

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