Observations of the Lisbon Addictions 2022 conference

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Executive Summary

The Lisbon Addiction 2022 conference was a multidisciplinary European Conference on Addictive Behaviours and Dependencies. The conference forum was a scientific debate showcasing leading European addiction research in the specialist areas of illicit drugs, alcohol, tobacco, gambling and other addictive behaviour and exploring treatment models from around the globe. The observations from the presentations at the conference are documented in summary in this report. Foremost, it includes an overview of the guidelines of the Portuguese model, which is argued to be the most innovative model for addiction globally and potentially one of the most researched models on the internet.

From January 2016 to December 2021, there were 29,052 deaths related to apparent opioid toxicity making the overdose crisis in Canada a significant public health concern. In British Columbia, the solutions to the crisis have caused harm to society, including increased crime, tents in public spaces, stranger attacks, murder, open drug use, and trafficking of a government-prescribed supply of addictive drugs known as "safe supply."

The aim of attending the conference was to inform stakeholders at Westminster House Society (WHS) of the findings from attending the conference. However, the information was broad and required subsequent investigations of Lisbon, Portugal and other European models, which were presented at the conference. WHS has been a bed-based addiction recovery program for youth girls and adult women since 1981. The Provincial Government Health authority contracts it as a Stabilization and Transition program. It is required to provide biopsychosocial treatment to the individuals they serve. WHS operates its government beds at a deficit.

WHS suggests that the government could dedicate more resources to interventions like prevention or bed-based treatment services in addition to the harm reduction models. Compared to the evidence provided, to end the overdose crisis, bed-based treatment, dissuasion, and wrap-around supports are needed, in addition, to harm reduction models and government-prescribed addictive drugs. Finally, the report findings are that the services provided in British Columbia are inadequate and service providers require better cooperation to fill the gaps and prevent continued harm to society.

Content

1 Introduction

There are four pillars of the Canadian drugs and substance use strategy in Canada: prevention, treatment, harm reduction and enforcement. As a result of the onset of the opioid overdose crisis in Canada, there have been provincial responses to the crisis. In British Columbia, the response has been investing heavily in harm reduction models, including safe supply and decriminalization of possession of small amounts of drugs and small amounts of certain illegal drugs. According to Bramham (2018), policymakers in British Columbia have been urged to "consider Portugal's robust recovery-oriented model, which offers universally accessible, comprehensive and coordinated treatment for drug users which includes treating those with addictive behaviours and dependencies with universal access to free treatment for its citizens (Bramham 2018). Six years into the overdose crisis, and a steady increase in overdose and poisoning deaths, the writer, an addiction treatment and recovery professional at WHS, observes inadequate access to government-provided free bed-based services. However, there is free prescribed addictive drug access and a new decriminalization policy, regardless that the death toll from overdoses continues to rise.

The following paper aims to inform the reader of the current addiction treatment models in Portugal and specific European countries to compare addiction treatment and recovery solutions. The document includes an overview of presentations on drug consumption and harm reduction models and reviews the decriminalization laws in Portugal. Furthermore, the document includes information based on the public perception of substance use and addiction in the city is Lisbon. Additionally, there is an overview of residential treatment, bed-based programs, therapeutic communities, treatments in the prison system and drug consumption in Europe, including Lisbon, Slovenia, Zurich, Ljubljana, Kyiv and the Czech Republic.

The document is limited to presentations at the Lisbon Addictions 2022 conference, follow-up interviews and research on the internet of things. Information and treatment theories are abundant across the globe. Therefore, the writer aimed to stick to models needed for comparison to the current policy and systems or lack of policy and system in British Columbia.

2 Methodology

The purpose of this document is to evaluate the current models of addiction treatment and recovery in Portugal and Europe to find solutions to the problem of the overdose crisis in British Columbia. In addition, the research aims to strengthen the information about the European and Portuguese treatment and recovery models for those with addictive behaviours and dependencies and provide recommendations better to serve the addicted population in British Columbia, Canada.

The writer tackled the research in a qualitative approach, gathering information from primary sources at the Lisbon Addictions 2022 conference while participating in workshops and analyzing the conference material. Additionally, the writer researched secondary data from the internet and secondary sources of qualitative research that relied on the interviewer asking questions to more than two people aimed to collect and verify data.

The methods used to analyze the data were descriptive and exploratory, which involved interpreting the data from the various sources at the conference and turning it into valuable insights to find connections and generate hypotheses and solutions to the problem.

3 The Portuguese Model

The Portuguese model (the model) revolves around lowering criminal activity and motivating behaviour change, dissuading use, promoting health, improving the quality of life and promoting adherence to services available that range from prevention to treatment and social integration (SICAD 2015). The model was created in response to the increasing harm caused by the heroin epidemic in Portugal in the 1990s when the country was in the grip of an opioid epidemic so intense that Lisbon was referred to as the heroin capital of Europe (Clay, 2018). In 2001 a law that went into effect turned its crisis around. It involved the government removing criminal sanctions for drug use and possessing small amounts of all illicit drugs for personal use, instead issuing administration tickets and civil sanctions. Shortly after, guidelines were established that involved technical teams intended to harmonize the interventions for those with addictive behaviours and dependencies by removing the stigma and bringing them closer to treatment services and recovery (SICAD 2015). So, when a person is found with a small quantity of a narcotic, defined, since 2008, as ten days' worth of substances for personal use, the drug is confiscated, and the person is summoned to a panel at the Commission for the Dissuasion of Drug Addiction (the Commission). If the Commission finds the person has an addiction problem, treatment is offered, but it is not ordered. However, civil sanctions like community service are ordered. Additionally, the Commission can impose other civil sanctions such as a €25–€150 fine to the suspension of a professional licence as well as a ban on visiting certain places and people. Finally, every region has a Commission (Correia 2022).

According to the Portugal Country Drug Report of 2019, published by the European Monitoring Center for Drugs and Drug Addiction (EMCDDA), trafficking drugs in Portugal may incur a sentence of 1-5- or 4-12 years' imprisonment, depending on specific criteria, one of which is the nature of the substance supplied. However, the penalty is reduced for users who sell drugs to finance their consumption (EMCDDA 2020).

According to the guidelines of the Portuguese model, those with addictive behaviours and dependencies sanctioned are summoned to face the technical team at the Commission, which includes jurists, psychologists and social service experts (Correia 2022). Their role is to try to make a diagnosis by starting with brief interventions and moving through a trans-theoretical model of change that aims to monitor the individual at any given moment of their behaviour change (EMCDDA 2020). The dissuasion process starts

with the police forces identifying those possessing an illicit substance for personal use and opening a police report. The next step is to focus on preventing and reducing the abuse of drugs by informing the user of the associated risks while keeping the health and protection of the community and the user at the front of the process (SICAD, 2015). Noted from SICAD (2015) are the tactics that include a structured interview, motivation of change evaluation, and risk level evaluation. Additionally, intravenous users are identified at this juncture because of the risk concerns for themselves or the community.

In theory, the process happens immediately or almost immediately. Still, when drilling down, Goulao (2022) acknowledges that individuals may be required to attend the Commission several times to access any service. Additionally, Goulao (2022) acknowledges that the drug policy in Portugal was very impactful 20 years ago but is now outdated.

3.1 Decriminalization Laws in Portugal

According to Gegaloto (2022), since Portugal's decriminalization laws of the possession and acquisition for personal consumption of narcotics and illicit psychoactive substances, again, which are not considered a crime but an administrative offence, came into force, approximately 172,000 cases of administrative offences have been opened. Furthermore, more than 154,707 people have been charged with an administrative offence, with most charges being a young demographic. In twenty years, 85,526 of the indicted drug users were considered nonaddicted, and 45,628 have been referred for specialized support. On the other hand, 16,457 of those indicted were considered problematic drug users and 77% were referred to treatment centers (Gegaloto, 2022).

Martins (2022) argues that since the 2001 decriminalization law, the social reality has proved to be more complex than the model allowed. The majority of the clients of the Commission are classified as non-dependants, corresponding to 68% of all clients and of those, they are mostly cannabis users (Martins 2022). In Portugal, 85% of the drug user population, the most common use of drugs is episodic and non-problematic drug users. Furthermore, the legal requirement of those whose nature of consumption does not require treatment is a significant setback. In this case, mandatory visits to the Commission have been problematic, especially when no social or criminal harms are at play, and it is the only implementation of the law (Martins 2022). The mandatory visits for those whose consumption do not require treatment could be a factor in others waiting for access. Conversely, Correia (2022) indicates that many attending the Commission may not even know they have a problem until they are assessed, including a cannabis addiction.

According to SICAD (2019), drug users in extreme situations and the most dependent users belong to the network of exceptional healthcare or the Referral Network for Addictive Behaviours and Dependencies (the network). The network encompasses specialized public services that provide treatment for illicit substance dependence under the authority of the regional Ministry of Health, non-governmental organizations and other public or private treatment providers interested and capable of providing

addiction treatment (EMCDDA 2020). Public services are free of charge and are accessible to all people who use drugs and who seek treatment. The network incorporates three levels of care: primary healthcare services, specialized care, mainly in outpatient settings, and finally, differentiated care, mainly in inpatient settings that include detoxification units, therapeutic communities, day centres and specialized mental or somatic health care (EMCDDA 2020).

3.2 Public Perception

The writer was able to conduct formal interviews in Portugal. The first was a female, approximately 42 years of age, who identified as an alcoholic addict. Anna (2022) acknowledges nine years of recovery. The second was an addiction psychiatrist, Dr. Cam (2022), a male, 41 years of age, who is an ex-pat living outside his native country of the USA. Dr. Cam identifies as an alcoholic and is in long-term recovery with 12 years of complete abstinence from all drugs. Additionally, as a professional, Dr. Cam attended the Lisbon Global Addictions 2022 conference. Both names of the interviewees have been changed to protect their anonymity.

Dr. Cam

Dr. Cam discussed the notion that the world associated Portugal with decriminalization and suggested that there was evidence that possession of drugs was de facto before the law was implemented. He argues that what happened in Portugal was an evolution in consciousness, a cultural change resulting from the addiction crises. The Portuguese have a strong culture of the family as the foundation of the country's social structure. Additionally, the Portuguese have a collectivist culture. Therefore, people tend to feel responsible for those around them (Culture Atlas 2022).

Dr. Cam explained his view of the positive services as an essential factor to the model, including total wrap-around services for people, adequate housing services, and they meet people where they are at with services for where they are at. They are also comfortable with meaningful forms of sobriety.

From a professional perspective, he argues that there was much public interest in addiction and recovery in early 2000 because of the intense opioid epidemic. However, now it is harder for people to access treatment and recovery services and get the support they need because there is less public support than at the onset of the crisis. In response to Dr. Cam, the writer had several conversations with random citizens of Lisbon and concluded that the Portuguese population believes they have a superior delivery of services for those with addictive behaviours and dependencies. As a result, the collectivist culture may not be as aware of the current addiction challenges.

Dr. Cam and the writer agreed that the decrease in services is possibly a global issue of healthcare professionals suffering from burnout and that many healthcare professionals in Portugal may have a brain drain. Additionally, it was discussed that some healthcare professionals might be tempted to leave

Portugal for a better wage; the medical workforce could be struggling with securing adequate funding; however, this discussion was unsubstantiated. Controversially, reports from the Portugal News (2022) indicate that Portugal spends approximately 9.1% of its GDP on healthcare, which places the country as the 12th biggest spender across the EU/EFTA.

Finally, the writer inquired with Dr. Cam about his perception of the opioid epidemic in Canada and the USA because they appear to be the only country with a synthetic opioid overdose crisis resulting in death. He suggested that global addiction professionals are perplexed as to why this is.

According to Heudtlass (2022), approximately 5200 fatal drug overdoses occur in Europe annually, and of those, 75% involved opioids. Additionally, fentanyl-related deaths across Europe, particularly since the beginning of the COVID-19 pandemic, have been reported in a minority of countries; the highest presentation of fentanyl toxicity was seen in the Baltic countries: Estonia, Lithuania and Latvia, as compared to an average of 0.2% fentanyl in the rest of the network (Heudtlass 2022).

Anna

Anna (2022) described the public compassion for substance users but thinks the line has been crossed into enabling. The people in Portugal feel for people using on the streets, and there is no mistreatment. However, most people do not want to see it, and wealthy families try to hide any addiction issues they may face.

Drug of choice correlates with the generation; for example, there is a large percentage of people who use heroin, but they are primarily second-generation Boomers, or Generation X. Drug of choice depends upon social status; for example, Generation X and Y primarily use cocaine and methamphetamines depending on social demographic. Anna described companies in Portugal that sold a product legally as fertilizer from a storefront to young people. This drug street name was "meow meow." The drug made people go psychotic. The government would attempt to shut down the companies, and then they would open up again with a new product. According to Ribeiro et al. (2012), Mephedrone is a chemical product with the street name "meow meow." The product was mainly sought for euphoria, social disinhibition, empathy, and increased libido. However, its use is associated with several adverse conditions, including neurological and psychiatric (Riberio et al. 2012).

Still, Anna explains that many people are hooked on substitutions, and vans drive around, delivering a "safe supply" or "fix." She could not tell me much about the demographics of the people but explained that there are queues of people waiting for the van in various locations throughout the city. She alluded to this van delivery system as having been going on for as long as she can remember.

According to Clifford (2020), the vans contain supplies of methadone, and the program has been a part of Portugal's answer to a heroin epidemic going back 20 years. Some people are homeless, and others are

men in suits who arrive in nice cars; the methadone keeps the users off illicit street heroin but allows them to function, have jobs, and look after their families (Clifford 2020). Anna says that this treatment method now also includes Suboxone. On the flip side, she suggested that although the treatment has helped eliminate crime, prostitution, and STDs and looks good on paper, the active addicts are still addicted and portrayed as not doing great.

The advice Anna would give a new person who has entered a recovery program, of which she is a member, and a sponsor, is to seek support from others in the program. According to Narcotics Anonymous (NA), a sponsor is described as a member of the NA program, living a recovery program, and willing to build a special, supportive, one-on-one relationship with another member (NA 2004). Anna explained that she often diverts people who need help to others she knows who have done state treatment. Her goal as a sponsor is to support all people in recovery; if that requires treatment, she helps them navigate the system. She currently has one person she sponsors who has been waiting for three months for a state treatment bed and is scheduled to enter treatment in January 2023 (2.5 months from the interview date) simply because she knows someone who knows someone. Anna said that if an induvial can pay for treatment, they could access it tomorrow. Some private treatment centres have state-subsidized beds, and the cost to access them is based on income. However, the cost is at most €3,000. Furthermore, not all treatment centres have subsided beds; for example, the English-speaking centres don't have subsidies. And not everyone goes to the Commission for help.

3.3 Homelessness

Currently, 9,000 people are facing Homelessness in Portugal, 800 more than in 2020. Most access temporary shelters, but 4,000 have no shelter (Silva 2022). In Lisbon, more than 50 field teams work together with 21 partners as part of the Municipal Plan for the Homeless, which includes a housing First strategy and a series of other actions and focuses on five major areas: alert, emergency, transition, insertion and prevention. Additionally, official figures and data from 2019 registered about 2,000 homeless people in Lisbon; 400 lived on the streets before the Covid-19 pandemic (Municipality of Lisboa 2022).

The writer observed homelessness throughout the city; in some cases, the homeless are very discreet. The writer ventured into neighbourhoods where poverty was evident and was able to interview residents who explained that the area was riddled with drug addiction. However, the writer observed that drug use in the neighbourhood was not visible anywhere. In another observation, the writer came across homeless camping. However, it appeared the campers were refugees, and upon taking a closer look, there was no evidence of excessive drug use, and the camp was clean and functional.

Interestingly, in Lisbon, aggressive beggars and drug dealers offer cocaine, cannabis, and MDMA, especially when crossing an intersection in tourist areas. Upon further investigation, the writer was

notified that if drugs were purchased in this area, they would likely be smashed oregano or crushed aspirin so dealers could earn money and avoid prosecution.

4 Bed-based Treatment

4.1 Europe Treatment and Therapeutic Communities

Europe has diversified drug treatment interventions, with most services encompassing a range of outpatient services. The bed-based treatment facilities are an essential part of the overall treatment responses to drug use but are less popular (EMCDDA 2014). Bed-based services are defined as residential treatment and include a range of treatment delivery models or programs that include therapeutic and other activities for drug users, "including the 12-step/Minnesota, model, therapeutic community and cognitive–behavioural (or other) therapy-based interventions, within the context of residential accommodation in the community or hospital setting" (ECMCDDA 2014 p. 4). The ECMCDDA (2014) study indicated that residential treatment programs provided individuals control over their drug use and achieved and maintained improvements in health, social and lifestyle domains.

Therapeutic Communities (TC) are historically the most common form of bed-based addiction treatment and recovery in Europe, dating back to 1960, aimed to meet the challenge of ill-equipped health and social care system for drug users, mainly heroin addicts (Vanderplasschen et al. 2014). However, in response to a changing environment, in 1990, TCs in Europe gradually evolved from long-term, generic treatment programs to short-term and modified approaches to meet the growing interest in harm reduction programs and to respond to the needs of specific drug user groups, such as women with children, imprisoned drug users and individuals with psychiatric disorders in addition to their drug problems (Vanderplasschen et al. 2014).

The modern modified approach to TCs in Europe has a typical capacity of 15 to 25 residents, and the planned length of stay is between 6 and 12 months. According to Vanderplasschen et al. (2014), positive treatment outcomes are associated with longer retention in treatment and treatment completion, "and almost all observational studies report that TC residents show reductions in drug use and arrests and improved quality of life" (Vanderplasschen et al. 2022 p. 10). Additionally, the TCs environments are intensive inpatient-type programs that target addictions and are organized and closely monitored. The TC clients are immersed in a treatment environment to undergo social conditioning designed to get people off drugs and provide a complete break from their past lifestyle (Vanderplasschen et al. 2022).

4.2 Portugal Residential Treatment

According to EMCDDA (2019), inpatient treatment settings in Portugal provided by the Network are referred to as differentiated care. They include detoxification units, TCs, day centres and specialized mental or somatic health care (EMCDDA 2019). Access to the programs is based on a comprehensive

diagnosis examining the patient's medical and social needs. Inpatient treatment and recovery are provided through third-level care services in Portugal that were introduced with the launch of the National Network of Long-Term Integrated Care aimed to impose a logical network of health care and social services that depend on each other (Santana & Redondo 2014). Inpatient treatment programs offer up to 10-day withdrawal management in eight public and private detoxification units. Additionally, 59 therapeutic communities provide 3 to 12-month bed-based treatment programs that are privately owned and publicly funded.

4.3 Ljubljana, Slovenia Inpatient

In Slovenia, the implementation of a dual diagnosis inpatient and outpatient treatment program in the city of Ljubljana, described as a comprehensive and holistic approach to addressing the needs of people with dual disorders, experienced successful outcomes such as partial rehabilitation, employment and continued education since opening in 2020 (Kastelic 2022). The 21 centers can be accessed by self or family referral and the public network. According to Kastelic (2022), the highly structured centres treat adolescents and adults, including a full continuum of care with an open/unlimited stay. For example, individuals can access detox, psychosocial programming, general psychiatric and forensic hospitals, and NGOs. Additionally, children can access psychiatric care. Furthermore, Individuals are provided integration into other services.

4.4 Czech Republic Therapeutic Communities

There are approximately 160 beds in TCs in the Czech Republic that are run by multidisciplinary teams with specialized training and education in addictions, including addiction training for medical doctors that has been incorporated as a specialization since 1980 (Vanderplasschen et al. 2014). In the Czech Republic, there is now a differentiation between special needs groups and changes in substance use patterns. Interestingly, illegal buprenorphine is the primary type of opioid dependence, creating a complex relationship between large-scale misuse issues and the need to access opioid agonist therapy. As a result, there is a call to improve access and affordability of opioid-agnostic treatment (OAT) for opioid-dependent individuals. Furthermore, individualized approaches and psychiatric approaches have been introduced in TCs to meet these emerging needs, including meeting the needs of those coming from prison.

5 Treatment in Prison Systems

Abstinence-oriented treatment for prisoners is provided predominantly in special therapeutic communities in most Europe countries. Therapeutic communities are intensive treatment programs for prisoners with histories of severe drug dependence and related offences, with a minimum of 12 – 15 months of a sentence. The programs are drug-free environments that implement a treatment approach that requires 24-hour residential care and comprehensive treatment and recovery services. Inmates are

required to participate in programs for between three and 12 months. They include appropriate treatment services, such as medical treatment, psychosocial interventions, harm reduction and broader social care that promotes resettlement and recovery. Opioid substitution, psychosocial support, and 12-step abstinence-based programs in therapeutic communities have strong evidential support (Stoever 2017). Additionally, most of the programs have built relationships with community services to provide a continuity of care for drug treatment between the prisons and community services that are effective and targeted abstinence-based treatment and medically assisted treatment based on the needs of the individual.

In Portugal, drug treatment for prisoners is said to reduce drug use, and re-offending rates are well-established. The Lisbon agenda for prisons indicated a positive experience from in-prison treatment supported inmates to continue treatment after release, reducing relapse rates and related health risks and reducing delinquency and recidivism (Uchtenhage 2013). Additionally, inmates participating in treatment during imprisonment are directed to community-based services to continue treatment after release.

Between 20-45% of persons in Belgium prisons use drugs. However, research indicates that many incarcerated people have never been in contact with drug treatment programs (De Pau & Leenan, 2022). Criticisms of a fragmented healthcare system, including drug treatment in detention units, have led to a pilot project in three prisons in Belgium. De Pau & Leenan (2022) present evidence of unique opportunities to reach out to this population and encourage them to participate in the drug treatment program. A pilot project, which included tailored care trajectories, specialized care, and psychosocial intervention, was implemented in the prisons. The study indicated that cooperation between welfare, health and judicial providers is needed for a connected care system. Furthermore, the service should not be isolated within the prison but connective and accessible. Additionally, the programs should include prevention and harm reduction based on gender, trauma and culture, and low threshold accessibility (De Pau & Leenan 2022).

Blatnikova et al. (2022) studied a therapeutic program for drug users in Czech prisons and demonstrated positive results in changing participants' criminogenic attitudes. The objective was to assess the effectiveness of reducing recidivism by providing a 21-hour-per-week program for drug users imprisoned for any criminal office. The positive results indicated that treatment alternatives to the imprisonment of drug-using offenders should be more available and used in the highest number of cases possible (Blatnikova et al. 2022).

The conclusions from the European review of TCs in prison resulted in lower reincarceration rates and reduced re-arrest and re-offending (EMCDDA 2014). In addition, it is recorded that most data provided indicated results from treatment planners within the UK prison system indicated good evidence for TC interventions in custodial institutions; a general conclusion drawn from the US and European review is

that people in TCs in prison had lower reincarceration rates 12 months after release than prisoners receiving no treatment. In addition, reductions were identified in measures of re-arrest, re-offending and time to reincarceration which was substantially greater than changes in criminal activity achieved by control groups" (EMCDDA 2014 p. 10)

Finally, Aslan's (2018) findings on how effective drug-free therapeutic communities are in prisons that treat substance-misusing offenders remain superior to other forms of drug treatment in reducing recidivism and drug relapse among addicts who offend. Additionally, the best results in reducing relapse and recidivism are when in-prison TC treatment is offered in conjunction with a community aftercare intervention (Aslan 2018). Additionally, she reports that those who completed prison TC treatment were less likely to be re-arrested and use substances in the first six months following treatment and up to 12 months after treatment than the comparison groups (Aslan 2018).

6 Drugs and Consumption

6.1 Lisbon, Portugal

According to Curado (2022), research and reflection about the process of integrating Drug Consumption Rooms (DCR) in Lisbon call to rethink the old laws because it has limitations that have historically set the bar too high and excluded those who may not be able to access services. Curado (2022) explains that the current model could no longer ignore users' health, safety and human rights. High-risk drug users are excluded from the current model, and DCRs are the missing piece in the network of services. Curado (2022) argues that the services must include a few barriers, including restriction on substances, with the priority of improving people's lives by helping them to overcome limitations.

In 2019 the first mobile medicalized test site included consultation with communities to gain the acceptance of local communities and the buy-in and participation of the substance users. The model aimed to be the integrated model most used in Europe (Curado 2022). She explains that the process included careful thought and consideration was extremely important before moving ahead with the project. Furthermore, in 2021, the permanent DCR was opened and included a second set of services to promote self-care, particularly for the homeless population and issues related to public health, while promoting community. Curado (2022) calls for a DCR to include a smoke inhalation room to create privacy, avoid street violence, and improve socialization and affection between peers and workers. She also mentions the difficulty in attaining community buy-in.

6.2 Zurich, Switzerland

According to Brugger et al. (2022), the harm reduction model in Zurich, Switzerland, works due to its wrap-around services. For example, the Zurich model operates safe consumption and drop-in centers that could include free heroin and, in some cases, alcohol and other drugs. The services include meals, counselling,

resting, smoke inhalations, injections rooms, community and connection and were described as complete addiction service centres (Brugger et al. 2022). Additionally, those registered for the safe consumption programs have a purpose as they must 'work' daily cleaning the parks and streets. The sex workers are provided sex pods to trade sex safely; the area is monitored – the process is clean and crime-free; however, anyone caught outside this area purchasing sex is arrested.

According to Brugger et al. (2022), employees of the Zurich model are all connected and working in unison, communicating and diverting people to services; the street teams go around and move people off the streets into the centers, and the centres divert people to other services, including bed-based programs when they are needed – and everyone works together. In the Zurich model, street camping is forbidden, and, in theory, the model is captivating as it works efficiently to improve the quality of life that affects drug users in the city; however, Zurich healthcare potentially has access to unlimited funding, and therefore, it is easier to accomplish a continuum (Brugger et al. 2022).

In a follow-up personal communication email with Mara Brügger (December 5, 2022), she discussed "the different institutions run by the city of Zurich, such as the safe consumption facilities, shelters, outreach work, sex worker counsellors and low threshold treatment centers mentioned above. Those treatment centers do not offer beds. They are more like a walk-in clinic with doctors and can also offer medication and counselling. Brügger explained that there are also privately run clinics that the clients can go to because the city pays for health insurance, so if someone doesn't have money to pay for it, they can still access services" (Brügger, M, December 5, 2022).

Furthermore, "suppose someone wants to go to a treatment center with a bed. In that case, it's mostly run by the psychiatric university clinic that the university or state or private treatment centers run". Brügger could not project any number of clients who access a bed in treatment because most clients would use different services. Finally, Brügger explained that clients who access safe consumption facilities or meeting points for alcoholics are considered harm reduction because they do not offer treatment. "Still, the harm reduction service could connect clients with treatment beds based on the client's will" (Brügger, M, December 5, 2022).

6.3 Ljubljana, Slovenia

Like Portugal, the development and upgrade of mobile units used for preventive and harm reduction programs in Slovenia include treatment programs and drug testing (Hren 2022). The program's results demonstrated success in providing stable users with more opportunities to enter the labour market and a higher quality of life, promoting the resocialization and employment reintegration of former users, and preventing the risk of slipping back into addiction (Hren 2022). Additionally, Hren (2022) notes the exceptional importance and usefulness of outreach programs because they have significantly contributed to the prevention of deaths and deterioration of health, prevented relapses and social exclusion and the spreading of viral diseases (COVID-19, HIV, hepatitis).

Interestingly, the outreach programs in Slovenia include multidisciplinary teams working in unison and initiating a mobile visiting unit for home visits for specialized groups and therapeutic communities (Hren 2022). The units provided on-site drug testing of old and new drugs, feedback to drug users, on-hand information and counselling regarding risk and protective behaviours. According to Hren (2022), the results indicated that the units were especially valuable during the lockdown (COVID). It also lowered the number of poisoning overdoses and improved health and social services cooperation. Finally, the level of social inclusion, employment and enrollment in schools was improved or increased (Hren 2022)

6.4 Kyiv, Ukraine

Finally, Pinchuk (2022) discussed the lack of pharmaceuticals, including methadone, in Ukraine due to Russian bombings that destroyed civilian infrastructures, schools, hospitals, and pharmaceutical manufacturing structures in Kyiv and beyond. According to Pinchuk (2022), 96% of the targets destroyed in Kyiv have been all civilian infrastructure, and only 4% are military targets.

7 Discussion and Recommendations

The importance and relevance of the findings of the Lisbon Addictions Conference 2022 is that when presenting decriminalization as a starting point for reducing harm and supporting drug addicts, it was clear that social services cooperation would improve all services for the population in British Columbia.

In Europe, it was presented that individuals with substance disorders and dependencies are being treated humanely. What they do for people works for them, and cultivating change must be worthwhile (Curado 2022). It appears that systems that work the best work in unison to help people, and potentially the systems that work in isolation, keep people and idea’s stuck in a solo. For example, in British Columbia, there are missed opportunities of streamlining people into services in real-time that could be improved by allowing instant referrals. This could be accomplished by eliminating the separation of broken healthcare systems and amalgamating all provincial services into one "British Columbian Commission of Dissuasion" (BCCD). Centralized data collection would provide instant information on the availability of services and where they are located, it will not only use Provincial capacity effectively, but it will also save the lives of those at the greatest risk. Changing the current strategies and potentially operating a provincial system so individuals can access services should be as simple as making reservations for an airplane ticket.

It would be recommended to take advantage of every opportunity and provide proper assessments for all those whose lives are at risk, including testing for STDs and substances in their system so the professionals working with them can understand the patient's needs—looking at the Zurich model that moves people around to services till they find what works. It is recommended to discontinue blindly medicating and drugging people without a course of action to improve their quality of life; if lives don't improve, the cycle will likely continue.

Research into therapeutic communities within prison systems for individuals engaged in drug use or sentenced to prison for drug-related offences indicated decreased drug use and helped with recidivism. It is recommended to implement European therapeutic models in prison, including pharmacological and psychosocial support, that are strategies to stabilize those imprisoned by meeting the needs of drug-dependent prisoners, which will be critical for effective drug services globally (Uchtenhagen 2013).

It is recommended that services to reduce harm are spread across cities and discreet and accessible to everyone. For example, creating van services for professionals and tradespeople to help them use substances safely in a controlled environment and monitor their use, as well as dissuade them into making behaviour changes and avoid risky circumstances; additionally, the unit could help to nudge people into treatment programs that best suit their circumstances. Spreading the systems across the province could potentially separate the clusters of drug users and homeless and allow for positive interactions and influences – it will also keep people safe from the encroachment of drug "kickstarting" known to drug users as freebee's giving by suppliers to restart their habit. By observation, this is a common practise in Government Funded single occupancy unit (SRO) housing.

If drug addiction and substance use are to be accepted, provide programs for people to learn how to manage their medication responsibly or move into abstinence-based models. Responsibility for managing medication in some cases must be taught and supervised, and all individuals involved must be accountable for the responsibility, including responsible dosing. Building capacity where the sole purpose is improving quality of life while teaching substance users how to use their medication responsibly, getting them back on their feet so they can move forward as citizens, thereby improving quality of life. Long-term monitoring of the treatment must be included in the continuum of care, whatever pathway is chosen and holding all involved accountable to the program.

Adequate housing and shelter must be provided that is safe and free from the encroachment of drug traffickers. Allowing people to sleep in tents on the street is inhumane and should be prohibited. Circling back to a reservation system, the service providers would be aware at any given time where supports are available and expedite the support immediately. Teams on the street time would be more useful in moving people along the support as well as addressing the addicts' immediate needs.

Improving shelter spaces and safe injection sites to be community intersections for drug users to help move them along the system to improve their quality of life. Registering individuals who access services and following them through the system will help to understand how to provide better support, including initiating the individual to care of their communities and spaces as a mandatory requirement for all those accessing services, providing purpose.

Lastly, the current policy in British Columbia is causing stigma to those that use substances. For example, there was a public outcry in a neighbourhood in a small community in Vancouver, Canada, due to a proposed building aimed to house approximately 140 individuals who are experiencing or are at risk of

homelessness (Burr 2021). Potentially the outcry is caused by the current condition of other SRO throughout the city that is encroached with crime and substance use and the acceptance of drug use and are grossly mismanaged. Mismanaged SRO could potentially destroy the communities. In addition, the visual of homelessness and harm reduction caused by the policies in British Columbia and failed projects to provide adequate support to suffering homeless individuals is also potentially causing stigma.

8 Conclusion

The report described what was learned at the Lisbon Addictions 2022 conference, including an overview of the Portuguese model of addiction treatment, residential treatment, bed-based programs, therapeutic communities, treatments in the prison system and drug consumption. Additional research substantiated and clarified their presentations and conversations during the conference. In addition, the writer compared the Portuguese model to other European models, including Zurich, Switzerland; Ljubljana, Slovenia; Kyiv, Ukraine; and the Czech Republic.

Addiction is addiction across the globe, and the presentations indicated similar challenges with addiction treatment as the challenges not uncommon in Canada. However, European models take advantage of opportunities to help addicts, including mobile units that offer wrap-around services, community centers that provide community and purpose, and therapeutic communities in prisons that start the treatment and dissuasion of imprisoned individuals. Additionally, the structure must be developed to improve working relationships between service providers for them to work cooperatively. The goal is to provide the best solutions to each person served.

The writer perceived a dramatic difference in the North American treatment of the homeless vs. Europeans. European models take advantage of chances to support their citizens at every opportunity by offering remote and mobile services and eliminating clusters of people engaged in harm reduction or who choose to be without a home—interactions with people who may not be in the same circumstance to initiate positive influence. Careful thought and consideration are critical, as well as finding a balance between consideration and over-complication.

More than 1800 people from 88 countries and 200 presentations attended the Lisbon Global Addiction 2022 conference. The overall theme at the conference was how best to reduce harm to individuals with substance abuse and dependencies while protecting societies. The word recovery was seldom spoken, and it was challenging to find a presentation about recovery from addictions. The Portuguese Policy presentation by SICAD presentation room was overfull, with over 50 people sitting on the floor or standing, signalling that the world wants to understand the Portuguese model.

In conclusion, British Columbia urgently needs systemic change. Developing cooperation across all services sectors and taking advantage of opportunities to help individuals recover in all settings, including while incarcerated, will decrease harm to society and save lives. Lastly, North American society could

benefit from an evolution in consciousness, and a collectivist culture that supports people around us, regardless of their social situation.

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