males and females. The social class findings thus did not explain the sex differences.

It would thus appear that the experiences at Ashmore House and the MHAC are similar. This similarity is reinforced when the source of referrals are compared. In Lewisham, GPs refer the bulk of patients seen each year, with self-referrals forming the next largest group. In Lewisham the proportion of self-referrals rose over the past 2–3 years but has always formed 15–20% of all new referrals. In Ashmore the self-referrals began at a high level and have risen, being 20–26% of all referrals. The Ashmore self-referrals form a slightly high proportion but one of approximately the same order as that found in Lewisham.

It is gratifying to see that other Community Mental Health Centres are monitoring new services and that in Ashmore, at least, the experiences are similar. It is hoped that centres will report any monitoring findings especially in view of the potential dangers of repeating the USA experiences in the UK which has been indicated in a recent survey of new CMHCs in this country (Sayce, 1987).

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References

BOARDMAN, A. P. & BOURAS, N. (1989) Self-referrals to a community psychiatric clinic. *Psychiatric Bulletin*, **13**, 490–492.

HUTTON, F. (1985) Self-referrals to a community mental health centre: a three year study. *British Journal of Psychiatry*, **147**, 540–544.

SAYCE, L. (1987) Revolution under review. *Health Service Journal*, **97**, 1378–1379.

Funding and planning of child psychiatric services in the NW Thames Region

DEAR SIRS

Questionnaires were circulated to all consultant child and adolescent psychiatrists in the North West Thames Region in mid-1988. So as to increase the response the same questionnaire was again circulated in early 1989. Out of 46, 29 responded.

The following questions were asked:

(1) *In what unit of management is the child psychiatric service?*

Since respondents might work in more than one district allowance was made for this.

The choices were: psychiatry; acute; community; other.

Virtually all our respondents were able to identify their unit(s) of management. Of the 29 who responded, all but two reported that they were managed in either a psychiatric, community or acute unit. Of the remaining 27, 24 worked in one district only, and three worked in two districts. None worked in more than two districts. Of the 27 who worked in the first district 20 were managed in one of the above units, while the remaining seven were in split units of various combinations. Of the three who worked in a second district, two were fully managed in a psychiatric unit, and one in a community unit.

Since these questionnaires were circulated, it is likely that some units of management will already have changed again.

(2) *In the district(s) in which you work is it possible to identify the percentage of the total health service budget, and/or the percentage of the psychiatric budget, spent on child psychiatry?*

Only eight felt able to say that they could identify any budgetary details. Six of the eight positive respondents gave further information. They reported the following percentages of the child psychiatric budget to the total psychiatric budget: 0.9%, 1.0%*, 1.5%, 2.7%, 7.0%, 7.7%, which are extremely low and indicate that child psychiatry as a specialty is seriously underfunded. It is surprising to find that although all the percentages of the total budget spent on child psychiatry were well below 10%, there was an eightfold difference between the highest and the lowest cases.

(3) *If not, have you attempted to achieve this? (i.e. budgetary figure)*

Of those who were unable to identify a budget answers were almost equally divided between 'yes' and 'no'.

Comments make it clear how difficult it is to get these figures. However, since this is a vital piece of information, it is in the interests of all child psychiatrists to make determined attempts to extract budgetary information from administrators.

Only three of our respondents were budget holders. Holding the budget gives some control over the service, and it is suggested that all child psychiatrists need to consider carefully and urgently whether they should not now be seeking to take responsibility for such control.

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*Partial costing only. Percentage figure includes contribution from psychiatric unit, but not that of community unit which was not available.

Services for pregnant drug users

DEAR SIRS

London *et al* (*Psychiatric Bulletin*, January 1990, **14**, 13–15) report results of urine drug tests on pregnant

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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Reference

CONDIE, R. G., BROWN, S. S., AKHTER, M. I., SHEEHAN, T. M. T. & PORTER, L. (1989) Antenatal urinary screening for drugs of addiction: usefulness of sideroom testing? *British Journal of Addiction*, **84**, 1543–1545.

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