



# the columns

## correspondence

### Protected research sessions

There has been considerable recent discussion about the strengths and weaknesses of the protected research sessions enjoyed by specialist registrars (Petrie *et al*, *Psychiatric Bulletin*, May 2004, **28**, 180–182).

The College feels that 'There is probably no better way to obtain insight into these matters (i.e. research) than to undertake a piece of original research' and, in practice, the aim of these sessions has been seen as the publication of research in peer-reviewed journals.

There are high levels of dissatisfaction with this system, and many problems have been identified as preventing specialist registrars from using this time effectively. Obstacles to the production of original research include deficiencies in motivation, supervision and training (Vassilas *et al*, *Psychiatric Bulletin*, August 2002, **26**, 313–314).

An excellent use for these research sessions is the undertaking of a relevant postgraduate degree. There is a wide variety of such courses, many of which provide training in research methods as well as supervision. Motivation is provided by the knowledge that original research, often in the form of a dissertation at the end of the course, is a mandatory requirement for the awarding of the degree.

Completion of relevant postgraduate degree courses with a research component should be seen as a valid use for research sessions.

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### Psychotherapy training

Janmohamed *et al* examined the impact of training arrangements in one large scheme on senior house officers' expectations of meeting College guidelines for psychotherapy training (*Psychiatric Bulletin*, March 2004, **28**, 100–103). In September 2003, clinical tutors across the West Midlands assisted with an audit of training opportunities and part II MRCPsych candidates' actual compliance

with current guidelines. It showed that logbook records of psychotherapy experience were often inaccurate. Where availability of supervision was relatively good, this did not guarantee good take-up.

Thirteen candidates could be fully assessed against the current guidelines for supervised practice (Royal College of Psychiatrists, 2002). They were most likely to have received supervision for brief individual psychodynamic psychotherapy and least for group psychotherapy. Supervision experience in cognitive-behavioural therapy was more common than in brief integrative or supportive therapy (which the current guidelines also require). Four trainees were effectively prevented from getting near the total requirement because they did not receive family therapy experience when rotating to posts in child psychiatry. Most trainees had not managed to see the recommended 'long' case, and this requirement alone prevented three from meeting the guidelines in full. The only two who did fulfil them had both undertaken a full-time 6-month placement in psychotherapy within the previous year.

Janmohamed *et al* reported high support among trainees for rotational psychotherapy posts when protected time is already provided. When, as here, this protection is not well established, dedicated full-time or half-time psychotherapy posts remain a reliable means of ensuring current guidelines are met.

ROYAL COLLEGE OF PSYCHIATRISTS (2002) Requirements for psychotherapy training as part of basic specialist psychiatric training (<http://www.rcpsych.ac.uk/traindev/postgrad/ptBasic.pdf>).

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### Sharing information/ disclosure

As I so often read the 'yellow' journal or the *Bulletin*, I wanted to know why children are excluded from the issues discussed. In child and adolescent psychiatry, the issues of access to records

and copying of letters to patients have quite different dimensions. Children, as well as adults, have rights.

The additional dimensions are:

1. The child is our patient. What rights have the parents? This is obviously complex and often age or development-dependent, but children tend to be ignored. Children as young as 8 can be consulted, even if their views are overruled, as to whether they want clinical information disclosed to their parents.
2. Letters sent to referrers can be copied to children and adolescents. Younger children cannot read and, in most households, parents control the correspondence so the child may not receive the letter. Should children and parents be copied separately? Should clinics arrange to read out letters about the child to the child or adolescent?
3. There is the problem of possible harm to the child by copying clinical correspondence to his or her parents. Are letters to be worded to be most child- or parent-friendly? How is our duty to the child and to the parents balanced? For example, when we know a letter is to be copied, we may omit negative opinions about a parent and his/her care. From the child's perspective, should this be included? Looking at this the other way round, including an opinion about the possible detrimental effect of, say, the parent's negative approach to the child might increase the hostility.

I realise there are answers of a sort to all these questions – from human rights, legal and therapeutic perspectives – but I wanted to raise awareness of children in such discussions and raise the profile of children and their rights in psychiatric practice.

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### Evaluation of copying letters to patients

I agree with Geoffrey Lloyd's sentiments that much more evaluation will be required concerning the issue of copying