# FROM THE STREETS TO ACCESSING CARE

## Coordinated Responses to Substance Use and Homelessness


FEANTSA

**AUTHOR:**

Raquel Carvalheiro, Health Policy Assistant, FEANTSA

**DESIGN BY:**

Emma Ackerley, Communications Assistant, FEANTSA

**IMAGES:**

Cover: *Street Lamp Light over Neon Hope Text, by Pramod Tiwari, PEXELS*

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## SHORT SERVICES GLOSSARY

- **Low-threshold services:** services made to facilitate access for people who use drugs by removing traditional barriers. These can include not requiring abstinence, minimizing bureaucracy, reducing or eliminating costs, and applying fewer strict rules.
- **Detoxification:** a short-term, medically supervised intervention aimed at the reduction and cessation of substance use.
- **Opioid Agonist Therapy (OAT):** an effective therapy for people who use opioids. It involves taking opioid agonists such as methadone or buprenorphine. These medications reduce cravings and withdrawal symptoms due to their long-lasting effect, unlike short-acting opioids such as heroin. They do not produce a typical “high” and help people stabilise their lives and reduce drug-related harms.
- **Drug consumption rooms:** are a fundamental health and social response that fosters the well-being of people who use drugs by providing hygienic and safer spaces to use substances in the presence of trained social workers and/or healthcare professionals.
- **Needle exchange programmes:** are designed to reduce the transmission of infectious diseases such as HIV and hepatitis, as well as other risks associated with injecting drug use, by providing people who inject drugs with sterile injecting equipment and related paraphernalia

# 1. INTRODUCTION

This paper provides an overview of the intersection between homelessness and substance use, alongside existing care responses and guiding principles. From a policy perspective, we aim to promote cross-sector collaboration between health systems, housing authorities, and support services.

When examining the link between substance use and homelessness, it is important to recognise that the relationship is complex and requires a flexible approach. Not all people experiencing homelessness use substances, nor do all who use substances become homeless. However, the needs of those who experience both must be acknowledged, and services should address this intersection empathetically and without judgment.

People experiencing homelessness often face extreme stigma and marginalisation from society, particularly in healthcare settings. When substance use is also a factor, this exclusion is often even more pronounced. People who use or have used drugs and/or alcohol often encounter judgment in many areas of life. This stigma, whether subtle or direct, creates major barriers to health and social service. Language plays a critical role, as stigmatising terminology can function as a powerful form of exclusion.[1] Research has shown how language can lead to cognitive biases that de-humanise people and legitimatise discriminatory behaviours.[2]

In this paper, we avoid terms such as "drug abuse" or "drug addiction." Instead, we give preference to terms such as **"substance use**," **"problematic drug use,"** and **"people who use drugs**." Using this person-centred, non-moralistic, and non-criminalising language helps avoid reinforcing harmful stereotypes and discrimination.[3,4]

The term **substance use** refers to the harmful or non-medical use of any regulated or unregulated psychoactive substances (e.g., alcohol, tobacco, opioids, stimulants, psychedelics, cannabis, depressants, synthetic cannabinoids, synthetic cathinones). It encompasses a wide range of behaviours, with some individuals using substances more frequently or in different ways than others. We use **problematic substance use** to acknowledge that people relate to substances across a spectrum of risk and harm, without necessarily meeting the clinical criteria for a *substance use disorder*. The negative impact of substance use also varies: for some it is non-problematic, while for others it may harm their health and social well-being. For the purposes of this paper, we avoid medicalised terms such as *alcohol use disorder* or *substance use disorder.*

To better understand the dynamics between substance use and homelessness, we begin with an overview of current knowledge and approaches, recognising the role of trauma and intersectionality, and examining health risks. We then explore how the homelessness sector responds to substance use, highlighting services with a focus on harm reduction and person-centred approaches. Finally, we provide an overview of European drug policy, emphasising human rights–based approaches to supporting people who use drugs. While regulated substances like tobacco and alcohol play an important role, especially in polydrug use, this paper focuses on policy aspects under the European Drug Strategy.

The goal of this paper is to raise awareness of these intersecting issues, contribute to the development of more inclusive practices in the homelessness sector, and advocate for human rights- and health-based drug policies.

# 2. EXPLORING THE INTERSECTION BETWEEN SUBSTANCE USE AND HOMELESSNESS

## 2.1. DATA AND EXISTING APPROACHES

Data collection and monitoring on the experiences of people facing homelessness who use substances is limited, as data is often not collected or analysed at national level. Clear, comprehensive data are lacking, for example, on service provision for people experiencing homelessness who use drugs, both across the European Union and within Member States.[5]

Over the years, various studies have presented flawed or inconsistent estimates, often portraying people experiencing homelessness as having a disproportionately high prevalence of drug use. However, these assumptions have been increasingly questioned. Variations in how homelessness and substance use are defined and measured, along with methodological limitations such as the oversampling of certain groups in cross-sectional studies, can result in inflated or misleading prevalence rates.

Current understanding emphasises that substance use is not a universal experience among people facing homelessness. However, when people experiencing homelessness use substances, the health consequences can be significantly more severe due to social exclusion and lack of access to healthcare. According to the European Union Drugs Agency (EUDA), homelessness and drug use are often related to experiences of chronic homelessness and high-risk drug use.

The EUDA defines high-risk drug use *as recurrent drug use that causes actual harm such as dependence, health complications, psychological or social problems, or significantly increases the risk of such harm.*[6] This can be linked to various factors, including co-occurring physical and mental health issues, social exclusion, and limited access to healthcare, all of which contribute to and reinforce the cycle of homelessness,[7] making this an important and relevant topic to further explore.

Researchers such as Mayock and O'Shaughnessy explore the causal relationship between substance use and homelessness.[8] In their chapter addressing this connection, they first introduce the **Social Selection Model,**[9] which attributes the cause of homelessness primarily to drug use. This model explains that substance use leads to behaviours that eventually result in social isolation and homelessness.

In contrast, the **Social Adaptation Model**[10] suggests that people experiencing homelessness may begin or increase substance use as a way of coping with the realities of life without stable housing. This theory views substance use as a consequence of homelessness rather than its cause.

Both perspectives are supported through literature, highlighting the complex and bidirectional relationship between substance use and homelessness. The authors argue that looking for a single causal explanation is too simplistic for

such a multifaceted issue. Instead, they propose an **Ecological Approach**, which considers the interplay between individual vulnerabilities such as chronic illness and mental health issues, and structural disadvantages such as poverty, social exclusion, and the lack of affordable housing. This approach emphasizes the impact of lifelong adversity, often rooted in trauma, which can deepen personal vulnerabilities.

At FEANTSA, we approach this relationship with a holistic understanding while recognising the individual factors of homelessness and substance use. We emphasise the role of structural and environmental barriers, such as punitive drug policies, criminalisation, stigma and discrimination, lack of stable housing, and barriers in accessing services and appropriate treatment. These can severely limit pathways out of homelessness for people who use regulated or unregulated substances.[11]

When applying a holistic approach to homelessness and substance use, it is essential to consider dimensions such as the role of trauma and intersectionality, which we will examine in the following subsection.

## 2.2. THE ROLE OF TRAUMA

It is crucial to address the role of trauma in the relationship between homelessness and substance use. Many acknowledge that difficult childhood experiences often play a role in the development of substance use issues later in life. For example, findings from a study conducted in the United States indicate that stressful life events and experiences of discrimination are associated with substance use among people experiencing homelessness.[12] Other studies also highlight a connection between past significant traumatic stressful life events and experiencing homelessness, emphasising the long-lasting impact of early adversity and trauma.[13]

In addition to past traumatic experiences, homelessness itself is often a source of trauma.[14] Living in unsafe and unstable conditions poses many challenges, including exposure to violence, lack of shelter, limited access to food, and constant uncertainty. These conditions can lead to a state of hypervigilance, chronic fear, and psychological distress. The absence of safety, comfort, and stability takes a significant toll on mental health. As a result, people facing these adverse environments may use substances as a coping mechanism to survive in such situations. The role of marginality, poverty, victimisation and trauma that some people experience must be acknowledged when trying to understand the relationship between homelessness and substance use.[15]

## 2.3. INTERSECTIONALITY

When discussing homelessness and substance use, it is crucial to adopt an intersectional lens. People come from diverse backgrounds (e.g., migrants, ethnic minorities, LGBTQIA+ individuals, women, among others) and face varying social contexts, which can add layers of complexity to the challenges that they might encounter on a daily basis. These intersecting factors often intensify marginalisation, discrimination, and limit access to social and health care services. Together, they create a complex web of vulnerabilities that cannot be understood in a vacuum.

A 2024 qualitative study conducted in four European cities, which interviewed people with a migration background who use drugs (e.g. asylum seekers, refugees, documented labour migrants and undocumented migrants), found that people face multiple personal challenges and systemic inequalities that heighten the risk of mental health issues and substance use.

Structural barriers to care and support, such as language difficulties, cultural differences, and forms of stigma and discrimination, together with the criminalisation of certain forms of homelessness, drug use, or migration status, not only disproportionately expose them to the criminal justice system but also limit their access to appropriate drug treatment and social services, putting them in a higher position of vulnerability.[16]

Women experiencing homelessness who also use drugs may have different needs than men, as their realities and experiences often differ significantly. Women who use drugs face higher levels of stigmatisation than men, largely due to societal expectations surrounding their roles as mothers and caregivers. This can lead to internalised guilt and shame, which in turn may discourage them from seeking help, particularly when services are discriminatory or gender blind.

Such circumstances place women at heightened risk and vulnerability, often reflected in poorer health outcomes. They may also face greater socioeconomic burdens due to lower levels of employment and income, and some may have had their children removed by child protection services, largely because existing support systems fail to accommodate their specific situations.[17]

Additionally, relationships with drug-using partners can further hinder help-seeking behaviour and increase their risk of experiencing gender-based violence. In fact, women who use drugs have a two to five times higher prevalence of experiencing gender-based violence compared to women who do not use drugs.[18,19]

**Women are often caught up in a vicious cycle of gender-based violence and drug use where the stress and trauma of violence perpetuate the women's drug use, and the actions and behaviours associated with drug use expose them to heightened risk of violence.**

These challenges are often compounded for those who belong to other marginalised sub-groups, such as trans women or migrant women, where overlapping forms of discrimination and vulnerability further intensify the barriers they face. These examples emphasise the importance of applying an intersectional approach in service provision.

# HEALTH RISKS

There is a growing body of evidence linking homelessness to poorer health outcomes. People experiencing homelessness have higher rates of both mortality and morbidity compared to the general population. People experiencing homelessness are disproportionately affected by a range of health conditions, including infectious diseases such as tuberculosis, HIV, hepatitis C (HCV), and hepatitis B (HBC); chronic illnesses such as cardiovascular and metabolic disorders; a high prevalence of mental health conditions; substance use-related issues; and increased exposure to external harms, including unintentional injuries.[20]

On average, people experiencing homelessness die significantly younger than the general population. Given the many variables involved, it is not possible to state what the life expectancy of a person who experiences homelessness is. However, homelessness dramatically increases a person's mortality rate and significantly lowers their expected age at death,[21] often due to preventable causes.

These health inequalities are closely linked to the marginalisation and destitution inherent to homelessness including unsanitary and harsh living conditions that increase vulnerability to health risks. Research has increasingly emphasised the role of social determinants in shaping these inequalities, highlighting the structural barriers people experiencing homelessness face in accessing healthcare, particularly the profound impact of lacking safe and stable housing on health.[22,23]

A qualitative study conducted across four European countries found that access to preventive and primary care is often limited for people experiencing homelessness due to a range of factors, including financial difficulties, transport, awareness of available services, long waiting times, and inflexible and fragmented healthcare systems. For example, low tolerance for missed appointments and requirements such as proof of address or identification to register with a general practitioner often exclude people without stable housing. Negative past experiences within the healthcare system, including trauma and stigma, further discourage individuals from seeking care.[24]

People who experience homelessness and use drugs are at increased risk of serious health harms, including the transmission of infectious diseases and drug overdose. This increased risk is due not only to the challenges mentioned above but also to the additional harms associated with substance use. Particularly, those who inject drugs are at the highest risk of harm.

There are several reasons for this. It can be due to **drug-related factors**, given that the drugs themselves are often unregulated, meaning there is no control over their quality or strength. This increases the risk of overdose, especially when different substances are mixed and interact in harmful ways.[25] Despite the limited evidence available, some studies have indicated that people experiencing homelessness face an increased risk of dying from drug overdose.[26,27]

Lack of stable housing and barriers to find shelter, such as abstinence pre-conditions to access homelessness services, can lead to social isolation and destitution, which increase the risk of preventable drug related overdoses.[28]A recent meta-analysis highlights the social risks (e.g., arrest, incarceration, injury) associated with public injecting settings and calls for housing interventions as an effective strategy to reduce public injecting and related harms.[29]

Other factors are related to **method and hygiene**. Injecting drugs incorrectly can cause tracking and bruising, such as collapsed veins, abscesses, and other injuries. When done in poor hygiene conditions, injecting can lead to bacterial and fungal infections such as cellulitis, abscesses, tetanus, endocarditis, and, in severe cases, sepsis, which can be life-threatening.

Homelessness often leads to unstable or unsafe living conditions, such as overcrowded shelters or sleeping rough, which can increase the likelihood of sharing drug equipment and reduce opportunities for hygienic injecting practices. This environment contributes to a higher risk of contracting infections such as HIV and HCV. Research has shown that people who inject drugs and experience homelessness or unstable housing are more likely to acquire HIV or HCV compared to those who are stably housed. Housing instability is therefore a major factor driving the spread of these infections among people who use drugs.[30]

Two other factors worth highlighting in the connection between poorer health outcomes and people experiencing homelessness who use drugs are the impacts of **stigma** and **criminalisation**

Stigmatisation of people who use drugs in healthcare settings is a common issue, often rooted in moralistic judgments about their "behaviour." People who inject drugs frequently encounter stigma within health services, leading to experiences of discrimination, judgment, and inadequate care. The stigma creates barriers to accessing timely and appropriate medical support, sometimes causing people to avoid or delay seeking help.[31] Consequently, their overall health outcomes are negatively affected.

Stigma is further reinforced by laws that criminalise people who use drugs and permit discriminatory practices against them. Research has shown that criminalisation and discrimination disproportionately affect the most marginalised groups in society.

**There is a clear need for a shift in drug policy, from punitive approaches to a public health model grounded in human rights and person-centred care. The objective of such an approach is not only to reduce the harms associated with drug use, but also to promoting safer, healthier communities.[32]**

# 4. FROM THE STREETS TO ACCESSING CARE

Care approaches for substance use are varied and can be placed on a continuum, ranging from abstinence-based interventions to harm reduction strategies. Abstinence-based treatments usually follow biomedical approaches and are typically provided in inpatient facilities such as Therapeutical Communities or Residential Units. Harm reduction interventions, on the other hand, do not necessarily require that people abstain from drugs. Instead, they aim at increasing the quality of individual and community life well-being.

The type and availability of treatments across Europe depend on the healthcare system and nature of the substance use context. The responsibility to organise such treatments also varies between public institutions and non-governmental organisations.

Correlation – the European Harm Reduction Network, defines Harm Reduction as *humane, non-judgemental, people-centred, and evidence-informed policies and practices that aim to minimise the adverse health, social, economic, and legal consequences of drug use and related drug and health policies.*

## 4.1. TREATMENT PROVISION IN EUROPE — A BRIEF EXPLANATION

In Europe, treatment for problematic substance use is offered in a variety of **outpatient and inpatient settings**. Outpatient services include specialist treatments, primary care, mental health services, and low-threshold services. Inpatient or residential treatment is less common and involves residing in a facility with the goal of abstinence. These facilities, which may be hospital- or non-hospital-based, often require people to stay for several weeks to several months. A prerequisite for entry to inpatient treatment may be detoxification.

In the European context, Opioid Agonist Therapy (OAT) is the most common intervention for **opioid users.** It is generally provided in **specialist outpatient settings**, though in some countries it is also available in inpatient settings and prisons. **Psychosocial intervention**—such as counselling, motivational interviewing, cognitive behavioural therapy, case management, group and family therapy—is the main form of intervention provided for users of stimulant drugs such as cocaine and amphetamines.[33]

When addressing substance use among people experiencing homelessness, there is a clear gap in service provision. Although homelessness responses are often shaped by national strategies, access to primary care, mental health, and addiction services is often not integrated. This fragmentation makes it harder for people who are homeless and use drugs to get the support they need, often perpetuating the cycle of homelessness.[34]

## 4.2. HOMELESSNESS AND HARM REDUCTION

A systematic review of studies examining the views of people experiencing homelessness on substance use treatment found that both harm reduction and

abstinence-based approaches show varying degrees of effectiveness in addressing substance use. The findings highlight that individuals have diverse needs, reinforcing the importance of offering a range of interventions rather than relying on a one-size-fits-all model.[35]

In the context of substance use and homelessness, it is essential to look at the continuum of interventions as a complementary set of services that should be made available and offered without judgment. Simultaneously, we should bear in mind that harm reduction services were often preferred by people experiencing homelessness. This preference was linked to the ability to set individual goals rather than being required to achieve and maintain abstinence. It also reflected a stronger identification with the culture and philosophy of harm reduction, a model that meets people "where they are."[36]

At the same time, people experiencing homelessness that use substances **face many barriers in accessing treatment** or mental health services. These barriers not only further exclude and marginalise people but also make them more vulnerable to substance related harms.

Requiring abstinence as a precondition for accessing services, including permanent housing, often excludes those most in need of support and can lead to poorer health outcomes by limiting access to essential care. Expecting someone to stop using substances in order to secure shelter forces a difficult and potentially dangerous choice. In particular, the self-detoxing from substances such as opioids, alcohol, or benzodiazepines without medical supervision can lead to serious health risks including mental health crises, seizures, heart complications, and dehydration, among other symptoms.[37]

Findings from the HR4Homelessness project in 2021 also analysed conditions related to the use of drugs or alcohol on service premises. The results showed that only 35% of services allowed drug use on their premises, while 45% permitted the use of alcohol on-site. However, 82% allowed access to individuals under the influence of substances. One of the main challenges highlighted is the availability of New Psychoactive Substances (NPS), which made it more difficult for services to adapt their responses. Indeed, the rapid transformation of current drug markets and patterns of use creates a need for constant adaptation by service providers.[38]

Many services also remain difficult to access due to strict eligibility criteria, complex administrative procedures, limited opening hours, high costs, language barriers, physical inaccessibility, and a lack of gender-sensitive approaches. These high threshold models frequently fail to address the diverse and complex needs of people experiencing homelessness.

Harm Reduction services play a crucial role in reducing the risks associated with drug use.  Examples include drug consumption rooms, low-threshold services, needle exchange programmes, targeted infectious disease programs, mobile clinics, and access to pharmacological therapies such as opioid agonist therapy (OAT), manage alcohol programs,

heroine-maintained programs. Other key interventions include peer work, HIV/AIDS and viral hepatitis testing, treatment and care services in community-based or community-led settings, as well as the provision of naloxone to reverse respiratory depression caused by opioid overdose. These services are essential for reaching individuals who cannot or do not wish to access high-threshold services. There is solid evidence supporting the effectiveness of harm reduction strategies.[39]

Over the past three decades, harm reduction in some EU countries has expanded to include innovative and pragmatic responses—including those supporting people experiencing homelessness.[40] These developments reflect a growing awareness that substance use harms are not only individual but are deeply shaped by structural factors—including inadequate housing, inaccessible or rigid services, stigma, and punitive drug laws. This underscores the importance of integrating harm reduction into broader homelessness responses.[41]

**Despite this progress, many homelessness services still lack the resources, training, or structural capacity to implement harm reduction effectively.**

The 2024 C-EHRN Monitoring Report on Essential Harm Reduction Services, covering 35 European countries, highlights persistent gaps in service provision for people who use drugs and experience homelessness. Only 5% of respondents reported that harm reduction services were available in shelters and housing services to a great or moderate extent, while 27.5% said they were available only to a small extent.

Moreover, 40% noted a decline in the availability of shelters and housing between 2020 and 2024. When asked about the ability of harm reduction services to provide targeted support for people experiencing homelessness, 45% responded "to a great extent," while 15% said "not at all." Half of respondents said harm reduction services do cooperate with housing institutions, though many described this cooperation as challenging.[42]

**The HR4Homelessness Project Called For A Human Rights-Based Service Provision Built On Harm Reduction (HR) Principles:**

1. **Meaningful Engagement:** People with lived experience of homelessness and substance use are involved in shaping and evaluating policies and services. Their participation is vital to improving outcomes and addressing unmet needs.
2. **Reducing Harms:** HR focuses on minimising the negative impacts of substance use on individuals and communities, while recognising factors such as trauma, incarceration, racism, social disadvantage, housing insecurity, age, sexual orientation, and gender that increase vulnerability.
3. **Pragmatic Perspective:** HR accepts that regulated and unregulated substance use exist in society and rejects the idea of "perfect" health behaviours, which are unattainable and shaped by social norms and determinants.
4. **Person-Centred Services**: HR responds to individual and community needs, addressing power imbalances, recognising the social conditioning of health, and promoting shared decision-making.
5. **Evidence-Based Practice:** HR supports interventions that are effective, relevant, and regularly evaluated and adapted.
6. **Accountability:** HR aims to reduce harms caused not only by substance use but also by policies, laws, services, and institutions, promoting systems that ensure accountability for decisions and actions.

While abstinence-based options should be available for those who actively choose them, making abstinence mandatory can cause harm, hinder meaningful engagement, and reduce adherence to treatment and ongoing care. It is therefore essential to further invest in and to develop HR in the homelessness sector. The HR4Homelessness project contributed to this objective by bringing together homelessness and substance use services. Its aim was to develop guidance materials to improve support for people who use drugs and/or alcohol and experience homelessness, while emphasising the **importance of integrating harm reduction into homeless service provision.**

In the next section we explore guidelines and good practices in service provision that can facilitate support for people experiencing homelessness who use drugs.

## 4.3. MEETING THE NEEDS OF PEOPLE EXPERIENCING HOMELESSNESS WHO USE DRUGS

A recent qualitative analysis highlighted the **role of stable housing in recovery journeys** and identified it as a crucial factor in supporting people experiencing homelessness who use drugs. The findings emphasised the **need for comprehensive and coordinated services** across mental health, addiction services, healthcare, housing, and social care, all of which should follow harm reduction and recovery-oriented approaches. [43]

Another study, conducted across eight European countries and based on data from adults using homelessness services, similarly highlighted the importance of housing in reducing the harms and other negative consequences associated with substance use and homelessness. The study compared individuals in **Housing First programmes** with those accessing traditional services (that follow treatment-first approach), finding that Housing First was associated with lower levels of problematic alcohol and drug use, and offered a better option to reduce the harms related with substance use. [44]

In addition to the central role of housing, the evidence suggests that **services promoting physical and emotional stability**, where individuals feel a sense of **belonging** and where their substance use is not the primary focus, are more effective. For instance, some hostels, as a form of housing support, may hinder recovery from both substance use and homelessness by failing to promote these key components.[45] Indeed, other studies have highlighted that, from the perspective of service users, substance use services should offer facilitative environments characterised by **compassionate and non-judgemental support**, ideally including **input from people with lived experience.** Effective interventions are those that are sufficiently **long in duration, provide continuity of care, offer choices regarding treatment approaches and, create opportunities for people to (re)learn how to live.**[46]

**Recovery is understood as more than merely abstaining from drug and/or alcohol use; it involves engagement with appropriate support services, access to adequate and unconditional housing, the development of positive relationships, and meaningful participation in daily life. Recovery is described as an active and mutually reinforcing process centred around participation in meaningful activities.**[43]

# GOOD PRACTICES

Building on the lessons from the HR4homelessness project and FEANTSA's earlier work on "Good practice guidance for working with people who are homeless and use drugs"[47], we have developed a set of recommendations to take be considered when developing and implementing services for people experiencing homelessness who use drugs:

1. **INVOLVE PEOPLE WITH LIVED EXPERIENCE** of drug and/or alcohol use and/or homelessness in the design, delivery, and evaluation of services, and ensure that their suggestions contribute to the ongoing improvement of those services.
2. **ADOPT A PERSON-CENTRED AND INTEGRATED APPROACH** to care and support by addressing physical and mental health needs and promoting social integration, while respecting individuals' personal priorities and decisions.
3. **SHIFT FROM ABSTINENCE-BASED INTERVENTIONS TOWARDS RECOVERY-ORIENTED** approaches that recognise individual pathways and progress.
4. **RECOGNISE RELAPSE AS A PART OF THE RECOVERY PROCESS** and avoid punitive responses, particularly those that involve denying or withdrawing access to basic care.
5. **ENSURE ACCESS TO PERMANENT HOUSING** for people experiencing homelessness who use substances**,** without requiring abstinence as a precondition.
6. **SUPPORT AND SCALE UP HARM REDUCTION SERVICES** such as needle and syringe exchange programmes, opioid agonist therapy (OAT), take-home naloxone programmes, drug and alcohol consumption rooms, and managed alcohol programmes.
7. **INTEGRATE HARM REDUCTION PRINCIPLES INTO HOUSING SERVICES** such as shelters and temporary accommodation (e.g., alcohol consumption rooms, managed alcohol programmes, syringe exchange schemes, HIV and hepatitis screenings, and drug consumption rooms).
8. **ENSURE THAT HARM REDUCTION, HEALTHCARE, AND SOCIAL SUPPORT SERVICES ARE LOW THRESHOLD,** allowing easy access and providing flexible hours adapted to the needs of service users (e.g., evenings, weekends, and holidays).
9. **PROVIDE DEDICATED SPACES AND/OR OPENING TIMES FOR SPECIFIC GROUPS** of service users, acknowledging the multiple vulnerabilities of people with diverse sexual orientations, cultural backgrounds, and age groups (e.g., women-only spaces or women-only opening times).
10. **PROVIDE REGULAR TRAINING FOR STAFF AND SUPPORT CONTINUOUS CAPACITY-BUILDING.**

## INSPIRING PRACTICE FROM FEANTSA MEMBERS: ARES DO PINHAL- PORTUGAL

The Municipal Emergency Shelter of Lisbon (CAEM) operates in partnership with Lisbon City Council, Associação Vitae, and Associação Ares do Pinhal, providing an integrated shelter service for 128 people experiencing homelessness. Ares do Pinhal is responsible for the Health Support Programme, which focuses on health screening, monitoring, and support, with particular attention to addictive behaviours and dependencies. This work is carried out in a dedicated space within the shelter known as ECAD.

As Part Of Its Health Intervention Goals, The Programme Aims To:

- Promote dignity and health education among residents.
- Provide medical assessments and ensure access to physical and mental healthcare.
- Monitor and support ongoing medical and nursing treatments.
- Carry out screening and provide referrals for transmittable diseases for all shelter residents.
- Offer tailored addiction awareness and risk and harm reduction programmes.

The programme also contributes to public health by reducing the transmission of infectious diseases. In addition, the programme delivers a targeted intervention for residents who use drugs (ECAD). This specialised response addresses the specific needs and barriers faced by individuals who inject or smoke drugs and/or consume alcohol within the shelter context.

Its objectives include:

- Developing individual, patient-centred care plans adapted to each person's needs.
- Preventing or reducing hidden drug use in shared shelter spaces (e.g. dormitories and bathrooms).
- Allowing for supervised substance use, with guidance on safer drug use practices.
- Distributing sterile consumption equipment and promoting harm reduction strategies for alcohol use.

The service aims to support safer and more controlled consumption in a hygienic, purpose-designed environment, while also reducing consumption-related waste and noise within the shelter and its surrounding community.

# 5. EUROPEAN DRUGS POLICY AND HOMELESSNESS

## 5.1. Organisation of the European Drugs Strategy

The EU Drugs Strategy 2021–2025,[48] approved by the Council of the European Union in December 2020, aims to ensure a high level of health protection, social stability, and security, while also raising awareness of the EU drugs situation.

The Strategy is structured around three policy areas: **reducing drug supply; reducing drug demand**; and **addressing drug-related harm**. It also identifies three cross-cutting themes**: international cooperation; research, innovation, and foresight;** and **coordination, governance, and implementation**. It also sets out the political framework and priorities for the EU's drug policy and complements national policies. It also provides the basis for t the Council's EU Action Plan on Drugs 2021 to 2025[49], which outlines 85 specific measures to achieve its priorities.

Beyond this, the Council and EU Member States are working together to better support people with mental health and *substance use disorders*. On 4 December 2023, the Council approved conclusions on people with *drug use disorders* that co-occur with other *mental health disorders*.[50] The Council invited Member States to consider *substance use disorders co-occurring with other mental health disorders* as an important challenge for drug and mental health services and policies. Achieving this requires a multidisciplinary and comprehensive response to the needs of people with these vulnerabilities. This includes facilitating access to effective treatment, in line with the goals set in the EU Drugs Strategy 2021–2025 and the related Action Plan.

The EU Drugs Strategy also involves close cooperation with both European and international agencies and organisations. The **European Union Drugs Agency (EUDA)** plays a central role in monitoring drug trends and emerging threats, issuing early warning alerts, developing evidence-based interventions, offering guidance, and promoting knowledge exchange across Member States. The agency provides a methodological framework and facilitates coordination among EU institutions, Member States, and relevant stakeholders. However, the formulation and implementation of drug policies remain the responsibility of each Member State, meaning that the application of EUDA guidance may vary depending on national political priorities.

Additional European agencies involved in drug-related topics, primarily from a law enforcement perspective, include Europol (EU Agency for Law Enforcement Cooperation), Frontex (European Border and Coast Guard Agency), Eurojust (EU Agency for Criminal Justice Cooperation), as well as CEPOL (EU Agency for Law Enforcement Training). On 18 October 2023, the European Commission

proposed a new EU Roadmap to counter drug trafficking and criminal networks,[51] which complements the existing Strategy. At the multilateral level, the EU engages in strategic cooperation with the United Nations Office on Drugs and Crime (UNODC) and actively participates in forums such as the UN Commission on Narcotic Drugs.

The EU also cooperates with the Pompidou Group of the Council of Europe, which promotes evidence-based, health-centred drug policies across 42 countries. At its 18th Ministerial Conference in December 2022, held under the theme *"Human Rights at the Heart of Drug Policies"*, the Group adopted the Lisbon Declaration, reaffirming its commitment to a human rights-based approach to drug and addiction challenges.[52]

In the current EU Action Plan on Drugs 2021 to 2025, homelessness is mentioned in relation to several strategic priorities:

- Increasing the partnership approach in the provision of effective, evidence-based, selective and indicated prevention measures to prevent the development of risk behaviours and reduce progression into severe *drug use disorders* among those experiencing multiple disadvantages, such as homelessness (Action 29);
- Developing and ensuring voluntary, non-discriminatory and gender-sensitive access to effective, evidence-based drug treatment, including person-centred opioid maintenance therapy, risk and harm reduction, rehabilitation services, social reintegration and recovery support (Action 32);
- Maintaining and, where needed, scaling up measures to reduce the prevalence of drug-related infectious diseases, in particular the early diagnosis of Hepatitis C and HIV/AIDS, promoting rapid testing and self-testing for HIV and outreach programmes, and promoting the diagnosis of tuberculosis among people who use drugs and homeless people (Action 44).

As previously highlighted by Correlation, the European Harm Reduction Network[53], the current EU Drug Action Plan recognises the three important pillars: **drug supply reduction, demand reduction, and addressing drug-related harm**, which acknowledges the crucial role of harm reduction services. However, its implementation has remained disproportionately focused on law enforcement and security. Particularly, the persistent shortage of funding for health and harm reduction services limits the availability and accessibility of service provision, undermining efforts to address the harms associated with substance use. This is especially true for marginalised groups such as people experiencing homelessness.

The independent evaluation of the previous European Drugs Strategy (2005–2012)[54] showed that harm reduction services remained largely under-implemented in the EU and suggested scaling them up. The recently published Commission Staff working document[55] notes that the Strategy and the Action Plan for 2021-2025 have also failed to ensure full coverage of harm reduction interventions across the EU, such as

opioid agonist treatment and needle and syringe programmes, with overall performance still falling below WHO targets. The Action Plan had a limited impact on access to harm reduction services across the EU. However, there are differences in the availability of services across Member States.

As previously highlighted in this paper, people experiencing homelessness are more vulnerable to drug-related harms. The current Plan has not been successful in reducing the number of overdose deaths, which have instead continued to increase. There is evidence pointing to inequalities in the continuum of care for infectious diseases, particularly for people with migrant backgrounds. The evaluation points out that the EU Drugs Strategy does not adequately reach people experiencing homelessness who use drugs and that partnerships with relevant stakeholders are very weak.

The situation remains a serious concern, as access to treatment for marginalised groups, such as people experiencing homelessness, has not significantly improved, and the prevalence of drug-related infectious diseases continues to fall behind of WHO targets. Additional challenges include the increase of right-wing governments across Europe and the appearance of new psychoactive and other substances, for which the EU and Member States are not sufficiently prepared to intervene.

## 5.2. EU DRUGS STRATEGY AND EU ACTION PLAN FOR 2026-2030

As the EU Drugs Strategy 2021-2025 nears its conclusion, the European Commission is working on an updated version that will define the political direction and priorities for the period 2026–2030. The initiative aims to update policy frameworks and propose concrete actions to combat drug trafficking both within the EU and internationally, highlighting a coordinated approach to adapt to emerging threats.[56]

This process presents a crucial opportunity to shift towards a balanced, health-focused, and human rights-based approach to drug policy. Such a shift would require dedicated EU-level funding for harm reduction, alongside the prioritisation of decriminalisation and responsible regulation.[57]

FEANTSA calls for the EU and Member States to use this opportunity and adopt a more health-centred and human rights-based approach to drug policy, which should be the core priority of the new Strategy. People who use drugs and other marginalised groups, such as people facing homelessness, are disproportionately affected by criminalisation and systemic exclusion from healthcare. To ensure both a public health and human rights approach to EU drug policy, it is crucial to shift the focus towards supporting, not punishing, people who use drugs.

# KEY POINTS

FEANTSA highlights the following Key Points Relating to People Experiencing Homelessness and Substance Use, to be considered in the design of the upcoming European Drugs Strategy for the period 2026–2030:

## 1. STRENGTHEN PARTICIPATION

Increase efforts and investment in initiatives that ensure the meaningful involvement of people with lived experience, alongside other relevant stakeholders, in the development and implementation of drug policies.

## 2. MAINTAIN FOCUS ON HOMELESSNESS IN EU DRUG POLICY

The previous Council Action Plan recognised the need to ensure effective support for specific groups of people who use drugs, explicitly including people experiencing homelessness. The new Strategy should continue to prioritise targeted services for this group, ensuring real progress. Supported housing and harm reduction measures have proven effective in reducing harms linked to substance use and homelessness. Therefore, EU Member States are encouraged to:

### 2.1 EXPAND HARM REDUCTION SERVICES

Ensure service provision based on a person-centred harm reduction approach and establish dedicated EU-level funding for evidence-based measures such as needle and syringe programmes, opioid agonist therapy (OAT), take-home naloxone, and drug consumption rooms. The latter two are crucial in responding to the challenges posed by synthetic drugs, opioids, and polysubstance use, and in preventing drug-related overdoses.

### 2.2 PROMOTE THE RIGHT TO HOUSING

Guarantee unconditional access to housing as an integral component of a comprehensive and person-centred response to substance use. This approach should be systematically embedded in national drug strategies and action plans, recognising housing as a fundamental prerequisite for health and social inclusion.

## 3. GUARANTEE HEALTHCARE ACCESS

Establish a funding mechanism to support health-oriented drug policy innovation and public health responses, ensuring access to healthcare for people experiencing homelessness who use drugs. Restricted or no access to healthcare—often faced by people with precarious residence status—places their health at serious risk and exacerbates the spread of undiagnosed infectious diseases. This can be achieved by:

### 3.1 SCALING UP COMMUNITY-LED HARM REDUCTION

Ensure service provision based on a person-centred harm reduction approach and establish dedicated EU-level funding for evidence-based measures such as needle and syringe programmes, opioid agonist therapy (OAT), take-home naloxone, and drug consumption rooms. The latter two are crucial in responding to the challenges posed by synthetic drugs, opioids, and polysubstance use, and in preventing drug-related overdoses.

### 3.2 ENSURING UNCONDITIONAL ACCESS TO TREATMENT

Guarantee access to drug- and alcohol-related services and treatment for all, without restrictions.

## 4. MAINTAIN FOCUS ON HOMELESSNESS IN EU DRUG POLICY

Incorporate the solutions developed during the pandemic into future policy action. Maximise the use of existing frameworks and funding instruments to end homelessness and strengthen support for people experiencing homelessness who use drugs. Particular attention should be given to best practices identified by the HR4Homelessness project, such as the low-threshold provision of methadone, benzodiazepines, and naloxone.

## 5. COMBAT STIGMA

Invest in awareness-raising to promote a shift away from stigmatising and discriminatory approaches that marginalise people and hinder access to care.

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FEANTSA

**European Federation of National Organisations Working with the Homeless**

194 Chaussée de Louvain, 1210 Brussels, Belgium

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