The threat of 'small' subspecialties being assimilated by the generalist type of liaison services is a reality. However, the question remains – is this the best way forward? Mental health trusts have already benefited from a number of diversifications of services.[6] The rapidly changing demographics in the UK population – with the older population doubling by 2050 from 10 to 19 millions[7] and the expected 80% increase in people with moderate or severe dementia in the following 15 years[8] – argues for urgent diversification of the health services to meet older people's health requirements, including their mental health. In this respect, it would be counterproductive to rely on liaison services catering for a single commodity. The steady growth of LSOA demand provides further support that this is the area for diversification of not only the psychology medicine portfolio, but also mental health services in general.

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We have read with interest the editorial by Sharpe.[1] Recognition of liaison psychiatry as valuable to patients, general hospitals and commissioners has been a long time coming.

We agree that the crisis of identity in psychiatry may have indeed resulted from the many decades of isolation from the rest of medicine. As such, there may be a temptation to redefine psychiatry based on the path of least resistance which is one left by the 'compassion' vacuum highlighted by the Francis inquiries.[2] Psychiatry does indeed 'retain strengths in humane social and psychological care',[1] although it has much to learn from the involvement of patients in the design of care[3,4] and often struggles with the interface between physical and mental healthcare itself.

There is indeed a need to 'enhance the patient's experience of medical care' and for medicine to move away from purely 'disease-focused medical care'.[1] However, we differ on the opinion that liaison psychiatry or psychological medicine 'aims to put these skills back into medical care'.[1] We may be at risk of medicalising the distress that is prevalent in healthcare settings.[5] Healthcare professionals have a duty to improve the experience of people they care for and to respond to their distress in a humane and compassionate manner.[6,7] From our experience of delivering training and support in general hospital settings, there are many barriers to liaison psychiatry being able to achieve this kind of change, not least the sheer scale of the task. This may actually be a strength of the current trend of psychiatric superspecialisation occurring in general hospital settings – more psychiatrists advocating and modelling change.

In the article, an excellent point is made that the current approaches to commissioning liaison psychiatry may be less than ideal.[1] It is unlikely that teaching from another specialty, let alone another organisation, will address these issues to a satisfactory extent or in a timely manner. We could avoid the temptation of calling for more training. Instead, perhaps each specialty and organisation could take seriously the responsibility of creating the right culture and putting patients first.

Indeed, it may be that lessons can be learned from psychiatry, but we have many lessons to learn ourselves. The key to medicine rediscovering its humanity may be more likely to lie in re-engaging with its patients and carers than looking to another medical specialty.

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Given my interest in liaison psychiatry, I could feel the passion in Sharpe's[1] piece, which he has extended to include the proposed future of psychiatry as a discipline. However, even though he has mentioned patient safety in passing, I would like to urge a wider debate on the fact repeatedly highlighted by several publications of the National Confidential Enquiry into Suicide and Homicide by People with Mental illness. In its last publication, it again highlighted that 72% of those who die by suicide (between 2001 and 2011), had no contact with mental health services in the year before their death. Given the massive variation in funding of mental health services across the country and some viewing it as a Cinderella service, I feel mental health providers and advocates have failed to grasp the nettle in terms of attempting to reach out to that group of individuals who 'successfully' take their own life. We are aware that a majority of those individuals could be diagnosed within F43.0 (Reaction to severe stress, and adjustment disorders) of the ICD-10.[3] Yet we fail to invest in services and concentrate efforts on a narrow remit to severe mental illness. With the 2007 amended Mental Health Act 1983 in England and Wales, we have successfully replaced the erstwhile four categories with a single category of mental disorder. Along with it, we have replaced 'treatability' and 'care' tests with appropriate treatment tests. Yet we do not seem to adequately invest and respond to the above-mentioned category, costing

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potentially a lot more to the community than accepted under the mental illness umbrella.

I raise this issue again with the hope of extending our roles not only to the 'Holy Grail' of reducing costs and improving outcomes, as the editorial focuses, but also to the wider losses our community and society suffer but are unable to react to. On another note, the editorial mentions the RAID model (Rapid Assessment Interface and Discharge). This along with the latest iteration of the National Institute for Health and Care Excellence guidance on schizophrenia,[4] which refocuses attention on combined physical and mental healthcare and the mandate around parity with physical and mental healthcare just debated in the English Parliament,[5] gives us hope for the future. Psychiatrists are unique in addressing the boundary disputes between specialties and offer value for money even in this economy.

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Author's reply: It is encouraging that the ideas expressed in my editorial on psychological medicine have stimulated such interest and associated correspondence. The three letters published above support the thrust of the editorial that a re-engagement of psychiatry with other areas of medicine in the form of psychological medicine services (also called liaison psychiatry) would benefit both medicine and psychiatry. Each letter also raises specific additional points.

Rowett & Udo doubt whether psychiatry is up to the 'sheer scale of the task' in helping other areas of medicine to address the 'compassion vacuum' highlighted by the Francis Inquiry. They conclude that medicine should put its own house in order by re-engaging with its patients and carers rather than seek solutions from another specialty. They are clearly correct in noting that the task is great and that the change required cannot be delivered by psychiatry alone. But I think they are too pessimistic, both about the appetite for change within medicine and about how much can be achieved by psychological medicine; it cannot transform medicine on its own, but it can be an important facilitator of change.

Mukaetova-Ladinska & Scully emphasise the importance of old age psychiatry in light of the rising age of general medical patients. They argue for the specific development of liaison psychiatry of old age. Although fully agreeing with them that expertise in the psychiatry of old age is an essential ingredient of a modern psychological medicine service, I am less convinced of the merit of subspecialised services. Integration with medical services requires that we map onto the way in which they are provided and the very demographic trend they have highlighted is breaking down the division between adult medicine and geriatrics. Hence although the skills of old age psychiatry are increasingly important for psychological medicine services, setting up service barriers defined by age is unlikely to achieve effective integration with medicine.

Finally, Kripalani makes the important point that we need to consider the role of psychiatry in ensuring patient safety. The point is made that services which concentrate on 'severe mental illness' may miss the risk of suicide posed by the individual suffering from stress and adjustment disorders. I am sure that most practitioners working in psychological medicine services would endorse this point. Psychological medicine can play an important role in helping medical services to reduce risk, as well as in improving patient outcomes and experience and making medical care more efficient.

I wish to thank these correspondents, and others who have emailed me personally, for their interest in the points raised in the editorial. The opportunities for psychiatry to re-engage with clinical medicine are enormous. I would strongly urge all those with an interest in developing integrated patient-centred psychological medicine services to help psychiatry to rise to this challenge. Our patients and our specialty need us to succeed.

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Assessing and staging bipolar disorder

We congratulate Duffy *et al* on their paper.[1] We have long argued that bipolar disorder is often underdiagnosed by community mental health teams, and that the reason for this is often failure to assess the longitudinal trajectory of patients with recurrent depression.[2,3] We have attempted to remedy this by developing 29 questions to be used in the history-taking of all patients with depression and recurrent depression to demonstrate the developmental trajectory of the illness.[4] These questions are presently being field tested in Bedford, UK, and at the University of Perugia, Italy. We have also demonstrated that when the systematic assessment of the trajectory of bipolar disorder is carried out in a community mental health team, the number of patients with bipolar disorder among the patients assessed by the team increases, but there remain a number of patients who do have unipolar depression;[5] in other words, the assessment of the trajectory of patients with mood disorder enables the discrimination between bipolar and unipolar depression.

We would comment that Duffy *et al* raise an important point in suggesting that a history of use of lithium by relatives of the patients changes the trajectory of bipolar disorder; however, in our experience it is very difficult to collect this information from patients, who often do not know details of their relatives' illnesses. Furthermore, Duffy *et al* are right in proposing that it is possible to suggest a staging of bipolar disorder similar to McGorry's staging of schizophrenia, but the schizophrenia staging is underpinned by Pantelis' neuroimaging of the different stages of schizophrenia. To propose a staging model of bipolar disorder, we require similar neuroimaging results describing the differences between the individual stages.

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2 Rogers J, Agius M. Bipolar and unipolar depression. *Psychiatr Danub* 2012; **24** (suppl 1): 100–5.