

# Newsletter

## Autumn 2010



## **Psychotherapy Faculty; Royal College of Psychiatrists**

As we welcome you to the Autumn Newsletter, the first under the Chairmanship of Kevin Healy, we also acknowledge the sad news that Chris Mace, the former Chair of the Faculty, died recently. Kevin represented the College at the funeral and has written a moving account of the service for those that could not make it. There are preliminary thoughts about holding a memorial event in due course and we will keep the membership informed.

We update you on the developing relationship with UKCP and the proposal to form an Accrediting Organisational Member of Medical Psychotherapy within UKCP. This is an alliance Chris was instrumental in forging with support from myself and Jale Punter. On this we seek your views, if there are 30 signatures of support from Faculty members who are UKCP Registered we will be in a position to take the next steps on this journey. See below for further details.

Electronic clinical records are discussed by Rex Haigh with specific reference to their use and ownership in a Therapeutic Community. Many, if not all of us, will be working in organisations which have or will shortly be moving to electronic records and a thoughtful article by Sarah Robertson was published in an earlier Newsletter. Hopefully this article will stimulate debate and consideration for colleagues.

The Faculty website has been given a new look, including some upcoming events that may be of interest. We thank Rex Haigh, webmaster, who has indicated that he is looking for a successor in this role.

The dates for the next Faculty Conference are the 2<sup>nd</sup>-4<sup>th</sup> March 2011. The meeting will be jointly held with the Faculty of Liaison Psychiatry and an exciting programme is taking shape. More details will be sent to Faculty members in due course.

Jan Birtle, Editor

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## Message from Kevin Healy: On Being 'Chair of the Psychotherapy Faculty Executive' 2010

I am very pleased to be writing this piece for our newsletter as the newly elected chair of the Psychotherapy Faculty. I want to thank Chess Denman and Jan Birtle for standing in the closely run election for chair and for sharing their vision of how best to address the challenges that face us as a profession and as an organisation. I also congratulate the newly elected members of the executive William Burbridge-James, Rosie Clarke, Pete Hobson, Steve Miller, Mark Morris and Ben Wright and look forward to working closely with them all on your behalf over the coming years alongside the ongoing members William Badenhorst, David Crossley, Kate Dufton, Mark Evans, Scott Hall, James Johnston, Ian Kerr, David Kingdon, Alyson Lee, Sue Mizen (vice chair), Stirling Moorey, Mary Murphy-Ford, Siobhan Murphy, and Jale Punter. We are the people you need to contact if you wish to raise anything with the faculty executive. We want to learn from you and from your experiences so that our work and progress over the coming months and years can be better informed by the realities of your working lives.

I am also very grateful for the hard work done by those who were ineligible to continue in office having already spent 4 years working productively on behalf of the faculty. Gwen Adshead, Birgitta Bende, Ronnie Doctor, Sally Mitchison and Sarah Robertson were each influential and effective in the work of the faculty executive in their own distinctive ways. I hope we can continue to use their experience locally and regionally in our ongoing work. Most of all I am grateful and indebted to Chris Mace the former chair of the faculty. Chris worked very hard to bring some real coherence to the life and work of the faculty over the past 4 years. He has diplomatically steered us through many internal and external storms. He has brought his clarity of thinking and encyclopaedic knowledge to bear on a great many issues to the great benefit of the faculty and the college. He has also at times shared his measured sense of humour and his wonderful multilinguistic baritone voice generously with us. He leaves a powerful legacy in the faculty of cooperation and of a willingness to learn from each other and from each other's distinctive skills and capabilities.

Some of you may recognise what is written in the next few paragraphs as it is some of what I wrote in my supporting statement when standing for chair. Those of you who actually read the statements of candidates in our smaller election that came so soon after the much more significant general election will probably have a feeling of 'déjà vu'. However I did write then what I believe to be important when thinking about our future as a profession and as a faculty. I don't apologise for repeating some of it here. I hope over time you will come to recognise, question and clarify alongside me the ideas and direction expressed in these words.

Medical Psychotherapy is at a cross roads. Many factors are having a direct bearing on the way we will work in the future. These factors include the delivery of interventions to patients and to their families within and across multidisciplinary teams; the development of integrated stepped care pathways and managed clinical networks; the delivery of clinical services in and as near to a patient's home as possible; the increasingly influential voices of patients and of their families in instigating and planning service developments; and the increasing financial pressures

on all public services in the current political and economic climate. All these pressures on service characteristics push us to be increasingly innovative and developmental in planning the delivery of psychological therapy services.

As medical psychotherapists we are increasingly well positioned to meet this challenge. Our role as doctors of the mind and as doctors of the body is more clearly being defined by the explosion of scientific knowledge on the development and functioning of the brain; by increasingly grounded and evidence based understanding of mental functioning; by new and exciting findings on epigenetics and attachment; by the advances in our understanding of trauma, of autonomic reactivity, and of sensorimotor bodily functioning. Our heretofore emphasised differences as medical psychotherapists in theoretical understanding and in clinical practice are increasingly seen to be complementary and to invite combinations of differing approaches in creating a more whole 'body and mind' experience that best supports effective therapeutic interventions and change.

As a faculty of medical psychotherapy we can be at the forefront of meaningful developments in medical psychotherapy, in psychiatry, within mental health services, and within public education initiatives that seek to promote better mental health now and for future generations. We can seek to have a strong voice within the Royal College of Psychiatrists. We can be seen to offer support to colleagues in areas that show our interest in the work they are doing and can continue to be thoughtful, mindful and good value for money in crisis situations. We can thus be seen as a faculty of medical psychotherapists as we might usefully be seen to be as individual professionals within our local services and clinical networks. I am enthusiastic, energetic, hardworking, fun loving, realistic and pragmatic. I am interested in leading us collectively as a Faculty to develop ourselves, our services, and our influence within the field of mental health. I know I can do very little without your continued active involvement in the work of the faculty.

As an executive we wish to encourage you who receive and read this newsletter to do all you can to make a healthy impact on the lives of your patients and of their families, and more importantly we encourage you to make a healthy impact on your own professional and personal life balance. Unless you feel can feel sustained you cannot be expected to sustain the work you do with others. There are a range of supports in place in the faculty and the college to help us all do this effectively. We want executive meetings to be more inclusive of all who travel considerable distances to attend. We want to use IT to its maximum advantage and do what we can do on line and on the telephone/Skype. You are one of more than four thousand members who receive this newsletter. We want to encourage individuals and groups from the large number of 'silent members' of our faculty to be more involved in making things happen within and outside your locality. We want to work within the RCPsych with other faculties and special interest groups and with centralised college structures and officers, and externally with other complementary organisations, to learn from their practice and to actively influence issues of joint concern. Please support us as an executive in working with you and on your behalf to achieve these goals.

Finally, I believe that we as medical psychotherapists are professionals who can by our trainings and experience pragmatically, flexibly and mindfully integrate a range of evidence based bio-psycho-social interventions. We can help patients, their families

and carers, and their professional and social networks to address, to understand, to manage and to change severe and complex psychological and physical difficulties. We work so that distress, disability and risk are minimised for patients, for their families and carers, and for their professional and social networks. We are multidisciplinary team players who offer coherence, consistency, containment and leadership qualities to a team. We will need from time to time in our professional careers to undertake additional trainings to expand our knowledge, our skills and our competencies as the evidence base for what we do evolves. I believe that as individuals and as a faculty we are prepared to learn.

Kevin Healy, Chair Psychotherapy Faculty Executive

### **Saying Goodbye to Chris Mace**

Chris died at home on Sunday 31<sup>st</sup> October 2010 having been comforted and supported through his final illness by Anna his soul mate, his life partner of 20 years and his wife of just 4 months. Chris was a mostly private person and quietly lived with his knowledge of his terminal brain tumour for the 5 months before his death.

A service of Thanksgiving for the Life of Christopher John Mace, 1956 – 2010, was held in the beautiful Church of the Nativity of the Blessed Virgin Mary in Studley, in the pre-winter Warwickshire countryside 16 miles south of Birmingham, on Tuesday 9<sup>th</sup> November 2010. It was attended by Anna, some close long-time friends of Chris and many colleagues from local and midlands NHS services, from the Institute of Group Analysis and from the Psychotherapy Faculty of the Royal College of Psychiatrists. While Chris was not religious he had been curious about life and death in his usual inimitable interested style and chose to be buried in the church yard of his local parish church. The service was very fitting for a devoted psychotherapist and for a man supportive of the development of others, both patients and staff, throughout his professional life.

The opening hymn expressed an awesome wonderment of nature and of human life and well reflected a man interested in astrology, nature, country life, music, and above all interested in people. Sheila Hollins, a long time friend of Anna and Chris, and past president of the Royal College of Psychiatrists, paid tribute to Chris and his life in a very moving way. She mixed humour sadness and thanksgiving for having known Chris in a very compassionate way. She spoke for us all in this. Uniquely however she claimed the honour of probably bringing Chris and Anna together some 20 years before.

Dale Mathers, another long time friend, then read the 'Autobiography in five chapters' by Portia Nelson that begins "As I walk down the street, there is a deep hole in the sidewalk, I fall in...." Psychotherapists will know this poem as one that shows the difficulties for all of us in attempting to change our usual habits and life patterns. There followed another hymn that again closely reflected Chris's life as a

psychotherapist who “never sought so much to be consoled as to console, to be understood, as to understand, to be loved, as to love with all his soul.”

We had been welcomed into the church and service by a lone flautist playing the music Chris himself played often on his flute. As close family and friends buried Chris in the churchyard those of us remaining in the church were treated to the sounds of Faure’s Requiem, another of Chris’s favourite pieces of music. Another engaging sound we heard throughout the service was the babble of twins aged eighteen weeks from the back of the church who had come with their parents Stella and Chris Newrith, colleagues of Chris Mace. The sound of this next generation was welcomed and probably created images for all of us of life and living carrying on alongside the sadness and loss of Chris’s death.

All were then invited back to Chris and Anna’s home, a lovely farmhouse up a country lane. This was an opportunity to share remembrances of Chris and to share with Anna an appreciation of the sad and lonely times ahead. There was a book for all attending the funeral to write in and to share their memories of Chris. Anna will likely find these memories very consoling as she faces her huge loss. Many could not make it in person to the funeral and very many had asked me to pass on their personal condolences. Anna will likely appreciate letters, memories and contact over the difficult months ahead.

There were some funny stories about Chris and his humour doing the rounds on the day. One related to Chris’s capacities and skills as a golfer. When younger he reputedly played a round of golf using only one golf club as a driver, wedge and putter. I don’t understand the point he was making in doing this at the time. It sounded like he was having some good fun. Apologies to all for the clumsy link I am now making, but I’m sure Chris would not wish any of us as psychotherapists to limit ourselves in using a repertoire of effective interventions. Chris in his time as Psychotherapy Faculty Chair encouraged us all metaphorically to look at and try each others golf clubs and shots. We are continuing to learn from each other as colleagues with a variety of skills and can now appreciate the value of differing interventions for differing clinical situations.

We can all appreciate the legacy Chris has left us all. He left the Psychotherapy Faculty in good shape internally and more able to work together to define and create our rightful place within services for those suffering from significant, distressing mental health difficulties. He left his imprints on our minds as a kind, caring, gentle, considerate, supportive and curious man. He will be greatly missed.

Kevin Healy, 9<sup>th</sup> November 2010

## Medical Psychotherapy: Proposal to establish an Accrediting Organisational Member of Medical Psychotherapy

During the past 18 months the Faculty of Psychotherapy has been working with UKCP to explore closer links between the organisations. This work has now been strengthened in the form of a proposal for establishing an Accrediting Organisational Member of Medical Psychotherapy within UKCP whose remit will be the support of Medical Psychotherapists.

As an accreditation body within a reorganised UKCP, the Accrediting Organisational Member for Medical Psychotherapy (ACOMMP) will provide a mechanism by which Psychiatrists will retain their primary registration with the GMC, by whom they would continue to be regulated, while they enjoy the benefits of recognition of their psychotherapy training and proficiency through UKCP.

It would absolve them of the burden of separate registration and regulation through the Health Professional Council.

### **Outline of background**

Of the national psychotherapy organisations that currently maintain a voluntary register of psychotherapists; the UKCP is the one with whom the College had had the longest and closest registration as a special member. We have had representation on the Board of trustees, registration board, and additional inputs through several of the modality trainings overseen by UKCP since its inception.

The Faculty of Psychotherapy has been exploring for sometime how training for the CCT in Psychotherapy might be simultaneously recognised for UKCP membership.

Substantial numbers of Psychiatrists have already completed independent trainings, in addition to the CCT training in Psychotherapy, that leads to them being eligible for UKCP membership and voluntary registration.

The onset of statutory regulation for all Psychotherapists, medical and non-medical, means that, unless alternative mechanisms are found, many Psychiatrists may have to either maintain a burdensome dual registration or chose between regulators when they do not wish to do so.

We understand that medically qualified Psychotherapists, consistent with their past training, skills and professional identity, wish to retain GMC registration and would prefer to have their Psychotherapy training and skills recognised on the medical register.

While this is relatively straightforward for Psychiatrists who are already recognised as Psychotherapy specialists on that register, a new mechanism would have to be established for the many others who practice Psychotherapy but are not registered as Psychotherapy specialists by the GMC processes.

We have had preliminary discussions with senior officers of the UKCP to discuss the issues raised by the current regulatory climate and the options currently available. They are the basis of the options for this proposal.

This environment is extremely complex and politically sensitive. The UKCP have a sophisticated understanding of the issues involved and excellent links with key personnel and organisations, together with a track record of influencing national policy development, a notable example being Skills for Health, where a broader range of modalities became recognised as a result of their contribution.

The clinical remit of UKCP, with the range of modalities, the academic and clinical rigor required by the trainings, is broadly consistent with that of the Faculty.

### **Proposal**

The new ACOMMP would operate as an accrediting body within UKCP framework. This would be established under the Faculty of Psychotherapy. The ACOMMP would have a central professional group that would be a subcommittee of the Faculty Executive. It would draw its membership from Psychiatrists working in a wide range of settings, all being eligible for UKCP membership.

The ACOMPP would have responsibility for vetting applications from practitioners, collectively and individually, for UKCP membership. It is expected that current standards for admission to the specialist register for psychotherapies would be accepted as at least equivalent to UKCP criteria for membership.

The ACOMMP would then formally ask the relevant college within UKCP to approve its recommendation for this to happen.

It is expected that acceptance of an individuals' training would then form part of their entry on the GMC register. We assume that this would entail a formal revalidation of registrants' competence to practice psychotherapy every 5 years and this would fall within the remit of the ACOMMP.

### **Practical Implications**

The remit of ACOMMP would be broadly similar to that of the College Education Office currently when dealing with queries of eligibility for admission to the Specialist Register.

There is no expectation or obligation that all Psychiatrists would use this as a way of having their psychotherapeutic proficiency recognised. The main route for Specialist Registration via the GMC through Specialist Psychotherapy Training would continue.

There is a need for significant administrative support which would take place through UKCP. This would be funded through membership dues received by UKCP. This revenue should also help to fund other joint activities in the areas of psychotherapy including research, quality standards, continuing professional development and service development.

There would be no direct burden for ACOMMP or the Faculty in terms of the procedures for concerns, complaints or issues of professional standards; these would be addressed through the GMC, consulting with the UKCP in relation to serious matters, and the incoming system of workplace regulation outlined in the 2007 White Paper that will apply across medicine in any case.

## **Evaluation**

### **Potential advantages:**

Strengthening of the Strategic alliance with major psychotherapy organisation with whom we will be working.

By being part of the UKCP medical psychotherapy will become more central in their strategic planning.

Accessing and contributing to services thru UKCP – eg complaints, CPD, revalidation, conference office, publications dept, research resources, setting standards of training and practice.

Although there will be a cost there will be potential reduction in fees and in regulatory duplication.

A unitary registration with UKCP can encompass diverse modalities in psychotherapies and thus has potential to develop a stronger cross modality identity for medical psychotherapists.

Expansion of the active participation and breadth of scope of the Faculty by including additional registered psychotherapists with range of CCT trainings – eg General Psychiatry, CAMHS, Forensic Psychiatry.

Potential for joint conferences, research, initiatives, shared learning.

### **Potential Disadvantages:**

Resource will be required from Faculty Executive Officers, in relation to their time, to organise and establish the ACOMMP.

Subsequent to the initial setting up phase there will be a need for ongoing involvement to continue to register individuals and oversee regulatory function, along with ongoing connections with UKCP – require the time and input of Faculty Executive and additional College members.

The potential for differing views from Faculty representing diverse factions may be exaggerated.

### **Action required by Faculty Members:**

If you are both a member of the Faculty and UKCP registered and support the formation of the ACOMMP please send your details, including College and UKCP registration numbers to [gsmith@rcpsych.ac.uk](mailto:gsmith@rcpsych.ac.uk)

Jale Punter and Jan Birtle

## **Clinical information policy for a new median-TC programme**

The nature of the information shared, verbally, in an intensive treatment programme like a therapeutic community is often extremely sensitive to the individuals concerned, and disclosure of it to others without absolutely clear boundaries of what can be said to whom can destroy confidence in the service and threaten trust in its clinicians.

However, all intensive therapy programmes and therapeutic communities keep some records: these may be little more than an annotated diary, or (more commonly in the NHS) they can be an extensive collection of notes, reviews, correspondence and reports – which are very often laborious to read and contain information that is ‘countertransference contaminated’.

At the moment we are starting “the East Berkshire Intensive Therapy programme”, which is a new ‘median TC’ in Slough. This essentially means a TC without enough resources to run it along the normal ‘Day-TC’ format (which generally implies staff being present during the programme time). In fact the ‘lean team’ means that it is me (present for two days per week, including all the necessary assessments), a DBT-trained team leader who is a long-experienced senior OT (for two sessions per week), and a collection of volunteer therapists and ‘experts-by-experience’. There are also other ‘resource efficiencies’ we are contending with (such as having to book the Mental Health Review Tribunal room to hold the groups in, and occasionally being turned out to accommodate the booking of MHRTs, and having had our furniture order for 20 group therapy chairs cancelled), but I do not want to get distracted with these minor details! The important point about clinical information is that we are working in a trust which is to have fully computerised records (using the Rio system) next year, and we have given considerable thought, with our prospective service users, about to how best to set up our clinical information system.

## **Four different types of record**

The ‘hospital file’ or ‘medical record’, is the well known to be the property of the NHS, and is held in a paper-based form as ‘the green folders’ in our trust. For our service users, who have often had long histories of involvement with the mental health services and numerous hospital admissions, there can be several volumes of these – which are of little use in planning a ‘fresh start’. Furthermore, the green folders are held and managed by the hospital’s Medical Records Department, together with a variable set of data being held in the rather out-of-date patient registration system. The green folders generally comprise the heterogeneous collection of paperwork including ‘multidisciplinary clinical notes’ (often written at considerable

length, daily or more often, with severe countertransference contamination), various reports, results of special investigations, correspondence between professionals, lab test forms, copies of any paperwork from legal proceedings such as child protection or criminal actions needing psychiatric opinions, and anything else on paper without a proper home. Our current rather minimal data on the soon-to-be-replaced computer system is nearly all for purposes of gathering demographic and activity information for commissioning and invoicing PCTs. There is some clinical use – if only to see who has been seeing particular service users, and when.

Once the new IT system is installed, we are told it will be all we could ever need – although of you colleagues who already have Rio may well not agree! But, however the system may work and however technically secure it may be, computerising all the intimate details that we collect for intensive psychotherapy sends shivers down many of our service users' spines, and mine too. So we will be dividing each individual's clinical record into two parts: that 'owned by the system' (the official medical record) and that owned by the service user and voluntarily shared with the staff, as long as they are with us. Any research records are considered to be quite separate from this, and will be anonymised and only accessible to the research team. Here is what the different parts of the record will consist of:

### **Official Records**

1. The computerised 'official medical record'. This will be entered into the NHS clinical record on a 'needs to know' basis, and will consist of the following:
  - a record of all sessions attended and responsible clinicians
  - diagnosis as discussed and agreed by the service user
  - a structured report on progression between each of the four clinical phases (engagement, assessment, therapy, recovery)
  - interim reports if the period between reports is greater than six months
  - all routine communication with other professionals (appointment letters, DNA letters, etc)
  - any communication with other professionals arising from required management of acute risk of harm to the service user or others (eg crisis team referral, alerting child protection officers, informing GP of likely self-harm)

### **Shared (or 'Personal') Records**

2. The service-user-held-and-owned paper-based file (red not green!) will be kept on the premises (when we have some) in a locked filing cabinet which will be accessible to group members. Each red folder will contain:
  - hard copies of the computerised records arising from membership of our programme (though probably not the attendance record)

- Assessment and outcome questionnaires and the results of them
- The detailed ‘Life Questionnaire’ we ask everybody to fill in (which can contain very intimate and sensitive details)
- Other notes written by staff (such as genograms, lifeline diagrams, notes from diagnostic, assessment or therapeutic interviews)
- Our ‘three way agreement’ between service users, our staff and their care coordinators – a basic contract outlining the expectations of each.
- Paper-based therapeutic tools, when used (such as contracts with the community, diaries and logs, written material to help in specific situations, social atoms from action method sessions, art produced)
- staff will not write regular handwritten notes in the clinical record, except to record items which need to be communicated across the confidentiality boundary of the group, as described in the last bullet point of the section above.

All this material will remain the property of the service user, although at admission they will have agreed to share it with staff when they sign the ‘three-way agreement’. When a member leaves, they choose whether to take the red file, have it destroyed, or incorporated into the NHS clinical record. If they leave without giving instructions, it will be held with the NHS clinical record until they express a wish otherwise.

## **Group records**

These are not documents about individuals – but those which form a collective record of the group’s activities – such as group notes, diaries, minutes of planning meetings and photographs – which are written by group members (staff or service users), and belong to the community as a whole. In day-to-day business, where risk does not need to be communicated to others outside the group, they will generally be the means by which the following commissioning standard for accreditation of therapeutic communities is met

*Quality Standard 2.1.2 for NHS commissioning of therapeutic communities for personality disorder:*

*“Clinical risk is reviewed as part of the daily therapeutic programme by all staff and community members and documented in daily records of community life e.g. group notes, individual files etc”*

*College Centre for Quality Improvement (2007)*

These records will be held on the premises in a locked cabinet to which group members have easy access. They will also be available for clinical supervision.

## Research records

When service users have given consent for their individual data to be used for research purposes, it will be anonymised and given to the research team. The ethical requirements on the research team will ensure that the data is handled, stored and processed in a rigorous and suitable way.

In practical terms, this will mean data is either photocopied with coded subject identifiers instead of names, or recorded directly into the researchers' IT systems in the same anonymised way. All paper, computer and online systems will be secured from unauthorised access.

## Summary

The table outlines our intentions for handling of our clinical data. If, as colleagues in the same specialty, you can see any errors or problems with it – please tell us!

| <b>Record type</b>           | <b>Ownership</b>           | <b>Access</b>            | <b>Fate</b>  |
|------------------------------|----------------------------|--------------------------|--|
| <b>Clinical</b>              | NHS:<br>Secretary of State | Caldicott<br>Guardian    | Held by MH Trust until 10 years after death  |
| <b>Group</b>                 | Community group            | By decision of community | Kept indefinitely by community.<br>Sent to Planned Environment Therapy Trust if community ceases to function         |
| <b>Personal</b>              | Service user               | By decision of member    | Keep, destroy or transfer to hospital record – at member's decision  |
| <b>Research (anonymised)</b> | Research team              | Research team only       | Held by researchers until at least 10 years after research publication, or sent to Planned Environment Therapy Trust |

**Rex Haigh**