while hospital consultants will be coded by GMC code number.

The location of patient residences will be by postcode but full addresses will also be needed; the purchaser and provider organisations will be coded by unique five character codes and these will be combined together with a further six character code to identify specific contracts.

The adoption of these coding systems will need major changes to all existing systems which are not at present designed to cope with other than local coding needs.

While concentrating on patient contacts, the report does move on to discuss the information requirements for medical audit and emphasises the importance of ensuring that audit systems have the ability to progress to interact with patient-provider systems both in terms of consistent data sets and the ability to physically transfer data. Issues such as use of postcodes and consistent clinical coding systems are seen to be of great importance and the report suggests close links between local audit initiatives and work being undertaken centrally by resource management teams at the DoH.

This view is reflected later in the report when discussing organisational structures and emphasises that individuals must recognise that creating an information island outside the framework of agreed standards not only cuts off the individual from others but also denies to others data which they might wish to utilise.

The work on medical audit is closely tied to development of measures of outcome and quality of care; because of the small number of established measures available these have not been included in the data sets for provider or contract areas but a project is to be set up to address this issue for 1993. The DoH has commissioned a study of outcome indicators and is pressing for improvements in coding and audit of coding efficiency.

The DoH has bought all the world-wide rights to the Read Clinical Classification and has set up the 'NHS Centre for Coding and Classification' with Dr Read as a director. The Read system was of course developed for primary care and its application in other areas has yet to be established. The overall direction and development of the codes will be guided by a supervisory board including representatives of the medical profession.

An overall strategy for medical coding and classification for the next decade is planned and the report indicates that the DoH will be consulting with interested parties on the nature of that strategy.

The report concludes with a list of over 200 organisations who were involved in responding to the original documents; the Royal College of Psychiatrists is not among that list. This document sets forth the direction that information systems will take within the NHS review; the changes in the information systems will carry along changes in clinical practice, workload, and involve major areas directly relevant to psychiatry. This document is not for consultation and states that comments are not being sought on its contents.

There are, however, further areas of consultation being proposed and these involve such central concepts as diagnostic coding and outcome measures. It would be wise to be involved in these discussions if we wish to be part of the shaping of strategy rather than being shaped by it.

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Problem Drug Use: A Review of Training
Report by the Advisory Council on the Misuse of Drugs. London: HMSO. Pp 87. £5.50.

The latest report from the Advisory Council on the Misuse of Drugs (ACMD) surveys training needs for the full range of drug misuse services from prevention through to specialist treatment. The report regrets that training on problem drug use did not expand sufficiently in the 1980s to meet the growing, ever changing nature of the drug problem and the arrival of HIV infection. The shortfall applies to many disciplines but most patently to medicine. It is essential to build on the training initiatives that have been unfolded. The ACMD selects examples of the fresh measures that were introduced; to them should be added the WHO-inspired courses on medical and pharmacy education conducted by St George's Hospital.

The negative and pessimistic attitudes of many doctors towards treatment of drug misuse is understandable in view of their undergraduate and postgraduate lack of training. A major recommendation of the report is expansion of the number of departments of addiction behaviour in medical schools. The departments will act as catalysts for education, research and service provision. Almost as an emergency step it is proposed that each medical school should quickly establish a working group to implement training on drug misuse and on the associated topic of problem drinking.

The deficit is pinpointed in psychiatric training of insufficient senior registrar posts for substance misuse. Here it may be noted that the deficiency persists despite an increased provision of senior registrars granted in the late 1980s partly with an intention to close the gap. Only four new posts in substance misuse were created in England and Wales; Scotland received no increment. During 1990 there has been

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a further, and very substantial, allotment of senior registrars that is again intended in part to improve training in substance misuse. In view of the continuing shortage of senior registrars skilled to meet the growing demand for consultant appointments in the subspecialty it is hoped that a substantial portion of the new tranche will be reserved for this purpose.

The report offers recommendations on training that cover many disciplines. Although occupational therapists are overlooked the needs of youth and voluntary workers are not forgotten. It is explained that medical officers who enter the prison service are not necessarily well informed about problem drug use and require appropriate introduction training. The ACMD hopes that prison officers will become more able to make referrals of drug takers to the prison medical and probation services.

The low priority sometimes accorded by managers to drug misuse reflects a lack of understanding of issues that were not prominent when managers received basic training. Therefore it is proposed that senior and middle managers should receive drugs awareness training at district level. The report considers that the training, which would include aspects of service development, should be given high priority by District Drug Advisory Committees.

The ACMD report notes that training programmes must cover the issues of prevention, early recognition and intervention. Members of primary health care teams and of the accident and emergency services are well placed to detect drug takers; so are occupational health staff and managers in the workplace. Drug misuse has long concerned employers and trade unions in the United States. Its increase in the United Kingdom now warrants similar attention in this country.

Part-time courses on substance misuse can play a major role, reaching staff who might only be available on a day release basis. One such course exists in the South of England. A similar course is proposed by the report for the North and a further for Scotland. The new courses, which would be multidisciplinary, should receive pump-priming from central funds.

The document repeatedly emphasises that training arrangements for drug and alcohol misuse should be combined. The practical differences between client groups generally call for separate facilities at ground level, but specialist managers frequently supervise both drug and alcohol services. More fundamentally the conceptual similarities between all forms of misuse justify linkage in education. Relevantly the College expects senior registrars aspiring to consultant posts in substance misuse to receive experience in the treatment of both licit and illicit intake.

The report attends to planning at national, regional and district level. A national body is advocated which would stimulate, monitor and coordinate developments in the field. Regional drug units should be established that are integrated with parallel activities for alcohol misuse and include in their steering committees academic and drug service representatives. At district level each major service can form its own training scheme to reflect local conditions.

The report closes with a section on funding. Many of its recommendations merely need the political desire to allot existing resources. Other measures require further central and local funding. The ACMD makes the point that the initiatives in training which followed its previous publication *Treatment and Rehabilitation* substantially raised the quality of service provision. Readers will share the concluding view of the report: a serious response to drug misuse necessitates the resolution and resources to attain the highest standards of training.

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Adverse Effects of Benzodiazepines
By Claire Gudex. Discussion Paper 65. The Centre for Health Economics Consortium, University of York, York YO1 5DD. 1990. Pp. 33. £3.50 including postage. Please make cheques payable to University of York.

The tranquilliser debate is gathering pace. Litigation against drug companies, doctors and the CSM is on the horizon and public concern is increasing. This report is therefore timely since there is a need for the true position of the benzodiazepine drugs to be established.

The report concentrates on four areas of particular concern: drug dependence and the consequent withdrawal symptoms; adverse psychological effects while taking benzodiazepines; their use by the elderly, and tolerance to the drug effects.

It broadly concludes that a benzodiazepine withdrawal syndrome does exist but that there is uncertainty about its incidence. There needs to be a better definition of what constitutes a withdrawal syndrome and there is a need for proper double blind prospective controlled studies, taking into account issues of the selection of patients, compliance with withdrawal and other treatments and adequate lengths of follow-up.

The report recognises that cognitive functioning is impaired by benzodiazepines and that amnesia is a common side effect of these drugs. It notes that even short-term use can result in dependence and comments that the elderly are particularly at risk for the adverse effects of benzodiazepines. This document highlights a need for a proper reporting system to establish the true incidence of adverse effects from the benzodiazepines. Most interestingly, the author