

symptoms and tablets and drugs taken. After all, the drug abuser is an expert at controlling his body using pharmacologically active substances.

An important additional factor that I have utilized is to use recent graduates of the withdrawal regime to lend support and encouragement to those withdrawing. This has proved helpful in combatting the depression which seems universal by the fifth day of the regime. How much of this is due to the clonidine, how much to lack of opiate 'buzz' and how much to pre-existing personality problems is not clear. Support from the group with or without subsequent antidepressant therapy seemed very helpful with this problem. The development of a self-help group linked to the local drugs council is being explored at present.

The need for hypnotics is universal. I tried to avoid giving tranquillizers during the day, most especially lorazepam which in my opinion, because of its buccal absorption, is itself a drug of addiction more than other benzodiazepines. I used diazepam or, perhaps better, flurazepam at night.

The regime is adjusted to the individual needs of the patients. Older patients seem to withdraw more severely, independent of quantity or duration of opiate abuse. Withdrawal symptoms seem to be greatest at the times of the day that abuse had previously taken place.

For certain patients, it is difficult to stop use of other drugs of abuse. Amphetamine has a definite adverse psychological and pharmacological effect. Cannabis has a heterogenous effect, exacerbating withdrawal symptoms in some and having little effect in others. Alcohol has a synergistic effect. In general the patients learn from their mistakes and this results, sometimes after a long time, in a sustained change in behaviour.

The regime can be modified to yield withdrawal courses of different degrees of intensity:

—*The most intense*; as a universal opiate antagonist, naloxone can speed up the process considerably but results in more intense withdrawal symptoms necessitating more clonidine. The naloxone can be used after seven days by those who are impatient to be off all medication.

—*The usual course of clonidine alone*; most patients were taking the maximum dose of 12 0.1mg clonidine tablets by the third day with a gradual withdrawal after this. On average it seems to take about three weeks to tail off the clonidine.

—*Use of dihydrocodeine*; either, in the case of one patient, at the begin-

ning (as he had evidence of noninfectious hepatitis) to reduce the severity of the process, or after about a week of clonidine to allow a reduction of the clonidine dose. There is no doubt that after about one week, most patients get fed up with the large dose of clonidine. It is relatively easy to reduce and then eliminate the residual small dose of dihydrocodeine.

Permutations of these regimes can be tailored to the needs of different patients.

Treatment of opiate addicts is multifactorial and can be problematic. Attention to social, emotional, financial and employment factors are all very important. The results of this combination of clonidine withdrawal, self help group support and treatment within the context of general practice may indicate relatively good results. Out of the 14 treated so far, 10 are doing well at present, four are not doing so well (in that they are using opiates) but of these four only two actually made the effort to withdraw in the first place. One of the failures who did withdraw successfully is trying again at present.

Treatment of heroin addiction with noncontrolled drugs is within the province of the general practitioner.

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Reference

1. Riordan CE, Kleber HD. Rapid opiate detoxification with clonidine and naloxone. *Lancet* 1980; 1: 1079-1080.

Sir,

I was surprised to read this paper (June *Journal*, p. 368). I had assumed that the supervision of withdrawal from opiates was not unusual for a general practitioner. In response to the author's request I report another case.

A 26 year old unemployed heavy plant driver came to me in December 1982 asking for help in 'kicking the habit'. He had abused many drugs for a number of years, but had found himself dependent on heroin for about three months. He was well motivated to stop and this was helped by the fact that his girlfriend had left him and refused to return until he was drug free. I felt an immediate rapport with him and I believed him.

I referred him to the Regional Drug Dependency Unit (DDU) but was told that there was a two month waiting list for an outpatient appointment and a longer wait for inpatient treat-

ment. This was unsatisfactory. With the shaky background of a student attachment to a DDU for two weeks, I decided to help him withdraw. I notified the Home Office and started to prescribe methadone tablets. We were very open about our expectations of each other and I saw him at least twice a week.

My plan was to withdraw him over several weeks. He progressed well but had several relapses relating to police enquiries about previous motoring offences. He stopped completely on several occasions for a few days at a time. We gained much insight into the nature of drug addiction. After four months of this, when I was beginning to despair, he suddenly found he could manage without drugs.

He remained drug free for three months. He then came back to me apologetically and handed over his syringes, having started again only a week previously. This time I withdrew him rapidly with diconal as he disliked methadone. I gave in to this request with reservations in view of recent publicity about diconal. Within a week he was drug free and 3 weeks later he has not started again.

I claim no special skills in dealing with drug abuse. I believe I was fortunate to have a patient with whom I had a good relationship and who was well motivated. I do not believe that I was abused or that he was obtaining drugs elsewhere. The lack of immediate specialized treatment spurred me to continue with my efforts alone. I believe opiate addiction can be treated by general practitioners.

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Medical Students and the College

Sir,

As an incentive to recruitment to College membership I would like to suggest that we have some form of student membership, then students would go on to join the College when qualified.

The British Medical Association have this arrangement. Associate members of the BMA are medical students who become full members when they qualify.

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