'Orange Book' views from the frontline

***Druglink* asked five individuals with substantial collective experience of the British drug treatment field for their views on the new clinical guidelines on the treatment of drug dependency. Even within this small sample, opinion seems deeply divided. The guidelines are both praised as humanitarian and condemned for lack of patient involvement; praised for being cautious, attacked for their authoritarian tone. The future may be orange, but strictures on how best to treat drug users will always make some people see red.**

At first glance, there would seem to be little in these guidelines to gladden the hearts of drug users.

With their emphasis on 'supervised consumption' of medicines and 'specialist' reviews for users in the care of GPs, these guidelines can leave a drug user feeling that there is precious little trust around these days.

We are told early on that the guidelines act as a template of good practice – a 'gold standard' against which clinicians will be judged in future enquiries. Guidelines are usually seen as a restraining force, reining in the 'over-generous' doctor. I believe that it is now time that these guidelines cut both ways. There are still areas of the UK where drug users do not get treatment to the standard laid down in these guidelines. The British Methadone Alliance will be advising drug users to use these guidelines as a template for judging their own local services.

Despite the international resurgence of interest in diamorphine prescribing over the past three years, this intervention is dismissed somewhat out-of-hand. Support, albeit heavily-guarded, is given to injectable methadone prescribing for some patients.

One reason for patients to welcome the guidelines is that they endorse methadone maintenance treatment in unequivocal terms – something which previous editions have singularly failed to do. The methadone doses recommended in the new guidelines (60–120mg and higher for some patients) are much more realistic than previously recommended (30–40mg).

Hopefully we will now see an end to patients being denied maintenance treatment at reasonable doses. Clinicians are also sensibly advised that there is 'usually little clinical improvement when detoxification is carried out against the wishes of the patient.'

Crucially, however, the guidelines lack any sense of patient involvement in their making. I hope that this is the last set of guidelines produced without the active participation of patients.

Peter Carmichael
General Secretary of the British Methadone Alliance.

This is a well presented, accessible document that will be useful to GPs and members of multi-disciplinary teams in the field of drug misuse. It is a systematic approach to clinical management which avoids unnecessary jargon.

There are some important principles in this document that are clearly underlined and consequently should be welcomed by all those working in this particular field. One of these is the importance of shared care. Emphasis on a multi-discipline approach is essential to tackle the problems presented by users.

It is also good to note that users are not seen as types – the guidelines stress that a variety of people use drugs, so a range of treatments should be available. The essential issue for street agencies is the right of our clients to GPs' services. The case for this is clear in these guidelines and will be helpful when finding GPs for drug using clients.

In an ever changing field, training is essential. The affirmation of this principle is clearly outlined on page 13 where it is noted: 'Effective training for participating personnel and the monitoring of competence will play an important role in achieving success.'

The guidelines are often forward-looking. An example of this is in the various maintenance treatments available and likely to be so in the future, for example LAAM and buprenorphine.

There are some areas in the guidelines that should provoke further discussion. In the examples of good practice in shared care of drug misusers, the scope of the drug agency is very limited while the role of the GP is too wide in many respects. If shared care is to be serious it needs a sense of equal partnership, which this example fails to provide.

Kaleidoscope is concerned about the administration and dispensing of methadone as recommended in the guidelines. It is our contention that the vast majority of those on a treatment programme should be dispensed to daily, with takeaways of methadone kept to a minimum. The administration of methadone should be supervised to ensure there is no leakage of the drug on to the black market. There is also an over-emphasis on urine testing in the guidelines and not enough attention given to alternatives. The problem with urine testing is that it is clearly abused and when properly monitored is an invasion of basic privacy. Alternatives such as saliva testing or skin swipes should be developed.

The annexes are helpful and information can be easily accessed. A criticism could be made regarding Annex 5 where the matter of postnatal management fails to deal with the problem of a drug dependent mother and baby in hospital. It is too often the case that the baby is monitored for a week or so after the birth, while the mother is discharged in the normal way. For a mother struggling with drug misuse, visits to develop bonding with the child can be impaired.

One key problem that led to ineffective implementation of previous guidelines remains. GPs are independently contracted. Until employment practice is confronted the problems of the past will continue.

Martin Blakeborough
Director of the Kaleidoscope Project in Kingston-upon-Thames. He is a member of the ACMD and on the managing committee of the London Drug Providers' Consortium.

This valuable document can operate as a textbook. The tone is humanitarian, emphasising rights to treatment.

The sections on pregnancy, youth and assessments are excellent, although it is disappointing that the heading 'Suicide' gave no advice since clinical depression is so prevalent.

But as the virtues are strong, so the defects. Of the 28 in the 'broad multi-disciplinary membership', 21 are doctors and the remainder 'establishment'. Evidence is chimerical: Lofexidine is 'equally efficacious as methadone' yet The Stockwell Project's experience of this for in-patient detox is unremittingly negative. Conversely there is, apparently, 'lack of evidence' about injectable physeptone despite a long history of good practice.

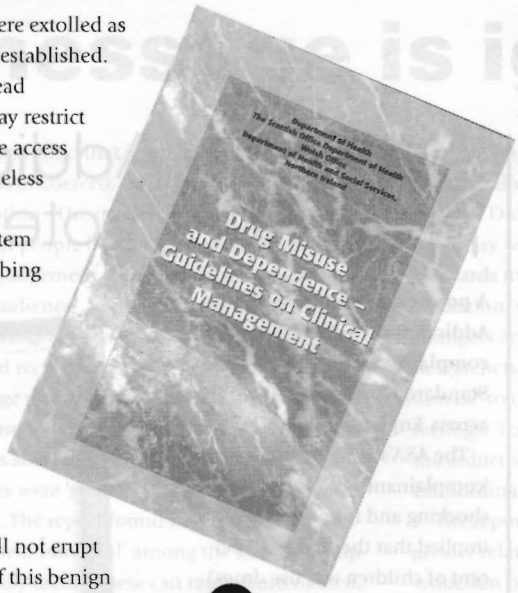
Equivalence rates from heroin to methadone are omitted and dose titration is imposed without a resource strategy. There is a disquieting assumption that many relying on Banks and Waller's classic conversion tables have become negligent overnight. What were pilots of supervised consumption are here extolled as though universally established. Ironically, widespread implementation may restrict rather than enhance access for vulnerable homeless patients.

The licensing system for complex prescribing is welcome if it empowers GPs and constrains private prescribing, but the patronising rigidity of the expertise structure is disturbing.

Controversies will not erupt around the detail of this benign text, but with its dogmatic interference with clinical judgment on prescribing and dispensing.

There is growing unease among experienced GPs and services who were quietly doing a decent job before the implicit threats in these April prophecies.

Lorraine Hewitt
Practice Manager of The Stockwell Project, a direct access service, which is part of the new South London and Maudsley NHS Trust. She is a member of the ACMD.



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It is a sad reflection of current thinking that in 1999, despite the title, we have moved from guidelines to dictats.

The 1984 guidelines were prepared to help doctors 'to provide an appropriate and constructive response based on their clinical judgement of the needs and circumstances of the individual patient.' The 1991 guidelines set out to offer 'flexible guidance to help all doctors.' The new 1999 guidelines state that '. . . any doctor not fulfilling the standards and quality of care in the appropriate treatment of drug misusers that are set out in these Clinical Guidelines, will have this taken into account if, for any reason, consideration of their performance in this clinical area is undertaken.'

In explanation of this heavy handed approach we are told that the current 'Guidelines' have been funded and published by the Department of Health rather than a professional body, 'because clinical interventions for drug misuse and dependence are subject to a number of regulations for the prescribing of controlled drugs.' Yet the more flexible 1984 and 1991 guidelines were also funded and published by the Department of Health.

Were it not for the fact that they are so inflexible I would be warmly welcoming this latest version of the guidelines. Of course they are not as evidence-based as they purport to be, but in general they make sound common sense.

They bring into the treatment arena of accepted good practice a number of new areas which have hitherto been omitted from previous guidelines. This includes titration and supervised consumption of methadone – neither of which are evidence-based from the point of view of clinical trials.

Yet, if the previous guidelines had been as inflexible, one wonders whether doctors undertaking titration or promoting supervised consumption would have been seen to be 'not fulfilling the standards and quality of care' expected of them. The 1999 guidelines are to be welcomed, but their rigid application may stultify future progress.

Tom Waller
Suffolk County Specialist in Substance Misuse, was a GP and was a member of the Advisory Council on the Misuse of Drugs (ACMD).

The long awaited 'Orange Guidelines' may have thrown up expectations that could, in time, be frustrated. On the whole they are a welcome contribution to the debate about good clinical practice and at first sight seem to do justice to the collective wisdom accrued over the last 15 years.

The general tone is rightly one of caution, presumably to minimise treatment-derived drug use. However, on closer reading certain anomalies and contradictions appear.

For example it states that because of non-compliance, '. . . many patients, despite requesting detoxification, are more suitable for maintenance treatment . . .' Yet, this may itself lead to an increase in the numbers maintained indefinitely and perhaps inappropriately. A section on maintenance prescribing consolidates the confusion of 'when to or when not to' maintain someone in treatment. An opportunity to tackle this thorny issue has been lost.

Perhaps the guidelines greatest weakness is in the implementation of its recommendations. It is not at all clear who would take the lead to ensure this happened appropriately. Shared care is one of the guiding principles of the document and this makes sense in the light of recent legislative changes and philosophical shifts, but it could also be a recipe for shared inaction.

Apart from training of practitioners, the resources that will be needed are not discussed in any detail. This issue seems to have been anticipated by the authors to some extent for they recommend the setting up at local level of a shared care monitoring group. Drug Action Teams should make this one of their priorities in order to ensure the speedy implementation of these otherwise helpful guidelines.

Andy Malinowski
GP Liaison Worker with the Bristol Drugs Project.