in adult mental health. It can be particularly worrying when a parent refuses access to the health visitor; although she has responsibility for the children in her area, the health visitor has no legal right of entry. There is bound to be delay while the health visitor becomes sufficiently worried to contact the social services and the social services become sufficiently worried to approach the courts.

There are, then, three main needs: firstly, residential and day care facilities for assessment of mother and baby and guidance and facilitation of parenting skills when these are lacking; secondly, extra community support over the time that the parent-child relationship is developing, provided by either specially trained health visitors or social workers; and, thirdly, simpler and earlier access to the court to allow the health visitor to carry out her usual function and to protect the child. Ideally, preventive action would be taken before birth to avoid the punitive overtones inherent in going to court later. Although provision for these needs does exist it is in short supply and unevenly distributed over the country.

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1 Mills M, Puckering C, Pound A, Cox A. What is it about depressed mothers that influences their children functioning? In: Stevenson JE, ed. *Recent research in developmental psychology*. Book supplement No 4, *Journal of Child Psychology and Psychiatry*. Oxford: Pergamon Press, 1985:11-17.

SIR,—Dr Greg Wilkinson's leading article nicely demonstrates the paucity of knowledge on this subject by the preponderance of unanswered questions it poses.

To determine the possible impact of mentally handicapped patients discharged from long stay hospitals into the "community," I compared the number of visits made to our surgery by the 14 mentally handicapped inmates of a small hostel we look after with those made by age and sex matched controls from the practice age/sex register for the year April 1984-March 1985.

I called each contact at the surgery for any new illness an "episode of illness" and divided the type of illness into "essential," when treatment, diagnosis, or medical follow up was necessary, and "non-essential," when the illness was trivial and self limiting.

The results clearly show that we provide considerably more attention to our mentally handicapped patients (table). As one might expect, "essential" episodes of illness required more visits —for example, for follow up of hypertension. Visits for episodes of non-essential illness were more frequent in the mentally handicapped, despite the presence of a psychiatric nurse in the hostel during the day.

Sixty seven of the visits for "essential" episodes of illness were for injections of cloxipol, which our practice nurse carried out and which would otherwise have fallen to the hard pressed district nurse. Only three of the mentally handicapped men did not attend at all in the study period, compared with six controls.

There are numerous explanations for the differences shown in this study; eight of the 14 mentally handicapped men smoked compared with only three controls, the diet in the hostel is high in fat and energy, and the men take little exercise.

Episodes of illness in mentally handicapped men and controls

	Handicapped		Controls	
		Non-		Non-
	Essential	essential	Essential	essential
No of episodes of illness	14	20	9	8
No of visits	87	21	17	9

Although visiting frequently with "non-essential" illness, more important illness was neglected. For example, one man had a total hip replacement but failed to exercise properly and developed gross quadriceps wasting in the affected leg.

In the Portsmouth and South East Hants district there is a population of half a million. The district plan involves discharging about 700 mentally and psychiatrically handicapped inmates into the community, an average of three per GP. Because the patients will be clustered in hostels or homes, some GPs will assume responsibility for far more handicapped patients than others. It is clear from this study that this may have a substantial effect on the workload of these GPs.

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Two different mechanisms in patients with venous thrombosis and defective fibrinolysis

SIR,—I was interested to read the article by Professor Inga Marie Nilsson and colleagues (18 May, p 1453) concerning an increased concentration of plasminogen activator inhibitor in some patients with venous thrombosis.

Most patients (73 out of 100) were said to be taking vitamin K antagonists "at the time of investigations . . ." yet the results show all patients had normal one stage prothrombin times, factor V concentrations, and protein C concentrations.

It would seem important to resolve this paradox as the influence of vitamin K antagonists on the concentration of plasminogen activator inhibitor is, to the best of my knowledge, unknown.

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** Professor Nilsson replies below.—ED, *BMJ*.

SIR,—In response to Dr Auger's query I should like to offer the following additional details by way of explanation.

Although 73 of the 100 consecutive patients with recurrent deep vein thrombosis were taking vitamin K antagonists when referred to our laboratory for coagulation investigation, we instructed them to stop taking them three to four days before their first scheduled visit. This is because a vein biopsy specimen is usually taken at the first visit to determine the plasminogen activator content in superficial veins and explains the normal or near normal values for the one stage prothrombin time.

As mentioned in the paper, the plasminogen activator inhibitor was checked in most patients at least twice and was consistently high; since vitamin K antagonists were not withdrawn in conjunction with such checks, clearly they appear to have no effect on the concentration of plasminogen activator inhibitor.

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Training in dental anaesthesia

SIR,—The news that the government is to fund more house officer training posts in dental anaesthesia (18 May, p 1519) is ironic in view of the remarkable decline in numbers of outpatient dental anaesthetics. Since 1975 the number of general anaesthetics funded by the Dental Estimates Board has gone down from 1·1 million to under 0·5 million in 1983, and there is no reason to suppose that this decrease will not continue.

The number of general anaesthetics carried out at the Charles Clifford Dental Hospital was over 6000 a year in 1957 but reduced to 964 in 1984. Statistical extrapolation using these and the intermediate years' figures predicts zero in 1992–3—an unlikely occurrence but one suggesting that the traditional dental gas will become a historical relic. There will still be a small reservoir of patients requiring general anaesthesia for dental extractions: the very young, patients with an abscess, and the mentally handicapped. These patients could be accommodated within an efficient day stay unit in a district general hospital or specialist dental hospital, where endotracheal anaesthesia with full monitoring facilities and postoperative care can be provided.

If this is the future trend then there will be no future for dentists with a year's training at senior house officer level in the hospital service. There will be no opportunities for them in general dental practice and they would not find a place in the anaesthetic service of a district general hospital.

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Treating drug misuse

SIR,—We were interested to read Dr Anne MacDonald's letter (11 May, p 1431) on the treatment of drug misuse. One of the difficulties of this problem is the paucity of good research into the relative values of different forms of treatment. Guidelines are needed where scientific evidence of efficacy is lacking, and it is for this reason we welcome *Good Clinical Practice in the Treatment of Drug Abuse*.

We were surprised to learn that most psychiatrists in Glasgow are prescribing benzodiazepines to opioid users undergoing withdrawal. There is only one paper in the more recent published reports on opioid detoxification mentioning benzodiazepines and this was a single case study in a general practice setting, where the main agent used was clonidine.[1] Psychiatrists seeing large numbers of drug users are in a better position than GPs to publish reliable data on which future treatment regimens can be based. We would urge the psychiatrists in Glasgow to collaborate and show how useful their treatment really is.

We presume that Dr MacDonald's method is restricted to inpatient use. To prescribe high doses of benzodiazepines on an outpatient basis would in our view, and that of many others of experience, be fraught with difficulties. Benzodiazepines may be relatively safe in overdose but they are certainly not safe from a standpoint of dependence or when combined with other, possibly illicit, drugs. They are commonly abused in their own right and may be sold to obtain other drugs.

Anxiolytic drugs will not, of course, specifically counter the opioid withdrawal syndrome. If it is felt that the correct approach is merely to reduce anxiety when someone is going through "cold turkey" would it not be better to do this by non chemical means?

So far as general practitioners are concerned drug addiction is a subject on which many will admit both inexperience and apprehension. These days more of us are beginning to meet such patients and are likely to do so even more in future. Diabetes and hypertension, which Dr MacDonald quotes in comparison, are, unlike addiction, thoroughly taught in medical school, and policies are based on long term statistical research.

Among postgraduate studies the one subject which is conspicuously absent from psychiatric study courses and pharmaceutical seminars is drug