Correspondence

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Are the current guidelines for referral to psychiatry correct?

Dear Editor,

In the recent article by Rogers *et al.* (2013), we were interested to note that the *Guidelines for the Management of Depression and Anxiety Disorders in Primary Care* (Irish College of General Practitioners, 2006) recommended referral to mental health services after two trials of antidepressant treatment. We would question this recommendation, given that it suggests that patients, by definition, should have a diagnosis of treatment-resistant depression before being referred to specialist care.

We concur with the guidelines' suggestion that patients with severe symptoms, an unclear diagnosis or who pose a risk to themselves or others should be referred to mental health services. It has been our experience, however, that a significant number of patients referred with depression do not have the disorder. Rather, they are experiencing psychosocial or relationship difficulties, have an adjustment disorder, or primary substance or alcohol misuse problems. This correlates with Rogers *et al.*'s finding that 34% of their referrals had diagnoses other than depression, or indeed no axis 1 diagnosis at all.

One very valid reason for the high rate of misdiagnosis of depression in general practice (GP) referrals is likely to relate to their necessarily brief consultation times. The average GP consultation time has been found to be 10.7 minutes in a study of six European countries (Deveugele *et al.* 2002), and indeed the authors of this study acknowledged that the practices studied had lower workloads than average doctors in the same countries. Previous evidence suggested an average GP consultation time of 8.4 minutes (Waller & Hodgkin, 2000). Obviously, it is impossible to adequately explore a full psychiatric history in that timeframe. We suggest that one constructive lengthy interview, such as is allowed for in a psychiatric new patient clinic, can allow elucidation of diagnosis and appropriate redirection of patients. Expedited assessment, rather than waiting for two unsuccessful trials of antidepressant treatment, is likely to lead to earlier correct diagnosis, earlier redirection to community resources if appropriate and ultimately benefit the patient to a greater extent. It also negates the notion that there is 'a pill for every ill'. Allen Frances, chair of the DSM-IV taskforce, and a critic of DSM-5's over-inflation of psychiatric diagnoses, has cautioned against the over-treatment of the 'worried well' and reliance on medication to treat normal life experience (Frances, 2013). As psychiatrists, we are uniquely positioned to treat illness in an evidence-based manner, but equally to know what alternative resources patients can avail of locally, if appropriate.

An argument could be made, of course, that this could open the floodgates, leading to increased referrals and longer waiting times. We suggest that perhaps alternative models of care such as onsite liaison by psychiatrists to primary care, such as that in the Cavan/Monaghan service, could be an effective solution (Russell *et al.* 2003). Rogers *et al.* reference the study by Meagher *et al.* (2009), which demonstrated that Irish mental health services have input into a greater proportion of patients with less severe illness than in the United Kingdom. We would argue that we are in a unique position to provide an expert diagnostic opinion, and not just assess severely unwell patients who will require treatment on an ongoing basis. In our service, we frequently discharge patients directly from our new patient clinic, referring them on to local counselling services or support groups. Non-attendance rates are also high at our new patient clinic, consistent with previous studies (Killaspy *et al.* 2000). This hints at a discrepancy between referral and need and ultimately leads to a natural attrition rate that consequently reduces the workload.

In considering the above arguments, however, we acknowledge that the practice of over-zealous referral of patients who have only just been started on an antidepressant is to be avoided. We suggest that patients be referred after an adequate trial of one antidepressant, rather than two, avoiding the suggestion inherent in the ICGP guidelines that psychiatrists should only see severe or treatment-resistant depression.

References

Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J (2002). Consultation length in general practice: cross sectional study in six European countries. *British Medical Journal* **325**, 472.

Frances A (2013). *Saving Normal: An Insider Revolts Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. Harper Collins: New York.

Irish College of General Practitioners (2006). *Guidelines for the Mangement of Depression and Anxiety Disorders in Primary Care*. Health Services Executive: Dublin.

Killaspy H, Banerjee S, King M, Lloyd M (2000). Prospective controlled study of psychiatric out-patient non-attendance. Characteristics and outcome. *British Journal of Psychiatry* **176**, 160–165.

Rogers C, Heatherington S, Carroll M, Leonard M, Cullen W, Meagher D (2013). An analysis of 100 referrals for depression from primary care to an adult mental health service. *Irish Journal of Psychological Medicine* **30**, 237–244.

Russell V, McCauley M, MacMahon J, Casey S, McCullagh H, Begley J (2003). Liaison psychiatry in rural general practice. *Irish Journal of Psychological Medicine* **20**, 65–68.

Waller J, Hodgkin P (2000). *General Practice: Demanding Work – Understanding Patterns of Work in Primary Care*. Radcliffe Medical Press: Abingdon, UK.

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