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SIR: Drs Drummond and Turkington have averaged one error of fact or interpretation for each of their six paragraphs. It is true that we did not cite the evidence for our claim of "high acceptability", but there are several free withdrawal programmes available to opiate addicts in London. That patients or their families were evidently prepared to pay for our programme, even though we now also offer out-patient methadone withdrawal, surely indicates a fairly high level of acceptability. Currently, over 80% of our withdrawal patients are self-referred.

The authors evidently believe our patients to be relatively affluent and unrepresentative. In reality, the large majority are from social class 3 or lower. Many are unemployed at the time of admission. One of the main reasons for speeding up the withdrawal process is that it reduces the cost. By further modifying our techniques, we can now discharge our patients after only 24 hours in most cases at a cost as low as £325. Even relatively poor families can often afford this sort of figure.

More importantly, Drs Drummond and Turkington seem to have overlooked the fact that the title of the paper is "Opioid withdrawal *and naltrexone induction* . . .", and that this technique is not simply a method of helping opioid addicts to stop taking opioids. It is also a method of getting them started on a drug which greatly reduces the risk of relapse (Brahen *et al*, 1984) without the usual delay of five to ten days after withdrawal when the risk of relapse is particularly high. In Drs Drummond and Turkington's own study, only 37% of their patients achieved drug-free status after 14 days, and several discharged themselves prematurely.

Objective measures of withdrawal symptoms would have been a useful addition to our study, but they are of less practical importance than whether or not a significant proportion of patients withdrawn using this technique continue to abstain from opiates after discharge. Whichever withdrawal technique is used, many addicts will report persisting discomfort, sometimes for weeks or even months after they have been officially 'withdrawn'. The preliminary results of a follow-up of our recent patients echo the findings of Brahen *et al* (1984) and others that provided naltrexone administration is supervised by a third party (usually a family member), early drop-out levels are low. Fewer than 10% appear to discontinue naltrexone during the first week. The value of supervision in preventing relapse is supported by studies of supervised disulfiram in the treatment of alcohol abuse, which involves similar concepts (Brewer, 1987). We did not compare our technique with other withdrawal methods using clonidine or methadone alone, but as we pointed out, others have already done so (Charney *et al*, 1986) and have found that clonidine-naltrexone comes out well.

Finally, although in a few cases the total diazepam dose for the first 24 hours exceeded the equivalent of the maximum daily chlordiazepoxide dose used by Drs Drummond and Turkington, most of our patients used considerably less. Furthermore, we prescribed daytime benzodiazepines for only two to three days, so that our total benzodiazepine dosage was very considerably lower than theirs. In our present 24-hour detoxification and naltrexone-induction programme, the total benzodiazepine dose is even less, further supporting our finding that speeding up the withdrawal process reduces the overall requirement for supplementary medication. Thus the suggested mechanism of rapid normalisation of opiate receptor sensitivity is indeed supported by our study and by our subsequent experience. However, I regret that in trying to be concise we inadvertently gave the impression that this theory originated with Kleber *et al* (1987), rather than with some of the studies cited in their paper.

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