Referral of Patients with Depression to Specialist Mental Health Services

Guidance for GPs

QUALITY IN PRACTICE COMMITTEE

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Guidance for General Practitioners (GPs) on referring patients with Depression to Specialist Mental Health Servies (MHS).

Key Points : The majority of people with depression can be treated effectively in Primary Care

- **Those who are considered at risk to themselves, or are failing to respond to treatment after three months, should be referred for Specialist opinion.**
- **Patients who are referred to MHS usually want their GP to remain involved in their care.**

➢ Once a decision is made to refer a patient, the following steps may be useful:

1. **Refer to the "one point of entry" for the mental health service.** Most mental Health Services use Community Mental Health Centres as the first place for referrals. Based on the patients address the local HSE office will be able to give you the community base and telephone number for referral of your patient.
   Local Contact Telephone Number ☐
2. **Urgent cases should be referred by telephone and followed with a letter.** If you wish to have a patient assessed urgently, this should be discussed with the Mental Health Professional in charge of accepting referrals. This person can be contacted through the "one point of entry" and will advise on where the patient can be assessed.
3. **Give the mental health services as much information as you can on the case.** All referral letters should include; current symptoms, treatment to date, reason for referring at this point in time, past psychiatric and physical history, social circumstances, current medication, and whether you have made any review appointment for this specific problem. If you think a telephone discussion prior to the assessment would be useful, state that on the letter.
4. **G.P.s should inform the patient of the process of MHS team referral assessment and discussion.**

➢ Once a referral is received in the Community Mental Health Service the following occurs:

1. **All urgent telephone referrals are dealt with on the day of referral.** This may include assessment at the community MHS base or, in exceptional cases, at the individuals home. Any decision to admit to hospital is made after this assessment.
2. **Letters on non urgent cases are discussed at weekly allocation meetings.** A member of the team may contact the practice to clarify information, and other options other than referral may be agreed in order to ensure the most efficient use of the specialist MHS team. Each referral will be discussed at a MHS referral assessment meeting (*see below). Depending on the structure of and resources available to MHS teams, and based on the information available to the team, the most appropriate mental health professional from the multidisciplinary team is allocated the referral, and they then arrange to complete a full assessment. The mental health professional may be a **Nurse**, where the mental health problem is not associated with major physical or social problems; a **Psychiatrist**, Consultant or trainee, usually where the case is quite complex, or has accompanying physical illness; a **Psychologist**, where the problems are linked to personality or childhood difficulties; a **Social Worker,** Where family or social problems are present; or an **Occupational Therapist**, where lifestyle issues are particularly relevant. Some teams also have **Cognitive Therapists** or **Family Therapists** and they may be the most suitable person to assess. The general principle is to allocate the mental health professional who will be working with the person throughout their time with the mental health service. *In teams with limited resources, referrals are triaged through medical assessment and then referred to other members of the team.
3. **Once assessed, the person's case will be discussed with the Multidisciplinary Team, led by the Consultant Psychiatrist, and a letter outlining the assessment and management plan will be sent to the referrer.** Depression will usually only require brief input from the specialist mental health service.

Management of Depression in Primary Care

Aims:

• To recognise depression in primary care.
• To manage mild, moderate and severe depression within primary care within a structured framework.
• To involve specialist mental health teams, including crisis teams, in the management of severe, treatment resistant, atypical and recurrent depression and for those at significant risk.

Depression Screening Tools:
Screening questions should be asked when patients present with symptoms suggestive of depression, or if patients are within a high-risk group e.g. a previous history of depression, existing chronic disease, physical illness causing disability, dementia, or other mental health problems.
Two Question Screen plus Help Question:
1. During the past month have you often been bothered by feeling down, depressed or hopeless?
2. During the past month have you often been bothered by little interest or pleasure in doing things?
3. Is this something you would like help with?

If the patient responds yes to either 1 or 2 and would like help then consider asking more detailed questions for depression. (PHQ- 9 can asssit in this http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/)

Recommendations:
Mild depression:
- Watchful waiting, guided self-help (http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/depression.aspx; http://www.aware.ie/help/information/treatments.html)
- Computerised CBT (http://www.getselfhelp.co.uk/; http://www.beatingtheblues.co.uk;
-Physical exercise (gpexercisereferral.ie), brief psychological interventions http://www.psychologicalselfhelp.org

Moderate depression:
- Antidepressant medication, psychological interventions, social support.

Antidepressant Medication:
• Antidepressant medication is not recommended in the management of mild depression.
• Antidepressant medication should be offered routinely to all patients with moderate to severe depression and before psychological interventions.
• An SSRI may be used first line unless contraindicated e.g. fluoxetine or citalopram. SSRIs are as effective as tricyclic antidepressant and are less likely to be discontinued due to side effects.
• Sertraline is recommended for the treatment of depression in patients with Ischaemic Heart Disease.
• Mirtazepine is effective when sleep and appetite are severely impaired.
• Antidepressant medication should be continued for:
- 6 months after remission of symptoms in a first episode of depression.
- 2 years after remission of symptoms if the patient has had two or more previous episodes of depression, or if the first episode is after age 50yrs.
- Patients on maintenance treatment should be re-evaluated, with consideration for age, co-morbid conditions and other risk factors, to continue their maintenance treatment beyond 2 years.
• Consider switching to an alternative antidepressant if there has been no response after 4 weeks; wait until 6 weeks if there has been a partial response.
• Dual acting antidepressants such as mirtazepine, venlafaxine and duloxetine, may be used, if there is failure to respond to two SSRIs. Augmentation may be considered if there is a partial response.
• Patients <30 years of age, and patients considered to be at increased risk of suicide should be monitored 1 week after commencement of antidepressants and frequently thereafter as appropriate.
•All patients require documented follow up.

Failure to Respond: If there is no response within three months, the diagnosis should be reviewed, co-morbid conditions re-considered, and if depressive symptoms remain, or worsen the case should be discussed with the Specialist Mental Health Team.

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