Correspondence

Experience psychiatry first-hand

Welch *et al*'s article[1] touched on numerous issues, some related to the recruitment crisis in psychiatry. Only recently, an article in the *BMA News* highlighted the limited exposure to psychiatry in medical schools and the foundation programme, in combination with the negative image that it is given by doctors in other specialties.[2] Mental health has long suffered from stigma, but this appears to start at home.

I recall my 3-week psychiatry rotation as a medical student which was described by senior students as 'psycho-holiday'. Approximately half of our allocated group of eight turned up for sessions, and although this was noted, they were not asked to account for their absence as it would have been done in surgical or medical rotations. Therefore, I, like most of my colleagues, never considered psychiatry as a serious career.

I found myself, like many others, in a chaotic situation, graduating the year that Modernising Medical Careers had just introduced the foundation years. As a result, I was allocated rotations that had not been my initial choice. Much to my dismay, psychiatry was one of these.

I started 4 months of psychiatry as a Foundation Year 2 doctor with dread and apprehension. I recall walking on to my acute adult in-patient ward wondering how I was going to get through the next few months. However, within a week, the feelings of resentment were replaced by curiosity and interest. I saw a spectrum of patients I had never imagined existed – an elderly lady with long-term schizophrenia, a young woman with postnatal depression, and a young man with his first psychotic episode. I watched in amazement as people whose lives had been falling apart regained their ability to function with the help of our team. I watched in awe as patients with acute psychosis recovered, developed insight and learnt to cope with their illness and associated stigma. Within a few weeks, my perspective of psychiatry had transformed and I spent the rest of my rotation absorbed by the challenges and variety of psychiatry.

Unfortunately, I had already applied and been accepted for specialist training in acute care common stem (ACCS) with a view to going into accident and emergency. For 2 years as an ACCS trainee, I gravitated to the patients with psychiatric issues – those with depression on the intensive care unit, those with acute psychosis in accident and emergency – much to the surprise of my colleagues. I remained heavily involved in psychiatric recruitment with my previous consultant. Finally, I made one of the biggest decisions of my life – I left my ACCS post and reapplied for specialist training in psychiatry. My medical consultants were horrified and did their best to talk me out of this 'mistake'. It was then I experienced first-hand the stigma associated with psychiatry within our own profession, from seniors and peers.

I am now a core trainee (CT3) in psychiatry, aiming to apply for higher training in old age psychiatry. I remain actively involved in recruitment to psychiatry. I love psychiatry and the fact I follow my patients through on their journey of recovery, unlike in my acute medical days. I have never once regretted my decision to do psychiatry – in fact, it was one of the best I have ever made.

I am evidence that it is not only those who are unable to get into any other specialty that end up pursuing psychiatry, like many of my colleagues told me. I am evidence that given the right experience in foundation years, psychiatry is just as viable an option as any other 'proper' specialty. We need more foundation posts in mental health, as proposed by Welch *et al*, if we are ever going to overcome the crisis in recruitment and tackle the stigma within the medical profession. We owe it to ourselves and to our patients to ensure that psychiatry is not seen as a second-rate specialty. Medical students often ask me for career advice about psychiatry and I tell them to experience working in mental health first-hand and then make a decision. I was lucky enough to be given the opportunity and am now very privileged to be part of such a unique and rewarding specialty.

1 Welch J, Bridge C, Firth D, Forrest A. Improving psychiatry training in the Foundation Programme. *Psychiatrist* 2011; **35**: 389–93.

2 Munn F. Battling for hearts and minds. *BMA News* 2011; 10 September.

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A comprehensive and specialist CAMHS service model

Byrne *et al*[1] describe a model of a specialist child and adolescent mental health service (CAMHS) which provides 24 hours' care. We must congratulate them on this unique study and using a model which combines a traditional on-call psychiatric provision with a paediatric liaison model of service delivery. However, we would like to make a few points here and request the authors to clarify three issues for us.

The authors said they were unable to find any published evidence regarding demands on or experience of a 24-hour specialist CAMHS or how in clinical practice in the UK and Ireland service models are implemented. However, a year before the publication of Byrne *et al*'s paper a British study[2] was published in this journal which highlighted some of the aspects of the service model and analysed the cyclic variations in demand for out-of-hours services in child and adolescent psychiatry, considering it an important factor for service planning. Hillen & Szaniecki's study included 323 individuals recruited from three London teaching hospitals over 4 years and reported that out-of-hours bedside assessments were required in 37% of cases. There were 50% more referrals in the spring compared with the rest of the year but no more referrals than usual during the holidays, a finding which was also seen in Byrne *et al*'s study.

First, we would like to know about the retrospective case study design as it is not clear in the paper and the authors claimed that data were collected prospectively on all presentations during the period reviewed. Second, 52% of the assessed patients required admission in general paediatric wards but there was no information given regarding

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