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# Writing clinic letters:

## College guidance on improving engagement with patients

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## Patient involvement in the production of this guidance

Obtaining and considering patient feedback was an integral part of developing this guidance. A small selection of patient quotes are included throughout the documentation relating to the recommendations made.

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# Introduction

## Why issue this guidance?

Historically, psychiatric patients have not consistently and routinely been sent a letter following an out-patient appointment.

The College's position is that:

- patients should always receive a copy of a letter (whether it is written directly to the patient and copied to the GP, or vice versa), unless they specifically decline to receive one.
- doctors need to be mindful and think very carefully about the fact that the patient will be reading the letter and consider how its contents and tone could be interpreted.

The purpose of this document is to reinforce the importance of patients receiving a letter and to support psychiatrists in communicating in a clear and helpful way.

## What does the guidance cover?

The scope of this guidance extends to out-patient letters written in the first instance. While many of the principles will be transferable to other pieces of written communication with patients, such as discharge summaries, this guidance is not specifically designed to deal these.

Please note that subspecialty-specific guidance is not provided for medical psychotherapy as the content of such correspondence varies according to the nature of therapy offered. However, this document's general guidance still applies, as it does to all subspecialties, and the example letters for some of the other specialties may still be a useful resource.

## What is provided in this guidance?

- 1 General principles of letter writing that apply across all of psychiatry, regardless of the subspecialty.
- 2 Specific points to consider relating to specific subspecialties.
- 3 Example letters, exemplifying good practice across different specialties.

As with any framework, there is room for flexibility depending on the individual patient, clinician or setting – there cannot be a one-size-fits all approach.

# 1. Key principles

The clinic letter provides several vital functions:

- It forms part of the patient's permanent clinical record.
- It communicates management plans to the GP.
- It supports the communication of clinical information and treatment plans to the patient.
- It provides patients with their own record, which serves as a reminder of what has been discussed, as well as providing the opportunity to alert the clinician of any inaccuracies or changes made by other clinicians.

Taking time to write a good clinic letter is important and worthwhile. However, it is also important that letter writing does not become a laborious workload burden. For this reason, there should be just one letter written, although there may be exceptions, as highlighted in the subspecialties section.

## Who should receive a letter?

As stated on the previous page, all patients should be sent a letter (whether written directly to them or sent as a copy), unless they explicitly decline.

Some patients may choose to have their letter sent to a carer or guardian, and the possibility of this option should be made clear to them.

In some instances, it may be appropriate to hold an open discussion with patients about their potential emotional reaction to receiving a letter to help them decide whether or not to receive one.

Below are varying responses from patients discussing the effect of having read their clinical notes:

**“When I would talk to my psychiatrist I would be very open and honest, so I guess when I was reading [clinical notes] back it almost made me realise the reality of my mental health and the impact that it has.”**

**“There would be times where I would read the notes and cringe... sometimes I didn't even recognise the person who they were talking about. There have been times when I wouldn't even read them and I would just rip it up because I didn't want to have to read what was discussed in the session due to further triggers.”**

## Who should the letter be written to?

The letter can either be written directly to:

- the patient and copied to the GP, or
- the GP with a copy sent to the patient.

Where a letter is written directly to the patient, a PS can be added at the end that is addressed directly to the GP or other individuals, where appropriate, as suggested by the Academy of Royal Colleges in *Please, write to me*, their guidance for doctors writing to patients.

## What should be included in a letter?

### 1. The mental state examination (MSE)

The MSE should be included in patient letters and be written using objective fact wherever possible. Language should always be non-judgemental.

While it can be difficult for a patient to read a description of themselves, we caution that selectively omitting this information is not ethically sound. Further, it could ultimately be more problematic to have omitted the information, only for the patient to discover it at a later point. Patients can, and now more regularly do, request to view their notes. Discovering omitted parts could have a negative impact on trust.

An exception to this is letters for children – whether writing directly to them or sending them copies of letters to GPs. In these situations a formal mental state examination may not be appropriate. If the objective information is particularly important for the patient, family or GP it can be worded carefully, for example: “How you seemed/presented to me in the appointment” or “At times, I noted you became very distracted and looked around frequently without it being clear to me what had distracted you.”

### 2. A record of difference of opinion between the patient and the psychiatrist

Where there is a difference in opinion between the patient and the psychiatrist, it can be helpful to reflect this in the letter, thereby demonstrating that the patient's views have been listened to and acknowledged. [Read more on this in the next section.](#)

### 3. A list of the current psychotropic medications, doses and allergies

It can be helpful for the patient's understanding, as well as for non-specialists, to include indications (e.g. Sertraline 50mg once daily for low mood).

Including this information ensures the patient has an up-to-date list both for their own information and to show to other healthcare providers, helping to reduce any potential errors in medication prescription or taking by the patient. Patients also find this a useful reference for explaining their treatment regimen to third parties, for example the Department of Work and Pensions.

#### **4. User-friendly evidence-based information and relevant links**

Where relevant, these should be included in the letter, for example information leaflets from [www.rcpsych.ac.uk/mental-health](http://www.rcpsych.ac.uk/mental-health).

#### **5. Contact details for the psychiatrist**

These should be provided to enable the patient or GP to direct any queries that might arise.

## 2. Considering the letter's impact on the patient

It is very important to consider how the letter's language, content and accuracy could affect the patient reading it. They will have the opportunity to read the letter, whether written directly to them or not. By choosing words appropriately and sensitively, psychiatrists can mitigate against damage to the patient–psychiatrist relationship and build trust with patients.

### Plain English

To assist patients in understanding the letters they receive, it is important to use clear and easy-to-understand language and minimise medical jargon, as specifically highlighted by the Academy of Royal Colleges in its guidance on this topic. It can be very helpful to put the medical term in brackets afterwards. For instance, you might explain to a patient:

*“Your medication is making it difficult for you to sit still (akathisia) and causing slowed-down movements (bradykinesia).”*

It is also important to limit the use of abbreviations by, for instance, spelling out dialectical behavioural therapy in full rather than only using its abbreviation (DBT).

In some instances, patients who are well informed may feel frustrated that the letter has been ‘dumbed down’. This highlights the importance of seeking and receiving feedback on the first clinic letter, as it can be useful in tailoring the tone of subsequent letters that the individual patient receives.

### Non-judgemental language

It can be difficult for patients to read about their appearance, behaviour etc as part of their MSE, and it can lead to them feeling judged.

**“I started to worry about what to wear to my appointments. Am I appropriately dressed? Am I too smart? Am I not smart enough?”**

For this reason, language used should be non-judgemental and as objective as possible.

### Where a patient is not taking their medication or attending treatment

Being described as ‘non-compliant with treatment’ can make patients feel disempowered and like they are being treated as being disobedient. Rather than describing a patient as being non-compliant, you can make a factual and neutral statement, such as: “You told me that you had not been taking your medication for the last three weeks.”

## Where the patient's view differs from yours

If the patient does not agree with an assessment or diagnosis that you make, this difference of opinion should be recorded using non-judgemental language while still including all the relevant details.

Direct statements from the patient, rather than your interpretation of what was said, can clearly illustrate the main issues. Similarly, discrepancies between the viewpoints of the patient and psychiatrist can be openly acknowledged.

This approach reduces risk of damage to the patient–psychiatrist relationship because it demonstrates the patient's voice has been appreciated, even if there are differences in opinion. Therefore, the letter can be useful for clarifying diagnoses and reducing any confusion or potential breakdown in trust between psychiatrist and patient. In fact, it could be more problematic to have omitted the information, only for the patient to discover it at a later point:

**“Unknown to me on my GP med records is PTSD. It's been there for years but I was never told.”**

**“Escorted to psych unit and discovered I had previously been diagnosed with EUPD. No one had ever told me.”**

Therefore, the letter can be useful for clarifying diagnoses and reducing any confusion or potential breakdown in trust between psychiatrist and patient.

### Language to avoid

- Avoid describing the patient as having 'no insight into their condition'. Sentences can be restructured to avoid this and instead can explain what the patient believes/does not agree. Below is an example from the [general adult example letter \(to the patient\)](#):

*“I explained my view is that these experiences are part of an illness called paranoid schizophrenia and you disagree. You do, however, agree that you currently are not very well and are willing to follow the plan discussed below.”*

- Avoid using the word 'deny'. So, rather than saying that the patient 'denied' taking drugs, for example, this could be reworded as 'reports not taking any illicit substances' or similar.

### Further examples of recording a difference in opinion:

- **Example 1:** The patient's forgetfulness reaching the threshold of dementia (from the [older people's services example letter to the patient](#)):

*“I explained that, taken together, your memory symptoms, the memory screen (the Addenbrooke's Cognitive Examination) we did at our last appointment and the brain scan suggest a diagnosis of dementia. The gradual onset, particularly affecting your short-term memory, along with the specific appearance of the brain scan fit with a type of dementia called Alzheimer's disease.”*



*You agreed your memory is “not as good as it was”, but said you think this is just down to “getting on a bit”. I told you that while people can feel their thinking slows down a bit as they get older, usually this would not affect them so much in day-to-day tasks. However, I said that the label we give your symptoms is less important than how we help you. You agreed it could be useful to hear about possible next steps in treatment.”*

- **Example 2:** The patient’s experiences being due to a psychotic illness (from the [general adult example letter to the GP](#))

*“She described second person auditory hallucinations (voices) calling her derogatory names which she experiences as real and finds distressing. She also describes delusions (beliefs) that people are out to intentionally annoy her. I explained my view is that these are part of an illness called paranoid schizophrenia. Janet disagrees. She does, however, agree that she is not very well currently and is agreeable to the plan as discussed below.”*

## Factual accuracy

Another way to strengthen the patient–psychiatrist relationship is by actively providing the opportunity for patients to check the factual accuracy of their records, including their letters.

The patient should be informed in the letter they receive that there will be the opportunity at their next appointment to raise any concerns, including concerns about the factual accuracy of their letter. Doing this provides the obvious benefits of identifying any inaccuracies in clinical documentation as soon as possible and serves to prevent additional and unnecessary distress or frustration for the patient.

**“Also in my notes, I’m misgendered and called ‘she’ and by my dead name [birth name, now defunct]. Even though I’ve changed my name and they know I’m transgender.”**

**“He had written that I had a history of taking overdoses – totally untrue. Also that I had a history of sexual abuse in my childhood – also totally untrue! He had given that as the reason for my referral for psychology.”**

Dictating the letter at the end of the appointment while the patient is still present is another way of minimising factual errors. However, time constraints can often mean this is not possible.

## Family and friends

Some patients may also find it helpful to share the information in their letter(s) with family or friends to help them in their interpretation and/or understanding.

**“It could be a matter of interpretation. Sometimes my husband and I have read something and he’ll have a different impression or opinion than me.”**

# 3. Specific guidance for subspecialties

There are, of course, different and specific challenges associated with writing to patients from different patient groups. Below we highlight some additional considerations relating to specific psychiatric specialties.

## General (working age) adults

There may be specific considerations for subspecialties within general adult psychiatry such as eating disorders and liaison psychiatry. For instance, letters to patients under the eating disorders service are likely to include current weight, height, BMI or percentage of target weight (as appropriate). Out-patient letters under liaison psychiatry services may have more emphasis on physical health conditions linked to mental health, and may therefore include physical health medications in addition to psychotropic medications.

We have provided a [general adult example letter \(to a patient\)](#) and a [general adult example letter \(to a GP\)](#) in the next section.

## Older people

Specific consideration should be given to patients with impaired memory. Patients may not recall conversations in clinic and therefore may be distressed and shocked to receive a letter reiterating a diagnosis that they do not remember receiving. This fits with the general advice of checking if the patient wishes to receive a letter, especially if they have been upset by letters in the past. In some instances, after discussion with the patient, it might be appropriate to send letters to the carer instead.

Letters in older people's services often include the results of investigations like MRI scans. It might be helpful to specifically acknowledge that the full report has been included for GP records, but that it includes medical language that might be difficult to follow. The most important results should be summarised for the patient in straightforward language within the letter itself.

Older people often have many professionals involved in their care (in addition to their GP) – e.g. hospital specialists and social workers. After talking to the patient, it may be appropriate for some of this wider multidisciplinary team to be copied into the letter. Where possible, avoid sending multiple paper copies of letters. Instead consider sending correspondence from and to secure email addresses (e.g. nhs.net).

We have provided an [older people's services example letter \(to the patient\)](#) and an [older person's services letter \(to the GP\)](#) to illustrate many of these points.

## Child and adolescent

There are several specific considerations for patient letters within CAMHS. The approach to written communication will differ according to the developmental age of the child. If writing directly to a child, the letter will need to include simple language appropriate to the child's level of understanding, and a more detailed one may need to be included for their parents or guardians. Older children may prefer to manage their health independently from their parents/guardians and would require a wholly personalised correspondence. This may be appropriate for adolescents over the age of 16 or those with relevant competencies.

As previously stated, the aim of this guidance is not to cause an additional burden of work, therefore clinicians may find it more straightforward to write one letter only.

In the case of looked-after children, social services hold their parental responsibility, not their parents. Therefore, any correspondence that would normally be directed to parents needs to be directed to social services or other guardians.

It is also important to only provide information after having gained consent. Often when working with children and adolescents, their parents or guardians are interviewed separately. While they may be happy for the medical notes to reflect their views or personal history, clear consent needs to be obtained about what will later be communicated to the child. This is also true of the reverse situation, where the child's experience will be communicated to the parent or guardian.

Further consideration may need to be given in the case of separated parents as they may share parental responsibility and therefore copies may need to be sent to both.

## Intellectual disabilities (ID)

As with CAMHS, correspondence will differ according to the intellectual abilities of each patient. Almost all patients under the care of ID services attend out-patient appointments with carers, be they informal or paid support. Information will need to be provided to the patient and/or carer(s) during the appointment and most likely more detailed information will need to be sent to the GP.

One approach is to write a simplified letter directly to the patient and/or carer(s), and to send the GP a separate, more detailed letter. However, this may cause an unnecessary duplication of work causing further time pressures. Easy read leaflets can be utilised instead to help mitigate this. Furthermore, some patients may struggle to understand a simplified letter received following a consultation and therefore the approach will differ from patient to patient.

To overcome these difficulties, another approach is to use a standardised crib sheet (in clinic) to allow quick and effective hand-written communication of the salient points to the patient and/or carers during the consultation. A crib sheet may include pictures and/or symbols indicating different facets of the patient's health and care such as mood and medication. It may include pictures of the treating team to aid memory and be handed to the carer/patient at the end of the appointment.

Use of a crib sheet should be followed up with a letter to the GP in line with standard practice.

## Forensics

Guidance for forensic psychiatry patient letters matches that for general adults, with the added requirement that a summary of forensic history and instances of the patient having been detained under the Mental Health Act are included.

## Example letters

### General adult example letter (to the patient)

Miss Janet Bell  
Walkergate View,  
Leeds  
West Yorkshire  
LS43 1BB

1 March 2020

Dear Miss Bell,

**Re: Janet Bell, DOB 12/01/1986, NHS number 987 654 3210  
9 Walkergate View, Leeds, West Yorkshire, LS43 1BB.**

Community Mental Health Team Clinic, Dr Psychiatry – 25 February 2020.

**Diagnosis:** Paranoid Schizophrenia (F20.0)  
**Psychiatric medications:** Olanzapine 15mg once nightly (for management of psychosis)  
**Allergies:** Nil

It was good to meet with you in clinic today. As we discussed, it has been over three years since you were last admitted to hospital due to a relapse of schizophrenia, and you remain pleased with your progress. You are functioning well at home and described to me how you are enjoying spending time with your partner Joe, particularly watching films and cooking. Most recently you took a trip to Scarborough. We discussed how this was understandably a big step for you, as going to unfamiliar places can be very difficult due to the level of discomfort this causes you, particularly in regard to negative thoughts and feelings of persecution. I was pleased to hear how much you enjoyed your trip, but at the same time I explained I was a little concerned about the recurrence of your hallucinations.

You described an incident in Scarborough where you were walking to the beach with Joe, your partner, when a small group of teenagers started calling you unpleasant names from across the street. Joe told them to go away and you decided to return to the hotel. You then heard a shop cashier from some distance away calling you derogatory names and you described the cashier following you back to the hotel. You have also described your neighbours starting to knock on your walls at night again and rattle the letterbox. Joe explained that he does not hear them. You are also hearing voices at night time calling you derogatory names, which is further negatively impacting on your sleep and mood. These experiences are understandably causing you a great deal of distress.

I explained that I was concerned that the voices and feelings of persecution you are experiencing are due to a recurrence of schizophrenia. You told me that you disagree on this point because your experiences are definitely real.

We also spoke about drinking alcohol as you explained your intake has recently increased. You understand how alcohol can negatively impact on your mood and sleep, but you do not have any plans to decrease your intake, as it helps alleviate boredom during the day as well as relieve some anxiety you experience from the voices.

You continue to take Olanzapine 10mg each night – you do not have any difficulties with this although are concerned about weight gain at higher doses. We agreed to try an increase in your dose to

15mg each night on a trial basis to see if this offers you any benefit. You hope this will help with anxiety and sleep. If you gain weight or have other difficulties, we have planned to look at an alternative antipsychotic. I gave you written information on Olanzapine including common side effects.

### **Mental state examination (MSE)**

After each appointment I have with a patient, I write a brief description of how they were during the appointment, in terms of their appearance and how they were thinking and feeling. This is known as a mental state examination (MSE).

A record of your MSE from our most recent appointment is below. It can be strange to read, but these 'snapshots' are useful in keeping track of how you are doing.

### **Your MSE**

You were dressed in clean, casual clothes and appeared relaxed and settled during our review. and you seemed relaxed and settled during our review. Your speech was normal and your thoughts were clear and logical. You described your mood as a little low and anxious. You were able to use humour at times. You described voices calling you derogatory names, which you find distressing. You also described feeling that people are intentionally out to annoy you. I explained my view is that these experiences are part of an illness called paranoid schizophrenia and you disagree. You do however agree that you currently are not very well and are willing to follow the plan discussed below.

### **Risks**

You do not feel at risk from your experiences and have not taken any steps to protect yourself or others. As you know, I always ask if you are experiencing any thoughts to harm yourself or others, and you explained this was not the case.

### **Impression**

My main concern is the recent recurrence of symptoms of paranoid schizophrenia and the increase in alcohol intake may be contributing to this. You otherwise appear to be managing very well and we are now treating you with an increased dose of antipsychotic medication and increased input from your care coordinator in the community. We do not think you need to be admitted to hospital admission at this time.

### **Plan**

- 1 Increase Olanzapine from 10mg each night to 15mg each night.
- 2 Misba, your care coordinator, will increase the frequency of visits to twice a week to monitor your progress and I have arranged to see you again in clinic in four weeks' time.
- 3 Our contact details are included at the top of this letter, and we would be more than happy to see you sooner if needed. In case of an emergency during working hours please call our duty worker on \*\*\*\*\* during working hours, or the crisis team (\*\*\*\*\*)/A&E out of hours.

At our next appointment, there will be the opportunity to discuss the content and clarity of this letter and you will have the opportunity to ask any questions, express any concerns or inform me of any inaccuracies.

Yours sincerely,

Dr ST4 in General Adult Psychiatry  
GMC 7654321  
cc: Dr General Practitioner

## General adult example letter (to the GP)

Dr Gen Practitioner  
Wellbeing Medical Centre  
Leeds  
West Yorkshire  
LS43 1AA

1 March 2020

Dear Dr Practitioner,

**Re: Janet Bell, DOB 12/01/1986, NHS number 987 654 3210,  
9 Walkergate View, Leeds, West Yorkshire. LS43 1BB.**

Community Mental Health Team Clinic, Dr Psychiatry – 25 February 2020.

**Diagnoses:** F20.0 Paranoid Schizophrenia  
**Psychotropic medications:** Olanzapine 15mg once nightly (for management of psychosis)  
**Allergies:** Nil

I met with Janet in clinic today for a planned review. It has been over three years since Janet was last admitted to hospital due to a relapse of schizophrenia. She continues to be pleased with her progress and is currently functioning well at home. Today she described how she is enjoying spending time with her partner Joe, particularly watching films together and cooking. Most recently they took a trip to Scarborough. We discussed how this was understandably a big step for her, as going to unfamiliar places tends to cause anxiety due to long standing negative thoughts and feelings of persecution. I was pleased to hear how much they enjoyed the trip, but at the same time I explained I was a little concerned about some of the recurrence of her hallucinations.

Janet described an incident in Scarborough where they were walking to the beach and a small group of teenagers started calling her unpleasant names from across the street. Joe, her partner, told them to go away and then Janet and Joe headed to the hotel instead of the beach. Janet then described how she then heard a shop cashier, in a shop some distance away from her, calling her names and believed she was being followed back to the hotel. Janet also described how her neighbours have recently started to knock on their walls at night again and rattle the letterbox; Joe does not hear them. She is experiencing an increase in intensity of voices calling her derogatory names, particularly at night time, which is further negatively impacting on her sleep and mood. These experiences are understandably causing Janet a great deal of distress. I explained that I was concerned that the voices and feelings of persecution she is experiencing are due to a recurrence of schizophrenia. She told me that she disagrees on this point because her experiences are definitely real.

We also spoke about drinking alcohol as her intake has recently increased. She understands that alcohol can negatively impact on mood and sleep but currently does not have any plans to decrease intake, as it helps alleviate boredom during the day as well as relieve some anxiety she is experiencing from the voices.

Janet has continued to take Olanzapine 10mg each night – she is not experiencing any unwanted effects but is concerned about weight gain at higher doses. We agreed to try an increase in dose to 15mg each night on a trial basis to see if this offers any benefit. She hopes

this will help with anxiety and sleep. If she gains weight or has other unwanted effects, we have planned to look at an alternative antipsychotic drug. I gave Janet and Joe written information on Olanzapine including common side effects.

### **Mental State Examination (MSE)**

Janet's MSE from our most recent appointment is below. I explained to her that after each appointment I have with a patient, I write a brief description of how they were during the appointment, in terms of their appearance and how they were thinking and feeling. This is known as a mental state examination. I explained that it can be strange to read, but these 'snapshots' are useful in keeping track of how they are doing.

### **Janet's MSE**

Janet was dressed in clean, casual clothes and she appeared relaxed and settled during our review. Her speech was normal and there was no disordering of her thoughts. She described her mood as a little low and anxious. She was able to use humour at times. She described second person auditory hallucinations (voices) calling her derogatory names which she experiences as real and finds distressing. She also describes delusions (beliefs) that people are out to intentionally annoy her. I explained my view is that these are part of an illness called paranoid schizophrenia. Janet disagrees. She does however agree that she is not very well currently and is agreeable to the plan as discussed below.

### **Risks**

There were no concerns today that would suggest Janet is a risk to herself or others. Although they are distressing, she does not feel at risk from her experiences and she has not taken any steps to protect herself or others. She is not experiencing any thoughts to harm herself or others. The main concern is that her mental health may continue to deteriorate but she is currently managing well in the community with appropriate support.

### **Impression**

I explained to Janet that my main concern is that she is experiencing a recurrence of symptoms of paranoid schizophrenia and that a recent increase in alcohol intake may be contributing to this. She otherwise appears to be managing very well at home and we are treating her in the community with an increased dose of antipsychotic medication and increased input from her care coordinator.

### **Plan**

- 1 Olanzapine has been increased from 10mg each night to 15mg each night – I have provided a prescription for 28 days.
- 2 I have arranged to see Janet again in clinic in four weeks' time. In the meantime, Janet's care coordinator Misba will increase the frequency of home visits to twice weekly to monitor her progress.
- 3 Janet and her partner have our contact details and we would be more than happy to see her sooner than planned if needed. In case of an emergency during working hours, I have asked Janet to call either her care coordinator or our duty worker on \*\*\*\*\* during working hours, or the crisis team/A&E out of hours.

Yours sincerely,

Dr ST4 in General Adult Psychiatry  
GMC 7654321

cc: Janet Bell, 9 Walkergate View, Leeds, West Yorkshire, LS43 1BB



# Older people's services example letter (to the patient)

Dr Older Adult Psychiatrist  
Older Adult Community Mental Health Team  
30 Paris Road  
LONDON  
SW20 3DR

Mrs Victoria Pointer  
C/O Marius Pointer  
24 Hugo Avenue  
LONDON  
SW20 5PT

9 February 2020

Dear Mrs Pointer,

**RE: Victoria Pointer; DOB:** 25/08/1942, **NHS number:** 423 560 300

**Diagnosis:** Dementia in Alzheimer's disease with late onset (F00.1)  
**Psychiatric medications:** Donepezil 5mg once nightly for one month (to help with difficulties with memory and confusion) (NEW)

Thank you for coming back to see me in the Paris Road Clinic on 8 February. Your son Marius accompanied you, as he did on your last visit.

## Progress

I was pleased to hear you have been eating better since the 'Meals on Wheels' started and that your Care Package has increased to twice a day. This is helping support you in taking your medication and in doing things like having a shower.

Marius confirmed you received the letter from our initial meeting in December 2019. He felt it was an accurate summary of the main issues. You could not recall the details, but Marius said he had read the letter with you. He told me that, at the time, you felt I had made your memory symptoms sound worse than they are.

Unfortunately, since the last appointment, you have continued to feel anxious when you are at home on your own. You reported this is because your neighbours come into your house and "crash about". They sometimes laugh and whisper about you, although you cannot make out what they say. Marius said you can get frustrated (and shout at him) when he tries to reassure you no one is in the house.

## Investigations

We discussed the results of the tests you have had since we last met. These were: blood tests, a heart trace (ECG) which measures the rhythm and electrical activity of your heart and a brain scan (MRI). The blood tests, which included checks of your liver and kidneys as well as blood sugar and cholesterol levels, were all reassuringly normal. The heart trace was also normal – your heart was not beating too fast or slow and the rhythm was nice and regular.

However, the brain scan showed more loss of brain tissue than would be expected at your age. The areas of the brain involved with memory were particularly affected. A full report of the

MRI, and the ECG, is attached. Some of the language might be difficult for you to follow, but it is important the GP has the reports and the main results are as I have summarised above.

### **Diagnosis**

I explained that, taken together, your memory symptoms, the memory screen (the Addenbrooke's Cognitive Examination) we did at our last appointment and the brain scan suggest a diagnosis of dementia. The gradual onset, particularly affecting your short-term memory, along with the specific appearance of the brain scan fit with a type of dementia called Alzheimer's disease.

You agreed your memory is "not as good as it was", but said you think this is just down to "getting on a bit". I told you that while people can feel their thinking slows down a bit as they get older, usually this would not affect them so much in day-to-day tasks. However, I said that the label we give your symptoms is less important than how we help you. You agreed it could be useful to hear about possible next steps in treatment.

### **Treatment**

We talked about how having a structured routine can be helpful when you are having problems with memory. Also, getting out the house and being around other people can be useful in reducing anxiety and in lessening experiences like hearing noises in the house that other people cannot hear. Marius and his family live nearby and visit most weekends. You agreed for me to refer you to the local day centre to give more company during the week.

I also suggested I refer you to our psychology service for some talking treatment – focusing on your anxiety about your neighbours. You were not sure how talking would really help the situation, but you agreed to meet with the psychologist to hear more about what they do.

Finally, I recommended you start a medication called Donepezil. This does not reverse the memory loss symptoms you already are experiencing but it may slow down further losses. The main side effects of this medication are feeling sick and/or having an upset stomach, but this usually settles after a short time. There is a risk of your heart beating more slowly which can make you feel dizzy, but this is less likely in your case because you have a normal heart activity and rhythm. I reassured you that we start at a low dose and slowly increase it.

### **Mental state examination (MSE)**

After each appointment I have with a patient, I write a brief description of how they were during the appointment, in terms of their appearance and how they were thinking and feeling. This is known as a mental state examination (MSE).

A record of your MSE from our most recent appointment is below. It can be strange to read, but these 'snapshots' are useful in keeping track of how you are doing.

### **Your MSE**

My impression of you was a woman in her late seventies of a healthy weight. You were dressed in warm trousers, a jumper and a thick coat as it was a cold day. Overall, you appeared relaxed during the appointment, although you became a little tearful when you were talking about your neighbours. You told me you get anxious at home on your own, but otherwise are 'ok' in your mood. You said you sometimes feel angry towards your neighbours because you think they are trying to take your house. You do not have any plans to confront your neighbours and do not have thoughts of harming yourself. You described hearing your neighbours making noises and laughing and whispering in the house. You have never seen them and do not know how they get in.

I explained to you that my view of your experiences with your neighbours is likely to be related to your memory problems. We spoke about how these are likely to be delusions (beliefs that your neighbours wish to take your house when there is no other evidence to suggest this) and third person auditory hallucinations (the experience of hearing your neighbours voices that others cannot hear). You do not agree with my suggestion that these experiences might be linked to your memory problems and are clear that your neighbours are making the noises in your house.

You remembered seeing me before but were not sure what my job was. You knew that it was morning at the time of our appointment, but could not recall the month or day of the week.

You were clear that your neighbours are making the noises in your house and did not agree with my suggestion that these experiences might be linked to your memory problems.

### **Risk**

You are eating better and now have carers visit you twice a day. This is helping with taking medications and with washing and dressing. You receive meals from Meals on Wheels so only use the microwave to heat your food, not the oven. You do not have thoughts of harming yourself or other people. Your son Marius said you sometimes shout when you are frustrated but he is always able to calm you down by talking with you. You have not had any falls recently and have never wandered away from home.

### **Plan**

- 1 Start Donepezil 5mg once nightly.
- 2 I will refer you to the psychology service for talking treatment
- 3 I will refer you to social services for day centre assessment.
- 4 Review again in clinic in one month's time – you will receive a letter with the appointment.
- 5 Letters to be sent to your son Marius' address rather than yours – you agreed this would be better as he reads the letters with you anyway.

At our next appointment, there will be the opportunity to discuss the content and clarity of this letter and you will have the opportunity to ask any questions, express any concerns or inform me of any inaccuracies.

Yours sincerely

Dr Older Adult Psychiatrist

cc:

Dr General Practitioner  
24 Fantine Walk  
London  
SW20 6GP

## Older people's services example letter (to the GP)

Dr Older Adult Psychiatrist  
Older Adult Community Mental Health Team  
30 Paris Road  
London  
SW20 3DR

Dr General Practitioner

9 February 2020

24 Fantine Walk  
London  
SW20 6GP

**RE: Victoria Pointer; DOB:** 25/08/1942, **NHS number:** 423 560 30

**Diagnosis:** Dementia in Alzheimer's disease with late onset (F00.1)  
**Psychiatric medications:** Donepezil 5mg once nightly for one month (to help with difficulties with memory and confusion) (NEW)

Dear Dr Practitioner,

I met with Mrs Pointer in memory clinic today, along with her son Marius. This was a planned review.

### **Progress:**

I was pleased to hear that Mrs Pointer has been eating much better since the 'Meals on Wheels' service started and her care package was increased to twice daily. She is finding this extra support is helping her with taking prescribed medications and with activities such as having a shower.

Marius confirmed that they had received the letter from our initial assessment meeting in December 2019. He felt it was an accurate summary of the main issues. Mrs Pointer was not able to recall the details, but Marius said they had read the letter together and at the time, his mother felt I had made her memory symptoms sound worse than they are.

Unfortunately, since the last appointment, Mrs Pointer has continued to feel anxious when at home on her own. In clinic today, she reported that this is because her neighbours come into her house and "crash about". She describes sometimes hearing them laugh and whisper about her, although she is unable to make out what they say. Marius said his mother can get frustrated (and shout at him) when he tries to reassure her that no one is in the house.

### **Investigations:**

The results of Mrs Pointer's recent blood tests and ECG (heart trace) were all reassuringly within normal range. The blood tests included LFTs (checks of liver function), U&Es (checks of kidney function) as well as blood glucose (blood sugars) and cholesterol levels.

However, the head MRI (brain scan) showed more atrophy (loss) of brain tissue than would be expected for her age, particularly in the medial temporal lobe (the areas of the brain involved with memory). A full report of both the MRI and the ECG are attached.

**Diagnosis:**

I explained to Mrs Pointer that, her memory symptoms together with the memory screen (the Addenbrooke's Cognitive Examination) and the brain scan (MRI) suggest a diagnosis of dementia. The gradual onset, particularly affecting her short-term memory, along with the specific appearance of the brain scan fits with a type of dementia called Alzheimer's disease.

Mrs Pointer agreed that her memory is "not as good as it was", but believes that this is just down to "getting on a bit". I explained that while people can feel their thinking slows down a bit as they get older, usually this would not affect them so much in day-to-day tasks. However, I also explained that the label we give her symptoms is less important than how we help her. She agreed it could be useful to hear about possible next steps in treatment.

**Treatment:**

We talked about how having a structured routine can be helpful when people are having problems with memory. Also, getting out of the house and being around other people can be useful in reducing anxiety and in lessening experiences like hearing noises in the house that other people cannot hear. Mrs Pointer's son Marius and his family live nearby and visit most weekends. Mrs Pointer agreed for me to make a referral to the local day centre to give her more company during the week.

I also suggested I refer her to our psychology service for some talking treatment, focusing on her anxiety about her neighbours. Mrs Pointer was not sure how talking would really help the situation, but she agreed to meet with the psychologist to hear more about what they do.

Finally, I recommended that Mrs Pointer starts a medication called Donepezil. I explained to her that this does not reverse the memory symptoms she already has but may slow down further losses. The main side effects are feeling sick or having stomach upset, but this usually settles after a short time. I also explained that this medication can sometimes make the heart beat more slowly causing a feeling of dizziness, but Mrs Pointer has a normal heart trace which makes this less likely. I reassured her that we start at a low dose and slowly increase over a few months.

**Mental State Examination (MSE)**

Mrs Pointer's MSE from our most recent appointment is below. I explained to her that after each appointment I have with a patient, I write a brief description of how they were during the appointment, in terms of their appearance and how they were thinking and feeling. This is known as a mental state examination. I explained that it can be strange to read, but these 'snapshots' are useful in keeping track of how they are doing.

**Mr Pointer's MSE**

Mrs Pointer presented as a lady in her late seventies, of a healthy weight. She was dressed for the cold weather in warm winter clothing. Overall, she appeared relaxed during the appointment, although became a little tearful when we were talking about her neighbours. She explained that she gets anxious at home on her own, but otherwise is 'ok' in her mood. She also explained that she sometimes feels angry towards her neighbours because she thinks they are trying to take her house away. She does not have any plans to confront her neighbours and does not have thoughts to harm herself. She described hearing her neighbours making noises and laughing and whispering in the house. She has never seen them and does not know how they get in. She was able to remember seeing me before and was not sure what my job was. She knew it was morning at the time of the appointment but could not recall the month or day of

the week. I explained to Mrs Pointer that her experiences of her neighbours sound like delusions (beliefs that her neighbours wish to take her house when there is no other evidence to suggest this) and third person auditory hallucinations (the experience of hearing her neighbours voices that others cannot hear). She was clear that her neighbours are making the noises in her house and she did not agree with my suggestion that these experiences might be linked to her memory problems.

### **Risk**

Mrs Pointer now has carers twice daily, which she finds is helping with taking medications regularly and with washing and dressing. Her dietary intake has improved as she now receives daily Meals on Wheels so only uses the microwave, not the oven. She does not have thoughts to harm herself or other people. Her son Marius explained that his mother sometimes shouts when she is frustrated but he is always able to calm her down by talking with her and there is no suggestion of any physical aggression towards others. Mrs Pointer has not had any falls recently and has never wandered away from home.

### **Plan:**

- 1 Donepezil 5mg once nightly has been initiated – I have provided a prescription for 28 days.
- 2 We have made a referral to the psychology service for talking treatment
- 3 We have made a referral to social services for a day centre assessment
- 4 I have arranged to see Mrs Pointer again in clinic in one months' time on the \*\*\* (one month after whatever date use end up using on the letter) at 10.45am.
- 5 We have arranged with Mrs Pointer and her son Marius, for letters to be sent to Marius' address rather than Mrs Pointer's as per their preference.

Yours sincerely.

Dr Older Adult Psychiatrist

Cc: Mrs Pointer C/O Marius Pointer  
24 Hugo Avenue  
London  
SW20 5PT

## CAMHS example letter (to a 10-year-old)

Dr CA Psychiatrist  
Child and Adolescent Mental Health Service  
Community Intensive Therapy Team  
Riverside Centre  
Birmingham  
B1 999

Michael Olowu  
78 Peartree Lane  
Birmingham  
B2 888

2 April 2020

Dear Michael,

**RE: Michael Olowu, DOB: 22/2/2010, NHS Number: 123 456 789  
78 Peartree Lane, Birmingham, B2 888**

Thank you for meeting with the Community Intensive Therapy Team (CITT) recently. You were seen by myself and Tony, both doctors on the team. It was lovely to meet you and your nan, Patricia. We enjoyed our chat and can see you are a funny and caring young man. I hope you find this letter useful to remember what we talked about. If you are not sure about anything, we can talk about it next time. As I explained to you, we have also written to your parents, nan, doctor and social worker so they know what's going on.

You said that your tics are something you feel unable to cope with and we would like to help with that. You told us that at times they are painful, as they can make you pull your neck or make you hit your arm against a wall. They also take up a lot of time, as you often go straight to your room after school to release your tics for an hour or two. You have had tics for many years now and feel like there is probably nothing that will help. I understand that you did not want to try several medications we talked about as you were too worried about the side effects. You also have not had any therapy to help your tics.

You spoke to me about being really worried about your family being harmed. At times, your nan has been worried that you hurt yourself because you think this will stop anything bad happening to your family. I know you found this really difficult to talk about, as you looked at your feet and became quite quiet. Hopefully as you get to know our team more these things will be easier to talk about. It is very important to us that we can help with these kinds of worries.

We also spoke about how you love biking and fishing. I understand you aren't a huge fan of school and find classrooms difficult to sit in. Often you feel distracted by your tics. However, you understand school is important and you enjoy break times with your friends. At the moment, you live with your nan and see your mum on some weekends. Your social worker, Claire, is supporting you to see your dad too. Other than your tics and worries, you are a healthy young man who has never had to stay in hospital. A doctor has listened to your heart before and you have had a test (ECG) to look at how your heart is beating. Your test results were normal

which is good and means your heart is healthy. It's important to know this in case we discuss you taking medication again in the future.

We would like to meet you in your home on a weekly or fortnightly basis and make a plan together with you. The plan is likely to include both therapy and medication. Therapy would be done with a nurse therapist, who I will bring with me next time we meet. The kind of therapy that often works best for tics involves helping your body relax and increasing your control over the tics. It will also look to understand and help you with your worries. I am aware you have tried several different medications for tics and we would need to think about which one might work for you together. While some may give you side effects, these may be easier to deal with than the tics.

I will be in touch with your nan soon to arrange our next appointment, which I understand is best done outside school hours, and I look forward to seeing you.

Yours sincerely,

Dr CA Psychiatrist



## CAMHS example letter (to a 16-year-old)

Dr CA Psychiatrist  
Children and Young People's Eating Disorders Service  
1a Castle Road  
Newcastle  
N98 0PQ

Miss Mia Rossi  
24 Michaels Avenue  
Cardiff  
CF28 9XQ

2 April 2020

Dear Mia,

**RE: Mia Rossi; DOB:** 03/02/04, **NHS Number:** 123 456 789  
**24 Michaels Avenue, Cardiff, CF28 9XQ**

**Diagnosis:** Bulimia Nervosa

**Treatment:** Family-based treatment for Bulimia Nervosa

**Next session:** Tuesday 5 May

**Further tests needed:** A bone scan to check your bone density (DXA scan); a repeat set of liver function tests.

Thank you for coming to an assessment today with the eating disorders team in Cardiff. You were seen by me and Katy, one of our clinical psychologists. We saw you together with your dad Carlo and we are sending a copy of this letter to him. We also met both of you separately and have not included confidential information in this letter.

Your weight with us today was 60.8kg and your height was 174cm, giving you a BMI of 20 (94% Median BMI), which is at the lower end of normal range.

We spoke about your family. You told us that you live with your dad and younger sister Anita (aged 14), and your pets – two dogs and a hamster. Your mum sadly passed away three years ago. You attend St David's College where you are studying your study A-levels in Chemistry, Biology and Psychology. You also work as waitress part time. You wanted to be doctor, but are now interested in clinical psychology.

You began by talking about your anger, which is affecting the whole of your family. Arguments are often caused by interactions about food. Your dad gets angry if a lot of food has been eaten, especially if it means your sister did not get any. You have explained that once a binge starts, you cannot control it. Arguments also occur when you or your family members are stressed. Your dad works long hours as a sales director and your extended family live in Scotland. You used to be a competitive hockey player, competing at regional championships. You stopped this last year and began to put on weight while you continued to eat as you did when you were playing hockey regularly. You tried to lose weight through careful dieting but were not successful. Approximately six months ago you tried more 'strict' dieting and became aware that at times you ate large amounts of food in binge episodes. You have not vomited following

these episodes. To prevent weight gain following a binge episode, you will exercise vigorously by, for instance, going on a 2-hour run or doing 'HIIT' training in your bedroom.

You described how you will fast throughout the day, not eating at college nor at work. The following morning you find yourself buying large amounts of chocolate or cakes on the way to college and eating these before you meet your friends. When you binge, you feel disgusting and guilty. Your dad has noticed that large amounts of snack foods have gone missing from the kitchen when he returns from work, and he has attempted to hide them from you to restrict your access. Your sister told your dad that you do not eat your evening meals and this causes further arguments. When your family are around you notice that your eating is better. Otherwise, you avoid carbs, sauces, dressings and exercise early in the morning doing 'HIIT', do jumping jacks at lunch time at college rather than eating lunch, followed by a long run in the evening. You explained how you think about food and eating all the time. You watch YouTube videos about food and exercise and look up low-fat vegetarian recipes on Pinterest. You weigh yourself several times a day and are currently ok with your weight of 60.8kg.

Your periods are irregular and you have not had one for two months. You constantly feel cold but otherwise feel fit and well. You do not faint or black out and have not noticed any palpitations. You said that you feel your mood is 'fine', you sleep well, and have not had any thoughts of harming yourself or ending your life.

At the end of our session, I explained your diagnosis to you (bulimia nervosa – non-purging subtype), and that we need you to have a DXA scan which measures bone density. We will also repeat your blood tests, which previously showed some liver abnormalities (slightly raised albumin and bilirubin). We spoke about treatment options which can include talking therapy for you individually or as a family. You decided on an individual approach. We introduced you to Carol, who is our eating disorders specialist nurse, and Reena, who is a specialist dietician. They will both work with you. I have sent you some information about starvation syndrome and regular eating. Once your eating behaviour has stabilised, I explained that we will explore emotional and psychological factors along with input from our psychologist Katy, who you met with today. We will discuss this further in your next appointment on Tuesday 5<sup>th</sup> May.

At our next appointment, there will be the opportunity to discuss the content and clarity of this letter and you will have the opportunity to ask any questions, express any concerns or inform me of any inaccuracies.

Thank you for coming today, it was a pleasure to meet you.

Dr Eating Disorders Psychiatrist

cc:

- Patient's Dad (Carlo Rossi)
- GP

# References

Academy of Medical Royal Colleges (2018) *Please write to me: Writing outpatient clinic letters to patients - Guidance*. [https://www.aomrc.org.uk/wp-content/uploads/2018/09/Please\\_write\\_to\\_me\\_Guidance\\_010918.pdf](https://www.aomrc.org.uk/wp-content/uploads/2018/09/Please_write_to_me_Guidance_010918.pdf)

General Medical Council, Good medical practice, Domain 3: Communication, partnership and teamwork  
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The Royal College of Psychiatrists (2018) [www.rcpsych.ac.uk/mental-health](http://www.rcpsych.ac.uk/mental-health)