

# Correspondence

## Effectiveness increases with integration in primary care

It is good to read of the work of Dr de Silva and his colleagues in South Tyneside.<sup>1</sup> They are seeing people at an impressive hit rate and providing a service which people like. As in Gnosall, the model being used takes advantage of primary care settings. I think the difference is that we provide expertise within primary care, with a view to a potential three tiers (primary, secondary, tertiary),<sup>2</sup> whereas de Silva is describing a secondary tier outreach. The advantage of Gnosall, which has been demonstrated now over nearly 9 years, is that continuity of support and integration of care are facilitated and sustained.<sup>3,4</sup> Great stuff though: people are catching on!

- 1 De Silva P. What about effectiveness? [Letter] *BJPsych Bull* 2015; 11 February.
- 2 Jolley D, Greaves I, Greaves N, Greening L. Three tiers for a comprehensive regional memory service. *J Dementia Care* 2010; **18**: 26–9.
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- 4 Clark M, Moreland N, Greaves I, Greaves N, Jolley D. Putting personalisation and integration into practice in primary care. *J Integrated Care* 2013; **21**: 105–20.

**David Jolley** is Consultant Psychiatrist, University of Manchester, email: david.jolley@manchester.ac.uk, **Susan M. Benbow** is Professor of Psychiatry at the University of Chester and visiting Consultant Psychiatrist at Gnosall Medical Centre, and **Ian Greaves** is General Practitioner at Gnosall Medical Centre, Staffordshire.

doi: 10.1192/pb.39.4.205

## CMHTs provide follow-up for patients with dementia and behavioural and psychological symptoms of dementia in both service models

David Jolley makes a valuable point about the need for ongoing support for patients receiving a dementia diagnosis and we agree that all patients deserve such input.<sup>1</sup> We disagree that our patients are failed by either the memory clinic combined with the community mental health team (CMHT) service or the traditional CMHT service described in our paper,<sup>2</sup> as both services have good relationships with general practitioners (GPs), who can refer rapidly into the CMHT arms of both services as any behavioural and psychological symptoms of dementia arise. Jolley criticises post-diagnostic signposting to the third sector as leaving patients and their relatives adrift. But these post-diagnostic services have been specifically commissioned from a third sector organisation and not from secondary care, which has the disadvantage of not being part of psychiatric services but is an acceptable, ‘non-medicalised’ service that can be accessed at any time. The study of the third sector organisation was not within the remit of our paper.

We did not comment specifically on referral rates and this study examined only a small part of the service in these trusts, so we are not certain where the figure of 5 per 1000 that Jolley quotes is derived from. In fact, the services have quite different levels of staffing (both medical and non-medical) and there are other memory services in the region provided by neurologists

and geriatricians as well (not examined in our paper), so we had specifically not commented on referral rates in total but only on these small patches within the service.

Both services have changed considerably since 2011 and some service improvements have been inspired specifically by this evaluation. Both services now ensure multidisciplinary follow-up for all patients (where patients and their carers are advised verbally and in writing how to contact various local services according to their needs in the future) and the memory-clinic-based service has cut down on some paper assessment tools. More therapy treatments are offered in both services. Other changes include the introduction of nurse specialists to assist in the memory-clinic-based service. The CMHT service continues to offer consultant medical domiciliary diagnostic assessment, with prescribing now done by GPs from the outset and initial monitoring and post-diagnostic support provided through the CMHT.

We are concerned about the lack of research into these services, rapidly changing across the country. The introduction of new models should be accompanied by robust independent evaluation and evidence of sustained benefit over a sufficient period to prove worth. Multiple innovations in the context of constantly reorganised health and social care systems have no evidence base to justify them from the perspective of frail older people where continuity has been demonstrated to be highly valued.

- 1 Jolley D. Heads in the sand may leave old age psychiatry looking foolish and vulnerable. Commentary on . . . A memory clinic v. traditional community mental health team service. *BJPsych Bull* 2015; **39**: 12–4.
- 2 Rubinsztein JS, van Rensburg MJ, Al-Salihi Z, Girling D, Lafortune L, Radhakrishnan M, et al. A memory clinic v. traditional community mental health team service: comparison of costs and quality. *BJPsych Bull* 2015; **39**: 6–11.

**Judy S. Rubinsztein**, Consultant in Old Age Psychiatry, Norfolk and Suffolk NHS Foundation Trust, email: judy.rubinsztein@nsft.nhs.uk; **Deborah Girling**, Consultant in Old Age Psychiatry, Cambridgeshire and Peterborough NHS Foundation Trust; **Carol Brayne**, Director, Cambridge Institute of Public Health, Department of Public Health and Primary Care, University of Cambridge.

doi: 10.1192/pb.39.4.205a

## Thoughts on the development of liaison psychiatry services in London

The clear strength of Naidu *et al*'s paper<sup>1</sup> is its attempt to map the development of liaison services in London over the past 8 years. The authors have also appraised the various models of liaison services. It was interesting to see which models have been adopted in Greater London as well as the variations that exist, including the absence of a liaison service in one trust.

When we were reviewing policy documents,<sup>2</sup> it has caught our attention that recommended staff numbers have not changed since they were first proposed by the Royal College of Psychiatrists in 2007. The context for this observation is the continuing reduction in acute bed numbers as well as increased recognition of the need to promptly identify and treat psychiatric comorbidities in acute settings.

These developments would have been expected to affect liaison psychiatry team sizes and/or structure. It may well be that these changes have balanced themselves, hence unchanged staff numbers recommendations.

Also, treatments which would normally be given in acute hospitals are being gradually moved into the community. One would have expected that there should be a corresponding development in community liaison services to facilitate good healthcare, but this has not materialised.

Evidence suggests that untreated mental illness is associated with an increase in hospital bed days.<sup>3</sup> Depression and anxiety, for example, are likely to increase the numbers of days spent in an acute hospital bed.<sup>4</sup> Hence, it would appear that benefits accrue to acute trusts where there is a liaison service on-site. This may be an impetus for acute trusts to fund the establishment of liaison services within their set-up, but this has generally not been the case, as Naidu *et al*'s paper illustrates.

To bring the study up to current standards, it would have been interesting for London services to have been compared against the RAID liaison psychiatry model which is now accepted as effective and efficient.<sup>5</sup> It proposes three consultants, which is an increase from the Royal College's recommendation of only one consultant.

Naidu *et al* suggest that demographics could possibly have had an influence on the variation in the commissioning of liaison services. For example, there may have been greater need in certain areas for particular services for older adults.

We think Naidu *et al*'s paper would be of interest to commissioners, as it illustrates how service models have developed, with funding but without corresponding investments in the community side of liaison services, to facilitate present government policy of moving care into the community.

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- 2 Aitken P. Mental Health Policy Implementation Guide: Liaison Psychiatry and Psychological Medicine in the General Hospital. Royal College of Psychiatrists, 2007.
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- 4 Pollack S, Alovio N. Psychological Comorbidity and Length of Stay in the General Hospital. *Am J Psychiatry* 1991; **148**: 324–9.
- 5 Aitken P, Robens S, Emmens T. (eds) *Developing Models for Liaison Psychiatry Services – Guidance*. Strategic Clinical Network for Mental Health, Dementia and Neurological Conditions South West, 2014.

**Adetokunbo Bamidele Shangobiyi**, Associate Specialist in Addictions, Tees, Esk and Wear Valleys NHS Foundation Trust, Durham, email: adetokunboshangobiyi@nhs.net, **Itoro Ime Udo**, Consultant Liaison Psychiatrist, Mersey Care NHS Trust, Liverpool.

doi: 10.1192/pb.39.4.205b

### 'Legal highs' – what's in a name?

I wish to draw the reader's attention to our study, 'Prevalence study of head shop drug usage in mental health', published in this journal in February 2013. This is in light of recent publications focusing on the differential effects of cannabinoids on the development of psychosis,<sup>1</sup> including the use of synthetic cannabinoids and an increased risk of acute psychosis.<sup>2</sup>

Our work examines the prevalence of the use of 'legal highs' among mental health patients and the self-reported effects of legal highs on mental health. We identified a prevalence rate of legal high use at 13% ( $n=78$ ), with over half of users reporting a deleterious effect on their mental state. This risk was particularly increased for those with a history of a psychotic disorder, with two-thirds of individuals with a diagnosis of schizophrenia or schizoaffective disorder reporting an exacerbation of psychosis. Although it was a self-report survey, its findings emphasise a particular risk for individuals with mental illness secondary to the use of legal highs, and to the best of our knowledge it remains the largest survey of its kind.

A recent systematic review which sought to examine, among other variables, subjective effects and the harmfulness of legal highs failed to identify our study.<sup>3</sup> This may be a consequence of our chosen title, which reflected the term commonly used for legal highs in 2012 in Ireland, namely head shop drugs (a moniker for shops which sold legal highs). This has evidently meant that our study findings are missing from systematic reviews<sup>2,3</sup> and even from commentaries relating to legal highs within this very journal.<sup>4,5</sup>

This letter is a valiant attempt to remind readers of our findings, and in the process highlight the risk to mental stability in a clinical population from the use of legal highs. We hope that in framing this letter in the context of legal highs, future research and systematic reviews in this field will now locate our article when searching for publications relating to legal highs, notwithstanding any future change in the descriptive term for these drugs to novel psychoactive substances!

- 1 Di Forti M, Marconi A, Carra E, Farietta S, Trotta A, Bonomo M, et al. Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study. *Lancet Psychiatry* 2015; **2**: 233–8.
- 2 Papanti D, Schifano F, Botteon G, Bertossi F, Mannix J, Vidoni D, et al. 'Spicephrenia': a systematic overview of 'spice'-related psychopathological issues and a case report. *Hum Psychopharmacol* 2013; **28**: 379–89.
- 3 Baumeister D, Tojo LM, Tracy DK. Legal highs: staying on top of the flood of novel psychoactive substances. *Ther Adv Psychopharmacol* 2015; doi: 10.1177/2045125314559539.
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- 5 Meacher BMC. Drug policy reform – the opportunity presented by 'legal highs'. *Psychiatrist* 2013; **37**: 249–52.

**John Lally**, Clinical Research Worker, Department of Psychosis Studies, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK, email: john.lally@kcl.ac.uk

doi: 10.1192/pb.39.4.206

### 'Background' and 'foreground' knowledge: targeting learning materials to trainees' needs

The dissemination of written educational materials may form part of an effective approach to knowledge translation.<sup>1</sup> It is therefore important to explore psychiatry trainees' use of information sources,<sup>2</sup> as by increasing our understanding of their reading habits, we may better target information to trainees.

Although Walker-Tilley *et al* state that examining the reasons why psychiatry trainees accessed information sources was beyond the scope of their study,<sup>2</sup> they suggest plausible reasons why advanced trainees consulted journals