Simon Communities in Ireland

Submission to Inform the National Drug Strategy

October 2016

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Introduction

Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be caused and exacerbated by traumatic experiences, including homelessness. Homeless drug and alcohol users tend to use drugs and alcohol more frequently, in increased quantities and in ways that increasingly put their lives at risk. Risk behaviour is correlated to housing instability with those rough sleeping and in emergency accommodation experiencing the highest levels of risk behaviour.[1] Every day, Simon Communities around Ireland work with people impacted by problematic drug and alcohol use, dual diagnosis and complex needs. We provide specialist health and addiction treatment services[2] including; residential alcohol detoxification, respite for clients with HIV and blood borne viruses, stabilisation, addiction recovery, aftercare, counselling, health and well-being and an addiction in-reach Housing Action Team (HAT). We also provide harm reduction services including a mobile health clinic, primary care nurses in housing and emergency services and a needle and syringe programme including safer injecting advice and on-site needle exchange in emergency accommodation and an emergency out of hours outreach backpack needle exchange service to rough sleepers. Our services are low threshold, integrated and outcomes-focussed. We work with clients at all stages on the continuum of addiction from working with people to reduce harm, providing treatment services, and supporting those in recovery and aftercare in supported housing or living independently.

Recommendations

General

- People who are homeless should be recognised as a specific target group in the NDS.
- The Drugs Initiative budget has seen cuts of 37% in the 6 year period from 2009 to 2015[3]. At the very minimum these cuts need to be reversed to ensure adequate support services are available. These cuts have had an impact on people who are homeless and are impacting on waiting times and waiting lists.
- Housing First must be recognised in the new National Drug Strategy (NDS) as a key strategy for ending long term homelessness especially amongst those with complex needs including drug and/or alcohol use. This requires considerable cross departmental and agency working. Detailed objectives should be published specifying key stakeholders, their roles and resource allocation to ensure efficacy of implementation. Key stakeholders should include the HSE; the Department of Housing, Planning, Community and Local Government, Local Authorities; drug and alcohol services; homeless services; and community and voluntary organisations.

Treatment

- Alcohol and drug services must be resourced nationally to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model[4]. This should include rapid access to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide and include all substances. Access to aftercare housing is particularly important for homeless persons exiting treatment, given the high risk of relapse in traditional homeless services settings.

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[1] Cox and Lawless (2005), *'Drug use Among the Homeless Population in Ireland'*, National Advisory Committee on Drugshttp://www.drugs.ie/resourcesfiles/research/2005/NACD_homeless_population.pdf.

[2] For example-in 2015 Dublin Simon Community reported

- 31% increase in those accessing Addiction Treatment Services.
- 845 GP consultations took place via the Mobile Health Unit.
- 699 accessed our Treatment Recovery and Counselling Services.
- 470 Harm reduction emergency needle exchange packs distributed per month.

[3]http://www.citywide.ie/news/2015/03/04/citywide-calls-for-confirmation-of-appointment-of-minister-for-drugs/ ibid.

[4] http://www.drugs.ie/resourcesfiles/reports/3966-42381118.pdf

- Rapid Access to treatment. People who are homeless often have to wait in homeless services until a treatment place becomes available. This in itself can make adherence to access criteria unrealistic for many homeless clients given their proximity in homeless services to substances and their inability to avoid triggers.
- Action item the Intermediate Healthcare Step up/Step down facility and development of Addiction Treatment Services on site at Ushers Island, Dublin 8 by Dublin Simon Community (DSC) in the establishment of up to a 100 bed low threshold addiction treatment facility. This development will consist of:
    - Implementing an Alcohol and Benzodiazepine Detoxification Unit for people who are homeless.
    - Pioneering a new Rapid Access Alcohol and Drug Detoxification Stabilisation service in partnership with Merchants Quay Ireland (MQI), in Dublin for people who are homeless, chaotic and require tailored treatment options.
    - Expanding the remit of HIV Stabilisation/Respite Service to include all blood borne viruses in particular Hepatitis.
    - Implementing a new Addiction Treatment (detoxification and stabilisation) service for people who are homeless and experience mental health difficulties.
    - Expanding Residential Addiction Recovery service and beds for people who are experiencing homelessness.
    - Creating a new Intermediate Care Step up/Step down Facility for hospital admission and discharge post-surgery and major treatment.
- Undertake a review of the efficacy of catchment areas in relation to access to drug detoxification, treatment and aftercare and mental health service to ensure those that need these services most have ease of access especially vulnerable target groups such as people who are homeless.
- Implement the prioritised recommendations of the *National Hepatitis C Strategy 2011–2014.*[5]
- The NDS should prioritise the implementation of the recommendations contained in the HSE *Opioid Treatment Protocol* Report.
- The NDS should prioritise trauma informed practices and counselling services including greater resourcing of social work, community and family services as a means of reducing the prevalence of problematic use and earlier drug taking by those that have experienced adverse traumatic experiences in childhood.
- Residential treatment centres should be resourced to address post-traumatic stress disorder concurrently with addiction treatment given an estimated prevalence rate of 66% amongst residential treatment participants (REF).
- All HSE funded residential treatment services should be upskilled to manage dual diagnosis cases as a basis of best practice care.
- The NDS should include addictions across the board. The destructive nature of process addictions[6] and their linkage to problematic drug and/or alcohol use cannot be underestimated.

Rehabilitation

- Outline specific actions necessary to address the rehabilitation needs of people who are homeless with addiction issues as committed to in the *Rebuilding Ireland Action Plan.*
- Provide in-reach support for people while in treatment to prevent homelessness on discharge.

[5] https://www.hse.ie/eng/services/Publications/HealthProtection/HepCstrategy.pdf
[6] Process addictions are addictions to activities or processes such as gambling, eating, video/gaming, spending, sex, Internet surfing as opposed to a "substance addiction" like that of drugs or alcohol.

- Develop, resource and implement discharge protocols for general hospitals, mental health services and drug treatment services for people who are homeless in conjunction with primary care networks and local primary care teams. Nobody should be discharged back into homelessness.
- Ensure that ring-fenced emergency accommodation options are in place for drug users experiencing homelessness when they are detoxing, working towards methadone maintenance or are trying to abstain from drug/alcohol use. This is a short term measure to facilitate the wider rollout of Housing First tenancies and the provision of in-house drug treatment and rehabilitation services.

Harm Reduction

- The NDS should prioritise the resourcing, expansion, availability and accessibility of harm reduction strategies and services.
- Establish and resource a full range of harm reduction services for those in rural settings including an adequate spread of residential treatment and rehabilitation places.
- Fast track legislation to establish medically supervised injecting centres (MSIC) in advance of the delivery of the NDS. MSIC should allow for the consumption of all 'carry in' substances and should promote the use of foil for smoking substances as a harm reduction measure rather than focus entirely on injection drug use.
- Expand the needle exchange programme and put in place funding for disaggregated data collection and service provider and practitioner training.
- Increase funding for needle exchange service providers to formalise referral mechanisms for BBV and TB screening and to carry out BBV screening where expertise is available to do so.
- Establish a post of National Policy Coordinator to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol use and their linkage to mental health services.
- Introduce increased incentives for GP's to encourage them to become level 2 GPs under the Methadone Protocol for methadone prescribing and methadone management.
- Implement the recommendations of the *Evaluation of the HSE Naloxone Demonstration Project*.
- Introduce a pilot heroin administration programme for opiate users based on the model developed in Switzerland.
- A specific action plan on overdose prevention with clear timelines and targets should be developed.

Criminal Justice System

- All outstanding drug charges should be consolidated before an offender enters drug treatment. Historical charges not brought forward under this consolidation should be expunged.
- All non-victim crimes (begging, possession for personal use) should be quashed upon completion of residential treatment programs. These are small crimes that are addiction driven. They do not have any direct victim and cause a strain on the legal system and tax payer (legal aid, court and Garda time) and create a huge relapse trigger in the anxiety and fear they create to clients compromising recovery.
- Further exploration of the de-criminalisation of drug use must be explored. Policing emphasis should shift from small scale personal use to large scale supply.

Review of NDS 2009-2016

- The 5 pillar structure adopted in the NDS 2009-2016 is a comprehensive approach to address the many issues associated with problematic drug and alcohol use. While we encourage the retention of this structure in the new strategy, overarching goals must be underpinned by specific time bound objectives as recommended in the *Report of the Rapid Expert Review of the National Drug Strategy 2009-2016.*[7] This will allow for targeted implementation and accurate evaluation throughout the duration of the strategy.
- The new strategy must complement existing government strategies and remain flexible to adapt to new strategies across all Government Departments. There must be clear synergies between the new strategy and the *Rebuilding Ireland Action Plan* given the commitment therein to address the rehabilitation needs of people who are homeless with addiction issues through the new National Drug Strategy. This is a welcome commitment that must be further underpinned in the new strategy by committing to the use and roll out of the Housing First model for the drug treatment and rehabilitation needs of people who are homeless.
- People who are homeless must be included as a target group in the new strategy. Overarching goals and specific objectives must be put in place to address barriers to treatment and rehabilitation, pathways between these services, discharge protocols from services and strategies to reduce drug related deaths. These issues are identified in the *'Report of the Rapid Expert Review of the National Drug Strategy 2009-2016'.*[8]
- We welcome the recommendation in the *Report of the Rapid Expert Review of the National Drug Strategy* that the new strategy be accompanied by one or more time bound action plans. Such initiatives would counter the recognised slowdown in implementation that occurred towards the end of the previous strategy. We would very much encourage the development of a homeless specific action plan, linking to commitments in the *Rebuilding Ireland Action Plan,* focussing on increasing access and availability of treatment and rehabilitation services or alternatively the rollout of a suite of homeless specific harm reduction strategies.
- The new National Drugs Strategy should include addictions across the board. Process addictions[9] are often overlooked due to the lack of visibility within relevant policy. There is huge overlap between process and problematic drug and/or alcohol use addictions. Process addictions are as destructive and in some cases more destructive than many substance use dependencies causing family breakdown, financial burden, engagement in illegal activity, suicidality and other mental health issues. Additionally, though many treatment centres offer treatment to process addictions, treatments are not subsidised resulting in inability for sufferers to enter into the recovery process.

[7] *Report of the Rapid Expert Review of the National Drug Strategy 2009-2016,* http://health.gov.ie/wp-content/uploads/2016/09/Rapid-Expert-Review-of-the-National-Drugs-Strategy-2009-2016.pdf.
[8] Ibid.
[9] Process addictions are addictions to activities or processes such as gambling, eating, video/gaming, spending, sex, Internet surfing as opposed to problematic drug and/or alcohol use.

Homelessness and Problematic drug and alcohol use

People who are homeless as a specific target group for the NDS

In September 2015, the Partnership for Health Equity published the *Homeless: An Unhealthy State* report. The report describes the findings of research conducted into the health status, risk behaviours and service utilisation of homeless people in Dublin and Limerick cities.[10] The report found there was a rise among participants in problematic drug and alcohol use in particular, as well as a dramatic rise in dangerous drinking among women who were homeless, a rise in illicit use of benzodiazepines, while poly-drug use among participants became the norm with a high use of prescribed sedatives. Cannabis was the drug most commonly used among current drug users followed by illicit use of benzodiazepines and heroin.

Some of the Simon Communities have seen an increase in the use of opiate drugs, prescription drugs (in particular, benzodiazepines) and also synthetic benzodiazepines drugs. Drugs from Head Shops and the use of 'legal highs[11]' are very difficult to control. Although many Head Shops have now closed 'legal highs' are still accessible online. It is very difficult to know what substances a person has taken if they were purchased/secured online. A report by European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol (April 2016) found that the use of 'legal highs' shows no signs of decreasing across Europe and there are challenges for Ireland in legislating for these drugs as they are quickly developed and disposed of; as soon as a ban is introduced for one substance another is developed quickly to replace it.[12]

The Simon Communities Snapshot Study Report found that over 50% of respondents reported that they were current alcohol users, while 31% reported that they were current drug users. Given the prevalence of problematic drug and alcohol use experienced by people who are homeless we strongly recommend their inclusion as a specific target group within the new National Drug Strategy (NDS).

Alcohol use

That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. Seventy percent of high-support housing residents and 64% of emergency accommodation residents that participated in the study reported alcohol use. The study found that 28% of all participants had health issues directly related to their alcohol use, and that 9% of the respondents had attended a detox facility in previous 12 months. Forty-four percent of respondents who indicated that they were current alcohol users at the time of the study also had alcohol related health issues. The most common alcohol related health issues included; falls/head injuries, memory loss, gastric problems, liver damage and seizures. Eighty-one percent of participants in the *Homelessness: An Unhealthy State* study reported alcohol consumption at least once in the previous month. Twenty-two percent of participants consumed alcohol on a daily basis. Sixty-eight percent of participants consumed in excess of five drinks on each typical occasion.[13]

Drug Use

The snapshot study found the highest level of drug use was found among people sleeping rough and those using emergency accommodation. Heroin was the most frequently used drug among participants, with more than 58% saying they used this drug. Cannabis was the second most frequently used drug with 47% of participants reporting that they use it. Forty-one percent of people reported taking methadone; with 29%

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[10] Ibid 1.

[11] Legal highs are substances that mimic the effects of illegal drugs, but are not currently controlled by the Misuse of Drugs Act. Legal highs can be purchased in Head Shops and on the internet http://www.aldp.ie/resources/legal_highs

[12] Article in Journal.ie 5th April 2016 *Ireland is the biggest user of legal highs in Europe as their growth shows 'no signs of a slowdown'* http://www.thejournal.ie/legal-highs-new-drug-report-2699032-Apr2016/
http://www.emcdda.europa.eu/system/files/publications/2373/TD0216072ENN.PDF.

[13] Ibid 1, P. 33.

using prescribed methadone and 12% using un-prescribed methadone. Eighty percent of participants in the *Homelessness: An Unhealthy State* study reported using illicit drugs. Fifty-five percent of participants reported using illicit drugs in the last three months. Cannabis was the drug most commonly used by participants. Forty-six percent of participants in Dublin and 22% in limerick had experience of intravenous drug use (IDU).[14]

Polydrug use

The health snapshot study found that levels of polydrug use[15] were high among drug users with 76% of drug users saying they used more than one drug. Twenty-eight percent said they used a combination of two drugs and 45% of drug users said they used three drugs. Fifty-two percent of those currently using drugs at the time of the study said they had used drugs intravenously (IV) in the previous 12 months, half of which said they experienced health complications as a result of IV drug use. Forty-three percent of participants in the *Homelessness: An Unhealthy State* study reported using 2 – 3 drugs in the previous three months. Twenty-two percent of participants reported using 4 – 6 drugs in the previous three months, 6% of participants reported using 7 or more drugs in the previous three months.

Problematic drug and/or alcohol use can lead to a range of physical and mental health conditions. Falls/head injuries and memory loss were the highest reported health problems caused by alcohol use. Fifty percent of those who were currently using drugs intravenously at the time of the snapshot study reported experiencing health complications as a result. The most frequently reported conditions included abscesses, Hepatitis B and/or Hepatitis C, overdose and vein damage.

Dual Diagnosis and Complex Needs

A person who is homeless very often has multiple needs or complex needs[16], such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. This makes it very difficult for people to be in contact with all the various services they may need at one time. If one issue was to be resolved, other issues would still be cause for concern (Homeless Link, 2002)[17].

The *Homelessness: An Unhealthy State* report found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. Thirty-five percent of participants had a mental health diagnosis and current illicit drug use.[18]

According to the *Simon Communities Health Snapshot study*, people who are homeless are more likely than the general population to experience complex needs, including a dual diagnosis of mental health and problematic drug and/or alcohol use due to environmental factors, in particular a lack of supported housing. It was very difficult to ascertain how many respondents had dual diagnosis and complex needs but 20% respondents were identified as having a diagnosed mental health condition as well as alcohol and drug related conditions.

People with dual diagnosis can find it very difficult to access services. They often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice would argue that the two issues should be treated at the same time and in a co-ordinated way.

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[14] Ibid 1, P. 35.

[15] Polydrug use is concurrent drug use, which involves a person using at least two substances during the same time period http://www.nacda.ie/images/stories/docs/publicationa/nacdpolydrugusebulletin5.pdf

[16] A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing (Turning Point, 2014) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf

[17] As cited in Feansta Health Working Group paper (2013) *'Health and Well-Being for All Holistic Health Services for People who are Homeless'.*

[18] Ibid 1.

Addressing the issue might involve the following measures:

- Ensuring that all residential treatment facilities funded by the HSE would be up-skilled to manage dual diagnosis cases as a basis of best practice care.
- Closing the current gap which enables psychiatric services to refuse services to addicted clients.

Urgent need for the development of low threshold addiction treatment service

- *Continue provision of low threshold[19] residential addiction detoxification services in Dublin for people who are homeless:*

  Drug or alcohol addiction affects over half of people experiencing homelessness with an increase level of poly substance use. Waiting lists for presenting to Dublin Simon Community's detoxification service is currently 31 days growing from 27 days in 2014. The current NDS recommended expanding the availability of and access to detoxification facilities. In addition, the working group on residential treatment and rehabilitation in 2007 stated a deficit of 104 inpatient detox and stabilisation beds nationally.[20] A 2015 progress report from the HSE on the NDA confirmed that there is still a recognised need for more detox and rehabilitation facilities.[21]

- *Develop a new Rapid Access Alcohol and Drug Detoxification Stabilisation service for people who are homeless, chaotic and require tailored treatment options:*

  Increasing numbers of poly substance users in the homeless population require a more flexible approach to detoxification. The cohort of chaotic drug users is increasingly using more than one substance and Ireland has the highest prevalence of New Psychoactive substance (NPS's) use among 18-25 year olds in the EU (EMCDDA, 2016). Poly drug use combined with chaotic lifestyles while living on the streets requires a response that takes into account the needs of the client in the first instance and a removal of all barriers to treatment. Implementation of the MQI / Dublin Simon Community Rapid Access Detox /Stabilisation model will ensure that homeless poly-drug users have rapid access to a suite of options including low threshold residential stabilisation (all substances) and the option of treatment, including detox in the first instance.

- *Development of an addiction detoxification service for people who are homeless and experience mental health difficulties:*

  People who are homeless and have problematic alcohol or/and drug use, often have high mental health needs and while outreach services have developed, there is a gap in appropriate residential addiction services for this group. Individuals often cannot access residential mental health services, until they address their addiction.[22] The *Homelessness: An Unhealthy State* report found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. Thirty-five percent of participants had a mental health diagnosis and current illicit drug use.[23] This detoxification and stabilisation service would address the needs of people who are homeless, who have a mental health difficulty and have problematic alcohol or drug use.

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[19] By 'Low Threshold' we mean that we do not set admission criteria unachievable by our client group. Also the programme imposes minimal constraints and exercises a high degree of flexibility to ensure that clients can complete the programme and achieve their goals. As a consequence we tend to work with those people often excluded from services due to medication management, poly substance use and associated behavioural issues.

[20] Corrigan, D et al. (2007) Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Users).

[21] HSE, 2016, National Drugs Strategy 2009-2016-progress report to end 2015

[22] Shari McDaid, Mental Health Reform, 2015 http://www.irishtimes.com/opinion/homeless-people-with-mental-health-difficulties-need-more-than-key-in-the-door-1.2062351

[23] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity.

- *Expand criteria for the Dublin Simon Community Addiction Respite/Stabilisation[24] Service from only treating clients with HIV to also treating those with Blood Borne Viruses such as Hepatitis C:*
  This facility has the capacity to also accept clients with Hepatitis C and the service provided is similar in nature. Hepatitis C is particularly common in problematic drug users, with over half of drugs users being hepatitis C positive.[25] The Hepatitis C strategy stated the low numbers (11%) of problematic drug users that were currently receiving treatment for hepatitis C and recommended the need for increased service provision for this particular group. Service also meets the recommendations of the 2011-2014 Hepatitis C strategy which insists that the most effective way of preventing Hepatitis C is by treating drug addiction and noted that long waiting lists were hindering drug addiction treatment. Dublin Simon Community are in a unique position to address this need in this group with currently existing services.
- *Continue and expand residential addiction recovery service for people who are experiencing homeless:*
  The demand and need for a residential addiction recovery service after going through a treatment service has been evidenced by the waiting lists and high levels of occupancy. This service is also in line with the rehabilitation framework which is yet underdeveloped, providing a tier 4 level service, and the full implementation of this framework was advised by the NDS Expert Review group.[26] Providing residential addiction services also supports the *Rebuilding Ireland Action Plan* action item 1.16, *'…address the rehabilitations needs of homeless people with addiction issues to ensure that drug rehabilitation pathways are linked to sustainable supported tenancy arrangements'.*

Barriers to Treatment

Cuts to Health and HSE Budgets

The impact of the crisis and cuts to HSE budgets are still being felt in health and homeless services. These cut-backs to funding and lack of resources have impacted most on high risk groups, especially on people who are homeless. Some health services that were available have been amalgamated with others or have almost disappeared, making it more difficult for people to access. We welcome the recent announcement in Budget 2017 of an additional €3 million euro in funding for drugs and social inclusion measures.[27]

Catchment Areas

Catchment areas can pose a problem for people when trying to access services. For example, Dublin Simon Community residential detoxification services operate within the Dublin Southside catchment area, and although the North-side services operate in the same surrounding area, people using the residential detoxification service are unable to access North side catchment areas services. The amalgamation of Mental Health services between Galway City and County and Roscommon is making it more difficult for people to access these services. Waiting times for appointments are longer and it can be more difficult for people to travel to city centre services.

[24] Stabilisation is the term generally used to describe compliance with methadone maintenance. This means that 'clean' or negative urinalysis results are given for illicit drugs, or prescription drugs which are not being prescribed by a doctor. Stabilisation generally involves a process for the individual which requires changes in their day-to-day activities and their drug use. This process can be supported through case management, relapse prevention sessions, counselling or day/residential programmes.

[25] HepatitisC strategy 2011-2014

[26] Griffths P. Strang J., Singleton N., (2016), Report of the Rapid Expert Review of the National Drugs Strategy 2009-2016. Drugs Policy Unit – Department of Health

[27] Department of Health, *'Minister Catherine Byrne announces additional funding of €3m in Budget 2017 for drugs and social inclusion measures'*, http://health.gov.ie/blog/press-release/minister-catherine-byrne-announces-additional-funding-of-e3m-in-budget-2017-for-drugs-and-social-inclusion-measures/.

Accessing healthcare in a rural setting

The challenge of responding to the healthcare needs of people who are homeless in a rural setting is accentuated by not having access to services. Homeless service users have to travel significant distances sometimes outside their own county to access health services. The additional costs incurred by Homeless Services because of rural isolation and poor transport infrastructure has not been recognised by State funders of homeless services.

Limited residential treatment and rehabilitation spaces nationwide

A full range of harm reduction services and responses is not available for those with problematic drug and alcohol use nationwide. There are also a limited number and spread of residential treatment and rehabilitation places across the country. This results in long waiting lists and people having to travel to access services only to have to return to their county of origin following treatment/rehabilitation.

Inadequacy of Rehabilitation of Offenders Measures

Many drug users seeking treatment have a criminal record resulting from their involvement in the drugs scene. Clients consistently report that old charges (up to five years old) are brought forward after they have begun treatment and/or moved in to recovery. This puts an undue strain on a sometimes precarious recovery process and can impede residential treatment as the client has to leave the treatment venue to go to court or has a large stressor to face in the early days post recovery. Engagement in treatment and treatment effectiveness can be fostered by linking such engagement to measure aimed at expunging criminal records for minor property crimes.

Inappropriate placement in emergency accommodation

For many, what should be a short term stay in emergency accommodation has become a long term issue. Many hostels and shelters are large institutional facilities and drug and alcohol use amongst residents can be widespread. This has the effect of undermining the efforts of those homeless service users who are detoxing, working towards methadone maintenance, or are trying to abstain from use. While our preference is for immediate housing for all those who are homeless with support provided in housing, we recognise that this will take some time to implement. In the meantime we argue that it is sensible to ensure that ring-fenced emergency accommodation options are in place for homeless service users who are detoxing, working towards methadone maintenance, or are trying to abstain from drug/alcohol use.

Harm Reduction Strategies

Harm Reduction International defines harm reduction as a set of '…*policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs*'.[28]

Harm reduction must be at the heart of homeless and drug service provision and is key to the success of Housing First approaches. According to Riley & O'Hare (2000, P.6-7)[29] key features of harm reduction include;

- Pragmatism: An acknowledgment that some drug use in society is inevitable.
- Humanistic values: This means that the user's decision to use drugs is accepted, without (moral) judgement and that the dignity and rights of the user are respected.
- A focus on harms: The extent of drug use is secondary to the risk of harms with neither a presumption, nor an exclusion of the goal of abstinence.
- A balancing of costs and benefits: There is a process of assessing the importance of drug related problems and associated harms vis-à-vis a cost-benefit analysis of interventions.
- A hierarchy of goals: Most programmes have a hierarchy of goals with the most immediate goal being to address the most pressing needs.

The explicit inclusion of the following harm reduction strategies and programmes in the new National Drug Strategy is crucial to ensure that the health needs of those who are homeless and problematic drug users are met.

Expansion of needle exchange programmes

The NDS should prioritise the expansion of and availability to needle exchange programmes across static, outreach and pharmacy exchange models. Such programmes need to go beyond the provision of 'one hit kits' in all areas to include a full range of injection equipment as the most effective harm reduction strategy. The contribution of these needle exchange models to the overall reduction in the number of newly diagnosed cases of HIV and Hepatitis C has been documented in the 2015 HSE *Review of Needle Exchange Provision in Ireland* report.[30] Other services attached to exchange programmes must also be expanded and made increasingly available across exchange models particularly referrals to other health, outreach and social care services in addition to services for BBV testing. The health impact of needle exchange programmes must be accurately captured by service providers though the development and use of a standardised disaggregated data collection system across all exchange models and service providers. Funding should be provided to those service providers to facilitate this data collection including the training and upskilling of staff in this regard.

Increased availability of screening and treatment of blood borne viruses and communicable diseases

Blood Bourne Viruses (BBV), such as HIV and Hepatitis are more common among people who are homeless than the general population[31]. 10% of respondents in the 2011 Simon Communities Health Snapshot study had a Hepatitis C diagnosis. According to the Hepatitis C Strategy 2009-2014 screening for Hepatitis C and other BBV is best offered when people come into contact with other services including

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[28] Harm Reduction International, '*What is Harm reduction – A Position Statement from Harm Reduction International'*, https://www.hri.global/what-is-harm-reduction.

[29] Riley, D & O'Hare P. (2000) Harm Reduction: History, Definition and Practice. In Inciardi, J. A & Harrison, L.D. (Eds) Harm Reduction: National & International Perspectives. Sage Publications California.

[30] HSE, '*Review of Needle Exchange Provision in Ireland'. 2015, P. 27,* *http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/ReviewOfNeedleExchangeProvisionInIreland.pdf*.

[31] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. http://www.healthequity.ie/#!report-launch/iuv63

needle exchange programmes. This however is not currently a viable option for all needle exchange providers given the resources and training required to carry out these additional services. Further funding must be made available to needle exchange services to carry out more widespread screening for BBV and TB.

Naloxone

In 2015, the HSE launched the Naloxone Demonstration Project involving 600 opioid users receiving take home naloxone on prescription.[32] In August of this year a full evaluation of the project was published.[33] The report recommendations must be included in the new NDS with added emphasis on the nationwide rollout of naloxone based on the National Drug Related Death Index. Increased funding must be made available to expand, upskill and train those responsible for the administration of naloxone in service settings in addition to greater awareness and training for those who will self-administer or administer the drug outside of service settings.

Medically Supervised Injecting Centres

In December 2015 the Cabinet approved a pilot scheme for a medically supervised drug injection facility. Medically supervised injection centres are a core harm reduction service providing a safe and hygienic place for injecting drug users while also providing a pathway into higher threshold treatment services such as medical and social interventions. Such facilities should allow for the consumption of all 'carry-in' substances on site, and should promote the use of foil for smoking substances as a harm reduction measure rather than focus entirely on injection drug use.

These facilities should form part of a suite of harm reduction measures committed to in the new NDS. We welcome the commitment to publish a Bill to legislate for the establishment of supervised injecting centres by the end of the autumn period.[34] The passing of this bill and its eventual commencement should be prioritised in advance of the NDS.

Heroin Prescription

In relation to opiate users the new NDS should consider adopting the Swiss Model of administering heroin for users. In this model users qualify for a heroin prescription where they meet six conditions as follows:

1) at least 18 years old;
2) been addicted (daily use) for at least two years;
3) present with signs of poor health;
4) Two or more failed attempts of conventional treatment (methadone or other);
5) Surrender driver's license;
6) Heroin can only be obtained at the clinic and must be consumed on site (oral or injection).

Policing, prison, legal and court costs for small quantities can be diverted to fund such programmes.

Evaluations of this model have found:

- Reduction in criminal offending: 60% drop in felony crimes by patients (80% drop after one year in the program).
- Reduction in drug dealing: 82% drop in patients selling heroin.

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[32] http://health.gov.ie/blog/press-release/ministers-welcome-availability-of-life-saving-antidote-to-heroin-related-overdoses-aimed-at-reducing-drug-related-deaths/.

[33] HSE, *(2016) Evaluation of the HSE Naloxone Demonstration Project*https://www.hse.ie/eng/services/publications/SocialInclusion/addiction/Naloxonedemoproject.pdf.

[34] Ibid 16.

- Reduced death rates: No one has died from a heroin overdose since the inception of the program (in the treatment room). The heroin used is inspected for purity and strength by technicians.
- Reduced disease rates: New infections of Hepatitis and HIV have been reduced for patients in the program.
- Reduced new use rates: Slightly lower than expected. 1) As reported in the Lancet June 3, 2006, the medicalisation of using heroin has tarnished the image of heroin and made it unattractive to young people. 2) Most new users are introduced to heroin by members of their social group and 50% of users also deal to support their habit. Therefore, with so many users/sellers in treatment, non-users have fewer opportunities to be exposed to heroin, especially in the rural areas.
- Studies from the Netherlands, Germany, Spain and the UK confirm the positive results from Switzerland.
- In Switzerland it is believed that the programme saves money when costs for criminal proceedings are factored in. (HAT Annual Report 2007).[35]

HSE Opioid Treatment Protocol

The recommendations contained in the HSE Introduction of the Opioid Treatment Protocol report must be implemented in full and should inform the development of the new NDS.[36]

Decriminalisation

At a time when de-criminalisation is being explored in Ireland there is a unique opportunity to shift policing focus from individual users and intensify efforts on suppliers. People caught in the cycle of addiction are continually being fined for carrying small substance amounts for personal use and for begging. This only goes to occupy court and police time, increasing the need for subsidised legal aid, pressure on prison systems and ultimately creates undue pressures on already burdened individuals.

Drug Rehabilitation Pathways and Sustainable Supported Tenancies

It is essential to provide funding for step down options and support for people once they have completed drug and alcohol treatment so they have accommodation to go to and have a support plan in place. We welcome the commitment contained in the *Rebuilding Ireland Action Plan* that through the new National Drugs Strategy, drug rehabilitation pathways will be linked to sustainable supported tenancy arrangements. It is essential that such approaches are underpinned by a Housing First approach to addressing homelessness.

Prevention through Trauma Informed Practice

Given the increased prevalence to risk of problematic drug and/or alcohol use and earlier drug taking by people that have experienced adverse traumatic experiences in childhood,[37] the NDS should promote increased resourcing to social work, community and family services in addition to trauma informed practices and counselling services in schools and community services as a means of developing greater quality and less adversity in childhood and to offer more therapeutic support when difficult and traumatic incidents occur. Such resourcing will increase young people's resilience and though may not reduce experimentation with substances, it may offset otherwise vulnerable young people's reliance on self-medicating with such substances. Such measures will also impact on early school leavers (ESL) as pupils

[35] http://www.globaldrugpolicy.org/Issues/Vol%205%20Issue%204/Switzerland%20the%204%20pillar%20drug%20policy%20in%20Switzerland%20Koeppel-SR%20edit.pdf.
[36] http://www.drugs.ie/resourcesfiles/reports/Opioid_Treatment_Protocol.pdf.
[37] Simon Communities in Ireland (2015) *'Women, Homelessness and Service Provision'*, P.41, http://www.simon.ie/Women_Homelessness_and_Service_Provision/pubData/source/Women%20Homelessness%20and%20Service%20Provision.pdf.

experiencing emotional overwhelm are more likely to see school as an extra stressor and have more difficulty engaging in lessons and school life.

Residential treatment centres should be resourced to address post-traumatic stress disorder concurrently with addiction treatment given an estimated prevalence rate of 66% amongst residential treatment participants (REF). This is important given evidence that unless both are treated together, both abstinence and substance abuse may make trauma symptoms worse. (Brown et al, 1998, Najavits, Shaw & Weiss, 1996).[38]

Primary Care and Level 2 GPs

Despite the target of there being access to health care in Ireland for all, many people who are homeless only access health services when they are in crisis or when illness is well developed and severe, a point at which they access health care through emergency departments. (Partnership for Health Equity, 2015)[39]. This is a prime illustration of the inverse care law in operation, whereby those that are most likely to need services are the least likely to get them. The Simon Communities in Ireland reported that having treatment services and multi-disciplinary teams in place is very advantageous however barriers to accessing off-site health care for people who are homeless still exist.

The development of the NDS is a prime opportunity to establish a post of National Policy Coordinator to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol use and their linkage to mental health services. Increased incentives and access for GP's must be prioritised to encourage them to become level 2 GPs under the Methadone Protocol[40] for methadone prescribing and methadone management. Provision must be made for initiating treatment of methadone on site in community and voluntary based organisations. Furthermore, there is a need to increase the number of methadone clinics in rural areas so people don't have to travel to city areas daily to collect daily doses of methadone. Consideration should again be given to the wider introduction of suboxone as an evidence based alternative to methadone nationwide.

Support in Housing/Housing First

There is a strong and well documented association between the experience of long term homelessness and a range of complex health and related needs. Housing First programmes are internationally considered to represent best practice in housing people who are long term homeless with complex needs. People with physical health, mental health, dual diagnosis and complex needs often remain trapped in homelessness. Without the necessary supports in place they are unable to access or sustain a tenancy or access support services. There can be issues accessing mental health hospital, attending primary health care facilities or utilising mental health housing programmes for active drug and/or alcohol users. People can be deemed ineligible for housing payments such as Rental Accommodation Scheme (RAS) or Housing Assistant Payment (HAP) scheme if they had rent arrears in the past three years or a criminal record in the last two years. This runs contrary to the ethos of Housing First approaches and presents a real risk of institutionalisation for those people in emergency accommodation.

Housing First offers housing without preconditions and offers a range of supports focussed on harm minimisation and supporting recovery and empowerment through Assertive Community Treatment (ACT) teams. The success of such initiatives depends not just on housing but also, crucially, on drug and/or

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[38] Najavits, Shaw & Weiss, "Seeking Safety": Outcome of a New Cognitive-Behavioral Psychotherapy for Women with Posttraumatic Stress Disorder and Substance Dependence, 1996, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.455.8836&rep=rep1&type=pdf.

[39] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. http://www.healthequity.ie/#!report-launch/iuv63

[40] http://www.drugsandalcohol.ie/6721/2/Butler_1983_The_Making_of_the_Methadone_Protocol.pdf

alcohol, mental health, and community integration services being available to tenants who were formerly homeless. There are two key aspects to the Housing First[41] approach - immediate provision of housing without pre-conditions or the requirement of housing 'readiness' and the provision of support in housing at the level required, for as long as necessary. With Housing First the goal is to move people out of homelessness as quickly as possible into permanent housing where tailored support services are more effective. These approaches, once properly resourced, improve the outcomes and quality of life for people who are homeless, or at risk in Ireland. Housing First approaches involve three dimensions of support:

Housing supports: The initial intervention of Housing First is to help people obtain and maintain their housing, in a way that takes into account client preferences and needs. Key housing supports include; finding appropriate housing; supporting relations with landlords; applying for and managing rent subsidies; assistance in setting up apartments.

Clinical supports: This recovery-oriented approach to clinical supports is designed to enhance well-being, mitigate the effects of mental health and addiction challenges, and improve quality of life and foster self-sufficiency.

Supports towards Community Integration: These supports are intended to help individuals and families improve their quality of life, integrate into the community and potentially achieve self-sufficiency. They may include: life skills; engagement in meaningful activities, income supports, assistance with employment, training and education, and community (social) engagement.

As mentioned, we welcome the commitment in the *Rebuilding Ireland Action Plan* to triple Housing First tenancies during 2017 and encourage its wider rollout nationwide. We further welcome the commitment to address the rehabilitation needs of people who are homeless with drug and/or alcohol issues. This commitment must translate directly into a core action of the new NDS.

Cross Departmental funding, communication and protocols to ensure effective delivery of Housing First
Addressing the housing and homelessness crisis requires cabinet and cross departmental support from key departments including Housing, Health/HSE, Finance, Public Expenditure and Reform, Social Protection and An Taoiseach. This is particularly pertinent given the multi-dimensional support envisaged through Housing First.

People must be supported to make a smooth transition from emergency accommodation to independent living as quickly as possible and must then be supported to maintain their tenancies and remain in their homes. For this to become a reality requires income adequacy, adequate rent supplement/Housing Assistance Payments (HAP) and health and social care supports. Integrated Cabinet and cross-departmental support as outlined above will be needed for these to work effectively. All of these Departments have a vital role to play in ensuring the resourcing of and access to affordable housing, to social protection supports and to the critical support services that offer the most effective means of preventing people from becoming homeless and of supporting people to move out of homelessness quickly. Increased communication between Departments is a vital component to ensure the effective delivery of Housing First supports.

[41] In 2014 research undertaken by Mental Health Commission of Canada as part of the *At Home/Chez Soi study*, the largest ever study examining the effectiveness of the Housing First approach compared with the traditional staircase approach. The study followed more than 2,000 people who were homeless over a two year period across 5 Canadian cities. The findings were very clear: The Housing First intervention was twice as effective as the staircase approach in ending homelessness for people who had been long-term homeless with complex support needs. Furthermore, the intervention led to significant cost savings when compared with traditional interventions[41]. The key to the success of Housing First is its comprehensive model of support for the most 'hard core' people who are homeless with the highest level of needs.

Step down options post-treatment and discharge protocols

The NDS must prioritise funding for the delivery of step down options and support for people once they have completed drug treatment. People must have accommodation to go to on completion of treatment. Discharging people from institutional settings e.g. hospital/prison/care system into homelessness remains an issue. Discharge protocols must be published, implemented and resourced. This is supported in the *Report of the Committee on Housing and Homelessness* (2016). An opportunity currently exists to publish detailed targets in the NDS in this regard given the absence of such targets in the *Rebuilding Ireland Action Plan.*

Conclusion

We welcome this opportunity to make this submission to inform the new National Drug Strategy. The development of a new National Drug Strategy is an unmissable opportunity to tackle the prevalence of problematic drug and alcohol use and the associated health implications experienced by people who are homeless. People who are homeless must be included in the new strategy as an 'at risk', 'hard to reach' target group. We know that drug and alcohol treatments are most effective when delivered to a person in a sustainable and secure tenancy. As such, Housing First must be prioritised as the primary means of service delivery for people who are homeless. We know this approach works and we know that it can transform the lives of people who are living in hostels, hotels and emergency accommodation. Existing harm reduction strategies must be resourced and expanded. New strategies should be fast tracked and developed in accordance with international best practice. Barriers to drug treatments need to be reviewed, those that need services most should be prioritised and not subject to hard-to-meet treatment criteria. Low threshold treatment services must be resourced and expanded. We believe that the new National Drug Strategy can have a beneficial impact on the improvement of existing drug treatment and rehabilitation services for people who are homeless and the delivery of future services and harm reduction strategies that specifically target the myriad of issues identified in this submission.

Submission to inform the National Drug Strategy

For further information contact

Niamh Randall
Head of Policy and Communications
E: niamh@simoncommunity.com
Ph: 085 8588 384

About Simon Communities

The Simon Communities in Ireland are a network of eight regionally based independent Simon Communities based in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East that share common values and ethos in tackling all forms of homelessness throughout Ireland, supported by a National Office. The Simon Communities have been providing services in Ireland for over 40 years. The Simon Communities deliver support and service to over 7,500 individuals and families throughout Ireland who experience – or are at risk of – homelessness every year.

Whatever the issue, for as long as we are needed, Simon's door is always open. For more information please visit www.simon.ie

Services include:

- Housing provision, tenancy sustainment & settlement services, housing advice & information services helping people to make the move out of homelessness & working with households at risk;
- Specialist health & treatment services addressing some of the issues which may have contributed to homeless occurring or may be a consequence;
- Emergency accommodation & support providing people with a place of welcome, warmth & safety;
- Soup runs & rough sleeper teams who are often the first point of contact for people sleeping rough.

Appendix 1: National Drug Strategy Service User Consultation

This service consultation was undertaken with some of the clients of Cork Simon Community

Supply Pillar:
The supply pillar of the current system and alternative models such as the Swiss Model and Portuguese model were discussed. The residents felt the Swiss Model best represented their feelings toward supply and legal policy, stating "at least I wouldn't have to deal with drug dealers and the cops".

Treatment Pillar:

- Low threshold services: Having lower criteria thresholds for homeless people entering treatment. These would acknowledge the extra difficulty homeless service users experience in trying to meet entry criteria in residential settings, e.g. having to reduce to 40mls methadone is more difficult in a homeless setting than the community. Service users felt that the expectation was for service users to tailor themselves to the treatment centre and would prefer a more person-centred approach of the treatment centre tailoring itself to the individual needs of the client. *"It's not a one size fits all".*
- *Bias: Stop the bias against heroin users. All residential treatment centres should cater to heroin users whether they are on methadone or street heroin. Bering a heroin addict should never be a treatment excluder.*
- Free access to treatment and assessments: Make treatment and assessments for treatment free across the board. The cost of treatment experienced at the time of assessment and throughout the treatment episode can put undue pressure on the person wishing to move into recovery and *"make it easier to be an addict than being in treatment"*. Though service users saw little problem with having to give money up while in treatment, there was consensus that this money could be better used to fund recovery upon completing the treatment episode by having enough money to pay a deposit or pay off drug debts.
- Trauma and anger informed services: Trauma and anger informed services that teach people how to manage in the world once they come off drugs/alcohol. The group spoke about the reasons they engage in substance misuse as a means of coping and so feel very vulnerable and triggered when they detox and/or become abstinent. To this end the group felt that treatment (be it residential or in the community) needs to teach and promote new coping strategies.
- Dual Diagnosis: Ensure as a bare minimum that all treatment centres have the necessary skills to manage dual-diagnosis and ensure that it doesn't become a treatment excluder. Some centres don't accept people on mental health medication (anti-psychotics) which excludes a significant portion of those looking for treatment. Others accept people with mental health medication but do not have the necessary skillset to manage the increase in mental health issues as the substance misuse subsides and the client moves into abstinence.
- Aftercare and step down housing: *"All client's should have a place to go after treatment"* – No recycling back to homeless services. Ensure greater provision of aftercare and step-down housing. Prioritise those coming from treatment for housing.
- Criminal charges: For charges where there was a victim addicts should be offered the option of treatment and recovery or jail. This could possibly be used in the same manner as a suspended sentence. All non-victim crimes should be dropped/excluded if person completes a treatment program – *"An addict shouldn't be punished for being an addict and begging should never be a crime."*
- Consolidation of charges: Put onus on Gardaí and courts to consolidate all charges that they may be dealt with before treatment. Any charges not brought forward at this point should be made void.

- Payment of fines: Ability to pay needs to be factored in to the issuing of fines for drug related offences.
- Referral times: Entry to community addiction counselling should be no longer than 2 weeks from the date of referral. Entry to residential treatment centres should be between 3 – 6 weeks with one to one addiction counselling being offered to get you ready during this period.

Education Pillar:

- Family Awareness: Parent classes should be offered to every parent in Ireland so as to prevent people from developing addictions as a result of poor parenting and to also curb multi-generational patterns in the parenting-addiction dynamic.
- School Programmes: All schools need to offer counselling for students – this service should be managed from outside the school to prevent any conflict of interests. Offer in-reach to schools by people in recovery as part of the syllabus.

Additional focus areas

- Family: Parents should have equal rights to their children – this would prevent some from entering addiction and improve many others chances of staying in recovery.
- Legal Aid: Free legal aid for family court cases for all parties involved.

Appendix 2: Housing and Homelessness Crisis in numbers

- During one week in August 2016 (latest available figures), there were 6,611 men, women and children in emergency accommodation across the country; a 36 % increase from the same week in August 2015. This included 2,705 adults with no dependents in their care and 1,151 families made up of 1,543 adults and 2,363 children. (DECLG, 2016).
- On Census Night, 24th April 2016, there were 171 people without a place to sleep in Dublin City. This included 102 people sleeping rough and 69 people sheltering at the Nite Café. Unfortunately, Dublin is the only area where an official rough sleeper count takes place, making it difficult to get a countrywide rough sleeping picture. (DRHE 2015).
- Figures from Cork Simon Community indicate that rough sleeping in Cork City increased nine-fold in four years (2011-2015) from 38 people sleeping rough in 2011 to 345 people sleeping rough in 2015.
- Homelessness and housing insecurity are more acute and visible in our cities but the Simon Communities are working at capacity countrywide – in urban and rural areas.
- There are at least 90,000 people on the social housing waiting list. (Housing Agency, 2014).
- Social housing commitments will take time to begin to deliver housing. This is far too long for the people we work with and those at risk of homelessness. Social housing output for 2015, reached 1,030 new builds and acquisitions, with new builds accounting for 75 units. (DECLG, 2016). This is below the Social Housing Strategy target of 18,000 new units for the period 2015-2017.
- The average rent nationwide has risen by over one third since bottoming out in 2011 and has surpassed its 2008 peak. The average national rent is now €1,037 (Daft.ie Rental Report Q2 2016).
- *Locked Out of the Market V* (October 2016 Simon Communities) found that 80% of rental properties are beyond the reach for those in receipt of state housing support.
- 41.2% of all accounts in mortgage arrears are in arrears of over two years. (Central Bank of Ireland, 2016).
- At the end of December 2015, 23,344 or 17% of buy-to-let mortgages, were in arrears of more than 90 days. (Central Bank of Ireland, 2016).
- 750,000 people are living in poverty in Ireland (*Poverty, Deprivation and Inequality* (July 2016) Social Justice Ireland Policy Briefing).
- Since 2007 the deprivation rate, which looks at the number of people forced to go without at least 2 of 11 basic necessities examined, in Ireland has doubled - 29% of the population or 1.3 million people are experiencing deprivation (Social Justice Ireland ibid).