

better decision-making and less restrictive care plans. The time it takes to write reports and attend tribunals seems a fair price to pay to ensure that those detained against their will have an effective right to challenge their situation.

- 1 Choong LS. The rise in the number of Section 2 detentions (letter). *Psychiatrist* 2011; **35**: 198.
- 2 The NHS Information Centre. *In-Patients Formally Detained in Hospitals under the Mental Health Act, 1983 and Patients Subject to Supervised Community Treatment: 1998–99 to 2008–09* (Appendix 2, Table 8). Health and Social Care Information Centre, 2009.
- 3 The NHS Information Centre, Community and Mental Health Team. *In-Patients Formally Detained in Hospitals under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, Annual Figures, England 2009/10*. Health and Social Care Information Centre, 2010 (<http://www.ic.nhs.uk/pubs/inpatientdetmha0910>).
- 4 Administrative Justice and Tribunals Council. *Annual Report 2007/2008*. TSO (The Stationery Office), 2008 ([http://www.justice.gov.uk/ajtc/docs/Annual\\_Report\\_2007\\_8.pdf](http://www.justice.gov.uk/ajtc/docs/Annual_Report_2007_8.pdf)).

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## Reader feedback is helpful, but are the leaflets readable?

I was heartened to see an article evaluating the Royal College of Psychiatrists' patient information leaflets using quantitative and qualitative methods.<sup>1</sup> The provision of information is critical to my clinical practice and has often involved these very leaflets. I was also pleased that the authors acknowledged that 'much patient information is written in complex language and is poorly presented' as these are often barriers to patients accessing information. Disappointingly, however, they did not conduct any analysis of the language; one respondent had commented regarding one leaflet that 'It has quite a high reading age'.

The complexity of language can be assessed using a range of readability measures such as Flesch Reading Ease (FRE; a document should have a score of greater than 60, the higher the score the easier it is to read) and Flesch–Kincaid Grade Level (FKGL; refers to US school grades, so lower scores indicate better readability – a 13 year old should understand a document scoring 7). These are widely available, contained within word processing packages, and have been used to evaluate patient information leaflets in other specialties<sup>1</sup> and standard appointment letters in child and adolescent mental health services.<sup>2</sup> When these measures are applied to the College leaflets (Table 3 in the paper), the mean FRE is 7.81 (7.1–8.4) and mean FKGL 63.13 (58.7–69.8). This suggests the leaflets are readable as far as these computerised measures are concerned but their readability could be improved. When the top- and bottom-ranked leaflets (Table 3, which, curiously, has four highest ranked and three lowest ranked rather than four of each as described in the text) are compared, there is no statistical difference on either of the measures. This confirms that, although the language may be readable, the reader may not like the content.

I was confused by the quantitative method employed in the study. The original feedback was on a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. These are

ordinal variables (variables which represent categories of a feature with some inherent ordering<sup>3</sup>); however, they were converted into continuous variables (one which can take any value within a range<sup>3</sup>) and analysed as such. Unfortunately, one cannot convert discrete categories into a linear scale in this way. Given this conversion, the values could only range 1–5, and it is unsurprising that the authors found there was little variability in the feedback 'scores' assigned to each leaflet. It was also confusing to find that a correlation between modalities was included in the discussion but not presented in the results. My understanding of the analysis would have been aided to see the information presented in the original categories which those reading the leaflets had decided.

Despite these potential improvements and confusions, the conclusion remains undoubtedly true that 'reader feedback provides invaluable guidance about the substance and presentation of our public mental health information.' One can only hope that we continue to strive to produce information which is accessible to those who need it.

- 1 Briscoe M, Briscoe S, Timms P, Ramsay R. Usefulness of reader feedback on the Royal College of Psychiatrists' public information leaflets. *Psychiatrist* 2011; **35**: 175–8.
- 2 Payne S, Large S, Jarrett N, Turner P. Written information given to patients and families by palliative care units: a national survey. *Lancet* 2000; **355**: 1792.
- 3 Bennett DM, Gilchrist A. Readability of standard appointment letters. *J Ment Health Fam Med* 2010; **7**: 101–6.
- 4 Harris M, Taylor G. *Medical Statistics Made Easy* (2nd edn). Scion, 2009.

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## Readability analysis?

As a trainee member of the Royal College of Psychiatrists' Public Education Editorial Board, I read with interest the review of reader feedback on the College online public education leaflets.<sup>1</sup> I was struck by both the popularity of the public information section of the website and the high volume of completed feedback forms. I wondered, however, whether the authors have considered further analysis of the College information leaflets, to identify potential causes for the poorly scoring leaflets that they describe in the article.

The authors refer to an analysis of free-text feedback in which they name the two highest and lowest scoring main leaflets. It is perhaps unsurprising that poorly scoring leaflets would be more likely to receive negative comments, but what interested me most was the example constructive comment in response to the cannabis and mental health leaflet that said 'It has quite a high reading age'.

If the College information leaflets aim to reach a wide audience, it would seem sensible to establish whether the comment about reading age is in fact true for all leaflets. Is their readability consistent with the recommended level? And have the authors considered analysing whether there is a correlation between the reading age of the highest and lowest scoring leaflets?

A number of papers have looked into the readability of information made available on websites<sup>2,3</sup> and in patient information leaflets.<sup>4,5</sup> According to the literature, a Flesch–Kincaid 6th Grade (equivalent to UK reading age of 11–12 years) is the maximum recommended level for public health information,<sup>1</sup> and would be consistent with the average UK reading age quoted as being between 9 and 11 years.<sup>4</sup>

There are, of course, a variety of different readability tests that could be used to examine the readability level of the College information leaflets, including Flesch–Kincaid and Flesch Reading Ease and Simple Measure of Gobbledygook formulae.<sup>2</sup> Whether or not a correlation exists between readability age and the leaflet scores, I would suggest it is pertinent to clarify whether all the College leaflets are written at a readability level consistent with that recommended for public health information.

- 1 Briscoe M, Briscoe S, Timms P, Ramsay R. Usefulness of reader feedback on the Royal College of Psychiatrists' public information leaflets. *Psychiatrist* 2011; **35**: 175–8.
- 2 Kalk NJ, Pothier DD. Patient information on schizophrenia on the internet. *Psychiatr Bull* 2008; **32**: 409–11.
- 3 Fitzsimmons PR, Michael BD, Hulley JL, Scott GO. A readability assessment of online Parkinson's disease information. *J R Coll Physicians Edinb* 2010; **40**: 292–6.
- 4 Clauson KA, Zeng-Triettler Q, Kandula S. Readability of patient and health care professional targeted dietary supplement leaflets used for diabetes and chronic fatigue syndrome. *J Altern Complement Med* 2010; **16**: 119–24.
- 5 Pothier L, Day R, Harris C, Pothier DD. Readability statistics of patient information leaflets in Speech and Language Therapy Department. *Int J Lang Comm Dis* 2008; **43**: 712–22.

### Declaration of interest

M.B. was educational supervisor during L.M.H.'s attachment to the Public Education Editorial Board.

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### Surprising discrepancy between high prevalence of suicidality and low BSI scores

I would like to congratulate Meerten *et al*<sup>1</sup> on their excellent paper about MedNet, a service for doctors experiencing psychological problems; and, furthermore, for setting up and running the service in the first instance.

The authors cite that doctors are a vulnerable group with high rates of psychological disorders. This is in keeping with previous work myself and colleagues conducted on junior doctors using the 12-item General Health Questionnaire, albeit at a time when they were undergoing a period of extreme stress (the MTAS fiasco).<sup>2,3</sup> We found that 79% of the sample scored above the cut-off point for psychological distress and 21% for severe distress (i.e. caseness for treatment).<sup>3</sup>

What perplexed me about the paper, however, were the high rates of suicidality in the MedNet sample (nearly half) but the relatively low scores on the Brief Psychiatric Interview.

I am not sure that this discrepancy is explained sufficiently in the discussion or, indeed, why the suicidality persisted post-treatment despite the other range of outcome measures used indicating improvement.

I would like to hear more from the authors about their views about this phenomenon.

- 1 Meerten M, Bland J, Gross SR, Garelick AI. Doctors' experience of a bespoke physician consultation service: cross-sectional investigation. *Psychiatrist* 2011; **35**: 206–12.
- 2 Whelan P, Jarrett P, Meerten M, Forster K, Bhugra D. MTAS fiasco: lessons for psychiatry. *Psychiatr Bull* 2007; **31**: 425–7.
- 3 Whelan P, Meerten M, Rao R, Jarrett P, Muthukumaraswamy A, Bhugra D. Stress, lies and red tape: the views, success rates and stress levels of the MTAS cohort. *J R Soc Med* 2008; **101**: 313–8.

### Declaration of interest

P.W. and M.M. know each other well.

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### Psychiatry training and career conundrums – a working mother's perspective

This letter stems from an experience of the numerous problems and choices that a working mother, and a psychiatric trainee, has to face and ones that I hope that many other working mums in psychiatry training will be able to empathise and identify with. Hopefully, it will provide some food for thought and determination to continue a career with a greater conviction.

Having chosen psychiatry as one of my specialty interests as a foundation doctor, I decided to continue my further training in psychiatry, fascinated by the subject, with the work-life balance it offers and the non-resident on-calls at many places as the added attraction. Being a trainee in core psychiatry training seemed to be the right job and the right pace of work I was looking for. But that is when our little one came into our lives and things changed.

Taking time off for maternity leave and coming back to part-time working as a less-than-full-time trainee prolonged the period of training. Specialty training lasts a good number of years and thus extended led me to think about the 'quarter-life crisis'<sup>1</sup> that many trainees in similar circumstances might face. Full-time training helps to achieve training goals earlier but part-time training allows for a more balanced life and more free time for family and children.<sup>2,3</sup> Trainees move in and out of jobs and are committed to training and flexible working.

Indeed, career goals need to be matched to individual circumstances. Many a time I struggled with swapping rotas and arranging for picking up and looking after our child. This made me think time and again whether I should just change my specialty to another interesting basic science or para-clinical subject that will help me avoid the rota headache. There is also the issue of career progression and being an