make it alright). Large institutions should renew their commitment to promoting tolerance and harmony among society's diverse cultures.

The article by Hickling & Hutchinson should be retracted immediately, and apologies offered by the publishers.

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## Reliability and validity of HoNOS

Sir: We looked in vain for evidence of the statement by Chaplin & Perkins (*Psychiatric Bulletin*, January 1999, **23**, 20–21) that their study had assessed the reliability and validity of the pre-final version of the Health of the Nation Outcome Scales (HoNOS). The first claim relates to a comparison of the scores of 32 (out of 248) patients interviewed either by a psychologist, psychiatrist or by a nurse. What they call a lack of reliability seems to be large difference in the man total scores (15.6 and 6.4 respectively). In a second comparison involving only eight patients, similar mean total scores (13.75 and 14.25) were obtained by nurses rating independently of each other. It is impossible to interpret these figures without knowing, in substantial detail, how the study was carried out.

In the equivalent study of the pre-final HoNOS during the field trials (further details available from the authors upon request), there was a small by significant difference between nurses ($n$=399) and psychiatrists ($n$=60), probably reflecting differences between the settings (acute longer term and community) where the ratings took place there was a much larger difference between clinicians and social workers, which appeared to be associated with different rating thresholds, indicating as other studies have done a problem of calibration between professions.

So far as we can tell, no trial of 'validity' was carried out by the authors.

A further incidental but important point relates to terminology. The formulation "HoNOS rated half with hallucinations . . ." is inadmissible. HoNOS is not a person. The clinicians rated HoNOS. We do strongly agree with the recommendation that training should be supplemented by supervision, as emphasised in the HoNOS documentation.

JOHN WING, *Professor of Psychiatry; and* PAUL LELLIOTT, *Director of College Research Unit, Royal College of Psychiatrists, 11 Grosvenor Crescent, London SW1X 7EE*

Sir: In response to the correspondence from Wing & Lelliott, I would like to make the following comments. HoNOS ratings were introduced as a routine measure of outcome in our service in 1995. An evaluation of their utility was considered necessary in order to assess their ability to measure change in our service which solely consists of people with severe and enduring psychiatric disability. Two senior staff members attended a training day organised by the Royal College of Psychiatrists and then trained all other senior team members. These senior professionals then trained professionals in all other areas of the service in the use of the scales and supervised the completion of the initial forms.

The scales were tested for reliability in only a minority of the patients as Wing & Lelliott commented. To do so on a larger group would not have been possible without additional funding. Ratings by different professionals were all made in the same setting (long-term) so could not explain the differences. The study did not explicitly test validity as Wing & Lelliott rightly state. However, some of the results were very surprising. The scales recorded zero on 6% of the patients which suggested a total absence of disability. In this group, the patients were reassessed by senior professionals who knew them well to confirm the clinical impression that they were indeed significantly disabled. This suggested that in this small group of patients that HoNOS lacked face validity. The most important finding of the study was that the different disciplines may have extremely different rating styles, a potential problem which can be addressed by multi-disciplinary group ratings.

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## Police management of dangerous patients

Your special article 'Police training for the management of dangerous patients' (*Psychiatric Bulletin*, January 1999, **23**, 46–48) raises a number of questions. National Schizophrenia Fellowship members recognise that police are in the front-line, not through choice but as a result of the resource and planning failing associated with care in the community. They remain the only service that can be relied upon to turn up at any time of the day or night when called.

However, the Police Complaints Authority and Metropolitan Police Commissioner Sir Paul Condon, among others, now recognise what the National Schizophrenia Fellowship has been saying for years, that police training in dealing

with people with a severe mental illness is inadequate. Whatever the experience of your correspondent, the reality on the ground is that many officers faced with a desperately ill person behaving in a bizarre manner respond inappropriately. It has taken a number of deaths during restraint and the controversy surrounding the use of CS spray on people with a severe mental illness to bring home this point to everyone.

During meetings with the Association of Chief Police Officers (ACPO) it has become apparent to us that ACPO guidelines are no more than that: the individual forces largely determine their own approaches to restraint and the use of CS spray. The National Schizophrenia Fellowship is seeking positive partnership, we have worked with over 4000 police officers at 10 conferences in the last two years.

The Metropolitan Police is establishing specialist multi-agency teams to overcome present shortcomings. What a pity that health and social services are not taking the lead in London and elsewhere to reduce the need for the police to be involved to an absolute minimum.

CLIFF PRIOR, *Chief Executive, National Schizophrenia Fellowship, 28 Castle Street, Kingston upon Thames, Surrey KT1 1SS*

## Management of pre-pubertal children with gender identity disorder

Sir: I am writing in regard to the Royal College of Psychiatrists, Council Report CR63, published in January 1998, regarding *Gender Identity Disorders in Children and Adolescents*. I draw your attention to the advice given on management on page 4: "where children or adolescents meet the criteria of a gender identity disorder under DSM–IV or ICD–10, there should be a referral for assessment and/or treatment in a multi-disciplinary gender identity specialist team which includes the input of child and adolescent mental health."

I am currently only aware of one such specialist service for gender identity disorder currently in Britain, based at the Portman Clinic in London. Although this clinic accepts referrals from outside the area I cannot help but wonder what sort of service could be offered to someone who lives a long way away. Perhaps the possibility of consultation for any professionals involved in a case, at the Portman Clinic, is more promising.

I also draw your attention to the line 'provision of consultant/liaison arrangements with a paediatric endocrinologist for the purpose of physical assessment, education about growth, endocrine issues and involvement in any decision about physical interventions.'

I would argue that it would be helpful if the report clarified when the involvement of a paediatric endocrinologist should be sought. It would seem sensible to make a distinction between the pre- and post-pubertal period and a referral made pre-pubertally, only if the clinician, child or carers have particular concerns about the hormonal state of the child or when there is a demand for physical intervention.

All these questions have clinical relevance to a case that I am currently seeing. It involves an eight-year-old with gender identity disorder. After reading the report I wondered whether I should be trying to manage this case locally or whether the case should be referred on.

Finally, I should like to echo the emphasis made in the report, upon assessment and subsequent therapy for individuals with gender identity problems and their families. This is indicated both to explore the core disorder and any associated emotional and behavioural problems. The need for therapy seems paramount in the pre-pubertal stage because of the greater fluidity of sexual development at this age and the hope that a more appropriate gender identification emerges as described in a case seen by Habner (1991).

HABNER, D. H. (1991) The psychoanalytic treatment of a pre-school boy with gender identity disorder. *Journal of the American Psychoanalytic Association*, **39**, 107–129.

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Gender Identity Disorders in Children and Adolescents. Guidance for Management*. Council Report CR63. London: Royal College of Psychiatrists.

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## Gender identity development service

Sir: Council Report CR63 is a first attempt to establish a framework for the management of an unusual and complex condition. Some issues in management, such as when to start hormonal interventions during adolescence, are controversial (Cohen-Kettenis & van Goozen, 1998) and the Report will change as clinical experience and research progresses. 'Referral' in the Report is intended in a broad sense, as this could include consultative work as Dr White suggests. In fact, it is my view that the support which a specialist service can offer to local services has to be flexible and negotiable according to the needs of the patients and of the local service.

In our service, following a referral, we will sometimes offer an assessment, and then we would negotiate a shared programme of management with the local service. This may include



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