line with 1983 Royal College recommendations. This will involve the immediate creation of at least 12 extra consultant posts. In addition it should review the demands on services, district by district, and evaluate the need for extra help for districts with special needs (inner city, widely dispersed populations etc.)

DORA BLACK
Consultant Child Psychiatrist
Royal Free Hospital
Pond Street
London NW3

Vice Chairman of NETCAP

References

[1]ROYAL COLLEGE OF PSYCHIATRISTS (1973) 'Norms' for medical staffing of psychiatric services. *News and Notes (British Journal of Psychiatry Supplement)*, December, 2–8.

[2]— (1978) Medical manpower requirements of teaching hospitals. *Bulletin of the Royal College of Psychiatrists*, December, 201–202.

[3]— (1983) Providing a district service for child and adolescent psychiatry: medical manpower priority. *Bulletin of the Royal College of Psychiatrists*, 7, 94–97.

[4]HAS (1985) *Bridges over Troubled Water*. Sutton: Health Advisory Service.

[5]RUTTER, M., TIZARD, J. & WHITMORE, K. (eds.) (1970) *Education, Health and Behaviour*, London: Longman. (Reprinted 1981, New York: Krieger, Huntington).

Addendum

This report was prepared for, and approved by, the NE Thames Regional Psychiatry Advisory Committee who recommended that it was published in order to encourage other Regions to examine their consultant child psychiatric establishment and consider measures to deal with any shortfall discovered. Districts which are inadequately staffed are already finding it difficult to attract high calibre consultant applicants for posts.

The abuse of drugs

DAVID BERESFORD, MDU Secretariat

Recent Government policy has encouraged initiatives aimed at preventing the spread of drug misuse and improving treatment for those who already suffer the effects of dependence. There are probably up to 100,000 opiate addicts in the UK and dependence on prescribed drugs such as benzodiazepines presents a problem of increasing medico-legal significance. All doctors have a responsibility to ensure that drug misusers are offered treatment and should be prepared to assist them with withdrawal from drugs if requested to do so. Many doctors still fight shy of becoming involved, often through fear of contravening the controlling legislation.

This article first appeared in the Summer 1988 issue of the *Journal of the Medical Defence Union* and is reproduced by kind permission of The Medical Defence Union.

The Misuse of Drugs Act 1971

Before the 1960s the control of addictive drugs was largely confined to restrictions on the use of opium and cocaine. With the 'hippie' era came extensive use of 'recreational' drugs such as cannabis, amphetamines and LSD, and their consequent control by the Drugs (Prevention of Misuse) Act 1964 and the Dangerous Drugs Act 1965. As opiate misuse became more and more widespread, legislation was consolidated and improved in the Misuse of Drugs Act 1971 which remains the basic statute in force today.

This Act tightened the regulations relating to the possession and supply of drugs of dependency. However, it was recognised that doctors should be able to treat their patients appropriately without being hindered by the prohibitions of the Act and Section 7 in particular defines the lawful uses of 'controlled'

drugs. Specific means of control are determined in three sets of regulations.

The Misuse of Drugs Regulations 1985 re-classified controlled drugs in five schedules according to the restrictions applied to production, supply, possession, prescription, record keeping and destruction. *Schedule 1* contains drugs such as cannabis and various hallucinogens which are rarely, if ever, used in medicine. Opiates and cocaine (*schedule 2*) are most strictly controlled, barbiturates and amphetamines (*schedule 3*) and benzodiazepines (*schedule 4*) less so. *Schedule 5* includes controlled drugs in preparations of such a dilution that they are exempt from restrictions of supply, possession and prescription. Safe-keeping of controlled drugs (*schedule 2*) is the subject of the 1973 regulations.

Supply of drugs to addicts

Before 1971, doctors maintained an absolute right to prescribe for their patients as they saw fit. The Home Office did not have effective powers to control overprescribing by doctors, nor were there mechanisms to assist doctors in monitoring the quantity of drugs prescribed for the addicts who sought their help. The 1971 Act aimed not just to control illicit possession, but also to stamp out overprescribing. It set up a statutory Advisory Council on the Misuse of Drugs. It introduced a mechanism for notification and restriction of prescribing while largely maintaining the doctors' highly valued clinical freedom. In particular, doctors could no longer prescribe heroin, cocaine or dipipanone (Diconal) to an addict, other than for treatment of injury or organic disease, except under licence from the Home Secretary.

Notification of addicts

Doctors who suspect they may be treating an addict must notify the Chief Medical Officer, Home Office Drugs Branch, 50 Queen Anne's Gate, London, SW1H 9AT within 7 days, preferably using the specially designed form *HS2A/1*. Extra information which is not required by regulation is also requested for epidemiological purposes. The doctor should repeat the notification every 12 months if he continues to treat the patient. Reporting is not necessary if the patient has been notified by a partner in the same general practice or by medical staff in the same hospital within the previous 12 months. Fifteen specified drugs are notifiable:

Notifiable drugs

Cocaine	Hydromorphone *(Dilaudid)*	Oxycodone *(Proladone)*
Dextromoramide *(Palfium)*	Levorphanol *(Dromoran)*	Pethidine
Diamorphine *(Heroin)*	Methadone *(Physeptone)*	Phenazocine *(Narphen)*
Dipipanone (a constituent of *Diconal*)	Morphine	Piritramide
Hydrocodone *(Dicodid)*	Opium	Papaveretum *(Omnopon)*

NB amendments may be made to this list in future legislation.

The name, address, sex, date of birth and NHS number of the patient must also be stated.

The information is maintained in a confidential *Index* to which doctors may refer. Indeed, the prudent doctor will always check with the *Index* when faced with a possible new addict before prescribing for him. This may be done by telephoning 01–213 3396.

The Misuse of Drugs Tribunal

When the Home Secretary considers a doctor may have failed to notify or may have prescribed prohibited drugs, or has prescribed a drug irresponsibly, he can refer the matter to a Misuse of Drugs Tribunal for investigation. If misconduct is proved, the Tribunal may recommend that a doctor be prohibited from possessing, prescribing and administering specified controlled drugs. Unwelcome attention from Home Office inspectors, leading to such a tribunal, can be prevented if doctors adopt sensible precautions where controlled drugs are concerned or drug abuse is suspected.

Guidelines of good clinical practice

Much literature is available, but doctors unfamiliar with this problem may choose to adopt the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* set out in the report of the DHSS' *Medical Working Group on Drug Dependence 1984* (HMSO). This publication contains detailed advice for doctors in various disciplines, including GPs, casualty officers and police surgeons.

The importance of a careful physical assessment, accurate recording of all prescriptions, prompt notification, fully informing deputising colleagues and of seeing the patient for each new prescription cannot be stressed too heavily. The Home Office *Index* should be used to avoid duplication of medical care. If controlled drugs are prescribed at all, a planned programme of reduction should be agreed and only small quantities at a time should be issued, preferably with arrangements for dispensing at a nominated local pharmacy. If possible, advice should be sought from a specialist in drug dependence.