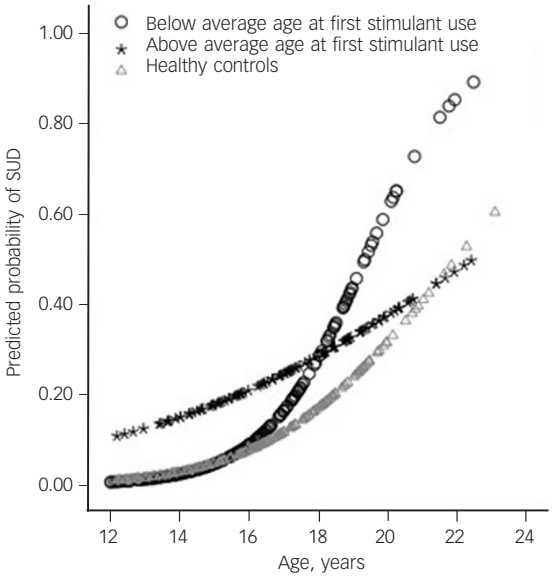

Fig. 1 Predicted probability of substance use disorders (SUDs).

Purely for illustrative purposes, we plotted the predicted probability of substance use disorder according to a generalised estimated equation model, that included age, gender and the interaction between age and age at first stimulant use. For healthy controls the model only includes age and gender. Below average age at first stimulant use: participants started before age 8.1 years; above average age at first stimulant use: participants started after age 8.1 years. Please note that predictions for healthy controls are not the product of the same model as prediction for stimulant groups.

ratio (OR) = 0.95, Wald $\chi^2 = 13.78$, $P < 0.001$). Verma *et al* are concerned that we excluded patients with shorter treatment durations. However, when we include all individuals who ever used stimulants, we find the same effect (OR = 0.95, Wald $\chi^2 = 11.89$, $P = 0.001$). Purely for illustrative purposes, we plotted the predicted probability of substance use disorder for the control group in Fig. 1. The figure shows that delay in the first age at stimulant use leads to marked increases in the probability of developing substance use disorder. In our article, we examined whether the effect of stimulant treatment depended on other factors (i.e. current use of stimulants, age at stimulant treatment initiation, age-adjusted duration of stimulant use and age-adjusted cumulative dosage), but found no other significant predictors than age at first stimulant use.

Verma and colleagues refer to a meta-analysis, but provide the wrong citation. Recently, a meta-analysis on this topic was published.[2] Here no difference was found between treated and untreated patients in risk of developing substance use disorder (including alcohol, marijuana, cocaine and non-specific drugs) and nicotine use. Unfortunately, in this meta-analysis specific moderator variables such as age at first stimulant use were not taken into account, probably because of the relatively low numbers of studies to date that include such variables.

We thank the authors for discovering the mistake in the table, 9% should have read 59%.

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doi: 10.1192/bjp.204.6.490b

Liaison services for older adults

Professor Sharpe's editorial summarises elegantly the latest developments in psychological medicine.[1] The economic evaluation of the liaison services that started with the evaluation of the Birmingham Raid Model has naturally progressed with the recent National Institute for Health Research Health Services and Delivery Research Programme on commissioning research grants for 'Organisation, quality and cost-effectiveness of psychiatric liaison services in acute settings'. This call was also accompanied by another one on 'Assessing alternatives to face-to-face contact with patients'. The outcomes of these two calls will undoubtedly bring a new wave of changes to our current liaison services that are already undergoing remodelling. The editorial argues that 'small' liaison subspecialties should 'join forces under a single banner' to provide 'flexible and shared service provision'. Liaison Services for Older Adults (LSOA) are among those that are numbered in the list of small subspecialties. Our analysis of the LSOA within our locality[2] and wider[3] confirms that the LSOAs appear to be the fastest growing liaison discipline. In Newcastle alone we witness a steady 10% yearly increase of older people referred to our service, with the overall numbers being very close to those of our Deliberate Self Harm (DSH) team (37% LSOA *v.* 39% DSH).[3] Those of us who already work in the newly integrated liaison services are under increasing pressure to become more generalist, shadow our DSH colleagues to 'broaden' our clinical experiences, while at the same time the suitability of referrals to our 'small' subspecialty is frequently scrutinised. And yet, the majority of hospital beds are occupied by older people who are physically compromised and cognitively impaired, who are either known to old age psychiatry services or are referred to the LSOA as a result of the Dementia Commissioning for Quality and Innovation (CQUIN). For many of them, our subspecialty would facilitate the diagnosis and initiate the treatment for their cognitive impairment, challenging behaviour and/or depression, and our expertise would aid the decision about their long-term needs and placement and enable/maintain that essential continuity of care that is currently failing them.[4,5] In addition, the LSOA medical expertise is not confined to our old age psychiatric knowledge, but many of us are also dual trained (e.g. family medicine, neurology) and/or hold diplomas in geriatric medicine.

https://doi.org/10.1192/bjp.204.6.491 Published online by Cambridge University Press

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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doi: 10.1192/bjp.204.6.491

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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doi: 10.1192/bjp.204.6.492

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

https://doi.org/10.1192/bjp.204.6.491 Published online by Cambridge University Press