

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.³ Depression and anxiety, for example, are likely to increase the numbers of days spent in an acute hospital bed.⁴ 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.⁵ 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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'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,¹ including the use of synthetic cannabinoids and an increased risk of acute psychosis.²

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.³ 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^{2,3} and even from commentaries relating to legal highs within this very journal.^{4,5}

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!

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- 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.

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'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.¹ It is therefore important to explore psychiatry trainees' use of information sources,² 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,² they suggest plausible reasons why advanced trainees consulted journals

more frequently, and textbooks less frequently, than their more junior counterparts. In addition to the reasons the authors put forward, I would also suggest that the differing information-accessing habits of senior and junior trainees can be explained by the distinction made in the evidence-based medicine literature between 'background' and 'foreground' knowledge.³

'Background' knowledge concerns well-established facts/general knowledge. The most suitable information sources for retrieving background knowledge are textbooks or electronic 'point of care' resources such as UpToDate (www.uptodate.com/home), Clinical Evidence (<http://clinicalevidence.bmj.com/x/index.html>) or DynaMed (www.dynamed.com/home). It is primarily junior health professionals or students who require background knowledge, hence Walker-Tilley *et al*'s finding that the junior psychiatrists made more use of textbooks than their more senior colleagues.

Senior clinicians' information needs typically relate to 'foreground' knowledge, which is usually needed to support a specific aspect of clinical decision-making. Textbooks are not a recommended source to answer 'foreground' questions because these questions require a synthesis of the latest research and there is no way to ascertain which information in textbooks is, or is not, current.³

It is plausible that advanced trainees are using textbooks less than more junior trainees² because they are posing more 'foreground' questions (owing to the more advanced stage of their training). It is also likely that advanced trainees are posing more of these questions because they work with greater autonomy in their clinical practice than their more junior counterparts.

I did, however, find Walker-Tilley *et al*'s categorisation of information sources somewhat confusing. In particular, the category of 'websites' seems imprecise because the term websites relates to a means of accessing and storing information (i.e. the internet) as well as covering a great many types of information source. The authors report that their psychiatry trainee respondents consulted websites via search engines more frequently than textbooks and journals. This accords with previous research which has found that clinicians commonly use internet search engines to access research.⁴ This finding is not, however, an end in itself because search engines signpost their users to many information sources but it is not clear which sources (or what kinds of websites) the clinicians then choose to consult. Also, while it is argued² that Google may be a valuable tool to physicians in clarifying diagnosis, much of the information which Google finds is unfiltered, meaning that the burden of critical appraisal falls entirely on the clinician.³ Likewise, Wikipedia users must counterbalance the advantage of being able to find information quickly and easily with the disadvantage of this information being of variable quality.⁵

It would be very valuable if future research could probe in more detail which websites/online resources psychiatry trainees are accessing in their clinical practice since, as Walker-Tilley *et al* rightly point out, it is vital that trainees continue to possess the necessary skills to identify, access and appraise relevant information at the point of clinical need.

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National Confidential Inquiry

It has been drawn to my attention that my article¹ implicitly criticises the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI), attributing to it comments which are rarely if ever found in its pages. In fact the NCI makes specific focused recommendations which, when implemented, reduce suicide rates.² My remarks, admittedly anecdotal, based on my own and colleagues' experiences, were directed not so much at the NCI, but at internal hospital enquiries and the double standards which pervade the way psychiatric and non-psychiatric deaths are handled. I stand however by the view that administrative fragmentation, underfunding and de-professionalisation of psychiatry all play their part when people suffering from psychiatric illnesses kill themselves.

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