

'As methadone maintenance is now firmly established, we are going to get an ageing population of opiate/opioid dependent people who will get conditions that require an opiate-based painkiller. This fills me with dread, so I was relieved to see Dr Ford's article... and that as a GP, she was willing to prescribe them.'

In our latest website poll we asked: Do you believe the Drug Intervention Programme has been a worthwhile initiative? Yes it has, say 63 per cent of you, including this DIP case manager:

Proactive partnership promotion

I have worked within the DIP project for the last year at Harlow, Essex. I am convinced the project is worthwhile when it operates in a proactive manner with its partners.

I do feel it still has a lot of growing to do and the opportunities for this to happen are there – I see this as a very positive element of the scheme.

DIP has had to create its own identity. This is starting to be recognised and appreciated by most of our partners, but there is still work to be done in this area. The rapid intervention ability of DIP has had an effect on the more chaotic offending clients and the variety of intervention services strengthen the project's ability to be effective.

DIP will continue to develop in the future as long as the partnership ethos is continually promoted.

Clive Emmett, DIP case manager

R.E.S.P.E.C.T.

I would like to applaud Dr Chris Ford for her article 'No pain, all gain' in the last issue (*DDN*, 29 January, page 9). It has been a growing concern of mine that opiate dependent people are not given opiate-based analgesics when needed, to relieve them from pain.

I have witnessed too many times people on methadone scripts in chronic pain go through a process (depending on their condition) of NSAIDs such as Ibuprofen, Naproxen etc. Then if they are still in pain the doctor may try drugs for neuropathic pain, such as gabapentin and amitriptyline, mentioned in Dr Ford's article. It seems that opiate dependant people in severe pain are given every analgesic under the sun except opiate-based pain killers.

We had a client who is undergoing palliative care for Aids. They were in severe pain so we fixed them up with an appointment with the pain management team at our local hospital. This person was on a small methadone script from the specialist service. The pain management team wrote to his GP saying he needed Sevredol, which the GP had no problem with prescribing.

However the specialist drugs team told the GP not to prescribe it, as they would not be able to tell if the person was using street heroin! We were dumbfounded and arranged a meeting with all the aforementioned teams; the patient was also present at the meeting.

Getting this meeting together took over three months because of the politics and ethics of the situation. In that time the person did start to smoke heroin as they felt they had lost the battle, plus they could not stand the pain anymore. I am pleased to say that the meeting was over quickly and the patient was prescribed a morphine-based painkiller, which did the trick. He has since stopped using street heroin.

I highlight this case because if it takes all this 'red tape' to get an opiate-based painkiller for someone who is dying of Aids, imagine what will happen if we have someone in severe pain who has not got a terminal illness!

As methadone maintenance is now firmly established, we are going to get an ageing population of opiate/opioid dependent people who will get conditions that require an opiate-based painkiller. This fills me with dread, so I was relieved to see Dr Ford's article highlighting that opiate dependent people do sometimes need opiate-based analgesics – and that as a GP, she is willing to prescribe them.

I applaud Dr Ford for this and hope that the message gets across to people in the medical profession. Also, I hope that drug users read this and that it will give them the confidence to push until they get opiate based painkillers when necessary – or at least get someone to advocate on their behalf.

Well done Dr Ford – respect.

A freelance South Wales Drug advocate, name and address withheld

Notes from the Alliance



Do hospitals, custody suites and prisons realise that withholding methadone could be grounds for legal action?, asks **Daren Garratt.**

At the inaugural Methadone Alliance Conference on 22 March 2000 at the Purcell Rooms in London, Professor Gerry Stimson delivered a speech entitled 'Blair declares war' or 'The unhealthy state of British drugs policy', in which he raised concern around the government's then new Drug Strategy, which clearly prioritised the reduction of crime over the promotion of public health. The knock-on effect of this, Gerry feared, would be the development of a new unhealthy drug policy that would both disregard and have adverse effects on the health needs of drug users. He said: 'More drug users will be detained: in police cells, on remand in prison, sentenced to imprisonment, and returned to prison. There will be more drug use in prison and more risk of death from overdose around after release.'

How right he was. In 2006, the inability of the prison system to respond effectively and appropriately to the health needs of an increasing population of detained users previously maintained on substitute medication, resulted in an unprecedented test case that highlighted the practice of involuntary withdrawal of methadone from prisoners. The Home Office was forced to compensate 198 prisoners on the grounds of clinical negligence and assault, but what are the implications for the continuation of this practice beyond the prison system?

The Alliance receives many requests for advocacy from users who have found that, following admission to a general hospital ward, they have had their maintenance script reduced or even fully withdrawn because of seemingly arbitrary decisions of ward doctors who call into question, and frequently override, the clinical assessment of a patient's own prescribing GP.

This is unjustified, inexcusable, discriminatory, and I would suggest, possibly even illegal. Under the Disability Discrimination Act (1995) it is unlawful for a contractor to discriminate against a disabled person – 'a person has a disability if he has a physical or mental impairment, which a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities' – by failing to comply with a duty, in which the effect of that failure is to make it impossible or unreasonably difficult to make use of any services provided. Further the DDA also states that a provider of services discriminates against a disabled person if (a) for a reason which relates to the disabled person's disability, he treats him less favourably than he treats or would treat others to whom that reason does not or would not apply; and (b) he cannot show that the treatment in question is justified.

Now I'm no lawyer, but it would seem to me that any hospital ward, custody suite or prison that knowingly withholds or alters an individual's legally prescribed prescription is in breach of this act, and there could be a whole new clutch of test cases and undisclosed payouts just round the corner. I wouldn't bet against it, would you?

Daren Garratt is executive director of the Alliance