st Charles Centre

DEAR SIRS

We are writing to correct some errors of fact in the letter from T.D. Scannell (Psychiatric Bulletin, 1992, 16, 509). This letter makes a number of comments about St Charles Youth Treatment Centre, now St Charles Centre, part of the Youth Treatment Service (YTS), which merit a reply.

The letter suggests that management are intending to employ more psychologists. This is not the case: the complement for psychologists at St Charles numbers two (as it does at the Glenthorne Centre in Birmingham, also part of the YTS). With regard to the role of psychiatrists, there are arrangements in hand for formalising service contracts that will benefit both Centres by having psychiatrists who will participate in the work of multidisciplinary teams. The role of psychiatrists, like their professional colleagues, will be to contribute to clinical work, research, and training within the YTS. This is a long way from the monitoring of medication noted in your correspondent’s letter, and will ensure the highest quality of service for the young people entrusted to the care of the YTS.

With regard to clinical autonomy, it is recognised within the YTS that clinicians have their professional codes of conduct and must act in the best interest of their client. It is not the policy of the YTS to seek to compromise clinical responsibility in any way.

There has not been a political directive that has changed the ethos at St Charles Centre. Further, despite your correspondent’s comments, the ethos at St Charles is not behavioural. (In any case, we would wish to resist the stereotype that behavioural practice has an emphasis on care and control: good behavioural practice is both psychotherapeutic and growth-enabling.)

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Doctors in management

DEAR SIRS

There is no doubt that management education should form part of the training of every clinician, as stated by Gadd & England (Psychiatric Bulletin, August 1992, 16, 484–485).

Doctors have been encouraged to be directly involved with the NHS management process (Griffiths Report, 1983). This report generated the clinical directorate concept for unit management. Exposure to management development aims at
personal management (managing, planning and control); staff management (recruitment, leadership and motivation); managing in organisation (organisational structure, culture conflict, managing change) and management and the external world. Developing the role of doctors in the management of the NHS was highlighted by the NHS Training Authority in its discussion document (1986). So management training became an ongoing process, with a number of possible options: in-service training, shadowing a manager, local mentor, managerial tailored senior registrar posts and secondment to regionally designed courses like those on offer by the North West Regional Health Authority, including the management education syllabus and open learning courses with the Open University. Therefore management syllabuses do exist. The Royal College of Psychiatrists’ working party on management training (1990) stated that management training should be recognised and endorsed as an intrinsic part of psychiatric training; a management training coordinator should be appointed in all training schemes; and that the JCHPT might consider making it a mandatory requirement for approval of higher psychiatric training. So, the structure in which training and development may be delivered also exists.

A separate “core curriculum” for management training of doctors, apart from other NHS professionals, might not be the right prescription in the new NHS, where partnerships based on collaborative working and a shared sense of ownership among all interested parties are keys to success.

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References


Thyrotoxicosis during lithium therapy

DEAR SIRS
I read with interest the report (Psychiatric Bulletin, July 1992, 16, 445–446) about thyrotoxicosis during lithium therapy in a mentally handicapped patient but do not feel it supports ‘the possibility of thyrotoxicosis as a rare complication’. While the author is correct to point out that the relationship between lithium therapy and concomitant thyrotoxicosis is unclear, the case only adds to the confusion as it contained no new data. The following points may be noteworthy.

(a) As there is no mention of pre-lithium measurement of thyroid antibody titre, thyroid ultrasonography, or even clinical assessment of thyroid status (e.g. a small firm goitre which may indicate Hashimoto’s thyroiditis), it is possible that the patient suffered from (subclinical) autoimmune thyroid disease prior to lithium therapy. There is growing evidence for the immunomodulatory effect of lithium on thyroid antibody activity, exacerbation of pre-existing autoimmune thyroid disease and hence thyroid dysfunction (Wilson et al, 1991). Higher age group, as in this case, is a recognised risk factor for thyroid autoimmunity.

(b) The subsequent need for radioiodine for antithyroid treatment suggests that the patient suffered from Graves’ disease (rather than Hashimoto’s thyroiditis which commonly presents as hypothyroidism). Although not mentioned by the author, Graves’ disease is usually associated with a diffusely enlarged, vascular, and soft-to-firm goitre. If this is the case, the thyrotoxicosis is most unlikely to be caused by lithium which has been used successfully in the treatment of Graves’ disease (Lazarus et al, 1974). The stopping of lithium in the patients, albeit temporary, was therefore unnecessary.

(c) Data on lithium-associated thyroid disorders are overwhelmingly based on Caucasian patients living in Western countries. Recently, we studied the thyroid function of 50 Chinese psychiatric patients on chronic lithium treatment. Apart from a high rate of goitres (50%), five patients (10%) had single or multiple episodes of hyperthyroidism, whereas only two patients exhibited biochemical hypothyroidism. We argued that variation in iodine status, dietary goitrogens, immunogenetic makeup and their complex interactions with chronic lithium treatment may contribute to ethnically different patterns of thyroid abnormalities (Lee et al, in press). Thyrotoxicosis during lithium therapy may not be as ‘unexpected’ in a non-Western culture.

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References