women and describe their experience of the Guy's Hospital Pregnant Misuser Project.

Anonymous urine testing on 600 consecutive attenders at the antenatal clinic, Dudley Road Hospital, Birmingham revealed a low incidence of drug abuse and a high false positive rate for cannabis and cocaine when using single immunoassay tests (Condie *et al*, 1989). Initial immunoassay revealed 1.2% positive for amphetamines, 29% for cannabis, 5.2% for cocaine and 1.0% for opiates. After re-testing by immunoassay and chromatography, positive results were reduced to amphetamines 0.7%, cannabis 0.4%, cocaine 0% and opiates 0.5%.

While stressing the importance of engaging pregnant drug misusers in treatment, London *et al* express disappointment that their "user friendly" service did not succeed in attracting more clients. This has not been our experience. The Mother and Baby Service at the West Midlands Regional Addiction Unit was established in June 1987 and offers help to the families of drug-using parents. The service comprises a full-time community psychiatric nurse (LP), full-time social worker (MH), senior registrar in psychiatry (JM) (one session weekly) with back-up from consultants in psychiatry, obstetrics and paediatrics when required. Self-referrals are accepted in addition to those referred by medical and social service agencies. All new cases receive a home assessment and medical out-patient appointment within one week of referral. Limited nursery facilities are available for those who require in-patient or day-patient treatment. Much of the work of the service has involved liaising with other agencies, encouraging recognition and acceptance of drug users by family doctors and obstetric services, supervising and supporting cases managed by community drug teams.

Demand for the Mother and Baby Service has steadily increased. In the first year 15 families were referred whereas in the last 12 months 47 families have been accepted. The number of pregnant drug-users has also increased from six in the first year to 13 in the last year. Of a total of 26 pregnant drug-users, one had a termination, three miscarried, 20 delivered healthy infants and two remain pregnant. No parents seen so far have tested positive for HIV. The service has proved highly acceptable to clients; none have dropped out of treatment and several new cases have attended on the recommendation of existing clients.

The demands of caring for children and supporting a drug habit are immense, management is labour-intensive and treatment options need considerable flexibility. Routine urine drug screens are unreliable and may deter drug-using mothers from booking in for ante-natal care. In our experience providing a specialist service has proved successful in attracting drug-using parents and retaining them through treatment.

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Infant observation

DEAR SIRS

Worrall's account of a child observation carried out during her registrar attachment to a child psychiatry unit (Worrall, 1990) has prompted me to write about the role of infant observation, viz. "regular visiting and detailed observation for periods of approximately 45–60 minutes of a baby growing with its mother from birth onwards, followed by discussion with a supervisor ± peers," in Higher Training in Child Psychiatry. To my knowledge, most senior registrars will not carry out an infant observation except in the context of a psychotherapy or psychoanalytic training being undertaken independently of their child psychiatry training. (I am currently carrying out a survey in order to clarify this.)

However, all child psychiatrists *are* expected to know about the physical, cognitive and emotional development of children. They are also required, in both their clinical and their research work, to have a certain attitude of mind "well expressed in Keat's notion of 'negative capability' – the capacity to be in doubts and uncertainties, not to reach after irritable fact and reason" (Waddell, 1988).

Rustin (1989) summarises the rationale for devoting time to infant observation as "learning about early emotional development – that is, about the actual baby – and also learning from one's own response to the observations". Emotions aroused in the observer are important, and should not be regarded as "a distraction or contaminant" but rather "an indispensable tool to be used in the service of greater understanding" (Miller, 1989).

Senior registrars on the Tavistock Conjoint Training Scheme are encouraged to undertake a formal infant observation for a period which includes at least the first year of a child's life. This experience is a unique way of learning as it addresses not only the child's development but also the relationship that the growing child has with his environment, including

mother, father, other family members and, on occasion, other caretakers. The process of 'observation' itself also constitutes a learning experience, the acquiring of an ability to observe without intervention, crucial in the development of clinical skills. The accompanying weekly seminars address both the meaning of the child's experience and the observer's; and support the trainee in his/her performance of a potentially emotionally-overwhelming task.

I believe that infant observation may have a valuable role to play in the training of child psychiatrists. I hope to be able to present the views of other trainees on the subject in the near future. In the meanwhile I encourage others to consider undertaking infant observation as part of their preparation to become consultant child psychiatrists.

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Psychiatric services in Australia

DEAR SIRS

As a College member and a practitioner in rural Queensland I would like to add to the debate raised by Dr J. S. B. Lindsay (*Psychiatric Bulletin*, December 1989, **13**, 703–704).

I am the only qualified psychiatrist in the Mackay region, which contains approximately 100,000 people. Support services of any sort are limited to a similar degree. I feel safe in stating that no other Western democracy provides so poorly for its populace by way of psychiatric services.

Under the Australian constitution it is the State Government's responsibility to provide health care. The virtual absence of proper services in rural Queensland is inescapably the responsibliity of the responsible State officials. Some might consider such a dereliction of duty to be negligent.

The tendency for specialists to accrete in major centres seems a universal problem and has been addressed in the UK but not in Australia.

Thus far you might think that I am in agreement with Dr Lindsay; however his analogies are opaque and contain a hidden agenda.

The psychiatric unit of which he was the *de facto* head has been seriously criticised by a variety of responsible professional people – not just a handful of political malcontents with an axe to grind as he seems to insinuate. Indeed attempts have been made to bring both civil and criminal charges concerning his Unit and individual members of it. The entire Hospital Board has been sacked for failing to meet its responsibilities. Indeed in his report (23 October 1989, page 47) M. R. Stubbins (the Chairman of the Health Complaints Unit appointed by the Minister of Health to investigate this matter) stated that "... by the year 1985 it had deteriorated in its level of patient care and treatment to become to my mind absolutely unsatisfactory".

Bulletin readers now have a more complete picture of events upon which to evaluate Dr Lindsay's opaque analogies. They may therefore agree that it is regrettable that our *Bulletin* has served as a forum for snide innuendoes about other unspecified "players", some of whom we must presume to be other doctors.

Responsibility and accountability are the central issues and must be dealt with straightforwardly and unemotionally. Firstly Dr Lindsay's Unit is responsible for discharging its duties properly even if understaffed. The arguments put forward in his letter are quite specious in this regard.

Secondly, there is the more distant but even more serious responsibility regarding the constitutionally defined duty of the State Executive to provide adequate health services. Legal precedent in Australia appears to indicate that the people do not have recourse, as they do in America, to obtain a judicial enforcement of such duties. Accordingly, I suggest it is the duty of the appropriate Royal Colleges to inform both the Government and the public, clearly and unequivocally, if the level of provision of services falls below an acceptable standard.

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Psychiatry and the private sector

DEAR SIRS

It is a common belief among fellow psychiatrists that the private sector caters largely for affluent, neurotic individuals and that it is unable or unwilling to provide adequate resources for the treatment of the acutely ill and psychotic patients and those requiring continuing care (*Psychiatric Bulletin*, May 1989, **13**, 249). This has not been my experience.

To substantiate my own observations I recently surveyed the admissions under the emergency service at The Priory Hospital and compared them with