

95–96), Drs House and Creed list a number of welcome recommendations. However, there is only passing reference to the likely benefits of training in liaison psychiatry as done by the old age psychiatrist, with the suggestion that such a placement for an SHO or registrar “cannot substitute for experience with younger adults”. No reference is made to the benefits in being involved in carrying out general hospital liaison work as part of an old age psychiatry placement as a senior registrar.

As part of the audit of liaison psychiatry activity within a large (870 beds) district general hospital, we examined the number and characteristics of patients referred to the consultation liaison psychiatry service (CLP), which deals exclusively with patients under 65, and the old age psychiatry service (OAP) which deals with referrals of patients above the age of 65 from the general hospital. In the three months of the study, the CLP service was referred 88 patients and the OAP Service 44 patients. There were a number of significant differences ($P < 0.005$) between the two groups. The OAP service saw predominantly female patients (70%), whereas the CLP service saw an excess of males (52%). Eighty-four per cent of referrals to the CLP service were following overdose or deliberate self-harm, compared with 6.8% of referrals to the OAP service. Of the CLP referrals, 34% were assigned the diagnosis of acute stress reaction, or situational disturbance, with a further 33% substance abuse. The largest diagnostic group in the OAP referrals were the organic psychosyndromes, 50% dementia and 13.6% delirium. Of referrals to the OAP service, 76% had significant ongoing physical illness as compared with 21% of referrals to the CLP service. The pattern of patient follow-up also differed significantly, with 41% of the CLP referrals compared with 16% of the OAP referrals being discharged without aftercare.

In this study, the CLP service dealt with more referrals than the OAP service. However, the local policy of referring all patients admitted after deliberate self-harm for psychiatric assessment to the CLP is reflected in the finding that many patients had no psychiatric diagnosis and required no follow-up. A greater proportion of referrals to the OAP service had significant psychiatric disorder requiring ongoing treatment.

In the recommendations from the Liaison Psychiatry Group Executive Committee, two particular areas of clinical experience at SHO and registrar level are suggested: the assessment and management of patients seen in medical settings, firstly with co-existent psychopathology and physical illness, and secondly with disorders of the nervous system. From our study, these areas of clinical experience are more readily obtained through attachment with the old age psychiatry service. It would also seem, from our study, that any liaison psy-

chiatrist attempting to provide a fully comprehensive service must recognise that most psychiatric morbidity is found in the geriatric population, and that these disorders require more intensive management.

We would suggest that SHO/registrar training in liaison psychiatry can usefully include attachment in old age psychiatry in the general hospital setting. A similar placement should also be a specific element in the higher professional training of the future liaison psychiatrist.

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Reply

DEAR SIRS

Drs Hall and Swann make a number of important points.

Firstly, a good old age psychiatry service involves good liaison practices. We believe that old age psychiatrists and child and adolescent psychiatrists are often ahead of adult psychiatrists in their forms of liaison with physicians, including joint ward rounds, joint clinics, joint assessment facilities. If general medical services for people aged 16–65 years had similar facilities, many of the problems of liaison psychiatry in this age group would disappear. For this reason, we have always hoped to have good old age psychiatry representation at liaison group meetings.

Secondly, they distinguish the types of patients seen on a consultation liaison psychiatry service and general referrals to the old age psychiatry service. The former is dominated by deliberate self-harm, the latter have a wide variety of clinical problems including those mentioned in our recommendations. It is the latter which we wished to highlight as currently they are under-represented in many liaison psychiatry services.

Thirdly, they do not address a key issue, the training component of the clinical work. A main point of our recommendations is the need for close clinical supervision by a consultant primarily concerned with the liaison service. Too often junior doctors are inadequately supervised on liaison referrals. For patients with organic psychosyndromes, somatisation and psychological reactions to physical illness supervision is essential if the physicians are to receive a good service and the junior staff to have adequate training.

Since the Liaison Group meeting is to be held in Scotland, with a view to involving more Scottish liaison psychiatrists in our workshop discussions, we

look forward to the involvement of Doctors Hall, Swann and other old age psychiatrists!

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Comparative costs of adult acute psychiatric services

DEAR SIRs

Peck and Cockburn on Cost Comparison (*Psychiatric Bulletin*, – February 1993, 17, 79–81) cannot be taken seriously. The authors admit to having conducted a methodologically weak study of DGH based adult psychiatric service with various community services which only looked at cost with scant regard to the quality of care.

It was indeed a very small sample. A great pity that only four out of 13 supposedly innovative community services gave good enough financial information for comparison. They admit that the costs are imprecise. At any rate, only two out of these four (Community Services 2 and 4) seemed to provide at first glance a comparable range of treatments to the hospital model. The quality of service is not at all known, nor is there any mention of the opinions of the patients, carers and GPs as to how useful these services are.

While it is easy to agree that the capital costs of a bed based service are indeed going to be higher, even from the authors' own figures (Table IV), it is impossible to agree that the revenue costs are significantly greater in the hospital service and that hospitals have any greater appetite for revenue consumption.

The revenue costs given are mistakenly reported to be highest in the hospital based service. The authors' own table provides very clear evidence that even with the highest bed usage, the hospital based service costs per 10,000 population at £170,000, are in the middle of the costs range of the four community comparisons which work out between £130,000 and £1,000,000 (see Table). The comparable services cost £130,000 and £1,000,000, the latter showing about six times higher revenue costs than the hospital model.

It does seem that the authors perhaps in their own preference towards community "models" of service failed to notice correctly what their own figures are clearly telling them. One hopes that they will quickly rectify their conclusion lest the anti-hospital enthusiasts and uncritical observers get unduly excited, and the health managers raise their hopes at these flawed conclusions. We all need much more comprehensive costs and quality analysis in papers to generate an informed debate.

TABLE

Comparative revenue costs per 10,000 population

Community service 2*	130,000
Community service 4	150,000
DGH based service*	170,000
Community service 1	270,000
Community service 3*	1,000,000

(*Comparable provisions to DGH)

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Reply

DEAR SIRs

(*Editor's Note: We regret that the final figure in Column 3 of Table IV should have read 100,000 and not 1,000,000.*)

I am grateful for the opportunity to reply to Dr Bhatnagar's letter. The major thrust of his argument is undermined by the correction noted above. I will deal briefly with his other points.

We endeavoured to ensure that the services being compared were attempting to deal with the same range of needs. We were deliberately modest in our claims for the paper and made no attempt to do a cost – benefit analysis; however Dean & Gadd have reported on the apparent satisfaction of users and carers with Community service 2 replicating the findings of both Stein & Houlst in this respect. Furthermore, Community service 4 was the end result of a very thorough process of consultation with users and carers as well as the traditional stakeholders, such as psychiatrists. Unfortunately limitations on space precluded us exploring these issues in more depth.

Dr Bhatnagar accuses the authors of a preference for community models – in my case any such preference is the result of over six years of listening to users discussing their needs and preferred solutions. Within such models the challenge is to construct an effective balance between community and hospital.

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Training in liaison psychiatry

DEAR SIRs

The recommendations of the Liaison Psychiatry Group Executive Committee (1993) on this subject were interesting. In Melbourne there is a well established tradition of consultation liaison psychiatry