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.

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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.

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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

https://doi.org/10.1192/pb.31.12.467 Published online by Cambridge University Press