the columns

correspondence

Consultant participation in therapeutic management

Sir: The articles by Haigh (*Psychiatric Bulletin*, October 2002, **26**, 380–382), Holmes (*Psychiatric Bulletin*, October 2002, **26**, 383–385) and Davenport (*Psychiatric Bulletin*, October 2002, **26**, 385–388) on the therapeutic management of the acute ward, were timely. It is not easy to manage a busy ward in this fashion but with determination from the consultant and a senior nurse, it is possible and very rewarding.

Contemporary registrar training does not always prepare well for this role. I was lucky to have the benefit of being Douglas Bennett's registrar in the 1960s when I was introduced to this style of management. I then went on to be a co-therapist in an outpatient psychotherapy group with Heinz Wolff. Heinz was a very active therapist and this is more what is needed in a ward group where practically all the patients, if given the option, would rather not be there. In any case, the purposes of the ward group are different from those of outpatient psychotherapy. At their most basic they are a reason for the patient to get out of bed in the morning and an occasion for recognising the existence of each individual. It is important not to exclude a difficult and disruptive patient. Often in the setting of the group, they can respond remarkably well, which makes it a positive experience for all. The group is also a highly efficient way of using staff time, when all the patients attend the group. It is also possible to include patients on special observations, which turns what is usually a tedious task into a therapeutic experience. It is not easy to maintain the group culture against unwilling patients and some unwilling staff and it is much easier if the group is a daily activity, well established and up to the expectations of new staff and patients. The group can also be a great learning experience, and I have never had any problems about including medical students and student nurses. It is vital to have a staff discussion after each group.

The main problem with the system is shortage of staff and staff who are not very experienced or comfortable with the approach. I had the advantage of having a gifted psychologist, Herbie Pillay, in the team, who offered specific training sessions, which were undermined by the shift system and the shortage of nurses. With the stripping of the inpatient service when priority was given to the community services, I lost psychology, just as I had lost a designated social worker. Because of the need to work as a team, the system works poorly where there are multiple consultants on one ward.

Finally I would like, with the writers, to emphasise the importance of staff groups and the particular importance of the consultant's participation. In his or her absence it is very likely that the group will project their problems on to the absent consultant, who will have his or her paranoid suspicions about what is being said in the group.

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Service provision for gender dysphoria

Sir: I was pleased to read the article by Murjan, Shepherd, and Ferguson (*Psychiatric Bulletin*, June 2002, **26**, 210–212), highlighting the variability of services available for the assessment of individuals with gender dysphoria.

However, I am concerned that their conclusions are not supported by the data provided. They state that "most transsexual people have access to NHS services for the treatment of gender dysphoria". The results presented are that 79/120 (65%) health authorities replied to the survey confirming that they had a commissioning policy, either from local or recognised national centres. It is not stated whether patients were actually referred or seen within a reasonable amount of time. At least one health authority imposes a 5 year "residency criterion" in their area for referral to a specialist service, despite the High Court ruling in *A, D and G*.

The article offers no evidence base for their description of a "full" service, or whether such services as are provided are effective. Worryingly, the authors refer to the 5th edition of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) *Standards of Care for Gender Identity Disorders* (1998), which differs significantly from the current 6th edition (2001).

The authors infer that there is a need for a standardised treatment approach across Great Britain, and attribute the negative experiences of patients using specialist gender identity services to inadequate commissioning of local services. Neither inference is justified by the data presented. The implicit call for uniformity is at odds with the HBIGDA standards of care, and potentially wasteful of resources.

HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION (1998) *The Standards of Care for Gender Identity Disorders*, 5th Edition. Dusseldorf: Symposion Press.

— (2001) *The Standards of Care for Gender Identity Disorders*, 6th Edition. Düsseldorf: Symposion Press.

MURJAN, S., SHEPARD, M., FERGUSON, B. G. (2002) What services are available for the treatment of transsexuals in Great Britain? *Psychiatric Bulletin*, **26**, 210–212.

A, D and G v NW Lancashire Health Authority, Court of Appeal 29 July 1999, Case Nos. QBC 1999/0226/4, 0228/4, 0230/4.

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Sir: I read with interest the paper by Murjan, Shepherd and Ferguson (*Psychiatric Bulletin* June 2002, **26**, 210–212).

In their assessment of services provided to transsexual patients, the authors relied on the 5th edition of the Harry Benjamin International Gender Dysphoria Association *Standards of Care for Gender Identity Disorders* (1998). In doing so they omitted to refer to the current edition which is the 6th edition, (2001), with revised standards and a modern approach favouring flexibility, rather than uniformity of provision. The current edition concludes that "in some patients, hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or surgery".

The unfortunate consequences of the authors' use of the old edition are manifest in two ways. First, their implicit criticism of a Health Authority for commissioning hormonal therapy without surgery for transsexual people; and

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second their statement that "management [of transsexual patients] includes . . . the real 'real life experience"' ("cross-living"). In similar vein, Ferguson (2002) recently proposed a 'uniform' national standard of care which stated that "the person will be expected to enter the Real Life Experience" and envisaged hormonal support (for male to female transsexuals) for no more than 3 months unless the patient committed to cross-living full-time.

The use of hormone therapy can sometimes suffice to spare transsexuals the medical and legal consequences of surgery or cross-role living, and accords with the principle of least intervention. The transsexual opting for surgery faces a battle with osteoporosis, yet the authors presented no data about the availability of endocrinological postoperative support.

FERGUSON, B. (2002) Guidance for the Management of Transsexualism, (paper presented to a meeting of the Faculty of Social and Community Psychiatry of the Royal College of Psychiatrists, at the Royal Society of Medicine, London, April 16 2002).

HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION (1998) *The Standards of Care for Gender Identity Disorders*, 5th Edition. Dusseldorf: Symposium Press.

— (2001) *The Standards of Care for Gender Identity Disorders*, 6th Edition, Düsseldorf: Symposium Press.

MURJAN, S., SHEPHERD, M., FERGUSON, B. G. (2002) What services are available for the treatment of transsexuals in Great Britain? *Psychiatric Bulletin*, **26**, 210–212.

Victoria Williams 3 Dr Johnson's Buildings, Temple, London EC4Y 7BA [The author is a professional member of the Harry Benjamin International Gender Dysphoria Association.]

Access to emergency assessments for adolescent populations

Sir: The article by Corrigall and Mitchell (*Psychiatric Bulletin*, October 2002, **26**, 388–392) provides a valuable contribution to the debate on emergency provision for adolescents with severe mental health difficulties. The authors describe a service offering emergency access 24 hours a day and 7 days a week. In 1995, "Pine Lodge" Young People's Centre in Chester set up just such a service (Cotgrove, 1997). In our experience, at times, an emergency admission adds nothing to the resolution of a young person's difficulties, but can result in a lost opportunity to enhance motivation through careful pre-admission objective setting and care planning. For this reason we perform our own assessment with a different emphasis which is not simply a duplication of the referrer's.

Alongside emergency admissions, we have continued to take planned admissions of young people with a wide range of complex disorders. However, treating youngsters with different needs within one unit is not without some cost to the therapeutic milieu and ward atmosphere.

It is vital that adolescent populations have access to emergency assessments and for some, immediate admission. However, I suggest that a range of in-patient services are required to meet the needs of adolescents with the most severe and complex disorders. Close working relationships between units, possibly to the extent of common assessment and admission pathways, can avoid fragmentation. Ideally, the service described by Corrigall and Mitchell should be seen as one in a network of services rather than an alternative to other specialist provision.

COTGROVE, A. J. (1997) Emergency admissions to a regional adolescent unit: piloting a new service. *Psychiatric Bulletin*, **21**, 604–608.

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the college

Annual elections – Honorary Officers

Council and Court of Electors

Members are reminded of their rights in connection with the forthcoming elections for the vacancies on the Court of Electors and for elected members of Council. There are four vacancies on the Court of Electors. There are vacancies for two Fellows and two Members on Council. The relevant Bye-Laws and Regulations are printed below.

The nominating meeting of the Council will be held on 24 January 2003 and the last date for receiving nominations will therefore be 21 February 2003. Nomination forms are available from Andrea Woolf.

Extracts from the Bye-Laws and Regulations

Bye-Law XXI
The Court of Electors

. . .

The Court of Electors shall be composed of:

(a) The President, Dean and Registrar, each of whom shall be an ex-officio member of the court of Electors; and
(b) Fifteen Electors who shall be chosen in the manner hereinafter prescribed from amongst the fellows.

. . .

At the first meeting of the Council in alternate years after the name of the President for the next ensuing College year has become known, the Council shall nominate a sufficient number of candidates for appointment as Electors to ensure an election, which will be held by a postal ballot of all Members of the College in the manner prescribed by the Regulations. Additional nominations may be lodged with the Registrar between the beginning of the then current calendar year and the end of four clear weeks after the meeting of the Council above referred to. No such nominations shall be valid unless it be supported in writing by twelve Members of the College and accompanied by the nominee's written consent to serve if elected.

. . .

Regulation XIX
The Council

Elections shall be held in alternate years to ensure that there are not less than six elected Members of Council and no more than six elected Fellows of the Council subject to the overall condition that no elected Member or Fellow shall serve on Council for more than six years in that capacity without a break of at least one year. At its first meeting in each alternate College year after the name of the President for the next ensuing College year has become known, the Council shall nominate the necessary number of Members and Fellows of the College to ensure that there are no more than six elected Fellows and not less than six elected Members serving on Council. Any nominee who is proposed and seconded and gives his or her consent in writing to serve, shall be validly nominated. Any twelve Members of the College may make nominations in writing at any time between the first day of January in each alternate year and the date which is four clear weeks after the meeting of the Council at which nominations were made.

Nominations other than those made by the Council shall be lodged with the Registrar and accompanied by the written consent of the candidate to serve if elected. Should there be more nominations than vacancies, an election shall be held by ballot of the Members of the

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