Correspondence

EDITED BY KHALIDA ISMAIL

Recruitment and retention in psychiatry

We read with interest the literature review by Brockington & Mumford (2002) on recruitment into psychiatry. We agree it is possible that recruitment might be improved by influencing medical student intakes and having greater understanding of the pathways leading to a psychiatric career. However, we believe that the factors governing career choice at both undergraduate and postgraduate levels are uncomplicated. Students on clinical attachments in psychiatry are exposed to wards which are often dirty, unpleasant, frightening and understaffed. They see a service that is underfunded and, subsequently, staff with low morale and burnout. It is hardly surprising that many pursue alternative specialities.

Attempts to encourage potential and existing recruits by repackaging psychiatry at any nodal point in a medical career are likely to fail unless there is the financial investment to provide fully resourced working environments. Attractive conditions might also reduce stigma, contributing further to recruitment. The findings of a study being carried out by the Royal College of Psychiatrists looking at why psychiatrists leave the profession and retire early will be of interest to us all (Camm, 2002).

Brockington, I. & Mumford, D. (2002) Recruitment into psychiatry. *British Journal of Psychiatry*, **180**, 307–312.

Camm, J. (2002) Psychiatrists condemn inaction on recruitment. *Hospital Doctor*, 11 April, 6.

C. O'Gara Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK

J. Sauer Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF, UK

We were encouraged to read both a review article and an editorial on recruitment in psychiatry (Brockington & Mumford, 2002; Storer, 2002). Recruitment and retention is surely one of the most important challenges for British psychiatry today. It may be of interest to point out that not only have similar recruitment problems been identified in Wales but also that research into this is ongoing.

An initial qualitative study using grounded interviews with medical students, pre-registration house officers and psychiatrists of all grades across Wales has been completed. On the basis of this, a questionnaire was developed which has been distributed to all psychiatric senior house officers, specialist registrars and staff grade doctors in Wales. These questionnaires explore various aspects of psychiatric training experience and motivations behind career intentions. From the responses, we hope to gain a greater understanding of the reasons behind the crisis.

From the initial work, one theme that is emerging is the importance of a positive training experience, initially at undergraduate level but also at later stages in a doctor's career. An enthusiastic teacher was particularly seen as a strong motivator to entering psychiatry. However, this was counterbalanced by the effect of the stigma of entering a speciality perceived as inferior. As well as problems with recruitment, there are increasing problems with retention of senior house officers, and subsequent lack of applicants for specialist registrar posts. Some disincentives to continue within training seem to be the perception of demoralised consultants not providing ideal role models for young aspiring psychiatrists. This is linked to the experience of a pressurised service that lacks resources. Both these factors appear to be an affliction affecting general psychiatry to a greater extent than the other specialities. Perceived stigma directed towards psychiatrists, mental health services and patients from our medical colleagues is a worryingly common observation, and is another potentially important finding in relation to the Royal College of Psychiatrists' 'Changing Minds' campaign.

We look forward to being able to share the results of our survey later this year and hope that it will provide some direction to develop solutions to this crisis.

Brockington, I. & Mumford, D. (2002) Recruitment into psychiatry. *British Journal of Psychiatry*, **180**, 307–312.

Storer, D. (2002) Recruiting and retaining psychiatrists. *British Journal of Psychiatry*, **180**, 296–297.

L. Clarke-Smith Cefn Coed Hospital, Waunarlwydd Road, Cockett, Swansea SA2 0GH, UK

R. Tranter Hergest Unit, Ysbyty Gwynedd, Bangor LL57 2PW, UK

Improving the CHI

Professor Burns (2002) makes some good points in his article on the Commission for Health Improvement (CHI). The CHI is a relatively new organisation and is constantly learning. Already, many of the suggestions for change to our clinical governance review process made in his article have been identified and implemented through our own processes of self-review and improvement. Such improvements include shortened clinical governance reviews and shorter, more accessible reports.

However, Professor Burns unfairly doubts the experience of CHI reviewers who undergo a rigorous assessment and training programme. He also questions the consistency of clinical governance review reports. We have developed assessment frameworks to help review managers, and reviewers make reliable and consistent assessments transparent to both the organisation and its stakeholders. This framework underpins the entire process, driving the collection of data and information and all reporting arrangements.

Professor Burns also makes unhelpful comparisons between homicide inquiries and CHI reviews. Our role is not to identify individuals to whom blame can be attributed, but to help encourage improvement where improvement can be made. Many have found CHI's reviews a positive experience enabling the organisation to recognise strengths as well as weaknesses. In the meantime, the CHI is committed to learning and improving our own systems through constant consultation. Feedback is always welcome; even better, why not become a CHI reviewer and make your own contribution?

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Declaration of interest

L.P. is Medical Director and J.C. is Director of Policy and Development at the CHI.

Burns, T. (2002) The Commission for Health Improvement (CHI) review of North Birmingham Mental Health Trust: what can we hope for from the CHI? *British Journal of Psychiatry*, **180**, 6–7.

L. Patterson, J. Cornwall Commission for Health Improvement, Finsbury Tower, 103–105 Bunhill Row, London EC1Y 8TG, UK

Author's reply: I am delighted that the CHI has identified similar improvements through its internal monitoring as I suggested in my editorial. I was trying to be helpful.

I did not question the assessment and training of CHI reviewers but their *experience as reviewers*. Obviously, CHI is new and so its current reviewers are new. A useful exercise at 2 years or so would be to report the average number of reviews conducted by members and to check the number where the seconded members are all first-timers. How comparable and consistent the reports are is also a judgement of outcome, not just of process. Stakeholders will make their own judgements – probably in the same way I did by reading a couple side by side and trying to compare and contrast. Time will tell but shorter reports will certainly help.

Linda Patterson's and Jocelyn Cornwall's comments on my 'unhelpful comparisons' with homicide inquiries do, however, warrant a reply. Homicide inquiry panels would also consider their aim to be 'to help encourage improvement where improvement can be made'. The point I was trying to make is that there can be a gulf between this wholly admirable ambition and the impact of such reports (and that this impact is both direct and indirect through the media).

This point is being made infinitely more eloquently by the Cambridge University philosopher Onora O'Neill in the BBC Reith Lectures entitled 'A question of trust' (O'Neill, 2002). In these she analyses with devastating precision how a pursuit of accountability and transparency at all costs can, and does, lead to the erosion of trust and, paradoxically, a reduction in disclosure and honest communication.

Having started my psychiatric training at a time when consultants really did seem free to do exactly what they wanted, I warmly welcome review and the establishment of consistent standards of clinical care. However, the age of innocence is surely passed. Professor O'Neill's analysis is a call to more careful thought on how accountability and transparency can be achieved without damaging the process they are meant to foster. Hopefully, now it will be accepted that we can have a debate on these issues without it being seen simply as protectionism. I wish the CHI well.

O'Neill, O. (2002) *A Question of Trust*. Cambridge: Cambridge University Press.

T. Burns Department of Psychiatry, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, UK

Estimating cognitive deterioration in schizophrenia

Two recent studies failed to establish a relationship between the duration of untreated psychosis (DUP) and cognitive deterioration in first-episode patients (Barnes *et al*, 2000; Norman *et al*, 2001). Both studies used the premorbid IQ (estimated using the National Adult Reading Test (NART)) minus the current full-scale IQ (measured using the Wechsler Adult Intelligence Scale (WAIS)) to measure cognitive deterioration. The validity of this approach to assessing cognitive deficit is open to question.

We examined DUP and cognitive deterioration in 42 individuals (mean age 22.3 years; s.d.=4.1) with first-episode schizophrenia (Amminger *et al*, 2002). The revised version of the NART and WAIS (WAIS–R) were administered at clinical stabilisation and we have since taken the opportunity to apply the NART IQ minus WAIS–R full-scale IQ approach. Current IQ was higher than the estimated premorbid IQ in 38.1% of cases, suggesting an IQ increase.

The NART has been validated in older samples. We were therefore interested in the relationship between age at admission and IQ measures. NART IQ, but not WAIS–R full-scale IQ, was positively correlated with age at admission in our sample, (r=0.331, P=0.032). The WAIS–R 'vocabulary' sub-test, suggested to be a better estimate of premorbid IQ than the NART (Russell *et al*, 2000), had also no relationship with age. It is possible that the NART underestimates premorbid IQ in young people with schizophrenia.

Age-standardised WAIS sub-tests are another method to estimate cognitive deterioration (Bilder *et al*, 1992). Performance on 'information' and 'vocabulary' sub-tests are relatively stable, whereas the 'digit symbol' sub-test is sensitive to brain insult. Bilder *et al*'s (1992) deterioration index (DI),

$$\mathrm{DI} = \frac{[(\text{Information} + \text{Vocabulary})/2 - \text{Digit Symbol}]}{[(\text{Information} + \text{Vocabulary})/2]}$$

is based on the principle that a larger discrepancy between an individual's best and poorest performance on cognitive functions suggests cognitive loss. We found longer DUP, male gender, higher NART IQ and younger age at depression to be independent significant predictors of the DI (Amminger *et al*, 2002).

A cross-sectional test score (e.g. low-average full-scale IQ) cannot indicate deterioration on its own. In the absence of longitudinal data, indices reflecting decline from premorbid levels of functioning are required. Limitations of proxy methods need to be considered and studies which aim to validate measures of cognitive deterioration should be pursued.

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G. P. Amminger Early Psychosis Prevention and Intervention Centre (EPPIC), MH-SKY, Department of Psychiatry, University of Melbourne, Australia, and University Clinic for Child and Adolescent Neuropsychiatry, Währinger Gürtel 18–20, A-1090 Vienna, Austria

J. Edwards EPPIC, University of Melbourne, Australia, and University Clinic for Child and Adolescent Neuropsychiatry, Vienna, Austria

P. D. McGorry EPPIC, University of Melbourne, Australia

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