

junior doctor and their presence would be purely for training purposes. Emergency risk assessment and management planning skills could also be attained by junior trainees working within the liaison psychiatry service, which is already a common practice in many areas of the UK.

There have been debates about the merits of developing specialist teams such as the IHTT.⁸ Despite these reservations there has been a huge expansion of crisis teams particularly in England and similar services are now emerging in Scotland. The evidence points to a reduction in admissions and shorter length of stay.⁹ In Forth Valley this has allowed a 20% reduction in acute beds while keeping bed occupancy at 80% with the remaining beds.¹⁰ In areas with 24-hour crisis services the only way that junior trainees will get meaningful experience in emergency assessments is with a formal placement with the service. This may be of benefit to psychiatry trainees but is unlikely to be possible for other trainees with such short rotations. More creative solutions are going to be needed to fill this gap.

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Liaison psychiatry services in south England

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Aims and method To investigate liaison psychiatry services across 38 acute trusts in the south of England. We used a telephone survey and compared the results to service structure and function as recommended by the Royal College of Physicians and the Royal College of Psychiatrists.

Results Approximately two-thirds of trusts surveyed had a dedicated liaison service and this was not significantly related to hospital size. Most liaison teams were understaffed in all disciplines and only a third had a full-time consultant. Services for specialist patient groups were generally well provided for; 37% of teams had been created in the past 5 years and 33% were planning to increase their staffing levels in future.

Clinical implications Liaison services in the south of England are similar to those in other parts of the UK that have been surveyed. Although the services did not meet the Colleges' recommendations, our study shows some recent growth and development in this specialty.

Declaration of interest None.

Liaison psychiatry service provision has been shown to be variable, despite clear guidance from the Royal College of Physicians and the Royal College of Psychiatrists.¹ Previous work in London, north-west England and Wales has shown

inadequate staffing and wide variation in availability of services.^{2–5} In 2008, the Academy of Medical Royal Colleges (AMRC) recommended a 24-hour mental health liaison service, specifying a timely first-line attendance and

promoting pathways of care for specific patient groups such as older adults, children and patients with intellectual disabilities.⁶ The south of England is an area not previously studied and the aims of this survey were not only to rectify that with relation to previous guidelines, but also to re-examine liaison services in light of the recent AMRC recommendations. We aimed to investigate staffing levels, including previous and future changes, service availability, patient groups seen, funding and management. We also examined response times and training of emergency department staff.

Method

We defined our area as all acute National Health Service (NHS) trusts within three strategic health authorities in south England: South East Coast, South Central and South West (online Fig. DSI). This embraces a population of approximately 13 million,⁷ making up over a quarter of the total population of England. Bed numbers were obtained from the Department of Health website (www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds).

Data were collected by one of the authors using an open-ended telephone questionnaire in the first quarter of 2009. We questioned either the team leader or an established member of the team, focusing on key areas as discussed above. Staffing levels were calculated in terms of whole-time equivalent posts. We categorised doctors as consultants, non-consultant medical staff (staff grade and associate specialist doctors) or trainee doctors. Working hours were grouped as 'core' (Monday to Friday 09.00 h to 17.00 h), extended hours and a 24-hour service. We categorised these data and analysed results statistically using SPSS version 16 for Windows. We compared staffing levels, hours of service provision, patient groups seen, response times, funding and management with guidelines from the Royal Colleges.

Results

All 38 acute trusts in the south of England consented to take part in this study. A dedicated liaison service existed in 27 trusts (71%). In other acute trusts, psychiatric services were provided by crisis teams or the on-call junior psychiatrist. The questionnaire was completed by the team leader in the majority of cases (85%); other respondents were consultants (7%) and senior nurses (7%). In all teams the team leader was involved in clinical duties.

Bed numbers

The mean number of beds in acute trusts with a dedicated liaison team was 761 (range 283–1261, s.d.=309) and in trusts without a dedicated liaison team 616 (range 392–1294, s.d.=282). There was no significant difference between these two groups ($P=0.1794$).

Working hours

Sixteen liaison psychiatry teams (59%) provided a dedicated liaison service that was either extended hours (52%) or 24-hour cover (7%). Of the 14 teams that worked extended

hours, 11 included weekends. In one trust the on-call doctor covered liaison needs during working hours and a dedicated liaison team was on duty out of hours.

Staffing levels and changes in dedicated liaison services

Ten teams (37%) had been set up in the past 5 years. Of 17 teams that had been in existence for more than 5 years, 9 (33%) had seen an increase in staffing levels, 4 (15%) reported no change, and 4 (15%) had seen a decrease. Teams ranged in size between 1 and 16 members (mean = 5.7, s.d. = 3.4), and most were not meeting recommended staffing levels (Table 1). Almost half the teams ($n=13$, 48%) had a consultant psychiatrist on the team; however, only 8 (30%) were full-time and the rest worked part-time or had a shared responsibility to another team. The 9 teams (33%) with trainee doctors all had a consultant psychiatrist.

The mean number of nursing staff per team was 3.6 (s.d. = 2.1), and most (58%) were more senior specialist nurses (UK band 6). One team had 3 nurses, of which one was covering liaison needs at any one time and the other 2 were part of a home treatment team. In total, 12 teams (44%) consisted of nursing staff only, 3 teams (11%) had a psychologist, 4 (15%) had a social worker and 2 (7%) had an occupational therapist; furthermore, 15 teams (56%) had a secretary or administrator.

Service availability

All liaison teams saw individuals who presented to accident and emergency with psychiatric problems. Most (93%) also saw in-patients in some capacity, although 3 (11%) assessed only in-patients who had self-harmed. Almost half (44%) had the staffing capacity to carry out out-patient work, but for some teams this was limited to a certain number of sessions.

Overall, 8 teams (36%) incorporated an older people's service into their liaison work: 11 teams (41%) had a separate liaison service for older people, and 6 (22%) teams assessed older people for self-harm alone, having a separate old age psychiatric service for referrals unrelated to self-harm. We collected limited data on separate older people's liaison teams; most consisted of one consultant or staff grade doctor and one nurse. The two teams that did not have any liaison services for older people referred these patients to community services.

Table 1 Teams that met Royal College of Psychiatrists and Royal College of Physicians staffing guidelines

Staff	<i>n</i> (%)
Consultant psychiatrist	8 (30)
Non-consultant medical staff	3 (11)
Trainees	9 (33)
5 nurses	6 (22)
Psychologist	3 (11)
Secretary	15 (56)

Four teams (15%) saw children and adolescents, although in all cases only those aged 12 or over were assessed. Only one team saw children and adolescents out of hours.

Individuals with intellectual disability could be assessed by 17 teams (63%). Drug and alcohol referrals were received by 19 (70%) teams, although of these 3 specified they would only see a person if drug and alcohol misuse was not the primary diagnosis. In total, 18 teams (67%) provided a service for perinatal patients and 7 (26%) teams were able to provide specialist services to other medical departments, covering 13 different specialist areas, including bariatric surgery, genitourinary medicine and renal medicine. All teams that provided services to other departments had a consultant psychiatrist as part of the team.

Response times

When assessed for response times, 13 teams (48%) estimated that they would see an accident and emergency patient within 1 hour and a further 3 teams (11%) within 2 hours. The response times for in-patients varied widely but the majority of teams (74%) responded within 24 hours; 15 teams (56%) said they would be able to respond to an acutely agitated patient immediately.

Training

Almost all teams ($n = 24$, 89%) provided training to staff in the emergency department, ranging from between every 2 weeks and every 6 months. Of the 3 teams that did not provide training at the time of the study, 2 were due to start a training programme in the near future.

Management and funding

Mental health trusts managed 24 (89%) teams, acute trust managed 1 team and 2 were managed jointly. As regards funding, 17 (63%) services were funded by the mental health trust, 2 by the acute trust, 2 by the primary care trust, and 6 were funded jointly. For example, one team funded jointly had nursing staff funded by the acute trust and medical staff funded by the mental health trust.

Future developments

When queried about future changes to the teams, nine teams (33%) had definite plans in place, mostly in terms of increasing staffing levels, with three teams planning to recruit a psychologist. One team was planning to increase their service hours to provide 24-hour cover and one was planning to expand the patient groups covered. A further six teams (22%) had plans to expand in the future.

Discussion

Our survey shows that the provision of liaison services in the south of England is patchy. We found no relationship between hospital bed numbers and the presence of a dedicated liaison psychiatry service. No service met the staffing recommendations of the 2003 Royal College of Physicians and Royal College of Psychiatrists guidelines¹ for

a 600-bed hospital, despite the fact that 48% of hospitals in the area surveyed exceeded this size.

We found that liaison services in south England were more limited than those in district general hospitals in Greater London, although staffing composition was similar to that in less urban populations previously studied in Wales⁴ and North-East England.³ Response times also did not meet recent recommendations, although several teams reported using a triage system to assess patients.

Those teams providing specialist services to other departments always had a consultant psychiatrist. A senior medical member of the team with appropriate liaison psychiatry training and expertise will be able to offer specialist input to the wider hospital and this is likely to strengthen relationships between mental health and other medical departments. Junior medical training posts existed only where a consultant was present, underlying the importance of a consultant for their role in 'educating trainee psychiatrists and other clinical staff' as specified in recent guidelines.¹

We were encouraged to find that 40% of teams had been created in the past 5 years, suggesting a growing appreciation of the importance of mental health within the acute medical setting, and that many established services reported an increase or a planned increase in staffing levels. We hope that our results are indicative of a trend to better fund liaison psychiatry in the UK so that further expansion can take place.

Limitations

There was no other survey with which to compare our results and thus assess the growth of liaison services. However, a question on how staffing levels had changed over the past 5 years gives an indication of recent developments. Questions around response times were limited by their subjectivity. Although not the main focus of our survey, they were useful in providing an initial idea of response times, which could be audited more accurately and thoroughly by the trusts. We assumed that questions relating to funding should yield less subjective responses, and we chose to direct them to the team leader wherever possible as the most competent in this area. In cases where a team leader or experienced team member were not available, we contacted them again at a later point.

This survey has deliberately not included liaison services provided by other community teams such as crisis teams; in doing so we are likely to have underestimated the services available. We are aware that south England is not a homogeneous region, with variations in population groups and mental health services; however, our aim was not to compare individual trusts but instead provide an overview to compare that with the rest of the UK.

Conclusions

This survey shows that liaison services provision across the south of England varies greatly and 29% of acute trusts still have no dedicated service. Those dedicated liaison services that exist all fall short of standards recommended by the Royal College of Psychiatrists and the Royal College of

Physicians in terms of staffing levels, hours covered, teaching and training, and response times. Specialist service provision is extremely patchy and dependent on the presence of a consultant psychiatrist.

Nevertheless, there is some expansion in liaison services in south England and we hope further growth will continue.

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Comparison of the effectiveness of depot antipsychotics in routine clinical practice

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Aims and method To compare effectiveness of long-acting injections in schizophrenia and related psychoses in Lanarkshire, Scotland, from 2002 to 2008. We retrospectively assigned Clinical Global Impression (CGI) scores and examined discontinuation and hospitalisation rates.

Results Risperidone, zuclopenthixol and flupentixol were associated with CGI improvement in 72–74% of individuals. Zuclopenthixol was associated with lower rates of discontinuation as a result of inefficacy compared with risperidone (hazard ratio (HR) = 0.11, 95% CI 0.05–0.27) and flupentixol (HR = 0.14, 95% CI 0.05–0.39), and lower rates of hospitalisation compared with risperidone (HR = 0.32, 95% CI 0.17–0.56) and flupentixol (HR = 0.34, 95% CI 0.16–0.71). ‘Very much improved’ or ‘much improved’ on the CGI was seen in risperidone (29%), zuclopenthixol (16%) and flupentixol (37%), $P < 0.001$.

Clinical implications No long-acting injection was clearly superior in all our outcome measures, supporting the continued need for a variety of long-acting depot antipsychotics to optimise the treatment of the range of patients seen in clinical practice.

Declaration of interest P.S., M.T. and A.P. have received honoraria and hospitality and E.S. and D.D. have received hospitality from various pharmaceutical firms including Bristol-Myers Squibb, AstraZeneca, Lilly and Janssen.

Adherence to antipsychotic medication has been shown to be the single most important determinant of relapse in schizophrenia.¹ Compared with oral antipsychotics, long-acting injections are associated with better global outcome,

reduced risk of hospitalisation and longer times to discontinuation.^{2,3} Risperidone long-acting injection is the first of the second-generation antipsychotics to be available in depot or long-acting formulation and has been used in