columns

It is admitted that there has been marked underprescribing of methadone and a failure to undertake methadone maintenance (Dole & Nyswander, 1965; Department of Health, 1999; National Treatment Agency for Substance Misuse, 2003). In addition, few if any current addiction specialists have adequate experience of prescribing injectables. Our current specialty appears unprepared to develop established and new practices.

Current biomedical ethics embrace four principles (Beauchamp & Childress, 1994):

- Autonomy. The patient's right to self-determination. This is the basis for 'informed consent'. These guidelines do not allow for autonomy. Drug users can justly say 'never about us without us'.
- The principle of non-maleficence. At the very least do no harm to our patients. How do we stand when we abruptly withdraw a patient from prescribed medication because of use of 'street drugs', as recommended by the 2003 guidelines?
- The principle of beneficence. This involves confidentiality and keeping a safe distance between our duty to the patient and the demands of the state.
- The principle of justice. We must not confuse morality, legality and respectability. It is just as right or wrong to give your children alcohol as it is to give them heroin, cannabis, ecstasy or any other recreational 'drug'. The moral status of a drug does not change with its legal status. The morality of using a drug is not altered by the fact that the use of one drug is respectable and another is not. Laws not sinful acts make crimes.

These 2003 guidelines for prescribing injectable heroin (National Treatment Agency for Substance Misuse, 2003) translate into clinical terms the state policies of the prohibition of drugs. The fact that most medical practitioners accept prohibition does not make these guidelines either ethically sound or good clinical practice. Addiction medicine is a specialty betrayed.

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Self-poisoning

I read with interest the recent article by Leslie *et al* (*Psychiatric Bulletin*, August 2005, **29**, 305–308) who reported that admission for self-poisoning is common and suggested that adequate provision of psychiatric and social support is particularly important to ensure access for a greater number of patients. I agree with their statements; current estimates of self-harm (including self-poisoning) are about 3 per 1000 population per year. This results in over 100 000 hospital admissions each year (Gelder *et al*, 2001). Most psychological and social interventions have been evaluated but none has been clearly effective in reducing repetition of self-harm (Hawton *et al*, 1998). Although there is a lack of evidence of the effectiveness of interventions, there are strong reasons for believing that well-organised care has other benefits. It enables recognition and treatment of major mental disorders and also should be made accessible for a majority of patients.

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