when problematic, may have led to an imbalance in public health approaches, with alcohol harm reduction often relegated to the background.

In addition, participants identified a lack of self-awareness on the part of alcohol users when presenting with problematic use, which further complicated the implementation of effective harm reduction programmes.

The complexity of the profile of alcohol users, ranging from recreational users to those in situations of social exclusion or who have developed progressive dependence over time, was identified as a challenge to the application

of standardised HR approaches. Participants expressed that the existence of heterogeneous profiles requires the development of personalised strategies that take into account the specific realities of each individual.

In relation to people who have not developed dependence, professionals indicated that it is crucial to recognise that HR should not be limited to general messages on moderate alcohol consumption, but should also include a wider range of empirically proven behaviours to reduce the risks associated with alcohol consumption. Encouraging practices such as controlling the quantity of drinks consumed, including simple behaviours that have been shown to be appropriate and help protect against the norm and social pressure to drink, and creating support networks to help individuals identify signs of excessive drinking were examples of effective measures that could be incorporated into alcohol-related HR strategies.

In addition, most participants reported a need to identify and address the cultural and social barriers that currently hinder the implementation of such programmes. By overcoming stigmatisation and historical resistance, it will be possible to foster a more inclusive and equitable approach to treatment and prevention of problematic alcohol use.

In addition, most participants reported the need to identify and address the cultural and social barriers that currently hinder the implementation of such programmes. By overcoming stigma and historical resistance, it will be possible to promote a more inclusive and equitable approach to the treatment and prevention of problematic alcohol use.

In summary, updating alcohol-related harm reduction strategies requires a paradigm shift that recognises the complexity of the problem and encourages adaptive and personalised approaches. By promoting greater awareness of effective harm reduction behaviours and addressing social and cultural barriers, progress can be made towards a more comprehensive and effective response to protect the health and well-being of those affected by alcohol use.

ADDRESSING NEGLECTED NEEDS: AN EXTENDED HARM REDUCTION PERSPECTIVE

In the area of social accompaniment and health care, a number of community profiles were identified that had been neglected in the context of harm reduction. These profiles reflected a diversity of challenges and issues that require more inclusive and adaptive approaches to the implementation of Harm Reduction strategies. Similarly, participants highlighted the need to broaden the scope of Harm Reduction beyond the traditional substance-specific perspective to include a wider range of behaviours and situations.

Participants indicated that a particularly vulnerable group that had been largely neglected was that of people with chronic alcohol problems and a long history of social exclusion. The complexity of their patterns of use, characterised as deeply entrenched and with co-existing physical and mental health problems, was identified as a challenge. The need for a creative and adaptive approach to effectively address their problem drinking became apparent.

In addition, participants pointed to the lack of attention paid to minors in the context of HR, both from a prevention and treatment perspective. The early onset of alcohol use and the need to address risk behaviours in this community were highlighted as critical areas requiring more attention from health professionals and policy makers. The importance of involving family and social networks in HR was also highlighted as an essential aspect of protecting and supporting underage drinkers.

In terms of procedures and services, the importance of considering HR as a transversal approach that should be present at all stages of care is overemphasised. This implied the need to redefine HR as a comprehensive philosophy rather than a simple Plan B, and to promote greater flexibility and personalisation in the care provided to consumers. The implementation of HR strategies was seen as an essential part of the therapeutic process, rather than a secondary or exceptional measure.

In summary, addressing neglected needs in the field of HR requires a thorough review of current approaches and greater sensitivity to the diversity of community profiles affected by problem alcohol use. It is imperative to adopt more inclusive and adaptive strategies that recognise individual complexity and encourage more active involvement of the social and family network in the recovery process. Only through comprehensive engagement and a deeper understanding of the realities of each group can significant progress be made in protecting and supporting those affected by alcohol use.

PROBLEMS AND HARMS THAT WE SHOULD ADDRESS THROUGH HARM REDUCTION

Participants identified a number of issues and challenges related to alcohol consumption and the need to address harm reduction in a more holistic way. Health professionals highlighted the importance of improving understanding of alcohol-related harm and the importance of preventing heavy drinking to reduce the incidence of serious health problems. It was emphasised that alcohol-related harm does not occur in isolation but is influenced by a variety of factors, including social and environmental conditions.

The importance of addressing substance use and its potential impact on health was also highlighted. The importance of understanding the risks associated with the simultaneous use of alcohol and other substances was stressed, as well as the role of alcohol in increasing vulnerability to the negative effects of other substances, such as cannabis, cocaine or other substances. Professionals highlighted the difficulties associated with treatment with psychotropic substances and the importance of addressing education on the interaction between psychotropic substances and alcohol use.

In addition, the importance of addressing the social exclusion of people who use alcohol and the need to implement awareness raising and training strategies for health and social care professionals was highlighted. The group discussed the importance of providing a supportive and understanding environment for homeless people facing challenges related to alcohol use. A number of participants highlighted the need to improve access to HR programmes and social support services, from which they are often excluded too because of their active substance use. Some participants also noted changes in shelters in Seville or Madrid that allow people to consume alcohol as long as it does not interfere with their interactions with others.

Dialogue among participants highlighted the challenges of addressing problem behaviour and the destruction of people's social networks caused by problem drinking. The need to protect people from the consequences of their own actions and to provide a compassionate environment for their recovery was emphasised. Overall, the need for a deeper understanding and a more holistic approach to addressing alcohol-related HR was highlighted.

ESSENTIAL APPROACHES TO HARM REDUCTION

HR has emerged as a key approach in addressing the problems associated with alcohol and other substance use. During the discussion, different perspectives were presented on the importance of institutionalising and standardising HR at all stages of use, from prevention at the early stages of the onset to clinical care for people with addiction problems.

The need to address the social stigma associated with substance use and to integrate HR into broader public policies was also highlighted. Possible strategies for the effective implementation of HR and for overcoming existing challenges in this field were discussed.

First, the importance of developing regulatory policies that integrate HR at all levels was noted, including early prevention and education about the risks of substance use. The need to train professionals to provide effective interventions and appropriate support to those who use without developing serious problems was emphasised.

One of the groups that has been neglected from a preventive harm reduction perspective is the underage community. The slogan '*Menores ni una gota*' ('Minors, not a drop') or similar does not seem to be very coherent and does a disservice to preventive approaches, especially knowing that historically substance use starts between the ages of 14 and 16. In other words, two to four years before adulthood, people are already drinking, learning and taking risks with alcohol.

In this context, the importance of working on prevention and early identification of problematic drinking, as well as providing resources and support to people experiencing difficulties related to alcohol use, was highlighted. The need to promote a culture of HR through awareness-raising and education at all levels of society, including community and educational settings, was underlined.

In addition, the importance of addressing barriers to accessing services and services for people seeking help and support to reduce the harms associated with alcohol use was discussed. The need to integrate HR into all mental health and social care policies, as well as the implementation of education and prevention programmes in communities and educational centres, was emphasised.

The importance of a personalised approach to clinical intervention, taking into account the individual expectations and needs of each person, was also highlighted. Possible therapeutic, psychopharmacological and psychotherapeutic strategies that could complement the HR approach were mentioned, including education, motivation, positive reinforcement and the creation of personalised plans to reduce alcohol consumption. The importance of working on the desire for self-care, including hygiene and personal image, was also highlighted.

The importance of tailoring the approach to people according to their profile was raised, highlighting that many people do not want to be directly confronted about their alcohol use because they feel judged and are tired of talking about the same thing over and over again. From a psychosocial intervention perspective, it was noted that it is necessary to focus on other problems that are more relevant to the person and therefore more likely to produce better results. In particular, and as an example, the role of alcohol in women who have experienced gender-based violence was mentioned, and it was noted that addressing the underlying emotional distress is fundamental to tackling alcohol use.

A harm reduction perspective was also presented, which is not only about reducing consumption but also

about minimising the negative impact on the person's environment. The importance of providing support and dignity for people in their environment, offering a metaphorical or real 'cushion' to reduce the potential harm in situations of excessive use, was highlighted. Often, and only in this way, is it possible to subsequently work towards a reduction or cessation of consumption.

In summary, the discussion highlighted the importance of an approach that is tailored to people's individual circumstances and needs. An approach that effectively addresses medical, social and psychological aspects. The need to work in partnership with different actors, including government authorities, health professionals and society at large, was underlined. The need to address the real concerns of individuals and provide a compassionate, supportive environment to facilitate informed choices about alcohol consumption and the overall well-being of those involved was emphasised.

HARM REDUCTION SERVICES AND ALCOHOL CONSUMPTION ROOMS:

The need to extend HR services to all settings, including drinking environments, was raised. The importance of offering HR support and perspectives in different settings, such as homeless shelters, recognising that there are already first successful experiences, though still very limited, in municipalities such as Madrid and Barcelona.

The need to change the paradigm of shelter services, to make them inclusive spaces that meet multiple needs, to bring HR programmes into spaces not traditionally associated with these services, and to encourage a self-regulatory approach among users was highlighted.

The importance of creating supervised drinking spaces (controlled consumption prescriptions) that are welcoming and encourage interaction and comfort was mentioned. The idea was raised that these spaces should be integrated into settings where there is a real need, transforming housing support or sheltered settings into more flexible places adapted to the changing needs of users. Spaces that could promote self-regulation and responsible care for alcohol users.

We would be talking about spaces built into services, such as:

- Shelters offering accommodation. First reception and housing support services for the homeless people.
- Low-threshold shelters, which provide a safe space for these people to engage with social services, help to reduce substance-related harm and public disorder.

The main objective of these spaces would be to provide a safe and controlled environment for homeless or marginalised people who consume alcohol, in order to minimise the risks and negative consequences associated with it, such as severe intoxication, violence, diseases transmitted through uncontrolled consumption or the impact of consumption on public roads, among others.

The components required for these rooms were described as follows:

- Professional supervision: These spaces should be supervised by trained staff, such as health workers or addiction specialists. These professionals should provide information, counselling and advice on safer use practices, as well as brief interventions or referrals to additional health services as needed. They should form a working group to promote a common standard of learning how to drink safely.
- Controlled supply of alcohol: In some cases, these supervised drinking areas with alcohol may provide alcoholic beverages to users. A method and limits are set for the quantity and alcohol content of the drinks to avoid excessive consumption. The importance of hourly administration patterns to reduce the risk of intoxication has also been noted.
- Safe and clean environment: Rooms designed to provide a clean, hygienic and safe environment. Where people can receive nutritional supplements and engage in recreational and vocational activities.
- Multi-dimensional approach: In addition to facilitating alcohol consumption in a safe environment, these spaces would offer other complementary services such as infectious disease testing, access to health services and general counselling.

These services should provide ancillary services such as meals, showers, recreation and assistance in finding and maintaining or obtaining accommodation. These programmes would aim to provide a holistic approach to the complex needs of individuals, including physical and mental health, housing stability and social reintegration.

However, the challenges of implementing these programmes were highlighted, including the need to persuade local authorities and professionals to adopt these perspectives. The difficulty of overcoming the stigma of substance use in housing support services and the involvement of local politicians was acknowledged.

3.10. HARM REDUCTION AND SERVICES COVERING BASIC NEEDS (*'CALOR Y CAFÉ'*)

AUTHOR: ELISABET GARCÍA FOLK

INTRODUCTION

The specific approach of drop-in services covering basic needs, as well known as '*Calor y Café*' services in the Spanish territory, appeared in the first phase of the study on harm reduction in the 21st century. In this study, professionals defined them as '*traditional, essential and functioning as a basis for the implementation of Harm Reduction strategies and/or programmes*.'

It was found that the people who used them were mainly men in a situation of homelessness. There was also an increase in the number of migrants, so we wanted to look at this community in more detail.

As infrastructures, they were of insufficient size and conditions to provide quality care. Similarly, the low accessibility of these spaces to women and people of different genders and the resulting masculinisation were elements of prejudice that were identified and that were decided to look into more closely (adding to this the lack of a transversal gender perspective in the spaces). The lack of an intercultural perspective and the lack of mental health professionals in the services were also denounced.

METHODOLOGY

Sampling was carried out theoretically, on the basis of convenience, by the entire research team. The search for participants was based on contacts with UNAD member organisations that are experts in harm reduction in Spain, supplemented by the research team's own suggestions of professionals who are references in the specific field.

The selection criteria for participants in this focus group (FG) were: be working in this service for more than one year in a direct care role. Representativeness was guaranteed in terms of gender, national territory, professional profiles in the social and health sectors and type of institution. This last element was particularly relevant to this FG, given that in Spain there are 2 models of '*Calor y Café*' services: facilities that only provide this service and programmes that are integrated into facilities that provide multiple harm reduction services.

A questionnaire was designed with the aim of finding out in advance about the services in which the participants worked, including aspects of availability, accessibility and operation specific to '*Calor y Café*' services, based on two framework bibliographical documents[45]. This instrument was reviewed and validated by the researcher coordinating the study.

The individual questionnaire was made available online to all participants prior to the FG. All participants reported that the centres where they worked did not offer night care, most offered showers, supplementary food and in some cases spare clothes and laundry facilities. All centres provided equipment for substance use, but only two had drug consumption rooms (DCRs). Similarly, only two of the centres had security staff and all but one had a community intervention team. Medication was dispensed and stored in three of the five centres.

Although it was noted that the nomenclature used to designate these services was not the same for all territories, it was evident that they shared similar characteristics. For this reason, it was decided to use the term '*Calor y Café*' as the main reference in the text, but to include them in the same category as CEAs (Meeting and Reception Centres), CeSSAs (Social and Health Centres for Addiction Care), for their initials in Spanish, and Emergency, Local and Social Space Centres.

The FG was facilitated by the researcher who is an expert in the field of '*Calor y Café*' services within the harm reduction network. It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2 hours. Participation was not remunerated.

Five people took part, three women and two men. The territories represented were the Region of Murcia, Basque Country, Andalusia and Catalonia.

All had a long history of working in harm reduction, particularly in drop-in services. Rural areas were not represented.

RESULTS

WOMEN, NON-BINARY AND TRANSGENDER PEOPLE

Participants were asked about the accessibility and adherence of women, non-binary and transgender PWUS

(4) Clua García, R. (2015). Salas de consumo higiénico en España (2000-2013). *Salud colectiva*, 11(2), 261-282.

(5) EMCDDA. *Drug consumption rooms: an overview of provision and evidence*. Lisbon; European Monitoring Centre for Drugs and Drug Addiction, 2018

to their services. All participants confirmed that the services where they work are masculinised, with men, cisgender, heterosexual and local as a privileged group. All participants indicated that they were taking positive action to correct this historical trend.

In terms of facilitating women's access to these services, three participants reported that in their centres, time slots were protected during the week so that the space could be used exclusively by women (in one centre, two afternoons were blocked, in another, a space according to the needs of the moment, and in the third, one afternoon). However, another of the centres that had a non-mixed space had to stop using it due to lack of space in the infrastructure. They always referred to drop-in service facilities, there was no mention of the need for a non-mixed space in DCRs unless they had '*Calor y Café*'. None of the participants indicated whether the design of these spaces had been done in a participatory way with the users. For example, it was not clear whether the time slots had been determined according to the needs of the centre or according to the needs of the female users.

> "It is true that we used to have an exclusive room for women to rest and so on, but due to lack of space we had to close it."
>
> Social Worker and Educator. Experience in HR. Andalusia.

Nevertheless, it was considered necessary to maintain and create harm reduction facilities exclusively for women and run by women users themselves (this model was not considered for mixed facilities). The current model was seen as old-fashioned and outdated.

> "It is fundamental and elementary that there should be services for women only, run by women only. Obviously we are wrong if we continue to perpetuate the role of masculinised spaces because then we are recruiting 5% or 10% of women to harm reduction services."
>
> Social Educator. Experience in HR services. Catalonia.

Only two of the participants mentioned care for non-binary and transgender people in their services (Barcelona and Murcia). In the other two (Seville and Terrassa), they were not mentioned and in the remaining one (Bilbao), the participant considered that she was not aware of the existence of female users in the area, not pointing to the possibility that there might be specific access barriers that were not identified for this community.

> "Both men and women come to our resource, although I haven't seen trans or non-binary people in the +20 years I've been working here."
>
> Social Educator. Experience in HR services and other services of the substance use care network. Basque Country.

Apart from creating non-mixed spaces, no other positive actions to implement a gender perspective in this type of services were reported.

MIGRANT COMMUNITY

Most centres agreed on the approximate percentages of native and migrant use of the spaces. Three of the participants agreed that about 40% of the migrant community used the resource, compared to 60% of native. The three centres were located in provincial capitals (Barcelona, Murcia and Seville). In the centres in the south of the Iberian Peninsula, the main countries of origin were from the African continent.

On the other hand, in the other two centres (Bilbao and Terrassa), the presence of migrants was a very unrepresentative sample, with the majority of those accompanied being native. It should be noted that in one of these centres, located in a city of 225,000 inhabitants, the presence of migrants was mainly related to people who had moved from large cities.

> "We associate the stay in the city with frustrated migration projects and people without a social support network that allows them to somehow count on help [...] and as for the origins of migration, in my experience it has varied over the years, there have been years when there have been more people from a certain country of origin and it seems that they are like a movement, I don't know if it is due to the issue of criminalisation in the country of origin regarding the use or possession of substances that makes it somehow attractive to move to another country."
>
> Social Educator. Experience in HR. Catalonia.

Despite these percentages, no specific action to implement an intercultural perspective was reported. None of the participants pointed out that changes in the characteristics of these people could be linked to the migratory routes, nor to whether their territory was considered a transit or a final destination. Nor did they point to differences in terms of gender, sexual orientation, age and/or ethnicity or country of origin that might be involved in providing support to these people.

CRITERIA FOR ACCESSING THE SERVICE

In this section, the admission criteria in use by each service were shared. Regardless of the resource, all participants agreed that the admission criteria were that the person was of legal age and reported active substance use. Differences were found between those '*Calor y Café*' services that were integrated into comprehensive HR services and also had a consumption room (DCR), and those that did not. In the '*Calor y Café*' centres that did not have a DCR, the inclusion criteria also included that the person was in a situation of social exclusion (without a defining criteria for this situation).

The legal status of substances used by people seeking access to a '*Calor y Café*' was described by participants as a screening element. All agreed that access was always given to people who reported problematic use of illicit substances (mainly cocaine, heroin and methamphetamine). In relation to the use of legal substances, participants working with DCRs in '*Calor y Café*' services indicated that, in relation to alcohol, they explored the place of substance in the person's pattern of consumption. If the person reported using both legal and illegal substances, alcohol was framed as a polymorphic substance and was not an exclusion criterion. On the other hand, if the person reported using only alcohol, there was a tendency to deny them access and refer them to another service specialising in alcohol or homelessness.

Under the same conditions, participants described access for people who reported problematic use of psychotropic substances, the only difference being that sometimes people who reported only using these substances were referred to outpatient treatment. Participants did not specify the reasons for this difference in referral between people who used alcohol and people who used psychotropic substances.

Several participants in the FG agreed that homeless people who only use these substances share consumption contexts with people who have different patterns of use, and pointed to this contact as a risk factor for moving towards substances that they consider to be more dangerous. From this contribution, it could be seen that prohibitionism continues to function as a referential framework for situating the dangerousness of substances in the majority of '*Calor y Café*' services.

All the FG participants referred to the use of psychotropic substances as the main substance used by young migrants in a situation of homelessness. Only one of the participants expressed the need to review the access criteria for people who report only using these substances, pointing out that the current reality in the city of Barcelona is that there are a large number of young people in a situation of vulnerability who have these characteristics.

> "Specifically, we did not initially decide to address this reality, I think it is an issue that needs to be reviewed in light of the current reality. Traditionally, this group has not been very strong or problematic. But nowadays, we are seeing young migrants who initially maintain a controlled use of benzos and then begin to use crack cocaine, especially in this area. And then we obviously see the fact that they are around will derive to another type of consumption, of other types of substances and by other means."
>
> Social Educator. Experience in HR. Catalonia.

In centres that also had DCRs, the route(s) of administration corresponding to the consumption supervision offered was also used as an inclusion criterion. All centres reported using anonymity as an element of recruitment. The use of recruitment strategies suggests that PWUS are still considered a hidden community, difficult to access. Nevertheless, the increase in the number of people living in a situation of social exclusion, the saturation of services and the guiding principle of protection for people who report substance use patterns subjectively considered to be less risky were the elements involved in the definition and application of exclusion criteria for access to these facilities, particularly visible in '*Calor y Café*' services, which also have DCRs.

Only one participant pointed out that people with non-substance-related addictions (pathological gambling) were also allowed access to the centre, which did not have a DCR.

All participants agreed that they had used the semi-structured individual interview as their initial data collection tool. None of the participants indicated that this instrument had ever been reviewed with regard to gender or intercultural aspects. Nor that it was a specific function of any particular professional category.

GEOGRAPHICAL LOCATION OF THE SPACE AND THE NEIGHBOURHOOD

All participants stated that the centres in which they worked were located close to points of sale and considered this a positive factor. This was particularly the case for those services that had a supervised consumption room, as it made it easier for users to access the centre and use the substance.

One of the participants focused on the reality of her city, where she described that the service is located in the historic centre, and made an assessment of the differences that coexist on the same ground. In the following quote, we can also see the invocation of drug trafficking that has taken place in the gentrification processes of most large Spanish cities. The use of degraded housing as points of sale for illicit substances,

to which highly marginalised PWUS have access, has become a common dynamic used by housing developers to promote the displacement of lower class neighbours and land speculation. PWUS are thus instrumentalised in their survival reality by the various actors in the housing market.

> "We are in the historic centre of the city, so it is a mixed area: we have people with very few resources and then we have people with a lot of money, which is usually the case in the historic centre. It is also very close to points of sale because there are also abandoned houses that are used as drug dens, and there are also gambling dens because it is very close to the port."
>
> Social Worker. Experience in HR. Region of Murcia.

Another participant reported that the '*Calor y Café*' where she worked was located at a strategic point in the city, between two parks, where a large number of homeless people usually slept (it is unknown which of these circumstances came first).

> "EWe are located between two large parks that are
>
> like open-air shelters in Barcelona: the "Estación del Norte" park, where they have somehow managed to let them in before closing time so that they can spend the night, and the "Ciudadela" park, which is also next to us and where there is a large camp of people sleeping rough."
>
> Social Educator. Experience in HR. Catalonia.

Two of the participants reported the existence in their respective cities of first reception centres (CPAs - commonly known as shelters) where the use of substances was criminalised, which was described as a criterion for refusing entry to this group of people. This rule was cited as the main reason why a large number of people ended up sleeping on the streets (without any participants specifically mentioning the greater vulnerability of women in this situation).

Three of the participating '*Calor y Café*' services also reported having an outreach or street community intervention team. These teams were described as ensuring good coexistence between neighbours, centre users and other actors in the neighbourhood. In two of the centres, it was reported that users participated in the community activities and this was seen as a very positive aspect of improving coexistence. No reference was made to the benefits that this activity could bring to users.

> "We have worked with the community and something that we keep on doing. We worked with all the associations in the area, there were even users who painted the neighbourhood association. They also did an activity at the summer school aimed at destigmatising PWUS."
>
> Social Worker. Experience in HR. Region of Murcia.

In all cases, the participants assessed the wear and tear involved in maintaining a good relationship with the community: they felt that interventions were essential for good coexistence and had to be constant, but at the same time they felt that their daily work was constantly questioned by all community actors.

HOMELESS PEOPLE, AND *'CALOR Y CAFÉ'* CENTRES

Regarding the users of these centres and their housing situation, all participants agreed that the vast majority of them were in a situation of homelessness[6]. The only exceptions were the centres that had DCRs, which were mainly used by people in a regular housing situation, who would occasionally and infrequently use the '*Calor y Café*' space.

> "People who are even working and living in apartments can come to the room because they've had an overdose before or they're having a hard time finding a vein and they need some kind of help, or sometimes because of the bond that is created. It's a space of trust where they don't feel judged and where they can feel comfortable."
>
> Social Educator. Experience in HR. Catalonia.

OPERATIONAL DYNAMICS: OPENING HOURS, USE OF THE *'CALOR Y CAFÉ'* SPACE, WORKSHOPS

None of the participants reported that '*Calor y Café*' centres were open at night, with the exception of one, which kept the service open all night during the cold campaign. Providing night-time services was a request from all the participants, as the only service that users could go to after the centre closed was the shelter (or First Reception Centre), which, as mentioned above, was reported to be generally not adapted to the reality of PWUS.

(6) Homelessness is understood to include not only people sleeping rough, but also those living in squats, hostels and other substandard housing.

> "The schedules have to be adapted to the needs of the place where you are located, you can't make mimetic replicas or chronicles of experiences in other places, because each place has its own reality."
>
> Social Educator. Experience in HR. Catalonia.

On the other hand, with regard to the reported dynamics generated in the '*Calor y Café*' space, similarities were found in all the participating services: in most cases, workshops were organised. In some cases, the infrastructure of the service had a specific room for these workshops; in other cases, all the activities offered by the service were organised to take place in a single room. All participants described the workshops as activities that were planned in advance by professionals, sometimes designed and sometimes waiting for the right situation to arise in the dynamics of the service.

The topics of the workshops were varied, but there were elements common to all the participants: health - sexuality - healthy habits, administrative procedures, citizens' rights and duties, socio-occupational reintegration, the digital divide, radio, etc. In one of the centres, time was also spent on gardening and board games. Three of the participants stated that users were paid to take part in these activities, especially those related to the prevention and care of opiate addiction.

In addition, in the two centres where DCRs were available, the '*Calor y Café*' space was also used as a place for post-consumption observation.

Irrespective of the activities carried out in these multi-purpose spaces, all participants agreed that the most important thing about the '*Calor y Café*' space was the opportunity for close interaction with the users, a place where they could talk to them, identify needs, and provide emotional support and active listening.

Surprisingly, despite the fact that the main function of '*Calor y Café*' is, by definition, to provide shelter and meet the basic needs of the users, the professionals highlighted as the main benefit that the harm reduction space offered the greatest opportunity to establish a therapeutic link. The following quote also shows how these facilities are a space for identifying the violence suffered by users, moving away from preconceived notions that these interventions are usually located in individual care offices and with confidentiality. This example confirms the strength of the link established by the '*Calor y Café*' services.

> "From my experience, I have to say that the 'Calor y Café' room is the richest, most magical place of the whole resource. It is the place where I enjoy myself the most, it is a meeting place where my reality and that of the users meet, where we can share and ask each other questions, where they tell stories and situations that they experience on a daily basis with the violence that living on the street means (including all kinds of violence). It is a space to meet needs, to be able to talk, it is a natural space for exchange and meeting between the care team and the users."
>
> Social Educator. Experience in HR. Catalonia.

VISION OF THE *'CALOR Y CAFÉ'* IN SOCIETY

When the group was asked the question which vision do the society have about the functionality of the resource, different opinions emerged. With the exception of one participant, all agreed that they felt the social function of these spaces was to reduce the visibility, permanence and activity of PWUS in public spaces. They emphasised that 'what is not seen does not exist', but at the same time they valued the fact that users had a space where they could meet and not feel judged. They reported that it was one of the few places where users felt free from stigma.

> "I have always thought that I am a band-aid for society and that when there is something bleeding, the services of the substance use network and other types of services put us on the wound to plug it up so that it does not show. We are "Mr Wolf" from Pulp Fiction, we clean everything up and leave it pure white, beautiful. But if we didn't exist, it would be worse, also agree."
>
> Social Educator. Experience in HR. Catalonia.

Other participants felt that accepting this award implied adopting a victimising and paternalistic role towards the user and preferred to focus on empowering users, adding that professionals had a role to denounce reality to the whole of society, to advocate for social justice. On the other hand, all participants expressed the common feeling of constantly having to justify themselves to the community and society. The professionals' view did not come close to a concept of self-criticism or self-worth.

> "The organisations that are on the front line need to knock on the door and say "hey, this is here" and accompany them in their inclusion process. I don't think [users] are hidden away so that they are not seen, because they are seen all the time on the street. We are on the front line, our role is to denounce a reality that exists."
>
> Social Worker. Experience in HR. Region of Murcia.

> "At the end of the day, the problem is structural: we are in the front line and we are part of "covering up" or "hiding" these people, when

the problem should belong to everyone and the solution should belong to society as a whole."

Educator and Social Worker. Experience in HR. Andalusia.

STIGMA AND SELF-STIGMA

Participants emphasised the dignity of the person who uses the '*Calor y Café*' and DCR spaces. However, some participants pointed out that these facilities are stigmatised by the community itself, which makes it difficult to determine the direction in which discrimination operates. They also suggested that there may be people who are not identified as PWUS by their communities, and that using the '*Calor y Café*' means making themselves visible, which may increase their risk of stigmatisation. That idea also led to the reasoning that there is a double stigma associated with substance use and the situation of social exclusion and poverty of these people. None of the participants mentioned other forms of discrimination, such as gender, race or age.

> "There is a lot of social hypocrisy around substance use. It is not a problem for the people we look after, but the double stigma of poverty and use is attached to them. The issue of consumption cuts across society much more radically, consumption exists throughout society in different ways, different characteristics, different substances. We are dealing with a part of this consumption that is obviously more risky because of the context in which it takes place; because in many cases it involves mental health, it involves poverty and social vulnerability, and it involves the use of certain substances that can be very risky for the lives of these people."

Social Educator. Experience in HR. Catalonia.

At the same time, cases of self-stigma were raised and how to work on this self-concept was discussed.

> "Another element to consider is whether the stigma exists at the point of entering a harm reduction service, or whether the stigma exists throughout the health and social care network, or in society as a whole, or whether the stigma is already fully internalised in the people we serve."

Social Educator. Experience in HR. Catalonia.

The only strategy reported in the reduction of stigmatisation of users carried out by '*Calor y Café*' was the accompaniment to the basic network of services. Participants considered it essential to reduce the discrimination suffered by users.

> "It happened to me that I accompanied a user who could not speak - whom I understood after so many years - to an administrative centre to carry out a procedure. When we saw the person who was going to look after us, the user expressed that this person was looking at him badly because of "the way he was dressed, because he was sleeping rough". Then when we approached this person who was going to look after us, she said "I understood what you were saying and I wasn't looking at you because of what you thought, I was looking at you because I already know you, you've been here before and I wanted to say hello to you."

Social Educator. Experience in HR. Catalonia.

Participants shared several situations in which they expressed the difficulty of coordination with the primary care network, from which they also identified situations of discrimination against users, against HR professionals and against the network's own services.

> "Today, for example, we had a user who had a psychotic break, but the psychiatrist said she was fine, that she was absolutely fine. We ended up having to record her, which I don't know if it's very ethical or not, but it was the only way I could think of to show the psychiatrist how the user was feeling. And so he listened to us and referred us to the psychiatric emergency department."

Social worker. Experience in HR. Region of Murcia.

In the final part of the meeting, participants were asked to express what needed to be improved or wanted to discuss further. The need for more flexible timetables to cover more people attending the services was the main request. Also, on the table was the need to design spaces that are suitable for onsite activities. And that the '*Calor y Café*' service should have DCRs in all cases. Lastly, the need to increase the budgets allocated to these facilities was emphasised..

3.11. HARM REDUCTION, PARAPHERNALIA AND SUPERVISED DRUG CONSUMPTION ROOMS

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INTRODUCTION

In Phase I of this study, participants highlighted the need to review the provision of services to people using HR services and programmes in order to adapt them to new contexts and communities.

For this reason, this section takes a closer look at those services and programmes with the longest track record, such as the distribution of hygienic paraphernalia and drug consumption rooms, in order to develop a diagnosis of their situation.

The distribution of hygiene materials is crucial in reducing the harm associated with substance use in Spain, as it addresses essential aspects of risk reduction and health promotion in this specific community.

In the context of prevention of contact-transmitted diseases, the provision of materials such as sterile syringes, pipes and condoms is seen as a key strategy for reducing the spread of infections among PWUS. From a gender perspective, it would be imperative to incorporate differences in needs and experiences across the gender spectrum into the approach, and to ensure that distribution is equitable and sensitive to these differences. In a diverse territory such as Spain, the diversity of communities and the need to adapt strategies to the specific practices and needs of different ethnic and cultural groups should be recognised.

Providing more information for the periodic review of the current situation of DCRs in Spain will allow the effectiveness to be complemented with qualitative data and specific areas for improvement to be identified. Ongoing review is essential to adapt to changes in substance use patterns, including the introduction of new substances. It also helps to take into account external factors that may affect how the rooms operate, such as changing legislation, government policies or community dynamics.

The aim is to stimulate reflection, identify possible improvements and identify new proposals by tracing a path between the founding actions and proposals of the programmes and the current arrangements.

METHODOLOGY

A qualitative methodology was applied using the focus group (FG) data collection technique.

The sampling was theoretical, of convenience and across the entire research team. Participants were identified by contacting UNAD member organisations that are specialised in Harm Reduction in Spain. In addition, there were suggestions from the research team itself of people who were experts in the field.

A number of selection and exclusion criteria were applied to the participants in order to set up the focus group. Priority was given to people who work with this group in different services and settings, such as harm reduction centres, health centres, street intervention teams, etc. The diversity of professional disciplines and different specialisations was also taken into account.

Another selection criterion was diversity in terms of geographical representation. Taking into account the fact that the community is mobile, moving and settling in different areas of Spain, and that there are areas of arrival, waiting, transit and permanence with specific characteristics, it was considered that the participants should come from different places. It was also taken into account that the gender representation should be as equal as possible in order to try to include the gender perspective in the debate,

The themes of the FG were therefore: 1) the status of needle exchange programmes, 2) material dispensing and 3) DCRs.

The FG was facilitated by the researcher specialised in material distribution.

It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2.5 hours.

RESULTS

NEEDLE EXCHANGE PROGRAMMES

Differential conceptions of the NEPs according to service typology

There is full agreement that the criteria used in the early days of the NEPs have evolved to achieve a higher level of inclusivity, mainly by not making delivery conditional on returns. Similarly, a negative consequence of this evolution was pointed out by all members of the FG, namely that the number of returns was much lower than the number of deliveries.

The consequences of this scenario were seen by some participants in several ways: the undermining of community harm reduction, misinformation about substance use patterns, and a lack of planning for HR. Below are two extracts from a conversation between a professional working in a primary care centre (PCC) and a professional working with PCCs, which illustrate these implications.

> "-When we say "exchange programme", we are telling a lie, because we know that there is no return [...] Therefore, as long as we say "exchange programme", we are leaving behind the pedagogy of proper waste disposal and that harm reduction is therefore not only personal, but also communal."

> "I don't know what they give back, if they give it back, or where the syringes end up [...] All the knowledge about the area has been lost, about how consumption is now in the neighbourhood [...] It's impossible to control or talk to anyone."

It is interesting to assess the type of service in which (or for which) both people worked. While the most strictly sanitary action, i.e. the distribution of syringes, was presented as universal - as in the rest of the programmes and services presented - other actions that gave RDD its community character seemed to be paralysed, and with them the collection of information that should have fed into the professional approach.

Another focus was on HR services and programmes. It could be observed that the health approach was applied from a vision that was more distant from medical issues, giving more importance to dimensions related to the integral well being of the person.

The testimonies of the HR services revealed a greater concern for elements such as the dignity and safety of consumption. A professional from an HR service, which had a professional specifically assigned to the NEP in person at night, thus referred to the benefits of this activity beyond the distribution:

> "They even offer post-consumption support to people who have been using on the streets and don't feel completely safe. They'll often go up to them and have a chat, so they're providing companionship. And it's a very interesting job."
>
> Female. HR service professional. Catalonia.

Other more pragmatic benefits could be observed, following the example of those services that had educational staff in the NEPs. One benefit, both in terms of knowledge generation and intervention, was that it was possible to identify different groups of PWUS within the group of injecting substance users. Although no specific reference was made to differences in gender or background, these groups were categorised according to where they were in the process of using substances. The following is a statement from a professional working in a HR service.

> "For example, people who have left a therapeutic community or who have not used for a while, to assume this idea, this failure for them when it comes to using... that even if you do it very well as a professional and you don't judge them, it gives them something like that."
>
> Male. HR service professional. Catalonia.

It was also possible to observe a greater number of preventive measures involving work with the user, such as avoiding impulsive behaviour when using, providing the NEP (traditional symbol of HR) with a risk-reduction approach. Suggestions have been made to allow the person to have a surplus of hygiene materials to manage autonomously in order to plan their consumption. A professional from an HR service described the reasons for this.

> "Working on the idea that I need the substance first and then go and get the paraphernalia [...] would lead into the improvisation of consumption and there can be quite a few risks."
>
> Male. HR service professional. Catalonia.

What was striking about the general approaches, according to the two typologies described, was that in the HR services, the founding objectives of the NEPs - of a more clinical nature - had evolved to include a wide range of sensitisation and educational tools, for which the exchange is a means. On the other hand, in the health centres, the social and psychological component of the NEPs had been removed, leaving only the strictly biological component.

This may indicate that health promotion standards, framed within the concept of public health, have not moved beyond the limitations of the biomedical model. This idea is suggested by the fact that in the PCCs, actions related to environmental and social interventions, although their benefits were recognised, seemed to function as 'value added' elements. This idea of added value could be observed in the testimony of a professional working on the implementation of the NEPs in care centres.

> "The PCCs. [...] When we implement the programme, when we give them talks to explain the reason for the programme, they say I'd like to have that here too because [...] they can't do anything but give them the syringe. That's why I say that the added value is ... someone who accompanies them."
>
> Male. NEP professional. Catalonia.

Bearing in mind that the PCCs are directly managed by the administration, it could be affirmed that this idea of educational actions as positive but optional elements originated there. Thus, the more biologically oriented action of the NEP was the object susceptible to aggregation and educational and social accompaniment, modular pieces that were very sensitive to the effects of health cuts. The anecdote of a professional working in a NEP illustrates this problem.

> "We used to have someone [...] who was a social pedagogue... [...] Then we had less resources... And now we don't have anybody, absolutely anybody. Nobody does promotion, nobody does education [...] It would be perfect to have somebody like we used to have, but there isn't any."
>
> Female. PCC professional. Catalonia.

The lack of bridges between PCC professionals and NEP users seemed to have two consequences. The first, and most obvious, was that it distanced people from the primary care network and limited them to the dignified accompaniment provided exclusively by the HR services.

The second, and more subtle, implication was that it consequently distanced professionals in the primary care network from contact with PWUS, promoting and perpetuating knowledge about substance use into preconceived notions, probably stigmatising and based on the healthy/sick paradigm. Both effects could be observed in this professional's testimony.

> "It is more convenient for them to go to an HR centre than to go to... Nowadays we have not done... Not all health and pharmacy staff are aware and treat people who use substances in the same way."
>
> Female. PCC professional. Catalonia.

Limitations of educational accompaniment in NEPs

AAlthough the inclusion of social accompaniment in the NEP brought obvious benefits, in almost all the services represented in the FG a syringe dispensing machine was provided. One of the reported benefits of the machines was the increased accessibility of hygienic material in those facilities that did not have night hours. However, despite this, the obvious difficulty in standardising these programmes was striking for several reasons.

Firstly, in areas of high community tension, the benefits of the machine were seen as short-lived, as there was a potential risk that people in the neighbourhood where it was located would boycott its operation. Secondly, the availability of financial resources to implement this programme was uneven across services, with practitioners reporting having to resort to making home-made solutions themselves in response. The following excerpt from a conversation between a woman and a man working in RDD services highlights these motives.

> "If it was a vending machine, for example, that covered the night shift, it's very clear to us that it wouldn't work, basically, because we see how the neighbours interact with the DCR, they would blow it up."

> "What we've been doing for the last few years is leaving a wooden bucket that we've made by hand so that users can dispose of syringes when the service is not open."

On the other hand, the installation of vending machines was associated with the disadvantage of preventing contact between professionals and users. This statement by a professional was a clear manifestation of this disadvantage.

> "People who need syringes come and take them from the machine right at the entrance of the PCC, and in 0.2 seconds they are in and out, and you can hardly see their faces."
>
> Female. CAP professional. Catalonia.

However, in the context of the debate about the importance of the educational work of the training machines, the concept of accompaniment was equated with the concept of supervision. This can be seen in the following extract.

> "I want (the user) to come and see me to get the two or three (syringes) he needs for the day, so I see him and talk to him and tell him how you are. If he takes 30 (syringes), I won't see him for 15 days."
>
> Male. NEP professional. Catalonia..

In order to adapt the NEP to new communities, it seemed important to take into account the fact that professional contact is limited for certain community groups for whom "*chatting*" can be a considerable effort due to

language or cultural barriers. In this respect, the very action through which the educational accompaniment was implemented (the exchange of syringes) could be an obstacle, given the internalisation of the stigma attached to substance use, especially for women or people from different cultural backgrounds. This element seemed to indicate that, at times and for certain groups, removing barriers meant reducing or eliminating professional supervision. In this quote, a practitioner explained the benefits of this.

> "Our case, for example, is very positive, it is very important, in the sense that they manage the machine among themselves and they can continue... they can inform themselves, they can be together with each other and in this case, as you say, of certain communities, it is a problem just because of the language barrier."
>
> Male. HR service professional. Catalonia..

Some of the elements observed in this quote, such as the agency's ability to self-manage the machine and the establishment of collaborative personal relationships, seemed to act as dynamisers of social support networks. However, it should be noted that the professional referred to the machine users in the masculine, although this may have been due to the generalised androcentric use of language, it was felt that the number of female users was low and it was questionable whether these partnerships were beneficial to them.

However, it was noted that where there were no donors, the same support networks were seen as a basic requirement for people who did not want to be recognised as PWUS in their community to have access to NEPs.

> "Here there are no dispensers like in Barcelona, people who didn't want to come, or I don't know, they wanted to protect themselves [...] They used these links or these people (to distribute)."
>
> Female. Professional in a HR service for homeless people. Valencian Community.

Therefore, in situations where there is no relational coverage, such as after a migratory journey without a trained reception network, and in communities that either use strategies of concealment or are hidden (such as women, migrants or LGTBIQ+ people), the absence of dispensers could hinder the exercise of the right to health of these groups that are more stigmatised. Therefore, a combination of these services and socio-educational accompaniment seemed ideal to achieve greater access to hygiene materials.

On the other hand, as there was full agreement that the demand for syringes increased significantly in areas where there was a greater supply of substances, another element that was highlighted as facilitating access to NEP was the mobile units. The usefulness of these units was evident in the exchange rates reported by professionals. This is illustrated in this extract.

> "The neighbourhood [...] is a centre for the sale of substances [...] It is the place where we distribute by far the most syringes, around 10 syringes a day and per person [...] summing up 150 syringes a day [...] In fact, there are people who even collect used ones from the forest where people consume and eventually they show up with a box of 700 syringes, so that's on their account and we deduct from that."
>
> Male. HR service professional. Catalonia.

DISPENSING MATERIAL

Inhaling paraphernalia

All FG participants agreed on the need to adapt hygiene paraphernalia for the inhalation route. Both those services that had done so, either by distributing materials or setting up DCRs for this route, and those that had not, pointed to the need for more resources to care for people using the inhalation route. Here is an extract from a conversation between a male and a female who work in supervised consumption centres.

> "- I'm telling you, we don't provide pipes and I think they should be distributed because we've also seen an increase in smokers.
>
> - We have noticed in the last few years that inhaling has become popular in the consumption rooms. And there is a lot of need, you know."

While materials intended for this purpose, such as aluminium, were dispensed in all the services represented in the FG, this was not the case for pipes, which faced more barriers to dispensing. The reasons for these barriers could be categorised as economic and political, both of which are closely related.

The insight that could be gained from describing this relationship between the two reasons was that political will was reflected in the design of the budget. While there was no specific mention of political discourses against the provision of inhalers, there was reference to dynamics that inhibit innovation in HR in some of the areas represented:

> "If the projects have been running for years and have continuity, they are already in the budget, the administrations already see them as items where money is allocated. Now... we (the administrations) have to do the same with the inhalation route, we have to make new budgets and include initiatives, although we lack the money to do so."
>
> Male. NEP professional. Catalonia.

From this fragment we can deduce that the design of these budgets was based on the effectiveness of the programmes, so that for those innovative proposals that were less far-reaching, any possibility of public funding was removed until they had been evaluated, regardless of the level of need felt by the target community. One professional described the different political views on injecting and inhaling.

> "Those who support the space financially, that is the government and the deputation, [...] there are things that are very obvious to them, like not sharing a syringe, but I doubt very much that they think it's something fundamental to make pipes [...] they still haven't integrated this very much."
>
> Male. HR service professional. Basque Country.

Following on from the previous conclusion, the significant difference in funding reported by this paraphernalia expert, depending on the route of administration, was that the NEP had achieved the epidemiological objectives set out in its original design. Thus, from this point of view, there was no room for improvement, which made the inclusion of new materials invisible and obscured the potential element of capturing hidden communities associated with it.

This element placed the limitations of the provision of hygiene materials in the same paradigm described above with regard to the NEP's educational activities.

Nevertheless, as the group was fully aware of the need to adapt hygiene equipment to the inhalation route, several assumptions and proposals were put forward for discussion during the meeting. Firstly, they agreed that the design of the distribution of pipes should take into account different conditions than those for syringes, since the latter are intended for single use only, whereas the more expensive pipes could be used repeatedly by the same person if the material was kept in optimal hygienic conditions. The following is an excerpt from the FG dialogue, where the proposals of two social educators working in NEP and HR services were observed.

> "- The syringe, it's not reusable, it shouldn't be reusable. So it's dispensed, it's given and that's it. As for the pipes, I think it's educational, the fact that I'm giving you the pipe, if you wash it well, use it well, take good care of it, it can last you a very long time, I'm not going to give you one every time you come here.
>
> - The system we are thinking of, if we manage to give out pipes one day, is that it should be something temporary, that you take care of it, that you can get one every x amount of time. And if you need one before, you pay for it."

In this excerpt, secondly, a proposal was observed, a report that raised discrepancies among the participants, and that was the experience of co-payment developed by CAS Baluard in Barcelona since 2012. When the question of making the pipes affordable in order to be able to buy the material and distribute them was raised, not everyone in the General Assembly agreed. During the debate on this issue, no data was presented on possible differences in the use and maintenance of the material by men and women, which was considered to be of interest for the design of the distribution.

Arguments against co-payment were mainly that setting a price would be a barrier to people using pipes, especially for those who were homeless and excluded from benefits. One professional also argued that it was dissonant to involve commercial relations, however symbolic, in educational work and suggested other forms of payment.

> "Rather than a financial co-payment, I imagine a co-payment for something else, like if you break the pipe you have and you want another one, then you go to a health education workshop about it, or how to cook (the substance) and so on."
>
> Woman. HR service professional. Catalonia.

On the other hand, the professionals who took part in the CAS Baluard experience of symbolic co-payment for pipes reported positive results in terms of the effectiveness of the programme, the durability of the material, the non-infantilization of PWUS and the rupture of the social imaginary that associated them as people without economic resources.

Otros materiales

When asked about other paraphernalia, this time aimed at specific communities: women, people who use substances during sex, or LGTBIQ+ people, all services reported having different types of condoms and materials focused on sexual health and intimate hygiene for people of the biological female sex.

> "We have condoms, lubricants, male condoms, female condoms and, well, American and Spanish syringes, different things. The problem, as I said, is that we haven't detected (these community groups) here."

Male. HR service professional. Basque Country.

However, as can be seen from this quote, the fact that it was available within the services did not necessarily mean that people accessed the material.

There were several suggestions from professionals who pointed to the need to bring these issues closer to the contexts of use, either by training other users or by bringing professionals into these spaces.

The most striking implication of the fact that in some centres the material was trapped in services labelled as HR was not only that the target audience did not have access to it, but also that for the professionals in these services the only knowledge they had of these groups was what they could imagine. Because it was not the beneficiaries themselves who came to the point of delivery, their identification and recruitment was diluted. The following quote illustrates this involvement very well.

> "There are many practices that we do not see, that we do not know, we imagine [...] So I understand that there is a hidden community of PWUS that does not have access to us or to any of the services that we know or that we share."

Male. HR service professional. Basque Country.

It could be argued that the fact that these materials were found within the services, under a self-service logic, once again cast the shadow that the biomedical model, very much embedded in HR strategies, had reduced the usefulness of community work and that of paraphernalia as an essential strategy for recruitment and adherence of hidden communities. This could also make women's actual access to hygiene materials invisible, as it may be other men who collect them for them, either by reducing their possibility of contact with the professional, fear of stigma, or simply by making themselves visible as PWUS in the community.

SUPERVISED DRUG CONSUMPTION ROOMS

All participants in the FG agreed on the usefulness of drug consumption rooms (from now on DCRs) as a space for connecting with PWUS, dignifying consumption, preventing overdoses and providing effective health education. This space was even identified as a fundamental element of HR.

> "The person sees how it (the room) is, sees that he/she feels comfortable and .... from here the link and the socio-educational work starts all over again [...] the consumption room is for me the basic pillar of harm reduction."

Male. HR service professional. Catalonia.

In reaffirming this idea of DCRs as a cornerstone of HR, it should be remembered that, like the NEP, these services were rooted in HR for the injection route and, more generally, for heroin, as this was the need that had to be addressed at the time of their design and implementation. And it is precisely in this orientation that professionals have identified the difficulties of DCRs today.

Need for adaptation to stimulant use

All professionals agreed that substances and their forms of use have changed, with a preference for stimulants. Below is an extract from a conversation between two men working in HR services in different Regional Autonomous Communities.

> "- Cocaine use has risen dramatically compared to heroin u."

> "- We have had an analysis service here for a year [...] and we also see that heroin is hardly ever brought to us, but cocaine, plenty."

These changes in preference were reported by professionals as distorting the tranquillity promised by DCRs. They pointed out that this interfered with the desired effect of substance use for those people who were looking for a place to do it in a pleasurable way, which sometimes meant that people refused to use DCRs.

> "You can easily find out that there is someone in the room who is using heroin. And it could be that there are three people next to me at that moment who have come in to use methamphetamine [...] well, sometimes the tranquillity of the room is not that, there are people who don't even like to enter the room."

Male. HR service professional. Catalonia.

These disturbances were largely related to the infrastructure itself, which was inadequate for all FG professionals working at DCRs. Not only was the use of stimulants reported to be more disruptive, but it also occurred in a closed and confined environment. This was particular-

ly the case with the increase in the use of inhalants, for which there are only 3 rooms in the whole of Spain, and therefore greater pressure on demand.

Another conflict mentioned was the difficulty in maintaining security. They mainly referred to robberies. In fact, the participants representing the DCRs agreed that they were not safe spaces.

> "I wouldn't say it's safe either. Sometimes it's complicated because of people's consumption, theft and so on."
>
> Woman. HR service professional. Catalonia.

It was found that these were spaces where basic needs were covered, such as a place to be, a professional team to accompany people and help with consumption. However, given the difficulties mentioned above, the benefits of the DCRs have been exhausted within the limits of the HR, which has hindered practices related to the care of pleasure.

Institutionalised environments

The absence of measures to maintain pleasure and wellbeing in the DCRs could take on the same tone as in the health centres: spaces where illness was dealt with.

The group was therefore asked about alternative strategies for transforming these environments into more participatory spaces. The starting point was two main axes: the redistribution of space and the figure of the peer. The following is a fragment of a conversation in which two men working in DCRs and NEP respectively shared their experiences on both axes::

> "- Before there were round tables, there was space to play cards and that was taken away, (now) it's not so inviting to stay for hours [...] Most of the people who come here have said they prefer this because there's less commotion, less fighting and less theft."

> "- A group of peers who manage things, maybe that group of peers breaks up and there is a natural leader [...]. I experienced this in a drop-in service [...] One person who had a driving licence, we told him, well, you can be the one who goes and picks things up. And because he was the one who went with a van to pick things up, he ended up thinking he was the assistant manager. And there were problems."

Este fragmento indicaba la proporcionalidad que eThis fragment showed the proportionality that the participants in the FG saw between the creation of spaces for participation and the increase in conflicts. This invited us to reflect on the opportunity costs of conflict avoidance, which seemed to imply a reduction in participation, and to assess whether these were the orientations that were of interest for the future, or if not, whether we needed to look at other modes, other non-professionalised spaces or other ways of intervening. In this sense, it was suggested as a possible line of research to analyse who contributes to this conflict, what kind of conflict it is and what solutions can be found by looking at it from a gender perspective.

3.12. HARM REDUCTION AND PROFESSIONAL BURNOUT

AUTHORS: SONIA ORTIZ MORENO

INTRODUCTION

The work of professionals in the field of HR who focus on supporting PWUS and often have experienced multiple episodes of violence and may also be homeless, presents unique challenges that can increase the onset of burnout syndrome. These professionals face the complexities of managing substance use, the stigma associated with it, and now the difficulties associated with homelessness. In this qualitative research, we sought to explore specific aspects that contribute to the burnout syndrome in those who work tirelessly in the field of HR.

These professionals are immersed in an environment where empathy and understanding are fundamental to building meaningful relationships with those seeking support. However, this constant connection with the daily struggles of people in extremely difficult situations can take a considerable toll on the mental and emotional health of professionals. The very nature of HR involves exposure to challenging and, at times, distressing scenarios. These professionals are exposed to situations where they have to deal with crises related to substance use, violence, homelessness, discrimination... and often they are also people who have experienced potentially traumatic situations. Constant exposure to these shocking realities can lead to emotional fatigue and psychological exhaustion, contributing to the development of burnout syndrome.

In addition, their exposure to situations of violence adds another layer of complexity to their lives. Violence, whether interpersonal or structural in nature, is a constant challenge in the lives of PWUS, and it increases exponentially if they are also living in a situation of homelessness. Professionals, when directly confronted with these situations, need to manage and address the physical and emotional consequences of violence suffered by PWUS. This exposure to violence can lead to additional burnout, adding to the emotional distress and contributing to the risk of burnout.

Burnout is characterised by a feeling of physical and emotional exhaustion, depersonalisation and a decrease in personal fulfilment at work. In the context of HR, these manifestations can be exacerbated by the pressure to provide effective responses in an often resource-constrained system. Work overload, lack of recognition and support, and the often thankless nature of the work can create a vicious cycle that contributes to burnout.

One of the most challenging aspects for these professionals is managing expectations, both their own and those imposed from outside. A lack of public understanding of the social vulnerability of PWUS can lead to a misunderstanding of the work of these professionals. Instead of recognising the importance of HR as an effective intervention strategy, they may be met with resistance and misunderstanding. This contributes to a sense of lack of recognition, which increases the risk of burnout.

In addition, lack of adequate resources and institutional support can exacerbate work-related stress. Effective implementation of HR programmes requires significant investment in human, training and material resources. In many cases, however, professionals are faced with the reality of working in conditions of scarcity, where demand far exceeds capacity to respond. This mismatch can lead to frustration and disillusionment, contributing to the erosion of initial motivation and enthusiasm.

The therapeutic relationship in the field of HR also presents unique challenges. Often, the need to set healthy boundaries must be balanced with empathy and understanding of the experiences of the person being supported. This constant balancing act can create an additional emotional burden as professionals are in the delicate position of facilitating change and autonomy without being judgmental or imposing.

The uncertainty inherent to HR also contributes to burnout. People with disabilities face many challenges and obstacles, and the unpredictable nature of their circumstances can create additional stress for professionals.

It is important to note that the experience of burnout may differ between female and male professionals working in HR. Gender differences may influence how stress and work pressures are perceived and managed. Female professionals often face additional challenges related to social expectations, unpaid workload and dual role management, both at work and at home. These factors may contribute to an increased vulnerability to burnout.

In conclusion, as the diagnostic phase of this research has shown, from a theoretical point of view, working in HR seems to contain very important ingredients for generating burnout and increasing the risk of burnout, and it is essential to consider the gender dynamics that influence these experiences.

METHOD

A quantitative methodology was used, based on the development of a focus group (FG) composed of profes-

sionals linked to the harm reduction network programmes at state level. The information was complemented by a semi-structured interview with a professional experienced in supervising HR teams, psychosocial accompaniment and disasters. This accompaniment is based on a 'Professional Care Model', which she developed herself.

An individual questionnaire was designed and administered telematically to all participants. The main objective of this instrument was to collect individual information about their first-hand experience of burnout and/or the development of burnout syndrome in the HR services and/or programmes in which they had worked.

This experience included aspects as a witness and/or as a person affected. The variables collected related to: 1) the years of professional experience in HR, where 100% of the participants had worked between 5 and more than 10 years; 2) the years of experience in managing people or teams dedicated to HR, which obtained the same result as the previous variable; 3) the type of company in which they had carried out their professional work, which showed that 50% of the people worked or had worked in companies managing public services, 33.3% had worked or had worked in the public sector and 16.7% in the private sector; 4) the satisfaction with the working conditions, where 83.3% said they were not satisfied; 5) having suffered from symptoms of burnout, where 50% replied in the affirmative and 100% said they had suffered from anxiety for work-related reasons; 6) having experienced burnout, where 66. 7% of professionals said they had accompanied or witnessed colleagues or partners experiencing burnout; 7) having been on sick leave due to burnout, where 100% answered in the affirmative and 100% affirmed that this temporary interruption (TI) of employment due to illness was not classified as work-related; 8) the existence or not of prevention protocols in the companies they work for, where 100% replied that they did not have any.

The sampling was theoretical, of convenience and across the entire research team. Of interest were: 1) professionals with a long track record in HR services and/or programmes; 2) professionals who were not currently working in the HR network and who could facilitate the collection of information with experiences from an emotional distance; and 3) professionals with experience in psychosocial accompaniment of HR teams.

The network of HR services and programmes involves different professional profiles, both health and social, and the inclusion criterion applied was based on ensuring the presence of voices from both sectors, with the aim of analysing the differences in possible impact according to the functions carried out in their daily practice. Representativeness was taken into account in terms of diversity of gender, cultures, national territories, types of equipment and characteristics of the working relationship (years of experience and responsibilities).

The FG was led by the researcher who is an expert in burnout. It relied on the observation of both the UNAD technical expert and the research coordinator. It was telematic. The total duration was 2 hours. The final number of participants in the FG was 6.

RESULTS

BURNOUT SYNDROME: CONCEPT AND INTERSECTIONS

The first aspect addressed was the definition of burnout itself. It was observed that the majority of the participants identified the symptoms of burnout as 'demotivation', 'weariness', 'fatigue', 'exhaustion', 'anxiety' and 'depression'. All agreed that, in the context of HR, the burnout syndrome has been observed to have differential elements compared to other industry sectors.

> "Of course, there are specific characteristics of burnout in HR. The situation that people are working with is very demanding. It is a community that is very damaged on an emotional level and therefore you have to work with people to contain them. And that takes its toll on you as a professional."
>
> Psychologist, Barcelona. Specialist in burnout and accompaniment of professional teams. Catalonia.

Another participant pointed out that bringing burnout to light in HR is 'to make it clear that there is an impact on people's mental health.' She added that this syndrome should not be seen as a final state, but as a process involving emotional exhaustion in a specific work context.

> "There are two legs to burnout, the emotional and the managerial. But the emotional one means that you have already given evidence that you are emotionally affected by the attention you are giving."
>
> Psychologist, Barcelona. Specialist in burnout and support to HR teams. Catalonia.

Age as an axis of inequality in the likelihood of developing burnout was mentioned several times by the older participants. They pointed to longer rest periods as a protective factor against the development of burnout syndrome in people with long careers in HR. They pointed out that there is no model of work management that encourages this and that there is still a fear of losing one's job or of losing stability when returning to work.

> "I don't know if it's an older mentality, I suppose it's that I used to think of myself as young, I wasn't afraid of losing a job and finding another one. Now you look for more stability, at least in my case. Or maybe more fears are active, I don't know if it's real or not. More fears are triggered because you are no longer ready to swallow anything or to start from scratch. You don't feel like joining a new team."
>
> Social Educator. Linked to HR Services. Catalonia.

In support to this argument, one of the participants linked to HR services complemented this discourse by expressing that, in her experience, she observed a greater presence of symptoms compatible with burnout syndrome in people with a long career and less training in recognising these symptoms as a work-related illness. The participant emphasised that taking on work responsibilities is a generational phenomenon that could influence the decision to take leave due to burnout.

> "The people who have been in HR the longest are the most burnt out, but also in the place where I have worked, they are the ones who find it hardest to take time off."
>
> Social Educator. Linked to HR Services. Catalonia.

Another of the professionals supported this idea and added another element relevant to the age of HR professionals, namely the impact of salary on the amount of financial support to be received in the legal allowance.

> "When you get older, you are afraid of change and you adapt to what you have. On the other hand, when you're older, you're also more afraid of retirement and you ask yourself: will I earn enough?."
>
> MD and Coordinator. Linked to HR service. Community of Madrid.

Despite the existing feminisation of HR network professionals and the fact that the vast majority of participants were women, the impact of gender on burnout in HR was an aspect that went over their heads and was barely mentioned. Only two of the participants described how gender bias affected the decision making process of requesting sick leave. Both reported pressure from their employer to withdraw the request.

> "I don't know if as a woman or as a woman in her forties, but for me personally, when I have to go to the doctor because I have gastroenteritis, I feel this thing, I don't know if it's Christian guilt to say, are you sure you're sick enough not to go to work?"
>
> Social Educator. Linked to a HR service. Community of Madrid.

In addition to this idea, another expert added her personal experience on the subject:

> "It is a combination of our internal judgement, which of course comes from having been taught some good gender mandates here, with the real prejudice. I mean, it happened to me when I was on a burnout break and my partner was also on another kind of sick leave for depression. And it was a different story, it was a different story how he went to the doctor, with the ease with which he was given leave, than how I was questioned."
>
> Social Educator. Linked to HR Services. Catalonia.

RISK FACTORS FOR DEVELOPING BURNOUT SYNDROME

High exposure to violence

The word violence was mentioned frequently in both of the FG reports and the individual interviews and was identified as a risk factor for the development of burnout syndrome in the different contexts of HR support. Several participants highlighted the normalisation of violence (shouting, threats, depreciation) in HR services.

> "A lot of things go unnoticed in teams, or are normalised. Because in harm reduction it is normal for a user to shout at you, for you to be afraid... Or that you leave the service thinking that a user might do something to you... or to your car, that you found it scratched. This should not be the case: "No, it's just that working in harm reduction, these things happen", sorry?!"
>
> Psychologist. Specialist in psycho-social accompaniment to professional teams. Catalonia.

> "We are often with people who live on the streets, who suffer sexual aggression on a daily basis, all kinds of violence. And in the end, these people, whether you like it or not, in direct care, often reproduce all the violence; from institutional violence to physical, sexual, social violence they may receive, they reproduce it towards you."
>
> HR Social Educator and Union Liaison. Catalonia.

All participants explicitly reported that they had experienced violence at some point during their working day. They pointed out that although the idea is automatically projected that violence comes from service users, participants emphasised that another source of violence is the neighbours of the community where the HR services where they work are located. One participant described this as follows:

> "You get a lot of violence from the neighbourhood, from the neighbours,... In other words, everything that the institutions don't pick up, all the grievances that aren't picked up, end up in the service. Because at the end of the day you're there, let's say, and you're accessible."
>
> Social Educator. Linked to HR Services. Catalonia.

Poor working conditions and external recognition

One participant used the term '*isomorphic institutions*' to describe the similarity between the situation experienced by HR professional teams and the situation of marginality experienced by service users. It was pointed out that both groups share and reproduce the condition of marginality and oppression in the eyes of people from their own discipline, institutions and administrations.

> "I remember I had a master's professor who talked about isomorphic institutions, which end up taking the form of the field in which you work... Sometimes they're the bottom rung of society... if you use substances, it's because you want to."
>
> Social Educator. Experience in HR services. Catalonia.

They indicated that the lack of external recognition reinforces this perception of discrimination, as does the pay gap with colleagues in other fields.

> "I think something that defines burnout in HR is marginalisation. I feel marginalised and so do my patients. We are marginalised. We are doing something that is not valued economically, institutionally or in any other way.... The salary a doctor earns here is shameful."
>
> MD and Coordinator. Linked to HR service. Community of Madrid.

Another element mentioned by all the participants was the lack of recognition by the managing body and/or the public administration responsible for the service and/or programme. They were unanimous in pointing out the outsourcing of services by the administration as an element linked to a reduction in the quality of care and a deterioration in the working conditions of the workers. These two elements were identified as risk factors for burnout.

> "But at the end of the day, we are a product that several companies buy every six years, and this is very noticeable in the quality of work and service."
>
> Social Educator. Linked to a HR service. Community of Madrid.

> "This fatigue has a lot to do with the constant struggle with the institutions, with how difficult it is to fit harm reduction into certain areas. In the health sector, for example, where we work, it's very difficult, isn't it? We have to support the service in very difficult conditions, in outsourcing conditions that are becoming more and more complicated."
>
> Social Educator. Linked to a HR service. Community of Madrid.

It was insisted that the administration, in the first instance, and the managing bodies, in the second, are responsible for promoting measures that favour professional care. They considered that the need for this professional care should be taken into account from the outset in the contracts, tenders and grants that the administration makes with the managing body, and also in the contracts that the professionals sign with the contracting company: 'contracts where it is envisaged that there will be psychological damage, making it clear that there is an impact on people's mental health, being able to explain it as a right of workers. And to be insured for it. To have sick days covered for these reasons, not just because my back hurts or I have a migraine.' Only the participant who was a trade union liaison officer pointed to the management company as being solely responsible.

The working conditions related to the management mode of the services and/or programmes mentioned by the participants were the lack of defined professional roles, work overload and multi-tasking. All these elements were reported particularly by the professionals in Barcelona, who linked them to stress and burnout.

> "Multitasking, being constantly interrupted. In technical work, you might be opening a door, writing a report, attending a fight and calling 112. It's exhausting."
>
> Social Educator. Experience in HR services. Catalonia.

> "Look, last week I had a really hard time. My job category suddenly multiplied and I was an educator, a coordinator, an administrator - I was covering everything. So I was doing the work of four people, knowing that if I didn't, the work wouldn't be covered. This is the level.... So it's something that directly increases the feeling of burnout. And not only that, but all the responsibility falls on you. If I don't know how to be a coordinator, I don't know how to be an administrator, that's not my job. And I know that if I don't do it, no one else will, or it has to be done anyway, whether I like it or not."
>
> Social Educator. Experience in HR services. Catalonia.

The professionals in Madrid reported that, despite several changes of service provider, they had achieved the

4-day working day, which had significantly increased the sense of rest and free time. This element was reported to compensate for poor conditions such as low pay or lack of external recognition.

> "We also try to have enough free time. As far as we can, there are two important factors and one of them is to be able to rest so as not to burn out. This used to be managed by an association and they always took care of us in that aspect of having to rest. So we work four days a week and that's something that helps us to stay at the job. That has prevented me from resigning, because I don't want to give up my free time. I have rested this week and that is a great advantage. One thing is financial, another is leisure."
>
> MD and Coordinator. Linked to a HR service. Community of Madrid.

Professionals linked to services and/or programmes in Catalonia were surprised by this improvement in their work, indicating that their reality was the opposite. Several participants indicated that their experience included working more than 10 days in a row to cover vacancies in the teams. This element was reported as a high level of stress. The variables of age and seniority were also identified as factors in the acceptance of poor working conditions, but not as protective factors in the development of burnout.

> "In my case, I see people who have very poor working conditions, especially substitutes or younger people. They come to work 9 days in a row, 11 days in a row, in other words, it's happening. So we find people, especially substitutes and young people, who are doing these marathons and you can see that they are at their limit."
>
> Social Educator. Experience in HR services. Catalonia.

Lack of professional care protocols and external monitoring

Participants stressed the importance of the fact that the administration, which is responsible for setting the minimum outsourcing conditions, does not take into account the need and cost of care agents into the professional structure, nor does it require professional care protocols. From this point of view, professionals pointed out that administrations are able to either cover this provision with their own resources or undervalue it, leaving professionals in a situation of legal helplessness.

> "As an institution and organisation, you have to be very aware that working with this community leads to burnout."
>
> Psychologist. Specialist in psycho-social support to professional teams. Catalonia.

> "The lack of care agents for the team. The number of supervisory positions is already increasing in the social field, but when I was working in harm reduction I didn't have supervision and I think it is a tool that should be very basic and essential for the care of the team and also for the praxis."
>
> Social Educator. Experience in HR services. Catalonia.

The professional experienced in this role argued that implementing the usual professional care measures and supervision, in her opinion, would be insufficient unless it is accompanied by adjustments in working conditions adapted to the service. Some examples given were a 4-day working week, careful breaks throughout the working day: '*you may need a room with cushions, quiet ... You may have just had an intervention in the street and need a calm and quiet place to go, and a telephone number to call in a crisis situation, outside of working hours, if you need emotional support*'.

MEDIATING FACTORS IN THE DEVELOPMENT OF THE BURNOUT SYNDROME

Professional team

Another factor associated with burnout that was also mentioned was the professional team itself. The professionals working in Catalonia indicated that the fact that they are responsible for the interaction between their members could act as a precipitating factor in the development of burnout syndrome, describing it as an expansive phenomenon among their members.

> "It's mutually reinforcing. That is, if we have a colleague who is burning out and he is still in the team, he will end up dragging others down."
>
> HR Social Educator and Union Liaison. Catalonia.

> "The team can be a trigger for burnout or a team that is completely burnt out".
>
> Psychologist, Barcelona. Specialist in burnout and support to HR teams. Catalonia.

On the contrary, some professionals based in Madrid reported that, in their experience, the professional team had acted as a protective factor against the development of burnout syndrome. Based on their own 19 years experience, they pointed to the seniority of the team members, the perception of support and care, and the commitment to continuity as positive factors.

> "The luck we have is that we have a team, most of us have been together for many years and we are very protective of each other. We grew up together, we created the project and that protects us a lot....

Social Educator. Linked to a HR service. Community of Madrid.

> "The truth is that we haven't had many cases of burnout here, the team has been pretty stable over the years. Personally, I have experienced it temporarily in specific moments of stress. I don't feel the need to take sick leave."

MD and Coordinator. Linked to a HR service. Community of Madrid.

Within professional teams, hierarchies were also found to exist between team members. Oppression due to this inequality was also identified as a possible risk factor for the development of burnout. One participant stated: '*In fact, it is these power dynamics that make me burn out and not the direct intervention*.' The construction of this power scale based on the biomedical model was identified, with the professions of medicine and psychiatry in positions of privilege and power, and social education professionals or care assistants in positions of oppression. On the contrary, it was reported that the horizontal structure of work organisation could be a protective factor, promoting a well-being working environment for professionals.

> "I was thinking about the issue of hierarchies within the team... if you work with a more horizontal dynamic, it's much easier for a team to feel good, to support each other. Sometimes you find that, but in a hospital? I was surprised. A very strong structure, with figures of great authority, like doctors, psychiatrists. It's a movement."

Social Educator. Experience in a HR service within the hospital environment. Catalonia.

It seemed that this aspect could be complemented by specific training for professionals leading and coordinating professional teams to legitimise and validate that a professional is wrong and to say 'bye, go away, you are not well', and to ensure that they have recourse to the implementation of horizontal models.

Professionals working in HR services and/or programmes in Madrid pointed to the equal sharing of responsibilities and decisions as a care dynamic among professionals.

> "I also think it's very important that we try to share the responsibilities, trying to share the weight of decisions to prevent burnout. Thanks to this we have avoided very serious or very obvious cases of burnout. At certain moments, of course, it has happened."

MD and Coordinator. Linked to a HR service. Community of Madrid.

Struggle for rights: individual involvement and collectivisation

Participants working in HR highlighted the lack of individual and collective commitment to defending workers' rights: '*If I think about individual responsibility, we are the least mobilised sector in history*', linking this element to individual isolation and demotivation. From this statement it could be concluded that the collectivisation of the struggle for rights could be a protective factor against burnout.

The possibility of creating and establishing a specific HR collective agreement as a regulatory framework was mentioned by some participants as a possible protective factor against burnout. The trade union liaison professional pointed out that '*HR is not like other fields... The working agreements that exist in hospitals do not address the reality that we have in harm reduction. The private health agreement does not address our reality. The social agreement does not address our reality either, it does not address the needs. Maybe we need to propose different salaries, or a shorter working day, or that we should have psychological care covered*.' Participants from Madrid questioned the need for a specific agreement on HR, pointing out that recent disruptions in the regional public health system boded ill for the future of public services. This led them to question the possibility of achieving an improvement in working conditions compared to other historically troubled sectors, such as the social sector.

> "Hyper-specialising the agreement (the social intervention agreement is already quite specialised), making it more hyper-specialised, tear us further apart. I don't see a good way forward."

Social Educator. Linked to a HR service. Community of Madrid.

Although the union liaison professional was convinced of the potential benefits that the creation of a specific agreement on HR could bring to the professionals, she pointed out the difficulties that would be encountered, referring to the involvement in improving the health status of professionals with a high level of mistrust.

> "The only problem I see is that I think there is a lot of literature missing to make a specific agreement on HR and to provide a basis on which to negotiate the agreement. On the other hand, well, they are not going to sign it. It's a fact, they're not going to sign an agreement where, in my view, you need more breaks or more spacing of working hours. They are not going to increase your pay. Unfortunately, that's the reality."

HR Social Educator and Union Liaison. Catalonia.

Substance use and traumatic experiences

The psychosocial psychologist appealed for individual responsibility from a self-care perspective, pointing out that if a professional lacks these strategies, the likelihood of developing burnout syndrome is increased. He pointed to two precipitating factors: substance use and the high prevalence of traumatic episodes in HR professionals. The presence of both factors was observed to represent a circular cause-effect behaviour that could potentiate the rest of the risk factors associated with burnout.

In relation to substance use, the expert identified it as a risk factor which, together with an accumulation of other potentially precipitating factors (such as exposure to violence, inadequate rest periods, immediacy of demands), contributed to an increase in the anxious symptomatology of the professional. This combination was reported to increase the person's discomfort and worsen their emotional state.

> "And if you sum up that often there is a personal substance use by professionals. It's a ticking time bomb, who's looking after who?"
>
> Psychologist. Specialist in psychosocial support to professional teams. Catalonia.

In contrast, the rest of the participating professionals pointed to the positive effects of substance use as a protective factor. Some of the functions reported were anxiolytic '*like another treatment, like taking a diazepam*' and avoidance '*helps you to escape*.' From both examples, it could be seen that participants prioritised continuity of work over discomfort in the face of emotional stress episodes that they might be experiencing individually.

Despite these initially contradictory positions, professionals highlighted that this strategy, if continued, could have negative effects on people: '*in the long run, it is worse for the process of burnout*' and, in turn, '*it is a cause-effect, when you suffer from burnout, you want to drink more*.'

The expert stressed the importance of also contextualising this use of substances, which she considered risky when it becomes an avoidance strategy associated with individual discomfort. She pointed out that some people who have not undergone a process of personal reflection and self-awareness may engage in the practice of prolonging the working day among peers by using substances to alleviate the suffering experienced during the working day.

> "If you can't find out what moves you, we have to channel it somehow. I have it at my fingertips. And I'm dealing with it. And in HR there's a lot of socialising after work. And you go out for a drink and you can have four beers after work, why? Because they are my friends. I leave work, but I go for drinks with people from work and I end up telling my personal stories, ... It's not a cliché, it's how I channel this growing unease. And if I haven't worked on my baggage..."
>
> Psychologist, specialist in psychosocial support to professional teams. Catalonia.

With regard to the personal report, she highlighted the high prevalence of traumatic experiences, especially abuse, which she had observed during his monitoring, as a differentiating element in the professionals involved in the reduction process. She pointed out that this element could also be a risk factor for substance use, which could aggravate the anxiety symptomatology.

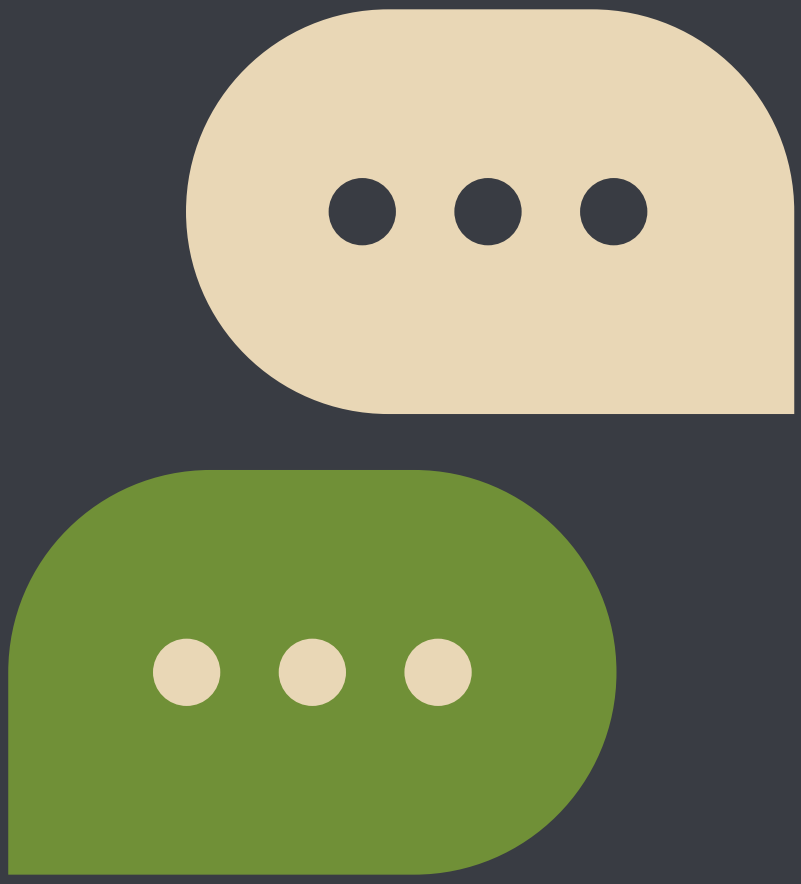
> "The consumption among teams. Also, as a risk factor, it's the baggage we carry. The people who work in HR, their life stories, have a certain profile when working with families. There is a lot of history of abuse."
>
> Psychologist, specialist in psychosocial support to professional teams. Catalonia.

She also highlighted that it had become clear that the intention and characteristics of the daily work of the HR could be a triggering factor for the connection to the previous traumatic experience that was denied or forgotten by the professionals.

> "The number of times I've seen, and I do professional work with HR, that stories of abuse have come up, they've been completely denied, forgotten or dismissed."
>
> Psychologist, specialist in psychosocial support to professional teams. Catalonia..

No reference to previous traumatic experiences or secondary traumatic stress was extracted from the speeches of the other participants. Only the potentially traumatic effects of frequent episodes of violence in the work environment were mentioned.

4 DISCUSSION



HARM REDUCTION AND SOCIAL JUSTICE

To date, and in contrast to other countries, the implementation of the harm reduction approach in Spain is unquestioned. The current model of the approach has common elements in most of the Regional Autonomous Communities involved in this research. It is characterised by being based on public health principles and applying a biomedical paradigm. Its main specific objectives continue to be designed and managed for epidemiological purposes through outcome and process indicators. These focus on reducing the transmission of HIV/HCV and reducing the number of deaths from opiate overdoses, with substance use at the epicentre of the approach. Overall, it can be seen that, even with the inclusion of HR, validated support for PWUS continues to have the ultimate goal of abstinence, regardless of the substance used.

The emergence of the HR, both in Spain and in other countries, is described as a combination of user and community needs, professional innovation and political courage. The 35 years of its implementation, the positive results in terms of effectiveness and the progress made in terms of guaranteeing rights do not seem to have been enough to silence the questioning of certain sectors of the community, professionals and politicians who maintain positions against it. In all the focus groups carried out, there are situations that illustrate this resistance.

Unfortunately, it is clear that HR continues to be imbued with ideological and moral issues, mainly based on drug prohibitionist discourses and policies, so that its sustainability and expansion aspects are not universally guaranteed and are subject to seemingly controversial questions. It is also striking to note the hyperlaxity with which administrations, public services and organisations report the application of HR strategies. Sometimes it seems to be a checklist item to be ticked off, without any follow-up on the content and quality of the checklist.

The focus of the HR model on substance use is seen as essential, opportunistic and effective at the initial stages of implementation, at both state and local levels. Accepting that the community itself is permeated and polarised by prohibitionism, it is seen as a functional strategy that is difficult to counter. Nevertheless, after years of implementation, it is still seen as a difficult strategy.

The hegemonic social and clinical view of this group is that of people who have become '*ill*' because of substance use and who will be '*cured*' if they stop using substances. The HR model is also described as the use of services and strategies to mitigate the consequences (health and social) of those who fail to '*cure*' themselves. The most worrying implications identified are the application of a mainly welfare-based approach, the invisibility of the structural factors involved, and the consequent rejection and discrimination they suffer from their communities.

The main proposal that emerges is the multi-level incorporation of the intersectional social justice approach into the current Spanish HR model. The proposals are based on promoting the re-establishment of PWUS as subjects with full rights, beyond being mere users of public services, thus recognising both the loss of fundamental rights and their capacity to struggle and the possibility of recovery. This approach recognises that social fragility and vulnerability are the result of the intersection of different axes of inequality and allows us to refocus the role of substance use, placing the person at the centre. The support network for the LGTBIQ+ community, specifically used in this research by people who engage in chemsex, is identified as a good practice to be replicated, as these people, despite being supported by services and/or programmes, maintain the component of collectivising oppression and politicising the struggle for rights.

In applying this new approach, the traditional Spanish division between risk reduction and harm reduction is seen as an element of revision. Professionals call for the two approaches to be unified, pointing out that it re-centred substance use, individualised and problematised certain substances and ways of using them, made structural factors invisible and encouraged stigmatisation of vulnerable groups. However, there is a consensus that this is an opportunistic strategy in areas where social punitiveness towards substance use is high, as was the case in Spain in the late 1990s.

Another aspect in which the model needs to be rethought is the strategy for implementing services and their relationship with the community. It has been observed that administrations sometimes implement policies that reinforce social polarisation, favouring the idea that the PWUS is not integrated into the fabric of the neighbourhood, but rather acts as a non-territorialised, displaced and/or expellable agent. On the other hand, although they are described as laborious and with medium/long-term results, it is good practice to base the intention and the discourse on awareness-raising, promoting a logic of community to guarantee the rights of the whole community, including PWUS.

Successful experiences have been identified and developed in Barcelona and Madrid, which are moving towards this new proposed model. In the case of the homeless, it has been observed that the integration of responses that combine the provision of basic needs and shelter with HR services (DCRs, provision of hygiene items, access to treatment) offers a more effective approach and reports higher satisfaction on the part of users. Similarly, with regard to women and people of different genders, the experience developed in Barcelona at a centre for the support of survivors of violence who

use substances is seen as a quality response to reduce the harm suffered by this community group, as is the creation of peer support networks.

In general, there is a need to include the pleasure component in the biomedical model, to strengthen the problematization of the use of substances and to offer responses in this direction.

AXES OF INEQUALITY AND OPPRESSION

In order to understand and describe the needs of PWUS, it is essential to adopt an intersectional approach.

Social class has been identified as the strongest axis of inequality in relation to substance use, with homelessness being the greatest expression of poverty in Spain nowadays. Obviously, this inequality is reinforced by gender, sex, sexual orientation, age and country of origin. Linking the causes of poverty and forms of substance use to structural factors promotes a broad understanding of the reality and reduces the individual's sense of guilt about their own situation.

Nevertheless, a rejection of being identified as poor is observed throughout the research, with aporophobic discourses and actions constantly at work, whether among PWUS themselves, among professionals, within services, in administrations or in the development of policies. The support given to people who engage in chemsex includes elements that are reminiscent of this rejection, and a certain invisibility of discourses that can link these practices to problems and, ultimately, to poverty can be observed.

The state housing crisis, gentrification and the touristification of cities are described as elements directly linked to the increase in homelessness. Possible causes include the general decline in wages, the reduction in the supply and high cost of rental housing, the scarcity of social housing, and the redirection of pensions to tourism, which eliminates affordable access to temporary housing for the lower classes.

The standard government response is to develop the homelessness network, which in most cases is the responsibility of the municipalities. All participants agree that the responses offered are inadequate and, in most cases, not adapted to PWUS. This lack of access consequently increases the vulnerability of this community group, making it essential to integrate the HR approach in these services.

Aspects of improvement identified in this network include the elimination of the staircase model, based on the meritocracy of the right to housing, the inclusion of individual housing and the specialisation of facilities. Single homeless people are a more visible group, and the responses offered are adapted to men, but not to women and people of different genders, especially if they also use substances. Madrid and Barcelona have successful facilities that take into account the gender and substance components and are considered examples to be replicated in the rest of the territories.

The '*Calor y Café*' centres, originally designed to provide shelter, basic hygiene and food supplements to PWUS, are now re-emerging from the HR network as an adaptive response to homelessness. Reports from large cities suggest that these spaces are oversubscribed and that similar models of care should be replicated by the homelessness network. The high presence of cis men makes them unsafe places for women and gender-diverse people, and they are also described as facilities that need to be reviewed and adapted to the current situation. In Catalonia and the Basque Country, successful services are identified that have been designed with gender mainstreaming in mind and report good results and user satisfaction.

The oversaturation of these facilities is accompanied by an increase in the number of poor PWUS in the immediate vicinity. This is seen as an element that reproduces the stereotype of poverty (poor hygiene, thinness, avoidance of substance abuse, conflicts), which worsens the relationship between users, professionals, the service and the rest of the community. All participants agreed on this aporophobic community behaviour: nobody wants to see and live with poverty.

Some '*Calor y Café*' services are integrated into DCRs. It is reported that the aim of providing a space to monitor post-consumption effects has now been diluted, with a focus on homelessness taking precedence.

In Barcelona, despite the experience of a drop-in service for young migrants in a situation of homelessness, which includes elements of '*Calor y Café*', the saturation of the service once again leads to a limitation of the support provided to PWUS who do not show a firm and demonstrable commitment to abstinence. In all the cities, the basic food and hygiene needs of this particular group are left in a state of limbo, putting them in a very worrying situation of vulnerability and risk. Analysing the discourses, it can be concluded that the age factor is working against them, despite the existing evidence of the impact of social exclusion on mental health at a young age. It appears that because they are young, they may have a greater number of individual and/or group coping resources. There is a racial component to these hypotheses, as no Spanish men are identified in this group.

In relation to women and the LGTBIQ+ community, this research proposes the use of a broad spectrum of gender,

in which the diversity of identities and expressions breaks the classic male-female binary. In order to avoid falling into a battle of vulnerability between women and the LGTBIQ+ community who use substances in a situation of social exclusion, it is observed that this second group is more invisible within the HR in Spain. In addition to this lack of specific attention, there are very worrying discourses of denial of the presence of LGTBIQ+ people in a given territory, of threats because they imply a relegation of the reality and needs of cis women, of disbelief in the possibility of identifying differentiated attention needs, or even of ignorance of the meaning of acronyms.

With the exception of people who are very sensitive to sex and gender issues, the discourse analysis shows that the male figure is maintained in the social imaginary of the PWUS. This is expressed primarily in the standardised use of pronouns and masculine declension, but also in the identification of supposedly gender-specific needs, which masks the hegemony of normativity and masculinity as unique structures.

Recently, there has been a tendency to create non-mixed spaces in mixed HR services. In most cases, they have not been designed in a participatory way, nor have they integrated a transversal gender component, applying a supposedly specific care approach adapted to the usual activity of the service. In these experiences, closing the non-mixed space when the service needs to use that part of the facilities in a mixed way is identified as a common practice.

These spaces were examined in a number of focus groups and it was reported that all experiences were consistent in not allowing access to cis men. Non-mixed spaces of longer duration raise the question of where there is a place for gay cis men, who are subject to multiple forms of violence in mixed spaces. The most successful experiences reported have involved a participatory and systematic examination of the identities of the people in the space.

The organisations and people who engage in chemsex report experiences of non-mixed spaces in LGTBIQ+ support network facilities that operate according to sexual practices or means of administration. The chemsex collective specifically shows a desire for social class relaxation, and it is clear that the barrier to accessing the HR network is identification with poverty.

At the intersection of substance use and age, we find the group of early agers. The main factor associated with this early ageing is homelessness, and it appears from the age of 45. Potential vulnerability is observed when the influence of gender, sex, social class and administrative status (regular/irregular) is taken into account. The lack of specific services for housing, but also for violence, mental health and older people, is a cause for concern.

Aporophobia and social stigmatisation of PWUS, in this case in addition to ageism, are noted to be present in some institutional protocols and professional practices. It is therefore observed that in some cases traditional, authoritarian and/or paternalistic models of care can be reproduced, and the lack of plasticity of the HR network to adapt to new needs, such as the increase in the number of people over 45, is pointed out.

Young homeless migrants are the other large group that emerges from an intersectional perspective. The HR approach must take into account the influence of the migratory journey stage at which the person is. Different factors are observed between transit and destination countries, taking into account the level of hardship, the breakdown of expectations and, consequently, the role of substance use. Experiences are mainly reported where substance use is aimed at escaping the traumatic context, where an integrated approach is essential.

The relationship with the family, which can sometimes be strained both by frustration at the financial investment made and by the shame of compulsive substance use, can add to the stress of this group.

From Barcelona, the destination area in many cases, it is pointed out that the use of substances observed after the child and adolescent protection services have ceased to intervene, is dangerous. It is reported that the DCRs, due to their hostility and overcrowding, become unsafe spaces for them, as it is common for them to visit the environment in order to acquire substances, rather than the consumption spaces. This example shows that placing consumption at the centre of the approach is not effective once you leave the general population of the HR.

In Barcelona, there are successful, albeit insufficient, experiences of the implementation of outreach work aimed at this community group, which adequately incorporate the HR approach. It is necessary to incorporate the intercultural perspective in the HR network, especially in the outreach work, '*Calor y Café*' and housing support services, but at the same time it is essential to increase the specific resources allocated to these young people.

FORMS OF SUBSTANCE USE AND RESPONSES

The first phase of the research highlighted changes in the typology of substances used and their forms of use. The main objective of this second phase was to get closer to the functions these substances might fulfil and thus to understand their changes and trends in a more holistic way.

In general, users choose substances on the basis of productivity. Stimulants are most valued for their increased ability to relate to others and to perform tasks (sex work, chemsex, bureaucracy, attending medical

appointments, etc.). In the case of homeless people, it is also clear that maintaining wakefulness becomes an essential need for survival, especially for women and gender-diverse people.

On the other hand, substances that reduce productive capacity are associated with immaturity, an inability to relate to others and an increased risk of violence. Barcelona, with its increase in methamphetamine use, is positioned as the most tangible example of this role, although the increase in crack cocaine use is also associated with a higher risk of violence (and a decrease in opioid use), which in all areas responds to the same function.

In terms of routes of administration, no findings of major relevance to Phase I of the research were extracted, where an increase in the use of the inhaled route and a decrease in the use of the injected route have already been reported. Despite this concordant report from users and professionals, the participating local public health authorities warn of the diversity of data collection systems that exist at national level, and the possibility of bias in the information due to the use of different indicators.

With regard to contexts of use, it is noted that there is no climate of concern about the use of substances on public streets, and that this is only raised when it affects the implementation or sustainability of HR services. The areas with DCRs agree that these services do not provide 24-hour coverage and that night is the most dangerous time for users.

The areas that have opted for the installation of dispensers and/or the integration of NEP into primary health care emergency centres are identified as good practices. With regard to the first response, although none of the territories carried out an evaluation with a gender perspective, it is assumed that these programmes may be unsafe for women and people of different genders. Both integrated NEPs and vending machines share the limitations of not providing direct professional care, which means not providing the relevant health education, and of only providing injecting equipment, which does not reflect the prevalence of the inhalation route.

The lack of programmes to distribute hygienic materials for the use of crack cocaine and methamphetamine by inhalation was identified as a major need in all regions. The Kit-Safe programme in Barcelona, which consists of distributing pipes to users, organisations and/or administrations, was identified as a good practice. It should be noted that these materials have been designed and evaluated by PWUS.

The most worrying context of use continues to be that of '*narcopisos*'. There is evidence of an expansion throughout the national territory, linked to the housing crisis, the demolition of towns and the processes of gentrification in large cities. There are warnings that in areas where DCRs are not available, drug dealers not only meet this need, but also perform a function of beautifying public space, thus reinforcing the ideological invisibility of the problem.

Areas with DCRs services point to the need to extend these services to the inhaled route and to adapt to the increased use of stimulants.

With regard to alcohol use, there is a great lack of involvement of HR programmes. The idea that problematic alcohol use is linked to the homeless community is reinforced, and remains invisible in groups that use more stigmatised substances. It is in this group that the successful practice of implementing HR programmes in first reception centres, both in Madrid and Barcelona, has been identified.

The main obstacles to the development of these specific programmes are identified as: the difficulty of implementing initial access and adherence strategies through the distribution of hygienic materials, the social normalisation of the substance use and the lack of training of HR professionals on the substance itself. It also highlights the influence of legality and pressure from the industry itself in approaching the substance.

There is concern about the use of alcohol in combination with benzodiazepines by young homeless migrants and the lack of specific HR strategies available to them.

Despite existing scientific evidence of gender differences in alcohol use, these differences were not reported in the present research and the need for specific training for HR professionals on this issue was also identified.

COMMUNITY

The role and importance of the community in HR is reflected in all the in-depth themes of this study. Of all the discussion elements, the need to consider PWUS as members of the community stands out. It can be seen that this discrimination is more or less pronounced depending on the social class of these people, with the lowest level being when they are also in a situation of homelessness.

In general, there is a high level of anecdotal evidence, both from professionals and users, including hate speech against these people, which is rarely formally denounced. The Anti-Stigma Observatory developed in Catalonia is reported as good practice, as is the involvement of the Ombudsman's Office in systematic discrimination in the primary care network.

Despite the fact that many of the participants reported the influence of the media and social networks in spreading hatred, only the network that supports people who engage in chemsex has taken a firm stance. The rest of the minority groups seem to accept discrimination and hate as part and parcel of their unequal situation.

There are warnings about the influence of support for right-wing ideologies that are not focused on social justice, which explicitly or implicitly promote this discrimination and rejection of minorities. In some areas with a greater presence of these political representations, there are reports of cuts in economic resources for HR services and/or programmes, and increased police pressure in places where homeless people who use substances live.

Despite the palpable influence of neighbourhood movements in the implementation and development of the HR network in Spain, they are often described as a body instrumentalized by politics and the administration, which receives just enough attention to prevent social outbreaks. Nevertheless, professionals warn that the community work they carry out is of a symbolic nature, and it is common for everyday practice to involve actions not aimed at promoting community cohesion, but rather at reducing the harm associated with substance use in public spaces and social and regulatory control. In Barcelona and Madrid, there are reports of neighbourhood groups from central areas that differ in their demands regarding security and drug trafficking, illustrating the importance of ideology in the responses offered and expected from HR.

The integration of PWUS into the community is seen as a vital necessity in order to promote their consideration as full citizens. Professionals recognise that they themselves often act as limiters and perpetrators of social isolation, infantilising PWUS and mobilising them from a paternalistic position. In particular, promoting the collectivisation and politicisation of PWUS is identified as a successful practice. This action allows them to take part in roundtables and spaces for community participation and negotiation, representing their needs and proposals in the first person.

It is worth highlighting in this research the consideration of associations of relatives of PWUS as community actors. It is noted that these groups also experience discrimination in their communities, with attitudes of shame and fear of being identified in these environments. On the other hand, professionals point out that it is necessary to involve them in the accompaniment of people accessing HR. The main obstacles identified are: the lack of professional training in systemic accompaniment, the view that abstinence is the only therapeutic success for families and professionals, anonymity as a strategy for attracting hidden communities and the consequent right to confidentiality of users, and the excessive workload that can be caused by the lack of training of professionals in systemic accompaniment.

No successful good practice was identified that specifically addressed (family and/or emotional) ties. The main barrier reported by families to maintaining contact with the PWUS is the fear that they will come home under the visible effects of substance use. In response to this need, it is proposed to develop family meeting places, mediated by specialised professionals, to promote the maintenance of these family ties. It is emphasised that work on relationships is a fundamental part of the gender approach, where it is also necessary to understand the different role of mandates.

Community acceptance of users seems to be higher among young people. Drug-checking services emphasise their successful experiences of getting these programmes to be seen as beneficial by the community as a whole. It is generally stressed that, at the community level, the differentiation between HR and RR promotes the problematization of substance use among people from lower social strata.

VIOLENCE

Violence, in all its manifestations, is the issue of greatest concern and priority for action among the themes examined.

Stigma, understood as a set of negative beliefs, attitudes and stereotypes that lead to discrimination and rejection of PWUS because of certain characteristics that are perceived as different or morally unacceptable, manifests itself at individual and structural levels. Such discrimination is also strongly reinforced on the basis of social class, race, gender, sexual orientation and age.

At the structural level, there are institutional policies and practices that perpetuate inequality and exclusion, which translate into institutional violence against PWUS. The impact of the prohibitionist model is seen in the degree of discrimination based on the type of substance used, with greater discrimination against those who use illicit substances.

Perhaps less visible, but no less important, is the impact of the productivity demands of contemporary neoliberal policies. Despite the different manifestations and implications, it can be observed that the individual relationship with the productivity mandate, both among users and professionals, has components of autolysis. Self-validation involves a constant demand to carry out tasks, whether they make sense or not, which leads people into risky situations. In the case of users, an increase in the use of stimulants is reported, accompanied by a deterioration in the associated state of mental health. In the case of professionals, an increase in workload is

reported, accompanied by a worsening of the associated mental health status.

Nevertheless, the research team believes that the axis of inequality that has the greatest impact on PWUS is social class, with poverty being the most rejected and discriminated against status. The research team identifies limited access to basic services, greater demands for the guarantee of basic rights and differential protection for homosexual women and men who are victims of violence.

There is a worrying increase in aporophobia, possibly linked to the poverty increase in Spain in recent years. Similarly, the rejection of homelessness seems to be linked to the housing crisis, individualism and a strong and not coincidental invisibilisation of structural causes. The social perception is that people who are homeless are because they have not tried hard enough. If these people also use substances, a punitive interpretation of hedonism is applied, which means that instead of working and earning a home, they prefer to have fun and not work hard, and that is why they have remained on the streets.

In addition, there is the normalisation and acceptance of stigmatisation on the part of PWUS, who do not expect the legal system to guarantee their rights. The wound caused in people by this structural level of violence is observed, showing the individual process through which they have come to believe and apply these negative ideas about themselves, feeling that they are not worthy of the basic support and protection that every other citizen receives.

The various NIMBY (Not In My Backyard) situations reported in this research are a clear example of how stigma operates and its impact on PWUS. The logic described above has a direct impact on communities, which do not see HR services and programmes as a community benefit, but as a reward for the idleness of PWUS. Punitive discourses and community suggestions of concealment are still very much alive, which at least allow us to maintain the dream that there is no poverty among my peers.

Community violence falls directly on the clients. However, professionals report that on most occasions community hate speech is heard and dealt with directly by the professionals themselves. They describe the situation as violent, exhausting and limiting in terms of their ability to respond, and that has not changed over the years.

Professionals and PWUS also point to the police violence they suffer, which is exacerbated when your '*home*' is a public space. Despite the popular belief that the street is a free space, first-person accounts point to a high level of control and violation of rights, which is exacerbated when there is no safe place to use substances. They warn of the serious consequences of forcing PWUS to live in and use drug dealing facilities such as DCRs.

At an individual level, the main element of violence that emerges is that PWUS are seen as troublesome and complex by the rest of the primary care network. These violent attitudes are diluted in arguments of subjectivity, which make them difficult to denounce, but translate into a limitation of options. This practice is seen by professionals as a cause for concern, but also as a risk factor to burnout.

The identification, management and accompaniment of gender-based and intra-gender violence is another complex issue that continues to emerge. The vulnerability of women, homosexuals and transsexuals who are victims of violence and whose protection depends on their use of substances is alarming. Attitudes are perpetuated: the history is questioned because they have used substances, they deserve protection because they use substances, and abstinence is demanded in order to receive specific support. Professionals are disheartened by so much struggle to guarantee rights and so much social pedagogy.

THE HEALTH OF USERS

The state of mental health of PWUS is a transversal issue for administrations, professionals and users themselves, regardless of the field.

A worsening trend is described since the implementation of the first HR services and/or programmes in Spain. The deterioration in the social situation of people, the most extreme manifestation of which is homelessness, and the increase in the use of stimulants are the two main reasons for this. If these people are also affected by axes of inequality (including substance use), the result is even more worrying.

It should be added that the results of the present research point to the importance of including the productivity component in the analysis of the mental health status of PWUS, in order to better understand and support them.

The term trauma is rarely used, and when it is, it is used by professionals in the field of psychology. Nevertheless, the research team affirms that the symptoms and effects on daily life described correspond to traumatic experiences. The accounts of the users and the information reported by the professionals coincide in the fact that, in contexts of vulnerability, substances are used as a strategy to overcome the extreme conditions and as a strategy to deal with the traumatic symptomatology caused by the experience of exclusion itself, as

well as by previous experiences. At this point, the organisations and professionals who accompany people who engage in chemsex describe with concern the increase in the number of people who, when in psychological treatment, report having experienced childhood sexual abuse (CSA) and the need for professional training to accompany these adults.

Only two agencies in Barcelona explicitly reported that they used the Trauma-Informed Approach (TIA). Both facilities, a shelter for homeless people and a drop-in service for women survivors of violence, work with a gender and social justice approach. The lack of specific professional training, combined with an apparent lack of resources, seems to mean that the care these people receive is often exclusively pharmacological, excluding psychosocial and community options.

With regard to homelessness, the discourses analysed in this study agree that living on the street is a particularly traumatic experience for any person because of the multiple forms of violence they are exposed to (assaults of all kinds, robberies, discrimination). Many situations are reported where institutional violence is also present, involving episodes of restriction or exclusion from access to basic services and/or stigmatising differential care.

In relation to the increase in the use of stimulants, the main concern observed is the individual, institutional and community support for episodes of induced psychosis. Professionals denounce early discharge from hospital emergency services, whose intervention is focused on symptom relief, the lack of specialised mental health courses integrating HR, and little development of gender and intercultural perspectives. Participants refer to these cases as being in limbo due to the lack of care in which they are placed. The mandate of productivity that seems to operate in this consumption trend, combined with the lack of perspective of change in current policies, foretells a worrying scenario in relation to the mental health of PWUS, which should be a priority for the competent bodies.

The experience of Barcelona, which has a community psychosocial mental health support team specifically for street people, is reported as a good practice to be replicated. However, the services provided are insufficient for the existing needs, with the result that people who actively use substances are relegated to a second level of priority. Another good practice reported in the same city is a proximity team made up of medical professionals (organic and mental health) who work on a voluntary basis with people living on the street that have low adherence to HR services and/or the basic network.

As mentioned above, the lack of general and specific mental health services, the barriers to access due to waiting lists, the lack of coordination between networks and active substance use are described as the reasons for the current crisis of over-medicalisation. This widespread trend in contemporary society is exacerbated when focused on vulnerable communities. Medication can be seen as a paradox. On the one hand, there is a serious problem of over-medication, but on the other, there is a warning that many PWUS in a situation of homelessness do not have sufficient financial resources to be able to afford the cost of a pharmacological treatment plan. However, this is a loose association, since in the case of psychotropic substances there are factors such as tolerance and abstinence. The influence of these two elements is demonstrated by the fact that there is only a parallel illegal market for this type of substance.

The organisations and professionals who accompany young migrants in a situation of homelessness, regardless of the territory analysed, warn that basic needs such as food, shelter and a sense of security are being covered by psychotropic substances (clonazepam and gabapentin). In addition to the addictive component to which this practice leads people at such a young age, they call for a transcultural and harm reduction approach to their accompaniment, which takes into account the psychological suffering associated with the stage of the person's migratory journey, the language barrier, the frustration of expectations, the cultural significance of the use of legal and illegal substances, and of course, the impact of the potentially traumatic experience that the triad of migratory journey, homelessness and discrimination may entail.

Although some areas, such as the Basque Country and Catalonia, have specific outreach teams for this group, the response capacity is limited within a network that is not adapted to specific needs. No effective comprehensive response to the alarming situation described has been identified, only the cry of professionals and users to the administrations aiming to control these pharmacological prescriptions and an increase in resources.

The mental health status of ageing PWUS is highlighted by users, professionals in '*Calor y Café*' services and in hostels. Thirty years ago, this group had very different life expectations, due to comorbidity with HIV/AIDS and tuberculosis, and mortality from fatal opiate overdoses. They now report a high prevalence of depressive clinics, which arise during the process of becoming aware of the individual's life situation, a factor that could be exacerbated by a sense of unproductiveness. The need for specific training and implementation of mental health strategies incorporating HR is identified. A housing support service of the Barcelona Homeless Network, which includes HR strategies (especially focused on alcohol use) and is exclusively aimed at older homeless people, is reported as good practice.

It is in this group that the most specific health needs are reported, such as the inclusion of physiotherapy, osteopathy, podiatry and cognitive rehabilitation. The health impact that can be promoted through social prescribing is also noted, exemplified by activities with and within the community.

In general, women's specific health characteristics and needs (physical and/or mental) are not described as being of particular concern. This may be due to the fact that specific programmes have been implemented with this community group in recent years. Good practices in sexual and reproductive health are reported in Barcelona, Madrid, Castellón and Murcia. Good practice is also reported in Barcelona in relation to support for female PWUS who are survivors of gender-based violence.

THE HEALTH OF HR PROFESSIONALS

Mental health care and the prevention of burnout syndrome in HR professionals emerged as an element of concern in Phase I of this research. It was the first publication in Spain to highlight the work-related deterioration of HR professionals' mental health. The country's 35 years of experience in implementing this type of service and/or programme allows the possible impact of factors such as time spent in these roles, age and gender to be included in the analysis. It is considered that these results can be very useful in preventing and improving the care of HR professionals, both in Spain and in countries that have recently begun to implement these strategies.

The specific aim of further exploring this topic was to find specific components operating in this field of work that may be related to the reported burnout.

The actual terminology of burnout is recently popularised, it is considered as a work-related illness and is described by all professionals with common characteristics. The following risk factors have been identified: exposure to violence, lack of external recognition, working conditions and work organisation.

With regard to exposure to violent episodes, it has been observed that these are sometimes extreme situations that have a major impact on the people who witness them. Explicitly, the protagonist of these situations can rely on the users themselves, but also between them and community agents (police, neighbours, services). In a non-physical but no less shocking way, it is reported as a witness to the serious institutional violence suffered by PWUS and to the position of independence in which the public in general and this group in particular find themselves. It is worrying that violence is identified as a completely normalised element, to the extent that working in HR and being exposed to violence seem to be inseparable.

Violence and its effects are undoubtedly gendered and were not directly identified. Nevertheless, a polarity in the coping strategies used by cis men and the other identities can be observed throughout the research. The latter group is the most vulnerable.

With regard to the lack of recognition, it is observed that working in HR is an element of contempt or disdain on the part of colleagues and the community in general, leading to devaluation and emotional exhaustion among professionals. Precisely this emotional exhaustion is also linked to the lack of resources and support from institutions, and they feel overwhelmed and frustrated by the neglect they observe in the care of PWUS. It seems that in Barcelona there is a greater integration of the HR in the rest of the basic networks, while the other participating territories report having to make great pedagogical efforts in external coordination spaces.

Working conditions are an element of concern that emerges immediately in the specific theme of burnout, although it is observed transversally throughout the research. It can be seen that the legacy of the charitable model of social accompaniment, together with the influence of the HR early days activism, is constructed as a perfect scenario for working conditions not to be reviewed. Professionals believe that pay, rest and danger should be the priorities to be adjusted by the public administration, which they see as the main party responsible for the situation. A service in Madrid reports a significant improvement in their emotional wellbeing with a four-day working week. Despite this experience, most reports agree that these poor conditions can only be offset by '*but I like what I do*'.

The diversity of the participating areas has made it possible to identify two types of service: the large macro-projects installed in large cities with a high burden of care, and the communes where the facilities can offer more individualised and higher quality support. This difference, which is also common to most of the services in the basic network, is highlighted as a factor to be taken into account when defining working conditions.

Elements of work organisation are confused with working conditions. They are identified as stressors in working environments where the professional does not have defined functions and habitually performs multiple tasks. Emotional discomfort is observed in services with hierarchical structures, especially when the top level is occupied by a cis man, which is exacerbated when he is also a doctor. In these cases, a number of unwritten rules were also identified, making it difficult for women or people of a different gender to gain access to positions of responsibility. In general, these are feminised teams that reproduce the gendered mandate of care, especially in the lower-paid categories.

Mediating factors are the relationship with the professional team, the use of substances and the experience of traumatic events.

Group cohesion and mutual support are identified as protective factors against burnout in teams. As soon as competitiveness, difficulties in dialogue or a non-supportive network between equals appears in the work environment, the professional team becomes a risk factor.

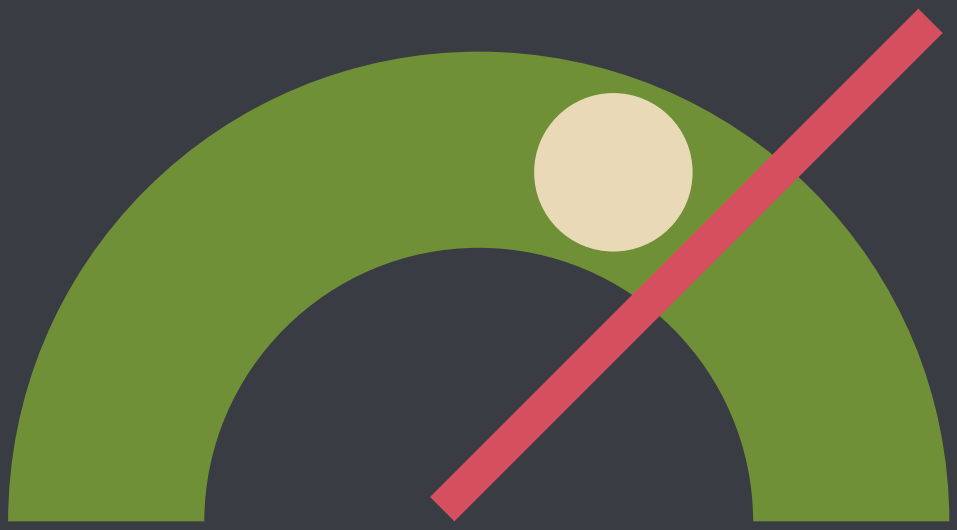
Substance use is also an element that has been explored. It has been pointed out that it is used for leisure and fun, but also as a regulator of anxiety at the end of the working day. Initially, it is identified and praised as a protective factor against burnout, providing spaces for collective decompression, where events of the working day can be shared, while at the same time using substances. However, older professionals and experts in team supervision warn that substance use can be a protective factor for burnout.

The authors of the study found that the risk of burnout is higher when this behaviour is persistent. They describe how it reduces the space for real withdrawal from work and masks the lack of alternative resources for coping with stress. Particularly in this respect, it is noted that in HR services with a high burden and pressure of care, an isomorphic relationship is observed between accompanied and accompanying staff in terms of stress management.

Another mediating factor that emerges is the professionals' own traumatic experiences, whether or not prior to working in HR. This element is also highlighted as different from other areas of support for vulnerable people (own substance use network, health network, mental health or homelessness), indicating that a higher prevalence of people with these experiences is observed in the field of HR. For professionals with an emotional background related to the traumatic experience, it modulates towards a resilient accompaniment, providing high quality closeness and empathy. However, it is reported that in many cases, exposure to experiences that may be related to the traumatic experience, or even alleviate it, can be a risk factor for burnout.

In general, a greater number of experiences of burnout, in first person or to third parties, are reported by women and people of the opposite sex than by men. Women report less external validation of burnout and emotional discomfort, more questioning of the discourse if the work organisation is not adequate, more attribution of being a complainer and/or weak, and more fear of losing their job if they need a break.

5 5.LIMITATION AND BIAS MINIMISATION



The present study was carried out in 2022 by a research team with many years of experience in HR services and programmes at international, national and Catalan levels.

Efforts were made to minimise possible bias in the selection of participants by involving the whole research team in the process and by conducting each focus group with users in different areas. In some cases the research team had a previous relationship with the participants, both users and professionals. Efforts were made to minimise this information bias by ensuring that the discourse was not identified. The research team viewed this as a positive circumstance, as it encouraged a climate of safety in conversations and the elaboration of more in-depth accounts.

Especially in the focus groups of professionals, this aspect promoted the identification of people as a support group, and feelings of relief could be observed in the collectivisation of discomfort and suffering. Through the triangulation of different methods (literature review, individual interviews, focus groups), we tried to analyse the phenomenon from different approaches, which allowed us to minimise the positive and negative effects of the phenomenon.

Possible contradictions do not diminish the credibility of the interpretations of reality.

The triangulation of the different researchers was ensured by the sessions that were shared throughout the research process, as well as after they were shared with the professional who took notes.

The selection and participation of professionals with a diversity of gender, disciplines, expertise, territories and current links to the HR allowed for the triangulation of theories, thus minimising possible biases. Nevertheless, it is acknowledged that this research has limitations in terms of geography: rural areas were less represented than urban areas; and in terms of origin and ethnicity: migrants were less represented than native people, and racialised people did not participate. Efforts were made to minimise the impact of the gender axis by ensuring a greater presence of women than men.

The participation of people involved in the sale of illegal substances was not achieved, nor was the participation of people deprived of their liberty.

6 CONCLUSIONS

For each of the themes studied, the main lessons to be learnt for adapting quality guidance and the successful practices identified are described below. Although effective responses are being developed, there is a need to further strengthen the support network and to continue to design and implement new strategies.

HARM REDUCTION MODEL
Mainstreaming Intersectionality and Social Justice
Decentralising substance use and centralising the person
The role of substance use and consumption as a symptom
Unifying HR and RR
Territorial inequalities and basic services
Evaluation design and implementation
Mainstreaming the transcultural perspective
Politicisation of PWUS
Mainstreaming families
Peer integration
SUCCESSFUL STRATEGIES
Substance analysis services integrated in the HR and LGTBIQ+ network
First Reception Centre for homeless people integrates HR
Non-mixed Drop-in Services for Survivors of Violence integrates HR
Trauma-Informed Approach
Gender-sensitive accompaniment of violence
Establishment of PWUS activist groups
Advocacy and peer support work to people who engage in chemsex

VULNERABLE COMMUNITIES
GENRE
Broad spectrum of the gender category
Visibility and specific support for the LGTBIQ+ community
Gender perspective in mixed and non-mixed services
Support from the violences experienced
Participatory and dynamic design of non-mixed spaces
Reducing stigma over LGTBIQ+ homeless people
Peer integration
Accompaniment of sex work according to gender
Incorporation of masculinity support
Mainstreaming intra-gender violence
SUCCESSFUL STRATEGIES
Non-mixed Drop-in Services for survivors of violence integrate HR
Design and implementation of a transversal gender perspective
Non-mixed spaces integrated in mixed HR services
Emergency protection circuit for PWUS and are victims of gender-based violence
Trauma-Informed Approach
Gender external supervision
Mobile units aimed at sex work and HR support
Advocacy and peer support work to people who engage in chemsex
Joint work between RDD community teams and the LGTBIQ network for the population practicing chemsex and experiencing homelessness.

EARLY AGEING
Growing community
Comprehensive care for ageing and homelessness
Strengthening the specific support network
Support to the homelessness network of indefinite duration
Strategies to reduce early institutionalisation and ageism
Strategies to reduce the over medicalisation of psychological pain and suffering
End-of-life care and substance use
SUCCESSFUL STRATEGIES
Housing support service for old PWUS and are homeless
Incorporation of social prescription
Collaboration between HR Housing Support Service and Home Care Programme on End-of-life Care

YOUNG HOMELESS MIGRANTS
Guaranteed coverage of basic needs
Substance use and the transcultural perspective
The role of substance use and consumption as a symptom
Incorporation of masculinity support
Strategies to reduce the over medicalisation of psychological pain and suffering
Strengthening the specific support network with a HR approach
Reducing institutional violence, racism and aporophobia
Inter-network work and coordination with HR approach
SUCCESSFUL STRATEGIES
Collaboration between HR Outreach teams and Jóvenes Sinhogar
Involving HR professionals as cultural mediators

HOMELESSNESS AND POVERTY
Elimination of the staircase model
The role of substance use and consumption as a symptom
Integration of Housing First and HR
Integration of specific mental health care
Strategies to reduce the bureaucratisation of the homeless network
Strengthening the specific support network with a HR approach
Reducing aporophobia and discrimination in relation to substance use
Strategies to reduce the over medicalisation of psychological pain and suffering
Visibility and differential support for women and gender diverse people
Support that understands violence suffered
SUCCESSFUL STRATEGIES
First Reception Centre for homeless people integrates HR
Community Homelessness and Mental Health Teams
Trauma-Informed Approach
Collaboration between homelessness community and HR teams
Collaboration between HR Outreach teams and LGTBIQ network of population who practise chemsex and are homeless
Gender perspective in mixed and non-mixed services
Observatory for Aporophobic Violence

COMMUNITY
Reorientation of HR Outreach teams beyond social and normative control
Reduction of the user's welfare model
Peer integration
Specific strategies against the resurgence of hate speech and right-wing extremist ideologies
Involving users in community activities
Politicisation of PWUS
Direct community violence against professionals
Family integration
Reducing aporophobia and discrimination in substance use
Decentralising substance use and centralising the person
SUCCESSFUL STRATEGIES
Community outlook and peer work on substance analysis services
Community round table spaces for participation
Advocating and peer supporting people who engage in chemsex
Participation in community round tables of activist groups of PWUS
Working with the media in the LGTBIQ+ community
Psychosocial Community Care Mental Health Teams

PROFESSIONAL SUPPORT AND BURNOUT PREVENTION
Overcoming the legacy of the charity model in professionalisation
State level review and equalisation of working conditions
Increased rest after crisis support and during normal working hours
Horizontal work organisation using the care model
Strategies for recognising the specificity of HR work
Recognising burnout as an occupational disease
Care-oriented external supervision of professionals
Developing specific burnout prevention protocols for HR
Support and accompaniment in potentially traumatic situations
Burnout prevention strategies with a gender perspective
SUCCESSFUL STRATEGIES
External supervision of professional teams
Compact 4-day workweek
Ensure continuity of HR programmes and/or services by the administration
Vertical validation of burnout syndrome as an occupational disease and its risk factors

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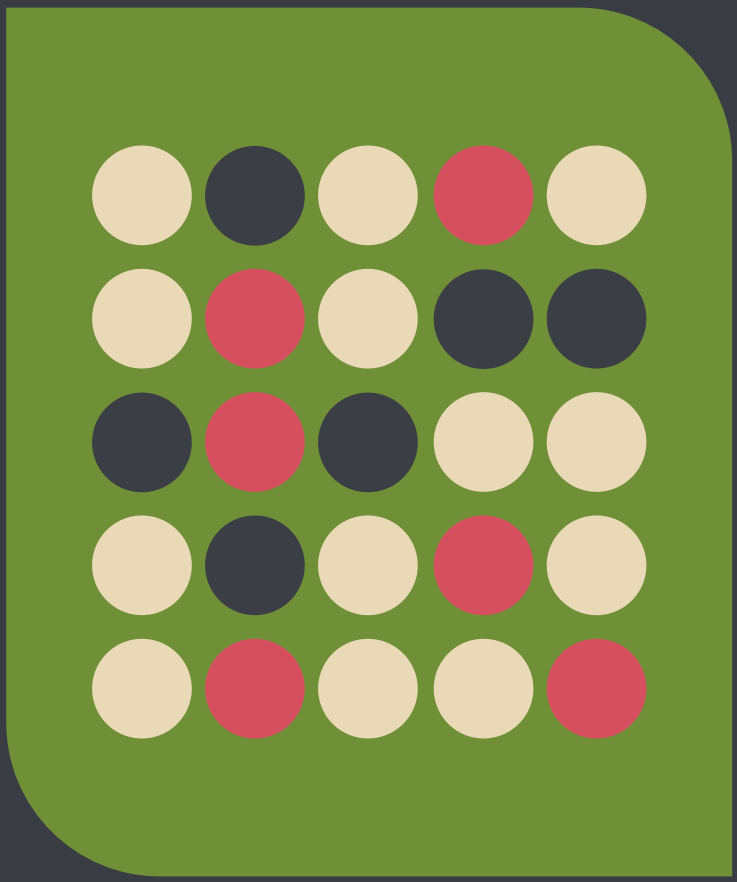

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