the columns

correspondence

Deskilling of junior doctors

Self-harm assessment is an integral part of any psychiatric training. The traditional training model of junior doctors has mainly focused on independent assessments routinely carried out in A&E and acute psychiatric units. However, nowadays, most self-harm assessments are carried out by the crisis teams. This has prevented trainees from actively participating in risk assessment processes, thereby resulting in reduced exposure to psychiatric emergencies (Woodall *et al*, 2006).

To ascertain the effect of this change on the training and the skills of junior doctors, a questionnaire was recently sent to all 22 trainees (with minimum 6 months' experience), excluding three general practitioner trainees, working in Lincolnshire Partnership Trust. It mainly included questions on opportunities for risk assessment and the number of self-harm assessments undertaken before and after the introduction of the crisis teams as well as implications for further training.

Before the introduction of crisis teams, 15 (68%) doctors were carrying out all emergency assessments themselves. After the introduction of crisis teams 12 (55%) doctors were carrying out no assessments and the remaining were conducting only one assessment per on-call shift. This lack of exposure was felt to be affecting clinical skills and training by 15 (68%) of the doctors, resulting in gradual deskilling. Half of the trainees thought the lack of exposure and proper training would have an impact on passing the MRCPsych membership examinations.

The study shows that the opportunity for trainees to undertake independent emergency assessments has significantly reduced, resulting in gradual deskilling. There is an urgent need for further development of training facilities for junior doctors in assessment and management of self-harm and other psychiatric emergencies. As suggested by Beale (2006) using an audit system would provide a useful opportunity to examine more closely the way different health professionals undertake assessment and management of acute psychiatric emergencies.

BEALE, C. (2006) Changing role of the junior psychiatrist – implications for training. *Psychiatric Bulletin*, **30**, 395.

WOODALL, A. A., ROBERTS, S., SLEGG, G. P., *et al* (2006) Emergency psychiatric assessments: implications for senior house officer training. *Psychiatric Bulletin*, **30**, 220–222.

***Rameez Zafar** Consultant Psychiatrist, Peter Hodgkinson Centre, Sewell Road County Hospital, Lincoln LN2 5UA, email: zafarrameez@hotmail.com, **Khurram T. Sadiq** Senior House Officer, Peter Hodgkinson Centre, Sewell Road County Hospital

doi: 10.1192/pb.31.12.467

Benchmarking a liaison psychiatry service

O'Keeffe *et al* (2007) highlight the lack of standards for evaluating liaison psychiatry services. They describe how timeliness of response is one possible quality indicator.

Our liaison psychiatry service serves a 600-bed general hospital in south London. Over a 3-month period in 2007 we audited our response times to 124 consecutive referrals against pre-existing standards.

We routinely categorise referrals according to the urgency of response required into one of the following three groups: emergency (including A&E) to be assessed within 1 hour; urgent, to be assessed within the same working day; routine, to be assessed within 2 working days.

For the three categories we achieved the response time standards for all referrals. The proportion of referrals in each group and the mean response times were as follows: emergency, 25%, 21 min (s.d.=20); urgent, 30%, 70 min (s.d.=86); routine, 45%, 200 min (s.d.=183).

A major advantage of an on-site liaison psychiatry service is the speed of response compared with psychiatric provision by community services (Royal College of Physicians & Royal College of Psychiatrists, 2003). it is difficult and expensive to conduct studies that might demonstrate the cost-effectiveness of a liaison psychiatry service in terms of reduced lengths of stay for general hospital in-patients and A&E patients. However, response time is a proxy measure. We hope that our data and the benchmarking recommendations by O'Keeffe *et al* will emphasise the importance of a high-quality liaison psychiatry service to healthcare commissioners.

O'KEEFFE, N., RAMAIAH, U. S., NOMANI, E., *et al* (2007) Benchmarking a liaison psychiatry service: a prospective 6-month study of quality indicators. *Psychiatric Bulletin*, **31**, 345–347.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) *The Psychological Care of Medical Patients: A Practical Guide* (2nd edn). (Council Report CR108). Royal College of Physicians of London & Royal College of Psychiatrists.

***Jim Bolton** Consultant Liaison Psychiatrist and Honorary Senior Lecturer, Department of Liaison Psychiatry, St Helier Hospital, Wrythe Lane, Carshalton, Surrey SM5 1AA, **Nicolette Kaneza** Foundation Doctor, St Helier Hospital

doi: 10.1192/pb.31.12.467a

Applying mindfulness to work-related stress

Murdoch & Eagles (2007) describe a range of stressors and stress-reducing strategies identified by consultant psychiatrists. Davoren & McCauley (2007) rightly note that stressful relationships with colleagues may also be problematic.

As a profession, we traditionally focus on managing, overcoming, getting rid of and controlling symptoms in our patients. In applying a similarly active 'stress-busting' approach to the remediation of our professional woes, there is a danger that the value of simply adopting a mindful stance may be overlooked. This is particularly relevant with respect to those stressors which lie beyond our immediate control (e.g. inadequately resourced teams, understaffing, government policy, unpredictable on-call duties). Mindfulness involves the cultivation of compassionate, non-judgemental awareness and acceptance of the present moment – a calm, purposeful and reflective presence which can be applied to all aspects of medical practice (Kabat-Zinn, 1990). It fosters the facility to witness events (internal and external), as opposed to becoming caught up in their intensity. Habitual and reflexive reactions to stressors often compound

columns

and exacerbate the original difficulty many-fold. The mindful practitioner can respond more skilfully to situations as they arise, rather than reacting automatically in accordance with conditioned behavioural patterns. One could argue that this is a prerequisite not merely for stress-free clinical practice but for good living. Perhaps the development of resilience in a profession increasingly fraught with stressors begins 'with the self as the first . . . object of knowledge' (Aronowitz, 1998).

ARONOWITZ, S. (1998) Introducton. In *Pedagogy of Freedom: Ethics, Democracy, and Civic Courage* (ed. P. Freire). pp. 1–27. Rowman & Littlefield.

DAVOREN, M. & McCAULEY, M. (2007) Work-related stress. *Psychiatric Bulletin*, **31**, 316.

KABAT-ZINN, J. (1990) *Full Catastrophe Living. Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness*. Bantam Doubleday Dell Publishing.

MURDOCH, J. M. & EAGLES, J. M. (2007) 'Stress-busting' groups for consultant psychiatrists. *Psychiatric Bulletin*, **31**, 128–131.

Claire Flahavan Registrar, Mater/UCD Psychiatry Training Scheme, Dublin 3, email: cflahavan@gmail.com

doi: 10.1192/pb.31.12.467b

Specialist learning disability psychiatry beds

Lyall & Kelly (2007) highlight the important issue of provision of specialist in-patient assessment and treatment facilities in learning disability psychiatry. The need for such specialist beds has been unequivocally mentioned in national policies on service provision (Scottish Executive, 2000; Department of Health, 2001). In-patient facilities have, however, developed in a variety of ways across the UK and the number of beds available within each National Health Service (NHS) trust has relied on the availability of existing community services and also the commissioning strategies in the local trust.

In Lothian there are 24 acute beds for a population of 800 000 and 348 admission episodes in 9 years (>38 admissions/year) and a trend towards increase in admission to general psychiatry wards.

North Essex learning disability services have a six-bed assessment and treatment unit for a population of approximately 900 000, admitting patients for a maximum of 6 months, and an adjacent eight-bed intensive therapy unit for patients requiring longer-term rehabilitation. A recent audit of the six-bed unit revealed 21 admissions in a 1-year period (2005/2006) with an average stay of 240 days. Since the inception of the intensive therapy unit there have been 19 admissions in 7 years. At this cross-sectional time-point 6 patients were admitted in the private sector and 4 in other out-of-area NHS facilities.

South Essex learning disability services have 10 acute beds for a population of approximately 750 000. A similar audit of one of the two five-bed assessment and treatment units for 1 year (2003/2004) revealed 18 in-patient admissions with an average stay of 53 days.

Variation in service development is illustrated by Essex having far fewer beds than Lothian, although North Essex has a home assessment and treatment service whose role is to prevent admissions and facilitate discharges. However, both areas have a similar trend towards out-of-area and general psychiatry admissions. Comparatively, the duration of in-patient admissions is much longer in North Essex than in South Essex, suggesting that the home assessment and treatment service has not reduced bed blocking and this emphasises the importance of having good-quality health and local authority community placements available.

In conclusion, in order to reduce requirement for in-patient facilities the development of adequate community resources is vital and a well-designed national study should set standards in this context.

DEPARTMENT OF HEALTH (2001) *Valuing People. A New Strategy for Learning Disability for the 21st Century*. TSO (The Stationery Office).

LYALL, R. & KELLY, M. (2007) Specialist psychiatric beds for people with learning disability. *Psychiatric Bulletin*, **31**, 297–300.

SCOTTISH EXECUTIVE (2000) *The Same as You? A Review of Services for People with Learning Disabilities*. TSO (The Stationery Office).

***Abir Mukhopadhyay** Specialist Registrar, North East Essex PCT, Heath House, Grange Way, Colchester CO2 8GU, email: Abir.Mukhopadhyay@NeEssexPct.nhs.uk, **Edward DaCosta** Consultant Psychiatrist, North East Essex PCT

doi: 10.1192/pb.31.12.468