Submission to the Public Consultation on the Personal Possession of Illegal Drugs

Simon Communities in Ireland

July 2018

1. Introduction

The Simon Communities in Ireland welcome the opportunity to make a submission to the public Consultation on personal possession of illegal drugs. Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be caused and exacerbated by traumatic life 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 correlates with housing instability with those rough sleeping and in emergency accommodation experiencing the highest levels of risk behaviour.[1] As acknowledged in the National Drug Strategy - *Reducing Harm, Supporting Recovery,* criminal convictions acquired for problematic drug use can represent a serious impediment to moving on from drug misuse and involvement in crime, particularly in the areas of access to employment, housing and travel. This brief submission firstly outlines the prevalence of problematic drug use amongst people experiencing homelessness. This is followed by an examination of the linkages between experiences of homelessness, trauma and problematic drug use. Thereafter, this submission focuses on the decriminalisation of personal drug use, using the Portuguese model as an example of best practice. Following this, a brief exploration of complimentary harm reduction measures is outlined.

2. Homelessness and Problematic Drug Use

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.[2] 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 synthetic benzodiazepines drugs in recent times. A 2011 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.[3] That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. In addition, it also found the highest level of drug use was among people sleeping rough and those using emergency accommodation.

Dual Diagnosis and Complex Needs

A person experiencing homelessness may have multiple or complex needs[4], such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural

[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] Ibid 1.
[3] Simon Communities in Ireland & Kathy Walsh, *'Simon Snapshot Report 2011'*, P.28, http://www.simon.ie/Portals/1/Simon's%20National%20Health%20Snapshot%20Study%20Report%202011.pdf.
[4] 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.

disorder, challenging behaviour and vulnerability. Homeless Link (2002)[5] argue that this means that even If one issue were to be resolved, other issues would still be cause for concern

This can make it very difficult for people to navigate the various services they may need simultaneously. *Homelessness: An Unhealthy State* found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem[6]. Thirty-five percent of participants had a mental health diagnosis and current illicit drug use[7]. People with dual diagnosis can find it very difficult to access services as they often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice argues that the two issues be treated at the same time and in a co-ordinated way.

3. Trauma, Homelessness and Drug Use

It is increasingly recognized that many people who are at risk of or are experiencing long-term homelessness have been exposed to trauma.[8] Trauma is prevalent in the narrative of many people's pathways to homelessness and during their experiences of homelessness. Homelessness itself can be considered a trauma in multiple ways. The loss of a home together with loss of family connections and social roles can be traumatic. This is because "like other traumas, becoming homeless frequently renders people unable to control their daily lives".[9] According to Eisenberger et al, social exclusion activates the same neurological systems as physical trauma, with a similar impact on people.[10] Added to this, homelessness can be such an additional stress in the life of a person that it can erode the person's coping mechanisms and the stress that it causes can rise to a level of trauma.

In 1998, Felitti et al carried out a national study to examine the impact of childhood trauma and adverse childhood experiences (ACEs) on healthy development and later life negative health related outcomes.[11] The study was the first of its kind carried out on a national scale and compiled results from over 9,500 patients across the United States who completed and returned a survey. This study has been replicated a number of times and results consistently indicate that exposure to toxic stress or trauma as a child is significantly correlated with deleterious adult health and social behaviours (Taylor et al., 2008). This ten-item scale poses questions related to an individual's exposure (before the age of 18) to physical, emotional and sexual abuse, and other household dysfunction.

The study revealed that more than half of the respondents had reported at least one ACE therefore determining that exposure to early life trauma was relatively common. However, analysis revealed that respondents with a score of 4 or more were at dramatically increased risk for negative health outcomes, and a dose response between the ACE score and risk for poor health experiences was noted

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

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

[7] Ibid

[8] FEANTSA, '*Recognising the Link between Trauma and Homelessness'*, January 2017, P.1, http://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf.

[9] Goodman et al, '*Homelessness as psychological trauma. Broadening Perspectives'*. American Psychologist, Vol 46(11), November 1991, Pp. 1219-1225.

[10] Eisenberger et al, 2003: Does rejection hurt? An fmri study of social exclusion' in Science Vol 302, p290-292, accessed at www.sciencemag.org and Kross et al, 2011, 'Social rejection shares somatosensory responses with physical pain', in PNAS Vol 8;15, p6270-6275, accessed at www.pnas.org/cgi/doi/10.1073/pnas.1102693108.

[11] Fellitti et al, Relationships of Child Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults – The Adverse Childhood Experiences (ACE) Study, 1998, American Journal of Preventative Medicine, http://www.traumacenter.org/initiatives/Polyvictimization_Articles/Felitti,%201998,%20Relationship%20of%20Childhood%20Abuse%20and%20Household,.pdf.

(Feltti et al, 1998, Murogy et al 2013). Where there is a 4+ score, the likelihood of depression increases by 460% and suicide by 1,220%. More recently, a UCC ACE study among homeless service users in Cork Simon Community revealed that there are significant levels of childhood trauma in the clients who participated in the research and that clients were experiencing a range of negative health related behaviours because of substance misuse, homelessness and associated behaviours. Fifty people participated in the study. One hundred percent had experienced one or more traumatic childhood events with 78% having experienced four or more traumatic childhood events.[12] A similar study conducted in Dublin Simon Community showed related findings with 95% of the sample (N=45) having experienced one or more traumatic events, 46% met the criteria for PTSD (Hallinan, 2015).

The prevalence of drug use amongst people who have experienced traumatic life events is well documented. Sixty-six percent of people seeking treatment for substance use disorders report one or more traumatic life events (Back et al., 2008). Seventy-five percent of clients presenting with addiction have comorbid histories of trauma (Jacobsen et al., 2001). Of clients sampled in substance abuse treatment, 12% - 34% had current posttraumatic stress disorder. For women alone these rates increased to between 33% - 59% (Najavitz, 2002). Of the 50 people who participated in the UCC ACE study at Cork Simon, the average age of first alcohol use was 12 years, the average age of fist cannabis use was 14 years, the average school leaving age was 15 years and the average age of first heroin use was 23 years.[13]

4. Decriminalisation of personal possession and use of drugs

The de-criminalisation of personal possession of drugs provides a unique opportunity to shift policing focus from individual users and intensify efforts on suppliers. Criminalisation of drug possession and use is a problem and has been in tension with health orientated service provision for years. People caught in the cycle of addiction are continually fined for carrying small substance amounts for personal use. Often, these multiple fines go unpaid due to socio-economic disadvantage leading to imprisonment. Imprisonment in this context is ineffective and serves as a further vector to increased engagement with crime. 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.

Stigma and prejudice associated with drug convictions create significant barriers to vital State services such as housing. Local Authority social housing allocations processes are a prime example of such barriers in action. The Simon Communities in Ireland are aware of Local Authorities frequently refusing people housing allocations because of active drug use, mental health related challenging behaviour and a history of tenancy breakdowns due to rent arrears or criminal conviction in the last three years. This practice works to disqualify the very group we should be prioritising for housing if we are to successfully implement the Government's housing-led/Housing First policy. Housing First offers housing without preconditions and offers a range of supports focussed on harm minimisation, trauma informed care 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 alcohol, mental health, and community integration services being available to tenants who

[12] Lambert, S and Gill-Emerson, G (2017) '*Moving Towards Trauma Informed Care. A Model of Research and Practice*' Cork Simon Community, http://www.corksimon.ie/wp-content/uploads/2017/10/Moving-Towards-Trauma-Informed-Care-Report.pdf.
[13] Ibid.

were formerly homeless. There are two key aspects to the Housing First approach - immediate provision of housing without pre-conditions or the requirement of housing 'readiness' and the provision of open-ended, support in housing at the level required, for as long as necessary.

In June 2015, a joint parliamentary committee on Justice, Defence and Equality visited Portugal and discussed the approach to drug addiction adopted there since 2001. The Committee reported that the approach in Portugal has had a very positive result for the communities concerned and is therapy-based rather than punitive. Following this visit, the Committee found that a health-led approach might be more effective and more appropriate for those found in possession of a small amount of illegal drugs for personal use, rather than a criminal sanction. We support the Committee's recommendation of a civil or administrative response to the possession of a small amount of illegal drugs for personal use rather than taking the criminal justice route. Tailored to the Irish context, such an approach could deliver greater outcomes for people caught in the cycle of addiction. These outcomes are explored below with regard to the decriminalisation of drug possession in Portugal.

Impact of decriminalisation of drug possession in Portugal

Decriminalisation of drug possession in Portugal has had a number of beneficial outcomes across a range of health and crime related indicators. Drug use has declined among those aged 15-24, the population most at risk of initiating drug use.[14] Rates of past-month and past-year drug use amongst the general population have decreased.[15] The number of newly diagnosed HIV cases among people who inject drugs in Portugal declined dramatically from 1,016 to 56 between 2001 and 2011, the decade immediately following decriminalisation.[16] During the same period, the number of new cases of AIDs among people who inject drugs decreased from 568 to 38.[17] Deaths directly attributable to drug use declined significantly from approximately 80 in 2001 to 16 in 2012.[18]

From a crime perspective, the decriminalisation and re-categorisation of low-level drug possession as an administrative rather than a criminal offence has had abroad impact on the criminal justice system. Predictably, the number of people arrested for drug possession reduced significantly from over 14,000 to 5,500 – 6000 per year once the policy came into effect.[19] The prison population with drug related convictions dropped from 44% of the total population in 1999 to under 21% in 2012.[20] Recorded increases in opportunistic thefts and robberies following decriminalisation have been attributed to increased police resources being redirected to other low-level crimes.[21]

5. Harm Reduction

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

[14] Murkin, G., *'Drug Decriminalisation in Portugal: setting the record straight'*, June 2014, P. 2, http://www.unodc.org/documents/ungass2016//Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Ibid.

prevention of drug use itself, and the focus on people who continue to use drugs'.[22] Harm reduction must be at the heart of homeless and drug service provision and is key to the success of Housing First approaches. Decriminalisation is a crucial harm reduction measure that must be pursued in tandem with the continued development of a suite of harm reduction measures as outlined below.

According to Riley & O'Hare (2000)[23] 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 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.

Expansion of needle exchange programmes

The expansion and availability of needle exchange programmes across static, outreach and pharmacy exchange models must be pursued. 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 2015 HSE Review of Needle Exchange Provision in Ireland documents the contribution of these needle exchange models to the overall reduction in the number of newly diagnosed cases of HIV and Hepatitis C.[24] The State must further resource and expand existing needle exchange services to ensure service providers are in a position to make effective referrals to other services and to ensure that BBV testing is available. The health impact of needle exchange programmes must be accurately captured by service providers through the development and use of a standardised disaggregated data collection system including outcome measures across all exchange models and service providers. The State must provide funding to those service providers to facilitate this data collection including the training and upskilling of staff in this regard.

The State must prioritise people who are homeless for screening and treatment for BBV and communicable diseases such as HIV and Hepatitis.[25] Ten percent of respondents in the 2011 Simon Communities Health Snapshot study had a Hepatitis C diagnosis. According to the Hepatitis C Strategy 2009-2014, the best time to offer screening for Hepatitis C and other BBV is when people come into contact with other services including needle exchange programmes. Given the resources and training required to carry out these additional services, this is not currently a viable option for all needle exchange providers.

[22] Harm Reduction International, '*What is Harm reduction – A Position Statement from Harm Reduction International',* https://www.hri.global/what-is-harm-reduction.
[23] 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.
[24] HSE, '*Review of Needle Exchange Provision in Ireland'. 2015, P. 27,* *http://www.drugs.ie/resourcesfiles/ResearchDocs/Ireland/2015/ReviewOfNeedleExchangeProvisionInIreland.pdf*.
[25] 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

Naloxone

In 2015, the HSE launched the Naloxone Demonstration Project involving 600 opioid users receiving take home naloxone on prescription.[26] In August 2016, the HSE published a full evaluation of the project.[27] The HSE must now implement the report recommendations 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

We welcome the establishment of a pilot medically supervised injecting centre at Merchants Quay Ireland for a duration of 18 months. 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 involving 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.

Heroin Prescription

In examining the decriminalisation of personal possession of drugs, we encourage the Department to broaden its scope to include the legalisation of the administration of certain opiates on a prescription basis. Consideration should be given to the Swiss Model of administering heroin for users known as Heroin Assisted Treatment (HAT). Under this model, users qualify for a heroin prescription where they meet six conditions as follows:

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

The decriminalisation of the possession of small quantities of drugs will lead to savings in policing costs and in legal and court costs, which could in turn be used to fund programmes as outlined above.

Evaluations of this model have found:

- Health outcomes for HAT participants improved significantly and use stabilised; heroin dosages stabilised in around three months and illicit heroin use reduced significantly. [28]

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

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

[28] Transform (2016) Heroin-assisted treatment in Switzerland: successfully regulating the supply and use of a high-risk injectable drug https://www.tdpf.org.uk/resources/publications/heroin-assisted-treatment-switzerland-successfully-regulating-supply-and-us-0.

- Reduction in criminal offending: There was a 60% reduction in patients committing felony crimes (with an 80% reduction after one year in the program).
- Reduction in drug dealing: 82% drop in patients selling heroin.
- Reduced death rates: No one has died from a heroin overdose since the inception of the program (in the treatment room). Technicians inspect the heroin used for purity and strength.
- Reduced disease rates: Patients in the program have a reduction in new infections of Hepatitis and HIV.
- Reduced new use rates: Slightly lower than expected. Initiation of new heroin use fell (the medicalisation of heroin making it less attractive), and, in turn, there were reductions in street dealing and recruitment by 'userdealers'[29]
- Studies from the Netherlands, Germany, Spain and the UK confirm the positive results from Switzerland. [30]
- In Switzerland, the programme saves money when costs for criminal proceedings are factored in. (HAT Annual Report 2007).

Conclusion

The National Drug Strategy '*Reducing Harm, Supporting Recovery'* marks a welcome shift towards a health-led response to drug and alcohol use in Ireland. This response will be crucial to delivering the necessary clinical and social supports to people experiencing homelessness who may have multiple complex needs due to problematic drug use and experiences of trauma. For this new approach to be effective, it must also include components that address the barriers to effective treatment for problematic drug use. For people experiencing homelessness the primary barrier is the lack of a secure affordable home, a basic requirement made increasingly unattainable due to criminal convictions for the possession of small quantities of drugs for personal use. Internationally, the decriminalisation of the personal possession of drugs has reduced drug use amongst the general population and has significantly reduced the detrimental health outcomes and harms associated with drug use. Pursued in tandem with the expansion of existing harm reduction strategies, the decriminalisation of the personal possession of illegal drugs can have a lasting and positive impact on problematic drug use in Ireland and in doing so deliver improved health outcomes for people experiencing homelessness.

[29] Ibid.

[30] Koeppel D., *'The Four Pillar Drug Policy in Switzerland – 20 years after'*, http://www.globaldrugpolicy.org/Issues/Vol%205%20Issue%204/Switzerland%20the%204%20pillar%20drug%20policy%20in%20Switzerland%20Koeppel-SR%20edit.pdf.

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 45 years. The Simon Communities deliver support and service to over 11,000 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.

For further information, please contact:

Niamh Randall

Head of Policy and Communications

E: niamh@simoncommunity.com

Ph: 00353 85 8588 384