What Factors Influence Future GPs' Treatment and Referral Decisions When Managing Patients with Mental Health Disorders?

June Fern Tan

Edith Cowan University
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What Factors Influence Future GPs' Treatment and Referral Decisions When Managing Patients with Mental Health Disorders?

June Fern Tan

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of Arts (Psychology) Honours,

Faculty of Computing, Health and Science,

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Submitted (November, 2007)

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Management of Patients with Mental Health Disorders in General Practice

June Fern Tan
Management of Patients with Mental Health Disorders in General Practice

Abstract

Currently, mental health reform in Australia is moving towards a broader and more collaborative system of mental health care, with focus on primary mental health care. The purpose of this literature review was to discuss the management of patients with mental health disorders, in terms of treatment and referral decision-making among GPs in primary care. This literature review indicated the importance of clinical psychologists liaising with GPs to build a good working relationship, support GPs, and provide GPs with the opportunity for referral of patients to their services when needed. To date, research in the area of management of patients with mental health disorders in primary care from Australia were mostly conducted using a quantitative methodology. A few qualitative studies have been conducted in the United Kingdom and New Zealand. The review concluded that more information on the process of referral would be obtained by a concentration upon qualitative studies.

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Management of Patients with Mental Health Disorders in General Practice

It is well established that the prevalence of mental health disorders in Australia is high; as mental health disorders are considered to be among the ten leading causes of disease in Australia, accounting for 13 per cent of the total (Australian Institute of Health and Welfare [AIHW], 2006). According to the 1997 National Survey of Mental Health and Wellbeing of Adults, it was estimated that 20 per cent of Australians will experience a mental health disorder at some point in their lives (McLennan, 1998). Currently, mental health care in Australia is moving towards a broader and more collaborative system, with focus on primary mental health care; as it is recognised by policy makers that GPs play a significant role as a mental health care provider and as a gatekeeper for entry into secondary and tertiary sectors of the Australian Health Care system (AIHW, 2006).

In response to the high prevalence of mental health disorders, the Australian Government committed $120.4 million in year 2001 to establish the Better Outcomes in Mental Health Care (BOIMHC) initiative. This initiative was established to improve the quality of mental health care in Australia by providing mental health education and training to General Practitioners (GPs), improve support for GPs from allied health professionals and psychiatrists, and to address financial barriers for GPs to provide longer consultations (Australian General Practice Network [AGPN], 2007a). In 2005, a further $538 million was allocated to fund the Better Access to Psychiatrists, Psychologists, and GPs through the Medicare Benefit Schedule initiative which builds on the BOIMHC initiative (AGPN, 2007b). In the Better Access initiative, referral pathways were expanded to increase community access to GPs, psychiatrists, clinical psychologists and other allied mental health professionals (AGPN, 2007b).

The purpose of this literature review is to discuss the management of patients with mental health disorders, in terms of treatment and referral decision-making among GPs in
primary care. Firstly, the Australian health care system and current mental health reform will be described followed by a summary of prevalence of mental health disorders in primary care. Then, the management of patients with mental health disorders in primary care including diagnosis, treatment, and referral will be discussed. Lastly, factors which influence GPs’ referral decisions will be discussed and a conclusion will be given. Limitations and implications for future research will be discussed throughout the literature review.

The Australian Health Care System

A description of the Australian Health Care System has been summarised in Appendix A.

*The Australian Mental Health System Reform*

In the past, mental health care in Australia was primarily focussed on institutional and community-based forms of service care (AIHW, 2006). However, mental health reform in Australia is currently moving towards a broader and more collaborative system of mental health care, with focus on primary mental health care. This occurs because GPs see 85 per cent of the Australian population at least once a year, which represents considerable potential in reaching a broader population (AIHW, 2005; AIHW, 2006).

A representation of a historical timeline of events that have influenced reforms in the Australian mental health care system can be seen in Appendix B. Other reasons for these new reforms include partnership between a range of mental health advocacy groups (e.g. ‘beyond blue’) and key professional groups such as the AGPN, Royal Australian College of General Practitioners (RACGP), Royal Australian and New Zealand College of Psychiatry (RANZCP) and, the Australian Psychological Society (APS); the Commonwealth Department of Health and Ageing who incorporated the concerns of the Primary Mental Health Care initiative in terms of the context of the Second Plan of the National Mental
Management of Patients

Health Strategy; and the commitment of a Federal Health Minister to implement reforms in both mental health and primary care sector (Hickie & Groom, 2002).

Two of the many important organisations that play a role in influencing the Australian mental health care system are the Australian Medical Association (AMA) and the Australian General Practice Network (AGPN). The AMA (AMA, 2006) is a health advocacy organisation which represents more than 27,000 general practitioners, specialists, teachers and researchers, and trainee doctors in both government and private practice, and promotes and advances public health and ethical behaviour by doctors; protects the academic, professional and economic independence and the well-being of doctors; preserves and protects the political, legal and industrial interest of doctors; and plays a role in the determination of national health priorities and activities through its representatives for both Federal and State agencies. The AGPN (AGPN, 2007c) which was formerly known the Australian Division of General Practice (ADGP) forms the largest voice for GPs as it represents 119 divisions of GPs in Australia. The vision of this organization is to provide integrated and quality primary health care services though GPs (AGPN, 2007c). It also contributes to the national health policy and provides national leadership in the Australian health care system development (AGPN, 2007c). Therefore, this indicates that changes in mental health care system in Australia is mainly initiated and influenced by GPs, who are the primary care providers.

**Better Outcomes in Mental Health Care initiative (BOIMHC) (2001-2005)**

Since mental health reform is mostly influenced by GPs, this indicates the importance to review the process of education, training and referral initiatives undertaken by the Australian Government since 2001. In July 2001, the Australian Government Department of Health and Ageing allocated $120.4 million over four years to establish the Better Outcomes in Mental Health Care (BOIMHC) initiative (AGPN, 2007a). The aim of the BOIMHC
Management of Patients

initiative was to improve the quality of mental health care in Australia by providing mental health education and training to GPs, improve support for GPs from allied health professionals and psychiatrists, and address financial barriers for GPs to provide longer consultations (AGPN, 2007a). The five main components of the BOIMHC initiative comprised of: the three step Mental Health Process (MHP), education and training for GPs, Focused Psychological Strategies (FPS), Access To Allied Psychological Services (ATAPS), and Access to Psychiatrist Support (AGPN, 2007a). Descriptions of these five components can be found in Appendix C.

It was reported by GPs that there were a few barriers to completing and claiming the 3 Step MHP (Thomas, Jasper, & Rawlin, 2006). Some barriers included difficulties in scheduling the required number of 20 minutes consultation, consumers not returning for the mental health review and administrative complexities arising from the Service Incentive Payments (SIP) as tax is charged on SIP and delayed payment (Thomas et al., 2006). In regards to education and training for GPs, while it is anticipated that it would lead to improved health outcomes in patients, it is still unknown if this is the case; as currently, data on measures of this outcome are still unavailable (Thomas et al.).

The study by Morley, Kohn, Pirkis, Blashki, and Burges (2004) which draws on information from the local evaluation reports of the Round 1 pilot and supplementary projects found that there were some difficulties that arose with the ATAPS. This includes confusion regarding how projects operate, payment issues, paper work associated with referrals, and variable levels of feedback from allied health staff (Morley et al., 2004; Thomas et al., 2006). However, there were also benefits that were observed by GPs. This included improved collaboration with allied health professionals, new skills and knowledge in the area of mental health, and new referral options (Morley et al.). Allied mental health professionals also reported improved relationships with GPs, an increased referral base, and professional
support (Morley et al.; Pirkis et al., 2006); and most importantly, it has enabled between 3,476 and 3,656 consumers to access high quality mental health care which would otherwise have been impossible without this project (Morley et al.).

Bradstock, Wilson, Cullen, and Barwell (2005) evaluated the Access to Psychiatrist Support by administering surveys to 450 randomly selected GP services users in Australia. However, the response rate of this study was low (only one-third of GPs in the sample responded); therefore, may not be representative of how all GPs who used the Access to Psychiatry Support felt about the service. Nevertheless, Bradstock et al. (2005) found that among GPs who responded, 85 per cent reported feeling satisfied with the service as it was accessible, reliable and the advice were appropriate. Additionally, more than 70% of GPs stated that contact with the service had increased their knowledge and in managing mental health problems, and thus, suggesting that perhaps the use of the Access to Psychiatrist Support may lead to an improved quality of care provided by GPs to their patients (Bradstock et al.).

The review of this section of the literature review suggests that not only do GPs appear to be the ones who propose changes in the mental health system, but they will also be the ones to evaluate whether the changes were beneficial. Whether this process has actually resulted in a better mental healthcare system will be further discussed in the following section.

**Better Access to Psychiatrist, Psychologists, and GPs through the Medicare Benefit Schedule Initiative (2005-Present)**

In 2006, the Australian Government committed $1.9 billion over five years to improve access to mental health services, with a commitment of $538 million over 5 years to continue and expand the new phase of mental health care through the Better Access to Psychiatrist, Psychologists, and GPs through the Medicare Benefit Schedule initiative (ADGP
The Better Access initiative builds on the BOIMHC initiative with an increased range of referral pathways to complement the range of initiatives funded under the BOIMHC in aim to increase access of community to GPs, psychiatrist, clinical psychologist and other allied mental health professional for mental health care (AGPN, 2006; AGPN, 2007b; GP Partners, 2006). The three new Medicare items for GPs introduced to provide a structure framework for GPs to undertake early intervention, assessment and management of patients with mental health disorders, where items are based on a similar model of care (assess, plan and review) as the BOIMH 3 Step Mental Health Process. (AGPN, 2006; AGPN, 2007b). The first new Medicare item is the GP Mental Health Care Plan (item 2710) which involves the assessment of a patient and a structured approach in preparation of the Mental Health Care plan (AGPN, 2006). Under this item, GPs can refer patients for psychological treatments to clinical psychologists, psychologists, social workers and other allied health professional who are registered with Medicare Australia (AGPN, 2006). The second new Medicare item is the GP Mental Health Care Plan Review (item 2712) which enables a review of the patients’ progress against goals outlined in the GP Mental Health Care plan and the third new Medicare item is the GP Mental Health Care Consultation (item 2713) which enables extended consultation with a patient (AGPN, 2006).

Under the Better Access initiative, a few changes were made to the projects introduced in the BOIMHC. Firstly, GPs were only allowed to use the GP Mental Health Care items instead of the 3 Step MHP as of 1 November 2006 (AGPN, 2006). Familiarisation training was no longer required and no practice accreditation or training was required for GPs to refer patients, including referral of patients though the ATAPS (AGPN, 2007b). However, in regards to GPs who wished to deliver FPS, training level two was still required (AGPN, 2006). Due to positive reports from GPs of Access to Psychiatric Support during the
BOIMHC, this project continued to be funded to provide a network for all GPs to seek patient management advice from a psychiatrist (AGPN, 2006; AGPN, 2007b; Bradstock et al., 2005).

Despite significant changes in the mental health reform in Australia over the last 15 years, recent submissions to the Senate Inquiry suggested that the mental health care system still requires substantial reform as the reform is still “incomplete” (Townsend, Pirkis, Pham, Harris, & Whiteford, 2006). Particularly, the importance of the system to be re-oriented towards benefiting consumers and carers as in the present moment, the mental health system seem to be focussed primarily on GPs’ inputs and evaluations, and the extent to which consumers and carers are consulted and have their views evaluated are small (Bracken & Thomas, 2001; Townsend et al., 2006). Therefore, this perhaps suggests the need for GPs to play a role in providing advocacy for their patients.

It was also suggested by Townsend et al. (2006) that more intersectoral linkages between mental health sectors, housing sectors, employment sectors and justice sectors are needed to improve care needed by people with mental health disorders. This model proposed by Townsend et al. presents a potential alternative to the current model which primarily involves input by GPs and policy makers responding to GPs’ input. It could be suggested that it would be useful to involve GPs in the process of developing this broader model proposed by Townsend et al., since policy makers highly regards the input of GPs. As mental health is now one of the top ten leading causes of disease in Australia, the issue of sustainability of funding to the mental health system is of concern (Townsend et al.). It was also reported that while most mental health care is delivered in primary care, there are some GPs who are still not trained in the area of mental health (Townsend et al.). It is possible that perhaps these GPs are only supported by other GPs who have done the training in their local practice (B. H. Tan, personal communication, August 25, 2007).
Prevalence of Mental Health Disorders in General Practice

Research by the Australian Institute of Health and Welfare (AIHW, 2005) found that 85 per cent of Australians visit a GP at least once a year, and from year 2003 to 2004, almost 11 million people visited their GPs regarding mental health issues (Britt et al. 2003). According to Britt et al., 11.3 per cent of problems managed by GPs are for mental health disorders. Depression was found to be the fourth most commonly managed problems in general practice (3.7 per 100 encounters) (AIHW, 2006). According to Mathers et al. (2003), depression is also identified as one of the leading causes of what they term disease burden in Australia, and is also predicted to be one of the major health problems worldwide by 2020. Other frequently reported problems managed were for anxiety, sleep disturbances and acute stress reaction (AIHW, 2006).

The issue of high prevalence of mental health disorders is of concern because it is estimated that 1 in 5 of the Australian population will experience a mental health disorder at some point in their lives (McLennan, 1998). The low level of people seeking help for their mental health disorders is also a concern as the BEACH (Bettering the Evaluation and Care of Health) program conducted by Britt et al., (2003) found that majority (62 per cent) of people with mental health disorders do not seek any professional help. It could be suggested that perhaps this was due to reasons such as fear of being stigmatised or labelled (Cape & McCulloch, 1999; McNair, Hight, Hickie, & Davenport, 2002). Nevertheless, the BEACH program found that of the 38 per cent who do seek professional help for mental health disorders, three quarters visited their GP as a first point of contact (Britt et al.). This underscores the importance for GPs to have the knowledge and training to identify, treat and refer patients with mental health disorders. Additionally, it also indicates that a broader view of mental health may be required for significant policy reform.
Management of Patients with Mental Health Disorders

As proposed by the Better Access initiative, the first step when managing patients with mental health disorders in general practice is the preparation of the GP mental health care plan where an initial assessment is conducted (AGPN, 2006). This includes taking patient history, present complaints, mental state examination, making diagnosis and administering outcome measurement tools where appropriate. This is followed by the development of the GP mental health care plan where the GP discusses the results of the initial assessment and treatment and referral options with the patient, set appropriate goals and finally the review the GP mental health care plan; whereby in this process, the GP reviews the patient’s progress against the goals outlined and may modify the plan if required (AGPN, 2006; Bower & Gilbody, 2005; Treatment Protocol Project (TPP), 2000). However, at the present moment, it is not known how many GPs in Australia actively manage their patients using the GP Mental Health Care Plan. Future research is needed to evaluate how many GPs use the Mental Health Care Plan to manage their patients.

Diagnosis of Mental Health Disorders

Different instruments and tools are used by GPs to diagnose mental health disorder in their patients. Some of these include the use of formal psychiatric classification tools such as the International Classification of Diseases (10th revision) (ICD-10) (WHO, 1994) and the DSM-IV (American Psychiatric Association, 1994); disorder specific scales such as the Kessler Psychological Distress Scale (K10), Depression Anxiety Stress Scale (DASS), the Alcohol Use Disorders Identification Test (AUDIT) (AGPN, 2006); mental state examination (TPP, 2000); and self-administered General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1988) However, despite the use of these instruments and tools by GPs to assist them in the identification of mental health disorders, there have been several studies that have found that mental health disorders are underdiagnosed by GPs (Aragones, Pinol, Labad,
Folch, & Melich, 2004; Borowsky et al., 2000; Burns, Dening, & Baldwin, 2001; Freeling, Rao, Paykel, Sireling, & Burton, 1985).

In Freeling et al.’s (1985) study, patients from 31 practices who consulted their GPs were screened for depression using the 30 item GHQ and then doctors were asked to review the consultation and identify patients who had been given treatment for depression. Patients who were unidentified were then interviewed by the researcher and findings were compared with those who were identified with the doctor (Freeling et al.). Similarly, in Aragones et al.’s (2004) study, 906 patients were screened for depression, and then randomly selected participants were interviewed using the Structured Clinical Interview for DSM-IV and then GPs determined which patients had depression. It was found in Freeling et al.’s study that only half of the patients with severe depression were diagnosed; while in Aragones et al.’s study, about 72 per cent of patients with depression were diagnosed. As found in Freeling et al.’s study, unrecognised patients were found to be more likely to have a physical illness which contributed to depression and were less likely to admit to symptoms of depression or complain about symptoms of depression. Therefore, this could be the reason why half of the patients with depression in Freeling et al.’s study remained undiagnosed. This speculation is supported by Aragones et al.’s (2004) study which found that the severity of depression and complaint of explicit psychological depression were factors which were positively associated with diagnosis of depression. Additionally, Aragones et al’s (2004) study also found that educational level was also associated with diagnosis of depression.

Thus, this may suggest that perhaps more training is needed for GPs to increase early diagnosis of depression, so that patients who show depression even in its milder form and in the presence of other physical illnesses can receive appropriate treatment. Early detection of depression may also reduce the large amount of funding needed for expensive
pharmacological and psychosocial treatment of depression; hence, allowing a more efficient use of the mental health budget.

A qualitative study by the MaGPIe Research Group (2005) was conducted to explore reasons why patients chose not to disclose psychological problems. Participants were 3414 patients who completed the GHQ-12 and were invited to participate in a structured in-depth interview. It was found in this study that patients’ reasons for choosing not to disclose psychological problems included their unwillingness to discuss their psychological problems with anyone, beliefs that a GP is not the appropriate person to talk to and concerns about aspects of their relationship with their own GP. Additionally, some studies have found that people who have mental health disorders may not want to reveal their problems due to stigma and labelling associated with mental health disorders (Cape & McCulloch, 1999; McNair, Hight, Hickie & Davenport, 2002) and may only initially present with physical symptoms such as sleep disturbances, weight changes or psychosomatic complaints (Krupinski & Tiller, 2001; Hickie, 2000; Montano, 1994). This suggests that there is a need to improve the knowledge of consumers regarding the role of a GP and the need to increase education regarding mental health disorders in the community to reduce the stigma associated with mental health disorders (MaGPIe Research Group, 2005). Furthermore, the results of this study by the MaGPIe Research Group suggests the importance of relationship building between GPs and patients as this may have a potential on increasing involvement of patients in the consultation and shared treatment decision-making which may then lead to better outcomes for the patient (Charles, Gafni, & Whelan, 1997).

Identification of mental health disorders can also be attributed to the GPs’ communication skills. GPs with good communication skill are more sensitive to verbal and nonverbal communication (Davenport, Goldberg, & Millar, 1987; Goldberg, 1998); therefore, are more likely to communicate in a way which would make their patients feel
comfortable so that they would be more likely to disclose any psychological distress that they may be experiencing (Weiner, Barnett, Cheng, & Daaleman, 2005). For example GPs with good communication skills would communicate with their patients using verbal encouragement, avoiding interruptions, expressing empathy (Beck, Daughtridge, & Sloane, 2002) and asking patients using open rather than closed questions to facilitate openness, so that their patients can tell a “better story” (Launer, 1998) and thus, making it easier for doctors to detect and identify psychological distress. Clearly, this again underscores the importance of relationship building between GPs and patients (Charles, Gafni, & Whelan, 1997; Elwyn, Edwards, Kinnersley, & Grol, 2000; Heszem-Klemens & Lapinska, 1984; Krupat et al., 2000).

Confidence in detection of mental health disorders can also be attributed to a GPs’ academic ability and training. A randomised-controlled study by Howe (1996) also found that United Kingdom (UK) GPs who were only given brief self-directed education intervention focusing on detection of psychological distress over a period of three months improved their ability to detect psychological distress following the intervention. The baseline percentage of detection for GPs in the trial group was 43 per cent and 45 per cent for the control group and following the intervention, detection of mental health disorders for control group GPs was 44 per cent while the trial GPs detection rates increase to 52 per cent (statistically significant compared to baseline results for trial GPs). Therefore, the results of this study demonstrated that even a brief training would be beneficial in significantly increasing GPs’ ability to detect and diagnose mental health disorders. It would be useful for future studies to replicate Howe’s study to a group of GPs in Australia to compare the results.

Dew, Dowell, McLeod, Collings, and Bushnell (2005) conducted a qualitative study in New Zealand (NZ) to explore the issue of GP recognition of mental health disorders and were asked to consider what they thought their role was in relation to mental health.
Participants in this study were 70 GPs recruited from a follow-up longitudinal cohort study known as the MaGPie study. In this study, data were collected based on three small-group discussions with GPs. Topics covered in the discussion groups were GP perceptions of barriers to mental health consultations, the extent to which mental health care was seen as part of their role as a GP, what influenced their decisions to initiate discussion of mental health issues and their views on what influences patients to disclose or not. To facilitate the discussion, fictitious vignettes of patients presenting for a consultation with a mental health issue were used. The discussion was audio-taped and transcribed verbatim, followed by thematic analysis to identify the recurring themes.

The four themes that arose from the analysis of Dew et al.’s (2005) study were practice pressures; medico-legal factors; socio-cultural factors; and the consultation process. Firstly, GPs reported that the main practice pressures were lack of time to provide a thorough consultation to identify the mental health issue and the difficulty with labelling a patient to ensure access to secondary services. Secondly, medico-legal factors were another factor which influenced the consultation process. For example, GPs reported that sometimes it was safer to not diagnose and treat psychological conditions and to even stay away from dealing with mental health disorders, in case they were wrong and led to the patient suffering disadvantages such as getting a lower insurance premium (Dew et al.). Thirdly, socio-cultural factors such as the stigma associated with labelling were also suggested by GPs as a factor which influenced the consultation process. For example, if a GP diagnoses a patient with a mental health disorder, the patient may take that as a label that defines them (Dew et al.). Dew et al. also suggested that some patients may resist and will not acknowledge the label and this may lead to the patients resisting treatment. One GP in this study suggested he or she would avoid using diagnostic labelling when discussing treatment options. Lastly, the GPs in
this study reported that mental health consultations were difficult when they were ambivalent about the mental health services that could be offered to the patients.

It was clearly indicated in Dew et al.’s (2005) study that GPs are aware that the medicalisation of mental health such as diagnosis and labelling can be disadvantageous to patients. Nevertheless, the diagnosis of mental health disorder is important to GPs, as it would allow appropriate treatment and referral decisions, and assist communications between GPs and other mental health professionals. Thus, perhaps the best practice is for GPs to be sensitive about the affect of diagnostic labelling on their patients (Dew et al.). The results of Dew et al.’s study also clearly indicate the need for good relationship building between GPs and their patients when dealing with mental health disorders and improvement of working relationships between the general practice and other mental health services. However, it is important to note that since this study was done in NZ, it is not known if the findings are transferable to Australia. Hence, this implies the need for Dew et al.’s study to be replicated in Australia.

_Treatment and Referral of Patients with Mental Health Disorders_

In 2001, Krupinski and Tiller conducted a study to assess the level of recognition and knowledge about treatment of depression among Australian GPs. This quantitative study included 2500 GPs who were asked about demographic details, and assessed in their knowledge and skills in regards to the treatment of depression. This was a followed by a presentation of four vignettes and questions on how they would make a diagnosis and suggest treatment (Krupinski & Tiller, 2001).

The findings were that GPs were competent in their recognition of depression but some GPs concentrated on somatic symptoms such as sleep disorders and weight change, instead of using the symptoms presented in the DSM-IV (Krupinski & Tiller, 2001). In regards to treatment of depression, around 60 per cent of the GPs in Krupinski and Tiller’s
study reported preference for using a combination of medication and psychosocial treatment for depression. This suggests that it may be the case that majority of GPs prefer to treat patients with depression themselves by means of medication and psychosocial treatment rather than referring their patients to other mental health professionals such clinical psychologists. Additionally, Krupinski and Tiller reported that there is a need to increase GPs' confidence as GPs were confident when managing depression in adults and elderly patients, but lacked confidence when managing depression in children, pregnant and suicidal patients.

The results of the Krupinski and Tiller (2001) study suggest that more mental health training is needed for GPs in primary care particularly in the management of depression, among patient groups who are children, pregnant, and suicidal. Additionally, there may also be a need for evidence-based clinical guidelines for managing depression in children and pregnant patients, and especially for patients with suicidal risk which requires urgent attention from GPs in primary care (Russell & Potter, 2002).

In 2005, the MaGPie Research Group conducted a cross-sectional survey among 70 GPs to describe the treatment of common mental health disorders in relation to the level and severity of psychological problems as defined by GPs. In this quantitative study, it was found that the more severe the level of psychological problem identified, the higher the level of treatment. Secondly, the likelihood of treatment being given was also positively associated with consultation frequency. When patients were given a clear diagnosis, over 90 per cent received treatment, with the majority (74 per cent) receiving pharmacotherapy, half receiving discussion and counselling, and 22 per cent referred to a mental health professional. However, for those patients without a clear diagnosis, management was provided only through counselling and discussion instead of pharmacotherapy. Hence, the results of this
study again indicate that referral of patients with mental health disorders to other mental health professionals such as psychologists and clinical psychologists were not common.

A qualitative UK study by Lucas, Scammell, and Hagelskamp (2005) was conducted to examine how GP registrars (GPRs) feel about managing mental health disorders in primary care. In this study, participants were 16 GPs (7 males and 9 females) who were interviewed, using a semi-structured interview regarding topics such as mental health training, experiences with detecting and managing mental health problems in primary care, area of confidence or concern, beliefs about the aetiology of common mental health problems and their treatment, and knowledge of resources and support (Lucas et al., 2005). Similar to Dew et al.'s (2005) study, the interviews in Lucas et al.'s study were audiotaped, transcribed, and analysed for identification of themes.

Lucas et al.'s (2005) study found that firstly, GPRs were able to think beyond the biomedical paradigm and knew how to interpret mental health disorders as a product of medical, social and psychological factors. Secondly, while GPRs were confident in detecting and diagnosing mental health disorders using the DSM-IV, they regarded management of mental health as an area of uncertainty and reported lack of confidence in discussing emotional problems. Some of the barriers to effective management of mental health disorders reported by Lucas et al. included inadequate time to deal with mental health disorders and lack of knowledge of referral to mental health services. Some GPRs had more understanding in knowledge of referral pathways than others and, even though there were practice counsellors attached to the practices, few GPs were aware of precise referral criteria and type of counselling offered (Lucas et al.). This is an important study which indicates that there are process issues (in terms of GPRs' knowledge and confidence about referral) with the service provision. Nevertheless, GPRs reported that training in psychiatry helped in increasing skills to deal with mental health disorders.
The results of Lucas et al.'s (2005) study suggests that GPRs are aware of the biopsychosocial nature of mental health disorders and are confident in using the DSM-IV to diagnose mental health disorders. However, GPRs may require more training in regards to appropriate and available treatments for mental health disorder and would also perhaps benefit from communication skills training (Langewitz, Eich, Kiss, & Wossmer, 1998) to improve their confidence in discussing emotional problems. Indeed, one might speculate that perhaps many GPs may report the same issues found in Lucas et al’s study.

On the basis of the studies reviewed in this section, the author has found that studies conducted in the area of management of patients with mental health disorders from NZ (Dew et al., 2005) and UK (Lucas et al., 2005; MaGPie Research Group, ) are mainly qualitative; while studies conducted in Australia are mainly quantitative (Harrison & Britt, 2004; Krupinski & Tiller, 2001). Thus, this suggests a clear need for more qualitative studies to be conducted in Australia.

Factors which Influences GPs in their Referral Decisions

It is important to understand the factors that influence the way GPs refer patients with mental health disorders to other mental health professionals as this understanding may lead to better working relationships between GPs and other mental health professionals and appropriate referrals of patients to mental health services. Earlier studies that were conducted to understand GPs’ referral behaviour usually adopted a quantitative methodology by administering surveys to measure variation of rates of referral among GPs and are focussed on finding correlations between referral rates, and GP characteristics (e.g. age, gender), patient characteristics (e.g. age, gender, condition) and service characteristics (e.g. psychiatric services, psychological services) (Wilkin & Smith, 1987; Creed, Gowrisunkur, Russel, & Kincey 1990; Verhaak, 1993). However, recent studies in the UK are leaning towards the use qualitative methods such as interviews to identify explanatory factors which
influence referral decision-making among GPs; as more information may come to light when qualitative questions are asked (Knight, 2003; Sigel & Leiper, 2004).

In 2003, Knight conducted a qualitative study to identify factors considered by UK GPs when making mental health referral decisions and to explore referral strategies and related individual difference between GPs. In this study, nine GPs completed a structured interview consisting of nine brief case vignettes, followed by three questions for each vignette. The questions that were asked included what treatment and action they would recommend, if they would refer, the main reasons for their decision and what outcomes they would expect. Additionally, a short questionnaire was administered to identify how much different factors were taken into account in the referral decision-making process. All interviews were audiotaped, transcribed and the data was analysed using content analysis.

In Knight’s study, the identified factors that influenced referral decisions were grouped into: (a) patient-related factors, (b) service-related factors, and (c) doctor-related factors. In terms of patient-related factors, the type of problem the patient was presented with had the most influence on referral decisions. Other important patient-related factors found in Knight’s study included the chronicity and severity of the problem, patient’s wishes and preference, patients’ needs and the patient’s characteristics and situation. Secondly, in terms of service-related factors, the availability of the mental health service were considered the most important factor which influenced referral. However, it was reported by Knight that several doctors expressed problems concerning waiting lists and the time it takes to get patients seen by mental health services. Other service-factors include the quality of the services, liaison, and the suitability of a service for a particular mental health disorder. The most frequent doctor-related factor mentioned in Knight’s study was GP time and availability as GPs reported they would refer when they did not have the time to deal with difficult mental health issues which needed intensive therapy. Other factors included referring to gain
advice and second opinion, when they were not experts in that field and when they could not cope with the emotional involvement. Lastly, Knight’s study found that UK GPs differed in referral rates, strategies used, confidence and interest in dealing with mental health problems.

The results of Knight’s (2003) study indicates that mental health services need to be improved in terms of providing quicker access for patients who are being referred by their GPs. Furthermore, more collaboration and interaction between GPs and other mental health professionals would also be useful as it may allow GPs to gain advice or a second opinion regarding management of mental health disorder (Sigel & Leiper, 2004). Additionally as suggested by Knight, it may also allow GPs to share the workload to avoid “burn-out” due to too much emotional involvement. It could be argued that the use of vignettes may have some limitations as it is not the same as seeing an actual patient. However, the vignettes in Knight’s study were actual case examples seen in psychology outpatient clinics, in community mental health teams and in primary care counselling and it was reported by GPs in Knight’s study that the case vignettes were realistic.

It is important to note that currently there has been no qualitative study that has been conducted in Australia to identify factors which influences referral of patients with mental health disorders. Thus, this show the importance of replicating Knight’s (2003) study in a group of GPs in Australia as the findings of Knight’s study may not be transferable to Australia since the structure of mental health services in the UK is different from Australia. Additionally, it would also be important to a replicate Knight’s study to group of future GPs in Australia to identify how they plan to treat and refer patients to mental health services, and the factors that they will take into account in future referral decision-making.

In 2004, a qualitative study was conducted by Sigel and Leiper to explore UK GPs’ views of their management and referral of psychological problems. Participants were ten GPs who were interviewed using a semi-structured, open-ended interview. Questions that were
asked included the following: how GPs define and detect psychological problems; GPs’ views of psychological therapies; factors leading GPs to refer for psychological therapies, as compared with pharmacological treatment; and factors which GPs consider in choosing between different psychological therapies (Sigel & Leiper, 2004). The interviews conducted were audiotaped, transcribed and then analysed using a grounded theory method. A theoretical model of how GPs explore psychological problems in the context of containing patient’s health problems in terms of five components were developed in this study (Sigel & Leiper, 2004).

The first step of the model is the exploration of the psychological problems where GPs evaluate symptoms in terms of potential mental health issues and make an evaluation of whether the issue needed attention (Sigel & Leiper, 2004). The second step of the model is the GPs’ role in containing the patients’ health problems such as helping patients through problems and facilitating access to other mental health services. The third step of the model is GPs’ views of the psychological problems and therapies. For example, GPs in Sigel and Leiper’s study conceptualised mental health disorders in terms of how the patients were coping with them and consider outcomes of psychological therapies which may help patients to better deal with their mental health disorders.

The fourth step of the model deals with referral decisions (Sigel & Leiper, 2004). Similar to the results of Knight’s study (2003), Sigel and Leiper’s study reported that doctor-related factors, patient-related factors and services-related factors all had an influence on referral decisions. Firstly in terms of doctor-related factors, GPs in Sigel and Leiper’s study reported referring patients to other mental health services when they felt that they have reached their limit of their expertise for addressing the mental health disorder or when GP’s treatment did not improve the patients’ outcome. It was also reported by GPs in this study that referral decisions were made when GP did not have enough time to deal with the mental
health disorders. In terms of patient-related factors, referral decisions were based upon the patient's preferred psychological treatment over the other treatments availability, the characteristics of the patients such as their insight and ability to articulate problems and their motivation and readiness to engage in psychological therapy. In terms of service-related factors, GPs in this study also reported the difficulties with accessing mental health services due to long waiting list. Lastly, GPs reported the importance of having good communication and a good relationship with psychologists to gain advice and feedback regarding progress of patients who were referred. Thus, this again suggests the importance for mental health services to improve their service and the need for more interaction between GPs and other mental health professionals. Sigel and Leiper’s study should be replicated in Australia as this study has demonstrated the benefit of using a grounded theory to develop a clear structured theoretical model of how GPs explore mental health disorders.

Patient-related Factors

As reported by Knight (2003) and Sigel and Leiper’s (2004) studies, the type of problem, chronicity and severity, patient’s wishes and preference, patients’ needs, patient’s characteristic and their motivation and readiness to engage in psychological therapy were all patient-related factors that influenced GPs’ decision to make referrals.

Other patient-related factors which may influence GPs’ referral decisions were found by Verhaak (1993). In this quantitative study, a total of 161 Dutch GPs were recruited and asked to provide data regarding reasons for patient’s visits, the diagnosis, the treatment and whether or not they were referred and complete a questionnaire regarding perception of tasks regarding mental health care, opinions about psychosocial nature of illness and mental health care services in the region. Data was then analysed using ANOVA and Chi–square. Firstly, it was found that age and sex had an influence on GPs referral decisions as GPs in this study tended to refer younger men to ambulatory mental health care, while elder patients were more
commonly referred to psychiatric services. Secondly, similar to Knight’s (2003) finding, Verhaak also found that severity of mental health problem was a factor which influenced GPs in their decision-making as GPs would refer severe psychiatric disorders to psychiatric services, whereas social problems were usually referred to social workers. However, there was no data on when GPs would refer patients to psychologists. More qualitative research is needed to identify other patient-related factors which influence GPs’ referral decisions. It is hoped that eventually a guideline or a handbook may be developed to advice and assist GPs in making referral of patients with mental health disorders to appropriate mental health services so that outcomes for patients may be improved.

Service-related Factors

Research has identified several service-related factors that influenced GPs in their decision-making in regards to referral of patients with mental health service (Hull, Jones, Tissier, Eldridge, & Maclaren, 2002; Knight, 2003; Sigel & Leiper, 2004; Trude & Stoddard, 2002) As discussed previously, both studies by Knight, and Sigel and Leiper have identified waiting time and availability of the service as a important service-related factor which influenced GPs in their decision-making in the referral of patients to mental health services.

In Trude and Stoddard’s (2002), study, a survey regarding information on practice arrangement and ownerships, and physician’s views on their medical practice, and a questionnaire regarding mental health services were administered to primary care physicians in 60 sites in the United States. It was found in this study that the locality of the mental health services was a factor which influenced a GP’s decision for referral. For example doctors who work with mental health specialists in the same practice in the same location reported to be less likely to have problems in obtaining mental health services for their patients compared to solo-practices doctors (Trude & Studdord, 2002). It was also found in this study that more than half of primary care physicians reported that they could not obtain
referral for high-quality outpatient mental health care all the time. Therefore, this proposes a
need for more high-quality mental health services to be available for access. In the future,
studies regarding GPs’ perception of mental health services should be conducted for the
group of GPs in Australia as it is anticipated that results would be similar.

Hull, Jones, Tissier, Eldridge, and Maclaren (2002) conducted a quantitative study
where surveys were administered to UK GPs to examine relationship style between GPs and
Community Mental Health Teams and the effect on referral rate. It was found that a
“consultation-liaison” relationship where there GPs and CMHT meet on a regular basis, with
face-to-face contact to discuss cases increased referral rates (Hull et al., 2002). It was also
mentioned by Knight’s (2003) study that liaison and collaboration with therapists were
considered by GPs as a positive factor. Thus, this suggests that a good working relationship
between GPs and other mental health professionals may influence GPs decision to refer. In
the future, more qualitative research is needed to explain how different relationship styles can
influence GPs’ referral decisions.

This section of the literature review has noted that the availability of access to mental
health services, especially to high-quality services and a good working relationship between
GPs and other mental health professionals are important factors which can influence referral
of patients to mental health services.

Doctor–related Factors

Time and availability were the most commonly mentioned factors that influenced
referral decisions among GPs (Knight, 2003; Meadows, Liaw, Burgess, Bobevski, & Fossey,
2001; Nandy, Chalmers-Watson, Gantley, & Underwood, 2001; Russel & Potter, 2002; Sigel
& Leiper, 2004; Trude & Stoddard, 2003). Referrals were most likely when GPs did not have
the time to deal with the mental health disorder appropriately during consultation time with
the patient (Sigel & Leiper, 2003; Knight, 2003). This again clearly indicates that GPs prefer
to treat their own patients rather than refer. Therefore, it could be suggested that perhaps it is important for mental health professionals such as clinical psychologists to build a good working relationship with GPs, support and advice GPs, and provide GPs with the opportunity for referral of patients to their service when needed.

Two other factors which influence GPs’ referral decisions were the GPs’ expertise and needing advice (Knight, 2003; Sigel & Leiper, 2004). For example, GPs would refer their patients to therapists when they felt the mental health disorder was out of their expertise and when they had reached the limits of their capabilities for treating a particular mental health problem (Kravitz et al., 2006; Sigel & Leiper, 2004). Studies by both Knight, and Sigel and Leiper also suggest that a GP would refer patients to other mental health professionals to receive advice regarding a patient’s mental health problems and to learn more about psychological therapies as it was reported by GPs that there is lack of training in GP education regarding psychological therapies (Knight, 2003; Sigel & Leiper, 2004). This suggests the importance of increasing GPs’ training to increase competency of GPs in providing mental health care. However, it should be cautioned that it is not known if this is the case in Australia; as the author has not found any Australian research which uses a qualitative approach such as in Knight, and Sigel and Leiper’s studies in the area of referral of patients with mental health disorders.

Another factor which may influence the GP’s decision to refer patients is the perception of success of the treatment. For example, Alvidrez and Arean’s (2002) study found that doctors who believe that psychotherapy would be useful for treating late-life depression would tend to refer more patients to psychotherapy. Also, as mentioned in Kravitz et al.’s (2006) randomised controlled study, GPs who have experienced the benefits of psychotherapy or have had a close friend or relative experience positive outcomes from psychotherapy would be more likely to refer their patients to therapists.
Lastly, the GPs' referral decision was also influenced by *perceived difficulties with a particular patient* (Knight, 2003). A study by Nandy, Chalmers-Watson, Gantley, and Underwood (2001) was conducted to describe and analyse GPs' decision-making processes when considering management and referral of patients with mental disorders. In this study, a semi-structured interview was conducted with 23 GPs and it was found that referral strategies were found to be either “referral to” or referral away”. It was indicated that “referral to” was a proactive strategy which involved an intellectual decision, such as needing to refer due to availability of counsellors with particular specialist skills (Nandy et al.). On the other hand, the “referral away” strategy was indicated as a reactive strategy triggered by strong negative emotional responses such as feelings of anger, irritation and frustration when facing difficulties in dealing with a patient’s mental health disorder (Nandy et al.). Therefore, perhaps in the future, it is important to inform trainee doctors or GPRs regarding potential emotional risks of dealing with mental health disorders and provide GPs with guidelines for dealing with patients with mental health disorders to prevent ‘burn-out’ (Defey, 2002; Knight, 2003). Currently in the literature, Nandy et al.'s study has been the only one that has identified referral strategies such as “referral away” and “referral to”. Therefore, it is recommended that in the future, more studies should be conducted to investigate this new area of research.

The author has not found any qualitative studies on the factors which Australian GPs take into account when making decisions regarding referral of patients with mental health disorders to mental health service; as majority of the qualitative studies reviewed in this area were UK studies (Hull et al., 2002; Knight, 2003; Kravitz et al., 2006; Nandy et al., 2001; Sigel & Leiper, 2004; Verhaak, 1993). Future studies in this research area would be worthwhile since the Australian Government has just commitment $538 million over 5 years to increase access of community to GPs, psychiatrist, clinical psychologist and other allied...
Future Australian studies should also aim to identify what service, patient and doctor-related factors may influence Australian GPs' referral decisions, using qualitative methods such as interviews and using vignettes which are actual case examples seen in the "real world" such as ones used in Knight's (2003) study. Research in this area would hopefully lead to an improvement in working relationship between GPs and other mental health professionals, such as clinical psychologists, and a development of a guideline to assist GPs in their referral of patients to mental health services, which may then potentially lead to an improvement in outcomes for patients with mental health disorders. Additionally, it would also be valuable for future studies to investigate how senior medical students who wish to be GPs plan to manage patients with mental health disorders, as there are currently no studies which have examined this. Research with this group of participants may also provide insight into mental health training in medical school. Lastly, since Sigel and Leiper's (2004) study has demonstrated the benefit of using grounded theory to develop a clear structured theoretical model of how GPs explore mental health disorders, it could be suggested that the study should be replicated in Australia as currently there has been no study which have developed a model of how Australian GPs explore mental health disorders.

Conclusion

In conclusion, the literature reviewed shows that, mental health reform in Australia is currently moving towards a broader and more collaborative system of mental health care, with focus on primary mental health care. However, despite significant changes in the mental health reform in Australia, the mental health care system still requires substantial reform. Particularly, the importance of the system to re-oriented towards benefiting consumers and
carers. Therefore, this perhaps suggests the importance for GPs to play a role in providing advocacy for their patients.

There have been many studies that have found that mental health disorders are underdetected by GPs and this may be attributed to patients not wanting to disclose their psychological problem due to beliefs that a GP is not the appropriate person to talk to or they may not want to reveal their problems due to stigma and labelling associated with mental health disorders. Thus, firstly, this suggest a need to improve the knowledge of consumers regarding the role of a GP and the need to increase education regarding mental health disorders to the community to reduce the stigma associated with mental health disorders. Secondly, there is a need to increase relationship building between GPs and patients as this may have a potential on increasing involvement of patients in the consultation and treatment decision-making. Moreover, more training is needed for GPs to increase early diagnosis of highly prevalent mental health disorders seem in general practice such as depression as early detection may reduce the large amount of funding needed for expensive psychopharmacology and psychosocial treatment; hence, allowing a more efficient use of the mental health budget.

It was also reported by some studies that majority of GPs prefer to treat patients themselves rather than referring their patients to other mental health professionals such as clinical psychologists, indicating that perhaps referral of patients with mental health disorders to other mental health services is not common. Nevertheless, it was reported by both Knight (2003), and Sigel and Leiper (2004) that referrals were likely when GPs did not have time to deal with the mental health disorder appropriately during consultation time with the patient. Therefore, this suggests the importance of mental health professionals such as clinical psychologists to work with GPs to build good working relationship with GPs, support GPs and provide GPs with the opportunity for referral of patients to their service when needed.
The difficulties with accessing mental health services due to long waiting list and the importance of having good communication and a good “consultation-liaison” relationship with other mental health professionals such as psychologists to gain feedback regarding progress of patients who were referred also suggests the importance for mental health services to be improved and the need for more interaction and relationship building between GPs and other mental health professionals.

As the author has not found any Australian literature regarding factors which influences Australian GPs' decisions to refer patients with mental health disorders, it was suggested that future Australian studies should also aim to identify what service, patient and doctor-related factors may influence Australian GPs' referral decisions, using qualitative methods such as interviews and using vignettes such as ones used in Knight's (2003) study. Research in this area would hopefully lead to improvement in interactions and working relationships between GPs and other mental health professionals, such as clinical psychologists and lead to a development of a guideline to assist GPs in making referral of patients with mental health disorders to appropriate mental health services so that outcomes for patients may be improved. It will also be valuable for future studies to investigate how senior medical students who wish to be GPs plan to manage patients with mental health disorders. Lastly, Sigel and Leiper's study should be replicated in Australia as currently there has been no study which has developed a model of how Australian GPs explore mental health disorders.
References


Management of Patients


Defey, D. (2002). General practitioners often used emotional responses for “referrals away” and intellectual decision making for “referrals to” in patients with mild depression and/or anxiety. *Evidence Based Mental Health, 5*, 31.


health specialists? A randomized trial using actors portraying depressive symptoms. 

*Journal of General Internal Medicine, 21*, 584-589.


Appendix A

The Australian Mental Health Care System

In Australia, many types of public and private sector service providers and a variety of funding and regulatory mechanisms form part of the health care system (AIHW, 2006). Funding is provided mostly by government (almost 70 per cent), with the Australian Government contributing to two thirds of this and the state, territory and local governments the other third (AIHW, 2006; Commonwealth Department of Health and Ageing [CDHA], 2000). The Australian Government’s contributions include the Medicare, Pharmaceutical Benefits Scheme and 30 per cent Private Insurance Health Rebate (CDHA, 2000). Medicare is funded by the Australian Government to provide free or subsidised payments for doctors and selected dentists and optometrists (AIHW, 2006; CDHA, 2000). Additionally, Medicare provides free treatment for patients who choose to be treated in public hospitals (CDHA, 2000). The Pharmaceutical Benefits Scheme subsidises payment for a high proportion of prescription medication bought from pharmacies and The Australian Government funding of the 30 per cent Rebate encourages and supports people’s preference to take up and retain private health insurance to decrease the pressure on the public system (AIHW, 2006; CDHA, 2000).

In Australia, a patient’s first contact with the health system is usually through a GP and for specialist care, patients may be referred to specialist medical practitioners, other health professionals, hospitals or community-based health care organisations (AIHW, 2006). Many people also visit other private sector health professionals of their choice such as physiotherapists, podiatrists and psychologists. However, while a person who self-refers to a GP is reimbursed for all or part of the GP’s fee by Medicare, a person who self-refers to a private sector health professional usually pay the charges themselves or with support of private health insurance (AIHW, 2006).
Appendix B

A Table of a Historical Timeline of Events that have Influenced Reforms in the Australian Mental Health Care System

Table 1

*A Historical Timeline of Events that have Influenced Reforms in the Australian Mental Health Care System*

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Research Study/ Report</th>
</tr>
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<tbody>
<tr>
<td>1991</td>
<td>The Mental Health Statement of Rights and Responsibilities 1991</td>
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<td>1992</td>
<td>National Mental Health Policy</td>
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<tr>
<td>1992</td>
<td>First National Mental Health Plan</td>
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<tr>
<td>1993</td>
<td>National Inquiry Concerning the Human Rights of People with Mental Illness</td>
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<tr>
<td>1996</td>
<td>WHO Global Burden of Disease Study</td>
</tr>
<tr>
<td>1996</td>
<td>McKay Report into the Specialist Psychiatrist Workforce</td>
</tr>
<tr>
<td>1997</td>
<td>The Mental Health of Australian: Profile of Adults Study</td>
</tr>
<tr>
<td>1997</td>
<td>Australian Health Ministers identify depression as focus of the National Health Priority Areas Initiative</td>
</tr>
<tr>
<td>1998</td>
<td>Second National Mental Health Plan</td>
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<tr>
<td>1998</td>
<td>Second National Mental Health Plan</td>
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<tr>
<td>1998</td>
<td>The Joint Consultative Committee Report on Primary Care Psychiatry</td>
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<tr>
<td>1999</td>
<td>National Health Priority Areas 1998 Report, Mental Health: A Report Focussing on Depression</td>
</tr>
<tr>
<td>1999</td>
<td>The National Primary Mental Health Care Initiative</td>
</tr>
</tbody>
</table>
1999  Draft National Depression Action Plan
2000  The National Depression Initiative: Beyond Blue
2000  The Australian Burden of Disease Study
2000  Review of Supply and Requirement of Specialist Psychiatry Workforce in Australia
2001  Federal Budget allocation of $120.4 million for Better Outcomes in Mental Health Care initiative
2006  Federal Budget allocation of $1.9 billion to improve access to mental health services, with a commitment of $538 million over 5 years to continue and expand the new phase of mental health care through the Better Access to Psychiatrist, Psychologists, and GPs through the Medicare Benefit Schedule initiative through the Medicare Benefits Schedule

(COAG, 2007; Hickie & Groom, 2002; Holmwood, Groom, & Nicholson, 2001)
Appendix C

A Description of the Five Components of the BOIHMNC Initiative

1. The 3 Step MHP includes a mental health assessment, a mental health plan and a mental health review. A service incentive payment (SIP) was also provided to the GPs to remove financial disincentives so that GPs can undertake longer consultations.

2. Education and training for GPs is the second component of the BOIMHC. The types of training accredited under the BOIMHC include: (a) familiarisation training which provides GPs with a background to what BOIMHC is (2 hours), (b) level on mental health skills training which seeks to increase knowledge and skills in GPs’ in terms of undertaking the three Step MHP for high prevalence mental health disorders such as depression and anxiety (6 hours), (c) level two mental health skills training which aims to provide GPs with skills to provided focussed psychological strategies (20 hours), (d) and the mental health continuing professional development which presents other General Practitioner Mental Health Standards Collaboration accredited training for GPs (Pirkis et al., 2006; Thomas, Jasper & Rawlin, 2006; AGPN, 2007a).

3. The Focussed psychological strategies (FPS), derived from evidence-based psychological treatment such as psychoeducation, cognitive therapy, relaxation therapy, and interpersonal therapy are normally delivered by GPs who are trained and registered at level two to provide counselling to their consumers through the provision of Medicare Benefits Schedule (MBS) rebates (Pirkis et al., 2006; Thomas et al., 2006). GPs are allowed to bill Medicare Australia for the time delivering FPS (minimum of 30 minutes) (Pirkis et al.).

4. The Access to Allied Psychological Services (ATAPS) was introduced to allow GPs who have completed level one training to refer their patients to Allied Psychological Services to support their patients with mental health disorders within the context of the 3 Step MHP (Thomas et al., 2006; Vagholkar, Hare, Hasan, Zwar, & Perkins, 2006). The allied health professionals were usually contracted to or employed by the divisions of General Practice (Pirkis et al., 2006; Morley, Kohn, Pirkis, Blashki, & Burgess, 2004). The ATAPS provides up to six free or low cost session of FPS, with a further six free or low cost sessions after the mental health review by their GP (Thomas et al., 2006). This additional provision may be an advantage to people with mental health disorders who are not able to afford private psychologists’ consultation fees.

5. The Access to Psychiatrist Support is a national non-emergency clinical advisory service through phone, fax and e-mail that is available 24 hours a day and seven days a week (Thomas et al., 2006; CDHA, 2006). It includes the new Medicare Benefits Schedule items 291 and 293 which enables the psychiatrist to be reimbursed for participating in case conference with GPs (Thomas et al.; Pirkis et al., 2006).
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- Submit a manuscript online

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1. Contributions should follow the general style described in the Publication Manual of the American Psychological Association, (4th ed., 1999), except that spelling should conform to The Macquarie Dictionary (2nd ed.). For matters of style not covered in these two publications the Style Manual for Authors, Editors and Printers (5th ed., Australian Government Publishing Service) should be consulted. Page references in the following notes are to the Publication Manual. The attention of authors is especially drawn to changes in the fourth edition (pp. xxviii–xxx).

2. Manuscripts (pp. 1–7, 237–248), not normally to exceed 4,500 words, should be typed on A4 (297 x 210 mm) paper, double-spaced throughout and with margins of at least 4 cm on all four sides. Four copies are required. Duplicated or photocopied copies are acceptable if they closely resemble typed copies. Manuscripts will not be returned to authors.

3. Title page (pp. 7, 8 248–250) for the manuscript should show the title of the article, the name(s) and affiliation(s) of the authors, a running head and, at the bottom of the page, the name and address (including postal code) of the person to whom proofs and reprint requests should be sent.

4. An abstract (pp. 8–11, 250) should follow the title page. The abstract of a report of an empirical study is 100–150 words; the abstract of a review or theoretical paper is 75–100 words.

5. Abbreviations (pp. 80–89) should be kept to a minimum and in particular not be used for "participant" and "experimenter." Full stops are omitted for many abbreviations, for example: cm, kg.

6. Metric units (pp. 105–110) are used according to the International System of Units (SI), with no full stops when abbreviated.
7. Statistics (pp. 15–18, 111–119) should be seen as an aid to interpretation and not an end in themselves. Authors are encouraged to state their rejection rate once (e.g., \( p = .05 \)) and then simply state whether a given statistic is significant or not, by that criterion.

8. Tables (pp. 120–141) should be typed on separate sheets with rules (if any) in light pencil only. Indicate approximate location in the text.

9. Figures (pp. 141–163) that have been produced as line art (e.g., graphs, flow charts, drawings) on a computer should be presented as Laser or photographic bromide output only at a minimum print density of 600 dpi. Figures should not include shaded areas of grey as these will be difficult to reproduce clearly; instead, use repeating patterns of lines or crosses (see Example 2 on p. 145). Half-tone art (e.g., photographs, photomicrographs) should be presented as prints rather than transparencies. Include only one figure per page and place the figure number and caption on the bottom of the page. Figures will only be accepted on disk if supplied in either Adobe Illustrator, EPS, or TIFF formats.

10. References (pp. 20, 168–222) are given at the end of the text. All references cited in the text must appear in the reference list.

11. The author should keep a copy of the manuscript for proofreading.

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What Factors Influence Future GPs’ Treatment and Referral Decisions When Managing Patients with Mental Health Disorders?

June Fern Tan
Abstract

Australian mental health policy focuses on empowering GPs to manage patients with mental health disorders. This qualitative study recruited eight senior medical students who intend to be GPs, and identified factors that influence their management processes and decisions when managing mental health patients. Using Knight's (2003) categorical approach, content analysis showed the separate factors that influenced future GPs' management decisions. In addition, exploratory thematic coding derived from grounded theory (Sigel & Leiper, 2004) appeared to explain individual differences in the management process between future GPs. In conclusion, researchers might consider combining the interview approach used by Knight with Sigel and Leiper's analytic framework, to potentially gain greater understanding of the decision-making process associated with the management of patients with mental health disorders. Further understanding of the decision-making process may provide an evidence-based tool for training future GPs and for ongoing professional development for practice GPs.

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What Factors Influence Future GPs’ Treatment and Referral Decisions When Managing Patients with Mental Health Disorders?

The prevalence of mental health disorders in Australia is high, and they are considered to be among the ten leading causes of disease in Australia, accounting for 13 per cent of the total disease burden (Australian Institute of Health and Welfare [AIHW], 2006). Research by the AIHW (2005) found that 85 per cent of Australians visit a general practitioner (GP) at least once a year, and from year 2003 to 2004, almost 11 million people visited their GPs regarding mental health disorders (Britt et al., 2003). According to Britt et al., 11.3 per cent of problems managed by GPs are for mental health disorders.

It is estimated that 1 in 5 Australians will experience a mental health disorder at some point in their lives (McLennan, 1998). Of these, the majority (62 per cent) of people with mental health disorders do not seek any professional help (Britt et al., 2003). Of the 38 per cent who do seek professional help for mental health disorders, three quarters visited their GP as a first point of contact (Britt et al.). This emphasises the importance for GPs to have the knowledge and training to identify, treat and refer patients with mental health disorders.

Current mental health policy reform is focused on empowering GPs in primary care to remain in their primary role in the management of patients with mental health disorder. However, they are given the option to refer the patients to specialist mental health services when needed. In 2006, the Australian Government committed $1.9 billion over five years to improve access to mental health services, with a commitment of $538 million over 5 years to continue and expand the new phase of mental health care through the Better Access to Psychiatrist, Psychologists, and GPs through the Medicare Benefit Schedule initiative (ADGP 2007b; Council of Australian Government [COAG], 2007; Commonwealth Department of Health and Ageing [CDHA], 2006). The Better Access initiative builds on the previous Better Outcomes in Mental Health Care (BOIMHC) initiative which operated from July 2001 till
2005 (Australian General Practice Network [AGPN], 2007a). The aim of the Better Access initiative was to increase the access of community members to GPs, psychiatrists, clinical psychologists and other allied mental health professional for mental health care (AGPN, 2006; AGPN, 2007b; GP Partners, 2006).

Three new Medicare items for GPs introduced to provide a structure framework for GPs to undertake early intervention, assessment and management of patients with mental health disorders. The first new Medicare item is the GP Mental Health Care Plan (item 2710) which involves the assessment of a patient and a structured approach in preparation of the Mental Health Care plan (AGPN, 2006). This includes taking patient history, present complaints, mental state examination, making diagnosis and administering outcome measurement tools where appropriate. This is followed by the development of the GP mental health care plan where the GP discusses the results of the initial assessment, discuss treatment and referral options with the patient, and set appropriate goals. The second new Medicare item is the GP Mental Health Care Plan Review (item 2712) which enables a review of the patients’ progress against goals outlined in the GP Mental Health Care plan and the third new Medicare item is the GP Mental Health Care Consultation (item 2713) which is an extended consultation with a patient (AGPN, 2006).

The emphasis on process embedded in the Mental Health Care Plan structure suggests the importance of research which identifies the factors that influence GPs’ management decisions and more importantly the decision-making process that GPs experience when managing patients with mental health disorders. Earlier studies (Wilkin & Smith, 1987; Creed, Gowrisunkur, Russel, & Kincey 1990; Verhaak, 1993) adopted a quantitative methodology by administering surveys to measure variation of rates of referral among GPs and focussed upon correlations between referral rates, and GP characteristics such as age and gender, patient characteristics such as age, gender and condition, and service characteristics
such as psychiatric services and psychological services. Recent UK studies (Knight, 2003; Sigel & Leiper, 2004) have employed qualitative methods to identify explanatory factors which influence GPs' management of patients with mental health disorders. This is the focus of the present study, as it is likely that improved understanding of the process of decision-making made by the GP will obtained through this method.

In 2004, a qualitative study was conducted by Sigel and Leiper to explore UK GPs' views of their management and referral of psychological problems. Participants were ten GPs who were interviewed using a semi-structured, open-ended interview. Questions included how GPs define and detect psychological problems, GPs' views of psychological therapies, factors leading GPs to refer for psychological therapies as compared with pharmacological treatment, and factors which GPs consider in choosing between different psychological therapies (Sigel & Leiper, 2004). The interviews conducted were audiotaped, transcribed and then analysed using grounded theory. The theoretical model of how GPs manage patients with mental health disorders demonstrated that the management of patients with mental health disorders includes the interaction of five components. These five components were (a) the exploration of the psychological problems, (b) GPs' role in containing the patients' health problems, (c) GPs' views of the psychological problems and therapies, (d) referral decisions, and (e) interactions with psychologists.

In 2003, Knight conducted a qualitative study to identify factors considered by UK GPs when making decisions in the management of patients with mental health disorders, and to explore referral strategies and related individual differences between GPs. Nine GPs completed a structured interview consisting of nine brief case vignettes, followed by three standard questions for each of the vignettes. The vignettes were considered realistic as they were actual case examples seen in psychology outpatient clinics, in community mental health teams and in primary care counselling. The questions asked included what treatment and
action they would recommend, whether they would refer, the main reasons for their decision and what outcomes they would expect. All interviews were audiotaped, transcribed and the data was analysed using content analysis.

In Knight’s study, the identified factors that influenced GPs’ management decisions were grouped into: (a) patient-related (b) service-related, and (c) doctor-related factors. In terms of patient-related factors, the type of problem, and the chronicity and severity of the problem that the patient presented with had the most influence on treatment and referral decisions. Other important patient-related factors found in Knight’s study included the patient’s wishes and preference, patients’ needs, and the patient’s characteristics and situation. The most frequent doctor-related factor mentioned in Knight’s study was GP time and availability as GPs reported they would refer, when they did not have the time to deal with difficult mental health issues which needed intensive therapy. Other factors included referring to gain advice and second opinion, when they were not experts in that field and when they could not cope with the emotional involvement. In terms of service-related factors, the availability of the mental health service were considered the most important factor which influenced treatment and referral. Several doctors expressed problems concerning waiting lists and the time it takes to get patients seen by mental health services. Other factors included the quality of the services, liaison, and the suitability of a service for a particular mental health disorder.

Knight (2003) indicated that management decisions are influenced by patient, doctor, and service-related factors, and decision-making is a process where the GP weighs up the pros and cons of various treatment or referral options. The present study seeks to extend her method to senior medical students intending to be GPs in the future, as her findings may not be transferable to Australia given the significant differences in the structure of mental health services between the UK and Australia.
No qualitative studies appear to have been conducted in Australia on the factors which GPs take into account when making decisions regarding management of patients with mental health disorders. It is important to understand these process issues, particularly in the light of recent legislative change in Australia. The use of qualitative method (e.g. Liamputtong & Ezzy, 2005) is valuable in obtaining a meaningful understanding of how GPs manage patients with mental health disorders, and more importantly how future GPs plan to manage patients with mental health disorders in their eventual practice.

The purpose of this research was to extend Knight’s (2003) study to identify the factors that influence management decisions and the processes involved in decision-making in senior medical students when managing patients with mental health disorders. Senior medical students were recruited for this Honours research project as it was presumed that it will be much easier and quicker to access senior medical students rather than GPs. The senior medical students who volunteered in this study all intended to become future GPs. The research question was “what are the factors that influence future GPs’ treatment and referral decisions when managing patients with mental health disorders?”

Method

Design and Procedure

This research was conducted using a structured interview to identify and describe factors influencing referral decisions and processes involved in decision-making. This present study was an extension of Knight’s (2003) study. The structured interview consisted of nine brief vignettes and three questions that were adapted from Knight’s study. The vignettes were actual cases seen in UK psychology outpatient clinics, in community mental health teams and in primary care counselling. Permission to use the case vignettes was obtained by the investigator from L. Knight (personal communication, March 19, 2007). It should be noted that although not all the scenarios in the case vignettes portray patients with mental
health “disorders” as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (American Psychiatric Association, 1994), this term was used throughout this research report for ease of readability. The research therefore refers to patients and to mental health disorders, rather than to clients and to mental health concerns or issues.

The case vignettes were presented in the same order for all participants. The scenarios were read out aloud by the investigator and the medical students answered the three questions after each case (see Appendix A). Each interview session was between 30 to 50 minutes. All interviews conducted were recorded for transcription. In the follow-up interview one month later, the participants were given feedback regarding their own responses in the interview and asked about their thoughts and opinion about the analysis.

Participants

The participants were eight medical students who were in their fifth or sixth year in medical school. They were recruited through the School of Medicine in the University of Western Australia (UWA). The method of sampling used was purposive sampling (Liamputtong & Ezzy, 2005) as it would only be relevant to select students in medical school who have decided that they wish to work as GPs after completing their degree. Students in their fifth and sixth years were accepted, as students in the lower years may not have been trained in the area of mental health. Participants were recruited through announcement in lectures by the investigator and flyers were handed out to the senior medical students during announcement in lectures (see Appendix B). A copy of the flyer was also placed on an online bulletin board that was accessible by UWA senior medical students. Prospective participants were invited to contact the researcher, and on expressing intent to participate, the researcher and the participant arranged a time and venue for the interview. One participant was a senior medical student from The University of Notre Dame (UND) in Western Australia who had
access to the UWA senior medical students' online bulletin board. This student had knowledge of mental health as she was a social worker, and is now in the second year of her postgraduate medical degree which is equivalent to fifth year UWA medical students. Of the eight participants who were interviewed, six were interviewed face to face and two were interviewed by telephone as they were doing their postings at Kalgoorlie and Geraldton, respectively.

Difficulties in recruiting senior medical students as participants. Although the researcher presumed that access to senior medical students will be much faster and easier compared to GPs, the researcher experienced considerable difficulties and delays in recruiting senior medical students as volunteer participants for this research. Despite repeated and regular assurances of support from academic staff of the host university, it took 14 weeks before the first interview occurred. In addition, the researcher had to access the lectures repeatedly to garner interest in fifth and sixth year medical students.

Materials

The materials used in this research included flyers, a digital voice recorder, and two sheets of paper which contains nine brief case vignettes with three questions (see Appendix A). The three questions were: (i) What treatment/action would you recommend? (Would you refer? If yes, where to?). (ii) What are the main reasons for your decision?, and (iii) What outcomes would you expect? The use of a digital voice recorder was an advantage as it provided an opportunity for the researcher to have greater eye contact with the participants, and a chance for the researcher to go over the interview session again to obtain details which were unobtainable from memory alone (Liamputtong & Ezzy, 2005). Furthermore, because the digital voice recorder was much smaller and silent than an analogue audiotape recorder, any distractions during the interviewing process were minimised.

Ethical Considerations
This research was conducted following approval from the Faculty of Computing, Health and Science Ethics sub-committee of the University Research Ethics Committee. Before each interview, participants were provided with an information letter regarding the purpose of their participation and the intended use of the information collected. Participants were also asked to sign an informed consent form before the interview commenced (for the information letter and informed consent documents, see Appendices C and D). In the informed consent, permission to record the interview on the digital voice recorder was asked of the participants. The audio files and transcriptions were labelled using pseudonyms to keep the confidentiality of the participants in this study. Consent forms were kept separately from the audio files and transcriptions. Only the researcher and her supervisor had access to the audio files, transcripts and all other confidential materials.

Analysis

The method of analysis employed followed Knight (2003). Hence, her categories (patient-, service- and doctor-related factors) were used to drive the categorisation of the material. Firstly, the transcriptions for each participant were classified into patient-related factors, service-related factors and doctor-related factors (see Appendix E). Next, as done by Knight, the number of times that each factor within the patient, doctor and service-related factors appeared in the transcriptions for all the participants were counted and converted into frequency percentages (see Appendix F). It should be noted that this is not a standard way of approaching qualitative analysis, first in using a categorical template to structure the data, and second, in converting the data into quantitative frequencies. Nevertheless, in the interests of consistency of analytic approach, it was decided to follow Knight (2003).

Content analysis was used to analyse the transcriptions. In the content analysis, the main emphasis was on what was being said by the participants and how the participants expressed what was being said (Crano & Brewer, 1973). In the content analysis, categories or
themes were identified prior to searching for them in the data and the numbers of times in which the categories or themes appeared in the data were counted (Liamputtong & Ezzy, 2006).

To ensure consistency of the analysis, the investigator and her supervisor both analysed and classified the data obtained from the first, second and ninth respondent individually. They then discussed and revised the classifications to ensure consistency in use of the coding classifications.

The researcher made research process notes throughout the research project to provide an audit trail. She noted how the data were collected and recorded, and the method of data coding and analysis to ensure the rigour of this research. (Liamputtong & Ezzy, 2005; Meyrick, 2006).

Findings and Interpretation

Summary Frequencies of Factors that Influence Future GPs’ Treatment and Referral Decisions

The type of problem or symptoms or diagnosis, the chronicity and severity of the mental health disorder, and excluding physical pathology to provide reassurance for the patients were the three most frequently mentioned patient-related factors (see Figure 1 overleaf). Figure one shows that the pattern of results for the present study were similar to that of Knight (2003). Additionally, with respect to patient-related factors, future GPs were also focussed towards patients’ characteristics and situation, exploring the types of social support that their patients have, and evaluating their patients’ progress and response to treatment. Depending on the type of problem, future GPs would also provide medication to relieve the patients’ symptoms, or provide initial counselling while they are being referred to mental health services. Other patient-related factors that future GPs take into account when making treatment or referral decisions were the effects of the problem on the family, the
patients' wishes and preference, patients' needs, motivation and lastly, previous treatment or assessment that the patient has undertaken.

In regards to doctor-related factors, the future GPs' competence or expertise, and success of treatment were the two most frequently mentioned factors (see Figure 1 overleaf). This was followed by the doctor-patient relationship, and needing assessment or advice from other mental health professionals. The experiences of future GPs in dealing with particular mental health disorders were also frequently mentioned as a factor that influenced their treatment or referral decisions. Other mentioned doctor-related factors included difficulty with particular patients, GP time and availability, safeguarding career or preventing mistakes, and obligation.

Of the three factors, service-related factors were the least mentioned by future GPs (see Figure 1 overleaf). Therapist interest and training was the most frequently mentioned service-related factors. This was followed by the need for future GPs to liaise with other mental health professionals to receive feedback regarding the patient, and the appropriateness of in-house counselling. Other service-related factors that were mentioned included previous experience with the service, quality of service, and the availability or waiting list of the mental health services.
Patient, Doctor, and Service-Related Factors that Influenced Future GPs' Treatment and Referral Decisions

Patient-related factors. The most frequently mentioned patient-related factor that influenced future GPs' treatment and referral decisions was the type of problem, symptoms or diagnosis (85 times/20.53%). In most cases, future GPs would confirm diagnosis initially by taking patient history to explore the problem. For example, George expressed “The first thing is to... confirm a diagnosis by history and examination and then you try to... determine the most likely diagnosis in this setting. You can stratify that into psychiatric and non psychiatric causes so the first would be an anxiety disorder and other non psychiatric causes.” (George, Case 1). Another future GP also expressed: “Look I think if you suspect sexual
abuse, you need to try and establish a history in more detail, so that’s one of the first things I would do.” (Paul, Case 6).

When the diagnosis was related to depression, future GPs reported that they would treat the patients themselves, either by counselling or by means of medication. For example, “...I would also explore the issue of depression because it says she seems quite depressed and it may be appropriate to give her some antidepressants.” (Sarah, Case 3). Consistent with Knight’s (2003) study, future GPs in this study mentioned that they would consider referring patients diagnosed with anxiety disorders to psychologists. For example, “I think it’s worth referring this patient to see a psychologist or counsellor again because she has elements of panic disorders, yep” (George, Case 3). For mental health disorders related to psychotic disorders or rare unspecified diagnosis, future GPs were more likely to refer these cases to psychiatrists. For example, “...I’d want to screw in [investigate] to see whether it’s a psychotic presentation, if that’s the case then I would refer them to a psychiatrist for a further assessment.” (Paul, Case 7), and “...I would also refer to a psychiatrist because this is like, it’s less of a common condition...” (Lisa, Case 5).

To ensure brevity and ease of readability of this report, further results for all other patient-related factors mentioned by future GPs are detailed in Appendix G,

**Doctor-related factors.** The most frequently mentioned doctor-related factor that influenced future GPs’ treatment and referral decisions was the future GPs’ competence or expertise (23 times/ 5.55%). For example, Jodie said: “...I would feel competent to manage myself and, in part, that would be about... normalising her grief, but exploring the fears and, and the panic etcetera, more, umm... yeah” (Jodie, Case 3). Some GPs also expressed that they felt competent in treating a patient when the presented mental health disorder was not too severe. For example: “...I wouldn’t refer at this stage, I’d feel comfortable, assuming there’s nothing which is too serious, I would feel comfortable in treating the patient in the GP
setting” (Paul, Case 1). In regards to expertise, a future GP mentioned that he would treat the problem if he had additional training in the area of mental health but would refer if mental health was not his area of expertise: “If I am a mental health GP I have additional training in psychological counselling, then I’m able to provide treatment for him. But definitely I’ll have a whole pool or list of psychologists with each respective credentials I can refer him to the psychologist for best outcomes.” (George, Case 2).

Service-related factors. The most frequently mentioned service-related factor was the therapist interest and training (12 times/ 2.89 %). Most future GPs would refer their patients to mental health services when they were aware of the speciality of a particular mental health service. For example: “...I would be more inclined to refer her to someone like SARC (Sexual Assault Referral Centre) or you know, a private therapist who has experience in working with abuse rather than to community mental health services or something like that” (Jodie, Case 6).

Further detailed results for all other doctor-related and service-related factors mentioned by future GPs can be found in Appendixes H and I, respectively.

Interpretation of the Findings

The three most frequent factors that influenced future GPs’ treatment and referral decisions were the type of problem or symptoms or diagnosis, followed by the chronicity and severity of the mental health disorder, and the exclusion of physical pathology to provide reassurance under patient-related factors. Knight’s (2003) study also found the type of problem or symptoms or diagnosis and the chronicity and severity of the mental health disorder to be the most frequent factors (see Figure 1). These results suggest that future GPs are primarily focused in making diagnoses based on the patients’ problems or symptoms that are presented to them in the GP setting.
The patients' source of social support under patient-related factors was also a frequent category linked to the outcome of the treatment and referral decisions. For example, a future GP perceived that supportive friends and family would assist the patient in coping with the mental health disorder emotionally and also financially, so improving the outcome of treatment or referral (George, personal communication November 2, 2007).

Perceived competence or expertise, and success of treatment were the two most frequent doctor-related categories that would influence future GPs' treatment or referral decisions. In most cases, future GPs would treat the patient by prescribing medication or offering counselling if they felt competent or if their expertise was within the mental health field. However, referral would be made when the management of the mental health disorders is beyond their expertise. Hence, this indicates that while most mental health disorder would be treated by future GPs, they would make referrals to specialist mental health services in some circumstances. This finding is consistent with the current government Better Access initiative which provides training for GPs to treat patients with mental health disorders, and the opportunity to refer their patients to specialist mental health services. Thus, this suggests that perhaps psychologists should consider working closely with GPs to support and provide GPs with the opportunity for referral of patients to their services when needed.

Service-related factors were not as frequently categorised as patient and doctor-related factors. Knight (2003) reported a higher frequency for service-related factors for her GP participants. In the present study, this factor was used for Jodie, who had previously worked as a social worker for 15 years prior to beginning her post graduate degree in Medicine. Together, these results might indicate that GPs with more experience in working with mental health services have a better understanding of how service-related factors could affect their treatment or referral decisions.
Individual Differences between Future GPs in their Management Approach

There were differences between future GPs in their management approach. Firstly, some were more medication-centred to their approach in the management of patients with mental health disorder, while some were focussed towards providing or referring the patient for psychological treatments. Secondly, those who mentioned that the cases were interesting, and that they had managed similar cases in their rotations, answered the interview questions more confidently, in that they took less time to think and respond to the questions. It is likely that experience is an important factor that influences a future GPs’ competence and confidence in managing patients with patients with mental health disorders.

The Follow-up Interview

A follow-up interview was conducted following the transcription and the content analysis of the data. Participants were given feedback regarding their own individual responses and were asked about their thoughts and opinions regarding the content analysis. Five out of the eight participants responded. Paul mentioned that in terms of service-related factors, he would add that “...patients can greatly benefit from the resources and input of a multi-disciplinary team based in the community and/or outpatient hospitals. I would consider referring patients to these services, dependent on the availability at the time”.

One of the participants said that the interview increased her awareness regarding her medication-centred approach in the management of patients with mental health disorders. She also mentioned that she will be more aware of her approach in her eventual practice (Lisa, personal communication, October, 13). This may suggest that feedback to participants regarding their own responses may increase their awareness about their approach in managing patients with mental health, and might even be considered as a training tool.
Researcher's Reflections on the Analysis and Findings

The researcher conducted a content analysis on all the transcriptions using Knight’s (2003) grid classifications whereby the transcriptions were classified into patient-related factors, service-related factors and doctor-related factors. The investigator and her supervisor both analysed and classified the data obtained from the first, second and ninth respondent individually, and then discussed and revised the classifications to ensure that the classifications used were consistent.

Initially, it was found that the researcher used a narrower approach in categorising the factors while her supervisor used a broader approach. The researcher used a narrower approach as she only classified quotes that were highly similar to Knight’s (2003) quotes. For example, for the classification “type of problems, symptoms or diagnosis” under patient-related factors, the quote that Knight (2003) provided as an example was used in the DSM-IV classification; therefore, the researcher in this study felt that she should also follow this rule.

The researcher’s supervisor used a broader approach based on the concerns and issues associated with mental health treatment and referral. This inconsistency in the content analysis was dealt with by discussion whereby the supervisor agreed to narrow his focus while the researcher broadened her approach. This resulted in the same classifications being made between the researcher’s and her supervisors’ classifications, therefore indicating consistency of the coding used.

Both researcher and supervisor also became aware of the importance of the case vignettes in helping to explain the decision-making process that future GPs experience, when thinking about the management of patients with mental health disorder. The categorical approach used in the content analysis seemed relatively rigid and outcome focussed, leading to a relatively impoverished interpretation of the separate factors that influenced future GPs’ management decisions, and how they interacted. This led the researcher to consider a process
oriented method of analysis, such as grounded theory, which may lead to an understanding of the interactive nature of the decision-making process.

Furthermore, the counting of frequencies as used in Knight's (2003) study did not provide any additional understanding in explaining how future GPs make decisions regarding management of patients with mental health disorders. This point was also made by Knight (2003). Moreover, some critical readers might consider the analysis used in the present study to be quantitative in nature, rather than truly reflective of the qualitative process. As a result of this reflection, the researcher subsequently applied a thematic analysis based on the grounded theory approach taken by Sigel and Leiper (2004) to the data obtained from this study. Preliminary results of this approach and interpretation are found later in the next section.

Implications

The Case Vignettes: A Limitation or Strength?

While Knight (2003) reported the case vignettes as a limitation of her study, this researcher found the opposite. Most future GPs in this study mentioned that the case vignettes were relevant to what they have encountered in their GP and Psychiatry rotations. Additionally, many senior medical students reported that the case vignettes were probably the types of cases that would be presented to them in their psychiatry exam. These comments suggest that the case vignettes were reflective of real cases that the future GPs' have seen, and were beneficial to the participants as it provided them with a practice exercise for their future exams. Furthermore, one participant in this study mentioned that after going through the interview, he felt a stronger intent to be a GP in the future as the interview helped make his realise that managing patients in primary care was his area of interest (George, personal communication, November 1, 2007).
The Process of Decision-Making

The difficulties encountered in the process of classifying the transcription into separate categories led the researcher and her supervisor to consider keeping the case vignettes but augmenting the coding method used by Knight (2003), as it did not capture the process of managing patients with a mental health disorder. The data and findings obtained with the categorical approach did not seem to lead to a rich understanding of the process of future GPs' decision-making. This concern was also raised by Knight in her discussion, although it was not considered by her to be a major drawback to the method in her conclusions.

A further concern of the researcher was the method of frequency counting which provided a quantitative outcome. This analysis did not explain how future GPs made decisions regarding the management of patients with mental health disorders. The researcher considered that these findings did not capture the process of decision making, but rather identified separate factors which influence GPs in the management of patients with mental health disorders. The identification of the separate factors is reflective of the diagnostic approach taken by future GPs and GPs, but does not necessarily improve our understanding of the process of how future GPs plan to manage patients with mental health disorders in their eventual practice.

A feasible alternative method was proposed by Sigel and Leiper (2004), who used a grounded theory analysis to develop a theoretical model that perhaps more adequately explain the process of decision-making in the management of patients with mental health disorders among GPs. Sigel and Leiper demonstrated that the management of patients with mental health disorders is a dynamic and interactive process which includes the interaction of the following components: (i) exploring psychological problems, (ii) containing patients' health
Management of Patients

problem, (iii) views of psychological problems and psychological therapies, (iv) referral
decisions, and (v) professional interactions with psychologists (see Figure 2).

Figure 2. Sigel and Leiper’s (2004) diagrammatic representation of the theoretical model of
how GPs manage patients with mental health disorders.

The case vignettes and interview questions adapted from Knight’s (2003) study
elicited responses that were reflective of an interactive process of decision-making described
by Sigel and Leiper (2004). To explore the applicability of this approach, the researcher
coded the transcriptions obtained from the present study using Sigel and Leiper’s framework.
Using this thematic approach, responses obtained from the eight participants based on case
vignettes 1 and 2 were coded on the basis of the theoretical model developed by Sigel and
Leiper’s from their grounded theory analysis (see Table 1 in the overleaf, which shows the
thematic analysis for one case and one participant, and Appendix J for further analysis).
Table 1


<table>
<thead>
<tr>
<th>Case 1</th>
<th>Component 1: Exploring psychological problem</th>
<th>Component 2: Containing patients' health problem</th>
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<tr>
<td>Participant</td>
<td><strong>A. GPs' processes for understanding patient problems</strong></td>
<td><strong>B. GPs' therapeutic activities</strong></td>
</tr>
<tr>
<td>Jodie</td>
<td>‘...I would probably discuss it more with him. I’d find out what, what he’s currently doing to try and manage. I’d find out about his... like whether there’s anything that he can do work wise, to address the pressures. I’d find out about his light sleep habits and practices so if he umm... you know, when is he going to bed, is he using alcohol or coffee or whatever at night. How much alcohol, how much caffeine, any other... medications or any self medication. Ask about exercise and lifestyle kind of issues as well. I would want to explore his relationship a bit more and whether there are issues there.’ (Developing understanding,) (Underlying agendas,)</td>
<td>‘...I wouldn’t be prescribing umm... benzodiazepines give it or, and would explain to him the nature of those that it’s very short term kind of a umm... option and that they, that tolerance and dependence both develop fairly quickly and I would... ‘A’ be addressing more the kinds of... lifestyle things that, the practical action that he can, can take to manage that. If it was more, if it was a mild kind of moderate sort of presentation so things like you know, cutting down on caffeine and alcohol and whatever, if that... how he’s managing it or... and, and you know sorting out his sleep etcetera...’ (Talking therapy activities) (GPs' sense of their ability to provide psychological therapies,)</td>
</tr>
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<table>
<thead>
<tr>
<th>Component 3: Views of psychological problems and psychological therapies</th>
<th>Component 4: Referral decisions</th>
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<tbody>
<tr>
<td><strong>A. Views of psychological problems</strong></td>
<td><strong>B. Views of psychological therapies</strong></td>
</tr>
<tr>
<td><strong>A. GPs' reasons for deciding to refer on</strong></td>
<td><strong>B. Patient suitability for psychological therapies</strong></td>
</tr>
<tr>
<td><strong>C. Access</strong></td>
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</tbody>
</table>
Jodie

he feels empowered to go home and do something immediately that will help and hopefully, he'll take up... the idea of the... therapy or whatever and that I would imagine that a course of that should have good effect. *(Qualities of outcomes)*

If it was more and, and then if there's significant relationship issues etcetera, then I would refer. If there, and also if it seems that it's kind of escalating into more panic related stuff, then I would probably refer for CBT. *(Referring by problem type)*

some GP practices have their own... psych services attached so I'd consider that as an option if I happened to be in a GP surgery that had that. I think community mental health services are over stretched and are unlikely anyway, to, to be taking a presentation like this given they tend to take the more severe ones. *(Ways of getting quicker access for patients)*
The results of the thematic analysis for case vignette 1 for Jodie (see Table 1) indicated that she would first explore the psychological problem by taking patient history to understand more of the patients’ presenting problem and then she would think in terms of the therapeutic activities that would be suitable for the patients’ psychological problem and her competence in providing initial treatment for the patient. She said:

...I wouldn’t be prescribing umm... benzodiazepines give it or, and would explain to him the nature of those that it’s very short term kind of a umm... option and that they, that tolerance and dependence both develop fairly quickly and I would... ‘A’ be addressing more the kinds of... lifestyle things that, the practical action that he can, can take to manage that.

Jodie would also contain the patient’s psychological problems by maintaining the therapeutic alliance so that she could discuss the benefits of therapy versus medications with the patients. She would make her decision on the basis of her view of the psychological therapies in terms of how she anticipated the outcomes would be for the patient if he was referred to therapy. In terms of her referral decisions, Jodie expressed that she would refer according the main causes of the problem. For example, she said: “If it was more and, and then if there’s significant relationship issues etcetera, then I would refer. If there, and also if it seems that it’s kind of escalating into more panic related stuff, then I would probably refer for CBT”. Jodie’s referral decisions would also be affected by the availability of mental health services at that time as she mentioned “...some GP practices have their own... psych services attached so I’d consider that as an option if I happened to be in a GP surgery that had that. I think community mental health services are over stretched and are unlikely anyway, to, to be taking a presentation like this given they tend to take the more severe ones. “

The results of the thematic analysis for the three other participants are reported in Appendix K, and these also support the decision-making process when future GPs think about management on patients with mental health disorder based on case vignettes 1 and 2.
Management of Patients

These provisional results indicated that most of the decision-making process was made in the context of the relationship and communication between doctor and patient, rather in terms of its separate factors as suggested by Knight's (2003) method of analysis.

One participant (Lisa) was more medication-centred and tended to focus more on the presenting symptoms and less on the doctor-patient relationship, in comparison with the other future GPs. This might indicate that the thematic coding using Sigel and Leiper's (2004) grounded theory analytic framework was useful in explaining the difference in the management process between future GPs. This understanding seems difficult to be reached using Knight's (2003) categorical approach in the content analysis.

Limitations of Sigel and Leiper's (2004) Study. The limitation of Sigel and Leiper's (2004) study was that the sample comprised solely of GPs who work closely with psychologists. This is not representative of normal practice in both the UK and Australia, where GPs primarily take responsibility for the management of patients with mental health disorders. In the present study, the fifth component of their framework (interactions with psychologists) was not used in the thematic analysis, as the present sample did not exclude those future GPs did not mentioned that they would liaise with psychologists. It is of interest, however, to note that only two future GPs interviewed in the present study mentioned that they would interact and liaise with a psychologist in the management of their patients.

The grounded theory method employed by Sigel and Leiper (2004) resulted in a framework that might be considered reflective of the decision making process of GPs in the management of patients with mental health disorders. The analytic framework seems to lead to an improved understanding of the process of management of patients with mental health disorders.
Directions for Future Research

Sigel and Leiper’s (2004) grounded theory analysis has been suggested to provide an opportunity for the development of an interactive and dynamic theoretical model which may explain the process involved in decision-making in GPs in the management of patients with mental health disorders. Although it is beyond the scope of the present study, it would be appropriate to complete the thematic analysis using Sigel and Leiper’s framework using all transcripts obtained from future GPs from this present study. Moreover, given the results of this study, there seems to be an opportunity for future research to use a similar grounded theory analysis for a group of Australian GPs.

The present study found that Knight’s (2003) case vignettes and interview questions were useful in eliciting responses that reflected future GPs’ decision-making process when thinking about management of patients with mental health disorders. The participants reported that the vignettes were similar to cases they had seen during their GP and Psychiatry placements. This indicates that the vignettes were realistic and are applicable to Australia. This researcher would recommend that researchers should consider the use of Knight’s case vignettes and interview questions to obtain data, and Sigel and Leiper’s (2004) analytic framework to code the data. This combined approach might lead to greater understanding of the decision-making process associated with the management of patients with mental health disorders.

Furthermore, it would be interesting to compare the differences in regards to the process of decision-making in the management of patients with mental health disorders between Australian and UK GPs. Future studies in this research area are important because the Australian Government has just committed $538 million over 5 years to the Better Access to Psychiatrist, Psychologists, and GPs through the Medicare Benefit Schedule initiative.
which provides GPs to undertake early intervention, assessment and management of patients with mental health disorders.

Summary and Conclusions

This Australian study showed and identified the factors that influence referral decisions and the processes involved in decision-making in medical students when managing patients with mental health disorders by using senior medical students who intend to become GPs. The use of Knight's (2003) content analysis was successful in identifying the factors that future GPs take into account when managing patients with mental health disorders. Consistent with Knight's study, future GPs consider patient-related factors, doctor-related factors and service-related factors when thinking about the management of patients with mental health disorders.

Although the results of Knight (2003) was extended to Australian senior medical students, the categorical approach used in the content analysis seemed relatively rigid, leading to an understanding of the separate factors that influenced future GPs management decisions, but not of the process involved in decision-making in the management of patients with mental health disorders. This led the researcher to test the applicability of a process oriented method of analysis by using a thematic approach where responses obtained from the eight participants based on case vignettes 1 and 2 were coded on the basis of the theoretical model developed by Sigel and Leiper (2004) from their grounded theory analysis.

Results of the thematic analysis potentially indicated that most of the decision-making process was made in the context of the relationship and communication between doctor and patient, rather than in terms of its separate factors as suggested by Knight's (2003) method of analysis. The thematic coding using Sigel and Leiper's (2004) analytic framework seemed useful in explaining the difference in the management process between future GPs which
otherwise could not be reached using Knight’s (2003) categorical approach in the content analysis.

The case vignettes in Knight’s (2003) study seemed useful in helping to explain the decision-making process that future GPs experience when thinking about the management of patients with mental health disorders. They were considered realistic and are applicable to Australia, as participants in this study reported that the vignettes were similar to cases they had seen during their GP and Psychiatry placements.

Future researchers should consider the use of Knight’s (2003) case vignettes and interview questions to obtain data, and Sigel and Leiper’s (2004) analytic framework to code the data as this combined approach may lead to improved understanding of the decision-making process associated with future GPs’ management of patients with mental health disorders. Opportunities for future research should include extending the study to a group of experienced Australian GPs so that the results from this study may be compared. Such a comparison may increase our understanding on how future Australian GPs and experienced Australian GPs may differ in their approach to management of patients with mental health disorders in primary care.

These directions for a future research programme are important given the focus of the Better Access initiative in empowering GPs in primary care to manage patients with mental health disorders. Research in this area by future psychologists and psychologists may assist future GPs and practice GPs to better understand the process that they experience when managing patients with mental health disorders. Further understanding of the decision-making process in future GPs and GPs in the management of patients with mental health disorders may also eventually provide an evidence-based tool for training future GPs and for on-going professional development for practice GPs.
References


Appendix A

Case Vignettes and Interview Questions

Case 1: A 38 year-old bank manager presents with stress-related anxiety symptoms. The pressures at work have increased recently. He cannot sleep at night, lost his appetite, tends to get irritable with his family and feels very frightened before going to work in the mornings. He is asking for medication to control his symptoms.

Case 2: One of your patients was involved in a road traffic accident two years ago. He is still very frightened of driving a car and is only able to travel in a motor vehicle for very short distances. He was recently seen by a psychiatrist for an assessment for his insurance company. The psychiatrist recommended referral for some psychological treatment.

Case 3: A 72 year-old woman lost her husband one year ago. Since then she has been frightened to be on her own and has suffered occasional panic attacks. Her two daughters are very supportive, but have got families of their own and find it hard to attend to their mother (who lives on her own) every day. The mother comes to see you about her blood-pressure, but seems quite depressed and lonely.

Case 4: A 29 year-old single woman comes to see you because she feels very depressed. She starts crying as she tells you that she does not enjoy her job, spends most weekends and evening in bed and has no motivation to do anything. She wants to do something about it, but does not know what. She also expresses some suicidal thoughts.

Case 5: A 50 year-old man visits your practice regularly. He is worried that he might have a brain tumour or multiple sclerosis. In the past, he has complained about a tingling in his legs
(which he perceived as a symptom of multiple sclerosis). At other times, he presented with
headaches (to him an indication of a brain tumour). Various investigations revealed no
abnormalities. Recently, he has been getting headaches again, which convinced him that he
has not got long to live. His own father died age 50.

Case 6: A 25 year-old patient of yours has presented over many years with panic attacks,
poor impulse control, and occasional self-harm. You suspect that she is also abusing drugs
and alcohol. She started a relationship recently, but finds it difficult to cope with her
boyfriend’s sexual demands. She wonders whether there is something physically wrong with
her and consults you. Some of her comments indicate that she might have been sexually
abused in the past.

Case 7: A 42 year-old married woman (with a young family) who has had various
psychological treatments in the past is back in your office. She describes herself as depressed
and frightened to go out. Because of a longstanding fear of choking, she has for years
liquidized all her food. She thinks there is something physically wrong with her (in her throat
or stomach) and this is getting her down.

Case 8: A 45 year-old man with a young family seeks your advice, because he cannot control
his temper. There are frequent arguments between him and his wife and he is frightened that
he might hurt her and that things might get out of control. Recently, he tried to strangle her in
his sleep. She woke him up and he was terrified—this led him to seek help.

Case 9: A 33 year-old woman enters your office crying. She has just found out that her
husband is involved with another woman. She feels she is going ‘mad’. She has been up all
night, can’t eat or sleep and feels unable to go to work.
These case vignettes will be presented individually, followed by three questions:

1. What treatment/action would you recommend? (Would you refer? If yes, where to?)

2. What are the main reasons for your decision?

3. What outcomes would you expect?

(Knight, 2003)

Note. Although not all the scenarios in the case vignettes portray patients with mental health "disorders" as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) (American Psychiatric Association, 1994), this term was used throughout this research report for ease of readability.
Appendix B

Flyer of the Research Project

Attitudes of Medical Students towards Management of Patients with Mental Health Disorders

1. What is the purpose of this study?
The purpose of this study is to identify factors that influence treatment and referral decisions in senior medical students who intend to become GPs, in the management of patients with mental health disorders.

2. What am I expected to do in this study?
A structured interview containing brief real life case scenarios will be presented to you followed by 3 questions.

3. How long will the interview take?
Your participation in this interview will require one session of approximately 30 minutes. A follow-up interview will be conducted in October.

4. How would participating in this study be beneficial to me?
This study may be beneficial to you as it will provide an opportunity for you to reflect on your eventual practice. At the end of this study, a summary of the results of the study will be sent to you via E-mail. Therefore, your participation in this study may be a valuable learning experience.

If you would like to participate in this study and have any questions concerning this research project, please contact: Junaerry Tan (Principal Researcher) Phone: (08) 94056257 Mobile Phone: 0412 3907 53 E-mail: jftan@student.ecu.edu.au

Your participation in this study is totally voluntary and you are free to withdraw at any time during this study without penalty.
Appendix C

Participant Information Letter

Dear Participant,

The purpose of this study is to identify factors that influence treatment and referral decisions in senior medical students who intend to become GPs, in the management of patients with mental health disorders. This research is being conducted by June Fem Tan, Honours student in Psychology from the Faculty of Computing, Health and Science, Edith Cowan University. This research has been approved by the Faculty of Computing, Health and Science Ethics sub-committee.

In this research, you will be required to listen to nine case vignettes which will be read out aloud by the investigator and answer three questions after each case is read out. The interview will be recorded using a digital voice recorder. The audio files and transcriptions will be labelled using pseudonyms to keep your confidentiality in this research. The consent form will be kept separately from audio files and transcriptions. Only the investigator and her supervisor will have access to the audio files, transcriptions and all other confidential materials. All identifying information in the transcriptions will be removed or changed. Your participation in this interview will be required one session of approximately 30 minutes. A follow-up interview will be conducted end of August. At conclusion of this study, a summary of the results will be sent to you to your given E-mail address.

This study may be beneficial to you as it will provide an opportunity for you to reflect on your eventual practice. At the end of this study, a summary of the results of the study will be sent to you via E-mail. Therefore, your participation in this study may be a valuable learning experience. Your participation in this study is totally voluntary and you may withdraw from the study anytime without penalty.
If you would like to participate in this study, please sign the informed consent form which is attached to this information letter on the next page. Any questions concerning this project can be directed to June Fern Tan (Principal Researcher) on (08) _______ (or via E-mail: _______ or Ken Robinson (Supervisor) on (08) _______. If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact Dianne McKillop on (08) _______ or via E-mail at _______.

Thank you.

Yours Sincerely,

June Fern Tan
Appendix D

Informed Consent

I (the participant) have been provided with a copy of the Information Letter explaining the research study and have read and understood the information provided. I have been given the opportunity to ask questions, and any questions I have asked have been answered to my satisfaction. I am aware that if I have any more questions, I can contact the research team. I agree to participate in this research, realising that I may withdraw at any time. I agree that the research data gathered for the study may be published provided I am not identifiable. I agree to be voice recorded and that the audio files and transcriptions will be erased when transcripts have been checked and verified.

__________________________________________  ____________________________
Participant or Authorised Representative        Date

__________________________________________  ____________________________
Investigator                                    Date
Appendix E  

The Classification of Patient, Doctor, and Service-Related Factors Using Knight’s (2003) Method of Content Analysis

Table A1  

*The Classification of Patient, Doctor, and Service-Related Factors (Zach)*

<table>
<thead>
<tr>
<th>Patient Related Factors</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Quotes</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of problem/symptom/diagnosis</td>
<td>'...I think if I was concerned about her suicidal thoughts, if I thought that there was any substance to them, I would refer her to a psychiatrist or a psychologist...but if it seemed to be... a depression out of the blue with, with no reasons for it then I would be more likely to refer her to the psychiatrist.' (Zach, Case 4)</td>
<td>Time/Availability</td>
<td>'...it’s probably a problem that would need a fair amount of time...' (Zach, Case 2)</td>
<td>Appropriateness of the in-house counselling</td>
<td>'...so I’d be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that... and, yeah that there are more qualified people to ((inaudible)).' (Zach, Case 7)</td>
</tr>
<tr>
<td>Competence/Expertise</td>
<td>'...the anxiety seems to be just produced from a work situation which... which may mean that... his lifestyle needs to change, his job may need to, to change. He may need to find... ways of relieving that anxiety and, and dealing with it in more appropriate ways.' (Zach, Case 1)</td>
<td></td>
<td>'I don’t think I’d refer him on to anyone at this point if I felt capable of helping him to work through it.' (Zach, Case 1)</td>
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<td></td>
<td>'...I think it, it’s a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified to, to help her do that.' (Zach, Case 9)</td>
<td></td>
<td>'...even as a GP, I think I’d feel qualified to at least start to get, to look into some of those issues.' (Zach, Case 5)</td>
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<td>'...on the background of what sounds like it could be a depressive episode, this would be most effectively assessed by a psychiatrist I think, who can prescribe medications if required.' (Zach, Case 4)</td>
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<td>'I think that as a GP, I’d be an appropriate first port of call for this woman...' (Zach, Case 9)</td>
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</table>
'...it's quite possible that this is a... a symptom of an anxiety state and so I think... she'd be well suited to being referred on to a counsellor. So a, a, yeah a counsellor so psychologist or psychiatrist, yep.' (Zach, Case 7)

'...anxiety state and so I think a psychiatrist could treat that with, with... cognitive therapy addressing a, psychological treatments as could a psychologist. A psychiatrist could also use medications to, to try and get on top if it.' (Zach, Case 7)

'...with medication, there would be some improvement of her symptoms if it's dependent on her anxiety...' (Zach, Case 7)

...it's unlikely to be fully resolved in the short term. This... either possibility the drug and alcohol or the sexual abuse. both would require long term counselling and, and assistance to deal with, but I'm hopeful that in the long term she would... be able to kick the drug and alcohol problems and resolve some of the tensions about her past as well.' (Zach, Case 6)

'...I'd be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that... and, yeah that there are more qualified people..' (Zach, Case 6)

'...after doing a little bit of work myself just in ruling out medical causes, I would refer her on.' (Zach, Case 6)

'...I think I would refer to... to someone who is better qualified to, to help this man... through maybe exposure therapy or, or some, some cognitive therapy... I think for a good outcome, he would need to see someone like a counsellor or possibly a psychologist.' (Zach, Case 2)

'...if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (Zach, Case 1)

'...I could probably give some, some helpful advice about just ways of meeting up with community groups to relieve that loneliness.' (Zach, Case 3)

'...I haven't, haven't been exposed to this sort of situation... ' (Zach, Case 8)

Experie

Success

...I don't think I would give him his medication straight away I would... probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety. That, yeah I think it would have to be a, a counselling discussion type treatment in his
...her symptoms are appropriate given the event. I don't think she should rush to medic, medication. I think it, it's a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified to, to help her do that.' (Zach, Case 9)

'I think medication is too quick and ready a solution. with a little bit of hard work... she will be better off in the long run if she, if she deals with this grief in her situation adequately...' (Zach, Case 3)

Patients' Needs

'...I think it may be really helpful for him to, to talk about his father and other stresses.' (Zach, Case 5)

'...treatment would be supportive, but not at this stage medication.' (Zach, Case 3)

'...I'd be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that...' (Zach, Case 6)

'...as a GP, I'd be an appropriate first port of call for this woman just to debrief her, ask her about her emotions and about... the evidence for, for what she believes.' (Zach, Case 9)

'...her symptoms are appropriate given the event. I don't think she should rush to medic, medication. I think it, it's a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified' (Zach, Case 9)

'...I would offer her counselling from a trained counsellor...' (Zach, Case 9)

'...I think sexual abuse is a very touchy subject for any patient that has encountered it and so... her being female and me being male I think I would refer it on for those reasons.' (Zach, Case 6)

As a GP, I'd be an appropriate first port of call for this woman just to debrief her, ask her about her emotions and about... the evidence for, for what she believes.

Patients' characteristics and situation

...being a bank manager he would probably be reluctant to, to... change jobs or to make any drastic changes at work where that would interfere with his career, but if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (Zach, Case 1)

'...majority of, of women her age and, and in that situation would respond to medical treatment and... yeah she should feel some

Needing assessment/Advice from therapists

Management of Patients 85

situation...' (Zach, Case 1)
Exclusion of physical pathology to provide reassurance

'...it could be a number of organic pathologies so we need to rule that out. (Zach, Case 5)

...as his GP I will give him a... yeah I would, I would... get the full headache (history), about his symptoms... a good examination and order appropriate investigations. If they came up with nothing, then... then I would try and reassure him of that.' (Zach, Case 5)

Effects of the problem on family

'

...I think if his wife is in danger it's important to deal with it...'(Zach, Case 8)

'Okay this seems to be quite a serious problem because it, it raises the possibility of harm to the man’s wife so I think it needs prompt treatment and, and investigation...I’d be very ready to refer him on to a psychologist of psychiatrist and hope that they can address it.' (Zach, Case 8)

Chronicity and severity

'...this is... an event that happened two years ago and he’s still not over it so I think it’s, it’s a significant problem. It really affects his life, I’m guessing, because a car is very necessary in many, many ways and so I think it’s important that he gets on top of it and so I think for a good outcome, he would need to see someone like a counsellor or possibly a psychologist.' (Zach, Case 2)

'...it’s been a year, but... but over time things should, should improve.' (Zach, Case 3)

'This seems to be a... a recurring pattern ...' (Zach, Case 5)

resolution of her symptoms.' (Zach, Case 4)

...he’s in a risky age group....' (Zach, Case 5)

'As her GP I’d rule out and organic cause for her symptoms, so make sure that she hasn’t got a, some obstruction, a tumour or some, some growth.' (Zach, Case 7)
Patients progress and response to treatment

'...I don't think I would give him his medication straight away I would... probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety. That, yeah I think it would have to be a, a counselling discussion type treatment in his situation..' (Zach, Case 1)

'I think medication is too quick and ready a solution. with a little bit of hard work... she will be better off in the long run if she, if she deals with this grief in her situation adequately...' (Zach, Case 3)

'...treatment would be supportive, but not at this stage medication.' (Zach, Case 3)

...as a GP, I'd be an appropriate first port of call for this woman just to debrief her, ask her about her emotions and about... the evidence for, for what she believes.' (Zach, Case 9)
### Table A2

#### The Classification of Patient, Doctor, and Service-Related Factors (Mike)

<table>
<thead>
<tr>
<th>Patient Related Factors</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Quotes</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of problem/symptoms/diagnosis</td>
<td>'I’d probably give her antidepressants if that’s indicated if she has other symptoms like appetite and sleep...' (Mike, Case 7)</td>
<td>Success of treatment</td>
<td>'I’ll probably give her antidepressants and then if that’s not working... it should help her a bit. But if she starts declining I would, declining after like still... after the medications which takes about six weeks I think, I’d probably refer her after that if she still has these suicidal thoughts, can't get on with her job, not coping well at home.' (Mike, Case 7)</td>
<td>Quality of the service</td>
<td>'Depending on how good the psychologist is he could help him out, I think like things like CBT and DBT could help him...' (Mike, Case 2)</td>
</tr>
<tr>
<td>'... if it’s actually depression and her fears of choking and... if it’s affecting her in her life, I’d give her antidepressants...' (Mike, Case 7)</td>
<td>'I’ll probably have to sit and talk to her about it for about as long as required because she, she just needs someone to talk to I think... and after talking to her and she’s still upset and she’s not able to sleep I’ll probably give her some sleeping tablets...' (Mike, Case 9)</td>
<td>Appropriate case for in-house counselling</td>
<td>'...try to refer her after getting a full history and if I can't help her in terms of medications and it’s affecting her, her whole life, she can't go to work or go to uni or whatever she's doing I’d probably refer her to see what the psychiatrist opinion is. (Mike, Case 6)</td>
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<tr>
<td>Depending on what it is, if it’s say for a tumour who knows what, it could be, could, maybe could be resected. If it’s substance abuse you will refer him to help on substance. If it’s psychiatric a psychiatrist would probably give him medications...' (Mike, Case 7)</td>
<td>'...probably get a more comprehensive history from him... in terms of like what’s causing him at work to be really stressed, why he’s being frightened or is very frightened to go to work, how long it’s been going for, any past history, anything in his medical history that could be causing it as well. So after discussion and a full history, try to actually find out what the exact causes and, because there’ll be numerous causes to it.' (Mike, Case 1)</td>
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<td>'...when she gets the panic attacks, how often she gets it, is it debilitating affecting her like, every day and is she coping at home, so those are some of the main factors I would look at.'(Mike, Case 3)</td>
<td>'...I would probably give him symptomatic relief with some medications. If that's suitable for him, but first and foremost is the history and find out what's exactly causing it and a referral if it's necessary to a, like allied health workers to help him...' (Mike, Case 3)</td>
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<tr>
<td>Doctor-Patient Relationship</td>
<td>Difficulties with particular patient</td>
<td>Chronicity and severity</td>
<td>Experience</td>
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<td>'...her main complaint is her relationship and their sexual relationship so if she wonders if there's something physically wrong so you talk to her about that...' (Mike, Case 6)</td>
<td>'If medications don't work I think I would probably, and if she's still not able to go to work, not able to take care of her family, I'll refer her if antidepressants might not work and she, in terms of her fear... she's probably had psychological treatments and doesn't help. If it's a recurring episode, I'd probably refer her the, the same psychologist again.' (Mike, Case 6)</td>
<td>'If the panic attacks are affecting her so much so that she can't take care of herself so...' (Mike, Case 3)</td>
<td>'I'm not sure about this one because he's a danger to the community in general so you would have to refer him...' (Mike, Case 8)</td>
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<tr>
<td>'...then you go into other things like her panic attacks, poor impulse controls, self harm, what's causing her to have those attacks...' (Mike, Case 6)</td>
<td>'...after talking to her and she's still upset and she's not able to sleep I'll probably give her some sleeping tablets for a while only and then if she get's back on her feet with social support, her friends, her family...' (Mike, Case 6)</td>
<td>'...find out what could be causing him to have these temper controls and probably refer him to... if possible to the police or a psychiatrist because he's a threat to the community...' (Mike, Case 6)</td>
<td>'...sounds like a complex case with previous history, but patients with previous history when they're young are quite difficult...' (Mike, Case 6)</td>
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<td>'...she's abusing drugs and alcohol... so talk to her about self harm, has she tried it before... is she doing it to herself right now... so the main points here would be the, the self harm, talk to her about the self harm, see if that's actually occurring and see why it's occurring.' (Mike, Case 6)</td>
<td>'But there's not much in terms of I can do, terms of... if there's medications that help maybe... no, I don't know if you would give her any medications so I would probably refer her...' (Mike, Case 6)</td>
<td>'But after talking to her about her self harm, the drug and alcohol and her previous sexual abuse, if that's affecting her in her daily life, I will probably refer to the drug and alcohol service and the psychiatrist.' (Mike, Case 6)</td>
<td>'So I would refer on the basis that I knew the patient before the psychiatrist recommends psychological therapy so I would just write a referral to help him out.' (Mike, Case 2)</td>
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<tr>
<td>'But after talking to her about her self harm, the drug and alcohol and her previous sexual abuse, if that's affecting her in her daily life, I will probably refer to the drug and alcohol service and the psychiatrist.' (Mike, Case 6)</td>
<td>'...find out what could be causing him to have these temper controls and probably refer him to... if possible to the police or a psychiatrist because he's a threat to the community...' (Mike, Case 6)</td>
<td>'...so would I refer? I would talk to her about it first and see if it's severely affecting her...' (Mike, Case 3)</td>
<td>'If her depress, if it's actually depression and her fears of choking and... these patients, they always come back...' (Mike, Case 7)</td>
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</table>
...I would talk to her about it first and see if it's severely affecting her... (Mike, Case 3)

...how long she's been feeling this way for... does she have any other symptoms like you know depressive symptoms like lack of sleep and decreased appetite, doesn't enjoy doing things any more. (Mike, Case 4)

...long term patient with many years of panic attacks, nothings helped her... (Mike, Case 6)

...she's had it in the past and she's come back again and patients who have these sort of complaints are not very amenable to treatment. (Mike, Case 7)

...if he like, doesn't like going into things like what's causing, causing him the stress at work and prefers pharmacological therapy, I think I would try to help him in that case. (Mike, Case 1)

...if it’s other things and he, he likes being helped in other ways, I think that’s more suitable getting to the cause of the problem rather than just giving him drugs just for symptomatic relief. (Mike, Case 1)

...what concerns her mainly about that... [sexual problems] (Mike, Case 6)

'I wouldn’t refer at the moment, if she declines then I would refer to people like relationship counselling or things like that, marriage counselling, social worker only if she declines... (Mike, Case 9)

...then if possible, get some input from her family, her... maybe she’s, her neighbours, her friends, see if she requires extra help and care. (Mike, Case 3)

In a seventy-two year old woman, depending for how long she'd been married to her, she's living alone I think a care facility would be helpful, but it'd be difficult to, even with like psychiatrists or psychologists help, if she's been married all her life to the same person it'd be very difficult. (Mike, Case 3)

...he's thirty eight years old and I think he's, depending on him as a person and how he approaches it and if he wants to discuss it with his general physician, if he wants to... if he's like more, more... I guess, amenable to drugs or, or other things that would help him.
I don't know how old he is... because the older he is the more difficult for him to, to... as a suitable driver, his social circumstances (Mike, Case 2)

... but patients with previous history when they're young are quite difficult, I'd probably just yeah, try to refer her after getting a full history... (Mike, Case 6)

...good prognosis after the initial period because she's young, she can be involved with more, meet more people and get involved with more relationships so just tell her that she's young so...

(Mike, Case 9)

'If he like, doesn't like going into things like what's causing, causing him the stress at work and prefers pharmacological therapy, I think I would try to help him in that case.' (Mike, Case 1)

...I would refer on the basis that I knew the patient before the psychiatrist recommends psychological therapy so I would just write a referral to help him out.' (Mike, Case 2)

Control and relief of symptoms
So just pain management for his headaches.' (Mike Case 5)

'...give symptomatic control with like sleeping tablets and hopefully, she'll, after a few consultations talking to her and listening to her about it and giving her just support like for sleep to get, for her to get back on her feet...' (Mike, Case 9)

Exclusion of physical pathology to provide reassurance
'...if it's an organic cause, you would do investigations to rule out organic causes...' (Mike, Case 1)

'... I would do further investigations to rule out all the, all the other pathologies as well...' (Mike, Case 5)
'...then I would talk to him about multiple sclerosis and brain tumours and like what sort of things people come in with and how they occur and try to tell him that it’s unlikely to be those things, it’s rare... for him to present at fifty multiple sclerosis as well so things like that.' (Mike, Case 5)

'...reassure him that his father died of something else not related. (Mike, Case 5)

Social Support

'...some of the main factors I would look at...how she’s coping at home, social support networks.' (Mike, Case 3)

'...if you can help him by discussing with other people in his workplace that could help him relieve that stress.' (Mike, Case 1)

'...if there’s family members who can drive him to work...’ (Mike, Case 2)

'How she’s coping at home, social support networks.’ (Mike, Case 3)

'...she just needs someone to talk to I think...’ (Mike, Case 9)

'I’ll probably have to sit and talk to her about it for about as long as required because she, she just needs someone to talk to I think... and after talking to her and she’s still upset and she’s not able to sleep I’ll probably give her some sleeping tablets...’

(Mike, Case 9)

Patient progress and response to treatment

'...I would probably give him symptomatic relief with some medications. If that’s suitable for him, but first and foremost is the history and find out what’s exactly causing it and a referral if it’s necessary to a, like allied health workers to help him.’ (Mike, Case 1)

'If medications don’t work I think I would probably, and if she’s still not able to go to work, not able to take care of her family, I’ll refer her if antidepressants might not work and she, in terms of her fear... she’s probably had psychological treatments and doesn’t help. If it’s a recurring episode, I’d probably refer her the, the same psychologist again.’ (Mike, Case 7)
"...after talking to her and she's still upset and she's not able to sleep I'll probably give her some sleeping tablets for a while only and then if she gets back on her feet with social support, her friends, her family..." (Mike, Case 9)

Effects of the problem on family

"...her partner if that's an abusive relationship and the sexual abuse you know..." (Mike, Case 6)

...I'll probably refer him straight away because he's tried to strangle her in his sleep..." (Mike, Case 8)

Motivation

"...I think he could get quite well in the future if he goes regularly to his psychologist and wants to be helped I guess." (Mike, Case 2)
### Table A3

*The Classification of Patient, Doctor, and Service-Related Factors (Paul)*

<table>
<thead>
<tr>
<th>Patient-Related Factors</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Quotes</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of problem/symptoms/diagnosis</strong></td>
<td>'...to me there's nothing glaringly, based on the information I have, nothing glaringly serious like a, like a psychotic disorder or suicidal thoughts which would require referral to a, to a psychiatrist.' (Paul, Case 1)</td>
<td>Competence/Expertise</td>
<td>'Well first of all I would want to get more of the history about his symptoms, specifically whether there are other symptoms because the things I'm thinking about are could this patient be depressed, could it, could he have an anxiety related symptom, could it be both... and I guess I'd try and find out whether there was a clear precipitant to his symptoms. I wouldn't refer at this stage, I'd feel comfortable, assuming there's nothing which is too serious, I would feel comfortable in treating the patient in the GP setting.' (Paul, Case 1)</td>
<td>Liaison/Feedback</td>
<td>'...yeah I'd expect it to be monitored, both by myself and whoever... undertaking the psychological care.' (Paul, Case 9)</td>
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<tr>
<td></td>
<td>'...I would want to get more of the history about his symptoms, specifically whether there are other symptoms because the things I'm thinking about are could this patient be depressed, could it, could he have an anxiety related symptom, could it be both...' (Paul, Case 1)</td>
<td>Previous experiences with the service</td>
<td>'...I would agree in referring for some psychological treatment so once again, a psychologist for some form of therapy, psychotherapy... the main reasons for this are I'd feel reasonably confident that his current symptoms are linked to a clear sort of, traumatic event two years ago...' (Paul, Case 2)</td>
<td></td>
<td>'...I'd expect her to be assessed by the multidisciplinary team over a course of probably a week or two and hope that she would be linked into outpatient mental health care if they thought that was required. I'd expect that, if they made the diagnosis of a major depressive disorder they would start her on medication as well and yeah, that allied and of course the allied health people probably would address, I guess, her social and occupational functioning so yeah.' (Paul, Case 7)</td>
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<td>'...I guess I may refer the patient on to a psychologist under the better outcomes for mental health scheme is one way to do, one option... I think, yeah it really depends on the final diagnosis though...' (Paul, Case 1)</td>
<td></td>
<td>'...I feel more confidently monitoring his symptoms for a while.' (Paul, Case 5)</td>
<td></td>
<td>'...I assume they'll [psychiatric services]perform a brief assessment, I wouldn't expect them to be admitted at this stage, yeah so yeah, I assume they'd assess them as an outpatient.' (Paul, Case 7)</td>
</tr>
</tbody>
</table>
I would agree in referring for some psychological treatment so once again, a psychologist for some form of therapy, psychotherapy... if we're looking at a PTSD or anxiety-related syndrome... cognitive and behavioural therapy I think would be useful in this case. (Paul, Case 2)

I would hope the patient would agree, I mean I'd hope that there will be a good therapeutic alliance so that the patient agrees that a referral to a psychologist would be in their best interest... (Paul, Case 2)

The social issues in this case are, should be highlighted. I mean this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives. (Paul, Case 3)

Secondly would consider input from a psychologist if she has been sexually abused in the past... yeah so I would in that case, refer to a psychologist as well. (Paul, Case 6)

...especially in this case she's expressed some suicidal ideation, I need to fully, I need to perform a risk assessment, see whether she can be managed in the community or managed at home, no sorry, managed in a hospital. (Paul, Case 4)

...in all honesty, I'm not sure what this patient may have umm... I'd probably phone a psychiatrist and give him the history over the phone and ask them for their input in this case. (Paul, Case 8)

...I guess we really need to try and address what the precipitating and the prevailing factor is for what seems like her mood disorder, mood disorder, possible adjustment disorder... (Paul, Case 4)

I think it's a very odd presentation and might be a rare syndrome which I'm not aware of and some, yeah because it's rare so I would probably, yeah call up a psychiatrist and give him a brief history and, and go on their recommendation really so. (Paul, Case 8)

...it sounds like a somatisation, somatoform disorder specifically elements of hypochondriasis sort of... I think... given that he's had multiple investigations for similar complaints... (Paul, Case 5)

...I think he'll go and see another GP if he's not satisfied that I'm not attending to his symptoms... (Paul, Case 5)

This presenting complaint has been investigated before... I guess you, something, given that the number of presentations and different types of disorders he's thought he's had, start to entertain the, the, have in the back of my mind the diagnosis of hypochondriasis always and otherwise another somatoform disorder so that's why I feel more confidently monitoring his symptoms for a while.' (Paul, Case 5)

'I guess next step is more about... what's the word, well rehabilitation from, of the abusing substance or from substance abuse... so I guess that includes treating a patient in the, in the withdrawal period as well as dealing with any dependence issues that they have.' (Paul, Case 6)

The need for assessment/advice from a therapist 'I'd want to refer, I'd want to review this patient again in probably two or three days to see how she's going... and perhaps recommend some counselling which may be in the form of a psychologist or, or a counsellor just to, for her to discuss her... her emotions at the time I suppose.' (Paul, Case 9)
...I wouldn't refer straight away in this case... unless there was something new in the presentation because he's presenting with headaches and he's already presented with headaches in the past before.' (Paul, Case 5)

'Look I think if you suspect sexual abuse, you need to try and establish a history in more detail, so that's one of the first things I would do. I would definitely explore the substance abuse aspect, or the organisity (?) aspects of her presentation. Definitely take the full drug and alcohol history...' (Paul, Case 6)

'...fear of choking is more an overvalued idea or maybe even, could even be a, I'd want to screw in to see whether it's a psychotic presentation, if that's the case then I would refer them to a psychiatrist for a further assessment.' (Paul, Case 7)

...the aspect that perplexes me is the, the strangling her in his sleep. I think that's... and then him waking up, sounds like he doesn't have, didn't have an awareness of it so. I think it's a very odd presentation and might be a rare syndrome...'(Paul, Case 8)

...could well just be an adjustment disorder or it could be, yeah probably an adjustment disorder at this stage, but it may develop into something worse ...' (Paul, Case 9)

'Social Support ...I mean this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives. So I think increasing social supports are very important for this patient. Referral, I mean there may be some sort of a community social worker, a social worker based in the community who can help link this patient into some groups to, to help her expand her circle of friends, increase her level of, increase her involvement in activities. I think that would greatly benefit her.' (Paul, Case 3)
"...I think a big part of her recovery will be the involvement of her family so I would hope that I would try and talk to the family as well and hope that they increase the level of support for the mother." (Paul, Case 3)

"...I guess we really need to try and address what the precipitating and the prevailing factor is for what seems like her mood disorder, mood disorder, possible adjustment disorder... so need to look at her social supports. I may try and link her in with some community supports." (Paul, Case 4)

Exclusion of physical pathology to provide reassurance

I'd want to explore more about why she's, has this longstanding fear of choking. If there is, you know whether there is actually a medical basis for it or yeah a physical basis for it..." (Paul, Case 7)

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"...I would try and reassure him, assuming he's not too unwell and compromising his activities of daily living..." (Paul, Case 5)

Chronicity and severity

'I could possibly refer the patient to the next step programme for, depending on the level of abusing of drugs and alcohol.' (Paul, Case 6)

...whether she attends or not, engages with them really depends on I guess, how much of a problem she see her substance abuse as..." (Paul, Case 6)

"...it really depends on the risk assessment whether I refer her on to a hospital or a psychiatrist." (Paul, Case 4)

Motivation

"...I guess the answer is the referral it's, it really depends on the risk assessment..." (Paul, Case 4)

"...I mean if she is ready to, to discuss it, then I think a psychologist could be, psychological input could be very helpful" (Paul, Case 6)
whether she attends or not, engages with them really depends on I guess, how much of a problem she see her substance abuse as... (Paul, Case 6)

...she may have had past surgery or she may have had problems swallowing before which is really physiological. If that’s the case then I’d... probably refer on to a gastroenterologist I suppose.' (Paul, Case 7)

I’d feel comfortable treating her in the GP place... I would possibly give her a sedative to aid her sleep such as a benzodiazepine... I think...' (Paul, Case 9)

I’d want to refer, I’d want to review this patient again in probably two or three days to see how she’s going... and perhaps recommend some counselling which may be in the form of a psychologist or, or a counsellor just to, for her to discuss her... her emotions at the time I suppose.' (Paul, Case 9)

...she would need some insight into that being a problem to be, for that to be successful...' (Paul, Case 6)

...this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives.' (Paul, Case 3)
### Table A4

**The Classification of Patient, Doctor, and Service-Related Factors (Lisa)**

<table>
<thead>
<tr>
<th>Patient Related Factors</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Quotes</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of problem/symptom</td>
<td>&quot;...it sounds like post traumatic stress disorder and it, the, and I think that psychological treatment is very important in that, that particular condition...&quot; (Lisa, Case 2)</td>
<td>Difficulties with particular patients</td>
<td>&quot;...she's had various treatments in the past and she's still here so I wouldn't expect a huge improvement, but at least I'd want to try something to make her a little bit better...&quot; (Lisa, Case 7)</td>
<td>Liaison/Feedback</td>
<td>&quot;...I would refer her to a psychiatrist as well because of umm...have better access to like, what services are available...&quot; (Lisa, Case 6)</td>
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<td>**Yea, I'd also discuss with him some techniques that he can use like, to reduce his stress like, so to help with sleeping he could exercise during the day more so than he might be already.&quot; (Lisa, Case 1)</td>
<td>Competence/Experise</td>
<td>&quot;...I think the GP can manage this lady quite well...&quot; (Lisa, Case 3)</td>
<td>Therapists interest and training</td>
<td>&quot;...I think that it is better assessed by a psychiatrist will assess it and with the psychologist I think, because it's more complicated the medications and stuff aren't tailored for this kind of a condition and so that's why psychotherapy has more of a role.&quot; (Lisa, Case 5)</td>
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<td>**Because of the suicidal thoughts, I think I'd like to admit her as an inpatient and also then she can commence medication with monitoring...&quot; (Lisa, Case 4)</td>
<td>Success of treatment</td>
<td>&quot;Would I refer her? No, I'd ask her to come back to me in a fortnight and see how she's going and then from there assess her again if, if she's either the same or gotten a bit better I'd say come back again in, in another fortnight. If she's gotten worse then I'd think about additional medication.&quot; (Lisa, Case 9)</td>
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<td>[...might also benefit from talking to a social worker to sort out her, like talking about her job and stuff.&quot; (Lisa, Case 4)</td>
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<td>&quot;...I would also refer to a psychiatrist because this is like, it's less of a common condition and I think that it is better assessed by a psychiatrist will assess it and with the psychologist I think, because it's more complicated the medications and stuff aren't tailored for this kind of a condition and so that's why psychotherapy has more of a role.&quot; (Lisa, Case 5)</td>
<td></td>
<td>&quot;...I think that it would be worth trying medication with her first and then if that has no effect, then you could use a adjunct therapy like psychological, like seeing a psychologist or something.&quot; (Lisa, Case 3)</td>
<td></td>
<td>&quot;...I've transferred the care to the psychiatrist so... I would expect it (uncommon mental health condition 'to be managed by the psychiatrist and I would expect that the patient, yeah, will report an improvement...&quot; (Lisa, Case 5)</td>
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|                         | "It sounds like she may have a personality disorder and she also has... like long, longstanding issues..." (Lisa, Case 6) | | | | "...it would be useful for him to have some low dose SSRIs and see if that has an effect, but the, the main part of his treatment will be, will be psychological therapy."
<table>
<thead>
<tr>
<th>Chronicity and severity</th>
<th>Experien</th>
<th>Motivati</th>
<th>Needing assessment and advice from a therapist</th>
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<tbody>
<tr>
<td>'She would definitely... yeah, be good for psycho, psychological, referral to a psychologist as well and, because she's got like kind of deep seeded issues that need to be dealt with. I don't, I think she'd be best off as well, in individual and or relationship therapy as well rather than a group therapy kind of a situation.' (Lisa, Case 6)</td>
<td>'...I think that a GP can, like anxiety and depression are very common and I think that a GP can manage them enough, but I do think that they need help from the, from like allied health and stuff.' (Lisa, Case 1)</td>
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<tr>
<td>'I don't think she's got like a major depression or something like that. So I'd, I'd just start with yeah, two weeks off, of diazepam five milligrams.' (Lisa, Case 9)</td>
<td>'...I'd just continue with the, whatever the psychiatrist had recommended.' (Lisa, Case 2)</td>
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<td>...she seems quite severely depressed so I would expect that she would need to be on a higher dose to see an effect.' (Lisa, Case 4)</td>
<td>'...I think, I haven't really seen this as much, I think that he would be another prime candidate to see a psychologist as well.' (Lisa, Case 5)</td>
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<tbody>
<tr>
<td>I think I'd like to admit her as an inpatient and also then she can commence medication with monitoring so that, because sometimes they become more suicidal before they get, they get worse before they get better type thing.' (Lisa, Case 4)</td>
<td>'With the psychiatrist because it is more complicated and not something I have had much experience with then I feel that they would be best.' (Lisa, Case 7)</td>
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<th>Motivati</th>
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</thead>
<tbody>
<tr>
<td>'...I would refer to a psychiatrist in that case because she's got yeah again, longstanding issues and, and the recurrent complaint...’ (Lisa, Case 7)</td>
<td>'...I don't know that much about it (uncommon mental health condition), but the psychiatrist hopefully, will.' (Lisa, Case 5)</td>
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<th>Needing assessment and advice from a therapist</th>
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</thead>
<tbody>
<tr>
<td>'...I would just start with two weeks of benzodiazepine because it looks, seems to be a situational kind of a crisis...’ (Lisa, Case 9)</td>
<td>'Oh with the psychiatrist referral I'd say he needs to be an urgent referral as well.' (Lisa, Case 8)</td>
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</thead>
<tbody>
<tr>
<td>'...provided she can act on what I say about joining some social groups and stuff, I think that it will improve a lot for her...' (Lisa, Case 3)</td>
<td>'...she should be feeling much better that she was before and with more motivation and stuff.' (Lisa, Case 4)</td>
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</table>
"...if he continue or he does what the psychiatrist says and so goes and sees a psychologist and then he could participate in like, group therapy and also maybe some individual therapy including some exposure type stuff." (Lisa, Case 2)

"...an antidepressant with a, anxiolic (?) like maybe venlafaxine (?)... so I'd expect for pretty much, all of the symptoms to reduce or even disappear with the medication..." (Lisa, Case 1)

"...I think that this woman would benefit from an antidepressant taken at night particularly..." (Lisa, Case 3)

"With the panic attacks I'd also give her some benzodiazepine. She may like to try Serapax at night or Oxazepam or whatever and... to help her with sleep..." (Lisa, Case 3)

...it would be useful for him to have some low dose SSRIs..." (Lisa, Case 5)

"...she might be good... having a, sort of an anxiolic (?) sort of SSRI or something like that as well and that ((inaudible)) but maybe like Serapax or something if she's not already treated..." (Lisa, Case 7)

...the medication would be because until she can get an appointment to see both of them I want to try and help her with her symptoms..." (Lisa, Case 7)

"...I think that it would be worth trying medication with her first and then if that has no effect, then you could use a adjunct therapy like psychological, like seeing a psychologist..." (Lisa, Case 3)

"Would I refer her? No, I'd ask her to come back to me in a fortnight and see how she's going and then from there assess her again if, if she's either the same or gotten a bit better I'd say come back again in, in another fortnight. If she's gotten worse then I'd think about additional medication." (Lisa, Case 9)
Patients' wishes and preferences

"...it would be useful for him to have some low dose SSRIs and see if that has an effect..." (Lisa, Case 5)

So I'd like to admit her as an inpatient... provided she agrees, not as an involuntary patient only as a voluntary..." (Lisa, Case 4)

Effects of the problem on family

...he's... a big risk to his wife and his family and there's a good chance that he'll hurt them so, even without wanting to really so he, so it needs to be addressed as soon as possible.' (Lisa, Case 8)

Social support

She would also benefit from having a, like joining a group or something, so I'd encourage her to get involved with like a seniors group or something so she's not relying on her daughters for social support as much. (Lisa, Case 3)

...her children need to be involved in her care and if she could come back with them that would be good.' (Lisa, Case 3)

Previous treatment or assessment

'Also because she's had various treatments in the past... as well, so that's why I think she should see a psychiatrist and the psychologist because she... umm... has, I don't know, her the things that she does and says are not what the medications are typically addressed towards so I think it's a bit more complicated so I think the psychologist could help in that regard.' (Lisa, Case 7)

Exclusions of physical pathology to provide reassurance

...if she hasn't had all the investigations to see if what she's saying is true yet, then I'd like to do like I don't know, like a... CT or something to investigate to see if maybe it was true. ' (Lisa, Case 7)
### The Classification of Patient, Doctor, and Service-Related Factors (Sarah)

<table>
<thead>
<tr>
<th>Type of problem/symptom/diagnosis</th>
<th>Patient Quotes</th>
<th>Doctor-Related Factors</th>
<th>Service-Related Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient related factors</td>
<td>'...I guess he needs some sort of psychotherapy where he can talk about what happened and be able to deal with the issues that he feels he's still got... and then also to address that he can't drive a car and can't travel in vehicles because this will be having some impact on his life.' (Sarah, Case 2)</td>
<td>'I would firstly... ask her to come back for a longer appointment because I think we need to talk about what's happened with her husband and her current living arrangements and also her ability to cope looking after herself and so forth and then I would also explore the issue of depression because it says she seems quite depressed and it may be appropriate to give her some antidepressants. Maybe on the next visit and also maybe look into some services like a nursing or maybe not a nursing home, but... some sort of, like Silver Chain visiting or something...' (Sarah, Case 3)</td>
<td>'Again I don't know what services are available, but I've heard of things such as anger management so I would ask someone if that's, if they're available and I can refer him there.' (Sarah, Case 8)</td>
</tr>
<tr>
<td>Quotes</td>
<td>(refer) After having done my own assessment...' (Sarah, Case 8)</td>
<td>(refer) After having done my own assessment...' (Sarah, Case 8)</td>
<td>(refer) After having done my own assessment...' (Sarah, Case 8)</td>
</tr>
<tr>
<td>Doctor-related factors</td>
<td>'...I would also explore the issue of depression because it says she seems quite depressed and it may be appropriate to give her some antidepressants.' (Sarah, Case 3)</td>
<td>'...seeing as I've been seeing her for many years I hope that I would have the kind of rapport with her that I could bring up this subject of sexual abuse and to see if... that had occurred...' (Sarah, Case 6)</td>
<td>'I would bring up the sexual abuse with her because I think, as a GP, that is appropriate and within the boundaries of your role if you've known a patient for many years' (Sarah, Case 6)</td>
</tr>
<tr>
<td>Service-related factors</td>
<td>'...I think that she's a bit depressed, that she seems lonely and she's elderly so... is going to be having some problems coping now that her husband's passed away. (Sarah, Case 3)</td>
<td>'I would bring up the sexual abuse with her because I think, as a GP, that is appropriate and within the boundaries of your role if you've known a patient for many years' (Sarah, Case 6)</td>
<td>'I would bring up the sexual abuse with her because I think, as a GP, that is appropriate and within the boundaries of your role if you've known a patient for many years' (Sarah, Case 6)</td>
</tr>
<tr>
<td>Social Support</td>
<td>Experiences</td>
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<tr>
<td>&quot;...I'd need to explore the family or friend supports... to check that she's got people with her...&quot; (Sarah, Case 9)</td>
<td>&quot;...I suppose they'd have a bit more experience with me, than me in terms of... when it's better to hospitalise someone...&quot; (Sarah, Case 4)</td>
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</table>

| ...This lady is... seems acutely depressed and suicidal so, depending on what more information I got about how active this plan is, she may need referral to hospital... so if that was the case, I'd probably ring the psychiatrist at the hospital nearest me to see what they think. But if not, otherwise it would be appropriate to start her on antidepressants straight away.' (Sarah, Case 4) |
| "...it would be appropriate to start her on antidepressants straight away. If you can trust her enough not to overdose on them or that she won't try any other means of suicide in the meantime.' (Sarah, Case 4) |

| ...I guess we also need to address the reasons why she's feeling depressed as well. (Sarah, Case 4) |
| "...she's come to me so... as long as she's happy to come back that's probably appropriate follow up' (Sarah, Case 9) |

| ...it may well be that these are more sinister sounding headaches and then I guess if that, those investigations are normal which I... imagine would involve some sort of imaging, then it... would be appropriate to refer him to a psychiatrist or I guess I could start him on antidepressants myself. But I think I, I think it would be better to refer him to a psychiatrist.' (Sarah, Case 5) |
| "...I'd probably ring the psychiatrist at the hospital nearest me to see what they think.' (Sarah, Case 4) |

| Also addressing this depression which is probably linked to the fear of choking, but I would explore that some more and if she's not on any medications that might be appropriate to start.' (Sarah, Case 7) |
| "...I'd hope that she would come back to me to keep me updated about how she's going ...' (Sarah, Case 9) |

| ...well he needs... anger management therapy and also to establish why he has difficulties with his temper so... that would involve exploring his background history when he was growing up, but also more recently why he's arguing with his wife umm... so... that would be the first thing to talk to him and then... I guess I would see if there's behavioural strategies I could refer him to.' (Sarah, Case 8) |
| "...if I wasn't sure I would ring the psychiatrist to see if he or she thought she should be admitted. I suppose they'd have a bit more experience with me, than me in terms of... when it's better to hospitalise someone..." (Sarah, Case 4) |

<p>| ...you might find out more things that he's... depressed or there's other things going on that you want to be able to treat...' (Sarah, Case 8) |
| &quot;I'd actually have to ask someone, I don't know, maybe a psychologist or... well the psychiatrist seems to have referred him back to me so... I'd ask a psychiatrist or a psychologist, I wouldn't feel like I'd know what to do.' (Sarah, Case 2) |</p>
<table>
<thead>
<tr>
<th><strong>Exclusion of physical pathology to provide reassurance</strong></th>
<th><strong>Safeguarding career/preventing mistakes</strong></th>
<th><strong>Difficulties with particular patient</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;...investigations have not ruled any pathology, he has presented with new onset headaches so I do think it is appropriate to reinvestigate these because, even though you might think he’s exaggerating his symptoms, you can’t afford to ignore what he’s saying...&quot; (Sarah, Case 5)</td>
<td>&quot;...I think doing something like a pap-smear’s also appropriate, but then referring on is the best thing to do if you’re not sure.&quot; (Sarah, Case 6)</td>
<td>&quot;...well this is a complicated case and I think it is not a quick fix...&quot; (Sarah, Case 6)</td>
</tr>
<tr>
<td>'I’d hope that we could rule out any actual sinister pathology and then reassure him...' (Sarah, Case 5)</td>
<td>...in terms of... the... physical examination... I guess if she’s happy for you to do, for me to do a pap-smear which probably is appropriate, or is appropriate given she’s started a sexual relationship... that will tell you, that will tell me about her anatomy I guess, and then if there’s anything unusual I see, I could refer her to a sexual health expert.' (Sarah, Case 6)</td>
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<tr>
<td>(...) I would hope that... you can start to establish if there’s been sexual abuse in the past and reassure her about her... physical, well that there’s nothing wrong with her.' (Sarah, Case 6)</td>
<td>'Well if she hasn’t had investigations for her throat and stomach, this is the first thing to do and some of these I could organise as a GP, but some may involve referral to, for example, a gastroenterologist. But she needs some sort of barium swallow or chest x-ray to check that she hasn’t got a stricture... so... that would be the first thing.' (Sarah, Case 7)</td>
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<tr>
<td>Well we might be able to reassure her that all investigations are normal if that’s the case and then address her... psychological issues.' (Sarah, Case 7)</td>
<td>...she thinks it’s something physically wrong with her so we should check that there’s no abnormalities.' (Sarah, Case 7)</td>
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<tr>
<td>'..it’s an acute situational crisis... but... and while it’s, it will be at it’s worst now...' (Sarah, Case 9)</td>
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<tr>
<td><strong>Chronicity and severity</strong></td>
<td></td>
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<tr>
<td>&quot;This lady is... seems acutely... depressed and suicidal so, depending on what more information I got about how active this plan is, she may need referral to hospital...&quot; (Sarah, Case 4)</td>
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</table>
...well this, this situation sounds like it's... almost getting very dangerous in that he tried to strangle his wife so this needs to be addressed urgently.' (Sarah, Case 8)

'...if she's had this long-standing fear of choking so... and that she thinks it's something physically wrong with her so we should check that there's no abnormalities.' (Sarah, Case 7)

'...it's an acute situational crisis... but... and while it's, it will be at it's worst now...' (Sarah, Case 9)

Control/relief of symptoms, sedation

'...we could get her over this particularly bad time and starting some antidepressant medication...' (Sarah, Case 4)

...it also is appropriate to give her... a short term sleeping pill as she's unable to sleep with her anxiety...' (Sarah, Case 9)

'I would hope, if I did give medication that that would make him feel better.' (Sarah, Case 1)

...giving her the short term sleeping tablet at least get her through this first week.' (Sarah, Case 9)

Patients' characteristics and situation

'...well he's fifty... and he seems quite worried about these morbid illnesses and also that his own father died at age fifty, that's a... fair reason to have these worries and this seems to have been going on for a while so it might be better to go to a specialist and get it sorted out.' (Sarah, Case 5)

I would consider medication in this man because he has come to you asking for medication. I think it's appropriate to respond to what he wants ... .' (Sarah, Case 1)

'... as long as she's happy to come back that's probably appropriate follow up.' (Sarah, Case 9)

(Referral) Not at the moment unless she specifically asks for it.' (Sarah, Case 9)

Patients' Needs

'...I'd also reassure her that she doesn't need to go to work for the next few days and it's entirely appropriate to take a few days off and she doesn't need to feel guilty about that...' (Sarah, Case 9)

'...give her some sort of work certificate or arrange that she doesn't need to go to work... yep.' (Sarah, Case 9)

Effect on family

... he tried to strangle his wife...’ (Sarah, Case 8)
Table A6

The Classification of Patient, Doctor, and Service-Related Factors (George)

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>'...this was a simple case of post traumatic stress disorder...the psychiatrist recommended a referral to psychological treatment so it depends who's the best person to treat him. Either a GP with mental health training who has trained to perform cognitive behavioural therapy or group therapy or even better refer this person to a psychologist or even a counsellor.' (George, Case 2)</td>
<td>'I'd like to refer her to a psychologist and as appropriate and also if she doesn’t get better I think I refer her to a psychiatrist, Oh and a psychiatric ward might, might actually be, be the best for her.' (George, Case 6)</td>
<td>'I'd refer him to a psychologist and there's also a helpline for domestic violence that remains... that keeps patient confidentiality so any time that he feels that he's having these anger bouts or having this (inaudible)) of, of aggression he can be assured that there is a helpline that he can call, yup the domestic violence call, helpline and he can actually speak to someone yeah.' (George, Case 8)</td>
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<tr>
<td>The first thing is to... confirm a diagnosis by history and examination and then you try to... determine the most likely diagnosis in this setting. You can stratify that into psychiatric and non psychiatric causes so the first would be an anxiety disorder and other non psychiatric causes...his symptoms are loss of sleep, loss of appetite, irritable and elements of fear of going to work so you're thinking of any drugs that he's taking, for example is he on intravenous drug usage or if there's any other endocrine disorders for example hypothyroidism and even diabetes in this case, yeah.' (George, Case 1)</td>
<td>'I'm not sure if his, he'll benefit from any pharmacological therapy at this moment, but if his symptoms do not improve I think a psychiatric referral will be better.' (George, Case 8)</td>
<td>'Either a GP with mental health training who has trained to perform cognitive behavioural therapy or group therapy or even better refer this person to a psychologist or even a counsellor.' (George, Case 2)</td>
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<tr>
<td>'...in the general practice setting in this case, the man does present stress-related anxiety symptoms...' (George, Case 1)</td>
<td>'...I don't think any patients would benefit for immediate pharmacological therapy, the first thing is always counselling and advice yeah, and if I don't have the experience to do it I think it's worth referring her to a psychologist or counsellor.' (George, Case 4)</td>
<td>'I'll have a whole pool or list of psychologists with each respective credentials I can refer him to the psychologist for best outcomes...' (George, Case 2)</td>
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</table>
"Well... obviously the problem is actually not her blood pressure, but problem is isolation. Some elements of depression in her and also since one year ago you want to see if, is she still bereaving. Yeah, bereavement is a process not a disorder disease and it usually goes for one to two years yeah. So I will I treat her, well first you like to treat her underlying problem, she's lonely and you think you can give her advice, things that she can do to keep herself busy, keep herself happy." (George, Case 3)

"...it depends on my experience, my knowledge and the level of my training. ' (George, Case 2)

"...because like she has all these anxieties and the phobic disorders yeah, it does point to a form of somatisation that leads to a functional dysphasia so referral to a psychologist may help her to cope with this issue.' (George, Case 7)

<table>
<thead>
<tr>
<th>Competence/Expertise</th>
<th>Difficulty with particular patients</th>
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<tbody>
<tr>
<td>...I think it's worth referring this patient to see a psychologist or counsellor again because she has elements of panic disorders, yep. Don't think a referral to a psychiatrist would do her any help. I think she'll benefit from a referral to a psychologist.' (George, Case 3)</td>
<td>But given this patient who's been seeing me regularly, I'm not sure has he been shopping for doctors and doctor shopping which is actually a, a, a typical activity for patient somatoform disorders... (George, Case 5)</td>
</tr>
<tr>
<td>...she has some underlying psychiatric conditions, some elements of panic disorders and she has a hypotension, she's bereaving and she's also lonely so elements of isolation. So this is a case where this lady should be managed by a multidisciplinary approach number one by their GP, number two by the psychologist of counsellor and number three perhaps counselling, Oh sorry some community support, yeah.' (George, Case 3)</td>
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</table>
suicidal so by that you really have six or seven elements that point to a major depressive disorder with elements of suicidal ideation... (George, Case 4)

...the most important thing you shouldn't miss is manic depressive disorder, but other organic causes would be pathology, anaemia... (George, Case 4)

'So my number one diagnosis in respect of other differentials will be his somatising at this moment... I think he might benefit from referral either number one, referral to another general practitioner, another GP for a second... opinion or number two you might refer this patient to a psychologist.' (George, Case 5)

Also like, you like to address other issues like boyfriends sexual impulsivity and... also because she's been sexually abused in the past a psychiatric referral with cognitive behavioural therapy will, will actually improve her outcomes.' (George, Case 5)

'I think she will benefit from a referral to a psychologist yeah, she has elements of panic disorders, then psychologist might help her reduce her anxiety and the poor impulsivity occasional self harm might be indication of either bipolar disorder, or even just a major depressive disorder but we have, a lot of psychiatric elements and ((inaudible)) disorders bipolar, major depressive disorder and also drug use or drug dependence... (George, Case 6)

'...so you do a thorough history with emphasis on the psychiatric history and also because she has fear of choking, yeah, you would do, focussing on psychiatric history and also gastrointestinal history...' (George, Case 7)
'I'll refer to psychologist on the basis that she has a longstanding history of psychological problem. Yep, she also has elements that lead to a depressive, frightened to go out, leads to agoraphobia, so because like she has all these anxieties and the phobic disorders yeah, it does point to a form of somatisation that leads to a functional dysphasia so referral to a psychologist may help her to cope with this issue.' (George, Case 7)

...presents with anxiety, elements anxiety and dysphasia so you’re going to figure, find out if the dysphasia is anatomical dysphasia for example an obstruction in the larynx or pharyngal structure or even a tumour yeah. If the dysphasia is a functional dysphasia, functional dysphasia due to an anxiety disorder.' (George, Case 7)

'...it looks like domestic violence in this case yeah. As a GP you may also like to get the wife involved, it’s refer him to a psychologist and there’s also a helpline for domestic violence that remains... that keeps patient confidentiality so any time that he feels that he’s having these anger bouts or having this ((inaudible)) of, of aggression he can be assured that there is a helpline that he can call...' (George, Case 8)

'...first thing we see the issues of conflict management and issues of shock so I like to address these two issues and also the insomnia symptoms.' (George, Case 9)

'Referral to a psychologist help her to umm... reduce anxiety symptoms and help her to cope with work and cope with her life yeah.' (George, Case 9)

This actually looks like what we call acute situational crisis when someone in the acute setting has been shocked by this new information that she got umm... in this setting again, you’d like to find out more about the reason why this has happened yeah.' (George, Case 9)

Some elements of depression in her and also since one year ago you want to see if, is she still
...it's worth doing a depression screen on this person and see if he's at risk of you know, harming himself, harming other people.' (George, Case 1)

So if she's at high risk then you might like to form her under the Mental Health Act and refer her immediately to a psychiatrist, psychiatric ward via ambulance yeah, but if she's at low risk or minimum risk then I'd like to see her again in the next two weeks, but I will not start any medication of course at this moment.' (George, Case 4)

'...occasionally she self harms herself so again you know, is like this on the basis of risk assessment is this patient at risk of harming herself, harming others or even harming her reputation, yeah. So if it's severe refer her to psychiatrist, if it's not severe then you manage her, I'll manage her myself and also refer her to a psychologist and it will be for better outcome.' (George, Case 6)

'...this man is at high risk okay of harming his wife, harming his family, may even harm himself and harm his reputation yeah.' (George, Case 8)

'If she's found to have umm... to be what we call a nervous wreck or she's at high risk of harming herself or even harming the woman or harming her husband and then in acute setting I might even form her under the Mental Health Act, but it is on a basis of risk assessment.' (George, Case 9)

'...management plan in a short term setting I think some anxiolitics or some benzodiazepine, oxazepam, and diazepam can help her with her sleep...' (George, Case 9)

'...she's not well, yeah and you can see that she is going out of control, that is a symptomatically we treat her symptoms that she presents with, yeah she can't sleep so we give her benzodiazepine of course on the basis that she's able to be comply with medication and she's not going
Exclusion of physical pathology to provide reassurance to overdose or she won't take the umm... excessive amounts.' (George, Case 9)

"You can stratify that into psychiatric and nonpsychiatric causes so the first would be an anxiety disorder and other nonpsychiatric causes. You'd like to rule out organic causes." (George, Case 1)

"...in the general practice setting in this case, the man does present stress-related anxiety symptoms, but first thing is my role as a general practitioner is to rule out all causes, also to look out for red flags that may lead to serious disorders that I shouldn't miss in this case.' (George, Case 1)

"...definitely you still want to rule out the organic causes for example anaemia could be a cause of this.' (George, Case 4)

"First thing is you still address the issue, so you've done all this investigations and abnormalities, well you still address it. The first thing you do is you do a baseline vital signs, perhaps you'd like to repeat the blood tests and all the other investigations to see is, if it might detect anything we miss out previously..."'(George, Case 5)

"I'd actually like to tell this patient that we've done all this investigation and we couldn't find underlying cause, yet it could be something organic or something psychological, but it's something where medical science hasn't found a definite diagnosis for it. But we've done various investigations and we found there is not a brain tumour or, and it's not multiple sclerosis. Brain tumours, multiple sclerosis can be picked up easily with imaging investigations for example CT or MRI yep, so when he has something that we couldn't confirm by those investigations we think maybe it could be something else for example mild fibrosis, it could be anaemia, it could be anxiety, it
could be anything, it could be he's somatising at this moment yeah.' (George, Case 5)

The referral to a gastroenterologist for endoscopy imaging study is on the basis that she is having dysphasia so to rule out organic causes..' (George, Case 7)

'Do a physical examination yeah, and you have to rule out the other causes.' (George, Case 7)

'...I'd like to refer this patient to two people, number one is to a gastroenterologist alright for endoscopy to rule out any Gi pathology for example yeah, oesophageal tumour umm... or other problems.' (George, Case 7)

'...refer her to a psychologist if we rule out that there's no other organic causes then a psychologist help her improve her symptoms.' (George, Case 7)

...Still you like to rule out what the causes of his aggressive behaviour and you'd still perform a history examination..' (George, Case 8)

'...first thing we see the issues of conflict management and issues of shock so I like to address these two issues and also the insomnia symptoms.' (George, Case 9)

Patient s' needs 'This person needs long term care and he needs a frequent follow up so umm... by referring to a psychologist or counsellor they'll... have the best management plan for this patient.' (George, Case 2)

This patient is a man I think, that needs reassurance, multiple reassurances so referral could be the best treatment for him.' (George, Case 5)

'...he's presenting with the same symptoms over and over again and we couldn't find anything wrong so main reason is that again, yeah, he needs that
reassurance. (George, Case 5)

Patient's progress and response to treatment
'I'm not sure if his, he'll benefit from any pharmacological therapy at this moment, but if his symptoms do not improve I think a psychiatric referral will be better.' (George, Case 8)

'I'd like to refer her to a psychologist and as appropriate and also if she doesn't get better I think I refer her to psychiatrist, On and a psychiatric ward might, might actually be, be the best for her.' (George, Case 6)

Effects of the problem on family
'We really don't want this family to become dysfunctional yeah, we don't want his wife to get injured and we want the family to get better as a whole and we want his anger to get controlled yeah and this is on the basis that I follow up to him, to see a psychologist, he's going through anger management yeah and he's gone through and he's seeking help through the domestic violence helpline.' (George, Case 08)

'She's seventy-two years old, it's worth knowing is she independent, is she able to survive on her own, alright.' (George, Case 3)

'...this man is at high risk okay of harming his wife, harming his family, may even harm himself and harm his reputation yeah.' (George, Case 8)

Patient's characteristics and situation
...she's an old lady, she's a widow...' (George, Case 3)

'...she's a single woman, twenty years so she's pretty young so you want to ask her if she has any recent trauma in her life, is she bereaving...' (George, Case 4)

'...this definitely a young patient with multiple psychiatric insults that might have began early in her life and that lead to a whole series of psychological disturbances in her life.' (George, Case 6)

'This, this is a forty year, two year old lady who presents with anxiety...' (George, Case 7)
Social Support

'Number two does she need any nursing care or she needs any nursing visits where Silver Chain or even local community support. Number three get the family involved; her family has got families of their own, but perhaps get family involved and ask them if they can visit her more frequently...' (George, Case 3)

'My outcome is always been for this person to get better, for him to address his problems and perhaps even get the family involved.' (George, Case 1)

Patient wishes and preference

'...So we address his issues, we give him what he wants and usually spontaneously the symptoms might even disappear...’ (George, Case 5)
Table A7

The Classification of Patient, Doctor, and Service-Related Factors (Alan)

<table>
<thead>
<tr>
<th>Type of problem/symptoms/diagnosis</th>
<th>Patient Quotes</th>
<th>Doctor-Related Factors</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>...she's, may, might not be depressed or something because post traumatic stress can last more than a year so, and yeah, so it could all, could be part of the grieving process... (Alan, Case 2)</td>
<td>...I could also as a GP you’d want to, you could follow up from that and do some counselling... (Alan, Case 1)</td>
<td>...I think the new mental health care plan requires a GP referral so you've got to take a full history from him and see what his issues are and, and then you refer him on, yep. So liaising with the psychologist. (Alan, Case 2)</td>
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<tr>
<td>...suicidal thoughts is the red flag for you to kind of do something about it there... (Alan, Case 4)</td>
<td>...he's obviously presenting with a problem and wants to you to help him fix it... (Alan, Case 1)</td>
<td>...as you're that patient's GP you are responsible for that, for him as well. So not just the psychiatrist, yep. (Alan, Case 2)</td>
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<tr>
<td>...what you can do then is to see what, what she's worried about and, yeah, she's been, about her sexual abuse in the past and... and yeah that needs to be looked into because, yeah it's obviously connected to what she's feeling now. (Alan, Case 6)</td>
<td>...it's a serious thing that needs to be looked into, a sexual abuse and yeah, it can have often, long term psychological repercussions for the patients... (Alan, Case 6)</td>
<td>...you do have a duty of care to help her out as much as you can with the medical issues as well. (Alan, Case 9)</td>
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<tr>
<td>Tried to strangle her in his sleep... maybe some psychological services and some like, counselling to see umm... about his temper and stuff, so you want to control about that. (Alan, Case 8)</td>
<td>Time/availability</td>
<td>...do the best you can to do all you can. With your time constraints as well as a GP. (Alan, Case 1)</td>
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</tbody>
</table>
**Chronicity and severity**
'It seems like a long term thing for him, anxiety...'
(Alan, Case 1)

...if you send them home she might kill herself. So you want to look into a bit more history, what... how severe is her depression and how... seriously she is about her suicide, like her risk assessment of suicide and... yeah and if you're serious then you would want to get her like, recommend her to go to hospital.' (Alan, Case 4)

**Doctor-Patient Relationship**
'...she has come to see you and it's a very serious thing that she's said... she's willing to express her feelings to you so you have a responsibility to do something about it, especially the suicidal thoughts.' (Alan, Case 4)

**Social Support**
'...like with support and you know, see what other social networks there are sort of thing as well. You could look into that as well, yep.' (Alan, Case 3)

...yeah take her history and understand where she's coming from. Make sure that you're available for her to come back to...
(Alan, Case 9)

**Control/relief of symptoms, sedation**
'...you can give her some medications for her sleep at that stage, however, you'll also want to refer her on to some counselling and psychological services.' (Alan, Case 9)

'...she's had treatment for it from, not by a GP I guess and so would need more help with that, like as a specialist help with that.' (Alan, Case 6)

**Exclusion of physical pathology to provide reassurance**
'...I believe is that it's not one of these serious conditions that you said so you'd have to have lots of reassurance for him and... so he's worried about... yeah he's, that he might die because his father died at fifty so you've got to have lots of reassurance and... with that like you'd go through the results with him and explain, explain to him what the results are and it's not anything serious.' (Alan, Case 5)

'For him to be reassured that it's not a brain tumour or multiple sclerosis and that he can continue with his daily life not worried about it.' (Alan, Case 5)

**Patients’ wishes and preferences**
'He's asking for his medication so that could be one line of treatment for like, some sleeping
Table A8

The Classification of Patient, Doctor, and Service-Related Factors (Jodie)

<table>
<thead>
<tr>
<th>Patient Related Factors</th>
<th>Quotes</th>
<th>Doctor-Related Factors</th>
<th>Quotes</th>
<th>Service-Related Factors</th>
<th>Quotes</th>
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<tr>
<td>Type of problem/symptoms/diagnosis</td>
<td>'...the evidence in, in anxiety is that CBT is in fact, better as a first line and... I'm disinclined to... I suppose, my personal... position is that people are going to be more empowered by being able to do something to manage their symptoms than taking a tablet which will address their symptoms, but not actually change the underlying problem and also because of the nature of benzodiazepines being or both tolerance so it's not going to work for his insomnia and then because of their, the dependence aspect of them.' (Jodie, Case 3)</td>
<td>Competence/Expertise</td>
<td>'..If I was in the context of a practice where... I you know, did some mental health GP work as an interest, then I would be inclined to manage that myself.' (Jodie, Case 3)</td>
<td>Liaison/Feedback</td>
<td>'..liaising with them [domestic violence counselling service] to ensure that he has in fact, followed up on that.' (Jodie, Case 8)</td>
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<tr>
<td></td>
<td>'..if there's significant relationship issues etcetera, then I would refer. If there, and also if it seems that it's kind of escalating into more panic related stuff, then I would probably refer for CBT you know, and talk to him about some basic breathing and relaxation sort of exercises.' (Jodie, Case 1)</td>
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to manage his symptoms.' (Jodie, Case 1)

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...it’s more PTSD or a specific phobia presentation... so I guess behavioural therapy or exposure sort of stuff building up to... yeah, so that increased exposure stuff considering the process of going in a car, managing his anxiety effectively in the context of that.' (Jodie, Case 2)

'I would feel competent to deal with that myself. That if it’s only occasional panic attacks and it’s not a, you know, full blown panic disorder...' (Jodie, Case 3)

'...look it depends a bit on the nature of the practice or the nature of the presentation. (Jodie, Case 3)

'...so just an assessment of her suicidal risk which I’d feel quite competent to do.' (Jodie, Case 4)

I think community mental health services are over stretched and are unlikely anyway, to, to be taking a presentation like this...I would be referring him for private because I think that the public system...is overloaded...' (Jodie, Case 4)

'Well initially I would be exploring the suicidal thoughts in more depth. I'd ((inaudible)) and the duration of her depression... and ((inaudible)) then the, you know, to other kinds of things so how else is it manifesting. Has it impacted on sleep, appetite... engagement in the... you know, socially and occupationally and, and whatever.' (Jodie, Case 4)

'I guess because I'd be concerned about her level of suicidality because that can potentially increase on, as you start antidepressants rather than decrease so I'd want to monitor it, monitor her wellbeing closely and provide support and I guess... ensure that she has made that link with a therapist.' (Jodie, Case 4)

So in my experience adult psych services are notoriously bad at looking at the families of their... clients, patients, that CAMHS [Child and Adolescent Mental Health Services] do a much better job of that so I'd be checking out the kids myself and seeing do they need referral.' (Jodie, Case 1)

'I would... look at medication in, if it’s been a sustained you know, depression and then if she fits the criteria of a, you know, moderate to severe episode of major depression.' (Jodie, Case 4)

'...I suppose I’d be inclined to manage it myself initially...' (Jodie, Case 7)

'Therapist interests and training
'...I would be more inclined to refer her to someone like SARC (Sexual Assault Referral Centre) or you know, a private therapist who has experience in working with abuse rather than to community mental health.
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...her grief would be acknowledged...' (Jodie, Case 3)

'I'd want to explore his... anxiety and concerns about his father and I guess, to ascertain how you know, resolved or not that is and, and what that you know, leads him to worry about.' (Jodie, Case 5)

That his headaches, I guess that, that if it is indeed purely psychological that he's able to make that link and that in making that link and in addressing his anxieties and the kinds of things that are triggering that, that the symptoms resolve.' (Jodie, Case 5)

...have a bit more of a picture of the kinds of sexual demands and whether they are unreasonable or unhealthy or whether, given her... queried (?) past abuse that she experiences them as such and I'd be referring her to someone who was experienced in sexual abuse counselling...’ (Jodie, Case 6)

...because the reality is that you've... in a general practice you're not going to have the time to do exposure therapy with him. (Jodie, Case 2)

...well it would depend a bit on what my... practice load was.' (Jodie, Case 9)

...because of the skills base to do it and the time factor. (Jodie, Case 2)

...he links with... a DV (Domestic Violence) organisation...' (Jodie, Case 8)

...in therapy she's going to have the privilege of a greater you know, consultation time than she's able to have with a GP... (Jodie, Case 4)

...I hope that I have engaged him adequately and have a sufficiently strong alliance that... that he would be able to weight up the benefits of... therapy versus medication.' (Jodie, Case 1)

...it would depend, whether I would use a contract would depend on the nature of my relationship with her.' (Jodie, Case 4)
'...would go depends somewhat on the... level of risk and then in addition, so maintaining frequent visits with her and looking at other aspects like you know, lifestyle issues, diet, exercise, sleep habits... you know or all of that stuff.' (Jodie, Case 4)

'...if... she's been my patient for many years that these are the kinds of things that I'd have been discussing with her over a long time and I would recognise her impulse control issues and self harm etcetera and that; I would have the kind of relationship with her where I could ask her whether she was abusing drugs and alcohol and to discuss some of what that might mean as well...' (Jodie, Case 4)

'...this is a relatively severe depression, then medication is indicated' (Jodie, Case 4)

'...would depend a bit on whether she was a, you know, long term patient or I'd just happened to see her out of the blue. If I'd happened to see her out of the blue I probably wouldn't, I'd, I'd, I'd choose to refer and if, if it's a family and relationship based issue if, I, I mean I would screen to see whether there were any other you know, more health related issues...' (Jodie, Case 4)

'...if she was at an imminent suicidal risk, I'd be wanting... her to be contacting them [other people who know her] and for them to be aware of her state and risk in order that she's got some protection.' (Jodie, Case 6)

'...yeah she's going to continue to have difficulties in the future and hopefully that she feels safe enough to continue to access me as a GP.' (Jodie, Case 6)

'...I suppose I'd be inclined to manage it myself initially and then if there didn't seem to be improvement then looking at a, you know, psychiatrist and preferably a more multidisciplinary... theme approach.' (Jodie, Case 7)

'Success of GP treatment

'So yeah, I'd guess the extent to which I would go depends somewhat on the... level of risk...' (Jodie, Case 4)

'...I'd want future, sort of like within the next few days, and to monitor that over the period of time that it takes until the antidepressants kick in.' (Jodie, Case 4)
Social Support

'...I would say if, if she’s got two daughters that are very supportive, then it’s likely that she comes from a reasonably functional family context and, and, and probably a functional community context of about, I guess, reconnecting her with that, with that and yeah, I guess, and that her, that she’s more socially independent as a result of my intervention.' (Jodie, Case 3)

'So if she... while it says she’s a single woman, is she... does she live alone or does she live with others and what’s her, I guess, looking at her, what her significant relationships and discussing with her the merit of them knowing...' (Jodie, Case 4)

'I would ascertain what supports she’s got, who she feels she’s able to talk about this with.' (Jodie, Case 9)

'...need to explore her social circumstances which would lead, I imaging, to finding out that she’d lost her husband and to talk to her about what that had meant for her.' (Jodie, Case 3)

'Safeguarding career/ Preventing mistakes

...nature of the panic attacks and if they were occasional panic attacks... so infrequent, I’d may be more inclined to explore her social circumstances more and look at what sorts of other links etcetera, she has within the community and of what interests and things she’s either maintained or developed since her husband’s death...' (Jodie, Case 3)

'S...if it seems that it’s kind of escalating into more panic related stuff, then I would probably refer for CBT you know, and talk to him about some basic breathing and relaxation sort of exercises to manage his symptoms.' (Jodie, Case 1)

'...so if she... while it says she’s a single woman, is she... does she live alone or does she live with others and what’s her, I guess, looking at her, what her significant relationships and discussing with her the merit of them knowing...' (Jodie, Case 4)

'I'd be exploring past medications, whether she’s had, so as well as psychological treatments, has she had, what medications has she had in the past so you know, antidepressants or, gives me... you know enclitics or whatever.' (Jodie, Case 5)

'...just in the immediate term to get her to have some space to get her head around that then I would address that and I guess what I would do beyond that is a bit dependent on the nature of the conversation and the outcomes of that.' (Jodie, Case 9)

'...he’s the kind of patient that’s to present, well she’s, ‘A’ she’s been a patient of mine ever many years so I’d have hoped that I’d have picked up on all of that sort of stuff a whole lot earlier... yes I’d be a bit concerned that hadn’t... yeah, recognised some of that already... (Jodie, Case 6)

'...that she was well connected to her community and support networks... that she’s more socially independent as a result of my intervention.' (Jodie, Case 3)
Control/relief of symptoms, sedation

'If the sleep deprivation was extreme then I might consider short term use of benzos [benzodiazepine]. (Jodie, Case 1)

Exclusion of physical pathology to provide reassurance

'I'd be... like, looking at say just a gastroscopy or something to check if there's indeed anything wrong, but suggesting that as an investigation in the context of also, that, that you need to rule that out...' (Jodie, Case 7)

'...I would screen to see whether there were any other you know, more health related issues.' (Jodie, Case 9)

'...the physical investigation I would do to an extent that ensured that, that there wasn't anything physically wrong rather than just to do investigations ad infinitum because she's worried. (Jodie, Case 7)

'I'd be normalising her... you know, experience, feelings, whatever as acute... stress related...' (Jodie, Case 9)

Patients' characteristics and situation

'...if he's a bank manager he's likely to have sufficient financial resources to manage that, to manage like private things so does he have private health insurance in which case I would probably refer him to a private therapist...' (Jodie, Case 1)

'I mean at least he's financial circumstances were such that he couldn't afford it, I would be referring him for private because I think that the public system... needs to be kept, is overloaded and needs to be kept for those who can't afford it and then... I guess in places like Relationships Australia or Kinway or other you know, non government options if he was reluctant to consider private given that's a reduced fee.' (Jodie, Case 2)

Patients' wishes and preferences

'...I would refer her would depend on her wishes and, and assets. So a private therapist or a relationship you know, counselling organisation so Kinway or Relationships Australia or somewhere like that.' (Jodie, Case 9)
What sort of medication is he seeking and what does he understand about how those might help... I guess to, yeah, get a clearer sense of, of why he sees that as a means to address it. So in part I guess, it would depend on the information I got back in relation to that.' (Jodie, Case 1)

<table>
<thead>
<tr>
<th>Previous treatment or assessment</th>
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<tr>
<td>'I guess I'd want to know what are the previous psychological treatments she's had and I'd be talking to her about their, her experience with them, whether she found them beneficial or not.' (Jodie, Case 7)</td>
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<td>'...because she's had psychological treatments in the past, I mean had they been effective then I would be referring her again for that.' (Jodie, Case 7)</td>
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<th>Patients' Needs</th>
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<td>'...just exploring that a bit more so is it that he's having panic attacks or is it just a feeling of anxiety and what is the nature of, of that. To explore that in more detail and also to look at what it is that he's doing in relation to that umm... so both his kind of thought process and how he's managing it.' (Jodie, Case 1)</td>
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<td>'...that I take his concerns seriously and his you know, physical symptoms, but that there's a psychological component to it as well. (Jodie, Case 5)</td>
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<tr>
<th>Patients' progress and response to treatment</th>
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<tr>
<td>'...if it seems that it's kind of escalating into more panic related stuff, then I would probably refer for CBT you know, and talk to him about some basic breathing and relaxation sort of exercises to manage his symptoms.' (Jodie, Case 1)</td>
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...in the first instance it's something I would be addressing myself and getting him, yeah to kind of make, make the link between his emotional state and his physical symptoms that he was
Effects of the problem on family

I'd be inclined to manage it myself initially and then if there didn't seem to be improvement then looking at a, you know, psychiatrist and preferably a more multidisciplinary... theme approach.' (Jodie, Case 3)

'...just in the immediate term to get her to have some space to get her head around that then I would address that and I guess what I would do beyond that is a bit dependent on the nature of the conversation and the outcomes of that.' (Jodie, Case 9)

...I don't want to be doing more of the same if the same hasn't worked.' (Jodie, Case 7)

'I'd also be concerned, given she's got a young family, that what's happening for the kids and to consider a referral for them, which is in fact probably another reason that I'd be referring to a, like to psychiatry or whatever in the hope that her children's needs are also going to be recognised in that.' (Jodie, Case 7)

'I'd be wanting to speak with his wife also... and I'd be encouraging him to have his wife contact me to ascertain her view...' (Jodie, Case 8)

...he links with... a DVorganisation and that he... takes responsibility for his behaviour and... that there is a more equal relationship within the family...' (Jodie, Case 8)

'...I'd be wanting the whole family ultimately to be part of that intervention...' (Jodie, Case 8)

'...would hope that she was able to work toward a more healthy relationship with her boyfriend...' (Jodie, Case 6)

'...ideally, that her level of motivation would increase, that her mood would improve, that she would, as her motivation and mood improved that she would be, she would have you know, more energy and a greater enjoyment...' (Jodie, Case 4)
Appendix F

Frequencies of Patient, Doctor, and Service-Related Factors that Influenced Future GPs' Treatment and Referral Decisions

Table B1

**Patient-Related Factors**

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<thead>
<tr>
<th>Type of problem/symptoms/diagnosis</th>
<th>Frequency= 85 (20.53%)</th>
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<tr>
<td>...I think if I was concerned about her suicidal thoughts, if I thought that there was any substance to them, I would refer her to... a... psychiatrist or a, or a psychologist...but if it seemed to be... a depression out of the blue with, with no reasons for it then I would be more likely to refer her to the psychiatrist.' (Zach, Case 4)</td>
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<td>...the anxiety seems to be just produced from a work situation which... which may mean that... his lifestyle needs to change, his job may need to, to change. He may need to find... ways of relieving that anxiety and, and dealing with it in more appropriate ways.' (Zach, Case 1)</td>
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<td>...I think, it's a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified to, to help her do that.' (Zach, Case 9)</td>
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<tr>
<td>...on the background of what sounds like it could be a depressive episode, this would be most effectively assessed by a psychiatrist I think, who can prescribe medications if required.' (Zach, Case 4)</td>
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<td>'This could be a, a delusion, it could be paranoia... but in all likelihood she's right and so I'd want to just try and establish that, make sure there's evidence... but yeah, it's, it's a terrible situation and I think just from talking it through and explaining that her feelings are consistent with the event could be helpful. I would offer her counselling from a trained counsellor and reassure her that she isn't going mad if, I don't think that's the case.' (Zach, Case 9)</td>
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<td>...it's quite possible that this is a... a symptom of an anxiety state and so I think... she'd be well suited to being referred on to a counsellor. So a, a, yeah a counsellor so psychologist or psychiatrist, yep.' (Zach, Case 7)</td>
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<td>'...anxiety state and so I think a psychiatrist could treat that with, with... cognitive therapy addressing a, psychological treatments as could a psychologist. A psychiatrist could also use medications to, to try and get on top if it.' (Zach, Case 7)</td>
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<tr>
<td>'...with medication, there would be some improvement of her symptoms if it's dependent on her anxiety... ' (Zach, Case 7)</td>
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<td>...it's unlikely to be fully resolved in the short term. This... either possibility the drugs and alcohol or the sexual abuse. both would require long term counselling and, and assistance to deal with, but I'm hopeful that in the long term she would... be able to kick the drug and alcohol problems and resolve some of the tensions about her past as well.' (Zach, Case 6)</td>
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<td>'...I'd be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that... and, yeah that there are more qualified people'... (Zach, Case 6)</td>
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<td>...her symptoms are appropriate given the event. I don't think she should rush to medic, medication. I think it, it's a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified to, to help her do that.' (Zach, Case 9)</td>
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<tr>
<td>'I'd probably give her antidepressants if that's indicated if she has other symptoms like appetite and sleep...' (Mike, Case 7)</td>
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| '...it's actually depression and her fears of choking and... if it's affecting
her in her life, I'd give her antidepressants...’ (Mike, Case 7)

Depending on what it is, if it's say for a tumour who knows what, it could be, could, maybe could be resected. If it's substance abuse you will refer him to help on substance. If it's psychiatric a psychiatrist would probably give him medications...’ (Mike, Case 7)

‘...when she gets the panic attacks, how often she gets it, is it debilitating affecting her like, every day and is she coping at home, so those are some of the main factors I would look at.(Mike, Case 3)

...her main complaint is her relationships and their sexual relationship so if she wonders if there's something physically wrong so you talk to her about that...’(Mike, Case 6)

‘...then you go into other things like her panic attacks, poor impulse controls, self harm, what's causing her to have those attacks...'(Mike, Case 6)

‘...she’s abusing drugs and alcohol... so talk to her about self harm, has she tried it before... is she doing it to herself right now... so the main points here would be the, the self harm, talk to her about the self harm, see if that's actually occurring and see why it's occurring. ’ (Mike, Case 6)

'But after talking to her about her self harm, the drug and alcohol and her previous sexual abuse, if that's affecting her in her daily life, I will probably refer to the drug and alcohol service and the psychiatrist.' (Mike, Case 6)

'...find out what could be causing him to have these temper controls and probably refer him to... if possible to the police or a psychiatrist because he’s a threat to the community...' (Mike, Case 8)

'...to me there's nothing glaringly, based on the information I have, nothing glaringly serious like a, like a psychotic disorder or suicidal thoughts which would require referral to a, to a psychiatrist.' (Paul, Case 1)

'...I would want to get more of the history about his symptoms, specifically whether there are other symptoms because the things I'm thinking about are could this patient be depressed, could it, could he have an anxiety related symptom, could it be both...’ (Paul, Case 1)

'...I guess I may refer the patient on to a psychologist under the better outcomes for mental health scheme is one way to do, one option... I think, yeah it really depends on the final diagnosis though...’ (Paul, Case 1)

'...I would agree in referring for some psychological treatment so once again, a psychologist for some form of therapy, psychotherapy... if we're looking at a PTSD or anxiety related syndrome... cognitive and behavioural therapy I think would, could be useful in this case. (Paul, Case 2)

'...the social issues in this case are, should be highlighted. I mean this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives. (Paul, Case 3)

'...especially in this case she’s expressed some suicidal ideation, I need to fully, I need to perform a risk assessment, see whether she can be managed in the community or managed at home, no sorry, managed in a hospital. (Paul, Case 4)

'...I guess we really need to try and address what the precipitating and the prevailing factor is for what seems like her mood disorder, mood disorder, possible adjustment disorder...'(Paul, Case 4)

...it sounds like a somatisation, somatoform disorder specifically elements of hypochondrias sort of... I think... given that he's had multiple investigations for similar complaints...’(Paul, Case 5)

'This presenting complaint has been investigated before... I guess you, something, given that the number of presentations and different types of disorders he’s thought he’s had, start to entertain the, the, have in the back of my mind the diagnosis of hypochondrias is always and otherwise another somatoform disorder so that's why I feel more confidently monitoring his symptoms for a while.’ (Paul, Case 5)
I wouldn't refer straight away in this case... unless there was something new in the presentation because he's presenting with headaches and he's already presented with headaches in the past before.' (Paul, Case 5)

'Look I think if you suspect sexual abuse, you need to try and establish a history in more detail, so that's one of the first things I would do. I would definitely explore the substance abuse aspect, or the organisity (?) aspects of her presentation. Definitely take the full drug and alcohol history... ' (Paul, Case 6)

'... fear of choking is more an overvalued idea or maybe even, could even be a, I'd want to screw in to see whether it's a psychotic presentation, if that's the case then I would refer them to a psychiatrist for a further assessment.' (Paul, Case 7)

...the aspect that perplexes me is the, the strangling her in his sleep. I think that's... and then him waking up, sounds like he doesn't have, didn't have an awareness of it so. I think it's a very odd presentation and might be a rare syndrome... '(Paul, Case 8)

...could well just be an adjustment disorder or it could be, yeah probably an adjustment disorder at this stage, but it may develop into something worse... ' (Paul, Case 9)

'...it sounds like post traumatic stress disorder and it, the, and I think that psychological treatment is very important in that, that particular condition... ' (Lisa, Case 2)

Yep, I'd also discuss with him some techniques that he can use like, to reduce his stress like, so to help with sleeping he could exercise during the day more so than he might be already. ' (Lisa, Case 1)

Because of the suicidal thoughts, I think I'd like to admit her as an inpatient and also then she can commence medication with monitoring... ' (Lisa, Case 4)

'...I would also refer to a psychiatrist because this is like, it's less of a common condition and I think that it is better assessed by a psychiatrist will assess it and with the psychologist I think, because it's more complicated the medications and stuff aren't tailored for this kind of a condition and so that's why psychotherapy has more of a role.' (Lisa, Case 5)

'It sounds like she may have a personality disorder and she also has... like long, longstanding issues...' (Lisa, Case 6)

'She would definitely... yeah, be good for psycho, psychological, referral to a psychologist as well and, because she's got like kind of deep seeded issues that need to be dealt with. I don't, I think she'd be best off as well, in individual and or relationship therapy as well rather than a group therapy kind of a situation.' (Lisa, Case 6)

'I don't think she's got like a major depression or something like that. So I'd, I'd just start with yeah, two weeks of, of diazepam five milligrams.' (Lisa, Case 9)

'...I guess he needs some sort of... psychotherapy where he can talk about what happened and be able to deal with the issues that he feels he's still got... and then also to address that he can't drive a car and can't travel in vehicles because this will be having some impact on his life.' (Sarah, Case 2)

'...also the symptoms that he's got in that his insomnia, anorexia or loss of appetite, is being irritable when he's scared of going to work, so obviously it's having a functional impact. Umm... and then, so I guess that's why I'd want to ask more and then either give medication or as you said, maybe refer later on.' (Sarah, Case 1)

'...I would also explore the issue of depression because it says she seems quite depressed and it may be appropriate to give her some antidepressants. ' (Sarah, Case 3)

...I think that she's a bit depressed, that she seems lonely and she's elderly so... is going to be having some problems coping now that her husband's passed away. (Sarah, Case 3)
'This lady is... seems acutely... depressed and suicidal so, depending on what more information I got about how active this plan is, she may need referral to hospital... so if that was the case, I'd probably ring the psychiatrist at the hospital nearest me to see what they think. But if not, otherwise it would be appropriate to start her on antidepressants straight away.' (Sarah, Case 4)

'...I guess we also need to address the reasons why she's feeling depressed as well. (Sarah, Case 4)

'...it may well be that these are more sinister sounding headaches and then I guess if that, those investigations are normal which I... imagine would involve some sort of imaging, then it... would be appropriate to refer him to a psychiatrist or I guess I could start him on antidepressants myself. But I think I, I think it would be better to refer him to a psychiatrist.' (Sarah, Case 5)

'Also addressing this depression which is probably linked to the fear of choking, but I would explore that some more and if she's not on any medications that might be appropriate to start.' (Sarah, Case 7)

'...well he needs... anger management therapy and also to establish why he has difficulties with his temper so... that would involve exploring his background history when he was growing up, but also more recently why he's arguing with his wife umm... so... that would be the first thing to talk to him and then... I guess I would see if there's behavioural strategies I could refer him to.' (Sarah, Case 8)

'...you might find out more things that he's... depressed or there's other things going on that you want to be able to treat...' (Sarah, Case 8)

'...this was a simple case of post traumatic stress disorder...the psychiatrist recommended a referral to psychological treatment so it depends who's the best person to treat him. Either a GP with mental health training who has trained to perform cognitive behavioural therapy or group therapy or even better refer this person to a psychologist or even a counsellor.' (George, Case 2)

The first thing is to... confirm a diagnosis by history and examination and then you try to... determine the most likely diagnosis in this setting. You can stratify that into psychiatric and non psychiatric causes so the first would be an anxiety disorder and other non psychiatric causes...his symptoms are loss of sleep, loss of appetite, irritable and elements of fear of going to work so you're thinking of any drugs that he's taking, for example is he on intravenous drug usage or if there's any other endocrine disorders for example hypothyroidism and even diabetes in this case, yeah.' (George, Case 1)

'...in the general practice setting in this case, the man does present stress- related anxiety symptoms...' (George, Case 1)

'Well... obviously the problem is actually not her blood pressure, but problem is isolation. Some elements of depression in her and also since one year ago you want to see if, is she still bereaving. Yeah, bereavement is a process not a disorder disease and it usually goes for one to two years yeah. So I will I treat her, well first you like to treat her underlying problem, she's lonely and you think you can give her advice, things that she can do to keep herself busy, keep herself happy.' (George, Case 3)

'...I think it's worth referring this patient to see a psychologist or counsellor again because she has elements of panic disorders, yep. Don't think a referral to a psychiatrist would do her any help. I think she'll benefit from a referral to a psychologist.' (George, Case 3)

'...she has some underlying psychiatric conditions, some elements of panic disorders and she has a hypotension, she's bereaving and she's also lonely so elements of isolation. So this is a case where this lady should be managed by a multidisciplinary approach number one by their GP, number two by the psychologist of counsellor and number three perhaps counselling, Oh sorry some community support, yeah.' (George, Case 3)

...course treat other underlying problems for example the blood pressure. You still wouldn't, you will not ignore the blood pressure, you still see if it's
complied with medications and the blood pressure’s controlled.’ (George, Case 3)

...confirm the diagnosis on the basis of history and examinations and the signs and symptoms that she’s expressing right now is feeling of depression, crying, lack of enjoyment or anhedonia spends most of her time in bed so hypersomnia, lack of motivation, lack of energy. So by that she also expressed some suicidal so by that you really have six or seven elements that point to a major depressive disorder with elements of suicidal ideation...

(George, Case 4)

‘...the most important thing you shouldn’t miss is manic depressive disorder, but other organic causes would be pathology, anaemia...’ (George, Case 4)

‘...So my number one diagnosis in respect of other differentials will be his somatising at this moment...I think he might benefit from referral either number one, referral to another general practitioner, another GP for a second... opinion or number two you might refer this patient to a psychologist.’ (George, Case 5)

Also like, you like to address other issues like boyfriends sexual impulsivity and... also because she’s been sexually abused in the past a psychiatric referral with cognitive behavioural therapy will, will actually improve her outcomes.’ (George, Case 6)

‘...I think she will benefit from a referral to a psychologist yeah, she has elements of panic disorders, then psychologist might help her reduce her anxiety and the poor impulsivity occasional self harm might be indication of either bipolar disorder, or even just a major depressive disorder but we have, a lot of psychiatric elements and (inaudible)) disorders bipolar, major depressive disorder and also drug use or drug dependence...’ (George, Case 6)

‘...so you do a thorough history with emphasis on the psychiatric history and also because she has fear of choking, yeah, you would do, focusing on psychiatric history and also gastrointestinal history...’ (George, Case 7)

‘I’ll refer to psychologist on the basis that she has a long standing history of psychological problem. Yep, she also has elements that lead to a depressive, frightened to go out, leads to agoraphobia, so because like she has all these anxieties and the phobic disorders yeah, it does point to a form of somatisation that leads to a functional dysphasia so referral to a psychologist may help her to cope with this issue.’ (George, Case 7)

...presents with anxiety, elements anxiety and dysphasia so you’re going to figure, find out if the dysphasia is anatomical dysphasia for example an obstruction in the larynx or pharyngal structure or even a tumour yeah. If the dysphasia is a functional dysphasia, functional dysphasia due to an anxiety disorder.’ (George, Case 7)

‘...it looks like domestic violence in this case yeah. As a GP you may also like to get the wife involved, I’d refer him to a psychologist and there’s also a helpline for domestic violence that remains... that keeps patient confidentiality so any time that he feels that he’s having these anger bouts or having this ((inaudible)) of, of aggression he can be assured that there is a helpline that he can call...’ (George, Case 8)

‘...first thing we see the issues of conflict management and issues of shock so I like to address these two issues and also the insomnia symptoms.’ (George, Case 9)

‘Referral to a psychologist help her to umm... reduce anxiety symptoms and help her to cope with work and cope with her life yeah.’ (George, Case 9)

‘...she’s, may, might not be depressed or something because post traumatic stress can last more than a year so, and yeah, so it could all, could be part of the grieving process...’ (Alan, Case 2)

‘...suicidal thoughts is the red flag for you to kind of do something about it there...’ (Alan, Case 4)
'...what you can do then is to see what, what she's worried about and, yeah, she's been, about her sexual abuse in the past and... and yeah that needs to be looked into because, yeah it's obviously connected to what she's feeling now.' (Alan, Case 6)

'...it's a serious thing that needs to be looked into, a sexual abuse and yeah, it can have often, long term psychological repercussions for the patients.' (Alan, Case 6)

'Tried to strangle her in his sleep... maybe some psychological services and some like, counselling to see umm... about his temper and stuff, so you want to control about that.' (Alan, Case 8)

'...the evidence in, in anxiety is that CBT is in fact, better as a first line and... I'm disinclined to... I suppose, my personal... position is that people are going to be more empowered by being able to do something to manage their symptoms than taking a tablet which will address their symptoms, but not actually change the underlying problem and also because of the nature of benzodiazepines being or both tolerance so it's not going to work for his insomnia and then because of their, the dependence aspect of them.' (Jodie, Case 1)

'...if there's significant relationship issues etcetera, then I would refer. If there, and also if it seems that it's kind of escalating into more panic related stuff, then I would probably refer for CBT you know, and talk to him about some basic breathing and relaxation sort of exercises to manage his symptoms.' (Jodie, Case 1)

'...it's more PTSD or a specific phobia presentation... so I guess behavioural therapy or exposure sort of stuff building up to... yeah, so that increased exposure stuff considering the process of going in a car, managing his anxiety effectively in the context of that.' (Jodie, Case 2)

'...I guess the nature of the panic attacks and if they were occasional panic attacks... so infrequent, I'd may be more inclined to explore her social circumstances more and look at what sorts of other links etcetera, she has within the community and of what interests and things she's either maintained or developed since her husband's death .. .' (Jodie, Case 3)

'Well initially I would be exploring the suicidal thoughts in more depth. I'd ((inaudible)) and the duration of her depression... and ((inaudible)) then the, you know, to other kinds of things so how else is it manifesting. Has it impacted on sleep, appetite... engagement in the... you know, socially and occupationally and, and whatever.' (Jodie, Case 4)

'I would... look at medication in, if, if it's been a sustained you know, depression and then if she fits the criteria of a, you know, moderate to severe episode of major depression.' (Jodie, Case 4)

'...her grief would be acknowledged...' (Jodie, Case 3)

'I'd want to explore his... anxiety and concerns about his father and I guess, to ascertain how you know, resolved or not that is and, and what that you know, leads him to worry about. ' (Jodie, Case 5)

That his headaches, I guess that, that if it is indeed purely psychological that he's able to make that link and that in making that link and in addressing his anxieties and the kinds of things that are triggering that, that the symptoms resolve.' (Jodie, Case 5)

'...have a bit more of a picture of the kinds of sexual demands and whether they are unreasonable or unhealthy or whether, given her... queried (?) past abuse that she experiences them as such and I'd be referring her to someone who was experienced in sexual abuse counselling...' (Jodie, Case 6)

'...this is... an event that happened two years ago and he's still not over it so I think it's, it's a significant problem. It really affects his life, I'm guessing, because a car is very necessary in many, many ways and so I think it's important that he gets on top of it and so I think for a good outcome, he would need to see someone like a counsellor or possibly a psychologist.' (Zach, Case 2)
Some elements of depression in her and also since one year ago you want to see if, is she still bereaving' (George, Case 2)
Exclusion of physical pathology to provide reassurance

'...it’s worth doing a depression screen on this person and see if he’s at risk of you know, harming himself, harming other people.' (George, Case 1)

Frequency=35 (8.45%)

'...it could be a number of organic pathologies so we need to rule that out.' (Zach, Case 5)

'...if it’s an organic cause, you would do investigations to rule out organic causes...' (Mike, Case 1)
... I would do further investigations to rule out all the, all the other pathologies as well...'' (Mike, Case 5)

''...then I would talk to him about multiple sclerosis and brain tumours and like what sort of things people come in with and how they occur and try to tell him that it's unlikely to be those things, it's rare... for him to present at fifty multiple sclerosis as well so things like that.' (Mike, Case 5)

''...reassure him that his father died of something else not related. (Mike, Case 5)

''...I would try and reassure him, assuming he's not too unwell and compromising his activities of daily living...'' (Paul, Case 5)

I'd want to explore more about why she's, has this longstanding fear of choking. If there is, you know whether there is actually a medical basis for it or yeah a physical basis for it...'' (Paul, Case 7)

''...investigations have not ruled any pathology, he has presented with new onset headaches so I do think it is appropriate to reinvestigate these because, even though you might think he's exaggerating his symptoms, you can't afford to ignore what he's saying...'' (Sarah, Case 5)

...if she hasn't had all the investigations to see if what she's saying is true yet, then I'd like to do like I don't know, like a... CT or something to investigate to see if maybe it was true. (Lisa, Case 7)

'I'd hope that we could rule out any actual sinister pathology and then reassure him...' (Sarah, Case 5)

...in terms of... the... physical examination... I guess if she's happy for you to do, for me to do a pap-smear which probably is appropriate, or is appropriate given she's started a sexual relationship... that will tell you, that will tell me about her anatomy I guess, and then if there's anything unusual I see, I could refer her to a sexual health expert.' (Sarah, Case 6)

'... I would hope that... you can start to establish if there's been sexual abuse in the past and reassure her about her... physical, well that there's nothing wrong with her.' (Sarah, Case 6)

'Well if she hasn't had investigations for her throat and stomach, this is the first thing to do and some of these I could organise as a GP, but some may involve referral to, for example, a gastroenterologist. But she needs some sort of barium swallow or chest x-ray to check that she hasn't got a stricture... so... that would be the first thing.' (Sarah, Case 7)

...she thinks it's something physically wrong with her so we should check that there's no abnormalities.' (Sarah, Case 7)

Well we might be able to reassure her that all investigations are normal if that's the case and then address her... psychological issues.' (Sarah, Case 7)

'...it's an acute situational crisis... but... and while it's, it will be at it's worst now...' (Sarah, Case 9)

'You can stratify that into psychiatric and non psychiatric causes so the first would be an anxiety disorder and other non psychiatric causes. You'd like to rule out organic causes' (George, Case 1)

'...in the general practice setting in this case, the man does present stress-related anxiety symptoms, but first thing is my role as a general practitioner is to rule out all causes, also to look out for red flags that may lead to serious disorders that I shouldn't miss in this case.' (George, Case 1)

'...definitely you still want to rule out the organic causes for example anaemia could be a cause of this.' (George, Case 4)

'First thing is you still address the issue, so you've done all this investigations and abnormalities, well you still address it. The first thing you do is you do a baseline vital signs, perhaps you'd like to repeat the blood tests and all the other investigations to see is, if it might detect anything we miss out previously...' (George, Case 5)
...I'd actually like to tell this patient that we've done all this investigation and we couldn't find underlying cause, yet it could be something organic or something psychological, but it's something where medical science hasn't found a definite diagnosis for it. But we've done various investigations and we found there is not a brain tumour or, and it's not multiple sclerosis. Brain tumours, multiple sclerosis can be picked up easily with imaging investigations for example CT or MRI yep, so when he has something that we couldn't confirm by those investigations we think maybe it could be something else for example mild fibrosis, it could be anaemia, it could be anxiety, it could be anything, it could be he's somatising at this moment yeah.' (George, Case 5)

The referral to a gastroenterologist for endoscopy imaging study is on the basis that she is having dysphagia so to rule out organic causes...' (George, Case 7)

'Do a physical examination yeah, and you have to rule out the other causes.' (George, Case 7)

'...I'd like to refer this patient to two people, number one is to a gastroenterologist alright for endoscopy to rule out any GI pathology for example yeah, oesophageal tumour umm... or other problems.' (George, Case 7)

'...refer her to a psychologist if we rule out that there's no other organic causes then a psychologist help her improve her symptoms.' (George, Case 7)

'...Still you like to rule out what the causes of his aggressive behaviour and you'd still perform a history examination... ' (George, Case 7)

'I believe is that it's not one of these serious conditions that you said so you'd have to have lots of reassurance for him and... so he's worried about... yeah he's, that he might die because his father died at fifty so you've got to have lots of reassurance and... with that like you'd go through the results with him and explain, explain to him what the results are and it's not anything serious.' (Alan, Case 5)

For him to be reassured that it's not a brain tumour or multiple sclerosis and that he can continue with his daily life not worried about it.' (Alan, Case 5)

'I'd be... like, looking at say just a gastroscopy or something to check if there's indeed anything wrong, but suggesting that as an investigation in the context of also, that, that you need to rule that out...' (Jodie, Case 7)

'I would screen to see whether there were any other you know, more health related issues...' (Jodie, Case 9)

'the physical investigation I would do to an extent that ensured that, that there wasn't anything physically wrong rather than just to do investigations ad infinitum because she's worried. (Jodie, Case 7)

'I'd be normalising her... you know, experience, feelings, whatever as acute... stress related...' (Jodie, Case 9)

'Some of the main factors I would look at...how she's coping at home, social support networks.' (Mike, Case 3)

'...if you can help him by discussing with other people in his workplace that could help him relieve that stress.' (Mike, Case 1)

'...if there's family members who can drive him to work...' (Mike, Case 2)

'How she's coping at home, social support networks.' (Mike, Case 3)

'...she just needs someone to talk to I think... ' (Mike, Case 9)

'I'll probably have to sit and talk to her about it for about as long as required because she, she just needs someone to talk to I think... and after talking to her and she's still upset and she's not able to sleep I'll probably give her some sleeping tablets... ' (Mike, Case 9)
'...I mean this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives. So I think increasing social supports are very important for this patient. Referral, I mean there may be some sort of a community social worker, a social worker based in the community who can help link this patient into some groups to, to help her expand her circle of friends, increase her level of involvement in activities. I think that would greatly benefit her.' (Paul, Case 3)

'...I think a big part of, a big part of her recovery will be the involvement of her family so I would hope that I would try and talk to the family as well and hope that they increase the level of support for the mother.' (Paul, Case 3)

'...I guess we really need to try and address what the precipitating and the prevailing factor is for what seems like her mood disorder, mood disorder, possible adjustment disorder... so need to look at her social supports. I may try and link her in with some community supports.' (Paul, Case 4)

She would also benefit from having a, like joining a group or something, so I'd encourage her to get involved with like a seniors group or something so she's not relying on her daughters for social support as much. (Lisa, Case 3)

...her children need to be involved in her care and if she could come back with them that would be good.' (Lisa, Case 3)

'...I'd need to explore the family or friend supports... to check that she's got people with her... ' (Sarah, Case 9)

'Number two does she need any nursing care or she needs any nursing visits where Silver Chain or even local community support. Number three get the family involved, her family has got families of their own, but perhaps get family involved and ask them if they can visit her more frequently...' (George, Case 3)

'My outcome is always been for this person to get better, for him to address his problems and perhaps even get the family involved.' (George, Case 1)

'...like with support and you know, see what other support networks there are sort of thing as well. You could look into that as well, yep.' (Alan, Case 3)

'...I would say if, if she's got two daughters that are very supportive, then it's likely that she comes from a reasonably functional family context and... and, and probably a functional community context of about, I guess, reconnecting her with that, with that and yeah, I guess, and that her, that she's more socially independent as a result of my intervention.' (Jodie, Case 3)

'...so if she... while it says she's a single woman, is she... does she live alone or does she live with others and what's her, I guess, looking at her, what her significant relationships and discussing with her the merit of them knowing... (Jodie, Case 4)

'I would ascertain what supports she's got, who she feels she's able to talk about this with.' (Jodie, Case 9)

...need to explore her social circumstances which would lead, I imaging, to finding out that she'd lost her husband and to talk to her about what that had meant for her.' (Jodie, Case 3)

...nature of the panic attacks and if they were occasional panic attacks... so infrequent, I'd may be more inclined to explore her social circumstances more and look at what sorts of other links etcetera, she has within the community and of what interests and things she's either maintained or developed since her husband's death.' (Jodie, Case 3)

...that she was well connected to her community and support networks...that she's more socially independent as a result of my intervention.' (Jodie, Case 3)

Patients' characteristics and situation

'I think sexual abuse is a very touchy subject for any patient that has encountered it and so... her being female and me being male I think I would refer it on for those reasons.' (Zach, Case 6)
...being a bank manager he would probably be reluctant to, to... change jobs or to make any drastic changes at work where that would interfere with his career, but if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (Zach, Case 1)

"...majority of, of women her age and, and in that situation would respond to medical treatment and... yeah she should feel some resolution of her symptoms.' (Zach, Case 4)

"he's in a risky age group....' (Zach, Case 5)

"In a seventy-two year old woman, depending for how long she'd been married to her, she's living alone I think a care facility would be helpful, but it'd be difficult to, even with like psychiatrists or psychologists help, if she's been married all her life to the same person it'd be very difficult.' (Mike, Case 2)

"...he's thirty eight years old and I think he's, depending on him as a person and how he approaches it and if he wants to discuss it with his general physician, if he wants to... if he's like more, more... I guess, amenable to drugs or, or other things that would help him. (Mike, Case 2)

I don't know how old he is.... because the older he is the more difficult for him to, to... as a suitable driver, his social circumstances

...but patients with previous history when they're young are quite difficult, I'd probably just yeah, try to refer her after getting a full history..." (Mike, Case 2)

...good prognosis after the initial period because she's young, she can be involved with more, meet more people and get involved with more relationships so just tell her that she's young so...' (Mike, Case 6)

"If he like, doesn't like going into things like what's causing, causing him the stress at work and prefers pharmacological therapy, I think I would try to help him in that case.' (Mike, Case 1)

"I would refer on the basis that I knew the patient before the psychiatrist recommends psychological therapy so I would just write a referral to help him out.' (Mike, Case 2)

...this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives.' (Paul, Case 3)

"...well he's fifty... and he seems quite worried about these morbid illnesses and also that his own father died at age fifty, that's a... fair reason to have these worries and this seems to have been going on for a while so it might be better to go to a specialist and get it sorted out.' (Sarah, Case 5)

"She's seventy-two years old, it's worth knowing is she independent, is she able to survive on her own, alright. (George, Case 3)

...she's an old lady, she's a widow...' (George, Case 3)

"...she's a single woman, twenty years so she's pretty young so you want to ask her if she has any recent trauma in her life, is she bereaving... ' (George, Case 4)

"...this definitely a young patient with multiple psychiatric insults that might have began early in her life and that lead to a whole series of psychological disturbances in her life.' (George, Case 6)

This, this is a forty year, two year old lady who presents with anxiety...' (George, Case 7)

"...if he's a bank manager he's likely to have sufficient financial resources to manage that, to manage like private things so does he have private health insurance in which case I would probably refer him to a private therapist...' (Jodie, Case 1)
...I mean at least he’s financial circumstances were such that he couldn’t afford it, I would be referring him for private because I think that the public system... needs to be kept, is overloaded and needs to be kept for those who can’t afford it and then... I guess in places like Relationships Australia or Kinway or other you know, non government options if he was reluctant to consider private given that’s a reduced fee." (Jodie, Case 2)

Control and relief of symptoms, sedation

So just pain management for his headaches. (Mike Case 5)

Frequency=18 (4.35%)

I’d feel comfortable treating her in the GP place... I would possibly give her a sedative to aid her sleep such as a benzodiazepine... I think...’ (Paul, Case 9)

‘...antidepressant with a, anxilitic (?) like maybe venliflaxine (?)?...so I’d expect for pretty much, all of the symptoms to reduce or even disappear with the medication...’ (Lisa, Case 1)

‘...give symptomatic control with like sleeping tablets and hopefully, she’ll, after a few consultations talking to her and listening to her about it and giving her just support like for sleep to get, for her to get back on her feet...’ (Mike, Case 9)

‘...I think that this woman would benefit from an antidepressant taken at night particularly...’ (Lisa, Case 3)

‘...I don’t think I would give him his medication straight away I would... probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety. That, yeah I think it would have to be a, a counselling discussion type treatment in his situation...’ (Zach, Case 1)

‘...management plan in a short term setting I think some anxiolitics or some benzodiazepine, oxazepam, and diazepam can help her with her sleep...' (George, Case 9)

‘...she’s not well, yeah and you can see that she is going out of control, that is a symptomatically we treat her symptoms that she presents with, yeah she can’t sleep so we give her benzodiazepine of course on the basis that she’s able to be comply with medication and she’s not going to overdose or she won’t take the umm... excessive amounts...’ (George, Case 9)

‘...you can give her some medications for her sleep at that stage, however, you’ll also want to refer her on to some counselling and psychological services.’ (Alan, Case 9)

Patients progress and response to treatment

‘I think medication is too quick and ready a solution. with a little bit of hard work... she will be better off in the long run if she, if she deals with this grief
Effects of the problem on family

'...I think if his wife is in danger it's important to deal with it...' (Zach, Case 8)

Frequency=15 (3.62 %)

'Okay this seems to be quite a serious problem because it, it raises the possibility of harm to the man's wife so I think it needs prompt treatment and, and investigation...I'd be very ready to refer him on to a psychologist of psychiatrist and hope that they can address it.' (Zach, Case 8)

'...her partner if that's an abusive relationship and the sexual abuse you know...'
Patients Wishes and Preferences

Frequency=13 (3.14%)

...I’ll probably refer him straight away because he’s tried to strangle her in his sleep...’ (Mike, Case 6)

‘I would look at his, how high is the risk of hurting other people. I’ll probably refer him straight away because he’s tried to strangle her [his wife] in his sleep...’ (Mike, Case 8)

‘...the main reason is because he’s a threat to other people and you’ll refer him straight away and see if they can help him out in that way...’ (Mike, Case 7)

‘...he’s... a big risk to his wife and his family and there’s a good chance that he’ll hurt them so, even without wanting to really so he, so it needs to be addressed as soon as possible.’ (Lisa, Case 8)

... he tried to strangle his wife...’ (Sarah, Case 8)

'We really don’t want this family to become dysfunctional yeah, we don’t want his wife to get injured and we want the family to get better as a whole and we want his anger to get controlled yeah and this is on the basis that I follow up to him, to see a psychologist, he’s going through anger management yeah and he’s gone through and he’s seeking help through the domestic violence helpline...’ (George, Case 08)

‘...this man is at high risk okay of harming his wife, harming his family, may even harm himself and harm his reputation yeah.’ (George, Case 8)

‘I’d also be concerned, given she’s got a young family, that what’s happening for the kids and to consider a referral for them, which is in fact probably another reason that I’d be referring to a, like to psychiatry or whatever in the hope that her children’s needs are also going to be recognised in that.’ (Jodie, Case 7)

‘I’d be wanting to speak with his wife also... and I’d be encouraging him to have his wife contact me to ascertain her view...’ (Jodie, Case 8)

...he links with... a DVorganisation and that he... takes responsibility for his behaviour and... that there is a more equal relationship within the family...’ (Jodie, Case 8)

‘...I’d be wanting the whole family ultimately to be part of that intervention...’ (Jodie, Case 8)

...would hope that she was able to work toward a more healthy relationship with her boyfriend...’ (Jodie, Case 6)

...if it’s other things and he, he likes being helped in other ways, I think that’s more suitable getting to the cause of the problem rather than just giving him drugs just for symptomatic relief.’ (Mike, Case 1)

...what concerns her mainly about that... [sexual problems]’ (Mike, Case 6)

‘I wouldn’t refer at the moment, if she declines then I would refer to people like relationship counselling or things like that, marriage counselling, social worker only if she declines ...(Mike, Case 9)

‘So I’d like to admit her as an inpatient... provided she agrees, not as an involuntary patient only as a voluntary...’ (Lisa, Case 4)

‘I would consider medication in this man because he has come to you asking for medication. I think it’s appropriate to respond to what he wants ...’ (Sarah, Case 1)

‘... as long as she’s happy to come back that’s probably appropriate follow up.’ (Sarah, Case 9)

(Referral) Not at the moment unless she specifically asks for it.’ (Sarah, Case 9)

‘...So we address his issues, we give him what he wants and usually spontaneously the symptoms might even disappear...’ (George, Case 5)

‘He’s asking for his medication so that could be one line of treatment for like, some sleeping tablets...’ (Alan, Case 1)

'...they're obviously not having a good relationship with each other and want to fix that.' (Alan, Case 8)
What sort of medication is, is he seeking and what does he understand about how those might help... I guess, yeah, get a clearer sense of, of why he sees that as a means to address it. So in part I guess, it would depend on the information I got back in relation to that.' (Jodie, Case 9)

Patients' Needs

'...I think it may be really helpful for him to, to talk about his father and other stresses.' (Zach, Case 5)

'I'd be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that...!' (Zach, Case 6)

'...her symptoms are appropriate given the event. I don't think she should rush to medic, medication. I think it, it's a social stress, a relationship problem that needs to be dealt with, with her partner and a counsellor is well qualified.' (Zach, Case 9)

'...then if possible, get some input from her family, her... maybe she's, her neighbours, her friends, see if she requires extra help and care.' (Mike, Case 3)

'...she would need some insight into that being a problem to be, for that to be successful...!' (Paul, Case, 6)

'...I'd also reassure her that she doesn't need to go to work for the next few days and it's entirely appropriate to take a few days off and she doesn't need to feel guilty about that... ...' (Sarah, Case 9)

'...give her some sort of work certificate or arrange that she doesn't need to go to work... yep.' (Sarah, Case 9)

'This person needs long term care and he needs a frequent follow up so umm... by referring to a psychologist or counsellor they'll... have the best management plan for this patient.' (George, Case 2)

'This patient is a man I think, that needs reassurance, multiple reassurances so referral could be the best treatment for him.' (George, Case 5)

'...he's presenting with the same symptoms over and over again and we couldn't find anything wrong so main reason is that again, yeah, he needs that reassurance. (George, Case 5)

'...just exploring that a bit more so is it that he's having panic attacks or is it just a feeling of anxiety and what is the nature of, of that. To explore that in more detail and also to look at what it is that he's doing in relation to that umm... so both his kind of thought process and how he's managing it...'(Jodie, Case 1)

'...that I take his concerns seriously and his you know, physical symptoms, but that there's a psychological component to it as well. (Jodie, Case 5)

Motivation

'...I think he could get quite well in the future if he goes regularly to his psychologist and wants to be helped I guess.' (Mike, Case 2)

'I mean if she is ready to, to discuss it, then I think a psychologist could be, psychological input could be very helpful' (Paul, Case 6)

'...whether she attends or not, engages with them really depends on I guess, how much of a problem she see her substance abuse as...' (Paul, Case 6)

'...provided she can act on what I say about joining some social groups and stuff, I think that it will improve a lot for her...' (Lisa, Case 3)

'...she should be feeling much better than she was before and with more motivation and stuff.' (Lisa, Case 3)

'...if he continue or he does what the psychiatrist says and so goes and sees a psychologist and then he could participate in like, group therapy and also maybe some individual therapy including some exposure type stuff.' (Lisa, Case 2)

'...ideally, that her level of motivation would increase, that her mood would improve, that she would, as her motivation and mood improved that she would be, she would have you know, more energy and a greater enjoyment...!' (Jodie, Case 4)
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<thead>
<tr>
<th><strong>Previous treatment or assessment</strong></th>
<th>...she may have had past surgery or she may have had problems swallowing before which is really physiological. If that's the case then I'd... probably refer on to a gastroenterologist I suppose.' (Paul, Case 7)</th>
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<td><strong>Frequency=6 (1.21%)</strong></td>
<td>'Also because she’s had various treatments in the past... as well, so that’s why I think she should see a psychiatrist and the psychologist because she... umm... has, I don’t know, her the things that she does and says are not what the medications are typically addressed towards so I think it’s a bit more complicated so I think the psychologist could help in that regard.' (Lisa, Case 7)</td>
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<td>'Look into it a bit more like what her, what is her history of the psychological treatments, what she has had done, who she’s seen and... I believe like, even after all that you’d probably need to refer on to a psychologist or maybe a psychiatrist.' (Alan, Case 7)</td>
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<td>'I guess I’d want to know what are the previous psychological treatments she’s had and I’d be talking to her about their, her experience with them, whether she found them beneficial or not.' (Jodie, Case 7)</td>
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<td>'...because she’s had psychological treatments in the past, I mean had they been effective then I would be referring her again for that.' (Jodie, Case 7)</td>
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<td>'I'd be exploring past medications, whether she's had, so as well as psychological treatments, has she had, what medications has she had in the past so you know, antidepressants or, gives me... you know enclitics or whatever.' (Jodie, Case 5)</td>
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**Table B2**

**Doctor-Related Factors**

<table>
<thead>
<tr>
<th>Competence/Expertise</th>
<th>'I don’t think I'd refer him on to anyone at this point if I felt capable of helping him to work through it.' (Zach, Case 1)</th>
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</thead>
<tbody>
<tr>
<td>Freq: 23 (5.55%)</td>
<td>'...even as a GP, I think I'd feel qualified to at least start to get, to look into some of those issues.' (Zach, Case 5)</td>
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<td>'I think that as a GP, I’d be an appropriate first port of call for this woman...' (Zach, Case 9)</td>
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<td>'...after doing a little bit of work myself just in ruling out medical causes, I would refer her on.' (Zach, Case 6)</td>
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<td>'...I think I would refer to... to someone who is better qualified to, to help this man... through maybe exposure therapy or, or some, some cognitive therapy... I think for a good outcome, he would need to see someone like a counsellor or possibly a psychologist.' (Zach, Case 2)</td>
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<td>'...if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (Zach, Case 1)</td>
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<td>'..I could probably give some, some helpful advice about just ways of meeting up with community groups to relieve that loneliness.' (Zach, Case 3)</td>
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<td>'Well first of all I would want to get more of the history about his symptoms, specifically whether there are other symptoms because the things I’m thinking about are could this patient be depressed, could it, could he have an anxiety related symptom, could it be both... and I guess I’d try and find out whether there was a clear precipitant to his symptoms. I wouldn’t refer at this stage, I’d feel comfortable, assuming there’s nothing which is too serious, I would feel comfortable in treating the patient in the GP setting.' (Paul, Case 1)</td>
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<td>'...I would agree in referring for some psychological treatment so once again, a psychologist for some form of therapy, psychotherapy...the main reasons for this are I’d feel reasonably confident that his current symptoms are linked to a clear sort of, traumatic event two years ago... ' (Paul, Case 2)</td>
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<td>'...I feel more confidently monitoring his symptoms for a while.' (Paul, Case 5)</td>
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<td>'I would firstly... ask her to come back for a longer appointment because I think we need to talk about what’s happened with her husband and her current living arrangements and also her ability to cope looking after herself and so forth and then I would also explore the issue of depression because it says she seems quite depressed and it may be appropriate to give her some antidepressants. Maybe on the next visit and also maybe look into some services like a nursing or maybe not a nursing home, but... some sort of, like Silver Chain visiting or something...' (Sarah, Case 3)</td>
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<td>(refer) After having done my own assessment...' (Sarah, Case 8)</td>
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<td>'If I am a mental health GP I have additional training in psychological counselling, then I'm able to provide treatment for him. But definitely I’ll have a whole pool or list of psychologists with each respective credentials I can refer him to the psychologist for best outcomes.' (George, Case 2)</td>
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<td>'...I will treat her, well first you like to treat her underlying problem, she's lonely and you think you can give her advice, things that she can do to keep herself busy, keep herself happy.' (George, Case 3)</td>
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<td>'...I think you'll benefit her if she's referred to a psychologist or some counselling services, yeah... but even before she leaves my practice because she expressed suicidal thoughts, first thing you should do is risk assessment.' (George, Case 4)</td>
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<td></td>
<td>'...I could also as a GP you'd want to, you could follow up from that and do some counselling...' (Alan, Case 1)</td>
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...If I was in the context of a practice where... I you know, did some mental health GP work as an interest, then I would be inclined to manage that myself." (Jodie, Case 3)

'If I was in the context of a practice where... I you know, did some mental health GP work as an interest, then I would be inclined to manage that myself.' (Jodie, Case 3)

'I would feel competent to deal with that myself. That if it's only occasional panic attacks and it's not a, you know, full blown panic disorder.' (Jodie, Case 3)

'...so just an assessment of her suicidal risk which I'd feel quite competent to do.' (Jodie, Case 4)

'I guess because I'd be concerned about her level of suicidality because that can potentially increase on, as you start antidepressants rather than decrease so I'd want to monitor it, monitor her wellbeing closely and provide support and I guess... ensure that she has made that link with a therapist.' (Jodie, Case 4)

'...I don't think I would give him his medication straight away I would... probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety. That, yeah I think it would have to be a, a counselling discussion type treatment in his situation...' (Zach, Case 1)

'I think medication is too quick and ready a solution. With a little bit of hard work... she will be better off in the long run if she, if she deals with this grief in her situation...' (Zach, Case 3)

'Treatment would be supportive, but not at this stage medication.' (Zach, Case 3)

...as a GP, I'd be an appropriate first port of call for this woman just to debrief her, ask her about her emotions and about... the evidence for, for what she believes.' (Zach, Case 9)

'I'll probably give her antidepressants and then if that's not working... it should help her a bit. But if she starts declining I would, declining after like still... after the medications which takes about six weeks I think, I'd probably refer her after that if she still has these suicidal thoughts, can't get on with her job, not coping well at home.' (Mike, Case 4)

'I'll probably have to sit and talk to her about it for about as long as required because she, she just needs someone to talk to I think... and after talking to her and she's still upset and she's not able to sleep I'll probably give her some sleeping tablets...' (Mike, Case 9)

'...probably get a more comprehensive history from him... in terms of like what's causing him at work to be really stressed, why he's being frightened or is very frightened to go to work, how long it's been going for, any past history, anything in his medical history that could be causing it as well. So after discussion and a full history, try to actually find out what the exact causes and, because there'll be numerous causes to it.' (Mike, Case 1)

'...I would probably give him symptomatic relief with some medications. If that's suitable for him, but first and foremost is the history and find out what's exactly causing it and a referral if it's necessary to a, like allied health workers to help him...' (Mike, Case 1)

'If medications don't work I think I would probably, and if she's still not able to go to work, not able to take care of her family, I'll refer her if antidepressants might not work and she, in terms of her fear... she's probably had psychological treatments and it doesn't help. If it's a recurring episode, I'd probably refer her the same psychologist again.' (Mike, Case 7)

'...after talking to her and she's still upset and she's not able to sleep I'll probably give her some sleeping tablets for a while only and then if she get's back on her feet with social support, her friends, her family...' (Mike, Case 9)

'But there's not much in terms of I can do, terms of... if there's medications that help maybe... no, I don't know if you would give her any medications so I would probably refer her...' (Mike, Case 6)

'...I think he'll go and see another GP if he's not satisfied that I'm not attending to his
symptoms...' (Paul, Case 5)

′I′d want to refer, I′d want to review this patient again in probably two or three days to see how she′s going... and perhaps recommend some counselling which may be in the form of a psychologist or, or a counsellor just to, for her to discuss her... her emotions at the time I suppose.′ (Paul, Case 9)

′Would I refer her? No, I′d ask her to come back to me in a fortnight and see how she′s going and then from there assess her again if, if she′s either the same or gotten a bit better I′d say come back again in, in another fortnight. If she′s gotten worse then I′d think about additional medication.′ (Lisa, Case 9)

′...I think that it would be worth trying medication with her first and then if that has no effect, then you could use a adjunct therapy like psychological, like seeing a psychologist or something.′ (Lisa, Case 3)

′...it would be useful for him to have some low dose SSRIs and see if that has an effect, but the, the main part of his treatment will be, will be psychological therapy.′ (Lisa, Case 5)

′I′d like to refer her to a psychologist and as appropriate and also if she doesn′t get better I think I refer her to psychiatrist, Oh and a psychiatric ward might, might actually be, be the best for her.′ (George, Case 6)

′I′m not sure if his, he′ll benefit from any pharmacological therapy at this moment, but if his symptoms do not improve I think a psychiatric referral will be better.′ (George, Case 8)

′...I suppose I′d be inclined to manage it myself initially and then if there didn′t seem to be improvement then looking at a, you know, psychiatrist and preferably a more multidisciplinary... theme approach.′ (Jodie, Case 7)

′...I′d want future, sort of like within the next few days, and to monitor that over the period of time that it takes until the antidepressants kick in.′ (Jodie, Case 4)

′...if it seems that it′s kind of escalating into more panic related stuff, then I would probably refer for CBT you know, and talk to him about some basic breathing and relaxation sort of exercises to manage his symptoms.′ (Jodie, Case 1)

′...in the first instance it′s something I would be addressing myself and getting him, yeah to kind of make, make the link between his emotional state and his physical symptoms that he was experiencing.′ (Jodie, Case 5)

′I′d be exploring past medications, whether she′s had, so as well as psychological treatments, has she had, what medications has she had in the past so you know, antidepressants or, gives me... you know enclitics or whatever.′ (Jodie, Case 5)

Doctor-Patient Relationship

′...Just in the immediate term to get her to have some space to get her head around that then I would address that and I guess what I would do beyond that is a bit dependent on the nature of the conversation and the outcomes of that.′ (Jodie, Case 9)

′So I would refer on the basis that I knew the patient before the psychiatrist recommends psychological therapy so I would just write a referral to help him out.′ (Mike, Case 2)

Freq: 14 (3.38%)
Need a therapist assessment/advice from a therapist
Freq: 10 (2.42%)

'...would depend a bit on whether she was a, you know, long term patient or I'd just happened to see her out of the blue. If I'd happened to see her out of the blue I probably wouldn't, I'd, I'd choose to refer and if, if it's a family and relationship based issue if, I, I mean I would screen to see whether there were any other you know, more health related issues...' (Jodie, Case 9)

'...yeah she's going to continue to have difficulties in the future and hopefully that she feels safe enough to continue to access me as a GP.' (Jodie, Case 6)

'...seeing as I've been seeing her for many years I hope that I would have the kind of rapport with her that I could bring up this subject of sexual abuse and to see if... that had occurred...' (Sarah, Case 6)

'I would bring up the sexual abuse with her because I think, as a GP, that is appropriate and within the boundaries of your role if you've known a patient for many years' (Sarah, Case 6)

'...it would be appropriate to start her on antidepressants straight away. If you can trust her enough not to overdose on them or that she won't try any other means of suicide in the meantime.' (Sarah, Case 4)

'...she's come to me so... as long as she's happy to come back that's probably appropriate follow up' (Sarah, Case 9)

'...I'd hope that she would come back to me to keep me updated about how she's going ...' (Sarah, Case 9)

'...I would hope the patient would agree, I mean I'd hope that there will be a good therapeutic alliance so that the patient agrees that a referral to a psychologist would be in their best interest...' (Paul, Case 2)

'I would offer her counselling from a trained counsellor...' (Zach, Case 9)

'Secondly would consider input from a psychologist if she has been sexually abused in the past... yeah so I would in that case, refer to a psychologist as well.' (Paul, Case 6)

'...in all honesty, I'm not sure what this patient may have umm... I'd probably phone a psychiatrist and give him the history over the phone and ask them for their input in this case.' (Paul, Case 8)

'I think it's a very odd presentation and might be a rare syndrome which I'm not aware of and some, yeah because it's rare so I would probably, yeah call up a psychiatrist and give him a brief history and, and go on their recommendation really so.' (Paul, Case 8)

'...I think that a GP can, like anxiety and depression are very common and I think that a GP can manage them enough, but I do think that they need help from the, from like allied health and stuff.' (Lisa, Case 1)

'...I'd just continue with the, whatever the psychiatrist had recommended.' (Lisa, Case 2)

'I'd probably ring the psychiatrist at the hospital nearest me to see what they think.' (Sarah, Case 4)

'...if I wasn't sure I would ring the psychiatrist to see if he or she thought she should be admitted. I suppose they'd have a bit more experience with me, than me in terms of... when it's better to hospitalise someone...' (Sarah, Case 4)

'I'd actually have to ask someone, I don't know, maybe a psychologist or... well the psychiatrist seems to have referred him back to me so... I'd ask a psychiatrist or a psychologist, I wouldn't feel like I'd know what to do.' (Sarah, Case 2)

'...she's had treatment for it from, not by a GP I guess and so would need more help with that, like as a specialist help with that.' (Alan, Case 6)

Experience
Freq: 8 (1.93%)

'...I haven't, haven't been exposed to this sort of situation...' (Zach, Case 8)

'I'm not sure about this one because he's a danger to the community in general so you would have to refer him...' (Mike, Case 8)

'...I think, I haven't really seen this as much, I think that he would be another prime candidate to see a psychologist as well. (Lisa, Case 5)
Management of Patients

Difficulty with particular patients

- With the psychiatrist because it is more complicated and not something I have had much experience with then I feel that they would be best. (Lisa, Case 7)
- I don't know that much about it (uncommon mental health condition), but the psychiatrist hopefully, will. (Lisa, Case 5)
- I suppose they'd have a bit more experience with me, than me in terms of... when it's better to hospitalise someone... (Sarah, Case 4)
- I don't think any patients would benefit for immediate pharmacological therapy, the first thing is always counselling and advice yeah, and if I don't have the experience to do it I think it's worth referring her to a psychologist or counsellor. (George, Case 4)
- It depends on my experience, my knowledge and the level of my training. (George, Case 2)

Freq: 8 (1.93%)

Time/Availability

- Sounds like a complex case with previous history, but patients with previous history when they're young are quite difficult... (Mike, Case 6)
- I think two things are going to happen, one he'll either continue to present or he'll present somewhere else... (George, Case 7)
- She's had various treatments in the past and she's still here so I wouldn't expect a huge improvement, but at least I'd want to try something to make her a little bit better... (Paul, Case 5)
- Well this is a complicated case and I think it is not a quick fix... (Sarah, Case 6)
- But given this patient who's been seeing me regularly, I'm not sure has he been shopping for doctors and doctor shopping which is actually a, a, a typical activity for patient somatoform disorders... (George, Case 5)
- It's hard to expect hundred percent improvements in all parameters... (George, Case 4)
- This a regular patient and seen me multiple times and all this non specific signs and symptoms... (George, Case 5)

Freq: 7 (1.69%)

Safeguarding career/preventing mistakes

- Do the best you can to do all you can. With your time constraints as well as a GP. (Alan, Case 1)
- If you have time look into some of the issues and if not, book another appointment for her to come back. (Alan, Case 3)
- Because the reality is that you've... in a general practice you're not going to have the time to do exposure therapy with him. (Jodie, Case 2)
- Well it would depend a bit on what my... practice load was. (Jodie, Case 9)
- Because of the skills base to do it and the time factor. (Jodie, Case 2)
- In therapy she's going to have the privilege of a greater you know, consultation time than she's able to have with a GP... (Jodie, Case 4)

Freq: 3 (0.72%)

Obligation

- He's obviously presenting with a problem and wants to you to... help him fix it... (Alan, Case 1)
- As you're that patient's GP you are responsible for that, for him as well. So not just the psychiatrist, yep. (Alan, Case 2)

Freq: 3 (0.72%)

Time/Availability

- As a safety net you know, always want to see him again... next few weeks to see his improvements. (George, Case 5)
- He's the kind of patient that's to present, well she's... A she's been a patient of mine for many years so I'd have hoped that I'd have picked up on all of that sort of stuff a whole lot earlier... yes I'd be a bit concerned that hadn't... yeah, recognised some of that already... (Jodie, Case 6)

Freq: 3 (0.72%)

Obligation

- He's obviously presenting with a problem and wants to you to... help him fix it... (Alan, Case 1)
- As you're that patient's GP you are responsible for that, for him as well. So not just the psychiatrist, yep. (Alan, Case 2)
issues as well.' (Alan, Case 9)
Table B3

Service-related Factors

| Therapist interest and training | '...I think that it is better assessed by a psychiatrist who will assess it and with the psychologist I think, because it's more complicated the medications and stuff aren't tailored for this kind of a condition and so that's why psychotherapy has more of a role.' (Lisa, Case 5) |
| Freq: 12 (2.89%) | '...might also benefit from talking to a social worker to sort out her, like talking about her job and stuff.' (Lisa, Case 4) |
| | '..I've transferred the care to the psychiatrist so...I would expect it (uncommon mental health condition) to be managed by the psychiatrist and I would expect that the patient, yeah, will report an improvement...' (Lisa, Case 5) |
| | 'I guess next step is more about...what's the word, well rehabilitation from, of the abusing substance or from substance abuse...so I guess that includes treating a patient in the, in the withdrawal period as well as dealing with any dependence issues that they have.' (Paul, Case, 6) |
| | 'I'd refer him to a psychologist and there's also a helpline for domestic violence that remains...that keeps patient confidentiality so any time that he feels that he's having these anger bouts or having this ((inaudible)) of, of aggression he can be assured that there is a helpline that he can call, yep the domestic violence call, helpline and he can actually speak to someone yeah.' (George, Case 8) |
| | 'Either a GP with mental health training who has trained to perform cognitive behavioural therapy or group therapy or even better refer this person to a psychologist or even a counsellor.' (George, Case 2) |
| | 'I'll have a whole pool or list of psychologists with each respective credentials I can refer him to the psychologist for best outcomes...' (George, Case 2) |
| | '...because like she has all these anxieties and the phobic disorders yeah, it does point to a form of somatisation that leads to a functional dysphasia so referral to a psychologist may help her to cope with this issue.' (George, Case 7) |
| | '..I would be more inclined to refer her to someone like SARC (Sexual Assault Referral Centre) or you know, a private therapist who has experience in working with abuse rather than to community mental health services or something like that.' (Jodie, Case 6) |
| | '...I'd be referring to a you know, domestic violence counselling service...' (Jodie, Case 6) |
| | '...he links with...a DV (Domestic Violence) organisation...' (Jodie, Case 8) |
| | '...private therapist or a relationship you know, counselling organisation so Kinway or Relationships Australia or somewhere like that.' (Jodie, Case 9) |
| Liaison/Feedback | ...yeah I'd expect it to be monitored, both by myself and whoever's...undertaking the psychological care. (Paul, Case 9) |
| freq: 4 (0.97%). | '...I would refer her to a psychiatrist as well because of umm...have better access to like, what services are available...' (Lisa, Case 6) |
| | '..I think the new mental health care plan requires a GP referral so you've got to take a full history from him and see what his issues are and, and then you refer him on, yep. So liaising with the psychologist.' (Alan, Case 2) |
| | '..liaising with them [domestic violence counselling service] to ensure that he has in fact, followed up on that.' (Jodie, Case 8) |
| Appropriateness of in-house counselling | '...so I'd be happy just to start talking to the, the drug and alcohol, and then refer her on if I felt that she needed help with that...and, yeah that there are more qualified people to ((inaudible)).' (Zach, Case 7) |
| Freq: 4 (0.97%) | '...try to refer her after getting a full history and if I can't help her in terms of medications and it's affecting her, her whole life, she can't go to work or go to uni or whatever she's doing I'd probably refer her to see what the psychiatrist opinion is. (Mike, Case 6) |
Previous experience with service

Freq: 3 (0.72 %)

'...I'd expect her to be assessed by the multidisciplinary team over a course of probably a week or two and hope that she would be linked into outpatient mental health care if they thought that was required. I'd expect that, if they made the diagnosis of a major depressive disorder they would start her on medication as well and yeah, that allied and of course the allied health people probably would address, I guess, her social and occupational functioning so yeah. (Paul, Case 4)

Freq: 2 (0.48 %)

'I think community mental health services are over stretched and are unlikely anyway, to, to be taking a presentation like this...I would be referring him for private because I think that the public system...is overloaded...' (Jodie, Case 1)

Availability/ Waiting List

Freq: 1 (0.24%)

'Again I don't know what services are available, but I've heard of things such as anger management so I would ask someone if that's, if they're available and I can refer him there.' (Sarah, Case 8)
Appendix G

Other Patient-Related Factors that Influenced Future GPs’ Management of Patients with Mental Health Disorders

The second most frequently mentioned patient-related factor (38 times / 9.18 %) was the chronicity and severity of the mental health disorders. This was related to the duration, severity and urgency of the mental health disorder. For a case where a patient was presented with suicidal thoughts (Case 4), knowing the severity and urgency of the problem was very important to future GPs and they would assess this by a risk assessment. For example, Alan said:

...if you send them home she might kill herself. So you want to look into a bit more history, what... how severe is her depression and how... seriously she is about her suicide, like her risk assessment of suicide and... yeah and if you’re serious then you would want to get her like, recommend her to go to hospital. (Alan, Case 4)

The third most frequently mentioned patient-related factor (35 times /8.45%) was the exclusion of physical pathology to provide reassurance. For cases 4 and 9, where patients were presented with concerns about their physical health, almost all future GPs in this study mentioned the need to rule out organic or physical pathology to provide reassurance for their patient. For example: “...I'd actually like to tell this patient that we’ve done all this investigation and we couldn’t find underlying cause.” (George, Case 5).

Social support was also considered important (21 times/ 5.07 %) in helping the patient to cope with the mental health disorders and to assist in recovery, as indicated in the following quotations:

...I mean this is a lady who is probably isolated from her family now, has lost her main life partner and her children, while supportive, are you know, have their own lives. So I think increasing social supports are very important for this patient. (Paul, Case 3)
...I think a big part of, a big part of her recovery will be the involvement of her family so I would hope that I would try and talk to the family as well and hope that they increase the level of support for the mother. (Paul, Case 3)

The patients' characteristic and situation, which includes taking into considering the patients' age, gender occupation and life circumstances was also mentioned as a factor that influenced treatment and referral decisions (20 times/ 4.83%). For example:

...being a bank manager he would probably be reluctant to, to... change jobs or to make any drastic changes at work where that would interfere with his career, but if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (Zach, Case 1)

The short-term use of medication for control and relief of symptoms or to provide sedation was mentioned 18 times (4.35%). It was mentioned particularly when the presented complaint was difficulty in sleeping. One future GP also expressed prescribing medication to provide immediate relief for the patient who is being referred to psychological therapy: “...the medication would be because until she can get an appointment to see both of them I want to try and help her with her symptoms...” (Lisa, Case 7)

The patients' progress and response to treatment was also mentioned by future GPs (18 times/ 4.35 %). For some future GPs, seeing whether the prescribed medication or initial counselling or assessment session provided by the GP led to improvement of the patients’ symptoms would be evaluated before referring the patient on to a psychiatrist or psychologist were mentioned. For example:

...I would probably give him symptomatic relief with some medications. If that's suitable for him, but first and foremost is the history and find out what's exactly causing it and a referral if it's necessary to a, like allied health workers to help him... (Mike, Case 1)
I'd be inclined to manage it myself initially and then if there didn't seem to be improvement then looking at a, you know, psychiatrist and preferably a more multidisciplinary... theme approach. (Jodie, Case 3)

The (negative) effects of the problem on the family were mentioned quite frequently by future GPs (15 times/ 3.62 %) as a factor that influenced how quickly they would refer their patient to mental health services: “...I’ll probably refer him straight away because he’s tried to strangle her in his sleep...” (Mike, Case 8), and “...the main reason is because he’s a threat to other people and you’ll refer him straight away and see if they can help him out in that way...” (Mike, Case 7). Additionally, the effects of the problem on the family would also lead future GPs to advise the family to be involved in therapy: “...I’d be wanting the whole family ultimately to be part of that intervention...” (Jodie, Case 8).

The patients’ wishes and preference were also mentioned (13 times/3.14%) by the GPs as a factor that influenced their decision to either use pharmacological treatments, counselling or refer the patient to mental health services. For example. “...if he like, doesn’t like going into things like what’s causing, causing him the stress at work and prefers pharmacological therapy, I think I would try to help him in that case.’ (Mike, Case 1)

Patients’ needs were also mentioned (12 times/ 2.89%) as a factor which influenced future GPs’ treatment or referral decisions. For example: “This person needs long term care and he needs a frequent follow up so umm... by referring to a psychologist or counsellor they’ll... have the best management plan for this patient.” (George, Case 2). However, similar to Knight’s (2003) findings, this study found that some of the quotes classified as patients’ needs may be interpreted as more of the doctor’s perception of what the patients’ needs.

The patients’ motivation was mentioned as a factor that determined the patients’ suitability for the type of referral needed and was also mentioned in terms of the predicted
outcomes of the referral (7 times/ 1.69%). For example, future GPs in this study mentioned:

"...I mean if she is ready to, to discuss it, then I think a psychologist could be, psychological
input could be very helpful" (Paul, Case 6) and "...I think he could get quite well in the future
if he goes regularly to his psychologist and wants to be helped I guess." (Mike, Case 2).

The patients’ previous treatment or assessment (5 times/ 1.21%) was the least
frequently mentioned factor. Future GPs mentioned that they would suggest treatments that
were beneficial to the patients previously and would alter the treatment if they have not been
beneficial in the past. As Jodie said: "...because she’s had psychological treatments in the
past, I mean had they been effective then I would be referring her again for that." (Jodie, Case
7)
Appendix H

Other Doctor-Related Factors that Influenced Future GPs’ Management of Patients with Mental Health Disorders

The second most frequently mentioned doctor-related factor was the success of treatment (21 times/ 5.07%). Most future GPs suggested the use of medication first to see if that was beneficial, before referring the patient on to see a psychologist. For example: “...I think that it would be worth trying medication with her first and then if that has no effect, then you could use a adjunct therapy like psychological, like seeing a psychologist or something.” (Lisa, Case 3). However, there were some cases where future GPs perceived counselling to be more beneficial than pharmacotherapy initially:

...I don’t think I would give him his medication straight away I would... probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety. That, yeah I think it would have to be a, a counselling discussion type treatment in his situation... (Zach, Case 1)

The doctor-patient relationship was found to be the third most frequently mentioned doctor-related factor that affected treatment and referral decisions. (14 times/ 3.38%). As mentioned by Sarah and Paul: “...it would be appropriate to start her on antidepressants straight away. If you can trust her enough not to overdose on them or that she won’t try any other means of suicide in the meantime.” (Sarah, Case 4), and “... I’d hope that there will be a good therapeutic alliance so that the patient agrees that a referral to a psychologist would be in their best interest…” (Paul, Case 2). Many future GPs in this study also mentioned that they hope to build good rapports with their patients as it would be easier to talk about sensitive mental health problems. For example “...seeing as I’ve been seeing her for many years I hope that I would have the kind of rapport with her that I could bring up this subject of sexual abuse and to see if... that had occurred...” (Sarah, Case 6).
Needing assessment or advice from a therapist was also mentioned by the future GPs (10 times/ 2.42%). Future GPs mentioned that they would usually phone a psychiatrist for advice when they are unsure of the presenting mental health disorders. For example: “...in all honesty, I’m not sure what this patient may have umm...I’d probably phone a psychiatrist and give him the history over the phone and ask them for their input in this case.” (Paul, Case 8), and “...if I wasn’t sure I would ring the psychiatrist to see if he or she thought she should be admitted. I suppose they’d have a bit more experience with me...” (Sarah, Case 4).

The experience of the future GP was mentioned eight times (1.93%) as a doctor-related. Future GPs in this study have mentioned that they would refer a patient to other mental health services when they had no prior experience in managing certain mental health disorders. For example, as stated by Mike and George: “I’m not sure about this one because he’s a danger to the community in general so you would have to refer him...” (Mike, Case 8), and “...if I don’t have the experience to do it I think it’s worth referring her to a psychologist or counsellor.” (George, Case 4).

The difficulty with particular patients was mentioned by most of future GPs (8 times/1.93%) for cases 4, 5, 6, and 7. Future GPs mentioned that some patients’ presenting mental health disorder would not be completely treated and they may keep presenting over time whether in their GP practice or in other settings. For example: “...it’s hard to expect hundred percent improvements in all parameters...” (George, Case 4) and “...I think two things are going to happen, one he’ll either continue to present or he’ll present somewhere else...” (Paul, Case 5).

Time or availability was a doctor-related factor that was mentioned seven times (1.69%). Future GPs mentioned that they were aware that their time or availability will affect their treatment and referral decisions. For example, Jodie said: “...because the reality is that you’ve... in a general practice you’re not going to have the time to do exposure therapy with
him. (Jodie, Case 2). This future GPs have also mentioned that referral would be the best for the patient if she had limited time as a GP. She said: “...in therapy she’s going to have the privilege of a greater you know, consultation time than she’s able to have with a GP...” (Jodie, Case 4).

Safeguarding career or preventing mistakes was also mentioned as a doctor-related factor (3 times/ 0.72%). A future GP mentioned the need for a follow-up to monitor the patients’ progress to treatment. For example, George said: “...as a safety net you know, always want to see him again... next few weeks to see his improvements.” (George, Case 5)

Obligation to manage the patients presented with mental health disorder was also mentioned 3 times (0.72%); however, by only one out of the eight future GPs. It was mentioned by Alan that: “...you do have a duty of care to help her out as much as you can with the medical issues as well.” (Alan, Case 9).
Appendix I

Other Service-Related Factors that Influenced Future GPs’ Management of Patients with Mental Health Disorders

The second most frequently mentioned service-related factor is liaison or feedback with the mental health service (4 times/ 0.97%). Some future GPs mentioned that they would prefer to liaise with another mental health service to receive feedback about the patient that is being referred. For example: “...liaising with them [domestic violence counselling service] to ensure that he has in fact, followed up on that.” (Jodie, Case 8)

The appropriateness of in-house counselling (4 times/ 0.97%) was mentioned as frequently as liaison or feedback. One future GP, Jodie mentioned that she would refer her patient for in-house counselling if she worked in a practice with an attached psychological service. For example, she said: “...some GP practices have their own... psych services attached so I’d consider that as an option if I happened to be in a GP surgery that had that.” (Jodie, Case 1).

Previous experience with the service was a service-related factor that was mentioned 3 times (0.72 %) by two future GPs. One of the future GPs mentioned that she would not send her patient to the same mental health services that she had had a bad experience with. She said: “So in my experience adult psych services are notoriously bad at looking at the families of their... clients, patients, that CAMHS (Child and Adolescent Mental Health Services) do a much better job of that so I’d be checking out the kids myself and seeing do they need referral.” (Jodie, Case 7).

The quality of service was a service-related factor that was mentioned twice (0.48%). For example, a future GP said that she would send her patient to a private mental health service as public mental health services are overloaded and are unlikely to take patients who are presented only with anxiety symptoms. She said: “I think community mental health...
services are over stretched and are unlikely anyway, to, to be taking a presentation like this...I would be referring him for private because I think that the public system...is overloaded...”
(Jodie, Case 1)

The service-related factor, availability or waiting list was only mentioned once (0.24%) by Sarah. As a future GP, she mentioned that she would refer a patient with anger problems to anger management depending on the availability of the mental health services that can provide that intervention for her patient. For example, she said: “Again I don’t know what services are available, but I’ve heard of things such as anger management so I would ask someone if that’s, if they’re available and I can refer him there.” (Sarah, Case 8).
### Thematic Analysis Based on Sigel and Leiper's (2004) Grounded Theory Framework for Case Vignette 1

<table>
<thead>
<tr>
<th>CASE 1</th>
<th>Component 1: Exploring psychological problem</th>
<th>Component 2: Containing patients' health problem</th>
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<tbody>
<tr>
<td></td>
<td>A. GPs' processes for understanding patient problems</td>
<td>B. GPs' therapeutic activities</td>
</tr>
<tr>
<td>Zach</td>
<td>'...it seemed, the anxiety seems to be just produced from a work situation which... which may mean that... his lifestyle needs to change, his job may need to, to change. He may need to find... ways of relieving that anxiety and, and dealing with it in more appropriate ways.' (Developing understandings) (Picking up cues about mental health problems)</td>
<td>'...I think it would have to be a, a counselling discussion type treatment in his situation...' (Talking therapy activities)</td>
</tr>
</tbody>
</table>
'...being a bank manager he would probably be reluctant to, to... change jobs or to make any drastic changes at work where that would interfere with his career...'(Developing understandings) 

'...if I could help him to, to see that these symptoms were the result of his work, then maybe, hopefully he would either come around to that idea or at least understand the way that the pressures are affecting him and that might help in itself.' (GPs sense of their ability to provide psychological therapies) 

'...I don't think I'd refer him on to anyone at this point if I felt capable of helping him to work through it.' (GPs sense of their ability to provide psychological therapies) 

Mike '...So the first thing I would do is probably get a more comprehensive history from him... (Developing Understandings) in terms of like what's causing him at work to be really stressed, (Underlying agendas why he's being frightened or is very frightened to go to work, how long it's been going for, any past history, anything in his medical history that could be causing it as well. So after

'....and in terms of the symptoms control... after the history and examination and working out what exactly caused it, I would probably give him symptomatic relief with some medications.' (Use of Medication for Psychological problems)
discussion and a full history, try to actually find out what the exact causes and, because there’ll be numerous causes to it. So I would say if it’s an organic cause, *(Evaluating physical symptoms)* you would do investigations to rule out organic causes and then if the, the stress related symptoms from work you could ask him what sort of things in his actual workplace, causes him to be stressed out.* *(Developing understandings).*

Paul

> 'Well first of all I would want to get more of the history about his symptoms *(Developing understandings)*, specifically whether there are other symptoms because the things I’m thinking about are could this patient be depressed, could it, could he have an anxiety related symptom *(Picking up cues about mental health problems)*, could it be both... and I guess I’d try and find out whether there was a clear precipitant to his symptoms...'

| I wouldn’t refer at this stage, I’d feel comfortable, assuming there’s nothing which is too serious, I would feel comfortable in treating the patient in the GP setting.' *(GPs sense of their ability to provide psychological therapies)* |
Lisa  'I’d also discuss with him some techniques that he can use like, to reduce his stress like, so to help with sleeping he could exercise during the day more so than he might be already. Try and talk to him about breathing deeply and stuff.’ (GPs sense of their ability to provide psychological therapies)

Sarah 'Well the first action I think I’d need to take more of a history to find out if there’s something going on at work (Developing understandings) ... like what exactly these pressures at work are and why he feels so under stress (Developing understandings) and also, I guess, if there’s anything going on at home because often patients don’t tell you... everything straight away (Underlying agendas) so there might be...

...would hope that he firstly feels that I was someone he could talk to and come back to if it didn’t get any worse, sorry if it didn’t get any better I mean... and I would hope, if I did give medication that that would make him feel better.’ (GPs sense of their ability to provide psychological therapies)
be more underlying this umm... and then I guess if appropriate...

...I would consider medication in this man because he has come to you asking for medication. I think it's appropriate to respond to what he wants..." (Developing Understandings)

...and also the symptoms that he's got in that his insomnia, anorexia or loss of appetite, is being irritable when he's scared of going to work, so obviously it's having a functional impact. (evaluating physical symptoms)
...the first thing is to confirm a diagnosis by history (Developing understanding) and examination and then you try to... determine the most likely diagnosis in this setting. You can stratify that into psychiatric and non-psychiatric causes so the first would be an anxiety disorder and other non-psychiatric causes. You'd like to rule out organic causes (Evaluation physical symptoms). His symptoms are loss of sleep, loss of appetite, irritable and elements of fear of going to work so you're thinking of any drugs that he's taking, for example is he on intravenous drug usage or if there's any other endocrine disorders for example hypothyroidism and even diabetes in this case, yeah.'(Developing understanding)

... but first thing is my role as a general practitioner is to rule out all causes, also to look out for red flags that may lead to serious disorders that I shouldn't miss in this case. Also it's worth doing a depression screen on this person and see if he's at risk of you know, harming himself, harming other people.' (Caring for psychological problems within primary care)
'Also it's worth doing a depression screen on this person and see if he's at risk of you know, harming himself, harming other people.'  
(Screening tools and protocols)

'He's asking for his medication so that could be one line of treatment for like, some sleeping tablets I guess and there's also other issues going along with that. So probably... I could have a chat with him then and I could also as a GP you'd want to, you could follow up from that and do some counselling, yep, and also possibly refer to a counsellor or a psychologist.'  
(Use of medication for psychological problems)  
(GPs sense of their ability to provide psychological therapies)

'He has come to see you for help and he's obviously presenting with a problem and wants to you to... help him fix it and you just do what your best, do the best you can to do all you can. With your time constraints as well as a GP yeah.'  
(Continuity of relationships with patients)  
(Dependency of patients on GP)
...I would probably discuss it more with him. I'd find out what, what he's currently doing to try and manage. I'd find out about his... like whether there's anything that he can do work wise, to address the pressures. I'd find out about his light sleep habits and practices so if he umm... you know, when is he going to bed, is he using alcohol or coffee or whatever at night. How much alcohol, how much caffeine, any other... medications or any self medication. Ask about exercise and lifestyle kind of issues as well. I would want to explore his relationship a bit more and whether there are issues there.'  
(Developing understanding.)  
(Underlying agendas.)

'Well I hope that I have engaged him adequately and have a sufficiently strong alliance that... that he would be able to weight up the benefits of... therapy versus medication.'  
(Continuity of relationshi p with patients)

...I wouldn't be prescribing umm... benzodiazepines give it or, and would explain to him the nature of those that it's very short term kind of a umm... option and that they, that tolerance and dependence both develop fairly quickly and I would... 'A' be addressing more the kinds of... lifestyle things that, the practical action that he can, can take to manage that. If it was more, if it was a mild kind of moderate sort of presentation so things like you know, cutting down on caffeine and alcohol and whatever, if that... how he's managing it or... and, and you know sorting out his sleep etcetera...'

(Talking therapy activities.) (GPs' sense of their ability to provide psychological therapies.)
'...as far as the actual, being frightened before work in the mornings... just exploring that a bit more so is it that he's having panic attacks or is it just a feeling of anxiety and what is the nature of, of that. To explore that in more detail and also to look at what it is that he’s doing in relation to that umm... so both his kind of thought process and how he’s managing it and... I would be asking what, when he’s, that, asking for medication to control his symptoms, what is it that he understands. What sort of medication is, is he seeking and what does he understand about how those might help... I guess to, yeah, get a clearer sense of, of why he sees that as a means to address it. So in part I guess, it would depend on the information I got back in relation to that. ' (Developing understandings, )

Component 3: Views of psychological problems and psychological therapies

A. Views of psychological problems

Component 4: Referral decisions

B. Views of psychological therapies

A. GPs’ reasons for deciding to refer on

B. Patient suitability for psychological therapies

C. Access
### Mike
"...why he’s being frightened or is very frightened to go to work, how long it’s been going for..." *(Duration and severity)*

"...a referral if it’s necessary to a, like allied health workers to help him... at home socially and to also... maybe help him at work as well..." *(Qualities of outcomes)*

"...if he like, doesn’t like going into things like what’s causing, causing him the stress at work and prefers pharmacological therapy, I think I would try to help him in that case." *(Patient preference)*

### Paul
"I wouldn’t refer yet or if I have to get into the actual cause of what’s... giving him this stress and anxiety and if there’s any other problems" *(Causes of origin)*

"...to me there’s nothing glaringly, based on the information I have, nothing glaringly serious like a, like a psychotic disorder or suicidal thoughts which would require referral to a, to a psychiatrist." *(Problems not referred)*
Lisa: 'I would also recommend he sees a psychologist about having CBT... Because I think that a GP can, like anxiety and depression are very common and I think that a GP can manage them enough, but I do think that they need help from the, from like allied health and stuff.' (Referring because GP at the limits of their capabilities)

'. . . I mean I guess I may refer the patient on to a psychologist under the better outcomes for mental health scheme is one way to do, one option... I think, yeah it really depends on the final diagnosis though, so...' (Referring by Problem type)
Sarah
George  ‘His symptoms are loss of
sleep, loss of appetite,
irritable and elements of fear
of going to work so you’re
thinking of any drugs that
he’s taking, for example is
he on intravenous drug usage
or if there’s any other
endocrine disorders for
example hypothyroidism and
even diabetes in this case,
yeah.’ (Causes of origin)

Alan  ‘It seems like a long term
thing for him, anxiety...’
(Duration and severity)
Jodie

'...he feels empowered to go home and do something immediately that will help and hopefully, he'll take up... the idea of the... therapy or whatever and that I would imagine that a course of that should have good effect.' (Qualities of outcomes)

'If it was more and, and then if there's significant relationship issues etcetera, then I would refer. If there, and also if it seems that it's kind of escalating into more panic related stuff, then I would probably refer for CBT. ' (Referring by problem type)

'...some GP practices have their own... psych services attached so I'd consider that as an option if I happened to be in a GP surgery that had that. I think community mental health services are over stretched and are unlikely anyway, to, to be taking a presentation like this given they tend to take the more severe ones.' (Ways of getting quicker access for patients)
Table J2

Thematic Analysis Based on Sigel and Leiper’s (2004) Grounded Theory Framework for Case Vignette 2

<table>
<thead>
<tr>
<th>Participants</th>
<th>Component 1: Exploring psychological problem</th>
<th>Component 2: Containing patients’ health problem</th>
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<tbody>
<tr>
<td>Zach</td>
<td>A. GPs’ processes for understanding patient problems</td>
<td>B. GPs’ therapeutic activities</td>
</tr>
<tr>
<td></td>
<td>‘It really affects his life, I’m guessing, because a car is very necessary in many, many ways and so I think it’s important that he gets on top of it...’ (Developing understandings)</td>
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</tr>
<tr>
<td>Mike</td>
<td>‘...it can be very debilitating if he’s... if he’s not able to drive the distances that he needs...’ (Developing understandings)</td>
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</tr>
<tr>
<td>Zach</td>
<td>‘...you would have to look at his risk as a driver, like if he’s safe as a driver...’ (Developing understandings)</td>
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<tr>
<td></td>
<td>‘...so I don’t know how old he is... because the older he is the more difficult for him to, to... as a suitable driver, his social circumstances, if he goes to work, if that affects his driving you know how, if there’s family members who can drive him to work. Yeah, just his overall circumstances, see if that’s plausible, possible for him and doesn’t give him too much... like... difficulties, other difficulties causing to work at home, family life and all those sort of things and the, those are the other things that you’ll consider.’ (Developing understandings)</td>
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</tbody>
</table>
Paul: '...I'd hope that there will be a good therapeutic alliance...'  
(continuity of relationship with patients)

Lisa: '...for the meantime they need medicine, medication acts more quickly than the, than the... psychological therapy so you need something to help him now as well.' (Use of medication for psychological problems)

Paul: '...I would hope the patient would agree, I mean I'd hope that there will be a good therapeutic alliance so that the patient agrees that a referral to a psychologist would be in their best interest...'  
(Supporting patients who are referred for psychological therapy)
Sarah: "...he can't drive a car and can't travel in vehicles...this will be having some impact on his life." (Developing understandings)

Sarah: 'I guess he needs some sort of... psychotherapy where he can talk about what happened and be able to deal with the issues that he feels he's still got... and then also to address that he can't drive a car and can't travel in vehicles because this will be having some impact on his life.' (Talking therapy activities)

Georg e: '...this was a simple case of post traumatic stress disorder so this patient definitely has seen a GP, he's seen a psychiatrist and now the psychiatrist recommended a referral to psychological treatment...' (Developing understandings)

Georg e: '...it depends on my experience, my knowledge and the level of my training. If I am a mental health GP I have additional training in psychological counselling, then I'm able to provide treatment for him.' (Talking therapy activities) (GPs' sense of their ability to...
Alan: '...you’ve got to take a full history from him and see what his issues are and, and then you refer him on...' (Developing understandings)

Alan: '...as you’re that patient’s GP you are responsible for that, for him as well. So not just the psychiatrist, yep.' (Supporting patients who are referred for psychological therapy)

Jodie: 'I would need to explore it further, but I guess it’s more PTSD or a specific phobia presentation...' (Developing understandings) (Picking up cues about mental health problems)

Jodie: '...so I guess behavioural therapy or exposure sort of stuff building up to... yeah, so that increased exposure stuff considering the process of going in a car, managing his anxiety effectively in the context of that...so I guess I would, yeah be saying look this is the kind of things that would occur in therapy and it would be you know, useful for you...' (Supporting patients who are referred for psychological therapy)

provide psychological therapies)
Zach 
'Being able to feel calm and then progressing to being in the car, driving in the car, travelling longer distances in the car given... the reliance on... you know cars in daily life that is very debilitating if he's not able to, to manage it.' (Developing understandings)

Component 3: Views of psychological problems and psychological therapies

<table>
<thead>
<tr>
<th>A. Views of psychological problems</th>
<th>B. Views of psychological therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zach</td>
<td>‘As a GP I think I would be able to help... a little bit, but this is... an event that happened two years ago and he's still not over it so I think it's, it's a significant problem.' (Duration and severity)</td>
</tr>
<tr>
<td></td>
<td>‘...I think for a good outcome, he would need to see someone like a counsellor or possibly a psychologist.' (Qualities of outcome)</td>
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Component 4: Referral decisions

<table>
<thead>
<tr>
<th>A. GPs' reasons for deciding to refer on</th>
<th>B. Patient suitability for psychological therapies</th>
<th>C. Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zach</td>
<td>'I think I would refer to... to someone who is better qualified to, to help this man... through maybe exposure therapy or, or some, some cognitive therapy.' (Referring because GP at the limits of their capabilities)</td>
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<td></td>
<td>'I think we could expect a good resolution of, of this man's symptoms. The psychological therapies, exposure therapy and that are quite effective in, in helping him to overcome this sort of thing.' (Qualities of outcome)</td>
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<td></td>
<td>‘...it's probably a problem that would need a fair amount of time and... and... possibly even... one to one work in a car to, to fix it... which I'm not sure that that really comes under a GP's role.' (Referring because GP at the limits of their capabilities)</td>
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</tr>
<tr>
<td><strong>Mike</strong></td>
<td>&quot;...I've seen him before and it looks like it's, like it’s affected him quite a lot' (Duration and severity)</td>
<td>&quot;Depending on how good the psychologist is he could help him out, I think like things like CBT and DBT could help him... those, those sort of things take time...&quot; (What happens in psychological services) (Qualities of outcome)</td>
</tr>
<tr>
<td><strong>Paul</strong></td>
<td>&quot;...his current symptoms are linked to a clear sort of, traumatic event two years ago...&quot; (duration and severity)</td>
<td>&quot;...cognitive and behavioural therapy I think would, could be useful in this case. The main reasons for this are I'd feel reasonably confident that his current symptoms are linked to a clear sort of, traumatic event two years ago...&quot; (What happens in psychological (therapies) (Outcomes for difficult problems))</td>
</tr>
<tr>
<td><strong>Lisa</strong></td>
<td>&quot;...it sounds like post traumatic stress disorder and it, the, and I think that psychological treatment is very important in that, that particular condition.' (Outcomes for difficult problems)&quot;</td>
<td>&quot;...it sounds like post traumatic stress disorder and it, the, and I think that psychological treatment is very important in that, that particular condition.' (Outcomes for difficult problems)&quot;</td>
</tr>
</tbody>
</table>
'...I think the most... the most benefit will come from the psychological therapy...' *(Qualities of outcomes)*

**Sarah**

'...psychotherapy where he can talk about what happened and be able to deal with the issues that he feels he's still got...' *(Coping with psychological problems)*

'...I imagine something like CBT would be appropriate...' *(What happens in psychological therapies)*

'I don't really know I'd need help with that... but I imagine something like CBT would be appropriate, but I wouldn't really know.' *(Referring because GP at the limits of their capabilities)*

'I'd hope that he'd see someone who's got good knowledge about this psychological treatment and that eventually, this patient would get back to being able to either travelling in a car or drive.' *(Type of beneficial changes)*

George

'...this was a simple case of post traumatic stress disorder... either a GP with mental health training who has trained to perform cognitive behavioural therapy or group therapy or even better refer this person to a psychologist or even a counsellor.' *(Referring by problem type)*

This person needs long term care and he needs a frequent follow up so umm... by referring to a psychologist or counsellor they'll... have the best management plan for this patient.' *(Patient characteristics)*

'I'll have a whole pool or list of psychologists with each respective credentials I can refer him to the psychologist for best outcomes.' *(Qualities of outcomes)*
Jodie: 'I guess behavioural therapy or exposure sort of stuff building up to... yeah, so that increased exposure stuff considering the process of going in a car, managing his anxiety effectively...'

(What happens in psychological therapies)

Jodie: '...well in part because of the skills base to do it and the time factor.' (Referring because GP at the limits of their capabilities)

Jodie: 'Hopefully that he can functionally drive a car and feel... yeah, not feel anxious in driving it... for long distances as well as short distances.'

(Types of beneficial changes)
Appendix K

The Results of the Thematic Analysis For Zach, Lisa and George

Case Vignette 1: A Patient Presented with Stress-Related Anxiety Symptoms

Zach. Firstly, Zach would explore the psychological problem by taking patient history to understand more of the patients’ presenting problem and based on the history, Zach would then think about therapeutic therapies, how it would be useful for the patient and in this case and whether he felt competent in treating the patient as Zach said: ‘...I think it would have to be a, a counselling discussion type treatment in his situation...’. In terms of containing the patients’ health problems, Zach mentioned that he would follow-up with the patient as he said: ‘...I would… probably have to book a lengthier appointment to discuss all the ins and outs of his anxiety.’

Case Vignette 2: A Patient Presented with Post-Traumatic Stress Disorder

Lisa. In the management of a patient with post-traumatic stress disorder, firstly, Lisa would treat by prescribing medication first while the patient is being referred to a psychologist. This decision was also part of the component, containing the patient’s health problem. Lisa also said: ‘...it sounds like post traumatic stress disorder and it, the, and I think that psychological treatment is very important in that, that particular condition’. This indicates the decision to refer was due to Lisa’s view that post-traumatic stress disorder is a mental health disorder that may be better managed using psychological therapy.

George. George’s approach was different to Lisa’s as he would first explore the psychological problems in terms of developing understandings of the previous treatments or assessment that the patient has experienced in the past. Secondly, George would think about his own capabilities to provide treatment for this type of mental health disorder as he said: ‘...it depends on my experience, my knowledge and the level of my training. If I am a mental health GP I have additional training in psychological counselling, then I’m able to provide
treatment for him.” According to George, if he was a mental health GP he would treat the patient himself but otherwise, he would refer this patient to a psychologist or counsellor as he viewed this type of psychological problem to be one that would be suitable for cognitive behavioural therapy or group therapy. However, George would firstly take into account whether this patient would be suitable for psychological therapies as he said: “This person needs long term care and he needs a frequent follow up so umm... by referring to a psychologist or counsellor they’ll... have the best management plan for this patient.”
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- Submit a manuscript online

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16. Manuscripts (pp. 1–7, 237–248), not normally to exceed 4,500 words, should be typed on A4 (297 x 210 mm) paper, double-spaced throughout and with margins of at least 4 cm on all four sides. Four copies are required. Duplicated or photocopied copies are acceptable if they closely resemble typed copies. Manuscripts will not be returned to authors.

17. Title page (pp. 7, 8 248–250) for the manuscript should show the title of the article, the name(s) and affiliation(s) of the authors, a running head and, at the bottom of the page, the name and address (including postal code) of the person to whom proofs and reprint requests should be sent.

18. An abstract (pp. 8–11, 250) should follow the title page. The abstract of a report of an empirical study is 100–150 words; the abstract of a review or theoretical paper is 75–100 words.

19. Abbreviations (pp. 80–89) should be kept to a minimum and in particular not be used for "participant" and "experimenter." Full stops are omitted for many abbreviations, for example: cm, kg.

20. Metric units (pp. 105–110) are used according to the International System of Units (SI), with no full stops when abbreviated.
21. Statistics (pp. 15–18, 111–119) should be seen as an aid to interpretation and not an end in themselves. Authors are encouraged to state their rejection rate once (e.g., \( p = .05 \)) and then simply state whether a given statistic is significant or not, by that criterion.

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