as long as it does not suggest that greater use of short-term contracts is desirable.

Conclusion

There is much to be welcomed in this report, seeking to ensure as it does that "training" means precisely that, while upholding the standards of practice of those deemed eligible for a consultant post. In psychiatry we must protect our achievements thus far and demonstrate that we provide most of what is required already, and are prepared to comply where we do not.

It is a pity that we are misrepresented on page 33 of 'Training for Specialist Practice'. There is no intention to reduce training in psychiatry to five to six years here. This comment is thought to be based on a misinterpretation of discussion about a possible target time. In most countries in Europe, there is a wish to lengthen the existing duration of training, and EC countries each determine the period of training in psychiatry required for their specialist certificate.

See also pages 610–612

Psychiatric Bulletin (1993), **17**, 579–581

Keynotes

Tomlinson on alcohol and drugs

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Recognition of the problem

Sir Bernard Tomlinson's *Report of the Enquiry into London's Health Service, Medical Education and Research* (1992) starts with an excellent analysis of the particular problems associated with providing health care in the capital with its high density and turnover of population and disproportionate burden of severe deprivation. He emphasises the particular problems that arise because of the flow into London of vulnerable people with mental illness, drug addiction problems and alcoholism, many of whom are homeless. The consequent difficulties are compounded by the fact that primary health care and community services are poorly developed in comparison with elsewhere in the country and may not be easily accessible to those who need them most. Inadequacies in comprehensive service provision contribute to the high usage of accident and emergency departments as providers of primary health care, where community nursing services are expensive because of higher staff costs and where the characteristics of the patient population referred to above, make maintaining effective contact very difficult.

All of this is familiar to those who work in London. It is Tomlinson's proposals for addressing the problems, and the impact that these solutions might have on substance misusers, that are, therefore, of interest.

Developing primary health care

The first recommendation is for a gradual and systematic transfer of resources from the acute sector to community health service and family health service budgets. This carries the risk that in the absence of extra, bridging finance, some acute hospitals could close before community provision is properly developed.

Hospital closures

Secondly, hospital closures, such as those recommended in the Report, would mean that accident and emergency services would be concentrated on fewer sites. Although the Enquiry emphasised the need for good access to accident and emergency departments, this was assessed in terms of the time travelled by road transport to a particular hospital. This approach largely ignores the needs of drug and alcohol users who attend accident and emergency departments regularly and who may not have access to transport. Substance misusers may not be registered with a general practitioner and any reduction in the number of accident and emergency departments will reduce the availability of an essential primary health care service, on which this group place great reliance.

Improving the quality of care in accident and emergency departments

Nevertheless, the quality of care provided by accident and emergency departments would be enhanced by including GPs and nurse practitioners among their staff as Tomlinson suggests. It would, however, be necessary to ensure that they are appropriately trained in the screening, recognition and management of drug and alcohol related problems, so that substance misusers receive care that is responsive to their particular needs. This requires resources and is linked with improving negative attitudes to substance misusers, recognising that prognoses need not be poor (Ghodse, 1978).

Liaison psychiatry

The promised review of the provision for acute psychiatric admissions seems long overdue to many in the field and the availability of in-patient detoxification services should be included within its remit. The impact of substance misusers (including nicotine) on acute medical and surgical services is well known, with 30% of acute admissions in these specialities suffering from alcohol problems. If their underlying problems are to be adequately dealt with, drug and alcohol liaison should be specifically included in the review of liaison psychiatry recommended in the Report (Simpson *et al*, 1993).

Collaboration with voluntary organisations

The Report's recommendations for improving primary health care and for alternative models of primary health care are widely-based and imaginative. While collaboration with voluntary organisations is to be welcomed, it should be appreciated that substance misuse services, both statutory and non-statutory, have to be developed in such a way as to avoid competition and wastage of scarce resources. For this reason, there must be some localised planning or advisory structure and the role of the District Substance Misuse Advisory Committee, which can retain an overview of local service developments, warrants some recognition.

Care in the community

The emphasis throughout the Report on developing care in the community is in tune with current best practice in the management of substance abuse problems. The need for close working relationships between health and local authorities is well recognised and the advantages of coterminosity are clear. However, these recommendations would be strengthened if the government were to issue guidelines to local authorities on the implementation of care in the community for drug and alcohol users with particular regard to ensuring adequate social work provision in community teams, and the continued access and availability of drug and alcohol services.

A London-wide response

The recommendation that London should be treated as a whole so far as public health is concerned is very sound. It is especially relevant to drug and alcohol related problems where there is an overwhelming need to ensure a cohesive, London-wide public health response in addition to an appropriate emphasis being given to substance misuse problems at district level.

Education and training

So far as doctors' training is concerned, the emphasis in the Report on the development of teaching in primary health care settings is welcome. Education in the community will provide significant opportunities for students to gain experience in the fundamentals of managing drug and alcohol problems which will stand them in good stead, whatever their future career choice. Indeed, addiction problems could well constitute one of the proposed "core" subjects in the revised curriculum because of the many causal factors with implications ranging from biochemical to social and psychological (General Medical Council, 1991).

However, directing greater resources and patients to primary care will bring health benefits to drug and alcohol users only if primary care doctors are skilled in the management of such problems. There is ample evidence to show that GPs show more willingness to treat drug and alcohol users when they have received specific postgraduate training. Such endeavours are not likely to succeed unless there is an appropriate investment in the development of community drug and alcohol teams, and it is unfortunate that they receive no mention in the Report. Such teams form a vital link between more specialist hospital-based provision and the GP and indeed in many settings undertake both primary and secondary health care provision. The community drug and alcohol team is also well placed to deal with the health care needs of itinerant drug and alcohol users, migrants and other minority groups who may not make much use of general practice based services.

Resource implications

Although the Report touches on the manpower and financial implications of its recommendations, this is not in the context of particular specialities. The report from The Royal College of Psychiatrists (1992) *Mental Health of the Nation* does, however, pay more attention to this very important issue and endorses the current trend towards combining services for

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alcohol and drug misuse managerially, while maintaining separation of service provision. It stresses the need for in-patient beds for short and long-term admissions; other residential facilities; out-patient clinics; and day hospital places. A conservative recommendation is made for an average three beds per 100,000 population for the management of substance misuse, although it is acknowledged that this number would have to be adjusted according to socio-demographic factors. Undoubtedly, the very factors identified by Tomlinson would necessitate a higher number of beds in London; because 12 beds is the minimum number if a "group" approach is to be adopted and a therapeutic milieu developed, collaboration between districts would be essential to develop a supra-district unit. The College also recommends that there should be 0.6 whole time equivalent consultants specialising in substance misuse per 100,000 population, but again this will be influenced by factors such as social deprivation.

Conclusion

It is regrettable that the government in its response *Making London Better* (1993) is muted on the subject of mental health in general and on substance misuse in particular, although specific reference is made to the latter in the stated aim to modernise primary health care. Whatever improvements are achieved in line, say, with The Royal College of Psychiatrists' Report, it seems unlikely that substance misusers' use of the comparatively anonymous, open access facilities of accident and emergency departments will diminish significantly. Currently there are about 4,200 substance misuse-related presentations in London's accident and emergency departments each month – clear evidence of their important role in meeting the diverse health needs of these patients. In view of the significant public health and social problems associated with substance misuse, it should be the subject of a specialty review before any changes are implemented that might adversely affect the services delivered to this vulnerable group. If there is any doubt about the importance of these services it should be remembered that there may be as many as 40,000 deaths annually in England and Wales due to excessive alcohol consumption and that injecting drug misuse is currently the most rapidly increasing category of exposure among those developing HIV/AIDS. Any deterioration in service could have a disastrous effect on public health in London.

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Lynette Napper

The Officers and the Secretary are extremely sad to announce the sudden and untimely death of Lynette Napper, Deputy Secretary and Education Officer at the College. Lynette died on Saturday, 28 August, after a brief illness.

Lynette joined the College in 1985 as Education Officer and she became Deputy Secretary in 1986. Many Members of the College will be very aware of the enormous contribution that she made to the work of the College. Her recent work on the preparation of the Presidential report *Mental Health of the Nation* and the College's response to the Ashworth Inquiry demonstrated her particular skill in producing succinct yet elegant prose from a mass of written material.

Lynette was a popular member of staff, with a delightful sense of humour. She was always willing to listen to colleagues' problems and offer wise advice. She will be deeply missed by everyone at the College.