editorial

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Copying letters to patients

Issues for child and adolescent mental health services

The NHS Plan (Department of Health, 2000) required that 'letters between clinicians about an individual patient's care will be copied to the patient as of right', with full implementation expected from April 2004. Guidelines were issued by the Department of Health in 2003 and there are examples of good practice, including paediatrics, given on the Department of Health website (http://www.dh.gov.uk). Consultation about the implications for child and adolescent mental health services (CAMHS) via the College Research Unit's FOCUS network in 2003 and within a major mental health trust elicited two main types of response: either that this was already the practice or that there were many difficulties. The majority, of course, was silent, presumably hoping the issue would somehow go away or be dealt with by administrative staff. More recently, it is clear that services and clinicians are engaging with the topic in a variety of ways.

There are special issues for CAMHS however, which need thinking through. This editorial is not a foolproof guide, but raises some of the issues and makes some recommendations about policy and practice. It is worth bearing in mind that the right of access to records is anyway quite extensive.

Aims for a CAMHS policy

Although there is no choice about implementation, we should not lose sight of the objectives of the policy; that is 'to improve communications with patients to benefit their healthcare without jeopardising communication with other professionals'. Letter-style is likely to change, some clinicians may take the opportunity to provide shorter and more structured letters, which general practitioners (GPs) have been shown to prefer. Others may find that avoiding technical jargon and being more explicit produces longer letters. The 'downside' of increased time spent in discussion, recording and reflecting must also be recognised before it is possible to minimise the impact of the policy. CAMHS professionals may have particular difficulties with their client group for many reasons: for instance, the possible difference of interests of the child and parents, confidentiality, determining competence, and the involvement of multiple agencies. It is possible that complaints from parents may increase, especially if insufficient care is given to wording.

Within a trust there should be a CAMHS-wide policy that is legally compliant but flexible according to local need and practice. Thus particular teams could have their own practices, but they should follow agreed principles. Such a policy could be integrated within a general policy with addenda, or be separate. A balance must be achieved between comprehensiveness and uniformity on the one hand, and length and accessibility on the other. Ideally there should be the opportunity for piloting and for consultation with the recipients, but the timescale has been short. The policy should be clear enough to be auditable, and also should be audited (perhaps by annual sampling) which would lead to improved practice.

There needs to be an agreed 'consent' format so that administrative staff can be confident of the procedure. The main alternatives here are either:

- separately recording what has been agreed within each letter
- having a signed form at the front of the notes
- having a note of the agreement made within the notes.

The last option would be most difficult to retrieve. Similarly there needs to be systematic recording of exceptions and the reasons for them. Training on 'copying letters' is likely to be necessary and should be part of induction for all staff, at least until it becomes well embedded in practice.

CAMHS specific issues

In CAMHS, parents or their legal equivalent are very much involved in any referral and need to know the outcomes of assessment and proposals for treatment. Who else needs to know, and in what terms, will now have to be clarified openly, and the child/adolescent also now has the right to be informed. This could involve considerable changes in practice, which are likely to be time-consuming both to develop and to maintain. Where the culture (especially for non-medical professionals) has

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been not to write letters in the first place, there are likely to be further difficulties.

What constitutes a letter?

'Letters' include communications between health professionals and letters from health professionals to outside agencies such as education, housing and social services. This should mean that parents already have received a copy of the referral letter if it is from a GP, and obviously it would be helpful if the letter was so marked. What may happen (as seen when a similar education regulation was implemented) is that there are pressures for self-referral, or that telephone calls are made which appear to, but should not, bypass the proposal.

Who can make the copying agreement?

It is clearly envisaged that the health professional takes responsibility for their side of the agreement rather than it being part of the administrative system, although this may change as all parties become more accustomed to the process.

'Where the patient is not legally responsible for their own care (for instance a young person, or a child in care), the letter should be copied to the person with legal responsibility, for instance a parent or guardian.' Where a patient is under 16 years it 'is up to the healthcare professionals to assess the competence of younger children to understand and make a decision.' For patients under 16 years without capacity, the agreement about copying should thus be made with the responsible parent, with the resident parent taking precedence over the non-resident one. Although the Department of Health envisages capacitous under-16-year-olds, generally CAMHS encourage parents to maintain responsibility, and would wish to share the outcome of assessment and treatment plans. Details of individual interviews can continue to remain confidential. A local pilot scheme successfully used joint discussion between 14- or 15-year-olds and their parents, with the expectation that both would consent and see the letter.

For a non-competent child 'in care' the wishes of the social worker would take precedence over those of the parent if the child is on a care order. Otherwise, because of a potential shared responsibility, copies to both would be appropriate, unless the parents refuse to allow the social worker to be copied and there is no reason to overrule that, or if the child would be placed at risk if the letter were copied to a parent.

The guidance is that 'young people aged 16 and 17 are able to make health care decisions for themselves' and should therefore be asked for their agreement to receive copies of letters about them. Although this is not a strictly accurate description of current case law, it is good practice to offer private consultations to discuss what information may be shared with parents, and offer other arrangements to see letters if receiving them at home might be difficult. In CAMHS the capacity of those of 16 years and over will have to be determined, and for those without capacity a 'best interest' policy will have to apply until the capacity legislation is amended.

Recording agreement

As indicated above the guidance places a lot of emphasis on the recording of the copying agreement. It can be argued that as the needs, capacity and risks of children and adolescents change over time it is best to specify in each letter what has been agreed about copying and why. If a template is used including 'Copying agreement' before the main body of the letter, this would act as a prompt for clinicians and secretarial staff. This would also be the place to record exceptions and reasons why. The foot of the letter should as usual indicate who is receiving copies.

However, letters are not always written immediately after an interview, so a general clarification of agreement may be helpful in addition. This could be part of original 'consent', but does not have to be 'signed', only recorded in the clinical notes in line with other consent.

An alternative is the completion of a standard form at the assessment stage; this was the generally preferred solution within the local mental health trust CAMHS (copies available on application to the author). Pilot studies indicated that this was acceptable to patients and families, although introducing it did take time and the clinicians needed to familiarise themselves with it.

As there must be compliance with equal opportunities legislation, provision of translation will be a key issue, especially if standard forms are used.

Adapting letters

Letters should be written clearly, 'avoiding unnecessarily complex language and subjective statements'. In psychiatry in general and perhaps particularly in CAMHS, 'medical diagnostic' language has often not been used directly with patients, although psychiatrists, if not other disciplines, might use such terminology when writing to GPs. Family views on terms such as 'conduct disorder' would be very helpful to establish.

Meanwhile writing directly to patients or parents with copies to GPs, etc. should not stop, and could usefully increase as it can focus the mind on what would be of most help to the family. Child mental health professionals quite frequently use this method already. An excellent guide is provided by Steinberg (2000).

Extensive family information within a letter may not be appropriate. Bear in mind that while the child may not currently have capacity they probably will later, and then be entitled to access records. Parents, if they have provided information separately, are also entitled to confidentiality. Consideration should be given to opening up separate case notes in the parent/s' name if only they are seen. Names of third parties (bullies for instance) should generally be omitted.

'No surprises' is a principle, so information or terminology not previously discussed should not be included. Obviously this could include material revealed by a child but unknown previously to the parents. Raw data, such

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as single test results, should not normally be sent directly to patients, but 'in due course the outcome of such tests should be included in a letter that is copied to the patient'. This is helpful advice for psychologists' reports, which are often already prepared in a form suitable for copying to parents.

Overall, letters should no longer be used as a legible (because typed) alternative and detailed form of case notes.

Exceptions

Letters should not be copied where the 'entitled' patient or parent does not want a copy; for instance, if they feel they already have the information or would find ensuring privacy difficult. In these instances the decision is in accordance with the 'copying agreement'.

If in the health professional's judgement there is 'a possibility of serious harm to the patient' copies may be withheld, irrespective of usual policy or any individual agreement. In CAMHS this may occur with child protection type letters or reports. These are very often automatically available at case conferences, so parents may eventually see them. However, immediate copying might potentially lead to 'serious harm'. A receiving competent child for instance might not be able to keep the letter private. A note either way needs to be made in the report or letter. Another example could be the correspondence to the GP immediately after an overdose. The young person, at the time of an emergency, may well temporarily not have capacity to make an agreement, and too little may be known of the family circumstances by the assessing professional to judge risk accurately. As this is a common occurrence, services might agree a standard practice and ensure that those on emergency call know what to do. Often it would be appropriate for the young person to see the 'emergency' letter later and receive a copy if they wish.

Another possibility for withholding a copy is if the letter contains information about a third party, who has not given permission for this use of the information, unless the information was originally provided by the patient. 'In such a case this part of the letter may be deleted, a separate letter sent, or the copy withheld with explanation. The patient may still seek access.' This advice would be rather complex to follow through in this way, and usually the receiving professional does not need this level of information.

It will be helpful for teams to develop a common understanding and even phraseology, particularly for 'exceptions', so that there can be consistency of standards and available justification.

Disagreements and uncertainty

Consent to receiving a copy of a letter is of course by no means the same as the right to consent to it being sent in the first place, or agreement to its contents, although it does bring such issues out into the open, which may be sources of potential disagreement. No guidance can predict absolutely what the courts may finally decide in individual cases, so the best approach is not to expect perfection but to be able to show that there is a well thought out policy, and that in each case the best interest of the child has been considered. Is this just more bureaucracy (Roy, 2004)? In some ways, yes, but it could offer an opportunity for CAMHS to improve practice and communication with their patients, their families and the referrers.

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