20 years of the Methadone Treatment Protocol in Ireland

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This is an overview of the ICGP Substance Misuse Programme as it has developed with particular reference to the 20 years of the Methadone Treatment Protocol which came into effect October 1998. We will depict this history through a series of reproduced articles and excerpts from Forum which reflect the context and challenges that were faced as well as the innovative developments that have occurred. The Reflections section illustrates individual insights from GPs and other Health Personnel as well as quotes from patients into the last 20 years in the area of substance misuse in Ireland.

Introduction

20 Years of the Methadone Treatment Protocol

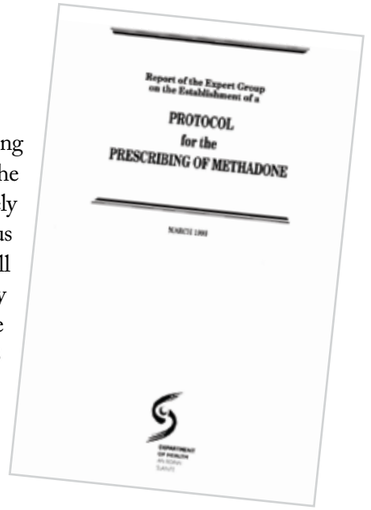
The Methadone Treatment Protocol (MTP) was introduced 20 years ago in October 1998. It was primarily introduced as a much needed response to the high rates of HIV infections and the deaths associated with an increasing heroin epidemic in socially deprived areas of Dublin at the time. Despite the body of medical evidence which supported methadone maintenance as a valuable harm reduction model, particularly in reducing HIV and HCV transmission rates and in improving the health and social functioning of opioid users, its introduction was met with responses ranging from outrage to acceptance. There was mixed support from politicians, policy makers and medical professionals as this approach challenged the existing traditional abstinence model of addiction treatment. Through the hard work of strong advocates, both statutory and non-statutory, the first twenty years of the MTP has been a journey of service improvement and political lobbying in order to get the best possible outcomes for patients in need of opiate substitution treatment (OST).

The ICGP has played a key role in lobbying for the expansion of methadone services throughout the country and in encouraging the mainstreaming of care for this marginalised patient group. The structured framework of the MTP has helped to allay the fears of many GPs who were reluctant to get involved in methadone treatment in those early days. This framework facilitated training, support, quality assurance and remuneration for GPs who wished to provide holistic care to drug users. Today a network of trained Level 1 and Level 2 trained GPs, as well as GPs working in HSE Addiction centres, provide methadone to over 10,000 patients across Ireland. We can continue to build on this successful model of care with the aim of normalising the treatment of all substance use issues in primary care.

Dr Íde Delargy, ICGP Director of Substance Misuse Programme

Context to the Methadone Treatment Protocol in Ireland

Background


Report of the Expert Group on the Establishment of a
PROTOCOL for the PRESCRIBING OF METHADONE
MARCH 1991

The Minister for Health (Mr. Sean Flanagan T.D.) established a Working Party on Drug Abuse in 1968 which led to the establishment of the Interdepartmental Committee on Drug Abuse in 1972 and ultimately the introduction of the Misuse of Drugs Act, 1977. "Prior to 1979 serious drug abuse was little known in Irish society. It was confined to a small group of addicts whose supply of drugs was unorganised and constantly changing." and "It was estimated there were 57 individuals living in the area in September 1981 who were using heroin".[1] However, by 1983 the Department of Health in recognition of a growing issue published Department of Health Involvement in Efforts to combat Drug Abuse: Position Paper.

"The Eastern Health Board became interested in direct service provision for problem drug users once the connection between HIV and injecting drug use became apparent. It was against this background that the GPs primarily in certain parts of Dublin had to operate. In 1984 the Psychiatric Services: Planning for the Future which was an influential report on the development of the public mental health services summarily stated "We are not in favour of the treatment by general practitioners of drug addicts".[2] Also "When dealing with individual drug users, the practice's policy is one of empathy, non-prescription, referral for detoxification and continuing support". [3]

In 1989 in his article "Drug problems in Dublin" Professor Gerard Bury points out that "General practice has much to offer in the care of drug misusers. The unique relationship between many GPs and their patients is an important resource in educating and motivating misusers to change their pattern of use. This is particularly important with respect to high-risk practices for the transmission of HIV." 4

By 1991 in the report Government Strategy to prevent drug misuse, the Department of Health showed a major shift in policy had occurred since the 1980's as evidenced in: Section 4.3 Training of General Practitioners. In the Strategy it stated: "Reference has already been made in Chapter III of this Report to the need for greater general practitioner involvement in the treatment of drug misusers in the community and recommendations have been made on the integrated treatment model which, in the Government's view, would best facilitate such involvement. In this context and in view of the limited exposure of general practitioners to the problems of drug misusers, both during training and in the course of their practices, the Government see a need for enhanced formal training arrangements in the field of drug misuse. They propose therefore to ask the Irish College of General Practitioners in conjunction with the Drug Treatment Centre Board and the other relevant training bodies to develop specific training arrangement to meet the requirements in this area."

In 1993 the Protocol for the Prescribing of Methadone was published which brought about the necessary legislative change required to bring about a harm reduction model of care for intravenous drug users.

"Methadone maintenance – method or madness?"

Editorial – Dr. Garrett Hayes, Forum Medical Editor

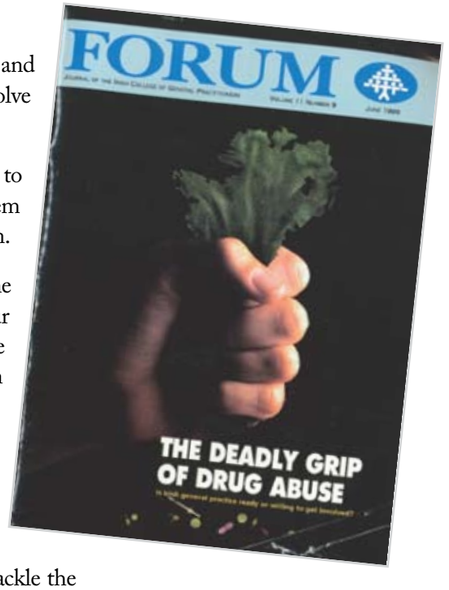
Drug abuse is now the most serious social problem facing this country. The problem is no longer confined to the larger cities with increasing evidence of the availability of drugs throughout the country. School children

1. *O'Kelly, F.D., Bury, G., Cullen, B. and Dean, G. The rise and fall of heroin use in an inner city area of Dublin, Irish Journal of Medical Sciences, 1988 Feb;157(2) pages 35–8.*
2. *Butler, S. "The Making of the Methadone Protocol: The Irish system? Drugs: education, prevention and policy, 2002, Volume 9(4), pages 311–324.*
3. *O'Kelly, F.D., O'Doherty, K., Bury ,G., O'Callaghan, E. Heroin use in an inner-city practice, Irish Medical Journal, 1986 Volume 79 pages 85–87.*
4. *Bury, G. Drug problems in Dublin, The Practitioner, 1989, Volume 233, pages 1486–89.*

as young as 10 or 11 years are being offered free trials of drugs in and around schools, in attempts by unscrupulous drug pushers to involve them in the habit.

For many years, our society has appeared to be unsure of how to proceed and rid our community of this menace. Now that the problem has impacted on all our society, desperate measures are being taken.

The main focus of activity must be on the detection and the prosecution of those who import and distribute illegal drugs in our community. Efforts by the Customs and Garda authorities must be maintained. But do we need more legislation and more Draconian laws to deal with those who appear to continue to distribute drugs with impunity?



We are all only too aware of the activities of groups such as Parents Against Drugs who have mobilised themselves locally in efforts to combat those who distribute drugs. As medical professionals we too have a role to play. But have we decided how we should tackle the problem? Are we satisfied that our current programmes are correctly directed? There is a lively debate as to whether a methadone maintenance programme or a drug free residential programme is more successful.

Last year alone, a report £13 million was allocated to drug treatment. At present, there are in the region of 700 addicts on the methadone maintenance programme in the Dublin area. It is estimated that a further 700 are under their GP's care with methadone.

At the ICGP AGM, the Minister for Health, while giving with one hand, was being critical of GPs with the other, as he felt that more GPs should become involved with the methadone maintenance programme. In theory this sounds reasonable. The reality is somewhat different. While £13 million may have been allocated to the drug programme last year, how much of this was allocated to GPs and how much infrastructural support have we had?

The impact on a GP taking on addicts for a methadone programme can be substantial. How much control will a GP have of the actual programme and the management with methadone? How can a practice be insulated from the "hangers on" at a practice where methadone is seen to be available? What kind of security measures are being provided to protect GPs, their staff and the other patients, should an addict become violent? What kind of insurance will be available for GPs providing a methadone programme in their practice and will the minister provide insurance cover for those who are unable to obtain it themselves?

Many GPs are more than happy to treat patients with drug addiction problems and become involved in programmes, such as the methadone maintenance, but if this is going to disrupt their practices, most will have serious reservations. A compromise should be considered.

Many GPs have expressed their support for the concept of GPs staffing a centre on a sessional basis to administer the programme. This would allow GPs to participate without extensive structural and administrative alterations to their practices and the other problems associated with running such a programme.

If the minister and his department are serious about the problem, they will consider the role of the GP, provide meaningful support, and consider the proposal of having GPs provide this service at specified locations rather than their own practices. In response to the increasing issue of drug addiction in Ireland the ICGP set up a Task Group on Drug Abuse (June 1996) to examine the issue and make recommendations.

Reproduced from Forum July 1996

Chairman's Page – "Setting ICGP policy on drug abuse"

A draft policy statement on drug abuse – with a major focus on the GP's role in methadone maintenance programmes – is being drawn up for ICGP approval, writes Declan Murphy (Chair of the Task Group on Drug Abuse)

We have all, either directly or indirectly, been affected by the enormous increase in the drug abuse problem over the past 20 years. Those who have suffered most are the poor and disadvantaged living in inner city Dublin, where the ravages of heroin have left hundreds dead and whole communities shattered.

In the past five years cannabis and ecstasy have spread to every town in Ireland and this has helped to focus society's attention on the whole issue of drug misuse. This was one of the priorities during Ireland's recent EU presidency; the EHB recently a full time programme manager for the area; and last June the ICGP set up a Task Group to:

- Finalise a series of educational fact-files for distribution to members
- To review and prepare an outline policy statement on the issue of drug abuse and the role of general practice.


TASK GROUP ON DRUG MISUSE

FINAL MEETING

DATE: Thursday 17th April 1997
TIME: 4.30 p.m.
VENUE: Corrigan House

AGENDA

1. Minutes from the previous meeting.
2. Matters arising from the minutes.
3. Finalise policy document – Members are asked to review the document and to forward any amendments directly to Dr. Declan Murphy or myself prior to the meeting, in order to facilitate the completion of the document.

CAROL WHITE,
9TH APRIL 1997.

At the outset the group clarified its position in relation to alcohol, declaring it outside its terms of reference (while accepting it to be the drug which most commonly causes ill health in Ireland).

The task group includes four members from the greater Dublin area who have been deeply involved in the treatment of opiate addicts. Their depth of knowledge and experience is balanced by the non-Dublin members how can take the perspective of communities where opiate addiction is rare or non-existent as yet.

The group includes Margaret Bourke who is a GP facilitator on the EHB Methadone Maintenance Programme Pilot Project and who had been writing a series of fact-files before the task group was set up. She has now completed this and the document "Working with drug users in general practice" has been agreed by the task group and is due to be published by the College in conjunction with the EHB.

The group's second task is to prepare a policy statement for the College on drug abuse and the role of general practice. The initial priority is to devise a policy in relation to the treatment of heroin abusers, and in particular to the methadone maintenance project for intravenous heroin abusers in Dublin. The group has already reached some important principles on this.

Opiate addiction is widespread in Dublin, particularly in areas of deprivation, and any effective drug treatment programme must take place in the context of community development and measures to address social exclusion. Opiate dependency tends to be a chronic relapsing condition with complex and multifactorial origins. Its treatment is multi-layered and must include psychosocial support for both the individual and his or her family.

General practice has an important contribution in respect of individuals, their families and communities. There must be local access to the range of services needed to access, treat and follow up these patients. An appropriate number of GP facilitators, with the necessary expertise and commitment to support and advise participating GPs must be appointed.

A range of treatments is available and the ideal outcome is a drug free lifestyle. Unfortunately this may not be possible for many patients. The use of methadone as a substitute for heroin is one strategy that can be

used in stabilisation and detoxification interventions as well as part of an on-going maintenance programme. Methadone is an opioid analgesic and is an effective substitute for other opiates, but without their euphoric effects. It can be taken orally. Its use as part of a maintenance programme lowers morbidity (HIV, HCV, HBV) and mortality, retains patients in a treatment programme, lowers crime rates, and improves physical health and pregnancy outcomes in heroin dependent patients.

GPs who decide to take part in a methadone maintenance programme must be given adequate training as well as refresher and updating courses, accompanied by an appropriate method of accreditation and re-accreditation. In general, GPs should not treat more than 10 patients at any one time. Most patients will receive their initial assessment and treatment in a community treatment centre or specialist services. When and if stabilised, they may be considered suitable for referral back to their GP for continuation of treatment, including methadone maintenance if applicable.

There must be clear guidelines on the selection of patients suitable for maintenance treatment in general practice. These patients must have an individualised treatment card and be entered on a central, confidential national methadone registry.

There must be a quick, flexible and easy referral and re-referral process for patients who destabililse while in GP care, or who for whatever reason become unsuitable for continuation of treatment in general practice.

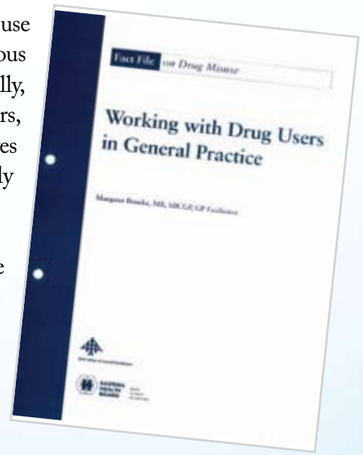
Doctors who wish to initiate methadone treatment in general practice must be given further education and training and be accredited appropriately. GPs outside Dublin face very different problems to those in Dublin, and their problems need to be addressed also.

GPs must be adequately resourced and remunerated for this demanding work. This is a dynamic area which is undergoing rapid change. Structures for continuous development of policy and services must be created together with audit and research. Education of GPs at all levels must be encouraged.

Drug misuse is as old as the history of civilisation and is unlikely to disappear in the future. It is hoped that an appropriate and adequate response is now being made to a problem which has caused so much suffering to so many in recent years.

Reproduced from Forum February 1997

In 1997 Dr. Margaret Bourke summarised the situation "The epidemic of drug use in the early 1980s and the current explosion of the 1990s has led to enormous problems with health care. One way or another, this explosion, however marginally, involves all general practitioners. We may find ourselves treating opiate users, poly drug users and recreational drug users. Alternatively we may find ourselves counselling, their families, or the victims of opportunistic crimes. Whether directly or indirectly, we all treat the problem, or the problems occasioned by drug use."



Pat McLoughlin in his role as Programme Manager of the AIDS/Drugs Service stated in the Eastern Health Board 1997 Service Plan that "the enlightened approach taken by both the Irish College of General Practitioners and the Pharmaceutical Society of Ireland is of even greater strategic importance to our Board as we continue to develop the role of the general practitioner and retail pharmacist as the cornerstone of our services for the future."

Recommendations of the Irish College of General Practitioners' Task Group on Drug Misuse May, 1997

SUMMARY OF RECOMMENDATIONS

1. General Practice has an important contribution to make in the management and prevention of drug misuse, together with other medical, social, and political agencies.
2. The causes of drug misuse have major social, economic, and educational roots, as well as medical, and proposed solutions to the problem much address all of the factors.
3. Alcohol and benzodiazepines (whether prescribed or obtained illegally) are the most common causes of drug misuse in Ireland, but this document deliberately confines itself to the problem of opiate addiction.
4. The Task Group recommends a model of care for opiate addicts based in general practice, with GPs providing methadone maintenance (Level 1) where appropriate, or methadone initiation as well as maintenance (Level 2) where appropriate.
5. There must be an adequate number of GP facilitators appointed, who have the necessary expertise and commitment to enrol, support, liaise with, and advise GPs.
6. There must be a confidential national treatment list on which all patients receiving methadone will be entered.
7. All patients receiving methadone must have an individualised treatment card, which is supplied to and kept at their pharmacy.
8. Methadone treatment, including prescriptions, should be free of charge to opiate addicts.
9. Prescribing of methadone should be budget neutral to GPs.
10. Methadone must be dispensed at a local pharmacy, and where indicated in daily doses, preferably with supervised ingestion on the premises.
11. There must be local access to the full range of services needed to assess, treat, and follow-up opiate dependent patients.
12. There must be a flexible, quick, and easily accessible referral and re-referral system available to GPs.
13. There must be suitable training and education for participating doctors, including assessment for certification and re-certification.
14. There must be adequate, negotiated, and agreed payment for certified participating doctors.
15. The number of addicts being treated by any single GP should not exceed 10-15 for Level 1 doctors or 30-35 for Level 2 doctors.
16. The criteria for patients suitable for treatment in general practice by Level 1 and by Level 2 GPs are proposed.
17. A joint ICGP/Health Board Review Group is proposed, which would have responsibility for overseeing and approving education and assessment, as well as policy development.
18. The field of drug misuse is dynamic and rapidly changing, and ICGP policy in this area will need to be kept under continuous review.
19. The ICGP expects this policy document, together with the Fact Files, will encourage its members to take part in the medical management of drug misusers at all levels, and to participate in the Methadone Protocol where clinically appropriate.

The ICGP Substance Misuse Programme

The First Two Decades

Milestones of the Methadone Treatment Protocol
The First Decade (1998-2008)

1998 – 1999
- Methadone Treatment Protocol (MTP) introduced
- ICGP Level 1 GP Training commenced

1999 – 2002
- ICGP Level 2 GP Training commenced
- Audit Nurse appointed and the first ever External Audit in general practice commenced

2002 – 2003
- Dept of Health/ICGP issued guidelines, "Benzodiazepines: Good Practice Guidelines for Clinicians"
- Dept. of Health requested the Methadone Prescribing Implementation Committee to conduct a review of the Methadone Protocol

2003 – 2005
- Level 1 training was offered to almost all of the vocational training schemes nationally
- Best Practice Guidelines, "Working with Opiate Users in Community Based Primary Care Setting", were launched

2005 – 2006
- ICGP proposed a draft protocol and training around the introduction of Buprenorphine

2006 – 2008
- "Drug Related Death and Strategies for Prevention" was published in March from the Working Group convened by the ICGP Drug Misuse Programme to examine the issue of drug related deaths in Ireland

2006 – 2008
- Updated Best Practice Guidelines "Working with Opiate users in Community Based Primary Care" were published
- Training roadshows entitled "Substance Misuse – From Recreation to Rehab" Effective interventions for GPs and Primary Care Staff were offered nationally
- First online Level 1 training programme was launched

The Next Decade (2009 – 2018)

2010 – 2011
- HSE Commissioned External Review of MTP "Introduction to the Opioid Treatment Protocol"

2011 – 2012
- HSE Convened a National Opiate Guidelines Committee established to review the guideline

2012 – 2013
- External Peer Review of the Audit Review Group (ARG)

2013 – 2016
- Certificate Course in Substance Misuse and Associated Health Problems was launched (formerly Level 2 training)

2016 – 2017
- Foundation Course in Substance Misuse was launched (formerly Level 1 Training)
- Online Self-Audit tool was launched
- Substance Misuse Webinar Series was launched

2017 – 2018
- HSE National Guidelines launched "Clinical Guidelines for Opioid Substitution Treatment"
- ICGP hosted a one-day, multidisciplinary National Conference, "Managing Problem Alcohol & Drug Use in Primary Care"

2018
- ICGP hosted Conference on Hepatitis C
- Substance Misuse Programme 20th Anniversary

‘Pushing back the tide of substance misuse’

The Methadone Treatment Protocol has put GPs at the forefront of tackling drug misuse. Ide Delargy reports on 10 years of the scheme.

The Methadone Treatment Protocol (MTP), which involved a change in the regulations around methadone and dispensing, was introduced on October 1, 1998. From that date onwards the new regulations meant that physeptone was no longer licensed in this country and therefore only methadone 1mg/ml could be prescribed as a substitute treatment for opiate dependency. The MTP also required that all patients in receipt of methadone treatment must now be registered on a central register called the Central Treatment List and have a signed photo identification lodged in the dispensing pharmacy.

A specially designed methadone script was the only legally admissible prescription form; GMS or private scripts were no longer acceptable. Many of these elements of the MTP were introduced to improve patient safety when on methadone and to eliminate the possibility of double-scripting. The new regulations were also intended to give GPs confidence in a well-structured, well supported programme.

Small Beginnings

Back in 1998, operations were relatively small. The scheme was overseen entirely by the former Eastern Health Board (EHB) and was essentially confined to the greater Dublin area.

The Methadone Implementation Committee, which included personnel from the Department of Health and Children, the ICGP, the EHB and the Pharmaceutical Society of Ireland (PSI) worked together for months preparing for the implementation of the protocol. There were significant logistical difficulties in ensuring that no patient was left without treatment when the new system went live on October 1, 1998. An information campaign which involved writing to all GPs and pharmacists was undertaken prior to the implementation date and as many patients as possible were switched over to the new system prior to the October 1 deadline.

Contingency plans to cater for the unknown patient numbers were put in place and the system went live as planned. Existing clinics extended their opening hours with additional staff available to assess and treat all patients who presented and were in treatment with GPs. For the first time, accurate information on all patients who were in receipt of methadone treatment was available as well as details of the treating doctors and the dispensing community pharmacist.

Expansion to Meet Demand

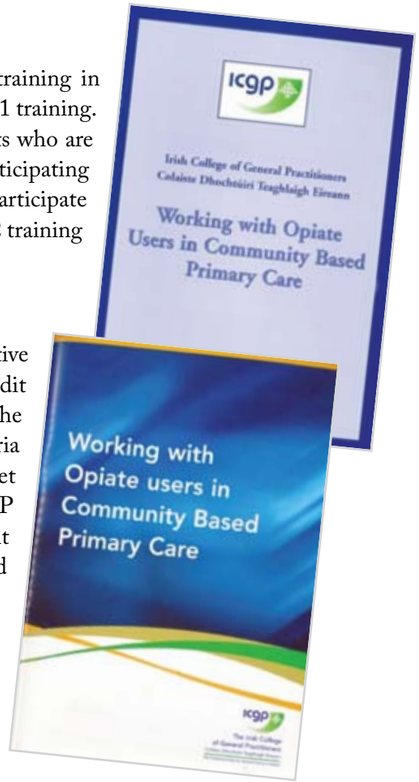
Since those early days of planning and implementation, the MTP has gone from its first stumbling steps to a fully-fledged well-organised programme. There are now in excess of 8,000 opiate users registered on the Central Treatment List and this includes patients who attend both the HSE clinic services as well as community GPs.

Over the 10 years, the former EHB has morphed through the EHRA and on to the HSE. There are HSE national committees overseeing the drug problem and the implementation of treatment. There is the National Advisory Committee on Drugs and also the National Drug Treatment Strategy recommending drug policy.

The last decade has also seen the opiate problem spread rapidly to all areas of the country. Satellite clinic services now exist in Galway, Limerick, Athlone, Portlaoise, Carlow, Waterford and more recently Cork. GP-led clinic services are provided in Ashbourne, Drogheda, Dundalk and Cavan.

GP Training

All GPs who wish to participate in the scheme are required to have training in substance misuse. There are now over 700 GPs who have completed Level 1 training. This training provides the basic training to equip GPs to manage patients who are stable on their methadone treatment. To date, more than 150 GPs are participating in the programme; completion of the training does not mean a GP must participate in the programme. GPs with experience at Level 1 may progress to Level 2 training and to date 67 GPs are registered as Level 2.



Audit

Another feature of the programme has been the introduction of an innovative system of external audit which was a first for Irish general practice. The audit is conducted by an audit nurse employed by the ICGP. In advance of the audit, participating Level 1 and Level 2 GPs are issued with the criteria on which their methadone practice will be audited. These criteria are set in conjunction with the publication of Best Practice Guidelines (ICGP 2003 and updated 2008). Apart from being a contractual requirement for participating GPs, the audit is intended to be both educational and supportive for GPs.

Support for a Challenging Role

Continuing medical education is another key element for GPs on the programme. The area of drug misuse treatment is an evolving field of medicine where best practice is under regular review. A discussion forum for consensus management of both medical and mental health and other emerging treatment issues is important.

Most important of all, substance misuse is an area of medicine where practitioners can easily experience ‘burnout’ due to the considerable demands of working with this client group. Many patients present with complex medical, mental health and social needs. Many have experienced traumas in the past. Some patients are involved in rearing their children and in some cases there are significant childcare issues which raise dilemmas for the treating doctor.

While I believe that all GPs have a role to play in managing their patients with substance misuse problems, the level of involvement will vary from doctor to doctor. One needs a particular skill set for this kind of work and regular debriefing with colleagues is an important aspect of the work which should not be overlooked. Just as peer support and supervision is important in the counselling profession. I believe that doctors should build in time to look after their own wellbeing, avoid taking on too many patients and arrange regular time off to recharge.

Problems Remain

While the programme has seen significant expansion over the past 10 years, problems remain. Waiting lists still exist in many areas of the country with long delays for those looking for treatment. Ideally, access to services should be demand-led. Access to 'key working' and regular, appropriate addiction counselling is also lacking in many areas. In some cases, patients are missing out on opportunities for rehabilitation and re-entry to education or the workplace and to move on with their lives.

Unanswered Questions

Does the fact that in Dublin access to treatment has improved so much show that it has moved down the political agenda? Do we have any alternatives to methadone? Has the media emphasis on the problems of cocaine shifted the focus away from opiate dependency? These are some of the questions facing us as we move into the next decade of the MTP. To borrow another phrase: "a lot done, but much more to do".

Reproduced from Forum June 2008

'Helping the Most Vulnerable Patients'

The Methadone Treatment Protocol, now 20 years old, is a remarkable system of life-saving, health-enhancing care, writes John Latham

This year marks the 20th anniversary of the implementation of the Methadone Treatment Protocol. This followed the Misuse of Drugs Act (Supervision of Prescription and Supply of Methadone) 1998….and so began one of the most successful chronic disease management programmes in Irish general practice. It came none too soon.

In 1993 the Department of Health published a report to advise on a protocol for the prescription of methadone. This included embryonic plans for the introduction of well-regulated prescribing of methadone in general practice.

Following the rapid growth of intravenous heroin use in Dublin in the early 1980s, the ICGP, individual GPs, the National Drug Treatment Centre, the health boards and the Department of Health strove to explore best practice and evidence based treatment options for heroin addiction. An immediate aim was treatment for distressed and increasingly ill heroin addicts, often brought to unprepared GPs by distraught relatives (frequently mothers). Public health was extremely worried by the increasing number of HIV/AIDS (as it was called then) cases, of whom at least 50% were intravenous drug users. Deaths from opiate overdoses were all too frequent. It was already very evident that most heroin users who had ever injected had been infected with hepatitis C.

As a GP on the ground in inner-city Dublin in those days I can vouch for the distress, misery, morbidity and extraordinary mortality figures. Antiretroviral treatment for HIV was in its infancy and many local families were losing sons and daughters to HIV or other complications of heroin injecting. To make things worse, unregulated prescribing of methadone by a tiny rogue minority of GPs for a private fee with no added care, was undermining efforts to bring rational treatment to this needy group. Fortunately, there were some courageous GP colleagues such as Kieran Harkin, Ide Delargy, Des Crowley, and the late Fiona Bradley, who took an active role in researching best practice methadone treatment in other jurisdictions. Scotland (in particular Edinburgh) seems to have been several years ahead of us in implementing evidence based treatment protocols using methadone as a harm reduction medication.

Meetings were arranged and Scottish colleagues were extremely helpful in informing the future shape of methadone treatment in Ireland.

The Report of the Methadone Treatment Services Review Group (DOHC 1997) recommended a change in the way methadone should be prescribed and dispensed in Ireland. It was then that the Misuse of Drugs Act 1997 was amended to enable this and in 1998 the Methadone Treatment Protocol (MTP) was launched. It was a remarkable step forward in both healthcare policy and treatment implementation for a vulnerable group of patients and for their GPs.

The ICGP has played an essential role in the design and roll out of this system of care under the leadership of Ide Delargy, Director of the Substance Misuse Programme for the past 20 years. Firstly, in informing the protocols for treatment itself and secondly, in providing courses and standard competencies for training of the doctors who would carry out the work. Thirdly, the College also became responsible for audit and CME for these GPs. Qualified GPs then became contracted to the health board/HSE at either Level 1 or Level 2 status, to provide methadone maintenance treatment for a registered cohort of patients within their practice. Level 1 GPs can accept referrals of patients stabilised on methadone from drug treatment centres or from other GPs. Level 2 GPs can initiate treatment for patients of their own practice following assessment by a local drug treatment service and their GP coordinator. The details of treatment cards, individual chemists, urine testing and other practice aspects of the MTP are now well known to most readers.

Apart from promoting best evidence-based practice in treating opiate misuse, the ICGP was (and is) committed to drawing vulnerable heroin addicted patients with multiple physical, psychological and social problems into the holistic care of general practice. Methadone treatment at the National Drug Treatment Centre and in drug treatment clinics is essential care for many who are not very stable. However, general practice (family and community) methadone care offers the best possible milieu for receiving maintenance (or detoxification) methadone treatment.

In late 2010, a comprehensive review of the Methadone Protocol was published, renamed the Opioid Protocol. This was so named because of an aspiration (yet to be realised) to extend treatment options in general practice to include buprenorphine. Most of the shifts in emphasis and some changes proposed in the Opioid Protocol have yet to be implemented in practice.

In 2016, the ICGP, College of Psychiatrists of Ireland and the Pharmaceutical Society of Ireland published the truly excellent Guidelines for Opioid Substitution (OST), which follows on from the recommendations of the 2010 report.

Twenty years on, the Opioid Protocol remains a remarkable system of life-saving, health-enhancing, public health positive care in the community. The protocol has ensured that this care is now available to about 10,000 patients nationwide. Practice has changed with regard to frequency and observation of urine sampling and I hope in future there will be more emphasis on encouragement and safe care for those wishing to detox and become drug-free.

Reproduced from Forum March 2018

Education & Innovations Through the Years

The ICGP's Substance Misuse Programme (SMP) has been proactive in updating and developing the educational needs of GPs working in the area of substance misuse. In this section we will review the education and innovations through the years, many of which were 'firsts' for the College.

Annual Conferences & Workshops

Over the years SMP has rolled out numerous workshops at the ICGP AGM, the ICGP Winter and Summer meetings as well as some dedicated Substance Misuse Conferences.

At the ICGP Drug Misuse Conference March 2002 were (l-r): Dr Kieran Harkin, Inchicore GP and conference organiser; Prof Michael Gossop, National Addiction Centre, Kings College London and Di Ide Delargy, Director of ICGP Drug Misuse Programme.

At the ICGP 6th Conference on the Management of Drug Users in the Primary Care Setting, 12th March 2005 in the Trinity Centre, St. James Hospital, Dublin were: Speaker Dr Conor Farren (Consultant Psychiatrist), Dr Finbar Corkery (President ICGP), Dr Ide Delargy, Speaker Prof. Colin Bradley (Professor of General Practice, UCC).

At the first Training Seminar on Use of Buprenorphine for Opiate Dependent Patients in Ireland held at the ICGP, 23rd November 2005 were: Dr Clare Gerada (Director of Drug Misuse Programme, RCGP, London), Dr Ide Delargy (Director Drug Misuse Programme, ICGP) and Ms. Kay Roberts (Lead Pharmacist, Certificate Training Programme in Drug Misuse, RCGP).

At the ICGP Alcohol & Drugs Conference 2008 were: Dr Jane Marshall (Consultant Psychiatrist, The Maudsley Hospital, London, UK), Dr Mark Walsh (ICGP Chairman), Dr Eilish Gilvarry (Consultant Psychiatrist, Newcastle & North Tyneside Addictions Service), Mr. Rolande Anderson (ICGP Alcohol Project Director).

At the 2011 ICGP Winter Meeting incorporating Substance Misuse Conference were: Prof Gerard Bury, Minister Roisin Shortall.

At the ICGP Summer School 2012 workshop "Children and Substance Misuse – the Chicken or the Egg?" were: Dr Ide Delargy, Minister Frances Fitzgerald.

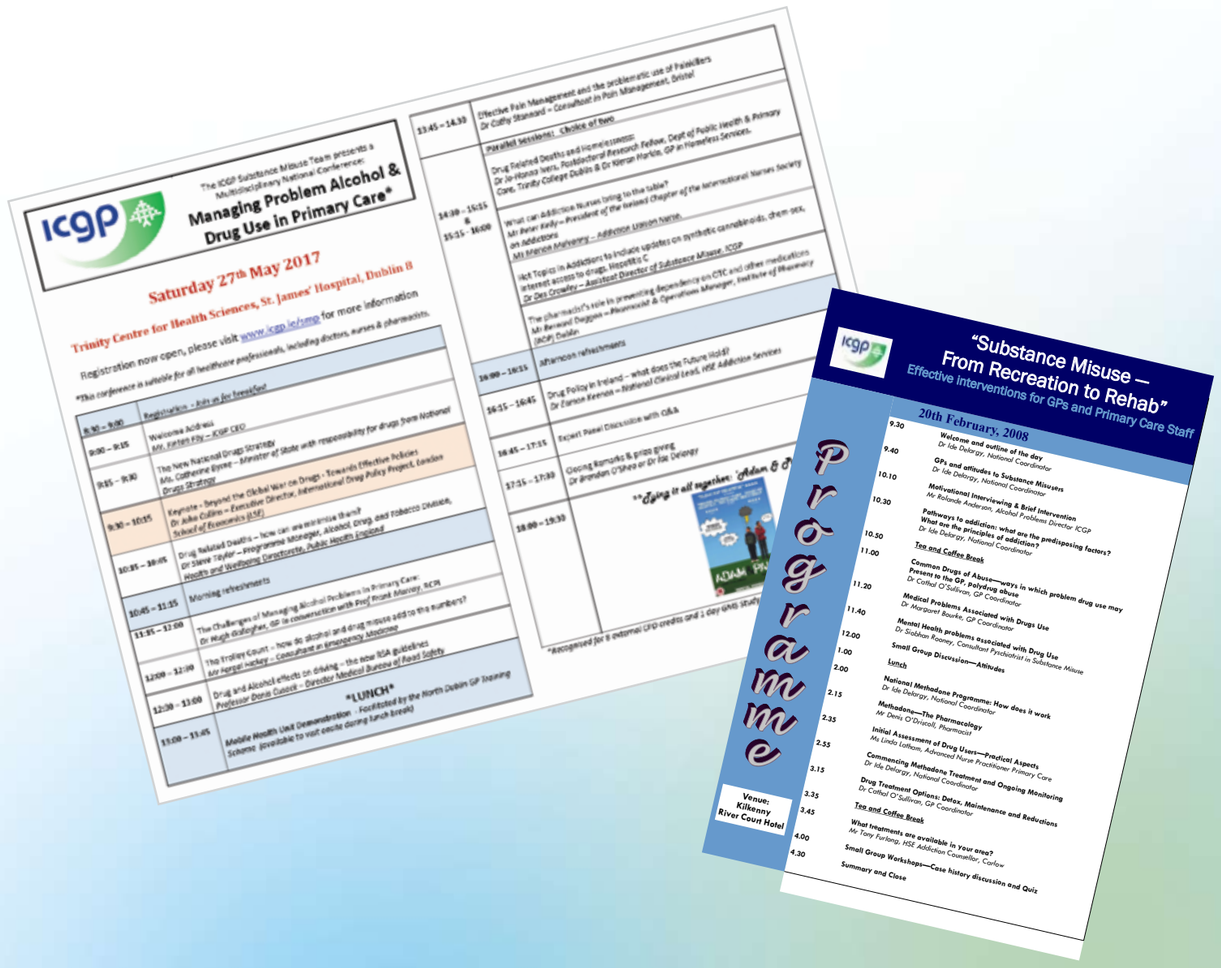
At the ICGP Summer School 2013 "Substance Misuse & Related Health Matters" were: Dr Frances Nangle-Connor, Dr Nuala O'Connor, Dr Lelia Thornton, Dr Ide Delargy, Dr Sussie Clarke, Dr Margaret Bourke.

At the 2013 ICGP Winter Meeting focusing on the issue of management of dependency on prescription and over the counter medications were: Dr John O'Brien, Dr Nial O'Leary, Dr Alfie Mannion and Dr John Latham.

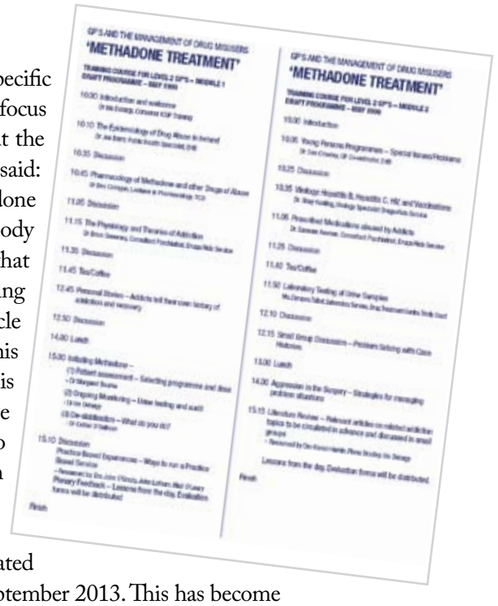
At the 2015 ICGP Winter Meeting, the SMP ran a workshop on recent advances in Hepatitis C treatment "A cure for Hepatitis C: How patients are assessed and selected for the new treatment" were: Dr Garrett Hayes, Dr Brendan Lee.

At the 2017 one-day multidisciplinary conference on 'Managing Problem Alcohol and Drug Use in Primary Care' in May in the Trinity Centre for Health Sciences, St James' Hospital were: Dr Des Crowley Assistant Director of Substance Misuse, ICGP, Ms Catherine Byrne Minister of State for Communities and The National Drug Strategy, Dr Ide Delargy, Director Substance Misuse Programme ICGP, Dr Brendan O'Shea, Director Postgraduate Resource Centre ICGP, Mr Fintan Foy CEO ICGP.

At the Hepatitis C Conference, "Hidden Disease: The future of Hepatitis C treatment in community and primary care", was held on Saturday 24th February 2018 in The Catherine McAuley Centre in Dublin were:Dr Des Crowley, Assistant Director Substance Misuse Programme, ICGP, Dr Margaret Bourke, Dr John Moloney, Dr Andrew Radley, Dr Marie Claire Van Hout, Ms Mags O'Sullivan, Prof Walter Cullen, Dr Richard Brennan, President ICGP.



Development of Courses


GP'S AND THE MANAGEMENT OF DRUG MISUSERS
'METHADONE TREATMENT'
TRAINING COURSE FOR LEVEL 2 GP'S – MODULE 1
DRAFT PROGRAMME – SEPT 2009

GP'S AND THE MANAGEMENT OF DRUG MISUSERS
'METHADONE TREATMENT'
TRAINING COURSE FOR LEVEL 2 GP'S – MODULE 2
DRAFT PROGRAMME – SEPT 2009

The overall direction of the SMP transitioned from a specific focus on Level 1 and Level 2 methadone training to a wider focus on the addiction problems which face every GP throughout the country. Interviewed in Forum in January 2009 Dr Delargy said: "When we started out, the emphasis was on the methadone treatment – Level 1 and Level 2 – and trying to get everybody trained. We have now broadened training and would hope that all GPs would be at Level 1 eventually. Now, Level 1 training is made available to GP trainees as part of their training cycle and by the time they graduate most GPs should have done this training. The plan would be that more specialist GPs in this area, ie. the Level 2 GPs, or the HSE addiction clinics, will see the more complex patients but eventually refer them back to their own GP for ongoing management, as you would with any chronic disease model."

The Certificate Course in Substance Misuse and Associated Health Problems (formerly level 2 training) launched in September 2013. This has become the academic training component of becoming a Level 2 GP and was developed with the help of Dr Ailis Ni Riain. The former Level 1 programme was then updated to the Foundation Course in Substance Misuse and was launched in early January 2016. This newly developed course encompasses all substance abuse, for example alcohol, benzodiazepines, prescription opiates and OTC medications. The course is suitable for all GPs and GP trainees and completion of this course is required in order to apply for a HSE Level 1 contract.

Distance & Online Training

The ICGP Substance Misuse programme was the first programme in the College to introduce online training. This online training was launched in September 2008. The programme gave an overview of all different substances that are misused, and gave GPs an understanding of all substance misuse. It aimed to have doctors skilled in treating ongoing methadone patients and qualified them as a Level 1 doctor.

Dr Delargy reported in Forum January 2009: "Our most recent development is an improvement on how we've been delivering the programme, using online training. Essentially, it entails both distance and online learning. This means that the GP can access our training course at a time and a place that is convenient for them. As long as they have a PC they can do the training. They can do it within their own practices or from home, or they can do it as a group. There's a lot of flexibility and includes accessibility to the programme."

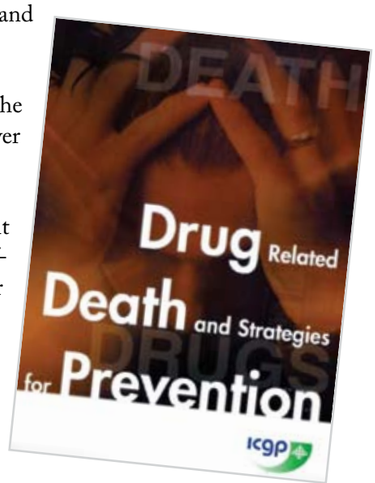
Webinars

In May 2016, a Substance Misuse Webinar Series was launched. The aim of the Webinar Series was to offer GPs and practice staff practical tips and tools for managing addiction and other substance misuse issues in Primary Care.

External Audit

As part of their contract of services with the HSE, GPs agreed to participate in CME and audit of their methadone patients. With the purpose of developing an audit process, the ICGP convened an audit review committee under the Chairmanship of Dr. Ide Delargy with the involvement of both the ICGP Director of Postgraduate Education, Dr. Michael Boland and Dr. Brion Sweeney from the Eastern Health Board. This joint Audit Review Committee (ARG), as it became known, developed a model of external evaluation which was the first of its kind in Irish general practice.

The ARG was given the remit of overseeing training, continuing medical education (CME) which would be delivered by the ICGP for GPs participating in the methadone protocol. An assessment of the quality of care provided by GPs to opiate dependent patients on methadone maintenance treatment (MMT) remains the aim of the audit process. This ensures that patient care meets national and international best practice standards, and also to enhance practice based learning and reflective practice.



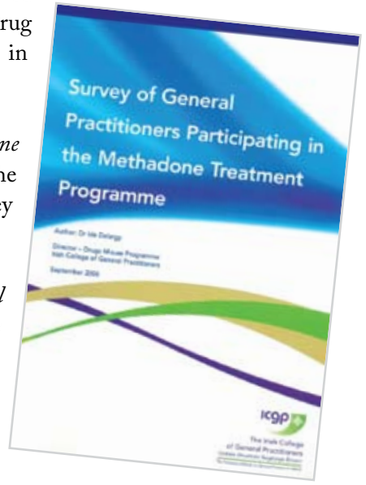
In 1999, an audit nurse, Ms. Mary Laing, was appointed jointly by the ICGP and the Eastern Regional Health Authority and the first ever external audit in general practice commenced.

In 2012 the process of developing an on-line tool for self-audit commenced. In April 2016, the SMP launched the new online self-audit tool to assist Level 1 and Level 2 GPs on the MTP to meet their annual audit requirement.

Developing a Body of Research

The ICGP SMP has also contributed and developed a body of reports and research in this area.

The report *"Drug Related Death and Strategies for Prevention"* was published in March 2006 from the Working Group convened by the ICGP Drug Misuse Programme to examine the issue of drug related deaths in Ireland.



A 2008 *"Survey of General Practitioners Participating in the Methadone Treatment Programme"* found that they were very happy with the protocol and said they would be willing to take more patients on if they were offered.

A follow-up study in February 2015, a survey entitled *"General Practitioners perspectives on and attitudes toward the Methadone Treatment Protocol in Ireland"*, was issued to explore GP attitudes to the Methadone Treatment Protocol and what additional services might support GPs in their work with opiate users.

Also in 2015 an abstract for WONCA Europe was accepted outlining the model of self-audit which has been developed by the SMP team. This model has applicability across other disease areas.

Recent Articles Published Include:

- Delargy I, Crowley D, Van Hout MC. (2018). Twenty Years of the Methadone Treatment Protocol in Ireland: Reflections on the Role of General Practice. For consideration.
- Van Hout MC, Crowley D, McBride A, Delargy I. (2018) Piloting online self-audit of methadone treatment in Irish general practice: results, reflections and educational outcomes. BMC Med Educ. Jun 27; 18(1):153. doi: 10.1186/s12909-018-1259-2.
- Van Hout MC, Crowley D, Collins C, Barry A, Lyons S, Delargy I. (2018) Characteristics of methadone-related overdose deaths and comparisons between those dying on and off opioid agonist treatment (OAT): a national cohort study. Heroin Addiction and Related Clinical Problems. 20 (1): 37-44.
- Van Hout MC, Crowley D, McBride A, Delargy I. (2018) Optimising treatment in opioid dependency in primary care: results from a national key stakeholder and expert focus group in Ireland. BMC Fam Pract. Jun 30; 19(1):103. doi: 10.1186/s12875-018-0792-8.
- Crowley D, Collins C, Delargy I, Laird E, Van Hout MC. (2017). Irish General Practitioner attitudes toward decriminalisation and medical use of cannabis: Results from a National Survey. Harm Reduction Journal. 14, 4. DOI: 10.1186/s12954-016-0129-7.
- Van Hout, MC, Collins, C., Delargy, I., & Crowley, D. (2017). Irish general practitioner (GP) perspectives toward decriminalisation, legalisation and cannabis for therapeutic purposes (CTP). International Journal of Addiction and Mental Health. Jun; 15 (3): 670-683.
- Delargy, I., O Shea, M., Van Hout, MC., & Collins, C. (2016). General Practitioners perspectives on and attitudes toward the Methadone Treatment Protocol in Ireland. Heroin Addiction and Related Clinical Problems. 18 (4): 43-50.

Representation on National Bodies and Agencies

The ICGP SMP has representation on a range of national committees and bodies in the area including:

- Ana Liffey Steering Committee
- Cannabis Prescribing Expert Group – ongoing
- Faculty of Pain Medicine
- HSE Hepatitis C Expert Group
- Methadone Implementation Committee
- National Advisory Committee on Drugs
- National Buprenorphine/Naloxone Working Group
- National Clinical Guidelines Development Group
- National Traffic Medicine Main Working Group & Subgroup on Substance Misuse (RCPI)

Reflections on 20 years of the Methadone Treatment Protocol in Ireland

This year marks the 20th anniversary of the implementation of the Methadone Treatment Protocol. This followed legislation…the Misuse of Drugs Act (Supervision of Prescription and Supply of Methadone) 1998…and so began one of the most successful chronic disease management programmes in Irish General Practice. It came none too soon.

As a GP on the ground in inner-city Dublin in those days I can vouch for the distress, misery, morbidity and extraordinary mortality figures caused by heroin addiction and its consequences. ARV treatment for HIV was in its infancy and many local families were losing sons and daughters to HIV or other complications of heroin injecting. To make things worse, unregulated prescribing of Methadone by a tiny (but malignant) minority of GPs for a private fee with no added care, was undermining efforts to bring rational treatment to this needy group. Fortunately there were some courageous GP colleagues such as Dr. Kieran Harkin, the late Dr. Fiona Bradley, Dr. Ide Delargy and Dr. Des Crowley, who took an active role in researching best practice methadone treatment in other jurisdictions. The ICGP under the leadership of Dr. Ide Delargy quickly provided education, regulation, audit facilities and CME for GPs wishing to participate.

In my own practice dozens of patients and their families have benefited from this chronic disease management system which combines harm reduction, holistic care for the person and detoxification when the circumstances allow.

Twenty Years a Growing and still evolving …how is the Opioid Protocol? ***It remains a remarkable system of life saving, health enhancing, public health positive care in the community.*** The protocol has ensured that this care is now available to about 10,000 patients nationwide. I hope in future there will be further enhancements including further emphasis on encouragement and safe care for those wishing to detox and become drug free.

Dr John Latham, GP

When I first encountered the plight of heroin addicts in Dublin fresh out of the RCSI, I was shocked and appalled that a compassionate Christian country would so let addiction problems run riot and cause mayhem. I met many excellent compassionate GP's who were hamstrung by inappropriate authoritarian controls placed upon them and who were chafing at the bit to do something for these poor victims.

Thanks to a handful of colleagues (a few of whose names immediately come to mind – Ide Delargy, Des Crowley, Kieran Harkin, Margaret Bourke, Joe Barry and Brion Sweeney) ***the Protocol was successfully launched and immediately – from Day 1 – started to save lives. I say this with first-hand experience too detailed to intimate here.*** To date, it has saved tens of thousands of lives and relieves the burden on the HSE Addiction services on a day to day basis.

Much work remains to be done – both educationally and politically. Treatment philosophies and methodologies continue to cause uncertainty and confusion and cloud the clarity of professionals in the field. Medicine still has considerable moralistic leftovers from the powerful Abrahamic faiths and much thought and care needs to be given in disentangling these threads. The goal of addiction medicine should be simple – how can I stop this person's suffering – but it's always coalesced within an enmeshed complex milieu that needs skills broader than can be gained by laboratory medicine.

What have I learned working with drug addicts? When you truly encounter the addict, you encounter the deepest and darkest depths of the human psyche and only then did I learn what it meant to be "human, all too human".

Dr. Anjum Madani, GP

"It helped to keep me on the straight and narrow"

Anonymous Patient

In the 1980s and early 1990s the scourge of opioid drug abuse and addiction plagued principally deprived communities of inner-city Dublin. However by the mid-1990s it had steadily spread to every town and village in the country. Communities and GPs throughout Ireland struggled to understand and cope with this new form of substance abuse. The model of alcoholism was familiar to all and decades of attempting to manage it were of little help or encouragement to health professionals and administrators. In 1996 the ICGP was asked to convene a committee to plan a national GP delivered programme for methadone-maintenance treatment. In my role as former chairman of the ICGP I was asked by council to chair the committee. I came to the task with no prior experience or specialist knowledge of the role of methadone. However I was acutely aware of the problem even in my own GP practice in a provincial urban area, and the individuals and families affected.

The committee was representative of almost all the stakeholders, and from the outset the conflicts over the ethical and practical issues were robustly declared and debated. Despite the difficulties we were able to produce a report that led to the introduction of the Methadone Maintenance Programme. The report made a number of recommendations that were essential to ensure the acceptability of the Programme to a critical number of GPs so as to provide a national GP-delivered service. These included the compilation of a central register of patients on the Programme (which GPs could consult to validate any patient's claimed Methadone Programme status); the training, certification and registration of participating GPs; guidelines on the appropriate numbers of patients registered with individual GPs; referral pathways for specialist help; and the overall governance of the programme including protocols for patient visits, prescriptions and dispensing.

The success of the programme is a testament to the commitment and professionalism of the committee members. No-one regards methadone as an ideal solution but in a world where perfection can be the enemy of the good it has transformed for the better the lives of very many patients and their families.

Dr. Declan Murphy, GP, Chairman ICGP Taskforce on Drug Misuse 1996/1997

In my opinion the methadone protocol has been one of the most effective health care interventions in Ireland over the past 30 years. Most patients registered with our practice can be offered methadone treatment with a 2 week period if appropriate- as opposed to a wait of 6 months or longer pre protocol.

While great strides have been made in terms of normalising drug addiction as an illness, we still have a considerable distance to go. I believe that it should be normal practice for GP's to offer methadone treatment to patients where clinically indicated. I understand that many GP's may be reluctant to engage with methadone treatment because of previous negative experience or second hand reports of same. However with the current support system in place difficulties are very few and readily managed. Although we have 100 patients in our practice on methadone, most drug related problems (alcohol or benzodiazepines) are caused by patients not on the methadone protocol.

In my view, a key objective going forward would be to have drug misuse regarded in practice as a core function of General practice. It seems to me that GP's manage diseases of greater complexity such as diabetes with much less resistance and we need to perhaps understand where the resistance to engage with substance misuse is coming from and to deal with it.

Dr. Kieran Harkin, GP

Dr Kieran Harkin, Dr Cathy Mullan, Dr Niall O'Cléirigh

"With methadone ok you're going to need to take it every day but it's a need that comes with hope attached to it because then you are in a regulated support system. You are part of a system whereas in the other place you are totally all over the place, completely unregulated, unsafe. So it's been around 18 months now had I not got intervention when I did not to be over fatalistic or dramatic or anything let's just say wherever I would be it would be a worse place than I am today"

Anonymous Patient

The initial discussion in the early and mid- nineties on Drug Misuse/ Methadone Prescribing at ICGP Council was vigorous to say the least. The discussion was led by Fergus O'Kelly and Gerard Bury both of whom were directly confronted with the Drug Misuse epidemic in their local communities and had undertaken research and advocacy which laid the groundwork for the structured development that followed in later years. It was then seen as a Dublin problem and even there confined to certain Inner City communities. However, the problem was gradually extending to areas beyond the Pale.

On the retirement of Fergus O'Kelly as Director of the ICGP Programme, Íde Delargy was appointed Director. In June 1996 the ICGP established a working group with a view to developing a Methadone Maintenance Protocol, which included a wide spectrum of representation. An initial outline was agreed, including training, and this was adopted by Council in 1997. The Department of Health provided funding and a protocol was adopted and launched by the Minister for Health, Michael Noonan, at the ICGP AGM in Waterford.

This strengthened the role of the GP and provided a support network. An oversight committee was established which later was formalised as the HSE/ICGP Audit Committee. The protocol was continually reviewed and enhanced, including the co-ordinated role of Community Pharmacists, and support for the service nationally was developed by way of a range of training, courses, advice and protocols. The programme continued to receive the support of the DoHC and the HSE and dovetailed with HSE Community Based services.

This was an important development for the College as it created direct structured links with other Community Services and added to the credibility of the College within the wider context of Healthcare Delivery.

Mr. Fionán Ó Cuinneagáin, ICGP CEO 1986-2011

In 1998 when the MTP was introduced I had worked as a Community pharmacist in Dublin's North Inner City for 21 years. I had completed my pharmacy pre-reg year in Jervis St Hospital and the first Drug Treatment Clinic had operated from the hospital since 1969.

As the debate occurs presently on the location of supervised injection centres, I can recollect that there were clients of the Centre who accessed injectable Methadone on a daily basis there.

In 1988 the Centre moved to Trinity Court in Pearse St. The spread of HIV brought about the opening of clinics in Baggott St., Amiens St. and Ballyfermot. While the demand for treatment places increased these clinics only treated clients from a very defined catchment area.

I worked in the area I called Community Care Area 6 and a half. There were no clinics a cohort of clients who accessed Pearse St for short detoxes which failed and nowhere to go. I would have known many of these clients and their families well. There were a small number of pharmacies dispensing Methadone to clients who attended local or sometimes not so local GPs. Other pharmacies were willing to involve themselves but wanted a defined structure around the treatment of patients. Initially there was a pilot project with clients receiving Methadone DTF 1mgm /ml in the Community pharmacies. These clients had treatment cards and were usually placed in local easily accessible pharmacies. The role of liaison pharmacist evolved, these pharmacists worked in clinics and also linked with community pharmacist to place clients who were ready to move out. Both Physeptone (Methadone 2mgm /5ml) and Methadone DTF 1mgm/ml were being dispensed from pharmacies and pharmacists were concerned. The Pharmaceutical Society and Irish Pharmaceutical Union worked on reports for a more structured service and this was incorporated in to the Methadone protocol. This structured approach to the involvement of community pharmacies has facilitated the involvement of a greater number of pharmacies involved in providing services to clients with drug misuse problems both in Dublin and many other areas of the country. . There is also Needle Exchange provision outside Dublin, a Suboxone pilot project in community pharmacies which has been completed may facilitate a wider Suboxone Supervised Scheme from Community pharmacies. There has also been training for pharmacists on the provision and administration of Naloxone. In my opinion the most successful aspect of the MTP is the team-working that facilitates the treatment programmes for clients.

While members of the public may feel that patients on Methadone stay on it forever and perhaps question this. Many pharmacists would see it as a tool to enable clients to stabilise their drug use and subsequent reintegration to a normal working life.

While there is certainly a far more varied poly drug use than when I started out. At least structured Methadone programmes with no charge provided either in Clinics or from local GPs means that we have not seen the devastating problems that Oxycodone known as "Hillbilly Heroin" has brought to parts of the central states of the US. I remain fascinated at the vast quantity of Oxycodone dispensed from a pharmacy in the Tennessee area on a weekly basis as related to me by a student who had completed a summer placement.

My involvement in the programme has given me a much broader perspective on how to manage and work with challenging patients both those with drug misuse and mental health conditions particularly to educate them to manage their conditions and recognise when they are struggling. It has been very rewarding. ***I passionately believed there had to be something better out there than what I was seeing on the ground in terms of our response to the problem of treatment for drug misusers in the 1990 era. I know now that there was and on a bad day with a difficult client could always say to fellow pharmacists that I can remember the bedlam before the MTP.***

Over the years there were many pharmacists who led the way in the provision of services particularly the Boles brothers Wiliam,David and John. Richard Collis, John Corr and Paddy Byrne who were involved in the IPU at the time, Richard and I had many frank exchanges of view. Nihal Zayed , Dennis ODriscoll and Sheila OConnor who were the original liaison pharmacists. Tom McGuinn was the Chief Pharmacist in the Department of Health.

Noeleen Dargan, Pharmacist

"When the new "AIDS /Drugs" programme was established in 1996,it faced huge challenges. The Government, Ministers and Senior Civil Servants were very supportive with the necessary finances but the Eastern Health Board faced difficulties in implementing its plans. Our strategy was to encourage G.P.'S and Community Pharmacists to become involved in treatment and embed services in primary and community care. Communities did not want large treatment centres and we needed the support of community activists, to localise treatment and to manage our centres in a professional way. There were just 6 treatment centres, 15 G.Ps and 35 Pharmacists involved with thousands on waiting lists, in 1996. The treatment register was a voluntary one, parents and family members were buying methadone on the streets for sons and daughters and clients were nervous to come forward because of vigilante activity.

The Methadone Protocol was critical in attracting new G.P's, Pharmacists, and Treatment Centres to be established. Community leaders could convince local groups that local treatment was for local residents. We had proper data on the numbers in treatment and the overall plan with money going into education, counselling, detox, rehabilitation, treatment and community projects through the task forces left it easier to point out that a comprehensive approach was being taken. By 1999, the number of treatment centres had risen to 45, the number of G.P.'S had risen to 106 and the number of community pharmacies had risen to 155. ***An external evaluation pointed out that our services and approach was one of the more innovative in Europe. Looking back, the model of care which was underpinned by the protocol was really what became known as "shared care" and "clinical pathways" with a highly participative multi-disciplinary approach. Given that the experience of chronic opiate addiction was, at that stage very much Dublin City based, great credit is due to the Irish College of General Practitioners for their willingness to embrace this new approach."***

Well done on writing it up and particularly for your foresight to develop the concept back in the "good old days, even if we didn't know it!!"

Pat McLoughlin, Chief Executive EHB, ERHA, Deputy CEO HSE.

The biggest success of the MTP has been the engagement of so many GPs in the prescribing of methadone. Moving opioid substitution into general practise normalises it as a treatment and reduces the stigma experienced by patients. It also allows for the engagement of drug using patients with general medical services which streamlines care and optimises outcomes. It has a knock on benefit of engaging other family members, in particular the children of these patients.

"It's been extraordinarily helpful. I don't want to be on it forever but certainly as I become more and more stable and I am able to benefit from the support structures I have as a result of that stability"

Anonymous Patient

The biggest obstacle that I see is the lack of choice in OST.
The delay and limiting of buprenorphine access is a major concern. We cannot underestimate the stigma attached to methadone treatment and the requirement for patients to attend large addiction clinics. The changing profile of opioid use in Ireland and internationally means that more and more patients are becoming opioid dependant from opioid based over the counter and prescribed pain medication. It is imperative that we create a patient friendly services the engage this cohort.

Addiction treatment is now the major part of what I do. I could not have envisaged twenty odd years ago that this would be my career path. I really enjoy the work and find it interesting, challenging and rewarding. I feel both privileged and proud to have contributed to this area of medicine.

Dr. Des Crowley, Assistant Programme Director, ICGP Substance Misuse Programme

"Certain things are still hard don't get me wrong – the isolation that's a big part of addiction. It's one I still find very hard to shake but ultimately I have hope whereas before I had absolutely none"

Anonymous Patient

The ICGP Substance Misuse Programme has been an integral part of the Methadone Prescribing Protocol since its inception in 1998. It has transformed the approach of General Practitioners in terms of attitudes to opiate addiction and has helped deliver quality medical care to those who never had it in any great numbers before. A GP colleague of mine tells me that his involvement in the Methadone Protocol is the most satisfying part of his busy general practice and he values his relationship with the patients for whom he prescribes methadone.

There are two initiatives which if implemented would enhance the quality of substance misuse care in Ireland. The first is to make receiving care for substance use, including methadone prescribing, from your General Practitioner the norm, rather than receiving it from clinics with hundreds of other drug users. The second initiative is to make suboxone and any other alternatives to methadone available through all General Practitioners participating in the scheme.

My own practice has been enhanced through participating in the joint HSE/ICGP audit committee where the quality of the ICGP component of the overall methadone programme is quality assured. The audit committee, hosted in ICGP headquarters in Lincoln Place, strikes a good balance between an audit function and facilitating participants to provide quality care. The health service would be enhanced if other aspects of health care provision adopted this model.

Professor Joe Barry, Trinity College Dublin

Dr. Ide Delargy, Mr. Fionan O'Cuinneagain (ICGP Chief Executive), and Ms.Linda Latham with members of CVS Learning who completed the IT development of Level 1 training online.

The Irish healthcare system was totally unprepared for the country's first experience of injecting heroin use (the so-called 'opiate epidemic') of the early-1980s. I have a vivid memory of trying to explain to a senior civil servant at the Department of Health some of the concepts – such as harm reduction, user-friendly agencies and low-threshold service - that were gaining currency internationally at this time. He listened with polite incredulity to my explanation before describing these ideas as 'very novel'. I was sufficiently familiar with the lexicon of the civil service to know that this was not a ringing endorsement of harm reduction and, on this basis, thought it unlikely that we would see the introduction of such practices for the foreseeable future. I was wrong and, within a year or two of this conversation, an incremental but somewhat surreptitious process of harm reduction service provision had begun.

"I felt for the first time the gravity of my situation was taken into account. It was being taken seriously. That was around Easter last year 2017 and I've been on methadone since. It's not a miracle drug, it has its downsides. I'm the most stable I've been in a very, very, long time in all senses. I am able to function. That's really it, the critical part of it for me"

Anonymous Patient

Undoubtedly, the coming of HIV/AIDS concentrated the minds of policy makers, and the generation of civil servants which succeeded my sceptical friend were open to pragmatic approaches to addiction treatment that would previously have been considered heretical. In the early days, it was commonplace to suggest not only that all services should be abstinence-based but also that there was no place for primary care providers in this aspect of healthcare provision: GPs were more likely to be considered part of the problem rather than of the solution. ***The implementation of the Methadone Treatment Protocol in 1998 represented the most radical abandonment of such negative ideas about the possibility of normalizing addiction treatment, side-lining the legendary 'rogue doctors' and building in a variety of safeguards for doctors, their patients and the community at large in a clever piece of legislative action in an unusually complex policy arena***. Credit for the Methadone Protocol, it seems to me, should be shared amongst several stakeholder groups: from the early-1990s onwards, Dublin GPs who had worked responsibly (and without much thanks) with drug users were joined by a new cohort of GPs who had experience of this kind in the UK; the voluntary harm reduction agencies (chiefly the Ana Liffey Project and Merchants Quay Ireland) played a helpful role; and, as already indicated, some Department of Health officials were crucial to this process.

I believe that the general policy climate in relation to drug use and addiction, both in Ireland and internationally, has shifted considerably over the past twenty years, best exemplified here by the impending creation of a medically-supervised injecting facility. ***The Methadone Protocol has played, and continues to play, an important role in allowing primary care providers to work constructively with problem drug users – Happy Birthday!***

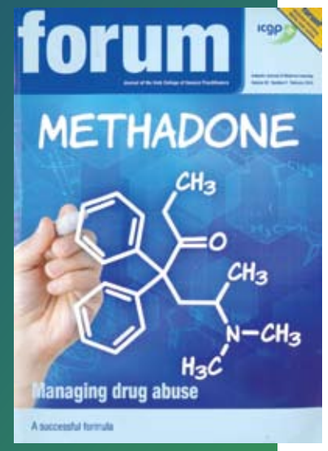
Dr. Shane Butler, PhD, Emeritus Fellow Trinity College Dublin

Dr. Kieran Harkin, Dr. Fiona Bradley, Dr. Des Crowley, Dr. Íde Delargy and Dr. Shane Butler

Proven Successful Model for Managing Chronic Disease – Where to From Here?

"The MTP is an example of how chronic disease can appropriately and effectively be managed in general practice" said Dr Richard Brennan, ICGP Chairman, at the opening of the ICGP Drug Misuse Conference, 1st & 2nd March 2002 in the Four Seasons Hotel, Dublin.

'A chronic care service that actually works'



Structured Methadone Treatment, introduced in the late 1990s, has been a success story in terms of the ongoing and holistic care of what are essentially chronically ill patients, says Ide Delargy, the ICGP's substance misuse programme director.

"The ultimate goal would be where necessary every GP would look after their own patients if they happened to be in need of methadone treatment. I don't think that is too idealistic. That would be the model they would subscribe to in the UK. It is recognised and well established now that addiction is a chronic relapsing condition, so it would come under the chronic disease model of care."

Therefore, says Dr Delargy, these patients should be managed by their own GP where it is appropriate.

Says Dr Delargy: "It should be pointed out this treatment scheme is remunerated. It is in fact one of the few areas of chronic care that actually attracts special remuneration for the work involved."

[Excerpt from Forum February 2015]

Review of the MTP

In 2002 the Department of Health and Children requested the Methadone Prescribing Implementation Committee to conduct a *Review of the Methadone Treatment Protocol* that was introduced in October 1998. Its report published in 2005 examined the protocols for good practice in the prescribing and dispensing of methadone and pointed to appropriate controls that could be put in place. It also set out the basis on which methadone treatment should continue to be developed and recommended a concise framework for the future operation of the Scheme. The report was circulated nationwide to every general practitioner and pharmacist. An implementation committee was established with responsibility for implementing the recommendations contained in the report.

In 2010, the HSE commissioned an external review of the Methadone Treatment Protocol which was conducted by Professor Michael Farrell, Consultant Psychiatrist (Maudsley Hospital London) and Professor Joe Barry from TCD. This external review was undertaken to; inform and maximise treatment provision and assess clinical governance and audit, referral pathways, doctor enrolment, training (Level 1 and 2) and GP co-ordination. Farrell and Barry commented on the inclusion of buprenorphine and naloxone treatment modalities and the need to revise the title of the protocol. The report, with revised title, *"The Introduction of the Opioid Treatment Protocol"*, was published in December 2010 and the ICGP was commended for its significant contributions to this area of work. ***Professor Joe Barry of TCD and co-author of the review said, "The landscape of illegal drug use has changed considerably since the Methadone Protocol was first introduced and this report provides a blue print for Opioid Treatment Services in the 21st century.***

In March 2012, an external peer review evaluation of the audit process was commissioned with the RCGP in Scotland. The report, *"Evaluation of the audit of the methadone treatment protocol in Ireland"*, by Dr Sayet Priyadarshi, Ms. Mary Clare Madden and Mr. Paul Rimmer was published in November of that year. A response to the review was drawn up by the Substance Misuse team and endorsed by the ARG.

Where to From Here?

The substance misuse landscape is an ever changing one and GPs have a key role in identifying patients who may have a problem. Raising awareness of the issues and equipping GPs to better meet the needs of their patients who may have substance misuse problems is of paramount importance. Offering care in the general practice environment is a less stigmatising one. In addition to the well documented alcohol problem in Ireland, benzodiazepine abuse, over the counter (OTC) codeine abuse as well as opiate analgesic dependency are a growing cause for concern. Normalising the treatment of drug users in primary care and reducing the stigma around OST is a challenge particularly in the context of ongoing criticisms of long term maintenance treatment. The ICGP has continuously made efforts to make substance misuse a mainstream issue rather than a niche area for a small number of GP's. The Foundation Training in Substance Misuse has been made accessible through on-line modules and substance misuse is now a core component of the GP training curriculum. This area of medicine needs to be accepted as relevant to every GP and substance misuse acknowledged as an issue we encounter, either overtly or covertly, on a daily basis in our practices. Much has been achieved over the past 20 years but the challenge remains to ensure that every GP is adequately trained to service the needs of patients who have addiction problems.

Other aspects that need to be considered for the future include the waiting times for treatment in some areas of the country, services for homeless people, the stigma associated with methadone treatment, negative patient experiences around service delivery and the lack of choice around substitution medication. The full implementation of the recommendations from the Introduction of the OST Protocol published in 2010 would contribute significantly to addressing these issues.