

# My great escape

In the third part of his story, Bri realises a change of scene is his only chance. Would he adapt to living on the south coast?



**I remember the day I left London.** London to me was as addictive as the drugs I was trying to escape from. It was so hard to actually make the break to leave a city that had been so instrumental in the negative parts of my life and even on the train down to the south coast, I got off three times. In a crazy way I was truly addicted to London itself.

The reason for leaving London was to go to my brother's wedding – and my plan was to never go back. I would find a place, anywhere that I could go, and just escape from my addiction. This was not going to be easy; I left London on the Friday and arrived in a south coast town to stay overnight with a family that my brother knew.

The next morning the guy who owned the house asked me to accompany him on a shopping trip; he was going to buy me a pair of shoes for the wedding. During the car journey we began arguing about his Christian faith. We talked about what had happened to me as a child – the way the church treated my foster parents and the way a particular member of the Church had threatened to throw me and my brother and sister out onto the street. I never forgot or forgave him for that, and it was a big, big hurdle to me about the Christian faith. I hated anything to do with God, Jesus and churches. As far as I was concerned, I had been hurt as a child and there was no way this phoney faith would ever convince me otherwise.

The journey seemed to go on forever, and all the time chat went back and forth – me telling him how much I hated God, and the driver saying how much God loved me. Then the driver said something that seemed to make so much sense I nearly missed the meaning: he said 'Bri, there is a rotten apple in every barrel,' and it was suddenly so darned clear I could not understand how I had missed it.

The next day I took my relatives to Church – under protest I may add. I found myself kicking the chairs in front of me, and little did I know that the chair I was kicking was the one that my future wife was sitting in. Not only did she become my best friend and constant companion, but I came to love her deeply. This was a whole new ball game for me: people seemed to care about me for the first time in my life and there were no conditions. All I needed to do was be me.

Back in that church, I grew more irate having to sit there and listen to the sermon. The minister started talking to the 300 people in the congregation about the keys to life. I thought to myself, 'New life? What's all this jive about?' After the service I went to see the minister and he led me through the prayer to get to know this Jesus guy. Who was he, and how could an invisible being change my life? Well that Sunday did change life for me beyond all recognition. I never imagined how much I could believe something that is unseen. It was truly amazing discovering faith.

*Next issue: Bri tests his new faith – and finds that old habits die hard.*

## Post-its from Practice

### Patient defined recovery

**Morphine sulphate can be a useful addition to the prescribing toolbox, says Dr Chris Ford.**



**I felt a bit proud** when Stuart came to see me to show me his first pay packet. It wasn't enormous but it was more than the benefits he had been on for years, and as he said: 'It's mine and I earned it'. We also chatted about his health and his maintenance script of morphine sulphate.

We laughed about the journey he had taken to get to this point but it was far from funny in reality. He had registered with us about six years ago having moved into the area and had lost his private script due to his doctor going before the General Medical Council. At that time Stuart was confrontational and demanded that I gave him the same script of 4 x 50mg (200mg) ampoules of methadone, 20 x 5mg (100mg) of dexamfetamine tablets and 3 x 10mg (30mg) of diazepam. He was also quite unwell with swelling and ulcers on his legs.

We concentrated on improving his health and after a few months he settled on 150mg of injectable methadone and 30mg of diazepam. After two years his legs had improved and he decided he wanted to stop injecting as a first move to getting off all drugs, and he requested a move to methadone mixture. He kept trying but he didn't settle and for a time returned to street heroin. A few weeks later he represented and said he would like to try buprenorphine.

Again he really tried to settle but was unable to, so after a few weeks he asked to go back on his injectable script because his life had become so chaotic in such a short time. We agreed and he soon settled and decided to remain on maintenance again.

Stuart remained well for a further six months on injectable maintenance but unfortunately developed an acute deep vein thrombosis in his leg. Because of this he again decided he must stop injecting. He asked me if there was anything else he could try.

I explained I had some experience of using oral morphine sulphate, codeine and dihydrocodeine and had found all these drugs helpful in certain individuals. I explained that none of them were licensed in the UK for the treatment of opioid dependency but they had some evidence base. Morphine sulphate is used extensively in Europe for maintenance and dihydrocodeine has a small evidence base in the UK (Robertson R et al 2007).

After hearing all the evidence, Stuart decided he would like to try morphine sulphate. When transferring people to it, I find each patient is different on the amount they need, but it is usually double the methadone (because of shorter half-life, which is about 12 hours) plus around a third more. We started him on MST 60mgx3 twice / day = 360mg and he settled on MST 2x100mg twice daily = 400mg.

He felt well on this and then began to talk about detoxification. But in his counselling sessions he identified how scared he was of going back to injecting and realised he wanted to work on developing skills and getting a job, and stay on maintenance. We did not have a problem with his plan and directed him to the local 'back to work' scheme and continued his script.

It is clear that morphine sulphate is not right for everybody and should only be used when other options have failed. But let's use them if necessary and not reduce our limited prescribing toolbox more than we have to. It is also clear that maintenance is not right for all, but a person's own choice about 'treatment' and recovery is fundamental, and 'recovery' needs to be self-defined. Stuart has defined his recovery as getting his first pay packet.

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