(3) should be videoed at least once interviewing a child or young teenager;
(4) should go at least one social services conference (e.g. on child abuse).

A possible extension of the principle to make the links with general psychiatry more tangible would be for the trainee to write up one case of an adult patient on their next clinical placement in child psychiatry terms i.e. with full formulation of development and family factors. This could then be jointly discussed between the trainee, their previous supervising consultant in child and adolescent psychiatry and the consultant responsible for the adult patient.

The First Year's Operation of a Regional Drug Problem Team

PHILIP M. FLEMING, Consultant Psychiatrist and Director, Wessex Regional Drug Problem Team, Northern Road Clinic, Cosham, Portsmouth

The recent announcement of a further £5 million which has been distributed to Regional Health Authorities[1] makes a total of over £22 million that has been made available specifically for the development and expansion of services for drug misusers over the past three years. An important element in the development of such services has been the formation of Regional Drug Problem Teams; this seemed a useful time to review the working of one such team over the past year.

Setting up the team

The Wessex Regional Health Authority produced its policy for services for drug misusers in April 1985[2] after wide consultation and after receiving advice from a steering group convened for this purpose. Amongst the proposals was one to establish a Regional Drug Problem Team (RDPT). This was to have three functions: (1) To advise and encourage Districts in developing their local services, advise on clinical policies and case management, set standards, provide and co-ordinate training programmes. (2) Where needed, and until District expertise has grown, to advise in specific difficult cases. (3) In the longer term to provide specialist advice, information collection, monitoring and evaluation of services to Districts and to the Region. In practice the RDPT was to act as a liaison agency for all organisations in the Region concerned with drug misuse. These are largely the functions for a Regional Drug Problem Team that were first set out in the Treatment and Rehabilitation Report of the Advisory Council on the Misuse of Drugs.[3]

Wessex Region is made up of 10 Districts and has a total population of 2.8 million. It includes the counties of Hampshire, Wiltshire, Dorset and the Isle of Wight and parts of Avon. The main centres of population are Bournemouth, Southampton and Portsmouth in the south, Swindon and Basingstoke in the north and the cathedral cities of Winchester, Salisbury and Bath; the rest of the region is mostly rural. At the time of the Regional Report in April 1985 only Portsmouth, Bournemouth and Southampton had any services for drug misusers. As the service in Portsmouth was the most comprehensive[4] it was decided to base the RDPT there. The team is made up of a representative of Hampshire County Council Social Services Department, who works as a Principal Officer with that Department as their adviser on addictions and has had many years' experience in the field; a full time community psychiatric nurse at clinical manager level who had had previous experience in the Portsmouth Drug Service; the author for two sessions a week as psychiatrist and director of the team. There was in addition part-time clerical support. The team shared office space with the Portsmouth staff for the first nine months of its existence but now has separate offices for itself.

Planning and development of services

The first task of the team was to meet those staff in Districts responsible for overseeing the development of services for drug misusers. This was normally the District Medical Officer—although these posts were often disappearing with re-organisation, and it was not always clear who would ultimately be responsible for drug services. One of the early requirements of Districts was to set up a District Drug Advisory Committee. These multidisciplinary groups (also proposed in the Treatment and Rehabilitation Report) are charged with monitoring drug problems in Districts and assessing and planning services. Where possible we have tried to attend meetings of these committees. In those Districts where services already existed or where personnel had been identified to start a service, we met the people actually concerned.

In these early meetings we were able to assist Districts in formulating their plans for services. We often found that Districts did not think they had much of a drug problem, and there was frequently scepticism about the need to develop specific services for drug misusers. I heard this view voiced by more than one Division of Psychiatry. Some Districts had tried to make some assessment of the incidence of drug misusers, although none used the strategies recommended by the Drug Indications Project.[5] Our advice was

https://doi.org/10.1192/S0140078900024020 Published online by Cambridge University Press

to encourage Districts to start a service even if this consisted only of a part-time community psychiatric nurse. Where there are no services for drug misusers the statutory agencies may see little of them; our experience has been that once a service has begun so referrals will increase and a better judgement of the need can be made.

In December 1985 we organised a Regional Day Conference aimed at looking at some of the issues involved in setting up services for drug misusers. This was an opportunity for representatives from different professional groups in each District, as well as representatives from non-statutory agencies, to meet and to share the experiences and problems associated with getting services started. Each District reported its progress (or lack of it!) and there was a series of discussion groups on particular issues: residential and rehabilitation services, easy reach centres, prevention and health education, the role of voluntary and non-statutory agencies. It was generally felt to have been a very useful day by the participants and it is hoped to repeat it.

A key element in the Wessex policy is the development in each District of an easy reach centre. This is intended as an informal, easily accessible place where drug misusers, their families, or other agencies can come for information, advice, assessment or counselling. It may also be the base for the local drug problem team. These services are developing in a variety of different ways in different Districts. In some Districts, for example in East Dorset, non-statutory agencies are providing this service.[6] In Portsmouth the centre has developed in association with an existing drug clinic; in other Districts the centres are developing separately from the medically based services.

Training and education

An important part of our work has involved education and training. The majority of Districts had no previous drug services, and those with responsibilities for starting these services usually had no previous experience of the work. We arranged for many of these people to visit or to have attachments to the Portsmouth clinic to learn at first hand something of the types of drug problem they were likely to meet and to learn about different approaches to treatment and management.

In March 1986 the RDPT, in conjunction with Hampshire Social Services Training Unit, arranged a five day training course for those within Wessex Region who were likely to come into direct contact with drug users in their professional work. About 45 people attended from a variety of statutory, non-statutory and voluntary agencies. The accent of the course was on working together, looking at attitudes and learning how to manage problem drug takers. The course was well received by those taking part and we are likely to repeat it.

Those working in drug services are often rather isolated. In any one District there may be only a few people involved and it is often difficult for them to get professional support and to share and exchange ideas with those working in the same field. For this reason we have set up a bi-monthly meeting known as the Wessex Drug Forum, at which workers from both statutory and non-statutory agencies can meet and discuss matters of common concern. This acts as an educational as well as a liaison meeting and gives the RDPT the opportunity of hearing about individual Districts' progress and problems.

Medical input

The question of the medical input drug services has often posed difficulties. The Treatment and Rehabilitation Report, and more recently the Health Circular on Services for Drug Misusers,[7] have recommended that in each District there should be a hospital-based consultant with, preferably, a designated sessional responsibility for drug misusers. Psychiatrists are busy people with full timetables and are understandably reluctant to take on additional responsibilities for services for which they may have little or no training or experience. However, we have found that where there is not an interested psychiatrist prepared to take part in planning and developing services, those services will tend to lag behind. It is necessary also to have one person who can co-ordinate arrangements for detoxification, and who can support other staff working with drug misusers. It is often helpful to employ a clinical assistant with one or more sessions to provide the immediate clinical support for a drug service. This reduces the clinical load on the psychiatrist so that taking on responsibility for drug services need not be so onerous.

The longer term solution, where it is difficult for a psychiatric division to take on this additional responsibility, is to ensure that any new post in the future has a specific sessional commitment to drug services written into the job description. These difficulties underline the importance of providing adequate experience for trainees in psychiatry in drug dependence. In my experience once trainees are exposed to an enthusiastic drug service their attitudes change, and they are much more willing to take on such sessional commitments in the future.

Further tasks

The RDPT has been involved in setting up a Regional Detoxification Unit in Portsmouth and in helping to design its operational policies. This Unit is part Regional and part District funded; it has 10 beds, five for District use and five for Regional use. Patients are admitted for detoxification and early rehabilitation and stay for a maximum of six weeks. The intention is that only more difficult cases are referred to the Regional Unit, and that straight-forward detoxification should be managed in District facilities. The RDPT liaises with Districts in arranging admissions. Finally, we are co-ordinating the collection of statistics by District drug services throughout Wessex Region. We hope that this will help us evaluate services and help us in advising both Districts and the Region on the pattern of future services.

Comment

What have we achieved in our first year? The Treatment and Rehabilitation Report stated "we would thus expect that

the team would act as a catalyst in the development of both existing and new services in the Region and as a means of achieving the co-ordination of this development". I believe we have met those requirements. We have been able to give advice and to encourage Districts in the development of their services. We have given support to those developing services and in particular to their staff. We have had an educational and training role and this will continue in the future. We have also been able to bring together workers in the statutory and non-statutory agencies. I believe this co-ordinating role to be of particular importance. In Wessex Region there is a lot of enthusiasm amongst a wide variety of agencies in developing services for drug misusers. It is vitally important for the optimal functioning of those services that they work closely together. To achieve this is one of the main challenges for the future.

References

[1]Department of Health and Social Security (1986) *Health Service Development: Services for Drug Misusers*. HC (86) 3, London: DHSS.

[2]Wessex Regional Health Authority (1985) *Regional Policy for Services for Drug Misusers*. April. Paper R 1102.

[3]Department of Health and Social Security (1982) *Treatment and Rehabilitation: Report of the Advisory Council on the Misuse of Drugs*. London: HMSO.

[4]Hicks, C. (1985) A better deal for addicts. *Health and Social Services Journal*, 4 July, 832.

[5]Hartnoll, R., Lewis, R., Mitcheson, M. & Bryer, S. Estimating the prevalence of opioid dependence. *Lancet*, i, 203–205.

[6]East Dorset Drugs Advisory Service (1986) *Annual Report*. Obtainable from EDDAS, 79 Old Christchurch Road, Bournemouth, Dorset BH1 1EW.

[7]Department of Health and Social Security. *Health Service Development: Services for Drug Misusers*. DHSS HC (86) 3. Appendix 1, para. 11.

Conference Report

A Subversive Foray into Private Practice

Sydney Brandon, Professor of Psychiatry, University of Leicester

The Private Sector is responding to Mrs Thatcher's call. Nearly one hundred psychiatrists of all varieties and persuasions each paid £10 to attend a Saturday morning seminar on Private Practice in Psychiatry at the Royal Society of Medicine—I wonder if they applied to their Health Authority for study leave and expenses.

Nine speakers offered succinct statements on 'How to Succeed in Private Practice without risk to your Ethics.' Even so they managed to fit in an elegant buffet with wine and, naturally, served tea before the contented punters departed a little before the 2.30 pm scheduled finish. A good example of how to spend a full and profitable day yet still fulfil your golf commitments.

All the speakers modestly declaimed their impeccable personal pedigrees and shot their immaculate cuffs before casting their pearls before a rather more mature (or older) audience than the organisers had anticipated.

We learnt that severely depressed and suicidal patients can be discharged as good as new after 19 days in hospital and that community care and job satisfaction are more meaningful when dealing with BUPA subscribers than when one is "getting somebody ready to return to some monotonous and repetitive job".

One consultant assured us that what the private practitioner needs to succeed is Availability, Affability and Ability—strictly in that order.

A gamekeeper-turned-poacher advised us on how to use the NHS consultant contract to maximal personal advantage including the subtleties of when to opt to go maximum part time and when to revert, how to hang on to your expenses and so on. Those suffering from impending burn out after their stressful years as asylum (or is it mental health) officers were advised on how to increase their lump sum and maximise their pension before retiring into private practice.

Once you pass on to those Elysian Fields there are, we were assured, no committees but managers whose only wish is to facilitate your every desire in providing patient care and the ultimate in multi-disciplinary (therapeutic staff) teams. They've finally cracked it! In private hospitals the multi-disciplinary team is, for the psychiatrists, 'at your command'. Warmth, comfort, security, convenience, a nicer class of patients and positively luxurious hotel services await the aspiring visiting consultant and the full-timer will be entering a 'smooth and expanding service'.

The growth in private practice in this country has not