In October 1991, a completely new system of management was introduced, wherein multidisciplinary discussion and planning was delegated to "mini-teams". Each mini-team consists of three or four staff members drawn from the pool of nursing staff, junior doctors, on-site school staff, occupational therapists etc. The mini-team is chosen by the clinical nurse manager in liaison with the consultant and senior registrar and an attempt is made to match the particular difficulties of the child with the expertise available. The team is chosen before the child is admitted and always includes the key nurse.

The mini-team meets as frequently as required, at short notice if necessary. The mini-team oversees the child's progress and is free to make day to day decisions asking for advice as appropriate. Also, each child has a full multidisciplinary review in the presence of the consultant, on average once every three weeks, and the mini-team is at this time expected to play a key part in immediate, short and long-term planning.

The reason for changing the system in this way included a hoped-for improvement in the working of the multidisciplinary team and in particular:

(a) improved access for all staff members for information regarding the children
(b) broader and more in-depth involvement by staff members in the management of children
(c) the safeguarding of time for discussion of the less challenging or threatening children
(d) to facilitate and prompt thoughtful crisis management between busy weekly meetings.

All staff involved in mini-teams were recently asked to take part in an anonymous survey of this new system. This showed overwhelmingly that the changes made were popular and have been felt to have led to better management of the children. In particular, it was felt that aims (a)–(d), previously outlined, had been attained.

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Correct dose of imipramine in panic disorder

DEAR SIRS

In their article on the prescribing of antidepressants for anxiety disorders, Tyrer & Hallstrom (*Psychiatric Bulletin*, February 1993, **17**, 75–76) are incorrect in advising a dose of imipramine of 100–150 mgs daily in the treatment of panic disorder. Patients suffering from this form of anxiety disorder are intolerant of the side-effects. If imipramine is prescribed in the dose usual for the treatment of depressive disorder, most patients with panic disorder will be unable to tolerate it and an extremely effective treatment for the disorder will be lost. This fact was noted by those who first advocated the treatment (Zitrin *et al*, 1978). Many of us, who recognise the therapeutic potential of antidepressants in panic disorder, advocate commencement at low dose (Snaith, 1991). Fortunately, because of its use in paediatric practice for eneuresis, imipramine is available in a 10 mg tablet. The better tolerance of this low dose regime, with gradual increase, has been demonstrated by Nutt & Glue (1991). They found that once tolerance had been established, the dose may be increased up to 100 mg daily. My experience is that frequently, when panic attacks occur in the absence of a concurrent depressive state, the attacks are effectively controlled by the 10 mg daily dose alone.

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Reply

DEAR SIRS

Dr Snaith emphasises a point that was already indicated in our article, when we described the dosage range (wrongly typed as 'rate') as between 3 and 300 mg/day. It is certainly a sound clinical strategy to begin with low dosage but we do not yet know whether some patients respond to a final dosage below that of a daily imipramine dose of 100–150 mg. Until we have studies which indicate significant imipramine/placebo differences in low dosage the recommendation for the higher dosage remains.

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Training in liaison psychiatry – the place of old age psychiatry?

DEAR SIRS

In their recommendations for training in liaison psychiatry (*Psychiatric Bulletin*, February 1993, **17**,

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 overdosage 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 psychiatrist 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