



# HR4Homelessness

**Integrating Harm Reduction in Homeless Services**

## **COUNTRY REPORT DENMARK**

Henrik Thiesen, Lene Tanderup, HealthTeam City of Copenhagen



**Erasmus+**

*This project is funded by the European Union.*



## Abstract

Homelessness has been on the rise in Denmark since the financial crisis in 2009. Homelessness has especially increased among specific groups: Among young people (below the age of 30) where homelessness has doubled, among migrants from other EU Member States, including people from Eastern Europe (after the EU-expansion in 2004) and people of African origin who, having lost their jobs in Southern Europe, came to Denmark. These developments strongly changed the demographics of homelessness in Denmark: whereas at the beginning of the 21st Century, most people in situation of homelessness were Danish origin, homelessness has been affecting more and more persons with migrant background. The lack of a regular residential status limits the person's access to health care to emergency treatment which is an important issue as many people in situation of homelessness have diverse health support needs.

There has been major improvements to harm reduction in the larger cities but the situation seems to be somewhat stagnated in the rest of the country. A reform of local governments in 2007 did put the regional drug treatment systems on hold and most of them were transformed into numerous local community systems. It is still not possible for migrants without regular legal status to access substitution treatment (they can only access emergency health care).

An important progress was the establishment of five drug consumption rooms were developed between 2015 and 2018, however no new sites or further development of existing sites has occurred since then.

Health outreach has been consistently developed in a few large cities but fluctuating in the rest of the country, mostly consisting of local projects with a 2-3 year lifetime which were not followed up after the pilot phase.

Over a 20-year period harm reduction has developed in Denmark but development has been slow outside the big cities. Periods of progress and (further) establishment of HR services were often followed by periods of little or no progress.

## 1. Trends in homelessness and drug use

### 1.1 Data on homelessness

Since 2007 the number of people living in homelessness (based on the ETHOS classification) has been registered in a national point-in-time (one-week) count every second year. From 2007-2017 there has been an increase, but in the last published data from 2019, a small decrease is seen. The number of people living in homelessness in Denmark in 2019 is registered to be 6.431, compared to a total population of 5,8 million. The number of people in situation of homelessness is expected to be underestimated, as only the ones who are in contact with an NGO or a public organization/institution during this specific week are included in the point-in-time count.

Table 1: Number of people in different homeless situations in a specific week, 2009-2019 (Benjaminsen et al. 2019)

Homeless situation	2009	2011	2013	2015	2017	2019
Rough Sleeping	506	426	595	609	648	732
Night shelter	355	283	349	345	305	313
Day Shelter	1.952	1.874	2.015	2.102	2.217	2.290
Family/Friends	1.086	1.433	1.653	1.876	2.177	1.630
Hotel/Hostels (emergency/temporary accommodation,	88	68	70	113	165	191

referred to by local authorities)						
Halfway House – a step from shelter to stable housing	164	227	211	178	169	121
Probation	86	88	64	90	68	72
Hospital	172	173	119	138	149	148
Other e.g. caravan or cabin	316	367	370	339	258	380
Not Specified (No available information)	273	351	374	348	479	554
Total	4.998	5.290	5.820	6.138	6.635	6.431

As Table 1 shows, the most people in situations of homelessness live in shelters, with family/friends or are sleeping rough. Most persons who experience homelessness live in one of the four largest cities in Denmark – Copenhagen, Aarhus, Odense and Aalborg. However, in the last few years, homelessness has slightly decreased in larger cities while it increased in smaller cities in urban areas.

Since 2017 there has been a decrease in the number of young people in situation of homelessness (<30 years old). The decrease is seen, after a 100% increase over a 10-year period was reported for this young age group. In contrast to this decrease, data from 2019 show a growing number of middle-aged and older homeless people (aged 50 or older) who represent a large number of rough sleepers and users of shelters. The increase in older people experiencing homelessness (>60) shows a growing need of nursing homes for homeless people who use drugs, and present physical and mental health problems - problems that are primarily caused by a lifetime of homelessness. Young persons in situation of homelessness are mainly couch-surfing with family and friends.

Table 2: Number of people living in homelessness, divided in age-groups

Age	2009	2011	2013	2015	2017	2019	%-change 2009-2019	%-change 2017-2019
< 18	200	204	144	96	39	13	-94	-67
18-24	633	1.002	1.138	1.172	1.278	1.023	62	-20
25-29	490	596	617	799	1.014	905	85	-11
30-39	1.221	1.155	1.189	1.261	1.328	1.312	7	-1
40-49	1.357	1.263	1.414	1.423	1.270	1.365	1	7
50-59	744	734	833	951	1.057	1.131	52	7
60 -	235	232	289	301	347	414	76	19
Total	4.880	5.186	5.624	6.003	6.333	6.163	26	-3
Unknown age	118	104	196	135	302	268		

In 2019 82% of the homeless population is of Danish ethnicity – including 8% from Greenland. 18% come from the Middle east, Africa, EU and other Nordic countries. Besides the 6.431 homeless in 2019, 519 homeless migrants with no permanent residency permit in Denmark were registered – the number is likely to be inaccurate and underreported, therefore they are not included in the total number of homeless.

In a gender perspective, 77% of the homeless are men, and 23% women, numbers that with smaller fluctuations has been the same over a 10-year period.

In a typical Scandinavian welfare state such as Denmark, homelessness is widely concentrated amongst people with severe psychosocial problems and complex support needs. The homelessness problem in Denmark is not widely associated with more general poverty problems, but more a part of a pattern of multiple social exclusion. If marginalized groups are excluded from the labor market, it has not only financial consequences for the individual but also represents an exclusion from daily meaningful activities and social contacts.<sup>1</sup>

## 1.2 Drug use among homeless people

The National Health Boards report – Drug situation in Denmark 2019<sup>2</sup>, estimate the number of people with High Risk Drug Use (opioids and other illegal drugs, cannabis not included) at 51,830 including people in substance use treatment. The definition of high-risk drug use is a consistent use of drugs leading to physical, mental and/or social harm. High risk users of Cannabis (use of Cannabis 20 days or more a month according to EMCCDA) is estimated to 32.600 people. The number of high-risk Cannabis users refers to self-reported numbers in national surveys. According to Danish Statistics (2018), 16.961 persons receive drug treatment in 2018.

When it comes to alcohol, data from the National Health Board (2018) shows that the consumption of alcohol in Denmark on average is 9,7 liters of pure alcohol per adult a year. It is perceived to be higher, as the alcohol bought and consumed abroad is not accounted for. The estimated consumption per person a year is of 12 liters (pure alcohol).

Denmark has an alcohol culture where alcohol is easily accessible and an accepted/expected part of many social events and everyday life. At the age of 16 you can buy alcohol, and the Danish youth have for years had the European record when it comes to the highest amount of alcohol intake. Many youngsters have had their alcohol debut before the age of 15.

In the adult population 640.000 has a harmful use of alcohol, and 147.000 people has an alcohol addiction that requires alcohol treatment. 17.583 receive public alcohol treatment. (National Health Board 2018) Among those who received treatment for alcohol/drug addiction in 2017, 4,8% received inpatient treatment, the rest outpatient. The criteria for receiving inpatient treatment include:

- Outpatient treatment has been tried - but not successful
- Cognitive well-functioning
- Secure housing and a stable network
- Motivation
- Only 'light' mental issues

---

<sup>1</sup> Homelessness in a Scandinavian welfare state: The risk of shelter use in the Danish adult population Benajmisen, L. (2016); Urban Studies 2016, Vol. 53(10) 2041–2063 ([https://pdfs.semanticscholar.org/2e74/08d302bd218c1eb69c99fb9d783ff5d16696.pdf?\\_ga=2.191954857.2011281191.1588859699-1574912824.1588859699](https://pdfs.semanticscholar.org/2e74/08d302bd218c1eb69c99fb9d783ff5d16696.pdf?_ga=2.191954857.2011281191.1588859699-1574912824.1588859699))

<sup>2</sup> Sundhedsstyrelsen. Narko <https://www.sst.dk/-/media/Udgivelser/2019/02-National-rapport-08-udgivelse.ashx?la=da&hash=1D4ABFF7A00F912010D914DBDA7B8D278BE733> tikasituationen i Danmark 2019 – delrapport 2

Many of the criteria's will be a barrier for the people in situation of homelessness to receive inpatient treatment, and as a result the majority of the homeless are offered outpatient treatment – and often not successfully.

In the homeless population 66% present harmful use/addiction to alcohol and drugs (Benjaminsen et al;2019). It is a difficult task to get hold of both homelessness and use of alcohol and drugs, when the living conditions do not offer the optimal frames for a successful detox. Furthermore, use of drugs and alcohol can be seen as a coping strategy. people experiencing street homelessness in Copenhagen in 2003, showed a division in the group in primarily alcohol or opioid users, and that most opioid users, used 4 or more drugs on a daily basis<sup>3</sup>. Compared to the total population, research has shown a 13-22 times increase in the risk of substance use among homeless men, and 28-45 times higher risk of substance use for homeless women.<sup>4</sup>

Table 3: Age-standardized risk ratios for substance use between the homeless and the rest of the population

	Men living in homelessness Compared to the total population		Women living in homelessness Compared to the total population	
	RR	95 pct. CI	RR	95 pct. CI
Use	13,52	12,75-14,34	28,51	24,27-33,49
Alcohol use	13,07	12,23-13,96	28,65	23,92-34,31
Drug use	22,66	20,28-25,33	45,35	33,78-60,88

Compared to the standard mortality rate in Denmark, mortality among homeless men is 7,8 times higher, and for homeless women 13,1 times higher than the overall population. Mortality increases almost exponentially with increasing numbers of stressful life circumstances – most significant if there are 3 or more stressful life circumstances present –e.g. abuse, homelessness, mental disorders and poverty.<sup>5</sup>

### 1.3 Access to harm reduction services among homeless people

Chapter 2.2 describes the laws that defines public access to substitution treatment and public Harm Reduction in the 98 communities of Denmark. All access to public systems is defined by the health laws and thereby also conditioned upon the individual having a Central Person Register number (CPR). Substitution treatment without a CPR is not accessible but individual hospitals and low threshold medical outreach services might provide a short-term medical withdrawal treatment. A homeless person with a CPR can access treatment anywhere in Denmark and payment has to be provided by the community where the person had housing.

Access to healthcare is free for all in an emergency and treatment for problems directly derived from the emergency will also be provided. This also covers individuals without a CPR.

The Red Cross has 3 free clinics for migrants without CPR<sup>6</sup>, where primary healthcare is provided by volunteer specialists. The larger cities have community paid low threshold clinics and outreach teams and several cities have out-reach nurses who will provide basic healthcare for free for homeless

<sup>3</sup> Evaluation report concerning The “Health Project” and “Street talk teams” Feb 2005 publication description Copenhagen City (Københavns Kommune)

<http://www.hjemlosesundhed.dk/downloads/Extract%20of%20the%20Health-project%20evaluation%20report.pdf>

<sup>4</sup> Hjemløse borgeres sygdom og brug af sundhedsydelser, Benjaminsen et al. 2013: <https://www.vive.dk/media/pure/4975/275801>

<sup>5</sup> <https://viden.sl.dk/media/6830/doedelighed-blandt-socialt-udsatte-2007-2012.pdf>

<sup>6</sup> <https://www.rodekors.dk/vores-arbejde/sundhedsklinik>

people, including migrants, who visit the clinics or low threshold day centers. The system in Copenhagen, as an example, is based on a close cooperation between the public and NGO organizations to provide basic care.

Public health and prevention of the spreading of infectious diseases is described in the health law and primarily a job for the primary healthcare system including general practitioners but since it is reliant on the CPR-system and assignment of a certain GP to every citizen it can be problematic for homeless to use their right to healthcare if they are not staying in the region where the GP on their health card is situated. Oversight with infectious diseases among homeless people is lacking focus in the CPR-driven healthcare system.

Tuberculosis: The Capital region has a dedicated out-reach nurse and a mobile X-ray clinic that constantly monitors drug users and homeless for TB. Treatment is provided via the regional hospital system.

Hepatitis: there is a growing awareness of active monitoring of Hepatitis. Hepatitis vaccine is free for marginalized groups, especially homeless and drug users. Provision of vaccine can be done at emergency encounters, by substitution treatment and by health outreach teams.

The Drug user's academy<sup>7</sup> has an active team of volunteer nurses who in collaboration with local healthcare takes samples for Hep C antibodies and afterwards tries to bridge the gap between drug users and the local healthcare system. Treatment for Hep C is available for all with a CPR but it is still a specialist job to treat.

Public shelters in general have the same approach and in general demands a CPR but since the individual acceptance into a shelter is determined by the shelter manager it is in principle possible to provide a room but the state will not refund the costs so publicly managed shelters will in general not provide housing for people without legal permit to stay. Several NGO's have day centers and night shelters<sup>8</sup> for undocumented migrants and these work on a voluntary base and financially supported by donations and eventually local public funding.

DCRs, the provision of needles and other paraphernalia is under the health-laws but funded, at least partially by the state as is naloxone provision and training. Access to these types of harm reduction is not dependent on a CPR so they might also be accessible for homeless and especially migrants without CPR.

## 2. Relevant Laws and policies

### 2.1 Laws and policies on homelessness

In Denmark there is no law on homelessness, but in 2017 the Governments '*National Strategy to reduce Homelessness 2018-2021*'<sup>9</sup> was introduced. The strategy is based on reports from the first National Homeless Strategy that took place from 2009-2013.

The present strategy consists of 4 focus points and 15 initiatives:

*Focus 1: National use of evidence-based practice (National Guidelines)*

1. Social investment fund into homelessness (investment in progressive preventive initiatives with a holistic focus, with the aim to reduce long-term cost for the municipalities)
2. National guidelines for homelessness

---

<sup>7</sup> <https://brugernesakademi.dk/>

<sup>8</sup> <https://kbh.kirkenskorshaer.dk/sted/kompasset-english/>

<sup>9</sup> Handlingsplan til bekæmpelse af hjemløshed. Børne- og Socialministeriet:

<https://socialstyrelsen.dk/projekter-og-initiativer/voksne/handlingsplan-til-bekaempelse-af-hjemloshed>

3. National guidelines for initiatives towards ending homelessness

*Focus 2: Strengthen the prevention of homelessness*

4. Housing First for youth
5. Youth Housing with support from social worker, established in already existing places for young people
6. Prevention of evictions
7. An overall scheme for financial- and debt counseling

*Focus 3: An easier way out of homelessness*

8. Strengthen the cooperation of shelters and municipalities, to make permanent accommodation available for the sheltered person.
9. Simple, minimized and flexible connection to job center, case manager etc.
10. Support for citizens in long term homelessness
11. Outreach Psychiatry
12. Revision of the 'crooked housing' scheme (single barracks for long term homeless)
13. Better information and securing of homeless rights – support for user organizations

*Focus 4: Other*

14. Explore on women and homelessness
15. Support for emergency-shelters (night shelters during the winter)

Overall, the aim of the strategy is to promote a holistic view on homelessness, and to prevent, rather than to 'cure'. One of the key tools in the strategy is to offer a social action plan to the homeless, a plan that ensures cohesiveness and continuity in the overall efforts to support the person in situation of homelessness. The purpose of the plan is to ensure that different municipal administrative units, regional and national authorities' efforts are well thought through and coordinated.

In April 2017 the Ministry of Justice approved a law - 'Extended authorization to lay down rules concerning zone-prohibition'. With this law the government want to act against foreign travelers, who made camps in public places – parks, pedestrian areas etc. The camps - called 'insecurity creating camps' - can be a nuisance to the surroundings in form of noise, turmoil and unsanitary conditions, and be seen as a threat to the public security. The law applies until March 2021 and gives the police a possibility to give the people who makes a camp a penalty and a 'zone prohibition', meaning that they are not allowed to enter a zone that can extend to the whole municipality.

The law is aimed at foreign travelers, often homeless foreigners from African and Eastern European countries, who try to make a living through begging or collecting bottles for deposit. Nevertheless, the law also concerns Danish homeless who are rough sleeping. In October 2018 a Danish homeless man who used to sleep in the streets with his dog, was given a penalty and was not allowed to enter Copenhagen Municipality for the next 3 months. The incident generated a lot of attention, as the man was not able to get his medicine from the street nurse, neither could he meet his outreach case manager etc., due to the ban from Copenhagen Municipality. The street lawyers took the case to court and politicians claimed that the law criminalized the homeless and made it illegal to take care of each other – a situation that further increased their vulnerability. The lawyers won the case, as the law is aimed at larger groups with permanent camps, and not at one or two persons sleeping rough. But the fear of sleeping rough in groups has remained among the homeless, they are afraid of getting penalties and zone prohibitions.

## 2.2 Laws and policies on drug use and harm reduction

Harm reduction seen as a broad approach to address the harms related to drug use and the legislation and policing against drugs is managed in different laws.

### *Health*

Access to healthcare is regulated in the general health-laws<sup>10</sup> and healthcare is performed by seven regional systems.

Everyone can access emergency care directly and immediate treatment can be granted if the attending physician assesses that immediate treatment is needed. Medical prescriptions are paid by the patient. If the patient has a social security card, there is a limit on 300 Danish kroner (40 Euro) a month on how much you have to pay for medicine. Amounts above 40 euros are covered by the government. Patients who do not have a social security card, has to pay the full amount with no refund from the government. Only acute medical treatment is possible to obtain for free.

General access to the Danish healthcare system is universal for people with a residence permit. People who have this permit is equipped with a social security number and card which in general opens access to all kinds of treatment, mostly via reference from a specific general practitioner named on the card.

The connection with a specific GP is important in understanding barriers to healthcare for homeless and undocumented migrants in the Danish society. It is only possible to access specialist care by direct inquiry if the patient pays for treatment. Access to free healthcare is granted via the reference from a GP and access to the GP is possible via the residence permit and the health-card.

Homeless Danish citizens without a permanent address does have access to healthcare via registration as homeless and a health-card without a specific address.

### *Drugs*

Which drugs that are included in general as illegal drugs are covered in the general narcotics law<sup>11</sup>.

Drug treatment including alcohol treatment and substitution treatment is also regulated by the health laws, but substitution is based in the 98 local communities which have an obligation to provide substitution treatment and communities can outsource substitution to other communities. There is a 14-day guarantee for treatment initiation but as with treatment in general there is only access for persons with residence permit.

Substitution is regulated directly in the health laws and via a guideline for medical substitution treatment<sup>12</sup>. The social/therapeutic part of drug treatment is regulated by a guideline from The National Board of Social Services<sup>13,14</sup>. There are no direct legal obligations connected to the social-work part but a best practice guideline<sup>15</sup> which can be brought into action by the supervisory board.

Heroin substitution treatment is regulated in the general narcotics law just other types of substitution.

Drug consumption rooms are regulated as part of the general narcotics laws but as with heroin treatment there is no obligation in general to offer that kind of treatment.

Permission to open Drug consumption rooms is given from the minister of health to specific local governments and regulated in the general narcotics law<sup>16</sup> and communities with a DCR must deliver

---

<sup>10</sup> <https://www.retsinformation.dk/eli/lta/2019/903>

<sup>11</sup> <https://www.retsinformation.dk/eli/lta/2016/715>

<sup>12</sup> <https://www.retsinformation.dk/eli/mt/2008/42>

<sup>13</sup> <https://socialstyrelsen.dk/voksne/stof-og-alkoholmisbrug/stofmisbrugsbehandling>

<sup>14</sup> <https://www.sst.dk/-/media/Udgivelser/2017/Vejledning-I%C3%A6gellig-substitutionsbehandling-opioidafh%C3%A6ngighed.ashx?la=da&hash=734430D636025C63F696D0F9445B5C98FFDFC21C>

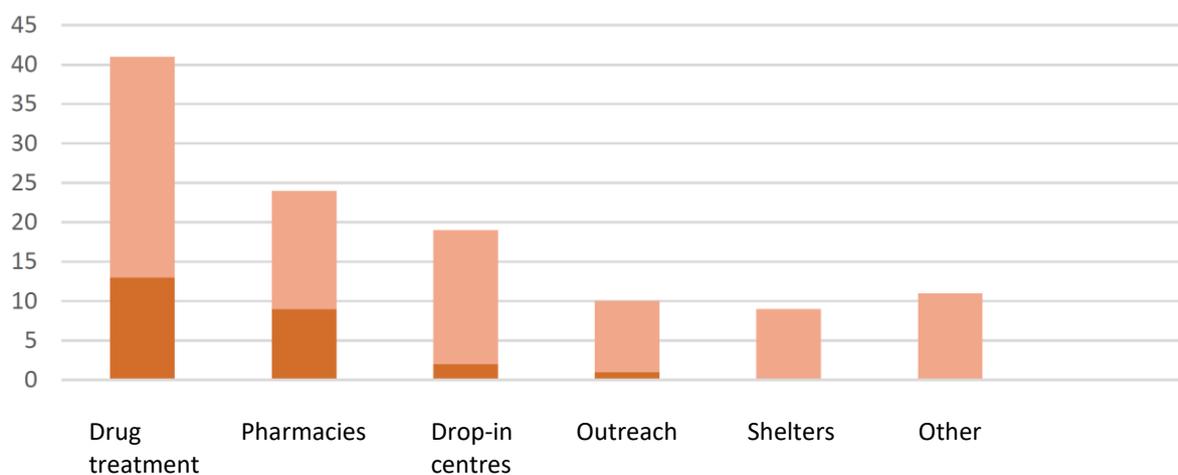
<sup>15</sup> [https://pure.au.dk/portal/files/52583118/Thylstrup\\_God\\_social\\_misbrugsbehandling.pdf](https://pure.au.dk/portal/files/52583118/Thylstrup_God_social_misbrugsbehandling.pdf)

<sup>16</sup> <https://www.retsinformation.dk/eli/ACCN/A20120060630>

an annual report to the minister of health. There are local variations in opening hours and staffing and the possibility of smoking drugs in the DCRs.

Clean drug use paraphernalia provision is also regulated in the health laws and as all other drug harm reduction provision delegated to local communities. 69 of 98 communities provide clean needles and syringes<sup>17</sup>. The organization *Streetlawyers* made in 2018 an analysis of best practice and the provision of clean injection paraphernalia to drug users in all parts of Denmark<sup>18</sup>. Part of the analysis was a survey of 97 communities. 56 communities deliver injection paraphernalia and 41 does not. About 25% of the Danish population lives in communities without access to clean needles and an estimated 3200 drug users do the same. There could be a bias since many drug users might tend to live in bigger cities with a larger potential for harm reduction facilities, but we do not have a good enough knowledge about drug users outside treatment. There is a constant change in the provision of needles and seen in communities with an earlier provision of needles and equipment they find that private stakeholders such as pharmacies might close down the handing out of needles if the management changes.

Figure 1: Provision of injection paraphernalia to people who use drugs in Denmark<sup>19</sup>



The National Board of Health released in 2019 a catalog of desirable practices as inspiration for local communities<sup>20</sup>. In the publication is underlined that “the responsibility to prevent deaths and diseases as a result of IV drug use, is anchored in the municipalities, which according to section 119 of the Health Act are responsible for establishing preventive services for the citizens”. On the other hand, it is not described in detail how this responsibility should be performed.

Provision of naloxone has been done on a project base since 2010 and from 2020 it has become part of the national provision of substitution treatment; thus, it has been written as a supplement to the health law. The national implementation will be done in 2020-21.

Vaccination for Hepatitis A & B has been free for certain vulnerable groups, including people with injection drug use since 2006<sup>21</sup>. Vaccine can be ordered for free by medical doctors.

<sup>17</sup> [https://www.sst.dk/-/media/Udgivelser/2019/Udlevering-af-sterilst-injektionsudstyr-til-personer-med-et-IV-stofbrug\\_-Inspirationskatalog.ashx?la=da&hash=273AAE5497039A922D97A9B338DC3B838D6365FD](https://www.sst.dk/-/media/Udgivelser/2019/Udlevering-af-sterilst-injektionsudstyr-til-personer-med-et-IV-stofbrug_-Inspirationskatalog.ashx?la=da&hash=273AAE5497039A922D97A9B338DC3B838D6365FD)

<sup>18</sup> <http://gadejuristen.dk/wp/wp-content/uploads/2018/12/Intraven%C3%B8se-stofbrugeres-adgang-til-sterilt-injektionsudstyr-i-Danmark-2018.pdf>

<sup>19</sup> *ibid.*

<sup>20</sup> [https://www.sst.dk/-/media/Udgivelser/2019/Udlevering-af-sterilst-injektionsudstyr-til-personer-med-et-IV-stofbrug\\_-Inspirationskatalog.ashx?la=da&hash=273AAE5497039A922D97A9B338DC3B838D6365FD](https://www.sst.dk/-/media/Udgivelser/2019/Udlevering-af-sterilst-injektionsudstyr-til-personer-med-et-IV-stofbrug_-Inspirationskatalog.ashx?la=da&hash=273AAE5497039A922D97A9B338DC3B838D6365FD)

<sup>21</sup> <https://www.retsinformation.dk/eli/lta/2006/746https://www.retsinformation.dk/eli/lta/2006/746>

Vaccination for pneumococcal pneumonia has been free since April 2020.<sup>22</sup>

As can be seen from this review, almost all provision of health- and harm reduction is based in the national health laws while the policing of drug users in public space and sale of drugs is included in the national narcotics laws. Since access to the universal healthcare system is conditioned upon a residence permit there is no possibility for migrants, including homeless migrants to access the treatment system. Needle delivery and DCRs are in general more public and therefore also accessible for people without legal residence.

### **2.3 Human rights situation of homeless people/drug users**

The UN World Declaration on Human Rights states that everyone has the right to a living that is sufficient for health and well-being, e.g. food, clothes, housing, medical help and necessary social benefits. All human rights are equal, interconnected and depended – e.g. housing has influence on the ability to benefit from other rights and vice versa.

In Denmark, the municipalities are obliged to offer a social action plan to the homeless (Service law §141), a plan that as mentioned earlier, is one of the key tools in The National Strategy to reduce homelessness. Studies show that only 28% of the homeless are familiar with having an action plan (Benjaminsen;2019) Affordable and secure housing is a human right, and as an approval to housing is one of the elements in the action plan - not having a plan can, among access to other human rights, be a barrier to get a place to stay<sup>23</sup>.

Health Care in Denmark is divided between 3 sectors - Hospitals, Municipalities and General Practitioners (GP). A GP is automatically provided when you get an address. Hospitals take care of treatment courses; the municipalities do rehabilitation and offer 'nurses at home' and the GP is the one who admit to hospital, refer to special departments/examinations and do the follow up after admissions – in short the GP is 'the entrance' to treatment, and the one that make sure that sufficient medical help is provided.

A lot of the homeless do not have access to a GP, maybe they have a former address in the other end of the country, maybe they have a GP, but are not allowed to come there due to former inconsistencies and often they are reluctant to go because they feel that the GP have no understanding of the life they lead – the GP's focus on reducing/cease drug use, overshadows the need to explore on the symptoms the homeless present.

If the access to a GP is none existing, or not functioning – the access to investigation and treatment of chronic diseases are insufficient, and important information between the 3 sectors in the health care are lost.

In our daily work as health workers in the streets, we experience a gap between reality and requirements when it comes to laws and policies, the gap is seen in:

- Lack of suitable access to addiction treatment for drugs and alcohol (suitable means treatment that takes the everyday life of the homeless into consideration)
- Lack of access to secure, and affordable public housing (not enough, not suitable and too expensive housing - and not enough homeless have a social action plan, which is one of the gateways to be approved for housing)

---

<sup>22</sup> <https://www.retsinformation.dk/eli/lt/2020/395>

<sup>23</sup> Hjemløse borgeres rettigheder i kommunerne (2017)

<https://menneskeret.dk/udgivelser/hjemloese-borgeres-rettigheder-kommunerne>

- Lack of access to a coherent treatment in the Health Care System (e.g. loss of information between sectors)

### **3. Barriers to access harm reduction services**

#### **3.1 Structural barriers**

Most of the harm reduction services are accessible for all, but when it comes to health care related harm reduction services, some of them can only be used by people with a 'yellow card'. A yellow card gives you access to free healthcare, and the card is automatically obtained if you are a Danish citizen, or get an address in Denmark, or if you work as an EU citizen in Denmark. Another health care related barrier is the fact that the Health Care system in Denmark is divided into five regions, all with their own economy. If you are homeless in another region than your last address, hospitals and e.g. x-ray clinics can be reluctant to take the homeless in for non-acute treatment. For undocumented migrants, only low threshold/minimum services that offer basic 'life support' are available.

Overall, economy can be a structural barrier between different municipalities – last address decide which municipality must pay for shelter/housing/drug treatment etc. E.g. if a person is homeless in Copenhagen, and the last address is in Aalborg which is in the other end of the country, Aalborg municipality can refuse to pay for a shelter, with a reference to the fact that they can offer the same housing in their own municipality.

Another structural barrier is gentrification. The largest cities in Denmark, has experienced a lot of construction and renewal in the last decade. As a result, the prices on housing has increased substantial, and the population is mainly resourceful people with a high income. With the new population a 'Not In My Backyard' mentality has made its way – homeless and drug users are still a part of the city, but they are also seen as a nuisance in some neighborhoods. The 'zone-prohibition' mentioned earlier is an example on areas where homeless can be removed by the police and be forbidden to enter certain zones, if they are perceived to create insecurity by establishing places to live in public areas.

If a homeless is referred to housing, the apartments and rooms are too expensive in the city, and often they are obliged to move to the suburbs. Harm reduction services, such as injection rooms etc. are often located in the center of the city, and the distance can be a barrier to benefit from the service. Furthermore, the distance often means isolation, and a lack of information on new harm reducing services attempts in the drug environment.

#### **3.2 Local conflict zones**

An example on a local conflict zone is in Vesterbro in Copenhagen. Vesterbro is in the center of the city and starts at the back entrance to the Central Train station. The conflict zone is a smaller area at the size of one square kilometer and for decades it has been home to northern Europe's largest open drug environment. The area contains among other actions, a large shelter 'The Men's Home', a smaller place - 'The Nest' - for female prostitutes, a church with services for homeless and drug users, and a local police station. During the last 10 years a walk-in health clinic, injection- and smoking rooms have been established in the area. The environment is very vibrant with hotels, small shops, prostitution, drug using/dealing and a lot of people in the streets 24/7. Social workers from the municipality, street lawyers and other NGO's do outreach work in the area.

In 1980's and 1990's the area went through an urban renewal. Before the renewal the homes on Vesterbro were mainly rental properties – many in very poor condition with relatively low rents. Today, the housing stock consists largely of sanitized cooperative and owner-occupied housing, and there have been large rent increases. The renewal brought new fashionable cafés and an area that

formerly contained 'slaughterhouses', are now the venue of fashion shows and expensive restaurants and bars. But despite the urban renewal, the drug environment is still present.

Since the renewal of the area, drug related problems have often been addressed by residents and businesses in the local environment. The drug scene is an open drug scene, where the public are confronted with drug related activities such as drug dealing, drug use and discard of drug use paraphernalia in the streets - activities often addressed as nuisance and an insecurity to the residents. One of the solutions to this problem was the amendment of the 'Law on Euphoriant Substances' (2012) that allowed the establishment of injection rooms in 2013 and 2016. In a report 'Drug environment and everyday life at Inner Vesterbro'<sup>24</sup> (2018) residents was given a questionnaire – some of the statements expressed the insecurity:

'Have on several occasions experienced drug addicts with threatening behavior where I have been unsure of my own safety (..) In addition, I have seen people covered in blood in the middle of the street in broad daylight who have needed help. To the danger to themselves and to traffic. Furthermore, I have poor experience with drug addicts who are in such deep intoxication that their behavior seems unaccountable. People trying to raise money, shouting at someone, talking in tongues and throwing up in the street'

Others stated another view:

'It has generally become much safer over the last five years. I'm no longer worried about my kids finding a needle in public spaces. I believe it is important to treat addicts with respect and care'

For the drug user's, injection rooms are a way of reducing harms and inject their drugs in a safe and clean environment. Some of the residents in the conflict zone, have another view on the injection rooms:

We're seeing a huge increase in the concentration of drug addicts in the area. Both my husband and I are unhappy, especially because our children feel uncomfortable. We often wake up at night when addicts because of the drug intake room in Halmtorvet either are shouting or arguing. We hope that in the future another place can be found outside family neighborhoods for drug intake rooms.

NGOs in the area (and the rest of the country) are after an acceptance from the government working on a new project - 'social free card' - a card that gives homeless and drug users a possibility to earn up to 2.600 Euros a year, without deduction in social benefits. The aim is to urge local compagnies to employ people 1-4 hours a week, doing small jobs, e.g. gardening, cleaning, helping at events etc. Besides earning a little money, the hope is that the project gives the employed a feeling of social belonging, and the community a better acceptance and understanding of the people they meet in the streets on Vesterbro.

#### **4. Implications for service providers**

As in other countries the provision of healthcare is expensive and different barriers are set up to avoid people without legal permission to stay to access healthcare. This leads to a series of inappropriate health problems and might lead to general public health problems like overdose deaths, spreading of infectious diseases etc.

---

<sup>24</sup> Stofmiljø og hverdagsliv på Indre Vesterbro. By Esben Houborg et al, Center for addiction research, Aarhus University. June 2018 [https://pure.au.dk/portal/da/publications/stofmiljoe-og-hverdagsliv-paa-indre-vesterbro\(42bded01-4e15-480e-9d9a-9fde2d565a46\).html](https://pure.au.dk/portal/da/publications/stofmiljoe-og-hverdagsliv-paa-indre-vesterbro(42bded01-4e15-480e-9d9a-9fde2d565a46).html)

There is no national drug strategy at the moment. The government in 2003 and 2010 published the policy strategies 'Fight Against Drugs'<sup>25</sup> and 'Fight Against Drugs II'<sup>26</sup>. However, the health law, in particular the parts regarding treatment, HR and public health initiatives, is the only existing policy framework which determines drug users' rights to treatment.

The social laws and the provision of funding from the state to local governments is based on the number of Danish citizens who are homeless. The National Homelessness Census<sup>27</sup> does not count people in homelessness without a CPR number (Central Person Register). (Without a registered address, it is extremely difficult to get a CPR number.)

People with migrant background overlap partly with groups who experience homelessness and/or use drugs. Policies do not always recognize this reality.

There is a lack of funding or co-funding for local low threshold healthcare from the national healthcare system which leads to insecurity for health outreach. Quite a large amount of low threshold health projects has run in the last 20 years but all except the ones in the Capital region have closed due to a lack of funding.

There is a gap between the intention of laws (and policies) and their implementation. Laws and policies define different demands to the local governments and municipalities. Not only do funds not follow the laws and the objectives defined by them, funding is also insufficient. The effects of underfunding are exacerbated by a strict budget control. This situation has led to a trickle down of underfunding for the social sector in general. Local tax revenues are in theory available for the local government, but the finance ministry has over the last 15 years restrained local use of money in a statewide attempt to control the general economy and the homelessness sector has not been spared from this control.

The health system is regional but without the possibility of regional tax collection and with an equally hard management of the sector. This leads to a problem with fee for performance and lack of public health initiatives in collaboration with the social, drug and homelessness sector. A system based on fee per unit of treatment does not recognize integrated treatment between social, drug and healthcare as a viable method but will tend to solve problems based on single treatments or diagnoses.

This leads to lack of intersectoral cooperation which is unfortunate since it leads to immediate reduction in health costs and immediate improvement in health for homeless<sup>28</sup>

### **Comments on the current COVID-19 crisis**

Due to the Covid-19, a lot of services for the homeless were suspended, almost from one day to the next. That included day-shelters and similar places like "soup-kitchens" where homeless people use to get a meal, a shower and a talk with a social worker.

The Copenhagen Drug Consumption Rooms closed for indoor waiting and closed the drug-smoking part while the injection rooms are still open around the clock. This has led to a rise in crack and heroin smoking just outside, but overdose treatment is still possible from staff inside the facility.

Low threshold Health Care Clinics remained open with the usual opening hours but only for one person at a time.

---

<sup>25</sup><https://www.google.dk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwjT0a-tjpjAhUq-yoKHSTBCXYQFjAAegQIARAB&url=https%3A%2F%2Fwww.sum.dk%2F~%2Fmedia%2FFiler%2520-%2520Publikationer%20i%20pdf%2F2003%2FKampen%20mod%20narko.pdf&usg=AOvVaw0plaN9RCxNzgQB3giGrfZH>

<sup>26</sup>[https://www.justitsministeriet.dk/sites/default/files/media/Pressemeddelelser/pdf/2010/Kampen\\_mod\\_narko\\_II.pdf](https://www.justitsministeriet.dk/sites/default/files/media/Pressemeddelelser/pdf/2010/Kampen_mod_narko_II.pdf)

<sup>27</sup><https://www.vive.dk/media/pure/14218/3352843>

<sup>28</sup>[https://micahprojects.org.au/assets/docs/Publications/IR\\_130\\_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf](https://micahprojects.org.au/assets/docs/Publications/IR_130_An-Economic-Evaluation-of-the-Homeless-to-Home-Healthcare-After-Hours-Service.pdf)

Both social- and health care workers still do outreach work, but as the access to hospitals, GP's, public offices etc., are restricted, the tasks are to accommodate basic and acute needs.

An example of a quick response to the Covid-19 was seen in Copenhagen. 2 weeks before the national lock-down an emergency isolation facility was set up for street- and shelter homeless. A small inpatient facility that normally offered 2 weeks stay, was closed and prepared to become the primary isolation facility for people who did need isolation but not hospitalization. When lock-down was set in motion the inpatient facility was quickly adapted to an isolation facility with 24-hour health service provision for people in situation of homelessness who needed isolation. Medical and drug use related medical support, including detox and substitution therapy, were provided by the Health Team.

On the day of the lock-down HealthTeam went from normal out-reach with dozens of contact points to keeping a network by phone from 7 am to 10 pm and working from home doing out-reach outside in manageable setting. Everyone was available on phone for wishes for physical outreach or advice. Ordinary medication was upheld. Facebook and other social platforms were used to inform people.

One team's MD was serving the isolation facility directly from home to avoid unnecessary contact, one was coordinating patient advice calls and kept contact with other health institutions, and one was based in the city doing clinical work and outreach. The nurse and MDs did not meet during the first 4 weeks.

After 4 days an emergency shelter for everyone but especially planned for undocumented migrants was opened in a sports arena.

After 1½ weeks, a larger isolation facility at a closed old age home was opened, increasing the number of isolation beds to 60. Staff from the in-patient facility was moved to that site after another week including the HealthTeam-MD. The facility is available for everybody tested COVID-positive including migrant homeless.

The target group for free pneumococcal vaccine has been expanded so that most homeless drug and alcohol users are included which means that HealthTeam and the substitution treatment system will begin vaccination in the beginning of May 2020.

Copenhagen substitution treatment began delivering substitution medication at people's home and after a short preparation period also began initiation of substitution to homeless in shelters. This is still only available for people with a health-card. Homeless migrants can get a detox from HealthTeam and all other medications are continued. Drug use paraphernalia are still delivered, heroin treatment is continued but not delivered home.

Other low threshold initiatives include:

- Nurses in some of the Health Clinics test for Covid-19
- Staff from the Health Care System can be requested to go to shelters, to people sleeping rough etc., to test for Covid-19.
- NGO's serve small meals and 'take away' in backyards of day shelters and other outside areas.

Status in the beginning of May is that only a few homeless have been tested positive for Covid-19, none, known to us has been hospitalized. In the second largest city in Denmark, Aarhus, 270 homeless and drug users were tested in April, none of them tested positive, the same results are reported from other larger cities.

The reports from the homeless is that everyday life is difficult. The income they usually have from selling the 'Big Issue' and from small day-to-day jobs have decreased. Some of them feel stigmatized as people on the streets are afraid of going near them, they assume that the homeless population spread the virus. For people who use drugs it has become difficult to raise money for drugs, and the prices on drugs has increased as the borders are closed. Consequently, the organization behind the

street paper 'Big Issue', has obtained funding to give shelter for homeless salespersons at local hostels and to fund medication for persons with a sales card.

As most places are suspended, the continuous treatment relation to the homeless is at risk to be interrupted. From a health care perspective, our worries are that symptoms and diseases develop too far before reacted upon. Our experience is that the homeless population do not seek health professionals unless the health problems are severe. a queue outside a closed door at a low threshold health clinic can be a barrier to seek help so keeping the network running is essential to delivery of appropriate healthcare at the right time.

## 5. Best practice and examples on innovative initiatives

In this report we have described some of the harm reducing initiatives that presently exist in Denmark. As mentioned, **open Drug Consumption Rooms** are present in the larger cities, and a national **Naloxone programme** is going on right now. Hepatitis A+B Vaccination is free for vulnerable groups, and due to the corona-virus crises Vaccination for pneumococcal pneumonia has been free for vulnerable groups since April 2020.

**Outreach work** takes place on a national level. In Copenhagen, Health Team for Homeless (doctors and nurses) and social workers from the municipality do both street-based outreach work and are present at the shelters. For mentally ill, an outreach psychiatric team has been established from the Health Care System. NGO's, e.g. street lawyers, user organizations etc. are present in the street and on the political agenda.

An innovative approach that has been established recently is the idea of using **Community Reinforcement Approach** (CRA) as a HR strategy which replaces abstinence-oriented goals by support to manage drugs and alcohol use in connection with workspace training and low-threshold access to healthcare. The CRA-project will form small groups consisting of the user, a craftsman and a nurse to try to achieve the individual goals for the user. In a pilot study taking place this year, a coherent and coordinated teamwork between employees from different organizations and professional backgrounds, all with a unified focus to reinforce the homeless' own motivation for change, CRA will be used as a treatment method targeted homeless people with substance use. Some of the components are skills training, substance free social club, case management and social employment.

Among other attempts, shelters and NGO's offer **social employment** for people living in homelessness, as a way of establishing social belonging in the local community. In some cases, an approach that lead to reduced intake of alcohol and drugs, and an approach that serves as a base towards a more stable living.

The **naloxone training** has since conception been focusing on involvement of peers in both the development and practice. The initial project was made in collaboration between the drug users union and HealthTeam where 25 drug users was trained in first aid with naloxone and the collaboration has existed since then. One of the core values of the central naloxone training has been to involve NGO's in the spreading of naloxone kits<sup>29</sup>. In the projects before 2020 140 staff members were trained and by the end of 2020, a total of approximately 4000 drug users, homelessness staff, relatives and police officers had been trained in overdose reversal with naloxone and first aid procedures and most had received a range of different naloxone kits over the 8 years. At present, HealthTeam coordinates a national implementation of naloxone programs in all Danish municipalities with substitution treatment. The naloxone programs consist of a train-the-trainer program where HealthTeam is training staff from treatment centers to become naloxone trainers who subsequently trains drug users and their relatives in first aid and delivers naloxone. It is expected that more than 350 staff members

---

<sup>29</sup> <https://www.facebook.com/naloxon/videos/237636496948374/>

will be trained as naloxone trainers before the end of 2021. There is no general plan for how this system can be maintained in the coming years.

Also, **screening for Hepatitis C** has been part of outreach work for the last 15 years but with the upcoming of an effective treatment the Drug Users' Academy began screening especially for Hep C in larger parts of Denmark via a van. In Copenhagen this has led to a more systematic screening in collaboration between HT and DA with a broader health focus<sup>3031</sup>.

In 2020 the National Board of Social Services published '**National guidelines for the fight against homelessness**'<sup>32</sup>. The publication is based on current legislation and current best knowledge from research and practice. A large group of national specialist and practitioners in homeless services contributed to this publication. The guideline aims to provide municipalities and other actors in the field of homelessness with a common basis for work in the field and can be used as a tool for organizing the work. The guidelines were drafted in collaboration with key players in the field of homelessness, and the guidelines distinguish between statutory requirements and recommendations for good practice. A total of 25 guidelines, are organized into 4 chapters: the prevention of homelessness, organization and collaboration, housing investments and citizen-oriented initiatives.

The national guidelines are primarily aimed at local municipal leaders and planners at both authority level and supplier level but also seeks to give all relevant actors and sectors working with homelessness knowledge and inspiration for the work to alleviate and eliminate homelessness.

---

<sup>30</sup> <https://www.facebook.com/naloxon/videos/324040555060815/>

<sup>31</sup> <https://www.facebook.com/naloxon/videos/543387249415337/>

<sup>32</sup> <https://socialstyrelsen.dk/udgivelser/nationale-retningslinjer-for-indsatsen-mod-hjemloshed/@@download/publication>