Referrals for Depression by Primary Care Physicians

A Pilot Study

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BACKGROUND. Communication between primary care physicians (PCPs) and mental health providers (MHPs) is integral to the management of depressive disorders. Our study investigated referrals from PCPs to MHPs in a rural research network.

METHODS. From April 1997 to September 1997, 5 family physicians tracked 6 weeks of referrals for depression and non–mental health problems and assessed the outcomes of these referrals after 3 months. The referrals were characterized by the nature and extent of communication between the PCP and the MHP and by the effectiveness of the consultation.

RESULTS. Sixty-seven patients (44 with non–mental health disorders and 23 with depressive disorders) were identified and followed. Analysis of the initial referral process showed that the referring physicians felt a greater sense of urgency for the referrals for depression. Written evidence of the referral in the patient's chart at the 3-month survey was more common for non–mental health disorders.

CONCLUSIONS. This pilot study demonstrates that there are communication barriers between PCPs and their mental health colleagues. Enhanced communication might improve satisfaction with the referral process. The details of the referral process need further study.

KEY WORDS. Depression; referral and consultation; primary care; communication; mental health. *(J Fam Pract 1998; 47:375-377)*

Submitted, revised, July 21, 1998.
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Collaboration between primary care physicians (PCPs) and mental health providers (MHPs) is an important part of managing depression.[1-3] It was addressed in the 1993 practice guidelines for the detection and treatment of depressive disorders developed for PCPs (Agency for Health Care Policy and Research/National Institutes of Mental Health Clinical Guidelines). Evidence from earlier studies supports collaborative treatment by PCPs and MHPs,[4,5] and suggests that successful referrals depend on effective communication between physicians.[6]

This study assessed physician communication patterns in referrals. The patterns for referrals for depressive disorders were compared with patterns in non–mental health referrals. We used the term referral to mean both brief, focused consultations and transfers of management of mental health problems.

Methods

Five family physicians from the Dartmouth Co-operative Research Network tracked their referrals for 6 weeks using pocket cards. All were attending physicians who worked in rural or suburban group practices with both prepaid and fee-for-service patients. Each provider was asked to record information regarding new referrals for depressive disorders and new referrals for non–mental health conditions, up to a maximum of 10 referrals per week. Repeat visits to consultants, visits to physical therapists, and laboratory and radiologic referrals were not included. No attempt was made to change the usual pattern of referrals. Three months after the initial data collection, providers were asked to complete chart-informed surveys to assess the outcome of the referrals.

We used descriptive and chi-square statistics to analyze the referrals of patients to MHPs compared with other non–mental health specialists. We assessed how referral processes and outcomes are related, and we compared differences between mental health and non–mental health referrals.

Results

Information on 67 patients was recorded: 44 referrals for non–mental health disorders and 23 for

TABLE 1

Initial Referral Process: Depressive Disorder Versus Non–Mental Health Conditions

Referral Characteristic	Depressive Disorder (n=23)	Non-Mental Health Conditions (n=44)	P
Urgency of referral as perceived by PCP, %			
Emergent	10	2	.0044
Urgent	50	16	.0044
Routine	40	81	
Scheduled follow-up interval with PCP, %			
None	14	19	.0038
1 to 2 weeks	37	9	.0038
3 to 4 weeks	37	34	
5 to 8 weeks	26	17	
≥9 weeks	0	40	
Person who contacted consultant, %			
Physician	65	44	.0021
Staff	10	51	.0021
Patient	25	5	
Was the referral scheduled at the time of the index visit?			
Yes, %	30	63	.0153
No, %	70	37	.0153
Type of initial communication from PCP to consultant, %			
None	9	10	.036
Written	21	54	.036
Telephone	70	36	

*Emergent = referral within 24 hours; urgent = referral within 2 weeks; routine = referral after 2 weeks.
PCP denotes primary care physician.

depressive disorders. Of the referrals for depression, the PCPs diagnosed 49% with a major depressive episode, 13% with minor depression, 8.7% with unclassified depressive disorder, 4.3% with dysthymia or chronic depression, and 25% were unclassified. The specialties of the consultants chosen for mental health referrals included: PhD-level psychologists (35%), psychiatrists (25%), community mental health agents (25%), and counselors (15%). Physicians from 19 different specialties provided the 44 non–mental health referrals; the greatest numbers were to general surgeons (5), ophthalmologists (5), gastroenterologists (4), podiatrists (4), dermatologists (3), urologists (3), rheumatologists (3), and neurologists (3). No significant difference in patient age or sex was noted for the depression referrals compared with non–mental health referrals.

Table 1 describes the initial referral process. The perceived urgency of the referrals for depressive disorders was greater than that of the non–mental health referrals. PCPs were more likely to schedule a return visit within 2 weeks for their patients with depression, a finding consistent with the perceived urgency of the clinical problem.

The nature of the contact between the PCP and the consultant differed according to the reason for referral. PCPs were more likely to contact the consultant personally by telephone for patients diagnosed with depression. Often this meant that referral to an MHP could not be scheduled at the time of the patient's first visit to the PCP.

Table 2 describes communication between the PCP and the consultant. Non-mental health referrals were more likely to have chart evidence of written communication from the consultant to the PCP. The PCP often did not consider the consultation for patients with a depressive disorder to be complete at the 3-month follow-up audit, and the number of visits scheduled with the consultant was significantly greater for these patients.

PCPs were less satisfied with the timeliness of the first consultation visit for depression referrals, and with the MHP's communication back to them. Despite their dissatisfaction with components of the referral process, however, PCPs were more positive about the relief of the underlying condition and its symptoms for depression referrals than they were for non–mental health disorders.

Discussion

Our study shows differences in the referral process for depressive disorders compared with non–mental health disorders, as reported by a network of family physicians. The results highlight the perceived urgency of referrals for depressive disorders, the challenge of making mental health appointments, the tendency of PCPs to initially communicate with their mental health consultants by telephone, and the relative paucity of communication back to the referring physician. The latter problem may be due in part to MHPs' concerns about confidentiality in the process of therapeutic relationships.[2,4] The importance of communication between PCPs and consultants suggested by these results is consistent with other studies of the consultation and referral process.[5,7] The PCP's satisfaction with the referral depends on how information is exchanged

TABLE 2

Referral Process and Communication as Described by Primary Care Physician After 3 Months

Referral Characteristic	Depressive Disorder (n=23)	Non-Mental Health Conditions (n=44)	P
Type of communication from consultant to PCP, %			
None	56	29	.0084
Verbal	22	6	.0084
Written	22	66	
Was the consultation complete at the time 3-month follow-up audit?			
Yes, %	35	74	.0067
No, %	65	26	.0067
Number of visits patient made to the consultant, %			
1	6	50	.015
2	13	11	.015
≥3	13	11	
Unknown	69	28	
"My patient was able to be seen as soon as I wanted," %			
Disagree	26	19	.043
Neutral	42	16	.043
Agree	32	65	
"The consultant has communicated to me the appropriate information relevant to this consultation," %			
Disagree	47	32	.031
Neutral	26	8	.031
Agree	26	61	
Regarding relief or resolution of the referral condition, what change do you see in this condition or its symptomatology?			
Negative change, %	5	0	.0082
No change, %	15	54	.0082
Positive change, %	80	46	

PCP denotes primary care physician.

between PCP and consultant. This is consistent with the view of the PCP as an advocate for all aspects of an individual's health care needs. The communication shortcomings we found may be amenable to change.

The limitations of our study include the small number of physicians and patients involved. The fact that the physicians were all men, practice in the same geographic region, and volunteered for the study may make them unrepresentative of primary care providers as a whole. The strength of our study is that it clarifies the differences between depression referrals and non–mental health referrals by examining the difficulties that PCPs experience when communicating with their mental health colleagues.

Conclusions

Referring physicians generally perceived good outcomes for patients with depressive disorders, despite some of the difficulties with the referral process. Further research should focus on refining our understanding of the referral process, with an emphasis on finding ways to improve the flow of communication in both directions between PCPs and MHPs. Possible improvements to the process of referral could include local focus groups of PCPs and MHPs, as well as further discussion regarding the balance between the importance of confidentiality and the need for effective communication.

ACKNOWLEDGMENTS

This study was supported by the John D. and Catherine T. MacArthur Foundation.

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