

Methadone: What's the Story?

UISCE (2003)

Union for Improved Services, Communication, and
Education

Acknowledgements

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PREFACE

UISCE, the Union for Improved Services, Communication, and Education is a group made up of users, ex-users, and professionals who believe that the voice of the drug user is integral in the development of drug policy and in realising an effective treatment response.

UISCE was formed as a result of a North Inner-City Drugs Task Force (NICDTF) initiative. THE NICDTF is one of 14 local Drugs Task Forces in Ireland overseen by the National Drugs Strategy Team. Set up in the aftermath of the murder of journalist Veronica Guerin, the Task Forces provide community based responses to tackling the growing drug problem in the areas most affected by drug use. The Task Forces consist of representatives from the statutory, voluntary, and community sectors. Many of them have also evolved to include political representatives.

The NICDTF recognised that drug users are also part of the community and, as recipients of the services, should be involved in the assessment and policy-making processes. A seat was reserved on the Task Force for a representative who would bring the concerns and issues of service users to the table. It was envisaged that this position would be held by someone who had been, or was currently, a drug service user. As a result, the Service Users Forum was formed which was the precursor to UISCE.

In 1999, UISCE constructed a questionnaire in order to ascertain the issues that were of most concern to drug users. The questionnaire was long and covered a broad range of issues such as homelessness, prejudice, prison conditions and methadone. It was answered by 96 people. People were overwhelmingly unhappy about the government's Methadone Protocol, especially the introduction of Methadone DTF to replace Physeptone. It emerged during this research process that the use of other drugs had increased dramatically since the Protocol, particularly benzodiazepines (prescription drugs) and alcohol.

These, and other issues which arose, prompted UISCE to conduct a second more in depth survey.

UISCE is not a professional medical body. This report reflects the opinions and observations of north inner-city service users who contributed, by interview or through focus groups, to this action research.

1. INTRODUCTION

Methadone is the drug on which the treatment of heroin addiction is based. At present approximately 5,000 people in Dublin are being treated with this drug. Where did it come from and how did it find its way into treatment? Why is it used instead of other opiates? How successful is methadone? This report hopes to answer some of these questions and to also look at the quality of the treatment that accompanies it.

1.1 *A Brief History of Drugs*

There is nothing new about drug use. It has always been a part of human nature to get high or to alter states of consciousness. Many ancient records refer to drug use of one kind or another such as cannabis, alcohol, coca, tobacco, or opium.

Of all the drugs known to humans, the one that has caused most concern is opium and its derivatives. Opium, referred to as the 'joy plant' in Sumerian texts 4000 years old, is the milk or sap of a particular type of poppy, *Papaver Somniferum*, which grows in the Middle East and Asia. Although many people used opium simply to get 'stoned' it was also widely used throughout the world as a medicine; it was used as a painkiller, a sleeping draught, and as a cough medicine.

The next link in the chain that leads from opium to methadone is the discovery of morphine. This happened in Germany in 1804 when a young chemist called F.W. Serturner managed to isolate the main ingredient of opium and name it morphine. Morphine was deemed to be ten times the strength of opium and it quickly found its way into mainstream medicine as a powerful painkiller. In 1843 the syringe was invented by Alexander Woodin, allowing drugs to be injected directly into a vein, and this increased the potency of morphine even more. At the time, morphine could be bought without a prescription at any drug store and there was nothing illegal about using it.

In London in 1874 a chemist named C.R. Alderwright boiled a sample of morphine with acetic anhydride, a chemical similar to ordinary vinegar and produced a compound which he called diamorphine. Four years later in Germany another chemist named Heinrich Dresser endorsed this drug for the treatment of coughs, chest pains, pneumonia, TB, and pain relief. He also gave it the name 'heroin'.

1.1.1 Drug Laws

Efforts to control the production and supply of opiates began to pick up steam in 1909 when an international conference on the control of opiates was held in Shanghai. Three years later at the Hague Convention it was agreed that opium smoking should be outlawed and that narcotics should be manufactured for medical use only. In 1914 the Harrison Narcotic Act was passed in the United States. The major thrust of this Act was to take the sale of narcotics away from grocery stores and other common peddlers and place it in the hands of the medical profession. From this point on, controlled drugs could only be obtained with a doctor's prescription and a doctor could only prescribe when acting in good faith or in the

legitimate practice of his or her profession. In essence, American doctors were forbidden to treat addicts by maintaining them on controlled drugs.

Years later, a British doctor, J.H. Willis, Consultant Psychiatrist in Drug Dependence wrote, *“This was a formidable piece of legislation which had the effect of virtually outlawing anyone who was an opiate addict; thus the attitude of the public and the medical profession became a negative one directed towards the addict who was automatically identified as a criminal”*.¹

Britain soon followed suit, amending the Dangerous Drugs Act of 1920 to include opiates, stating that possession and use of drugs were to be limited to doctors prescribing such drugs only as far as may be necessary for “the exercise of his (sic) profession.”

However, a conflict soon arose over what this phrase meant. In 1924, the Minister of Health appointed a group of leading physicians headed by Sir Humphrey Rolleston, president of the Royal College of Physicians, to advise the government as to what the legitimate practice of medicine was in relation to drug dependence. The report was delivered in 1926 and determined addiction to be a manifestation of a disease rather than pure indulgence. In 1958, the Minister of Health appointed a committee to review the Rolleston Report. Chaired by Russell Brain, the report recommended no changes to the Rolleston guidelines. However, as the number of addicts grew, a second report of the Brain Committee was issued in 1965, finding an increase in the number of addicts who were not using opiates for therapeutic purposes. Recommending that heroin and cocaine be categorised as restricted drugs, the Brain Committee also initiated the setting up of specific treatment centres for addicts in 1968.

1.1.2 Methadone

Following the Second World War, heroin use in US cities again attracted public attention and new laws mandating more severe penalties for sale or possession of opiates were passed. Despite this, heroin use did not disappear and crime rates continued to grow. As it was believed that a lot of this crime was due to addicts who used the money to buy heroin, there was an increasing interest in finding a way to prevent and treat addiction.

Because of the Harrison Act, US law forbade doctors to treat addicts with drugs. Between 1920 and 1945, 25,000 doctors were prosecuted for prescribing to addicts. The usual way to treat addicts was a hospitalised de-tox, but studies showed that almost all addicts relapsed within the first year after release. Doctors Vincent Dole and Marie Nyswander introduced the use of oral methadone as a form of treatment in New York City in 1964. Methadone is a synthetic drug, first invented in Germany during the Second World War by scientists who, having discovered pethedine some years earlier, were developing other similar compounds.

This approach was a sharp departure from previous practices and results were consistently better than that which had been previously observed. Soon, other doctors began to use oral

¹ Willis, J.H. (1969). *Drug Dependence: A Study for Nurses and Social Workers*, London: Faber and Faber, p.25.

methadone in the treatment of heroin addiction. Early reports were almost unanimous in finding that those who remained in treatment showed a sharp drop in their use of heroin, a marked decrease in criminal activity, and an increase in legitimate employment as compared to their behaviour prior to entry into treatment.

Oral methadone has several advantages that made it particularly useful at the time of its introduction in the US. The most important is its long duration of action. It was important to have a drug that would have a stable level of tolerance so that progressive escalation of dosage would be unnecessary. It also seemed important to be able to state that addicts derived no euphoria from taking methadone and that large doses produced a blockade of the 'high' from heroin. Also, because methadone is chemically different from heroin and morphine, it was possible, through urinalysis, to demonstrate a decline in the use of heroin by addicts on methadone programmes.

1.1.3 The Dublin Context

Illicit drug use was virtually unknown in Ireland until the late 1960's. There was no organised black market and the supply of heroin was sporadic. The most popular drugs among addicts were Diconal, Palfium, and Morphine Sulphate. Users acquired these drugs from 'liberal' doctors, by forging prescriptions, or by breaking into pharmacies and stealing the drugs.

In 1972 drug treatment was "centralised" and any doctor who encountered an addict was advised to refer them to the National Drug Advisory and Treatment Centre in Jervis Street. The objective of this centre was to promote abstinence and methadone was used mainly for gradual detoxification. In rare cases, however, methadone was used over a prolonged period of time to maintain addicts and stabilise their condition.

In the late 1970's the number of heroin addicts in the city increased dramatically when 'crime lords' took over the supply of illegal drugs. However, in the mid-1980's the supply of illegal heroin dried up and drug users turned to other drugs, such as Morphine Sulphate Tablets (MST's). Although these tablets were meant for oral consumption, they were often crushed and injected, causing abscesses, thrombosis, and occasionally the amputation of limbs. Worldwide there were also growing concerns about a 'new' virus (HIV) which led to AIDS and it had been determined that this virus, along with Hepatitis, could be contracted through the sharing of syringes. Needle exchange programs and more methadone maintenance programmes were implemented to address growing HIV infection among drug users. The 1980's also saw the formation of Concerned Parents Against Drugs, a community based movement that sought to address the drug problem from a community perspective.

In the early 1990's the use of heroin began to significantly increase in the city and by the mid-1990's there was a new epidemic. Thousands of young people began to use heroin and some local authority housing complexes became open markets for all kinds of drugs. People were injecting openly in public places and injecting equipment was being discarded in schools and children's playgrounds, giving rise to fears about children inadvertently contracting HIV. Drug related crime was at an all time high and gangland murders were not uncommon. From the communities' perspective it seemed that dealers were openly flaunting their wealth and the police appeared to be doing nothing to address the problem. Many young people were dying as a result of drug overdoses, drug-related suicide, and AIDS related illnesses.

The residents of communities most affected by the problem were outraged and decided to take steps to rid their areas of this drug dealing. People were trying to cope with the stresses and strains of handling a situation which was out of control and which threatened to undermine the social fabric of the community. The Coalition of Community Against Drugs (COCAD) took up the mantle of Concerned Parents Against Drugs. Neighbourhood committees were formed and drug dealers, who were often addicts themselves, were sometimes forcibly evicted from their homes. The 1997 Housing Act legitimised evictions by allowing Dublin Corporation to evict tenants of drug related 'anti-social' behaviour.

As thousands of people marched on Dáil Éireann demanding a response from the government, community leaders insisted that the community be involved in any policy making process. In 1995, people in the most disadvantaged communities across Dublin city were trying to deal with the devastating impact of the drug crisis on their local areas. ICON (Inner City Organisations Network) took the initiative of inviting groups to come together to a meeting in Liberty Hall to launch a joint campaign on behalf of all the communities affected. This was the beginning of the Citywide Drugs Crisis Campaign. The community leaders involved in the campaign had learnt from their experiences in the 1980's Concerned Parents movement and knew that, as well as action at local community level, their campaign had to be aimed at the policy makers and decision makers. The communities most affected by the drugs crisis had to campaign for the right to have a say in how drug policies were developed and how resources were allocated. Citywide held a number of meetings that looked at the key policy areas of health, education/prevention and supply control and produced its first policy document in May 1996. The work of Citywide continues to have the dual focus of supporting communities at local level in responding to the drugs crisis, while at the same time increasing their involvement and impact in developing policy at local, regional, and national level.

The high profile assassination of the investigative journalist Veronica Guerin by alleged drug dealers, along with a growing political awareness of the seriousness of the situation, led to the creation of community-based Task Forces. These agencies would act as a co-operative effort between statutory and non-statutory agencies and local communities in tackling the drugs crisis.

2. BACKGROUND TO RESEARCH

Following the establishment of the working group and management committee, UISCE began receiving feedback from drug service users about issues that were of major concern to them. This feedback was gleaned through street outreach, public meetings for drug users in Liberty Hall, as well as letters to the UISCE Newsletter.

As already mentioned in the Preface, the initial survey that we undertook highlighted many issues but clearly showed a high level of dissatisfaction with Methadone DTF provision in light of the Methadone Protocol.

The Protocol was introduced by the government in 1998 to streamline drug treatment and to address the growing concerns about the methadone 'black market'. In effect this meant that GPs could no longer prescribe methadone unless they 'signed up' to the protocol procedures. These procedures included limits on methadone patient numbers, centralised patient records, and the issuing of Photo ID cards to methadone patients. They also guaranteed that no one would have to pay privately to attend a GP for methadone treatment. In addition training would be provided for GP's who were willing to prescribe methadone and engage in the protocol. As part of this protocol, Methadone DTF was introduced to replace Physeptone which had been deemed by health authorities to be less suitable for longer term maintenance purposes. However, our first questionnaire found that many drug users found Methadone DTF to be far less effective than Physeptone resulting in earlier withdrawal symptoms and an increase in self medication in order to compensate for this effect. The issues around the comparison of Methadone DTF (green), to Physeptone (brown) came to the fore at a focus group held with drug service users at Liberty Hall.

As a result of these growing concerns, UISCE decided to carry out a comprehensive survey of drug service users in the city. This survey hoped to systematically research the impact of the Protocol on those in drug treatment.

However as with the best laid plans, this process highlighted a much broader and complex range of problems faced by clients within drug treatment services. While UISCE did their best to confine the parameters of the research, it was clear that respondents were going to take full advantage of being asked for their opinion on drug services. The organisation had certainly won the confidence of drug service users and as a result many people contacted UISCE wanting advice or assistance with problems they were having with their clinics, GP's, and chemists. This ground swell forced UISCE to respond by creating a space where people could feel safe to discuss the problems they were having. Focus groups were held in Liberty Hall and these were extremely well attended. Many of the issues related to how powerless people felt about decisions taken in relation to their drug treatment. While we set out to focus on the physiological impact of Methadone DTF, we also gathered extremely important additional information and insights from drug service users which we include in this report.

3. METHODOLOGY

Information was ascertained through focus groups held at Liberty Hall as well as a brief questionnaire² administered to service users. A unique aspect of the methodology was the fact that the focus groups and questionnaires were co-facilitated and designed by drug service users. This is in marked contrast to the external evaluation commissioned by the Eastern Health Board by Farrell et al 2000.³ From UISCE's point of view, the omission of service users from the research process could be seen as indicative of an invalidation of their views. Methadone patients are rarely seen as a consumer group whose expectations and experiences need to be taken into account when designing and operating treatment programmes.

With this in mind, UISCE undertook to ascertain the level of satisfaction with Methadone DTF, as compared to Physeptone; and also to gauge the change in usage patterns of other drugs over a three-year period, corresponding with the introduction of the Protocol. Provision was also made for service users to make comments on the stated questions as well as any additional comments they might wish to make.

In agreeing a methodology for the research, UISCE decided to keep the survey as brief as possible to facilitate its implementation in a variety of settings. Members of UISCE carried out the questionnaire in drug treatment centres, in restaurants, in individuals' homes, and on the street.

The questionnaire first ascertained the age and gender of respondents, the brand of Methadone they were being prescribed, and the length of time the respondents had been on Methadone DTF. Respondents were then asked to compare Methadone DTF to Physeptone and to state any differences they might have perceived. Finally, respondents were asked to state whether their use of individual drugs had increased, decreased, or stayed the same after the introduction of the Methadone Protocol.

² See Appendix 1.

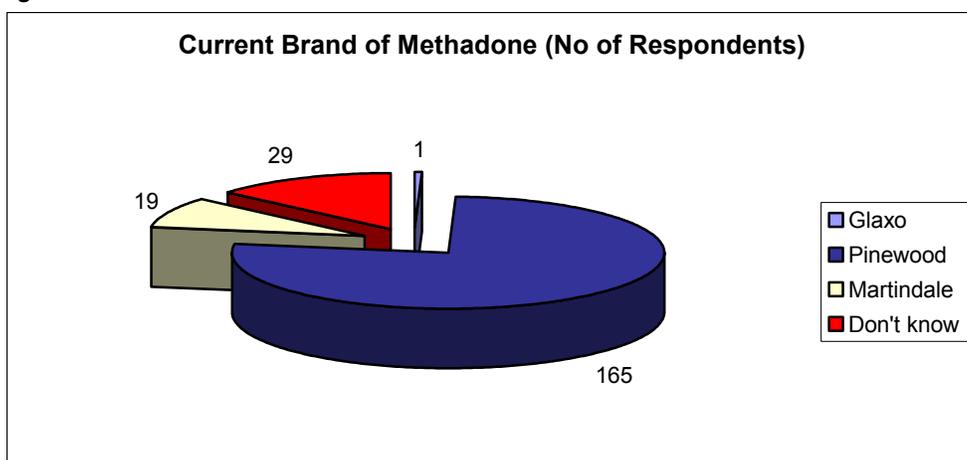
³ O'Farrell, M. et al (2000). *External Review of Drug Treatment Services for the Eastern Health Board, National Addiction Centre*, London: Institute of Psychiatry. In this research, informants were "key policy makers, teams and individuals, including GP co-ordinators, Consultant Psychiatrists, Area Managers, Counsellors, Education Officers, Outreach Workers, Nurses, Voluntary Sector Agencies and Individuals" (p.2).

4. FINDINGS OF QUESTIONNAIRE

A total of 214 people responded to the questionnaire and 53% (n=113) were male and 47% (n=101) were female. The respondents ranged in age from 19 years to 49 years with the average age being 30.5 years. Respondents had been in receipt of Methadone DTF for an average of 8.5 years.

While 0.5% (n=1) of service users were being prescribed the Glaxo brand of Methadone, 9% (n=19) were being prescribed Martindale, and the majority (77%, n=165) were being prescribed Pinewood. 14% (n= 29) of service users did not know what brand of Methadone they were being prescribed. **(See Fig 1)**

Fig 1



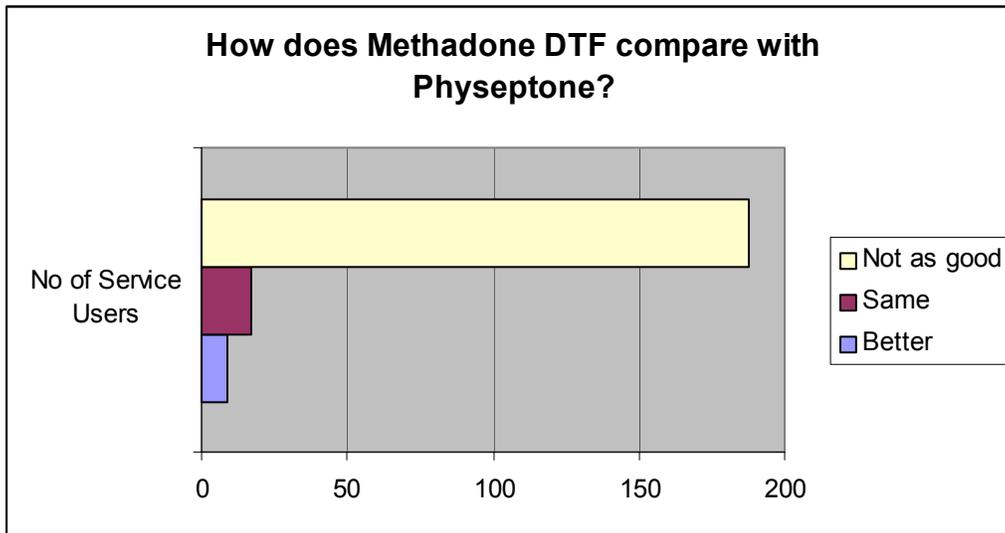
When comparing Methadone DTF to Physeptone, only 4% (n=9) of service users felt DTF was better than Physeptone. When UISCE explored this further, the only reason given for this preference was that Methadone DTF was less damaging to teeth than Physeptone.⁴

⁴ Interestingly some people who are maintained on Methadone DTF and who have never used Physeptone claim that their teeth are decaying despite good oral hygiene care. This would be worth further study.

The majority of respondents (88%, n=189) felt that Methadone DTF was *not* as effective as Physeptone while 8% (n=16) felt that they were both equally effective. **(See Fig 2)** Respondents reported the following reasons for their belief that Methadone DTF was less effective than Physeptone:

- Difficulty sleeping with Methadone DTF.
- Waking up early and experiencing withdrawal symptoms.
- Takes longer to take effect ('kick in') than Physeptone.
- Increases tendency to perspire and feelings of discomfort.
- Constipation and wind.
- Weight gain and obesity.

Fig 2



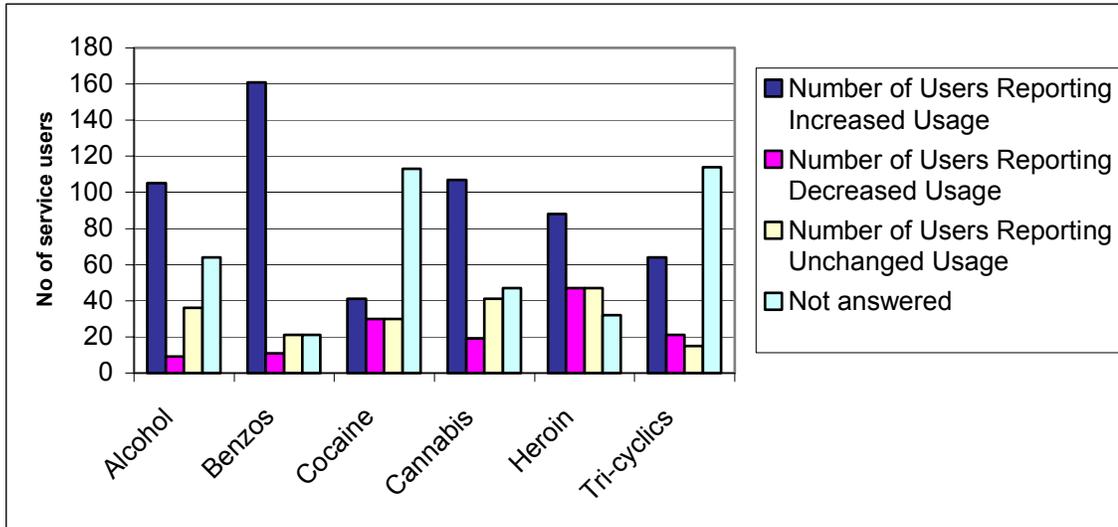
4.1 Perceived Differences Between Methadone DTF and Physeptone

71% (n=152) of respondents felt that Methadone DTF does not stave off withdrawals as long as Physeptone. 64% (n=138) stated that Methadone DTF does not provide the 'warmth and glow' of Physeptone and 34% (n=73) stated that Methadone DTF did not provide the 'buzz' of Physeptone.

4.2 Impact on Drug Use

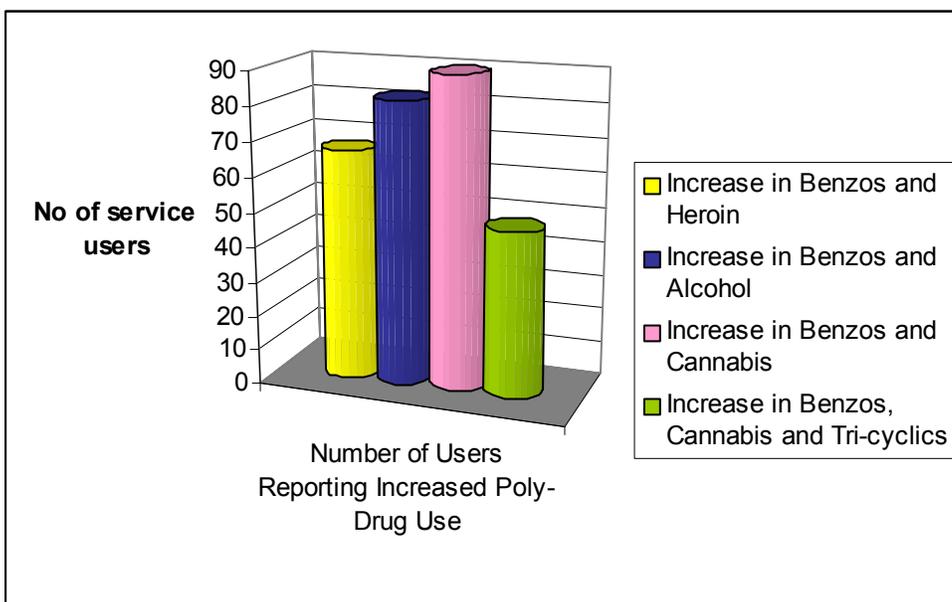
Respondents were asked to describe their drug use since the introduction of the Protocol. They were asked whether their use of certain drugs had decreased, increased, or remained the same. (See Fig 3)

Fig 3



As the above chart indicates, there has been a substantial increase in the use of other drugs. The percentage increase ranges from 19% (Cannabis) to 75% (Benzodiazepines). Heroin use increased by 41%. Poly drug use also increased. (See Fig 4)

Fig 4



5. ADDITIONAL CONSULTATION WITH SERVICE USERS

As already mentioned, focus groups were held with drug service users to feed back initial results from the survey findings. However, these groups were also used as an opportunity to allow people to voice their concerns about the findings and other aspects of their drug treatment programme. The main areas of concern were as follows:

- Problems with the effectiveness of Methadone DTF
- Attitudes of 'Protocol' staff (e.g. GP's, Pharmacists, and Clinic staff) towards drug users
- Use of medication sanctions
- Use of chemist/client contracts
- Urinalysis
- Privacy issues
- Feelings of powerlessness in relation to decisions on drug treatment
- Complaint procedures

5.1 Problems with Effectiveness of Methadone DTF

It is clear from the survey results that many people experience problems with Methadone DTF (see section 4) and that they are self medicating to ease the physical discomforts of early withdrawals. The following are a selection of quotes by drug service users taken directly from the focus meetings:

"I'm scoring more on the streets; I feel the Meth is not holding me"

"By 8 or 9 o'clock in the evening I start to feel sick. I always get Meth in the morning but it is not holding me until the next morning"

"I have taken a lot of tablets since the green; I never have before"

"My alcohol use has increased an awful lot; I'm now drinking every day"

"Since the new Meth was introduced I increased my use of benzos"

"I never sweated when I was on the brown" (Physeptone)

"The Meth they are giving us now takes too long to kick in"

5.2 Attitudes of ‘Protocol’ staff (e.g. GPs, Chemists, and Clinic Staff) Towards Drug Users.

The majority of those drug users who attended the focus meetings felt that they were ‘treated’ very badly by professionals within the drug services. Whether these problems are real or perceived it is very clear that the drug treatment services have serious issues to consider. Perceptions of a problem can be as damaging and as invidious as any ‘real’ problem.

“We’re just a number to them”

“They say jump and you jump”

“They think we’re thick as bricks and scumbags because we want Phy off them”

“We’re dismissed and ignored”

“The chemist is too controlling and disrespectful”

“I had a problem with wind and the doctor was sarcastic”

“I want to be treated as a person, yet I don’t want to be pampered or have them crawling all over me”

5.3 Use of Methadone Sanctions

Many of the respondents reported that they had been at the receiving end of medical sanctions for what they described as minor infringements of their drug treatment programme. UISCE had, during this period, been receiving many requests for advocacy on behalf of clients who had had their Methadone dose reduced for reasons which included unsubstantiated allegations, lateness, loitering, and ‘negative’ behaviour.

“For being with someone I lost my takeaway and got strung out again”

“I was seen giving money to somebody and my takeaways were taken away”

“I was hanging around the clinic and I was punished and I lost 10 to 20 mls”

“People have been accused of loitering without seeing video evidence”

“People are convicted on hearsay”

“People that are being cut off medicine feel suicidal and depressed”

5.4 Use of Chemist/Client Contracts

Some clients obtain their Methadone from chemists in the community. One of the aims of the Methadone Protocol was to increase the number of participating chemists to allow for more decentralisation of drug treatment. Arguably this would also allow a greater deal of flexibility and control for the drug user. However many people reported having bad experiences with their local chemists but had no avenue of recourse open to them to address these problems. Many people are forced to sign behavioural contracts before they will be allowed to receive their Methadone from that particular chemist. UISCE has viewed one of these contracts and were concerned to note some of the conditions which had to be signed up to before a person could receive his/her Methadone. These included guaranteeing that a person receiving methadone would not enter the chemist's premises with another person and that he/she would not talk to any chemist staff. In addition, people could not purchase any other item at the time of receiving their Methadone. More alarmingly, the contract stated that the Chemist could at any time refuse to dispense Methadone without giving a reason.

“You’ll sign anything or you can fuck off. Your pride goes with that sometimes”

“There’s nothing for us in the Chemist contract. All chemists are watching their backs”

“I don’t seem to have any rights as a customer”

5.5 Urinalysis

As a condition of drug treatment clients are required to provide urine samples when requested. These samples are tested for the presence of non-prescribed drugs. The urinalysis results can be used as a tool for doctors to decide the amount of Methadone a client is prescribed. If, for example, a client’s urine shows positive for the presence of non-prescribed opiates a doctor may decide to reduce the amount of medication given. This is usually deemed to be in the clients’ best interests in order to reduce the risk of overdose. If clients refuse or are unable to give a urine sample, this is taken to mean that they have non-prescribed opiates in their system and the urine is automatically deemed ‘dirty’. However, clients reported that there is a lack of confidence in the urinalysis process with many people claiming that they have obtained incorrect results leading them to believe that there are flaws in this system. Additionally, respondents reported that they find the process of supervised urine collection degrading.

“I feel very vulnerable in the clinic and giving a urine is too exposing and undignified”

“It’s horrible the way you have to give a urine. There’s no respect, no dignity, and they don’t care”

“If you can’t produce a urine in 15 minutes, it’s put down as a refusal. It’s considered worse than dirty”

“I’m after having a baby. I’m being punished for not being able to give a urine”

“After complaining about a doctor’s attitude I had a mysterious, “positive” urine”

5.6 Privacy Issues

Given that one has to be registered with the state as a drug user in order to obtain treatment, respondents frequently reported feeling quite exposed to scrutiny when registering with a drug treatment programme. The personal registration of information automatically means that many professionals have access to this information. While confidentiality is a key principle within the drug treatment services, the reality for people in drug treatment is very different.

“People are breathalysed in public. There is no confidentiality. People then know you are drinking”

“Everyone who works in the clinic seems to have access to the files; even the porters and the cleaners. Where is the confidentiality?”

“When you are talking to counsellors you are effectively talking to the whole clinic”

“If you are spoken about at weekly staff meetings everyone knows your business when it is supposed to be confidential”

“If I have a dirty urine, my doctor threatens to ring the Social Services and have my baby taken into care”

5.7 Feelings of Powerlessness in Relation to Decisions on Drug Treatment

As the current drug treatment service is structured, there is no client/patient involvement in the decision making process. While a few people reported having a healthy relationship with their doctors and clinic staff, the majority felt excluded and powerless, leading to frustration and apathy on the part of many clients. Those who had a good working relationship with their doctor were clearly more confident and empowered and felt a sense of control around their drug use. However, those who said they did not have a good relationship with their clinicians were clearly upset and angry.

“There’s no continuity of care. I feel undermined all the time”

“There’s a lack of consultation. I’m not being taken seriously”

“We cannot be late but the doctors can”

“Doctors are playing God”

“They are controlling us”

“We are never going to be on the same wavelength as doctors”

“You should be able to be involved in your own treatment plan. It’s an excellent way of empowering people”

“I wanted to detox but I got maintenance. Even though I said it to the doctor he didn’t listen”

“I can’t choose my dose. I want more involvement”

5.8 Complaints Procedures

There is no current user friendly complaints procedure in place within the drug treatment services, although a pilot project is underway in City Clinic (Dublin 1) where a client complaints procedure is being piloted. The outcome of this evaluation is due in late 2003. Many respondents said that if they complained about their treatment, they felt they would be victimised in some way by their clinic, GP, or chemist. Indeed many were unaware that they had any right to complain. Consequently, unresolved problems were escalating causing tension and frustration for service users.

“Methadone stops people complaining. They are afraid of getting sanctioned”

“There should be someone independent to go to with complaints from drug users”

“There should be someone neutral that you can speak to as a person, who doesn’t think you are a pain in the arse”

“People complain but there is never any response”

“I complained and got thrown off the Clinic for six months”

“I complained and was told to leave the room by the doctor”

“I had a kidney complaint and couldn’t give a urine. I was sanctioned and I complained but there was no result”

“When I complained I was labelled as a trouble-maker”

“If the doctor had less power in docking Phy, I would feel a lot safer about complaining”

6. MEETING WITH THE CONSULTANTS

A decision was made by UISCE to seek a meeting with the senior Consultants in the drug treatment services in order to present to them the findings of the research process to date and to get feedback from them. In addition to the information already gleaned, a number of case studies⁵ were documented, which gave a more in depth view into the difficulties some people were experiencing with their drug treatment programmes. It was the intention of UISCE to have another public meeting with drug service users sometime after meeting the Consultants to feedback the latter's responses.

The meeting took place in February 2001 and was attended by members of UISCE and three senior members of the drug treatment services. The Consultants had already been sent a copy of the research findings including case study documentation and a draft of this report; this formed the basis of the meeting.

The Consultants were presented with the range of problems that drug service users reported experiencing in their drug treatment programmes. (See Sections 4 and 5).

The following were some of the responses to our questions:

Pinewood is the most predominantly prescribed of the three brands of Methadone DTF. A contract was put out to tender by the health authorities and Pinewood were the only company who could meet the criteria outlined in the contract. These criteria included meeting the demands of supply and delivery. Cost was not specifically mentioned as a factor; no cost comparisons were discussed.

Regarding the many questions as to why Methadone DTF seemed to be more problematic than Physeptone (including 'holding' time, excessive sweating, weight gain, etc) the Consultants acknowledged there might be a problem with Methadone DTF and reported that they had asked Dr. Des Corrigan at the School of Pharmacy, Trinity College Dublin to carry out research on their behalf.⁶

On the issue of confidentiality, the Consultants stated that the rules are very clear and strict. Any breach of confidentiality can lead to dismissal. They stated, however, that clients often talked too openly in the waiting areas about their own personal problems, thus leading 'many' people to be aware of their personal situations.

On the subject of chemist contracts, the Consultants stated that they had not previously seen a contract and were quite surprised when UISCE showed them contracts from two different pharmacies. They said that they had no control over pharmacies and needed them involved as a way of coping with the increasing numbers seeking drug treatment. The same situation also applied to G.P.'s, i.e. the Consultants had no say in how G.P.s dealt with service users. UISCE explained that many people who had enjoyed a good relationship with clinic staff reported feeling isolated and vulnerable when trying to engage with their GP or community

⁵ Six case studies showing a range of different experiences within drug treatment services were documented (see Appendix 2).

⁶ To the best of our knowledge, this research is still ongoing.

pharmacy. UISCE also asked if there was any follow up on people who had moved on to GP treatment to see how they were getting on. The Consultants told UISCE that this was due to happen soon and that it would be carried out through group sessions rather than on a one-to-one basis.

The question of how people can make legitimate complaints was addressed by UISCE. The Consultants stated there was an existing structure through which clients could complain. This involved putting the complaint in writing and having it dealt with within the clinic. If the client was not satisfied with the outcome the complaint could be taken further. They did accept however that the complaints process took a lot of time and effort and that many clients were not articulate or literate enough to see it through. Although we did not get around to dealing with the case studies individually, the need for an accessible and realistic complaints procedure was present in each one. The Consultants felt however that sometimes complaints can be unjustified and that a 'filtering' system should be put in place if there were to be an advocate.

The issue of dual diagnosis was raised. It has been observed that there are people who have both a drug problem *and* a psychiatric problem. UISCE wanted to know if such people are being treated primarily for their drug problem or their psychiatric disorder. The Consultants accepted that this was a major problem and that it was difficult to deal with. Psychiatric hospitals are often reluctant to treat drug users who suffer from a mental illness and GP's often won't deal with drug users who also have a psychiatric problem.

UISCE brought to the Consultants' attention the need for a short stay residential or respite house where people could stabilise their drug use or deal with other traumatic issues. The Consultants agreed with the need for this and told us they had already obtained a 12 bed house in Cherry Orchard. The house is fully prepared but they were unable to recruit staff.

6.1 Follow up Meeting with Drug Treatment Service Users in Liberty Hall

A further public meeting was held in April 2001 to feedback to drug service users the responses from the consultants and to discuss complaints procedure. Over 100 service users attended from all over the city. The outcome of this meeting is reflected in Section 5 of this report. In addition, and in light of the emerging views of service users throughout this entire process, UISCE asked those attending the meeting to describe what their 'Ideal Treatment Centre' would look like. Their ideas and dreams for this centre are described in Section 8.

7. CONCLUSIONS AND RECOMMENDATIONS

Although many problems and issues have come to light during the course of this research the initial purpose was to look at Methadone DTF and whether or not it meets the needs of the people to whom it is prescribed. Unfortunately the evidence clearly shows that Methadone DTF is not adequately maintaining people who are opiate addicted. While they do go beyond the original scope of this report, the following recommendations are vital for the future good practice provision of drug treatment services. Therefore the following is a list of conclusions and recommendations emanating not only from the survey results but also from the ongoing developmental process which this research report initiated. UISCE are calling on the relevant drug treatment services to address these recommendations as a matter of urgency.

7.1 Effectiveness of Methadone DTF

88% of those surveyed felt that Methadone DTF was not as effective as Physeptone in staving off withdrawals. The impact of this has led to drug users relying on other forms of self-medication, i.e. an increase in alcohol, benzodiazepine, cocaine, and even heroin usage itself. Service users reported 'scoring' more heroin, being sick every day and having sleepless nights. It is clearly not in anyone's interests, neither drug treatment services nor service users themselves, to allow this situation to continue. The rationale behind prescribed opiate substitutes is to stabilise and establish some sense of normality back in drug users' lives. If Methadone DTF is not effective enough in dealing with opiate addiction, the resulting process of self medicating (which is leading to people gaining new addictions to other substances whilst engaging in criminal behaviour to raise money to feed these addictions) will have a catastrophic effect on drug service users, their families, and the community.

Recommendation 1: An urgent impetus be given to the research currently being conducted by Dr. Des Corrigan, Director of the School of Pharmacy, TCD to establish the scientific effectiveness of Methadone DTF.

Recommendation 2: While awaiting the results of the scientific effectiveness of Methadone DTF, clients should be allowed to choose the type of opiate substitute that they feel is most appropriate to them. This should be done in conjunction with their doctor or clinical team.

Recommendation 3: For those clients who describe themselves as having developed poly addictions since the introduction of the Methadone Protocol, resources need to be made available to assist them to detoxify and recover from these 'new' addictions.

7.2 Attitudes of 'Protocol' Staff

A large number of those who took part in this research process felt that they were 'treated' very badly by some professionals and staff within the drug treatment services. This included those who were attending GPs and community pharmacies. If people feel that they are being looked down on or feel their opinions are dismissed or ignored, this can quickly lead to resentment building up, with the result that many people become uncooperative in their drug treatment programme. Once again it is not in anyone's interest

to allow situations like this to build up. While UISCE recognises that this is a difficult area to comprehensively address (as attitudes and values are very deeply held by all individuals) nonetheless there are some recommendations which will help to address these problems.

Recommendation 4: Training in values and attitudes should be made available to all staff working with drug service users. This training should be culturally appropriate and specifically focus on the lives of drug users.

Recommendation 5: Adequate support structures need to be put in place for staff who work in drug treatment services. These services are, by their very nature, extremely stressful environments to work in and staff need to be supported and supervised to enable them to deal with difficult situations.

7.3 Use of Sanctions

Most services include Methadone sanctions as a necessary part of treatment. These sanctions include dose reductions, loss of privileges (i.e. loss of 'take-aways' at weekends), loss of support services within clinics (being put on the Methadone bus), etc. Those consulted during this research process say that they are often sanctioned for minor transgressions such as being late, being early, loitering, or giving 'cheek' to clinic staff. Clients report that they have no say in these decisions. The clients must accept this sanction without complaint even if they believe they are innocent.

Recommendation 6: UISCE is calling for the absolute abolishment of the use of methadone sanctions as a behavioural control mechanism. Motivational devices, which engage the cooperation of clients, should be explored as opposed to using punitive measures to coerce cooperation. UISCE recognises that drug treatment staff need to feel safe and secure in their work environment. In the case of violent behaviour, or where a member of staff is threatened in any way, then the Gardai should be called in to deal with this situation.

7.4 Use of Chemist/Client Contracts

As already stated, some clients obtain their Methadone DTF from chemists in the community and many people reported having bad experiences with their local chemists. The practice of forcing someone to sign a behavioural contract before allowing them to use the chemist to collect their medication is questionable. As drug users seem to be the only people who are asked to comply with these contracts, issues of discrimination and inequality can certainly be raised.

Recommendation 7: There is a moral obligation on the relevant health authorities to ensure that their patients are treated fairly and equitably. Although the Consultants did state that they had no control over these situations, UISCE strongly recommend that appropriate criteria for involving chemists in the Methadone protocol are developed and the situation monitored regularly to ensure that clients are not victimised further because of their drug addiction. These negotiations should take into account the amount of income that chemists derive from dispensing methadone to their customers. In

the event that chemists refuse to engage, clients should be allowed to re-establish their treatment programme with their original treatment centre.

7.5 Urinalysis

Urinalysis is the only method currently used to test an individual's drug consumption. As already stated many service users find urinalysis an embarrassing and humiliating experience. It is obvious that any procedure which causes this effect on an individual is not conducive to a healthy, trusting relationship – essential ingredients for an overall holistic approach to drug treatment and recovery.

Recommendation 8: UISCE recommend that other methods of establishing an individual's drug consumption should be investigated, e.g. hair or saliva analysis. Using either hair or saliva as a means of analysis would also minimise the possibility of deceptive behaviour. It would cut out the 'middle-man' role of those who have to supervise the collection of urines. The doctor or any other clinician could take hair or saliva samples directly from the client.

7.6 Privacy Issues

There is a feeling among drug service users that their personal information is circulating inappropriately among many professionals and other clients within their clinic setting. The system ensures that drug users lives become very public with many other agencies being aware of the fact that they are on a treatment programme without them ever having disclosed this to them. Many service users reported that their privacy had been violated when they discovered that information went beyond the person they had initially spoken to. This may be a necessary way of working within a clinical setting but this must be made clear to clients who can then decide what information to give and what to withhold. Additionally, many service users are reluctant to engage with counsellors because they originally understood a counselling relationship to be absolutely private and confidential. Subsequently some service users discovered that issues they discussed were talked about at other clinical meetings. While the very sensitive and core issues may not have been discussed, the fact that anything was taken out of their conversation and relayed in a more public space made people feel insecure about disclosing personal information.

Recommendation 9: If the drug treatment centre structure demands a team based approach, then it is vital that every service user is made aware of this.

Recommendation 10: UISCE recommends that drug treatment services explore the possibility of separating the counselling aspect of a client's drug treatment programme from other clinical aspects. This would help to develop good, healthy, trust based relationships between clients and counsellors.

Recommendation 11: General staff in drug treatment centres should make a concerted effort to ensure privacy at all times. For example breathalysing people in a private space will ensure that other clients will not know that a person has a drink (as well as a drug) problem.

7.7 Feelings of Powerlessness in Relation to Decisions on Drug Treatment

As already mentioned, the current drug treatment service is structured in such a way that it mitigates against client involvement in decision making processes. It stands to reason that if people feel they have a sense of control around their treatment programme they will respond more positively to treatment suggestions.

Clients reported that they felt completely powerless in every aspect of their drug treatment. This sense of powerlessness only served to further isolate and de-motivate. The relationship between doctor and patient is ideally a partnership where both parties need to work towards the same goal in order to ensure the best outcome.

Recommendation 12: UISCE would recommend that a more equal system of partnership between client and drug treatment services be developed. This partnership approach would mean that clients can discuss their particular needs with their doctor and a 'tailor-made' treatment programme be devised for them. For example the patient should be able to choose between detox and maintenance and they should be able to choose, within reason, the dose of methadone suited to their needs – whether that is an increase or a decrease. Furthermore, it is important to consider the times when people need to collect their medication as some people reported having to give up work because their clinic could not facilitate them.

Recommendation 13: It is evident that clients have not been involved in any aspect of the provision or evaluation of services. A system of clinic monitoring needs to be devised in order to ensure public accountability and good practice. Also clients' views of the services should be regularly ascertained in a manner that guarantees confidentiality in order to maximise good quality honest information and feedback.⁷

7.8 Complaints Procedure

With the exception of the current pilot project in City Clinic, there is no user-friendly complaints procedure in place within the drug treatment services. Respondents stated that if they complained about their treatment, they felt they would be victimised in some way. The system that deals with complaints at the moment is too complicated and has no safety net for clients who wish to use it. People are often afraid to make a complaint in case their Methadone is reduced. Clients need to have their complaints dealt with fairly quickly but the present system takes too long before there is any resolution.

Recommendation 14: There is a need for a simple, transparent complaints procedure which ensures client safety.

7.9 Dual Diagnosis

As already mentioned, the issue of Dual Diagnosis is one which is causing much distress to many drug service users. The stark reality is that many people who are turned away from psychiatric hospitals attempt to commit suicide (some succeed) while others are living lives of misery because they remain untreated. It is ironic that a person who is legally prescribed

⁷ Trinity Court currently have forums so that users of their service can have a voice. The Service Users Forum meets on a regular basis with the management team in Trinity Court. The Consultants are hoping that this practice will spread to other treatment centres and go some way towards meeting some of the recommendations in this report.

Methadone by a state health service can have their medication used against him/her when trying to avail of another state health service.

Recommendation 15: Senior level discussions need to take place urgently between the health authorities as to who is responsible for drug users who present to hospitals with psychiatric problems.

7.10 Respite Care

There is a declared need for residential short term respite for people on Methadone who need to further stabilise their drug use, for those who need to deal with a positive HIV and Hepatitis result, for drug users and their families who need to deal with certain issues away from their environment, and for drug users who are returning to the community having been in prison.

Recommendation 16: To make renewed and vigorous efforts to attract staff for the 12 bed unit proposed in Cherry Orchard.

Recommendation 17: To work with drug agencies to look creatively at respite options which might be available or which could be developed.

8. IDEAL TREATMENT CENTRE

As already mentioned, those drug service users who attended the last meeting in Liberty Hall were asked to describe their 'Ideal Treatment Centre'. As well as the recommendations already mentioned, clients felt the following areas were important to be addressed.

8.1 Assessment

There would be shorter waiting lists to facilitate the individual's readiness to stabilise his/her drug use.

People would have a choice as to whether they want to detox or go onto a maintenance programme on entry.

8.2 Counselling

Counsellors would be independent and not be part of the clinical team. This would ensure confidentiality as well as ensuring confidence in the client.

There would be no repercussions for divulging personal information such as drug usage.

There would be more counsellors available for crisis intervention.

Counselling would be offered seven days a week and continuity of individual counsellors would be assured as much as possible.

The client would dictate the agenda of each session.

8.3 Urinalysis

Other ways of determining opiate, cocaine, or benzodiazepine usage would be used. The terminology used in urinalysis, i.e. clean and dirty, would be changed to negative or positive.

8.4 Complaints

There would be an independent body or group to deal fairly and honestly with complaints from clients. This body would be made up of workers from outside agencies and Task Force representatives. Individuals who become part of this group would be given training in the language used by professionals and service users.

8.5 Additional Aspects

Clients would be given options to test for Hepatitis and HIV. They would be made fully aware of the implications of testing as well as receiving pre- and post test counselling. Test results would be confidential and given tactfully and compassionately to clients. There would be nutrition and general health classes particularly for people who are HIV or Hepatitis positive.

Patients would be informed of all facilities in the clinic and given the name of a key worker who they could contact if needed. There would be adequate staff to meet the needs of clients. Each clinic would have its own dentist for service users.

**Appendix 1
(Questionnaire)**

UISCE SURVEY ---METHADONE

AGE _____years

SEX Male Female

How long have you been taking Methadone? _____years

Can you tell us what brand of Methadone you are getting?

- Glaxo-Phymet
- Pinewood-Pinadone
- Martindale
- Don't Know

IF ON METHADONE FOR MORE THAN TWO YEARS:

Compared to the old brown methadone (Physeptone), do you think the new green Methadone is:

- Better
- The Same
- Not as good

What would you say is the main difference for you,
between green and brown methadone?

- The Taste
- The Texture
- The Amount of Liquid
- Holds me Longer
- The Buzz
- Warmth/Glow

Anything Else?

Since the introduction of green Methadone about three years ago, can you tell us whether your use of the following drugs has increased, decreased, or stayed the same.

Alcohol:	Increased	Decreased	The Same
Benzo's:	Increased	Decreased	The Same
Cocaine:	Increased	Decreased	The Same
Hash:	Increased	Decreased	The Same
Heroin:	Increased	Decreased	The Same
Tri-Cyclics:	Increased	Decreased	The Same
Other _____:	Increased	Decreased	The Same

Appendix 2

Case Studies⁸

Case Study 1

“I was released from James’s Hospital after I injected contaminated heroin two weeks previously. I was on 120mls of Methadone when I was discharged. I was sent to Trinity Court where I hoped to be taken on in the fourth floor clinic. Instead I was taken on in the first floor⁹ which I knew was a bad start. At this stage I was still very sick, weak, and in a lot of pain. They started me off on 50mls of Methadone and said they would bring me up to a higher dose if my urines got clean, which I find ridiculous because there is no need to increase the dose if you can clean your urines on 50mls.

However considering the condition I was in, 50 mls was not enough. I went into severe withdrawals which I could only relieve by taking heroin or extra Methadone and I told my doctor about this. The response was to reduce my dose which only made matters worse as I was now completely unable to manage on the dose they were giving me. I went in to see the doctor again to ask if they were aware of where I came from and of my condition. He made it clear they were well informed of my background and that it made no difference.

The next thing he did was to cut my dose even further. At this stage I realised I was going nowhere and it was only a matter of time before I was cut off. At this stage I was falling apart and I was back to square one. A few days later I was called into the doctors and I was told I was knocked off and put on the Night Train.¹⁰ Now I am back to zero again – using, abusing, and going downhill fast.

I feel that from day one I was never given a chance. It seems as if they just made their minds up that I wasn’t worth the trouble and gave me no help whatsoever. I was in and out the other side within the space of three weeks”.

Case Study 2

John was with a Health Board satellite clinic for three years. He was on a Methadone maintenance programme of 65ml per day and Zimmovane¹¹ at night. He was using Valium which he purchased from the streets. He informed his doctor of this a long time ago. John

⁸ All names have been changed.

⁹ Two separate treatment programmes operate in the National Drug Treatment Board. Service users often differentiate these programmes by referring to them as the “Ground Floor” (or “First Floor”) and the “Fourth Floor”.

¹⁰ The Night Train is the late afternoon programme in Trinity Court which only prescribes 20mls and assumes that people are also using heroin.

¹¹ Traditionally prescribed as a sleeping tablet.

said he never had any particular problems with the clinic before. His problems began in the middle of August 2000.

Week 1:

Monday: John gave a urine which was supervised by a G.A.¹² The G.A. told him it was clean as it was 'tested on the spot'. The doctor (who was a stand in for his regular doctor) called John and informed him that his urine had heroin in it. John's take-away was stopped immediately. John claims his urine had no heroin in it as he had not used.

Tuesday: John went to the clinic for his Methadone, got his medicine and left.

Wednesday: John went to the clinic for his Methadone, saw his own doctor and was given back his take-aways.

Week 2:

John gave a urine. It was again 'tested on the spot'. The G.A. told John that it was clean. Again the doctor (who was a stand in) said there was a slight bit of heroin in it. John went to the G.A. and told him what was happening. The G.A. rang the doctor and told him he believed the urine was clean. John's take-aways were stopped again.

The following day John's take-aways were given back by his own doctor. He had also gone to see a solicitor about the treatment he was receiving in the clinic. A nurse who dispenses the Methadone told John he had 12 months of clean urines.

Week 3:

Monday: John gave a urine. It was clean and he got his take-aways and left.

Wednesday: John wasn't due to go to the clinic himself but he went in with a long time friend. John's doctor told John to leave. He left. On Thursday he went to the clinic, gave a urine and he was told it was clean. He was then called in to see his doctor and was told he was having no more take-aways. John asked why and was told that as he was coming to the clinic so often at non designated times with friends, it was clear that he *could* attend every day himself to collect his Methadone. John explained how awkward it would be and he was told he should have thought of that before. John began to get verbally aggressive and tried to stick up for himself. He also pointed out the mistakes of his urine testing. He was told to come back the next day. A week or two later he came back to state he was on the Methadone bus, using heroin every day, robbing daily and having problems with his partner. He said he had met with the 'top man' (a Consultant) and was reassured by him that his case would be dealt with by him. The Consultant made arrangements to see him in 10 days. John had hopes of a stabilised lifestyle.

Case Study 3

"I have been years on maintenance. I was going to Pearse Street even as far back as when Jervis Street treated drug users. I was controlled for years. I say controlled because of the facts. When I was on Physeptone I was on 100mls. When they changed to green I was put up to 150mls. Over the years I was grand on the brown. Every so often I would feel a bit sick but it did not last too long so I never bothered having my dose raised while I was on the brown. But the green is another story. I am more often sick on this than well. It makes you very frustrated. The only way I can describe it is there is something missing but you

¹² GA is a General Assistant in a Clinic; usually they have door and urine supervision responsibilities.

don't know what it is. I was never on tablets but I even got myself into trouble with them. I think it was because I was looking for what I was missing. I am trying to stay off the tablets now. I am just taking them to sleep. I take two at night after over a year or more taking 10 to 15 a day. I am back stable now. I was scripted out to a doctor about six months ago. At first I was delighted but now I hate it. The doctor is treating me like a child. I have two grandchildren. I am not a child. I have been an addict for many years now. After being so controlled I can honestly say I am in control of myself. I know when I am in danger. I can pull myself together when I need to. The chemist I go to is always leaving me short at least 20mls. When it first happened I was explaining that by measuring out each dose up to 60mls they were not allowing for what was left in the measure. I said take 80mls out of the 500mls bottle, give me 60mls and seal the bottle. That would make it exactly right. The chemist fellow said to me that there was no more than 500mls in the 500mls bottle. I said if it was a little over it was to allow for spillage and for measuring with a small cup and it was better to have more than less. The next time I was left short it was two weeks later and when I complained they gave me a contract to sign".

Case Study 4

On his release from prison, Mark went on a Methadone programme in his community. The mother of his children is also a heroin addict. He felt he was doing fine and had gained access to see his children every weekend. Mark did not have any problems and was working on and off for about two years. In the first year things started to go wrong for him. His partner was charged with Grievous Bodily Harm and got a three year sentence. She is now in Mountjoy. Both children are now in the custody of their maternal grandparents. They refused Mark access to see his children and when he tried to get the family home in order to get full access of his children the council refused him as he had not lived there for the last two years.

Mark got very depressed and was drinking a lot. He also had a few run-ins with the clinic. He felt his Methadone was not holding him. When he asked his doctor to up his dose he was refused and was told drink was the reason his Methadone was not holding him. Five months ago Mark started using heroin again as he was very stressed. He gave three dirty urines over a period of six weeks. His doctor then told him he was cutting his Methadone down to 20mls a day within a week, that was 10mls per day. This was to teach him a lesson. The doctor will review his case in two months. Mark has to use heroin every day as he was dropped from 80mls to 20mls daily and was experiencing severe methadone withdrawals.

Within those two months he was spending up to £100 per day on heroin. This caused him a lot of problems with his family and also with his community. He has built up a debt of £2000 and feels that everything he worked for in the past two years was destroyed in two months. He got back on his programme two weeks before this interview but feels very bitter and angry that the doctor had such power over his life.

Case Study 5:

“Before the Protocol I had been on with a GP. I was prescribed three Valium 5mg, two Rohypnol¹³ and 150mls of Physeptone per day. I visited the doctor once a week and gave my urine with the door open. I got a week’s script at a time until the protocol. First I went to Trinity Court and then to the fourth floor¹⁴ and was given 60mgs per day. I collected once a week. The change from brown to green was extremely difficult. Not just the volume of liquid. My chest cough got worse and irritating. If I could have collected my Methadone earlier I would have; it wasn’t holding me. With the brown I could wait a couple of hours but with the green I needed it immediately. Phy-meth is better. Both Pinewood and Martindale changes from batch to batch and chemist to chemist. There is no consistency. Pinewood and Martindale don’t register. They are too gradual. No effect and they are shorter acting. The green didn’t hold me. I was increased to 80mls and had to collect twice weekly. I was buying more on the street and was actually taking 90mls every day. I started taking Valium more often. I moved to a clinic in Rathmines and had to attend in the evening twice a week. Due to the complaints of residents the clinic switched to mornings – 7.30am to 8.30am. I was cut down to 70mls, then put up to 80mls, then put back down to 70mls. My father went to the doctor and I was upped again to 80mls and then eventually to 90mls. After three months I was told, “Stop taking Valium and start taking Zimmovane”. The doctor gave me more Zimmos and more Methadone. Shortly after I was cut by 20mls for giving a “dirty” urine. I started taking Valium again and scoring gear to compensate.

I wanted to go to the hospital for a break from the pressure but I got no assistance from the clinic. I went to another GP and told him I was afraid of having a breakdown. The only referral he would give was for a detox but I wanted respite. The doctor said there are plenty of services for users but he didn’t know of any. Since then my Dad spoke to the doctor. I was upped to 90mls on condition of clean urines. This meant no opiates. Valium is okay and I have to give two urines a week. I have very little say in my life as regards health issues. Someone with a minor health problem would get better treatment. All of my symptoms are dismissed. Everything is put down to drug taking. When I am talking to the doctor people in the waiting room can hear. I feel I can’t speak to the doctor about treatment or anything else. A patient has to be there on time but the doctor doesn’t. I am afraid to go to the toilet before going to the doctor. If I can’t give a sample it is marked as dirty.

I had a good relationship with my GP. He treated me like a person. I missed that. If there were problems with the chemist he would sort them out, tell you about new forms of treatment, ask your opinion on what can be done and ask about your general health. When I was with him I had anonymity. I was going to a doctor and a chemist in an area where I didn’t live. Only my friends knew I was on Phy. Now everybody in the area knows what is going on. Neighbours stare at me when I am drinking my methadone in the chemist. I have no privacy at all. The chemist doesn’t like me drinking it there either.

The dole suggested I go on Disability Allowance. They said that unless I stopped taking Methadone I would be considered unfit for work. I am afraid to stop taking Methadone in case I relapse and couldn’t get back on a clinic”.

¹³ Traditionally prescribed as a sleeping tablet.

¹⁴A programme located in the National Drug Treatment Board.

Case Study 6:

“I was on Pearse Street and was on a maintenance of 40mgs brown. I was tried out on five or six anti-depressants – none of which worked. I stayed on that for five years and was upped to 60mls of green. Two years ago I started taking benzos. They helped me cope; it wasn't for a hit. The benzos kept turning up in the urine. With brown I was able to hold it together. The green was not as satisfying. The clinic had cut me 10mls because of the benzos. I'd clean up for a week or two; then the methadone would be upped. Then benzos would turn up again and I would be cut again. Seven or eight months ago it was suggested I go to Beaumont to detox from benzos. I had too many personal problems and felt I wasn't ready. But eight weeks ago I went to Beaumont for two and a half weeks. I was put on four Ativan¹⁵ for five days and then cut to three and then cut to one pill every three days. Three days later I was discharged. They thought I had done well but I did not feel strong enough. I felt very vulnerable. I knew I had to face personal circumstances again and I was not prepared. They didn't prepare me for coming out. When I went into Beaumont I was on four take-aways a week and was on the first card¹⁶. I thought if I fucked up I would be on a first warning. After a week they stopped giving Zimmovane to everyone except those on combination therapy. I was getting two Zimmovane per night from my GP since 1997 and the clinic put me on them in 1999. I refused to take my Methadone and asked to see Dr. (name). He offered to raise my Methadone which I refused. He wouldn't give me Zimmovane and he offered me Melleril¹⁷ which I also refused. The next day I tested positive for benzos and was given a red card. I was told to clean up my act in three weeks or else. I feel I need to be prescribed a small amount of benzos. I really can't function without them. I am very anxious and worried about the future. If I am put on the night train I feel I might start using gear again or worse.

¹⁵ Traditionally prescribed for anxiety.

¹⁶ Some drug treatment clinics operate a card warning system, yellow and red.

¹⁷ Traditionally prescribed for psychoses.