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# Mailing GP reply letters after psychiatric assessment

## A pilot randomised controlled trial

### Background

Patients are not always fully aware of the details of their assessment and management plan detailed in the letter sent from the specialist to the general practitioner following referral. One approach to solving this problem is for the specialist to copy the GP reply letter to the patient.

### Objective

To determine whether receiving a copy of the GP reply letter improves outcomes in patients referred by their GP for a psychiatric assessment.

### Method

A single blinded randomised control trial comparing outcomes following a one-off consultation for a depressive and/or anxiety disorder in patients who received the GP reply letter sent from a community mental health service, to patients who did not.

### Results

Data was collected for 21 letter recipients and 18 control participants. A significant group by time interaction found total DASS-21 scores improved to a greater extent for the letter recipient group, no significant difference in adherence was found.

**Keywords:** psychiatry; general practice; communication; doctor-patient relations



General practitioners are often overwhelmed with paperwork, including correspondence from specialist colleagues incorporating detailed management plans and suggestions for patient care. It can be difficult to ensure that these are always communicated to the patient or followed up systematically over the long term. One approach to this problem is for the specialist to copy the GP reply letter to the patient.

Understandable concerns have been raised about copying letters to particular patient groups, including those with a psychiatric diagnosis.<sup>1-4</sup> However, studies on the whole have demonstrated that patients with psychiatric diagnoses react positively to receiving a copy of the correspondence sent to their GP.<sup>2,5-11</sup>

While studies to date have been important in addressing the feasibility and acceptability of the practice of letter copying, the authors wanted to explore the effects on clinical outcomes.

Compliance with treatment plans has received some attention, with one study finding a (nonsignificant statistical) improvement in compliance when correspondence was received.<sup>7</sup>

This study sought to extend existent research by looking at whether receiving a copy of a reply letter improves clinical outcomes and adherence to treatment in patients referred by their GPs for a psychiatric assessment.

### Method

#### Sample selection

Patients referred by their GP to the Inner South East Primary Mental Health and Early Intervention Team (PMHT) from September 2006 to January 2008

were considered for inclusion in the study. The PMHT is a community based mental health service established to aid GPs in the management of high prevalence disorders via primary or secondary consultation and education. Following assessment by a senior psychiatry registrar or senior clinical psychologist at a single session, patients meeting the inclusion criteria (a Diagnostic and Statistical Manual [DSM] IV)<sup>12</sup> anxiety disorder and/or depressive disorder in patients aged 18 years or over) were eligible to participate. The patient and their GP's consent were sought.

The study was approved by the Alfred Human Research and Ethics Committee and registered with ClinicalTrials.gov (NCT0030769).

#### Randomisation

Following consent, participants were randomised by computerised random number generation to either the experimental ('letter') or control group. All clinicians were aware of the potential of their letters being sent to patients but were blinded to group allocation.

#### Letter intervention

Following the assessment, the clinician produced a detailed letter to the referring GP. As was usual practice, the letter was reviewed by the supervising psychiatrist. A researcher posted an unedited copy of this letter to participants in the letter (but not the control group), at the same time it was posted to their GP. Recipients had the option of registered or regular post.

#### Follow up

Following baseline assessment, participants were followed up by telephone interview at 1 month and 3 months, dated from when the letter was

sent. Interviews covered the DASS-21 responses (questionnaires were mailed to participants before the call) and questions regarding adherence.

## Outcomes

Primary outcomes were measured in symptoms of depression, anxiety and stress; and levels of adherence.

## Measures

### DASS-21

The DASS-21 is a set of three self report scales designed to measure depression, anxiety and stress symptoms.<sup>13</sup> It is a brief, self administered questionnaire with demonstrated responsiveness to change in clinical populations.<sup>14</sup> Raw DASS-21 subscale scores were multiplied by two, the total DASS-21 is the sum of the adjusted subscores so as to be comparable to other studies.

Data was missing for one participant at 1 month and in that case an average of data from that patient's baseline at 3 months was calculated.

### Adherence

All participants were asked how closely they followed each management item in the letter. Their responses were then rated independently by two clinicians (RS and MM) on a 3-point scale (0, 1 or 2 corresponding to nil, somewhat or complete adherence). Discrepancies between raters were discussed and consensus arrived at after deliberation. At 3 months some items were considered no longer applicable (eg. regular GP appointments when the patient had started seeing a psychologist). These nonapplicable items (control = 5; experimental = 7) were treated as missing data.

### Analysis

Statistical analyses were conducted using SPSS version 17.0 for Windows. The criterion for significance was  $p < 0.05$ , however, the Bonferroni correction was applied to the analysis of change over time for the total, depression, anxiety and stress scales of the DASS-21, owing to multiple comparisons. Given the small sample size, nonparametric tests were used to provide a more conservative analysis of the change over time in DASS-21 scores, with Chi-square tests used for frequency data. Separate Chi-square tests of independence were conducted comparing the level

of adherence to recommendation items across the letter and control groups.

## Results

### Sample

Figure 1 details participant entry into the study. Of the 50 participants at entry, 39 were successfully followed up for at least one of the two research interviews. One participant allocated to the control group requested to be in the experimental group. Her results were removed from analysis. Another participant allocated to the control group was inadvertently given a copy of her letter (without her asking) by her GP. She was transferred into the experimental group.

The final sample of 39 was made up of 21 letter recipients and 18 control group participants.

### Baseline characteristics

Table 1 shows that the two groups did not have significantly differing baseline characteristics.

### Time for letter production

General practitioners were contacted by telephone within a few days of the patient assessment. However, the time for letter production ranged from zero to 110 (an outlier) days with a median of 23.5 days.

### DASS scores

DASS scores at baseline, 1 month and 3 months are displayed in Table 2. The nonparametric

Friedman test found that while both the control and letter groups showed a reduction in total DASS over time, the reduction was statistically significant in only the letter group: letter group  $H(2)=12.65$ ,  $p=0.002$ ; control group  $H(2)=5.33$ ,  $p=0.07$ . The DASS subscales showed a reduction over time in both groups (except for stress in the control group) but this was not statistically significant.

### Adherence

Analysis revealed there was not a significant difference in adherence between the two groups at either 1 month,  $\chi^2(2, n=287)=3.58$ ,  $p=0.17$ , or 3 months  $\chi^2(2, n=274)=3.81$ ,  $p=0.15$ .

## Discussion

### Study limitations

The study recruited fewer participants than anticipated. This may have contributed to the absence of effect on some of the measures. In addition, baseline differences may not have reached statistical significance because of the small numbers and so potentially the two groups may have fared differently because of initial differences.

Patients who could not speak or read English were not included in the study.

We also excluded patients at risk of self harm, for concern about outcome of receiving an emotionally laden letter when potentially without support. (This group may be best served by initially reviewing the letter in the company of the GP or

**Table 1. Baseline characteristics of participants in the letter and control groups**

Variable	Letter (n=21)	Control (n=18)	Significance
Age (mean $\pm$ SD)	41.3 $\pm$ 13.3	34.4 $\pm$ 12.7	$p=0.14^*$
<b>Gender n (%)</b>			$p=0.31^{**}$
Male	5 (23.8%)	7 (38.9%)	
Female	16 (76.2%)	11 (61.1%)	
<b>Diagnosis n (%)</b>			$p=0.07^{**}$
Depressive	7 (33.3%)	11 (61.1%)	
Anxiety	7 (33.3%)	1 (5.6%)	
Mixed	7 (33.3%)	6 (33.3%)	
Number of management items per patient (mean $\pm$ SD)	7.3 $\pm$ 2.5	7.9 $\pm$ 1.7	$p=0.21^*$

\* Mann-Whitney U-test group comparison

\*\* Chi-square test of independence

other health professional.) Indeed for most patients, reviewing the letter with their GP at some point would seem valuable.

The study's researcher was not blinded to group allocation, which potentially biases the recording of patient responses. Also the authors' adherence measure is unvalidated.

There was significant dropout with only 39 of the 50 participants enrolled in the study being included in the complete analysis and it is possible that drop-out participants differed in some clinically significant way. Of interest is that there were fewer dropouts in the letter group.

The authors acknowledge (with chagrin) that some letters took a long time to produce (although GPs were contacted by telephone very soon after the patient was seen). Also, letters were lengthy and detailed, and the writers were conscious that patients may view the letters: as such they are not necessarily representative of all medical correspondence.

**Possible explanations for effect**

Having an illness is typically stressful. Tangible evidence of the consultation, as in a letter, can be powerful<sup>15</sup> and reassuring.<sup>7,8</sup> This may explain why letter recipients improved more compared to controls. Moreover, a thorough, comprehensive report with a statement of understanding (a formulation) can make patients feel understood,<sup>7,9</sup> which in and of itself is a powerful tool in psychological healing. Letter recipients would be more likely to have felt empowered.<sup>8</sup> This sense of empowerment may act synergistically with treatments to hasten symptom amelioration.

Other potential benefits of receiving a GP reply letter include an opportunity to correct inaccuracies,<sup>7-9,16,17</sup> as well as providing a stimulus for discussion with the GP or other health professionals.<sup>15,17</sup>

**Implications for general practice**

While the authors are conscious of the limitations of the study, it provides a preliminary case for depressed and/or anxious patients receiving their GP reply letters. Potential caveats are that some groups may prefer a more simple, separate letter,<sup>18</sup> or there may be cause to be careful about specific areas of content (eg. distressing information or concern that others may view the letter).<sup>4</sup>

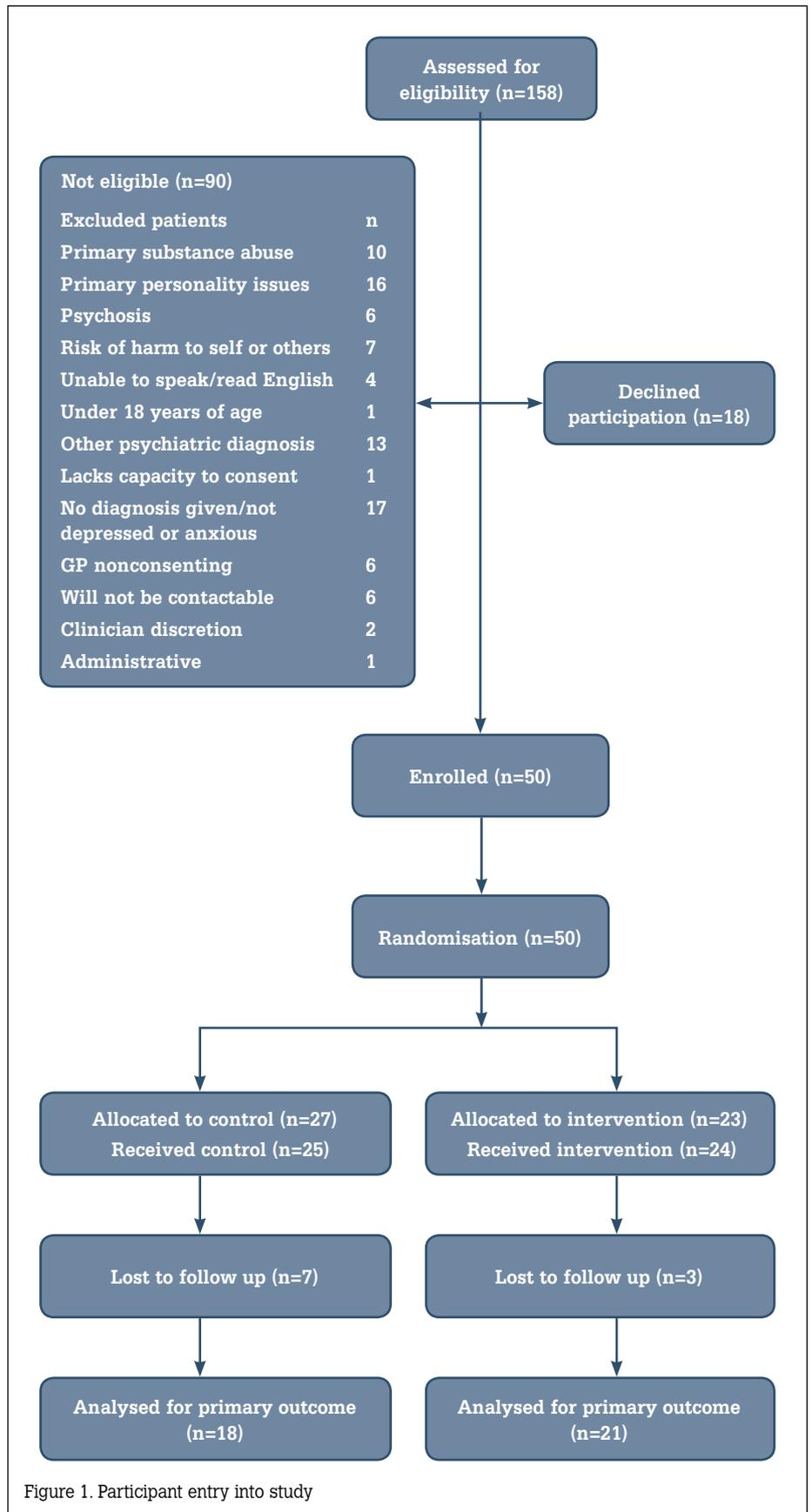


Figure 1. Participant entry into study

**Table 2. DASS scores (mean ± SD) for the letter (n=21) and control (n=18) groups**

Variable	Baseline	1 month	3 month	Friedman test p value
DASS total				
Letter	69.2±26.2	57.6±30.3	48.5±31.4	p=0.002*
Control	62.2±29.3	61.1±23.3	54.1±26.9	p=0.07
DASS depression				
Letter	24.7±26.2	22.4±12.6	17.4±12.8	p=0.01
Control	21.9±10.5	21.5±9.8	16.6±12.0	p=0.06
DASS anxiety				
Letter	17.4±10.1	13.3±10.5	12.0±10.5	p=0.02
Control	17.2±10.6	15.7±9.3	14.6±8.9	p=0.40
DASS stress				
Letter	27.1±9.1	21.9±10.5	19.2±10.1	p=0.01
Control	23.1±11.5	23.9±9.2	23.0±8.9	p=0.78

\* Significant change over time after applying the Bonferroni correction ( $\alpha=0.006$ )

Patients attending consultations other than psychiatry could benefit clinically from receiving their correspondence. This practice also has the paradoxical effect of lessening the potential of medicolegal actions,<sup>15</sup> and when dictated in front of the patient may improve letter accuracy.<sup>19</sup>

## Conclusion

Further research is needed to address this question on a larger sample. Additional important issues for focus are the processes by which patients receive a copy of their letters, potential contraindications, specific requirements for different patient, specialist and service groups and education and/or guides for letter writers.

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Conflict of interest: none declared.

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