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Copying letters to families: attitudes and experiences of child and adolescent psychiatrists

AIMS AND METHOD

A national survey of consultants in child and adolescent psychiatry was conducted to explore their attitudes to copying correspondence to patients and their families and the impact of recent national guidelines on practice.

RESULTS

Of the 290 respondents, 261 (90%) agreed in principle with copying

letters to patients but only two-thirds ($n=186$) were routinely doing so. Nearly half ($n=139$, 48%) had changed their practice as a consequence of the guidelines. The majority ($n=160$, 55%) felt that the guidelines lacked clarity with regard to the complexities of child psychiatry and a third ($n=93$, 32%) had experienced difficulties when copying letters to patients.

CLINICAL IMPLICATIONS

This survey highlights some of the benefits and risks involved in child and adolescent psychiatry when letters are routinely shared with families. Increased openness and transparency can enhance the therapeutic relationship; however, given the complexities and sensitivities implicit in child psychiatry, there is a risk of jeopardising engagement and alienating the family.

Good practice guidelines implemented in April 2004 give patients the right to receive copies of all correspondence from health professionals which concerns them, if they so choose. The general principle is that all letters that help to improve a patient's understanding of their health and the care they are receiving should be copied to them as of right (Department of Health, 2003).

Copying medical correspondence to patients is intended to encourage respect, openness and trust between the doctor and patient. By involving patients in making decisions about treatment options, there is an intention to foster a collaborative doctor–patient relationship which in turn leads to improved understanding and adherence. It also provides opportunities to inform patients about their health and ensure that inaccurate information is corrected. The guidelines apply to all medical specialties but the implications for psychiatry are likely to be more complex (Tahir *et al*, 2005). Child and adolescent mental health services (CAMHS) pose a particular challenge when considering the impact of copying letters (Roy, 2004). The guidelines give only limited consideration to many issues that are unique to the therapeutic practice of child psychiatry.

Studies published to date have mainly addressed patients' attitudes to receiving letters in adult psychiatry (Fitzgerald *et al*, 1997; Marzanski *et al*, 2005; Sain *et al*, 2005). We are not aware of any published study evaluating the practice of copying letters in CAMHS. In her recent editorial, Subotsky (2005) raised some important issues for child and adolescent psychiatry. Hence we carried out a survey of all consultant child and adolescent psychiatrists in England to explore current practice, attitudes and experiences of copying letters to patients and families and the impact of the Department of Health guidelines on such practice.

Method

We devised a questionnaire to evaluate the practice of copying letters to patients/families prior to and after

implementation of the Department of Health guidelines. We explored knowledge of and attitudes to these guidelines and asked whether consultants had experienced any difficulties with this practice.

A draft questionnaire was piloted on local child and adolescent psychiatrists. The results highlighted areas of particular relevance to child psychiatry, which included child protection concerns and concerns about confidentiality of individual sessions, the risk of alienating the family and the emotional impact of the letter. The final questionnaire incorporated further questions relating to these issues and their influence on practice.

Using the College's mailing list, we sent the questionnaire to the 537 consultant child and adolescent psychiatrists registered in England in January 2005. The results were confidential but the questionnaires were not anonymous. The results were analysed using descriptive statistics.

Results

We received 290 completed questionnaires giving a response rate of 54%. Qualitative and quantitative data were generated. Almost all ($n=284$, 98%) of the respondents were aware of the guidelines and two-thirds ($n=197$, 68%) had read them. Although 90% agreed in principle with the practice of copying letters to patients, over a third ($n=104$, 36%) were not doing so 9 months after implementation of the guidelines. More than half ($n=160$, 55%) did not consider the guidelines to be clear with respect to practice within CAMHS. The reasons given are shown in Box 1. The guidelines refer to causing harm to a patient in certain sensitive circumstances if they receive a copy of the letter. Only 101 respondents (35%) felt that these circumstances were clear from the guidelines.

Nearly half of the respondents ($n=139$, 48%) had changed their practice as a result of the guidelines. Of these 100 (72%) have changed the content of their

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- Defining who is the patient (child or family)
- Who should receive a copy of the letter (for example when parents are separated, looked after children)
- Disclosure of third-party information and intra-familial confidentiality
- Capacity and competency
- Confidentiality of individual sessions (child or parent).

letters and 107 (77%) the style of writing. Information omitted from letters and the consultants' level of confidence in the practice of copying letters to patients are summarised in Table 1. Only one in six (48) consultants had received advice or training in the practice of writing letters to be copied to patients. Although 174 respondents (60%) felt they would benefit from further training, a minority (4) stated that they felt strongly that such training was unnecessary.

We asked whether any difficult experiences had been encountered when copying letters to young people and their families. Nearly a third of respondents ($n=93$, 32%) acknowledged some difficulties (Box 2).

We received numerous positive comments from consultants who were strongly in favour of the practice of copying letters. Many had found that the openness and transparency associated with sharing letters with families had benefited the therapeutic relationship and helped to dispel fantasies about the letter. The opportunity for correcting factual errors and misunderstandings was felt to be useful for both the family and the clinician.

Box 2. Difficult experiences encountered when copying letters

- Complaints from parents regarding comments made about their behaviour and parenting style
- Concerns that reading the letter might increase the risk of further self-harm
- Writing a letter in the knowledge that it will be read by the family can result in omission of important information-sharing between professionals
- Increased administrative effort and clinician's time required
- Confusion as to whether non-resident parents should receive a copy of the letter
- Breaches of confidentiality, for example postal errors and confidential third-party information being shared by one parent without the other's permission
- Comprehension of written English in non-English-speaking families and those with limited literacy skills.

Discussion

The rate of response to the survey was 54% but we were aware from local knowledge that the College mailing list was overinclusive and thus considered this a good response rate. Despite widespread support for the guidelines, a significant minority of child and adolescent psychiatrists were opposed to copying letters to patients. This was reflected in the polarisation of views of the risks and benefits of this practice. Some consultants described an enhanced therapeutic relationship whereas others feared a potential loss of engagement and alienation of the family.

The significant number of consultants that were not routinely copying letters to families could well be linked to our finding that certain trusts and CAMHS have decided to delay implementing the guidelines until formal local protocols have been devised. It is likely that adherence to the guidelines will increase once these are in place.

The guidelines refer to situations when it would not be appropriate to copy letters but, especially in the area of child protection, this is open to considerable interpretation and many consultants expressed the opinion that the nature of these circumstances was unclear. Conversely, some consultants commented that this lack of clarity could be useful in allowing for clinical discretion.

The Department of Health guidelines were designed for all medical specialties and this survey has identified some of the difficulties in applying them to the complex and sensitive area of child and adolescent psychiatry. However, the guidelines do allow for some flexibility, so that sharing of letters can be delayed until a relationship has been established with the family, or in certain circumstances, not sent at all.

This survey was carried out only 9 months after implementation of the guidelines, so it is perhaps not surprising that we identified some reservations and resistance to the imposed change in practice. We predict that with time and experience confidence will improve and anxieties will be reduced as we develop the skills to write letters so that information can be sensitively, appropriately and safely shared with patients and their families. The challenge to child and adolescent

Table 1. Responses to questions on content of letters

	<i>n</i>	(%)
If you copy letters to patients are there topics or aspects of the consultation that you omit in some circumstances?		
Diagnosis	48	(19)
Opinion	68	(26)
Observations	90	(35)
Child protection concerns	116	(45)
Do you use additional forms of communication to impart omitted information when copying letters to patients?		
Telephone call	143	(54)
Face to face	95	(36)
Additional letter	90	(34)
Email	14	(5)
Are there specific circumstances in which you would like to use your clinical discretion?		
Child protection concerns	194	(70)
May be prejudicial for child	212	(77)
May alienate family	202	(74)
Confidentiality of individual child sessions	209	(76)
Issues involving other family members	200	(73)
Emotional impact of letter	174	(64)

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psychiatrists is to learn to convey information in such a way that letters enhance the therapeutic relationship and do not risk alienating the family.

Declaration of interest

None.

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Auditing the care programme approach for people with learning disability: a 4-year audit cycle

AIMS AND METHOD

Annual audits of the enhanced care programme approach (CPA) were conducted from 2002 to 2005 to evaluate and improve the implementation of CPA in two inner-London community learning disability services. The CPA standards included those stipulated by the Department of Health. The notes of all patients on

enhanced CPA were analysed using a structured data collection form.

RESULTS

There was a gradual improvement in the attainment of targets by both services. Areas of strength included allocating a date for the next CPA review, crisis plans and documentation of service users' comments.

Areas of weakness included completion and review of risk assessments and the availability of a care plan for the previous 6 months.

CLINICAL IMPLICATIONS

Completing the audit cycle and re-auditing improves attainment of targets and encourages service development, but further progress is required.

The care programme approach (CPA) is considered a model of good practice in delivering efficient, effective and coordinated mental healthcare in the community. It was introduced in April 1991 to ensure that individuals received appropriate after-care following discharge from hospital. It identified four key components: systematic arrangements for the assessment of health and social needs, the formulation of a care plan, the allocation of a named keyworker who would monitor the individual and coordinate care, and the requirement of a regular review of the individual's needs and revision of the care plan (Department of Health, 1990).

The CPA has evolved over the years following further guidance and recommendations by the Department of Health, which has acknowledged problems such as professionals finding the CPA process bureaucratic and service users finding the process inconsistent. Important changes in the implementation of the CPA were highlighted in two key publications: *Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach* (Department of Health, 1999a) and *The National Service Framework for Mental Health*

(Department of Health, 1999b). The CPA now encompasses all individuals receiving input from specialist mental health services, in all settings, including residential and community care, and is not just simply an after-care arrangement. Two levels of CPA have been developed – 'standard' and 'enhanced' – addressing the different needs of individuals.

The Department of Health has given great importance to audit and the assessment of the quality of CPA implementation. An audit pack has been issued for this purpose as a guidance (Department of Health, 2001a).

The need for CPA in learning disability

The importance of CPA in learning disability is highlighted by the increased prevalence of mental health problems among people with such disability compared with the general population. Several epidemiological studies have shown that rates vary between 10 and 39% (Borthwick-Duffy, 1994).

People with learning disabilities often have complex physical, psychological and social needs and therefore