

Correspondence

Experience psychiatry first-hand

Welch *et al*'s article¹ 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.

Suhana Ahmed, core trainee (CT3) in psychiatry, Sutton Hospital, Sutton, Surrey, UK, email: suhana.ahmed@doctors.org.uk

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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 study² 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

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.

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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.

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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