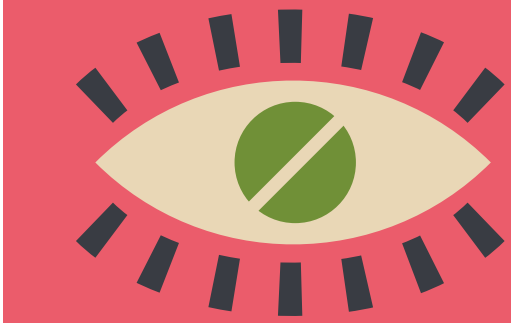
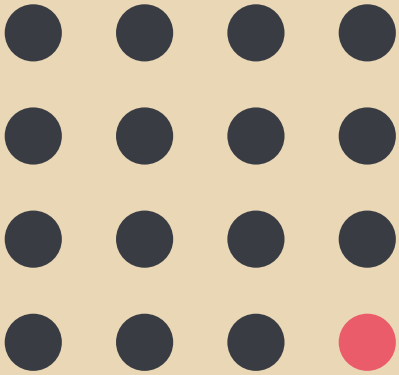
STUDY

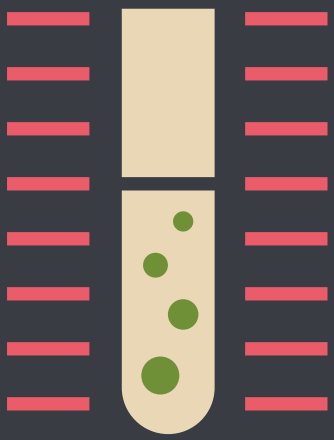
HARM REDUCTION

IN THE 21ST CENTURY

PHASE I
DIAGNOSIS







UNAD LA RED DE ATENCIÓN A LAS ADICCIONES

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LETTER FROM THE PRESIDENT

UNAD is an NGO that works in the field of substance and non-substance addictions and the problems that derive from them. We represent more than 200 entities that, in addition to forming our social base, share a common model of intervention that focuses on the person, their family and the community.

Our work in the field of addiction intervention encompasses a number of areas, including prevention and risk reduction treatment, socio-occupational integration, and harm reduction. This last area is of particular importance, as it allows us to defend the rights of people who use substances and have addictions, and to avoid early deaths and improve their state of health.

Our aim is to minimise the harm associated with consumption, without necessarily reducing or eliminating it.

These strategies address the harms of people who consume by increasing the safety of consumption and decreasing the spread of disease, while promoting a series of recommendations that aim to respect fundamental human rights.

Despite the fact that in Spain we continue to make progress in terms of harm reduction, we still have many challenges ahead of us, especially considering that addictions and the people who use them are changing.

With this study, we aim to gain a deeper understanding of the characteristics of people who use substances, the pattern of substance use and the social context in which they are found. This will help us to identify the current needs of harm reduction programmes in Spain and to improve them. We hope that this will lead to harm reduction being given the priority it deserves in public policies and budgets. Finally, we hope that this will help us to build a solid network.

I would like to express my gratitude to all those who have contributed to this study. Their efforts have enabled us to gain a comprehensive understanding of the current situation. We will continue to work towards further progress in this area, with the aim of conducting phase II of the study in 2023.

UNAD plays an important role in driving change, and this study is a testament to that. Let us continue to build on our achievements, to move forward together, and to defend the rights of all people with addictions and their communities.

LUCIANO POYATO ROCA

ACKNOWLEDGEMENTS AND RESPONSIBLE DECLARATION

This study comes to me after 15 years of developing various functions in the field of Harm Reduction, mainly in the city of Barcelona. My current position as a researcher has not prevented me from recognising the limitations of my own experience as a woman, white, native of Barcelona, young and occupying a professional position. It seems responsible to me to acknowledge upfront that my perspective in this research has been situated and biassed.

I am also one of those professionals who did not receive specific training during my undergraduate studies on substances, addictions and approaches. I am also one of those professionals who found myself on a game board, feeling like a pawn in a very complex and crude system. Like my colleagues, I had to nourish myself with books on substances, international scientific publications where it seemed that everything was going well, conferences and congresses that did not land on harm reduction, meetings with other professionals who also had more doubts than certainties and hundreds of talks with people who use substances who came at some point to the service where I was working.

The preparation of this study represents a pause for reflection that I believe Harm Reduction in Spain deserves and requires after 30 years of development. The need for immediate responses in the accompaniment of people in extreme vulnerability and exclusion is a challenge that affects the daily lives of users, professionals and public administrations. This can leave very little space for listening, understanding perspectives, reviewing the professional practice and focusing on opportunities.

It is becoming increasingly clear that there are aspects of this situation that are undeniable. For instance, it is evident that the community plays an important role in driving change, that there is no Harm Reduction without a gender perspective and a transcultural approach, and that users must be given the opportunity to play an active role in their processes and in the programmes and services they inhabit. Unfortunately, it is also becoming clear that the condition of using substances is having a negative impact on the human rights of this community.

As a professional, I would like to express my gratitude to UNAD for choosing to conduct a qualitative research study on the current state of Harm Reduction. I believe that this approach is essential for understanding the diverse realities that exist within this field. On behalf of the research team and as the author of this text, I would like to thank the 40 participants in this study for their time and willingness to share their experiences and knowledge. And as part of the community, I would like to thank harm reduction for all the efforts to fight for and respect the rights of people who use substances.

ESTER ARANDA
Barcelona, December 2022

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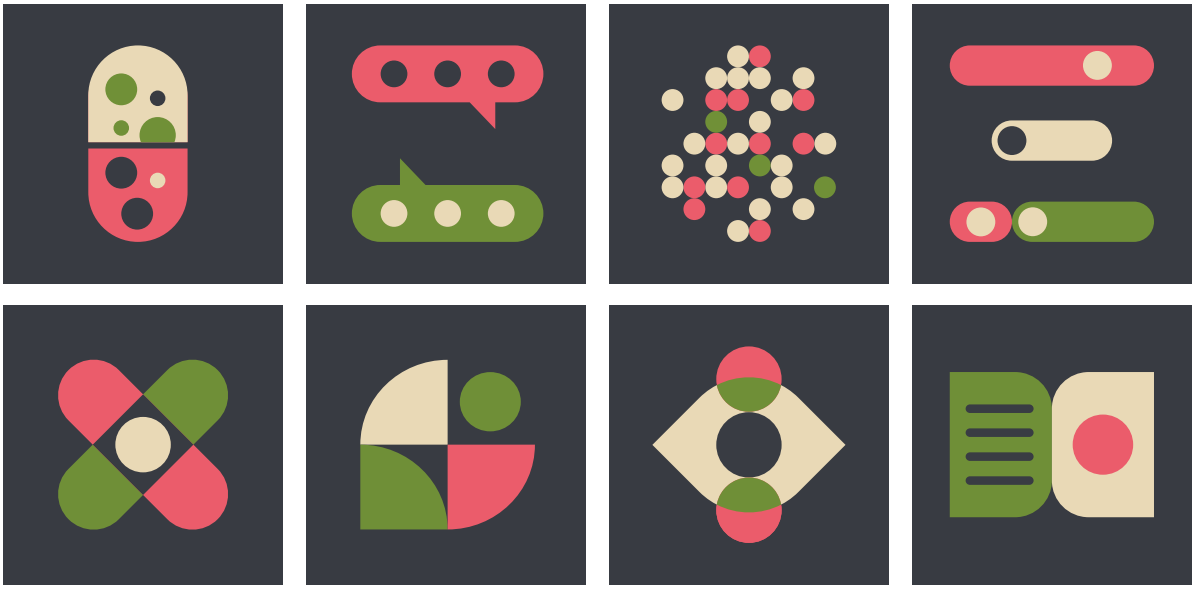
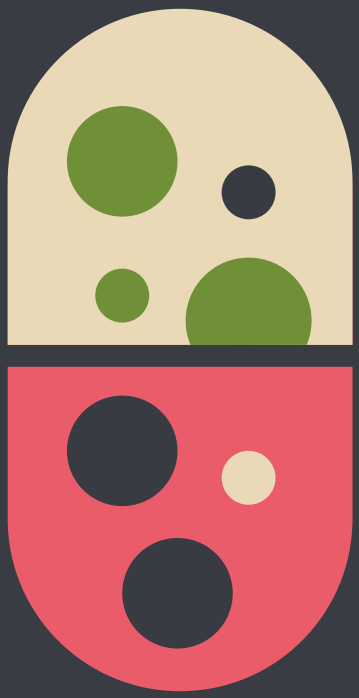


1 INTRODUCTION



1.1. BACKGROUND

The implementation of the Harm Reduction approach (HR) was born in Spain in the 1980s, within a prohibitionist context that focused on the application of criminalisation and persecution policies to substance use in the face of the popularisation of heroin and cocaine use, the expansion of injecting drug use, the HIV epidemic, the alarming increase in fatal opiate overdose deaths, and the creation of the network of care and treatment for drug dependence by civil society, where abstinence was the only possible option and response (Rovira et al. 2018). Harm reduction emerged at that time as a pragmatic and humanitarian approach based on public health and human rights principles aiming to prevent early deaths and improve the health status of people who use substances (PWUS) through strategies to minimise the harms associated with substance use.

From this scenario, the community organisations were laid to build the network of HR devices made up mainly of methadone programmes, needle exchange and services to cover basic needs. Some local communities were initially resistant to the implementation of this type of services whose main objective was not abstinence. The outreach teams, through the collection of contaminated syringes, were essential for their integration into the territory. The emergence of new problems, as well as the generation of international scientific evidence in the field of HR, allowed new strategies and programmes to be progressively incorporated, such as drug consumptions rooms (DCRs).

Undoubtedly, Spain is today one of the EU countries that has achieved the most positive HR targets in substance-using communities (according to the European Strategy evaluation), thanks to the variety and coverage of the programmes. It is worth highlighting the great achievements in the reduction of HIV+ and HCV+ transmission. In recent years, there has been a significant reduction in the injection administration and in HIV+ and HCV+ cases (National Strategy, 2017-2024). HR has shown, on the one hand, its pragmatism in addressing issues related to substance use, and, on the other hand, the importance of placing the person as an active subject of their own decisions (and life) by defending, respecting and validating their rights.

Despite these unquestionable improvements and good results, more than 30 years and a pandemic have passed since then, and significant changes have inexorably occurred in the characteristics of users, their substance use patterns and the social context in which they occur. The seriousness of the needs and vulnerability of some of these communities often required an immediate response, leaving aside further reflection on the changes that were taking place, the possible related causes and the different options for addressing them.

It is indisputable that the initial designs failed to consider the stark reality experienced by women substance users compared to men. Today, many professional efforts have been made and consequent improvements have been achieved in the incorporation of a gender perspective in the field of substance use in Spain. Examples can be observed at different levels. In the academic field, the *Drogas y Género* (Drugs and Gender) line of the *Fundación Salud y Comunidad*, started in 1999, now offers an extensive virtual library with more than 100 specialised publications. In the field of training, led by the third sector, La Red de Atención a las Adicciones (UNAD), made up of more than 200 community organisations, has a permanent gender commission formed by a group of experts whose objective is to train, influence and raise awareness in this area. The non-profit cooperative Metzineres (Barcelona) has become an international reference in accompanying women who use substances and survive multiple situations of vulnerability and violence. Unfortunately, it is true that the implementation of the gender perspective continues to be a long-distance race in our society and, therefore, an aspect of continuity of work in HR.

Even so, there are elements that today should also be essential in the design of HR responses, strategies and interventions, and they continue to be a pending task. According to data published by the European Commission in 2019, Spain was the country with the second highest number of people of migrant origin, with 78.2% of them in an irregular administrative situation. However, it was not until 2019 that the first European publications began to point out the importance of incorporating cultural competences in addressing substance use among migrant people or minority ethnic communities (De Kock, 2020). It is obvious that the initial designs and implementations did not take transcultural awareness into account and were designed by white people for white people. Neither did they take into account the consequent differences in substance use that may occur in these population groups. The diagnosis and collection of experiences in the implementation of the transcultural perspective in HR responses will be therefore considered as an interesting element in our territory.

The situation is similar with regard to homelessness. In the last 15 years, some cities in Spain, such as Barcelona, have seen a 45% increase in the number of homeless people, despite a 79% increase in the number of emergency shelters in the same period (De Ines et al, 2017). The risk of problematic substance use in

situations of extreme poverty and/or in processes of high vulnerability (as is the case both for women victims of violence and for migrants in an irregular administrative situation) has been extensively described (Pleace et al, 2022). Even so, it is necessary to examine in greater depth whether HR in Spain has contemplated and incorporated this differential accompaniment. Or whether the need for an immediate response to this increase in homeless people has led to the incorporation of homelessness as a criterion for inclusion in HR services and/or programmes.

Neither there were LGTBIQ+ groups and specific competencies in relation to substance use taken into account in those early programme designs. The emergence of the chemsex phenomenon in 2013 in Spain (published by Antidote) brought to the table this 'new' intersection where substance use, sexual practices and heteronormative oppression seemed to converge in a group of people where the substances and routes of administration involved were familiar to HR. It is also on this diagnostic aspect that the present research will focus.

In relation to substance use, the appearance of substances other than heroin and cocaine has been reported, such as methamphetamine (Rovira, J. 2022). However, this research has also pointed again to more familiar substances such as alcohol or psychotropic drugs in HR. The initial programme designs focused on the substances that had the greatest comorbidity and mortality associated with them. Today our society seems to have broadened the patterns of use, and it is essential that HR also considers these changes and reviews the responses it is offering to them.

The involvement of PWUS has been another element to be highlighted. Numerous scientific publications propose an analysis from the academic field applied to the study populations. Listening to and involving PWUS is a distinctive element of the HR model itself, and it was therefore almost mandatory to include them in this first exploration, in the same way as the voice of the HR staff .

As shown in the Method section of this paper, the exploratory themes included on the HR model itself, the populations accompanied, the forms of substance use, the HR services and/or programmes and the HR staff currently working in this network were addressed. Given the lack of specific reviews to date and the potential impact identified, an in-depth bibliographical review of five specific fields was conducted focusing on the HR model, the transcultural perspective, the homelessness and the chemsex phenomenon.

HARM REDUCTION MODEL

As described by Brocato in his publication *Harm reduction: a social work practice model and social justice agenda* (2003) the HR model under a public health approach was built on four essential pillars: alternative to abstinence, combating substance use-related diseases, reducing related mortality and preventing stigma.

These four elements made it possible to differentiate from the previous model of care and approach to substance use. The previous model focused on the elimination of substances as a strategy to improve health, abstinence as the only final objective and the imposition of treatment as the exclusive approach. The same constructed a fatalistic social imaginary of the PWUS as a marginalised subject, to whom a process of social delegation was applied. This was because the person was ill, unwilling, irresponsible and therefore society had to take care of them by removing them from all access to substances and offering them resources to cure them. This imaginary also constructed the self-image of the substance user as someone to blame for their own situation who failed if they did not manage to stay away from drug use (Romani, et al. 1989). The main consequence of this first prohibitionist and individualistic model of substance use (which did not take into account health inequalities) was the status of the substance user as someone to be excluded for not making sufficient efforts to improve their health status.

In this context, it is not surprising that regardless of the territory, the first HR programmes were surrounded by panic and social questioning, where it was pointed out that they could be encouraging an increase in the prevalence of substance use, as well as causing people to dismiss any abstinence-oriented process in an immediate and standardised way (Brocato, 2003).

The HR proposed a new model of attention for substance use that went beyond a mere welfare approach. It was a new philosophy of looking at substance use. This new approach pointed, for the first time, to the structural inequality that concerns systematic differences in health status between different socio-economic groups. It situated this injustice as a product of social processes for which the responsibility does not lie directly with the individual user. This model made it clear that the harms associated with substance use affect certain community groups (e.g. women) in different ways. It identified risk factors (e.g. economic disadvantage, history of violence, presence of mental illness, lack of family support) that have little to do with the social imaginary of a vicious and irresponsible substance abuser.

This change in the moral context guaranteed access to health and social basic services for all vulnerable substance-using communities, leaving aside strategies that placed sole responsibility on the individual. Similarly, it was assumed that HR was a response to reducing inequalities and not an approach to changing the social conditions produced by socio-economic inequality (Pauly, 2007).

Spain faced significant challenges in implementing HR programmes. Professional and institutional opposition had to be overcome, and there was a significant delay in both qualitative and quantitative terms. The progress and extension of HR policies was unevenly spaced according to the Regional Autonomous Communities, and it was not until the end of the 1990s that these programmes became standardised and found greater development for the whole of Spain. The first HR programme to be considered was the Methadone Maintenance Programme. The Needle Exchange Programme (NEP) followed, albeit with greater difficulties. By the 2000s, HR Drop-in Services (also known as Social Emergency Centres, *Calor y Café*...) were already up and running in several communities, offering basic social and health care services. The first DCR was opened in 2001. HR started operating in the preventive field dedicated to nightlife and recreational use from 1997 with the foundation of the *Energy Control programme*. This was followed by the incorporation of drug checking the following year (Rovira et al. 2018).

While nowadays HR is widely accepted and developed in Spain, and is recognised as an indisputable pillar in public drug policies, its position and economic support is still fragile and very subsidiary when compared to abstinence programmes. This unequal territorial coverage, especially in terms of population, depending on the regional autonomous community, is a clear indication of this.

Recent years have seen several authors (Pauly, 2007; Fry et al., 2005; Keane, 2003; Young, 2001) make the case for a revision of the public health model in HR that incorporates social justice and human rights. As previously stated, the social justice view of substance use was initially applied under a utilitarian approach, where the best outcome for the majority of the population was to orient substance use towards abstinence. Subsequently, social justice was understood from an egalitarian approach, where it was finally accepted that there were unequal opportunities for certain community groups in accessing the health care system. In the early 2000s, the demand for social justice incorporated the equity approach. It was recognised that people who used substances had fewer opportunities to access the health system, and this inequality was recognised as a violation of rights.

In the last decade, some authors have proposed that the term social justice in HR should be defined as a combination of these approaches (public health, equality, equity) with a community ethics approach. Young (2001) asserts that it is crucial to recognise that there are axes of domination and oppression in communities that affect minority groups. He is clear that these disadvantages must be incorporated into the reading of reality. He believes that this will empower these groups and their communities in the development of policies and practices oriented towards the struggle for the guarantee of their own rights (Pauly, 2007).

In summary, these authors suggest that the model of HR based on the pillars of public health should incorporate a social justice lens to consider the intersections and intentions of different axes of inequality. Furthermore, they place people themselves as protagonists in socio-political transformation, eschewing earlier models in which people were simply seen as either sick or marginalised, with no agency for change.

Introducing these aspects of transformative justice would allow immediate survival needs to be addressed, recognising that the systems that are supposed to provide security and protection (basic services, protection from violence, housing) are not doing so (Spade, 2020). Implementing this community responsibility approach could create security by building communities and support networks, integrating many people and realities, and dismantling the charity model where a few experts solve very serious problems for many communities.

TRANSCULTURAL PERSPECTIVE

The axis of inequality by territory of origin and/or ethnicity has been described in detail. As noted at the beginning of this section, Spain is estimated to be the second European country with the highest number of people of migrant origin and the first European country with the highest number of people in an irregular administrative situation. The integration of transcultural competences is described as an essential aspect in understanding the use of substances in this community. The intersection with other axes of inequality, as well as the lack of protection in which these people may find themselves, points to HR as an approach that could offer pragmatic support and guarantee the rights of migrant people who use substances.

The social imaginary of migrant people who use substances in Spain includes various stereotypes, such as the fact that, in addition to using substances, they are also involved in drug trafficking (implying that their presence in the community increases crime-related problems), that they use substances with lower purchasing power, that they have a lower level of education and that they receive more social assistance. These last three stereotypes are directly linked to poverty.

Cultural competences are defined as a set of congruent behaviours, knowledge, attitudes and policies that come together in a system, organisation or among professionals to enable effective work in intercultural settings (De Kock, 2020).

The need to incorporate cultural competencies in substance use and HR services arises from the

observation of differences (even assuming that they are micro-represented in the analysis of results) in terms of accessibility and adherence to services and/or programmes for this community group. Like any other perspective (such as gender), its implementation requires new lens to understand the circumstances and reality of this person, identifying the meaning, place and forms of substance use and, consequently, the harm they cause and the reasons for it; as well as identifying the professional teams as they perceive themselves in the world and perceive the attitudes and actions of the other person.

Aspects such as the duration of the migration process, the place of origin, the purpose of the journey, the nature of the decision taken (forced or unforced), the qualitative characteristics of the person, legal status, and cultural differences appear to be factors associated with the onset or increase of substance use in this population. It should be noted that some people may be substance users prior to the migration process, and that the conditions and experiences associated with migration increase the use and related harms.

It has been observed that these experiences can be potentially traumatic for the individual. It has also been described that people who have lived through traumatic experiences may use substances as a coping and/or survival strategy for post-traumatic symptomatology, anxiety, depression and integration of experienced violence (Pompidou Group; 2022). These experiences may also be intersected by various axes of action that place the person in a situation of greater vulnerability, such as being a woman, a migrant, in an illegal administrative situation, with a language barrier, a racialized substance user.

Over the last five years, a number of authors (De Kock 2020; Federova 2012; Pompidou Group; 2022) have explored the relationship between substance use and the migration process. People are unprepared for the changes involved in moving from one place to another (culture shock), and even less so in situations where it seems to be the only option for survival. The new culture is often perceived as incomprehensible and strange in all its manifestations. Some factors that are considered successful in terms of migration are: overcoming language barriers, good living conditions, access to the labour market, access to social and health services and family structure.

The risk factors associated with meeting diagnostic criteria for Substance Use Disorders (SUDs) described in people who have undergone a process of migration were poor living conditions in the country of origin and in the country of arrival, having experienced periods of deprivation of liberty, long periods of detention, social instability in the territory of arrival, the experience of long frustrated processes aimed at administrative regulation, separation from the family nucleus, exposure to violence during the migratory journey and in the territory of arrival, social exclusion in the new territory, unemployment, experiences of discrimination, and the development of trauma-related symptomatology due to experiences in the territory of origin.

The adoption of this new approach has been identified by several authors as a key factor in the treatment of this community. Several examples have been described of migrant substance users initiating and adhering to abstinence-based treatment. At the end of treatment, opportunities for building social capital, integration into the labour market, access to housing, culture or basic services were virtually non-existent, leading to a revolving door towards substance use (Pompidou Group; 2022).

In 2015, Spain recorded an increase in the arrival of unaccompanied young men (sometimes minors) of Maghrebi origin, whose migration process involves crossing the Mediterranean sea. In Morocco, there is a law stipulating that minors who use substances must be offered treatment by their families, always with a view to abstinence and dropping out of school during this period (Pompidou Group; 2020). Irrespective of the degree of compliance with this law, its very existence indicates the place that substance use occupies in the lives of these young people and the kind of education they receive in relation to substance use.

In 2021, a comparative study was published (Carrasco-Garrido, 2021) on substance use among native Spanish minors and migrant minors between 2006 and 2016. The results pointed to language barriers, cultural distance and the presence of anxiety symptoms as factors associated with initiation of use. Non-native adolescents reported higher use of non-prescribed psychotropic drugs. These findings are consistent with another study on the effect of migrant status in the Spanish context, which also found that young people of Muslim origin in Spain had lower alcohol consumption than native youth and higher use of psychotropic drugs (substances permitted by Islam), pointing to a greater number of experiences of discrimination and difficulties in cultural adaptation as associated factors (Sarasa-Renedo et al. 2015).

Some European reports (Federova 2012; Pompidou Group, 2020; Pompidou Group, 2022) have identified elements of concern for HR services and programmes specifically in this population, such as mistrust of institutions, communication in a non-native language having an impact on the quality of care they receive (even if they speak Spanish), fear of being singled out as substance users in their community, the need to share and restore the construction of terms such as 'health', 'addiction', 'drug' across cultures, and the vision of divergent worlds in relation to care and support for substance use.

The following have been identified as possible strategies for integrating cultural competences: the

importance of internal communication between professionals in an intercultural context, the inclusion of specific variables in the individual therapeutic plan, the implementation of the trauma-informed model, the guarantee of accompaniment to basic services, the inclusion of social mediators workers, the inclusion of peers and the inclusion of specialised external supervision of work teams.

HOMELESSNESS

Over the last decade, some countries have seen a worrying increase in homelessness. Spain does not have data on changes in the number of homeless people, but according to the National Statistics Institute (INE), the number of people using shelters and hostels increased by 32% between 2014 and 2018. According to the report 'How many homeless people live in Spain?' (Sales, 2015), data on the evolution of the different forms of homelessness are incomplete and biassed, there is no research with reliable sources at national level and in most cities the number of people sleeping rough is unknown.

There is an extensive literature describing the links between long-term homelessness and alcohol dependence, risk of illicit substance use, poor physical health and comorbidity with mental health problems. In particular, the length of time a person lives on the street is directly related to the risk of substance use (Pleace et al, 2022).

In analysing the phenomenon at the state level, it has been observed that there are considerable differences in the strategies to tackle and/or eradicate homelessness, but a common element is that homelessness networks are usually not linked to primary care, mental health and addictions, and HR networks. This disconnection appears to be one of the reasons for the invisibility and exclusion of people who use substances in housing policies.

According to Pleace (2022), two groups of substance users can be distinguished among homeless people: those whose homelessness was caused by heavy substance use and those who started using substances when they lost their homes. From a social imaginary point of view, the author warns that when we talk about homeless families, we do not assume that any member of the family might be a substance user.

The most common characteristics of the homeless are: men, who have been living on the streets for a long time, suffering mental pathologies, unemployed, who have a high number of contacts with the justice system, who have spent short periods in prison and who are recurrent users of the emergency services. This group is therefore the one that has been studied most closely, as it is the one that uses the network's services without having to work, although it is estimated that it represents only 10% of homelessness. As described in Pleace's report on homelessness in Europe (2022), it is common for substance use conditions to limit access to basic services, and most studies on homelessness are based on people linked to these services. For this reason, it points out that people who use substances are underrepresented when it comes to homelessness.

A similar situation occurs in relation to female homelessness (Bretherton, 2017). Gender status is associated with different trajectories of homelessness, with lower network attachment and different substance use patterns. For young people, homelessness is associated with having been in contact with the protection system during childhood, substance use and/or linked to the mental health network.

There is no single model for HR and homelessness services in Europe. Different responses include HR drop-in services, mobile units, housing support, integrated emergency and HR services and housing first. The staircase model is still dominant in many European countries, including Spain. It is less effective than housing first and it has been observed that the gradual increase in demand is not adapted to people with complex needs (addiction, mental pathology, gender, migration, etc.). It is noted that interventions focused only on substance use, without taking into account the individual's needs for social support in relation to homelessness, have limited effectiveness.

At European level, there is a tendency for HR services to focus on homeless people, particularly those living on the street, as a result of the significant increase in homelessness worldwide. The different European reports indicate that these services are more effective than those based on abstinence criteria, which are only more effective when accompanying people on Methadone Maintenance Programmes in a homeless situation (Peace, 2008).

CHEMSEX

THE *CHEMSEX* PHENOMENON AND ITS EVOLUTION

The practice of chemsex, which is part of what is known as 'substance use in sexual contexts', certainly has its own peculiarities, with a series of codes that make it a particularly important area for study and prevention in terms of health. As it is a relatively new problem, there are not many studies available and the definitions given by experts vary.

Chemsex refers to the deliberate use of substances to engage in sexual intercourse over a long period of time. This can last from hours to days. It is important to clarify that there is still no definitive consensus on its definition. However, based on motivations, codes and types of substances, the practice is mostly associated with homosexuals, bisexuals and other MSM (men who have sex with men). These encounters, commonly known

as 'sessions', are characterised by the excessive use of recreational drugs, which combine to produce effects of both heightened euphoria and disinhibition, as well as to increase physical stamina and thus the duration of the session. It emerges as an alternative form of sexualised partying that allows participants to avoid the potentially critical nature of 'public space'. While the sessions tend to be organised around sex, there is some evidence that they can serve a variety of social purposes for their participants, including the opportunity to meet other men, engage in erotic play and experimentation, and recreate relationships of intimacy and complicity in safe, non-discriminatory spaces. Other common motivations include social isolation, reducing feelings of self-doubt caused by internalised homophobia, or increasing sexual confidence, which is clearly affected by the perception that one's body image does not meet the standards demanded in meeting spaces, whether physical or virtual.

The Chemsex phenomenon emerged in the United States over a decade ago, and only appeared in Europe via the United Kingdom early in the last decade.

This is a relatively new phenomenon in Spain. And regarding its evolution, as in some European countries, there are still few epidemiological studies on chemsex and how it affects public health. There is some consensus that its prevalence is higher in large cities, especially Madrid and Barcelona, although it has also been observed in other cities such as Malaga and Valencia, as well as in the most popular gay tourist destinations.

In order to understand the evolution of this phenomenon, it is important to acknowledge the so-called relationship between sex and drugs. Although various surveys and studies have investigated substance use in the GBMSM (gay, bisexual, men who have sex with men) community since 2010, none have collected information on chemsex per se. The alarm about the emergence of chemsex was arguably sounded by Antidote in 2013. This service for LGTBQ+ PWUS warned of the changing patterns of use among GBMSM, with increased use of methamphetamine, mephedrone and GHB/GBL in sexual contexts, and high rates of injecting. It was also highlighted that this increase was more pronounced in the group of GBMSM living with HIV. Since then, several studies have attempted to shed light on this reality in our country, either through the analysis of secondary data or through studies carried out for this purpose.

The organisation Apoyo Positivo carried out a study in 2021, which drew some interesting conclusions. For example, it found that the average chemsex participant profile is a gay man between 25 and 44 years old, active in the labour market and without a steady partner, with the most common channel being geolocation apps. The most common reasons for engaging in chemsex were 'to make sex more pleasurable, to have more physical stamina and to have more confidence in sex.' These data suggest that motives for engaging in chemsex are diverse, not mutually exclusive, and highly dependent on individual differences.

This study also revealed a large number of theses related to dissatisfaction with the practice, either because it did not meet their expectations or because it had at some point affected their personal, family or work relationships. In addition, anxiety disorders, dependence on the substance leading to an inability to have sex without it, or anxiety-depressive disorders resulting from long-term use are common. It should be added that, given the characteristics of these practices, there is a high-risk component in the sexual sphere, which increases the likelihood of contracting multiple STIs.

In summary, this seems to be a phenomenon that requires greater attention from the different competent bodies, given its rapid establishment and evolution in the social context. We can affirm that it is a public health problem that mainly affects GBMSM. The combination of elements such as stigma, marginalisation, minority stress and maladaptive coping (including substance use) contribute to participation in syndemic 'risk environments', and there is a correlation between health problems and psychosocial factors, which together increase the vulnerability of the group. These underlying factors, together with the impact and development of geolocation apps, the hypersexualisation of the gay entertainment industry and the imposition of beauty standards, have been key drivers in the development of this phenomenon. In the absence of more data that could shed more light on the subject, the collaboration and coordination of different disciplinary teams is necessary to promote the care and health of GBMSM who engage in chemsex in Spain.

INTER-PROVINCIAL DIFFERENCES

It is not surprising that this type of phenomenon finds the best space for its expansion in large cities. In fact, it was in the most gentrified areas of the country, such as Valencia, Barcelona and Madrid, where this practice began to germinate. However, we should not overlook openly gay tourist or leisure hotspots such as Sitges in Barcelona, Torremolinos in Malaga or Maspalomas in Gran Canaria. Today, the regions most affected are those mentioned above, with the addition of the Andalusian community, especially Seville.

There are no major differences in the type of substance used by region, although recent studies suggest that mephedrone is more commonly used in Madrid, Valencia and Seville, while methamphetamine is more commonly used in Barcelona.

The use of narcotic drugs, whether or not in a sexual context, does not necessarily imply pathology, as the DSM-5 recognises that a person may use recreationally without having a negative impact on any area of their

life. Specifically, the DSM-5 classifies the diagnosis of substance use disorder as mild, moderate or severe, depending on the number of criteria met, and without the need for physical dependence.

Similarly, it is beneficial to carry out psychotherapeutic intervention before the onset of negative symptoms or on symptomatology without a diagnosis (Curto et. al, 2020; Ministry of Health, 2020).

Curto and Dolengevich (2020) have recently developed the '*Abordaje de la Salud Mental del usuario con prácticas de Chemsex*' Technical Document, in which they emphasise that the practice of this sexualised consumption is a transformation of the use of one or more substances, which, due to its modulating variables and a series of associated behaviours, such as the sexual practices themselves and the compulsive use of mobile apps, makes it difficult to provide a diagnosis or to clarify whether there is problematic use according to the criteria established in the DSM-5. Furthermore, in terms of temporality, these self-investigators find little realism in the criteria set out in the diagnostic manual, because while the DSM-V uses 12 months as a criterion for substance use disorder, cases can be found in chemsex users where the person is experiencing serious problems in as little as one month. These problems may be due to an increase in both the frequency of use and the route of administration, moving from nasal or oral routes to injections, which are considered more dangerous.

Given the diversity of behaviours involved in the chemsex phenomenon and the complexity of the pathology, various studies have highlighted the need for a comprehensive and multidisciplinary health approach. Experts in the field of addiction, and chemsex in particular, advise against limiting interventions to cessation of drug use. Many chemsex users do not perceive their situation as problematic, despite the consequences, whether observed or not, in various areas such as social, physical and psychological. On the other hand, there are people who have repeatedly failed in their attempts to stop using and who would benefit from improving their health and quality of life before aiming for abstinence.

For this reason, it is proposed to include in the services action plans for prevention and harm reduction in consumption and psychoeducation on sexuality (Curto et. al, 2020; EMIS-2017, 2019; Morris, 2019). This line of intervention aims to reduce the possible direct and indirect consequences of substance use and to support and mitigate the harm that already exists.

STI prevention education programmes, provision of barrier methods, counselling and referral for pre-exposure prophylaxis (PrEP) treatment.

Curto and Dolengevich, in the technical document '*Abordaje de la Salud Mental del usuario con prácticas de Chemsex*' (2020), and Ruiz-Robledillo et al. (2021), among others, also emphasise community reinforcement, interpersonal skills training, sexual psychoeducational interventions and personalised strategies in the occupational, social and leisure spheres.

David Stuart at 56 Dean Street was a pioneer in recognising the need to provide specific services for this phenomenon and in implementing interventions based on his personal and professional experiences. These experiences, through the author's personal communications, have become a point of reference in the professional field for other professionals and organisations working in this field.

An increasing number of organisations have found it necessary to extend psychological services to chemsex people. Apoyo Positivo in Madrid and Torremolinos, COGAM and Imagina Más in Madrid, ABD, Barcelona Checkpoint, Gais Positius and Stop Sida in Barcelona, Adhara Sevilla, Comité Antisida de Valencia, GTT-HIV online and in person in Madrid and Barcelona, ALAS Baleares, Colectivo GAMA in Las Palmas de Gran Canarias, among others.

As it is a living and constantly changing phenomenon, it is necessary to regularly update a needs assessment adapted to the specific requirements at both individual and community level.

First of all, multidisciplinary intervention is essential, ranging from control and follow-up at the sexual health level to support from community intervention and the various relevant bodies or associations.

From an individual point of view, it is important to provide therapeutic guidance in which the user is free to define, without judgement, the goals he or she wishes to set in relation to substance use. In this dimension of the therapeutic process, it is essential to focus on the factors and motivations behind this behaviour, looking closely at the personal relationships established, as well as their life history and social coping difficulties.

In parallel with the individual therapeutic process, the work is complemented by a group therapeutic process where resonances can be created and awareness of the ways in which attachments are formed can be raised. The group can also be a vehicle for building or reinforcing social skills that allow you to value your choices, as well as appropriate boundaries that help you to heal.

Reconstructing sexuality is a crucial aspect of this process. It is important to accompany the person in this process so that they are able to carry out a cognitive restructuring that allows them to reconnect with their body and rediscover eroticism from a different place, where sexuality can take place from a real encounter in a richer intimacy.

Finally, the person's support networks must be strong for this process to be successful. It is important to rebuild the existing ones, most of which have been neglected or deteriorated. It is also important to create new links where leisure and habits are free from these elements. In short, to accompany the person on their journey to question, abandon and replace unadapted behaviours with healthier ones that help them to improve their self-image and their relationship with the world.

1.2. CONCEPTUAL FRAMEWORK

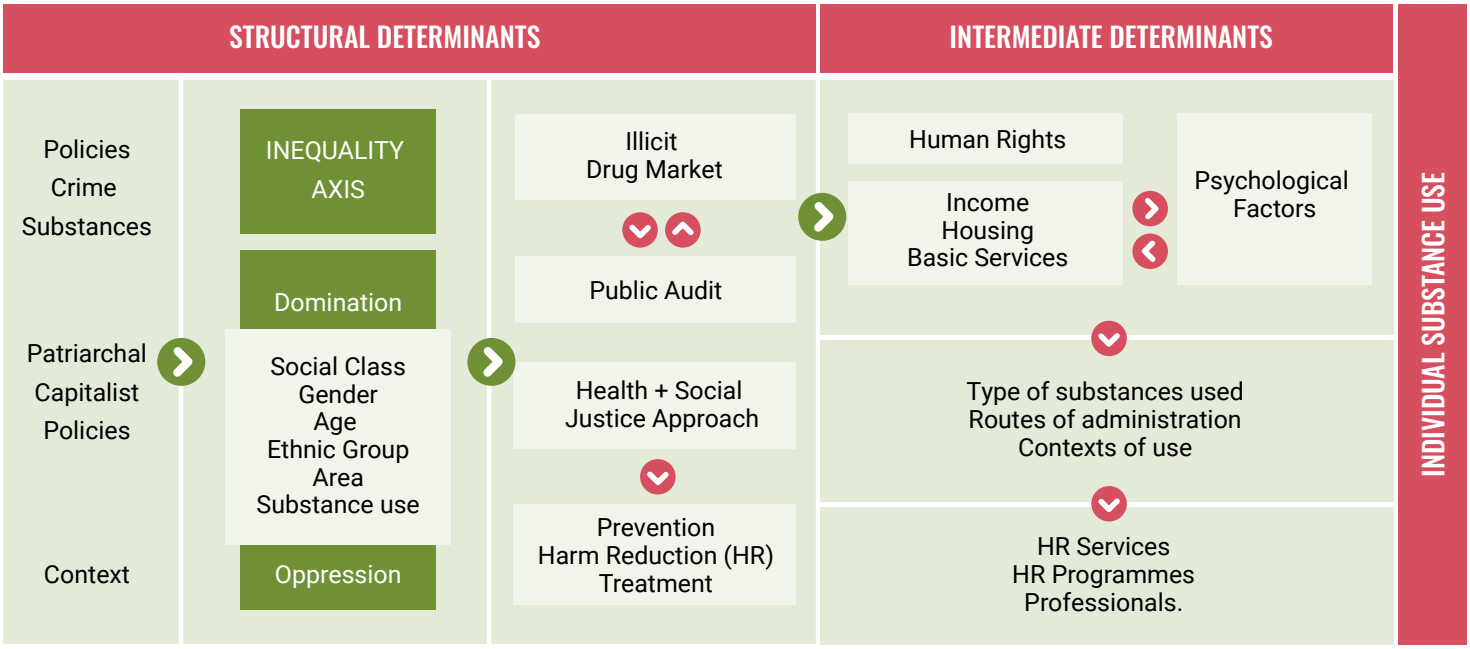


Figure 1. Conceptual framework of individual substance use. Own elaboration. 2022.

This phenomenological research was conducted from a **feminist, intersectional and psychosocial perspective**. The feminist approach allowed for reflection, implementing situated knowledge and seeking alliances with the participants themselves, with the aim of creating a shared epistemological framework of reality. Intersectionality was used as a theoretical and analytical perspective that allowed understanding, explaining and making visible how different systems of domination and social privilege interact and configure the social inequalities that lead to the specific discrimination of substance use. By addressing the personal, family, community and societal dimensions, the psychosocial approach made it possible to address the causes, development and consequences of human rights violations of people who use substances.

This theoretical framework is the result of a reflective process involving the literature consulted, the participants and the research team's own experience. It aims to recognise the personal and social resources of the people involved within the category of subjects of rights.

The social inequalities that are directly caused by neoliberal economic policies, the patriarchal social order system, and prohibitionist policies on the use of psychoactive substances are a widely demonstrated reality that seems undeniable nowadays. These inequalities manifest in a complex social system that must be interpreted in terms of both positions of oppression and positions of power. The intensity with which these axes of oppression-power are transformed will depend on the context.

The precise geographical context in which the analytical approach will be applied will be a crucial factor in the interpretation of this theoretical framework. In order to describe the diversity of existing realities in harm reduction in Spain, experiences from different national territories were collected in this study. Therefore, the social inequalities and discriminations described will be entirely related to the specific context in which these people have found themselves.

There are some social divisions, such as gender, age, origin, ethnicity and social class, that tend to condition

most people's lives. The number and type of categories used will depend on this context. Thus, in regions with little or no migrant presence, the origin axis will operate with less intensity than in large cities with a greater migrant presence.

The different axes of intersection have been described according to Rodo-Zarate (2022). The different dimensions, presented in a very simplified way, are interrelated, but the purpose of distinguishing them is to show their complexity. It is important to note that it is possible to be in positions of oppression and privilege at the same time.

One possible relationship between categories is that of intensity, either in the sense of intensification or mitigation. Intensification occurs when, in a relationship between (at least) two categories of oppression, one increases the effects of the other. In the relationship between homelessness and substance use, the last one intensifies gender oppression because women who are homeless and use substances will find it more difficult to access emergency services than women who do not use substances. This does not mean that both groups of women are not in a situation of oppression, but that in this case the relationship with the substance use axis differentiates the degree of discrimination experienced.

The *sex-gender* system has different dimensions that are framed by the normativities derived from the cisheteropatriarchal system. These dimensions include gender, gender identity, gender position, gender expression and sexual orientation. For example, masculinity is an attribute of superiority, so femininity implies all kinds of inequalities and violence. At the same time, discrimination and violence will be more intense if the woman is not heterosexual and thus deviates from the norm of desire.

Origin, rationalisation and ethnic, cultural or religious diversity may be related in some contexts, but it will be necessary to understand that they are configured differently and in multiple interrelationships. In the European system, the system of migration control is based on colonialism, which gives people different rights depending on their origin. For example, Spanish citizenship gives access to the right to vote. Violence and inequality along these dimensions are linked to colonialism, but also to imperialism, Eurocentrism and white supremacy.

Social class is a form of social stratification related to productive function, additive power or access to resources. In our current context, aporophobia would be a concrete form of discrimination.

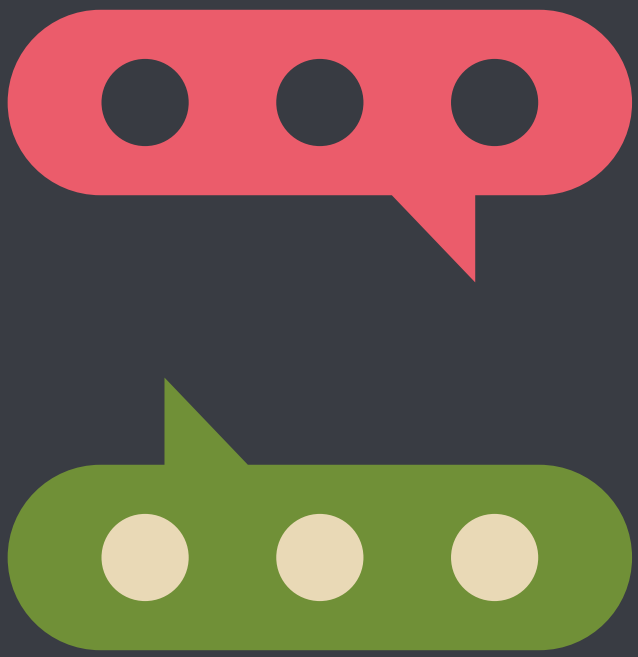
In the course of this study, it has been observed that the effects, inequalities and violence associated with **the condition of substance use act as an axis of discrimination** in the national context and, unfortunately, in most of the global context. It is in this context that the experiences of discrimination and violence reported by participants and the extent of human rights violations can be understood and comprehended.

In this context, it is described how prohibitionist policies on the use of substances crystallise a scenario in which there is an initial division between legal and illegal substances, articulated by a whole framework of regulatory and criminalising legislation. At the same time, a hierarchical order of the substance market is established, in which a difference is made between those substances whose access involves a high economic cost, compared to others whose economic cost is considerably lower. Access to these substances therefore depends on their availability on the market (legal or illegal) and on the individual's purchasing power, which in turn depends on social class, gender, race, etc.

The approach to substance use is based on the biomedical model, which distinguishes between prevention, harm reduction and abstinence-based treatment. Specifically, harm reduction applies the public health model with a social justice approach. The definition of *what it is just in such a society* is directly related to the context. As described in the Background section of this document, the social justice approach has evolved and the involvement of users and communities in harm reduction and the consideration of these people as subjects of rights is now seen as essential.

It is therefore difficult to rely solely on the influence of individual factors and to ignore this complex web of systems, oppression and violence that shapes the daily reality of people who use substances in our territory, where human rights are violated on an almost daily basis.

2 OBJECTIVES AND RESEARCH QUESTIONS



GENERAL OBJECTIVE

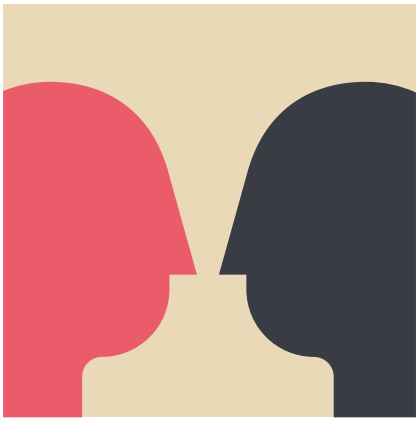
The general objective of this study is to describe the current needs of the HR network services/programmes in Spain.

SPECIFIC OBJECTIVES

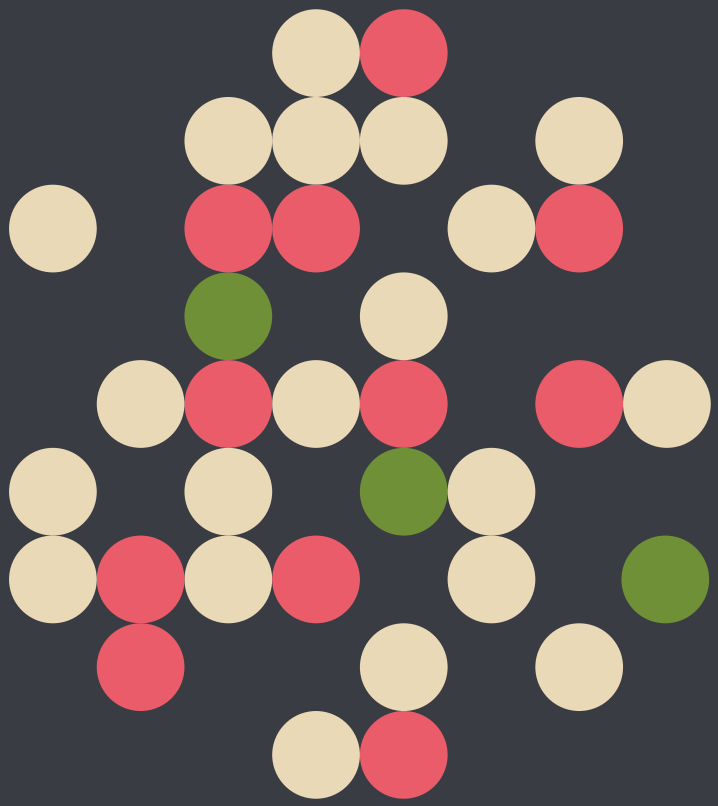
1. To explore the needs of substance use patterns of people using HR services/programmes in Spain.
2. To explore new community groups that may be potential users of HR services/programmes in Spain.
3. To explore how the existing HR network and facilities in Spain can be improved.

RESEARCH QUESTIONS

1. Are there community groups that could be targeted by the HR network in Spain that do not currently use these services/programmes?
2. Have there been any changes in the patterns of substance use among people using HR services/programmes in Spain?
3. Do the existing facilities meet the current needs of the users of the HR network in Spain?



3 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

The research team consisted of:

1. 1 female researcher with experience in HR.
2. 1 male researcher with experience in Drug Policy and Management of harm reduction and addiction services and/or programmes.
3. 1 female expert on gender and substance use.
4. Work Team Group: 1 female drug policy expert representing UNAD, 1 female drug checking expert, 1 chemsex expert, research team and the gender expert.

The members of the Work Team Group were agreed between the research team and the UNAD representative, with the aim of ensuring the presence of the different axes of expertise related to substance use and HR. To ensure a cross-gender perspective, the gender expert professional participated in all phases of the study except the data collection.

DATA COLLECTION INSTRUMENTS

CONSTRUCTION OF THE THEORETICAL FRAMEWORK

The following methodology was used to develop the theoretical framework:

1. Definition by all members of the of the research team:
   - Preliminary themes of interest
   - Research questions
   - The experts to be interviewed
2. Review of scientific and grey literature on HR.
3. Conducting semi-structured interviews with professional experts in different fields related to HR.
4. Elaborating the conceptual framework of the use of substances as a central axis of phenomenological understanding.

FOCUS GROUPS

The Focus Group (FG) technique was used to gather information from the population sample. Four types of groups were set up: women users of HR services and/or programmes (this group will be referred to as 'FG-Women'); mixed users of HR services and/or programmes (this group will be referred to as 'FG-Mixed'); professionals currently working in HR services and/or programmes (this group will be referred to as 'FG-Prof'); and professionals who have had a professional career in HR and whose professional work is currently carried out in the primary network (this group will be referred to as 'FG-Ex-Prof').

All groups were facilitated by one of the study researchers.

The FG-Women and FG-Mixed groups were facilitated by a professional from the service where the session took place. Both were face-to-face and lasted a maximum of 120 minutes. Participants accepted the consent form and data processing. There was no compensation for participation.

For the FG-Prof and FG-ExProf groups, the member of the Work Team Group representing UNAD was involved in the note-taking function.

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

PROFESSIONALS WITH EXPERTISE IN SUBSTANCE USE AND POLICIES

The sampling was theoretical, of convenience and across the entire research team.

The selection criteria were: evidence of a long professional career in the field of HR; ensuring a greater representation of women and/or non-binary professionals than men; representation of national territorial diversity; representation of diversity of expertise; and representation of different professional disciplines.

It was determined that the subjects of expertise to be representative would be extracted after the theoretical framework had been developed and reviewed by the entire research team.

The following figure describes the characteristics of the final sample of experts. Six semi-structured interviews of a maximum duration of 60 minutes were conducted telematically by the research team. All individuals agreed to participate voluntarily and gave informed consent for the transfer of data and the recording of images and sound. One of the interviews was conducted jointly with 3 technical staff members of the professional team of the represented organisation.

GENDER	DISCIPLINE	TERRITORY	EXPERTISE	ORGANISATION/ENTITY
Non-binary	Sociology	Europe	Drug policies Homelessness Gender Migration	Correlation European Harm Reduction
Female	Medicine	Madrid	Drug policies Addictions	Assistance Department of the Sub Directorate General for Addictions of Madrid Salud
Female Female Female	Psychology Psychology Nursing+Psychology	Catalonia	Drug policies HR Prevention	Sub Directorate General for Addictions, HIV, Sexually Transmitted Diseases and Viral Hepatitis
Female	Educación Social	Catalonia	Gender Homelessness Outreach	ABD
Male	Psychology	Galicia	Diversity HIV Chemsex	Apoyo +
Female	Medicine	Basque Country	HR Treatment Homelessness	Gizakia
Female	Psychology	Catalonia	Supervision Care of professional team	Independent

Figure 2. Characteristics of HR Experts sample surveyed. Own elaboration. 2022.

PWUS PARTICIPATING IN THE FOCUS GROUPS

Sampling for both focus groups (FG-Women and FG-Mixed) was done by convenience sampling conducted by one of the researchers in collaboration with the UNAD representative of the Work Team Group.

The criterion for selecting the focus group areas was to have implemented HR services with a track record of more than 5 years. The only inclusion criterion for participants was to have been associated with at least one HR service and/or programme for more than 3 years. Efforts were made to ensure a diversity of substance use patterns.

Based on the development of the theoretical framework, the thematic guide was designed for each of the focus groups, all of which were reviewed by the professional gender expert. These are included in the appendices to this document.

The following figures describe the characteristics of the PWUS who participated in each of the focus groups. A total of 13 people took part (6 people in Barcelona and 7 in Seville), of whom 9 were women, 5 men and 1 non-binary. The average age of the participants was 46.5 years. In terms of substance use patterns, 76.9% used cocaine and 53.8% used inhalants.

FG - WOMEN		
Average age: 47.5 years (minimum: 42 years; maximum: 53 years) Location: Barcelona		
SUBJECT	GENDER	CURRENT SUBSTANCE USE PATTERN + TREATMENT
1	Non-Binary	Methamphetamine; injected route
2	Female	Cocaine + Psychotropic drugs; injected + oral route Opioid Substitution Programme (Morphine)
3	Female	Alcohol + Cocaine; oral + inhaled route
4	Female	Alcohol + Cocaine; oral + injected route Alcohol Maintenance Programme
5	Female	Cocaine; injected route Opioid Substitution Programme (Methadone)
6	Female	Cocaine + Psychotropic drugs; inhaled route + oral route

Figure 3. Characteristics of the sample FG-Women. Own elaboration. 2022.

FG - MIXED		
Average age: 45.5 years (minimum: 35 years; maximum: 56 years) Location: Seville		
SUBJECT	GENDER	CURRENT SUBSTANCE USE PATTERN + TREATMENT
1	Female	Cocaine and Heroin; inhaled route
2	Female	Alcohol Opioid Substitution Programme (Methadone)
3	Male	Alcohol + Speed Opioid Substitution Programme (Methadone)
4	Male	Cocaine and Heroin; inhaled route
5	Male	Cocaine and Heroin; inhaled route Opioid Substitution Programme (Methadone)
6	Male	Cocaine + Psychotropic drugs; inhaled route + oral route
7	Male	Cocaine + Psychotropic drugs; inhaled + oral route Opioid Substitution Programme (Methadone)

Figure 4. Characteristics of the sample FG-Mixed. Own elaboration. 2022.

PROFESSIONAL PARTICIPANTS IN THE FOCUS GROUPS

Sampling for both focus groups (FG-Prof and FG_ ExProf) was of convenience and across the entire research team.

The criteria for including participants in the groups of professionals were: to ensure representativeness of the Spanish territories, including large cities and smaller municipalities; gender; diversity of professions; and diversity of types of services and programmes. All those who were proposed to participate, accepted.

Both groups were conducted telematically, via UNAD's Zoom platform, with a maximum duration of 120 minutes. Based on the elaboration of the theoretical framework, the thematic guide was designed for each of the focus groups, all of which were reviewed by the professional gender expert. They are included in the appendices to this document.

A total of 17 professionals participated (8 people in each group), 13 of whom were women. The territories represented were Catalonia, Andalusia, Community of Madrid, Galicia, Basque Country, the Balearic Island and the Canary Islands. Some professionals reported work experience in more than one national territory. All participants reported experience in more than one HR service. Both groups represented rural areas.

The HR services and/or programmes represented by the participants in both focus groups were: HR Drop-in Service, HR Non-Mixed Drop-in Service, Community Intervention Teams, SCS (inhaled, injected, oral), HR Mobile Unit, HR Mobile Dispensing Unit and HR Housing Support. The HR Drop-in Services had Needle Exchange Programmes (NEP), Primary Care and/or Nursing.

The basic care networks that were represented by the participants in the FG-ExProf group were Social Care, Addiction Treatment, Migration, Child and Adolescent Protection, Gender Violence Protection, Homelessness, Mental Health, Primary Health Care and LGTBIQ+ Sexual Health.

The following figures describe the characteristics of the users who participated in each of the focus groups.

FG - PROFESSIONALS (FG-Prof)				
GENDER	PROF. CATEGORY	TERRITORY	SERVICES AND/PROGRAMMES OF EXPERTISE	POPULATION
Female	Coordination Social Worker	Galicia	HR Mobile Unit HR Drop-in Service	Rural Urban
Male	Nursing	Balearic Islands Catalonia	Mobile Methadone Medication Unit HR Drop-in Service HR Drop-in Service Mobile DCR Unit DCR	Urban
Female	Social Worker	Catalonia	HR Drop-in Service DCR HR Housing Support	Urban
Male	Community Education	Catalonia	HR Drop-in Service Outreach	Urban
Female	Social Worker	Andalusia	HR Drop-in Service	Urban
Female	Coordination Social Education	Catalonia	HR Drop-in Service DCR	Urban
Female	Nursing	Catalonia	DCR	Urban
Male	Nursing	Andalusia	HR Mobile Unit	Urban
Male	Coordination Psychology	Basque Country	HR Drop-in Service DCR HR Housing Support	Urban

Figure 5. Characteristics of the sample FG-Professionals. Own elaboration. 2022.

FG - PROFESSIONALS (FG-ExProf)				
GENDER	PROF. CATEGORY	TERRITORY	SERVICES AND/PROGRAMMES OF EXPERTISE	POPULATION
Female	Social Worker	Catalonia	Social Care HR Drop-in Service DCR	Urban
Female	Psychology	Catalonia	Addiction Treatment Centre HR Drop-in Service DCR	Urban
Female	Social Educator Social Worker	Canary Islands Catalonia	Residential Centre for Youth Migrant Outreach HR Drop-in Service HR Housing Support	Urban
Female	Social Educator	Basque Country Catalonia	Social Care Homelessness Outreach HR Drop-in Service Women / Non-binary HR Drop-in Service	Urban
Female	Psychiatrist	Canary Islands Catalonia	Mental Health Unit Psychiatry Emergency Department HR Drop-in Service HR Housing support DCR	Rural Urban
Male	MD	Catalonia	Primary Care Homelessness Addiction Treatment Centre HR Drop-in Service DCR	Urban
Female	Social Educator	Catalonia Community of Madrid	Gender-Based Violence Protection Residential Youth Migrant HR Drop-in Service Outreach Homelessness HR Drop-in Service	Urban
Female	Social Worker Coordinator	Community of Madrid	LGTBIQ+ Sexual Health Chemsex HR Unit	Urban

Figure 6. Characteristics of the sample FG-ExProfessionals. Own elaboration. 2022.

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 Regional Autonomous Community to which they belong.

The individual interviews, group 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 was present in all the sessions.

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.

TIMELINE

PREVIOUS	PROVISIONAL DESIGN	THEORETICAL FRAMEWORK	DATA COLLECTION	ANALYSIS	RESULTS CONCLUSIONS
Problem definition + Funding	Objectives Methodology Sample Design Data Collection Interview Guide Focus Groups Guide	Bibliographic review Semi-structured interviews with experts	4 Focus groups: 2 Professionals + 2 HR users (mixed + non-mixed)	Narrative analysis Mixed category generation Triangulation analysis	Description Internal/ External Review
UNAD	Researchers Work Team Group Gender Expert	Researchers Gender Expert	Researchers	Researchers Work Team Group Gender Expert	Researchers Work Team Group Gender Expert
2021	Feb - May 2022	Jun - Jul 2022	Sep - Oct 2022	Nov 2022	Nov 2022

Figure 7. Timeline of the research phase. Own elaboration. 2022.

CONSTRUCTION OF THE THEORETICAL FRAMEWORK

DEFINITION OF THE THEMES OF INTEREST

The theoretical framework was developed during the first quarter of 2022. The first phase consisted of a 5-hour face-to-face meeting in Barcelona with the participation of the research team, the gender expert and the work team group. The aim of the meeting was to jointly define the research plan. The differential elements observed in HR in Spain from its inception (late 1980s) to the present were explored and the research questions were formulated. On the basis of this preliminary analysis, the study themes were configured: *Model, Harms, Substance Use Patterns, Populations, and Services and Programmes*.

BIBLIOGRAPHICAL BACKGROUND

The literature review consisted of searching and reviewing literature in Spanish and English, without date restriction, in the specialised database Pubmed; and in the search for grey literature in the following complementary sources: generic search engines (Google and Google Scholar), semi-structured interviews with experts and websites of organisations, bodies and projects dedicated to HR at international, national and local levels.

First, a generic search strategy was used with the terms *Reducción de Daños, Harm Reduction* and free language, adapted to the different themes extracted in the preliminary analysis. The first category tree of the research study was then developed (Figure 2).

SEARCH AXIS	THEMES	CATEGORIES
Harm Reduction	Model	Definition Model Risk Reduction
	Harms	Health Housing Gender-based violence Stigma
	Substance Use Patterns	Substances Routes of Administration Contexts
	Community Groups	Women Elderly Chemsex
	Services and Programmes	Supervised Consumption Sites Outreach Professionals
	Basic Services	Mental Health Homelessness

Figure 8. Tree of themes and categories from the literature review. Own elaboration. 2022.

IN-DEPTH INTERVIEWS WITH PROFESSIONAL EXPERTS

FOnce the thematic bibliographic search was completed, the sample of experts was drawn. The research team, the Work Team Group, and the gender expert jointly drew up a list of 11 HR professionals in Spain. The data collection instrument was the semi-structured interview, and the thematic script of the same was designed on the basis of the information extracted from the literature review.

After analysing the discourse, it was observed that all the interviewees pointed out as the most important issue the burnout suffered by professionals who provide direct attention in HR programmes and services. For this reason, the research team decided to include a seventh interview with a professional expert in supporting professional teams in the field of HR.

Below is the tree of themes, categories and subcategories that emerged from the analysis between the literature review and the interviewees' discourse. The added elements are highlighted in **colour**.

THEMES	CATEGORIES	SUBCATEGORIES
Model	Definition Model Difference between Harm Reduction and Risk Reduction	Public Health Approach Social Justice Approach
Harms	Health Housing Violences Gender-based violence Motherhood/Fatherhood Support/Family Network Stigma	
Consumption Patterns	Substances Routes of Administration Contexts	Opiates; Cocaine; Alcohol; Psychotropic Drugs; Methamphetamine Injected; Inhaled Rural; Urban Narcopisos; Consumption Sites; Street
Populations	Women Elderly Chemsex Young Migrants	
Services and Programmes	HR Respones Professionals	Calor y Café, Legislation; Access Barriers; Trauma; Burn-out; Training
Basic Services	Gender-Based Violence Protection Mental Health Homelessness	

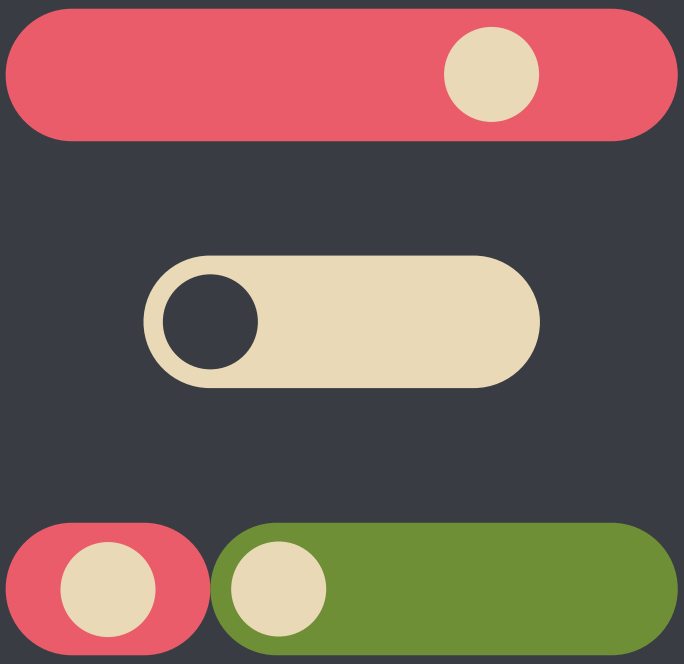
Figure 9. Tree of themes and categories from the literature review and the analysis of the interviews to experts. Own elaboration. 2022.

COMPLEMENTARY EXPERT PARTICIPANTS

After conducting the 4 focus groups, the research team identified the need to supplement the collection of information with three new complementary individual interviews:

1. One-on-one interview with a professional currently working in a non-mixed HR service who had been invited to the FG-Professionals but was unable to attend.
2. Personal visit and semi-structured interview with the professional team of a low-threshold HR day service located in a district of a medium-sized city.
3. Individual interview with a professional currently working in a 24-hour low-threshold HR service in a district of a medium-sized city.

4 QUALITATIVE ANALYSIS



4.1. HARM REDUCTION

DEFINITION AND MODEL OF HARM REDUCTION

Harm reduction as an approach to dealing with people who use substances was the first aspect discussed with the research participants. In both groups of PWUS, there was very little knowledge about the meaning of the concept of harm reduction and its objectives. Most of them said that this was the first time they had heard the term.

Participants felt that it could be related to individual health care by reducing the use of substances, without implying the ultimate goal of abstinence. The only example they gave of a HR service was DCRs, which they described as safe consumption spaces, for their work in dealing with intoxication and as an alternative to street substance use. Another woman of Italian origin explained that in her country, the services she knew about in relation to substance use were always treatment services, whose objective was also limited to abstinence. When she arrived in Barcelona, she came into contact with a new approach based on respect and accompaniment.

> "For me it is moral support, material support, it is a place, and it is people. Where you have a good time, including the moment of substance use, you can find yourself as you like and you can get high. They give you a good vibe... it's the most peaceful way to use substances, they don't tell you that you have a problem with drugs."
>
> Female. Linked to HR services. Catalonia.

On the other hand, in the group of PWUS living in Seville, where there are currently no DCRs , they felt that harm reduction could mean that the person receives professional guidance that allows a gradual reduction of substance use until abstinence is achieved. They did not identify any specific HR services and/or programmes in their city.

All the professionals who took part in the research had worked in services and/or programmes using the harm reduction model with a public health approach. They agreed that, from a theoretical point of view, harm reduction has a broad definition that should allow it to address multiple communities, substances and/or contexts. Several participants referred to harm reduction as a way of '*understanding life' and 'caring for people*' that could be applied to any area of the individual and the community (mental health, social, housing, violence...) and at any point in their substance use history.

Similarly, they agreed on the historical account that in Spain in the 1980s, HR programmes were designed with the aim of serving mainly men who used heroin and cocaine by injection and who had difficulties in accessing and adhering to the main network of basic services.

All the participating national territories reported that they had noticed many changes in the population and in their ways of using substances, and pointed out that most of the original services had not applied a logic of adaptation and that most of the new services had maintained these initial conditions. Several professionals currently working in long-established services agreed that there had been an internal discussion within the resources about the possibility of attending people with characteristics different from those of the project design. They pointed out that there was individual resistance from professionals, which could be related to a lack of experience in the field.

> "'We see young people with benzos, women with alcohol, chemsex... but nevertheless we have always stick to this profile because it is what we know... it is not a matter of laziness... it's more than that... but what we know how to do, or what we have done, or what we have known how to do, is to look after people who use heroin and cocaine together or separately, by injecting; the rest is yet to be learnt."
>
> Social Educator. Experience in Community Intervention Teams and HR Drop-in Services. Catalonia.

They agreed that these conditions were currently a limitation and that the inclusion criteria should be elaborated in a more flexible manner in terms of substances used and routes of administration. Thus enabling to provide a more comprehensive and diverse approach that could meet emerging needs. This need for flexibility in the HR model was seen as essential by the group of professionals currently working in the primary care network.

> "Reality must be permeable, otherwise there is a waste of resources."
>
> Nurse. Experienced in HR, Homelessness and Mental Health services. Balearic Islands.

The expert on drug policies and homelessness at the European level pointed out in her interview that '*accessing the HR network when the rest of protection networks have failed unfortunately reduces the number of possible responses, which exponentially increases the vulnerability of the person and the possible chronification of their process*'. This quote was read out verbatim in the focus groups of professionals and all participants confirmed its content. From the group of professionals currently working in the HR network, it was pointed out that professional willingness exists, although it is also essential to increase resources in order to be able to attend to a greater number of people. Both groups agreed that this logic also increases the stigma attached to people using the HR network, which has a direct impact on coordination and referral to services in the primary network.

Several professionals pointed out that it is now essential to incorporate a social justice perspective into the classic HR model, as the condition of substance use directly implies a violation of social rights. One gender expert described it as follows: '*There is a need to assess how resources are being distributed. It is a socio-economic structural violence that crosses, reproduces and aggravates this community, depriving them of basic rights*'.

HARM REDUCTION AND RISK REDUCTION

Another aspect that was discussed in the focus groups was the possible implications related to the distinction between risk reduction and harm reduction. All PWUS were unaware of this difference and could not express an opinion.

On the other hand, the professionals agreed that this is an uncomfortable difference in daily professional practice, which generates inequality among people who use substances and increases discrimination against those whose use has had an impact on a greater number of spheres of their lives. They agreed that in the social imaginary the word harm is related to structures of poverty, while the word risk is related to fun and control.

> "It seems to me that it gives some people more privileges than others, which ultimately translates into opportunities. I would prefer to focus on the risks rather than the harms. So it seems to me that the approach here says a lot about the way we look at people who use substances, from the continuum of substance use and from the continuum that should be harm reduction. If I use nicotine every day I am a risk user, if I use heroin every day I am a harm user. When we classify, we create inequalities.'
>
> Social educator. Experience in HR and gender services. Basque Country.

One professional pointed out that this categorisation means that each individual would have to review their relationship with each of the substances they use, what social meaning is attached to the substance, and subjectively determine what kind of services and/or programmes to approach. People with professional experience in the child protection network pointed out that in this specific field, risk reduction is linked to prevention, highlighting that this link is an opportunity gap in the approach to substance use among minors. People from the specific LGTBIQ+ network indicated that for them the terminology encompasses both concepts, always using the term risk and harm reduction, adding that they consider the risks and harms associated with substances, but also with sexual practices and the use of mobile applications.

IDENTIFICATION OF PRIORITY HARMS

The *harm reduction* approach requires the identification of the harms to be reduced. From the semi-structured interviews with professionals, six areas of greatest harm were identified: health, housing, violence, gender-based violence, motherhood/parenthood, emotional/family network and stigma. Professionals were asked to prioritise these harms in the populations that frequent their services and/or programmes.

All participants considered **health** to be an indispensable aspect of human survival and agreed that the harm specifically related to organic health, regardless of the state territory analysed, is currently responded to by the HR services and/or programmes themselves, by the primary care network or by hospital emergency care.

Both groups highlighted the lack of specific **mental health** care for people using HR services. Only one HR service in Catalonia was reported to have an integrated mental health team. It was noted that access to mental health care is sometimes conditional on entering treatment and willingness to abstinence.

> "The big gap in our field is mental health. I've always thought it's a bit neglected, right? Accompanying people who are in constant traumatic and shitty situations because of their marginalised condition, that goes with marginalised consumption of violences they experience on the streets, together with their lack of attention... Well, these people who don't deserve counselling until they agree to be treated."
>
> Social Educator. Experience in HR Drop-in Service, Catalonia.

> You see it coming... how they are hurting themselves... how they are going to hurt them... And you knock on every possible door and "it's because of the drugs" and that's not true. Sometimes it is, sometimes it is not, but these are people you have been working with for a long time and you see what the consumption and post-consumption is like, and without being a psychiatrist you see that there is another story behind it and it is not being treated."
>
> Coordinator. Barcelona. HR Drop-in Services and DCRs.

It is noteworthy that professionals with experience in single-sex HR services, services for the protection of women victims of gender-based violence and/or LGTBIQ+ oriented services and programmes stated that **sexual and reproductive health** should be included when referring to the term health and that this area in particular remains a pending issue for women, trans and non-binary people who use substances.

The next most important element prioritised was access to **stable housing**. All experts, professionals and PWUS interviewed highlighted homelessness vulnerability as a major concern. It was reported from all areas that substance use is a condition of access to most housing resources, regardless of the person's substance use pattern. The group of professionals currently working in the HR network highlighted the high number of people accessing resources who are living on the streets, with particular emphasis on the extreme vulnerability of women in this situation. They pointed out that having a roof over one's head is a key factor in starting any kind of therapeutic process.

> If you don't have a place, if you don't have a nest, if you don't have a base... any process approach... is very difficult."
>
> Social Educator. Experience in HR Drop-in Service, Catalonia.

HR staff agreed that sleeping rough was a violent behaviour itself, both inflicting violence on the individual and exposing them to a greater number of potentially violent situations. One PWUS recounted the following aggression she had experienced during a night of sleeping rough with her partner at the time.

> 'A folk attacked me and X, he broke my leg and I was in hospital for a month. I should have filed a complaint, but I didn't... anonymous? I don't know the name, we don't know who it was..."
>
> Female. Linked to HR Services. Catalonia.

Professionals emphasised that the right to housing does not seem to be guaranteed, that a staircase model is used in which the person has to earn a roof over their head, that the condition of the substance-using population increases the demands on the therapeutic process itself, that most people cannot sustain this model, and that it becomes a cycle between living on the streets and living in emergency accommodation.

One professional pointed out that although there was evidence of resources using the Housing First model, she could only remember two people associated with the service who had managed to gain access. She insisted that she was aware of these cases because the people had asked her for information about the sharing registration data of DCR , as they had initially reported being abstinent and thus guaranteed access.

In both Seville and Barcelona, PWUS confirmed this staircase model in homelessness care.

> 'We are talking about the fact that people who actively use substances do not have access to housing, do not have access to protection, do not have access to economic benefits, do not have access to shelter... the condition of being a substance user reduces all opportunities to achieve well-being. I have seen colleagues in the social care network who have not looked after someone because they are actively using drugs and are under the influence of substances."
>
> Social Educator. Linked to HR services and Primary Social Care. Basque Country

> I think if I had stopped using I would have an apartment now. They clearly told me: "We're not providing you with accommodation because you're using". At the moment I don't see myself as being able to be completely clean. I'm trying, but I can't do it overnight. I really can't."
>
> Female. Linked to HR Services. Catalonia.

The third harm they prioritised was the lack of an **affective and support** network. In the case of migrant people, the professionals outlined a greater harm, linking it to the emotional impact of being away from the family and affective network, and to the construction of the peer support network. Conversely, in the case of women, they reported a greater preservation of a member of the family support network as a survival resource and the role of partners between protection and aggression.

Some professionals underlined that there is no tradition of working with families and/or the affective environment in HR services and resources. They agreed that it is usually focused on requesting a reference person to contact in case of emergency (disappearance, serious hospitalisation or death) and/or receiving calls from relatives requesting specific information about their loved one. In the latter case, they indicated that the law on data confidentiality was an obstacle to building a relationship of trust with the PWUS relatives. It was commented that, particularly in the case of street people, the relationship with the family and/or affective network is not systematically explored. There is a tendency to assume that people who find themselves in this situation are there because of a lack of support. Nevertheless, as will be seen in the following account, some professionals stressed the need to include people's environment in the daily operations of HR services and programmes, pointing to the benefits of a bidirectional nature.

> "I think we are at a time of rethinking. Although it is difficult, which it is, and costly to work with families, I believe that the family systemic approach is fundamental. [...] I think that many families would be reassured to know that in this case what their children are doing, they are doing it in a better way... than if they were using in the streets without any kind of accompaniment. This could be a good thing, a good thing for the family environment, for the peace of the families. But we are far from working on it."
>
> MD. Experience in HR services and treatment. Basque Country.

In relation to homelessness, as in relation to the affective and support network, several professionals indicated that they observed a greater impact on people living in large cities compared to places with smaller populations. A professional who coordinates both a mobile service that travels to rural areas in Galicia and a drop-in service in a city reported that in less populated areas, the presence of people living there is lower in relation to the informal responses that the person receives from their own social network.

> "In the rural areas we didn't see homeless people, even in slightly bigger villages, and this is just because there's a bigger family or neighbourhood support network. They help them a bit more because there are not so many people, so in a way the people who are left behind have more support. Well, maybe they live in houses and they let them sleep in the garage, which is less of a nuisance, but at least they are not homeless."
>
> Coordinator. Experience in HR and Gender Services. Galicia.

Despite this more specific prioritisation, all professionals agreed that the vulnerability of these PWUS is undoubtedly influenced by one factor: **violence**. They noted that the violence they receive comes from the system and the community itself, which discriminates against them and does not consider them as subjects of rights, from their childhood, where they were often victims of physical and/or sexual violence within the family, and from their current environment. The violence suffered by women who are victims of gender based violence within the couple and the violence stemming from the current patriarchal system itself was highlighted as an element of particular concern. One professional stated that in the field of HR, the conditions of being a woman and being a victim of violence are an inseparable binomial.

> "When we talk about women, we have to talk about violence, either in childhood or in adulthood. All of them are very closely linked to it. I can't talk about women and harm without using the word violence."
>
> Coordinator. Experience in HR. Catalonia.

Structural violence was found to operate mainly through stigma. Among both groups of professionals, the word stigma was the most repeated, up to 96 times. They pointed out that situations of discrimination experienced by substance users occur in the community in which they live, in the network of basic services they use (including substance treatment services), in the HR services they use, and among their own peer group. One professional participant emphasised the importance of this issue, pointing to structural causes as the main factor involved and expressing the need to address them in order to bring about change at a smaller scale.

> Stigma should be a priority issue, I have always thought that fighting stigma is something very ethereal, that it is multidimensional and that it is very difficult. It's just a reflection of how shitty we are as a society. So for me, tackling stigma is a titanic task of trying or pretending to solve so many things that are socially fatal... but I think that in the short term and in a pragmatic way, things should be done to address it."
>
> MD. Experience in HR and Primary Care. Catalonia.

PWUS were asked directly about their experiences of discrimination and reported mainly experiences related to aporophobia. Below is one woman's account of her experience of discrimination during her admission to hospital and the differential attention she received when a professional accompanied her on previous occasions.

> Especially when they know you are homeless, they look at you very badly. I felt terrible. I told them to discharge me... I'm leaving this place... In general, they treat you badly everywhere. When you're alone or when you don't have anyone, the treatment is very noticeable... I notice it a lot when I go with you... and they tell you in a way... lacking any sensitivity. You see that other people are not treated that way."
>
> Female. Linked to HR Services. Catalonia.

However, the analysis of their discourses reveals several examples of discrimination based on the condition of being a substance user and the development of coping strategies. The following PWUS recounted his experience in primary care services, expressing that, after being assigned a different reference professional, he had adopted the strategy of explicitly verbalising his substance use as a protective strategy in the face of looks or questions that judged his situation. Similarly, in the discourse, it can be observed that the answer they receive has always abstinence as the ultimate goal.

> For me, I prefer to say it before they ask me.... "look, I like getting high", that way they know and they stop asking weird questions. In the end, they always end up giving me a dirty look and saying "well, you should stop before something happens to you."
>
> Male. Linked to HR Services. Andalusia.

4.2. POPULATIONS

CHARACTERISTICS OF PWUS POPULATIONS

With the exception of the focus group made up of professionals currently working in the primary care network, the other participants were asked directly about the characteristics of the people who usually use HR services and programmes.

The mixed group of PWUS conducted in Seville was consistent in its description: middle-aged people, mainly of Spanish origin, in a situation of homelessness, primarily using crack and inhaled heroin, non-prescribed psychotropic drugs and/or alcohol. They indicated that it was not a criterion for exclusion to be living in an emergency shelter or to have an occupied, rented or owned roof over one's head. They stated, however, that being a substance user did not mean that they could access services under the influence of intoxicants.

The group of female PWUS in Barcelona was consistent in the following description: women or non-binary persons of different ages, from different countries of origin, living on the streets and using mainly heroin and/or cocaine by injection and/or inhalation. Although the focus group took place in a service also used by people who primarily use alcohol, this substance was not mentioned.

The group of HR professionals agreed that the majority of PWUS are middle-aged, homeless men who are or have been in treatment. Only services in Catalonia reported a balance between injecting and inhaling route, with the rest of the territories agreeing that inhaling was the predominant route. In terms of substances, they emphasised that cocaine or crack are the main substances used, and pointed out that heroin use is of a 'residual' nature, with the result that people who use this substance are also in opiate substitution treatment (usually methadone). The professional representative of the non-mixed service noted that she had observed that the women attending this service were not usually living on the streets, but were homeless.

WOMEN AND VIOLENCE

Female PWUS were identified by the groups of professional participants as a priority for attention because of their differential exposure to multiple forms of violence and the resulting situation of vulnerability and lack of protection. Those who are also in a situation of homelessness, especially those living on the streets, were identified as a group of greatest concern. The professionals with experience in non-mixed HR services emphasised that women show differences in the use of substances compared to men. They indicated that these differences range from the onset motivations, the meaning, the type of substances used, the forms of use, the associated health problems or the impact on different areas of life.

The state of vulnerability was described by the professionals based on the identification of different inequalities resulting from the intersection between being a substance user and being a woman.

> "In the case of women, everything goes further, it is crossed by the intersection of the sexes, so with the social task of caring for the family or motherhood or the double stigma of being a user, they continue to be hidden."
>
> Social Educator. Experience in HR services. Catalonia.

These oppressions, together with the prevailing male hegemonic logic in society and consequently in HR services, were the main reasons cited for the invisibility of female PWUS inside and outside HR services.

Professionals reported various measures taken in the services to implement the gender perspective, such as: segregated care time slots, segregated individual or group care rooms, health workshops on specific topics, review and adaptation of service regulations, involvement of professionals specialised in gender or gender training.

Nevertheless, they expressed that positive results are very slow, that mainstreaming is not a priority in all services (overburdened by direct day-to-day attention), that it often depends on the willingness of professionals, that in many cases it is not transversal, and that it is essential for the whole primary care network to incorporate a gender perspective, considering the reality of women who use substances as just another intersection.

One professional reported very good results in the HR service where she works in Barcelona, after introducing specific external supervision on gender issues. Another professional from a drop-in service in Vigo indicated that after implementing some actions specifically for women, their attendance highly increased (from 10% to 22%) and they were more consistent than men.

The first oppression identified that was directly related to the violence experienced by women in the context of HR responses in their relationship with their partners. It was pointed out that most of these relationships are heterosexual, in which the privileged role is undoubtedly that of the man, and that serious situations of violence in which the woman is the victim are normalised. On many occasions, the professionals stated that the activation of care and protection circuits for gender-based violence is essential to guarantee the survival of the woman. All professionals expressed great concern about the level of abstinence required by these protection services for women who are actively using substances. One professional described the following question on the need for protection by professionals outside the field of HR: '*what does a woman who has been assaulted while consuming?*' The following is the experience of a social educator in Barcelona.

> "I was supporting a woman whose attacker was at the door and wanted to kill her, he had already attacked her. [...] for many women, when they are victims of violence, there is an increase in consumption as a self-medication mechanism, to calm down, to feel better... We went to social care and they didn't understand. This person needed to consume before going through the whole protocol of many days: she goes to the hospital, to emergency room, then to recovery services, then to see where she was referred... and they were already asking for abstinence. I had to argue with the staff, they had 0 sensitivity, they didn't understand that this person had to consume and that this was not the problem. The problem was the guy at the door who wanted to kill her... how is that not an overwhelming logic?"
>
> Social Educator. Experience in HR Services. Catalonia.

This situation of discrimination coincides with a PWUS's account of her experience after being assaulted by her ex-partner and having to go to the emergency room because of the seriousness of her injuries.

> "My partner beat me up, I had to go to the hospital and file a complaint. Police showed up... they questioned me. They don't let you explain yourself properly, they ask you "are you on drugs?" You don't feel comfortable anymore, you don't fit in that situation. You're out of place. You don't do it the way you want to do it, you can't, you're on the focus... and with the nerves you just want to go and consume... they don't do it well. Then they took me by van to a place and again the questions about drugs. I needed to use, they didn't understand."
>
> Female. Linked to HR Services. Catalonia..

Female professionals and PWUS agreed that starting treatment (if they are not already in treatment) and immediate abstinence are essential conditions for accessing and maintaining protection. A professional from a housing support service with a HR approach in Barcelona explained that this service has two emergency beds for female PWUS who are victims of gender-based violence. She pointed out that this service was set up in response to this gap in attention: '*What was the option? To leave all these women unprotected?*'

The second oppression identified was related to motherhood. PWUS identified this condition as one of the barriers for women to accessing HR services and/or programmes, linked to the fear that it would affect the custody of their children.

> "There are fewer women than men because mothers are afraid that their children will be taken away. Even if you only go to a centre for treatment, everyone already knows that you use substances."
>
> Female. Linked to HR services. Catalonia.

Professionals currently working in HR services mentioned this as an element of concern without elaborating on the reasons. A professional currently working in a protection service, where women live with their own children, reported the following service functioning.

> "Women who drink arrive on Friday and you have to control what time they are checking in, what they will do. Women who don't aren't supervised at all. That is violent. And it is also important to say that these mothers have minors dependent on them. If their children are taken away from them, their context will remain unknown."
>
> Social Educator. Experience in HR and Gender-Based Violence Protection Services. Madrid.

PEOPLE OVER 45

The experts interviewed and the group of professionals currently working in the network of HR services and/or programmes identified people over 45 years of age with long-term substance use as a priority group for special attention, regardless of the state territory they represented. It was observed that in most of the experiences reported by the professionals, the protagonists used alcohol or injected drugs.

The state of vulnerability was described by the professionals based on the identification of various inequalities resulting from the intersection of being a long-term substance user, and their age and social class.

The first oppression identified was related to the age difference found in relation to the general population. Professionals equated the deterioration of health and life domains of long-term PWUS aged 45 and over with that of people aged 65 and over who do not use substances.

The professionals pointed out that these people need support and companionship that cannot be provided by their families, as is the case in the general population. They described a first scenario consisting of people who keep their parents and maintain a relationship with them, who are very old and cannot take care of them. A second scenario was described as people whose families already take care of the PWUS's children and therefore do not have additional resources to integrate the care of this person. A third group indicated that they had no family support, so all their care should be provided directly by public institutions. In all the scenarios described, the professionals assumed that the PWUS did not have sufficient financial resources to access the private care network.

A MD currently working at a HR drop-in service gave the following description:

> "We have a lot of people over 45, we have a lot of people without parents because they have died, or we have a lot of people with elderly parents. What you would ask a mother of a person who came for treatment 30 years ago, you can't ask a person who is 30 years older, because they are now 80."
>
> MD. Experience in HR services. Basque Country.

Professionals pointed out that the primary care network for the elderly sets an access criterion of 65 years or older which immediately excludes this group of younger PWUS. They highlighted this limitation as a cause for concern, as there is currently a care gap that is partially and precariously filled by the services and/or programmes of the HR. Nationwide, they reported only one residential service in the city of Barcelona that provides this specific support.

The second oppression identified was that people with active substance use who are referred to geriatric and/or social health services are rejected or expelled because of their condition. A MD in the municipality of Madrid reported the following experience of refusing to refer a PWUS to a geriatric residential service because he was an active injecting heroin user.

> "If I have a person who is 65 years old, and is on methadone treatment and who is entitled to a nursing home... I am very sorry, but you give me a place. And I think you have to fight just like someone with hypertension or someone with heart failure or someone with Alzheimer's. It doesn't make any difference to me. Look, if addiction is a chronic disease, then all the resources that are available for other diseases like hypertension or Alzheimer's, should also be available for PWUS, right?"
>
> MD. Experience in HR services. Community of Madrid.

Many of the PWUS who participated had a long history of substance use and were over the age of 45. When exploring the possible specific needs of this group, they did not feel identified and used responses that indicated a lack of future projection. Two of the female participants shared a history of European migration and a long period of homelessness. Both focused their responses exclusively on having stable housing in their places of origin.

CHEMSEX

People who practise chemsex were identified by the experts interviewed and by both groups of professionals as a priority for specific attention from the HR network. Of all the participating PWUS, only one woman knew about the phenomenon and reported never having practised chemsex.

The condition of vulnerability was described based on the identification of different inequalities resulting from the intersections between being a person who has used drugs, having a sexual orientation and/or non-normative sexual practices, and low social class.

A professional from the LGTBIQ+ Sexual Health Care Network in Madrid indicated that she only works with HR services and/or programmes in the referral and coordination of cases of sex workers in a situation of homelessness, even so, she indicated: '*I can't contribute much, it's not the profile we work with, we support people with high income*.'

Professionals in Barcelona indicated that over the last four years they had noticed an increase in the number of people who engage in chemsex at their services and/or programmes, although they described them as a minority. They described this group as male sex workers who are homeless, who move between clients' homes and the streets, and who mainly use methamphetamine by inhalation and/or injection and heroin by inhalation and/or injection. They indicated that some women also come to their services and report chemsex practices. This last statement was echoed by the professional working in a non-mixed drop-in service, who added that she had observed GHB and popper use among this group of women. The use of inhalants and injections was also reported in this group.

In the rest of the country, there were no reports of this group accessing HR services and/or programmes.

The invisibility to which these people are subjected in public spaces and in HR services, due to the discrimination and violence they experience, was identified as oppression. Professionals suggested that they might occasionally be able to travel to large cities (Madrid, Barcelona, Vigo) from where they could access some kind of HR service and/or programme. A professional from a HR service in Catalonia compared the progress made in implementing the gender perspective with the implementation of new specific programmes for people who practise chemsex and made the following reflection.

> "How are we going to include the LGTBIQ population in harm reduction centres if the issue of women is not yet addressed?"
>
> Coordinator. Experience in HR Services. Catalonia.

Professionals agreed that identifying as a person who uses HR services and/or programmes means suffering a new oppression and consequently increasing discrimination and exposure to violence. As one professional from Barcelona described it, 'despite the fact that they use drugs, the same stigma makes this distinction: "I'm not going to go to an HR service because I don't think that's what I am".'

One professional interviewee suggested that the link between chemsex and harm reduction is not made through the usual service provision of the HR network, but through the night-time context.

> 'What we are seeing in the chemsex world are specific responses in the community and for the community that are able to respond to behaviours, substances, infrastructures, platforms, spaces, feelings, cultures that harm reduction itself often cannot. Sometimes it is not seen as harm reduction as such, but on the other hand it is harm reduction in the sense that it retains the principles and has evolved in that way. But they are two different forms of harm reduction, sometimes recognised and sometimes not."
>
> European Drug Policy Expert.

In Spain, this type of intervention is mostly provided by agencies that focus on risk reduction. These types of interventions are not identified with stigmatised substance use, and access to them offers greater security in terms of exposure to violence and discrimination than the formal HR network. This scenario was confirmed by a participating professional who reported that the most popular HR programme is drug checking.

Another aspect that several professionals highlighted was the number and characteristics of sexual assaults that occur during the practice of chemsex, which they had recently discovered, the difficulties that victims

have in recognising the violence, the questioning that victims receive because they are under the influence of the substance, and the lack of protection offered by the violence support network. The professional from the HR residential centre in Barcelona stated that on some occasions she has covered the seats reserved for the protection of serious violence victims, with men, sex workers, in a street situation linked to the HR services, who had suffered aggression during chemsex by another man with similar characteristics.

MEN, YOUNG PEOPLE, MIGRANTS AND HOMELESSNESS

Male PWUS of Magrebian origin, homeless and in an irregular administrative situation were described by the experts interviewed, the groups of professionals involved and the PWUS group, as a priority group in the attention provided by the HR services. The participating professionals from Catalonia added that in many cases, these are also people who have been taken into care by the Directorate General for Childcare and Adolescence (DGAIA). All participants agreed that these people mainly use inhalants, alcohol, psychotropic drugs (benzodiazepines and/or pregabalin) and/or cannabis in very high doses. They pointed out that the use of these substances is due to their easy accessibility in terms of legality and price.

The condition of vulnerability was described based on the identification of various inequalities resulting from the intersections of being a substance user, a non-white male, a migrant and belonging to a lower social class. Language is a further axis of oppression in this case.

Professionals with experience in child protection and harm reduction services described how, in addition to the experience of discrimination that these people experience, they are influenced by a collective social imaginary that directly associates them with crime. They described how they tend to have no affective or family network in the territory, their support network being family bond (aunts, cousins, neighbours) and/or their peers. They agreed that the process of migration and displacement was usually a traumatic experience, '*where they even saw people die*,' motivated by expectations that did not correspond to the reality they encountered, and '*being very confused about how this new system works*.' Substance use is an element of concealment from family and peers, with a self-medication of post-traumatic stress function.

A professional with many years' experience in the field of HR recounted her experience as a social educator in a first reception centre, believing that this approach could respond to 'it seems that because they are minors we don't want to see it [related to substance use], because if we admit it, we already have a problem and we don't know what to do there.' She also pointed out that the first experience these young people have as PWUS is of prohibition and punishment.

> "If anything related to consumption is used either in the centre or in an external educational activity... that's already a reason for withholding their pay... That is to say, consumption is very much sanctioned from an educational point of view and, well, I think it creates a lot of unease in the teams."
>
> Social Educator. Experience in HR Services and Child and Adolescent Protection Services. Catalonia and Canary Islands.

Professionals described how, after this experience of punishment, contact with any drug-related treatment service is associated (or not) with alternative punitive measures. A 42-year-old male participant with similar characteristics to those of this community group stated that, in his opinion, most of these young people are not aware of the existence of the HR network and cannot imagine it.

Some professionals reported that there was a debate in the HR services where they worked on whether this group of PWUS had the characteristics to access the resource. One professional indicated that it had been decided in his service that this group could not access the primary care service unless they could demonstrate that they were inhaling heroin and/or cocaine. The main reason for this decision was to protect them from a 'dangerous environment where people are problematic users.'

Female PWUS who participated in the research reported that they felt discriminated against as a group within HR services. One of them said: '*They are very racist towards junkies, they don't realise that they are also drug addicts because they take pills, because they drink...*'

All participating professionals agreed that the HR model can provide answers to their needs according to the characteristics mentioned, although they pointed out that in order to provide specific attention, the intercultural perspective should be included.

> "This is where a strong commitment should be made and the transcultural issue should be mainstreamed. We are not just going to talk about drugs, we are going to talk about everything that is part of harm reduction. We need to rethink the services, how white our resources are, how many references we have to other cultures, even in our environment."
>
> Social Educator. Basque Country. Experience in Child Protection and HR Services.

4.3. PATTERN OF SUBSTANCE USE

SUBSTANCES

In the focus group with female PWUS in Barcelona, the following substances were mentioned; in brackets is the frequency with which they appeared in the common discourse. It was decided to include the different types of benzodiazepines and pregabalin in the category of psychotropic drugs, and methadone was counted as a substance if its use was not related to treatment. The result was: cocaine (73), alcohol (57), psychotropic drugs (54), heroin (31), methamphetamine (17), mephedrone (10), cannabis (10), solvents (4) and methadone (2).

On several occasions, professionals reflected on the existence of a socially accepted hierarchy of the dangerousness of substances, with illegal substances (heroin, cocaine, methamphetamine) at the top, followed by substances that are regulated in some areas (cannabis) and then legal substances (alcohol, psychotropic drugs, solvents). They felt that this scale did not correspond to the harm observed among the people associated with the services and/or programmes in which they work, and therefore reproduced a scale of discrimination. The participating PWUS identified alcohol as the most harmful substance in relation to their health and social situation. In the PWUS' accounts, self-stigma was more prevalent among opiate users.

COCAINE

The analysis of discourses indicates that cocaine is the substance most commonly used by people in contact with HR services and programmes. All the areas represented by the participating professionals reported that cocaine base is mainly used by inhalation. In the case of Barcelona, it was stated that historically the injecting route was the most common in this population, but in recent years there has been a notable increase in the use of cocaine base by inhalation. The evidence of an increase in the number of low-dose cocaine base outlets in recent years was mentioned as an indicator.

PWUS and professionals agreed that they are not aware of any points of sale where crack cocaine can be purchased directly, as it is common practice for the dealer to transform cocaine hydrochloride into cocaine base. In all participating areas, ammonia was reported to be used for this transformation, except in Barcelona, where bicarbonate was also mentioned. Some professionals in this city informed that they run specific training workshops for PWUS on the use of bicarbonate as a HR strategy.

PWUS agreed that it is difficult for them to access the substance without high levels of adulterants, and that it is essential to establish a relationship of trust with the dealer. In both Barcelona and Seville, they agreed that the usual points of sale they access are *narcopisos* (drughouses) or people who travel by scooter to a fixed meeting point.

All participating PWUS who use cocaine (in any form) reported that they also use other substances such as alcohol, cannabis and/or heroin. Most also reported being in a methadone maintenance programme.

As aspects of concern for PWUS, they pointed out that 'paranoia' is common after long-term use of the substance, and they called for professional aftercare. As protection strategies, they highlighted seeking quiet places, outdoors, with little noise and in the company of a few trusted people.

ALCOHOL

Alcohol and its approach in HR programmes and/or services was identified as an area of interest and improvement by professionals participating in this research. They indicated that the social normalisation of its use, together with the low perception of risk associated with the oral route, makes it invisible to people who use other substances and/or higher risk routes of administration, such as inhalation or injection.

All professionals agreed that since the COVID-19 pandemic they have seen an increase in alcohol use among PWUS of their services and/or HR programmes. They pointed to difficulties in accessing illicit substances, which may have occurred during the period of incarceration, as a possible reason.

PWUS indicated that they use this substance when they do not have sufficient economic resources to access other more expensive depressants, and reported that the greatest discrimination associated with alcohol use occurs when they are not denied access to local bars.

They noted that alcohol intoxication was a cause for concern, posing a higher risk than other substances, and the lack of self-regulation strategies. Several PWUS reported experiences of self-medicating with alcohol to manage opioid withdrawal. All participating PWUS agreed that alcohol is a substance that increases violent behaviour. The following dialogue excerpt from the focus group of female PWUS illustrates this.

> Q: I get aggressive with alcohol, my head works in a way that I insult, but I don't know who I have in front of me... and the next day I don't remember. That's why I prefer to stop drinking.
>
> C: EAlcohol is the worst. I don't even drink one beer.
>
> M: Alcohol changes people... it changes their voice, they talk to you differently, they express themselves differently... when someone drinks alcohol I pick it up quickly... I know that it's better not to mess with that person.

The reality observed among female alcohol users was described by professionals as differentiated. They pointed out that in heterosexual couples where both partners use substances, the woman's alcohol use increases when the relationship ends. This change in the pattern of substance use was linked to the reduction of exposure to risky or violent situations associated with the use of illicit substances (reducing economic costs and avoiding access to high-risk outlets) and to the need for social acceptance.

Several professionals agreed that they had observed that women who use alcohol and who have some level of homelessness (unstable, substandard housing or shelter) come to the HR network after being evicted or fleeing from their 'home' because of severe gender-based violence. The identification of these situations was pointed out as the main reason for the existence of a hidden community for HR hypothesis, made up of this particular group of women. It was also added that these women show an increase in alcohol consumption after the episode of male violence (a potentially traumatic event) and in potentially re-traumatising situations.

Professionals also indicated that they had identified another differential population group in relation to alcohol, namely people over 50 years of age. They reported that these are people who move from regular use of illicit substances to regular use of alcohol only, linking this event to the greater accessibility and legality of the substance.

PSYCHOTROPIC DRUGS

The description of the use of benzodiazepines and pregabalin by people involved in HR programmes and/or services was reported by all professionals involved in this research. For benzodiazepines, clonazepam (trade name *Rivotril*), clorazepate (trade name *Tranxilium*) and alprazolam (trade name *Trankimazin*) were mentioned. Pregabalin was always referred to by its trade name in Spain (*Lyrica*).

The participating professionals and PWUS pointed out that the misuse of psychotropic drugs (with or without a prescription) has always been present in the pattern of substance use of people linked to HR, although they have observed an increase in the number of people and in the use of these substances since the COVID-19 pandemic. PWUS reported two patterns of use: 1) having the prescribed drug and not following the guidelines set by their doctor; 2) acquiring the drug on the illicit market. Both scenarios were identified as being directly influenced by the restrictions on prescribing by doctors, despite the fact that access to the drug is easy. One PWUS reported that ten years ago in Barcelona the most widely available drug was *flunitrazepam* (trade name *Rohypnol*, popularly known in Spain as *Reinoles*), then clorazepate was introduced, followed by alprazolam and then clonazepam. He noted that pregabalin became available the year before the pandemic.

Despite this widespread and normalised use, PWUS expressed concern about the emergence of new drugs on the illicit market and reported experiences of intoxication that were difficult to manage. Professionals currently working in the Spanish System of Health Accounts warned of an increase in the number of intoxications treated in the last two years and of the complications that arise when the person has also used alcohol and/or heroin.

Professionals linked the increase in the use of these substances to their legality, the low perception of risk associated with pharmacological prescription, the low cost on the illicit market and the normalisation of their use in the general population (non-stigmatised substance).

The reality of women who use these drugs was described as being very similar to that of women who use alcohol and have a home. Professionals agreed that this is a community group that is even more hidden from the HR, that they do not observe this group identifying themselves as users of psychoactive substances, although they observe parallels in patterns of use with people linked to the HR, and that they note an increase in use after being victims of gender-based violence.

Professionals agreed that they currently observe a pattern of use of clonazepam and pregabalin in combination with alcohol and/or cannabis among men, young people, and migrants in a situation of homelessness. Some governmental HR services and/or programmes already provide them with care and support, while others raise discrepancies about the need for specialised care. Professionals emphasised that these people may also be adding inhaled cocaine to their consumption.

They also pointed out that people who have experienced situations of deprivation of liberty (admission to juvenile or adult prisons and/or detention centres for foreigners)

have higher levels of use. Some professionals pointed out that in the case of such admissions, there is a tendency to prescribe pharmacological guidelines aimed at containment. In the case of people who are admitted several times during their stay at liberty, they reported difficulties in maintaining abstinence guidelines and resorting to supplementing guidelines from the illicit market.

HEROIN

The use of heroin by injection, which prompted the start of the HR in Spain, was described by most professionals as '*residual*'. The majority of areas reported that those who now use it, mainly use the inhalation route, with the aim of compensating for the undesirable effects of stimulant use, and added that this pattern of use is followed by the majority of people currently accessing the methadone maintenance programme.

Professionals from Vigo and Barcelona pointed to the detection of inhaled heroin use among people who engage in chemsex as a strategy to compensate for the undesirable effects of stimulant use.

METHAMPHETAMINE

Participants in Barcelona and Madrid reported the emergence and steady increase of methamphetamine use in recent years. In the case of Barcelona, professionals reported the identification of two contexts of use of the substance.

HR services and/or programmes indicated that people who use methamphetamine have different characteristics (young people in poor housing situations, greater presence of women and LGTBIQ+ groups, use associated with sex work and chemsex in urban areas traditionally used for cruising) compared with people who use heroin and/or cocaine, and that it is mainly used by inhalation (although it is also reported to be used by injection). The increase in psychotic episodes requiring admission to hospital emergency departments associated with continued substance use was reported as a concern. Professionals pointed out that in the last year, teams have been specifically trained to deal with this substance use pattern and interdisciplinary working groups have been set up with the presence of the Public Administration.

Professionals linked to sexual health organisations in Barcelona and Madrid identified another context of methamphetamine use related to people who practise chemsex. They reported an increase in the use of injecting drugs (slam) in recent years, an increase in psychotic symptoms among this group of people and an increase in the number of places where they knew people were using the substance. The professionals involved warned that they have found that PWUS describe the transition to injecting as a one-off experience that is then maintained as a habit.

All the PWUS in Barcelona were familiar with the substance and had tried it in the past. They agreed that the positive effects were a reduction in tiredness, sleep, hunger and pain, and the negative effects were the appearance of ideas of danger and persecution. They all agreed that they had not noticed any increase in sexual thoughts and/or practices associated with the use of the substance. One of the women described her experience as follows.

> "I started with methamphetamine 6 years ago and it was fucking great, two hits and you were flying. And that's all you needed. You knew everything. There are many effects, many ways of doing it, quite a ritual, a lot of people use it because it concentrates you. Someone says that for sexual activity... It doesn't make me horny. Well, it takes away the other needs of the body: thirst, sleep, hunger... I would spend the night with the same beer in my hand and at noon it was still in my hand... What an outrage! Up, down, very good. Now it's not like that."
>
> Female. Linked to HR Services. Catalonia.

MEPHEDRONE, GHB AND GHL

Participating professionals linked to sexual health services in LGTBIQ+ groups in Madrid identified mephedrone as another emerging substance in recent years. They reported its use in combination with GHB, GBL and/or methamphetamine.

There was agreement that people who use mephedrone and are linked to sexual health services and/or programmes are concerned about GHB and/or GHL intoxication occurring during chemsex sessions, where the effects of mephedrone previously mask the overdose of GHB and/or GHL.

CANNABIS AND SOLVENTS

Cannabis and solvents were the only substances mentioned by the professionals participating in the study as common in the patterns of use of young male migrants in a situation of homelessness. A professional with extensive experience in first reception services for migrant minors pointed out that the use of solvents is occasional for the majority of these young people, noting that this is a social imaginary constructed by the media that does not correspond to the usual reality of this population.

From the testimonies of the participating PWUS, the perception of cannabis is that it is a regular substance with little impact on their health and that its use is socially accepted.

METHADONE

PWUS reported using methadone as a psychoactive substance, regardless of any prescribed treatment regimen. None of the participants reported that it was or had been a regular substance in their pattern of use. They emphasised that in most cases it is used to compensate for the negative effects associated with the use of stimulants, especially cocaine.

They reported the existence of an illicit market for access to the substance, which is cheap and can be bought from other PWUS or from outlets such as *narcopisos*.

ROUTES OF ADMINISTRATION

In the previous section, it was noted that the PWUS and professionals interviewed reported a hierarchisation of the dangerousness of substances. It was found that the same pattern of hierarchy was reproduced in relation to routes of administration. The routes of administration mentioned and discussed were inhalation and injection. None of the participants mentioned any element of attention or improvement related to the use of the oral or snorting routes.

INHALED ROUTE

The inhaled route was considered by the participating professionals and PWUS to be the most common among those involved in HR services and/or programmes, except from Barcelona, where they reported that the use of the inhaled route was on a par with the injected route.

Professionals emphasised that, for the time being, the use of this route does not cause alarm or social rejection, and consequently PWUS experience fewer episodes of discrimination from the community. Professionals linked to administrative bodies pointed out that the strategies used to date to identify areas of use, which were valid for the use of the injected route, were not applicable to the use of the inhaled route and needed to be revised. The following extract from a professional's report describes the current experience in Catalonia, where the increase in inhalation use, the decrease in injecting use and the new challenges of community care can be observed.

> "We have areas where we no longer find syringes, we no longer see people using on the streets, or if you see someone, they are smoking. Well, finding silver paper on the ground doesn't raise the same social alarm as finding syringes. I would say that's one of the things that changes and challenges us, it doesn't set off the same alarms. Here we might think that it is more difficult for us to detect in certain areas and at different levels of response. Because the intervention for injecting drug use can start with the provision of material, it is something very simple, but the needs of inhaling drug use, even if it includes paraphernalia, are not so much reduced to that, are they? Here, too, our path and our tools are not as mature as we would be in the case of injecting."
>
> Technical professional in the Public Administration. Catalonia.

All participating regions agreed that the main inhaled substances used by people in contact with HR services and/or programmes were cocaine, heroin and, in the case of Barcelona and Madrid, methamphetamine.

Only professionals in Barcelona, Lleida and Bilbao reported specific HR services and/or programmes for the inhaled route. A professional from Barcelona, with years of experience in outreach work and gender, highlighted the experience of one service in her city in developing specific paraphernalia for the inhaled route, although she clarified that in her view this was an experience that was not specific to the inhaled route.

> "For example, at CAS Baluard [Barcelona] many years ago, prototypes of pipes were tested with the direct participation of the PWUS - it was essential to distribute pipes and design programmes in a participatory way. Of course, with the presence of professionals who could contribute the data that would make this material reduce the damage caused by the use of the inhaled route. But I see it as the "Baluard Island" when we talk about the inhaled route. But we still need a lot of training and acceptance that this is now the normal way of using. It's difficult, sometimes we get stuck."
>
> Social educator. Experience in HR services. Catalonia.

Professionals agreed that most HR services (methadone maintenance programmes, syringe exchange programmes, SCS, drop-in centres, outreach teams, etc.) were designed to respond to an initially hegemonic group (men who inject opiates without meeting their basic needs). Therefore, the inclusion of HR services and/or programmes related to the inhalation route with a gender and/or transcultural perspective, as well as the need for specific training for HR professional teams, were identified as elements for improvement.

PWUS indicated that they observe an inequality in HR programmes between injecting and inhaling substance users.

INJECTION ROUTES

As shown in the previous section, injecting among those in contact with HR services and/or programmes is reported as 'localised' in most territories, with the exception of Catalonia, where prevalence has remained stable over the last decade. This route of administration is considered by both PWUS and professionals to be the one with the highest number of associated harms.

From the PWUS' accounts, it is clear that injecting substance use is directly linked to addiction, a poorer external image and being the victim of discrimination. One of the participants described her experience of self-stigma: *'It's a way of getting high that you don't want anyone to see or know about... it makes you feel ashamed.'*

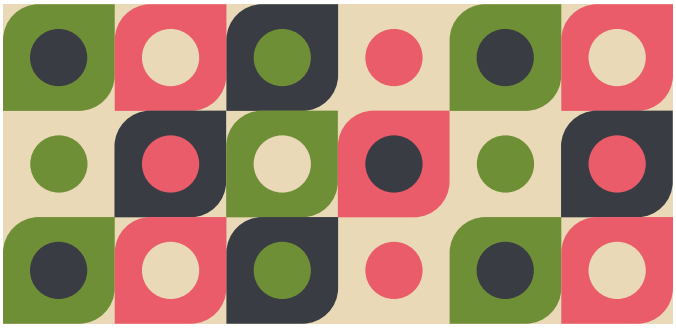
Only professionals working in LGBTBIQ+ sexual health services and/or programmes reported an increase in the use of slam among those they worked with.

> "In 2016, maybe 15-20% of our users were slamming, and in 2021 it's 80%. And not all of them will have a problem, but they have tried it. So not actively using by injecting, but "yeah I've tried it. Yeah, I do it occasionally, I'm starting to do it more... it scares me, I've been doing it every weekend since I tried it a year ago". We are definitely seeing that."
>
> Psychologist. Experience in LGTBIQ+ Sexual Health Services. Madrid and Ourense.

Professionals linked to Catalonia's public administration agreed with this report, stating that after the discovery of chemsex practices, '*10% of organisations asked us for syringes, after a year 30%, at the moment I think there are few organisations that don't have syringes to distribute. The number of syringes is increasing, it is undeniable.*'

CONTEXTS OF SUBSTANCE USE

All PWUS and professionals expressed different aspects according to the context in which people involved in HR services and/or programmes use substances. The following contexts were identified: Drug Consumption Room (DCR), At Home, *Narcopisos*, Public Spaces and Saunas.



DRUG CONSUMPTION ROOMS (DCRS)

Professionals in Madrid reported that in their area they are called 'harm reduction sites,' they are integrated into the emergency services (mixed and non-mixed) of the homelessness network and access is limited to people admitted to the alcohol maintenance programme. Professionals in Barcelona reported two similar experiences in homeless shelters, the main difference being that in Barcelona access is not restricted to those on the alcohol maintenance programme; the rest of the residents of the facility can also use it for occasional use.

DCRs aimed at inhaling and/or injecting were described by professionals from Catalonia and Bilbao. One of the professionals from Barcelona reported very good results from an experience of a DCR in a non-mixed service, where the design was carried out in a participatory way. Professionals linked to the rest of the DCRs pointed out that these devices do not allow the development of collective care strategies and promote vertical care relationships between professionals and PWUS.

PWUS described DCRs as a safer environment in terms of health and personal protection, highlighting the hygiene and disinfection of these rooms. In the case of DCRs for injection, PWUS emphasised the support provided for venipuncture, particularly for the use of stimulants, and the attention given to episodes of intoxication or overdose. The following is the experience of a woman who has used a DCR for more than 10 years and is a regular injecting cocaine user.

> "For example, I can't do it on the street, I don't have any veins, I need help. Every time I've tried it, I've destroyed myself.... here I can do it myself, but if I'm calm, if I'm with the professionals. I am with the professionals."
>
> Female. Linked to HR Services. Catalonia.

Nevertheless, PWUS and professionals who participated reported that extortion and/or theft between people was common, especially in DCRs with a large number of places. Furthermore, these large facilities were associated by PWUS and professionals with a greater presence of ambient noise, commotion and distrust towards other PWUS. The following extract corresponds to the experience of a professional who has also worked in a DCR for more than 10 years.

> "In a room of 12 people, there is extortion. It happens because the consumption rooms can't be that big... and they will tell you "that's the way it is" and I will tell you "then, we need more". You can't get that many people together. The professional part is also very small, we are all together. The thing is, either you open a really big room and then yes, or you set up a lot of small rooms. But not an overused mini-room. Of course, we're not going to close places of consumption for lack of space, but it's fatal for the PWUS."
>
> Social Educator. Experience in HR Services. Catalonia.

Female professionals indicated that these are very masculinised spaces that are hostile to women and non-binary people. Female PWUS indicated that the main barriers to access were related to the risk and the consequences of being identified as a mother who use substances. They prefer to consume at home if available. They identified as main barriers of adherence to this service the environmental noise, overcrowding of the device and professional stress.

These aspects are even more important in the case of stimulant use. Professionals in Barcelona reported difficulties in monitoring inhaled methamphetamine use in DCRs, which they attributed to the small size of the room, the high level of exposure to unfamiliar stimuli and the overcrowding of the service.

A woman who actively uses cocaine by the enjected and snorted route at a DCR in Barcelona reported the following experience.

> "Doing heroin is one thing, doing cocaine is very different. So heroin you can just shoot up and go, cocaine you need a moment... you get high for 15-20 minutes or so, you're in another world, you can't hear "go away..." Let me go, I can't go out anymore... I wish I was well, I would have gone by now. It cuts the high and you get very nervous."
>
> Female. Linked to HR. Catalonia.

HOME

At home was mentioned by PWUS as the context of choice for those who have a house and where DCRs are not available. All female PWUS agreed that in heterosexual relationships it is common for the woman to stay at home while the man goes out to buy the substance. They were very reluctant to accept this behaviour because it puts them in an inferior position and because of the multiple deceptions the man usually commits with the purchased dose. One woman illustrated her experience with the following story.

> 'The man takes the lead, *"You stay here, you'll be robbed, don't let anything happen to you, I'm going, I'm a man"*, then the woman is left behind. Unless you say, *"Where are you going, my friend, I'm going with you, I want to see what you're doing"*. But yes, the typical man is the one who gets dope and you do what he wants.'
>
> Female. Linked to HR services. Catalonia.

Professionals from HR and sexual health services and/or programmes working with people who engage in chemsex indicated that houses also functioned as a private meeting place where practices took place. They pointed out that these accommodations could be shared with a single person or in a group, and that meetings could be spontaneous or pre-arranged through the apps. They reported that sessions are sometimes segregated according to the route of administration of the substances to be used.

NARCOPISO

The participating professionals from Madrid, Barcelona, Seville, Vigo and Bilbao reported the use of this type of setting. Both professionals and PWUS were asked directly about the functioning of these places. Professionals call them '*narcopisos*', while PWUS distinguish between '*pisos*' (points of sale), '*fumadero*' (points of sale where the substance can also be used by inhalation) and '*chutadero*' (points of sale where the substance can also be used by injection). It was described that substance dealers who allow the use of substances indoors engage in extortion if the person decides to leave the place with the substance. A male PWUS described the following experience

> "There are security guards who look for minimum consumption, they are next to the guy who sells, because if you buy 2-3 grams and you leave, he warns the guy downstairs, and when you get to the exit... you already have 2 with the knife so you can give them the 2-3 grams. And if the guy upstairs is the one who told the other one at the door... you're already a victim..."
>
> Male. Linked to HR Services. Andalusia.

In the case of the city of Barcelona, participants reported that there had been several police interventions in recent years, reducing the number of available *chutaderos*, maintaining the number of *fumaderos* and increasing the number of *pisos*. In the case of Vigo, Seville and Bilbao, fewer police interventions were reported, making these contexts more stable.

The following common characteristics of the areas were described: degraded dwellings located in central neighbourhoods, squatted, activity of the space focused on the sale of illicit substances, inhabited by the workers of the business itself, each inhabitant assigned a function based on gender stereotypes (guarding, cleaning, selling, organising), poor hygienic conditions inside, scarce presence of female PWUS.

It was noted that the difference between these outlets and those in villages or lower-class neighbourhoods is that the former are more unstable and the people who work there are not directly part of the drug trafficking network, with the point being regularly supplied with substances by outsiders. They also indicated that there are squats inhabited by PWUS in a situation of homelessness, where small doses of substances can be acquired. In this case, the motivation for staying is to have a roof over their heads, not to sell or use substances. They reported that there is another type of housing used for sex work, where substances can also be acquired and used during sex work.

All participants agreed that cocaine, cocaine base, heroin, methadone, beer, tobacco and psychotropic drugs can be bought in *narcopisos*. They reported that in those where the use of substances is allowed, the person has a maximum time limit for consumption. In the specific case of Seville, slot machines are also available. Cash, sex (only for women), valuables or barter for odd jobs are accepted as payment. One PWUS described the following.

> You can pay with sex *"come on, I'll buy you a pipe or a beer and... then we'll go to that room together"*, giving them a mobile phone, or they say *"you do me a favour and I'll give you drugs. Bring this thing to that place."*
>
> Female. Linked to HR Services. Catalonia.

The most worrying element described by PWUS in this context was the risk of death associated with intoxication. A total of 12 different experiences of intoxication in a *narcopiso* were reported. On all occasions, the action described was the removal and abandonment of the intoxicated person in a public space. Participants also reported that the availability and administration of naloxone in opiate overdose care is dependent on the PWUS of the space themselves. The following are two experiences reported by participants, one in Barcelona and the other in Seville.

> I went with a friend to a smoking den, he had tachycardia and a heart attack. The same people who ruled the place took him and left him next to the rubbish bin... They took half the money...he died there."
>
> Male. Linked to HR services. Andalusia.

> The typical thing is that they come for the person who has overdosed and they take them away... but they leave them in the street and that's it, they don't even call the ambulance... I have seen it several times... it is something very bad, they leave them there..."
>
> Female. Linked to HR services. Catalonia.

The professionals pointed to the number of sexual assaults on women that take place in these spaces as an element of concern. The participants complemented this information by adding that sometimes the woman is kept in the house for a certain period of time. All participants agreed that these are not safe places for women and that they are always accompanied. One professional summed up the reality of female PWUS in the following way.

> 'In a *narcopiso* there is rape, there is coercion, there is kidnapping... it happens. This is what the women we see say, and it happens often, it is not an isolated incident. The police interventions are related to the trafficking, not to the violence that the people there suffer."
>
> Social Educator. Experience in HR Services. Catalonia.

PUBLIC SPACES

Participating professionals reported that public space is a common context for substance use by people involved in HR services and/or programmes. Those working in areas where there are no DCRs indicated that this is the only alternative available to homeless people who use substances, with the exception of the harm reduction shelters mentioned above. They described how this group tends to congregate and set up in places close to drug outlets with low foot traffic. A professional from Seville, linked to an HR drop-in centre, reported that '*here, under every bridge, there is a "chiringuito" - that is what they call it here - where you can buy, and there is a little corner where they go in and use*'.

Professionals and PWUS in cities with presence of DCRs indicated that another reason for the use of public space is a consequence of the limited time coverage of these services. One professional reported that in the neighbourhood with a DCR where she works, public spaces are regularly intervened for this reason, forcing PWUS to move to another nearby location.

> Here the waste ground phenomenon is booming because the DCR has limited opening hours. There is consumption, maybe not at 3am when there are fewer sales, but there is consumption at 12am or 1am. Before, people used to go to the railway tracks, but the ADIF fenced them off. They got tired of the photo of junkies using next to their tracks, and since they fenced them off, people are consuming in open spaces and in the parks in the neighbourhood. And so on. It's absurd."
>
> Coordinator. Experience in HR services. Catalonia.

The focus group of female PWUS in Barcelona felt that at night, when the SCS are closed, the public space is the safest place to use substances. They felt that in the event of an emergency, such as intoxication, the community is used to responding and activating an ambulance. However, they also qualified that the use of public space

is sometimes a choice, noting that the use of stimulants outdoors reduces the occurrence of negative effects.

Professionals from public services pointed out that, in both the Community of Madrid and Catalonia, there has been a reduction in the number of mandates to intervene in public spaces where groups of people using illicit substances are established.

In Barcelona, professionals reported that another context of substance use related to chemsex also occurs in public spaces. They agreed that in areas historically used for cruising, methamphetamine pipes and abandoned injecting paraphernalia can be found, as well as overnight stays by sex workers.

All the PWUS interviewed said that whatever the motivation for using public space, it is always a context in which a person has to hide from being seen by the community and protect themselves from the possibility of being intercepted by the police.

SAUNAS

Professionals currently working in sexual health services and/or programmes for LGTBIQ+ groups indicated that saunas are a context where people associated with HR services and/or programmes use substances. One professional reported difficulties in establishing common working lines with these venues, suggesting that there is a fear of making substance use visible inside and of the same being accused of allowing or facilitating drug trafficking.

Professionals reported experiences of PWUS who, due to the inaccessibility of materials, reuse methamphetamine pipes and/or syringes left in the rooms. One professional reported that in Andalusia, teams carrying out sexual health interventions in saunas reported an increase in the number of pipes and syringes found.

4.4. HR SERVICES AND/OR PROGRAMMES

Existing services and/or programmes in the territories, their functioning and aspects of review were discussed with all the research participants.

An analysis of the discourses shows that in Spain there are two models of services and/or programmes offering HR support. The first model offers professionalised services and/or programmes that are integrated into the health or homelessness network, and the second model offers community-based services and/or programmes that are not integrated into the network. A European harm reduction and drug policy expert described the Spanish scenario as follows.

> "There are many services within HR that could be brought more into the social sphere and out of the medicalised one. Thus, opening the doors a bit more towards the social for other people... Looking at HR in a wider way... Also linking with other non-institutionalised support networks... It is true that there are reduction centres that are super integrated into the networks, but it is also true that there are contexts and people where this is not going to be possible. We have to start by understanding what processes we are in now, so to understand who the people in the services are, and that maybe not all services need to be professionalised. Often, the professionalisation of services happens right in the middle of communities, disempowering them from their own resources."
>
> HR and European Drug Policy Expert.

This observation coincides with that of the majority of the participating professionals, who point to the need to review the care and support provided to the communities accessing the services and/or programmes, to those who are excluded, to new contexts and new substances that do not correspond to the initial scenario for which they were designed. All the professionals involved reported that the main strategy for accessing and adherence is to avoid the need for real identification of the people using the services and/or programmes.

They also agreed that all areas should have at least one 24/7 resource integrating NEP, DCR and outpatient crisis intervention for stimulant intoxication. This demand was shared by all participating PWUS.

THE PERSON'S FIRST ACCESS TO A HR SERVICE AND/OR PROGRAMME

The experience of accessing HR services and/or programmes for the first time was an issue discussed with the participating PWUS. Regardless of the HR approach, it is clear from their discourse that there is a real or symbolic individual expectation of abstinence and that access to the HR network is understood as a form of failure in the therapeutic process.

The majority of PWUS, regardless of the area, reported that their peers made them aware of the existence of this type of service and/or programme. Another PWUS who was already connected, accompanied many of them on the first day to the service. Only one participant discovered the service on her own through stereotypical observation of PWUS near the HR service.

On entering the facilities, all participants agreed that the first emotion they felt was one of shock, as they had never been in a place where the connection between people was so explicitly a condition of substance use. Despite this, many participants reported that once there, they knew people they had met beforehand. The only element of concern they mentioned was the possibility of becoming a victim of theft.

Most professionals reported that the first contact with the service involved an individual assessment, where basic personal, social and health information about the person was collected. Some services indicated that, as a recruitment strategy, they encourage this interview to take place at the person's first verbal request. One migrant woman gave a very positive assessment of her experience where the first professional contact was made in her mother tongue.

In the case of the first access to DCRs, some participants indicated that this was the first time they were informed about this specific service. All participants who had this experience agreed that the first emotion they felt was embarrassment at being observed by other people (PWUS and/or professionals) using substances. One woman described it as follows.

> It was the first place I had ever been where people were using. It got my attention because some of them went into the infirmary and I saw them coming out... it's a little bit of an impression at first. You think *"Fuck! What a party this is, isn't it?"* Then I went in and everybody was looking at me and I hadn't had a shot in a thousand years and that's why I went there... I was scared. I didn't speak. But when I saw that everyone was calm, I said *"Ah! Fuck the shame"*."
>
> Female. Barcelona. Linked to SCS, non-mixed HR service and HR Housing Support Service.

All the PWUS who participated, both in Seville and Barcelona, agreed that the professionals gave them confidence and that they did not feel judged for being PWUS.

The majority of participants agreed that their individual situation at the time was homelessness (being homeless or having inadequate housing), not being in a relationship and using substances.

HR SERVICES AND/OR PROGRAMMES AND GENDER

Existing HR services and/or programmes are mainly mixed, with the exception of some non-mixed facilities that show very good results. Most of the participating services reported experiences of gender mainstreaming through the implementation of non-mixed services, specific activities and workshops for women, women's groups and/or the inclusion of sexual and reproductive health care. Despite this specific approach to women, all professionals agreed that it is a long-term process. One of the participants, a European policy expert, described the current scenario as one in which it is essential to work with both men and women if social change is to take place.

> The women's issue has to do with the predisposition of the professionals, it has to do with the fact that they have this capacity, it has to do with the spaces that are created. There are spaces where a response is given, but the problem is not being responded to, but the problem is not being tackled either, because there is also a kind of social intervention that needs to be done, and you need common spaces where realities coincide."
>
> European Expert on Drug Policy and Homelessness.

Most professionals felt services and/or programmes as masculinised and hostile spaces for women, where gender mainstreaming is still a work in progress.

> 'And it is still a difficult approach, because even when we ask them "what do you need? what do you want?" there is no clear demand for action on our part.."
>
> MD. Bilbao. Experience in HR Services. Basque Country.

The lack of safe and confidential spaces within the service infrastructure is a concern for most of the participating professionals, especially when caring for women who are victims of a recent episode of gender-based violence, where the carer may also be a user of the service and/or programme. One professional shared her own experience of supporting women in different HR services.

> There is a need to create spaces where these conversations can take place. That you find them or create them, because we are even capable of making love out of dirt and finding a corner where we can cuddle up and have a quiet conversation. But what you see is the exact opposite, isn't it? They're totally hostile spaces, without a ray of natural light, tables that separate you from the person you're with, tables that separate you from the person... where you can talk about these things, where talking about these things really doesn't fit in."
>
> Social Educator. Experience in HR Services. Basque Country and Catalonia.

Barcelona was the only city reported to have a non-mixed HR service. All professionals and PWUS who had experience working in and with this resource reported very good results. Professionals added that it would be necessary to implement more services with these characteristics.

All the participating professionals pointed out that the approach to sexual health of PWUS has recently been integrated into the HR and highlighted some experiences such as: the inclusion of a gynaecologist in professional team, the inclusion of health agents, referral circuits and coordination with specific sexual and reproductive health services, the distribution of the contraceptive pill or PrEP. However, they also felt that this was a new aspect that needed to be addressed and that there was still a long way to go.

In relation to the inclusion of specific competences for the care and support of the LGTBIQ+ community, professionals indicated that few actions have been implemented in the majority of HR services and/or programmes.

HR SERVICES AND/OR PROGRAMMES AND COMMUNITY

The community was considered by the professionals to be an essential actor in HR and was described at the macro level as society in general, at the local level as a group of people living in the same area as the HR services and/or programmes (professionals working in primary care networks were included in this category), and at the psychosocial level as the family and direct environment of the PWUS.

Discrimination and the denial of human rights suffered by people because of their state of substance use was highlighted as an element of great concern, review and mobilisation by all the professionals who participated in this study. The following excerpt from one professional's account shows how structural factors were identified as possible related causes and empathy as a mechanism for social change.

> "There is still a moral that [people who use substances] are evil, that they do it because they want to.... This would be the case in certain cases where everything is determined by their choices. There is a lack of understanding that some people have social circumstances that are different from yours. This creates a problem. You have to be able to put yourself in the other person's position, in the position of someone who is rejected everywhere, who carries a stigma, with disastrous socio-familial and community circumstances..."
>
> MD. Experience in HR Services. Basque Country.

Professionals also pointed out that integration should be a mechanism in which it is not only the PWUS who makes the effort and succeeds in being accepted as a member of the community, but the community itself should act as an agent of integration. The following excerpt shows how a professional referred to the PWUS's participation in the community as a mechanism to reduce the professional assistance typical of accompanying people in situations of exclusion.

> "It is precisely when people feel that they belong to a community, when they feel that they are part of it, that levels of exclusion are reduced. It is then when it is possible for PWUS to reduce their self-stigma and to speak out because they are in a community and it is their own space. I think it is when you give them the opportunity to participate in the community sphere that the levels of assistance that we can achieve go down."
>
> Social Educator. Experience in HR services. Basque Country and Catalonia..

A European policy professional added that the community can weave support networks for socially excluded PWUS in areas where HR services and/or programmes are inaccessible, adding the idea of collectivising suffering as a mechanism for social change.

> "There is another set of support networks that are not always articulated at the moment. It is true that there are reduction centres that are super integrated in the care networks, but it is also true that the networks do not reach all parts of the person. For example, working with people from the neighbourhood, working with people from the local structures... understanding the things they don't have. We would all take a little break and it would open up the possibility of thinking together about how to move forward."
>
> European expert on drug policy and homelessness.

Nevertheless, professionals described how, in daily practice, the role actively played by the community tends to focus on issues of public order, which do not always focus on improving the quality of life of PWUS involved. Professionals from Bilbao and Barcelona mentioned experiences in which the community was the mobilising agent for the implementation of syringe collection programmes. One professional pointed out that the outcome indicators in the evaluation from the community side were the reduction of discarded contaminated material and the invisibility of the HR service in the daily life of the community. She herself paraphrased the voice of a community member who commented: '*It's really very good, you can't even tell you're there*'.

Professionals reported that the main responsibility for community information and awareness lies with the Community Intervention or Approximation teams. They indicated that these teams were born out of the need to catch people using public space as a place to use substances and to remove the syringes they might leave behind. They indicated that these teams were born out of the need to catch people using public space as a place to use substances and to remove the syringes they might leave behind. One professional shared the following reflection on the functions of this type of service in large cities, where several political, social and community processes can converge.

> In all outreach work there is a social control objective. It is always there. Always. There is a question of controlling what happens on the streets. Yes, there is an objective of reducing the impact of the dynamics of consumption on the streets, but often it is also to see, to cover up, to run away, so that nobody sees anything. So that the city looks beautiful and is consumable for the tourist. It is also the result of the process of gentrification of the city."
>
> Social Educator. Experience in HR Services. Catalonia.

Professionals from Madrid added that, at present, the main function of these teams is to detect PWUS in public spaces who are not in addiction treatment and/or not linked to homeless services, provide them with information about the existing network and accompany them to outpatient treatment centres. Professionals in Barcelona pointed out several times that the outreach teams linked to the services and/or programmes of the HR network do not consider people who use alcohol in public places as their target group.

The participating professionals linked to the LGTBIQ+ sexual health care network reported as good practice the peer approach to PWUS, which avoids the professionalisation of care.

Professionals highlighted that another common function of the outreach teams is to accompany PWUS to the primary care network services. The aim of this work is to accompany the person in their therapeutic process, although in many cases it also functions as a strategy to reduce discrimination against people who use substances.

HR SERVICES AND/OR PROGRAMMES IN RURAL AREAS

Professionals described HR services and/or programmes as being located in urban areas, which reflects territorial inequalities. They felt that extending the network to rural areas would pose difficulties in terms of prioritisation, the stigma associated with substance use in these settings and the consequences of being visible as a PWUS in the community. The following professional describes her experience in a small area.

> Consumption is totally criminalised, hidden and concealed... Yes, alcohol consumption is something that is visible, but other types of substances are something that is judged and they don't reach them. There is a huge barrier to access. The stigma, in a way I would link it to the affective and family aspects because I also believe that working on the stigma with the affective and family network could be improved and also that these families could be agents of change in their own community."
>
> Psychiatrist. Experience in HR and Mental Health Services. Canary Islands.

Some professionals also pointed out that it is the PWUS who move around the dealer points, which means that in small communities access to substances can be limited, as likewise can be the access to other LGTBIQ+ people. This logic was highlighted by professionals as a personnel strategy for people with problematic chemsex practices.

> Well, he'll probably have a hard time finding a HR service. But he will have one good thing, which is that in this rural environment it will be difficult for him to have access to sex, because people don't use apps as much or have to hide without a photo or the substances themselves. He'll be a bit restricted in that sense, and it'll allow him to regain a bit of control and maybe he'll be able to rest for a few weeks."
>
> Psychologist. Experience in Sexual Health Services. Community of Madrid and Galicia.

On the contrary, PWUS agreed that providing services in rural areas is a good strategy for normalising the use of illicit substances and reducing migration from villages to cities when patterns of use affect the rest of the individual environment.

> "You are afraid to come to light because of the people from the villages. So of course, if there were [HR] services, you would go. People wouldn't be so repressed. Because if you don't have to hide in the streets... You would feel more welcomed. In the villages when you are pointed out you feel more depressed, you don't go out there."
>
> Female. Linked to HR Services. Catalonia.

There were two territories (Vigo and Álava) that presented HR experiences in rural areas, dependent from HR drop-in services in the surrounding cities. They were similar in that they identified a community that they described as isolated, with a disorganised pattern of substance use and disconnected from the basic network of services. The approach developed in both experiences was to set up a multidisciplinary HR mobile unit, dependent on the HR drop-in service, to move around small communities, recruiting and linking with people with these characteristics.

HR SERVICES AND/OR PROGRAMMES AND HOMELESSNESS

Professionals indicated that the number of homeless people linked to HR services and/or programmes has increased exponentially over the last decade in urban areas across the country. At the same time, they noted an increase in emergency services (shelters) provided by local homeless networks.

Some professionals pointed out that administrative efforts in this regard seemed to be focused on public order issues rather than on improving the quality of life of people experiencing homelessness.

> "Everything responds to a logic of gentrification and to economic interests in which the city is offered as a consumable and attractive product. I think there is now a certain tendency towards a residential model, which I advocate and defend. But you can see that the interest of the Public Administration is once again to clean up the city and that these people are living in a space where they are not seen. Because accommodating long processes and permanent housing is very scarce. It seems that you have to earn your housing."
>
> Social Educator. Experience in HR services. Catalonia.

Despite this increase in the number of facilities, the participating professionals and PWUS agreed that, in most cases, they are not adapted to the people and behaviours of people who use substances. A PWUS participant from Seville shared his experience after his temporary stay in a shelter.

> "I don't like shelters. It's like being in prison. You can leave at 6am but at 1pm you have to be here....out at 4pm but in again at 8pm to eat your tray... and in between I have to make a living to consume. That's why I prefer the streets."
>
> Male. Seville. Linked to an HR Drop-in Service.

The participating professionals highlighted different national experiences with services aimed at providing (partial or complete) coverage for people who use substances. They reported that in Madrid there are 24/7 shelters with alcohol HR rooms (one of them non-mixed), that cover basic needs. Bilbao described a drop-in centre located next to the DCR. In Barcelona, three housing support services were reported: a mixed night shelter, mainly for people who use alcohol; a mixed housing support centre, also mainly for people who use alcohol; and a mixed HR housing support service, providing DCR for inhaling, injecting and alcohol. Good outcomes were reported for all these services.

The rest of the work with homeless people who use substances is carried out by the outreach teams and the HR drop-in services.

HR SERVICES AND/OR PROGRAMMES AND ALCOHOL

All respondents agreed that alcohol-related HR programmes and/or services were a pending task for the network, pointing to low risk perception as the main reason, possibly related to the normalisation of alcohol use. It was pointed out that in the case of people who also use other substances, the pattern of alcohol use is usually masked.

Professionals from Catalonia reported that the exclusion criteria for access to some HR services in this area include people who are mainly people who use alcohol. This condition was considered a priority for review.

Among the HR programmes and/or services specialised in this substance, the Alcohol Maintenance Programme implemented in a housing support HR service in Barcelona and the HR Alcohol Consumption Room implemented in emergency residential services (shelters) in Madrid were highlighted. Both experiences were described as working in a similar way, with the difference that in Madrid this service is offered as mixed and non-mixed services. A participating health professional described the functioning of this type of programme as follows.

> "The drink is bought by the centre and served on the facilities. The amount is fixed and agreed with the person. That's why we have to make an assessment taking into consideration the person's opinion, and depending on that, we calculate the standard drink that they are entitled to. In other words, they don't bring their drinks to have them inside. The drink is in the custody of the service and it is administered every hour, every half hour, or the way they have previously determined. The standard drink that are given are low alcoholic drinks, wine or beer, and never strong alcoholic drinks."
>
> MD. Experience in HR Services. Community of Madrid.

In Barcelona, the experience of an overnight shelter exclusively for people with alcohol problems in a situation of homelessness was also described.

Two models of addressing homelessness were observed:1) services belonging to the homelessness network supported by professionals from the addiction network (Madrid); 2) specialised services addressing homelessness and alcohol dependence simultaneously (Catalonia). No other alcohol-specific HR programmes and/or services were described that were not specifically targeted at people experiencing homelessness.

Experts from administrative services interviewed pointed out that harm reduction interventions related to alcohol use should be carried out by primary health care.

DROP-IN SERVICES AND COVERING BASIC NEEDS

The participating professionals used different nomenclatures depending on the area to refer to drop-in services, using terms such as '*Calor y Café*', 'emergency centres', 'local' or 'social space'. Sometimes this type of service was found to be integrated into the primary care network, the homelessness network, or community-based and funded by several government subsidies. All the areas represented in this research had such a service.

In all cases it was pointed out that they are located near fixed points of sale of illicit substances, where PWUS tend to congregate and where the need is. Some of these services have mobile units that move to remote neighbourhoods or communities with smaller communities.

Professionals described them as traditional, essential services that provide a basis for implementing HR strategies and/or programmes. Most of them provide emergency care: non-sectoralised care, completely free of charge and with immediate access. The services offered are similar in all areas and are common: provision of breakfast and snacks, showers, laundry, food delivery, clothing delivery, syringe exchange programme, safekeeping of documents and money, safekeeping and directly observed dispensing of medicines, individual social care, training and referral to the primary care network of social and health services. Some of these can be integrated into services that also provide DCRS, nursing, medical care and/or outreach work.

Professionals highlighted the impact of homelessness on the daily functioning of these services. They reported that it is mainly this group that accesses these services, with substance use sometimes linked to this condition. They described them as people who find themselves in a situation of social isolation and loneliness. PWUS and professionals stressed that the service usually acts as a reference point for the person concerned, for example by providing support when they are admitted to isolated services (hospitals, closed psychiatric units and/or prisons).

With regard to the facilities of the drop-in services, which are designed to meet basic needs, the professionals agreed that in most cases the dimensions of the spaces are inadequate for the volume of the population served, with a lack of ventilation and a precarious infrastructure for the activity carried out. One professional stated that '*the services are oversubscribed, there are more needs than resources, you feel bad when you are denying food or checking the shower times. It ceases to be an education of habits to become a rationalisation of resources*.'

Professionals reported the need to review and include internet access and power (charging devices) as basic needs at the present time. They pointed out that since the COVID-19 pandemic, a large number of administrative procedures are carried out exclusively via online. The lack of individual devices with internet access, as well as the lack of knowledge on how to use the technology, has a direct impact on the processes of the supported people and consequently increases the workload of the professionals.

PWUS who took part in the study reported very high levels of satisfaction with these services and with the professionals who work there. They described them as places of reparation and restoration of their dignity as subjects of rights. A male PWUS participant linked to a HR drop-in service in Seville shared his experience. It is noted that the service also acts as a gateway to abstinence-oriented therapeutic processes when the person, for some reason, resumes substance use.

> I came to this centre in 2003, then I did Proyecto Hombre and I left. I was clean for a long time, until I had a big relapse because of an illness that I didn't know how to deal with, and I crashed. I came back here, and being on the street, places like this are a blessing, places where you can get freshen up, where they look after you, where they can assist with some paperwork, places where they give you attention and care, and that's something to be grateful for."
>
> Male. Linked to HR Services. Andalusia.

PWUS were specifically asked for their views on including in HR support for people who are currently excluded from existing HR services and/or programmes. Although they recognised that these were people with similar needs, they were reluctant to share the same spaces.

NEEDLE EXCHANGE PROGRAMME (NEP)

NEP was identified by the professionals and PWUS involved as the starting point for the HR programme. It was described that currently areas such as Catalonia have developed a very extensive network that combines two models: permanent (integrated in HR services, addiction treatment centres, pharmacies and primary care emergency centres) and mobile services (through community intervention teams and mobile units). In the case of this network, professionals have indicated that its implementation was preceded by a demand from a logic of equalisation of basic rights for people who use substances in rural areas.

In other areas, where such an extensive network does not exist, the professionals involved warned that people linked to HR services who use substances would commute between communities, transporting contaminated injection material with the aim of disposing it in a NEP.

Buying injecting paraphernalia from pharmacies, whether or not they are part of NEP, was reported as a bad experience by PWUS. They all agreed that it is common to experience discrimination in these settings. They reported situations in which they were treated differently from the rest of the clients and situations in which the pharmacy refused to sell or distribute 10ml syringes. One woman reported the below experience in a city centre pharmacy.

> Pharmacies are very expensive, it is a lie that they give you syringes. They charge up to 80 cents. There are a lot of pharmacies near 'narcopisos' that don't give you syringes because they don't want junkies in there. And they only give you the big one. It's because of the clientele, the tourists, the foreigners, and of course if they see you with a needle, well, fuck... I think the tourists shy away, they leave and don't buy any more."
>
> Female. Linked to HR services. Catalonia.

Professionals and PWUS reported that survival strategies had been developed within the PWUS group itself, with some people taking on the role of vendors, supplying themselves with hygiene products and then selling them in areas or places where PWUS do not have access to this service. One PWUS described this as follows.

> There are people on the street who sell them for 1 euro. You can get them for 80 cents if they know you. They go around selling kits. In narcopisos" they give them to you, sometimes for free, sometimes for a fee. There are people who make a living out of it, but..."
>
> Female. Linked to HR Services. Catalonia.

The professionals from Barcelona explained that some NEPs have been implementing the distribution of hygienic paraphernalia for the inhalation route (pipes) for some years now, with very good results. Some professionals from outside Catalonia were not aware of this experience and were very positive about the universal implementation of the distribution of these materials in all NEPs nationwide. PWUS familiarise with this specific service reported the following experiences.

> The pipe was a great invention. I've never smoked in a bottle again. When it's closed [the service] there's no way of getting supplies. Sometimes I say, well, I'll inject it in because using the dirty bottle that is on the floor... I'm sorry, I can't do it anymore."
>
> Female. Linked to HR services. Catalonia.

All PWUS and professionals agreed that NEP should be a service available in all areas, with 24/7 coverage. PWUS

reported unhygienic practices and sharing of syringes when they do not have access to hygienic materials.

> “There are a lot of people who, because they don’t have syringes, will take anything. People rattling will get anxious and hysterical... they don’t care if you’ve shot yourself up before... they take whatever they can get their hands on and shoot up in it.”
>
> Female. Linked to HR services. Catalonia.

4.5. PROFESSIONALS

The description of the current situation of people working in HR services and/or programmes and the identification of elements for improvement were addressed in the semi-structured interviews with professionals and in the two focus groups of professionals. The PWUS' vision of the professionals working in HR services and/or programmes was also collected.

The professionals and experts agreed that HR is in a moment of generational change, and this aspect was seen as an opportunity for reflection and incorporation of new aspects. During one of the individual interviews, a professional expert described the current context as follows.

> "In HR you have people who have been doing this for 30 to 40 years, who feel burnt out nowadays, and then you have some 25 year olds. You have people who are 20 years ahead of us, who started building the whole thing when none of this existed! And they built a model that may be working better or worse now, but they built the capacity to respond. They did things that were unimaginable. And this is how it was done, a box of syringes and from there small action. Small action that has been taken to the institutional level. We have to understand that what these generational changes bring are very powerful questions that push the capacity to do a very cool revision. We need to have the capacity to listen. And then to share experiences. We don't need to reinvent everything."
>
> Sociologist. Experience in European HR policies. The Netherlands.

Most of the participating professionals reported that the work teams in which they worked consisted of social educators, social workers and psychologists. In the case of services providing health programmes, these included nursing assistants, nurses and MDs. Only one professional in Barcelona reported the presence of a psychiatrist MD in the service where she works.

Professionals identified the inclusion of a mental and sexual health approach in HR services and/or programmes as a priority. They considered it essential to have female psychiatrists trained in a gender perspective in DCRs, HR drop-in centres and housing services, as well as training in mental health in general in the teams, especially in dealing with traumatic events.

In relation to sexual and reproductive health, they highlighted the need for specific training in this area and the acquisition of LGTBIQ+ cultural competences. It was underlined that this need has become visible after the efforts made to include a gender perspective and the recent access to HR services and/or programmes for people who engage in chemsex. A sexual health professional in this group pointed out that sexual health training needs to be accompanied by awareness-raising and volunteering in order to be incorporated into daily practice.

> "It still depends on professionals being motivated, trained and willing to provide this [sexual health] care. There is a lot to learn. When we talk about sexuality, we also have to talk about general sexuality, one's sexuality... and that sometimes clashes at a professional level. We have to train ourselves and get used to talking about sexuality."
>
> Psychologist. Experience with sexual health in LGTBIQ+ groups. Galicia.

All respondents agreed that the field of HR was unknown to them prior to their first work experience in a service and/or programme of this kind. Although the administrative professionals pointed out that in some undergraduate curricula, such as nursing, a specific seminar on HR related to substance use is taught, none of the participating professionals reported having received such training during their undergraduate studies. They pointed out that this lack has a direct impact on professionals who, in addition to their normal duties, have to provide ongoing training to new staff. Nevertheless, all the participating professionals agreed that there are HR skills that are difficult to transfer. One professional described it as follows.

> "If HR was in universities, it would open up the possibility of providing adequate tools for more normative or institutionalised processes. But... it's not just a question of knowledge, it suddenly has to do with the way you feel, the way you live...The problem is that in the end it becomes this, they have no training and certain skills cannot be taught."
>
> Social Educator. Catalonia. Experience in HR and homelessness.

BURN-OUT

In both focus groups, where the participants were professionals, they were asked which functions were most related to professional burnout. In terms of professional categories, they agreed that there were no figures on which burnout had a greater impact. As one professional put it, 'Harm reduction is burnout, all functions are burnt out, you are a retaining wall on all fronts.' Aspects of this observation coincide with the view of a PWUS participant who had recently used a HR service. In his account, he relates the treatment he received related to the burnout of the professional team.

> "The feeling is that the professionals are tired... because they have been there for many years...they have been deceiving people....so...then you arrive for the first time and you see that they have no patience...but you can't think everybody is the same"
>
> Male. Seville. Linked to a HR service.

In both groups of professionals, it was highlighted that those in service and/or project coordination positions expressed that the burnout they suffered was different from that of the other professionals. They did not elaborate or give details.

All professionals agreed that a social class system is reproduced in the care and support of PWUS, in which HR is the lowest level. They expressed that this hierarchy operates on the same axis of inequality as the condition of being a substance user, with prevention or abstinence-based treatment receiving greater recognition.

They added that, beyond this moral scale, they saw HR as a discipline with a short history, whose scientific rigour, efficacy and effectiveness are questioned, and which requires constant external pedagogy. The impact of these circumstances was identified as a perceived **lack of credibility and lack of recognition** by other professionals in the field, by the rest of the basic networks and by the community. Professionals linked this to demotivation, isolation and burnout.

> "It is a constant battle to be able to refer someone, to sell the product, to justify a serious mental disorder when it is a personality disorder, nothing more... It is a constant battle against a wall. I also felt a stigma attached to me... this sounds strange... by my colleagues in psychiatry, a sense of disbelief, as if they didn't value HR, as if it was a matter of hippies..."
>
> Psychiatrist. Experience in HR and mental health. Catalonia.

> "When you explain to people close to you where you work, they see it as a place where nobody wants to work. Because of course we are talking about daily violence and low wages, so you are like an enlightened person who wants to save the world."
>
> Social worker. Linked to HR services. Catalonia.

Some professionals indicated that PWUS linked to the HR represent such a violation of human rights that their daily work of accompaniment is focused on the fight for the guarantee of these rights. **Barriers to articulation with the rest of the primary networks** were reported, centred on the lack of resources, the absence of specific circuits, and elements of discrimination and inequality towards PWUS.

Professionals indicated that in many cases these discriminations sometimes operate through the invalidation of professional judgement. All professionals linked these elements to burnout.

> "To be working and seeing yourself absolutely alone. People here seem to carry a sign that says '"fend by yourself", "with this severe mental disorder that is very difficult to manage, don't refer them." This is what happens when it comes to coordinating with primary care services or even your own managers. It's a question of "where are the few resources?" It sounds redundant to ask for resources, but it has to be said. It's a feeling of loneliness, i.e. "am I going into a bad circle, or is it that people here don't believe me, or do you just not give a damn about people?" And you have to live with that feeling of loneliness, but... you think about it and you say... the only thing that makes this case different from the other one is that they use drugs."
>
> Nurse. Experience in HR, homelessness and mental health services. Balearic Islands.

Some professionals pointed out that this historical restriction of access or subsequent exclusion of services from the primary care network on the basis of substance use status has led to the introduction of a culture of subsistence in HR services and/or programmes, based on '*either we do it or nobody else does it.*' This situation was also associated with waste. One professional described it as follows.

> The HR teams have to deal with several characteristics that you are often not prepared for, but you know that there is no alternative to dealing with them. In the end you learn that it can cause a lot of exhaustion."
>
> Social Educator. Linked to HR, gender and homelessness services. Catalonia.

Working conditions were an aspect that the professionals focused on several times. They described these poor conditions as non-covered occupational risks, low pay and unequal working conditions between different services and/or programmes within the state and municipal territory, even though they perform exactly the same tasks. The participants agreed that the elements of danger and risk to which they are exposed in their work are not properly assessed and consequently not included in the working conditions. They reported excessive exposure to violence and to the transmission of diseases, the latter being the most common, especially among professionals linked to services with DCRs.

All the professionals who got pregnant while working in HR services and/or programmes shared the difficulty of recognising the risks involved in carrying out their regular duties. One professional who left the HR network compared her experience with the working conditions of people working in prisons.

> The team was organised so that I could do as many tasks in the office as possible as opposed to nursing, to reduce conflict management... which I had to manage...I have had situations where they have pulled a knife on me being pregnant... If you work in the mental health section of a hospital you are sent home after week 13. And in prison you have security people everywhere, inmates are super-medicated... I think in terms of risks you are more exposed in HR... you need a good risk assessment, you can't be left to your fate."
>
> Nurse. Experience in HR. Catalonia.

Some female professionals reported difficulties in reconciling emotions in the private sphere; one of them, no longer working in the HR network but still linked to the addictions network, compared it to working in the emergency department of a hospital.

> You go from being a mother, using assertive, emotional, non-violent parenting all the time... to constant stress, which is like working in the emergency room, but you're badly paid, it's all boom-boom-boom... and on top of that violence and containment... it was already getting on my nerves, it didn't fit in with the personal life I had... and I decided to change."
>
> Psychologist. Experience in HR services. Catalonia.

None of the male professionals working in any of the HR services and/or programmes reported difficulties in reconciling fatherhood and work, nor did they report any specific gender-related risks. Most of the institutions were described by the professionals with adjectives such as '*degraded*' and '*hostile climate*.' These environmental characteristics of the institutions were also linked to poor working conditions, job instability and a lack of credibility on the part of HR management. One professional gave the following description.

> HR services are shitty. They give a feeling of lack of continuity, lack of dignity... they will be shutted down when the public administration wants. Like the mosques in the garages, that temporary sensation. In the summer it's so hot that you die, and in the winter it's cold. This dreariness goes hand in hand with the importance given to it by the public administration."
>
> Social Worker. Experience in HR services and social care services. Catalonia

The historical influence of charity and voluntarism in social care, the similarity of their daily human rights struggle to activism, the lack of academic and peer recognition, and the lack of knowledge of the HR model and approach by the public administration, other networks and professionals were also identified as associated factors. The main consequence they observed in relation to poor working conditions was burnout and the high staff turnover.

Despite the aspects discussed so far, **overexposure to violence** was identified by the participating professionals as the main element related to burnout. It is worth mentioning that one of the focus groups had to be interrupted since the facilities where she was at were attacked with a blank gun and the professional had to move to a safer place.

The services were described as masculinised places where the relational model is violence, with situations of

homophobia, transphobia and male chauvinist violence. Professionals pointed out that this relational model is an adaptive mechanism resulting from the multiple physical, psychological and structural violence suffered by PWUS, especially when they are in a situation of vulnerability and marginalisation. Moreover, they added that it is precisely in this aspect that they see the barrier to adherence for non-hegemonic communities. A professional with a long career in various HR services gave the following description.

> “These are places where there is a lot of violence, violence is present in everything. In the faces, in the bodies, in the interactions, when they go out and come back, in their ways of earning an income, in everything that happens to them, there is violence. They have to deal with a cruel reality.”
>
> Social Educator. Linked to HR services, homelessness and gender services. Catalonia..

This overexposure to violence was reported both within the services and in the community. A professional with long experience in outreach work gave the following account of conditions in the public space where she works on a daily basis..

> “They are environments with a lot of violence, a lot of consumption, where there is blood, where there is everything... always being in degraded places at that level... there is something that consumes you, that depletes you.”
>
> Social Educator. Experience in HR services, homelessness and child protection. Canary Islands.

Some professionals indicated that hearing and repeatedly receiving discriminatory messages towards PWUS from community members also had a direct impact on this burnout. Situations of questioning and discrediting of professional work (effectiveness, specific training) by the community were reported. One professional also reported being a victim of a hate crime on social networks after having carried out an intervention in a community centre in the city of Madrid.

Many of the participating professionals stated that they did not have security in the services; only 2 services in Barcelona reported otherwise. In these conditions, security depends on the public forces of law and order.

All participants reported bad experiences in emergency care in terms of police security. A professional from Seville shared the following experience, where both the handling of the violent conflict and the subsequent emotional management fell to the professional team. In this account we can see how the figure of external supervision is seen as a possible improvement in relation to the emotional impact on the professionals.

> “There are conflicts that are just as bad as having your facilities blown up, aren’t there? For example, we don’t have security, so if we call the police, we know it will take them three hours to get here. It’s crazy: you get all the people out, but the person making the mess is left alone. By the time the police get there, everything is destroyed. And so it goes, day after day, feeling exhausted until you forget. We need someone to give us energy and the right tools to get through those moments, because you come back home burnt out, which means you have no life for the day. If you add to that the fact that salaries are not enough, the system does not value you, everything goes to rent...”
>
> Social worker. Linked to the HR service. Seville.

The participating professionals also highlighted the differences in the degree of exposure to violence according to gender. In the case of male professionals, they noted that they observed a greater exposure of women to violence, as well as an exaggeration of gender stereotypes towards them. Some professionals reported developing gender-sensitive protection strategies, such as providing individual care accompanied by another

professional or avoiding wearing certain clothing at work. One professional described this difference in the following way, pointing to the peer care strategy as the main response to the lack of external supervision.

> “It is overexposure to violence and overexposure to the body, and what bodies? Because almost all of us here are women, and we know that this has a different impact. But not only the constant exposure to scenes of violence in which one can mediate or be directly involved, but also the lack of accompaniment and reception of all these experiences. It’s good that there seems to be more and more supervision, but there are many gaps... for example, the emotional impact of what we have experienced falls on our colleagues who have also accompanied us.”
>
> Social Educator. Experience in HR and gender services. Basque Country..

Some professionals reported experiences of violence in the work environment that required aftercare and psychological follow-up. The focus was on the fact that some of these situations may be linked to previous traumatic experiences of the individual or PWUS involved and may also have potentially traumatic characteristics.

> “Harm reduction has to talk about trauma. Our past traumas, of course, but also the traumas of our users and the traumas we may develop at work. One of the criteria for developing post-traumatic stress disorder is being exposed to painful and violent situations at work. So we need to talk about trauma, and not just talk about it, but understand it and deal with it in the people we work with, trauma and re-traumatisation”
>
> Psychologist. Experience in HR services and treatment. Catalonia.

This overexposure to violence was linked by professionals to increased social isolation and feelings of loneliness and frustration. As mentioned above, the main coping strategy they reported developing was peer support. They described that in most cases this support takes place outside of working hours because they do not have space for emotional release and venting during the working day. Some professionals reported the use of alcohol and other substances as a post-exposure stress reduction strategy. The following quote from a professional participant illustrates this as follows.

> “For example, the people who lived through it with you, what you experienced, the impact of the violence or the emotional effect.....I think that yes, you end up having a relationship with the people you work with, just to understand each other, to support each other. Sometimes alcohol is added as an accessible depressant after work.”
>
> Social Worker. Linked to HR and homelessness services. Catalonia.

Participating professionals indicated that the inclusion of case supervision from a technical perspective would improve professional practice, build referrals within services and allow the generation of expertise.

> “One of the things that struck me the most when I started working was the lack of external supervision, which for me is fundamental. So after the cases there could be a space where professionals could rate our positive and negative experiences and that there should be external supervision to make you see... at the end of the day, one of the things that causes the most burnout is the lack of an established framework for professional action.”
>
> MD. Linked to HR and primary are services. Catalonia.

They also emphasised that team support sessions should be integrated into the operational planning of harm reduction services and/or programmes. Some professionals from Catalonia and Galicia reported successful experiences with this type of support, and pointed out that the professional taking on this role should have training or experience in substance use, harm reduction and social exclusion.

5 RESULTS

The research findings are presented below in the same structure as the qualitative analysis. They are divided into five blocks: Harm Reduction, Communities, Substance Use Pattern, Services and Programmes, and Professionals.

HARM REDUCTION: MODEL AND HARMS

The Harm Reduction (HR) model, which has been applied in governmental drug policies since the end of the 1980s, was the first aspect discussed with the participants. The participating professionals stressed that, in contrast to previous policies based on the elimination of psychoactive substances, the definition of harm reduction proposed a pragmatic approach. This point is consistent with the literature (Romani 1989; Andreo et al, 2013; Klein 2020; Rovira 2018).

It highlighted the common idea that, after some time working in HR, professionals perceive that '*harm reduction is a philosophy of life*.' The participating professionals who are currently working in the primary care network emphasised that they still maintain the application of the HR model in terms of: reduction of discrimination that the people they care for may suffer, pragmatic goals and reduction of possible associated risk behaviours.

The bibliography consulted and the participants' accounts described the same initial context for the application of HR policies, programmes and services in Spain: the HIV/AIDS epidemic, a high presence of men who inject heroin, high associated morbidity and mortality, and a collective social imaginary of PWUS as lazy, delinquent and sick. It was observed that the self-identification of PWUS as sick is still in force as a result of the legacy of the application of the previous biomedical model and this social imaginary. In some cases, this condition was found to affect their self-esteem and motivation to change. This consideration was described by Romaní et al. (1989) as an element of concern, since the application of this biomedical theoretical framework meant that PWUS felt that the responsibility for '*curing the disease*' lay with the institutions, thus diminishing their condition as protagonists of change.

Professionals indicated that early HR services and/or programmes were designed to respond to the most visible population: male, white, Spanish, middle-aged, injecting heroin users. The invisibility of historically oppressed groups (e.g. women, non-native, youth or elderly) in these designs was identified as the main barrier to adapting services and/or programmes to meet the needs of the new context. They reported that they were currently observing the use of different substances, routes of administration and communities who did not have access to HR. Other barriers mentioned were the lack of contact with good practices already implemented at national or international level, the lack of specific training, the generation gap within the teams and the demotivation linked to burnout among professionals. In general terms, two suggestions for adapting HR services and/or programmes were described: making existing designs more flexible and increasing funds.

Of great concern was the finding that the term and meaning of '*harm reduction*' was unfamiliar to all the PWUS involved in this research. They intuitively decided that it must be related to reducing substance use.

The analysis showed that the use of DCRs could help people to understand that HR does not necessarily have abstinence as an end goal. All the people who had never used a DCRs associated the term harm reduction with support in reducing substance use, which differed from the previous group, as in that case the goal is always abstinence. It was also observed that people from countries with more prohibitionist policies were very positive about the state model, emphasising aspects of respect and freedom over their own substance use.

The legacy of the biomedical model was also evident in many PWUS participants who shared feelings of frustration and failure at being involved in HR services and/or programmes after failing to achieve abstinence goals in previous treatment pathways.

In general, it appears that people are currently accessing HR services and/or programmes after the failure of all other basic protection systems and/or after the failure of a previous process aimed at abstinence. This last aspect is contrary to the general definition of the HR model (Andreo et al. 2013), where the pillars (supply/demand reduction, prevention, harm reduction and treatment) are not presented as a linear sequence of processes, but as interventions that can be implemented simultaneously.

The need to incorporate a social justice approach to the HR model described in the literature (Pauly 2008; Brocato 2003; Young 2001) was also highlighted by the participating professionals. The human rights violations suffered by people as a result of their substance use were reported as an element of great concern. The intensity, oppression, violence and discrimination described indicate that this condition currently operates as an axis of inequality or intersection in the national territory.

These aspects of improvement described by academics were confirmed by the participating professionals, who pointed out that they perceive the HR as being in a moment of generational change, which needs to adapt to the new social processes that are taking place.

Nevertheless, the professionals indicated that there is a theoretical hierarchy within the HR, where the privileged status falls to those who use risk reduction services and/or programmes (RR). This differentiation between harm

and risk was described as uncomfortable by the participating professionals, indicating that it creates inequalities between PWUS and that the categories respond more to moral issues than to scientific evidence. This inequality appeared to increase the stigma attached to PWUS of harm reduction services and/or programmes.

As with the term harm reduction, participants were unaware of the existence of risk reduction. They intuitively stated that they were probably synonymous. This contribution is of particular interest as the professionals linked to the LGTBIQ+ sexual health network reported using the terms risk and harm reduction from a holistic approach, where the person may be engaging in risky behaviour in one aspect (substance use) and harmful behaviour in another (sexual practices) at the same time.

All professionals agreed that the difference in practice creates confusion for PWUS, who do not always have the information and knowledge to decide which specific network to approach.

In terms of the impact of this categorisation in the different intersections, it was highlighted that risks are mainly associated with young and middle/upper class people, while harms are associated with older and poor people. RR was highlighted as an effective strategy that provides an opportunity to accompany underage PWUS. No mention was made of whether women, migrants and/or racialized people have greater access to one network or another.

In terms of the harm currently being addressed by the HR network, professionals indicated that health was the main area of concern for those involved in the services and/or programmes. In all the areas represented, it was reported that optimal coverage is offered, articulated between the HR itself, the primary care network and the hospital emergency network.

However, within this dimension, it was noted that in recent years there has been a deterioration in the mental health of people who use drugs, associated with a lack of social protection (e.g. an increase in unresponsive homelessness) and an increase in the use of stimulants. Difficulties in coordination and articulation with the mental health network were reported, centred on the requirement for readiness and maintenance of abstinence processes, the diagnostic condition of severe mental disorder, the lack of a gender perspective in the symptomatology of post-traumatic stress related to being a victim of gender-based violence, and the lack of credibility in the diagnostic criteria of HR professionals. These difficulties could lead to discrimination against PWUS in general mental health care. The inclusion of psychiatrists and psychologists in HR teams and HR training for professionals in this network were seen as possible responses.

In the health dimension, there was a need to include sexual and reproductive health, especially in the case of female, trans and non-binary substance users. As well as orientations other than heterosexual.

The second area of greatest harm identified was related to housing. The increase in the number of people living on the streets nationwide, as described in the literature (Sales 2015; De Ines et al. 2017), was confirmed by PWUS and professionals. The second indicated that services are overwhelmed by the increase in this population and the lack of adequate responses.

Professionals in Madrid reported good results from emergency housing that included DCRs for alcohol harm reduction. In Barcelona, good results were also reported from a housing support service with a HR approach that includes three different DCRs. These experiences of integrating combined responses to homelessness and substance use with a HR model are consistent with what has been reported from other European countries (Kasper, 20-21) as good practice to be replicated by local policy makers.

It can be seen that the state of substance use among homeless people is an aspect that is invisible and minimised in counts, reports and research, despite the fact that professionals have indicated that it limits access to most existing housing services. This exclusion increases the already extreme vulnerability of these people, who are exposed to more violent situations than those who have a home. PWUS who had been living on the streets reported experiences of serious violence and difficulties in finding a place to complain (both because their stories are questioned and because it is difficult to identify the perpetrators).

PWUS and professionals questioned the effectiveness of the staircase model used by homeless service networks in most large cities. It was agreed that a common type of process had been identified, characterised by a cycle of long periods of living on the streets and short stays in emergency shelters. The inclusion of new alternatives such as the *Housing First* model with a HR approach and a gender perspective was proposed, especially for people who have lived on the streets for a long time.

The lack of a support and affective network was prioritised as the third harm with the greatest impact on people accessing HR services and/or programmes. The magnitude of the impact of this harm or its total lack was related to the different axes of inequality, with greater oppression felt by less privileged populations. White, local males appear to receive support from a member of the family network (particularly mothers). Functional relationships based on temporary housing, emergency financial support and food assistance were described.

Female PWUS were found to retain a member of the family network with whom they maintain a functional but also a supportive relationship, and they tend to form heterosexual couple relationships that oscillate between protection and aggression. PWUS with migrant origin were identified as the most vulnerable group, describing that the family nucleus tends to remain in the area of origin and that the new network in the area of arrival tends to consist mainly of peers. In addition, substance use may have started or increased after the migration process, becoming an unknown and/or hidden element to their network in the territory of origin.

Professionals emphasised that there is no tradition of working with families, pointing to the law on data protection and confidentiality as a reason for this, and claiming that there is a tendency to assume that the absence of a network means there is no network. However, it was emphasised that in emergency situations the HR network acts as a link between families and PWUS.

Both homelessness and social isolation were described as having a greater impact on people living in urban areas than on people living in rural areas. This difference was linked to the fact that in places with fewer inhabitants, despite being excluded, the person is still recognised as a member of the community and therefore benefits from different informal support structures.

All professionals were very concerned about the impact of violence and discrimination against PWUS. They identified experiences of structural, institutional, community, family and affective violence. All the participating PWUS expressed that they had recently been victims of violence and observed the development of protection and coping strategies based on survival.

It should be noted that HR services themselves are not safe spaces for people who use substances, as the system of relationships that operates is based on violence. In addition, they expressed particular concern about the violence suffered by women who are victims of gender-based violence at the hands of the protection system, which does not consider them as subjects with full rights, as it makes protection conditional on the abandonment of substance use.

COMMUNITIES

It was found that there is currently a community in the state territory that is the main beneficiary of HR services and/or programmes. These people were characterised as male, heterosexual, middle-aged, local, homeless, using alcohol, some psychotropic drug(s), cocaine and/or heroin by inhalation.

In the case of Catalonia, the number of people using the inhalation route was similar to those using the injection route, although the substances used were the same.

Applying an intersectional analysis, it was found that there is an axis of inequality within the population accessing HR services and/or programmes, with this group being the privileged one. At the other end of the axis are dimensions of oppression that vary in intensity depending on conditions such as being female, non-heterosexual, young or old, migrant, living on the streets, using other substances or other means of administration.

The classification of these categories responds to the same inequalities that are reproduced in other contexts due to the hegemonic application of prohibitionist, patriarchal and neoliberal models. Their validity provokes experiences of discrimination. On many occasions, the severity of the impact of this violence was particularly worrying to the participants due to the extreme vulnerability of the people involved, and the consequences were seen as a violation of human rights. This is consistent with what has been reported in the literature by Romo (2005) and Meroño (2019).

The most commonly identified condition of vulnerability was related to the gender axis, where women are always in an inferior position to men. Two oppressions became visible. The first was in the area of gender relations, where in heterosexual relationships the man is always in the position of power. Most of the participants pointed out that it is a common tendency to identify and react to gender-based violence only after extremely serious attacks (physical and sexual assaults, attempted murder, kidnapping). In addition, institutional violence against these women was noted, with access to protection services (sometimes essential for survival) being linked to therapeutic processes aimed at abstinence. Professionals highlighted the lack of specific training on gender-based violence and substance use, as well as the insensitivity of this basic network. They also pointed out that these women usually have histories of potentially traumatic events in which substance use plays a role that must be understood and integrated for optimal care. Faced with this serious violation of rights, the HR network is developing its own responses, such as the inclusion of emergency places in a housing support service or the implementation of non-mixed services where the victim's safety is guaranteed.

A second area of oppression identified was that of motherhood. As Altell (2022) describes, motherhood is one of the issues where the stigma suffered by female PWUS is most evident. Her approach is based on an essentialist view that the ability to bear children is inherent to femininity and that transgressing this norm is socially punished. In this case, the 'failure' of these women is to use substances. To this regard, a difference was observed in relation to male PWUS, which shows that this is a mandate that falls specifically on women. None of the participants reported the existence of specific responses to this perceived problem.

Participants pointed out that this is perhaps the main barrier to accessing HR services and/or programmes for this group, as HR ends up being non-punitive only for women who do not have children or who do not have the custody of their children.

A third area of oppression identified was housing. Women's homelessness is less visible, and homelessness policies have defined service portfolios and intervention methodologies that are better adapted to men's needs and lifestyles (Sales et al. 2017). Professionals pointed out that although the number of women connected to HR services and/or programmes in the city is lower than men, the majority of them are homeless. They confirmed that the homelessness network does not adapt to their needs, often forcing them to remain in precarious housing as the only alternative to the street. The HR network reported as a good practice the methodology of mainstreaming the gender perspective in a residential service in Barcelona, carried out with the advice of a professional expert in gender and substance use, who also supervises cases with a gender perspective.

In line with what has been reported by some authors, such as Altell (2022), Meroño (2019), the professionals stated that there are differences in the use of substances between women and men, such as motivations for the onset, meaning, types of substances, forms of use, associated health problems, impact on different areas of life and social punishment for not complying with the norm. The participating female PWUS did not agree with this statement, which may be related to the historical lack of a gender perspective in our society.

It has been widely described that gender mainstreaming is the best response to accompany differences and be able to reduce gender inequality (Altell, 20-22; Llort et al. 2013; Meroño, 2019; Romo, 2005; Sales and Guijarro, 2017). The participants reported that several efforts have been made through years to incorporate positive actions, such as non-mixed time slots, non-mixed individual or group care spaces, health workshops on specific topics, adaptation of internal regulations, training and involvement of professionals with specific competences. Despite the good results observed, they indicated that the main obstacles they identified to implementation were related to the fact that it was not always a priority of the daily activity of services and/or programmes, and that it was common to apply isolated interventions and a lack of transversality.

Another vulnerability identified was related to the age inequality axis, with younger or older people being ranked lower than middle-aged people. Looking at the intersection of age and substance use in the field of HR, the boundaries of discrimination would be under 18 and over 45.

The oppression of minors was described in terms of their inability to access the HR network. The participating professionals pointed out that there is no consistent argumentation around this rule, as the state reports on substance use record the age of onset at the adolescent stage, and the activity reports of outpatient centres mark the start of treatment at 18. This gap in care may be related to the dominance of the child protection model, which does not take a pragmatic approach to substance use.

In line with what was stated by Johnston et al. (2017), professionals reported that in all state territories they had identified a community made up of people over 45 years of age with a long history of substance use, currently using alcohol, heroin or cocaine by injection and/or inhalation, in an active situation of opioid substitution treatment, with a low social and family support network, who also present a state of health that is more deteriorated than the general population of the same age.

The first oppression was related to economic resources. People over the age of 65, who are equated with them in the literature in terms of health and social needs, would receive specific support and care from the elderly care network. The criteria for access to this network is mainly based on age, which is an unchangeable factor and therefore discriminates against this group of PWUS. One option available to them to meet these needs would be the private network. The professionals pointed out that their lack of financial resources makes it impossible for them to benefit from these services. Alternatively, they could depend on the family network to receive this care, although in most cases this network is not able to provide this care for various reasons.

Participating PWUS showed resistance to projecting themselves into this scenario, possibly mobilised by fear. Migrant women proposed a scenario with less substance use, which would allow them to return to their community of origin by settling in family properties.

This situation was described with concern by the professionals, who pointed out that it is the HR network that is taking on this work in a precarious way. It was expressed that, in the immediate future, there is a need for specific training for the professionals of the HR network on the elderly and addiction. In the medium term, professionals indicated that the elderly care network should include specific competences in dealing with PWUS, with the aim of preventing a future situation in which the use of substances again becomes a new condition for accessing care services.

The oppressions described above would be even more intense in the case of women who have different health problems and who are also socially obliged to be carers. These 45-year-old women are being punished for being in breach of the social norm of taking responsibility for

the care of their elders. If they are also mothers, they would be violating a double responsibility, as they are not considered 'qualified' to care for their children either.

It is also worth noting the greater oppression of migrants in an irregular administrative situation. This means that they cannot access financial benefits and are excluded from accessing the elder care network. As a result, their care and accompaniment is limited to emergency situations, where the health network takes over.

Another condition of vulnerability highlighted was related to the inequality axis of sexual orientation, with people who engage in chemsex as the main group affected. As indicated in the literature (Curto et al. 2020; PNS 2019 and 2020; Incera 2021; Ruiz-Robledillo 2021), in recent years there has been an increase in the number of people who practise chemsex in Spain, so as an increase in the use of injecting route, an increase in the number of people entering treatment and an increase in the incidence of sexually transmitted infections within this group. These indicators suggest that this is a population that is vulnerable to access and adhere to HR services and/or programmes. Nevertheless, only one female PWUS participant was aware of the existence of this phenomenon. On the other hand, participating professionals reported that in recent years they had noticed a slight increase in the number of people from this group to the HR services and/or programmes where they work. They linked access to HR with homelessness, pointing out that these were mainly men involved in sex work who combined periods of living in clients' homes with periods of living on the streets.

Contrary to most published reports on the characteristics of chemsex, participating professionals indicated that they had encountered non-heterosexual women in services who reported practising chemsex in sessions with men.

It was reported that there is currently a lot of discrimination against LGTBIQ+ people and/or people with non-normative gender expression in the HR network, and that openly showing their identity is a risk of violence. It is only in recent years that some services have started to include positive action for this group. Barriers to their inclusion were identified as a lack of training in specific skills related to the triad of addiction (substances, sex and apps), demotivation due to previous difficulties in implementing a gender perspective and a false sense (due to their invisibility) that the LGTBIQ+ population is a minority.

Professionals linked to the LGTBIQ+ sexual health network indicated that they mainly accompany people with medium to high economic resources who suffer structural violence because of their LGTBIQ+ status and who refuse to identify with problematic substance use.

Despite the fact that the strategies for accompanying substance use are very similar, these two options described above could be seen as the main reasons that hinder the articulation between the two networks. The short-term response proposed by all professionals involved was the implementation of services with a HR approach, specifically targeted and adapted to the chemsex community. It was noted that strategies historically developed by HR have good results for this group, such as peer support, substance analysis and direct contextual interventions.

Lastly, a final condition of vulnerability has been identified, combining the axes of inequality age and place of origin, which points to men which are young, migrant, homeless and in an irregular administrative situation as a group of particular concern. As the literature shows (Carrasco-Garrido et al. 2021; De Kock, 2020; Montserrat Boada 2021; Samy et al. 2022, Sarasa-Rene-do et al. 2015), migrant status is a category of oppression. If we add to this the fact that substance use is an axis of discrimination, the situation of this group should be of great concern.

The characteristics of substance use were described as differentiated, with a higher prevalence of easily accessible substances in high doses (alcohol and psychotropic drugs) and a higher number of intoxication episodes.

The description provided by professional participants is consistent with what has been reported in the literature: this group presents traumatic experiences related to the migration process, who may also have had previous traumatic experiences. In most cases, their families and networks of origin are unaware of their current substance use, the little contact they have had with institutions has been in the child protection system where substance use is punitive, they use substances as self-medication, they do not share symbolic language and meanings with the community, and they do not know how the HR network works.

Some professionals indicated that, despite the increase in the number of people within this group requesting access to HR services and/or programmes, they are not always allowed to do so. This situation could be linked to a paternalistic approach with a protective objective of professionals when dealing with these young people, but it could also be linked to the saturation of some services and the serious lack of specific transcultural competences in the HR teams.

It was also pointed out that the massive arrival of youth of migrant origin in recent years has made them visible as a group, although in the past they were linked to services and/or programmes without prior questioning. As a result of these experiences, the participating professionals concluded that the HR network offers facilities

that are suitable for their care and support, although it would be essential to increase the resources available.

PATTERNS OF CONSUMPTION

On the basis of three categories: substances, routes of administration and contexts of use, a diagnosis on the pattern of substance use was made by people in contact with HR services and/or programmes. Both PWUS and professionals pointed to the existence of a social hierarchy of substances according to their dangerousness, which does not correspond to the observed associated harms, but to the legal-illegal binomial. Professionals warned of the impact on PWUS' perceptions of risk. This observation by participants is a response to the impact that prohibitionist policies have had on Spanish society.

In all areas, cocaine inhalation was reported as the most common substance and form of use among those involved in the HR network. This information suggests that all those services and/or programmes that were originally designed to work with people who use cocaine though the injected route should have been adapted in terms of methodology and services. From participants' accounts, it is clear that this adaptation has not been standardised, particularly in terms of facilities and professional training. Only injecting cocaine use was reported as common in Barcelona.

With regard to cocaine base, PWUS reported that in recent years the market has adapted to an increasing demand by multiplying the number of dealer points where it can be purchased directly. They agreed that it is a substance that requires reliable sellers to avoid highly adulterated doses. They pointed out that ammonia is the main substance used to transform it into base, with the exception of the city of Barcelona, where sodium bicarbonate is also used. Its use is combined with other psychoactive substances.

PWUS asked for accompaniment after using the substance, and reported the usual occurrence of undesirable symptoms such as paranoia, persecutory thoughts and/or parasitic delusions. The development of protective strategies was observed, such as the use of open, quiet spaces and being accompanied by someone they trust.

The prevalence of the use of alcohol and psychotropic drugs (clonazepam, clorazepate, alprazolam and pregabalin) in the population linked to the HR network was reported as an element of concern by all research participants. All had noted an increase in their use following the COVID-19 pandemic.

PWUS regularly highlighted the use of alcohol in combination with other substances, their concerns about the lack of self-regulation strategies, the fear of harm associated with intoxication and the use of self-medication in the management of opiate withdrawal.

Some professionals indicated that some HR services and/or programmes (drop-in services, DCRs, outreach work) have a policy of excluding people whose main substance of use is alcohol from their accompaniment, even when they are in a situation of extreme vulnerability. They found this element uncomfortable and unjustified, and hypothesised that it could be related both to the effects of the prohibitionist model and to a lack of resources. All the participants suggested that it should be reviewed and that this group should be included in the HR network.

An increase in the use of both alcohol and these substances was reported among women after the end of their relationship. In general, many of the women involved in the HR network have a history of multiple violence which, due to their traumatic state, may be more likely to be repeated in gender-based violence relationships. This increase in alcohol use, often combined with psychotropic drugs, may be related to post-traumatic stress. It has also been observed that in relationships where both partners are involved in HR, the woman reduces her use of illicit substances and increases her use of licit substances after the end of the relationship. This situation could be related to the use of protection strategies, which reduce the avoidance of points of sale of illegal substances, which are more prone to violence. These reasons for the transition to alcohol use were also reported among men over 50 years of age who had previously used illicit substances.

Some professionals in Catalonia indicated that the emergency HR shelters, available in the city of Barcelona, sometimes receive women victims of gender-based violence who show this pattern of use and who have previously lived in unstable accommodation. They are referred to this service after having been excluded from the usual protection resources for disruptive behaviour linked to intoxication from these legal substances. They pointed out that, after reviewing their social and medical histories, these women had never before been linked to any of the HR and addiction network services. The identification of this specific group was linked to the possible existence of a hidden community for HR, with urgent access, motivated by a need for protection, a specific pattern of substance use and different needs.

The only specific HR provision related to alcohol that was reported to be implemented in Madrid and Barcelona was the Alcohol Maintenance Programme. Participating professionals working in the Public Administration indicated that this should be the starting point when providing primary care to this group.

The variety of psychotropic drugs available on the illicit market seems to be more related to the prescribing restrictions imposed on professionals than to PWUS demand. PWUS and professionals in services with SCS reported difficulties in treating intoxication, especially when the person has combined alcohol and/or heroin. Similar characteristics (accessibility, social acceptability, low risk perception) were described for alcohol, making both substances less stigmatised.

It has been pointed out that people who have experienced deprivation of liberty (admission to juvenile, adult and/or foreign detention centres) show higher use than the general population. The tendency to use pharmacological restraint in these contexts and the difficulties people have in coping with withdrawal symptoms on release from prison were identified as elements of concern.

The expansion of injecting heroin use, historically the driving force behind the implementation of HR in Spain, was described by participants as 'residual'. They reported that the use of inhalants remains focused on reducing the undesirable effects of stimulant use. Some areas reported seeing an increase in this combination among people who engage in chemsex.

According to Rovira (2022), the use of inhaled methamphetamine by those associated with the HR network seems to be increasing, especially in the city of Barcelona. PWUS indicated that the positive effects were a reduction in tiredness, sleep, hunger and pain, and the negative effects were the activation of the alarm system.

The characteristics of this community were described as very heterogeneous. The urban context, the age below 35 years, the presence of women and LGTBIQ+ groups, and substance use associated with sex work, chemsex practices and homelessness seemed to stand out. They reported the detection of cases of injecting substance use.

The most worrying element reported was the detection of an increase in psychotic episodes requiring admission to hospital emergency departments, associated with the continued use of methamphetamine. The emergence of this substance and its alarming effects have led to professional training on how to deal with it, the introduction of the paraphernalia distribution and multi-level working groups bringing together the public administration, PWUS, community agencies and HR services.

Other substances mentioned in the pattern of use were mephedrone, GHB and GBL, which were associated by people linked to HR who engage in chemsex, cannabis, solvents, and methadone.

Irrespective of the substance, the increase in the use of the inhaled route appears to be related to the fact that it has fewer associated comorbidities and is associated with less discrimination than the injected route. Professionals warned of the importance of adapting HR programmes and/or services to this new reality, in order to avoid creating elements that support inequalities between the two routes of administration, since this could favour the transition to the intravenous route. Barcelona has been identified as the city that has made the most progress in implementing specific programmes (distribution of paraphernalia for the inhalation route, specific DCRs, adaptation of professional support, integration of the gender perspective, etc.). The lack of strategies to identify areas of consumption was noted as a concern. This aspect could be linked to the fact that the use of inhalants in open spaces has its own difficulties related to wind, the general decrease in the use of substances on public streets and the increase in the number of *narcopisos* that allow the use of inhalants indoors.

The only increase in injecting substance use is among people who engage in chemsex, which is consistent with the published literature and reports (Curto et al. 2020; PNS 2019 and 2020; Íncera 2021; Ruiz-Robledillo 2021).

As described by Rodó-Zarate (2022), the spaces in which substances are used are not only a geographical entity, but also a political one; the space is the social relations that shape it, which place social groups in different and unequal positions. In this sense, the same space has different meanings, and different emotions are associated with it, depending on, for example, gender, ethnicity, class or sexual diversity.

In total, five different contexts were identified in which people connected to the HR network currently use substances: DCRs, home, *narcopisos*, public space and saunas.

Three types of DCRs operating in the country were identified, differentiated according to the route of administration (oral, inhaled and injected). They are spaces that favour peer socialisation, although they encourage vertical care relationships between professional-PWUS, and thus discouraging collective care relationships.

Oral route DCRs are located in Madrid and Barcelona. They only allow the use of alcohol, always include the provision of managed alcohol programmes and are located in housing support services for homeless people. No elements were described to indicate a gender perspective approach.

Inhalation and injection DCRs are located in Bilbao and Catalonia. With the exception of one experience in Barcelona, all are integrated into mixed services. PWUS praised the provision of support for venipuncture, especially for people with a long history of intravenous use and stimulants. They were also recognised for the management of intoxication episodes. On the other hand, long waiting times due to overcrowding, environmental

noise, the need to adopt protective strategies to avoid theft and/or extortion, and the impact of professional stress were the main barriers to adherence reported by PWUS in these contexts. Professionals reported difficulties in monitoring the use of inhaled methamphetamine. They stressed the importance of adapting the operation of these devices.

For those who have a house, the private home was reported as their first choice for consumption. Women reported that in the case of couples, there are situations of oppression related to the equal distribution of doses and care. In the case of people who practise chemsex, there are sessions at home where they also engage in sexual practices with another person or in a group. They reported that these may be segregated according to the route of administration.

The phenomenon of drug trafficking was detected in Madrid, Barcelona, Seville, Vigo and Bilbao. Three types of drug distribution points were identified: points of sale (called '*narcopisos*'), points of sale and consumption of substances by inhalation ('*fumadero*') and points of sale and consumption of substances by injection ('*chutadero*').

The following common characteristics were identified: dilapidated housing in inner-city neighbourhoods, low occupancy rate, activity focused on the sale of illicit substances, inhabited by the dealers themselves who receive a pay for the role they play. This role is always based on stereotypes: watch-men, women-clearer, men-dealer, men-organiser. Other characteristic reported were: poor hygienic conditions, low presence of female PWUS, regular supply of substances (cocaine, heroin, methadone, alcohol, cigarettes and psychotropic drugs) by outsiders, cash, sex (only in the case of women), valuables or barter in exchange for occasional work, distribution of consumption paraphernalia (syringes, aluminium foil), regulation of the maximum time spent in the room and 24-hour surveillance.

Professionals and PWUS were most concerned about the risk of death associated with intoxication care. The usual approach is to leave the intoxicated person in the public space.

This is a place of multiple oppressions related to gender, substance use and social class. Female PWUS reported that the level of violence is so high that they never go there alone. Twelve different experiences were reported, including extortion, verbal, physical and sexual assault, kidnapping, robbery and murder.

Participating PWUS noted that it is the main point of sale for substances, but the last place of choice for their use. Homeless people from areas without DCRs warned that it was the only private space they could access to use substances. This disparity between areas in terms of the availability of DCRs was an element of great concern because of the extreme vulnerability it places on PWUS.

It has been observed that the '*narcopisos*' reproduce aspects of DCRs' functioning model (differentiation according to route of administration, vertical power relations, distribution of hygienic paraphernalia, maximum consumption time) and improve these spaces in terms of daily coverage and accessibility of the substance. The DCRs, on the other hand, guarantee the care in the event of intoxication and the hygiene of the room.

One of the reasons for introducing DCR is to reduce substance use in public spaces. However, public space remains an alternative, although it is not the first choice.

Some PWUS reported that they preferred this space to use stimulants accompanied. This space was also reported as a place to practise chemsex.

Public space is seen as a context of equal relationships, collective care, but also of oppression and violence in the PWUS-police relationship. Participants reported experiences of being arrested for using substances in public spaces.

Saunas were reported by professionals linked to the LGTBIQ+ sexual health network as a space for substance use. Difficulties were reported in establishing care and support strategies with the staff and owners of these venues. Peer-care relationships were identified, but also oppression between the surveillance of the premises and PWUS. There is currently no access to on-site hygienic paraphernalia in these spaces, and there is evidence of people reusing syringes and/or pipes for methamphetamine use.

HR SERVICES AND/OR PROGRAMMES

To carry out this research, databases, registers, reports and publications detailing existing HR services and programmes in Spain were searched for. At the regional or local level, some of the administrations consulted provided this information, although it was noted that in general this data is either not accessible or, if published, there is no guarantee that it is up to date.

Areas of multi-level articulation and coordination on drugs and their approaches (treatment, prevention, policies, etc.) were identified. For example, national committees with representatives from regional administrations, national and regional groupings of third sector organisations, working groups between administrations and service providers, etc. Nevertheless, it cannot be said that a specific HR network has been created in Spain.

The focus groups also revealed that in most areas there is no networking between HR services and/or programmes, nor are there structured and systematised coordination spaces between services in the same city or

province. The lack of these structures could be linked to the sense of isolation and loneliness reported by all the professionals involved.

It was also noted that PWUS participation in decision-making was very low at all levels. However, specific experiences were described where participatory methods were used in the design, development and evaluation of the services themselves and/or of specific projects. In Barcelona, for example, the participatory design of the non-mixed drop-in service and the programme for the distribution of hygienic paraphernalia for the inhalation route stood out. Participation spaces were also reported in some services through meetings designed, convened, managed and evaluated by the service professionals and PWUS.

Unfortunately, the idea of 'helping people in need' is perpetuated, based on the notion that poverty and marginalisation are not a systemic problem, but are caused by personal shortcomings. This implies that whoever 'helps' is more privileged, singles out PWUS as inferior, and makes it difficult to articulate processes of community responsibility or transformative justice.

Beyond the isolated examples, there are vertical, hierarchical and rigid governance structures in which the participation of PWUS in the HR network is non-existent. The hegemony of this approach seems to be justified by the idea that PWUS are particularly ineffective, inefficient, irresponsible or do not know how to voice their concerns. This inequality in decision-making is violent, discriminatory, immobilising and perpetuates both the position of power and the gap between the privileged and the oppressed.

At the demographic level, it was reported that the HR network operates mainly in urban areas, with a serious territorial inequality between small and large municipalities. Some of the reasons given were budgetary priorities, double standards regarding substance use (if the problem is not seen, it does not exist), the difficulty of accessing certain substances, the possible discrimination suffered by PWUS in these small communities, which could lead them to choose between hiding or moving to places of greater anonymity. Professionals working with people who practise chemsex pointed out that the same scenario is reproduced in the care of the LGTBIQ+ community. PWUS involved stressed the importance of implementing HR projects in small communities that promote and protect the visibility of PWUS. Professionals from Vigo and Álava reported good results in accompanying PWUS in rural areas by taking mobile units to these areas.

The community was mentioned as a key social actor in the HR, but very few experiences were described in which PWUS and the community had some kind of articulation space.

Nor was there any experience of the community acting as a support network. On the contrary, this actor was described as not very empathetic, not integrated, whose interests are focused on cleaning up the public space and reducing the supply of substances. In turn, they value the implementation of services highly, the more invisible they are.

The relationship between HR services and/or programmes operates in the communities through the outreach work. It was pointed out that the theoretical psychosocial objectives of these teams (raising awareness within the environment and promoting the integration of PWUS) do not correspond to daily practice. It was highlighted that the practical activity focused on the collection of contaminated material left on the public spaces, the identification and referral of potential candidates for HR actions, the accompaniment of PWUS to primary care services (with the aim of minimising discriminatory incidents) and the containment of the community's discomfort. This last aspect was highlighted by the professionals as an element of attrition, frustration and exhaustion, indicating that the reality of the relationship between HR and the community is generally one of conflict.

The description of this scenario of confrontation confirms the imperative and urgent need to adopt new strategies that promote the transformation of this unequal relationship between the community and PWUS. The reduction of professional assistance through processes based on the construction of support networks and community care, as well as the approach and accompaniment by peers, were proposals highlighted both by professionals and in the literature (Yung 2001, Pauly 2008; Spade 2020).

It was observed that in all areas there is a dominant mode of professionalisation of HR services, which has been successful in some contexts over the years, but which may currently act as a barrier to access and adherence for communities that are not in a situation of marginalisation.

With the exception of some needle exchange programmes in emergency health centres, most existing services and/or programmes do not provide 24-hour coverage. This aspect was identified as a major concern by all participants, who felt that at least every major city should have a HR service with unlimited hourly coverage, integrating the distribution of hygienic paraphernalia and DCRs.

PWUS agreed that when they first accessed a HR service they were coming from previous treatment failure and had an expectation (real or symbolic) of professional support towards abstinence. They reported having heard about the service from their peers, being accompanied by someone they knew, being homeless and not in a

relationship. On entering the facilities, the first feelings they experienced were one of shock at sharing a space with so many PWUS, and fear that they might be victims of robbery. The reception processes reported by professionals had common features: individual interview and needs assessment. The fact that the interview was conducted in the mother tongue was highly valued by migrants. All PWUS agreed that professionals gave them confidence and that they did not feel judged because of their substance use.

In relation to gender, it was pointed out that existing HR services and programmes are mixed, with the exception of the above-mentioned non-mixed experience in Barcelona. There was agreement on the need to implement a greater number of non-mixed programmes and/or services. In terms of facilities and atmosphere, the usual masculinisation and hostility of spaces and the lack of safe and confidential spaces were described as barriers to access and adherence for women and non-binary people. Despite this reality, only two examples of masculinity-oriented actions were reported. Professionals agreed that mixed contexts promote transformative work with both men and women. They were particularly concerned about the vulnerability of women victims of recent violence when services do not provide these spaces of safety and privacy.

The need to integrate the mental health approach into existing HR services and/or programmes was also highlighted. Only one service in Barcelona reported the presence of a psychiatrist and a low presence of psychologists. In both cases it was noted that they provide psychosocial support. Participants called for specific training in skills related to this area.

The needle exchange programme was one of the first HR programmes implemented in Spain. Professionals reported that, with the decline in the use of the injecting route, their central activity had been significantly reduced. In Barcelona, it was reported that the distribution of hygienic paraphernalia for the inhalation route was adapted to these programmes. This consists of the distribution of various hygienic materials, such as cocaine-base pipes, methamphetamine pipes, aluminium foil, filters, single-dose bicarbonate, etc., accompanied by other HR materials related to sexual practices, such as lubricants, condoms, intimate gels, etc.

All the territories that took part in the research had HR drop-in services in their network of services. These services are located on the ground floor of the staircase model of support, they are governed by internal rules that regulate coexistence and, when situations of violence are detected, they apply restriction measures that may vary from temporary to permanent. Professionals pointed out that there is great concern about the helplessness of those who are permanently excluded, and that the public administrations should develop specific responses for complex cases. Currently, these actions are carried out by outreach work teams. In some cities, such as Madrid, Barcelona or Bilbao, there were reports of working groups in which the processes of the different networks involved are articulated.

These centres had common features: they were located close to attention points and offered emergency care, food distribution, hygiene and self-care services, a programme for the distribution of paraphernalia, storage of documents and medicines, and socio-educational accompaniment. Some had nursing, DCRs and outreach teams. They were described as overcrowded, small places with a lack of ventilation and natural light. This picture coincides with the elements of precariousness and lack of stable funding described by Rovira (2018), and was also linked by professionals to poor working conditions, exhaustion and lack of professional recognition by administrations.

On the contrary, PWUS reported a very good evaluation and satisfaction with this type of services, describing them as places of reparation and restoration of their dignity as subjects of rights. This contrast between the views of professionals and PWUS confirms the extreme conditions and discrimination experienced by the last, but it could also point to a lack of commitment on the part of the authorities to improving the quality of their daily lives, by providing care in comfortable spaces subject to more demanding procedures.

In general, it was noted that neither PWUS nor professionals currently consider methadone maintenance as an element of interest from a HR perspective, but rather as an aspect to be reviewed in terms of treatment interventions.

PROFESSIONALS

The last dimension to be explored in depth was the situation of the professional teams. An alarming and worrying number of examples of burnout situations were identified in the analysis of the professionals' discourses.

They pointed out that, in general, burnout is common to all the professionals in the teams. They pointed out that within the network of care and support for PWUS (from prevention to treatment) there is a hierarchy in which HR occupies the lowest level of consideration. This observation reflects yet another example of the impact of the prohibitionist model, but this time with a focus on assistance, where services aimed at preventing or eliminating substance use receive more resources and recognition than those that accompany substance use.

Professionals also reported a lack of credibility and recognition from professionals in other primary networks and from the community. These aspects were linked to

the short history of HR as a model of support and to the reproduction of elements of discrimination linked to the condition of substance use. They expressed a sense of exhaustion and weariness in response to questions about the scientific rigour, the efficacy and the effectiveness of the interventions carried out, as well as moral challenges regarding the type of accompaniment that they are developing. Although they described this pedagogical task as arduous and constant, they were also very motivated to design and participate in external training, understanding that this work should include formal and awareness-raising aspects.

This scenario of discrimination of PWUS and professionals who attend them was directly related to the struggling, exhausting and frustrating culture of HR services and/or programmes based on 'either we do it or nobody else does it'. Elements of demotivation, isolation and loneliness were observed.

In terms of work, all professionals reported that the HR field offers very poor working conditions, including: lack of a specific regulatory agreement, lack of equality of conditions between areas and services with the same characteristics, low salaries, risk of disease transmission not considered, psychosocial risks (related to excessive exposure to violence) not recognised, and insufficient rest between shifts. The situation of women who had been pregnant or breastfeeding was alarming, as they reported difficulties in recognising these risks and, as a result, being exposed to very dangerous situations of violence. No male professionals reported difficulties in reconciling parenthood.

From this last element we can extract the inequality and oppression that the gender axis exerts in the field of work, where it makes women more vulnerable and exposed to violence than men.

The environmental characteristics of the services (hostile, degraded, unventilated) were perceived as a lack of interest, prioritisation and resources on the part of the administrations, and consequently they translated this into job instability, valuing the possibility of losing their job at any moment.

Despite these nuances, burnout was directly and unanimously linked to excessive exposure to violence. The masculinisation of the workplace, originally designed to meet men's needs; the normalisation of a relationship model based on violence, again of a masculine nature; and the suffering caused by the numerous situations of discrimination and violence experienced by women in the workplace. This suffering is caused by the numerous situations of discrimination and violence experienced by PWUS, often expressed through violent communication. All of these could be the elements causing the environment described above and could encourage the incorporation and validation of violence as an adaptive survival mechanism. In addition, they pointed out that exposure to poverty and violence experiences is sometimes linked to personal traumatic experiences, activating old wounds where the responses offered are survival responses.

Professionals observed that exposure to violence differed according to sex and gender, resulting from reinforced gender stereotypes. Men were more exposed to physical violence and women to other, less visible forms of violence. They reported the use of protection and survival strategies.

The main consequences reported were the reproduction of this type of relationship among the professionals themselves, an increase in the use of alcohol and other substances, absenteeism, an increase in the number of temporary incapacities or long-term medical leaves, the need for external psychological support and, finally, a change of job. Some professionals reported symptoms of post-traumatic stress (insomnia, anxiety, dissociation, ideas of persecution, harm, isolation, loneliness) after experiencing a situation of extreme violence at work.

Faced with this alarming situation, professionals stressed the importance of a professional, organisational and administrative work organisation that promotes mutual help, care and cooperation. They identified the lack of key structures, the presence of 'groups' that make decisions, the lack of answers from superiors and/or management, confusion about roles, lack of references, vertical distrust and lack of consensus as elements of attrition that lead to professional turnover.

These characteristics coincide with those described by Spade (2020), who suggests combining cooperative leadership with supervision and care in groups overexposed to situations of human rights violations.

At the organisational level, it identifies important aspects such as wanting to know how people are doing, encouraging compassion among peers, reliability, encouraging diversity of opinion, authenticity, avoiding controlling attitudes and supporting participatory processes. At the level of supervision, it proposes group spaces for mutual support, integrated into the working day and led by figures from outside the service, which make it possible to detect overwork and burnout and create support structures.

The incorporation of external supervision was the main demand of the participating professionals, who considered that it would not only directly improve their mental health, but that these improvements would promote the loyalty of the professionals in the services and, in the long term, allow the generation of referrals and expertise.

6 LIMITATIONS AND MINIMISATIONS OF BIAS

This study was carried out in 2022 by a research team with vast experience in HR services and programmes at international, national and Catalonian levels. Efforts were made to minimise possible biases in the selection of participants by involving the whole Work Team Group in this process, as well as by conducting half of the focus groups with PWUS in an area without any kind of professional link.

In some cases the research team had a previous relationship with the participants, both PWUS 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. In particular, in the focus groups with professionals, this aspect facilitated the identification of people as a support group. Feelings of relief could be observed in the collectivisation of discomfort and suffering.

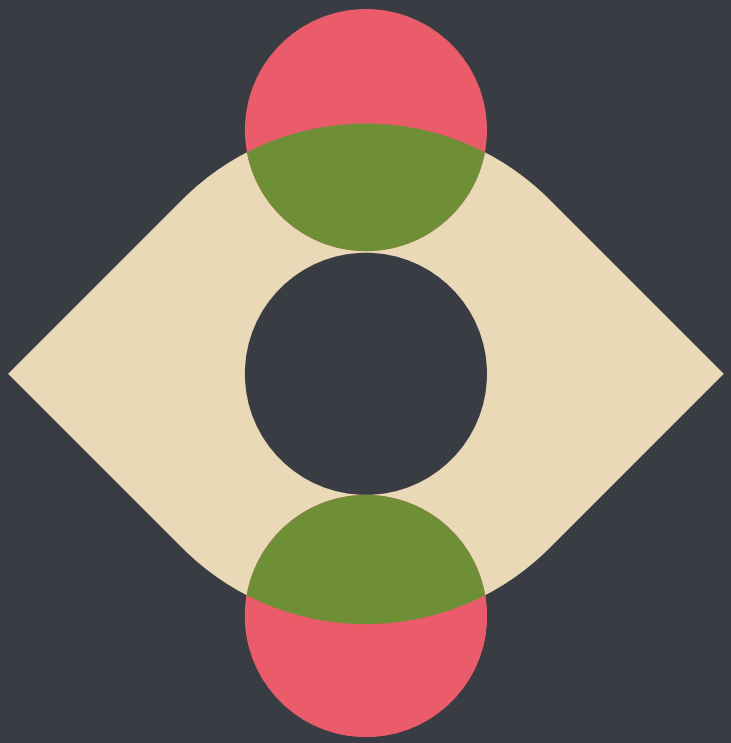
By triangulating different methods (literature review, individual interviews, focus groups), we tried to analyse the phenomenon through different approaches, thus minimising possible biases in the information. Possible inconsistencies do not undermine the credibility of interpreting reality.

The triangulation of different researchers was ensured through the participation of the Work Team Group throughout the research process and, after the focus group sessions, with the professional who took notes.

The selection and participation of professionals with a diversity of gender, disciplines, expertise, territories and current links to HR allowed for the triangulation of theories, thus minimising possible related biases.

Nevertheless, it is acknowledged that this research has limitations in terms of geography, with less representation from rural than urban areas; and in terms of origin and ethnicity, with a lower presence of migrant population than natives and lacking racialized people participating. Efforts were made to minimise the impact of the gender axis by ensuring a greater presence of women than men.

7 CONCLUSIONS



The aim of this research has been the study of the main elements, such as the pattern of substance use, the communities and the services, which may be in a state of flux in the current HR scene in Spain, in relation to its initial implementation at the end of the 1980s.

The use of qualitative methodology made it possible to gather the diversity of discourses and experiences that make up this reality and to draw up an initial diagnosis of such a complex phenomenon. The incorporation of intersectional analysis was essential in approaching and understanding the different processes that might be at work. Nevertheless, it must be said that the interpretations were valid at this specific moment and in this specific context, assuming that the intersections and their intensity are dynamic and temporal.

The participation of PWUS, as well as professionals linked to the HR network and professional experts in the field, gave equal value to the knowledge of the actors involved. This aspect was particularly important, both because of the participation of people in a situation of extreme vulnerability and discrimination, and because of the perception of the reality of the people who accompany them.

The main diagnostic conclusions were structured according to the different subjects of analysis. They have been presented in a schematic format to facilitate their understanding.

THEME 1: HARM REDUCTION	
MODEL	• In structural terms, neo-liberal policies, the patriarchal system and prohibitionist policies on the use of substances come together. • Drug policies in Spain have been constructed according to a biomedical model of the disease (prevention, treatment, harm reduction). • The initial context was characterised by injecting heroin use, high co-morbidity and associated mortality. • There is a social imaginary of PWUS as lazy, delinquent, sick and responsible for their own situation. • HR uses a model based on public health principles. • The initial design of HR services and/or programmes did not take into account the different intersections and intensities of social inequality. • The incorporation of a transversal social justice approach is proposed to build on the current model. • Substance use status functions as an axis of social inequality. • Most HR services and/or programmes provide responses for the privileged group: male, white, local, who use heroin through the injected route. • The categories of oppression define population groups that have difficulties in accessing and adhering to the HR network.
HARM REDUCTION AND RISK REDUCTION	• PWUS are unfamiliar with the terminology and meaning of 'harm reduction' and 'risk reduction'. • Abstinence is perceived by PWUS as the ultimate goal; any other option is seen as a palliative response to this failure. • The differentiation between 'risks' and 'harms' provides opportunities to work with minors and facilitates access for privileged populations. • The differentiation between 'risks' and 'harms' reinforces the oppression of the people served by the HR network.
IDENTIFICATION OF HARMS TO REDUCE	**HEALTH** • Guaranteed care and support through primary and hospital emergency networks. • Need to mainstream mental health and sexual and reproductive health. **HOUSING** • Serious increase in homelessness among PWUS linked to HR. • Serious lack of protection for female PWUS in homeless situations who are victims of gender-based violence. • Exclusion of PWUS from the homeless network. • Need to include housing alternatives that are not based on the staircase model **SUPPORT AND AFFECTIVE NETWORK** • Very degraded appearance, difficulties in repairing and rebuilding support networks. • Intense inequality at intersections (gender, origin, age...). **VIOLENCE** • PWUS are victims of multiple (structural, institutional, interpersonal, gender, racist, homophobic, transphobic, etc.) forms of severe violence. • Evidence of institutional discrimination in violation of human rights.

Figure 10. Main Conclusions Table: Harm Reduction. Own Elaboration. 2022.

THEME 2: COMMUNITIES	
CHARACTERISTICS OF COMMUNITIES LINKED TO THE HR NETWORK	• Privileged group: male, heterosexual, middle-aged, local, homeless, using mainly alcohol, some psychotropic drugs, cocaine and/or inhaled heroin.
WOMEN	• Vulnerability related to the sex/gender axis, exacerbated by origin, age, religion... Access and adherence to the HR network identified as oppressive. • High number of female PWUS who have been victims of gender-based violence. No guaranteed protection for PWUS who are victims of gender-based violence. • Low level of knowledge about substance use, gender-based violence and traumatic experiences in other primary care networks. • Difficulties in access and adherence to the HR network for women who have given birth. Mainstreaming a transversal gender perspective in HR is essential. • Good results reported in non-mixed services and in services with a mainstreamed approach.
OVER 45 YEARS OLD	• Vulnerability related to the age axis, reinforced by gender, origin, administrative situation, substances... • They have a long history of substance use, currently using alcohol, heroin or cocaine by injection and/or inhalation, in an active situation of opiate substitution treatment. They lack a social and family support network. • Age makes it impossible to access the elderly care network + No financial resources to access the private care network + Families cannot afford support and care. • Care taken over precariously by the HR network. • Female PWUS increased oppression by encroaching on the caring role of their families • Irregular migrants have great difficulty accessing services. • People linked to HR live in fear of their future projection. • Lack of specific training in the elderly network and in the HR network.
PEOPLE WHO ENGAGE IN CHEMSEX	• Vulnerability linked to the sexual orientation axis, reinforced by substance use, gender expression, origin, administrative situation, etc. • Increase in the number of people (including women) practising chemsex in a situation of homelessness linked to the HR network. • Increased stigma. • Most HR resources are not safe spaces for the LGTBIQ+ community. • Lack of LGTBIQ+ perspectives and skills in the HR network. • The need to include strategies and models of HR support in the LGTBIQ+ sexual health network. • The need for specific LGTBIQ+ support services with HR benefits.
HOMELESS MEN AND YOUNG MIGRANTS IN AN IRREGULAR ADMINISTRATIVE SITUATION	• Vulnerability linked to age, place of origin and administrative situation, exacerbated by substance use, gender, language... • Identifying and predicting the growth of this group in the HR Network. • Differences in patterns of substance use. • First contact with institutions through the child protection system (punitive logic of substance use). • They do not share a symbolic language with the community. • Overcrowded HR drop-in services requiring more resources. • Lack of training and skills in intercultural perspective.

Figure 11. Main Conclusions Table: Populations. Own Elaboration. 2022.Own Elaboration. 2022.

THEME 3: PATTERN OF SUBSTANCE USE	
SUBSTANCES	• It applies a logic of the dangerousness of substances that is based on prohibitionist policies. **COCAINE** • High prevalence of inhaled cocaine use. • Services and programmes need to be adapted to changes in the substance and prevalent pattern of use. • Lack of programmes to distribute hygienic paraphernalia. • PWUS call for more support in the management of intoxication and assistance for the venipuncture of stimulants. **ALCOHOL** • Increased prevalence of alcohol consumption. • People who use alcohol report a lack of self-regulation strategies and a need for accompaniment when intoxicated. • Restricted access to people who use alcohol to HR services. • Women victims of violence show a different pattern of use. • Alcohol maintenance programmes are the only strategy implemented by HR. Territorial inequality. No gender perspective. Focus on homelessness. **PSYCHOTROPIC DRUGS** • Increased prevalence of psychotropic drug use. • A common combination is pregabalin and clonazepam. • People who use psychotropic drugs and professionals warm of difficulties in managing intoxication from this substance in combination with alcohol and/or opiates. • Female victims of violence show a different pattern of use. • Differential patterns of use among young, migrants and homeless people. **HEROIN** • The prevalence of heroin use is decreasing. • Maintain inhaled use to reduce undesirable effects of stimulants. • Observation of onset among people who engage in chemsex. **METHAMPHETAMINE** • Increasing prevalence of methamphetamine use. • Concentrated in Madrid and Barcelona. • Heterogeneous community characteristics. • Use mainly by inhalation. • Concern about increase of associated psychotic episodes..
ROUTES OF ADMINISTRATION	• Declining prevalence of injecting, except among people who engage in chemsex. • PWUS demand distribution of hygienic equipment for inhalation.
CONTEXTS	**DRCS** • There are 3 types of DCRs, depending on the route of administration. • Oral DCRs offer Alcohol Maintenance Programmes. • Inhaled and injected DCRs are the first choice for PWUS. • PWUS demand availability in all major cities. • Need to adapt to increasing use of stimulants. **AT HOME** • First choice for those who have a home. • Situations of oppression between heterosexual couples. **NARCOPISOS** • Identified in all the main participating cities. • Different typologies. • Common characteristics regardless of the area. • They reproduce the DCRs model of care. • Refusal of help in case of intoxication. • Evidence of serious assaults on female PWUS. • Last resort, the only alternative in areas without DCRs. **PUBLIC SPACES** • Space of choice for some people who do not have DCRs or who use stimulants. **SAUNAS** • Spaces used by people who engage in chemsex. • PWUS request the distribution of hygiene paraphernalia. • Difficulties in articulating with establishments for fear of legal reprisals.

Figure 12. Main Conclusions Table: Pattern of Substance Use. Own elaboration. 2022.

THEME 4: SERVICES AND PROGRAMMES	
HR NETWORK	• Need to create a national HR resource map. • Need to create specific multi-level spaces for HR. • Need to involve PWUS in decision making. • Serious inequalities in the distribution of resources between urban and rural areas. • Communities at odds with HR services, professionals and PWUS. Successful implementation is invisible. • Need to reduce welfarism and promote community care and support networks. • Professionalisation and medicalisation of services is a barrier to access for non-marginalised populations. Community-based initiatives should be supported.
FIRST CONTACT WITH THE HR NETWORK	• PWUS become aware of services through peers. • They come for the first time in a situation of homelessness and after previous treatment failures. • Migrant people are very positive about being welcomed in their mother tongue.
DEVICES	• Predominantly mixed, calling for an increase in non-mixed services. • Masculinised and hostile spaces. • Lack of safe spaces and confidentiality. • Need to involve mental health professionals. • Need to include a transversal gender perspective. • Need to include an transcultural perspective. • Need to include LGTBIQ+ skills. • Drop-in services: - Oversubscribed due to increased homelessness. - Insufficient space, lack of natural light and ventilation. - Offer poor working conditions for female professionals. - Facilities conducive to violence. - PWUS believe that they favour the restoration of their dignity.

Figure 13. Main Conclusions Table: Services and Programmes. Own elaboration. 2022.

THEME 5: PROFESSIONALS	
• Little research on the emotional health of HR professionals. • Identifying indicators of high levels of burnout. • Establishing a culture of 'we do it or nobody else will'. • Development and normalisation of protection and survival strategies in the face of excessive exposure to violence. • Need to build professional loyalty to ensure expertise.	
BURN-OUT	• Generalised across all professions. • Lack of recognition within the addiction care and support network. • Questioning over the HR network and its professionals by the primary care networks. • Episodes of violence from the community. • Evidence of poor working conditions and non-recognition of psychosocial risks in the working environment. • Overexposure to violence, identification of post-traumatic stress indicators. • Importance of ensuring work collaborative models and management within HR services. • Burnout and exhaustion were associated with high staff turnover and sick leave. • Professionals call for the immediate involvement of external supervisors for care and support.

Figure 14. Main Conclusions Table: Professionals. Own elaboration. 2022.

Following the preparation of this first diagnosis of the situation of HR in Spain, it is recommended that the relevant public administrations and organisations continue to research each of the thematic dimensions described. The design of specific strategies and responses to promote the HR implementation has been identified as a priority: the implementation of the social justice approach in the existing HR model, which allows for the reduction of stigma and the consideration of PWUS as subjects with full rights; access and adherence of identified minority community; the review and adaptation of programmes and services to the new patterns of substance use identified; the transversal integration of the gender, transcultural and LGTBIQ+ perspective in the services and programmes of the HR network; and the improvement of the working conditions of professionals.

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ANNEXES

THEMATIC GUIDE: FOCUS GROUP HR PROFESSIONALS

PROBLEM DEFINITION			
When is a person eligible for HR?			15 min
Based on these harms, what is the order of priority for the population you attend to?		Main harms: stigma, health, violence, childhood sexual violence, adult sexual violence, housing (homelessness + insecure housing), affective/family network, work, income sources, culture. Motherhood equals fatherhood?	
		Rural vs Urban	
PATTERN OF SUBSTANCE USE			
Substances	In most areas, heroin and cocaine are the main substances used by the population attended to by HR services. Have you noticed any changes in the substances used in recent years?	Stress on alcohol and medicines prescribed if they are not brought up.	30 min
	Is there any difference between men, women and non-binary people?	Literature and experts refer to OH+BZP women as a hidden community until the home is no longer a safe place or is lost.	
Admin routes	Have there been any changes in the predominant routes of administration among PWUS in recent years?	Emphasise that alcohol and BZP are taken orally and the inhalant is smoked. These are all outside the classic HR range.	
	Is the use of a particular route of administration the line between risk and harm reduction? Where is this line? What are the implications of this distinction?	Experts point out that segregation by route of administration stigmatises one group of PWUS and creates a barrier to access HR for another group.	
	Where do users of the services you work at tend to consume?	Phenomenon of narcopisos (drug houses) in different Spanish cities, different approaches. Narcopiso is not related to the DCRs in the city. Stress on diff M/W/NB.	
	Do they coincide with places in smaller territories?	Rural vs. urban spaces	
	The reasons that should lead a person to use a DCR are: non-lethality of overdose, non-transmission of diseases, safety and security. Are these characteristics being met?	According to the literature, experts point directly to consumption rooms as an unsafe space for women and young people. Stress on diff M/W/NB.	

COMMUNITY GROUPS ATTENDED TO			
Women	The usual profile of most HR services and programmes is male, Spanish, homeless. Does this correspond to the reality you see?	Stress on rural vs. urban spaces.	45 min
	The majority of mixed HR services have some strategy in place to recruit and retain women. Yet no service exceeds 22.3%. What else is wrong?		
	What are the views of professionals working in non-mixed services and/or programmes? What programmes or resources still need to be developed from a HR approach?	Differences exist in various dimensions such as: schedules, treatment, confidentiality, etc. Training?	
Elderly	According to the EMCDDA, people over 45 who are long-term opiate users have a health status similar to that of people over 65 in the general population; is there a specific programme for this group in the services you work at?	Stress on rural vs. urban barriers	
	Are the services you work at and the usual strategies adapted to care for this group?	Training?	
Mental Health	Generally speaking, would you say that the mental health status of people using your HR service has changed in recent years? Please state possible causes	Differences in diagnosis or symptoms between men and women? Training?	
HR HIDDEN COMMUNITIES			
	Do you think there is a community group that is not accessing HR services and programmes?	Young, Non-Binary, Trans, Chemsex.	
	Which are the main barriers in accessing and adhering to these services?		

SERVICES			
Needle Exchange Programmes	One of the main HR programmes is the NEPs, which has been improved in recent years with new services and preventive territorial coverage. What else needs to be improved?	Stress on rural vs. urban areas	15 min
'Calor y Café´	It is common for HR services to have a space called 'Calor y Café', whose purpose is to cover basic needs, provide respite and security. Are these services particularly relevant to homeless men?		
	What improvements or suggestions should be made to ensure an appropriate response to other minority groups?	Women, Non-binary, Trans, LGTBIQ, young people, functional diversity.	
Outreach Work	Outreach teams are designed with the aim of recruiting and serving people who are not associated with HR and the removal of syringes from the street. Although these are still aspects of need, what other functions should be recovered and/or incorporated?	Stress on rural vs. urban. Stress on violence identification.	
	Are HR users considered members of their communities?		
PROFESSIONAL TEAMS			
Gender Role	Which of your professional functions do you associate with the greatest degree of exhaustion?	Stress on the dif M/W/NB.	15 min
	Do they mostly fall into the category of professional women?	Women do more care work.	
Burn-out	Burnout among people working in the social sector has been highlighted as a concern in several studies. Do you agree with this?		
	What could be the reasons? What could be done to improve this?	Leadership, rest, individual, group and institutional care. Stress on the dif M/W/NB	
Group Culture	There is a group culture in some HR services, do they see themselves as a mutual support group?	Stress on the dif M/W/NB	
	What are the motivations for creating this structure?		

Trauma	What is the place of traumatic experiences in HR professionals?	Stress on the dif M/W/NB	
	Is there awareness among professionals?		
COORDINATION WITH THE HEALTH AND SOCIAL SERVICES NETWORK			
Mental Health	Are people who use HR services also included in this network?		15 min
Women Protection	Which difficulties do they encounter in accessing and adhering to these services?		
Chemsex	Are there coordination structures in this network?		
Minors	Do HR professionals participate directly?		
Elderly			
Homelessness			

THEMATIC GUIDE: FOCUS GROUP WOMEN WHO ATTEND TO HR SERVICES

PRIMERA VEZ EN RDD		
Definition	What does 'Harm Reduction' mean to you?	
Approximation	What HR services and/or programmes have you used in the course of your life?	
	When did you first become aware of the existence of an HR service? What was it like?	Stress on the characteristics of the informant (gender, age, country of origin, PWUS/professional, context in which information is received) or the informant service (type of service, trusted professional, reasons for referral).
Admission	When was the first time you used an HR service?	Stress on the reason when accessing for the first time
	What was your situation (housing, pattern of use, partner, motherhood, treatment, mental health, biological health, source of income, etc.)?	Stress on partner, motherhood, family, Male Violence, Sexual Violence
	What were the reasons that led you to use this HR service?	Identification of initial needs: HR on substances, dealers, peer pressure, professional contact, lack of protection...
	Can you describe how you remember the first time you used this service? What would have made you feel more welcomed? Feel free to provide examples...	Stress on: did they go by themselves or accompanied, was it at day or night time, did they go in or watch from the outside, what were your feelings when you went in, were there many or few professionals, how you remember them (men/women), what did you think of other PWUS, what feelings did other PWUS arise on you? Stress on the influence of individual intersections: migrant, functional diversity, mental health, age
	Was your initial perception that you were in a safe place (that you could not be attacked, that the environment was protected, that your privacy would be respected...)? Please provide examples.	
	Generally speaking, what aspects of those first times would you improve if you could go back?	Stress on: opening times, professionals, facilities, support, privacy...
Abstinence objectives	Did you previously feel that getting help meant giving up the use of substances and/or alcohol? Has any professional or service made it a condition to provide assistance? Please provide any examples...	

Drugs Network	Previously, what other services in the drug dependence network have you used?	Stress on: prevention, out-patient treatment, therapeutic community
Difference with other services	Was it different from accessing a healthcare centre for the first time? What were the differences?	
Difference with other services	Was it different from accessing social care centre for the first time? What were the differences?	
Harms	Based on these harms, what is the order of priority for women who use substances and/or alcohol?	Main harms: stigma, health, violence, child sexual violence, adult sexual violence, housing (homelessness + insecure housing), affective/family network, employment, sources of income, culture, motherhood, sexual and reproductive health, substances.
	Do you think that if you were a man this rank would have been the same?	Is motherhood the same as fatherhood?
PATTERN OF SUBSTANCE USE		
Substances	In most areas, heroin and cocaine are the main substances used by the population attended by the HR network. Have you noticed any changes in the substances used by female PWUS in recent years?	Stress on alcohol and prescribed medicines if they do not appear
	Do you think that the substances used by men differ from those used by women?	
	Is the substance use pattern the same (in terms of quantity, frequency, routes of administration, consumption spaces…?) Why do you think differences occur? Please provide examples.	
	Have you noticed any changes before/after COVID (points of sale, price, quality, dealers…)?	
Points of sale	Are points of sale safe spaces, and are they as safe for women as for men?	
	Are there any female dealers? Do they consume? What jobs do they do? Are these different from men?	Narcopisos, dealers, settlements, houses…
Consumption Rooms	Consumption Rooms are mainly used by men, where do women use substances?	Stress on how they use substances (accompanied, hidden, same consumption pattern, impact of having a house…)

	The reasons that should lead a person to use a consumption room are: non-lethality of overdose, non-transmission of diseases, security and protection. Are these characteristics covered?	Are these the same for men and women?
SERVICES		
General	Most HR programmes or services are located in cities. Do you think these services are also needed in smaller communities? Why do you think these areas have less or none of these services and/or programmes?	Rural
NEP	Are you or have you been a user of a NEP? Taking into consideration the following dimensions: opening times, activities, individual care and professionals, do they meet your needs as a female PWUS? How could they be improved? Are they better for men? Please provide examples.	
Outreach teams	Have you ever been assisted by outreach teams? Taking into consideration the following dimensions: opening times, activities, individual care and professionals, do they meet your needs as a female PWUS? How could they be improved? Are they better for men? Please provide examples.	
	Did they accompany you to any service? Why would you have requested this accompaniment?	
	Do you think that male PWUS will request for the same kind of accompaniment (places)? What might be the reasons for this?	
	Has an outreach team ever had to mediate in a conflict in which you may have been involved in your neighbourhood or community? Elaborate...	
Calor y Café	Have you ever used these services? Taking into consideration the following dimensions: opening times, activities, individual care and professionals, do they meet your needs as a female PWUS? How could they be improved? Are they better for men? Please provide examples.	

	'Calor' corresponds to the need of protection and 'Café' to the need of food and being heard, do you think these services cover these needs?	
	Have you ever had a conflict while using these services?	Stress on who (male/female PWUS, professional)? How did professionals, PWUS act? Difference if you would have been a man.
Regulations	Generally speaking, do you consider that HR services are violence-free spaces?	Why?
	Could you describe what violence is experienced?	Validate the perception of tension, not only violence per se.
	Have you ever been involved in developing rules for any service or programme?	
PROFESSIONAL TEAMS		
	Generally speaking, are there more men or women working in HR services?	
	Generally speaking, is there any difference in treatment when this is provided by a man or a woman?	Stress on confidentiality, support, boundaries, protection, safety, security.
	Have you ever felt that you were treated differently by an HR professional because you are a woman?	
	Do you relate to male and female professionals in the same way?	
HEALTH AND SOCIAL SERVICES BASIC NETWORK		
Professionals	Generally speaking, do you observe any difference between HR professionals and professionals working in other basic services (healthcare, social care, soup kitchens, etc.)?	
Stigma	Do you explain that you use alcohol/drugs in other services you attend to?	
	Have you ever experienced a situation where, because you are a woman in active substance use, you have not been able to access a service, help or programme? Please provide examples…	
	Do you think this statement is also true for male PWHS?	

CIRCUIT OF VIOLENCE		
	Have you ever sought protection because of male aggression? What was the experience like?	Stress on the decision making, reporting processes, injury report, protection service, street protection, trial
	Has your story ever been called into question on the grounds that you were a PWUS?	
	Have you had to explain your relationship with substances and/or alcohol use?	
	Do you feel that you have received the same attention as a woman who does not use substances?	
	Has any HR professional ever advised you to explain your substance use in a 'disguised' way?	
	Did you access any protection services? What was your experience like?	
	As a woman without a home, how did you protect yourself from possible contact with the aggresor? Please provide examples.	Only if applicable
	Do they consider these to be isolated experiences or do they know other women who have experienced similar situations?	
MOTHERHOOD		
	Have you ever been asked about your status as a mother in HR?	
	Of all the questions you have been asked about motherhood, what has affected you the most?	
	Do you think that fathers who use substances are treated in the same way?	
NEW COMMUNITY GROUPS		
Elderly	Certain life situations (sleeping rough, overdoses, poor diet...) could make them need certain types of attention earlier, do you know any PWHS who are already in this situation?	
	Do you think there is a need for services aimed at elderly women who are active PWUS?	
	Do you think elderly male PWUS have the same needs?	

Youth	Do you think there should be a minimum age for accessing to HR services?	
	Are HR services generally suitable for young people and what aspects should be considered for improvement?	
MENTAL HEALTH		
Mental Health	Have you ever seen a psychologist or psychiatrist at an HR service?	
	If so, what was your experience with them?	
	Have you ever been treated in a differently because you are a woman?	