HOLISTIC CARE AND DRUG TREATMENT OF ADDICTS WITHIN AN IRISH CONTEXT

Is the Methadone Maintenance Model Enough?

A dissertation submitted to the Human Development Department of St. Patrick’s College, Drumcondra, Dublin 9, in partial fulfilment of the requirements for the degree of Bachelor of Arts.

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GLOSSARY OF TERMS

Addiction

Type ‘addiction’ into the Google search engine and you will be presented with an explanation that addiction is ‘the fact or condition of being addicted to a particular substance, thing, or activity’ or ‘the state of being enslaved to a habit or practice or to something that is psychologically or physically habit-forming’.

Heroin

Street name – gear

The opium poppy, known by the ancient Sumerians as ‘the flower of joy’ is the natural plant of which heroin derives. Grown on land stretching across Southern Asia, it begins its journey in the soil, before its sap is collected and transported to a refinery where it is boiled with lime until a white band of morphine appears. This is skimmed off, boiled again with ammonia, filtered and boiled again to reduce it to a brown paste. It is then moulded into pots and allowed dried in the sun before it becomes a morphine base. This base can now be smoked in a pipe.1 In 1874, an English chemist C.R. Wright working at St Mary’s Hospital Medical School in London, accidently boiled this morphine base with a chemical acetic anhydride (a liquid used in making synthetic fibres) hence heroin was created (Navarro, 2007). Heroin used for human consumption today goes through a further process of mixing, filtering and purifying before its distribution around the globe.

Heroin was first marketed in 1897 by Bayer as a non-addictive morphine substitute and cough medicine for children.2 It is worth noting that farmers who grow poppy seeds are paid $600 for their crop. By the time it reaches our communities, it is estimated that the profit from the heroin trade increases in value 5,000 times.3 Today, according to the UNODC World Drug Report 2012 Ireland has one of the highest street prices for heroin in Europe; its street value being €145 per gram.
**Methadone**

Street name – phy (Physeptone)

In contrast to heroin, methadone’s journey begins in a laboratory. During the early 1880s, scientists were on a mission to discover a synthetic medicine that would reduce fever and eliminate pain. A breakthrough in scientific research led to the discovery of Pethidin (Dolantin), an effective opiate analgesic. By 1939, development in research being conducted at the pharmaceutical laboratories of the I.G. Farbenkonzern, Germany, led scientists to synthesise the compound [2-dimethylamino-4, 4-diphenytheptanon-(5)], consequently numbered Va 10820 (Barceloux, 2012, Gerlach, 2004). The compound caused side effects, so as a precaution it was decided not to produce it for commercial production. After WWII, all German research was confiscated by the U.S. Department of Commerce Intelligence, ‘investigated by a Technical Industrial Committee of the US Department of State, and then brought to the United States’ (Gerlach, 2004). In 1947 the Council on Pharmacy and Chemistry in the American Medical association renamed the compound Va 10820 - ‘methadone’. Despite research suggesting the fatal implications of methadone use, it was released for commercial production.

Currently in Ireland there is no charge for methadone supplied to patients participating in the Methadone Treatment Scheme. However, according to a report by Jerome Reilly in The Independent newspaper it is calculated that ‘it costs [the government] €7,034 per patient each year to provide methadone and clinical support’ (2010).
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**GLOSSARY OF TERMS**

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*The most authentic thing about us is our capacity to create, to overcome, to endure, to transform, to love and to be greater than our suffering.*

Ben Okri
INTRODUCTION

Heroin is a major contributor to social problems in Ireland. Addiction to this drug impairs personal, social and economic development by not only demoralising the individual using the drug, but by causing a ripple of devastation to their families, throughout communities and the wider society. Research suggests that of all the illicit drugs widely used within Irish society, such as cannabis, ecstasy, amphetamines and cocaine, it is heroin that poses the highest risk to the individual and the general public (O’ Gorman, 1998, MQI, 2006, NCAD, 2005). I would agree with this statement. I would also propose that treatment for heroin addiction is the most controversial. Addiction to other drugs, as mentioned, is generally treated by counselling or psychotherapy, whereas addiction to the opiate heroin is treated with another opiate methadone. I became aware of this when my teenage daughter became addicted to heroin. Heroin was alien territory to me so the news came as a great shock. My initial response was to seek advice from a local addiction service. Their response was to start methadone treatment to curb my daughter’s craving for heroin and eliminate the need for her to support her heroin habit. After meeting with a specialised Doctor in Trinity Court on Pierce Street, treatment soon started. I made it very clear this was to be a short term solution, and it was. After three months of methadone treatment and successive sessions of counselling my daughter recovered from her heroin addiction. In hindsight, I believe we were the lucky ones, in that the treatment was effective, but I feel this was because of my insistence of a short programme and my daughter’s determination to overcome her addiction. The experience of having to go to a grubby, unwelcoming environment is not one I would wish on anyone. However,
it is through this experience and through dialogue with other service users that I became aware of the tribulations of methadone: ‘it gets into your bones’ one said, ‘it makes me sweat’, said another, the stories went on. These stories inspired me to get involved with a group of local people who were setting up a local addiction service that would advise and support addicted individuals and their families. It is my community work that exposed me to the full extent of the methadone problem. Time and time again I’ve heard that when service users asked their Doctor for support to come off methadone, the answer is ‘no – you’re not ready’. These people, who are left on methadone for years, are being treated like automatons. It is as if the methadone programme is designed to work for every heroin addict with little regard for the person’s sense of agency, their autonomy or concern for the holistic well-fare of the addict.

One key question that this thesis seeks to explore is why does methadone maintenance as a systematic medical intervention not work? In other words, why does it not respond to all or some of the goals of overcoming addiction? To try to answer this question I will take a multi disciplinary approach to investigating the varying factors that shaped methadone treatment in Ireland.

In chapter I propose to give an overview of the drugs crisis in Ireland and elucidate the two main areas of concern in relation to heroin drug use: the social aspect and the harm to the individual using the drug. Then I will trace the history of heroin in Ireland highlighting the key moments that changed Irish drugs culture and shaped Irish drugs policy. In Chapter II will explain how methadone was considered a solution to heroin addiction. Then I hope to highlight the pros and cons of methadone
treatment in an attempt to see if it works, offering my personal views, the voice of service users and staff who work within the methadone clinics. Then I will explore the model of treatment methadone maintenance favours setting this model within a historical framework to trace the shift in how one views addiction. In chapter III I will conclude my thesis by demonstrating the changes that are currently happening within Irish policy and community development, changes that promote a more holistic model of care for the addicted individual within a social context.
CHAPTER I - THE IRISH CONTEXT

An overview of the drugs crisis in Ireland

To illuminate the extent of the heroin problem in Ireland I will first turn to an interview conducted by journalist Una Mullally, where a recovering addict stated;

With heroin you’re only talking about a hundred pound a day. Three bags would do anyone a day, and if anyone says they’re using more than three bags a day, that’s ridiculous; they don’t need to use it. You need one for the morning – that would cover you for the whole morning – one for the afternoon and then one for the night. You’re brand new then (2011).

If we take the interviewee’s word as a median for daily heroin use, the weekly cost of a heroin habit can amount to €700. This is a substantial amount of money to spend on drugs, and unless one is financially comfortable, the heroin habit compels the individual to engage in criminal activity to support their habit. This criminal activity may involve bag snatching, hold-up’s, shop lifting and any other means by which to get cash quickly. I’ve heard the expression ‘you’d rob yer Granny’ quite often. If you weren’t good at stealing, that is, if you hadn’t got the nerve or you were consistently getting caught, the other option was to prostitute your body. The longing and craving for heroin is so strong that it overcomes any of the addicts moral deliberation of their actions.

However, this drug related criminal activity is almost in the shadow of a more grave concern – the spread of HIV among IDUs. Of the 14,452 heroin users in Ireland (NACD: 2005) approximately two thirds are IDUs (Moran, O’Brien, Dillon, Farrell, Mayock, 2001). This raises concern over behaviour associated with injection drug use and is an issue that is well researched and demonstrates that sharing injection equipment increases the risk of spreading HIV and other hepatitis infections, thus
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contributing to premature death (Crofts et al, 1993; Crofts & Aiken, 1997; WHO, Smyth BP, Keenan E and O’Connor JJ, 1998).

Consequently, tackling the heroin crisis is two fold – 1) to reduce criminal activity associated with problematic drug misuse and 2) to decrease the harms associated with intravenous drug use. These were the key issues that were considered and were the gateway that allowed methadone treatment entry as a response to combating drug related issues. However, Aileen O’Gorman, in her study of policy responses to illicit drug use in Ireland, states that this treatment ‘tended to focus on the medical treatment of the individual, rather than tackling the wider social and economic issues’ (1998, 156). While this treatment was effective in addressing the issues associated with heroin use, these issues seem to be its primary focus.

The history of heroin use in Ireland

1960 – 1986

According to Dean et al. ‘there was little empirical evidence of serious drug abuse in Dublin during the 1960s’ (1987, 1). Drug misuse was confined to a small group of individuals who were known to the Gardai. In 1969 the National Drug Advisory and Treatment Centre (Jervis Street Drug Centre) was established to provide detoxification from alcohol and drugs. According to the same report, by the 1970s ‘there were now 940 persons abusing drugs’ due to an increase in the availability of amphetamines, barbiturates and synthetic opiates, Diconal and Palfium (1987, 1). By 1979 an influx of heroin into Ireland, following the fall of the Shah in Iran, and from Pakistan in more recent years, changed Irish drug culture drastically (1987, 2). By the
late 70s Coolmine Therapeutic Community opened, which promoted the total abstinence approach to treating alcohol and drugs that was being used in Jervis Street Drug Centre. Garda reports documented an increase in possession of heroin and crime related to the drug. The number of patients attending Jervis Street Drug Centre for heroin treatment increased from 294 in 1979 to 1,314 in 1983. However, many of the addicts who finished detoxification reverted back to misusing drugs. This was because the treatment of heroin addiction tended to focus on the symptoms and not the root of the addiction. Treatment was carried out in isolation, away from the drug environment, which meant that when the recovering addict returned to the environment in which they were using, there were ‘triggers’ that would reengage them in heroin use. Researchers and health care workers realised this and began to shift focus from the micro level of drug experience to include the macro level of social structures in the hope of offering socio-cultural explanations as to why treatment was unsuccessful, and develop new treatment strategies. This shift is reflective of Urie Bronfenbrenner’s (1917 – 2005) ecological systems theory which stated that there are many factors that contribute and influence one’s psychological development and behaviour. However, this shift was slow in its implementation, I will discuss why in the section ‘1986 – 1996’. The people who were living in the drug environment, who were not addicts became frustrated with the level of drug activity and took matters into their own hands.

Community response
Before I discuss the government response, I want to briefly look at the community response to the drug crisis. The surge of heroin was concentrated within certain neighbourhoods in Dublin’s inner city that had ‘high level of unemployment, poor housing, lack of recreational facilities and low educational attainments’ (O’Kelly et al. 1989, 1). These became places where drug dealing and drug activity were visible. This activity instilled fear within the people living in these communities. Barry Cullen states that these areas were -

least desirable local authority flat complexes in the inner city whose local economy has declined and failed. They are areas that have been badly neglected in the share out of institutional resources for social and economic development (16).

Due to a sense of alienation and a lack of immediate response from authorities, local communities responded by setting up initiatives to reduce drug activity in their areas. While some community responses had a somewhat vigilante motif they were successful in stopping drug dealers entering the area. The Concerned Parents Against Drugs (CPAD) movement and (the late) TD Tony Gregory were instrumental in highlighting how they believed that the Garda did little to prevent crime in the area as their priority was to contain the drugs within the disadvantaged areas of Dublin. However, despite their conflicting issues with the law, these activists were successful in tackling illicit drug misuse in their communities and highlighting the problem of the lack of education and support for drug addicts and their families.

1986 - 1996

In the 1980s the spread of problematic drug use, mainly regarding the use of heroin; the high prevalence of HIV and hepatitis infections, and the criminal activity
associated with injecting drug users, prompted societal institutions to intervene and develop a more pragmatic approach in treating opiate users (O’Gorman, 1998). The initial response from policy makers in dealing with the surge of heroin was to effectively deal with the organised criminal distribution of drugs, while treatment centres adapted a total abstention approach, as favoured by the disease model, to combat heroin mis-use. These approaches were ineffective and had little impact in controlling the heroin crisis as there was uncertainty over whether the key issues of illicit drug use was a health issue to be managed by health care professionals, or a criminal matter to be dealt with by the justice system. There seemed to be a ‘passing of the buck’ between the justice and health care systems. Nonetheless, policy responses veered towards health care and embraced the notion that addiction is a medical condition. Shane Butler of Trinity College Dublin argues that in Ireland political leaders have not participated in debate about methadone or other harm reduction measures, and so the Department of Health seems to have undisputed dominance in this arena. He states

it can be argued that the civil servants who have responsibility in this area are so caught up in the daily administration of a wide range of health services that they lack the time, detachment, and perhaps the expertise, to become involved in formal debate on the subtleties of drug issues (Butler, 1991, p 11).

In turn, the Department of Health trusts psychiatrists and their research supporting the disease model, particularly in the efficacy of methadone (O’Brien, 2007, 43). Dr. Tom O’Brien draws on political theorist Antonio Gramsci to highlight how ‘discourses like biomedicine are maintained through hegemony over medical practice, psychology and psychiatry’ (2007, 44). In the section ‘1996- 2009’ I will speak more
about the significance of this. When this happens the holistic approach to treating a person is dominated by the practice of medicine as a means of fixing every ailment.

**Government response**

In 1988 a newly formed committee introduced *The Government Strategy to Prevent Drug Misuse*. There were a number of key stakeholders in the policy process; Trinity Court, Eastern Health Board (EHB), GPs, Pharmacists, Department of Health, Voluntary drug treatment sector and politicians (Butler, 1993). The aim of the new strategy was to shift from the traditional abstinence philosophy to one of harm reduction. Irish drugs policy had avoided the subject of harm reduction for some time as the Irish government had an unrealistic view of illicit drug use. The strategy called for the EHB to focus more on the health and well-being of drug users, with particular emphasis on AIDS and HIV awareness among IDUs. This instigated the launch of a needle exchange clinic where IDUs could exchange their used needles for clean ones. This was to reduce the risk of sharing needles, and also ensured needles were discarded in a safe manner. A major shift in Irish drugs policy saw the introduction of the *1998 Methadone Protocol* which allowed specially trained GPs to prescribe methadone from their private clinics. Despite the conflict of interests between these stakeholders, mainly being between total abstinence and harm reduction approaches and ambivalence in service delivery, they all agreed ‘the value of methadone prescribing as a means of stabilizing opiate-dependent drug users’ (O’Gorman, 1993, 7). The introduction of a *central treatment list* of patients was devised to avoid multiple prescriptions of methadone.
Publication of these policies was largely covert with little public debate, primarily due to conservative views towards drug addiction in Ireland (Butler and Mayock, 2005). Methadone maintenance and needle exchange schemes had a tendency to create a moral panic, which I believe, is created by the media. There is no regulation in Ireland on what newspapers can print and so the media portray Irish drugs culture as violent and negative. This creates a moral panic and an injurious view of drug addicts and results in the public voting for politicians who give us policies we want, not what we need. One example of ineffective Irish policy is there is no needle exchange in the Irish prisons, despite the fact that it is widely know that there is an addiction problem within the prison services. We, as a society, don’t seem to care if prisoners, or the larger drug population, get HIV. This lack of understanding about drug addiction and insensitivity towards addicts creates harmful stigmatisation which undermines and degrades the addicted person’s existence. I will discuss this more in the next chapter.

Nevertheless, negative reactions towards drug users are present in all levels of society. Yet it is most alarming that discrimination is rampant within the medical profession that treat addicts and professionals who make decisions around drug policy. This is captured at the 1989 Irish Medical Organisations [IMOs] annual general meeting, when a discussion about methadone maintenance and the treatment of heroin addicts provoked a political representative to divulge that

It was time we spoke about the vast majority of people who are not perverts or addicts but who were paying their taxes and rearing their children and could not get treatment. There were people who needed hip replacements, immobile by day, sleepless by night, who might have to wait three years for their
operation. These were honest to God people in our community who had to do without because of the allocation to these people (Butler, 2002).

‘These people’ are the addicts who, because of their addiction and the measures they go to support it, are stigmatised as ‘perverts’. The new strategy proposed to address these negative attitudes towards addicts by designing educational and training programmes at community and statutory level.

1996-2009

By 1996 the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* initiated and funded the establishment of Local Drug Task Forces (LDTFs) in eleven disadvantages area’s of Dublin that had a high rate of substance misuse. These communities are North Inner City, South Inner City, Ballyfermot, Ballymun, Blanchardstown, Clondalkin, Coolock, Crumlin, Finglas/Cabra and Tallaght (1996, 10). The primary strategic aim of the LDTFs was ‘to build and maintain a working Task Force structure facilitating all stakeholders to participate in the development of responses to local drug-related issues’ (1996, 11). The implementation of the *National Drugs Strategy 2001 - 2008* (NDS) planned to achieve the aims of the 1996 report under the four pillars of 1) supply reduction, 2) prevention (education and awareness), 3) treatment (rehabilitation) and 4) research.

Interestingly, by this time, this attracted another key stakeholder; the Pharmaceutical Society of Ireland. I want to recall what Butler highlighted in section ‘1986 – 1996’, and develop on O’Brien’s concerns regarding the issues of how ‘discourses like biomedicine are maintained through hegemony…’ (2007, 44). Dr. Tom O’ Brien states that the pharmaceutical industry has close links with psychiatry,
which promotes the disease model in treating addiction, and leads to ‘the medicalisation of everyday problems… expand[ing] the market for pharmaceutical drugs’ (2007, 45). His research examines methadone treatment and states:

Access to addiction treatment data or to participants in treatment is strictly controlled by psychiatrists who have a vested interest in the outcomes of any research in this area. Evidence based medicine (EBM) is the dominant scientific methodology employed to examine addiction treatment and is central to the continued dominance of the biomedical discourse in the treatment of addiction. Studies are generally designed, monitored and controlled by a consultant psychiatrist or clinical psychologist and are published in prominent medical journals (2007, 45).

This dominance of the biomedical discourse within drug treatment hinders a move towards a holistic model of treatment because its primary focus is on best cost production and not in the welfare of the patient. It would appear that the underlying concern in dealing with opiate addiction is tied up with Charles Taylor’s concept of ‘instrumental reason’ from his work *Three Malaises of Modernity*. Taylor’s instrumental reason highlights how production has come to dictate so many realms of human existence. Medicine is a big business; pharmaceutical and medical industries promote medical interventions that will cure almost everything. Their priority is not with the holistic welfare of the individual, it is with making money. This would be reflected in the fact that with the implementation of the four pillars mentioned, there was an emphasis on the pillars medical treatment and supply reduction.

Having discussed the heroin problem and the responses to tackling this crisis, I will now attempt to explain how methadone was considered a solution to heroin addiction before laying out the pros and cons of methadone treatment in Ireland in an attempt to
see if it works. To do this I will offer my personal views, the subjective voice of service users and the staff who work within the methadone clinics.

**Methadone as a perceived panacea for heroin addiction**

In 1964 the Methadone Maintenance Research Programme, pioneered by Doctors Vincent Dole and his wife Marie Nyswander, was initiated as a safe and effective medical response to stabilise heroin users and prevent them from engaging in criminal activity (Dole, 1988). Their research indicated that ‘methadone had euphoric properties and can repress the physical signs of opiate dependency’ (Barceloux, 2012, 579). Treatment began in the metabolic ward of the Rockefeller University Hospital New York on six patients. The results were ‘sufficiently impressive to justify the trial of maintenance treatment’ (Dole, Nyswander 1967), thus the distribution of methadone, as a substitute for heroin, was set in motion. The reason why this treatment was considered successful was that methadone (unlike heroin and morphine) was absorbed into bodily tissues (mainly the liver) and was released slowly. This meant that the longing for heroin was overcome by a daily oral treatment of methadone, consequently reducing the risks (as mentioned above) that go hand in hand with heroin use.

**Is Methadone successful in its treatment of heroin use?**

Methadone treatment, which was marketed as a ‘safe and effective medical response’, seemed to be a redeemer for all. If one measures its success against the aims of its treatment, that is to reduce criminal activity and harm to the individual, it seems to be successful.
For the heroin user it was a treatment that alleviated the full-time task of supporting their habit. In Marie Lawless and Gemma Cox’s research conducted with staff and service users at Merchants Quay Ireland (MQI) a staff member stated ‘Being a chaotic drug user is a total full-time job. It's a very pressurised, stressful job that takes a large amount of ingenuity, intelligence with resources and time management’ (2002, 119). Methadone Treatment was a way of stabilising the individual and reducing the risks associated with their drug use.

For law enforcers it also reduced criminal activity related to drug mis-use. This has also been documented in Lawless and Cox’s study. In an interview with a 33 year-old female service user, she stated;

Meself and that girl we shoplifted all the time to keep our habit, but we never robbed anybody. I know robbing is robbing but the way I used to look at it we weren't robbing from poor people or people like ourselves. Just to keep the habit going, we used to go into town in the morning and you'd be dying sick from not having anything. When you 're sick you 're off form and are watching around ye and you 'd get paranoid and you 'd be getting yourself caught some times. But I don't need to do that anymore, I wouldn't be able to rob a thing now. At least now in the morning you can get up and get your phy [methadone] and I don't need to go out and shoplift. At that time I had to shoplift to get drugs or else I'd be sick for the whole day (2002, 122).

Furthermore, for health care workers it reduced the harms associated with the behaviours of intravenous drug use. As methadone is orally transmitted it reduces the risks associated with IDU. Another goal of methadone is to stabilise the heroin addict so they may reintegrate back into society via training or work placement. This is captured by another service user, a 35 year-old female FAS participant, who disclosed;

I done a year of FAS in another place and this is me second year. I found the two of them great. The first one I benefited a lot. It's not that they trained me,
but they helped me stay off. It helped me get through. When you're tryin' to come off drugs and you've have nothin' to do and you're bored, you tend to go to X and you just use like everybody else is, cause that's what your doin' at that time. But if you've something to get up for every mornin' even if it's just a FAS course, it s somethin' that keeps you together, do ye know what I mean (2002, 120).

However, many, including myself, would question does replacing an illegal opiate with a legal opiate really deal with the issue of overcoming addiction? It would appear that heroin addicts who entered into MMTs in the 1990s, done so to relieve the pain and suffering of their drug mis-use. After many years (in some cases over 20 years) service users were still receiving methadone treatment with little support from their Doctors to tackle the underlying causes of their addiction. This is captured by a 41 year old female service user who stated;

When I first got onto a maintenance of phy [methadone] I thought it was a God send and now twelve years later it was the sorriest thing I ever did (2002, 123).

This is echoed in another 35 year old female client’s testimony;

When I first went on methadone I thought it was a very good idea, I had already being addicted to heroin for about ten years, and when I got my methadone doctor I thought he had saved me life. I didn't have to go out to score anymore and to a point that was very true. But this is ten years later and I'm still on methadone.... (2002, 123).

The reality is that addiction to methadone is, for most, worse than a heroin addiction. Additionally, the withdrawal from methadone is worse than the withdrawal from heroin. In the same study as above, a 36 year old female client admits

The way I see it, it’s easier to get off gear [heroin] than phy. Like I was tryin' to get off phy a few months ago and I went through awful sickness. It frightened the fuckin' shit out of me, I was in bits (2002, 130).
Taking these subjective experiences into account it can be established that MMTs somewhat failed to take a holistic approach in treating the person’s addiction. Not only are service users left on methadone for years but their treatment by staff in Irish clinics can be unfavourable. One experience is captured in a report by Dr. Cathal O’Sullivan, a GP who was relatively new in the addiction field. He raised concern over the ‘undignified process’ of collecting weekly urinal analysis from heroin users entering into treatment of methadone maintenance (2009, NP). In Ireland, it is recommended that patients on methadone treatment have a test at least once weekly. The annual bill comes to around €5,500,000 (in Baxter, 2009). O’Sullivan noted the paradox in the language used by staff at the treatment clinics specifically around urinalysis, ‘positive opiate tests were called “dirty”, negative were “clean”. One can still hear doctors working in the addiction service today, referring to a patient as ‘he’s dirty this week”. This echoes the attitudes towards leprosy in Ancient times, where sufferers were seen as unclean and sent away from the city, yet we are supposed to be enlightened about such things today.

Lawless and Cox stated that ‘although the provision of methadone treatment was regarded as a favourable treatment option, the delivery of this treatment modality was in need of review’ (2002, 132). This would suggest that the medical model of treatment used to treat opiate addiction is deficient in its understanding of how to treat ones addiction, as it doesn’t engage in dialogue with the service user as to what might be the best option for their recovery. Personally, I find this quiet disturbing to think service users could be left on methadone for this amount of time. How can this happen? It appears that when one enters into Methadone Maintenance Treatment
(MMT), the primary goal is harm reduction and not in helping to address the underlying causes of addiction. Service users are consistently told by their Doctor that they are not ready to come off heroin. If they admit that they still have an urge for heroin, their dose is increased. If they try to self medicate off methadone, with little support they may end up poly-using (using other drugs). This shows up in their urine analysis, they are deemed chaotic and their dose is increased. This frustration may cause a conflict with their doctor which gets reported as a mental health issue. There is no win-win solution for them.

However, despite my concern, and the obvious frustration of the service users, I should acknowledge that there are many people who work in the drugs field who are passionate about their work and genuinely believe that methadone treatment works. Through my community work, I came to know Dr. Paul Quigley, one of the first Doctors to develop and deliver methadone treatment in Ireland. Many times I questioned Dr. Quigley about methadone treatment, particularly in relation to the stories service users had told me of their experience. His response was always the same - ‘I save lives’. Paul truly believes that the methadone programme is vitally important for harm reduction, yet he does agree that there is a lack of services to compliment treatment, in particular services that deal with the underlying causes of addiction. Due to funding cuts there are no addiction counsellors in the local methadone clinics. This means there are no options for holistic therapy, that is, to deal with the root causes of one’s addiction. This is another example of bad Irish drugs policy and the affects of HSE funding cuts.
CHAPTER II – ADDICTION AND MODELS OF TREATMENT

In this chapter I hope to explore the model of treatment methadone maintenance favours. I will set this model within a historical framework to trace the shift in how one views addiction. How one conceptualises addiction will inevitably impact on how one treats the person who is addicted.

Models of addiction

Moral

Over the years our understanding of addiction has changed. If one traces back to Ancient Greek philosophy, Aristotle (384–322 BC) offers an explanation ‘that such people [addicted people] are incontinent of will’ (Geppert, 2008, 40). Aristotle placed huge emphasis on the importance of practical wisdom (phronesis) which characteristically enabled the ‘high-minded man’ (phronimos) to be decisive about what he should do by engaging in practical reasoning rooted in a community of ethical enquiry. According to Geppert’s study this lack of will (or akrasia as Aristotle calls it) translates to a "lack of mastery….The akratic person cannot master his passions; he lacks that continence, which in Greek philosophy requires that reason control the emotions’ (2008, 40). Addiction was generally portrayed as something that is negative, a moral flaw. Geppert notes that ‘there is a tendency in Greek philosophy to associate akrasia with moral opprobrium’ (2008, 41). The moral model suggests that addiction is a choice based on bad decisions. Treatment within this ancient moral model often involved the individual being imprisoned or sentenced to asylums or death.
Advances in science

A move to modern times, and a shift in the paradigm of the imagination and science, brought a new understanding of addiction and how to treat it. Advances in the field of psychiatry and psychology promoted the concept that ‘addictive behaviour is the direct result of some physiological change in [the] brain’ (Foddy & Savulescu, 2010, 1). This new way of understanding addiction placed less focus on personal culpability and the ethical community and focused more on the pathology of the addiction. Hence, the disease model became the dominant model for treating addiction in Western culture. Despite having first emerged in the 18th century with Dr. Benjamin Rush, founder of modern psychiatry, defining it as ‘a disease syndrome caused by alcohol’, it wasn’t until the 1930s that it re-emerged ‘as a dominant explanation of etiology and guide for treatment’ (Rasmussen, 2000).

AA and Jung - spiritual

Subsequently, Alcoholic Anonymous (AA) was set up as a result of psychoanalyst Carl Jung’s (1875-1961) meeting with patient Rowland H. According to Dr. Jeffery Satinover, Jung expressed to Mr. H. that he was not going to get over alcoholism if he didn’t find God or embrace a spiritual experience. Jung accounted in one of his letters to Bill Wilson, co-founder of Alcoholics Anonymous, that ‘His (Mr H.) craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness, expressed in medieval language: the union with God’.

Jung, a former
student and friend of Sigmund Freud (1856-1939) who is best known for his theories on the unconscious mind and psychosexual development stages, developed a theory that focused on one’s spirituality. He divided the individual into three parts; the self (the unconscious), the persona (social personality) and the anima (soul image). Unlike Freud, who believed the unconscious contains repressed memories within the individual psyche, Jung maintained there are two parts to the unconscious; the personal (as Freud stated) and an infinite collective unconscious that is more universal in nature. In applying this to understanding how one becomes addicted, Jung believed that an addiction is replacing a void in the addicted person’s life. This may come from a conflict between the three parts of his or her being. He believed that for one to maintain a healthy life he or she must have a balance of these aspects of their being. The craving can only be overcome when one has embarked on a spiritual journey, a journey that fulfils one’s spiritual existence. Many who have embraced a spiritual journey of recovery have been successful in their recovery from addiction.

**The disease model - biology**

However, advances in the field of medicine suggested and promoted the idea that addiction (perceived as a disease) could be overcome by taking medicine. The cause of the illness is in the biology of the individual, as such, and not in some holistic spiritual existence, as proposed by Jung, or indeed the interplay between the two. Professional literature such as the *Committee of the Research Council on Problems of Alcohol 1938* promulgated ideas that ‘an alcoholic should be regarded as a sick person, just as one who is suffering from tuberculosis, cancer, heart disease, or other
serious chronic disorder’ (in Kurtz, 2002, 5). Subsequently, Elvin Morton Jellinek’s provided a theory based on a genetic concept of disease The Disease Concept of Alcoholism (1960). His approach to treating addiction as a disease had a tendency to label clients as sick and lacking in agency and will power. The disease model believed an addiction can be controlled but never cured so total abstinence is vital. While the disease model was originally related to alcoholism it has since been generalised to include other drugs and addictive behaviours.

Ironically, the treatment of heroin addiction became controlled by another addictive opiate - methadone. This is the model of treatment that is favoured in the treatment of heroin users. A collaborated team of psychiatrists, medical professions and the pharmaceutical industry, supported by neuroscience evidence, suggested that addictive behaviour results chiefly from the effects of prolonged drug exposure on brain functioning. This echoed what Dole and Nyswander discovered in their research - that disturbance in the brain's chemical environment can lead to a metabolic disorder (1967). This research hypothesised that heroin addiction is the result of a ‘metabolic disease that causes a permanent biochemical change in the addict, resulting in a permanent biological need for narcotics’ however, they argued it can ‘be stabilised through pharmacological intervention’ (in Saris, 6). Jamie Saris suggests that this ‘effectively establishe[d] the paradigm for what we might call the current pharmacological imaginary of human mental, emotional, and behavioural ills’ (2008, 5). These are the issues that Shane Butler and Tom O’Brien argue (in the last chapter) dominate the Irish drugs arena. If the health board, government and people designing Irish drugs policy continue to view and treat addiction as a disease, the sole
focus of recovery will be on treating the symptoms of the addiction and not the root cause. This, in turn, creates centralised services that take little consideration for the experience of the service user.

*Non medical models - biopsychosocial*

In 1969 Stanton Peele purported that addiction was not limited to a chemical substance, therefore, the disease model would not work for addictions like sex or gambling. He introduced the concept of *controlled drinking* (CD) and harm reduction as a means to help combat one's addiction. CD had an important role to play in alcohol treatment but there are other factors such as age, beliefs and values that play a part. He also believed social influences had an impact on one’s addictive behaviour and that values were a key factor, as one’s value system affects one’s decision. Peele set up a *Life Process Programme* which identified that a person could improve their coping skills to overcome their addiction. He suggested that addiction is a habitual response which offers a source of gratification and security as a way of coping with feelings (Peele, 1992). His attitude was that

> Addiction is a way of coping with life, of artificially attaining feelings and rewards people feel they cannot achieve in any other way. As such, it is no more a treatable medical problem than is unemployment, lack of coping skills, or degraded communities and despairing lives. (Peele, 1990)

What this means is that sometimes when a person engages in drug use (or other addictive behaviour), it is to avoid painful feelings. The drug offers escapism and a defence against anticipated pain. The person forms an attachment to this addictive behaviour; however, this behaviour becomes necessary to maintain stability (O’Driscoll, 2012). Peele believed that the pattern of learned addictive behaviour
could be overcome by a person learning to manage their feelings. This could improve personal development and the individual would gradually disengage in drug use. The *1998 Methadone Protocol* adapted Peele’s harm reduction approach to treating heroin addicts.

Professor Norman Zinberg, a psychoanalyst, greatly influenced the work of Peele. He was of the idea that a person’s biological, psychological and social (biopsychosocial) are all key factors to consider when treating a person’s addiction. According to Zinberg there are three components to consider – the person, the situation and the addictive involvement. His theory is known as Drug, Set and Setting (1984): *drug* considered what drug was being used, what way was it administered (smoked, injected, sniffed) and the availability of the drug; *set* refers to the mind set and make up of the individual. This entailed looking at gender, genetic factors, age, health, values and other personal attribute’s. When considering *setting* he looked at the social contexts like the environment, peer and media influence and cultural factors. Zinberg’s theory believed one must understand the interrelationship between these factors in order to comprehend the individual’s drug experience and be able to help them.

James Prochaska & Carlo Di Clemente’s ‘Stages of Change’ transtheoretical model states that change is a process involving progress through a series of six stages; precontemplation, contemplation, preparation, action, maintenance and relapse (1983). In the first stage the individual may not have considered addressing their addiction. They may be in denial about their addiction so there is little motivation to change their behaviour. In the second stage the person has considered addressing
their addiction. The third stage is when they prepare and commit to stop using drugs
(or other addictive behaviour). The fourth stage is when they address and change the
behaviour. The fifth stage is when the person is successful in their recovery.
However, the sixth stage realises that there may be a relapse. If this happens the
person will be encouraged to start the process again (and again) until eventually they
will have the tools to remain drug free. There is no time limit on the stages, a person
may move quickly between stages, or revert to a former stage or they may stay in one
stage for the course of their life. It is said that therapists, when using this model, must
be as cognitively complex as their clients. A directive action oriented therapist may
be moving a person in the contemplation stage too quickly. Therapists, like clients,
may get stuck in a favoured stage of change (Baum, 441). In general this has been a
powerful tool in the treatment of addictions. It’s as simple as identifying your stage
and the model tells you what to do next.

*The process and object of addiction.*

In terms of treatment it is important to understand the process and object of addiction.
The *process* of addiction believes there is a cycle of addiction (Nakken) with four
elements which are 1) function, 2) progression, 3) preoccupation and finally 4) loss of
control. This is reminiscent of Jellinek’s disease model of addiction as it believes an
addiction is progressive leading to a loss of control. The *object* of addiction is
divided into two categories – substances and behaviours. Let’s look at two illegal
substances first - heroin and cocaine. Heroin has a morphine base and is physically
addictive, that is, the body becomes addicted to the substance and the person will go
through a physical withdrawal when they stop using it. Treatment for this substance is generally methadone, as methadone, like heroin is an opiate. The idea is that replacing an opiate with an opiate will eliminate a painful withdrawal. Cocaine is a psychological addiction, that is, it is considered a drug that has no physical craving and so the treatment would focus on the psychosomatic aspect of the addiction. This requires interventions that focus on cognitive-behavioural therapies (CBT). CBT focuses on a learning process and can be used for both substance misuse and behavioural addiction. This is reminiscent of Peele, Zinberg and Prochaska & Di Clemente’s non-medical theories of addiction. Both the disease model and non-disease models help the addict to identify triggers to using but they differ when it comes to concepts about loss of control. The disease model, as discussed, believes an addiction can be controlled but never cured. The non-disease models believe that addiction is a learned behaviour which can be modified through facilitating intrapersonal and interpersonal skills. Harm reduction is also used to help address the difficulty of achieving total abstinence by customising a treatment plan to suit individual goals.

I will conclude this chapter by surmising that in order to address heroin addiction (or any addiction) there should be a shift in policy that focuses, less on the disease model of addiction, and more towards a model that deals with the root cause of the addiction, that is a non-medical model that focus on holistic care. However, there is a lack of government funded holistic centres in the addiction field as the government tends to allocate funding to the services that promote medical intervention. For example, although counselling uses a non-medical approach to
treatment a person, and is a more humanistic way of treating a person, it can be a long and costly process. The government doesn’t seem to want to invest time and money in an area that has little research (holistic care was generally for people who could afford it, it was very privatised, but this is changing). The government want a quick fix solution so they rely on the research conducted by people in the field of biomedicine that says methadone works, that it doesn’t harm the individual and that it is cost effective. When methadone was marketed and introduced as a treatment for heroin addiction, it was a considered a solution that would eliminate the craving for heroin, reduce crime related to drugs and, most importantly reduce the risk of spreading AIDS and HIV through IDU. However, over the years it has come to light that, while methadone may be successful in stabilising the heroin user, it should definitely not be considered a long term solution. The people I have come to know over the years, who are engaged in methadone treatment, have said ‘they are sick and tired of being sick and tired’. They are tired of being tied to a clinic or doctors surgery. They are tired of constantly having their opinion shut down. In other word they want change. But how can this change be imagined?
CHAPTER III – A TRANSFORMATIONAL MODEL OF RECOVERY

A transformation in treatment and prevention

Over the past few years, there have been some improvements in Irish Drugs Policy despite the cuts to some services. In 2009 the government launched The National Drugs Strategy 2009-2016 which assessed the previous NDS 2001–2008. One of the key priorities identified in this policy was to establish an Office of the Minister for Drugs. There had been no statutory government body overseeing the drugs situation in Ireland. I find this very distressing to think that nobody in our government cared about this serious human and social problem. Did they not care about the addicts who were dying through lack of services that could have helped them combat their addiction? Did they not care about the disadvantaged communities that were literally on their knees pleading for help? In 2011, almost 40 years after the heroin epidemic, the government appointed Róisín Shortall as the minister responsible for drugs. Her role was to ‘co-ordinate, support and drive the on-going implementation of the NDS 2009 – 2016’ (NDS, 2009, 93). In the same year Dr. Tom O’Brien, the manager of Sankalpa, Finglas, wrote to Mrs Shortall asking her to vote ‘against the measures contained in Budget 2012 relating to the savage cuts to FAS CE programmes’ (O’Brien, 2011). In his letter he emphasised that

On the same day as the cuts in the Budget were announced, the latest figures from the Health Research Board (HRB) National Drug-Related Deaths Index (NDRDI) were released showing the number of heroin-related deaths had increased by 20% in 2009 and a further report from the Mercy University Hospital Cork stated that 47% of psychiatric patients admitted had a substance misuse problem (O’Brien, 2011).
Despite the alarming statistics that showed an increase in deaths related to heroin, and the link between substance misuse and mental health, this request fell on deaf ears. The funding cuts were implemented that year. A year later Mrs Shortall resigned claiming it was due to a ‘lack of support for the reforms in the programme’ (Carr, 2012). However, despite the government’s lackadaisical attitude, and in spite of the ongoing detrimental cuts to services, their new policy did identified gaps within services.

I mentioned earlier that there were four pillars identified in the NDS 2001–2008; 1) supply reduction, 2) prevention (education and awareness), 3) treatment (rehabilitation) and 4) research. However, only two pillars were being implemented – treatment and supply reduction. There was little focus on prevention and research. Although the treatment plan was put into practice, it focused chiefly on the medical model to treating addiction, such as the MMT. In the new report, it was acknowledged that the treatment pillar should develop its rehabilitation programme to include alternative options for recovery (that is, options other the medical model). This was identified as a key development priority and so the new policy committed to focusing on prevention, research and alternative options to rehabilitation, specifically MMT. What this meant is that policy makers were once again shifting in their approach to treating addiction. Under the treatment model they would address alternative options to treatment and rehabilitation, under prevention they would focus on raising awareness of drugs in communities and under research they would constantly evaluate the impact of services.
I hope to demonstrate how these changes have positively impacted my community of Finglas. I will look at two services, that despite operating on a shoestring budget, they have demonstrated resilience and community spirit through their holistic model of care.

The first service is Finglas Addiction Support Team (FAST) which targets the gaps in the treatment and prevention pillars, i.e. the lack of addiction counsellors and the lack of support and education for the individual and their family. The people FAST tend to deal with are poly drug users (the dynamic of drug use is constantly changing) so FASTs focus is not specifically around MMT; it deals with the holistic care of all addictions. FAST is the only addiction counseling service in the whole of the Greater Finglas area. The other service Sankalpa also addresses the gaps within treatment and prevention pillars. This service focuses on a holistic model of care to creatively support the person specifically on the MMT. It provides education and holistic therapies to people who are currently on methadone but want to detox or maintain their dose. There are student counsellors on the premises if the service user needs support. I will speak more about these services in a moment.

In order for me to fully measure the transformation happening within the community and with the treatment of people prescribing to MMT, I will first describe the medical treatment under the headings 1) the setting; the methadone clinic, 2) the patient/doctor relationship, and finally 3) the model of treatment used. Then I hope to explore the two services under these headings, specifically pointing out the difference between these services and the clinics, and the beneficial impact they have on the individual, the family and the wider community.
In the LDTF catchment area of Finglas/ Cabra there are two methadone clinics. One is in Welmount Clinic, the other is beneath the office of the LDTF in an industrial estate between Finglas and Cabra. **Note the setting** – one is a clinic while the other is on the outcast of society. People on heroin will initially meet with the doctor and describe their drug activity and amount they use daily. The doctor will start the person off on a low dose of methadone and then gradually increase the methadone dose until the person no longer feels the need to use heroin (this is referred to as the amount that ‘holds them’). **Note the relationship** - because of what the client has told the doctor the doctor will make the decision. The service user will be asked to give a urine sample at least once a week to give the doctor an indicator if they have been using heroin or other drugs. As I mentioned before, if there are traces of drugs other than methadone, the person’s methadone dose will be increased. The whole process of trying to stabilise the person; that is get them at a position where their body doesn’t feel the need to use other drugs, involves the doctor increasing their methadone, reducing their methadone and prescribing valium. This process will go on and on until the person gives a ‘clean’ urine sample (no heroin or drugs showing up) and doesn’t complain about their treatment plan (I mentioned earlier, if you don’t conform to the plan, you are considered to have a mental health issue). **Note the model of treatment**; the medical or disease model of treatment, i.e. a response with medical intervention.

Sometimes, I see people on Methadone, their eyes are half closed (goofy), they can barely talk (their voice is very shaky), the sweat is rolling down their face (from the methadone) and I think, there has to be another way to treat heroin
addiction. There has to be a more humane approach to how we treat our fellow humans. The two community projects in Finglas that I will discuss have adapted an approach that creates a warm welcoming environment, offers a client orientated service and works from the non-medical model of addiction.

**Case study I - Finglas Addiction Support Team (FAST)**

Finglas Addiction Support Team (FAST) is a community project that was set up by few local women in Finglas who were frustrated with the lack of addiction services in the area. These women worked voluntary from an unused premise offering support and advice to people affected by addiction. In 2002 I came on board when they were applying to the Finglas/ Cabra LDTF for a grant. After receiving the grant, they were able to rent a space and provide a basis for the project. The demand for support from addiction problems was evident by the number of people accessing the service. By 2004, the service became a legal entity with support from the community, and statutory and voluntary organisations. The service outgrew its small premises and in 2012 moved to a purpose built building that would provide the much needed support in dealing with addiction in Finglas. While FAST was initially set up as a drop in, they identified gaps in the treatment and prevention pillars, particularly around the lack of addiction counsellors and the lack of education around drug awareness. This was addressed in their *2009 Services Report* which aimed to provide a range of confidential support services to individuals and their families affected by addiction.
These services are counselling, cocaine support, aftercare support, family support, holistic therapies, drop in and community involvement.

The new building is warm and inviting and right in the centre of Finglas. When one enters the premises one is welcomed and brought to the drop in area for a cuppa. *Note the setting;* a community project accessible to local people. The person is treated with the upmost respect and dignity at all times. As the centre takes a client centred focus, it encourages the client to be involved with as much of their recovery as possible through active participation in their care plans and an open non-judgemental attitude. In the first meeting with the counsellor, the service user will be asked if they can identify their problem, identify their goals and then identify strategies to address the problems and goal. The counsellor and service user will agree on when they will meet and how often. *Note the relationship;* the service staff will not tell the client what will work in their recovery, they encourage an equal client/staff participation.

When the service user has participated in the care plan, counselling will normally commence. The counsellors have special skills in dealing with addiction and use different methods of counselling to help the individual on the road to fulfilling their true potential. A person centred approach of Carl Rogers would be used as the therapist is skilled in three specific areas –congruence, empathy and unconditional positive regard. Cognitive therapy could be used to initiate positive change, to remove systematic biases in thinking and modify the core beliefs that predispose the person to future distress (Foy, 2012). The goal of CBT is to help clients unlearn their unwanted reactions and to learn a new way of reacting. *Note the*
model of treatment; a non-medical holistic of treatment. This model of treatment seeks to work with the root of the addiction problem and not the symptoms, as is the case of MMT. Although this process takes time, (as opposed to the quick fix solution of methadone) in the long run it is of more benefit to the individual as they will have learned the skills to change how they think about using drugs and how they view their self-worth.

Another major service that FAST offers is service offers in aftercare support. The clinics continuously administer methadone to clients and don’t engage in dialogue over the future plans of the individual. The aftercare service in FAST, however, links in with other services to provide support to individuals who want help in maintaining a drug free life. This service organises day trips, hill walking, canoeing and other fun days out. The service user may be used to an unhealthy, static environment and so this change promotes a new alternative to their life style. Another area that is vitally important to a person’s recovery is family support. Very often the service user will be the only person the clinic deals with. FAST offers support to the families affected by their loved ones drug addiction. It raises awareness about enabling the addiction and supports the family members in moments of crisis. This is vital process in healing the family that has been torn apart by drug addiction. The Methadone Maintenance centres do not normally engage with the wider community. However, FAST recognises the importance of community negotiation (remember these are the communities that have alienated the addict because of his or her harmful behaviour, so a dialogue must always remain open in order for the addict to be accepted back into society). There are community members on the board of
management and a range of community drug information sessions in local schools, youth clubs and community training workshops. These programmes help raise awareness about addiction in the community, which may prevent a new generation from using drugs and help the community to be more understanding of people addicted.

All of the services FAST offers are to help the individual, the family and the wider community. The methadone clinics are solely confined to treating the addict and pay little concern to the wider issues impacting the person’s life. This demonstrates that there are changes happening that are moving away from the sterile environment and medical ethos of the clinics to spaces that offer holistic care.

Case study II - Sankalpa

Sankalpa is a community rehabilitation programme in Finglas, funded by FAS and the HSE, which offers an integrated program of training, education and addiction support to people on methadone. Sankalpa is somewhat vocal in its quest to address the model of treatment being used to treat people on methadone. Its manager Dr. Tom O’ Brien believes that methadone has done little to help the majority of heroin addicts move out of the cycle of addiction (2007, 41). In his article Is There a Way out of This Clinic? (of which I have made reference to in chapter I) O’ Brien states that ‘consultant psychiatrists effectively control every aspect of addiction treatment in Ireland’, that is, the management, delivery and evaluation of methadone treatment.
programmes (2007, 41). His response to this is to provide a non-medical approach to treatment that will support methadone users when they reduce or detox from methadone.

O’Brien believes that education plays a major role in personal learning and development as this will empower the person and promote social change. His ideas are principally embedded in Paulo Freire’s tradition of conscientization which help to ‘unmask oppressive power, overcome alienation and engage learners in a process of liberation’ (2007, 42). O’Brien further believes that each individual can be transformed through a process of life long learning and not limited by a lifelong treatment. It is through this process that the individual will become a ‘critically reflexive and politicised human subject’ (in O’Brien, 42). Often the people who misuse drugs are early school leavers, people from disadvantaged areas or people with little self-belief. When using drugs the individual would not be able to focus on personal development as they have other needs to address (specifically around where they will score again). Once the person has stabilised they can embark on a journey of self directed learning. O’Brien is against the static medical model of treatment as he knows the detrimental impact it has on one’s welfare. He states that

Medicine requires compliance. Within the medical model, the patient normally becomes a passive recipient and consumer of treatment. As a result, a dependency is created between the patient, the doctor and the medicine. Adult and community education nurtures a degree of resistance to oppressive discourses and an awareness of relationships based on imbalances of power or knowledge. It seeks to enable the patient to become an active participant in their own treatment and rehabilitation process (2007, 49).
Sankalpa nurtures this degree of resistance by offering FETAC accredited courses in yoga and meditation, community development, ceramics, dance, drama and art. It is not surprising that there are courses in herbal medicine and nutritional therapy as that’s O’Brien’s forte. It is through the film production course that participants learned the skills to make a short documentary ‘The Pharm’ about the over prescribing of valium by doctors. This helped raise awareness, not just with participants, but in the wider community about the medical model of treatment. Sankalpa also feels it has a responsibility to educate the policy makers about what services they run, in the hope that they too can support the service to continue in its approach to treating addiction.

What I like about these projects is their resilience to tackling the addiction problem in Finglas. Both projects are over shadowed by the consistent threat of funding cuts yet they have reached out their open arms to the community of Finglas and demonstrated that they care. I truly believe that without these services promoting a belief that the individual can overcome their addiction through a holistic model of treatment, we would see an increase in fatalities related to drug addiction. The truth is these services save lives, repair broken families, and promote a community spirit. They are a testimony that methadone maintenance is not enough. MMT treats only one aspect of the addiction, whereas holistic care looks at the complete person and nurtures them on their road to recovery. MMT does not engage the person in discussing their treatment and options, holistic care encourages this. MMT fosters the belief that you have a disease and you need this drug. Holistic care promotes the idea that you can overcome this addiction with guidance and support. MMT treats all
patients in the same manner…. ‘You’re on heroin?’….take this methadone. Holistic care treats each person individually and respects their autonomy.
Conclusion

To conclude I would like to firstly like to acknowledge that due to the limitations of this thesis (the word count) I could not elaborate more on the community response to tackling the heroin crisis. This aspect is a thesis in itself. Without the community setting up local initiatives I fear the situation would be worse. It is the people who have lived with heroin in their homes and communities that have been most instrumental in breaking down the barriers and limitations of methadone maintenance treatment (MMT). Instead, to answer the question Is the Methadone Maintenance Model Enough? I have focused on the main social, political and individual issues relating to methadone treatment. I wanted to highlight the drugs crisis and then discuss the history of heroin use in Ireland, in the hope of capturing the impact heroin has on Irish society and the perplexity evident among government officials, health care workers and the community in how to handle it. Then, by focusing the lens on the micro aspect, I hope to have offered a subjective voice to explore the limitations of methadone treatment. My conclusion is that methadone maintenance does not address the underlying issues of addiction. It is through community projects, like FAST and Sankalpa, who promote dialogue, active participation and a non medical approach to treating addiction that one can recover from the horror of heroin (and it would appear methadone). Through the community awareness initiatives of these services there has been a break down in the stigmatisation of drugs addicts, which means that addicts can re-integrate back into society without fear of being alienated. The services offer a non-medical approach to care which means that there is no
further harm to the body. This non-medical approach helps re-invent how the addict thinks and thus impacts how they view their life.

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