

Lives on Hold

Fifth Monitoring Report by Service Users Rights in Action (SURIA)
2024

Preface

Lives on Hold Monitoring Report is an in-depth analysis by Service Users Rights in Action (SURIA) of Peer Led Research into the current Methadone Maintenance Treatment (MMT) practice 2024. This is part of longer-term monitoring by SURIA of the progressive realisation of the right to adequate health of service users. The research explores the current life narrative of the MMT client and is the latest of five sets of data collected since 2012. It is based on a collaborative project, facilitated by Community Action Network (CAN) between the following projects

The Canals Local Drugs and Alcohol Task Force, covering Rialto and Inchicore in Dublin
The North East Regional Drugs and Alcohol Task Force, covering Meath, Cavan, Louth and Monaghan
The South West Regional Drugs and alcohol Task Force covering Kildare
Uisce, A National Advocacy Service for People who use Drugs in Ireland.

Introduction:

SURIA's research is routinely underpinned by service user narratives and experiences of engaging with OST (primarily methadone), using a human rights perspective that traces the progressive realisation of rights instruments pertaining to the highest attainable level of health care (Article 12 of The Economic, Social and Cultural Rights among a number of other rights instruments). Our rationale for this approach stems from the fact that OST/MMT is a public health service and therefore clients should enjoy the same rights and treatment as others who are accessing modalities of treatment for other illnesses. However, our research continuously demonstrates that this is not the case and those using methadone often allude to institutional stigma, poor treatment practices and not being afforded any input in their own service provision, (Healy et al. 2022). This research is SURIA's fifth research output, as we continuously attempt to highlight the plight of those engaging with methadone and other OST services in Ireland. We have repeatedly highlighted that these services are sub-standard, stigmatising and often harmful for those seeking refuge from problematic opiate use, (SURIA 2018, 2020).

Our research suggests that Irish OST (Opioid Substitution Treatment) and MMT (Methadone maintenance Treatment), as harm reduction modalities, often paradoxically produce harm in the lives of clients. Our work continuously highlights the lack of progress in client's lives, poor re-integration, the over-extension of power into the lives of clients (including in matters that have little to do with drug use) and the poor quality of life for those who expected to be helped by methadone services, (SURIA 2020, 2018).

SURIA's work is underpinned by four principals that have emerged continuously in our research. They include supervised urinalysis, the lack of care plans, choice of treatment and meaningful review, and the absence of an independent and robust avenue for complaint for clients who feel they are not being provided the highest attainable level of healthcare, as per the Economic, Social and Cultural Rights Agreement (1976) of which Ireland is a signatory. However, it must be noted that the State has not ratified the Optional Protocol, which arguably reduces the potential of this rights mechanism to propagate meaningful change.

The importance of this research lies in the timing of its publication, as Ireland enters a post lockdown landscape. COVID 19 enforced a plethora of changes to MMT practice in Ireland. Clinics and GPs were forced to allow clients to avail of more takeaways (doses that are taken home). Prior to COVID, the administration of takeaways was considered a privilege that was earned by providing urine samples that 'marked' the client as drug free. However, the provision of extra takeaways did not perpetuate chaotic drug use, as many key stakeholders predicted. Instead, even the EMCDDA alluded to the fact that for the vast majority of service users, extra takeaways did not lead to more opiate use. Instead, Alexis Goosdeel, the Director of the EMCDDA is on record as suggesting that COVID illustrated that service users could be granted more takeaways, more trust and that the paternalistic disposition that dominates much of MMT was in fact a misnomer. The International Network of People who Use Drugs (INPUD) echoed this sentiment, positing that COVID represented a chance to implement a "new normal" in how methadone (and other OST models) are prescribed and managed (Chang et al. 2020).

Ireland is currently in the process of a Citizen's Assembly on Drug Use, as the State, with the help of key actors and stakeholders commence an in-depth examination of Irish drug policy. Therefore, one would assume that change is imminent, that years of advocacy and nuanced debate is potentially beginning to bear fruit. Unfortunately, this research suggest that not much has changed in how OST and MMT is practiced in Ireland. The same four principals are still embedded in how service users are

treated, the same four principals suggest that the human rights of this vulnerable populace are still being overlooked at best, blatantly ignored at worst. Service users are still experiencing the same levels of opprobrium as SURIA have been highlighting since our inaugural research in 2012.

The empirical evidence that informs this research is drawn from 229 service users, from three different areas in Ireland. As such, we believe that we have employed an effective, credible and cogent methodology, from which the Irish service user narrative can be captured and explored. This analysis of the data will be demarcated by the four principals that have emerged from all our research projects, 2012, 2017, 2018/19, 2020. The common themes that are repeated across all of these projects potentially suggest that little progress has been made in the provision of OST and MMT in Ireland. Lack of treatment choice, supervised urinalysis, no treatment plan and the lack of a robust and independent complaint mechanisms are shortcomings that our research has continuously identified. Within this barrage of failure, there are some signs of progress. However, the question of whether this enough is debatable. While progress is welcome, the perennial stigma and poor treatment that drug service users routinely endure is quite simply unacceptable.

SURIA is a service user-led group that campaigns for rights-based MMT/OST. One of our principal objectives is to recognise service users as consumers as opposed to passive recipients of a public health service. As such, we advocate for a symmetrical partnership dynamic to inform doctor/client interaction. We are committed to reform within the MMT/OST sector that will enable service users to be seen as partners in their own recovery plan, as opposed to engaging with services that are frequently characterised by a highly imbalanced power dynamic in favour of the service provider, (Bennett 2011, Harris & McElrath 2012). Within this system, any form of recovery is unlikely, the quality of life remains poor and services become buttressed by “us and them” relationships.

This analysis will commence by comparing some of the findings of our last project, *Nothing About Us Without Us* (2020). In this way, our continued tracing of the progressive realisation of the right to health provides the backdrop to this analysis. The nuances and challenges that are routinely endured by Irish service users will be captured, highlighting that the potential of methadone and other substitute treatment models are inhibited by poor practices, a lack of training and a refusal to follow international best practice and literature. As part of this cycle of continuous analyses, this report will also discuss some of the new findings that have emanated from this round of research.

Urinalysis

SURIA are not the first to draw attention to the shortcomings of Irish MMT/OST. Apart from a number of research articles that illustrate the poor practices, inept training and other failings of MMT (Bennett 2011, Harris & McElrath 2012, Healy et al. 2023), the HSE commissioned the publication of the Farrell Report in 2010 (Farrell & Barry 2010), an evaluation of methadone services in Ireland. The report was a damning indictment of Irish services and suggested that MMT was “entrenched in urinalysis”. While SURIA accept that urinalysis can potentially be justified in certain circumstances (for example, upon commencing MMT to ensure the individual is using heroin), and despite the practice representing the infantilization and surveillance that is common within services, it is the over reliance on testing that advances our critique. Urinalysis is used to routinely test service users and to restrict heroin use. However, our prior work demonstrates that urinalysis is not just an important facet of contemporary MMT/OST, rather the entire service is predicated upon the result of a test.

In reality, a urine test has limited value to service providers, and across the existing body of literature, there is a distinct lack of tangible evidence that this invasive intervention technique

restricts heroin use, (Ward, Mattick & Hall, 1998). However, it is arguably the principal practice that informs the overtly rigid structure of Irish MMT, which aims to police the conduct of service users with punitive measures that are determined by sampling. This form of oversight precludes the meaningful, therapeutic dynamic that is necessary to perpetuate a powerful change in lifestyle. As opposed to encouragement and support, clients often feel they are being interrogated, scrutinised and demeaned, as the therapeutic relationship fails to transpire. Valentine (2007:497) suggests a dehumanising process or “radical change” in patients who engage with MMT services. However, this research suggests that methadone, as a medication is not the agent of dehumanisation. Rather, the practices and strategies employed by services are considered the primary factor in inhibiting the agency and liberty of the client. SURIA argue that urinalysis is central to this process.

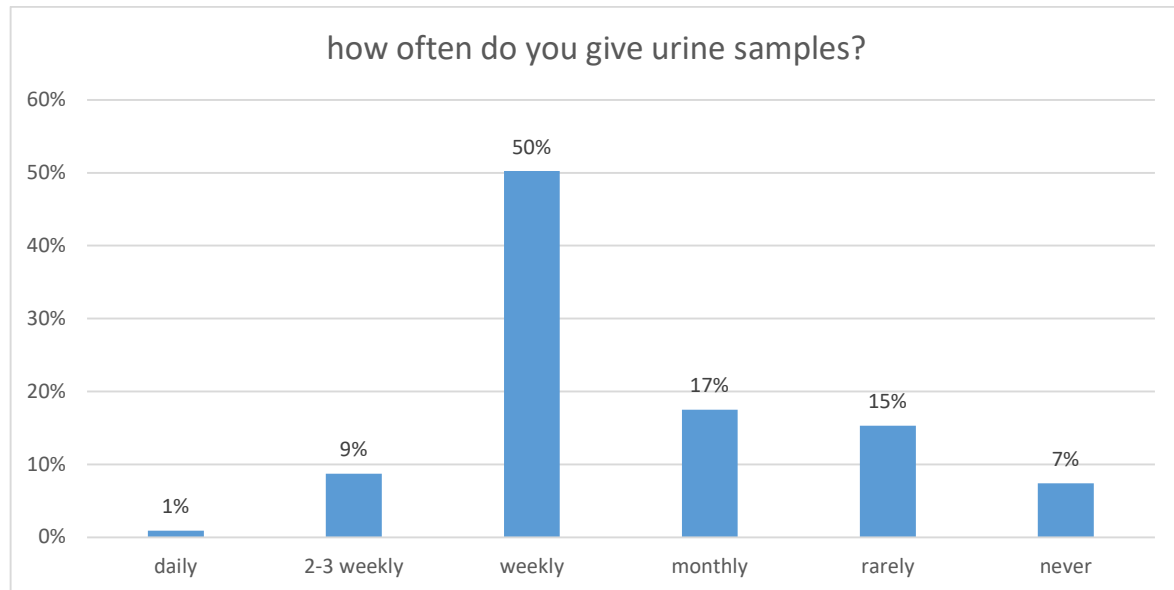


Figure 1. How often do you provide urine samples as part of your treatment

This research explored the frequency of urinalysis across participating service users. The data indicates that urinalysis is becoming less prevalent, with those providing daily samples reducing from 2.6% in 2020 to 1%, while those providing weekly samples increasing from 45.3% to 50%. While these statistics are welcome, SURIA retain our concerns regarding the overuse of urinalysis. Our research and findings suggest that re-integration, quality of life and agency are still not paramount to service providers. Indeed, testing, sanction and continuous observation are still arguably the primary objectives of MMT/OST services. In this way, clients often comment on feeling controlled and dominated by a model that is underpinned by demands of abstinence from *all* drugs. SURIA recommend that the practice of urinalysis is stopped completely, that it has little value in a harm reduction model and frequently advances a lifestyle that restricts employment and education, both key facets of re-integration, (Mayock et al. 2018). Providing a sample, particularly in a clinical setting can be a time consuming endeavour. With other obligations that are deemed necessary for those engaging with MMT/OST, the prospect of accessing work or employment is severely hampered. As such, the trajectory to becoming a “responsible citizen” is made virtually impossible, keeping clients in “high-risk, specialist clinical settings”, (Moran et al. 2018:1).

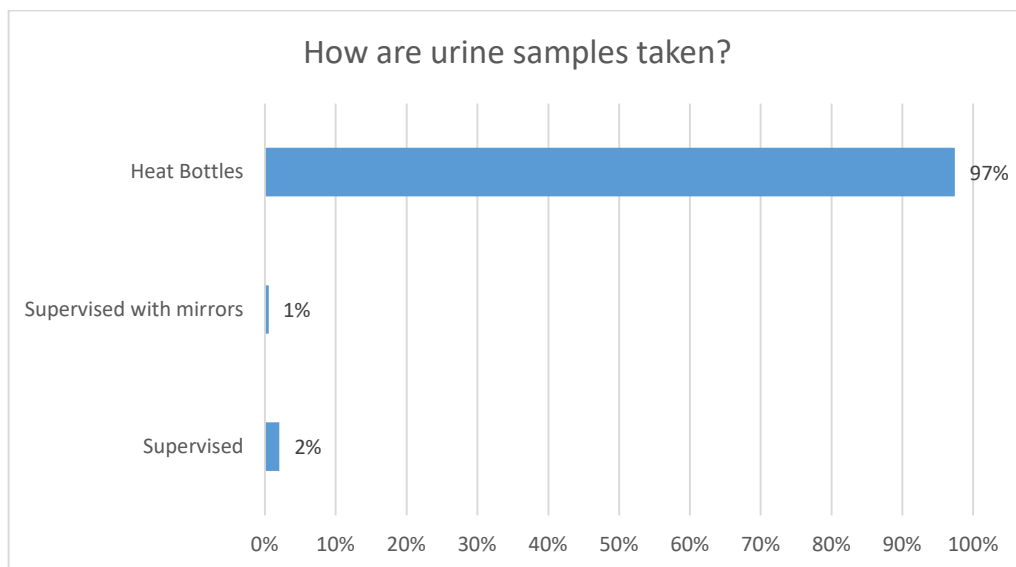


Figure 2 In what way are urine sample taken

Respondents were asked about how service providers conduct urine samples. The data demonstrates a much welcome decrease in supervised urinalysis, with just 1% posited the use of mirrors for supervision and 2% elucidating that urine sampling was directly supervised. Although the remainder reported the use of heat bottles, we believe that even 3% of service users being obligated to provide urines under supervision is 3% too much. This unnecessary practice must be eliminated entirely from MMT/OST services. Supervised urinalysis is dehumanising, can be humiliating and reinforces the rationale that drug users are underservant of human rights and standard public healthcare, (Gilmore 1995, Grover 2010, Stevens 2011).

Care Plans and Quality of Life

Care plans are a crucial element of rights based service provision. Much like the pre-discussed narrative of service users and urinalysis, SURIA's critique of the absence of ancillary services to substitute medication is not new, nor are we the first to challenge the penal culture that is inherent in OST/MMT treatment provision. In 2012, an external audit of the role of GPs in MMT was published by *The Irish College of General Practitioners* (ICGP), (Priyadarshi, Madden & Rimmer 2012). Priyadarshi, a reputable, international expert in MMT protocol and practice, was scathing in his criticism of the practices employed by GPs participating in Irish MMT provision. His recommendations included an immediate implementation of the findings of *The Farrell Report*. Furthermore, this international review advocated for service user participation, client centred treatment, privacy, care plans, choice of treatment and a review of testing modalities, (Ibid.). It must be noted here that both Priyadarshi's and Farrell's work are dated, however this is testament to the lack of progress and the perpetual resistance to align Irish harm reduction with international evidence, research, best practice and guidelines. Moreover, our own body of literature also demonstrates that service users have continuously alluded to the lack of care plans, (CAN and SURIA 2018).

Care plans advance purpose to MMT/OST, as opposed to the continued policing of the conduct of services users. They further represent an opportunity for service users to be partners in their own treatment, to retain a semblance of agency and autonomy in how they engage with MMT/OST, while prompting re-integration and increasing the quality of life of service users. Contemporary MMT must

be re-imagined for these reasons, many of which are characteristic of consumer participation in other public health services. Consumer participation is supported by the Declaration of Alma Ata and is endorsed by the WHO and UNICEF, with the objective or aspiration of promoting equity and social justice in health care (Goodhewetal et al. 2018). It also postulates that people have “the right and duty to participate individually and collectively in the planning and implementation of their health care” (WHO, 1978, p. 1).

The data collected for this research again suggests that the catastrophic failure of Irish MMT/OST that we have continually emphasized in our prior research is in the midst of some improvement in some areas. In 2020, just 3.3% of participants knew what a care plan was, (SURIA, 2020). This research illustrates that the percentage who know what a care plan is has increased to 56%.

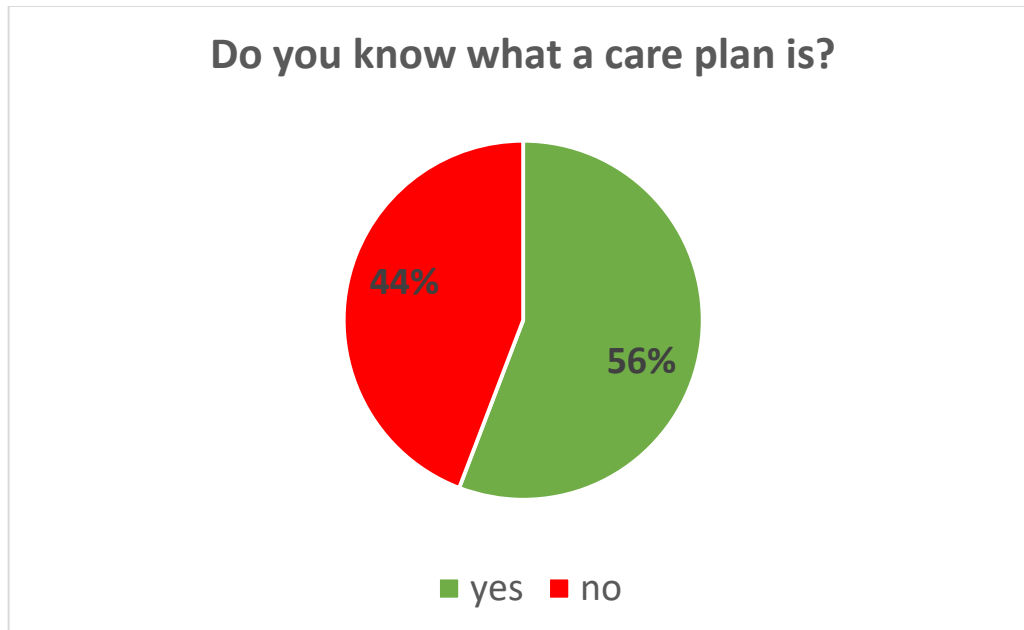


Figure 3 percentage of participants who "know what a care plan is"

The progress in the provision of care plans by service providers is again made manifest in the percentage of participants who allude to actually *having* a care plan. 58% of participants stated that they their treatment was now informed by a coherent care plan. However, again, while this data is welcome, there is still a significant cohort of service users who (a) have no idea what a care plan is (44%), and (b) do not have a care plan (42%). SURIA recommend that care plans replace urinalysis as the principal element of MMT/OST practice.

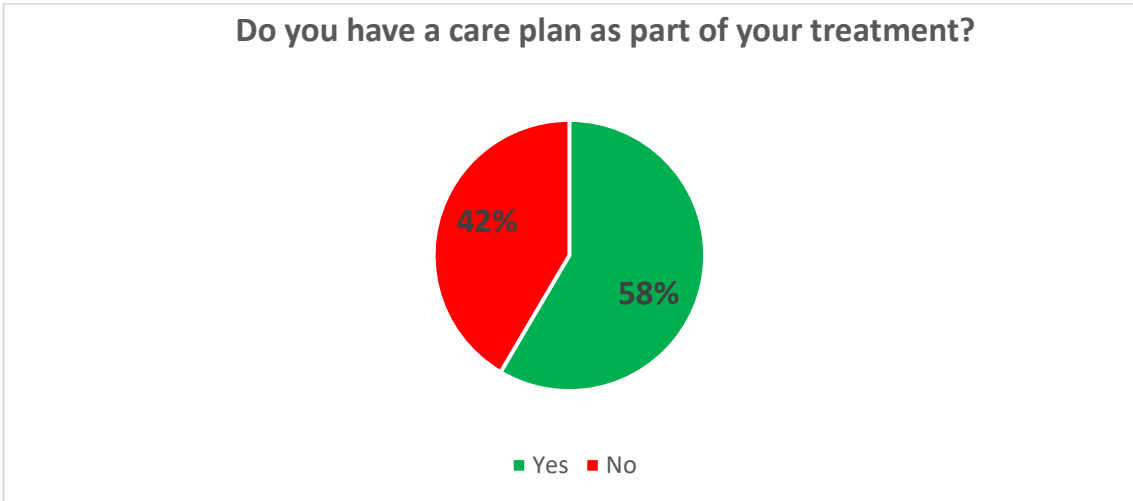


Figure 4 Do you have a care plan as part of your treatment?

The absence of care plans is argued to be a primary factor in service users remaining on methadone for decades which leads to an aging population of MMT/OST clients, (Carew and Comisky, 2018). While SURIA recognise that service users should be entitled to engage with MMT/OST services for as long as they desire, it is of little surprise that clients are accessing treatment for long periods when there is a lack of direction, meaningful partnership and agency or therapeutic alliance between service providers and users. Instead, treatment can become stagnant, with little tangible progression in the lives of clients combined with a poor quality of life.

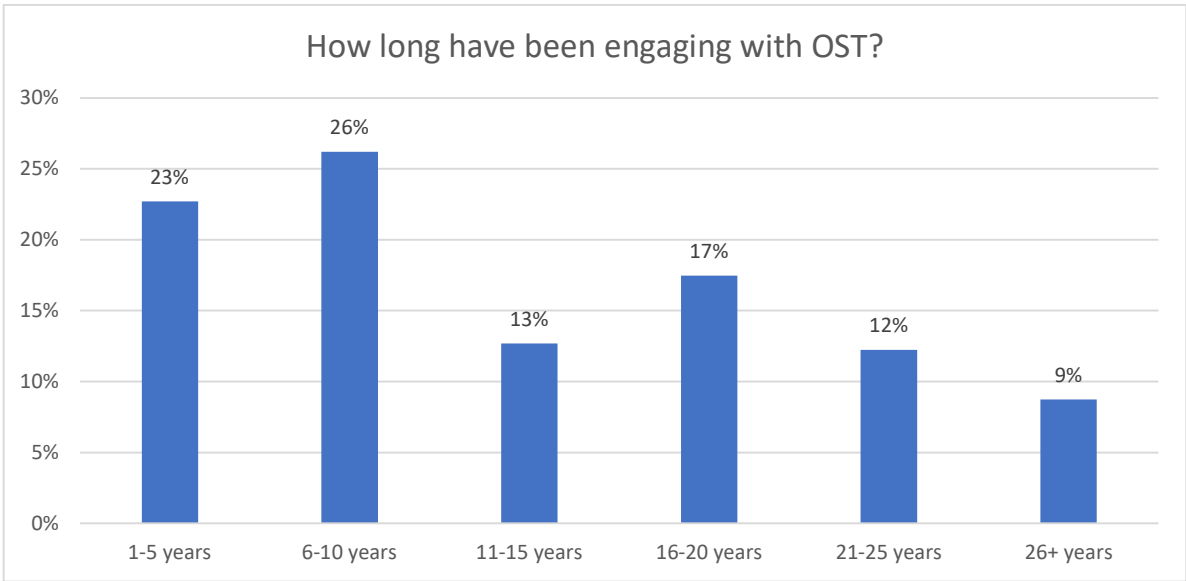


Figure 5 How long have you been engaging with OST/MMT?

Regarding this question, the largest cohort of participants, 26%, postulated that they had been engaging with services for 6-10 years. However, a significant 38% of respondents reported that they had been engaging with services for over 16 years and almost one in ten (9%) for over 26 years. When one considers that many MMT/OST clients live a life of perpetual queuing in clinics, pharmacies, providing urines and presenting at clinics to collect and take their medication under

supervision, in short living a life of consistent surveillance and control, the length of time that is routinely spent living this life is of particular concern.

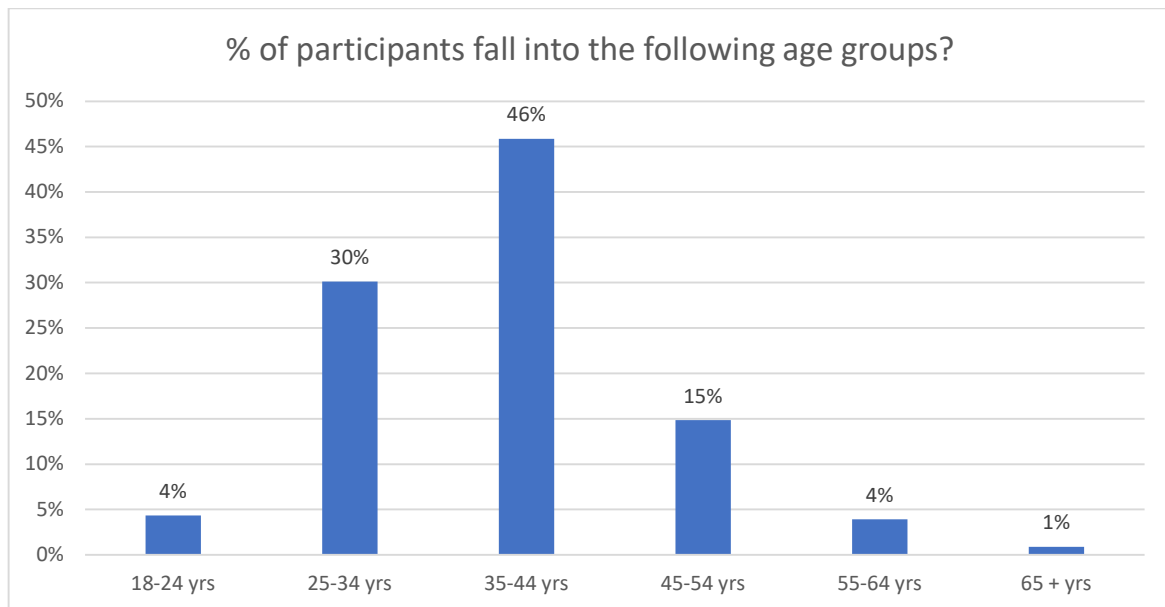


Figure 6 % of participants fall into the following age groups?

It is not surprising therefore, that the majority of participants are between the ages of 35-44 years old, with 66% being older than 35 and one in five being aged over 45. While our prior research discussed this in detail, an issue that was also explored in Irish academic literature (Carew and Comiskey, 2018), SURIA suggest that the absence of care plans for many service users is inherently linked to this. Also, while it is noted that this data represents an improvement when compared with our last round of research, we continue to call for full partnership and the realisation of the highest attainable level of healthcare for MMT/OST clients. Irish service users should be considered consumers of public health, in line with other public health service, as opposed to the current practices that situate service users as passive recipients of a treatment model that is not evidence based and fails to propagate meaningful change in the quality of life for many.

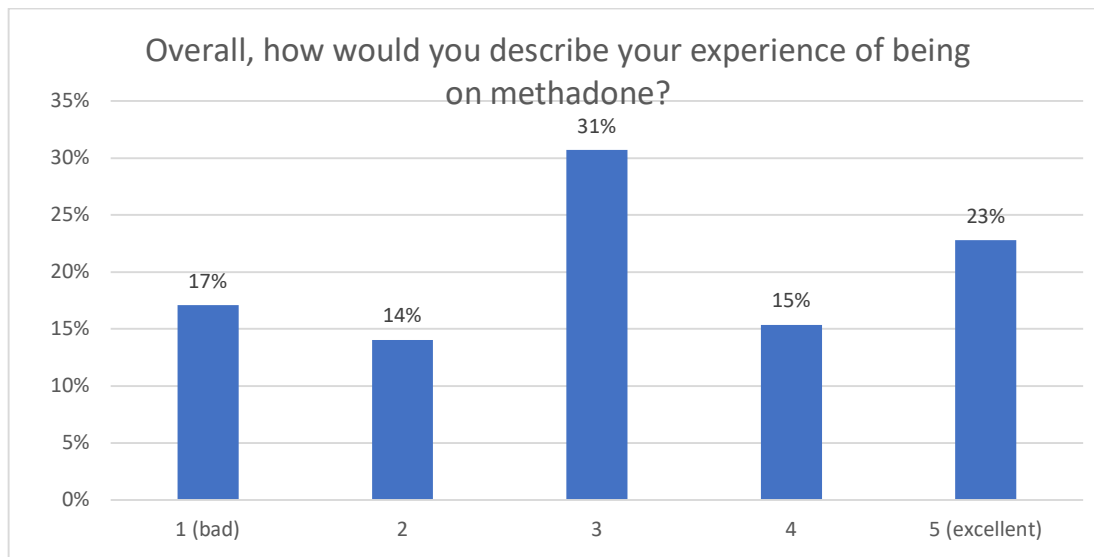


Figure 7 Overall, how would you describe your experience of being on methadone?

When participants were asked to rate their experiences of MMT/OST treatment, the responses were mixed. On a scale of 1 to 5 (1 being bad and 5 being excellent), 31% reported their experience of using services as 3 out of 5.

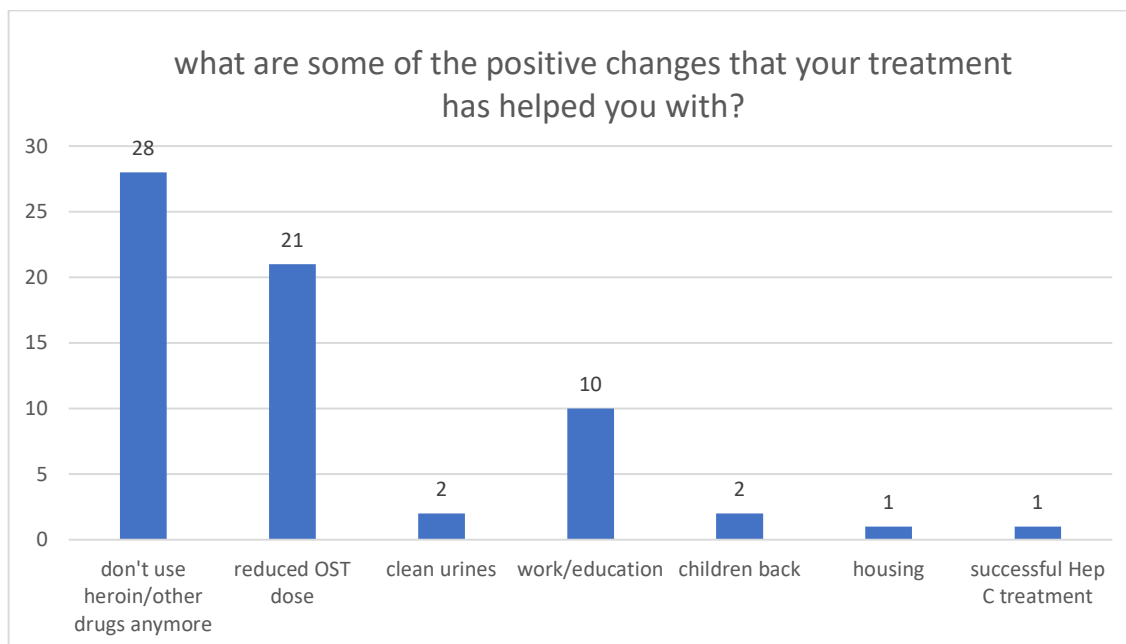


Figure 8 what are some of the positive changes that your treatment has helped you with?

While this data again represents minor progression, many of the reason given for rating their treatment highly epitomised the low expectations of many MMT/OST clients. Some of the reasons given that represented a positive experience for service users included: staying out of prison, avoiding withdrawal, “clean” urines with a reduction of drug use being reported as the most prevalent ground for a positive experience. While the reduction of drug use is an obvious objective of treatment, many of the others highlighted the normalisation of low expectation. Just 10 participants cited work and education, 2 “getting their children back” and one reported housing. SURIA believe

re-integration and quality of life embody purposeful treatment and outcomes. However, due to institutional stigma and the normalisation of poor treatment, poor outcomes are now routinely accepted by service users from OST/MMT. This is further made manifest when one unpacks the qualitative data that was part of the surveys. Many of the quotes powerfully capture the life of many MMT clients. Participants were asked “in what ways have you been treated differently due to being an MMT/OST client?”. Some of the responses included:

- *I hate the way people look at me differently walking into the clinic.*
- *I am treated differently all the time, especially by nurses who are handing it (medication) out.*
- *I am treated like a scumbag junkie.*
- *they tell me I can't get (additional) medication until I am clean.*
- *staff think they can treat you what ever way they want.*
- *I do feel less than (others) and feel I am not listened to and didn't see doctor for 3 and half years.*
- *I am treated differently especially in hospitals.*
- *I feel like an alien.*

Choice of Treatment and Meaningful Review

One could argue that if MMT/OST clients are unhappy with the provision of services they should change to another clinic, doctor or treatment mode. However, our research continues to indicate that for many MMT/OST service users, choice of treatment is not an option they enjoy. Moran (2018) and her colleagues posit that the majority of MMT clients remain trapped in high-risk clinical settings, becoming long-term patients of public health services. 13% of service users articulated that they would prefer to engage with a different treatment model to the one they are currently participating with. This report indicates that 69% of participants have been offered other treatments, a statistic is arguably informed by the welcome increased availability of counselling, support and Hepatitis C treatment.

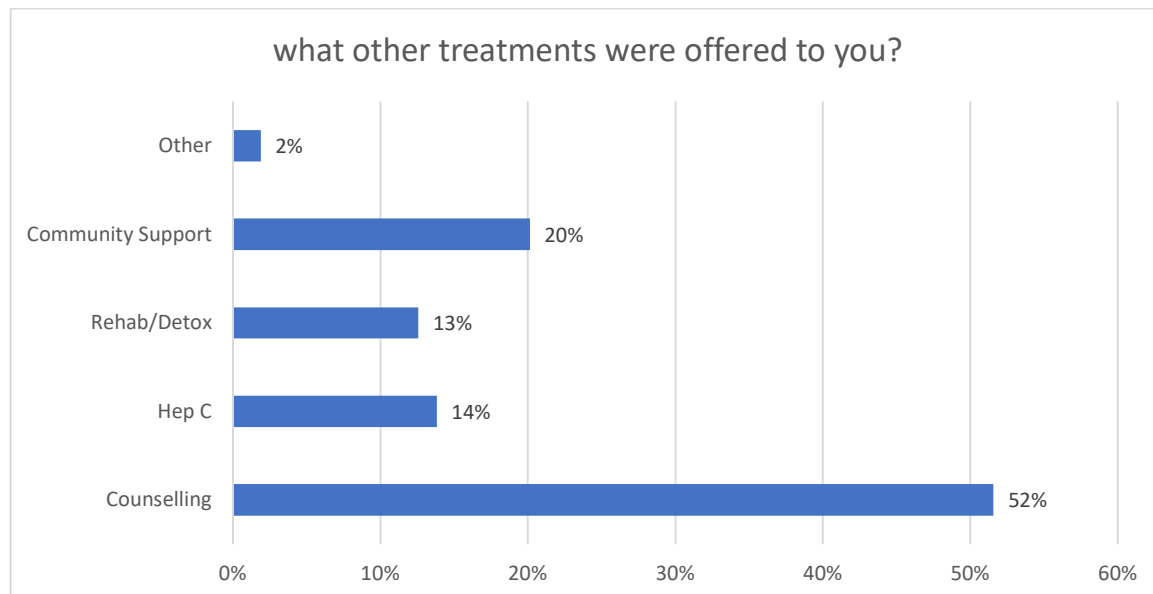


Figure 9 What other treatments were offered to you?

52% of respondents articulated that they had been offered counselling, 14% Hepatitis C treatment, 13% detoxification and/or rehabilitation, 20% Community Supports, with 2% reported “other”. While this represents a vast improvement on our last round of research (SURIA, 2020), there is a significant caveat to this data. Unfortunately, despite what appears to be a concerted effort by some services to offer some choice in treatment, participants stipulated that there was a range of barriers that inhibited them from engaging with these choices.

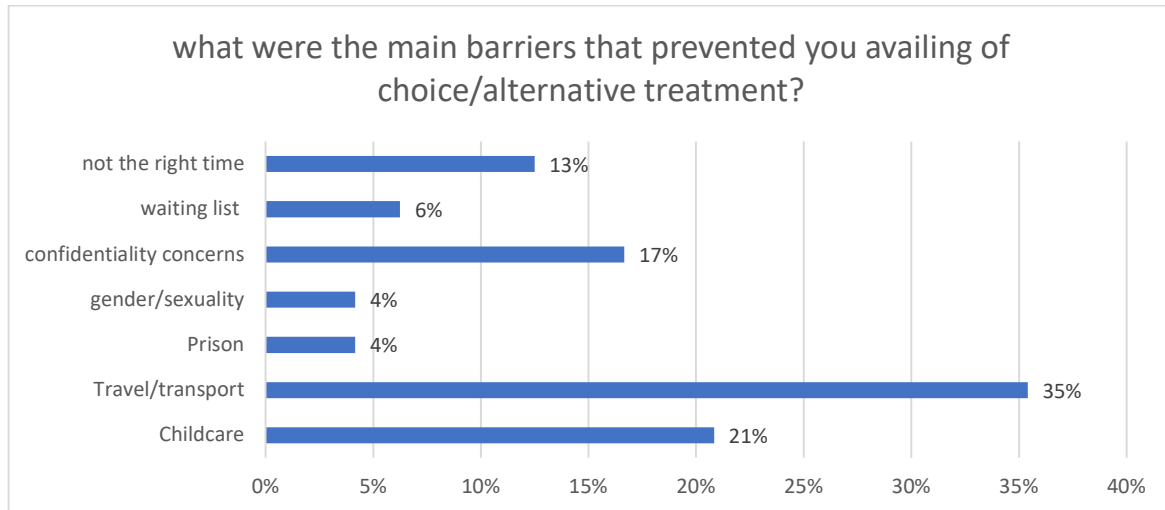


Figure 10 what were the main barriers that prevented you availing of choice/alternative treatment?

Fig 10 illustrates these barriers, which include not having access to childcare and not being unable to travel to engage with these alternative or ancillary services. The mention of waiting lists and prison, alongside the pre-mentioned barriers suggest that communication between services is poor, that there is a distinct lack of a unified approach by different service providers to best serve clients. The absence of other medications as an indicator of choice requires further analysis, while the inclusion of gender/sexuality and confidentiality concerns as barriers to availing of choice should also be explored further. As a primarily quantitative report, an in-depth analysis of these barriers is beyond the scope of this research.

Meaningful review, as opposed to uniform, unchanging practices is crucial to cogent, effective treatment, in particular when one considers both the relative lack of care plans and the long periods of time that we have demonstrated service users are engaging with their services. Meaningful review can be defined as the embodiment of the partnership approach and the dismantling of the power imbalance that often permeates the doctor/patient dynamic. It asks that service providers liaise with their patients regarding changing circumstances and objectives, while responding with relevant changes to their client’s treatment. It begins with dialogue between the doctor and patient.

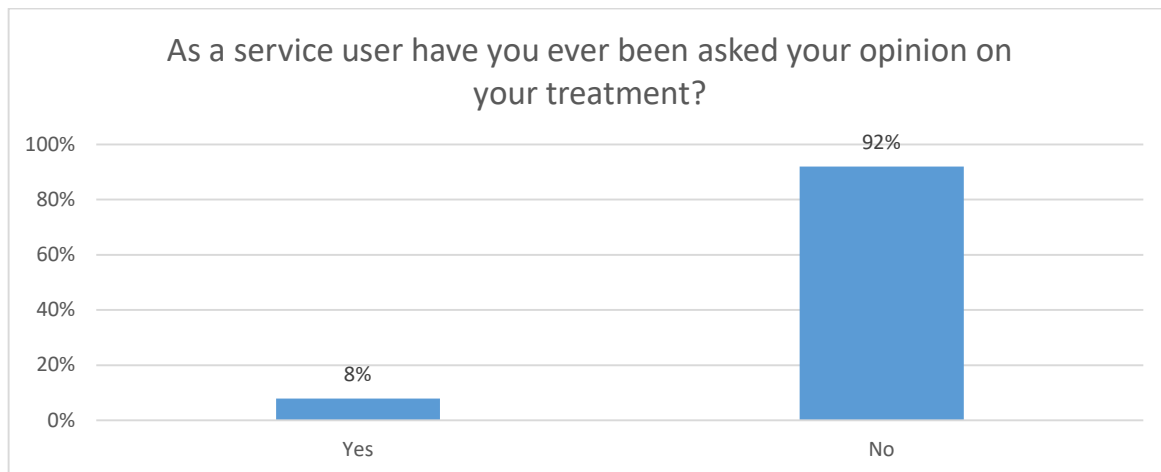


Figure 11 As a service user have you ever been asked your opinion on your treatment?

However, only 8% of the research cohort reported that they were asked for their opinion on their own treatment. As per our prior research, meaningful review remains an aspiration for many service users. Instead, the propensity of providers to advance practices that dominate, control and survey the lives of clients through punitive practices remain the norm. All are predicated on the reward/punishment binary that are advanced by testing and sanction. The continued refusal to meaningfully review MMT/OST practice further highlights the resistance to adhere to the international evidence base and many service providers inclination to link treatment to enforced obedience. It is extremely unlikely that there are any other treatment modalities or forms of public health that decline to seek the opinions of patients. The simple question “how are you finding your treatment?”, a basic question that should underpin any form of medical care, is one that is consistently replaced with “can I have a urine?” in Irish OST/MMT services.

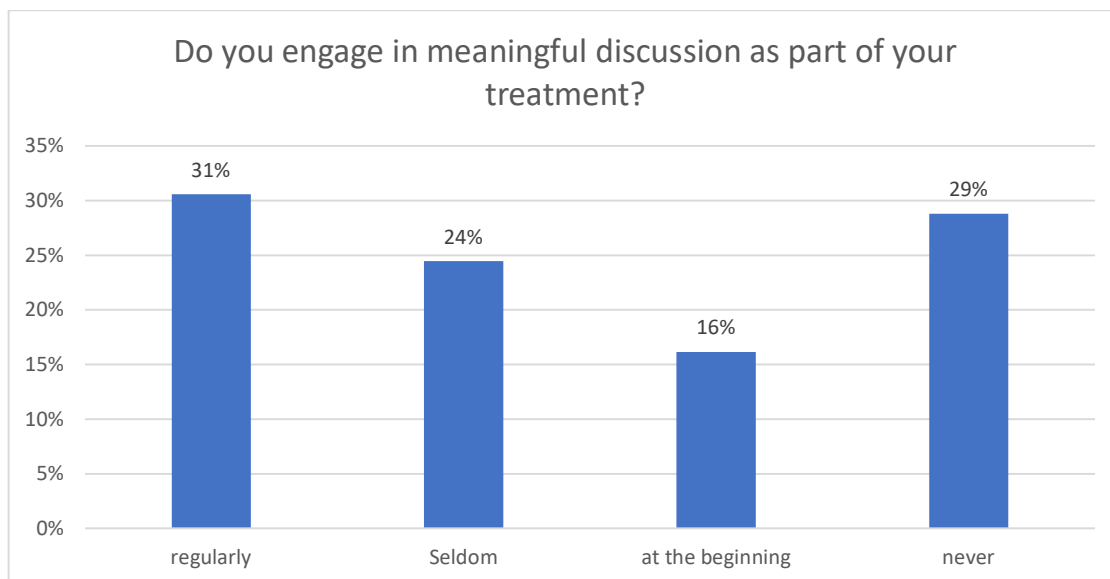


Figure 12 Do you engage in meaningful discussion as part of your treatment?

Less than one third, just 31% of our cohort, stated that they regularly engage in meaningful discussion with their service providers. Almost the same percentage, 29%, have *never* engaged in meaningful discussion. SURIA recommend that meaningful review, as part of evolving care plans, must be central to OST and MMT in Ireland. Only then will clients feel they are valued or are being treated with dignity and respect. Instead, the continued non-use of meaningful review and partnership reinforces the institutional stigma and opprobrium that many service users experience.

A Robust Avenue for Complaint

A robust avenue to report poor treatment, mistreatment or clinical abuse is essential in OST/MMT. It is also necessary that any such mechanism be independent from services. Across the existing body of literature, the lack of a platform for the service user voice to be heard regarding poor treatment frequently resonates with service users, (SURIA and CAN, 2018, SURIA 2020, Healy et al. 2023, King 2011). Indeed, this report suggest that the vast majority of service users are unaware of their rights, adding further credence to our findings that service users have become desensitised to treatment that is not rights based; rather poor practices are accepted as normal by many service users.

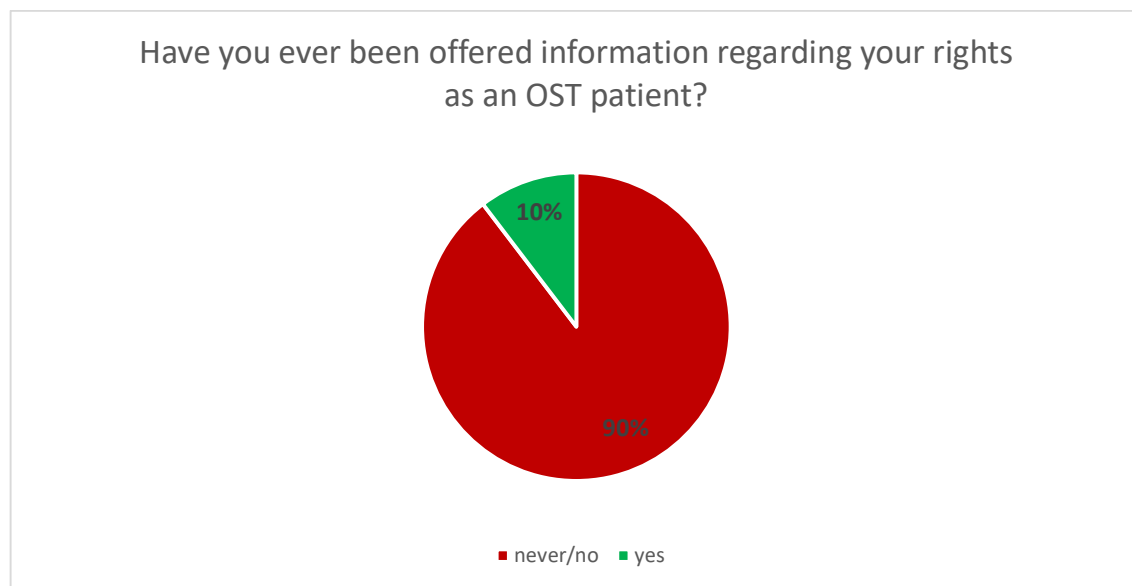


Figure 13 Have you ever been offered information regarding your rights as an OST patient?

Further unpacking the data, our research indicates that just 10% of participants have been offered information regarding their rights as a consumer of this form of public health care. Service users who are not aware of their rights are unlikely to know how to make a complaint in the event of the development of grievance or perceived injustice while engaging with OST/MMT services. As such, it is therefore not surprising that just 38% of participants were aware of the mechanisms and instruments that are routinely used for making a complaint (Fig 14). Furthermore, just 5% of participants had ever made a complaint, (Fig. 15). In comparison with previous research, service users are now less likely to know how to make a complaint or to actually submit a complaint. While almost every other area that this research explores demonstrates that OST/MMT service provision is improving to some degree, service users are still not realising their right to the highest attainable level of health care, as per a number of rights mechanisms and instruments.

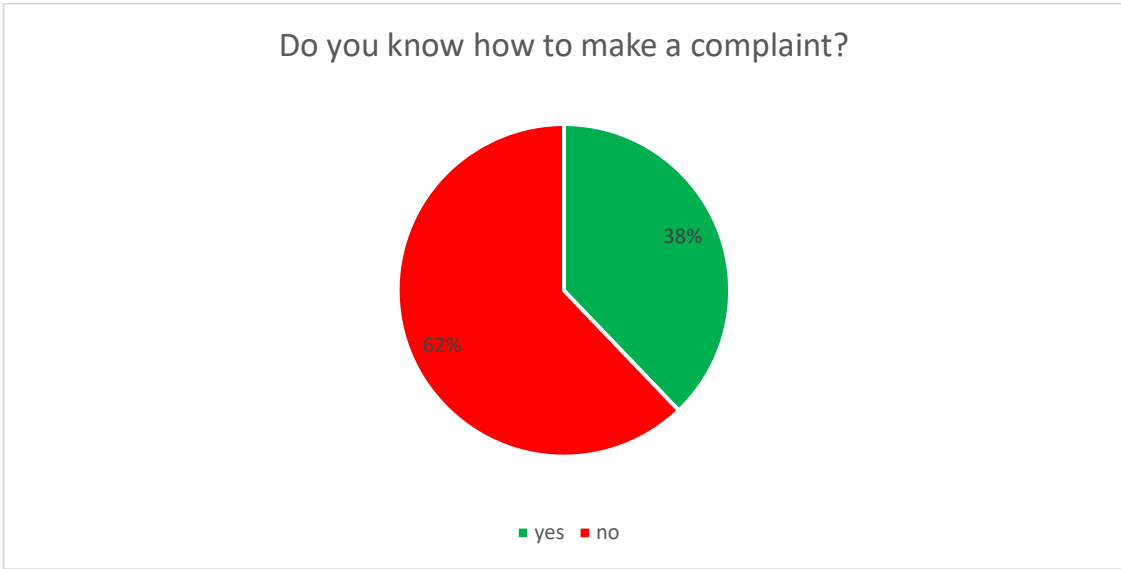


Figure 14 Do you know how to make a complaint?

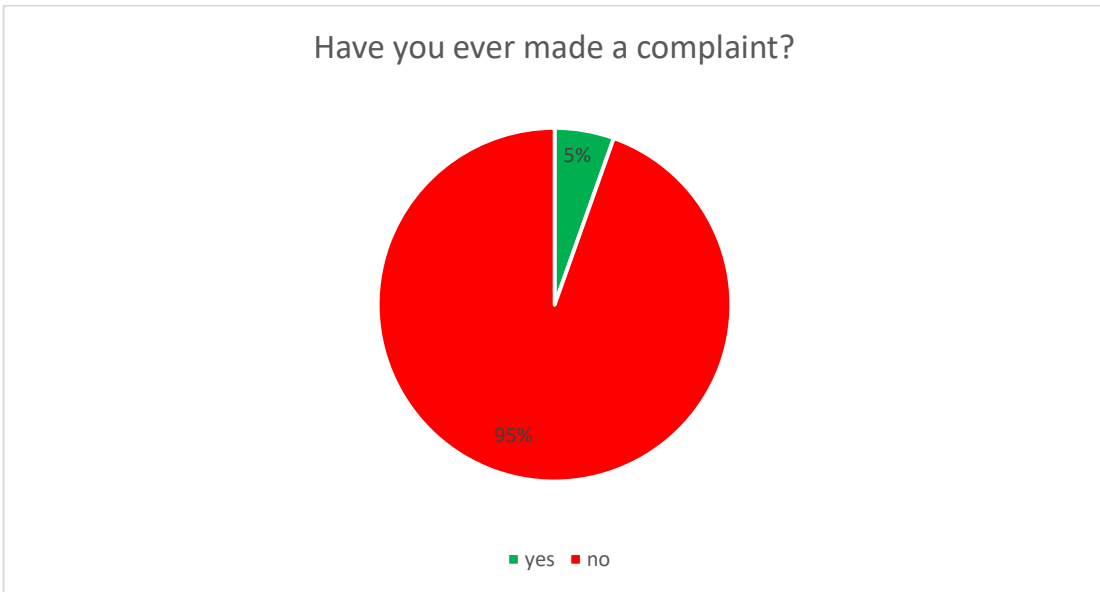


Figure 15 Have you ever made a complaint?

Considering many of the findings elicited from this research situate Irish MMT/OST against a backdrop of sanction, a lack of re-integration, the invasion of privacy and concerns regarding confidentiality, one would expect that complaints would be a common occurrence among service users. However, this is not the case, even though the data suggests there is a tangible lack of satisfaction and a poor quality of life within a treatment modality that is played out against a fluid interplay of sanction and restriction. Again, the qualitative data enables us to delve deeper into why

complaints are uncommon in Irish services. Participants have postulated that among the rationale for not seeking accountability for poor service provision are the following:

- Service users cited being having their doses reduced.
- Others discussed being moved to a different clinic.
- Many feared the consequences of making a complaint.
- Others posited that making a complaint was a waste of time.
- Very few had their issues resolved.

To this end, SURIA recommend the immediate development of an independent, effective and robust mechanism for complaint. The ability to lodge a complaint has the potential to reduce the power imbalance that is inherent in services, promotes dignity and respect and creates an arena in which service users are heard and their voice amplified. Through two way oversight, complaints have the potential to improve services and should not always imply criticism. Instead, service user participation in their own treatment is an opportunity to propagate better outcomes from services. SURIA recommend that the implementation of a platform for complaint should be employed to reduce the us and them dynamic that is often prevalent in OST and MMT services.

New Findings

The research was informed by the narratives and experiences from more participants than prior research, while also exploring more services from outside the Dublin area. This enabled us to make more in-depth inferences pertaining to Irish service users. Using this methodology facilitated an inaugural comparison between service users accessing services from both urban and rural areas. To this end, the data elucidates a marked difference between both.

Rural and Urban Differences

Our research demonstrates that MMT and OST services in rural areas are inclined to employ practices that are considerably more aligned with best practice, human rights and the evidence base. Rural service users repeatedly alluded to the following, many of which are not enjoyed by their urban counterparts:

- Less urinalysis.
- Rural services users tend to engage with services for shorter time frames.
- Many posited more choice of treatment, suboxone is prescribed more often in Cavan and Monaghan but not in the HSE clinics in Louth
- Rural service users posit higher levels of satisfaction.
- Many stated that they enjoyed meaningful discussion with service providers.
- Rural service users described having better relationships with their doctors.
- The use of care plans is part of normative treatment practice in rural areas.
- Rural services facilitate better outcomes.
- Rural service users are more likely to be offered detoxification.
- Service users in rural areas are far more inclined to be engaging with the labour market or accessing education.

While rural service providers may work in more favourable conditions, with more service users who are not homeless (homelessness is more common in urban cities) and therefore likely to be more stable, the striking differences between both requires in depth analysis. Notwithstanding this, it should also be noted that many rural service users discussed the challenges of using pharmacies to collect their medication, as opposed to the clinical setting which can be more common in the urban.

Many discussed the shame, stigma and lack of privacy that they experience when using local chemists. Furthermore, many rural service users expounded that poor transport facilities in rural regions restricted alternative treatment and choice. SURIA recommend that MMT and OST service provision is standardised across Ireland, underpinned by human rights based guidelines and uniform training for staff and national oversight by the HSE. The quality of service provision should not be determined by the locality and region in which service users engage with their treatment.

Changes to Treatment that Service Users want to see Implemented

As a point of departure, this section of the research examines the elements of MMT and OST that service users would like to see changed. Fig 16 illustrates that service users (rural and urban), reported a number of changes they would like to see implemented in their OST or MMT services. 22% of participants referred to the lack of adequate supports, which reinforces the pre-discussed requirement for more care plans and meaningful review. Interestingly, only 4% mentioned more takeaways, while the 12% who articulated that they should not have to attend daily epitomises that for some, MMT and OST is likely restricting re-integration. Attending clinics, doctors and/or pharmacies daily precludes education and employment, fosters disenchantment and reduces the quality of service users’ lives. Service users’ lives become dominated by travel, queuing, waiting, providing samples and living a surveyed life. SURIA argue that daily attendance is largely unnecessary and potentially disrupts the attainment of any form of recovery capital. 16% of respondents also made manifest their fears of being “left on methadone”, suggesting that there is a significant cohort who aim to move away from methadone maintenance and detox.

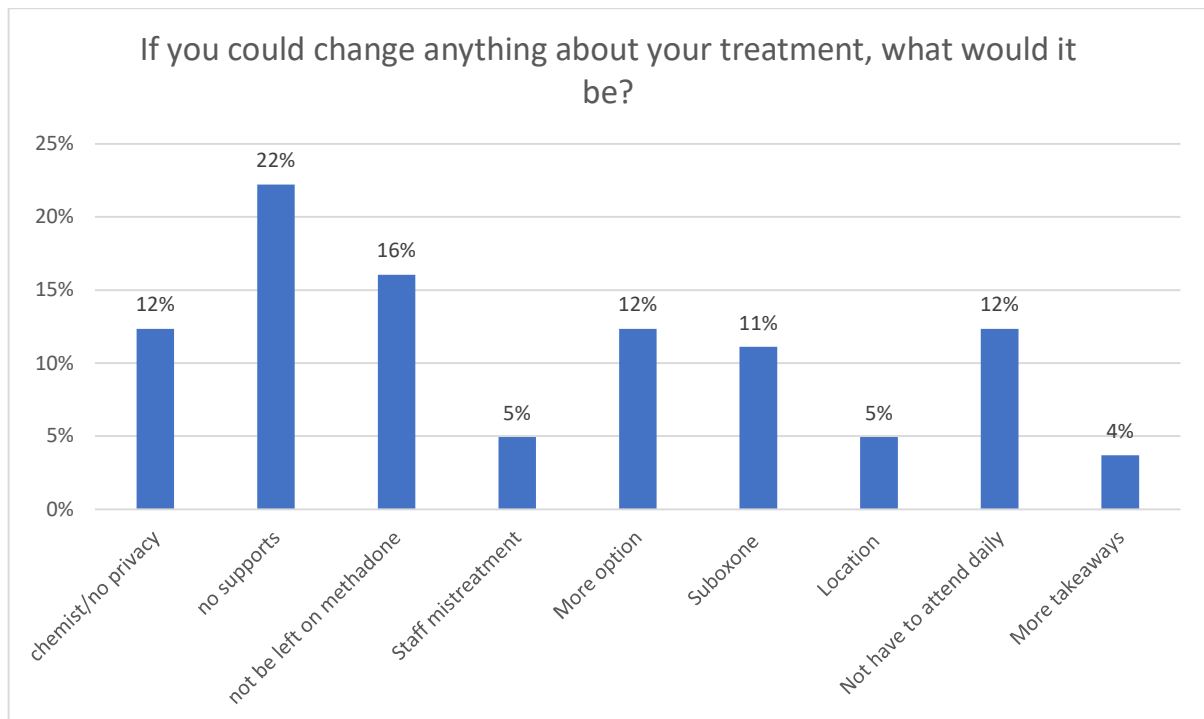


Figure 16 changes service users want to see implemented in their treatment

However, Fig 17 indicates that just 42% of participants have discussed detox with their service provider, thus potentially trapping clients in a treatment model with a rigid structure underpinned by a myriad of rules, obligations and duties.

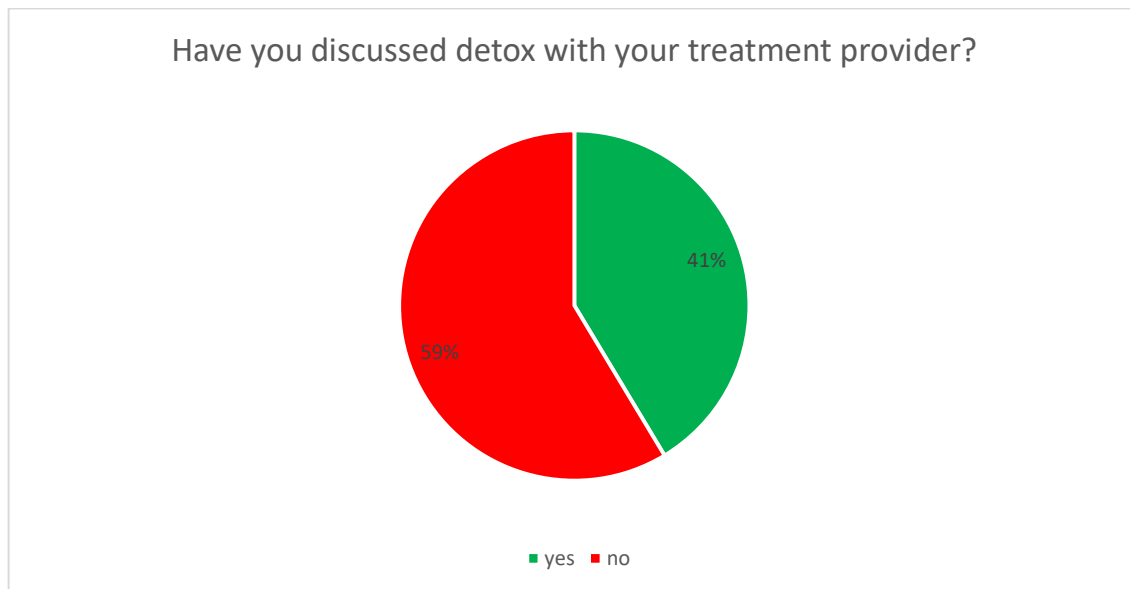


Figure 17 Have you discussed detox with your treatment provider?

Re-integration through Employment and Education

Mayock (2018) delineated re-integration as a nexus of education, employment and the restoring of family relationships. However, this research demonstrates that just 17% of respondents are engaged with work or education. It is also notable that rural service users are twice as likely to be in work or education.

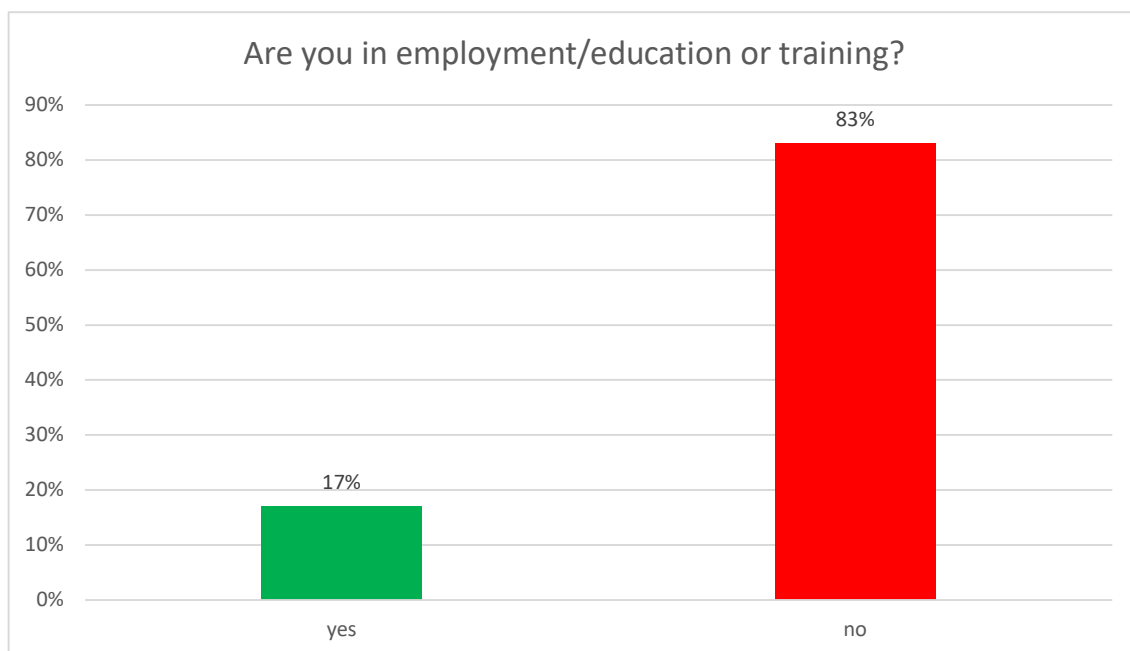


Figure 18 Are you currently in work or education?

Many of the factors that prevent service users from engaging with the labour market or education emerge from the pre-discussed over-extension of power into the lives of service users. Providing

urines, collecting medication, the supervised consumption of medication and the broad range of duties that form part of the everyday life of the contemporary Irish service user leave little time or opportunity to work or access education.

Conclusion

Human rights-based recovery advances treatment practices that promote dignity, respect and agency. Participation, autonomy, non-discrimination, equality and accountability are also values which should translate as tangible entitlements of rights based care, (Barrett 2010, Vizard 2011). Although Ireland is a signatory of several human rights instruments that ratify the *Right to Health* and *The Public Sector Duty Act*, these rights are rarely made manifest in contemporary Irish MMT practice. The findings of this report suggest that the methadone/OST apparatus requires an urgent review of policy, governance and practice if the model is to rehabilitate, re-integrate and reduce the harm for those who have difficulties with opioid use.

Many of the issues that have been discussed and made manifest by this peer led research are linked. MMT/OST in Ireland has the primary goal of “working to incite, reinforce, control, monitor, optimize and organise”, (Harris & McElrath 2012). It is paradoxically rigidly structured in terms of inhibiting the agency and autonomy of service users, while being simultaneously unorganised and arbitrarily managed, when one considers the lack of coherent care plans, clear, evidence based guidelines and the prevalence of non-uniform practices and approaches in different regions of the State. As our latest report tracing the realisation of rights and standard of treatment, SURIA welcome many of the improvements to service provision that this research has demonstrated. However, we also maintain our evidence informed perspective that the standard of MMT and OST in Ireland is still not adequate. Service users continue to be demonised, experience institutional stigma and have low expectations regarding the outcomes of treatment.

The continuing employment of control through sanction does little to promote dignity and respect. This is particularly evident in the use of language by service users throughout this report. Many participants expressed a desire to be “clean”, which suggests that they were once “unclean” or “dirty”. This is the language that is routinely used *by* services, by those employed to form therapeutic relationships with clients. Instead, the asymmetrical power imbalances that we have repeatedly discussed in our prior reports are still central. The reduction in service users who know how to engage with the largely inept complaints procedure, and the repeated postulation that it is a meaningless, tokenistic endeavour, further demonstrates that service users are very aware that their voices, choices and perspectives are rarely afforded meaningful expression. As such, many echo the sentiment that emerged from Paula Mayock’s work in 2021, in which a number of service users lamented a life “on hold” and spoke of “being held hostage” and “oiled up for the day”.

Previous research, now almost three decades old, illustrated the common disposition in Ireland that those who used heroin were the most stigmatised group in the country, (MacGreil, 1996). This research has captured a life in which vulnerable people are regularly dehumanised, disempowered and have arguably been forgotten by stakeholders who are responsible for their care. Despite some improvement in the narrative and experience of those engaging with Irish MMT and OST, these harm reduction modalities still fall short in the realisation of the highest attainable level of health care. Instead, our public health sector continues to hurt, punish and

blame many service users who are homeless, have experienced trauma and struggle to navigate a world of frenetic competition during a cost of living crisis. To continue to do so casts a dark shadow of Irish society. For SURIA, the current Citizen's Assembly on Drug Use in Ireland will be considered a failure if the plight of Irish service users continues to be overlooked.

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