

Letters

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The challenge of recruiting people with schizophrenia to trials

We appreciated the article by Abbott *et al* for its honest discussion of difficulties encountered with recruiting participants to trials.¹ We have also learnt much from studies with people who have a diagnosis of schizophrenia, which we would like to share. What appeared to encourage recruitment and retention was:

- service users with direct experience of schizophrenia helped to design the study and patient information leaflets and helped recruit and train researchers who interviewed patients;
- practitioners welcomed the study and clearly introduced the study to their patients;
- researchers had past or current experience of using services themselves. This can allay people's fears about being judged or bullied, especially if paranoid;
- repeated attempts were made to contact homeless people and those who were hard to reach and we asked relatives and staff to help us make contact;
- emphasis was put on the participants' role of assisting us with research in order to help future patients, rather than expectations of benefit from the intervention being tested;
- participants were reassured that those in the control group would still be interviewed regularly by the researchers, thus maintaining the social contact.
- at the end of the interview participants were given positive feedback so that they were not left feeling they had failed some test;

- participants were thanked for their time spent completing each research interview with a £10 shopping voucher;
- as well as the repeated assessments every 3 months, contact was maintained throughout the 12 months with a newsletter and cards at Christmas time.

Similar to the study reported by Abbott *et al*, our studies used occupational therapy researchers and has included primary care based work.² In our current pilot randomised controlled trial of occupational therapy for people with psychosis: 50 people were referred by care coordinators; 44 consented; the maximum number of visits to gain informed consent and complete the baseline assessment was four; all those randomised to the experimental intervention have engaged with treatment; and near the end of the 18-month study only two have dropped out of the research. What is different however, and may have made recruitment easier, is that our studies have just focused on mental health and functioning in self-care, leisure, work and relationships. They have not focused on physical health or healthy lifestyles. We agree with the authors that combining these topics with mental health may not be welcomed by potential research participants and require a great deal of sensitivity and consultation.

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Referrals for cataract and Action on cataracts, evidence-based guidelines

The most common referrals made to ophthalmology units are for cataract with the majority of patients referred from the optometrist via the GP.^{1–3} Increasingly we have direct referral from optometrists. We audited our referrals for cataract to assess the information included in the referrals and the outcomes in terms of listing for surgery and reasons for not listing.

We received 412 cataract referrals over a 2-month period, of which 15% ($n = 62$) were referred by the GP. Our 'gold standard' for information was taken from the document *Action on cataracts*,⁴ in which recommendations were made that cataract was the cause of visual loss, that this visual loss resulted in a detrimental effect on the patients lifestyle and the patient was willing to have surgery. The 'gold standard' was reached in 9.7% of referrals from GPs, 8.1% only included willingness for surgery, 3.2% only included effect on lifestyle and 79% just stated the presence of cataract. The overall listing rate for GP referrals was 72.5%. Analysing the full data set of referrals revealed that referrals containing the 'gold standard' information resulted in higher listing rates (85.2% [$P = 0.029$]) compared to referrals just stating the presence of cataract (75.8% [$P = 0.716$]).

Of the 17 GP referred patients not listed, the most common reasons were patient declining surgery (41% [$n = 7$]) and no effect on lifestyle (29% [$n = 5$]). These results were consistent with the full data