# THE PRESCRI

**Until recently most doctors were moving quietly away from the long-term, 'maintenance' prescribing of the '60s, but disputes within the medical profession and the need to counter the spread of AIDS have brought the prescribing issue back on to the policy agenda. On pages thirteen and fourteen of *Druglink* are the first in a series of papers from doctors with differing views on the role of prescribing in addiction treatment. Here John Strang introduces some of the key issues in the debate.**

John Strang

THE 1980s will probably be looked back on as a decade of considerable change for drug services. We are entering a new age — drug problems are no longer the exclusive domain of the specialist but have become part of the array of problems which comprise the work of the generalist. However, as yet, most generalists have been slow to contribute to the service. Confusion about their role probably accounts for much of this resistance. In medicine, confusion and controversy is nowhere greater than over the issue of prescribing to addicts, where even the 'experts' publicly disagree, sometimes to the point of personal attack.

The AIDS issue is forcing a re-examination of present treatment approaches. More liberal prescribing is once again being discussed as a possible way to bring more drug users into contact with treatment services. Clinics would then work with these newly contacted drug users to reduce their risk of becoming infected and — crucially — to reduce the spread of the virus to the general population. Experimental schemes are being established in which drug injectors are being given needles and syringes on an exchange basis. Where, then, will prescribing fit into such a new-style service? Arguments over prescribing are now sharper and perhaps more important than ever before — but no less confused. This article is an attempt to clarify some of the key issues and concepts.

FLEXIBILITY is often wrongly equated with malleability. Services need to be flexible to achieve the optimum match between the patient and the available treatments, but this is not the same as a service which the drugtaker manipulates and 'beats' to obtain the 'treatment' option that most satisfies their desire for drugs. It is not just a matter of handing the patient a shopping list of all the available treatments: rather it is a matter of advising them on the much smaller list of potentially appropriate options and attempting to tailor the response to the individual to maximise the likelihood of the sought-after change.

For this reason the DHSS *Guidelines of good clinical practice in the treatment of drug misuse* distributed to doctors in 1984 (for summary, see page 12) recommend the early identification of goals which are accepted by both doctor and patient. Straight 'consumer choice' is a poor measure of the worth of the treatment as it presumes popularity goes hand in hand with appropriateness. An obvious illustration of the flaw in this argument is that prescriptions for vodka would be extremely attractive to those attending an alcohol treatment unit, even though we would all presumably see this as against their long-term interests. If there is one element which is a *sine qua non* of treatment of drug addicts, then surely this must be *change*. Debate should not be over *whether* change is the goal, but over *how* to reach agreement on the specific change to be sought, how to monitor progress towards this goal, and what to do in the event of lack of progress towards the agreed goal.

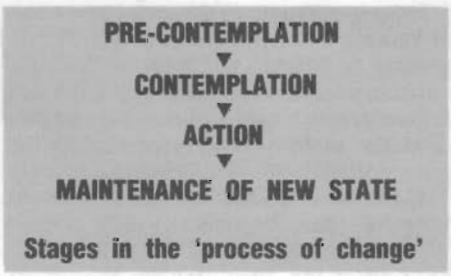
In this regard, I find it useful to look at a model of the 'process of change' described by Prochaska and Di Clemente in 1983 (see diagram) and to develop this by considering factors which may promote or impede flow through the process. Police activity, fear of AIDS, black-market prices, pressure from family or the courts, are all forces which may influence flow through this process — likewise the prescribing of drugs or enrolment in a treatment programme. It is a truism within medicine that if a drug has good effects, then it probably also has harmful effects, so what are the impacts of different types of prescribing?

In recent years, drug clinics have concentrated on those who have at least reached the stage of 'contemplating' change towards abstinence. Advent of HIV necessitates reconsideration of this narrowing of their repertoire. Harm-reduction approaches can also be considered within the framework of a 'process of change'. Merely supplying drugs or injecting equipment is unlikely in itself to bring about an adequate and durable change in behaviour. But having shaken the drugtaker from their 'pre-contemplative' complacency, having assisted them in their 'contemplative' cost-benefit analysis of their present versus alternative circumstances, then perhaps one can work with them to implement a change (and then to maintain this change). Merely enticing the 'pre-contemplator' into contact with the drug clinic is of little value if not accompanied by a change for the good in drugtaking behaviour.

It should be possible to identify goals for each patient and to monitor progress through the process of change towards achieving these goals. A prescription for drugs might be seen as lubricating the passage through the process, thus increasing the likelihood of achieving the goal. Many drug clinics now use written 'contracts' and an implicit contract exists with all patients. Although the 'contract' can sometimes degenerate into little more than a set of rules, it should presumably indicate ways of measuring passage through the process of change.

A particular area of concern is over the possible harmful impact of the ready availability of a prescription to a drug user on the verge of deciding to return to drug use. The benefit that the crisis intervention of today may intercept anticipated high risk behaviour (illegal drug use) needs to be balanced against the danger that it may result in a long period of medium risk behaviour (prescribed drug use). Prescribing drugs may promote healthy flow in one instance, and yet the same prescribing may impede flow in another.

The process of 'un-change' is often multi-step (eg, moving from stage four back to stage one) and seems altogether different from the process of change. At a practical level, a particular problem is how to cater for a population at one point in the process of change without having a damaging effect on those who are at a different point in the process: the intervention with one patient may leak out of the consulting room and distort the next consultation.




**Stages in the 'process of change'**

DIFFERENT RULES may be required for different levels of drug services. Once we recognise drugtakers are a mixed bag, it becomes easy to understand why some may be 'straightforward cases' who can be managed at an early level of health care provision — such as the primary health care team — while more 'difficult' cases will need to be referred on to a local service with more expertise, time and resources. More complicated cases will need to be referred on to drug agencies such as in-patient units and rehabilitation houses.

It then becomes necessary to identify the different types of services to be provided at different levels of health care provision. The DHSS guidelines advise those working *outside* specialist agencies on how to deal

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# BING DEBATE

with drug users' general health care needs as well as their drug dependence needs within a primary health care and general hospital setting. But some treatments are thought to require specialist involvement. Thus the guidelines say non-specialist doctors "should not undertake to treat drug misusers by long-term prescription of opioids unless in consultation and conjunction with a specialist . . . who has experience of this approach".

MAINTENANCE prescribing is used here to refer to drug treatments which seek to confirm the drugtaking *status quo* while bringing stability to the drug user's lifestyle, rather than working towards abstinence from all opiates. It is fundamentally different from approaches which attempt to help the drugtaker break free of their addiction. The area of confusion comes with long-term, abstinence-orientated treatment programmes, in which intermediate goals short of abstinence may need to be adopted while gradually working towards abstinence.

The sad reality is that much long-term, non-reducing prescribing of methadone occurs by default, rather than as a result of a decision to prescribe on a maintenance basis — perhaps following an initial *ad hoc* prescription for a few days given to a drugtaker who presented inconveniently at the end of a GP's surgery. Frequently, no decision will ever have been taken to continue with the prescription: it is just that no careful consideration has been given to the context in which the prescription is being given. For this reason, emphasis is placed on being clear about the purpose and likely duration of treatment and on agreeing its goals and time-scale with the patient beforehand.

IT IS IMPORTANT to look beyond the particular drug being prescribed when we attempt to identify an appropriate level of concern about a particular treatment approach (or the prescribing habits of a colleague): we must also look at the *way* it is being used. Prescribing some types of drugs is sufficiently controversial and/or problematic to make it wise for these approaches to be left to those specialising in the drug field (usually the drug dependence units).

Such areas would include prescribing any injectable drugs as part of a treatment plan, where it is especially important for both doctor and patient to be clear about the purpose, and about the length of time during which the agreed change is expected to occur. There is the world of difference between someone injecting ampoules or crushed tablets containing methadone and someone taking non-injectable forms of methadone by mouth, even though the actual drug is the same. Problems multiply when the discussion moves on to prescribing 'accessory' drugs such as methylphenidate (Ritalin) or prescribing tablets of drugs such as dipipanone/cyclizine (Diconal), dextromoramide (Palfium) or methadone (Physeptone). Such tablets are frequently crushed and injected, causing even greater medical problems than the injecting of purpose-made injectables.

TREATMENTS that may include long-term prescribing are usually considered only in relation to the opiates. But as we move towards an understanding of dependence and problem drugtaking that covers a much wider range of substances, is it still appropriate to treat opiate addiction as different from the rest? If arguments about prescribing as a way of undercutting the illicit market (and arguments for easy access to drugs as a way of reducing the harm associated with drug use) are pursued to their logical conclusion, where would one stop? With opiates alone, or would amphetamines also be included? What about barbiturates, LSD or solvents? Indeed, what about alcohol?

Is the prescribing of a drug always a 'treatment' in the simple sense of the term? The answer is: it all depends. Short-term opiate prescribing as part of a rapid inpatient withdrawal procedure is a clear example of the drug being used primarily as a way of treating the withdrawal symptoms that would otherwise emerge. At the other end of the spectrum, it is clearly a different use of the drug when it is being prescribed in non-reducing doses, year in, year out: here it is perhaps better to see the drug as part of a 'social contract'. Once we accept that prescribing fulfils a variety of functions, then it becomes more possible to consider different codes of practice for different functions, even though the substance may be the same.

HAZARDS and potential abuses of the service will differ with different treatment approaches. Safeguards, controls and caution before embarking on treatment should be proportionate to the risk of the particular drug or treatment approach. Caution should be exercised and safeguards adopted in all treatment. Nevertheless it seems reasonable that prescribing high ▷

Arguments over prescribing opiates to opiate addicts have been central to British drug policy since the 1920s. A regulation made under the 1920 Dangerous Drugs Act said doctors could possess and supply controlled drugs, including opiates, "so far only as is necessary for the practice of [their] profession" — but how did this apply to addiction treatment?

In 1922 the Home Office called for an "authoritative statement . . . that regular prescription of the drugs on the ground that without them the patient will suffer or even collapse . . . is not legitimate, and cannot be recognised as medical practice". But restricting the powers of the influential medical profession, and cutting off respectable middle and upper class addict patients from their accustomed supplies, was not to be done lightly.

Reporting on the issue in 1926, the 'Rolleston committee' composed of eminent physicians identified two classes of patients for whom regular opiate use was the lesser of two evils: "In one . . . withdrawal produced severe distress or even risk of life; in the other . . . a certain minimum dose . . . was necessary to enable the patients to lead useful and relatively normal lives".

For these patients indefinitely prescribing a minimum quantity of opiates — opiate 'maintenance' — could, they said, be justified as "medically advisable". As put into practice, Rolleston's recommendations left doctors free to prescribe any opiate to any addict in any quantity for any length of time, curtailed only by the limits of ethical conduct.

Reliance on clinical judgment seemed to work well, until the '60s threw up a new breed of addict — young drop-outs who had rejected their conventional upbringings, and petty criminals not born into the 'respectable' classes in the first place. Rather than the bare minimum, these youngsters sought opiate-induced euphoria by extracting maximum amounts of drugs from un-prepared doctors. Many had surpluses to distribute to friends or customers.

Heroin addict numbers spiralled and in 1964 the Minister of Health reconvened the Brain Committee. Their recommendations led to government action in 1968 restricting the prescribing of heroin or cocaine for the treatment of addiction to a few hundred hospital doctors. Nevertheless any doctor could still prescribe addicts heroin-substitutes like morphine or methadone.

But most chose not to. Addiction treatment became concentrated in specialised hospital clinics, which soon began replacing heroin prescriptions with the longer-acting methadone to flatten the peaks and troughs of the three to four hourly heroin cycle, and then replaced injectable methadone with oral methadone — an attempt to minimise the harm caused by injection.

By the '80s, the clinics were turning away from maintenance prescribing of any opiate — even oral methadone — but at the same time GPs and private doctors were becoming more involved, and a few prescribed maintenance doses. Once again there was concern that "injudicious" prescribing was feeding the illicit market. In their 1982 *Treatment and rehabilitation* report, the Advisory Council on the Misuse of Drugs sought to eliminate these doctors' remaining rights to prescribe opiate-type drugs for addiction, but, except for restrictions on dipipanone prescribing, their advice was rejected.

One recommendation that did get through was the distribution to doctors of a set of *Guidelines of good clinical practice in the treatment of drug misuse*. In the formulation of the guidelines and in the aftermath of their publication in 1984, disagreements between doctors over the need for further prescribing controls became sharper, linked to disputes over the clinical and social benefits of opiate maintenance.

The backdrop to these developments has been an increase in the supply of smuggled heroin, to the point where pharmaceutical overspill is now a minor part of the overall illicit market in opiates. In the '60s, the issue was whether prescribing could stop the development of a black market; now it is about whether maintenance prescribing can mitigate the worst effects of that market, without compromising the addict's chances of overcoming dependence on opiates, legal or illegal.

**Mike Ashton**

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doses of injectable drugs on a long-term basis should demand more pre-treatment consideration and more ongoing monitoring of compliance than a short-term, oral treatment package — if for no other reason than that the potential abuse of the former service is substantially greater. So, for example, pre-treatment urine testing need not be so extensive for non-prescribing and short-term prescribing approaches, but may even need to be extended before long-term or maintenance prescribing.

THERE IS an urgent need for the 'middle ground' to be promoted. Several recent debates have imposed an artificial polarisation on the issue of prescribing to drug addicts so that the lay audience and many non-specialist doctors might be forgiven for thinking the choice was between methadone maintenance on the one hand, and total abstinence on the other.

Many drug addicts seeking help encounter confusion and hostility from general practitioners or general hospital doctors, who fail to realise the important contribution they could make by providing the addict with short-term help to become drug free as the first step in a process of rehabilitation. The *Guidelines* have occasionally been mistakenly viewed as an attempt to stop the GP from prescribing to problem drugtakers. In fact, while warning against excessive prescribing, they encourage the over-cautious practitioner to provide help to the addict to help them become drug free — and such help may frequently include the prescribing of reducing doses of drugs such as methadone over a period of up to many months.

AS THE NUMBER of patients seeking help has increased, so it has become increasingly important for the generalist to become competent and confident in providing the more straightforward elements of the service. The *Guidelines* identify two areas as particularly appropriate for doctors in a general practice or general hospital setting: the provision of general health care, and the prescribing of oral withdrawal regimes over a period of several weeks or months when appropriate. Experience in parts of the country where this clearly identified area of responsibility has been actively promoted suggests it is possible to involve a large number of generalists in the provision of these elements of the service, while acknowledging that more complicated treatment approaches (as well as the management of more complicated cases) should be referred on to specialist drug clinics. This experience contrasts sharply with other areas where prescribing seems to be an 'all-or-nothing' response. If we allow it to be seen as this, then we are likely to have a small number of cases of 'all' and a vast expanse of 'nothing', which will be of less value than the wider provision of the middle ground. □

# DHSS ADDICTION TREATMENT GUIDELINES

### Guidelines for all doctors

**1.** All doctors have a responsibility to provide care for both the general health needs of drug misusers and their drug related problems.

**2.** The aim of treatment should be to help the drug misuser to deal with problems related to his or her drug misuse and eventually to achieve a drug-free life.

**3.** The diagnosis of drug misuse is of central importance and every effort should be made before treatment to check that the history of drug misuse given by the patient is genuine. This involves:

— taking a careful history and conducting a physical examination;

— testing of urine for the presence of drugs;

— checking with the Home Office Addicts' Index;

— arranging blood tests which may be useful in further assessment.

**4.** Every doctor must notify the Chief Medical Officer of the Home Office if he attends a patient whom he considers to be, or has reasonable grounds to suspect is, addicted to certain controlled drugs.

**5.** Doctors and other staff should take care that no items (particularly prescription pads) of potential interest to drug misusers are left unattended or where they could easily be stolen.

**6.** Reassurance and the prescription of non-controlled drugs may be an effective temporary measure in dealing with anxiety about anticipated withdrawal symptoms.

**7.** When detoxification is undertaken, the doctor and the patient should have mutually agreed on the treatment regime.

**8.** Doctors are advised not to undertake long-term prescription of opioids unless in consultation and conjunction with a specialist in a drug treatment unit or elsewhere who has experience of this approach.

### Guidance for general medical practitioners

**9.** Before initiating treatment of a drug user as a temporary or private patient, the general practitioner should, with the patient's knowledge, consult the patient's previous or current medical attendant.

**10.** Whenever possible an appointment which allows sufficient time for a full diagnostic interview and physical examination should be offered.

**11.** At the first interview it should be made clear that treatment will not necessarily involve the prescribing of opioids or barbiturates nor will it involve long-term maintenance prescribing.

**12.** Depending on the interview time available immediate treatment of medical conditions, arrangements for specialist investigations and notification should precede a full assessment.

**13.** Referral to the local drug treatment unit and where appropriate to local authority social services or voluntary agencies should be considered.

**14.** Following the diagnostic interview further consultations should be offered.

**15.** If a decision to prescribe opioids is made, certain precautions are recommended.

**16.** Pregnant women dependent on opioids need particular management and treatment.

**17.** Babies born to drug dependent mothers require careful supervision.

### Guidance to psychiatrists

**18.** It is the responsibility of psychiatrists to ensure adequate arrangements for the necessary treatment and continuing care of those drug misusers referred to them, and in particular to provide advice and support for general practitioners in areas where there is no specialist drug treatment unit.

**19.** Psychiatrists should undertake the supervision and treatment of difficult or unstable drug misusers, including those dependent on barbiturates, in cooperation with the referring practitioner and other appropriate and available services. For more stable drug misusers the possibility of shared care with the general practitioner should be considered.

**20.** The need for emergency admission of pregnant drug misusers to obstetric units and of barbiturate dependent patients for detoxification should be recognised, as should the need for early assessment and in-patient treatment of motivated opioid misusers who cannot tolerate withdrawal in the community.

**21.** It is unwise to admit more than two or three drug misusers at any one time to a ward of a general psychiatric unit. Clear ward policies should be established and these should be explained to and agreed by the patient before admission.

**22.** In-patient treatment should work towards reintegrating the drug misuser into the community and should involve detoxification, counselling of the patient, family, and friends, and help, or referral for help, with social and legal problems.

**23.** Continued care after discharge, whether by out-patient attendance, by community based professionals or in residential accommodation, is essential and should be arranged before discharge.

*Extracted from the summary given in* Guidelines of good clinical practice in the treatment of drug misuse, *the report of the Medical Working Group on Drug Dependence published by the DHSS in 1984.*