Orange Book signals sweeping changes

Although submissions officially closed at the end of March 1997, the revision of the *Guidelines for Clinical Management* (the so-called 'Orange Book') still looks a long way off. *Building a Better Britain* said it would be out in May, but latest estimates put its publication date at "sometime in the autumn". *Druglink* though has seen a recent draft of the section dealing with prescribing and licensing regulations – and it will surprise few in the field to learn that it looks as if the British System is well and truly dead.

The current guidelines, published in 1991, state that, "any doctor can prescribe methadone and most other opioids to a drug misuser. It is only for the prescription of three specific drugs (cocaine, diamorphine [heroin] and dipipanone [Diconal]) that a special licence is required".[1]

While pre-publication changes are likely to be made to the draft leaked to *Druglink*, we do understand that the general thrust of the revised guidelines will not alter substantially. And that thrust is summed up in the fifth recommendation made by the Working Group which drew up the new version:

"A licence should be required to prescribe any schedule 2 or 3 controlled drug in any form except methadone liquid or mixture on an NHS prescription."

If taken up by government – something which would require legislation – this recommendation would effectively mean that doctors will need to obtain a Home Office Licence if they want to prescribe any controlled drug except methadone mixture. Methadone would, therefore, be given the seal of approval as the official drug of choice for treatment.

All or nothing?

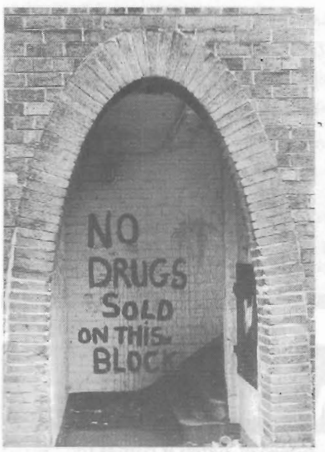
This is not to say that this is the Home Office's preferred option. The current guidelines state that, "the most common source of problems in prescribing for drug misusers is the prescription of an open-ended supply of drugs" – in other words, leakage into the illicit market.

Given this situation, some members of the Working Group (the Home Office included) may have preferred to recommend for the licensing of *all* controlled drugs. The 'methadone exemption' seems to be a later compromise.

> If a doctor needs a licence to prescribe any drug other than methadone mixture, there will be considerable pressure *not* to prescribe any other drug

It is still too early to judge what this could mean for the field if it is indeed the final recommendation of the Working Group, and if it then clears the ministerial and parliamentary hurdle. But perhaps it indicates a centralising tendency, with the prescribing ball now firmly in the court of the Drug Dependency Units and Community Drug Teams, which have the political, financial and human resources to pursue licences, a luxury in terms of time and effort which individual doctors may not be able to afford.

Certainly, if a doctor needs a licence to prescribe any drug other than methadone mixture, there will be considerable pressure *not* to prescribe any other drug. One or two drug-using clients may not be seen as sufficient motivation for doctors to open up their records to an audit from the licensing body.



And as one service user told *Druglink*, "All the best drugs in the country will now be in the hands of the dealers. People aren't stupid. If methadone is the only drug on offer, they'll go elsewhere".

Restricted access

The Working Group has also recommended that "a licence should be required to prescribe any controlled drug in an injectable form" and has blocked doctors from prescribing heroin, cocaine or dipipanone privately. More worrying still for private practitioners, forever tarred with the 'over-prescribing' brush, the draft guidelines push for the licensing of all private prescribing – including methadone.

Given the ambivalent outcomes of recent Home Office action against private prescribers, this legislative route may actually prove more 'successful' than the prosecution one, finally cutting private doctors out of the prescribing loop.

Taken as a package, then – and if acted upon – the licensing recommendations on their own would freeze out the lone GP (whether in NHS or private practice), potentially leading to a drastic cut in the provision of medical care to drug users.

Pushme, pullyou

But things are not always that simple, and it seems that these recommendations have *not* been drawn up in glorious isolation. There are strong hints emanating from the Working Group that the Guidelines will call for the creation of specialist 'superGPs', trained up to provide appropriate care and support for drug users as well as being properly 'plugged in' to local services.

There are three major implications of this move: firstly, the Working Group believes that at present, GPs are not as well informed about dealing with drug-using patients as they should be.

Secondly, it confirms the view that many GPs no longer see treating drug users as part of their core services. And thirdly, in the future, the only route into prescribing drugs other than methadone mixture will be to become one of these specialist GPs.

Whether the field can support yet another layer of provision is anyone's guess, but the informed 'superGP' may at least mitigate the effects of a licensing system which seeks to narrow the range of available drugs and to place methadone beyond reproach.

1. Department of Health. *Drug Misuse and Dependence: Guidelines on Clinical Management*. HMSO, 1991.