BMC Medicine

CORRESPONDENCE

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Importance of accurate and accessible recording of healthcare contacts in mental health

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Keywords Mental health, Electronic health records, Data availability, Primary care, Secondary care, Children and young people

Thank you for drawing our attention to the correspondence article by Taxiarchi et al. [1]. Our original study [2] used linked primary care electronic health records (QResearch) and secondary care data (Hospital Episode Statistics) to assess whether there were records of children and young people (CYP) visiting NHS-funded paediatric or psychiatric specialists in secondary care within the 12 months before or up to 6 months after their first primary care antidepressant prescription.

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Taxiarchi et al.'s [1] work looks at a group of CYP in the Clinical Practice Research Datalink (CPRD) in a similar period who had a coded record in their primary care data of being "Seen in child and adolescent psychiatry clinic" or "Seen by child and adolescent psychiatrist" and identifies whether there was a relevant inpatient or outpatient hospital episode recorded in the 12 months before this. This estimates that 27.5% (or at most, 56.0% in a sensitivity analysis looking at 24 months before the primary care record) of those with a CPRD record of having seen a child and adolescent psychiatrist had a corresponding HES record. We highlighted the limitation in our paper that it was "possible that we did not capture all interactions with specialists" [2], and Taxiarchi et al.'s [1] work may point to the extent of contact with the private sector, which is not included in HES data.

These studies are looking at different outcomes for different populations in different datasets, but both highlight the importance of accurate and accessible recording of healthcare contacts in order to describe and quantify healthcare utilisation. In response to the commentary article published at the time [3], we highlighted the information gap that exists when trying to assess issues around mental health care, in particular for children and adolescents [4]. When the Mental Health Services Dataset (MHSDS) was available as linked data to CPRD, it did not contain information from Child and Adolescent Mental Health Services (CAMHS) [5].

Acknowledgements
Not applicable.

Authors' contributions
RHJ wrote the original draft, with all other authors reviewing and editing the manuscript. All authors read and approved the final manuscript.

Funding
The original work was funded by the National Institute for Health Research (NIHR) and conducted by the NIHR Nottingham Biomedical Research Centre. RM is supported by the NIHR MindTech MedTech and in Vitro Fertilisation Collaboration and the NIHR Applied Research Collaboration East Midlands. AC is supported by the NIHR Oxford Cognitive Health Clinical Research Facility, by an NIHR Research Professorship (grant RP-2017–08-ST2-006), and by the NIHR Oxford Health Biomedical Research Centre (grant NIHR203316). The views represented are the views of the authors alone and do not necessarily represent the views of the Department of Health in England, NHS, or the National Institute for Health Research.
The funder had no role in the original design, analysis, and interpretation of the data or in writing either manuscript.

Availability of data and materials
Not applicable.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
CH was the chair of the NICE guideline for psychosis in children and young people (CG155) and a member of the NICE ADHD Guideline update committee (NG87).
SC has received honoraria for talks/lectures from the Association for Child and Adolescent Mental Health (ACAMH), British Association of Psychopharmacology (BAP), Canadian ADHD Alliance Resource (CADDRA), and Healthcare Convention.
AC has received research, educational and consultancy fees from INCiPiT (Italian Network for Paediatric Trials), CARIPLO Foundation, Lundbeck, and Angelini Pharma.
JHC is a professor of clinical epidemiology and general practice at the University of Oxford and co-director of QResearch®—a not-for-profit organisation which is a joint partnership between the University of Oxford and Egton Medical Information Systems (the leading commercial supplier of IT for 60% of general practices in the UK). JHC was also a paid director of ClinRisk Ltd. which produces open and closed source software to ensure the reliable and updatable implementation of clinical risk equations within clinical computer systems to help improve patient care.
RHJ, CACC, RMJ, RM, and RDK declare that they have no competing interests.

Received: 5 April 2023 Accepted: 21 August 2023
Published online: 12 September 2023

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