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Harm reduction on film

I am holding a film festival in Leicestershire this June, to reach groups that do not have much contact with local services and to enable people to have a greater understanding of what constitutes harm reduction. We hope it may ultimately save lives.

I'm writing to ask if any readers would be happy to give or lend films that we can show. We are looking for any movies that can be classed as harm reduction, and can be in any format. So please dust off those old videos and send them along.

The event is supported by our local DAAT and will be open to everyone. Invites are going out to hostels and housing staff in Leicestershire, drug workers, service users, parents and carers – anyone who might be interested. Representatives from local agencies will be available to chat to people on the day.

Please help me to make this a fabulous day – it will only be a success with your support. We are looking to gather all films together by March 2007.

Please contact me as soon as possible at Alyson.Taylor@leicester.gov.uk.
Alyson Taylor, substance use policy and development officer, Leicester City Council.

And then I got high

I was interested to read 'Alternative high' (DDN, 15 January, page 6).

I was on a 24-hour expedition climbing the three highest peaks in Britain – Ben Nevis, Scafell Pyke and Mount Snowdon – all through Merseyside Probation, Fresh Start programme. I was a recovering substance misuser and found that attempting this challenge and completing it became one of my biggest accomplishments of my life.

I became higher than any point in the country (Ben Nevis) and have pictures to prove it, this giving me a high no drug could ever give me. It turned my life around.

I am now volunteering as a client support worker within the Lighthouse Project (Alternatives) Liverpool.

David Ashley, by email

Small reward – high price

I recently heard on the news that a chief of police suggested that it would be a good idea to give heroin to prolific offenders to try and stop them committing offences. As a recovering heroin addict myself, I could not believe what I was hearing. Surely the message that needs to be addressed is that if you repeatedly commit offences you will get punished for it through the justice system, not given free drugs as a kind of reward.

I think more money should be invested in helping people get off the drugs – this will surely reduce the crime rates and perhaps agencies should be more available as the waiting list can be up to three months. I also think there should be more funding for courses like the Offender Substance Abuse Programme (OSAP), which I am currently on through probation.

When users are clean or are being medicated, boredom is a big factor that triggers people back into crime or drug use. Perhaps then, we should be focusing on what aftercare can be offered – like gym passes at a discounted price or something that can keep the people who genuinely want to stay clean the help and support they need to become a better member of society.

I currently have a job two hours a night, but my daytimes are empty and I do not have the money to keep myself busy. However, if I was given a gym pass or something to do during the day I would feel a lot better about myself and be able to meet people who are not involved with crime or drugs. This would give me more fulfilment than drugs could ever give.

Also, what happens when the crime rate goes up because of people using crack-cocaine? Do you then start giving them free drugs?

I would be very interested in comments on this.

Jodie Nind, High Wycombe

Going through changes

There is nothing new or surprising in Alex Stevens and Tim McSweeney's comments about the difficulties people experience in adapting to the concept of abstinence and recovery (DDN, 15 January, page 9). Resistance to change is part of the human condition.

What does disturb me is the implication that they were asked to do just that 'quickly'. To even consider that it is possible, shows a remarkable lack of understanding of the complex nature of addiction, therefore that such attempts met with resistance and failed is hardly surprising. But it is alarming to be made aware that those who attempted such a clumsy approach not only appear to be unaware of the complexities of addiction, they also appear to be unfamiliar with the psychological and emotional processes described in the 'Cycle of Change'.

The journey of recovery is slow and unpredictable; attempts to rush it are predisposed to failure. People do not become 'ready' for abstinence by accident, or just the passing of time. They become ready following patient, determined, enthusiastic, and not infrequently, repetitive application of time tested and successful principles.

I am in complete agreement that treatment can be a successful alternative to imprisonment – as long as there is a willingness to engage in an individual's life, with a view to

establishing what might motivate them, rather than seeking to engage him/her in some predetermined box ticking format within a specific period of time.

I also agree 'insisting on abstinence' would not in itself reduce the number who reoffend; it is also true that those who achieve abstinence are far less likely to offend than those who are still using and therefore pursuing activities to fund that use.

But I have to regard the suggestion by the contributors that abstinence focused interventions would 'lead to an increase in imprisonment', as a very large 'red herring'. We know that in the real world the revoking of court orders does not automatically lead to transgressors being incarcerated. On the contrary, recent highly publicised cases show only too clearly that even those on parole have to commit horrendous crimes before action is taken, and in almost every case we learn that they have breached their parole orders over and over again, without action being taken.

Peter O'Loughlin, The Eden Lodge Practice

Suffer the children

I have recently read the NICE guidance on psychosocial interventions and note that it includes people from the age of 16 years up. As a specialist in young people's drug treatment I was keen to see how young people's psychosocial treatment issues were differentiated from those of adults. On reading the document it is clear that they are not, in fact the adolescent literature does not appear to have been specifically included.

I would like to highlight this issue to readers to encourage people to contact stakeholder organisations and submit comments. I am concerned that otherwise they may slip by without anyone noticing and soon become adult based evidence for young people's policy. It is a very important document and has big implications and changes in practice for adult service users too.

Jill Britton, Outcome Consultancy, London

Timely intervention

Thank you for an opportunity to vote on whether DIP has been a worthwhile initiative (DDN, 15 January, page 8).

When people are arrested, charged,

tried or sentenced for a crime, an opportunity presents itself to identify whether the individuals need help to resolve a substance misuse problem related to their offending.

In that context, a programme that seeks to ensure that such people promptly receive an appropriate assessment and are referred to suitable treatment under a coordinated care plan must be viewed as welcome, when compared with the deficiencies in providing such services in many areas prior to the introduction of the DIP. Carrying out the DIP scheme has resulted in more cases receiving treatment, and improved communications between agencies about individuals' treatment.

However, I do not think that achieving these objectives by using the DIP scheme has been all 'worthwhile' as it has involved massive administrative waste and duplication of effort. The same results could have been achieved at a fraction of the price, by creating a nationally accessible database in a standard format with links to templates for a properly qualified assessment and care plan and an inter-agency referral and information transfer form, with a further template for recording contact and work done.

The current DIP scheme suffers because the Drug Interventions Record (DIR) system is not a suitable assessment tool nor a suitable communications tool, and the discrepancies between area borders in the different agencies (health, prison, probation, police, drug agencies, council and social services) require inordinate efforts to track down individuals.

In my view these problems have resulted from a lack of consultation and could be repaired with some effort to consult further, which would no doubt improve the 'worthwhileness' of the system.

**Eleanor Levy,
Substance Misuse Officer**

Has DIP (Drug Intervention Programme) been worthwhile?

Consultation is still open on our website: visit www.drinkanddrugs.net to vote.

Post-its from Practice

No pain, all gain

Dr Chris Ford looks at the need to manage pain in people who use drugs



Nicky is 42 years old and has been registered with the practice for a couple of years. Until recently she received her drug treatment from the local specialist drug service and was on 200mg injectable methadone. She used to be a national cross-country runner and also suffered from anorexia as a teenager. She started opiates in her late 20s for severe knee pain. For pain relief, she first bought heroin but quickly transferred to methadone, firstly from a private prescriber and more recently from the drug service. She uses no illicit drugs and does not drink alcohol.

She came to see me to explain that her knee pain was getting worse and that the methadone was no longer helping. About a year ago her orthopaedic surgeon had decided the best solution was bilateral knee replacements. The first one was done about eight months ago and had failed, causing more pain. Over the years she has seen a number of pain teams who have prescribed a number of medications, most recently gabapentin and amitriptyline, but never opioids and none of the drugs tried have helped.

She requested an increase in methadone and/or alternative analgesia from the drug team, but they said they had reached their maximum dose and that she should discuss pain relief with her GP.

It was a difficult problem for me to address. However, I felt the first thing to do was take over her methadone and ask her to try splitting the dose four times a day. Dose splitting can be more effective as pain relief, and this did help a little, but she continued to experience severe pain. Her sleeping and mobility decreased and she began to get depressed.

Having tried most analgesias other than opioids, we decided together that we needed a new approach to try and get the pain under control. We started with a small dose of long-acting morphine, which required increases until the pain was more under control. The only remaining problem was breakthrough pain, especially after any mobility and sometimes at night, so we added quick acting morphine, which she takes very occasionally.

Nicky is now on 200mg of methadone, which she splits into two, as she feels this works the most effectively for her, 100mg long-acting morphine twice daily and 50mg of short acting morphine as required and she is almost pain-free. Her mood has improved, as has her mobility and sleeping. She does not feel chemically affected by these doses and she feels that she is 'living again' (her words). She is thinking about returning to college and has recently started as a volunteer in a charity shop.

Nicky's pain management proved difficult and daunting for me as this was the first time prescribing these doses and this combination, but seeing the excellent results for her has made the risk worthwhile. In my experience (and the evidence supports this) people on long-term substitution therapy often need higher doses of pain relief – don't forget they also do feel pain!

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP