Methadone Maintenance Treatment in an Irish Context

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The previous speaker has given a reasoned a balanced argument in favour of the use of methadone as an effective intervention in the treatment of opiate dependence syndrome. One interesting point to emerge and one that highlights the emotive nature of methadone treatment, is his justification of methadone maintenance on utilitarian moral grounds. That a medicinal product, with proven scientific merit, should require justification on such grounds goes some way towards explaining the controversy surrounding methadone. Today rather than justify my use of methadone maintenance as a treatment intervention, I will simply talk about its use in the Irish context.

The fact that I am speaking about the Irish context implies something rather different to other contexts. What is remarkable about the methadone maintenance treatment provision in Ireland that caused two external evaluators to describe the service as 'unique in Europe'? In my attempt to answer this question I will examine the use of methadone in Ireland over the last three decades.

Some people may be surprised that I will be talking about more than 30 years but it must be acknowledged that treatment services did exist in Ireland before the harm reduction approach of the late 1980's and early 1990's.

The Drug Treatment and Advisory Service was established in Jervis Street hospital in 1969 following the report by the Working Party on drug abuse to the Minister of Health. Two years later, in 1971, methadone was introduced as a standardised therapeutic approach for the treatment of those dependent on opiates and synthetic opiates. During the 1970's the option of maintenance was available to a small number of clients attending the service in Jervis Street. Between 1973 and 1977 the average number of patients attending the clinic per month was 100-125(many were alcohol dependent), however in 1977 only 6 individuals per month were presenting abusing heroin. One survey carried out in 1978 looked at the characteristics of 10 patients, 5 male and 5 female, on methadone maintenance. The average age of first drug use was 14.5 years, average age at first presentation was 21 years and 4/5ths of the sample were polydrug abusers, findings remarkably similar to cohorts today. The survey also notes that the aim of the treatment was to maintain the individual on as low and exclusively oral dose as possible, between 25-50mgs per day. Some information on individuals presenting for the treatment of opiate use in the 1970's is available but this needs to be interpreted with caution as many of the individuals were abusing synthetic opiates and heroin use was not the problem it was to become.

However in the early 1980's Dublin experienced what is now described as 'the opiate epidemic'. During this time period, the number of heroin users presenting to Jervis Street increased dramatically. Between 1.7.81 and 30.6.82, a total of 426 individuals with drug related problems presented to Jervis Street. Of these, 292(68.5%) were abusing heroin and 272 were using intravenously. Also, at this time, the Virus Reference Laboratory noted a marked increase in the numbers of cases of hepatitis B. From 10 per year between 1975-1979, the figure rose to 158 in the first 8 months of 1981. One case report in the Irish Medical Journal of 1982 identifies chronic active hepatitis due to hepatitis B in a 12 year old boy who began injecting heroin at age 11.

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The Drug Treatment Centre was thus faced with a serious outbreak of injecting heroin use in young people and responded by providing methadone detoxification to those who presenting and adopting an abstinence orientated approach. To a certain extent this initially appeared successful and two scientific papers seemed to indicate that the problem might have been abating 'The Opiate Epidemic in Dublin: are we over the worst?'(1987) and 'The rise and fall of heroin use in an inner city area of Dublin'(1988). Figures from the Drug Treatment Centre showed a decrease in 1984 both in the number of new patients and in the numbers presenting with a history of heroin use.

Unfortunately this optimism was short lived. Routine voluntary testing of drug users for HIV began in 1985 and over the first 2 years, 19% of those tested were diagnosed as being HIV positive. Prior to this the Drug Centre had been providing methadone maintenance to pregnant opiate addicts and showed improvement in 40% of cases. With the advent of HIV, they extended the methadone programme on a pilot basis to certain individuals who were HIV positive. Initially 50% of individuals dropped out, however those who remained showed reductions in intravenous use. The doses used in these cases were generally in the low to moderate ranges, with few patients being prescribed greater than 60 mgs.

At this stage the problem in relation to HIV became very much a Public Health issue and affected both the gay and heterosexual communities. On a world wide basis there was evidence emerging that methadone maintenance was have a beneficial effect in decreasing rates of HIV. Therefore in the early 1990's the Health Board, driven largely by the Public Health department, began to invest manpower and resources in the development of a community based methadone maintenance programme. This programme aimed not only to provide services locally within a community but also involve primary care in the provision of methadone treatment.

The term 'Community Based' had been used before in relation to the development of the Mental Health Service. However if this is examined more closely, it could be said that the Mental Health Service simply moved from an institutional setting to a physical location in a community. Yes, ease of access improved and yes, community psychiatric nurses were employed to interface with the community but there was no sitting down around a table with local community groups discussing issues in relation to development of the service.

While the statutory services were developing sophistication in relation to the treatment of opiate addiction, there was also a shift in perspective among local communities. During the 1980's there had been an emphasis on short-term detoxification and getting rid of the problem. When this was manifestly not happening, a sense of frustration emerged and in areas of already deteriorating social conditions, an intolerance towards drug users grew, This led to some community protests and some public acts of anti drug vigilantism. However this began to change in the early 1990's and the areas of community development and urban regeneration began to gain importance. Within this framework there was a recognition that services for individuals with heroin problems should be provided for primarily within their own communities and that such facilities should reflect the community in terms of their structure and operation.

Important changes were also occurring in relation to methadone. Certain GP's within the city had begun to prescribe to opiate users. For the most part these doctors aimed to provide a service, which they recognized, was needed at local level. However the absence of formalised structures for delivering a methadone programme led to considerable difficulties. Double scripting was common and there was considerable leakage of methadone onto the black market. Some local communities began to recognize methadone as a significant problem and began to question the appropriateness of having such a treatment locally.

The timing was right for the statutory services and the local communities to begin to work together to deal with the problem of heroin addiction. The health services introduced the methadone protocol to control the prescribing and dispensing of methadone. The communities

began to lobby successfully for local resources and services. The local Task Forces were established to provide a forum for community, voluntary and statutory services to work together in providing a comprehensive response to opiate addiction

The health boards also followed the example of some local communities who were working with GP's to provide local treatment to local people. This resulted in the health boards developing not only treatment centres to provide methadone on site but also smaller satellite clinics. At satellite clinics the health board staff including sessional GP's and counselling work with the local community to provide a comprehensive service to the opiate user at a local level. Methadone is dispensed at a local community pharmacy and the ultimate aim of the service is to stabilize the chaotic lifestyle of the individual and return them to a functioning role within the family and the community.

Today, almost 6500 individuals in Ireland, the vast majority in the Dublin area, are on methadone treatment. Over 55 clinics exist in the Eastern region. Almost $^1/_3$ of patients are placed with community GP's. The statutory services must recognize than the expansion would not have occurred without the support and commitment of the local communities. Similarly the communities must recognize that the expansion could not have occurred without the professionalism and expertise of the health boards. This support and respect for each other will allow the health board and community to work together in delivering a unique service to the opiate user on methadone programmes.