Appropriateness of GP referrals of patients with anxiety and depression

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In their guidelines on anxiety and depression, NICE recommends a stepped care approach to patient management. In this study, the authors assessed the appropriateness of GP referrals to their community general adult mental health services of patients with anxiety and depression, according to the NICE guidelines.

In primary care, anxiety and depression account for 80 per cent of consultations for mental health problems.1 (Author: reference a bit out of date - could you find a more recent one?) The National Institute for Health and Clinical Excellence (NICE) guidelines on anxiety and depression outline how to manage these mental health disorders in primary and secondary care.2,3 In order to manage these patients effectively, good communication between GPs and community mental health teams is key. It is therefore important that everyone works from the same framework. In addition, by cutting down on unnecessary referrals to secondary care, there will be less strain on the community mental health team, thereby allowing them to deal with the appropriate referrals more efficiently.

The management of anxiety and depression in primary care presents significant issues for workload and understanding the patient in terms of a biopsychosocial model.4 It is therefore important that strategies are developed within primary care to detect and manage these conditions so as not to divert secondary care resources from so-called severe mental illnesses. It is also likely that patients prefer being managed by a GP whom they have known for a number of years and whose surgery is often closer to their home. While referral does offer a specialist opinion, some patients feel that psychiatry has a stigma attached to it, with which they do not want to be associated.

This study examines the current practice in an urban area with particular reference to primary care management of anxiety and depression. It specifically looks at the stepped care model recommended in the NICE guidelines and identifies the improvements that should be made to patients’ care in the future. The stepped care model provides a framework for appropriate patient care at different stages of their illness. If the patient does not benefit from an intervention, then one from the next step in the model should be offered.

Methods
We examined all GP referrals to our community general adult mental health services, covering a population of 38,000 during the period of June 2008-March 2009. Referrals were assessed against NICE guidelines, specifically monitoring standards of the stepped care model (see Table 2) in patients suffering from anxiety and depression. We examined what care had been given to these patients in primary care prior to their referrals to secondary care mental health services.

Results
We received a total of 204 referrals from seven GP practices during the study period. We included 64 GP referrals (31 per cent) that mentioned primary problems such as anxiety and depression. We excluded all non-GP referrals and referrals that mentioned problems such as drug or alcohol misuse, eating disorder, personality disorder, recurrent depressive disorder with cyclothymia, psychosis, severe depression with or without psychotic symptoms, no diagnosis of mental illness, bipolar affective disorder, obsessive-compulsive disorder, ADHD, evidence of organic illness, psychosexual problems and where there were no details of current symptoms or treatment.

Exactly half of all referrals (32/64) followed the stepped care model (see Table 2). Of the half not following the stepped care approach (Author: Sentences added – OK?), the majority of patients (28/32, 87.5 per cent) had not received any psychological therapy prior to referral to secondary services (or at least this was not mentioned in GP letters). Only one GP had commented on the use of self-help strategies. On the other hand, only a minority of patients (4/32, 12.5 per cent) had not been tried on medication before being referred to secondary care mental health services.
Step | Who is responsible for care? | What is the focus? | What do they do?
--- | --- | --- | ---
Step 1 | GP, practice nurse | Recognition | Assessment
Step 2 | Primary care team, primary care mental health worker | Mild depression | Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 3 | Primary care team, primary care mental health worker | Moderate or severe depression interventions, social support | Medication, psychological
Step 4 | Mental health specialists, including crisis teams | Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk | Medication, complex psychological interventions, combined treatments
Step 5 | Inpatient care, crisis teams | Risk to life, severe self-neglect | Medication, combined treatments, ECT

NB. The stepped care approach in the NICE guideline for anxiety is similar to the depression guideline. Step 1, Recognition and diagnosis; Step 2, Treatment in primary care; Step 3, Review and consideration of alternative treatments; Step 4, Review and referral to specialist mental health services; and Step 5, Care in specialist mental health services

Table 1. Stepped care model for the management of depression, as recommended in the NICE guideline

Discussion

**Author: could you start the discussion by making some more general comments about the proportion of referrals that followed/didn’t follow the stepped care approach? Was this lower than expected? Also, why do you think that some practices performed much better than others? E.g. Practice 1 — could others therefore learn from their practices?**

Only one letter mentioned that the GP had recommended self-help and online cognitive behavioural therapy (CBT); however, this does not necessarily mean that the other GPs had not tried this – they may have just not detailed this in the referral letter. The referral letters were often unclear regarding the interventions (pharmacological/psychological/self-help) that GPs had tried. It was felt that the referral letters should have stated the patient’s current symptoms, the effect on the patient’s life and the interventions tried, which then could have allowed a better assessment by secondary services.

Our results indicate that there seems to be a definite lack of CBT services for patients falling into the category of mild to moderate anxiety/depression. Not all practices had an internal practice counsellor and even if they did there was often a long waiting list (this point was made in several of the GP referral letters).

Our response to several referrals was that the team felt the patient would be more suited in the first instance to being seen by the Primary Care Graduate Mental Health Worker (PCGMHW). However, GPs often seemed confused as to who the PCGMHW was, what their role was, who they could refer to them and how to access them. This resulted in several letters back and forth from the team to the GP and sometimes to the CBT department, often resulting in the team eventually agreeing to assess the patient. This obviously led to long delays to the patient’s care.

It is possible that some GPs were unaware of the NICE guidelines for referral, as some referral letters had not tried to refer the patient to a practice counsellor. It was therefore left to the CMHT to highlight the guidelines in their response letters to the GP.

In order to improve current practice, we suggest that a referral form would be useful, allowing GPs to write their letter as usual but in addition, have a few boxes to tick asking, for example, if psychological or pharmacological measures have been tried, as often there was inadequate information on the GP referral letters.

Regarding self-help strategies, the NICE guidelines (Author: for anxiety or depression, or both?) refer to bibliotherapy based on CBT principles, support groups and computerised CBT programmes. Perhaps a document could be prepared listing suitable books, web-
sites and support groups that GPs could consider trying before referring to CMHT. GPs could also consider referral/signposting patients to other services first such as the Condition Management Programme via the Job Centre, Cruse Bereavement Care, Relate, counselling via work/university or online CBT.

The Improving Access to Psychological Therapies (IAPT) Programme\(^5\) has still not been fully implemented in this area and this programme is currently under review, following the change in Government. Furthermore, waiting lists for the psychological services that are available are often long. We have experienced this working as doctors both in general practice and psychiatry. While it would be useful to circulate the results of this study among GPs, it seems that the real problem lies in the lack of psychological resources. It would be useful to have feedback from GPs to see what they think the main reasons are for not meeting the NICE stepped care guidelines.

**Declarations of interest**

**Author: Any to declare – or may we write ‘None’?**

Dr Belgamwar is a Consultant Psychiatrist, Dr Bates is a GP Vocational Training Scheme (VTS) Trainee, Dr Goes is a GP VTS Trainee and Dr Taylor is a Foundation Trainee, Radbourne Unit, Royal Derby Hospital, Derby

**References**


### Table 2. Proportion of referrals in the seven GP practices studied not following the NICE stepped care model\(^2,3\) for the management of anxiety and depression (n=64)

<table>
<thead>
<tr>
<th>GP practice</th>
<th>No. of referrals not following the stepped care model</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice 1</td>
<td>2/16</td>
<td>12.5%</td>
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<tr>
<td>Practice 2</td>
<td>9/19</td>
<td>47.3%</td>
</tr>
<tr>
<td>Practice 3</td>
<td>13/20</td>
<td>65%</td>
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<tr>
<td>Practice 4</td>
<td>3/3</td>
<td>100%</td>
</tr>
<tr>
<td>Practice 5</td>
<td>4/4</td>
<td>100%</td>
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<tr>
<td>Practice 6</td>
<td>0/1</td>
<td>0%</td>
</tr>
<tr>
<td>Practice 7</td>
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<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>32/64</td>
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