The need for a leap of faith is an unfortunate reality of services adapting to fast-changing business environments. Organisations that succeed place their trust in the analysis of experts to place them into a strong position to face new challenges. The pace of change is rarely sympathetic to the needs of more cautious individuals whose grasp of the issues and need to change may be equally acute but whose ability to make rapid intuitive shifts is limited by their need for security. The principles of Fair Horizons are unarguable, its service model addresses these, and we suggest that any service model demonstrating equal adherence to such principles will be sustainable in the future.

Dr Moliver is concerned about the fate of older people within age-blind services. Fair Horizons retains highly specialist services for those with dementia and other specialist needs. Many with less severe illness will be managed in primary care as proposed by the *National Dementia Strategy*. For those with functional illness, it is increasingly difficult to identify at what age people move to older people's services, given the advancing age and increasing health of the population. This has been an issue for many years and we would draw Dr Moliver's attention to the significant number of patients whose care continues in adult generic services into their seventh and eighth decades. Colleagues in older people's mental health recognise that such individuals continue to receive appropriate care within services for younger adults: Fair Horizons provides for joint working with older people's specialists if required.

Dr Tyrer makes the point that any service model works only if local clinicians commit to it. We have commitment from the majority of local colleagues from across professional groups. Nevertheless, there is work to do to ensure that all colleagues are fully supportive of the principles underpinning Fair Horizons.

1 Tyrer SP. An innovative service but will it work in practice? Commentary on . . . Fair Horizons. *Psychiatrist* 2012; **36**: 30–1.

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Recruitment in psychiatry: a complex and multifactorial problem

We read with interest the paper that explores the attitudes of those delivering undergraduate teaching in psychiatry as a factor in poor recruitment.[1] We appreciate that a positive attitude to teaching students is vital in the delivery of education and in creating appropriate role models, but we believe that these attitudes play a relatively minor role in this problem. The reasons for poor recruitment in psychiatry are multifactorial.

In recent years we have seen competition for psychiatry posts gradually decline.[2,3] One major factor that has contributed to this are the changes to visas for doctors trained outside the UK. International doctors have traditionally contributed significant numbers to British psychiatry, but current restrictions make it near impossible for international graduates to secure training positions.

Psychiatry as a specialty has always been considered somewhat separate from other hospital-based medical specialties, but we have to consider whether geographical and structural changes to mental health services are further reinforcing this idea and contributing to poor recruitment. We have come a long way from the asylum culture, but many psychiatric hospitals remain geographically separate from the main hospital, giving medical students the impression of psychiatry being a 'Cinderella branch' of medicine. Similarly, a streamlining of services has often led to a reduced presence of liaison psychiatry within main hospitals, giving an image of an isolated and understaffed specialty.

In years gone by, junior doctors enjoyed flexibility in training that allowed them to experience a wide variety of placements and specialties before choosing a career path. Changes to training have meant that doctors are now under pressure to choose a specialty early in their career, often without the luxury of having been able to explore all available options. As a result, the 'less obvious' options, such as psychiatry, may be overlooked. Early exposure to psychiatry through foundation year 1 posts has been suggested,[4] but caution should be exercised as we cannot underestimate the general medical experience and decision-making involved in an often community-based or 'off-site' placement such as are typical in psychiatry. It would not serve the specialty well to discourage potential applicants through asking too much of an inexperienced junior doctor.

This lack of exposure to the specialty may extend back to undergraduate training, where psychiatry is a comparatively small component of the syllabus and often not experienced until the later years of medical school. As a specialty that is often subject to outdated myths or jokes, the junior doctors and students who are relatively naive to the reality of psychiatry are at risk of adopting such untruths, which thus influence their opinions and, in turn, recruitment rates.

Exploring the factors affecting recruitment is complex. For this reason it is useful for studies such as that by Korszun *et al* to consider an individual factor. Much of the literature has concentrated on teaching and the opinions of medical students.[5] These writers believe that there is a need for further evidence on the opinions of foundation trainees, in particular whether the negative opinions suggested by studies such as this are widespread and affecting recruitment. A study to explore this factor has therefore been undertaken and we aim to release the results to add to the evidence to be used in tackling declining recruitment rates in the UK.

Psychiatry is one of the most exciting branches of medicine. Because of its very nature and complexity, innovation in psychiatry has been slow relative to other specialties. As a result, we now stand at the door of a major revolution in this branch of medicine. We are now where other medical specialties were half a century ago. We now know that one in four of us will suffer from a mental illness in our lifetime and with a vast amount of research ongoing, this remains a very exciting medical branch to be part of.

There is no doubt that we are guilty of underselling psychiatry. The time has come for us to excite the next generation of doctors and open their eyes to a fascinating specialty that will offer a challenging and fulfilling career. To

secure the future of psychiatry we need to ensure that we attract the best candidates for training posts, and as such, studies into recruitment will need to continue.

1 Korszun A, Dharmaindra N, Koravangattu V, Bhui K. Teaching medical students and recruitment to psychiatry: attitudes of psychiatric clinicians, academics and trainees. *Psychiatrist* 2011; **35**: 350–3.

2 Royal College of Psychiatrists. *Psychiatry National Recruitment 2011: CT1 Outcomes*. Royal College of Psychiatrists, 2011 (http://www.rcpsych.ac.uk/pdf/CT1%20recruitment%200utcomes-03.08.2011.pdf).

3 Scottish Medical Training. *Competition Ratios 2009–2010*. Scottish Medical Training, 2010 (http://www.scotmt.scot.nhs.uk/media/27625/smt%20website%20competition%20ratios%202009_2010.pdf).

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

5 Brockington IF, Mumford DB. Recruitment into psychiatry. *Br J Psychiatry* 2002; **180**: 307–12.

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Knowledge of mental health legislation in junior doctors training in psychiatry

We read with interest the study by Wadoo *et al*[1] focusing on the knowledge of mental health legislation in junior doctors training in psychiatry. As rightly stated by the authors, this is a concerning issue due to the possibility of inappropriate use of legislation that could potentially threaten patients' fundamental rights.

We would like to highlight a couple of issues which are concerning. We felt that doctors' knowledge of various aspects of the Mental Health Act will increase after they become Section 12(2) approved and attend the mandatory training. We feel that most of the sections of the Act are only used by doctors after they are Section 12(2) approved; however, there are certain aspects of the law which apply before the approval. These are mostly used in emergencies, when junior doctors are often the first port of call, often outside working hours when the support from senior and more experienced staff might not be as readily available.

We were anxious at the lack of knowledge of Section 5(2), where 65% of the trainees felt that they needed to examine the patient and 60% knew about the requirement to fill out a form.

We feel that junior doctors in training are frequently called to prescribe medications for agitated or disturbed patients. In the current study the trainees' knowledge about the consent to treatment fell to 20% (statement in the study is: 'after 3 months, second opinion must be obtained if the patient does not consent'). It can be concluded that the doctor may not be aware whether the patient's current consent to treatment form (T2) or a second opinion (T3) is covering the emergency medication. There is a risk a patient may be prescribed medication without consent and without the legal paperwork completed. We felt that such scenarios, apart from damaging the therapeutic relationship, could possibly lead to complaints or litigation against individual staff or the managing trust.

Although it is reassuring that experience results in improved knowledge of the legislation, we agree that training in mental health law and its clinical implications should be emphasised at an earlier stage in the junior doctors' career. Regular testing of competencies, as set out in the Royal College of Psychiatrists' curriculum, should follow attendance at mandatory formal training at induction and refresher courses.

1 Wadoo O, Shah AJ, Jehaanandan N, Agarwal M, Laing M, Kinderman P. Knowledge of mental health legislation in junior doctors training in psychiatry. *Psychiatrist* 2011; **35**: 460–6.

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Feelings of shame in a community psychotherapy group

Crossley & Jones' article on shame and acute psychiatric in-patient care[1] was of great interest as the themes discussed are pertinent to the psychodynamic group we facilitate in a community rehabilitation service (an open group for patients with psychosis). The patients frequently bring up shame about their illness in different ways. The superordinate themes they identified are persistent themes within our group.

Patients talk about feeling looked at 'differently' by the public when on the streets or using public transport. They question this, wondering whether people can tell that they have a mental illness or whether they are paranoid. Avoiding potential feelings of shame has led to self-isolation and loss of independence for several of our patients.

Patients describe their 'loss of adulthood' and autonomy, especially when admitted to hospital. Their accounts of being cared for by mental health services are full of shameful experiences, such as being restrained. They notice the distance between their current position and a potential future 'adulthood', leading to feelings of hope and loss.

Issues regarding medication have obviously featured, including the pride felt in taking the responsibility of self-medicating. They reflect on the stress of taking responsibility against the rewards of achieving goals. Our patients are undoubtedly being observed which, as stated in the paper, inevitably heightens feelings of self-consciousness. The group is able to voice these feelings when considering why they choose not to express opinions on certain topics. They have acknowledged feeling observed by other group members, as well as the facilitators, and the worry about being judged.

The group is developing increased self-worth and protesting against shameful feelings by expressing their concerns. There is compassion in the group for one another and a wish to increase each other's feelings of worth. Patients emphatically and movingly encouraged another physically immobilised patient to keep trying to 'recover'. They stated that it would be painful and he may cry but that he should not be ashamed of it and he would not be judged by them.

The paper helped us to consider the shame we may feel as group facilitators, especially when the group is curious about our lives. Envy of our idealised lives, in and out of work, has been present in the group. We feel guilt about how much