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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Treating drug misuse

SIR,—As the father of a heroin addict who has experienced, like many others, the appalling deficiencies in the present system of drug abuse treatment, I greatly welcome the guidelines of good clinical practice in the treatment of drug misuse[1] (10 November, p 1317). Yet if we are to achieve a realistic improvement in the treatment and rehabilitation of drug misusers, certain factors need to be considered with great urgency.

Facilities for the treatment of drug misusers are non-existent in many areas of the United Kingdom. Few doctors either in hospital or in general practice want to treat drug abusers, nor do they have the knowledge and training necessary to undertake the demanding work of treating addicts. Most areas do not have the important non-medical skills available to reintegrate the drug abuser into society.

The guidelines appear to emphasise the importance of detoxification rather than the more important phase of treatment—namely, counselling and psychotherapy. Many an addict, like my daughter, goes through the present system of detoxification only to revert to the drug scene—largely because of the lack of expert counselling being provided pari passu with detoxification. What a tragedy for the addict and his or her family, and what a waste of precious time and money. Since 1968 drug dependency units have formed the main statutory treatment facility. Most are centred in or around London attached to psychiatric hospitals. Most have long waiting times for outpatient and inpatient appointments. Many addicts do not consider themselves to have a mental illness and are often reluctant to seek help from these centres; perhaps in part this explains the reason why fewer than half the addicts who do seek treatment do so at a drug dependency unit. The fact that less than 10% of all drug abusers get any form of treatment is disturbing and surely must bring into question the relevance of our existing drug abuse treatment philosophy to the present generation of drug abusers. In his book *The Heroin Solution* Trebach states, "The experts in drug prevention and treatment are widely divided on virtually all the major issues involved and ... the more closely one looks at the English experience, the more difficult it is to discover what the British system is, or whether there is a system at all."

The guidelines of good clinical practice would be of even greater value if combined with the realistic political action necessary to ensure that all health authorities had the facilities and staff required to carry out this treatment. Many drug dependency units adopt a rigid and inflexible philosophy of treatment, being unwilling to vary the type or method of treatment according to the needs of the individual addict and unwilling to consider "injectables" for physical and psychological drug dependency. Seventy four per cent of addicts first notified in 1981 were addicted to heroin in the first place: this drug should have an important part to play in treatment. For many within the therapeutic establishment the suggestion that heroin could have a major role in treatment is hailed as scandalous, yet this unrealistic attitude continues to complicate the mystique of heroin, to the advantage of no one save the criminal organisations who are so deeply implicated in this destructive illness and social problem. For many of us the tragedy of heroin addiction under the present system lies in the inevitable involvement of a loved one in crime with a drug adulterated with substances at times more lethal than the drug itself.

We need the guidelines but we also need both the government and the clinics to encourage and give support to those doctors working in general and private practice who wish to assume a greater responsibility for the treatment and management of drug abuse.

If we accept the approximate figure of 40 000 people dependent on drugs in Britain, with the numbers rising annually at an alarming rate, we need the help of every medical and non-medical person who shows an interest in this problem. "Our liberties, our culture, and our democratic civilisation depend upon our youth, and their resolve, abilities, and spirit must not be eroded by drugs." (Captain George L Negron, US Navy).

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1 Medical Working Group on Drug Dependence. *Good clinical practice in the treatment of drug misuse.* London: DHSS, 1984.

Failure of single dose amoxycillin as prophylaxis against endocarditis

SIR,—The case reports on failed antibiotic prophylaxis (1 December, p 1499) would have been better published as Lesson of the Week, as the real point is surely not that antibiotic prophylaxis for patients at risk of infective endocarditis occasionally fails—a