

any psychiatric admission and one would assume that the 7 patients who presented with psychotic symptoms would have been admitted to a psychiatric unit. Finally, we know interdisciplinary liaison appears to carry many advantages but it has both clinical and resource implications,³ more so in the current climate where availability of funds is limited. We would be interested to know how the authors dealt with it.

- 1 Byrne P, Power L, Boylan C, Iqbal M, Anglim M, Fitzpatrick C. Providing 24-hour child and adolescent mental health services: demand and outcomes. *Psychiatrist* 2011; **35**: 374–9.
- 2 Hillen T, Szaniecki E. Cyclic variations in demand for out-of-hours services in child and adolescent psychiatry: implications for service planning. *Psychiatrist* 2010; **34**: 427–32.
- 3 Black J, Wright B, Williams C, Smith R. Paediatric liaison service. *Psychiatr Bull* 1999; **23**: 528–30.

Imran Mushtaq, Locum Consultant Child and Adolescent Psychiatrist, Driffield-CAMHS Union Street, Driffield, YO25 6AT, UK, email: imranmushtaq@doctors.org.uk; **Muhammad Nabeel Helal**, Specialty Registrar (ST5) Child and Adolescent Psychiatry, Westcotes House, Leicester, UK.

doi: 10.1192/pb.36.1.34a

Authors' reply

We would like to thank Dr Mushtaq and Dr Helal for their letter, and welcome the opportunity to clarify the points they have raised. With regard to the study design, since 2002, data on emergency presentations have been prospectively collected at the time of presentation and recorded on a secure database within the hospital network. Access to this information is regulated, and in 2008 we sought and received ethical approval to access and analyse these data retrospectively for the purpose of this study. No data other than those recorded at the time of presentation were included in the study.

During the study period there were no direct admissions from the emergency department to specialist child and adolescent psychiatric in-patient units. This finding most likely reflects the significant lack of capacity within such units as discussed in the paper. Of the subset from 2006 for which data on onward referral were collected ($n = 278$), 20 were referred onwards for in-patient psychiatric assessment. Presenting complaints for those referred were self-harm, suicidal ideation and psychosis.

We agree on the many benefits of interdisciplinary liaison and acknowledge the clinical and resource implications. Indeed, the need to review the efficacy and value for money of services we deliver was a significant factor in our decision to conduct this study. We have presented the findings to all the involved service providers, to encourage awareness of the demand and the rationale for ongoing service provision. Although a cost–benefit analysis was outside our study design, possible cost savings attributable to the model of service provision have been considered in the study discussion. Finally, within a national context in Ireland, improving child and adolescent mental health and reducing suicide are both key performance indicators for our health services, thereby supporting the ongoing provision of services.

We would like to acknowledge the study of Hillen & Szaniecki, and that this study also addresses many aspects of the service model and demand for out-of-hours services. This paper's publication coincided with the timing of our original

submission, and the lead author apologises that this study was not located at the time of revision of the paper.

Patricia Byrne is a consultant child and adolescent psychiatrist at St Frances Clinic Psychiatric Liaison Service, Children's University Hospital, Dublin, Ireland, email: patricia.byrne4@hse.ie. **Lorna Power** is a research psychologist at University College Dublin. **Carole Boylan** is a clinical nurse specialist at St Frances Clinic, Children's University Hospital, Dublin. **Mohammed Iqbal** is a consultant child and adolescent psychiatrist at the Mater Child and Adolescent Mental Health Service in Dublin. **Margo Anglim** is the clinical director at St Frances Clinic, Children's University Hospital, Dublin. **Carol Fitzpatrick** is a professor in child and adolescent psychiatry at University College Dublin and a consultant child and adolescent psychiatrist at St Frances Clinic, Children's University Hospital, Dublin.

doi: 10.1192/pb.36.1.35

Are some subspecialties better with foundation doctors?

Welch *et al's*¹ qualitative exploration and findings on the views of foundation trainees on psychiatry placements were interesting and hopefully will contribute towards creating posts that are valuable to trainees. The transition from medical school to the ward environment is a challenging one² and early impressions can influence trainees a great deal in their choice of careers.³

The conclusions of Welch *et al's* paper are not as favourable as the outcomes described by Boyle *et al.*⁴ There could be several reasons for this: larger numbers of respondents, trainees' individual preferences, life choices and career plans. Perhaps another reason was the subspecialty in Boyle *et al's* report – old age psychiatry. The large amount of physical and mental health comorbidity in this patient group gives trainees the opportunity to contribute to the management of physical health (which they are more familiar with) as well as learn about assessment and treatment in psychiatry. If Welch *et al* had broken down feedback from trainees by subspecialty, this might have helped clarify whether some subspecialties lend themselves better to foundation year programmes and the unique challenges they pose in terms of trainee needs.

Welch and colleagues report on the importance of maintaining links with the acute hospital and sense of isolation trainees experience away from their peers. Liaison psychiatry services are uniquely placed to bridge this gap and working within liaison psychiatry teams based in the acute hospital gets around these problems. Trainees would not need to travel to attend mandatory teaching sessions or medical grand rounds. Liaison psychiatry is also a good training experience to those trainees who do not opt for psychiatry as a career but would still have to assess and manage patients with mental health problems in their chosen specialty. Liaison teams, too, benefit from having foundation trainees attached to them. Not only are their medical skills and knowledge of medical terminology of value to multidisciplinary team members, but their informal contacts with peers on medical wards often clarify the covert reasons underlying referrals and lead to successful consultations.

It is also our experience that news of positive training placement by foundation trainees gets around the hospital, and we often get requests for psychiatry taster days or weeks by